



Office of the Inspector-General of Aged Care

28 March 2024

Dear Inspector-General,

Thank you for the opportunity to provide a submission regarding the progress on the implementation of the Royal Commission into Aged Care Quality and Safety (RCACQS) recommendations.

The Victorian and Tasmanian PHN Alliance (VTPHNA) includes seven Primary Health Networks (PHNs) that collectively aim to achieve the best possible outcomes for local communities and organisations through leadership, collaboration, coordination, and synergy. VTPHNA is making this submission to demonstrate how as a collective we can achieve efficiency in the health and age care systems, and design solutions to address local needs. PHNs play a key role in access and navigability across the primary, aged and acute health sectors. The recommendations presented in Table 1 have been identified as meeting the criteria to support access and navigability that have or can be supported by PHNs.

Table 1. PHNs have received investment to deliver these recommendations.

Royal Commission Recommendation	PHN Delivery
15. Establishment of a dementia support pathway	This has been successfully completed by all PHNs.
29. Care finders to support navigation of aged care	More details below. This program has been carried out with considerable success and the PHNs welcome the extension of funding to FY26.
58. Access to specialists and other health practitioners through Multidisciplinary Outreach Services	PHNs have been funded for the component of this recommendation relating to the Greater Choice for at Home Palliative Care program. The current program is achieving success in building capability, but with the demand for palliative care services anticipated to increase by 50% between now and 2035 , there will still be need for investment in the future.
63. Access to specialist telehealth services	This has been funded to all PHNs. Equipment grants were provided in FY23 and FY24, and in the coming months ubiquitous education will be available for clinicians, RACH staff and patient/carers.

Aged Care has been one of the seven priority areas for PHNs since inception in July 2015 however, the first aged care deed was provided to PHNs in March 2022. The PHN aged care investment articulated a specific role and desired outcomes for PHNs to achieve in aged care and provided an opportunity to strengthen



PHN-provider relationships that were established during the COVID-19 pandemic. The PHN aged care deed was focused on access and navigation, and included four deliverables:

1. Support greater uptake of telehealth in Residential Aged Care Homes (RACHs) through supporting equipment purchases and telehealth training.
2. Support RACHs after hours through the development of an After-Hours Tool Kit that would increase the use of MyHealth Record and provide localised care pathways.
3. Commission Early Interventions that would reduce the burden of chronic conditions.
4. Implement the Care Finder program, including the transition of Assisted Care Housing (ACH) providers.

In separate deeds, all PHNs were required to:

5. Develop Dementia Care pathways, including consumer resources.
6. Deliver Greater Choice for At Home Palliative Care (GCfAHPC) Program.

VTPHNA have provided a collaborative and coordinated response to deliverables 1, 2, 4 and 5. It was optional for PHNs to participate in the collaborative approach; Murray and Tasmania were not involved in deliverable 4 and Eastern Melbourne and Tasmania were not involved in deliverable 5. There has been collaboration across the three regional PHNs (Murray, Western Victoria, and Gippsland) in resource development for the GCfAHPC program.

The VTPHNA aged care collaboration optimised efficiencies in planning and design and allowed for localised implementation.

The Care Finder program is a great example of a collaborative approach that aimed to minimise inconsistencies in provider reporting, performance indicators, and engagement. Improved coordination in networks of practice and data collection strengthened delivery for the vulnerable target group of the Care Finder program. A collaborative approach drew on broad expertise across various internal PHN teams (including CEOs, Corporate Services, Data Analytics, Operations Executives, Operations Officers, Communications) and resulted in significant efficiency gains compared to seven organisations acting independently.

The collaboration resulted in the Care Finder program being rolled out within tight time frames and achieved greater ease in access for consumers, as providers are transparent with capacity and due to the integrated design, have warm intake processes to different providers, across different regions, if required. Case studies of the Care Finder program from two PHNs are provided for further information (please see Attachment 1).

The Telehealth education for RACHs is another excellent example of PHN-led collaboration. This program started out as collaboration between the seven VTPHNA PHNs, and rapidly expanded nationally to other interested PHNs. Fifteen PHNs coinvested to collectively develop the telehealth education customised for the specific needs of RACHs. The education program will be RACGP, ACRRM and APNA accredited, and freely available to clinicians, consumers, and providers. As a semi-national initiative, the quality of the education is of a significantly higher standard, than had each PHN attempted to create and deliver it independently.

