Australian Government
Department of Health

phn
An Australian Government Initiative

Primary Health Networks – *Greater Choice for At Home Palliative Care*

Gold Coast PHN

When submitting the *Greater Choice for At Home Palliative Care* Activity Work Plan 2017-2018 to 2019-2020 to the Department of Health, the PHN must ensure that all internal clearances have been obtained and has been endorsed by the CEO.

The *Greater Choice for At Home Palliative Care* Activity Work Plan must be lodged to Lisa Bai via email to Qld_PHN@health.gov.au on or before 17 February 2018, and subsequently updated, on an annual basis.

Introduction

Overview

The key objectives of Primary Health Networks (PHN) are:

- increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and
- improving coordination of care to ensure patients receive the right care in the right place at the right time.

The *Greater Choice for At Home Palliative Care* (GCfAHPC) provides funding to improve coordination and integration of end-of-life care across primary, secondary, tertiary and community health services to support at home palliative care through funding Primary Health Networks (PHNs).

In line with these objectives, the PHN GCfAHPC Funding stream will support PHNs to:

- improve access to safe, quality palliative care at home and support end-of-life care systems and services in primary health care and community care;
- enable the right care, at the right time and in the right place to reduce unnecessary hospitalisations;
- generate and use data to ensure continuous improvement of services across sectors; and
- utilise available technologies to provide flexible and responsive care, including care after usual business hours.

1. Planned activities funded under the Activity – Primary Health Networks Greater Choice for At Home Palliative Care Funding

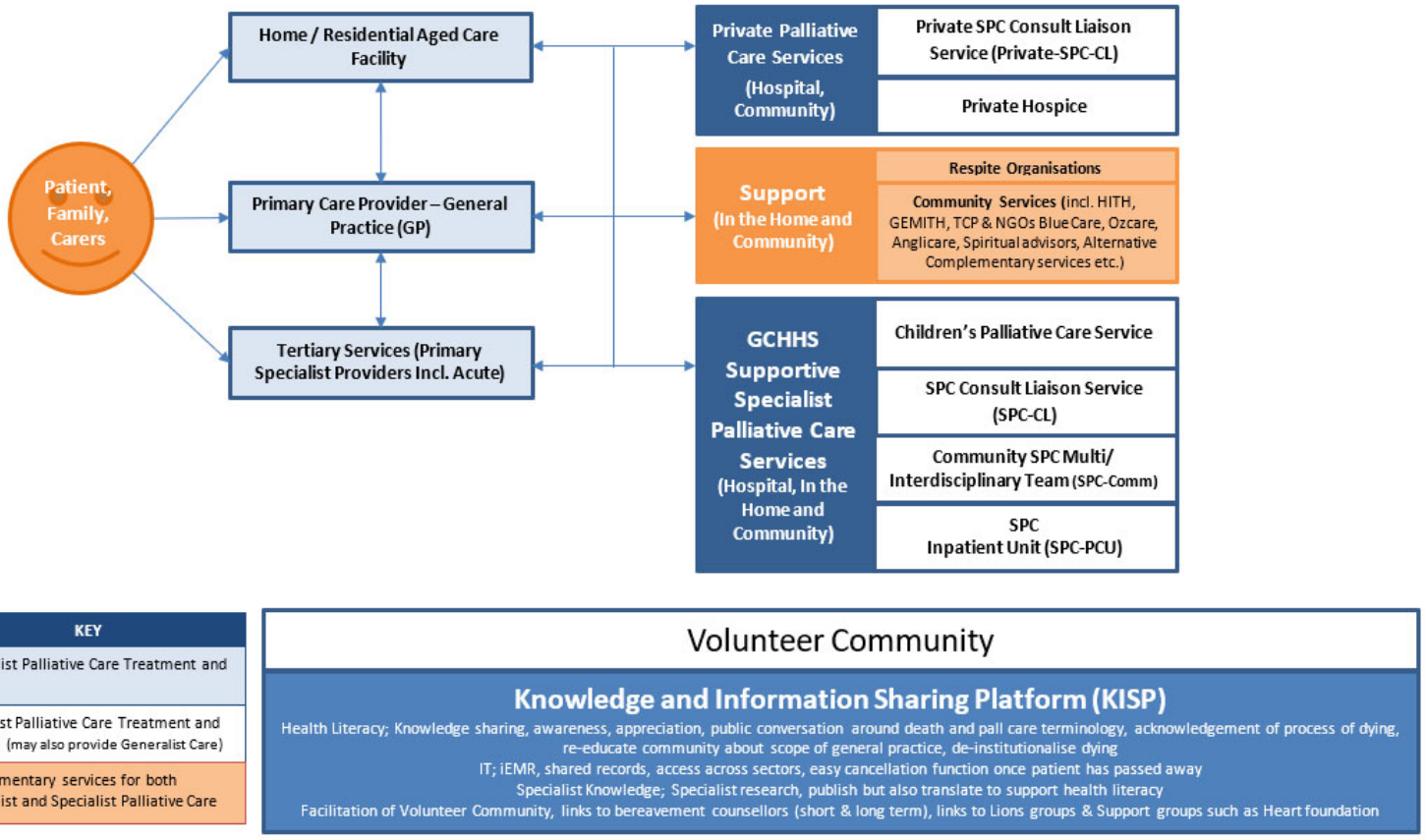
PHNs must use the table below to outline the activities proposed to be undertaken within the period 2017-18 to 2019-2020 These activities will be funded under the *Greater Choice for At Home Palliative Care* Funding stream under the Schedule – Primary Health Networks Core Funding.

