An Australian Government Initiative

Primary Health Network's Submission to Royal Commission into Aged Care Quality and Safety

The Primary Health Networks (PHNs) welcome the opportunity to provide this submission to the Royal Commission into Quality and Safety in Aged Care.

Contribution to Submission:

This submission is informed by General Practitioners and General Practice staff, Allied Health and Aged Care providers, hospital services, PHN Clinical and Community Advisory Councils and other advisory groups working in Aged Care.

About Primary Health Networks:

Primary Health Networks (PHNs) were established on 1 July 2015 with the key 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 by the right person. PHNs are implementing the Federal Government's six key priorities for targeted work. These are mental health, Aboriginal and Torres Strait Islander health, population health, health workforce, eHealth and aged care.

PHNs achieve these by working directly with General Practitioners (GPs), the cornerstone of primary healthcare, and other primary health care providers, secondary care providers, non-government organisations, aged care services and hospitals to ensure improved outcomes for populations. In addition, PHNs undertake extensive population health planning to identify service gaps and inform local strategies to meet these needs.

PHNs are commissioning organisations. Commissioning describes a broad set of linked activities, including needs assessment, priority setting, service design and procurement through contracts, monitoring of service delivery, and review and evaluation. As such, PHNs are well placed to work with a broad range of stakeholders, including older people and their families and carers, and across sectoral boundaries of primary, acute, public and private organisations to improve outcomes for older people. Most importantly PHN's are well placed to introduce structural reform to the aged care sector to support the Commonwealth's reform agenda.

The PHN's vision for Older Australians is:

All older persons receive a level of care that meets their needs, commensurate with all other Australians, whether living in the community or in supported accommodation.

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1. Access to Aged Care

The Australian Bureau of Statistics reported that in 2015 most older Australians (94.8%) were living in households, while one in twenty (5.2%) lived in 'cared accommodation' such as residential aged care. The aged care sector in Australia provided services to over 1.3 million Australians in 2017– 18. The great majority received home-based care and support. The proportion of all older Australians who needed assistance was most commonly for health care tasks such as taking medications.[1] Presently, the number of individuals waiting for home care packages at their approved level (132,366) is far greater than the number of people receiving home care packages (91,847).

Experience of Access to Aged Care Services

There are multiple barriers to older persons accessing aged services. PHNs report that delays in commencement of aged care assessment and home care services are common. Central and Eastern Sydney PHN (CESPHN) reports 60.4% of GPs surveyed reported that patients wait more than one month and 34.5% reported that patients wait 3-6 months for home care services. Sydney North PHN (SNPHN) reports difficulties in accessing services in Northern Sydney due to long wait-lists. This increased wait time causes frustration both for consumers and GPs assisting patients to access the care needed.

Greater support and education are required for consumers, carers and families to navigate the system and negotiate with providers in the consumer directed care model. Often, people are confused about the process and need to enlist their families to assist. There is a need for improved care planning and management for older people within the community and in Residential Aged Care Facilities (RACF), especially for those with complex and deteriorating conditions, and those at the end of their life. Community providers and RACF need to build capability to manage unexpected deterioration, end of life care, deprescribing, and behavioural and psychological symptoms. They need to ensure availability of GPs during and after business hours, as well as greater access to telehealth consultations.

With more older Australians living in their own homes for longer, there is increasing pressure on primary health care providers to meet the demands of the ageing population. Additionally, those in RACFs have reduced access to General Practice, allied health, dental and mental health services, leading to poorer health outcomes and avoidable Emergency Department presentations. GPs often have to manage the complexities associated with ageing including patients' deteriorating physical health conditions and a high prevalence of mental health issues. Furthermore, GPs often have to navigate an aged care system that does not adequately meet the growing needs of the population, increasing the difficulty of delivering primary health care.

North Coast PHN is implementing, in collaboration with the Northern NSW Local Health District, the *Safe and Well at Home* project. Nurse Practitioners provide comprehensive health assessments and follow up care in collaboration with local and Community Health teams. The Nurse Practitioner supports older people with complex health care needs to stay safe and well at home and avoid unplanned hospitalisation

Access to services in rural and remote Australia present unique challenges which are highlighted throughout this document. It is important to note that while there are similarities with the issues facing both, there needs to be recognition that reference to remote regions of Australia also includes Aboriginal and Torres Strait Islander communities, many of which are geographically isolated. As a consequence, all of the issues highlighted in the submission are not only exacerbated but further complicated by a need to understand the Indigenous cultural context in particular the connection to country. This is particularly relevant when an older person needs to relocate from their "place", country or community resulting in significant stress and disruption to individuals, families and carers. The right to 'age in place' should be a principle that is applied equally across Australia regardless of where the older person lives.

[1] The Royal Commission into Aged Care Quality and Safety Background paper 1, Navigating the Maze: An Overview of Australia's Current Aged Care System, February 2019

Impact on aged persons, carers, families and health care providers

Those requiring aged care should receive the right level of care based upon their assessed need. Prolonged wait times for both home care services and access to RACFs can result in higher risk of hospital admission. Inability to access timely care packages can contribute to deterioration of health, place older persons at risk of harm and physical decline, cause distress for their loved ones burdening them with providing the required care and premature transition to permanent residential care.

In 2009, 12.7% of people in residential aged care were assessed as having a high care need rating for complex health care. In 2016 this figure was 61.0%.[2] These figures highlight changes to demand on aged care providers over the past decade. This could be as the result of people staying in their own home longer. While this is not necessarily a negative outcome, it does mean that access to care in the community, including primary health care, and support for the families and carers must commensurately increase. With gaps in the care provided, additional strain is placed on Emergency Departments to care for people whose needs are not being met, and increased care burden is placed on families and other unpaid carers. There is concern that the system (My Aged Care included) cannot accurately assess need or stratify population to adequately address supply throughout Australia.

What could better access look like

Improved navigation of services would improve access to care. Navigation could be facilitated through development of pathways of care; information exchange; improved documentation of care provided and improved systems supporting navigation.

Better care would be supported by greater financial incentives for rural/remote providers, recognising the increased economic cost of delivering services in the regions. It would also foster improved models of care to allow General Practice more flexibility in the delivery of services to people in their homes or RACFs which currently struggle to obtain GP service provision.

Brisbane South PHN is a consortium member trialling different models of aged care service navigation support across Australia for implementation from July 2020. This will test a broad range of services, activities and measures that support people to learn more about Government supported aged care programs and how to access them.

