



Allied Health
Professional Executive Committee

Allied Health Professional Executive Committee: Response to white Paper – Exposure Draft March 2015

The Allied Health Professional Executive Committee (AHPEC) is the strategic allied health leadership group in DHHS with a high level strategic focus on: Quality and safety; Workforce development and specialisation; Clinical education and research; and, Inter-professional collaboration.

Allied health professionals (AHPs) in Tasmania comprise a large number of professional groups providing essential services across the spectrum of the Tasmanian Health and Human Service System. They are the second largest workforce after nursing. AHPs are tertiary trained practitioners who apply their expertise to diagnose, treat, support and rehabilitate people of all ages. Together with a range of assistant, technical and support staff working under supervision, they may deliver direct patient care, rehabilitation, treatment, diagnostics and health improvement/prevention/support interventions to restore and maintain optimal physical, sensory, psychological, cognitive and social functions. This includes strategies for recovery following medical interventions and to maintain good health and well-being, supporting clients in the community and preventing admission/re-admission to the acute sector, or working with families in the human service area. As autonomous health practitioners, AHPs are employed in each Tasmanian Health Organisation and the Department of Health and Human Services: Population Health, Ambulance Tasmania, Disability Housing and Community Services, Children and Youth Services and the corporate areas of Strategic Control Workforce and Regulation and System Purchasing and Performance. AHPs are employed in a variety of structural and reporting contexts across both acute and community/primary health depending on the service delivery model in which they work and they are dispersed across the state.

Within the Tasmanian public sector, AHPs include: audiology, ACAT assessor, alcohol and other drug worker, counsellor, dental therapy, dental prosthetics, dietetics and nutrition, diagnostic radiography, echo-cardiology technologist, environmental health, epidemiology, exercise physiology, forensic anthropology, health physics, medical librarian, medical physics, medical scientists, music therapy, microbiology, nuclear medicine, neurophysiology science, occupational therapy, optometry, orthoptics, orthotics and prosthetics, oral health therapy, oral hygiene, perfusion, pharmacy, physiotherapy, podiatry, psychology, radiation therapy, respiratory science, speech pathology, social work and youth justice worker.

Allied health services are essential components of acute, subacute and primary health services. These services provide management of morbidities, enable patient flow through the health system, improve quality of life and prevent functional decline, readmission and reliance on the health care system; all of which are essential aspects of improving the health of Tasmanians and reducing the cost of health care. In

2009, the National Health and Hospital Reform Commission (NHHRC)¹ noted marked variations in health care and unsustainable cost increases across Australia. Accordingly, health care systems focus on greater accountability and affordability, with services and practitioners challenged to examine their practice and justify service performance, productivity and outcomes. Hospital costs are commonly associated with hospital admission and avoidance, length of stay, readmission rates, complications of care, functional decline and poorer outcomes. These are all areas where AHPS can, and do, provide services that address these areas where hospitals incur additional cost.

AHPEC supports the Government's proposals to address the issues of health service delivery in Tasmania; to strengthen the acute sector and implement the role delineation framework. However, the White Paper Exposure Draft (the Draft) focuses inequitably on the medical workforce and the medical model of service delivery. AHPEC would like to state very strongly that health care is provided by a team of health practitioners. The Draft refers to the need for multidisciplinary teams and breakdown of silos, but the language and content of the Draft reinforces silos rather than teams. AHPEC suggests those engaged in the consideration of the submission refer to the 2008 document, "Allied Health Professionals in Tasmania: Their Role and Benefits to the DHHS and Tasmanians" (http://www.dhhs.tas.gov.au/intranet/scwr/allied_health/projects/past_allied_health_projects). AHPs have a breadth of skills essential to the health care team that are not being fully utilised in the current models of care.

It is noted the Draft remains acute service focused as was the Green Paper, and AHPEC would like to highlight the need for parallel review and investment into the community sector to minimise the number of Tasmanians requiring admission to the acute sector. The acute sector reforms will not succeed without this work.

I Time for Change

AHPEC notes the issues for Tasmania - our health status, our health system challenges, our current performance – and agree there needs to be significant change in how our health services are delivered, where and by whom to address these issues and enable better care for Tasmanians.

2 Designing a better health care system

Tasmania's Health System Profile

The data in this Profile is misleading as it fails to define the "primary health system". The AHP public sector health workforce was recently mapped and the data based on number of paid FTE as at March 2015 for staff paid under the Allied Health Profession (Tasmanian State Service) Agreement and the Radiation Therapists (State Service) Union Agreement was 1232.65. This includes the public pharmacy workforce. A breakdown of this data by profession can be seen at Appendix I.

