Palliative Care

Clinical Services Plan

2017–2022
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Metro North Hospital and Health Service (MNHHS) is committed to delivering tailored high quality timely palliative care that supports quality of life for people who are dying. Palliative care services across MNHHS are under significant demand pressures. With a growing and ageing population, demand for palliative care is expected to significantly increase over the next five years. Service demand pressures together with out-dated service models and built infrastructure constraints have resulted in the development the MNHHS Palliative Care Clinical Services Plan 2017-2022.

This Plan describes our commitment to redesigning MNHHS palliative care services for adults to better meet the care needs of people who are dying, their families and carers across Brisbane North. Our care will be tailored to what is important to the individual, being respectful and responsive to the diverse cultural, spiritual, social and emotional care needs of patients, families and carers. We recognise families and carers are the mainstay of care for many people who receive palliative care. Ensuring families and carers are supported to undertake this role is a priority. Figure 1 below displays MNHHS future service state with the needs of the patient, families and carers at the centre.

MNHHS’s future palliative care service network will complement services provided by private, non-government and community providers of palliative care across Brisbane North. We will work in partnership with all service providers to deliver excellent care for palliative care patients, families and carers in the home, community and hospital settings.

The Plan outlines five service directions with corresponding actions to be implemented over the next five years.

**Service Direction 1: Excellent high quality palliative care will be delivered across MNHHS**

MNHHS staff will provide timely, responsive and appropriate palliative care across all specialities. Patients will be involved in planning their care including making decisions about what is important to them — their goals of care and how these may change over time. All care will be respectful and responsive to individual cultural, spiritual, social and emotional care needs and preferences.

**Figure 1: Future services that will support palliative care patients, families and carers across the phases of palliative care**

![Diagram showing future services for palliative care patients, families and carers across phases of care](image-url)
Service Direction 2: MNHHS will develop a networked service delivery system across settings

Over the next five years MNHHS will create an integrated palliative care service system across settings, for patients requiring palliative care. The redesigned service network will be supported by cohesive teams which provide care across community, hospital and designated inpatient palliative care settings.

We recognise the important role of general practitioners, non-government, community and private palliative care service providers in supporting care of palliative care patients to remain at home. MNHHS will remove organisational barriers, streamline policies, processes and procedures, and introduce new models of care to deliver care seamlessly across settings.

Service Direction 3: MNHHS will enhance patient access to home and community based palliative care services

MNHHS recognises most people receiving palliative care prefer to be cared for at home. We also recognise that many people do not achieve this goal. Our priority is to change this and enable more people to receive palliative care in the home. We recognise families and carers provide the mainstay of care for many people who receive palliative care at home.

Ensuring families and carers are supported to undertake this role is a priority. Multidisciplinary specialist palliative care teams will be established to provide 24/7 advice and support to people being cared for at home (including residential aged care).

Service Direction 4: MNHHS will grow specialist palliative care capacity

Over time specialist palliative care capacity will be enhanced to provide improved local access to palliative care consultation liaison and inpatient services at all hospitals. Specialist palliative care teams will work with specialist treatment teams across care settings to ensure patients receive the highest quality evidence-based palliative care. Sensitive timely conversations with patients, families and carers will take place regarding treatment that is not likely to bring benefit or prolong life to an acceptable quality.

Service Direction 5: MNHHS will advance research, education and training to deliver innovative evidence-based palliative care

Palliative care research and education and training will be actively pursued. Efforts in research and education will directly benefit patients receiving care in MNHHS, their families and carers and contribute to a larger body of evidence statewide, nationally and internationally.

*Note: Planning for Caboolture Hospital redevelopment will include designated palliative care services
How to read this plan

The MNHHS Strategic Plan describes our vision, purpose and service objectives.

The Health Services Strategy describes four focus areas which reinforce MNHHS’s commitment to providing high quality care centred around individual need and preferences.

