Australian Government
Department of Health

phn
An Australian Government Initiative

Primary Health Networks – *Greater Choice for At Home Palliative Care 2018-2020*

Central Queensland Wide Bay Sunshine Coast PHN

When submitting the *Greater Choice for At Home Palliative Care* Activity Work Plan 2018-19 and 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 Jade Reading via email to QLD_PHN@health.gov.au on or before 14 February 2019, 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.

In the context of the PHN *GCfAHPC,* funding under this stream will support the recruitment of 2.7 Full-Time Equivalent positions within the PHN to deliver the activity in accordance with the GCfAHPC Expression of Interest (EOI) submission/proposal and any aspects agreed to during clarification sessions post EOI outcome.

PHNs are required to outline planned activities, milestones and outcomes to provide the Australian Government with visibility as to the activities expected to be undertaken by PHNs selected to implement the GCfAHPC pilot project.

GCfAHPC Activity Work Plan must:

- reflect the individual PHN GCfAHPC Expression of Interest (EOI) proposal and anything agreed to in the clarification sessions post EOI outcome;
- demonstrate to the Australian Government what the PHN is going to achieve and how the PHN plans to achieve this; and
- be developed in consultation with local communities, Clinical Councils, Community Advisory Committees, state/territory governments, Local Hospital Networks/Local Health Districts and other stakeholders, as appropriate.

This GCfAHPC Activity Work Plan covers the palliative care component of Core Funding provided to PHNs to be expended within the period from 1 July 2019 to 30 June 2020.

Background

Through an EOI process undertaken in August – September 2017, all 31 PHNs were invited to submit their interest in implementing the GCfAHPC pilot measure. Through this process, 11 PHNs were selected to receive funding to implement the measure.

Further information

The following may assist in the preparation of your GCfAHPC Activity Work Plan:

- GCfAHPC measure Communique (provided to PHNs 3 Aug 2017);
- Department of Health website:
  - GCfAHPC measure – Frequently Asked Questions
  - National Palliative Care Projects
  - Key Facts Budget 2017-18 – *Greater Choice for At Home Palliative* Care measure
  - Decision Assist palliative care and aged care Linkages document

Please contact your Grant Officer if you are having any difficulties completing this document.

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 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.

Instructions: please delete instructions (in blue font) within the 'Description' column before submitting to the Department, but do not delete or remove any text (in black font) in the Activity Work Plan template. Text in black font indicates information that has been pre-populated and must be retained in the Activity Work Plan. Also, do not alter the structure of the table (i.e. do not add/delete columns/rows, or insert tables/graphs), unless specifically instructed to, e.g. Risk Management

Proposed Activities	Description
Activity Title Existing, Modified, or New Activity Program Key Priority Area Needs Assessment Priority	*Greater Choice for At Home Palliative Care* (GCfAHPC) Project. Existing Other – Palliative care Health Needs Assessment, references:- Older person's health (page 94). Ensure safe and quality care (page 97). Improve collaborations, support integrated care practices and create culturally competent workforce and practices (page 108-110). Improve knowledge about available workforce (page 92). Enhance workforce capacity to meet the needs of vulnerable population group's (page 93).

