Tasmanian Government

TASMANIAN HEALTH SERVICE

Submission to the *Our Healthcare Future – Immediate Actions and Consultation Paper.*

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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?

To ensure a sustainable and balanced mix of services is delivered across the State the investment in supporting Clinical Advisory Groups could be a consideration. The CAGs made up of groups of conditions rather than condition specific able to provide feedback to a Clinical Senate who then provides policy advice and strategy against the reporting provided by the Clinical Advisory Groups. Encouraging the combination of CAGs identified for the Role Delineation Paper to support relevant partnerships to improve integration and cross-communication would be imperative. For example, a cardiovascular CAG may include diabetes, obesity, cardiology and nephrology. The previous condition specific CAGs became time-limited and were disbanded following the Role Delineation paper; however, combined CAGs could provide clear direction about innovation and partnerships that should be invested in.

Their strength lay in the commitment of the members and cross representation from across health care organisations. Combined CAGs could identify innovation to improve services and enable timely services in the right place sustainably.

A Clinical Senate could then provide the overarching advice. A clinical senate **funded** to create real change by identifying how systems can align more closely when providing similar services and integrating the hospital system more closely with primary care. The remit of the clinical senate would be to negotiate these closer collaborations and to create closer linkages between each of the clinical areas through strategy and policy. The Green Paper of Role Delineation Paper of 2015 draws on this to some level. Lead clinical groups and councils to the Minister of Health have led similar discussions; however, there has not been funding to implement the change. The initial investment could be regained by improved collaboration and reduced repetition of health care in the future. It should be evidenced-based and led by experts in many different fields.

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

As per point one – by investing in the change. By enabling different speciality hospital-based services to identify how they can work more collaboratively, which can free them up to support better care coordination to community care. A mechanism (e.g., combined CAGs) and service created that directly supports the discussions and connection between the two, i.e., hospital and primary care. It can often be challenging in busy specialist hospital-based units to understand and appreciate all the community services available and ways to refer to and/or access these services.

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

Staff who feel ill-equipped will often seek out hospital services due to their knowledge deficit and their appreciation that hospital services across the day have a breadth of disciplines available. In Tasmanian

and particularly consumers in rural, regional areas and low-income access to GPs and/or a regular GP can be difficult. GP practices in north west Tasmania often have their booked closed to taking on new patients. The afterhours commonwealth funded Super Clinics may not have met their expectation in terms of after-hours services provided.

Consideration should be given to developing out of hours services that cross hospital to community services. These could be staffed primarily by nurse practitioners with different specialities, able to diagnose, prescribe and coordinate care to GP, hospital and/or complete the care required on site. Other disciplines could be considered depending on the needs of the community.

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?

Not any that are immediately apparent. Consumers from rural regional areas are often not averse to traveling for health care; however, the social economic standing may be a barrier as they already travel more than their urban counterparts just to go grocery shopping and attending school sports and medical appointments. Furthermore, in rural regional areas of Tasmania, many GP practices are not taking on any new patients. Consequently, consumers can use emergency services as they have not other options. An Urgent Care Centre as per option 7a in the report, would be similar to what was suggested in the previous point. Out of pocket expenses should be minimal given it can be a barrier to low-income consumers for accessing healthcare in a timely manner.

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?

Telehealth can be better utilised by better training and allocation of administration staff to ensure that clinicians can timely connect with their respective clients. It has been done well in many parts of Australia. For Example, Professor Anthony Russell, endocrinologist and Director, Department of Diabetes and Endocrinology, Princess Alexandra Hospital, Brisbane, Queensland and School of Medicine, University of Queensland has provided closely aligned telehealth services to outback Queensland for many years. He has presented on the service many times, and a essential component is the allocation of specific administration to support the service so that clinics move forward smoothly and the clinicians have confidence in using the platform more regularly. Tasmania could look at models like the Queensland model, and identify what they have learnt and what works well.

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?

Increase the specialisation of staffing; if there is difficulty recruiting doctors with different specialities nurse practitioners could be utilised. NPs often have close linkages with many specialists across the nation that they can consult with for ongoing advice when required and are trained to an advanced level to support the management of care and coordination.

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?

