Australian Nursing & Midwifery Federation (Tasmanian Branch)

Tasmanian Strategic Health Workforce Framework – Discussion Paper

Submission
September 2013
Australian Nursing & Midwifery Federation (ANMF)

Organisation Overview

The Australian Nursing and Midwifery Federation (ANMF) is both the largest nursing union and the largest professional body for the nursing team in Tasmania. We operate as the State branch of the federally registered Australian Nursing and Midwifery Federation. The Tasmanian Branch represents over 6,500 members and in total the ANMF across Australia represents over 250,000 nurses. 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 and nursing, 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 nursing 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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Introduction

ANMF Tasmania appreciates the invitation to contribute to the discussion paper; *Tasmanian Strategic Health Workforce Framework*. ANMF acknowledges the complex and rapidly changing national climate within which Tasmania’s health workforce reform is currently being planned. Within this broader national and international context, ANMF is supportive of health workforce reform in Tasmania proceeding in a systematic and coordinated manner. We are aware that the next five years will be crucial to ensuring that the Tasmanian health system is sufficiently robust and flexible to cope with the demands posed by an ageing population, changing community expectations and altered disease profiles.

ANMF joins DHHS in acknowledging the many innovative programmes and strategies already in place that are designed to improve client centred care and improve efficiency within a constrained budgetary environment. We need to consider how to make best use of the skills and expertise of the existing workforce and also be open to the possibility of different ways of working. We can learn from the experience of other states, territories and countries – but also must be mindful of the unique characteristics of our island state which may present challenges when attempting to ‘transplant’ models and programs developed elsewhere.

ANMF takes seriously its responsibility in providing considered and constructive feedback on the Discussion paper, as a precursor to the development of the *Tasmanian Strategic Health Workforce Framework 2013-2018*. To this end, ANMF adopted a consultative process for collecting and collating the viewpoints of ANMF staff, members, council and executive in response to the 47 questions contained in the Discussion Paper. Key priorities of ANMF 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 Discussion Paper.

The full Discussion Paper was circulated to these groups, along with an invitation to provide a (de-identified) response to the questions. These responses were then collated and formed the basis of a workshop held on August 30, 2013, at the ANMF Health Education and Research Centre in Hobart. The workshop opened with a brief overview of the Calderdale Framework, due to the framework being mentioned in Points 83 and 84 of the Discussion Paper but no further detail provided.

During the workshop, participants gained an understanding of the historical development of the Calderdale Framework in the UK, its structure and components, and the publicly available evidence relating to its application as a workforce reform tool. Workshop attendees then discussed the summaries that had been developed on the basis of the earlier written survey approach. Following the discussion of the specific questions, attention turned to the opportunities, risks and implications of reform and wider contextual issues that require further consideration.

This document represents a distillation of the opinions expressed by ANMF staff, council, executive and members, during the survey and the workshop. As such, the ANMF response provides DHHS with both points of agreement and some areas of contention, the latter of which will require ongoing consultation throughout the workforce reform design and implementation processes.
Due to the limited time constraint, the response reflects only those suggestions from the initial consultation and ANMF looks forward to broader consultation i.e. through the ANF Rural Remote Special Interest Group to ensure a more robust response and identification of solutions is provided.

ANMF is in strong agreement with the following:

- The urgent need for health workforce reform in Tasmania
- The need for a planned, coordinated and evidence-based approach to the design, implementation and evaluation/monitoring of health workforce reform that occurs in consultation with the health professions, including ANMF (Tas Branch)
- Quality of Care considerations at forefront of decision making

ANMF also considers there is scope for change in:

- Models of care;
- Roles and responsibilities of existing health care workers the development of new support roles;
- Resource allocation;
- Governance and leadership; and
- Communication pathways.

Before proceeding to a consideration of the individual questions, this document outlines a number of questions and concerns relating to the process to date which, arguably, need to be resolved as a matter of urgency.

1. What is the link between Tasmania’s Health Planning Framework document produced by the Tasmanian Lead Clinicians Group and the Tasmanian Strategic Health Workforce Framework Discussion Paper? (In their current drafts, neither document appears to make reference to the other despite being released in the same month)

2. What is the link between the Tasmanian Strategic Health Workforce Framework Discussion Paper and the National Health Workforce Innovation and Reform Strategic Framework for Action produced by Health Workforce Australia? (While some of the key domains of this framework are evident in the Tasmanian Strategic Health Workforce Framework Discussion Paper, the relationship between the two frameworks is only implied)

3. How have the findings of the report Health Workforce 2025 Doctors, Nurses and Midwives¹ contributed to the Tasmanian Strategic Health Workforce Framework Discussion Paper?

4. Has the DHHS considered the recommendations of the Richardson report Tasmanian Hospital System - Reforms for the 21st Century² (May 2004) with respect to growing the nursing workforce rather than introducing new support roles and constraints to implementing the recommendations arising from the DHHS Leading the Way report?

