

DELIVERING SAFE AND SUSTAINABLE CLINICAL SERVICES

PATIENT TRANSPORT SERVICES
WHITE PAPER COMPANION DOCUMENT
JUNE 2015



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Foreword

Supporting access to better health services is a key part of the *One State, One Health System, Better Outcomes (One Health System)* health reforms.

The *One Health System* reforms make a number of essential changes to the Tasmanian Clinical Services Profile (TCSP) of our hospital system to enhance the safety, effectiveness, and efficiency of the services that we provide.

This paper outlines the current patient transport services provided in Tasmania and the impact of the changes outlined in the *Delivering Safe and Sustainable Clinical Services White Paper* (the White Paper) on patient transport requirements. It further looks at ways we can help to avoid patients having to travel to services through providing a greater range of outreach services and how better utilisation of eHealth can support the safe delivery of services close to people's homes.

Individuals, the community, health professionals, and organisations that provide patient support across Tasmania have told us that supporting patient transport is a key enabler of the health reforms.

The Government has recognised this and has listened to feedback and that is why we have committed \$24 million to provide better support for patient transport right across the State.

This will support the provision of better aeromedical and medical retrieval services across the State, including for our vulnerable babies. Emergency ambulance services in the North West and non-emergency patient transport (NEPT) in the North and North West will be improved.

New innovative workforce models will be supported through the support of extended care paramedics to provide assessment of low acuity patients leading to better response times for emergencies and diversion of patients from hospital emergency departments in the North.

Community transport options across the North and North West will be improved, to help people access clinic appointments, and for families and friends to visit loved ones in hospital.

Accommodation support will also be improved for patients and families travelling to access health services.

The Government is committed to providing better health services through the implementation of a truly networked single health system. We are also committed to supporting better access to that care by investing in patient transport services around the State.

Hon Michael Ferguson MP

Minister for Health

Summary of Additional Investment in Patient Transport, Accommodation and Coordination

This report outlines expected changes in the demand for patient transport, accommodation, and coordination support in Tasmania. To assist with addressing these changes, the State Government is investing in the following areas:

Emergency Ambulance Service

Commencing 1 July 2016, there will be 12 Ambulance Tasmania (AT) additional paramedics, including relief, employed in Devonport to provide additional emergency and medical coverage during peak periods of operation. The additional investment will see the introduction of an additional day shift and afternoon shift to be combined with the existing staff services.

Total Cost: \$5.4 million

Extended Care Paramedics and First Intervention Vehicle (Launceston)

Commencing 1 January 2016, there will be three additional AT paramedics, including relief, employed in the North as extended care paramedics. The model was successfully trialed by AT in 2014 and won a national innovation award. This highly successful program will now become permanently funded and will result in the provision of a higher level of care for patients in their home and in many cases will avoid direct transfer to hospital emergency departments (EDs).

Total cost: \$1.4 million

Enhancing Tasmania's Retrieval and Referral Services

A new integrated retrieval and referral service will be developed to improve access to timely, high quality care before, during and after transport for trauma victims, critically ill patients, newborns, and children from across the State.

This enhanced service will build on and improve the current aeromedical and retrieval service, the newborn and paediatric emergency transport service (PETS) and the perinatal emergency referral service, with the aim of enhancing coordination between referrers, retrievalist and receiving institutions, optimising resource utilisation and supporting clinical standards of care.

Importantly, governance structures will be established that recognise the continued importance of credentialled expert clinicians in managing retrievals as well as the operational capability to treat and transport patients statewide. The new service will combine:

- medical oversight
- clinical coordination, and
- operational coordination.

Strategic capacity will also be built to ensure the system continues to develop over time.

In addition, to support aeromedical retrievals, the Government will build dedicated helipads at the North West Regional Hospital (NWRH) and the Mersey Community Hospital (the Mersey).

Total cost: \$5.875 million

Extended Hours Non-Emergency Patient Transport

Commencing 1 July 2016, there will be additional funding for supporting NEPT, including out of hours support. This investment will support those areas most impacted by the clinical service changes outlined in the White Paper. A competitive process will be run to ensure the investment delivers maximum value for patient care.

Total Cost: \$0.875 million

Patient and Family Hospital Transport Service

The Government will work with existing transport service providers as part of an upcoming review of bus contracts in the region to establish a low cost bus service for patients and families between the Launceston General Hospital (LGH), the Mersey, and the NWRH.

The service will provide regular low-cost transport services, particularly supporting patients travelling for outpatient appointments or elective surgery, and families travelling to see patients that are receiving care at health facilities outside of their region.

People travelling on the bus will be given priority access to clinics and pharmacy services to ensure they are able to comfortably get on their return bus service.

The transfer lounges in each hospital will also be upgraded to support patients and families that are waiting for the service.

Total cost: \$2.2 million

Enhancing the Patient Transport and Accommodation Scheme and Reducing Travel Demand

A review of the eligibility criteria for the Patient Transport and Accommodation Scheme (PTAS) will be undertaken to ensure that the scheme supports the implementation of the *One Health System* reforms. In particular, this will support patients to travel to the Mersey to access elective surgery.

The administration arrangements will be reviewed to address identified concerns about the difficulty some people have in affording the travel costs up front and waiting for a reimbursement, people being discharged late in the day when transport options were not available, and people being asked to travel for multiple appointments that were not coordinated in a way that meant they could be undertaken on the same day.

Funding will be provided to support capital investment in affordable accommodation for patients and families who must travel for health care. The funds may be used to establish new accommodation options or to upgrade existing accommodation services. A competitive process will be run to ensure that the funding is directed to projects that deliver the best outcomes for patients and their families.

The Government will also invest in reducing the need for patients to travel for services. Additional funding will be provided to upgrade equipment in clinical areas to support the use of telehealth and to review and improve the digital medical record capacity to support the service.

Additional funding will be provided to run a community education program to assist people in making decisions about how best to access their health care.

Total cost: \$8.25 million

Introduction

As part of providing patients with access to better care across the Tasmanian health system, the Tasmanian Government has looked at the ways patients access health services and how they are supported to access the most appropriate care in the most appropriate location.

This involves providing emergency transport to patients who have emergency medical care needs, transporting patients between facilities to access the care that they need, providing transport for people to access non-urgent medical appointments and providing subsidies to support private travel and accommodation where necessary.

In the context of this companion document, Tasmanian patient transport includes the following services:

- emergency transport
 - ambulance service
 - fixed wing service
 - rotary wing (helicopter) service
 - neonatal, paediatric and perinatal emergency transport service
- NEPT
- community transport, and
- PTAS
 - travel
 - accommodation.

Accessing care is not always about requiring the patient to travel to the service. There are other ways to provide access to specialist care:

- taking the care to the patient through health professional travel, or
- delivering care through advanced communication technology.

The *One Health System* reforms will mean our health system will operate as one single statewide system with each hospital having an important but different role to play. Hospitals will specialise in the procedures they are best suited to provide and patients will go to the hospital expert in providing the care they need.

Hospital systems will need to change to give priority to patients who have to travel for specialist appointments and to access timely pharmacy services.

This paper identifies changing patient transport requirements resulting from the reforms. It also raises ongoing issues in the transport systems patients may use to access health care that have been highlighted during the consultation on the White Paper Exposure Draft (Exposure Draft).

Section I: Patient transport - *Bringing the patient to the care*

I. Emergency Transport

Emergency transport is delivered in Tasmania through:

- the emergency ambulance service
- the aeromedical and medical retrieval service by rotary and fixed wing operations, and
- the neonatal and paediatric emergency transport service.

Ambulance Tasmania manages the emergency ambulance service and coordinates the Aeromedical and Medical Retrieval Division (AMMRD).

Adult and paediatric retrievals are currently performed by the AMMRD with a team based in Launceston, while neonatal and limited paediatric retrievals are performed by the Neonatal and Paediatric Emergency Transport Services (NETS/PETS) based in Hobart. The NETS, PETS, and Perinatal Emergency Retrieval Service (PERS) rely on clinical collaboration between AT and the Neonatal and Paediatric Intensive Care Unit (NPICU) based at the Royal Hobart Hospital (RHH).

I.1 Emergency ambulance service

Ambulance Tasmania provides emergency ambulance services across Tasmania through a network of 54 ambulance stations and five community emergency response teams. Twelve stations are staffed with salaried staff, 16 with salaried staff supported by volunteer staff, and 26 with voluntary staff only. The 26 volunteer stations include the community emergency response team stations.

Each year, almost 79 000 ambulances are dispatched across Tasmania, which equates to about 220 each day. Of these, 22 500 are in the North, 18 000 are in the North West and 38 500 are in the South.

Ambulance Tasmania's State Communications Centre deals with all incoming calls for ambulance assistance and dispatches all crews statewide, 24 hours a day, seven days a week. The Centre is co-located with AT's state headquarters in Hobart.