Developing Clinical Advisory Groups across the State, as was done for the Role Delineation Framework with cross representation from different sectors of the health care system. However, enable different condition groups to come together that may have commonality, e.g., diabetes, renal and cardiovascular disease. The CAGs should be led by leaders and not always the Director of a Service; a person able to bring different people and services together, and promote appropriate dialog. Investment in combined CAGs would allow cross-communication and identification of ideas that may improve care, reduce repetition and reduce consumer required access. Concepts or innovation

developed by the CAGs could be reported to the Clinical Senate, funded to provide strategy or develop policy to drive changes to implement some of these initiatives. Perhaps commencing with a proof-of-concept model with economists involved to understand the true value of the investment. The CAGs should include clinicians and researchers from hospital, primary, community, private and academia sectors.

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

Hospitals are not always the ideal environment for the management of aged care, and aged care management requires consideration of multiple morbidities, target and expectations, and awareness of support services etc. Increasing the numbers of NPs may be one consideration or the development of aged care clinical nurse specialists focusing on care coordination and diagnosing and treating conditions. As much as possible, the aged person should be cared for outside the hospital.

The interface may warrant the development of an AMU for aged care as a stepping stone. Better triaging and referral pathways that are agreed by, by different organisations and groups. Currently, individual services develop their guidelines often in accordance with what they have the capacity to offer with their current resources and by determining clinical need.

Many referrals to hospital services could be better managed by primary care, nurse practitioners or specialist nurses in the community. However, they are still referred to hospital services by overstretched clinical staff. Also, a dedicated service for triaging, which reviews patient cases according to established pathways across services and the State that overlap (i.e. do not have any gaps) could strengthen the interface between hospital and community services.

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

The development of an MOU or agreement with private hospitals to accept patients immediately for treatment if they are received at a public hospital and have private health cover may support better use of co-located private hospitals. Consumers want to be assured that they are getting benefit from their health fund and their out-of-pocket money outlay. Consider reimbursing the patient’s out of pocket costs to some level to provide them with the incentive to move across. Also, include private hospital representatives on any CAG and/or clinical senate to support policy and decision making.

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

Most nurses and allied health staff working in the hospital setting have a stronger focus on acute care. Despite dealing with an acute problem, some health professionals can forget the client has multiple chronic conditions and should be cared for within a chronic condition’s framework. For example, on any given day up to 22-30% of consumers accessing multiple health services across the nation have diabetes for many reasons other than their diabetes. Hence, better and ongoing training of all health professionals about chronic conditions management should include health literacy and self-management approaches.

Also, consider developing a unit to support the permeation of these concepts through the health system. For example, the unit could be focused on written education materials provided to consumers from the health literacy perspective, with resources in the area, which may help, e.g., PEAMT-A/V – this is the health literacy guided assessment tool for both written and video resources (https://www.ahrq.gov/sites/default/files/publications/files/pemat-p.pdf). It looks at the understandability and actionability of a material/video. It is user-friendly with minimal training; however, clinician across the board may not be able to implement it at all times. A service such as this could support better implementation across the public and community health service. Individuals from a service such as this could also be involved in CAGs.

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?

A mechanism to promote such a thing across the range of settings because currently health services across Tasmania are funded from different funding pockets, including Federal and State funding. A Statewide Clinical Senate funded to create change may provide strategic direction to this matter via advice from CAGs. The latter may support closely aligning services across the State as currently many works independently, e.g. although there are 3 diabetes centre across Tasmania and Diabetes Tasmania there is no mechanism to support cross planning of services to better support each other despite many attempts.

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

Primary Health Tasmania have developed health pathways for utilisation by GPs. The level to which they are used is unknown, however, all health professionals and services can promote them and triage systems can be advertised through these pathways. The pathways currently provide advice only and are not specifically linked to established referrals mechanisms. Investment in the latter would make it easier to use by GPs and establishing ways that public services could also utilise them may be useful.

Reform Initiative 2 – Consultation questions:

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

Currently most services have their own digital platform and although some digital platforms will allow multiple health professionals to review information, in the consultation setting, time limitations can impact on the ability to move from one digital platform to another. For example, in diabetes the clinician may also have multiple other digital platforms opened to review insulin pump downloads or continuous glucose monitoring systems from different companies. Ultimately its about ease.