5. Has the DHHS considered frameworks or models other than the Calderdale Framework, which could be used to guide the process of health workforce reform in Tasmania? If so, what are they and what evidence exists to support their adoption?

6. Has the Calderdale Framework been selected as the overarching framework to guide implementation of the proposed health workforce reform in Tasmania? (The Calderdale Framework is mentioned briefly on pages 26-27 of the Discussion Paper, but it is not mentioned in the Executive Summary or dealt with in detail elsewhere in the document)

7. Is the Calderdale Framework being proposed for managing discrete pilot workforce projects (in selected organisational settings) – the outcome of which would determine whether or not the Framework was adopted for larger scale workforce reform?

8. Is the DHHS confident that the Calderdale Framework is sufficiently robust (i.e. with its effectiveness having been objectively and reliably demonstrated), relevant (i.e. transferable to the Tasmanian context), and appropriate (i.e. has the necessary scope) for achieving the breadth and depth of change required to reform the Tasmanian health workforce?

9. Does the DHHS anticipate an intermediate consultation phase in which health workforce reform objectives, risks, and anticipated outcomes will be presented and discussed?

10. How has strategic health workforce reform work informed the development of the Tasmanian Strategic Health Workforce Framework Discussion Paper? (For example, how have the outcomes of Tasmania’s Health Professionals Leading the Way: Shaping Future Care developed by the ‘Leading the Way’ Taskforce shaped the Tasmanian Strategic Health Workforce Framework Discussion Paper).

ANMF would welcome a verbal or written response to these ten questions in the near future. Clarification of these issues forms part of the foundational ‘stakeholder engagement’ that will be necessary for significant workforce changes to be implemented successfully and sustainably. Additionally, ANMF would like to request a consultation strategy, with appropriate timeframes and feedback mechanisms, be made transparent to the nursing and midwifery profession and all relevant stakeholders, including those from the private sector.

1. Workforce Reform – The Context

Q1. Given the Tasmanian healthcare context, how should service delivery models be shaped for the future?

- A more holistic and interprofessional approach embedded into both clinical education and service delivery
- Integrated systems to enable support of the patient/client journey and clinical pathway coordination through the multiple jurisdictions
- A strong emphasis on primary care and preventative models
- Potential expansion of hospital-in-the-home and early discharge options (where clinically appropriate), with the focus on quality care for patients and their families rather than simply cost-savings
- Wider availability of electronic health records with true integration and access for all appropriate staff/services
- More streamlining of work health and safety, leadership, philosophies and mandated reporting systems between the different providers of mental health care in the state
• Focus on provision of appropriate accommodation, transport and ongoing support options for
  the long term mentally ill, to reduce hospital admissions and provide care within active recovery
  models
• Greater emphasis on self-management models of care and health promotion, commencing
  through early childhood education i.e. re-introduction of school health nurses
• Careful design of carer/support staff roles to enable nurses to devote less of their time to
  non-nursing tasks. These roles must not compromise patient safety or quality of care
• Recognition of advanced practice roles and nurse practitioner roles

Q2. Do you have examples of innovative models that may have applicability elsewhere in
Tasmania?

This response is not limited to the following examples;

• Case Load Mental Health as per the Victorian model
• Birthrate Plus model of care as per the NSW model
• Hospital-in-the-home which is potentially of benefit in aged care as well as the acute care
  sector
• Aboriginal Health Centre - multidisciplinary health centre with an emphasis on a broad
  definition of 'health' rather than just medical needs
• NW Youth Health Mental Health Nurse working in high schools

Q3. What types of skills would be required in these models?

NOTE: (AMNF (Tas) is concerned that the language used in the Tasmanian Strategic Health
Workforce Framework Discussion Paper may be inadvertently reinforcing the historical 'silied'
approach to health care provision)

• A truly interprofessional approach
• Sound understanding of work expectations
• Strong clinical governance and accountability
• Need for sound communication systems
• Evidence based research to inform clinical redesign
• Recognition of advanced scope

Q4. What key aspects of service redesign do you think would have the greatest impact for your
area and service delivery? What implications would these have for workforce redesign?

• Evidence based quality assessment
• Improvement of hospital discharge processes (from the perspective of both patients/families
  and staff). Need for smoother, more organised processes in which the criteria are
  understood by all, and there are no unnecessary delays (e.g. by scripts not being available

  Standard-2011
after hours). Possible consideration of Criteria Led Discharge System being piloted in South Australia?5

- Electronic records with true integration/access i.e.
  o reliable systems
  o integration with other health services such as radiology and pharmacy
  o appropriate security safeguards
  o sufficient computers available to access
  o staff trained and competent
  o time factored into workloads
  o Private/public interface
- Careful and coordinated development of new support roles which involve the delegation of non-nursing duties to other support workers
- Valuing all roles for their contribution; relative wage and work value within interdisciplinary teams
- E.g. Expansion of Cardiac rehabilitation into preventative care
- Integration of Enrolled Nurses where clinically appropriate into acute care and community nursing areas
- Implementation of true multi-disciplinary approaches to patient care across all acute in-patient areas e.g. LGH Acute Medical Unit would be an example of benefits, however appropriate funding for re-design and staffing would be required

### 2. National Health Workforce Innovation and Reform

Q5. Can you provide examples of successful collaborative care arrangements? Are there opportunities for improved collaborative practice within your area that could be used more broadly?

