TASMANIAN HEALTH SERVICE

PRIMARY HEALTH NORTH

Submission

Our Healthcare Future

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Our Healthcare Future Response
Primary Health North, THS

Reform Initiative 1

Recognition and investment in primary healthcare is vital to ensure a sustainable and balanced health system. While there is no question of the need to invest in acute healthcare and be responsive to acute healthcare needs, we currently have a reactive health system. The system needs to be balanced by further investment in primary health care, health promotion and chronic disease treatment and prevention. We must accept that this will require a long-term strategy but will have future benefits for individuals, our communities, and our health care system. From a values-based health care delivery perspective there are significant investments both from improved health and clinical outcomes and also financial benefits.

Primary Health North Staffing and Services

Under the Tasmanian Health Service (THS), Primary Health North, has a headcount of approximately 620 employees and its services are diverse consisting of 8 District Hospitals, 5 Community Health Centres, Day Centres, Specialist Palliative Care Service, Youth Health Service, Community Dementia Service, Aged Care Assessment Team and various other community services such as Community Nursing, Personal Care, Domestic Assistance, Day Centre, Transport, Home Maintenance / Modifications, Specialist Nursing Services including Continence and Wound Care and Allied Health Services.

These services and employees are supported by only 3.5 FTE of Clinical Nurse Educators (CNEs) who work across both our district hospitals and community services and provide education, training and support to both clinical and non-clinical staff.

Principally, other than the introduction of the Community Rapid Response Service, Primary Health North's services and human resources have remained relatively stagnant for a number of years, noting that:

- In 2016-17, Primary Health North ceased to be funded by the Commonwealth under the Rural Primary Health Services Program. This led to the loss of program funded Allied Health positions, namely 1.00 FTE Mental Health Worker, 1.00 FTE Youth Health Worker and 1.00 FTE Social Worker in the Meander Valley and a 0.80 FTE Mental Health Worker and 0.10 FTE Social Worker in Dorset.
- Effective 1 May 2017 residential aged care, kitchen and laundry services and associated staff at North Eastern Soldiers Memorial Hospital Scottsdale, as well as the Scottsdale and Gladstone day centres, were transferred to an external non-government organisation, May Shaw.

PRIMARY HEALTH NORTH - SUMMARY				
Description	**2019-20**	**2018-19**	**2017-18**	**2016-17**
Average Paid FTE	428.26	429.40	422.71	455.61
Average Worked FTE	355.70	356.02	351.18	380.38
Net Result*	$46,491,067	$41,645,684	$41,202,254	$41,568,651

** 2019-20 incurred a 27th pay period and back payment for 2018-19 wage increase back dated to December 2018 as well as the impact of COVID-19.*

In a health system that focuses on acute care services there is not a wide understanding of what is provided by Primary Health North. Primary Health North employee's commitment to their roles, teams and communities is a recognised asset. Staff members demonstrate great initiative and innovation to utilise our limited resources to the ultimate benefit of community members, but this often relies on the good will of individuals which cannot continue to be overextended.

District Hospitals

The 8 District Hospitals vary in terms of patient mix across sub-acute inpatient, emergency and residential aged care, and for 2019-20:

- emergency presentations totalled 7,969 with St Helens and Scottsdale accounting for approximately 55% of that activity;
- planned presentations to emergency (ward attendances) totalled 5,252;
- there were 2,559 admissions, 2,566 discharges and 368 transfers in from LGH; and
- occupancy was approximately 64% with 14,399 residential aged care patient care days and 16,332 sub-acute care patient bed days.

For 2019-20 Primary Health North provided 42,510 hours of community nursing, 4,759 hours of community personal care, 20,871 hours of domestic assistance and 3,623 hours of home maintenance/modifications. With only one District Hospital having any weekend Community Nursing service there are increasing planned presentations to our rural hospitals to support Community Nursing clients on weekends and public holidays which impacts on inpatient staff.

Primary Health North continues to endeavour to look at further development in our sites and services by applying for appropriate available funding and trialling new initiatives. We has been successful in securing funding for various projects, such as the Statewide Subacute Care Rehabilitation (Developing a Statewide Model of Care for Rehabilitation Services in District Hospitals) National Partnership Agreement (NPA) funded project, however these are predominately time limited with no ongoing resources or recurrent additional services. Despite the demonstrated success of the Statewide Model of Care for Rehabilitation Services in District Hospitals project (572 saved bed days for the Launceston General Hospital) the opportunity is yet to be taken to either support this model to continue at the project trial site (Deloraine District Hospital) or pursue implementation across other District Hospitals in the State and expand the model to other patient cohorts such as GEM (Geriatric Evaluation and Management) patients. The project developed and

implemented a model which works. We should be building on this work to increase utilisation of our District Hospitals.

With the aim of continuing to support the health service Primary Health North again submitted a project proposal for funding under the Statewide Subacute Care Project NPA, 'Improving Subacute Pathways to District Hospitals'. This project is targeted at improving the capacity of the District Hospitals to provide appropriate subacute services and support for a range of subacute patients. Again, this funding is time limited, but Primary Health North continues to look at opportunities to further support the community and our health service.

Primary Health North has responsibility for operational and clinical governance over most of the allied health professionals who provide support to inpatients and the community via the eight District Hospitals and the four Community Health Centres. While Primary Health North has a defined Allied Health clinical governance structure, professional support for each discipline is also available via the LGH discipline leads.

The past investment in the New Norfolk District Hospital (NNDH), and subsequent increase in occupancy and activity, demonstrates what can be achieved when a facility is adequately resourced. NNDH has high occupancy and can provide much needed support to the RHH. While NNDH has both a Nurse Practitioner and a full complement of Allied Health professionals and support services, the remainder of the District Hospitals in the State continue to operate with minimal resourcing.

Adequate nursing staff is an essential component of the ability to provide safe and appropriate care at our rural sites and essential to supporting the LGH with ongoing pressure and bed demands. At the current time there is variable, but minimal staffing, across our District Hospitals. In June 2021 our District Hospitals safe staffing model (District HiTS) will be trialled following the announcement in late 2020 of 12 months funding to implement and evaluate the model. In addition, our Primary Health sites need adequate support staff resourcing.

In the north there is no after-hours administrative support for any of our District Hospitals or community services. We are very reliant on systems such as iPM and Patient Flow Manager (PFM) and the nonexistence of any after-hours administrative resourcing places additional pressure on nursing staff who endeavour to undertake some of these duties on evening and night shifts, weekends and public holidays. Duties such as answering the phone, data input, keeping Patient Flow Manager up to date, processing referrals etc.

There is very limited support services after-hours with most District Hospitals having a couple of hours of cleaning support on weekends. This results in nursing staff having to undertake terminal cleaning of beds if needed after-hours to accept a patient transfer from the LGH. This is an area that must be addressed to meet infection control standards, the increased cleaning requirements associated with COVID-19 and to support increasing activity at our sites.

Increasing awareness of District Hospitals and what can be provided at these facilities would also be useful both for community members but also across our health system. In 2018 a number of meetings were held to discuss the development of a media campaign. Particularly for planned admissions to the LGH, patients could be informed at that point in time that they may be transferred

to a District Hospital as part of their recovery plan before they are discharged. We need to normalise this process and provide an acceptance of this process.

Currently, no Primary Health North service inputs its records directly into Digital Medical Record (DMR) and 2 of its 8 district hospitals do not have wi-fi, with another 2 district hospitals having inadequate wi-fi with only a small area of the site covered wirelessly. Lack of wi-fi at rural facilities is a major barrier to use of telehealth at our sites along with minimal staffing for both nursing and support staff which directly impacts on the capacity to assist patients and community members with telehealth consultations at rural sites.

