Launceston General Hospital Clinical Services Plan

STAKEHOLDER CONSULTATION SUMMARY REPORT

Prepared for the Tasmanian Health Service

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KPH
knowledge into practice

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Part A: Public Consultation

A.1 Key findings from public submissions

Public submissions to the Department of Health to inform the LGH Master Plan were reviewed and thematically analysed. Submissions from staff of the LGH or Tasmanian Health Service were reviewed to inform the clinical service workshop discussion. Key clinical themes identified in submissions from the public (individuals and organisations) are presented here.

Overarching priorities

Key overarching priorities identified from the public submissions include:

- collaborate with other healthcare providers to support seamless healthcare provision across the continuum of care;
- invest in hospital avoidance strategies to reduce hospital service demand and provide care closer to home;
- recognise that infrastructure investment will not improve care in the absence of appropriate staffing and sustained operational funding;
- partner with education providers and private healthcare providers to strengthen the healthcare workforce through targeted support for the training, recruitment and retention of staff with specialist and generalist skills; and
- explore private hospital and specialist private provider co-location opportunities.

Key clinical priorities

Priority	Provide care closer to home
Key concern	A hospital-centric approach to healthcare is contributing to demand pressure at the LGH.
Recommended approach	Reduce avoidable hospital admissions and re-admissions by strengthening home-based and community-based care. Opportunities identified include: • increase home-based and community-based service provision particularly in the areas of chronic disease management, wound management, uncomplicated medical infusions, mental health management, palliative care, and multi-disciplinary team post-discharge review; and • increase district hospital service capacity with support from rural generalist staff and enhanced emergency retrieval and transport support.

Priority	Provide contemporary mental healthcare
Key concern	Current mental health facilities are not fit-for-purpose and there are gaps in mental health service provision in Northern Tasmania. Patients with acute mental health issues are presenting to the Emergency Department, contributing to Emergency Department service demand, avoidable admissions, bed access blocks and frequent readmissions. Need to enhance acute and community-based care for patients requiring access to mental health services.

Recommended approach	That the Master plan include: • co-located community mental health services and alcohol and other drugs services providing integrated services to reduce avoidable hospitalisation and provide a safe, holistic, therapeutic environment; • infrastructure to support delivery of integrated outpatient child and adolescent mental health and paediatric services children with complex mental and behavioural disorders; • a purpose-built, contemporary older persons unit for the care of older people with complex care needs; • infrastructure to support delivery of care to patient subgroups with complex needs, including people with eating disorders and perinatal mental health services; and • services for the provision of electroconvulsive therapy and transcranial magnetic stimulation. Strategies identified to support further integration of care for mental health services include: • integrated mental health triage and intake assessment functions; • direct assessment of patients in mental health crisis (with Emergency Department bypass where appropriate); • continuity of care support for mental health consumers transitioning from inpatient to community-based care; and • facilitation of community-based care and recovery.

Priority	**Provide Emergency Department alternatives for urgent care**
Key concern	Emergency Department congestion at the LGH due to urgent care needs
Recommended approach	Support for the expansion of alternative sources of care for patients with urgent care needs to reduce Emergency Department congestion, such as: • after-hours general practice availability; • hospital avoidance programs; • specialist chronic disease clinics; and • community-based mental health support. One stakeholder recommended development of an extended-hours urgent-care facility that operates independently of the Emergency Department staffed by rural generalists and general practitioners, providing urgent care for patients with non-emergency presentations.

Priority	**Update medical ward facilities**
Key concern	Outdated medical ward facilities in the LGH do not support contemporary models of care.
Recommended approach	Update medical ward facilities in line with contemporary care.

Priority	**Increase surgical capacity**
Key concern	Lack of capacity to meet endoscopy service demand. Lack of staffing (not facilities) to meet elective surgery demand.
Recommended approach	Increase day procedural service capacity and throughput.

Priority	Improve access to outpatient specialist services
Key concern	Long and ambiguous wait times for outpatient specialist clinic appointments.
Recommended approach	Increase access to, and transparency of, outpatient appointments. Suggestions include: • increase access to specialist outpatient appointments using telehealth direct to patients; • provide telehealth enabled general practitioner access to specialist support; • provide outpatient services closer to home using telehealth supported by nursing staff at district hospitals or residential aged care facilities; • publish outpatient clinic wait times; and • improve communication with patients waiting for an outpatient appointment.

Priority	Access to palliative care
Key concern	Access to palliative care support is limited by insufficient availability of palliative care inpatient beds and a lack of support for home-based palliative care.
Recommended approach	• Increase access to palliative care inpatient beds. • Increase support for home-based palliative-care support for patients that prefer to receive care at home.

Priority	General infrastructure to support clinical care
Key concern	Various infrastructure deficiencies
Recommended approach	Identified infrastructure improvements to support clinical care include: • improve the adequacy, accessibility and affordability of public car parking; • improve traffic and pedestrian safety at intersections and high-volume pedestrian crossing areas; • create dedicated pick-up and drop-off areas to assist in relieving parking pressure; • improve signage and wayfinding throughout the hospital; • install additional seating along corridors; • include green spaces around the hospital with suitable seating; and • provide access to healthy food options in hospital vending machines.

