FUTUREHEALTH

GOVERNMENT RESPONSE AND ACTION PLAN

Review of Current Tasmanian Patient Transport Services
and
External Review of Tasmanian Medical Retrieval Services

NOVEMBER 2008

Department of Health and Human Services

Tasmania
Explore the possibilities

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Foreword

Ensuring access to sustainable health services for all Tasmanians, regardless of where they live, is the primary principle underpinning *Tasmania's Health Plan*.

We know that to make the plan work, transport and accommodation assistance are the keys to creating a positive experience of the health system for patients and their families.

In making Tasmania's health system sustainable, and ensuring we are best placed to meet the growing demand for health services into the future, hard decisions had to be made about where we should concentrate some services, particularly a number of specialised clinical services provided in acute hospitals.

As a consequence, and in recognition of the changes made to guarantee a sustainable future for our health services, the Tasmanian Government acknowledged the need to ensure equitable access by looking seriously at improved health-related transport and accommodation assistance.

Therefore, as part of our commitment to ensuring fair health access into the future, we are enhancing patient transport services and health-related accommodation assistance for those people, and their carers, who need to travel to healthcare services based outside their local community.

This Government Response keeps the promise we made to you in 2007 under *Tasmania's Health Plan*.

At my request, earlier this year the Department of Health and Human Services engaged specialist consultants to conduct two reviews – The Banscott Review of Current Tasmanian Patient Transport Services, and the External Review of Tasmanian Medical Retrieval Services (the Sharley Review).

This response addresses the findings and recommendations of both reports – it also incorporates Action Plans that set out all the tasks we will perform in response to the Reviews, and when we will do them.

One of the most important recommendations to be implemented from 1 December 2008 is the significant enhancements to the Patient Travel Assistance Scheme, which will see increased financial benefits to those people across Tasmania who need to travel for important healthcare services.

The Tasmanian Government is grateful for the Australian Government's support for *Tasmania's Health Plan* and for committing $10 million to improve patient transport, particularly for north and north-west Tasmanians. The Tasmanian Government's contribution of $12.4 million will see a joint total of $22.4 million spent over four years to implement the immediate priorities of these reforms.

The Government is also delighted to usher in substantial reforms to the patient transport and medical retrieval services – reforms that will see us even better positioned to provide sustainable, high quality health services for the benefit of all Tasmanians.

Lara Giddings

Lara Giddings MP
Deputy Premier
Minister for Health

Government Response

The key points of this Government Response are:

- The Government is substantially increasing subsidies for patient travel and for health-related accommodation for patients and carers;
- We are also reducing the distance people with chronic conditions must travel for dialysis and oncology treatment before they qualify for assistance;
- There will be uniformity of patient transport services including community transport and the travel assistance scheme across the State;
- We will introduce centralised coordination of ambulance services, patient transport and medical retrieval services in Tasmania;
- We are introducing new statewide (outreach) renal services and chronic health services to deliver care closer to people's homes;
- The Government will ensure there is greater flexibility to meet special needs and respond to an increasing range of health conditions;
- We are improving assistance and access to services for Bass Strait Islanders;
- The Government will purchase more patient transport vehicles;
- Medical Retrieval Services will transition over the next three years from 2009 to a statewide service based in Hobart, with additional helicopter services, and with a fixed wing aircraft staying at Launceston (at this stage);
- We are investing in patient accommodation upgrades in Launceston and Hobart, and will be providing more accommodation options in Burnie; and
- The Government will ensure information on these changes is disseminated across Tasmania to patients, carers, general practitioners and health services.

The Government has accepted all but seven of the 91 recommendations made by Banscott Health Consulting in their *Review of Current Tasmanian Patient Transport Services* (the Banscott Review).

The recommendations we have not accepted are those that would limit eligibility for transport and accommodation subsidies to cardholding patients and carers. The Government is committed to ensuring that financial assistance for health-related travel and accommodation is available to all Tasmanians who need it.

The *External Review of Tasmanian Medical Retrieval Services* (the Sharley Review) made 24 recommendations. The Government has accepted all the Sharley recommendations, subject to the transition arrangements noted above.

Listed below is a summary of the key actions, ranked by priority, which we are taking to improve patient transport, health-related accommodation and medical retrieval services in response to these two important reviews.

Note: A detailed Government Action Plan is set out in Appendix A (in response to both the Banscott Review and the Sharley Review). Copies of the Banscott and Sharley Reviews are available on www.dhhs.tas.gov.au/futurehealth or by telephoning (03) 6233 7190.

Immediate priority actions

The Government will take the following action in response to the two reviews:

Patient Travel Assistance Scheme (PTAS)

- Increasing the PTAS fuel subsidy from 13 cents per kilometre to 19 cents per kilometre.
- More than doubling the interstate accommodation subsidy from $30 to $64 per day, and increasing the intra-state accommodation subsidy from $30 to $46 per day, payable to both eligible patients and their carers.
- Retaining PTAS eligibility for all Tasmanians, regardless of employment or financial status – the Government made a promise to all Tasmanians about fair access to our health services, and we intend to keep it.
- Ensuring that financial assistance keeps track with rising costs, by adjusting PTAS rates in line with changes to the rate payable to Tasmanian Government Employees under the Community and Health Services Award.
- Expanding the PTAS eligibility criteria to include patients travelling from Scottsdale, Deloraine and George Town to the Launceston General Hospital for renal dialysis treatment.
- Expanding the PTAS eligibility criteria to include patients travelling more than 50 kilometres to the Royal Hobart Hospital for renal dialysis treatment.
- Expanding the PTAS eligibility criteria to include oncology patients travelling more than 50 kilometres to the Launceston General Hospital or Royal Hobart Hospital for treatment.
- Ensuring the ability to add new services and treatments to those eligible for PTAS, starting with Lymphodema – chronic diseases of the Lymphatic system that in some cases can develop after cancer treatment or major surgery. In the longer-term consideration will be given to additional services such as mental health, allied health and dental services.

Capital expenditure

- Purchasing five new vehicles for the North West Patient Transport Service fleet and three new vehicles for the Southern Patient Transport Service.
- Establishing a centralised coordination of patient transport and community transport services, with a new IT platform and an increase in staff and enhanced training to deliver statewide coordination of non-urgent and community transport.
- Enhancing Telehealth infrastructure to provide care and advice as close as practicable to patients' homes thereby reducing the need for any unnecessary travel.
- Upgrading Queenstown Airport to allow fixed wing planes to takeoff and land safely.

Health-related accommodation

The Government will immediately provide the following modest capital grants to address the current critical accommodation shortages in Launceston and Hobart:

- Contributing $90 000 to the Spurr Wing in Launceston to allow bathrooms to be installed in the three large ground-floor bedrooms.
- Contributing $70 000 towards a facility in Hobart operated by the Bone Marrow Donor Institute to provide low-cost quality accommodation for up to 21 patients, family and carers, predominantly from the North and North West.

Residents of Bass Strait Islands

- Ensuring there is appropriate patient transfer and lifting equipment in airport facilities as necessary.

Medical retrieval services

- Establishing coordination of medical retrieval services through the Tasmanian Ambulance Service (TAS) Communications Centre.
- Ensuring a senior, clinically-trained Ambulance officer or appropriately trained clinician is available to advise the TAS Communications Centre 14 hours per day, seven days a week.
- Increasing extended scope of practice training for Paramedics.

Non-emergency patient transport and community transport

- Ensuring non-emergency patient transport continues to be provided for card-holding renal dialysis and radiotherapy patients based on vehicle availability.
- Wherever possible, ensuring community transport is used to convey patients needing renal dialysis, chemotherapy, radiotherapy or nursing home travel.
- Introducing centralised coordination of all non-urgent patient transport, with the Tasmanian Ambulance and Health Transport Service (TAHTS) as the preferred provider of non-urgent patient transport.

