



**Australian Nursing & Midwifery Federation  
(Tasmanian Branch)**

**One State, One Health System, Better Outcomes  
Delivering Safe and Sustainable Clinical Services**

## **Submission**

24 February 2015

## Australian Nursing & Midwifery Federation (ANMF)

### Organisation Overview

The Australian Nursing and Midwifery Federation (ANMF) is both the largest nursing and midwifery union and the largest professional body for the nursing and midwifery teams in Tasmania. We operate as the State Branch of the federally registered Australian Nursing and Midwifery Federation. The Tasmanian Branch represents over 7,100 members and in total the ANMF across Australia represents over 240,000 nurses, midwives and care staff. ANMF members are employed in a wide range of workplaces (private and public, urban and remote) such as health and community services, aged care facilities, universities, the armed forces, statutory authorities, local government, offshore territories and more.

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

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Within the health sector there is a strong consensus about the need to reconfigure health services with the aim of improving the quality of health services and care. Reconfiguring health services is driven by wanting to deliver better quality clinical services for individuals and communities, to reduce the time it takes for them receive definitive and specialist treatment, and to reduce unwarranted variation in the quality of care. Changing health care needs and the advent of new technologies mean that we need to update how we respond to the pressures to ensure the best quality of care. This is about recognising the best location to provide care which balances the needs and convenience of patients/consumers with achieving a critical case mass to ensure the best possible clinical outcomes. The ANMF (Tas Branch) however cautions that without preparedness to consult with key stakeholders groups in a genuine, timely and transparent way and over reliance on a top down approach without equipping existing organisations and services to both lead and adapt to change will hinder the significant reforms and elicit negative consequences.

### Key Responses:

1. ANMF (Tas. Branch) is in agreement with the case made out for change and recognises the reconfiguration of health services in Tasmania is a necessary precondition for Tasmanians to have a health system which is safe and sustainable.
2. The ANMF (Tas Branch) cautiously supports the use of the modified Role Delineation Framework, following consultation with ANMF, only where there may be demonstrated improvements in outcomes and reductions in variation of standards of care.
3. The ANMF (Tas Branch) accepts the process of delineation recognises levels of clinical service and corresponding levels of support. However ANMF (Tas Branch) expresses significant concern at the narrow prescriptions of staff profile, lack of specificity and workforce requirements related to the nursing profession and nursing teams.
4. The ANMF (Tas Branch) would assert there is a requirement to redesign the scope of the work before redesigning the workforce models.
5. The ANMF (Tas Branch) contends nurses are well positioned to act as navigators for patients/consumers across multidisciplinary teams by virtue of their professional knowledge and adaptive capacity.
6. The ANMF (Tas Branch) argues nurses and midwives are the largest workforce within the clinical streams and have the potential to play a leading role in driving overall productivity and efficiency.

7. The ANMF (Tas Branch) strongly advocates the introduction of **Nurse Sensitive Indicators** to monitor and analyse trends and unit specific patient/ client outcomes in addition to the monitoring and measuring conducted in compliance with the National Health Reform; Performance and Accountability Framework.
8. The ANMF (Tas Branch) strongly advocates the use of dashboards to inform the health professions, community and funders of the performance as well as compliance against these key measures.
9. The ANMF (Tas Branch) cautiously supports the Mersey Community Hospital being designed and designated as a Centre for Excellence for High Volume Short Stay procedures. This includes Day Only Surgery and Extended Day (23hr) models of care. However this may be extended to 72 hrs. The ANMF (Tas Branch) believe it is necessary to keep a High Dependency unit available at the Mersey to support the capacity to escalate care if needed.
10. The ANMF (Tas Branch) supports the maintenance of low risk midwifery services at the Mersey Community Hospital and Emergency services access.
11. The ANMF (Tas Branch) asserts the RDF is a clinician to patient ratio model significantly skewed toward the medical profession and seeks assurance this will not compromise the existing evidence based workload models of nurses and midwives to patients which currently operates in Tasmania.
12. The ANMF (Tas Branch) would suggest the registered nurse as the only generalist clinician within the health workforce, however nurses are prevented from practicing to their full potential by a range of legislative, administrative, funding, policy, custom and practice barriers.

## Introduction

The ANMF (Tas Branch) welcomes the opportunity to contribute to the development of an integrated, effective, safe and sustainable health system for Tasmania into the future. The ANMF (Tas Branch) takes seriously its responsibility in providing considered and constructive feedback on the Green Paper, *Delivering Safe and Sustainable Clinical Services* as a precursor to the development of the White Paper due for release in March 2015. To this end, ANMF adopted a consultative process for collecting and collating the viewpoints of ANMF (Tas Branch) staff, members, council and executive in response to the questions contained in the Green Paper. Key priorities of ANMF (Tas Branch) include, *inter alia*, patient safety, consumer welfare, and workforce conditions for care workers, nurses and midwives and these priorities are embedded in our responses to the Green Paper.

The Green Paper was circulated to these groups, along with an invitation to provide a (de-identified) response to the questions. The purpose of the One State, One Health System, Better Outcomes Reform Package is intended to lead to improved leadership, accountability and governance in response to the multiple reports, analysis and reviews conducted over many years.

### ***The Case for Change***

ANMF (Tas Branch) is in agreement with the case made out for change and recognises the reconfiguration of health services in Tasmania is a necessary precondition for Tasmanians to have a health system which is safe and sustainable. The pressure to reconfigure health services will continue to grow in response to the changing demographic profile of the State, financial imperatives and workforce constraints. However transforming health services in Tasmania will be less dependent on gestures by politicians and more on engagement with the clinical service workforce in its entirety. Integrated systems are well placed to deliver innovations in healthcare but are entirely reliant on models of health care provision which are fit for purpose. The arguments outlined in the *Green Paper* are relevant to plans to improve patient safety and quality however reconfiguration is an important but insufficient approach to improve quality as it represents clinical, financial and social risk through the potential for dislocation of services. It must be aligned with other measures to strengthen delivery of care and to instil organisational cultures of improvement. The local context and specialty specific balance between access, workforce, quality, finance and technology need to be the deciding factors in determining how local services are configured and delivered and underpinned by detailed workforce plans aligned to service plans.