A.2 Public submission questions regarding clinical service provision

The following questions were provided on the LGH Masterplan website for public submissions[1] to prompt feedback on clinical services in the Northern Region

- What are the key clinical issues that you believe the redevelopment should address?
- What clinical service areas do you think should have first priority for expansion or development?
- What services are currently difficult to access, what could be done to improve access?
- What clinical services could be better provided in people's homes or community health centres, rather than in hospital?
- What clinical services should be provided by the LGH for residents of the North West region?
- 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)?
- How could services be provided in a way that focuses more on patients and their individual health journey?
- How could the redevelopment support patients better as they move between different care settings?
- In what ways could the redevelopment further support partnerships between the LGH and other important parts of the local healthcare system (i.e. general practitioners, private healthcare providers, community-based health services.)
- In what ways could the redevelopment further support health research, education and training in Tasmania?
- 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?

[1] Department of Health. LGH Hospital Master Plan 2019: Consultation. [Cited 2020, Mar 1]. Available from https://www.health.tas.gov.au/about_the_department/clinical_planning_taskforce/launceston_general_hospital_masterplan_2019

Part B: Targeted consultation

This section includes the key issues and considerations related to specific service areas. Issues are those raised by stakeholders working within and outside of the respective service areas.

B.1 Workshop consultation – summary of findings by clinical area

B.1.1 Emergency Department and Ambulance Services

	Issues	Infrastructure considerations	Models of care considerations
Capacity	• Emergency department overcrowding due to poor patient flow through the hospital and a lack of community-based capacity to manage low-urgency issues. • Overcrowding will not be alleviated in the long term by increasing Acute Medical Unit beds; rather, new models of care are required.		• Improve patient flow through better management of long-stay medical patients. • Implement emergency department avoidance strategies and new models of care. • Support general practice to provide more low-urgency care. • Provide general practitioners with access to an after-hours on-call physician for advice.
	Emergency Department block is largely caused by: i. elderly patients with complex chronic conditions; ii. patients with mental health co-morbidities; and iii. low-urgency presentations.		Implement new models of care that support Emergency Department avoidance for all three patient types.
	• The Emergency Department space requires: ○ appropriate space for paediatric patients to wait;	• Provide an age-appropriate waiting area for children and adolescents. • Provide isolation room(s) for immunocompromised patients.	Provide fast-track assessment of immunocompromised patients presenting to the Emergency Department.

	Issues	Infrastructure considerations	Models of care considerations
	○ appropriate space for waiting oncology patients to be isolated; ○ dedicated paediatric bays to accommodate significant growth in attendances for patients aged between 3–15 years; and ○ private physical patient transfer capacity.	• Include dedicated paediatric bays in the Emergency Department. • Determine a patient transfer pathway from the Emergency Department to the medical ward that does not require patients to be moved through public areas.	
Mental health presentations	• Mental health seclusion rooms in the Emergency Department lack patient amenity. • Poor access to private interview rooms.	• Refurbish mental health rooms located within the Emergency Department. • Improve access to private interview rooms in the Emergency Department.	Encourage direct admission of known patients to the ward as an emergency department avoidance strategy. Provide alternative service setting for assessment and initial management patients with acute mental health care needs.
	Medically cleared patients experiencing acute mental health crises should be supported away from the Emergency Department.	• Support patients with mental health needs in a separate facility in close proximity to Emergency Department. • Alternative care setting should have a less agitating environment, medical support, access to security, extended hours of operation, and a crisis support function.	• The facility could include the following models of care: ○ drop-in centre; ○ mental health urgent care centre; and ○ community crisis centre including the 'base' for extended hours community-based crisis care. • Facilitate community-based service acceptance of direct paramedic and police referrals.
	Children and adolescents presenting with complex mental health issues and social issues are often accommodated in the Emergency Department until they can receive assessment. These patients should receive community-based	An Emergency Department alternative facility is required for children and adolescents with social/behavioural/complex mental health issues so that they can receive appropriate community-based treatment.	Ensure needs of paediatric patients are met in separate facility for medically cleared paediatric patients with acute mental health needs.

	Issues	Infrastructure considerations	Models of care considerations
	services; however, such services are limited and slow to access.		
Ambulance services	• Ambulances are routinely required to park on the street due to insufficient parking bays. • Ambulance Tasmania staff are triaged with the general public within the Emergency Department. • Ramping	• Increase the number of ambulance parking bays. • Include an Ambulance Tasmania–specific triage area within the Emergency Department.	Consider models of care to divert non-urgent care from the Emergency Department to more appropriate places for care.
Emergency Department diversion	Paramedics are only permitted to take people to the Emergency Department. A significant number of Emergency Department presentations could be avoided if there were alternative referral pathways for: • patients with acute mental health issues; • patients with alcohol and other drug issues; and • elderly patients with chronic health conditions.	Investigate opportunities for paramedics to triage patients to alternative care settings.	Consider alternative referral pathways and paramedic triage for: • patients presenting with mental health issues or drug and alcohol issues; and • elderly patients with chronic health conditions.
	Need an expanded ComRRS service to assist in Emergency Department avoidance and support people in residential care to receive support from their residential care facility.		• Expand ComRRS • Include a medical officer with primary care training on staff. • Allow paramedics to triage to ComRRS. • Dispatch ComRRS to patients in residential care to reduce low-urgency emergency department presentations.
	Paramedics estimate that almost half of all ambulance presentations are for low-urgency care.		Integrate paramedic services with alternative care settings (with pathology

	Issues	Infrastructure considerations	Models of care considerations
			and radiology) that can deliver urgent care. Consider developing nursing or allied health urgent care models (i.e. led by nurse practitioners or extended care paramedics with prescribing rights).
	A lack of access to after-hours support for palliative care patients, leading to palliative care patients presenting to the Emergency Department and experiencing long wait times.		• Improve community-based after-hours support for palliative care patients, including an on-call phone-based support from a medical practitioner and palliative care specialist. • Improve integration of care for palliative care patients.
	District hospital capacity to manage local presentations without transferring to the LGH.		Consider extended care paramedics in rural areas or virtual care options to support district hospitals manage low-urgency presentations.

