

# TASMANIA'S HEALTH PLAN

Summary

MAY 2007

# Table of contents

<b>Foreword by the Hon Lara Giddings MHA</b>	<b>4</b>
<b>Executive summary</b>	<b>6</b>
<b>Introduction</b>	<b>10</b>
The scope of Tasmania's Health Plan	10
Processes for the development of Tasmania's Health Plan	10
<b>Planning parameters</b>	<b>11</b>
Geography	11
Population size and distribution	11
Population age	12
Population health	14
Cultural diversity	14
Indigenous population	15
Socio-economic status	15
<b>Tasmania's health service system</b>	<b>16</b>
Community Health Centres	16
Rural inpatient facilities	16
Palliative Care services	16
Youth Health Services	17
Other primary health services	17
General Practice	17
Home and Community Care services	17
Residential aged care services	18
Regional Health Services	18
Major acute public hospitals	18
Private acute hospitals	19
Self-sufficiency of public hospital care	19
The Tasmanian Ambulance Service	20
Medical retrieval services	20
<b>The health professional workforce</b>	<b>21</b>
The medical workforce	21
Nursing and allied health professionals	22
<b>Allocating health resources appropriately</b>	<b>23</b>
Health care costs	23
Ambulatory care sensitive conditions	23
A mismatch between primary health funding allocations and community needs	24
<b>Lessons from the Richardson Report</b>	<b>26</b>

<b>A sustainable health service system for the future</b>	<b>27</b>
Key principles	27
Acceptable cost	27
Service sustainability	27
<b>Integrating primary and acute care</b>	<b>29</b>
A new service model to better integrate Tasmania's Health Services	29
Integrated care centres	29
Enhancing primary care	30
Clinical networks	30
<b>The Primary Health Services Plan</b>	<b>31</b>
The primary health approach	31
The prevention and management of chronic conditions	31
Improved relationships with general practice	32
Application of the service model to primary health	32
A changed and expanded role for Rural Health Centres	33
Communication and collaboration between service providers	35
Maintaining a focus on safety, quality and clinical governance in primary care	35
<b>A service capability framework for acute hospital services</b>	<b>37</b>
Local, regional, single site and state-wide services	37
Principles for single site and state-wide service development	39
Clinical networks	40
Clinical Advisory Council	41
Ensuring effective credentialling and defining the scope of clinical practice	41
Roles and responsibilities of the acute hospitals	42
<b>Strategies for acute hospital services in the South</b>	<b>43</b>
<b>Strategies for acute hospital services in the North</b>	<b>46</b>
<b>A new strategy for the North West Regional Hospital</b>	<b>48</b>
Approach to planning sustainable services	48
Ensuring sustainable service design	49
Intensive care services in the North West	50
Emergency medicine in the North West	50
Obstetric services in the North West	51
Consequences for vascular surgery	51
Other medical and surgical services in the North West	52
Role of the Burnie campus	52
Role of the Mersey campus	52
Implications of the changed services in the North West for Launceston General Hospital	53
<b>Strategies for specific acute services</b>	<b>54</b>

<b>Enabling factors</b>	<b>56</b>
Teaching, training and the health workforce	57
Research	57
Transport and retrieval	57
Patient and carer support	58
Relationships with the private sector	59
System governance	59
<b>Future Health Tasmania</b>	<b>61</b>
The implications of health service integration	61
Capacity of existing resources	61
Implementation plan and change management strategy	61
Evaluation	62
<b>Appendix 1 – Primary Health coordination areas and catchment populations</b>	<b>63</b>
<b>Appendix 2 – Services provided by rural inpatient facilities</b>	<b>64</b>
<b>Appendix 3 – Australian Government-funded regional health services</b>	<b>66</b>
<b>Glossary</b>	<b>67</b>

# Foreword by the Hon Lara Giddings MHA

*Minister for Health and Human Services*



Tasmania, the rest of Australia and much of the Western world faces challenges meeting the health needs of the community.

Together with these challenges, there are exciting opportunities to redesign our health system to improve health services and community health and wellbeing.

Addressing health workforce shortages, keeping pace with rapidly changing technology, managing the rising cost of health care and meeting the health care needs of the ageing population are universal challenges. Tasmania faces particular challenges, however, because of its size, location and the more rapid ageing of its population compared with the rest of Australia.

The proportion of Tasmanians who are aged more than 65 years is above the national average and is increasing. Because older people require more health services than younger people, demand for health care in Tasmania will continue to rise far more quickly in coming years than the rate of population growth. In addition, Tasmania is suffering an epidemic of chronic disease, creating very high demand for health services. This demand will not lessen until the health risk factors for chronic disease in the community are addressed.

At the same time, we are experiencing escalating costs in our hospitals and a clear mismatch between our current services and the needs of the community.

There is a growing recognition that the way in which health services are configured impacts on their quality, requiring health systems everywhere to ensure that the configuration of their services supports the delivery of quality care. Achieving local access to health care must be balanced with the need to ensure appropriate service configuration.

There are opportunities to consider the introduction of new services and technologies to Tasmania, enabling our community to become even more self-sufficient in health care.

Increasingly, health care is delivered in community settings rather than in acute hospitals. There are opportunities for us to redesign systems of care to ensure that care provided across different settings is integrated seamlessly and that communities can access a comprehensive mix of services in appropriate settings.

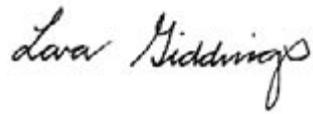
The Tasmanian Government has seen the need for a new and comprehensive health plan that will position the health system to meet these challenges now and into the future.

This is that Plan – Tasmania's Health Plan.

Tasmania's Health Plan has two supporting plans – the Clinical Services Plan for Tasmania and the Primary Health Services Plan. It supports the whole of government plan *Tasmania Together*, a 20-year plan that sets out the future directions for Tasmania under five key themes: community; culture; democracy; economy and environment.

A key theme throughout the development of this Plan has been the need to ensure the sustainability of our health services. If services are designed for sustainability, they will remain affordable and the community can depend on their availability and rely on them to provide quality care.

Tasmania's Health Plan defines the way in which our community-based health services and major acute public hospitals should be developed, including the roles and services they will provide, to ensure sustainable excellence in public health care for Tasmanians for the future.

A handwritten signature in black ink that reads "Lara Giddings". The signature is written in a cursive, flowing style.

Lara Giddings  
Minister for Health and Human Services

# Executive summary

Tasmania's Health Plan provides a blueprint for the integrated development of primary and acute health services. It draws together the recommendations of the Primary Health Services Plan for primary health services and the Clinical Services Plan for acute health services, both of which were developed following comprehensive processes of stakeholder consultation and data analysis.

The Plan establishes a clear case for change in the way our health services are designed and delivered. It describes the current and increasing future health care needs of the community. It also identifies the challenges and opportunities facing Tasmania's health system, including the ageing of the population, the need to focus on preventive and early intervention services, the need to ensure proper system design to support quality care and opportunities to introduce new models of care and benefit from new technologies. It further develops the service system design concepts introduced in the 2004 report: *The Tasmanian Hospital System. Reforms for the 21st Century* (the Richardson Report).

The recommendations of the Plan are based on explicit principles for sustainable service design. If services can be provided safely, effectively and efficiently, the Plan proposes that they should be delivered locally. Where centralisation of services is necessary because of quality, cost or sustainability considerations, access should be facilitated through patient and carer support and service accountability arrangements.

The Primary Health System will be redesigned to focus more on prevention and community-based care, reserving acute hospital resources for people who cannot be managed in non-hospital settings. Service changes will be introduced to enable:

- greater capacity to treat diabetes at the primary health level;
- greater access to home-based services such as post acute care and specialised community nursing;
- more emphasis on health promotion and management of chronic disease;
- working with young people, through collaborative partnerships, to adopt healthy lifestyles;
- increased access to mental health and alcohol and drug programs in rural areas;
- an expansion of the approaches to chronic disease self-management;
- increased access to community nursing; and
- increased day respite services.

A new four-tier service model has been established, providing an integrated network of health services across Tasmania, based on sound health planning principles. Community health facilities will be developed as a key resource for their community, acting as an access and referral point for community health services and intrinsically linked to other parts of the health care system. New community-based services called integrated care centres providing a range of short stay, ambulatory acute and primary care services will be developed in the Clarence/Sorell area and in Kingborough. Integrated care centres providing a comprehensive mix of non-emergency ambulatory and short stay acute and subacute services for admitted patients will be developed in Hobart (within or adjacent to the Royal Hobart Hospital) and in Launceston close to the Launceston General Hospital.

Relationships with general practice will be strengthened through various partnership mechanisms, providing the opportunity for general practice to be funded for the provision of community health services, with the objective of achieving better integration and effectiveness of service delivery.

Home and Community Care Services will be enhanced and Primary Care Partnerships will be established, following a review of interstate experience, to strengthen and support the primary health sector.

In applying the health planning principles to rural health sites in Tasmania, it is clear that some are not meeting the criteria established to demonstrate sustainability. It is not possible for them to deliver current services to their community in a way that is safe, effective and at an acceptable cost. Nor will it be possible to continue to provide these services in the future when workforce issues worsen.

Consultation has occurred with the communities of St Marys, Ouse and Rosebery in relation to this issue and new models of services are being developed that will better meet the needs of these communities on a more sustainable basis.

At Swansea and New Norfolk, there is a recognised need for additional inpatient beds and this will be considered over time as resources become available.

In our major acute hospitals, new models of emergency and short stay care will be introduced, to ensure the best use of scarce hospital resources and the provision of care in the most appropriate locations. Co-located GP clinics will be considered for introduction at each of the major acute hospital sites in Tasmania.

Across the State, acute hospital services will be configured based on a defined service capability framework comprising:

- designation of clinical services according to their clinical roles and responsibilities as local, regional referral, single site and state-wide;
- adoption of principles for the future development of single site and state-wide services;
- the development of multidisciplinary, system-wide clinical networks, overseen by a Clinical Advisory Council, to facilitate increased collaboration, service integration, monitoring and development;
- best practice processes for credentialling and defining the scope of practice for all senior medical staff, and the introduction of new technology to Tasmania; and
- clarification of the roles and responsibilities of each of the acute hospitals.

The roles and responsibilities of each acute hospital have been designated as follows:

- the Royal Hobart Hospital (RHH) is the major tertiary referral hospital for the State, and it should continue to provide most single site and state-wide services because of its capital city location, level of infrastructure, associated services and access to important non-health organisations;
- the Launceston General Hospital (LGH) is the major referral hospital for the North and North West of the State, providing a comprehensive range of acute hospital services and a significant number of tertiary services, including some single site services; and
- the North West Regional Hospital (NWRH) provides local acute hospital services to the communities of the North West and West of the State.

In the South of the State, the redeveloped RHH will need to accommodate a substantial growth in demand. Integration of most overnight and ambulatory care services in one setting at the hospital is recommended, with ambulatory and short stay services incorporated in an integrated care centre within or adjacent to the redeveloped hospital. New integrated care centres also will be developed in population growth centres in Clarence/Sorell and Kingborough.

Considerable growth in demand will occur in Launceston and surrounding areas and the LGH is likely to be affected by changes to the NWRH. The Launceston General Hospital will be developed to accommodate significant increases in demand and an integrated care centre will be developed in the City of Launceston, close to the hospital.

The configuration of services across the two NWRH campuses has been the subject of robust debate, concern and opinion both before and during the development of this Plan. The value to their local communities of the services provided at each campus and the obvious difficulties that have been experienced providing a sustainable service over a long period of time have necessitated considerable attention during the planning process.

Forty one per cent of current public hospital services in the North West are provided at the Burnie campus and 26 per cent are provided at the Mersey campus. Five per cent of residents of the Burnie catchment access care at the Mersey campus; while 19 per cent of residents of the Mersey catchment access care at the Burnie campus.

Present patterns of service delivery, however, reflect past policy, planning and operational decisions. Decisions about the future have been based on the needs of the population and an understanding of good service design, rather than on current patterns of service delivery.

Considerable growth in demand for inpatient care in the North West will need to be accommodated, and current service design problems must be addressed.

The NWRH should provide a comprehensive service to the entire community, but continuing efforts to duplicate services across both campuses are creating sustainability problems and threatening the quality of care for the whole community.

Delineation of the roles of the two campuses is proposed, with high acuity inpatient and emergency services consolidated on the Burnie campus. Specialist aged care and subacute rehabilitation, low acuity obstetric and paediatric services, high volume medical and surgical day-only services (including general surgical, orthopaedic and gastroenterology procedures for patients requiring hospital admissions of up to 23 hours, chemotherapy and renal dialysis) will be provided at the Mersey campus, together with a full range of non-inpatient consulting services. There will be an emergency care centre at the Mersey and the theatre recovery area will be capable of providing resuscitation support so that procedural and obstetric patients can be supported appropriately in the event of an emergency requiring transfer from the campus.

An opportunity will be provided for the existing vascular surgical service to be relocated to the Launceston General Hospital as a component of a state-wide service.

A number of acute hospital services posed particular planning issues which have been addressed during this planning process. The introduction of cardiac electrophysiology and PET scanning to Tasmania has been assessed as clinically feasible and appropriate – implementation will depend on a thorough assessment of additional costs and relative budget priorities. Recommendations based on best practice planning principles are made to maintain some services, including bariatric surgery, complex upper gastrointestinal surgery and bone marrow transplantation, as single site or state-wide services. Other services including pathology and medical imaging should be considered for formal designation as state-wide services. State-wide cystic fibrosis services and specialist pain management services need continued development and considerable additional investment will be required in community-based multidisciplinary prevention and management of diabetes. Substantial growth in renal dialysis demand will be accommodated, in the main, through home- and community-based services including the development of additional facilities in integrated care centres.

An additional linear accelerator for radiation oncology treatment will be required in Tasmania. The feasibility of establishing this as a single machine service in the North West, provided on an outreach basis from the Holman Clinic at Launceston, will be investigated thoroughly.

A series of significant enabling factors including education, training and research, relationships with and supporting the private sector; transport and accommodation support for patients and their carers and strong system-wide governance have been identified as crucial to the ongoing success of the Tasmanian health system. A range of strategies is proposed to support and improve performance in these areas.

The changes proposed in this Plan need to be implemented through a careful and well-considered change management process, supported by more detailed investigation of the relevant physical facilities and their capacity to manage projected activity at each of the key sites.

As a first step, a change management plan is being developed with a tight timeline for the Mersey campus of the NWRH which will cover its relationship to both the NWRH Burnie campus and the LGH.

The Department of Health and Human Services will then develop a detailed implementation plan which clearly identifies timelines, actions and responsibilities for the wider clinical service changes across Tasmania. The implementation plan will set out a change management strategy to be adopted so that clinicians, staff, other service providers and the community are partners in the required change process.

# Introduction

## The scope of Tasmania's Health Plan

The Tasmanian Government Department of Health and Human Services (**DHHS**) is responsible for governance, policy, planning, funding and overseeing the quality of service delivery in the public health care system.

Tasmania's Health Plan (**the Plan**) provides a blueprint for the future integrated development of:

- primary health services, currently delivered through community health centres and small rural health facilities; and
- acute health services, currently delivered through the major acute public hospitals (the Royal Hobart Hospital, the Launceston General Hospital and the North West Regional Hospital Burnie and Mersey campuses).

The Plan complements other DHHS policy and planning documents including:

- DHHS Corporate Plan 2003-2006;
- Strengthening the Prevention and Management of Chronic Conditions, Policy Framework 2005;
- Mental Health Services Strategic Plan 2006-11;
- Aboriginal Health and Wellbeing Strategic Plan;
- Aged and Rehabilitation Services Plan (draft);
- Strategic Framework for State-wide Cancer Services (draft); and
- Tasmania's Diabetes Action Plan.

## Processes for the development of Tasmania's Health Plan

This Plan represents the outcome of a detailed and collaborative planning process undertaken by the Acute Health Services Group and the Community Health Services Group of the DHHS.

The key features of both the Acute Health Services Group's Clinical Services Plan and the Community Health Services Group's Primary Health Services Plan have been synthesised into Tasmania's Health Plan.

A comprehensive stakeholder consultation process conducted over six months underpinned development of the Clinical Services Plan and the Primary Health Services Plan. There has been significant input into both plans by the health care professionals who provide services to the community and by those who use health services or have a community interest in them. Both plans also have been informed by comprehensive data analysis.

# Planning parameters

## Key points

- Tasmania is a small state with a dispersed population. Population growth over the planning period is expected to be modest, but the proportion of older people in the community will increase more rapidly than elsewhere in Australia.
- Tasmania has a higher level of socio-economic disadvantage than other Australian jurisdictions.
- The ageing and socio-economic status of the population have important implications for the health service system because older people and people who experience socio-economic disadvantage have greater needs for health services.
- The Tasmanian community has higher rates of preventable disease than communities in almost all other Australian States and Territories. These diseases are causing significant morbidity and mortality for individuals and are creating an unsustainable cost burden for our community.
- There are substantial opportunities to redesign our service system and change our models of care to provide better care in more appropriate settings for our community.

## Geography

The major population centres in Tasmania are Hobart in the South, Launceston in the North and Burnie and Devonport in the North West.

There are major road networks between Hobart and Launceston; and between Launceston, Devonport and Burnie. Many areas of the State are not well served by major road networks, however, which influences the ways in which residents access health services.

There are 29 Local Government Areas (**LGAs**) which, for DHHS planning purposes, are categorised into seven Primary Health Coordination Areas and three catchment populations: the South, North and North West. This categorisation is demonstrated in Appendix I.

## Population size and distribution

The Estimated Resident Population of Tasmania at June 2006 was 488,948 persons, an increase of 3.7% from 2001. The population is expected to increase by 3.2% between 2006 and 2021, with population growth in the South (1.4%) and North (2%) and a decrease in population in the North West (-7.5%).

Many Tasmanian communities are small, creating a tension between the desire to deliver comprehensive health services locally and the need to structure services so that they are sustainable. This is a particular challenge for small and/or complex services.

