Australian Allied Health Professionals led Telehealthcare: Key lessons for Scotland

Lesley Holdsworth, PhD, FCSP DPT
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AHP Director, NHS 24
Lesley.holdsworth@nhs.net
SUMMARY

This report summarises the information collated whilst undertaking a Winston Churchill Memorial Trust (WCMT) Travel Fellowship. The information was obtained from a range of meetings and experiences with key stakeholders throughout Victoria and Queensland, Australia during April – May 2011. The aim of the fellowship was to research the experience of Allied Health Professionals (AHPs) providing healthcare through the use of technology and distill the learning to inform the future direction of healthcare delivery in Scotland.

Key Findings from the Fellowship

- The issues that challenge current health care delivery in Australia are very similar to those currently faced by the United Kingdom although currently fiscal constraints are not so pressing in Australia.
- There is a collective recognition that telehealthcare is a proven mechanism through which a range of healthcare solutions can be delivered and particularly so in remote areas.
- The agenda requires policy support in terms of direction and resources to support its implementation.
- Telehealthcare is warmly accepted by recipients in Australia who value its availability. Despite this however, it is not mainstreamed and application is ad hoc and therefore relatively unknown. There needs to be greater public awareness to overcome this.
- There are recognized challenges associated with telehealthcare that Australia is also working through. These relate to:
  - Infrastructure to support
  - Data definitions and data security
  - Workforce education and training
- There are opportunities for future collaboration between a number of AHP telehealthcare initiatives and Scotland particularly the work being taken forward by the University of Queensland.

Acknowledgements

I would like to offer my sincere thanks to the Winston Churchill Trust for the support they made available that allowed me to undertake this most enlightening tour. In particular, the personal support provided by Mr. Jamie Balfour and Mrs. Julia Weston during the planning, undertaking and follow up. I am indebted to the WCT for their foresight in sustaining this scheme. The Trust can be assured that I will use the new knowledge learned and the networks established to further the telerehabilitation agenda in Scotland. The legacy I believe will be long lasting and directly benefit the people of this country.

I would also like to include a mention of Keith Holdsworth who was one of the first recipients of a WCT fellowship in 1966, a fact only learned while undertaking my own fellowship. Keith is a distant relative of mine living in Melbourne for the last 50 years who was responsible for establishing the Guide Dogs for the Blind Training Centre in Australia.

I cannot forget to acknowledge my husband Richard for his continued long suffering support and understanding of the need for me to be absent from home for these weeks, I am a lucky lady.
BACKGROUND TO THE PURPOSE OF THE FELLOWSHIP

The Allied Health Professions consist of ten individual professions (*Arts Therapy, Dietetics, Occupational Therapy, Orthoptics, Orthotics, Physiotherapy, podiatry, Prosthetics, Radiography and Speech and Language therapy*). There are 9,745 AHPs working within the NHS in Scotland (ISD, 2010) in the full range of settings with patients of all ages. They perform functions of assessment, diagnosis, emergency care, treatment and discharge throughout the care pathway – from primary prevention through to specialist disease management and rehabilitation and are, in the main, first-contact practitioners. Although involved in the management of many conditions, AHPs’ principle activity focuses on rehabilitation and amelioration and particularly so with regard to long term conditions.

NHS 24 is a special Health Board in Scotland with responsibility for providing both emergency out of hours care for the country as well as pursuing the use of technology to support the delivery of a range of healthcare delivery options. NHS 24 is committed to the on-going development of systems and approaches using available and emerging technologies that not only improve access generally but also support direct access to an expanding range of healthcare professionals. To support this aim, in October 2010, NHS 24 appointed an Associate Director for Allied Health Professions (AHPs) to drive and shape this agenda.

WHAT IS TELEHEALTH? some definitions

**Telehealth** is the provision of health services at a distance using a range of digital technologies. Examples of telehealth include video consultations to support diagnosis and management, clinical networks and health professional education.