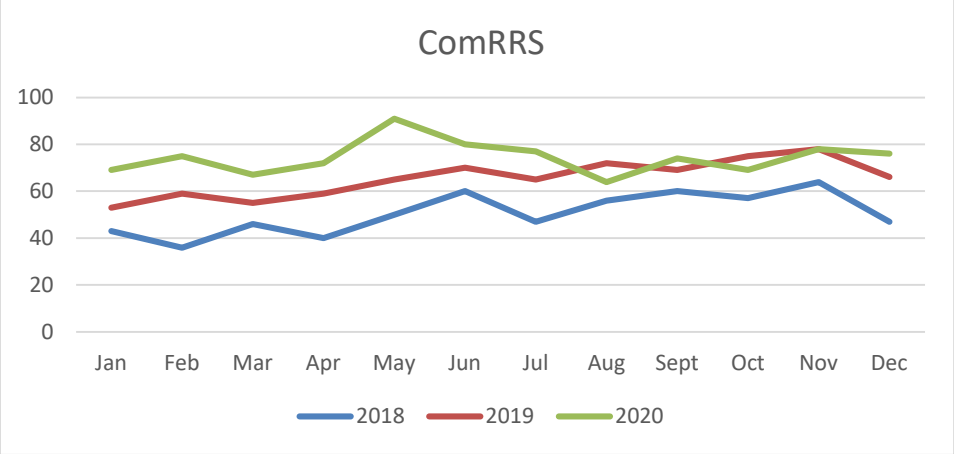
Transport services for clients are an important component of increased community support. Non-urgent patient transport services are currently quite restricted and difficult to access. The viability of transport options to enable the transport of community clients to community clinics, community-based programs, GPs, or for acute reviews would be beneficial. This is particularly important in rural areas where there are limited transport options. Often complex clients with limited mobility remain at home for extended periods without access to a GP and then when their care needs change their only option is transport to ED for a reassessment. Transport for patients in rural settings to access specialist consultations or diagnostics is also problematic.

Community Services

ComRRS:

The Community Rapid Response Service (ComRRS) is a hospital avoidance service which is a shining example of the benefit of investment in innovation and primary health care.

This service operates extremely well, referral rates remain consistently high and, as can be seen from the data below, referral rates to the service have consistently increased over the past three years. The service operates from 8.00am to 10.00pm daily, including weekends and public holidays. The service is now operating at full capacity and any further increase in referrals or expansion of service delivery would require an associated allocation of additional resources.



Because the service has been so successful there have been references to the need to expand and increase the service and it is very tempting to do this by either broadening the geographic area of operation or expanding referral sources. However, a key factor in the success of ComRRS in the north is that the integrity of the model has been maintained and the quality of clinical service delivery is very high, and it is important that this is not compromised. There have been ongoing suggestions that there should be the ability for the LGH Emergency Department to directly refer to ComRRS. This does not align with the service delivery model and presents several issues, particularly in relation to medical governance, and needs to be considered as a separate service delivery option. The service does not have the ability to flex staffing up and down in times of high demand nor the budget allocation to support this action. Any expansion of geographical service area and/or increase in service delivery level in the north would necessitate significant additional resources and almost a doubling of the existing structure. This may make the service less cost effective and also presents issues in terms of maintaining the efficient functioning of the team and the quality and skill level of staff which are vital components of this service.

Wound Care:

Wound care represents over 30% of Community Nursing service delivery and a significant component of hospital presentations and admissions and a very significant cost to the health system. Improving management and consistency of wound care has the potential to result in significant savings.

There is 1.0 FTE Wound Care Consultant community position working Monday to Friday for the north and new referrals currently average 21 per month. There are also a significant number of referrals from Residential Aged Care Facilities (RACF's) and GPs have to be rejected due to lack of capacity. The north west (NW) lacks any specialist wound care consultant and consequently staff in the north also provide a degree of support to the NW. The current 1.0 FTE is not commensurate with the level of need and wound care service delivery.

A key issue is the lack of any form of electronic system that interfaces between sectors and enables wound care assessment and care to be viewed by all stakeholders involved in client care. This at times results in inconsistencies in treatment and care which can delay wound healing. There are also often issues with the cost of wound care service delivery and debating about this between sectors which should be seamless. This occurs particularly with more expensive wound treatments such as negative therapy wound devices.

The use of compression and lymphoedema treatment in the community is a vital aspect of wound care and needs to be strengthened. Specialist lymphoedema practitioners associated with Community Nursing services would be very beneficial as would a specialist lymphoedema physiotherapy support within community nursing services.

Increasingly there is also a need for specialist clinical facilities and resources to treat wounds in the community. A significant number of wound care clients are bariatric clients of size and may have

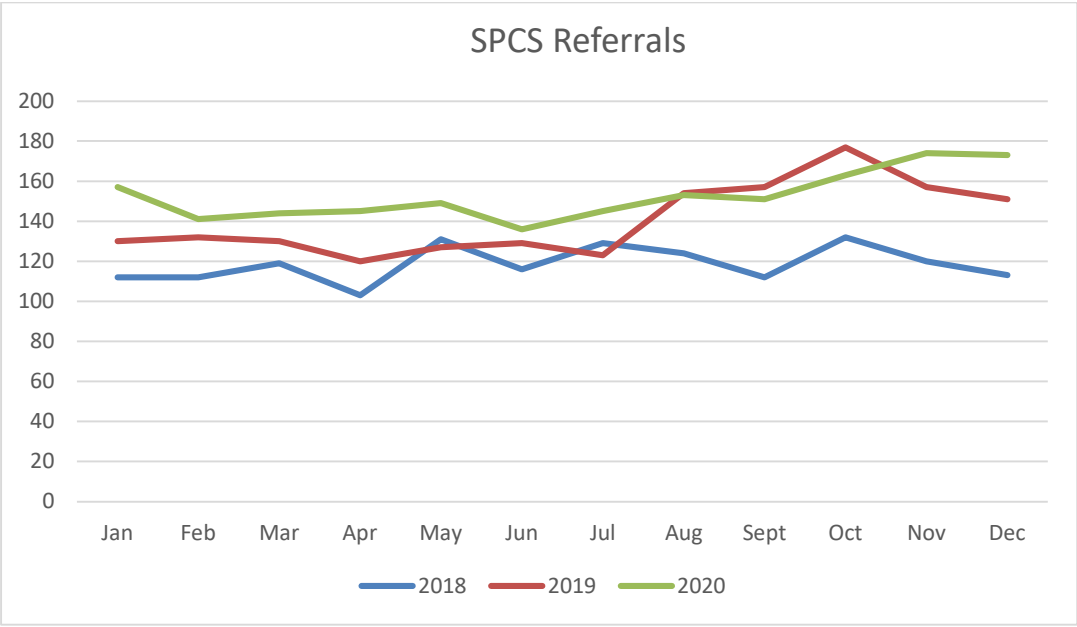
dressings that take two nurses up to an hour and a half each visit which is a very significant resource requirement. Leg lifting devices and other aids could reduce this need. Similarly specialised or potentially mobile clinics should be considered as it is difficult for many of these clients to travel significant distances.

