CARING Together
# Contents

A message from the executive .................................................. 05

About our partnership ............................................................ 07

Bridging the gap between primary and acute care ..................... 08

A good start to life ................................................................. 11

Healthy families and communities .......................................... 14

Acute illness and injury ......................................................... 17

Recovering well .................................................................... 21

Living well with chronic conditions ........................................ 23

Healthy ageing and a good end of life ...................................... 25

Consumer engagement .......................................................... 28
Community Facilities
Health facilities based in Caloundra, Gympie, Maroochydore, Nambour and Noosa

GYMPIE

NOOSA

NAMBOUR

MAROOCHYDORE

MALEY

BIRTINYA

CALOUNDRA
Gympie Hospital
Emergency Department, Surgical and Medical Services, Maternity, Palliative Care, Rehabilitation, Renal Dialysis, Specialist Stroke Unit, and a range of community-based adult and child services.

Nambour General Hospital
Emergency Department, Surgical and Medical Services, Chemotherapy, Renal Dialysis, Mental Health Services, Rehabilitation, Subacute Services, Specialist Ambulatory Care Services, and Community Health Services.

Glenbrook Residential Aged Care Facility
45 bed purpose built facility, providing aged care in a home-like environment.

Sunshine Coast University Hospital
Emergency Department, Cancer Care including radiation therapy and chemotherapy, Specialised Medical and Surgical Services, Trauma Service, Paediatric Service, Maternity Services, Special Care Nursery, Rehabilitation, Renal Dialysis, Mental Health, Interventional and Diagnostic Clinical Support Services, Specialist Ambulatory Care Services, and Allied Health Services.

Sunshine Coast Health Institute
Purpose built facility for clinical research, training and teaching, in partnership with University of the Sunshine Coast, TAFE Queensland East Coast, and Griffith University.

Caloundra Health Service
Palliative Care, Community Services including Oral Health and Child Health, Renal Dialysis, Ophthalmology, and Minor Injury and Illness Clinic.

Maleny Soldiers Memorial Hospital
Emergency Department, Medical Services, Palliative Care, Ambulatory Clinics, Essential Diagnostic and Clinical Support Services, Community Based Services.

Services are also provided for Sunshine Coast Hospital and Health Service patients at Noosa Private Hospital and Sunshine Coast University Private Hospital, in Birtinya.
Message from the Board Chair and Chief Executive
Central Queensland, Wide Bay, Sunshine Coast PHN

A message from Dr Peter Dobson, Board Chair Central Queensland, Wide Bay, Sunshine Coast PHN and Pattie Hudson, Chief Executive Officer PHN.

Central Queensland, Wide Bay, Sunshine Coast PHN (the PHN) and Sunshine Coast Hospital and Health Service (SCHHS) have long enjoyed a strong and collaborative partnership.

This goes back to at least 2014 before Sunshine Coast Health Network Ltd won the bid to operate the PHN for the Central Queensland, Wide Bay and Sunshine Coast region.

Over the years, we’ve been able to build on that shared history to deliver, improve and enhance healthcare services throughout one of Queensland’s fastest growing areas, which stretches north to Gympie and the Cooloola Coast, and as far south as Caloundra and the Glasshouse Mountains.

Today, we step out of the busyness of creating enhanced primary health care services for our community, to stop and reflect on our many achievements. This report is testament to the strong working partnership we have with SCHHS, and what’s possible when like-minded organisations come together with a shared goal.

The future of our collaboration lies in the Integrated Care Strategy 2018-2021 and I can’t help but be incredibly proud of the community-focussed, patient-centred care it reflects, connecting people with programs to optimise the health and wellbeing of individuals and their families across the age continuum.

We thank the wonderful teams at SCHHS and the PHN who continue to work together tirelessly towards creating better health outcomes for all in our community. This report offers a powerful insight into the many inroads the PHN and SCHHS have made to drive health reform across the Sunshine Coast, in partnership with our stakeholders and the community.

Year-on-year we continue to build on these partnerships, and the initiatives outlined in this document show we are keeping pace not only with community expectations, but advances in technology and academic thinking. Another of the reflections I make as I look through this report, is that many of these shared programs represent real progress in areas of priority for the region.

Chronic disease as a health burden, continues to grow, and the Sunshine Coast’s ageing population means aged and palliative care services will soon become even more of a priority than ever before. Working together, we are better able to use health data to identify patient issues and find effective solutions for them.

