

Health and Community Services Committee
Inquiry into palliative care services and home
and community care services in Queensland

Silver Chain

Introduction and background:

Silver Chain welcomes the opportunity to make a submission to the Queensland Parliament Palliative Care Services and Home and Community Services Inquiry. This submission will focus on what has been identified as a best practice model of specialist community palliative care provision and the challenges in Queensland.

Silver Chain is a community owned and operated not-for-profit, non-government provider of community-based health and care services.

Silver Chain has a rich history and credibility with the community that extends back more than 100 years. Today we are a national, modern, diverse, client focused organisation. We drive success across our diverse programs in order to achieve our mission, which is to build community capacity and provide flexible healthcare services to improve quality of life, health and wellbeing by supporting people to live independently in their community.

Silver Chain has a long history in providing professional health services to the community including assessment, client care coordination and care services. Silver Chain provides community acute, post-acute and sub-acute health care. We have been innovative in the development of numerous models that integrate with primary healthcare including palliative care, Home Hospital and chronic disease.

Silver Chain community health and care services have been developed within the Silver Chain culture of excellence in clinical health and care, technological innovation, research evidence, quality and safety. Our health and care services are supported by key business units which have sustained our reputation for quality and best practice in health and care services delivery for more than a century.

We would welcome the opportunity to provide further information in relation to this submission, and in particular greater detail about our models of care and their many outcomes contributing to the discussion for a sustainable way forward in community-led solutions to significant healthcare issues.

Response to the Terms of Reference:

2. That, in undertaking this inquiry, the committee should consider:

- **the capacity and future needs of these services (including children and adolescents palliative care)**
- **the effectiveness, efficiency and adequacy of palliative, frail and chronic care services**
- **examine opportunities for reforms to improve collaboration and cooperation between chronic, disability and other health services, and**
- **consideration of segmenting the current Home and Community Service system based on the age of the client needs of the client their carer and the providers.**

Capacity and Future Needs

Nationally, Silver Chain provides palliative care support to more than 1,100 clients each and every day.

In Queensland, Silver Chain provides palliative care services 24 hours a day, 7 days per week to the Sunshine Coast and the Brisbane South Metro Hospital and Health Services.

In WA, Silver Chain is the sole contracted provider of services throughout the metropolitan Perth area (population greater than 1.8 million people) by the Department of Health (WA) and provides palliative care services to many parts of country / rural Western Australia.

Silver Chain is also contracted by the Department of Health (WA) to provide two state wide telephone consultancy service functions: Rural Palliative Consultancy Service; and, Metropolitan Palliative Nurse Consultancy Service. These two consultancy services operate 24 hours a day, 7 days per week to support providers in rural communities, aged care facilities, General Practitioners, and other health professionals in acute hospital settings to support the care of the palliative care client.

In SA, Silver Chain (trading as the Royal District Nursing Service) provides palliative care services to the Department of Health (SA) under the Health Care @ Home and Non-Post-Acute contracts. The services operate 24 hours a day, 7 days per week, being a combination of direct in-home support and call centre services.

Supported by our 24/7 Call Centre, Silver Chain is able to provide direct access to information and advice, including specialist Medical and Nurse Consultant support through our on call services.

Silver Chain currently delivers over 110,000 palliative care visits every year. Silver Chain is the largest independent provider of community based palliative care services in the Perth and Adelaide metropolitan areas.

We have proven capacity and capability to deliver care in the final stages of life with positive client outcomes. Silver Chain palliative care clients have a home death rate of 60% (WA) compared to the national average of 25-30%. We are able to achieve this as a result of:

- Working in partnership with both primary and acute care to deliver home based care.
- Implementing evidence based practice using the best evidence internationally and formalised into standardised care pathways.
- Status as a Registered Training Organisation, with a comprehensive suite of training modules in palliative care.
- Our multi-disciplinary workforce with the right skills, qualifications and confidence to deliver quality in-home palliative care.
- The comprehensive Clinical Governance Framework including automated systems driving process.
- Sophisticated technology, logistics, HR systems, quality systems and organisational governance designed for the community.

Our internationally renowned Research Unit which drives evidence based practice across the organisation. Our client intake process in the Call Centre matches approximately 66,000 funded episodes nationally to our services per annum.

Models of care and clinical services offered

The models of care provided by Silver Chain vary depending upon the jurisdiction, and explicitly the funding models in place. Silver Chain's community palliative care service in WA is often quoted as a national best practice model for specialist community service delivery.

Silver Chain provides three specific service offerings:

1. *Metropolitan Community Palliative Care Service*: Provision of in-home specialist palliative care to clients within the metropolitan area and to all metropolitan care facilities that do not have a registered nurse managing care 24 hours a day.

