One State, One Health System, Better Outcomes

DELIVERING SAFE AND SUSTAINABLE CLINICAL SERVICES

WHITE PAPER
JUNE 2015

Department of Health and Human Services

Tasmanian Government

Foreword

Hon Michael Ferguson MP
Minister for Health

This White Paper outlines a design for a sustainable Tasmanian health system that will provide all Tasmanians with better health services.

I know Tasmanians care passionately about their health system. That is why the Tasmanian Government have undertaken comprehensive consultation with the community and health professionals to design the best health system for the needs of Tasmanians.

The *One State, One Health System, Better Outcomes (One Health System)* reforms recognise Tasmania will be best served by having a single health system with facilities and people networked to achieve high quality, safe, and efficient services.

We are fortunate in Tasmania that we also have a single primary health network and a single university (University of Tasmania). This provides us with an unprecedented opportunity to achieve true health reform supported by a well trained workforce driven by evidence based innovations.

The design outlined in this White Paper focuses heavily on our four major acute hospitals. This does not discount the role and importance of the other parts of the health system, including our rural hospital facilities and the primary and community care sectors. This focus is a reflection of the persistent issues that Tasmania has faced in the delivery of acute hospital services. 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 by 2025.

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.

These reforms will be supported by a $24 million investment in patient transport, accommodation and coordination to ensure that the impacts on patients who need to travel to receive their health services will be minimised.

From July 1 of this year we have established a new single Tasmanian Health Service (THS) with an appropriate and accountable governance structure. This is a vital building block for the system and will be the foundation structure upon which the health reforms can be implemented.

This White Paper outlines the destination. Our task now as a government, through the THS and the Department of Health and Human Services (DHHS) is to cooperatively build the pathways that will take us from where we currently are to that destination.

When it comes to reform, it is never complete. A health system that stands still is a health system that is caught up in facing the challenges of the past. While the suite of reforms reflected in this White Paper 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 self-examination, self-challenge, improvement and redesign.

I look forward to working with the THS, our dedicated staff, and the Tasmanian community as we make that transition journey.

Hon Michael Ferguson MP
Minister for Health

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Executive summary

The *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, complemented by one Tasmanian Primary Health Network (TPHN) and one university (University of Tasmania), including the Faculty of Health and the Menzies Institute for Medical Research. This provides an unprecedented opportunity to achieve true health reform supported by a well-trained workforce, 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 a defined role in the system. This does not discount the role and importance of the other parts of the health system. Rather, it is a reflection 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 and governance 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 or triplication of services resulting in inefficiencies, identifiable service gaps and even some examples of oversupply. It is also a driver of what are reported nationally as the highest costing hospital services in the nation. These issues continue to dramatically limit our ability to deliver the range and volume of services that Tasmanians need.

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. We have achieved this through the development of a Tasmanian Role Delineation Framework (TRDF), informing the mapping of services to determine a valid Tasmanian Clinical Service Profile (TCSP).

This process tells us how to configure our services most 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 quality care (as opposed to simply better access to care without consideration of its quality and sustainability), and
- more efficient services with less duplication, freeing up resources to provide more services that the community needs and cannot currently access.

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

It is clear all 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 decisions in this White Paper that, when taken together, will cement the role of each of our acute hospital facilities by defining their role in a true system or service network:

- 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 and 24-hour emergency services to the local community, as well as playing a vital role in a statewide hospital service network by specialising in elective surgery and subacute care
- the Launceston General Hospital (LGH) will continue as the principal referral hospital for the North and North West of Tasmania. The new THS will strengthen this and the LGH will provide a number of tertiary services. The THS will give greater attention to using the services and expertise at the LGH to support quality services across the North and North West, in some cases for the first time, and
- the Royal Hobart Hospital (RHH) will continue to be the principal referral hospital for the South and will provide a number of tertiary services for the State.

Establishing Tasmania's only dedicated elective surgery centre at the Mersey

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

This reform provides an opportunity to build a dedicated elective surgery centre at the Mersey, supported by specialist surgical staff from across the State. This will be a keystone in improving Tasmania's elective surgery performance. Often in our current system, a hospital needs to cancel elective surgery due to overriding emergencies. By providing a dedicated 23-hour elective surgery service, the cancellation of surgery due to emergencies presenting at the Emergency Department (ED) will be virtually eliminated.

A number of changes at the NWRH and the Mersey will result in a decrease in the complexity of some services provided, on quality and safety grounds. The THS will repurpose the current High Dependency Unit (HDU) at the Mersey over time to support the elective surgical service. This unit will also be able to provide care to critically ill or injured patients who require stabilisation prior to transfer to a larger centre.

23-hour elective surgery

A 23-hour elective surgery is a model of care for elective surgery patients who require no more than one overnight stay. The aim of these units is to provide safe and effective patient care by experienced clinicians skilled in managing short-stay patients for more complex day surgery procedures. In these units, patients can be monitored post-operatively and discharged within 23 hours.

Providing more services across the North and North West

As a result of resources in the North West being utilised inefficiently (such as through employing extraordinarily large numbers of locums at massive cost), there are service gaps in clinical services that impact on large numbers of patients. Examples include pain medicine, rheumatology, neurology, geriatrics, palliative care, and rehabilitation services. As a result, some people are unable to access the services they need closer to home. These are the sorts of services people may require for an extended period of time and unfortunately have been deprived of for many years.

The Mersey will have an enhanced role in providing subacute services such as palliative care, rehabilitation, and geriatric care to the community of the North West. These are all important services that will be vital for maintaining the health 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 in the North West, such as rheumatology and pain management, and provide better access to 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 enhanced cancer services across the North West, including providing the support required to open and operate the new highly specialised radiation oncology service at the NWRH. The Mersey and NWRH will also provide improved care in medical oncology.

Building better, more sustainable services

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

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

The THS will continue to deliver some services on a statewide basis. These are high complexity, low volume services that require significant and specific clinical support, and can only warrant health professionals providing care at one site. These services currently include cardiothoracic surgery and neurosurgery, both of which will remain at the RHH.

There is also a set of services, including cancer services, where there has been ongoing difficulty in managing and delivering stand alone services in the North and North West. When taken as a whole, the greater northern population can support these services. For this reason, the Northern Integrated Cancer Service, operated with the support and experience of the LGH, will provide better integrated services across the North and North West. Together with the development of a critical mass of specialist workforce, the THS will commission the new linear accelerator at the NWRH to provide vital radiation oncology treatment to people battling cancer. This will be supported by enhanced medical oncology services so many more North West patients can receive their full treatment in the North West.

We already utilise interstate expertise for the management of some patients with highly complex conditions, and this will continue wherever the low volumes of certain conditions cannot support the safe or efficient delivery of services locally in order to get the best possible results for our patients.

In some cases, patients are receiving treatment interstate when there is the local expertise to provide it in Tasmania. This leads to increased costs and a potential loss of valuable experience that affects the viability of local services. Further investigation of this will occur to ensure the Government is only supporting interstate treatment when it is not available locally.

The effective transport of patients to and between facilities is, and will continue to be, central to the vision of *One Health System.* This will include the requirement for both emergency transport services (including aeromedical resources and medical retrieval) and inter-hospital transfer. This is why the government has committed to a $24 million package to support transport, accommodation and patient coordination across the State.[1]

In addition, the THS will continue to provide the patient travel assistance scheme (PTAS) to assist patients where they are required to travel to access health care that is not available locally. It will be important for the THS to work with its partners in the private and community sector to assess the availability of intrastate and interstate accommodation and, where possible, negotiate rates to reduce the out of pocket expenses incurred by patients. The reforms will be supported by additional investment in accommodation facilities close to our hospitals.

Supporting the reforms

As the system becomes more integrated and all acute hospital facilities are more effectively utilised, the implementation of these reforms will result in new patterns of movement of both patients and health professionals, particularly across the North and North West.

The reform will be supported by an additional investment in patient transport (emergency and non-emergency), as well as support for families, and initiatives to reduce the need for patients to travel. Doctors, nurses, and allied health professionals will also be supported to travel to provide services closer to where patients live.

[1]Patient Transport Services, White Paper Companion Document, June 2015

Our approach to workforce management is also crucial to the sustainability of the system as a whole. 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, midwifery and allied health workforce, has the potential to provide a more efficient overall health service.

Embedding a culture of research and innovation is key to achieving a high performing health organisation. With the move to a single THS, there is an unprecedented opportunity to maximise relationships with the university and other educational institutions, research bodies, and the primary health care sector to enhance these functions collectively.

eHealth[2] is another essential underpinning building block for an effective, networked system. While we have made some inroads into enabling our information systems, and there are many good examples of pilot projects, we are not currently working as a cohesive whole. There are opportunities to build on the eHealth capability of the system, enhancing the implementation of networked services across the State. Improving the use of telehealth in clinical services and improving the ability to access digital medical records will support better, more efficient services in Tasmania.

Implementing the reforms

Supporting the *One Health System* changes is a governance structure that will provide leadership and stewardship of the health system.

From 1 July 2015 we will have one Tasmanian health system.

This system will have greater accountability and transparency, and be effective, efficient and importantly, participatory. This means Tasmanians will enjoy a single statewide THS that will break down the existing barriers to providing better health services for all Tasmanians.

The TCSP provides us with a destination for the first suite of clinical service reconfiguration. The task now is for the THS to identify and develop pathways that will most efficiently and practically lead us to that destination.

The reforms outlined in this document will take a number of years to fully implement.

While some of the changes identified will be able to be implemented quickly, there is still a lot of work to be done, consultation required with staff and the community as well as a change management process that need to be undertaken within the health services before some of the plan can be implemented.

This will require the ongoing participation of everyone that has direct contact with the health system including clinicians, consumers and community members, DHHS, the TPHN, the University of Tasmania, and the Government.

[2]eHealth refers to the use of information and communication technology (ICT) in the health system. In a broad sense, it includes electronic systems, processes, infrastructure and health information. It includes 'telehealth' facilities, for example, which are essentially secure videoconferencing facilities used to coordinate, manage and deliver patient care

Introduction

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

The reforms are about doing more with our current resources. They are about improving the safety, quality, and range of public health services by targeting inefficiencies we know are in our current system.

In September 2014, the Tasmanian Government released an Issues Paper to prompt community discussion on the challenges 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.

The Government then released an Exposure Draft of this White Paper on 31 March 2015, outlining a health reform package aimed at delivering improved safety, quality of services, and greater efficiency. Once implemented, the reforms will deliver improved patient support and access to higher quality services within the resources that are available.

Submissions to the Exposure Draft of the White and Green Papers, including those from the Clinical Advisory Groups (CAGs), have identified a significant number of potential improvements to specialty services. The Department has captured many of those relevant to the TCSP. 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.

This White Paper represents the outcomes of this significant consultation process.

1. 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, the Green Paper, and the Exposure Draft of the White Paper, the community and clinicians have overwhelmingly told us they support change in the system.

1.1 Tasmania's health status

The health of Tasmanians is improving, with longer life expectancy and better self-reported health than a few years ago. Tasmania has made progress 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.

Life expectancy

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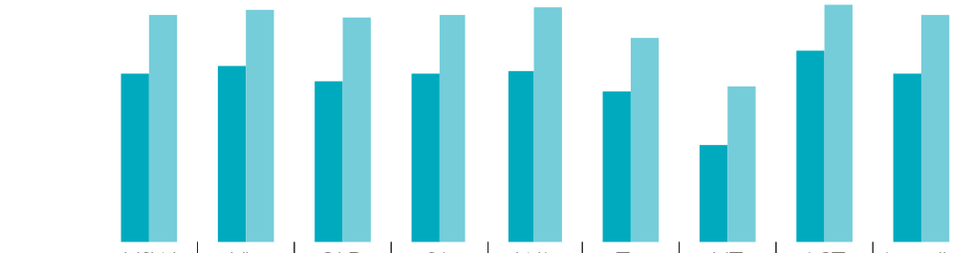


	NSW	Vic	QLD	SA	WA	Tas	NT	ACT	Australia
Males	80.0	80.7	79.6	80.0	80.3	78.8	74.9	81.7	80.1
Females	84.3	84.7	84.1	84.3	84.8	82.6	79.2	85.0	84.3

Figure 1.1.1: 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 20 per cent of 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, with 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 nine 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 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, we need to take action 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 or government.

The challenge

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.

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.

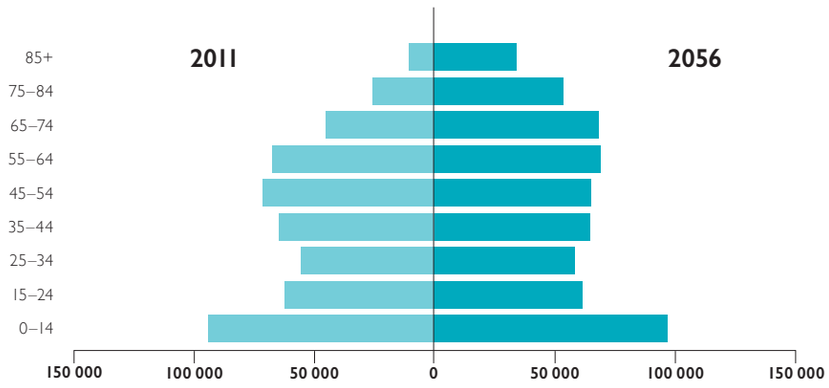


Figure 1.2.1: Population Projections 2006-11 *Source: ABS Population Projections 2006-11*

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

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 heath 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.