Short-to-medium term changes

The Government will also be introducing a range of service developments over the next few months. These will include:

- Commencing planning for patient accommodation facilities in Burnie.
- Negotiation with selected accommodation providers in Launceston, Hobart and Burnie with a view to having special discounted hospital rates offered to patients and their families and carers.
- Commencing development of a renal service designed to deliver quality renal care and dialysis as close as possible to patients' homes across Tasmania.
- Commencing development of a chronic disease service designed to manage the secondary and tertiary prevention of complex and chronic conditions.
- Engaging three Clinical Authorisers to approve health-related travel and a statewide Administrator to implement improvements to PTAS and to support the three PTAS Coordinators (one each for the North, North West and the South).
- Introducing a simple default system of single authorisation for multiple trips needed for a course of treatment, with periodic clinical review.
- As standard practice, assisting patients to travel to their appointments by providing prepayments and vouchers wherever possible.
- Invigorating the PTAS Review Committee with new clinical membership, to provide up-to-date information on PTAS to rural medical practices.
- Ensuring patients and carers are provided with up-to-date information – in printed and electronic form – where patient travel and health-related accommodation are likely to be needed.
- PTAS Coordination forming a separate but integrated part of the Tasmanian Ambulance Service's Communications Centre in Hobart.
- Establishing a 24 hours per day, 7 days a week phone number to be used by people from isolated areas (including King Island and the Furneaux Islands) who are discharged from hospitals (including Emergency Departments) and who require assistance in obtaining overnight accommodation and/or transport home. (This number will be prominently displayed in all hospital Emergency Departments, and widely advertised to clinicians and primary health centres).
- Introducing a new system, operated through the Communications Centre, which will manage booking and coordination of all urgent patient transport across Tasmania, 24 hours per day, 365 days per year.
- The Communications Centre will coordinate and book all non-urgent and community transport from 7am to 10pm, seven days per week, all year round (except Christmas Day, Good Friday and Easter Sunday).
- Purchasing vehicle navigation equipment, identification capacity and tracking facilities, and upgrading radio and paging functionality in ambulance and patient transport vehicles to improve system reliability and coverage.
- Upgrading the current Computer Aided Dispatch (CAD) system, introducing an advanced Medical Priority Dispatch function in the Communications Centre, and developing service standards for response times.

Longer-term developments

In addition, the Department of Health and Human Services (DHHS) is developing longer-term strategies to meet health-related accommodation needs and other demands – these include:

- Establishing additional, low-cost accommodation in Burnie for patients, their families and carers, with maximum community involvement in the project, while keeping costs and charges to an acceptable level.
- Consider contracting with the private sector for provision (by new construction or by redevelopment of existing buildings) of blocks of rooms in Launceston and Hobart suitable for patients and their families/carers. If necessary DHHS will consider guaranteeing occupancy of a specified number of rooms.
- Also examining construction of self-contained motel-style accommodation in various configurations for 20 people on land in Launceston, possibly adjacent to Spurr Wing (with the building administered as part of Spurr Wing), and/or by participating in the Tasmanian Cancer Council's proposed development.
- Working with non-government organisations (NGOs) in Hobart to manage a health-related accommodation enterprise that utilises a surplus government-owned building, or a suitable building purchased by or constructed for the government, including the possibility of a facility adjacent to the new Royal Hobart Hospital.

DHHS is also developing longer-term capital strategies – these include:

- As noted above, augmenting the patient transport fleet with additional vehicles statewide.
- Reviewing the Emergency Transport Policy.
- Establishing helipads where they can be shown to improve our services.
- Relocating the Tasmanian Medical Retrieval Service (TMRS) administration to Hobart, reviewing the current Helicopter contract before its expiry, and reviewing the fixed wing contract with the Royal Flying Doctor Service (RFDS).

Introductory background

Tasmania's relatively small population and dispersed nature of settlement, together with its diverse geography, pose considerable challenges in providing accessible health services to the entire community.

Many areas of the State are not well served by major road networks or adequate public transport – facts that influence the ways in which residents access health services. As well as lengthy travel to some facilities, patients may face considerable difficulties in accessing health services because of their age, mobility, or lack of family or carer support.

Costs incurred in travelling to health services away from home can also be prohibitive, leading some patients to consider not proceeding with treatment. This can risk their health, and potentially increases the healthcare burden and costs to the community in the longer-term.

Commitments in *Tasmania's Health Plan*

With the release in May 2007 of the *Tasmania's Health Plan*, the Government set the direction for a safe, effective, responsive and integrated health system to meet the future needs of the people of Tasmania.

The Plan addressed the problems facing Tasmania's healthcare system in a systematic and sustainable way. In so doing, it identified the need to improve transport and accommodation support for patients and clients who require health services and medical treatment some distance from their homes.

Indeed, given the importance of ensuring fair access to health services for all Tasmanians, enhanced patient transport, community transport and accommodation assistance are critical to the successful implementation of *Tasmania's Health Plan*.

Because of the need to ensure sustainable health services, many specialist medical services are provided only at the major acute hospitals in Tasmania, with more resource-intensive services provided only at one or two of Burnie, Hobart or Launceston (and, in some highly specialised cases, only available interstate).

Patients who need access to these services may make quite lengthy journeys to hospital, and in some circumstances must stay away from home overnight or longer. Carers and family members often have to accompany patients to provide support during their treatment.

Rural communities have regularly reported problems with the way rural patients' access care in major hospitals. These included such concerns as limited coordination of outpatient appointments, and a lack of understanding about the support needed to ensure patients can return home safely after discharge.

The Government also acknowledged that, with access to suitable accommodation and transport, patients can be more safely and efficiently discharged from hospital, so allowing more effective use of scarce acute inpatient resources while better supporting patients who have travelled to access health services.

The *Clinical Services Plan* and the *Primary Health Services Plan*

Tasmania's Health Plan has two major components – the *Primary Health Services Plan* (PHSP) and the *Clinical Services Plan* (CSP), both released in May 2007.

The fact that Tasmania has many small communities dispersed across the State creates a tension between the desire to deliver comprehensive health services locally and the need to structure services that are sustainable.

In response, the CSP defined the roles, services and strategic direction for Tasmania's three major public acute hospitals in accordance with the following key principles:

- Health services are to be as close as possible to where people live, if services can be delivered safely, effectively and at an acceptable cost; and
- Where services cannot be delivered safely, effectively and at acceptable cost locally, access will be facilitated through service coordination, transport assistance and other appropriate support.

The CSP established the foundation of sustainability upon which future development of the State's health system is to be built – a foundation for a safe, effective and affordable system.

To do this, we needed to change the way we configure and deliver our health services. The CSP recommended a review of existing appointment booking and hospital discharge policies that could identify opportunities for patients to access services more readily, and return to their place of residence following treatment.

The CSP noted the merit of, where practicable, scheduling clinical consultations and treatment according to rural patients' travelling arrangements, so minimising avoidable overnight stays for patients and carers away from home.

Both the CSP and the PHSP also canvassed development of a statewide service for the central coordination of patient transport, community transport and medical retrieval services, in order to enhance service quality and optimise the effective use of resources.

These changes involve new responses to ensure access to health services is equitable across Tasmania – they will improve the way people obtain urgent transport and retrieval services, patient travel assistance, non-urgent patient transport, community transport, health-related accommodation and carer support.

Patient transport and accommodation support

In 1987, the Commonwealth Government transferred the responsibility of providing travel assistance to travelling patients to the State Governments.

The Tasmanian Government subsequently established PTAS to help reduce the financial burden experienced by people needing to travel for healthcare. PTAS helps to ensure equity of access for Tasmanian residents to specialist health and medical services.

The Government knows that the cost of health-related travel and accommodation, together with other costs associated with being away from home, can be difficult for many Tasmanians to meet. This is particularly so where patients need to undergo long periods, or frequent sessions, of treatment – for example with radiation therapy, chemotherapy, or renal dialysis.

The scheme, operated by DHHS, is targeted to all Tasmanians who have to travel long distances (within Tasmania or interstate) in order to access specialised health services. PTAS contributes to the cost incurred by patients and their carers for that travel and accommodation.

The current PTAS arrangements were implemented in October 2007 and amended with effect from 15 May 2008.

The scheme currently meets its purpose by contributing to the costs of: patient travel; patient accommodation (if required); and travel and accommodation for an escort (or carer) who might be required to travel with the patient.

However, as with similar schemes in other states and territories, PTAS provides a subsidy only, and does not cover all of the costs associated with health-related travel.

In 2006–07, 15 705 patient trips were funded under PTAS. Of those, 48.2 per cent were undertaken by pension cardholders, 32.5 per cent by health care cardholders, and 19.3 per cent by non-cardholders and patients who have private health cover. The total cost of PTAS expenditure for 2006–07 was $2 933 331.

Over the same period, patient contributions of $75 per trip from non-cardholders totalled $140 844. Concession cardholders paid contributions of $15 per trip totaling $129 782.

The average annual growth rate of PTAS over the past five years has been 4.8 per cent. While some moderating influence can be expected with the introduction of new specialist services in Tasmania (such as PET scanning), the overall level of PTAS activity is expected to continue to increase.

The Senate inquiry into patient transport

In September 2007, the Senate's Standing Committee on Community Affairs reported on its inquiry into the operations and effectiveness of State Patient Assisted Travel Schemes (PATS).

The inquiry resulted from several reports of serious adverse clinical outcomes in some jurisdictions, as well as community complaints and expressions of concern about the administration of PATS in various states and territories.