There will also be an overall change in the distribution of the population across the State. Populations in local government areas such as the West Coast, Circular Head and the Derwent Valley will decrease, other local government areas such as Kingborough and Meander Valley will grow.

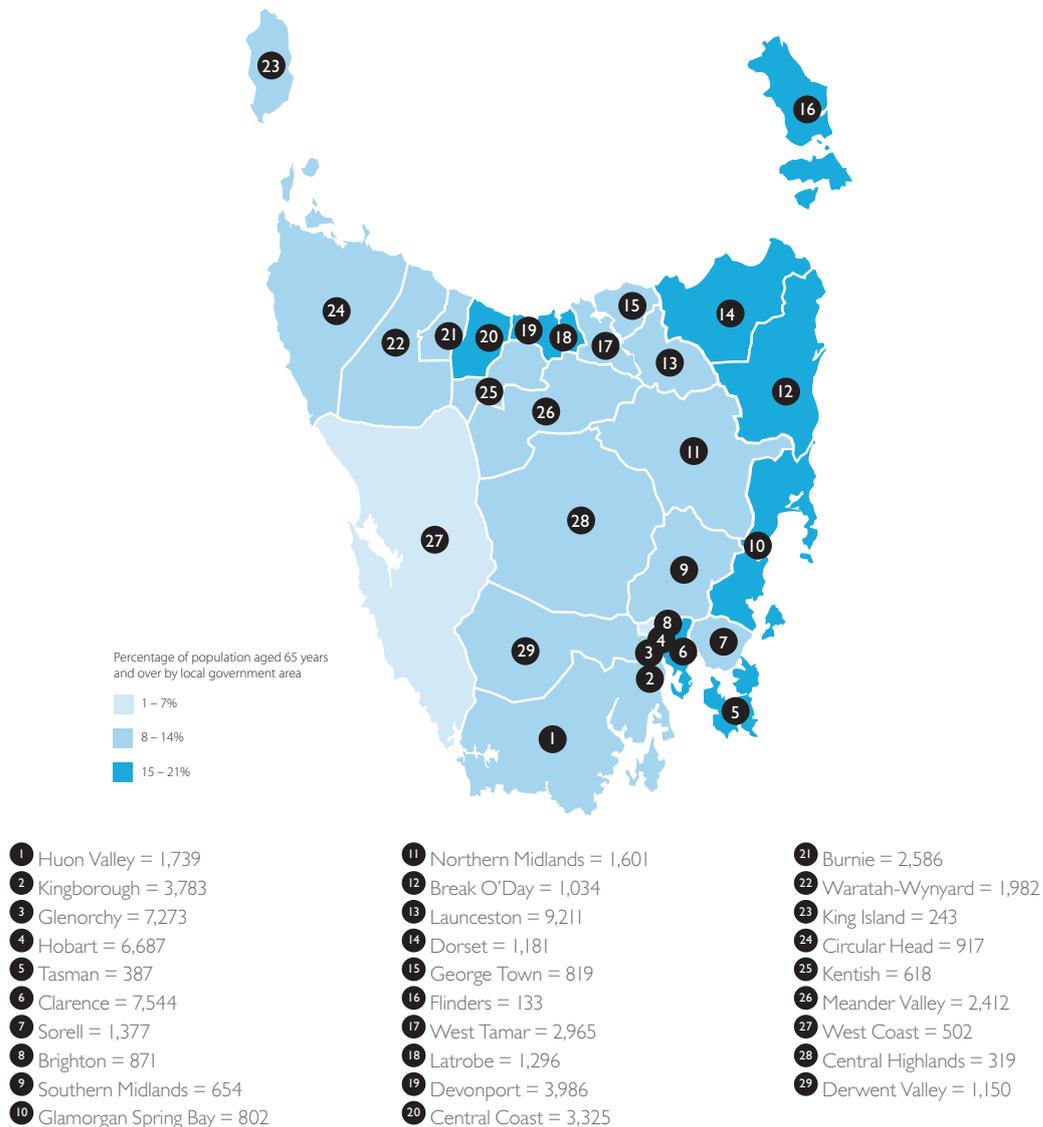
## Population age

In June 2006, Tasmania had the second highest proportion of people aged 65 years and over of any Australian state or territory.<sup>1</sup>

The Tasmanian population is ageing at a more rapid rate than the populations of other States and Territories. The proportion of people aged 70 years and over will increase from 10.6% in 2006 to 16.6% in 2021, and by 2021 there will be 28,236 more people aged 70 years and over.

Figure 1 shows the uneven distribution of the older population across the State. The unevenness of this distribution is likely to increase as more Tasmanians move into retirement.

**Figure 1: Population aged 65 and over by LGA (2003)**

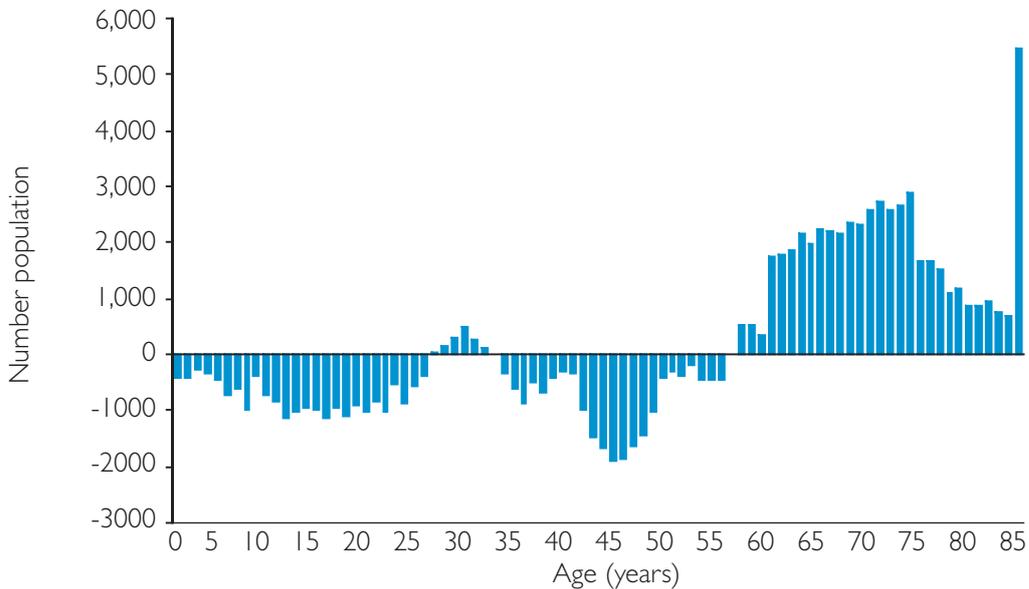


Source: ABS 2003, National Regional Profile.

<sup>1</sup> Australian Bureau of Statistics (2006) *Australian Demographic Statistics*, Catalogue no. 3201.0.

Figure 2 shows the projected changes in population numbers by age group between 2006 and 2021. While the population is predicted to increase by about 3% overall, almost all growth occurs in the older age groups with a decrease in the size of almost all younger age groups.

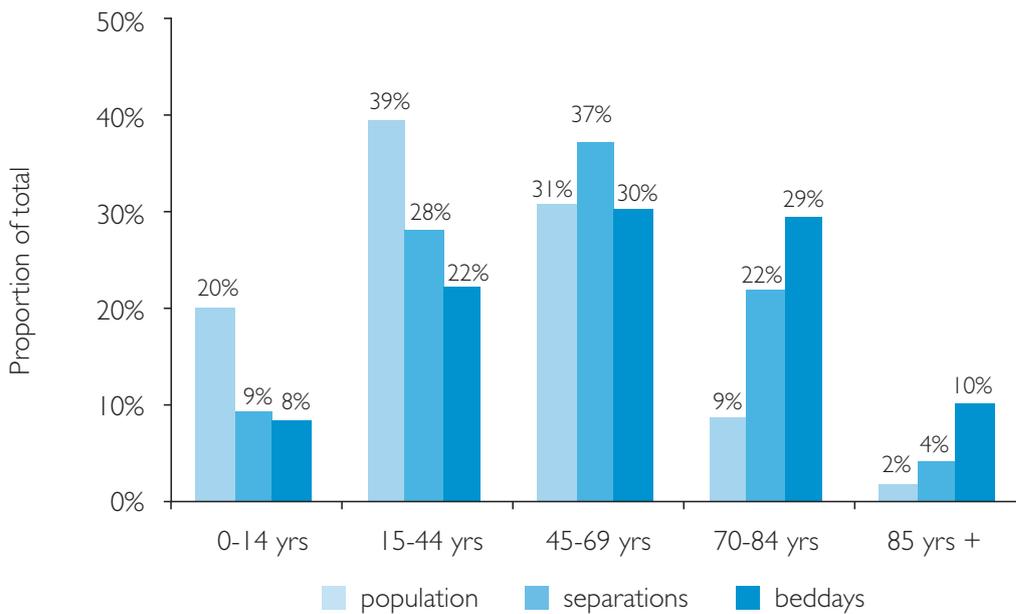
**Figure 2: Projected change by age in the Tasmanian population, 2006 to 2021**



Source: Australian Bureau of Statistics *Population Projections Australia 2002-2101* Catalogue no. 3222.0. Cited in *Tasmania's Population 2003, An information paper on recent trends and State Government policies*, Department of Treasury and Finance, 2003, ISBN 0 7246 5092 X

These changes have important implications for the health care system, because, as demonstrated in Figure 3, older people have greater needs for health services. In addition, their needs are more likely to relate to chronic diseases.

**Figure 3: Resident utilisation of acute beddays and population share, 2004-05**



Source: Productivity Commission (2005) *Economic Implications of an Ageing Australia*, Research Report, Canberra.

## Population health

Compared with the national average, Tasmania has:

- a higher proportion of the population who report a long term health condition (79.0% compared with 76.7%);
- a higher proportion of the population aged 18 years and above who smoke (25.4% compared with 23.2%);
- a higher proportion of the population who are obese (17.1% compared with 16.6%);
- a lower proportion of the population consuming the national recommended fruit and vegetable intake; and
- significantly higher smoking-related mortality rates than the national average.<sup>2</sup>

Diabetes and its complications are a major problem for Tasmanians. In 2004-05, Tasmanians went to hospital for diabetes more frequently than people in most other states<sup>3</sup> (after Western Australia and the Northern Territory) at 10.72 separations per 1,000 population, compared with the national average of 9.77 per 1,000 population.<sup>4</sup> Tasmania's age-standardised death rate<sup>5</sup> for type 2 diabetes has more than doubled over the past decade and Tasmania has the second highest incidence of this disease of all States and Territories. Tasmania also has the highest numbers of new cases of type 1 diabetes.

Tasmanians, on average, have shorter lives and higher death rates than the national average:

- between 2002 and 2004, the average life expectancy at birth of Tasmanian males was 76.7 years and of Tasmanian females 81.8 years, which is below the Australian average of 78.1 years for males and 83 years for females;<sup>6</sup> and
- the age standardised mortality rate for 2005 in Tasmania was 6.9 per 1,000 population; higher than the national average of 6.0 per 1,000 population.<sup>7</sup>

Nationally, Tasmania has the second highest:

- death rates for cancers overall;
- death rate for circulatory diseases;
- incidence of respiratory cancers; and
- rates for accidents and intentional self-harm.

Many of the conditions that are impacting significantly on the health and wellbeing of our community are preventable or their effects can be reduced by active prevention and early intervention strategies.

## Cultural diversity

While most Tasmanians are Australian born and speak English at home, a large number of overseas-born groups are represented by a small number of people. The top five countries of origin of settlers to Tasmania in 2004-05 were Sudan, the United Kingdom, New Zealand, Sierra Leone and the Philippines. In 2005-06, individuals and families from Fiji, Egypt, Thailand, China, Korea, India, Brazil, Ethiopia and South Africa also settled in Tasmania.

It is challenging to provide necessary services in a culturally appropriate way to small numbers of settlers from broadly diverse backgrounds.

2 Australian Bureau of Statistics (2006) *National Health Survey, 2004-05*, Catalogue no. 4364.0.

3 Hospital 'separations' are the total number of patients who were discharged, transferred out or died.

4 Australian Institute of Health and Welfare (2006) *Australian Hospital Statistics 2004-05*, AIHW Catalogue No. HSE 41. AIHA: Canberra.

5 Age-standardised death rate is an indicator of death rates across the population, adjusted so that comparisons can be made across (say) states with different population structures. It is usually measured per 1,000,000 population and is used as an indicator of health care need across the population.

6 Australian Institute of Health and Welfare (2006) *Australia's Health 2006*, AIHW Catalogue no. AUS 73. AIHW: Canberra.

7 Australian Bureau of Statistics (2006) *Deaths, Australia, 2005*, Catalogue no. 3302.0.

Tasmania continues to settle the highest proportion of refugees in comparison to other States – in 2004-05, almost 32% of our settlers were refugees compared to the national proportion of around 10%. Many of these new arrivals have high needs for health and wellbeing services.

### Indigenous population

Three and a half per cent of the total Tasmanian population is indigenous.<sup>8</sup> The majority of the Indigenous population is located in the South (47.9%), followed by the North West (31.9%) and the North (20.1%).

### Socio-economic status

The Australian Bureau of Statistics produces the Socio-Economic Indexes for Areas, which provides a method for determining the level of social and economic wellbeing of Australian communities. Tasmania has the second highest level of disadvantage of any Australian jurisdiction. Of the twenty-nine local government areas in Tasmania, only seven scored average or above average in socio-economic status, in 2001.<sup>9</sup> The socio-economic status of the Tasmanian community has important implications for the health care system. People who experience socio-economic disadvantage also experience higher levels of chronic disease.

<sup>8</sup> Australian Bureau of Statistics (2001) *Census of Population and Housing* <http://www.abs.gov.au/websitedbs/d3310114.nsf/Home/census>.

<sup>9</sup> Australian Bureau of Statistics, *Census of Population and Housing: Socio-Economic Indexes for Areas 2001*, Catalogue no. 2033.6.55.001.

# Tasmania's health service system

## Key points

- Tasmania has a well-developed primary and acute health service system comprised of a range of facilities providing non-admitted community-based services and inpatient services in metropolitan and rural areas.
- Publicly funded services are complemented by private community- and hospital-based services to provide a comprehensive health service system for our community.
- There is an increasing level of activity across all service areas and a high level of self-sufficiency for health services within the State.
- Effective planning will ensure that the system develops in a systematic, integrated way so that valuable resources are used efficiently to improve the health of our community.

## Community Health Centres

There are 23 community-based health centres in Tasmania, offering a variety of non-inpatient services including counselling and support, health promotion, medical, nursing and allied health services and accommodation and meeting spaces for visiting services including housing, disability, and family and child health services.<sup>10</sup>

Community Health Centres are located in Bridgewater, Bruny Island, Burnie, Cape Barren Island, Clarence, Clarence Plains, Cygnet, Devonport, Glenorchy, Huonville, Kings Meadows, Kingston, New Norfolk, Ravenswood, Risdon Vale, Sorell, Strahan, Swansea, Triabunna, Ulverstone, Westbury, Wynyard and Zeehan. Community health services are also provided from larger service centres in Hobart (Repatriation Centre), Launceston (John L Grove, Allambie) and Burnie (Parkside).

## Rural inpatient facilities

Tasmania has 158 rural health inpatient beds provided through 20 inpatient facilities: 144 beds (15 facilities) are run by the DHHS and 14 inpatient beds (five facilities) are funded by the DHHS and run by other organisations. There are four stand-alone facilities with less than 11 beds, and all facilities have less than 50 beds. Fourteen facilities also provide aged care services and in these cases, most have very small numbers of inpatient beds (between two and eight). The current service delivery profile of rural inpatient facilities is illustrated in Appendix 2.

DHHS-funded inpatient beds also are provided at residential aged care sites operated by non-government agencies (such as the May Shaw Nursing Centre, Huon Eldercare and Toosey Aged and Community Care) and by local governments (such as the Tasman Multi Purpose Centre and the Esperance Multi Purpose Centre).

## Palliative Care services

In this Primary Health service, specialist palliative care clinicians work within a consultancy framework across the whole health sector to support primary health service providers in urban and rural areas to provide quality palliative care. The Palliative Care Service has three specialist community teams based in Hobart, Launceston and Burnie, with outreach to rural areas. It has dedicated inpatient facilities for palliative care patients in Hobart and Launceston and an in-reach service into the State's teaching hospitals.

<sup>10</sup> Family and Child Health is a primary health service delivered through Human Services (which is also responsible for the Child Protection Services; Adoption and Information Service; Family Violence Counselling and Support Service; and Sexual Assault and Support Service).

## Youth Health Services

Youth Health Services offer young people aged 12-24 years a flexible and confidential service including information, education, support, referral, and counselling. Services are provided by three regional teams based in Hobart, Launceston and Burnie.

## Other primary health services

Specific primary health services including Aged Care Assessment Teams; Community Equipment Scheme; Community Options Service; Community Rehabilitation Services; Community Therapy Services (Physiotherapy, Speech Pathology, Occupational Therapy and Podiatry); Continence Services; and Health Promotion Activities may be provided at a Community Health Centre or Rural Inpatient Facility or as a visiting service across an entire region.

## General Practice

General Practice is a key component of primary health. Nationally, there is an average of one General Practitioner (GP) for every 1,000 persons.

In May 2006, there were 541 GPs in Tasmania or 1.1 GPs for every 1,000 people. Approximately 50% of Tasmanian GPs practice in cities of more than 100,000 people and 25% practice in rural areas with a population of less than 10,000 people.<sup>11</sup> While Tasmania is not disadvantaged in GP numbers on average, the number of GPs in 22 of the 29 LGAs falls below the national average. Under these circumstances, the impact of retirements and other departures from the workforce is highly significant. Table 1 demonstrates the number and distribution of GPs in Tasmania.

