Queensland
Clinical Senate

Clinician leadership. Consumer collaboration. Better care.

Innovation and transformation of models of care in response to COVID-19

18 May 2020   -   Meeting Report

Queensland
Government

Contents

Chair's report

COVID-19 has disrupted our health system and society. This has given us an unexpected and once-in-a-lifetime opportunity to disrupt the way we provide care. In a very short space of time, we have been able to innovate and implement new models of care so that Queenslanders can access care at, or closer to home. We have also seen a real shift towards stopping low benefit care.

The enablers of this significant change can be attributed to having an overarching, clear and compelling goal, flexible funding, local permission to experiment and implement what was needed, effective communication and feedback, diverse engagement and collaboration in real time, intolerance of obstruction and establishment of networks across silos. The joint ownership of problems and solutions led to a flow of systems based on direct outcomes.

The feedback and data tell a compelling story – change can work. Patients can receive care sooner and closer to home. Importantly, for our First Nations people, this means care on or closer to country. New collaborations and virtual care options have opened up access to some services which previously were essentially inaccessible. We have seen what is possible when we are able to 'just crack on and do it'.

Queensland, and indeed Australia, has realised the benefit of an early and pro-active political, social and public health response to COVID-19. We are one of a handful of countries which have so far been able to contain this virus, giving the health system time to prepare and respond when the next waves of the virus emerge. Even though restrictions will progressively lift, COVID-19 will affect how we deliver care indefinitely.

Redesigning what our "new normal" could look like is exciting, and clinicians, system leaders and consumers are all eager to be part of the process. No-one wants this true co-design opportunity to be missed. It is not feasible to return to the pre-COVID-19 normal.

To enable clinicians, system leaders and consumers across Queensland to contribute to this incredible reform, a virtual meeting of the full Senate was held on 18 May 2020. Around 200 people attended the online meeting to discuss models of care that have been successful over the past few months, which ones should continue, and what barriers and enablers exist to make that happen. Delegates were exceptionally engaged and discussion was optimistic and authentic.

Acknowledging the jump in maturity of our networked governance system[1], the outcome from the meeting is a list of recommendations on the *system-level* strategies that are needed to embed these changes. You can read these recommendations on the next page of this report. We have also included as an appendix the full list of initiatives submitted by Senate members and Statewide Clinical Networks in the lead up to the meeting.

---

[1] McGowan J, Philip P, Tiernan A. Advice on Queensland Health's governance framework. 2019
https://www.health.qld.gov.au/__data/assets/pdf_file/0039/929955/Final_Advice-on-Queensland-Healths-Governance-Framework.pdf

The Senate will continue to focus on this important reform agenda and explore further opportunities for clinicians, consumers, health services and the system to work together to provide a better experience and outcomes for Queenslanders in ways that we always wanted but never thought possible.

Dr Alex Markwell
Chair
Queensland Clinical Senate

Recommendations

The COVID-19 pandemic has resulted in significant disruption to the way healthcare is delivered in Queensland. This disruption has given us the opportunity to change the way care is provided indefinitely. It is not feasible to return to the pre-COVID-19 normal. The Senate recommends the following key principles, highlighted during the crisis response, underpin ongoing care provided across the system:

1. **Care delivered at or closer to home and centred around the patient**:
    a. Support a flexible hybrid combination of face-to-face care and virtual care[2] across the whole of system including primary, secondary and tertiary care
    b. Deliver virtual care wherever desired by the patient and clinically and logistically appropriate
    c. Strengthen IT infrastructure to expand virtual healthcare services in rural and remote Queensland
    d. Implement and evaluate virtual integrated multi-disciplinary, multi-specialist models of care
    e. Expand Hospital in the Home and similar services which provide face-to-face care at home
    f. Expand the implementation of e-consultation to enable consultation between primary care and specialist clinicians to enable faster and more effective decision making
    g. Enable the delivery of care across geographic boundaries, e.g. HHS boundaries, including workforce movement and patient flow
    h. Facilitate greater collaboration across clinical and service silos to ensure seamless patient journeys
    i. Develop services addressing population and public health needs and targeting priority populations

2. Permanently **discontinue low benefit care** (LBC) that has been ceased during the pandemic:
    a. Empower consumers not to request LBC, and to decline low benefit or futile care
    b. Empower clinicians to not offer LBC, and to actively decline requests for low benefit or futile care
    c. Embed national guidelines and Choosing Wisely recommendations supporting these approaches into models of care
    d. Update clinical decision support tools (such as HealthPathways) to guide and promote evidence-based practice by explicitly stating the potential benefits and harms to patients of different management options.

---

[2] ***Virtual care*** *has been defined as any interaction between patients and/or members of their circle of care, occurring remotely, using any forms of communication or information technologies with the aim of facilitating or maximizing the quality and effectiveness of patient care.*

Shaw J, Jamieson T, Agarwal P, et al. **Virtual care policy recommendations for patient-centred primary care: findings of a consensus policy dialogue using a nominal group technique**. *J Telemed Telecare* 2018;24(9):608–15.