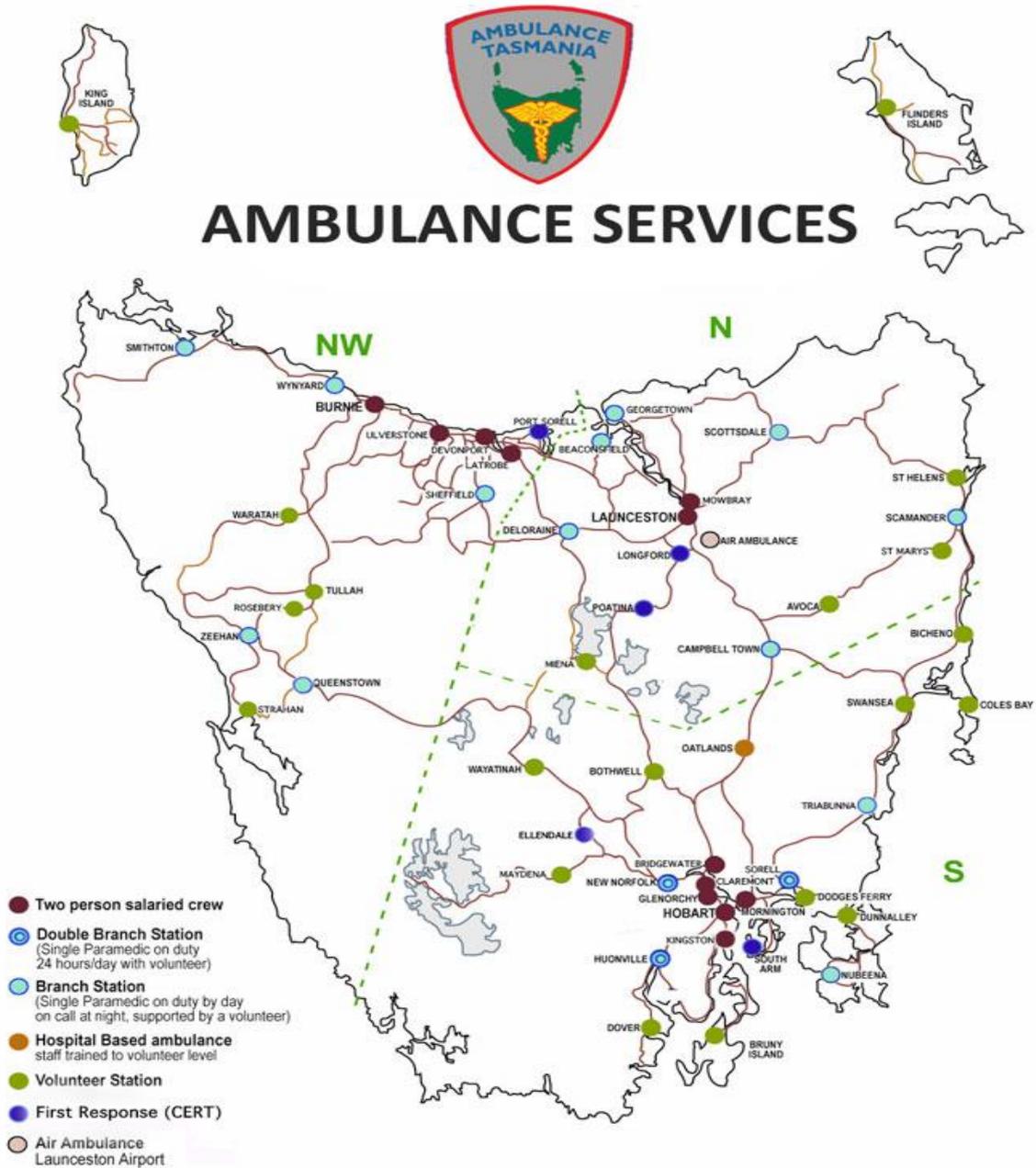


Figure 1: Ambulance service locations¹

¹ http://www.dhhs.tas.gov.au/ambulance/emergency_ambulance, note that Oatlands will be moving to a branch station model during 2015-16.

The emergency ambulance services have experienced growth over the past five years with a 17 per cent increase in ambulance dispatches. The growth has been similar across the three regions.

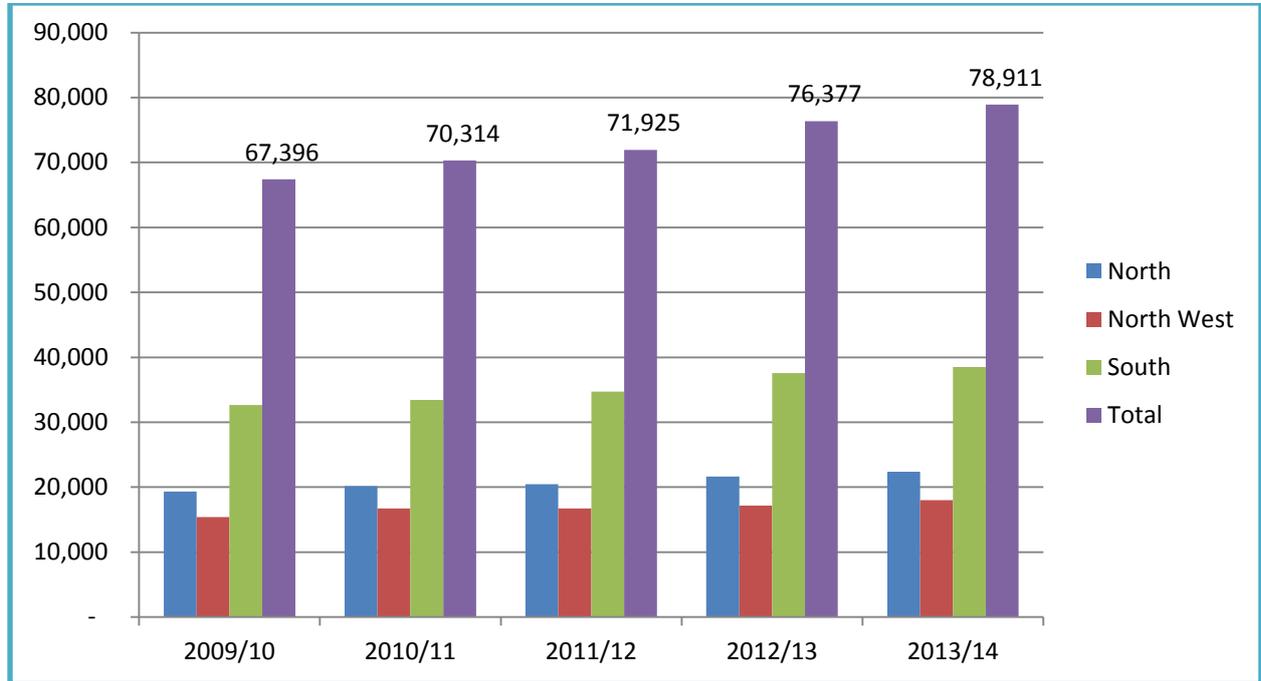


Figure 2: Emergency ambulance dispatches 2009-10- 2013-14, statewide and by region

Source: Ambulance Tasmania internal data

Note: Ambulance dispatches are the number of ambulances dispatched to clinical incidents. This number is greater than the number of incidents because more than one ambulance may be sent to a single incident.

A number of changes in the *One Health System* reforms may change the demand for emergency transport.

Table 1: One Health System changes - potential impact on emergency ambulance demand

| <i>One Health System change</i> | Potential change in emergency ambulance demand |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Formally acknowledge the role of the RHH as a level 6 trauma service for the whole State, rather than only for the southern population. This means that the most serious trauma cases will receive treatment at the RHH.</p> | <p>This may increase demand with a greater number of severe trauma cases being transferred to the RHH. It is likely that the increase in demand will be in the AMMRD.</p> <p>The State Government will provide an additional \$5.875 million to enhance state retrieval and referral services. This will improve access to timely, high quality care before, during and after transport for trauma victims, critically ill patients, newborns and children from across the State.</p> <p>We will undertake targeted consultation with our health workforce and other key stakeholders to consider the most appropriate model of service in this area.</p> |
| <p>The profile of the EDs across the State will change. Patients with serious conditions picked up by ambulance in the North and North West will be transported directly to the NWRH or the LGH, with the possible exception of patients with acute chest pain, who may be stabilised at the Mersey prior to transfer.</p> | <p>This will increase the travel time for the initial emergency ambulance journey; however, this may be offset by a decrease in secondary transfers of patients who currently are taken to the Mersey then require subsequent transfer.</p> <p>An additional \$5.4 million will provide additional emergency ambulance coverage based in Devonport during peak periods of operation.</p> |
| <p>Consolidation of acute overnight medical services in the North West to the NWRH and repurposing the current High Dependency Unit (HDU) service to support elective surgery patients.</p> | <p>There may be a flow on increase in emergency transport required for deteriorating patients and those presenting to the ED requiring overnight admission.</p> <p>An additional \$5.4 million will provide additional emergency ambulance coverage based in Devonport during peak periods of operation.</p> |
| <p>Increased consolidation of complex surgery in the larger hospitals.</p> | <p>There may be an increase in the demand for emergency ambulance transfers of cases requiring complex surgical services.</p> <p>An additional \$5.4 million will provide additional emergency ambulance coverage based in Devonport during peak periods of operation.</p> |

Consolidation of maternity services to one site in the North West at Burnie.

There may be an increase in demand for ambulance transfers of women in labour.

An additional \$5.4 million will provide additional emergency ambulance coverage based in Devonport during peak periods of operation.

1.2 Aeromedical and Medical Retrieval Division

The AMMRD of AT provides inter-facility transport and mobile critical care for patients requiring movement within and outside Tasmania.

Adult and paediatric retrievals are currently performed by the AMMRD with a team based in Launceston. AT utilises a range of transport options for aeromedical and medical retrieval activity, which includes road ambulances, the fixed wing air ambulance, special operations vehicles, and occasionally, the Tasmanian rescue helicopter. Inter-facility transfers are performed by fixed wing aircraft or by road, depending on resources, weather conditions, destination, and patient factors.

A comprehensive external review of Tasmanian medical retrieval services was undertaken in 2007 by Dr Peter Sharley OAM (The Sharley review).² This review made a number of recommendations including that the service continued to be based in Launceston, supported by additional staffing. A consolidation of the management, coordination, and tasking for the service also occurred as a result of this review with these functions being allocated to AT.