AHPs are also employed in NGOs and work as independent practitioners in the private sector. These workforces are not large and as highlighted in the recent NDIS review are insufficient to meet current demand for even NDIS services. There is not a lot of capacity for public private partnerships, but any opportunities for public private partnerships/collaboration should be considered within appropriate governance frameworks.

¹ National Health and Hospital reform Commission: *A Healthier Future for all Australian – Final Report of the National Health and Hospital Reform Commission*, June 2009

AHPEC welcomes “The Way Forward” (p21) advising of ongoing consultation with allied health, nursing and medical workforce to build a more comprehensive Tasmanian role delineation framework and while the mechanism of such engagement is not clear, looks forward to this engagement.

Key Service Issues

Surgical and Critical Care

AHPS have a significant role in surgical services providing both pre- and post-operative care that facilitates safe surgery and post-surgery outcomes. (Please refer to the Role Delineation Framework, March 2015 attached for the relevant AHPs engaged with surgical services.) Physiotherapists, dietitians, speech pathologist are just of few of the professions working within surgical services. AHPs work in cancer services, critical care, sub-acute, maternity and neonatal and burns services, and as shown by national and international literature, there are significant opportunities in these services to implement allied health led models of care that national and international evidence shows will reduce waiting lists, provide savings and improve client outcomes and satisfaction. It is crucial for the outcomes of these service areas for AHPs to be partners in the development of these service profiles.

Cancer Care

The primary care sector is vital to the cancer care workforce to deliver a planned services across the continuum of care from diagnosis to treatment recovery and living with or after cancer. As well as medical and nursing care, allied health professionals (AHPs) are engaged in both the acute and primary care services for cancer. AHPs involved in the management of clients with cancer include medical scientists, nuclear medicine technologists, medical physicists, radiation therapy, dietetics, psychology, social work, music therapy provide management and support to the client and family. Other professions such as speech pathology, prosthetics and orthotics, physiotherapy, occupational therapy also have a role in the post surgical management of cancer clients. Delivery of high quality cancer services is depended on the availability of an integrated workforce across all sectors of the health workforce – medicine, nursing and allied health – and a continuum of care across both acute and community services.

Emergency Care

The Draft notes the primary reasons for admission are stroke and musculoskeletal conditions (fractures and joint conditions). AHPs have a recognised primary role in the recovery and rehabilitation of these clients, but they also have a role in prevention of these conditions, maintenance of function, and enabling clients to continue to live, or return to their homes. For example, there are client management opportunities by using AHPs in emergency departments, as an alternative care pathway that frees up medical staff time and provide good evidence base care for our clients. There is strong evidence to support these roles which may prevent costly admissions. For example physiotherapists managing musculoskeletal conditions, podiatrists managing diabetes foot care, and social workers dealing with crisis management. This all points to the need for AHPs as part of the emergency department team.

Alternative Models of Care

Other opportunities for AHPs in service areas are models that enable full and expanded scopes of practice for AHP and allied health assistants. For example, appropriately trained and credentialed AHPs requesting diagnostic tests and prescribing. The recently published “Ministerial Taskforce on health practitioner expanded scope of practice: final report”, Queensland Health June 2014, Appendix A provides a comprehensive summary of allied health service delivery models that were identified in

Queensland Health services or the literature. The document can be found at: <http://www.health.qld.gov.au/ahwac/html/hpmintaskforce.asp>

It is important for all health practitioners to be focused on the client's journey and achieving the best outcomes possible. This will not happen with professional groups working in silos and single groups being the focus for advice on service models. We can only achieve the best service and outcomes for our clients by working in multidisciplinary teams (with appropriate skill/profession mix) that respect and recognise the skills each profession brings to the management of the patient's journey.

AHPs already work with a hub and spoke model of service delivery; developed to address issues such as recruitment to small sites and no funding for services at the smaller sites. This service model can be enhanced by a greater investment into the allied health assistant roles. With VET Cert IV training, which can be achieved by a mixture of on line and on the job training, local populations can be sourced to provide support, working under AHP supervision, to the implementation of locally based therapy programs, health literacy training, health and well-being, rehabilitation, etc.

AHPs are already using telehealth models of service delivery. There is an opportunity for a greater use of telehealth by AHPs, for example to engage with clients prior to surgery to enable prehabilitation programs, dietary advice, and post discharge to facilitate ongoing rehabilitation. This service model is another opportunity for better services where there are locally based allied health assistants. Such a model is used with audiology services where the audiologist can be sited in Hobart and with the locally based assistant still provide quality client centred management while creating savings for both the organisation and the client.

Investment in allied health assistants and telehealth will also enable better access to quality services at the local level. This is important in Tasmania where the majority of the population does not live in or near the capital city.

