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Building a statewide clinical service delivery structure

I write in response to the consultation paper *Building a Statewide Clinical Service Delivery Structure*.

The Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical education, training and high standards of practice in Australia and New Zealand. RACS has always been strongly committed to improving standards and access to care. As part of this commitment, the College takes informed and principled positions on issues of public health where we feel our unique input will assist decision makers.

In February 2015 the Tasmanian Regional Committee made a response to the Tasmanian Government's *Delivering Safe and Sustainable Clinical Services Green Paper*. We believe that several of the recommendations made in this submission are relevant to the current consultation paper, in particular those on Clinical Advisory Groups, state-wide waiting lists, role delineation and sustainability. The issues raised in this submission will be directly impacted by the final design of the clinical service delivery structure in Tasmania. A copy of this submission is attached.

RACS is pleased to have the opportunity to provide further input to this issue through the October 2016 consultation paper.

The proposal to implement a well-structured, coordinated health system that provides high quality, safe and effective care close to home is a positive one. However, while the suggested top-down structure outlined in the consultation paper will achieve a single system with a single CEO at the helm we are concerned that it will not translate into improved clinical outcomes or ensure that people receive the right care, at the right time, in the right place. RACS is concerned that the structure outlined in the consultation paper may not be workable in its current format and requires significant additional input from the sector and local management structures across the system.

To achieve true system reform we would like to see a bottom-up approach that engages clinicians at all levels of the governance structure. This structure should be appropriately resourced and supported by the State. Implementing a new governance structure in Tasmania is going to be resource intensive and it is vital that the structure and implementation processes achieve the best possible outcomes for patients and clinicians from the start.

RACS appreciates the opportunity to provide input into this consultation process, and work with THS, in order to ensure the best governance and service structure is developed for all Tasmanians.

Proposed Composition of Streams

The structure of the Clinical Service Streams outlined in the consultation paper may create difficulties in implementation. The current divisions do not take a realistic approach to the functional relationships that exist and

therefore will not facilitate better patient outcomes or improve integration of service delivery. The streams outlined in the consultation paper are at such a high-level that, if implemented, they would likely end up having the opposite effect and creating silos of care with complex patients falling through the cracks. To avoid siloing of services, streaming should be based on the actual patient journey instead of treatment pathways which appear to fit neatly into a single stream.

The Clinical Service Streams outlined in the consultation paper also fail to clarify how the streams will be integrated with each other. The current budgetary based streams risk patients falling through the gaps because they do not fit neatly into any single stream. Any streaming structure must include local craft groups and multi-disciplinary teams who can ensure strong links across streams to ensure that patients can access treatment seamlessly.

Reasonable role-delineation and service streaming is practical to ensuring good patient outcomes. It is not safe or fiscally responsible to deliver every service in every setting but the rationalisation and streaming of services must be logical and reflect patient needs.

Many of the services listed under each stream share resources, including staff and fabric. For example, the following services are inextricably linked to the Surgical and Perioperative Services stream and should logically be grouped together;

- Cardiothoracic Surgical Services,
- Gastroenterology and Endoscopy, and
- Paediatric Surgery,
- Intensive Care, as this service is closer to a surgical service than any of the other proposed streams,
- Pain Management as this is frequently provided by anaesthetists who are part of the Perioperative team, and
- Neurology services as they are closely linked to neurosurgery and often involve surgeons.

While it is clear that services such as Paediatric Surgery are philosophically aligned with Women's and Children's Services from an operational resourcing and service-delivery perspective, it is much better aligned with Surgical Services because it relies on the same set of resources. There is a risk that by separating the service it will be viewed and treated as a separate process which could lead to difficulties in access, resourcing and ultimately impact on patient care.

Proper service streaming is important but patient care is often provided across multiple service streams. It is therefore vital that strong communication processes between service streams are put in place to ensure timely and appropriate cross-stream collaboration. Service streaming and the delivery of patient care must be based on close collaboration and advice from local management structures and clinicians. Without local engagement patient care will suffer.

Any rationalisation of surgical services must also consider the possible impacts on the surgical workforce, in particular training and access to sufficient case load and complexity. Resourcing of surgical services must take account of the fact that whilst emergency surgery and elective surgery are streamed separately they are delivered by the same workforce, using the same available resources. There must be sufficient resourcing and workforce to ensure that elective surgery does not suffer.

RACS looks forward to working with THS to develop an appropriate service streaming model that will facilitate better patient outcomes.

<u>Clinical Service Stream Governance</u>

Effective governance is fundamental to the provision of safe and effective patient care.[1] [2] Clinical input and decision making must be at the forefront of any service in a healthcare setting as it improves the ability of the

[1] Arnwine, D. L. (2002). Effective governance: the roles and responsibilities of Board members. *Proceedings (Baylor University. Medical Center)*, *15*(1), 19.
[2] Bismark, M. M., & Studdert, D. M. (2014). Governance of quality of care: a qualitative study of health service Boards in Victoria, Australia. *BMJ quality & safety*, *23*(6), 474-482.

organisation to maintain quality care, puts clinical governance at the heart of healthcare, and is central to good practice.[3]

The proposal to replace three independent health regions with a single service has the potential to reduce duplication and bureaucracy costs but any success in this area will be dependent on the right structures being put in place to support the new service system.

The consultation paper does not provide sufficient details on how the planned structure will work, particularly at the local level. This lack of detail means that the key issues of increasing patient numbers and complexity, the tightening fiscal situation and the availability of beds and other resources are not considered. In order to achieve comprehensive system reform these issues must be addressed or the planned structure is unlikely to result in any measurable improvement to patient access, quality and safety.