- Supportive Care Clinic (involving a Nephrologist, a Chronic Kidney Disease Nurse, and a Social Worker) designed to see patients with Chronic Kidney Disease and help them with symptom control/relief
- Launceston – Ward 4D Interprofessional Practice Trial - Evaluative research report completed by Dr Lisa Dalton and Sam Saunders-Battersby
- Implementation of the Acute Medical Unit that has a true front loaded multi-disciplinary approach to patient care
- PEN nurses in ED
- Nurse Practitioners in Aged Care
- Burnie Acute Care at Home (BACH) model potentially of great benefit for aged care
- Tasmanian Medical Locals - successful collaboration between TML, GP’s and the acute areas providing services which prevent hospital admissions
- Tasmanian Medicare Locals – successful development of Emergency Decision Making Guidelines for aged care facilities to support personal care workers

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• Tasmanian Medicare Locals – collaboration with ANMF (Tas Branch) to develop and implement education program for nurses (Registered and Enrolled) and to teach personal care workers about recognising and responding to the acutely unwell older person using the Emergency Decision Making Guidelines.
• Elder Care Programs to identify individual patient requirements and pull together services to keep people out of hospital
• Langford Villas - Mental Health collaborative case management – includes public housing.
• North West Mental Health Youth Nurse Consultant

Q6. What mechanisms and support are needed to better enhance greater collaborative practice within and across Tasmania’s health and human services areas?

• Leaders who value and demonstrate collaboration and reduction of the silo approach to health care organisation governance
• More financial support for providers to improve access to health (employ more nurses, allied health professionals, etc.)
• Interdepartmental and private/public interface and access to software would improve efficiencies and collaboration between departments e.g. Emergency Department, radiology, radiography, pathology, Tas Ambulance Service. More generally, improved access to communication technologies – computers, software, electronic records – and training in the systems and processes
• Better public awareness (via advertising) and consultation/engagement re available services
• Interdisciplinary professional development and simulation.
• Flexibility of professional networking to enable outreach and working outside normal work environments

Q7. Reviews of roles open up numerous questions for example, can we better utilise the skills of pharmacists within their scope and with collaborative care models? What impacts could this have on improving services?

• Re: pharmacists – many community pharmacists are already incorporating aspects of primary health care and health promotion in their roles and extension of this type of service has the potential to free up physician time (e.g. dealing with minor health issues, providing sick leave certificates)
• Re: pharmacists - ward based pharmacists could be fully involved in patient care on admission, during hospital stay and prior to discharge, rather than providing independent one off reviews
• New Nurse Practitioner roles and extended scope of practice issues represent significant opportunities for health workforce reform, but the process must be approached in a more strategic and considered manner and funded

6 Recent (2012) doctoral research undertaken in Tasmania by Dr Kate Squibb, who is a radiographer, reports the inefficiencies created by the delays between taking radiographic films in rural and remote areas and the reporting of radiologists’ interpretations to medical staff. This research was undertaken at the University of Tasmania.
• Review of the radiographers role to allow for interpretation of radiographic images and generation of reports may alleviate some of the delays between diagnosis – treatment – care for clients (particularly in rural and remote areas of Tasmania)

Q8. Given Tasmanian health care needs and pressures on the acute system what should emerging models of care look like in your area?

• More emphasis on, and better resourcing for, health promotion and disease prevention in line with national initiatives focussed on strengthening primary health care
• 24-hr access to community nursing, home and community care and nurse-led community (drop-in) clinics
• Nurse Practitioner roles in both acute and non-acute areas
• Options for home dialysis (with appropriate incentives and support e.g. assistance with power bills, safe removal of biohazard waste etc.)
• Strengthen HACC funding and review distribution to ensure equitable statewide distribution
• Stronger emphasis on self-management models of care and resource allocation into the area of chronic disease management
• Stronger family and child health continuum within health and child protection to be maintained in justice
• Electronic care pathways between all sectors with single record
• Psychiatric recovery model to be implemented and funded

Q9. Can you identify potential areas for extended scope of practice? If so, what would this look like and how would this help to improve service delivery?

NOTE: ANMF (Tas.) is deeply concerned about the 40 % reduction in Nurse graduate positions in Tasmania since the 2011 budget cuts, and reiterates the need to keep patient safety and quality care at the core of any decisions regarding task delegation and support role introduction.

