ANMF
Tasmanian Branch

AUSTRALIAN NURSING & MIDWIFERY FEDERATION (TASMANIAN BRANCH)

SUBMISSION

Our Healthcare Future

ANMF Submission

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Australian Nursing & Midwifery Federation (Tasmanian Branch)

Organisation Overview

The Australian Nursing and Midwifery Federation Tasmanian Branch (ANMF) is both the largest nursing and midwifery union and the largest professional body for the nursing and midwifery teams in Tasmania. We operate as the State Branch of the federally registered Australian Nursing and Midwifery Federation. The Tasmanian Branch represents around 8000 members and in total the ANMF across Australia represents over 280,000 nurses, midwives and care staff. ANMF members are employed in a wide range of workplaces (private and public, urban and remote) such as health and community services, aged care facilities, universities, the armed forces, statutory authorities, local government, offshore territories and more.

The core business of the ANMF is the industrial and professional representation of nurses, midwives and the broader nursing team, through the activities of a national office and branches in every state and territory. The role of the ANMF is to provide a high standard of leadership, industrial, educational and professional representation and service to members. This includes concentrating on topics such as education, policy and practice, industrial issues such as wages and professional matters and broader issues which affect health such as policy, funding and care delivery. The ANMF also actively advocates for the community where decisions and policy is perceived to be detrimental to good, safe patient care.

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Introduction

The primary role of the Australian Nursing and Midwifery Federation Tasmanian Branch (ANMF) is to support nurses, midwives and carers to provide better care for patients. The Tasmanian Branch is part of the wider Australian Nursing and Midwifery Federation, which has over 280,000 members made up of nurses, midwives and care workers. We are a professional organisation as well as an industrial one. Consequently, through our members, we have a complete understanding of the nursing and midwifery professions. Our members work across the entire public health service from acute hospitals, in our district hospitals in communities within the community delivering community health care and Midwifery services, in schools, in correctional facilities, public health and in the department of health. Our public sector members often intersect with private health care services in the acute, community and aged health care sectors. This allows the ANMF and its members a holistic understanding of the entire health system, its successes and also its challenges. Importantly, it allows a unique perspective on the solutions to improve the health system not only in the short term but also in the longer term.

We thank the Minister for Health and the Tasmanian Government for the opportunity to provide a response to the Our Healthcare Future Consultation Process including the Health Workforce Strategy.

The ANMF broadly support the proposed initiatives across the areas of Better Community Care, Modernising Tasmania's Health Systems and Planning for the Future. However, the position of the ANMF and its members will be discussed further in response to the consultation questions. The ANMF look forward to continuing to work collaboratively with the Minister for Health and the Tasmanian Government, as has been the case during the COVID-19 response, and we look forward to continuing to do so on the Governments Our Healthcare Future.

The ANMF and members understand all too well the challenges faced by the health system and are at the forefront of experiencing those challenges in every health care setting as well as experiencing some challenges within their own profession. The ageing population, the chronic disease burden and the socio-economic status has a significant impact on the demand of health care services in Tasmania and these pressures are likely to increase. The need to balance prioritisation of acute care services with preventative health strategies along with a strategic health and workforce plan that is informed by evidence and matches the projected needs of the Tasmanian population, is now absolutely critical.

While the ANMF acknowledge that to varying degrees some of the strategies within the One State, One Health System, Better Outcomes White Paper and associated Role Delineation Framework have been implemented, there are others that have not. It is the view of the ANMF that if this continues to be the basis of the health care reforms, that identified strategies are implemented in full and continue to be supported and resourced appropriately.

Many of the reforms announced by the white paper have focused on acute health care service, while noting the mental health reforms have progressed, the reforms projected in the sub-acute areas have not been fully realised and need to be in order for the overall strategy to be successful. For example, the Mersey Community Hospital (MCH) has not become the elective surgery centre for the state, nor has it supported an increase in rehabilitation services, especially given the loss of the Rehabilitation beds at the North West Regional Hospital (NWRH). In addition, the Patients First Strategies have not been fully implemented and where they have, have mostly focussed on the Royal Hobart Hospital (RHH) while the Launceston General Hospital (LGH) has some of the worst waiting times in the country. The NWRH also continues to experience increasing unacceptable wait times for patients accessing care. Moving all acute hospitals to true 24/7 operation with appropriate resourcing of healthcare staff, allied health, pharmacy and radiology services is imperative.

There absolutely must be a state-wide uniform approach to implementation of health strategy and it must not be solely focussed on the acute sector. There is no doubt however, that meeting the health needs of the Tasmanian community will need dedication to resourcing acute health care services in the short to medium terms whilst a greater emphasis is placed upon primary health care, preventative health care and improving the health literacy of the next generation of Tasmanians.

The ANMF believe that the nursing and midwifery professions are and will be instrumental in achieving strategic health system outcomes in the future. With nurses, midwives and assistants in nursing found at the majority of points of contact with the health care service and in health promotion from cradle to grave, there are many opportunities that can be maximised by building on existing services, infrastructure and indeed the expertise of the health care professionals.

Reform Initiative 1

Reform Initiative 1 – Consultation questions:

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

ANMF members have seen many strategic changes in recent years from changes to the legislation on the health system governance to implementation of some of the service reforms based on the white paper and role delineation framework. However, the lack of uniformity and even changes with the application of strategic aims has not assisted in achieving benefit from current investments in healthcare.