This Palliative Care Clinical Services Plan 2017-2022 will assist in delivering key actions contained in the Health Service Strategy, together with contributing to delivery of the MNHHS Strategic Plan.

The relationship and cascade of strategic documents and health service plans is described below.

Effective: October 2019 / Review: October 2020
Introduction

Providing high quality and timely palliative care to people with a life limiting illness, their families and carers is a priority for MNHHS. MNHHS delivers care to a local population of over 957,000 people and also supports the care of people from other Hospital and Health Services (HHS) who are receiving treatment in MNHHS hospitals. MNHHS has a long history of supporting the care needs of people who are approaching end of life, their families and carers through:

- domiciliary community services including personal care, nursing and allied health support in the home;
- consultation liaison services in the acute ward setting;
- specialist palliative medicine outpatient services;
- specialist palliative care teams providing palliative care in dedicated palliative care facilities.

MNHHS has led the way in Queensland advancing the palliative care nurse practitioner model to enable people who are dying to remain at home (including residential aged care). Complementing our community services, specialist multidisciplinary palliative care teams provide care at Royal Brisbane Women’s Hospital (RBWH), The Prince Charles Hospital (TPCH) and Redcliffe Hospital. Palliative care services at Caboolture and Kilcoy Hospitals are provided through a partnership arrangement with Redcliffe Hospital.

MNHHS recognises that we are not the only provider of palliative care services in Brisbane North. MNHHS will work in partnership with non-government, private and not-for-profit palliative care services to complement rather than duplicate care.

This Plan demonstrates MNHHS’s commitment to redesign palliative care services to ensure equitable access across the region and to better meet the care needs of our patients, families and carers. Once implemented the outcomes of the Plan will result in:

- patients and their support network (including families and carers) being at the centre of all care decisions throughout the course of their illness;

improved access to safe, sustainable and evidence based palliative care services across service settings;

- enhanced collaboration and coordination of services between service providers;

- increased capability and capacity of MNHHS staff providing palliative care to participate in education, training and research activities;

- translation of palliative education and research into practice across community and facility based services.

Scope of this plan

Recognising the benefits of working together across MNHHS this plan considers community, ambulatory, inpatient and subacute health services.

For the purpose of this Plan adults aged 16 years and above are in scope. Children and neonates are not in scope for this plan.

3.1 Definitions

For the purpose of this Plan, the following definitions will be used to ensure consistent understanding of issues and solutions. MNHHS recognises these definitions may not be consistent with other published definitions.

Palliative care

Palliative care is an approach that improves the quality of life of patients facing life-limiting illness and their families. Palliative care incorporates the prevention and relief of suffering through early identification, timely assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Figure 3 depicts the palliative care definition.
End of Life
Healthcare services aimed at meeting the holistic needs of people (including infants and children) whose life expectancy is anticipated to be shortened as a result of known progressive life-limiting illness and where the primary intent of care may be shifted from life prolongation to a focus on quality of life.

Phases of palliative care

Stable
Patient problems and symptoms are adequately controlled by an established plan of care, further interventions to maintain symptom control and quality of life have been planned, the family/carer situation is relatively stable and no new issues are apparent.

Unstable
An urgent change in the plan of care or emergency treatment is required due to at least one of the following: the patient experiences a new problem that was not anticipated in the existing plan of care, the patient experiences a rapid increase in the severity of a current problem or the patient’s family/carer circumstances change suddenly impacting on patient care.

Curative Care Dying Death
Person with illness
Support for families and carers
Families Carers
Disease progression

Specialist palliative care service
A specialist palliative care service is a multidisciplinary health care service that predominately cares for complex patients who have a progressive life-limiting illness. Specialist palliative care professionals have recognised qualifications or accreditation in palliative care.

This Plan has been developed within the context of a range of national, state and local directions and frameworks for palliative care. Consideration of Brisbane North’s growing and ageing population, increasing incidence of disease, a changing service system together with a review of literature and evidence-based practice have informed the development of this Plan. A summary of the palliative care context is described below.