Our stepped care approach to mental health services ensures patients can more easily access the services they need, when they need them, for example acute inpatient services or online support tools. Providing early intervention for maternal and child health issues is a crucial step in supporting the wellbeing of the Sunshine Coast’s next generation.

There is, as always, much to do in the primary health care sector, and it is imperative we continue working hand in glove with the Hospital and Health Service to improve the patient experience wherever possible, both in and out of the clinical environment.

On behalf of the board, we congratulate the dedicated and passionate SCHHS and PHN staff who have contributed to the many achievements outlined in this report—no doubt there’ll be many more to come.
With one of Queensland’s fastest growing populations, Sunshine Coast Hospital and Health Service (SCHHS) is committed to delivering quality healthcare and continuous improvement in all that we do. On behalf of the Sunshine Coast Hospital and Health Board and the dedicated staff of the health service, we are proud to present the 2018-2019 Caring Together (a year in review for Sunshine Coast Hospital and Health Service and the PHN).

For SCHHS, the year was one of record service levels with more than 175,000 patients presenting to our emergency departments and 546,782 outpatient occasions of service. Our hard-working team delivered unprecedented levels of care, building both on the strengths of existing services, as well as the introduction of new and expanded services to bring care closer to home. With demand for our services growing each year, it is collaborations with our partners such as the PHN which help ensure the delivery of healthcare is sustainable in our region.

This report offers you a snapshot showcasing the collaboration between both organisations striving together to provide innovative, high quality health care to our communities. Our collaborations extend throughout the continuum of care from birth through to the end of life.

Strengthened by our Integrated Care Alliance, our partnership has made great progress in connecting and integrating healthcare in our region. In 2018-2019, our focus remained firmly on ensuring all residents have access to the healthcare they need, closer to home.

We know our vision for SCHHS can only be achieved through collaborative partnerships. We will continue to partner with industry, communities, governments and non-government bodies to develop collaborative models of care that create living and work environments that support improved health.
About our partnership

Since the inception of both Central Queensland, Wide Bay, Sunshine Coast PHN and Sunshine Coast Hospital and Health Service, we’ve had a shared understanding of the power of collaboration, and have actively worked together to improve the health and well-being of the communities in which we live, work and play. At the heart of our partnership is an integrated approach to care, based on six key platforms where our individual activities align: a good start to life, healthy families and communities, acute illness and injury, recovering well, living well with chronic conditions and disabilities, and healthy ageing and a good end to life. In this document, you'll find powerful examples of this strategy in action, as well as many instances of our joint key collaborative groups, and the relationships we’ve built together with our stakeholders to address the social determinants of health now, and into the future.

About the PHN

Central Queensland, Wide Bay, Sunshine Coast PHN (the PHN) is an independent, not-for-profit commissioning body funded by the Department of Health to improve health outcomes for the region. Our region encompasses more than 161,000 km² from country to coast, and our staff work across several local government areas—including the same population as the Sunshine Coast Hospital and Health Service.

Within this footprint, we commission organisations to deliver primary and preventative healthcare services and work closely with general practice, allied health care providers, community stakeholders and hospitals to ensure patients receive the right care in the right place, at the right time.

Everything we do is for better health.

www.ourphn.org.au

About the health service

Sunshine Coast Hospital and Health Service (SCHHS) is the major provider of public health services, health education and research in the Sunshine Coast, Gympie and Noosa local government areas. The health service covers approximately 10,000 km², stretching from Gympie in the north, south to Caloundra and out to Kilkivan in the west.

Established in 2012, SCHHS is an independent statutory body governed by the Sunshine Coast Hospital and Health Board. Over this relatively short history the health service has undergone significant change particularly in more recent years with the successful design, build and move into our first ever University Hospital on the Sunshine Coast. While further development is underway with our other facilities we have also had one of the largest digital implementation programs over the past year that has set the future platform patient and community benefits. It is this significant change that has shaped the Sunshine Coast Way of doing things. We are an organisation committed to looking at ways to do things better, and one that prides itself on its commitment to continuous improvement. We also acknowledge that our success to date was not achieved in isolation, and as such, conduct our business in a highly collaborative way both locally and across Queensland with an extensive range of stakeholders.

Our vision is to provide health and wellbeing through exceptional care.

Bridging the gap between primary and acute care
The PHN and the health service have a strong history of working together to strengthen the partnership between primary, community and specialist care to improve health outcomes in the region.

