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Strategy and Planning Unit
Department of Health - Tasmania
GPO Box 125
Hobart, TAS 7001
Via email: cpt@health.tas.gov.au

To whom it may concern,

Submission: Launceston General Hospital Masterplan 2019

Thank you for the opportunity to provide a public submission regarding the Launceston General Hospital Masterplan. The Rural Doctors Association of Tasmania is the peak rural body for doctors working in rural and remote Tasmania and represents the views and aspirations of rural doctors. We aim to promote career pathways in rural practice and support services provided by rural doctors in Tasmania, including development of improved support incentives and rewards for high standard clinical practice.

Please find our responses to the suggested questions below:

What are the key clinical issues that you believe the redevelopment should address?

The Launceston General Hospital is under increasing pressure to service the demands of North and North West Tasmania. The key to prevent avoidable hospital admissions is to appropriately fund and incorporate primary care (e.g. General Practice) into the Health Services Model.

Key issues to also be addressed are:

- Reduced waiting times for elective surgery
- Reduced waiting times in the Emergency department
- Reduced access block to inpatient beds
- Reduced waiting times for specialist outpatient appointments
- Reduced waiting times for Allied Health appointments.

What clinical service areas do you think should have first priority for expansion or development?

There is a significant demand for service in the Emergency Department and for Mental Health Services.

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We believe that the first priority areas include access to non-urgent care (e.g. after-hours General Practice, Community Rapid Response, hospital avoidance programs, nurse lead specialist chronic disease clinics [e.g. heart failure clinics]) and access to Community Mental Health support.

What services are currently difficult to access, what could be done to improve access?

There are two key areas for improvement:

1) Improved access to non-urgent sub-specialist care e.g. outpatient clinics
    a. Solutions include transport and overnight accommodation options for patients travelling from rural and remote areas to LGH for outpatient or inpatient care.
    b. Improved access to telehealth to prevent the need for patients to travel
    c. Better incorporation of the General Practitioner into sub-speciality consultations e.g. video link in, timely communication from hospital to GP
2) Improved coordination of emergency retrieval and support of the smaller peripheral hospitals in the state
    a. Solutions include improved agreements and pathways for receiving patients from smaller facilities. Possibly a coordinator to take the role of deciding where and how a patient will move when their care requires escalation from their current location. This role is currently provided by clinicians in a haphazard and time consuming method of “phoning around”.
    b. Other jurisdictions in Australia have defined retrieval pathways and a ‘one phone call’ policy, which allows the rural GP to phone once to retrieval requesting help and then the Retrieval or Ambulance Service as responsible for sourcing an accepting clinician, an receiving bed and an asset to transfer the patient.

What clinical services could be better provided in people’s homes or community health centres, rather than in hospital?

Hospital avoidance strategies should be a priority for the State Government. The support and expansion of the Community Rapid Response Service should be encouraged. Services that could be provided in the community include:

- Chronic disease management
- Wound dressing clinics

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- Intravenous antibiotic infusion
- Mental health management
- Outpatient follow up
- Palliative Care
- Post-hospital discharge follow up e.g. multi-disciplinary teams who meet patients in hospital and follow up their progress in the community and focus on preventing readmission to hospital
- Telehealth could support these services with a carer or nurse onsite to facilitate
- Telehealth could also be used more widely for outpatient services so that patients from rural areas do not have to travel to LGH for appointments, these appointments could be carried out via telehealth either at the patients home or at the GP medical centre

What clinical services should be provided by the LGH for residents of the North West region?

The North West region relies on the LGH and THS North to provide subspecialty medical and surgical care. Greater ownership of these patients needs to exist. Currently the culture within the THS is that accepting patients from the NW is a 'burden' and that patients are forgotten or lost to follow up once they return to the NW. The THS North and North-West need to work collaboratively to provide a network of services that allow for smooth patient transition between the two regions and greater patient satisfaction. Services include:

- Medical outpatients, including Cardiology, Renal, Gastroenterology, Respiratory
- Surgical outpatients, including Urology, Upper GI, Colorectal, ENT
- A range of low risk day procedures provided by clinicians visiting from the Northern region
    - This allows care closer to home
    - It gives local doctors and nurses the skills to look after these patients in the post-operatively period
    - An expansion of services to the NW, including the MCH would see the demand for inpatient beds at the LGH decrease and prevent issues with cancellation of procedures due to access block
- Timely transfer between facilities for acute care and appropriate handover between the

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North and North West for step down care

The Mersey Hospital would be ideal as a Rural Generalist run hospital, as outlined in the Workforce plan outlined by RDAT (see link). LGH could assist in this by specialists being true consultants for this style of care, as happens in hospitals of this size in other states. It would provide a training hub for trainee Rural Generalists who would then work in other rural hospital around the state, improving care around rural Tasmania. This would also provide significant savings in the cost of locums currently used at the Mersey Community Hospital.