Safe, effective patient care is reliant on good communication. This communication must link up services across acute, primary and community settings.[4] Breakdowns in communication and lack of coordination can lead to poor patient outcomes[5] and the structure proposed for implementation does not adequately outline how these links will operate.

Active staff physician involvement in governance leads to a significant positive effect on quality improvement.[6] The structure outlined in the consultation paper effectively removes control and input into patient care from clinical healthcare leaders and active clinicians which will severely impact the safety and efficacy of services provided. Any restructure of the system must include clinician engagement through to the most senior levels as a minimum requirement.

A key concern with the structure outlined in the consultation paper is the potential loss of local Directors of Surgery who are able to coordinate services at the local level. To ensure effective planning and service delivery the system must have local structures in place that provide 'on the ground' planning and oversight and the capacity to problem-solve.

Local engagement is vital. The Royal Australasian College of Surgeons Position Paper *Hospital Departments/Divisions of Surgery* (attached) states that:

- All health services should have a Department/Division of Surgery embedded within their overall structure which is appropriately resourced, and
- An open and transparent process should be utilised for the appointment of surgeons to the leadership positions.

A good health system needs a clear clinical service structure with local governance and strong communication at its core to ensure the effective day to day operation of individual services and the system as a whole.

It is impossible to run a major hospital without clinical leadership "on the ground". An Executive Director who is remote is not going to be able to manage the day to day aspects of a hospital, such as managing patient flows or replacing staff, from a remote location.

It appears the structure outlined by THS does not take account of any local governance structures or how these integrate into the new structure. It is unclear where current local management positions will fit into the new structure and how the new positions will communicate with existing local structures. Without clear communication and governance arrangements in place the structure outlined in the consultation paper will be difficult to implement effectively.

The structure outlined in the consultation paper will involve substantial additional costs. The eight Executive Director positions will involve significant recurrent funding and RACS is concerned that the funding for these

[3] Cockram I, E., & Hicks, S. (2013). Clinical Decision Making. *Advanced Practice in Healthcare: Skills for Nurses and Allied Health Professionals*, 21.
[4] Banger, A., & Graber, M. L. (2015). Recent Evidence that Health IT Improves Patient Safety.
[5] Künzle, B., Kolbe, M., & Grote, G. (2010). Ensuring patient safety through effective leadership behaviour: a literature review. *Safety Science*, *48*(1), 1-17.
[6] Weiner, B. J., Alexander, J. A., & Shortell, S. M. (1996). Leadership for quality improvement in health care: Empirical evidence on hospital boards, managers, and physicians. *Medical Care Research and Review*, *53*(4), 397-416.

positions will come from the proposed changes to reporting lines and adjustments to the proportion of employees in different healthcare practitioner categories, in particular frontline clinical staff.

In addition, there are significant cost implications associated with the Director of Operations roles as they will be operating remotely. The nature of remote roles is that they cover extensive distances and will require additional resources, including travel and accommodation, to enable them to properly engage with local hospitals.

RACS supports an increased focus on quality and safety but having a separate quality department is not appropriate. Quality and safety is the function of all staff, in particular the clinical team, and a 'quality unit' should only exist to provide support to these clinical teams. If quality and safety are not integrated into any new structure, then financial considerations are likely to become the key focus which will overshadow opportunities for innovation. Quality and safety must form part of every role, across the entire governance structure and should be supported by an appropriately resourced quality unit.

RACS appreciates the opportunity to provide input into the design of the new governance system and is happy to continue to work with THS to ensure that the best model is implemented.

Health Profession Portfolios

As the key questions posed in this section of the consultation paper relate to the position of Executive Director Allied Health Profession our ability to provide detailed comment is limited.

The creation of the position of Executive Director Allied Health Profession alone will not lead to any significant improvements in patient care if it remains as a single independent service stream. The key to ensuring effective professional accountability, standards, improving models of care and workforce redesign and planning will be ensuring an integrated system of service delivery that supports patients in multidisciplinary settings.

The RACS believes that the patient journey rarely operates in silos. From an operational perspective it is imperative that allied health services are completely integrated into other services. RACS considers that a purchasing model for allied health services would be one way to ensure a fully integrated approach to service delivery. While there would remain an allied health stream from a professional perspective it is not the best model of care to refer patients to multiple allied health departments. The patient journey would be significantly improved by integrating allied health services into acute care settings. Rather than referring a patient to the Occupational Therapy Department post tendon repair that service should be integrated into the post-operative treatment with the Occupational Therapist forming part of the care team at the point of service delivery (such as on ward rounds).

RACS is happy to work with THS to strengthen the relationship and develop a safe, effective, workable governance structure based on functional relationships to best facilitate good patient outcomes, improve integration of service delivery and strengthen governance across the system.

RACS would be pleased to meet with THS to assist in developing the best governance structure that provides the best outcomes for all involved.

If you would like to discuss anything in this submission further please contact Dianne Cornish, Manager Tasmanian Regional Office on 03 6223 8848.

Yours sincerely

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Chair, Tasmanian Regional Committee
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Attachment: Royal Australasian College of Surgeons Response to Tasmanian Department of Health and Human Services Green Paper: Delivering Safe and Sustainable Clinical Services Green Paper (2015)

Attachment: The Royal Australasian College of Surgeons Position Paper *Hospital Departments/Divisions of Surgery*

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