



INITIAL DISCUSSIONS

Clinical Council members were asked what they would like included in Board and CEO updates to support their advisory role. Members emphasised that updates prioritising service outcomes and performance over time—particularly for Medicare Urgent Care Clinics and commissioned mental health services—rather than only focusing on announcements or new initiatives. They suggested that updates be audience-led and framed around what clinicians and service providers need to know, including practical implications for local service navigation.

This included more forward-looking intelligence (e.g., early notice of funding or role changes) and a clearer feedback loop on commissioned services using routine measures such as utilisation, wait times, demand trends and any observed impacts on hospital presentations. Members also sought clear, current advice on program availability and referral pathways (including changes, pauses/closures, funding duration, whether services are accepting referrals, and oversubscription), and noted the value of bringing key service reviews and proposed changes back to the Clinical Council for input before wider communication to the sector.

The next iteration of the GCPHN strategic plan will draw on feedback from the Board and Councils Dinner alongside internal staff and leadership input, with ongoing Board involvement. Members supported using the Clinical Council as a point of advice and input at key stages of development and review.

CC MEMBER REQUESTED INFORMATION

Medicare Mental Health Centre (MMHC)

Members noted that the Community Advisory Council have been asking for updates on the Medicare Mental Health Centre, reinforcing that this is a priority topic across advisory groups.

The group highlighted that progress updates are timely and valued. Some members indicated they did not yet feel well informed about the service details.

NDIS changes and potential impact on GCPHN commissioned services

A question was raised about whether current NDIS changes, such as Children with mild–moderate developmental delays may be redirected via a different pathway (outside NDIS). GCPHN is not aware of any specific NDIS-related changes that would directly affect GCPHN activities or commissioned services with commissioning expected through the state government rather than the PHN.

MBS item numbers – March changes (137,139 and M10 disability items)

Members noted March changes to disability-related MBS items (137, 139 and M10), including expanded eligibility for common speech conditions, and reported confusion about correct GP use.

MBS guidance is hard to interpret; members requested practical clarification on billing steps, including access to the initial four allied health assessment sessions without a care plan and how to enable access to remaining sessions (up to 20 lifetime).

Item taken on notice—GCPHN to confirm authoritative guidance and circulate a clinician-friendly summary.

Alcohol and Other Drugs (AOD) services

A member requested that Alcohol and Other Drugs (AOD) services be revisited as a Clinical Council topic, noting it was last discussed more than 12 months ago. AOD was added as a potential priority topic to be included in forward agenda planning.

Secretariat noted that content is expected to come to the Clinical Council in the coming months.

TOPIC ONE - CONFLICTS OF INTEREST

DETAILS

A brief session was held to emphasise conflict of interest (COI) expectations for council members, noting that transparent COI management is critical to GCPHN's reputation as an honest broker across the Gold Coast health sector. Members were reminded to declare COIs on joining and to update declarations as circumstances change, including verbally at the start of meetings or agenda items if a COI becomes apparent, and that significant conflicts relating to funded programs may need to be reported to the Department. The discussion emphasised that conflicts can and do occur and that the focus is on appropriate declaration and management (e.g., documenting in minutes, removing a member from discussion/voting, temporary leave from the room, independent probity support, or in rare cases divestment/resignation). COI declarations are managed via Kerry (forms stored in Folio), with the Chair and the Quality, Compliance and Risk Coordinator (governance@gcphn.com.au) available for guidance, particularly for sensitive matters.

TOPIC TWO - JOINT REGIONAL OLDER PERSONS STRATEGY

DETAILS

The Joint Regional Older Persons Strategy is a collaboration between GCPHN, Gold Coast Health, Kalwun and Queensland Ambulance Service to produce a practical regional roadmap aligning priorities across the older person care continuum. Members were asked to review the steering committee–endorsed draft and provide feedback; the Strategy aims to better “join the dots” across services and does not commit to new commissioning or replace partner strategies.

The Strategy builds on the Joint Regional Needs Assessment and was developed through partner mapping plus consultation (interviews, workshops and surveys). Key themes included person-centred and equitable care, easier navigation (including My Aged Care), safer transitions, workforce pressures (including dementia and palliative care), and better digital/data sharing; the framework spans the continuum across the five phases of care.

