Stakeholder Submission to the Green Paper “Delivering safe and sustainable clinical services”, One State, One Health System, Better Outcomes

Community Options Service North - Primary Health Services (THO North) submitted by Lisa Shearing
(COS North Team Leader)

COMMUNITY CONSULTATION QUESTIONS:

Q) Is the Tasmanian health system all it should be, or should we be open to change in order to improve outcomes for all Tasmanians regardless of where they live?

The Tasmanian Health System and health outcomes could certainly be improved and we should always be open to change in order to improve outcomes and a focus on best practice evidence and continued improvement to achieve quality service delivery. However in order for change to be truly effective and sustainable into the future across a State-wide health system reform, the following also needs to be taken into consideration as part of the reform process;

- A Staged Reform Implementation Plan once the White Paper is completed, with attention given to the ongoing support and implementation needs of effective change management processes, some following examples include;
  - Looking at and properly evaluating past Tasmanian Health Care/System reforms over the last 10 years to confirm what did not work and why, what could have been done better and what was effective/what did produce positive outcomes, to avoid past mistakes and guide more effective and sustainable change management into the future

  - Attention given to changing and supporting organisational/staff culture which should be at least a 3 year plan as a minimum and using a 360 degree model approach (top down and bottom up) and requiring commitment and ongoing support to succeed. Without change to attitudes and culture formed over decades there is a risk of continued silo operations across regions and between areas of the health system

  - A strong Consumer Engagement strategy, utilising as a start point the THO consumer advisory groups that have been established. This is a prime opportunity as part of health care reform to involve consumers, including special needs consumers and advocacy groups throughout the implementation of this reform. This approach may assist in working with the smaller/rural communities who may be more resistant to any loss of clinical services in their local community. This is also an opportunity to forge stronger partnerships with other local community services such as the local neighbourhood and community houses.

- Change does not have to mean starting from scratch as there are currently a number of positive examples of how across regions and across acute/sub-acute/community sectors where some services are working very well in collaboration and achieving positive outcomes for clients/patients and community. Would be good to first find out more information about current positive models that are already in existence and run further consultation with those direct staff on the ground + clients/patients of those services to find out why their model is effective, what has worked and how can things like this be replicated as part of the system reform to avoid re-inventing the wheel and to assist with positive cultural change E.g. Community Options Service North, Community Podiatry North, Community Dementia Service, John L Grove, Outpatient Rehabilitation Service, NICS etc.
- A review and change of the current funding structure and requirements, ensuring these are not working against the implementation of a new model and new way of working e.g. more focus on collaborative partnerships to try and decrease some of the competitive tendering that occurs and the impact this can have on collaborative practices at times, opening up eligibility criteria so that the services can be more flexible and wrap around the consumer to meet their needs, opening up catchment areas so that a service in the North can actively work with someone travelling to the North for procedure/treatment i.e. to provide support if required whilst they are in the North and assist in transition back to the region they live at the same time as working alongside the respective service in the client’s home region (and this not being seen or perceived as double dipping or service duplication) etc.

- A review and change of the current reporting structures and requirements so that service providers are able to report on both quantitative as well as qualitative data and to have the ability to report more on outcomes rather than just outputs (as per outcomes reporting framework being developed and applied to Non-Government Organisations funded by DHHS).

Q) How would you find out about what travel support, information and services are available to you to get the right care, by the right person, the first time?

The best way to do this initially is at the entrance point to the health system for each individual once it is determined that they will need certain services/treatment/travel etc. – the first and initial contact point/person who the consumer or carer has contact with e.g. GP or specialist/clinician who refers the patient for the treatment, Emergency Department staff, community service provider etc. who could provide the person with the basic initial information on available services or travel support options and contact numbers for people to be able to find out more. The point to make is that the people who are providing this information need to be confident that they have timely access to the most current and correct information in the easiest way.

