

WORKING SMARTER TOGETHER:

An example of true integration to benefit a whole community



This project employed a *Clinical Service Redesign* methodology to ensure a systems approach that works to add value, reduce burden on patients and families and ensure a systematic approach to care coordination.

Planning

The West Moreton region is facing some significant health challenges:



Population Expected to increase by 43% by 2026



Population of older people (currently 12%) is expected to increase by 81% by 2026



Poor health indicators: 15% people smoke daily 35% adults are obese 12% adults are inactive

The aim of developing an integrated model of palliative care for West Moreton was to co-design a sustainable, coordinated regional model of service delivery that can meet the challenges above, in the context of a low socioeconomic community.

Diagnostic

As independent organisations, West Moreton Health Palliative Care Service and Ipswich Hospice Care provided a range of similar services. The graphic below shows the services provided by WMH in green and IHC in purple.

The objective of the co-design process was to ensure, effective efficient service provision, without duplication and putting the patient and family needs at the centre of the model of care.



Solution Design Inpatient Services atient is medically stable an no longer requires an acute There are currently 20 care setting (and is not able to return home). inpatient palliative care beds in the West Moreton region. Acute, complex palliative care Subacute, non-complex Patients are admitted to a palliative care needs: Patients requiring Non-complex symptom setting of inpatient care specialist palliative care management Medication man physician support according to their needs. 20 Palliative Care rotation Patients requiring **Inpatient Beds** interventional pain Inpatient care during Daily communication management, complex palliative radiotherapy imaging, surgical review Complex discharge between the service planning (3+ months chemotherany prognosis) providers ensures the Palliative respite Palliative care emergencies and emergent, unstable · End of life care right care in the right symptoms End of life care setting at the right time. Patient is medically unstable and requires acute care Managed by Community Outreach, pported by Nurse Navigator Nurse **Community Services** Practitioner for rapid response (includes palliative care HITH) All community referrals are Malignant received and triaged through Managed through Ipswich Hospital palliative care outpatient clinic WMH eReferrals. Non-malignant As a single person service, Managed by Ipswich Hospice Nurse **IHC Nurse Practitioner** Practitioner through outpatient clinic or home visiting Community Service is supported by the WMH Managed by Ipswich Hospice Nurse Practitioner through outpatient Outreach Team. clinic or home visiting

Implementation

The project team employed a range of implementation tools and strategies to support the integrated model of care:



Clear pathways for referral.



Shared learning opportunities.



Shared equipment and resources.



Communication and professional support pathways.

Future opportunities:

- Shared clinical roles
- Research collaborations
- Shared regional on-call model