For the purposes of this report, virtual care includes telehealth, telephone calls and other ICT enabled communication

Telehealth is the delivery of health services and information via telecommunication technologies. Models of care that Queensland Health considers as Telehealth include: Clinical videoconferencing, eConsultations, and Remote Patient Monitoring

3. **Remove barriers to innovation and change** to enable, not hinder, the delivery of efficient, modern healthcare:
    a. Pursue supportive funding arrangements which overcome the disconnect caused by multiple funders
    b. Implement change and new models quickly—evaluate and adapt in real time
    c. Remove unnecessary red tape and streamline approval processes with appropriate but not constraining governance
    d. Ensure the system supports changes that will enable the timely and wide-spread adoption of innovations (policy, procedures, etc.)
    e. Reconsider risk to allow innovation and rapid change e.g. facilitate joint stewardship of quality and safety within new models of care[3]

4. Maintain the **mature network governance, leadership and collaboration** with **health consumers** and **healthcare providers** across sectors:
    a. Recognise and harness existing consumer and clinical leadership forums in solutions and redesign brokerage
    b. Support **Statewide Clinical Networks** and other groups to promote and expand models of care that have emerged, been enhanced, or been imagined during the Pandemic.
    c. Have regular (e.g. annual) '**think-tanks**' using different scenarios to reimagine the delivery of care in environments highly constrained by financial, infrastructure and workforce limitations.
    d. Maintain the delivery of useful, timely **communication** to clinicians, with single source of truth.
    e. Enable access to, and promote use of, statewide **data collection** and analysis systems to drive identification, understanding and quantification of the issues for COVID and non COVID patients.

5. Ensure integrated and robust system-readiness from a **supply** perspective, including rapid scale up and distribution strategies.

---

[3] See Bowen A, Casadevall A. *Increasing disparities between resource inputs and outcomes, as measured by certain health deliverables, in biomedical research. Proc Nat Acad Sci USA (PNAS)* 2015; 112 (36): 11335-11340.

Introduction

Queensland declared COVID-19 a "public health incident of state significance" on 21 January 2020. Eight days later, the state's first case of COVID-19 was confirmed.

Health Services responded to the pandemic with fever clinics, stopping non-urgent elective surgery, moving traditional outpatient clinics to a virtual model where possible to continue to provide care for patients. Virtual hospital wards were established and Hospital in the Home (HiTH) models expanded to care for COVID-19 patients. Targeted support and helplines were created for patients with chronic disease to provide the support they needed without leaving home. A major public health education campaign was also launched to promote hand and respiratory hygiene and the need for isolation.

The rapid response gave clinicians and the system time to prepare for the worst-case scenario in Queensland —an overwhelmed health system.

With the spread of COVID-19 currently contained in Queensland, clinicians and health system leaders have the opportunity to consolidate the incredible work that has been done to introduce new models of care across the state and ensure that sustainable models continue post COVID-19. The degree of collaboration across all levels of the system and with health consumers has been an exemplary enabler of success. In looking at the system outcomes, the considerations of positive change to culture and collaborative leadership from clinicians and consumers also must be understood and nurtured going forward.

The Senate meeting

The Queensland Clinical Senate brought together 200 clinicians, consumers and health executives from across the state for its virtual meeting on Monday, 18 May 2020 to discuss 'Innovation and transformation of models of care in response to COVID-19'.

The meeting was conducted through Zoom videoconferencing and GroupMap participation software remotely.

The meeting covered three main sessions:

1.   **What** changes and innovations have we seen?

2.   **So What** have we learnt from these changes (enablers and barriers)?

3.   **Now What** is our strategic advice to the system moving forward?

The four-hour virtual meeting gave Senate members and guests the opportunity to capture some of the successful models of care that have been implemented during COVID-19 and decide what needs to be in place at a system level to enable those models to continue post COVID-19.

A copy of the meeting agenda can be viewed at **Appendix 1**.

Prior to the meeting, Senate members were invited to provide feedback on their experience of innovations to models of care during the COVID-19 Pandemic via a survey. A summary of the themes that emerged is available at **Appendix 2**.

The Statewide Clinical Networks were invited to submit the innovative models of care that they had implemented, existing models that had been expanded, proposed models, and challenges experienced during the COVID-19 Pandemic. These submissions will be further explored to identify bodies of work for development and implementation, and can be found at **Appendix 3.**

Health Consumers Queensland undertook a rapid consultation process and created a report which was distributed to attendees prior to the meeting and can be found at **Appendix 4**.

Speakers and panellists

Meeting facilitators: Dr Erin Evans, Chair, Health Consumers Queensland and Mr Will Bessen

Dr Cameron Bennett, Physician, Virtual Ward Medical Director, Metro North Hospital and Health Service

Ms Hannah Christensen, Principal Project Officer Child, Development Sub-Network, Queensland Child and Youth Clinical Network

A/Prof Carl de Wet, Clinical Lead Healthcare Improvement Unit / Gold Coast Primary Health Network

Ms Melissa Fox, Chief Executive Officer, Health Consumers Queensland

Mr Matt Page, A/Manager, Statewide Telehealth Team, Healthcare Improvement Unit

Ms Sue Rayner, Respiratory Nurse Navigator (CNC) / CHHHS COPD Coordinator, Cairns and Hinterland Hospital and Health Service

Ms Zehnab Vayani, health consumer

Presentations and key messages

Session 1: Changes and innovations

Metro North Virtual Wards

Dr Cameron Bennett, Physician, Virtual Ward Medical Director, Metro North Hospital and Health Service

- Faced with the prospect of overwhelming numbers of COVID-19 patients, the policy of confinement as inpatients was not a feasible option.
- Metro North established 'virtual wards' at its four hospitals - all COVID positive patients were referred by email and automatically accepted.
- The wards were 'staffed' by a multidisciplinary team including doctors, nurses and allied health professionals.

- Patients were admitted to the ward but remained in their homes, or equivalent, in isolation and were initially risk-assessed followed by ongoing monitoring.