- This is a massive task and would require ongoing staffing and support (probably most effectively run and maintained by DHHS as central point and holder of funding contracts) to ensure at all times the information remains current and covering the required basic summary information regarding large range of health services and funding (Government as well as Non-Government/Private).

- Ideally a centralised health information system for Tasmania which is accessible by all and at all different levels e.g. the general public and consumer themselves, DHHS, all THS staff, GP’s and specialists/clinicians, non-government and private providers – ensuring everyone is accessing and using the same information, hence consistency across Tasmania. I am aware that this has been tried many times across different states and has failed either because of inadequate resourcing and/or technical difficulties.

- Currently there is +++ repetition and duplication throughout our health and aged care industry in Tasmania as many services and organisations create their own service manuals/reference points or brochure displays to know what is out there and available but find it difficult to keep these up to date and current due to the rapid pace of funding and service changes across Government and Non-Government sectors.

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• This also needs to be accessible to GP's/clinicians/specialists/THO staff via click onto 1 icon on their computer desktop (rather than having to search internet etc.) to ensure effective and efficient use of the system.

• This system could also have attached the relevant fact sheet and/or service brochure for each service which could summarise what services are provided, their contact details and basic funding info e.g. who is funding the service and funding date ranges if applicable.

• This would provide opportunity to present the same service across different categories if a service provides more than 1 type of service, so that they can easily be located in a number of different search criteria e.g. COS North provides HACC funded complex case management as well as HACC funded Dementia Nurse + HACC funded Home Maintenance Program + 38 Level 2 Community Aged Care Packages – this could be spread across different search categories RE case management, Dementia, Home Maintenance, Community Aged Care etc.

• This could initially be built from current information systems that have already been established and who already have some local information RE what services and service types are out there e.g. Tas Carepoint, My Aged Care, DHHS internet and other health directories e.g. Council etc., so that there was a baseline of data/service information to start from.

• This would need to be built around health literacy principles from the very beginning and have options to provide the hard copy fact sheets/brochures as well as video presentation options to consumers if the consumer is unable to access the internet/computer or has issues with language and literacy etc. Health Literacy is critical and needs to be taken into consideration so that the entire system meets required health literacy principles. This may also assist to decrease the burden and impact on consumers of every health service they access providing them with a handful of information and brochures that can be too overwhelming, not be effective for those with literacy or cognitive issues.

Other suggestions include:

• Quality of current technology RE tele health/video conferencing needs to improve and this will hopefully increase the number of people accessing and using these resources as this also provides valuable opportunities to access interstate specialists in a more timely manner with better outcomes because of this. This technology does exist but I feel has not been implemented due to lack of commitment to provision of adequate resources to run it effectively and many Doctors/Health Professionals don't utilise the technology enough. The Community Options Service North Dementia Nurse has already utilised this technology to access a specialist which had positive outcomes for the consumer, carer and overall health outcomes.

• In relation to accessing required transport services to assist the new health care model, this is going to be of major importance as current demand for this service clearly exceeds supply levels. There is not enough transport funding and availability across all areas of Tasmania, especially in the more rural and remote areas to currently be able to meet future requirements of this reform. There needs to be more transport assistance options e.g. 1) hospital to hospital patient
transport 2) home to hospital/health service transport (including stretcher options where required) + across regions and 3) home to community transport for social support needs. There also needs to be considerable growth in the number of wheelchair accessible vehicles across all areas + more training and support for drivers and transport providers regarding transportation of people with more complex needs i.e. cognitive impairment, Dementia and people with behavioural issues, as these are the client groups that currently experience barriers to accessing required transport services. A good start to looking at the current transport system and how it is working is via the current Community Transport Study that professor Corinne Mulley is involved in as there has been a lot of consultation in 2014 occurring around Tasmanian HACC funded transport services where this information could be useful.

Q) If it improves the quality and safety of care, do you agree we should limit the number of sites at which some services are provided?

Yes – as long as there are adequate resources to get people to the services they need at the right times

Q) If yes, what should we consider in deciding where a service is located and what support needs to be considered to ensure patients have equitable access?

