

***Victorian and Tasmanian PHN
Alliance submission***

**Consultation – ACCRM
Advanced Specialist Training in
Palliative Care curriculum**

October 2019



The **Victorian and Tasmanian Primary Health Network Alliance (Alliance or VTPHNA)** is pleased to provide feedback on the Australian College of Rural and Remote Medicine (ACRRM) draft **Advanced Specialist Training in Palliative Care** curriculum.

The Alliance provides a platform for the Tasmanian and six Victorian Primary Health Networks (PHNs) to work together. The Alliance enables the PHNs to collectively achieve the best possible outcomes for local communities and organisations through leadership, collaboration, coordination and synergy across the jurisdictions. Information about the role of PHNs and associated enablers in health system reform are provided in Appendix 1.

The Alliance proudly acknowledges Australia's Aboriginal and Torres Strait Islander community, their rich culture and pays respect to their Elders past and present. We acknowledge Aboriginal and Torres Strait Islander peoples as Australia's first peoples and as the Traditional Owners and custodians of the land and water on which we rely.

We recognise and value the ongoing contribution of Aboriginal and Torres Strait Islander people and communities to Australian life and how this enriches us. We embrace the spirit of reconciliation, working towards the equality of outcomes and ensuring an equal voice.

The voice of people with lived experience is essential in the development of our work.

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Key points

The Alliance supports the development of a curriculum for a Rural Generalist undertaking Advanced Training in Palliative Care. The development of this curriculum is acknowledged as an important approach to advancing palliative care as an important field of specialist medicine and an essential competency within the rural health sector.

The Alliance feedback emphasises the following key points:

- A stronger emphasis on **person and family centred models of care** is required. Rural Generalists delivering palliative care are ideally delivering contemporary models of palliative and end-of-life care. Practices are **holistic and needs based**. A curriculum which reflects the traditional medical model may have its limits. There are a range of other national developments that can further contribute to primary healthcare capacity which supports team based multidisciplinary care. These include the Medicare Benefits Schedule (MBS) Review.¹
- The Alliance highlights the distinction between a **palliative care approach, palliative care, and end-of-life care**. These concepts differ in some marked ways, while in others the nuance may be subtle. In the absence of definitions of key concepts, and the underlying model of clinical for Rural Generalists delivering palliative care, it is not possible to comprehensively assess how the essential and desired skills, knowledge and attributes are aligned with intended workforce outcomes. The Alliance proposes that developments linked to the Compassionate Communities movement offers an approach. The final curriculum would ideally articulate expectations for evidence-based service provision consistent with a **defined model of care**. Evidence-based interventions are contextualised in practice and enabled by quality improvement systems.
- The **implementation of the final curriculum** will provide a platform to facilitate improved consistency and expectations of interventions and supports delivered by the Rural Generalist workforce. The Alliance note that there are likely community or regional implementation considerations for **change management**, and the people, processes and systems underpinning the desired model of care. The transition and implementation of the final curriculum by Rural Generalists within **communities and regions** would benefit from a commensurate level of support with community member, provider, and system readiness and transition.

¹ <https://www.health.gov.au/internet/main/publishing.nsf/Content/MBSReviewTaskforce>





Curriculum feedback

The drivers for the development of a curriculum for Rural Generalists undertaking Advanced Training in Palliative Care are acknowledged. The Victorian and Tasmanian PHNs understand the current and projected demand for better practice palliative and end-of-life care needs of regional, rural and remote communities.

It is acknowledged that specialist service provision and capacity vary, and opportunities exist for further workforce and organisational reform. Solutions to the levels of unmet need must be addressed systematically and through sustainable models.

Hence, the Alliance welcomes the development of the curriculum.

There are a range of items that were identified as part of the review of the draft curriculum. The importance of language and definition of key concepts is important. The Alliance notes that there is a distinction between a palliative care approach, generalist palliative care, specialist palliative care, and end-of-life care. Government and stakeholders have made clear distinction of the difference between these concepts,^{2 3} and the curriculum risks **using palliative care and end-of-life care interchangeably**. There is benefit from clarity of definitions from the outset. There is also a need for clarity in relation to the **underlying model of care or paradigm** which is to be applied by Rural Generalists. A range of national and jurisdictional exemplars exist.^{4 5 6} The Alliance proposes that developments linked to the **Compassionate Communities** movement offers a useful framework which may anchor workforce development with a broader community based approach.⁷ A number of Victorian communities have embraced this approach.⁸

It is also important to note that Victoria has recently become the first Australian state to pass **voluntary assisted dying laws** which provide a safe legal framework for people who are suffering and dying to choose the manner and timing of their death. A number of other Australian states have also indicated interest in developing similar legislation.⁹ These developments should be considered as part of the curriculum. Clarity of the model of care will assist with assessment of how the curriculum will deliver the required skills, knowledge and attributes.