Ideally, Tasmania would have one digital platform across public, primary and community services that all clinicians can access. In particular, diagnostics, where viewing results depends on the public or private service the consumer accesses. The system should be able to capture information such as biochemical and physical markers and appointments etc so that meaningful analysis can be undertaken. Any data analyses could provide information about better ways to streamline services, priority areas and risks.

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

As above a statewide platform supported and promoted by primary, community and hospital services. A program that ‘speaks’ to alternate services if it is not possible. In discussion with consumers, they often assume that health professionals can already see their diagnostics when ordered by others, which is not the case. Consumers assume that all clinicians can see correspondence from other

clinicians involved in their care, which is often not the case. The platform should be automatically opt-in unless the patient indicates that they do not want certain information shared.

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)?

My Health Record is a useful tool; however, does not 'speak' to the programs that hospital and private clinicians are currently using. Hence, the clinician is less likely to engage with the program due to moving from different platforms in short consultation times. Medical history, current medications, referrals and their expected wait time (so that alternatives can be considered if too long) and pathology.

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?

Not sure whether this question relates to current programs that may already be in existence. There is an appetite for a digital interface by clinicians to support improved care coordination and reduce repetition of, e.g. pathology etc. However, it is the ease at which these programs can be used which determines usage. The latter is a paramount consideration.

Biogrid [https://www.biogrid.org.au/] allows collecting patient data and direct communication with GPs; however, it also supports the data being collected to drive health care decisions. It allows the capture of, linking, and analyses of privacy-protected data in a more cost-effective, efficient manner. The analysis can support strategic decision making.

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

How to access or directions to coordinators that can assist with understanding information, navigate the system and the importance of relevant information. For example, in preparing forms for ACAT for elderly relatives, the questions are often obscure to us as clinicians, let alone a lay person. Confusion reduces engagement and the use of services promptly. The ability to reach out to a coordinator that may assist with direction and/or completing forms etc. Wait times for certain public procedures to ascertain whether other approaches and/or choices should be undertaken.

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

Technology such as BioGrid as mentioned earlier in question 4, as it allows the analysis of data from different patient cohorts. It would enable a clinician to identify whether there is a need for clinical emphasis in one area, whether there is growth in the type of consumer accessing the service and areas of risk that may require attention. The analysis of data would enable timely prompt decision about, e.g. staffing skill-mix or increased focus on kidney function management.

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

The COVID-19 period saw more patients being seen by clinicians by telehealth. Certainly, a number of patients preferred this in rural regional areas as it reduced costs such as driving costs and was more convenient. In the diabetes centre, administration staff were tasked with contacting patients to ask them to download pumps and CGMs before the appointment to make the consultation time more streamlined. More consumers engaged with company reps to undertake this activity. The patient undertook this because they 'had to' but it can continue to be promoted and supported if required.

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

Administration support by knowledge and trained staff is essential.

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Reform Initiative 3a – Consultation questions:

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

- Supportive IT and appropriate training and ongoing support to ensure ease of use.
- Enable viable transport options across the regions to reduce late healthcare access due to transport disadvantage – difficulty accessing public transport due to cost, availability or accessibility of services. Improving connections between people and the services they need, particularly for vulnerable and disadvantaged.
- Investment in afterhours UCC to support prompt care and improve interface of community and hospital care.
- Training and policy to alter culture in acute care setting to support increasing resilience in staff and reduce poor behaviour; to promote a culture of innovation and growth.
- Appropriate selection of management staff with relevant training rather than senior clinicians. Leadership and management are skills sets in themselves.

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

Ensuring the right balance of infrastructure can be identified by a Clinical Senate who has gathered information from Clinical Advisory Groups that represent all sectors. The CAGs able to identify ways of improving care and partnership, which can lead to better investment across the services.

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

Support and fund local innovation particularly if focused on improving healthcare services. Often clinicians in a hospital setting, undertake research with minimal support and in their own time to improve care. Some good results may be obtained; however, there is no mechanism (or support person) to support these staff initiative, support the writeup of reports in a meaningful manner and support wider implementation of the work.