### ***The Role Delineation Framework***

The implementation of the Clinical Services Profile is identified in the *Green Paper* as a critical element of the delivery of safe, sustainable health services and will be achieved through the use of Role Delineation Frameworks (RDF) *Working Draft*. The use of this

framework is not new and not without risk and should not be conceived or implemented as a 'one size fits all'. RDF's are guides only and designed to describe minimum service requirements without due regard for innovation and service integration. Hospitals are part of an interconnected web of care stretching from the patient/consumer's home to the most specialist tertiary-level service. Clinical networks, innovative models of care and new technologies offer opportunities to strengthen that web and deliver more co-ordinated care, but in planning services there needs to be cognisance across that web to ensure the most efficient distribution of services, to remove duplication, and to ensure that patients receive the right care, in the right location, at the right time. Any proposal needs to have come out of a process with strong engagement from **all** clinicians and the public. Doctors are a constrained and expensive resource yet remain the dominant workforce drivers within the consultations to this point. The medical profession have also proven they are slow to innovate.

The ANMF (Tas Branch) cautiously supports the use of the RDF only where there may be demonstrated improvements in outcomes and reductions in variation of standards of care. The engagement of health professionals and consumers will be pivotal to a successful transition. However the failure of the existing mechanisms for consultation combined with a culture of vested interest will require extensive re visioning of the ways of working with both cohorts. The ANMF (Tas Branch) asserts the RDF is a clinician to patient ratio model significantly skewed toward the medical profession and seeks assurance this will not compromise the existing evidence based ratio models of nurses and midwives to patients which currently operates in Tasmania.

The alignment of state-wide system configuration with efficiency should produce a system able to respond more flexibly to changing demands. However this should not be seen as an opportunity to reduce internal resources in the guise of operational efficiencies through service redesign. The need for a clear and transparent relationship between clinical governance activities and outcomes is vital in ensuring the right services are delivered in the right place at the right time by the right person.

### ***Critique of the Role Delineation Framework***

1. There is substantial risk for the harmful effects of organisational instability and transient leadership, the existence of a culture of compliance and fear based on targets and performance management, and a gulf between clinicians and managers.
2. The Role Delineation Framework forms the basis of the clinical services profile. This is a critical threshold measure for change. However there may be unrealistic expectations about what the changes in clinical service profiles will deliver.
3. There is potential for change with obscene haste without supporting staff to lead and adapt to change.

4. The selective consultation with clinicians able to improve quality of care is lamentable. The medico centric nature of both consultation and design negates the opportunity for innovation and alternative nursing led models of service delivery.
5. The definitions matrix focuses on core clinical services and it is acknowledged they will broaden over time. However the levels of complexity require significant adjustment to meet current particular and specific contexts. The NW does not have inpatient specialty services e.g. Alcohol and Drug services, as all are treated in the community as ambulatory care.
6. The *Green Paper* states the definitions matrix was developed in consultation with Tasmanian clinicians. Consulting with approx.120 medical practitioners does not equate to “consulting with Tasmania clinicians”. The ANMF (Tas Branch) states nurses are the majority of the clinical workforce and were excluded from the consultations.
7. The inference to be drawn from this is the perpetuation of models of doctor delivered care as opposed to trans-disciplinary led care where managing the continuum from illness to health involves a range of healthcare professionals.
8. The ANMF (Tas Branch) accepts the process of delineation recognises levels of clinical service and corresponding levels of support. However there are circumstances where nursing roles must be uniquely recognised and valued e.g. mental health and medication management. The framework does not mention nursing specific roles for mental health.

### ***Redesigning Clinical Services***

The *Green Paper* describes clinical service redesign as evidence based approach to improving acute health care. To maximise the potential benefits which may be elicited through the clinical redesign process will require both horizontal and vertical integration of services. There is little evidence within the paper this has been considered and substantial evidence to support a continued over medicalization of health services. The paper also asserts that: clinical services will be redesigned to “...*utilise clinical redesign and evidence based models of care to improve patient flow*” and “*invest in new workforce models and ensure that our workforce resources...meet peak periods of demand*”. The ANMF (Tas Branch) would assert there is a requirement to redesign the scope of the work before redesigning the workforce models. Workforce redesign must have as major goals sustainability and the ability to harness the social capital available within the existing workforce. In the health care system of the future, hospitals will still play a major role but are likely to work more collaboratively rather than being standalone institutions. There should be a drive towards working more closely with community, social and



primary care services in locally integrated systems to ensure that people are only cared for in hospital when appropriate. However the link between volumes of care and outcomes does not necessarily demonstrate a causal relationship. Volumes should not be used in isolation as a justification for centralising care.<sup>1</sup> There needs to be congruence between the complexity of the services delivered and the requested levels of service and there needs to be a distinction between whether a model is safe and whether it is sustainable.

The *Green Paper* states ‘...workforce planning will be based on outcomes for communities, consumers and the population...rather than existing professions and their interests and skills, demarcations and responsibilities.’ The ANMF (Tas Branch) contends nurses are well positioned to act as navigators for patients/consumers across multidisciplinary teams by virtue of their professional knowledge and adaptive capacity. Research in clinical settings demonstrate a quantifiable link between appropriate levels of skilled nursing staff and reduced hospital mortality, hospital acquired infections, failure to rescue and length of stay.<sup>2</sup> A clinically appropriate proportion of registered nurses on medical and surgical units has been associated with reduced medication errors and wound infections.<sup>3</sup> Bray *et al* (2014) describe the intensity of nurse staffing at weekends had a bigger impact on stroke outcomes than additional consultant ward rounds.<sup>4</sup> The ANMF (Tas Branch) argues nurses are the largest workforce within the clinical streams and nursing and midwifery services have the potential to play a leading role in driving overall productivity and efficiency.