Description of Activity	Our PHN is currently implementing the state wide strategy for end of life care (EOLC) and the Greater Choice for At Home Palliative Care in our region through a number of key strategies (outlined below). These are led through Palliative Care Interagency Steering Committees that include key partners with links to existing relevant advisory structures including Clinical Councils and the Sunshine Coast Integrated Care Alliance. Palliative Care Manager and Project Officer positions (up to 2.5 FTEs, with an increase to 2.7 FTEs from Jan 2019 to 30 June 2020), have been appointed across the PHN region, based in the Central Queensland, Wide Bay and Sunshine Coast areas, with senior management oversight of these positions. The positions work collectively to plan and implement the key strategies outlined below to ensure consistency across the region and share knowledge and expertise. They have commenced interagency steering committees in each of the three areas and have agreed Terms of Reference (ToR) and an area level plan with each committee. The team also works closely with the National Evaluator Deloittes provided by the DoH to inform the Key Performance Indicators (KPIs) and the provision of data to inform the national evaluation of the Measure. As part of our commissioning approach the CQWBSCPHN has defined where we **procure** health services, **partner** with other agencies to implement health system solutions, and where our staff **provide** health system support services (e.g. general practice support, allied health engagement, education, digital health leadership). This approach allows us to provide clarity and transparency to our stakeholders. This activity work plan uses this method. **PAL-P1: Improve access to safe, quality palliative care at home and support EOLC systems and services in primary health care and community care.** **Provide:** PAL-P1.1 - Improve access to safe, quality palliative care services at home by scoping existing health care services of available EOLC across our PHN region. This will include Aboriginal and Torres Strait Islander, Culturally and Linguistically Diverse (CALD), Residential Aged Care Facilities (RACFs) and hard to reach populations in rural and regional areas. PAL-P1.2 Improving public awareness of available EOLC services across our PHN regions, including Aboriginal and Torres Strait Islander, CALD, and hard to reach populations and improve public knowledge of end of life care.

	PAL-P1.3 - Create effective communication strategies and advocate for quality palliative care at home where needs for priority areas are identified. **Partner:** PAL-P1.4 - Work collaboratively with Hospital and Health Services (HHS) and non-government primary and secondary health care providers in our region to continue the interagency steering committees (in each area) and ensure activities align/complement National and State strategies. PAL-P1.5 - Under the guidance of an interagency steering committees, we will continue to identify geographic hotspots through mapping EOL services and collecting de-identified data sets to monitor the impact across the indicators. PAL-P1.6 - Promoting EOL HealthPathways of care to improve the patient journey and experience of care at home. PAL-P1.7 - Strengthen current palliative and EOLC models of care for each specified area. PAL-P1.8 - Engage with GPs, practice nurses and community health services to identify clients who will require palliation (e.g. promoting the 'surprise' question with GPs) and encourage the use and uptake of best practice to promote Advance Care Planning (ACP), tools and resources. **Procure:** PAL-P1.9 - Provide funding for Palliative Care Manager and Project Officer positions to complete all related palliative care EOL strategies within funded period. PAL-P1.10 - Source and procure EOL training and education through peak bodies and other training providers. This refers to working with Peak Bodies and organisations who provide evidence based and accredited education and training (e.g. PEPA, Advance Care Planning Australia, Palliative Care Qld and *caring@home*). We would work collaboratively with them to promote and support clinicians to attend and participate in palliative care and EOL workforce initiatives to build their skills and confidence to provide at home medical care. **PAL-P2: Enable the right care, at the right time and in the right place to reduce unnecessary hospitalisations.** **Provide:**

	PAL-P2.1 - Create effective communication strategies (for identified community target groups) to promote the right care, at the right time to reduce unnecessary hospitalisations. PAL-P2.2 - Create effective communication strategies to advocate the right care at the right time to GPs, allied health services and other related service providers. **Partner:** PAL-P2.3 - Assist in providing information and resources to support service providers to build patient and families' understanding of the benefits of palliative care and know where and how to access home services (both clinical and non-clinical). PAL-P2.4 - Assist clinicians to improve referral criteria and processes for care co-ordination services to reduce unnecessary hospitalisations and increase at home care options. PAL-P2.5 - Strengthen local models and share with health providers alternative options that are based on evidence and best practice and align with state-wide and national strategies (including digital health options). PAL-P2.6 - Identify key partners for example, peak organisations (e.g. Advance Care Planning Australia) to assist in EOL including ACP collaboration to increase uptake of ACP guidelines, increase ACP education (e.g. building capacity and awareness). PAL-P2.7 - Identify and build workforce capacity through a range of training and upskilling programs in consultation with peak bodies and local service providers (see strategy 6). PAL-P2.8 - Facilitate ongoing communication between pharmacists and health providers to ensure medication safety systems are in place that better enable access to medications and more streamlined prescribing and supply for residents in RACFs and for patients receiving care at home. PAL-P2.9 - Work collaboratively with ambulance services to ensure an integrated approach. **PAL-P3: Generate and use data to ensure continuous improvement of services across sectors.** **Provide:** PAL-P3.1 - Identify local palliative care data to enable baseline measurement.

