

Queensland Clinical Senate

Clinician leadership. Consumer collaboration. Better care.

Innovation and Transformation in Models of Care in response to COVID-19

Extraordinary Meeting

Video/Teleconference

Monday 18 May 2020, 9.30 am – 2.00pm

Meeting Report

Overview

Queensland Clinical Senate members held an extraordinary meeting with invited consumers and stakeholders on Monday, 18 May 2020 to identify and reflect on innovations and changes to models of care in the Queensland health system during the response to COVID-19.

The meeting was conducted through Zoom videoconferencing and GroupMap participation software remotely, with over 200 individuals participating from across QLD.

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?

This Meeting Report collates and provides a thematic analysis of the outputs from these three sessions captured through GroupMap

The Meeting facilitation process and reporting was conducted by Will Bessen of Tuna Blue Facilitation with support from Kieran Bindaheem.

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Process

The following speakers set the context for Session One:

- Dr. Alex Markwell, Senate Chair Welcome
- Zehrab Vayani, Consumer Consumer Perspective
- Dr. Cam Bennet, Medical Director Metro North HHS, Virtual Ward
- Sue Rayner, Nurse Navigator Respiratory Network Cairns

The participants used GroupMap to provide input based on the focus question:

What is one positive change or innovation that you've noticed during the response to COVID19 in the QLD health system?

The participants also used the 'like' function in GroupMap to indicate pertinent comments from others.

Key Changes Noticed

The top 5 most 'liked' changes are:

Change	Comments	Likes
➤ A bureaucracy that supported and trusted the front line to re-organise clinical care within the system.	Thanks to Dr John Wakefield for leading this culture change :)	17
➤ Doctors washing their hands		9
➤ Hybrid care models with face to face and telehealth options to provide flexible, responsive care e.g. hybrid community based rehabilitation models		5
➤ Microsoft teams are more efficient when having meetings	Zoom a standout compared to Teams	5
➤ Flexibility in work practices		4

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

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 technology 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, technology 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, plus 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 and provision of low(er) value healthcare

Session Two: SO WHAT have we learnt from these changes?

Process

The following speakers set the context for Session Two:

- Dr. Jillann Farmer, Incoming DDG CEQ Welcome
- Hannah Christensen, Child & Youth Network Virtual Child Development Clinic
- Matt Page, Telehealth Support Unit HIU Telehealth Update
- Dr. Carl De Wet, Primary Care Lead Primary Care Collaboration

The participants used GroupMap in breakout groups to provide input based on two focus questions:

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

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

The participants also used the 'like' function in GroupMap to indicate pertinent comments from others.

Key Enablers

The top 5 most 'liked' enablers are:

	Title	Comments	Likes
➤	Very efficient communication from Clinical senate and clinical networks.	One major advantage was the request for questions and feedback	22
➤	Leverage off the consumer / public (there's an expectation there now) – “why do I have to go to the physical hospital, can't it be done virtually?” Partner with the consumer, highlight consumer satisfaction, look at PREM/PROMS. The building blocks enable, and are of, value to the system funder		15
➤	Case management as a model of care, more multidisciplinary	Nurse Navigation as a strong subset of this And medication review for deprescribing unwanted therapy	11
➤	A massive change in the relationship with Primary Care becoming a valued partner, not a troublesome extra		11
➤	Clinical leadership demonstrated through rapid uptake and adoption of new practice and innovation, empowered individuals with the capacity to co-design and assign resources without the usual process etc		10

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

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 cross 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 to allow for rapid innovation and possible failure as an option
9. Case management, including nurse navigator roles
10. Willingness and supporting frameworks to address low value care activities

Key Barriers

The top 5 most 'liked' barriers are:

	Title	Comments	Likes
➤	Today's funding model is based on activity, people through the door		11
➤	Lack of connectivity between general practice and public hospitals (role of ieMR?)		8
➤	Does our system have the know-how to drive transformational change?		8
➤	Telehealth technology - access to patient devices and data; related to affordability. Need to support marginalised patients.	Need more admin support to effectively support patients to optimise what they have available - cannot be done with existing admin for clinics	7
➤	Timeliness of communication	Since the changes are so rapid, the content of information and updating is important too.	6

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

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 adverse culture, a disjointed / federated health system and fear of the unknown
3. A funding model focused on activity and hospital beds
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, AOD, STI's, chronic disease) if the focus isn't placed on these conditions and cohorts
7. Need to review and evaluate new models and existing policies and procedures in alignment with recent innovations
8. Potential for greater fragmentation or isolation of services and roles with greater Telehealth use
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
10. Inconsistent messaging from Commonwealth and State levels

Process

Dr Alex Markwell, Senate Chair set the context for Session Three by providing a summary of the first two sessions plus an overview of the survey results and network submissions received prior to the meeting.

The participants used GroupMap in breakout groups to provide input based on the 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?

The participants also used the ‘like’ function in GroupMap to indicate pertinent comments from others.

Key Suggestions

The top 5 most ‘liked’ suggestions are:

Title	Comments	Likes
➤ Today’s funding model is based on activity, people through the door		11
Title	Comments	Likes
Incentivise HHS's to work together through workforce movement and patient flow across boundaries. Include mapping rural HHS's with metro HHS's		20
Clear collaboration with health consumers and their allies, for key messaging as feedback from community it’s clear the messaging worked and was relevant. Format and processes to be aligned with disability groups (e.g. language appropriate).		16
Supporting research and education to ensure we’re delivering most appropriate model of care: using telehealth as appropriate for long range / cross HHS boundaries, based on the type of care (some care works better virtually than others)		12
If we can substitute ED presentations with something else, think about how many of these ED presentations were really required. Ramping of patients in ED had suddenly gone in COVID outbreak time. Bring health-direct hotline back to keep the reduced surge in EDs.		11
Embed telehealth from undergraduate training.	And training for existing consultants and senior clinicians. Also, a mandatory training for anyone working in Outpatients	10

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

1. Move to an outcomes based funding model that incentivises collaboration within the system based on PREMs & 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 consume 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, 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 QA 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

The GroupMap input in common theme clusters (as identified by the facilitator) are:

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

- A bureaucracy that supported and trusted the front line to re-organise clinical care within the system.
 - Thanks to Dr John Wakefield for leading this culture change :)
- Health professionally led, not political, with great health outcomes a wonderful lesson for the future of our health system
- Openness to change
- The speed at which change has successfully been adopted
- Focus on solutions not barriers
- How quickly things can happen when required
- Efficient ability to implement change
- The public health system can be nimble and respond quickly and ably when it needs to
- Speed of change and people willing to adapt
- Reduction in usual barriers
- Reduction in red tape to fast track innovation
- Willingness to constantly adapt
- Clinicians open to more innovative ways of working.
- I've enjoyed the way that each HHS has been allowed to adapt to their local situation
- Agile engagement and redesign opportunities
- Rapid change
- Staff response to changing requirements to provide patient care
- The ability to look at things differently
- Increased flexibility and willingness to collaborate across the health sector to achieve agreed goals
- Willingness to test out new things fast, so lots of opportunity for micro experiments to find what works and what may not.
- Time to implement a change
- The willingness to enact change rapidly, accepting that things may go wrong and we can always adjust processes
- Getting things done quickly at every level of the system with a focus on practical outcomes
- Willingness to change
- Focus on practical outcomes and willingness to change
- There has been a willingness to change
- Much quicker implementation of innovative ideas
- Opportunity to do things that I couldn't do during the past few years
- Rapid flexibility in developing new workflows
- Ability to change quickly.
- Decisions get made more quickly
- Streamlined admission processes

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

- Doctors washing their hands

- Increase in education and compliance with infection control practices.
- A renewed focus on hand washing and PPE use, which should just be normal but hasn't been...

