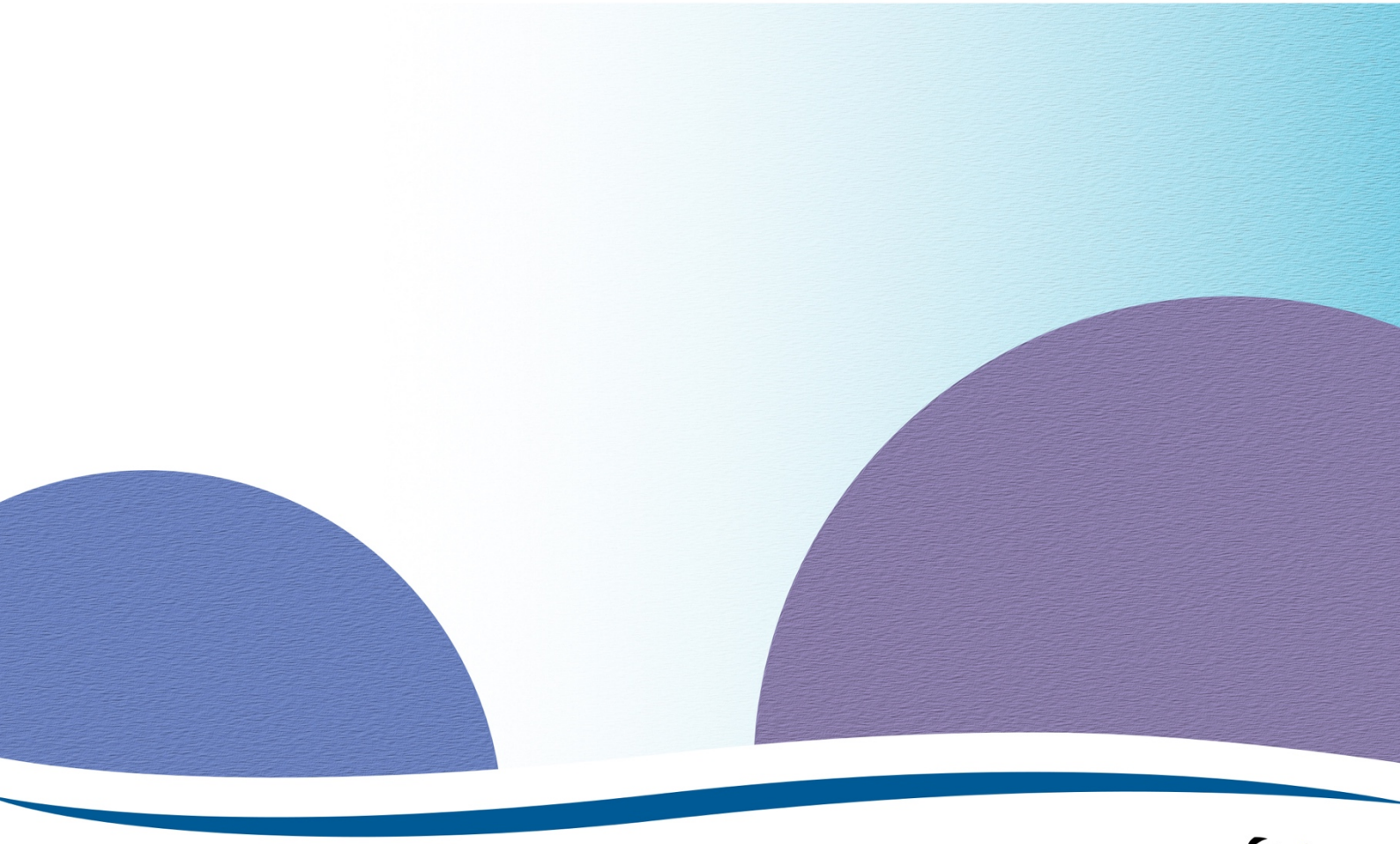
OUR HEALTHCARE FUTURE

IMMEDIATE ACTIONS AND CONSULTATION PAPER

EMERGING THEMES



Department of Health

Tasmanian Government

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Our Healthcare Future

Our Healthcare Future is the second stage of the Tasmanian Government's long-term agenda to consult, design and build a highly integrated and sustainable health service.

The *One State, One Health System, Better Outcomes* reform program was the first stage, clearly defining the role of our major hospitals in the health system.

The focus of *Our Healthcare Future* is connecting and rebalancing care across acute, sub-acute, rehabilitation, mental health and primary health sectors through to care in the community.

Our Healthcare Future Immediate Actions and Consultation Paper was released on 6 November 2020 for consultation.

The *Our Healthcare Future Immediate Actions and Consultation Paper* outlines immediate actions the Government is taking now, and consultation questions to guide future planning across the three key areas of: 1) Better Community Care, 2) Modernising Tasmania's Health System, and 3) Planning for the Future.

The call for submissions in response to the *Immediate Actions and Consultation Paper* closed on 12 February 2021. The original deadline for written submissions of 12 January 2021 was extended in response to requests from some stakeholders for additional time to complete their submissions.

A number of organisations and individuals were granted a further extension of time to complete their submissions with the last of the submissions received on 26 February 2021.

Ninety-seven submissions were received – 80 written submissions were provided by organisations and individuals, and 17 individuals provided feedback via email or telephone. A number of responses received from organisations also represented the views of members and broader stakeholder groups across the Tasmanian community.

Submissions are available on the Department of Health's (DoH) website at www.health.tas.gov.au/ourhealthcarefuture.

Submissions have been published in accordance with the Tasmanian Government Public Submissions Policy, available at: www.dpac.tas.gov.au/divisions/corporate_and_governance_division/government_services/public_submissions_policy

Purpose of this Paper

The purpose of this paper is to identify themes emerging across the submissions received in response to the consultation questions identified in *Our Healthcare Future Immediate Actions and Consultation Paper.*

Information provided in submissions which did not emerge as a theme during the analysis or was outside of the consultation questions is not highlighted in this paper. This information will however be considered throughout the *Our Healthcare Future* process and is available in the published submissions.

As part of the Emerging Themes, a Mapping Exercise was also conducted to consider the key themes to emerge from the consultation against the *Our Healthcare Future* Immediate Actions and the Tasmanian Government's 2021 Election Commitments.

Methodology

The following methodology has been used to conduct the analysis of submissions.

Submissions were categorised as follows:

- Consumer perspective – this category included submissions from organisations and groups who identified as providing a consumer perspective. It also included submissions from individuals who identified as a consumer in their submission and individuals who provided information that was related to an experience of care within the Tasmanian health system.
- Clinician perspective – this category included submissions from individuals, professional bodies and colleges, clinical streams, clinical groups within and outside the Tasmanian Health Service (THS) and areas of the DoH providing a clinical perspective function.
- Provider perspective – this category included submissions from providers of health services that were not considered to fall within the clinician perspective. Individuals offering a provider of health services perspective were also included in this category. Submissions from providers of services outside of the health sector such as education providers were not included in the sector category.
- Sector perspective – this category included submissions from individuals and organisations representing a defined sector of the Tasmanian community and/or a defined sector of the Tasmanian health system. As noted above, providers of services outside of the health sector were also included in this category.
- Health policy/whole of system perspective – this category included submissions from individuals and organisations offering a health policy perspective and/or a whole of health system perspective that was considered to be broader than a sector perspective.

Analysis of feedback was conducted to identify common themes within stakeholder perspectives and common themes across stakeholder perspectives relative to the Improvement Areas identified in the *Our Healthcare Future Immediate Actions and Consultation Paper* and the associated consultation questions. The three Improvement Areas are:

- Better Community Care
- Modernising Tasmania's Health System
- Planning for the Future

Findings from the analysis are outlined below. It should be noted that each submission did not necessarily respond to all Improvement Areas and all associated questions. Therefore, all perspectives (as categorised above) may not be indicated in relation to all Improvement Areas in the findings below. Further it should be noted that findings are based on the opinions expressed in the submissions and do not necessarily reflect the views of the Tasmanian Government or the DoH. These opinions have not been assessed for accuracy or consistency with current literature, evidence and practice. This is outside of the scope of this analysis. Themes that have emerged from the analysis will however be subjected to assessment for accuracy and consistency with current literature, evidence and practice in the next stage of the *Our Healthcare Future* process.

Findings

Improvement Area 1 – Better Community Care:

Reform Initiative 1: Increase and better target our investment to the right care, place and time to maximise the benefits to patients.

Consultation questions:

1. *How do we target our current investment as well as future investments in health to ensure a sustainable and balanced mix of services is delivered across the whole of the health system to provide right care in the right place at the right time?*
2. *How can we shift the focus from hospital-based care to better care in the community?*
3. *How can we facilitate increased access to primary healthcare, in particular:*
    a. *After-hours and on weekends*
    b. *In rural and regional areas*
    c. *For low-income and vulnerable clients*
    d. *For extended treatment options (urgent care or non-emergency care)?*
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?*
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?*
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?*
7. *How can we improve integration across all parts of our health system and its key interfaces (eg primary health, mental health, disability services, aged care and acute care)? What should be our priorities for integration?*
8. *How can we strengthen the interface between hospital services and aged care to improve community healthcare for older Tasmanians?*
9. *How can we make the best use of co-located 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?*
11. *How can we better incorporate preventative health and health literacy into current and future care, across the range of settings, including acute, community, primary and private?*
12. *How do we provide clear pathways into our health system so that patients are accessing the most appropriate care to them?*

Right Care, Right Place, Right Time

Themes emerging across stakeholder perspectives

Across stakeholder perspectives there was support for establishing a balanced mix of services delivered across the whole of Tasmania's health system.

It was highlighted that current and future investment in the health system should be based on analysis of existing data, current population health needs and projection of future health needs, along with consultation with consumers, health professionals and local communities.

Feedback noted the need to invest in services outside of acute hospitals, with a particular emphasis on the need to bolster prevention, care for people with chronic disease, primary care and community care services. Examples of community care services included community palliative care and community mental health services, District Hospitals, community rapid response services, hospital in the home services, out-reach and community nursing services. It was however noted that any investment in primary and community care should not diminish investment in acute care.

Consumer perspective

Submissions offering a consumer perspective tended to combine feedback relevant to questions 1 and 2, with a primary focus on establishing community models of care. Analysis of this feedback has therefore been provided at question 2.

Clinician perspective

Feedback noted the need for current investment to be based on health and population data (including population demographics such as age, socioeconomic status and chronic disease burden) and the current needs of the community. The importance of targeting future investment to meet projected and emerging demand was also highlighted.

Feedback proposed that increased investment was required by the Tasmanian and Australian Governments across prevention (in particular prevention of chronic illness), primary, community and acute care.

It was highlighted that the Tasmanian Government could not afford to continue to simply fund acute care beds and people should not continue to be hospitalised if this could be avoided through better investment in primary care and prevention of chronic illnesses. It was however noted that any increased investment in areas outside of acute hospitals should not come at the expense of the acute sector. It was noted that the acute sector required continued investment to ensure sufficient beds to meet demand across the state.

The need for funding models to support people to access GPs and other primary care providers including allied health services was highlighted. It was noted that most healthcare is delivered outside of hospitals and primary care providers are critical to reducing demand on acute care. Submissions noted primary care is highly dependent on Federal funding delivered through fee for service schemes, and that when funding is not adequate to cover all costs to deliver these services providers need to apply a fee to cover the gap. This often means that people on low incomes cannot afford to access care through a GP, including referrals to allied health services, or are unable to pay out-of-pocket expenses to access allied health services directly, resulting in poorer health outcomes and the need to seek care at emergency departments (EDs).

The need for continued investment in services outside of the acute hospital system was also highlighted. This included District Hospitals, community nursing, community rapid response and hospital in the home services, outreach services (outreach from hospitals and in-reach into community services – including medical, nursing and allied health), community palliative care services, including 24/7 access for GPs to specialist palliative care services to assist with treatment of patients in the community, community alcohol and drug services, and community mental health services, in particular innovative diversion and alternative mental healthcare models in the community.

Challenges relating to increasing rates of chronic illness and an ageing population were also highlighted, signifying a need for investment in geriatric care including for example psychogeriatrics, geriatric trauma and dementia care, and increased clinical support to residential aged care.

Service provider perspective

Submissions indicated support for targeting current and future investments to better deliver the right care in the right place and at the right time. In particular, the need for investment in services outside of the acute hospital system, with particular emphasis on prevention and management of chronic illness and the opportunity offered by models of anticipatory care and primary care, was identified.

Sector perspective

Submissions supported the goal of building capacity and capability across the whole of the health system, with a particular focus on community-based care. Respondents cautioned against *Our Healthcare Future* being about more beds in hospitals.

It was proposed that historically during times of pressure on public hospitals, Tasmania had defaulted to increasing investment in emergency and acute care, often at the expense of investment in substantial long term community care. The gap in community care was viewed as a major contributor to the current dependency on hospital beds. It was suggested that unless this is addressed the same challenges will continue. Sub-acute care was a particular gap highlighted. As a result of gaps in this type of care, people spend prolonged periods of time in acute inpatient beds because they cannot move to sub-acute care (rehabilitation, palliative care, geriatric evaluation and management and psychogeriatrics). The need to build sub-acute capability in Tasmania's health system was therefore highlighted, including sub-acute inpatient beds and sub-acute community care models, such as rehabilitation in the home. In addition to sub-acute care, submissions identified a need for other community care models, including hospital admission risk programs and health independence programs (noting both models currently operate in Victoria) and hospital in the home. Further it was noted that models such as hospital in the home can play a role in community care for people with complex chronic conditions by supporting the transition of people from hospital back into the community and ensuring the person's GP is involved and engaged in this transition to reduce unnecessary readmissions to hospital.

Submissions also highlighted the importance of investment in prevention more broadly to improve population and treatment outcomes and support the right care, at the right place and at the right time.

Health policy/whole of system perspective

Submissions supported targeting investment to ensure a balanced mix of services. It was suggested this requires a shift in spending beyond hospital-based care to community care and needs to include the full range of allied health and social services and supports that hospital-based care currently provides. It was noted that in addition to a bed, hospital-based services provide free, onsite diagnostic and allied health services in environments that are physically safe and personally supportive. It was submitted that any targeting of investment to community care needs to consider these factors and find a way to provide for them in the community setting. It was noted that discharge from hospital for Tasmanians on low incomes can mean loss of access – due to cost, lack of mobility or social isolation – to basic health monitoring (eg blood pressure), scans, physiotherapy, safety features such as bars on toilets and showers, regular meals or a friendly face.

Value-based healthcare was offered as an approach to identify the health outcomes that matter to patients relative to the resources or costs required. It was suggested that value-based healthcare provides a mechanism for supporting the pursuit of sustainable health services, while also providing a patient centric way to design and manage health systems. It was also noted that assessing outcomes and costs should not be confined to single episodes of care, rather a longitudinal view of a person's sequence of healthcare encounters should be used to properly assess the outcomes realised and the costs incurred.

Shifting the Focus from Hospital-Based Care to Better Care in the Community

Themes emerging across stakeholder perspectives

Overall, there was support for shifting the focus from hospital-based care to community care. A range of suggestions were offered as to how this could occur. These included supporting consumers to access and navigate the health system through new initiatives such as community driven health hubs, development of health connector roles within existing services, continuation and expansion of community rapid response and hospital in the home services, prevention and early intervention initiatives that reduce avoidable hospital admissions such as chronic disease self-management programs, anticipatory care models and coordinated care, and early discharge planning to prevent unplanned readmissions following discharge from hospital.

Consumer perspective

Shifting the focus from hospital-based care to better community care was a primary focus of submissions offering a consumer perspective. It was proposed that such a shift requires establishment of a community model of healthcare that includes centralised and easily accessible information to support consumers to navigate the health system, community driven health hubs, a proactive model of delivering health services and increased access to healthcare, including after-hours services.

Establishing a community model of healthcare

It was suggested that a community model of healthcare aimed at greater community health and wellbeing and incorporating a whole of community or whole of person approach is needed to make meaningful and long-term improvements to the health of Tasmanians. This should be a proactive model that strives to reduce the burden on hospital and ambulance services by focussing on primary and preventative health, including social prescribing. A community health model was also viewed as an opportunity to provide more outreach care for people with chronic and/or complex health needs. It was proposed this could occur through extending the current community health centres, multipurpose centres and District Hospitals to provide more sub-acute and outreach care for people experiencing chronic and complex health conditions, and extending the capacity of current community rapid response services to enable more people with chronic conditions to receive care through those services.

It was also highlighted that the voice of consumers from a particular area or region where a community model of care is being established is critical for the design and delivery of the services. Also noted was the need for ongoing monitoring and evaluation of the arrangements, to ensure health services remain appropriate given the everchanging nature of patient needs and the delivery of health services in the community to meet those needs.

Further it was proposed that a much stronger and coordinated community response is required to the vulnerable, linguistically or culturally diverse, those with mental health issues and those who are isolated or elderly. It was noted people still need and value the personal connection and a helping hand. Submissions suggested communities want to take ownership of their health and wellbeing and to have a long-term holistic focus on both the health of individuals and the health of their communities through better prevention activities, such as being able to link people socially, through work and recreation-based initiatives. It was also submitted that communities want to have a stronger voice and a say in what services are provided locally.

Centralised and easily accessible information to support consumers to navigate the health system

It was submitted that the health system is becoming increasingly harder to navigate. Submissions noted that while support may be available, consumers may not be made aware of the services or may be given incorrect or out of date information regarding eligibility or pathways. Navigation of the system may also be more challenging for some people within the community, including older people, people who are socially isolated or disadvantaged, people with mental health issues and people with disabilities.

Submissions noted people within the health system (not just those trying to get into the health system) also continue to need support to navigate their way through treatment options, follow-up care, management of medications, transport to and from care and to have their voice heard in relation to what matters to them regarding their treatment and their health more broadly.

Information hubs were viewed as a solution. These hubs would provide centralised information for health consumers which could be accessed in a number of ways, including online, over the phone or face-to-face. Information hubs could also provide a personalised or triage service to give people guidance on what services to access and allow people to have all of their health needs assessed in one place. Tourism information centres were highlighted as an example of a model that could be adapted for this purpose.

Others proposed that further investigation into the development of a healthcare workforce whose primary role is to help consumers navigate and connect with appropriate healthcare providers such as health navigators, peer supporters, care facilitators and health connectors was required.

Community driven health hubs

It was submitted that healthcare is becoming increasingly unaffordable for Tasmanians due to the costs associated with seeing GPs and allied health professionals. In addition, it was noted lack of availability of GPs and allied health professionals can result in an overreliance on EDs for non-urgent or semi-urgent care and people seeking care later than they should, leading to poorer health outcomes.

Community driven health hubs located across the suburbs and regional towns where patients can have all of their health needs assessed in one place were identified as a solution. These were likened to community-based nursing hubs, with more nurse practitioners located across community centres, together with GP clinics and other health services – a one stop shop. Community driven health hubs were viewed as centres that could bring different community services together, provide after-hours service, and follow up people who are receiving treatments and people recently discharged from hospital. It was proposed that these hubs should be community connectors and be proactive in health promotion and should not simply wait for people to come to the hub when they have a problem.

A proactive model of delivering health services

Consumers noted that the current hospital-centric model inadvertently encourages consumers to wait until they are at crisis point to access health services. As a result, consumers are often required to access the most intensive and most expensive treatments at the outset, rather than less invasive interventions that could be offered through a greater focus on prevention. It was noted that when consumers are at crisis point they are not necessarily in the best place to seek help and make informed choices about treatment. Consumers proposed that a proactive model of delivering health services was required, including follow up care for people who are receiving treatments or who have recently been discharged from hospital.

Increased access to healthcare including after-hours

Consumers noted that health services are generally only available 9am to 5pm, Monday to Friday and outside of these hours the only option was the ED. It was proposed that community health services needed to be available 24/7.

Clinician perspective

There was support for shifting the focus to community-based care where appropriate, noting that this shift should not result in reduced investment in acute care. Particular areas of opportunity for community-based care commonly identified in submissions included:

- continuation and expansion across the state of hospital in the home models, including Mental Health Hospital in the Home, and Community Rapid Response Services (ComRRS), along with consideration of expanding the scope of ComRRS and community nursing to deal with urgent care needs in the community and prevent presentation and/or re-presentation to the acute sector, along with increased investment in District Hospitals
- support for GPs to access nursing and specialist medical resources (including 24 hour specialist palliative care support), thus providing greater opportunity for GPs to support more patients in the community without the need for patients to go to EDs because care is not available in the community.

Service provider perspective

Across provider submissions there was support for shifting the focus from hospital-based care to care in the community. Key elements of effective community care programs were considered to include preventative and early intervention practices to avoid unnecessary hospital admission, early discharge planning, collaboration with hospital staff to prevent unplanned readmissions post discharge from acute care, and community rapid response programs to reduce the number of hospital admissions because people cannot access the care they need in the community. It was acknowledged that health professionals are critical to the delivery of community programs, however there is also an opportunity to engage non-clinical staff trained to specific contexts to support the delivery of community-based programs.

The importance of supporting infrastructure to enable a shift from hospital-based to community care was also highlighted, in particular transport to enable people to get to and from healthcare providers in the community.