The Health Services Innovation Network has been allocated substantial funds through the Health Reform Package and asserts all clinical redesign offices will follow the five (5) main clinical redesign steps of: scoping, diagnosing, implementing, evaluating and sustaining. It is difficult to grasp within the *Green Paper* how this work will inform the redesign of clinical services, yet is pivotal in clinical service profile determinations. There appears to be a lack of alignment between the capacities for each body of work to support each other. Nurses have assisted in the reshaping of health services and advanced practice nurses are now a vital element of contemporary health systems. This is of particular importance in healthcare systems being able to respond to the growing number of people with chronic health conditions. Strengthening the use of data and information technology to support clinical decision making will assist with the

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<sup>1</sup> Harrison A (2012). ‘Assessing the relationship between volume and outcome in hospital services: implications for service centralization’. *Health Services Management*, vol 25, no 1, pp 1–6.

<sup>2</sup> Kane, R.L, Shamliyan, T.A, Mueller, C, Duval, S & Wilt, T.J 2007, ‘The association of registered nurse staffing levels and patient outcomes: systematic review and meta-analysis’, *Medical Care*, vol. 45, no. 12, pp.1195-204

<sup>3</sup> McGillis Hall, L, Doran, D, & Pink G.H 2004, ‘Nurse staffing models, nursing hours, and patient safety outcomes’, *J Nurs Adm*, vol. 34, no. 1, pp. 41–5.

<sup>4</sup> Bray BD, Ayis S, Campbell J, Cloud GC, James M, Hoffman A, Tyrrell PJ, Wolfe CDA, Rudd AG 2014, ‘Associations between stroke mortality and weekend working by stroke specialist physicians and registered nurses: prospective multicentre cohort study’. *PLoS Med*, vol 11, no 8, p e1001705

transformation of and efficiency of clinical care. The ANMF (Tas Branch) strongly advocates the introduction of **Nurse Sensitive Indicators** to monitor and analyse trends and unit specific patient/client outcomes in addition to the monitoring and measuring conducted in compliance with the National Health Reform; Performance and Accountability Framework. The ANMF (Tas Branch) strongly advocates the use of dashboards to inform the health professions, community and funders of the performance as well as compliance against these key measures. Nurse Sensitive Indicators have been comprehensively introduced in Queensland and embraced by all clinicians, managers and leaders. This strategy would recognise the valuable contributions the nursing profession makes to safe, sustainable quality healthcare.

The Clinical Advisory Groups structure has emerged as the mechanism through which planning and reform advice will be developed and given to both the Health Council of Tasmania and the Minister. The role of the convener is unclear. Is this a leadership role or a facilitation role? Will the convener of each CAG be an impartial member supporting decision making related to the evidence or will they be steering the decision making process? There are a large number of existing reviews and service plans already in existence. It is imperative the Clinical Advisory groups ignore work already done. Adult mental health, aged care, sub-acute care and rehabilitation appear to be unrepresented.

### ***What does this mean for our Public Hospitals?***

The inconsistent language used within the *Green Paper* to describe the role and function of existing hospitals as they may align with the role delineation framework prevents a coherent understanding of what each may look like in the future.

### ***Mersey Community Hospital and the North West Regional Hospital***

The *Green Paper* states ‘...both campuses will remain general hospitals...’. What is a general hospital within the meaning of the role delineation framework? This is very unclear and may be interpreted by various stakeholders including the community as obfuscation.

The ANMF (Tas Branch) cautiously supports the Mersey Community Hospital being designed and designated as a Centre for Excellence for High Volume Short Stay procedures. This includes Day Only Surgery and Extended Day (23hr) models of care. However this may be extended to 72 hrs as currently operates in NSW Health. This model of service has proven effective in improving access to elective surgery and has had a positive impact on the capacity of hospitals, reduced waiting times and cost efficiencies. This model of care is managed by evidenced based clinical protocols and dedicated staffing. Service coordination is ideally led by nurses liaising and managing teams. Nurses have a great level of autonomy within this model as they are responsible for nurse led pre admission and post operative care and discharge. This combined with criteria led discharge should become standard practice for elective admissions. However

based on the information within the *Green Paper* and *Supplement Papers* there is little to advice on the risk management strategies of providing these services with cognisance of the clinical co-dependency which exists for escalation of care and the potential for the resulting domino effect where loss of anchor services may destabilise the service provision over time.

The Mersey Community Hospital has already ceased paediatric admissions and emergency surgery in response to safety concerns. However the Emergency Department has a high number of presentations, at least equal to the North West Regional Hospital. The inpatient units accommodating medical patients have high occupancy rates. The ANMF (Tas Branch) believe it is necessary to keep a High Dependency unit available at the Mersey to support the capacity to escalate care if needed. This would also enable the Mersey Community Hospital to remain a 'safe keeper' for those waiting access to cardiac services at the Launceston General Hospital. Different specialties and levels of clinical need will require clinical networks which can take a long time to establish, can present governance challenges, and require effective leadership.

## ***Transport***

Systems and processes to accurately triage and rapidly transport patients should be a key part of any proposal. However a few studies suggest that greater distance to hospital is associated with an increased risk of mortality once illness severity has been taken into account. Nicholl *et al* (2007) found a 1 per cent increase in mortality risk for each 10km increase in distance, an effect that was amplified in people with respiratory distress.<sup>5</sup> Mungall (2005) has described a 'distance decay' effect under which distance from hospital services reduces patients' utilisation of them (services are taken less often or later).<sup>6</sup> This impact is disproportionately felt by those with low incomes, poor access to transport, and by elderly people and people with disabilities. This is of particular relevance to the particular demographic profile of the population on the NW coast. The existing experience of nurses working in the North and NW would suggest the transport aspects of redesign are immense. Limited access to after-hours transport both scheduled and emergency, long waiting times for transport, and inappropriate use of transport type would all characterise the existing arrangements. These factors combined with particular sets of 'house rules' related to admission and transfer criteria by existing organisations is fraught with risk.