The abolishment of the Governing Council, while necessary, was costly and has added further uncertainty within the state health service. The new Health Governance structure is still not yet fully implemented, while the nursing and midwifery professions lost the Statewide Nursing and Midwifery Executive Director of Nursing and Midwifery (EDON) at the outset of the new governance structure announcement. From a nursing and midwifery perspective, this has meant a lack of leadership and progress on strategic workforce matters, which are essential to maintaining quality and safe care.

A key to maximizing on current investment is good leadership and constant evaluation and feedback from stakeholders from clinicians to managers. Reappointment of the Statewide EDON will greatly assist in maximizing on current investments in nursing and midwifery and will allow for statewide consistency and implementation of strategic aims on a statewide basis. This role will be an integral interface between the operational and strategic health sectors and will be vital to support and implement health system reforms.

In addition to stakeholder feedback, targeting current investment must too be based on current health and population data and the projected needs of the community. As previously stated, there must be investment to support current needs, but also allow the opportunity to pivot in the future to meet the projected emerging needs based on the population demographics such as age, socioeconomic status, chronic disease burden and the likely health services required as a result.

Resourcing current services to enable these to operate to full potential now is likely to have a two-fold effect. Services that are well resourced are likely to be more efficient and offer greater capacity to meet demand and also are able to think strategically on how the existing services can meet emerging and projected future health needs. An example would be district hospitals. Staffing these permanently, rather than by way of fixed-term contracts, allows certainty of the current model of care, allows district hospitals to operate to their full potential including as a step up/step down and also primary health service as well as looking at ways in which these existing resources (in terms of infrastructure) could support additional health services to meet the needs of the community in a holistic way e.g., wound clinics and diabetes clinics.

ANMF members recognise that there must in future be as a focus on health education, building health literacy and improving modifiable risk factors that are contributing to the chronic disease burden in Tasmania. This will mean greater investment, if not equal investment, in primary health care, building health literacy and education. Again, using existing services where great outcomes are already achieved rather than introducing new reforms or strategies is likely to be most cost efficient and yield better results. An example would be to fund more school nurses, to allow for opportunity to build upon the current health education program and ensure that this continues through primary and secondary education.

In addition, expanding the child health and parenting service and investing resources to allow for engagement with families who are doing well, would also welcome reinforcement and expansion of health education regarding developmental milestones, healthy food and circle of security. Currently, servicing those families and children only for specific age checks and for those at risk is missing a valuable opportunity to continue to build on health literacy and health promotion.

In addition, looking at areas of greatest needs and proactively addressing concerns is likely to reduce costs and improve efficiency. An example would be the LGH Emergency Department (ED). With some of the longest wait times and performance in the Country, the fatigue and stress this has placed on nurses in the LGH ED for years has taken an incredible toll, with many experienced staff leaving due to sustained workload pressure. This creates a perpetual cycle of staff exodus, costly recruitment exercises, more workload on current staff who need to train new nursing staff which in turn leads to burn out and ultimately seeing many nurses leaving. Stability and consistency are required to ensure that there are sufficient staff to deal with the current demand without the stress and anxiety due to not having enough nursing staff to deal with the demand. In turn, this would eventually allow for planning for longer solutions, analysis of trends that can be addressed with the support of staff who will have the time and energy to be part of the solution.

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

The ANMF fully support the shift to community-based care where appropriate rather than continuing a sole focus on acute care. The ANMF have long advocated for the return of the Hospital in the Home Program across the State, the Community Rapid Response Service (COMRRS) implementation statewide and have supported the implementation of the Mental Health Hospital in the Home.

In addition, the ANMF have actively engaged to date on the urgent care centre feasibility study and are in support of the implementation of this model, particularly in communities in most need of health care services that can be bulk billed. Although, given the success of the Australian Capital Territories Nurse-Led Walk-in Clinics, disagree that this should unilaterally

be General Practitioner (GP) led. The ANMF look forward to continued consultation on the urgent care centre model and exploration of a model which can look at partnerships where Nurse Practitioners (NP) can have a role in the urgent care centres to build capacity, as recruitment of GP's may also prove difficult, which will also allow opportunities to build the NP workforce.

In addition, the ANMF and its members are of the view that there are enormous opportunities to extend current community services which have the potential to reduce the over reliance on the acute sector. These include resourcing palliative care services to a 24-hour model, more resourcing of community mental health teams so that, in addition to addressing urgent mental health needs, it will allow for dedicated case management and hopefully prevent ED presentations. Similarly, expanding the capacity of community nursing and COMMRS will also allow for expanded scope to deal with urgent care needs in the community and prevent presentation and/or re-presentation to the acute sector.

3. *How can we facilitate increased access to primary healthcare, in particular:*

a. After hours and on weekends

Expansion to the existing NP fast-track model for weekend and after-hours care will assist in addressing the lower triage category presentations if they do present to ED. However, co-located NP or GP clinics that have after-hours operating hours but could potentially utlise existing pathology, radiology and pharmacy services could also prevent actual presentation to the ED. In addition, the ANMF support urgent care centres to operate after hours and on weekends with services that are multi-disciplinary and have appropriate diagnostics that are nurse led.