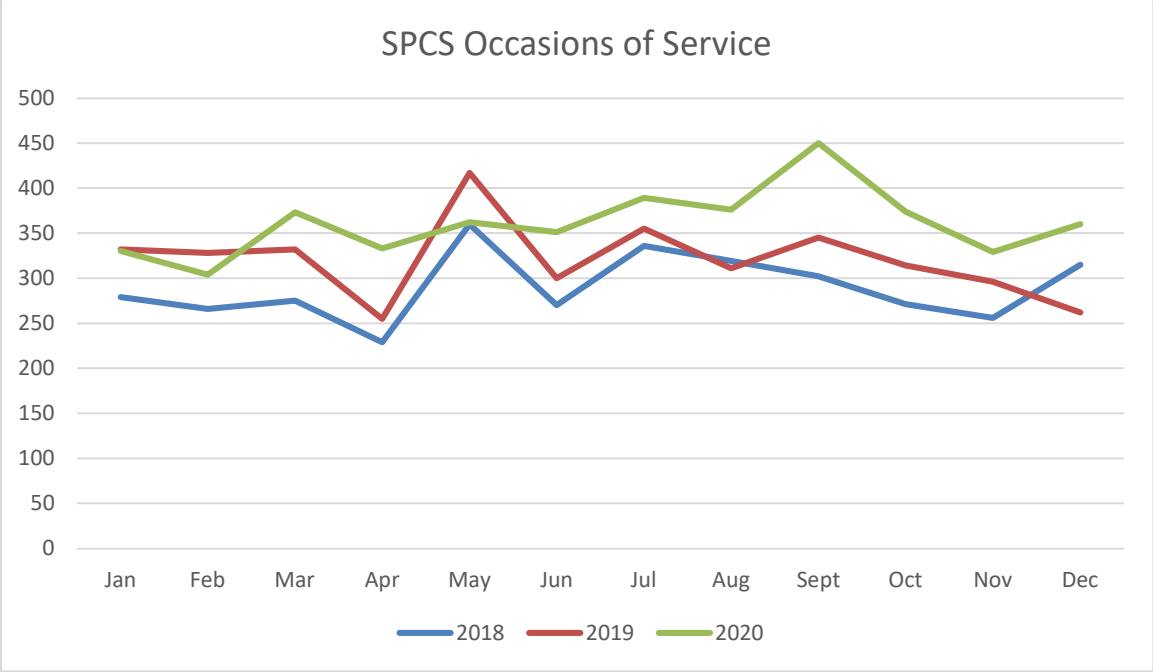
There is the potential to rollout similar models to the south's lower leg foot clinic to other areas. Consideration should also be given to the implementation of a flat fee for wound care products. Tasmania is one of the few Australian states which do not charge for wound care products and this presents a number of issues.

Palliative Care:

Palliative support needs are expected to significantly increase in Tasmania due to the ageing population and additional staffing levels need to reflect this increase in demand. According to the Australian Institute of Health and Welfare, demand for palliative care in Tasmania is greater and likely to increase more rapidly than in most states and territories due to Tasmania having the highest overall incidence of cancer, the second highest rate of chronic disease burden, and a rapidly ageing population. A significant issue is the at home death rate, although over 60% of patient indicate their preference would be to die at home the at home death rates for palliative clients in the north is currently only 13% largely due to the limitations in at home community care options.

The Specialist Palliative Care Service (SPCS) North currently has an average of 160 referrals per month with referral rates and occasions of service steadily increasing over the past three years as evidenced by the graphs below, since 2018 there has been a 30% increase in referrals. The service operates during business days only except for the Palliative Care Medical Specialists who provide an after-hours service seven days a week, predominantly for doctor to doctor advice and support.





The service underwent a clinical review in 2017 which subsequently resulted in the allocation of some an additional FTE of 2.16, across social work, volunteer support and nursing areas. Funding for the establishment of full time CNE resources for each region was an election promise in 2017 and these positions have been beneficial in educating and upskilling staff in a palliative approach and supporting the rollout of palliative resources such as the new Advanced Care Directive and Caring Safely at Home boxes. These positions have now been extended for a further two-year period but a determination on their permanent retention would assist with longer term planning, aid greatly in staffing recruitment and retention and ensuring ongoing appropriate palliative education and support of staff across all sectors.

After hours palliative care support remains a significant issue. The District Nurses in Tasmania previously received significant Commonwealth funding for the provision of Hospice in the Home services, but the cessation of this service left a significant gap. The Tasmanian Government has since provided funding to The District Nurses (TDN) to deliver End of Life Supplementary Support Services (EOLSS) for a 3-year period to provide in-home carer and nursing supports for clients in the terminal phases of their illness. This service has addressed a service gap which has been very beneficial for clients, families and community services but is due to end shortly.

A similar process has occurred in relation to the establishment of after-hours phone support. Each of the three THS regions agreed to fund the provision of After-hours Phone Support services for palliative patients and their carers via a contracted arrangement with GP Assist. Initially this was established for the north and north-west but has now become state-wide. Since this expansion there have been an increasing number of calls and also an increase in client complexity and the need for medical input and advice which was not a contracted component. As a result of these issues GP Assist have recently reduced the level of support provided which is creating a number of issues. After hours phone support is currently only contracted with GP Assist by the Department of Health

on a 6-12 monthly basis only and there is no specific THS budget allocation for this service. There is a need for this service to continue.
There is also a need to be able to access after-hours support staff to administer medications or provide in-home support at short notice as this is currently a significant gap and often leads to potentially avoidable hospital presentations.

EOLSS and After-Hours Phone Support services are currently unable to interact with THS or Ambulance Tasmania systems which can be problematic and impacts on communication and client outcomes. Similarly, GP Assist cannot see any documentation for patients contacting them via the GP Assist After Hours Phone Support services which again can often necessitate referral to ED. An electronic version of the My Envelope system used in the NW may be beneficial but would require some resourcing to implement efficiently across the North. This includes all relevant palliative documentation including Advanced Care Directives, Guardianship, Notification of Expected Death at Home forms, medication charts and recent notes all being stored in one place and accessible by all caregivers but would still be a manual system and would not negate the benefits of an electronic system.

Community Palliative Care Registrar positions in the north would be very valuable. This would enable short term placement of local GPs with the Specialist Palliative Care Service (SPCS) to develop skills and knowledge in palliative care. This knowledge would then go back to the GP Practice which would be beneficial at a number of levels as well as having the potential to establish a network of GPs willing to provide after-hours support to palliative community patients. In the north there is also a need for SPCS resident/registrar positions in the acute hospital. For the last quarter of 2020 the palliative care service had a total of 489 contacts at the LGH and averaged 2 new referrals and 8 client visits per day for LGH patients which is significant. Currently in the north the SPCS Medical Specialist has total responsibility for all aspects of medical support and follow-up for inpatient and community patients which, with increasing referrals and client numbers, is becoming very challenging.

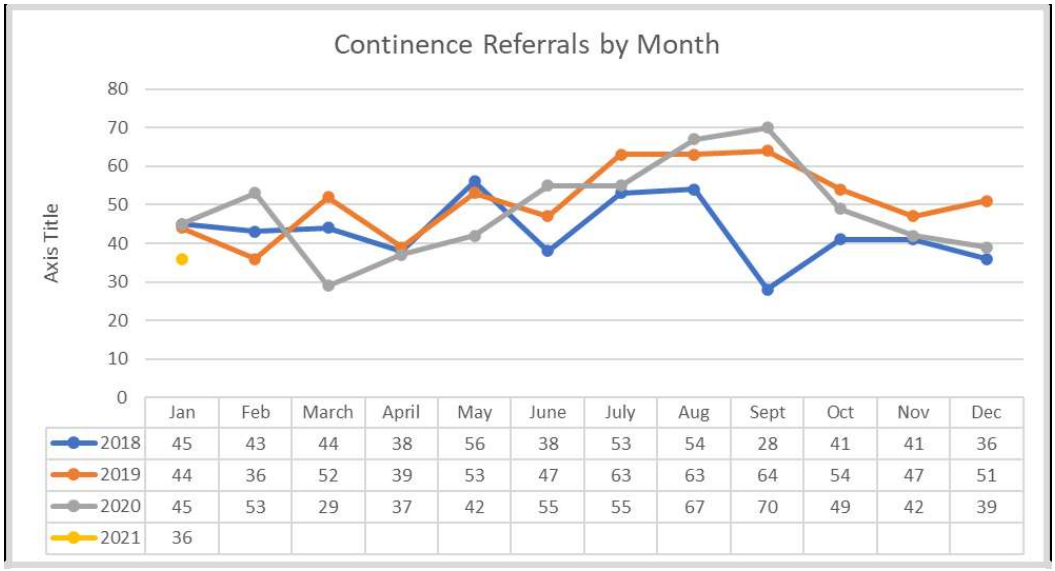
There is also a need to look at data collection systems to ensure that data on the number of palliative patients presenting to ED and being treated in acute settings is recorded and clearly identifiable which is not possible within existing data systems.

