HEALTH AND COMMUNITY SERVICES COMMITTEE

Members present:

Mr TJ Ruthenberg MP (Chair)
Mrs JR Miller MP (Deputy Chair) (via teleconference)
Ms RM Bates MP (via teleconference)
Dr AR Douglas MP
Mr JD Hathaway MP(via teleconference)
Mr JM Krause MP(via teleconference)
Mr DE Shuttleworth MP

Staff present:

Ms S Cawcutt (Research Director)
Ms L Archinal (Principal Research Officer)

PUBLIC HEARING—INQUIRY INTO TELEHEALTH SERVICES IN QUEENSLAND

TRANSCRIPT OF PROCEEDINGS

THURSDAY, 31 JULY 2014

Brisbane

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Committee met at 1.05 pm

CHAIR: Good afternoon and welcome. I declare open the Health and Community Services Committee public hearing for its inquiry into telehealth services in Queensland. My name is Trevor Ruthenberg. I am the chair of the committee. Sitting next to me here today is Mr Dale Shuttleworth MP, member for Ferny Grove. On the phone we have Mrs Jo-Ann Miller MP, member for Bundamba and deputy chair of the committee. We also have Jon Krause MP, member for Beaudesert, and Mr John Hathaway MP, member for Townsville.

We will hear today from the Department of Health, represented by Dr Michael Cleary, Deputy Director-General, Ms Jan Phillips and Mr Andrew Bryett. Witnesses are not required to give evidence under oath, but I remind you that misleading the committee is a serious offence. I remind those present that these proceedings are similar to parliament and are subject to the Legislative Assembly's standing rules and orders. Under the standing orders, members of the public may be admitted to or excluded from the hearing at the discretion of the committee. Mobile phones or other electronic devices should now be turned off or switched to silent. Hansard is making a transcript of the proceedings. The committee intends to publish the transcript of proceedings unless there is good reason not to.

I thank the department for the written answers to questions on notice provided to the committee. We may have some follow-up questions around those answers a little later. The committee has also asked the department to brief it on some specific issues today. I ask you to take up to 30 minutes to brief the committee on those issues. Those issues are training and guidance in the use of telehealth; plans for evaluation and how the impact of telehealth will be measured; hospital credentialing of doctors—and I note that the department's updated website explains credentialing, and we have screenshots of that so that explanation may be fairly brief; and models of care—the specialties for which telehealth models of care have been developed and adopted in Queensland.

Just so everyone in the room is aware, Dr Alex Douglas MP, member for Gaven, will join us shortly, as will Ms Ros Bates MP, member for Mudgeeraba. They are on their way. Dr Cleary, would you like to begin? Please aim to finish by about 1.40 pm. I will give you a reminder as we get closer. We will then move to questions about the issues in your briefing, the matters dealt with in your written responses to our questions and any other matters which may arise.

BRYETT, Mr Andrew, Director, Telehealth Support Unit, Clinical Access and Redesign Unit, Health Systems Innovation, Department of Health

CLEARY, Dr Michael, Deputy Director-General, Health Service and Clinical Innovation Division, Department of Health

PHILLIPS, Ms Jan, Executive Director, Health Systems Innovation Branch, Health Service and Clinical Innovation Division, Department of Health

Dr Cleary: I first thank the chair and the committee for their time and for their interest in this very important issue. Thank you for the opportunity to speak to the committee once again on behalf of the Department of Health. I hope the committee have found value in the various forums you have attended and meetings you have attended to better understand telehealth in the Queensland environment. I also hope the written response has adequately responded to the questions that you raised in your recent correspondence. In the committee's letter to the director-general dated 9 July 2014, the committee requested a briefing on four specific issues. As the chair has already indicated, we will be providing a response to those by way of a verbal briefing.

In response to the first item, issue 14 in the committee's letter to the director-general, this related to training and guidance in the use of telehealth and plans for guides, online training or other resources to support staff in the telehealth environment. The department acknowledges that clinicians, administrative end users and support staff must be highly conversant with the clinical

applications and the use of telehealth technologies. End users must feel at ease using the equipment to support service delivery and they must also be assured that the systems that are supporting them provide for the necessary privacy and confidentiality as well as security. We must also be confident that the staff using these systems have the appropriate credentials and scope of practice to allow them to provide clinical services using telehealth systems. It is only then really that telehealth can enable the models of care and that those models can be safely and sustainably delivered across Queensland.

The telehealth coordinator network established across the hospital and health services represents the central point of contact for all telehealth matters in each of our hospital and health services. The telehealth coordinators provide training, support and information to facilitate the implementation of telehealth enabled services which are tailored to meet the needs of the local hospital or hospital and health service. The Telehealth Support Unit, which is within the Health Service and Clinical Innovation Division in Brisbane, plays a central role in supporting and enabling the state-wide telehealth coordinators. The unit provides detailed training, information on service planning, development and engagement plans, how to monitor service provision, how to put in place reporting arrangements and obviously to look at project management and other systems required to make sure the telehealth network is fit for purpose.

The telehealth coordinators work very closely with the Telehealth Support Unit to ensure that they are well equipped to provide training on telehealth equipment, identify options for service expansion, facilitate service implementation and engage with the clinical workforce in a very meaningful way to ensure that this project is successful. I recently had the privilege of opening the recent forum with the coordinators and I was very pleased they could all be available. The enthusiasm with which they have approached this opportunity was remarkable in my mind. Certainly they are a group of very committed people who are going to make sure that the changes in clinical service provision are delivered at a local level.

In addition to day-to-day operational support, the Telehealth Support Unit provides an induction process to new telehealth coordinators. The induction process introduces coordinators to the unit's function, providing a comprehensive overview of the technology and infrastructure, the network, the end-point solutions and general technical capabilities, as well as a range of tools and reference materials including a user manual and the reporting arrangements to support the coordinators in their role.

The Telehealth Support Unit also plays a significant role in encouraging and supporting collaboration between telehealth coordinators and other key external partners. Quarterly knowledge and skill sharing workshops are occurring, and all the telehealth coordinators are invited to attend those. The content is delivered by a range of internal and external stakeholders including our Health Services Information Agency, which is the IT infrastructure group; the Australian College of Rural and Remote Medicine; CHECKUP, which is a group that coordinate education and training for GPs; Retrieval Services Queensland; the Telehealth Emergency Management Support Unit; and other elements of the corporate office that are key to making sure this commitment of government is delivered. The workshops present an invaluable opportunity for the coordinators to network, to share ideas and successes, to discuss ways to overcome some of the barriers that they experience and to explore the opportunities that are coming our way. Again, from my perspective, it has been very pleasing to see the level of engagement and the way that the coordinators are working together as a cohesive group to solve their local problems.

The Telehealth Support Unit and the network of coordinators work together in supporting clinicians to adopt telehealth solutions. Coordinators are routinely provided with referral and patient travel data which specifies the type and location of specialty services. The coordinators are supported to analyse this information and to look at the information insofar as they are then able to identify opportunities to substitute existing face-to-face services with telehealth enabled models and to provide evidence that will influence and promote clinical workforce changes. Cooperation across the teams has resulted in a range of products and services to support end-user training, and this is again a very pleasing area.