Proposed Activities	Description
Activity Title	*Greater Choice for At Home Palliative Care* (GCfAHPC) Project.

Description of Activity	A local palliative care needs assessment has been completed and a regional plan has been endorsed by Gold Coast Health and GCPHN. This plan is in final stages of development and will be publicly launched once all design work is completed. The program of work to be progressed as a result of this work under GCfAHPC funding are the following four streams of activity: 1. Enhanced support for General Practice to deliver Palliative Care through an evidence based, locally relevant and user friendly "shared care" framework including: ○ review, prioritisation and localisation of existing appropriate guidelines, tools and resources ○ define and document clinical support and pathways with Gold Coast Health Specialist Palliative Care Unit (GCH SPCU) ○ protocols agreed and documented ○ embedded within usual general practice business processes ○ document published in appropriate online and hard copy formats ○ general practice user acceptance testing ○ awareness, training and support for use of framework ○ explore potential use of new tailored general practice PCOC tool for suitability to implement locally

	2. Enhanced Palliative Care Capacity in Residential Aged Care Facilities (RACFs) o Recruit 5 RACFs o Contract palliative care nurse to provide clinical support and liaison for framework development o Onsite delivery of education and guidance and coordination with GCH SPCU and After Hours navigation services 3. Enhanced palliative care volunteer capability/capacity o Increase the existing community sector volunteer capability/capacity to deliver palliative care volunteer support 4. Community Awareness Campaign o Modest campaign to increase community health literacy about Advance Care Planning and the dying process Please note other GCPHN projects including the Advance Project (funded through Hammond Care), funding after hours telephone support for RACFs and the ongoing progress of local implementation of the Gold Coast Integrated Care Alliance Palliative Care Model of Care will contribute to and support the above activities.
Rationale/ Aim of the Activity	The palliative care needs assessment undertaken in 2018 (published December 2018) identified the following specific local health needs and service issues: • Care coordination and support to general practice to be the centre of care where possible • Current systems not always supportive to ensure planning, commissioning and delivery of integrated and coordinated service matrix • Access to integrated palliative care system across the health and social sector so people are supported as early as possible • Need to ensure people can access good quality end of life care 24/7 • Current systems not always established for the provision of clinical coordination of end of life care between providers • Residential Aged Care Facilities (RACFs) service high numbers of palliative patients • To ensure all providers are skilled and competent in delivering high quality palliative and EOL care • Carers require support to ensure they don't "burn out" • Current limitations for ensuring that patient choice and wishes are respected • Provisions of care required to allow patients achieving their preferred place of death • Limited uptake of Advanced Care Plans (ACPs) • Options for better conversations about death and dying, and involvement • Access to clear communication, and accessible information for patients, families and healthcare professionals. In addition to the needs assessment findings, the GCPHN and Gold Coast Health Integrated Care Alliance agreed new Palliative Care Model of Care (MoC) was finalised in late 2018 and reinforced the importance of the medical home and specifically, the role of general practice in

supporting palliative care patients at home/in the community. A high level diagram of the MoC detailing these service needs is provided below.