A major increase in technology 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

- Microsoft teams are more efficient when having meetings
 - Zoom a standout compared to Teams
- Utilising our award-winning MECare platform to support the virtual program and the hub, we can support up to 4000 'live' patients. This is a program that could be easily extended to a state-wide service. A great example of alternate care to Hospital care
- Better use of technology
- How willing the Qld public has been to embrace telehealth and comply with new social rules
- Reduction in "unnecessary" meeting. More "electronic" meetings.
- Increased use of telehealth.
- Use of technology (Telehealth and TEAMS for consultation)
- The nudge we needed for increased telehealth.
- Telehealth
- Telehealth outpatient options
- Telephone / video in general practice and reimbursement through MBS for GP's and nurses able to access
- Most positive feedback on innovation is to do with telehealth and the success of this method.
- An openness to move towards using a Telephone or Tele health OPD
- Telehealth to GPs and patients
- Use of telephone and telehealth for consultations - consumer choice, has improved attendance at our diabetes clinic as people don't need to take time away from school or work
- Alternative work arrangements - WFH / Telemeetings / Teleconsults
- Convenience of telehealth/phone/app consultations
- Telehealth positive impact for people with diverse disabilities
- Telehealth and the opportunity to improve person-centred care access to care in our very decentralised country
- Rapid increase in use of telehealth in many sectors
- Utilisation of technology to provide care and facilitate meetings.
- Access to telehealth services.
- Support to deliver services using telehealth and telephone occasions of service
- More efficiency in OPD using telephone reviews
- Telehealth is great for consultation.
- GP telehealth ease of consultations
- Embracing technology for virtual meetings
- Telehealth appointments
- Acceptance of using ZOOM or other platforms for meetings
- The whole system can work very efficiently using telehealth especially for chronic disease management. We have successfully implemented this for renal patients.
- Increased use of telehealth - both phone and video
- Increased use of telehealth into the home
- Telehealth

- For many people with disability where physical examination not needed for their appointment, telehealth has been a positive
- Rapid introduction of many remote service enabling technologies
- Understanding the different potential between telehealth episodic care and/or virtual care as benefiting rural and remote Indigenous populations
- Hybrid care models with face to face and telehealth options to provide flexible, responsive care e.g. hybrid community based rehabilitation models

Greater consumer engagement and an increased focus on the patient journey

- Efficient and robust health consumer engagements
- Heightened consumer engagement
- In Mental Health staff have embraced new ways of working, particularly the willingness to draw on the consumers strengths - asset focused care rather than a deficits focused approach
- A real focus on the patient journey- what works for consumers rather than what is the most efficient approach for our clinicians and infrastructure.
- Enabling me and my GP to talk to the specialist together, rather than expecting me to be the line of communication between primary and secondary care (e.g. MECARE at West Morton HHS)
- Rapid consultation with consumers
- Improved consumer engagement and faster feedback cycles
- Streamlined engagement with community

Rapid development of alternate models including COVID clinics, virtual hospitals, technology enabled HiTH and rapid discharge pathways

- "West Moreton Health COVID-19
- Hospital In The Home (HITH) – a quick response adaptation of an existing service... COVID-19 patients admitted into the HITH Program (separate stream) are provided with an IT kit which includes a mini iPad and Bluetooth equipment. Patients observations and health status are monitored closely using the point of care devices within their homes.
- Virtual OPD clinics
- Alternate models being considered
- Opened unfunded beds
- Creation of additional negative pressure rooms in a variety of units including rural hospitals.
- Creation of a COVID positive pod in the ICU
- Rapid pre-anaesthetic chart review clinic
- NDIS rapid discharge pathway
- Steps taken to enable comms and maintaining relationships during isolation (e.g. virtual visiting in Ipswich hospital, HITH)

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

- People working together rather than in silos
- Greater collaboration across sectors
- Increased cooperation and streamlining between inpatient and community based services (public and NGO/PHN) delivering care across the full patient journey (subacute, community reintegration and maintenance as well as acute care)
- Barriers that have usually existed in some instances disappeared immediately
- Increased collaboration

- Collaboration between groups and recognition of (consumer) expertise
- People were more prepared to help each other
- Enhanced communication and supported one renal voice for Queensland.
- The statewide directors of Obstetrics and midwifery are now meeting weekly and collaborating with each other and consumers in a way I have not seen in the past decade. It would be great to see this continue on past the COVID-19 response.
- The improved communication across different areas of a HHS, and across external partners
- Enhanced collaboration and communication
- Collaboration
- Strong collaboration and focus of the Clinical Senate and clinical leaders
- Increased professional co-operation
- Great collaboration
- Feeling a lot more like ONE health system
- Willingness to work together with a shared purpose
- Increased collaboration between clinical teams that don't often intersect
- Strengthened relationships and partnerships- with new groups as well as established
- Collaboration across services
- Bringing together a range of primary care key stakeholder organisations to collaborate to support COVID-19 response to support primary care
- COVID19 Application - even used as part of OH&S

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

- Nurses opportunity to refresh and build on clinical skills.
 - Finally flexibility for consumers they asked for over years.
 - Within our organisation we saw an influx of staff willing to participate in our upskilling program. Almost 150 nurses were transitioned through a rapid upskilling program for our intensive care unit; the challenge now is how to we maintain the knowledge and skill development in these staff...
 - better flexibility in accessing the elective sessions to enable emergency flow
- Accelerated training programs for upskilling and retraining nurses to increase the pool
- Nurse to nurse referral and ability to work to full scope of practice in either virtual ward and or community settings
- Enhanced operational flexibility of all professions and of Nurse Navigators in particular

Greater flexibility in working practices, particularly working from home arrangements

- Ability to work from home and being available more often than usual
- The ability to work from home regularly has been a nice change
- Workers who don't need to be in the office have been able to work from home without onerous paperwork requirement
- flexibility in work practices

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

- Recognition that we have first-class health care.
- Greater appreciation of the importance of population health in clinical care
- More focus on Clinician wellbeing

- Increased public recognition and thanks for frontline workers

Reduced presentations to ED and provision of low(er) value healthcare

- Reduced unnecessary presentations to ED
- Dis-implementing low(er) value healthcare activities

Appendix Two: SESSION TWO – Detailed GroupMap Chat Input

The GroupMap input in common theme clusters (as identified by the facilitator) are:

Enablers

Efficient, concise and broad communication and messaging to all components of the System, particularly via the Clinical Senate and Clinical Networks

- Very efficient communication from Clinical senate and clinical networks.
 - one major advantage was the request for questions and feedback
- Strong communication and governance processes
- Effective systems and processes for communication
- The frequency and breadth of inclusion in communication from QHealth and QCS.
- Communication channels internally and externally that have been used have been really positive - this has assisted with networking and greater engagement including LDMG etc...
- Once developed good ongoing communications
- Communication improvements - from (and to) State, between providers.
- Clinical communication platforms/portals between health and consumers
- Communication overkill = I love it! It was great to have so many levels of comms to staff and it was fairly consistent across the different areas I received information.
- Make sure the communication between system elements continues/improves
- Trust has been an enabler and this has been aided by consistent messages
- Consistent messaging from senior Qld Health with current and contemporary information

Opportunities to display clinical leadership and access direct lines of communication and feedback with executive decision makers

- Clinical leadership demonstrated through rapid uptake and adoption of new practice and innovation, empowered individuals with the capacity to co-design and assign resources without the usual process etc
- Clinical leaders are EXCELLENT change managers
- At organisational level, being given the permission to think big and outside the square
- Clear lines of support for frontline clinicians from senior management
- As an immunocompromised staff member, I was extremely well supported by Qld Health to remove me from the workplace and enable me to work from home - nothing was too much trouble.
- Clinician and management interaction across health services and other providers - a dynamic engagement, not relying on centralised department control
- Ability of clinicians to provide feedback to executives
- Innovation from the ground up, but also from the service level - make it systemic. Need to scaffold with project methodology, cross sector governance - otherwise everyday activity takes over. Disciplined systems approach focussed on outcomes.
- The speed in which innovative models of care were implemented without the bureaucracy was remarkable and very impressive.
- Clinicians willing / keen to deliver care in different modes concurrently depending on patient needs and risk/benefit considerations - change champions
- An energised and engaged workforce
- Staff and service wanting it more than consumers (many homeless, no technology), mental health assessments can miss subtleties over phone. Hybrid model is ideal. Mental health needs higher level of F2F and scaffolding for clients.