**Table 1: Number of GPs working in Tasmania by region and per 100,000 headcount, headcount and full time equivalent, 2006**

Region	Number	FTE	Population*	Headcount per 100,000	FTE rate per 100,000
South	310	195.6	239,444	129.5	81.7
North	135	97.3	137,936	97.9	70.5
North West	96	64.6	107,883	89.0	59.9
<b>Total</b>	<b>541</b>	<b>357.3</b>	<b>485,263</b>	<b>111.5</b>	<b>73.6</b>

\* Population is based on ABS estimated resident population by LGA at June 2005.

About 50% of the total rural Tasmanian GP workforce receives some funding support or incentives from the DHHS. Only the general practices in the Clarence and Risdon Vale Community Health Centres are managed by the DHHS.

## Home and Community Care services

The Home and Community Care (HACC) Program is funded jointly by the Australian and Tasmanian Governments. It provides a comprehensive range of community-based services to frail older people and younger people with a disability, and their carers. The overall objective of the HACC Program is to enhance independence of clients and avoid admission to inappropriate care settings.

In Tasmania the program funds around 60 non-government organisations, as well as business units within the DHHS, to provide services such as community nursing, allied health, centre day care, domestic assistance, personal care and community transport.

11 Tasmanian General Practice Divisions (2006) *Census of Tasmanian General Practitioners, 2006 Results*, TGPD: Hobart.

## Residential aged care services

The Australian Government Department of Health and Ageing (**DoHA**) funds residential and community aged care, the availability of which is crucial to the efficient functioning of the public acute hospital system. Inability to discharge patients who require residential aged care or high level community-based support reduces the efficiency of Tasmania's public hospitals and their ability to provide high quality care.

The number of RAC places, CACPs and EACH packages per 1,000 persons aged 70 and over is higher in Tasmania than in any other State or Territory other than South Australia, but is below the current DoHA benchmark of 88 RAC places and 20 CACP per 1,000 persons aged 70 and over. The allocation of resources to the South is greater than to the North and North West.

## Regional Health Services

The Australian Government Rural Primary Health Program funds a number of rural health and wellbeing programs in more than a dozen rural Tasmanian communities. Programs include the Regional Health Services, More Allied Health Services and the Medical Specialist Outreach Program. Many non-government organisations play an active role in the provision of health services in Tasmania. Funded Regional Health Services and the services they provide are described in Appendix 3.

## Major acute public hospitals

### The Royal Hobart Hospital

The Royal Hobart Hospital (**RHH**) is the principal tertiary referral hospital for Tasmania and a major teaching and research hospital linked to the University of Tasmania.

The RHH provides primarily a range of services to its local community as well as complex tertiary services in medicine, surgery, critical care, aged care, rehabilitation, mental health, obstetrics and paediatrics. The RHH is the sole provider of a number of complex services in the State, including cardiothoracic surgery and neonatal and paediatric intensive care. It operates from a maximum base of 550 beds including 460 acute overnight and 90 day-stay beds and the co-located Hobart Private Hospital share some patient care and support services.

### Launceston General Hospital

The Launceston General Hospital (**LGH**) provides a comprehensive range of acute hospital services to its own community and on a regional referral basis to people from the West and North West of the State. It provides several tertiary-level services, is a teaching hospital of the University of Tasmania and supports significant research activity.

The LGH provides services in medicine, surgery, critical care, aged care, rehabilitation, mental health, obstetrics and paediatrics. It is the sole site for a number of subspecialty services. It operates from a maximum base of 339 beds including 283 acute overnight and 56 day beds. The private sector is contracted to provide public ophthalmology and nuclear medicine services.

### North West Regional Hospital (Burnie and Mersey Campuses)

The North West Regional Hospital (**NWRH**) has campuses at Burnie and Latrobe (approximately 60 km apart) operating under a single management model. The campus at Latrobe is called the Mersey campus. The NWRH provides acute hospital services, mainly at role delineation levels 3 and 4 in medicine, surgery, critical care, obstetrics, paediatrics, mental health, drug and alcohol services, aged care and rehabilitation to the communities of the West and North West of Tasmania. It is a teaching hospital of the University of Tasmania and the University's Rural Clinical School is located on site. The NWRH Burnie operates from a maximum base of 157 beds including 142 overnight beds and 15 day beds.

The NWRH Mersey campus operates from a maximum base of 115 beds including 96 acute overnight beds and 20 day beds. There are contracts for the provision of public services by private providers for maternity services, ophthalmology services and diagnostic pathology and imaging services.

## Private acute hospitals

### Calvary Health Care Tasmania

Calvary Health Care Tasmania operates five campuses – Lenah Valley, St John's (South Hobart), the outpatient rehabilitation service (New Town), St Luke's (Launceston) and the St Vincent's Hospital (Launceston).

Together the five campuses provide a comprehensive range of acute services, subacute and ambulatory services.

### Healthscope Tasmania

Healthscope Tasmania operates two hospital campuses – the Hobart Private Hospital and St Helen's Private Hospital.

The Hobart Private Hospital is co-located with the Royal Hobart Hospital, and provides a range of medical and surgical services and a 24 hour department of emergency medicine.

St Helen's Private Hospital, also located in Hobart, is a 37-bed hospital, which includes a dedicated 31-bed acute psychiatric inpatient unit.

### The Eye Hospital at Launceston

The Eye Hospital is a private hospital dedicated to medical and surgical ophthalmology. It has a theatre complex and offers an extensive range of day surgery procedures. Its facilities also are used for dental procedures requiring general anaesthesia.

### The North West Private Hospital

The North West Private Hospital is a 70-bed hospital co-located with the North West Regional Hospital (Burnie campus). It provides services in general surgery, orthopaedic surgery, general medicine, ophthalmology, gynaecology, and obstetrics. The hospital is operated by Health Care Australia Pty Ltd.

### Other acute private hospitals

Hobart Clinic (Rokeby) is a 27-bed inpatient hospital providing assessment and treatment for a wide range of psychiatric and mental health disorders.

Philip Oakden House Hospice is a six-bed private hospital which specialises in palliative care for both private and public patients.

## Self-sufficiency of public hospital care

There is a high level of self-sufficiency in the provision of public hospital services within Tasmania. The state supplies 98.8% of acute public hospital services. In 2004-05 there were 1,359 outflows to interstate public hospitals which accounted for 1.2% of public hospital utilisation. Public outflows were:

- primarily for people aged 0-14 years and 15-44 years; and
- for the Service-Related Groups of cardiology (5.7%), Interventional cardiology (7.4%), haematology (5.4%), medical oncology (5%), neurology (5.4%), non-subspecialty medicine (5.4%), neurosurgery (3.5%), orthopaedics (8.4%) and non-subspecialty surgery (6.6%).

## The Tasmanian Ambulance Service

The Tasmanian Ambulance Service has a network of 47 stations and operates through a hub and spoke service model around each of the major acute public hospitals. Four hundred and fifty volunteer officers work alongside paramedics in 14 locations as well as from 23 stations staffed wholly by volunteers.

## Medical retrieval services

The adult medical retrieval service operates with the use of a fixed wing aircraft based at Launceston. The service is coordinated from the LGH and presently is staffed on a rotational basis by staff from the LGH and the RHH.

The neonatal and paediatric retrieval service operates with the shared use of a helicopter based at Hobart and is staffed by the RHH.

# The health professional workforce

## Key points

- Tasmania has experienced considerable challenges attracting and retaining skilled health professionals – these challenges will continue for the foreseeable future.
- Tasmania's health professional workforce is ageing and the distribution of some key professional groups within the State is uneven.
- Creating an environment in which health care professionals can practise their skills efficiently and effectively to deliver high quality care will assist recruitment and retention efforts in a highly competitive environment.

## The medical workforce

The Australian Medical Workforce Advisory Committee (**AMWAC**) has developed population-based benchmarks for medical and surgical specialists, which have been compared to Tasmania's existing specialist numbers. This comparison does not seek to analyse future workforce needs and in particular takes no account of demographic trends or succession planning issues. Rather, it presents a current snapshot of specialist supply across the health system, encompassing private practice as well as the public and private hospital workforces.

Tasmania meets or exceeds the AMWAC benchmarks in 21 of the 35 specialties considered. In seven specialties, Tasmania does not meet benchmarks, and in another seven specialties no benchmarks have been established.

AMWAC population benchmarks indicate that Tasmania is supplied adequately with specialists in anaesthesia, critical care medicine, emergency medicine, general surgery, geriatric medicine, neurosurgery, obstetrics and gynaecology, orthopaedic surgery, paediatric surgery, pathology, psychiatry, radiation oncology, radiology, rehabilitation medicine, respiratory medicine, urology and vascular surgery. In Ear, Nose and Throat (**ENT**) surgery, gastroenterology, medical and haematological oncology and ophthalmology there will be an adequate supply of specialists, according to AMWAC benchmarks, if the vacancies that were identified at the time the benchmarking exercise was undertaken were filled. Palliative medicine now reaches national benchmarks as vacancies have been filled. The population benchmarks indicate that cardiologists, dermatologists, neurologists and paediatricians are in relatively short supply and that shortages also exist in cardiothoracic surgery and renal medicine.

For a variety of reasons many GPs are working fewer hours and the number of "full-time equivalent" GPs is less than the number of individuals practising. In May 2006 there were 531 GPs, or 351.7 full time equivalent GPs working in Tasmania. While Tasmania is not disadvantaged on average GP numbers, in 22 of the 29 Local Government Areas (LGAs) there are fewer GPs than the national average.<sup>12</sup> Under these circumstances, the impact of retirements and other departures from the workforce is highly significant.

The average age of Tasmanian GPs during GP Census week 2006 was 49.7 years. About one third of the workforce was aged over 55 years, one third was between 45 and 54 years, and one third was less than 45 years of age.<sup>13</sup>

<sup>12</sup> Based on Tasmanian General Practice Divisions (2006) *Census of Tasmanian General Practitioners, 2006 Results*, TGPD: Hobart and Australian Bureau of Statistics (2005) *National Regional Profile, 1999 to 2003*, Catalogue no. 1379.0.55.001.

<sup>13</sup> Tasmanian General Practice Divisions (2006) *Census of Tasmanian General Practitioners, 2006 Results*, TGPD: Hobart, pp 4-5.

## Nursing and allied health professionals

There also are considerable challenges facing the nursing and allied health workforces in both primary and acute care settings, for example:

- the nursing workforce is ageing. At April 2007 44% of the current Primary Health Services nursing workforce was aged 51 years and over and 77% of the total workforce was aged between 40 and 60 years;
- Tasmania has an equitable share of the national allied health workforce but its distribution within the State is uneven. Outer regional and remote regions of Tasmania have 36% of the population but only 24% of the allied health workforce. Some professional groups such as orthotics and prosthetics are based entirely in the larger population centres; and
- the allied health workforce in Tasmania grew by 5% between 1996 and 2001, but the very small professions such as orthoptics, orthotics and audiology showed significant decline. In addition, there are current acute shortages in some key allied health professions including nutrition, dietetics, exercise physiology and speech pathology.

# Allocating health resources appropriately

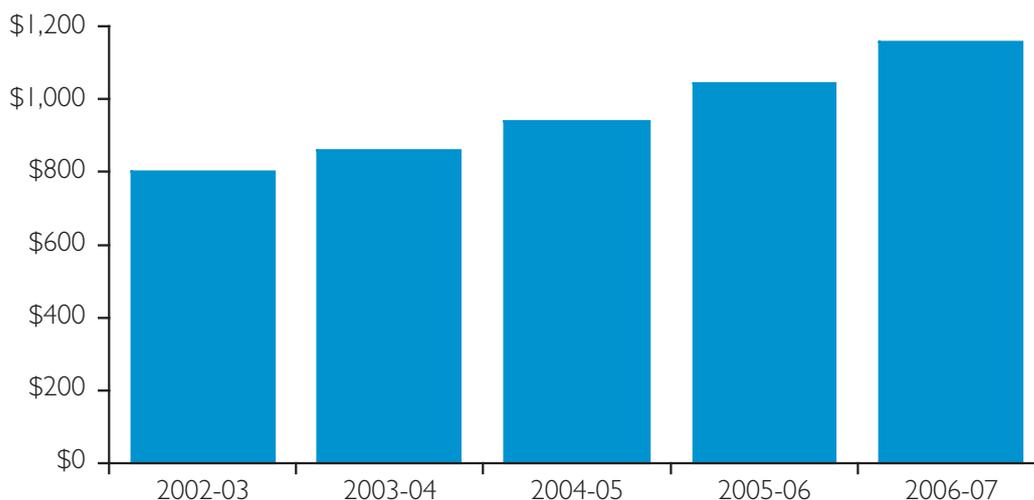
## Key points

- A key challenge for the health system is to ensure that scarce resources are allocated efficiently to achieve the best value for the community.
- Some high cost inpatient care is not as efficient or effective as new models of non-inpatient care that support better health outcomes and enable people to stay in their communities.

## Health care costs

The cost to the State of providing public health services is increasing dramatically. As shown in Figure 4, in 2002-03 the average cost of acute care was \$802 per person but by 2006-07 it had risen to \$1,156, representing an annual growth rate over 5 years of 10% per annum.

Figure 4: Average cost of acute health care per person



Source: Department of Health and Human Services, 2006.

## Ambulatory care sensitive conditions

Ambulatory care sensitive conditions, also referred to as potentially avoidable hospitalisations, are hospital admissions that are avoidable if timely and adequate non-hospital care, such as specialist non-admitted patient services and primary care, is provided.

An analysis of activity at the RHH in 2004-05 indicated that there were almost 4,000 separations and 13,500 beddays attributable to patients who could be managed in non-inpatient settings. This is a significant proportion of inpatient activity, accounting for some 38 inpatient beds. At the LGH in the same period there were almost 2,300 separations and 10,300 beddays attributable to patients who could be managed in non-inpatient settings. The relevant figures for the NWRH were 1,400 separations and 6,500 beddays.

## A mismatch between primary health funding allocations and community needs

Current primary health service funding allocations are based largely on historical decisions rather than on a planned distribution of resources. The increased demand for inpatient care across the acute sector that is likely to arise as a result of the ageing population is not anticipated across smaller rural sites due to changes in clinical practice and a reduction in the rural population.

The use of Tasmania's small rural inpatient facilities is decreasing. Changes in both clinical practice and workforce have resulted in increasing concentration of more specialised care in the major hospitals and increasing care of patients in the community, aimed at allowing them to remain in their own homes. Three key indicators for inpatient activity show the extent of this trend across the State. Separations, the average length of stay and the overall occupied beddays give some indication of how busy an inpatient facility is. These three indicators show an overall downward trend in the activity levels of rural inpatient facilities over the last eight years. Between 1998-99 and 2005-06:

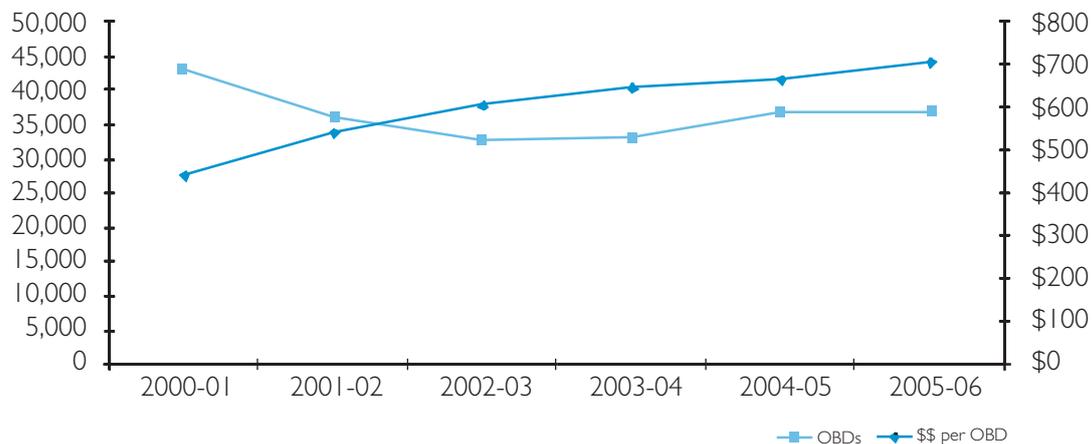
- the number of separations decreased from 5,335 to 5,052;
- the average length of stay decreased from 8.35 days to 7.29 days; and
- the number of occupied bed days decreased from 44,533 to 36,813.

This means that the overall average occupancy of rural inpatient facilities has dropped from 78% to 64%.

At the same time, in 2005-06 funding allocations to community nursing services consumed 27% and rural hospitals consumed 44% of the total Primary Health Services budget. Allied health, palliative care and health promotion accounted for only 15% of funds.

There has been a decline in rural inpatient activity but expenditure has continued to rise (Figure 5).

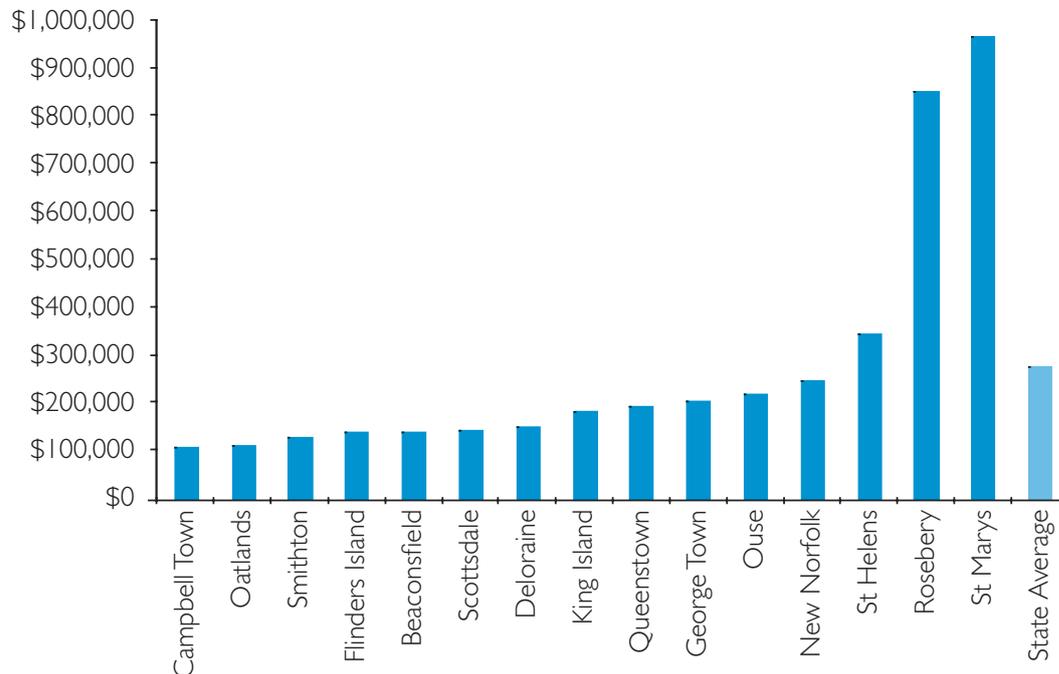
Figure 5: Activity, cost per occupied bedday, 2000-01 to 2005-06



Source: Department of Health and Human Services, 2006.