**Telecare** is the remote or enhanced delivery of care services to people in their own home or in a community setting by means of telecommunication and computerised services. Telecare usually refers to sensors and alerts which provide continuous, automatic and remote monitoring of care needs, emergencies and lifestyle changes using information and communications technologies (ICT) to trigger human responses or shut down equipment to prevent hazards.

**Telehealthcare** is the convergence of telecare and telehealth to provide a technology-enabled and integrated approach to the delivery of effective, high quality health and care services. It can be used to describe a range of care options available remotely by telephone, mobile, broadband and videoconferencing.

**Telerehabilitation** is telehealthcare that focuses on the provision of rehabilitation.

We are living in a technological age. The use of technology to support the delivery of healthcare has been recognized by the National Health Service in Scotland as crucial to improving access, providing person-centred support and treatment for a range of conditions as well as a mechanism through which to support the continuing professional development of the workforce. At present, we have yet to grasp its full potential with initiatives that do
exist tending to be isolated and not mainstreamed from a national perspective. Telehealthcare offers wide ranging opportunities and not only for remote communities. It also needs to be recognised that the NHS throughout the UK is experiencing significant challenges in terms of its ability to deliver high quality healthcare to its population during fiscally constrained times. Telehealthcare does offer one potential solution to addressing this challenge.

THE PURPOSE OF THE FELLOWSHIP

The purpose of the fellowship was to learn from the experience of AHP telehealthcare considerations and service delivery in two regions of Australia, Victoria and Queensland to inform the developing Scottish AHP strategy. This included exploring issues such as national data definitions, data security, confidentiality and supporting technology from a government perspective. It also involved spending time with national professional organisations exploring professional issues, considerations, experiences and solutions associated with telehealth AHP healthcare delivery. A particular focus was placed on professionalism, leadership, public awareness strategies, patient and carer issues, training and education.

Time was also spent with key researchers who have and are undertaking significant research in relation to AHP telerehabilitation to learn from their experience and develop contacts for potential future collaborations. Visiting field sites, spending time with practicing clinicians and healthcare commissioners gaining their insights and experiences, seeing and experiencing systems in action in Queensland. This also included spending time with patients and their families gaining an insight into their issues and establishing the level of confidence they have in such systems and suggestions for improvements that Scotland should consider.

Currently in Scotland, we are utilizing technology to support the redesign of musculoskeletal services and how patients gain access to these services. This approach has attracted global interest including interest from Australia. During my fellowship, I also engaged with those who had expressed interest in our progress, sharing experiences and mutual interests.

KEY FINDINGS FROM THE FELLOWSHIP

What follows is a chronological account of my time in Australia, documenting the key meetings, visits, summary conclusions and key learning points.

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION, MELBOURNE, VICTORIA

The first working day was spent with the Australian Physiotherapy Association in Camberwell, Melbourne learning about their current issues. The session was organised by Jonathon Kruger, Policy Manager and Victoria Branch President, Sarah Brentnall. Physiotherapy in Australia, in terms of education, approach and ethos resonates well with current UK physiotherapy issues. It has to be noted however that due to the funding structure within Australian healthcare systems, the development of the profession in terms of extended roles has not attained the level currently experienced within the UK although this agenda is being swiftly
progressed. Control of access and actual treatment options is still more explicitly outwith the sphere of the profession although this is changing but has resulted in a slower adoption of extended roles. UK physiotherapist have a greater degree of professional autonomy, they can accept referrals from patients directly even within the NHS system and determine the content and duration of their treatment. Progress in Australia is not so advanced, primarily due to the fact that 50% of healthcare is funded through the private sector which relies heavily on the input and patronage of doctors. APA were most keen to learn about the experience in the UK and key issues that could assist in speeding up this process.

Discussions about the role of physiotherapy and telerehabilitation focused around the position statement published by the APA in 2010.


