PHN Pilots and Targeted Programs

Activity Work Plan - 2025/26 - 2028/29

phn
DARLING DOWNS AND WEST MORETON
An Australian Government Initiative

Local Integrated Primary Health Care

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1. Greater Choice for At Home Palliative Care

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Aged Care

AIM OF ACTIVITY

This Activity aims to improve the provision of palliative care and end-of-life services for residents in the Darling Downs and West Moreton PHN region with a focus on greater choices in quality, appropriate at-home services.

The Darling Downs and West Moreton PHN will achieve this by improving the integration of care between health providers across the public, private and community sectors, creating greater awareness of the palliative care services provided in our region and increase awareness and uptake of Advanced Health Care Planning. The PHN will also establish mechanisms for quantitative and qualitative data collection and outcome measurements.

DESCRIPTION OF ACTIVITY

Activities will improve coordination and communication between services, across organisational boundaries and between public and private sector providers. We will continue mapping the primary, secondary, and tertiary care services across the region, including levels of service and service areas.

Our regional palliative care initiatives align with the West Moreton End of Life Care Collaborative (EOLCC) and reinstated Darling Downs EOLCC Action Plans, as well as the PHN Palliative Care Needs Assessment and Joint Regional Older Persons Strategy to ensure regional key priorities are identified, built upon and inform palliative and end-of-life care best practice.

The PHN, in conjunction with End-of-Life Collaboratives and informed by the Palliative Care Needs Assessment, will:

- Continue to promote existing Palliative Care Health Pathways for both regions to ensure referral information is accurate and optimal for the range of supports across the region.
- Build on the existing West Moreton Care at End-of-Life Collaborative and to continue to grow the Darling Downs Care at End-of-Life Collaborative Action Plan, with a focus on scoping region-specific gaps in palliative care capacity and capability, to provide better quality care for people in our region at the end of life
- Work to address current and ongoing challenges across the region identified in our Palliative Care Needs assessment. Existing gaps include Palliative care workforce, professional development and training requirements for providers, Advance Care Planning and community education.
- Work to build a skilled and capable workforce, in line with our Joint Regional Older Persons Strategy. Our PHN will advance this priority by continuing to scope available pathway/orientation programs for care at the end of life for new nursing students/staff in the region.
- Build community awareness around talking around death and dying and increase the availability of resources to support this awareness through the provision of:
    - Education and Resources to build capacity and understanding of care at the end of life. Community and Provider education and resources include:
        - Development of culturally appropriate Palliative Care kits, containing specific information and resources on advance care planning, dying on country, and other supports designed for First-Nations families, co-designed with local elders.
        - Palliative Care resource packs with supports for carers, including education, respite and peer networks.

- Hosting Workshops "Death Cafes", yarning circles, and other community death literacy events.
- Hosting and attending events and expos on death, dying, grief, bereavement, Advance Care Planning and loss for providers and community members (E.g. Darling Downs Death Expo).

- Improve access to in-home care at the end of life for people in the region, through broad system mapping and the development of user guides that make in-home care more accessible, timely, and responsive to the needs of patients and families across the region.
- Build sector capacity to care for people approaching the end of life Work with local government and community groups to codesign an approach to compassionate communities that draw on their strengths resources and resilience to deliver holistic care to those experiencing death, dying, caregiving, loss and bereavement.
- Strengthen GP Engagement to provide more consistent Information-sharing and awareness around palliative care, including:
  - Biennial GP forums in the Darling Downs Region
  - Provide targeted GP education on Advance Care Planning
  - Voluntary Assisted Dying awareness
  - Information on using Palliative Care pathways
- Work With Priority Populations within the Darling Downs and West Moreton regions, to ensure palliative care supports are culturally sensitive and appropriate. including:
  - Culturally and linguistically diverse people
  - People living in rural communities and
  - Aboriginal and Torres Strait Islander people, to support dying on country and implementing Advance Care Planning.

NEEDS ASSESSMENT PRIORITY

Joint Regional Needs Assessment 2025-28

PRIORITY
Priority populations
Care across the lifespan
Partnerships and integration

ACTIVITY CONSULTATION AND COLLABORATION

CONSULTATION

The following group/s are expected to be convened and utilised as a resource during the project for consultation:

- GCfAHPC PHN Community of Practice
- Community Working Group/s
- GP / Health Service Provider Advisory Groups

Collaboration

The following key stakeholders were initially consulted and continue to be actively involved throughout this activity.

From the Darling Downs Region:

- CNC Palliative Care, Darling Downs Health

- Palliative Care Physician, Darling Downs Health
- CNC Rural and Remote Palliative Care Telehealth, Gold Coast Health (SPaRTa)
- CNC Palliative Care Coordinator – Southern Downs, Darling Downs Health
- CNC Palliative Care Coordinator – Western Downs, Darling Downs Health
- Director of Nursing, Toowoomba Hospice
- CNC Palliative Care Coordinator – South Burnett, Darling Downs Health
- Director of Nursing Medical Services Toowoomba Hospital, Darling Downs Health
- CNC – SPACE Project, Darling Downs Health
- Nurse Practitioner Palliative Care, St Andrew's Hospital Toowoomba
- Clinical Nurse – Palliative Care, St Andrew's Hospital Toowoomba

From the West Moreton Region:

