Australian Government
Department of Health

phn
An Australian Government Initiative

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

North Western Melbourne PHN

15 February 2018

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 two 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 January 2018 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, 10 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

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

Description of Activity	Since June 2018, one full time equivalent position has been in place to support this work and the equivalent of two full time positions have been in place from January 2019.
	
	Key milestones achieved since July 2018 include: completion of a literature review, engagement of key stakeholders and collaborators, and co-design engagement activities with the community.
	
	Key insights developed from these activities have informed a more focused approach to realise the GCfAHPC objectives. These include:
	
	• Workforce capacity building
	  ○ Develop a quality improvement toolkit for general practice focused on end of life care, including palliative care, advance care planning and voluntary assisted dying.
	• Consumer, carer and family engagement
	  ○ Improve access to respite care for carers and families of palliative care patients.
	  ○ Support a community dialogue on end of life and 'dying well'.
	• Improving care pathways
	  ○ Support access to medications for palliative care patients in the community.
	  ○ Review and implementation of palliative care suite of HealthPathways.
	
	Please find a link to the 'Project Description' below:
	http://www.health.gov.au/internet/main/publishing.nsf/Content/F05F44AFC3F8F5BBCA2581760005993D/$File/PHNs-funded-to-implement-the-Greater-Choice-for-At-Home-Palliative-Care-GCfAHPC-measure.pdf

Rationale/Aim of the Activity	**Aim**: The aim of the GCfAHPC funding is to improve coordination and integration of end of life care across primary, secondary, tertiary and community health services to support at home palliative care. **Rationale**: There are multiple hospital and community services providing specialist palliative care across the North Western Melbourne region, including medical deputising services, over 500 general practices and more than 130 RACFs. This complexity leads to service fragmentation and creates barriers for general practitioners (GPs) to be more actively involved in the provision of palliative care in the home. This complexity also makes it difficult for patients to navigate the service system to access safe, high quality palliative care at home.
Strategic Alignment	NWMPHN's approach for the GCfAHPC project is closely aligned with the PHN programme objectives of 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. Planned activity aligns with the four objectives of the GCfAHPC project as follows: **Objective 1: 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** • NWMPHN will seek to increase **workforce capacity** and confidence of primary health care and community care providers to engage earlier with patients who need palliative care and improve referrals to palliative care services to better support palliative care at home. This will contribute to improving access to safe, quality palliative care at home. **Objective 2: enable the right care, at the right time and in the right place to reduce unnecessary hospitalisations** • Building **workforce capacity** and **improved care pathways** will contribute to ensuring that consumers are provided with the right care at the right time and in the right place and may in turn contribute to a reduction in unnecessary palliative care-related hospitalisations. • **Consumer, carer and family engagement** will help NWMPHN to understand how to improve access to palliative care at home for consumers, carers and families. This will contribute to

	ensuring that consumers are provided with the right care at the right time and in the right place and may in turn contribute to a reduction in unnecessary palliative care-related hospitalisations. **Objective 3: generate and use data to ensure continuous improvement of services across sectors** • **Data driven quality improvement** will involve NWMPHN staff collaborating with key stakeholders/partners and general practice teams to establish a baseline and use this data to inform continuous improvement of services. **Objective 4: utilise available technologies to provide flexible and responsive care, including care after usual business hours.** • NWMPHN will utilise appropriate strategies and technologies to seek to improve integration and therefore streamline **care pathways** to improve general practice and broader primary care involvement in a palliative approach. This will contribute to enabling primary health care and community care providers to support at home palliative care during and after usual business hours.
Scalability	The outcomes/ findings from NWMPHN's GCfAHPC work that could be scaled across the NWMPHN region or transferred to other PHN regions may include: • integrated models of care; • practice and system level quality improvement initiatives; • multidisciplinary team structures across sectors; • knowledge exchange and upskilling; and • role clarification across settings/organisations. It should be noted that applicability/relevance of NWMPHN's work in this area to other PHN regions will depend on the context/settings in these regions – for example, community palliative care arrangements may be different in other states and territories.
Target Population	People with a known life-limiting condition and their families; people living with chronic conditions, including cancer; and areas that have lower rates of dying at home.