- Tolerance for ambiguity and rapid change at all levels - clinician to executive/state
- HR / Legislative flexibility due to COVID
- High level support for new models during this period - the green light to try new models and encouragement to reach out between services and Networks
- Change accepted rapidly with clinical change leaders.
- Interactions between clinicians and decisions-makers and PHN - working together - shows what we're capable of

Willingness of staff to embrace change and innovation across traditional silos, hierarchies and cross sector barriers, particularly between acute and primary care settings

- A new focus on innovation and willingness to change
 - not just R & R, all of this needs administrative and tech support
- Having the "silos" go made things/actions happen with greater speed and process efficiency. Noting the ongoing need for transparency and safety considerations should be factored. This was leveraged by a shared/common ground. We wonder why we can't have a bit more common goal/ground more often. A positive enabler for change. Everyone was affected; supporting an environment for change and improvement. Generating a willingness and embracement for change.
- Willingness of staff to augment and adapt how we do business
- Innovations have been happening very quickly, with willingness to abandon established models and hierarchies
- Allowing individuals to be flexible
- New and flexible way of thinking, and of working. knowledge and skills.
- People have been more open to innovation - can work remotely, access is possible (choice) - innovation open environment.
- Willingness of people to work together to find solutions especially with eHealth
- A willingness to be solution focused and this is underpinned by attitudes and a willing to reach agreement on processes, resources, funding.
- A MASSIVE change in the relationship with Primary Care becoming a valued partner, not troublesome extra
- A willingness to engage with GP community
- Relationships developed between public hospitals, PHNs, private practice especially general practice
- Greater engagement and a common purpose across the primary and acute health sectors, private and public
- Managed to create better connections and pathways. outpatient network in children's. Lighted up engagement within across and also with outside organisations
- Across the state, HHS and PHNs.
- Collaboration, GPs, Consumers, local hospital
- Cross sectoral collaboration, in particular general practice into acute system has been turbo-charged. GPs finding it easier to access specialist advice
- Cross-sector collaboration and communication, so all the providers in a consumers health-care journey can
- Meaningful collaborative leadership
- Difference between extroverts and introverts - working together differently to co-design systems and models of care - allowing for voices that would not normally be heard to be voiced and listened to.
- Collaboration across groups/breaking down barriers
- Collaboration and working together and willingness to embrace change at a rapid pace
- Townsville, common need at this time has drawn people together and collaboration, willingness to change. Agility and flexibility to look at positive change.

- Willingness to collaborate and work together - agility and attitude to try new approaches and change. The motivation to change, and collaborate was informed by a desire to respond effectively to the seriousness of the pandemic, its impacts on patients, but also on workforce (in this together).

People 'had to work together'; the crisis provided a common goal for innovation across the community, consumer and clinical spaces

- "Great crisis leads to great opportunity"
- People have had to work together.
- Rapid adoption of change when supported/encouraged by clinicians
- The NEED to change in response to a pandemic situation has been a major enabler at an HHS level - has removed some of the traditional barriers to implementing new/extended programs or care delivery models.
- COVID has given us a burning platform
- A common feeling of "greater good" allowing sharing of staff and resources
- Crisis indeed was a key enabler.
- Deadline and need - 'it had to be done'
- We don't know what we don't know... we know we need innovation to support change.
- The crisis has created a common goal
- Disruption has been an enabler
- Disruptive change has been forced on the system and this is driving the change
- Shared focus amongst all stakeholders to accelerate implementation of improvements
- Will to embrace rapid change
- We had to change because of COVID, forced us to be proactive and use the options available e.g. Tele health, ZOOM for meetings
- Greater community acceptance and recognition of change. Now is a good time to introduce change
- Public's appetite to partake will hopefully overcome everything!
- An understanding that public health is central to the health of the community and is therefore an essential part of primary care...
- Everyone working with a common purpose - how do we embed a more innovative culture
- The momentum provided by the COVID emergency has given energy to enact change

Early and frequent engagement with consumers in the design and delivery of innovations

- Early engagement with consumers, frequent engagement and great feedback loops
- Health Consumers QLD - a conduit, a facilitator, providing effective consumer engagement at a time of crisis
- The value placed on consumer feedback for new models/care delivery. A strong presence and voice from Health Consumers Queensland from the outset.
- Increase of consumers engaging QH services, particularly Aboriginal and Torres Strait Islanders and Rural and Remote populations due to the flexibility and limited impact on their lives. Now we are listening to what communities requested from us over many years, we have real collaboration.
- Consumers have been open to change
- Different models that are more consumer centric and improving access to care especially in drought impacted communities that are now further impacted by COVID-19
- Focus on Queensland's First Peoples
- Reflecting on lived experience of the consumer - truthful and authentic relationship building.
- Health literacy and trust both ways from patients - clinicians - patients

- From consumer perspective, greater readiness and willingness to look at other ways of doing things e.g. seeing a specialist in person - getting a quicker response to a phone call. Communication needs to be responsive, whether in person or face to face.
- Triangle of 3 points risk adversity, values based health care and safety and quality With the consumers in the centre of this virtual model
- Consumer compliance has been greater
- The partnerships with consumers and engagement with QHealth and QCS help to keep the patient at the centre.
- ENCOURAGED COLLABORATION. Avoided barriers. Got things done e.g. NDIS. Solutions based e.g. long stay patients in hospital beds e.g. spinal injury
- Great collaboration with consumers and clinical senate and networks
- Empowerment of consumers and involvement in decision-making
- The ability for staff to be strengths focused and be adaptable to ensure consumer care is delivered. more open to change however still very red taped process the systems
- From CHQ, being able to give families a choice. e.g. face to face, phone or video conference. Lots could be done by phone and had good admin support to take families through various options.
- A valuing of every voice; a genuine feeling that we are all in this together (Not just a cliché)
- Rapid and meaningful health consumer collaborations and engagement
- Consumers want convenient delivery
- Consumer and wide stakeholder and community Involvement and Consultation, Engagement ; (Health) Education - clear, simple, achievable, memorable messages
- QHC has been an excellent conduit between the State and Health Consumers.
- Partnering with consumers!
- Introduction of consumer focussed outcomes

An outcomes focused funding model that enables flexible, patient focused innovations

- A funding model that isn't constrained by geography - Brisbane specialist can provide care to anywhere in Qld (but can't hinder own service's funding).
- We should have evidence based outcomes in response to the current innovations
- Lobbying for ongoing funding model that rewards outcomes instead of just activity - driven by PREMS & PROMS - important to both clinicians and community.
- Funding should be consumer focused
- Flexible funding models to drive the use of technology rather than physical location of patients
- Identification and solution for problems prioritised, with funding/finances a secondary consideration. Patient care was the primary motive/consideration. e.g. NDIS previously hadn't approved interim accommodation, and now, there is a trust and interim accommodation is approved.
- 2021 - funding models reflecting Commonwealth change (national change reform - block funding). Currently driven by counting activity - difficult to innovate - penalised if not doing activity.
- Funding model to support change of practice
- Models of funding
- More flexible use of funding to improve patient selection and flow

Uptake of technology (primarily Telehealth) to facilitate Statewide access, meet consumer preferences and manage clinical resources; relies heavily on effective IT infrastructure

- I have been trying for a long time to encourage my clinicians to use a digital platform for information sharing and for meetings - with a little push-back, until COVID-19 hit. It has just happened and been embraced overnight. Brilliant!

