Department of Health

Tasmanian Government

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Our Healthcare Future Consultation Response

This document was collated by the DoH GP & Primary Care Unit; with input from the Primary, Rural and Palliative Care Unit; THS GP Liaison Officers, and members of the Centre for Antarctic Remote and Maritime Medicine (CARMM) Council.

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Executive summary

This paper is in response to the Our Healthcare Future consultation and will focus on General Practice and Primary Care within the Tasmanian health system.

The Australian Charter of Healthcare Rights includes the right to access healthcare services and treatment that meets patient needs. 83.2% of Australian's saw a GP in 2019-2020. Tasmania has an aging population with an increasing burden of complex and chronic disease. Prevention of disease and of complications associated with chronic disease often occurs within the community setting with the patient partnering with a multidisciplinary team of healthcare professionals.

Primary Health Care is generally the first contact a person has with Australia's health system and relates to the treatment of patients who are not admitted to hospital. While general practice is the cornerstone of primary care in Australia, primary health care is multidisciplinary with care provided through nurses (GP nurses, community nurses, nurse practitioners), allied health professionals, midwives, pharmacists, dentists and Aboriginal health workers. Primary health care can be provided in the home or in community-based settings such as general practices, other private medical practices, community health centres, as well as local government and non-government services settings, such as Aboriginal Community Controlled Health Services.

It is important to consider the breadth and depth of Primary Health Care to facilitate an accurate and inclusive discussion – WHO says:

"A primary health care approach includes three components:

- *meeting people's health needs throughout their lives;*
- *addressing the broader determinants of health through multisectoral policy and action; and*
- *empowering individuals, families and communities to take charge of their own health.*

By providing care in the community as well as care through the community, PHC addresses not only individual and family health needs, but also the broader issue of public health and the needs of defined populations."

https://www1.health.gov.au/internet/main/publishing.nsf/Content/Fact-Sheet-Primary-Health-Care

General practice is a discipline defined by the following characteristics:

1. Person centredness
2. Continuity of care
3. Comprehensiveness
4. Whole person care
5. Diagnostic and therapeutic skill
6. Coordination and clinical teamwork
7. Continuing quality improvement
8. Professional, clinical and ethical standards
9. Leadership, advocacy and equity
10. Continuing evolution of the discipline

In Australia, the GP:

1. Is most likely the first point of contact in matters of personal health
2. Coordinates the care of patients and refers patients to other specialties
3. Cares for patients in a whole of person approach and in the context of their work, family, and community
4. Cares for patients of all ages, both sexes, children, and adults across all disease categories
5. Cares for patients over a period of their lifetime
6. Provides advice and education on health care
7. Performs legal processes such as certification of documents or provision of reports in relation to motor transport or work accidents

https://www.racgp.org.au/education/students/a-career-in-general-practice/what-is-general-practice

The persons writing this paper acknowledge the role of the Commonwealth Government in supporting General Practice and primary care through the Medicare Benefit Scheme, and programs such as the Practice Incentive Payments. Acknowledging there is a National Primary Health Reform Strategy currently being developed, it is behoved of the Commonwealth Government to adequately support communities to access general practice and primary care. Unnecessary access barriers, such as the use of telehealth only for those with a 'regular GP' risks increasing inequities between those that can and those that cannot access primary health care, for whatever reason.

General Comments:

It is suggested that the Our Healthcare Future consultation process result in a structured paper linked back to core health frameworks such as the quadruple aim: safer patient care, better patient experience, better staff experience, and more effective; or shared values of the Tasmanian health system. It is suggested that any goals or actions are linked to outcome-based measures, and that value-based health care is considered, where value is thought of in terms broader than a single fiscal dimension.

In the future, and taking from the IAP2 Spectrum of Public Participation, the preference of the group is to collaborate on such documentation, rather than be consulted upon after the document has been written.

Reform Initiative 1:

Increase and better target our investment to the right care, place and time to maximise the benefits to patients.

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 health system to provide right care in the right place at the right time?

In public health, the analogy of a river is used to describe elements of a person's health journey. The upstream social determinants of health refer to the macro factors that determine the individual's health such as government policies, social, physical, economic and environmental factors. In Tasmania, we talk about the 'housing crisis', transportation barriers to accessing health care, food security, unemployment, educational attainment.

The evidence is unequivocal that adoption of a Health in All Policies approach is essential as health outcomes are directly related to the Social Determinants of Health (SDoH) i.e. meaningful and ongoing employment, sufficient income, safe and well planned built environments, access to fresh water and food, access to quality education, and more. This is best achieved through cooperative and integrated approaches across national, state, and local government, non-government and private sectors. In fact, Tasmania has previously promoted the Health in All Policies approach through the Premier's Health and Wellbeing Advisory Council and the Healthy Tasmania Five Year Strategic Plan. Despite this, and for too long, Tasmania has been distracted and focused on 'band aid' solutions that address the issues of those most easily heard, most visible and most easily fixed.

Meaningful community participation in the planning, implementation and evaluation of health and associated services is required to understand the wicked problems our communities face to co-design appropriate solutions as far upstream as we can. In the absence of this consultation and joint approach, providing fit for purpose services that meet community requirements and which will be well used has the potential to become a hit and miss exercise and a significant waste of resources.

More community designed and driven initiatives like the Tasmanian Anticipatory Care Project (AC) involving a broad range of stakeholders working together at the local level, trialling and testing local interventions based on locally identified needs and priorities are required. Community-based initiatives that 'join up' local systems need to be established over longer periods of time in order to allow opportunity to evaluate their effectiveness. There also needs to be consideration given to the outcomes of community consultations and how implementation of the outcomes will be resourced and progressed.

