

# TRANSCRIPT

## STANDING COMMITTEE ON LEGAL AND SOCIAL ISSUES

### Inquiry into end-of-life choices

Mornington — 29 October 2015

#### Members

Mr Edward O’Donohue — Chair

Ms Nina Springle — Deputy Chair

Ms Margaret Fitzherbert

Mr Cesar Melhem

Mr Daniel Mulino

Ms Fiona Patten

Mrs Inga Peulich

Ms Jaclyn Symes

#### Participating Members

Mr Gordon Rich-Phillips

#### Staff

Secretary: Ms Lilian Topic

#### Witness

Ms Lisa Rollinson, chairperson, Ageing Well Alliance, The Peninsula Model.

**The CHAIR** — I would now like to welcome Ms Lisa Rollinson, chairperson of the Ageing Well Alliance at the Peninsula Model. Thanks very much, Ms Rollinson, for being with us today. Before I invite you to make some opening remarks I caution you that all evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Legislative Council standing orders. Therefore you are protected against any action for what you say here today, but any comments made outside the hearing are not afforded such privilege. Today's evidence is being recorded. You will be provided with a proof version of the transcript in the next week or so. Transcripts will ultimately be made public and posted on the committee's website. We have allowed approximately half an hour for your session today. Again I would like to thank you for being here and apologise for our running a little bit behind time. I invite you now to make some opening remarks, and we will have questions thereafter.

**Ms ROLLINSON** — I have been invited along to give an overview of the Peninsula Model, and then the Ageing Well Alliance actually sits underneath that. Forgive me if I refer to my notes. The Peninsula Model was formulated as a sustainable collaboration and a platform for ongoing service development, integration and evaluation. It basically came out of the Mornington Peninsula Primary Care Partnership that I am sure you are familiar with, and then when the Medicare Locals were commissioned the Peninsula Model was formed through those two organisations because they saw the opportunity to expand on some of the work that had already been put in place by the primary care partnership. But, more importantly, what they also saw was that there was the potential for overlap and duplication on the peninsula in some of the work that was being done by both the primary care partnership and the brief that the Medicare Local had as well.

It also built on some of the work that was initiated back in 2011, which was where there was a multi-agency planning process, which was really about aligning some of the health and wellbeing plans that go through from the Victorian government through the local government. Then of course there is the strategic plan that is required for the primary care partnership and ensuring that that was then all aligned and then building on that to create the Peninsula Model. I guess why I am giving some of that background is to say that the platform is very robust.

The partners that were involved work across health, education, human services, aged care and justice, so it is really about that health in all policies approach. It is about getting all the players at the table, not just looking at it purely through a health lens. The model itself was launched in April 2013, and it was governed through the Primary Care Population Health Committee, which is with Peninsula Health, and there is also quite a robust governance committee that then looks at the ongoing work.

Overall there were 30 agencies; 40 private primary care providers, including GPs and allied health professionals; and public and private hospitals as well. The objectives were based on and were developed through a population health planning platform and targeting areas of high socio-economic disadvantage. In this region we are top of the pops as far as an ageing population is concerned, but also we have high levels of disadvantage around unemployment, youth, domestic violence — there is a whole raft of them.

The work that is actually carried out with the Peninsula Model is through seven alliances, of which ageing well is only one. We have the vulnerable children and families; ageing well, as I said; Aboriginal health; chronic disease; mental health; and prevention and better health. We also have an eHealth alliance as well, which is looking at secure messaging and linking of the GPs on that platform.

Insofar as what the goals are based on, the goals of the Peninsula Model are built on the same goals as the primary care partnership, which are service coordination, health promotion, early intervention and obviously the client and patient experience. Some of the significant outcomes to date of the Peninsula Model, one of which you just heard some of, include the advance care planning which has been developed, which is one tool across the whole of the peninsula, versus the 30 tools that were in existence prior to that. We developed an interagency dementia strategy, which is around early diagnosis and referral; a homelessness strategy; a mental health peer workforce framework; improved service coordination and referrals between GPs, maternal health, child health and early intervention. Localised care pathways were also developed, and that is a web-based tool that we are actually using, and 87 organisations were signatories to a smoke-free charter. Over 12 to 18 months there has been some significant work done. It got off the ground very quickly and was really about getting runs on the board.

