Eastern Melbourne - Greater Choice for At Home Palliative Care

2019/20 - 2019/20

Activity Summary View

[PC - 1 - Greater Choice for At Home Palliative Care (GCfAHPC) Project.]

Activity Metadata

Applicable Schedule *

Greater Choice for At Home Palliative Care

Activity Prefix *

PC

Activity Number *

1

Activity Title *

Greater Choice for At Home Palliative Care (GCfAHPC) Project.

Existing, Modified or New Activity *

New Activity

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

End of life care is a well-recognised priority area, both nationally and locally, with Australia's rate of dying at home being comparatively low compared with other similar OECD countries. The Grattan Institute report, Dying Well (Swerrissen and Duckett, 2014) states "in the next 25 years the number of Australians who die each year will double. People want to die comfortably at home, supported by family and friends and effective services." Whilst acknowledging that people want to be able to die in their place of choice, there are numerous factors that preclude this from happening for many people.

In June 2016 EMPHN undertook a workshop in the Eastern region of the catchment, to engage a broad range of stakeholders in understanding the issues that prevent people in the catchment from being able to die in their place of choice. The workshop identified key themes that included:

1. Training and education – for staff of both community and acute care facilities, and families – across all phases of end of life care. Topics include death literacy in the community, community awareness to make informed choices and carer capability to deliver person's choice
2. Service gaps – interagency coordination and communication channels – at transition of care, after hours access to services.
3. Services for carers throughout whole process – by all service providers, bereavement support
4. Individualised holistic care – including isolated/difficult to reach people/cultural and ethical issues/disabilities
5. Availability of resources to support people to die in their place of choice – physical (equipment etc.) and financial
6. Staff and/or family unwillingness/ability to follow EOLC plans – resources, practicality, knowledge, capability, comfortable with choices
7. Variation in understanding of patient centred care
8. Staffing skill mix to provide EOLC in Aged Care facilities – adequate staff skills in RACF to manage palliative care
9. Staff recognising end of life and then being comfortable with having appropriate discussions with families – identification of dying, the timing of the conversations and all options being discussed, cultural differences around language
10. Advanced Care Plans – ensuring the 'where' is part of the planning – not just 'how'

The learnings from this workshop have informed the work of the Eastern Melbourne Primary Health Care Consortium End of Life Care working group. A similar approach will be undertaken in the remaining regions of the EMPHN catchment.

Description of Activity *

Two project roles will be employed to undertake the activities required under the Greater Choice for At Home Palliative Care funding:

- Project Facilitator (1.0 FTE) with responsibility for leading the working groups, broad stakeholder engagement and relationships and ensuring implementation of projects that are occurring or are developed, and

- Project Officer (1.0 FTE) to work on data collection and analysis, to understand the depth of the problem and gaps identified, and as project support to assist with implementation of working group activities.

Governance for the Greater Choice for at Home Palliative Care will be overseen by the Executive Director, Integrated Care (Figure 1).

** Refer to figure in AWP

The project roles will employed within the Integrated Care Team and directly report to the Lead, Redesign and Integrated Care. The two positions will work closely with other relevant teams within and outside Eastern Melbourne PHN, including:
- Collaborative Executive Officers,
- Sector Capacity,
- Health Pathways,
- After Hours and Workforce and
- Development teams.

To achieve the measure we will implement programs to:
1. Deliver an individual case based approach for in-home support to improve the skills and confidence of GPs and staff in aged care. The approach will provide a hospital based support to manage particular patients;
2. Use human resources and/or technological approaches to provide care at home, particularly after hours;
3. Increase the number of Advance Care Plans being completed in the community
4. Improve education for GPs, community service providers and volunteers assisting palliative care patients in the community using programs including Program of Experience in the Palliative Approach (PEPA);
5. Integrate services that exist in the after-hours period, with a particular focus on GP deputising services;
6. Focus on ensuring more people are able to die in their place of choice or remain in their home as long as possible; and
7. Promote the increased use of HealthPathways Melbourne, which has a comprehensive suite of palliative care pathways, to provide comprehensive clinical decision-making tools and referral pathways for GPs.

Eastern Melbourne PHN has developed strong links with the health providers across the catchment to enable a consistent approach to system improvement by developing region wide platforms of service providers and organisations focused on primary health care system collaboration. These structures referred to as 'Collaboratives', include Eastern Melbourne Primary Health Care Collaborative (EMPHCC) in the East, and Better Health North East Melbourne (BHNEM) in the North, will enable

the PHN to work closely with the service providers to implement the activities under the Greater Choice for at home Palliative Care program across the entire catchment.