In addition, better promotion and communication regarding GP Assist after hours as an alternative to ED presentations which is bulk billed for children and those with concession cards may also reduce some of the non-emergency presentations.

b. Rural and regional areas

In rural and regional areas, utilisation of the district hospitals are an excellent opportunity to be used as a touch point for the community when needing to access healthcare, whether it be primary healthcare or acute care. Utilisation of the district hospital as a foundation for a staffing model to attract the multi-disciplinary team could then assist in allowing outsourcing of services from the hospital or nearby (as is the case on King Island with a co-located GP service) or as a hub for the provision of community nursing services. Implementation of a robust staffing model at the King Island site allows for greater opportunity to provide additional avenues for community members to utilise health services and opportunity to provide primary health care.

In other rural and remote areas where access to reliable internet and phone coverage is difficult, utilization of existing public sector infrastructure like libraries could accommodate a nurse to facilitate tele or video conferencing to enable better access to medical and specialist staff, with the benefit of a nurse providing pre- and post-reinforcement, practical demonstration of equipment if required and ongoing follow up support.

In addition, strong community-based nursing services will allow for provision of holistic care in communities even without a district hospital as a hub.

c. Low-income and vulnerable clients

There is a critical need for bulk-billed health services to ensure services and access to services for low-income people. There is no doubt that ANMF members report those presenting to the ED often present as they cannot afford the expensive out-of-pocket or gap fees charged by GP's. The previous comments regarding the urgent care centres which offer bulk billing or NP-led co-located urgent health care support could assist in addressing this need. It should also be noted that some GP's have effectively closed their books to new clients, a point that reinforces the need for some form of a shared care model.

d. Extended treatment options (e.g. urgent care or non-emergency care)

See previous comments.

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?*

As previously stated, the ANMF support the urgent care centre service and implementation of such a model. The benefits are clear. However, the model of care must be reconsidered to include a nurse and NP-led model or, at least, a shared partnership model. The success of the ACT model which is nurse-led is evident as the model is currently being expanded.

The opportunity to build on developing the nurse and NP roles should not be overlooked as a benefit and opportunity to complement the urgent care centre. In addition, this model should also be explored for implementation in district hospitals after hours and on weekends as this may reduce the additional infrastructure that would be required and also allow the sharing of all health staff (nursing, allied health and medical) across the core district hospital and the urgent care centre after hours, particularly for sites that do not currently offer emergency services.

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?*

ANMF members report that the use of facilitated telehealth generates positive outcomes and patient satisfaction. However, they also report that the health literacy (and for that matter the general literacy) of many clients and patients should not be underestimated and it is likely that older Tasmanians may also not have the IT literacy to participate in telehealth without assistance. Fortunately, once a telehealth appointment has commenced there is generally no need for the participant to make any changes to the computer system.

However, ANMF members see that telehealth has an important role in the future. This has been reinforced by our members' experiences with the use of telehealth during COVID-19 as well as being part of nurses and midwives' usual practices, especially as part of a follow-up or disease management strategy.

A facilitated model, as previously mentioned making use of existing infrastructure in communities, could be a possible way to improve use of telehealth services and possibly link

in additional support services during that interaction. Clearly, the staffing resource of nursing staff would be required.

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?*

There are enormous opportunities in rural and regional areas to build capacity in district hospitals which, if resourced appropriately, could offer holistic health care services. However, investment in these sites to build infrastructure within the hospitals and also for staff is required to facilitate recruitment of permanent nursing, medical and allied health staff. This may also include provision of accommodation that is at a basic satisfactory level for working professionals, such as private bathrooms and independent living quarters.

Overtime systems could build upon service provision whereby services are offered 24/7, like pathology and radiology or at least remote reporting on radiology, so that when acutely unwell patients present, they can be treated on site where appropriate. In addition, including Allied Health Professionals (AHP) as part of the service will improve health outcomes and prevent unnecessary acute transfers. For example, on the West Coast, the lack of access to a social worker means that at risk clients who are known to be living in sub-standard living arrangements are having difficulty accessing the required support services. This means it is very difficult to provide the holistic care these clients require. In addition, the support for those with disabilities not getting timely access to significant disability funding, which would reduce strain on the service and the client, has also not been able to be met.

The remoteness of some of these district hospitals and the connection with the local communities, allows for a good understanding of what services, health needs etc. are required. Working with the district hospitals to provide facilities to meet current and emerging health needs flexibly 24/7 will allow for health promotion, possible remote management of chronic health disease through video or teleconference with the support of a Registered Nurse (RN) and preventative health care with allied health support.

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?*

ANMF members believe that an absolute priority needs to be the sharing of clinical information that it is readily accessible and updated in a timely way via a shared IT system or at least a system that allows for linking in when required. The duplication of healthcare services due to clinicians in all sectors not being able to access relevant clinical data in a timely way results in patients undergoing repeat investigations and reviews whereas, if this information was shared, the efficiency in each health sector would be greatly improved and importantly could result in a timelier diagnosis, appropriate follow-up appointments, review of results and allow for applicable ongoing care implementation.

Clearly, issues around confidentiality and security of information need to be addressed. However, members in general practice report not receiving discharge summaries for acute patients presenting with ongoing care needs days after an acute admission. This can lead to uncertainty for the health care staff as well as the patient and increases the risks of re-presentation or poorer health outcomes.