4.1 Policy

The ‘National Palliative Care Strategy 2010: supporting Australians to live well at the end of life’ continues to represent Commonwealth, State and Territory Governments’ commitment to palliative care. The strategy describes five goals that aim to support a coordinated and consistent approach to the delivery of high quality palliative care to all. The five goals are shown below:

Table 1: National Palliative Care Strategy 2010: supporting Australians to live well at the end of life, Goal Areas

<table>
<thead>
<tr>
<th>Goal Area</th>
<th>Number</th>
<th>Goal</th>
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<tbody>
<tr>
<td>Awareness and Understanding</td>
<td>Goal 1</td>
<td>To significantly improve the appreciation of dying and death as a normal part of the life continuum.</td>
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<td></td>
<td>Goal 2</td>
<td>To enhance community and professional awareness of the scope of, and benefits of timely and appropriate access to, palliative care services.</td>
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<tr>
<td>Appropriateness and Effectiveness</td>
<td>Goal 3</td>
<td>Appropriate and effective palliative care is available to all Australians based on need.</td>
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<tr>
<td>Leadership and Governance</td>
<td>Goal 4</td>
<td>To support the collaborative, proactive, effective governance of national palliative care strategies, resources and approaches.</td>
</tr>
<tr>
<td>Capacity and Capability</td>
<td>Goal 5</td>
<td>To build and enhance the capacity of all relevant sectors in health and human services to provide quality palliative care.</td>
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</tbody>
</table>

Palliative Care Australia also developed ‘Standards for Providing Quality Palliative Care for all Australians’ in 2005\(^2\). Although developed in 2005, the 13 Standards and 88 quality elements continue to be applied today as quality management measures for improvement of activities and for benchmarking at a local, state or national level for palliative care. The Standards are based on a number of core values identified as: dignity, empowerment, respect for the patients, families and carers; advocacy of patient, families and carers wishes; and accountability towards patients families and carers in the community.

The Australian Commission on Safety and Quality in Health Care National Consensus Statement: "Essential Elements for Recognising and Responding to Clinical Deterioration 2010 provides an endorsed national approach for recognising and responding to clinical deterioration in healthcare in Australia. The Statement describes the essential elements for prompt and reliable recognition of, and response to, clinical deterioration. The provision of palliative care services in Queensland is guided by the Statewide Strategy for End of Life Care 2015. The strategy was developed “to strengthen the capacity of Queensland Health services to respond to the needs of those with a progressive life-limiting illness (at any life stage) through the delivery of services that prioritise patient goals for quality of life as key components of care”.

4.2 Population profile

MNHHS currently has a population of over 957,000 people. By 2026 our local population is anticipated to grow to almost one million, with the population growth for older people aged 65 years and over projected to increase by 40 per cent. This population growth will not be equally distributed with a high population growth expected in the northern part of MNHHS around Caboolture and Redcliffe Hospitals.

MNHHS also delivers services to regional and statewide catchments for complex specialist services. Approximately 20 per cent of patients cared for in MNHHS hospitals reside in other HHSs and as a result many patients referred to palliative care services in MNHHS are from outside our local catchment.

4.3 Mortality

It is estimated the total number of deaths of MNHHS residents will grow by over 1000 people from 5000 people in 2011-12 to over 6000 by 2026. This represents approximately 17.5 per cent of all deaths in Queensland.
In 2017 the majority of MNHHS palliative care services are operationally managed by the Community, Indigenous and Subacute Services Directorate (CISS). Palliative care at the RBWH is managed by the RBWH Directorate within the internal medicine services stream. As at April 2017 the palliative care service system in MNHHS includes:

