QUEENSLAND HEALTH

Metro North Hospital and Health Service

Submission to Health and Community Services Committee

Inquiry into palliative care services and home and community care services in Queensland

Committee Terms of Reference

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

Executive Summary

This submission is substantially drawn from the Metro North subacute services plan 2012 (Section 5). The submission is focussed on the current state of palliative care within the Metro North Hospital and Health Service.

Topics addressed

1. Increasing demand and insufficient resources
2. Community Palliative Care
3. Community and Hospital linkages
4. Consulation Liaison services
5. Palliative Care Beds
6. Capacity of specialist palliative care teams (hospital and community)
7. Home and Community Services (HACC)
8. Chronic disease and palliative care

Recommendations

Short term:

- Increase workforce capacity of existing services in line with identified priorities (see capacity topic below) to ensure existing service delivery is safe and appropriate for the settings and patient cohorts they are delivered to, with regard to the significant gap in specialist community services, CSCF (v3) and PCA (2003) guidelines.

Medium term:

- Review the funding levels and distribution methods for palliative community services.
- Resource inpatient bed capacity at Caboolture and the RBWH to address the deficit in Palliative Care beds.

1. Increasing demand and insufficient resources

- The demand on Palliative services has substantially increased nationally over the previous decade. This has been attributed to the ageing population and changing patterns of disease that mean that an increasing proportion of people are expected to suffer and eventually die from chronic progressive illnesses (AIHW, 2011)
- The population of Metro North will increase from 875 551 in 2011 to 954 481 in 2016, a nine per cent increase.
- Metro North population with weighting for palliative care needs show a 2011 weighted population of 1 052 206 increasing to 1 248 185 in 2016, an 18.6 per cent increase.
- In Metro North there has been very little increase to resourcing to match this increasing demand. Only a small amount of recent National Partnership Agreement (NPA) funding was allocated to palliative care in Metro North. These funds were justifiably directed to community palliative care services, however hospital based specialist services have received no NPA funding to allow these services to grow to meet demand.
- As set out under some of the topics below, particularly 'capacity' it is clear that Metro North Palliative Care services are insufficiently resourced to meet these increasing demands.

2. Community Palliative Care

- Funding of external providers in Queensland is administered through the scripting of Commonwealth provided Palliative Care Program (PCP) funds, along with some block funding of certain providers. This dual system has lead to the perception of some services 'double dipping' and placed strain on the links between specialist services and external community providers. A survey of community NGO providers conducted by the Metro North working party in 2012 revealed strong and consistent dissatisfaction with PCP funding. Frustrations included the time limitations attached to funding and the insufficiency to meet client needs (particularly for consumables and equipment). PCP funding should be reviewed, both in the way it is administered and the sufficiency of the funding to meet community demand.
- In one Western Australian study, those who accessed community based specialist palliative care had a seven times higher chance of dying in their usual place of residence (McNamara & Rosenwax 2007). The capacity of specialist nurses and palliative care medical staff available to perform community work across Metro North are well below recommended levels (see capacity topic below). This must be addressed to allow equitable access to specialist palliative care community services and appropriate support for other community providers. The potential for community palliative to reduce hospital admissions is both an improvement to quality of care and a potential cost savings to acute hospitals.

3. Community and Hospital linkages

- In Metro North multiple community NGO services operate in isolation from each other, with overlapping geographic boundaries. This makes integration of hospital and community services difficult. Efforts are being made to consolidate these services and establish consistent linkages and processes.
- The role of palliative care Nurse Practitioner has proven of great value in maintaining effective and supportive links between services. Community providers involved with the Nurse Practitioner role based out of Redcliffe Hospital have consistently highlighted the benefits of having this support. For example:

  'The opportunity that the Nurse Practitioner role has provided has been beneficial. Joint visits with the Nurse Practitioner have allowed education opportunities as well as facilitating client choice for place of end of life care.' (2012 Community Survey)

- It is recommended that the Nurse Practitioner role be promoted and funded as a valuable supportive link between specialist and generalist services in the community. This focus on the Nurse Practitioner role as a key aspect to the delivery of community palliative care is promoted in the South Australian service model (SA Health, 2009, p.21) and is a minimum requirement of CSCF Level 5 and 6 services (CSCF v3.0, 2007, p. 11).

4. Consultation Liaison services

- The Palliative care service delivery framework and funding model: final interim report (The Aspex Consulting, 2010) highlighted the role and benefit of consultation services and that growth in this sector was key to meeting increased demand, particularly with regards to providing specialist palliative care when and where it is needed. The traditional role of the consultative team has expanded beyond the provision of patient and family support, pain and symptom control and discharge planning support. It is front line medicine with high-level expertise providing primary direct care for patients with advanced disease rather than discretionary care (Lagman et al, 2008).

- Consultation Liaison services need to be considered in service planning so that expansion occurs in line with growth of related services, primarily oncology but also chronic diseases. These need to be staffed adequately in FTE and professional skill sets (for example with CNC level nurses) in order to provide a specialist service able to support palliative training places. This is not currently the case across Metro North (see capacity below).

