PRIMARY HEALTH NORTH, THS

Submission

Rural Health Inquiry

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Rural Health Inquiry

Primary Health North, Tasmanian Health Service

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.

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

In addition, 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. The loss of these positions has had negative community health impact including an increase in local suicide rates, a now complete lack of the provision of any youth related health and development services in the Meander Valley and no locally based mental health support or care options for community clients. Unfortunately, these positions were long term and had impacted statistically positively on the Meander Valley's health and wellbeing status which then fuelled the position that they were not needed in the community.

District Hospitals

Primary Health North (PHN) is responsible for the management and operations of 8 District Hospitals across the Northern region. The District Hospitals have varied bed numbers and bed types (sub-acute inpatient, emergency, and residential aged care). All the District Hospitals provide emergency care, 24 hours per day, with emergency presentations totalled 7,969, in 2019-20. District Hospitals admit patients directly from the community and also support our tertiary hospital facilities by accepting transfers from these sites.

As only one District Hospital has 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. These presentations have, and are expected, to continue to increase due to the increasing complexity and acuity of community clients. If needed after-hours care is unable to be provided at the District Hospitals these clients would require admission in a hospital setting.

PHN also provide community nursing services, community personal care, domestic assistance, and home maintenance/modifications services both in Launceston and rural areas.

PHN 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. The project developed and implemented a rehabilitation model which works. The model has the potential to increase utilisation of our District Hospitals and could be extended to other patient cohorts if supported with needed resourcing.

With the aim of continuing to support the health service PHN was successful in gaining funding under the Statewide Subacute Care Project NPA, for a project titled '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 PHN continues to look at opportunities to further support the community and our health service.

PHN 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. This will be the first time that our District Hospitals are staffed with a defined staffing model. Ongoing funding of the District Hospital safe staffing model would 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) has 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 and supports the provision of safe and appropriate care at sites. In addition, our Primary Health sites need adequate support staff resourcing as none of our sites have after-hours administration staff and limited domestic staff after-hours.

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-

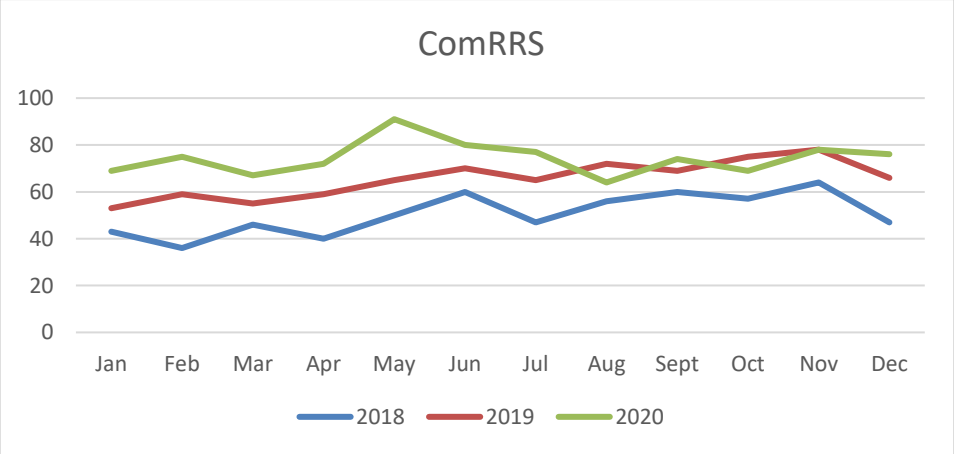
based programs, GPs, or for acute reviews would be beneficial. This is particularly important in rural areas where there are limited transport options. Often complex clients with limited mobility remain at home for extended periods without access to a GP and then when their care needs change their only 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. Currently the service only operates in the greater Launceston area with further outreach at times depending on capacity, but travel is generally limited to 30 minutes one-way.

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. Any expansion of geographical service area and/or increase in service delivery level in the north would necessitate significant additional resources.

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 63 region in the north and new referrals currently averaging 21 per month. There are also a significant number of referrals from Residential Aged Care Facilities (RACF's) and GPs which 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. Specialist wound care services are currently only able to be provided to rural areas on an average of once every six weeks. This results in care and support tending to be reactive with clients being seen by the consultant when their condition worsens rather than utilising a pro-active approach focussing on early assessment and review which would be preferable. This can also at times result in inappropriate dressings being utilised for extended periods while a review is arranged.