The Integrated Care Alliance MoC identified a series of recommendations to support the above MoC. Those that relate to the PHN's role and as described in this Activity Work Plan are the following:

Recommendation 1*: Promotion of ACP through all health providers, making it routine for patients 65+ as well as public awareness campaign of the importance of ACP.*

Recommendation 2: the GCH resource the specialist service to increase training to GPs and their practice nurses.

***Recommendation 3**: the clinical group suggest the GCH and GCPHN create a pilot program to create RACFs as 'Centres of Excellence' with resourcing for education and in reaching Specialist Nurses, Allied Health and Doctors following models developed elsewhere (e.g. Metro South/Calvary NSW).*
Recommendation 4: the current SPC-Comm team staff be significantly enhanced to allow greater consultative work in line with Palliative Care Australia guidelines, incl. enhancement of navigator roles.
***Recommendation 10**: provide resourcing for a palliative care volunteer coordinator to focus on building up a set of volunteers from the 'caring community' that may be utilised in homes and hospitals.*
Recommendation 11: the GCH and GCPHN provide resourcing that allows for the development of the knowledge sharing platform with a project officer.
***Recommendation 13**: the GCPHN facilitate the means to educate the GPs about the appropriate Medicare item numbers.*

Subsequent work with stakeholders, considering the needs assessment outcomes, ICA Palliative Care MoC and a review of evidence and other models identified the following priorities to address through regional planning:

- Workforce capacity building
- Service integration
- Sector collaboration
- Volunteer availability
- Community awareness and education

The activities identified above aim to address these priorities and the specific issues that informed them through the following four streams of activity.

1 **Enhanced support for General Practice to deliver Palliative Care.** To create an evidence based, locally relevant and user friendly "shared care" framework to support general practice deliver integrated and coordinated patient centred care within their usual business frameworks; define and document clinical support and pathways with general practice and GCH SPCU.

2 **Enhanced Palliative Care Capacity in Residential Aged Care Facilities (RACFs).** Providers supported to improve coordination and clinical management of palliative and end of life care for residents, preventing unnecessary transfers to hospital. By the end of this project a comprehensive evidenced base palliative approach to care for people residing in RACF's and their families will be developed and implemented within the 5 identified RACF's in collaboration with the GPs servicing those RACF's.

3 **Enhanced palliative care volunteer capability/capacity.** To increase the community volunteer capability/capacity over 1 – 2 years to leave a lasting increased pool of suitable people willing and able to support those caring for loved ones dying at home.

	4 **Community Awareness Campaign** To increase the awareness, uptake and use of Advance Care Plans, and to improve health literacy regarding the dying process.
Strategic Alignment	The GCfAHPC aligns with the intent of the Department of Health Funding Agreement and Gold Coast Primary Health Network's (GCPHN) and the Gold Coast Integrated Care Alliance's key objectives and performance outcomes. The connection between the GCPHN, Integrated Care Alliance and GCfAHPC objectives are outlined below. **GCPHN Strategic Objectives** ○ Improve coordination of care to ensure patients receive the right care at the right place at the right time ○ Increase efficiency and effectiveness of health services for patients particularly those at risk of poor outcomes ○ Engage and support general practice and other stakeholders to facilitate improvements in our local health system, and ○ Be a high performing, efficient and accountable organisation **GCH and GCPHN Gold Coast Integrated Care Alliance Objectives** To work together collaboratively to create a single integrated healthcare system for the Gold Coast by: ○ Improving the coordination of care to ensure people receive the right care at the right place at the right time by the right person ○ Increasing the effectiveness and efficiency of health services for patients ○ Engaging and supporting clinicians to facilitate improvements in our health system **The Greater Choice for At Home Palliative Care objectives** ○ working directly with general practitioners, other primary health care providers, secondary care providers and hospitals to ensure improved outcomes for patients ○ understanding the health care needs of their communities ○ responding to identified national and PHN specific priorities ○ being outcome focused and performing a critical function in networking health services.
Scalability	The learnings from this activity will be shared across GCPHN throughout the period and well as at completion. It is envisaged that sustainability will be built into the work so that all improvements and new investments will be done to ensure sustainability over the long term.
Target Population	**Patient Types** **Clinician Types** **Local Community**