The Alliance is concerned that the curriculum may inadvertently overemphasise a medical model approach to the provision of palliative care. The Alliance would like to highlight the National Palliative Care Standards 2018¹⁰ which are anchored in evidence, expert opinion, and the community perspective. It would ideal to ensure that the curriculum is reflective of the National Palliative Care

² https://www.aci.health.nsw.gov.au/_data/assets/pdf_file/0019/184600/ACI-Framework-for-Statewide-Model-of-PFoLC-Service-Provision.pdf

³ <https://palliativecare.org.au/what-is-palliative-care>

⁴ https://www.dhhs.tas.gov.au/_data/assets/pdf_file/0006/249333/Tasmanian_Palliative_Care_Policy_Framework_v16.pdf

⁵ <https://www.aci.health.nsw.gov.au/palliative-care-blueprint>

⁶ <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/palliative-care/end-of-life-and-palliative-care-framework>

⁷ <http://charterforcompassion.com.au/what-is-a-compassionate-community/>

⁸ <https://www.comcomhub.com/blog/2019/2/12/compassionate-communities-launch-in-warrnambool>

⁹ <https://www1.racgp.org.au/newsop/clinical/voluntary-assisted-dying-the-current-state-of-affa>

¹⁰ https://palliativecare.org.au/wp-content/uploads/dlm_uploads/2018/02/PalliativeCare-National-Standards-2018_web-3.pdf





Standards with appropriate contextualisation for the settings for which Rural Generalists operate. It is acknowledged that these guidelines are for health services.

National Palliative Care Standards 2018¹¹

- Standard 1: Initial and ongoing assessment incorporates the person's physical, psychological, cultural, social and spiritual experiences and needs.
- Standard 2: The person, their family and carers work in partnership with the team to communicate, plan, set goals of care and support informed decisions about the care plan. Standard 3: The person's family and carers needs are assessed and directly inform provision of appropriate support and guidance about their role.
- Standard 4: The provision of care is based on the assessed needs of the person, informed by evidence and is consistent with the values, goals and preferences of the person as documented in their care plan.
- Standard 5: Care is integrated across the person's experience to ensure seamless transitions within and between services.
- Standard 6: Families and carers have access to bereavement support services and are provided with information about loss and grief.
- Standard 7: The service has a philosophy, values, culture, structure and environment that supports the delivery of person-centred palliative care and end-of-life care.
- Standard 8: Services are engaged in quality improvement and research to improve service provision and development.
- Standard 9: Staff and volunteers are appropriately qualified, are engaged in continuing professional development and are supported in their roles.

In the absence of clarity on the underlying model of care, the Alliance identified the following questions during the review of the draft curriculum:

1. **The appropriateness of a focus on patients at risk of within the next 12 months** – There are a range of government and peak body frameworks which make no reference to the 12 month timeframe but are more patient focused. For example, a motor neuron patient who may have five years to live requires a palliative care approach to ensure a sound quality of life. The Tasmanian Government Department of Health and Human Services acknowledges that palliative care can extend for up to as long as two years,¹² while Palliative Care Australia and the World Health Organization make no specification of a defined timeframe.¹³ ¹⁴ The Alliance considers that palliative care should not be determined by a prognosticating timeframe.
2. **The breadth of summative case discussion consistent with a broader understanding of priority populations** – There is benefit in expanding the scope of the nominated key areas to

¹¹ https://palliativecare.org.au/wp-content/uploads/dlm_uploads/2018/02/PalliativeCare-National-Standards-2018_web-3.pdf

¹² https://www.dhhs.tas.gov.au/_data/assets/pdf_file/0006/249333/Tasmanian_Palliative_Care_Policy_Framework_v16.pdf

¹³ <https://palliativecare.org.au/what-is-palliative-care>

¹⁴ <https://www.who.int/cancer/palliative/definition/en/>





be more responsive to priority populations that may experience added complexities which contribute to unmet palliative care needs.