The Committee found that a review of all PATS (including Tasmania's PTAS) was urgently needed. The Committee also confirmed a number of community concerns about PATS that had given rise to its inquiry. Its findings included:

- The PATS are important means of addressing locational disadvantage across Australia. The schemes provide significant, and in many cases vital, travel support to Australians living in regional, rural and remote areas who need to access specialist medical services.
- Rural, regional and remote communities face considerable disadvantages in accessing health services. While many factors contribute to deciding whether to travel for treatment, the schemes put in place to assist with access should not impede it.
- For patients from rural, regional and remote areas, the costs of transport and accommodation can add significantly to the burden of illness.
- In some instances the financial burden is such that treatment decisions and health outcomes are compromised and, in some cases, patients are choosing not to receive treatment.
- Patients will have to travel more in future to access services because of: the move to centralisation of services; costly medical technology; workforce shortages; safety and efficiency concerns; and improved patient outcomes for those accessing multidisciplinary teams.
- It is therefore imperative that access to services be improved on the grounds that failure to do so means health priorities are undermined – costs to Government may increase in the long-term and, most importantly, the health status of those living in rural, regional and remote communities will not be improved.
- Current subsidy levels for travel and accommodation are clearly insufficient and have not kept pace with rising living costs. The subsidy levels should better compensate people disadvantaged by their residential status, and should reflect current costs for such inputs as petrol and accommodation.

For those reasons, the Committee found that the reform and increased funding of the PATS was urgently needed, not only to improve health outcomes for people living in rural, regional and remote areas, but also to ease the healthcare burden in the longer-term.

The Committee was particularly concerned about prioritising those who are most disadvantaged – health cardholders, the working poor, and asset-rich but cash poor residents – who may be inadequately supported by the current schemes.

Scope of the Banscott Review

Following release of the CSP, DHHS commenced a transport and accommodation review involving a number of projects across all patient and health-related transport, travel and accommodation services – this included community transport, non-urgent patient transport and access to PTAS.

The CSP identified enhancement of both Ambulance and patient transport services in the key changes required to ensure accessibility to health services.

In February 2008, DHHS engaged Banscott Health Consulting to review current Tasmanian patient transport services and to provide recommendations for a modern, integrated service to enhance service quality, to optimise appropriate resource utilisation, and to improve service efficiencies. The review concluded in July 2008 with a report being provided to DHHS.

For the purposes of the Review, Tasmanian patient transport included patient transport by means of the following services:

- The Tasmanian Ambulance Service (TAS), which provides both statewide emergency ambulance care across the State, and a non-emergency patient transport service in the South;
- Non-emergency patient transport services in the North and North West are managed by the Launceston General Hospital and the North West Regional Hospital respectively;
- The Patient Travel Assistance Scheme; and
- Community Transport Services.

The Banscott Review recommended that PTAS transport subsidies be limited to cardholders only, and that accommodation subsidies only be available to non-cardholders after four nights stay away from home.

While the objective of reducing demand on revenues is understandable, the Government does not believe that the public benefit outweighs the disadvantage this would cause.

The Government is committed to ensuring that the one in five PTAS customers who are non-cardholders not be disadvantaged by any changes we make to the scheme. As the Senate Committee noted, many patients and their families, even though working, may not be well off – and could be discouraged from seeking necessary and appropriate health care if we were to restrict PTAS payments.

Scope of the Sharley Review (October 2007)

The *Clinical Services Plan* included a recommendation for a review of medical retrieval services with a view to them being reconfigured as a statewide clinical service. Shortly thereafter, Dr Peter Sharley OAM, a medical retrieval specialist, commenced his review.

The objective of the Sharley Review was to provide a set of recommendations on how medical retrieval services – covering both the Tasmanian Medical Retrieval Service (TMRS) and the Neonatal Emergency Transport Service (NETS) – can be structured sustainably.

The review considered a wide range of factors – including staffing, transport and procedures – which will enable sustainability of the Tasmanian medical retrieval services into the future. DHHS's criteria for service sustainability included:

- Sufficient patient volume to support and maintain the competence of healthcare professionals;
- Staffing infrastructure that can withstand temporary shortages without excessive cost or operational burden;
- Quality equipment and facilities;
- Appropriate access to necessary clinical and non-clinical support services; and
- Reasonable costs given competing demands for resources.

Consistent with the CSP, the Review focused on a number of important principles and objectives for medical retrieval services to ensure a robust and sustainable service that meets reasonable operational demands and is accessible to the population, regardless of location or diagnosis.

These included:

- a focus on patient outcomes;
- safety for patients and staff;
- encouraging responsive, efficient and effective services;
- adequate resourcing, particularly in staffing;
- clearly defined clinical governance structures; and
- statewide clinical coordination with dynamic flexibility.

The Banscott Review – Summary of findings and recommendations

The complete set of 91 recommendations in the Banscott Review is available at www.dhhs.tas.gov.au/futurehealth or by phoning (03) 6233 7190. The following is the Government's summary of the Report's key findings and recommendations.

Patient Travel Assistance Scheme

The first 36 recommendations cover the Patient Travel Assistance Scheme (PTAS) and related matters.

Recommendations 1 to 3

These recommendations relate to the level of subsidy provided through PTAS. The Report recommends that the travel and accommodation allowances paid to approved recipients be set at 50 per cent of the rate payable to Tasmanian Government employees under the Community and Health Services Award (CAHSA), namely:

- $45.85 within Tasmania for each overnight absence from home (currently $30 per night);
- $64.05 outside Tasmania for each overnight absence from home (currently $30 per night); and
- Fuel subsidy of 19.435 cents per kilometre (currently 13 cents per kilometre).

The Report also recommends the accommodation allowance and fuel subsidy rates payable to approved PTAS recipients be adjusted in line with changes in the CAHSA rates.

The Government has accepted these recommendations, but has for simplicity's sake decided to round out the sums payable to $46 per night, $64 per night and 19 cents per kilometre respectively.

Recommendations 4 to 10

These recommendations relate to the eligibility criteria for PTAS and the level of co-payment. The current PTAS arrangements vary from region to region. The Report recommends the scheme be consistently and equitably applied across the whole of Tasmania.

The Report recommends that PTAS criteria continue to require an eligible recipient to have to travel more than 75 kilometres (one-way) by the shortest practicable route to access the nearest specialist medical service. However, the Report also makes the following new recommendations regarding eligibility:

- That the minimum distance by the shortest practicable route that patients are required to travel to access the nearest dialysis/oncology treatment centre be reduced to more than 50 kilometres one-way.
- That the PTAS accommodation allowance and fuel subsidy be made available only to approved recipients who hold an Australian Government health care or pensioner concession card (cardholding patients) and their approved escorts, and to such other classes of patients as the PTAS Review Committee shall, from time to time, include on a list of eligible recipients.
- That approved non-cardholding recipients/escorts who are required for clinical reasons to pay for accommodation either within Tasmania or interstate for periods in excess of four nights, receive the accommodation allowance for each night after the fourth night on each occasion.

As noted above, the Government has accepted the recommendations regarding minimum travel distances, but will continue to make PTAS benefits available to eligible patients who are not cardholders.

The Government also does not support an additional burden placed on non-cardholders of having to pay for four nights' accommodation prior to accessing the subsidy – the existing criteria of non-cardholders paying for two nights' accommodation will therefore be retained.

The Report also makes the following recommendations with regard to level of co-payment:

- No change to the level of co-payment from cardholding patients ($15 per trip capped at $120 per financial year); but
- Changing the level of co-payment required from non-cardholding approved recipients from $75 per trip (capped at $300 per financial year) to $120 per trip (capped at $480 per financial year).

The Government has accepted the first but not the second of these two recommendations. Existing co-payment criteria will remain.

Recommendations 11 to 24

These recommendations relate to the administrative arrangements, budgeting and management of PTAS. They include:

- that the PTAS Review Committee be reconstituted to consist of a Senior Clinician as Chair, with three Clinical Authorisers, three PTAS Coordinators, and a statewide PTAS Administrator as Executive Officer and Secretary;
- that the Review Committee manages the PTAS budget and is responsible for the administration, management and on-going review of the scheme, including responsibility for the review and issuing of the Guidelines and Policies under which the scheme operates;
- that the PTAS Administrator, working under the direction of the PTAS Review Committee, administers the PTAS budget allocation;
- that the PTAS Administrator provides an annual report on PTAS, and that the report be published as part of DHHS's Annual Report;
- that, where possible, the regional PTAS Coordinators be located in premises away from the three major hospitals, so that they focus on providing a PTAS service that is well-integrated and coordinated with other transport services;
- that there be only three Clinical Authorisers – one in each of the major hospitals – with each consulting where required with the chair of the PTAS Review Committee and working with the relevant PTAS Coordinator;
- that PTAS Coordinators ensure adherence to the guidelines and policies approved and promulgated by the Review Committee;
- that, wherever possible, a course of treatment involving multiple visits to a specialist or a treatment centre require only a single approval, with periodic review by the relevant Clinical Authoriser/PTAS Coordinator; and
- once approval is given, that the patient be entitled to make appropriate claims against that approval throughout the course of treatment.

The Government has accepted most of these recommendations. The fifth recommendation is subject to an assessment of practicalities and the effect on patient access to PTAS services.

Recommendations 25 to 27

These recommendations relate to consistency and equity of eligibility arrangements. The Report suggests that:

- Eligibility criteria be amended to provide that cardholding patients travelling from Scottsdale, Deloraine or George Town to the Launceston General Hospital for renal dialysis treatment be eligible to receive travel allowance.