In terms of the information that has been presented, some of the information is new to Queensland Health in that it has not been presented before in a clear and concise manner and has meant that many of the hospital and health services, as well as their telehealth coordinators, are now looking at this information to determine how they might change the models of care not only around Telehealth, but also around service development in a particular area; for example, if there is a large number of patients who are being transferred using the Patient Travel Subsidy Scheme, for

cardiac problems it would seem reasonable that you would establish some form of cardiac service to ensure that patients are getting the care locally in addition to supplementing that with telehealth consultative processes. So it has actually had some significant flow-on benefits.

Mr HATHAWAY: Sorry to interrupt, Dr Cleary. Chair, I think someone on the dialling system does not have their system on 'mute' and it is really hard to hear and it is cutting in over Dr Cleary's responses.

CHAIR: There are three people on the teleconference. Could I ask you just to put your 'mute' button on, please? Thank you. Dr Cleary, if you would continue.

Dr Cleary: Thank you. Another exciting and innovative approach which has been taking off across the system, but certainly in health, is the use of online training videos that demonstrate the use of different types of health technology. These videos are available to department and hospital and health service staff as are required. Additionally, the Telehealth Support Unit provides a web page with a range of links to relevant resources and information that allows both patients and providers to access that information relatively easily.

I would now like to move on and address the second issue that the committee has asked about, issue 15, which is the evaluation plans for the program. Evaluation of the telehealth service represents a key body of work in 2014-15 and was a consideration when this policy was initially identified as one to be implemented. A multifaceted plan to evaluate telehealth services is under development, and the evaluation approach will reach across a number of themes including: acceptance, travel optimisation, cost arrangements, access to services and clinical outcomes, as well as including quality. The evaluation will be informed and assessed through the development of a widespread patient and clinician satisfaction survey, and the analysis of that will also be linked back to the Patient Travel Subsidy Scheme data, referral flows and telehealth activity more generally. The evaluation of clinical outcomes and quality of care will occur in collaboration with the hospital and health services and providers as they assess and often publish much of this online. They will also be taking advantage of the online publications that are available.

The patient satisfaction survey will capture patient demographics and perceptions regarding acceptance of the use of the technology, the facilitated service delivery, perceptions of how telehealth improved local care and the benefits that have been provided to them. Details of where the patient could have travelled to in the event telehealth was not available will also be captured, and this will inform some of the analysis around the economics of telehealth. There will be two clinician satisfaction surveys developed to enable the assessment of perspectives and the experience of recipients and end user providers. These surveys will aim to capture the clinician's perspective of the telehealth service: time saved, travel, satisfaction with the use of the technology, the effectiveness of video conferencing, as well as a modality to support clinical service delivery. It is anticipated the surveys will be developed and will be distributed to clinical streams within hospital and health services and to external parties such as rural GPs participating in the program. To ensure that a comprehensive perspective is portrayed, the surveys will also be reviewed to make sure that they may be updated should there be questions in the surveys that are not being clearly articulated. That will give us the opportunity to improve the data collection.

In terms of the PTSS activity and expenditure in that area, this is being monitored very closely by the state at the moment. This data will be reviewed in conjunction with the patient flow data and will give a context to patients where they are travelling to for face-to-face services and what type of clinical support these patients require if they were to receive the same support through telehealth. This data is already being collected, and we will be sharing that with the telehealth coordinators to enable them to better target clinical service development.

CHAIR: Sorry, Dr Cleary. Just for the purposes of Hansard I would like to welcome Dr Alex Douglas to our hearing.

Mrs MILLER: Excuse me, Chair, I will ring off now that Dr Douglas is there, thank you.

CHAIR: Thank you, Jo.

Dr DOUGLAS: Thanks very much, Jo. I appreciate you standing in.

CHAIR: I would note that the member for Bundamba has left the meeting but we have a quorum, so we will continue. Thank you, Dr Cleary.

Dr Cleary: Thank you. In addition, the Department of Health will introduce a telehealth KPI under the category of equity, effectiveness and access in our service level agreements with the hospital and health services. The KPI has been set up for rural and remote hospital and health services including central west, north-west, south-west, Cape York and Torres. The KPI targets the

requirement for hospital and health services to increase the number of nonadmitted telehealth service events by 10 per cent compared to the previous financial year, so we are looking to see that they are progressively increasing their level of service year on year. The evaluation of this and other data will be undertaken by the Telehealth Support Unit and the coordinators and the range of clinicians that are involved.

I would just like to briefly mention some of the literature that is out there and some of the literature that has been developed in Queensland around telehealth programs. If the committee wishes, we can provide that for the committee. Dr Sabe Sabesan, who runs the telehealth oncology service, delivers services to people in northern Queensland from Townsville. It has been previously discussed, and this model I think has demonstrated the enormous clinical, social and financial benefits of having this type of model. There are three documents that I would like to table for the committee's interest that may also provide further background to this particular program: firstly, the minister's recently released Better Health for the Bush; the second is the cancer care services state-wide health plan; and finally there is the Queensland Remote Chemotherapy Supervision Guidelines. They are a suite of documents that do fit together, but the last of these outlines for our staff how the remote supervision arrangements work. I was very privileged to be involved with the oversight of the development of that document.

CHAIR: Sorry, Dr Cleary, I just need to get permission from the committee to have those tabled. I will come to you individually on the phone. Just here, could I see if it is okay to have those tabled? Yes. Yes. On the phone: John Hathaway?

Mr HATHAWAY: No objection.

CHAIR: Jon Krause?

Mr KRAUSE: Yes.

CHAIR: Thank you. Thank you, Dr Cleary.

Dr Cleary: Thank you. The other areas that you might be interested in and may already be aware of are: the cystic fibrosis telehealth project administered by the department of nutrition and dietetics at the Royal Children's Hospital, which provides a range of services in remote and rural Queensland; the Royal Brisbane Hospital speech pathology head and neck cancer telehealth project, which provides patients with care and treatment remotely; Dr Michael Williams' telehealth project, which is related to paediatric emergencies in rural hospitals; the telehealth project in paediatric surgery developed out of the Royal Children's Hospital; and the intensive care based product at the Royal Brisbane Hospital which has looked at standards of care for ICU patients when managed through a telehealth arrangement. I guess the reason for mentioning that is that these areas of interest have been published and are in refereed journals, so it is good to see that Queensland is not only leading the way with the introduction of the technology but with the formal evaluation of these technologies, and that's been recognised through publication in refereed journals.

In relation to the next question, which relates to Queensland's approach to credentialing doctors, a medical practitioner providing clinical services locally at a remote hospital site is credentialed in accordance with part 2 of section 4 of the guide to *Credentialing and defining scope of clinical practice for medical practitioners and dental practitioners in Queensland Health* which is dated June 2014. Medical practitioners credentialed in accordance with these guidelines are endorsed by their home hospital and health service to provide clinical services in the hospital and health service in which they are employed. When services are provided to remote facilities using telehealth the specialist provider of the service requires state-wide credentialing, and the scope of practice is defined then by the receiving facility to ensure that it aligns with the service level of that particular hospital. Specialists may be credentialed to provide services across a number of hospital and health service boundaries in accordance with this policy guide. I have a copy of that which I would also like to table for your information.

CHAIR: We have approval, yes. On the phone: Jon Krause?

Mr KRAUSE: Yes, no worries.