B.1.2 Medical Services

	Issues	Infrastructure considerations	Models of care considerations
Medical Services	Older medical inpatients who are aggressive, confused, or delirious require a safe and appropriate environment to be cared for within the hospital. These patients are currently managed via the use of one-to-one sitters throughout the hospital.	• Provide a secure and appropriate environment for older persons with mental health co-morbidities (delirium, depression, disordered thinking). • Provide a secure area that includes: an area for wandering, diversional activities, safe furnishings, adjustable lighting, and shared therapy spaces.	Older persons' unit with multidisciplinary service delivery.
	Complex medical patients are experiencing long lengths of stay due to insufficient availability of community-based services to support discharge for patients with chronic disease co-morbidities.		• Improve integration of acute and primary care for patients with chronic disease. • Support improved chronic disease management, particularly for frail elderly patients.
	There is a need to provide support for long-stay, multi-morbid patients that are too complex for discharge to general practice but are well enough to be cared for outside of hospital with support.	• Use the NICS building for chronic care management. • Widen NICS lifts to accommodate a hospital stretcher. • Add a centralised reception area. • Remove access and wayfinding barriers. • Include shared therapy areas and consultation areas.	• Implement in-reach and out-reach models from the NICS using a multidisciplinary approach that supports community and hospital partnership. • Develop a NICS chronic care management service. It could include services such as Hospital in the Home (HITH), Rehabilitation in the Home (RITH), the Integrated Operations Centre ComRRS, aged care in-reach, and home-based monitoring. The service should include after-hours availability. • Consider a team-based care model that includes community nursing, allied health, community pharmacy, a general practitioner supported with

	Issues	Infrastructure considerations	Models of care considerations
			consulting advice from a general physician, Aged Care Assessment Team support, National Disability Insurance Scheme support, community palliative care, and community mental health services as core team members, and access to post-discharge allied health services such as podiatry, dietetics, pulmonary rehabilitation and cardiac rehabilitation. • Team to determine goals of care and provide care planning and coordination.
	A new treatment space is required for non-cancer infusions, this should not occur within the hospital campus.	Consider off-campus options for non-cancer infusions such as Newstead, Mowbray, or Rocherlea.	
Renal services	New models of care for dialysis involve community-based services for chronic dialysis and mobile units (not fixed chairs) for inpatient dialysis.	• Remove fixed-chair inpatient dialysis and replace with mobile units. • Move chronic dialysis off the main campus.	
Cardiology	• Cardiology is overcrowded due to increased demand. • A second angiography suite is required.	• Consider moving the Day Procedure Unit to increase the cardiology footprint. • Increase ambulatory capacity within the cardiology space. • Add an additional angiography suite (see also B.1.11 Diagnostic and Clinical Support Services).	
Intensive Care	The Intensive Care Unit is underused. Consider converting some of the 18 beds to high-dependency beds.	Consider converting some Intensive Care Unit capacity to high-dependency beds.	
Endoscopy	Demand for endoscopy services is high.		Improve function and flow of Day Procedure Unit

	Issues	Infrastructure considerations	Models of care considerations
Specialist clinics	Specialist clinic rooms have sub-specialist needs. These needs are not addressed by locating all the clinic rooms together and configuring all rooms the same way.	• Consider grouping specialist clinic rooms according to sub-specialty needs. • Do not put all clinics in one area but instead place them where they naturally fit and where sub-specialty areas will take ownership of them; i.e. medical services to run medical clinics and surgical services to run surgical clinics.	

B.1.3 Sub-acute Services

	Issues	Infrastructure considerations	Models of care considerations
Sub-acute services	Within the long-stay medical cohort, sub-acute patients need to be recognised and supported in a timelier manner.	• Sub-acute services should be housed together as a hub, located away from the central campus in a facility that supports flexible ward spaces for surge capacity. • Provide a service from John L Grove and Allambie so that patients are not required to present to the main campus. • Include shared therapy areas.	• Improved role definition and streaming for sub-acute care. • Consider early recognition programs to prevent admissions of sub-acute patients. • Improve identification of admitted patients ready to transition from acute to sub-acute care. • Consider the role of district hospitals in providing sub-acute care with specialist support. • Increase allied health support for sub-acute care.
	Key barriers to patient discharge from sub-acute services are: • a lack of interim accommodation available for patients awaiting house modification;	Consider interim housing options for patients awaiting house modification.	Consider development and expansion of community models of care (Health Independence Programs, Rehabilitation in the Home) to facilitate community management of sub-acute patients.