Continence:

Continence Services are not widely acknowledged or referred to but are important. In the north almost 30% of community nursing client visits relate to continence issues which is very significant. A high number of ComRRS visits are also continence related. With Tasmania's ageing population and high incidence of chronic diseases this need is likely to further increase. These clients are generally only CHSP or HACC clients and not NDIS clients which is another population group with a high incidence of continence issues. The default position of many RACFs and NDIS service providers is to send patients with any catheter related issues to the ED as they lack the level of expertise need to manage them at home or in RACFs. Strengthening of community continence support would potentially avoid a proportion of hospital presentations.

There is a need to also increase continence expertise within the acute sector. Currently the LGH have no specific Continence CNC position. The current Community Continence Service in the north is only able to provide services to THS community clients due to high levels of service demand and options need to be considered for other client groups.

THS Continence Services do work very well together and have a degree of statewide cohesiveness and consistency and are also very open to innovating and improving their service model. Staffing of the Continence Service in the north is 2.4 FTE with the service operating during business hours only. Continence Service referral rates for the North averaged 49 per month for 2020 with waiting times for non-urgent clients up to 12 weeks.



	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
2018	45	43	44	38	56	38	53	54	28	41	41	36
2019	44	36	52	39	53	47	63	63	64	54	47	51
2020	45	53	29	37	42	55	55	67	70	49	42	39
2021	36											

Community Dementia Service:

Dementia Australia state that in 2021 there are an estimated 11 800 people living with dementia in Tasmania with an anticipated growth rate of at least 1% per annum. The Community Dementia Service (CDS) provides high level services which support clients with dementia to stay living at home for as long as possible and has prevented a significant number of hospital admissions.

The CDS provides consultation, assessment, information, and the provision of direct care to people with dementia living in the Launceston area. Similar services could potentially be rolled out to the south and north west. The service maintains an average number of 50 active community clients at any one time as well as additional Day Centre clients and average 1100 contact visits a month. Community support services operate seven days a week from 8.00am to 10.00pm.The service has no capacity to increase service delivery and due to increasing referrals closed access via the My Aged Care (MAC) portal last year and maintains a waiting list as required.

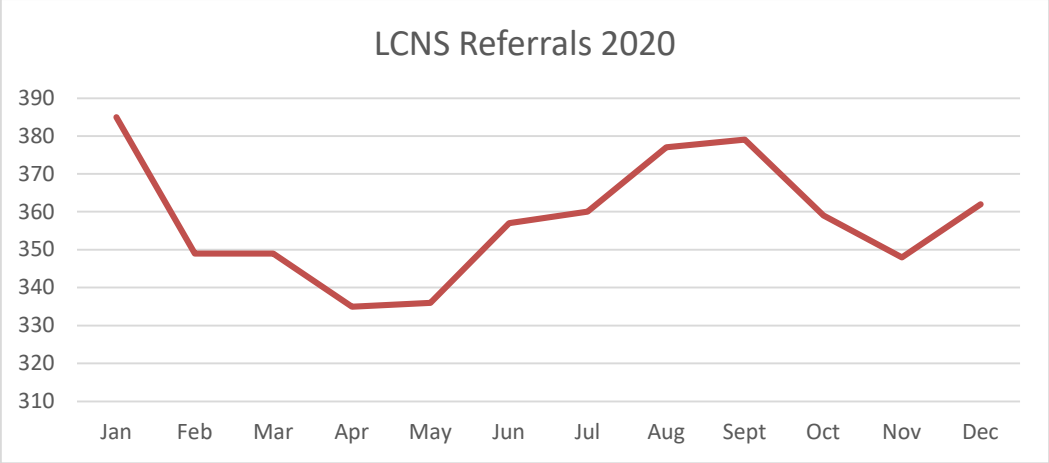
The CDS would benefit from the addition of a Social Work position to provide additional sport for carers of clients affected by dementia and to assist in managing issues such as guardianship, elder abuse and financial management which are reasonably common. The ability to provide designated in-reach for clients with dementia admitted to acute facilities would also be very beneficial as this would improve care management during their acute stay and assist in discharge planning and transitioning out of hospital. Unfortunately, current resources for this service do not support an in-reach model. There is also a need to consider additional higher level in-home support options for clients affected by dementia whose health may have temporarily deteriorated and who require more continuous care. Currently these clients are transferred to acute settings which is not ideal for dementia patients and creates a number of challenges.

Launceston Community Nursing Service:

There has been very minimal expansion of Community Nursing services over the past decade, yet these services have perhaps the greatest potential to be strengthened and expanded to increase community care options, prevent avoidable hospital admissions, and promote early discharge. Other than in urban settings Community Nursing services are currently restricted to Monday to Friday with no weekend or after hours support available which at time limits care provision, particularly for palliative clients.

Launceston Community Nursing Service (LCNS) currently average 350 active clients at any one time with an average of 2100 contact visits a month. Direct community nursing FTE is 18.6 and the service operates seven days a week from 8.00am to 10.00pm but is restricted at weekends. As can be seen from the data below referrals, contact visits and hours of care delivery have all been trending upwards over the last twelve-month period. This data also indicates that not only are client number increasing but also the time required to provide client care, reflective of increasing client complexity. LCNS are currently experiencing significant resource issues and are currently limiting acceptance of referrals due to consistently high workloads.

Community Nursing in Launceston has three aspects of service provision including provision of nursing care in clinic settings or client homes, Community Nursing Enhanced Connections Service (ConECS) program which is for higher acuity clients who have previously presented to ED and require ongoing care and would otherwise have been required to re-present to EDs, and an Ambulatory Infusion Therapy (AIT) service. The number of potential clients which could be referred from acute settings to the CoNECS and AIT services is significantly less than the number of clients referred and has been for some time.



Expansion of the Hospital in the Home (HITH) service which operates in the north-west and south of the State to the north needs to be considered. This would enable more acutely unwell patients to be transferred to the community sooner with appropriate medical specialist oversight and support. This would then mean that there are referral options for more acute care options pre-hospital (ComRRS),

from ED (CoNECS) and from acute areas. There is also the potential to move care currently provided within the acute setting to the community, for example care of vascular access ports, immunoglobulin therapy and more intravenous antibiotic and wound care treatments. There was a proposal that increased provision of these services occur in the community in the early stages of the COVID-19 pandemic, but this did not progress. There is also at times a degree of reluctance to transfer some of this care to community services due to a belief that the more activity that is provided in an acute setting the greater the funding the hospital receives and the potential for negative impacting on funding. If these activity types are moved to the community setting there is the potential of sourcing Independent Hospital Pricing authority (IHPA) funding.

The Tasmanian Ambulance Service Secondary Triage Project will be valuable in determining what additional activity could potentially be referred to Community Nursing, but any additional activity needs to be appropriately resourced.