- **Community nursing and allied health care** is provided in patients homes across Brisbane North by CISS.
- **Specialist community nursing** support care by advising, educating and triaging ongoing clinical management of palliative care patients with complex care needs in the community 24/7 by a nurse practitioner and community clinical nurse consultants.
- **Outpatient palliative care consultations** are available at RBWH, TPCH, Redcliffe Hospital and Caboolture Hospital. Outpatient palliative care consultations enable patients to receive multidisciplinary care to reduce pain and other symptoms without the need for admission to hospital. Telehealth outpatient consultations are provided to Kilcoy Hospital by the Redcliffe Hospital palliative care specialist.
- **Inpatient consultation liaison services** provide direct specialist palliative care for patients with advanced disease in consultation with the patient’s treating team. This service is provided by specialists in palliative medicine and clinical nurse consultants with access to other multidisciplinary team members.
- **After hours support** provides a palliative care consultant rostered on-call on week days from 5pm to 8am and 24 hours a day on weekends. All emergency departments in MNHHS to provide after hours support.
- **Acute inpatient units** provide acute nursing, medical and allied healthcare to patients with a broad range of medical, surgical and complex specialty conditions. Specialist palliative care services for patients admitted to an inpatient ward is provided by the consultation liaison service affiliated to the facility.
- **Designated inpatient palliative care** is provided at TPCH and Redcliffe Hospital. Each hospital has a 16-bed unit that provides inpatient specialist palliative care to residents of MNHHS and from other HHSs. Kilcoy Hospital also has a dedicated palliative care bed that can be supported by staff from Redcliffe Hospital.

MNHHS hosts the Centre for Palliative Care Research and Education (CPCRE). The CPCRE was established to enhance palliative care services in Queensland through education and research.

A number of community, non-government and private providers deliver palliative care services in Brisbane North. Each provides different services ranging from inpatient care, consultation services, outpatient services and specialist palliative services in the community/home for patients, families and carers.
5.1 Service activity

Analysis of data from services delivered/funded by MNHHS shows demand for palliative care services has increased over time. MNHHS recognises there are limitations in the ability to analyse palliative care data due to varying clinical practices across settings and services. There is also limited ability to consider activity across service providers as there is no agreed minimum data set.

Until early 2016 community palliative care was provided by Blue Care and Silver Chain. A review of activity reported by these service providers indicates:

- approximately 840 individual patients received community based palliative care totalling over 24,200 days of service in 2015-16;
- Redcliffe Hospital and Caboolture/Kilcoy Hospitals catchments had the highest numbers of patients receiving community based palliative care;
- over 75 per cent of people being cared for in the community were described as being in the stable phase of palliative care.

The following is a summary of service activity analysis from inpatient-admitted data sources only. Data indicates that:

- the demand for inpatient palliative care services for MNHHS residents has remained relatively stable over the last three years following a 23.3 per cent increase in total admitted (overnight and same) activity in the previous three year period;
- public hospitals provide the majority of inpatient designated palliative care services for MNHHS residents;
- a large proportion of palliative care patients die in hospital. This is consistent with other HHSs;
- over 73 per cent of all inpatient palliative care separations at MNHHS public hospitals in 2015-16 were people aged 65 years and over;
- over 56 per cent of all palliative care separations in 2015-16 were for people with a primary diagnosis of cancer. Patients with diseases of the respiratory system and diseases of the digestive system are increasingly referred to palliative care.
A range of issues and challenges have been identified through a review of literature, data analysis and stakeholder consultation. A summary of these are described below.

**Demand for palliative care**

As a result of a growing and ageing population together with the increasing incidence of chronic disease, demand for palliative care services in MNHHS will increase substantially over the next five years. Palliative care services in MNHHS will be challenged to meet demand for palliative care within current resources and current models of care.

**Patient expectations**

Patient’s expectations regarding palliative care and death are changing. Just as the expectations of curative care are high, the expectations of having choice in end of life care are increasing. The appropriateness of care, preferred places of care and death, as well as equity of access to care are becoming more increasingly important and people wish to be involved in decision making about their end of life care (AIHW, 2011).