The significance of transport costs to access medical and specialist medical services needs to be better resourced. Many rural and remote people do not access specialist services because of cost, illness or not wishing to leave country or farms with stock during drought. A telehealth consultation in a multipurpose centre or GP surgery supported by a practice nurse or GP is cost effective, person centred and builds local practitioner capacity.

Improved transparency would ensure better health outcomes. This could be achieved by independence of aged care assessors from home care providers, as compared to aged care assessments being conducted by the organisation providing the home care service. Additionally, increased performance reporting could contribute to improved transparency.

The voices of consumers, carers and families should be respected in the planning and delivery of care for older Australians. Care should not only meet a person's health needs but should be delivered in a way that respects the person's wishes, cultural needs and lifestyle choices.

Wait times could be shortened by appropriate numbers of assessors and availability of higher-level home care packages to meet demand at the appropriate level; and
short-term interim services or short-term restorative care packages, for those waiting for higher care packages.

[2] AIHW national Aged Care Data, Clearinghouse, unpublished

The role PHNs can play

Ensuring community members have access to the right care at the right time and in the right place is within the remit of Primary Healthcare Networks nationally. The PHN program is tasked with increasing the efficiency and effectiveness of health and social services, particularly those at risk of poor health outcomes, and to improve integration and coordination of care. PHNs work across the health and social care continuum:- pharmacy, social services, allied health, aged care services, hospitals and community-based care.
It is necessary to reconceptualize the aged care sector to place greater emphasis on wellness, healthy ageing, enablement and restorative care. This means creating a social environment that acknowledges older persons' ability to improve physical functioning and wellbeing, removes an ageist approach to health care and social policy and redefines older persons as empowered protagonists for their own health.

To this end, a similar approach to the step up, step down model in mental health could be beneficial and may support greater flexibility in the use of services. Well supported and planned primary care can enable individuals to age in place and choose to remain in their homes and communities for as long as possible. Supporting earlier and greater investment in allied and other support services, is integral to enabling individuals to feel supported to remain at home for as long as they reasonably can, with more Home Care Packages to provide additional support until they need to access residential aged care services or tertiary health services. Comprehensive primary care can reduce social isolation, increase health and wellbeing, reduce chronic conditions and enable individuals to live in their place of choosing for longer.

PHNs are well placed to play a major role in improving access to aged care and supporting – especially as it relates to system improvement and commissioning of services. An example of this is in mental health, where PHNs have been tasked with funding primary mental health services and reforming the current system, including developing regional cross-agency mental health plans. PHNs in many regions have developed Older Persons' Regional Plans in concert with LHNs, aged care providers and older persons to meet identified needs within specific regions.

PHNs could commission community home assessment and support services, particularly for disadvantaged populations. They could implement programs of work to improve care navigation; information exchange – including consumer information; change management; workforce issues and service pathways (e.g. HealthPathways). A key element of this would constitute improving linkages between primary health care, acute care, community, social services and residential aged care. One way this could be achieved is by engaging various stakeholders in cross agency aged care planning and assessment processes.

Brisbane North PHN has operated a Regional Assessment Service (RAS) in the Brisbane North, Caboolture and Brisbane South Aged Care Planning Regions since 1 July 2015. The BNPHN consortia-based RAS model has been highly successful and is acknowledged as the lead performing RAS in Australia.

PHNs have a unique role in building partnerships and supporting integration across the system. It is critical to strengthen the links between community, primary care, tertiary care, and residential aged care, ensuring both positive consumer care outcomes and the efficient usage of each element of the care system.

PHNs are uniquely placed to facilitate better interdisciplinary and community collaboration. Improving consumer access to information is critical. PHNs have much experience and could set up processes to assist GPs and older people to better understand what care and support is available, the quality of these services, and how to access them. PHNs develop annual needs assessments to help identify population groups at risk of poor health outcomes and work with other agencies to respond to these. Thus, PHNs could assist health professionals to initiate and better understand the aged care assessment referral process in order to assist older people access aged care services. As PHNs are established with the remit to improve the care and service system, they are well equipped and experienced to undertake these functions.

PHNs commission psychological treatment services targeting the mental health needs of people living in the community and residential aged care facilities (RACFs). These services facilitate access to mental health services similar to those available in the community through the Better Access to Psychologists, Psychiatrists and General Practice through the MBS Initiative.

Another key mandate of PHNs is commissioning and funding programs to address gaps and ensure cohesion of the system. A key plank of this work is delivery of multidisciplinary and person-centred care (consumer assessed need) that improve consumer experience and outcomes and system efficiency.

Additionally, PHNs have a wealth of experience and insight into the delivery of tele-medicine programs; programs to reduce depression, anxiety and other mental illness; and most importantly programs to address social isolation and loneliness in older persons. The use of multidisciplinary team case conferences in health has resulted in integration of care for clients as well as greater input by the client and carer regarding care received. This allows a team of clinicians to work together towards the same care plan and outcomes. This experience is transferrable and could result in much benefit to the aged care clients who often receive multiple services in a fragmented and incoherent manner, or cannot access specialist services due to remoteness.

Case Studies – Access to Care

Hunter New England Central Coast PHN reports that reconceptualising the RACF as a place of reablement could be achieved through programs such as the Aged Care Emergency (ACE) program; provision of services such as mobile imaging; and changes to funding structures which better support GPs to engage with older persons in their homes and RACFs both in person and via telehealth technologies. Piloting alternative models which utilise nurse practitioners more fully in primary care would also help to test models of sustainability in rural and remote areas.

Central Queensland, Wide Bay and Sunshine Coast PHN: The Geriatric Emergency Department Intervention (GEDI) is a specialist service targeted at persons aged 70 and over who present to EDs in Nambour and Sunshine Coast Hospitals. The GEDI team comprises of a Clinical Nurse Consultant, ED Physician and Clinical Nurse. The team prioritises the assessment and management of the care of frail older persons. The service assists in reducing inappropriate hospital admissions and delivery of care at the right place. The program's evaluation showed statistically significant reductions in hospital length of stay and savings in ED and hospital admissions. Importantly it demonstrated improved patient and clinician experience.

HIPS (Health Intervention Projects for Seniors) - RACF and primary health sector mediated interventions including provision of a Nurse Practitioner Candidate (NPC) within the RACFs to support an enhanced model of primary health care (PHC) encompassing GPs (GP); development of advanced care plans for residents; better coordination of GP care in the RACF; a training program for RACF staff; and development of a sustainable model of care through endorsed Nurse Practitioner Medicare billing.