Sector perspective

Submissions supported a shift from hospital-based care to care in the community. Similar to the consumer perspective, submissions included a focus on investment in hub and spoke models of healthcare such as health hubs – located in communities, with locations informed by community consultation and providing the opportunity to expand social prescribing. Submissions also highlighted the opportunity to build on the strengths of existing local health and community services (including local government), infrastructure and networks to support improving the health of Tasmanians, and highlighted potential opportunities for anticipatory care frameworks and the development of local health connector hubs.

Submissions also highlighted the need for sustained investment in care delivered in non-hospital settings, including community settings with primary care providers, in homes and in residential aged care, and community palliative care.

Submissions also identified the importance of considering the needs of particular population groups in any future healthcare reform, including (but not limited to) Tasmanian Aboriginal people, LGBTIQ+ and culturally and linguistically diverse (CALD) communities. Also highlighted was the need for service policies and practices to be respectful of identity and culturally safe.

Health policy/whole of system perspective

It was proposed that better community care required a shift from hospital-based care to focussing on integrated care in the community, improving health promotion, prevention of ill-health and disease, improving health literacy, and a redirection to keeping people from becoming severely ill in the first place.

A shift in focus from hospital-based care to better care in the community was said to require:

- a change in focus and resources to focus on health promotion, ill health and disease anticipation, and prevention and early detection and intervention, in order to keep health issues from emerging in the first place or keeping them at a level of urgency that can be addressed at the community level and outside the acute care system
- acknowledging and addressing existing inequities in health outcomes and inequities in access to all elements of healthcare systems, including primary, specialist, mental, dental and allied healthcare, diagnostic services, and social support services.

It was asserted that inequities in health outcomes are due to factors such as high rates of chronic illness and associated high rates of adverse lifestyle factors, and high levels of disadvantage experienced by some Tasmanians. Inequities in access to healthcare arise for example when people on low incomes are not able to afford primary healthcare due to lack of bulk-billing GPs and cannot afford for example costs associated with prescription medications and out-of-pocket expenses for diagnostic services, specialist consultations, dental care, and mental health and allied healthcare.

Increasing Access to Primary Healthcare

(after-hours and on weekends; rural and regional areas; low income and vulnerable clients and extended treatment options)

Themes emerging across stakeholder perspectives

Submissions supported the need to increase access to primary healthcare. Inequities arising due to people on low incomes not being able to afford primary healthcare and challenges associated with the current bulk-billing system were common themes identified across submissions.

Consumer perspective

Submissions noted that people often could not access and/or afford to pay to see a GP and instead might end up seeking care at an ED. Submissions also noted a need for access to after-hours community services, particularly on the North West Coast. Community driven health hubs were proposed as providing a potential solution to increasing access to services, including access to primary care and after-hours services.

Clinician perspective

Submissions offering a clinician perspective proposed a number of opportunities to increase access to primary healthcare after-hours. These included working with existing medical practices and after-hours services to build on current services and infrastructure to increase access to care, and financial incentives for GPs to cover all costs associated with operating after-hours and on weekends (including costs associated with nursing and administrative staff required to support general practice operation).

The need for GPs to be able to access after-hours pathology and medical imaging in the private or public system to help prevent GPs transferring patients to hospitals to access these services was also highlighted.

Submissions also considered opportunities to increase access to primary healthcare in rural and regional areas, including:

- appropriate resourcing of GPs to increase services to these areas, such as a rural item on the MBS rebate (it was noted that this was not a state responsibility) and appropriate renumeration of GPs servicing District Hospitals in rural communities by the Tasmanian Government
- establishment of a robust multi-disciplinary staffing model for District Hospitals to enable community members to access a broader range of primary healthcare in their local communities
- continuation and expansion of telehealth services in rural areas through District Hospitals or other existing public sector infrastructure to enable better access to medical and specialist staff.

It was suggested that improving access to primary healthcare for vulnerable people and/or people on low incomes required people to be able to access bulk-billed services. Submissions noted people often present to EDs because they cannot afford the out-of-pocket or gap fees charged by GPs. GPs often apply a gap fee to cover costs that are not currently provided for in the existing Federal funding scheme. It was submitted that addressing this situation would either require a change to the Federal primary care funding model to enable GPs to bulk bill and have all costs covered, or a mechanism to provide funding to people so they can pay for GP visits, such as an allowance for concession card holders (in addition to existing concessions) for a defined period of time or defined number of GP visits per year.

Service provider perspective

Submissions highlighted the need for sustainable resourcing for primary care across the three tiers of government and the opportunity for partnerships across providers and funders to take primary healthcare to at risk groups.

Transport was also highlighted as a factor that needed to be considered in supporting people to access primary healthcare.

Sector perspective

Sector responses tended to consider improving access to primary healthcare broadly through responses to questions 1 and 2. Some submissions did however highlight particular issues relevant to their sectors, for example, the need for comprehensive after-hours specialist palliative care support for people in the community and opportunities to improve access to mental health primary care through integration of the public, primary, private and community sectors. This was viewed as a way to address primary care workforce challenges and improve access and expansion of the short-term psychological intervention program to provide greater affordable access to psychological services in the community.

Like service providers, sector submissions highlighted the importance of transport infrastructure to enable people to access primary healthcare.

Health policy/whole of system perspective

Submissions highlighted that people on low incomes cannot afford to access primary healthcare due to out-of-pocket and gap payments to see GPs, for medical imaging, for specialist consultations and to access allied health services. It was noted this needed to be addressed to improve access to primary healthcare after-hours and generally.

A Model of Urgent Care

Themes emerging across stakeholder perspectives

There was support for looking at models of urgent care for Tasmania as part of a broader focus on better community care and as a way of reducing pressure on EDs.

The opportunity to further consider models of urgent care for Tasmania beyond those identified in the Urgent Care Centre (UCC) feasibility study was welcomed. The need to ensure consumers, primary care providers and clinicians – including nursing and allied health – were part of any further consultation was highlighted.

Rather than the model proposed in the UCC feasibility study, submissions suggested looking at new and emerging models and services currently offered through public and primary care providers in the state and the potential to expand on these services to deliver a model of urgent care for Tasmania.

Consumer perspective

Submissions highlighted that wherever possible people want to be treated in the community rather than in a hospital. Initiatives such as urgent care centres were viewed as providing an opportunity to enhance community care.

Clinician perspective

There was support for considering models of urgent care. However, submissions raised concerns about the model proposed in the UCC feasibility study. In particular:

- delivery of urgent care does not have to be reliant on physical infrastructure as proposed in the study, as technology presents the opportunity to explore delivery of urgent care, supported by telehealth and point-of-care testing and diagnostics

- the urgent care centre model identified in the study was limited to larger centres. There is an opportunity to look at options that are not limited to metropolitan areas and that reach rural communities. This could be achieved by strengthening existing services at District Hospitals and community health centres, which are already points of contact for rural communities and have existing links to GPs, rural medical practitioners and a range of specialist visiting services and clinicians. It was further suggested that rural generalist doctors who work across general practice with advanced skills (eg emergency medicine, internal medicine and mental health), allowing them to work in specialty areas and acute hospital secondary care, provide a potential staffing model to support urgent care in both rural and larger centres
- the recommended model in the feasibility study was a doctor-led model. Some submissions highlighted the need to consider nurse-led models of urgent care, drawing on the experience of the Australian Capital Territory nurse-led walk-in clinics and exploration of nurse practitioner and GP partnership models of urgent care
- the feasibility study appeared to assume that an urgent care centre would be able to both meet patient needs and also reduce pressure on EDs at public hospitals. It was suggested it should not be assumed that one model of urgent care will both address patient needs and reduce pressure on EDs at public hospitals. There may be a need for a variety of models of urgent care to support patient needs and help to address access block and overcrowding in EDs
- the study proposed a "no fee" urgent care service. It was noted that the current Federal funding model for primary care makes it difficult for GPs to be able to bulk-bill and cover the costs to deliver care. A "no fee" urgent care service delivered by GPs would require the Tasmanian Government to fund the gap between the cost of the service and the Medicare Benefits Schedule (MBS) payment. Assistance with infrastructure and the cost of nursing and other staff may also be required
- the study did not sufficiently highlight how an urgent care centre would complement rather than compete with existing GP services. It was noted that models of urgent care should not become a substitute for primary care and the first option should continue to be a GP. It was however noted that in some areas accessing GPs can be difficult due to costs and/or availability.

In addition to the points raised above, submissions proposed there was a need to consider new and emerging models of urgent care. This included:

- opportunities to develop models of urgent care that leveraged existing community-based services. For example, trials of community rapid response type services operating out of general practices and/or District Hospitals and better utilisation of current integrated care centres with reviewed medical governance and staffing models, point of care diagnostics and telehealth access to public sector specialists
- a pilot program of grant funding to existing general practices to enable them to extend their scope of practice and operating hours to prevent people needing to present to EDs
- establishment of a short stay unit where patients can stay for up to 24 hours in a GP led surgery, based on the Pegasus Model operating in Christchurch, New Zealand, which offers 24/7 urgent medical and accident healthcare
- developing a new level of care in Tasmania to address the gap between primary and acute care. This could include models of urgent care, community rapid response and hospital in the home programs, quick and easy access to public sector specialists when required and provide care to the Tasmanian community after-hours.

The need for all urgent care models to address the issue of accessing medical imaging and pathology, particularly after-hours, was raised consistently throughout the submissions, along with the need for dedicated funding. It was proposed that funding from EDs should not be diverted to pay for alternatives such as models of urgent care, at least until it could be demonstrated that these alternative models are able to relieve pressure on EDs.

Service provider perspective

Submissions suggested that community care models such as urgent care centres, hospital in the home programs, rapid access to medical specialists locally and telehealth services have been trialled and have been underway across Australia and internationally for over a decade. It was submitted it is time to move from pilots and trials to implementation of these services to provide better community care.

Sector perspective

It was highlighted that in recent times there had been significant change in available health services in Tasmania, including development of general practice service models providing extended urgent care and extended hours walk-in clinics. It was suggested that given these developments the standalone model at the core of the UCC feasibility study may no longer be the right model for Tasmania. Instead it may be more appropriate to build on existing services offering urgent care models.

Health policy/whole of system perspective

It was noted that the UCC feasibility study was focussed on delivery of care in a clinical healthcare setting. It was proposed that a more ambitious approach to improving healthcare and in particular community care would be to strengthen the primary/community health system including community-based service relationships across community sector organisations at the regional level.

Better Use of Telehealth

Themes emerging across stakeholder perspectives

Many stakeholders chose to provide feedback in relation to better use of telehealth services in response to questions relating to Improvement Area 2 – Modernising Tasmania's Health System.

Those who provided feedback were positive about the potential opportunities that telehealth services offered to improve access to care across Tasmania. Submissions did however highlight that while telehealth was appropriate in many settings and for many people, it was not always the best option for all people and it should never completely replace face-to-face care.

Consumer perspective

Submissions supported continuing and expanding telehealth service options, and drew on Tasmania's positive experience using telehealth to access healthcare during the COVID-19 pandemic. The potential for telehealth services to enable greater access to specialists without the need for people to travel to main centres to attend specialist appointments was also highlighted.

It was noted that the survey conducted by Health Consumers Forum of Australia in March/April 2020 identified that 82 per cent of consumers surveyed found telehealth services to be excellent and of good quality. It was however identified that barriers to accessing telehealth services included unreliable and unaffordable internet services, lack of awareness of telehealth as an option, no access to the required technology for consumers to participate in telehealth services, and telehealth services not always being flexible enough to meet the needs of diverse consumer groups.

It was further noted that a survey conducted by Health Consumers Tasmania (HCT) in mid-2020 found that of those who participated in the survey, 90 per cent had heard of telehealth, yet only 68 per cent knew how to use telehealth. People who did not know or were not sure about telehealth were more likely to be older (over 75) or were twice as likely to have finished schooling at year 11 or below. Those who did report using telehealth were either very satisfied (40 per cent) or satisfied (46 per cent).

It was proposed that further extension of telehealth services would need to address the barriers identified above and would require continued funding of telehealth services through the MBS to ensure access to these services through health professionals.

Clinician perspective

Submissions supported the use of telehealth, however the extent to which telehealth services should be embraced varied across submissions. Some focussed on the importance of telehealth augmenting rather than replacing care, and the continued need for face-to-face consultations. Others drew on the positive experience of telehealth to deliver healthcare during the COVID-19 pandemic and the opportunity to build on this experience. Some examples identified included:

- building on the current use of telehealth as part of nurses and midwives' usual practices, especially as part of follow-up care and/or disease management
- further exploration of the broader application of telehealth, including the role it plays in supporting access to preventative care services and improving the standard of care delivered
- consideration of the role telehealth could play in best practice hybrid models combining face-to-face and telehealth, particularly in relation to allied healthcare
- introduction of telehealth co-ordinator positions in each health district/service and the use of telehealth champions, such as allied health assistants, to support access to telehealth services.

Some of the challenges highlighted in relation to telehealth services included low levels of health and digital literacy amongst patients and consumers, health professionals and the Tasmanian community.

Service provider perspective

Submissions noted that the provision of telehealth services in local communities required continuation of the relevant MBS item number that had been established during the COVID-19 pandemic. This was essential to enable a local health practitioner to be available alongside a patient when connecting to specialist, diagnostic or other services.

Sector perspective

Submissions expressed support for a statewide approach to telehealth and virtual healthcare which brings together Tasmanian and Australian Government initiatives, as a way to significantly improve patient care and experience and increase access to primary and community-based healthcare.

Responses highlighted the use of technology, such as the internet and telehealth, as important for prevention and treatment approaches and as a potentially effective tool for reaching new or hard to reach communities, including people in rural areas or people with inequitable access to healthcare services. Submissions also recommended continuation of a mix of preferences in the way services and supports are delivered to consumers, with further consideration being given to best practice in telehealth for mental health consumers along with the suitability of telehealth for particular cohorts, such as CALD, Tasmanian Aboriginal people and young people.

Like others, sector submissions identified the need to acknowledge and address digital literacy, user skills to access equipment and costs of internet access and usage. It was submitted that digital literacy and digital access should be addressed alongside the implementation of a telehealth strategy. Submissions also noted the importance of further consultation with stakeholder groups to identify and address the barriers to the uptake of telehealth initiatives.

Health policy/whole of system perspective

It was suggested Tasmania needed to shift towards adoption of an approach which included telehealth as a model within the broader suite of virtual healthcare. It was proposed that virtual healthcare provides care at a distance and is more than using telephone and video calls as a substitute for traditional face-to-face care. It includes a diversity of technologies and models of care that are integrated to support health system reform that is patient centred, outcomes focussed and sustainable.

Sydney's Royal Prince Alfred Virtual Hospital was provided as a positive example of virtual healthcare. This initiative combines the Sydney Local Health District's integrated hospital and community care with the latest digital solutions, offering an alternative, sustainable solution to increasing demand for healthcare, and acting as a bridge between hospital specialist services and patient care in the community.

The challenges of digital exclusion experienced by people in the Tasmanian community was also highlighted. It was suggested that current telehealth arrangements frequently do not take account of digital exclusion, in particular Tasmanians on low incomes who do not always have access to digital services or the ability to use digital services effectively.

Better Use of District Hospitals

Themes emerging across stakeholder perspectives

The opportunity to enhance and strengthen the role of District Hospitals in the Tasmanian health system was recognised and supported across all stakeholder perspectives. Some submissions focussed on the role of District Hospitals in reducing demand and pressure on EDs and acute public hospitals. Others tended to look at the role of District Hospitals in improving access to care in community settings and the broader role these facilities could and did currently have within communities.

Consumer perspective

District Hospitals were identified as an important component of community care and community health models and were viewed as potential locations for community health hubs. District Hospitals were also seen as facilities that could support early intervention and access to care when a person's health first starts to deteriorate, particularly for people with complex conditions and/or chronic illness. It was proposed this could occur through step-up care from the community into sub-acute care at District Hospitals, along with increased in-reach specialist care to those facilities.

Clinician perspective

A theme across submissions was the opportunity to build the capacity of District Hospitals to offer holistic community-based healthcare services and enable them to operate at full potential, including step-up/step-down community-based services and primary health services to meet the needs of the community and to reduce demand on public hospitals. It was noted however that this would require increased investment and clear guidelines and mechanisms to enable easy transfer of patient care between district and acute hospitals.

Some submissions identified that increased staffing across medical, nursing and allied health, along with improving the funding model for the GPs providing care to District Hospitals, was key to expanding the role of these facilities in Tasmania's health system. District Hospitals currently operate with very limited allied health support. Increasing allied health services to deliver rehabilitation and recovery clinics, physiotherapy and speech therapy at these facilities was viewed as vital to improving health outcomes for people in the community and preventing unnecessary transfers to acute facilities.

Some submissions proposed that with increased investment, over time District Hospitals had the potential to offer 24/7 services, like pathology and radiology (or at least remote reporting on radiology), so that when acutely unwell patients presented they could be treated on-site where appropriate. Increased investment would also provide opportunities to introduce additional health services to meet the needs of the community, such as wound and diabetes clinics, health promotion and preventative services, and remote management of chronic health disease.

Service provider perspective

Submissions highlighted the significant and at times under-utilised infrastructure provided through the network of District Hospitals and the potential to use these facilities in different ways to offer care locally rather than at an acute hospital facility.

District Hospitals were considered to play an important role in providing services that support the roles of major acute hospitals by providing sub-acute care, freeing up capacity in the acute hospitals to take on additional patients.

District Hospitals were also viewed as providing a useful model for integrated care, with GPs providing oversight across a continuum from home care to rural hospital admission, including referrals and case conferencing with outreach clinicians, along with visiting services such as medical specialists, child health, pain management and allied health teams. Respondents also noted that these facilities are equipped with video-conferencing technology and can therefore assist with eHealth delivery.

Sector perspective

Stronger investment in District Hospitals and community health centres was viewed as providing an opportunity for a greater focus on rural and community health services.

Increased investment would enable District Hospitals to provide step-down care from acute hospitals and to also be the primary site of care for selected medical conditions within the scope of practice for the treating health professionals located at the site. It was considered that employment of Rural Generalists with an extended scope of practice and special skills in a variety of areas at District Hospitals would enable more complex patients to receive care at these facilities. Support from non-GP specialist services, via telehealth or outreach services, would also assist to provide care for this patient group. Adequate allied health, particularly physiotherapy and occupational therapy, as well as nursing staff with generalist skills was also considered essential. Together, this would support robust emergency care, inpatient care and rehabilitation at District Hospitals.

Submissions recommended further consultation with key stakeholders, including consumers, should be undertaken to consider the role District Hospitals and regional community hubs could play in supporting better healthcare in regional communities.

Health policy/whole of system perspective

Submissions focussed on the importance of asking locals about their needs and the challenges and opportunities for these facilities. This could occur through consultation days in all district hospital communities.

Improving Integration Across Our Health System

Themes emerging across stakeholder perspectives

Few submissions provided specific feedback in relation to improving integration across our health system. Submissions tended to consider integration more broadly in response to questions 1 and 2.

Consumer perspective

Submissions offering a consumer perspective tended not to focus on integration as a separate area of feedback. Responses to questions 1 and 2 tended to include consideration of integration of service areas. One consumer noted the importance of integration between aged care, health and other community services, to ensure that older people continue to engage with their communities and do not become segregated.

Clinician perspective

The need for a new level of integration between acute and primary care was highlighted in some submissions. It was noted that the integrated care centre model was intended to provide a bridge between acute services and primary care services. It was suggested that the integrated care centre model was not resourced sufficiently to achieve its full intent.

Information and communications technology (ICT) systems to enable rapid flow of information across the health system was consistently identified as necessary to support integration across the Tasmanian health system. Better ICT systems were considered to lead to better communications across areas, which in turn would lead to better outcomes for patients. Examples provided of information exchanges which would benefit from improved ICT systems included from the hospital system to primary health and aged care on discharge of patients, from primary health and aged care into the hospital at time of admission/transfer, and better links between the hospitals and community services, including mental healthcare.

Other suggestions for improving integration of services included:

- expanding in-reach services into residential aged care through ComRRS to prevent acute admissions and provide education and training to build capacity of residential aged care providers
- models of care provided in the home, through general practice or in residential aged care facilities, with defined mechanisms that enable escalation to specialist and/or acute care quickly and easily if required
- presence of appropriately resourced community nursing teams to provide follow up and ongoing care to prevent recurrent admissions and allow for ongoing management of chronic diseases
- dedicated case managers to provide integration across a number of services for complex patients
- mental health GP liaison officers who are employed within specialist mental health services and help GPs to provide mental healthcare
- drawing on the clinical networks currently operating and models that have previously operated such as clinical advisory groups (CAGs), develop conditions groups to come together (for example diabetes, renal and cardiovascular disease) and bring together all key stakeholders that have a role in the delivery of care for a particular condition across the Tasmanian health system. It was also proposed that the clinical network model could be used to strengthen integration across particular sectors, with an aged care clinical network being suggested.

Service provider perspective

There was support for looking at opportunities to improve integration across the health system. It was noted that the voice of stakeholders was important to improving integration, in particular the voice of the consumer.