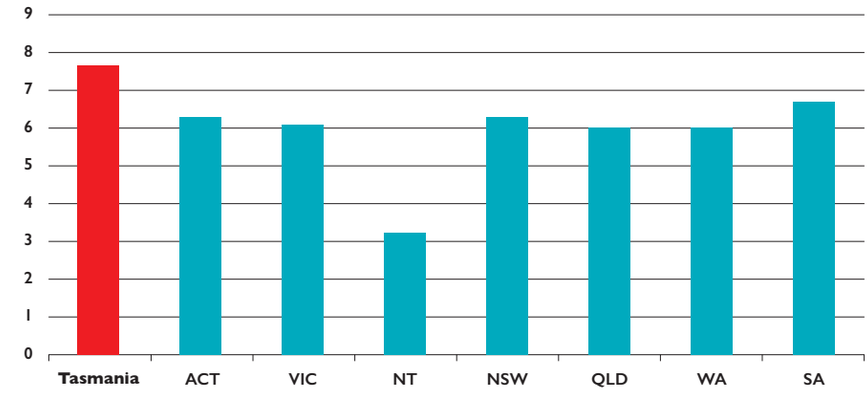


Figure 1.3.1: Adverse Events per 1 000 Separations *Source: Department of Health and Human Services*

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 systemic failures in safety and quality. Patients are experiencing harm, sometimes resulting in potentially avoidable death.

The costs of delivering services in our acute hospitals are higher in Tasmania than other states, the North West in particular. The two North West hospitals are the most expensive hospitals in Tasmania to provide health services. This has a negative effect on what range of services are also to be offered. The figures below illustrate the increased costs at the NWRH.

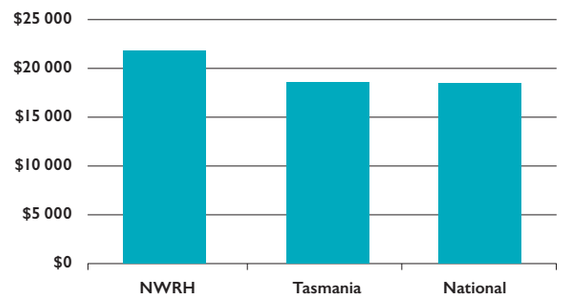


Figure 1.3.2: Cost Comparison – Knee Replacement

Source: National Hospital Cost Data Collection, 2012-13

Medical staffing costs in the North West are very high. The North West region currently spends around $16 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. This is more than double the expenditure on locums in the North and four times that in the South.

Thirty nine per cent of the FTE medical staff establishment at the Mersey in 2014-15 was filled by locums compared to 15 per cent at the NWRH.

In addition to the direct cost of the locums that is up to $2 500 a day, there are significant additional expenses with payments to locum agencies, airfares, cars, and accommodation support. These additional costs add up to around $3 million in the North West in one year alone.

Through greater collaboration across the regions we can reduce these unnecessary costs so we can invest in better services for all Tasmanians, including new services in the North West that have been lacking for too long.

These are examples of the significant body of evidence that, when taken as a whole, clearly demonstrates the compelling 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 2011-12[3].

[3]Report of the Commission on Delivery of Health Services in Tasmania – April 2014

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 the THS need to take to achieve that outcome.

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 TRDF for clinical services and the application of this framework to develop the TCSP of each of our clinical services in each hospital campus.

The Department undertook the development of the TRDF and TCSP 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, and
- 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 cannot 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, 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 cardiothoracic surgical service with surgical care delivered at the RHH but outreach support provided to all sites for the clinical management of patients where cardiothoracic 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. The State Government has delivered this through the development of the TRDF, and followed by the analysis of the services to determine the optimal current clinical service profile.

Tasmania's Health System Profile

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

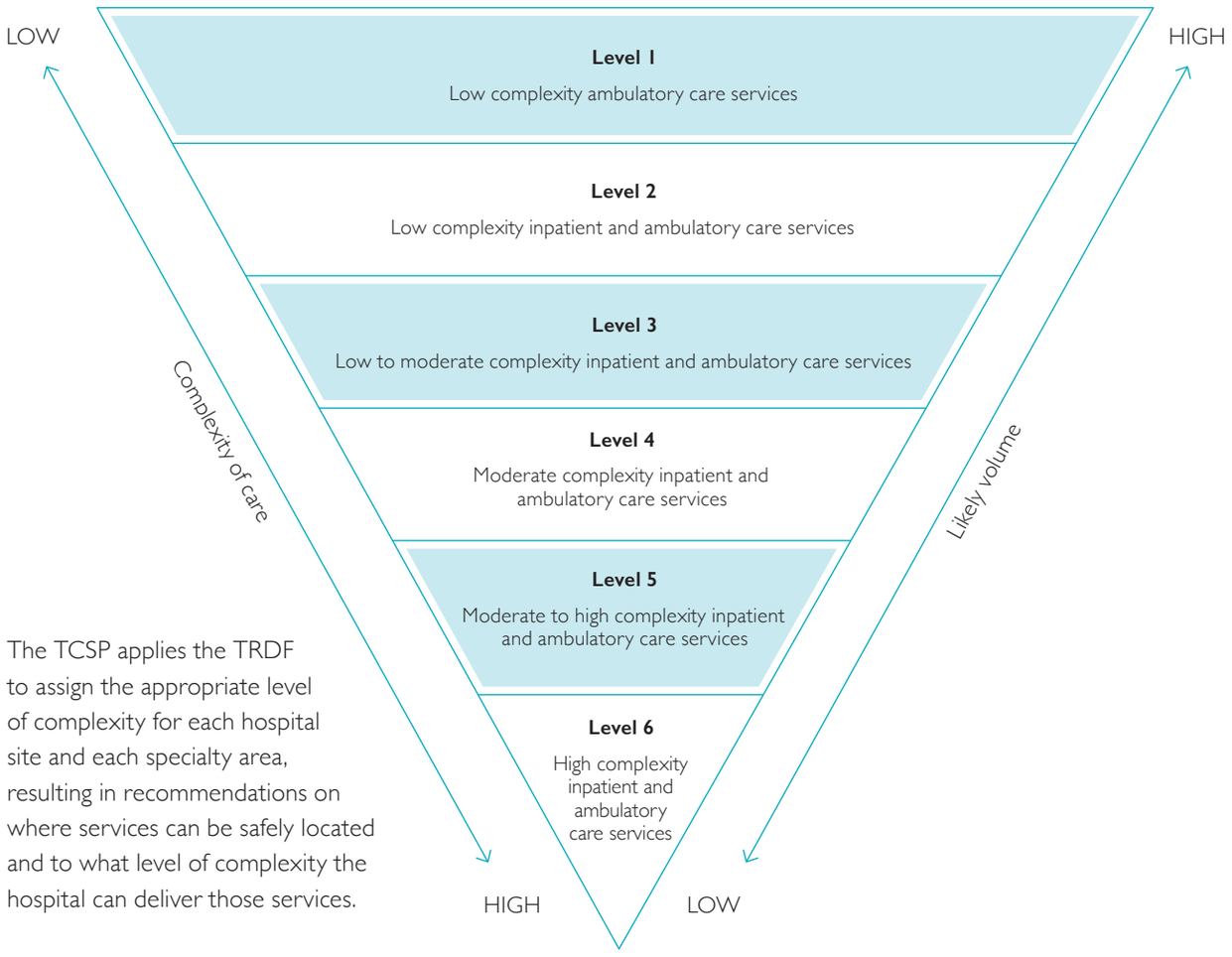
It recognises that for each level of clinical service provision, corresponding clinical support and staff profiles are required to ensure services are delivered in a safe, efficient and appropriate manner. The volume of activity is also an important factor in determining the appropriate level of service.

The Department developed the TRDF through utilising best available evidence, including consultation with Tasmanian clinicians.[4]

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.

[4]Tasmanian Role Delineation Framework

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 the hospital can deliver those services.

Tasmanian Clinical Services Profile

The level assigned to each hospital needs to be read in conjunction with the level of complexity outlined in the TRDF.

	RHH		LGH		NWRH		Mersey	
	Current	Future	Current	Future	Current	Future	Current	Future
Emergency Medicine	6	6	5	5	4	4	3	3
Medical Imaging Services	6	6	5	5	4	4	3	3
Pathology	6	6	5	5	5	5	4	4
Pharmacy	6	6	5	5	3	3	3	3
Trauma Services	5/6	6	5	5	4	4	3	3

Level 6 Pathology Service description

A level 6 service provides services at level 5 plus sub-specialty services and a statewide referral role complex, highly specialised and sub-specialty pathology services. This level of service can be provided by a category GX accredited pathology laboratory.

The decisions 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, and
- safety and quality – risks to the patient, organisation, and system.

The TRDF that underpins the TCSP is a living document and will be updated from time to time to reflect significant changes in technology or resource allocation across the network or when new services or new frameworks are developed and endorsed. Likewise, service levels within the TCSP are under active consideration and, where there is resource and statewide service consolidation issues, the Department will discuss these with the THS as part of the implementation strategy.

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 service changes that have been identified through this process that would make the system safer and more sustainable within the resources currently available. We have outlined these changes below in two ways:

1. specific service issues that have been identified as requiring change, and
2. specific 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 located at: www.onehealthsystem.tas.gov.au

The TCSP is provided at page 87.

2.2 Key service issues

The Department has identified a number of services where key changes are required to ensure the State is delivering evidence-based, high quality and safe care. They include:

- integrated surgical services
- integrated cancer services
- trauma and critical care services
- subacute care services
- maternity and neonatal services
- burns services, and
- mental health services.

2.2.1 Surgical services

All four of the acute public hospital sites currently provide surgical services. 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 percent 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.

The reforms will create an integrated northern surgical service managed from the LGH and operating across the North and North West to increase access to specialist services in the North West, and reduce the disparity in costs between the NWRH, Mersey, and LGH. The disparity can be addressed through having a more stable and consistent workforce and creating efficiencies in delivering the service through managing the service from one site rather than three.

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, 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 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 facilities[5] will also be promoted so that patients can access health services without having to leave their home or local community.

[5]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'

In addition to the continuation of core services such as emergency care, the THS will develop the Mersey as a dedicated elective surgery centre. This service will be developed over time as a 23-hour elective surgery model allowing for up to 70 per cent of the range of possible surgical activity to be undertaken at the Mersey. This means that the majority of existing surgery undertaken at the Mersey will continue and that additional elective surgery services can be provided to patients from around the State.

This will serve to:

- help to reduce unacceptable waiting times for surgery by expanding elective surgery at a dedicated facility that will not be subject to interruptions caused by emergency surgery
- increase both the safety and efficiency of elective surgery performance, by concentrating a greater proportion of elective surgery at the Mersey, consequently increasing the critical mass of services and introducing economies of scale
- maintain a broad range of staff skills and contribute to retention
- increase capacity in other sites for performing more complex surgery by moving less complex cases to the Mersey, and
- accommodate targeted short term investment to improve elective surgery waiting times in areas of high demand.

The profile of elective surgery procedures to be undertaken at the Mersey will be developed in consultation with relevant surgeons across the State and supporting clinical staff at the Mersey. Factors that will be considered in redirecting elective surgery to the Mersey include:

- reducing the current requirement for North West patients to travel for elective surgery
- targeting procedures that have surgical preparation requirements consistent with travelling
- ensuring surgical staff can be dedicated to the service without compromising the capacity to support emergency procedures at large hospitals, and
- maximising the efficiency of theatre and bed utilisation at the Mersey and other hospitals, including reducing the cancellation of procedures due to emergency surgery or staff and bed availability.

Work has commenced on the strategy to develop a dedicated elective surgery centre at the Mersey.

There will be statewide access to some surgical services that will be provided at the larger hospitals such as the RHH or LGH. These are very highly complex, 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 will remain at the RHH.

We already utilise interstate expertise for the management of some patients with highly complex conditions, and this will continue wherever the low volumes of certain conditions cannot support the safe or efficient delivery of services locally in order to get the best possible results for our patients.

In some cases, patients are receiving treatment interstate when there is the local expertise to provide it in Tasmania. This leads to increased costs and a potential loss of valuable experience that affects the viability of local services. Further investigation of this will occur to ensure that the Government is only supporting interstate treatment when it is not available locally.

The RHH and the LGH currently provide high complexity upper gastrointestinal surgical services. The Tasmanian Statewide Surgical Services Committee (TSSSC) has provided advice that the best configuration for these services is through a single statewide service, with a statewide lead, but operating from two sites (RHH and LGH). The RHH will be the site for the highest complexity cases in the State, given the availability of support services. The core feature of this new service would be the systematic management of cases via a statewide Multidisciplinary Team (MDT) meeting model.