There is wide variation in the annual cost of an occupied bed across rural sites (Figure 6).

Figure 6: Annual cost per occupied bed 2005-06



Source: Department of Health and Human Services, 2006.

Those sites with the highest costs are affected by small unit size (\$1.5 million minimum costs to run a stand-alone rural inpatient facility); low levels of occupancy; and severe staff shortages, with excessive reliance on high cost locum staffing.

As well, there has been a decline in the recorded activity of community nursing services, although funding for those services has increased by 21% to \$14.7 million over the past five years. Although there could be a number of potential explanations including different data collection methodologies, there is no evidence to show that it is due to increasing complexity of care. There is an increasing number of people with chronic disease who need good community-based care but the system is unable to provide this because its resources are used to provide high cost services that are used infrequently and are neither effective nor efficient.

All health services are highly valued by the community, but there are opportunities to develop new models of care that better meet the needs of the community.

The roles of both community nursing and rural health centres need to be examined in relation to the future health needs of Tasmanians and a process will be established to ensure that the best health outcomes are achieved from the effective use of existing resources.

There is very strong stakeholder support for increasing the effectiveness of investment in community-based services, particularly primary and secondary prevention services and post-discharge services. There also was strong support for reforming the acute and rural hospital system so that it is designed for sustainability, can withstand short-term workforce challenges and can deliver high quality care reliably.

# Lessons from the Richardson Report

## Key points

- Government has addressed many of the important Richardson Report recommendations through the *Better Hospitals Packages*.
- This Plan will implement the Richardson Report recommendations for the development of dedicated and general service centres and a greater focus on community-based models of care. The Plan further develops Richardson's service system design concepts.

In 2004 an Expert Advisory Group led by Professor Jeff Richardson presented a report to the Minister for Health: *The Tasmanian Hospital System. Reforms for the 21st Century* (**the Richardson Report**), which made 34 recommendations for the improved operation of Tasmania's public and private tertiary hospital sector.

The Richardson Report included two major system design recommendations:

- The first was to implement dedicated service centres, in which complex, less frequently performed procedures would be concentrated in one hospital (a "dedicated service centre") while the less complex elements of treatment could be provided in another setting (a "general service centre"). The dedicated service centres would create a critical mass of clinicians and procedures on one site.
- The second related recommendation was to consolidate the specialist clinical workforce in the North West region – predominantly at Burnie – and to progressively implement dedicated and general service centres in the North West.

The Richardson Report also discussed the impact of chronic disease and recommended that the Tasmanian Government examine ways to increase prevention and health promotion effort and assess the benefits from a move to a more community-based model for chronic disease and palliative care services.

The Tasmanian Government responded with the following strategies:

- the first *Better Hospitals Package* (2004) which committed \$75 million over five years for the recruitment of additional staff, equipment purchases, the provision of specialist state-wide services and the establishment of an aged-acute care transition unit; and
- the second *Better Hospitals Package* (2005-06) which committed \$8.8 million to additional medical and support staffing.

The specific recommendations regarding dedicated and general service centres have not yet been implemented systematically and the service system issues in the North West have not yet been resolved. There also is considerable opportunity to progress the recommendations about different approaches to the prevention and management of chronic disease.

This Plan further develops the service system design concepts introduced in the Richardson Report. It is imperative that these concepts are implemented to assure the sustainability of our health system.

# A sustainable health service system for the future

## Key principles

Tasmania's health services will be:

- accessible as close as possible to where people live, providing services can be delivered safely, effectively and at an acceptable cost;
- appropriate to community needs;
- client and family focused;
- integrated through effective service coordination and partnerships between providers; and
- designed for sustainability.

Where services cannot be delivered safely, effectively and at an acceptable cost locally, access will be facilitated through service coordination, transport assistance and other appropriate support.<sup>14</sup>

## Acceptable cost

This Plan is based on the following premises:

- public resources for health services will always be limited;
- responsible budgetary management requires government to make transparent and evidence-based decisions on priorities;
- both government and the community aim to achieve the best possible value for public expenditure, so that the greatest community benefit can be achieved; and
- some services, because of their remoteness or special local factors, inevitably will cost more than equivalent services delivered in other locations. Responsible planning, however, requires that an assessment is made of whether significant additional costs incurred to provide services in particular settings are justified by a corresponding health benefit.

A decision about whether a service cost is acceptable, therefore, involves an assessment of the financial cost of providing the service, the benefit individuals and the community derive from the service, whether alternative services are available, and the cost to individuals and the community of accessing those alternative services.

## Service sustainability

Services designed for sustainability:

- have sufficient patient volume to support and maintain the competence of health care professionals;
- support a staffing infrastructure that can withstand temporary shortages without excessive cost or operational burden;

<sup>14</sup> The DHHS has adopted the following definitions to support these principles:

**Accessible** – ensuring care is available when (at the time) and where (in the location) people need it

**Safe** – minimising risks, so that patients are safe from unintended harm

**Effective** – providing care that results in a good outcome

**Efficient** – using available health care resource wisely

**Appropriate** – providing the 'right' care at the 'right' time, including health promotion and integrated community-based and hospital-based services

**Patient and family focused** – designed to meet the needs of patients and their families/carers, respectful of patients as individuals and enabling them to access information and be engaged as active participants in their own care

- have quality equipment and facilities, and appropriate access to necessary clinical and non-clinical support services;
- have costs that are reasonable and manageable over time, in the context of competing demands for limited resources; and
- have transparent and predictable funding allocations.

If services are not designed for sustainability, there may be:

- safety and quality consequences, because providers have to modify other services without adequate planning to cover service gaps; or there are delays in accessing services; or workforce compromises are made in an effort to address shortages;
- cost consequences, because short-term solutions to support unsustainable services almost invariably generate excessive costs;
- poor continuity and integration of care; and
- reduced community confidence in the health care system.

High costs and safety and/or quality concerns often are indicators of unsustainable services.

Designing for sustainability is a key objective of this Plan. Ongoing sustainability will be assured through the adoption of the following service development guidelines:

- services will not be introduced to Tasmania's hospitals unless they have undergone an evidence-based assessment of their longer term clinical and financial impact;
- any service which involves frequent out-of-hours recall for specialist practitioners will only be established where there is sufficient patient demand to support a service comprising a minimum of three, and preferably four, specialist practitioners, and a realistic prospect of recruiting those practitioners in the foreseeable future;
- services without onerous recall requirements may be established with fewer practitioners and will be assisted to develop reliable arrangements for short- and longer term locums and other necessary supports;
- where the quality or efficiency of an established service is volume-dependent, no similar services will be established in Tasmania unless it can be demonstrated unequivocally that the clinical quality or efficiency of the existing service will not be compromised; and
- no specialist practitioner will be permitted or required to work in isolation. All specialist practitioners must participate in effective peer support and review processes. Where a service is provided in one location by only one or two practitioners, formal and accountable arrangements will be made with other providers (either in Tasmania or, if no relevant Tasmanian service exists, interstate) for peer support, peer review and quality assurance.

# Integrating primary and acute care

## Key points

- There are considerable opportunities to improve the performance of Tasmania's health system by redesigning systems of care.
- A tiered service delivery model will provide a basis for on-going role delineation across services. The model will include new integrated care centres that provide a range of health services working in partnership in an integrated manner, regardless of which organisation funds or provides them.
- Integrated care centres are highly efficient and provide greater certainty of access for the community because they do not mix emergency and elective services.
- Together with the introduction to our acute hospitals of new models of emergency and short stay care, the development of new integrated care centres at a number of sites across the State will enhance access to and quality of care.

## A new service model to better integrate Tasmania's health services

There will be increasing collaboration between primary and acute health services through the development of new facilities and models of care that enable the delivery of quality care in ambulatory and short stay settings. This allows larger centres to support smaller communities in the provision of sustainable, high quality services.

The department will develop a tiered service delivery model establishing an integrated network of health services across Tasmania that will be applied to all health services delivered by the department. A state-wide service model will set clear directions about what services will be available where, to improve the match between service distribution and population need; to provide the minimum requirements for a safe and effective service; and provide a level of certainty for both communities and staff. While the model will be state-wide, it will be adapted to local circumstances and innovation will be encouraged.

## Integrated care centres

Traditionally, settings for the delivery of health care have been determined largely by their sources of funding. State-funded health services have been provided mainly through state-owned facilities which often have been established in relative isolation from Commonwealth or privately funded health care providers such as GPs, private hospitals, private community nursing services and private allied health services.

There has been increasing recognition of the urgent need to integrate services to reduce gaps and duplication and ensure client access is unimpeded by funding or organisational boundaries.

Integrated care centres are facilities which:

- accommodate a range of health services that provide efficient, integrated care regardless of who funds, owns or provides each element of the services;
- operate under a philosophy which is less interventional and oriented towards care in the community rather than institutional care; and
- provide greater certainty of access for clients because they focus on non-emergency services including a broad range of non-admitted primary, secondary and tertiary services, short stay elective services and specialised subacute services.

Integrated care centres may be stand-alone facilities; co-located with acute hospitals; or incorporated within acute hospitals.

The benefits of such centres include:

- because they do not provide high acuity emergency services, booked elective procedures at integrated care centres are unlikely to be cancelled or delayed because of unpredictable emergency demand; and
- they do not require the expensive infrastructure that is provided in major acute hospitals and the costs of both capital and service delivery, and therefore, are likely to be lower than comparable costs in acute hospital settings.

This Plan proposes the development of new integrated care centres in the South (within or adjacent to the RHH and stand-alone on the Eastern Shore and in Kingborough); and in the North (sited close to the LGH).

### Enhancing primary care

Primary health care services can contribute significantly to the broader sustainability of the health system by assisting to manage demand for acute hospital services. Traditionally, primary health services have provided post acute episodic and chronic care and rural hospitals have acted as step down facilities. More can be done to enhance this role.

The following actions will be taken to strengthen the linkages between hospitals and the community:

- the development of cross-program integrated care centres will extend the availability of dialysis and chemotherapy services to some community-based sites, facilitate the introduction of more after-hours GP clinics and enable providers to work together to develop processes to deliver more specialised care in the community;
- the role of Community Nursing will be redefined in order to provide more acute level care in the community, for example cancer nurses, Hospital in the Home arrangements;
- outreach services from the major hospitals to rural areas will be developed further, as has already occurred in pre- and post-natal services on the West Coast;
- the concept of Community Health services having an “in-reach” role into the major hospitals has already been established in Palliative Care and will act as a model for the further development of this concept in other areas, for example alcohol and drug services; and
- admission and discharge processes will be reviewed jointly by Community Health Services and Acute Health Services.

### Clinical networks

Networking assists the coordination of care across the continuum from community to acute, with benefits in improved safety and increased support for rural service providers.

Clinical networks will be developed across primary and acute care services. Shared protocols for clinical management will reduce inefficiencies and duplicated effort within the current system. Networks will systematise the provision of clinical support between local and central services, identifying what each can do to support the other so that care can be provided safely at different sites. Clinical networks also will provide the mechanism to improve the general practice/hospital interface and for support to be provided from the major acute hospitals to rural GPs.

Co-located GP clinics have been trialled throughout Australia and have been shown to reduce waiting times for people with less serious illnesses and conditions, reduce bottlenecks within waiting areas and free up emergency medicine specialists to manage higher acuity presentations.

Co-located GP clinics will be considered for introduction at each of the major acute hospital sites in Tasmania.

# The Primary Health Services Plan

## Key points

- The focus of the health system on health and wellbeing, not just illness, and community-based care, in particular on prevention of and early intervention in chronic disease, will be increased substantially through the implementation of this Plan.
- A new state-wide model for Primary Health Services will be implemented, clearly designating the roles of different services.
- Relationships with general practice will be strengthened.
- The Government will implement a range of service changes in rural communities to expand services and to place them on a more sustainable footing, ensuring that the services delivered are safe and reliable and better meet the needs of their communities.
- Monitoring services against standards of quality, safety and sustainability is an ongoing process. As the needs of communities change and health workforce issues arise the roles of our rural health centres may need to change.
- Access to Home and Community Care Services and community transport will be enhanced.
- Primary Health Partnerships will be introduced to Tasmania, following a review of the interstate experience.

## The primary health approach

A primary health approach will be promoted throughout the network of primary health services to guide day-to-day practice and to better meet the needs of Tasmania. Key elements of the primary health care approach include:

- a focus on health and wellbeing not just illness;
- a population perspective on health not only for individuals;
- a multidisciplinary team approach to care;
- a partnership approach in which a range of groups and organisations need to work together on improving health;
- a focus on actual health needs, such as chronic disease, rather than service needs; and
- fostering individuals' control over their health and participation in health decision-making.

Each health centre will work with key stakeholders and the local community to design and implement programs to support healthy life conditions and choices, and address local causes of illness and injury.

There will be an expansion of the number of Health Promotion Coordinators by four positions throughout the State, and integration of health promotion approaches across the primary health workforce.

## The prevention and management of chronic conditions

Community-based health services will be changed and expanded over time to better respond to the changing needs of the Tasmanian population. Service change will be implemented to enable:

- greater capacity to treat diabetes and other chronic diseases at the primary health level;
- greater access to home-based services such as post-acute care and specialised community nursing;
- more emphasis on health promotion;

- working with young people, through collaborative partnerships, to adopt healthy lifestyles;
- increased access to mental health and alcohol and drug programs in rural areas; and
- an expansion of the approaches to chronic disease self-management.

Each health centre is to have a role in working with key stakeholders and the local community to design and implement programs to support healthy life conditions and choices, and address local causes of illness and injury. In addition, existing service providers, such as community nurses, will be provided with additional training to enable them to undertake an expanded role, specifically in relation to health promotion and prevention and the management chronic disease.

### Improved relationships with general practice

A new relationship will be established between general practice and the DHHS that better supports the sustainability of the sector and provides additional capacity to respond to the challenges of chronic disease. Initiatives will include:

- the DHHS will work with general practice representatives to progress general practice provision of state-funded community health services;
- a demonstration site in Launceston will be developed and operational within one year;
- a consistent DHHS policy concerning the availability of support arrangements for general practice will be developed in collaboration with general practice organisations;
- closer links will be developed between rural GPs and acute hospitals, especially for training and support;
- co-location of general practice and state health services will occur where this is possible and would benefit service arrangements;
- demonstration sites, in urban and rural communities, of new chronic disease/community and population health initiatives using a team approach incorporating community health and general practice will be funded; and
- following the evaluation of demonstration sites, as benefits are proven and resources become available, it is envisioned that these initiatives will become established elements of Tasmania's primary health service system.

### Application of the service model to Primary Health

A new tiered model will be applied to Primary Health sites. Tiers 1-3 represent primary health service sites and have been developed considering current and future needs, specifically:

- population trends and levels of community need;
- distance from other services; and
- sustainability considerations, such as cost and workforce availability.

**Tier 1** sites provide core primary health and community care services within a local community. They reflect the increasing emphasis on community- and home-based care and the provision of these services through an integrated team approach.

**Tier 2** sites operate rural inpatient services (subacute beds) in addition to their primary health and community care services.

**Tier 3** sites provide extended primary health services with significant outreach across the network and a stronger representation of acute services including integrated care centres developed in association with the Acute Health Services.

Complex primary health services will also be provided within Tier 4 integrated care centres.

*This model will be applied to existing Primary Health Services as follows:*

**Tier 1** – Core Primary Health: Bridgewater, Bruny Is, Burnie (Jones St), Cape Barren Island, Cygnet, Huonville, Kings Meadows, Ravenswood, Risdon Vale, Rokeby, Sorell, Strahan, Rosebery, Ouse, Swansea, Triabunna, Ulverstone, Westbury, Wynyard, Zeehan.

**Tier 2** – Rural sites that provide both Tier One level services and inpatient services: Beaconsfield, Campbell Town, Deloraine, Dover; (Esperance MPC), Flinders Is, Franklin (Eldercare), George Town, King Is, New Norfolk, Nubeena (Tasman MPS), Oatlands, Queenstown, Scottsdale, Smithton, St Helens, Swansea (May Shaw Nursing Centre).

**Tier 3** – Extended primary health sites with significant outreach across the network and incorporating over time a stronger representation of acute services: Burnie (Parkside), Devonport, Launceston (developing into a Tier 4 Integrated Care Centre<sup>15</sup> over time), Glenorchy, Kingston (upgraded over time from its current Tier 1 status), Clarence, Hobart (Repatriation Centre).

### A changed and expanded role for rural health centres

A changed and expanded role for rural health centres will be implemented to ensure these services better meet the needs of the Tasmanian population and their local communities. This will include:

- greater access to home-based services such as post acute care;
- more health promotion and management of chronic disease; and
- increased access to visiting services such as allied health or mental health services.

All rural health centres which require an emergency response role will continue to have the appropriate facilities to enable on-site care of minor injuries as well as, where necessary, stabilisation and transfer of those patients who are seriously unwell or injured.

Current assessments of some inpatient rural services indicate that workforce shortages are affecting their capacity to continue to provide services in a safe, reliable and affordable manner. Several sites are experiencing serious shortages of both doctors and nurses and without these, inpatient service delivery cannot be maintained. This situation is likely to deteriorate further in future years. In addition, some inpatient facilities are barely used and the cost of providing these services precludes the development of other badly needed services within the communities.