Current investment is largely directed at acute care. There is a need to reset the balance and invest more in early intervention and prevention. Without new investment in early intervention and prevention we will continue to perpetuate the problem and continue to drive people into acute care. To shift a proportion of resources from a focus on acute hospital care, to community-based primary health care a change in the ratio of investment is required recognising that:

- Most people live and manage their well-being and ill health largely within the community not in acute facilities
- It is 'better to build a fence on top of the cliff than put an ambulance down in the valley'. The return on investment from preventative health approaches (health promotion, community development, population health, etc) exceeds that from acute care e.g. reduction in morbidity/mortality burdens, improved engagement/productivity/profitability across workforces

resulting in better standards of living, reduced welfare system burdens, improved mental health for individuals and communities and so on.

- Timely access to a diverse range of primary and community care services is essential for reduced LOS and timely discharge as well as reducing preventable hospital admissions. Investment in these sectors has a cumulative effect by reducing acute/sub-acute costs and pressures.

Primary Health Tasmania have access to primary health care data that may be able to inform gaps in health service delivery prior to presentation to acute facility or state service. This could be raised through the Primary Health Information Network (PHIN) of which the Department of Health is a member.

Tasmania has a very distributed population and many small towns. Remote, rural, and regional Tasmanians have poorer health outcomes than Tasmanian's located in more urban areas. Targeted investment to provide sustainable health services in remote, rural, and regional Tasmania will contribute to addressing the imbalance and inequity allowing remote, rural and regional Tasmanians care closer to home.

Addressing this inequity will require investment in multiple areas:

- Workforce: There are fewer rural generalist and rural general practitioners, per head of population in more remote and rural areas. This can be mitigated by providing a dedicated, visible training pathway for doctors wanting to live in and provide services to rural communities. The Tasmanian Rural Generalist Pathway is establishing a Coordination Unit as part of the National Rural Generalist Pathway. The success of this pathway relies on dedicated prevocational training rotations and vocational additional skills posts within the Tasmanian Health Service. This will require investment from the State. While the TRGP is currently focused on medical workforce, it is important that the broad range of workforce required is enabled. This includes nursing, allied health, ambulance, and non-clinical health workforce to support rural health teams and their communities.
- Health Infrastructure: Limitations in consulting rooms in some areas reduces the capacity for rural areas to host additional workforce and trainees.
- Housing infrastructure for trainees: Limitations in furnished housing for visiting workforce or trainees further exacerbates difficulties hosting trainees in rural rotations.
- Education, Training & Research: Building a vibrant learning community will both assist recruit and retain workforce that can work to the top of their scope. This can be done using available evidence base, as well as innovating to contribute to the evidence base. Tasmania is home to the Australian Antarctic Division (AAD) who are leaders in remote health delivery from which there are opportunities to adapt research and development from their experience to the remote and rural Tasmanian context.

The Centre for Antarctic Remote and Maritime Medicine (CARMM) brings together expertise and innovation in delivery of remote healthcare through its partners including the Tasmanian Government, the University of Tasmania and the AAD. CARMM stands ready to be engaged in adapting these models of care to remote, rural and regional Tasmania.

Tasmania also has an aging population that benefit from care in their home, which may be a residential aged care facility. Older persons have higher rates of chronic disease and access primary health care more than younger persons. Given the health profiles of older persons they are at risk of exacerbations of their illness, incidents related to frailty, and medication error. It is essential that older persons can access the primary health care they need to stay independent for as long as possible and maintain the best possible quality of life available to them. Health care will not be enough on its own, with community care (meals, cleaning, assistance with activities of daily living, social interaction) paramount to supporting an older person's health and wellbeing. Investment at a community level is required to prevent situations where older persons are sent to an acute facility for care they are unable to access closer to home, and then

unable to be discharged from hospital should the appropriate clinical care not be available at their point of discharge. Older persons should be involved in the decisions relating to their care, and goals of care discussed as a routine part of care for anyone at risk of not being able to make their own decisions – elderly or otherwise.

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

Multiple approaches are needed to change a complex adaptive system. Options to shift the focus to better community care include:

- Shift to patient-centred care, rather than facility, location, discipline, or specialty-centred care.
- Working with communities to co-design solutions. No longer is it appropriate for government to create strategies without consultation through a top-down approach. Transparency and co-design are accepted contemporary tenants of health care service planning and delivery. This is overtly stated through the National Safety and Quality Health Service (NSQHS) Standards, including Standard 2. Partnering with Consumers. Accreditation of health facilities requires health services to partner with consumers at every level of the health service.
- Building strong partnerships with organisations such as Primary Health Tasmania, national, state, and local governments, not-for-profit organisations to jointly plan and implement reforms ensuring the best value for Tasmanian communities.
- Increasing the generalist healthcare workforce that may work between primary and acute care settings, improving interprofessional relationships across health care teams, and sharing of information within and between teams, including the patient, preferably enabled by a single electronic health care record, innovation in diagnostics and a coordinated, supported telehealth approach.
- Increasing exposure of doctors in training to general practice. The Rural Junior Doctor Training Innovation Fund (RJDTIF) has enabled the establishment of rural primary care intern and RMO positions in Tasmania. There may be opportunity to expand these positions in the future which will allow doctors seeking a career in general practice, considering a career in general practice, or wanting to understand general practice to assist their future hospital work and patient care the opportunity for this experience.
- Increasing the capacity of general practice liaison and embedding the positions within the system permanently. A co-ordinated approach between primary and secondary care is essential to underlying principal of patient care “right treatment, right time, right place” and their role is crucial to support this. The areas of scope for GP Liaison are broad within their role to enhance communication avenues between the GP and the hospital and provide advocacy for each sector regarding the most appropriate use of each service and resources available. This assists with a co-ordinated approach between primary and secondary care. Effective communication and collaboration between hospital clinicians and GPs is essential to the underlying principal of patient care “right treatment, right time, right place”. Currently there is only temporary positions of 0.5FTE in the NW, 0.5FTE in the North and 1FTE in the South. Consideration should be given to the importance of these roles and the benefits to be gained from achieving optimal coordination of care between General Practice and hospital clinicians.
- Consolidating relationships with Primary Health Tasmania by formalising the outstanding Memorandum of Understanding between the State and the PHN.
- Clarifying the roles and responsibilities of areas within the THS and DoH that relate to community care. This is outstanding after the last restructure. Primary and community care is currently