	Issues	Infrastructure considerations	Models of care considerations
	• long wait times for residential care facility placements; and • long wait times for NDIS plan approvals.		
	Need subacute service delivery for paediatric patients.	Ensure outpatient redevelopment of 4K includes paediatric allied health outpatient and therapy spaces.	Enhance paediatric allied health therapy services integrated with paediatric outpatient functions.
Rehabilitation	Improved access to rehabilitation for long-stay complex patients is required to prevent long length of stay in medical beds and 'spill over' of medical inpatients into surgical inpatient beds.		Improve capacity for HITH and RITH to support early discharge of medical patients.
	• Rehabilitation services need to meet the differing needs of the younger/fit population and the elderly/frail population, whilst sharing common resources required by both groups. • Elderly/frail rehabilitation services need to provide a joyful normalised living environment.	• Community-based rehabilitation needs to be near acute rehabilitation services as staff are shared. • Rehabilitation services require more consultation rooms and an accessible gym.	• Consider expansion of rehabilitation including: community-based rehabilitation models, consolidated ward-based rehabilitation • Ambulatory rehabilitation, and telehealth rehabilitation including app-based support for RITH.
	Require a Geriatric Evaluation and Management (GEM) service.	• Include capacity for a GEM service in a sub-acute hub. • Include sufficient telehealth infrastructure to support GEM service delivery.	• Develop GEM models. • Include dementia care with a re-enablement focus in GEM service.
	Require activities of daily living (ADL) practice facilities to assist in rehabilitation and re-enablement.	Consider inclusion of ADL practice facilities in sub-acute hub.	
	Demand for re-enablement services is increasing, particularly among cancer survivors.	Consider capacity to support re-enablement services in sub-acute hub.	

	Issues	Infrastructure considerations	Models of care considerations
Palliative Care	Currently there are three public palliative care beds provided through a contract with Calvary. Access to more palliative care beds in an off-campus location is required.	Investigate opportunities to increase palliative care beds available through the current contract arrangements.	
	• Community palliative care is not a 24-hour service; this creates issues for patients and carers that require support after-hours and results in patients presenting to the Emergency Department. • Palliative care patients are experiencing long waits in the Emergency Department.	• Increase palliative care bed availability (public or private). • Inpatient palliative care service should be located on the ground floor to facilitate access to garden and family access.	Consider support for community-based palliative care that is available 24 hours a day, every day. This will require strengthening of the palliative care workforce.

B.1.4 Primary Health

	Issues	Infrastructure considerations	Models of care considerations
Primary Health	Primary Health facilities require significant refurbishment, including: • improved clinic and consulting spaces; • reception areas; • group therapy spaces; • rehab facilities and equipment; • an observation area; • flexible and configurable spaces; • security cameras; and • improved parking availability.	Consider investment in primary care infrastructure to support contemporary models of care including: • improved clinic and consulting spaces; • reception areas; • group therapy spaces; • rehab facilities and equipment; • observation area; • flexible and configurable spaces; • security cameras; and • parking availability.	

	Issues	Infrastructure considerations	Models of care considerations
	Increase acute and primary care integration.	Create a hub facility to house those services that support transition between acute and primary care to facilitate improved integration of care.	Include the following service types in the integration hub: • palliative care; • wound care; • community rehabilitation; • Community Rapid Response Service (ComRRS); • Community Nursing Enhanced Connection Service (coNECS); • Hospital in the Home (HITH); • allied health; • youth health; • home care services; • community dementia service; • community continence services; • care coordinators; • TasEquip; • OPALL/ persistent pain services; • pre-habilitation; and • ACAT and NDIS support.
	Enable integration between acute and primary health sites with IT infrastructure.	• Improve telehealth infrastructure. • Improve visibility of the Integrated Operation Centre boards.	Develop telehealth linkages with inpatient medicine, Kings Meadows, district hospitals, specialists, general practice, older persons' mental health, community health, allied health, and primary health providers.
	Improve ability to harness capacity in rural hospitals	• Strengthen telehealth infrastructure and invest in home monitoring and biometrics to support remote care for rural and remote patients.	• Consider adaptation of the New Norfolk model of care to enhance sub-acute capacity in other District hospitals.

	Issues	Infrastructure considerations	Models of care considerations
		• Develop a shared health record across Tasmania and ensure consistent wifi in district hospital sites.	• Consider medical support in the Integrated Operation Centre to utilise rural site capacity. • Champion change in patient transfer culture and practice. • Ensure safe staffing levels in district hospitals that account for service activity, volume, scope and building size. • Expand the ComRRS model to improve out of hours capacity and include a hospital avoidance arm as well as a post-discharge function. • Improve integration of district hospitals with Ambulance Tasmania. • Leverage community nursing capacity in the region through the use of a liaison position, particularly in the areas of palliative care and HITH.

B.1.5 Mental Health Services and Alcohol and Drugs Services

	Issues	Infrastructure considerations	Models of care considerations

Mental Health	The inpatient mental health services building is no longer fit for purpose and requires an upgrade.	• Consider a new purpose-built integrated mental health centre that has three distinct care types:
		  ○ inpatient care (20 beds);
		  ○ acute community crisis (6–10 beds); and
		  ○ integrated mental health services (community and acute).	

	Issues	Infrastructure considerations	Models of care considerations
		• Use flexible 'pod' arrangements to separate patient types further according to need (i.e. new mothers, patients with eating disorders).	
	Require more high dependency unit capacity as this area regularly has insufficient space.	Develop a separate high dependency unit with flexible layout.	

	• Require a community-based approach to mental health services.
	• Move patients out of hospital and into community-based care.
	• Improve integration of services (acute, community and social care).
		• Require facilities to support new models of care and integrated care.
		• Need effective security (code black) for offsite facility options.
		• Consider opportunities to co-locate community mental health services in the hub facility.
			• Consider new models of care including:
			  ○ a drop-in centre or urgent mental healthcare centre;
			  ○ community-based crisis care beds; and
			  ○ an integration hub that includes mental health services, Headspace, a general practitioner, and community service organisations such as Centrelink.
			• Require an extended hours model.
			• Consider a shared intake assessment model.