Other Initiatives

- Better Health Care Connections Video Consultation pilot (HNECCPHN and WNSWPHN)
- Analysis of allied health services in Residential Aged Care Facilities (HNECCPHN)
- Telehealth in Residential Aged Care Facilities – TRAC (WNSWPHN, NBMPHN)
- Aged Care Emergency (ACE) project development (HNECCPHN)
- Effective Clinical Handover Education using the ISBAR Framework delivered into RACFs via an on-line learning module (WNSWPHN, NBMPHN)
- Dementia Partnerships Project - NE Region (HNECCPHN)
- Influenza immunisation in RACF's (NBMPHN)
- Social Connections for older Australians pilot (NBMPHN)

2. Primary Care

An increasing number of GPs are choosing not to provide services to people living in residential aged care, and many are no longer making home visits to older people living in the community.

Delivery of Primary Care to aged persons in their homes and RACFs

Clinical staff in aged care facilities and state based mental health services[3], highlight active GP engagement as central to improving the wellbeing of people at home and in aged care facilities.

However, older persons have more limited access to GP services, allied health, dental and mental health services, leading to poorer health outcomes and avoidable Emergency Department presentations. Inadequate remuneration structures result in few home visits and visits to aged care facilities.

Access to quality GP services after hours is particularly difficult. Residential facilities report that GPs routinely fail to attend facilities on request, and when services are provided, they are of inconsistent quality. Central and Eastern Sydney PHN (CESPHN) and Adelaide PHN (APHN) report that while demand for GPs in RACFs and for home visits is increasing, many GPs are choosing not to provide services to people in RACFs or undertake home visits. There are reports from GPs about the difficulties in navigating My Aged Care and the increased pressure on GPs from patients requesting help to move things along and provide alternatives.

CESPHN reports that GPs are dissatisfied with the arrangements for providing services to residents in RACFs. Thirty eight percent of GPs surveyed by CESPHN stated their intention to stop visiting RACFs within the next 12 months, or to decrease their visits, or to maintain visits to current patients in RACFs only. Sydney North PHN (SNPHN) reports that many GPs will not take on new patients since the new MBS items in RACF came into effect in November 2018. Younger GPs have no interest in aged care and in general GPs are reticent to home visit. It is especially challenging for RACFs to have access to after-hours GPs. Similarly, in Brisbane North, as well as other jurisdictions, residential aged care providers acknowledge ongoing difficulty in accessing a consistent quality of GP care for residents. In some regions such as Western NSW, PHNs report that in regional towns there are no GPs that provide home visits. North Coast PHN (NCPHN) reports that many GPs in the Hastings Macleay region have withdrawn their services from aged care facilities due to workforce capacity issues. After-hour doctors who are not the resident's primary care providers, lack an ongoing relationship with residents, do not have knowledge of their medical history and are more likely to recommend a risk averse course of action - transfer to hospital.

Often GPs perceive themselves as 'visitors' in the aged care facilities. They report attending on a per patient basis when requested by the aged care facility, patient, or family. This significantly limits the GPs involvement in the residents' clinical care. In terms of factors that contribute to GPs' reluctance to engage with aged care facilities, GPs highlight low levels of funding including inadequate patient rebates to compensate for lost time in their practice; substantial amounts of unpaid work; patient complexity; out-of-hours responsibilities; a lack of RACF staff and infrastructure support; challenges accessing clinical information and challenges accessing required specialist services. The aged care funding model limits the ability of providers to respond to clinical care needs of residents appropriately and do not support workforce training and up-skilling.

If GPs and allied health clinicians are to be more integrated into aged care facilities, national level changes need to be implemented. Government backing is required to address problems created by the current Medicare payment structure; the work practices of GPs and other allied health clinicians including psychologists; and the culture and work practices in RACFs.

What could better Primary Care look like

A better primary care system would be responsive to the wholistic needs of individuals. In order to achieve this, health care providers, the broader community and the social care system must respect the fact that the client or patient is a whole person whose health is affected by a range of social, emotional, cultural, spiritual

[3] As experienced by WAPHN and other PHNs.

and economic factors. Care teams must collaborate to collectively provide *'whole of person'* care, rather than responding in isolation to single clinical issues or diagnoses requiring treatment.

PHNs report that assisting GPs to provide quality care in RACFs requires the following:

- appropriate funding incentives for GPs to visit RACFs;
- the funding of Registered Nurses to accompany GPs when attending patients in RACFs, and the subsequent ability of these nurses to ensure implementation of GP recommended action, will enhance the experience of GPs and residents in RACFs;
- changes in systems and processes to enable greater sharing of clinical information between RACFs, GPs, and hospital care partners;
- establishment of localised groups of doctors that can provide consistent services to residents during and after hours;
- establishment of clinics with set hours at RACFs[4];
- avoidance of meal time clinics to afford privacy to GP and patients.

SNHN and NSLHD work in partnership to deliver *DETECT training* to RACF staff. The online module allows more people to have access to the information, not just those that were able to attend face to face sessions. Learning outcomes include:

- Performing an acute assessment of a deteriorating resident
- Identifying symptoms that require immediate action
- How to use the flip chart and action urgent care when appropriate
- Utilising ISBAR to communicate relevant information to other health practitioners
- How to access the online module for self-guided education

Better primary care also depends on due attention to the needs of the carers and families who provide, or support, the care of older people. GPs, aged care staff, Emergency Department staff, and other care providers should have the capacity and skill to integrate the needs and insights of carers in clinical decisions, and engage with them throughout the care journey. Similarly, carers should be provided with information that can empower them in their support of older people. This could include education pertaining to such issues as dementia, abuse, reporting, and effective communication with those in care. This education should be provided with due regard to the person's health literacy and be easily available in the community (for example through pharmacies) and in RACFs.

Improved primary care for older people at home should include: appropriately funded access to GPs at home for frailer older persons; alternate models of sustainable care which utilise nurse practitioners and allied health practitioners to alleviate some of the burden placed on GPs, particularly in regional and remote areas; greater access to primary care allied health; delivery of telehealth consultations by GPs or nurse practitioners and support for consumers and clinicians to navigate and coordinate care.

Improved primary care in RACFs should include: support services to manage unexpected deterioration; end of life care; deprescribing; appropriate responses to behavioural and psychological symptoms; regular access to GPs within the RACF, both during and after business hours; access to GPs and allied health professionals through funded telehealth consultations; and review of RACF clinical information storage systems.

Western NSW PHN operates across large parts of rural and remote NSW. As a part of nation-wide pilot to trial a GP led telehealth model of care in residential aged care settings it enabled over a 16 month period, 840 GP Video Consultations resulting in a 59% reduction in hospital transfers and a 19% reduction in hospital admissions. The project achieved a 98% GP Satisfaction rating and a 94% Positive Care Experience for the Resident.