The Department of Health and Human Services is examining alternative service models in conjunction with local communities to see if these will better meet their needs. Examples of services that could be part of alternative local service models are:

- overnight planned respite capacity as required for non-health related conditions (ageing and social support situations);
- individualised packages of care for older people to enable them to remain in their own homes (both post-acute and community care);
- additional day centre respite;
- more allied health services as an outreach;
- maintenance of general practice
- additional community nursing and on site nurse clinics (especially for chronic disease treatment, including diabetes); and
- an increased focus on health promotion and healthy lifestyle activities.

<sup>15</sup> For a description of an Integrated Care Centre, please see page 29 of this Plan.

Some of these sites continue to experience extreme difficulty in attracting staff and have very low inpatient occupancy and low acuity levels. In the face of the pressures of increasing chronic disease, serious sustainability issues, high cost and low usage, and with effective alternative models of care available, it is essential to reform locally by redirecting scarce resources from little used inpatient beds to key primary health services that will bring clear, sharp benefits to the local community.

The application of health planning principles to Tasmanian rural health sites shows that some cannot demonstrate sustainability. It is not possible for them to deliver the current service to their community in a way that is safe, effective and at an acceptable cost. Nor will it be possible to continue to provide these services in the future when workforce issues worsen. Consultation has occurred with the communities of St Marys, Ouse and Rosebery in relation to this issue to develop models of service that will better meet their needs on a more sustainable basis. Ouse and Rosebery will be developed as Tier 1 sites in the short term.

As a Tier 1 site, the Ouse Community Health Centre will provide a broader range of primary health and community aged care services which will include:

- overnight planned respite capacity as required for non-health related conditions (ageing and social support situations);
- individualised packages of care for older people to enable them to remain in their own homes (both post-acute and community care);
- additional day centre respite;
- more allied health outreach services;
- maintenance of general practice rooms for usage when the GP is there;
- community nursing and on-site nurse clinics (especially for chronic disease treatment, including diabetes); and
- increased focus on health promotion and healthy lifestyle activities.

The department will work with the Australian Government to identify opportunities for further community aged care packages in the Central Highlands community.

Developed as a Tier 1 site, a Rosebery Community Health Centre will provide a broader range of primary health and community aged care services on a seven day a week basis with extended hours (early morning to evening). Services will include:

- overnight planned respite capacity as required for non-health related conditions (ageing and social support situations);
- after-hours emergency support from local general practice and nursing staff ensuring twenty-four-hour coverage;
- individualised packages of care for older people to enable them to remain in their own homes (both post-acute and community care);
- additional day centre respite;
- more allied health services as an outreach;
- on-site nurse clinics (especially for chronic disease treatment, including diabetes);
- holistic community nursing service expanded from one day a week to a minimum of five with options explored for weekend cover improving the sustainability of community nursing across the whole West Coast;
- increased visiting services in relation to Mental Health; and
- increased focus on health promotion and healthy lifestyle activities.

The recruitment of a General Practitioner is very difficult within the current service model at the St Marys Community Health Centre. Maintaining the facility at a Tier 2 level is not sustainable in the long term. The Department recently received a submission that raises the potential for a new approach to the delivery of services in the Break O'Day municipality. This requires further investigation and extensive consultation with the communities of St Helens and St Marys before a firm direction can be established. This proposal may provide significant improvement in health services for the whole municipality and deserves further consideration.

At Swansea and New Norfolk, there is a recognised need for additional inpatient beds and this will be considered over time as resources become available.

Monitoring services against standards of quality, safety and sustainability is an ongoing process and as the needs of the community change and as health workforce issues arise, the roles of our rural health centres may need to change.

### Communication and collaboration between service providers

**Primary Health Partnerships** will be developed, linking services owned and/or funded by the Australian Government, local government, non-government organisations, general practice and the DHHS. This concept is intended to foster greater coordination of services within each area, to develop clinical links between local services in order to enhance the quality and safety of services, to support workforce sustainability and to achieve greater efficiency in the use of resources. Local emphasis will enable greater involvement of the community in health service planning and improvement.

In the planning of such partnerships the DHHS will undertake a comprehensive assessment of the experience of other states.

The newly appointed Primary Health Coordinators in the DHHS will be a key resource in the development of local Primary Health Partnerships.

The **Home and Community Care** Program will actively develop and implement services, which prevent or delay decline, and promote client independence. A percentage of HACC funding allocations will be allocated specifically to rural and remote areas.

Cooperation between Primary Health and other **Community Health Services** will be strengthened through the development of consultation, liaison and outreach services from Alcohol and Drug Services and Mental Health Services to primary health centres

### Maintaining a focus on safety, quality and clinical governance in primary care

Communities around the world are concerned about the safety and quality of health care. The Primary Health Services Group applies continuous quality improvement practices and principles to ensure the safety and satisfaction of consumers and increase the knowledge, skills and accountability of all staff, the standard of their work and the work of the service generally.

The recent Service Capability Framework self-assessment undertaken by rural inpatient facilities showed that in some areas the available clinical support is not sufficient to deliver these services safely and effectively. Access to allied health professionals (in most sites) and access to the nursing and GP workforce (in some sites) were raised as significant concerns. This raises questions about the safety and sustainability of the current model of inpatient services in rural Tasmania.

Primary health care services must meet appropriate standards of quality and safety. The following actions will be taken to address service quality and patient safety issues:

- Primary Health will continue to place a high priority on quality and safety through the development and maintenance of its clinical governance framework. The results of the clinical role delineation framework assessment will be applied so that in the event that services do not have appropriate access to clinical support services, an appropriately skilled and available workforce, equipment, suitable facilities and appropriate capacity to maintain clinical standards, alternative arrangements for delivery of services will be considered;
- credentialling of primary health care service providers will continue, ensuring practitioners are qualified, registered and competent to provide the required services; and
- external accreditation of broader primary health care services will be established to underpin the quality agenda, and to ensure that the community can have confidence in its services. This will augment the well-established accreditation system for general practice and residential aged care.

# A service capability framework for acute hospital services

## Key points

The configuration of acute hospital services proposed in this Plan is based on a defined service capability framework comprising:

- designation of clinical services according to their clinical roles and responsibilities;
- adoption of principles for the future development of single site and state-wide services;
- the development of multidisciplinary, system-wide clinical networks, overseen by a Clinical Advisory Council, to facilitate service integration, monitoring and development;
- best practice processes for credentialling and defining the scope of practice for all senior medical staff; and the introduction of new technology to Tasmania; and
- clarification of the roles and responsibilities of each of the acute hospitals.

## Local, regional, single site and state-wide services

The service capability framework provides for clinical services to be categorised according to whether they are provided locally to a hospital's immediate referral population or to a broader population. Services provided locally in all three hospital referral regions (South, North and North West) must attract adequate patient volume to sustain quality service delivery, have no special equipment requirements or critical relationships with other services, and be capable of being staffed on a sustainable basis in multiple sites. Some of these services are provided on an outreach basis in community settings – for example, the NWRH obstetric service provides outreach pregnancy care to communities on the West Coast. For the purposes of this Plan these services are described as **local acute hospital services**.

Some services, because of workforce, service volume, cost or equipment constraints can only be delivered sustainably from two sites in the State – one in the North and one in the South. The catchments for these services extend to half of the State's population. Some elements of these services may be provided from Launceston on an outreach basis to the North West, either on an inpatient or non-admitted patient basis. For example, renal services are provided by the LGH to a referral population comprising the whole of the North of the State and some service elements (eg renal dialysis) are provided on an outreach basis in Burnie. For the purposes of this Plan, these services are described as **regional acute hospital referral services**.

Finally, some services, because of workforce, service volume, cost or equipment constraints or because they are critically dependent on other single-site services, must be managed from a single site in Tasmania. Again, some elements of these services may be provided in distributed locations, either on an inpatient or non-admitted patient basis. These services may be:

- specific specialised clinical components of larger clinical services – for example, cancer services are provided at both the LGH and the RHH, but brachytherapy, which is a subspecialty cancer treatment, is provided only at the LGH; and paediatric surgical procedures are provided in all centres, but subspecialist complex paediatric surgery is provided by a single specialist based in Hobart who offers some outreach services; or
- stand-alone specialist services providing comprehensive care – for example, cardiothoracic surgery, which is provided only by the RHH.

For the purposes of this Plan, these services are described as:

- **single site services** – where a service is based at a single site and may provide outreach services, but has no formal state-wide responsibility or accountability for distributed service development; and
- **state-wide services** – where a single-site service is designated as such and has a significant state-wide coordinating role, a responsibility to accept all emergency referrals and formal responsibility and accountability to the system as well as to its host hospital for its performance.

The characteristics of each type of service are described in Table 2.

**Table 2: Service designation framework for acute hospital services**

Characteristic	Local acute hospital service	Regional acute hospital referral service	Single site service	State-wide service
<b>Clinical Governance Responsibility</b>	Based at host site – NWRH, LGH, RHH	Based at host site – LGH. May be networked clinically to equivalent RHH units for quality and professional support	Based at LGH or RHH. May be networked to complementary local units or specialist interstate units for quality and professional support	Based at LGH or RHH. May be networked to interstate units for quality and professional support
<b>Management</b>	Based at and responsible and accountable to host site – NWRH, LGH, RHH	Based at and responsible and accountable to host site – LGH	Based at and responsible and accountable to host site – LGH or RHH	Based at LGH or RHH. Responsible and accountable to host site for operations and to whole-of-state for clinical performance
<b>Throughput</b>	Sufficient to support throughput for at least 3 practitioners at each host site if frequent out-of-hours recall	Sufficient to support throughput for at least 3 practitioners at both LGH, RHH if frequent out-of-hours recall	Specialised service. Sufficient throughput to support at least 3 practitioners at single site if frequent out-of-hours recall unless special arrangements apply	Comprehensive service at all levels of complexity, Sufficient throughput to support at least 3 practitioners at single site if frequent out-of-hours recall unless special arrangements apply
<b>Outreach</b>	May provide outreach in community settings	May provide outreach from LGH to community or inpatient settings in the North West	May provide outreach from host site to community or inpatient settings across the State	Generally will provide outreach from host site to community or inpatient settings across the State
<b>Complexity</b>	Less complex services although role delineation may vary across sites	More complex than local services	High-complexity low-volume services	High-complexity low-volume services
<b>Workforce</b>	At least 3 medical practitioners at each of NWRH, LGH, RHH if frequent out-of-hours recall. Other clinicians as required to support a quality service	At least 3 medical practitioners at each of LGH, RHH if frequent out-of-hours recall. Other clinicians as required to support a quality service	At least 3 medical practitioners at either LGH or RHH if frequent out-of-hours recall. Other clinicians as required to support a quality service	At least 3 medical practitioners at either LGH or RHH if frequent out-of-hours recall. Other clinicians as required to support a quality service
<b>Support Services</b>	Not dependent on high-cost technology or other highly specialised services	May be dependent on expensive but not very high-cost technology	May be dependent on very high-cost technology	May be dependent on very high-cost technology

Under the Service Designation Framework, Tasmania's acute hospital services have been designated as follows:

**Table 3: Acute Service Designation Framework**

Local services	Regional referral services	Single site service	State-wide service
Aged care services	Cardiology (diagnostic and interventional)	Bariatric surgery	Adult cystic fibrosis
Critical care services (ICU/HDU/ED)	Medical oncology	Brachytherapy	Adult retrieval
ENT surgery	Neonatal high dependency care	Cardiac electrophysiology	Bone marrow transplantation
General medicine	Radiation oncology	Complex ENT/head and neck surgery	Cardiothoracic surgery
General paediatrics	Renal medicine	Complex upper GIT surgery including pancreatic, major oesophageal and hepatobiliary surgery	Complex materno-foetal medicine
General surgery	Subspecialty medicine and surgery	Gynaecological oncology	Forensic pathology
Medical imaging*		Paediatric surgery	Genetics
Obstetrics and gynaecology		PET/CT	Hyperbaric medicine
Ophthalmology		Retinal surgery	Infection control
Orthopaedics			Major burns
Pain management			Major neurosurgery
Pathology*			Medical imaging*
Rehabilitation			Neonatal intensive care
Trauma excluding major neuro			Paediatric cystic fibrosis
			Paediatric intensive care
			Paediatric/neonatal retrieval
			Pathology*
			Pharmacy
			Specialist pain management
			Vascular surgery (two sites for service delivery)

\*There are opportunities to move to a state-wide service model for both pathology and medical imaging services – this issue is discussed in detail in the Clinical Services Plan.

### Principles for single site and state-wide service development

There has been, and is likely to continue to be, considerable debate about where various single site and state-wide services should be based in Tasmania.

The following principles will apply for the sustainable development of single site and state-wide services:

- single site and state-wide services will not be designed or developed around the needs of individual clinicians, individual regions or individual hospitals. A system-wide approach will be taken, based on the needs of the entire community;
- critical clinical interdependencies will be taken into account when planning the location of single site and state-wide services;
- funding for supporting infrastructure for single site and state-wide services (eg to enable the provision of outreach services) will be provided as appropriate through funding streams independent of normal hospital budgets;
- single site services will be required to participate in the usual quality and accountability processes that apply at their host hospital;

- state-wide services will be accountable to their host hospital but also will be required to account for their performance on a state-wide basis, addressing issues such as accessibility and outcomes of care;
- most single site and state-wide services will continue to be located at the RHH because it has the highest level of infrastructure, necessary associated services and access to important non-health organisations that aid in quality service provision and attraction and retention of professional staff for those types of service; and
- when a single site or state-wide service does not depend on critical internal or external relationships that are more achievable at the RHH, the service may be located at the LGH.

## Clinical networks

Clinical networks have been developed in a number of Australian states and internationally to improve the integration and coordination of services across organisational boundaries. Their functions may include information exchange, development of referral protocols and procedures, establishment of clinical guidelines, coordination of scarce resources, evaluation of performance, professional development, support and leadership and service development.

Multidisciplinary clinical networks will be established in Tasmania where services would benefit because:

- there are small numbers of clinicians, based at different sites and/or operating under different management structures, who would benefit from coordinated peer review and support processes;
- there is a need to coordinate and plan for the efficient management of scarce system-wide resources;
- services are complex, pose high clinical risk and/or are costly and would benefit from state-wide clinical guidelines, referral protocols and monitoring of quality; and/or
- there are opportunities to improve service integration within and/or across the primary and acute care sectors.

Clinical networks advise the DHHS and service providers. Clinical network leaders will be selected on merit and interest. Efforts will be made to ensure that there is equitable representation in leadership positions from each area of the State. Clinical networks will span the primary, secondary and tertiary sectors and advise on diverse issues including policy, planning, governance, training of health professionals and service quality.

The following clinical networks will be established:

- aged care and rehabilitation;
- cancer services;
- cardiology/cardiac surgery;
- diabetes and chronic disease;
- emergency, critical care services and trauma services;
- maternal and perinatal services;
- medical imaging;
- medical services;
- paediatric medicine and surgery;
- pathology;
- renal medicine; and
- surgical services.

Clinical networks will only be necessary in medical imaging and pathology if state-wide services are not established. If state-wide services are established, service coordination will occur through a single administrative structure.

### Clinical Advisory Council

A new multidisciplinary Clinical Advisory Council will be convened, comprising clinicians from the primary and acute service systems. The Clinical Advisory Council will lead and coordinate the clinical networks and will be the principal vehicle for clinical advice to the DHHS about the structure and performance of the service system as a whole.

### Ensuring effective credentialling and defining the scope of clinical practice

This Plan will ensure that only well-designed, sustainable services are offered to the community. To complement the Plan, effective processes are required to ensure the initial and ongoing qualifications, experience, competence and performance of health care practitioners and the capability of the service system to support the services they offer:

Credentialling refers to the formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of health care professionals for the purpose of forming a view about their competence, performance and professional suitability to provide high quality health services within specific organisational environments.

**Defining the scope of clinical practice** follows on from credentialling and involves delineating the extent of an individual health professional's clinical practice in a particular organisation, based on the individual's credentials, competence, performance and professional suitability, and the needs and capability of the organisation to support the requested scope of clinical practice.

There is a National Standard for *Credentialling and Defining the Scope of Clinical Practice*<sup>16</sup> (**the National Standard**) which has been endorsed by Australian Health Ministers and should be implemented in Tasmania, initially in relation to senior medical practitioners but also in relation to other clinicians whose clinical decisions are not supervised directly and whose practice generates significant clinical risk.

The credentialling process is an important administrative process which could be centralized for the State. The process for defining the scope of clinical practice, however, should be specific to each facility, because an appropriate scope of practice depends on both the clinician's competence and performance and the hospital's needs and capability. Each facility should have a committee, constituted and operating in compliance with the National Standard, which is responsible for advising on the appropriate scope of practice for each senior medical practitioner.

The National Standard also defines a process for the introduction of new clinical services, procedures or other interventions.

There is an urgent need for a robust and transparent process for the introduction of new clinical services, procedures or other interventions into Tasmania's hospitals. The process must take account of a number of issues, including:

- whether it is safe to introduce the service in the setting and manner proposed;
- the costs that will be incurred by introducing the service; and
- the impact on the quality and cost of existing services.

These are not issues that can be decided at a single hospital level – the system as a whole has a legitimate interest. There should be a single process introduced for the State, consistent with the National Standard, to ensure that new clinical services, procedures or other interventions are

<sup>16</sup> Available at [http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/A0E19BFE6489F6E1CA2571C70008A86A/\\$File/credentl.pdf](http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/A0E19BFE6489F6E1CA2571C70008A86A/$File/credentl.pdf)

introduced in a planned and systematic manner over time, avoiding harm to existing services and ensuring ongoing quality of care.

