#

METRO NORTH BRISBANE MEDICARE LOCAL SUBMISSION TO QUEENSLAND PARLIAMENTARY INQUIRY INTO PALLIATIVE CARE AND HACC

6 August 2012

Contact: Jeff Cheverton, Deputy CEO

medicare local
METRO NORTH BRISBANE
Connecting health to meet local needs

1. About us

Metro North Brisbane Medicare Local (the Medicare Local) was established in July 2011 as part of Australia's national health reform. Our aim is to improve Queenslanders' access to primary health care services in our region by identifying and responding to local need or gaps in health services. We also work with the local Hospital and Health Services, Queensland Health to smooth people's journey from hospital to home. We try to improve health service coordination in the community and improve connections amongst health professionals.

2. Palliative care as a priority

One role of the Medicare Local is to undertake an analysis of the primary health care needs of our population. To produce this Needs Assessment we consulted with Queensland Health in our region, reviewed national data on health and social services, mapped the service system and analysed information from our contact with more than 200 agencies working in primary health care in our region. Further detail of this Needs Assessment is available on our website.

The Needs Assessment identified thirteen top priorities from amongst all the many and varied populations and service gaps in the region. Palliative Care was identified as a key priority and for this reason we are sharing our understanding of the challenges in this area with the Inquiry.

3. Key issues we have identified

Prior to the formation of the Medicare Local in July 2011, our predecessor organisation, GPpartners also undertook considerable work to better connect primary care services in the region. The information which follows is drawn from the experience of staff in both organizations over the last five to ten years.

The need for a structured, funded framework across Queensland

Queensland Health does have a Clinical Services Capability Framework, but unlike the frameworks of Victoria, South Australia and Western Australia, Queensland Health describes levels of palliative care requirements and the workforce that should be available to provide these services, but does little to describe a structure as to how that is achieved.

There are "pockets of excellence" in palliative care in Queensland but the majority of that is champion led and not necessarily strongly embedded in strong organsiational structures and processes. For example, we had an excellent outreach service for residents of residential aged care in the northern suburbs of Brisbane run by nurse practitioners from The Prince Charles Hospital. However when that nurse practitioner and the Director of Services vacated their posts, the service declined.

Unfortunately because of this – those "pockets of excellence" fluctuate as unsupported staff burn out and exit the system.

Queensland needs a **structured** framework that clearly identifies with the needs of the community requiring palliative management.

Queensland Health has a Clinical Services Capability Framework for Palliative Care, but this simply identifies pre-requisites for levels of care within the Queensland Health system. Most of the palliative care work, however, occurs in community by community service providers. A hospital framework alone is not sufficient to create a performing palliative care system. A collaboration of all providers in palliative care that is community-led will produce an effective framework.

One of the major problems with Queensland's services is that there is very limited dedicated funding to support the palliative system.

Current systems, gaps and issues

Current systems in palliative care bed management refer to access for people in their last 12 to 6 weeks of life. This is an outdated approach that does not provide sufficient flexibility. For example, if you have an acute exacerbation of your symptoms that require tertiary level intervention than you should be able to access this, whether or not a determination is made that your life will end within six weeks.

Our best knowledge is that there are currently no hospice beds in Brisbane, significantly reducing choice for clients and their families and placing significant pressure on palliative care units in hospitals and residential aged care facilities (RACF).

Professor Yates reminds us in her public briefing paper: *"because progress in medical management has been made, we are able to provide a broader range of support and intervention, extending that last phase of life. This means that there will be more need for clear pathways across community and public and private health systems."*

Individuals have choice, and many prefer to manage at home as much as possible. There is little clear fluidity in our system to enable easy movement of patients across the 'levels' of care (let alone providers of care) sufficient to provide management to stabilise their acute symptomatic exacerbation enough for them to return home and be maintained by their General Practitioner (GP) and community supports.

Even reading the Victorian Palliative Care Framework it is still unclear if the structure around community and acute relates within Victoria itself, or if those support structures are available to non-government organisations working in the community.

One of the largest gaps in the Queensland framework is the complete lack of inclusion or formal recognition of residential aged care in the palliative process, despite this being a hot topic of conversation when the acute faculties talk about 'hospital avoidance', appropriateness of admission, and bed management.

Care provided in residential aged care will – and does – cover most levels of care service, except for tertiary Level 6 and perhaps Level 5 care but, lack the access to the service requirements as written in the Queensland Clinical Services Capability Framework, Version 3.0 such as "close liaison with a Department of Emergency Medicine (and is this appropriate? Should it not be with a Specialty Palliative Care Service?) and access to relevant mental health services.

