RURAL DOCTORS ASSOCIATION OF TASMANIA

AND

RURAL DOCTORS ASSOCIATION OF AUSTRALIA

WORKFORCE PLAN FOR MERSEY HOSPITAL

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RURAL DOCTORS ASSOCIATION OF TASMANIA

The Rural Doctors Association of Tasmania (RDAT) is a state body representing the interests of rural doctors and their communities.

RURAL DOCTORS ASSOCIATION OF AUSTRALIA

The Rural Doctors Association of Australia (RDAA) is a national body representing the interests of all rural medical practitioners and the communities where they live and work. Our vision for rural and remote communities is accessible, high quality health services provided by a medical workforce that is numerically adequate, located within the community it serves, and comprises doctors and other health professionals who have the necessary training and skills to meet the needs of those communities.

INTRODUCTION

RDAT has for a number of years has promoted the value of a Rural Generalist Pathway as a key medical workforce solution to the address the increasing reliance on specialist locums.

In 2013 at the World Summit on Rural Generalist Medicine held in Cairns a definition was agreed:

We define 'Rural Generalist Medicine' as the provision of a broad scope of medical care by a doctor in the rural context that encompasses the following:

- *Comprehensive primary care for individuals, families and communities;*
- *Hospital in-patient and/or related secondary medical care in the institutional, home or ambulatory setting;*
- *Emergency care;*
- *Extended and evolving service in one or more areas of focused cognitive and/or*
- *Procedural practice as required to sustain needed health services locally among a network of colleagues;*
- *A population health approach that is relevant to the community;*
- *Working as part of a multi-professional and multi-disciplinary team of colleagues, both local and distant, to provide services within a 'system of care' that is aligned and responsive to community needs.*

Tasmania Health Service (THS) has made some efforts to create a Rural Generalist Pathway, with the establishment of the role of a Director of Rural Pathways. However, without a supported training program, and post Fellow career opportunities, a Rural Generalist Pathway will not achieve its maximum potential.

A Rural Generalist workforce provides one of the most efficient workforce solutions for small rural to medium size regional hospitals.

The current Mersey Hospital contract negotiations with the Commonwealth government provides a unique opportunity to shift the workforce direction, and over the next 3-5 years build the workforce infrastructure to create a sustainable workforce at the Mersey, but also the smaller rural facilities across the state.

This proposal is aimed at reinvesting current levels of expenditure into creating a strong Rural Generalist medical workforce model at Mersey Community Hospital. Once the transition is completed, there is significant savings to be achieved.

RECOMMENDATIONS

The RDAA provides the following recommendations for consideration in the redesign the workforce of Mersey Community Hospital:

1. *Reallocate current expenditure on locums to establish Rural Generalist positions at Mersey Community Hospital (and potentially North West Regional Hospital).*

2. *Review Specialist Medical Officer positions and convert a number of positions, particularly at Mersey Community Hospital to Rural Generalist positions.*

3. *Review current intern and Resident Medical Officer positions (including registrar positions) to establish prevocational and advanced skills training opportunities for Rural Generalists.*

4. *Establish a strong clinical governance framework to support Rural Generalist practice, which integrates with Specialists and enables a strong peer review process.*

5. *Membership of clinical stream committees to include appropriate rural representation.*

6. *THS to apply to the Commonwealth Government to access funds under the Rural Innovation Pipeline to create additional prevocational positions in General Practice, and integrate these rotations into the Rural Generalist pathway.*

7. *Negotiate with University of Tasmania Rural Clinical School to facilitate, promote, and support medical students to undertake clinical placements in locations where they will be exposed to the Rural Generalist clinical environment and Rural Generalist Mentors.*

8. *Invest in the support for Rural Generalist training, increase Clinical Director role to 1 FTE, create the position permanently and provide the position with Administration support.*

BACKGROUND

Mersey Community Hospital is a 99 bed facility, which is currently the only hospital funded by the Commonwealth Government. The current funding arrangement is until 30 June 2017, and with recent changes within the Health Ministerial portfolio, there is a degree of uncertainty as to what the future of Commonwealth's continued support will be.

Mersey Hospital is located 58.1km (approx. 45 min drive) from North West Regional Hospital located in Burnie. In 2016 marked the closure of birthing services at Mersey Hospital and consolidating the service at North West Regional Hospital.