- Escalation thresholds were set for further assessment and referral for urgent assessment in hospital via ambulance transport.

- Subsequent recovery was determined according to CDNA (Communicable Diseases Network Australia) guidelines and release from isolation was facilitated.

- At the time of this Senate meeting: 237 patients had been admitted to the virtual wards.

- Outcome: Hundreds of patients avoided hospital admission thus avoiding use of personal protective equipment and exposure of health care staff without any apparent harm to COVID-19 positive patients.

- Trust was fundamental for the success of the virtual ward – we trusted referrers to have made a reasonable assessment of the patient and we trusted the patient to know when they were sick as an inpatient of the 'virtual ward'.

- The concept of the virtual ward can be extrapolated to non COVID-19 activity – *"Do you have any patients under your care that you would discharge today if you knew they could be monitored and supported in their home by a medically governed multidisciplinary team?"*

Ms Zehnab Vayani, health consumer

'The barriers removed during the COVID pandemic made accessing services so much easier. We didn't have to travel back and forth to hospital, which meant it was much safer for us, and quick turnaround times for appointments after having waited months for an answer. We hope that we can use these removed barriers and techniques going forward so that access is made easier, especially for those living a little bit further away from where they need to access the services.'
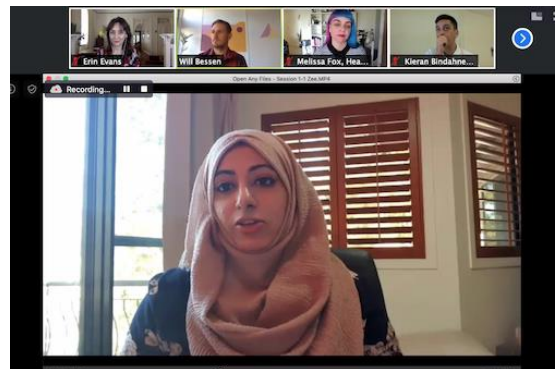
Cairns COPD Rapid Access Help Line

Sue Rayner, Respiratory Nurse Navigator CNC

- Chronic obstructive pulmonary disease (COPD) patients are one of the most vulnerable patient cohorts.

- The driving factor to establish the help line was patients reporting 'fear' about going to hospital during COVID-19.

- A point-of-call triage line (7 days a week) was established for patients to seek advice about their exacerbations.

- The model included three modes of care:
  - Come to hospital – too unwell to stay at home. Early discharge where appropriate with Hospital in the Home (HITH) support.

- o   Stay at home, start medication and receive twice daily home and virtual visits.

- o   Patient to see GP and receive ongoing support from hospital team.

- The program went live on 5 May 2020 - 30 calls were received in the first two days.

- From a hospital avoidance perspective, COPD patients will engage if they have the correct level of support and trust in the service.

- The model can be supported – it's not labour intensive or costly because most is done by phone.

- Outcome: Targeted support, HITH and action plans equal reduced presentations and reduced bed days.

Phil Carswell, health consumer

'Business as usual doesn't apply, and therefore people have been really good at working their way around problems. This crisis has led to a mindset of "how can we do this differently, better and in a way that gets the results we need". Allowing people to be flexible, inventive and creative is a really good thing for professionals and us consumers.'

Session 1 common themes from thematic analysis of GroupMap (in no particular order):

Focus question: What is one positive change or innovation that you've noticed during the response to COVID19 in the QLD health system?
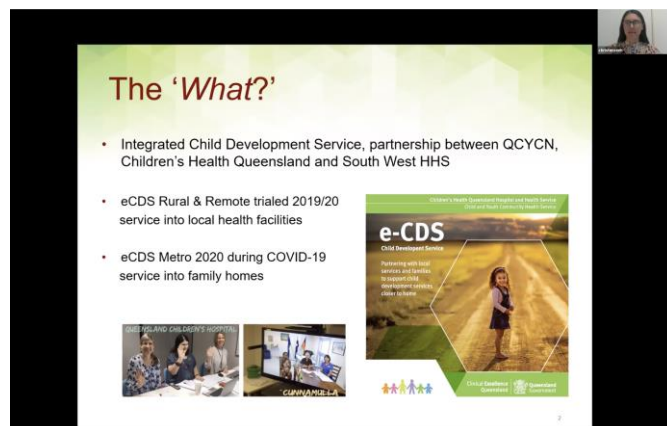
1.   Rapid and widespread innovation enabled by a general willingness to change, a focus on practical outcomes and a reduction in red tape and other barriers

2.   A renewed focus on handwashing, PPE use and infection control education and compliance

3.   A major increase in information and communication technology (ICT) uptake, particularly Telehealth and Microsoft Teams, to enable more efficient and person-centred care, especially for chronic disease management and a range of outpatient care

4.   Greater consumer engagement and an increased focus on the patient journey

5. Rapid development of alternate models including COVID clinics, virtual hospitals, ICT-enabled HiTH and rapid discharge pathways

6. Increased cooperation, collaboration and streamlining between clinical teams across the patient journey

7. Increased opportunities for nurses to refresh and build on clinical skills, and to operate to their full scope of practice in ward and community settings

8. Greater flexibility in working practices, particularly working from home arrangements

9. A greater recognition of, and focus on, frontline staff and clinician wellbeing.

10. Reduced presentations to ED of patients who can be effectively managed in alternative care settings

11. Reduced provision of low(er) value healthcare

Session 2: What have we learnt from these changes

Integrated Child Development Service (CDS)

Hannah Christensen, Queensland Child and Youth Clinical Network Project Officer

- e-CDS Rural and Remote is a patient- direct service reaching families who may otherwise have faced significant barriers accessing vital diagnostic child development services. Children's Health Queensland clinicians (developmental paediatrician, psychologist, social worker) work with the family and the local

health practitioner on a rapid multidisciplinary assessment clinic via Telehealth, and together with the family make a diagnosis to tailor therapeutic recommendations.