### **Roles and responsibilities of the acute hospitals**

The service capability framework includes designation of the roles and responsibilities of each acute hospital as follows:

- the RHH is the major tertiary referral hospital for the State, and most single site and state-wide services should continue to be provided by it because of its capital city location, level of infrastructure, associated services and access to important non-health organisations;
- the LGH is the major referral hospital for the North and North West of the State, providing a comprehensive range of acute hospital services and a significant number of services, including some single site services at a tertiary level; and
- the NWRH provides local acute hospital services to the communities of the North West and West of the State.

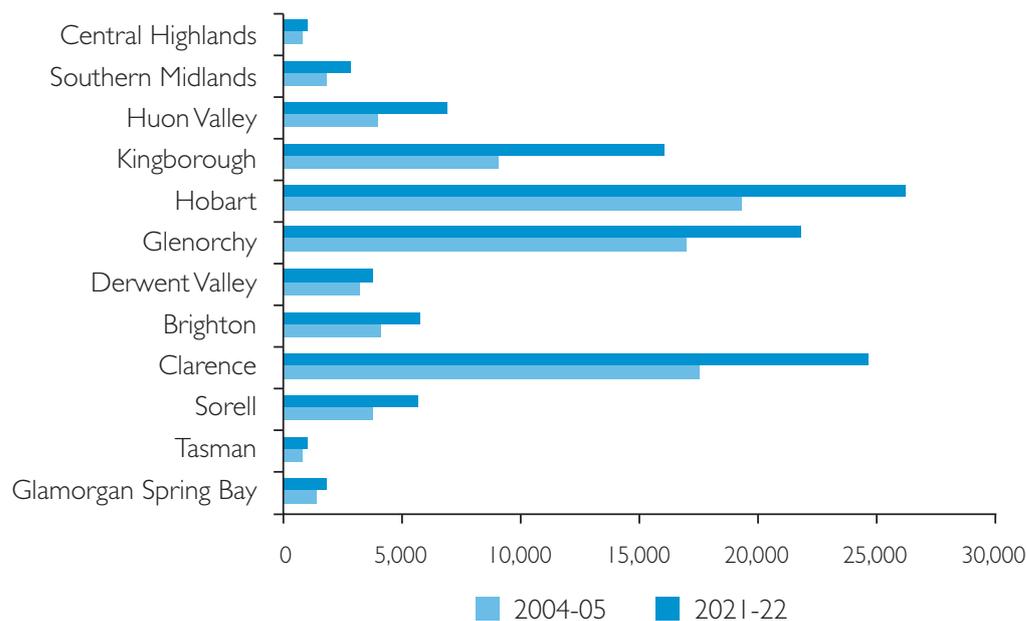
# Strategies for acute hospital services in the South

## Key points

- The Royal Hobart Hospital will remain as the major tertiary hospital for the State, providing a comprehensive range of services.
- Substantial growth in demand will need to be accommodated in the redeveloped hospital. Integration of the majority of overnight and ambulatory care services in one setting at the hospital is recommended, with ambulatory and short stay services incorporated in an Integrated Care Centre within or adjacent to the redeveloped hospital. New integrated care centres will be developed in population growth centres in Clarence/Sorell and Kingborough.

Significant growth in demand for inpatient services is predicted in many LGAs in the South of the State (Figure 7).

**Figure 7: Current and projected resident demand by LGA, South region, 2004-05 and 2021-22 (inpatient separations, excludes renal dialysis and neonates)**



Source: HARDS Data.

The RHH will remain the major tertiary hospital for the State, providing a comprehensive range of secondary and tertiary acute services to the population of the South and to the broader Tasmanian community for certain specialised services.

Table 4 demonstrates projected inpatient activity, separations and beddays based on the RHH continuing as the sole provider of acute hospital multi-day and same-day services in the South. There will be major growth in demand for inpatient services, with inpatient activity projected to grow by 54% from 52,698 separations to 81,251 separations by 2021-22. Same-day separations are predicted

to grow by 73% while multi-day separations are predicted to grow by 23%. Clinical areas in which major growth in overnight services is projected include renal medicine, neurosurgery, rehabilitation, non-acute care and drug and alcohol services. There is major growth projected in chemotherapy, medical oncology, haematology and renal dialysis.

It should be noted that activity projections have not been adjusted for the management of Ambulatory Care Sensitive Conditions in other settings.

**Table 4: Projected inpatient activity, separations and beddays, RHH, 2004-05 to 2021-22**

	Stay type	Year				Change	
		2004-05	2011-12	2016-17	2021-22	Nos	%
<b>Separations</b>	Day only	32,701	43,092	49,777	56,619	23,918	73%
	Overnight +	19,997	22,209	23,339	24,631	4,634	23%
	<b>Total</b>	<b>52,698</b>	<b>65,301</b>	<b>73,116</b>	<b>81,251</b>	<b>28,553</b>	<b>54%</b>
<b>Beddays</b>	Day only	32,701	43,092	49,777	56,619	23,918	73%
	Overnight +	131,152	147,964	161,324	177,012	45,860	35%
	<b>Total</b>	<b>163,853</b>	<b>191,057</b>	<b>211,101</b>	<b>233,631</b>	<b>69,778</b>	<b>43%</b>

Taking into account current and projected demand, future facility requirements have been analysed according to three options:

- full integration of all overnight and ambulatory care services in one setting at the RHH;
- full integration of all acute overnight and ambulatory care services in one setting at the RHH, with subacute services located elsewhere at a strategic site; and
- integration of the majority of overnight and ambulatory care services in one setting at the RHH, with a series of integrated care centres in strategic locations and in population growth centres around Hobart.

The third option is recommended as it best meets the service principles of the Plan. Two stand-alone integrated care centres are proposed, one on the Eastern Shore and one in Kingborough.

Tables 5, 6 and 7 demonstrate projected activity, separations and beddays for the RHH and two stand-alone integrated care centres in other areas in the South.

**Table 5: Projected inpatient activity, separations and beddays, RHH adjusted for development of two integrated care centres, 2004-05 to 2021-22**

	Stay type	Year				Change	
		2004-05	2011-12	2016-17	2021-22	Nos	%
<b>Separations</b>	Day only	32,701	33,857	36,432	41,325	8,624	26%
	Overnight +	19,997	21,883	22,630	23,669	3,672	18%
	<b>Total</b>	<b>52,698</b>	<b>55,740</b>	<b>59,062</b>	<b>64,994</b>	<b>12,296</b>	<b>23%</b>
<b>Beddays</b>	Day only	32,701	33,857	36,432	41,325	8,624	26%
	Overnight +	131,152	140,315	144,923	155,239	24,087	18%
	<b>Total</b>	<b>163,853</b>	<b>174,172</b>	<b>181,355</b>	<b>196,564</b>	<b>32,711</b>	<b>20%</b>

Table 6: Projected inpatient activity, 2004-05 to 2021-22, Eastern Shore Integrated Care Centre

	Stay type	2004-05	Year			Change 2011-12 to 2021-22	
			2011-12	2016-17	2021-22	Nos	%
<b>Separations</b>	Day only	0	9,236	10,609	12,086	2,851	31%
	Overnight +	0	326	447	593	267	82%
	<b>Total</b>	<b>0</b>	<b>9,561</b>	<b>11,056</b>	<b>12,697</b>	<b>3117</b>	<b>33%</b>
<b>Beddays</b>	Day only	0	9,236	10,609	12,086	2,851	31%
	Overnight +	0	7,649	10,392	13,433	5,784	76%
	<b>Total</b>	<b>0</b>	<b>16,885</b>	<b>21,001</b>	<b>25,519</b>	<b>8,634</b>	<b>51%</b>

Table 7: Projected inpatient activity, 2004-05 to 2021-22, Kingborough Integrated Care Centre

	Stay type	2004-05	Year			Change 2016-17 to 2021-22	
			2011-12	2016-17	2021-22	Nos	%
<b>Separations</b>	Day only	0	0	2,736	3,208	472	17%
	Overnight +	0	0	262	370	108	41%
	<b>Total</b>	<b>0</b>	<b>0</b>	<b>2,998</b>	<b>3,578</b>	<b>580</b>	<b>19%</b>
<b>Beddays</b>	Day only	0	0	2,736	3,208	472	17%
	Overnight +	0	0	6,009	8,340	2,331	39%
	<b>Total</b>	<b>0</b>	<b>0</b>	<b>8,745</b>	<b>11,548</b>	<b>2,803</b>	<b>32%</b>

The proposed integrated care centre in the Clarence/Sorell area will be the larger of the two proposed centres and will be developed as a Tier 3 service.

The second integrated care centre will service the communities of Kingborough and the Huon Valley. Services should commence in 2016-17 as population growth and ageing results in a sufficient volume of services to support the Centre's acute ambulatory services. This centre will be developed as a Tier 3 service in the longer term as well.

# Strategies for acute hospital services in the North

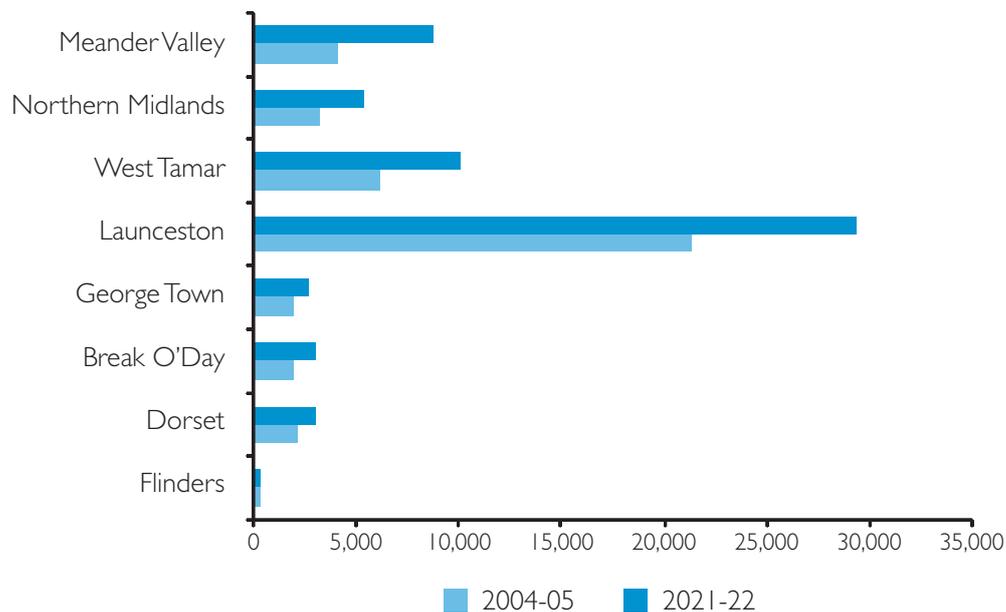
## Key points

- Considerable growth in demand also is predicted in Launceston and surrounding areas, and the Launceston General Hospital is likely to be affected by changes to the North West Regional Hospital.
- The Launceston General Hospital will be developed to accommodate significant increases in demand.
- An integrated care centre will be developed in the City of Launceston, close to the hospital.

The major focus for the LGH is to consolidate its role as the community hospital for Launceston and surrounding areas and as the major referral hospital for the North of the State.

The major growth in demand over the life of the Plan will be in the City of Launceston itself. Projected trends are shown in Figure 8.

**Figure 8: Current and projected resident demand by LGA, North region, 2004-05 and 2021-22 (excluding renal dialysis and neonates)**



Source: Greg Hardes & Associates.

Table 8 shows the projected inpatient activity, separations and beddays based on the continuation of the LGH as the sole site of service provision for multi-day and same-day services in the North of the State and not taking into account any change in role for the North West Regional Hospital.

**Table 8: Projected inpatient activity, separations and beddays, LGH, 2004-05 to 2021-22**

	Stay type	Year					Change	
		2004-05	2008-09	2011-12	2016-17	2021-22	Nos	%
<b>Separations</b>	Day only	32,017	36,874	41,701	49,622	57,967	25,950	81%
	Overnight +	13,058	14,498	16,001	17,061	18,230	5,172	40%
	<b>Total</b>	<b>45,075</b>	<b>51,372</b>	<b>57,703</b>	<b>66,683</b>	<b>76,196</b>	<b>31,121</b>	<b>69%</b>
<b>Beddays</b>	Day only	32,017	36,874	41,701	49,622	57,967	25,950	81%
	Overnight +	80,574	89,859	99,509	109,741	121,620	41,046	51%
	<b>Total</b>	<b>112,591</b>	<b>126,734</b>	<b>141,210</b>	<b>159,363</b>	<b>179,587</b>	<b>66,996</b>	<b>60%</b>

The proposed strategy for the North is to:

- develop the LGH to accommodate role changes to the North West Regional Hospital; and
- develop an integrated care centre in the City of Launceston, close to the LGH.

On the advice of clinicians and other stakeholders in the North West, it has been assumed that following changes to the role of the Mersey campus of the NWRH, one-third of adult medical and surgical overnight patients and paediatric patients will choose to seek care in Launceston, creating increased demand on the LGH. Transitional care services provided at the LGH will be transferred to the Mersey campus of the NWRH.

The projected demand based on these strategies is shown in Tables 9 and 10.

**Table 9: Projected inpatient activity, separations and beddays, LGH, 2004-05 to 2021-22 with integrated care centre and enhanced referral role for North West**

	Stay type	Year					Change	
		2004-05	2008-09	2011-12	2016-17	2021-22	Nos	%
<b>Separations</b>	Day only	32,017	34,074	36,267	41,998	47,961	15,944	50%
	Overnight +	13,058	14,452	15,208	15,847	16,491	3,433	26%
	<b>Total</b>	<b>45,075</b>	<b>48,526</b>	<b>51,476</b>	<b>57,845</b>	<b>64,452</b>	<b>19,377</b>	<b>43%</b>
<b>Beddays</b>	Day only	32,017	34,074	36,267	41,998	47,961	15,944	50%
	Overnight +	80,574	87,888	81,338	81,747	85,939	5,365	7%
	<b>Total</b>	<b>112,591</b>	<b>121,963</b>	<b>117,606</b>	<b>123,745</b>	<b>133,900</b>	<b>21,309</b>	<b>19%</b>

**Table 10: Estimated facility requirements, 2004-05 to 2021-22, integrated care centre, Launceston**

	Stay type	Year					Change	
		2004-05	2008-09	2011-12	2016-17	2021-22	Nos	%
<b>Separations</b>	Day only	0	0	2,434	4,075	5,956	3,521	145%
	Overnight +	0	0	641	966	1,546	905	141%
	<b>Total</b>	<b>0</b>	<b>0</b>	<b>3,075</b>	<b>5,041</b>	<b>7,502</b>	<b>4,427</b>	<b>144%</b>
<b>Beddays</b>	Day only	0	0	2,434	4,075	5,956	3,521	145%
	Overnight +	0	0	13,456	20,438	33,382	19,926	148%
	<b>Total</b>	<b>0</b>	<b>0</b>	<b>15,890</b>	<b>24,513</b>	<b>39,338</b>	<b>23,448</b>	<b>148%</b>

The tables above indicate that demand would justify the development of an integrated care centre by 2011-12. The Centre would be developed as a Tier 4 facility incorporating community-based renal dialysis services, overnight rehabilitation services and non-acute services including services under the transition program.

# A new strategy for the North West Regional Hospital

## Key points

- The configuration of services across the two campuses of North West Regional Hospital – at Burnie and the Mersey campus at Latrobe – has been the subject of much attention and robust debate for a number of years.
- The cost of acute care services in the North West is higher than for the other two major acute hospitals due to a number of factors, including the cost of recruitment of clinical staff to the services, and the inefficiencies created by two hospitals in close proximity, each providing similar services to the same population.
- Current service patterns reflect a number of past policy, planning and operational decisions. Decisions about the future have been based on the overall health needs of the population of the North West region, coupled with careful consideration of well-integrated service design.
- Continuing efforts to duplicate services across both campuses have created major problems of sustainability and have compromised the quality of health care for the whole community.
- Addressing these problems has necessitated a change of role for both campuses, with each complementing the other. This will allow the North West Regional Hospital, in conjunction with primary health services, to provide a comprehensive service to the entire community.
- High acuity inpatient, intensive care and emergency services will be consolidated on the Burnie campus. The Mersey campus will refocus on high-volume medical and surgical day-only services; low-risk maternity and paediatric services; specialist aged care and subacute rehabilitation; and a full range of non-inpatient consulting services.
- There will be an emergency care centre at the Mersey open 24 hours a day and the theatre recovery area will be capable of providing resuscitation and high dependency support when necessary.
- Ambulance and paramedic support will be enhanced to ensure that emergency transport is available at all times for residents of the Mersey catchment area to be taken quickly and safely to appropriate emergency services at either Burnie or Launceston.

## Approach to planning sustainable services

Considerable attention has been paid to ensuring a sustainable solution to the ongoing service delivery problems that have been experienced in the North West of the State.

While present service delivery patterns and models of future growth are interesting, it is clear that past policy, planning and operational decisions have had a significant influence on the current configuration of services between the two campuses. Current activity and service capability on each of the campuses are not necessarily indicative of what could be achievable if there were a clear service plan for the NWRH and each of its component campuses. For that reason, decisions about the future roles and responsibilities of the two campuses have been based on an analysis of the needs of residents of the catchment population of the North West and the capability of the NWRH as a whole, rather than on the current distribution of services or between the campuses or their relative activity levels.

The conclusions the planning team has drawn from the analysis of service provision and future demand in the North West are:

- the 74% self-sufficiency of the North West for public hospital services is lower than targets set in other States (eg the Victorian target is 85% self-sufficiency for public hospital inpatient services). There currently is significant out-of-area flow of patients, to LGH and RHH in particular;
- residents of the Mersey sub-catchment have been utilising services in several locations, including Burnie, at a significant rate; and
- there will be significant growth in demand for services by residents of the North West, but future locations for service delivery are more likely to be influenced by policy and planning decisions than present patterns of service delivery.

### Ensuring sustainable service design

The recommended service design for the NWRH is based on the following principles, which were supported strongly by stakeholders during the development of this Plan:

- each campus is an important component of the NWRH, rather than a stand-alone hospital. Together with community-based health services, the NWRH should provide a comprehensive health service that meets the needs of the entire referral population;
- each campus should retain a vibrant and cohesive range of sustainable services which may differ in their orientation, but not their importance to or influence on the health and wellbeing of the community; and
- patient transport services should facilitate reasonable access to both campuses for the entire community.