The APA position
It is the Australian Physiotherapy Association’s (APA) position that:

- Telerehabilitation offers significant benefits to physiotherapists and their clients and can improve access to physiotherapy services
- While there are many benefits to the use of telerehabilitation, care must be taken to ensure client safety and appropriateness of treatment when choosing to deliver physiotherapy services through telerehabilitation
- Appropriate, evidence based technologies should be chosen to deliver telerehabilitation services
- Technical standards, specifications and clinical guidelines on the use of telerehabilitation need to be developed
- Governments and third party payers should provide rebates for telerehabilitation services
- Government assistance should be provided to physiotherapists wishing to invest in telerehabilitation equipment
- Telerehabilitation is a useful complement to local rehabilitation services but should not be considered a substitute for the employment of physiotherapists based in the community
- Inequities between remote, rural and metropolitan health services must be addressed to ensure access to telerehabilitation services.

In the evening, at the request of the Victoria Branch of the APA, I gave a presentation to approximately fifty physiotherapists, members of the Melbourne branch about the Scottish landscape and the developments we are taking forward at NHS 24. A simultaneous article was also published within the national professional magazine (append 1)
Summary Conclusions and Key Learning Points

- The UK and Australian physiotherapy professions share many common issues
- Extended professional roles are not as advanced within Australia but this agenda is being progressed. Australia is keen to learn from the UK experience
- Telerehabilitation is fully supported by the APA who are clear about the potential benefits this can bring
- There remain professional challenges in determining the technical specifications and clinical guidelines for practicing telerehabilitation
- At present, there is no formal inclusion within undergraduate training programmes in Australia of telerehabilitation practice
- Current telerehabilitation initiatives throughout Australia are isolated, ad hoc and mainly occur within more remote areas
- There is a desire to look at mainstreaming approaches through telerehabilitation
- Future interest in collaborating in relation to these issues was expressed

VICTORIA GOVERNMENT: DEPARTMENT OF HEALTH, WORKFORCE DEVELOPMENT UNIT

Healthcare workforce planning and considerations throughout the state of Victoria are under the control of the Department of Health’s workforce team based at 50 Lonsdale Street, Melbourne. The team comprises of clinical leads for nursing, medicine and the AHPs with generic project managers and administrative support. Organised by Kathleen Philip who heads the AHP team, they provided me with an overview of their work programme. With respect to all professions, there are considerable challenges in terms of preparing and supporting the workforce to practice using and through technological media. These relate to not only a different range of required competencies but also culture, custom and practice. This had been recognised federally although progress to address these issues are in their infancy. Positively from the Scottish perspective, we have agreed to share progress, resources and key learning resources and experience into the future. I also shared a presentation about key issues in Scotland, policy context and the work of NHS 24.

The medical, nursing and AHP Workforce Victoria State Clinical Leads
The time in Melbourne also included a 7am breakfast meeting organised by the Victoria Workforce Unit. The event was attended by approximately 50 people, representing all healthcare disciplines at The Rydges Hotel on Exhibition Street. International futurologist, Mark Pesce provided an overview that aimed to stimulate thinking re innovation with technology at the fore. Key observations were that to date, like many countries, the state of Victoria has not embraced technology universally and its use is in its infancy. This position is not helped by the fragmentation of their approach across the primary – secondary interface. I shared the UK experience which has placed a major emphasis on providing seamless services based around the whole patient journey lessening the divide between hospital and primary care and the considerable efforts we have made to try to address this. It would appear that services in Victoria have a long way to go to achieve this approach to patient care and that although technology could support many of the individual processes, if the overall system is fragmented, there is limited value from both the patients and clinicians perspective.

Summary Conclusions and Key Learning Points

- Victoria has recognised the challenges associated with workforce development and the use of technology
- The current infrastructure does not fully support the requirements
- AHPs, unlike their medical and nursing colleagues do not receive the same degree of federal support for technological health solutions
- Issues such as training and education to support such practices are in their infancy
- Considerable efforts are being made to address these challenges
- Future collaborations and sharing of resources have been agreed

THE NATIONAL E-HEALTH TRANSITION AUTHORITY

The National E-Health Transition Authority Limited (known as NEHTA) was established by the Australian, State and Territory governments to develop better ways of electronically collecting and securely exchanging health information. [http://www.nehta.gov.au/](http://www.nehta.gov.au/)