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

Distance to relevant services. For example, in more rural areas, certain conditions such as diabetes, obesity, cardiovascular disease or cancer are higher per capita. Other niche services with smaller consumer numbers should be in larger facilities where expertise can be developed.

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

By strategic advice sought from a Statewide Clinical Senate with information derived from combined CAGs with cross representation of health sectors. The Clinical Senate should also include non-clinicians such as representation from education, health economist and ? accounting to ensure decisions are both ethical, evidence-based and economically sound.

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 aligned to meeting the future health needs of Tasmanians?

Any workforce strategy needs to consider the need to invest in time to allow for forward planning and review current services to identify areas for change. Training in change management and access to ongoing mentorship and professional development. Many staff use mentorship in the early part of

their career; however, research shows that ongoing mentorship supports clinicians with much experience to continue to work at their peak.

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?

A vehicle such as the Statewide Clinical Senate may support the development of clear strategic advice and develop relevant policy, to support the workforce's cross identification of needs. However, private sector is less likely to take on more complex time-consuming patients in some cases as it may not align with their business model or access to expertise. There needs to be a mechanism and support to allow public acute sector staff to run clinics alongside private sector.

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?

Improving schooling facilities to attract younger families who may stay longer. Providing packages that incentivise the initial transfer to the State, which may allow future long-term planning if they settle. Creating community for younger families once they arrive.

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?

The Australian Public Service Commission (2020) has recently indicated that to increase workforce capacity, organisations need to be designed for its health professionals' potential and capabilities, not the limits of their expertise. Therefore, restrictive boundaries need to reviewed and removed wherever possible. For example, in diabetes education and care, Credentialled Diabetes Educators (CDE) are not only nurses, but come from multiple disciplines: nursing, dietetics, podiatry, exercise physiology and midwifery. Close mentorship is the mechanism for developing expertise and maintaining the different disciplines within the diabetes centre provides this bidirectional potential.

However, hospital units tend to have governance structure that only allow for disciplines to sit with their relevant disciplines. Consideration should be made to allow different disciplines who show interest in an health area to develop their knowledge by working with the respective team and supervision to their respective discipline. This increases the team's expertise providing care overall and increases the condition specific expertise in each different discipline. The consumer ultimately accesses a team with a breadth of expertise that complements each other. Clinicians are more on the 'same page' and advice is more succinct, which can make the consumer experience more satisfying. Furthermore, increases awareness of services.

Moreover, given the constant deficit of medical practitioner in Tasmania models of care can be designed utilising more senior level allied health with statements of duties which enable expansion of their expertise. Working alongside advanced practices nurses such as nurse practitioner and relevant teams. Staff that work at senor clinical roles are often very aware of all the current evidenced based guidelines and are skilled to either implement the advice or advise the GP to do so. Non-medical models therefore create an opportunity for allied health and nursing staff, and a career pathway that would attract suitable people and would support the medical deficit.

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

Queensland Health has completed much work in this area to meet the geographical restrictions and poor dispersion of different health professionals of their State. It would be useful to review their work and the steps they have made to progress increased scope of practice of allied health professionals and nurses.

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

Scholarship to attend interstate university and training with a recommendation that they return to Tasmania for 2-3 years as part of the workforce in repayment for the scholarship. For example, Tasmania does not train most allied health professionals or nurse practitioners. Once they have settled interstate and met new friendship groups they may be less likely to return. Also, consider a new graduate or leadership plan for when they return for their 2-3 years so that it may enable then to develop more connections and roots in the Tasmania healthcare system.

Reform Initiative 3c – Consultation questions:

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

Tasmania has had two similar groups in the consultation papers timeline, i.e. the Leads Clinician Group led by Professor Alasdair Macdonald and the Health Council led by Professor Denise Fassett. In both cases, the groups brought together those with clinical expertise from across the State and different health sectors. In both cases, neither were funded to create change that came from innovation from the group or others. Further, the purpose and work of the lead groups were not well understood by their colleague more broadly thus preventing further utility of the strategic groups. Thus, investment in a Statewide Clinical Senate more involved in providing advice on health policy to respond to current healthcare needs of the Tasmanian consumer and health professionals would be significant.
The Statewide Clinical Senate could provide strategic advice to guide policy which enables innovation that supports improved collaboration and efficiencies. Policy that directs funding in appropriate directions could support the development of project plans to implement such initiatives. A Clinical Senate will help guide health planning by understanding the commitment and strategic direction of individual organisations and/or sectors. Policy and strategy advice provided by a Clinical Senate could align services across the State more closely, so that wait times do not differ across the State, and consumers are not disadvantaged.