Primary Care, Preventative Health and Health Literacy

“The roots of, and solutions to, many problems currently manifesting in hospitals lie in the community and primary health sector” (White Paper Exposure Draft P53). Primary care occurs at all levels within a community. It includes services provided by health practitioners in the private sector and NGOs. The services may be in practitioner rooms, community and local government sites and in the client's home. It is the sector that has the opportunity to make the greatest impact on the health of Tasmanians and the need for acute services. There needs to be greater investment into the sector to: prevent avoidable health conditions through education and management programs, minimise the need for costly acute admissions, and support clients moving from the acute sector to prevent readmission. Unfortunately this sector is fragmented, due in part to factors such as business models, Commonwealth funding processes, multiple players with conflicting priorities. The new preventative health policy, *A Healthy Tasmania* is an opportunity for greater investment into this sector. There needs to be a recognition that much can be achieved in health and wellbeing before a person presents to the GP. AHPs have a major role in this preventative work, eg dietitians, psychologist, social workers, exercise physiologist. AHPs provide services that then support the GP in client management – psychologist for mental health, pharmacist to fill a prescription, radiographer to provide an x-ray, pathologist to analyse a blood sample. The client's management cannot be undertaken without this team, and none can function alone.

The role of the Primary Health Networks commencing 1 July 2015 will be of interest.

The submission to the Green Paper (Attachment X) outlines the roles of AHPs in the primary care/community care sector.

Alternatives to Hospital

AHPEC agrees there is more that can be done to provide services outside the expensive acute hospitals. Unfortunately, there is a history of cutting these programs when there are budget constraints. Examples of such services in clients' homes and nursing home are: home dialysis; Hospital in the Home (Vic Health <http://www.health.vic.gov.au/hith/>; <http://www.hithsociety.org.au/>; <http://www.health.qld.gov.au/rbwh/services/hinh.asp>) These programs provide access to a number of health practitioners, while managing the client in their home or nursing home creating significant more savings in the mid to long term than these services cost.

Working with Partners to Effect Change across the System

This is essential to maximise the use of and access to our health practitioners, however the Draft is medically focussed, with no mention of AHPs even when referring to provision of rehabilitation, mental health, hospital avoidance and chronic pain management. All areas that require team management and in which the AHPs have a major role.

3 Governance of the Health System

A review of the Clinical Governance Framework is welcomed and a statewide credentialing system is a way of operationalising this governance. Unfortunately, the current credentialing framework is focussed on medical, dental and nurse practitioners only. Work undertaken in 2010 provided a "Credentialing and Defining Scope of Practice Clinical Practice for Healthcare Practitioners in Tasmanian Health Services: The Policy Handbook" which addressed all health practitioners. Unfortunately, this work is no longer available and was not incorporated into the current process. AHPs have progressed their own governance processes through the Chief Allied Health Adviser with the completion and implementation of "Allied Health Professional Clinical Governance Framework", "Allied Health Supervision and Support Framework", "Allied Health Professional Standards", Allied Health Assistants Supervision and Delegation Framework" and "Governance Framework to Support the Introduction of Expanded Scope of Practice for Allied Health Professions in the Tasmanian Health System". This last work will require a credentialing process and a credentialing framework for AHPs is currently being drafted.

As noted in the Draft, there needs to be clarity for the roles of the THS and the DHHS. This work is currently underway. There also needs to be clarity and transparency for the roles and functions of the Clinical Advisory Groups and the Health Council of Tasmania given points 3.3 and 3.4 of the Draft. An issue for AHPEC how the Health Council of Tasmania will source the information on which this group will be providing advice to the Minister and other key stakeholders to set strategic priorities and advise on key clinic, consumer and community issues that are the best for the State rather than interest groups. If the Clinical Advisory Groups are to be a source of information, AHPEC is concerned with the process for appointing members to these groups and the current membership which lacks transparency and a process of appointment that can be seen as equitable and merit based. At present across 15 CAGS there are over 100 medical staff, 57 nursing staff and 20 AHPs. In light of need for team management of client through their pathways, there needs to be a review of the appropriateness and equity of the current membership. This is extremely important if the CAGs are to provide evidence based advice to the Minister on models of care that are going to maximise utilisation of all our workforce, create savings and provide best practice, quality care for Tasmanians.