2. *Palliative Nurse Consultancy Service*: Provision of a palliative nurse consultancy service to metropolitan public/private hospitals and residential facilities where client care is managed by a registered nurse 24 hours each day. The service provides specialist nursing advice, assessment, procedures, specific staff education and telephone follow up to meet the care needs of a specific client. Referrals are accepted from medical practitioners, registered nurses and allied health staff that are providing care within the facility. Involvement is limited to a period of five days following which the client is separated from the service. The client can be re-referred and there is no charge to the facility or the client.

3. *Palliative Rural Telephone Advisory Service*: Clinical Nurse Consultants who have specialist skills and knowledge provide telephone advice to rural service providers regarding managing the palliative care needs of a specified client. This service is available via a free call telephone number 24 hours per day, seven days per week.

Silver Chain's service model is guided by the following principles:

- Build capacity within families to care for their own;
- Integration and service coordination;
- Interdisciplinary care planning;
- Evidence-based, client-centred care.

In comparison to many community palliative care services, Silver Chain's model varies in a number of distinct ways including:

1. Whole of Metropolitan Service
 - Improved workforce development and planning across a significant number of staff and disciplines;
 - Improved resource utilisation and allocation;
 - Reductions in administrative overhead and burden;
 - Single point of referral;
 - Population-based approach to service development and planning;
 - Coordinated service provision across specialist, primary care and primary health care where Silver Chain is a major provider in all areas.

2. General Practitioner Engagement

Silver Chain employs 32 up-skilled General Practitioners across Perth who support each of the 8 geographically based care teams. These doctors serve as a bridge between specialist community palliative care and primary care, and work closely with the client's general practitioner to discuss and plan ongoing care. The client's general practitioner has the following clinical governance options:

- *Full Care*: Where the general practitioner is available to the client, family and Silver Chain team 24 hours per day.
- *Shared Care*: Where the general practitioner is available during business hours, while the Silver Chain doctors provide services out of business hours.
- The Silver Chain doctor is the only medical decision-maker.

3. 24/7 Service

The large scale of the service enables staff to be available 'out on the road' to respond 24/7 with shift that cover day, evening and night, and enables:

- Rapid response to crisis events;
- Planned after-hours support for client, carer and family where required;
- Symptom assessment and management 24/7 at home;
- Back up support (on-call) by senior nursing and medical staff in support of rostered staff 24/7;
- Customer Centre Representative availability 24/7;
- Provision of equipment 7 days a week via CarePlus;
- Consultancy support to rural and metropolitan providers.

4. Personal Care and Respite Provision

Care Aides are employed as members of each team for the support / provision of personal care at home and respite care. As members of the team, full care provision can be coordinated internally to support the client's wishes to remain at home. Where respite care is provided (average duration of 4 hours each) in the last weeks of life, 80% of those clients are supported to die at home.

Silver Chain has taken a population based approach in development of its community palliative care model, together with an understanding of differing care pathways that are responsive to the needs of specific populations – with enhanced integration of services within Silver Chain to meet the needs of people with malignant and non-malignant disease.

This is coupled with a workforce with skills and capabilities to meet community expectations of safe and quality care.

Silver Chain utilises an integrated IT solution across all areas of operation – ComCare. This purposely designed software assist us to deliver a better level of care while reducing costs and improving productivity. All staff utilise hand-held technology allowing access to required information in all environments, supporting care decision-making and delivery, and collection of required clinical information that assists targeted care delivery, internal and external benchmarking activities

There is no charge for the service, and includes the provision of equipment and medical devices from Silver Chain's supply chain management service, CarePlus. This is a comprehensive service and demonstrates that where such a focus is provided people can be well supported to die at home.

Silver Chain's model of care increases the provision of palliative care delivered in the home and creates a shift from unnecessary and undesirable admission to acute care.

The core competencies of inpatient services are to deliver where resources required exceed those able to be delivered in the community. Silver Chain's core competency on the other hand is to deliver increasingly complex care to patients in the community. The tools, software, logistics, clinical governance systems are uniquely tuned to deliver precisely this service.

Effectiveness, Efficiency and Adequacy of Services

Growth of aged care services for older people with chronic and complex conditions will need to be complemented by an expansion of the capacity and competence of primary health care services to provide generalist palliative care for people living in the community and in aged care homes, supported by increased collaboration and networking with expanded specialist palliative care services (Palliative Care Australia). As a provider of specialist and primary health care services, Silver Chain's model of care is principally focussed on collaborative efforts supporting the delivery of palliative care in the community, and enablement of access to services 24/7 through developed internal and external integrated pathways.