As at 30 January 2017, La Trobe Tasmania, where Mersey Community Hospital is located is considered a District of Workforce Shortage.[i]

Each facility has struggled to maintain a full permanent establishment of specialist workforce, across the various service units. This continues to increase costs to maintain services for the Tasmania Health Service at both facilities. With the emergency department specialist roles predominately staffed by locums specialists and 100% of the General Physician team at Mersey Community Hospital staffed by locums, the cost implications are huge, but this further impacts on training accreditation, and other workforce sustainability strategies.

Model for Rural Generalists

The locations across Australia where the Rural Generalist model has been implemented, particularly for hospital services have now achieved sustainable medical workforce levels.

Importantly rural generalist medicine is considered an attractive career choice by younger doctors in locations where there is strong integration with the hospital and General Practice and there is Specialist engagement within the model of care.

Generalist medicine across many streams in addition to rural and remote practice is seeing a resurgence in medical staffing models. The skill of the general surgeon, and the general medicine physician are roles, which are now more in demand than in the last decade where there had been a push for doctors to more and more sub specialise.

The Commonwealth Government has committed to implementing a National Rural Generalist Pathway. However, with Queensland and New South Wales with well-established programs, and the situation at Mersey Community Hospital, the THS cannot afford to wait for the national program to be implemented.

THS has tentatively supported the concept of the Rural Generalist Training program with the establishment of a Clinical Director position. This position is funded at 0.4 FTE, and only until 30 June 2017. However, the implementation of a streamlined pathway, which is easy to navigate and understand for junior doctors considering this as a career, has not been achieved to date. With the temporary appointment to the Clinical Director role there is a perception that this is potentially not a program that THS wish to support long term.

There are also issues with the THS recognizing the benefit of Rural Generalists providing limited opportunity post Fellowship for Tasmanian's Rural Generalists to be employed. This has lead to a number of Fellowed Rural Generalists relocating to the mainland as a result. RDAT is working with THS to have the remunerations issues addressed as part of the negotiations for the new certified agreement/s for medical officers, but the THS would benefit from designated Rural Generalist trainee and senior positions.

KEY ISSUES

Clinical Governance Framework: To Support Rural Generalist & Rural Medical Practice.

A framework for robust clinical governance is essential in any health service facility for the provision of safe and quality services. With an introduction of Rural Generalists into the staffing model across the THS, and medical workforce changes being proposed in this document to the Mersey Community Hospital, a new framework for clinical governance needs to be developed and implemented to support the changing nature of the medical workforce.

Creating a strong clinical governance model that integrates Rural Generalists with the Specialist workforce is critical for the long term sustainability of the model. THS has worked with a heavily lead specialist model of care for a number of years, which focused on a centralised model for acute care. Therefore, introducing the Rural Generalist Model will have some sensitivity, which need to be addressed. However, the long term sustainable workforce and patient safety benefits should be the focus when addressing these issues.

To assist in creating a shared respect and commence the change management from a fully specialist lead model to support the implementation and sustainability of a strong Rural Generalist workforce, it is essential the clinical governance models incorporate Rural Generalists into its current model. RDAT recognise that the clinical governance model for THS and DHHS is still in its infancy based on discussions with representatives at various meetings.

RDAT strongly recommends, local Rural Generalists are invited to be members of the former Clinical Advisory Groups which have now been established as committees of some nature under clinical streams. It is critical for the quality and safety of the service that there is rural representation on groups such as emergency medicine, obstetrics, anaesthetics, mental health, paediatrics and surgery.

RDAT also views appropriate Rural Generalist representation on the Credentialing and Clinical Privileging committees as non-negotiable to ensure suitable peer review. In some other Districts/Local Health Networks there is a pure rural credentialing subcommittee, which undertakes peer review and then makes a recommendation to the full credentialing committee. This may be a model Tasmania should consider.

Mersey Community Hospital and North West Regional Hospital are currently both struggling with the lack of permanently appointed staff and are relying on the use of specialist locums to maintain services. Such high use of locums impacts on continuity of care, understanding local procedures, performance management, and engagement within the clinical governance processes, these are all risks to patient safety.

There has also been some difficulty recruiting local GPs in the NW to work within the hospitals, in either the Emergency Departments or in procedural practice e.g. Obstetrics, Endoscopy and Anaesthetics. This is a problem that the Rural Generalist model can solve but will have to be a phased approach to create this capacity.