In addition, a shared vision across the health sector led by the State Service that is developed through collaboration with all health provider stakeholders will allow for a single understanding of how the interfaces and integration can be better defined and improved over time. While each provider has their own agenda, a siloed approach to healthcare is not efficient and doesn't provide holistic patient care. Beginning with an IT solution, further work can then occur, opening up communication channels to look to future solutions. For example, this may result in expanding in-reach services (for instance into residential aged care through COMRRS) that can prevent acute admissions or providing education and training to build capacity. While this would come at a cost to the public system, it would be far more cost effective in the long term than is an ongoing reliance on the acute sector.

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

Community delivery of health care to older Tasmanians is one that is supported by ANMF members where appropriate. Providing care in the home or through general practice or indeed in residential aged care facilities with options to escalate care if required would be the preferred model for the health system and for those accessing care.

Ensuring that there are options to access increased levels of care or acute care such as through COMRRS is one example where an escalation of care to an acute level can continue to be managed in the community. The presence of appropriately resourced community nursing teams to provide follow-up and ongoing care, delivering post-acute care and also ongoing care, is one way to prevent recurrent admissions and allow for ongoing management of chronic diseases.

The interface with aged care, particularly residential aged care and hospital services, is one that is disjointed and no doubt impacted by the funding arrangements. While aged care services are federally funded and also are governed by the Commonwealth, the fact that older Tasmanians live in Tasmania and many have done so for their entire lives, incorporating their health care needs services into a Tasmanian Government agenda is critically important. An example of this may be a provision of specialized palliative care services in aged care facilities through the State palliative care service. While this would require additional funding, it allows for specialized care to be provided to residents who need it when staffing models in aged care facilities don't allow for anything more than basic care due to the staffing levels and it would likely reduce acute presentations to the hospital sector. Likewise, a roving NP (Aged Care) covering a number of sites might reduce admissions for illnesses which could be treated in the home of the resident.

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

A shared understanding of what services a co-located hospital will and won't offer is absolutely critical in identifying how and if a co-located hospital will avoid presentations and admission by privately insured patients to a public hospital.

There is no doubt that there are significant opportunities in co-located hospitals with potential sharing of infrastructure and also staff. However, members at the RHH report that many privately insured patients still present to the ED to avoid paying a $250 up-front gap fee. In addition, it is reported to members that parents presenting with pediatric patients in private sector ED's are told to attend the RHH ED.

The opportunity for a co-located private hospital in the North with the LGH is great. These service delivery challenges need to be understood and worked through in order to see a benefit for public hospital presentations and admissions. It is possible that an up-front fee for ED services in a future private hospital at the LGH ED may similarly discourage private hospital presentations. In addition, the service profile must be well understood along with the staffing model as recruitment challenges already exist from a nursing and midwifery perspective and it will be critical that the staffing requirements can be met for both the public and private hospital in order to achieve maximum use of the private hospital by privately insured patients.

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?*

This will require significant investment in the staffing profiles both in terms of additional resources and supporting the staff that are already working in health care services to attend education and training to better understand how such priorities can be built into day-to-day practices.

Many members across the system report not having time other than to complete the basics of care requirements due to workloads. Having a staffing profile that enables staff to have the time to spend with patients and clients to provide education, understand the needs of the client and patient to whom they are providing care, will assist significantly in achieving this objective.

Giving nursing and midwifery staff the opportunity to attend education and training is also critical in achieving this objective. Building professional development time into the leave relief factor for nurses and midwives will allow for roles to be back filled so participants can actually attend the training and education. Otherwise, the current situation will continue where staff cannot be released from the roster to attend the education sessions.

In addition, provision of more Clinical Nurse Educators (CNE) and Clinical Facilitators to deliver the education and training and provide clinical support and reinforcement of learning through the Clinical Facilitator in the clinical environment is critical. Having a twofold approach with education delivery by a CNE and ongoing support by way of a Clinical Facilitator in the clinical environment alongside nursing and midwifery staff will aid in embedding learnings into everyday practices.

Lastly, a culture within the health system that values and supports education, research and learning is essential. Our members report repeatedly that when the health service is busy, which they report is the majority of the time, any learning and education opportunities are the first to be cancelled in order to fill roster shortages and replace short-notice sick leave. This culture needs to change if nurses, midwives and their health care colleagues are to build in another health service into their day-to-day practices.

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?*

See above comments.

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

Our members report that patients often present to the ED as this was what the patient perceived as the only available option for care. After hours, the ED is often the only real option, however these presentations are not always time critical.

Improving accessibility is important so that the most appropriate pathway is available to those who need assistance. This includes providing alternate after-hours options for acute care that doesn't require treatment at an ED, such as nurse-led walk-in centres, access to child health and parenting services which can be accessed without an appointment, well-resourced community mental health services and palliative care services that can be accessed via a variety of avenues 24/7. So many of our member report that health service delivery is built around a business model of 0900 hours to 1700 hours when health requirements, particularly those that are acute, occur at all hours of the day.

