



**Queensland  
Parliamentary Health and  
Community Services  
Committee**

**Inquiry into**

**Palliative Care  
Services and Home  
and Community Care  
Services in  
Queensland**

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**HEALTH AND COMMUNITY  
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*Submission 24*

Signed by and with the authority of:

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Submission by Blue Care and UnitingCare Health to the Inquiry  
into Palliative Care and Home and Community Care Services in  
Queensland

**Table of contents**

1.	Introduction	4
2.	Background	5
3.	Blue Care's Submission	6
3.1	Blue Care's Service Model	7
3.2	Home and Community Care Services	7
3.3	Community Care Program	7
3.4	Disability Services	8
3.5	Palliative Care Services	8
3.6	Residential Services	9
3.7	Services Delivery Challenges	9
3.8	Funding Issues	10
4.	UnitingCare Health's, The Wesley Hospital Submission	13
4.1	History of the Palliative Care Service and Oncology services at The Wesley Hospital	13
4.2	Strengths and Weaknesses of the service	15
5.	Future opportunities for Service Improvement	18
6.	References	20

## 1. Introduction

UnitingCare Queensland delivers quality and compassionate care through its network of service groups which include Blue Care, UnitingCare Health, UnitingCare Community and Crossroads.

This submission briefly addresses the inquiry terms of reference within Blue Care and UnitingCare Health's The Wesley Hospital. Representatives from Blue Care and UnitingCare Health look forward to the opportunity to discuss the terms of reference with the members of the committee in more detail in person.

Both organisations have played substantial roles over long periods of time in the Palliative Care and Community Care areas in Queensland. Each is recognised for their work in this area which has included being members of the Queensland End for Life Alliance commissioned by Queensland Health.

Blue Care recently participated in the Australian Government's Senate Standing Committee on Community Affairs' inquiry into Palliative Care in Australia by submitting a paper and appearing at the public hearings. The submission is published on the official Senate website.

It is our belief that the current system of funding and delivery of palliative care, which is reliant on secondary funding through hospitals, requires reform.

## 2. Background

UnitingCare Queensland is the health and community service provider of the Uniting Church and supports more than 14,000 people throughout the state every day of the year. With over 15,000 staff in more than 400 geographic locations across Queensland, UnitingCare Queensland is one of Australia's largest non-profit health and community service providers.

### ***Blue Care***

Blue Care is one of Australia's largest not-for-profit providers of residential aged and community care. We support community based clients, residents of our aged care facilities and their families, throughout Queensland and northern New South Wales, through all the stages of palliative care.

Our passion is to assist people to remain independent for as long as possible. As part of UnitingCare Queensland, we are committed to providing quality holistic care services that express the Uniting Church's Christian values and address the physical, intellectual, emotional and spiritual needs of the people we care for.

Our palliative care program incorporates recommendations made by Palliative Care Australia, which has been active in the development of a number of palliative care best practice documents.

### ***UnitingCare Health***

Launched on June 13, 2000 UnitingCare Health now operates one of the largest not-for-profit private hospital groups in Australia. The group of hospitals contain over 1,034 licensed hospital beds spread amongst our five facilities. Hospitals operating under the UnitingCare Health banner include The Wesley Hospital, St Andrew's War Memorial Hospital, St Stephen's Hospital Maryborough and Hervey Bay, and The Sunshine Coast Private Hospital.

Today the group employs approximately 3,520 staff, being a mix of full-time, part-time and casual. UnitingCare Health will admit around 97,000 Queenslanders in these 12 months and undertake around 66,000 surgical procedures.

Hospitals operating under the UnitingCare Health banner include The Wesley Hospital, St Andrew's War Memorial Hospital, St Stephen's Hospital Maryborough and Hervey Bay, and The Sunshine Coast Private Hospital.