	Need an appropriate space for inpatient geriatric patients with behavioural issues.	Create a secure ward for elderly patients with behavioural issues (see also *B.1.2 Medical Services*).	• Increase capacity to provide community support through an older persons' team arrangement. • Support residential aged care facilities to manage patients with mental health diagnoses.
	• Increase Crisis Assessment Team capacity to meet the needs of patients presenting to the Emergency Department and those in community. • The Crisis Assessment Team provides a service for adults only.		• Increase community-based crisis assessment capacity. • Increase Crisis Assessment Team scope of practice to include patients under 18 years.

	Issues	Infrastructure considerations	Models of care considerations
	• Mental health support for parents with personality disorders. • Need for permanent perinatal mental health workers in the North or North West of Tasmania.		Consider a perinatal mental health worker role for North and North West Tasmania.
	Require appropriate space for acutely disturbed adolescents to be managed away from the acute hospital setting and the Emergency Department.	• Establish a drop-in centre or urgent mental healthcare centre. • Need a dedicated and appropriate space for children and adolescents accessing mental health services.	
	Children with behavioural issues in the community are experiencing long wait times for access to a community paediatric psychiatrist.	Facilitate a shared space for the Women's and Children's Service and CAMHS to improve service integration whilst maintaining appropriate scope of practice.	Consider substitution models and alternative recruitment practices to increase CAMHS and community paediatric psychiatry capacity.
	Increase the capacity of the community forensics team to provide a service to people under 18 years and detainees of the Ashley Detention facility. This service should be co-located with the Mental Health Service and the Alcohol and Drugs Service.	Co-locate forensics with Mental Health Services and Alcohol and Drugs Service.	Increase forensics capacity to support patients under 18 years, including Ashley Detention facility detainees.
	• Public services are constrained due to difficulties in recruiting psychiatrists. • Additional allied health support is required (i.e. occupational therapy and speech pathology).		
Alcohol and Drugs Service	• The Alcohol and Drugs Service is a weekday service. • Inpatient services are required for patients of the North and North West of Tasmania.	Co-locate the Alcohol and Drugs Service with Mental Health Services, including the forensics team, in a new purpose-built facility with inpatient, after-hours and crisis response capacity.	Consider home detox services and supported district hospital-based detox.

	Issues	Infrastructure considerations	Models of care considerations
	• After-hours capacity, and crisis response capability is required.		

B.1.6 Women's and Children's Services

	Issues	Infrastructure considerations	Models of care considerations
Paediatrics	The clinical areas to be housed on the 5th floor of the 4K construction have not been finalised as yet. As such, Women's and Children's Services do not have an allocated space for paediatric allied health services or a pregnancy assessment area.	• Retain paediatric allied health on the 5th floor of 4K as originally planned. • Locate the pregnancy assessment clinic near the birthing suits.	
Birthing	Distance of labour rooms from theatres.	Consider options to improve timely access to operating theatres.	
	Birthing suites require refurbishment	Refurbish birthing suites to improve patient amenity	Consider role of co-located private hospital to determine number of birthing suites that are required and their use by private patients
	Models of care do not support early discharge of all mothers and babies for whom this is appropriate.		• Expand home-based and community-based support options.
	Need access to close-to-campus accommodation alternatives for women from the NW to prevent unnecessarily long inpatient stays.	• Consider local accommodation options with appropriate parking and IT connectivity rather than inpatient beds.	
Maternity	As women are presenting with increasing age and complexity, more integrated care between maternity and medical / allied health services is required.		• Support integration of care through a hospital hub arrangement (preconception clinic, antenatal clinic, women's and children's outpatients) with community service spokes.

	Issues	Infrastructure considerations	Models of care considerations
			• Consider expansion of allied health models such as continence and first contact physiotherapy models.
	Poor amenity of maternity wards	Provide single patient rooms that accommodate family and support people	
Gynaecology	• Provision of contemporary outpatient care for women with gynaecology care needs	Gynaecology clinic development in 4K outpatient redevelopment	

B.1.7 Child Health and Parenting Service

	Issues	Infrastructure considerations	Models of care considerations
Child health and parenting service (CHAPS)	• Future planning towards a hub (collaborative space) and spoke (community sites) model. The current site at 25 Wellington Street could be modified to provide the hub space. • Seeking to improve integration with Women's and Children's Services and CAHMS.	• Need a community-based consolidated child health collaborative space, possibly co-located with perinatal mental health and CAMHS. • The 25 Wellington Street space requires three consulting rooms, four management offices, reception and administration space, a meeting room to house 50 people, VC capacity and space for nurses visiting from spoke sites. • Space is required for developmental assessments, group parenting sessions, child observation, breastfeeding, and bathrooms that facilitate nappy changing. • Hub to be community-based but near Women's and Children's Services to facilitate service interaction.	• Provide a community-based service as much as possible. Women's and Children's Services midwives to provide antenatal clinics from CHAPS to facilitate continuity of care. • Paediatric team to visit CHAPS rather than locating CHAPS in the hospital.

	Issues	Infrastructure considerations	Models of care considerations
	Require more consulting room space in Kings Meadows, a space to provide residential support for parenting (i.e. day stays and overnight sleep and settling support), and a safe play space for children.	Consider increasing the Kings Meadows' footprint to include more consultation rooms and a residential parenting support area.	
	Require inpatient support for mothers experiencing acute psychosis.	• Consider a mother-baby flexible bed arrangement as part of an integrated mental health building.	