The General Practice Liaison Officer (GPLO) role acts as a vital conduit of information and integration within both organisations. GPLOs are experienced medical officers who work to improve the quality of patient care by bridging the gap between primary and specialist health settings. In order to work together as a cohesive unit, a GPLO committee was formed in October 2014. The committee was comprised of the key stakeholders from the health service working in GPLO and ehealth roles, and the key PHN GPLO, ehealth, and health outcomes team roles.

This committee collaborated fortnightly with the following aims:
1. Improving the patient journey through developing integrated and coordinated services
2. Provide support to clinicians and service providers to improve patient care
3. Identification of the health needs of local areas and development of locally focused and responsive services
4. Facilitation of the implementation and successful performance of primary health care initiatives and programs
5. Be efficient and accountable with strong governance and effective management.

The GPLOs also act as agents of change—working collaboratively on current initiatives such as Smart Referrals, the clinical prioritisation criteria, HealthPathways and GP education. These initiatives enable the seamless delivery of patient care in a hospital and health service and general practice setting.
Dr Jon Harper is the PHN’s Sunshine Coast-based GPLO. The Buderim GP first qualified from medical school 20 years ago in the UK, and credits his love of figuring out how things work for his interest in medicine.

“The human body is the ultimate puzzle, with so many complexities to understand. I chose general practice because it requires a holistic approach to every problem. A good GP has to take into account not only the medical complaint, but also the social context,” he said.

Dr Harper says the GPLO position appealed to him for much the same reason.

“When I came to Australia, I was intrigued by the complexities of the health system; with its multiple funding streams from state and commonwealth agendas.

“Medical practitioners, particularly GPs, seemed isolated and poorly supported. I was keen to understand the system, creating new networks, to enable a culture of clinical leadership in the Sunshine Coast medical community,” he said.

Dr Harper sees the GPLO role as one of the few interfaces between clinicians and senior level health system management.

“GPLOs understand the difficulties facing GPs, and readily identify opportunities to improve the system. A network of GPLOs has proven to be an invaluable resource to health policy makers.

He says it’s also changed the way he now practices medicine:

“My role gives me visibility over all the great programs and resources available in the region. It also allows me to take systems issues that I encounter as GP, and bring it into my GPLO role to find a solution.

“Working with the team at the SCHHS, we’ve been able to improve access to services and better integrate new and existing health systems, including HealthPathways and Smart Referrals.

“In general practice, we’ve been able to reduce avoidable hospital visits and admissions, and emergency department presentations.”

The Dutch native is a general practitioner who works in the hinterland at practices in Montville and Maleny, having relocated to Australia shortly after finishing his GP training in Amsterdam.

“My father was a doctor and he used to take me on hospital rounds when I was eight or ten or so,” Dr Kruys says.

“After my mother passed away from breast cancer when I was 12, I decided that I wanted to support patients and their loved-ones through difficult episodes in their lives.”

It’s the idea of facilitating that support that made the GPLO role appeal to him.

“One of the big challenges of healthcare at present is the lack of connectedness,” he says.

“Silos remain as a result of cultural differences, distances, ignorance, funding issues and failing digital interconnectivity and interoperability.

“At the General Practice Liaison Unit of the SCHHS, I am in a position to ‘connect the dots,’ linking people and systems to improve care and the patient journey.

“It’s not only rewarding for a health professional, but often cost-saving too—it’s all about the big picture!”

Dr Kruys says the GPLO role has undoubtedly changed the way he practices medicine.

“It has made me realise again that every referral I make as a GP takes up significant resources at the hospital end and lengthens wait lists—as a referring GP I have a real influence on waiting times.”

“This comes with responsibility and I take more time these days to have a conversation with my patients about referral requests and alternative pathways where appropriate.

“The opposite is also true, for example, we know there is a measureable relationship between the hospital re-admission rate and the timeliness of sending hospital discharge summaries to general practitioners who continue the care in the community.

“Patients are more likely to be re-admitted when a hospital discharge summary is delayed beyond seven days.”
A good start to life
Providing timely access to services for kids 0-12 years with developmental and behavioural issues

In 2018, referral pathways within the SCHHS for patients under 12 with developmental, learning and behavioural issues were often fragmented, time consuming, and misunderstood, resulting in inappropriate referrals and waiting times of, on average, three weeks.

With funding from Queensland Health, the SCHHS and the PHN sought to address these issues with the Child Health Integrated Care Project, or CHIC, by developing a faster and more streamlined referral process to connect young patients to the appropriate healthcare services in the SCHHS.