Clinical Council members were supportive of the strategies and did not identify any significant omissions. They then discussed considerations for implementing the Strategies.

PHASE ONE – HEALTHY AGEING STRATEGIES:

KEY INSIGHTS

- 1.1 - Increase health literacy on modifiable risks particularly for frailty and dementia
- 1.2 - Identify and address cancers and chronic conditions early through recommended screening and population level risk identification.
- 1.3 - Manage early stages of chronic disease.

Health literacy is the hardest lever (vs screening/early chronic disease management):

Strategies around screening and early chronic disease management are seen as “business as usual” in general practice, while improving health literacy/behaviour change and information dissemination is the main challenge.

Access to practical, printable community resources (not just websites):

Strong preference for tangible resources (e.g., Active & Healthy booklets, neighbourhood/community centre listings). Concern these are under-promoted and Active and Healthy booklets are no longer available.

Dementia and frailty prevention is under-recognised and under-systematised:

Dementia risk factors are not well understood by the community; there's no clear “dementia screening program” equivalent to cancer screening/recall systems, so dementia/frailty prevention conversations are easily missed.

PHASE One – Healthy Ageing cont.

Strategies:

KEY INSIGHTS

Need to better use (and improve uptake of) midlife health checks:

Discussion highlights variable implementation of 45–49-year health checks across practices, with heavy dependence on proactive practice nurses; consumers may not realise they've had one.

Prevention messaging lacks salience until personal relevance is felt:

Cancer prevention feels more immediate because it's widely known and visible; dementia/frailty feel abstract until someone has direct experience. Early-onset dementia (under 65) is flagged as a particularly difficult gap with limited supports.

Continuity of care and My Medicare/registration barriers (especially for First Nations patients):

Hesitancy and practical barriers to completing First Nations health checks when patients aren't "regulars"; broader challenge of continuity (patients not wanting a single GP; MDT models not currently feasible).

Equity and social complexity influencing aged-care entry pathways:

Examples raised where AOD issues, unstable housing, and late engagement with My Aged Care can precipitate earlier residential aged care admission—suggesting prevention/early support needs to account for social determinants, not just clinical factors.

PHASE Two – Managing increasing need at home

Strategies:

KEY INSIGHTS

2.1 – Embed Coordination of Care.

2.2 - Increased screening for frailty and cognition to enable intervention, stratifying older adults by level of need to align support intensity.

2.3 - Support older people to more easily access the care they need to optimise their health.

2.4 - Ensure carers have the information and resources they need to support their older person.

Equity-focused workforce gap in mental health:

Need for First Nations nurse navigator roles in mental health, particularly for people aged 45–50 who may not meet criteria for other programs.

Inconsistent cognitive screening across the system:

Frailty/cognition screening shouldn't sit only with GPs; it should occur at every touchpoint (including ED/hospital), using quick screens with clear escalation to fuller assessment when indicated.

Information capture and findability problems (IeMR):

Cognitive assessments may be done but are hard to locate, poorly located in discharge documentation, inconsistently scanned/filed, and not stored in a chronologically intuitive way.

Fragmented information-sharing across sectors:

No reliable mechanism to share information between public services, general practice, and allied health; limited/unclear access to My Health Record for some providers and poor communication about access changes.

Need for practical, best value for money priorities:

Acknowledgement that the work is complex; emphasis on identifying a small number of high-impact focus areas rather than trying to fix everything at once.

PHASE Three – Managing acute care needs

Strategies:

- 3.1 - Improve options for timely emergency care to improve patient experience and reduce preventable hospital admissions for older people.
- 3.2 - Provide high-value, multi-disciplinary care that focuses on optimising wellbeing and physical capability.
- 3.3 - Embed partnerships between hospitals and primary and community care providers to improve transition of care.
- 3.4 - Enhanced capability and capacity to provide quality dementia, delirium and complex cognitive care.