The establishment of Complex Care Coordinator role, similar to those in the acute settings, would be beneficial. These positions have been invaluable in linking hospital clients to more appropriate care and support but there is no similar role for community patients.

Wellness and reablement is now a key objective in the Commonwealth Government's home-based care programs and has significant benefits for clients including improved functional independence and quality of life, improved physical and emotional wellbeing and the improved ability to self-care. LCNS conducted a twelve-month Wellness and Reablement Project, which commenced in July 2019, and focused on embedding of wellness and reablement practices in the service. The Project had a designated 0.5FTE staff member with specialist coaching skills working with clients with long term complex issues. Individual self-directed goal development was promoted with monitoring of achievement and support processes. This project resulted in very positive outcomes for most clients involved, decreased hospitalisations for a number of clients and decreased dependence on health services. The project targeted the benefit of this approach for clients with significant long-term health issues and clearly demonstrated the need and benefits of allocating specific resources to this model. It would be beneficial to be able to continue this approach and potentially conduct a research project or a more formal evaluation associated with this service innovation. As with other time-limited projects there is no funding to continue to drive this reform and further embed this valuable approach within the service.

Integration of Community Nursing and other specialist community services is preferable as this promotes care coordination and integration. Consequently, co-location of Community Nursing, Continence, Diabetes, Wound Care, Dementia and Palliative Care would be ideal. Associated with this is the need for LCNS to provide a holistic approach to care provision which necessitates the availability of Allied Health support directly associated with its service provision, particularly Occupational Therapy and Physiotherapy. Currently the waiting lists for community clients to be seen by an LGH Physiotherapist is around 6 months. This delay results in clients often not being referred for these services or deteriorating significantly while waiting to be seen. Early referral and assessment would be preferable.

The very significant delay in clients being able to access Home Care Packages (HCPs) causes significant issues. Often clients have gone through the appropriate assessment process and are deemed eligible for a HCP but have to wait a significant period of time before care can commence. During this waiting period clients are often subject to hospital admissions due to the lack of available care. The establishment of an urgent community care team not subject to a My Aged Care or other type of assessment process, other than that of their health care providers, to provide time limited higher levels of care to clients who have more urgent needs, for example those whose carer may be unwell, those who have had a temporary deterioration in health, or deteriorating palliative clients would be very beneficial. This team would need to include nurses but also Health Care Assistants and care support staff. The south had a similar model they were trailing which was positive.
The above initiatives would require significant additional staffing and associated resources such as additional vehicles, and establishment of a designated CNE position.

Additional Information:

CNE support: While the majority of LGH acute wards have one CNE per ward, Primary Health North have 3.5 FTE for eight District Hospitals and all of their community services. District Hospitals and community service staff work with a degree of isolation and nursing staff must be specialist generalists maintaining skills across a broad area which is challenging. District Hospital and community staff also lack the ability to network or link to specialist staff on site such as pharmacy, pathology, oncology etc to provide training and so appropriate educational support is vitally important in ensuring safe contemporary practice and appropriate staff support. PHN CNE's provide training for both clinical and non-clinical staff which also contributes to their high workload.

Hours of Operation: Increasingly health care needs are seven day a week and as such future service planning needs to reflect this need, particularly for areas such as Palliative Care and Community Nursing. Extension and flexibility in hours of operating also needs to be considered for rural areas which are currently only Monday to Friday with no wound care, Community nursing or palliative care support options available to clients at weekends necessitating care provision by already under-resourced District Hospitals or referrals to acute settings for clinical needs to be met out of hours.

IHPA, ABF and Other Funding: Some current community activity could be regarded as hospital type activity and potentially claimable via IHPA as occurs for ComRRS activity. This particularly applies to CoNECS activity. As this statewide activity the consideration of claiming for CoNECS activity through IHPA should be a statewide process. Currently ABF funding is not returned to the service delivery area claiming the activity. If this funding was returned to service delivery areas the greater the level of activity the greater the revenue for that area which would result in an increased ability to flex service delivery up and down in line with needs.

Community Allied Health Professionals/Services

The community Social Work, Physiotherapy and Podiatry teams, which operate across the northern region including the provision of services for the District Hospitals, are limited in resourcing with only 8.45, 6.84 and 4.8 FTE respectively inclusive of team leader / manager roles.

Community Physiotherapy

With its small FTE Community Physiotherapy has been able to provide:

	2019	**2020**
Total Number of Attendances	854	1950
Total Number of Clients Seen	272	614
Sum of Client Minutes	47,158	108,312
Number of Groups Run / participants	Strength & Balance: 7 groups, 54 clients Hydrotherapy: around 10 groups OPALL (Overcoming Pain and Living Life): 24 sessions, 20 clients	Strength & Balance: 9 groups, 76 clients Hydrotherapy: 29 clients (suspended in March due to COVID-19) OPALL: 21 sessions, 30 clients
Current Waiting List		Total: 544 clients (Priority 1 85; Priority 2 81; Priority 3 239; Priority 4 Recall: 139)
Current Open Referrals		1761

The level of service provision is outstanding given the Community Physiotherapy has a total of 6.84 FTE which includes the Physiotherapy Team Leader position. Unfortunately, such a small FTE means that there is little ability to backfill planned and unplanned leave in a timely manner, limited ability to flex up the workforce in response to demand or to access more appropriate and dedicated allied health assistant hours at our District Hospitals.

Community Physiotherapy, along with our other Allied Health services need to have a much more flexible and responsive workforce to enable services to flex up and down as needed. As demonstrated in the Statewide Rehabilitation Model of Care Project this is an effective and efficient means to provide needed support across our District Hospitals and to support our tertiary sites by facilitating safe and appropriate transfers of care to our rural facilities. This would also allow the ability to increase group sessions as the current staffing does not support concurrent sessions to be conducted at multiple sites. This is a more cost-effective means of meeting client needs and supporting individuals to remain in the community due to the staff/client ratios and an effective way to manage community waiting lists. It would also assist with staff retention and workload scheduling for part-time allied health staff members.

A Primary Health community team 'Hub and Spoke' model would also support group programs at rural sites by allowing Allied Health Assistant hours to be used flexibly to go to sites as required. Increased resourcing would improve the ability of community physiotherapy to push more into the preventative health space: osteo-arthritis groups; ante-natal exercise groups; etc, and increase the ability to support and liaise with the other services to set up and deliver appropriate groups for frail aged and people with ongoing health conditions.

The Primary Health North community team need a domiciliary physiotherapist - this is essential to have within the community team. While there is a domiciliary physiotherapist operating out of the LGH the community need is far greater than can be supplied by this one position. Inclusion of a domiciliary physiotherapist, based within Primary Health North, would allow appropriate triage and response to all referrals. There are many clients who are housebound without transport that don't fit the parameters of the LGH role which is generally focused on discharge issues.

Work needs to be done in identifying an ideal physiotherapy: population ratio so physiotherapy can meet the needs of the local community. e.g. St Mary's, George Town and Beaconsfield where there are high chronic health conditions and lower socio-economic levels.

A hydrotherapy pool in the North is also needed as there are currently no public spaces that have appropriate availability and accessibility for community physiotherapy clients. Since the closure of the pool, in the suburb of Newstead, hydrotherapy programs are dependent on the availability of private pools which have been closed for all of 2020.

Community Podiatry

Community Podiatry, with the funded 4.8 FTE (which again includes the Team Leader position), sees an average of 65 clients each week across both rural and metropolitan areas. Currently the team have 595 active Commonwealth Home Support Program (CHSP) clients registered. Current referrals are: 78 for rural outreach programs; 88 for Ravenswood Community Health Centre; and 130 for Kings Meadows Community Health Centre. Over the last year the community team has received 296 referrals (around 25 new referrals per month). Again, the service delivery numbers may have been increased with more flexibility in the workforce, e.g. ability to backfill planned and unplanned leave in a timely manner, ability to flex up workforce in response to demand, and dedicated allied health assistant hours all of the district hospitals.