A further recommendation of this review was to develop helicopter retrieval capability. This has not been implemented to date.

Table 2: Aeromedical and medical retrieval service: current and five year trend

| | 2011-12 | 2012-13 | 2013-14 |
|---------------------------------|---------|---------|---------|
| Fixed Wing Patients Transported | 1 006 | 1 003 | 1 004 |
| Rotary Ambulance Responses | | | 201 |

Source: Ambulance Tasmania, internal data

Note: Only figures for 2013-14 are available for rotary ambulance responses due to a change in the way the data for these responses is collected.

² Tasmanian Medical retrieval Services external review, Dr Peter Sharley OAM, December 2007

The number of fixed wing responses have remained steady over the three years from 2011-2014. A number of recommendations in the Exposure Draft will have a potential impact on the demand for services. These are outlined in the following table.

Table 3: One Health System changes - potential impact on the aeromedical and medical retrieval service

| <i>One Health System change</i> | <i>Potential change in aeromedical and medical retrieval demand</i> |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Formally acknowledge the role of the RHH as a level 6 trauma service for the whole State, rather than only for the southern population. This means that the most serious trauma cases will receive treatment at the RHH.</p> <p>A feasibility study will be undertaken to determine the infrastructure requirements for the RHH to maintain a level 6 service for the State.</p> <p>The decision of government to provide \$10.5 million for the installation of a helipad at the RHH as part of its redevelopment provides the opportunity to further consider the role of aeromedical retrieval services in Tasmania.</p> | <p>This will increase demand on the aeromedical retrieval services.</p> <p>The State Government will provide an additional \$5.875 million to enhance State retrieval and referral services. This will improve access to timely high quality care before, during and after transport for trauma victims, critically ill patients, newborns and children from across the State.</p> <p>We will undertake targeted consultation with our health workforce and other key stakeholders to consider the most appropriate model of services in this area.</p> |

1.3 Neonatal and Paediatric Emergency Transfer Services

The Neonatal and Paediatric Emergency Transport Service (NETS/PETS) relies on informal clinical collaboration between AT and the RHH NPICU. The NPICU staff provide the clinical care and receive retrieval requests then liaise with AT in relation to the appropriate transport arrangements. This is an essential service with 78 neonatal/paediatric higher acuity retrievals undertaken across Tasmania in 2014 (69 intrastate and 9 interstate).³

The NETS/PETS Working Group within the Women’s, Adolescents, and Children’s Services (WACS) Clinical Advisory Group’s (CAGs) has identified the need to consolidate and formalise arrangements for NETS and PETS to ensure safe, timely retrieval and transfer services for critically ill neonates, children and emergency transport of perinatal women within Tasmania.

It has identified four main challenges to providing retrieval services⁴:

- I Lack of clarity regarding governance and roles and responsibilities of the contributing services, (i.e. role of AT and regional hospitals).

³ NETS/PETS Working Group of the Women’s, Adolescent’s and Children’s Services Clinical Advisory Group - response to the *One Health System Green Paper*.

⁴ NETS/PETS Working Group of the Women’s, Adolescent’s and Children’s Services Clinical Advisory Group - response to the *One Health System Green Paper*

- 2 Lack of formalised leadership roles to implement the requirements of the service.
- 3 Lack of neonatal and paediatric service specifications.
- 4 Lack of dedicated funding for clinical staff to provide safe and efficient retrieval services, in addition to providing an inpatient NPICU service.

Table 4: One Health System changes - potential impact on the neonatal and paediatric emergency transport service

| One Health System change | Potential change in NETS/ PETS |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>In order to bring Tasmania in line with the National Maternity Services Capability Framework, the current levels of services at the LGH and in the North West would not need to change, however, there does need to be a change in the gestational age at which the different services institute a transfer policy for premature infants.</p> <p>The LGH will provide care to infants greater than or equal to 32-weeks gestational age, as there is no neonatologist.</p> <p>The North West will provide care to infants greater than or equal to 34-weeks at the single level 4 maternity service at Burnie.</p> | <p>This will increase demand on the NETS service and associated staffing resources.</p> <p>We will ensure that the service can support the increased demand for neonatal transfers both to higher level facilities and for their return.</p> <p>The State Government will provide an additional \$5.875 million to enhance State retrieval and referral services. This will improve access to timely high quality care before, during and after transport for trauma victims, critically ill patients, newborns and children from across the State.</p> |

2. Non-Emergency Patient Transport (NEPT)

Ambulance Tasmania’s Health Transport Services (HTS) division is responsible for all NEPT across Tasmania. It is an integrated statewide service with a dedicated communications centre based in Hobart.

There is a contribution to the funding for the administration of this service from both the Australian and the Tasmanian Home and Community Care (HACC) services⁵. This funding stream may change over time with changing funding priorities of the HACC scheme.

The HTS transports low-acuity, medically stable public patients without cost to the patient to, from and between health facilities when the patient's condition precludes the use of alternative transport. It forms part of the continuum of care for public patients who require a stretcher or wheelchair, a basic level of care or observation in transit or where the patient's condition prohibits the use of public or alternative transport means. An example of the type of patient this will assist is an elderly resident of a nursing home with limited mobility who requires a minor day procedure in a hospital facility.

The NEPT service was consolidated under AT as part of the implementation of the recommendations of the 2008 Banscott Report.⁶

⁵ From 1 July 2015, the Commonwealth HACC program will be rolled into the new Commonwealth Home Support Program.

At that time there was also a \$2.92 million investment for the lease and fit out of vehicles to “provide suitable patient transport vehicles to improve non-emergency patients’ access to health care services”⁷. Eight vehicles were commissioned as part of this process:

- three bariatric patient transport vehicles, one each in the North West, North, and South that became operational in March 2011
- three wheelchair patient transport vehicles, one based in the North West (operational April 2011) and two based in the South (operational October 2010 and December 2010), and
- two vehicles for the Cancer Council of Tasmania based in the North and North West.

Ambulance Tasmania’s non-emergency patient transport work is supplemented by private providers when the AT service is fully booked or when the service is required after hours and AT resources are not available. In some circumstances, individual health services engage and arrange the private providers to deliver the transport service.

There has been growth in NEPT dispatches arranged through AT of around 18 per cent over the four years from 2010-11 to 2013-14.

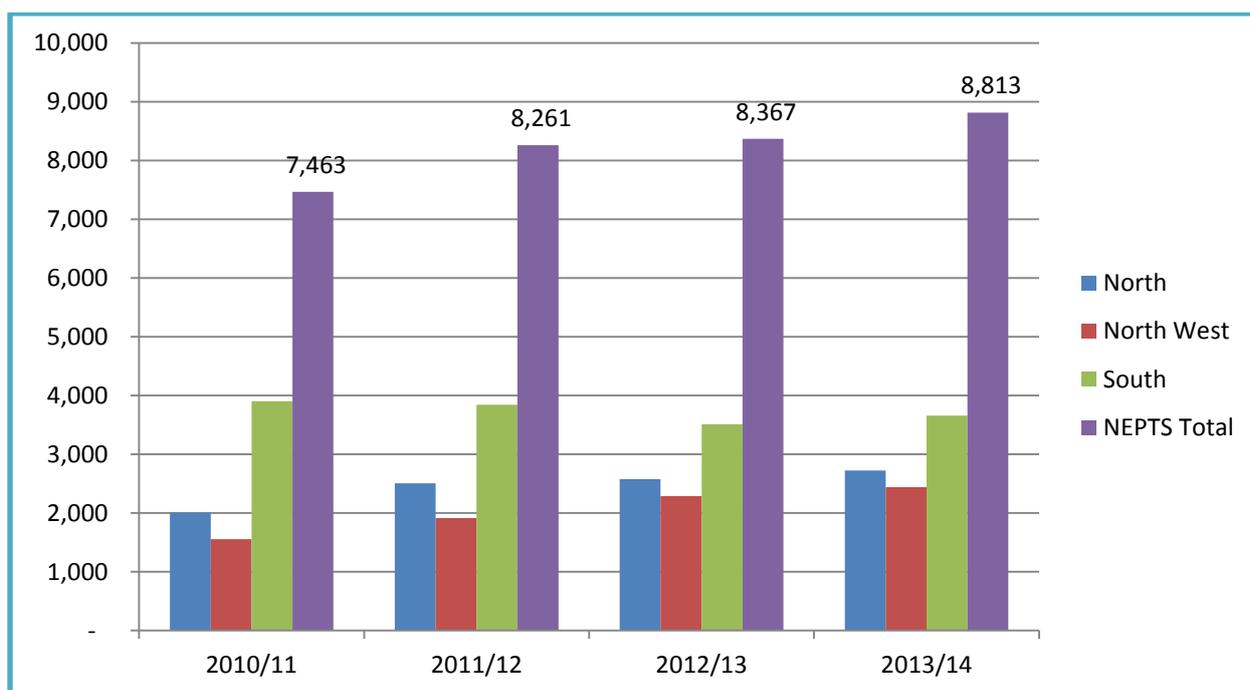


Figure 3: Non-emergency patient transport dispatches 2010-11- 2013-14, statewide and by region

Source: Ambulance Tasmania internal data

Note: Ambulance dispatches are the number of ambulances dispatched and may not be equivalent to the number of patients transported.

⁶ Report of Current Tasmanian Patient Transport Services, Financial Assistance, Transport Coordination and Health-Related Accommodation, Banskott Health Consulting Pty Ltd, 10 July 2008.

⁷ Report of Current Tasmanian Patient Transport Services, Financial Assistance, Transport Coordination and Health-Related Accommodation, Banskott Health Consulting Pty Ltd, 10 July 2008.