CHAIR: John Hathaway?

Mr HATHAWAY: Yes, thanks.

CHAIR: Thank you, Dr Cleary.

Dr Cleary: Thank you. Authority to approve the state-wide scope of practice for practitioners rests with me as the Deputy Director-General for the health service and Clinical Innovation Division and with the Chief Health Officer. This delegated authority to approve a state-wide scope of practice for practitioners may also rest with the chief executive officers of our hospital and health services, and we are currently going through a process by which that delegation will be put in place.

I will now move on and speak about the fourth item, which is related to the models of care for speciality services using telehealth models. I note the telehealth model described in detail by Dr Sabe Sabesan at the public health inquiry on 21 May. There are a range of other telehealth enabled models that have been successfully implemented in Queensland, and in 2013-14 the top 10 reported nonadmitted clinic types delivering telehealth across the state included: oncology; orthopaedic surgery; diabetes, paediatric medicine; gastroenterology; general medicine; cardiology; preadmission; preanaesthesia; midwifery and obstetric care. The activity reports of these by clinics represents about 60 per cent of the nonadmitted patient telehealth occasions of service. We have also been able to look at this and compare it to the PTSS data and, possibly not surprisingly, some of the areas where patients are frequently being transferred also coincide with these; for example, cardiology, which is frequently an area where patients require transfer. I think we are seeing take-up in those areas and a decrease in the need for interhospital transfers. There are over 40 clinical specialities and subspecialities that provide service remotely using telehealth. Many of these clinics have proven to be sustainable and scaleable over time and provide evidence for the implementation of those models more broadly in the state.

Queensland clinicians are also regularly involved in the design and implementation of telehealth applications, and a few have been highlighted in the response to question 15 from the committee. In addition to these there are a number of others that stand out such as the state-wide coordination of the area medical services which have been enhanced through telehealth capacity, and the trial that we are running at the moment using telehealth to enable radiology reporting between Brisbane and Townsville. This is for a specific speciality area of ultrasound.

Further achievements in 2013-14 were the design and implementation of a new telehealth enabled model to support clinicians managing patients presenting to emergency departments in rural settings, and I believe the committee has had the opportunity to visit the centre at Kedron where the Telehealth Emergency Management Support Unit has been established. I am very pleased that this unit is in place and I was involved, as was Andrew, with the design of that service. It was one of the key underpinnings of the rollout of the telehealth system across the state.

To conclude my response, I have gone through those issues identified by the committee very quickly. In closing, I would again like to thank the committee for their interest in this area and for the opportunity to provide the additional information as described. Thank you.

CHAIR: Thank you, Dr Cleary. Just before we get going, is there scope in your timetable to go a little bit past that 2.30 time frame in case we run past that?

Dr Cleary: Yes. I do not believe that there is any impediment to continuing.

CHAIR: Thank you. I appreciate that. We will first take questions associated with Dr Cleary's explanation just now and then we will follow into questions associated with the written responses that came from the department. So let us move first to clarifications or questions around the verbal responses just now. If anyone has an immediate question, they can commence.

Mr SHUTTLEWORTH: Mine ties all of that together.

CHAIR: Okay. Why do we not start then.

Mr SHUTTLEWORTH: Thank you, chair. Dr Cleary, in listening to your address just now and in reading the responses that have been made and also addressing the fact that I am sure you may have seen earlier in the week there was an article in the paper on telehealth services being provided, one of the underlying themes that seemed to be reoccurring at almost every place that we have visited as a committee in our tours to date was the inequity, let us say, in the recovery of funds for the GP at the recipient end. There seems to be a devalued service provision in that regard. You just then outlined also the top instances of the provision of telehealth. All of those seem to lend themselves to having the GP with the patient at the recipient end. Are we addressing that in any way? How are we going to overcome that issue?

Dr Cleary: The issue is probably best considered in two parts. One is how the Queensland public sector is managing this matter and the second is how the private sector, which is obviously the medical benefits scheme, is managing this matter. Within Queensland—and I might ask Andrew Bryett who is with me to expand on this in a moment—we fund providers at both ends. So if there is

a doctor in Roma coordinating a telehealth consultation and they are consulting with another specialist in Toowoomba, then under our state government funding arrangements both ends of that are funded through our funding model.

Mr SHUTTLEWORTH: Can I just clarify, though? That is only for in-patients, is it not at the moment—or is that both in- and outpatient?

Dr Cleary: That arrangement is for both in- and outpatients. The difficulty, I believe, is in relation to the Commonwealth funding model, which funds just the remote, the central end—I will say the specialist end. That means that, if you are consulting from a general practice to a specialist in a major centre, the specialist service in the major centre receives funding but the centre where the patient is located does not receive the funding arrangements. I might hand over to Andrew Bryett to perhaps provide a bit more detail with your agreement.

CHAIR: Sure.

Mr Bryett: I think there is a bit of crossover in some of the aspects in answering that question. Firstly, I think what you are referring to is the capability for a general practitioner to bill Medicare for their involvement in a telehealth consultation. Is that correct? The scenario, basically, is that the current MBS rules stipulate that the specialist bills or no-one bills. So where it is a consultation that occurs between a general practitioner who is providing patient-end support engaging in a consultation with a private specialist, all is well. Where I would believe that you have received commentary from communities that you have engaged with would be around a general practitioner's inability to bill when consulting with a public hospital specialist. That comes down to the Medicare billing rules.

We have recently started some dialogue with Medicare around those issues, particularly looking at rural and remote communities. We are looking to prepare a submission to continue that discussion with Medicare where we would hope that we can push the arrangements such that Medicare could consider flexing their guidelines, which would allow GPs in certain locations perhaps, maybe in rural and remote communities, if they cannot provide that patient-end support it would result in an impact on the patient in terms of accessing that care—either having to travel or not having their GP involved in the consultation, which adds to continuity of care. So what we are hoping to do is, through our engagement and discussions with DoHA, that we may be able to come to some position where perhaps that can change such that GPs may be able to, in some circumstances, bill for their interaction with public specialists.

Mr SHUTTLEWORTH: Thank you.

CHAIR: Can we just expand on that just a fraction just down that same line? Please correct me if I am incorrect here. The department's response for telehealth between facilities within a HHS are in scope but telehealth within a facility is not. So it does not specify that telehealth between two different HHSs are eligible for the $350 payment.

Mr Bryett: That is for admitted patient activity.

CHAIR: Right.

Mr Bryett: So what we have done there is that those new incentives were just released on 1 July. So they are very new. The only exclusions are around services delivered within the same facility. So what we wanted to ensure was that you could not deliver an in-patient consultation to a patient who was sitting two floors below you. All others are in scope.

CHAIR: Just so that I am very clear, if we have a doctor at Roma hospital, for example, who wants to seek some specialist advice from the PA, that would okay? Thank you. I appreciate that.

Mr Bryett: Yes.

CHAIR: Dr Douglas, would you like to ask some questions?

Dr DOUGLAS: Michael, my question is a little bit about the payments but you are clarifying it as it goes along. I will come back to that in a minute. My concern was the point that you made there and it is something that has been going on for a while. I realise that this may be a question that maybe does not have an answer. You have said that there are 40 different programs going on currently with regard to these things. Is there a generic auditing model of those that looks at all of them? I presume each one of them has some kind of internal model. Is that giving you information in such a way that will answer emerging problems in this area?