Comparing Costs

The use of locums at Mersey Community Hospital is having a significant impact on the budget position of the Tasmanian Health Service. RDAT is proposing that a review is undertaken to redirect current expenditure and for THS to invest this in a Rural Generalist Model which will create a sustainable workforce across the continuum from junior doctors to senior specialists.

For one full time equivalent the cost variance is significant of a rural generalist compared to a locum working within the hospital. Tables 1 and 2 outline the costs of locums vs a Rural Generalist workforce model. The cost estimates for locums are at the lower end of the scale while the RG model has been built at the higher end of the scale to demonstrate even with a senior procedural workforce employed, there are still significant cost savings to be made.

TABLE 1 – Expenditure comparison for salaried position Senior Medical Specialist (Fellow) v's Senior locum

	Lvl 7 medical specialist**
Base Salary as at 23/01/2015	$174,334.00
Professional Development allowance	$21,500.00
Communication package	$1,600.00
Motor Vehicle Allowance	$21,387.00
Overtime based on 3 nights per wk for 4 hours rate 1.5	$78,449.00
Oncosts 25%	$74,317.50
Backfill for 7 weeks planned leave Procedural locum rates $2300	$80,500.00
Two days off coverage per wk salary 45 wks per year	$49,608.00
Current package value	$501,695.50
Possible 35% base salary retention incentive	$52,300.20 $14,882.40
Amended package value	$568,878.10

Locum 365 days per year $2,300 / day*	$839,500.00

*includes travel, accommodation, overtime after 12 hr shift, car hire costs (some reports indicate this is estimated at $3,000/day) etc.

** Medical Specialist definition in the Award indicates a medical officer who holds Fellowship of Australian Specialist College.

TABLE 2 – Expenditure comparison for salaried Registrar level position v's locum[ii]

	Lvl 7 (Registrar/Non accredited position)
Base Salary as at 23/01/2015	$95,381.00
Professional Development allowance	$3,500.00
Communication package	$0
Motor Vehicle Allowance	$0
Overtime based on 8 hours per week double time 52 weeks	$38,152.40
Oncosts 25%	$34,258.25
Backfill for 8 weeks planned leave Additional FTE (rec, sick, PDL)	$15,212.46
Internal relief backfill 110 days per year	$29,799.75
	$216,303.86

Locum 365 days per year $800 / 12 hour day*	$292,000.00

*no overtime has been included in locum costs

Locums upfront are a more expensive model than permanently recruiting to vacant positions. In addition there are hidden costs for using locums eg lost time for orientation of each locum, impacts to continuity of care for patients within the hospital, clinical governance and performance management. RDAT recognises that there will be a transition period, however, there is opportunity to commence a phased implementation of a strong Rural Generalist model as early has January/February 2018.

The Rural Generalist Model is also a cost efficient model due to the ability to redeploy the RG workforce within areas of the hospital based on patient activity needs. In comparison to a specialist model where they are limited to work within their specific department rural generalists are trained to work across hospital units and into General Practice. Therefore, the Rural Generalist model is not a one for one swap, with a review of the specialist positions, there may be the ability to have one position work across two areas of the hospital eg emergency in the morning a frequent busy time, and antenatal, or pre-anaesthetic clinic in the afternoon where appointments are often scheduled.

Based on the current level of expenditure, there is potential within a short period of time (3-5 years) for the THS to achieve significant savings, but also improve patient outcomes, and achieve a sustainable workforce. In the earlier years there will be savings but these will increase as the new cohort of trainees progress through the system.

Challenge the Current Workforce Profile.

Currently Mersey Hospital works mainly on a specialist base practice. Based on patient presentations, current clinical services provision and with consideration to the scope of practice of Rural Generalists with an Advanced Skill there is opportunity to redesign the workforce.

A redesign of the workforce to a predominately Rural Generalist model, will stabilize the workforce, enable training of registrars, reduce the locum utilisation and costs, and improve the quality and safety of patient care to the community.