During my time in both Melbourne and Brisbane, I was able to explore with a number of key NEHTA personnel their current work programme, key challenges and areas of interest. A particular global challenge associated with the use of technology in the healthcare setting relates to ensuring that information is collated, stored and transmitted securely. They are
seeking to introduce across Australia electronic patient records by July 2012 which is a federal government pledge. It would appear from all the conversations that this timeline will pose a considerable challenge. Key observations are that Scotland is battling with similar challenges but on a more manageable scale. I met with a number of people including Kathy Dallest (pictured left) who heads up NETHA’s clinical safety division. Kathy previously worked for the Scottish Government in ehealth and I have worked on a number of national projects with her in the past. We were able to discuss the direct relevance of the Australian and Scottish issues which are broadly similar and have agreed to continue to share our experiences into the future. Kathy spoke of the pace of the current reforms and the problems with having no nationally defined terminology and definitions which hindered the approach. The national clinical e-health leads group meet regularly but their agenda is self rather than externally determined which can be productive but does also pose the problem of driving things forward at a federal level with each lead having a slightly different view of the overall agenda.

Kathy also feels that there is a lack of clinical input within the 300 plus members of NEHTA, the majority of whom are IT focused with little or no previous knowledge of the health service. This again poses a problem for them in ensuring that the agenda is fit for purpose and that system development is in alignment.

Further meetings with key national leads including national e-health clinical lead Dr Mukesh Hakerwahl, Louise Shafer (AHP lead), Jo Thomson (clinical engagement) and David Stokes (psychology lead) to continue the general discussion. Louise had recently undertaken a study looking at the barriers AHPs face in using technology which is of great interest and has agreed to share the findings of this report with Scotland. Key summary findings from the Australian experience resonate with the challenges the UK face and are being considered within the Scottish Strategic Framework.
Summary Conclusions and Key Learning Points

- NEHA has an ambitious programme of work particularly in meeting the government target of introducing an electronic health record by July 2012
- There are considerable challenges to overcome in relation to data encryption and security
- Terminology and definitions need to be nationally agreed
- AHPs in Australia report similar challenges to the use of technology as those expressed by UK AHPs
- AHPs are not being supported financially to the same extent as doctors and nurses to meet this agenda

A PIONEER OF PHYSIOTHERAPY PRACTICE

Whilst in Brisbane, Queensland, I was most privileged to be able to spend a couple of days with Prue Galley. Prue is a veritable legend within the physiotherapy profession. It was during the early 1970's that Prue instigated and led the debate that resulted in the rescinding of the physiotherapy code of conduct in Australia and led to the introduction of first point of contact practitioner status being conferred on the profession. What this meant in practice was that for the first time, a patient could refer themselves to a physiotherapist without having to have a referral from a doctor.

This represented a major development in terms of professional autonomy of global importance.

The work that Prue spearheaded in Australia was followed shortly afterwards by a similar change in the UK in 1978. Prue was working in the UK at that time and contributed to the overall efforts taken forward by the Chartered Society of Physiotherapy. I had had the opportunity to meet with Prue previously on a trip to Australia in 2005. Since the late 1990's my personal research interest has been in establishing the efficacy of patient self referral, and I have undertaken studies and led trials on a national and international basis. The findings from this work provided for the first time, clear evidence about the appropriateness of self referral into public systems of healthcare as a mode of access. I spent time with Prue at her impressive ‘Queenslander’ house, going through her considerable archive. Prue has made this available to me and I brought much of this most
interesting material back to Scotland with the intention and Prue’s blessing to pull together an overview for publication. From this archive, it was clear that the fight for professional autonomy at that time was significant and challenging. Prue encountered significant opposition in taking forward this quest during the period 1973-76 and, somewhat surprisingly even from her own peers to the detriment of her own professional career. This is a story that needs to be told so that future generations of physiotherapists and other healthcare practitioners know about the fight for autonomy and the details around the historical birth of the modern day profession. I envisage that this will keep me engrossed until the end of the year. She is a lady of immense courage and character with a story that needs to be told and heard. I will do my best to honour this tremendous legacy and feel humbled by the fact that she has bestowed this honour (and responsibility) on me. I now count her as a dear friend with whom we share such common interests, We, the physiotherapy profession and the public who refer themselves directly to physiotherapists and myself personally, have much to thank her for. The World Congress of Physiotherapy meets every four years. This year, 2011, the venue was Amsterdam which I attended to witness Prue receiving a much deserved lifetime achievement award. I have also recorded an interview with this tremendous lady which can be viewed in two parts on YouTube at:

