Queensland General Practice Liaison Network

2018-2020 BIENNIAL REPORT

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CENTRAL QUEENSLAND, WIDE BAY, SUNSHINE COAST
An Australian Government Initiative

Clinical Excellence Queensland

Queensland Government

Acknowledgement

We respectfully acknowledge the Traditional Custodians of the land on which we work and live, and recognise their continuing connection to land, water and community. We pay respect to Elders past, present and emerging.

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Foreword

General Practice Liaison Officers (GPLOs) identify and address service gaps at the interface between primary care and secondary care, bridging the gap between primary care and hospitals. The GPLO focus on integration of transfer of care from general practice to specialist outpatients and return transfer of care to primary care is highlighted in this biennial report by the many stories about the innovative projects GPLOs have contributed to.

This report gives us the opportunity to reflect on the achievements of the Queensland General Practice Liaison Network, particularly achieving the outcomes of the Specialist Outpatient Strategy. GPLOs continue to be pivotal in progressing key initiatives including GP Smart Referrals, GP access to the Health Provider Portal, HealthPathways, new models of care including GPs with a Special Interest and improved transfer of care documentation.

Clinical Excellence Queensland has supported the GPLO positions and the Queensland General Practice Liaison Network since its inception. In 2019 the Central Queensland, Wide Bay, Sunshine Coast Primary Health Network (PHN), partnered with Queensland Health to provide statewide support for the network. The work GPLOs do could not be achieved without the collaborative partnerships between general practice, Hospital and Health Services (HHSs) and PHNs.

I would like to take this opportunity to thank our partners and all GPLOs for their commitment and contribution to improving patient outcomes through improved integration at the interface between primary and secondary care. I look forward to seeing the significant contribution that General Practice Liaison Officers will make to improving patient outcomes in Queensland in the years to come.

Michael Zanco
Executive Director
Healthcare Improvement Unit
Clinical Excellence Queensland

We would like to recognise the partnership between Central Queensland, Wide Bay, Sunshine Coast PHN and Queensland Health in the coordination of the Queensland General Practice Liaison Network. This opportunity to collaborate with Clinical Excellence Queensland (CEQ) has been a privilege and I extend thanks to our CEQ partners for their hard work, commitment and engagement in supporting the dynamic and essential GPLO roles across Queensland.

I also acknowledge the achievements and contributions our predecessors CheckUP Australia made in providing this role and for their long history of supporting the GPLO program.

The GPLOs form such an engaged and supportive network, not only through their individual work areas but the opportunities brought about by COVID-19, exploring some exemplary models of care, innovative ways in improving the patient journey and better integration of services at the interface of primary and specialist outpatient care.

I commend all our GPLOs and acknowledge the work they undertake being integral to benefiting our community's health and wellbeing across the state. We are very proud of the work that GPLOs have contributed this year. We look forward to supporting future endeavours, building on strengths in partnership with Queensland Health and continuing to drive integration at the interface between primary and secondary care in Queensland.

I look forward to 2021 and being able to build on our learnings from COVID-19 and acknowledge the partnership and collaboration to solve some of the more challenging issues facing our health system in the future.

"Alone we can do so little, together we can do so much." – Helen Keller

Pattie Hudson
Chief Executive Officer
Central Queensland, Wide Bay, Sunshine Coast PHN

It gives me great pleasure to share the third Queensland General Practice Liaison Network (QGPL Network) report for 2018-2020. The report highlights the outstanding work of the QGPL Network, undertaken in partnership between the HHSs and PHNs. General Practice Liaison Officers (GPLOs) are a dedicated group of clinicians who are improving the patient journey by identifying and addressing barriers between primary and secondary care.

The Network continues to support a range of initiatives sitting under the Specialist Outpatient Strategy since 2016. During 2018-2020 we saw the implementation of the new outpatient e-referral system Smart Referrals Workflow Solution, GP Smart Referrals, GP access to the Health Provider Portal, the Referral Service Directory and the GPs with a Special Interest models of care. I am sure that you will enjoy reading the stories in this report. GPLOs continue to support their local hospitals and general practice in the rollout of these programs and future initiatives.

2020 has been a year of significant change in the way healthcare is provided and with new models of care emerging to assist in managing the COVID-19 pandemic. The QGPL Network has supported HHSs and general practice in responding to the COVID-19 pandemic, ensuring the safety of Queenslanders.

I welcome our new GPLOs who have joined our network over the past two years, some of whom will be introduced in this report to show the coverage the network is now providing across Queensland.

General Practice liaison across Queensland continues to go from strength to strength and I encourage you to seek out your local GPLO to assist you with any initiatives being undertaken at the interface between primary and secondary care.

Dr James Collins
Chair
Queensland General Practice Liaison Network

Queensland General Practice Liaison Network

The Queensland General Practice Liaison Network (QGPL Network) is a multidisciplinary collaboration of clinicians that provides expert direction and advice on all strategic matters relating to the integration of care; identifying and addressing service gaps at the interface between primary and secondary care.

The QGPL Network provides leadership to the broader advisory groups and services related to general practice liaison to achieve improvements across the interface between primary and secondary care focusing on communication and engagement, transfer of care, new models of care, education, and supporting the general practice liaison role.

The General Practice Liaison positions were based on the *General Practice Queensland paper Enhancing Integration: The General Practice Liaison Model, 2011.* Improving the hospital and primary health care interface is a key enabler for improved delivery of health services. The QGPL is funded by the Healthcare Improvement Unit, Clinical Excellence Division, Queensland Health.

General Practice Liaison Officers (GPLOs)

GPLOs identify and address service gaps at the interface between primary care and specialist outpatient care.

The roles and responsibilities of General Practice Liaison Officers include facilitating:

- appropriate clinical pathways between settings
- transfer of care, clinical handover and hospital discharge documentation and processes
- better integration of services
- identifying and addressing service gaps, especially at the interface between primary and specialist outpatient care.

Membership

- Reflects the various health disciplines involved in general practice liaison services from within Queensland Health, Primary Health Networks, and other relevant government and non-government organisations.
- Represents the diverse geographical spread of Queensland with representation from each Hospital and Health Service (including Children's Health Queensland) and / or Primary Health Network (PHN).

Objectives

- Build the capacity and capability of GPLOs through shared learning, experiences, resources and innovations.
- Identify effective local strategies, solutions and service delivery models, share them with the network and support their wider implementation.
- Provide opportunities for QGPL Network members to build mutually supportive and collaborative relationships to enhance individual and network growth and development.
- Implement the QGPL Network Annual Work Plan.
- Showcase QGPL Network and member achievements, including individual GPLOs, HHS and PHN teams at local and state levels.

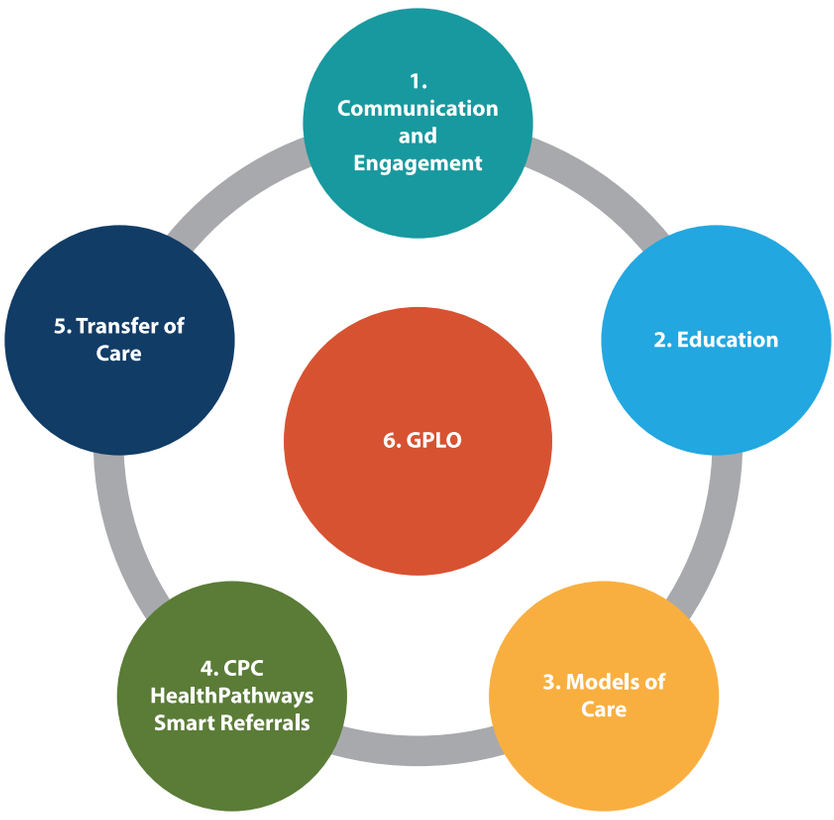
About the QGPL Network

- 2008: Initial network meetings started by General Practice Queensland (Now CheckUP Australia). Initial GPLO positions funded by PHNs.
- 2012: Queensland Health funded 20 GPLO positions for two years in the 20 largest public hospitals under an election commitment. These GPLO positions were recurrently funded following further funding from the Department of Health for 12 months and evaluation.
- 2013: Queensland Health provided funding to CheckUP Australia to partner and facilitate the QGPL Network.
- May 2019: Central Queensland, Wide Bay, Sunshine Coast Primary Health Network was contracted by Queensland Health to partner in coordinating the network.

QGPL Network Work Plan

The QGPL Network Work Plan highlights priority areas for GPLOs and prioritises six key focus areas of work.

1. Improve communication, collaboration and engagement between general practice, Hospital Health Services (HHSs) and Primary Health Networks (PHNs).
2. Facilitate general practitioner education regarding strategies to improve integration, transfer of care and engagement to increase use of HealthPathways and Clinical Prioritisation Criteria (CPC).
3. Contribute to the development and implementation of new models of care and increase GP engagement with these models.
4. Support development and implementation of digital health solutions including HealthPathways, GP Smart Referrals, Clinical Prioritisation Criteria and GP access to the Health Provider Portal.
5. Contribute to safer and more reliable transfer of care and clinical handover between settings.
6. Support the development of the General Practice Liaison Officer (GPLO) role.



