Please find below the feedback from Clinical Quality, Regulation and Accreditation (CQRA) and the Quality Patient Safety Service (QPSS).

Overarching themes

Strong sense from consultation within the CQRA and QPSS teams is that whilst the initiatives outlined in the Our Healthcare Futures document are valuable pursuits, the document would benefit from a clearly articulated overarching plan. It would be helpful to have more detail on how they integrate into existing strategic plans across Tasmanian public health services. The overarching plan needs to highlight why these particular areas were chosen as a focus, and how they integrate into other long-term aims/strategies aligned from both an organisational and national perspective. There also appears to be a missed opportunity in early engagement with this document.

Reform Initiative 1 – Consultation questions:

1. How can we target better our current investment as well as future investments in health to ensure a sustainable and balanced mix of services is delivered across the whole of the health system to provide right care in the right place at the right time?

Firstly, tying this aim to a strategic plan would be helpful in aligning the various initiatives and preventing cross purposes.

Consideration should be given to guiding principles and themes:

- **Understanding where future health reforms are focussed https://www.publichospitalfunding.gov.au/public-hospital-funding/about-agreement**
- **Understanding and addressing patient/community articulated needs.**
- **A Value Based Care approach, including the requirements under the *Quality Governance Framework for Tasmania's publicly funded health services*.**
- **Clarification of workforce issues (*Health Workforce 2040*)**
- **Taking into account health activity data**
- **Investing and supporting Clinical Research, Quality Improvement Initiatives and Clinical Registries in order to facilitate collaboration, increase awareness of local issues and translate findings into demonstrable improvements in patient care/outcomes. There is also the Tasmanian Data Linkage Unit that could be used more strategically to help us understand our local population needs better and the Tasmanian Collaboration for Health Improvement that is poised to assist with translating research outcomes into well-integrated, people centred, effective health system.**

If there is still a commitment to providing the "right care, right place at the right time" then it is important to consider what reporting and monitoring requirements are to be established to demonstrate these changes. It must also consider what supports Health invests in, in order to achieve consistency and best patient outcomes.

2 How can we shift the focus from hospital-based care to better community care in the community?

Integrated eHealth systems across the care continuum - including remote monitoring solutions can facilitate the expansion of health delivery in non-acute settings and build upon existing models.

- **Adequate nursing recruitment for fully staffed services, including Nurse Practitioner led models in primary and acute care.**
- **Clinical pathways, including the use of the Commission on Safety and Quality in Health Care's Clinical Care Standards**
- **Funded weekend community care.**
- **Look at private- public partnerships or supported access to private carers - eg "vouchers"**
- **Early intervention programs**
- **Increased referral systems for primary care clinicians including data to assist referrers to understand where our current systems are oversubscribed, wait times, particular requirements of a clinic, Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) for particular conditions to assist with patient expectations.**
- **System that link Ambulance Tasmania information (pre-hospital) to hospital system (acute sector) and Development of the Ambulance Tasmania - GP interface to facilitate communication especially in relation to the secondary triage project. This could lead to ambulances, where appropriate, taking patients to primary care services rather than relying solely on the THS services.**

Equally examining broader integrated community approaches can build health literacy and capacity within the community an example of a broader health response is the "Blue Zones" approach e.g. https://www.sharecare.com/pages/blue-zones. This requires investment in public and population health outside of the COVID-19 response.

Page 13 of the larger document notes the funding responsibility for preventing hospital care is a State responsibility. We do not believe this to be entirely true. We believe that when the full spectrum of preventative care is considered then it can be reasonable seen to be a shared state and federal responsibility.

3 How can we facilitate increased access to primary healthcare, in particular:
after-hours and on weekends
in rural and regional areas
for low-income and vulnerable clients
for extended treatment options (e.g. urgent care or non-emergency care)?

These issues require a person-centric approach. There should be heavy consultation with health consumers. Data from PROMs, PREMs, Patient Experience Surveys, Staff Safety Culture Surveys can provide a base level of information. There is also potential for Working with partner organisations such as PHT that have additional data from primary care sector.

Building up adequate linkage between Tier 1 District Hospital EDs and the major hospital EDs is important and can raise up the whole sector teaching and education platform. Simples things such as Ultrasounds in EDs for GP and visiting specialist use in District Hospitals would enhance the ability to do things quickly by people who are already qualified. Looking at Multidisciplinary Model of Care and remote support of rural practitioners by staff at urban centres.

Consideration of single statewide telehealth service (rather than AT, SMHS, GP Assist, ED advice, AMR advice, etc all separate). Furthermore, telehealth should be further explored; enabling mobile technologies, national strategy, best practice and innovative

improvements to support current literacy and health literacy issues in Tasmania.