http://www.youtube.com/watch?v=1xWTrGI6EhpE
http://www.youtube.com/watch?v=gAS4s_ZTarA&feature=mfu_in_order&list=UL
I spent a number of days with key researchers from the University of Queensland in Brisbane exploring a range of telehealth issues.

Getting to work University of Queensland style!

And arriving….. Similarly
Dr Anne Hill is a senior researcher at the University of Queensland National Telehealth Research Unit.

In 2009-10, Anne spent a year in Scotland commissioned by the Scottish Centre for Telehealth to undertake a national scoping report into the opportunities for telerehabilitation. The report [http://www.sctt.sctot.nhs.uk/pdf/rehabreport.pdf](http://www.sctt.sctot.nhs.uk/pdf/rehabreport.pdf) contains 15 key recommendations which I have used to inform the thinking about our future strategic direction in Scotland. It is a seminal piece of work and a comprehensive report that identifies current work and future opportunities aligned to national policy. The session with Anne had two primary aims:

1. to discuss the Hill Report and Anne’s thoughts on Scottish telerehabilitation, and,
2. to discuss her current research focus, an RCT in the use of Lee Silverman Voice Therapy in Parkinson’s patients

Anne’s experience of developing the report she reported as a positive one and involved her visiting all over Scotland sourcing material, views and experience. We discussed the key recommendations and the context of healthcare in 2011. I outlined the current vision for telehealth generally and telerehabilitation specifically. We also discussed the current approach which focuses on four key priority areas and the intention to use Anne’s recommendations to support the development of our approach. I informed Anne about progress since the publication of her report and provided her with a copy of my paper endorsed by NHS 24’s Board in response to the report which identified which of the key recommendations we will be focusing on in the first instance.

Anne is currently involved in a three year randomised controlled trial looking at the clinical and cost effectiveness of the Lee Silverman Therapy (LSVT) approach to delivering speech and language therapy to Parkinson’s patients. The LSVT is an approach that has been proven to deliver positive outcomes for these patients and is in fact, the treatment of choice. It does however require an intensive regime which is time consuming for therapists who often have to travel to patients homes to administer the therapy. Many services in Scotland do not offer this as a therapy due to demand on their capacity. I had been specifically approached by a number of speech and language therapists to explore any potential opportunities in using telehealth to administer this type of therapy could have and to bring back this learning to Scotland.

The aim of Anne’s trial is to establish the clinical and cost effectiveness of delivering the programme via three arms

1. telehealth in the patients own home in rural settings
2. The same but in urban settings
3. Normal face to face therapy.

Anne believes that telehealth could be an ideal medium to deliver this therapy as the system can measure quantifiably changes in the voice to monitor progress and inform treatment options, is easy for patients to use and enables the clinician to deliver intensive therapy at a distance with considerable time savings. The software package and computer system is used by both clinician and patient and allows for the transmission of data to
monitor progress and outcomes. Patients report ease of use, convenience, confidence and increased compliance. The aim is to recruit 75 patients and is due to complete in 2013. I was given a guided tour of the system and shown how the software works in practice when I observed a patient therapy session, with the patients full consent. I was able to speak with the patient and ask them about their own experience. The patient, Mr A reported being ‘most lucky’ to be part of the trial and having the system installed in his house. He reported that he felt that he was able to access far more therapy through this medium. He also reported that he would have experienced problems getting to a conventional clinic due to his mobility problems and infirmity of his wife. He reported that having the system at home had been a ‘total godsend’ and that he intended to give it his ‘all’.