Table 2 Breakdown of the current staffing profile for each the Mersey and North West Hospitals.[iii]

Specialty Area	Mersey Community Hospital – 80 beds	North West Regional Hospital – 160 beds
Emergency	23,000 – majority category 3 – 5	25,000 presentations – 20% admitted 7 Bays 6 FACEMs 4 Registrars 4 RMOs 1 Intern
Medicine	30 beds with seasonal increase up to 60 beds 3 General Medicine Specialists 1 General Medicine/Haematology 3 Registrars 3 RMOs	
Surgery	25 Bed Surgical Ward & 2 operating theatres Elective day cases only Visiting specialist service from Burnie or Launceston. Registrars attend with the specialist.	
Obstetrics & Gyaen	Birthing service closed 2016.	24 Beds 2 Consultants 1 Snr O&G Reg (accredited) 1 O&G Reg non accredited 1 RMO
Anaesthetics	Provided by North West Regional Hospital	8 Specialists 1 Registrar on rotation from RHH 3 Reg ICU/Anaes 2 Emerg Reg

		1 RMO
Mental Health	Outpatient Mental Health Service Acute inpatients are transferred to Burnie. Crisis Assessment Team will be notified for advice for any potential inpatient admissions.	
Paediatrics		10 Beds Director 1 Staff Paediatrician 1 Registrar 1 RMO (rotating)

It is recommended the following changes be made to the workforce:

Emergency –

Across the two hospitals the THS has struggled to sustain a specialist Emergency Medicine workforce. Even within locum ranks, RDAT is aware that at least one Rural GP is working as a locum in the emergency department.

There would be benefits to consolidate the specialist workforce at North West Regional Hospital. However where specialist FACEM positions remain vacant at North West Regional Hospital, two of the specialist positions could be recruited to with a Rural Generalist with Advanced Skills in Emergency Medicine.

At Mersey Community Hospital it is proposed that all FACEM specialist positions be converted into Rural Generalist positions. Up to three positions could be designated specifically as a DEM or Adv Skills Rural Generalist roles. Due to the high number of category 3-5 presentations, alternate model of care eg primary care clinic should be considered, working with the Primary Health Network to support these patients accessing a regular GP rather than presenting at the hospital.

Medicine -

It is essential that Mersey hospital continue to support acute admissions in the community. While North West Regional Hospital is less than one hours drive, the patient profile for admissions to Mersey, indicate the patients are elderly, or need ongoing chronic disease management support, and any travel creates an added burden to people accessing care.

Currently Mersey Community Hospital has 100% locum coverage for specialist positions. For elderly patients and patients with chronic disease a critical element to providing quality of care is a continuity of care model. While it may not always be the same doctor providing the care, creating a multidisciplinary team environment ensures there is understanding of local arrangements & team dynamics, strong clinical handover, and in the background a robust clinical governance mechanism to ensure quality and safety, these are only things which can be achieved where there is an element of stability to the workforce.

Due to the changing locum coverage at the specialist level, Mersey Hospital is unable to achieve accreditation for registrar training. It is proposed that these positions are designated in the first instance for advanced skills posts for General Medicine/Internal Medicine. Accreditation for these posts is facilitated by the

Regional Training Organisations and either RACGP or ACRRM advanced skills training standards would need to be met.

Through telehealth/videoconferencing trainees could participate in the education sessions for RACP registrars provided at North West Regional Hospital.

Surgery –

The current surgical service profile for Mersey Hospital is elective day procedures only. Visiting specialists from North West Regional Hospital, and also Launceston Hospital provide this service.

It is proposed that one full time equivalent be established as a Rural Generalist Advanced Skills Surgery. A large number of the services currently provided by specialists are in the scope of practice for a Rural Generalist Surgeon. This reduces the demand on North West Regional to provide an outreach service on an almost daily basis, but also provides Mersey to have capacity to respond to short periods of increased demand.

It is also proposed that the funding model support .5 FTE for visiting specialist surgeon. This would enable the urgology service from Launceston to be maintained, but also provide supervision, peer review, ongoing skill development and access to services, which may be outside of the scope of the RG surgeon, but the facility has the appropriate support services if a specialist provides procedure.

Anaesthetics –

A rural generalist anaesthetic model has been highly successful in many locations across Australia. With the close relationship between Mersey and Burnie Hospitals there is an opportunity to have a fully integrated RG workforce alongside the specialist team.

Information on the utilization of locums in the anaesthetic service was not available however it is understood that the anaesthetic service is based at Burnie and does an outreach service to Mersey for elective surgery days.

There are a number of advantages to having some rural generalist anaethetists on staff at Mersey. Due to the clinical services capability framework of the hospital and patient risk management strategy the majority elective case patients would be suitable for a GP Anaethetist to provide the anaesthetic. Days when these doctors are not required in operating theatre they are able to be rostered to other areas of the hospital.

One major advantage, from a patient safety perspective is with these doctors on staff they can provide assistance in an emergency when a patient presents with a difficult airway.