- Greater use of telehealth for rural and remote consumers so that they don't have to travel long distances for a 10-minute appointment with their GP or specialist.
 - not just R & R, all of this needs administrative and tech support
- WMHHS up to 66% telehealth (using MeCare). Necessity is the mother of invention. Capitalise on the change readiness. Population now very used to virtual, videoconference for family interactions, no different with healthcare.
- Telehealth can bring the GP into the consultations with the multidisciplinary care team in the tertiary hospital
- Technology platforms availability and accessibility
- Rapid shifting to Telehealth and getting this modality integrated into the routine daily workflows, enhanced through the MBS
- Regional challenges with travel to Brisbane, telehealth was now able to be used!
- Having access within the clinical area to skilled and available IT interface for clinicians for use of telehealth, access to iPads with SIMMS, having sufficient AO support to support families for telehealth into the home, families having access to sufficient data and mobile devices
- Education and support for patients to learn how to use, be comfortable with and access telehealth
- Can appointment be done by telehealth yes or no? Should be the first question
- Need a new language post-COVID to keep the telehealth momentum going.
- Telehealth, change of practice,
- Expansion of telehealth platforms to support activity
- An existing, effective telehealth service system with multiple platforms for delivery
- Telehealth has worked!
- Telehealth as a driver of rapid change and access to care
- Telehealth - don't knock it till you try it.
- Telehealth
- Telehealth and regular consultation
- Receptionists need to assess tele-readiness when clients call to access services. Now same day rather than weeks to see/speak to someone - timelier, especially with mental health.
- Can do 3/4 of work virtually, coupled with F2F consult as needed.
- Technology is enabler in this environment
- Building a virtual system that gets consumers and clinicians to a point where it is simple and is as easy as picking up the phone or being invited into someone's home.
- Failure to attend issues - have been zero because we can catch people on the phone. Only issue is if they don't have a phone.
- Technology of our choice to be accessed for patient contact
- Digital technology
- Use and combination of different methods, e.g. phone calls, health,
- People are ready for change. Technological limitations. must take all clinicians on the journey (not just the enthusiasts / early adopters). Need the technology and the skills.
- TECHNOLOGY very positive enabling patient support
- Telephone consults up a lot in some areas but not video consults.
- More options for people to do this e.g. smart phones. Although can be a barrier
- Statewide solutions group proactively evaluate technology options
- Covid19 APP, nimble and agile
- There needed to use workarounds to operate with individual accounts
- Special planning group and key stakeholders (e.g. statewide pharmacy network) - Live dashboard
- IT infrastructure was a key enabler in the clinical setting

- Need decent info platforms and band width
- Flexibility of work practices enabled by technology

A refocusing of risk through the removal of administrative barriers and red tape to allow for rapid innovation and possible failure as an option

- Removal of many administrative barriers to change - clinicians allowed to "just do it"
 - remove red tape but don't remove risk management approach
- "Good ideas" getting very rapid support
- Reduction in red tape but not risk management approach
- System disruption has facilitated an open mind to new models
 - agility, less red tape
- Leverage off the consumer/public - there's an expectation - why do I have to go to the physical hospital - can't it be done virtually? Partner with the consumer, highlight consumer satisfaction - look at PREM/PROMS. The building blocks enable, and are of, value to the system funder.
- Change in expectations and reduction in amount of red-tape
- Reduction in red tape e.g. not the same multiple levels of approval, one decision maker and approvals
- Cementing unification processes and shared objectives between HHSs that have cut red tape during COVID-19
- Good network infrastructure, cut through the red tape,
- Great openness to try new things
- Supporting innovative change and balancing innovation with patient safety
- Allow proposals to be pitched and then if approved follow up with paperwork after
- Build trust and allow for calculated risk "inverted risk profile"
- An environment where failure is an option
- Structures put in place that removed bureaucracy and allowed for quick considered decision making, these included regular meetings with decision makers, rapid frequent engagement with grassroots, being sensible as to where to spend money and effort
- A principle of "robust enough"
- Going outside the policing of the system controllers
- The workarounds need to become system based solutions
- People have been very willing to try something new, despite that not being their usual practice
- There has been a refocus of risk and acceptance of risk, which has allowed innovation - rapid change. Centralised and trustworthy source of information with regular dissemination, so there is one point of truth, everyone receiving the same information about the main priority. Clinicians re-enforcing the messages to health consumers with their engagement.

Case management, including nurse navigator roles

- Case management as a model of care, more multidisciplinary
 - Nurse Navigation as a strong subset of this
 - And medication review for deprescribing unwanted therapy
- Nurse Navigators who recognise patients at risk of deterioration
 - and other key workers as not all use NN
- NURSE NAVIGATORS. Proactive recognition of vulnerable patients. Data to become available.
- Health Services had clearer visibility to vulnerable/prioritised people for better quality of management of these patients

Willingness and supporting frameworks to address low value care activities

- Frameworks for de-implementation (values based approach to stop lower value things)
- Work is prioritized - what matters is getting done
- Willingness to consider the low-value activities - rapidly moving to authentic patient centred approaches, immediately measurable - avoiding the things that were not providing a wider benefit. (i.e. repurposing diagnostic + supports to minimise travel)
- Altered perspective on "value" of healthcare

Other comments

- Huge outpouring of public support for healthcare workers and appreciation of Qld health system
- OPD clinics just needs to change permanently
- A lot of time energy and dedication - need to be careful sustainability
 - especially with move re health sustainability \$ - how to do this and maintain discretionary effort, creativity and goodwill
- Biotech industry, e.g. 3D printing for PPE and others
- Upskilling of the full workforce, across all professions.
- The benefit of Health Pathways as an excellent source of clinical truth during COVID19 and a great example of its usability
- Training
- Leadership with the implementation of local disaster plans,
- Need to systematise workarounds
- Rapid updates to ESM in the background.

Barriers

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

- Telehealth technology - Access to patient devices and data . Related to affordability. Support marginalised patients.
 - need more admin support to effectively support patients to optimise what they have available - cannot be done with existing admin for clinics
- Rural and remote, having access to the technology, ensure infrastructure in place and working well to ensure telehealth works appropriately.
 - need to ensure resource available to discuss and support patients to optimise what they do have
- Vulnerable patient groups unable to access alternative models , particularly new technologies
- Inequality of electronic connectivity e.g. possession of devices, technology knowledge and comfort, signal
- The digital divide - affordability and accessibility for some of our most vulnerable consumers.
- Clinician reluctance to use digital processes
- Preparation and policies and procedures. The system is not prepared for wholesale transformation into virtual clinic model. Those clinicians and healthcare workers who are familiar with telehealth moved into the space very efficiently. Those who are not struggled with the concept.
 - perhaps need someone on one training for some senior consultants
- Different health professions may not be able to utilise telehealth options as efficiently – e.g. physiotherapy, occupational therapy. Require an "assistant", either carer or private provider present to facilitate.
- Lack of access to longer-term remuneration for Telehealth
- Inconsistencies of mobile internet coverage and access to most appropriate platforms
- Fear of technology from practitioners and patients. Concerns about information privacy.
- Poor internet connectivity and mobile phone black spots in rural and remote communities.
- Digital divide that exists for people with disability who don't have a device that they can use like a phone/computer and fixed income that means that having data is challenge
- Access to technology and the latest versions of mobiles/devices/bandwidth.
 - This is particularly important in rural and remote areas
- Poverty and location - isolation
 - Technology needs improvement - infrastructure - bandwidth and literacy
- Lack of agility with technology procurement and use
- Taking up a new model like telehealth has put additional pressure on clinicians providing face-to-face care. We need a tiered response to introduce more telehealth care, recognising clinicians' decision-making
- Increase positive engagement for consumers for telehealth, e.g. peer support groups look at those opportunities.
- Health literacy and other barriers linked to consumers access to Telehealth (disabilities, cost, connectivity etc)
- For clinicians and consumers meeting for the first time, virtual methods may not be the best forgetting to know people
- Technology - access and system issues
- MDT computer programs, different. Need to be able to share
- Integration between ED and inpatient systems