### 3. Blue Care's Submission

**Table 1: Overview of the scale of Blue Care's services**

Staff employed	8,396
Volunteers	2,200
<b>Residential aged care</b>	
Number of Aged Care Facilities	50
Number of operational residential aged care beds (approx. 2.5% of funded residential aged care beds)	4,346
Days of residential aged care provided per annum	1,500,079
Provisional	278
Number of Independent Living Units	1,110
<b>Community care</b>	
Number of client home visits per annum	2,873,549
Number of occasions of service per annum	3,465,568
Number of community care centres	80
Number of respite centres	55
Number of day therapy centres	9
Number of Commonwealth Respite and Carelink Centres	4
Number of Community Aged Care Packages (CAPS)	1,431
Extended Aged Care at Home Packages (EACH)	207
Number of National Respite for Carers Programs (NRCP)	22

*Source: Blue Care as at 30 June 2011*

### 3.1 Blue Care's Service Model

In February 2012 after an extensive state-wide community consultation process, Blue Care launched its new service model - *Blue Care Tailor Made*.

Blue Care's service model approach places the person at the centre of all we do. Each individual's uniqueness is appreciated in an equal partnership. The role of the family and friends is also recognised and is an important part of the partnership. Guided by the individual's needs and wants and their skills and abilities we aim to design and deliver service and accommodation solutions that are individually 'tailor made'. Services will then be delivered in such a way that the person is in control rather than controlled.

There are five key components of *Blue Care Tailor Made* – *Connecting, Wellbeing, Restoring, Caring, and Dying with Dignity*. A person can engage with one or several components at any time to receive a combination of care and services that is right for them.

### 3.2 Home and Community Care Services

Blue Care provides Home and Community Care Services (HACC) for people over the age of 65 years across a range of service types including:

- Nursing care
- Allied health support
- Domestic support
- Personal care
- Social support
- Respite services
- Meals
- Home assist services

Blue Care is contracted to provide 2,547,072 hrs of care in the HACC program for 2012/13.

### 3.3 Community Care Program

Recently with the transition of aged care services to the Australian Government, Blue Care has signed a contract to deliver community care services across Queensland to people under the age of 65 and ATSI under the age of 50. Blue Care is contracted to provide 1,363,651 hrs of care in 2012/13, delivered predominantly through services which also provide HACC services. Many people with acquired disabilities e.g. Parkinson Disease, Multiple Sclerosis and degenerative neurological conditions access services through this funding. In addition people with chronic conditions also access either HACC or Community Care Program funding, depending on their age and if support is required.

### 3.4 Disability Services

Blue Care provides specialist disability services to 380 clients in the 2011/2012 financial year, across a number of service types including supported accommodation, living and lifestyle, and respite. In 2008, 57 percent of people who had specialised disability funding also accessed HACC funding to further support their needs. It is anticipated that many of these people will continue to access support through the Community Care program because their support needs are higher than the support provided within their current disability service funded program.

### 3.5 Palliative Care Services

Blue Care has adopted the recommendation made by Palliative Care Australia regarding service levels and provides primary care palliative services in the form of:

- multidisciplinary palliative services including clinical management, and care coordination and assessment
- triage and referral using a palliative approach for people with uncomplicated needs associated with a life-limiting illness
- end of life care.

The palliative care support can include clinical services such as nursing and allied health services for quality of life and symptom management; bereavement and grief and loss support for the person and their family; as well as the range of service types included above.

Many people receiving palliative care through Blue Care also access services under HACC or Community Care Programs. In some instances at the time of a palliative diagnosis they will already be in receipt of other services and for others the referral will be generated because of their palliative condition.

**Table 2: Blue Care's scale of palliative care in 2011**

*Source: Blue Care as at 30 June 2011*

Number of clients receiving Queensland Health funded palliative services in the Community	1,228 (27% of these under 65 years old)
Percentage of HACC funded clients receiving palliative care	6.2% (27% of these clients are under 65 years old)
Number of hours of palliative care delivered to community based clients	234,940

NB: Some data extrapolated from Brisbane cluster data due to data collection anomalies.



### 3.6 Residential Services

Blue Care provides Residential services to 4346 beds across the state through 50 aged care residential facilities.

Residential services find providing care for younger people with a life-limiting illness, with or without a disability, challenging as their programs and care are developed for older people who have different interests.