distributed across the THS regions in various formats, CMHW, Health Planning – PPPR, and CQRA – GP & Primary Care at least.
- Utilising health and social care services in the community to assist with hospital flow issues.
- Understand gaps in current community care that are aligned with opportunities that may require some leverage to assist their establishment. An example with shared benefit includes the HeaRT initiative proposed by HRPlus to build allied health workforce in areas where community are accessing less than expected NDIS packages.
- Consistent and repeated messaging and promotion that prevention (not hospital avoidance) is better than cure. This needs to be supported by publicised investment in public and population health services, primary health care and community care.

In order to ensure effectiveness of ongoing funding in primary and community care, evaluation must be embedded into any project or change process and undertaken on an ongoing and detailed basis to allow analysis of the investment outcomes to guide funding allocation and set KPIs across community, primary and acute care services.

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

Utilising the COVID-19 experience to adapt and change out of necessity, Tasmania has a unique opportunity with a discrete small, but dispersed population to undertake a step-change improvement in access to quality and safe healthcare. Quality and safe access to care across all hours and areas could be enabled through empowering patients, their communities and their healthcare providers with an innovation, generalist skills supported by remote point of care diagnostics, and telehealth access to specialist care. A virtual model of care is thus developed, supported by shared single health record with patient centric healthcare delivered by professionals with the right skills, in the right place delivered at the right time and could be applied to and enable work in all of the four subcategories below.

After-hours and on weekends

Promote the tele triage services that the DoH is already funding i.e. Healthdirect and GP Assist.

Full scoping study to assess after hours care needs and current gaps to address the current complications and disjointed nature of the system after hours.

In rural and regional areas

Support primary care practitioner recruitment and retention strategies to bring clinicians into these areas

Support strategies that make primary care services accessible/affordable e.g. bulk billing arrangements, mobile services, etc

Consider salaried primary care practitioners including GPs, outreach services, partnering with private providers, etc.

Incentives for primary health and community care providers to deliver outreach services

For low-income and vulnerable clients

Prioritise work on health literacy

Work with services to ensure their policies and practices are clear to local communities i.e. bulk billing

Work with other agencies to improve public and community funded transport to assist access to services

Partner with local government and other relevant agencies to plan for and locate primary care/community care services in accessible places including shopfronts and providing services in innovative ways e.g. through schools, shopping centres, mobile vans, Neighbourhood Houses, community centres, etc

For extended treatment options (e.g. urgent care or non-emergency care)?

Ensure the ongoing availability of after-hours tele triage services such as GP Assist and Healthdirect Better marketing of these types of services; improved profiling and understanding of these types of services within planning and service delivery areas within DoH.

Have formalised options for primary healthcare professionals to seek specialist advice at all hours

Consider ways to enable the access of primary health workforce to pathology and imaging out of hours and on weekends

Support development and promotion of GP facilitated telehealth support for the Tasmanian community

Increased use of community-based nurse practitioners or other similar models

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

The UCC is an option for delivery of urgent care in Tasmania. It has limitations which include being limited to larger centres. Care must also be taken to build upon existing resources within communities rather than competing with these.

Urgent care needn't be reliant on physical infrastructure. Other options not discussed in the paper include more distributed and technology enabled (point of care diagnostics and telehealth) models of care that leverage from existing community resources. Examples might be trial of ComRRS-type services run from District Hospitals or general practices where nurses could otherwise work within primary care if a full-time position was not required for ComRRS.

Rural Generalist doctors who work across general practice with advanced skills (eg in emergency medicine, internal medicine, mental health) allowing work in specialty areas and the acute hospital secondary care provide a potential staffing model even in larger centres.

Current Integrated Care Centres could be better utilised with reviewed medical governance and staffing models and potential enabled by shared single health record, point of care diagnostics and telehealth access to distant specialists.

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 has progressed significantly throughout the COVID19 pandemic. Uncertainty exists around the nature of the ongoing commitment to Telehealth from the Commonwealth Government relating to GPs. Despite this uncertainty over the future Commonwealth funded models, the Tasmanian Government must ensure the coordination and access to specialist services via telehealth is assured to ensure appropriate healthcare delivery and minimise often hazardous patient travel, social dislocation and unnecessary presentations to acute services.

With Tasmania's small but dispersed population with increasing acute presentations telehealth is critical to future health care delivery. In the absence of developing new systems, supporting the development and promotion of existing GP facilitated telehealth support would be useful.

The Centre for Antarctic Remote and Maritime Medicine (CARMM) and the Australian College of Rural and Remote Medicine (ACRRM) are world leaders in training and delivery of telehealth. Lessons can be learned to direct and support implementation across Tasmania.