Service changes outlined in the White Paper will have a potential impact on the requirement for NEPT.

Table 5: One Health System changes - potential impact on non- emergency transport services

| <i>One Health System change</i> | <i>Potential change in non-emergency transport demand</i> |
|---------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Establishment of subacute care services at the Mersey: geriatrics, palliative care services, and rehabilitation services. | <p>This may increase demand for non-emergency transport from the LGH and the NWRH to the Mersey for these services.</p> <p>The Government will provide \$875, 000 to support NEPT, including out of hours support. This investment will support those areas most impacted by the clinical service changes outlined in the White paper.</p> |

3. Patient Travel And Accommodation Assistance Scheme (PTAS)

PTAS provides financial assistance with travel and accommodation costs for Tasmanian residents to access a range of specialist medical services, where these services are not available locally.

PTAS is able to assist over 30 000 patient trips each year by helping with both travel and accommodation costs for patients and their escorts as appropriate.

The PTAS is a targeted scheme and employs eligibility criteria and co-contribution requirements so that the scheme can support those most in need of assistance.

The PTAS Ministerial Policy states that the level of co-contribution is subject to periodic review and indexed to the annualised increase in the Australian Government aged pension at 1 July each year, commencing 1 July 2014.

When implemented, the changes outlined in the White Paper, are expected to result in significantly fewer occasions of patient travel in and out of the North West, particularly for radiation oncology and elective surgery services. The impact of this on the level of demand for PTAS assistance is not yet clear, but would be expected to change in the same direction.

A number of challenges in accessing PTAS have been expressed through the health reform consultation processes.

PTAS rates and co-contributions increased from 1 July 2014. The scheme remains the most generous in Australia.

Table 6: PTAS rates and co-contributions

| | Current rate |
|--------------------------------------------------------------------|---------------------------------------------|
| Accommodation allowance within Tasmania | \$66 per night |
| Accommodation allowance outside Tasmania | \$87 per night. |
| Fuel subsidies | 21 cents per kilometre |
| Co-contributions for pensioner/health care card holders | \$16.50 per trip, capped at \$132 per annum |
| Co-contributions for non-pensioner/health care card holders | \$82.50 per trip, capped at \$330 per annum |

Eligibility for the scheme currently includes:

- Tasmanian residents who are required to travel interstate to access an eligible specialist medical service that is not available in either the public or private sector in Tasmania
- Tasmanian residents who need to travel more than 75 kilometres one-way within Tasmania by the shortest practical route to access the nearest appropriate specialist medical service or lymphoedema treatment
- Tasmanian residents who need to travel more than 50 kilometres one-way within Tasmania by the shortest practical route to access the nearest dialysis or oncology treatment centre, and
- residents of King and the Furneaux Group Islands who have to leave the islands to access an eligible service.

The eligibility requirements for PTAS will be reviewed to ensure that patients from across State are able to be supported to access dedicated elective surgery services at the Mersey.

Administrative Arrangements

The operational responsibility and management of PTAS currently lies with the Tasmanian Health Service (THS).

A statewide PTAS advisory committee provides clinical advice and recommendations regarding the practical application of PTAS policy.

Medical authorisers are responsible for the approval of all PTAS claims by determining eligibility under the scheme. There are six medical authorisers across the State, all of whom are senior staff specialists.

Patient travel coordinators are employed at each major hospital. They are responsible for providing assistance through booking and paying for travel and accommodation as well as administering the reimbursements to patients in line with PTAS policy.

Patients can either make their own travel and accommodation arrangements, and claim the subsidy upon their return home following specialist treatment, or consult with the local PTAS Coordinator to pre-book travel and accommodation.

Financial Management

PTAS funding is encompassed within the block funding allocation for “non-hospital costs” under the Tasmanian Funding Model.

PTAS funding provides the THS with the capacity to determine whether it is better, both clinically and operationally, to provide required services locally, or to seek alternative, out-of-area solutions with suitable transport and accommodation support.

Activity levels

The number of visits that are supported by PTAS has consistently risen each year, as have the corresponding costs of the scheme. The implementation of the Banscott Report and the decision to increase the PTAS reimbursement rate as well as publicity around the scheme in 2008-09, resulted in a 56 per cent increase in the activity levels between 2008-09 and 2013-14.

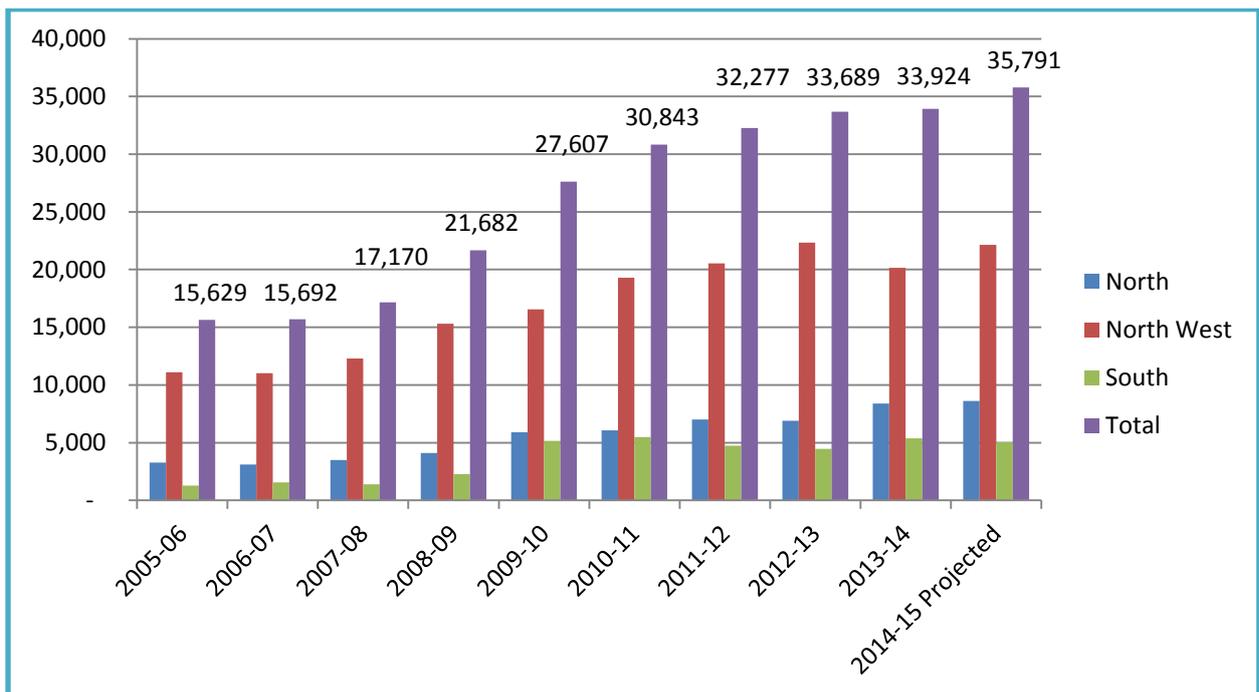


Figure 4: PTAS supported visits by region- intrastate and interstate

Source: Department of Health and Human Services, internal data

Note: 2014-15 utilises data to 31 March 2015. A projection is then made for the full financial year.

The number of supported visits is highest in the North West, indicating that a significant number of medical services are being accessed outside of the region of residence.

This increase in activity has been accompanied by 70 per cent increase in the costs of the scheme, which totalled \$6 million in 2013-14. This reflects a combination of increased activity as well as increases in rates for travel and accommodation over that time, most significantly in 2008-09.

Aside from the eligibility criteria and tiered co-contributions, PTAS is an uncapped scheme that presents financial risk.

Without reform, it is likely that the PTAS activity and consequent costs will continue to grow and place further pressure on resources available to deliver services.

The scale of this growth will be influenced by a number of factors including (but not exclusive to):

- location of services
- future changes to PTAS rates and eligibility
- future health care demand
- increases in use of telehealth, and
- costs of air travel.

The *One Health System* reforms will significantly reduce the level of patient travel in many areas. For example, the establishment of a radiation oncology service in the North West has the potential to reduce the need for travel from the North West to Launceston by 7 500 trips.