Introduction

In Queensland, 2020 began with bushfires and flooding natural disasters. This was closely followed by the COVID-19 pandemic, which has dominated 2020 with its devastation across the world. Fortunately, in Australia and particularly in Queensland, we have so far been successful in supressing COVID-19 in the community.

The primary aim of General Practice Liaison is to identify and address service gaps at the interface between primary and secondary care, and this has been critical in managing coordination across boundaries in the healthcare sector as the pandemic has unfolded. 2020 has been a year where new ways of working, adaptation of models of care and integration at the interface between primary and secondary care has developed at a rapid pace and been critical in ensuring the health of Queenslanders.

The following stories highlight both the importance of strong partnerships and the general practice liaison role in managing COVID-19 and natural disasters, and increasing integration at the interface between primary and secondary care.

Strengthening collaboration and communication between primary and secondary care during the COVID-19 pandemic

Dr Carl de Wet, Primary Care Lead
Healthcare Improvement Unit,
Clinical Excellence Queensland

In February 2020, a few primary care clinicians voluntarily commenced informally organising a primary care response to the COVID-19 outbreak. Additional general practice and primary care organisations were invited or asked to participate. The aims of this small but evolving primary care group were to liaise with the Queensland Health Chief Health Officer, Dr Young, and the State Health Emergency Coordination Centre (SHECC) and communicate key developments and guidance in relation to general practices, as well as the wider primary care community.

There were immediate and visible benefits from this work. However, as the workload and resources required quickly escalated, it became clear that there was a need to assign a person to help coordinate and lead the work of liaising between primary and secondary care.

Dr Carl de Wet was appointed to the temporary, part-time role of Primary Care Lead for COVID-19 in Queensland. The role is supported by the Surgical and Outpatient Reform Team, the Queensland General Practice Liaison Network, the wider Healthcare Improvement Unit team and the Queensland HealthPathways community.

Outcomes and achievements

- Established regular meetings (initially twice a week, now fortnightly) with a wide range of primary care organisations, including: all seven PHNs, Rural Doctors Association of Australia, Australian College of Rural and Remote Medicine, Royal Australian College Of General Practitioners, James Cook University, General Practice Training Queensland, CheckUP Australia, Office of Rural and Remote Health, Australian Medical Association Queensland, Rural Doctors Association Queensland, QGPL Network and the State Health Emergency Coordination Centre (SHECC). Stakeholder representation and engagement with primary care is unprecedented in Queensland. The spirit and culture of these meetings are incredibly positive and supportive, and have identified solutions for many management issues.
- Curating and disseminating regular updates (92 to date) about COVID-19 information that is relevant to primary care stakeholders.
- Strongly and successfully advocated for changes to the MBS items, described as: '10 years of work in 10 days'.
- Supported the development of validated evidence-based COVID-19 specific HealthPathways by the Queensland HP community. The development of the COVID-19 HealthPathways was funded by the Healthcare Improvement Unit.
- Requested and supported the development a COVID-19 assessment and management summary flowchart that is regularly updated by the Queensland General Practice Liaison Network.
- Supported the two direct messages to the approximately 10,000 GPs in the Secure Transfer Service address book providing clinical information resources to Queensland GPs to assist management of COVID-19.
- Supported Healthcare Improvement Unit staff in responding to and resolving individual queries, complaints, and feedback from consumers, primary and secondary care clinicians.
- In collaboration with the Healthcare Improvement Unit, created, requested and supported the development and regular updating of a fever and respiratory clinic list resource for general practitioners, housed on the Queensland Health website.
- Responded to SHECC/Queensland Health requests for support including primary care services for Australians in hotel quarantine, residential aged care facilities (RACF) and hospices.
- Supported the establishment by the Healthcare Improvement Unit of a single source of truth for primary care clinicians on the Queensland Health website www.health.qld.gov.au/clinical-practice/guidelines-procedures/novel-coronavirus-qld-clinicians/resources-for-clinicians.
- Supported the development of dedicated COVID-19 related pandemic plans, governance frameworks and resources for RACFs, patients with disability and rural and remote regions by providing feedback to the Primary Care Lead and project leads.
- Represented primary care on state-wide COVID-19 related committees and working groups.

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HealthPathways

Dr Aaron Kennedy, Senior GP Clinical Editor and Regional Clinical Advisor
Mackay HealthPathways and Queensland HealthPathways

Dr Fabian Jaramillo, GPLO and Clinical Editor
Metro North Hospital and Health Service, Brisbane North PHN

Toni Simmons, GPLO and Integrated Health Manager
Mackay Hospital and Health Service

HealthPathways is an online manual for clinicians across Queensland to help assess, manage and assist in specialist request decisions for hundreds of conditions.

Each pathway is an agreement between primary and specialist services on how patients with particular conditions will be managed locally.

For the past four years, PHN and HHS GPLOs have worked together, visiting general practices to introduce, offer guidance and receive feedback about the use and development of HealthPathways.

GPs often use it during consultation as a reminder for diagnostics, medicine, community and specialist assistance available to their patients. This is an important resource within a constantly changing operational framework for visiting and locum practitioners.

Benefits

- Relationships with their primary care and hospital specialist colleagues.
- Greater confidence and options to manage their patients.
- General practice and other services being able to do more for them in the community.
- The greater clarity clinicians can provide about appropriate specialist services and alternative options.
- Less demand on acute and residential care services as patients are better managed in the community.

GPLO Dr Jon Harper demonstrates HealthPathways.

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HealthPathways enabling COVID-19 collaboration across Queensland

The HealthPathways program has facilitated a level of engagement, communication and collaboration between primary care, Primary Health Networks and the Hospital and Health Services on a scale that has not previously occurred. HealthPathways and the COVID-19 Health Pathway response package are funded by the Healthcare Improvement Unit.

These relationships are exciting and have the potential to create meaningful change in the provision of healthcare in Queensland.

This collaboration was evident during the rapidly evolving COVID-19 pandemic in 2020, resulting in a partnership between the Healthcare Improvement Unit, HealthPathways Network, Queensland General Practice Liaison Network, State Health Emergency Coordination Centre (SHECC) and Streamliners New Zealand to create a single sourced COVID-19 package shared across Queensland.

Response Package aims:

- rapidly get emergency COVID-19 guidance into practice (adapted for local use).
- support the safety of frontline health workers.
- communicate impacts on clinical care and other health system services.

The Response Package is managed in three layers to help keep general practitioners informed about rapidly changing COVID-19 information: International, national/state and local.

Dr Fabian Jaramillo (Brisbane North) took on the role of Lead Clinical Editor for the overall suite of pathways and development of the COVID-19 Assessment and Management pathway.

The following regional clinical editors took a lead on specific aspects of care including:

- Far North Queensland (Dr Helen Pedgrift):
    - COVID-19 in residential aged care facilities
    - COVID-19 mental health support for clinicians
- Townsville (Dr Kingsley Mudd): COVID-19 mental health
- Mackay (Dr Aaron Kennedy): COVID-19 impact on clinical care and services
- Central Queensland (Dr Bhavesh Dhamsania): COVID-19 community support
- Sunshine Coast and Gympie (Dr Jon Harper): COVID-19 practice management
- West Moreton (Dr Naomi Bower): COVID-19 end of life care.

Outcomes

- Coordinated, collaborative, and rapid approach to information dissemination to guide Queensland general practitioners via HealthPathways.
- Supported the safety of frontline health workers during the pandemic.
- Improved communication of impacts on clinical care and other health system services.
- Improved communication and engagement strategies.
- Connection established between the Queensland HealthPathways Network and Queensland General Practice Liaison Network with the inclusion of Dr Aaron Kennedy and Dr Fabian Jaramillo to ensure consistency and avoid duplication of content, time and effort.
- Connection with the State Health Emergency Coordinator Centre (SHECC) to ensure clear, accurate and informed responses disseminated from authoring body.

Achievements

- COVID-19 pathway and resources package has been adopted by all Queensland HealthPathways teams.
- Data analytics demonstrated good uptake and use of the COVID-19 HealthPathways across Queensland.
- Streamliners rapidly progressed the implementation of the Western Queensland HealthPathways site to ensure uptake of the COVID suite was available.
- Streamliners provided in kind resources to Gold Coast PHN to ensure the same information was provided across its catchment as the Gold Coast did not have HealthPathways at that time, with implementation currently being progressed.

General Practice readiness supported by development of COVID-19 flowchart

Dr Meg Cairns, GPLO
Metro North Hospital and Health Service
Brisbane North PHN

In Queensland, confirmed cases of COVID-19 have been managed by local Public Health Units and Hospital and Health Services rather than in primary care. However, identification of people who meet Queensland Health agreed COVID-19 testing criteria and referral for testing mostly occurs in primary care.

Collection of respiratory samples for COVID-19 PCR testing has occurred either in General Practices or via referral to private pathology provider collection centres, GP Respiratory Clinics or Fever and Community Assessment Clinics.

In response to the COVID-19 pandemic, GPs and General Practices developed practice readiness policies and procedures, often with the support of their local Primary Health Networks.

In March 2020, COVID-19 temporary MBS telehealth item numbers were introduced whereby patients could receive telephone or telehealth consultations. This facilitated General Practice telephone and telehealth assessment and management of patients with suspected COVID-19.

A comprehensive suite of COVID-19 HealthPathways was developed and published by the end of March 2020.

Given that the identification of patients with suspected COVID-19 and referral for testing mostly occurs in primary care, General Practice requested a single page decision support tool for GP assessment and management of patients with suspected COVID-19.

Our knowledge of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and coronavirus disease 2019 (COVID-19) is evolving so rapidly that evidenced based clinical guidelines and care pathways have to be updated frequently.