Improved navigation of services would improve access to care. This could be achieved through an increased focus on pathways of care, information exchange, improved information about care, multidisciplinary care coordinators promoting integrated care and systems supporting this.

There are examples of programs which have generated significant momentum in delivering enhanced primary care to older clients. These programs are located in the gap between

[4] GPs visiting at all hours is disruptive for staff and residents.

primary care and acute care, an area which remains largely and problematically unfunded.

The role PHNs could play

PHNs have an important role to play in changing and improving the health care system, trialling new models of care and providing information and support to GPs. Some PHNs have built on their existing collaborations and partnerships with various agencies including hospital services, to create consortia and alliances. These consortia seek to tackle healthcare problems which have otherwise defied solution and which transcend the mandate of any one organisation or part of the health sector. The Brisbane North Health Alliance is one such example (see case studies).

Geriatric Outreach Assessment Service (GOAS) pilot – Brisbane North has two components: an outreach geriatrician-led 5-day service, and the provision of training for RACF staff on clinical best practice. Evaluation of the pilot showed that this model was successful in improving quality of care and reducing potentially preventable ED presentations and hospitalisations for acutely unwell older persons residing in residential aged care facilities, the program is now rolled out to the four major hospitals in the Brisbane North region.

PHNs are commissioning organisations that address gaps in health care systems and improve the integration and quality of health and social services. PHNs could commission place-based services to address challenges and gaps in aged care, and to improve primary care service delivery. This could include:

- developing programs that support older people with co morbidities to self-manage and programs promoting healthy ageing;
- community home assessment and support services, particularly for disadvantaged populations;
- care navigation support;
- care information exchange;
- enhanced primary care arrangements such as General Practice;
- improved linkages between primary health care, acute health care, community, and residential aged care.

In addition to commissioning requirements, the PHNs play a pivotal role in integrating health systems centred around the whole needs of those accessing the system. This includes addressing equitable access to primary care, such as that provided by GPs, pharmacists, allied health practitioners, and dentists. It also includes addressing equitable access to secondary or specialist health care, as well as community-based services that support access to treatment.

PHNs are well placed to work collaboratively with pharmacies to better understand their patient cohorts, and to integrate with other parts of the health sector. The WA Primary Health Alliance has been trialling *integration of the role of non-dispensing pharmacists within General Practice* through its comprehensive primary care model. This has greatly enhanced the function and capability of the General Practices to better understand medication management, drug use evaluations, prescribing audits and counselling on both medication and lifestyle issues, in particular managing transitional care.

The current supply of home care packages is not adequate. Failure to access the level of care required, can contribute significantly to decline in the health of an individual. This gap in supply and demand causes additional strain on the primary care system. In particular this burden falls on GPs and pharmacists who are called upon to respond to health care needs that are increasing in scope and complexity. PHNs support General Practice to better understand their patient cohorts through analysis of data, and build capacity through provision of training, building referral pathways, and commissioning primary health services.

General Practice and pharmacies note an increase in attendance of older people. PHNs can:

- assist GPs to access appropriate aged care education and skills training;
- implement systems to risk stratify patients, to target interventions where they are most needed earlier;
- assist with the development of integrated approaches to clinical care between hospitals and GPs;
- facilitate sharing of clinical information through utilisation of My Health Record;
- assist with the coordination of after-hours General Practitioner support services.

All patients with a chronic disease over the age of 65, or diagnosed with a terminal illness should have a fully developed advance care plan, including an advance health directive; enduring power of attorney and enduring power of guardianship. Advance care planning is important for clinicians to fully understand the wishes of patients with regard to treatment decisions and with regard to whom to involve in the clinical decision-making processes. PHNs play an important role in educating primary care clinicians in the use and uptake of advance care planning. This includes building capacity within General Practice to assist patients to complete an advance care plan.

Extended Primary Care for Residential Aged Care Facilities a Dandelion & Access Treat Stay – Adelaide PHN
These programs are designed to support GP access and availability in the afterhours period, reduce unnecessary hospital admissions and build capacity of aged care staff to improve the coordination of care for residents. Two aged care providers deliver the projects across four residential aged care sites in Adelaide's northern and southern suburbs. Both projects use multi layered strategies involving GP and staff training, liaison work with local hospitals, ambulance services and enhanced access to on-site clinical support from advanced practice nurses and nurse practitioners.

Case Studies: Primary Care

Brisbane North PHN Ageing Well Initiative: Building on a track record of collaboration and partnership in the Brisbane North region, Metro North Hospital and Health Service (MNHHS) and Brisbane North PHN created the Health Alliance. The Alliance is an approach to tackling healthcare problems which have otherwise defied solution and which transcend the mandate of any one organisation or part of the health sector. The Health Alliance focuses on three population groups, one of which is frail older people. The program which aims to improve the health and wellbeing of this population is known as the *'Ageing Well Initiative'*. The Ageing Well Initiative applies evidence based best practice to local provision arrangements. It also creates an enabling and learning environment to sustain transformational change in the care of older people. The initiative focuses on interventions which international evidence indicates, reduce unnecessary hospitalisation of frail older people. This includes an increased system focus on living well; improving the hospital and primary care interface and reduction of polypharmacy. The initiative is also considering how to reconceptualise the RACF as a place of reablement.

Eastern Melbourne PHN is currently working with service providers to develop new pilot programs to address current needs and gaps in older persons' mental health. This includes commissioning community-based pilots in order to develop tailored services for the older population. The pilot program aims to support GPs and practice nurses to better identify mental health challenges in older people, and support them to manage the care of older persons with mental health difficulties in the community. The program aims to reduce preventable admissions and enable timely and supported discharges back into the care of GPs following admissions.

A number of PHNs are currently working alongside Hammond Care to deliver the *'Advance Project'*. This encourages the use of advance care planning by means of a series of workshops and training opportunities to encourage General Practice staff to work collaboratively to provide palliative care.

Sydney North PHN: In collaboration with the Australian Digital Health Agency, Sydney North Health Network is leading two digital health test bed projects. Over three-years SNHN will work with 9 Residential Aged Care Facilities and thirty-two private specialists, and their clinical networks, to test and measure the benefits of embedding My Health Record and Secure Message Delivery into daily working practice

3. Chronic Disease Management

Chronic diseases are common in aged care service users. Eighty-seven percent of people aged over 65 years have at least one of the eight most common chronic diseases. Co-morbidity or multi-morbidity are also common and occur in 60% of people aged over 65 years.