B.1.8 Surgical and Perioperative Services

	Issues	Infrastructure considerations	Models of care considerations
Day procedure unit (DPU)	DPU requires additional space for the volume of work performed. The infusion service located in the middle of the DPU could be relocated offsite provided it remains within vicinity to the main campus.	• Consider relocation of infusion service. • Consider expansion of DPU into nuclear medicine and the kiosk area. • Consider relocation of DPU to cardiology area.	
	• Patient flow in the DPU space is constrained. The DPU requires a designated admissions area; and • The DPU requires more intake and recovery space.	Require a designated admission and consultation space. The admission space does not need to be on the same floor or in the same area as the procedural space.	
	Staff estimate that 80% of day procedure work comes from gastroenterology. There is benefit in keeping the DPU and gastroenterology in close proximity. Other key referral areas are procedural cardiology and radiology.	Locate DPU near gastroenterology, cardiology and radiology.	
	Theatres were recently refurbished. They are fit for purpose and in good proximity	Retain current theatre space. Upgrade not required in short/medium term.	

	Issues	Infrastructure considerations	Models of care considerations
	to the Emergency Department and Intensive Care Unit.		
Theatres and surgical ward	Surgical wards require additional single rooms to support for infection prevention and control practices	• Increase number of single rooms in the surgical ward. • Ensure sufficient negative pressure rooms.	
	The surgical ward routinely accommodates long-stay medical patients.		Implement models of care to reduce medical patient LOS (as described in *B.1.2 Medical Services*).
	Require an appropriate space for allied health staff to provide therapy for surgical patients.	• Add a therapy space for allied health	
	The surgical workforce is required to remain close to theatres at all times for time-critical surgical needs	Consider retaining surgical outpatient clinics on campus.	
	Time-critical services should be co-located.	Consider a time-critical tower that houses the Emergency Department, pre-op services, theatres, DPU, surgical wards and surgical outpatients.	

B.1.9 Oral Health Services

	Issues	Infrastructure considerations	Models of care considerations
Oral health services	The Special Care Dental Unit (SCDU) is located within the LGH (other services are provided in the community). The unit doors limit access and temperature regulation can be challenging.	Fix doors to the SCDU and install cooling to the entire wing.	
	The majority of the SCDU work comes from oncology.	If relocating the SCDU, consider location near oncology.	

	Issues	Infrastructure considerations	Models of care considerations
	Oral Health Services has limited access to LGH theatres and largely use the Mersey Community Hospital theatres as it is easier to access a theatre and theatre staff.		Improve OHS access to theatre lists locally and at MCH.
	Children's dental services are currently provided using mobile vans, some fixed clinics in community settings would be useful.	Consider capacity for child dental units in paediatrics/CHAPS community service locations or health hubs.	
	Capacity to provide student placements is limited by space at the community dental service at Howick Street. Currently able to place 6 students, would like to increase to 12 students.	Consider capacity to provide teaching at Kings Meadows site.	

B.1.10 Cancer Services

	Issues	Infrastructure considerations	Models of care considerations
Northern Cancer Service (NCS)	Growth in outpatient chemotherapy year-on-year. Chemotherapy facilities are now at capacity.	Staff wish to stay on the same floor and extend footprint, rather than moving outpatient chemotherapy to an off-site location such as Kings Meadows due to concerns about pharmacy, pathology and code-blue support for an off-site location.	Consider national guidelines and models of care regarding appropriateness of off-site chemotherapy provision.
	Increasing need to provide care beyond acute treatment (i.e. survivorship programs, exercise programs).	Need increased physical capacity for community-based care programs.	Need increased allied health–led re-enablement support for NCS patients.
	Single room availability on 5D for isolating immunocompromised patients.	Increase the number of single rooms available in 5D for immunocompromised patients.	
	NW based patients receiving chemotherapy or radiotherapy are	Consider step-down care support facilities or medical hotel arrangements.	

	Issues	Infrastructure considerations	Models of care considerations
	accommodated as inpatients. Need alternative accommodation support.		

B.1.11 Diagnostic and Clinical Support Services

	Issues	Infrastructure considerations	Models of care considerations
Medical Imaging	CT scan activity has increased significantly over the past five years. A second CT scanner is required to meet current and future demand.	• Additional CT scanner to be located within or near the Emergency Department and with lift access to the Intensive Care Unit and surgical wards (possibly where HITH and the sexual assault service is currently located). • Consider capacity for a third scanner in 5–10 years.	
	The current Medical Imaging footprint requires expansion. Maintain co-location with the Emergency Department and nuclear medicine if possible.	• Consider expanding current footprint to the roadway. • Retain co-location with Emergency Department and nuclear medicine.	
	The ultrasound space requires expansion, the procedural space requires refurbishment in line with contemporary standards for infection prevention and control, and patient privacy needs.	• Include a holding bay, two large private procedural ultrasound rooms and two private basic ultrasound rooms. • Include a dedicated administration area, a store and disinfection area.	
	The cardiac angiography space requires expansion. A second angiography suite is required.	Consider a new purpose-built cardiac angiography space that includes a second angiography suite. This could be located in Medical Imaging or within the theatres' complex.	
	Magnetic resonance imaging (MRI) services are at daytime capacity.	Build capacity to put in a second MRI within the next five years.	