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 as these have the potential to significantly decrease wound healing rates and recurrence. Specialist lymphoedema practitioners associated with Community Nursing services would be very beneficial as would a specialist lymphoedema physiotherapy support but currently these services are not available for any clients in rural areas.

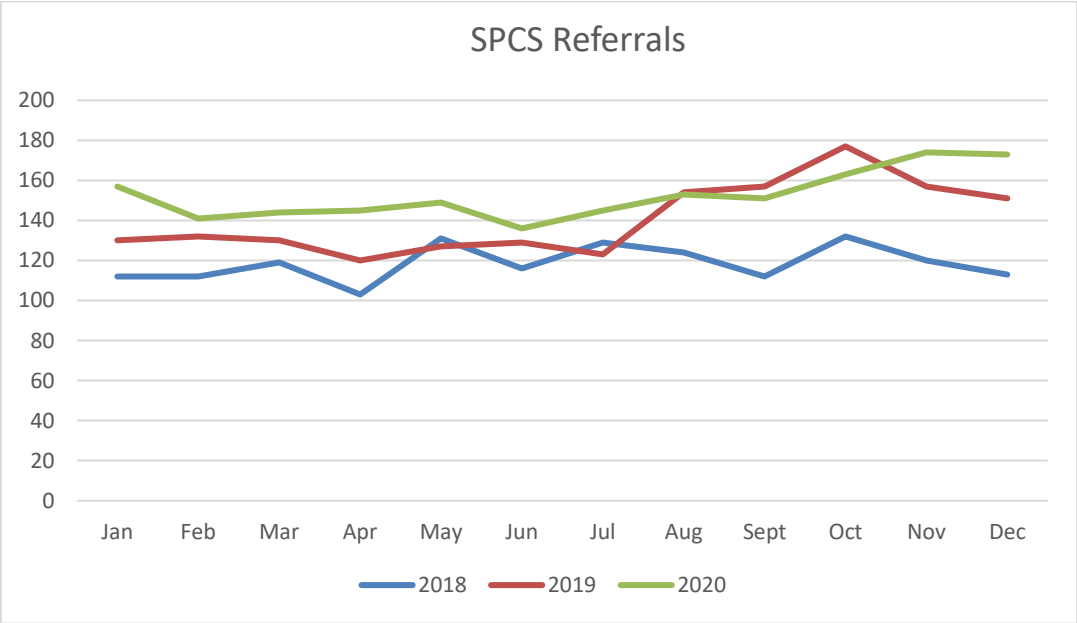
Increasingly there is also a need for specialist clinical facilities and resources to treat wounds in the community. A significant number of wound care clients are bariatric clients of size and may have dressings that take two nurses up to an hour and a half each visit which is a very significant resource 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.

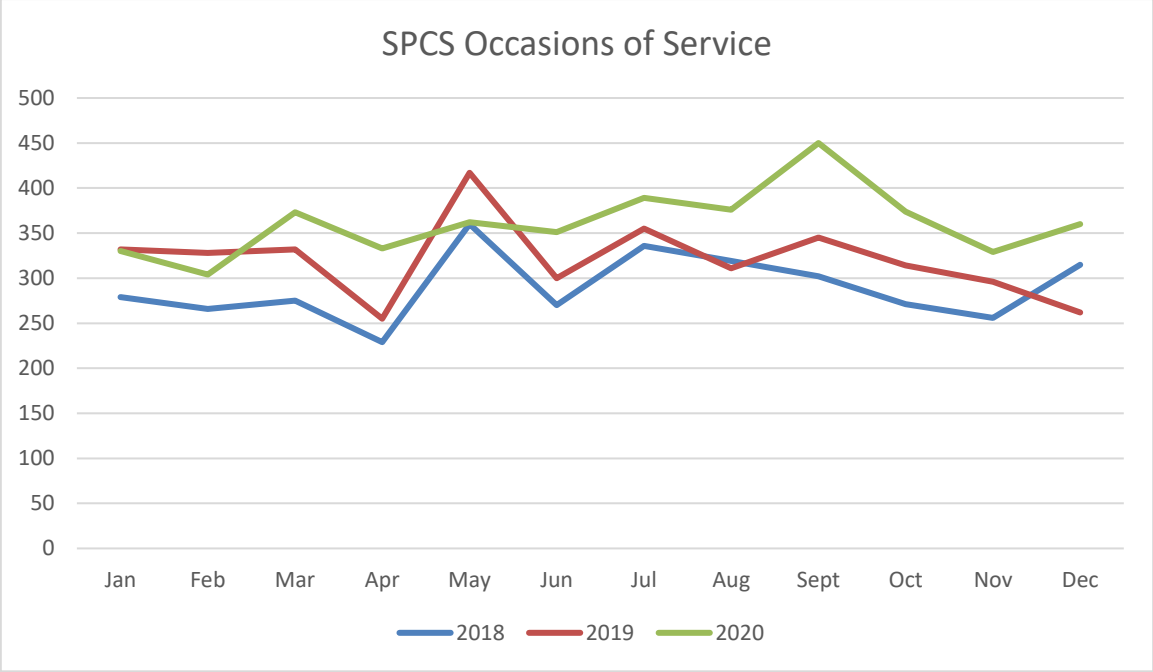
There is the potential to rollout similar models to the south's lower leg foot clinic to other areas. Consideration should also be given to the implementation of a flat fee for wound care products. Tasmania is one of the few Australian states which do not charge for wound care products and this presents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