Under this model, the highest complexity cases would be discussed at these meetings and decisions made on the most appropriate location for individuals to receive surgery.

The THS will undertake further work on this model to determine the feasibility and sustainability of the proposed service in relation to service volumes and number of proposed consultant surgeons required to manage a service at two sites.

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.

Many clinicians have identified the inefficient management of patients and patient records as a significant contributor to avoidable surgical costs. Similarly, inefficiencies in patient changeover can result in delays and underutilisation within the public hospital theatres.

Improving the management of surgical theatres will both improve the outcomes for patients and reduce the costs for the public health system. The THS and DHHS will redirect these costs to provide increased volumes of surgery, thereby reducing waiting times further.

The increased utilisation of the Mersey for dedicated elective surgery procedures will reduce the pressures on theatre services at the LGH, NWRH and RHH, and reduce the competition for theatre time 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 dedicated elective 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. During 2006-10 in Australia, the five-year relative survival rate was 66 per cent for all cancers combined.[6]

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 designed to deliver accessible high quality treatment 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, all four of our major acute hospitals deliver cancer services.

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

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. These services currently comprise around 20 per cent of all claims under the patient travel and assistance scheme.

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.

[6]AIHW and AACR (2012). Cancer in Australia: An overview 2012. Canberra: AIHW

Developing integrated cancer services

Access to high quality cancer services equipped to deliver services into the future depends on an integrated service 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.

The Southern and Northern Integrated Cancer Services will deliver cancer services. These services will work together on maintaining a statewide model of care for cancer services that delivers better outcomes for all Tasmanians.

The THS will develop a Northern Integrated Cancer Service 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. It has the potential to reduce the number of trips undertaken to the LGH by residents of the North West by up to 7 500 a year.

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: Future clinical services profile

		Northern Integrated Cancer Service		
	RHH	**LGH**	**NWRH**	**Mersey**
Medical oncology	6	6	5	4
Radiation oncology	6	6	5	No level
Haematology	6	5	4	4

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 Launceston 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	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.

However, some capabilities are unsustainable at State level (e.g. some pelvic fracture reconstructive surgery, some sub-specialty paediatric, or neonatal trauma and burns). These will need referral to larger interstate centres.

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

The Department has established a CAG to provide advice on the optimal configuration of trauma services across the State. The Trauma and Burns CAG 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.

The TCSP acknowledges 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.

The Government's $24 million investment in patient transport includes provision to establish a dedicated retrieval and referral service. Senior clinical staff will be employed to improve leadership and coordination of the service and the capacity will be built to establish a statewide trauma registry.

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: Future clinical services profile

	RHH	LGH	NWRH	Mersey
Trauma	6	5	4	3

2.2.4 Critical care services

The current TCSP for emergency and intensive care services provides that high complexity services are to be delivered from the LGH and the RHH. Lower complexity services are to be 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.

The NWRH and Mersey currently provide 24-hour ED services. Advice from clinicians indicates the complexity of cases currently taken to the Mersey via ambulance is too high for the ED and associated support services available on site.

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

From 2009-13, 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. Patients admitted to an ICU/HDU in the North West region compared to those in other regions has a shorter average length of stay and a lower average number of comorbidities. This is a reflection that many patients currently being managed in ICU in the North West are of lower acuity and 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.

The 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: Future clinical services profile

	RHH	LGH	NWRH	Mersey
Emergency	6	5	4	3
ICU/HDU	6	5	4	Post-operative support unit

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. While 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, where early time-critical intervention has been shown to be of benefit, may be stabilised at the Mersey prior to transfer, and
- 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.

These changes to the ED at the Mersey will ensure the local community will continue to be able to access 24-hour urgent care when required and 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 reduce waiting times for those accessing the lower acuity services at the Mersey, and ensure those requiring higher level care will be able to access the necessary support services in the larger centres.

The Mersey will still require the capability to assess and stabilise higher acuity cases, because despite all efforts to send patients to the right ED for their needs, there will always be some walk in patients.

As the TCSP changes, the THS will repurpose the current HDU at the Mersey over time to support the elective surgical service. This unit will also be able to provide care to critically ill or injured patients who 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 in emergency situations. However, patients who are assessed as requiring ICU admission because of an elective surgical procedure or who require prolonged ventilation will receive their care at a higher level site.

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

- improved emergency transport services through an additional paramedic crew in peak hours based in Devonport
- 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

  - this policy will reflect the role delineation of the hospitals. Patients will 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
- more resources for non-emergency patient transport
- an investment in accommodation 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, and
- an enhanced bus or other transport service so families can visit their inhospital relative easily. This is important in the North West as travelling out of area is already a significant financial burden.

These transport improvements can be found in detail in the companion document to this paper *Patient Transport Services.*

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 ED 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 38 dedicated rehabilitation beds, while the South with a similar population has 62 beds. The North West has 12 dedicated beds based at the NWRH. There have been ongoing difficulties in recruiting and maintaining a workforce in this region. Both public and private hospitals provide inpatient subacute care. Subacute 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 psycho-geriatric care are largely provided in public hospitals.

In Tasmania, particularly in the North West, subacute care service 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, and
- combined with Tasmania's lower overall hospitalisation rates, this 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 seven per 1 000 head of population.

The South provides most Tasmanian inpatient subacute care. During 2007-08 to 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).

The interface between specialist services in the acute hospital system and primary care services is particularly important in the provision of palliative care so the patient can access care and support appropriate to their needs, at the right time and as close to home as practicable. The review of the current palliative care service delivery model being undertaken through the Better Access to Palliative Care Program (BAPC) and the development of a Strategic Plan for Palliative Care will both inform the development of palliative care health services statewide, as well as any further refinements of the TRDF, including determining appropriate support service levels.

Table 1: Current clinical services profile

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

*Level 6 service provided interstate

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

***Services purchased from the private sector

Table 2: Future clinical services profile

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

*Level 6 service provided interstate

**Palliative Care service level determined by the National Palliative Care Role Delineation Framework – the TCSP for palliative care services in acute hospitals will be informed by the release of the BAPC Program

***Services purchased from the private sector

The 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 and allied health 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 North West. Nurse led MDTs will deliver overnight subacute services and care.

2.2.6 Maternity and neonatal services

The four major acute hospitals take the lead in providing maternal and neonatal services and supporting maternity care that is available in rural areas and in the community more broadly.

Maternity care in Tasmania is provided by registered health professionals in the public and private sector.

Maternity services

Maternity care in Tasmania is provided by registered health professionals in the public and private sector. Health professionals include obstetricians, midwives and general practitioners.

Current models of care provided in Tasmania include:

- obstetric led care, as a private service of in circumstances where the pregnancy requires medical care
- 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. Care is provided in the woman's home, in the community and in hospitals, and
- GP and obstetrician team-based shared care.

Table 1: Current clinical services profile

	RHH	LGH	NWRH	Mersey
Maternity services	6	5	4	4

The Mersey and the NWRH, via a private provider, currently provide maternity services in the North West. Approximately three-quarters of these births occur at the North West Private Hospital (NWPH).

There have been numerous reviews of maternity services in the North West.[7] All of these reviews have identified a need to change the way that the services are delivered in order to provide a stronger, higher quality birthing and maternity services. These recommendations are based on:

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

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

Maternity services can be considered in two groups: activity that occurs in the hospital (birthing and inpatient maternity services), and care that occurs in the community (outpatient antenatal and postnatal services). While a significant period of time is spent by mothers and babies accessing antenatal and postnatal services, the greatest risks are associated with birthing and inpatient maternity services.

Antenatal and postnatal services in the North West will continue to be delivered in the community and at multiple sites and work will be undertaken to maximise access to these services, including through greater levels of midwife led outreach and home visits after the birth. Work will also continue on implementing and expanding 'continuity of care' models, where mothers receive support from a dedicated midwife throughout their antenatal, birthing, and postnatal care.

The decision on consolidating birthing and inpatient maternity services to a single location was made on consideration of the following factors:

- capacity to deliver a safe and quality service that meets current and future demand
- capacity to deliver service volumes and scope of practice to attract and retain suitable medical, midwifery, and other clinical support staff
- accessibility of the service, including distance travelled and available of transport options for mothers and their families
- capacity to be integrated with, and support a broader maternity model of care throughout the State, including integration with antenatal and postnatal services across the North West Coast
- availability of emergency, critical care, and other support services, and
- sustainable use of resources.

[7]Reforms for the 21st Century, Richardson, 2004; Obstetrics and Midwifery Services Report to Government, Kathy Alexander, 2004; Tasmanian Health Plan, Primary Health Services Plan Heather Wellington, May 2007; NW Maternity Services Review, October 2009

Considering the above factors, the Government has decided to consolidate birthing and inpatient maternity services to Burnie. Decisions on reforming maternity services on the North West coast are long overdue. They have been avoided for many years, leaving good staff trying to deliver an unsustainable service. This decision was made on the basis that:

- consolidating birthing and inpatient maternity services to one site is necessary to attract and retain obstetricians, to ensure a safe and sustainable roster of on call support staff such as anaesthetists and paediatricians, and to provide an overall increase in the volume of services that will support the associated neonatal service
- consolidating midwifery and obstetrics services in the North West enables a collaborative working partnership between midwives and obstetricians. This model enables women to make choices about their care, while retaining a robust clinical governance framework. This approach would allow midwifery led group practices or other contemporary midwifery led services to be developed over time
- while consolidating services to Burnie will increase the travel requirement for mothers and their families from Devonport, Latrobe and surrounding areas, the alternate option to consolidate services to Latrobe would have a great impact on a larger number of people needing to access services from the west of Ulverstone, including the far North West and West Coast areas, and
- consolidation of services to Burnie provides the greatest opportunities for providing support through access to the ICU, acute general medicine, anaesthetics, paediatrics, and other support services.

Consolidating the birthing and inpatient maternity services to Burnie will mean the combined NWRH and North West Private Service will continue at level 4 and the Mersey will provide a level 1 maternity service. Antenatal and postnatal services will continue to be delivered at a range of locations across the North West including in Burnie and at the Mersey.

There are complexities in the current way services are delivered in the North West, including a private contracted model at the NWPH and physical capacity issues that will have to be considered before more detailed decisions can be made on whether the service is in the NWPH or is established at the NWRH. The final service profile for a consolidated birthing and inpatient maternity service will have to meet a number of essential criteria, including that the service is:

- safe and of high quality with robust and transparent monitoring and reporting arrangements
- fully integrated with broader maternity services both in the North West region and across the State, including governance that is consistent with the governance of maternity services
- efficient, and
- accessible.

All arrangements for the consolidation of the service, including contractual and industrial arrangements, will be finalised before the THS makes any changes to existing services. Women and their families across the North West will be kept informed of any changes well in advance of any change in service configuration.

There is some evidence to suggest that bacteria associated with poor dental health may contribute to premature births and low birth weights. There is strong evidence to suggest that if a mother has poor oral health this impacts on her child's oral health in the formative years. A trial will be conducted across the North West to improve mothers' oral health by providing priority access to oral health services for eligible pregnant women. If successful, the THS will consider extending the policy to other areas of the State.

Table 2: Future clinical services profile

	RHH	LGH	NWRH	Mersey
Maternity services	6	5	4	1

Neonatal services

Neonatology services provide a range of care to healthy infants through 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 services profile

	RHH	LGH	NWRH	Mersey
Neonatal services	6	5	4	3

There is a *National Maternity Services Capability Framework* that outlines service capability for neonatology. Tasmania, along with other jurisdictions, has signed up to this Framework.

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 North West will provide care to infants greater than or equal to 34-weeks' gestation at the site of the level 4 maternity service
- the LGH will provide care to infants greater than or equal to 32-weeks' gestational age, and
- the RHH will continue to provide a level 6 neonatal service to premature infants at less than 28-weeks' gestation.

In-utero transfer (transfer of pregnant women) should occur when there is a risk of delivery below these thresholds, and when this is clinically and logistically possible. When this is not possible and the neonate is under the transfer criteria threshold, clinicians will apply discretion to the decision to transfer, dependant on the condition of the neonate in consultation with a neonatologist.

Clinical guidelines will be developed to inform the implementation of the changes.

The Tasmanian data for outcomes for infants born at less than 28-weeks' gestation has been reviewed and will continue to be monitored, as previously, through reporting to the Australian and New Zealand Neonatal Network and to the Tasmanian Council of Obstetric and Paediatric Mortality and Morbidity. The care of extremely preterm infants is particularly complex and outcome data will continue to be interpreted in this light. The Tasmanian Neonatal and Paediatric Intensive Care Unit, and the Neonatal, Paediatric and Perinatal Emergency Transport Service will continue to be supported to maintain a high standard of care for infants, children and their families.

The implementation of these changes will be supported by improvements in patient transport services, including the neonatal emergency transport service, and support for parental accommodation.

Table 2: Future clinical services profile

	RHH	LGH	NWRH	Mersey
Maternity services	6	5	4	No level

2.2.7 Burns services

All four acute hospitals currently treat burns. The RHH has a well-established burns unit. Northern and southern Tasmania both have highly developed plastics and reconstructive surgical services able to manage complex burns, while the North West hospitals can only manage low complexity burns as they do not have the necessary support services available.