CHIC addressed service demand by consulting with stakeholders to redesign the referral process and update the triage pathways within the SCHHS catchment accordingly.

General practitioners with postgraduate qualifications in child health and their practice nurses were recruited via the PHN’s GP networks to help provide the early assessments needed to inform the process.

As a result, CHIC successfully established a central intake service for children with developmental, learning and behavioural issues within the SCHHS and this new referral triage pathway significantly decreased the mean time from referral to appointment.

Over an 18-month period, the waiting time between referral and appointment was slashed by an average of nearly 19 days—making the average length of time between referral and appointment now just three days.

There have been other positive provider and system outcomes too: an increased number of referrals can now be processed, a wider range of services referred to and GPs have increased knowledge and support to provide early intervention for children with developmental needs.

Good start to life Gympie workshop

In the first half of 2019, the Gympie Local Level Alliance (LLA), Gympie Regional Council (GRC), and a number of representatives from SCHHS programs participated in a Good Start To Life Workshop organised by PHN.

A true example of patient-centred, community driven health programming, the objective of Good Start to Life is to reduce health inequalities by actively targeting areas of disadvantage for improvement, like the health of Aboriginal and Torres Strait Islander people, for example.

The foundations of the program were already established, thanks to the work of the LLA and the immunisation improvement activities to date. The workshop sought to connect services which might address the Good Start to Life priority area of the joint Integrated Care Strategy.

Stakeholders were asked to consider the biggest needs for 0-5 year olds in Gympie, and what services are available to meet those needs. They then reflected on how those gaps could be bridged, and what opportunities existed for improvement.

As a result of the workshop, stakeholders are now sharing existing data sets and connecting with Children’s Health Queensland to update data for the LLA’s State of Children in the Gympie Region Report.

The group has used this information to inform their community-facing events like the annual Little Kids Day Out, a Gympie family fun day led by GRC and supported by the SCHHS. The most recent event incorporated health checks into the day’s activities, as well as existing wellness programs for Aboriginal and Torres Strait Islander women.
The 2018 Australian Early Development Census results show that 27.9 per cent of children in the Gympie/Coooloola community were vulnerable on one or more domain, compared to 12.3 per cent for Queensland and 9.6 per cent for Australia.

Healthy Play is a community driven initiative of the Gympie Local Level Alliance (LLA) aiming to support child development and school readiness for vulnerable families in the Gympie area, through mobile play and education sessions facilitated by a social worker and volunteer parent mentors.

The social worker will undertake an intake snapshot (based on an initial conversation as well as observations) of each family, looking for areas of possible developmental delay and social vulnerability. Any families identified as vulnerable will be supported by the social worker to identify and access health and social services.

Healthy Play will be funded by the PHN and will start later in 2019, using a soft-entry approach to connect with families who would not traditionally access health services at frequently visited locations like shopping centres, early learning centres and family fun day events.

The 12-month initiative aligns with the joint Integrated Care Strategy priority area to ensure a Good Start to Life.
Healthy families and communities
Kilkivan community consultation

Early in 2018, residents of the Kilkivan and Goomeri community petitioned state parliament requesting community health nurse services for their region. The petition followed a letter-writing campaign to the Minister for Health by community members, highlighting a lack of supplies and nursing support for the visiting general practitioner.

As a response to community’s concern that health care needs were not being met, SCHHS commenced a 12-week trial to provide Nurse Navigator Service alongside the existing GP, who was visiting Kilkivan two consecutive days per fortnight.

The PHN joined the SCHHS to coordinate a community health forum in Kilkivan on 21 June 2018, to raise awareness of the government and non-government services available to the Kilkivan and Goomeri communities, and to meet with the residents and gather information to better understand their health care needs.

More than 60 local residents attended the forum and along with stallholders and staff, a total of 95 people came together on the day.

As a result of the community consultation, several solutions to the lack of services were explored, including a longer-term plan advocating for a satellite private practice, and a more immediate solution to co-fund a part-time nurse practitioner role.

Additional nursing services for Kilkivan

In response to community feedback after the forum, SCHHS and the PHN submitted a proposal to CheckUP Australia to fund a nurse practitioner in the Kilkivan area.

As a result of a collaboration between the SCHHS, the PHN and CheckUP, Jenny Doherty commenced as the visiting nurse practitioner in January 2019, delivering primary health care two days per fortnight to the rural communities of Kilkivan, and Goomeri. Based at the Kilkivan Community Health Centre, Ms Doherty has more than 40 years’ experience in rural communities across Queensland.