Dr Cleary: In terms of the clinics, we record our outpatient clinics using an outpatient clinic model. There are, I think, 82 different clinics in that model. So we know from the information that we have available that about 40 of those clinic types, or those services, are being provided using a

telehealth model. Of all the clinics that we provide, some are obviously lending themselves towards that and others are perhaps not lending themselves towards that type of a model. I think that there are many reasons for that—partly the more specialised the clinic, if you are having neurosurgery, you probably wish to speak with your surgeon and get a good understanding of the services whereas other clinics where you have, perhaps, a long-term relationship, such as those where there is a mixture of telehealth and face-to-face consultations—cystic fibrosis patients, for example—I think that is a good one where you can see the multidisciplinary teams operating using telehealth.

In terms of the arrangements that are in place, because these are normal consultations in terms of the clinical consultations, all of the normal quality and safety arrangements would apply in terms of clinical audit, the assessment of any case where there are any problems using the same quality and safety systems that we apply on a day-to-day basis. So in terms of our systems, they would be the same.

The benefit, I believe, of the evaluation that I talked about before briefly is that we will drill down further than that when we are evaluating the programs to make sure that we are picking up the clinical benefits and any risks. But obviously, any risks that are emerging, for whatever reason, as part of the implementation of a program of work we will pick up and deal with immediately. Mr Bryett may also have some comments around the program to look at the quality and safety of services in terms of the evaluation.

Mr Bryett: Sure. Thanks, Dr Cleary. I think one of the points that you commented on is key to this. Telehealth is a service delivery modality. It is not about a telehealth model of care; it is a technology enabled model of care, if you like. So the underpinning quality and safety requirements around clinical service delivery do not change whether those are delivered via face to face or via telehealth and will be looked at through our evaluations. Things like clinical documentation et cetera all fall within that basket. So whilst there are some nuances when delivering those services via telehealth it remains the same. If you are providing a service to a patient you need to do that within the quality and safety guidelines of the HHS and you need to adhere to the relevant legislation around clinical documentation.

Dr DOUGLAS: Can I then follow up? I agree with you about the service delivery. If you looking at it holistically and that this is just one way of doing it, is there a way of linking that back to—I know that it is a terrible term because it certainly came up in the doctors' contract issue—KPIs, or key performance indicators, in other words, to drive its availability? We have people teleconferencing in here today. You have to make an effort periodically to try to get there. You are right about the neurosurgical things. We have a great history of experience, particularly with Queensland Radium Institute—the QRI people—when they implemented changes. Can you tell me what methods you are proposing or you have proposed to try to optimise it, make it more widely available et cetera?

Dr Cleary: Thank you, Dr Douglas. In terms of the operating model within Queensland at the moment—and you would be very well aware that it is really a decentralised model with the hospital and health services taking the lead in developing and driving change with the department of health taking a more oversight role in setting policy and assisting as the ministry for health—what has happened, I think, is that we have moved to setting targets and outcomes rather than looking at the details of how a program is delivered. I would have to say as well that, in this case, we have some involvement in making sure that components are delivered well.

For the targets that we are setting, and we are incrementally increasing those targets, making it much more favourable for people to use telehealth, the targets were those where we accept the expectation that, for the rural and regional health services, they will be delivering 10 per cent more telehealth work this year.

In terms of the drivers, there is no financial disincentive. In fact, if anything, there is a financial incentive to use telehealth, because the reimbursement from the department probably exceeds your expenses. So if you are looking at what would drive you to make the changes, the first thing is that it is a good idea clinically and the clinicians want to do it, be they doctors, nurses, or allied health professionals. It is then our role to make sure that we incentivise that to occur and do not allow roadblocks to get in the way. For that reason there is an incentive, which is we would anticipate a 10 per cent growth per year but also there is no obstruction in terms of the financial side of things. That is one of the reasons that we funded both ends of the telehealth consultation, because we did not want to see people not do that.

My personal experience from talking to our chief executives in the regional centres is that these types of arrangements really put back on to the chief executives and the board the need to look at innovative models of care. Providing them with those incentives, plus information such as the PTSS information or the telehealth utilisation information, has certainly meant that they look at that quite closely.

I have recently had a very long discussion with one of our chief executives around their data. They were very interested in the fact that they had a large number of patients being transferred for cardiology. They were looking not only at the options to include a telehealth arrangement but also at what that could do in terms of developing a local service. From my perspective, I think the importance of local control and driving innovation is where we are going to see the benefits. As we go around the state and talk to the chief executives, we can certainly see the types of projects that they are putting in place and the enthusiasm with which they are moving forward. The last comment I would make is: we have a minister who is passionate about telehealth. I think that also provides a significant level of stimulation to the system to focus on looking at those opportunities.

Dr DOUGLAS: That answers my next question, because I was concerned from your discussion before that the financial thing was, in terms of a tiered system of obstacles in some ways, rating above the other obstacles. But it is actually now not the case? Is that what you are saying? It is below the others?

Dr Cleary: If I were back in a chief executive role, there would be no obstacle in terms of the financial model. If anything, I would be looking at doing as much telehealth as I possibly could, because it is actually a really good service to provide clinically, especially if I were working in a regional area. I am sure that the clinicians that I would work with would be enthusiastic to look at those innovative arrangements. But certainly funding is not a consideration in terms of the establishment and rollout of this.

If I may make one further comment, as you know we had seven evaluation sites and while I have given you some general idea about how we would see performance improving, those evaluation sites have increased their utilisation of telehealth by, I think, over 40 per cent in the first six months of this year. So as those evaluation sites have come online they have far exceeded the 10 per cent target. It just, I think, shows that if you release people to look at innovative practices and they can actually go and make decisions locally about how best to provide care—and there are a few examples of how it works well—you will see that almost explosion. The other thing that I find interesting is that we have gone from having seven evaluation sites to somewhere between 20 and 30 sites now that have decided they will also join in. So the number of sites coming online has been significant and driven by success. Mr Bryett may have some more specific details on the number of extra sites that are coming online.

Mr Bryett: That is specifically in reference to the telehealth emergency management support service that the committee had visited out at Kedron. We had initially targeted the seven evaluation sites, as announced by the minister in July last year, and found that through our engagement and planning activities with the relevant HHSs where those communities were located there was far more interest than, I guess, using this resource to service a single community. So as a result of that we have started taking more HHS-wide approaches, which to date has meant that we have implemented in five of the seven evaluation sites but in reality it has been rolled out across 36 facilities and have a plan for this financial year around further expansion of that program, incorporating the other two evaluation sites. An early discussion with those HHSs has already indicated that they would like to look at HHS-wide models as well. Beyond that we will then look to engage the remaining HHSs that did not house one of the evaluation sites and ultimately look to establish a state-wide service.

CHAIR: I have just had a quick look through this. I will be interested to read it. This is the Queensland Remote Chemotherapy Supervision Guidelines. I can do nothing but sing praises of Dr Sabe Sabesan. This is one of those circumstances where you have overnight success but it has taken eight years to get there. I think the work he has put in place has been outstanding. In fact, based on our conversations with the folks in Canada—we look at that system and say it is a fairly mature system—I would say that they would be looking sideways and saying, 'This is actually a guide that we need to pick up.'