It was also considered that a better understanding of the different parts of the health system and their interrelationships by all stakeholders of the health system could be useful to improving integration across the health system. It was proposed that an integrated communication strategy would be useful to contribute to this understanding. Improved booking and scheduling systems and integrated health records were also identified as possible opportunities to improve integration.

Sector perspective

Some submissions considered integration of mental health and alcohol and drug services a priority, suggesting that substance use and mental ill-health are two key comorbidities that interplay and require extensive support and care. They highlighted that operation of these services in Tasmania is currently siloed, with limited integration.

Health policy/whole of system perspective

Person-centred, team-based models of care were proposed as a strategy for improving integration and addressing the inherent interdependency and increasing complexity of healthcare. Also highlighted were the need for priority setting and shared action with patients across settings broader than healthcare.

Care coordinators or system navigators were also identified as important for some individuals for whom support at the interface with the health system is needed and to support integration across the health system.

Strengthening Interface Between Hospital Services and Aged Care

Themes emerging across stakeholder perspectives

Few submissions provided specific feedback in relation to strengthening the interface between hospital services and aged care. Submissions tended to consider this more broadly in response to questions 1 and 2 and consequently not all stakeholder perspectives are identified below.

Clinician perspective

The interface with aged care was viewed as being disjointed, particularly between residential aged care and hospital services, and impacted by the current funding arrangements. While aged care is Federally funded and governed, older Tasmanians access healthcare services across the health system run by the Tasmanian Government.

It was suggested that Federal funding schemes to renumerate GPs to provide services into residential aged care facilities are inadequate and if funding was strengthened to cover all costs for GPs, GPs could increase services into residential aged care facilities. Without GP services into residential aged care facilities, residents can end up in EDs and being admitted to public hospitals, and the process for residents to return from hospitals to their homes in residential aged care facilities can be long. This is not good for the person and puts pressure on the hospital system.

Examples provided of ways to improve the interface with aged care included drawing on existing services that could expand their scope with increased investment to operate in residential aged care facilities, such as the ComRRS, hospital in the home and specialist palliative care services. This would enable people to stay in the facility (their home) and not have to be hospitalised.

Sector perspective

Submissions proposed the Tasmanian Government work with the Australian Government, health and aged care stakeholders and older Tasmanians as a priority to ensure aged care residents have equal access to health services.

It was suggested that continuing communication between hospital-based services and primary care providers in relation to older patients was important to improving aged care outcomes. When people are admitted to hospital from residential aged care facilities they may have unique challenges and often have extensive comorbidities. Their GP is likely to be the best source of information and well placed to assist with the care delivered in hospital. Communication between the admitting consultant and the primary GP would be beneficial to clarify health status, goals of care, any Advance Care Directives (ACDs) and plans to transition back to the community. Whilst admitted, comprehensive geriatric review and input from specialist clinical nurse consultants would be a beneficial service for the THS to offer appropriate patients.

It was also proposed that on discharge, a medication summary, separation summary and verbal clinical handover to the GP and residential aged care facility from the hospital would improve continuity of care.

Health policy/whole of system perspective

Submissions noted integration required person-centred, team-based models of care, as well as priority setting and shared action with patients across settings broader than healthcare. A system-wide approach to enabling team-based care should focus on:

- population health planning and data driven models of care, with practices and services engaged in this process at the local level
- clinical governance, with frameworks that span and link jurisdictional and professional boundaries and provide local ownership and shared agreement of the care to be provided
- person-centred data and interoperable technology, with the use of indicators and measures embedded in clinical workflows, enabling real-time, shared goal settings and decision making with the patient across sectors
- investment in physical infrastructure, creating environments where teams can share and collaborate
- workforce development, fostering capabilities such as co-design, data analysis and quality improvement and technology that support team-based care, with placements available to students to allow them to experience how high-functioning teams work
- funding models which incentivise the use of indicators and measures in routine clinical practice, support participation in population health planning and provide greater flexibility in how teams achieve the desired outcomes.

Best Use of Co-located Private Hospitals

Themes emerging across stakeholder perspectives

Few submissions provided specific feedback in relation to using co-located private hospitals to avoid public hospital presentations and admissions by privately insured patients. Consequently, not all stakeholder perspectives are identified below.

Clinician perspective

Some submissions highlighted the opportunity for sharing of infrastructure and staffing with co-located private hospitals. Others outlined concerns in relation to loss of revenue for the public hospital private patient scheme, which in turn will reduce the income of public hospital medical practitioners and may lead to public sector doctors leaving the public system.

It was also noted that privately insured patients can present to public hospitals to avoid paying an upfront gap fee required at private hospitals. Public hospitals may also be the only facility that have the specialist expertise required to care for a patient. For example, privately insured patients will be directed to go to public hospitals if paediatric care is required or if a person has had a stroke, as private hospitals in Tasmania are not equipped to respond to these particular matters.

It was further noted that the service profile for co-located and all private hospitals needs to be well understood, along with the supporting staffing models, and there is a need to ensure that staffing requirements for both public and private hospitals can be met.

It was suggested development of a memorandum of understanding (MoU) or similar agreement between public hospitals and co-located private hospitals may be helpful to clearly define patient pathways for transfers between public hospitals and private hospitals. This was suggested as a way to ensure quality patient care and that transfer can occur without unnecessary delay.

Health Literacy, Self-Management and Preventative Health Approaches

Themes emerging across stakeholder perspectives

There was a very high level of consistency of feedback from stakeholders in relation to health literacy, self-management and prevention. Consequently, responses to questions 10 and 11 have been combined and presented together in this section.

Respondents put forward a wide range of evidence and examples of successful prevention programs and called for a stronger focus on this area. Common themes across stakeholder groups included:

- a desire for prevention programs into the future to be holistic and sustainable
- a focus on health information and health education, particularly in community settings
- support for health professionals to integrate health promotion into daily practices
- building upon existing services and organisations that have demonstrated positive outcomes
- calls for a stronger focus on the social determinants of health and Health in All Policies approaches.

Consumer perspective

Feedback called for a stronger, more coordinated approach to preventative health. There was also an emphasis on the provision of tailored support services for vulnerable groups, such as people living with mental illness, LGBTIQ+ and CALD groups.

There was also a very clear message in regard to the importance of health education, with consumers indicating that they want to be supported to take ownership of their own health and wellbeing through better prevention. It was felt that an important element of this would be incorporating community perspectives into prevention programs.

Another clear theme to emerge from a consumer perspective was the importance of taking an intersectoral approach to prevention, that draws on portfolios that sit outside of the health sector, such as housing, education and employment. This was in recognition of the social determinants of health and the potential for Health in All Policies approaches to address this.

Several practical suggestions were put forward by consumers that centred around the theme of health education:

- public education programs to improve health literacy, self-management, and prevention
- united messaging from health professionals on healthy lifestyles (eg physical activity)
- the provision of healthy lifestyle classes in community settings (eg Active Launceston).

Clinician perspective

There were calls from a clinical perspective for a greater focus on and investment in prevention and primary healthcare. This included intersectoral action or Health in All Policies approaches to address the social determinants of health and reduce health inequities. A range of evidence was put forward by respondents in support of preventative health strategies at all levels of the healthcare continuum, including evidence of cost-effectiveness.

A number of respondents felt any additional investment should be targeted at building upon existing services and organisations where good outcomes have been achieved, rather than introducing new reforms or strategies. Respondents saw this as more likely to be cost efficient and yield better results. An example would be funding more school nurses to allow opportunities to build upon the current health education program and ensure this continues into primary and secondary education.

Potential priority areas identified from a clinician perspective included:

- expanding child health and parenting services to include other cohorts of families and children
- preventative and restorative oral health services, with a focus on the early years
- health literacy programs across the lifespan
- preventative health screening and early intervention
- ensuring equal access to healthcare for vulnerable groups (including health literacy strategies)
- improving health information, including communication and translation
- effectively promoting existing services, including the consideration of "linking persons" or "health connectors" who have a role in supporting people to access available services
- health education programs in workplaces, schools and other community settings (eg Neighbourhood Houses, multicultural organisations and Tasmanian Aboriginal groups)
- supporting health professionals to work to their full scope of practice (eg pharmacists)
- falls prevention programs for older Tasmanians
- anticipatory care models, such as those funded under the Anticipatory Care Project
- consideration of new funding models/remuneration that focuses on health outcomes
- programs that respond to emerging evidence of the impact of Adverse Childhood Experiences (or childhood trauma) on future health and wellbeing outcomes.

There was a clear theme around the need for greater support and investment in the health workforce to support its ability to deliver prevention initiatives. This included funding (and backfilling) staff to attend training programs and managing workloads so that staff have the capacity to build prevention activities into their day-to-day routines. The employment of additional Clinical Nurse Educators to deliver education and training and provide clinical support to other staff was also suggested, as was building a positive workplace culture around prevention. Another specific suggestion was the continued investment in rural general medical training, including a drive towards a preventative and early intervention model delivered by generalists.

Overall, there was consensus that prevention strategies need to be sustainable and holistic, embedding prevention across the entire health system, from governance and decision making through to the delivery of patient care. This includes a focus on health education, building health literacy and improving modifiable risk factors that are contributing to chronic disease in Tasmania.

Service provider perspective

Again, education was a key theme, together with the direction of greater resourcing into the provision of community education campaigns. Another recurring theme was that existing health promotion services are seen to be working well, but that further investment is needed to ensure they keep pace with the needs of the community and changes in policy and programs, and can extend into high needs areas, such as regional and rural communities.

Emerging issues and priorities identified from this group of stakeholders included the expectation that post COVID-19, there may be a rise in the need for health and wellbeing supports amongst the community as the full social and economic impact of the pandemic is felt. In line with this, the need for greater mental health promotion and prevention activity was highlighted, as was the need for greater investment in peer-led health promotion programs.

Sector perspective

There was very strong recognition of the importance of preventative health. Several submissions put forward peer-reviewed evidence that investment into the prevention of ill-health can alleviate pressure elsewhere in the system, from primary through to acute health services. In other words, respondents felt that preventative health should be viewed from a system perspective, with the knowledge that pressure on one part of the healthcare system affects all other parts of the system.

In line with this view, there were calls for greater investment in preventative health. Investment in preventative health was seen as a key element in ensuring the sustainability of the health system. The Alcohol Tobacco and Other Drugs (ATOD) sector provided the example that investment in ATOD prevention can provide broader benefits across generations, and different areas of a person's or family's life (eg personal and social dysfunction and legal issues). ATOD primary prevention strategies aim to shift focus to "upstream" by helping people to avoid, reduce or modify drug use, rather than reacting to subsequent "downstream" problems that require acute and sometime emergency response.

In line with other stakeholders advocating for a Health in All Policies approach, there was a consistent view that action is needed to target the social determinants of health, and that a coordinated, holistic response is needed at a whole of government level. Other themes that clearly aligned with other stakeholders included the need to focus strongly on education and the creation of healthy environments, and to continue to build on existing prevention efforts rather than 'reinventing the wheel'. For example, a range of successful prevention programs were identified for further investment including the *National Strategic Framework for Chronic Conditions* as an overarching policy direction that is already in place on the prevention and management of chronic disease in Australia.

There was also a clear view from a sector perspective that further effort needs to be invested into integrating preventative health strategies into the day-to-day practices of clinicians working within acute health settings. This included establishing referral pathways from health professionals to community organisations that can support individuals to positively self-manage their own health. The provision of brief advice on health risk factors from health professionals during occasions of service was also suggested (eg Ask, Advise, Help) as was supporting the broader uptake of cardiovascular risk assessments as a part of routine care.

Health policy/whole of system perspective

There were calls from a health policy/system perspective for a greater focus on preventative health strategies through *Our Healthcare Future.* Specific programs that were put forward for greater investment included health information resources within communities, health literacy education programs, and health and wellbeing services within communities.

To effectively build health literacy, self-management and preventative health approaches, it was suggested that Tasmanians need to be supported to think of themselves as healthcare decision makers, not simply passive consumers, and that individuals and communities need to be engaged in the identification, mobilisation, co-design and delivery of appropriate support services. A part of this would be to ensure that programs address the health-related behaviours, beliefs, barriers, experiences and emotions of individuals, and include appropriate social support.

To support individuals to self-manage, it was felt that devices and other resources need to be made available at little or no cost, to empower disadvantaged Tasmanians to access digital healthcare and information. Expanding the rollout of community-level digital literacy initiatives was suggested, including coaching and mentoring to empower digitally excluded Tasmanians to access digital healthcare and health information. To support this, a potential idea put forward was to extend Tasmania's concessions scheme to include telecommunications.

There was further feedback that self-management relies upon a focus on the autonomy and the actions of individuals. However, the underlying drivers and determinants of self-care capability are influenced by a range of environmental, economic and social factors that sit beyond the individual. Therefore, it was felt that building health literacy and self-management approaches requires broader consideration of the environments that either inhibit or enable self-care at the population level.

Feedback from a health policy/system perspective also put forward ways in which health professionals and models of care can be supported and influenced to adopt self-care:

- clinicians need appropriate measures and monitoring systems to support better self-care
- workforce skills and capabilities need to be in place to provide self-care support across all health services and all settings
- funding arrangements need to be in place to enable collective care (including preventative health and social care interventions) and explicitly support self-care engagement.

Clear Pathways to Access Most Appropriate Care

Themes emerging across stakeholder perspectives

Few submissions provided specific feedback in relation to providing clear pathways into Tasmania's health system so that patients can access the care most appropriate to them. Submissions tended to consider this more broadly in response to questions 1 and 2. Consequently, not all stakeholder perspectives are identified below.

Clinician perspective

Submissions that responded to this question offered a number of suggestions in relation to providing clear pathways into Tasmania's health system so patients can access the most appropriate care. This included enhancing structured pathways and referral mechanisms, providing communication and clear information to front line health professionals and services supporting patients and consumers to access pathways and more broadly so the community was aware of available services, engaging with local communities to identify and define local health pathways, providing mechanisms for coordination of care, and supporting people to navigate pathways to care and access to community-based care options.

It was noted that Primary Health Tasmania (PHT) in partnership with the DoH and the THS has developed Tasmanian HealthPathways (THP), first for use by GPs and now expanding for use by all health practitioners, with a focus on increased use within the THS. This presents an opportunity to identify clear pathways to access appropriate care in appropriate settings across the Tasmanian health system. It was proposed that linking THP to established referral mechanisms might help to strengthen the utility of these pathways.

Ensuring front line health professionals and services had clear information about pathways into the health system, relevant to the needs of patients and consumers, was considered to be important. It was suggested this should include GPs, child health and parenting nurses, children and family centres and other services providing frontline support to vulnerable groups. The importance of communication and education of the broader community about available health services and the need for information to be available in a variety of modes to accommodate varying health literacy levels and community diversity was highlighted. Submissions also suggested engaging with local communities, consumers, clinicians, service providers and other key stakeholders to identify and design local pathways and communicate pathways at a local level.

Potential mechanisms for coordination of care and supporting people to navigate pathways to care were identified. These included supporting GPs as the central point of the health system. GPs can refer patients onto other specialities, allied health, hospital services, pathology and other services, and can coordinate care of the patient and provide dedicated positions to support coordination of care, such as case managers. It was also proposed that incentives and support could be offered to primary providers and community-based services to be guides and to support client and patient access to services and supports beyond their services.

Others identified health connectors as a possible option to facilitate connection and navigation of local health systems and to build health system literacy in the local community. Health connectors were said to work on making it easier for individuals and communities to access, understand and use health information. It was submitted that health connectors have also been shown to be an effective strategy in improving access to health services, particularly for those people who find accessing services more difficult. Health connector models were said to be proving to be effective internationally and nationally and most recently the Tasmanian Anticipatory Care Project 2020 examined local community-based approaches to understand what models of anticipatory care could prevent and reduce the impact of chronic conditions. The project recommended decentralised, flexible and locally driven models of healthcare to empower community led responses that build connections between organisations and localised preventative health responses, including community connectors.

Improving accessibility to community-based services and in particular alternatives to accessing EDs was also viewed as important to ensuring patients had clear pathways to access the most appropriate care for them.

Service provider perspective

Submissions noted that developing and expanding primary care services and addressing issues in relation to access and affordability of primary care services was vital to establishing clear healthcare pathways and relieving some pressure on the acute sector.

Sector perspective

Submissions noted that mechanisms to support patients and families and carers to navigate the complexities of the health system were needed. This included ongoing community education to meet the needs of the community including (but not limited to) vulnerable people, people with limited access to services or limited health literacy, people with disabilities, people from CALD, LGBTIQ+ and Aboriginal people. Ongoing education for people working in health to be able to better support patients and consumers and their families and carers was also highlighted.

Improvement Area 2 – Modernising Tasmania's Health System

Reform Initiative 2: Invest in modern ICT infrastructure to digitally transform our hospitals, improve patient information outcomes and better manage our workforce.

Consultation questions:

1. *How can we best target our digital investment to improve timely sharing of patient information across key health interfaces?*
2. *What digitisation opportunities should be prioritised in a Health ICT Plan 2020-2030 and why?*
3. *What information should be prioritised for addition to the My Health Record to assist clinicians in treating patients across various health settings (eg. GP rooms, Hospital in the Home, Hospital Specialist Outpatients)?*
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?*
5. *What information would help to improve your experience as a patient or consumer interacting with public hospital or health services in Tasmania?*
6. *What technology would best help you to delivery improved patient outcomes?*
7. *How can we use technology to empower patients with their own self-care?*
8. *What is the key paper or manual administrative process that would provide the most benefit to digitise/bring online?*

Targeting Digital Investment to Improve Sharing of Patient Information

Themes emerging across stakeholder perspectives

There was support across stakeholder perspectives for investment in the development of an electronic medical record (EMR). This was viewed as the key mechanism for improving sharing of patient information. There was some variance in the scope proposed for an EMR. Some submissions suggested an EMR should be established across all public sector health services with the ability for other health professionals outside of this sector to view information relevant to patients in their care. Others proposed an EMR across the whole of Tasmania's health system, not just public sector health services.

The need for a digital inclusion strategy so that everyone can access digital healthcare was also highlighted. It was noted that technology has the potential to be a great enabler of healthcare, however it needs to be easy to use, affordable and accessible for all Tasmanians.

Consumer perspective

Submissions highlighted the importance of investment in information technology to provide a seamless, efficient and effective process to access healthcare across Tasmania.

Digital health programs were considered to have the potential to improve care, for example through better coordination of care for complex and chronic conditions, reduced duplication of tests, better informed health professionals and consumers when considering treatment options, supporting consumers to have control of their health and their care, reduced errors in care, and reduced hospital admissions.

The importance of investigating barriers to uptake of current digital health initiatives and information sharing, implementing strategies to overcome barriers and including the consumer voice in this process was also identified.

Clinician perspective

Submissions consistently identified the need for an EMR that provided real time access to patient information across the full spectrum of care as a future digital solution. As noted above, there was some variance in relation to the scope of the EMR. Some submissions proposed that the EMR should operate across all public sector health services, while others advocated for one digital platform that operated across public, private, primary and community services.

Those advocating for an EMR across public sector health services only identified the importance of clinicians outside of these services being able to access the EMR to view information about care provided to their patients. Information commonly highlighted to be available in an EMR to clinicians outside of public sector health services included patient diagnostics, biochemical and physical markers, patient appointments, discharge summaries and referrals.

Some submissions outlined that digital transformation across public sector health services needed to focus on connecting all parts of the public sector health system and including primary health and community-based services, such as District Hospitals and community health centres, and not just acute public hospitals. It was suggested that District Hospitals had not historically been prioritised for investment in digital platforms and technology provided an opportunity to enhance services at those facilities.

Submissions also highlighted that any new systems introduced in public sector health services needed to "talk" to current systems at a regional and statewide level. It was noted that currently many services having their own digital platforms and clinicians are required to access a number of systems to obtain all relevant patient information. This is inefficient and creates potential for patient information to be missed, which can impact on the quality of patient care.

Service provider perspective

Submissions acknowledged that digital technology has the potential to improve the quality and safety of healthcare, the effectiveness and efficiency of interactions between health professionals and consumers, and provide new options to deliver and scale the health system to improve equity of access for remote and regional communities.

Providers did however highlight that care should be taken to ensure digital servicing did not diminish service quality and access. It was important to retain face-to-face services for particular types of care and for consumers or particular community groups who are unable to access care through digital platforms.

Sector perspective

Some submissions highlighted the need for GPs and other primary care practitioners in the community to have access to the same ICT systems that are in hospital environments, including any future development of an EMR, in order to deliver effective quality care.

The need for strategies to support everyone to access digital healthcare also featured in submissions. Some submissions called for the implementation of the Premier's Economic and Social Recovery Advisory Council (PESRAC) interim report recommendations 54 and 55 to address the digital divide as follows:

Recommendation 54 – The State Government, with the support of the Australian Government, should address digital inclusion and equity across Tasmanian communities, including by:

- addressing critical regional mobile and internet black spots
- making available at little or no cost, devices and other resources needed to enable disadvantaged Tasmanians to engage in education, employment and to seek the assistance they may require from support services, regardless of location.