- Its principles include pre-synthesis of information, rapid dynamic assessment and formulation, and therapeutic feedback followed up by letter to family copied to health professionals.

- The local clinicians are part of the team, and capability and capacity building is key, in addition to enhanced professional satisfaction from "both ends". The service is enabled by interprofessional practice and wraps around the family at the centre.

- During COVID-19, the service was rapidly mobilised to support metropolitan outpatients in their homes – existing category 3 children who had already waited up to 12 months for CDS and were at risk of long waits due to COVID-19.

- High engagement: 100% attendance rate, 85% of families were identified as Aboriginal and Torres Strait Islander.

- Cost effective service that alleviated long outpatient waits for specialist services and that reach patients in most need.

Professor Liz Kenny AO, Chair, Queensland Clinical Networks' Executive

'Two things are required to successfully translate new models that are working for patients with chronic conditions - the capacity to share information from the hospital sector into community and primary care and getting the funding right. How do we actually get money flowing that reflects the model of care that actually starts to wrap care around the patient.'

Telehealth during COVID-19

Matt Page, A/Manager, Statewide Telehealth Team, Healthcare Improvement Unit

- In January 2020 Telehealth[5] was recognised as a major enabler of our system's response to COVID-19.

- Key improvements focused on capacity and recognising that the most common setting for people was going to be receiving care in their homes.

- Capacity was rapidly increased from 90 to 1000 concurrent calls into patients' homes.

- The delivery of healthcare via telehealth increased from 2.1% to 5.1% of all Queensland Health non-admitted patient service events between February and March 2020. This does not capture the additional care provided by other virtual models including telephone.

- Telehealth virtual clinic was launched - replicates the traditional outpatient clinical flow into a virtual environment. Allows clinicians and administration officers to visualise who has joined the waiting room, how long they have been waiting and transfer the video conference call into the virtual consultation.

- Remote patient monitoring is an essential part of the COVID response.
- Telehealth and virtual care models proved effective strategies to keep patients and clinical staff safe.
- The response truly demonstrated the value of Telehealth – maintain momentum.

Dr Philip Masel, Co-chair, Statewide Respiratory Clinical Network

'Unfortunately, we've been living in silos for too long and this pandemic has forced us to collaborate much more and understand each other's worlds - the spirit of collaboration.'

Primary care collaboration

A/Prof Carl de Wet, Clinical Lead Healthcare Improvement Unit / Gold Coast Primary Health Network

- **3 enablers for collaboration within primary care**
  - Clear and consistent communication
  - Coherence and clinical information
  - Common ground – PPE, RACFs, how we are going to tackle the non-COVID-19 issues that may have had less focus while we appropriately dealt with COVID.

- **3 barriers**
  - Fear
  - Finance
  - Fatigue.

Session 2 common themes from thematic analysis of the enablers in GroupMap (in no particular order):

Focus question: Reflecting on the COVID19 experience, what are some key ENABLERS to change and innovation for the QLD health system going forward?

1. Efficient, concise and broad communication and messaging to all components of the System, particularly via the Clinical Senate and Clinical Networks
2. Opportunities to display clinical leadership and access direct lines of communication and feedback with executive decision makers
3. Willingness of staff to embrace change and innovation across traditional silos, hierarchies and across sector barriers, particularly between acute and primary care settings
4. People 'had to work together'; the crisis provided a common goal for innovation across the community, consumer and clinical spaces
5. Early and frequent engagement with consumers in the design and delivery of innovations
6. An outcomes focused funding model that enables flexible, patient focused innovations
7. Uptake of technology (primarily Telehealth) to facilitate Statewide access, meet consumer preferences and manage clinical resources; relies heavily on effective IT infrastructure
8. A refocusing of risk through the removal of administrative barriers and red tape which both allowed rapid innovation and accepted possible failure as an option
9. Greater use of case management, including nurse navigator roles
10. Willingness and supporting frameworks to address low value care activities

Session 2 common themes from thematic analysis of the barriers in GroupMap (in no particular order):

Focus question: Reflecting on the COVID19 experience, what are some key BARRIERS to change and innovation for the QLD health system going forward?

1. The digital divide (an inequity of technology access, connectivity and skillsets) for both consumers and clinicians; compounded by systemic funding disincentives for using telehealth and clinician reluctance to change to digital processes

2. The pressure to get back to 'normal' or 'the old ways' given the inertia of a change and risk averse culture, a disjointed / federated health care system and fear of the unknown

3. A funding model focused on activity and hospital beds, rather than integrated and longitudinal person-centred care

4. Lack of connectivity and standardised patient information sharing cross systems and care settings

5. Gatekeeping, bureaucracy and siloed governance and decision-making structures

6. Potential for an escalation in other health challenges that have arisen out of the pandemic response (mental health, alcohol and substance abuse, STI's, chronic disease management and prevention, including for children, domestic violence) if the focus isn't placed on these conditions and cohorts

7. Need to review and evaluate new models and innovations against existing policies and procedures

8. Potential for greater fragmentation or isolation of services and roles with greater Telehealth use, and less opportunity for direct face-to-face contact with patients for purposes of physical examination and emotional support ('touching hand of comfort')

9. Need to address capability and workforce flaws made evident during the pandemic response, particularly health literacy and onboarding / supervision of junior and casual staff in regards to PPE use and appropriate use of investigations and treatments.