Dr Cleary, given that, and given my background in the implementation of application systems across international borders, this is the type of guide that I would see being phenomenally useful, especially where we have 17 different HHSs. I was looking at who has published this, and I saw that it is a Queensland Health document. One of the things that we have spoken about as a committee and one of the things we have seen is that there seems to be far less of a deliberateness in regard

to particular specialists and it is much more relationship based. Someone is sitting in a remote hospital and they need a particular specialist so they think, 'I went through university with this fellow. I will give him a call.' That is opposed to being really a much more deliberate focus in regard to specialists that would be available in various specialties and subspecialties who would be available to hospitals and/or aged-care facilities, for example. They could say, 'We could go to that person and see if we could get on their list.'

Are there any plans that you are aware of to produce this quality of document or guide? In effect, I think what it does is document the health-care model or the best practice for delivering health care against that particular specialty or subspecialty. Is there any intent from Queensland Health's perspective to actually deliberately go and find or develop that sort of document as a model of care so that we can drive consistency of health care?

I know that I am rambling here a little bit, but I want to draw your attention to—for example, I know there is work being done across Australia through DoH with regard to developing a framework for ED doctors so that there is a common framework that may be used right across Australia. Another area of specialty, for example, would be geriatrics. We know that we already have phenomenal outcomes using telehealth. Another area would be diabetics, with what is happening up in Cairns. If we document those sorts of things and have a central repository and a common point of feedback, then our best practice continues and you can update that and make it available. Common experiences and common outcomes would drive much better models of care, efficiencies and things like that. Is there any plan to actually deliberately go after developing these, making them available and then improving them and making that available so that there is a common focus on developing that care model—be it telehealth—that will be used and people can benefit from others' experiences? I know that is a very long-winded question, but I am trying to get to the heart of it because I think that for us to move forward that sort of stuff is going to have to be made available. That is based on, as I said, that relationship nature as opposed to a very strategic, deliberate nature of what is occurring right now.

Dr Cleary: There certainly is. I guess for us one of the drivers has been our recently formed Rural and Remote Clinical Network. That is something that was established by Minister Springborg soon after he took office. That network has driven a lot of these activities. I think there were about 11 that they identified that were high priority—telehealth being one but cancer care being another, and the two of them obviously intersected. Where there is that intersection I think you would be quite right to say that they are the areas we would look at. There is a range of those. I might hand over to Mr Bryett to answer that, but Jan Phillips also oversights all of the clinical networks, including that one, and it may be useful to just join those two thoughts. one is what we are doing with telehealth and the other is the clinical network roles.

Mr Bryett: Referencing specifically the QReCS document, I agree wholeheartedly with you: I think it is fantastic. It is really purpose designed in the fact of supporting administration of remote chemotherapy. Should we go out and create numerous iterations of that type of document? Probably not in the fact that we should reach out to a range of—where we cannot find evidence based guidelines, absolutely we should be the ones to support development of those. But let us use something like Telestroke, for example. We are in our infancy in terms of having some discussions around establishing acute stroke services to support lysis for patients in remote locations where they have access to CT. We should not reinvent the wheel and develop our own guidelines for telestroke. The guys in Canada do it well. The guys in the States do it even better. The guys in Scotland do it remarkably well. So what we would want to do is, as we start to mature these models, look at what is available nationally and internationally. In terms of stroke, the Victorians are doing some wonderful work as well. What we should do is leverage the existing guidelines and policy documents so that we can jump-start, really, in terms of implementing these new programs. So I think where we cannot find them already existing then we should certainly explore.

I think there is probably one other part to that answer as well. That is, where there is complexity around service delivery such as the administration of chemotherapy or the administration of tPA for lysis for stroke patients, you really need robust documents like this to sit behind it and provide the governance. Where there are existing mature models already around some of the chronic disease management stuff to do with respiratory, endocrinology or diabetes, or indeed some of the heart failure follow-up programs, they are longstanding, they are a whole lot about managing patients on a day-to-day basis and the complexity of them is not such that you need a really robust guideline that sits around them. If the consultation is that every six months you check in to get your bloods assessed by a cardiologist, check your weight, check your girth and get an ECG done, you do not need a 40-page document around that. That model exists and we can transfer that and implement that quickly.

CHAIR: You said a lot of 'shoulds' there: 'We should be doing that.' Does that mean that we do not currently have any particular deliberate strategic intent to do that?

Mr Bryett: To develop these—

CHAIR: As in go internationally. I mean, we have—

Mr Bryett: No, no. As I said, we are in our infancy with regard to things like Telestroke. We are acting on that right now. We are engaging the guys from Victoria. We have engaged the guys from Canada and from Scotland to source their content. I should not use the word 'should'; we are.

CHAIR: I appreciate that. Thank you.

Ms Phillips: The Rural and Remote Clinical Network have a very conscious focus on telehealth in rural and remote, so they have an entire agenda that sits around telehealth, in particular in relation to maternity services. That is one area where they see a huge amount of potential. I guess I want to reinforce what Andrew was saying, that there are bodies of work already underway to look at how to use telehealth and document correct use of telehealth services in relation to a whole number of fields. So it is not just telehealth driving the use of telehealth in fields; the clinical networks themselves look at telehealth as an integral part of their own service delivery and drive the use of telehealth within their specialty fields utilising, I guess, the expertise and advice of the telehealth unit. That was one of the reasons for the deliberate colocation of the telehealth unit in the same organisational unit where the support of the clinical networks and indeed the clinical senate sits, so that we can actually drive the integration of those services and not have to reinvent wheels all the time, because in some respects the clinical networks themselves are quite advanced in their understanding of the potential of telehealth.

CHAIR: I want to pick up on something that you have said there. Again I appreciate the intent and this may be my ignorance, but based on where we have been and people we have spoken to, it almost feels that that is being done in pockets and that there are whole areas of people with specialities that just have not got a clue that that is going on. We spoke to some people who are recent converts. There is an anaesthesiologist in Toowoomba who does preadmission through the Roma Hospital. He said to us, 'I have been doing this for three years now and I was a sceptic when I started and I am a complete believer now'. My concern with that, though, is that we spoke to other specialists in other areas who simply could not see the benefit in using telehealth and felt that they had to feel and touch and be available the whole time. That leads me to a question around the use of KPIs against doctors and/or specialists to require them or drive them toward having to use telehealth. Right now, based on our experience, it really feels like it is still very much relationship based, and I have said that before. That very much was our impression. A surgeon, for example, at a particular hospital has a need for some speciality experience and it is based on what he or she knows. If there were expectations that for a specialist or a senior SMO a part of their time would have to be in delivering telehealth services, we would see an uptake significantly in that area and we would see a coming together, I guess, of the need versus the capacity. Do you have any thoughts on that?

Ms Phillips: My thought is that it is like any form of change that you are attempting to bring about through a whole system: you have your champions, your early adopters, in any change and then you have others who take a little while to come on board with any big change. I think telehealth is exactly an example of that. You have your early adopters, you have those who are relationship based. That is great, because they can become champions in their own fields and start to spread the word. A lot of the activities that Andrew's unit does around marketing and showcasing successes in telehealth also have an incredible effect in driving a culture that sees telehealth as a normal part of the service delivery. They are the positive drivers in a system. The issue of looking at more formal ways of embedding telehealth into the performance of clinicians is something that I think will come.