### 3.7 Services Delivery Challenges

Blue Care community services have regular and consistent involvement with many families and are perfectly placed to support care coordination and case management as well as provide a range of clinical and lifestyle services for people with palliative conditions. In many cases, clients are adequately supported through the palliative stages of their condition by Blue Care without the specialist palliative care team involvement and without additional funding.

However there are a number of challenges which occur consistently across the state. These include:

**Inadequate Support for families:** Families are faced with inability to access services they expect and need because of service capacity and funding limitations. In addition this may sometimes mean that families take on more of the burden of caring for their loved one at home, including attending to equipment and administering medication through syringe drivers. Access to flexible respite options is also limited. People often want respite in their own home and overnight.

**Rural and remote:** Families living in rural areas are faced with the challenges of travelling to regional and metropolitan area for treatment and then often having prolonged stays in order to have follow up. Sometimes this can be in hospital but at other times may be in the community. This increases isolation and expense incurred by the family.

**Medical Support:** Community based medical support including home visits by General Practitioners can be difficult to access especially when home visits becomes a need and if after hours support is required. In some instances General Practitioners have limited knowledge of the community services available and this impacts on the referral of clients to these services.

**On call support for Community Service Delivery:** On call arrangements are generally not funded but it is often after hours that people most need support. In some instances problems can be dealt with by phone call only but on occasions visits are also required.

**Equipment and Medication availability:** Access to specialised equipment which is frequently used for only a short time frame can be difficult and costly for people. Items can be limited in supply, costly to hire, and when only needed in the short term not feasible to purchase. Generally quick turnarounds are required. The size of some equipment items makes storage difficult. Rural and remote access is even more difficult

with less options and further distances to travel. Some pharmacies do not hold the full range of drugs.

**Timeliness of referrals:** Palliative Care should be introduced early and gradually as the illness progresses. Many people access care initially in the hospitals and frequently referral to Blue Care is only made late in the process. This means that not only do a range of services not become available to people and their families until quite late, but also the ability of the service staff to develop a caring relationship with the clients is limited.

**Care continuum:** In some instances the care continuum is disrupted because of readmission to hospital, which may result in referrals to different agencies. The process of admission and leave from services may also require that the person is discharged from the community service and readmitted when they return to the service.

There is inequitable access to palliative care specialist services in residential.

**Professional Development for staff:** Attendance by staff to professional development activities is influenced by capacity to backfill the staff member in their absence. Many of the education programs have a practical nature and therefore are best delivered with face to face training. Access is even more difficult in rural and remote areas. Ability to access appropriate education directly impacts on the ability to deliver evidence based services.

**Younger people with disabilities:** Younger people with disabilities have increased support needs in addition to the specific health condition which further highlights the need which frequently cannot be met. Those under the age of 65 and the younger patients are not eligible/ or needs are not suitable for nursing home placement and Disability Services will not review because they do not have a disability to fit their criteria. However, often people with this need have a poor prognosis of 12 months with a life limiting illness.

**Evaluation:** The Palliative Care Outcomes Collaboration (PCOC) has been established as an evaluation platform for specialist services but does not work well in the community context when these services are contracted. A gap exists in measuring the outcomes for people who have palliative conditions but do not ever access specialist services. Blue Care visits a great many of these clients.

### 3.8 Funding issues

Funding for the provision of palliative care in the community setting is fragmented and can be difficult to access. The average Blue Care hospital-funded palliative admission in 2011 covered only 20 visits which represents less than three weeks. Most funded palliative visits are nursing related and time limited to one hour. In some instances appointments may be over a couple of hours. There is no funding for early intervention, advanced care planning or grief and loss and bereavement services.

Blue Care receives some funding from Queensland Health Palliative Care services managed locally by Queensland Health entities to support people on a regional basis with their palliative conditions. Palliative funding generally only becomes available in the last three months of life. The difficulty predicting this means some people die with in

four weeks of commencing the service and others live beyond the three months and are vulnerable to having their funding withdrawn just when they need it most. This further puts stress upon the client and caregiver. This model better suits patients with cancer. Those with disabling progressive disease and chronic illness often will not be able to have their needs met within this funding model.