There is considerable evidence which demonstrates the importance and benefits of 24 hour high quality palliative care services and support in both community and acute settings for dying patients and this is currently not available in the north of the state with afterhours palliative care support a significant issue. There has also been considerable Australian research which indicates that a significant number of patients would prefer to die at home, around 60%, if given the opportunity yet the at home death rate remain relatively low, in the north for the past six months this was around 14%.

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 quite limited and due to end shortly. There is a particular need for appropriate after-hours medical oversight of care. Currently if a client requires after hours medication prescribed or changed there are extremely limited options to ensure this occurs. This often results in patients being referred to hospital

Emergency Departments rather than being able to remain in the community which is not ideal. Similarly, if a patient lives in a rural area and has afterhours issues with a syringe driver for example the current advice often has to be for them to be transferred by ambulance to the Emergency Department as there are no alternative after hours options. In more isolated rural areas this can add further issues as it results in ambulance services being out of an area for a significant period of time, it can limit family support for the palliative patient and it adds significantly to the cost of palliative cares service provision.

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 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 additional challenges. 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 but GP Assist are requesting an additional funding allocation to cover the medical component of after-hours support which may make the service cost prohibitive. 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.

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 on several levels as well as having the potential to establish a network of GPs willing to provide after-hours support to palliative community patients.

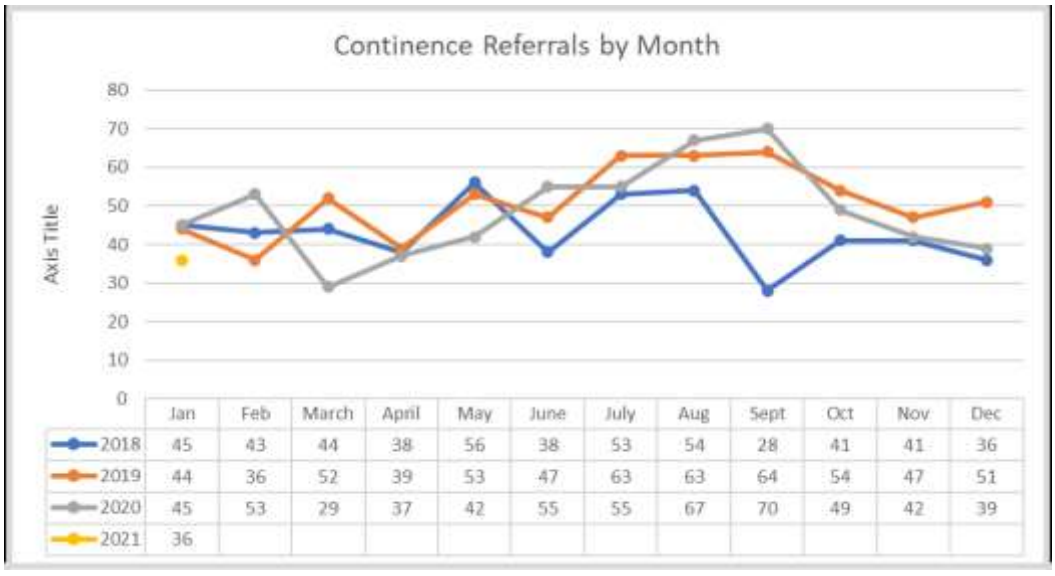
In the north there is also a need for SPCS resident/registrar positions in the acute hospital. For the last quarter of 2020 the palliative care service had a total of 489 contacts at the LGH and averaged 2 new referrals and 8 client visits per day for LGH patients which is significant. Currently in the 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. This registrar position could also act as a conduit between the acute sector and the patient's GP and assist in facilitation of effective discharge planning and community

management and support which is a component currently often lacking and resulting in potentially avoidable readmissions.