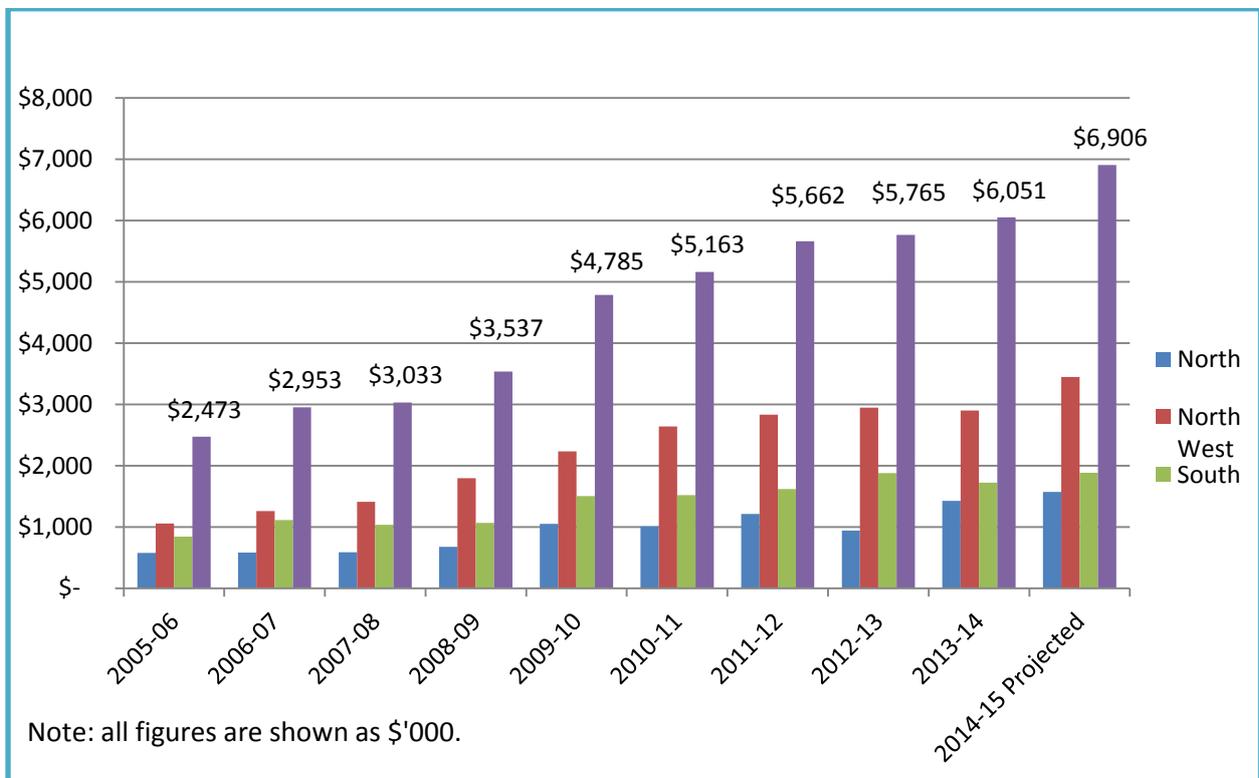


Figure 5: PTAS, Costs by region ('000's)

Source: Department of Health and Human Services, internal data

Note: 2014-15 utilises data to 31 March 2015. A projection is then made for the full financial year.

The majority of PTAS activity is intrastate activity. The proportion of interstate activity varies significantly across the regions, increasing from around 10 per cent in the North West to around 60 per cent in the South.

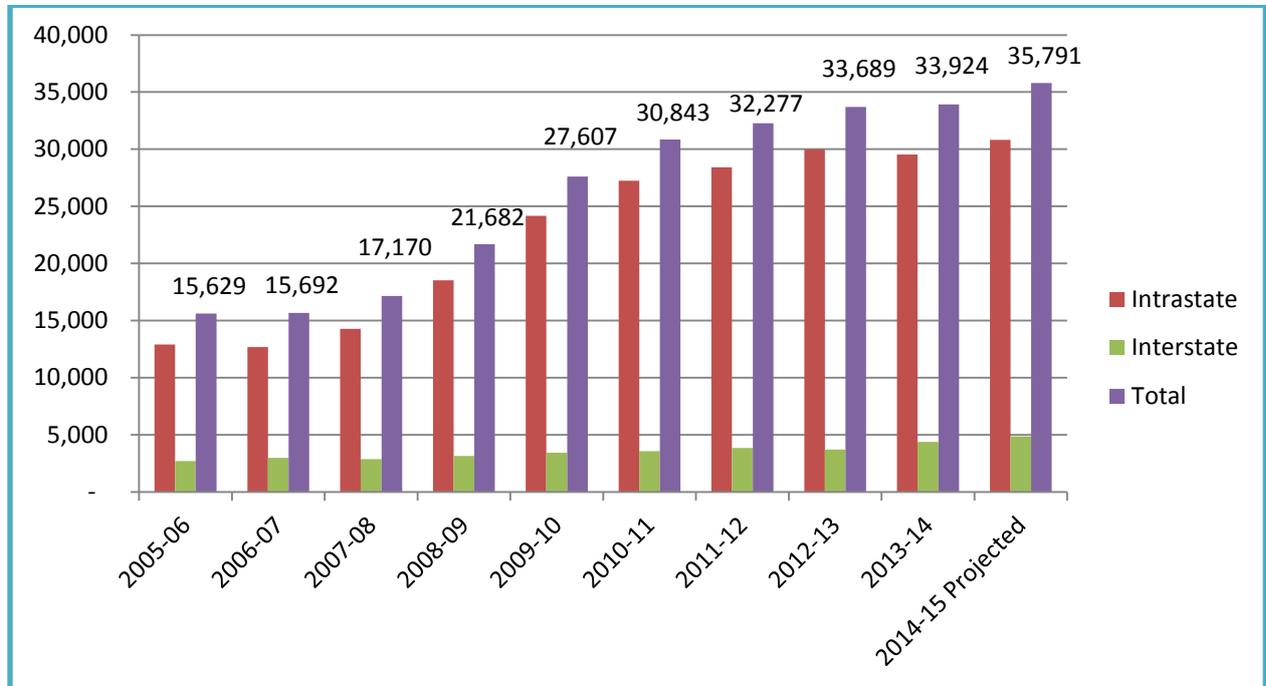


Figure 6: PTAS, supported visits by type (intrastate and interstate)

Source: Department of Health and Human Services, internal data

Note: 2014-15 utilises data to 31 March 2015. A projection is then made for the full financial year.

Given the higher costs of supporting patients to travel interstate for treatment, despite the lower number of visits supported, the total cost to support patient travel for interstate treatment is higher than that for intrastate travel.

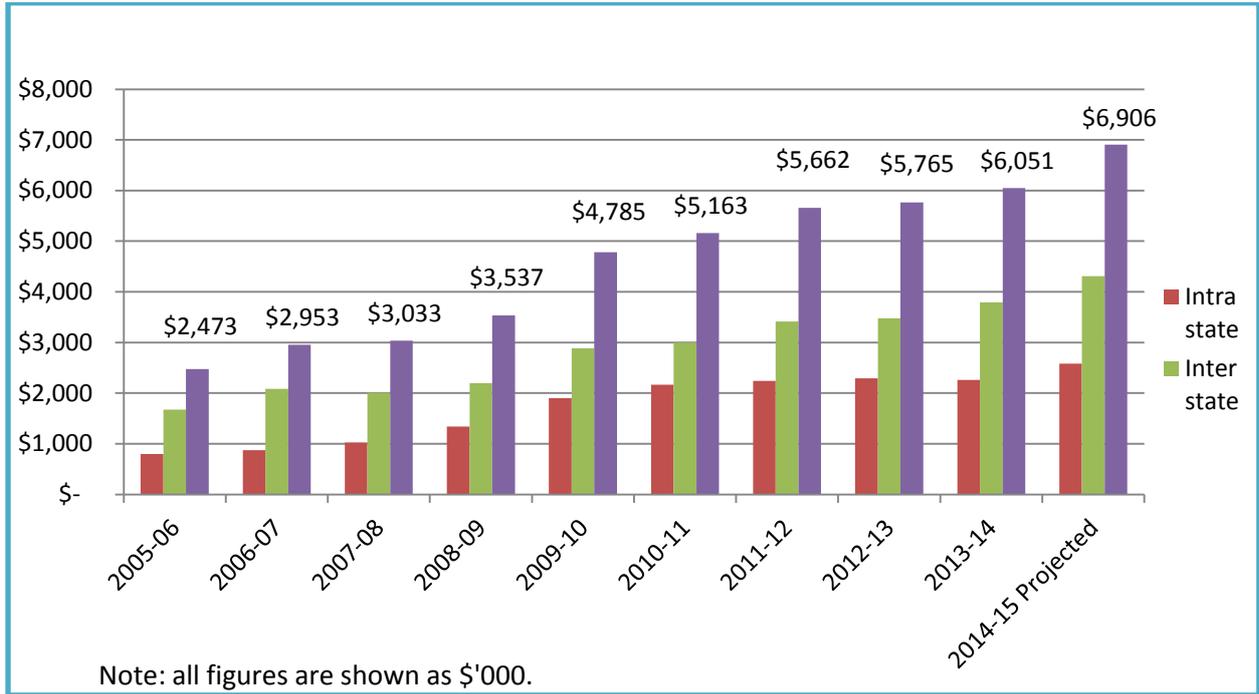


Figure 7: PTAS, cost by type (intrastate and interstate)

Source: Department of Health and Human Services, internal data

Note: 2014-15 utilises data to 31 March 2015. A projection is then made for the full financial year.

Radiation therapy, chemotherapy, and dialysis make up the top three intrastate procedures for which PTAS is claimed. These are all procedures that usually require multiple visits by single patients.