- The Royal Hobart Hospital cease offering travel allowance to patients residing within the Hobart metropolitan area, but that cardholding patients travelling more than 50 kilometres to the Royal Hobart Hospital for renal dialysis treatment be eligible to receive travel allowance.
- That cardholding oncology patients travelling more than 50 kilometres to the Launceston General Hospital or the Royal Hobart Hospital for treatment be eligible to receive travel allowance.

As noted above, the Government has accepted the recommendations regarding minimum travel distances, but will continue to make PTAS benefits available to eligible patients who are not cardholders.

Recommendations 28 and 29

These recommendations relate to providing more care for chronic conditions closer to home. The Report suggests that the Government establishes two new statewide services to provide care at a range of sites across Tasmania for particular groups of patients, so reducing their need to travel.

These services include:

- A statewide renal service to deliver quality renal care and dialysis as close to home as possible – this should be developed in partnership with communities and health facilities, following rigorous assessments of patient safety and sustainability, and will require investment in equipment, staff and education.
- A statewide chronic disease service, delivered by teams based as close to the community as possible. These teams will manage the secondary and tertiary prevention of diabetes, cystic fibrosis, chronic obstructive pulmonary disease, and other complex and chronic conditions.

The Government has accepted these recommendations.

Recommendations 30 to 32

These recommendations relate to the expansion of eligible treatment services for assistance under PTAS. The Report recommends including Lymphodema treatment, with the Advisory Committee to list dental and orthodontic services, mental health services, physiotherapy services, and rehabilitation services that are subsidised.

The Government has accepted these recommendations.

Recommendations 33 to 36

These recommendations relate to improving information and communication about PTAS. The Report recommends that:

- Members of the PTAS Review Committee and PTAS Coordinators develop and maintain a program of regular visits to rural medical practices to provide information about PTAS.
- Patients be advised about PTAS at their initial medical consultation wherever there is likelihood that travelling and/or accommodation expenses are likely to be incurred during the course of their treatment.
- PTAS Coordinators ensure medical practitioners, specialists and the Tasmanian Divisions of General Practice are kept informed about PTAS, and are encouraged to provide appropriate information to relevant patients.
- The PTAS brochure be updated and revised in consultation with consumers, so that it clearly details the eligibility criteria and benefits claimable. That the revised brochure should be made widely available, especially through PTAS offices, hospitals, healthcare providers, medical practices and Service Tasmania, as well as being easily accessible online.

The Government has accepted these recommendations.

Transport coordination

Recommendations 37 to 77 cover transport coordination and integration of patient transport services.

Recommendation 37

This recommendation relates to the Southern Non-Emergency Patient Transport Service. The Report recommends that the Southern Patient Transport Service fleet be augmented with additional appropriate vehicles as soon as practicable.

The Government accepts this recommendation, with an initial purchase of five vehicles for the North West and three vehicles for the South.

Recommendations 38 to 46

These recommendations relate to the full integration of Patient Transport Services with the Tasmanian Ambulance Service. The Report recommends that:

- The statewide Patient Transport Service retain operational bases in Hobart, Launceston and Burnie, with each being located at the Tasmanian Ambulance Service station in the area to maximise the benefits of the linkage.
- The Patient Transport Service be a separate business unit within the Tasmanian Ambulance Service (TAS), with a specific manager of the statewide Patient Transport Service.
- The operations of the Patient Transport Service units be coordinated from the TAS Communications Centre, with the head of the Communications Centre determining (with appropriate clinical input) eligibility for transport, the type of transport required, and the provider of that transport.
- DHHS's Non-Emergency Patient Transport Policy be reviewed and revised in accordance with the recommendations of this Review, and be reissued to ensure consistency and uniformity across Tasmania.
- Regardless of proximity to a treatment centre, non-emergency patient transport be available for card-holding patients who need renal dialysis, chemotherapy or radiotherapy, with the Communications Centre to decide on the allocation of transport based on resource availability and accessibility.
- Hospital staff be required to book all patient transport through the Communications Centre.
- Staff for the Communications Centre be sourced from existing staff of the TAS emergency communications centre, and that additional staffing positions be allocated for the operation of the Communications Centre.

The Government has accepted the recommendations, subject to budgetary approval and negotiations with relevant industrial organisations.

Recommendations 47 to 52

These recommendations indicate a wider role for the TAS Communications Centre. The Report suggests that:

- The Communications Centre becomes the sole facility integrating, coordinating and managing all patient transport and community transport in Tasmania.
- The Communications Centre operates 24 hours a day, 365 days a year, but that coordination of non-emergency transport and community transport services operate from 7am to 10pm, 7 days per week, except Christmas Day, Good Friday and Easter Sunday.
- The Communications Centre allocates and dispatches all non-emergency patient transport in Tasmania.

- The Communications Centre be a development of the existing TAS Emergency Patient Transport Communications Centre, managed by TAS (now TAHTS), but be relocated within Hobart to enable the required new staff and equipment to be suitably accommodated.
- An Advisory Committee, consisting of all relevant stakeholders, be appointed to oversee the development and implementation of the new Communications Centre.

The Government has accepted these recommendations, subject to budgetary considerations and discussions with TAHTS.

Recommendations 53 to 55

These recommendations relate to Community Transport. The Report suggests:

- That the allocation and dispatch of community transport for the Tasmanian Cancer Council, Australian Red Cross Society and Home and Community Care (HACC) funded non-government agencies be coordinated from the Communications Centre, and that a Community Transport Manager be appointed to the centre to ensure an appropriate interface between it, service providers, and DHHS.
- That, wherever possible, community transport be used for transporting patients for renal dialysis, chemotherapy and radiotherapy, and patients being transported to and from nursing homes.

The Government has accepted these recommendations, subject to discussions with the relevant non-government organisation (NGO) transport providers.

Recommendations 56 and 57

These recommendations relate to clinical input. The Report suggests that:

- The Communications Centre be staffed with appropriate senior personnel to provide 24-hour supervision, command and control of the centre.
- The Communications Centre have an appropriately qualified Clinical Support Officer on-site for monitoring and making transport-related clinical decisions, that clinical decisions comply with the clinical governance standards of the Tasmanian Ambulance and Health Transport Service (TAHTS), and that 24-hour on-call access to an experienced senior medical officer be available to the Clinical Support Officer.

The Government has accepted these recommendations, subject to consultation with TAHTS.

Recommendations 58 to 62

These recommendations relate to private providers. The Report recommends:

- That the Communications Centre make decisions about whether and in what circumstances to book a privately operated patient transport service rather than using a non-emergency Patient Transport Service (provided by TAHTS).
- That, in accordance with Cabinet's decision of November 2000 not to outsource public work, TAS (now TAHTS) be the preferred service provider for the allocation of non-emergency patient transportation.
- That private providers be licensed, with DHHS strictly monitoring the licences.
- That private service operators provide non-emergency patient transport only when TAS services are not available.
- That private providers be chosen only from a panel of approved providers maintained by DHHS, with listing on the panel of approved private providers being subject to contestable renewal every five years.

The Government has accepted these recommendations, subject to consideration of legislative requirements for licensing of private providers.

Recommendations 63 to 72

These recommendations relate to the Communications Centre. The Report suggests that:

- The current CAD system be upgraded to cope with the increased workload of the Communications Centre.
- The Government approve the purchase of existing and currently available computer software for the Communications Centre to enhance administration of non-urgent patient transport and community transport systems.
- Specifications for the purchase of computer systems for the Communications Centre take into account systems currently used or planned for use by the other emergency services in Tasmania.
- As part of the upgrade of the functionality of the Communications Centre, the Government purchase vehicle navigation, identification and tracking capacity.
- The Government implement an advanced medical priority dispatch system, and in so doing investigate the possibility of funds being available from Australian Government sources for this development.
- The Communications Centre's operating system includes the capacity to link case information to the management information system, ensuring that allocation of resources, service decision-making, and research is based on solid data.
- There be an examination of the options to achieve direct communication between ambulance personnel at accident/emergency scenes and medical staff at receiving hospitals.
- The radio and paging systems in emergency ambulance and patient transport vehicles be upgraded to increase system reliability and coverage.
- The Communications Centre's operational system includes development of a computerised billing system.

The Government has accepted these recommendations, and in many cases has already implemented them.

Recommendations 73 to 76

These recommendations relate to service standards and training. The Report suggests that:

- The Communications Centre reviews the training and performance development needs of communications personnel.
- In particular, the Communications Centre introduces specific clinical and systems training programs for its staff, with training of staff both before they commence employment and through regular in-service training programs.
- The Government recruits two additional non-emergency patient transport crews for southern Tasmania.

The Government has accepted these recommendations.