- Technology infrastructure efficient and reliable
- Only having one approved platform has been a limitation in some areas. E.g. community based providers needing to use Cisco with limited licences and system capacity initially.
- Some service users and clinicians don't have access to the technology required, data, internet, computers, web cams, or the skills required to use new methods.
- Group based care delivery. Running consumer based and team based interactions on current technology platforms.
- Technology doesn't always work.
 - Either no technology, no mobile network, not data, need better resources in place. Plus increase technological literacy
- Staff skills and experience in digital technologies
- Connectivity issues in remote areas (for access to wifi and video call)
- Technology access - internet availability and capacity. Smart Device access.
- Most consumers and clinicians are not aware and updated with where we are with digital health system in QLD

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

- Does our system have the know-how to drive transformational change?
- Pressure to get back into 'production-mode'. Low disease burden in Qld: 'get on with it!' risk that we just go back to the same old way of delivering care.
- Automatic return to "old ways"
- Loss of impetus e.g. we didn't know what things were going to look like; now, how do we maintain momentum when the driving force has minimised? In allied health - a lot of preparation for new models, which haven't been activated. Note: innovation registers within Allied COVID response - contains all new models, including those conceived but not as yet implemented/required. Opportunities to review these models should be factored into future review.
- Cultural change.
- Overcoming inertia of how our systems worked in the past
 - we can't just let things slide back to the way they were, no more "business as usual". Changes that have worked need to be embedded (and funded)
- Our federated health system which separates primary care from secondary, tertiary and public health care....when the consumers live in the community and primary care is their doorway into the health service
- Balance between political drivers and clinical decision making
- The risk of the organisation to revert to the old way, with slow approval processes, very slow change cycles. Are there ways of maintaining our new COVID level of modified risk aversion?
 - Ongoing work is needed to improve the technology options, bandwidth, access to technology, usability of the resources.
- Getting comfortable again
- There have been so many ideas floating up about improvement, but very few have progressed due to resistance and turf-protection. Time to break through some of these barriers.
- Fear, finance and fatigue.
- There are continuing barriers between State and Commonwealth funded services which contribute to poor communication and confusion for health service providers and can impact on patient care
- Resistance to change and fixed ideas around models of care including resistance to changing low value care practices

- There are still some "choke points" who are not collaborating well. they stand out as the not effective. this behaviour needs to be redirected to being more collaborative. rather than thinking they need to "protect" leaders or the system. it doesn't help collaboration and trust.
- Desire to protect your position
- Many health staff are willing to change but there is also a recognition of risk - a resistance to innovation and actively manage more conditions in the community has held back new initiatives. Clinicians are not necessarily good change managers
- Culture of healthcare - less geared up for innovation
- Sometimes a reluctance of clinicians to change to virtual modalities and clinical redesign of workflows
- Old ways of thinking. How do we encourage blue-sky thinking?
- Fear Fatigue and Failure
- I would hope that many of the innovative things that have been done will continue like telehealth consultations and also in certain areas, work from home - the workload and output has been more than 100% in some cases and the in-office costs have been substantially reduced in these cases.
- Inertia
- The old ways are strong - risk appetite
- Risk appetite low once the forces of the disruption dissipate

A funding model focused on activity and hospital beds

- Today's funding model is based on activity, people through the door
- The way we are paid for activity (e.g. pressure to use hospital beds to generate WAU)
 - and the WAU weightage change every year so unable to put sustainable models based on funding
- Funding model - temporary Medicare numbers will be made permanent or not is creating anxiety
- Message about hospital avoidance has led to patients avoiding seeking care acute and chronic models of funding
- Finance difficulties in allowing GPs to get a quick bit of advice. Current models revolve around proper "consultation" episode
- Financial considerations with telehealth verses face to face appointments
- Funding models of telephone vs true telehealth.
- Funding and some policy

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

- Lack of connectivity between general practice and public hospitals, role of ieMR?
- Timeliness of communication
 - Since the changes are so rapid, the content of information and updating is important too.
- Effective e-Health record usage across the health system
- Sharing of information (e.g. Viewer, GPs can't add to this)
- We don't have a system that is able to connect the patient information across primary and secondary care
- Quickly establishing a 'single source of truth' to quickly get reliable accessible information, across National and State jurisdiction
- A common platform to share info
- Cumbersome distribution, procurement e.g. PPE, technology e.g. ieMR capability
- We need to be absolutely confident in Privacy and Security of data when clinicians are rapidly adopting Telehealth models of care
- lack of consistency in system
- Not having a standardised systems for consumers to use

- Speed - the ability to disseminate info quickly
- A lack of understanding about information privacy can create artificial barriers between primary and acute care
- ieMR - too restricted - need to be able to add to the standard platform that was installed
- Different groups involved with database access, needed lots of advocacy.

Gatekeeping, bureaucracy and siloed governance and decision making structures

- Hypervigilance of gatekeeping information and communications at a senior level; this really reduces trust and levels of communication.
- Centralised control mindset in department and government, that slowed down the dynamic response.
- Getting proper governance structures in place around what are otherwise great idea
- Hyper vigilance of gatekeepers
- Bureaucracy
- Redtape to some extent!!
- Bureaucratic ways of making decisions
- Silo way of working
- Siloing of professional disciplines - especially in metropolitan areas
- Silos in health care: primary , secondary and tertiary care
- Difficult lengthy documentation processes prior to approval
- Risk aversion and lack of trust
- Pathways for decisions at a central level are overly complex and have become more so with COVID

Potential for an escalation in other health challenges that have arisen out of the pandemic response (mental health, AOD, STI's, chronic disease) if the focus isn't placed on these conditions and cohorts

- Possible breakouts of other infections/health issues every time we are getting out of waves, e.g. STI, alcohol, and drugs
- How non-COVID care was de-prioritised, with examples of loss of service e.g. podiatry for high risk foot patients resulting in poor patient outcomes. Recommend review of categorising of services to maintain essential ongoing care. Planning for service provision incorporating learning of what is essential, minimising patient dis-engagement with health care etc.
- Mental health issues due to social isolations, recessions, health inequalities, changes in health care and economic environment.
- Likely deep recession that will result from the pandemic. Need to talk about this. What will a deep recession do to an already fragile environment. Government won't have money, won't have the post-bushfire type resilience. Mental Health issues will emerge. Many drug and alcohol and mental health patients are already quite resilient. New type coming through of those who haven't experienced much hardship.
- The 'street light' effect - the risk that by focusing on one area others are neglected
- Consider the social and emotional well-being of all communities ongoing, rather than attending to the crises situations, let's do intervention and prevention with all.

Need to review and evaluate new models and existing policies and procedures in alignment with recent innovations

- Policy, procedure needs to catch up to where models have moved - there may be unintended consequences of rapid introduction of new MOCs.
- There has not been the time to do any evaluation of the new models. need to evaluate before we roll out more widely. needs to be multiple lines - consumer satisfaction, clinician satisfaction, clinical outcomes

Potential for greater fragmentation or isolation of services and roles with greater Telehealth use

- Nurse navigators Could become isolated. Connecting them to multidisciplinary team. Multiskilling. Ready access to allied health and specialist nurses and specialists. Medication reviews via telehealth.
- Having multiple GPs looking after each patient. Usual GP might not be the one who referred them in for episode of care
- Complications of complex multi co-morbidity calls for a more complex connection with primary care.
- A great risk of increased fragmentation with dependence on telehealth, unless having multiple participants (e.g. GP, Nurse Nav, IHW) accompanying patient
 - Important that telehealth enhances good healthcare delivery, and supports team-based healthcare. So if a person is seeing a number of health professionals (few different medical specialists) and allied health and community/primary care, that it is easy for the whole team to communicate and share decisions.