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, required a review of the current service model.

Health professionals specialising in burns from around the State have worked to determine the best service delivery model for Tasmania as a whole.

As a result of these discussions, a single burns system for the State will be established. Services will provided from the major hospital sites in accordance with agreed protocols and coordinated through the RHH.

By working as a cohesive statewide service, there is the capacity within the State to manage the majority of the burns caseload effectively, with the requirement for only very highly complex patients to be transferred to an appropriate interstate service for treatment and management.

Uniform statewide criteria will be utilised to determine appropriate referral and transfer within the system, supported by communication between consultant specialists.

Significant work has been undertaken by the TSSSC to determine the detailed referral and transfer criteria with agreement reached on the criteria for interstate referral. Further work remains on determining the detailed intrastate referral criteria. These will be developed in the coming months utilising experts in burns management.

2.2.8 Mental health services

Mental health services in Tasmania are currently the subject of the comprehensive Rethink Mental Health project. The focus of this project is to develop an integrated Tasmanian mental health system that provides support in the right place, at the right time, and with clear sign posts about where and how to get help.

The Tasmanian Government is working in partnership with the Mental Health Council of Tasmania to progress this important work.

As part of this work, an extensive consultation process has been undertaken from October 2014 through March 2015. Information and feedback gathered through this process is currently being analysed and will help to inform the development of a long-term plan for mental health in Tasmania.

The TRDF describes different levels of mental health services and the requirements, minimal staffing needs, and clinical support services required within each level.

Table 1: Current and proposed clinical services profile

	RHH	LGH	NWRH	Mersey
Mental health inpatient services	6	5	5	3

The interface between services in the acute hospital system and community services is particularly important in the provision of mental health care. This continuum of care is being considered through the current processes.

There are no current proposed changes to the adult acute hospital clinical services profile around the State.

While acute mental health inpatient services will continue to be provided at the LGH at level 5, 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.

The Rethink Mental Health project will inform the development of statewide mental health services.

Child and adolescent mental health services (CAMHS)

The mental health needs of children and adolescents are also being considered through the Rethink Mental Health project. However, there is a significant awareness about current service shortfalls and it is clear services need to be improved.

Table 1: Current clinical services profile

	RHH	LGH	NWRH	Mersey
Child and adolescent mental health acute inpatient services	4	3	3	No level

The RHH Redevelopment will establish an adolescent mental health unit. This unit will have the capacity to provide inpatient mental health services to adolescents in an appropriate environment. This will allow the RHH to establish a level 5 service that is the basis for a statewide model of care for the delivery of psychiatric services to child and adolescent patients and their families and carers, from around the State.

The LGH service will increase to a level 5 service to provide inpatient services to patients of the North and North West.

Table 2: Future clinical services profile

	RHH	LGH	NWRH	Mersey
Child and adolescent mental health acute inpatient services	5	5	3	No level

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 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.[8]

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. The THS will provide greater attention 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.

[8]Report of the Commission on Delivery of Health Services in Tasmania – April 2014

Service	Current Service Profile	Future 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.
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.

Service	Current Service Profile	Future Service Profile	Benefits
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	The LGH currently provides a rheumatology service. This service is ambulatory and is provided by a multidisciplinary team, led by a specialist medical practitioner with subspecialty training in rheumatology.	There will be a level 5 service provided at the LGH.	This change will improve access to specialist treatments for rheumatological for people in North and North West Tasmania.
Pain management	The LGH currently provides a pain management service. This service is ambulatory and is provided by a multidisciplinary team, led by a specialist medical practitioner with subspecialty training in pain management services.	There will be a level 5 service provided at the LGH.	This change will improve access to specialist treatments for pain conditions for people in North and North West Tasmania.
Surgical services	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 to increase access to specialist services in the North West, and reduce the disparity in costs between the NWRH, Mersey and LGH. High complexity upper gastrointestinal surgical services are currently being provided at both the RHH and the LGH. The TSSSC has provided advice that the best configuration for these services is through a single statewide service, with a statewide lead, but operating from two sites (RHH and LGH). The RHH will be the site for the highest complexity cases in the State, given the availability of support services.	Consolidating some high complexity 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.
Oral health services	The LGH currently provides a level 3 oral health service, which includes general community dental services by registered dentists.	This service will be increased to level 4.	This will address the considerable inequity between regions in terms of waiting times and types of care provided. The increase in level would also support the development of increased service access across the North West.

Service	Current Service Profile	Future Service Profile	Benefits
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. Babies born at less than 32-weeks' will receive care at the RHH (Neonatal and Paediatric ICU service). In-utero transfer of neonates should occur where there is a risk of delivery below these thresholds when this is clinically and logistically possible. When this is not possible and the neonate is close to the transfer criteria threshold, clinical discretion should be applied to the decision to transfer dependant on the condition of the neonate, in consultation with a qualified neonatologist.	This will ensure there are greater support services available for these babies if their care needs become more complex.
Mental health inpatient services	The LGH currently provides a level 5 inpatient mental health services. There is significant regional variation in inpatient service provision for peopel receiving mental health treatment.	This service will remain at level 5. 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.	The development of enhanced subacute services at the Mersey will mean people in the North and North West will have better access to locally enhanced mental health subacute services.
Child and adolescent mental health inpatient services	Currently a level 3 service.	This service will increase to level 5 and will provide inpatient services for residents of the North and North West.	This change will increase the availability of inpatient services locally for residents of the North and North West.
Geriatric services	The LGH currently provides a level 4 geriatric service, which provides inpatient care by a specialist geriatrician and physicians practicing in general medicine.	This service will be increased to level 5. Acute geriatrics services will be delivered at the LGH and across the North West. 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.	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.

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.[9]

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. This 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	Future 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. However, patients who are expected to 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. This will lead to a more sustainable service with higher volumes of patients.

[9]Report of the Commission on Delivery of Health Services in Tasmania – April 2014

Service	Current Service Profile	Future Service Profile	Benefits
Cancer services	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.	A northern regional cancer service will be established that will administer integrated cancer services across the North and North West, managed from the LGH. Upon commissioning of the linear accelerator at the NWRH, there will be a level 5 radiation oncology service at the NWRH.	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 and address service gaps. The establishment of a Northern Integrated Cancer Service will enable the THS to commission the new linear accelerator at the NWRH using shared staff delivering services across the entire north of the State.
Neurology services	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.	This service will increase to level 4. Higher level services will provide increased visiting specialist neurology services to the NWRH.	People in the North West who have neurological conditions, particularly those with multiple sclerosis, Huntington's disease, and motor neuron disease, will have shorter waiting times to access specialist services, with a consequent improvement in outcomes.
Acute stroke services	The NWRH currently provides a level 4 service.	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 subacute stroke services at the NWRH and the Mersey. We will review the capacity to develop a stroke unit based on the volume of services that are provided from the NWRH. This would require level 5 capability.	People in the North West who have neurological conditions, particularly those with multiple sclerosis, Huntington's disease, and motor neuron disease, will have shorter waiting times to access specialist services, with a consequent improvement in outcomes.
Rheumatology	No current service.	This service will be established at level 4. Higher level facilities will provide visiting specialist rheumatology services. This service will be provided on an outpatient basis by a multidisciplinary team, led by a specialist medical practitioner with subspecialty training in rheumatology. The service will be supported through telehealth.	This change will improve access to specialist treatments for rheumatological conditions for people in North and North West Tasmania.

Service	Current Service Profile	Future Service Profile	Benefits
Pain management	No current service.	There will be a level 4 service provided. Higher level facilities will provide visiting specialist pain management services. This service will be provided on an outpatient basis by a multidisciplinary team, led by a specialist medical practitioner with subspecialty training in pain management. The service will be supported through telehealth.	This change will provide access to specialist treatments for pain conditions for people in North West Tasmania.
Surgical services	The NWRH currently provides some general surgical services at level 5 and 6, but it has been identified that it only has the service capability to safely provide on-site high complexity services to level 4.	High complexity surgery will be provided at other facilities within the THS and will no longer be performed on-site. The NWRH will continue to provide on site and on-call low and moderate complexity surgical services. Patients requiring more complex surgery or complex care will travel to the LGH, RHH or interstate. Visiting specialists from higher level services will increase the delivery of subspecialist pre-operative and post-operative surgical care to people in the North West. This includes an enhanced urology service in the NWRH and the Mersey.	These changes will increase access to subspecialist surgeons for people in the North West. It will also ensure that there is an adequate volume of surgery to maintain the safety and quality of local surgical services. Residents will still have access to on-site ENT and orthopaedics. Greater access to specialist urological outpatient and surgical services will mean less travel for North West residents.
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 will remain at level 4.	Inpatient services for the North West will be consolidated at the NWRH. This will lead to a more sustainable service with higher volumes of patients and better care for women.

Service	Current Service Profile	Future Service Profile	Benefits
Neonatology services	The NWRH currently provides a level 4 neonatology service.	This service will remain at level 4, however, consolidation of the birthing services in the North West will mean that there are higher volumes. Babies born at less than 34-weeks' will receive care at the LGH or the RHH depending on the gestational age. In-utero transfer of neonates should occur where there is a risk of delivery below these thresholds when this is clinically and logistically possible. When this is not possible and the neonate is close to the transfer criteria threshold, clinical discretion should be applied to the decision to transfer dependant on the condition of the neonate, in consultation with a qualified neonatologist.	This change will ensure there are greater support services available for these babies if their care needs become more complex.
Maternity services	The NWPH currently provides level 4 maternity services.	Maternity services in the North West will be re-configured to improve their safety. There will be a single level 4 maternity service provided in the North West in Burnie. Further work will be undertaken to determine how birthing and inpatient maternity services will be consolidated to Burnie.	Consolidating birthing services to a single site and maintaining antenatal and postnatal care across the region will improve the sustainability, safety and quality and of maternity services in the North West. This will benefit local mothers and babies. The health of mothers and their babies will continue to be the highest priority.
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. These enhanced services will deliver better care to elderly Tasmanians closer to home.

Service	Current Service Profile	Future Service Profile	Benefits
Rehabilitation medicine services	The NWRH currently provides rehabilitation services at level 4 providing inpatient interdisciplinary care for functional restoration in patients following an episode of disability.	This service will remain at level 4.	Enhanced subacute specialist rehabilitation service capability will be provided to residents of the North and North West through the additional development of subacute rehabilitation services at the Mersey site.
Mental health services	The NWRH currently provides level 5 mental health services.	There is no change to the service level provide at NWRH.	Greater collaboration across services provided at the NWRH, Mersey and LGH will be of benefit to residents across the North and North West.

2.3.4 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 Australian and Tasmanian Governments have reached an in-principle agreement to ensure the Mersey continues to play an integral role in the health of the local community. A new two-year Heads of Agreement will provide $148.5 million for the continued management and operation of the hospital from 1 July 2015.

This safeguards the future of the hospital and allows much needed changes and improvements to add a range of new services to the Mersey and deliver better health outcomes across the State.

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.

Access to specialists and subspecialist care will improve through the provision of increased outpatient clinics. Networked services across the State will support statewide services with specialists working across the system rather in individual silos.

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 a Dedicated Elective 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 meet future growth.

Changes to service profile of the Mersey include:

Service	Current Service Profile	Future Service Profile	Benefits
Emergency medicine	The Mersey currently provides a level 3 emergency medicine service.	This will remain a level 3 service and will continue to be provide on a 24 hour, 7 days a week basis.	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. 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. Increased workforce support will occur through the introduction of physicians with both general practice and emergency skills into the ED. This model of care is more consistent with the care needs of patients in the areas surrounding the Mersey. The ED will continue to operate on a 24 hour, 7 days a week basis and will be available to provide emergency care to patients locally.
High dependency unit (HDU)	The Mersey currently provides HDU services.	The current HDU at the Mersey will be repurposed into a post operative surgical support unit to support the elective surgical service.	The current HDU at the Mersey will be repurposed over time to support the elective surgical service. This unit will also be able to provide care to critical ill or injured patients who require stabilisation prior to transfer to a larger centre.

Service	Current Service Profile	Future Service Profile	Benefits
Cancer services	The Mersey currently provides medical oncology and haematology services at level 4. This 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. Level 4 medical oncology and haemotology services will continue to be provided.	The Northern Integrated Cancer Service will provide cancer services across the North and the North West. This will continue to support the Mersey's role in providing access to visiting oncologists and specialised day treatments. The introduction of the Northern Integrated Cancer Service will mean less travel for cancer patients as services will be provided closer to home.
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 for residents across the region.
Surgical services	The Mersey currently provides some general surgical services at level 5 and 6, but only has the service capability to safely provide on-site services at level 4.	The level of complexity for these services will be changed to level 3. No emergency surgical services or elective surgical services requiring a greater than 23-hour stay 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. A dedicated Elective Surgery Centre will be established at the Mersey. This will be a 23-hour surgical service allowing a broader range of surgeries to be undertaken than day only surgery. Subspecialist surgical providers from LGH (and potentially RHH for some disciplines) will provide increased access to subspecialty surgery at the Mersey. This will particularly benefit residents of the North West but will provide services to all Tasmanians.	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. 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.