Further, AMNF (Tas.) believes that Nurse Practitioners can make a substantial contribution to improving service delivery in Tasmania, immediately and into the future. A number of priority areas for Nurse Practitioner roles are outlined below and in response to Question 16.

• Nurse Practitioner for Chronic Kidney Disease or Post Transplant Care (for example) – which would have the effect of freeing up physician time
• Employment of Nurse Practitioners across Aged Care facilities
• prescribing protocol for Registered Nurses and authorising specific non-medical immunisations or medical intervention
• Wider scope for Enrolled Nurses contributions to the acute care sector, research, project management and community nursing
• Assistant in Nursing (AIN) role in clinically appropriate wards/units to support nursing team, not substitute. (Note -the AMNF (Tas) believes that AINs should be students of nursing (BSc or EN)
• Fund implementation of the nursing clinical career pathway recognising work value and improve patient care and flow e.g. Clinical Co-ordinators
Q10. Would the development of an overarching skills or competency framework assist your area to undertake workforce redesign and innovation in your area

NOTE: The AMNF (Tas.) considers that question 10 is difficult to answer in its current format. It is not possible to comment on whether a framework would assist with workforce redesign and innovation unless the details of the framework are provided.

- What potential frameworks is the DHHS currently considering?
- What evidence exists to support their use in this context?
- Is there an implied link to the Calderdale Framework here?
- Does the question relate to professional competency standards, and if so, how will the competency standards across different health professions be considered?

Depending on the particular framework adopted, it may

- Reduce duplication and inefficiency
- Ensure that skills acquisition/training is equivalent across all disciplines for the same procedures

Q11. How would increasing the generalist workforce provide expanded opportunities for your service?

NOTE: The AMNF (Tas.) considers that this question is difficult to answer because lacks specificity and is also ‘loaded’ (i.e. it implies that it would provide expanded opportunities). This point is open to debate and should be presented as such. Innovation in health workforce reform opens opportunities for increasing the productivity and efficiency of the existing workforce and looking for new models of service delivery before considering increasing the supply of health workers.

The following general points can be made in response to question 11:

- Improved employment opportunities are needed to retain nurses in Tasmania and meet researched predicted shortages. (For example, a more robust graduate transition program)
- Improved support opportunities for health workers to rejoin the health workforce. (For example, re-entry and refresher programs for nurses, and professional development programs for midwives)
- Improved funded career pathways would encourage skilled staff to stay in Tasmania
- Expanded scopes of practice for selected clinicians may result in efficiencies and improved patient-centred service
- Risk of fragmentation due to task driven workforce

Q12. What strategies do you think would be most effective in developing a generalist workforce?

NOTE: The AMNF (Tas.) considers that Question 12 requires elaboration. What is meant by ‘a generalist workforce’? Would this apply to medicine only, or other professions as well? What evidence exists internationally to support this as a workforce reform strategy (which does not negatively impact on patient care)?
The need for controlled articulated pathways is critical as a range of courses are now being provided e.g. Ass Dip of Aged Care or proposed with no regulation or pathway professional or industrially.

The following general points can be made in response to question 12:

- The Ocean to Outback Programme could potentially be adopted/adapted
- Policy frameworks must be clear
- Bureaucratic processes e.g. payroll must be streamlined
- Support recognition of different scopes and support interdisciplinary professional development

Q13. How can we better work across health care settings to improve patient/client centred care and ensure critical services are provided?

NOTE: The AMNF (Tas.) considers that this question should be aligned with Question 6, relating to collaborative practice. The aim to improve patient/client centred care and ensure critical services are provided should be fundamental to any health workforce reform.

The following general points can be made in response to question 13:

- There is an urgent need to:
  - develop and embed electronic health record systems (with staff training and appropriate access);
  - provide professionals with more training in client-centred care; and
  - extend the emerging culture of trust between health professions via supporting true interprofessional practice and training opportunities.
  - improve links with community housing, NGO’s, Centrelink and CHAPs

Q14. Are there specific technological advances that could be implemented to improve the way we work? If so, how will this make the workforce more efficient, impact service delivery and improve health outcomes?

- Electronic health records with appropriate access/interface and integration across acute and non-acute areas (preferably including automatic uploading of observations etc)
- Electronic care pathways
- Utilising the National Broadband Network capabilities to expand opportunities for home monitoring of patients, as clinically appropriate
- Online ordering of pharmacy and diagnostic tests
- More computers in workplaces/cars and smart phones/ipads for staff
- Access to GPS to locate clients’ homes
- More automation of bureaucratic processes to free up time for clinical tasks

Q15. Do you have examples of innovative and interdisciplinary practice that could be applied more broadly across Tasmania?