Preliminary results from the trial support appear to support its application through the use of telehealth and have identified considerable benefits in terms of patient adherence, acceptability and cost effectiveness with no compromise to outcome.

These key points will be brought back to Scotland and further discussions held as to the opportunity to replicate this work and forge international collaborations.

Professor Deborah Theopolous and Dr Trevor Russell

The National Telehealth Research Unit was founded in 2000. It exists to carry out and report on research into telerehabilitation with a specific emphasis on measuring outcomes remotely. The unit has developed the ‘ehab’ system which is a portable and mobile system used with a range of connection options including dial up. This is especially useful in remote areas where there is commonly poor broadband coverage. Of particular potential interest to Scotland, the ehab system has been extensively trialled and validated with a number of disciplines including: physiotherapy, Occupational therapy, Speech and language therapy and Audiology. Trevor indicated however, that it had wider applicability to any number of professions. The system can make a number of measurements which assist in assessment and on-going progress monitoring via a software package which takes a range of measures from a web cam. It can also record static and movement measures via optical measurement. This includes gait, motion and linear measurement including functional and spinal sway. Its validation involved comparing the reliability against manual measures. It requires minimal patient interaction and minimal patient and/or clinician training. A patent has been granted within Australia under the medical devices scheme

Ehab is being actively used in a number of settings throughout Queensland. In Toowoomba 6 units are being used to support transitional care. It forms the basis of an 8 week rehabilitation package and is being used by both therapists and nurses. It was the focus of a two year trial with impressive outcomes and has now been mainstreamed. There are also 6 units being used in Cairns although the emphasis is slightly different. Its being used more as a staff support tool for high needs patients. It is also being used in the islands to undertake remote consultations. Other users include Tasmania, Bluecare and the Cerebral Palsy League who are using it to undertake wheelchair assessments and prescription in more remote settings. This has reduced the time to receipt of wheelchair form 18 months to 3-6 months. They are also using the system in nursing homes with healthcare assistants.
who have received a degree of training via the system to support patients with swallowing problems.

Professor Theopoulous and Dr Russell reported that there had been a significant increase in interest in telerehabilitation over the last 2 years from healthcare commissioners, clinicians and patient representative groups who have all expressed a desire for its increased use. Feedback about their system has been positive with significant benefits reported by patients and therapists in being able to ascertain and use measures to inform care in real time with the additional functionality of being a mechanism though which training and education can be delivered. This is a particular advantage for clinicians practising in remote areas who commonly experience problems in accessing continuing professional development opportunities. They see a big future for in a range of applications including current clinical supervision for undergraduates in remote areas.

They also have integrated the issue of technology as a mode of service delivery within the university’s under graduate education programmes and run clinician workshops which are practically and decision focused. These sessions challenge therapists to think about how they could use technology to deliver services and includes a range of everyday technology commonly used in social settings i.e. smart phones, telephones, email, V/C and specific software and systems.

The research team would welcome the opportunity to enter into collaborative research with Scottish sites. I agreed to discuss this further with Scottish colleagues on my return and continue our contact.

Post Note: This I have done and have a group of speech and language therapy managers interested in introducing the system in Scotland. A teleconference to discuss future collaboration has been timetabled for September 2011.

Dr Liz Ward
Royal Brisbane Women’s Hospital

Liz heads up the speech pathology services at RBWH and has developed a telehealth service for patients with dysphagia following laryngectomies. They developed their approach through a study, the results of which were published in 2007 and 2009. The approach involved developing a system for use in a ward or supported home environment and delivered with help of an assistant who would be with the patient. The system is run on a laptop at the bedside which has a split screen to allow the patient to see both the clinician and also themselves to assists auto feedback. The second trial involved a modified system which included a collar microphone to enhance the transmissions of patient voice and noise. The second iteration also included a modified clinical swallow assessment, the use of clear spoons and coloured liquid to ensure the clinician could have as much visual knowledge of all procedures. It also included using tape which is placed over the patients’ neck to allow for movement and the timing of the movement to be viewed.