“Back in 2005 I completed my training as a nurse practitioner just down the road in Murgon, so the opportunity to practice in Kilkivan is almost like coming full circle. Since then I’ve practiced in communities like Mt Isa, Dajara, Cammoweal and Dayboro. It’s really satisfying to be able to meet the needs of people living in those more rural areas and deliver the best possible care for my patients,” Ms Doherty said.

As a nurse practitioner, Ms Doherty can deliver a wide range of services from diagnosing illnesses, ordering and interpreting tests, to prescribing medication and formulating treatment plans.

CheckUP CEO Ann Maree Liddy said the funding of a new nurse practitioner position was a great result for the people of Kilkivan and Goomeri.

“More people will be able to access bulk billing health services through CheckUP’s visiting GP service at the Kilkivan Health Clinic. It’s been great to have the opportunity to respond to the needs of the community and ensure the community can access quality health services without having to drive 50km to Gympie,” Ms Liddy said.

PHN CEO Pattie Hudson said many rural and regional communities faced significant challenges accessing primary health services.

“Community feedback is essential when we look to improve health services in communities like Kilkivan and Goomeri. By hearing the community’s experiences, we can identify the gaps and solve those issues,” Mrs Hudson said.
After the success of the community consultation in Kilkivan in 2018, the PHN and SCHHS joined forces in 2019 to present the Cooloola Coast Community Health Forum at the Tin Can Bay Country Club.

Facilitated by the PHN’s Senior Manager Robb Major, more than 200 residents came along to the forum, to hear from, and learn more about, the health care providers in their region.

Stakeholders from the physical and mental health care fields were represented, including the alcohol and other drug sector, suicide prevention groups, and telehealth.

The two-hour meeting was a valuable opportunity to engage with the community not only to raise awareness of the services and expertise currently available to them, but to listen to their concerns via a facilitated feedback session.

The key concerns for locals were around access and availability—transport is required to access the majority of services and can be prohibitively expensive, specialist treatment demands travel to SCUH or Brisbane—and the need for healthy competition on the Cooloola Coast for general practice.

Nine out of 10 participants agreed or strongly agreed they had been given enough opportunity to share their feelings and opinions at the forum and most simply appreciated that they were being heard.

Following the success of the forum, the PHN and SCHHS will continue build on the learnings via the establishment of a working group, which it’s hoped will include local residents.
Acute illness and injury
SpotOn hospital avoidance

The PHN and the health service work together on a number of initiatives to redirect lower acuity patients away from the emergency department (ED), and instead toward the general practice setting for treatment. This includes the SpotOn project, the implementation of a Link Nurse, and the Right Place Right Time campaign.

In 2011-2012, there were 2707 potentially avoidable hospital presentations to emergency departments per 100,000 people, age-standardised by Medicare Local catchments. Based on this, in 2016, the PHN, in collaboration with Queensland Ambulance Service (QAS), and SCHHS piloted the Supporting Patient Outcomes through Organised Networks (SpotOn) Project.

The aim is to reduce avoidable presentations to the ED by targeting those patients who call the QAS for treatment and/or transportation. SpotOn provides paramedics with the clinical pathways to identify patients who are suitable to have their healthcare needs met in primary care, and where possible, to transport these patients to their GP for treatment.

Results from the six month pilot were encouraging, but the project isn’t just about empowering paramedics to support patients to access their general practice, it’s also about educating the general public on where best to seek treatment.

The SCHHS and PHN communications teams are producing a consumer-facing information video detailing when to see your GP, when to consider using the Minor Injury and Illness Clinic (MIIC) or other hospital alternative services, and when to seek clinical care at the ED.

Currently operating in Gympie at the Excelsior Practice and Caloundra at the MIIC, SpotOn has the potential to be expanded to other sites in the future.

To further support SpotOn in a clinical setting, administrative support in the form of a part-time position has also recently been approved, and engagement with contracts and procurement has commenced for 2020.
The Link Nurse program is another outcome of the PHN and SCHHS’s commitment to reducing emergency department presentations, with an 0.8 FTE role funded by the PHN within the SCHHS.

Focusing on frequent presenters—those presenting at the ED more than three times in three months—the aim of Link Nurse is to reduce those rates on post-acute programs, and to increase My Health Record registrations with the frequent presenter cohort.