10. Inconsistent messaging from Commonwealth and State levels

Session 3: What is our advice to the system

The common themes from thematic analysis of the strategic suggestions in GroupMap (in no particular order):

Focus question: Based on these examples and your discussions of the 'new normal', what are the three – five key pieces of strategic advice to guide decision making in the QLD health system moving forward?

1. Move to an outcomes-based funding model that incentivises collaboration within the system based on patient reported experience measures (PREMs) and patient reported outcome measures (PROMs)
2. Ongoing investment in telehealth models, infrastructure, equity of access and capacity building / training
3. Increased collaboration and co-design with health consumers in service and model developments; increased engagement with consumers in decision making
4. A reconsideration of governance and decision-making structures to provide ongoing and balanced innovation centred on consumer needs
5. Greater collaboration across clinical and service silos to ensure more seamless patient journeys
6. Improved data collection and access across the system
7. Expansion of multi-disciplinary clinics, interprofessional team-based care and virtual care settings
8. Investment in the health sector including workforce development, necessary infrastructure and technology platforms
9. Ensure technology access is equitable for all clinicians, consumers and communities
10. Foster sustainable innovation by balancing evaluation, review and quality assurance with the opportunities, support and culture needed for frontline innovations and new models across the system
11. More inclusive decision making and change management with input and leadership from all stakeholders
12. Disaster planning that moves beyond short-term disasters and includes how we manage workforce, communication and services. Pandemic-relevant and pandemic-proof ongoing collaborations between research, health system, non-government organisations, and consumers.
13. Consider innovations of dedicated virtual care rooms or facilities in remote areas that provide a virtual care centre.
14. Develop services addressing unmet population and public health needs and targeting priority populations
15. Support a flexible hybrid combination of face-to-face care and virtual care across the whole of system including primary, secondary and tertiary care
16. Investigate use of better pre-clinical care delivered virtually to address long waiting lists and ensure that patients are not waiting in limbo before being seen.
17. Embed and enable the underpinning culture that supported the successful response to the Pandemic. This is characterised by greater trust in the front line and collaboration with clinicians and consumers. This enables reinvention and a system that supports new levels of readiness and rapid reconfiguration.

Next steps

The recommendations contained in this report will be presented to Queensland Health, Board Chairs, Health Service Chief Executives and Health Consumers Queensland for endorsement.

The Senate will seek updates on the implementation of endorsed recommendations to keep members and other interested parties informed of progress and provide further input into bodies of work as appropriate.

The Senate will explore opportunities for follow-up meeting/s on this topic.

Special thanks

- Dr John Wakefield, Director-General, Queensland Health
- Professor Keith McNeill, A/Deputy Director-General, Clinical Excellence Queensland
- Dr Jillann Farmer, incoming Deputy Director-General, Clinical Excellence Queensland
- Mr Nick Steele, Deputy Director-General, Health Purchasing and System Performance
- Mr Damian Green, Deputy Director-General, eHealth Queensland
- Ms Meegan Fitzharris, Chair, Queensland Health Reform Panel

Organising committee

- Dr Alex Markwell, Chair, Queensland Clinical Senate
- Dr Erin Evans, Chair, Health Consumers Queensland
- Mr Chris Raftery, Deputy Chair, Queensland Clinical Senate
- Ms Melleesa Cowie, Director, Healthcare Improvement Unit, Clinical Excellence Queensland
- Mr Will Bessen, Tuna Blue Facilitation
- Mr Ian Johnson, Acting Manager, Queensland Clinical Senate Secretariat
- Ms Rebecca Griffin, Communications Lead, Queensland Clinical Senate

Appendices

Appendix 1 – Meeting agenda

Queensland Health

Queensland
Clinical Senate

Clinician leadership. Consumer collaboration. Better care.

Innovation & transformation of models of care in response to COVID-19
Monday 18 May 2020, 10.00am – 2.00pm

To join this virtual meeting, please click on the following **Zoom** link:
LINK REMOVED

We will be using **GroupMap** as a working platform *in addition* to Zoom. This will allow us to capture a wealth of information from breakout and whole of group discussions. You will need to have GroupMap open and ready to use during the meeting. Follow these steps to access GroupMap:

1. Open your web browser (Chrome, Edge, Explorer, Safari, Firefox, etc.)
2. Use this link to join the GroupMap workspace LINK REMOVED
3. Alternatively, you can go to www.groupmap.com, click 'join a map' and enter the code
4. Once inside the GroupMap workspace, hold tight and we'll provide instructions
5. Please keep this GroupMap browser tab open and ready to access during the Zoom meeting

Time	
9.45am	**JOIN (LINK REMOVED) trouble-shoot any technical issues, etc.**
10.00am	**Welcome and context** Dr Alex Markwell, Chair, Queensland Clinical Senate
10.10am	**Session 1: *WHAT* changes and innovations have we seen?** **Objective:** *Share examples of successes and challenges to delivering care during the COVID-19 response*
	Participant exercise
	The consumer perspective Ms Zehnab Vayani
	The Virtual Ward - Metro North Hospital and Health Service Dr Cameron Bennett, Physician, Virtual Ward Medical Director, Metro North Hospital and Health Service, and Steering Committee Member, Statewide General Medicine Clinical Network
	Cairns COPD Rapid Response Help Line Ms Sue Rayner, Respiratory Nurse Navigator (CNC) / CHHHS COPD Coordinator, Cairns and Hinterland Hospital and Health Service
	Whole of group plenary and questions