## ***Current Barriers***

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<sup>5</sup> Nicholl J, West J, Goodacre S & Turner J 2007, 'The relationship between distance to hospital and patient mortality in emergencies: an observational study'. *Emergency Medicine Journal*, vol 24, no 9

<sup>6</sup> Mungall IJ 2005, 'Trend towards centralisation of hospital services, and its effect on access to care for rural and remote communities in the UK'. *Rural and Remote Health*, vol 5, p 390.

Services have previously not been provided or actively managed and supported over a seven day week, 24 hours a day. Medical, allied health and radiology staff are reportedly unwilling to change to a rotating roster over seven days working varied shifts, to cover for the 24 hour service provisions. However nursing leaders have been forced not to work 'out of hours' and this has reduced the availability of nursing/midwifery clinical leadership at times of the day and week where other disciplines are not readily available. Health services currently work on a system of between 9am-5pm when the most senior medical officers and nursing staff are available, radiology is open and allied health staff are abundant. Out of hours and weekends 5pm-9am the hospital is staffed by the most junior and unskilled staff. Patients present at all hours of the day, and patient's conditions deteriorate and improve at all times of the day. Service provision should not be dependant on what day and what time of the day patients present to the health service.

Anecdotally patients have remained inpatients over weekends and for longer then required time frames due to waiting for procedures not performed on a weekend, or waiting for a consultant or senior staff member to deem them safe for discharge. The costs incurred in these non required longer stay patients are unacceptable. Health services are currently under cost pressures, and providing services throughout the whole of hospitals over a 24/7 period will allow for potential cost savings and decrease length of stay, whilst we acknowledge that the initial outlay would be high, the potential cost benefits would out weigh this. The presence of senior staff, and allied health staff to service all areas of the hospital does not need to be on-site but staff need to be available for consults and advice, so the patient is seen at the right time, the right day and by the right person.

### ***Workforce of the Future***

*Supplement Paper No. 2 - Tasmania's Health Workforce* asserts there are growing trends toward specialisation and therefore a deficit of 'generalists' within the health workforce. The ANMF (Tas Branch) would suggest the registered nurse as the only generalist clinician within the health workforce. However nurses are prevented from practicing to their full potential by a range of legislative, administrative, funding, policy, custom and practice barriers. This is particularly challenging when the proposed changes in health service delivery will require both service capacity and capability. The experience reported by nurses in relation to the recruitment and retention in many services is one of disregard. There is an absence of appropriate skill mix, frequent exploited working arrangements and workload management, inconsistent staffing, casualization and heavy workloads brought about through short sighted workforce planning and devaluing by senior management. One of the most important stated aims of these reforms is the improvement of patient/consumer quality and safety yet there are systemic processes, ill considered decisions and short sighted financial imperatives which seek to destabilise an already fragile system where both recruitment and retention of nurses is compromised.

The ANMF (Tas Branch) suggests the hallmark of a safe, effective quality system is one which develops systems of human resource management premised on these same values and includes:

1. Permanent nursing staff and less reliance on casual relief staff.
2. Employment of graduate nurses with educators to support practice consolidation.
3. Recognise the importance of allied health and other support staff in maintaining safe effective patient care.
4. Consistent vision with *Supplement Paper No.2* in supporting the education and training of the existing and future nursing workforce.

The nursing profession is flexible and responsive enough to provide solutions to strengthen healthcare services through key strategies to optimise nursing:

1. Enable nurses to work to their full scope of practice across all settings.
2. Expand the delivery of nursing services in a range of settings to increase service capacity and consumer choice.
3. Optimise the influence of nursing, improving quality and value for money in healthcare services.
4. Support high-performing nursing services through continual learning and evidence-based practice.
5. Support nursing services to enhance patient care through information systems and decision-making tools.
6. Pharmaceutical reform arrangements to allow nurse practitioners in specialist services to access drugs.
7. Amend the MBS, incentives and exemptions to be extended to nurses.
8. Expand diagnostic and referral privileges for nurse practitioners employed in the public sector.
9. Introduce Nurse Endoscopists to manage routine endoscopy lists under medically delegated protocols - these programs have been implemented and evaluated in Queensland.
10. Support education pathways for nurse in rural and remote areas to develop as advanced practice nurses and nurse practitioners.

## **Consultation Questions**

### **A. How well does the proposed framework align with practice in your discipline?**

The proposed Role Delineation Framework identifies the minimum requirement for nursing services. The lack of specificity related to the skill and scope of the nursing workforce is of concern. The generic nature of the descriptions within the workforce descriptions provokes concern.

#### **Renal Services**

The definition of RDF is based on a number of factors: number of staff and their expertise. Renal patients have multiple co-morbidities which require access to aligned services. Cardiac and diabetic involvements are two major contributors to kidney failure (chronic), and as such these areas should be considered for 'other disciplines' that can influence the service.

'Growth potential' is also another defining measure in determining the role classification: as per the 2010 renal health service plan, the North and North West have the biggest growth area for renal services in the state. This should influence some of the long term plans of service delivery.

Level 1: There are none in the state.

Level 2: This level of service provides 'access to self-care units'. At present the northern renal unit utilise the services of a room at George Town Hospital where a fully independent patient uses a dialysis machine. This is instead of 'home haemodialysis' option for him as home haemodialysis was not an option. This system could be set up at other Multi-Purpose Centres [MPC] (e.g. Campbell Town) if the need arose, the patient deemed suitable and service need could be performed at the MPC (space demands). The patient needs to be fully trained (or a family member) in all aspects of haemodialysis, and will be monitored by the 'home dialysis nurse'.