Service	Current Service Profile	Future Service Profile	Benefits
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.	This service will be changed to level 3. Low complexity, same day gynaecological services will be provided at the Mersey.	Overnight gynaecological services will be consolidated to the NWRH. 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.
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'.	Maternity services for the North West will be consolidated to a single site in Burnie. No neonatal services will continue to be provided.	This change will ensure that there are high quality and sustainable services for babies if their care needs become more complex.
Maternity services	The Mersey currently provides maternity services at level 4.	Birthing and inpatient maternity services in the North West will be reconfigured to improve their safety. There will be a single level 4 maternity service provided in the North West in Burnie. The Mersey will provide level 1 antenatal and postnatal maternity services. Further work will be undertaken to determine how birthing and inpatient maternity services will be consolidated to Burnie.	Consolidating services to a single site will improve the sustainability, safety and quality and of maternity services in the North West. This will benefit local mothers and babies. Antenatal and postnatal services will continue to be delivered at a range of locations across the North West including in Burnie and at the Mersey.
Drug and alcohol services	No current service.	This service will be established at level 4.	Establishment of mental health services enables on-site, collocated drug and alcohol services to be provided to residents of the North and North West of Tasmania. Better services will be available closer to home for residents in the North West.
Rheumatology	No current service.	This service will be established at level 4. Higher level facilities will provide visiting specialist rheumatology services. This service will be provided on an outpatient basis by a multidisciplinary team, led by a specialist medical practitioner with subspecialty training in rheumatology. The service will be supported through telehealth.	This change will improve access to specialist treatments for rheumatological conditions for people in North and North West of Tasmania.

Service	Current Service Profile	Future Service Profile	Benefits
Pain management	No current service.	This will be established at level 4. Higher level facilities will provide visiting specialist pain management services. This service will be provided on an outpatient basis by a multidisciplinary team, led by a specialist medical practitioner with subspecialty training in pain management. The service will be supported through telehealth.	This change will improve access to specialist treatments for pain conditions for people in North and North West Tasmania.
Geriatrics	No current service.	This will be established at level 4 across the North and North West. Enhanced subacute geriatrics service capability will be available to residents of the North and North West through the development of subacute geriatrics services at the Mersey.	Services will be provided locally, reducing the need for patients, their families and carers to travel.
Rehabilitation services	No current specialist service. Allied health services do commence appropriate rehabilitation services while patients await a rehabilitation bed.	A level 4 rehabilitation service will be established at the Mersey.	These services will be provided locally, reducing the need for patients, their families and carers to travel. The changes will mean that better care is available to North West residents closer to home.
Mental health services	The Mersey currently provides level 3 mental health services.	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.	The changes will mean that better care is available to North West residents closer to home.

2.3.5 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 are 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	Future Service Profile	Benefits
Trauma services	The RHH currently provides a level 6 trauma service. This is the full spectrum of care for the most critically injured patients, from initial reception and resuscitation through discharge and rehabilitation.	A feasibility study will be undertaken to determine the infrastructure requirements for the RHH to maintain a level 6 service for the State.	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. This will benefit patients by getting trauma victims to the most appropriate facility for their care as soon as possible.
Respiratory medicine	The RHH is currently a level 5 service.	This will be increased to level 6.	Contemporary specialist respiratory services include the provision of a complete range of diagnostic services and highly developed bronchoscopy and sleep services. 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.

Service	Current Service Profile	Future Service Profile	Benefits
Surgical services	The RHH currently provides high complexity sub-specialist surgical services across a broad range of disciplines. Some high complexity surgical services are provided at low volumes in Tasmania. The safety and sustainability of these services needs to be optimised.	The optimal service configuration for providing some low volume surgical oncology services, particularly complex head and neck surgery is yet to be determined. High complexity upper gastrointestinal surgical services are currently being provided at both the RHH and the LGH. The TSSSC has provided advice that the best configuration for these services is through a single statewide service, with a statewide lead, but operating from two sites (RHH and LGH). The RHH will be the site for the highest complexity cases in the State, given the availability of support services.	Quality monitoring systems will be developed in conjunction with clinicians to identity additional areas where quality improvements can be made. The RHH will continue to provide statewide cardiothoracic, neurosurgical and vascular surgical services. Through the implementation of the TCSP, all Tasmanians will have access to stronger more consistent services.
Burns services	The RHH and LGH currently both manage complex burns with the North West hospitals managing less complex burns. There are no detailed protocols for how the services work as a whole to provide optimal burns care.	A single burns system for the State will be established. Services will provided from the major hospital sites in accordance with agreed protocols and coordinated through the RHH. Detailed transfer criteria will be developed to support the delivery of care at the most appropriate facility, including interstate where appropriate.	The development of a statewide burns service will support the delivery of care at the most appropriate facility, including interstate where appropriate. This will contribute to better outcomes, greater consistency and improved long-term outcomes for burns victims.
Child and adolescent mental health acute inpatient services	The RHH is currently a level 4 service.	This will be increased to level 5.	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. 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.
Neonatology	The RHH is currently a level 6 service.	The RHH will continue to provide a level 6 service. The Tasmanian data for outcomes for infants born at less than 28-weeks' gestation has been reviewed and will continue to be monitored.	By applying the new transfer thresholds across the State as per the National Framework, there will be an expected increase in volume at the RHH to improve the sustainability of Tasmanian neonatology services.

2.4 Strengthening our primary care system and linkages

The Tasmanian heath system has many elements and needs to be coordinated and integrated allowing flexibility and innovative response to new challenges 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. If we remain focused on the acute hospital system only, we will miss the opportunities to improve health, prevent illness and reduce hospital demand. We have an opportunity in Tasmania to have a whole of health system approach to planning and delivering healthcare.

Improving the coordination and 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 and improve the outcomes of our health system. 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.

The Tasmania Medicare Local will transition to the TPHN on 1 July 2015. It will have the key objectives of:

- increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and
- improving coordination of care to ensure patients receive the right care in the right place at the right time.

Collaboration with the TPHN and other primary health stakeholders will be important to improving the coordination of and outcomes from our health system in Tasmania.

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 mindful of the impact travel has on access to services
- 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

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.

Tasmania Medicare Local

- 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 TCSP, 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.

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.

In addition, there has been a nationwide exponential rise in the need for predictive genetic testing and counselling for hereditary cancer syndromes (e.g. hereditary breast, bowel, and ovarian cancers) in order to allow timely intervention to prevent these cancers from developing.

The Government has commissioned a group of clinicians, academics and community representatives to develop a strategy to advance the preventative health policy, *A Healthy Tasmania,* and the health system will be actively working with our partners in primary health and the community sector to progress this policy.

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 by accessing care in GP rooms, community health centres, private clinics, and in the home.

The activities that occur in the primary and 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 and 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.

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, rural and regional settings can be significantly strengthened through:

- building clinical pathways between GPs and specialist services
- the up-skilling 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, nurse practitioners, nurses and allied health professionals working to the full scope and/or extended scope of practice)
- better utilisation of local pharmacy expertise (e.g. for medication management, triage, and minor ailments), and
- increasing the utilisation of telehealth, especially video consultations, to reduce waiting times.

The Tasmanian public health system has responsibility for only part of the primary health sector. Consequently, this has limited influence on GPs and privately practising clinicians. For this reason, linkages to, and partnering with, the THPN 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.

The Mental Health Council of Tasmania is a good example of community members and consumers working in partnership with government, most recently through the Rethink Mental Health project to develop and improve services.

Primary Care
is health care provided in the community for people making an initial approach to a health professional or clinic for advice or treatment. This is the often the first level of contact with the health system.

Community Care
is care provided to people in their community rather than in a hospital or formal medical centre.

2.4.3 Alternatives to hospital care

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.

The Government has committed a further $3 million to improve alternatives to hospital care, including restoring Hospital in the Home at the LGH.

Rapid response community nursing, hospital avoidance and diversion initiatives, and community support for under 65-year-old Home and Community Care (HACC) 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.

*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 EDs, and promises to reduce levels of health interventions for individuals.*

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 not well coordinated 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 hospitals currently play an important role in providing services that support the roles of the major acute hospitals. This includes the provision of subacute care, freeing up capacity in the acute hospital to take on additional patients.

Rural general practitioners play a vital role in their community, often supporting the medical services provided from local rural hospital or multipurpose facilities.

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.

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 eHealth delivery.

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. Similarly, the Tasmanian community sector provides a broad range of services, predominantly in primary care to Tasmanians who also access services in the acute hospital sector.

Collaboration with the TPHNs and other primary health stakeholders will be important to improving the coordination of and outcomes from our health system in Tasmania.

General Practitioners 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 eHealth 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 Australian Government is a key funder of primary health (especially in rural and remote areas) through the Medicare Benefit Scheme (MBS), Pharmaceutical Benefit Scheme (PBS), and programs such as the Rural Health Outreach Fund and the Medical Outreach Indigenous Chronic Disease Program (Tazreach) and the Rural Primary Health Services Program. It will be important to build greater cooperation and flexibility in the relationships between Australian and State Governments, and to direct resources in a coherent way toward the shared goal of improved health outcomes.

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.*

eHealth *is the use of information and communication technology (ICT) in the health system.*

Telehealth *is the use of electronic equipment to support long-distance health care. This can also be used for education of community members and health professionals. For example, the use of video technology to support consultations between patients and specialists who are remote from each other.*

Tasmania provides residential aged care in areas where there is no alternative provider. There is a need to partner effectively with the Australian Government 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

As part of providing patients with access to better care across the Tasmanian health system, the Tasmanian Government has looked at the ways in which our patients access health services and how they are supported to access the most appropriate care in the most appropriate location.

Accessing care is not always about requiring the patient to travel to the service: the patient can be brought to the service, the care can be taken to the patient through health professional travel or the requirement for patient travel can be reduced through the use of advanced communication technology.

Providing support for patients to travel to services involves providing emergency transport to patients who have emergency medical care needs, transporting patients between facilities to access the care that they need, providing transport for people to access non-urgent medical appointments and providing subsidies to support private travel and accommodation, where that is required to access health care.

Tasmanian patient transport includes the following services:

- emergency transport
  - ambulance service
  - fixed wing service
  - rotary wing (helicopter) service
  - neonatal, paediatric and perinatal emergency transport service
- non-emergency patient transport
- community transport, and
- PTAS
  - travel
  - accommodation

The *One Health System* reforms will see our health system 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 that is expert in providing the care they need.

The Tasmanian Government has undertaken a comprehensive analysis of the changing transport requirements that are expected as a result of the clinical service profile changes to our acute hospital facilities. These, along with a $24 million package of investments that support those changes are outlined in the White Paper companion document – Patient Transport Services.

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, when duplication of services in both the public and private systems is not 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.

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 instances 'share' registrars across sectors to enable there to be a critical mass of activity to support training.

***Co-dependence** is inevitable in Tasmania. The Royal Australian College of Surgeons (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.*

Royal Australasian College of Surgeons

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 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 White Paper 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.[10]

A well-governed health system requires[11]:

- 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 significant changes to the way the health system is governed, providing the leadership and structures that will assist the Government's vision for Tasmania to have the healthiest population in Australia by 2025 to be realised.

These initiatives include:

- the creation of the THS, in place of the previous three regional Tasmanian Health Organisations (THOs). The THS will have a governing council that will lead the implementation of new statewide governance and service delivery structures, including the prioritisation of the implementation of service delivery changes

[10]Commission on delivery of Health Services in Tasmania – Working towards a sustainable health system for Tasmania

[11]Commission on delivery of Health Services in Tasmania – Working towards a sustainable health system for Tasmania

- 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 the new Health Council of Tasmania (HCT) which will, among other roles, advise on the appropriate strategic priorities to guide health service planning and delivery in Tasmania. The HCT is supported by discipline specific CAGs, and
- 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. The reforms will support 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

Prior to 1 July 2015, Tasmania had 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 *Tasmanian Health Organisation Act 2011* established the THOs as separate legal entities and commenced on 1 July 2012. Each THO had its own Governing Council (GC) and Chief Executive Officer (CEO).

Evidence indicates that having three separate THOs resulted in sub-optimal outcomes due to duplication of resources and impediments to collaboration. Moving to a single THS will address these issues by reducing waste and duplication, enabling the adoption of consistent statewide policies and take responsibility for the seamless coordination of care for patients requiring health services across different sites.

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

The THS will have a contemporary governance structure, including:

- a single GC, 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 statewide service delivery structure designed to improve the coordination of services and reduce duplication in both administrative overheads and clinical support services.

The THS CEO and GC will lead the implementation of new statewide governance and service delivery structures. The THS will progressively transition services and functions from regional to statewide models. This staged process is critical to ensure there is no adverse impact on service delivery or patient care.

The DHHS will work in partnership with the THS to support it to provide the best 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, and
- ensuring care is provided in locations with the necessary resources to perform procedures safely and efficiently.