A digitally enabled telehealth FIRST model for healthcare should be considered, as clinically appropriate, to ensure appropriate triage, coordination and timeliness of services, and safety and quality of care.

Safety and Quality of healthcare must be at the forefront with district hospitals and their communities supported by a workforce of rural generalists for face to face care supported by advanced point of care diagnostics, shared single electronic health record and coordinated and timely telehealth access to distant specialist advice.

Structured telehealth support of health professionals, self-managing patients and their carer's in the community 24/7 would increase the healthcare capacity within the community and seek to avoid potentially preventable hospitalisations. This could be achieved through establishment of virtual care centres and could be run state-wide.

A recent trial of palliative care after hours support through the GP Assist line was well received by patients and carers, however, the service required multiple long consultations to be provided to patients and carers in the after-hours period which made the service unsustainable alongside the acute tele triage requirements of the practitioners. A 24/7 virtual care support service state-wide could provide such services and include related clinical areas such as aged care support after hours.

It should be noted that there is a digital divide with many Tasmanians unable to access the required technology, without the skills or the confidence to engage with telehealth. Some people need support to utilise telehealth and digital platforms e.g. older people and vulnerable populations. Community centres, such as local Neighbourhood Houses, community health centres, Men's Sheds, Child Health Clinics, Family Centres, and others, could be developed as support venues/places where people could access telehealth services.

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?

A vision for District Hospitals should be developed and informed by community need. A new model of care and multidisciplinary workforce can then be guided by a strategy that is supported, resourced, and monitored to ensure it meets the needs of the community. This should be co-designed with both the community and the health services involved.

Opportunity exists to develop rural areas into Centres of Innovation in Regional Health, where people from regional areas develop research questions, complete research projects and are beneficiaries of evidence that is relevant to their community. This will foster a learning culture that can be further strengthened by supporting health professional trainees to spend training time in regional centres. This must include supports such as transport, accommodation, mentors and community linkages for both the trainee and their family members.

Steps toward this future include:

- Commitment of the State to review Service delivery and Staffing/Employment Models in Regional Facilities with an update due by 31 December 2020, including scope, timeframes for implementation and consultation/engagement plans (extension as per RMPA negotiation to mid-2021)

- Introduction of a nurse practitioner to the New Norfolk District Hospital, which has both enabled increase usage of beds at the facility by the RHH geriatric team and support to the local GPs and community to provide and receive care locally and sustainably (Completed)
- Development of Health Consumers Tasmania (Completed)
- Establishment of the Tasmanian Rural Generalist Pathway Coordination Unit which is transitioning to a new governance model under the Centre for Antarctic, Remote and Maritime Medicine (CARMM) Council, including the Department of Health, Tasmanian Health Service, University of Tasmania, Department of State Growth, and Australian Antarctic Division; and with ongoing engagement and guidance from the Tasmanian Rural Generalist Collaborative, including the Australian College of Rural and Remote Medicine, the Royal Australian College of General Practitioners, General Practice Training Tasmania, the Rural Doctors Association of Tasmania, registrars, Rustica, the Hub, HRPlus, and others. All who contribute significantly to the development of rural medical workforce in Tasmania. (In progress)
- Formalised implementation of step down and step up policies, protocols, and pathways to better utilise the District Hospitals as part of the Tasmanian Health Service
- Work with and leverage local community support for District hospitals to co-design their ongoing and/or future use as hubs for health and community services, perhaps through a hub and spoke model, where the District Hospital is the Hub of health services for the surrounding geographical area
- Create opportunities for innovation through CARMM to support healthcare delivery in District Hospitals through rural generalist additional skills training to meet community needs, coordination, and investment in advanced point of care diagnostics, radiography and ultrasound, and eHealth.
- Redistribution of state funds toward proactive primary and preventive care that will increase the health of all Tasmanian's into the future and avoid reactive expensive episodes of care in tertiary centres.

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?

Consistent with previous comments, looking at community need, then service need, skills mix to deliver the service, and workforce, there are multiple enablers required to integrate the system components. Some critical enablers of integration across all parts of a patient centric health system are as follows:

-Patient empowerment

-Shared single health record

-Digitally enabled virtual care coordination

-Trusted professional relationships from community to tertiary specialists

Co-designing the health service first requires us to understand what is integration and what does it look like on the ground from i) patient perspective ii) family and carer perspective iii) health staff perspectives? Once we understand the components of an 'integrated' service then we can focus our strategies and investment.

Some steps have been taken toward consultation with communities through the anticipatory care project. Taking the next step to support communities to implement initiatives from the Tasmanian AC project, which gave communities resources to work on local system improvements, identifying local priorities, gaps and to trial initiatives to improve collaboration, partnerships and functioning of local systems is important.

Implementing the components of the integrated services requires appropriate organisational structures so that services are planned, implemented, and delivered by integrated planning/policy/operational units and not siloed departments. This includes looking at elements such as:

- fit for purpose IT systems and integrated clinical software that support centralised record keeping and referral intake and which span and connect all sectors/the continuum of care
- pooled funding arrangements that permit flexibility in planning, implementation, and delivery of services
- physical co-location of selected services so that different clinical teams can talk with and support each other and common clients

From a workforce perspective, feedback from practices where the interns initially rotated to remote and rural sites included that the interns knew the main hospital and system well which allowed for improved linkages between the remote and rural sites, for example in palliative medicine.

Similarly, where there are staff working between primary and secondary care, increased understanding of both systems and how they integrate is improved. Rural Generalists provide a unique opportunity to identify opportunities for improved integration and models of care across the health system, particularly in rural areas.