Palliative Care funding is discretionary at the local level and the arrangements vary across the state. In Townsville for example Blue Care has a contract with the health district to provide these services. Positive outcomes including reduced hospitalisations are reported from this program although it has not been formally evaluated. In other areas, there are various other models in place ranging from an expectation that all palliative care services will be funded through other funding programs, to one off arrangements on a case by case basis.

One model which supports good outcomes for palliative clients is collaborative partnership between a local hospital and Blue Care residential facility where an unlicensed bed is available to take palliative patients from the hospital and the hospital and residential facility work together to identify the client and meet the ongoing needs.

Palliative funding is usually provided in the last three months of life as defined by a medical practitioner, and prior to this people rely on other funding programs. The HACC service only provides a basic level of support and maintenance.

The recent changes with the Aged Care funding for HACC moving to the Australian Government and the funding for those under 65 staying with the State exposes people to real risk that they may not receive access to services as they had in the past, leaving them with the cost.

In 2011 Blue Care also received funding from sixty-five Queensland hospitals for 1,228 palliative clients across Queensland and northern NSW:

- 37% of these clients were under 65 years of age
- 26% of these clients also received HACC services either concurrently or preceding this funding.

Provision of hospital funding can be affected by:

- available funds in the hospital palliative budget
- knowledge of the person's diagnosis and condition by the medical officer or clinical nurse consultant managing the funding
- the ability of the community provider to determine an expected date of death.

This results in inequity of access for clients to palliative care services throughout Queensland.

Issues for discharge planning when leaving hospital include the inconsistencies across health care districts, North side Brisbane is very strict on the "3months" of funding for all patients including equipment, and only a bed and mattress, and nursing hours are funded now. Wheelchairs and other equipment the patient needs to fund themselves.

Occasionally funding may be received for oxygen for non pensioner patients who do not qualify for the Medical Aids Subsidy Scheme (MASS).

Private health funds, depending on the fund, will pay for some medications, but usually not all.

A range of issues regarding the Aged Care Funding Instrument (ACFI) in residential means that people often do not get assessed earlier enough to access correct funding.

## 4. UnitingCare Health's, The Wesley Hospital Submission

### 4.1 History of the Palliative Care Service and Oncology services at The Wesley Hospital

In the late 1980s, patients receiving chemotherapy in Queensland were admitted to the urology ward (Ward 4A), at The Wesley Hospital (TWH). An oncologist, visiting from a local public hospital, admitted private patients for treatment. In the early 1990s a number of medical/haematology oncologists established a private day chemotherapy service in the adjoining medical centre, and a radiation oncologist established a private radiotherapy service; these two services were the first private oncology services for Queensland. Since that time oncology services at the Wesley have grown substantially. Today they include four wards with sixty-five beds covering haematology/oncology, bone marrow transplantation, chemotherapy and radiotherapy. A dedicated Medical Oncology/ Palliative Care Unit (Ward 4A), which contains seventeen beds supporting patients with symptoms related to their life-limiting illness, is a critical component of these services.

The Palliative Care Service (PCS), which is based around a multidisciplinary team (see Box 1), emerged through recognition of the need for specialised palliative care as a vital component of the comprehensive cancer services offered through the Wesley Hospital. It was established in 2003 following the employment of a Director of Palliative Care; a specialist in Palliative Medicine, who oversees the multidisciplinary services provided through the Medical Oncology /Palliative Care Unit (Ward 4A). Following the appointment of the Director, existing staff in the unit were up skilled and specialist palliative care nurses were employed to care for the patients. The environment was refurbished and six beds were dedicated for care of patients with a life-limiting illness.