- CNC SPACE Project (NUM – Palliative Care), West Moreton Health
- Manager Clinical Education, Queensland Ambulance Service
- CEO/Director of Nursing, Ipswich Hospice
- Academic Researcher, USQ
- Advance Care Planning CN, West Moreton Health
- Executive Director Community & Rural, West Moreton Health
- Policy and Projects Officer, Palliative Care Queensland
- Palliative Care Physician, West Moreton Health
- CNC Nurse Educator – SPACE Project, West Moreton Health
- Director and Nurse Practitioner, Ipswich Nurses
- CEO, St Andrew's Hospital Ipswich
- CEO, Ipswich Hospital Foundation

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2. Endometriosis and Pelvic Pain Clinics

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Population Health

AIM OF ACTIVITY

Despite the profound impact on health, work, and wellbeing, endometriosis, pelvic pain, perimenopause and menopause remain under-recognised and undertreated. This activity will continue to support a GP-led, multidisciplinary Endometriosis and Pelvic Pain Clinic (EPPC) in the Darling Downs region to reduce fragmentation in service delivery, prevent avoidable hospital admissions, and enhance overall health outcomes through a patient-centred, multidisciplinary, and sustainable model of care.

DESCRIPTION OF ACTIVITY

This activity will continue to support a GP-led, multidisciplinary Endometriosis and Pelvic Pain Clinic (EPPC) in the Darling Downs suburb of Drayton to improve timely, evidence-based, and coordinated care for people experiencing endometriosis and pelvic pain across the region.

Once fully established the EPPC will:

Provide diagnosis, medical pain management and ongoing monitoring for people experiencing pelvic pain and endometriosis through:

- Management of menopause (lifestyle, non-hormonal and hormonal therapies, and bone health) and endometriosis/pelvic pain (first-line treatments such as hormonal therapy and NSAIDs, with ongoing monitoring)
- Provide a dedicated phone line service to assist in the assessment and triage of patients

Provide dedicated EPPC staff to assist patients using the EPPC, including:

- Pelvic Pain Physiotherapist
- Nurses

Coordinate complex cases through Chronic Disease Management Plans, either locally or in collaboration with the patient's regular GP by:

- Providing continued care and referrals to allied health services as needed to support patient outcomes.
- Providing external referrals for complex cases to other multidisciplinary health care services including pain specialists, physiotherapists, psychologists, dietitians and specialist clinics.
- Purchase specialised equipment, including a medical exam table specifically for gynaecological procedures, for the insertion or removal of Intrauterine devices (IUD), etc.
- This activity also supports the upskilling of health professionals within and outside of the EPPC to provide care to this patient cohort.

The PHN will support the Drayton EPPC by:

- Working with the EPPC, system partners and stakeholders to ensure the clinic is functioning in a way that supports place-based programs and partnerships such as PHN Urgent Care Clinics and other MDT Commissioning.
- Ensuring stakeholder and patient cohort needs are addressed, establish clear principles and guidelines for service delivery, and incorporate flexible, innovative care models, including telehealth, to respond to workforce pressures.
- Supporting the opening of the Drayton EPPC by providing communication support and promotion through PHN communications channels including newsletters and social media.
- Supporting the expansion of the multidisciplinary team by connecting the EPPC with potential allied health professional partners.
- Aligning services with the National Action Plan for Endometriosis and the National Women's Health Strategy.
- Ensuring clarity and visibility of referral pathways with local providers and stakeholders.
- Developing and implementing a comprehensive Stakeholder Engagement Plan to promote EPPC services to GPs, community and health consumer groups following the new site opening.

- Raising awareness and supporting related CPD opportunities for GPs and primary care providers.
- Leveraging learnings from the PHN's existing EPPC's Community of Practice, general practices and stakeholders.
- Facilitating data capture, reporting, and monitoring tools.
- Promoting and ensuring utilisation of My Health Record and secure messaging to ensure secure and continual communication between care providers within the multidisciplinary team.
- Supporting and facilitating regular engagement and education opportunities with the EPPC and other healthcare professionals to support care of menopause, perimenopause, endometriosis and pelvic pain.

The PHN will monitor the commissioned EPPC by:

Providing grant administrative and program support, overseeing assessment and reporting, including:

- Processes are followed to meet reporting obligations.
- Managing a contract with KPIs, flexible service models, and reporting requirements to maximise patient volumes. Reviewing service at regular intervals to enable adjustments to the service model in response to demand.
- Holding regular performance meetings to track milestones.

Conducting ongoing evaluation, ensuring activities align with program objectives, and supporting the EPPC to complete required evaluations.

NEEDS ASSESSMENT PRIORITY

Joint Regional Needs Assessment 2025-28

PRIORITY
Priority health conditions
Partnerships and integration

ACTIVITY CONSULTATION AND COLLABORATION

Collaboration

Our PHN will support stakeholder engagement and collaboration between the EPPC and other key system partners including:

- Engaging with specialists and primary care providers for streamlined referrals.
- Collaborating with Toowoomba Hospital for coordinated care.
- Partnering with organisations such as Endometriosis Australia, Jean Hailes, and local First Nations health services and Aboriginal Medical Centres to ensure culturally safe care.

Once connections have been made, ongoing engagement strategies will include regular multidisciplinary meetings and education for primary care peers, a Patient Advisory Women's Health Focus Group, and community workshops on endometriosis and menopause.

In addition, stakeholder collaboration will include using My Health Record and secure messaging to improve communication between GPs, hospitals, and specialists, and providing support to multidisciplinary team members to attend endometriosis and menopause masterclasses, with knowledge shared across the team and clinical peers.

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