Level 3: There are no renal services at this level.

Level 4: This status would apply to current 'satellite' units. Currently 3 within the state; New Town in the south, Kings Meadows in the north, and Burnie in the north-west. The home therapies units operate from these locations and not in the Level 5 as per the paper suggests.

Level 5: This level equates to the LGH. The 'teaching' role is fulfilled in the north with nursing students (at the satellite unit centre). There are no post graduate nurse opportunities at the LGH as there is no Clinical Nurse Educator position. The unit have an 'advanced trainee' medical registrar each year, under the care of the Nephrologists.

There are no dedicated vascular access nurse, chronic kidney disease educator or transplant co-ordinator, at the LGH even though there is an expectation for this level of support within a Level 5 service. The chronic kidney disease educator in the north of the state has ceased as the funding originated from an external source and has now ceased but the DHHS is not going to provide the funding for the future. There is also no Transplant work-up nurse in the north and this role is expected to be subsumed into already excessive workloads. This currently prevents this service from benchmarking patient outcomes. This poses a clinical risk.

Level 6: This would be the RHH - There is a vascular team there 24 hours, where at LGH there is some-one on call and visiting vascular services, but not full-time access.

### Adult Mental Health

The specificity related to the qualifications required for nurses working within mental health is very broadly described and fails to accurately reflect the current expectations related to the role. There is lack of differentiation of nurses required for medication management in multidisciplinary teams. Nurses are an integral part of teams and should therefore be cited within the workforce requirements as specialist mental health nurses with post graduate qualifications.

## **B. Where are the Gaps?**

1. Reconfigured stroke services should shift from treating stroke patients in the local A&E department to a Hyper Acute Stroke Units (HASU) staffed by expert nurses and doctors in the management of stroke. There is demonstrated evidence that this approach to the immediate management of stroke has reduced the mortality rate within seven days of admission. The improved mortality rates for these patients are particularly pronounced for patients admitted over the weekend. The evidence from the reorganisation demonstrates it is better to travel further to a HASU than to a local emergency department only to be stabilised and then wait for a transfer to a specialist unit.<sup>7</sup>
2. Child and Adolescent mental health is in a parlous state in Tasmania. There is little or no access to services across the state with existing staff expected to manage unrealistic demands on workloads and leave young people at risk. This negates any opportunity for early intervention and reduction in the incidence of stalled health development. There is also no access to specialist teams able to provide crisis management and care.

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<sup>7</sup> Morris S, Hunter RM, Ramsay AIG, Boaden R, McKevitt C, Perry C, Pursani N, Rudd AG, Schwamm LH, Turner SJ, Tyrrell PJ, Wolfe CDA, Fulop NJ 2014,. 'Impact of centralising acute stroke services in English metropolitan areas on mortality and length of hospital stay: difference-indifferences analysis'. *British Medical Journal*, vol 349, no 4, g4757

3. Criteria Led Nursing Services: Nurse Discharge Planners have either been removed or numbers diminished to the point where the capacity to fulfil the role of efficient patient flows is seriously compromised. The registered nurse as the only generalist within the health workforce has successfully fulfilled these role in the past. Discharge planning is a complex activity and is crucial to ensure timely discharge and unnecessary readmissions.<sup>8</sup>
4. Early supported discharge teams – providing rehabilitation, equipment, personal care, medical review, nursing interventions and tailored to the individual's needs for a time limited period – have been shown to be effective in reducing readmissions and improving outcomes.<sup>9</sup> The benefits of criteria led nursing services includes 'the specific belief that it will contribute to reducing hospital stay and unblocking acute beds used 'inappropriately' for non-acute patients'<sup>10</sup>, and encompasses the 'additional motivation that such autonomous nursing services fulfil in advancing nursing's status as a profession'<sup>11</sup>. Research through randomised controlled studies showed that 'patients feel significantly more satisfied with nurse-led care'<sup>12</sup>, with many more benefits being shown in 'shorter waiting times, less readmissions and a reduction in medical workload'<sup>13</sup>. Nurses working in this area ' must be prepared for and motivated by a higher level of professional autonomy in which they can become drivers, rather than just recipients of the organisational culture'<sup>14</sup>, increasing their autonomy and becoming leaders within their fields and organisations. It is imperative that the nurse's full extent of practice be realised in order to effectively care for their patients, and to provide the best care possible. A survey resulted in a 'total of 84% of people saying they would use a nurse-led clinic if one opened in their area and offered more convenient access than general practice'<sup>15</sup>, these results substantiated an earlier survey that showed 'most Australians would be happy to visit nurse practitioners for prescription renewals and everyday health concerns such as colds and flus'<sup>16</sup>. Whilst 'Nurse practitioners provided more choice and better access to primary care in affordability, shorter waiting times and 'filling the gap'

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<sup>8</sup> Lees L (2007) *Nurse Facilitated Hospital Discharge*. Keswick: M&K Update.

<sup>9</sup> Shepperd S, McClaran J, Phillips C, Lannin NA, Clemson LM, McCluskey A, Cameron ID, Barras SL 2010, 'Discharge planning from hospital to home (Cochrane Review)'. *Cochrane Database of Systematic Reviews*, no 20, article CD000313.