Improving accessibility of health care services will enable Tasmanians to enter the health system through an appropriate pathway. In support of this, communication and education of the community about the health services that are available to them is crucial. Members highlight the Raising Children's Network as a great resource for families with children. It provides content in a variety of modes, accommodating a variety of literacy levels. This includes information being shared through practical demonstrations via video, fact sheets and illustrations. Advertising of available health services through a portal like the Raising Children Network may also support those who are actively trying to navigate the health system and make informed choices. It could also provide advice to those who need support and need some direction and assistance.

In addition, mainstream media, social media and advertising in prominent places (for example on the back of buses) should be considered as part of an overall communication strategy as it is likely that Tasmanians who are not already engaged with the health system will have a greater chance of seeing this communication.

Reform Initiative 2

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

The ANMF and its members fully support the immediate actions to procure and implement a fully integrated Human Resources Information System (HRIS) to replace payroll, rostering, work health and safety conduct and leave management. Implementation of these processes will streamline onerous and time-consuming processes that have largely been paper based and allow nursing and midwifery managers and others to spend their time focused on their clinical priorities rather than on administrative tasks.

Looking at ways in which access can be facilitated with existing digital platform or ways in which they could operate alongside and link into a new digital investment would be beneficial. Understanding what digital platforms health service providers currently use and looking at identifying short term solutions while working on implementation of a broader plan to address

the digital needs to allow sharing of patient information in a timely way may provide a way for limited sharing to occur until a broader strategy and digital solution can be implemented.

Importantly, systems must be consistent across the state and must be able to 'talk' with each other.

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

ANMF member report access for GP's, aged care facilities and community health services to the Digital Medical Records as a high priority in order to facilitate the sharing of timely health information enabling the continuity of care of patients post discharge from their acute admission.

In addition, access to private radiology and pathology services is also raised as being a key priority in order to reduce the duplication of diagnostic procedures and also allow for early implementation of care plans.

ANMF members also highlight that the digitisation of medication charts and patient vital signs will significantly increase the safety and quality reassurance processes, by allowing for automated inbuilt triggers for referral and review.

3. *What information should be prioritized 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)?*

The information that the ANMF believe should be added to the My Health Record to assist clinicians as a priority is included in answer to the previous questions. However, ANMF members query whether this is the best option as the digital solution to the sharing of health information. ANMF members report that the My Health Records are often not updated in a timely way, is missing information or is not used at all.

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?*

See response to previous questions.

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

ANMF members advise that often patients will report that they have had contact with a health provider or have accessed a service but have not understood the outcome of that contact or indeed understood who each of the care providers were,= and what role that they had. Patients often report to members that they been asked to repeat their 'health experience' on multiple occasions and don't understand why that is the case.

Clearly, each member of a multi-disciplinary team seeks to understand the needs of the patient from their perspective but co-ordination and sharing of the patients' needs across the team would assist in reducing this duplication which is frustrating for the patient and raises concerns in their mind as to the safety of their records. However, this information does need to be

coordinated and where this does work well, CNC's are able to bring the multi-disciplinary team together to do so.

In addition, providing patients and clients with written information to reinforce and remind them of their continuing care requirements and an overview of their interaction with the service, much like a discharge summary, helps to provide information for individuals who proactively seek ongoing support or services. In addition, formal follow-up of patients and clients at set intervals post engagement with health services works well in providing additional advice and support and also allows for opportunities to implement additional service or referrals if required to ensure the patient or client receives the ongoing care they need via the appropriate pathway. This approach works very well in improving the satisfaction of patients and clients but does need to be resourced appropriately so that there are nursing staff enabled to carry out this function.

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

As previously stated, ANMF members have indicated that digitized medical charts and vital signs charts would assist in improving patient care by having built-in triggers for review.

In addition, digitising the significant amount of paper-based nursing documentation would assist in ensuring screening tools were completed in a time appropriate way. An example of this is a falls assessment which is largely a screening tool with check boxes that could be completed online yet is still a paper-based tool. In addition, digitising these screening tools allows for timely updates to other services, such as food services who may need to provide a modified texture diet to an inpatient in an acute setting as well as triggering a speech pathology referral. Of course, this requires resources such as access to computers, tablets or other devices. While these devices can be shared, there needs to be sufficient support to allow access to all at times of high demand.

ANMF members also report that better telephones would assist in improving patient outcomes. Members working in the community have reported that mobile devices do have not the coverage nor the ability to receive and send photos if required for clinical purposes. Those working at the RHH have also identified numerous areas in K block where mobile phones and the internal phone systems do not work. Improving the communication in these areas will no doubt lead to better patient outcomes and would also reduce the frustration felt by clinicians freeing them to do other patient care tasks.

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

See previous answers.

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

In addition to the HRIS (see above), the main paper-based task that is time consuming and onerous to nurses and midwives is the significant amount of paper-based documentation. Bringing paper-based documents onto a digital platform will allow for more opportunities to share the documentation to allow for more timely treatment and reviews and allow for easier referrals. The need for the multi-disciplinary team to physically attend a ward or area to review a patient file and associated documentation is time consuming and inefficient.

Reform Initiative 3A

1. *What are the major priorities that should be considered in the development of a 20-year infrastructure strategy to ensure the right care is provided in the right place and at the right time?*

The ANMF and its members are of the view that prioritisation of increasing bed capacity now to address the ongoing access block crisis is critical. This must, however, be done in tandem with fully resourcing current community services to ensure these can operate to their full potential 24/7. For example, many client accessing COMMRRS are palliative care patients after hours, when palliative care could be seeing these clients with additional staffing resources allowing COMMRRS to focus on additional acute care needs in the community.