Patients are seeking support from complementary services such as massage, music therapy, leisure therapy and aromatherapy. Recognising the role of complementary services is challenging in the traditional palliative care service delivery model.

**Consistent understanding of palliative care**

The language used to describe care at the end of life is not consistent across MNHHS. This often results in differences in interpretation of information among our staff, patients, their families and carers.

**Clinical coding of patients receiving palliative care**

Across MNHHS there are varying coding practices to capture palliative care activity across settings and services. This results in limitations in the ability to analyse palliative care demand and supply. Poor clinical coding practices also result in the loss of potential revenue due to inconsistency in recognising palliative care activity through care type change (sub and non-acute patient (SNAP)) and appropriate coding of palliative care using the Z51.5 International Classification Diseases (ICD) code.

**Patient’s care choices and decisions regarding death**

Many people die in MNHHS services without having conversations regarding end of life care. Documentation of a patient’s end of life choices and decisions regarding death are also often not prepared prior to death.

**Support for carers and families**

MNHHS does not have a consistent approach to supporting the cultural, spiritual, psychosocial, emotional and bereavement needs of families and carers. Access to information, support and education for families and carers will be different depending on where care is provided and who is providing the care.

**Recognition that all deaths are not the same**

Non palliative care staff are not always aware a ‘one size fits all’ approach to caring for patients who are dying is no longer appropriate. Evidence recognises life trajectories will be different depending on the disease. People who are dying of cancer commonly experience a period of relatively high function following their diagnosis, followed by a short sharp decline and then death. People with other conditions lose functions more slowly, with intermittent periods of serious illness before death. Those who are frail or have dementia are more likely to have a long period of relatively poor quality of life before death. Figure 4 on the following page displays the typical patterns of chronic illness leading to death.

**Access to MNHHS palliative care**

There are gaps in MNHHS palliative care services and access is often dependent on diagnosis and geography. People who are diagnosed with cancer and/or live in Redcliffe, TPCH and RBWH catchments are more likely to receive access to specialist palliative care. People who live in the Caboolture/Kilcoy Hospitals catchment have limited access to MNHHS palliative care services locally.
Care in the home setting
Most people at end of life in MNHHS die in hospital. Activating home based care takes time—coordinating medical care, nursing care, home care, home modifications and equipment. In many cases, the MNHHS palliative care service system cannot respond rapidly and the patient dies in hospital.

Palliative care in the home is reliant on the availability of families and carers. Often families and carers do not feel supported to fulfil this role with limited access to consistent clear information, education, training and support. There are limited respite care options in MNHHS.

MNHHS escalation protocols to enable families and carers to obtain advice regarding changes in the patient’s pain and symptom management are not clear. This often results in a crisis situation for families and carers where they feel they have no option other than presenting to emergency department for support.

Fragmented service system
There is poor service connectivity between services and service providers in Brisbane North. Each operates independently of the other often resulting in fragmented care for the palliative care patient.

MNHHS palliative care services have complex governance arrangements and operational environment which has contributed to segregated and complex referral procedures, unclear reporting structures, variability in service provision, inability for workforce skill sharing, limited sharing of information with missed opportunities for sharing good practice, education sharing, dissemination and inconsistent data management and reporting.

There is lack of uniformity in measuring patients’ outcomes (through use of tools like Palliative Care Outcomes Collaboration (PCOC)) and lack of consistency in reporting including performance outcomes.

Care tailored to diverse populations
There is limited focus on understanding and meeting the needs of MNHHS’s diverse communities including palliative care needs of Aboriginal and Torres Strait Islander populations and those from different cultural and religious backgrounds.

Workforce
There is great variance in the understanding and recognition of the benefits of palliative care across staff, across settings and can result in poor professional recognition across specialities. This, together with the emotional demands of delivering palliative care, results, in workforce shortages and challenges recruiting to palliative care positions across disciplines.