Experience of aged persons in their homes and in RACFs

The Australian healthcare system is experiencing an increase in demand due to various factors including the changing profile of the population (ageing, longevity) and the shifting burden of disease from acute to chronic and complex conditions. It is estimated over half of the Australian population, 65 years or older, has at least one chronic condition. Twenty-nine percent of this population has three or more chronic conditions. And as the population gets older the prevalence of multiple chronic conditions increases. The continued rise in chronic disease prevalence amongst older Australians contributes to considerable pressure on the health care system. It is estimated that chronic disease is responsible for 80% of the total burden of disease as measured in disability life adjusted years. Furthermore, as the prevalence of chronic disease increases, more and more older persons are prescribed multiple medications and polypharmacy and thus experiencing increasing risk of adverse medication events.

The need for improvements in chronic disease and comorbidity management for older people is urgent. As people choose to live in their homes for longer, with a limited supply of home care packages, they inevitably become sicker, relying more on primary health care and Emergency Departments to provide for their health care needs. The medical model of treating the disease rather than the person is still the prevailing approach in aged care.

To improve patient outcome and experience, it is increasingly necessary to design integrated, whole of person-centred care for older people with chronic conditions, delivered in a coordinated team-based approach by competent clinicians. CESPHN stakeholders report low confidence in the knowledge and skills of RACF nursing staff to manage and implement chronic care treatment plans. Over twenty-three percent of GPs reported 'rarely' or 'never' feeling confident in the knowledge and skills of RACF staff. An additional thirty-three percent felt confident in the capacity of RACF staff only 'occasionally' or 'sometimes'.

Managing a person's growing and complex health needs, including co-occurring mental health issues, places additional strain on General Practices and other primary care providers. The challenges associated with management of patients with chronic conditions is exacerbated when there is movement between health care providers or geographical locations.

What could better chronic disease management look like

As the Australian population ages, there is a corresponding increase in the prevalence of chronic disease. Also related to the ageing of the population is the increase in the number of people living with multiple care needs. To respond to this reality, the various components of the health system must be connected. Primary care must be linked to hospital care. There must be willing collaboration between different parts of the health workforce, administrators, funders, researchers and governments. There is a need for better coordination across social and community support services which have traditionally existed separate to the health system. These include disability services, social care services, aged care, housing, education, transport and others.

A fully integrated and coordinated health system that is easy to access and navigate improves the patient journey, and enhances the experience of consumers, carers and families. Such a health system, supports the provision of personalised, high quality, safe treatment. It revolves around the person, providing choice through shared decision-making with health professionals and the capacity to self-manage where feasible. The use of shared digital health records is an enabler to linking aspects of the system and building the capabilities of the workforce to ensure continuity of care.

The Aged Care Emergency (ACE) project has reduced hospital transfers and hospitalization in the Hunter and New England areas. This is achieved by supporting better clinical care in RACFs. Mobile imaging on the Central Coast has enhanced clinical care in RACFs, eliminating the need for resident transfers.

GPs as the coordinators of care for older people, prevent more expensive downstream health costs including visits to the Emergency Departments, and hospital admissions. High quality and safe, early treatment by a GP with an ongoing relationship with an elderly patient, can circumvent a hospital visit. Apart from thus reducing pressure on the public hospital system, the support of such a GP is likely to result in much better patient outcomes.

Many PHNs, have initiated programs for those aged 65 years and over, promoting healthy living activities and healthy ageing. Chronic disease management evidence indicates that the best approach to managing chronic disease incorporates the adoption of a tailored person-centred approach; building professional capacity; integrating care; and improving health literacy and self-management.

Currently co-ordination of care between multiple aged care service providers is limited. Older patients would benefit from improvement in the knowledge and skills of GPs and practice nurses, RACF nurses and care staff and home care provider staff, in the management of chronic disease.

Brisbane North PHN delivers a successful Team Care Coordination service aimed at patients with long-term chronic health conditions. Team Care Coordination is a community-based service delivered by clinical nurses. It aims to improve the patient's self-management and quality of life, and support their ability to remain living well at home.

How can better management be achieved and what role can PHNs play

Better chronic disease management can be achieved by:

- development and implementation of new models of care that place the patient at the centre of care design and ensures seamlessly coordinated care;
- addressing the current fragmented approach to care whereby it is delivered by multiple providers who are neither in communication with each other, nor aware of the care provided by the other;
- improving clinical handover between GPs, hospitals and RACFs;
- ensuring input from patients and families is incorporated into care plans;
- ensuring care plans are reviewed and adjusted with input from patients and families, and with due respect to patients' experience and outcomes;
- establishing funding mechanisms that provide incentives to keep clients well, and out of hospital;
- investing in training and education of the primary care workforce, including General Practice, RACFs and community nurses;
- provision of support to specialist Local Health District chronic disease management teams;
- provision of scaled up chronic disease management support hubs in General Practice to meet the chronic disease management needs of older people;
- building capacity in RACFs to manage the chronic care needs of residents in RACFs in-house and where appropriate away from traditional hospital care management hubs;
- increasing opportunities to encourage lifestyle medicine including physical activity in older people and efforts to reduce loneliness and isolation;
- increasing the knowledge of nurse and allied health professionals about the Physical Activity Guidelines which contain local referral pathways;
- development and trial of a screening tool to identify older people at risk of an adverse medication event;
- adoption of practices such as social prescribing.

PHNs can improve the integration between community and acute care within the broader health system. PHNs can play a vital role working with the rest of the system, especially hospital services, to strengthen and promote regional collaboration in commissioning community-based services to support the care of older people living with chronic disease.

PHNs support General Practices to move toward more person-centred, integrated, team-based models of care. This supports the management of patients with chronic conditions and multiple morbidities in the primary care setting. The effective management of patients with chronic disease in the primary care setting can help reduce the number of potentially preventable hospitalisations (PPHs), and early entry into RACFs.

The *Gold Coast PHN Complex Care* project for over 75s, risk stratifies patients at risk and uses health assessments and care plans to agree and support people to achieve their goals. High satisfaction was achieved in encouraging choice in care options, self-care, and goal setting to address everyday problems.

New models of care and funding agreements are required. These new models should centre care on the wholistic needs of the individual, in the way that Patient Centred Medical Home (PCHM) models provide services to the general population. Examples of this approach and model are emerging. These models are

based on strong primary care that is timely and appropriate to the person's needs. They play a pivotal role in achieving improved health of populations and ensuring the right care is provided at the right time, thus enhancing patient experience and outcome.

PHNs are uniquely placed to apply population health approaches and to assist improve equitable access to chronic disease management for older people. PHNs can:

- assist in the development and implementation of new models of integrated chronic disease management for older people, which encourage more home-based assessments, and holistic integrated care for older people with chronic disease and multimorbidity;
- improve capacity of home care provider services to participate in holistic integrated care for older people with chronic disease and multimorbidity;
- assist GPs and other primary care staff to access appropriate chronic disease management training.