Of the 49.8 % preventable conditions that are admitted to acute care hospitals a significant portion of these patients are admitted for diabetes complications of the foot. Currently THS North only have one High Risk Foot position and the clinic is often full with patients waiting between 3-6 weeks for each appointment and those in rural and remote areas are being seen at local District Hospitals every 6 weeks where possible in-between travelling to the High Risk Foot Clinic. However, the funding does not reflect this with rural sites being mainly funded by CHSP. The ability to provide a quick response with these patients is vital and waiting for weeks before the next appointment can

be the difference between saving or losing a limb. Community Podiatry already have highly skilled Podiatrists but need some Level 1-2 positions, or new graduate Podiatrists, to undertake the more basic work. This will also help with workforce retention of existing staff.

Community Podiatry currently do not have the resources to work with ComRRS or Community Nurses to ensure the patients with complex foot needs who have intravenous/vascular access lines or are awaiting revascularisation. Current FTE means that the team often struggle to attend multidisciplinary case conferencing for these patients. This is an area were IT and e-health could be utilised especially in relation to wounds and education.

This basic work is also the vital work in slowing the next wave of high-risk feet especially in the education of the patients with diabetes. When Community Podiatry had a new graduate podiatrist, through Commonwealth funding, they were able to provide extra education to not only the patients but the GPs and nurses who are on the front line of care of these patients often with little knowledge of the high risk foot. This position was also able to support the 2 Allied Health Assistants (AHA's) enabling complex patients to be seen and maintained, when appropriate, by AHA's rather than podiatrists. If Community Podiatry had a similar position, they could look at supporting AHA's at District Hospital sites with basic nail care and could upskill Registered Nurses (similar to what has already occurred at Beaconsfield District Hospital for aged care residents).

We would also like to explore potential partnerships with interstate Universities. Podiatry North have had great results using remote telehealth to access lectures and connect with other health professionals. Utilising this for staff, including a podiatrist undertaking final practical exams with us, could lead to beneficial partnerships with other universities and potential funding. A graduate position linked with our team would facilitate future recruitment to positions by providing an entry to both the profession and working in Tasmania.

An increase in FTE would also enable a more proactive model, e.g. the current system means that anything muscular skeletal is referred to orthopaedics where individuals can wait for up to a year to see a surgeon before being referred to podiatry. There would be a benefit in both waiting times, waiting lists and client outcomes.

Occupational Therapy

Primary Health North Allied Health Team has only 0.3 FTE of permanent Occupational Therapy (OT). While all our allied health staff work closely with the OT team from LGH the community would benefit immensely from having more OT resourcing. Ideally these positions would be part of the flexible 'hub and spoke' model and be sited in an appropriate community health centre as part of the Primary Health North Allied Health team. This would assist with discharge planning from rural sites but also allow preventative and early intervention work in falls prevention, etc, through involvement in health promotion, therapeutic groups and home environmental assessments.

The LGH OT team simply does not have the capacity to provide vital services within the community. Additional OT resources in Primary Health would also allow them to further engage in collaborative and consultative partnerships with other services within Primary Health and to support clients in the

community and at rural sites with a range of specific therapeutic procedures, e.g. techniques to enhance perceptual and cognitive process and manual therapy skills.
This is a significant gap and one which is a priority to address.

Social Work

Community Social work team consist of 8.45 FTE which includes the full-time Team Leader position. The team is located in 10 rural facilities and Community Health Centres in the north of the state making resources very overextended. The team utilises an evidence based-clinical social work model to assess and deliver biopsychosocial interventions to clients in regional sites and regional communities (including Launceston) and work closely with other Allied Health professionals and nursing staff to deliver evidence-based services to clients in need.

The main reasons for referrals to Social Work vary from trauma related presentations, mental health issues (e.g. suicidality, anxiety and depression), persistent pain, elder abuse and capacity issues, grief and loss, chronic conditions, social isolation, and substance abuse.

During the Tasmanian Government mandatory quarantine response, the Community Social Work team, despite its small size, provided the bulk of the needed support for people in Government Funded Quarantine Hotels. Over 300 referrals or client enquiries relating to Quarantine Hotels have been received and actioned by the Social Work team since May 2020.

The following is a snapshot of social work client numbers for the last two years: -

	2019	**2020**
Total Number of clients who received individual therapeutic interventions (both face to face and telephone)	454	506
Occasion of services individual therapeutic interventions	1135	1265 (Normal referrals) > 700 (for people in Quarantine hotels. Including all contacts direct or indirect with clients, GPs, family members & GLOs)
Average number of open clients per 1 FTE	23	26
Number of Groups Run / participants	**OPALL** **Target Pain:** *Persistent pain, trauma and mental health* 3 groups/ 34 clients Total sessions: 36 Session Duration: 3 hours	**OPALL** **Target Pain:** *Persistent pain, trauma and mental health* 2 groups/ 30 clients Total sessions: 21 Session Duration: 3 hours

	Total attendances – 408 **Stanford 6 Weeks Persistent Pain Group** **Target:** *Persistent pain and mental health* 3 groups/31 clients Total Sessions: 12 Session duration: 2.5 hours Total attendances – 276 **Mindfulness in motion** **Target:** *Chronic health condition and mental health* 1 group/12 clients Total Sessions: 6 Session duration: 2 hours Total attendances – 72 **Art and Health Therapy Group** **Target**: *Chronic Health condition and mental health* 2 groups/30 clients Total Sessions: 6 Session duration: 3 hours Total attendances – 180 **Train the Trainer – Standford Persistent Pain** **Target**: *Health professionals* Participants – 13	Total attendances – 360 **Stanford 6 Weeks Persistent Pain Group** **Target:** *Persistent pain and mental health* 1 group/13 clients Total Sessions: 6 Session duration: 2.5 hours Total attendances – 78 **Train the Trainer – Standford Persistent Pain** **Target**: *Health professionals* Participants – 15 (NB: Group offerings impacted by Covid restrictions in 2020)
Top 4 areas by referrals received	1. Launceston 2. Campbell Town 3. Meander Valley 4. Dorset	1. Launceston 2. Campbell Town 3. Break O'Day 4. Meander Valley

Current Numbers	
Waiting List	11
Total Open clients	220
Monthly referrals	45
Average individual client load per FTE	31.9

Further development of the ground-breaking persistent pain Overcoming Pain and Living Life (OPALL) program and launch of the leader manual was a major achievement in 2020. This program integrates contemporary pain science and practice with trauma-informed care and has been recognised as 'cutting-edge' work. The manual was quality reviewed and endorsed by Professor Lorimer Mosley of the University of South Australia, CEO of the Pain Revolution Organisation and author of the world-renowned Explain Pain texts.

The Primary Health North Social Work team has a strong focus on providing face to face clinical services for clients presenting with a health complaint due to the level of risks these presentations tend to have. There is anecdotal evidence that the number of referrals received by Social Work is not a true reflection of need in our communities. For instance, Campbell Town with a fulltime Social Worker, is one of the highest need areas according to referral and case load numbers. On the other hand, where the Social Worker is only available part-time, these areas generally have lower referral numbers which could link to the available resources.

Community feedback suggests that having full time Social Workers in all sites will offer more opportunities to build trust in social work service and allow the Social Worker to invest more time in service and health promotion, building community capacity and social capital and be part of preventative and health promotion activities in those communities. Currently, except for Campbell Town, all our regional hospitals and health centres only have part time social workers. Consequently, in a lot of these areas, the focus has been on individual case work with little time for preventative care and other community development and health promotion work that is critical in building and maintaining healthy communities.