<table>
<tr><td></td><td>
<table>
<tr><td>Chronic Disease</td><td>General Practitioners (including After Hours Medical Deputising Services)</td><td>City of Gold Coast population</td></tr>
<tr><td>Cancer</td><td>Specialists</td><td>Residents of Residential aged care facilities</td></tr>
<tr><td>Other Palliative Care</td><td>Nurses (with a varied range of scope of practice)</td><td>Gold Coast Health and Hospital services</td></tr>
<tr><td>All Ages and Ethnicity</td><td>Allied Health – inclusive of all disciplines</td><td>General Practitioners</td></tr>
</table>
Gold Coast SA4
</td></tr>
<tr><td>Anticipated Outcomes</td><td>
<table>
<tr><th colspan="2">Goal:</th></tr>
<tr><th>Outcomes that Matter to people</th><th>Outcome that Matter to the Health system</th></tr>
<tr><td>

individuals who have a known life-limiting condition will have choice, quality of care and support
more people with a life-limiting condition will receive end-of-life care in the place of their choice;
the burden on families and carers will be reduced
Improved consumer experience of care[1]

</td><td>

unnecessary hospitalisations and avoidable transfers from aged care facilities to emergency departments will be reduced;
Improved referral processes for primary health care providers; and
Improved co-ordination and integration of health services
Improved support to families and carers.
Improved provider experience[2]
Efficient use of resources[3]

</td></tr>
</table>
</td></tr>
<tr><td>Measuring outcomes</td><td>Note – Continue to work with the Deloittee External Evaluator to effectively report and measure progress of activities to meet the set of core Key Performance Indicators (KPIs) developed for the national evaluation of the GCfAHPC.
Ongoing work is continuing by GCPHN to develop an evaluation plan that details how the inputs, processes, outcomes and impacts of GCPHN activities and commissioned services will be measured and evaluated in line with GCfAHPC.</td></tr>
</table>