Recommendation 77

This recommendation relates to reducing the need for patients' travel. It states:

- That, wherever possible, Tasmania uses contemporary technology to obviate the need for patient travel. To that end, DHHS should approach the Australian Department of Health and Ageing and other agencies to explore using Telehealth and the National Health Call Centre Network to reduce the need for patients to travel.

The Government has accepted this recommendation.

Health-related accommodation

Recommendations 78 to 86

These recommendations concern health-related accommodation. The CSP identified the accommodation needs of patients, families and carers as important considerations in the delivery of health services. This is particularly the case for patients (and their families/carers) travelling long distances to access services.

The CSP recommended developing innovative solutions to provide accommodation to patients, their families and carers, and for investing in accommodation options in or near public acute hospitals and health facilities.

The Banscott Report confirms the findings of the CSP, and recommends that the Government address the need for accessible and affordable accommodation for patients, their families and carers.

The Report suggests that, regarding accommodation in Launceston, the Government:

- Makes funding of up to $90 000 available for the installation of bathrooms in the three large bedrooms on the Ground Floor of Spurr Wing in Launceston General Hospital.
- Negotiates with selected accommodation providers in Launceston with a view to having special discounted hospital rates offered to patients and their families and carers.
- Considers contracting with a private sector developer for the provision (by new construction or by redevelopment of an existing building) of a specified number of rooms in Launceston suitable for patients and their families/carers, with DHHS guaranteeing occupancy.
- Also considers addressing health-related accommodation shortages with the construction of self-contained motel-style accommodation in various configurations for 20 people on land adjacent to Spurr Wing (with the building administered as part of Spurr Wing), and/or by contributing towards the cost of the proposal developed by the Tasmanian Cancer Council.

The Government has accepted these recommendations. In relation to the third recommendation, DHHS will consider guaranteeing occupancy of a specified number of rooms, should this become necessary.

The Report suggests that, regarding accommodation in Hobart, the Government:

- Negotiates with selected accommodation providers in Hobart with a view to having special discounted hospital rates offered to patients and their families and carers.
- Considers contracting with a private sector developer for the provision (by new construction or by redevelopment of an existing building) of a specified number of rooms in Hobart suitable for patients and their families/carers, with DHHS guaranteeing occupancy.
- Also considers addressing health-related accommodation shortages by providing assistance to an appropriate NGO by way of a suitable surplus government-owned building or a suitable building purchased by or constructed for the government, with the recipient to manage the enterprise.

The Bone Marrow Donor Institute (BMDI) has leased a facility on the corner of Murray and Bathurst Streets to provide low-cost quality accommodation for up to 21 patients, their family members and carers travelling from the North and North West to Hobart for medical treatment.

The BMDI has requested a $70 000 capital grant to provide proper fit out of the facility.

The Government has accepted these recommendations, and has already provided funds of $70 000 to meet the BMDI's request. In relation to the second recommendation, DHHS will consider guaranteeing occupancy of a specified number of rooms, should this become necessary.

The Report suggests that, regarding accommodation in Burnie, the Government:

- Considers establishment of additional, low-cost accommodation for patients, their families and carers, with maximum community involvement in the project while keeping costs and charges to an acceptable level.
- Negotiates with selected accommodation providers with a view to having special discounted hospital rates offered to patients and their families/carers.

The Government has accepted these recommendations.

In addition, the Report recommends that:

- Consulting-room staff at major acute hospitals be encouraged to set aside blocks of time in the middle of the consulting day for appointments required for people from remote locations.
- DHHS ensures clinicians in Tasmanian public hospitals widely disseminate information about the availability of PTAS.
- PTAS Coordinators compile comprehensive lists of accommodation near hospitals that offer concessional rates to patients, and make those lists readily available online and through brochures and information sheets.

The Government has accepted these recommendations, subject to the need to operate sustainable, effective and efficient clinical services.

Residents of Bass Strait Islands

Recommendations 87 to 91

These recommendations relate to matters affecting residents of the Bass Strait Islands. They include:

- The Government using part of the $10 million Federal Government election commitment to purchase appropriate patient transfer and lifting equipment, in order to improve patient transport. This equipment to be installed at airport facilities as necessary.
- The PTAS Review Committee, in consultation with the King Island Council and key clinical decision makers from each Hospital, develop a policy detailing the circumstances under which residents of King Island obtain clinical services from Victoria rather than from Tasmanian hospitals and specialists. These circumstances should include the primary clinical reason to seek treatment elsewhere, the proximity of appropriate support networks, as well as any other considerations.
- The Tasmanian Government to commence immediate negotiations with the Victorian Government, with the aim of accepting King Island as an approved border area. This would enable residents to join the Ambulance Service Victoria Membership Scheme, thereby entitling them to utilise Victorian air ambulance services between King Island and Victoria.
- DHHS to ensure that arrangements covering cross-border charging are in place and appropriately applied to King Island residents treated in Victorian public hospitals.
- The Communications Centre establishes a 24 hours per day, 7 days a week phone number for use by people from isolated areas (including King Island and the Furneaux Islands) who are discharged from hospital (including Emergency Departments), and require assistance in obtaining overnight accommodation and/or transport home. This number should be prominently displayed in all hospitals, and be widely advertised to clinicians and primary health centres.

The Government acknowledges the links that the King Island community has with Victoria. Tasmania's Health Plan provides for services for King Islanders on the Island and links patients to appropriate services on the mainland of Tasmania.

The Government has committed $5 million over four years to improve the King Island Health Centre. The Government supports discussions with the Victorian Government on approved border areas, however, the decision on where a patient should receive treatment will be made by the PTAS Review Committee, taking into account patients' clinical needs first and foremost and other considerations as they see fit. The Government supports developing a policy in consultation with King Islanders.

In relation to the first recommendation, the Government acknowledges that lifting equipment already exists at some airports and will appropriately resource areas of need.

The Sharley Review of Tasmanian Medical Retrieval Services – Summary of findings and recommendations

The Sharley Review found that Tasmania requires a more rapidly responsive service than is the current practice. Accordingly, the Review has developed recommendations to bring the service up to a sustainable level consistent with national standards.

The TMRS currently has use of one fixed-wing plane, based in Launceston, through a contract with the Royal Flying Doctor Service (RFDS). It also pays for use of a Tasmania Police contracted helicopter on a case-by-case basis. The helicopter is based at Hobart Airport.

While not all retrieval missions are time critical, the relatively slow retrieval response to support smaller rural hospitals is of particular concern. This reflects a lack of suitable transport resources, rather than the quality of staff involved.

The Review found that dependence on one fixed-wing plane for retrieval operations reduces flexibility, increases system fragility and impairs the ability to respond rapidly to the need for retrievals from many locations in Tasmania.

The Review's preferred model is to locate TMRS and Neonatal Emergency Transport Service (NETS) staff at the Royal Hobart Hospital (RHH), using the helicopter based in Hobart, with the fixed wing plane remaining in Launceston at least for the duration of the current contract.

The Review recommended that there be increased use of the Hobart-based Tasmania Police helicopter for retrieval activity, as this would be cheaper than buying a second fixed-wing plane to be based in Hobart, or a second helicopter based in Launceston.

The Review also recommended that DHHS review the existing helicopter contract prior to its expiration, and in so doing considers the health needs of the whole State.

The Review recommended that the fixed-wing plane remain in Launceston at this stage to service the larger requirement for non-retrieval air ambulance activity in the North. The location of the fixed-wing should be reviewed when the current RFDS contract expires.

The Review also recommended that patients originating at the Launceston General and Mersey Community Hospitals and requiring medical retrieval to the RHH – whether by TMRS and NETS – be transported by helicopter as the preferred mode of transport.

The Review recommended that the TAS Communications Centre in Hobart coordinate statewide medical retrieval services by all modes of transport. To this end, a senior clinically trained ambulance officer should be based at the TAHTS Communications Centre for at least 14 hours a day, seven days per week.

In response to the Review, DHHS has been working with the TMRS, Tasmania Police and clinicians across the State to develop the Action Plan.

The Government accepts the recommendations of the external review.