Coverage	NWMPHN region.
Anticipated Outcomes	Outcomes as referenced in the Final GCfAHPC Evaluation Plan: **Activity Stream:** General improvement in service pathways and coordination. **Medium term outcome:** Increased collaboration and coordination across and between existing primary, acute and palliative care providers **Activity Stream:** Capacity building among palliative care providers. **Medium term outcome**: Increased provision of quality information related to palliative care planning and choices to patients/carers. **Activity Stream:** Raising awareness of palliative care options among patients/carers (and communities) **Medium term outcome**: Family and carer have a greater knowledge of what to expect and are better prepared for the death of a family member.
Measuring outcomes	Number of GPs reporting perceived increased confidence in palliative care management (survey). Number of patients / carers reporting increased awareness of palliative care options (survey). Palliative Care specific admissions (from the Victorian Admitted Episodes Dataset) to establish a baseline in order to be able to measure impact of the project in the longer term.
Indigenous Specific	No.
Collaboration/Communication	NWMPHN utilises a range of mechanisms to facilitate consultation, including through the Community Advisory and Clinical Councils, and expert advisory groups. Consumers and people with lived experience are core to the work we do. A 'Dying Well Community Panel' was convened in December 2018. Twenty-seven community panellists took part in a deliberative engagement process over two weeks that examined the remit 'What does dying well look like and how can we help people achieve this?'. The Community Panel wrote a recommendations report as an outcome of this process. This report, together with a literature review and feedback from stakeholder

	engagement has informed the activities identified above and will be used to inform future planning for this measure. NWMPHN will continue to seek opportunities for consumers to be involved at all stages of the project, and in any associated commissioning process, including co-design to support positive consumer experience. Collaboration with key stakeholders will occur throughout the project. Consequently, the following stakeholders may be involved in prioritisation, planning, implementation, monitoring and evaluation of activities: • NWMPHN regional and strategic partnerships and collaboratives • Local Hospital Networks e.g. specialist palliative care services • Community Health Services • General Practice • Residential Aged Care Facilities • Pharmacy • Allied Health • Community based organisations e.g. Carer Links North • Research institutes e.g. Palliative Care Unit, LaTrobe University • Peak and professional bodies e.g. Palliative Care Victoria • Victorian Department of Health and Human Services • Local government • Other identified providers
Timeline	**Recruitment and onboarding**

<table>
<tr><td></td><td>July and December 2018

Develop insight phase
July 2018 – December 2018

Plan and deliver phase
Jan 2019 – May 2020

Evaluate and improve phase
May 2020 – June 2020</td></tr>
<tr><td>Risk Management</td><td>
<table>
<tr><th>Risk</th><th>Mitigation</th></tr>
<tr><td rowspan="3">Limited stakeholder engagement</td><td>• Develop a clear and robust engagement strategy as part of the co-design process.</td></tr>
<tr><td>• Build on existing relationships with stakeholders that are highly engaged.</td></tr>
<tr><td>• Provide appropriate support and single point of contact for stakeholders with a dedicated PHN staff member.</td></tr>
<tr><td rowspan="2">Outcomes are achievable within timeframes</td><td>• Ensure goals/activities are specific, measurable, achievable, relevant and time bound, informed by clinical and community input.</td></tr>
<tr><td>• Ensure activity complements and integrates with existing NWMPHN work where appropriate.</td></tr>
<tr><td rowspan="2">Complexity of the palliative care service system with the NWMPHN region</td><td>• Ensure goals/activities are specific, measurable, achievable, relevant and time bound, informed by clinical and community input.
• Ensure activity complements existing NWMPHN work where appropriate.</td></tr>
<tr><td>• Target specific cohorts of consumers and carers across the NWMPHN catchment.</td></tr>
<tr><td>Sustainability</td><td>• Ensure the question of sustainability is incorporated into planning, prioritisation and implementation phases of this work.</td></tr>
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