The Role Delineation Framework and process from a clinical perspective seems to be a core body of work and model which enables this to be looked at regarding clinical capacity across Tasmania’s health facilities, population data etc. however this also needs to be something which is fluid and reviewed regularly enough to ensure that changes to clinical need, complexity, population data and capacity are recognised in an appropriate time frame and that the system is set up in a way that is flexible enough to make changes to this structure and where services are located/provided from as required to ensure the new system can continue to adapt to meet changing future needs in a sustainable way.

Other things to be considered:

• All rural hospital/health sites need access to all community areas which many of them are currently limited in number of community services accessible to them e.g. Case Management Services, Community Nursing, Community Social Work, Community Allied Health e.g. Occupational Therapist, Physiotherapist, Speech Pathologist, Podiatry, Community Mental Health Services etc. This would also contribute to ensuring adequate discharge linkages/pathway support and very importantly maintaining a focus in community services at these rural sites on early intervention, preventative strategies and health promotion + the ability to provide local follow up support in the consumer’s local community to ensure best patient and health outcomes are achieved and sustained.

• There needs to be a policy in place that ensures the patient is never discharged from hospital until the required supports are in place to ensure that person’s safety and this process needs to be actively monitored to ensure it occurs.
• For rural/remote health care sites/services – if certain treatment/surgery is to occur in another region, that person’s local community and health service can still provide the consumer with the required local supports to assist them to the place where procedure/treatment will occur, pathways and service linkages as required by the consumer to achieve best health outcomes, discharge follow up and more involvement in discharge planning (e.g. D/C planning meetings to start looking at including video conference / tele health linkages so that health services linked to that consumer in rural areas can be actively involved in the discharge planning meetings where required in other regions) etc. These more rural communities can still respond locally to assist the consumer through the treatment process and back home/into the community again and can still do this to a high standard with having local knowledge and networks and working in collaboration with other community and non-government services e.g. community mental health services like the Personal Helpers and Mentors Program, community and neighbourhood houses, local HACC providers etc.

• Improved transport assistance/service options at an affordable cost for low income earners/pensioners who will be required to travel to receive treatment

• Utilising the rural hospitals/health sites to assist with overflow stays in order to free up beds in the larger hospitals e.g. for the purpose of rehabilitation services (inpatient as well as outpatient), people who are taking up hospital beds awaiting permanent placement into residential aged care etc.

Q) What services do you currently receive in a hospital setting that you think could be safely delivered in your community?

• Low risk surgical treatments that don’t require general anaesthetic that can be safely done from a GP surgery

• GP surgeries are already starting to widen their service delivery with practice nurses and allied health staff however the costs to accessing these services need to be kept at reasonable level so low income earners and pensioners can still access them in a timely manner for earlier intervention and better outcomes

• If more clinical/surgical treatments are not occurring as much in the rural health sites as part of the State-wide reform, focusing on how community, rehabilitation and allied health services can effectively operate from these rural sites as a support structure to the local community e.g. COS Case Management, Community Nursing, Community Social Work, Community Mental health workers, Occupational Therapists, Physiotherapists, Speech Pathologists etc. and if being based at these sites was not feasible in the new model, looking at a visiting structure where that rural site and regional area will still have regular access to these health professionals and types of support services.

• The problem for many community providers is in relation to funding limitations and lack of current capacity e.g. restrictive eligibility criteria based on funding type, competitive tendering processes and the influences this has on culture and attitudes – hence a new funding
structure/contracts etc. is also required to adequately support the state-wide health service reform in a flexible way

- Outpatient and Slow Stream Rehabilitation services

- Health Promotion and Early Intervention Services

- There are also things that could be occurring where primary and community services are more involved in to assist in taking some of the work pressure and expectations off the hospitals, examples include;
  - Primary and Community Health being more actively involved in hospital discharge planning prior to the discharge occurring, especially for those consumers who have complex needs as this would greatly improve discharge outcomes. Currently we are experiencing +++ difficulties with this system and in some cases even after notifying hospital staff and writing in patient file notes etc. our community case manager is still not informed of discharge planning and at times finds out about this after the person has already been sent home without the appropriate equipment or set up of the equipment, without services in the home being reinstated, and there have been cases where this has even occurred without the appropriate transport home arranged i.e. a client of ours was discharged from LGH after hours and was required to catch a taxi from LGH to their home in the Scottsdale area because community transport does not operate after hours and the current patient transport system only transports people from hospital to hospital.

