Australian Government
Department of Health

phn
An Australian Government Initiative

Activity Work Plan 2019-2021:

Greater Choice for at Home Palliative Care

Gold Coast PHN

When submitting this 2019-2021 Activity Work Plan to the Department of Health, the PHN must ensure that all internal clearances have been obtained and the Activity Work Plan has been endorsed by the CEO.

Overview

This Greater Choices for at home Palliative care Activity Work Plan covers the period from 1 July 2019 to 30 June 2021. To assist with PHN planning, each activity nominated in this work plan can be proposed for a period of up to 24 months. Regardless of the proposed duration for each activity, the Department of Health will require PHNs to submit updates to the Activity Work Plan on an annual basis.

Important documents to guide planning

The following documents will assist in the preparation of your Activity Work Plan:

- Activity Work Plan guidance material;
- PHN Needs Assessment Guide;
- PHN Program Performance and Quality Framework;
- Primary Health Networks Grant Programme Guidelines;
- Clause 3, Financial Provisions of the Standard Funding Agreement.

Formatting requirements

- Submit plans in Microsoft Word format only.
- Submit budgets in Microsoft Excel format only.
- Do not change the orientation of any page in this document.
- Do not add any columns or rows to tables, or insert tables/charts within tables – use attachments if necessary.
- Delete all instructions prior to submission.

1. (a) Planned PHN activities for 2019-20 and 2020-21

▪ Greater Choice for at home Palliative Care

PHNs must use the table below to outline the activities proposed to be undertaken within the period 2019-2021.

ACTIVITY TITLE	**PC-1 Greater Choice for at home palliative care**
Existing, Modified, or New Activity	Modified Activity
Program Key Priority Area	Workforce
Needs Assessment Priority	**Palliative care** (Page 343 of 359 of full Needs Assessment submitted)
Aim of Activity	To build the capacity and skills of general practitioners in providing palliative care to people with a life-limiting illness. This will be achieved through the provision of coordinated care, and improved information transfer between service providers, with patients and families. This will be available to all GPs across the Gold Coast region. The Key Aims of the Activity • To provide a high quality, effective and supportive framework for Shared Care and Health Pathways for General Practitioners and the local community in order to support local general practitioners to deliver optimal palliative care for their patients. The model ensures GPs are supported by a clinical specialist, referral to local specialists (as necessitated) according to current management guidelines. • Promote and support the role of general practitioners in providing continuity of care and end of life support in the community for people experiencing a progressive, life limiting illness. The Key Objectives of the Activity are: • Increased confidence reported by GPs in the region to deliver palliative care • Increased uptake of advance care planning • Increased palliative care-related attendances by GPs into patient's homes and RACFs • Increased number of linkages and partnerships with non-health related community organisations relating to raising awareness about palliative care and death and dying • Increased effectiveness of clinical handovers of palliative patients reported by hospital clinicians, GPs, community clinicians and RACF staff • Improve health, death and compassion literacy within the Gold Coast community • Increased number of people accessing palliative care services and their carers and families reporting that they feel better connected to information and supports • Increased number of linkages and partnerships with non-health related community organisations relating to raising awareness about palliative care and death and dying.