Need to address capability and workforce flaws made evident during the pandemic response, particularly health literacy and onboarding / supervision of junior and casual staff

- GP's let's link up to upskill everyone to help with healthcare going forward.
- Supervision of junior staff is more challenging and limited
- Health literacy
 - - In the areas where it is most needed [disadvantaged, remote, at-risk populations] lack of health literacy inhibits engagement and inhibits trust of the system
- Existing capability flaws in current system
- Health literacy challenges
- Inadequate public health infrastructure, resource and capability within regions and remote areas
- Workforce
- Onboarding new people on ieMR when large numbers need to happen rapidly, especially for Casual appointments

Inconsistent messaging from Commonwealth and State levels

- Messaging at a local level, there have been inconsistent messages.
- Different messages from State and Commonwealth (e.g. 'flu vaccinations). Created concern, fear, anger in the community
- inconsistent messaging for rural vs metro and contextualisation
- Reliant on the local health centre, access at local hubs need to be adequately equipped, ensure confidential space, sufficient networks and staffing to advocate and support and navigate for the patient.
- Lack of statewide COVID disaster plan
- Getting GPs on board.
- Consistency
- Apparent lack of CV19 specific statewide disaster plan.

Other comments

- Not have adequate supplies of PPE and other healthcare products in our more remote areas of the state. Ensuring an equitable allocation of resources across urban, regional and non-urban areas of the state.
- Systemic bias
- Private facilities to be more accountable to resolving the problem for public patients not restricted to the private patients
- Transport of clinicians during border restrictions and limited transport options

- QH not default to past culture of e.g. expecting patients travel to Brisbane for 10 min consult, let's continue the engagement and let go of the control.
- Challenge not barrier - Whole-of-community engagements, e.g. Aboriginal and Torres Strait Islander, CALD, people with disability
- Balance of elective and urgent medical appointments
- Not giving consumers the option and being open about such options.
- No caller id numbers were on the system originally and people didn't pick up - that has since been changed.
- For some consumers, need to have in person or video consultation, to be able to assess environment and non verbal cues, which may not be able to be assessed by phone alone, particularly for new patient/clients. May need to get collateral information from the supports that are working with a person. So person and their environment,
- How we can refine the model with use of face to face / outpatient as an option. ensuring that the work is sustainable.
- Private hospitals need to be more transparent in providing resources to assist in getting public patients treated
- That it is a very good system with facilitation
- Infrequent nature of exec decision meetings
- Coding
- How we can provide health services across the board.
- Sustainability of the changes and how can we work longer term.
- The flip-side of what we've covered in enablers - , including technology not in place .
- Cancellation of important (discharge) appointments during telehealth appointments. Instead of rescheduling.
- Until now, the need for a rapid response has meant people feel unable to have consumers at the decision making table in a way they would have before.
- Social distancing
- Second wave and possible subsequent waves

The GroupMap input in common theme clusters (as identified by the facilitator) are:

Move to an outcomes based funding model that incentivises collaboration within the system based on PREMs & PROMs

- Incentivise HHS's to work together . Workforce movement, Patient flow across boundaries. Mapping rural HHS's with metro HHS's .
- Funding model to be changed between primary and secondary care. Break the shackles
- Funding based on outcomes rather than activity. Can we put what is happening to the patient as being more important than what is happening for the Health service?
 - Please don't assume that HHSs are opposed to this. It is often the clinicians (those wedded to activity) who are opposed to it, not the HHSs.
- Timeframe of review and planning is required to be adjusted. Year on Year budget doesn't provide enough opportunity to change or improve.
- New funding model to attach funding to patient not hospital e.g. in aged care and disability care. Ensure enough reach in system to get to patient with poor access.
- Modernise funding mechanisms for sustainability
- Start/restart discussions around commonwealth/state funding divide - good time to do this.
- Financial advice - financial remuneration; pushing forward with telehealth payments, outcome based funding models utilising multidisciplinary care in different environments (primary, community, hospital based). Reduce rigidity in current funding models to be responsive to the changing needs of the models of care. Funding model needs to be more flexible.
- Commitment to use patient-reported experience measures - outcome measures that really matter - driving investment. Fits into the choosing better care together philosophy. A whole refocus from activity-based funding to outcome-based funding. System not to do pilots and take 3 years to evaluate - need to evaluate in real time.
- New funding models need to reflect system changes and demands
- Funding based on outcomes - PREMs and PROMs, not ABF
- More flexibility in moving funding between capital and labour buckets
- Funding - what will be an enabler e.g. for telehealth MBS produced transformation quickly. System can be mobilised with the right incentives. E.g.
- See funding point: simple single platform for virtual care. Some constraints with Statewide telehealth system - not being tied to one way of doing things if a simple platform can work.
- Keep funding innovative models that have proven value, defined not only by financial and volume metrics
- Change to outcome based funding from activity based funding
- How do we match the system with funding models that match new normal
- Paying more for outcomes that matter, and less for others – enablers: the questions that really matter, feedback, how you measure it (PROMs & PREMs), overall economic impact to both system and consumer
- PREMs and PROMs not ABF and WAU!
- Current ABF is required to be changed. More work we do in primary network doesn't add to ABF in current perspective.
- A 3-5year budget projected expenditure should be reviewed by Queensland health, working 3-5 yrs ahead.
- The initiatives and focus need to be prioritised - choose those things that will impact patient / consumer outcomes and build on the momentum

Ongoing investment in telehealth models, infrastructure, equity of access and capacity building / training

- Embed telehealth from undergraduate training.
 - And training for existing consultants and Senior clinicians.
 - Also a mandatory training for anyone working in Outpatients
- Ensure telehealth is supported from network capacity.
- Make Telehealth-virtual clinics- routine for chronic disease management
- Continue to support the Telehealth which is here to stay
- Telehealth rebate less than F2F.
- Supporting telehealth model financially. e.g. getting tele stroke model in QLD.
- Cultural change. Define what hospital care can only be provided and then the other sectors can do the rest , e.g. geriatricians doing telehealth
- Strategic, e.g. Medicare numbers quickly with telehealth.
- Supporting research and education to ensure delivering most appropriate model of care: using telehealth as appropriate from long range / cross HHS boundaries, based on the they type of care - some care works better virtually than others.
- Ensuring stable internet connectivity, particularly in rural and remote localities, so video telehealth sessions are useful and not frustrating for users - consumers and practitioners.
- Add education models for clinicians and allied health to move to Telehealth (similar to digital transformation as done with ieMR)
- Investment required for training of clinicians and consumers to use telehealth/virtual care
- Consistency, collaboration, partnership telehealth and regular feedback
- Telehealth

Increased collaboration and co-design with health consumers in service and model developments; increased engagement with consumers in decision making

- Clear collaboration with health consumers and their allies, for key messaging as feedback from community is the clear messaging worked, as was relevant. Format and processes to be aligned with Disability groups, e.g. language appropriate.
- Consumers at the table at every level
- Hospital in the Home, virtual home visits let's maintain with the desire from consumers and the current climate.
- Mechanisms in place that provide consumers with the information they need and provide them with the opportunity to provide feedback, particularly as we now move beyond the emergency and disaster planning to include stakeholders engagement so people have the information that is about the emergency but also keep people informed about things like it is still safe to attend to health care. Information for clinicians as well that is clear and consistent. E.g. reconciling the information from various agencies
- Major capital projects: hospital design and rebuilds/significant rebuilds need to involve consumers and staff on the space design from the beginning and across the whole process. example of Jacaranda place was a great example of learning for the architects and planners that they have written up a paper on.
- Involve consumers and clinicians in the design of new funding and service models (at all levels and all parts of the planning and implementation) including continuing to use the available technology (like Zoom) to include broad range of perspectives from these groups.
- Build more formal channels for consumers to be empowered and engaged and valued in their contribution to planning and delivery of healthcare. Valued consumer engagement should be supported through effective education on how they can contribute. Acknowledge some consumers have a particular interest area. Build broader engagement of community engagement, e.g. a panel of consumers to provide advice, using technologies where possible.