Supporting additional skills posts in areas such as palliative medicine and mental health increases capacity within the community and integration between hospital and community services. Opportunities may exist in aged care to develop similar additional skills posts if dedicated training positions were available within the THS.

The workforce also needs to consider models of care that support multidisciplinary teams where the focus is on achieving patient determined goals as part of a patient centred approach.

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

A large amount of work has been commenced under the Aged Care Emergency Operations Centre (ACEOC) in relation to the interface between hospital services and aged care. From this work PHT and others are seeking to establish an ongoing community of practice to facilitate increased communication and relationships between the two sectors.

Actions to consider implementing to support strengthening the interface between THS and aged care include:

- Hospital liaison officers
- Funding agreements and contracts with KPIs and resources that support, require and enable joined up ways of working between hospitals and aged care providers
- Support and resource the Aged Care Assessment Teams including Associate Assessor models
- Improved discharge planning and pre-admission processes

9. How can we make the best use of collocated private hospitals to avoid public hospital presentations and admissions (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?

Work upstream needs to be done across public and population health and primary health care. Ongoing collaboration with community, local government, organisations such as the Heart Foundation, and programs like Active Launceston are important elements of promoting preventative health activities within the community. Drawing on the skills, resources and capabilities of existing organisations and groups that have a great deal to offer in this space is critical, for example neighbourhood houses, Aboriginal Community Controlled Health Organisations, local councils, TasCOSS and other peak bodies. Preventive health practices need to be made available and convenient, so they become easy options to take. The DoH has commenced work by development of a wellbeing framework.

Some examples of existing work that could be supported include The Right Place, It's Ok to Ask and Hello My Name Is. Another example is Health Lit4Kids, where the University of Tasmania is leading a WHO endorsed program that aims to bring members of the education and health sectors together with families and communities to improve health literacy in Tasmania. It supports positive health and educational outcomes for children and works towards reducing health inequities for families. www.utas.edu.au/hl4k

New funding models that focus on outcomes, not only outputs and activities, and which encourage and support providers across the system to include a focus on prevention, health literacy and supporting people to self-manage are required. Many current funding agreements and business practices actively promote throughput with no incentives for preventive work.

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?

To be successful, preventative health and health literacy cannot be approached piecemeal with a loose agenda to 'incorporate' into existing and future activities. There must be dedicated strategic and operational plans, organisational structures, policies, and processes that facilitate not only the work to be done but position preventative health practitioners to be part of critical planning and resourcing discussions. Only when this has been achieved can plans for multi-level approaches be successfully oversighted.

Any preventive health and health literacy initiatives must be promoted to both health care workers and community members so they are aware of what is available in the community and how they can access it. Communication within the health system and between the health system and the community must improve.

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

Engaging local communities in identifying and designing local pathways and communicating those at a local level is recommended. (see Connecting Care Portal – Find out what's happening in the Central Coast (connectingcaretas.com.au)). Working with Health Consumers Tasmania will assist an understanding of what consumers think will help them as there is often a difference between what the 'system' thinks is a good strategy and what works on the ground for consumers.

Consideration should be given to providing incentives and support to primary providers and community-based services to be guides and to support for client and patient to access other services and supports - beyond the walls of their own immediate service., with the aim of strengthening the interface between hospital and clinical health services and community based supports. The Health Connector role trialled in the Anticipatory Care project was showing promise as a potential local initiative that can facilitate the connecting and navigation of local health systems.

Investment in the promotion of service directories and apps that facilitate navigation of services in the community e.g. the National Health Services Directory (NHSD), is important so that services the DoH already funds are known about and utilised by community. Communication needs to be at a level aligned with community health literacy and be accessible via multiple modes of communication to reflect the diversity of community.

Primary Health Tasmania in partnership with the Department of Health and the Tasmanian Health Services have developed the Tasmanian HealthPathways (THP) first for use by General Practitioners, and now expanding for use by all health practitioners with a focus on increased use within the Tasmanian Health Service. The third stage of evolution of the Tasmanian HealthPathways may include a patient facing platform that provides patients information on a clear pathway of care for them. Previous data from HealthDirect indicates that Tasmanian's call the HealthDirect line with questions about how to access services at a higher rate than other jurisdictions.

Reform initiative 2:

Invest in modern ICT infrastructure to digitally transform our hospitals, improve patient information outcomes and better manage our workforce.

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

From a clinical perspective a single shared eHealth record is required. COVID-19 has shown the need for this in similar ways to the Christchurch Earthquake experience that saw the roll-out of a new eHealth system across the affected region of New Zealand. Ensuring that primary health and community-based services are included in the digital transformation is essential, as any transformation must connect all parts of the health service, not further fragment it. There are many existing projects and systems that can be built from incrementally in a strategic way, where leveraging from local and national work can bring reform and return on investment for Tasmania and assist it stay in synch with advances nationally.

From a data perspective, existing work through the Tasmanian Data Linkage Unit can be built upon and opportunities sought to strengthen connections with custodians of primary care data, such as Primary Health Tasmania on behalf of general practice.

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

Shared understanding of a patient's history and plans are essential to providing safe, quality patient care. Communicating for safety is highlighted through Standard 6 of the NSQHS Standards. Integration of Health ICT across Tasmania's health services and systems is key to health professionals being able to provide the best care for Tasmanian's when they need it. This must integrate across health sectors.

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)?