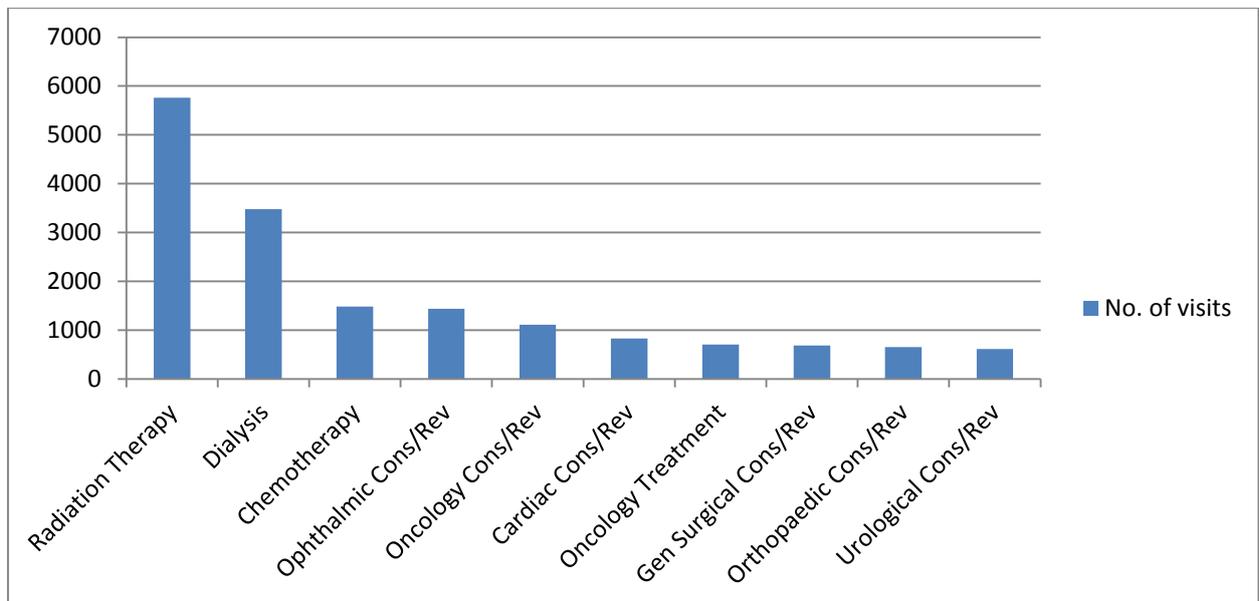


Figure 8: PTAS, Intrastate top 10 by procedure, statewide, 2013-14

Source: Department of Health and Human Services, internal data

Paediatric, cardiology, and oncology are the three specialties most commonly associated with PTAS assistance for interstate travel, making up approximately 50 per cent of the supported visits. There are some regional variations with travel for neurological services provided in the North and South being a common reason for travel.

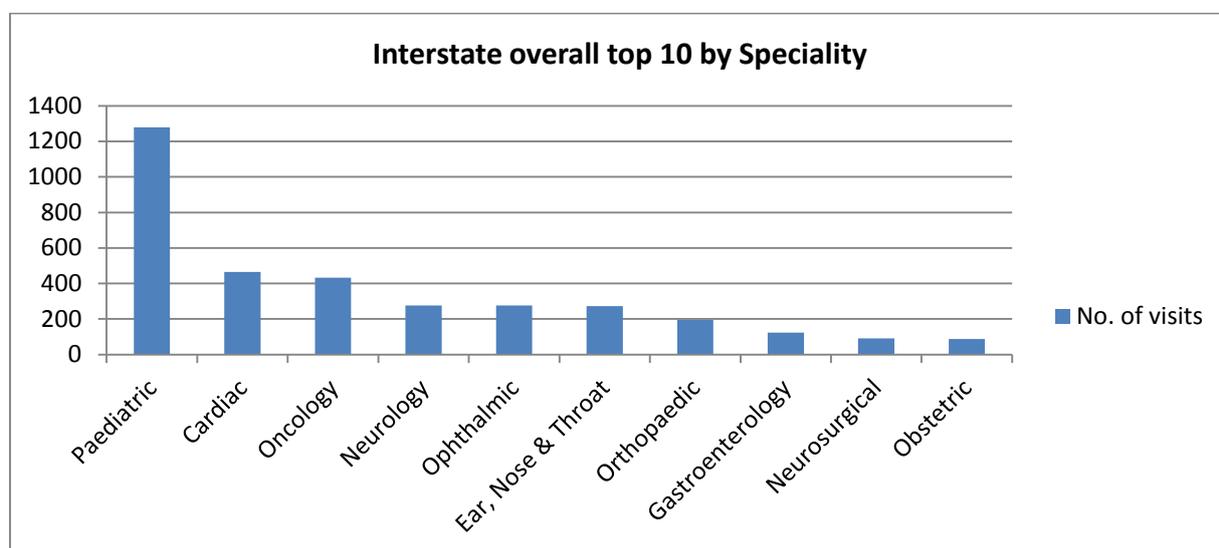


Figure 9: PTAS, Interstate top 10 by procedure, statewide, 2013-14

Source: Department of Health and Human Services, internal data

Accommodation

The Banscott Report made a number of recommendations in relation to accommodation support provided to Tasmanian patients who had to travel for medical treatment. Under the Banscott Report, contributions toward upgrading accommodation provided by non-governmental organisations (John Opie House in Hobart and the Spurr Wing accommodation complex in Launceston) were made.

The Government provides ongoing financial support to the Spurr Wing accommodation and the Ronald MacDonald House, allowing those organisations to provide low cost accommodation for patients and their families who need to travel for medical treatment. Twelve new accommodation units were also built at the NWRH site and were opened in 2011.

There are a number of changes outlined in the *One Health System* reforms White Paper that will have a potential impact on the requirements for patients to travel. In a number of cases, we expect there to be a decrease in the requirements for travel with a greater number of networked hospital services providing outreach services and new services for the North West region in particular.

There will always be some high complexity services that are currently provided interstate and we expect that these will continue, however, as technology advances there will be ongoing changes in what that range of services will be.

Table 7: One Health System changes - potential impact on the patient transport assistance scheme

| One Health System change | Potential impact on PTAS |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>A Northern Integrated Cancer Service will be established that will administer integrated cancer services across the North and North West, managed from the LGH.</p> <p>Upon commissioning of the LINAC at the NWRH, there will be a Level 5 radiation oncology service at the NWRH.</p> | <p>Travel for radiation oncology treatment is the most common reason for patient travel assistance from the North West accounting for 3 500 PTAS supported visits.</p> <p>The establishment of a radiation oncology service will not eliminate the need for travel but would significantly decrease the number of people who have to travel and decrease the distances of those remaining journeys.</p> |
| <p>A Dedicated Elective Surgery Centre will be established at the Mersey.</p> <p>Visiting subspecialist surgical providers from LGH (and potentially RHH for some disciplines) will provide increased access to subspecialty surgery for the people of the North West of Tasmania.</p> | <p>There were 2 039 of 10 755 episodes of same day care for residents of the North West provided by hospitals in the North and South.</p> <p>Modelling⁸ has indicated that the development of expanded specialist same day surgical services at the Mersey could result in between 1 482 and 1 698 of these services now being available in the North West.</p> <p>This would result in significantly less travel for residents of the North West.</p> <p>In addition, there will be an increased range of surgical consulting services available at the Mersey.</p> |
| <p>High complexity, low volume surgery will be provided at other facilities within the THS and will no longer be performed on-site at the MCH.</p> | <p>This is likely to increase the requirement for patient transport and accommodation support for patients from the North West requiring complex surgery.</p> |
| <p>Establishment of drug and alcohol services at the Mersey and rheumatology and pain management services at the NWRH.</p> | <p>This may reduce the requirement for people to travel to Launceston to access these services.</p> |
| <p>Consolidating acute medical services at the NWRH.</p> | <p>This may increase the travel and accommodation requirements for some residents of the North West, with eligible patients receiving PTAS support.</p> |

⁸ Potential to reduce flow of patients out of North West Tasmania for same day services, Preliminary Advice, Health Consult.

Enhancing the Patient Transport and Accommodation Scheme

A review of the eligibility criteria for PTAS will be undertaken to ensure that the scheme supports the implementation of the *One Health System* reforms. In particular, supporting patients to travel to the Mersey to access elective surgery.

The administration arrangements will also be reviewed to address concerns raised about the difficulty for some people to afford the travel costs up front and waiting for a reimbursement, people being discharged late in the day when transport options were not available, and people being asked to travel for multiple appointments that were not coordinated in a way that meant they could be undertaken on the same day.

Additional funding will support capital investment in affordable accommodation for patients and families who must travel for health care. The funds may be used to establish new accommodation options or to upgrade existing accommodation services.

A competitive process will be run to ensure that the funding is directed to projects that deliver the best outcomes for patients and their families.

4. Community Transport and Care Coordination

Community Transport

There are a number of alternatives to mainstream transport services in Tasmania. These are generally program specific and users must meet eligibility criteria. These services and programs may provide access to public health services, although this is not their primary function.

Australian and Tasmanian HACC funding⁹ currently provides community transport for eligible persons for health and social reasons. The Australian Government funds services for eligible people over 65, or over 50 for Aboriginal and Torres Strait Islander people, and the State funds services for the eligible younger target population. The Australian Government program provides over 70 per cent of the funding contribution. Clients pay fees for the trips taken and the services are provided by volunteer drivers.

In addition, community groups like the Cancer Council provide transport buses to transport patients for cancer services and renal dialysis. There are also a number of funding sources for older persons and persons with disabilities to access concessions, managed through Australian Government departments, (including the Department of Veterans Affairs) and the Department of State Growth. Services provided under these systems are not specifically for access to health care but can be used for these purposes.

A review of both the Australian and Tasmanian HACC funded non-emergency and community transport in Tasmania was undertaken in 2013.¹⁰ This review was commissioned to determine the best method of coordinating HACC community transport, and in particular how relevant the Banskott Report recommendation to consolidate the coordination into the centralised AT communications facility remained.

The Report did not support a centralised coordination process based in AT. It did support development of a real time fleet management process to improve coordination and efficiencies in the use of HACC vehicles. Exploration of this option has been deferred in the context of potential significant Australian Government changes.

The review also found that demand on HACC community transport services was increasing both in terms of real numbers but also through the complexity of the client group with greater numbers requiring physical assistance.

The review undertook a survey of HACC funded transport over a four-week period. There were a total of 12 849 trips equating to around 3 000 supported trips a week.

| | North | North West | South | Total |
|-----------------------------|-------|------------|-------|--------|
| Group transport | 1 970 | 2 713 | 3 440 | 8 123 |
| Individual transport | 1 720 | 1 279 | 1 561 | 4 560 |
| Not stated | 0 | 2 | 164 | 166 |
| Total | 3 690 | 3 994 | 5 165 | 12 849 |

Table 8: Number of HACC Community Transport Trips by Type by Region 2013

⁹ From 1 July 2015, the Commonwealth HACC program will be rolled into the new Commonwealth Home Support Program.