- Consumer engagement has often been allocated as responsibility of one section of HHS. Consistent ongoing engagement is required each department has access to consumer engagement and it becomes a normal day to day function.
- Oppose going back to the way things were done previously - maintain the progress.
 - Achieving this will require collaboration with consumers and between primary and secondary care
- Keep and re-enforce the new ways of engagement with clinicians and consumers
- Develop a network within QLD to share what works best for healthcare delivery with consumers and for consumers.
- Consumers to be involved from the very beginning of every discussion and throughout the discussions, and involved in decision making. Ensure consumers are treated equally.
- Collaboration with consumer groups (Health Consumers Queensland) at all levels of strategic development.
- Full consumer involvement in all decision-making
- Creating flexibility and hybrid models of care - allowing variety to enable efficiency and consumer driven care delivery. Use this as a springboard to enable clinicians (nursing, medical, allied health, pharmacy) to work to top of scope with the right skill mix to deliver care in the way it is required.
- Utilisation of the clinician/consumer relationship and conversation to progress change, to continue the push to keep beneficial processes going.
- Ensure leadership values and is receptive to consumer and clinician involvement at all levels in the system. Leadership that models the
- All levels moving forward - consumer engagement, co-design. This will continue the phenomenal changes already seen over the last few months.

A reconsideration of governance and decision making structures to provide ongoing and balanced innovation centred on consumer needs

- Keep the streamlined decision-making going, with strong consumer involvement.
- Consider a triangle and each point is represented by risk aversity, safety and quality and valued based healthcare. Place consumers in the centre of the triangle and you can help balance the tension between all these and ensure considered, inclusive, collaborative decisions are being made.
- Look at decision-making from a system level. What decisions can/should be made by the Dept? What decisions should be consistent across whole state? Where should they be tailored according to geography, healthcare need, diversity of population, and communication needs of community/consumers?
- Look at system governance and ensure decision-making is being in a way that supports collaboration (between HHSs, between professional groups, and with consumers), is transparent, timely and is consumer-centred.
- Greater transparency of department to HHSs and key providers, partners, consumers and clinicians
- Model/framework (straight-forward, more operational, not too research heavy) to support a balanced approach e.g. choosing better care together philosophy. Trifecta of Quality & Safety – Innovation – Value based Healthcare (with the patient in the middle)
- Opportunity for rapid service improvement, options to experiment, to trial a change without every parameter being mapped out - does not have to be perfect, being able to evaluate as we implement with feedback from consumers, clinicians, systems
- Transparency about decision making and governance for all in the system. clear understanding of how it all fits together and specific roles for issues and themes. .
- Reduction in red tape to support rapid decision making which occurred with strong clinical governance.
- Creative tension should be welcomed – makes a more robust decision

- Decision making made locally (as close to the “front line”) as possible (principle of subsidiarity) with good local engagement – decision-makers trained in engagement skills

Greater collaboration across clinical and service silos to ensure more seamless patient journeys

- Processes in place for sharing information that do not restrict communication and collaboration, e.g. sending information via email to external providers outside of QH multiple platforms available and need a clear simple guidance for clinicians.
- Collaboration at all levels and less siloed approach. We all need to work together as a whole of system (everyone, consumers, GPs, not just HHSs).
- Ensure that for the patient journey there is integration and collaboration between primary and secondary/tertiary care.
- Coherence - new normal, systems and collaborations , hospitals, primary care, whole of governments, consumers and service users, engagement and collaboration - fit together, feels seamless, person centred in the context of that individual service To be sustainable.
- Involving partners, let's maintain this respect, appreciation, collaboration and value we have developed through COVID-19.
- Pandemic-relevant and pandemic-proof ongoing collaborations between research, health system, NGOs, and consumer

Improved data collection and access across the system

- Statewide data collection to drive identification, understanding and quantification of the issues; not just to COVID pts but also non-COVID pts. we need buy in from all care and consumer partners to understanding the importance of data collection to "tell the story of people and place to tell their experience". There needs to be practical application to place and understanding of strategies for why understanding, driven by data collection, is vital. This also requires appropriate funding and any cost savings be paid back into the system. Good way to partner with communities but needs to meet the need of the consumer and the community.
- Data access across all sectors
- Data access into multiple areas , e.g. disability, nursing home, retirement villages ,palliative care, Target care in the disadvantaged communities/more isolated areas

Expansion of multi-disciplinary clinics, team based care and virtual care settings

- Dedicated VC rooms or facilities in remote areas. Like a virtual care centre
- Could we eliminate long Waiting Lists by using better Pre-Clinic care through Virtual care models so that patients aren't waiting in limbo before seeing seen?
- Establish multi-disciplinary multi-speciality clinics to minimise patient interaction with clinicians. Same patient seen by different specialists- for example Diabetic, renal cardiac reviewing the patient in clinic with similar objectives and outcomes
- Extend the emerging safe space concept, to a virtual safe space, for those who require brief intervention - a digital safe space.
- Embed team-based care as the new standard
- Sharing clinical governance, changing the hierarchy of approvals for change. Allow clinicians to innovate and then assess, rather than needing to prove what a service will look like before being able to put it in place.
- Empowering nurse navigators to be fully functional in assessment and management of patients
- Instead of silo approach, more collaborative solutions, now just to build in sustainability
- Virtual ED Clinics for all chronic diseases
- Patient tailored speciality led approach

Investment in the health sector including workforce development, necessary infrastructure and technology platforms

- Develop new workforce models that work effectively with technology and support new workflows including necessary up-skilling
- Development of health as a sector, utilising the resource from loss of work in other sectors to train to boost the health sector. There needs to be ongoing interest from the government - are there actually going to be health jobs for all these individuals who have started nursing training. Consumers can join the voice to continue pushing.
 - This is a really important opportunity as there is no going back in society to the pre covid19 society - even without a 'second or subsequent wave' many small businesses and even NGO's have disappeared or shrunk in size, the unemployed, their families present the potential to develop illnesses relating to poverty so let's rebuild a strong economy through expanding Health as a sector - more employment across the board which allows the current extra time devoted by clinicians to continue to innovate
 - More jobs in health care provides not only social capital in a post covid19 world, but also allows us to be in a stronger clinical position until this post covid19 world arrives!! it will also be a great salve to prevent crisis around unemployment etc thus assisting to reduce the mental health impact
- Infrastructure, planning the space in health care to cater for such a pandemic into the future, including rural and remote, regional and metropolitan.
- How do we create the infrastructure which assesses patient care outcomes rather than activity? Subtle changes in outcomes can't wait until major problems have arisen before being corrected
- The importance of appropriate infrastructure investment to enable optimum functionality and clinician and consumer engagement. One platform may not suit all - we need to be open to other systems/platforms.
- Invest in infrastructure - laptops and tablets to make staff agile
- Enabling technology to provide seamless communication across the sectors .
- Investment in technology and the human support of that technology, across models of care and models of work.
- Need to not chase Technology just for the sake of it; be wary of the hype factor
- Embrace technology

Ensure technology access is equitable for all clinicians, consumers and communities

- Need to establish pathways for those in the community who don't have the technology.
- Not to leave anyone behind who cannot use or access technology.
- Technology - funding to ensure access is equitable

Foster sustainable innovation by balancing evaluation, review and QA with the opportunities, support and culture needed for frontline innovations and new models across the system

- We need to carefully evaluate these new models of care against the criteria of quality of care/outcomes and satisfaction of staff and consumers. However, just as importantly, before any new resourcing is provided, we need to understand whether the new models are truly providing hospital care (inpatient and outpatient) more efficiently, or are they replacing or augmenting primary care services. Funding and
- Value-based health care. Identify values, new or expanded, through knowledge management framework.
- Learning from other countries who are doing this well. E.g.: Emergency TH in Western Australia became self funded. QLD Health needs to rapidly uptake system based models.
- Move away from pilots that take years to evaluate; instead, evaluating in real time.
- Consider COVID forced efficiencies as the new BAU
- Embed the learnings from COVID-19 into 5 year Road Maps from Clinical Networks because all the bright and useful innovations cannot be implemented in response to one meeting.
- Cultural change and appetite for new ways of doing things to be supported into the future.