#### **Box 1: The Multidisciplinary Team of the Palliative Care Service**

- Medical Director –a Palliative Care Specialist – employed by the organisation. 1.0 Full time equivalent (FTE)
- Palliative Care Specialist (medical) 0.5 FTE
- Palliative Care registrar 0.8 FTE
- Clinical Nurse Manager – 1.0 FTE also responsible for running Ward 4A managing staff and budgets, general day to day running of the unit
- Clinical Nurse Consultant –1.0 FTE assisting with complex discharge planning and triage of new referrals and readmitted patients appropriate for transfer into Ward 4A
- Nurse Counsellors – 1.2 FTE provide psycho spiritual and bereavement support for patients and families
- Pastoral Care – Chaplains depending on denomination, 0.5FTE assigned to the ward permanently, the others visit as needed
- Physiotherapy – 1 FTE
- Other allied health personal as requested – Occupational therapy, speech therapy and podiatrist
- Pharmacist 0.5 FTE

**Submission by Blue Care and UnitingCare Health to the Inquiry  
into Palliative Care and Home and Community Care Services in  
Queensland**

- Nursing staff on Ward 4A consisting of Clinical Nurses, Registered Nurses, Enrolled Nurses, Nursing Orderly, Assistant in nursing, administration staff, cleaner and kitchen stewards.
- Life Line Financial Counsellor available two days per week to assist families and carers

At its inception, admission was restricted to patients, who as a result of their disease were in the last few weeks of life. As the service has developed, the focus of the Palliative Care Unit has shifted from end-of-life care to reviewing symptoms earlier in the patient's disease trajectory. Gaertner et al., (2012) argue early integration of palliative care improves overall quality of life. They also suggest that by providing an integrated collaborative model of care, patients and their families can be supported along their journey.

Data obtained from the Health Information Unit at TWH shows the Diagnostic Related Groups (DRG's) in 2004 and comparison 2010, data chosen as a snap shot for three months –February to April (see Table 1). Across this period the majority of patients had been diagnosed with cancer. Time spent in the Unit has increased, reflecting the service's shift from end of life care to symptom management.

**Table 3 Diagnostic Related Groups (DRG's)**

• February –April 2004	• Average length of stay (ALOS)	• February -April 2010	• (ALOS)
• Digestive malignancy +complications	• 9 days	• Digestive Malignancy +complications	• 9.82 days
• Respiratory neoplasms +complications	• 9 days	• Respiratory neoplasms +complications	• 18.55 days
• Lymphoma and non acute leukaemia	• 5.45 days	• Malignant Hepatobiliary/ pancreas + complications	• 14.14 days

*Table 1 data obtained from Health Information Unit TWH*

The age of patients using the service is expected to continue to rise, reflecting broader population health projections (i.e. 50% of people aged 65 and over are expected to be diagnosed with cancer in their lifetime) (AIHW, 2012).

#### 4.2 Strengths and Weaknesses of the service

Developing strong referral networks through the broader hospital has been a critical challenge facing the PCS. Melvin and Oldham (2009) argue palliative care should be available to patients in the time of most need; usually the last six months of life, but recognition of this was limited during the early stages of the PCS. In 2003, only patients suffering pain were referred for specialist palliative care support as oncologists did not recognise the benefits of timely referral or acknowledge the need for additional support for patients and families who may be experiencing psychosocial and spiritual distress (Johnson et al., 2011).

Leonard (2009) notes that managing life-limiting illness can be challenging for physicians as oncologist struggle to initiate difficult conversations regarding diagnosis and prognosis of disease. The oncologist knows the medical treatments the patients are receiving are palliative, but may not have been able to explain the difference between palliative and curative treatments, or clarified the ultimate aim of treatment to the patient and their family (Leonard, 2009). These challenges have been associated with higher levels of distress when the patient is referred to the PCS and the patients are unsure of treatment intentions.

At a broader facility level the PCS has been challenged by limitations of recognition and space. Over the last ten years Ward 4A has grown from six beds dedicated to palliative patients to now utilising the seventeen beds on the ward with an average of six-eight patients under the care of the service in other wards around the hospital. Problems arises when the patient is in the community experiencing distressing symptoms and requires admission into Ward 4A, it is reliant on a bed being available. The projected increase in numbers of patients being referred to Palliative care does not match the number of physicians or beds available to care for these patients. To some extent this reflects broader workforce issues (Duckett 2000), as the time and resources required to train and recruit specialist medical and nursing staff undermines the Service's ability to respond to need.