	Issues	Infrastructure considerations	Models of care considerations
	• The Medical Imaging Department requires a holding area for patients waiting for x-ray, ultrasound and interventional radiology. • The holding area requires wall oxygen/suction, call bells, and disabled toilet facilities for waiting patients.	Upgrade facilities to include appropriate waiting areas for patients, wall oxygen and suction, call bell facilities and disabled toilet facilities.	
	Limited access to hybrid theatres limits the interventional radiology service, as does sole-person dependency.		
	Require additional space to comfortably house four radiologists and other specialists that use the medical imaging space; for example, gastroenterologists, intensivists, respiratory specialists and renal specialists.	Ensure sufficient space to accommodate medical imaging staff and visiting specialist staff.	
	Radiology workforce is outsourced to a private provider due to inability to recruit and retain.	Investigate imaging service plans for co-located private hospital.	Consider workforce opportunities with co-located private hospital.
	Access to after-hours imaging and pathology may reduce Emergency Department presentations.	Consider after-hours provision of imaging in consultation with the private sector.	
Pathology	• A consistent increase in workload with significant growth in tests performed. • Require more space for phlebotomy and consultant offices.	• Consider expanding into the orthopaedic OPD space and biomedical workshop. • The blood collection area could be located away from the main pathology area.	
	Staff are supportive of a sample collection room in Holman Clinic due to the volume of work that is performed there.	Consider including a pathology sample collection room in Holman Clinic.	

	Issues	Infrastructure considerations	Models of care considerations
	Stem cell transplant tasks are not performed locally but in Hobart, and could be performed locally in the future.	Consider space and equipment for local stem cell transplant preparation.	
	Opportunities for further service expansion include point-of-care testing in the community using mobile pathology staff; i.e. domiciliary visits		Consider role of pathology point-of-care testing for HITH-like models of care.
	Coronial autopsy caseload will eventually be shifted to Hobart within five years. Despite this, the LGH will still need to maintain the capacity to perform hospital post-mortems.	• Consider long-term plan for anatomical pathology space; decrease mortuary capacity.	
	Private co-location may provide opportunities to increase service provision and share workload.	Investigate private hospital intention for pathology services.	
	Pneumatic tube delivery service increases pathology workflow efficiency; significant workload originates from the Emergency Department, extend current pneumatic tube capacity to the ED (and other) key areas.	Extend pneumatic tube delivery capacity.	
Pharmacy	Pharmacy has a refurbishment plan for both existing sites (main pharmacy and oncology pharmacy) that is currently unfunded.	Review the existing pharmacy refurbishment plan.	
	Off-site chemotherapy provision would be appropriate for low risk therapy. In all cases Cycle 1, Day 1 chemotherapy should be administered at the LGH.	• Any off-site chemotherapy provision must include consideration of pharmacy support infrastructure requirements and medication/staff logistics needs. • On-site capacity must be retained for patients that cannot be safely treated off-site.	Consider impact on Pharmaceutical Benefit Scheme reimbursement for oncology treatment provided off the LGH campus.

	Issues	Infrastructure considerations	Models of care considerations
	Pharmacy staff increasingly provide ward-based services (i.e. ward technician program, clinical pharmacist staff).	Provide sufficient space for pharmacy staff to provide ward-based services.	
	Consider sufficient storage for medications located on the ward including the capacity to implement electronic medication storage systems.	Include medication storage areas that support electronic medication storage systems in ward design.	
	Opportunity to implement a robotic dispensing system into the future.	Consider capacity for a dispensing robot within the main pharmacy footprint.	
	Improve pneumatic tube delivery service.	Expand the pneumatic tube delivery service and consider 'silent tube' capacity for high-traffic areas such as the pharmacy dispensary to prevent blockage.	
Nuclear Medicine	This service is provided by an on-site private provider. The service appears to be growing.	Investigate nuclear medicine service plans for the co-located private hospital.	

B.1.12 Allied Health

	Issues	Infrastructure considerations	Models of care considerations
Allied Health	• Allied health staff numbers are growing and expect to grow further with the introduction of new allied health courses commencing at the University of Tasmania in 2020. More staff accommodation and clinic rooms are required. • With increasing growth in allied health assistant models of care, more space is required to facilitate additional student placements.	Require sufficient space to accommodate growing workforce.	

	Issues	Infrastructure considerations	Models of care considerations
	Allied health staff are eager to pursue workforce substitution models of care but are constrained by a lack of clinical service modelling and infrastructure that facilitates this.	Require flexible collaborative spaces throughout key areas such as sub-acute care, paediatrics, cancer services that can be used by allied health providers to support allied health–led models of care.	• Consider the role of allied health in substitution models of care. • Consider opportunities for team-based models to support care close to home.
	The NDIS is affecting allied health services as workforce flow back to the private sector. Patients that cannot access services in the community are presenting to acute services. NDIS administration requirements are time-consuming.		

B.1.13 Teaching, Training and Research

	Issues	Infrastructure considerations	Models of care considerations
Teaching, Training and Research	There is no funded accommodation in Launceston for students.	Consider repurposing a building from within the LGH precinct to provide accommodation for students.	
	As part of the Northern Transformation Program, the University of Tasmania plan to increase its presence in Launceston.	• Require increased teaching and training spaces for students on clinical placement. • Consider a joint facility with a flexible training space to support training across disciplines. • Require storage for discipline specific training equipment.	Consider clinical training models that support interprofessional models of learning.
	Clifford Craig is currently located in a clinical area of the hospital and need to relocate in the near future due to accreditation requirements. The current space is insufficient in size to accommodate growth and the layout is	• Clifford Craig require: ○ a location that is easily accessible by clinicians, research participants, and donors.	