Outcomes

- The GP assessment and management of patients with suspected COVID-19 flowchart developed in March 2020 and has been regularly updated. It supports General Practice readiness, telephone/telehealth triage, epidemiological and clinical assessment, infection control precautions, specimen collection, referral for testing, and referral for emergency assessment of patients with symptoms suggestive of severe disease.
- The flowchart is available on the Queensland Health website page that provides COVID-19 information for clinicians www.health.qld.gov.au/clinical-practice/guidelines-procedures/novel-coronavirus-qld-clinicians.
- The flowchart is also a key link from the HealthPathways COVID-19 Assessment and Management pathway and from Primary Health Networks and RACGP websites.
- The GP assessment and management of patients with suspected COVID-19 flowchart is regularly updated by the GPLOs in accordance with updates to key national and Queensland documents, including:
    - Australian Government Department of Health Coronavirus (COVID-19) resources for health professionals, including aged care providers, pathology providers and health care managers
    - Communicable Diseases Network of Australia Series of National Guidelines for Public Health Units COVID-19
    - Public Health Laboratory Network Guidance on Laboratory Testing for SARS-CoV-2
    - National COVID-19 Clinical Evidence Taskforce
    - MBS Online
    - Queensland Chief Health Officer Public Health Directions
    - Queensland Health Public Health Alerts
    - Queensland COVID-19 private pathology provider collection centres, GP Respiratory Clinics or Fever and Community Assessment Clinics database.

Achievements

- The GP assessment and management of patients with suspected COVID-19 flowchart, developed by the GPLOs, addressed an unmet need and has been requested repeatedly by Queensland GPs. It is a popular document on the Queensland Health website and has received positive feedback.

Challenges

- Creating a clear and concise message consistent with both national and Queensland guidelines.
- Keeping the flowchart current given the rapid and sometimes significant changes in SARS-CoV-2 and COVID-19 clinical guidelines and care pathways.

Disaster communication between primary care and tertiary healthcare services

Dr Toni Weller, GPLO
Townsville Hospital and Health Service

The big shift for Townsville HHS to increase the communication with primary care during 2018-2020 occurred with the coordination of the primary care emergency response team during the Townsville floods in February 2019.

The Townsville Hospital and Health Service Health Emergency Operations Centre (HEOC) meetings sought GP input, with Dr Toni Weller invited to attend these meetings alongside a Northern Queensland PHN representative to provide primary care input.

GPs and community pharmacy also needed to work together using a multidisciplinary team approach with everyone working to their full scope of practice.

As rapid messaging between GPs and pharmacists was needed, appropriate and careful engagement and communication strategies were established. These involved both HHS and PHN communications teams, using email, phone, social media and HealthPathways. HealthPathways is an online manual for clinicians across Queensland to help assess, manage and assist in specialist request decisions for hundreds of conditions and is funded statewide by the Healthcare Improvement Unit, Clinical Excellence Queensland.

HealthPathways and Facebook became the most reliable and vital forms of communication during the disaster. An updated list of practice and pharmacy opening hours was created and maintained.

This collaboration has been continued and built on during the COVID-19 pandemic. Regular update meetings have been held between the Director of Public Health and the Townsville region GPs as well as GP representation from the GPLO on the Townsville Health Emergency Operations Centre (HEOC). HealthPathways has been the main form of centralised up to date information being accessed for COVID-19 and the platform for clinical communication.

Outcomes and achievements

- Townsville HHS GPLO and Northern Queensland PHN membership of and input to the Townsville Health Emergency Operations Centre (HEOC) meetings.
- Updated resources were enabled with frequently updated lists of general practices and pharmacies opening hours maintained.
- A framework for GPs Emergency Kit developed for emergency readiness.
- Chronic disease management activities incorporated into business as usual as an ongoing part of disaster management.

Challenges

- GP credentialing and identification during emergencies.
- GP integration with emergency team and other services.
- Medical Officer supply at the evacuation centre.
- Patients were poorly prepared and evacuated without essential medicines such as insulin, a medical summary or knowledge of their medications and conditions.
- Chronic disease management and pain management for vulnerable patients.
- Community mental health patient treatment, medication management and provision of required trauma care.
- Patient record accessibility.
- Chronic wound dressings, cold chain maintenance and dressing supplies.
- Mental health first aid for many patients.

Modified maternity model of care in response to COVID-19

Dr Meg Cairns
Metro North Hospital and Health Service
Brisbane North PHN

Metro North HHS introduced changes for women requiring pregnancy care following recommendations in the *Queensland Clinical Guideline: Maternity care for mothers and babies during the COVID-19 pandemic.*

Where possible, face to face care has been provided in the community and supported by telehealth to reduce risk to women and maternity carers.

Models of care such as midwifery continuity of care and GP shared care were well suited to these adaptations.

Additional face-to-face changes included:

- Visits were, where possible, less than 15 minutes duration and involved the minimum number of participants.
- Visits focused on the usual clinical assessments, vaccinations and enquiry about fetal movements, perinatal mental wellbeing, and domestic and family violence.

Royal Brisbane and Women's Hospital

In addition to routine antenatal care, services that had previously been only delivered in the hospital face to face such as childbirth education classes, social work, perinatal mental health, diabetes education and dietician support were also provided in the community and supported by telehealth.

Royal Brisbane and Women's Hospital (RBWH) obstetricians, midwives, social workers, psychologists, diabetes educators, dieticians, Metro North Perinatal Mental Health Team and Metro North Women's and Children's Stream GPLO worked together to modify:

- **Models of maternity care:** GPs providing shared care were also asked to provide an antenatal visit for women having midwifery models of care at around 20 weeks gestation to coincide with vaccination for Pertussis.
- **Models of care for Gestational Diabetes Mellitus (GDM):** During the pandemic, women having GP shared care and GDM treated with diet and/or Metformin could continue their antenatal care with their GP supported by the RBWH Maternity Diabetes Service. Traditionally, women having GP shared care who develop GDM would have the remainder of their antenatal and diabetes care in the hospital setting rather than continue in the GP shared care model.
- **Social work referral pathways:** Screening during pregnancy for psychosocial risk factors, alcohol and other drugs and mental health is usually conducted face to face in the hospital setting. GPs were supported to do these assessments and a new referral pathway was developed allowing GPs to directly refer into the RBWH Social Work service.

Outcomes

- A database of GPs providing face to face and telehealth maternity shared care with Metro North HHS maternity facilities (Royal Brisbane and Women's Hospital, Redcliffe and Caboolture Hospitals) was created and shared.
- Documents which were emailed to Metro North Shared Care GPs and hosted on the Metro North Refer your patient web page were developed, including:
    - Antenatal, postnatal, and newborn care during the COVID-19 pandemic - useful resources such as Queensland Clinical Guidelines, Royal Australian and New Zealand College of Obstetricians and Gynaecologists guidelines, Royal College of Obstetricians and Gynaecologists guidelines, MN HHS patient resources, Brisbane North HealthPathways
    - COVID-19 changes to Maternity Services in Metro North HHS
    - Maternity GP Shared Care for low-risk women during COVID-19 guidance.
- Additional RBWH documents were developed and emailed to Metro North Shared Care GPs:
    - RBWH COVID-19 Maternity Outpatient Care Schedule
    - RBWH Maternity Social Work Referral flowchart
    - RBWH Maternity Social Work Domestic and Family Violence services list for GPs
    - RBWH Gestational Diabetes Mellitus GP Shared Care letter suite.
- These documents were also communicated via Network Link the Brisbane North PHN newsletter, Brisbane North PHN electronic daily messaging and Metro North GP Alignment Program Maternity Workshop.
- An evaluation is underway to determine if some of the modified models of care can be continued as business as usual.

Achievements

- Collaboration across primary care and hospital care sectors to provide best practice antenatal, postnatal and newborn care for families during the COVID-19 pandemic.
- Better communication between primary care and Metro North HHS maternity services.

Challenges

- Ensuring the modified models of care and associated documents and resources remain current given the rapid and sometimes significant changes in SARS-CoV-2 and COVID-19 clinical guidelines and care pathways.

General Practice Liaison Unit re-established

Dr Kate Johnston, GPLO and
Dr Asma'a Gundru, GPLO
Gold Coast Hospital and Health Service

Gold Coast Hospital and Health Service (HHS) re-established the GP Liaison Unit (GPLU) from February 2020. Former GPLO Dr Kate Johnston (2007-2015) has returned and is joined by Dr Asma'a Gundru to take the new program of work forward.

The first job was to re-establish some of the GPLO team's core business, reaching out to practices to ensure they were aware of support available, updating their contact details in the Secure Transmission Service address book, as well as developing a communication channel for important updates from Gold Coast Health to General Practice.

The emergence of COVID-19 gave us the opportunity to engage with more than 60 GPs who offered their availability for the potential workforce response. Many contributed to the Gold Coast HHS COVID-19 ward early in our pandemic response and several GPs continue to assist with Fever Clinic.

COVID-19 also gave us the opportunity to further develop our GP Hotline to assist GPs with outpatient service changes during this period.

The GPLU linked with the Outpatients Team to ensure GP and patient voices were heard while managing demand with reduced capacity and social distancing restrictions. Many specialties nominated a senior clinician as a key contact during this time and committed to promptly addressing any GP queries or concerns.

The GPLU worked closely with the Residential Aged Care Support Service (RaSS) and Public Health Unit to ensure all residential aged care facility information and key GP contacts were current. We surveyed GPs to understand work intentions if a patient tested positive to COVID-19 in one of our facilities and encouraged uptake and access to our RaSS service. On a positive note, we were able to advise the availability of long-awaited services such as mobile x-ray and ultrasound for these patients.

As GPLOs we participated in regular webinars, bringing together Gold Coast Health and PHN executives, GP and HHS clinical leaders, and local GPs. Senior hospital leadership and GP leaders met weekly on the Gold Coast during COVID-19 and continue to meet regularly to share understanding of the local situation.