Recommendation 55 – The State Government should expand the roll out of digital literacy initiatives in communities around Tasmania utilising existing networks such as Libraries Tasmania and Service Tasmania.

Health policy/whole of system perspective

The issue of digital inclusion and ensuring all Tasmanians were able to access digital healthcare was highlighted. Possible suggestions to support this included:

- making available, at little to no cost, devices and other resources needed to empower disadvantaged Tasmanians, and the Tasmanian community sector that supports them, to access digital healthcare and information
- expanding the roll-out of community-level digital literacy initiatives, including coaching and mentoring, to empower digitally excluded Tasmanians to access digital healthcare and health information
- extending Tasmania's concessions scheme to include telecommunications.

Health ICT Plan Priorities

Themes emerging across stakeholder perspectives

Similar to information provided in relation to question 1, development of an EMR that provides real time patient information, along with solutions to address low levels of digital inclusion were identified as priorities for a Health ICT Plan across submissions. Continuation of electronic prescribing was also highlighted as a priority for inclusion in the Health ICT Plan.

Submissions also noted the importance of consultation with stakeholders to identify priorities for the Health ICT Plan, in particular consumers, clinicians and local communities.

Consumer perspective

Submissions highlighted the importance of consumers and their supporters being appropriately involved in any digital reform process and provided with education and training needed to effectively navigate and have trust in the systems developed.

Continuation of electronic prescribing was also an area identified for prioritisation in the Health ICT Plan to complement telehealth services and support people to receive care in the community.

Clinician perspective

Similar to question 1, the establishment of a single real-time integrated EMR was consistently identified as a key priority for the Health ICT Plan. It was proposed that this should be a statewide platform supported and promoted by public sector, primary, community and hospital services and should "speak" to alternate services if possible. It was highlighted that consumers often assume that health professionals can already see their diagnostics when ordered by others and correspondence for other clinicians involved in their care, which is not the case.

It was noted that establishment of an EMR will likely take some considerable time and in the interim it was proposed that health professionals outside of public sector health services should be provided with access to information about patients in their care through the current digital medical record operating in public sector health services. Providing access to this system for health professionals outside of the public sector was identified as having the potential to end avoidable admissions by enabling a greater understanding of the patient's medication and condition, tests undertaken, results and treatment provided while an inpatient. This could allow health professionals to provide continued care and to avoid medication errors and duplicate testing.

Other areas identified as priorities for the Health ICT Plan included:

- continuation of electronic prescribing to improve patient care and provide efficiencies across the health system
- digitisation of note taking and record keeping, medication charts and patient vital signs to significantly increase the safety and quality assurance processes by allowing for automated inbuilt triggers for referral and review
- exploring advances in technology to provide better monitoring of a patient remotely and helping to provide better supported care in the home
- improving access to allied health services through digital platforms, particularly in rural and remote settings and more broadly to increase access to preventative health services, including physiotherapy services. For example, frailty and immobility can reduce a person's ability to attend face-to-face appointments, however digital platforms may enable people to participate from their homes
- opportunities to improve interoperability of hospital ICT systems to ensure better integration, for example between ED and other hospital and community ICT systems and better data access for senior decision makers working within EDs to enable reporting on emergency care flow, access and outcomes
- continuation of existing digital platforms such as the Safety Reporting and Learning System (SRLS) operating within the THS for the reporting and management of patient safety events within the hospital system and the ARIA medical oncology system.

Service providers

The importance of consultation with local communities, including health consumers, to identify priorities for the Health ICT Plan was highlighted.

Service providers also highlighted the need for significant investment in ICT infrastructure to enable local facilities, such as community health centres to function effectively and, for example, to utilise telehealth seamlessly to access services, particularly mental health, dementia care, diabetes, health education, and outpatient specialist care. Access to digitised patient records was also viewed as a key component of this ICT infrastructure.

Sector perspective

The development of a Health ICT Plan was supported and viewed as a significant opportunity to support integration of community, primary and acute services through a "joined up" health data and information sharing environment.

Similar to information provided in relation to question 1, investment in solutions to address low levels of digital inclusion in Tasmania through the development and implementation of a digital inclusion plan was a common theme across submissions.

Also similar to information provided in relation to question 1, end-to-end electronic communication that includes primary care referrers and enables general practices to access information about care their patients received while in hospital was also highlighted. The ability for other acute care patient management systems – for example Tas Ambulance – that have no current ability to transfer a patient record to general practice to be integrated into future platforms was also highlighted. It was considered systems that do not integrate with the rest of the health system are a major impediment to communication and integration. It was also proposed that any future ICT infrastructure should include a patient-facing information access portal. This would allow patients to access contemporary information about their care maximising capacity for them to be actively involved in healthcare decision making.

Other priorities suggested for inclusion in the Health ICT Plan included:

- establishment of a GP digital medical record viewer to provide GPs with access to information about care provided by the THS to their patients. The Queensland Health GP Viewer was highlighted as an example, providing all GPs with read-only access to hospital inpatient records relevant to patients in their care
- a Tasmanian telehealth system that incorporates for example Telehealth Tasmania, primary care providers, GP Assist and the THS
- eReferral system rollout in hospital and primary care and integration of eReferral, telehealth and a GP digital medical records viewer platform within hospital, ambulance and community systems
- continued adoption of My Health Record (MHR) across both primary, secondary and tertiary settings. and expanding information entered in MHR to include pathology results and medications, shared health summaries, medications and investigations from GPs and event summaries for EDs, hospital in the home services and outpatient clinics
- digitisation of ACDs. It was submitted these documents need to be accessible immediately by medical professionals and substitute decision makers if a person loses legal capacity. Systems recording ACDs need to integrate with health ICT systems to ensure this happens smoothly.

Health policy/whole of system perspective

Submissions noted that any plans for adoption of digitisation and technology needed to ensure effectiveness, efficiency, equity and sustainability. In particular, consideration needed to be given to smaller, independent service providers such as primary healthcare providers who may find it challenging to adopt digital healthcare platforms at the same pace as larger providers and as the system as a whole. There is a need to ensure advances do not contribute to inappropriate shifts in the provision of care from primary healthcare to hospital care.

Submissions also proposed the importance of being able to measure the value of new technologies by considering if they provide better patient outcomes at an efficient cost. This will ensure the right patients are receiving the right treatments and promote equity in the health system. It was noted that value is only achieved across the whole health system if everyone who needs it can access it.

My Health Record (MHR) Additions

Themes emerging across stakeholder perspectives

Limited use of My Health Record (MHR) was identified across submissions as a challenge to it providing a suitable platform for sharing of patient information, with the aim of improving patient care.

The importance of further consultation with key stakeholder groups in relation to additions to MHR was also highlighted.

Responses to this question were primarily received from stakeholders with first-hand clinical experiences in the use of MHR and consequently not all stakeholder views are identified below.

Consumer perspective

Submissions noted challenges with the current use of MHR. It was suggested that at the beginning of 2020 more than 90 per cent of Australians had an MHR, however only just over half of records had anything uploaded into them and approximately only one in 10 consumers had ever logged in to view their record.

Submissions further noted that the barriers to using MHR needed to be addressed for it to be a helpful platform for sharing patient information with the goal of improving healthcare. The need for consultation with consumers, carers and healthcare providers about the barriers and the information that should be prioritised for addition to MHR was also highlighted.

Clinician perspective

Issues related to MHR not being regularly updated, missing information, not being used, not speaking to the programs that hospital and private clinicians currently use were all identified as challenges to MHR being a good digital solution to the sharing of health information. It was noted clinicians were less likely to engage with MHR if it required using a number of digital platforms in a short consultation time period.

Submissions noted improved supports to assist with the use of MHR – including re-visiting training in the use of MHR, what it includes and how it works – may create an improved understanding of MHR, its role, opportunities and limitations.

Submissions that identified possible additions to MHR to improve sharing of patient information included the following:

- medication listings for patients and particular emphasis on identification of medications that are critical to a person's care. When medication conditions become more complex patients can find it more challenging to manage their medication regimen and this has the potential to compromise care
- radiology and pathology results of patients, any other recent tests and results, correspondence from other treating doctors and allied health staff, and ECGs and other physiological measurements that ambulance officers collect
- list of planned outpatient appointments, referrals in the system and estimates of wait list times based on triage category and separation summaries (available at time of discharge wherever possible and at a maximum within 48 hours of separation from that service)
- clinical notes which provide the additional context of an episode of care the patient received from another practitioner or at a hospital facility

- care plans and associated documents, including for example survivorship plans for people having cancer treatment and ACDs so that they are always available to every clinician involved in care.

Submissions also proposed that as MHR is intended to be a consumer-controlled health record, further consultation is needed with consumers to identify additions to MHR to support the sharing of patient information to improve care.

Sector perspective

Feedback focussed on the need to address barriers to uptake of MHR, including health literacy, understanding the benefits of MHR and privacy concerns. The need to engage with health professionals and community members in a meaningful and targeted way to draw from their experience on how to improve the use of MHR was highlighted.

Submissions that identified areas for addition to the MHR commonly noted the following:

- medication lists, pathology and other diagnostic testing. Patients are frequently responsible for ensuring that test results are available to health professionals and tests are often repeated when this may not have been necessary if health professionals could access this information electronically
- discharge plans to prevent readmission to hospital. Without clear plans there is potential for confusion between health practitioners and the person receiving care, which can result in the person being readmitted to hospital, which may have been avoided
- care plans and associated documents relevant to the person's condition and associated care, such as asthma plans, to help manage this condition and ACDs to ensure care is provided consistent with a person's expressed wishes.

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

Themes emerging across stakeholder perspectives

Submissions tended to consider this more broadly in response to questions 1 and 2, consequently not all stakeholder perspectives are identified below. Common themes across submissions that responded specifically to this question included the need to provide health professionals with access relevant to information about their patients in current systems used by public hospitals and any future EMR systems, to improve the timely sharing of information and the quality of patient care, and the need for secure exchange of information to ensure the privacy of consumers.

Clinician perspective

Similar to responses to other questions, it was suggested that enabling health professionals in the public and private sector, GPs, aged care facilities and community health services to access relevant information about their patients in the current Digital Medical Record system used by public hospitals and any future EMR system would improve the timely sharing of information and the quality of patient care. Information highlighted for sharing included patient medications, hospital admissions and discharges and patient pathology and medical imaging results.

Some submissions focussed on the need to ensure the secure exchange of patient information across Tasmania's health system to provide safe, continuous clinical care, no matter where in the system the patient is receiving care. This should include the use of encrypted communication between parties for sharing of patient information. Many of these platforms are already in use, particularly in the private sector, and may be able to be further adopted across public sector services.

Supporting primary care providers, including allied health professionals, to continually upgrade their digital and data systems, including telehealth and other technologies, was also highlighted. If all providers are not given the opportunity to keep up with changing technology this will create barriers for health professionals to provide services and to consumers accessing services.

Service provider perspective

Similar to the clinician perspective, providers highlighted the need for patient information to be exchanged across the whole of the Tasmanian health system. They noted the opportunity for an e-referral system between primary care and the THS, and mechanisms to enable GPs to view key patient information held by the THS to be being fully extended to community-based health services.

It was also noted that some people do not have ready access to suitable technology for telehealth consultations and the like, or the digital literacy required to use such equipment. For these people digital technology may instead be an extra hurdle they face in accessing health services. Digital technology therefore cannot be used at the expense of patients who require face-to-face contact to be able to access services.

Sector perspective

Submissions supported establishing information sharing systems between hospitals and other care providers, including information sharing models extending beyond primary and public health services and including community sector services.

Information sharing systems were viewed as providing an opportunity to further support and assist in an integrated care approach. Additionally, information sharing systems were considered to minimise the need for a person to repeat their story and to enable a quick response should a person's circumstances change, requiring a higher level of care. It was noted however that in establishing information systems there are several key considerations to address, particularly the privacy and security of the consumer, along with the resourcing and capacity for all parts of the health sector to participate in updating their systems to comply with information sharing arrangements.

Information to Improve Patient/Consumer Experience

Themes emerging across stakeholder perspectives

Submissions noted the importance of consumers receiving comprehensive information in relation to all available care options so they could make an informed choice, along with comprehensive information about care they are provided. Ensuring health professionals can easily access all the information they need in their practice to improve the patient/consumer experience was also highlighted. Again, responses to this question tended to be from stakeholders with more firsthand experience of service delivery, so not all stakeholder views are identified below.

Consumer perspective

Submissions focussed on the importance of health practitioners being able to access information about social supports for consumers, for example a service directory of community sector services so that health practitioners have the tools to enable social prescribing. This is the practice of health professionals linking their patients in with social services to address social factors that are contributing to the patient's poor health. It was suggested this could be supported through a referral pathway built into the existing THP online infrastructure that has been developed and is being used by PHT and the THS.

Clinician perspective

Submissions noted that often patients reported they have had contact with a health provider or had accessed a service but had not understood the outcome or they could not recall who was providing their care. Patients also reported that they are often required to repeat their "health experience" on multiple occasions and do not understand why they have to continue to repeat this information.

Providing patients with information (in a format most suitable for the patient) to reinforce and remind them of their continuing care requirements and an overview of their interaction with the service was suggested. This could include copies of letters, reports, discharge summaries, information about their medications (including what doses they are on following discharge for services) and their test results. The information provided should focus on enabling an understanding of the treatment the patient received in hospital and why, appointments made for follow-up and why these are important to attend. Patients should be informed this information has been shared with their GP.

Some submissions proposed development of a patient portal so patients could access up to date clinical information about their care, which could include upcoming appointments. Current manual mechanisms of providing patients with letters about upcoming appointments can create confusion and often do not account for a change in residential address. Increasing the use of SMS reminders was also viewed as a potential option for assisting with management of appointments.

Support to navigate the health system was also identified. This included updating the DoH website to make it easier to navigate and establishment of coordinators/navigators that could help people to fill out forms to access services, access information in relation to wait times for certain public procedures, and to ascertain whether other approaches and/or choices should be undertaken.

Submissions also highlighted the importance of feedback in relation to a consumer's experience of care and considered that consumer experience questions, Patient Reported Outcome Measures or Patient Reported Experience Measures should be considered routinely to improve patient care.

Service provider perspective

Providers noted that to improve the consumer experience there was a need for real time information relating to access to services (including wait times) to help people make an informed choice about available service options. Wayfinding information systems were also identified as a way to help patients find the location of their appointments and to reduce "did not attend" events.

Sector perspective

Online education and information services, along with digital platforms enabling live chat forums between consumers and health professionals, were identified as mechanisms to improve patient outcomes. An example cited was online antenatal breastfeeding education followed by referrals to the Australian Breastfeeding Association's free Live Chat information service. Online peer support groups were identified as options for consumers to access information to improve their outcomes.

Online portals and/or service directories specific to particular health conditions (for example palliative care) were also proposed as opportunities to improve information about available services and in turn improve the consumer experience.

Technology to Deliver Improved Patient Outcomes

Themes emerging across stakeholder perspectives

Submissions tended to consider this more broadly in response to questions 1 and 2, consequently not all stakeholder perspectives are identified below. Similar to responses to previous questions, establishment of an EMR featured in submissions and was viewed as a mechanism to improve patient outcomes. Again, it was highlighted that not all Tasmanians can access healthcare through digital platforms and this needs to be accommodated in current and future planning.

Clinician perspective

A modern EMR was commonly identified as a platform for improving patient outcomes. The ability to add the following to an EMR was viewed as having the potential for improving patient outcomes:

- uploading of information from monitoring devices directly into the EMR, and where the parameters are outside a set range an alarm can sound and action can be taken accordingly
- digitised medical and vital signs charts and screening tools such as falls assessments
- enabling secure access by GPs to a patient's hospital record and digital inpatient medication charts that feed into separation summaries so that the primary care providers can see what was prescribed upon separation.

Sector perspective

Submissions highlighted that not everyone in the Tasmanian community has the same access and capacity to engage with technology and this needed to be considered. Examples provided included older Tasmanians, people with low literacy, people from CALD backgrounds and people who may not be able to physically access technology due to cost or provider/infrastructure issues in their region.

It was proposed that technology could be used to enable a patient to set up their "circle of care or support" – potentially via an app – which would assist that person to engage with existing supports and reach out for additional supports. It could include the details of primary health carers and community services the patient accesses; family, friends, carers and support people; and appointment details. "Gather My Crew" was provided as an example of an existing digital platform that could be modified to provide this support.

Technology to Empower Patients to Self-Care

Themes emerging across stakeholder perspectives

Submissions tended to consider this more broadly in response to questions 1 and 2, consequently not all stakeholder perspectives are identified below. Submissions that provided feedback in relation to this question highlighted the importance of education and training to support use of technology to empower patients to self-care and strategies to improve digital literacy more broadly.

Consumer perspective

It was proposed that empowering patients to self-care (via technology or otherwise) required appropriate access to training, preventative health education, peer support and the opportunity to extend access to self-care initiatives to the natural support networks of a consumer (that is, their family members and friends).

Clinician perspective

It was noted that new and emerging digital platforms such as wearables, implantable devices, remote health monitoring via mobile phones, big data, artificial intelligence and social media are providing options for the way in which people interact with healthcare services and have great potential to empower patients in relation to their self-care.

Further it was noted that continuation and expansion of telehealth services and online self-management programs helped to enable people, particularly people in rural areas, to access care support to self-manage their health.

Sector perspective

Stakeholder feedback focussed on enabling people to manage their own care through:

- improving digital literacy and involving health consumers and health professionals in designing innovative, patient-centred technology solutions to health management
    - Submissions noted technology is a great enabler, but it needs to be easy to use, accessible and the pitched at the right level. Digital access in Tasmania is still poor and digital inclusion is fundamental to empowering patients to use technology in their own self-care. Affordability of digital technology continues to be an issue for consumers.
- specific investment in awareness raising initiatives that clearly communicate the benefits to the patient of digital health options, overcome barriers to usage, foster peer-to-peer learning including online peer support groups, and provide this information in both digital and non-digital formats
- resourcing and promoting existing community-based technology hubs – such as libraries and online access centres, neighbourhood houses and community centres – as places where people can actively manage their health online
- providing support for telehealth installations at locations in the community where people who do not have computers in their home can participate in a consultation with their health professional
- automatic e-referral for consumers to relevant community care on discharge from hospital and automatic reminders for annual reviews
- easy access to assistive technology to support consumers to self-care and participate in community life.

Key Paper or Manual Administrative Process to Digitise

Themes emerging across stakeholder perspectives

Submissions tended to consider this more broadly in response to questions 1 and 2, consequently not all stakeholder perspectives are identified below. Submissions that provided feedback in relation to this question flagged referrals, discharge summaries and transfers of care as the key paper processes to be digitised.

Clinician perspective

Referrals were consistently identified as a paper-based process that could be digitised. This included referrals from GPs to public hospitals specialists and referrals for medical imaging and pathology.

Hospital discharge summaries were also commonly identified as a current paper-based processes that should be digitised.

Like previous responses, the need for an EMR to enable a real time record of a patient's care and all associated documentation/processes was also consistently identified.

Service provider perspective

The key manual administrative processes identified as providing the most benefit by being digitised were referral and discharge/transfer of care processes. It was considered bringing these processes online would reduce duplication of services, testing and diagnostics; improve triage processes and workflows and efficiencies for referral management; and improve accuracy of information and communication between healthcare providers. This would enhance clinical decision making and improve patient care.

Sector perspective

The need to establish a consistent electronic medical record across the THS to remove manual processes was identified.

Improvement Area 3 – Planning for the Future

Reform Initiative 3a: Co-design a long term health infrastructure strategy for Tasmania.

Consultation questions:

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?*
2. *How should the Government ensure we achieve the right balance of infrastructure investment across the range of care settings including acute, sub-acute and care delivered in the community?*
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?*
4. *What are the key factors that should be considered in the development of modern health facilities in a community setting – eg location, proximity to other community services?*
5. *How do we integrate our capital investment planning with the private sector to help complement and/or supplement the public system?*

Priorities for 20 Year Infrastructure Strategy

Themes emerging across stakeholder perspectives

Not all submissions responded to questions regarding long term health infrastructure, consequently not all stakeholder perspectives are identified below. Submissions that provided feedback highlighted the need for a 20 Year Infrastructure Strategy to be informed by current and future health needs, to consider the health system as a whole and to consider opportunities to build on existing infrastructure.

Clinician perspective

Submissions identified the need for a 20 Year Infrastructure Strategy to be informed by the current and future health needs of the Tasmanian population (including through use of population projections and considering demographics and areas of specific need) and current and future service and workforce models. The importance of stakeholder consultation to inform development of the 20 Year Infrastructure Strategy was also highlighted.

It was noted that the 20 Year Infrastructure Strategy needs to consider the health system as a whole, building on the acute sector's requirements, but also considering future models of care where health services are delivered in the community. It was suggested the opportunity existed to further develop primary health facilities, in particular community health centres, multi-purpose centres and District Hospitals to strengthen and enhance the delivery of services in a community setting. However, it was noted this should not be done in isolation of master planning currently occurring for acute public hospitals. Submissions acknowledged the need for increased investment in primary care infrastructure, along with the need to continue to focus on redevelopment of acute hospital sites.