As a consumer-controlled health record, consumers should be asked what should be added to MyHR. Further education of Departmental staff and health professionals on what MyHR is, what it includes and how it works may create an improved understanding of MyHR, its role, opportunities, and limitations.

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?

Primary Health Tasmania have worked with the THS on projects such as the eReferral and are well placed to be ongoing partners for progress related to the digital interface.

Opportunities need to be identified at a senior level where strategic discussions and environmental scanning occur. The development of the first Clinical Advisory Group to the Chief Information Officer within the DoH is a welcome development. Work needs to be undertaken with relevant stakeholders/partners to identify opportunities and potential for savings by reducing duplication of effort and infrastructure – PHT, Australian Digital Health Agency (ADHA), Healthdirect, peak professional bodies, etc.

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

This question is best answered by a dedicated consumer representative body such as Health Consumers Tasmania, who are skilled in not only unpacking consumer requirements but also advocating for their uptake. There is a long history of consumers being asked what would help their experience without action being taken to address that feedback. The role of the system is to evolve to actioning consumer feedback moving from consultation, to true involvement, collaboration, and empowerment – as per the IAP2 Spectrum of Public Participation.

The system can support this through ongoing consumer engagement training.

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

Access at District Hospitals to technology such as ultrasound, also for video linkage with tertiary site emergency departments.

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

Please see question 5 – defer to the consumers.

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

That depends on the outcome sought, the environment and the patient.

Priority areas highlighted through the NSQHS Standards include:

- Medication Safety
- Communicating for safety – including clinical handover and discharge processes

Priority areas highlighted during the COVID-19 outbreak, include HR information systems to assist contact tracing.

Priority areas raised through clinical incident reviews include an electronic food management system within the hospital setting.

Priority areas within the DoH, include HR information systems that currently required a large amount of manual data handling to create reports that could be done electronically if resourced. This would heavily impact the workloads of the small Health Workforce Planning Unit, for example.

Reform initiative 3a:

Develop a long-term health infrastructure strategy for Tasmania.

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

Greater emphasis on needs-based planning, involving local communities and directing resources based on need is necessary. In the first instance, this involves mapping existing infrastructure and required maintenance and renewal. Then align this work with strategic planning on the future health needs of Tasmania, potential service models, future workforce needs and challenges, population projections and demographic changes, etc. so that infrastructure planning aligns with what is likely to be needed and not a disconnected activity.

Physical infrastructure is a major barrier to expansion of training and services in remote, rural, and regional areas. Without consultation rooms and education space, training local workforce will be an ongoing challenge. Supporting infrastructure such as stable internet access, ultrasound equipment, video linkage with tertiary centres are also sought.

Infrastructure needs to be broadly inclusive and not involve only buildings, but large assets and equipment such as radiology equipment (MRI, CT, etc) and ICT infrastructure. Much of this technology involves large investment and has a known and predictable life span. Maintenance and replacement schedules should be developed to ensure lack of planning does not impact community access to services. Many of Tasmania's services rely on a level of radiology, pharmacy, emergency, and ICU support to be able to safely undertake certain procedures and treatments which would otherwise not be safe to proceed with. Lack of access to imaging also has downstream impacts on waiting list times and further exacerbation of conditions.

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?

Infrastructure investment should be driven by the evidence that is sourced, analysed, and reported on by agency planning and service reform units i.e. draw on the expertise of the public service in the required areas. Evidence should include an openness to international and national directions and learnings from health and other sectors that could have local application. This evidence should inform conversations about strategy with key stakeholders and potential partners from across government, non-government, local government, and private sectors. Local communities can find creative ways to make better use of the local infrastructure that does exist. This needs to be supported and encouraged. There needs to be more emphasis on encouraging and supporting residents, community groups and service providers to work together and to form partnerships to make the best use of local resources (as opposed to relying on market forces alone and expecting that competitors will provide choice and make the best use of available resources).

The Anticipatory Care project highlighted that local communities (through the Local Advisory Groups that were established) are very capable of identifying and responding to local priorities, including identifying gaps in acute, sub-acute and community-based care options. The challenge (which DoH and other government agencies can assist to mitigate against) is that all voices are included and heard.

Where possible use of existing infrastructure or underutilised infrastructure should be considered. For example, large community health services that are not open after hours could provide an option for after

hours or urgent care services. Services such as ComRRS require little infrastructure compared to 'in room' consultation.

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

Consistent with previous comments, planners should be looking at community need, then service need, skills mix to deliver the service, and workforce. The District Hospital Review is due for completion by mid-2021 and should inform future District Hospital infrastructure needs. Planning work needs to integrate demographic, population, services, and other data to inform future requirements.

For an accurate picture of the local service needs, engage local communities in the planning, design and implementation of services and match this to infrastructure management. Ask the sites what they need to function or to support improved models of care and future needs of communities.

As with any element of a system, KPIs aligned with this work and its recommendations should be transparently guided and supported by evidence.

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?

It depends on the community. Communities are each different and the solutions for communities need to be matched to the existing services and community need.

Governance should be considered in the development of modern health services, that may not always be associated with a facility. An example is the Community Rapid Response Service (ComRRS) where clinical governance remains with the patient's usual GP, and the service is provided by the THS Nurse-led team under a shared management plan.

All services and facilities should consider infection prevention and control, particularly in respect of the lessons learned from COVID19.

Where physical facilities are required, they should be designed to facilitate multidisciplinary team approaches and have the capability to be repurposed as community needs shift and change. They should include thought to accessibility and needs for a range of patients, clinical requirements, and given future thought. For example, is the facility technology enabled.