4 Supporting the Health System of the Future

The DHHS and THS continues to recognise services are to be provided in the interests of the patients and maintain a structure to support the delivery of safe and sustainable services that will attract and retain the needed health workforce and the need to embed a research culture. DHHS has developed a *Strategic Framework for Health Workforce 2013-2018*

http://www.dhhs.tas.gov.au/intranet/scwr/education/noticeboard/tasmanian_strategic_health_workforce_framework

Currently, health workforce is largely unplanned and services develop without coordination or planning. We do not collect or use data in a way that will facilitate workforce planning. There has not been any significant investment in workforce planning for some years. The AHP workforce has recently been mapped, and this work is highlighting issues with our workforce data systems but is also producing a methodology applicable to other professional groups, which are far less complex, and data management guidelines are being developed. This work will enable us to better understand our health workforce for service planning and managing supply and demand in collaboration with our partners in the VET and tertiary sectors.

Workforce planning will facilitate the appropriate skill mix for service delivery, and may address some of the issues where services are not meeting the needs of Tasmanians eg mental health service skill mix, community dietetic services are non-existent, numbers and distribution of rehabilitation beds and services, vulnerability of small professions (orthoptics, perfusion, medical physicists). It will minimise the issues that arise when a service is proposed by an interest group, a single profession supports it and there is no consideration of other services required to support that service. The development of the role delineation framework and service profiles must take these factors into account, but this can only work well with good data.

We need to make better use of the second largest workforce group in health, AHPs (roughly one third of the health workforce), their breadth of skills and patient centred care and autonomy of practice which facilitate a high level of flexibility to enable service delivery to maximises patient outcomes.

There are opportunities for Simulated Learning for AHPs, for increasing both assistant and professional training capacity and for junior staff. The current focus of simulation in Tasmania is on nursing and medicine. Opportunities for AHP are limited but work is being undertaken with support of the Tasmanian Clinical Education Network funding and forming partnerships with private hospitals.

Research is another area in which AHPs are not highly engaged, giving us space for creating opportunities. An AHP symposium is being held every 2 years to provide a forum for the presentation of AHP research, and promotion of AHP research is a key focus area for the Chief Allied Health Adviser and AHPEC.

AHPs also have access annually to an award for innovation in service delivery with a prize of \$1000 across 3 categories.

As noted above, AHP is not a single professional group and while there are similar issues across the professions there is also a diversity of profession-specific issues. Tasmania only trains a small number of allied health professions. We are at a disadvantage for recruitment and this is more difficult in regions and for part-time positions (for some professions). Mal-distribution of our health workforce is an issue for Tasmania.

Innovation and Opportunities

The AHP workforce. There are significant opportunities in the public health system to use the AHP workforce more effectively and efficiently and to their full scope of practice. However, there are barriers

within the public system preventing AHPs from working to full scope of practice; eg, a physiotherapist can order plain x-rays in private practice, but not in the public system; dieticians have the training and competence to order enteral feeds, but currently have to arrange this to be done by a medical practitioner; and speech pathologists in other states use local anaesthetics in speech pathology led swallowing clinics. Other examples include broadening the services provided such as psychologists being used in the Older Person/Dementia Behaviour Management programs and employment of speech pathologists in Mental Health Services to facilitate differential diagnoses in children and adults; and allied health led models of care.

Allied health assistants and technicians. While this workforce has been in place for many years, there is an opportunity to review and expand the allied health assistant and technician workforce in those professions currently using these staff and in developing new roles in dietetics, social work, optometry and psychology. Research has shown these roles improve access and enable greater treatment dosage which improves outcomes for clients and levels of satisfaction. We also need to use these support staff to their full scope of practice. Increasing numbers of allied health assistants working at full scope of practice enables AHPs to use their higher level skills more productively and expand their scope of practice to reduce demand on busy medical services.

Expanded scope of practice. There is capacity to develop AHPs expanded scopes of practice as has happened in other jurisdictions and overseas; eg podiatrists, physiotherapists and psychologists with the appropriate therapeutics training being enabled to prescribe; physiotherapy led low back pain and rheumatology clinics (pilot programs are currently running); orthoptists administering eye drops; pharmacists prescribing and undertaking immunisations; dental therapists with additional training providing services to adults. A framework to implement full scope and expanded scope of practice for AHPs within the Tasmanian public health system is being finalised to provide a governance structure to facilitate these opportunities.

Clinical Redesign. Some services have made significant change to their models of care to meet increasing patient demand and morbidity complexity, and the Health Services Innovation project will provide an opportunity for further AHP engagement in clinical redesign and development of new models of care.

Workforce models. Along with development of AHP workforce mapping and data reporting there is an opportunity to look at new workforce models such as the Calderdale Framework being implemented in the Northern Territory and Queensland.