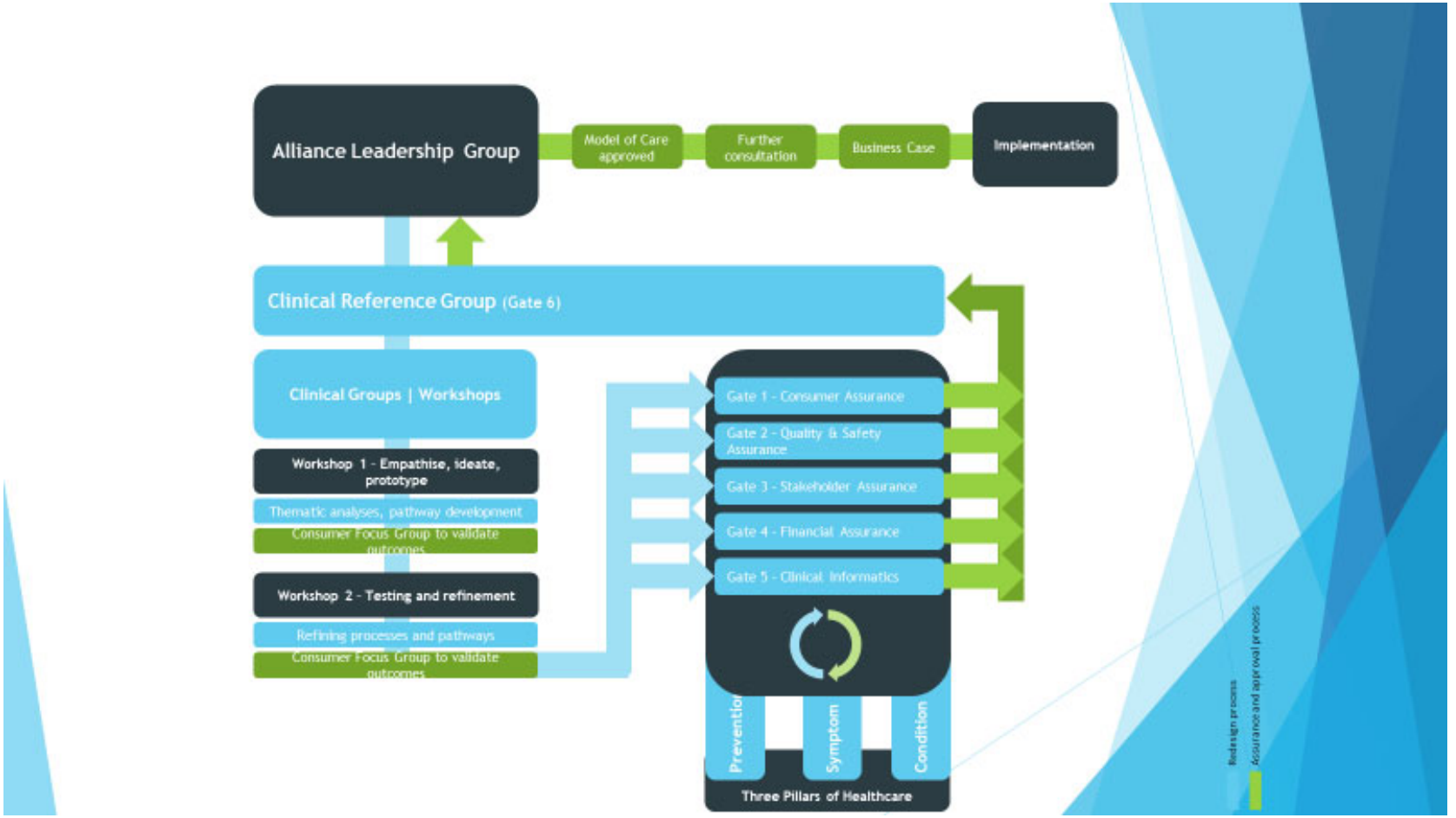
[1] Related to the Triple Aim: Improved patient experience

[2] Relates to Triple Aim: Improved Provider Experience

[3] Relates to Triple Aim: Value for Money

	GCPHN evaluation methodology has been aligned to the Institute for Healthcare Improvement's Triple Aim and Quadruple Aim evaluation framework of improving population health, experience of care, experience of providers and cost per capita. These will be used to measure and evaluate the outcomes of the *GCfAHPC.* The primary hypothesis being considered is whether the service or system changes implemented will provide quality, patient centred and cost-effective interventions that will enable more people with a life-limiting condition will receive end-of-life care in the place of their choice.
Indigenous Specific	No, however, while these activities will be targeting the broader palliative patient population of the Gold Coast, implementation will ~~work~~ include specific needs of Aboriginal and Torres Strait Islander community and service sector
Collaboration/ Communication	GCPHN has longstanding relationships with palliative care providers including GCH, non-government and private agencies who provide community nursing, allied health, residential care, and general practice which have and will continue to support this project. In addition GCPHN's standard governance committees will be supporting and advising on this work (including our Community Advisory Group, Clinical Council and Primary Care Partnership Council) a Palliative Care leadership was established with representation from the Gold Coast Health Specialist Palliative Care Team, General Practitioners, community palliative care services and consumers. The implementation work will be completed in partnership through the Gold Coast Integrated Care Alliance (Alliance) which has been established in partnership between GCH and the GCPHN to achieve a single integrated health system. The Palliative Care Working Group established by the Alliance will develop, or provide clinical and consumer input into appropriate frameworks, systems and processes for the development and validation of future models of care. The group meets on a regular basis. The Alliance leadership group signed off the Regional Palliative Care Plan and Needs Assessment in January 2019 and agreed to provide ongoing support and endorsement for the activities detailed in this plan. GCPHN will continue to coordinate a group to meet quarterly to oversee the PHN workplan. The role of the group will be to review emerging developments of this program and ensure alignment with related work that is being progressed through other partners and in other related activities.