The Alliance proposes the following:

- o Expansion to include patients where cultural considerations bear influence on approach
 - o Palliative care patients at risk of dying at 13 months or beyond (i.e. not limited to 12 months)
 - o A patient with mental health concerns that may be mild, moderate or severe
 - o A patient with co-occurring alcohol or other drug dependence issues
 - o A patient with elevated complexity or risk such as those affected by homelessness or those living alone.
3. **The focus on person and family centred model and a holistic approach** – While it is acknowledged that the competencies of a rural generalist (as outlined in 1.11) emphasise a patient centred approach to care, many government and peak body frameworks make stronger emphasis on family centred approaches and a holistic model.^{15 16} Again, this would be clarified by details on the definitions and model of care for which the curriculum operates in support of. Where person, family and holistic approaches are of equivalent importance, it is anticipated that there is merit in including a category to this effect in the competencies (alongside communication skills, history taking, physical assessment, clinical management in the local context, and professionalism). This approach would explicitly emphasise the requirements to improve quality of life with a life-threatening illness.

The Alliance support continued refinement of the draft curriculum. The launch of the final curriculum is ideally supported by community or regional level approaches to change management and transition support. The PHNs partner to support these efforts, and most recently are supporting health practitioner capacity building with regarding to voluntary assisted dying in Victoria.¹⁷ The opportunity to consolidate insights and local health system intelligence must be maximised to support the realisation of the intended patient, provider and system benefits.

¹⁵ <https://palliativecare.org.au/what-is-palliative-care>

¹⁶ <https://www.who.int/cancer/palliative/definition/en/>

¹⁷ <https://vtphna.org.au/voluntary-assisted-dying/>





Appendix 1. Primary Health Networks

The objectives of Primary Health Networks (PHNs) are to increase the efficiency and effectiveness of medical services and improve coordination of care to ensure patients receive the right care, in the right place, at the right time. PHNs apply a regional perspective, informed by the needs of consumers, carers, and communities examining and supporting:

- the health workforce
- organisational processes
- networked systems of care.

PHNs are change agents for health improvement at the ‘meso’ or middle layer of the Australian primary healthcare system, acting as a conduit between individual providers / services and State, Territory and Commonwealth Governments. PHNs provide a nationally consistent infrastructure for solutions design and implementation support at the local level. Central to this are inclusive and participatory methods involving consumers and providers to design and achieve change. PHNs achieve objectives by:

- Understanding the health care needs of PHN communities through analysis, planning in collaboration with clinical and community / consumer advisory groups (and other consumer engagement and co-design mechanisms), while maximising value and efficiency.
- Providing practice support services so that GPs are better placed to provide care to patients subsidised through the MBS and Pharmaceutical Benefits Scheme and help patients to avoid having to go to emergency departments or being admitted to hospital for conditions that can be effectively managed outside of hospitals.
- Supporting General Practices in attaining the highest standards in safety and quality through showcasing and disseminating evidence of best practice. This includes aggregating and reporting data to support continuous improvement.
- Assisting General Practices in understanding and making meaningful use of digital health systems, to streamline the flow of relevant patient information across the local health provider community.
- Working with other commissioners of services and purchasing or commissioning health and medical / clinical services for local groups most in need.

The Victorian and Tasmanian PHNs support the primary healthcare services using system levers in a range of ways.

As an improvement partner – PHN provider and whole-of-organisational support for quality improvement efforts. PHNs are one of several primary healthcare service improvement partners, which is reflective of inter-organisational or networked approaches to patient safety and quality. Victorian and Tasmanian PHN contributions include:

- Facilitating all General Practice staff to have access to meaningful data analytical capability using data, and supporting data integrity.
- Collaborative approaches to change implementation, involving clinical support and networking





- Delivery of continuous professional development training for the primary healthcare workforce including GPs, nurse / nurse practitioners, allied health and pharmacy.

As a commissioner – PHNs commission primary healthcare services in areas of community need and operate consistent with the relevant clinical governance policies and protocols. This includes commissioning of the following:

- Alcohol and other drug services, General Practices and community pharmacies for the provision of afterhours support.
- Mental health stepped care services, utilising a diverse mental health workforce, including allied health professionals, mental health nurses, and other workforce structures.
- Providers to assist Aboriginal and Torres Strait Islander people access primary healthcare services and better manage complex and chronic health needs through care coordination and outreach support.

PHNs provide a unique contribution to system capacity to advance **safety and quality** within primary healthcare.

As a commissioner, PHNs have a role in developing and shaping primary healthcare services to deliver evidence-based models of care across a geographical area. These services are understood as ‘the market’ in economic terms, and the task of procuring primary healthcare services cannot occur in isolation of market development to mitigate the risk of market failure. PHNs have a lead role in working alongside primary healthcare services and fostering a market which can meet expectations in relation to a suite of measures of effectiveness, including safety and quality expectations (e.g. scope of practice, clinical supervision and workforce credentialing).