Strengths of the Silver Chain service

- Provider of community palliative care services across Western Australian, South Australia and Queensland;

- Commitment to client needs, and focus on client outcomes of care (in WA more than 60% of admitted clients die at home; with research demonstrating that a person admitted to this service is 7 times more likely to die at home);
- Engagement with primary care sector, where general practitioners are specific employed members of the interdisciplinary team;
- Clinical training ground for undergraduate medical, nursing and allied health professionals;
- Provider of medical education/support and supervision for Registered Medical Officers, and Specialist Training Program (Registrar) positions;
- Innovative provider of services, with well-developed and articulated models of care;
- Large scale integrated provider enabling coverage, quality, engagement, integration, and good governance – all 24/7;
- Investment in sophisticated approaches (not expensive approaches) in community health care services improves and enables primary health care infrastructure to address the needs of the small proportion of the population who use significant percentage of health care expenditure;
- Best practice community service care is a systemic approach that supports the population; requiring sophisticated technology, logistics, HR systems, quality systems and organisational and clinical governance designed for the community.

The challenges to the Silver Chain service

A new paradigm – best practice community care

70-75% of people express the desire to be cared for, and die at home – yet most will die in inpatient facilities across the country.

Why?

'If we want to tackle a problem that affects all of us, let's think big. If we want to transform health care, let's change the way we die.' -Ellen Goodman, Harvard Business Review, 2012

From our experience, it is clear that there is a direct correlation between the resources provided to support a large scale integrated community palliative care service and the positive outcomes derived that are in line with community expectation for end of life care.

We need to reconsider health care in an entirely new paradigm, one that is viewed through the eyes of the individual, one where the individual is situated in a community setting.

Preferred Place of Care

So, what do we know about dying in Australia today?

- 75% of all deaths can be anticipated
- Patterns of death have changed radically in the past 100 years.
- 61% of residents admitted as high care into residential aged care will die within 12 months
- By 2056 the death rate will be more than double that today
- It is estimated that 5% of people accessing the Australian healthcare system consume almost 25% of its entire funding in the last 12 months of their life
- It is about five times less expensive to care for a person with a life threatening illness at home than it is to care for them in hospital.
- Inpatient settings are typically poorly placed to address the social determinants of health and the complex family and social dynamics that complicate a terminal illness.
- Inequitable funding of community palliative care service provision across the country provided at a whole of population level can vary from \$1 to \$10 per person/annum – a 1000% differential!

Clearly, if the community's expectation is to be cared for and die at home, then this requires a significant shift in the way in which we conceptualise and resource community services. Creating more hospital beds will not in the main lead to more people being cared for and die at home – we need to utilise the beds we currently have in the system better.

Complex care in the community is not a casual undertaking and must be the **core** business of the provider. Such care provision can be patchy and inefficient when delivered as an isolated outreach program from a hospital setting. Best practice community care needs to be a systemic approach that supports a whole population. It requires investment in sophisticated and community-tailored (not expensive) approaches in technology, logistics, HR systems, quality systems and organisational and clinical governance.

Opportunities for Reform

Funding

There is an inequitable and haphazard approach to the funding of community palliative care service provision across the country. The outcomes that our communities want, and indeed expect of us – to be well supported and cared for at home – are at odds with how the

resources are currently distributed. The provision of resources for community palliative care that are provided at a whole of population level can vary across the country from \$1 to \$10 per person/annum – a 1000% differential.

Inpatient facility capacity

Our communities require the provision of appropriately resourced palliative care beds to specifically meet the complex needs of people who are unable to be supported at home. But, how many beds does a community require? Resources to support the palliative care sector will always be limited. We need to be prudent in our allocation. It has been our experience that where there is not an adequately resourced community service, there is of course a greater requirement for more beds to address the unmet palliative care needs in the community. Without addressing the core issue – community resource distribution – it is a self-perpetuating argument. We need to address the core issue at the community level ensuring resources are targeted to achieve community-driven outcomes.

Governance concerns

The issue of quality and safety in a community sector is a pervading concern to traditional inpatient service clinicians concerning clinical governance around complex care. Indeed, community centric services are more satisfying to clients, provide safer outcomes, and are more connected to other support services in the environment in which they operate. The clinical governance delivered by the community clinical provider occurs within the context of the broader governance role, which includes financial and corporate functions, setting strategic direction, managing risk, improving performance and ensuring compliance with statutory requirements.

Large scale community models of care

The community infrastructure currently in place to provide palliative care services across Australia is as broad and diverse as the country itself. Whilst many services have developed in response to local community need, most have not been specifically designed in accord with a population based approach at the service level. We believe that large scale models of care are required to enable coverage, quality, engagement, integration, and good governance – all 24/7.

The Need for Large Scale and Coordinated Funding for Community

Investment in sophisticated approaches (not expensive approaches) in community health care services will improve and enable primary health care infrastructure to address the

needs of the small proportion of the population who use significant percentage of health care expenditure.