<sup>10</sup> Griffiths P, 2006, Intermediate care I nursing- led units- a comprehensive overview of the evidence base, *Reviews in Clinical Gerontology*, Vol 16 pgs. 71-77

<sup>11</sup> Griffiths P, 2006, Intermediate care I nursing- led units- a comprehensive overview of the evidence base, *Reviews in Clinical Gerontology*, Vol 16 pgs. 71-77

<sup>12</sup> Faithful S and Hunt G, 2005, Exploring nursing values in the development of a nurse led service, *Nursing Ethics*, Vol 12 (5)

<sup>13</sup> Faithful S and Hunt G, 2005, Exploring nursing values in the development of a nurse led service, *Nursing Ethics*, Vol 12 (5)

<sup>14</sup> Faithful S and Hunt G, 2005, Exploring nursing values in the development of a nurse led service, *Nursing Ethics*, Vol 12 (5)

<sup>15</sup> Anonymous, 2011, Nurse led clinics in demand, *Australian Nursing and Midwifery Journal*, Vol 18 (7)

<sup>16</sup> Anonymous, 2011, Nurse led clinics in demand, *Australian Nursing and Midwifery Journal*, Vol 18 (7)



due to GP shortages'<sup>17</sup>. Similar to Australia the United Kingdom have also seen the benefits of increasing the role of nursing staff, '*pressure is increasing on NHS resources and nurses are in a unique position to develop advanced roles to help meet increasing demands*'<sup>18</sup> and have been seen as the solution to the ongoing problems. The UK NHS has seen improvements within two of their sites with the introduction of nurse led clinics in their cancer services which has resulted in a 'dramatic reduction in treatment and surgery waiting times'<sup>19</sup>. In a study focusing on rheumatoid arthritis, a trial suggested that 'patients receiving nurse led care do not get inferior treatment to that offered by consultant rheumatologists'<sup>20</sup>. Further results showed that 'compared to doctors nurses made fewer changes to patients' medications and ordered fewer X-rays and steroid injections, while providing patient education and psychosocial support more frequently'<sup>21</sup>. Health is a multidiscipline that provides care to people who are vulnerable and in need, the provision of this health care should be administered by the most cost effective and capable member, whilst acknowledging that all professions work collaboratively and recognising the skills of all professions involved and the need to incorporate these skills where there is a demand.

5. Nurse Led "*See and Treat*" clinics have been implemented across the United Kingdom, Canada and the ACT and provide patients access to the best clinical care whilst reducing the wait in ED, resulting in a prompt senior clinician review and commencement of treatment, whilst reducing delay and increasing the opportunity for frontline staff to increase their skills and giving frontline staff ownership in patient led services and service delivery. It has been shown through the literature that 'nurse led clinics are as effective as clinics managed by other health practitioners'<sup>22</sup>, and the see and treat clinics 'reduce waiting times for patients with minor injuries and illnesses and has a positive effect on waiting times for patients elsewhere in the department'<sup>23</sup>, with the 'average wait to see a doctor or emergency nurse practitioner dropping from 56mins to 30mins, and the total average time in the ED dropping from 1hr 39 minutes to 1 hr 17 minutes'<sup>24</sup>. Best evidence shows that the time to be seen for patients with a minor illness or injury have been significantly decreased and the time for patients with major illnesses have also decreased, as the clinicians are free to treat these patients, whilst reducing the capacity within the ED as these minor illness/injury presentations are

<sup>17</sup> Anonymous, 2011, Nurse led clinics in demand, *Australian Nursing and Midwifery Journal*, Vol 18 (7)

<sup>18</sup> Townsend A, 2014, Patients views on a nurse led prostate clinic, *Nursing Times*, Vol 110 no 9, pg. 23

<sup>19</sup> Blakemore S, 2009, Nurse led clinics reduce waiting times for surgery, *Cancer Nursing Practice*, Vol 8 (3) pg.4

<sup>20</sup> Anonymous, 2013, Specialist nurse led clinics for rheumatoid arthritis show benefits over doctors care, *Nursing Standard*, Vol 28 (3) pg16

<sup>21</sup> Anonymous, 2013, Specialist nurse led clinics for rheumatoid arthritis show benefits over doctors care, *Nursing Standard*, Vol 28 (3) pg16

<sup>22</sup> Anonymous, 2011, Nurse led clinics cut risk, *Australian Nursing Journal*, Vol 19, pg5

<sup>23</sup> Rogers T, Ross N, and Spooner D, 2003, Evaluation of a see and treat pilot study introduced to an emergency department, *Accident and Emergency Nursing*, Vol 12 issue 1, pg. 24-27

<sup>24</sup> Rogers T, Ross N, and Spooner D, 2003, Evaluation of a see and treat pilot study introduced to an emergency department, *Accident and Emergency Nursing*, Vol 12 issue 1, pg. 24-27

seen, treated and discharged in an efficient and effective manner. These clinics are the best model of care to treat minor injuries/aliments, as they decrease ED over crowding. The system is 'entirely nurse led and only requires medical input when requested due to the competency falling outside the nurse's scope'<sup>25</sup>. Treating these patients first who will take the shorter time to treat allows for the prompt care of these patients, increases patient satisfaction and will reduce the occurrence of did not wait classifications. The nurse led see and treat clinics have been able to show a reduction in 'patient waiting times by a third and provide patients with a more holistic approach'<sup>26</sup>, it has 'cut patient journey times within the ED by almost a third and increased patient satisfaction'<sup>27</sup>. The nurse led clinics have been able to reduce 'the median journey time for major patients from 3.34 to 2.32 hours'<sup>28</sup> by having the clinicians free to care for the acute patients, as the 'simple' patient has been treated and discharged.