Dr Cleary: My perspective on this is that we are on a journey. We have a very clear idea of where we want to get to. In the past, we have had quite a large amount of infrastructure deployed across Queensland, which has not really had the level of uptake that you would reasonably expect. That was where we still had some performance indicators in place and there was a desire to increase the use. What has happened over the last two years has been the evaluation sites being established within the rural areas. We are really looking towards developing an attractive model that people will want to participate in and that will capture their minds and their hearts. The thing that makes me feel very positive about using this as a model to catalyse change is that we started with seven sites and now we have 35 as the sites for some of our activities and when we have introduced them, the health services have said, 'We want to do our entire health service, not just one of these evaluation sites'.

I think the next piece of work that will help us will be the report from the Ontario telehealth group, because they will provide us with some information around what they see as the opportunities for us going forward. I also look forward to the report from the committee, because I think that is going to be a very important report for us to look at and to make sure that we are able to effect change, given the opportunity that the committee has had to visit extensively through the state and to have contact with people whom people such as myself and Andrew do not necessarily have regular contact with. I think that is going to be another important piece of our work plan. Then, as you have indicated, it is going to be, in my mind, the opportunity of getting this to then roll out across the state, for the chairs of boards to take up the challenge of rolling out telehealth knowing that, when they do, sitting behind the system is the telehealth emergency support unit in Brisbane. So when you do have to access an emergency—not an emergency in the true sense of emergency medicine, but you have an acute situation that you need advice on—you can go there and get that advice. In my mind, one of the weaknesses of the previous system was that it was, 'Here is the technology; why don't you go and use it'. In this case, we are saying, 'We have these services that we can provide over the system; if you want to turn your system on, you can access these tomorrow and they will work for you 24 hours a day, seven days a week'. Clinician culture expects a high degree of reliability. I think it is difficult to expect people to use a system when it is 9 to 5, Monday to Friday, but when you know that it is definitely there when you are at work that increases the attractiveness.

In terms of the process going forward, I believe that we have seen the first tick in the box, which is the expansion of local projects and the take up locally. The Ontario report and the committee's report will further inform us in terms of the steps that we should take.

CHAIR: That is good. I have a few more questions, but I will hand over to Mr Shuttleworth.

Mr SHUTTLEWORTH: Thank you, Chair. I may have missed it earlier because I know you started to talk about the PTSS. Throughout our travels a constant theme arose around the fact that if the recipient end felt that some of the savings that could be derived by using telehealth and, therefore, not paying patient travel subsidy scheme reimbursements, et cetera, could be returned to that HHS area, there would be a mutually beneficial outcome. Are there any thoughts about addressing that going on into the future, so that those cost savings could be delivered back to the HHS?

Dr Cleary: The budgets for the PTS Scheme sit with the hospital and health services at the moment. If you take Rockhampton, for example, the funding for PTSS sits with Rockhampton. This is a slight variation in that program funding, which is that certain growth funds are funded centrally and paid for annually, but the core level of PTSS funding sits within the board's purview to manage. In terms of the benefits of establishing telehealth programs, if there was a cost offset that would be something that would benefit the Rockhampton community. In terms of driving the benefit locally, I think there are a number of clear reasons to do that. One is that the board may elect to establish a local service and fly a specialist up and do the clinics in town or they may wish to look at a telehealth option, but both of those are going have a financial impact on the local service. Therefore, being able to offset any change in the service model locally with some revenue locally I think is a positive thing.

In terms of the remote sites, I think a lot of the patients who travel are travelling for outpatient clinics. The demand on those outpatient clinics is such that if there were reduced numbers because of telehealth that would be a very positive benefit for those health services and it would enable them to manage locally. Under the Queensland Health funding model, they also get funded for any telehealth activity that they do. If I was a local clinician, there would be two benefits. One is that patients would no longer have to travel and, therefore, there was the opportunity to—not increase the number of people I am seeing in a clinic, but to see different people in the clinic. Also, there is no disadvantage in using a telehealth system because there is a funding model that does provide reimbursement for the expenditure that you incur around that. I think there is no obstacle to that happening. Certainly, the regional centres, I would suggest, would be well placed to retain any PTSS benefits that they have from making some of those changes. In some respects, they are the people who drive those changes. If we look at the central west, out at Longreach they have been really very active looking at how they can use telehealth and bring specialist services into the central-west region. Their business case has been based on some of those financial offsets being able to be used to purchase additional services. I do not know whether that explains—

Mr SHUTTLEWORTH: It certainly goes part way, Dr Cleary. While you were talking, I thought also that where this presented often was that the remote areas thought that by offering a telehealth service, sure, they were able to provide benefits to individuals, but it also expanded the number of

people who were willing, therefore, to participate in the program. In that, it created an increased demand for on-the-ground resources, as well. It was that hurdle or that gap where the telehealth, by itself, increased the demand but they could not deliver necessarily that capacity, because they could not have the on-the-ground resources. It was kind of looking at whether the savings that were, therefore, in the PTSS could be redirected into additional resources in that local area.

CHAIR: Certainly, for example, in allied health delivery: when we were in the Torres Strait, for example, looking at things such as dieticians, physiotherapists and those types of things, even mental health. Right now those allied health professionals would attend one of the outer islands maybe twice a year, but the advent of telehealth allows them to actually focus for a period of five or six weeks, which would be a normal expectation if you were in a populated area. But with that allied health increase in being able to see them once a week by telehealth, all of a sudden you had a resource need increase, not just in regard to that professional's time but also in regard to where you actually see them, because you are now sitting in the district nurse's office who would otherwise be seeing other patients. There was a bit of dilemma there. The feeling was that if we could take some of that PTSS funding that was being saved and redivert it to develop further resources, it became fairly obviously. The flip side to that was that we could start to use specialist times. Instead of a specialist spending a day travelling to Mount Isa, for example, the specialist was actually spending time dealing with patients, there would be substantial extra capacity to be found inside a specialist's daily time allocation. On the one hand, there was an increase in resource requirement and, on the other hand, there was a substantial increase in capacity capability. It is rather interesting where that will actually land long-term. I will hand over to Dr Douglas, who has a couple more questions.

Dr DOUGLAS: These are in the specifics areas, which is where we are now. Like everyone I saw and heard the issues about the impediments. As you would know, every time you have impediments in medicine they are opportunities. I heard about the impediments, everything from the machine familiarity, queuing times, the difficulty of the look, feel, move specialties—mainly orthopaedics which is a huge part—paediatrics, probably a lot of obstetrics and the cardiology with the first visits. There were also issues with file sharing. In other words, they were not able to get the latest file, which in medicine is the bane of our existence. I heard that from some but not from all. There was the issue of getting a common tool that they could read from. The other issue was the technology, which was Cisco Jabber, which was not quite fully embedded and not universally approved—that is what I am hearing—whilst they all seem to use it, is that right?

Mr Bryett: Cisco Jabber is a software based video client that can be used on desktops, iPads et cetera. It is still in beta. Cisco has released it. As many software developers do, they release it to the market so that the market can test it and sort the bugs out. It is the only free software based video client available on the market. So it is attractive to people. There are a number of other options which cost a few dollars. So predominantly you find people want to, particularly when they are starting up, try the free option first to see if it works for them and see how it fits in with their clinical work flow and within their service line. Where it is then seen to be of benefit, they may then opt for an alternative.