Importantly, the single THS will deliver the 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, the Australian Council on Healthcare Standards defines clinical governance 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."[12]

The Commission on Delivery of Health Services in Tasmania, in their 2014 report noted concerns about the adequacy of the mechanisms to support clinical governance and safety and quality in health care in the Tasmanian system.[13]

A Statewide Clinical Governance Framework for Tasmania's public health care system was developed in 2013, however, there was a lack of acceptance across segments of the system hampering the operationalisation of the system.

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

[12]Australian Council on Healthcare Standards, 2004

[13]Report of the Commission on Delivery of Health Services in Tasmania – April 2014

An example of how the THS might operationalise this is through the development of a statewide credentialing system. This will authorise clinicians 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 statewide 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 Government has established the HCT 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, DHHS and TPHN.

3.4 Clinical advisory groups

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

Sixteen 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 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.

Royal Australasian College of Surgeons

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 oversee the public health system effectively.

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
- is collaborative across regions and across the primary, secondary, and tertiary health sectors, and
- forges alliances and collaboration between the public, private and community sectors as well as interstate providers to ensure Tasmanian's get the best care we can provide to them.

4. Supporting the health system of the future

A number of building blocks underpin the effective and efficient delivery of high quality health services. These include:

- workforce planning in collaboration with major education providers, developing a health professional workforce that is matched to the health service requirements of the community
- workforce development, education and training ensuring that the system embraces and supports teaching and training to build a sustainable workforce that is suitable for the Tasmanian environment
- research, innovation and continuous improvements ensuring a robust and integrated culture of research, innovation, high performance, and excellence that leads to a health system able to adapt to changing health workforce models, service needs, and advances in technology, and
- making the best use of technology to improve the safety, quality and efficiency of health services across a united network of health services.

4.1 Workforce planning

Effectively planning a health workforce requires addressing the immediate health needs of the community, as well as developing a health workforce for managing future health service needs.

The length of time needed for health professional training means that looking to future health service is essential. Any necessary up or downsizing of the workforce will have a long lag time. Importantly, the skills and expertise of the workforce will have to adapt over time as the burden of disease changes, new workforce models emerge, and technologies and practices change the way we deliver healthcare. The contained nature of the Tasmanian health system and our ageing demographic makes Tasmania an important national player for innovative models of health workforce development.

The public sector health service cannot undertake workforce planning in isolation. There needs to be an alignment with education providers at all levels of the training continuum, and this must include the private and community sectors.

More importantly, the community and health consumers have a right and a role in determining the configuration of the health system they want. Also, Tasmanian students and health professionals deserve access to high quality health education and training opportunities. This in turn will have an impact on workforce planning and supply.

The health workforce contributes the largest proportion of recurrent health system costs. It is therefore important that available resources are considered in determining the size and shape of the future workforce.

Where are we now?

Like many jurisdictions, Tasmania has had peaks and troughs of workforce supply. Tasmania has a small population with a high proportion living outside the major metropolitan centres. This leads to challenges in providing safe and sustainable services across the major 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 makes it difficult to recruit and retain a stable workforce to support those services.

The smaller the health service or specialty service, the greater the impact of small changes in workforce numbers. For example, the recent loss of two part time endocrinologists in a short space of time in the North West, combined with difficulty in recruiting, is likely to result in their being no employed endocrinologists in the public system in the North West. Likewise, diminished access to high quality postgraduate training and professional development may affect recruitment of the best staff.

Health workforce development in Tasmania is currently largely under-planned, driven by immediate operational decision-making, and is poorly aligned with universities and other education providers.

We have generally had a passive approach to workforce supply that has been largely historically driven. This has contributed to the development of unsustainable services that have not responded to the changing health service needs of the community.

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

Tasmania, like other jurisdictions, has traditionally had siloed workforces with slow and patchy adoption of new workforce models. An example of such a workforce model is the nurse practitioners model, supported through State legislation since 2005 and through Australian Government legislation to provide access to PBS and MBS since 2010. Nurse practitioners have the potential to provide efficient and effective health care in a range of clinical areas. This could improve access to services while ensuring we are utilising our health professional workforce in the best way possible. Despite this, there were only 25 registered nurse practitioners in Tasmania in 2014.[14]

[14]http://www.nursingmidwiferyboard.gov.au/About/Statistics.aspx

Nurse endoscopists

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 territories.[15] Bowel cancer is the second most common cause of death of males and third most common cause of death of females.[16] The adoption of nurse endoscopists could assist in meeting the high demand and waiting times for endoscopy services in Tasmania.

A range of key strategies are being progressed by the DHHS 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, and
- efficiency and flexibility[17].

Where do we want to be?

The development of an agreed TCSP for the major acute hospitals, combined with a governance system with a statewide focus provides opportunity to develop a planned approach to a health workforce that will more closely meet the health service needs of the community.

An effective and strategic health workforce needs to be able to respond to the changing health service requirements of the future, particularly given our rapidly ageing State population. For example, there is the opportunity to provide more care in community settings to create a more efficient and personcentred system. This would need to be matched by a parallel increase in the number or proportion of time that practitioners spend in community settings.

We want to be proactively planning for the health workforce requirements in partnership with education providers, primary care and the private hospital sector.

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

[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*

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

Next steps

Develop workforce plans matched to the agreed clinical services profile of the health services outlined in the White Paper. These plans need to be developed in collaboration with the public sector, private sector, health professionals and teaching and training institutions. These plans then need to be available and communicated to students and prospective health professionals.

4.2 Workforce education and training

A positive and productive interaction between health service delivery, teaching and training, and research is essential for the delivery of excellent health care.

The provision of quality professional education supports the attraction of highly skilled health practitioners to the State. The supply of new graduates to the Tasmanian system complements the attraction and retention of highly skilled health practitioners by providing variability in practice with the ability to provide health services, teach and undertake research if desired.

Tasmania has a dispersed model of professional entry that assists in the attraction and retention of academic and research expertise to all the regions. This aligns with the vision of a distributed health service network to serve all regions of the State.

Linkages and good relationships between the University of Tasmania sector and health services increase the tailoring of the education of the future generation of health professionals to identified health challenges and priorities. As an example, providing more care in community settings for an ageing population with multiple comorbidities will require a medical workforce with experience and expertise in this area.

International evidence shows high quality health practice is related to having a clinician profile that is highly skilled in implementing the best evidence. The current Tasmanian health workforce needs upskilling in their capacity to make use of the best evidence. In addition, recruitment of nationally and internationally leading clinicians may depend on their capacity to be supported by an excellent academic environment, with access to quality research facilities.

Making better use of our health professional workforce – nurses, midwives and allied health professionals – has the potential to provide a more efficient overall health service. For example, nurse and/or allied health 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 high quality clinical care.

Where are we now?

Governments, universities, medical colleges, and employers are all making individual decisions that influence how many doctors, nurses, and allied health professionals are trained. In addition to frequently being made independently, these decisions do not always align to meet the health service needs of the community. This means that while some health professional groups or specialties are in very poor supply, others may be in oversupply, or at the least, in a state of maldistribution.

Training priorities may be matched to the health service needs of individual hospitals or specific services within them, with little or no alignment to the broader requirements for health practitioners for the community as a whole, including the private sector. The Tasmanian health workforce requires greater opportunities to develop their skills through access to high quality postgraduate education and professional development.

Ensuring training decisions are aligned to the likely future needs of the community is essential and will be assisted by the implementation of the TCSP.

Where do we want to be?

Moving to one THS supported by the TCSP provides a greater opportunity for health professionals to work cooperatively with colleagues across campuses. This will enable the delivery of services of a complexity that is able to be safely supported in each hospital site. This in turn would provide an environment where teaching and professional development is supported across the system from services that provide low complexity services to those that provide high complexity services.

There will also be better linkages with the University of Tasmania, providing health professionals with greater opportunity for professional development, as well as to participate in high quality teaching and research. This will have a positive impact on the ability to train, recruit, and retain world-class health professionals.

Through the *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 Tasmanian graduates. In this way as a State, we can be better planning for building the health workforce that is able to deliver the services identified in the TCSP.

The THS can also enhance statewide partnerships through training partnerships that promote training opportunities between facilities.

In short, our long term and clearly defined plans for health services should create demand for an appropriate mix and supply of health professionals to deliver those services.

Next steps

Identify and regularly update health professional training priorities with input from the public sector planning and service delivery arms, the University of Tasmania, and Vocational Education and Training (VET) sector providers, the private hospital sector, and the primary health care sectors.

Establish a Research, Education and Workforce advisory group that sits alongside the CAGs. This group needs to comprise the University of Tasmania and other health professional education providers (including Specialty Colleges that provide vocational training), the private sector, THS health service providers, the TPHN, and representatives of students and advanced trainees.

Establish medical training networks aligned to and supported by professional leadership to increase local training pathways.

4.3 Research and innovation

A high performance health service requires the health system and the university sector to be aligned and working towards common goals that have as their endpoint the health of patients and the broader community. This alignment drives quality in health service provision, training for the current and future health professional workforce, and a culture of ongoing quality improvement that supports better population health outcomes.

Effective partnerships between the health services, the University of Tasmania, the system manager (DHHS), and other health system organisations are essential to driving this culture.

Research and innovation are necessary enablers for quality improvements in the health services and ultimately better health outcomes for the community. The most advanced health organisations internationally are those that successfully integrate high quality clinical service provision with excellent research and education.

Where are we now?

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, ensuring Tasmanians receive care that is of the highest international standard.

Research priorities and health service delivery needs have not always been in alignment, meaning that opportunities for health services improvements and ultimately health outcomes for the community have not been optimised.

By failing to capitalise on the potential relationship between the University of Tasmania, research bodies and the health services, Tasmania has missed opportunities to secure high quality teaching and research staff and to make gains in service delivery and patient outcomes.

Health Services Innovation (HSI) Tasmania

HSI Tasmania is a stand alone, statewide research and implementation centre within the Faculty of Health, University of Tasmania with expertise essential to the transformation of healthcare services.

It was established in early 2014 to work with the State and help implement a program of clinical redesign across the Tasmanian hospital system.

While the focus is on the acute hospital sector, the critical importance of the community interface is recognised and the work is fostering cross-sectoral collaboration, particularly via joint activities with the TML.

Projects are currently underway around the State in the areas of emergency access and bed capacity, overall bed demand and flow and elective surgery.

Training programs in clinical service redesign/health improvement, undergraduate teaching and leadership development programs are all being delivered.

Where do we want to be?

The Department and THS still have much work to undertake in developing a truly integrated system where the health services and the educational and research institutions work synergistically. To achieve this vision we want to:

- embed a research culture and support innovation to allow the health system to develop a culture and delivery of high performance
- utilise research and innovation to drive quality and safety improvements in health services
- align and plan research priorities with University of Tasmania and other key organisations to drive a high performance health system that can adapt to the changing health service requirements of the community. A system that is continuously learning how to improve, manage new challenges and that is taking advantage of new opportunities
- build a shared vision, shared workforce and high quality shared information between the health service and the university, and
- build health professional leadership across the system.

Next steps

Establish a Research, Education and Workforce advisory group that sits alongside the CAGs. This group needs to comprise the University of Tasmania and other health professional education providers (including specialty colleges that provide vocational training), the private sector, THS health service providers, the TPHN, and representatives of students and advanced trainees.

Health Services Innovation Tasmania should continue to be supported while it continues to contribute to a high performing health system.

4.4 Technology

Technology plays a critical part of a modern health system. Used well, it can improve the safety of health care, make interaction between health professionals and consumers more efficient and effective, and provide new options for how we deliver care. This is particularly the case for patients and health professionals in rural and remote locations, as it can reduce the need for travel.

The term 'eHealth' refers to the use of ICT in the delivery of health care. In a broad sense, it includes electronic records, information systems, processes, infrastructure, and health information. It also incorporates 'telehealth', which uses secure facilities (including videoconferencing) to coordinate, manage and deliver patient care.

The purpose of eHealth is to electronically connect different points of health care and ensure that patients and health professionals have access to up-to-date, accurate and reliable health information and knowledge. It is a critical enabler of health reform as it has the capacity to improve the quality, safety, accessibility and efficiency of the health care system.

eHealth can be used to treat patients, conduct research, educate the health workforce, track diseases, and monitor public health. As a result, eHealth also supports other health reform enablers identified in this chapter of the White Paper.

While there have been significant efforts both within Tasmania and nationally to improve our eHealth systems and practice, we need further work and significant investment to ensure Tasmania has a fully networked and connected eHealth system.

This section describes the current state of the eHealth system in Tasmania and the benefits of further investment. It also outlines priorities for future action and investment and the next steps the Government will take to progress Tasmania's eHealth capabilities.

Where are we now?

While there are basic ICT infrastructure and systems in place, Tasmania has a relatively low level of eHealth maturity. Current ICT systems are unable to support a fully networked health system across the state, and are beset by "legacy" systems and difficulties communicating across the spectrum of health care.

Tasmania's four major hospitals, to varying extents, still rely on paper systems. Modern eHealth programs are not in place to support efficient and safe practices. Although discharge information from hospitals is provided electronically to GPs and other service providers, referrals into and out of the system are not managed electronically in all instances.