Appendix A

Government Action Plan and Timetable

	Implementation Commitment	Timeframe
	Financial assistance	
1	That the accommodation allowance payable to approved Patient Travel Assistance Scheme (PTAS) recipients be set from 1 July 2008 at a rate equivalent to 50 per cent of the overnight accommodation allowance rate payable to Tasmanian Government employees under the Community and Health Services Award (CAHSA), namely: • $45.85 within Tasmania for each overnight absence from home; and • $64.05 outside Tasmania for each overnight absence from home. *The Government will round out the sums payable to $46 per night and $64 per night.*	Commencing from 1 December 2008
2	That the fuel subsidy payable to approved PTAS recipients be set from 1 July 2008 at a rate equivalent to 50 per cent of the occasional user less than two litres rate payable to Tasmanian Government employees under CAHSA, namely: • 19.435 cents per kilometre. *The Government will round out the sum payable to 19 cents per kilometre respectively.*	Commencing from 1 December 2008
3	That the accommodation allowance and fuel subsidy rates payable to approved PTAS recipients be adjusted in line with changes in the CAHSA.	Ongoing
4	That, to be eligible for PTAS, a patient must: • be a permanent resident of Tasmania, and be required to travel more than 75 kilometres one-way by the shortest practicable route to access the nearest appropriate specialist medical service, or more than 50 kilometres one-way by the shortest practicable route to access the nearest dialysis/oncology treatment centre; • be referred to the nearest appropriate specialist in the particular specialty by a medical specialist or by an oral/maxillofacial surgeon or by a rural GP; and • be an approved recipient (i.e. be approved for receipt of PTAS benefits by a Clinical Authoriser).	Ongoing
5	That, except as provided in Recommendation 6 below, the PTAS accommodation allowance and fuel subsidy be made available only to approved recipients who hold an Australian Government health care or pensioner concession card (cardholding patients) and their approved escorts, and to such other classes of patients as the PTAS Review Committee shall, from time to time, include on a list of eligible recipients. *The Government will continue to make PTAS benefits available to eligible patients who are not cardholders.*	*Not accepted*
6	That the PTAS accommodation allowance be made available to approved non-cardholding recipients/escorts (including approved non-cardholding transplant recipients/donors and escorts) who are required for clinical reasons to pay for accommodation in the vicinity of an eligible specialist medical service either within Tasmania or interstate for periods in excess of four nights on any occasion of PTAS supported travel, with the allowance being paid for each night after the fourth night on each such occasion. *The Government does not support an additional burden placed on non-cardholders of having to pay for four nights' accommodation prior to accessing the subsidy – the existing criteria of non-cardholders paying for two nights' accommodation will therefore be retained.*	*Not accepted*

	Implementation Commitment	Timeframe
7	That PTAS payment of air/sea/ground transport charges be made available to any approved recipient/escort who is: • a resident of King Island or of the Furneaux Islands required to leave the island to access an eligible specialist medical service either within Tasmania or interstate; or • a permanent resident of Tasmania required to travel interstate to access an eligible specialist medical service that is not available in either the public or private sector in Tasmania.	Ongoing
8	That PTAS payment of air/sea/ground transport charges require a co-payment from cardholding patients of $15 per trip with a maximum contribution of $120 for each financial year, with the co-payment and ceiling being adjusted each year on 1 July in line with movements in the Australian Government's age pension.	Commencing from 1 December 2008
9	That PTAS payment of air/sea/ground transport charges require a co-payment from non-cardholding patients of $120 per trip with a maximum contribution of $480 for each financial year, with the co-payment and ceiling being adjusted each year on 1 July in line with movements in the Commonwealth age pension. ***The Government does not support additional financial hardship for non-cardholders who are distanced from medical services, and will continue to apply the existing criteria of $75 per trip with a maximum of $300 for each financial year to non-cardholders.***	*Not accepted*
10	That, wherever possible, patients experiencing financial difficulty with the initial outlay to cover payment of air/sea/ground transport charges be assisted by the PTAS use of a pre-payment system using, for example, vouchers, tickets or advance bookings.	By January 2009
11	That PTAS expenditure be no longer made from the global public hospital budgets, but be separately appropriated as a separate line item within the DHHS portfolio budget.	From 1 July 2009
12	That the PTAS budget allocation be managed by a Statewide PTAS Administrator working under the direction of, and responsible in all PTAS matters to, the PTAS Review Committee.	Appointment of PTAS Administrator by December 2008
13	That the Statewide PTAS Administrator provide a detailed annual report on PTAS, and that the report be published as part of the DHHS annual report.	Ongoing
14	That the number of Clinical Authorisers be limited to three (one in each of the major hospitals), with each Clinical Authoriser consulting where required with the chair of the PTAS Review Committee and being supported by and working with the relevant PTAS Coordinators.	By January 2009
15	That a senior clinician be appointed chair of the PTAS Review Committee and be provided with an appropriate level of administrative support.	By January 2009
16	That, where possible, regional PTAS Coordinators be located in DHHS premises away from the three major hospitals. ***The Government accepts this recommendation in principle, but will assess the practicalities and effect on patient access before implementation.***	Ongoing
17	That the PTAS Review Committee be reconstituted to consist of a senior clinician as chair, three Clinical Authorisers, three PTAS Coordinators, and the Statewide PTAS Administrator as Executive Officer and Secretary.	By February 2009
18	That the role of the PTAS Review Committee include: • management of the PTAS budget appropriation; • responsibility for the administration, management and on-going review of the scheme; and • responsibility for the review and issuing of the guidelines and policies under which the scheme operates.	Part completion by November 2008 Refer Recommendation 12 Full Recommendation completion by July 2009

	Implementation Commitment	Timeframe
19	That Coordinators and others involved in the administration of PTAS be obliged to adhere to the guidelines and policies as approved and promulgated by the Review Committee.	By April 2009
20	That, consistent with the provisions of Recommendations 5 to 9 inclusive, where a hospital in-patient is required to travel intra or interstate for treatment that is not available at the patient's hospital, any costs of transport, medical retrieval or air ambulance in relation to the patient be allocated against the hospital's budget and not against the PTAS budget.	Ongoing
21	That, consistent with the provisions of Recommendations 5 to 9 inclusive, where one or more escorts are approved to accompany a hospital in-patient required to travel intra or interstate for treatment that is not available at the patient's hospital, any travelling costs or allowances/subsidies met in relation to the approved escort(s) be allocated against the PTAS budget.	By July 2009
22	That, except where specified below or in Recommendation 4, the eligibility criteria continue to include a provision requiring an eligible recipient to have to travel more than 75 kilometres (one-way) by the shortest practical route to access the nearest appropriate specialist.	Ongoing
23	That, wherever possible, a course of treatment involving multiple visits to a specialist or to a treatment centre require only a single approval, with periodic review by the relevant Clinical Authoriser/PTAS Coordinator, and that, once approval is given, the patient be entitled to make appropriate claims against that approval throughout the duration of the course of treatment.	1 December 2008
24	That PTAS be excluded from the Department's travel arrangements, and that PTAS Coordinators be required to obtain the cheapest available flight on each occasion.	By July 2009
25	That, subject to the provisions of Recommendation 4, the eligibility criteria be amended to provide that cardholding patients travelling to the Launceston General Hospital for renal dialysis treatment from Scottsdale, Deloraine or George Town be eligible to receive travel allowance. ***The Government accepts the recommendations regarding minimum travel distances, however, as noted in Recommendations 5, 6 and 9, the Government will continue to make PTAS benefits available to eligible patients who are non-cardholders through the existing criteria.***	*Not accepted*
26	That, subject to the provisions of Recommendation 4, the Royal Hobart Hospital cease offering travel allowance to patients residing within the Hobart metropolitan area, but that the eligibility criteria be amended to provide that cardholding patients travelling more than 50 kilometres to Royal Hobart Hospital for renal dialysis treatment be eligible to receive travel allowance. ***The Government does accept recommendations regarding minimum travel distances, however, as noted in Recommendations 5, 6, 9 and 25, the Government will continue to make PTAS benefits available to eligible patients who are non-cardholders through the existing criteria.***	*Not accepted*
27	That, subject to the provisions of Recommendation 4, cardholding oncology patients travelling more than 50 kilometres to the Launceston General Hospital or Royal Hobart Hospital for treatment be eligible to receive travel allowance. ***The Government does accept recommendations regarding minimum travel distances, however, as noted in Recommendations 5, 6, 9, 25 and 26, the Government will continue to make PTAS benefits available to eligible patients who are non-cardholders through the existing criteria.***	*Not accepted*
28	That Departmental and Government consideration be given to the establishment of a statewide renal service (to include dialysis), and to the delivery through that service of quality renal care and dialysis as close to home as possible, always following rigorous assessments of safety and sustainability, with the necessary investment in hardware, people and their education, and in partnerships with communities and health facilities.	Commence immediately

