QUEENSLAND PRIMARY HEALTH NETWORKS

Submission to the Queensland Parliament Community Support and Services Committee

Inquiry into social isolation and loneliness in Queensland

August 2021

Submission made by:

Queensland Primary Health Network

Contact Details: Michelle Marks Mobile: [redacted]

On behalf of the Chief Executive Officers of:

Brisbane North PHN

Brisbane South PHN

Darling Downs West Moreton PHN

Gold Coast PHN

Central Queensland, Wide Bay, Sunshine Coast PHN

North Queensland PHN

Western QLD PHN

Acronyms used

ACCHO	Aboriginal and Torres Strait Islander Community Controlled Organisation
HHS	Hospital and Health Service
CALD	Culturally and Linguistically Diverse
PHN	Primary Health Network
QPHN	Queensland Primary Health Network
RACF	Residential Aged Care Facility
MHAOD	Mental Health Alcohol Other Drugs
LGBTIQA+	Lesbian, Gay, Bisexual, Trans/Transgender, Intersex & Queer/Questioning and Asexual
PEN CAT	PEN Clinical Audit Tool
BN PHN	Brisbane North PHN
BS PHN	Brisbane South PHN
DDWM PHN	Darling Downs West Moreton PHN
GC PHN	Gold Coast PHN
CQWBSC PHN	Central Queensland, Wide Bay, Sunshine Coast PHN
NQ PHN	North Queensland PHN
WQ PHN	Western Queensland PHN
WMHHS	West Moreton Hospital and Health Service

Introduction

This submission is made on behalf of the Queensland Primary Health Networks (QPHNs).

In 2015, the Commonwealth PHN Program established 31 PHNs nationally to strengthen primary care and improve patient centric service integration.

PHNs are primarily funded by the Commonwealth Department of Health with the aim of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and to improve coordination of care to ensure patients receive the right care in the right place at the right time, through –

- increased understanding of local health needs,
- the development of effective partnerships fostering integration (particularly with Hospital and Health Services (HHSs) and
- innovative ways of commissioning services.

PHNs are also funded for specific services or projects by various Queensland Government Departments (e.g. Child Safety) or individual HHSs.

The focus of the QPHNs is on primary care through the support of General Practitioners, and working with a range of government and community organisations, service providers and the community to develop and better integrate health and community care services, and improve access to services with an emphasis on those most vulnerable people at risk of poor health outcomes.

PHNs are the experts on the primary health needs of their region and the central drivers for planning, reform, integration and equitable access across its health and social care system. As regional commissioners, they reduce fragmentation and address unmet needs working with HHSs and other partners through innovative and consistent service delivery.

PHNs support the health care workforce to build capacity and capability and are positioned to support coordinated primary health care responses to emergency and natural disasters.

The PHN role in coordinating primary healthcare to improve whole-of-life health and wellbeing over the last few years, have proved to be an important resource to the community and the health system in disaster situations including drought, flood, fire and now, the Coronavirus pandemic.

Our Programs

The PHN work program furthers an integrated, coordinated health care system that delivers high quality, patient centred care.

We are committed to the simultaneous pursuit of:

- Improved quality of care and population health outcomes
- Enhanced patient experience of care
- Sustainable cost
- Improved provider experience

We are positioned to achieve this through:

- System coordination and integration
- Regional Commissioning
- Primary care system stewardship and management
- Primary healthcare education, training and workforce development
- Health system transformation and reform

Each PHN assesses the health and wellbeing needs of their communities and produces a comprehensive Health Needs Assessment every three years, which is updated annually. Some PHNs undertake this process jointly with their local HHS. This is based on data on health and wellbeing need, service access and consultation and co-design with stakeholders, including consumers and carers. Our Health Needs Assessments also look at the wider social determinants of health.

In responding to local need PHNs can partner with others to effect change, procure services from providers in the community or directly provide system reform and capacity building activities. PHNs deliver across a number of program areas including:

- primary and allied health capacity building
- integration of primary health, hospital services and community care
- mental health and suicide prevention
- alcohol and other drugs treatment
- Aboriginal and Torres Strait Islander health
- chronic disease
- aged care
- digital health
- health literacy
- service navigation
- place-based health and wellbeing priorities
- disaster response

PHNs continue to improve the health outcomes of the communities they serve. PHNs now lead the commissioning of a wide range of services to address local needs across national and local health priorities, provide practice support for Primary Care providers and drive system integration across state and federal health jurisdictions as well as the interface with disability, aged care, social and community services.