Continence:

Continence Services are not widely acknowledged 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 Emergency Department as they lack the level of expertise needed to manage them at home or in RACFs. Strengthening of community continence support would potentially avoid a proportion of hospital presentations.

Continence Service referral rates for the North averaged 49 per month for 2020 with waiting times for non-urgent clients up to 12 weeks. As with wound care services currently Specialist Continence Clinics are only provided to rural areas on an average of once every six weeks which, as with specialist wound care, at times delays care and support for patients and can result in a more reactive rather than pro-active approach.



	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 service is

however limited to the greater Launceston area and there is a need to provide smaller similar type services in larger rural centres.

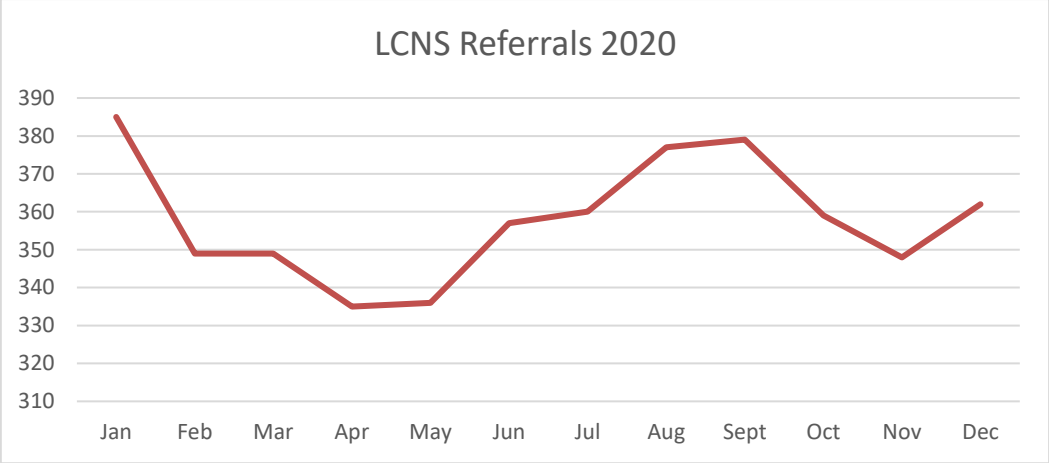
The CDS provides consultation, assessment, information, and the provision of direct care to people with dementia living in the Launceston area. Similar services could potentially be rolled out to the south and north west. The service maintains an average number of 50 active community clients at any one 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. 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.

Community Nursing Services:

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 numbers increasing but also the time required to provide client care, reflective of increasing client complexity. A simlar trend can be seen with many rural Community Nursing services, a significant number of which are ccurrently experiencing significant workload and staffing issues and are consequently monitoring acceptance of referrals.



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.

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.

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.

The substantial 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.

Additional Information –

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.

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

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. The PHN Community Physiotherapy team provide a number of group programs in addition to individual sessions. These include Strength & Balance, Hydrotherapy and OPALL (Overcoming Pain and Living Life). Unfortunately, such a small FTE means that there is 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.

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.

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. Over the last year the community team has received an average of 25 new referrals per month.

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 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.

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.

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 across 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.

In 2020 the Community Social Work team received 1265 referrals and participated in group programs including the Stanford 6 Weeks Persistent Pain Group, OPALL, Mindfulness in Motion and Art and Health Therapy Group.

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.

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

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.

There is a need to be able to expand allied health 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.

Telehealth

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 across our health service.

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, 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.

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.

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.

Primary Health North has an established foundation and framework. We know our local communities and facilities. We can build on this framework to increase our capacity to provide much needed community health programs, increase our focus on preventative health programs and health promotion activities. We also need to look at health care that is 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.