Finally, The Gold Coast HHS will join the remainder of Queensland with the implementation of HealthPathways and Smart Referrals in the coming months. The GPLU is actively involved in building and working with the team who will deliver these programs.

Outcomes

- 85% Gold Coast GPs send electronic communications via Secure Transfer Services.
- 40 new GPs credentialled to work in Gold Coast HHS COVID-19 response.
- Bi-monthly publication in the *Gold Coast Health News – An update for General Practice.*
- 1300 phone line est ablished with access to consultants to support GPs with Category 3 referrals returned due to COVID-19.
- Regular meetings between HHS executive, PHN executive and clinical leaders since March 2020.
- Monthly COVID-19 update webinars since March 2020 for general practice.

Ensuring GP service availability in RACFs during a pandemic

Dr Kylie Norris, GPLO
Metro North Hospital and Health Service
Brisbane North PHN

The Metro North HHS Residential Aged Care District Assessment and Referral (RADAR) team provides in reach and outreach services to residential aged care facility (RACF) residents for the Royal Brisbane and Women's Hospital, The Prince Charles Hospital, Caboolture Hospital and Redcliffe Hospital catchments.

In late March 2020, during COVID-19 meetings for RACF preparedness and response, some local teams became aware of RACF residents and facilities that did not have a regular visiting GP to provide medical services.

An article in the Brisbane North PHN weekly GP email newsletter highlighted this issue and asked for expressions of interest from available GPs to work in RACFs.

Dr Kylie Norris is the GPLO lead for RADAR. She provides a GP perspective about RADAR activities, looking at models of care, advising about the work that GPs currently do, and attends the RADAR Clinical Advisory Group meetings.

Kylie Norris (GPLO RADAR), Denise Hobson (Clinical Lead RADAR), Karen Venaglia (Nurse Navigator, RADAR)

Outcomes

- 26 GPs and several back up locum services responded within the week of the published article.
- GPLO and local RADAR team contacted each GP and provided contact details of local RACFs requiring extra GP services, encouraging them to make their own arrangements with the RACFs.

Achievements

- Responses from GPs exceeded the RADAR team's expectations as more GPs replied than were required.
- GPs agreed for their names to be held in a database for future requests.
- At a time of uncertainty and disruption during the COVID-19 pandemic, it provided an opportunity for the RADAR teams to connect with GPs working in RACFs.
- GP engagement has continued with email newsletters and GP webinars focused on RACF and COVID-19 topics.

Challenges

- GPs continue to withdraw their services from RACF work for many reasons out of the control of the HHS. This trend is not unique to MNHHS.
- RACF residents may require unnecessary hospital admissions and Emergency Department presentations due to reduced GP services.
- The COVID-19 pandemic provided an unusual set of circumstances for the MNHHS, which would not normally be involved, or responsible for, recruitment of GPs to RACFs.
- We recognise that adequate GP services at a local facility level are optimal for the care of their residents. However, it is the responsibility of RACFs to continue to build relationships and discuss their working arrangements with GPs rather than rely on the HHS to arrange GP services.

Cardiology discharge audit tool enables earlier transfer of care to General Practice

Dr Mike Hamilton, GPLO
Metro North Hospital and Health Service
Brisbane North PHN

In 2017, Professor Darren Walters initiated a review of patients seen in general cardiology clinics. The purpose was to reduce the number of review appointments for low-risk patients, free up consulting time for new patients and reduce long waits.

GPLOs within Brisbane North PHN and Metro North HHS identified and refined criteria to determine patients suitable for transfer of care to their GP using a spreadsheet tool.

While an international literature review informed the initial criteria, information from more than 200 clinic letters refined the criteria to eight simple clinical questions, which would normally be asked during a standard clinic review and did not impose a greater workload than usual.

Importantly, safeguards were built within the standardised framework scoring system developed to prevent inappropriate discharges.

Three cardiology specialists trialled the discharge criteria framework in 2019. This trial examined the criteria's ease of use, patient acceptability and if the criteria improved the discharge rate.

Patients were followed up after three months to determine if they had re-entered the hospital system for the discharged condition or if a re-referral was submitted by the patient's GP.

Dr Mike Hamilton has been working with cardiology as a specialty for several years. Mike designed an audit capturing information around diagnosis, investigations, reason for review and suitability for discharge, resulting in the development of a Discharge Audit Tool.

Outcomes

- The trial showed there were no adverse events (ED attendance for the discharge condition).
- At the three-month review none of the patients had been re-referred or re- entered the hospital system for the discharge condition.
- The trial was then expanded to all cardiology registrars using the tool to identify patients that should be considered for discharge from clinic follow up. Clinic models using more than one registrar per specialist would particularly benefit.
- A recommendation was made that all discharged patients should have a management plan in the discharge letter to the GP which should also include information about access to specialist advice and/or re-entry information.
- While the tool performed a good screen, it was not a substitute for the specialist's final decision taking into consideration each patient's circumstances.

Achievements

- The discharge criteria for general cardiology clinics has been adopted into business as usual practice at The Prince Charles Hospital.

Challenges

- Ensure this tool continues to be used even as pressure on new appointments eases.
- GPLOs must continue to reassure specialists that general practice is capable and ready to manage the return of these patients to primary care.

The general practice engagement journey for Cairns and Hinterland HHS

Dianne Shkurka, GPLO
Cairns and Hinterland Hospital and Health Service

In 2016, there was little or no engagement with local GPs from the Hospital and Health Service (HHS). Communication was poor and the GP community felt powerless to effect change.

The commencement of the GP Liaison Service (GPLS) with one position working in the service seemed like a drop in the ocean with the enormity of the task ahead.

Since then, confidence has returned in the community and the working relationships between General Practice, the PHN and the HHS. The critical success factors included:

- The establishment of a dedicated resource in a hospital-based GP Liaison Officer that primary care could contact, provide feedback to and over time gain confidence in. This led to the establishment of an enquiry service to support primary care.
- Projects to address clinical handover issues led to the introduction of secure web transfer messaging for clinical handover in some departments and the roll out of GP access to the Health Provider Portal which was received positively by general practice.
- The employment of a practicing General Practitioner one day a week to assist with the Clinical Prioritisation Criteria (CPC) project in 2018 greatly improved general practice connections within the HHS; with activities participation in outpatient committees, assisting with education and capturing GP feedback.

Engagement activity (2016 – 2020)

3500	**General enquiries**	**350**	**Practice visits**
55	**Clinical updates**	**23**	**Accredited education**

Outcomes

- Hospital-led GP education events established and continue from the identification of this as a need following feedback from stakeholders.
- More than 20 education sessions held with over 100 GPs involved from February 2018.
- GP enquiries continue daily with the establishment of the GP enquiry line. Feedback about this resource continues to be positive and valued by the GP community.
- Appointment of a practicing GP one day per week significantly improved GP practice engagement with the HHS.
- 55 COVID-19 clinical updates were published in 2020 with more than 480 primary care subscribers.

Challenges

- Limited resources within the GPLS is challenging and therefore building positive partnerships with other stakeholders is vital to continue our engagement journey.
- Planning educational events and clinical updates with current and interesting topics and information.

- The development of regular education events from February 2018 gave local GPs the opportunity to meet in the hospital environment and to network and meet the HHS specialists who receive their referrals. The General Practitioners also received CPD points from either the Royal Australian College of General Practitioners and/or the Australian College of Rural and Remote Medicine for participating in the education.
- In 2020, development and distribution of regular and often daily clinical updates during COVID-19. These updates began with the COVID-19 primary care updates provided by the Primary Care Clinical Lead, HIU, and Clinical Excellence Queensland. These continued as regular clinical updates to primary care across Cairns, the Hinterland, Torres and Cape, sharing crucial changes about the pandemic, general health service updates and primary care resources. Partnering with Far North Queensland HealthPathways, the GPLS has moved to a shared media platform:
    - The new platform provides information on the number of people opening and viewing the updates: 53% of subscribers open the information, which is above average for electronically distributed information.
    - We now have hospital departments and GP practices asking us to share information using this distribution method.
- Regular monthly meetings involving the private hospital, Northern Queensland PHN, James Cook University, GP registrar training provider and the GPLO office have increased GP engagement, knowledge of events, issues, education and organisational changes across all the sectors. They allow a more collaborative and cohesive approach to education events, without the sectors duplicating work, competing against each other or running similar events.
- An annual GP survey provides a mechanism to allow GPs to provide feedback on the health service communications and initiatives that engage with primary care. Feedback is discussed in the governance committees and the identified outcomes form part of the following year's improvement activities. Due to the COVID impact an interim survey was conducted gathering insights from primary health stakeholders to shape the current communication activity and future GPLS engagement (53 responses collected, approximately 24%).

Building relationships between hospital and primary care

Heath Cooper, Primary Care Liaison Officer
North West Hospital and Health Service

I was diving in the deep end, being new to both Mount Isa and the newly created position of Primary Care Liaison Officer (PCLO) in mid-2019.

The PCLO role was developed as part of the North West HHS ED Department Avoidance Project and was the first general practice liaison role.

Since starting in this role, I have focused on building and maintaining relationships with local and remote GPs, general practices and the Western Queensland PHN.

A major focus in establishing the role was to improve communication and relationships between the hospital and primary health care settings.

Working in this space I quickly developed a passion for timely and relevant clinical handover from the hospital to community stakeholders. This has built on my experience working as the Discharge Coordination Clinical Nurse Consultant in Townsville.

Outcomes

- Introduced GoShare to Mount Isa Hospital – in use within Emergency Department and Maternity.
- HealthPathways - contacts developed, HealthPathways promoted and implemented.
- Smart Referrals Workflow Solution promoted and implemented.
- Secure Transfer Services address book updated and maintained
- Promoting the value of primary care within Mount Isa Hospital
- Improved quality and timely discharge summaries

Achievements

- Built strong relationships with GP practices and Western Queensland PHN.
- Regular visits and engagement with GP practices in collaboration with Western Queensland PHN.
- Provided general practice liaison advice to the Western Queensland GP Integrated Care Collaborative and Health Care Homes projects.