The original feasibility study involved using across rather than patients. After a positive outcome, ethical approval was granted to allow for a 40 patient trial which concluded at the end of 2010. the results are being written ready for publication. The validation process included patients being assessed by clinicians both remotely and at the bedside. Correlation was high between the decisions with no unsafe decisions being found.

The next step is for a 120 patient study which will start in July 2011, it is anticipated that recruitment of the cohort will take between 12-18 months. One clinic will be held each week and approximately 4 patients assessed during that time. In parallel and at the same time, a further telehealth clinic is being established to provide assessment and treatment to head and neck patients from all over Queensland. Liz reported that there is a full commitment
from the government to support telehealth and that television adverts had reinforced this message. She also feels that telehealth is an ideal medium for many SLT services.

**A CONVERSATION WITH ROD WELLINGTON,**
**Services for Australian Remote and Rural Allied Health  www.sarrah.org.au**

I had the most interesting conversation with Rod who is the Chief Executive Officer of SARRAH, a membership organisation that aims to represent and develop issues for remote and rural AHPs, based in Canberra.

In Australia, 32% of the population live in remote and rural areas, with 3% living more rurally. In Scotland 20% of the population live remotely. It would appear however that the healthcare budget in Australia does not reflect these statistics which Rod wants to see follow this statistic. Under Rods leadership, the organisation has increased its turnover from $5 million to $20 million in three years. Rod talked of the challenges both patients have in accessing therapy and also that of therapists in providing the required care in rural settings. He spoke of how one diabetic educator goes into the ‘bush for two weeks at a time, with her supply of food, a satellite phone and ‘swag’ to deliver services to patients.

Rod spoke about the fact that traditionally AHPs have been the poor third cousin after the doctors and nurses and that still remains the same in terms of gaining financial support. For example, the current investment in telehealth does not include AHPs, although undoubtedly, things are improving. He described the challenges of taking the organisation from a ‘cake store’ to one with business orientation. Impressively, Rod has managed through persuasion and negotiation to gain a seat for SARRAH on the national clinical e-health leads group and also the Medicare board Group, and on the ministerial workforce round forum who are specifically looking at remote and rural issues.

There is a growing focus on patient involvement in healthcare design in Australia and Rod spoke of the newly established Medicare locals which are locally determined groups who have a major emphasis on consumer involvement and engagement, this he believes will help the AHP cause. He thinks that AHPs do see the opportunity of e-health but not telehealth. He also believes that there is the need to focus on the younger workforce offering e-health solution training whilst simultaneously providing continuing professional development, training and support for older workforce. Rod spoke about the need for the development of best practice standards in relation to technology based on the evaluation of initiatives and particularly so in relation to AHPs.

Rod reported that there are two issues for SARRAH AHPs

1. general support, and
2. remote and rural challenges.

There have been significant increases in budgets as a consequence of the Health reform agenda over the last 2 years but there is doubt as to the sustainability in future years.

At the request of the Federal health minister in 2008, an audit into general workforce carried out and identified that AHPs did not substantially figure in remote and rural areas. He wants to see the professions less compartmentalised sharing tasks and tools with other HCPs. He also reported that there are some leadership issues. The question of the quality of AHP leadership was raised and how specific efforts had been made by a number of organisations including AHP Australia in raising the bar.
He spoke about the real challenges around technology or the lack of it. Many AHPs and their patients in rural areas don't even have a phone, mobile reception is poor in remote areas and even between main cities. Regional centres supporting communities of 60-100,000 have no broadband infrastructure, dial up only. He told of the experience at their recent national conference which could not support a live hook up with the health minister due to poor connections. He questions the ability of the network to support HCP activity, how can it be done without this?

Currently, national support for telehealth initiatives only covers doctors, nurses and aboriginal health workers, and doesn't include AHPs as of yet and there is no idea when they will join the table. The government have already put $350 million into national telehealth initiatives but none of the funding was for AHP activities. There is a shortage of doctors in Australia with little idea about who will take on some of their roles although it is well recognised AHPs are well placed to do so.