Investment in Tele-Trials will also allow for patients receiving care through Clinical Trials to receive care closer to home through the Hub-Spoke model. This should also reduce the need for interstate travel to access clinical trials.

Nurse Practitioner led models in primary and acute care.

The State was funded to run a Tasmanian Rural Generalist Pathway Coordination Unit however the DoH and THS have not dedicated training positions for the Ruralist Generalist Pathway. This could be rectified by establishing dedicated Resident Medical Officer rotations and Additional Rural Skills posts (which are based at the tertiary hospitals) to specifically train Rural Generalist. Without allocating training posts, there is no defined pathway to becoming a rural generalist in Tasmania.

4 The UCC Feasibility Report 2019 identifies UCCs as a feasible service model for Tasmania. Are there other barriers and opportunities for implementing a model of urgent care in Tasmania not identified by the study?

The UCC Feasibility Report 2019 has some embedded erroneous assumptions for example that the radiography required could be provided by a nurse under extended scope of practice this is not consistent with current legislation or best practice and is unlikely to be endorsed by Ahpra.

The UCC report also potentially contains other errors and the group was not able to consider a "no UCC" option, which suggest the report is not robust and should be only considered with caution.

5 How can we make better use of telehealth, so people can receive care closer to home, and what are the barriers preventing utilisation of telehealth?

Barriers requiring resolution are; Internet connectivity and Wifi access, dedicated staff training time to understand how to use the systems, dedicated space to carry out telehealth programs, the validation of safe, quality digital apps (e.g. cardiac rehabilitation apps or gestational diabetes apps) and quality research on which programs do or do not produce safe and quality results with patients (e.g. early pregnancy monitoring by telehealth has been shown by Victorian services to be a high quality service while geriatric mental health assessments were showed to be poor quality and not well adapted to a telehealth model).

Robust, reliable connectivity and Wifi was identified within the Aged Care visits as a barrier in Telehealth solutions.

Health literacy and people knowing where to go to access information are also issues.

Within Tele-trial, a major barrier is staff training and have dedicated staffing for a tele-trials model which is very different from just having clinical trial staffing. There needs to be government commitment to funding research staff to run tele-trials. Most other jurisdictions already have a tele-trials program that has been running for the past few years. Tasmania is sorely behind in the tele-trials space.

Better use and uptake of My Health Record is required. We nationally have a tool that has great potential to be a useful tool, but we fail to use it. Tasmania could be an

exemplar in the use of this technology, and we have a small, fairly stagnate population of which the majority tend to only access care on the island.

6 How can we make better use of our District Hospitals to enable maximum utilisation of beds in these facilities as a step-down from public hospitals and a step-up from the community to improve patient flow in acute hospitals and care in the community?

We have work force issues as the rural facilities often have a small skilled workforce. We need public discourse to accept that moving a loved one further from home (i.e. transferring a Sandy Bay person to New Norfolk) may actually be the best care or equivalent care and not 'turfing' from the acute sector. This need a public campaign and some early wins. We need to revisit the Rural Medical Practitioner (RMP) Agreement and the associated supports needed for these practitioners (e.g. computer access) to ensure it is attractive to keep RMPs involved and engaged. Opportunity exists to leverage from the unique THS contracted bed model in accredited RACF to expand to any appropriately accredited facility to support hospital level care in RACFs where it is safe and in the best interest of the person to do so.

We can use personal monitoring devices which may be DoH/THS supplied (e.g. the Telstra platform Mycaremanager that we are using in quarantine hotels). This has the facility for remote monitoring, but additionally has video capability so we can see wounds, talk to the patient, monitor heart rate etc. It enables some efficiencies in workforce, freeing up Face-to-Face appointments for high need/complexity tasks. The Telehealth areas of the DoH is also exploring ways to assist with other downloadable Apps. The safety, quality and efficiency of these methods needs to be explored before full implementation. The risks of these new technologies also need to be considered and recorded.

Health literacy is a huge issue and having locally facilitated teaching spaces will be useful (e.g. utilising Family and Child centres, Mens's sheds, LINC library session etc.) The culturally and linguistically diverse community needs should be explored with those areas as well as with the different indigenous groups within Tasmania in order to hold relevance for them.

7 How can we improve integration across all parts of our health system and its key interfaces (e.g. primary health, mental health, disability services, aged care and acute care)? What should be our priorities for integration?

Improved portals for communication, the use of a full digital medical record for real time availability of notes, results, referral, research and appointments bookings.