Queensland
Government

10.55am	**Short Break**

11.05am	**Session 2: *SO WHAT* have we learnt from these changes?** **Objective:** *Identify enablers and barriers to change and innovation in delivering care during the COVID-19 response*

A few words from the new DDG CEQ
Dr Jillann Farmer, incoming Deputy Director-General, Clinical Excellence Queensland

Integrated Child Development Service
Ms Hannah Christensen, Principal Project Officer Child Development Sub Network, Queensland Child and Youth Clinical Network, and Practising Physiotherapist

Telehealth during COVID-19
Mr Matt Page, A/Manager, Statewide Telehealth Team, Healthcare Improvement Unit

Primary care collaboration
A/Prof Carl de Wet, Clinical Lead Healthcare Improvement Unit / Gold Coast Primary Health Network and Primary Care Lead for State Health Emergency Coordination Centre (SHECC)

Whole Group Plenary and Questions

Breakout Group Discussions
-   Reflecting on your experiences of COVID-19: What are some key ENABLERS and BARRIERS to change and innovation for the QLD health system going forward?

12.05pm	**Lunch (Opportunity to scan through the Session 2 GroupMap submissions)**

12.35 pm	**Session 3: *NOW WHAT* is our strategic advice to the system moving forward?** **Objectives:** *Reimagining the 'new normal' that repositions the health system to be better than it was before. Recommend priorities and strategies to guide decision making in the system.*

Brief overview of the 'new normal' that is forming
-   Summary of key themes from the meeting
-   Key themes from the pre-survey

Breakout Group Discussions
-   Based on these examples and your discussions of the 'new normal', what are your three – five key pieces of strategic advice to guide decision-making in the QLD health system going forward?

Whole Group Discussion

1.40pm	***Summary & close***

Wrap-up and reflection

Dr Alex Markwell, Chair, Queensland Clinical Senate

2.00pm	**Meeting Close**

Appendix 2 – Senate Member Survey results

Queensland
Clinical Senate

Clinician leadership. Consumer collaboration. Better care.

Qld Clinical Senate - Embedding New Models of Care
Survey of Senate Members - Abbreviated Results

Members of the Queensland Clinical Senate were invited to provide feedback on innovations to models of care during the COVID-19 Pandemic via a Survey Monkey survey. The following themes emerged from the 21 responses:

Regions/organisations: Primary Health Networks; Medical WBHHS; Queensland Health, Aboriginal and Torres Strait Islander people; Allied Health QCH HHS; NWHHS; Australian Primary Health Care Nurses Association; CHQ; Mackay Hospital and Health Service - Rural Nursing; Qld Health Darling Downs Health and Hospital District; Toowoomba Hospital – DDHHS; TCHHS; Podiatry; Sunshine Coast; IUIH; APNA; GP Liaison Network; Aboriginal Medical Service - north/regional (Wuchopperen, Cairns); Allied Health - West Moreton Health

New models of care that have improved patient outcomes, experiences receiving and/or providing care and better effectiveness and efficiencies

THEMES	THEMED RESPONSES
Primary Care	GP Respiratory Clinics Enhanced use of primary care databases Improved access to primary and secondary care telephone and telehealth services, improved access to clinician-to-clinician specialist advice Reduced barriers in scope of professional practice (real or perceived) Reduced wait times Walk through flu vaccination
Telehealth	Telehealth (telephone and televideo) - major catalyst to transition clinicians onto telehealth, enabling delivery of promise to deliver care closer to home - 'Stay at home Use the phone' - shift to virtual waiting rooms - Preadmission - Outpatients - telephone, improved experience for families, seen as complementary to existing F2F rather than long-term replacement. some improvements in efficiency, not necessarily effectiveness. Additional work for administrative staff. - Cancer Care - Extensive clinical reviews - Discharge of outpatients back to their GP - MBS Item numbers (phone and telehealth) for GP (time-effective appropriate care for those not requiring face to face consultations) - refusal to see patients face-to-face is causing problems, particularly where mental health services need to be delivered

Queensland
Government

	- Healthy Weight Management Clinic, providing allied health via phone/telehealth, saves patient time and money, improved access for people with disability, assists with social anxiety re: morbidly obese exercising in public - real time support available via smart phone, potential for clinician work from home, fewer consultation rooms required. - Primary care delivered appropriately and safely
Virtual Ward	New service providing phone call follow-up for COVID patients not requiring hospitalisation, nursing phone calls 1-2 per day, 7 days per week. - Medical follow-up over the phone - Allied Health input over the phone as required, incl. social worker, pharmacy, physiotherapy
Clinical Coordination Hub	Manages all specialist outreach and case management for vulnerable patients - primary healthcare team at centre of the patient's care
Attendance	Increased attendance through use of MS Teams - Clinical meetings - Staff education sessions
Care outside the Hospital	Localised, specialised care Enhanced HiTH - Aged care, community aged care in frail older person's home, prevent unnecessary admissions and potential COVID exposure - COVID - inpatient, outpatient & procedural HiTH - Mental Health Remote Devices / Telemonitoring - BP Monitors - loan equipment, improves ability to alter medication doses via telehealth - Thermometers Rehab in the Home - through PAH for SCI and AVI, less available in other areas incl. CHQ HHS Remote patient monitoring Virtual Viral Clinic Hotel accommodation for homeless people and couch surfers
Discharge	Improved discharge planning
Emergency	Emergency - Reduction in non-urgent presentations to the ED - ED clinics via phone - Acute Aged Care Unit - extension of ED for cat 3-5, de-stimulated environment, admit to hospital or send home with appropriate arrangements, or admit to aged care HiTH. Reduced exposure to COVID and other hospital acquired complications and unnecessary admissions - drive through COVID/Fever clinics (those without cars can't access this, can't safely put them in bus/Uber/Tax) - Fever clinics enable separation of symptomatic patients, increasing consumer sense of safety
Hospital	screening of inpatients and visitors, well-received by both staff and consumers
Integration	Improved engagement with the Private Sector Frequent meetings between primary care organisations to share issues
Engagement	Improved staff and community engagement Use of social media to keep people informed Identification and monitoring of 'vulnerable families and checking in program
Innovation	Improved
Capturing Changes	working to capture all the changes that have happened.