Challenges

- Building a trusted relationship between the hospital and local GPs.
- Assisting GPs to navigate the North West HHS system.
- Developing processes to support continuous quality improvements and share achievements with primary care.
- Developing governance framework and stable reporting lines for the PCLO position.
- Continuing to engage with North West HHS staff to improve discharge summaries and clinical handover to primary care.

A collaboration across West Moreton and Darling Downs HHS General Practice Liaison programs

Dr Tanusha Ramaloo, GPLO
West Moreton Hospital and Health Service
Darling Downs West Moreton PHN

Dr Theresa Johnston, GPLO
Darling Downs Hospital and Health Service
Darling Downs West Moreton PHN

The collaborative journey between West Moreton and Darling Downs HHSs started when a fellow GPLO became aware of the need to fill the West Moreton GPLO position and introduced us.

From our first conversation we realised we had a common understanding of the unmet needs in primary care and a passion for GP support.

As our maturity has grown within our GPLO role it has been great to work together and have access to a second lens on any ideas or issues that we encounter.

One of the first examples of collaboration was the Paediatric Symposium held November 2019 which addressed a specific need for both regions. At this event we introduced an educational and problem exploring segment called 'GP Practice Pearls'. These GP Pearls incorporated information about the National Disability Insurance Scheme (NDIS), Medicare Benefits Schedule (MBS) billing codes and HealthPathways. We based the structure and format on the successful Antenatal Symposium held in June 2019 in the Darling Downs.

Challenges and opportunities

- The differences in culture between Darling Downs and West Moreton and how practices operate are clear, however working together we have enabled efficiencies for common problems, built confidence and enabled capability building in our regions.
- During COVID-19 we realised there was an ongoing need to support GPs to keep abreast of, and safely navigate, the changing landscape.
- Within the PHN we have leveraged our Training Needs Analysis and Education Coordinator to plan collaborative events across both regions. Examples include our paediatric series and COVID-19 public health updates which are particularly useful for border towns, and our children in care HealthPathways webinar.
- The Virtual Snippet Series was launched to provide individual practices with visibility of PHN and HHS services provided in the community to enable care closer to home. This has allowed the opportunity to discuss practice-specific needs in lieu of face to face practice visits due to COVID-19.
- The value of our partnership in the reflection process and continuous improvement for GP education was evident in the GP feedback was received for the Paediatric symposium.

GPLOs integrating care at the interface between primary and secondary care

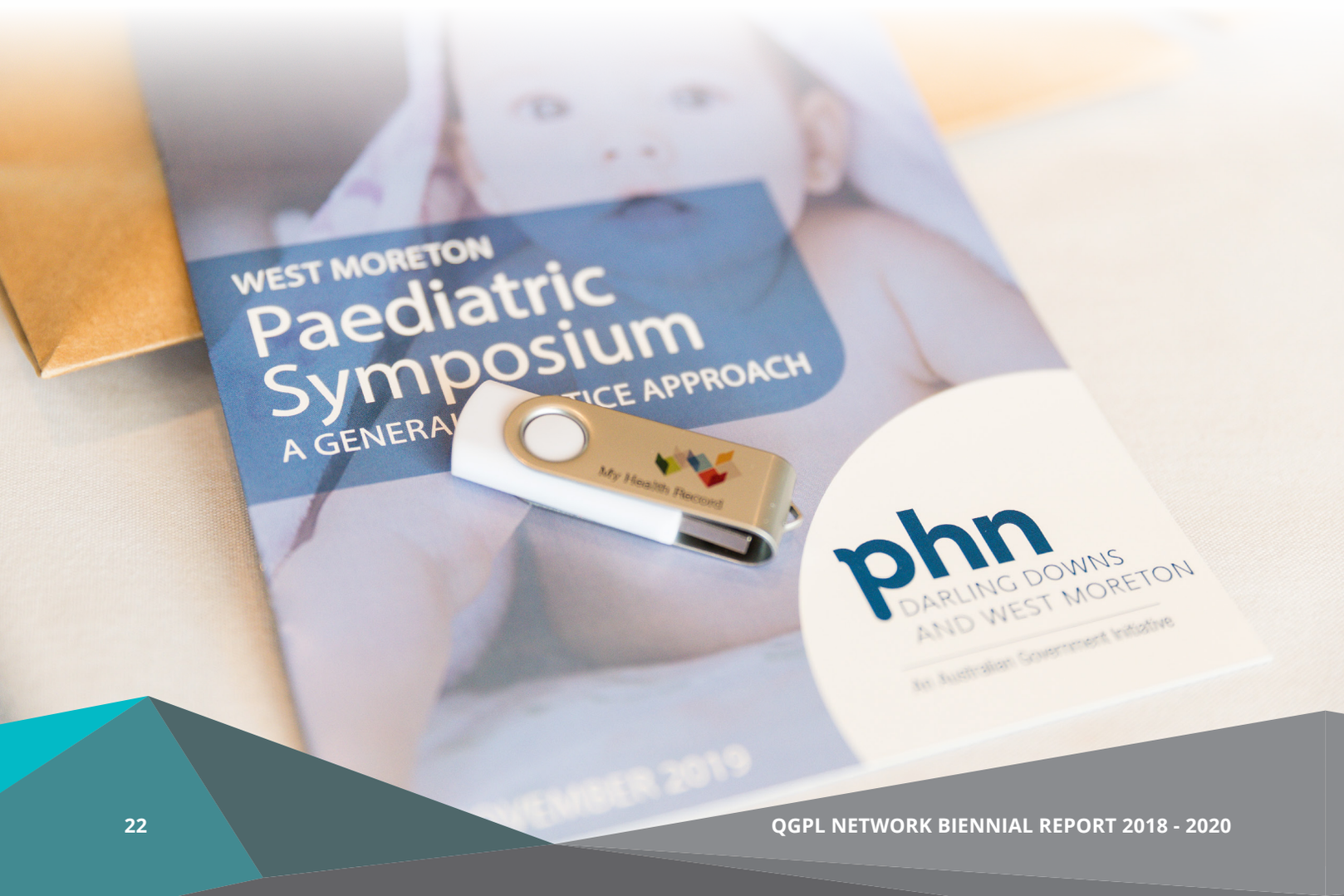
Another good example of the power of collaboration was the GPLO discussion document that we developed after realising we were both tasked with developing strategies to assist our GPs and HHSs to manage the impact of Covid-19 on the Specialist Outpatient Department (SOPD) waiting list.

The value of this focused discussion created the need for a framework and tool that provided a concise and consistent narrative to our stakeholders. Central to this framework is HealthPathways and we have worked together across Darling Downs and West Moreton to unlock efficiencies by leveraging our GPLO collaboration.

We have both presented this to our clinical teams and the ethos has resonated with many and translated into further education opportunities and shared models of care.

There is now general agreement between General Practice and our HHSs that any shared care or new models of care must be built on trusting relationships and a common understanding of the various contexts and constraints under which we work within primary, secondary and tertiary care. The framework further develops these ideas and concepts and we will continue to work on platforms to build mutual understanding and relationships to enhance alignment between primary and secondary care.

L-R: Dr Robert McGregor (Paediatrician), Dr Naomi Bowers (GP), Dr Megan Yap (Developmental Paediatrician), Dr Theresa Johnson GPLO, Dr Tanusha Ramaloo GPLO, A/Prof. Deepak Doshi (CMO WMHHS), Dr Ian Shellshear (Developmental Paediatrician) presented with Dr Rebecca Kerr (not pictured) at the Paediatric Symposium.



GP representation on Statewide Clinical Networks

Statewide Clinical Networks improve patient outcomes and processes of care across Queensland. Statewide Clinical Networks are a key initiative of Clinical Excellence Queensland (CEQ) to engage clinicians from multidisciplinary backgrounds and consumers in decision making about clinical services planning and implementation, clinical practice improvement, quality and safety enhancements.

As the peak body of expertise in Queensland, the Statewide Clinical Networks serve as an independent point of reference for clinicians, Hospital and Health Services and Queensland Health. GP representation provides an integration mechanism between primary care and hospital-based care, from the primary care perspective and an understanding of the transfer of care information requirements from a General Practice perspective. GP representation is funded by the Healthcare Improvement Unit, Clinical Excellence Queensland.

Central Queensland, Wide Bay, Sunshine Coast PHN is contracted by Queensland Health for the administration, support and recruitment of GP representation to the networks and sub-groups as required. Recruitment for GP representation on Statewide Clinical Networks was initiated and supported by CheckUP Australia under its contract with Queensland Health. Since May 2019, the PHN, in partnership with the Healthcare Improvement Unit, has supported the recruitment of GP representatives to a number of Statewide Clinical Networks, subgroups and Quality Councils.

Recruitment is initiated through Expressions of Interest to general practice distributed through the Queensland General Practice Liaison Network, PHN practice visiting officers and wider general practice contacts that the Queensland General Practice Liaison network maintains.