- Persistent Pain Service (Royal Hobart Hospital) should be rolled out statewide
- Spinal Assessment Clinic should be rolled out statewide
• Simulated Learning Environments project, currently funded by Health Workforce Australia, should be extended and sustained beyond the funding period.
• Eastern Shore Leg Club

Q16. Are there other roles you would like to see developed in other professional areas?

The AMNF (Tas.) considers that there is great potential for Nurse Practitioner roles to be developed in a range of areas including (but not limited to)

• Chronic Kidney Disease
• Post-transplant care
• Chronic Disease Management
• Wound Care
• Respiratory Disease Management.
• Paediatrics

Additionally,
• Mental Health Staff roles could be further developed for Emergency Departments
• Allied health (e.g. Occupational Therapy, Physiotherapy) roles could be further developed in the Community Palliative Care Team.
• Enrolled Nurse roles could be developed in acute care areas e.g. Renal Unit
• Youth Health and School nurses

Q17. Are there specific or collaborative practice areas where Allied Health Practitioners could improve health outcomes and reduce demand on the acute care sector?

• Osteoarthritis Hips and Knees service at the Southern THO should be considered for wider application
• Interprofessional Chronic Disease clinics utilising a ‘one stop model’
• Dedicated social worker, physiotherapist etc roles in Renal Units to address issues early, and put health programs in place to reduce or preventing acute admissions
• (See also response to Question 16, above, re OT/Physio in Palliative Care and mental health in Emergency Departments)
• This question is limited to Allied Health and would be helpful to have same question for all professional groupings

Q18. Do you have examples of expanded scopes of practice or generalist approaches that could be considered for piloting in Tasmania?

• Assistant in Nursing Role is being trialled Royal Hobart Hospital
• Southern Cross – Practical skills at Rosary Gardens
• Nurse Practitioners
• Advance Practice Nurse
• GP Practice Nurses

Q19. ENs qualify at the Diploma level. How can we maximise the skills of the skills of Enrolled Nurses within your area to support your team to work to its full capacity?

NOTE: AMNF (Tas.) wishes to reinforce the importance of providing sufficient numbers of appropriately trained Registered Nurses (whose mentoring role is reflected in their workload) to provide support and mentorship to Enrolled Nurses.
The following general points can be made in response to question 19:

- Employ more ENs where clinically appropriate – e.g. in specialist clinics (e.g. Renal Unit – but must have IV endorsement) and chronic disease clinics
- Enable ENs to access further education and provide incentives of remuneration, allowances, study leave, scholarships/bursaries etc
- Preceptor and Transition To Practice Programs for EN’s
- Strengthen the career pathway for Enrolled Nurses – e.g. opportunity for Enrolled Nurses to study Advanced Diploma of Nursing – but this is not linked to articulation possibilities at UTAS or career progression through employment
- Investment in clinical supervision models and support mechanisms for Enrolled Nurses (similar to those established for Registered Nurses) is urgently required in Tasmania
- Clear articulated career pathway required – there is some confusion with new qualification Associate Diploma of Aged Care and where this worker fits in with career pathway

**Q20. How would the introduction of more assistants in the workforce provide greater flexibility for your area? How would this be implemented?**

**NOTE: AMNF (Tas.) has concerns regarding the potential proliferation of various undefined unregulated support roles within the Tasmanian health workforce, which may have implications for patient safety and quality of care, and may pose risks for existing health professionals. A statewide project that critically reviews the various emerging models producing support role workers in Tasmania’s health sector would be useful to inform a coordinated and considered strategy for introducing assistants and support workers in a safe and useful way.**

AMNF (Tas.) wishes to reinforce the importance of nurses being fully involved in the process of role design, and seeks assurance from DHHS that quality care for patients and families will not become secondary to cost-containment objectives.

As noted earlier in this submission, AINs (which should be nursing undergraduates) could potentially:

- Escort stable patients between hospital departments (or home, in the case of the Soft Landing project)
- Line, strip and clean medical devices e.g. dialysis machines, plasma exchange
- Assist with non-nursing and non-clinical tasks (bed making, clinical cleaning, errands, sample transportation)
- In addition to considering the outcomes of the Royal Hobart Hospital trial of AINs in the acute care setting, ANMF (Tas Branch) encourages DHHS to review the outcomes of similar projects in Australia and internationally to reflect on the impact on patient, nurse and system level outcomes.7

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7 See for example, the work of Professor Christine Duffied, Professor Di Twiggy and Associate Professor Anne Williams at Edith Cowan University. These researchers have examined the impact of adding new support workers on patient, nurses and system level outcomes.
Q21. Can you see the potential for new roles in your area to support your team to provide services?