In its initial stages, it has been imperative to establish baseline datasets on the frequent presenter cohort, with a view to developing a more sustainable and integrated solution.

Data visualisation techniques are being implemented to track the ED frequent presenter cohorts over time, to assist with the implementation of the Link Nurse program.

Right place, right time

In early 2017, the PHN launched the Right Place, Right Time campaign to outline the alternatives for people in need of non-urgent health advice and treatment.

Since the awareness-raising campaign started, elements have included a dedicated website, billboards on major roads, cinema advertising, targeted social media ads, posters in general practice clinics and emergency departments, and advertising in local shopping centres.

At its inception, PHN CEO Pattie Hudson said: “This campaign is about informing the both residents and visitors to the Sunshine Coast of the reliable health resources that are available when it comes to seeking medical treatment, and to find the most appropriate level of care for their needs.

“Going online to find medical services close to home can save you waiting in an emergency department, and keeps our emergency services for emergencies.”

In 2018, the PHN and SCHHS worked together to install a digital tablet in the emergency department, in order to help patients locate an open general practice, and gain the most suitable care in the moment, and into the future.
Recovering well
One of the innovative ways the HHS and PHN are working together to address multiple challenges with one program, lies in the creation of a dedicated full-time role for a medical officer with right to private practice (MORPP). The MORPP role was introduced in 2018, with the primary aim of reducing emergency department presentations and admissions of chronic disease patients by using GP registrars working in both Gympie Hospital ED and a local general practice. The role, in an area known for skilled workforce shortages, has proven to be an ideal way to introduce new GPs to the community, and link patients to general practice for ongoing care. Since it was introduced, there has been a reduction in Category 4 and 5 presentations to the Gympie ED.

Dr Shaun Hosein was the first registrar to take on the MORPP role based between Gympie Hospital and Excelsior Medical Centre. Among his achievements in the role, Dr Hosein was awarded the annual Dr Frank Le Bacq award for Patient Safety at Gympie Hospital for his analysis on patient transition from Gympie hospital back to the community. His work reviewed current research into how to prevent hospital re-admissions and put patients first. Dr Hosein analysed current Gympie data and illustrated that there was a problem with failed discharges. He found that: older people were at higher risk, there were many re-admissions within seven days and that most of these were for a similar reason.

**Medical officer with right to private practice**

**Why did the MORPP program appeal to you?**
It was a natural lead-in from my interests and previous academic work in quality improvement and transitions of care. Transition of people from hospital is about effective communication and processes. It is an area that is of increasing importance, since there is increasing evidence that poor transition to general practice results in suboptimal preventable health outcomes such as re-admission to hospital. I also enjoyed the dual role of working in the hospital but also the community. It really gave a variety to the week.

**How was it first received in either setting—did other staff ‘get it’?**
I think it is a space of development and flux. During my year I felt people got to know me and what I was able to offer and assist with, however this can be individually-based, and we need to develop this role further.

**What were some of the challenges?**
There are numerous organisations involved with the role, and clear structure and outcomes are necessary. This isn’t simply a half-time GP and half-time hospital medical officer role. Appreciation of the broader outcomes is necessary. I think it would be good to run a small research program to show complex patients that were successfully transferred to general practice, and further outcomes regarding hospital avoidance through community care.

**When and why did you start working in medicine?**
I really enjoy communicating with people and families, especially about complex matters. Like most doctors, I also like problem solving, which when coupled with communication made it a natural fit. I’ve found in my medical career that just simple communication can lead to excellent outcomes.

**What advice would you have for others looking to work as a MORPP?**
Enter the position with an open mind and look to improving the patient’s health journey through effective communication and transition to community care. Try to get integrated with the Gympie community, and help to build bridges between community and the hospital.

**Where are you working now?**
I’m now on Palm Island working as a senior medical officer for Queensland Health. I really wanted to work in a remote Aboriginal community, and this was a great fit. Believe it or not, I have looked at how our Palm Islanders are discharged back to the island from the mainland. Surprisingly it is the same processes and issues we face on the Sunshine Coast. I am planning on returning home to the coast next year, and look forward to continuing my work on transitions of care, especially our Aboriginal peoples, and the elderly.