Summary Conclusions and Key Learning Points

- Services need to be more patient centred
- Improvements are needed to the national technological infrastructure to support remote and rural telehealth
- Under and post graduate education needs to be overhauled
- Greater AHP engagement needs to occur
- The profile of the professions and the role they could play needs to be raised
- Government funding for telehealth initiatives should be open to AHPs

GOLD COAST HEALTH, QUEENSLAND

I was invited by Morven Gemmill to the Gold Coast Health Authority. I know Morven from Scotland where she was AHP Director in NHS Ayrshire and Arran, an AHP by background she now is an Executive Lead with Gold Coast, Queensland Health. Morven had invited me to visit her area to share my experience in leading redesign of musculoskeletal services (MSK) at a symposium was organising. Since moving to the area and undertaking a review of services, Morven had identified that significant benefits were to be realised by redesigning local MSK services and she was keen to start that process. She had also organised for me to meet with clinicians using telehealth. I spent the afternoon with Morven in discussion about Queensland Health and met with her executive colleagues to hear about their strategies, vision and challenges. These chimed well with those current in the UK. What also struck me however was that in terms of models of service delivery, the UK is possibly five or so years more advanced in terms of experience and progress in this respect. A prime example of this, is the continuing focus on secondary care and the need to build bigger hospitals whereas UK policy for the last
decade has focused on building up primary care and focusing care away from reducing hospital based services for many reasons including cost and a recognition of the value in ‘demedicalising’ our approach to care.

We were joined by another longstanding colleague, Dr Rosalie Boyce, Leading Global AHP Strategist from the University of Queensland with whom I have shared experience and undertaken workshops all over the world previously.

All of us spent a further day at Griffiths University planning for the Allied Health MSK Symposium with key organisers from the university. Head of Allied Health, Dr Liisa Laakso took me through their research programme which included elements of utilising telehealth through student placements in remote and rural areas. I was able to see how they delivered clinical supervision via VC, providing students and rural clinicians with access to support and CPD.

The following day, around 95 individuals, clinicians from Queensland Health, policy fora, academia and patient representatives attended the day symposium (appendix 2). The symposium aimed to examine the need for a total redesign of Gold Coast MSK services. I provided the keynote lecture and described to the audience my work in determining the efficacy for self referral and current MSK Scottish related activity which generated a lot of questioning and stimulated debate. The keynote was filmed and screened to other clinical staff not able to attend in person. My observations from the previous few days in terms of models of care was borne out and it was obvious that the audience were grappling with issues we had dealt with over the last few years.

Some of the symposium delegates exploring the redesign process
Summary Conclusions and Key Learning Points

- Queensland Health have recognised the need to redesign MSK services
- Practice and service organisation is not as advanced as in the UK and probably about five years behind
- There are challenges in terms of geography that telehealth could help in providing potential solutions
- Clinicians and patients are keen to make improvements to their services and were keen to hear about the experience from the UK and maintain links into the future

CONCLUSIONS

The WCMT fellowship has been a tremendous, unique and very much valued experience. I was able to spend precious time totally focused on issues which resulted in a substantial amount of information to digest and reflect upon. Although there were many real and potential points of learning for Scotland and for the future direction of AHP telehealth, without a doubt, the greatest personal value was in the networks and contacts made. We recognised a shared agenda, shared challenges and therefore potentially the opportunity to share solutions and, through the use of technology into the future, will be able to stay well and easily connected.

Scotland and Australian AHP telehealth is not so dissimilar. Without a doubt, they have some leading lights who were generous with their time and willingness to share their experiences for which I am most grateful.

I will use this experience, the learning and contacts to help to shape the future direction of AHP telehealth activity in Scotland bringing benefit to many of its citizens.

I am so grateful for this ‘once in a lifetime’ opportunity which I will not squander in terms of its legacy.
What is happening at the NHS in Scotland?

Lesley Holdsworth, WCT Fellow Report June 2011

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