KEY INSIGHTS

Stigma and unintended impact of language:

Terms like “frailty” and “dementia” can deter engagement because people associate them with being “old” or end-stage decline rather than prevention/early intervention.

Need for more effective community education:

There’s a perceived gap in public understanding that dementia isn’t an immediate end of life diagnosis and that earlier-stage support and planning matter.

Cultural/translation risks:

Direct translations of terms (e.g., “frail” into Mandarin) can be derogatory or offensive, suggesting a need for culturally safe wording and testing.

PHASE Four – Residential Aged Care

Strategies:

- 4.1 - Support the development of a sustainable, skilled, aged-care workforce.
- 4.2 - Enable the ongoing improvement of safe, high-quality care pathways for RACHs.
- 4.3 - Transform models of service delivery to enable more care in place in Residential Aged Care Homes, preventing unnecessary hospital admissions.
- 4.4 - Establish collaborative, coordinated partnerships across the health and broader system.

KEY INSIGHTS

Variable GP capability in RACHs:

Non-regular/visiting GPs may lack aged care standards knowledge, creating inconsistent quality and recommendations that don’t align with facility protocols.

Misalignment with restrictive practice and facility pathways:

External clinicians may suggest interventions (medication/restraints/environmental changes) that conflict with restrictive practice guidelines and operational realities.

Fragmented communication and teamwork:

When external providers don’t link back with the nurse unit manager/care team, continuity and implementation break down.

Specialist access constraints:

Limited access to geriatricians and other specialists drives reactive, hospital-based specialist review and medication changes.

Need for a clear care coordinator (often the GP):

Strong emphasis on having a “regular GP” coordinating proactive reviews/care plans rather than ad hoc problem-based visits.

Practical and financial barriers to continuity:

It’s often not viable for a community GP to visit many RACHs; residents may transition to facility-rounding GPs despite preference to keep their usual GP.

PHASE Four – Residential Aged Care cont.

Strategies:

KEY INSIGHTS

Consumer expectations vs system reality:

Consumers may expect to keep their long-term GP (including via telehealth), but deterioration and high needs in RACHs require a different, facility-integrated care model.

Structural/financial barriers in the retirement-to-care continuum:

Some housing/care models can trap people financially, limiting ability to move to settings with appropriate higher-level care or access providers.

Avoidable escalation from RACHs to ED/Triple 0:

Behavioural or situational issues in residential aged care often trigger triple 0 calls, leading to hospital presentations that may be distressing and low-value for the person.

Workforce/support needs in RACHs:

Aged care staff may need more education/tools to manage behaviours and escalation pathways so hospital transfer is not the default.

PHASE Five – Palliative and Aged Care

Strategies:

KEY INSIGHTS

5.1 - Strengthen Advance Care Planning across the lifespan and system to empower older people and enable better care that respects patient agency and dignity of risk.

5.2 - Grow timely access to specialised multidisciplinary palliative and end-of-life care.

5.3 - Develop end-of-life models of care in the home and community that support patients and families.

5.4 - Equitable, timely and compassionate access to Voluntary Assisted Dying in-place.

Preference for end-of-life care at home/in place:

Families and residents generally want comfort and care at home/RACH rather than hospital transfer.

Avoidable escalation driven by uncertainty and distress:

When dying progresses, families may panic and call triple 0, leading to distressing ED deaths; in RACHs this can be driven by distant family pressure to “send them to hospital.”

Need for caregiver/family education and support:

Practical education on what dying at home looks like and how symptoms are managed could reduce unnecessary transfers.

Communication is difficult despite being important:

End-of-life conversations are emotionally hard; consumer-facing resources are challenging to complete, and people often disengage.

Advance care planning (ACP) needs earlier uptake and visibility:

ACP is not “just the GP’s job”—it should be prompted across touchpoints (lawyers, oncology, etc.) and must be easy to find in urgent situations.

Documentation usability issues:

ACP language can be hard for clinicians to interpret; documents can be buried in records; people need to know where it’s stored and how to update it.

NEXT STEPS

Member feedback will be considered and as appropriate incorporated into the resource for improvements.
Resource printed ready for the Aged Care Symposium in May.