Submissions focussed on the need for increased investment in appropriate infrastructure for District Hospitals, community health centres and multi-purpose centres to develop facilities to support the current and future range of services to be delivered from those facilities.

A common theme was the need for infrastructure that supports responses to the health needs of an ageing population and the increasing levels of chronic disease, so people can get care in the community and avoid unnecessary hospitalisation.

Infrastructure development in the North West featured in some submissions. Suggestions included retaining and redeveloping the current facilities of the Mersey Community Hospital (MCH) and the North West Regional Hospital (NWRH) through appropriate master planning, development of a new hospital on the North West to replace the MCH and NWRH, and consolidation of services at one site, either by expanding the size of and services offered at either the MCH or the NWRH, or through the development of a new hospital for the North West. Consolidation of services to one site was proposed as an option to reduce duplication of services, assist with recruitment and retention of specialist staff, and decrease the need for ambulance transfers between hospitals.

The need for designated areas/sites specific to patient and clinical needs to be considered in infrastructure planning was also flagged in submissions. This included for example cancer services, outpatient services, palliative and renal care, stroke units and mental health services outside the hospital footprint and in environments conducive to the delivery of mental healthcare. Some submissions also highlighted the importance of infrastructure planning considering management of infectious diseases, in particular COVID-19.

Some submissions highlighted the importance of new facilities being developed in locations that are easy for people to get to and/or the need for new facilities or redeveloped existing facilities to be supported by further investment and development of transport options, to help people access healthcare.

Opportunities to promote the health of staff through infrastructure were also highlighted in some submissions, including natural light, good ventilation and design, breakout areas, gymnasium areas, bike racks, easy to find and use stairs, along with the need for sufficient consultation rooms, teaching areas, clinical research facilities, simulation centres and staff accommodation, particularly in rural areas.

Service provider perspective

A common theme across submissions was the opportunity to build on the existing infrastructure of District Hospitals and community health centres to develop community health hubs for better out of hospital and community care and the need for this to be recognised in a 20 Year Infrastructure Strategy.

Submissions also highlighted the importance of consultation with health consumers and local health workers when developing the 20 Year Infrastructure Strategy.

Like submissions offering a clinician perspective, submissions highlighted the need for a 20 Year Infrastructure Strategy to consider transport infrastructure and options so people can get to services easily, cost effectively and on time.

Some submissions noted that a 20 Year Infrastructure Strategy should consider ways in which non-government services can access infrastructure investment support or can use public sector health infrastructure, particularly as a way to help address service challenges in rural and remote areas. For example, consultation rooms and telehealth facilities at District Hospitals could be developed for use by private service providers to deliver services in rural and remote communities.

Sector perspective

Submissions highlighted the need for a 20 Year Infrastructure Strategy to support care being delivered in the most appropriate setting. This is likely to require development of infrastructure that was flexible, scalable and suitable to respond to a broad range of healthcare needs and changing models of care.

Like service providers, submissions identified the opportunity to explore partnerships with non-government organisations to share the use of state health infrastructure and utilise service co-location where this can support integration of public and community services and the development of new and innovative models of care. This was considered to be particularly important in the areas of complex chronic and rehabilitative care and mental health service redesign.

Some submissions also highlighted that integrated service delivery was a whole of government issue and an integrated approach to health infrastructure planning needed to extend across Government portfolios, in particular health, transport, housing and education. The importance of broad consultation during the development of the strategy and inclusion of external stakeholders in the development process was also a common theme.

Health policy/whole of system perspective

Common themes across submissions offering a health policy/whole of system perspective in relation to development of a 20 Year Infrastructure Strategy included the:

- need for investment in physical infrastructure to align with the redesign of services, to shift the focus from hospital-based care to care in the community, including virtual and team-based models of care
- importance of consulting with communities about local healthcare services, service use, gaps and needs, to ensure infrastructure is available to provide the right care in the right place at the right time and to understand the key factors for development of modern health facilities in community settings
- need for new facilities to include co-location of primary, mental, dental and allied health services (including the ability to provide or access diagnostic services), with community services and in locations that provide appropriate access and parking
- importance of consulting with the private sector and community sector to ensure that private, public and not for profit infrastructure investments complement and supplement each other.

Right Balance of Infrastructure Investment

Themes emerging across stakeholder perspectives

Most submissions that addressed the questions relating to infrastructure tended to do so in response to question 1, consequently not all stakeholder views are identified below. Submissions offering a clinician perspective were however more likely to respond to all questions.

Clinician perspective

Submissions supported investment in infrastructure across the system and a focus on developing a range of facilities in community settings. The need to continue to modernise public hospital facilities so they continued to be fit for purpose was also noted.

Similar to question 1, the need for health infrastructure to be developed to respond to emerging health needs was flagged. For this to occur it was proposed that infrastructure planning should be informed by stakeholder feedback, research and supporting evidence and relevant data, community need, population projections and demographics, service need, the skills mix required to deliver the services and workforce requirements.

Responses also highlighted the need for local communities to be engaged in the planning, design and implementation of services and supporting infrastructure in community settings.

Some submissions suggested there may be opportunities to redevelop existing and/or underutilised infrastructure to enhance community care. For example, infrastructure redevelopment may enable large community health centres to provide after-hours and/or urgent care services.

Continued Investment in Current Facilities so they Continue to be Fit-For-Purpose

Themes emerging across stakeholder perspectives

Most submissions that addressed the questions relating to infrastructure tended to do so in response to question 1, consequently not all stakeholder views are identified below. Submissions offering a clinician perspective were however more likely to respond to all questions.

Clinician perspective

Similar to the previous question, submissions highlighted the importance of considering population needs when undertaking infrastructure planning, along with the need for masterplans for acute hospitals, a strategic asset management approach to buildings and associated plant and equipment for District Hospitals and community health centres, and more broadly asset management plans for equipment across the state and in all facilities.

The need to accommodate social distancing requirements relevant to the COVID-19 response and for broader infection control was also identified. It was proposed this should include small spaces such as medication storage rooms, treatment rooms, multi-disciplinary spaces and tea rooms, as well as staff locker rooms, change rooms and showers, through to having sufficient negative pressure rooms. It was further proposed that this should become part of usual planning for new health facilities to guard against a future pandemic and staff-to-staff and patient-to-patient transmission. The need for ongoing grants to enable general practice clinics to continue to upgrade their infection control infrastructure and personal protective equipment was also flagged.

Like the previous questions, the need to include community, consumer and staff voices in planning new facilities or renovating existing facilities was also highlighted.

Development of Modern Health Facilities in Community Settings

Themes emerging across stakeholder perspectives

Most submissions that addressed the questions relating to infrastructure tended to do so in response to question 1, consequently not all stakeholder views are identified below. Submissions offering a clinician perspective were however more likely to respond to all questions.

Clinician perspective

Information provided in relation to development of modern health facilities in community settings was similar to information provided in response to previous questions. In particular, submissions noted:

- communities and their needs vary, therefore development of health facilities in community settings should match with the local community need and consider existing services and infrastructure – consultation with the local community is important to identify local needs
- facilities in community settings should facilitate multi-disciplinary team approaches and have the capability to be repurposed as community needs shift and change – there should also be thought to accessibility and the needs of a range of patients
- opportunities for co-location of community and health services in a precinct should be considered to increase accessibility of services for community members, encourage communication and collective action across service providers to meet community needs, and enable shared resources where appropriate, including meeting rooms and ICT infrastructure
- ensuring community facilities have the infrastructure to support the latest technology to facilitate quality community care, expand service options into the future and integrate services, through ICT enabled mechanisms, across public hospitals, rural facilities and general practice
- the need to consider infection prevention and control in all community health facilities, particularly in respect of the lessons learnt from the COVID-19 pandemic.

Integration of Capital Investment Planning with the Private Sector to Complement/Supplement the Public System

Themes emerging across stakeholder perspectives

Only a small number of submissions responded to this question and all offered a clinician perspective.

Clinician perspective

Consultation with key stakeholders in the private sector to allow an opportunity for a shared vision for healthcare services was considered to be an important starting point that could continue to inform infrastructure investment planning into the future.

Other suggestions included exploration of opportunities to lease/sub-lease and share clinical space and facilities with private providers, including private providers outside of the health sector.

Reform Initiative 3b: Build a strong health professional workforce, aligned to a highly integrated health service, to meet the needs of Tasmanians.

Consultation questions:

1. *How should the Health Workforce 2040 strategy be further refined to guide and inform the development of a strong and sustainable workforce that is aligned to meeting the future health needs of Tasmanians?*
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?*
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?*
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?*
5. *How do we support health professionals to work to their full scope of practice?*
6. *How do we support Tasmanians to access the education and training they need to be part of the State's future workforce?*

Along with the *Our Healthcare Future* consultation process, dedicated consultation specific to the draft *Health Workforce 2040* strategy was conducted by the DoH Health Workforce Planning Unit. The analysis provided below relates only to the questions identified in the *Our Healthcare Future Immediate Actions and Consultation Paper* and not the consultation process conducted by the Health Workforce Planning Unit.

Health Workforce 2040

Themes across stakeholder groups

Submissions generally supported the draft *Health Workforce 2040* strategy. Across stakeholders as identified below there were a range of suggestions regarding scope of the strategy and inclusion of other workforces not currently identified in the strategy.

Consumer perspective

Submissions highlighted the importance of the peer workforce being considered as part of the Tasmanian health workforce, in particular the mental health and alcohol and drug sectors. Peer workers have a lived experience as either a consumer of health services or as a family member, carer or friend of a consumer. It was noted the mental health peer workforce is significantly progressed and offers a model that could be extended to the broader health sector, particularly within primary care and the community sector.

Clinician perspective

There was a high level of interest in *Health Workforce 2040* from clinicians and organisations that represent or advocate on their behalf. There was consistent support for a long term approach to tackling Tasmania's health workforce challenges. The specific feedback received in response to *Health Workforce 2040* tended to be along clinical and professional lines.

One theme that emerged from the submissions was calls for particular workforces, specialties or sub-specialties to be provided greater recognition within *Health Workforce 2040* or within the composition of the Tasmanian health workforce itself. Examples included:

- calls for greater recognition of the peer workforce, often across specialties, eg Alcohol Tobacco and Other Drug Services, Mental Health Services, and Cancer Services
- calls for stronger acknowledgement of, and delineation between, the different categories of allied health professionals, for example physiotherapists and occupational therapists
- calls for new or emerging professions to be embedded into the Tasmanian health workforce, eg exercise physiotherapists, massage and myopathy
- calls for a more nuanced consideration of the role of generalist specialists in Tasmania
- calls for recognition of the non-clinician workforce, for example non-government organisations.

Several submissions made comment on the workforce profiles presented in *Health Workforce 2040* and the use of head count/full time equivalent (FTE) staffing numbers to compare Tasmania's health workforce with other jurisdictions. There was a view that head count/FTE per capita was not always a useful measure as Tasmania often requires a higher staffing ratio than other jurisdictions because of service demands that are unique to Tasmania (for example the state's dispersed population, patients experiencing higher levels of acuity, and the need to operate 24/7 services that require higher staffing ratios for on-call and after-hours).

Several submissions commented upon staff shortages in particular areas, for example emergency medicine, nursing and midwifery. These submissions noted that staff shortages have flow on effects, such as an over reliance on locums, double shifts and higher workloads, burnout and cultural issues. Solutions put forward included finding an appropriate balance of junior to senior medical professionals to support and train staff, recruitment and retention programs targeted at improving working conditions, access to leave and backfill, and workers compensation. It was also suggested that service planning needs to be linked to workforce strategies (for example identify the future demand for services such as cancer care or dentistry in Tasmania, then match the workforce to that need).

Submissions also highlighted the potential for the Health Workforce Strategy and underlying data to be combined with other existing needs analysis including HR Plus (the Tasmanian rural workforce agency), and PHT's community needs analysis to inform models of care and target areas of workforce development. It was also suggested that the Health Workforce Strategy had the potential to inform numbers and placements of doctors in training statewide to ensure doctors are supported to train towards areas of community need.

The need to support and continue to strengthen the Rural Generalist Training Pathway was highlighted, along with the development of a rural generalist allied health professional pathway to ensure good allied health provision of care to rural communities.

Service provider perspective

Submissions highlighted that providers had unique workforce models that had been adapted to meet the needs of their staff including clinical staff and as such providers believed they could make a valuable contribution to workforce planning processes.

Sector perspective

A theme across submissions was a call for greater recognition of the peer, volunteer, non-government and non-clinician workforces across sectors, and the need for those workforces to be included in Tasmania's health workforce. It was also proposed that a person's natural support networks should be viewed as an extension of the workforce and entitled to targeted investment in education and training. For example, family members often provide healthcare consumers with support 24/7, reducing the level of service provision required/delivered by healthcare services. This may come at significant physical, emotional and financial cost to the family member.

Some sector submissions called for recognition of their particular sector workforce in the *Health Workforce 2040*, for example the Alcohol and Tobacco and Other Drug sector, or recognition that a sector is impacted by workforce issues across all specialities and across all areas of health, such as palliative and cancer care.

Feedback also proposed that recruitment and training of new health professionals was only part of the solution to sustaining a high-quality workforce and maximising capability to respond to emerging health needs. Submissions highlighted the importance of clearly defining emerging population health and care needs and then shaping the training of the future workforce specifically to meet those challenges. Responses also suggested enabling workforces to move across sectors (eg public and private) through supportive funding models and clinical governance arrangements. Further it was noted that identification of workforce profiles would support step up/step down models of care and ensure health inequities are addressed by prioritising workforces to support access to healthcare in rural and regional areas and to disadvantaged populations.

Some submissions also proposed that the workforce strategy needed to consider the full continuum of the health workforce, including public and preventative health and the role of community-based organisations. Respondents suggested clarification of the full scope of the strategy was required.

The need to implement strategies to employ more Aboriginal people across registered health professions in Tasmania and the need to include strategies to improve the cultural competence of the health workforce were highlighted.

Health policy/whole of system perspective

Feedback from a policy or system perspective also supported taking a long term approach to workforce planning. Conversely, workforce strategies were also seen as a potential lever for driving long term change across the health system. For example, it was suggested that workforce development, education and training strategies could be used to support a shift across the health system towards the greater adoption of outcomes-focussed service delivery and value-based healthcare. Workforce development, education and training was also seen as vital to the adoption of an expanded scope of practice amongst health professionals. There was a view that *Health Workforce 2040* should be a driver of this type of systemic change.

It was also suggested that *Health Workforce 2040* should reflect the need for a workforce that provides healthcare that is culturally safe, sensitive to the priorities and needs of diverse groups and is trauma informed.

Working with the Private Sector, Primary Care and Other Levels of Government

Themes emerging across stakeholder perspectives

Working collaboratively across the private and public sectors, across the continuum of health services from prevention to acute, and across levels of government was strongly supported across stakeholder groups. Many respondents put forward ideas and suggestions for how this could be achieved, such as conjoint appointments, joint workforce planning, joint workforce recruitment and retention strategies, training placements for junior health professionals, and health professionals roles and pathways that work across sectors and services.

Submissions offering a consumer perspective did not specifically address this question, and consequently are not identified below.

Clinician perspective

There was interest in this area from a clinician perspective and several suggestions were put forward for improving collaboration with the private sector, primary care and other levels of government in relation to workforce. One suggestion was for joint public-private sector workforce planning and recruitment/retention activities, for example, planning to recruit and retain Visiting Medical Officers working across both sectors by looking at their overall needs. Another suggestion was for dual appointments across public and private hospitals to assist with attracting particular specialists to Tasmania and to provide opportunities for the nursing and midwifery workforce to gain clinical experience across the different settings, particularly in areas of need by providing expanded clinical placements and the sharing of skilled clinical supervision. There may also be opportunities for collaboration across sectors to promote particular professions as careers of choice.

Another area of concern was the need to ensure junior doctors seeking to become GPs can gain the hospital experience they need in Tasmania to enter general practice and succeed. Submissions also highlighted the need to continue to support and strengthen the rural generalist pathway in remote, rural and regional areas across primary and secondary care.

Service provider perspective

A number of suggested strategies were made from providers relating to greater collaboration across sectors. Examples included:

- facilitating dual appointments between local public and private hospitals
- planning workforce needs in partnership across sectors
- extending training posts for the junior medical workforce to the private sector
- providing opportunities for the nursing and midwifery workforce to gain clinical experience across different settings, particularly in areas of need
- expanding clinical placements and sharing skilled clinical supervisors
- collaboratively promoting health as a career path, particularly for areas of need
- achieving the right mix of staff across the Tasmanian health workforce
- cross-facility credentialling of consultants
- cross-facility education and training
- collaborative research projects and clinical trials.

The statewide Clinical Senate was also named up as a potential opportunity to work across the primary and private health sectors.

Sector perspective

The mental health sector was identified as providing an example of greater collaboration across sectors, with the Tasmanian Government's mental health reform program outlining an intention to work with all parts of the mental health sector in the development of workforce planning.

Another suggestion put forward from a sector perspective was that referral pathways need to be established that cross the public system and into the private sector and primary care, as well as professional organisations that sit outside the clinical sector, and provide care and emotional support. An example of this is the Cancer Care Co-ordination role in the THS, which works across organisational boundaries. It was suggested that a Memorandum of Understanding (Mo)U could be used to formalise such arrangements between public and private sector organisations.

Health policy/whole of system perspective

There was feedback from a health policy/system perspective, that the proposed *Health Workforce 2040* strategy would need to move beyond traditional workforce planning approaches, to a broader outcomes focussed and value-based approach, in order to meet future healthcare needs and ensure clinicians are working at their full scope of practice. It was suggested that to achieve this education, regulation and funding strategies will need to be coordinated at a national, state, territory and regional service level, and across regulated and unregulated practitioners and health service environments. The *2020-25 Addendum to the National Health Reform Agreement* was suggested as a vehicle to pursue this coordination through joint planning and funding opportunities.

Similarly, other respondents suggested that the knowledge of multiple sectors and levels of government will need to be combined with that of the community to realise solutions. It was suggested that formal, strategic partnerships be developed towards this end, including shared and integrated planning and service reform approaches (for example data sharing, multi-sectoral projects and governance structures).

Attracting and Retaining Health Professionals in Regional Areas, Particularly the North West

Themes emerging across stakeholder perspectives

There was a high level of interest in strategies to attract and retain health professionals within regional areas, particularly amongst clinicians. One theme related to the development of a local health workforce that was more likely to remain in the state long term, rather than a reliance on recruitment from interstate. Another theme captured the importance of strengthening the Rural Generalist Pathway via a strong commitment to training positions and capacity development in Tasmania. Other suggestions made to attract health professionals to work in regional areas covered areas such as salary packages, working conditions, lifestyle factors and facilitating welcoming local communities.

Submissions providing a consumer perspective did not specifically address this question, and consequently are not identified below.

Clinician perspective

There was a high level of interest in recruitment and retention strategies from a clinician perspective. A number of suggested ways to attract health professionals to a career in Tasmania were commonly put forward. Suggestions included:

- provision of greater after-hours cover in rural areas, including the NWRH, and greater recognition of the demand of being on call in these areas
- ensuring medical staff in regional areas are supported to retain their medical skills
- access to education and recreation leave when needed and cover by locums during periods of leave
- competitive salary rates and conditions
- flexible options for Southern medical specialists to travel to the North West and support their colleagues in the region
- employment of staff as "state" employees and not "hospital" employees so that people can be rotated across Tasmania to cover areas of need
- increasing the full-time specialist contingent rather than using Visiting Medical Officers, although it was noted that this was difficult to achieve
- strengthening the Rural Generalist medical role through commitment to training positions and developing the capability for Rural Generalists to train solely in Tasmania, including adequate training places for Advanced Skills Training such as emergency, anaesthetics, obstetrics and gynaecology, palliative care, mental health, adult internal medicine and retrieval medicine (once a Rural Generalist has qualified there continues to be a need to maintain skills through rotations into bigger centres for intensive periods of upskilling)
- increasing supported nursing and allied health placements in the North and North West and boosting training locally
- clinical coaches to support the skill mix of the current workforce and clinical supervision from appropriately qualified clinicians, even if this has to be sourced from outside of Tasmania
- staff wellbeing programs
- addressing current workloads and access block
- support for new graduates entering the system and attracting as many new graduates as possible into the health system, particularly in nursing and midwifery
- market allowances that provide an attraction and retention incentive for working in regional areas, in particular the North West, and support for family members to find employment and become part of the local community
- improving human resources processes and recruitment capacity, including promotion of medium to long term career pathways for clinicians
- housing and infrastructure support for trainees and visiting health professionals, including housing and travel subsidies
- establishment of clinical networks to provide smaller centres with support from larger centres or support between smaller centres.

There was also feedback in relation to growing and maintaining a local workforce, for example, ensuring the local supply of new nurses to counter the ageing nursing population. In relation to dentistry, it was suggested that rural municipalities could be encouraged to support new dentists in the area to feel a stronger part of their community. It was suggested that research showed dentists working in rural areas are more likely to stay if they enjoy the social and physical environment, as well as job satisfaction, as social and personal factors are most important in relation to workforce retention.