For more information about the administration and recruitment of GP representation on Statewide Clinical Networks, please contact admingplonetwork@ourphn.org.au

For information about Statewide Clinical Networks visit https://clinicalexcellence.qld.gov.au/priority-areas/clinician-engagement/statewide-clinical-networks

GP Representation EOIs 2019-2020

- Statewide Cardiac Clinical Network
- Statewide Dementia Clinical Network
- Statewide Diabetes Clinical Network
- Statewide Digital Healthcare Improvement Clinical Network
- Statewide Infection Clinical Network
- Statewide Maternity and Neonatal Clinical Network
- Statewide Older Persons Health Clinical Network
- Statewide Trauma Clinical Network
- Statewide Rehabilitation Clinical Network
- Statewide Respiratory Clinical Network
- Statewide Renal Clinical Network
- Statewide Persistent Pain Clinical Network
- Surgical Advisory Committee
- Statewide Adverse Drug Reaction re-exposure prevention working group
- Smart Referrals and Clinical Business Advisory Group
- Termination of Pregnancy Steering Committee
- Queensland Paediatric Sepsis Project Clinical Advisory Group
- Queensland Paediatric Quality Council
- Queensland Child and Youth Clinical Network and subgroups
- Non-Admitted Reform Implementation Group (NARIG)
- Inform My Care Roadshow: Testing and optimisation
- COPD and Reducing Preventable Hospital Admissions Project
- BreastScreen Queensland Strategic Participation Committee
- Wound Management CPC Clinical Advisory Group

GP engagement: GP Smart Referrals

Dr Jon Harper, GPLO
Central Queensland, Wide Bay, Sunshine Coast PHN

GP Smart Referrals is a digital system enabling faster, streamlined management of referrals to and within Queensland public hospitals. The program allows those involved in patient care to better manage the patient journey, improve patient safety and reduce specialist outpatient wait times.

Queensland Health's GP Smart Referrals program was funded by Clinical Excellence Queensland as part of the Specialist Outpatient Strategy 2016-2020. GP Smart Referrals has depended upon timely feedback from GPs about their experiences using the system to identify and design required improvements.

At many stages through the course of development and implementation, the Queensland General Practice Liaison Network (QGPL Network) has been consulted on important issues, such as Clinical Prioritisation Criteria (CPC) template development, promotion to general practice and governance.

During the 18 months of GP Smart Referrals development and implementation, regular presentations were provided to the QGPL Network forums. These presentations provided key opportunities to 'test the water' for template design and generate feedback for the GP Smart Referrals project team.

As most GPLOs work at the interface of primary and specialist care, the network is well placed to understand the needs of GPs, referral administration staff and triaging specialists. Using developed networks, the QGPL Network has been able to rapidly collate user feedback, identify and provide advice to rectify key defects and translation of clinical information through different parts of the system.

The network has also developed a clear vision of the opportunities that the GP Smart Referrals program could bring and the potential role of this new messaging technology in establishing new models of care.

Using Smart Referrals reporting and analytics, GPLOs and Business Practice Improvement Officers (BPIOs) are excited about new data available to streamline outpatient care, such as:

- Enhancing auditing of referrals
- Real time data on service availability
- The potential ability to ascertain CPC compliance.

The QGPL Network continues to advocate for enhancements to the GP Smart Referrals program, working with the program team through representation at the Clinical and Business Working Group.

The QGPL Network chair sits on the Smart Referrals Governance Committee.

Challenges

- Promotion of GP Smart Referrals has been most successful with intense peer-to-peer engagement.
- Due to COVID-19, opportunities for face to face GP engagement and training have been limited.
- Due to initial program issues, some GPs stopped using GP Smart Referrals.
- Now that the GP Smart Referrals initial system issues have been rectified, engagement to re-engage these GPs will be undertaken.

Smart Referrals workflow solution improves varied referral processes in a remote setting

Margaret Windsor, GPLO
Central West Hospital and Health Service

Working as a GPLO in the Central West Hospital and Health Service provides a unique experience. All specialist services are provided by visiting and outreach services in a rural and remote primary care setting where the HHS also manages many of the General Practices.

The Specialist Outpatient Services team manages both private and public referrals and appointments. There are many variations to the models of specialist services provided to enable a comprehensive service for the people of Central West.

As well as some specialties visiting regularly, endocrinology and rheumatology referrals and appointments are referred to external services while other specialties visit a limited number of times during the year, requiring Category 1 and some Category 2 patients to be referred elsewhere to ensure patients are seen within clinically recommended timeframes.

Initial consultations regarding implementation of the Smart Referrals Workflow Solution for Central West HHS Specialist Outpatient Services in January 2019 provided insights to the existing workflow, identifying that existing processes for receiving and handling referrals were not well defined and created an increased patient safety risk. Clinical Excellence Queensland funded Smart Referrals and Clinical Prioritisation Criteria (CPC) as part of the Specialist Outpatient Strategy 2016 – 2020.

The introduction of the Smart Referral Workflow Solution provided a mechanism to improve patient safety by:

- Improving the processes of receiving and tracking referrals, and
- Integrating Clinical Prioritisation Criteria (CPC) into the workflow.

External referrals for specialist outpatient services received by a central hub in Longreach

2019 implementation timeline

February: GPLO begins visits to general practices across the HHS, including consultation with the Specialist Outpatient Services about referral pathways and processes, which resulted in:

- a CPC template for GP clinical software was created to assist with practitioners' buy in and was a great leverage in the initial consultation.
- GPs and general practice staff responded positively about the CPC implementation

"It is actually a lot of stuff we already know"

March: Engagement with Clinical Excellence Queensland's Smart Referrals team.

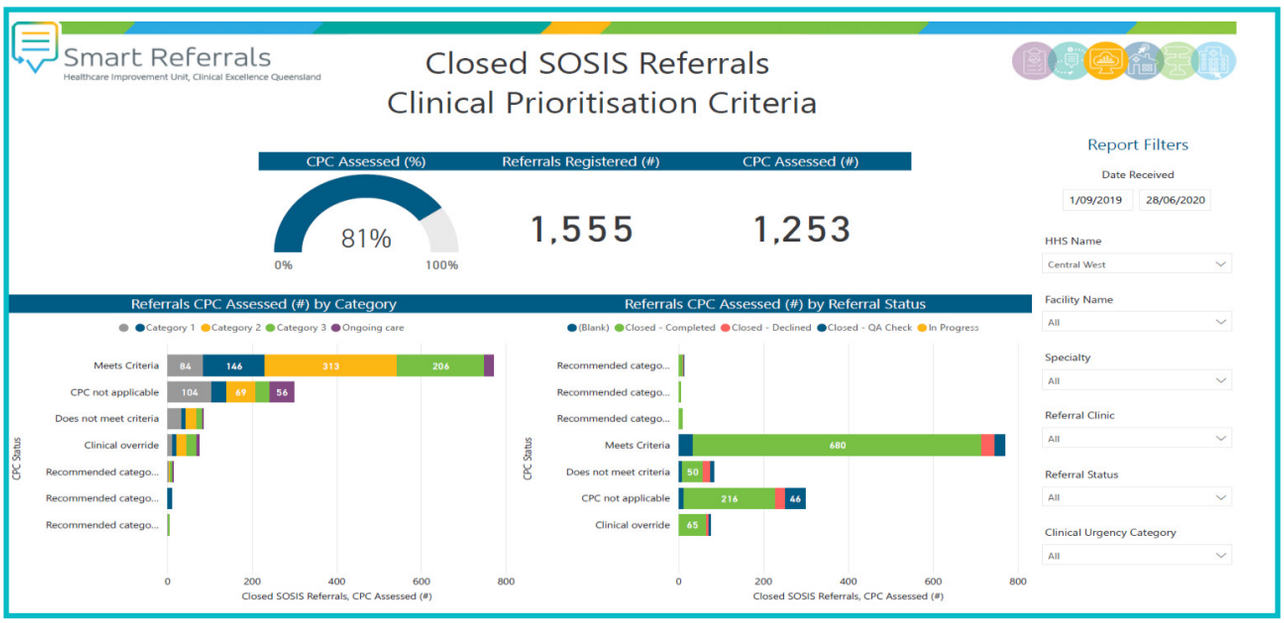
April: The GPLO followed up the initial visits with a 30-minute presentation at a Central West HHS-wide doctors breakfast meeting via video conference to reinforce CPC key messages, further demonstrate the use of the template in the clinical software and the CPC website.

May: Boot camp held.

Implementation project plan submitted to Smart Referrals project team.

June: Central West HHS begins implementation stage.

9 September 2019: Smart Referral Workflow Solution launched and used to enable CPC triaging and reporting.



1 September 2019 - 28 June 2020

Outcomes and achievements

- The Specialist Outpatient Services team has embraced the Smart Referral Workflow Solution.
- The CPC implementation would not have been as successful without the Workflow Solution implementation.
- Specialties where the visiting physician works in the both the public and private sectors (Ear, Nose and Throat [ENT], Respiratory and Gastroenterology) now have a good understanding of the CPC process and the Specialist Outpatient Services Implementation Standard guidelines for categorisation.
- Access to Sullivan Nicolaides results has been arranged for nursing staff to address the frustration of referring practitioners having to supply additional information such as pathology results.

Challenges and opportunities

- All specialist services are by visiting specialists. Although the referral triaging and CPC application is managed by Central West HHS, only four of the services are public: flying surgical and flying obstetrics; gynaecology services; general paediatrics and orthopaedics.
- Enforcement of CPC compliance with referrals from practitioners and categorising physicians.
- Turnover of nursing staff and high number of locums who assess the referrals, resulting in loss of experience. A planned solution is to identify other existing staff who can be upskilled to manage the triage process until new staff are recruited and trained.
- Responses such as 'we are not progressing your referral' damages complex therapeutic and collegiate relationships in rural and remote areas. A phone call or email to discuss and clarify details would support team building and will be implemented as part of the Central West HHS process, especially where the referrer is an incumbent Central West HHS staff member.
- Central West HHS plans to implement GP Smart Referrals into the GP practices medical software to enable easier access to CPC.

Establishing an extensive GPs with Special Interest program

Dr Michelle Johnston, GPLO
Sunshine Coast Hospital and Health Service

Dr Matt Ranaweera,
GP with Special Interest
Sunshine Coast Hospital and Health Service

During 2018 and 2019, Sunshine Coast Hospital and Health Service (HHS) employed 24 GPs to work as GPs with Special Interest (GPSI). The GP with special interest program was funded by the Healthcare Improvement Unit, Clinical Excellence Queensland as an element of the Specialist Outpatient Strategy.

The GPs with Special Interest were recruited part-time and allocated to 12 specialties: dermatology, gastroenterology, general surgery, gynaecology, immunology, mental health, neurology, orthopaedics, paediatrics, the persistent pain clinic, respiratory medicine, and urology.