Establishment of statewide clinical networks that are not only acute focussed but subacute and primary care focused too. The Cardiology primary care network is a good example. An Aged Care network would be appropriate and we deem necessary. There is interest from with the THS and within Primary Health Tasmania to create this and we believe this group could help focus on how to address issues that arise with bed block.

Making the privacy framework clear as community providers and family carers are often excluded from information for "privacy concerns" which are erroneous if the privacy legislation is properly understood.

Consolidation of resources, reduced duplication of services, and better integration between NDIS and the health sector are all areas for improvement. They may be

scope to explore things like HRPlus's projected called HEART – where they have identified a gap in service provision and availability in a regional town resulting in loss of significant funds to the community and health of Tasmanians.

8 How can we strengthen the interface between hospital services and aged care to improve community healthcare for older Tasmanians?

Broader and deeper engagement with the aged community and aged care services/providers. Including hospital-based programs being used to upskill community sector clinical staff. Supportive development of communities of practice. Consideration of employment of "reach in community aged care workers" in the hospital as well as enhancement of the HITH and COmRRS projects. This would need to not detract from the already small numbers of age care workers in the community but would need to be in addition.

Development of an Aged Care Clinical Network would be supportive.

As noted above in Q 7 – A full digital health record.

Mandating and standardising transfer processes between facilities across the state and auditing adherence.

As above in previous questions, the development of the Ambulance Tasmania - GP interface to facilitate communication especially in relation to the secondary triage project.

Working with community based groups to understand their thoughts and opinions on areas that needs further development and focus.

9 How can we make the best use of co-located private hospitals to avoid public hospital presentations and admissions (by privately insured patients)?

Part of the issue is the availability of the Emergency Departments attached the private hospitals being closed and as such private patients start off in the public system. The private hospitals should have staff that 'catch' patients that arrive in a public hospital but have private insurance and filter them into the private hospitals if they are unable to open their emergency departments. These filtered patients would be assessed via a criteria that notes they are appropriate transfer to the private facility.

We do note that if their hospitals are full or they don't have appropriate staffing to take new patients and it is unsafe to do so, then patients should not be transferred into the private hospitals.

Another issue is capability of private hospitals. At times there may be no specialist for a particular discipline available to accept care, or the care needed is too advanced. It would help if we could transfer patients across to private hospitals more easily after the initial treatment plan, investigations and/or stabilisation. It would also assist if we the private generalist surgeons or physicians took on some of the complex patients with support from public "super specialists."

The public and private hospitals should work more closely when developing new programs or technology so that there is enough volume but also a teaching and training pipeline for the state.

Tasmanians traditionally are poor at taking up private insurance or only take up low levels of insurance. We need to be sure that private hospitals are offering care that is seen by the Tasmanian public as value for money. Without a bigger base of privately insured, there may be few that can be diverted to the private hospitals.

10 How can we build health literacy, self- management and preventative health approaches into the day-to-day practices of our health services across the whole of the health system?

In part, this is a systemic issue. The education system was structured in such a way for many decades secondary students historically exited secondary education on completion of year 10. The patient cohort accessing our services with chronic health issues are in all likelihood to have exited the secondary education at year 10 level. Public messaging and better connections to consumer and indigenous groups is required. We must ask them what they need, rather than developing things and then asking if it is 'ok' from their perspective. Key focuses should be on reducing chronic disease, reducing burden & pressure on hospitals and encouraging healthier lifestyle choice.

It is also problematic that Tasmania has low level of private care, particularly top level care.

Health literacy is multi-faceted. First, we need to determine the components of the health system – it's not all about hospitals. Consumers will typically say they don't know where to go, there is too much information, or they cannot find the information they are looking for. Better consumer engagement is required at the consumer/community level.

The younger generation is much better informed and able to access services easily on their mobiles and computers. The challenge for younger people is to decipher what is correct information. The HealthLit4Kids Tasmanian program (recognised by WHO for its work) should be supported. Rosie Nash is the project lead at UTAS.

There are effectively two levels – those that have trouble with basic reading, and those that read fluently, but perhaps not reading evidence-based information.

There is a need to train/educate health professionals on how to present information to a consumer that can be digested/understood. Examples could include utilise a DoH Facebook, THS Facebook and other social media channels. Another option may be to have regular talk back sessions on local radio by paid senior clinicians/educators. We need to be honest and open with information even if it does not always show us in a good light and be open to negative feedback and public debate if we are serious about improving health literacy. The events surrounding COVID-19 have shown the advantages of this. The Communication strategy needs to promote the positive work going on in the DoH.