Case Study: Chronic Disease

North West Melbourne PHN: Social prescribing is a way to enable primary care to refer individuals to a range of non-medical services offered by community-based organisations. It aims to empower costumers to improve their health and wellbeing and social welfare by building skills to manage their health, complementing traditional forms of medical and health care

Gold Coast PHN: GCPHN and Gold Coast Hospital implemented the InterAct program to provide outreach specialist support to RACF residents at risk of preventable transfer to emergency departments. This service is provided both during business and in the afterhours period. During 2018/19, 1894 patients were supported by the service, resulting in reduced transfers from RACF to hospitals and less residents admitted to hospital.

4. Palliative Care

Each year, approximately 60,000 people die in residential aged care facilities (RACFs). However, data from 2012–14 indicate that only 15% of older Australians who died in permanent residential aged care were identified using the Aged Care Funding Instrument assessment, as needing palliative care.

Experience of aged persons in homes and in RACFs

Research indicates that many people would prefer to die at home. The quality of palliative care service delivery varies. Consumers and key stakeholders often report difficulty accessing both palliative care services in the home, and residential aged care facilities. Subsequently many people die in acute hospital facilities rather than their preferred location for death.

Experience within the aged care sector, and feedback from stakeholders and consumers, indicates that residents of residential aged care facilities are often not afforded the same level of palliative care as people living in the broader community. Contributing factors to the provision of inadequate palliative care in some residential aged care facilities include lack of experience and knowledge in palliative care on the part of residential aged care staff, and limited medical input from both GPs and specialist palliative care services.

Demands on GPs and RACFs to provide palliative care services are likely to increase, given the increasing age and acuity of people ageing at home or entering residential care. Both GPs and RACF providers need much greater support to enable the delivery of quality palliative care. The current funding structure for palliative care at home and in residential aged care provides little financial incentive for a palliative or end of life diagnosis and care. The Resource Utilisation and Classification Study recommendations are a way to rectify this and ensure that residential aged care funding for palliative care is sustainable into the future. SNPHN highlights that Palliative care in the home does not provide enough clinical hours of support (i.e. nursing care). GPs are reluctant to facilitate palliation in RACFs and patients who are palliative in hospital are not linked into services before being discharged back to RACF, highlighting the general poor clinical handover between GPs, hospitals, RACFs and aged care workers.

CESPHN stakeholders report concerns over the low levels of, and inadequate quality of palliative care being provided in RACFs. These contribute to inadequate pain management, inappropriate hospitalisation, and at times lack of consideration for the wishes of residents. The stakeholders also report concerns about poor coordination and lack of palliative care contributing to inappropriate referrals to specialist care and unnecessary transfers to acute care settings.

GPs working in residential aged care facilities report daily use of palliation. At time of entry into a residential facility, patients have rarely considered what palliation needs they require, their end of life wishes, or by whom they would like to be treated. GPs report that staff in the RACFs are given demanding workloads and much responsibility without the allocation of adequate time to attend to this work. Some nursing staff routinely work an additional one to two hours without remuneration in order to complete their work. In addition, there is a significant administrative burden on staff. Thus, staff spend extensive periods completing paperwork, detracting from time providing care to patients. The stress incurred by these circumstances contributes to burnout and a subsequent attrition of the workforce. It may also contribute to levels of clinical incidents. This environment does not support good palliative care practices. Pressure to complete tasks limits staff capacity to tailor their care to the individual needs of patients. High patient to staff ratios also makes it difficult to provide an individualised approach to palliative care.

What could better Palliative Care services look like

Investment is needed into community-based models that are flexible and promote care in the consumer's place of choice. Service models must allow providers to respond quickly when an individual's condition changes, to avoid inappropriate or unnecessary Emergency Department presentations at the end of life. Service models should support people to remain in their location of choice – whether that be their homes or RACFs, for as long as possible.

In addition to an improvement in provision of resources, better palliative care services require improved collaboration between primary and acute services, between the private and NGO sectors, and between health and social services. Improved sharing of information among all of these sectors and services is an important part of this improved collaboration. Through the Greater Choices for At Home Palliative care project many PHNs have developed enhanced jointly agreed shared care systems and pathways between all providers.

WNSW PHN *Shared Health and Advance Care Record for End of Life Choices* (SHARE) implements a shared palliative approach across far West and Western NSW Local Health District regions. The electronic Palliative Approach Framework (ePAF) involves:

i) Web Resource Centre https://www.wnswphn.org.au/epaf
ii) Shared Locality Record
iii) Electronic data extraction.

The project is funded by Commonwealth Greater Choice for at Home Palliative Care.

A key to better palliative care is the use and increased uptake of advance care planning. It is critical that people clearly articulate their wishes for care prior to a decline in function. Inclusion of families and carers in these processes is critical to providing quality palliative care. Improving education is another important strategy. Better education should be available to GPs, staff of RACFs and families of those requiring care. One result of such education should be the facilitation of family involvement in and support of palliative care.

Better palliative care would involve:

- consultation with older people regarding their end of life care choices;
- access to quality palliative care in RACFs in a timely manner;
- reduced transfer of RACF residents to acute care settings for palliative care that can be managed in RACF or at home, when this is the wish of residents' family and carers.

How could better Palliative Care be achieved

There are a number of ways that palliative care and end-of-life care could be improved. A number of jurisdictions, including Queensland, have developed Palliative Care priorities. Consumers and key stakeholders have expressed[5] the need for change that incorporates models with the following characteristics:

- palliative care is provided in the setting of patients' choice;
- end-of-life care is provided at the patients' preferred location for death;
- carers and families are actively engaged in person-centred care planning and ongoing needs assessment;
- pathways for transition between settings over the course of the palliation are improved to ensure people receive more coordinated and integrated palliative care;
- MBS item numbers better enable generalist and specialist palliative care to be provided across the health sector;
- support is provided to rural and remote locations by means of better funding models, infrastructure such as telehealth and innovative models of specialist palliative care.

These improvements could be achieved through integration projects that work across settings and sectors. Projects should aim to have universal triage processes, universal information documentation, shared care agreements and guidelines, data enablers that facilitate sharing of information and joint training and education. This would support development of a system that operate as a single cohesive unit, and utilise resources in the most effective way.

[5] See page 21 for more information.

Some additional improvement ideas are noted in the table below.