Limitations of staffing and resources have also critically undermined the Service's ability to extend beyond the inpatient model to provide community care. Historically referral to the PCS required patients to be admitted into hospital for symptom management. However, most recently the Medical Director of the PCS has commenced an outpatient clinic that is run from the private chemotherapy clinic utilising the oncologists' rooms. Patients can now be discharged from hospital and can receive follow up review in the clinic; this allows for continuity of care and ongoing pain management in conjunction with the GP and community services. Smith et al (2012) discuss the importance of referral to palliative care early in the disease trajectory leads to improved patient and carer satisfaction, a reduction in unnecessary admission to intensive care units. Early involvement of palliative care has shown improved outcomes for patients and their carers as the common goal is to improve quality of life and relief from symptoms whatever the diagnosis (Smith et al., 2012).

The oncologist are encouraged to continue an integrated model of care in collaboration with the PCS after referral, this provides an easier transition from curative treatment to palliation.

Public perception of palliative care, in the community, is still the medical practitioners have lost all hope. Inability to provide curative treatment and a sense of failure by medical practitioners has been seen as a major reason for lack of referral earlier in the disease trajectory (Melvin & Oldham, 2009).

Continuing education and raising public awareness about palliative care services and the ability to provide support at any stage of the disease trajectory to deal with distressing symptoms (Melvin & Oldham, 2009). Melvin and Oldham (2009) suggested a strategy to reduce the fear of palliative care was including a palliative care nurse when patients and their families have the first interview with the oncologist, or when their disease has relapsed.

Palliative care specialists are prepared to conduct the difficult conversations related to prognosis ensuring families have had the time to discuss their wishes for end-of life, forward planning for these patients, such as ensuring that they have a current will, advanced health directive and enduring power of attorney for medical and financial support (Bakitas, Kryworuchko, Matlock & Volandes, 2011).

Strengths of the service include the nursing care provided to this group of patients, once introduced to the service and understand the concept of Palliative Care providing symptom control. A family member wrote a letter of thanks in relation to the care of her mother – “the staff of Ward 4A were dedicated, caring and compassionate at all times ... with their assistance she was able to maintain her dignity until the end.” (Personal communication from letter of thanks dated 18<sup>th</sup> February 2012)

McIlpatrick and colleagues (2009) discuss the need for new models of care to increase public awareness around palliative care and the support for people to “live well until they die” (p.135).

Referrals to PCS have been on the increase over the last twelve months June 2010 – June 2011, (personal communication Dr Ralph McConaghy 26/03/2012) with an average of thirty referrals per month, predominately cancer patients, though referrals for heart failure patients and other non cancer diseases are increasing.

#### **Private hospital Medical Support for Palliative Care Challenges**

- Palliative care services in the private sector need more funding to train registrars and employ specialist Palliative care physicians. There is palliative care experience to be gained with the types of patients being referred to the service, and the number of referrals warrants the utilisation of a registrar. The issue of funding is the main stumbling block.
- Palliative Care specialty is a relatively new speciality in the face of the burgeoning aging population, leading to a lack of supervisors and trained trainers.
- The nature of palliative care is a low throughput as it is time based as compared to procedural based, intensive, extensive history taking required for holistic care. The involvement of the family as well as the patient means more extensive psychosocial involvement of the multidisciplinary team to ensure best care for patient and family. This is time consuming – and non profitable for corporate sector – with fundraising as the main form of ongoing financial support for the service.
- Current ratio of Palliative Care physicians to Radiation/ medical oncologist current is approximately 1:10. This leads to increased length of time for referral to be seen with extended inpatient bed days and increased number of patients dying in hospital.



Submission by Blue Care and UnitingCare Health to the Inquiry  
into Palliative Care and Home and Community Care Services in  
Queensland