Nil Change	Nil change as a direct result of COVID-19

Things that have not worked well.

THEMED RESPONSES

Delays	Lengthy wait for test results in remote areas
Technology	Telehealth limited by poor bandwidth and devices (at patient end), choosing telephone instead, difficult to establish rapport and engagement Initial issues with set up of technology have been resolved Lack of adequate internet connection at patient's home is biggest impact on telehealth.
Service discontinuation	Closing of dental clinics - impacting chronic diseases for low socio-economic groups Withdrawal of specialist services with no alternative provided Drop in client numbers General Practice implementing excessive rates of telehealth, 'scare medicine', patients with urgent needs not being provided appropriate face-to-face care. Some practices have literally locked their front door. Category creep, e.g. cat 3 becoming cat 2 The Healthy Weight Management Clinic involves a strong physical-exercise component, which has been stopped due to COVID-19 outpatient protocols. Future consideration about how some physical exercise programs could be facilitated via video-link.
Integration	Inter-agency working
Communication	Friday afternoon release of major information - doesn't work for small facilities. Inertia preventing timely release of information via social and mainstream media to the community. Lack of timely information and communication. Excessive COVID meetings, disconnect between national and state guidance and internal Queensland Health. Conflicting messages.
Change	Inability to adapt to change, revenue missed through delay in converting clinics in ESM (Enterprise Scheduling Management)
Workplace impacts	Trying to do clinics from home.
Nil	Nil

Positives and innovations consumers want to keep after COVID-19

Health Consumers Queensland has been running a series of Consumer Conversations for the last 2 months to hear directly from consumers during the global pandemic. We have previously produced summaries of consumer feedback on the key themes on *Rebalancing the health system* and *Delaying healthcare*.

During the week beginning 4 May, Health Consumers Queensland ran three separate consumer conversations with 37 consumers from across Queensland on *success stories which are coming out of the public health system's response to the crisis*.

- Experienced consumers (10): Statewide HHS CAG Leaders, consumers members of the Health Consumers Collaborative of Queensland and HCQ's consumer advisory group
- Community of Interest (15): comprising more than 120 consumers from across the state, very diverse group with cultural, geographic, financial, and (dis)ability and health experiences.
- Consumer representatives of Statewide Clinical Networks (12): A group of experienced consumer representatives

Consumers outlined what they would like maintained during COVID-19 and beyond:

Improved consumer engagement

- Online video conferencing has opened up and democratized opportunities for consumers to engage more frequently, more meaningfully and on a much broader range of issues with more diverse range of health consumers and carers than traditional engagement methods.
- Opportunities such as HCQ's Consumer Conversations and the Director General's VideoCast have signalled that the health system wants to listen and respond to consumer input.
- Timely consumer involvement from the early stages (of some key projects) has made a huge difference.
- Efficiency and speed of consultation turn around.
- Improved access, equity and transparency in decision-making. Consumers highlighted the need to maintain this level of consumer involvement.
- Groups with some of the greatest health needs have been able to engage in conversations that shape decisions including First Nations and rural and remote people, people living with a disability or chronic health conditions, or culturally and linguistically diverse people have been given a seat at the engagement table.
- Consumers are better informed and better connected e.g. information sharing into consumer networks and into local HHS groups.
- COVID-19 has created a sense of urgency and a need to collaborate with all stakeholders. For this level of consumer engagement to continue consumers identified the benefit of shared goals and mechanisms/willingness to continue to partner.

Decision making – at system level and point-of- care

- Consumers can see that the health system has changed its decision making and value the new: collaboration, speed, transparency and shared vision.
- The Renal Clinical Network and AKC2026 have come together almost as a single entity to make decisions and ensure care for people with renal/kidney disease is fit-for-purpose during these changed times.
- A new maternity decision-making group has formed with Directors of Midwifery, Obstetrics, consumers and key Department staff. Consumers value this group's ability to make decisions on clinical care, pathways, place of birth and communications to families receiving maternity care.
- HCQ has a seat at many decision-making tables, which allows the organisation to provide timely, and diverse consumer experiences and perspective on issues on the agenda. This effectiveness supports better real time understanding of the experiences of consumers in response to the health system across the state.

Queensland Health has shown greater transparency and collaboration between staff and leaders across the system

- Consumers recognise that the COVID-19 pandemic caused massive levels of change in the health system. Disruptive change on many issues that have been discussed for years was implemented rapidly. Collaboration and inter-professional relationships between staff has made decision-making more efficient and effective. People in the health system now value learning from each other and can see what they are gaining through collaboration and openness. They are growing in confidence that it is safe to do this and want to hear this from consumers.
- Consumers have also seen health staff working collaboratively with each other and across different health sectors. In contrast where there are pockets of staff that are (still) working in silos, it is now glaringly obvious.