There are several RCACQS recommendations yet to be implemented that PHNs are well placed to support. These are listed in Table 2 along with the opportunities for PHN involvement.



Table 2. PHNs are well placed to support implementation of further recommendations.

Royal Commission Recommendations	Possible PHN Involvement
26. Improved public awareness of aged care	In the Australian Government's Response to the Final Report of the RCACQS, PHNs were identified as being funded to support achieve this recommendation, however no funding has been received. The Interim progress report published by the Inspector-General in July 2023 notes that there was no progress of this recommendation. Having spent two years engaging with the aged care sector and other key stakeholders, PHNs are well placed to support this and would welcome funding to process this recommendation.
34. Assistive technology and home modifications category. 35. Care at home category	While this does not specifically sit with PHNs it needs to be noted that technology, when well designed, does achieve support for access and navigation. The care at home programs should form part of the boarder stakeholder group in aged care and communities of practice. This will reduce program siloing and improve connected services. [Note: this does mention GCAHPC]
36. Care at home to include allied health care	PHNs are well placed to commission allied health services.
52. Funding cycle	While this recommendation is specific to funding Aboriginal and Torres Strait Islander aged care pathways, the PHNs support the longer funding cycles of up to seven years. This creates more certainty for providers and consumers and creates stability in the sector.
59. Increased access to Older Persons Mental Health Services	As commissioners of psychology services into RACHs, PHNs would be well placed to progress this indicator. PHNs could also support the commissioning of these services in a community-based setting.
67. Improving data on the interaction between the health and aged care system	There is incredible duplication needed for patient/resident information. Two lots of medical records need to be kept across the general practitioner and the RACH and there is inconsistent upload or portability with pathology and radiology providers. Implementation of this recommendation would enable increased access and navigation and would reduce a GPs duplication (and likely human error) that results in manual and double handling of records.
68. Universal adoption by the aged care sector of digital technology and My Health Record	PHNs have supported the increased use of My Health Record both during and after hours at RACHs. As per the comment above, there is considerable gains that still need to be made that would be to the benefit of the patient/resident, provider and system.



Royal Commission Recommendations	Possible PHN Involvement
72. Equity for people with disability receiving aged care	This recommendation is reported as 'subject to further consideration.' Four PHNs nationally have piloted programs to improve access to primary care for people with an intellectual disability. The learnings from these projects would make PHNs well placed to support this recommendation.
107. Aged Care Research and Innovation Fund	PHNs are well placed to support translational research. This have been achieved with WVPHN and the University of Sydney in the Face Dementia project, which is funded via the Medical Research Future Fund.

In summary, over the past two years PHNs have developed a much deeper understanding of the aged care sector and have individually strengthened relationships with providers and practitioners at a local level. There has been success in all programs in which PHNs have been engaged. There are a number of recommendations above that have not yet been achieved that could be supported by the broader PHN network.

For further information please contact Executive Director Operations at Western Victoria Primary Health Network, Janelle Jakowenko; janelle.jakowenko@westvicphn.com.au.

Kind regards,



Quinn Pawson
VTPHNA Chair and CEO South Eastern Melbourne PHN



Attachment 1: PHN case studies

Case Study 1: Gippsland Primary Health Network

Identified Need

The Gippsland Care Finder program provides tailored person centred supports to vulnerable older people living in the Gippsland Region. The case study below highlights the complexity of clients who require support, complexity of the sector, and the dedication of the Care finder team to reach a positive resolution for their clients.

Approach Undertaken

An 80-year-old female client, living alone in a caravan park with complex medical conditions, who was socially isolated and estranged from her family, was referred to the Care Finders program in December 2023. She needed support to access an aged care facility as a permanent resident. She had multiple hospital admissions for her complex physical and mental health issues, and functional decline.

The client understood she needed to be in residential care and had a particular facility in mind to live to the end of her life, according to her choice. Unfortunately, the Residential Aged Care Home (RACH) denied the client entry as a resident, unless VCAT/State trustee guardianship was in place.

The Care Finders advocated to the RACH senior management to seek a permanent residential place for client, however RACH insisted they would not accept client without a guardian. This was a problem as she was estranged from her family. The RACH offered the option of respite while waiting for VCAT orders, however the client could not pay respite fees and rent. An application for hardship support via Services Australia takes 28 days, so this was not an option.