Figure 4: Typical patterns of chronic illness leading to death

Trajectory A: Short period of evident decline
Mostly cancer

Trajectory B: Long-term limitations with intermittent serious episodes
Mostly heart and lung failure

Trajectory C: Prolonged decline
Mostly frailty and dementia

What matters to patients, their families and carers

Carers have told us what matters to them when a loved one is dying. Being gentle and genuinely caring helps to develop a connection and trust between patients, families, carers and staff. It is important to have experienced care providers that can bring confidence and can minimise feelings of vulnerability for patients, families and carers. Patients, families and carers want to feel safe and be treated with kindness.

“It was a horrible thing to go through and I can’t thank them enough. Mum adored them, you could see the care they had for her. They were caring for our well-being as well as mum’s.

Nurses rotating at the weekends became a problem. Some of them you felt didn’t want to be there. Some weren’t as emotionally gentle and we were like ‘this is our mum’. It’s not that they did a bad job, but it was the difference between talking to her and not talking about her.”

“It is difficult to understand the care options available for our loved one. It is important to be given this information and for different care providers to work together.”

“Look at all the types of care—it’s confusing. Why can’t you all work together? How do we know what services are out there?”

“It would be helpful to get young people to help and support the broader family network.”

“We don’t teach young people what’s involved in life, going to work, paying taxes, looking after children, getting old and dying. We teach them all about things that most of them won’t have to deal. Let’s teach young people about how they can care for older people, look after their mum and dad.”
The future of palliative care services in MNHHS over the next five years

Over the next five years MNHHS will enhance its commitment to palliative care and establish a sustainable and coordinated service network. Working together across settings, MNHHS palliative care services will provide timely, responsive high quality care to support people who are dying. We recognise that MNHHS is one of many palliative care providers within Brisbane North and we commit to partnering with others to connect care, strengthen care coordination and explore opportunities to co-design care.

Palliative care, death and dying are confronting topics for many of us. Over the next five years MNHHS will actively contribute to state and national palliative care directions. In partnership with other agencies we will influence development of comprehensive evidence based multimodal public awareness campaigns to improve the appreciation of death as a normal part of the life continuum. Advancing our staffs’ professional awareness of the scope and benefits of timely and appropriate access to palliative care services will improve patients’, families’ and carers’ experience. In MNHHS, enabling quality care throughout the life continuum including end of life is a priority. There will be greater focus on educating clinicians at all levels in managing the progressive care needs of palliative care patients.

Our care will be tailored to what is important to the individual, being respectful and responsive to the diverse cultural, social, emotional and spiritual care needs of patients, families and carers.

Families and carers will be recognised as having a key role in supporting all aspects of patient care. This role will be supported through timely access to information, support and advice.

MNHHS will design our future palliative care services to complement palliative care services provided by private, non-government and community agencies across Brisbane North. We will work in partnership with these agencies to deliver high quality, timely care for palliative care patients, families and carers in the home, community and hospital settings.

Patients, families and carers will be actively involved in care planning and provided with information to make informed decisions regarding changing care needs through the palliative care phases. The service network will evolve to support patients to transition between services in a safe and timely manner with appropriate care and resources.

Over the next five years MNHHS’s palliative care service system will grow capacity and capability. Innovative service approaches will deliver increased care for complex palliative care patients in their home (including residential aged care). New service models will be explored including interim palliative care. Our specialist palliative care service capacity will grow through increasing consultation liaison services at all hospitals and improving access to inpatient designated specialist palliative care beds.
MNHHS palliative services will collect, monitor and report service performance and outcomes consistently across all services to enable benchmarking within MNHHS as well as with external peers. Working collaboratively with MNHHS palliative care service colleagues to review this information will provide opportunities to draw on expertise and perspectives of all clinicians to discuss evidence based practice and embed improvements locally.