**How has your experience as the MORPP changed the way you practice medicine?**
It certainly did, I got a better appreciation for the challenges faced on both sides of the fence (Queensland Health and the GP community). I also got to work with a fantastic healthcare team, and wonderful community. It was an excellent rural experience.
Living well with chronic conditions
When 74-year-old Charles Said was diagnosed with type 2 diabetes over 20 years ago his blood sugar levels were almost six times the normal average. “My blood sugar levels were all over the place and I couldn’t control them. I was tired all the time and constantly needed to rest,” he said.

Charles’s average morning blood sugar reading was dangerously high at 17. Now his readings are at a normal average of 6. “Thanks to the additional support (from the Diabetes Educator) my blood sugar levels are stable, I’ve lost weight and have so much more energy.”

As a result, three action groups were formed to address some of the six priority growth areas in the months and years ahead:
1. Raise awareness and increase communication with diabetes consumers and local health professionals about the range of local diabetes services and prevention initiatives by developing a local diabetes directory
2. Improve gestational diabetes health literacy by developing a survey for local mums with gestational diabetes to identify health communication preferences
3. Improve patient flow and access to services and support for people with diabetes, including the development of cultural support links for Aboriginal and Torres Strait Islander people living with diabetes; by mapping the diabetes referral pathways; and informing electronic HealthPathways system used by GPs.

Looking ahead, the DiPP will develop promotional resources to showcase local diabetes services, programs and events, engage more consumers and primary health care practitioners and identify consumer needs and advocate for change accordingly.

Diabetes prevention partnership

Since 2017, the Diabetes Prevention Partnership (DiPP) has quickly become an important local force to bring service providers together to spread the word about diabetes initiatives.

Diabetes has one of the highest rates of potentially preventable hospitalisations across the region, and the DiPP was formed to tackle six priority areas: awareness and communication; clinical working group; diabetes health literacy; cultural support for Aboriginal and Torres Strait Islander people; creating a digital platform for information sharing and discussion; and the establishment of local diabetes support groups.

Membership of the DiPP is growing, with representation from Diabetes Queensland, SCHHS, the PHN, North Coast Aboriginal Corporation for Community Health, a consumer and a number of non-quorum members. Its meetings provide an attendees abundance of information sharing, collaboration and opportunities to ‘join the dots’, with presentations from Diabetes Queensland about the My Health 4 Life program, SCHHS with a gestational diabetes snapshot, the PHN on general practice accreditation measures and feedback from consumers on diabetes shared medical appointments.

In Gympie and surrounding areas, people can now manage their diabetes better thanks to an innovative support service funded by the PHN and implemented by SCHHS.

Recent data from Queensland Health shows there are almost 16,500 people diagnosed with diabetes across the Sunshine Coast region and many more at risk of diabetes in the region. Since 2018, a dedicated credentialed diabetes educator has been embedded within the Gympie hospital, delivering more than 1600 sessions of an innovative at-home program.

Diabetes Educator Liam Flynn is the first to hold the role, and says the program demonstrates how simple it can be to manage diabetes effectively and live without complications.

“People have responded well to the free service, they can set achievable goals and work to identify barriers to improving their health. A typical visit starts with getting to know the individual and their family, and having a look at their current medications,” Mr Flynn said.

“I then give them an outline of how they can make small changes like checking their blood sugar at regular intervals and tips to improve their diet. In the end they get a detailed assessment that identifies issues and educates them on the multidisciplinary team that is involved in all aspects of their care.

“We discuss the current management of their diabetes and outline a plan for the future. Seeing people in their home allows me to see the challenges they face from day to day and look at other services that could be required.”

Mr Flynn said people really benefitted from personalised care and accessing a clinical experience in a familiar environment and a way that was convenient for them.

“By working with people in their homes or at school I’ve found that they really come away with a better understanding of diabetes and the risks involved.

“There’s a level of convenience that comes with the education that also helps them to be responsible for improving their health and managing their diabetes,” Mr Flynn said.

Credentialed diabetes educator
Healthy ageing and a good end of life
Geriatric Emergency Department Intervention

A great example of how both the SCHHS and PHN were able to contribute support and expertise to a project driven by another major stakeholder of health on the Sunshine Coast—the University of the Sunshine Coast—can be found in the development and implementation of the geriatric emergency department intervention (GEDI).

Born out of the Care coordination through Emergency Department, Residential aged care and primary health Collaboration (CEDRIC) project, GEDI provides a dedicated single point of contact within the emergency department (ED) for residential aged care facility and primary health professionals.

Dr Elizabeth Marsden, consultant physician at the SCHHS Emergency Department, conceived the idea for GEDI in order to reduce the time older people wait for care in EDs, as well as reducing inappropriate transfer of aged care residents to EDs.