Develop and expand other models of care. Some services have been implementing new models of care for some years, but there is opportunity for more to be undertaken. Alternative models of care utilising the AHP workforce include: an expansion on AHPs services to provide a rapid response service in the community; trial an after-hours AHP community service; use alternate conservative AHPs pathways and self-management strategies to avoid or delay surgery; fully include AHPs in pre-admission clinics to prepare clients and their homes for surgery and improve and monitor nutrition status which evidence shows improves client outcomes and contributes to shorter lengths of stay; comprehensive assessments to prevent poor outcomes through failed rehabilitation; increase AHP input to surgical services to provide alternate pathways for obesity management, hand therapy and shoulder, hip and knee surgery (pre- and post-surgery); engage dietitians more in the management of obesity surgery, eating disorders, chronic disease and cancer; use of pharmacy technicians on wards to support nursing staff with medication management.

Employment of emerging professions. Exercise physiologists are trained in Tasmania and have a complimentary skill set to physiotherapy, providing exercise prescription for clients in rehabilitation, but they are not employed in the public sector.

Increasing use of technology. There is an opportunity for AHPs to use telehealth more as the evidence has shown this to improve access to services; use of simulated learning to increase student placement capacity; and, using technology to provide more efficient services; eg, although demand for laboratory services has increased, purchase of technology (a one-off cost) enabled this demand to be met without any increase in staff.

Conclusion

The reform of the Tasmanian Health System is an opportunity to address the issues impacting on our ability to provide safe sustainable services across the continuum of health care and including mental health, drug and alcohol, rural and community services. Service redesign needs to be undertaken in the context of workforce planning and innovation.

The significant role of allied health professionals is often not recognised, with media and government where the focus is on medical practitioners and nursing, resulting in missed opportunities for the value adding and efficiencies AHPs professions can offer to the health system.

APPENDIX I: Public Sector Allied Health Professionals by Profession and paid FTE

Profession	Occupied FTE
ACAT Assessor	11.77
Alcohol and Other Drug Worker	9.60
Audiologist	3.50
CYF* Health Professional	3.60
CYF* Child Protection Worker	120.72
CYF* Case Manager	29.12
CYF* Family Violence Worker	19.04
CYF* Youth Justice Worker	16.72
Cardiology Health Professional	5.40
Counsellor	11.50
Dental Prosthetist	13.10
Dental Therapist	43.80
Dietician	41.45
Environmental Health Officer	7.75
Epidemiologist	1.80
Librarians	2.50
Physicist – Health	3.00
Physicist – Medical	8.00
Medical Scientist	76.59
Microbiologist	2.00
Music Therapist	0.25
Nuclear Medicine Health Professional	4.00
Occupational Therapist	91.75
Optometrist	0.30
Orthoptist	0.21
Orthotist/Prosthetist	10.40
Perfusionist	2.00
Pharmacist	110.80
Physiotherapist	122.70
Podiatrists	23.18
Psychologist	40.83
Radiation Therapist	53.21
Radiographers	66.48
Radiographer/Sonographer	1.40
Sonographer	4.90
Social Worker	97.31
Speech Pathologists	31.47
Other**	140.50
Total	1232.65

*CYF – Child Youth and Families

** Other comprises staff paid under the AHP award in positions and units that do not define the professions such as management; quality and safety; complex, chronic and community services; and some rehabilitation and mental health staff in generic positions such as Allied Health Professional.

Appendix 2: AHPEC submission to the Green Paper February 20, 2015

DELIVERING SAFE AND SUSTAINABLE CLINICAL SERVICES GREEN

PAPER – REBUILDING TASMANIA’S HEALTH SYSTEM

ONE STATE, ONE HEALTH SYSTEM, BETTER OUTCOMES

Allied Health Professional Executive Committee

Response to the Green Paper

Executive Summary

Allied health professionals are essential across all health services and this review is an opportunity to look at this workforce and how the skills of each professional group are being used to best advantage in the public health system.

The health sector needs to be open to change, building a health service delivery model, culture and policy/legislative context that has the flexibility to change with changing health demographics, evidence based research, health practitioner training and changes to scopes of practice, workforce demographics and new roles.

AH are required at all levels of the core services outlined in the Role Delineation paper.

Allied Health Professional Executive Committee (AHPEC)

The Allied Health Professional Executive is the strategic allied health leadership group in DHHS with a high level strategic focus on: clinical governance, workforce development and specialisation, clinical education and research, and inter-professional collaboration.

Allied Health in Tasmania

Allied health is an umbrella term used to refer to a range of professions that are not medical practitioners, nurses or dentists. They are tertiary trained health and human service professionals. Allied health professionals work in all sectors of the public health care system providing diagnostic, research, scientific, therapeutic, staff development and community services that support and enable other health practitioners providing health care to Tasmanians. In Tasmania this includes those allied health professionals providing health and welfare services in the Human Services, including Disability, Housing and Community Services, the Tasmanian Health Organisations and Public Health Services.