This was expanded in 2020 to include cardiology and rheumatology. Further opportunities are being explored in palliative care, radiation oncology and addiction/dual diagnoses.

The GPs are required to hold vocational registration with their specialty college and have a minimum of five years' general practice experience.

In a setting where sustainability and effectiveness of services is critical, GPSIs provide an efficient model of care. The higher discharge rate from GPSI clinics in combination with GPSI-facilitated follow-up plans are an important strategy to reduce wait lists.

GPSIs can help build hospital team confidence in primary care handover and identify which patients can be appropriately transferred back to the regular GP.

The success of the GPSIs has led to interest by other teams in our service as they gain appreciation of the benefits of incorporating a GPSI on their team. We believe it is important to continue to develop and invest in integrated models of care as they can be part of the solution to a growing demand on Queensland Health services.

The GPSI model can be easily scaled and implemented in other regions. Our early successes and barriers may benefit others embarking on implementing this model of care.

Achievements

- Patients benefit from shorter waiting times and streamlined care to the most appropriate clinician for their health needs.
- Clinicians benefit from shared learning, upskilling, and improved communication.
- Patients, clinicians and the Sunshine Coast HHS benefit from an efficient model of care that improves access and reduces long waits.

Recommendations for success

- Ensure the new GPSI role is understood and supported by specialty teams.
- Ensure an appropriate cohort of patients.
- Induction of GPs into hospital outpatient processes and systems.
- Sourcing skilled, proactive GPs who are often already committed to private practice.

Specialty long wait list % change (January 2018 – December 2018)

↓ 72%	↓ 42%	↓ 39%	↓ 24%	↓ 4%
Gastroenterology *(Dept focus not solely GPSI impact)*	**Orthopaedics** *(Cat 3 discharge back to GP)*	**General surgery** *(GPSI reviews allowed consultant to double new patients)*	**Neurology**	**Urology**

↓ 1%	↑ 10%	↑ 57%	↑ 165%
Respiratory general	**Dermatology** *(loss of consultant staff)*	**Paediatrics** *(increased referrals)*	**Gynaecology** *(new cervical screening program impact)*

Proportion of long wait lists reduced in two-thirds of the specialties measured.

Waitlists were not measured in immunology, mental health and persistent pain. Number of episodes of care provided and clinical outcomes were measured with positive results.

L to R: Dr Sam Manger, Dr Michelle Johnston, Dr John Wakefield and Associate Professor Carl de Wet at the Clinical Excellence Showcase, 2019. Dr Manger and Dr Johnston presented on the Sunshine Coast GPSI program. Event MC A/Prof de Wet was instrumental in building the GPSI program at the Gold Coast Hospital and Health Service.

Dr Heather Courtney, GPSI, Gynaecology.

Children's Health Queensland Hospital and Health Service

Enabling GP integration with rehabilitation services

Dr Aaron Chambers, GPLO
Children's Health Queensland Hospital and Health Service

Melanie Mildenhall, Physiotherapist
Children's Health Queensland Hospital and Health Service

The project aim was identification of key points in the inpatient rehabilitation pathway where integration with GPs is most beneficial, including the best approach for maximising outcomes during transfer of care from the hospital to the community setting. This project was funded by Clinical Excellence Queensland through the Statewide Rehabilitation Clinical Network.

Three specialised Queensland Health rehabilitation services were identified as the pilot sites for GP integration during the project from October 2019 – June 2020.

Implementation of the new model of care was developed and trialled at the three pilot sites:

- Cairns and Hinterland Hospital and Health Service
- Gold Coast Hospital and Health Service
- Children's Health Queensland Hospital and Health Service.

This included working closely with the GPLOs.

In November 2019, Melanie Mildenhall, project lead and physiotherapist at Queensland Paediatric Rehabilitation Service, Children's Health Queensland Hospital and Health Service, presented to the Queensland General Practice Liaison Network Forum about the project.

The General Practice Liaison Network provided feedback that assisted with identifying enablers and barriers to the proposed project outcomes and model developed for specialised rehabilitation services to integrate with general practice.

Solutions implemented:

- A new model of care, with recommendations for GPs and Rehabilitation Clinicians to support GP integration.
- Resources for consumers, GPs and rehabilitation clinicians developed to support transfer of care or patients and their families from inpatient rehabilitation to community general practice services.

Survey recommendations

A survey was conducted across various healthcare settings in Queensland and interstate through multiple networks including the QGPL Network, with 45 responses which provided the following recommendations for implementation:

- Clear expectations for content and timeframe for completion of inpatient rehabilitation discharge summary.
- Clear processes and contacts for multi-modal communication with Rehabilitation Units.
- Education for rehabilitation clinicians on the GPLO role, including building awareness that the role exists (and where) and their role in supporting patients to identify a GP.
- Education for GPs on available rehabilitation services.
- Further exploration of novel practices (such as a community rehabilitation registrar doctor medical training position) already in place at other facilities.
- Further exploration around the use of technology, including health software platforms for communication.

As the primary aim of general practice liaison is to identify and address service gaps between primary care and hospital settings, the QGPL Network has been very keen to support the development of resources and relationships that improve integration between GPs and rehabilitation services.

Using GP feedback to improve junior doctor transfer of care documentation

Louise O'Reilly
Mater Health

Education has always been a key focus area of the GP Liaison work. Complementing an annual education program designed for GPs, Mater delivered a series of sessions in 2019 for hospital clinicians facilitated by a GP Educator to build capacity and improve the quality of handover at transfer of care.

This opportunity for bilateral learning across settings is an important strategy for continuity of patient care and integration between hospitals and general practice. Historically, the review for quality in discharge summaries at transfer of care has been overseen by internal clinical supervisors, not by the clinicians receiving the transfer of care documentation. To address this, the GP Liaison Program partnered with the Mater Medical Education Unit to initiate a new learning series in 2019.

Based on the premise that clinical handover should satisfy the needs for continuing care by the receiving clinician, a GP led education and audit rotation was designed for junior doctors and built into the existing Practice Improvement Program. Co-designed and facilitated by Dr Monica Steel, a GP in private practice and working with extended practice in the orthopaedic department at Mater, the education includes:

- Foundational education session on transfer of care and clinical handover: why, what, how.
- Individual review of randomly selected summaries authored by participants.
- Follow up feedback session with Q&A between facilitator and participants.

Outcomes

- The Medical Education Unit evaluates the sessions through participant feedback which indicated extremely high satisfaction with the session facilitation and that the content was meeting their learning needs.
- "This has been a valuable resource for our junior doctors. They appreciate the individualised feedback which has led to improved communication with their GP colleagues in the community, ensuring continuity of care upon discharge," said Dr Ryan Frazer, Mater Director of Clinical Training.

Achievements

- Establishing the program of work has taken time for relationship and profile building within the organisation by asking: How can we leverage the feedback and intelligence of our partners in primary care to build our capacity within the hospital?
- An enabling strategy in shifting this narrative was a deeper dive into the request for information process through the privacy office that revealed a rich source of information around the types of information requested by our GP partners.
- This question and supporting data has moved education conversations in the GP Liaison space away from traditional topics of referral quality and service navigation aimed at GP audiences to what hospital-based clinicians can learn from medical peers in the community setting.

Challenges

Sustainability in team resourcing has been a challenge to this work. The integral resource of a GP Educator as Subject Matter Expert has been recognised by the Mater Education team who are working to support a submission to ensure the ongoing delivery of the program with the GP Liaison team.

Developing a shared care model for maternal and child health in regional Queensland

Helen Wiltshire, Maternity GPLO
Central Queensland, Wide Bay, Sunshine Coast PHN

I've been in the GPLO role in Central Queensland since 2017 and have enjoyed the opportunity to facilitate communication and collaboration about maternity care between GPs and the local hospitals.

GP Antenatal Shared Care had not been a well recognised option for maternity care in the Rockhampton region, despite the known benefits for pregnant women and their families from other shared care programs operating in Queensland.

Central Queensland HHS and OurPHN have worked towards establishing a shared care maternity program, facilitating educational workshops and developing tools to provide resources for maternal shared care. The increased educational opportunities for general practice in relation to maternity care were greatly supported by General Practitioners.

Central Queensland HHS and the obstetrics and gynaecology specialist staff have supported this role and been actively involved in providing education topics at our workshops. The education workshops have been running successfully in a face to face format, and successfully transitioned to an online platform in 2020 due to COVID-19 requirements.

Although the professional network and collaborative opportunities that are part of face to face events were missed, it was great to be able to provide the education to all General Practitioners whether or not they were able to attend the face to face events.

Challenges

- Moving education to online platform and missing the professional networking and collaborative opportunities that are part of face-to-face events.
- GPs having all updates provided by webinar, and the fatigue of dealing only in this medium.
- Not able to do face to face practice visits due to COVID-19.

L-R: Dr Helen Wiltshire, GPLO, and Stephanie Chen, Children by Choice, at February 2020 workshop in Rockhampton.

Shared Care resource card

- guideline to antenatal shared care and contact details for HHS maternity providers

Women's health workshops

- February 2019 and 2020

February 2020 workshop

Children by choice

- upskilling in management of unintended pregnancy in general practice
- 27 participants
- GPs, GP registrars, medical students, practice nurses

Women's health

- Presentations from GPs, physio, obstetrician and gynaecology specialists
- 30 participants
- GPs, GP registrars, medical students, hospital doctors, GP practice nurses

Antenatal shared care GP workshops

- Up to **40** participants
- October **2018**: Rockhampton Hospital
- **October 2019: Rockhampton Hospital and** Gladstone evening workshop

Webinars

August 2020: Introduction to shared antenatal care

- 16 attendees
- GPs and practice nurses
- Designed to fill some of the gap due to cancellation of October face to face workshop

September 2020: Pregnancy at higher BMI and after bariatric surgery

- **Louise Bolger**, Senior Dietitian from Gladstone Hospital presented on specific needs of pregnant women following weight loss surgery
- Small numbers, but highly evaluated
- Both sessions recorded for PHN YouTube channel

A dynamic collaboration

Michelle Reynolds, GPLO
Metro South Hospital and Health Service

The Metro South Health GP Liaison Officer Program (MSH GPLO) and Brisbane South Primary Health Network Regional Support Coordinators (RSC) continue to develop a dynamic, cohesive and collaborative partnership.