Figure 5: Displays the future services that will be available to support palliative care patients, families and carers across the phases of palliative care.
This Plan provides service directions, each with its own set of objectives and actions, to guide palliative care service development. Signs of success will measure achievement towards the National Safety and Quality Standards End of Life Acute Hospitals and meeting the Palliative Care Australia Standards of service provision across the continuum from hospital to community. The Plan aligns and supports delivery of the End of Life Strategy, Department of Health 2015. Actions have been grouped into two groups—those actions that should be implemented as a priority within the next one to two years and those that can be achieved within the next five years.

Many actions in the Plan will be delivered by doing things differently within existing resources. Some actions will require resources to progress. It is important to recognise that palliative care services operate within a health service system with competing needs and finite resources and that allocation of new resources required to progress the actions will be subject to normal budgetary processes.

### Service direction 1: Excellent high quality palliative care will be delivered across MNHHS services

Providing high quality, timely palliative care to support quality of life for people who are at end of life is everyone’s business. Working together with patients, families, carers and service partners, MNHHS will support the delivery of timely, responsive and appropriate palliative care across all specialities. Patients will be empowered to be involved in early palliative care planning including making decisions about goals of care and how these may change over time until they die.

The process of dying and grieving can be different for people of different backgrounds. MNHHS acknowledges the cultural diversity of people who are cared for by our health services and commits to providing palliative care that is respectful and responsive to cultural, spiritual, social and emotional needs and preferences of individuals who are dying and their families and carers.

Across MNHHS’s service settings provision of palliative care is an integral part of standard clinical practice for most staff. Caring for patients approaching end of life, patients with progressive or symptomatic illness and bereaved families is part of clinical care. Recognising when a patient is approaching end of life and identifying the right time to move to palliative care conservative treatment rather than curative treatment is a focus of this Plan. Advancing timely sensitive conversations regarding palliative care with patients, families and carers will enable more people to die with their wishes being met. Across MNHHS some staff display excellent skills in advancing sensitive conversations in a timely manner. We recognise these conversations are very difficult for many clinicians. Supporting, training and educating our staff to advance sensitive conversations will be a priority. We will also support our regional HHS partners for care of regional patients.

Supporting our staff to have proactive discussions with patients, families and carers regarding planning for end of life will enhance patients’ and families’ involvement in care, reduce unwanted medical interventions and ensure cultural, spiritual, social and familial needs are met. Documentation of a patient’s wishes may be through:

- **Advance Health Directive**: a legal document which allows a person to give instructions about their future healthcare and appoint an Enduring Power of Attorney. It comes into effect only if they are unable to make their own decisions.
- **Enduring Power of Attorney**: a legal document giving another person or people the authority to make personal/health and/or financial decisions on a person’s behalf. For personal/health decisions, it comes into effect only if the person is unable to make their own decisions. For financial decisions, the person can nominate whether they want the attorney to begin making financial decisions immediately, or at some other date or occasion.
- **The Queensland Statement of Choices (SoC)**: focuses on a person’s wishes, values and beliefs. It is a document in use in some Queensland Health facilities, residential aged care facilities and general practices to support advance care planning conversations.
- **Acute Resuscitation Plan**: a document used in Queensland Health facilities to document doctor patient discussions regarding a patient’s capacity to make healthcare decisions and resuscitation choices.
Broader strategies will be supported to raise awareness and enhance community understanding of issues relating to death and dying, the limits of medical interventions, the benefits of palliative care, and the importance of advance care planning.

**Objectives**

- Improve patient, family and carer experience of palliative care delivery.
- Improve education, information and health literacy to enable informed decisions by patients, their families and carers.
- Increase education access for all staff to enhance the palliative approach including dignity of care particularly for Aboriginal and Torres Strait Islander populations and culturally and linguistically diverse communities.

**Signs of success**

- 80 per cent increase in MNHHS staff participating in training and education in evidence-based palliative care;
- 90 per cent of palliative care patients have their values and goals of care documented;
- 10 per cent increase in patient experience survey response rates across MNHHS;
- Number of quality improvements implemented in response to patient experience data.