- In addition to the ‘assistant’ roles noted above, we draw attention to the responses to Questions 16 and 17.
- Funding the implementation of Clinical Co-ordinators on each ward/unit would assist the flow and quality of patient/client care
- Implemented and funded career structures
- Discharge planning co-ordination
- Regional Wound Management Initiative (VICTORIA)
  - Management of wounds is an important part of the care provided by District Nursing, Bush Nursing and Public Sector Residential Aged Care (PSRAC) services in Victoria.
  - In metropolitan Melbourne the Royal District Nursing Services (RDNS) delivers wound management through community nurses supported by a tiered structure of senior nurses and nurse consultants.
  - In regional Victoria, nurses providing wound care in community nursing funded through Home and Community Care (HACC) and high care PSRAC services have not had consistent access to the same level of support. Training needs analyses in rural areas have identified gaps in the capacity of the services delivering quality wound management for the management of chronic and complex wounds to clients and residents.
  - The Regional Wound Management Clinical Nurse Consultant (CNC) Initiative (the Initiative) commenced in 2008. The objective of the Initiative was to improve the capacity of Community Nursing, Bush Nursing and PSRAC services to implement evidence based wound management practice in regional Victoria. It was also to improve the capability of nurses to support that capacity. The anticipated outcomes were improved quality of care for clients and residents.
  - The initiative has been effective in improving the capacity of District Nursing, Bush Nursing and PSRAC services in regional Victoria to provide evidence based wound management to HACC clients and high care PSRAC services residents. The services identified improved client outcomes as one of the top three impacts, together with nurses being willing to seek advice about wound management and being able to access up to date information.

Q22. How would a skills/task delegation framework assist in the introduction of new roles within your area and allow existing workforce to work to their full scope of practice?

AMNF (Tas.) considers questions 22 and 23 to be difficult to answer, due to a lack of specificity. Does the ‘skills/task delegation framework’ mentioned here partially (or completely) overlap with the ‘overarching skills or competency framework’ mentioned in question 10? Is the Calderdale Framework considered a skills/task delegation framework? If so, is the use of the Calderdale Framework suggested or proposed? It is important to AMNF (Tas.) that no ‘fractionalisation’ of
care occurs as a result of the application or introduction of any frameworks or resultant workforce redesign.

In a general sense, AMNF (Tas.) considers that use of a skills/task delegation framework could potentially:

- Provide clear policy and procedure guidelines
- Improve governance
- ‘Free up’ time for clinical staff to focus on clinical tasks/skills and thereby improve efficiency and productivity of the existing workforce
- Holistic team approach
- CNE support

Q23. What areas would be suited to piloting a skills/task delegation framework?

Notwithstanding the concerns noted above, AMNF (Tas.) considers that such a framework could potentially be piloted in non-acute areas such as:

- Nursing Homes
- Rehabilitation Wards
- Gerontology Wards
- Mental health

3. Distribution, Attraction and Retention

Q24. Do you have examples of innovative models of service delivery that have worked well in rural and remote regions?

NOTE: ANMF (Tas.) understands that Dr Stephen Duckett will soon be releasing a discussion paper on rural and regional workforce reform which will be relevant to this Discussion Point.

- Telehealth
- Multi-purpose centres
- Aboriginal Controlled Community Health Services
- Outreach Services, such as
  - Hub and spoke models of service delivery
  - Visiting Services
- RURAL workshop needs to help

Q25. What types of educational preparation and support should underpin these models?

- Competencies specific to rural and remote health service provision (see CRANA for example)
- Clear guidelines and policies
- Electronic records
- Health Informatics
- Telehealth clinics
- CNE support and additional ward based support
• Funded CPD; elearning not only methodology

Q26. Do you have examples of attraction and recruitment strategies that could be used more broadly?

• Relocation costs/accommodation/ travel costs (not just for physicians)
• Consistency, recognition and valuing roles employed in other states to translate and attract nurses to Tasmania
• Wage relativity
• Child care/elder care
• More permanent vacancies, not just contract work, which encourages and sustains a transient health workforce
• Undergraduate student scholarships for rural background students
• Professional development programs with backfill
• Streamlining the recruitment process to expedite the appointment of new staff
• Nurse management admin support
• Work/life balance and flexibility

Q27. Do you have examples of flexible working arrangements and strategies that could be applied effectively to improve service delivery in rural and remote areas?

• Nurse-led after hours/drop in clinics
• Sustain the accommodation for staff – for example, the Rural Health Teaching Site Network (managed by the University Department of Rural Health at the University of Tasmania).
• 12 hour shifts and/or ‘4 days on, 4 days off’ rosters
• Drive in/drive out options and support
• Ability to rotate/work in acute specialised units in hospitals as refresher for skills e.g. ED, Maternity
• Support annual access to CRANA or equivalent courses in paid time
• Healthy/optimal work programs e.g. Victorian Nurses Health Program

Q28. Do you have examples of effective strategies for attracting and retaining staff in rural and remote areas? What do these look like and what support is required?