- In Outpatients a palliative care physician will see 3 - 4 patients in a half day due to the complexity of the patients – especially new patients. Based on MBS item \$130 per visit x 4 \$520 per day this is not financially viable to pay overheads such as room rental, electricity, reception staff etc.
- Community / home visits for medical staff needs better funding arrangements. Maximum home visits is 3-4 per day due to distances covered and need for complete assessment on patient and family, especially new referrals. This is an essential component of community service as GP's are reluctant to do afterhours services and home visits. This impacts on patients unable to attend GP clinics due to illness or deterioration in condition requiring hospitalisation leading to lack of continuity of care for primary providers and resulting in more patients dying in hospital and not their place of choice, such as home or hospice.
- No hospice inpatient service in the greater Brisbane area. There are also a limited number of palliative care beds. The Wesley Hospital palliative care patients are from all over Queensland and Northern NSW. Reliance on GP support to enable them to be cared for at home in rural and remote areas are vital.
- The opportunity for follow up care such as a phone call post discharge currently has no item number on MBS for Medical staff to claim.
- The Wesley Palliative Care service currently relies on the medical staff to take their own after hour's calls. There is no formalised after hours service, patients and relatives do phone the ward for advice, this can be an issue if the ward are not familiar with the patient or their condition. This then necessitates admission to the Wesley Emergency department and involves an extra cost – as this is run separately to the hospital.
- Further challenges providing Palliative Care include issues with Private Health Funds and their contractual arrangements do not consider certain procedural interventions, such as Vertebroplasty for stabilisation of vertebral fractures and Percutaneous endoscopic Gastrostomy (venting PEG) placement for drainage only, with patients who have ongoing malignant gut obstruction. These procedures can have an impact on quality of life and symptom control for palliative patients. As well as a financial burden for patients and carers.
- Issues relating to discharge – a number of patients fall through the cracks because they are too well to be in an acute hospital, however family cannot manage them at home due to the patient requiring 24hr care. Prognosis is too short for the patient to be in a nursing home placement /ACAT, and people are unable to access interim care as they are not DVA. There is unpredictability for most patients in the service – e.g. the resources required to complete an ACAT for a patient – the family to go through the process and the patient unexpectedly dies of their disease. This impacts on length of stay for these patients, especially in an acute care hospital. Lack of palliative care beds in the community for slightly longer stays of 35 days.

## 5. Future opportunities for Service improvement

Blue Care believes a more accessible, equitable approach to funding community-based palliative care is required. This funding should be able to be accessed directly by the organisation providing care, rather than brokered through the local hospital, and should not be determined by estimated prognosis. Once a palliative diagnosis is determined, funding could be staged to cover increasing needs and be flexible to incorporate clinical care (nursing and allied health), after hours care and lifestyle support. Funding could also include the ability to access time-limited interventions such as overnight respite services and Grief Recovery Programs. Additional support should also be available for people with complex palliative conditions living in residential care.

A primary care model including informal and formal relationships with specialist palliative care providers, General Practitioners, hospitals and residential providers needs to be robustly established across all geographical areas.

Blue Care recommends the development of an effective interdisciplinary model of care with improved communication resulting in the cooperative palliative approach to improve continuity of care in a service delivery model which commences at early intervention.

Utilisation of technology including telecare, telehealth and telemedicine devices in the community care sector will enable alternative options of interventions and support efficiency measures.

Funded overnight respite services will assist in supporting choice for people with life-limiting illnesses and reduce long-term carer stress with improved access to additional carer support.

Adequate funding for services providing after hours care and improved access to specialised medical/clinical phone support.

There should be use of technology to make education and support, specific to paediatric palliative care, available to primary care providers, for example, videoconferencing and web-based training for supporting staff professional development.

Funded Case management and utilisation of a primary care models needs to be expanded and implemented in other areas across Australia and supported by adequate funding. The role of the community service provider who has regular and consistent contact is important. Blue Care has been involved in the Curo program in SWQ where the community service undertook a care coordination role model to support people with chronic diseases to access services.

The system can be improved through increased access to specialised resources, particularly covering lifestyle support that would improve outcomes for people with disabilities and their families.

A funding allocation for early intervention, after hour's on-call services or Grief Recovery Programs would support people at home.

The ability of all care providers to access eHealthcare records would improve communication across services and enhance seamless holistic care.

A national consistency in law and policy for advance care directives and advocates national consistency, policy and training for individuals and staff in advance care planning is recommended.

Collaborative research centres with target areas identified under the National Palliative Care Strategy would address imbalances in future capacity building.

An independent evaluation of the impact and usefulness of PCOC as an avenue for palliative care data should be undertaken.

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