Service provider perspective

Feedback from a provider perspective included a number of suggested health workforce attraction and retention strategies, including: increases to salary options, training, mentoring, awards and entitlements in return for working in regional areas; consideration of rotational arrangements to move health professionals around different services and agencies; and increased focus on staff wellbeing programs, such as access to coaching and wellbeing assessments.

Sector perspective

Growing the local workforce in the regions was seen as key to attracting and retaining health professionals. It was reported there has been considerable success in growing the local workforce capacity in Medicine through the Rural Clinical School in Burnie. In addition, the University of Tasmania (UTAS) place-based strategy has to date delivered Dementia Care, Psychological Science, Nursing and more years of the Bachelor of Medicine and Bachelor of Surgery (MBBS) to Burnie during 2021.

Collaborative efforts are also occurring between UTAS and the DoH in relation to the development of rural generalist pathways. Initiatives such as these were viewed as central to attracting and retaining health professionals in rural and regional areas.

Conjoint appointments were also thought to be a key consideration to recruitment and retention, and are particularly attractive to health professionals in rural and regional centres. Conjoint arrangements connect practitioners to the discipline and to research opportunities, and afford them higher education opportunities which are highly regarded. The current conjoint recruitment process was thought to be too complex and opportunities are missed to strategically recruit staff as conjoint appointees.

Health policy/system perspective

Several suggestions were put forward from a health policy/system perspective for attracting and retaining health professionals in regional areas.

It was proposed that local councils could be encouraged to ensure that health professionals in rural communities are strongly welcomed into their communities as a simple and cost effective retention strategy and in light of the fact that lifestyle factors have been shown to play a major role in retaining health professionals once they settle in these communities.

Others suggested there are opportunities to establish a blended, locally based and visiting health professional workforce, as well as allied health assistant roles to support access to health professionals (both digitally and face-to-face). It was also felt that community-based, public and private health professionals could be better engaged within “step up and step down” health facilities and services to manage those at risk of hospitalisation or post-discharge, to relieve pressure on the major acute hospitals.

Other specific suggestions put forward included improving school facilities in rural areas in order to attract young families who may stay for longer and creating a welcoming environment for these young families once they arrive. Providing incentive packages for health professionals to move to Tasmania was another potential suggestion put forward.

Innovations to Align Professional Health Teams with Future Needs of Tasmanians

Themes emerging across stakeholder perspectives

There was variation across stakeholders in terms of suggested innovations to the health professional workforce. Suggestions included completing population health needs assessment and then aligning this with workforce planning, a greater focus on health professionals specialising in the care of older people, prevention and self-management within the workforce, and on the role of health professionals in supporting emerging models of care (eg generalist roles and senior allied health professionals). There was also support for an increasingly team-based approach to align professional health teams with the future health needs of Tasmanians.

Responses to this question came predominately from representatives of the health workforce, consequently not all stakeholder views are identified below.

Clinician perspective

A wide range of suggested innovations were put forward from a clinical view. It was suggested that in the first instance, the population health needs of Tasmanians need to be identified to enable appropriate alignment of workforce and training positions with community need to ensure an appropriate mix of staff.

Given Tasmania's ageing population and increasing chronic illness and co-morbidity, it was proposed the focus needs to be on community geriatricians and support for nursing homes to deliver more healthcare or for professional groups to deliver more care into nursing homes, including allied health. Support to GPs to be able to care for complex patients in a joint care arrangement with hospital specialists was also raised. Complex care co-ordinator positions to liaise between acute and community settings and to support people with complex care needs, along with facilitating a greater role for community pharmacists in chronic disease management, were also proposed.

The need for a focus on prevention (primary, secondary and tertiary), health promotion, health literacy and self-management support was also identified.

More team-based approaches with medical, nursing and allied health staff working together collaboratively as teams was also seen as required reform.

Funded scholarships for nursing and midwifery post graduate training in areas of high need, such as mental health, critical care, dementia care and midwifery, was also put forward as a suggestion to build the knowledge and skills of the existing workforce.

Exploration of models that use generalist positions (where it is appropriate to do so) and rotational/secondment models with national and international health services, and preparation of the workforce for the ever increasing use of digital health technology, were also ideas put forward.

The need for allied health nurse practitioner training capability to be developed within the state and having shared teaching with pharmacy, medicine, allied health and nursing to facilitate trust and early cross-disciplinary collaboration was another suggestion.

It was also highlighted that where there exist constant workforce deficits, for example in some specialty areas, then consideration should be given to models of care which utilise senior allied health (with expansion of expertise consistent with professional and organisational requirements) and/or advanced nurse practitioners. This was consistent with a view that non-medical models need to be explored in areas where medical shortages cannot be addressed and to ensure services can continue to be delivered and meet the health needs of Tasmanians, now and into the future.

The challenges of developing a workforce to meet current health needs and current models of care which may need to change in line with contemporary care into the future were acknowledged. It was suggested that the nursing workforce has flexibility to support changing needs and that the nurse practitioner workforce provides an opportunity to meet current and emerging health needs.

It was proposed that a robust professional development model for nursing and midwifery is needed across the state to enable innovation.

Sector perspective

In regard to innovation, there was some feedback from the non-government sector that peer workers are a potential area of opportunity. For example, the Alcohol Tobacco and Other Drug sector and the Asthma sector saw peer workers as a future workforce direction. This tied into a general theme around public health services working more collaboratively with external professional organisations, such as the Cancer Council Tasmania. It was felt that the role of these non-government, non-clinical service providers, which are often responsible for the provision of care and emotional support, should be more formally recognised through mechanisms such as MoUs.

There was also feedback that there is need for investment in innovative models of complex and chronic care, in order to engage the existing primary healthcare workforce (private and public). These models should expand community team-based care and include nurses, allied health professionals, paramedics and pharmacists working in a structured team environment with medical oversight and/or support, increasing access to services for patients and reducing dependency on hospital admissions. Current examples of successful models include palliative care (community-based palliative care), rural health (training and employment of rural generalist medical practitioners) and nurse-led community rapid response services or people with exacerbating chronic illness.

Supporting Health Professionals to Work to Full Scope of Practice

Themes emerging across stakeholder groups

There was variation in views regarding the type of supports needed for health professionals to work to their full scope of practice. Some proposed that working in a multidisciplinary team environment or providing greater exposure to colleagues across professionals supports health professionals to reach their full scope of practices. Others suggested changes to the scope of practice of nurses, piloting an extended scope of practice for pharmacists, and looking at existing credentialling, clinical policies and procedures and professional practice frameworks as mechanisms for supporting health professionals to work to their full scope of practice.

Again, there was a tendency for health professionals and service providers to respond to this question, consequently not all stakeholder views are identified below.

Clinician perspective

Clinicians put forward several suggested strategies to ensure they are working to their full scope of practice. It was suggested that working within a multidisciplinary team environment supports clinicians to work to their full capacity and builds confidence in the roles of others. It was thought that where clinicians are not directly positioned within a team, they should be supported to connect with colleagues elsewhere for the sake of their professional development and to ensure they are not working in isolation. Simulation training was also identified as creating an opportunity to bring together health professionals to work to their full scope and with other colleagues across streams to see what is possible in a safe and monitored environment.

Clinicians also identified the need to review existing credentialling, scope of clinical practice policies and procedures, and profession-specific scope of practice frameworks, to ensure alignment with the various scopes of practice required across the Tasmanian health system and to provide health professionals with the opportunity to operate at the top of their scope of practice. Industrial agreements and indemnity provisions were also seen as needing to support working at top of scope of practice.

A number of other suggestions for maintaining scope of practice were put forward:

- upskilling through short clinical rotations
- nurse-led discharge from acute hospitals
- more employment opportunities for nurse practitioners
- greater implementation of the Advanced Enrolled Nurse (AEN) classification
- implementation of nurse endoscopists as per other jurisdictions
- advanced skill training of rural generalists in the areas of emergency, anaesthetics, obstetrics, palliative care, adult internal medicine and mental health.

Service provider perspective

Some submissions suggested the Tasmanian Government consider piloting expanded scope of practice for pharmacists. This included for example pharmacists being able to provide ambulatory/home-based withdrawal management services in partnership with an appropriate team of health professionals, including GPs, nurses and medical specialists.

Sector perspective

It was suggested that in other parts of Australia a focus on the expanded scope of practice (with particular emphasis on procedural skills) had been successful in attracting the required workforce. Healthcare professionals seek a workplace where they can use their hard-earned skills.

Actions to improve access to continuing professional development for Tasmania's nursing and midwifery workforce, including creating structured and regular rotational opportunities between regional and urban hospitals, was also identified to provide the necessary skills and knowledge sharing opportunities to support a full scope of practice.

Supporting Tasmanians to Access Education and Training to be Part of Future Workforce

Themes emerging across stakeholder perspectives

Feedback from respondents in relation to education and training was fairly consistent and several themes clearly emerged. One such theme was a desire for health services to work more strongly in partnership with existing education and training providers to meet local needs. Another theme was that scholarships and subsidised education and training opportunities could be used as an incentive to encourage more health professionals to upskill or develop their skills in particular areas of need. A final theme was education and training programs need to be tailored to health professionals working in rural areas to meet their unique needs.

Consumer perspective

Feedback from a consumer perspective focussed on the need for education and training of clinicians to appreciate and understand the lived experience of consumers and their families, carers and friends.

Clinician perspective

There was significant interest from a clinician perspective in education and training. A clear theme that emerged was the desire for health services to work more strongly in partnership with existing education and training facilities, such as the Australian Nursing and Midwifery Association's Health Education and Research Centre, TasTAFE, UTAS and others to address areas and regions of need. This included partnering with these organisations to offer supported education and training places for areas of need such as midwifery, critical care and aged care.

Building the capacity of Tasmanian education and training institutions to provide allied health education and training pathways, particularly in areas which are currently not provided in Tasmania, such as occupational therapy, was another theme. It was suggested that an opportunity exists to develop an allied health equivalent role to the clinical nurse educator position, to provide educational services for allied health professions, and to increase access to education and training.

Education and training in the areas of health promotion, disease prevention, health literacy and self-management support was also identified.

Another clear theme to emerge was the need to provide greater support to young health professionals during their training. For example, workforce shortages were seen to be placing emergency medicine trainees under increasing pressure, leading to burnout, and resulting in some choosing to move interstate. This was seen as a cyclical issue, as those trainees who remain are placed under further pressure. In this sense, recruitment and retention strategies were seen as intrinsic to the education and training of young health professionals and should be dealt with holistically. This was seen as an issue across medical fields.

The promotion of scholarships and/or subsidies for midwifery and other specialised nursing programs, particularly in areas of need across public and private sectors, was suggested so that Tasmania can have appropriately skilled and qualified healthcare professionals to meet the future healthcare requirements of the community.

Service provider perspective

In line with the views of other stakeholder groups, it was suggested that scholarships and subsidised education and training opportunities (eg post graduate programs) are a potential tool for encouraging more health professionals to upskill. Other Australian jurisdictions were seen to be doing this successfully to address skills shortages.

The need for dedicated training for health professionals in rural areas was also identified. It was noted that health professionals working in rural areas have different training requirements from those in urban areas and need to be supported and empowered to provide a range of services that their counterparts in urban centres are not required to provide. Examples included upskilling nurses to provide medical imaging and other diagnostic testing.

Sector perspective

Several submissions named up potential areas of focus for health professional education and training, for example: preventative health; alcohol, tobacco and other drugs; asthma; mental health; public health; and dental health.

Health policy/whole of system perspective

It was suggested from a policy/system perspective that education and training should be targeted towards community health service profiles. For example, using education and training to change the behaviours of health professionals (and their consumers) in response to emerging health needs at a community level, such as dementia, trauma, mental health, health literacy and self-efficacy.

Reform Initiative 3c: Strengthen the clinician and consumer voice in health service planning.

Consultation questions:

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?*
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*
    b. *Local: participation and engagement in service improvement at a local level*
    c. *Policy and service systems: participation and engagement in planning, developing, reviewing, evaluating and reforming services at a system level?*
4. *Are there particular models of consumer engagement and participation that we should consider?*
5. *How can we improve opportunities for consumers to feed back on their healthcare including following discharge from care?*
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?*
7. *What format would be best to engage with future health leaders?*

Statewide Clinical Senate

Themes emerging across stakeholder perspectives

As is evident below, the feedback received from different stakeholder groups in relation to a Statewide Clinical Senate was very consistent. The major themes emerging from submission were:

- a strong desire for a Statewide Clinical Senate to be highly representative of the clinicians and consumers that make up Tasmania's health system
- a perceived role for a Statewide Clinical Senate in the provision of strategic advice and health service co-design, with a view to supporting health service quality and safety and reform
- a desire for the Statewide Clinical Senate to be co-designed by clinicians and consumers
- a desire to learn from the experiences of similar committees (eg resourcing, operations, governance), including best practice examples of Clinical Senates operating interstate, and current and previous clinical advisory committees to the Tasmanian Government.

Consumer perspective

There was a high level of interest in a Statewide Clinical Senate from a consumer perspective. A number of users of health services, as well as organisations that represent or advocate on their behalf, made comment on the specific makeup, operation, and functions of a Statewide Clinical Senate. Overall, it was viewed as an opportunity to strengthen both clinician and consumer engagement in health service quality and safety activities and reform initiatives.

The major area of feedback from consumers was the makeup of the Statewide Clinical Senate. There is an expectation that consumers will be well represented amongst the Senate membership. The following groups were named up across various submissions as requiring representation on the Statewide Clinical Senate:

- older people
- CALD communities
- rural, regional and metropolitan consumers
- people living with chronic conditions
- people living with mental illness
- users of primary health services (as well as acute health service users)
- people living across the three regions of Tasmania.

Some submissions referred to consumer representation levels in place within Clinical Senates operating elsewhere in Australia. For example, the Victorian Clinician Council was described as consisting of 72 members, 10 per cent of which are consumer representatives. This was seen as an example of best practice alongside some other interstate Clinical Senates with lower levels of consumer representation. Another submission suggested that lower levels of consumer representation (eg one to two per cent) would be perceived as tokenistic.

A potential suggestion put forward to ensure that a broad range of consumer perspectives can be practically represented on a Statewide Clinical Senate was to recruit a core membership of consumers, supported by a broader pool of consumers who could potentially be pulled into Senate hearings to represent different perspectives (depending upon the focus of the Statewide Clinical Senate at a given time).

It was also suggested that consumers, together with clinicians, should:

- co-design the Statewide Clinical Senate, including its terms of reference and operating framework
- contribute to decision-making around health service reforms or initiatives at a Departmental Executive level via the Statewide Clinical Senate
- co-chair the Statewide Clinical Senate, or alternatively, that the Senate be chaired by a person with a theoretical and working knowledge of the levels of consumer engagement in healthcare.

Beyond the issue of consumer representation and roles within the Statewide Clinical Senate, other feedback from a consumer perspective covered the need for:

- multidisciplinary health professional representation
- health professional representation that is drawn from staff of all levels, from junior to senior staff
- resourcing for administrative, project and research support.

Clinician perspective

There was also a high level of interest in a Statewide Clinical Senate from a clinician perspective. A number of clinicians, as well as organisations that represent or advocate on their behalf, made comment on the specific makeup, operation and functions of a Statewide Clinical Senate. Clinicians also viewed a Statewide Clinical Senate as an opportunity to strengthen their relationship and engagement with decision-makers, and to provide input into quality and safety and reform activities.

Several submissions quoted examples where Clinical Senates are working effectively in other jurisdictions, such as Western Australia, Victoria, Queensland and South Australia. On the back of these success stories, it was suggested that a Statewide Clinical Senate for Tasmania had the potential to involve clinicians in decision making processes, including the co-design of health services.

Again, the major area of feedback from clinicians was around the makeup of the Statewide Clinical Senate and the importance of a broad, multidisciplinary membership that was able to adequately represent Tasmania's health workforce. The following groups were named up across various submissions as requiring representation on the Statewide Clinical Senate:

- health professionals drawn from across the whole health system, from preventative to acute health service delivery, and public and private sectors
- health professionals drawn from rural, regional and metropolitan areas
- new and emerging health professionals, to represent the workforce of the future
- a balance of doctors, nurses and allied health professionals
- representation across the various categories of allied health professionals
- working clinicians.

It was also suggested that consideration should be given to membership of some non-clinical professionals or non-working clinicians who may be able to assist in the preparation of strategic advice, such as researchers and academics, health economists, and service managers. Likewise, it was suggested that a Statewide Clinical Senate should have established relationships with non-clinical committees, including the DoH's corporate governance committees, to allow clinicians to provide strategic advice into health service strategy and policy development, and investment decisions in regard to infrastructure, capital and service delivery.

A number of submissions referred to previous or existing clinical advisory committees with a similar remit. For example, the Health Council of Tasmania and Lead Clinicians Group were put forward as examples of previous committees made up of clinical representation with an advisory role to Government. It was suggested that these groups have been limited by a lack of resourcing and were not well understood by clinicians more broadly, thereby reducing their impact. As a solution to this, it was suggested that resources are invested into a Statewide Clinical Senate to drive the work of the Senate, and to develop communications to inform clinicians of its activities.

Another suggestion put forward was to revise and resource the existing CAGs and for a Statewide Clinical Senate to sit above these and provide overarching advice to Government.

A small number of submissions put forward possible areas of focus for a Statewide Clinical Senate. One suggested that providing an equal voice to representatives working in health provision across all parts of the healthcare continuum would support a shift in focus towards building greater capacity in preventative healthcare and primary healthcare. Another suggested that embedding the principles of the *Choosing Wisely* program within a Statewide Clinical Senate would help to support value-based healthcare as a broad policy objective across all levels of health service delivery. This is turn would support lasting change towards higher quality, higher value healthcare.

Service provider perspective

There was minimal feedback on a Statewide Clinical Senate from service providers. Similar to the feedback outlined above, the provider perspective generally supported a Senate, with consideration given to the following:

- successful models are in operation interstate that provide examples of best practice
- clinical representation should predominately consist of working clinicians
- clinical representation should broadly reflect the makeup of the health workforce
- broad consumer representation is strongly supported.

Beyond this, specific suggestions put forward by service providers included:

- the call for a Statewide Clinical Senate to be involved in co-designed health service planning
- that the makeup of Clinical Networks be expanded to reflect the potential makeup of a Statewide Clinical Senate (ie inclusive of the private health sector).

Sector perspective

There was less feedback in response to this area from a sector perspective than was received from a consumer or clinician perspective. However, those organisations that did respond were supportive and raised similar issues to those outlined above. There was strong support for balanced clinician and consumer representation on the Senate, and as a part of this, calls for representation from particular disease or population groups.

A notable suggestion was the call for a Statewide Clinical Senate to play a role in ensuring consistent models of care are in place across the three regions of Tasmania. It was felt that clinical leadership has the potential to help ensure consistent service delivery regardless of region.

Health policy/whole of system perspective

Similar themes emerged from a health policy or system perspective. The value placed on broad representation amongst the Senate's membership, drawn from both clinicians and consumers, was evident from submissions. It was also noted that if the Senate was perceived as inadequately representing the health sector, there is a risk that it would become viewed as tokenistic. Generally, those groups identified in the sections above were put forward as requiring representation on the Senate. It was also suggested that members should receive training in clinical re-design thinking and change management strategies to support their role.

Generally speaking, the health policy or system perspective supported a Statewide Clinical Senate, provided appropriate representation to balance clinical expertise with consumer and community perspectives, insights, and lived experience as the end users of the Tasmanian health system. It was suggested that a well-functioning Statewide Clinical Senate could help pave the way for broader system level collaboration and partnership, such as co-design and co-commissioning activities, which are viewed as contemporary and efficient mechanisms to share and manage resources and responsibilities across the health system.

Meaningful and Effective Engagement

Themes emerging across stakeholder perspectives

There was a high level of consistency across the submissions, all of which positively supported a stronger approach to consumer engagement. The key themes emerging from the submissions were that:

- mechanisms exist for consumer engagement and should be appropriately resourced and utilised, for example Consumer Community Engagement Councils (CCECs) and HCT
- community groups and local councils can be leveraged to provide further access to local communities
- consumer engagement processes should ensure they encourage participation by a range of participants, including those from vulnerable communities and with lived experiences. This can be assisted by providing a number of different means to participate in the consumer engagement process, including face-to-face meetings, digital and hard-copy methods

- a system-wide approach to consumer engagement should be implemented across the Tasmanian health system, encompassing strategies to involve consumers at all levels of health service design, policy and planning, delivery, and evaluation (eg staffing and reimbursement for consumer engagement, requirements within job descriptions, performance indicators, and participation in governance structures).

Consumer perspective

Feedback indicated that frameworks and forums already exist for consumer engagement, but these must be adequately resourced and used. Examples highlighted included:

- THS CECCs – the purpose of the CECCs is to partner with the THS to implement, monitor, improve and evaluate the services provided by the THS for consumers and the community
- Consumer Advisory Panel to the Secretary, DoH – creating a forum for the Secretary and CECCs to discuss issues about the health service that matter to consumers and the community
- the THS Ministerial Charter
- criterion outlined in the *National Safety and Quality Health Service – Standard 2 Partnering with Consumers*
- current THS policy and protocols including the framework for patient centred care – *The Patient Will See You Now* and the *Consumer and Community Engagement Principles.*

It was noted that DoH needs to provide greater awareness and support for the CECCs, actively promote their activities across the healthcare system, and embed the culture of consumer engagement across all structures of the health system

It was also suggested that the process of co-design needs to be taken seriously and planning and development of the health system needs to be inclusive of consumers.