The MSH GPLO is a unique nurse-led program which consists of integration and engagement GPLOs who provide phone and face to face support to primary care and participate in new models of care across Metro South Hospital and Health Service (HHS).

This collaborative relationship has developed into a successful working partnership consisting of fortnightly team meetings, twice yearly joint planning days, shared goals and a commitment to greater communication and transparency. Coordination of messaging along with joint visits highlights the strong relationship and shared approach to support General Practice.

A data sharing agreement allows the GPLO and RSC teams to drive targeted engagement with general practices including the highest referrers and practices having higher revised referrals across Metro South Health. This data-led engagement has reduced incomplete or duplicate referrals, completed Secure Transfer Service (STS) address book entries, increased Health Provider Portal (HHP) GP registrations and increased awareness of the General Practice Liaison program's value.

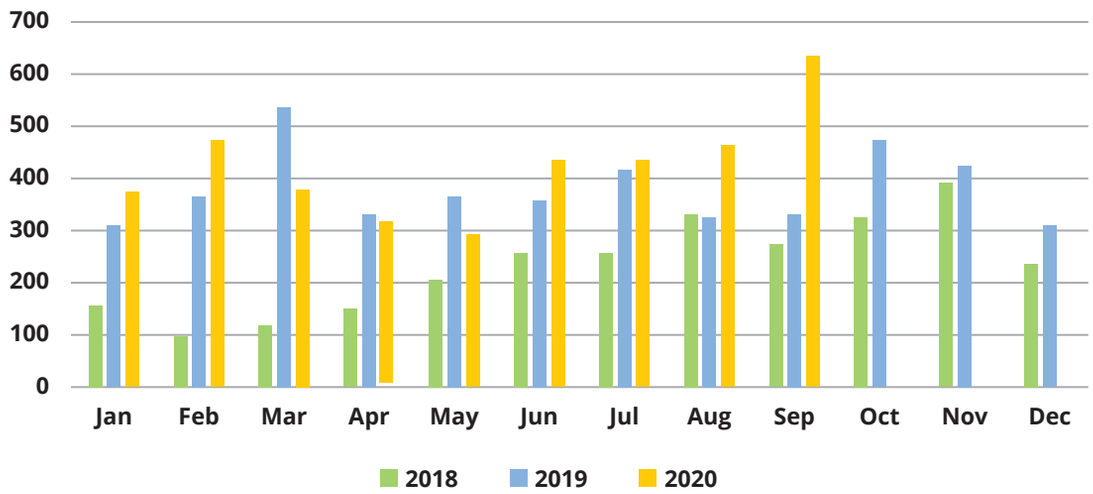
Outcomes

- Joint engagement between HHS and PHN has improved the relationship with primary care.
- Joint messaging to GPs to improve the patient's journey through the healthcare system.
- Joint initiatives such as SpotOnHealth HealthPathways, GP access to the HPP, STS address book updates, shared GP orientation packages, seminar presentations, representation at General Practice Training Queensland and practice manager coffee mornings.

Achievements

- Between January 2018 and September 2020 General Practice contact grew from 150 to 633 points of engagement per month.
- General Practice now contact the GPLO team for advice about GP Smart Referrals, referral pathways, essential referral Information (CPC Guidance), clinical handover, and referral progress.

GPLO - General Practice contact 2018-2020 (external/internal/SOH)



Thoughts from a new Metro South GPLO

As a new member of the team, each GP Liaison Officer has shared with me their diverse wealth and breadth of knowledge to work together in achieving optimal outcomes for patients. I also enjoy the collegial relationship between the MSH GPLO Program and PHN Regional Support Coordinators as we share information to improve the communication between primary and secondary care. Since joining the MSH GPLO team I've appreciated its positive unit culture which encourages innovation and collaboration, and I feel I can make a valuable contribution to the GP experience of Metro South Health and in turn improve the patient journey.

- Casey Riches, GPLO

L-R: Danielle McLeod, Lisa Lee, Michelle Reynolds, Alison Skiba, Casey Riches (Metro South Health GPLO Project Team)

Improving health outcomes for children in out-of-home care

Dr James Chanaka, GPLO
Central Queensland, Wide Bay, Sunshine Coast PHN

Central Queensland, Wide Bay, Sunshine Coast PHN is working with GPs, child safety officers, foster and kinship care services, health and wellbeing services, carers and parents in Maryborough and Hervey Bay to improve the health outcomes of children in out-of-home care.

Funded by the Department of Child Safety, Youth and Women, the Out-of-Home Care Project is a state-wide strategy led by PHNs and first launched in 2018.

The project aims to improve health outcomes by strengthening the health assessment pathways and implementing timely and ongoing health treatment in line with the national clinical assessment framework.

The Maryborough Child Safety Service Centre was selected as one of the pilot sites for this project. Children in out-of-home care (OOHC) are likely to have complex health needs, including poorer physical and mental health and more developmental delays than their peers.

These children may also not be accessing the full range of options available within healthcare services, in part due to placement instability combined with limited coordination and information sharing between service providers.
Dr James Chanaka, GPLO has been working with the Project Coordinator Lee Hammond across the Maryborough and Hervey Bay region, providing training on the national clinical assessment framework to general practice and other key stakeholders.

In April 2019, a Community of Practice was established that aimed to strengthen local health pathways and improve communication strategies. This brought together all professionals and foster parents involved in the management of children in OOHC to navigate ways of having a health pathway for children and young people in care, from the day they leave their homes and enter care.

GPLO role

- An advisory role in developing care models and ensuring that policies and pathways were practical and appropriate.
- Information dissemination to foster parents, other GPs, child safety officers and ensuring the completeness and accuracy of the information within HealthPathways for children in care.
- Liaising with the Wide Bay HHS paediatric services about shared care between paediatrics and general practice.
- Boosting communication between GPs and the department of child safety.

Closing the loop for patient correspondence

Dr Toni Weller, GPLO
Townsville Hospital and Health Service

Townsville HHS GPLO team uses the Queensland Health secure file transfer communication tool, Kiteworks, and email (depending on practice preference) for returned clinical correspondence from general practices.

This creates a central place to forward communication from the appropriate internal departments, including emergency department letters, outpatient letters and discharge summaries.

With the GPLO team central knowledge of practices, we can often identify delivery failure errors and advise the internal department involved and Enterprise Discharge Summary (EDS) Coordinator.

As part of this work the GPLO team updates the GP directory in our Hospital Based Corporate Information System (HBCIS) patient registration module and is now responsible for advising our clinical information services department of GP changes in the community and keep the HBCIS address book updated.

The GPLO service also takes direct responsibility for maintaining the accuracy of our region's GP and practice details in the Secure Transfer Service address book at least annually. Previously, these updates relied on GP practice managers and administrative staff to complete this task.

In addition, we have worked with our Business Practice Improvement Officer to create a simple procedure for typists to determine the correct general practitioner for outpatient letters and the GPLO email has been added to letter footers.

These actions in ensuring the GP communication is addressed correctly and delivered accurately are critical for maintaining patient safety across the interface between primary care and secondary care.

Outcomes

Patient safety during transfer of care achieved by:

- Accurate record of patient's GP maintained by updating directory in HBCIS for each patient.
- HHS patient communication delivered accurately and securely to GP.

Expanding General Practice Liaison with the establishment of Mater Queensland

Louise O'Reilly, GPLO
Mater Health

In Queensland's south-east corner the Mater GP Liaison Program works with neighbouring HHSs and PHNs to support strategies of public health service navigation, improved communication and service access.

In 2020, Mater private hospitals and services in the northern and central Queensland regions merged with those in the south east, bringing the opportunity to scale a methodology of collaboration based on local need and priority.

The Mater GP Liaison Program is investigating how regional Queensland private sites can work better to establish local collaboration and improvement by leveraging the established partnerships and connections within the QGPL Network.

The formation of Mater Queensland provides the opportunity to inquire with interest and curiosity through the local members of the QGPL Network:

- What can we work on better together?
- What are the priorities for primary care?
- And what role can a private hospital play?

Early opportunities include:

- Sharing intelligence – bringing the primary care view to the hospital setting
- Participating more through HealthPathways
- Planning, coordinating, resource sharing for education
- Joining the dots – perspective sharing on local service issues
- Partnering not duplicating

The role of partnerships

One of the enabling strategies in health integration is the development of partnerships between many different groups. This might include the government sector and non-government agencies as well as local communities and individuals.

Since the establishment of the QGPL Network the associated network of individuals working in roles across the state has matured and evolved.

The diverse skill mix within the inter-professional QGPL Network brings a depth of knowledge of persistent and emerging health systems issues and innovative responses from the perspective of the primary care sector.

The collective of practitioners also has a well-grounded insight into local needs and issues that are relevant to communities across Queensland.

There is also a level of engagement and cross pollination of the network to other key areas such as HealthPathways, Smart Referrals and hospital avoidance; while consultation with E-Health projects and programs ensures these significant strategies are informed about the needs of primary care and supported by the active QGPL Network.

2020 has been a year of significant and overwhelming change and has highlighted the need for cross sectoral cooperation by building on established programs of good work. For Mater, as a private organisation working closely with Queensland Health across initiatives, particularly in south east Queensland, this state-wide merger presents new and exciting ways to scale previous years of work of the QGPL Network into new sites in other regions.

Contact us

Healthcare Improvement Unit

07 3328 9148

HIU@health.qld.gov.au

Central Queensland, Wide Bay, Sunshine Coast PHN

07 5456 8100

admingplonetwork@ourphn.org.au