Intern and Resident Medical Officer (RMO) Workforce (including registrars) –

It is recommended that a review of the RMO workforce including specialist training registrars is reviewed to create positions to support rural generalist advanced skills training. Based on current accreditation standards for advanced skills posts across Burnie and Mersey, advanced skills posts in emergency, surgery, general medicine, paediatrics and mental health would be achievable with minimal to no investment. It is understood that even at registrar level positions are being filled through the use of locums at times.

Secondly, for intern and post graduate year two positions (PGY2), create a prevocational program to support future rural generalists to access the terms they require to have some level of experience in addition to their mandatory intern terms such as anaesthetics, mental health, paediatrics and obstetrics.

THS could also apply to the Federal Government to access funds under the Rural Innovation Training Fund to establish rotations in prevocational years into General Practice. This would enable increased headcount to be employed at Mersey Hospital, and expose young doctors to the General Practice environment early in their careers.

With savings from reduced utilization of locums some of this needs to be reinvested to supporting Rural Generalist trainees. It is recommended that the Clinical Director position be increased to a full time and permanent role, and administration support also be provided to this role. It is essential this rural generalist program has clear leadership within the system which is enjoyed by each specialist unit with their designated clinical directors. One designated clinical director that can support trainees across the state is sufficient for this program.

Based on other state experiences, there is benefit of facilitating a small number of workforce for Rural Generalist trainees, one during prevocational training and another while completing their General Practice component of their Fellowship training.

Medical Student Placements –

To build a successful Rural Generalist Pathway it is essential that medical students are also exposed to the RG environment for clinical rotations as well as Rural Generalist mentors. A commitment from the Rural Clinical School at University of Tasmania must be obtained if the THS wishes to progress a strong RG model. One of the key foundations of the successful programs around Australia has been to provide medical students and then doctors into their prevocational years, opportunities to undertake clinical rotations where supervision is provided by Rural Generalists.

Also for Rural General Practice, medical students have a different experience than what placement in city General Practice offers. The expectations of community, access to services, the broad range of clinical experiences everything from farm accidents, sports injuries, retrieval medicine,

The value of Rural Generalist mentors can not be under estimated. In the current environment, junior doctors are exposed to specialists and senior registrars from all specialty colleges, with the exception of RACGP and ACRRM, on a daily basis in the large city and regional hospitals. These specialists directly and indirectly act as a recruitment strategy for all specialist colleges, so ACRRM and RACGP are at a disadvantage unless the THS in partnership with the University of Tasmania commit to supporting increased rural placements.

With a change in the workforce design at Mersey Community Hospital, there is opportunity to facilitate medical student rotations, which are promoted as a rural generalist experience.

RDAA is not recommending significant growth in positions to achieve this model. Initially a review of positions and identify a number of positions currently staffed by specialist locums or locums which could be converted to rural generalist positions. Recruitment to these positions will take time, however it would be timely to identify

intern, resident medical officer positions and registrar positions suitable for rural generalist training in preparation for the 2018 RMO recruitment campaigns.

Continue to Partner with Burnie Hospital to Achieve Sustainable Workforce & Training Models

Mersey Community Hospital and North West Regional Hospital over the last five years has established a very strong relationship between facilities, where a range of services have been consolidated into one facility eg maternity, and staff, particularly senior medical staff have been rostered across both facilities.

While this proposal outlines an alternate workforce model to stabilize both facilities and provide maximum opportunity to recruit and retain medical staff, a strong relationship and integrated support services must be maintained between the two.

Due to the close proximity of the North West Regional Hospital located in Burnie, and the Mersey Community Hospital there is an opportunity for staff partnership arrangements, consolidation of medical education and provision of outreach services. A partnership will enable facilities to share staffing resourcing sufficient to maintain or achieve accreditation for intern, resident medical officer and specialty training.

A quality and sustainable Rural Generalist model relies on integration and support of a specialist workforce. With largely consolidating the specialist workforce in North West Regional Hospital, there will be greater opportunity to achieve critical mass at that facility.

With the establishment of a Rural Generalist Model at Mersey, North West will play a key role in training the future Rural Generalists, supervising upskilling and skills maintenance of the RG team, and participating in the clinical governance mechanisms for Mersey Community Hospital eg clinical audit, peer review, Morbidity and Mortality meetings. A range of delivery methods can be utilized to facilitate this relationship, outreach from North West to Mersey, Mersey staff attending training/upskilling at North West, videoconferencing and teleconferencing.