In Tasmania, allied health is the second largest workforce after nursing numbering just over 1400 staff. It comprises a large and diverse group of health professions, essential to the functioning of the health sector at all levels. Allied health professions in Tasmania are: Audiology, Chaplaincy, Counselling, Dental Therapy, Dental Prosthetics, Dietetics and Nutrition, Diagnostic Radiography, Health Physics, Environmental Health, Epidemiology, Exercise Physiology, Medical Librarian, Medical Physics, Medical Science, Music Therapy, Nuclear Medicine, Occupational Therapy, Optometry, Orthoptics, Orthotics and Prosthetics, Oral Health Therapy, Perfusion, Pharmacy, Physiotherapy, Podiatry, Psychology, Radiation Therapy, Speech Pathology, Sonography and Social Work. Allied health professionals may work with assistants and technicians under their direct supervision.

Allied health professionals and assistants have a significant role in acute, subacute and primary health care.

Response to the Green Paper

The Green Paper and Tasmanian Role Delineation Framework propose changes to our health system that focus on the delivery of safe sustainable clinical services tertiary services and primary care. It does not impact on those services provided by Human Services and Public Health.

The Green Paper recognises the need to review services to provide access to better care and establish the profile of services across the state to ensure equal access to quality services for all Tasmanians. The data shown in the Green Paper on service timeliness, quality of care, service inefficiencies and provision of services not based on service capability, highlight the need for change.

Improving outcomes:

Our health service needs to re-focus on primary and community care; shifting the balance of care from the hospital to the community, redesigning clinical services and strengthening local public-private and interstate partnerships. This is a key area for Allied Health. Allied Health professionals work across the continuum of care; integrating the acute, and community sectors and providing key linking services for clients. The health service needs to focus on outcomes rather than outputs to meet the Minister's target of the healthiest population in Australia by 2025. This will require a change to the KPIs for the health service.

There is a need to refocus on true multidisciplinary teams that have a well-developed understanding of person centred care, that are enabled to work within their full scope of practice and the autonomy of these practitioners respected. There are times when the best leader for a team may not always be a medical practitioner, for example in a rehabilitation team. Allied Health and their nursing colleagues could be well utilised leading teams where the team leadership is based on the best role for the job rather than profession.

Alternative models of care need to be supported where research and evidence based practice show they improve the quality and safety of services and provide appropriate support in the smaller district hospitals and community health centres building local capacity. There is a growing body of evidence to support the use of Allied Health professionals and assistants in alternative models of care (i.e. such as orthopaedic pre-surgical programs, holistic approaches to bariatric surgical programs). The use of telehealth will also play a key role in service delivery now and into the future. The provision of alternative models of care requires careful review of workforce planning and staffing levels in order to develop these further (i.e. Calderdale Framework, Skills for Health).

Community based service provision which is allied health focussed with education, prevention, and self-management at its core, has an evidence base and has the ability, with appropriate support, to positively impact on hospital avoidance and/or length of stay, and, in general, a healthier community.

Tasmanian Role Delineation Framework

The Green Paper focus is on providing better quality care. Better quality care requires a holistic approach focussing on the patient journey (i.e. person centred care); an important function of allied health. We have the opportunity to look at the health system as a whole and how the resources of its workforce can be best utilized for the benefit of Tasmanians. The current Role Delineation Framework focuses on a medical model and acute services which limits the aim stated in the Green Paper for providing access to better care. AHPEC notes that consultation prior to the release of the Role Delineation framework was with medical practitioners only. This was a significant oversight and

assumption that medical practitioners are the sole providers of our health service. This devalues the significant contribution of allied health, nursing and support staff in the provision of health care.

A focus on local service, closer to home, may not equate to better quality care or improve patient outcomes. The strength of Allied Health is its ability to provide a variety of services in different settings. (Please see the Role Delineation Framework paper to be submitted with track changes.)

AHPEC supports the principles of the Role Delineation Framework in the context of clinical capacity of the health facility being determined on the basis of an assessment of the service need, number, range and expertise of all health practitioners. AHPEC supports the definition that clinicians are medical, allied health and nursing professionals, i.e. not only medical practitioners.

Access to care:

When planning access to services, those issues listed in the Green Paper are important, but so are those such as site, ease of access, cost of access (client and THS), parking, accommodation, short stay and follow up to home, HITH, impacts on workforce and service design.

Telehealth research and pilots has been shown to be an effective adjunct to some allied health services. There is growing evidence from QLD on the benefits and provision of services such as Telerehab.