Feedback suggested that consumer representation is required at all levels of health planning, delivery and quality improvement, from government health policy, governance and planning, through to health service governance and planning and clinical service delivery. This range of consumer representation would support consumers' experiences and perspectives being integrated into the design and governance of services.

To identify strategies to increase consumer engagement at higher levels of need, it was felt that there needs to be a greater understanding of the barriers that exist to consumer engagement, including language, culture, poor health literacy and health professional attitudes and behaviours.

It was proposed that there needs to be a commitment to increasing consumer involvement, including consulting, involving and partnerships/shared leadership engagement. Submissions suggested development of a consumer involvement framework and strategy should cover all levels of direct care, organisation design and governance, and policy making. Feedback recommended further investment in staffing resources to support effective consumer engagement, investment in feedback and evaluation mechanisms, and identification in all job descriptions and performance indicators that consumer involvement is a priority in planning, implementation and evaluation of healthcare delivery.

Clinician perspective

There was support from a clinical perspective for more meaningful and effective engagement with consumers and other stakeholders in planning and delivering health services, and in quality improvement activities. A number of respondents felt that the Tasmanian health system stands to benefit from a stronger approach to consumer and community engagement, including clinical co-design and shared decision-making.

A mixture of new and existing strategies for building better engagement were discussed. Several submissions suggested that, where possible, the Tasmanian Government should leverage existing consumer engagement mechanisms (eg CECCs and HCT) or build consumer engagement into planned and existing activities (eg strategic committees, clinical networks and the Statewide Clinical Senate). Others put forward a range of potential new activities for consideration, including:

- establishing a pool of interested consumers for engagement opportunities
- including consumers more widely within service redesign activities
- greater adoption of surveys and suggestions for improvement
- incentives for consumer participation, such as prizes for completing surveys
- building engagement and feedback options into the DoH/THS website.

There was also a general theme around ensuring a variety of means are in place for providing input, including face-to-face, digital and paper-based, to encourage and enable a wide range of participants to participate in the consultation processes by catering to different needs and preferences.

Finally, there was also some feedback in relation to improving the quality of information that is available to consumers, for example on the DoH/THS website, and in relation to services and engagement opportunities available at a local level (eg District Hospitals).

Service provider perspective

Providers noted the submission provided by HCT is supported as a framework for consumer engagement. They also noted the importance of investing and building genuine relationships with consumers over time, and in ensuring vulnerable communities have equal opportunity to participate in the consumer engagement process (eg Aboriginal Tasmanians).

Sector perspective

Feedback from sector representatives was similar to that from providers, supporting the recommendations of HCT and noting the importance of participation from indigenous and other vulnerable communities. Like others, sector representatives also called for consumers to be included within the membership of a Statewide Clinical Senate.

The sector representatives also emphasised the importance of recognising the contribution of people with lived experiences (eg alcohol, tobacco and other drugs) in the development of health policy and programs. This was seen as extending to the level of the co-design of health services planning, delivery and quality improvement. Several submissions were willing to partner in such a process.

Health policy/whole of system perspective

The feedback received from a health policy/system perspective aligned with that of consumers and clinicians. In particular, the suggestions of leveraging existing mechanisms for consumer engagement (eg HCT) and adequately resourcing consumer engagement activities (eg renumeration for consumers).

Notable suggestions put forward from this group included the opportunity to partner with other organisations to increase access to consumers. For example, the University of the Third Age to gain access to older people, and local councils to gain access to consumers in particular geographical locations. The importance of actively promoting consumer engagement to staff at all levels of DoH/THS – from the Senior Executive to entry level employees – was also expressed, as well as supporting staff to listen and act on the feedback they receive.

Strengthening and Optimising Consumer Engagement and Participation

Themes emerging across stakeholder perspectives

Again, feedback was very consistent across stakeholder groups in response to this question. Improving consumers' health literacy to enable them to better participate in the engagement process was a major theme. Respondents also reiterated the advice provided in respect of question 2, that while mechanisms already exist for consumer engagement, such as CCECs and HCT, they must be properly resourced and utilised. Supporting frameworks, including strategies for embedding consumer engagement at multiple organisational levels; as well as wholistic, patient-centred care approaches also came through clearly as priorities.

Consumer perspective

Consumers, and the organisations that represent and advocate on their behalf, provided detailed feedback on how consumer participation and engagement can be strengthened at a personal, local and policy level. To summarise:

- ***At the personal level*** – participation and engagement in a person's own care – requires clinicians to provide care to patients that is respectful, continually share information, work with patients, carers and families to make decisions and plan care and support and encourage patients in their own care and self-management.
- ***At a local level*** – participation in service improvement – requires patients, carers and families being involved in overall design of the service, department or program. This could be as members of quality improvement and re-design teams and include participation in planning, implementing and evaluating change.
- ***At a policy and service systems level*** – requires involvement of consumers in overall governance, policy and planning. Consumers and consumer representatives need to be full members of key organisational governance committees in areas such as patient safety, facility design, quality improvement, patient and family education, ethics and research.

Other key themes to emerge were:

- participation by consumers and consumer networks needs to be embedded in the development of health programs. This could involve the development of formal consumer engagement frameworks within DoH
- CCECs should be resourced to enable them to assist more broadly with the consumer engagement process in their regions

- to enable greater community engagement, one option proposed was the creation of "local health connectors" – independent people within their communities who are resourced to establish or leverage existing groups to bring together local networks.

Clinician perspective

In addition to their responses provided to Question 2, clinicians put forward a variety of suggestions for building consumer participation and engagement at a personal, local and policy/service system level. Suggestions included:

- digital options such as iPads or online platforms made available at the bedside within acute facilities
- directly seeking feedback from people accessing services within the community
- using social media to highlight available services
- health services having a visible presence at community events
- establishing a broader network of active health consumers
- strengthening health professional training and professional development
- embedding consumer engagement in co-design and decision making at a cultural level
- a forum for consumers (for example a statewide consumer group) feeding into clinical governance structures.

Clinicians also noted that it was important to improve consumers' health literacy so that they are coming from a better information base to make meaningful contributions to the engagement process.

Service provider perspective

Again, the provider perspective was aligned with that of other stakeholders on this issue. In particular, providers highlighted the need to more strongly invest and promote the THS' *The Patient Will See You Now* frameworks and the CECCs as available resources. There were also suggestions around strengthening governance committees to foster greater inclusivity, and balancing clinical expertise with consumer and community perspectives, insights, and the lived experiences of the end users of health services.

Key themes to emerge were:

- local government can be a useful mechanism to leverage existing networks
- health literacy is important to enable consumers to better participate in the engagement process and
- existing mechanisms exist for consumer engagement, such as the CCECs and HCT, but there needs to be better delineation of their roles.

Sector perspective

There was some interest in this topic from a sector perspective that aligned to the responses of other stakeholder groups. Notable suggestions not covered elsewhere included: coaching consumers in how to present information to government, preventative health campaigns and education designed to meet the needs of vulnerable communities, peer support programs, and adoption of *Self-Care for Health: a National Policy Blueprint as a Guiding Framework for Person-Centred Care.* Key themes to emerge were:

- person-centred care should be embedded throughout the policy and program development cycle, from development to evaluation
- improved health literacy will assist consumers to participate in the engagement process
- existing community groups can be leveraged to assist with the consumer engagement process.

Health policy/whole of system perspective

The health policy/system response to this question echoed that of other stakeholders. There were calls for consumer representation at all organisational levels, organisational frameworks, the employment of peer workers, and greater transparency and involvement in decision making processes, including service co-design. One submission made a strong link between wholistic/patient centred-care and the empowerment of consumers as *active* not *passive* decision makers in their own healthcare.

Other key themes to emerge include:

- prioritise engaging with vulnerable communities which may not normally have the opportunity to participate in consultation processes
- aim to improve consumer health literacy so consumers can more effectively contribute to the consultation process
- have consumers participate in bodies which are responsible for implementing policies and programs, not just the consultation process and
- appropriately fund consumer bodies which will assist in the consumer engagement process.

Models of Consumer Engagement and Participation

Themes across stakeholder groups

Feedback on this question generally noted that while mechanisms exist to enable consumer feedback, it is important the model used is appropriate to local needs and enables participation by a range of different consumer representatives. A wide variety of specific models, resources and approaches were put forward. A common theme across these models is taking a systemic approach at all organisational levels.

Consumer perspective

There were several suggested models of consumer engagement put forward from a consumer perspective. Feedback recommended leveraging existing mechanisms such as the CCECs but ensuring they are part of an overall co-design model, and that the CCECs and the areas supporting them are adequately resourced. The following models/resources were also put forward:

- *The Patient Will See You Now: THS Consumer Engagement Model of Care: A Framework for Patient Centred Care*
- *Consumer Participation in the Health System: Victorian Auditor General's Report 2012*

- *Consumer and Community Engagement Model: An Outcome of the WentWest – Health Consumers NSW Joint Consumer Engagement Project 2015*
- *The Experience Based Co-Design Toolkit: Australian Health and Hospitals Association 2017.*

Clinician perspective

Clinicians noted the need to ensure all levels of the health system including clinicians, policy makers and consumers are involved in the engagement process and have an opportunity to collaborate. Other suggestions included the need to combine top-down and bottom-up approaches to engagement, continuing to strengthen the CECCs, "on the spot" feedback to improve communication between services and consumers, and potentially tapping into health professionals' own experiences as health consumers.

Service provider perspective

Providers noted that HCT offers a means to provide consumer engagement but will require appropriate resourcing to be effective. Like other stakeholder groups, a commitment to building health literacy in the community, and to implementing person-centred care was also mentioned. Other specific suggestions included building participatory and collaborative partnerships with communities, and engaging with Tasmanian Aboriginal youth and elders. It was also noted there needs to be a range of consumer engagement mechanisms to engage a range of different consumers.

Sector perspective

Feedback from sector representatives noted that models of consumer engagement should formalise participation by a range of health consumers and their support networks. Suggestions put forward included:

- adopting a community development model similar to Health Consumers NSW
- the Peter MacCallum Cancer Centre's *Consumer and Community Engagement Compass 2020*
- having accurate data sets available to inform consumer engagement activities
- models of consumer engagement occurring in the mental health, alcohol and drug sectors

It was also noted that collaboration with all three levels of government (state, local and Federal) is important to ensure system integration.

Health policy/whole of system perspective

Respondents noted many existing models are available to facilitate consumer engagement. However, it is important the model used is appropriate to local needs. Examples put forward included:

- *The Experience Based Co-Design Toolkit: Australian Health and Hospitals Association 2017*
- *The Central Connect Leadership Roundtable*: *Local Community Wellbeing Governance Model*
- *National Model Clinical Governance Framework*
- *Australian Commission on Safety and Quality in Healthcare Resources*
- *International Association for Public Participation's Spectrum of Public Participation*
- *HeLLOTas! Toolkit: Health Literacy Learning Organisations Tasmania*
- *The Tasmania Project, UTAS' Institute for Social Change*
- *Local Government Association of Tasmania Approaches to Community Engagement.*

It was also noted consumers with lived experiences are valuable not only in the consultation phase but also the development phase, and should be included in relevant committees.

Consumer Feedback on their Healthcare

Feedback on this question was consistent across all stakeholder groups. They recommended that consumers be provided with more timely means to provide feedback on their experience, in particular immediately upon discharge but also throughout their patient experience. There should be a range of feedback mechanisms (including electronic and verbal) to facilitate this feedback. The need to appropriately resource feedback mechanisms was also highlighted. A wide range of specific suggestions were put forward, including:

- continuous patient experience surveys
- compliments, suggestions or complaints forums
- root cause analysis
- surveys and interviews by peer workers or volunteer consumers
- post-discharge phone calls
- confidential hotline to provide feedback
- GP feedback of patients' acute services experiences
- embedding consumer feedback opportunities into episodes of care.

Education and Training for Health Professionals, Health Policy Makers and Planners about the Importance of Consumer Engagement and Participation

Themes across stakeholder group

Responses to this question indicated that while it is broadly recognised that seeking consumer engagement should be a core aspect of the health system, additional support may be needed to embed this in day-to-day operations, including embedding it as part of standard procedures and providing the necessary time and resources for it to occur.

Consumer perspective

There were a small number of suggestions put forward from a consumer perspective. This included ensuring Statements of Duties for DoH/THS employees contain statements relating to consumer engagement. Implementing education and training programs for health professionals that focus on communication, cultural change, approaching consumers as partners, and shared decision-making in healthcare was also suggested.

Clinician perspective

Clinicians noted that health professionals are generally aware of the importance of consumer engagement but may need additional support to facilitate this, for example by having additional time and resources to allow for collection of feedback and embedding consumer engagement as part of the organisational culture.

Several respondents to this question also made specific suggestions around education and training. For example, the Hush Foundation has toured a theatrical play nationally that is targeted at health professionals. The play has been very successful, well-received and focuses on patient-centred care, with an underlying message around the importance of listening to the patient and each other. Other suggestions around training included the need to motivate health professionals to inspire their patients, and the possibility of making consumer engagement training mandatory across professions.

Provider perspective

Provider feedback noted it is important to recognise that consumer engagement is a key part of the health system, and the necessary time and resources should be provided to enable health professionals to provide this engagement. It was also suggested that providers themselves need to better acknowledge the benefits of consumer engagement. For example, Aboriginal and Torres Strait Islander people have been shown to be more likely to access service providers who communicate respectfully, have an awareness of the underlying social issues, as well as some understanding of culture, and where Aboriginal and Torres Strait Islander people are part of the healthcare team. This also applies to other groups in our community.

Sector perspective

Feedback recommended health professionals should be provided with formal training in consumer engagement by heath sector representatives. Drawing on existing training programs was also suggested.

Health policy/whole of system perspective

There was support for health professional education and training from a policy/system perspective. Key themes to emerge were the need to:

- make training more accessible by providing it in a range of formats and times
- resource HCT to provide relevant training
- support engagement with frameworks, policies and protocols, organisational champions, resources and staffing support
- embed engagement with consumers across all levels of healthcare as a core function of the organisation.

Future Health Leaders

Themes emerging across stakeholder perspectives

There was less consistency of feedback in relation to a Future Health Leaders Forum when compared to a Statewide Clinical Senate. However, the following key themes were seen to emerge across different stakeholder groups. These themes align closely with the feedback received in relation to a Statewide Clinical Senate:

- a desire for a Future Leaders Forum to be representative of the clinicians and consumers that make up Tasmania's health system (now and in the future)
- a desire for the Future Health Leaders Forum itself to be co-designed by clinicians and consumers
- a call for the resourcing of specific activities, such as scholarships, professional development programs, formal networking opportunities and online platforms.

Consumer perspective

There was some interest in a Future Health Leaders Forum from consumers and their representative groups and organisations. A variety of mechanisms were put forward to engage new and emerging health leaders, including forums, focus groups, surveys and the general opportunity for junior health professionals to provide feedback to Government.

It was also suggested that a Future Health Leaders Forum be co-designed by consumers and include appropriate consumer representation. The suggestion that a Future Health Leaders Forum be co-chaired by a consumer was also put forward.

Clinician perspective

There was strong interest from a clinician perspective in the makeup, operation and functions of a Future Health Leaders Forum. Clinicians put forward a range of suggestions for engaging with and developing the younger members of their workforce. In general, there was broad support for such an initiative, and for building upon the existing mechanisms already in place.

A common theme from clinician submissions was the importance of including new and emerging health leaders within the membership of a Statewide Clinical Senate, in order to both represent the health workforce of the future and develop leadership capacity.

Another theme was the need to recognise and build upon existing professional development activities and resources that are seen to be working well, such as the:

- Royal Australian College of Medical Administrator's leadership and mentoring programs
- Post Graduate Medical Council of Tasmania's resources for junior doctors
- Royal Australian College of General Practitioner's future leaders' program
- UTAS' Post Graduate programs in health-related fields.

Alternatively, partnering with the organisations listed above (and others with similar roles across the health sector) to establish new programs was also suggested.

A range of potential opportunities were put forward for developing new leadership development programs and resources, including:

- online engagement platforms, including web-based meetings and forums, to ensure equality of access around the state and high participation rates
- formal networking opportunities
- leadership programs targeted at specific professions
- scholarship for post graduate study targeted at leadership development
- formal processes for identifying and supporting emerging leaders
- building consumer engagement into ongoing education and development opportunities.

There was also a range of suggestions put forward regarding training and mentoring opportunities that could potentially be delivered by more experienced clinicians within the workplace. For example, providing junior staff with exposure to service delivery outside of their clinical stream; mentoring by senior health professionals; peer reviewed reporting on performance; reflective practice and quality improvement activities (eg the LEADs Framework); and involving junior staff in decision-making processes, clinical governance and quality and safety initiatives.

Several submissions made the comment that leadership programs need to be supported with resourcing, both in terms of funding and time for staff to participate. It was also suggested that focus groups could be held with junior health professionals to canvas what professional development is needed, and what practical supports will assist them to participate.

A final theme was the need to focus on lifelong learning and development, to foster and retain a "homegrown" health workforce and health leaders. Examples included vocational work experience for school students, student bursaries, university scholarships, professional recognition, and awards for excellence across both the public and private health sectors.

Service provider perspective

It was suggested the Future Health Leaders Forum be underpinned by a principle of improving quality and safety, to help drive quality and safety initiatives across health services.

Sector perspective

There was some interest in a Future Health Leaders Forum from a sector perspective. Representation was again discussed, with the suggestion put forward that clinicians and consumers should be well represented within a Future Health Leaders Forum. Specific areas for inclusion put forward included rural areas, indigenous health workers and peak bodies. A further suggestion was made that the Future Health Leaders Forum work closely with peak bodies to determine the identification, promotion and messaging of future health leaders.

Health policy/system perspective

There was some interest in a Future Health Leaders Forum from a health policy or system perspective. In relation to the clinician voice, it was suggested that a Future Health Leaders Forum be co-designed with consumers and carers, have consumer and carer representation and be co-chaired by consumers/carers.

Activity Mapping – Tasmanian Government Commitments against Key Themes

As part of the analysis of submissions, the following Mapping Exercise was also conducted to consider the key themes to emerge from the consultation against the *Our Healthcare Future* Immediate Actions and the Tasmanian Government's 2021 Election Commitments.

The Mapping Exercise shows there is a good degree of alignment between the key themes to emerge from the consultation, the *Our Healthcare Future* Immediate Actions and 2021 Election Commitments. The Department is progressing multiple improvement initiatives and long term strategies against many of the identified areas of need. However, there are also gaps identified which represent opportunities for further reform under *Our Healthcare Future*.

In particular, there is further work to be done under *Our Healthcare Future* Reform Initiative 3c: "Strengthen the clinical and consumer voice in health service planning". This was evident from the large number of submissions that commented on this issue and the key themes to emerge from the consultation. The need to strengthen the Departments' approach to clinical and consumer engagement is reflected in the next steps.

Other areas identified where further opportunities exist include strengthening the Department's approach to needs based population planning, as well as strategies to strengthen healthcare in the community to deliver the right care, in the right place, at the right time. While the Tasmanian Government is investing heavily in strengthening care in the community, this is an area of great opportunity to strengthen the sustainability of our health system. Further work will continue to take place to identify innovative and evidence-based strategies for Tasmania, as is reflected in the next steps.

Improvement Area 1 – Better Community Care

Reform Initiative 1: Increase and better target investment to the right care, place and time to maximise the benefits to patients.