Many ICT systems are still regionally based and disconnected. For example, pathology results are managed through different systems in each of the three regions. When patients are transferred between hospitals, pathology tests are often re-done as the information is not accessible to treating clinicians. Similar observations can be made on the management of patient records in each centre, and the capacity to access them from other parts of the public hospital system.

If anything, this fragmentation is even more evident when examining the interface between primary and acute care. Communications between hospitals and GPs can be variable in detail and timeliness, and the decision on what information is transmitted is decided by the transmitter, not the receiver. As such, the GP or hospital doctor caring for the patient may have only limited access to relevant information obtained in other health care settings. Patients and clinicians would benefit from a greater degree of information sharing across the health care spectrum.

In April 2014, the Commission on the Delivery of Health Services in Tasmania[18] reported that ICT procurement processes appear inefficient, with even generic requirements being undertaken individually by each hospital.

Telehealth facilities are available in the four major hospitals as well as in a number of rural sites around the State. Consultation indicates that telehealth facilities are used well for departmental meetings and clinical networks, but not so well for patient care. There are administrative, logistical, and other barriers to effective use of this infrastructure. At the moment, the process is complicated, time intensive, and inadequately supported to position telehealth where clinically appropriate as a practical alternative to face to face consultation.

Tasmanian hospitals have been benchmarked against the internationally used Health Care Information Management Systems Society's Electronic Medical Record Adoption Model (EMRAM) for assessing eHealth maturity. This model identifies the levels of Electronic Medical Record (EMR) capability ranging from limited systems through to a paperless EMR environment.

In this self-assessment, Tasmanian hospitals scored around two on a seven-point scale.

[18]The Commission on Delivery of Health Services in Tasmania Working towards a sustainable health system for Tasmania, Report to the Australian Government and Tasmanian Government Health Ministers, April 2014, p.49

Electronic Medical Record Adoption Model

The EMRAM is an internationally recognised measure of an organisation's eHealth capability on a scale of 0-7. It is widely used across the United States (US), Canada, and Europe. Around one third of all US hospitals are EMRAM 5, while in Australia and Canada, the majority of hospitals are EMRAM 2 or 3.

The 7 stages of EMRAM are:

0 No electronic systems.

1 Electronic systems for pharmacy, pathology, and radiology.

2 A clinical data repository allows data to be sourced from across the hospital(s) and presented as an integrated view.

3 Electronic patient care documentation.

4 Electronic ordering of medications and diagnostic tests, with decision support.

5 "Closed loop" medication prescribing and administration.

6 Structured recording of clinical documentation, with full decision support.

7 Complete electronic record with structured data across all stages of health care provision, including outpatient care.

The biggest challenge for Tasmania is its capacity as a small State to fund eHealth initiatives, particularly in the current fiscal environment. This is a significant challenge given the high demand for resourcing in this area, including capital and recurrent funding. Support for eHealth initiatives would allow Tasmania to progress both its own priorities for eHealth investment, and the objectives of the national eHealth agenda (see below).

Tasmania's Connected Care approach

The Department has adopted a Connected Care approach to eHealth, which aims to support new models of health care and drive greater continuity of care across multiple settings. It focuses on providing stable, secure and highly available ICT infrastructure to support current and future service delivery.

The Connected Care approach identifies priorities for ICT development and investment to support a connected and fully networked health services system in Tasmania. It will enable DHHS to manage and address a number of risks and challenges in the system including the current disconnected ICT service system, incomplete and inadequate data, and fragmented and inefficient service delivery.

To date, a pragmatic approach has been taken to implementation of eHealth initiatives, as funding and/or policy opportunities arise. The availability of Australian Government funding under the Tasmanian Health Assistance Package (THAP) in 2013-14 provided an opportunity for DHHS to make progress on both the national eHealth agenda and its own eHealth priorities.

This included acquiring a new health informatics capability – the Connected Care Platform. It is underpinned by a Clinical Data Repository with the capability to bring together the full range of clinical patient information, such as pathology, diagnostic imaging, allergies, previous admissions, and treatments. With further investment, the Connected Care Platform will support safer and more efficient care by providing clinicians with an integrated view of a patient's medical information.

Other initiatives that have been progressed in recent years include:

- sending electronic discharge summaries between hospitals and GPs
- sending discharge summaries and electronic medication management system data to the Personally Controlled Electronic Health Record (PCEHR) (see further below)
- a statewide comprehensive cancer treatment system, and
- a combined scanned and directly entered medical record across THO-South and THO-North West, with deployment to THO-North by December 2015. This will offer a truly statewide view of patient medical records.

The national eHealth agenda

Nationally, there has been significant effort and investment into eHealth by the Australian, state, and territory governments.

This included the establishment of the National Electronic Health Transition Authority (NEHTA) in 2005 to govern and coordinate national eHealth efforts. All governments fund NEHTA on a cost-shared basis. As part of the 2015-16 Federal Budget, the Australian Government announced that NEHTA will be replaced by a newly formed Australian Commission for eHealth.

A key component of the national eHealth framework has been the development of the PCEHR. The PCEHR is a shared electronic health summary that allows health care providers and hospitals to view and share an individual's health information, including diagnoses, allergies and other alerts, medications, and treatment history. The PCEHR was launched on 1 July 2012.

In 2013, the Australian Government announced a review of the PCEHR. The Australian Government released the Review Report[19] in May 2014. As part of the 2015-16 Federal Budget, the Australian Government announced that the PCEHR will be renamed as *My Health Record* and that the system will be enhanced to be more user-friendly and better reflect the needs of health professionals. Governance arrangements for the rollout and management of the system will also be strengthened.

[19]Review of the Personally Controlled Electronic Health Record, December 2013

The Department's Connected Care approach is aligned with and informed by the national eHealth agenda. According to NEHTA, around 14 per cent of Tasmanians have signed up to the PCEHR, which is above the national average. Work has been undertaken to include connectivity and integration with the PCEHR.

Where do we want to be?

Tasmania needs to build on what has already been achieved to improve eHealth capability. Tasmania requires an eHealth system that enables seamless integration of health services across a network of sites in the State, effectively crossing sectoral boundaries to follow the needs of the patient and the treating clinicians. This will require substantial future investment.

At its meeting in April 2015, the HCT endorsed a set of Principles and Strategic Priorities to assist the Government in achieving its commitment to Tasmania being the healthiest State by 2025. One of the Strategic Priorities is to 'develop and invest in eHealth and ICT services'. The HCT developed this principle with two purposes in mind:

- to use intelligent systems to improve the safety and efficiency of patient care in Tasmanian hospitals. This will also improve the sustainability of Tasmanian hospitals and enable them to deliver care at the National Efficient Price, and
- to allow data collection to facilitate improved management of the health system at a holistic level.

In 2014, the Commission on Delivery of Health Services in Tasmania recommended that DHHS should progress its activities to improve statewide ICT systems as a matter of priority, ensuring any new work undertaken is effective and builds on investments already made in ICT systems and network upgrade projects.

The benefits of further work and investment

There is international evidence that successful implementation of a connected eHealth network has capacity to improve the, safety, quality efficiency, and accessibility of the health care system. There are also significant financial benefits, in terms of cost savings, that can be realised at both the State and Australian Government level through investment in eHealth.

The benefits of eHealth apply to healthcare providers, patients, governments (both State and Australian) and private funders (e.g. private health) and include the following[20]:

[20]NEHTA eHealth Cost Benefit Analysis Framework 2015

	Key Benefit
Safety	• Reduction in Adverse Drug Events (ADEs), leading to fewer hospitalisations. • Reduction in ADEs, leading to fewer Emergency Department visits. • Reduction in ADEs, leading to fewer visits to clinicians. • Reduction in ADEs in hospitals, reducing the length of stay.
Quality	• Improved decision support and adherence of providers to best practice. • Enhance risk stratification and targeted disease management. • Enhanced patient self-management. • Improved chronic care through care coordination.
Efficiency	• Avoided duplication and unnecessary pathology and imaging tests. • Reduction in time looking for and gathering patient data. • Faster turnaround time in hospitals. • Reduction in time processing prescriptions. • Reduction of unnecessary patient transfers though telehealth.
Accessibility	• Reduction of the need to travel for patients in rural and remote areas through telehealth.

Case Study

Home Monitoring of Chronic Disease for Aged Care: A Telehealth Pilot

THO-North hosted a CSIRO telehealth pilot that looked at the use of home telemonitoring of vital signs and symptoms for the management of chronically ill patients.

There were 30 patients who undertook daily vital signs measurement and were monitored remotely by specialty nurses at the LGH or the TML.

The trial found that treatment of exacerbations was instituted earlier, there was an avoidance of GP visits and potentially avoidance of hospital admissions.

This model of care could potentially decrease hospital admissions but also allow for earlier hospital discharge.

Priorities for action and investment

In order to prioritise health activities, a work program has been developed by the DHHS to target activity where it will most readily improve the productivity and safety of Tasmania's health system.

The priorities of this program align with the key elements of the DHHS Connected Care approach that support the *One Health System* reform program and could be progressed as funding becomes available.

The priority program has been developed in collaboration with key stakeholders including the THS, the TPHN, and HSI Tasmania.

By continuing to work in collaboration with the THS, TPHN, and HSI Tas, these initiatives will be targeted to develop and accelerate substantial clinical redesign elements already underway, delivering opportunities for improved sustainability of the Tasmanian health system and driving efficiencies into the future.

The aim of this work is to build on the foundations delivered through earlier THAP projects and extend them to achieve greater eHealth connectivity strengthening Tasmania's ability to implement its national eHealth commitments.

The priorities identified for investment of eHealth funding, as it becomes available in future, are:

- support a networked, statewide model of care by ensuring that patient information is stored centrally and can be accessed by health professionals across all public health facilities
- improve hospital efficiency, productivity, safety and quality, through improved electronic workflows and forms to support patient pathways
- ensure medications are used safely and cost effectively through enhanced Electronic Medication Management
- enable care integration and transition by ensuring timely and improved communication between GPs and specialists, and hospitals, including the exploration of clinicians outside the public health sector having access, where appropriate, to the public hospital records of their patients
- use data to improve research and system performance and make information available to inform decision making
- support the national eHealth work program, continuing to contribute to the development of the My Health Record System, and
- improve and expand the use of telehealth, streamlining processes to enable an increase in the use of telehealth for coordination of care within the Tasmanian health system.

Future Patient Journey

John visits his GP in Wynyard feeling unwell. Following a thorough assessment John's GP refers him to a specialist at the NWRH specialist clinics. An electronic referral (eReferral) is sent to the clinics from John's GP, which includes all of John's previous medical complaints, current medications and notes his allergy to Penicillin.

At the specialist clinic, John's records from his GP are available to the treating specialist who examines John and determines that he needs surgery. Due to the low-volume, high-complexity nature of the surgery it is only available at the RHH.

John attends a pre-admission clinic consultation at the NWRH via video link with the surgeon in Hobart. When John is ready for surgery, he travels to Hobart while his complete medical record, including CT scans and MRIs, are available to the surgeon electronically. Following discharge from hospital, information is sent to John's regular GP and a copy uploaded to his My Health Record.

John's six-week post-surgery follow-up appointment is booked with the surgeon in Hobart. Instead of John having to travel back to Hobart to attend the appointment he is able to attend his local GP clinic for a telehealth appointment. This appointment is also attended by John's GP. This allows the GP to take over primary management of John's recovery from the specialist.

Next steps

- Continue to recognise eHealth as a critical enabler of the development and delivery of a truly networked *One Health System* for Tasmania.
- Continue to participate in discussions on national eHealth reform, including implementation of the 2015-16 Federal Budget initiatives, such as changing the PCEHR to *My Health Record* and implementing new national eHealth governance arrangements.
- Continue to work collaboratively with the Australian Government to facilitate investment to support eHealth initiatives to progress the identified priorities.

5. Implementation

This paper outlines a number of clinical service changes for the Tasmanian health system that need to be implemented in a way that ensures:

- health service delivery continues uninterrupted across the system
- the dedicated workforce that provides the health services are fully supported to implement the changes that are required. This includes managing any changes in workplace environments and any education and training requirements for changes in roles
- the physical capacity of the hospitals can accommodate any changes in service volumes resulting from the changes
- the financial sustainability of the organisation is maintained, and
- any increased patient transport requirements are matched by increased capacity.

The implementation of these changes into a newly networked hospital system is a complex task, in particular managing the significant service changes proposed at the Mersey.

Changes to the clinical services profile of major acute hospitals will not be implemented until they are able to be integrated into the development of services across the State and are adequately resourced and planned.

5.1 Implementing the Changes

The THS was established on 1 July 2015. The THS is responsible for delivering health services across the hospital network and it is therefore important the THS have the responsibility to develop and enact the implementation framework for the TCSP.

The DHHS will continue to provide support to the GC of the THS and the incoming CEO until a robust capability for driving reform is established in the new organisation.

An implementation framework for the TCSP will be developed by the THS by 30 September 2015 with an appropriate governance structure in place to ensure that:

- appropriate accountabilities are established
- there is the authority to implement the changes at the service level
- service delivery challenges are addressed, and
- clinicians and the community at the statewide level and at the local level are engaged in designing and implementing the changes.