Social recovery: as the main provider of Tasmanian Government personal support services under the Tasmanian Emergency Management Plan (TEMP), our Social Work team is doing a lot of this work from the side of their desks. Additional investment in this space is critical to ensure our team has capacity and the skills to respond during and after an emergency event. It is estimated that with our current FTE, we can only resource an evacuation centre for no more than 2 weeks without significantly impacting existing services. Whilst efforts to train and engage Social Workers from across government to assist during social recovery responses will provide us with additional capacity, the mobilisation of these workers during recovery responses relies on the good will of their managers.

Information Management: This is a top priority for our service for the next financial year due to the geographic spread of our team and the need to maintain services during staff leave and during recovery responses. The Social Work team is in the process of moving onto the iPM system to manage all referrals and client appointments. There is recognition that this transition will result in additional administrative work requiring administrative support. Any additional investment in administrative support to assist with this transition will be of great assistance and benefit.

Other Disciplines

Our District Hospitals and the community would benefit from additional Allied Health support including Psychologists, Speech Pathologists and Dieticians. The teams at the LGH have very limited ability to provide support and follow-up. Primary Health nursing staff could be trained in swallowing assessments (for example) but there is still a need for review by the Speech Pathologist for which there is no current resourcing.

These disciplines play an important role in early intervention and prevention but have no current capacity to operate in this space. As an example, a Community Dietician within the Primary Health Allied Health team would be able to review diets for clients identified at risk by community nursing teams, home care services, aged care etc, along with supporting meal plans at District Hospitals. Australian Burden of Disease studies have identified overweight and obesity as one of the risk factors that caused the most disease burden along with dietary risks and high blood plasma glucose including diabetes. Links to improved outcomes across a myriad of health conditions particularly wound care, diabetes, palliative care, and support for person of size. In 2020 district hospital had to source private dieticians to undertake menu reviews at our aged care sites as the LGH did not have any capacity to provide any support.

Additional Information

Increased administrative support for allied health would support a patient centred approach, especially at rural sites where the clinician is not in attendance every day. For example, if a patient cancels at a rural site administration could then contact the next person on the waitlist and rebook someone into the clinic appointment space rather than waiting until the clinician was on site. While this happens at some sites it should be standard but currently relies on the extremely limited administrative support. As an example, all physiotherapy clinic bookings at St Helens are done by the Allied Health Assistant (AHA) and this takes up all of their one day a week of AHA time so they have no capacity to support clients and the clinician in more direct activities. This further support the need for an increase in administrative support for rural sites.

Allied health within Primary Health North have a specific focus on supporting the most disadvantaged members of our population to develop strategies to reduce the impact of chronic disease. Increasing the Primary Health Allied Health team would also allow a greater role in community Health Promotion activities. Our current team are providing around 50% of the sessions at the inaugural ‘live well, live long’ program being conducted in Launceston in 2021. This program has been very successful in the south of Tasmania and promotes lifestyle change and accessing appropriate health services that may prevent avoidable hospital presentations.

Anticipatory care can support individual and community health needs, both current and in the future. We need to look at how we support and empower local communities by working together to meet their primary health care needs and focus on preventative health or management of existing chronic disease. A shift in focus on how we can keep people well rather than how to care for them when they are unwell would be a more sustainable model and focus for the future.

Equity of service structures and service delivery needs to be reviewed. The structure and resources provided to specific services can vary significantly between regions. For example, the budget allocation for the southern ComRRS service was double that for the north yet occasions of service and service delivery levels are lower. This is also similar in the case of some allied health and specialist nursing services.

Summary

The information provided above is an overview of the level of care and service currently being provided within Primary Health North. While teams and services do all that they can to meet the needs of our communities, minimal resources result in a focus on the provision of meeting immediate direct healthcare needs with limited ability to focus on community and individual capacity building.

PHN has a suite of programs aimed at improving client health and well-being including pain management programs, such as OPALL, a Breathe program, Strength and Balance programs, and land and water-based exercise programs. These programs currently have limited capacity and are restricted primarily to urban areas. There is a need to be able to expand these programs to rural areas and to include additional programs such as cardiac rehabilitation, lung buster programs etc. This would link extremely well with any Community Nursing wellness and reablement focussed activities but would necessitate enhanced allied health capacity within the community.

We have under resourced District Hospitals and Community Services who cannot continue to be stretched, can no longer create further efficiencies within existing resources and cannot continue to be creative and innovative in how limited resources are used to meet identified community or individual health needs. Primary Health North has an established foundation and framework. We know our local communities and facilities. Support us by resourcing Primary Health North to build on this foundation and framework to increase our capacity to provide much needed community health programs, increase our focus on preventative health programs and health promotion activities.

Rather than consideration of UCC ‘s we need to look at options that are not limited to metropolitan areas and will reach our rural communities. This could be achieved by strengthening existing services, models and resources at District Hospitals and Community Health Centres which are already central points of contact in rural communities. They also have existing links to GP’s, Rural Medical Practitioners and a range of specialist visiting services and clinicians. We should look at building on these existing relationships and expanding the level of service and support that is currently provided.

Our health care system can be strengthened by investing in primary healthcare. From a value based health care perspective investing in primary healthcare would be a sound investment. We must use our resources optimally to improve outcomes for individuals and our communities.

Reform Initiative 2

There is an increasing move towards digital medical records and the need for technology within health services such as telehealth consultations, medical equipment with wireless capability, requirement for capture of patient data at the bedside etc. Currently, no Primary Health North service inputs its records directly into Digital Medical Record (DMR) and 2 of its 8 district hospitals do not have wi-fi, with another 2 district hospitals having inadequate wi-fi with only a small area of the site covered wirelessly. Lack of wi-fi at rural facilities is a major barrier to use of telehealth at our sites is also an additional stressor for staff given connectivity is an essential requirement for an increasing number of tasks and systems such as quality audits, accessing telehealth for staff education and patient appointments, pharmacy reviews and patient counselling, the upcoming MCAP project and the introduction of smart pumps among other needs.

DMR was implemented into the LGH in June 2016 and needs to be rolled out across our district hospitals but there is no funding for this to occur. This impacts on visibility and access to clinical information and communication and would improve healthcare delivery and the safety of the patient journey. As it stands now if a patient is provided with care at a district hospital LGH or RHH clinical staff are unable to view the patient medical record and there is limited access to this clinical information. It also results in rural facilities having to store and archive patient paper based medical records. The THS should have an integrated digital medical record systems for all health clients not just those who receive care at a tertiary facility.

It remains that Primary Health North is not funded or supported to address this gap across our sites which should be a fundamental requirement for a responsive health system. The above will continue to be a challenge for Primary Health North without access to funding to purchase the required equipment, and cover its future replacement cost, and pay for associated ongoing recurrent costs such as licencing fees, rental of wireless access points etc.

PHN Community services are increasingly using DMR for progress notes and have commenced e-form development in several areas, but the existing services are quite limited in their capacity. For example, an e-form cannot be sent anywhere, it must be printed and scanned and attached to an e-mail which is not ideal. E-forms also lack the ability to include any diagrams which is another limitation particularly when considering the development of electronic wound care forms. Use of DMR notes by community services have improved communication between acute and community reviews but navigating them can be difficult and time consuming as there are few tabs or separations and at times you have to search through a large amount of material to find the information that you need.

The use of technology to provide a direct video link between District Hospital emergency areas and the LGH Emergency Department would be a significant support for Rural Medical Practitioners and nursing staff. This was explored several years ago, following a serious safety event at a District Hospital, but the response was that there was no capacity to support this request. This would provide much needed support for staff at rural sites, optimal patient outcomes and has the potential to reduce transfers into tertiary facilities.