The Statewide Clinical Senate could be highly involved in providing policy advice against the reporting provided by combined Clinical Advisory Groups. Furthermore, it could advise on the combination of CAGs to support relevant partnerships to improve integration and cross-communication. The Statewide Clinical Senate may have a role to play in determining the priorities and best options. The CAGs strength lay in the commitment of the members and cross representation from across health care organisations. The Statewide Clinical Senate, as an interface to the Minister, could provide sound and considered advice to improve the interface between acute/sub/acute and specialist services, and primary care. To improve performance, collaboration and partnerships, integration, systems and business processes, and ultimately health outcomes.

An important strength of the Statewide Clinical Senate would be its reflection of professionals from across healthcare organisation and clinical areas. It can provide a unique avenue for cross conversation and better systems understanding. The Senates purpose should also include providing sound strategic advice and expect to be called upon to provide this advice as issues or opportunities arise.

The current Premier's Health and Wellbeing Advisory Council does not appear to have a significant cross-health sector representation; therefore, it may create a different type of conversation and understanding of systems and opportunities than a Statewide Clinical Senate. Strategic advice should be led by evidence and not necessarily by different organisations' strategic direction; it should focus Tasmanian consumers' needs. Ideally the Statewide Clinical Senate would also include other professionals who may not be clinicians, however, may support the development of appropriate

strategic advice, e.g. health economists. Also, a means of maintaining communication across the board to both consumers and health professionals to encourage involvement by all, e.g. funded media personal to establish prompt communication about the work for the Clinical Senate and how people can be involved or provide feedback.

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

Surveys across services that patient can complete following access to a service which review components of access, wait time, experience and concerns. Furthermore, any ideas they may have to improve their care better. Consumer forums often draw on similar consumers but may not capture the voice of all consumers. However, they are also a vehicle for collecting information about specific questions and strategic advice sought. Furthermore, should the Statewide Clinical Senate have adequate media support, consumers could provide feedback and advice via a feedback portal on a Clinical Senate site. The consumer would then know that their feedback is going to 'policy makers'.

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

By better training health professionals about self-management and literacy for all. Health professionals need to listen to their patient stories to appreciate their immediate focus and concerns, which may not be the pending health problem. When patients are 'heard' they are more likely to engage. Better and ongoing training to provide supportive counselling techniques within a framework of shared decision-making when guidance on actions is required and to identify emotional health issues such as stress, burnout and depression. Staff who are more resilient and work more closely together with opportunity for mentorship and deliberate practice are more likely to provide consistent health care advice.

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

Each region of Tasmania currently has active consumer groups that have had additional training to support them in being proactive in environments with expert health clinicians and academics to feel confident to provide their voice. Many health professionals themselves are daily consumers of health services also and this should not be under-estimated. Both these groups have potential for providing sound advice.

5. How can we improve opportunities for consumers to feedback on their healthcare, including following discharge from care?

Regular surveys as mentioned before or by providing an online mechanism such as that used by hospital clinicians to identify risk. Volunteers services currently exist in most hospital and they can be brought in to support capturing general advice. If the advice sought is specific to an issue or condition, consideration may be given to community forums with clear questions and outcomes.

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

In the hospital setting, there is an imperative to support improvement in culture. There should be focus on training and support health professionals to become proficient at communicating with the intention of an effect; to inspire, motivate and encourage both the consumer and fellow health professional. Leaders need to be supported to lead with purpose and promotes wide-reaching advocacy for people living with health conditions.

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

Utilising established groups across the State, e.g. RACGPs, Australian College of Nurse Practitioners, Podiatric Society of Australia, Australian Diabetes Educators Association, Australian Diabetes Society, Clinical Oncology Society of Australia. Also, the major hospital executives and relevant primary health organisations such as Primary health Tasmania and university.

These groups will often be able to identify the leaders within their group; individuals who are able to evaluate detailed information, promote and inspire innovation and bring others along.