The infrastructure priorities should then be focused on a broader strategic plan that has the support of all key health stakeholders in each region building on the acute sector requirements but also builds on future models of care where health services are delivered in communities. Having health hubs to allow for collaboration between health professionals and easy referral is essential. However, there is opportunity to build upon exiting health services in communities with these models of care, like district hospitals, so that investment can be in staffing these models rather than bricks and mortar.

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?*

See previous comments. Additionally, infrastructure funding should be a proactive investment rather than a reactive investment (which is largely too late and outgrown by the time it is implemented) so that health infrastructure is online when the health need emerges. The strategy around this should be based on health stakeholder feedback, research evidence, population demographics and available data.

However, there must also be a balanced approach which addresses current needs as well as the future needs while also ensuring that each sector is considered rather focusing primarily on the acute sector.

3. *How do we ensure current facilities continue to be invested in appropriately, so they continue to be fit-for-purpose, including during the COVID-19 pandemic?*

The recommendations from the Inquiry into the COVID-19 outbreak in the North West should be implemented in full across all health services. The urgent requirement of social distancing and preventing transmission between health care workers cannot be solved purely by altering ways of working. There must be short term solutions to address the small spaces where health care staff are required to work, such as medication storage rooms, treatment rooms, multi-disciplinary spaces and tea rooms as well as the lack of lockers, change rooms and showers. Additionally, the need for negative pressure rooms, must also be addressed in the short term as a matter of urgency.

In the longer term, these facilities must be considered as part of strategic planning and indeed in infrastructure planning for new health facilities to ensure that these issues do not contribute to staff-to-staff transmission and staff to patient transmission in the inevitable next pandemic.

In addition, the changing demographics of the population must also be considered in terms of capital works, given the increasing need to assist patients with bariatric needs. Often these present challenges in terms of current clinical spaces, use of shared facilities and also in the community when providing care in homes.

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?*

Maximizing on current health care services in a location that is easily accessible by the community is incredibly important. Consideration of locating these health services in co-location to other community services such as Service Tasmania, libraries and council offices have some merit as it increases the likelihood of community members accessing the service and also allows the opportunity for easier referrals and potential for collaboration between health service providers.

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

Consultation with key stakeholders in the private sector to allow an opportunity for a shared vision for health care services would be a good starting point to develop relationships that can continue to inform health service strategy in the future would be helpful.

Reform Initiative 3B

The ANMF broadly agree with the key findings of the specific Nursing and Midwifery Workforce consultation paper. Further work to assess and improve data surrounding the nursing and midwifery workforce to inform the broader strategy is required. Working on retention strategies to address burnout and culture in the health system is vital to improve job satisfaction and keep those nurses and midwives currently working in the health system. Recruitment strategies that support local growth of the nursing and midwifery professions is also essential and the ANMF are committed to supporting this endeavour through the ANMF Health Educating and Research Centre (HERC) by delivering the Diploma of Nursing. Lastly, the sustainability of the nursing and midwifery professions is essential. Addressing workloads, overtime and double shift rates and resourcing nursing services is a key priority and should be addressed as a matter of urgency.

As previously mentioned, updating the leave relief factor to incorporate back filling of nursing and midwifery staff while they take various types of leave (annual, personal, parental), undertake professional development, as well as long term sick or Workers' Compensation leave will greatly assist in reducing burnout, fatigue improve retention rates, reduce sick leave and allow for meaningful ongoing education and training.

While the data indicates the third highest number of nurses and midwives per 100,000 population, Tasmania has specific nuances which need to be taken into account when analysing the data. The dispersed population, high chronic disease burden, ageing population and low socio-economic status means that Tasmanians have more health needs and often more complex and high acuity requirements. This requires a greater number of nurses and midwives to support the Tasmanian community's health needs across multiple settings.

Further compounding this is that Tasmanian has less Intensive Care Unit (ICU) and High Dependency Unit (HDU) beds than most other jurisdictions, which results in higher acuity patients and higher nursing workloads being managed in alternate settings such as in general medical and surgical wards. This also requires increased staffing requirements and it is the view of the ANMF and its members that these factors, which are Tasmanian specific, are often not taken into account when establishing or reviewing nursing and midwifery staffing needs. Rather, the focus is to debunk the need for additional staff based on the fact that other states and territories don't use the same. Such an assessment is to compare apples with oranges and it is not helpful.

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?*

The Health Workforce Strategy needs to further explore the proposals that have been included as potentially being beneficial to improving the nursing and midwifery professions and identify strategies that will deliver concrete solutions on how the sustainability of the nursing and midwifery professions in Tasmania will be supported. The data shows the increase in numbers of nurses and midwives who are over 60 years of age and the decreasing average age of the professions. The need to ensure a local supply of nurses and midwives across the state now is imperative.

It is the experience of the ANMF and its members that the impact of those staff who are leaving the professions due to retirement and burnout are increasing every month. This is having a significant adverse effect on staffing, workloads and skill mix. Implementing short solutions such as Clinical Coaches to support skill mix is also required. The Health Workforce 2040 strategy must explore the impact that reduced skill mix has on the nursing and midwifery professions so that a consistent strategy to addressing this issue can be implemented. The system also needs to invest in the new graduates who will be the nursing and midwifery workforce of the future. Concentrating on the support of these graduate in their new workplace so as to retain them in the public service, graduates who leave the state may never return.