6. Surgical and Medical Assessment Units: These units should have a maximum length of stay of 24-36 hrs. These are internationally recognised innovations to reduce overcrowding in emergency departments and manage undifferentiated, complex, chronic, noncritical medical and surgical patients. Assessment units are designed to improve quality whilst improving patient flow.<sup>29</sup> Assessment units are staffed by experienced and comprehensive multidisciplinary teams able to make determinations of patient suitability within 1 hr. Once assessed patients are returned home with community services or referred to an inpatient team. These units are well supported by senior clinical nurses who provide nursing care to patients in waiting rooms and are skilled in patient assessment and are able to escalate care or refer to external agencies if required.<sup>30</sup>

**C. How do we promote and maintain safe primary and community care to consumers and communities such that they seek out these services rather than attend Emergency Departments when their conditions are more advanced?**

New technologies offer opportunities to sustain local access to services and improve communication between clinicians, patients/consumers and between regions. The current situation which leads to the inability of both internal and external IT systems to communicate seriously risks patient safety and consumes unnecessary time. The changing needs of patients – often frail, some with dementia, many with comorbidities

<sup>25</sup> Westby J, 2007, How to see and treat, Synergy; ProQuest Nursing and Allied Health Source, pg. 10

<sup>26</sup> Westby J, 2007, How to see and treat, Synergy; ProQuest Nursing and Allied Health Source, pg. 10

<sup>27</sup> Liple N, 2003, See and Treat Success Story, Emergency Nurse, Vol 11, issue 8

<sup>28</sup> Liple N, 2003, See and Treat Success Story, Emergency Nurse, Vol 11, issue 8

<sup>29</sup> Brand CA, Kennedy MP, King-Kallimanis BL, Williams G, Bain CA, Russell DM (2010). 'Evaluation of the impact of implementation of a Medical Assessment and Planning Unit on length of stay.' *Aust Health Rev.*;34 (3): pp. 334–9.

<sup>30</sup> NSW Ministry of Health and Emergency Care Institute, Emergency Department Models of Care pg2 8-31, retrieved 27th June 2012 from: <http://www.ecinsw.com.au/>

may be afforded opportunities offered by new treatments and technologies. Tele health can offer a number of potential benefits such as reducing the need to travel to outpatient clinics, providing quicker diagnosis and avoiding referrals to hospital for diagnosis or treatment. It also has the potential to deliver clinical services more efficiently. There is increasing recognition of the interdependence between hospital and community-based health and social care services, particularly for those who are frail and/or suffer from long-term conditions. All evidence on implementing patient pathways, having direct admission pathways, improving discharge and transfer of care practices and realigning services have a direct impact on the ED access and availability of admission from within the ED. Mental health interventions and decreased waiting times within the ED will also assist with creating ED capacity. Additional initiatives to create appropriate patient flows in ED include:

1. Introduce nurse triage models to streamline referral pathways into outpatients and specialist services to improve capacity and efficiency.
2. Introduce and expand Nurse-Led clinics to increase access to specialist services in priority areas of chronic disease management and palliative care.
3. Introduce Walk-In Nurse-led clinics – not reliant on GP referral, which have successfully been introduced in 3 Australian states.
4. Alternative primary care based services for persons with chronic diseases, the aged and those living with mental illnesses that are targeted at avoiding escalation of conditions such that they require hospital care.
5. Creation of sub-acute services for patients no longer in need of acute medical care but who are not fit to live independently.
6. A consistent approach to case management of adult mental health clients in the community by appropriately skilled nurses able to guide clients through the system and ensure accountability and continuity of services and prevent acute presentations at emergency departments.
7. Hospital avoidance programs do not exist in Tasmania. There have been successful services over many years which have faltered through lack of ongoing funding. These have been decisions motivated by cost shifting and seem to be in the realm of services delivered and funded through national programs.
8. Nurse-led Ambulatory Care Clinics in the community would provide rapid assessment of older people with complex needs at risk of deterioration.<sup>31</sup>
9. Investment in Gerontic Nurse Practitioners: Building on the success of Emergency Department Nurse Practitioners dedicated Gerontic Nurse Practitioner roles across

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<sup>31</sup> Purdy S, Paranjothy S, Huntley A, Thomas R, Mann M, Huws D, Brindle P, Elwyn G 2012, *Interventions to reduce unplanned hospital admission: a series of systematic reviews*. Independent research commissioned by the National Institute of Health Research (NIHR).

metropolitan hospitals could 'see and treat' residents in aged care facilities, order diagnostics and prescribe medications and also promote assessment and treatment in the community.

10. Investment in Mental Health Nurse Practitioners to provide comprehensive psychiatric assessments and management for individuals with high prevalence disorders who are either not engaged or intermittently engaged with psychiatric services.

#### **D. How do we determine which services to focus on to expand the role of primary and community care?**

Making integrated care happen requires collaboration across organisations and sectors which to date has proven almost impossible. There remains a gap between intentions and impact due to insufficient commitment and lack of funds to support to support execution and implementation. A significant proportion of hospital beds are occupied by frail older people and people with long-term conditions who would be more appropriately cared for in the community. For some conditions, admissions could be avoided with more proactive care and, in many cases; length of stay could be reduced if there were more services to support rehabilitation and discharge. This would deliver a much better patient/consumer experience.

#### Clinical Pathways

The key to improvement lies in changing ways of working across a system (including within hospitals), supported by good continuity of primary care. Even with successful Implementation, there is evidence to suggest that more community-based models of care will improve patient/consumer outcomes and generate significant savings. Many older people experience needs that tend to be characterised as 'minor', but which can significantly affect their independence, wellbeing and social engagement. These include mobility problems, foot health, chronic pain, visual and hearing impairment, incontinence, malnutrition and oral health. Service design must not underestimate the importance of providing services to recognise and address these 'minor' needs, and should re-examine local provision, addressing any gaps.

Case management in the community has been defined as 'a targeted, community-based and proactive approach to care that involves case-finding, assessment and care planning'.<sup>32</sup> It works best as part of a wider programme to integrate care, including good access to primary care services, supporting health promotion and primary prevention, and co-ordinating community-based packages for rehabilitation and re-ablement.

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<sup>32</sup> Bauer M, Fitzgerald L, Haesler E, Manfrin M 2009, 'Hospital discharge planning for frail older people and their family. Are we delivering best practice? A review of the evidence'. *Journal of Clinical Nursing*, vol 18, iss 18, pp 2539–46.