	Implementation Commitment	Timeframe
29	That Departmental and Government consideration be given to: • the establishment of a statewide chronic disease service; • the management through that service of secondary and tertiary prevention of diabetes, cystic fibrosis, chronic obstructive pulmonary disease, and other complex and chronic conditions; and • the delivery through that service of chronic disease management services as close to the community as possible, and within a coordinated team framework.	Commence immediately
30	That PTAS continue to regard both organ donors and organ recipients (as well as approved escorts) as eligible for assistance, subject to the application of the cardholder patient requirements for receipt of travel allowance and fuel subsidy.	Ongoing
31	That PTAS Clinical Authorisers continue to make decisions relating to the provision of assistance to patients participating in clinical trials on an individual basis, subject to the application of the cardholder patient requirements for receipt of travel allowance and fuel subsidy.	Ongoing
32	That PTAS eligibility be expanded to cover Lymphodema treatment and specified clinical services to be listed by the PTAS Advisory Committee covering dental and orthodontic services, mental health services, physiotherapy services, and rehabilitation services.	Commence for Lymphodema on 1 December 2008 Commence for other services on 1 July 2009
33	That members of the PTAS Review Committee and PTAS Coordinators develop and maintain a program of regular visits to rural medical practices to provide information about PTAS.	Ongoing
34	That relevant patients be advised about PTAS at their initial medical consultation wherever there is likelihood that travelling and/or accommodation expenses are likely to be incurred during the course of their treatment.	Ongoing
35	That PTAS Coordinators ensure that medical practitioners, specialists and the Tasmanian Divisions of General Practice are kept informed about PTAS, and that medical practitioners, specialists, and their staff are encouraged to provide appropriate information to relevant patients.	Ongoing
36	That the PTAS brochure be updated and extensively revised in consultation with consumers, with the brochure clearly detailing the eligibility criteria and the benefits claimable, and that the revised brochure be made widely available, especially through PTAS offices, hospitals, healthcare providers, medical practices, and through Service Tasmania, as well as being easily accessible online.	1 December 2008
Transport coordination		
37	That the Southern non-emergency patient transport service be augmented with additional appropriate vehicles as soon as practicable.	1 December 2008
38	That a fully integrated statewide Patient Transport Service be part of the Tasmanian Ambulance Service.	By March 2009
39	That the statewide Patient Transport Service retain operational bases located in Hobart, Launceston, and Burnie, with each of those bases being located at the Tasmanian Ambulance Service station in the area to maximise the benefits of the linkage.	Ongoing
40	That the Patient Transport Service be a separate business unit within the Tasmanian Ambulance Service with a manager of statewide Patient Transport Service appointed.	By July 2009

	Implementation Commitment	Timeframe
41	That the operations of the Patient Transport Service units be coordinated from a central location, namely the Tasmanian Ambulance Service Communications Centre, with the head of the Communications Centre (with appropriate clinical input) determining eligibility for transport, and the type and provider of the transport to be provided.	By March 2009
42	That the Non-Emergency Patient Transport Policy be reviewed and revised in accordance with the recommendations of this Review, and be reissued with a view to achieving consistency and uniformity across the State.	By March 2009
43	That, irrespective of their proximity to a treatment centre, non-emergency patient transport be available for transporting cardholding patients for renal dialysis, chemotherapy and radiotherapy, with the Communications Centre making decisions on the allocation of patient transport based on availability and accessibility of resources. *The Government does accept that non-emergency patient transport be available to patients requiring these treatments, however, does not accept that access be restricted to cardholders only – the existing criteria for cardholders will be applied to non-cardholders.*	*Not accepted*
44	That the current role of hospital staff in booking non-emergency patient transport be changed so that hospital staff be required to book all patient transport through the Communications Centre.	By March 2009
45	That the staffing for the Communications Centre be sourced from the existing staff operating the Tasmanian Ambulance Service Emergency Communications Centre.	By October 2008
46	That additional staffing positions be allocated for the operation of the Communication Centre, with the positions funded by a transfer of resources from current transport related areas of hospitals and other government areas and, only as a last resort, requested from Treasury.	By July 2009
47	That the Communications Centre established pursuant to Recommendation 5 be developed and implemented as an integrated, coordinated and managed communication centre for all patient transport in Tasmania.	By March 2009
48	That the Communications Centre operate 24 hours a day, 7 days a week, 365 days a year, but that non-emergency transport coordination services and community transport services operate from 7am until 10pm, 7 days per week, every day of the year, except Christmas Day, Good Friday and Easter Sunday.	By March 2009
49	That all non-emergency patient transport in Tasmania be allocated and dispatched from the central Communication Centre.	By March 2009
50	That the Communication Centre be a development of the existing Tasmanian Ambulance Service Emergency Patient Transport Communications Centre, be managed by the Tasmanian Ambulance Service, be located in Hobart, but be relocated to enable the required new staff and equipment to be suitably accommodated.	Ongoing
51	That a manager be appointed to take responsibility for the development of the detailed planning and specifications for the development of the Communications Centre.	Ongoing
52	That an advisory committee, consisting of all relevant stakeholders, be appointed to oversee the development and implementation of the Communications Centre.	Ongoing
53	That the allocation and dispatch of community transport for the Tasmanian Cancer Council, Australian Red Cross Society, Community Transport Services Tasmania and other Home and Community Care (HACC) funded non-government agencies be coordinated from the central Communication Centre, and that a Community Transport Manager be appointed to the Communications Centre to ensure an appropriate interface between the Centre, service providers and DHHS.	By February 2009

	Implementation Commitment	Timeframe
54	That, in the allocation of community transport, Communications Centre staff be linked to a Community Transport Access Centre that will undertake the necessary assessment of eligibility for HACC-funded transport and provide details thereon to the Communications Centre prior to allocation of a vehicle.	Ongoing
55	That, wherever possible, community transport be used for transporting patients for renal dialysis, chemotherapy and radiotherapy, and patients being transported to and from nursing homes.	Ongoing
56	That the Communications Centre be staffed with appropriate senior management personnel to provide 24-hour supervision, command and control of the Centre.	Ongoing
57	That the Communication Centre have an appropriately qualified Clinical Support Officer on-site for monitoring and/or making transport related clinical decisions, that all clinical decision comply with the clinical governance standards of the Tasmanian Ambulance Service, and that 24-hour on-call access to an experienced senior medical officer be available to the Clinical Support Officer.	By June 2009
58	That any decision regarding whether and when to book a privately operated patient transport service rather than non-emergency Patient Transport Service be made and actioned solely by the Communications Centre.	Ongoing
59	That, in accordance with Cabinet's decision in November 2000 not to outsource public work, the Tasmanian Ambulance Service, as the government funded and operated service, be the preferred service for the allocation of non-emergency patient transportation.	Ongoing
60	That private service providers be used for the provision of non-emergency patient transport only when Tasmanian Ambulance Service services are not available.	Ongoing
61	That private providers be licensed, with DHHS strictly monitoring the licences.	Ongoing
62	That private providers be chosen only from a panel of approved providers maintained by DHHS, with listing on the panel of approved private providers being subject to contestable renewal every five years.	Ongoing
63	That the current Computer Aided Dispatch (CAD) system be upgraded to cope with the increased workload of the Communications Centre.	Completed
64	That the Communications Centre be developed through the purchase of an existing and currently available computer software program, currently being used in coordination and call centres at a national and/or international level for administering non-urgent patient transport and community transport systems.	By December 2008
65	That the development of specifications for the purchase of computer systems for the Communications Centre take account of systems currently used or planned for use by the other emergency services in Tasmania, thus leaving open the possible longer-term co-location of all emergency communication functions in Tasmania.	Ongoing
66	That, as part of the upgrade of the functionality of the Communications Centre, the government purchase vehicle navigation, identification and tracking capacity.	Ongoing
67	That an advanced medical priority dispatch system (eg Pro QA) be implemented to ensure that the dispatch algorithm is at industry best practice standard, and investigate the possibility of funds being available from Commonwealth sources for this development.	Immediately
68	That the development of the operating system for the Communications Centre include capacity to link case information generated by the Communications Centre's system to the management information system, thereby ensuring that allocation of resources, service decision-making, and research is based on solid data.	Ongoing

	Implementation Commitment	Timeframe
69	That there be an examination of the options available to achieve direct communication between ambulance personnel at the accident/emergency scene and medical staff at receiving hospitals.	Ongoing
70	That the radio and paging systems in emergency ambulance and patient transport vehicles be upgraded to increase system reliability and coverage.	Ongoing
71	That a computerised billing system be developed and implemented as part of the operational system of the Communications Centre.	Ongoing
72	That charges for each form of patient transport be standardised and regulated by DHHS, and to facilitate this, that the 2001 KPMG Report on Competitive Neutrality be reviewed and reset in line with current costs of operating transport services.	Ongoing
73	That a review be undertaken of the training and performance development needs of communications personnel, with the review using, as a starting point, the recommendations of the Report by Andrew Climie in 2007.	Ongoing
74	That specific training programs for Communications Centre staff be introduced, with training available to staff both prior to their commencing work in the Communications Centre and as regular in-service training programs, and with the training including both systems and clinical material.	Ongoing
75	That service standards regarding response times and required levels of utilisation of government funded transport resources be developed.	Ongoing
76	That two additional non-emergency patient transport crews for Southern Tasmania be recruited.	By December 2008
77	That every attempt be made in Tasmania to make the fullest possible use of contemporary technology to obviate, wherever possible, the need for travel, and that an approach be made by DHHS to the Australian Department of Health and Ageing and other appropriate agencies to explore the joint development of initiatives utilising, for example, Telehealth and the National Health Call Centre Network to reduce the need for patients to travel.	By July 2009
Health-related accommodation		
78	That the Department open discussions with Spurr Wing with a view to making funding of up to $90 000 available for the installation of bathrooms in the three large bedrooms on the Ground Floor.	1 December 2008
79	That consideration be given to the establishment in Burnie of additional, low-cost accommodation for patients/families/carers using a model that maximises community involvement in the project while keeping costs and charges to an acceptable level.	By March 2009
80	That consulting-room staff at major acute care hospitals be encouraged to set aside blocks of time in the middle of the consulting day for appointments required for people from remote locations.	By December 2008
81	That DHHS ensure that clinicians at Tasmanian public hospitals widely disseminate information about the availability of PTAS, and PTAS Coordinators at Tasmanian public hospitals compile comprehensive lists of accommodation near hospitals or offered at a concessional rate to patients and make those lists readily available through brochures, information sheets, which are also accessible online.	1 December 2008