Standardised measures could provide opportunities to focus improvement in key areas: The Australian Commission On Safety And Quality In Health Care has conducted a review on health literacy (https://www.safetyandquality.gov.au/sites/default/files/migrated/Health-Literacy-Taking-action-to-improve-safety-and-quality.docx) and cites commonly used tools for measuring individual health literacy. The most commonly used tools for measuring individual health literacy are the Test of Functional Health Literacy in Adults (TOFHLA), the Rapid Estimate of Adult Literacy in Medicine (REALM) and the Newest Vital Sign

(NVS).

TOFHLA measures reading fluency and consists of a reading comprehension section (a 50-item test using the modified Cloze procedure) to measure prose literacy, and a numeracy section with 17 items that assess an individual's capacity to read and understand actual hospital documents and labelled prescription vials. REALM is a 66-item word recognition and pronunciation test that measures the domain of vocabulary. Although these two tests measure different capacities, they are highly correlated with each other and with general vocabulary tests. The NVS is a short practical questionnaire that requires the interpretation of health information from a nutritional label.

Telehealth remuneration has also helped and should be capitalised upon because home monitoring has allowed transmission of personal data (heart rate) to the primary carer - who can then provide advice remotely (and still bill). Telehealth has opportunities to teach the person self-care techniques.

We need to support clinicians (including health promotion officers or potentially GPs) to go to Men's Sheds, Probus etc to directly teach health literacy. This is potential scope to work with Primary Health Tasmania and/or the UTAS to embed these community based opportunities into their training program for students in health related courses.

11 How can we better incorporate preventative health and health literacy initiatives into current and future care, across the range of settings, including acute, community, primary and private?

By developing an overarching strategy that is based on best evidence e.g for health literacy : The Australian Commission On Safety And Quality In Health Care review on health literacy (https://www.safetyandquality.gov.au/sites/default/files/migrated/Health-Literacy-Taking-action-to-improve-safety-and-quality.docx) …
And being informed and aligning with the National Preventative Health Strategy that is currently in development
https://www1.health.gov.au/internet/main/publishing.nsf/Content/national-preventive-health-strategy

See comments above on engagement with Primary Health Tasmania and UTAS above, and the improving transparency and encouraging debate and teaching in answer #10.

12 How do we provide clear pathways into our health system so that patients are accessing the most appropriate care for them?

We have the publicly facing outpatient website who have as their secondary intended audience the public (primary audience is referrers) but we need to invest in them as a primary user. Maternity services have developed a website, paediatrics is doing the same as is statewide renal services have i.e. invest in user friendly websites and pamphlets and radio. The research governance space is also working to improve the outward communication platform so that potential participants can access timely, current information on clinical trials.

Consult with patient/public group to guide this.

Reform Initiative 2 – Consultation questions:

1 How can we best target our digital investment to improve the timely sharing of patient information across key health interfaces?

By developing long term strategy with clear milestones and ensuring interoperability of any new systems with current systems.

It is imperative that we develop an Electronic Medical Record (EMR) that provides real time access for the full spectrum of care (e.g. Ambulance officer provided care through to discharge from the acute health service), it requires a patient portal component so people can view their appointments and separation summaries, and a portal view for clinicians to find results and reports, and a section for further developed e-referrals. There is also potential opportunities for enhancement of communication portals such as the ones associated with Health Care Suite (HCS) to be able to send documents.

Current issues with privacy rules and email (not encrypted) is causing a loss of communication mechanisms and inefficiencies. There has also been a change to eFax which does not integrate with GP systems further impacting on good communication.

2 What digitisation opportunities should be prioritised in a Health ICT Plan 2020- 2030 and why?

SRLS reaches end of life March 2024. Planning to replace will commence at the end of 2021/early 2022. SRLS has become a critical patient safety system, partially due to staff familiarity but partially because of the expansion of SRLS into different facets of safety and quality.

SRLS is required for the reporting and management of patient safety events required for the hospitals to be accredited. It is also best practice and gives the system manager oversite into major safety events and into trends.

SRLS also is used to capture WHS, Risk management, Alerts and Recalls (such as safety alerts with devices as issued by the Therapeutic Goods Administration, Mortality and Coroner electronic form management and notifications.

Digitisation opportunity could include the purchase of a technology solution that allows form design with different workflows. There are large risks currently such as the use of access databases in Health, key person dependencies and regionally focussed processes and data capture (e.g. death review, medicolegal, MET calls). Any addition or change should promote solutions that are utilised Statewide. World digital health leaders such as the AAD Polar Medicine Unit have a single EMR, are located in Tasmania may have translatable technology and clinical models of care that could be leveraged in partnership.