	Issues	Infrastructure considerations	Models of care considerations
	poorly configured. Clifford Craig are interested in bringing together all LGH research interests in under the one area.	○ an active clinical trials area that can accommodate clinical trials units. • Co-location with the University of Tasmania would be beneficial. • If Clifford Craig were to move the new site must be commensurate with current accommodation finishes.	
	The University of Tasmania is currently considering degree models with a greater emphasis on research. It would be beneficial for the current university space at the LGH to be co-located with Clifford Craig and located on campus or across the road from the main campus	Co-location of existing University of Tasmania offices and Clifford Craig office on or near the main campus.	

B.1.14 Enablers (Workforce, IT, Change Management)

	Issues	Infrastructure / Model of care considerations
Information Technology	Statewide eHealth strategy.	Require a statewide eHealth strategy that addresses the following needs: • an integrated real-time digital medical record and a closed-loop medication management system to support patient-centred care, care integration, evidence-based clinical decision making at the point of care, and information sharing between acute and community settings; • access to digital technology at the point of care; • consistent access to wifi throughout facilities; • increased capacity for automation, particularly messaging automation and predictive tools; • expanded eReferral capacity; • increased telehealth capacity; and • telemonitoring to support remote care provision in district hospitals, RACFs, HITH programs and domiciliary monitoring programs.

	Issues	Infrastructure / Model of care considerations
Workforce	• Sufficient staffing to provide robust clinical services. • Recruiting and retaining staff with specialist skill sets.	• Review appropriate staffing levels, particularly in allied health, district hospitals and acute-community liaison services. • Implement innovative models of care that best utilise the existing workforce to support care across the continuum. • Investigate possible staff sharing arrangements with a co-located private hospital.
Change management	Leadership, change management and project support.	• Improve partnerships between acute and primary health; these partnerships are currently not robust. • Support community providers to handle increasing complexity in the community. • Use co-design approaches to support integration of care. • Change management to be driven by respected leaders that understand both the acute and primary health sectors.

B.1.15 General Infrastructure to Support Clinical Care

Infrastructure issues for consideration
Northside, D Block and Allambie require complete refurbishment to support contemporary models of care.
Ward design to support point-of-care models and line-of-sight monitoring.
Ward design to include bariatric bed capacity and bariatric bathrooms.
Additional single rooms and isolation rooms are required across all ward types.
Improved air handling and segregation in accordance with contemporary standards.
More shared therapy and clinical space is required, particularly in Wards 5A and 5B.
Additional storage capacity for equipment, beds, pharmaceuticals, and linen, particularly on the medical wards.
Extend pneumatic tube capacity throughout the main campus.
Priority carparking is required for services that support patients with mobility issues.
Improved wayfinding throughout the hospital.

B.2 Targeted consultation workshop participants

The consultation workshop groups and participants are listed below.

Workshop	Participants	Workshop	Participants
Medicine (1)	• Peter Renshaw • Alasdair McDonald • Lorinda Upton-Greer	Women's and Children's Services	• Annette Brierly • Jannette Tonks • Annette Brierly
Medicine (2) Rehabilitation and Aged Care	• Lee Wallace • Sukhpal Kaur • Anita Fahey	Ambulance Tasmania	• Brent Pendrey • Rick Shegog • Angela Hodgson • Jade Howard • Jess Warren
Medicine (3)	• Alasdair McDonald • Lee Wallace	Statewide Hospital Pharmacy	• Tom Simpson • Liam Carter • Liza D'Ettore
Community and Consumer Engagement Council North	• Ally Mercer • Chris Beswick • Joyce Bisland • Michelle Ogulin • Paul Dare • Robin McKendrick • Tony Deane-Shaw • Peter O'Sullivan • Ella Dixon • Fiona Young	Mental Health Services	• Adie Gibbons • Raelene Tabor • Ben Elijah • Helen Vandermolen • Shani Tattam • Marlene Cronin • Tessa Oldfield
General Practitioners	• Izzy Morse • Alison Turnock • Jan Redfern • Maxine Glanger	Department Executive	• Kath Morgan-Wicks • Tony Lawler • Shane Gregory • Ross Smith • Sharyn Cody
Access and Patient Flow	• Helen Bryan • Liz Gadsby • Deb Stewart • Lucy Van Hooven • Robyn Hayes	Primary Health	• Fiona Young • Pat Wrigley • Annette Barrett • Kylie Jarvis • Lester Jones • Meredith Prestwood • Lyn Lendvay
Northern Cancer Service	• Stan Gauden • Natalie Kidd • Joanne Bennett • Andy Brown	Surgical and Perioperative Services	• Stuart Day • Liz Gadsby • Sharon Stuart • Ian Waterhouse
Child Health and Parenting Services	• Dominica Kelly • Nicole Kinghorn • Libby Dawson	Oral Health	• Amy Bowden • Shaun Rose-Nel

Allied Health Services	• Paula Hyland • Cindy Hollings		Primary Health Tasmania	• Phil Edmondson • Susan Powell
Clifford Craig Foundation	• Peter Milne		Pathology	• Gerald Bates
Medical Imaging	• Garth Faulkner • Vicki Murphin		University of Tasmania	• Tim Strong • Bill Costin • Ben Jones