• Relocation costs for all staff, not just medical staff
• Assistance with housing/rental costs
• Support annual access to CRANA or equivalent courses in paid time
• Access to ongoing, guaranteed professional development with backfill
• Efficient bureaucratic processes for the above
• Ability to rotate/work in acute specialised units in hospitals as refresher for skills e.g. ED, Maternity
• Enable flexibility and support i.e. accommodation/travel costs to encourage nurses to rotate to remote areas from permanent city positions

Q29. How can we improve our training pathways for rural and remote areas?

• Placements in large hospitals for rural and remote health professionals
• Placements in rural facilities for urban health professionals
• Rural and remote graduate nurse transition program
• Nurse Educators to be established in rural and remote areas
• Special interest groups – reflective practice using telehealth

Q30. If you work in a rural or remote area have you accessed education, training or a peer support network via telehealth? If yes – how can this experience be enhanced?

• No response-further consultation required

Q31. What strategies could be used to improve the locum/agency workforce?

NOTE: AMNF (Tas.) does not generally support the use of locum/agency workforce and would prefer to see strategies being devised to support, reform and sustain new models of health workforce reform that do not require transient nursing professions. It does, however, acknowledge this stance may not apply to other health professions.

In a general sense, the following strategies could be helpful:

• Support with housing costs
• Remote allowances
• Increased support for relevant conferences
• Travel allowance
• Backfill rostered

4. Ageing Workforce

Q32. Do you have examples of strategies that have worked well to support older workers in the workforce?

• Part time work and/or removal of rigid requirement for night duty
• Changing the workers compensation act for those over the age of 60
• Rest/sleep breaks on night duty
• Supportive non-nursing staff available after hours
• Relocation to less ‘physical’ areas
• Health and well being strategies including warm up sessions at commencement of shift
• Respite support for aged care family members

5. Capacity Building, Education and Training

Q33. How can we better develop and support Vocational Education and Training Sector career pathways?

NOTE: ANMF (Tas.) would welcome the opportunity to discuss strategies to develop and support Tertiary Sector career pathways.

• Streamlined application processes
• Enhancing the training to meet the needs of the growing burden of disease
• Accelerating the entry to the workplace
• Stronger career planning pathways
• Improved articulation pathways between VET and Tertiary sectors (i.e. Rather than the standardised one year advanced standing for Enrolled Nurses to enter the Bachelor of Nursing, the credit process could reflect the Diploma of Nursing and Advanced Diploma of Nursing levels of study within the VET sector)
• Establish reverse articulation pathways between VET and Tertiary sectors (i.e. Mechanisms for Bachelor of Nursing Students who are not successful to enter Diploma of Nursing courses in a more streamlined manner)
• ANMF (Tas Branch) encourages DHHS to review the work undertaken by:
  o Professor Sue Kilpatrick at the University of Tasmania, who is working on a statewide project to strengthen the pathways between the VET and Tertiary sectors
  o Mr Rob Bonner and Dr Diane Wickett at the ANMF (SA Branch), who are working on a national project to strengthen the pathways between the VET and Tertiary sectors

Q34. What are the elements that should be included in clinical education?

• Better support of educators on wards (e.g. workload adjustment, provision of additional support staff)
• More focus on aboriginal health/culture
• Time management & effective communication
• Access to clinical support
• Manual handling and WHS issues
• Client safety and personal safety
• Contemporary approaches for practice (clinical reasoning, critical thinking, primary health care, self-management models, health promotion, early intervention, disease prevention)

Q35. How could your area contribute to closing the gap in Aboriginal and Torres Strait Islander health? What information and skills would you need?

• 24 hour support from Indigenous liaison services, not just Monday-Friday 9am-5pm
• Better understanding of Indigenous health needs and culture
• Improved partnerships between nursing staff and social aspects of Aboriginal health
• Role extension and support for Aboriginal Health Workers
• Need to consider other disadvantaged groups

Q36. What opportunities do you see for building the capacity of the workforce to include a stronger preventive focus and work in health promoting ways?

• Chronic Disease management programs that have a true interprofessional basis
• Electronic care pathways and accessible systems and information
• Education for health awareness to start at a younger age
• More Registered Nurses in Public Health roles
• Greater investment in health literacy programs
• Greater investment in self-management programs

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• Greater investment in early intervention programs
• Opportunities in Cardiac Rehabilitation – once again with a true interprofessional focus
• Early childhood – reintroduction of school nurses/youth health nurses
• Youth health mental health nurses in high schools

Q37. Do you have an example of a successful cultural change strategy or program that has increased the capacity of staff to work in different ways?

• ‘Be Well’ program by Gordon Fyfe, which adopts a multi-level approach for working towards cultural changes in health. At the organisational level, changes are encouraged and supported through whole team approaches to critical review, reflection and commitment to changing towards healthier modes of working. At the community level, ‘Be Well’ centres offer services for promoting healthy lifestyles.

Q38. How can we further build capacity for education and training to address future workforce need?