A full EMR will also allow for smoother work to occur in research were data can be reviewed to help with a scientific review prior to submitting for ethics review through to assisting with auditing a trial.

3 What information should be prioritised for addition to the My Health Record to assist clinicians in treating patients across various health settings (e.g. GP rooms, Hospital in the Home, Hospital, Specialist Outpatients)?

"Read access" for GPs particularly the Radiology and Pathology results.

Separation Summaries. These should be present at time of admission but certainly with 48 hours of separation from that service.

Integrated medicines lists, not pdfs of dispensing,

ECGs and other physiological measurements that ambulance officers collect

Advanced Care Directives so that they are always available to every clinician involved in care.

4 What are the opportunities to develop a digital interface between hospitals and other care providers (such as GPs, aged care and the private system) to improve the timely sharing of patient information?

All these questions lead to an EMR as a priority.

GPs have basically two information systems they use across Australia and the Aboriginal Community Controlled Health Organisations (ACCHOs) uses others, whichever hospital EMR is deployed must be capable of integrating via an encrypted portal process to the GPs and with ACCHOs.

Coding data could help with knowledge of current diseases

The eReferral system should be rolled out across all specialities as a priority, including to allied health services and should be owned by the THS.

5 What information would help to improve your experience as a patient or consumer interacting with public hospital or health services in Tasmania?

Access to a patient portal for up to date clinic information. This should include appointments. For example, radiology currently changes appointments often and advises patients by letters. Those letters do not have the date they were created on them, so patients are not sure what is most up to date.

Increased use of SMS reminders, but also a way of using them to inform the hospital about acceptance of an appointment.

Inpatients should have accessible information about their care team and plans and should be given a separation summery when leaving the service.

The DOH website is difficult to navigate and contains a lot of out of date information. Refreshing this would be helpful.

Consumer experience questions, Patient Reported Outcome Measures or Patient Reported Experience Measures should be considered as part of this document development and feedback process.

6 What technology would be best to help you to deliver improved patient outcomes?

Digital radiology referrals (even internal within a hospital) are currently paper based that is faxed from some wards in the South. This risks duplication of examination and

so requires exacting business rules to prevent. A digital request process would reduce risk and improve efficiency.

Digital pathology referrals for the same reasons above.

Digital inpatient medication charts and ones that fed into the separation summary so that the primary care providers could see was prescribed upon separation.

Increased computer on wheels or iPad Access in the hospitals as access can be an issue in some areas.

E-signatures for research governance processes and for research consent forms.

7 How can we use technology to empower patients with their own self-care?

Digital meal ordering systems that allows for special diets, alerts/allergies and goal setting could greatly assist patients.

Patient IPADs would help not only with food ordering but also contain information about their care team, their planned appointments, referrals whilst an inpatient and also their medicines they are being given and their expected date of discharge.

These are also helpful devices during lockdowns or during times when restricted visitor access means the persons who know them best are not available.

8 What is the key paper or manual administrative process that would provide the most benefit to digitise/bring online?

The care record directly going digital so patient notes are instantly live, it needs to be current even during an admission. Get rid of a reliance on retrospective scanned documents. This includes what occurred in the operating theatres and recovery room so staff are up to date about the patient that they are receiving from these areas.

Medication charts. Evidence shows that electronic prescribing reduces errors.

Admission forms particular if you can get the patients to start the electronic process if they are well enough.

Elective surgery forms because again these can be sent to the patient for completion electronically or they can complete at the time of the appointment.

Reform Initiative 3a – Consultation questions

1. What are the major priorities that should be considered in the development of a 20 year infrastructure strategy?

First and foremost, we need to understand where the Tasmanian population is growing (e.g. Launceston, New Norfolk) to ensure infrastructure is based on the population needs. We should be thinking about how the infrastructure could be linked to

accommodation, simulation centres, radiology, consultation rooms, teaching areas etc so that it's not just the clinical spaces being considered.

IT/ Information Management development is vital.

The development of remote access for patient monitoring and staff work.

Outpatients has regionally specific nuances in care, and some statewide standardisation in terms of appointment management, triage management is needed.

A proper research and clinical trials centre both physical location but also linked into the IT programs so that the researchers and clinical trial auditors can quickly review cases.

Staff physical activity centre. It is very poor that there is no current staff gymnasium or bike racks at a major tertiary hospital or the DoH given we are a health care organisation. We need to make it easier to find and use stairs, offices should have natural light, good ventilation and good design. Current areas of the hospital and DoH are very poor office work environments. If we do not prioritise our staff then how can we set a good example? With obesity and chronic disease two major health concern areas we should be promoting health lifestyles.