As an improvement partner, PHNs have an active role in supporting the clinical and non-clinical workforce to build individual skills and expertise and to implement systems of care.

PHN enablers

PHNs have a host of enablers to assist the implementation of the final Framework, encompassing prevention through to early intervention, treatment and recovery services.





Organisational governance and accountability

PHN governance arrangements encompass the diverse expertise and interests of regional communities. These include:

- Good governance of the commissioning process will ensure that public money is spent in an efficient and effective way and that PHNs are held accountable for the decisions made and the impact on the local health population.
- Clinical governance structure which recognises the importance of delivering clinically safe and effective services and which holds service providers accountable for the way in which services are delivered on behalf of the organisation.
- Clear accountability between commissioners and providers of services, in relation to the volume, quality, equity, and community / patient satisfaction with services provided.

Population health planning and performance measurement

PHNs commission programmes that generate the best return on investment, with a focus on improving AOD outcomes and high-quality service provision. PHNs monitor and evaluate the efficacy and effectiveness of commissioned mental health programmes by managing service provider performance, demonstrating value for money and supporting continuous improvement processes.

Community and clinical participation

Commissioning is undertaken in partnership through co-design with consumers and carers, communities, clinicians and service providers.

People with lived experience inform and support PHN commissioned activities and evaluate the quality and efficacy of care provided and drive best outcomes.

PHNs acknowledge that for consumers and carers to control, lead and participate directly in the decisions that affect them. Consumers and carers require information and support in order to effectively self-manage mental ill health, make health care choices and to interact with a variety of services to obtain the clinical and psychosocial support.

PHNs empower people with lived experience by providing information and support to enable them to participate in all stages of commissioning.

PHNs engage stakeholders and develop partnerships and trusting relationships, representing the diversity of consumers and carers. This includes children, youth and aged, Aboriginal and Torres Strait Islanders, culturally and linguistically diverse (CALD) and lesbian, gay, bisexual, transgender, and intersex (LGBTI) communities.

PHNs have established formal mechanisms to engage clinicians and service providers through representation in PHN Clinical Councils, Community Advisory Groups, and reference groups, along other opportunities for participation in all phases of the AOD commissioning cycle.

PHNs have a comprehensive approach to engaging clinicians to understand the demand for AOD services and the value of a person-centred approach to mental health service delivery. Person-centred





care is about adopting a social determinants and inclusive approach, and requires consideration of the individual's desires, values, family situations, social circumstances, lifestyles and mental health status.

Quality improvement and workforce development

In commissioning AOD services, PHNs appropriately consider and support the AOD workforce necessary to deliver evidence-based, integrated, sustainable, quality and safe care.

PHNs provide AOD health training and workforce development activities to General Practices and other clinical and community service organisations to support the regional integration of services.

PHNs collaborate closely with AOD stakeholders to build the social and cultural competency of the workforce to provide appropriate care to Aboriginal and Torres Strait Islanders, CALD and lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) communities.

PHNs endeavours to break down silos across programmes and jurisdictions by facilitating advocating for cross-sector coordination and collaboration across service providers in order to deliver sustainable, quality, safe and evidenced based services. Coordination of programmes and service delivery is essential, particularly at transition points, in order to deliver seamless care and a smoother consumer journey.

Digitally enhanced care pathways

PHNs develop primary healthcare led pathways (referral and access) to ensure communities are supported to receive seamless referral to tertiary and primary healthcare in the region. PHNs develop and drive digital platforms tools and usage across our region to ensure quality use of these progressive opportunities and enable meaningful data capture to support ongoing regional planning and design.

PHNs provide and support HealthPathways, a web-based information portal, designed to support local GPs and primary healthcare providers by providing evidence-based information to assist in the assessment and management of a range of medical conditions; and support referral processes for GPs, to assist patients to access local specialists and services.

PHNs and service providers leverage technology to engage and involve consumers and carers in the planning and co-design of reforms. PHNs also support improved information flow by promoting the use of MyHealthRecord and the eReferral system to consumers and service providers in each region.

Communication and engagement

PHNs deliver communications and engagement initiatives to raise awareness of AOD health and wellbeing issues.

PHNs ensure that commissioned activities and approaches are shared with regional communities and the sectors in a meaningful way through consultations, practice visits, publications and newsletters.