The Care Finder

- *Contacted State Trustee to discuss her case unfortunately they couldn't help because she's not in a RACH yet*
- *Attended GP appointment for health summary and capacity assessment*
- *Completed VCAT application form and submitted application on behalf of client*
- *Assisted with finding another Residential Aged Care Home who agreed to accept client as permanent resident with VCAT application in progress*
- *Completed application forms, direct debit forms, submit medication chart to GP*
- *Client had no ability or motivation to sort her clothes and personal belongings, no ability to dispose of unwanted items or to pack for the move.*
Care Finder advocated to CHSP to obtain support to sort and reduce clothing for the move, CHSP provided 2 hours support. Care finder organised transport of donated items to charity
- *Client was constantly overwhelmed and agitated with packing and preparing to move, Care Finders provided support and encouragement to the client*
- *Care Finder arranged for client and belongings to be transported to her new home at an excellent RACH and supported the client to move.*

The client is happy, safe, settled and well supported in the new RACH. The Care Finder has undertaken a comprehensive handover to the RACH and arranged for a geriatrician review.

Outcomes

This case study was extremely complex and involved extensive advocacy on behalf of the client who was living in extremely challenging circumstances.

There were barriers which included challenges with client complexity, RACH entry, challenges in delays to access hardship funding for respite, challenges with VCAT application, capacity assessment, and navigating a complex system.

Since moving into the RACH, the client has visibly improved, is enjoying her caring environment, and clearly enjoying the company of the other residents.

Client has expressed she is overwhelmingly grateful for Care Finder support, saying she could not have done this alone.



Case Study 2: Murray Primary Health Network

Identified Need

The client is an 84-year-old gentleman living alone in his own unit in a rural area. He is of sound mind and is somewhat socially isolated by choice. The client was referred to the Care Finder Program for assistance with "the MAC process". The client's daughter had approached a local Home Care Package provider and they had referred the client and his daughter for follow up and assistance. The assessment was undertaken by ACAS, and they had denied the client the opportunity to be assessed for a Home Care Package. The client has been awaiting CHSP funded Domestic Assistance from the local provider but so far has not been successful in obtaining support. The client was assessed for support in December 2021. His short-term goals were to obtain some domestic assistance to help keep his unit tidy. Through further discussions with the client, it was found that he now needs assistance with shopping and getting to and from appointments as he doesn't have a drivers license and riding his push bike is becoming too challenging. He also required an in-home assessment by an Occupational Therapist to review safety in the home and to consider eligibility for a PAV alert. The client also agreed to a trial of delivered meals.

Approach Undertaken

The client has family support but remains very independent with his decision making. ACAS attended to an assessment over the phone with his daughter in October 2023 but deemed him ineligible for a Home Care Package. Care Finder Program called My Aged Care and requested another Support Plan Review for an ACAS assessment. Through further discussions with ACAS it was agreed he should be assessed for a Home Care Package. Care Finder also engaged the client with CHSP funded Home Delivered meals and Care Finder support group at local Salvation Army Hall. Care Finder also ensured client was invited to Christmas Dinner, which he attended, and ensured client received Christmas food hamper.

Social and Emotional wellbeing

The client expressed happiness and gratitude to The Care Finder Program for assisting him to become socially connected again and feeling like he had "someone in his corner, battling for him". Client also expressed understanding and appreciation of the wonderful work the Salvation Army does for community members.

Successes and Challenges

The client is very happy with the support he is receiving and looks forward to visits from the Care Finder Clients family expressed gratitude and relief that her father now had someone to support him and that he was accepting of support and assistance. He will continue to engage with Care Finder to ensure he receives the supports and service he requires to help keep him living in his own home.

The success was the support group created for the Care Finder clients to get to know each other and to engage with each other on a social level. Client felt good about meeting new people.

The challenges in a rural and remote township include access to service provision and shortages of staff and lengthy waitlists for service. There is limited ability to access an assessment for a Home Care Package without support and assistance from someone with experience in conducting meaningful and insightful discussions with MAC and ACAS.

Outcome

The client commenced home delivered meals and thoroughly enjoys them and the interaction with the people who deliver the meals. His daughter expressed her relief at client having support to navigate the Aged Care system and that he was now engaging in activities in the community and accepting support at home.