We should find ways to keep staff breakout areas so that when staff are not working, they have a place to rest, connect with each other and these should be separate from where you train or complete education. It may seem small but RMO/Registrar quarters are not insignificant spaces and valued by the staff that use them.

We need to have a renewed focus on palliative care, renal care (including younger persons and indigenous clients) and mental health services outside of our hospital footprint. At present, we also do not have a service or place for younger patients with acquired brain injury (alcohol or Chronic Traumatic Encephalopathy) who are not able to live on their own but do not fit the clinical picture necessary for entry into other places such as Roy Fagan,

2 How should the Government ensure we achieve the right balance of infrastructure investment across the range of care settings including acute, subacute and care delivered in the community?

The domains of quality are a useful overarching framework that can be useful to guide the right balance of infrastructure investment as this means the proposed investments can be viewed through the lens of efficiency, equity and effectiveness in the deployment of services, equipment and consumables.

The assessment and/or development of proposals for new infrastructure should have close consideration by the community in order to achieve the values and outcomes expected. This will require broad consultation as there are many different angles within the Tasmanian community.

Preventative Care is equally as important where care is delivered.

3 How do we ensure current facilities continue to be invested in appropriately so they continue to be fit-for-purpose?

Facilities are itemised and audited: A value-based lens is always applied to all services and each service expect a 2 yearly review of quality, function, safety and

appropriateness.

4 What are the key factors that should be considered in the development of modern health facilities in a community setting – e.g. location, proximity to other community services?

Sustainability of workforce, safety, community need, value in terms of outcomes desired.

Consideration also given to efficiency/consolidation of DoH/THS infrastructure. Multiple locations across the Hobart may assist.

The government narrative is also important. Will State Government, Local Government Association, the City of Hobart, Launceston, Devonport etc accept the movement away from a city-centric view? If there is no political will to ensure the best care is delivered in the right place and that it may sometime be unpopular to provide care in only particular settings, there is no point in developing up models that rely on something that will no be acceptable politically.

5 How do we integrate our capital investment planning with the private sector to help complement and/or supplement the public system?

Encourage a "Health in all policies and agreements" including at a LGA council level with a values-based lens approach to the Health component.

Sub-lease space to private providers e.g. https://perkins.org.au/about-perkins/.

If we can widen the 'private sector' to beyond just the health private sector (e.g. private hospitals) and talk to private sector on a whole then the *20 March 2019 Environment Sustainability in Health Care 2019* document is very helpful to think about how private sector can be used to create sustainability and investment.

Another great resource is the Cleveland Clinic's *Sustainability and Global Citizenship Report* (now in it's 11th year!) This program not only worked to partner the hospital with private entities, but in doing so created more local jobs, improved local health literacy and raise living standards which had a direct impact on the social determinates of health.

Reform Initiative 3b – Consultation questions:

1 How should the Health Workforce 2040 strategy be further refined to guide and inform the development of a strong and sustainable professional workforce that is aligned to meeting the future health needs of Tasmanians?

Page 25 of the Our Healthcare Futures paper contains assumptions that are not necessarily justified e.g. First paragraph, 'the health professional workforce is not equally distributed across the state' implying this is not desirable however it may be considered this is due to a very reasonable and rational reasoning related to acuity index and Tasmanian Role Delineation Framework. The website https://www.safetyandquality.gov.au/our-work/partnering-consumers/shared-decision-making/risk-communication-module provides insights into communication and consumer interpretation of information. We suggest that the acuity index is identified if a regional approach is undertaken (e.g. average acuity index) and overall headcount per professional per 100,000 population.

2 How do we work with the private sector, as well as other levels of government, to ensure our combined workforce serves the future needs of our community?

Close work with the University of Tasmania plus college, other training providers to assist with education around coding, security, infection prevention and control. Other training institutions could be used to ensure that projected community need and workforce are addressed. A focus needs to be on continuing to facilitate training program at all stages and a focus on retraining to ensure we develop our existing workforce to cope with need.

Ask the community! Ask the private sector! Start a dialogue i.e.. Public facilitated workshops, work with the Rural Clinical School to engage more with the Tasmania Education sector in other parts of the state to find way to encourage our Year 10-12 students to consider these roles and to start training early. Perhaps have a secondary college with a health specialist program: https://www.maneasc.wa.edu.au/#

Another option would be to discuss recruitment of difficult to recruit positions with the private hospitals to see what 'carrots' be may have across the whole sector.