  - Removing regional barriers where it does not matter where the person lives but instead a focus on where they are receiving their treatment and what region would be best to provide the service to get the best health outcomes. An example to demonstrate this point – if COS North could pick up and work with a consumer who lived on the NW coast but due to their complex needs required short term case management support whilst they were in the North receiving active treatment and with the focus on supporting that person to remain where they needed to be to get the best outcomes. Once the person was discharged home, if they needed longer term case management support COS North could refer back through to COS NW to continue this on if required.

  - Current practices lend themselves to community and primary health services not actively providing a lot of support to clients when they are an inpatient as they are considered to be ‘on hold’. I believe these practices can also be improved because when someone is admitted into hospital, for many people this is when they are the most vulnerable and I believe this is where community and primary health services can also be doing more where required and appropriate to integrate more into the hospital/acute systems and provide more active support to our clients whilst they are an inpatient.
Q) How can we better help you understand the standard of care you are entitled to, and support your involvement in your healthcare decisions?

- Consumer Engagement, consumer engagement, consumer engagement – and not just at the surface level, right throughout the new Tasmanian Health Service. A good starting point would be to ask the consumers first and involve them more in the implementation of these health care reforms. This could initially commence with utilising the THO’s consumer advisory groups and speaking with organisations such as TasCOSS who have done a huge amount of work around consumer engagement. This should also be a question that is asked to any consumer when they first enter the health system either as an inpatient or a community client.

- Ensure that all information about health services and clients rights is provided and discussed with consumers in a way which uses health literacy principles and ask the consumer where able to state how they would like information provided to them and how to assist them to best understand this information. Further examples to demonstrate;
  - Not providing a consumer with a bulk of information and paperwork prior to discharge and when a person is still recovering from anaesthetic
  - Ensuring where possible that there is a family member or support person/advocate present when information is being provided to and discussed with the consumer (so that there is another person hearing the information in case the consumer themselves do not understand)
  - Follow up with the consumer via a phone call or follow up appointment within reasonable time frame (not 3-6 months post discharge) where there is opportunity for questions and answers based on the information provided to the consumer and their level of understanding
  - Provision of information at the consumers own pace following health literacy principles – it may require 2-3 meetings/appointments over a 1 month period instead of 1 appointment to provide the required information in a staged way.
  - Look at being creative in what media is used to communicate this information – i.e. client narratives, motivational interviewing and consumers speaking to consumers could increase opportunities for increased understanding of these things (especially for those consumers who have issues with literacy, health literacy and cognitive impairment) – please see our enclosed Client Narrative Video as an example to demonstrate this

Q) What public-private partnerships should we explore for the delivery of health services in Tasmania?

- Firstly to focus on increasing and strengthening internal partnerships within the Tasmanian Health Service not only across regions but also across Acute and Community settings.

- Then, increased focus on Partnerships through funding submissions where THO (Government) and community (Non-Government/Private) providers are required to submit funding applications based on partnership and collaborative approaches to service delivery to encourage this practice more and try and decrease some of the impacts of competitive tendering for
limited funding. This will also support increased opportunities for smaller community/non-government organisations

- Good starting point would be to find out who is already doing positive partnership work and learn from them i.e. what did not work/what to avoid, what did work, how it worked so that the positive aspects of these approaches and models can be used and built on e.g. THO North working in collaboration with providers such as Neighbourhood and Community Houses, Tas Medicare Locals, District Nurses (Hospice at Home), Gateway disability model, Community Mental Health Models such as the Personal Helpers and Mentors Program and Partners to Recovery etc.