Reform Initiative 3a

PHN operates from, and has responsibility for, a range of buildings including 8 district hospitals and 5 community health centres, with approximately 8.93 permanent FTE of maintenance / gardening positions across PHN. The Directors of Nursing (DoNs) and site managers are responsible for the maintenance and gardening arrangements at their respective sites, including day-to-day operational matters, breakdowns, compliance, involvement with and/or on-site oversight of approved projects as well as identifying and putting items forward for submission under the Capital Improvement Program – Essential Maintenance, Rural Hospital Fund program etc.

Whilst the DoNs and site managers can access advice and support from LGH Building & Engineering and parts of DoH Infrastructure Services, responsibility for asset management including maintenance rests with their position which poses a range of challenges given the technical nature of the matters including underpinning Standards and legislative requirements, it is not their core business or area of expertise, lack of resource capacity which is exacerbated when projects or capitals works are undertaken etc.

PHN would benefit greatly from the implementation of a strategic asset management approach to its building and associated plant and equipment assets with links to condition assessment reports as well as rolling forward programs of work that factor in not only major redevelopments, but also the upkeep of the current sites including provision for items like floor covering replacement, re-painting, roof replacement, replacement of nurse call bell systems, replacement of fire alarm systems etc, noting that sufficient funds and resources would need to be made available.

Given the geographical location of sites, PHN DoNs and site managers are likely to always have some level of responsibility for the maintenance of their buildings and associated plant and equipment, but for the reasons noted above their involvement should be limited, with those with the technical skills and expertise taking the lead, and providing the sites with central points of contact for advice and support.

Having a centralised strategic asset management system and pool of resources that reside within a business unit that has the required technical knowledge and expertise to ensure consistency and appropriateness of specifications, consolidation of works for like items to enhance procurement value for money, implementation of most appropriate solutions, best practice etc. but also strong communication linkages to operational managers and service delivery business units is considered essential to developing a long term health infrastructure strategy for PHN.

Primary Health North desperately needs a dedicated education and training space which can cater for high numbers of attendees. A dedicated area would negate the need for equipment to be transported and set up, and then unpacked, as is the current situation. It is simply not feasible, particularly with the physical distancing requirements of COVID-19, for our small CNE team to provide multiple sessions when face to face training is needed to meet education needs of our large staffing numbers. The unavailability, or unreliability, of wi-fi and telehealth at sites also impacts on confidence in providing education through other platforms.

Community Physiotherapy would benefit immensely (as would our other Allied Health services) from a purpose-built space where all Community Health clinics could be run. The current spaces available are inadequate and inflexible resulting in Allied Health professionals being quite segregated due to lack of appropriate spaces which impacts on clinical communication, information sharing and limited ability to provide community health programs and activities.

The master planning exercise being currently undertaken provides the THS with an opportunity to look at current and future health care and organisational needs. We must be open minded about what is currently being delivered within the LGH precinct area and what could, or would be better placed, to be delivered in a community setting. These decisions will inform the development of community spaces that can meet these identified needs. As an example, the Kings Meadows Community Health Centre (KMCHC) is an outdated building which is at full capacity. For those who work in the KMCHC their accommodation spaces are less than ideal with the CHC not being designed for the services and programs which now operate from the building. The KMCHC would require a significant investment of funds to address the needed building works but has huge potential. The centre sits on a large body of land that presents enormous opportunities for the design of a purpose built CHC that could be centrepiece for THS-N.

Reform Initiative 3b

Ongoing funding of the District Hospital safe staffing model will assist in recruitment and retention of staff at our rural sites. Having only one Registered Nurse (RN) on shift, which is the case at most of our District Hospitals, impacts on the ability to recruit and attract less experienced RN's. The District Hospital in Tasmania Staffing Model (District HiTs) will result in a minimum of two RN's on morning and afternoon shifts. This supports the ability to recruit and mentor less experienced RN's at our rural sites.

Planning needs to be undertaken on increasing Nurse Practitioner (NP) positions within the THS in a considered manner to review innovative models of care that will support clinical service delivery in the future and feed into THS workforce planning. ComRRS is an example of innovation in practice with the service led by a NP. Consideration needs to be given to implementation of NP clinic models where services are provided in community centres with GP support, Specialist Dementia Care NP position who could lead a community-based Memory Clinic, and other specialist positions such as respiratory, pain, wound and urology NP's within PHN to support District Hospitals and GP's.

PHN would also benefit from a community based Complex Care Coordinator who could liaise between community and acute settings regarding discharge and care planning and case management of complex clients in the community. Dedicated resourcing would support improved outcomes for these clients and reduce hospital presentations. This position would also assist in improving coordination of care lor clients with multiple services and improve health outcomes of this client group.

Already, our community services and rural sites are providing care for increased acuity patients e.g. provision of day infusions and IV antibiotics. Extended scope for nurses and allied health staff to

provide a wider range of services in the community, including post-acute care, chronic disease management services, extended care coordination, case management and high-level clinical care and clinical function needs to be supported.

Resourcing to support the ability for community services to provide in reach support in acute settings would enable these specialist community positions, such as continence service, to better coordinate needed care for patients. We have seen the benefits of this with both Specialist Palliative Care Service and Community Nursing liaison positions.

Reform Initiative 3c

THS North is very fortunate to have a highly respected and well-functioning Consumer and Community Engagement Council (CCEC). The CCEC is seen as the primary resource for consumer engagement for a range of activities across THS North.

The actions and achievements of the CCEC are underpinned by 'The Patient Will See You Know' framework which sets out a strategic approach to support compliance with the NSQHS Standards. The THS Consumer and Community Engagement Principles are also referenced in the Ministerial Charter 2018. Our CCEC has a well-balanced membership who have a broad range of professional backgrounds and experience, interests and life experiences resulting in a diverse and rich Council that supports our health service.

CCEC members are actively involved across THS North in a range of activities from membership on NSQHS Standards Committees, selection panels for recruitment of senior management positions, RCA panel membership, complaint management, induction and onboarding for new staff members, policy development and review, redesign and redevelopment projects and many other areas. The CCEC is supported by a Senior Advisor, Quality & Patient Safety Service, and an Executive Sponsor from THS management. CCEC meetings also have regular attendance from THS staff members who have requested to attend a meeting to discuss areas of service delivery, varied projects and initiatives to gain consumer input and advice which demonstrates how well respected and embedded the CCEC is within THS North.

The CCEC Chair is a member of both the Health Executive North and the Clinical Governance Committee which indicates the level of respect for our CCEC and this position. The three CCEC Chairs form a Clinical Advisory Panel which meets quarterly with the Secretary, Department of Health (DoH). This forms a very important and crucial link between the CCEC members, THS and the DoH.

All 8 of our District Hospitals also have very active local Auxiliaries with members who are very committed to supporting their rural hospitals by providing a direct link between the hospital and their wider communities and through community fundraising activities. The Auxiliaries are highly respected throughout Primary Health North who value the tremendous support provided and the opportunity for consumer engagement and input.

It is appropriate that the questions that relate to consumer engagement and input are answered by our consumers. However, areas of improvement that should be considered to support our consumer

representatives are the provision of training and education to invest in and acknowledge the significant contribution of CCEC members to our health organisation and also consider of renumeration for our CCEC members. This was previously not supported by the CCEC in the North but members are now reconsidering this position given the significant investment from members in multiple areas across THS North.

I would also like to see a delineation of roles between the CCEC and Health Consumers Tasmania. I very much view the CCEC as the central contact for THS-N but believe there is a lack of understanding and clarity about the aim and role of Health Consumers Tasmania.