Don't forget that a strong research sector and the ability to do research in the workplace (including private sector research from drug and device companies) makes a difference not only to attracting clinicians but also to retaining them. The system also benefits from the private investment and it also benefits from having the expert knowledge of the research outcomes on our own population. Tasmanian is small and our Data Linkage program is mighty, this should be communicated more widely. We need to create a learning culture that supports quality improvement and access to new and innovated treatments.

3 What steps can be taken to improve the State's ability to attract and retain health professionals in regional areas, particularly the North West?

We need to take a broad approach; rotations as students, placements as graduates, contract workers as a STATE employee not a HOSPTIAL employee and have people move to cover shortages – they may like what they see and want to stay.

Look toward building a stronger local community e.g. Blue Zones make community a more attractive place to live.

More specifically, and we appreciate that this is a hard task, but increase our full-time staff specialist contingent rather then Visiting Medical Officers, and build into this model some "work swap" arrangements to give doctors a rotation to the LGH or RHH, also a break from continuous on-call.

Strengthen the Rural Generalist medical role. This requires commitment to training positions and a pipeline for training so that rural generalist can train solely in Tasmania. Rural Generalists in the state need to be supported and we need to find ways to make it easier for the system to integrate them rather than expecting them to integrate into the system.

Increase supported nursing and Allied health placements in the N and NW and boost training locally.

4 What innovations or changes are needed to our health workforce to more closely align our

professional health teams with the future needs of Tasmanians?

Services – more support for primary care – allied health support to nursing homes, e.g. pharmacy, physiotherapy, medical imaging. But also upskilling GPs to feel confident in managing some types of patients in a 'joint care' type situation with hospital specialists. Moving clinics out of the hospital to an offsite location is another option. These models worked well in Canterbury Health in New Zealand.

Training - suggest we develop allied health training within the state and have shared teaching at various stages during the Uni courses with pharmacy, medicine, allied health, nursing to facilitate trust and cross disciplinary collaboration early.

Accept placement students from other universities - even where the university does not pay for the placement as an option for opening up other sections of the sector to trainees.

Look at the provision of nursing type quarter/ subsidised quarters for students on placement so that Tasmanian rental and temporary house issues do not factor into a person's decision to come and train or do placements here.

5 How do we support health professionals to work to their full scope of practice?

Co-training experiences builds trust and allows other disciplines to work alongside each other without antagonism (e.g. Nurse practitioners and Doctors).

Simulation training is a great space to create opportunities to bring together health professionals to work to their full scope and to work with colleagues from other craft groups. The RHH has been without its Simulation lab for months now since the relocation into the new block. This should not be allowed to occur and an immediate 'home' for the lab should be allocated so that training can recommence.

Better support for support staff to undertake professional development. If our Coders, DoH staff, Stores personnel etc can upskill and bring in new ideas/technology the whole system benefits. A focus only on health professionals is a narrow view if you are wanting to raise the whole sector. Training cafeteria staff in allergies or in basic CPR may come in handy. Having Patient Safety Observers trained in Mental Health first aide might save a life. It also makes the workplace a much more enjoyable place to work because you feel you are being 'invested in'.

6 How do we support Tasmanians to access the education and training they need to be part of the State's future workforce?

Scholarships, research training and protected teaching time are a good start. Nursing seem to do this best amongst the craft groups at finding ways to support their colleagues and make time for training.

Again we would point to potential solution as above in our answer to #5.

Reform Initiative 3c – Consultation questions:

1 How could a Statewide Clinical Senate assist in providing advice to guide health planning in Tasmania.

The Clinical Senate (CS) model is recognised as an effective means of achieving clinician engagement which is regularly acknowledged as challenging to achieve. In turn, clinician engagement is known to improve quality, safety, effectiveness and efficiency in health services (Quinlivan, Basile, Gibson and Crocker, 2016). While there may be detractors against the CS model (Van Der Weyden, 2009), there are also jurisdictional success stories of the CS model across Australia.

Quinlivan, Miller and Hutton (2017) found the Western Australian Clinical Senate (CS) 'played a role in clinician engagement (95%), contributed to healthcare reform (82%), knowledge of contemporary health issues (92%), feedback to decision makers (82%), clinician networking (94%), debate on important issues (93%), enabled clinicians to work on recommendations to improve health at a state level (87%), contributed to clinician thinking on health reform (88%) and enabled clinicians to share their knowledge (91%).' The survey data indicates significantly high responses from the current or immediate past WA CS members. Quinlivan et al (2017) present insight into the WA healthcare and CS models, and while Tasmania's health service model does not include 'healthcare boards' this is not a reason to preclude consideration of a Tasmanian CS. With appropriate and apolitical members, fully and authentically engaged in the work a CS would undertake and not driven by personal agendas. A Tasmanian CS has the potential to be a useful body to guide health planning/delivery/evaluation/improvement, and to provide strategic and policy advice and support as well as propose recommendations to the Minister. This is all done from the CS informed position of what might best achieve optimum health outcomes for the community based on identified needs.