The concept of sustainability is central to this Plan. The factors that determine sustainability are described on page 27 of this Plan and are reiterated here for reference:

- sufficient patient volume to support and maintain the competence of health care professionals;
- a staffing infrastructure that can withstand temporary shortages without excessive cost or operational burden;
- quality equipment and facilities and appropriate access to necessary clinical and non-clinical support services;
- costs that are reasonable and manageable over time, in the context of competing demands for limited resources; and
- transparent and predictable funding allocations.

The NWRH has not been able to achieve service sustainability across both campuses. There is inappropriate dependence on locum staffing, creating high levels of clinical risk. Services at the Mersey campus, in particular, have been unreliable. The cost of service delivery in the North West is excessive, resulting in opportunity costs for the residents of the North West, as well as for the health system as a whole. The planning team concurs with the conclusions of several previous reviews that ongoing sustainability problems at the NWRH are a direct consequence of poorly designed services and in particular, of attempts to provide key volume-dependent services across two campuses when only a single service for the combined population of 100,000 people is sustainable.

The impact of these issues on the cost and quality of care is likely to worsen in the future as workforce shortages become more acute. It is imperative that the structural deficiencies are addressed.

At present, each campus of the NWRH provides services to a referral base of approximately 50,000 people and the NWRH as a whole provides services to a referral base of approximately 100,000 people. Application of the requirement for sustainable service development in the North West results in the following framework for decision-making:

- if it is not possible to design a sustainable service for a population of 50,000 people, but it is possible to design a sustainable service for a population of 100,000, the service should be provided on one campus only; and
- if it is not possible to provide a sustainable service for a population of 100,000 people, the service should not be established in the North West but should be provided on a regional referral or state-wide basis with outreach services as appropriate.

### Intensive care services in the North West

Sustainable specialist intensive care services require a population base of at least 100,000 people. The current intensive care service is attempting to service that population from two discrete campuses. It is not viable to provide high-quality intensive care services in two separate locations, each serving a population base of 50,000 people.

Neither the unit at the Burnie campus, nor the unit at Mersey has an optimal caseload. The Burnie campus has a higher admission rate than the Mersey campus (240 patients at Burnie, 158 at Mersey). At present, neither has continuous in-house registrar staffing, an important requirement for the safe delivery of intensive care services.

Consolidation of intensive care services into one campus is essential. It will enable the unit to be better equipped, will ensure sufficient patient throughput to support a viable specialist and registrar roster appropriate to the level of care being provided and will assist the service to withstand short-term fluctuations in staffing.

There has been detailed consideration of which campus is most appropriate for provision of higher acuity services including intensive care. The Burnie campus has been selected because:

- it is well located for residents of the West and Far North West of the State who otherwise would be unable to access emergency and critical care services readily;
- it is a more modern facility than the Mersey campus and has supporting infrastructure consistent with the proposed role;
- it is co-located with the University of Tasmania Rural Clinical School and offers specific training opportunities for health professionals; and
- the Mersey campus is within clinical distance requirements for safe transport of emergency patients to other sites as required.

### Emergency medicine in the North West

As with intensive care services, there has been significant difficulty staffing emergency medicine services in their current configuration across two campuses. As a consequence these services, particularly those provided from the Mersey campus, have been extremely unreliable.

It is necessary to consolidate scarce specialist Emergency Medicine resources in the North West to ensure a sustainable service for the population of the whole region. If all Emergency Department presentations occurred on one campus there would be a standard number of presentations for a fully functioning emergency service in a rural area.

Thirty-six per cent of cases at Mersey and 32% of cases at Burnie could be managed in a GP service because of their low urgency and low acuity, the diagnosis is not Emergency Department specific, and they present during normal work hours.

An increasing number of residents of the North West, particularly those from Devonport and the Central Coast, bypass the NWRH and present to the LGH for emergency care. This trend has continued since the Mersey returned to government control.

Because of the critical interrelationships between Intensive care and Emergency Medicine, the Emergency Department should be located on the same site as the Intensive Care Service. For the reasons discussed, that site is the Burnie campus.

### Obstetric services in the North West

There is a projected decline in births to North West residents in public hospitals from 1,035 to 803 births by 2021-22. Births at Burnie (including the North West public contract with the North West Private Hospital) are projected to decrease from 593 to 431 in that time; births at Mersey are projected to decrease from 344 to 296 over the same period. Residents in the Mersey sub-catchment currently use the Mersey campus for only 60% of births.

Non-admitted pregnancy and post-natal care can be provided safely at both campuses. Low-risk birthing services can be provided safely in facilities with lower levels of staffing infrastructure. Their success depends on staff training and competence and implementation of protocols for patient eligibility, management and transfer.

It is feasible, then, to continue to provide pregnancy and post-natal care (both inpatient and non-admitted) and low-risk birthing services on both campuses of the NWRH, even in the absence of an on-site intensive care service on the Mersey campus.

Medium-risk birthing services depend for their safety on the availability of teams of skilled health care professionals including anaesthetists, specialist obstetricians and paediatricians and registrars, and require sophisticated infrastructure including intensive care/high dependency units. The consolidation of intensive care and associated services at Burnie will necessitate a corresponding consolidation of medium-risk birthing services at the same site.

For these reasons, medium-risk birthing will continue at Burnie, while Mersey will focus on providing a local, low-risk maternity service, with related pre- and post-natal care services.

### Consequences for vascular surgery

Because there is an established service operating in the North West provided by a resident clinician, and there have been significant concerns about access to and the responsiveness of vascular surgical services for patients from Launceston, in particular for renal patients, the following structure will be implemented:

- vascular surgery designated a state-wide service, led from Hobart;
- the existing surgeon in the North West offered the opportunity to relocate his practice to Launceston and be appointed to the LGH as a member of the state-wide vascular surgical team;
- the state-wide vascular surgical team to ensure that there is backup and support for the Launceston service through the provision of visiting consultancy services and offering on-call, professional and locum support to the resident vascular surgeon;
- outreach services continue to be provided from Hobart and/or Launceston to the North West, by arrangement with the state-wide service; and
- all vascular surgeons, as a condition of their appointments, participate in a state-wide audit, which may be linked to the Victorian State Vascular Surgical audit.

## Other medical and surgical services in the North West

The proposed consolidation of intensive care services at one site necessitates a corresponding consolidation of higher acuity medical, surgical and trauma services, which may require intensive care support, at the same site.

Services to be provided from each campus are detailed in below.

**Table 11: Services to be provided from the Burnie and Mersey campuses**

Burnie campus	Mersey campus
Intensive care	Recovery unit
Inpatient acute medical including some subspecialties	Specialist aged care (admitted and non-admitted), sub-acute rehabilitation and transition care
Inpatient acute surgical including some subspecialties	23-hour acute elective surgical
Low- and medium-risk obstetrics	Low-risk obstetrics
Ante-natal and post-natal care (admitted and non-admitted)	Ante-natal and post-natal care (admitted and non-admitted low-risk)
Inpatient paediatrics	Short stay paediatrics (12 hours)
Emergency medicine	Emergency care centre 24 hours, 7 days a week
Satellite renal dialysis (Parkside)	Satellite renal dialysis (new service)
Day chemotherapy	Day chemotherapy
Specialty and subspecialty consulting	Specialty and subspecialty consulting

### Role of the Burnie campus

The Burnie campus will provide the following services:

- inpatient general medical and general surgical services, selected subspecialist surgical services including gynaecology, ophthalmology, orthopaedics and urology, paediatrics and low- and medium-risk obstetrics;
- non-admitted consulting services in a full range of subspecialty areas, provided on an outreach basis if necessary;
- consolidated ICU services for the North West; and
- a full Emergency Department service.

### Role of the Mersey campus

The role change for Burnie provides an opportunity for the Mersey campus to refocus and concentrate on lower risk and sub-acute services, short stay services including day surgery and specialist outpatient services.

The Mersey campus will focus on providing a range of services that are relevant to and valued by the community.

Services provided from the Mersey campus will include high-volume medical and surgical day-only services, specialist aged care and rehabilitation services, low acuity maternity and paediatric services. Some services provided at the Mersey campus will be whole-of-region services for residents from throughout the North West.

The theatre recovery suite will be capable of providing resuscitation support so that procedural and obstetric patients can be supported appropriately in the event of an emergency requiring transfer from the Mersey campus. There also will be a short stay observation area for low-acuity paediatric patients.

Day-only services will include renal dialysis and chemotherapy. A full range of non-inpatient consulting services will be provided and there will be an emergency care centre.

### **Emergency care centre**

An emergency care centre will operate at the Mersey campus 24 hours, 7 days a week.

Any triage Category 1 and 2 and complex Category 3 patients who present to the Mersey emergency care centre will be assessed, stabilised and transferred to the Burnie campus or the LGH. Short-term observation services will be available within the emergency care centre.

There will be no arrangement for usage of theatres for emergency patients presenting to the Mersey campus – any patients needing theatre services will be transferred.

There will be rostered GP services and the option of Career Medical Officer rostered support from Burnie. The service will be supported by a triage nurse and associated support services will be available consistent with the Centre's role, including the possibility of nurse practitioner support.

### **Elective surgery and post-procedural recovery services**

A 23-hour elective surgical service will be provided at the Mersey campus enabling the provision of a comprehensive range of surgical specialty and subspecialty services on a short stay basis, as well as a diagnostic endoscopy service. A post-procedural HDU recovery service also will be provided.

### **Additional specialty services**

An extended range of medical and nurse-led specialty clinics also will be provided on the Mersey campus as well as a renal dialysis services, chemotherapy services, chronic disease management programs, ACAT team and other visiting services.

Mersey campus will provide sub-acute inpatient rehabilitation services, aged care services and transition care services for the North West.

### **Support services**

The Mersey campus will have routine radiography services (general x-rays) provided on-site and an Image Intensifier Service to support same day surgery and the emergency care centre.

Pathology services will be provided as a collection service with transport of specimens to the Burnie campus.

## **Implications of the changed services in the North West for Launceston General Hospital**

There is a natural flow of residents from the eastern end of the North West region to the LGH due to the proximity of Launceston and because it is a major regional centre. It is anticipated that some 50% of patients now attending LGH for same-day surgery will be able to attend Mersey for elective day surgery services with increased capacity and resulting reduction in waiting times.

# Strategies for specific acute services

The Clinical Service Plan provides considerable detail about current and predicted activity and the future configuration of various local, regional, single site and state-wide services. The detail is not reproduced in this Plan, but a summary of issues and recommended strategies for state-wide, single site and other major services is provided in Table 12 below.

**Table 12: Major clinical service strategies**

Clinical service	Service strategies
<b>Cardiothoracic surgery</b>	<p>The RHH will continue to be the state-wide provider of cardiothoracic surgery for Tasmania.</p> <p>The RHH will consolidate and formalise agreements with interstate hospitals to facilitate ongoing cover for cardiothoracic surgery in Tasmania.</p> <p>The DHHS and RHH will consider strategies for interstate flow reversal back to the RHH due to service volumes.</p>
<b>Cardiac electrophysiology</b>	<p>There is sufficient volume to support the introduction of the service within Tasmania and this strategy will be considered in the context of the development of cardiology services including interventional cardiology inpatient demand.</p> <p>This service could be located as a single site service at the LGH or the RHH.</p>
<b>Complex upper gastrointestinal (GI) and hepatobiliary surgery</b>	<p>The LGH will continue to be the sole provider of complex upper gastrointestinal and hepatobiliary surgery in Tasmania.</p>
<b>Neurosurgery</b>	<p>The RHH will continue to be the state-wide provider of complex neurosurgery in the public sector for Tasmania.</p>
<b>Bariatric surgery</b>	<p>The RHH will continue to be the sole provider of public sector bariatric surgery in Tasmania.</p> <p>The Department of Surgery at the RHH will establish criteria for admission to the program, audit outcomes and monitor demand.</p>
<b>Vascular surgery</b>	<p>Vascular surgery will be confirmed as a state-wide service, led by RHH.</p> <p>Vascular surgery will relocate from the NWRH Mersey to LGH and be part of the state-wide service.</p> <p>Outreach services from RHH to the LGH and NWRH will continue.</p>
<b>Complex ENT and head and neck surgery</b>	<p>Complex head and neck surgery should be provided as a single site service although some cases will continue to be transferred interstate.</p>
<b>Pain management service</b>	<p>Specialist pain management services will be provided as a state-wide service from the RHH, with local pain management services provided at the LGH and NWRH Burnie.</p> <p>Pain management services should be delivered through a partnership approach with Drug and Alcohol Services and the Pharmaceutical Service branch to ensure the burgeoning prescription of opioids and benzodiazepine and related problems are managed within a quality framework.</p>
<b>Complex burns</b>	<p>The RHH will continue as the state-wide provider for the treatment and management of patients with complex burns.</p> <p>Some complex burns cases will continue to be referred to Victoria for specialised treatment.</p>
<b>Cystic fibrosis</b>	<p>The RHH will continue to provide a state-wide service for both paediatric and adult Cystic Fibrosis patients. Continued development of multidisciplinary services is required and there should be a significant outreach element to these services.</p>

Clinical service	Service strategies
<b>Clinical genetics</b>	<p>TCGS will continue as the state-wide service. Testing of new born babies will continue to be conducted by Genetics Health Services Victoria on a contract basis.</p> <p>A Familial Cancer Registry will be established in line with other Australian states.</p>
<b>Hyperbaric medicine</b>	<p>Hyperbaric medicine will continue to be delivered as a state-wide service from the RHH.</p> <p>DHHS and RHH will review the demand for hyperbaric medicine services and infrastructure available to meet demand.</p> <p>DHHS and RHH will review opportunities for integration of hyperbaric medicine with other specialties to enhance treatment efficiency. This includes scope for the potential benefits of hyperbaric medicine to other specialties, and opportunities for service integration eg multi-disciplinary outpatient clinics).</p>
<b>Bone marrow transplantation</b>	<p>The Royal Melbourne Hospital will continue to provide allogenic BMT for Tasmanian residents.</p> <p>The RHH will continue to provide stem cell harvesting and be the state-wide provider of autologous BMT.</p> <p>The LGH will continue to provide stem cell harvesting only, with stem cells transferred to the RHH for cryopreservation.</p>
<b>Brachytherapy</b>	<p>The LGH will continue to be the single site provider of brachytherapy services.</p>
<b>Gynaecological oncology</b>	<p>Gynaecological oncology will continue to be provided from the RHH as a single site service with an outreach to the LGH.</p>
<b>Forensic pathology</b>	<p>Forensic pathology will continue to be provided as a state-wide service as a business unit of the Acute Health Services Group of Department of Health and Human Services.</p>
<b>Pathology services</b>	<p>A state-wide pathology service will be considered for Tasmania.</p> <p>Issues to be addressed within the scope of a state-wide service are greater role delineation of services between providers with complex and specialised specimen testing provided at dedicated sites; and implementing an effective specimen transport service.</p>
<b>PET scanning</b>	<p>If the service is affordable, a combined PET/CT scanner should be introduced in Tasmania to augment the delivery of multidisciplinary cancer care in Tasmania.</p> <p>The combined PET/CT scanner should be located at the RHH.</p>
<b>Radiation oncology</b>	<p>There is a need for a fifth linear accelerator in Tasmania. Because demand for services is distributed relatively evenly between the North and the South, the new linear accelerator could be located in either Launceston or Hobart.</p> <p>On a population basis, however, the North West will generate sufficient patient demand to support a single machine service.</p> <p>A feasibility study is required to assess whether a linear accelerator can be operated safely and efficiently as a stand-alone unit at the Mersey campus.</p>
<b>Infectious diseases</b>	<p>The RHH Department of Microbiology and Infectious Diseases will continue to provide a state-wide service to Tasmania, and to conduct regular clinics including outreach services to the LGH and NWRH.</p>

# Enabling factors

## Teaching, training and the health workforce

Teaching and training are core elements of the Tasmanian health system because:

- they contribute to a culture of inquiry, learning and reflection which is crucial to workforce quality;
- they are vital to the future availability of a skilled workforce; and
- the opportunity to participate in these activities makes a significant contribution to the professional satisfaction of the health workforce and assists in recruitment and retention.

The new health service models arising from the Plan will generate a specific set of health workforce issues that require an overarching health workforce plan. This will include a longer term strategy to link Tasmania's workforce needs to health care education, training and research. Early workforce actions will include:

- increasing support, through General Practice Workforce Tasmania, to aid in the recruitment of GPs to Tasmania;
- implementation of nurse practitioners working in rural health teams in 2008;
- considering new service requirements, eg generic health degrees that will equip health providers to undertake lifestyle counselling and support in relation to chronic disease, increased utilisation of therapy assistants, direct care providers, expanded scope of practice for rural paramedics;
- establishing teams focused on the prevention and management of diabetes;
- through the clinical networks, reviewing postgraduate medical training opportunities and accreditation requirements and ensuring that Tasmania's accredited registrar positions are optimised through cooperative arrangements across the State; and
- delegating additional authority to hospital CEOs to manage their health professional workforces within agreed budgets, enabling local flexibility in decision-making within a framework of strengthened accountability.

Opportunities to recruit and retain health care professionals to the NWRH are expected to improve as service design is strengthened, enhancing both the level of support that is available to clinicians and their capacity to delivery quality care within well-designed services.