Home Based Palliative Care	Residential Aged Care
• Improved funding and support for GPs • 24-hour access to specialist palliative care support • Improved access to Commonwealth Home Support Program services, including improved timeliness and access • Greater number of support multidisciplinary health professionals • Better support for carers. • Ongoing education in palliative approaches and end-of-life care for staff	• Improved funding mechanisms to incentivise palliative care provision in residential aged care • Improved access to specialist palliative care in residential aged care • Ongoing education in generalist palliative care and end-of-life care for staff • Palliative care Nurse Practitioners working across acute, community, residential aged care and primary care • Promotion of advance care planning.
• Palliative Care Nurse Practitioners working across acute, community, residential aged care and primary care • Funding and support of Aged Care End of life pathways, clinical tools and symptom management	

Palliative care needs for residents of RACFs and for those living at home in the community can be provided by palliative care teams if effective systems and staff training are in place in RACFs. RACF providers need to work with GPs, local geriatricians and Local Health District palliative care services to ensure that a high quality palliative care is provided in their facilities.

Successful innovative models and the role PHNs could play

The provision of palliative care for RACF residents can be supported by palliation medicine services provided by Local Health Districts (Hospital Services) at a lower cost than is done in the hospital setting. Team-based, multidisciplinary approaches work most effectively when delivering palliative care within a residential facility. This requires GPs, allied health and residential staff to work collaboratively, responding to the individual's health care plan - including utilising palliative specialists, and adhering to the persons advance care plan and advance health directive.

A number of PHNs have implemented initiatives to strengthen palliative care outside the hospital setting, and to build the workforce capacity for delivery of palliative care. These initiatives include scholarships for palliative care nurse practitioners[6], peer support, and professional development.

Specialist palliative care provider, HammondCare, was commissioned by Sydney North Health Network to provide *'Quality End of Life Care'* education and training for staff working in residential aged care across Northern Sydney. Improvements in care at the end of life were demonstrated for residents receiving the Clinical Advice Service This included increased advance care/forward planning, increased proportion of residents dying in their preferred location, increased care coordination through palliative care case conferences and access to bereavement support for families

Quality palliative and end of life care requires good death literacy amongst consumers and the broader community. Concomitant with this is a responsive system that values consumer choice. End of life experience is often compromised for the person and family when this stage of life involves transition from one part of the system to another. PHNs are well placed to support an integrated system that provides service navigation and supported transition between specialist palliative care, generalist palliative care, primary care and aged care. As per the PHNs' role in the improvement of the mental health systems, they could play an important role in the development of the palliative care system. This could include development of regional cross-agency plans for palliative care.

The role of PHNs extend to providing resources to enable GPs to have conversations with their patients about dying. They can also support General Practices and aged care facilities to deliver better care. PHNs already

[6] See page 21 for more information.

promote the inclusion of an advance care plan including an Advance Health Directive to a person's My Health Record.

PHNs support increasing the provision of palliation in primary care. Providing better and early palliative care can prolong the quality of a person's life through treating the pain, symptoms and distress caused by the underlying illness. This requires access to timely and appropriate primary care for people living within residential aged care facilities.

> *Gold Coast PHN* and Gold Coast Health are developing a framework for *Shared Care and Pathways* that enables the sharing of care between GPs, specialist palliative care services, and all palliative health and social care sectors with clinical support and guidelines to assist GPs in meeting the needs of their patients and improve patient transitions between care settings.

Based on the current experience, PHNs could

- assist aged care providers to implement systems and care planning processes to appropriately identify and manage the palliative care needs and wishes of older people;
- assist RACFs to build relationships with Local Health District palliative care services and GPs to extend palliative care services in RACFs;
- assist aged care providers to access appropriate palliative care training and skill development;
- assist aged care providers to implement policies that promote the generation of clear advance care plans for residents in RACFs, detailing choices regarding end of life care.

Case Studies: Palliative Care

Adelaide PHN Enabling Choice for South Australians (ECSA): Building capacity to support people to plan and make decisions about their end of life care. ECSA is the Adelaide PHN's response to the Commonwealth Government's Greater Choice for At Home Palliative Care measure. ECSA supports capacity building and continuous quality improvement in residential aged care around the planning and delivery of palliative and end-of-life care. Quality Improvement Facilitators work directly with aged care organisations to build organisational, workforce, resource and partnership capacity and improve resident choice around treatment and care at end of life through Advanced Care Directives and anticipatory prescribing practices. Six residential aged care organisations are currently participating in the ECSA project, with quality improvement activities being undertaken at 26 sites across the Adelaide metropolitan region.

Brisbane North PHN Enhancing Workforce Capacity: To strengthen the local palliative care workforce, Brisbane North PHN currently provides scholarship funding to registered nurses working in aged care to complete a Master of Nurse Practitioner specialising in palliative care. This project also provides peer support and professional development for the students, with the aim of improving collaboration between local palliative care health professionals across all sectors.

5. Quality, Safety & Funding

Quality of aged care services

The aged care system is changing at a rapid pace. Given the increasing complexity of care required to support residents in RACFs and older people at home, the role of aged care providers as clinical care providers requires greater attention. The development of systems for monitoring quality of care in RACFs and the home care service sector lags behind the advances made in the acute health care sector, as does the adoption of electronic medical records in RACFs. CESPHN stakeholders report that the systems and processes in RACFs to monitor clinical care standards are inadequate. Stakeholders report that clinical governance structures, systems and processes are inadequate in RACFs.

Aged care service providers consistently report difficulties in attracting and retaining care workers, nurses and allied health professionals. This is particularly true for small to medium sized service providers and rural and remote providers. Workforce availability is a key contributor to quality of aged care services. The lack of registered nurses with aged care training who can make complex clinical decisions could have direct and consequential impact on the quality and competency of aged care services and the transfer of clients to hospital for care. Increased availability of a skilled clinical workforce would allow many health issues to be addressed in-house, with support from the hospital sector.

The increase in older people remaining in their homes and living with dementia, chronic disease, chronic pain and the need for palliation creates a higher demand for nursing, allied health and other services. The number of people waiting for, or receiving a HCP at a level lower than needed, is indicative of a system that is underperforming. At one level it signals the inadequacy of aged care funding for people with higher care needs. An increase in the supply of high level home care packages is required to respond to the combination of increasing demand for aged care services, and the growing number of older persons choosing to stay in their own home for longer and receive care.