Description of Activity	The key activities are: 1. Palliative Care Health Pathways and Shared Care Finalisation and Implementation of Shared Care Model and Health Pathways integrating Primary Care with interdisciplinary palliative care specialist teams to improve access to quality palliative home care / Residential Aged Care addressing multiple domains of end-of-life issues and needs. Implementation Program • Implement and trial the final arrangement of works from market testing and embed training and education within the GCHHS, community and Primary care. • Revise the Palliative Care products/resources and upload to online platform • Implement the principles of shared care framework for the seamless transfer of the care from the hospital or specialist service setting to general practice. • Trial the Shared care prescribing guidelines and local policies to enable general practitioners (GPs) to accept responsibility for monitoring of medicines/treatments in primary care, in agreement with the initiating specialist service. • Trail shared care principles and framework linked to and complemented by local integrated care pathways and shared care policies. 2. Living Matters Resource implementation for Primary Care linking to Advance Care Planning P.I.P. Q. I program. 3. Development and Implementation of a Quality Improvement Toolkit for General Practice in Advance Care Planning Utilising the lessons learns from the "Hammond Care "Advance Care Project finalise and implement a quality improvement toolkit to be available for all General Practices on the Gold Coast. Implement as a business and usual tool. Maintenance of resources, information, and education via GCPHN website. 4. GCPHN Project & Contract Management of CF4 Enhanced Primary Care (PMP Clinical Educator – Palliative) • Transition the project into every day care within RACF's, from the time of admission, to identifying a change in condition, and communicating and documenting relevant information; inclusive of the quality improvement components of the program into business as usual. • Embed quality improvement actions within the facility and local community level inclusive of primary care and the HHS. • Complete joint Research with Griffith University and GCHHS for the evaluation of the Project 5. Advance Care Planning: Indigenous & C.A.L.D. Improve the effectiveness of Aboriginal and Torres Strait Islander people's journey through the system for those that are affected by palliative illnesses – 'Sorry Business" across Gold Coast communities by: • Dying to Yarn Expo • Indigenous PEPA program GCHHs • Reverse Indigenous PEPA training for mainstream

	• Implement and sustain the program within Aboriginal Medical Services (AMS) • Adapt "The Advance Project" for A.M.S • Adapt "The Advance Project" for C.A.L.D communities. 6. GCPHN Aged and Palliative Care Leadership Group Provide leadership and co-ordination of the GCPHN Aged and Palliative Care leadership group who oversee the deliverables of the GCPHN/HHS Palliative Care Regional Plan. 7. Partnering with PEPA Queensland to support a State Conference to be held on the Gold Coast in June 2021, originally scheduled in June 2020 but re-scheduled due to Covid 19 This component links closely with CF4 Enhanced Primary Care (PMP Clinical Educator – Palliative) 2020/21 • Greater Choices for At Home Palliative Care (GCFAHPC) Project
Target population cohort	People with Palliative Care Needs Hospital and Health Service
Indigenous specific	No
Coverage	Gold Coast PHN Region (Gold Coast SA4)
Consultation	A local palliative care needs assessment Regional plan was endorsed by Gold Coast Health and GCPHN in 2019. The Palliative Care Regional Plan was developed through consultation with key sector stakeholders, including our Gold Coast Health partners, primary care providers, and the carers and representatives of people who have undertaken the palliative care journey in the Gold Coast region. A joint GCPHN and GCH work plan developed as an outcome of the regional plan is overseen by a Palliative Care Leadership group who meet bimonthly to provide advice on the projects and their deliverables. In addition to the joint governance arrangements, a number of specific working groups have been established to progress key pieces of work in the plan. GCPHN will be regularly conducting stakeholder and service user interviews and feedback sessions throughout the year. Consultations will take many different forms, such as: o Consultative Palliative Care Workshops o Public workshops o Champion Palliative Clinical Advisory Workshops PHN advisory councils and other committees
Collaboration	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 establishment of the;

	1. Shared Care – Health Pathway Steering Committee which has been established in partnership between GCH, primary care, broader service providers and the GCPHN. 2. Clinical Champion Palliative Care Working Group established to 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. 3. The Gold Coast Health and GCPHN Integrated Care 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.
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 30/06/2020 Activity end date: 30/10/2020 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☒ Not yet known ☐ Continuing service provider / contract extension Turning Pain into Gain will continue to be commissioned from the same provider. ☐ Direct engagement. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No 4a. Co-design or Co-commissioning details Activity was undertaken as a Joint development project between Gold Coast Health (HHS) and GCPHN
Decommissioning	1a. Does this activity include any decommissioning of services? No 1b. If yes, provide a description of the proposed decommissioning process and any potential implications.
Funding from other sources	NA