	PAL-P3.2 - Develop service-mapping tool/s to capture service information, which can be mapped by LGA and back to the PHN health needs assessment. PAL-P3.3 - Share data/information with interagency steering committees and identify other sources of data that will ensure continuous improvement of services. **Partner:** PAL-P3.4 - Utilise existing relationships with service providers to map the current data landscape and identify opportunities for further development. PAL-P3.5 - Liaise with relevant stakeholders to contribute data to gain a comprehensive understanding of progress against national KPIs. PAL-P3.6 - Link with Clinical and Community Advisory Councils and Integrated Care Alliance to provide regular updates on data collection opportunities. **PAL-P4: Utilise available technologies to provide flexible and responsive care, including care after usual business hours.** **Partner:** PAL-P4.1 - Partner to build community and health care service communication and technology strategies to increase awareness, uptake and meaningful use of My Health Record for consumers and health providers. **Provide:** PAL-P4.2 - Use HealthPathways to map existing EOL services (including primary and secondary services) to identify service gaps within our PHN region. PAL-P4.3 - Promote clinical and referral pathways and improve workforce uptake and use. PAL-P4.4 - Promote existing technologies e.g. access to the Viewer (HHS initiative). PAL-P4.5 - Investigate digital health solutions to improve access to palliative care information after hours.

	PAL-P5: Increase community capacity building (e.g. Compassionate Communities Network) within our PHN region. **Partner:** PAL-P5.1 - Promote the benefits of palliative care and build community capacity, leveraging existing work with other providers (e.g. Compassionate Communities consultation initiatives). PAL-P5.2 - Participate in existing HHS EOL committees to explore current Compassionate Community activities. PAL-P5.3 - Assist to improve levels of health (death) literacy and understanding to include ACPs. **PAL-P6: Increase Workforce Development and Capacity.** **Provide:** PAL-P6.1 - Improve EOLC workforce development by; 6.1.1 Implementing results of the learning needs assessment survey to continue to build workforce capacity in EOL care in the primary care sector. 6.1.2 Using the results from the learning needs assessment survey, provide General Practice and Practice Nurses with support to deliver effective EOLC including for example; a) Providing a range of information including symptom management and ACP guidelines b) Increasing the use of the palliAGEDgp tool c) Advocate to include the 'surprise' question in 75+ health check, 715 health check, dementia and chronic disease health checks. d) Building the skills to identify clients who will require palliation through the increased uptake and awareness of decision support tools and resources (e.g. HealthPathways, My Health Record and meaningful use and effective use of MBS items) **Partner:** PAL-P6.2 - Provide support to GPs, RACFs, QAS and HHS to adopt standardised processes for documentation for ACPs and Transfer of Care between health sectors.

Rationale/Aim of the activity	• The updated National Palliative Care Strategy 2017 Draft 2.1 and the National Palliative Care Strategy 2010 are evidence-based documents that can be used by people and organisations at all levels of the community and service system seeking to improve the experience of palliative care. The strategies recommend key approaches and importantly recognises for example, *'that services are person-centred and include social, emotional, cultural and spiritual aspects in a variety of clinical and non-clinical settings and from professional and non-professional providers'.* • Consultation with clinicians and community sector organisations through the Palliative Care Interagency Steering Committees, and Clinical and Community Advisory Councils has drawn on evidence based research and practice in the development of the AWP Strategies. • Where to Research – provides research and recommendations into GPs' attitudes and approaches towards evidence based palliative care (including the use of ACP in general practice). Our PHN has used this research and recommendations to develop Strategy 3 above.
Strategic Alignment	The strategies outlined have a direct link with the PHN Program's objectives and our PHNs needs assessment as they aim to ensure the needs of those at risk of poor outcomes are better met, and that patients receive the right care in the right place at the right time. We have included strategies that will both identify service gaps for patients with palliative and EOLC needs and provide GP support to reduce unnecessary hospitalisations (including digital health strategies).
Scalability	Through a monitoring and evaluation process and consulting with key stakeholder, we can assess the effectiveness of the strategies throughout the life of the project. We can identify key barriers and enablers to scaling up and consider the potential reach, adoption and impact of any identified initiatives and these would need to be consistent with national and state policy directions.
Target Population	• Local HHS specialists, community service providers from NGO sector, private sector, GPs, nurses Qld Ambulance Services and RACFs. • Community social networks- we will partner with the HHS and other key community networks/organisations (e.g. to build Compassionate Communities Networks). • Identify populations within RACFs who require ACPs. • Identify populations within GP who require EOLC support including ACPs. • Identify priority populations (e.g. Aboriginal and Torres Strait Islander, CALD, older persons).