Complex care in the community is not a casual undertaking it must be the **core** business of the provider. Such care provision is patchy and inefficient when delivered as an isolated outreach program from a hospital setting. Best practice community service care needs to be a systemic approach that supports the population; and requires sophisticated technology, logistics, HR systems, quality systems and organisational and clinical governance designed for the community.

The provision of high quality care at the end of life is not possible without adequate and equitable resourcing. The current mix of federal, state and territory funding for palliative care works against the integration of both GPs and specialist palliative care providers into the primary care team, only further exacerbating the problem.

In a recent Harvard Business Review article, Pulitzer Prize winner, Ellen Goodman, noted *“the public debate about health care is framed in the language of cost cutting and rationing – as what health reform will take away from you. But what if we could break out of that frame? This is one area in which letting patients’ choices drive decisions could result in lower costs – financial and emotional ones. We may even be able to rebuild trust in the medical system by respecting patient’s wishes. Most important, we can ensure more humane deaths.”*

There is, of course, a limited resource that can be spent on health care in all our communities. As we have already noted, the funding and delivery mechanisms for community based services vary markedly throughout Australia. A guiding principle underpinning funding is that there should be quality and equitable palliative care and support available to all Australians. However, as highlighted previously, the provision of resources to community palliative care services at a whole of population level can vary across the country from \$1 to \$10 per person/annum.

The Likely Impact of Current Funding Reform

The introduction of new funding arrangements through Activity Based Funding (ABF) creates opportunities for community based service organisations to be better configured to respond to health needs within the community, and should promote lower cost community solutions where appropriate. However, there is a competing risk that inpatient facilities will pursue additional funding potential by extending their outreach services (inherently inefficient) that sustain the inpatient centric culture that pervades first world health systems.

The primary role of ABF is to efficiently use the most expensive resource in the health system - hospitals. To this end, an outcome of ABF will be to rebuild the primary health care infrastructure to more adequately assist the GP to support higher needs people within their social context.

The efficient use of palliative, health and aged care resources

A More Efficient and Effective Model

Improved access to community palliative care services has the potential to improve both the effectiveness and the efficiency of healthcare services for people with a terminal illness, and the healthcare system as a whole:

Efficiency – the avoidance of inappropriate and preventable admissions to emergency and inpatient facilities, along with minimising or avoiding investigations, treatments and procedures that offer no improvement in quality of life provides a more cost-effective use of health resources.

Effectiveness – by providing better outcomes for clients and their families.

As highlighted previously, 60% of all people admitted to Silver Chain's Hospice Care Service die at home. Of this group, a further 60% will have no admissions to an inpatient facility during their whole episode of care, and a further 28% will only have one admission.

Helping to meet people's wishes to die at home makes economic sense. A 2009 review found it is about five times less expensive to care for a person with a life threatening illness at home than it is to care for them in hospital. This is also confirmed by overseas studies that show palliative care can reduce costs by reducing hospital admissions and use of acute beds, length of stay and pharmacy costs, and improve health-system efficiency without compromising client care.

Conclusion

It is clear that the challenges we face are:

- Australia's population is growing and ageing
- The way we live in old age, and the way we die, has changed
- Meeting people's wishes to be cared for and die at home

People aged over 70 are admitted to hospital more often, stay longer in hospital and use more healthcare bed days than younger age groups. It is likely that this group will have more complex needs and require more specialised care from a wider variety of specialists, including palliative care. The major causes of death for Australians have changed. There is a clear trend in the increasing prevalence of chronic diseases, including cancer, as the main causes of death.

It is clear to us that there is a direct correlation between the resources provided to support a large scale integrated community palliative care service and the positive outcomes that are in line with community expectation for end of life care – assisting us to meet these challenges.

We need to reconsider health care in an entirely new paradigm, one that is viewed through the eyes of the individual, one where the individual is rooted in a community setting.

We believe there is real opportunity to bring fundamental positive change to the quality of care and outcomes for Australians living with a terminal disease. This also supports general practitioners to continue to be involved in advanced patient care in the community and allowing hospitals to discharge all patients who do not necessarily need inpatient care.

We believe there is an opportunity for a better health system for all patients who can be managed in the community to achieve systemic improvements such as we have achieved alongside hospital based clinicians for palliative care in Western Australia. We need to seize the opportunity to build more capability in the community care system through community based services and the general practice sector to significantly improve both patient care and reduce healthcare costs.

A vision that every Australian receives high quality, coordinated and robust health care over which they retain control, choice and dignity is our challenge – this has to start with a re-think of community models of care.

Key Messages

People want to die at home



There are barriers to dying at home



Silver Chain has a viable community palliative care model – with defined links, roles and responsibilities within primary health care, aged care, rural and remote communities



Funding is a key lever but not currently supportive of community models across the country



**Significant cost and outcome benefits are possible with large scale coordinated
community palliative care**