¹⁰ Review of Home and Community care (HACC) Non-emergency and Community Transport, Creating Preferred Futures, 2013.

Source: Department of Health and Human Services, internal data

The majority of trips were for social purposes (such as grocery shopping), however, around 25 per cent were for medical purposes. There were differences in the pattern of usage with respect to general practitioner (GP) and hospital visits noted from 2006 and 2013.

| Trip Purpose | 2006 (%) | 2013 (%) |
|--------------------------------------------------------------|----------|----------|
| To/from hospital outpatient clinics | 9.1 | 5 |
| To/from GP or medical Specialist | 13.6 | 16.8 |
| To/from diagnostic services (x ray, blood test, or pharmacy) | 1.8 | 0.6 |
| Non-medical purposes | 75.5 | 77.6 |

Table 9: Purpose of HACC Community Transport Trips, 2006 and 2013

Source: Department of Health and Human Services, internal data

The majority of users are over 65, up to 16 per cent of who required assistance to travel for medical purposes. As this is not a program specifically geared towards the provision of health appointments, the type and nature of the medical need is not broken down further.

The Australian Government is currently implementing major reforms of the aged community care system, including its HACC services, which may impact on transport. Two key changes are the introduction of a nationally consistent fees policy and the review of its role in community transport provision. Further work may be required to account for the impact of these changes.

It is expected that there will be a change in the number of services required through the implementation of the TCSP.

Table 10: One Health System changes - potential impact on community transport services

| One Health System change | Potential change in non-emergency transport demand |
|---------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
| Establishment of subacute care services at the Mersey: geriatrics, palliative care services, and rehabilitation services. | The development of these services may decrease the travel requirements for those people residing in the North West who access these services. |
| Increases in subspecialty surgical services and neurology services in the North West. | This may decrease the demand on community transport services with people in the North West now being able to access these services closer to home. |

A Northern Integrated Cancer Service will be established to administer integrated cancer services across the North and North West, managed from the LGH.

Upon commissioning of the LINAC at the NWRH, there will be a level 5 radiation oncology service at the NWRH.

The establishment of a radiation oncology service will not eliminate the need for travel but would significantly decrease the number of people who have to travel and decrease the distances of those remaining journeys.

Consolidating overnight surgical and acute medical services at the NWRH, providing more complex surgery at the larger hospitals, and establishing Dedicated Elective Surgery Centre at the Mersey may increase the transport requirements for relatives and friends of those travelling for surgery around the State. This service is currently that is not covered for eligible people under HACC.

Care Coordination

Good care coordination can play a significant part in reducing the need for travel or the burden of travel if it is required to access care. For example, feedback indicates that appointments are often not made with the needs of patients travelling from another region in mind. Appointments are often made at the beginning or the end of the day making it difficult to fit them into a day trip, or appointments in different areas of the health service are not coordinated in a way that makes it easy for patients who need to travel to attend them. This will become increasingly important as our population ages and the incidence of multi-morbidities (people having a number of concurrent medical conditions) increases.

Good eHealth systems that support the secure availability of patient information at the different health services where they receive care are an important enabler of care coordination.

Increasing use of telehealth requires coordination at the system level, however, for the individual, can limit the travel required to access specialist care.

5. Public Transport

A networked hospital system, as detailed in the White Paper, will create an additional demand for transport services for patients who are attending appointments and friends and relatives of those who are receiving treatment, in particular in the North and North West.

Public transport is distinct from the other transport services in that it operates on a scheduled and open access basis. It does not have the freedom of timing and directness of route that a specially chartered bus or community transport vehicle might have.

Long distance travel and travel from urban fringe areas are general access bus services and by their nature cannot be targeted at personalised destinations. It is inevitable that those services will not fit the particular needs of every potential passenger.

Bus services do need to have greater consistency across Tasmania in terms of similar areas receiving similar service levels and, and the Department of State Growth is actively considering this as part of developing new bus contracts.

There have been particular ongoing issues with the efficiency of public transport services between the North West population centres. For example, it can take up to four hours and four separate services to travel between Latrobe and Burnie.

That is why the Tasmanian Government has committed to a trial of a commuter bus service with reduced travel times between Latrobe and Burnie.

The Government is currently working with stakeholders to improve the bus service with work already being undertaken to identify improvements in scheduling and timetabling to enable more efficient transport options between Latrobe and Burnie. This work will be supported by the development of a “one stop” web-based resource that will provide information about fares, routes and timetables on the North West Coast.

Enhancing Community and Public Transport

The Government will work with existing transport service providers, as part of an upcoming review of bus contracts in the region to establish a low-cost bus service for patients and families between the LGH, the Mersey, and the NWRH.

The service will provide regular low-cost transport services, which will particularly support patients travelling for out-patient appointments or elective surgery, and families travelling to see patients receiving care at health facilities outside of their region.

People travelling on the bus will be given priority access to clinics to ensure that they are able to comfortably make it to their return bus service.

The transfer lounges in each hospital will also be upgraded to support patients and families that are waiting for the service.

Section 2: Health professional travel - *Taking the care to the patient*

Bringing health professionals to the patient where it is appropriate to do so can help to reduce the burden of travel on patients as well as provide training and professional development opportunities for health professionals.

Current System

There are already a number of outreach services provided by local and interstate health professionals. However, the culture of single site hospitals has limited the number of networked services across the State. An example of this is the services provided by the Rural Health Outreach Fund (RHOF).

Rural Health Outreach Fund

The RHOF is an Australian Government funded service that currently provides a number of specialist services into the North West and rural sites that would not otherwise be available.

A total of 10 058 patient consultations were provided through this fund in 2013-14, which meant 9 052 occasions of patient travel were avoided, saving patients and the health system time and money.

The RHOF recognises that support is required for the health professionals who provide outreach services and without this support the services may not exist. As we move toward a truly networked hospital system across Tasmania, we will need to ensure that adequate administrative support and financial arrangements exist to ensure that outreach services become a reality.

One State, One Health System, Better Outcomes

The number of health professionals travelling to deliver health services across facilities within the THS network is expected to increase.

This will be a significant change from what takes place at present, where health practitioners largely practice within their home health organisation and therefore their own region. It is not reasonable to expect the patients to always travel to the service when it is possible in some circumstances to provide that service closer to where people live. This movement of staff will not only support the delivery of more health services closer to where people live, it will also benefit staff through providing greater opportunities for collaboration with colleagues, and providing greater clinical training capacity and opportunities for networking training across the State.

Further, the changes will bolster the system by ensuring that there are critical numbers of staff to support services located in one location but with the capacity to provide outreach services where it is safe and to do so. By moving to a truly networked hospital system there should also be greater collaboration between hospitals to ensure that where short term gaps in a key workforce exist, they can be supported by health professionals from other sites.

Table 11: One Health System changes - potential impact on health professional travel

| <i>One Health System change</i> | <i>Potential change in non-emergency transport demand</i> |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>A Northern Integrated Cancer Service will be established that will administer integrated cancer services across the North and North West, managed from the LGH.</p> <p>Upon commissioning of the LINAC at the NWRH, there will be a level 5 radiation oncology service at the NWRH</p> | <p>A Northern Integrated Cancer Service to service the North and North West will require greater movement of health professionals across the regions, in particular to support the operation of radiation oncology services.</p> |
| <p>A Dedicated Elective Surgery Centre will be established at the Mersey.</p> <p>Visiting subspecialist surgical providers from LGH (and potentially RHH for some disciplines) will provide increased access to subspecialty surgery for the people of the North West of Tasmania.</p> | <p>It is anticipated that surgeons across a range of disciplines will provide services through the new elective surgery centre. These are likely to be initially from the North west and North but may potentially include those from the South as well.</p> |
| <p>Establishment of drug and alcohol services at the Mersey and rheumatology and pain management services at the NWRH.</p> | <p>These may be supported by outreach services from the LGH or the RHH.</p> |
| <p>Neurology services at the NWRH will increase to provide increased visiting specialist neurology services to the NWRH.</p> | <p>This may reduce the requirement for people to travel to Launceston, Hobart, and interstate to access these services by having staff specialists from the LGH and the RHH provide these services.</p> |
| <p>Establishment of subacute care services at the Mersey: geriatrics, palliative care, and rehabilitation services.</p> | <p>It is anticipated that these services will be utilised by patients across the North and North West. It is expected that there will be a level of support provided from the LGH for these services.</p> |

Section 3: eHealth including telehealth - *Delivering care through technology*

The use of eHealth and telehealth presents considerable opportunity to reduce the need for patients to travel. In the short term, the greatest advantage lies with patients and practitioners located in regional, rural and remote locations.

eHealth allows for improved processes across hospitals as well as better exchange of information across health care sectors and is a critical enabler of a networked hospital system across the State. An effective eHealth system is necessary for instituting effective telehealth services, including making sure that the clinical notes and investigation reports for individuals across the State are available at the site of the specialist.

Utilised in the right circumstances, telehealth can minimise patient travel, improve equity of access to health services and provide peer support and advice for medical practitioners working outside of the major metropolitan hospitals.

Telehealth, formally networked with larger health services to provide specialist support at the other end of the line, can provide vital clinical support in real time. This is particularly important in smaller health services where there is not the same level of collegial support available on site.