	Implementation Commitment	Timeframe
82	That DHHS: • negotiate with selected accommodation providers in Hobart, Launceston and Burnie with a view to having such providers offer a special discounted hospital rate to patients and their families/carers; and • give serious consideration to contracting with a private sector developer for the provision (by new construction or by redevelopment of an existing building) of a block of rooms in Hobart and/or in Launceston suitable for patients and their families/carers, and that the Department guarantee occupancy of a specified number of rooms. *The Government accepts this recommendation in principle, but will consider the need to guarantee a specified number of rooms, if it becomes necessary to do so.*	Completed Ongoing
83	That DHHS consider addressing health-related accommodation shortages by: • the provision in Hobart of assistance to an appropriate non-government organisation by way of the provision of a suitable surplus government-owned building or a suitable building purchased by or constructed for the government, with the recipient required to apply an appropriate management model to the enterprise; and • the development in Launceston of additional accommodation by either utilising land adjacent to Spurr Wing for the construction of self-contained motel-style accommodation in various configurations for approximately 20 people, with the building administered as part of Spurr Wing, and/or by contributing towards the cost of the proposal developed by the Tasmanian Cancer Council.	By 2015 By December 2010
84	That the redevelopment of the Royal Hobart Hospital make provision for appropriate, on-site (or nearby) accommodation facilities to be incorporated into the planning and design of the new hospital.	In line with new RHH timelines
85	That the redevelopment of the Royal Hobart Hospital make provision for a medi-hotel to be incorporated into the planning and design of the new hospital.	In line with new RHH timelines
86	That responsibility for, and hospital-based staff and resources devoted to, the provision of financial assistance, transport coordination and health-related accommodation be transferred to the Department's Health Services Group, and that a provider unit be established within that Group to manage and coordinate all patient travel, transport and accommodation services.	By July 2009
Matters affecting King Island residents specifically		
87	That appropriate patient transfer and lifting equipment (wheelchairs, lifting platforms) be purchased using part of the $10 million recently committed by the Australian Government to provide funding of patient transport in Tasmania, and be installed at airport facilities as necessary. *The Government acknowledges that lifting equipment already exists at some airports and will appropriately resource areas of need.*	By December 2009
88	That the PTAS Review Committee be requested to draw up, within three months and in consultation with the King Island Council, a policy detailing the circumstances under which residents of King Island obtain clinical services from Victoria rather than from Tasmanian hospitals and specialists. These circumstances should include the proximity of appropriate social/family support networks, as well as clinical and financial considerations. *The decision about where a patient should receive treatment will be made by the PTAS Review Committee, taking into account patients' clinical needs first and foremost and other considerations as they see fit. The Government supports developing a policy in consultation with King Islanders.*	By February 2009

	Implementation Commitment	Timeframe
89	That immediate negotiations be opened between the Tasmanian and Victorian Governments leading to an agreement whereby King Island is accepted as an approved border area enabling residents to join the Ambulance Service Victoria Membership Scheme, thereby entitling them to utilise Victorian air ambulance services between King Island and Victoria. *The decision about where a patient should receive treatment will be made by the PTAS Review Committee, taking into account patients' clinical needs first and foremost and other considerations as they see fit. The Government supports developing a policy in consultation with King Islanders.*	By March 2009
90	That DHHS ensure that arrangements covering cross-border charging are in place and are appropriately applied to King Island residents treated in Victorian public hospitals. *The decision about where a patient should receive treatment will be made by the PTAS Review Committee, taking into account patients' clinical needs first and foremost and other considerations as they see fit. The Government supports developing a policy in consultation with King Islanders.*	Ongoing
91	That, as part of the coordination arrangements recommended elsewhere in this Report, a 24 hours per day, 7 days a week telephone number be established within the Communications Centre to be used by people from isolated areas (including King Island and the Furneaux Islands) who are discharged from hospital or from emergency departments and who require assistance in obtaining overnight accommodation and/or transport home. This number should be prominently displayed in all hospital emergency departments, and be widely advertised to clinicians and primary health centres.	By March 2009
Tasmanian Medical Retrieval Services (TMRS)		
1	DHHS to fund three full-time equivalent (FTE) Senior Registrar positions at the RHH for the TMRS. One registrar in the Anaesthesia Department, one in the Intensive Care Unit and one in Emergency Department is proposed (1.0 existing, 2.0 FTE new).	By December 2009
2	The RHH neo-natal emergency transport service (NETS) receive DHHS funding for a Senior Registrar to assume the responsibilities of retrieval staffing, quality assurance, data collection and reporting demands (1.0 FTE new).	By December 2008
3	DHHS fund the equivalent of two FTE Consultant positions for retrieval duties (1.5 FTE existing, 0.5 FTE new).	By December 2008
4	Flight paramedic training be extended to embrace the role of retrieval paramedic in the Doctor/Paramedic team setting but not to increase independent paramedic activity in place of retrieval medical staff.	Ongoing
5	The use of hospital transport vehicles to support retrieval operations be investigated.	Ongoing
6	Royal Flying Doctor Service fixed wing to remain in Launceston for the duration of the current contract.	By 2011
7	DHHS need to confirm adequate accident insurance coverage for staff working in retrieval medicine. Coverage specific to helicopter and fixed wing duties is required.	By December 2008
8	Review of the helicopter contract is indicated. The renewal of the helicopter contract should involve ambulance and health at the highest level. A whole-of-government helicopter contract is proposed.	By December 2010
9	The RHH requires a helipad. Plans to rebuild the RHH must include a helipad at its earliest stage of conception.	In line with new RHH timelines
10	Development of a helipad at the Mersey Community Hospital.	March 2009
11	A rapidly responsive helicopter and road retrieval capability to be developed out of the RHH.	By September 2009

Implementation Commitment		Timeframe
12	An additional secure emergency oxygen supply source to be located in the BK 117 helicopter. An internal supply is preferred.	By October 2008
13	The medical equipment used in retrieval and air ambulance duties undertaken by helicopter and fixed wing must be standardised.	By December 2009
14	The TMRS medical equipment inventory requires an overhaul. The TMRS medical equipment should be located with the TMRS team.	By March 2009
15	Emergency Departments at the Launceston General and Burnie Hospitals require sufficient equipment, monitors and human resources to provide occasional safe local retrieval in their region.	By March 2009
16	A uniform retrieval charge to the region of referral should be considered. This should be independent of the mode of transport used.	By July 2009
17	A TMRS Cost Centre be formed and supported by the appropriate administrative and resource accountant expertise. This cost centre should be placed with those responsible for its management.	By July 2009
18	A senior Tasmanian NETS representative be confirmed on the TMRS Committee.	By July 2008
19	The fragmentation and duplication of fixed wing and helicopter clinical coordination should be eliminated through centralisation to Tasmanian Ambulance Service (TAS) Communications.	By April 2009
20	A senior, experienced, clinically trained ambulance officer to be based in TAS Communications in Hobart for at least 14 hours per day.	Refer Recommendation 57
21	A DHHS website be developed to list policies, procedures and guidelines relevant to critical care retrieval, including the NETS policies.	By July 2009
22	Databases with a common minimum data set complete with incident monitoring should be established for TAS air ambulance, TMRS and NETS missions.	By December 2009
23	Formation of a subcommittee of DHHS TMRS Committee to identify risk exposures, system problems and potential solutions. The subcommittee should review data, problem cases, system issues and generate a risk register. Meetings should occur at least quarterly.	By October 2008
24	The preferred model for the TMRS is to have TMRS and NETS staff based in the RHH. The fixed wing would remain based in Launceston (for the present) with the helicopter to remain based in Hobart.	By 2011
Other related North and North West initiatives		
1	Upgrading Queenstown Airport to allow fixed wing planes to land and take off safely.	By December 2009
2	Enhancements to existing primary health services for rural and remote locations.	By 2012
3	Augmenting non-emergency patient transport services with five additional vehicles.	Refer Recommendation 37 By July 2009
4	Contribute funding to the Bone Marrow Donor Institute's Hobart facility enabling low-cost accommodation for up to 21 patients, with a need to travel from the North and North West.	Refer Recommendation 82 completed
5	Refresher training and backfill for King and Flinders Island GPs.	By 2012
6	Establish helipads where they can be shown to be cost effective and improve services.	By 2011

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