Many of the projects that are outlined as offering possible solutions are projects have been in training for years with no tangible outcomes. The career structure refinement has not progressed to achieving an agreed outcome despite this being agreed to in the 2016 Nurses and Midwives Industrial Agreement.

Reviewing the progress of the strategies included in the paper as to further progress and likelihood of achieving an outcome is recommended.

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

Governance structures incorporating all health delivery services where nurses and midwives work must include all key stakeholders to enable collaboration and shared strategies to address concerns and build on the nursing and midwifery workforce. The separation of mental health services to a stand-alone statewide model has, in ANMF members' experience, reduced opportunities to work collectively on addressing challenges to improving mental health care to clients and is one example where Governance structures can either improve or drastically reduce the collaboration and uniform approach.

Again, stakeholder committees like the clinical senate should include all sectors where nurses and midwives work and be approached from a health needs and service requirement perspective in the first instance rather than from a funding or jurisdictional perspective.

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?*

ANMF member feedback across the state is that retaining nurses and midwives is incredibly difficult due to the workloads, the reliance on part-time staff as a strategy to pick up extra shifts and fill rosters due to the leave relief factor not being accurate and roster shortages being the norm, overtime and double shift rates which continue to trend upward year upon year and the poor culture with the health system where access block appears to be accepted, instead of addressed, is leading to burnout, disillusionment and looking to work elsewhere in Australia or even in another profession. Addressing these issues will greatly assist in improving retention rates of nurses and midwives.

Attracting nurses and midwives to Tasmania is and will continue to be a challenge. The housing prices are now comparable to many other areas in Australia and the wages of Tasmanian nurses and midwives largely are not competitive with other States and Territories. In the absence of competitive wages, it will be difficult to attract nurses and midwives from other states and territories.

As noted above, it is essential that the health system seek to capture as many new graduates as they can. Given the level of staff attrition, an oversupply of graduates, if they can be obtained, is likely to be quickly absorbed into the system. However, these graduates also need to be provided with sufficient support from experienced nurses and midwives who have the capacity and time to nurture these new additions to the profession. This should be set as an immediate action of government as implementing this initiative whilst maintaining a safe skill mix becomes more difficult as our experienced nurses and midwives leave the workforce.

With regard to recruitment specifically to the North West, attention should be focused on offering a competitive package that is comparable to other remote areas in Australia. This should include a market allowance, accommodation that is a basic standard of a health professional including a private bathroom and independent living, relocation assistance and support for families who are willing to move to and work in the North West. In addition, addressing the above matters will also assist in making the North West a more attractive workplace destination.

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?*

There is an opportunity to provide education and training that will equip the nursing and midwifery professions to deal with emerging and expected future health needs. Offering funded scholarships to undertake post graduate training in the areas of need such as mental health, critical care, dementia care and midwifery will build the knowledge and skills of the existing workforce. The current support in place with assistance for post graduate study with the University of Tasmania (UTAS) may need to be expanded to include other education providers to ensure that the relevant learning needs can be addressed through applicable courses. There are also courses that can be undertaken online from interstate educational providers but time needs to be given to employees to undertake further education that will provide benefit to the health system.

ANMF members acknowledge that differing models of care need to be implemented both now and into the future to address the growing demand for health care services. Nurses and midwives have been instrumental in the success of community-based programs like Midwifery Group Practice (MGP), Hospital in the Home (both Mental Health and Acute care programs), and the CommRRS. Nurses and midwives can and will continue to support these flexible and innovate ways of working, provided appropriate consultation occurs and the services are well resourced to reach their full potential.

As previously mentioned, utilizing NP's to meet current and emerging health needs in areas such as aged care, wound care, urgent care centres, diabetes and dementia management, just to name a few, will allow expansion of the nursing workforce, improve opportunities for within profession referrals and increase learning and improved patient outcomes.

Similarly, we need to implement a professional development model that is valued and prioritised by the health system that supports professional development of nurses and midwives that is also flexible enough to respond to emerging health needs in the Tasmanian population. Disappointingly, professional development and education and training has not been well supported in the health system with the North of the State still without a Nursing Director for Education and Research and members across the state reporting their professional development repeatedly being cancelled due to staffing challenges. This cultural and resourcing barrier must be overcome so that the professional development of nursing and midwifery staff can be supported and enable innovation.

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

Further, to the comments regarding education and training, members report cultural and policy barriers prevent them from being able to work to their full scope. The ANMF have long supported nurse-led discharge form acute hospitals but this has not been implemented across the state leading to increased length of stay.

Challenges for NP's to secure positions also means that there are qualified NP's not being able to practice to their full scope despite having the necessary qualifications. Similarly, despite the Advanced Enrolled Nurse (AEN) classification being included in the career structure, there has been limited implementation of the role. Utilizing the available career structure to its full range is likely to assist in health professionals practicing to their full scope.

The ANMF also support a plan to train and implement nurse endoscopists as has been initiated and implemented in other jurisdictions.