Current System

Across the health system there is a range of eHealth infrastructure in place, including videoconferencing facilities at 40 sites across the State. These are located in the four major acute hospitals as well as in a number of rural sites. This investment is being utilised to varying extents for teaching and professional development, meetings and clinical uses. Consultation indicates that telehealth facilities are becoming well utilised for departmental meetings and clinical networks, but not so well for patient care. Clearly this is a missed opportunity.

A number of barriers to the use of telehealth for clinical purposes have been identified. These include:

- a lack of knowledge on how to use the equipment
- the telehealth equipment is often concentrated in board and meeting rooms rather than in the clinical areas of the hospitals, and
- a lack of operational and administrative support to make using telehealth feasible at the clinician level (such as through scheduling and appropriate facilities).

There have been some great examples of telehealth having been utilised to support improved clinical services, however, these have often been pilots or short-term projects and have not been incorporated into the everyday practice of the health services.

Epilepsy Clinic

As part of a North West telehealth pilot, a telehealth service was established to improve clinical management. All review patients attending the epilepsy clinic were offered telehealth consultations.

Prior to the pilot the review appointment waiting list was steady at 42 patients. The majority of these patients were over clinical waiting time boundaries. Following the pilot study 12 patients remained on the waiting list, none of which were over boundary. This represents a 71 per cent reduction in the number for patients waiting for a review appointment.

The efficiencies gained from utilising telehealth resulted in an increased patient throughput from nine patients per month to 22 patients per month. This represents a 144 per cent increase in the availability of appointments.

Medicare Funded Telehealth Activity

There is a telehealth initiative at the Australian Government level that provides for Medicare funding for video consultations between specialists and patients in remote, rural and regional areas (based on ASGC-RA¹¹ 2-5 areas) and in eligible aged care facilities and Aboriginal Medical Services throughout Australia. The uptake for these services in Tasmania was 3 114 services in 2013-14.¹² This represents 10 per cent of the national total, however, it is clearly a small number of services in relation to the total number of specialist consultations that occur each year.

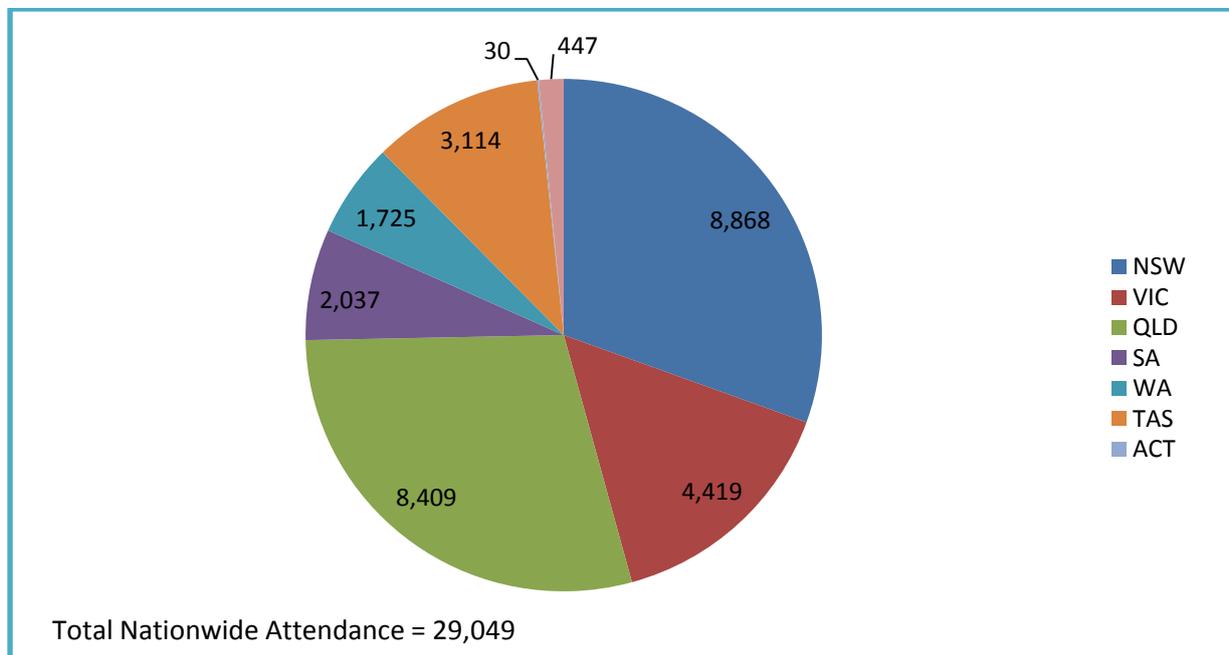


Figure 10: Medicare benefits schedule (MBS) funded telehealth items, 2013-14

Source: <http://medicarestatistics.humanservices.gov.au/statistics>, report generated 29 April 2015.

¹¹ Australian Standard Geographical Classification – Remoteness Area.

¹² Medicare Australia Statistics - accessed online 12 September 2014.

Opportunities

There is an opportunity to harness the existing investment in telehealth to provide better professional support for the medical workforce as well as to provide clinical services to patients.

There is a clear opportunity to improve the administrative structure that supports the use of telehealth. At the moment the process is complicated and time intensive, and there are inadequate supports to ensure that telehealth is routinely considered as a practical alternative to providing face to face consultations where it is clinically appropriate to do so. Until these barriers are addressed, it may be difficult to better support the use of telehealth and in doing so, realise associated benefits for patients through improved access to services and a decrease in travel requirements.

There is also an opportunity to work across Australia and Tasmania to build a culture of utilising telehealth more effectively both in the primary care sector and within our hospitals.

Investing in eHealth

The Government will invest in reducing the need for patients to travel for services.

Additional funding will be provided to:

- upgrade clinical areas to support the use of telehealth and to review and improve the digital medical record capacity to support the service, and
- run a community education program for people to assist them in making decisions about how best to access health care.

In addition, the State Government will continue to work with the Australian Government on joint initiatives like the Personally Controlled Electronic Health Record and to facilitate further investment to support eHealth initiatives.

Acronyms

| | |
|--------------|----------------------------------------------|
| AMMRD | Aeromedical and Medical Retrieval Division |
| AT | Ambulance Tasmania |
| CAG | Clinical Advisory Group |
| DHHS | Department of Health and Human Services |
| ED | Emergency Department |
| GP | General Practitioner |
| HACC | Home and Community Care |
| HTS | Health Transport Services |
| HDU | High Dependency Unit |
| ICU | Intensive Care Unit |
| LINAC | Linear Accelerator |
| LGH | Launceston General Hospital |
| MBS | Medicare Benefits Schedule |
| NEPT | Non-emergency Patient Transport |
| NETS | Neonatal Emergency Transport Service |
| NPICU | Neonatal and Paediatric Intensive Care Unit |
| NWRH | North West Regional Hospital |
| PERS | Perinatal Emergency Retrieval Service |
| PETS | Paediatric Emergency Transport Service |
| PTAS | Patient Travel Assistance Scheme |
| RHH | Royal Hobart Hospital |
| RHOF | Rural Health Outreach Fund |
| TCSP | Tasmanian Clinical Services Profile |
| THS | Tasmanian Health Service |
| WACS | Women's, Adolescents and Children's Services |

Glossary

Aeromedical -A plane (sometimes called fixed-wing) or helicopter (sometimes called rotary-wing) specifically used for medical purposes, including transport and retrieval.

Ambulance- A vehicle designed to transport ill or injured patients. It may be used under emergency or nonemergency conditions and is equipped with supplies and personnel to provide patient care en route.

Ambulance dispatch- Sending an ambulance to an incident in response to a notification.

Bariatric patient- An obese patient

Community transport- Community transport provides assistance to individuals to help them access services. There is no medical assistance provided.

Credentialed clinician- Credentialing is the formal process of assessing a health care professional's qualifications, training, experience and clinical competence in relation to their role.

Dialysis - A process used to remove waste and excess water from the blood when your kidneys do not work properly.

eHealth - The use of information and communication technology (ICT) in the health system.

Emergency ambulance service- provides transport under clinical supervision

Emergency transports- Patient transported under clinical supervision with warning devices (lights and sirens).

Extended care paramedic- Experienced paramedics with advanced training and skills in patient assessment, delivery of quality care and coordination of appropriate referral pathways. ECPs treat identified patients in collaboration with other health professionals, in their usual place of residence, thus reducing emergency department presentations and providing a more holistic level of care.

First intervention vehicle- A specially equipped and marked ambulance sedan with an Ambulance Paramedic able to be quickly deployed to incidents during periods of high demand. The roving vehicle could be deployed more quickly than the traditional ambulances at the station, saving critical minutes for patients.

High Dependency Unit - A specialised unit that deals with severely unwell patients who need a higher level of care than a general ward but a lower level of care than intensive care.

Interstate travel- travel to another state.

Intrastate travel- travel within the state.

Neonatal Service - A branch of paediatrics dealing with newborn babies, called neonates. In medical terms, this means a baby that is no older than 28 days.

Non- emergency patient transport- Patient transported without clinical supervision - including but not limited to hospital to hospital transports, hospital to rest home facilities transport, routine transport requested by a health facility, etc.

Paediatrics - A speciality that deals with a child from birth up to maturity.

Radiation Oncology - A branch of medicine dealing with the use of radiation to treat cancer (this is different to chemotherapy).

Subacute Services - Services that are not an emergency or requiring urgent medical attention (like rehabilitation or palliative care etc.).

Telehealth - Telehealth is the use of electronic equipment to support long-distance health care. This can also be used for education of community members and health professionals. For example, the use of video technology to support consultations between patients and specialists who are remote from each other.

Urgent transports- Patient transported under clinical supervision without warning devices.

