Cairns and Hinterland Hospital and Health Service (CHHHS)

Submission to Inquiry into palliative care services and home and community care services in Queensland (Issues Paper June 2012)

Contributor 1 – Allied Health:

- Allied Health Discipline Directors, CHHHS
- Cairns Base Hospital Cancer Care Service Allied Health (inpatient and ambulatory care outpatients)
- Cairns Base Hospital Paediatric Occupational Therapist
- Community and Primary Prevention Services Allied Health Teams

Background:

- Palliative Care Services in CHHHS:
    - No dedicated palliative care inpatient beds at Cairns Base Hospital.
    - Palliative Care Physician position (long term vacancy – planned for commencement in next few weeks).
    - Gordonvale Memorial Hospital – 12 palliative care specific inpatient beds; community nursing providing support and advice to patients and carers; limited availability of community support services e.g. hygiene assist; have equipment store for community use; inreach service two times per week to Cairns Base Hospital with CNC and Registrar.
    - Only dedicated palliative care allied health are 1.5 FTE social workers based at Gordonvale Memorial Hospital.
- Clinical Services Capability Framework v 3.0 - Cairns Base Hospital self assessed levels as per Draft CHHHS Health Service Plan (November 2011).
    - Radiation Oncology Services level 5
    - Haematological Malignancy Services level 4
    - Medical Oncology Services level 5
    - CBH Palliative Care Services level 0 (Gordonvale Memorial Hospital level 1)
- Current allied health services in CHHHS, designated to palliative care do not meet recommendations made in Palliative Care Australia's document, Palliative Care Service Provision in Australia: A Planning Guide (September 2003).
- CHHHS population in 2009 was estimated at 245 554 as per Draft Cairns and Hinterland Hospital and Health Services Plan, Demographic and Health Status Profile, Queensland Health 2011).
- The demand on palliative care services is higher in regional, rural and remote centres as, the further a cancer patient lives from a metropolitan centre the more likely they are to die within 5 years of diagnosis. Factors which contribute to this include geographic isolation, transport issues, greater proportion of disadvantaged groups (Jong, KE., Vale, PJ. & Armstrong, BK. (2005). Rural inequalities in cancer care and outcomes. *Med. J. Aust*. 182: 13-14).

Responses to Terms of Reference:

1. Capacity and Future Needs

Current capacity:

- Social work (1.5 FTE) is the only dedicated allied health resourcing for existing hospice and community based Gordonvale palliative care service. (i.e no dedicated psychology, physiotherapy, occupational therapy, dietetics or speech pathology services). Existing cancer care allied health at Cairns Base Hospital (CBH) have extremely limited capacity to provide outreach service.

- Currently community based palliative care clients access community health and HACC staff for Occupational Therapy, Physiotherapy, Speech pathology (although some gaps exist). CBH Dietetics provides basic cover to Gordonvale Memorial Hospital patients, while home based patients are split between CBH and Community Dietitians. All above mentioned staff service multiple client groups (palliative care only one component). Therefore the current challenge is limited dedicated palliative care allied health professionals. This model of care is very unusual compared to the rest of State.

- Gordonvale Memorial Hospital staff report up to 12 hours per week is spent organising medications due to no Pharmacy service on site.

- A palliative care equipment pool is made available which is a strength of the service. Unfortunately equipment to assist with activities of daily living (i.e. mattresses, beds, wheelchairs, etc) and tracheostomy/ laryngectomy patients (suction, humidifiers and consumables) is limited and reaching the end of its life. Equipment is a key aspect in ensuring smooth transition to community for palliation. Often unavailability of equipment leads to increased length of stay in acute beds at Cairns Base Hospital.

- Commencement of radiation 1.5 Linear accelerators has also increased palliative care workload due to significant amount of palliative radiation offered i.e. wound care, increased life expectancy etc.

- Paediatrics – gap in services exists in the community for children who have deteriorating medical or neurological conditions. They are not supported by the palliative care team with Children's Hospital and are not eligible for community services in Cairns. The wait list for HACC assessment is incredibly lengthy and palliative care cannot accept patients until they are in the terminal stage of disease. CBH paediatric Occupational Therapist picks up the load despite this service being more suitable for a community setting.