On the Ageing Well Alliance itself, the members include community and residential aged-care providers; the two shires — Mornington Peninsula and Frankston; Peninsula Health, which has three members from different

parts of the organisation; palliative care; GPs and community RACFs, which is through PACE, which is an advisory committee to the Mornington Peninsula Shire. As you heard, there is the single advance care plan and there is a suite of resources that are now available. It is also about providing advance care planning to the hospice services but also to GPs over that period of time. That is what we have done to date.

Obviously there has been a change of government. Because the governance was so robust — there was some future gazing insofar as what would happen if we got a change of government — we put structures and strategies in place to ensure that the model could continue, and it has. We have been very fortunate. We have been able to seek other sources of funding to enable the alliances to continue, and we are now building on the work that was initiated. A lot of it was actually finalised around July this year. That is the model.

**The CHAIR** — Fantastic. Thank you so much for that brief overview on the Peninsula Model. Clearly it is delivering benefits already. Do you think that the model, given that the peninsula is bound by the water — —

**Ms ROLLINSON** — Girt by sea?

**The CHAIR** — Indeed. It is a quite discrete community with Peninsula Health providing services across Frankston and the Mornington Peninsula area. It is a quite discrete area. Do you think that model could be replicated in other parts of Melbourne and Victoria?

**Ms ROLLINSON** — Absolutely. You are quite right. The benefit of it is that it does have a regional focus, but there is no reason why you could not duplicate the model in different regions moving across metropolitan Melbourne and even in rural areas. The benefit of it is that it is about building on the existing partnerships. The way that we were able to launch the advance care plan, which is the focus of why I am here today, was because we had so many partners involved. We were able to tap into them, and through that we were able to trial it; we were able to get feedback, as you heard from Rosemarie, insofar as looking at it through different lenses, looking at it from different communities. It was because of the robust platform that we were able to really get this piece of work off the ground.

I have been hearing about advance care planning for years. I have been in this industry for most of my working life, and I think that this is the first time that I have actually seen something get up, get developed, be supported and get rolled out in a two-year period. I just think it is remarkable. It is not perfect, as you heard, but we now have an e-tool available for people, and then it is about building on that further. But it was because of the model that we were able to do that.

**The CHAIR** — You referenced GPs. We have heard evidence from others that one of the challenges for GPs is that there is no Medicare number, so it is difficult to create the time for a GP to have these discussions with patients. Would you like to comment on the response from GPs who have this tool and perhaps what inhibitors there might be to it?

**Ms ROLLINSON** — We had a wonderful GP, and still do, on our alliance. A lot of them have practice nurses. He has incorporated the advance care planning into I think it is the 70-plus review that they do. They have incorporated that into that discussion with the practice nurse. That is one way of doing it. But what he is also saying is that GPs' approach to advance care planning is very fractured. They have limited knowledge, they have limited time, and we all know about the pressures on GPs, so that is something that needs a lot more work to actually get a structured approach insofar as saying, 'Okay, you are going to have your review'. The 70-plus review is not for everybody obviously. Everybody should have an advance care plan, and that is one starting point that he has found to be effective. I suppose it is about enabling touch points across the broad spectrum of where people come into contact with different health professionals and others, including pharmacists — there is a whole range of them — where you can start having that conversation. Having an online tool is one way of doing it, but there are lots of other ways to get the message out as well.

**Ms SPRINGLE** — On that, can you talk a little bit about how other service providers outside the health industry interact with this alliance? How are they participating with consumers in this work?

**Ms ROLLINSON** — As I said, with the alliance and rolling it out, we have had a range of community forums. We have had the model evaluated, where we have invited people to come in to have a look at the work we have done. We have PACE. We have a member of PACE on the alliance itself and he is able to then feed back to his committee. PACE has a lot of members from Probus, Rotary and those types of very

community-minded and very involved citizens. That is one way of getting the message out. Is it perfect? No. But certainly that is something we have worked on over the two years. Where we could improve is in having greater community participation, and we have acknowledged that insofar as our work moving forward. The fellow from PACE has been fabulous.