• More financial support and backfill for staff to attend work related conferences
• Stronger collaborative approaches between organisations who have the capacity to provide professional development and organisations who have staff requiring professional development – this will allow the creation of meaningful, relevant and timely education and training for meeting current and future workforce needs
• Offer courses/educational programs within and across the state to maximise accessibility for geographically diverse Tasmanian health professionals
• Support local projects designed to import national and international experts in contemporary health, education, research and service delivery
• Address ‘underpaid’ areas e.g. aged care to address longer term recruitment/retention
• Currently one 1 CNE for community nursing in THOs; more educators would build capacity for education & training
• Need to address urgently for current workforce

Q39. What other key areas of focus should be included in the TCEN Work Plan activity?

NOTE: AMNF (Tas.) considers question 39 to be difficult to answer, given that no information about the TCEN Work Plan activity has been provided as part of this discussion process.

Q40. Is there potential for Inter-professional learning within you area? If so what does this look like and what is required to support this?

NOTE: AMNF (Tas.) is disappointed that interprofessional learning, which is foundational to contemporary health workforce training and practice, is first mentioned in Question 40 of the document. It is hoped that interprofessional learning features more prominently in the Tasmanian Strategic Health Workforce Framework 2013-2018.

Q41. Can you identify any mechanisms that could be used to further assist in the engagement of new graduates in the short term?

• Create more funded positions for Graduate Nurses and ease of rotation
• More supernumerary hours at beginning of new placements
• Support networks
• Develop similar graduate nurse programs at the Enrolled Nurse level
• Implement a statewide approach to recruitment
• Critically review and improve the recruitment and appointment processes to expedite new staff appointments
• Ensure graduates nurses completing the one year fixed term contracts are case managed and offered ongoing employment and not terminated
• Many of the suggestions provided for question 33 may assist in retaining graduates of nursing (Enrolled and Registered) in Tasmania

Q42. Would an interactive program for newly qualified health professionals and support staff, such as Flying Start, assist workforce integration in your area? How could greater use of technology assist with this?

NOTE: AMNF (Tas.) would not be supportive of an online course being provided if this resulted in fewer resources being directed to on-the-job mentoring from appropriately trained and qualified mentors.

In a general sense, an interactive program would need to be:
• Readily available from the workplace
• Accessible via all smart devices as well as computers

Q43. Do you have examples of strategies to enhance career pathways that could be more broadly implemented?

• Reduced ‘red tape’ with job applications
• Career education/planning (in person/online)
• Advanced training in specific areas e.g. Mental health
• Fund and value advanced clinical roles to enable employment at correct level.
• Fund career structure implementation e.g. Endorsed Nurse Practitioners currently working at lower levels due to budget constraints

Q44. How can we more effectively provide mentoring and support?

• Provide more (paid) time ‘off the floor’
• Advertise availability of mentoring
• Provide appropriately skilled and educated staff
• Adopt mentor and support models that are educationally sound and tested, with appropriate resources for ongoing management
• Need for leadership and management mentoring systems
• Non-stop students mean that RN’s burn out. Staff can’t give 100% to both students and clients continuously so something gives eventually.
• Provide training and education of mentors and preceptors
Q45. What are the barriers to development of staff?

- Workload pressures
- Financial constraints
- No backfill of positions
- Strategic targeting of skill mix required
- Interstate education providers colonising the state and offering educational programs at exorbitant prices
- Lack of employment/HR practices to enable easy rotation of workplaces in public system
- Lack of promotable opportunities

6. Clinical Leadership

Q46. How can we create a culture that values the role of leader, supervisor/preceptor and educator?

- Recognition and development of true leaders who teach and model leadership by example
- Leadership courses where the participant is taken out of the workplace for the duration of the course and obtains a certificate or actual qualification
- Support and development of emerging leaders
- Career development/support throughout career
- Coordinated and strategic approach to identification of the areas in which leadership requires growth and increased capacity and a targeted plan for addressing these gaps.
- Professional role modelling and formalised mentorship programs
- Departmental support of the Tasmanian Leaders Program, with participants and graduates becoming ‘champions’
- Leadership values

Q47. What are the barriers to providing supervision support, and what can be used to address these barriers?

- Workloads and time are among the most pressing barriers
- Unsustainable workloads
- Inappropriate skill mix
- Giving students longer practical times on the wards
- Address by having adequate staff and appropriate skill mix
- Multiple and different policy frameworks for clinical supervision
- No shared language or understanding of the various terms related to supervision
- Development of a statewide and coordinated approach to clinical supervision for undergraduate nursing students at both the VET and tertiary levels rather than duplication of a) policies b) resources c) education and support programs d) liaison with agencies and education providers e) various payment/agreement models and f) industry / education consultation on workforce needs. This is a key area in which waste and duplication occurs in the state.
- UTAS guidance and support to ensure clear understanding of student learning needs

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