Future Needs:

Consideration needs to be given to a change in the model of care, for example all palliative care professionals co-located at one site. Some allied Health positions are funded for palliative care, but this is not a full service currently.

2. **Effectiveness, efficiency and adequacy of palliative, frail and chronic care services:**

- Significant delays are experienced in accessing local HACC services with a six week wait (approximate) for HACC assessments. There are also significant difficulties getting clients under 65 years of age HACC assessed.
- Due to multiple segmented services, a common complaint from patients is that they feel over assessed (being assessed for the requirements of each individual service).
- Another challenge often faced is the provision of palliative care and HACC services in rural and remote regions. These patients often require more financial input. Up-skilling of local staff is also required as they are often contracted to provide services but they do not have specialist training in palliative care. For example, Kuranda patients receive less continuous and quality care due to contracting and access to GP as medical person etc. This is increasingly difficult as services extend up to Cape York and Torres Strait.
- Significant gap exists for patients who are temporarily incapacitated but not accepted for palliative care services or HACC. There are no community services available to support this group. This has a significant impact on the patient's quality of life and increases their length of stay in acute hospital settings.
- Challenges are also faced by patients receiving cancer treatment through the private hospital, as no private palliative care services are available. These patients are placed under community palliative care services. Referrals are then made for these patients to gain access to Qld Health allied health services and equipment/products, which places additional strain on those services.
- Community Health Occupational Therapists (OT) indicated that they have great difficulty accessing any information on patients in the palliative care service which makes provision of care very difficulty. They also indicated they do not receive feedback from the patient/carer or palliative care service regarding changes in circumstances where the OTs could be involved and improve care.
- Non-cancer related palliative care patients have the potential to fall through service gaps, while the Community Health OT's experience is there is potential for over servicing by patients accessing HACC, palliative care, etc.
- There is a very large gap in the management of lymphoedema and oedema, which are common symptoms in the palliative care patient group. Currently the only trained therapists and nurses are available through HACC, the OT service at CBH, and occasionally through the physiotherapy in one community health centre. Demand far exceeds supply in each of these services. These patients also require significant consumables and garments which require regular replacement. These items are costly and there is limited or no allocated budget within services to cover these costs. Limited resources must be prioritised and therefore these clients are at risk

of not receiving optimal treatment. This results in discomfort, incapacity and cellulitis.

3. **Examine opportunities for reforms to improve collaboration and cooperation between chronic disability and other health services:**

    - Nil comments

4. **Consideration of segmenting the current Home and Community Service system based on age of the client, needs of the client, their carer and the providers:**

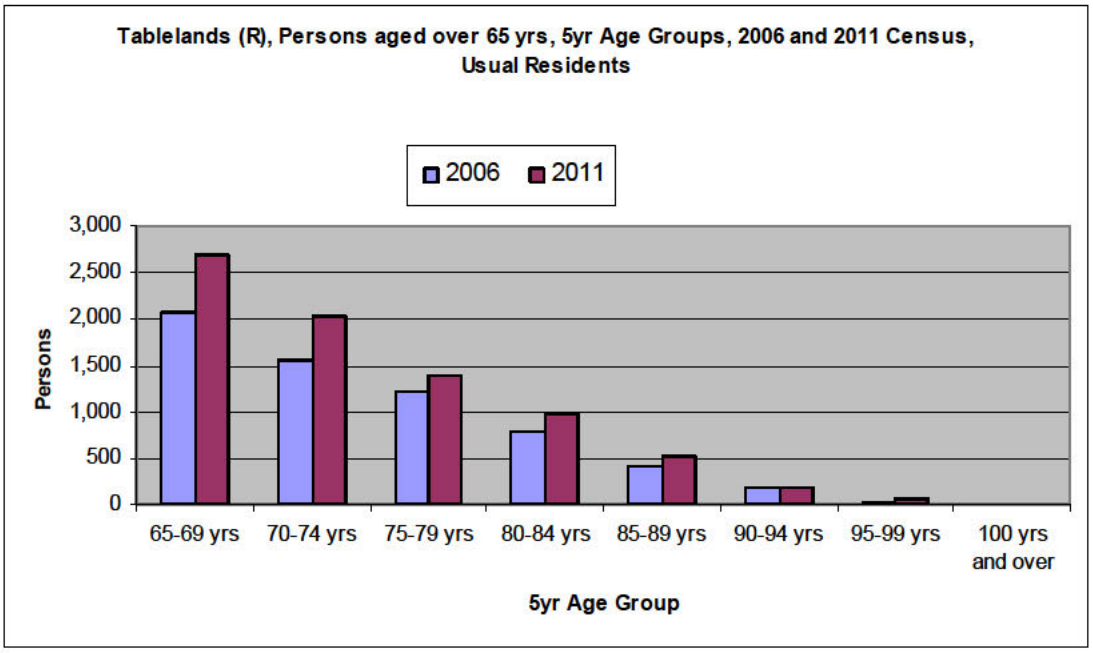
    - Concerns are held that this may result in a 2 tiered system with inequality in service provision from federal and state funding due to funding reporting requirements differing within commonwealth and state arenas.