Key Themes from Consultation	Tasmanian Government Commitments	Source
Right Care, Right Place, Right Time – a balanced mix of services across our health system, including a shift towards more care in the community.	***<u>Prevention and Early Intervention</u>***	
	$20 million to prioritise prevention and early intervention.	Election Commitment
	Redevelopment of the *Healthy Tasmania Strategic Plan.*	2020-21 State Budget
	Immediate Priorities	
	Commence expansion of Tasmanian Men's Shed Association Grants Program guidelines to include mental health and wellbeing initiatives.	First 100 Days
	Commence development of new Active Ageing Strategy, working alongside Council on the Ageing Tasmania.	First 100 Days

Key Themes from Consultation	Tasmanian Government Commitments	Source
	Primary and Community Settings	
	Finalise implementation and evaluate the Southern Hospital in the Home (HITH) Trial.	OHF Immediate Action
	Develop a rapid access to staff specialists service to support GPs and other primary care health professionals in the North and North West to care for people with complex needs.	OHF Immediate Action
	$52.0 million to palliative and community healthcare to strengthen in-home and local community-delivered services: • $27.5 million to continue Community Rapid Response Service (ComRRS) in all regions of the State, and to further pilot HiTH • $10.5 million in additional funding to strengthen in-home palliative care and after-hours services • $6.8 million to better palliative care services, in partnership with private hospitals and service providers • $1.0 million Hospital Avoidance Co-Investment fund, to match private sector investment in capital upgrades for GPs and primary care providers to deliver improved after-hours care • $600 000 for the Heart Foundation, to support heart attack and angina patients following hospitalisation • $1.4 million for Community Transport Services Tasmania to continue to support Tasmanians to access care • $4.25 million for Palliative Care Tasmania for GP education and training programs, workforce development and community education and awareness.	Election Commitment
	Immediate Priorities	
	Work with Palliative Care Tasmania and private hospitals and service providers to kickstart $17 million in new investment into better in-home palliative care and after-hours care services.	First 100 Days
	Increase access to Medical Cannabis, including authorising GP prescription, and allowing more pharmacies across the State to dispense.	First 100 Days
	Acute Health Services	Election Commitment
	22 300 additional elective surgeries and endoscopies state-wide, investing an additional $120 million for a total investment of $156.4 million.	
	280 full-time equivalent additional staff, including more than 160 nurses, 14 doctors, 30 allied health staff as well as more than 70 hospital support staff.	Election Commitment
	20 000 additional dental appointments state-wide, across emergency dental, general dental care and denture clinics.	Election Commitment
	$8.1 million to double capacity for cancer treatment at the North-West Cancer Centre.	Election Commitment
	Support Family Planning Tasmania to deliver health services across the State for women.	Election Commitment

Key Themes from Consultation	Tasmanian Government Commitments	Source
	Immediate Priorities	
	Develop a plan for the first year of an additional 22 300 elective surgeries and endoscopies state-wide – with an extra 8 300 surgeries in 2021-22.	First 100 Days
	<u>Paramedic and Regional Services</u>	
	Commence good faith negotiations with Royal Flying Doctor Service (RFDS) on long-term strategic partnership to support health services in remote and rural areas.	Election Commitment
	$26.8 million for 48 paramedics over the next two years, including 24 new paramedics for two crews in Launceston and Hobart (announced mid-March). Subject to consultation, place 24 additional permanent paramedics across all regions of the State, including: • Three new paramedics each for Sheffield, Dodges Ferry, Campbell Town, and New Norfolk. • Two new paramedics each for St Helens, the West Coast and the North East. • Making permanent the placements of two paramedics each for Swansea, Miena and Bruny Island, to work closely with volunteers to support the local services.	Election Commitment
	Establish Double Branch Stations in Sheffield, Dodges Ferry, Campbell Town, with three new paramedics at each station, providing 24/7 paramedic coverage.	Election Commitment
	Once all 48 paramedics are in place, commission a review of ambulance service demand for future investment.	Election Commitment
	$300 000 for new helipad for the East Coast located near new St Helens Hospital.	Election Commitment
	$300 000 for new helipad at Dover, to support the Esperance Multi-Purpose Centre.	Election Commitment
	$1.5 million additional per annum for the Health and Wellbeing of all emergency service personnel and volunteers.	Election Commitment
	Immediate Priorities	
	Memorandum of Understanding (MoU) signed with RFDS to provide $300 000 in 2021-22 and commence good faith negotiations on long term strategic partnership of up to ten years from July 2022, including aeromedical flight services, as well as primary healthcare in rural and regional areas, with a focus on dental and mental health.	First 100 Days
	Consult with our emergency services on the best outcomes from the additional $1.5 million per annum investment into their health and wellbeing.	First 100 Days
	Begin work to draft legislation for mandatory disease testing for delivery blood and body exposures against frontline workers.	First 100 Days

Key Themes from Consultation	Tasmanian Government Commitments	Source
Urgent Care – exploring new models of urgent care as part of a broader focus on better community care and reducing pressure on Emergency Departments.	Consult stakeholders on *Urgent Care Centre Feasibility Study* findings and finalise future delivery models. $1.0 million Hospital Avoidance Co-Investment fund, to match private sector investment in capital upgrades for GPs and primary care providers to deliver improved after-hours care ***Immediate Priorities*** Open applications for $3 million After Hours Support Program (previously announced in the State Budget), to help primary health services deliver improved after-hours care. Establish the guidelines for the $1 million Hospital Avoidance Co-Investment fund to match private sector investment in supporting capital upgrades for GP, pharmacies and primary health providers who will extend facilities to provide after-hours care.	OHF Immediate Action Election Commitment First 100 Days First 100 Days
Telehealth Services – improving access to care across Tasmania through Telehealth Services, noting ongoing need for face-to-face options.	Develop and implement a Telehealth Strategy for Tasmania that provides high quality patient care and integrates service delivery across acute, subacute, primary and community care.	OHF Immediate Action
District Hospitals – enhancing and strengthening District Hospitals to support Emergency Departments and major hospitals and provide better care to communities.	$3.4 million for rural hospital staffing and a further $5 million for new equipment for rural hospitals: • $560 000 for additional staffing at the St Helens District Hospital, with $400 000 for upgraded equipment at the Hospital • $200 000 to both St Mary's Community Health Centre and May Shaw at Swansea, for upgraded equipment, and $560 000 for additional staffing at May Shaw • $840 000 for additional staffing at the North East Soldiers Memorial Hospital at Scottsdale, and $600 000 for upgraded equipment • $200 000 for George Town District Hospital for upgraded hospital equipment • two additional paramedics for the West Coast, $560 000 for staffing at the West Coast District Hospital, and $400 000 to upgrade hospital equipment • $200 000 for upgraded health equipment at the Flinders Island Multi-Purpose Centre • $840 000 for additional staffing at the New Norfolk District Hospital, working with stakeholders attract more health professionals to regional communities.	Election Commitment

Key Themes from Consultation	Tasmanian Government Commitments	Source
Health System Integration – pursuing greater integration through a range of strategies (eg ICT systems, ComRRS, person-centred and team-based models of care).	$56 million to continue transformation of Tasmania's mental health system, alcohol and drug treatment system, and improve the health and wellbeing of all Tasmanians.	Election Commitment
	$26 million on top of $41.2 million announced in March 2021 to fund the fundamental shift in the delivery of Child and Adolescent Mental Health Services. • $8.5 million for Mental Health HiTH pilot in the north-west • $500 000 to commence roll-out of *Rethink 2020* • $5.1 million to pilot Emergency Mental Health Co-Response Team model in southern Tasmania by the end of 2021 • $1.9 million to deliver a Peer Workforce Coordinator and establish the Youth Peer Worker model as part of the Tasmanian Peer Workforce Development Strategy • $2.25 million to boost community mental health services to meet increasing demand – Rural Alive and Well, Baptcare's Choices, Butterfly Foundation • $7.83 million to continue and expand services established during COVID-19 pandemic – Regional Coordinators, Community Engagers targeting mental health literacy initiatives.	Election Commitment
	$5 million to expand the health hub at TasTAFE's Alanvale site, to deliver alcohol and drugs, youth and mental health training, as the foundation of a new Centre of Excellence.	Election Commitment
	$1 million to recruit an additional five therapeutic staff within the Prison to provide drug and alcohol intervention programs.	Election Commitment
	$10 million of new funding invested into alcohol and drug treatment services.	Election Commitment
	Immediate Priorities	
	Commence recruitment of new therapeutic staff at the Tasmania Prison Service.	First 100 Days
	Release implementation plan for *Rethink 2020*, Tasmania's new overarching mental health plan.	First 100 Days
Private Hospital Co-Location – taking up opportunities to share infrastructure and staffing and increasing working knowledge of private hospital service profiles.	Deliver co-located private hospital adjacent to Launceston General Hospital (LGH), with an expected investment of around $120 million.	Election Commitment
	Provide a one-off $20 million fund to deliver care sooner for Tasmanians by ensuring private hospitals are better able to support public hospitals to meet demand.	Election Commitment
	Immediate Priorities	
	Meet with major private hospitals, the community nursing and home-care sector, to discuss services to take pressure off the public system and put arrangements in place by 30 June 2021.	First Week
	Finalise with Calvary Health Care a MoU to remove any outstanding impediments to the $120 million co-located private hospital adjacent to the LGH.	First 30 Days

Key Themes from Consultation	Tasmanian Government Commitments	Source
Health System Pathways – clearer journeys into and through the health system for consumers (eg pathways and referral systems, care coordination, system navigation supports, access to community-based options).	See Improvement Area 2 – Sharing Patient Information	

Improvement Area 2 – Modernising Tasmania's Health System

Reform Initiative 2: Invest in modern ICT infrastructure to digitally transform our hospitals, improve patient information outcomes and better manage our workforce.

Key Themes from Consultation	Tasmanian Government Commitments	Source
Information Communication Technology (ICT) Systems – increasing investment in ICT to improve information sharing across providers and enhance patient experiences.	Procure and implement new, fully-integrated Human Resources Information System (HRIS) to replace payroll, rostering, workplace health and safety, conduct and leave management. $21.6 million for new HRIS in the Department of Health.	OHF Immediate Action 2020-21 State Budget
Digital Inclusion – taking an inclusive approach to ICT for Tasmanians with technology and digital literacy limitations.	Develop Health ICT Plan 2020-30 encompassing EMRs, new patient information system, electronic tools for managing care for patients in appropriate settings, and the new HRMS.	OHF Immediate Action
Electronic Medical Record (EMR) – prioritising a new EMR to improve information sharing across the health system.	See above – Digital Inclusion	See above
Sharing Patient Information – in addition to a new EMR, increasing integration across systems (eg pharmacy dispensing, hospital administration and discharge systems, diagnostic results).	Partner with Primary Health Tasmania to improve patient care by enhancing the interface between specialist and primary healthcare through: • implementation of a single eReferral system between primary care and the THS • scoping the requirements to implement a secure web-based application to enable GPs to view key information about patients in their care held by the THS • a continued partnership-based focus on the development and implementation of jointly agreed clinician led Tasmanian health pathways.	OHF Immediate Action
Patient Experiences – assisting patient experiences through ICT, particularly during hospital stays (eg information on continuing care needs).	See above – Digital Inclusion	
Empowering Self-Management – exploring existing technologies to help patients to self-manage (eg apps, wearables), including community supports (eg Libraries, Online Access Centres).	See above – Digital Inclusion	

Improvement Area 3 – Planning for the Future

Reform Initiative 3a: Develop a long term infrastructure strategy for Tasmania.

Key Themes from Consultation	Tasmanian Government Commitments	Source
20-Year Health Infrastructure Strategy – a range of key considerations for the health infrastructure strategy emerged from the consultation. For example: • needs based population planning • further development of existing facilities in community settings • alignment to hospital master planning processes • consideration of transport options between facilities • consideration of access to public facilities by private and community sector providers.	Develop a 20-Year Tasmanian health infrastructure strategy to ensure health facilities enable the right care, in the right place and at the right time to improve access to quality healthcare and help manage demand for acute hospital services. This will be informed by the masterplans for each of the major hospitals and also include District Hospitals, community health centres, ambulance services and mental health infrastructure.	OHF Immediate Action
	Northern Region Commence next stages of LGH redevelopment masterplan in 2021-22, with a $580 million major investment over 10 years. $300 000 for new helipad for the East Coast located near new St Helens Hospital. ***Immediate Priorities*** Begin planning and consultation for the construction of the next stages of the $580 million redevelopment of the LGH, with a full staged plan to be made public this year.	Election Commitment First 100 Days
	Southern Region Deliver expanded Stage II of Royal Hobart Hospital (RHH) redevelopment, with over $200 million in new facilities. Build second angiography suite at RHH and upgrade equipment. Build $30 million Stage II Kingston Health Centre. $1 million upgrade over Dover Medical Centre. $600 000 to upgrade equipment at New Norfolk District Hospital. $1 million to Huonville Council to upgrade Dover Medical Centre. $300 000 for new helipad at Dover, to support the Esperance Multi-Purpose Centre. $3.5 million to refurbish and upgrade Midlands Multipurpose Centre at Oatlands.	Election Commitment
	Immediate Priorities Commence the detailed design work on the $200 million Stage II redevelopment of the RHH, including new wards, an expanded ICU and expanded ED. Meet with Huon Valley Council to discuss plans for the upgrade of the Dover Medical Centre. Commence community consultation on $3.5 million Midlands Multi-Purpose Centre and $30 million Stage II Kingston Health Centre redevelopments.	 First 100 Days First 100 Days First 100 Days

Key Themes from Consultation	Tasmanian Government Commitments	Source
	North-West Region	
	$500 000 for updated masterplan for North West Regional Hospital (NWRH) and local health facilities.	Election Commitment
	$33 000 for the replacement of the King Island community car, a key essential service for community health and wellbeing.	Election Commitment
	$60 million Stage I redevelopment of the NWRH to meet future demand: • $40 million for the first stage of a new Mental Health Precinct adjacent to NWRH • $20 million for ward upgrades	Election Commitment
	Expand the Mersey Community Hospital (MCH) Redevelopment with a further $20 million to provide a total upgrade of $55 million.	Election Commitment
	$8.1 million to operate and staff a second Linear Accelerator at the NWRH to meet demand for cancer patients on the Coast.	Election Commitment
	Immediate Priorities	
	Deliver funding to King Island for new community car and establish parameters for new $500 000 Community Car and Coach Fund for access for local communities.	First 30 Days
	Commence work on updated Master Plan for the North-West Regional Hospital, and local health facilities.	First 100 Days
	Commence planning and consultation, including the Latrobe Council, for the expanded redevelopment at the MCH, including a new kitchen, new ward and more bed capacity.	First 30 Days
	Begin the planning for $60 million NWRH redevelopment, including the first stage of the new Mental Health Precinct to replace the Spencer Clinic, for completion in 2025.	First 100 Days
	Begin the planning for the installation and recruitment of staff for the second linear accelerator at the North-West Cancer Centre, for operations to commence in 2022.	First 100 Days
	Statewide	
	$20 million for an additional, new statewide hospital equipment fund. $200 000 will be provided per hospital to purchase new and upgraded equipment for: • King Island Hospital and Health Centre • Smithton District Hospital and Community Services • Beaconsfield District Health Service • Campbell Town Health and Community Service • Deloraine District Hospital • Flinders Island Multi-Purpose Centre • George Town District Hospital and Community Centre	Election Commitment

Key Themes from Consultation	Tasmanian Government Commitments	Source
	• Midlands Multi-Purpose Health Centre • May Shaw Health Centre at Swansea • St Marys Community Health Centre.	
	Paramedic Equipment	
	$500 000 for more defibrillators throughout communities.	Election Commitment
	Commission a review of ambulance service demand for best-targeted future investment.	Election Commitment
	$1.4 million for Community Transport Services Tasmania.	Election Commitment
	$9 million to upgrade our Ambulance Tasmania vehicle fleet and deliver contemporary equipment.	Election Commitment
	Immediate Priorities	
	Scope the procurement for the $9 million investment into the Ambulance Tasmania fleet, with contemporary vehicles and replacement of critical equipment.	First 100 Days
	Launch first round of the new community defibrillator program.	First 100 Days

Reform Initiative 3b: Build a strong health professional workforce, aligned to a highly integrated health service, to meet the needs of Tasmanians.

Key Themes from Consultation	Tasmanian Government Commitments	Source
Health Workforce 2040 – broad support emerged for the long-term, strategic approach proposed by H*ealth Workforce 2040*	Release *Health Workforce 2040* for consultation. Provide an opportunity for health professionals, health services, educational institutions, and future health professionals to review and provide further input into the draft *Health Workforce 2040* strategy. This will inform the final Focus Areas and Actions in the strategy.	OHF Immediate Action OHF Immediate Action
Alignment to Community Needs – aligning workforce and training positions with needs-based population planning to identify potential priority areas (eg support for healthcare within nursing homes, support for GP management of complex patients, complex care coordinator positions).	***Immediate Priorities*** Start recruitment of additional health staff for elective surgery blitz. Commence the move to enable pharmacist immuniser access to the National Immunisation Program for the first time in Tasmania. Begin scoping the operational model for the $5.1 million Emergency Mental Health Co-Response Team to assist police and paramedics in mental health emergency call-outs, through an Inter-Agency Mental Health Co-Response Reference Group.	 First 30 Days First 100 Days First 100 Days
Private Sector Collaboration – shared workforce planning strategies across the private and public sectors (eg shared resources, dual appointments).	See above – *Health Workforce 2040*	
Rural Attraction and Retention Strategies – to develop a local workforce, including strengthening the Rural Generalist Program.	Partner with UTAS to better support the recruitment of targeted specialists in regional areas through conjoint appointments, with a particular focus on the North West. Establish a Health Staff Recruitment Taskforce. $4.3 million to establish a new Rural Medical Workforce Centre at the MCH to support the recruitment and retention of permanent doctors for the region – $1 million for the establishment of the Centre, $3.3 million for staffing. Enter into a Memorandum of Understanding (MoU) with the Volunteer Ambulance Officers Association of Tasmania, to work together on attraction, retention, training and support for ambulance volunteers. The Association will be provided with $50 000 to ensure volunteers are supported with contemporary training and new equipment. ***Immediate Priorities*** Convene the new Health Staff Recruitment Taskforce with professional organisations, including ANMF, AMA and UTAS, to look at how to improve recruitment across the health system.	OHF Immediate Action OHF Immediate Action Election Commitments Election Commitments First 30 Days

Key Themes from Consultation	Tasmanian Government Commitments	Source
	Commence work with the Volunteer Ambulance Officers Association of Tasmania on a MoU to work together on attraction, retention, training and support for ambulance volunteers. Begin recruitment of a locally-based mental health specialist for the Circular Head region.	First 30 Days First 100 Days
Partnering with Education and Training Providers – to address priority areas and regions (eg TasTAFE, UTAS, ANMF Health Education and Research Centre).	Engage with UTAS to explore the alignment of future course offerings to future identified gaps in the workforce.	OHF Immediate Action

Reform Initiative 3c: Strengthen the clinical and consumer voice in health service planning.

Key Themes from Consultation	Tasmanian Government Commitments	Source
Strengthening Clinical and Consumer Engagement – respondents supported a stronger focus on clinical and consumer engagement.		
Statewide Clinical Senate – ensuring the Senate is broadly representative of the health system's workforce and consumers.	Establish a Statewide Clinical Senate to provide expert advice to the Secretary, DoH and Ministers on health service planning. The purpose, role and function of the Clinical Senate will be co-designed with key stakeholders.	OHF Immediate Action
Meaningful and Effective Consumer Engagement – strengthening existing mechanisms (eg HCT, CCECs), and taking a systems approach to involve consumers at different levels of the health system, in different ways.		
Healthcare Experiences – timely feedback on patient experiences (eg continuous patient experience surveys, feedback to peer workers or volunteers, post-discharge phone calls, hotlines).		
Education and Training – for health professionals and administrative staff to embed consumer engagement into day-to-day practices.		
Future Health Leaders Forum – ensuring current and future clinicians and consumers can participate in new and existing opportunities (eg scholarships, professional development, networking, online platforms).	Establish a Future Health Leaders Forum to support and develop emerging health leaders.	OHF Immediate Action

Next Steps

The next step in the *Our Healthcare Future* reforms is to co-design a new long-term plan for healthcare in Tasmania that builds on the solid foundation provided by the *One State, One Health System, Better Outcomes* reforms.

This plan will take an evidence-based approach that includes statewide clinical services planning and detailed modelling of Tasmanians' current and future health needs. This will ensure a more sustainable health system focused on achieving better outcomes for consumers, their families and carers now and in the future.

Developing a new long-term plan for healthcare in Tasmania

The release of the public submissions and Emerging Themes report marks the completion of the first phase in the consultation and mapping phase of the policy process.

An Expert Advisory Group will be established by the Department to engage key stakeholders and guide further policy development. The Group will guide:

- a Literature Review focused on strengthening healthcare in the community as a part of a focus on delivering the right care, in the right place, at the right time, to identify evidence-based strategies for Tasmania
- a Data Analysis Exercise to model projected demand for healthcare in Tasmania based on population needs, with a focus on identifying the future need for community care
- development of the Plan.

The Expert Advisory Group will include representatives from key stakeholder groups including health consumers, clinicians, academia, primary health and social services, together with senior members of the Department of Health.

Following the release of the long-term plan, the *Our Healthcare Future* reforms will move to a focus on implementation and change management.

Collaborative Design Processes

As the Department continues to implement the Immediate Actions set out in the *Our Healthcare Future Immediate Actions and Consultation Paper*, several collaborative design processes will occur in parallel with the development of our long term Plan for healthcare in Tasmania.

Collaborative design processes will focus on strengthening the clinical and consumer voice in health planning, as set out in Reform Initiative 3c under *Our Healthcare Future*.

The following activities will take place in close collaboration with stakeholders:

- co-design of a Statewide Clinical Senate with clinicians and consumers
- establishment of a Future Health Leaders Forum.

The collaborative design process will kick off with the upcoming release of an Issues Paper on the establishment for a Statewide Clinical Senate for Tasmania, engagement with Clinical Senates in other States and Territories, and a series of Regional Workshops with clinicians and consumers.

For further information, or to stay informed about the reform process contact ourhealthcarefuture@health.tas.gov.au.

Department of Health
GPO Box 125, Hobart 7001 Tasmania
www.health.tas.gov.au