The National Health Reform Agreement 2020 includes substantive requirements for jurisdictional Departments of Health and HHSs to establish and progress working partnerships with PHNs. The proposal for a National Mental Health Reform Agreement would likely see a prominent role for PHNs in the ongoing reform of the mental health system.

QPHNs are pro-actively working with Queensland Health on developing regionally based mental health commissioning and comprehensive joint regional planning. We seek efficiencies in the use of resources that results in improved system responses and better health outcomes.

Our strengths

1. The QPHNs demonstrated their agility and effectiveness in rapidly responding to COVID-19, enabled by their existing relationships with general practices and commissioned clinical providers, in addition to ACCHOs, pharmacists, allied health providers, Residential Aged Care Facilities (RACFs) and primary care peak organisations.
2. QPHNs have strong networks with consumers, community organisations and community leaders. They possess extensive local knowledge and health intelligence assembled using a variety of tools including GP data via PEN CAT and PHN Health Needs Assessment processes.
3. PHNs support primary health care to quickly adopt new models of care and adapt technology into practice for improved health outcomes. The creation of virtual health services and their benefits continue to be a critical service accessibility pathway during the pandemic response.

4. PHNs support a consistent, collaborative, strategic approach to primary health care within the broader health system to provide greater health outcomes for populations.
5. Established relationships across the Hospital and Health Services (HHSs) and the primary health and community sectors supports cohesive problem-solving locally. Access to existing primary health models and resources can be adapted and scaled up to deliver a primary care response as needed.
6. QPHNs communication channels with GPs and commissioned services provides for timely, collaborative co-ordination of information and material. This includes social media messaging for consumers, production of media content, website development and publication, and the development and dispersal of resources such as guides, posters, and support materials.
7. Prioritising delivery of place based responses that meet the defined primary care need for those at risk of poor health outcomes, by improving coordination of care to ensure patients receive the right care in the right place at the right time.
8. QPHN CEOs and chairs work continuously with their counterparts in the HHSs, there is untapped capacity at the state level for the PHNs to contribute to and help drive systemic change.
9. QPHNs are all actively working on cross sector programs which work to address the social and emotional determinants of health in communities including Indigenous people, older people, people with a disability and young children.
10. PHN's have a proven capacity to work in an agile and responsive manner, based on changing/evolving regional needs and priorities (something that sets PHNs apart from large government bureaucracies).

Key Issues

Social isolation and loneliness can be harmful to both mental and physical health, while mental and physical health can impact social isolation and loneliness. Through the work of PHNs and our commissioned providers, it is clear that social isolation and loneliness is a significant community need and service gap.

People must be at the centre of all service provision and the needs of the person should be understood holistically. However our health, community care and wider social determinant of health (e.g. housing, employment) systems often work in silos. It is difficult for people and their families to navigate these multiple systems and to stitch together the range of services and supports they need at the right time and in the right place. Greater service navigation and integration support is needed so that people experience a seamless care journey.

Much of service delivery, especially in primary care, is funded on a fee for service basis. People present to providers with symptoms and the practitioner looks for a medical cause for the symptoms and recommends a course of treatment. There is little capacity to understand the underlying social determinants of health and possible social prescriptions for care.

83% of Australians visit a GP at least once each year. This makes GPs central to understanding the health and wellbeing needs of their patients and acting as a gateway to wider services and supports.

QPHNs support of notion of a 'medical home' where patients are registered with a general practice, which understands the full health and wellbeing needs of the patient and is able to respond both reactively and proactively to need. This is especially a priority for people with chronic and complex conditions. Different funding models such as bundled payments or capitation will be needed to enable general practice to respond in this way.

While primary care can respond on an individual patient basis, there also needs to be a response at the community level. As noted in the *Ending Loneliness Together in Australia* White Paper November 2020, loneliness is a consequence of a multitude of factors and therefore solutions will differ across different communities. Place-based solutions that bring together multiple stakeholders to identify a common goal and implement shared actions to achieve their goals are needed. This is a key skill of PHNs that could be utilised to address social isolation and loneliness.