Options for using local private providers is limited for most allied health services due to the small private sector and the types of services provided by NGOs. Use of the private sector is also dependent on the level of private health insurance in the Tasmanian populations and the significant gap payment required. Further, sustainability of funding for these services is often not guaranteed long term (i.e. Commonwealth funded TML programs such as Care Coordination).

Effective interaction and collaboration between the public sector allied health service providers on any proposals for non-public services and/or pathways would provide a more constructive and seamless process for clients to navigate, post discharge and for support available within the community..

The health workforce is our greatest cost. Access to better care also requires consideration of the whole health workforce and how we are using the skills of the workforce to benefit the client and the organisation.

Greater focus on primary and community care:

As noted in the Green Paper Supplement No.3, Primary Health refers to a range of community health and care services that are provided in the community close to where people live and work. These services are the first point of contact for people accessing the broader health care system.

Primary care requires more investment to maintain the health of the population keeping them out of hospital, and supporting them when they return to the community. It is the sector that can deliver the most benefit to Tasmanians in the development of health literacy, community health and well-being programs.

The sector receives a mixture of state and commonwealth funding which leads to service fragmentation, competition (for dollars) rather than collaboration, and has a history of non-sustainability. Funding for allied health services is often not recurrent. Where there is sound evidence as a result of the evaluation

process, to support pilot programs, there needs to be dedicated funding into this sector to meet the needs of Tasmanians and to fulfil the goals of the public health system and the Minister for Health.

Greater service provision by the private sector in the community is not always an option for allied health where, for some professions, private services are limited or non-existent. This requires expansion of Medicare enabling access to allied health professionals as first contact providers without a medical practitioner referral. This will facilitate greater access to services.

The integration of primary and community care with acute services is most apparent in allied health services. This model provides greater flexibility for service provision along the continuum of client care and is more person-centred. Primary and community care must be considered as part of the whole health service; if not the fragmentation of services and disconnect between community and hospitals will escalate. This would be in direct contrast to the provision of person-centred care and the continuum of care. It also provides significant clinical and corporate governance risks, reduces flexibility, increases barriers for clients, and increases navigational issues and the risk of people falling through gaps between service providers, lowering the health outcomes for the population. Primary and community care services must continue to work in tandem with hospital service to ensure a seamless service for our community.

What does this mean for the health system?

There is an urgent need to redesign workforce and service models to provide services that are effective, efficient, patient centric and evidence based. This will require changes to culture; recognising and enabling the scopes of practice of all health care team,

The proposed Clinical Services Profile will provide a vehicle to systematically review the workforce capability and capacity to deliver services, link workforce planning to service need and focus investment on the workforce of the future. All sectors of the health workforce need to be consulted in this process.

A strategic workforce planning unit is recommended that can build on the work done to date and move to the future including all professional groups (i.e. allied health, medical and nursing).

Evidence shows that the best care for the client occurs where it is provided by a multidisciplinary team that is respected and enabled to work to their full scope of practice and competence.

Supplements

I. Sustainability

There is a need for research to understand the financial impost of all aspects of a health service that can lead to more informed discussion on where sustainability issues lie.

There needs to be collaboration across sectors and State and Australian Governments to decrease the fragmentation of services, improve planning and coordination to ensure programs with appropriate evidence base are the best way to use scarce health dollars and can be implemented and sustained.

We need to make the most of our workforce skills, enabling full and expanded scopes of practice where supported by evidence and best practice research. Allied health professionals have a significant role in the area of expanded scopes of practice and alternative workforce models. They are accountable for their work practices and have measured statistics on service provision for many years. In 2014 allied health services in the THO's implemented a statewide statistics system – Activity Bar Coding (ABC). There are a number of non-allied health services now introducing the same system (i.e. Palliative Care, Persistent Pain Service). This focus on measurement can provide evidence to support sustainability into the future.

2. Tasmania's Health Workforce

Health workforce reform does not only mean a re-configuration of the workforce but also the education and training programs that prepare and support them. The majority of allied health professionals are trained on the mainland and Tasmania competes with other jurisdictions in recruitment and retention. This has most impact on the smaller professions. The majority of students who leave Tasmania for training elsewhere do not return². We need a workforce strategy that considers services holistically for all professions.

We need to invest in allied health professional workforce research to address the issues and build opportunities to improve the interface between the tertiary training programs and health workforce needs. Current programs nationally, are already creating issues of over-supply in some professions (Occupational Therapy, Dietetics,) and shortages in others, such as Orthoptics and Medical Radiation Physics, is creating an imbalance of skills sets available to our workforce.