**Mr MULINO** — It is a really interesting approach. There are a number of issues that I think relate to some of the challenges you are facing that have been raised — for example, trying to give effect to people's wish to die at home and to have more care in the home and so on. One of the challenges for government is trying to resource that and give more training to staff in the community and equipment in the community. By the same token, by giving effect to people's wishes on that front, it probably frees up resources elsewhere. I imagine that one of the advantages of your approach is that you look at the system in a more holistic way, and that if you can give more resources to one part of the system, it probably frees up resources elsewhere. Is that something that you have already been able to observe, in a sense — that if you can give more resources to the community side of things, it probably does free up resources in the hospital or on the institutional side?

**Ms ROLLINSON** — I could only speak anecdotally. I do not actually have any statistics on that yet. Certainly the gathering of the statistics is something that Peninsula Health is looking at now. The online tool went live a couple of months back now; I cannot remember whether it was July or August. But insofar as the approach is concerned, the approach of the primary care partnership has always been about systemic change and about service coordination and avoiding that duplication. So by enabling people to come in with their wishes clear insofar as 'This is what I want. I want to be at home. I want to have the services at home', it then certainly would prevent that reaction by services that want to do the right thing, which is where they always come from, and then instantly start running people through more expensive sides of the system as opposed to saying, 'Yes, we are clear on what you want. It's written here. When you filled out this directive, you were clearly competent because that is the requirement of the directive, so we are able to work with you in a very comfortable partnership approach'.

**Mr MULINO** — That is useful. Thank you.

**Mr MELHEM** — Just going back to the GP issue, that has come up more and more both through this committee and from just talking to people. Is it about time that we look at that aspect with doctors — let's talk about the economy — where a doctor is able to charge? For example, if the whole plan takes an hour and you could see four or five patients in an hour depending on the doctor and the issues, should we then advocate to Medicare that for people to get a directive or a plan you are able to charge X? Similarly, would that apply to doctors visiting people at home who are actually at that stage of their lives? They have a plan in place; that is what they want to do; the difficulty is in finding doctors to come to visit on that basis. What level of importance do you reckon that should have and what recommendation should we be making to government?

**Ms ROLLINSON** — I do not think it should be an either/or approach, because the thing with the doctors is that they are the primary health touchpoint. Everybody in this room has a doctor; not everybody in this room is going to come into contact with community aged care, residential care or whatever it happens to be. I think certainly that would be important, but I think it is also about providing resources within the community to be able to roll some of the work out and roll the education out. I agree — I think GPs are important — but I do not think that is the only answer.

It is about having a variety of touchpoints. Pharmacists are a classic example. Everybody goes to the pharmacist, so where do they fit in? Also libraries. It really is about those community touchpoints where people will be and where you can get the information out and get people educated around the importance of having something like this in place. The same goes for wills, for powers of attorney and for medical powers. All of this goes together, but I agree with you that it would be an advantage insofar as for a lot of older people obviously that is their first touchpoint with any of the systems, as such.

**The CHAIR** — Is there anything further you would like to say before we conclude?

**Ms ROLLINSON** — There was one thing that certainly came out of some of the work that we have done. With the advance care directive, it has been rolled out through the shires, as you heard. They have incorporated it into their assessment process, and with the huge amount of reform that is going on in aged care at the moment what we have discovered is that advance care planning has not been incorporated into the initial needs assessment — that is, into the national tool.

We have attempted to make contact with some of our commonwealth counterparts — but that was during the change when the portfolio was being moved from one minister to another one — insofar as saying, ‘Why has this been missed?’. This is clearly very important, and it is certainly something that needs to be incorporated, because everybody will be going through the My Aged Care portal, as I am sure you are aware. Everybody will be getting assessed for very low level services, so this is one of those touchpoints that does not necessarily involve a doctor, so it would be critically important to actually have some sort of a trigger in there, insofar as saying, ‘Have you thought of ...’, ‘Did you know about ...’, ‘I hear you’re asking about power of attorney; have you also thought about this?’, and actually having that in that initial needs assessment. I think that has been a gross oversight in not having that in there, given the population that we are talking about.

**The CHAIR** — Thank you for that feedback, and thank you very much for your evidence today. It is a really innovative, interesting model, and we do thank you.

**Ms ROLLINSON** — Thank you very much.

**Witness withdrew.**