Victoria has worked on developing a framework for residential aged care and evaluation of this could assist in framework development for Queensland.

Work to support staff of residential aged care in palliative care management in Queensland, again is spasmodic, champion led and non-sustainable, nor reliable.

Improved support to residential aged care staff and GPs in the form of easily accessed phone advice 24 hours/7 days a week would assist in reducing hospital admissions. There is currently a 24hr/7days per week helpline for families and palliative care individuals, through Karuna Hospice Service. I believe this is funded through Queensland Health.

Quality/Education/Funding

While so much work is being done by RACFs and community organisations in palliative care, there remains no consistent structure or quality framework around this work. One example of such a framework is that used by Silver Chain in Western Australia.

The Australian Government has also funded a University led program called the Palliative Care Outcomes Collaborative (PCOC). However, this is just starting to roll out to non-government organisations, and still does not address the structure needed to provide quality outcomes, but acts as a measure that will enable organisations to benchmark outcomes in the future.

The Palliative Education Program trains GPs and previously required a six month commitment. This does offer some funding to cover costs of the GP attending but it remains a predominantly self-funded education program. Our engagement with GPs three years ago suggested that re-directing this funding to establish GP mentoring programs might be a more effective use of these Commonwealth funds. The Centre for Palliative Research and Education has now changed this program to a four-day course with a quota of 20 GPs annually which includes a strong mentoring component. There remains limited evidence about the outcomes this program has produced.

GPs, on the whole are generalists. Some do undertake special interest education, however, in the main, what they require is specialist support and clear guidelines about symptom management.

Palliative care is also significantly impacted by the ability of GPs to undertake home visits and provide after hours service. The current significant transition program in the delivery of after-hours funding, may well impact the delivery of primary palliative care services. Similarly quality systems and practice frameworks should apply to deputising services that provide care after hours on behalf of GPs.

Support to GPs could also be provided through an accessible phone and/or telehealth service. Funding for this type of service could clearly be offset by reducing admissions to the acute system.

Attempting to provide supported, quality, and appropriately flexible palliative care to individuals in the community is hampered by the constrictions of the funding instruments such as HACC. Palliative care services need identified funding to provide evidenced based, quality services relative to the current needs of the individual and not based on the funding criteria.

Palliative care for children appears as the specialty that it is and requires its own structured and funded framework. Although family support and wellbeing are of high importance for all age groups, it appears there is a more intense need for these supports for the family of the young.

Collaboration

There have been collaboration projects in Queensland but they have been sporadic and have not attracted sustained corporate support.

Metro South Brisbane Collaborative has been a functioning collaborative for some time. This collaborative has developed and implemented a number of interventions to assist health carers in the management of palliative care for individuals, however it does not reach easily across the Brisbane river.

The Universities have aligned themselves with various health districts. Griffith University works more closely with the Metro South Brisbane region while Queensland University of Technology and University of Queensland tend to work more with the north Brisbane region. An identified structured framework could help consolidate research into service delivery across universities and across health regions.

The Metro North Brisbane Health Service do have a working committee amongst the Directors of Palliative Care for the northern public hospitals and the Nurse Managers for palliative care units in the District. This group as yet does not include the private health system, nor the non-government (not for profit) community organisations nor residential aged care.

4. Future plans

The Medicare Local has already provided funding for experienced palliative care nurses from Queensland Health to undertake a train the trainer course in End of Life decision-making. We are now funding the delivery of this training to nurses in residential aged care facilities. This is only one aspect of what the community needs but it is a concrete step.

We are concurrently in negotiations with the Commonwealth to fund a Palliative Care Framework project. This project will work with Queensland Health, private hospitals and residential and community-based aged care providers, and those directly affected and their families to establish a Palliative Care

Framework. This framework will ensure quality and consistency for those people nearing the end of life and requiring palliative care services.

www.mnbml.com.au
Suite 2, Ground Floor, Centro Lutwyche
543 Lutwyche Road, Lutwyche QLD 4030
PO Box 845 Lutwyche QLD 4030
t 07 3630 7300 f 07 3630 7333

Level 2, 10 Endeavour Boulevard
North Lakes QLD 4509
PO Box 929 North Lakes QLD 4509
t 07 3490 3490 f 07 3630 7400

Partners 4 Health Ltd (ABN 55 150 102 257), trading as the Metro North Brisbane Medicare Local.

Medicare Locals gratefully acknowledge the financial and other support from the Australian Government Department of Health and Ageing