Important components of the implementation framework will include:

- the development of statewide-networked clinical services, including clearly documented models of care, workforce strategies, and a robust monitoring and reporting framework. The CAGs will provide advice to the incoming CEO and GC to assist in developing the statewide models of care that will be required to deliver the networked service
- identification of efficiencies in service changes that can be reallocated to implementing the clinical services profile
- timeframes for implementing the changes to the clinical services profile, and
- consolidated reporting of progress on securing efficiencies and implementing the changes articulated in the White Paper.

Given the extensive changes recommended at the Mersey there will need to be a defined implementation and reporting framework for that hospital.

The THS is only one component of a broader health system that needs to work together to progress the implementation of the changes:

- the DHHS will support the delivery through the statement of purchaser intent and the service agreement process
- the DHHS and THS will work with the CAGs to develop statewide models of care that articulate how the four acute hospitals will work together and integrate with the community and private sector, and
- the Chair of the THS will report regularly to the Minister for Health.

5.2 Identified areas for early improvement

There are a number of areas where early improvements in services will be made in line with the decisions in the White Paper. The CAGs are assisting in identifying these and include:

- implementation of the Northern Integrated Cancer Service
- implementation of the Northern Integrated Surgical Service
- increased elective surgery at the Mersey
- increased outreach services from the LGH
- targeted improvements in the use of telehealth, and
- improved coordination of statewide trauma services.

At the same time, work is already underway on the development of statewide models of care in a number of the clinical service areas. This work will underpin the way the networked hospital system provides health care services to the community in a way that best utilises the skills and expertise of staff around the State.

6. More information

For more information on the One Health System reform package please visit:
www.onehealthsystem.tas.gov.au

Acronyms

ACT	Australian Capital Territory
ADEs	Adverse Drug Events
BAPC	Better Access to Palliative Care
CAGs	Clinical Advisory Groups
CEO	Chief Executive Officer
CT	Computed Tomography
DHHS	Department of Health and Human Services
ED	Emergency Department
EMR	Electronic Medical Record
EMRAM	Electronic Medical Record Adoption Model
ENT	Ear, Nose, and Throat
FTE	Full Time Equivalent
GEM	Geriatric Evaluation Management
GC	Governing Council
GP	General Practitioner
HACC	Home and Community Care
HCT	Health Council of Tasmania
HDU	High Dependency Unit
HSI	Health Services Innovation
ICT	Information and Communication Technology
ICU	Intensive Care Unit
LGH	Launceston General Hospital
MBS	Medicare Benefits Scheme
MDT	Multidisciplinary Team
MRIs	Magnetic Resonance Imaging
NEHTA	National Electronic Health Transition Authority
NSW	New South Wales
NT	Northern Territory
NW	North West
NWRH	North West Regional Hospital
NWPH	North West Private Hospital
PBS	Pharmaceutical Benefits Scheme
PCEHR	Personally Controlled Electronic Health Record
PTAS	Patient Travel Assistance Scheme
QLD	Queensland
RACS	Royal Australasian College of Surgeons
RHH	Royal Hobart Hospital
SA	South Australia
TAS	Tasmania
TCSP	Tasmanian Clinical Services Profile
THAP	Tasmanian Health Assistance Package
THO	Tasmanian Health Organisation
THS	Tasmanian Health Service
TML	Tasmania Medicare Local
TPHN	Tasmanian Primary Health Network, an Australian Government initiative replacing Tasmania Medicare Local
TRDF	Tasmanian Role Delineation Framework
TSSSC	Tasmanian Statewide Surgical Services Committee
US	United States
VET	Vocational Education and Training
VIC	Victoria
WA	Western Australia

Glossary

Acuity	The level of severity of an illness or injury. It often relates to the severity of a condition and its potential to get worse.
Acute Hospital	A hospital that provides emergency care, surgery, or other short-term treatment for severe injury or illness.
Adverse Event	A situation where a patient experienced harm caused by the care received (including medication or surgery) where no harm should have reasonably happened.
Aeromedical	A plane (sometimes called fixed-wing) or helicopter (sometimes called rotary-wing) specifically used for medical purposes, including transport and retrieval.
Age-standardised	A process used when working with statistics to make sure all factors are reasonably accounted for, like geography, age, different periods of time etc. This is a way of making sure data used to show statistics is comparing 'apples-with-apples'.
Allied Health Professionals	A large range of professionals from a large range of professions, working alongside nurses and doctors to provide patient care (like social workers, speech therapists, or psychologists etc.).
Anaesthetist	A specialist doctor who gives medication to put a part or whole patient to sleep for a specific medical or surgical procedure.
Antenatal	The period before birth, or during labour but before the baby is born.
Cardiology	A branch of medicine dealing with the heart and its functions.
Cardiothoracic	A branch of surgery relating to the heart, chest, or lungs.
Chronic Disease	A long lasting disease that can be controlled, but not cured (like asthma, allergies, or diabetes etc.).
Community Care	Long term care provided to people in their community rather than in a hospital or formal medical centre.
Congenital	A condition that affects a baby from before birth and extends into the baby's life. A condition that develops after the birth is described as "acquired".
Dermatology	A speciality dealing with the hair, nails, skin, and diseases that affects them.
Dialysis	A process used to remove waste and excess water from the blood when your kidneys do not work properly.
Economies of Scale	The effect where doing more of something means it is cheaper each time it is done. An example is where the higher number of surgeries undertaken in a location makes it cheaper to perform.
eHealth	The use of information and communication technology (ICT) in the health system.
Endocrinology	A branch of medicine dealing with the function of the glands and hormones. It manages diseases like diabetes or thyroid disease etc.
Gastrointestinal	Relating to the stomach or the intestines.
General Hospital	A hospital that can provide care to patients with a broad range of conditions or issues.

Geriatrics	A branch of medicine that focuses on the health of older people.
Gynaecology	A speciality dealing with the female reproductive system, and its function.
Health Literacy	The level of understanding the community has on health issues and being healthy. This includes understanding health and medication advice.
High Dependency Unit	A specialised unit that deals with severely unwell patients who need a higher level of care than a general ward but a lower level of care than intensive care.
Hospital Avoidance	A process to help people avoid going to hospital by healthier living, treating a patient in their home, other facility outside of the hospital, or by other means.
Hospital Bed Days	The length of a patient's stay in hospital is measured in "bed days". A patient who is given a bed, then goes home the same day, has used one bed-day. A patient who stays overnight, has used two bed-days, and so on.
Hyperbaric Medicine	A specialty that uses pressure chambers to deliver oxygen to the body at high pressures. This is to treat decompression illness from diving accidents, but can also be used to treat smoke inhalation, or other conditions.
Hypertension	High blood pressure.
Hysterectomy	The surgical removal of the uterus (womb).
Intubation	The process of placing a tube into the windpipe to keep the airway open, and enable assistance with breathing.
Ischaemic Heart Disease	A disease that affects the supply of blood to the heart, and may result in angina, heart attack, or heart failure.
Linear Accelerator	Sometimes called a LINAC, this is a device that beams high-energy x-rays to specific organs usually used to treat cancer (often used in Radiation Oncology).
Locum	A staff member on a short-term or temporary contract, employed to address a particular shortage.
Morbidity	The health impact of illness, injury, or disease.
More Invasive Procedure	An invasive procedure is one that in some way crosses the skin to enter the body. A more invasive procedure might mean the difference between getting a needle (invasive procedure) and having your chest cut open for major surgery (more invasive).
Mortality	Death, commonly as a result of illness, injury, or disease.
Neonatal Services	A branch of paediatrics dealing with newborn babies, called neonates. In medical terms, this means a baby that is no older than 28 days.
Neurology	A branch of medicine dealing with the brain and nervous system.
Obstetric Care	A service that deals with the processes around pregnancy, delivery, and the period following birth.
Ophthalmology	A specialty that deals with the eyes and diseases that affects them.
Orthopaedic	A branch of surgery relating to the musculoskeletal system, which includes bones, muscles, joints, and ligaments.

Paediatrics	A speciality that deals with a child from birth up to maturity.
Pain Medicine	A speciality dealing specifically in relieving pain in patients from a range of conditions, including after surgery.
Palliative Care	Care provided to patients with terminal conditions to support them through their end of life experience.
Primary Care	Health care provided in the community for people making an initial approach to a health professional or clinic for advice or treatment. This is the often the first level of contact with the health system. GPs and pharmacists would consider themselves primary care professionals.
Prostatectomy	The surgical removal of the prostate.
Psychogeriatric Care	A service that deals with disorders affecting the mind and mental state in older people (like Alzheimer's, dementia, or depression etc.).
Radiation Oncology	A branch of medicine dealing with the use of radiation to treat cancer (this is different to chemotherapy).
Renal	Relating to the kidneys and associated structures.
Rheumatology	A branch of medicine dealing with conditions involving joint, soft tissue, or immune system problems.
Separation	A "separation" means when someone is discharged from hospital.
Short Stay Unit	A unit operated by the Emergency Department for patients requiring brief observation or intervention, but not required multi-day ward admission. The length of stay is typically less than 24-48 hours.
Subacute Services	Services that are not an emergency or requiring urgent medical attention (like rehabilitation or palliative care etc.).
Telehealth	Telehealth is the use of electronic equipment to support long-distance health care. This can also be used for education of community members and health professionals. For example, the use of video technology to support consultations between patients and specialists who are remote from each other.
Tertiary Services	Specialist services provided to patients from outside a hospital's primary catchment area.
Tonsillectomy	The surgical removal of the tonsils.
Trauma	A significant injury, often including multiple parts of the body, that require a high level of care in an appropriate hospital.
Triage	A process of clinical prioritising based on how unwell you are, and your potential to get worse. Patients should be seen in order of need, not simply on how long you have waited.
Urology	A branch of surgery dealing with the male and female urinary systems, including the male reproductive organs.
Vascular	Vessels in your body, such as veins and arteries.
Ventilation	The process of moving air in and out of the lungs, such as using a squeeze bag or machine.

Profile of Tasmanian Clinical Services in Tasmania

The table below provides the current and future 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	Future	Current	Future	Current	Future	Current	Future
Clinical Support Services								
Anaesthetic services	6	6	5	5	4	4	3	3
ICU/HDU	6	6	5	5	4	4	Stand-alone HDU	Post-operative support unit
Medical imaging services	6	6	5	5	4	4	3	3
Pathology	6	6	5	5	5*	5*	4	4
Pharmacy	6	6	5	5	3	3	3	3
Core Clinical Services								
Acute stroke services	6	6	5	5	4	4	4	3
Cardiology	6	6	5	5	4	4	3	3
Cardiothoracic services	6	6	5	5	No level	No level	No level	No level
Child and adolescent mental health acute inpatient services	4	5	3	5	3	3	No level	No level
Drug and alcohol services	5-6	6	4	4	3	3	No level	4
Ear, nose and throat	6	6	5	5	Level 4 capability but some surgery per-formed at level 5	4	Level 3 capability but some surgery per-formed at levels 4 and 5	3
Emergency medicine	6	6	5	5	4	4	Level 3 capability but some services provided at level 4 and above	3
Endocrinology	6	6	4	5	4	4	3	3
Gastroenterology services	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 and 6	4

	RHH		LGH		NWRH		Mersey	
	Current	Future	Current	Future	Current	Future	Current	Future
General surgery	6	6	5	5	Level 4 capability but some surgery currently per-formed at levels 5 and 6	4	Level 4 capability but some surgery per-formed at levels 5 and 6	3
Geriatric services	6	6	4	5	3	3	No level	4
Gynaecology services	6	6	5	5	4	4	Level 3 capability but some surgery per-formed at level 4	3
Hyperbaric medicine	6	6	No level	No level	No level	No level	No level	No level
Infectious diseases	6	6	4	5	4	4	No level	No level
Integrated cancer services								
• Haematology	6	6	5	5	4	4	4	4
• Medical oncology	6	6	6	6	5	5	4	4
• Radiation oncology	6	6	6	6	No level	5	No level	No level
Maternity services	6	6	5	5	4	(4)	4	1
Mental health inpatient services	6	6	5	5	5	5	3	3
Neonatology service	6	6	5	5	4	(4)	3	No level
Neurology	6	6	4	5	3	4	No level	No level
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
Paediatric medicine	5**	5	4	4	3	3	1	1
Paediatric surgery	5**	5	4	4	3	3	1	1
Pain management	6	6	4	5	No level	4	No level	4
Palliative care***	4	4**	4	4	3	3	No level	3
Plastics and reconstructive surgery	5**	5	5	5	4	4	3	3
Rehabilitation services	5**	5	5	5	4	4	No level	4
Renal services	6	6	5	5	3	3	2	2

	RHH		LGH		NWRH		Mersey	
	Current	Future	Current	Future	Current	Future	Current	Future
Respiratory medicine	5	6	4	5	4	4	3	3
Rheumatology	6	6	4	5	No level	4	No level	4
Trauma services	6	6	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

*Service provided by private provider (in full or part)

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

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

( ) = Service to be consolidated into one site at Burnie – facility yet to be determined


Tasmanian
Government