Clinical pathways allow patients to be treated the same reducing the risk of variability in care and predicting patient outcomes therefore allowing standardised planning and expectations for all involved in the care and treatment of these patients. All patients who present with a common diagnosis should be on a clinical pathway/model of care which has been developed by the multidisciplinary team, to avoid variation and increase care processes. The literature has shown that 'critical pathway guidelines have emerged as one of the most popular new initiatives intended to reduce costs while maintaining or even improving the quality of care'<sup>33</sup>. They have been shown to 'reduce unnecessary variation in patient care, reduce delays in discharge through more efficient discharge planning, and improve the cost effectiveness of clinical services'<sup>34</sup>.

Pathways are 'associated with reduced in-hospital complications and improved documentation without negatively impacting on length of stay and hospital costs'<sup>35</sup>, whilst maintaining 'structured multidisciplinary care plans which detail essential steps in the care of patients with specific clinical problems'<sup>36</sup>.

The clinical pathways have shown a 'reduction in in-hospital complications and improved documentation along with reports of significant reductions in LOS'<sup>37</sup>, and have had a 'positive impact on the organisation of care processes'<sup>38</sup>. The pathways allow the staff to 'develop and implement plans to identify and mitigate impediments to efficient patient flow throughout the hospital'<sup>39</sup>, nurses/midwives are at the forefront of improving efficiency and patient flow by assessing current practice and identifying areas for improvement whilst formulating and implementing alternatives and evaluating these.

Best evidence shows that patient's length of stay is reduced when using clinical pathways, which reduce the costs incurred.

### Direct Admission Pathways

Direct admission pathways provide patients and referral sources an evidence based process to best clinical care whilst bypassing the ED, resulting in a more prompt senior clinician review and commencement of treatment. All patients who present with a

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<sup>33</sup> Pearson S, Goulart-Fisher D, and Lee T, 1995, Critical Pathways as a Strategy for Improving Care; problems and potential, *Annals of Internal Medicine*, 123 (12), pg. 941-948

<sup>34</sup> Vanhaecht K, White K, Massimiliano P, and Sermeus W, 2009, do pathways lead to better organised care processes? *Journal of Evaluation in Clinical Practice*, Vol 15, Issue 5, pgs. 782-788

<sup>35</sup> Rotter T, Kinsman L, James EL, Machotta A, Gothe H, Willis J, Snow P and Kugler J, 2010, Clinical Pathways; effects on professional practice, patient outcomes, length of stay and hospital costs (review), *The Cochrane Library*

<sup>36</sup> Rotter T, Kinsman L, James EL, Machotta A, Gothe H, Willis J, Snow P and Kugler J, 2010, Clinical Pathways; effects on professional practice, patient outcomes, length of stay and hospital costs (review), *The Cochrane Library*

<sup>37</sup> Rotter T, Kinsman L, James EL, Machotta A, Gothe H, Willis J, Snow P and Kugler J, 2010, Clinical Pathways; effects on professional practice, patient outcomes, length of stay and hospital costs (review), *The Cochrane Library*

<sup>38</sup> Vanhaecht K, White K, Massimiliano P, and Sermeus W, 2009, do pathways lead to better organised care processes? *Journal of Evaluation in Clinical Practice*, Vol 15, Issue 5, pgs. 782-788

<sup>39</sup> Wiler J, Gentle C, Halfpenny J, Heins A, Mehrotra A, Mikhail M, and Fite D, 2010, Optimising Emergency department front end operations, *Annals of Emergency Medicine*, Vol 55 no 2

common diagnosis or from determined care facilities (e.g. other ED's, OPD's, inter-hospital transfers) are put through the direct admission pathway resulting in a triage and admission away from the ED with a direct transfer to the appropriate unit for treatment and ongoing care, reducing the delay in ED and bed block. Direct admission pathways reduce the requirement for patients to present and clog the triage/ED area when they can be treated just as effectively in a more appropriate setting within the hospital. Pathways are 'associated with reduced in-hospital complications and improved documentation without negatively impacting on length of stay and hospital costs'<sup>40</sup>, whilst maintaining 'structured multidisciplinary care plans which detail essential steps in the care of patients with specific clinical problems'<sup>41</sup>.

Pathways reduced the ED bed block, and 'appeared to be effective in reducing length of stay and costs'<sup>42</sup>, by 'avoiding variation in the clinical process'<sup>43</sup>. Using Direct Admission Pathways 'eliminates all steps between the patient arrival and placement in a patient care room, thereby bypassing triage'<sup>44</sup>, allowing for patients to be directly admitted into the area where their care will best be provided, in a safe and efficient time frame.

**E. What services do not have sufficient volume or activity in Tasmania to maintain a safe, high quality service?**

There is insufficient volume related to paediatric nephrology to maintain a safe, quality service.

**F. What additional areas should we be considering for interstate partnerships in order to improve service within Tasmania?**

The ANMF (Tas Branch) does not support the delivery of services to Tasmanians in Victoria unless there is significant evidence to support the practice. The challenges to patients/consumers and families must always be weighed against the benefits on merit.

The ANMF (Tas Branch) understands there are a substantial number of patients undergoing cardiac ablation surgery in Melbourne at enormous expense.

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<sup>42</sup> Rotter T, Kinsman L, James EL, Machotta A, Gothe H, Willis J, Snow P and Kugler J, 2010, Clinical Pathways; effects on professional practice, patient outcomes, length of stay and hospital costs (review), *The Cochrane Library*

<sup>43</sup> Rotter T, Kinsman L, James EL, Machotta A, Gothe H, Willis J, Snow P and Kugler J, 2010, Clinical Pathways; effects on professional practice, patient outcomes, length of stay and hospital costs (review), *The Cochrane Library*

<sup>44</sup> Rotter T, Kinsman L, James EL, Machotta A, Gothe H, Willis J, Snow P and Kugler J, 2010, Clinical Pathways; effects on professional practice, patient outcomes, length of stay and hospital costs (review), *The Cochrane Library*