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

Working with the education and training facilities like ANMF HERC, TasTAFE and UTAS to address areas of need and also work toward offering training options in regions that are most in need.

Offering supported places to complete training in return for entering the nursing and midwifery professions in a clinical area that is in need like Midwifery, Critical Care, Aged Care etc. will encourage Tasmanians to consider training for the professions and also address the areas in most need clinically of new staff. The costs for completing these courses in areas of need should be covered, at least in part though preferably in full, by the employer.

Reform Initiative 3C

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

It would allow a multi-disciplinary group made up of clinicians who are immersed in the clinical environment to provide ideas and solutions to health service strategy and policy and would also accommodate a review of any proposed service delivery or model of care changes.

For some time now, even with the removal of the Governing Council, ANMF members have reported that policy and service delivery changes do not meet the needs of staff, patients and clients in the health system and are disappointed by the lack of opportunity to provide advice and alternate views prior to the implementation in the clinical area.

The clinical senate must include clinicians from all disciplines across the State and include a variety of skill sets and grades of staff to allow for new and innovative ideas to be explored in a consistent way across the State.

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

Offering opportunities for engagement on issues within the community and through various avenues to achieve a broad understanding of the issues in health will assist in heath service planning. Including involving consumers on strategic committees to include consumers experiences and input part of these processes will assist health in meeting consumer needs.

Utilising a variety of digital mediums to engage with the community is likely the best way to engage the in-heath service planning and learning about opportunities for quality improvement. One area that ANMF members identify as needing improvement is the Department of Health (DOH) website which offers little information regarding health services, is often not up-to-date with current information or contact phone numbers and could be improved through interactivity to allow for the option for engagement and seeking feedback from visitors to the site.

3. *How can we strengthen and optimise consumer engagement and participation at all levels of healthcare including*:

    a. Personal: participation and engagement in a person's own care

See previous comments regarding health literacy and literacy levels. However, digital options with iPads or digital platforms at the bedside in the acute sector, with rehabilitation exercise videos, information on healthy eating and modifiable risk factors that patients and clients can engage with while accessing or admitted to a health care setting could assist in providing better opportunities for engagement of individuals in their own care.

Different models of care, such as primary nursing could be explored to better engage and empower patients and clients in their own health care.

    b. Local: participation and engagement in service improvement at a local level

Seeking views of community members while accessing current services through short surveys, providing bite sized social media tiles on local and community social media platforms

to highlight services available and also through promotion of health services at local community events.

c. Policy and service system: participation and engagement in planning, developing, reviewing, evaluating and reforming services at a system level?

Working with consumer reference groups to build health literacy that will enable the required level of health literacy to participate in policy and service system engagement should form part of the broader health reforms. Developing and supporting a broader network of consumers to allow for their active participation in health groups and to act as health consumer representatives would enable increased consumer engagement.

Assisting consumers with their IT requirements, travel and, if necessary, accommodation requirements will also facilitate better engagement.

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

A top-down bottom-up approach to consumer engagement with consumers is essential. In order to have community support for health system reforms, a top-down approach will not facilitate the buy in and ownership of health services at the local level. A top-down approach in combination with a bottom-up approach is essential to provide opportunity to take into account the local context and consumer needs before delivering an outcome.

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

Again, offering a variety of avenues to provide this feedback is essential. More often than not, if a consumer is being discharged from care, this will involve a discharge interaction. An iPad if face-to-face could be given to the consumer to complete a survey prior to their discharge, an email may be sent to those in the community where appropriate and also on-line platforms. Bearing in mind that people may be reluctant to give identifiable feedback if they are likely to require more services in the future.

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?*

See previous comments on the need to value education and training and providing the resources that are required to assist health professionals in finding non-clinical care delivery time to engage with this education.

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

Offering opportunities for career development outside of their local clinical areas through mentorship programs and a variety of opportunities where emerging leaders have the opportunity to participate in strategic health service delivery planning face-to-face with senior health professionals through a shared governance model would assist in completing written opportunities distributed via email and in the local workplace.

There are outstanding nurse and midwives with enormous leadership potential who are stifled by an ingrained culture of a governance hierarchy being the only option for leadership

development. Innovative engagement with the emerging leader groups in clinical regions on specific topics and will hopefully provide a broader perspective for emerging leaders on how they can progress on their leadership journeys.

Conclusion

The ANMF welcome the opportunity to provide feedback on the Our Healthcare Future Consultation Paper on behalf of and following consultation with members across Tasmania.

In principle, the ANMF supports the immediate actions identified in the consultation paper, provided that ongoing consultation with the ANMF and its members occur.

The ANMF also support consistent and methodical application of strategic improvements to the health system to address the immediate challenges as well as laying the foundations for addressing emerging and future health needs.

However, it is the view of the ANMF that implementation of previous strategies outlined in the white paper and Patients First should also be an immediate priority. In the alternate, if there is a deviation from these strategies, then this must be communicated to all stakeholders and importantly nurses, midwives, their health care colleagues and the community.

In addition, prior to the addition of additional services and infrastructure, current health services and infrastructure should be fully resourced to allow the services and facilities to reach their full potential.

The ANMF remain committed to working collaboratively with the Tasmanian Government in support of nurses and midwives. The ANMF welcome the opportunity to further discuss any aspects of this submission.

12 February 2021