Engagement with working clinicians is needed to bring real life realities to ideas and make the ideas workable. A clinical senate would provide practicality and innovation and if resourced and listened to in a way that genuinely wanted to hear what clinical leaders thought would work. This in turn helps the clinicians stay motivated and work well as they can see their opinion shaping their workplace and the care for the people in the community.

Training for a clinician leaders and managers can be done through the Royal Australasian College of Medical Administrators. They have been supportive of upskilling Tasmanian medical doctors.

2 How can we better engage meaningfully and effectively with consumers and other key stakeholders in health service planning, delivery and quality improvement?

Increased and improved communications with consumers when consulting would definitely be beneficial. The communication to community members for consultation on Our Healthcare Future appears to have been scant. Good communication with the community is paramount to this work making any real progress.

Getting a seat at some U3A forums could provide an avenue for engagement with older Tasmanians. Face-to-face engagement may be challenging to achieve across the state, so verbal or written communication via U3A is an alternative means of engagement. There are many forms of media (regular and social) that could be used to promote consultation forums +/- call for feedback via email. Communications could go out to local councils for raising within their community and council members. The Consumer

Health Forum (CHF) is a relatively newer group but one that is gaining momentum and could be a first point of contact.

If a Clinical Senate was formed in Tasmania, the public and patient could be included among the membership, or at least among any smaller groups/working groups formed to discuss specific items, to ensure the public voice has representation and involvement in health service planning.

Citizen's juries can be utilised to help gain understanding of whether public opinion agrees with health provider/planner opinion.

3 How can we strengthen and optimise consumer engagement and participation at all levels of healthcare including:
Personal: participation and engagement in a person's own care
Local: participation and engagement in service improvement at a local level
Policy and service system: participation and engagement in planning, developing, reviewing, evaluating and reforming services at a system level?

Consumer representative at all levels, employ peer workers in most areas of the health sector, improve community health literacy and increase transparency of planning decisions, and encourage public discourse.

4 Are there particular models of consumer engagement and participation that we should consider?

From a health care perspective, National Clinical Governance Framework. The Commission for Safety and Quality in Health Care had many resources and can link you to areas/services that do this well.

5 How can we improve opportunities for consumers to feed back on their healthcare including following discharge from care?

This does exist but could be improved to provide more useful information in more appropriate timeframes. For example, patient surveys exist in some form in Tasmania but if they occurred closer to the episode of care, they would be more likely to provide more accurate recall on the experience which could better inform service improvement. The best model used in other jurisdictions is at the point of discharge on electronic devices at the service or an SMS immediately after leaving the service.

If the health service invited the feedback with open-ended question (i.e. "would the consumer like a follow up about their experience?") the provider may get rich information spread out overtime rather than getting a large dataset all at once.

Develop an App to get feedback for use by all users of the system, have iPads available for completion of feedback at the time of discharge, email link to an online version, send email reminders. A multi-modal approach would be helpful so long as if you did the App version you did not keep sending email reminders for an on-line version.

6 How do we strengthen education and training for health professionals and health policy makers and planners in relation to the importance of consumer engagement and participation across all levels of healthcare?

Make training available in a range of formats and times (e.g. in/out of normal working hours time). Run webinars and workshops which incorporate a "show and tell active component or training component e.g. walk around of the hospital, with a meet the

specialist and some teaching component on a weekend afternoon or mid-weeknight around 7pm.

The clinical networks have started evening teaching - Q&A sessions (e.g. cardiology with good attendance – virtually). CPD points needed!

There also needs to be a top down approach to this. If senior leaders see this as important and model good behaviours, then there is trickledown.

7 What format would be best to engage our future health leaders?

A Clinical Senate is one means. Another, although potentially unpopular, is for peer-reviewed +/- public reporting on performance/outcomes.

RACMA has programs to upskill clinicians in medical management and medical leadership. The Post-graduate Medical Council of Tasmania has great resources for junior doctors and is well respected. RACGP has a future leaders program and UTAS runs a Leadership in Health course. Partnering with them may be helpful.

Regardless of what we do, we need to support with time, money, and opportunity the emerging leaders to get to education, training and networking opportunities within the State and outside of the State. You cannot be what you don't see.