So much of today's society is based on people being seen as individual consumers, purchasing services and experiences. There are few spaces for people to gather and build connection that don't have a cost attached. While service delivery as outlined above is widely funded, community development activities are not. Neighbourhood and community centres, properly resourced, have a key role in building local communities and bringing people together.

Some people identify with and connect with their local geographical community or neighbourhood, but others will identify with a community of interest (e.g. Aboriginal and Torres Strait Islanders, Culturally and Linguistically Diverse communities or Lesbian, Gay, Bisexual, Transgender, Intersex and Queer people). Many people have both a geographical and one or more community of interest identities and connections. Activities to reduce social isolation and loneliness also need to happen within communities of interest, by resourcing organisations for and by those communities. Often this will need to be funded at a regional or state level.

Social media provides a growing opportunity for people to connect with others like them, family and friends, and to find new interests and connections. However access to knowledge, skills and devices is unequal across the community, with cost being a major barrier. The 'digital divide' needs to be addressed to ensure that all people have equitable access to social media and new technologies. Social media can also create or reinforce loneliness and isolation, by creating unrealistic expectations, a focus on physical appearance and online bullying. People need to be equipped with the skills and understanding to manage social media and their online activities.

Bringing a diverse group of unconnected people together and building connection and community is hard and may not always work. Often people develop connections and friendships as a by-product of social interactions. Volunteering can provide a reason for people to come together and through working with each other, develop connections and friendships. More resources supporting volunteering would both result in additional services in the community and increased social connection.

Recommendations

The QPHN makes the following recommendations to the Inquiry:

1. The Qld Government establish a cross government forum, including the PHNs, with responsibility to address the interface of primary health with other sectors, including aged care, disability, social services and communities to leverage off and build on existing initiatives and infrastructure. There must be representation from both urban and rural and remote PHN regions.

2. Any strategies to address social isolation and loneliness leverage off existing infrastructure.

3. The Qld Government considers targeted investment in programs leverage off existing infrastructure. This could include an opportunity to utilise local neighbourhood and community centres to create a place based approach that builds on social connections that foster friendships, support and community connections via a 'clubhouse' model (as exampled by The Junction Clubhouse Cairns)QPHNS recommend both place based and 'community of interest' approaches. That is targeted strategies to address social isolation and loneliness be tailored to local needs and address relevant communities of interest (e.g. First Nations people, CALD, LGBTIQA+) and be led by community organisations representative of/from those communities.

4. Any strategies implemented should acknowledge limitations exist including digital literacy and accessibility, lack of funding and complexity of implementation. There is limited availability, capability and experience within the paid and volunteer workforce.

5. Agreement to share data between local, state and federal agencies to fill a void in available statistical information that is current, would assist in driving the delivery of services in areas of identified need.

6. In the development to a statewide – strategy to address social isolation and loneliness, the Qld Government consider working collaboratively with the QPHN to leverage off:

   - the existing network and capability of PHNs as commissioning organisations that can codesign and support targeted interventions that meet local needs throughout Queensland;
   - build responses that are informed by statewide data as well as drawing from QPHN local need assessments;
   - leverage QPHNs ingrained knowledge and understanding of their communities and vulnerable groups within them;
   - tap into QPHNs ability to plan, respond and scenario test program responses in clinical and community settings.

QPHN Exemplars

These examples have been chosen based on their capacity to demonstrate innovation, integration and cross sector collaboration in the Queensland primary health sector.