Modern health facilities should be the product of:

- extensive community consultation and engagement mechanisms that support collaborative leadership (see AC paper, Organisation co-design approaches)
- consultation with relevant stakeholders across government, local government, NFP and private sectors
- evidence based work undertaken by relevant teams/units to ensure fit for purpose and appropriately location

Ideally community and health services would be co-located in a 'precinct' to:

- make them accessible to all community members particularly where there are multiple needs and transport options are limited
- encourage communication/cross fertilisation/collective action between service providers about community needs, gaps in service, etc.
- galvanise action for initiatives that benefit communities as a whole

- share resources where appropriate e.g. meeting rooms, IT infrastructure, childcare, transport hubs, etc.

If not physically located close to GP practices in rural locations close interaction and communication would be key.

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

Through published information about the State's future capital investment needs, locations, and types of services to enable the private sector to strategically place itself for opportunities as they arise. Relationships between organisations can be strengthened through strategic executive partnerships that keep abreast of opportunity and innovation and which have the delegation to progress action.

Reform initiative 3b:

Build a strong health professional workforce, aligned to a highly integrated health service, to meet the needs of Tasmanians.

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?

Data should be used for community in combination with the Health Workforce Needs Analysis of HRPlus (the Tasmanian rural workforce agency), and Primary Health Tasmania's community needs analysis to inform models of care and target areas for workforce development.

The HW2040 strategy should also inform numbers of and placements of doctors in training statewide to ensure doctors are supported to train towards areas of community need.

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

The combined knowledge of both sectors as well as the communities themselves will inform this work. Strategic partnerships need to be developed and maintained to identify opportunity and innovation. Shared and integrated planning and service reform approaches need to include data sharing, multi-sectoral projects, and clear governance structures.

The Health Workforce 2040 report highlights that 27% of Tasmania's 631 GPs were over 60 years of age in 2018. Ensuring there are dedicated rotations and positions within the Tasmanian Health Service to ensure junior doctors seeking to become GPs in Tasmania can gain the hospital experience they need to enter and succeed in general practice training. There are increasing demands for care in primary health care and across the aged care sector as our population is older and has more chronic disease. This is occurring at a time where we will have an expected decrease in number and full time equivalent of GPs to deliver the services. A workforce maldistribution makes remote, rural, and regional areas more vulnerable to these changes.

The rural generalist pathway is specifically focused on this in remote, rural, and regional areas, also across primary and secondary care. Key stakeholders are represented in the Tasmanian Rural Generalist Pathway – Coordination Unit (TRGP-CU) Collaborative, including General Practice Training Tasmania (GPTT), Australian College of Rural and Remote Medicine (ACRMM), Royal Australian College of General Practitioners (RACGP), Remote Vocational Training Scheme (RVTS), Tasmanian Health Service (THS), University of Tasmania and the Rural Clinical School, Postgraduate Medical Council of Tasmania (PMCT), Rural Doctors Association of Tasmania (RDAT), HR+, Department of Health (DoH), as well as a registrar representative and student representative.

The GP & Primary Care Unit meet with HR+, Tasmania's rural workforce agency monthly to identify any areas of workforce need, risks, solutions, and areas for collaboration.

The GP & Primary Care Unit are also a member on the THS Credentialing and Defining Scope of Clinical Practice Committee. Work is required to review the policies and procedures of this group in acknowledgement of the skills and activities of medical professionals working in the District Hospitals. There is plan to undertake this work during 2021 and will be informed by the District Hospital Review and infrastructure and equipment decisions around availability of resources for use in District Hospitals so practitioners can work to their full scope of practice within the facilities role delineation.

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?

There is a lot of evidence about attracting and retaining rural workforce. Strasser et al (2018) have published *making it work, a framework for remote rural workforce stability.* The Framework consists of nine key strategic elements that fall into three sections:

PLAN: Assess population service needs

Align service model with population needs

Develop profile of target recruits

RECRUIT: Emphasise information sharing

Community Engagement

Supporting Family/Spouses

RETAIN: Training future professionals

Relevant professional development

Supporting team cohesion

Current Tasmanian employment and training conditions are contributing to loss of workforce outside the State. Areas to improve the experience of the workforce across many domains, including psychosocial and financial, may include:

- improvement in HR processes and recruitment capacity, including promotion of medium-long term career pathways for clinicians
- system improvement in understanding medical workforce and that FTE/headcount is not the only factor for consideration. More people may be more cost effective.
- visible workforce pathways and end-stage jobs
- housing and infrastructure support for trainees and visiting health professionals
- access to resources to undertake work to high level e.g. purchase of new equipment when required,
- support to attend regular professional development
- clinical networks in place for support from larger centres or between smaller centres
- clinical supervision from suitably qualified clinician even if this must be sourced from the mainland
- increased use of multidisciplinary networks and support
- housing and travel subsidies

Trainees are attracted to work in locations with positive workplace cultures that have supportive clinicians with the skills, time, and resources to undertake quality teaching and supervision. This requires adequate staffing and skills mix within the workforce. Health professional's roles and responsibilities as a supervisor also need to be supported through training and processes. The right people need to be in the right jobs to enable such a learning culture.

Private-public partnerships are not only possible across hospital systems but across all health sectors, including primary health care. Engagement with private partners may assist to attract and retain health professionals in regional areas, with examples of partnerships with private organisations that manage the medical workforce at some of Tasmania's District Hospitals, and aged care facilities that manage some THS rural contracted beds.

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?

Collaboration is key.

Alignment of the workforce with community need.

Alignment of training positions with community need.

Explore models that use 'generalist' positions where it is appropriate to do so.