Challenges to delivering quality aged care services

Challenges in delivering better quality aged care include:

- lack of meaningful data on the quality of clinical and personal care, which creates a significant barrier to designing an appropriate quality framework for RACFs and home-based aged care services;
- absence of publicly available quality aged care data to assist consumer choice, support compliance with care standards, and provide the basis for ongoing quality improvement in the aged care sector;
- lack of appropriate staffing in RACFs which hampers efforts to implement appropriate clinical governance structures, systems and processes including collection of quality data;
- lack of knowledge pertaining to delivery of a national aged care system that recognises regional differences;
- the disparity between aged care registered nurse's wages and that of the acute sector.
- the utilisation of an unregistered workforce with limited knowledge delivering care in both residential and community services;
- contradictions between various government agencies in key policy settings and in the operationalisation of quality standards between residential and community care.

Challenges in ensuring workplaces are properly staffed include those pertaining to recruitment of staff, availability of staff, and ensuring the optimal skill mix. In relation to skill mix, decreasing numbers of registered nurses employed in the sector is universal. This contributes considerably to the quality of care. Better quality services are facilitated by better resourced facilities, served by a more skilled clinical workforce, including registered nurses, and consistent and ongoing training of staff.

In rural and remote areas, the challenge of a skilled workforce availability is greater, leading to even greater shortage of staff. Patients in rural and remote areas experience greater challenges accessing GPs and relevant health services. Additionally, the distance to acute healthcare services, and costs poses risk, aged persons and RACF residents travel further to access tertiary services such as medical specialists. The costs of travel – in terms of time and money – are also borne by rural and remote service providers who routinely cover greater distances, with poorer access to internet services to deliver services.

Australia's *Aged Care Workforce Strategy, A Matter of Care*, outlines many of the key challenges the sector faces in meeting the growing demand. The strategy highlights in particular: a fragmented system made up of small to medium enterprises, relying on a diverse workforce that is experiencing rising consumer expectations, much outside its direct control; an education and training system that does not adequately provide the skills and knowledge to support safe and quality care and older Australians having increasingly complex care requiring a multidisciplinary team-based approach drawn from across the health and community sector.

What could quality and safe services look like

Improved access to allied health and General Practice, and the ability to link with hospitals for information and support are critical to better care. Consistency in clinical information storage, pathways of care and referral are important. Better use of data would help identify, reduce and eliminate substandard care practices and unwarranted clinical variations in RACFs and home care services. Incentives for the delivery of quality care could be developed using data to drive improvements.

Improved navigation of services would enhance access to care, and this could be achieved through an increased focus on pathways of care, information exchange, improved information about care, and improved systems supporting navigation. Better use of data would involve:

- collection and monitoring of minimum data sets (such as the National Aged Care Quality Indicator Program for RACFs) which provide an objective benchmark for care outcomes;
- RACF Quality and Safety collaboratives;
- publication of quality and safety data, and health outcomes;
- publication of RACF and home care provider costs.

It is important that aged care facility staff have appropriate training and qualifications for the roles they are fulfilling and practice within the scope of their training. The Aged Care Workforce Strategy Taskforce report, *A Matter of Care: Australia's Aged Care Workforce Strategy, June 2018*, is an extensive and important report that should guide the changes to create a sustainable labour market for aged care, and deliver high quality of care to older Australians.

Workforce problems will also be reduced by modifying aged care standards regarding skill mix, and ratios of registered nurses to assistants in nursing. Ongoing training and development would further support the skills, morale and retention of the workforce. Better aged care workforce will

- experience lower levels of staff shortage;
- have the appropriate skill mix of clinical and other staff at the right skill level;
- have the right level of remuneration reflecting the demands of the roles; and
- have access to ongoing continuing professional development and training.

Improvements in aged care funding can result in improvements in quality and effectiveness of aged care services. Improved aged care funding requires a wholistic approach to both aged care funding and health care funding in general. Investing in services in the community can keep people healthy and out of hospital, resulting in large savings for the system. PHNs have a role in the delivery of primary care for older people. A majority of this primary care is managed through General Practice. Thus, improvement can be made to patient experience and outcomes by enhancing GPs engagement with cohorts of older persons. With better funding arrangements, GPs can be supported to increase the rate of over 75 annual health assessments; utilise the aged care practice incentive payments; and better understand data about, and therefore the make-up of their patients.

The role PHNs could play

PHNs can play a role in coordinating or supporting training and development for RACFs and community Aged Care providers in safety, quality and dignity of care. They can also commission services to support RACFs and home-based settings.

PHNs could implement improved care navigation, information exchange, change management, workforce issues and pathways (such as HealthPathways) to improve linkages between primary health care, acute health care and community and residential aged care. PHNs can also support care providers in improving clinical information systems.

A Matter of Care: Australia's Aged Care Workforce Strategy, June 2018, strategic action 9, is "strengthening the interface between aged care and primary/acute care", PHNs can play a critical role in implementing this strategy. As has been acknowledged earlier in this submission, PHNs are uniquely placed to work across the system and foster a collaborative approach in providing safe and quality care.

PHNs could assist in workforce development through the provision of training and education of staff including GPs, nurses, aged care workers and allied health professionals. They could assist and guide RACFs on issues of staffing levels, ratios, and skill mix. PHNs could assist with the establishment of centralised workforce systems to assist RACFs fill staffing gaps at short notice. This would assist in minimising the risk of substituting untrained staff for qualified health professionals and aged care workers.

As set out in the Productivity Commission's *Shifting the Dial Report*[7], better aged care funding could be achieved by forming regional alliances between LHNs, PHNs, aged care providers and others. The healthcare system should be reconfigured, informed by the principle of patient-centred care. The report recommends the establishment of funding pools for LHNs and PHNs to use for preventative care and management of chronic conditions at the regional level. It proposes that PHNs be given access to MBS funds that are aimed at addressing chronic conditions, such as the over 75 health check. It also proposes that LHNs be permitted to use some of their funding for preventative care, rather than hospital activity, without losing funding - under the current activity-based funding, patients treated in a different setting to the hospital by the hospital, or efforts to curb the flow of patients to the hospitals, results in reduced funding.

In addition to the role highlighted by the Productivity Commission, PHNs should be funded to carry out system reform in the aged care sector. PHNs could be given the task of developing a regional Older Persons Plan and be resourced to implement it. A key enabler of this system reform work would be the PHNs' role in patient assessment and care coordination. Similar to work in mental health, a PHN could create an alliance or consortium. As providers and their staff identify gaps and obstacles, the consortium could fund system reform projects to overcome the issues. Thus, the role of PHNs could include assessment, care coordination and system improvement. Furthermore, PHNs could provide more targeted support to primary care staff and RACFS, as well as actively monitor and report on system impacts.

[7] Shifting the Dial, Supporting Paper number 5, Integrated Care, August 2017, https://www.pc.gov.au/inquiries/completed/productivity-review/report