The DHHS will work with the University of Tasmania and other educational providers to provide sustainable health workforce training and development, including a commitment to vocational, undergraduate and postgraduate student placements in primary health care and multidisciplinary settings. Specific strategies will include:

- strengthening the Partners in Health agreement with the University of Tasmania;
- undertaking research and evaluation of the outcomes of demonstration sites established as part of the implementation of the Primary Health Services Plan;
- exploring the potential to expand allied health tertiary education in Tasmania, including consideration of addressing priority workforce issues such as access to physiotherapy, nutrition, dietetics;
- further developing a degree course for Environmental Health Officers in Tasmania;
- developing a nurse clinical school in Hobart;

- working with the University of Tasmania to examine the feasibility of a Primary Health Clinical Education Centre at the Clarence Community Health Centre providing inter-professional learning experience for medical, nursing and allied health staff in a community based setting;
- working with the University of Tasmania to examine the feasibility of developing the LGH precinct as an enhanced primary/secondary Education Centre providing inter-professional learning for health professional students;
- developing all Rural Health Centres as Rural Health Teaching sites; and
- increasing workplace clinical psychological training across the DHHS.

## Research

Engagement in and publication of research enables Tasmania to contribute to the broader national health care agenda and fosters pride in the Tasmanian health care community. It enables an understanding of the factors that contribute to the health and wellbeing of Tasmanians, thereby contributing to the development of the health care system over time. It can be argued that all developed health care systems have a responsibility to engage in these activities.

The Australian Government's Primary Health Care Research, Evaluation and Development (PHCRED) Strategy aims to increase the pool of primary health care researchers by up-skilling early and mid-career researchers and supporting the sustainable advancement of research careers in primary health care.

The Menzies Research Institute is an established centre for population health research with a global reputation in epidemiology and expanding roles in genetics and clinical epidemiology as well as biomedical research.

The Clifford Craig Medical Research Trust facilitates and funds medical research. Its main base is in Launceston but it also supports medical research in the North West of the State.

The RHH Research Foundation is an independent private organisation established to promote and fund medical, health care and scientific research in Tasmania.

Both the Clifford Craig Medical Research Trust and the RHH Research Foundation rely on the corporate and general communities for fundraising.

The research sector in Australia is highly competitive and there are views that Tasmania has fallen behind other Australian jurisdictions in its performance.

The DHHS will work with the Menzies Research Institute, the Clifford Craig Medical Research Trust, the RHH Research Foundation, the University of Tasmania and other research stakeholders to develop a formal strategy for health research in Tasmania which will ensure that Tasmania consolidates and expands its research effort through a cooperative partner approach.

## Transport and retrieval

The DHHS currently is reviewing medial retrieval and patient transport arrangements. A review of ambulance services is planned for the near future.

The following strategies are recommended:

- implement a state-wide service for central coordination of non-emergency patient transport, ambulance transport and medical retrieval;
- implement transportation between health services, in particular between the two campuses of the NWRH;

- establish transit centres in acute hospitals to streamline bed management and improve patient transport efficiency;
- review the medical retrieval services including arrangements for fixed-wing and helicopter retrieval services; and
- develop a strategy for the retention of volunteer ambulance service providers and develop targeted strategies for the recruitment and retention of paramedic officers, particularly for areas of identified shortage.

Access to community transport will be improved. The Department of Health and Human Services will commence a project to establish community transport networks that will better coordinate and improve transport options for people attending health care services where public transport is not available or is inappropriate. To advance the project, the following actions will be taken immediately:

- provision of additional funding to assist in meeting the needs of people who are transport disadvantaged, but outside the HACC target group to access transport for non-urgent health related needs; and
- engagement of a project manager to map existing resources, develop a working model and project plan and undertake the necessary liaison with the community sector and local communities to engage them in the process.

The HACC program will continue to expand community transport resources in line with established community needs.

### Patient and carer support

Some patients face significant difficulties accessing health services because of age, mobility, distance, illness and a lack of family or carer support. In addition, with suitable accommodation, patient discharge often can be facilitated, allowing more efficient use of scarce acute inpatient resources.

Rural communities have consistently reported concerns about the way rural patients receive care in the major hospitals concerning, for example, lack of coordination of outpatient appointments or a lack of understanding about the support required to ensure patients can return home safely after discharge.

The major hospitals will better consider the needs of rural patients and a specifically designated staff member will act as a rural liaison officer within each hospital to ensure how the best possible care can be provided for those who need to travel to access it.

A range of patient and carer accommodation models have been developed internationally and in other Australian jurisdictions.

Medi-hotels in Victoria, for example, provide alternative patient accommodation for people who do not require direct nursing supervision, but need to remain close to nursing or medical support. People who stay in this type of accommodation must be self-managing and may have a carer staying with them.

Accommodation support needs to be complemented by transport support and the scheduling of appointments to minimize demands on patients.

The development of a medi-hotel will be considered within the scope of the RHH redevelopment. Accommodation options in Launceston and Burnie will be reviewed and consideration given to investment in additional facilities.

## Relationships with the private sector

The planning process has identified the significant interdependencies of the public and private sectors in Tasmania.

The private sector provides a significant proportion of acute hospital services as well as the majority of non-admitted patient services in Tasmania. In addition, a number of arrangements are in place for the private sector to support public service delivery.

The public and private acute hospital systems are too small to be regarded as independent of each other. The public sector has a clear interest in the viability of the private sector, and vice versa.

Advice has been received that some private sector services are at risk due to lack of clinician availability, particularly for after-hours services, and impending retirements. This is particularly the case in general medicine and paediatrics.

There would be an immediate impact on the public sector if the private sector failed in these areas, and there would be flow on effects in other areas. For example, the private sector will be unable to sustain major acute surgery if there are insufficient physicians to provide medical support to those patients.

There is a need for a close and effective working relationship between the public and private sectors generally and the organisations that deliver public and private health services in the State. The following strategies will be implemented:

- establishment of a Health Industry Forum incorporating representatives from the public and private sectors, to meet regularly to discuss key issues including workforce planning and strategies;
- participation of the private sector on clinical networks;
- development of a framework for the employment and engagement of medical and allied health professionals in the public sector which ensures appropriate accountability for public sector services but also enables, where appropriate, provision of services to the private sector; and
- identification of opportunities for partnerships between the public and private sectors based on shared capital infrastructure, including development of medical and allied health consulting suites, incorporation of private sector services in integrated care centres and maximizing opportunities for co-location of private hospitals supported by appropriate contractual arrangements.

## System governance

This planning process did not incorporate a review of governance of the Tasmanian health system, but a range of governance issues were raised which require further attention:

- The financial accountability of the system needs to be improved. Many acute and rural hospitals are operating outside their approved budgets. This situation is unsustainable. In addition, resource allocations within the acute and primary health systems are based on historical decisions.
- Some stakeholders are concerned that delegation of decision-making is ineffective and in particular that decision-making is cumbersome because of onerous central office approval requirements leading to lost opportunities, particularly in relation to the health workforce.
- There are gaps in the coordination of clinical governance, particularly for privatised services, state-wide services and across the primary/acute continuum.
- There are opportunities for greater community and consumer engagement, particularly in relation to service system priorities.

In relation to resource allocations and financial accountability, the Richardson Report recommended consideration of the introduction of a casemix system of funding. This should be progressed as a priority.

There is considerable opportunity to streamline decision-making, but if greater decision-making authority is to be delegated to senior operational managers, there must be a corresponding delegation of responsibility to manage budgets actively and to ensure that service demand is managed appropriately so that unsustainable budget overruns do not occur. A performance agreement with managers, for example, could provide for greater delegation of operational decision making within defined policy boundaries, but would need to be accompanied by appropriate sanctions for unsatisfactory performance which could include withdrawal of authority to make independent budget decisions once certain budgetary thresholds were crossed.

Clinical governance will be strengthened substantially through the implementation of this Plan, in particular through the implementation of clinical networks, role delineation and best practice processes for credentialling, defining the scope of clinical practice and approving the introduction of new clinical services.

Decisions about how Tasmania addresses a range of health care challenges and opportunities should be taken in consultation with the communities who will be affected by them at local and regional levels. Community and consumer engagement in the implementation of the Plan will be fostered through a state-wide strategy that will include:

- engagement with community representatives, local government and community organisations in local primary health partnerships; and
- development of regional consumer engagement processes involving Primary Health and Acute Health services that will provide an opportunity for community representatives to be involved in the implementation of the Tasmanian Health Plan, along with service providers, local government and other stakeholders.

# Future Health Tasmania

## The implications of health service integration

Tasmania's Health Plan provides a coherent, whole-of-system framework for the delivery of integrated health care. Planning priorities and the capacity of existing services to meet future health service demands have been amongst the key factors in determining the development of local, regional and state-wide services.

Partnerships and collaborative approaches are crucial to the management of the health needs of the community. The planning process has revealed the necessity for integration of service delivery across acute inpatient and primary health services to ensure effective delivery of health care in the future. Hence the focus on clinical networks and the state-wide service model, including the introduction of integrated care centres.

All health services provided in Tasmania, from local to state-wide services, have been carefully assessed to ensure their capacity to meet the future health needs of the community. The capacity of DHHS services to meet future needs has been calibrated against the principles articulated in this Plan, with an emphasis on:

- population trends and levels of community need;
- distance from other services; and
- sustainability considerations such as cost and workforce availability.

The proposed clinical networks and the clinical governance structure in general will be enable integration along the following dimensions:

- across the acute sector, including integration across public acute facilities and between the public and private acute sector;
- between acute and primary care services, including integration with rural hospitals, general practitioners and other primary care providers; and
- across the primary health sector, at varying levels of government and with other community services, such as residential aged care and disability support services.

## Capacity of existing resources

The service strategies create a ten- to 15-year plan for health services in Tasmania. In order to adopt them, the DHHS will need to change the service delivery models at each site significantly. This will require a detailed analysis of current services capacity and of the capacity to implement these changes.

A feasibility study undertaken by the DHHS to determine if short-term changes can be accommodated within existing infrastructure has shown that a change in service delivery to meet the Plan objectives by 2008 is achievable, as long as there is willingness on the part of clinicians to embrace change and support the new directions set by government.

## Implementation plan and change management strategy

These changes need to be implemented through a careful and well-considered change management process, supported by more detailed investigation of the physical facilities and their capacity to manage the projected activity at each of the key sites.

Implementation of the changes to primary health services, as outlined in this Plan, will be carried out through processes which effectively involve local health professionals, health facility staff, local government

and community members. It will involve regional Primary Health managers, Primary Health coordinators and, where appropriate, dedicated project managers to carry out the implementation program.

Implementation will be guided by the Tasmanian Government Project Management Guidelines. Governance arrangements will include the formation of fixed-term regional Primary Health Advisory Committees to oversee the implementation of the Plan.

Individual projects, around such areas as the development of Primary Health Partnerships, will also feature community engagement at a local level.

Within Acute Health Services, critically, and as a first step, a change management plan is being developed for the Mersey campus of the NWRH, and its relationship to both the NWRH Burnie campus and the LGH, which will establish a tight timeline.

The department will then develop a detailed implementation plan, which clearly identifies timelines, actions and responsibilities for the wider clinical service changes across Tasmania. The implementation plan will set out a change management strategy so that clinicians, staff, other service providers and the community are partners in the required change process.

Implementation will include the development of regional consumer engagement processes involving Primary Health and Acute Health services that will provide an opportunity for community representatives to be involved in the implementation of the Tasmanian Health Plan, along with service providers, local government and other stakeholders.

## Evaluation

One of the commitments made earlier in this Plan is to undertake research and evaluation of the outcomes of demonstration sites established as part of the implementation of the Primary Health Services Plan. The Tasmanian Government Project Management Guidelines states that evaluation of project performance can occur in a number of ways.

Evaluation of the Plan will be undertaken through a number of these methods, as appropriate.

# Appendix I – Primary Health coordination areas and catchment populations

Local government area	Primary Health coordination areas	Catchment population
Brighton	Fawkner	South
Central Highlands		
Derwent Valley		
Glenorchy		
Southern Midlands		
Clarence	Rumney	
Glamorgan Spring Bay		
Sorell		
Tasman		
Hobart	Wellington	
Huon Valley		
Kingborough		
Break O'Day	North Esk	North
Dorset		
Flinders Island		
George Town		
Northern Midlands		
Launceston	South Esk	
Meander Valley		
West Tamar		
Burnie	Hellyer	North West
Circular Head		
King Island		
Waratah-Wynyard		
West Coast		
Central Coast	Mersey	
Devonport		
Kentish		
Latrobe		

## Appendix 2 – Services provided by rural inpatient facilities

Name/Location <sup>17</sup>	Inpatient (subacute) beds	Residential aged care beds	2005-6 total beds	Other services
Beaconsfield District Health Service (Multi Purpose Service)	4	18	22	Respite, palliative and post-natal care Community and visiting services and support groups
Campbell Town Health and Community Service (Multi Purpose Service)	6	20	26	Day centres, information, advocacy, home visiting, social support, recreation, referral, coordination, podiatry, equipment hire
Deloraine Hospital	20	0	20	Coordination of a broad range of community and allied health services in Meander Valley
Flinders Island Multi Purpose Centre	4	9	13	Coordination of a broad range of community, visiting services and support services
George Town District Hospital & Community Health Centre	15	0	15	Visiting services Base for community nursing, home help/personal care and home maintenance
Health West – Rosebery Hospital	7	0	7	Visiting diabetic clinic, needle exchange Coordination of community nursing and other support programs
Health West – West Coast District Hospital, Queenstown	10	16	26	Visiting radiology, diabetic clinic, physiotherapy, podiatry Community nursing, home help/personal care and home maintenance
King Island Hospital and Health Centre	6	14	20	Coordination of community services, visiting service and community nursing, child health, dental, antenatal, and alcohol and drug services
Midlands Multi Purpose Health Centre – Oatlands	4	19	23	Coordination of delivery of community and visiting services. Coordination of community nursing, child health, disability and diabetic education services
New Norfolk District Hospital	10	0	10	Radiology, physiotherapy, podiatry, community health, mental health, child health and visiting consultants
North East Soldiers Memorial Hospital Scottsdale	20	29	49	Radiology, physiotherapy, visiting services to Scottsdale and communities Community nursing and home help/personal care

<sup>17</sup> Under the terms of the Multi Purpose Agreements, funds can be used flexibly according to community need.

Name/Location <sup>20</sup>	Inpatient (subacute) beds	Residential aged care beds	2005-6 total beds	Other services
Ouse District Hospital	4	6	10	Visiting family child health, podiatry, physiotherapy, mental health, diabetes education. Outreach: occupational therapy and speech pathology
Smithton Hospital	16	22	38	Visiting radiology, diabetic clinic, obstetrics and continence services Community nursing, home help/ personal care and home maintenance
St Helens District Hospital	10	0	10	Radiology, physiotherapy, and visiting services
St Marys Community Health Centre	8	0	8	Visiting physiotherapy, podiatry, and audiology. Community nursing base, home help/community care, home maintenance
<b>Total</b>	<b>144</b>	<b>153</b>	<b>297</b>	

Source: Department of Health and Human Services

# Appendix 3 – Australian Government-funded regional health services

RHS	Auspice	Services
Break O'Day Regional Health Service	Break O'Day Health Resource Association	Social Worker, Podiatry, Palliative Care, Youth Worker, Health Promotion
Bruny Island Regional Health Service	Department of Health and Human Services	Physiotherapy, Podiatry, Social Work, Occupational Therapy, Nutrition and Dietetics, Speech Pathology, Health Promotion Coordinator, Community Transport
Central Highlands Regional Health Service	Department of Health and Human Services	Youth Worker, Social Worker, Podiatry, Mental Health, Health Promotion
Circular Head Regional Health Service	Circular Head Rural Health Services Inc	Youth Work, Social Work, Mental Health, Podiatry, Health Promotion
Dorset Regional Health Service	Dorset Council	Social Worker, Youth Worker, Mental Health
Flinders Island	Department of Health and Human Services	Podiatry
George Town Regional Health Service	George Town Health and Welfare Committee Inc	Mental Health, Youth Health, Social Work, Health Promotion
Glamorgan/Spring Bay Regional Health Service	Glamorgan/Spring Bay Council	Social Worker, Psychologist, Youth Worker
Huon Valley Regional Health Service	Huon Valley Council	Youth Health, Seniors Health, Rural Health and nutrition
Kentish Regional Health Service	Tandara Lodge Community Care Inc	Mental Health, Podiatry, Physiotherapy, OT, Youth Worker, Health Promotion
King Island Regional Health Service	King Island Council	Psychologist, Youth Worker, Health Prevention Projects
Meander Valley Regional Health Service	Department of Health and Human Services	Community Mental Health Worker, Social Worker, Youth Worker
Southern Midlands Regional Health Service	Department of Health and Human Services	Social Work, Podiatry, Physiotherapy
Tasman Regional Health Service	Tasman Council	Youth Worker, Social Worker
West Coast Regional Health Service	Department of Health and Human Services	Social Work, Youth Worker, Chronic Disease Self Mgt Worker

Source: Australian Government Department of Health and Ageing.

# Glossary

<b>ALOS</b>	Average length of stay: the average number of days that a patient was in the hospital
<b>CACP</b>	Community Aged Care Package
<b>CCHC</b>	Clarence Community Health Centre
<b>CEO</b>	Chief Executive Officer
<b>CHC</b>	Community Health Centre
<b>COPS</b>	Community Options Service
<b>DH</b>	District Hospital
<b>EACH</b>	Extended Aged Care in the Home
<b>FTE</b>	Full Time Equivalent
<b>GP</b>	General Practitioner
<b>HACC</b>	Home and Community Care: a joint Australian Government and State-funded program
<b>LGA</b>	Local Government Area
<b>MBS</b>	Medicare Benefits Schedule
<b>MPC</b>	Multi Purpose Centre
<b>MPS</b>	Multi Purpose Service
<b>NC</b>	Nursing Centre
<b>OBD</b>	Occupied beddays: the total number of days in which hospital beds were being used by patients
<b>PTAS</b>	Patient Travel Assistance Scheme
<b>RAC</b>	Residential Aged Care
<b>Separations</b>	Separations: the total number of patients who were discharged, transferred out or died in a hospital
<b>Subacute beds (rural health beds)</b>	The beds in our rural health facilities are used for a number of levels of treatment including medical care not requiring specialist treatment, post-natal care in some sites, respite and care awaiting placement
<b>Subacute Care</b>	Care needs and treatment that are driven primarily by the patient's functional status, not the underlying medical diagnosis. The goal of treatment is functional improvement





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