PHN	Example
BN PHN	BN PHN has funded 3 services to provide support to older Australia's in a stepped care approach. This includes care coordination delivered through our three mental health hubs, psychological therapies and a community peer navigator program. Most notably, the Community Peer Navigation Program is a new program developed and delivered by COTA Queensland in local libraries to support older people to: - Find reliable health and wellbeing information - Access free library resources – including technology upskilling - Discover new activities and opportunities to socialise in their local area - Connect and access carer supports - Connection within the community The program is delivered by peer navigators who are volunteers aged 55 and over who live locally, have strong community connections and have a desire to help reduce social isolation and loneliness of older Australians. COTA Queensland has partnered with the local libraries who are involved to take on this program and the volunteers at the end of the funding cycle to ensure sustainability and continuity of supports. An evaluation of this program will also be conducted to demonstrate the effectiveness and provide recommendations and learnings for future programs.
DDWM PHN	DDWMPH is currently undertaking two social prescribing projects – • one is based on lifestyle modification programs (targeting people with "at risk" health concerns such as diabetes). This is in partnership with Checkup. We are using two platforms, GoShare and green prescriptions.

	• The other is just in its infancy. This social prescribing project is in partnership with Health and Wellbeing Queensland and WMHHS and is one part of a broader project which is focusing on the health and wellbeing of the youth and young people in the West Moreton area. While these are not specifically about social isolation it is felt that there will be multiple benefits included increased social participation.
GC PHN	• Establishment of various regional governance and working groups to support the delivery of Gold Coast Joint Regional Plan initiatives. • Joint commissioning of a role between GC PHN and GCH to support regional planning and service integration – under development • Development and implementation of a data governance and information sharing agreement between GC PHN and GCH. • Development and implementation of safe and secure client data sharing between GCH and Wesley Mission to support client continuity of care for The Way Back Service.
CQWBSC PHN	CQWBSC PHN has a number of programs and initiatives that demonstrate innovation, integration and cross sector collaboration and evaluation in the Queensland primary health sector. **Moving Moments** is an innovative cross-generational social and centre-based creative program to Seniors (people over 65 and First Nations people over 55) in Biloela, Caloundra and Hervey Bay who are living independently in the community. The program aims to: • Facilitate respectful discussion and building of relationships over time between students and older people • Teach Older Persons how to use smart phones, tablets, and laptops so that they can increase their contacts with families, friends, and each other • Build sustainable social networks for the Older Persons which can occur outside of the activities provided • Create meaningful cross-generational connections • Arrange visits to art galleries, parks, concerts etc to build social networks • Reconnecting Older Persons with social networks • To break down inter-generational barriers and create a valuing of older people and their ability to provide a unique perspective and input to the lives of younger people in our society Moving Moments is an enhancement on Lutheran Services existing pilot program. The evaluation to date shows the positive outcomes for both the children and older persons who are involved. This initiative is being evaluated by Griffith University. **Older Person Strategy:** As a key priority group for the PHN, we are embarking on developing an Older Persons Strategy. The Strategy will focus on the PHN's priorities for older persons' health for the next 5 years to ensure our investments and activities meet the needs of our communities. The vision and aims of the Strategy will assist us to stay focussed on the outcomes we want to achieve. This is being achieved through a collaborative codesign process working across the PHN programs.
NQ PHN	Veteran community health and wellbeing A Community Grants Program to enhance connections in the Veteran Community. The grants are intended to encourage applications from Ex-Service Organisation, veteran community groups and associations. Projects and activities are sought that improve the wellbeing of the

	members of the ex-ADF community, including families. Specifically, projects and activities must focus on at least one of the following areas to assist ex-ADF members and their families: strong social connections, good physical health, good mental health, and respect and recognition. Similarly, after the February 2019 monsoon event within the Townsville Hospital Health Service region, an identified area of need was in supporting communities to drive their own recovery based on that community's need. Community grants were administered to hold community-based events and/or activities that promoted social cohesion and community resilience. It is envisaged that the community grants would allow Local Government Authorities (LGAs) to drive community recovery through community-led approaches that understand the community context and build community capacity through community-based events and/or activities that promoted social cohesion and community resilience. Specifically, events and/or activities could target social, mental, and/or physical wellness through the below criteria: • support the development or operation of local community networks or coordinating alliances that help create linkage within the community that promotes wellbeing, • increase community health and wellbeing by promoting early help-seeking as well as health information and resources that meet the diverse needs of the population, • increase community cohesion and engagement focused on providing an opportunity for people to connect, share experiences, and enhance individual and community wellbeing and resilience and to build strength and capacity for the future, • increase inclusiveness and participation of hard-to-reach individuals and priority segments of the population who are experiencing hardship due to extreme climatic conditions.