Rural Generalist Training Supporting General Practice

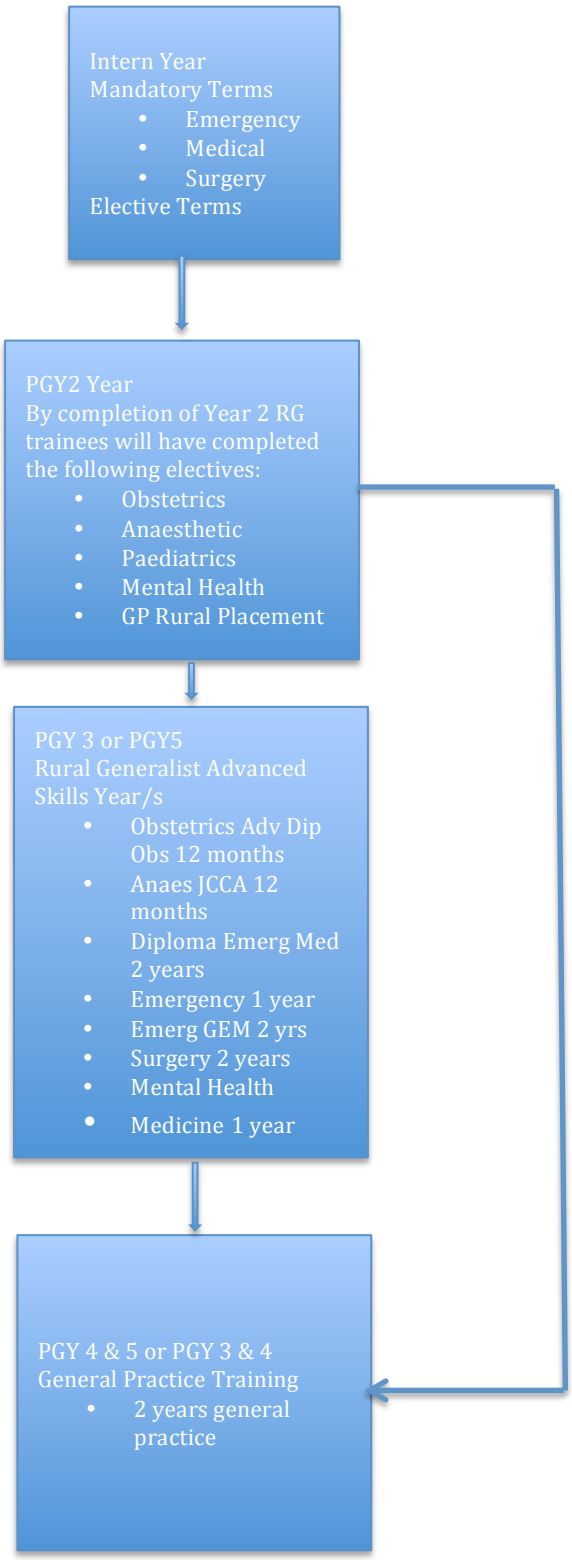
With Mersey Community Hospital located in an area identified as a District of Workforce shortage, there is an opportunity for the primary care services and hospital to work collaboratively to deliver a strong recruitment campaign and employment model.

In developing a Rural Generalist model this will promote the career opportunities in General Practice and the broader Primary Health services as well. Exposing junior doctors early in their career to General Practice, which is integral to the RG Pathway, will see some trainees' progress down a straight GP training program.

However, what a large cohort of Rural Generalist trainees and Fellows do is work between General Practice and local Hospital. The employment arrangements of Visiting Medical Officer or a joint appointment between General Practice and the Hospital have had significant success to building a sustainable workforce in rural towns where previously both hospital and General Practice were struggling.

Rural Generalists with Advanced Skills in paediatrics and mental health have many opportunities to use their advanced skill in the General Practice environment as well as the hospital setting.

Rural Generalist Pathway Model



[i] http://www.doctorconnect.gov.au/locator

[ii] http://www.tic.tas.gov.au/__data/assets/pdf_file/0010/311023/T14294_of_2015_-_Salaried_Medical_Practitioners_Interim_Agreement_2015.pdf

[iii] http://www.dhhs.tas.gov.au/hospital/mersey-community-hospital/departments

http://www.dhhs.tas.gov.au/hospital/north-west-regional-hospital/departments