5. Palliative Care Beds

- To determine the demand for palliative care beds, two benchmarks are applied to Metro North with similar results:
    - Applying the PCA (2003) benchmark of 6.7 beds per 100 000 unweighted population to the 2016 unweighted population of 954 481 leads to a total of 63.9 designated palliative care beds (combined public and private).
    - Applying the Queensland Health (2010) benchmark of 4.9 beds per 100 000 weighted population to the 2016 weighted population of 1 248 185 leads to a total of 61 public and private designated beds. Applying the Queensland Health (2010) benchmark of 3.9 beds per 100 000 weighted population to the 2016 weighted population of 1 248 185 leads to a total of 48.7 public designated beds.

- Taking into account the known private palliative beds in Metro North, this leaves an existing gap of 12 to 17 designated palliative care beds (or bed equivalents), depending on which benchmark is used and what number of public beds is attributed to the St Vincent's specialist service.

- It is recommended that future allocation of designated palliative care beds in Metro North should be prioritised to Caboolture and the Royal Brisbane and Women's Hospital (RBWH). This recommendation is based on population needs and the patient types cared for by these services:

    - Caboolture has no designated public palliative care beds and must access these through Redcliffe, TPCH or St Vincent's Hospital. Caboolture has been identified as having a higher indigenous population, lower socioeconomic status and a higher prevalence of chronic diseases which amplifies the need of this region for public designated palliative care beds.

    - The RBWH also has no designated palliative care beds and must access these through Redcliffe, TPCH or St Vincent's Hospital. In addition to the population needs of the RBWH, the RBWH provides a CSCF Level 6 oncology service, one of the largest bone marrow transplant units in Australia, which draws patients from all over the state. Transferring patients to other facilities involves complex decision making at the end of life, with patients and families often wishing to stay within the facility that has provided care since diagnosis. A dedicated unit would provide best evidence based care to a quaternary facility of 1000 beds thereby decreasing the burden on medical and nursing clinicians who may not have the resources, skills or experience to provide the required care.

- A dedicated unit needs to reach a certain size to establish efficiency of service delivery, as well as to allow the appropriate appointment of key positions under currently accepted standards for all types of inpatient units. The number of beds that this equates to is thought to be somewhere between 10 and 16 beds (SA Health, 2009), though Queensland Health have not yet set a benchmark in this area.

6. Capacity of specialist palliative care teams (hospital and community)

Medical:

PCA guidelines recommend 1.5 full time equivalent (FTE) of palliative care specialist and 1 FTE registrar per 100 000 (PCA, 2003). These are recommended levels to work across the areas of community, consultation liaison and inpatient units.

Table 1: Palliative Care Medical FTE Metro North (across all areas of community, C/L and inpatient units)

	Current	2011 PCA	2016 PCA
Specialist	6.6	13.13	14.32
Registrar	5	8.76	9.54

This shortage particularly impacts on the volume of specialist care that is able to be delivered in the community as care delivery in this setting has the additional time requirements of travel and poor access to resources.

The shortage also impacts consultation liaison (C/L) services. The Australasian Chapter of Palliative Medicine (ACHPM) defined the number of staff specialists required to support a designated number of referrals in an acute hospital as one specialist per 250-300 referrals. At the RBWH, 948 separations occurred in the 2011 calendar year (PCOC data, 2011). Based on the recommendations above, this would require 3-4 specialists for C/L services alone. There are currently 2 Palliative Care specialists funded at the RBWH. Caboolture Hospital is only able to be visited for consultation liaison services once per week by the Redcliffe team.

Nursing:

Two Nurse Practitioners (NP) are funded to provide specialist palliative care community nursing across Metro North. No clinical nurse consultants (CNC) and 2 clinical nurses (CN) are allocated to community specialist palliative care, within Queensland Health facilities. The 2012 community survey confirmed that no CNC or NPs are employed in palliative care external to Queensland Health. Some CNs are employed in this sector, though this does not close the 15 FTE gap to the PCA level.

Table 2: Nursing FTE dedicated to community within SPCS

	Current	2011 PCA	2016 PCA
NP	2	Not included	Not included
CNC	0	8.76	9.54
CN	2	17.5	19.09

PCA guidelines recommended 14.3 FTE CNC level nurses dedicated to consultation liaison based on the number of beds covered across Metro North. Currently the RBWH has two CNC, TPCH team has one CNC and Redcliffe team none.