Coverage	Our PHN region has an estimated resident population of 842,057 persons, with an average annual growth rate of 1.5 percent over the past five years. Aboriginal and Torres Strait Islander Australians numbered 29,567 or 3.5 percent of the region's population. This percentage is slightly below the State figure of four percent. Within the region, Woorabinda had the largest percentage of Aboriginal and Torres Strait Islander people at 94.4 percent. Implications for service delivery: Currently, there are shortfalls in in-home care, community care, residential aged care and palliative care services across the region, especially in the coastal communities. These shortfalls are expected to increase as the region's population ages and more people move to the coast to retire. Future investments in aged care services and facilities will need to be capable of adequately addressing the changing service needs of older residents throughout the region.
Anticipated Outcomes	• Cross-sectoral collaboration will result in increased awareness of EOLC and ACPs among targeted groups (e.g. RACFs, General Practice and community). • Streamlined and standardised transfer of care information and systems between service providers (e.g. between RACFs, Queensland Ambulance Service and secondary care settings). • Professional development initiatives provided in consultation with peak bodies to broaden the understanding of palliative care with service providers to include cultural safety and holistic concepts of health. • A clearer understanding of the barriers and unmet needs in accessing services in identified geographical areas and for some population groups including Aboriginal and Torres Strait Islander and CALD groups.
Measuring outcomes	Some anticipated outcomes include: **PAL-P1**: Improve access to safe, quality palliative care at home and support EOLC systems and services in primary health care and community care. • Map of number of at home palliative care services available within our region (including: break down into LGA) • Number of partnerships established with HHSs, non-government, primary and secondary health care providers in our region

	• Map of EOL services available within our region • Palliative care Manager and Project Officers in place (up to 2.5 FTEs, with an increase to 2.7 FTEs from Jan 2019 to 30 June 2020) **PAL-P2:** Enable the right care, at the right time and in the right place to reduce unnecessary hospitalisations. • Number of identified partnerships/stakeholders that are included in the development and or utilisation of the communication tools • Communication methods to advocate for quality at home palliative care • Number of HealthPathways developed and utilised relating to EOLC **PAL-P3:** Generate and use data to ensure continuous improvement of services across sectors • Agree baseline measure of planned at home deaths with key stakeholders • Establish baseline (with key stakeholders) for number of ACPs in RACFs • Identify baseline measure for over 75s medication management reviews (RACFs/ community) • Development of a service mapping tool to enable LGA mapping **PAL-P4:** Utilise available technologies to provide flexible and responsive care, including care after usual business hours • Number of My Health Record ACP uploads • Establish baseline of clinical pathways and referral pathways for EOLC • Number of new GPs access to the Viewer (HHS initiative) **PAL-P5**: Increase community capacity building within our PHN region. This activity is an increase in the awareness of the Compassionate Community's model and how this may aid the objectives of the GCfaHPC measure. **PAL-P6**: Increase Workforce Development and Capacity. • Numbers of education resources on EOLC provided to General Practice and RACFs • A learning needs assessment survey tool developed and outcomes implemented. • Number of education sessions provided to Residential Aged Care Facilities (RACF) staff, community service providers and General Practice around EOLC and ACP.