We will take an Action Research approach to improve capacity within our catchment to deliver palliative care services to people in their homes. Using this methodology will ensure a collaborative approach to a continuous cycle of improvement. This is consistent with the PHN's Commissioning Framework, which will support any collaborative driven projects that require additional funding.

The EMPHCC has established an End of Life Care (EoLC) Working Group that has identified a lack of integrated data collection as an issue. Data will be sourced from partner organisations, including RACFs, local hospitals and palliative care providers. The Project Officer will ensure data is collated, shared and used to inform the activities of the working groups. Data collection will include:

- service mapping information;
- statistical and demographic data;
- increased palliative care provision at home;
- averted emergency presentations and inpatient admissions;
- increased advance care plans completed and registered;
- patient journey understanding and experience; and
- service/hospital presentation data.

This link provides access to the Project Activity Description Summary.

Needs Assessment Priorities *

EMPHN Needs Assessment 2019/20-2021/22

Priorities

Needs Assessment Priority	Page Reference

Activity Demographics

Target Population Cohort *

- Consumers. Through this activity, improvements to the palliative care system at end of life will improve the ability for consumers to be able to die in their place of choice. Numbers will be defined through the data analysis part of the project, but a quantifiable increase of people who are able to die in their place of choice will be established.
- Carers. Carer stress will be reduced when the system has improved integration.
- Local hospital clinicians.
- Local specialist palliative care providers.
- GPs and the general practice team. A key aspect of the project is to better integrate GPs in the end of life and palliative care process. GPs are a key clinical resource for patients and other clinicians and have an integral role to play. This activity will work towards better inclusion and support for GPs and the general practice team (practice nurses).

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments *

This activity is not specifically targeted at Aboriginal and Torres Strait Islander people. EMPHN will ensure, however, that the local Aboriginal population is included in this project and that the specific needs of this cohort of patients are identified and considered throughout all elements of the activity.

Coverage *

Whole Region

SA3 Name	SA3 Code
Boroondara	20701
Manningham - West	20702
Whitehorse - West	20703
Banyule	20901
Nillumbik - Kinglake	20903
Whittlesea - Wallan	20904
Knox	21101
Manningham - East	21102
Maroondah	21103
Whitehorse - East	21104
Yarra Ranges	21105
Monash	21205

Activity Consultation and Collaboration

Consultation *

Collaboration *

EMPHN has well established collaborative arrangements in the East and North of our catchment. Through End of Life Care working groups, one of which is established and another to be established, governance arrangements will be put in place through Terms of Reference for each group. In the east, the working group will sit under the Eastern Melbourne Primary Health Care Collaborative. In the north it will be stand alone

Working groups will include public and private providers, including GPs, aged care facilities and providers, hospitals, specialist palliative care providers, and peak bodies including Palliative Care Victoria. EMPHN will also work with North Western Melbourne PHN, particularly in the northern part of the catchment where we have significant cross over with services and providers. Carer and consumer representation will also be included, when appropriate, with consideration to the delicacy of engaging carers and consumers in end of life discussions.

EMPHN has letters of support from Monash Health and Palliative Care Victoria and existing collaborative arrangements with Austin Health and Eastern Health.

Activity Milestone Details/Duration

Activity Start Date *

Activity End Date *

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

April 2018 – Employment of two FTE project staff
April 2018 - June 2018 – Comprehensive project and evaluation plan developed
November 2018 – End of life care workshop held in Northern Region of catchment
February 2019 – First draft of End of life care data report developed
June 2019 – Establishment of Northern Region End of Life Care working group and inclusion of Monash Health in the Eastern Metropolitan Region End of Life Care working group.

August 2019 – Follow up end of life care workshops held in each region

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Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity: *

Not yet known: No

Continuing service provider / contract extension: No

Direct engagement. Please provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date: No

Open tender : No

Expression of interest (EOI): No

Other approach (please provide details) : No

Is this activity being co-designed? *

Is this activity the result of a previous co-design process? *

Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? *

Has this activity previously been co-commissioned or joint-commissioned? *

Decommissioning *

Decommissioning Details? *

Co-design or Co-commissioning details *