What clinical services should be provided in the small district hospitals that are part of the LGH catchment area (i.e. those located in townships such as Deloraine, Scottsdale and Campbell Town)?

Many jurisdictions around Australia utilise district hospitals for generalist medicine, led by GPs.

The district hospitals in the North are appropriate for:

- Rural Generalist managed inpatient Adult Internal Medicine
- Rural Generalist managed inpatient Rehabilitation Medicine
- Rural Generalist managed inpatient Palliative Care
- Rural Generalist managed Emergency Medicine
- Rural Generalist managed low risk Obstetrics (Scottsdale)
- "Step down" inpatient care from LGH e.g. post surgery care
- Medical Oncology day procedures and chemotherapy
- Outpatient/outreach clinics in all core specialist disciplines

Support from the THS to promote rural generalist training pathways between the district hospitals and the LGH should be a priority for the clinical redesign.

How could services be provided in a way that focuses more on patients and their individual health journey?

Provision of an urgent care facility that operates independently of the emergency department staffed by rural generalist and other suitably qualified GPs in a model that allows affordable access to a GP during episodes of urgent (but not emergent) illness. These centres can have extended hours such as 8am-10pm. Examples of urgent care facilities are now operating in other cities in Australia

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including Adelaide, Perth and greater western Sydney and is a successful model that has been in practice in NZ for more than a decade.

Increased emphasis on the role of the Family Doctor/GP and the provision of Primary Care services that focus on keeping patients out of hospital. The GP is the centre of care coordination and needs to remain a key focus of any clinical redesign.

More community drivers for access to outpatient appointments and, where appropriate, transport to their GP for all episodes of care.

How could the redevelopment support patients better as they move between different care settings?

Active involvement of the patient's Family Doctor/GP in the entire patient journey through different care settings.

A plan for follow up in the circumstance that the patient is housebound or otherwise unable to access an affordable GP. "See GP" is not an appropriate plan if the patient does not have access to a GP. Barriers to accessing a GP include transport and cost and more community drivers to allow GP access and funding for follow up appointments is appropriate.

Timely and appropriate handover between the hospital and Primary Care. Currently there are hundreds of outstanding discharge summaries within the THS North. Junior doctors need to be supported by their Consultants to have dedicated time to complete these important handovers. Timely communication prevents adverse outcomes and patient re-admission. There have been two recent coroners reports in Tasmania regarding untimely handover to GPs subsequent deaths.

The State Government needs to invest in more transparency with the general public. This includes releasing waiting times to outpatient clinics and elective surgery. The Government should improve its communication with patients who are waiting to be reviewed by sub-specialists. Many simply do not receive any communication and are left in limbo whilst waiting for their appointments. Clinician led triage should be a key feature of outpatient clinic procedure, including timely communication back to the referring doctor (normally a GP) that a patient is on a waiting list and suggestions on interim recommendations.

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In what ways could the redevelopment further support partnerships between the LGH and other important parts of the local health care system (i.e. general practitioners, private health care providers, community-based health services.)

Introduce Rural Generalist led inpatient care (e.g. Adult Internal Medicine) with active collaboration with specialist practitioners to promote continuity and consistency of high standard care to patients particularly those with chronic diseases and significant non-medical issues leading to or complicating hospitalisation.

Rural Generalist doctors provide a broad range of skills and scope of practice. Incorporating them into the hospital health care model will see a decreased reliance on locum services and improved continuity of care from hospital to community.

In what ways could the redevelopment further support health research, education and training in Tasmania?

Develop LGH as a centre for Rural Generalist training in Northern Tasmania (similar to the model developing in the North West).

More emphasis on *General* medical training (eg General Medicine, General Surgery) with less emphasis on subspecialty training.

Opportunities for rural GPs to upskill or re-skill in hospital based medicine relevant to their own communities.

How could technology be included in the redevelopment to i) improve communication between care providers and ii) improve timely access to care for people regardless of where they live in the North or North West of Tasmania?

Better telehealth services for both inpatient and outpatient care - coordination is required for a patient to be in the appropriate location with the appropriate equipment and a specialist ready to receive the consult. A telehealth champion for each region should be developed to support patients and clinicians in the progression of telehealth consults.

More consistent and sustainable specialist outreach services to the North West - especially for consults that must be in person (e.g. first visits, examination required) that the NW have equitable access, including the West Coast of Tasmania.

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We look forward to an ongoing relationship with the Department of Health.

Kind regards,

BDodds

Dr Benjamin Dodds

Secretary
Rural Doctors Association of Tasmania

Board Member
Rural Doctors Association of Australia