**CLINICIAN CONSULTATION QUESTIONS**:

**Q) How well does the proposed framework align with practice in your discipline?**

I believe the framework is very brief in its descriptions regarding service access levels and what will be provided under the different clinical areas (e.g. language used such as ‘limited’ but no indication of what this means or indicates). It is important to raise again the barriers that need longer term focus and commitment to effectively be addressed i.e. decades of development of current organisational cultures, working in silos, competitiveness which does impact and influence on collaborative work practices and partnership approaches at times. This is a prime opportunity for positive change however there are a very large number of staff who are quite negative and sceptical about yet another health system reform.

Our Service is a primary health community service and we are currently working well and in collaboration with acute/sub-acute/community/non-government and private service providers to ensure our clients are directing their care where able and achievement of positive outcomes for the consumer as well as the broader health system e.g. minimising hospitalisations and recurrent calls to ambulance, decreasing length of hospital stays etc. I believe the framework aligns well with a community and integrative/collaborative model, especially in also considering prior point RE culture and attitudes.

**Q) Where are the areas of service duplication in your discipline?**

There are a number of services and staff within the sub-acute areas that at times can take on more of a community case management/coordination role than what they should, especially if it is quicker and easier to get positive outcomes in comparison to attempting to link with appropriate service and not being able to access required services in a timely manner due to waitlists + difficult process created by consumers not meeting the eligibility criteria of services. This is not only happening internally within the THO’s but is also occurring externally e.g. Tasmanian Medicare Locals, Gateway Services for Disability, Mental Health Services, Outpatient Rehab etc. I am not saying that this is done in an inappropriate way but at times it can fall outside of the service’s funding boundaries and scope which can then build consumer expectations that are not sustainable.

➢ If the structure around current and future funding changes to increase flexibility in provider approaches to service delivery, this would enable the best person/service at the time to be assisting the consumer with less focus on if the person meets the eligibility criteria. I am
aware of a very large number of consumers (especially those with complex needs in the community) who continue to be ‘hand balled’ from 1 service to another being consistency told they don’t meet eligibility criteria, many of these people are at risk of ‘falling through the cracks’ where positive health outcomes are not being met.

- Need designated ‘roles’ with authority to step in, assess the situation, bring relevant services together and ensure they reach agreed plans for how the client can manage their situation. Then being able to go ‘up the chain’ if services don’t cooperate or carry out the agreed plan.

Q) Where are the gaps?

Complex Case management - There is not enough funding for this service type. Many other services (Government and Non-Government) are only funded to provide a care coordination element specific to the person’s disability or chronic health condition e.g. current models with services such as Mental Health, Outpatient Rehab, Tasmanian Medicare Locals, and Disability Gateway Model etc. This is very different to providing a holistic complex case management service which does look at and address all relevant areas of a person’s life and health to ensure positive health outcomes are achieved and where longer term case management is required, to ensure the positive outcomes are sustained. Things to also be considered with this include;

- This funding for case management needs to be flexible enough to provide short term case management where required as well as long term case management options for people with more complex needs that require this level of ongoing support.

- It needs to be broader than the HACC target group to capture people who fall outside of other eligibility criteria e.g. someone recovering from acute illness, self-funded retirees, those with a temporary disability such as protracted hospitalisation, delirium, sub-acute mental health etc.

- There is not enough consideration given to transitional rehabilitation

- More consideration needs to be given to enabling more carer support through carers also being able to access required services (again – need for review of all eligibility criteria/funding requirements) because as the carers decline, it impacts on the carer, the person being cared for and the carers immediate family.