Consumer vignette:

A mother shared how a decision about her child's care that would normally take a few months to make was made in 30 min. The head of each department providing care for this child, simply got on the phone and talked to each other to collaborate on decision-making about her care and treatment. This bypassed many messages, delays and enabled shared understanding on the needs of the child leading to an efficient and effective decision.

What are the efficiencies of care to keep?

- Access to telehealth (discussed further in the next section)
- Development of new models of care and guidelines that will serve beyond COVID-19 e.g. end of life, dementia care.
- Great opportunity to have long-overdue conversations on low-value care treatments/ surgeries and to drop these in favour of high-value care that optimizes investigations and to de-prescribe medications.
- Ethical decision making framework – co-design between consumers and clinicians. Involvement of clinical ethicists (it was even suggested that one be available in every health service). Real awakening of decision making and dilemmas that need to be discussed and resolved in a collaborative way alongside consumers and carers. Innovative processes to

ethical dilemmas especially on equity and access. Ensure that organizational values are aligned with staff behaviours and actions.

- Elective surgery – Use principles of value based health care to rethink and reprioritize surgery and wait lists.

Telehealth and virtual wards and hospital in the home

- Teleheath has been a success story on many levels.
- It has enabled rapid access to care and equity of access in both metropolitan areas and particularly across rural and remote Queensland. The ability to have a consultation or assessment with a health professional has saved consumers time and money.
- It does not replace the importance of human connectedness or the need for appropriate face-to-face appointments and examinations but for certain consultations it is valuable.
- Consumers want to keep Telehealth and continue to improve it. Going forward the lack of internet access for many people must also be addressed.
- Health Consumers Queensland has suggested that Telehealth could co-design information for consumers about telehealth including what it is, how to use it, what are the costings for consumers etc. Telehealth is keen to work with consumers to further improve both the current experience of receiving care via telehealth and information about it.
- Consumers also identified a need to continue Medicare funding for telehealth post COVID-19. Additionally, they would like longer consultations via telehealth funded by Medicare.
- Technology to enable medical care and monitoring in the home is supported by consumers especially those who live with a disability. This means people can receive the care they need from the comfort of their own home with enormous benefits for them.

Consumer vignette:

A consumer with significant disabilities from the Townsville region normally has to access his specialist health care in Brisbane which means having to travel down a couple of times a year. He requires high intensity support to be able to attend these appointments and it can take up to two months to organise with doctors, NDIS and care workers. As he is high risk he has been told he must isolate for many months but he can now speak to his specialist and GP regularly via telehealth from the comfort of his lounge. He is still unable to have MRIs, specialised testing or planned surgery locally but telehealth has relieved the considerable strain of having to travel regularly to Brisbane for consultations.

Increased health literacy has changed the conversations consumers want

- Levels of health literacy have increased and become more sophisticated amongst consumers. There has never been this level of respect for science and maths.
- Improved levels of health literacy require health staff to have different conversations with consumers. COVID-19 has required us all to become more comfortable with ambiguity and to be able to present different options and make informed decisions about care together.
- Consumers want more nuanced information including the evidence behind key decisions. This is reflected at both a whole of community level and at the point of care.
- In a post-COVID world, the ability to communicate authentically and to make information relevant will be critical in building continued trust and collaboration with consumers and community. Consumers no longer want to be told. Instead they want to explore the issue or problem alongside a health professional and take on board information which has been made relevant to us. It's time to talk "with" us and not "at" us.

- This in turns means that consumers will be expecting to have different conversations with their health professionals around the benefits, risks and alternatives of proposed treatments
- People are now in the habit of looking at QH sites and platforms for trusted information on COVID-19. There is an opportunity for QH to capitalise on these new behaviours and levels of trust to increase people's awareness about chronic conditions and how people can look after their own health. Many spoke of the opportunities for prevention and well being.
- Part of the uncertainty, confusion and reticence from some people who feel unsafe accessing care in hospitals and primary care at this time comes from unclear messaging and the overwhelm of COVID-19 TV programming. Consumers would like one daily, short, sharp briefing from Queensland Health (eg. 5 minutes). They would like to know they could tune in at the same time each day (television or Facebook) and be told any new, important information that would guide their decision making about accessing care and moving about in the community.

Mental health given equal weight alongside physical health

- Stigma associated with mental health has been reduced.
- Amount and availability of high quality information and support has signalled the importance of a holistic approach to healthcare.

Appendix 4 – Statewide Clinical Network submissions

The Statewide Clinical Networks were invited to submit the innovative models of care that they had implemented, existing models that had been expanded, proposed models, and challenges experienced during the COVID-19 Pandemic. These submissions will be further explored to identify bodies of work for further development and implementation.

Please click on the following link to access the compilation of these submissions: https://clinicalexcellence.qld.gov.au/priority-areas/clinician-engagement/queensland-clinical-senate/meetings/innovation-transformation

Appendix 5 – Summary of Group Work

During the Senate meeting, participants broke into small virtual groups to further explore several topics via the online platform, GroupMap. A summary of the discussions, along with the full notes are available at:
https://clinicalexcellence.qld.gov.au/priority-areas/clinician-engagement/queensland-clinical-senate/meetings/innovation-transformation

This page intentionally left blank