Better use of aides e.g. in allied health.

Access to regular professional development to assist with skill development and role changes

Explore rotational/secondment models with national/international health services

Prepare the health workforce to be technology (including telehealth) skilled.

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

Review the existing Credentialing and Scope of Clinical Practice policies and procedures to ensure it aligns with the various scopes of practice required across the Tasmanian health services.

Provide adequate infrastructure, training, equipment, and support to focus on skills at the top of scope.

Support and resource health professionals to be proactive and innovative in providing services to meet demand pressures and other constraints

Ensure health professional participation in an appropriate level of planning, service reform and co-design.

Supportive environments (physical and mental) that encourage and nurture health professionals

Provide access to quality clinical supervision and consider innovative supervision models, which may have remote elements

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

Whole of government approaches with a focus on lifting literacy and numeracy levels across the population, with an tertiary education completion being a possibility for more people. Learn from the work of the rural clinical school that has been embedded with community for many years, including visiting programs to primary and high schools, as well as community activities such as Agfest Health Tent.

Continued support of roles such as the University of Tasmania Aboriginal Health Careers Promotion Officer.

Ensure selection processes integrate from medical school selection at the University of Tasmania, including the Aboriginal Entry Application Process and Rural Application Process, through the hospital system where doctors spend their junior years, and into general practice training. This can be applied to all health professionals and specialty areas and should be done so in alignment with community need, noting that this must be projected the number of years forward to train the professionals.

Collaboration is required with the TRGP-CU Collaborative an example of this.

Reform initiative 3c:

Strengthen the clinical and consumer voice in health service planning.

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

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

The Tasmanian Anticipatory Care project has shown considerable promise as a model for engaging local communities in driving health systems change at the local level. Meaningful and effective engagement requires commitment and some resourcing to support community capacity to engagement. The four Tasmanian communities involved in the AC project established local advisory groups to drive their local projects. These groups have been so effective and valued that most of the participating communities are finding ways to sustain their local advisory groups. We need to work closely and consistently with the independent health consumer body for Tasmania, Health Consumers Tasmania (HCT) and other consumer representation bodies, and develop, implement, and promote consistent state-wide frameworks, policies, and protocols about consumer engagement and participation.

Ways we can do this include:

- Identify a champion/s for consumer engagement/participation at senior executive level.
- Educate all staff in the principles and practice of consumer engagement/participation including additional training for managers to create supportive environments for staff to engage with consumers.
- Quarantine agency funds for consumer remuneration.
- When consumers participate – listen, enact and feed back

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

Using a more holistic and person-centre practice approaches needs to be encouraged and supported rather than the current 'transactional' approach to health care. This should focus on what's important to the person by:

- Prioritising improvements in health literacy including working with educational agencies to improve literacy and numeracy statewide.
- Advocating for patient centred care to be central to all health professional training
- Prioritising training in working with CALD, ATSI, disabled, vulnerable communities, etc
- Ensuring all staff are delivering patient-centred care

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

See above example from the Tasmanian Anticipatory Care project and the establishment of local advisory groups

- Create an organisational culture that supports this engagement as part of everyday business

- Resource Health Consumers Tasmania to train consumers to participate and offer remuneration where it is appropriate to do so
- Put in place consistent state-wide frameworks, policies, and protocols to guide engagement and participation
- Identify champions at senior executive level who lead by example (have consumers participating in high level committees, projects, etc) and with consistent messaging around engagement and participation

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

Ensure staff across the Tasmanian health services are skilled in consumer and community engagement. Health Consumers Tasmania delivers training in this space by:

- Create an organisational culture that supports this engagement as part of everyday business
- Resource Health Consumers Tasmania to train consumers to participate and offer remuneration where it is appropriate to do so
- Put in place consistent state-wide frameworks, policies, and protocols to guide engagement and participation
- Identify champions at senior executive level who lead by example (have consumers participating in high level committees, projects, etc) and with consistent messaging around engagement and participation

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

As per the International Association for Public Participation (IPA)2's Spectrum of Public Participation was designed to assist with the selection of the level of participation that defines the public's role in any public participation process. It is used internationally and delivered as part of Health Consumer Tasmania's consumer engagement training delivered to DoH and THS staff.

We should remain open to learn and evolve the models of consumer engagement with advice from bodies such as Health Consumers Tasmania, learnings from projects such as the Anticipatory Care project, and through engagement with our local communities to understand what will best serve them.

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

Health Consumers Tasmania should be empowered to lead this work with the Tasmanian health service and system. Strategies may include:

- Feedback as part of discharge.
- Is there anything you would like to ask about your admission/service?
- Is there anything you found particularly useful that we should keep doing?
- For the purposes of our ongoing improvement, is there anything we could do differently next time to improve your experience?

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?

Budget for Health Consumers Tasmania to deliver increased amounts of working with consumers training for health professionals, policy makers and planners.

Resource Health Consumers Tasmania to provide more education to a wider range of staff in the health sector.

Support this investment in education with consistent state-wide frameworks, policies and protocols (and senior executive champions) that embed/support/resource staff to engage health consumers at all levels of healthcare making consumer participation part of the everyday business of the organisation.

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

Engage consumers and future health leaders in learning opportunities from medical student through to consultant. Include working with consumers training delivered by consumers as part of orientation for interns, doctors in training and all new employees.

Reflective practice and quality improvement activities often highlights lessons learned from interactions with our patients. This reflection is part of the LEADS framework, where L stands for 'leads self.' The regular introduction of consumers on root cause analysis panels at the Royal Hobart Hospital is an important example of engagement.