Table 3: Nursing FTE dedicated to Consultation Liaison within SPCS

	Current FTE	2011 PCA FTE	2016 PCA FTE
CNC	3	14.3	Dependent on future bed numbers

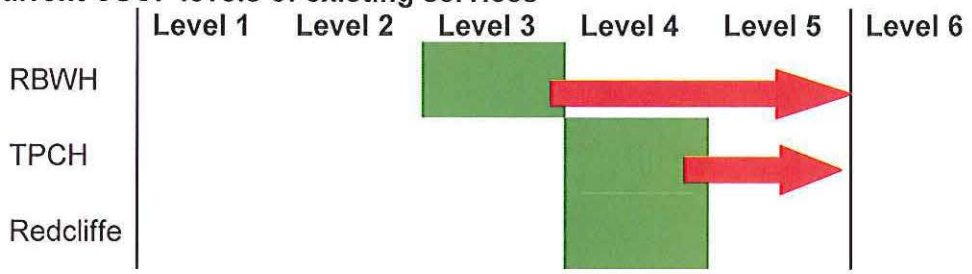
Allied Health:

The PCA (2003) guidelines recommend a total of more than 20 FTE Allied Health dedicated to specialist community palliative care based on Metro North population. There is some access to Allied Health through the P&CHS and various NGO. It is difficult to conclude how significant the gap may be in this area, given the unknown capacity outside of the dedicated palliative service.

CSCF Levels:

The CSCF framework (CSCF v0.3 2007) recommends that a cancer service of CSCF Level 5 or 6 should be supported by a specialist palliative service of at least CSCF Level 5. This applies to both the RBWH and TPCH services. There is currently no Level 6 Palliative Care service in Metro North.

Current CSCF levels of existing services



Arrows indicate appropriate CSCF levels in consideration of cancer services supported.

RBWH

The RBWH meets the minimum requirements of a Level 3 palliative care service, and has almost all requirements of a Level 4 service with the exception of 24 hour access to a medical specialist in palliative care. In order to meet Level 5 the service would additionally require:

- designated inpatient beds
- on-site bereavement service
- 24 hour access to a registered nurse with palliative care qualifications or demonstrated competency in palliative care
- a dedicated multidisciplinary Allied Health team, including a pharmacist (not just access to a team)
- A Palliative Care Nurse Practitioner with relevant advanced training desirable.

TPCH and Redcliffe teams

Both TPCH and Redcliffe specialist palliative care teams meet the minimum requirements of a Level 4 service and would require a designated bereavement counsellor to meet Level 5 requirements.

In Metro North this insufficient resourcing means that:

- Patients cannot be admitted after hours or on weekends causing inefficient utilization of available beds and delays in transferring patients from acute beds. This also results in reducing occupancy rates giving the impression that the beds are not being utilized when in reality the beds are almost always full with multiple patients waiting for a bed.
- Important services such as support for RACF cannot be provided
- Some services are insufficiently equipped to adequately cover the beds allocated to that service for consultation liaison services and are not sufficiently staffed to take on palliative care student placements
- Rosters and staffing are stretched to the degree that burn out is a constant challenge for specialist palliative care teams.
- Specialist Palliative Care Services are not appropriately aligned with CSCF levels, based on services and staff available in each service.

Workforce Priorities

Priority areas for future workforce have been identified below. Consideration has also been given to the identified demand, CSCF service levels and PCA (2003) guidelines. For example, the Redcliffe C/L service does not have a CNC allocated to it. PCA guidelines recommend 2.89 FTE CNC for the number of beds covered (482) and it is also a requirement of the RACP that at least one CNC is on staff for the service to be able to take advanced training registrars for their consultation liaison module. The Redcliffe C/L service is currently only able to visit Caboolture hospital on a weekly basis for C/L services.

Table 4: Future Workforce priorities for Metro North SPCS

	Medical FTE	Nursing FTE	Allied Health FTE
RBWH	+ 1 Consultant + 1 Registrar	+ 1 Nurse Practitioner + 0.5 CN	+ 1 Social Work + 0.5 Pharmacy
TPCH	+ 1 Consultant + 1 Registrar	+ 1 CNC	+ 0.5 Pharmacy + 0.5 SW
Red / Cab	+ 1 Consultant + 1 Registrar	+ 1 CNC	+ 0.5 Pharmacy + 0.5 SW

These proposed increases to staffing levels were selected according to areas of greatest need that would best contribute towards the future Model of Care. Even if each of these positions was funded, significant gaps would remain between recommended and actual staffing levels.

7. Home and Community Services (HACC)

With regard to Home and Community Services (HACC), Metro North recognises that increasingly, provision of these services fall outside its remit. We are of the view of those patients who require domestic assistance, low level support etc would benefit most if these services were delivered by community providers whose core business revolved around such activity e.g. domiciliary organisations in the non government sector.

8. Chronic disease and palliative care

People who are frail or elderly, or with significant disability requiring home support services, and people requiring palliative services, are more likely to also have acquired chronic disease with one or more co-morbidities. They have high care needs and often have restricted access to care that is not home-based or at least provided from a single, convenient community location. To support continued capacity to live as independently as possible at home, palliative, and home and community services, need to be supported by local, community based multidisciplinary teams with general skills in chronic disease care. To further ensure best practice, general teams should be directly supported with ready access to specialised advice. This support will generally be best provided by collaboration with public hospital based disease-specific or chronic disease specialist teams, but could also be provided in some circumstances by the private sector, where local arrangements to provide team-based multidisciplinary care are in place.