We need to enable our workforce to maximise their skills. The Chief Allied Health Adviser is working to develop expanded scope of practice with the development of the Expanded Scope of Practice Framework and establishing podiatry prescribing in Tasmania. The allied health professions offer a significant opportunity for the health system to create efficiencies in service delivery, supporting and freeing up other professionals to focus on using their skills to the best advantage.

Allied health assistants work under the supervision of allied health professionals and there is potential to grow this workforce. Assistant and support staff need to be supported by strong governance frameworks using clear mechanisms of delegation and clinical supervision to build clinical capacity without compromising safety and quality. Allied health has this governance in place with the Allied Health Assistant Supervision and Delegation Framework. We need to ensure full use of assistant scope of practice through appropriate delegation by allied health professionals.

3. Building a Stronger Community Care System

Allied health professionals are essential to health and social care in the community providing programs that prevent admission to tertiary care, facilitate discharge back into the community for post tertiary care, and provide maintenance in the community.

The Green Paper is focussed on moving services to the community sector and the formation of partnerships to deliver services. Allied health services in the community are provided by the public sector (outpatient programs running from clinics, community home visiting services), private services and NGOs. NGO services/programs may be funded by the State or Federal public sector, as well as donations. The allied health private sector is limited in professions and services available. The public sector is required to fill the gaps. For example, allied health professionals, particularly the public sector may work with clients with complex high needs that do not fit the funded programs and services are difficult to access particularly in rural and regional areas.

It is cost effective to move services from the acute sector, but these savings need to be re-invested into the primary sector; an area chronically underfunded, but one that has the opportunity to provide significant saving to the public health sector in the long term.

Neither the Green Paper nor the Role Delineation Framework consider the role of the District Hospitals or Primary Health Networks. The role of the District hospitals is still to be clarified, however, the objectives of the Primary Health Networks is to be focused almost solely on general medical

² Report on Tasmanian Student undertaking AHP training interstate 2002 - 2007

practitioners. This focus will not enable seamless care and access to other health services in the community.

4. Emergency Care (ED)

Management of ED services is complex, however, there are opportunities through the Health Service Innovation, Clinical Redesign project to look at the workforces and models of care in ED that will facilitate management by allied health professions of appropriate conditions presenting to ED; particularly programs that minimise wait times and maximise opportunities to get these clients back into the community for ongoing care such as working as part of the assessment team, providing alternative care pathways and diversion from EDs. Research has shown allied health professionals roles in ED result in improved access to care, greater efficiency of services and freed up medical specialist time. For example, the current pilots on the role of physiotherapists in EDs funded by Health Workforce Australia, aged care services provided in ED, mental health teams in ED, and management of low back pain in ED.

5. Elective Surgery

While it is important to address those factors impacting on surgery wait lists, there is also a need to consider alternative programs such as surgery diversion programs that research has shown to decrease wait lists for medical specialists. Allied health professionals have a role in providing alternatives to surgery, for example physiotherapy incontinence programs decreasing the need for pelvic surgery, speech pathology programs minimising the need for vocal nodule surgery, multidisciplinary orthopaedic waiting list programs, and prehab programs. Enabling full scope of practice for allied health professionals and for those with relevant post graduate training is a cost effective way to deliver health services. Allied health services providing management alternatives to surgery are significantly cost effective.

Allied health have an essential role in preparation for surgery, for example nutrition assessments for abdominal surgery, speech pathology assessment for head and neck surgery, physiotherapy assessment for orthopaedic surgery, and in post-surgery such as rehabilitation and other programs, that improve post-surgery recovery and minimises risks of re-admission.

Summary and Recommendations

Allied health professionals are essential across all health services and the review is an opportunity to look at this workforce and how the skills of each professional group are being used to best advantage in the public health system.

The health sector needs to be open to change and to build a health service delivery model, culture and policy/legislative context that has the flexibility to change with changing health demographics, evidence based research, health practitioner training and changes to scopes of practice, workforce demographics and new roles.

Allied health professionals are required at all levels of the core services outlined in the Role Delineation paper.

Recommendations include:

- Allied health professions are included in all levels of the Role Delineation Framework – please see additional paper with tracked changes that includes allied health as a Support Service.
- An allied health professions workforce plan be developed that is integrated with the medical and nursing workforce plans.
- Service development be need and capability based and framed in models of task assessment and delegation to the professional with the best skill set, such as the Calderdale Framework.
- Public funded allied health services provision be recognised as an integral and essential in the provision of community care.

- Strong pathways are required to provide collaborative care across providers e.g. Canterbury pathways, and such pathways are adhered to.
- Recognition, and expansion, of the role and expertise of allied health professionals in the leadership of multidisciplinary and person centred models of care.