- With the current Commonwealth Aged Care Reforms, the aged care sector is already at risk and is highly likely to have negative flow on effects onto the State’s Health System due to increased hospitalisations and length of hospital stays and a decrease in case management funding for this target group out of HACC Group 2 funding – this is going to create an even larger gap in this service type area when this starts to occur. These Commonwealth Reforms are also starting to have an impact that double disadvantages rural/remote clients where the cost of travel can be taken out of their allocated community aged care package funds, therefore leaving less money in their package for actual services.
Having access to greater funding for case management services will also assist in leading culture change in a positive and collaborative way e.g. case management practices such as the facilitation of case conferencing involving the consumer and all required services/clinicians (acute/sub-acute and community)

The current Community Options Service North case management model is the ‘Active Service Model’ which focuses on wellness, strength based and person-centred care approaches to service delivery which can be used in conjunction with medical models as and when required e.g. when someone is in an acute setting. We currently provide a central/key service or worker involved to assist in pathway planning, service linkages, care planning, consultation etc.

Transport Assistance/Services needs to be increased considerably as current demand for these services already exceeds supply levels and this demand will only increase with the proposed Health System Reforms.

Q) How do we promote and maintain safe primary and community care to consumers and communities such that they seek out these services rather than attend Emergency Departments when their conditions are more advanced?

Utilisation of the current THO’s Consumer Advisory groups to get consumer engagement occurring around this question as they may be able to provide valuable ideas around this and what consumers are saying they need and want

Increase creativity in the promotion of primary and community care services, also taking into consideration health literacy principles so there is a range of options available to promote these services, for example;
- As discussed on page 2 - Ideally a centralised health information system for Tasmania which is accessible by all and at all different levels e.g. the general public and consumer themselves, DHHS, all THS staff, GP’s and specialists/clinicians, non-government and private providers to ensure that everyone is accessing and using the same information to ensure consistency across Tasmania. Accessible to GP’s/clinicians/specialists/THO Staff via desktop icon, attached relevant fact sheet and/or service brochure to summarise what services are provided, their contact details etc., could initially be built from current information systems that have already been established with local information e.g. Tas Carepoint, My Aged Care, DHHS internet and other health directories e.g. Council as a starting point
- Different ways of presenting service information – Please See attached COS North Client Narrative Video as a demonstration of creative ways to promote services
- More advertising of available health care services via newspaper articles and television news showing more stories about positive health outcomes that are being achieved and different health services offered within the Tasmanian Health Service – as this would capture more consumers who may not read the newspaper, may not be literate let alone health literate and who don’t have access to a computer
• Health literacy principles must be taken into consideration when looking at any promotional material, especially in relation to the development of brochures/service fact sheets and how this is provided and delivered to consumers. Currently it is not effective and is very overwhelming to many consumers and I would imagine that a large majority of the information would end up in the bin or not understood. This is a great opportunity to look at full consistency in how the Tasmanian Health Service will promote our services across all regions and in a way that meets health literacy principles – the best people to assist with learning more about this is the consumers themselves and utilisation of Health Promotion North for further information and ideas around this.

• Facilitation of more public health system information forums e.g. 6 or 12 monthly which is opened to the general public/community and promoted via print in newspaper, television and flyers to mail boxes or via service providers etc. This would create ongoing opportunity for community members to come in and learn more about what health services are available in their area, meet some of the service providers who can explain to them what it is they provide and look at collaboration activities across service types for the forum so that the members of the public can see for themselves examples of different health areas and services working together collaboratively. This may also assist in building trust overtime in the new health system and reform.

Q) How do we determine which services to focus on to expand the role of primary and community care?

Initially you need to be looking at current service structures and models that are already doing it well (Government and Non-Government) and who are achieving positive health and service outcomes with consumers e.g. Community Options Service North, John L Grove Slow Stream Rehabilitation, Community Care NESB, Launceston Volunteers for Community, Community and Neighbourhood Houses, Outpatient Rehab etc. and start meeting with direct staff and consumers of those services to find out how it is working, what makes their service delivery model and approaches effective etc. and then try and replicate positive aspects and ideas from these models as a starting point for statewide reform.