- Need thorough review of model of care to improve community based access. Currently need to be very unwell to receive support in mental health.
- Enabling front line innovation as a core value in the culture of Qld Health
- Have a 'shark tank' like set up where ideas can be pitched to group of HHS CEs, purchasing branch etc, the approval is given/or not granted based on the information provided (remove long winded written applications)
- Consistent learning and communication strategy for all participants in the healthcare system to support change
- System approach to invest in the transformation changes. Take some level of risks. Agile and flexible. Communicate the risks to stakeholders.
- Continue with streamlining approvals and creating opportunities to rapidly expand systems that support delivery of care, e.g., digital dashboards. How do we ensure privacy issues are maintained
- Ensuring capability around finances to support innovations (bubble of support). e.g. protected time supported by a COVID cost centre has been an enabler
- Ideal opportunity to de-implement things that aren't high value (do higher value things than what we're currently doing). Leveraging opportunity to not restart low-value things.
- Cultural change to be nurtured and supported going forward.
- Huge degree of upcoming change during Recession needs to incorporate new Models of Care; start thinking about WHOLE OF HEALTH system, not just Hospitals vs Private care
- Innovation as a core value of Queensland Health
- Assess and develop risk appetite that allows for forward momentum and change
- Scalability of local innovations to state purposing.
- Opening platforms for sharing of innovations and support responsiveness.
- Robust QA and research framework
- Capitalising on the new innovations - virtual care/blended model

More inclusive decision making and change management with input and leadership from all stakeholders

- Greater clinician involvement in change leadership.
- Now and future deliberations must involve every sector involved in healthcare - primary, community, specialists, private, public. Build on what we've done over the last few months, PHNs and HHSs need to work collaboratively. Recognise key, joint priorities for communities we serve, keeping consumer at the centre of the planning
- The ongoing support and promotion of Clinical Networks as a sharing and communication platform.
- Develop a strategy to engage with primary care
- Relationship with private sector.
- Use Department of Health to facilitate coordination and communication across all HHSs allowing local adaptation of policy within a strong statewide patient safety and quality framework
- Integrate across sectors any new developments/ models of care
- Leadership that models positive and constructive response to necessary change.
- Improved relationships between the public and private facilities
- Clinical ethicists in each HHS

Other comments

- If we can substitute ED presentations with something else- think about these ED presentations were really required. Ramping of patients in ED had suddenly gone in COVID outbreak time. Bring health-direct hotline back to keep reduced surge in EDs.
- Specialist access to GP, reduced patient travel from remote areas to secondary or tertiary hospitals.
- Establish Local First Nations Community Health Plans

- Continue to support face to face when required, we cannot replace assessments with telehealth for all.
- Need to explore and encourage Agility in changing our models of consultation. Is a face-to-face consultation really necessary? Could it be done in conjunction with the GP?
- Support a formal bi-lateral and ongoing process to provide strategic intent and embed a co-design (formal communication and engagement) across the hospital, primary care and social care, (2) harnessing Telehealth through universal adoption of modalities that are interoperable and affordable from a clinician and patient / consumer perspective; (3) recognising and harnessing existing clinical leadership forums in solutions and redesign brokerage; (4) facilitate joint stewardship of quality and safety within new models of care; (5) create and integrated and robust system readiness from a supply perspective, including rapid scale up and distribution strategies; (6) elevate public health visibility and relevance in primary and hospital care strategies; (7) consider an evaluation of what has worked well in responding to the pandemic, and provide a planning approach to how these are adopted and embedded in practice to build and strengthen collaboration (8) ensure new models of care prioritise vulnerable patients including packaging financing and incentives linked to their wholistic needs (planned and structured care, remove duplication, co-designed with patients and carers)
- Digital health system - address the distrust from society towards government
- Equity across the system. Regional and rural places are not left behind. Staff and patients are on board.
- Good patient-centred care
- Investments in new health promotions strategies and implementations for various health conditions - from chronic to sexual health - that are relevant for lives in the COVID-19 world and sensitive to inequalities caused by social determinants of health
- Education of the community regarding change and ownership of their own health
- consider policy enablers to enhance efficient and contemporary delivery of health services long term
- Hospitals need to be seen within the community, part of the broader service delivery team. Do health services even need to be delivered within a Hospital building at all?
- Develop state-wide guidelines for chronic disease management via Telehealth
- Better information for the public.
 - assuming that this means including general information and learning about health, the health system and consumer options
- Pathways between public and private - mental health patients receive very different care between the two systems. e.g. \$210 to see private psychologist, public can't provide this - where do they go?
- Commitment from key decision makers to support the changes and fund the need.
- Rebalancing the messages to consumers to ensure that they present for concerns - e.g. less patients mild stroke or TIA are seeking medical attention. patients not attending outpatient as well - physical or tele modes.
- System focused on wellness rather than illness. Regardless of consumer's health status.
- Get down to delivering core public health services - currently deliver more than we will be able to going forward. Doing lots of primary care currently. Where should the system focus?
 - Absolutely agree that Primary care DOES NOT belong in Hospital setting
- Is there sufficient value for money being provided by the private insurance. how do we mitigate the leaving the private health insurance and entering the public system.
- Connected information systems and medical records. Utilising what we have e.g. Viewer, My health record and iMR; Getting better synergy from these. Interoperability.
- Ensure that care is delivered as close to home as possible on all occasions.
- A new normal requires not just system response it requires speciality specific responses that meet patient

- Individual framework for patients . Avoid negative outcomes, e.g. Disability, Moved 200 patients to supported living care . Challenge is business as usual with the correct systems in place
- Trying to find Asynchronous solutions to allow everybody to come together at once
- Relationship with the private hospitals and what the contracts means with the commonwealth. how much activity in the privates. clarify communication with privates - are consumers being communicated with.
- Targets including reduced travel for healthcare. Reduce waitlists through better management. look carefully at new-to-review ratios.
- Maintain the IT support, Medicare innovation quickly and admin resource to support the consumers.
- Health needs assessment (we say we do these but we don't really). need to do this with the community - what do we need, in light of limited budget, but what are the priorities?
- Advancing Qld (overall strategy) - need a really clear strategy for Qld Health. timelines are often disjointed. Need the key strategies that we want to deliver. E.g. targets for how much service to be delivered virtually (x%). Look at all the resources combined across all HHSs to deliver best results for all QLD'ers - work across the HHS boundaries.
- Review the financial models as we emerge from the current situation. lack of clarity about how COVID will impact future money and need to meet activity targets.
- Need to have rules of play clear and spend time in terms of changed activities, new models of care and initiatives. Need to spend time on legislation, policy, rules of engagement, getting consumers on board, rather than knee-jerk events driving change.
- There needs to be an uplift in technological investment this is poles and wires, bandwidth, hardware and systems - for both the system and consumers - there also needs to be policy that is instep with this.
- Need State/Federal coordinated source of information to provide common, evidence-based messages and advice to clinicians, consumers. Need best information available at the time, in changing and complex environment.
- Clear, consistent and timely communication with stakeholders
- Communication - clear, concise, a single source of truth supporting wider-spread of communication pathways to clinicians, consumers, primary health, partners including the private health sector (ALL).
- Disaster planning needs to move beyond short term disasters (e.g. natural disasters or multi trauma) and include finer details for longer term "disasters" and how we manage workforce, communication and services
- The Reform Planning Group has to consult broadly and capture inputs to inform priorities
- Critically review HR policies around flexible work - are all the requirements necessary?
- Potential health conditions post covid-19 e.g. mental health, substance abuse, STI's etc
- Unions cannot hold us to ransom on these vital changes
- A more consistent, affordable, and accessible mental health system - virtual and face to face
- How we work with primary care: overall waiting list management and referrals has worked well. but concern about how responsive the system can be. proper analysis of capacity - people in the system or likely to join the system. need to have a joint decision making approach to design the system.
- Who need to do what differently...
- Utilisation and expansion of existing services such as HITH to incorporate virtual wards into "normal" care (incl. for other infectious diseases or chronic diseases that need a short term intensive service in the home environment)
- Explore how to instil the patient journey at the heart of our models of care
- We need to ensure we support, rather than replace, primary care
- Health care in and out of the waves, and face to face and virtual, differences in outcomes and experiences