Indigenous Specific	Aboriginal and Torres Strait Islander care will be integral to the work undertaken with the interagency steering committee groups. Palliative Care positions will work closely with key Aboriginal and Torres Strait Islander organisations, GP practices and local community to understand the palliative and EOLC cultural needs of Aboriginal and Torres Strait Islander peoples. Evidence based resources and information will be sourced through palliative care peak bodies including 'Care Search Palliative Care Knowledge Net' and 'health info net' to support health providers providing care for patients, family and community. Local issues and opportunities will be discussed through the Palliative care Interagency Steering Committees, Clinical Councils and Community Advisory Councils to develop sustainable improvements in the quality of EOLC.
Collaboration/Communication	The PHN has well established links into the local community and health provider networks. Regular forums currently convened by the PHN would be a key source of EOLC-specific input to improving service delivery in this area. Examples of these include: o Community Care Support Network (80 community aged care service providers on the Sunshine Coast); o Gympie Collaborative Network (40 Gympie community service providers); o Gympie Aged care subgroup; o Seniors Network for service providers and an annual forum (Bundaberg); o Aged Care Committee (Capricorn Coast), o Integrated Care Alliance (Sunshine Coast – 31 members from 12 organisations). In each area (Central Queensland, Wide Bay and Sunshine Coast) interagency steering groups work in partnership with EOLC providers to develop sustainable models of care. Members for the committees have been selected using an expression of interest process and through local discussions with the HHS. Members are expected to contribute to the long term vision of;

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Scoping the gaps that relate to the key priority areas to improve and increase at home palliative care services (eg. WBHHS Palliative care physician recruitment and after hours challenges)
Support the current work of the HHS and collecting EOLC specific community and consumer input to strengthen the model within the region
Identifying service and data development opportunities to support a more integrated model of patient centred care.

The Palliative Care Manager and Project Officers provide outcome reports to the Clinical Councils in each area and more detailed reporting provided to the PHN. Members of the interagency steering groups provide feedback to their respective organisations.
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<tr><td>Activity milestone details/ Duration</td><td>
Provide the anticipated activity start and completion dates (including the planning and procurement cycle):
Activity start date: 1/07/2019
Activity end date: 30/06/2020
<table>
<tr><th>Milestones (updated)</th><th>Start</th><th>Finish</th></tr>
<tr><td>Palliative Care interagency steering committees continue bi monthly to progress local initiatives.</td><td>July 2019</td><td>June 2020</td></tr>
<tr><td>Resources shared, sourced and disseminated including relevant state and national EOLC strategies, policy frameworks, legislative and clinical governance documents.</td><td>July 2019</td><td>June 2020</td></tr>
<tr><td>Bi monthly meetings with DoH, Deloittes National Evaluator and other successful PHNs to share and support project implementation.</td><td>July2019</td><td>June 2020</td></tr>
<tr><td>Linkage with key consumer and community groups across the region and supportive work commenced with Compassionate Communities Network.</td><td>July 2019</td><td>June 2020</td></tr>
<tr><td>Targeted professional development based on General Practice survey Learning needs analysis survey results.</td><td>July 2019</td><td>July 2020</td></tr>
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	Measure impact and process indicators developed in consultation with DoH and Deloittes National Evaluator.	July 2019	June 2020
	Work collaboratively with National Evaluator Deloittes	Aug 2019	June 2020
	Partnering with peak bodies to source education and training for clinical workforce	July 2019	June 2020
	Mapped community based EOL services and gaps identified to Interagency Steering Committees.	July 2019	Nov 2019
	Commence delivery of education and training in Advance Care Planning with RACFs, GPs and community service providers.	July2019	Dec 2019
	Completed all three HHS/PHN Strategic planning sessions to include Palliative Care into the joint PHN/HHS Integrated Care Strategies.	July 2019	Nov 2019
	Other activities as identified through the Palliative Care Interagency Steering committees.		