As stated in earlier comments, from what I have read and heard to date I really feel there is more need for case management services within the new health system with the aim of having a central contact and coordination service (especially for those consumers with more complex needs who require linkages with multiple health and community services pre and post discharge). Case management is more than care-coordination as it takes a holistic approach to looking at client’s needs, is not driven by a medical model and includes advocacy, care planning, pathway support and linkages etc. This needs to have more open and flexible eligibility criteria to ensure that people with a temporary disability e.g. protracted hospitalisation, delirium, sub-acute mental health, and those recovering from acute illness can also access this service type when required. This service type could not only complement current funded case management services already being delivered (e.g. Community Options Services across the current Tasmanian Health system) but could also be implemented/integrated into other health service areas i.e. acute/sub-acute and community where required and appropriate e.g. Hospital Aged Care Liaison Team, Outpatient Rehabilitation, Other Slow Stream Rehabilitation services such as John L Grove, Community Dementia Service, Mental
Health Services, Gateway Disability Services etc.. This would also support an increased focus and ability to expand more of this role of primary and community care in a partnership approach with acute and sub-acute services across regions. Further Examples to demonstrate:

➢ Primary Health North already provides a range of health promotion, early intervention, care and assessment, inpatient and outpatient treatment, residential aged care and community health services to individuals, groups and communities across Tasmania. Many Primary health services are delivered from community health Centre’s and rural inpatient/health facilities.

➢ Rural inpatient facilities (including multi-purpose services) provide valuable and quality inpatient care and community health services. Some services are provided in isolated locations. Primary health services based at and delivered from these sites are generally targeted to meet the needs of the surrounding community. There is a commitment to complex clients and rural and disadvantaged communities and through its structure, is cognizant of the plethora of issues related to the provision of quality health care and aged care services.

➢ Within our service we have a very strong and positive model that we work within called the ‘Active Service Model’ which takes a wellness, strength based and person-centred care approach to working with consumers. This Active Service Model focuses on client and caregiver goals being central to needs identification and care planning. The core business of COS North for the last twenty three years has been the provision of complex case management services. Because of our current approaches to service delivery, our experience within this and current collaborative practices across the Northern Tasmania, Primary Health North services such as COS North and the Community Dementia Service are already strongly established and skilled in these areas. We seek to enable people to do as much as possible for themselves by optimising a person’s functional and psychosocial independence, with the focus on capacity building, re-enablement, maximising independence and restorative care where possible and practicable.

➢ In relation to the COS North ‘Active Service Model’, it is much broader than a ‘service delivery’ approach, in that it looks at all aspects of a client’s life, what clients would like to achieve, their social networks and personal relationships and support, what is important to the client, ongoing participation in life, their goals, and milestones towards them. This service type can be provided on a short term basis or a longer term basis if required and appropriate, ensuring positive outcomes are achieved. Keeping a care recipient engaged in every aspect of their life, for as long as possible, builds client confidence and their self-esteem. Tools have been developed to assist in the implementation and promotion of this approach. I wish I had a financial figure to provide to show how much we have saved the health system in decreasing hospital admissions and length of hospital stays, decreased use of emergency services, early intervention strategies etc., unfortunately I do not but I believe it would be saving the overall health system a lot of money and freeing up those acute services for those who truly need it.
We provide a single point of contact for care recipients and caregivers who require a complex range of services and/or intensive levels of support. Service planning and delivery is client centred and driven based on client's goals, is flexible, planned, coordinated and reliable. We utilise local resources and informal networks and supports, and are mindful of consumers' rights, values and preferences which respects, accommodates and dignifies changes that may occur in a care recipient or carer's life circumstances, including progressive cognitive deterioration. This enables us to flexibly respond to complex needs arising from interacting physical, emotional, psycho-social and cultural factors. It also supports a creative and lateral approach to care planning, maximising what already exists to maintain the care recipient's functional capacities and skills and ensuring the consumer remains central to these processes and decision making.

Lisa Shearing
Team Leader – Community Options Service North

Attachment to this submission document = 1 DVD Titled "Person Centred Care — Client Stories", Community Options Service.