What you will see within HHSs is two versions. There used to be a product called MOVI and a product called Jabber. Jabber is the free one. So that is the one you may often hear experience some issues with. What is rolled out within Queensland Health in terms of software based clients is MOVI, which is not in beta. It is a supported product.

Dr DOUGLAS: My question then really is about the issue of these so-called impediments. If these are the common impediments and they are a common subset of a broader thing, I admit that—and I know you have done the evaluations and that sort of thing—there was such a commonality of these types of things that they all did seem to be able to be bridged and seem to be things that would make the system work in a more complete fashion. If that is part of the problem—and I am not saying that everyone would have ideas; I am sure you have discussed this—have you discussed these types of things and thought if we allocate and expedite some solutions in a framework to run in parallel to what we are doing we may well address those things as we complete this? Can you give me some ideas on that?

Dr Cleary: In terms of the file sharing, just to touch on that briefly, we have a product in Queensland called the Viewer. It has won some substantial national awards for being an innovative product. We are using that to drop in all the relevant clinical information we can. The Viewer can be accessed very easily and can be accessed from across the state. You can look in and see what is happening in Cairns in terms of a particular patient. The type of information in there is not live clinical information; it is actually discharge summaries, summaries of emergency department attendances, radiology reports and so on.

As we have been rolling that product out, which is available across the state, we have been adding in additional components so that as a viewing product it allows you to see pretty well what a patient's history is that is relevant to Queensland Health. It is not the patient controlled electronic health record which has obviously got different information in it. It is much more tailored to the sorts of things that a public health system would be interested in.

We would envisage that that will be expanded over time. It sits in parallel to the telehealth program. The Viewer is one of the products that is integrated into the new e-health record system. One of our hospitals went live with one of the releases recently. I visited the site last week. It was pleasing to see these modules running. There on the screen was the little button you press to bring up the Viewer. That means you can then pull up information that is not necessarily available on that local site but available from other sites.

In terms of the technology, I will not comment on that. That is beyond my scope of practice. I do have Jabber on my iPad. It is linked into the telehealth network. I find that it is quite a useful product. I have another one on my desk which is much more complicated. I suspect it is the formal licensed and purchased version. I think there is still work to be done in making those systems easier to use.

I am impressed that our retrieval services people, so the emergency healthcare team, are starting to use the current release of the Jabber product. I saw a scenario that they presented on recently where they used that to provide advice to someone remotely when they were needing care.

In terms of the technology, it is rapidly moving. The rural and remote clinical network is very interested in the technology and the connectivity of the products. I would endorse your comments that there needs to be further work done on the types of technology, not just so that we can share information or videoconference between facilities in Queensland Health or between clinicians in Queensland Health but between Queensland Health facilities and clinicians and those people external to Health. We need to move away from being as careful about confidentiality and privacy as we have been and have systems in place that allow that interconnectivity.

Dr DOUGLAS: I was going to stay away from it for the time being, Michael. That leads to my second question, which you have partially addressed, which is the issue of training. This was raised by a couple of people. It came up primarily with people in Roma. It came up with the Royal Brisbane people, to so some extent, although I was not really certain what was going on there.

It is variable by the sounds of things. It seems to be an ideal way to step people into various models and also those who have a natural hesitancy. We saw some great models with all the allied health people. It is a tremendous way of getting it used. It would be interesting to see what the genuine take-up is, in terms of happy sheets even, to see what is going on. I would be interested to know what is going on with those. It is one thing someone saying that officially when you meet them. It is another thing when you actually see whether that has a deliverable on a tangible result and that is truly how they are using it. I was certain I was hearing that. But I am not saying that it was.

The other thing was certain groups who would not use it. I mentioned the look, feel, move guys. That is primarily the orthopods who obviously have this incredible resistance to it. Obviously there is a vast need for it. Is there a way of addressing that model in some way through a training model? In other words, you step people through it, they get familiar with using it and then it becomes a natural addition to the way they do things. Are you actively doing that?

I know that you have talked about a few other things. Can you give me a clue about what is going on in terms of training programs? How involved are people? I know we heard from some people that registrars are included sometimes. It was hit and miss from what I saw. Is that true?

Dr Cleary: The deployment of the telehealth coordinators is only recent. So that has only gone out in the last six months. I think they have only been employed in the last four or five weeks.

CHAIR: On page 6 you provided the detail to us.

Dr Cleary: To my thinking, these telehealth coordinators are going to do just what Dr Douglas mentioned which is really drive that opportunistic training and bring people along on the journey with them. I think before these coordinators were put in place there was very much a challenge in the take-up because there was no-one to go to and ask how to do this—can you give me some help.

Dr DOUGLAS: The literature calls it conditioned barriers. Are you aware of that? In other words, we are conditioned to have it as an obstacle rather than naturally wish to go through it or over it?

Dr Cleary: I must admit, from my experience, working in an environment where I did not have that support, I found it difficult to use the telehealth arrangements that are in place. The reason I say that the telehealth coordinators have only just been introduced is that they really have not had time to make some of those systematic changes work. That is a big part of their role. They are not there to mechanically manage the technology. They are there as an absolute resource within each of the hospital and health services to drive that change.

CHAIR: Dr Cleary, we actually saw that. In Cairns we saw real evidence of that with the delivery of diabetic services. They have had a coordinator in place for some years. You could see the significant difference that one person made to actually ensuring that the logistics behind the scenes were properly in place. We were privileged to watch several actual consultations out of that diabetic centre in Cairns with some areas in Far North Queensland. That coordination really came into its own. You really saw that.

Dr DOUGLAS: That was conditioned seamlessness. I am sure you are aware of it. Trevor is quite right. It was conditioned seamlessness. Everyone was conditioned to believe it was seamless and see it as that. It is one thing me saying that and Trevor saying that, but it is another thing people practising like that. You have to believe it and practise in that way. They obviously do it. It is harder for some. Do you believe that this strategy that you are rolling out will address that?

Dr Cleary: Yes, I do. There are other components to it. I believe that the coordinators are the key. They are on the ground. They are relating to people. As Dr Douglas would know, the medical profession is based on relationships, be it for referrals or for other reasons. I think we have to have the right people in those jobs. They need to have very good relationships with our clinical staff and with the technical teams to make sure that the connections can occur. They also have the advantage of being able to join up services so the person from Longreach will be able to link in with the person from Rockhampton.

People are not just being put into a role. They are going to be well supported. Firstly, with the tools, education and training they have been provided with. That training includes how to undertake clinical engagement and how to get the best out of the system and find the right areas to look at. We are planning to run workshops every six months to look at what we can do to make sure that we break down some of those barriers.

I think you are right, though. There is a cultural issue that is more complicated and probably professionally it is going to take more time to challenge. Jan is probably better placed to talk about the culture in Health than almost anyone in Australia. I think we are looking at changing the culture here. This is not a technical implementation. We can do the technical stuff. We know we can do that. It is actually the strong focus on the relationships and cultural change that is important.