Contributor 2: Tablelands Health Service, Qld Health – HACC Services

The Atherton Tablelands has an increasingly ageing population appropriate for HACC services :-

Tablelands (R) local government area:

Total population, usual residents	43,727 persons
Usual residents aged 65 years and over	7,817 persons
Persons aged 65yrs+ as % of Total population	17.9%



There are a large number of HACC service organisations, both NFP's and government in the area. Since their inception there has been a central model of referral and assessment. The Tablelands HACC Assessment Team (THAT), which is auspiced via QH and line managed and integrated into Atherton Community Health, do the assessment for all services (and the 14 HACC service types available), encompassed in the geographical area covered. HACC services are not the only services available to HACC eligible clients.

This model ensures consistency of access, equity and expert assessment and referral of HACC eligible clients to ALL services not just HACC service, or HACC service providers. Whilst not the cheapest model, it is effective and efficient, ensuring integration across service providers whether public, private or NGO.

In the short medium and long term this provides:

- high quality client services (right service/s, right time, most appropriate provider)

- single contact point for clients and services for when things change e.g. increasing needs, moving away, new services required.
- improves general health and outlook of clients, reduces inappropriate hospital admissions
- provides access to services for clients and reduces the number of health professionals involved and reduces client confusion.

There is a need within this program to incorporate the (service type) element of case management to better coordinate those HACC eligible clients with multiple problems (health, psychosocial), who are most vulnerable and often with little or no family or friends to advocate for them. We believe that there is a perception, that often this role is assumed by General Practise. But our experience is that, in the main, general practise are very busy, with waiting time to see GP's between 2 and 3 weeks in our area. General practice also have limited other staff who can support the time required for these clients with in their business model. In addition, for some Tablelands residents, they have difficulty accessing a GP practice, and therefore will not be case managed by a GP.

In a recent round of HACC funding tender, the provision of personal care and domestic assistance was provided to a new provider with no base in FNQ. They did receive money for Tablelands services, none of which have ever been delivered. Whilst the idea of choice for clients and competition in theory are good, if savings are made with economies of scale, then it would be more sensible to provide existing providers in smaller population areas, such as ours, with the opportunity to tender, rather then wear the cost of establishing the infrastructure etc to set up a new office and result in the reduction of service for HACC clients. It is very important, that the HACC funds be utilised, as much as possible for services to clients.

Palliative Care

The Tablelands Health Service has a palliative care service, auspiced under Mareeba Community Health. This service has community health nurses to case manage these clients and to make referrals to appropriate service providers eg allied health and Blue Care nursing. They also oversee and maintain an equipment pool for palliative care patients to be cared for in their own homes. This is an excellent model, providing care for this group of patients close to their homes, family and support networks.

With the lack of private allied health services on the Tablelands, especially services that will visit clients at home, there needs to be consideration of additional funding being available for allied health services - social work, occupational therapy, physiotherapy, dietetics, speech pathology, psychology for these clients.

It is also important to be aware of the need for social work/psychology follow up for families, once a palliative client passes away. This is currently being absorbed by hospital social workers, on top of their growing caseloads.