The Gold Coast Integrated Care Alliance Governance Structure.



Integrated Care Alliance Membership and Representation

Leadership Group –	Clinical Reference Group	Palliative Working Group

Purpose to act in a governing capacity and be responsible for the development of a single integrated health system	Purpose to provide expert clinical advice and direction on the development of new seamless models of care across the range of conditions identified	Purpose to provide expert clinical advice and direction on the development of new seamless models of palliative care supported by the Alliance Clinical Reference Group.
• Chief Executive, GCH (Co-Chair) • Chief Executive Officer, PHN (Co-Chair) • Director-General, Department of Health Qld • Deputy Director-General, Healthcare Purchasing and System Performance Division • PHN General Practitioner • Chair, General Practice Gold Coast • Chair, Community Advisory Council, PHN • Chair, Consumer Advisory Group, GCH • Chair, Models of Care Working Group • Chair, Primary Care Partnership Council • Chief Operating Officer, GCH • Clinical Director, Diagnostic, Emergency and Medical Services, GCH • Executive Director, Centre for Health Innovation, GCH • Community Services Director for the City of Gold Coast • Director General Queensland Health	• GCH Clinical Director • GP's (2) • Nurses (2) • Allied Health (2) • Consumer representative	• GCH Palliative Clinical Director • GP • GCH Nurses • Community nurses • Allied Health • Emergency Clinical Director **Palliative Consumer Group** • Chair, Community Advisory Council, PHN • Clients • Consumers

	Practice	Task description	Time required	Start date	End date	Accountable	Responsible	Progress
Timeline	Shared Care Project	RRP	17 months	February 2019	June 2020	Senior project Officer	Senior project Officer	In Progress
	Localised pathways Project	RFP	17 months	February 2019	June 2020	Senior project Officer	Senior project officer	In Progress
	Volunteer Project	EOI	16 months	March 2019	June 2020	Senior Project officer	Project officer	planned
	Education Awareness Project	Co- design with leadership group Identify key linkages with: ▪ Advance Project ▪ RACF Project ▪ Share Care ▪ Pathways Government initiatives	14 months	May 2019	December 2019	Senior project Officer	Project officer	planned
	Nurse educator Position (RACF model of care)	Contract with Gold Coast Health service		February 2019	June 2020	Senior project officer	Project officer	In Progress
	Reporting	Reporting and convening of Leadership group		June 2018	Ongoing	Senior project officer	Project officer	In progress
	Review and evaluation of projects: Shared care Pathways Nurse educator	Evaluate project methodology for appropriate expansion		March 2020	July 2020	Senior project Officer	Project officer / senior project officer	Planned

Risk Management

Our Risk Management Framework includes a formal risk management process based on the ISO 31000 standard to ensure that risks are appropriately identified, classified, assessed and treated.

Context	Risk	Mitigation
External environment:		
Stakeholder		Resources to support ongoing effective engagement
Culture	Low change readiness	There are 800 GPs in the GCPHN catchment: • 14% will actively avoid working in the area of palliative care • Over 60% of GPs are eager to develop capability in palliative care or are already confident[4] Our change approach will be to identify and work with the >60% and respect that for some GPs, palliative care is not their area of special interest.
Information & systems	Limited ability to share data	Ensure most effective use of clinical hand over tools and case conferencing
Capacity	Ability to re-direct resources to identified areas of need	Data analysis and mapping will identify palliative care needs in the community. It will also identify areas of non-beneficial care; allowing these resources to be re-directed to areas of need.
Capability	Capability for service provision in the community	Strong emphasis on education between palliative specialists and community providers/clinicians is embedded in our planning
Internal environment:		
Workforce	Recruitment of candidates with the skillset to achieve our vison	Broadly advertised open recruitment processes

[4] Source: Department of Health (2017): *Final report: research into awareness, attitudes and provision of best practice advance care planning, palliative care and end of life care within general practice*. Principal authors: Charles Coulton and Catherine Boekel

	Information systems	Availability and quality of data to inform needs assessment	Leverage our previous experience in sourcing and using federal data (MBS, PBS)	