Ms Phillips: Yes. It certainly is a culture change. A lot of the technical issues we are dealing with. But, as I mentioned before, the need to find clinical champions who have credibility, the need to be able to back the changes with clear evidence, because how you get change amongst the clinical workforce is to be able to show them so that they can try it out, they can touch and feel it, they can hear from their colleagues that something is working and reliable and they can see evidence within the literature and elsewhere that something works. Which is why the list of articles, the growing list of academic articles, is so important, because that is part of that cultural shift with clinicians and with doctors, in particular, and gives them that growing confidence that something is going to work for them. So bringing about change through their relationships and connections, particularly with other members of their specialty, is the way that you bring about willing adoption and those barriers start to break down over time.

CHAIR: Thank you. I would like to give the members on the phone an opportunity to ask a question. Roz, do you have any particular questions that you would like to ask? John and Jon, if you could be thinking about that. John Hathaway, do you have any questions?

Mr HATHAWAY: No, I am good, thank you.

CHAIR: Roz, we did not hear from you. You may be on mute. We will move on. Roz, if you can hear me, buzz in when you have the opportunity. Dr Cleary, just a couple more questions, if I may. When we were in Cairns, one of the hiccups they had was the use of electronic signatures for the administration of drugs. I am not a clinician and, Alex, please help me. My understanding is, especially with chemotherapy, that there had to be two signatures for the administration of drugs and if we had a specialist who was remote we could not use an electronic signature. I understand that there is something in the state legislation that stops that from occurring. Are you aware of that and are we dealing with that?

Dr Cleary: I am not aware of that particular issue, but I can certainly follow that up. What we will do, now that you have raised it with us, is, if you are happy, we will get in contact with—

CHAIR: We can provide you some of that information.

Dr Cleary: And we can follow that up. In terms of addressing it, this is something that we are addressing both in the short-term and the long-term. We have legislation in Queensland which relates to drugs and therapeutics which is based on a 1937 piece of legislation. That was before most medications had actually come into practice. So we have a piece of legislation that is possibly in need of review. The government has enforced a review of the drugs and therapeutics arrangements and I am aware, I am oversighting that project, it is progressing quite well. One of the considerations in the review of that legislation is obviously how we move forward into the future. Electronic systems are coming into place and if you look at St Stephen's Hospital up in Hervey Bay they are looking at putting in a full digital hospital and we will be wanting to make sure that they have got electronic systems in place for their medication management. We are very much aware of this, both from the public sector and from the private sector. In terms of electronic signatures, there is a process which can be used under the existing legislation to provide authority to use electronic signatures, but it does require an application to the department for that to be considered.

Dr DOUGLAS: It is a one-off thing, too, is it not? It is individual patients, is it not? Do you do a broad group? They were worried in Mareeba they could only do individual patients.

Dr Cleary: I think we should follow that up. I am aware that we have done it for health services recently which have been able to demonstrate they have good systems and processes in place to make sure that the safety of patients is assured. In terms of looking at those individual applications—and individual here is not for individual patients, but for, say, a service or an area of a service—the critical component is moving from the existing system, which is that double check where two staff endorse that a medication is correct, to a new system. Where we have done that I am aware that we have been very careful to check that the new quality assurance system that they have in place is one that provides either better or the same level of safety for patients and the community. I guess it is a three-step answer. In relation to Cairns we would be very pleased to follow that up. I will see what we can do. They have not raised that with me personally. I suspect there are opportunities for us to assist.

Dr DOUGLAS: It can be defeated using the Commonwealth act where you actually write it on script paper, fax it and sign it with your instructions, which obviously they are clearly doing intermittently, but then you are defaulting back to using the Commonwealth legislation which I presume is what they are doing intermittently. But to be honest you should not have to do that.

CHAIR: Can I check who is on the phone?

Mr HATHAWAY: John in Townsville.

Dr DOUGLAS: We have lost Jon Krause.

CHAIR: We still have a quorum. We will need to wrap up. I have one more question. In Torres Strait one of the things we witnessed, and this is a technical issue, was some pretty psychedelic colours coming out of some of those screens. I understand some of those technical issues. I see that within the budget we have $1 million for capital infrastructure. My suspicion is that it is going to take a lot more than that in that area of the world to provide the bandwidth requirements that we would seek. I am assuming a lot of that is wireless. You would be looking at talking to someone like Telstra—I do not know who provides the technology—about a 3G upgrade, I am assuming. Have you spoken with HHSs or has Queensland Health looked at upgrading that? There is a real impediment in some of those areas. Having said that, the network that we have is the envy of a lot of people. Please do not see it as a criticism. It was an observation. When we look at the remoteness of those islands, the delivery of health care could be substantially improved in the allied health areas and with chemotherapy, things like that. Do we know if there are any plans at this point in time?

Dr Cleary: A quick comment more around the arrangements in place first and then Andrew can talk through the technical issues. We are very fortunate that our hospital and health services are very local and are able to make decisions locally. They are very careful about their investment strategies. I know that the newly formed health service up there and the chair of that health service and the new CEO are certainly the type of people who will be looking at where do they invest and what are the things that will provide the best benefits for the local community. I have discussed this with them. I think that they have certainly got this type of arrangement on their agenda. Dr Jill Newland, who is the new chief executive of the Torres and Cape Hospital and Health Service, has

had long experience in working in communities and working in education and training, support roles and in looking at quality and safety arrangements in place. I think we are very fortunate to have someone like Jill take up the role as the chief executive.

In terms of the technical issues, we have had discussions with Telstra over, from what I can recall, the last four years. Telstra has been of great assistance in putting in the infrastructure to Thursday Island and looking at the other arrangements that might be put in place. I think, as you say, bandwidth to the outer islands is still an area that could be looked at. Andrew will no doubt have some more technical expertise to offer.

Mr Bryett: Thank you, Dr Cleary. Certainly, the experience as you referred to in the outer islands in some instances are problematic. The links up there are dependent upon which island, microwave, there are still some copper links, but they are highly, I suppose, contingent upon weather and other arrangements. Sometimes you will get a good connection, sometimes you will not. It is high cost to try to address those issues. We hope that NBN would maybe do something for us in that space. There are other things that we can look at around satellite infrastructure. Satellite doesn't provide the best experience in telehealth due to latency, but there are other opportunities for us to look at. I guess it comes down to, referring back to Dr Cleary's comments, a whole-of-government perspective in terms of delivering services into these communities. It is not just about health and certainly not just about telehealth, it is about policing, it is about education, it is about those whole range of community services that could be better enabled into these communities with better technical infrastructure in place.

Dr Cleary: Just a very quick comment about the satellite technology, we are trialling the satellite technology in one of our health services to determine whether that is going to be a useful alternative. As you have heard, there is an issue with the delay that you sometimes experience that may make it a less than desirable alternative, but if a satellite alternative is available to us that may, in fact, give us the opportunity to expand the services to where we don't have broadband in place or the NBN hasn't rolled out to.

CHAIR: Thank you. I appreciate your time and for allowing us to go a little bit over time. The time allocated for the hearing has expired. Thank you, Dr Cleary, thank you, Ms Phillips, and thank you, Mr Bryett. We truly appreciate your time. I declare this hearing of the Health and Community Services Committee closed. Thank you, those of you on the telephone.

Mr HATHAWAY: My pleasure. Thanks, Chair.

Ms BATES: Thank you.

Committee adjourned at 2.41 pm