The GEDI team focus on all presentations from aged care facilities as well as older people from the community who are identified as frail via screening on presentation to the ED. It is aimed at cost effectively maximising the quality of care for older people who present to the ED and is facilitated by a nurse-led, physician championed team providing frontload assessment, communication, care coordination and appropriate discharge planning.

Further to local facilities, the GEDI model is now being implemented across the state, and is delivering incredible results for clinicians, patients and our local health systems.

There have also been a number of research outputs from this project, with grants for research on the project now totalling $1.5 million via the Department of Social Services.

Dr Marsden was actively involved in the research project and is completing her PhD on the GEDI model of care for residents of aged care.

The PHN’s program management office manager, Amanda Glenwright, also completed a Masters in Health Management on GEDI entitled “A cost analysis of a Geriatric Emergency Department Intervention (GEDI): a secondary analysis of data from a non-randomised clinical trial with matched historical controls”.

GEDI recently underwent a structure and process research evaluation including health economics with results due for publication soon.

GEDI is currently available in the EDs of the Nambour General and Sunshine Coast University hospitals, part of SCHHS. GEDI has clinical nurses managed by a clinical nurse consultant employed in the ED providing coverage from 7am to 5:30pm on overlapping shifts weekdays and 7am until 3:30pm weekends.
Safe, high-quality and person-centred End of Life Care (EOLC) requires the availability of appropriately qualified, skilled and experienced multidisciplinary teams, effective communication, collaboration and teamwork. Patients must be empowered to direct their own care where possible, and participate in authentic, trust-based discussions around health care options that are focussed on patient-directed goals, wishes and personal values. The needs of patients and their families must be balanced by clinical realities and the availability of services and other resources.

Significant work undertaken internationally, nationally and by Queensland Health for standards of EOLC highlight the need for better integrated care across health care settings to help alleviate the complex needs of older people, and people living with chronic disease and serious illness across the lifespan. Improving the experience of patients at the end of life, and that of their carers and families is a high priority for SCHHS. The SCHHS Strategic Plan for End of Life Care for 2018-2023 will drive a continued program of work to embed new and existing standards of EOLC into SCHHS core business, into the future.

Person-centred care is crucial to delivering the most effective services at the end of life. The plan has been developed under the auspices of the EOLC Committee, and involved wide ranging consultation throughout the organisation. The result will be a strong focus on quality care for all who rely upon SCHHS at the end of life.
Consumer engagement
Glynda Summers is a nurse and midwife with a range of experience in metropolitan, regional and rural hospitals, most recently at the Cairns and Hinterland Hospital and Health Service where she spent 15 years as the Executive Director of Nursing and Midwifery.

During Glynda’s time at the CHHHS, Cairns, underwent a $450 million redevelopment, giving her a unique insight into the processes and requirements of infrastructure planning.

She also has a significant background in digital technology, as the clinical advisor for the Queensland Health implementation of the integrated electronic medical record (ieMR) and was the executive lead for its implementation at Cairns Hospital, one of the first sites to receive the software.

Glynda also qualified as a Certified Health Informatician in 2014, and surveys hospitals for ACHS accreditation under the national quality and safety standards.

Now retired from full-time work, Glynda has relocated to the Sunshine Coast, where her family has already had occasion to use the services of Nambour General Hospital more than once.

It’s these moments as a consumer, as well as her professional qualifications and significant experience will no doubt be of great benefit to the Nambour General Hospital consumer group.

Margaret Willis arrived in Australia with her husband and children in the mid-1960s and having grown up in a small family business, quickly found a niche working in retail.

After moving to Queensland from Victoria in the early 1970s, Margaret started to work her way up the corporate ladder, working for Coles then Coles/Myer in a management stream, with a special interest in training and human resource management.

For much of her working life, Margaret was the HR manager for 19 stores across Queensland, and responsible for hiring and training staff for new stores throughout the state, and continued to work even into retirement, taking on special projects for the organisation on secondment.

Margaret has a unique perspective of the health care sector, having retired to help her sister care for their mother, who was living with Alzheimer’s disease before she passed away in 2009, and for the past few years has volunteered at Prince Charles Hospital, where her husband is a regular heart patient.

Some of the projects Margaret has worked on in recent times already inform health care planning, like talking to older people in community centres about advanced care directives, preparing for hospital as an in-patient, end-of-life care and Ryan’s Rule.