**Actions**

<table>
<thead>
<tr>
<th>Priority actions</th>
<th>Responsibility</th>
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<tbody>
<tr>
<td>1.1 Establish a whole of MNHHS engagement and communication strategy that builds on the Department of Health care at the end of life public awareness campaign. The campaign will support staff, patients, families and carers to discuss death and dying and reinforce the importance of early conversations and documentation regarding end of life care. Communications will include:</td>
<td>Medicine Stream with MNHHS Communications</td>
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<td>- tailored resources for culturally diverse populations including Aboriginal and Torres Strait Islander people and culturally and linguistically diverse communities. These will be developed in partnership with each diverse population group;</td>
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<tr>
<td>- resources for people who live in other HHSs but receive care in MNHHS. These will be developed in partnership with other HHSs;</td>
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<td>- palliative care for people who live in a residential aged care facility;</td>
<td></td>
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<tr>
<td>- importance of conversations and documentation regarding advance care planning (ACP);</td>
<td></td>
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<tr>
<td>- fact sheets to debunk common myths regarding palliative care.</td>
<td></td>
</tr>
<tr>
<td>1.2 Develop and/or review and update:</td>
<td>Medicine Stream</td>
</tr>
<tr>
<td>a) education and information for patients, families and carers regarding patient journeys including management of common symptoms, pain and escalation pathways</td>
<td></td>
</tr>
<tr>
<td>b) information to support families and carers in caring for a person with a life-limiting illness</td>
<td></td>
</tr>
<tr>
<td>c) information regarding a) and b) above be tailored to diverse communities.</td>
<td></td>
</tr>
<tr>
<td>1.3 Work with staff, universities and educational bodies to develop palliative care training specific to the needs of MNHHS staff to enable provision of standardised high quality care to people who are dying. This would include education and training on the palliative care therapeutic guidelines.</td>
<td>Medicine Stream</td>
</tr>
<tr>
<td>1.4 Establish support structures for all staff working in palliative care to have opportunities to debrief, reflect and receive support as needed.</td>
<td>Medicine Stream</td>
</tr>
</tbody>
</table>

Note: RBWH – Royal Brisbane and Women’s Hospital, TPCH – The Prince Charles Hospital, CISS – Community, Indigenous and Subacute Services
## Actions

<table>
<thead>
<tr>
<th>Priority actions</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.5</strong> Continue to promote the uptake of advance care planning. All staff will be encouraged to lead discussions supported by current ACP coordinators to:</td>
<td>Medicine Stream</td>
</tr>
<tr>
<td>• discuss in the community end of life decisions with patients who are unable to be seen in the hospital setting;</td>
<td></td>
</tr>
<tr>
<td>• provide education to clinicians to support respectful and timely communication with patients, families and carers.</td>
<td></td>
</tr>
<tr>
<td><strong>1.6</strong> Work with Queensland Ambulance Service regarding protocols to support the care wishes of palliative care patients cared for at home.</td>
<td>Medicine Stream</td>
</tr>
<tr>
<td><strong>1.7</strong> Implement the Connection and Respectful Experience (CaRE) patient, family and carer experience survey across MNHHS service settings to capture feedback and implement improvements in response to survey results.</td>
<td>CISS, RBWH, TPCH, Redcliffe and Caboolture Hospital Directorates</td>
</tr>
<tr>
<td><strong>Actions to be achieved over the next five years</strong></td>
<td>Responsibility</td>
</tr>
<tr>
<td><strong>1.8</strong> Implement the Connection and Respectful Experience (CaRE) patient, family and carer experience survey across MNHHS service settings to capture feedback and implement improvements in response to survey results.</td>
<td>Medicine Stream</td>
</tr>
<tr>
<td><strong>1.9</strong> Advance partnerships with cardiac, respiratory, neurology, cancer and renal services to continue to advance joint management of patients through joint care planning to enable timely progression to palliative care.</td>
<td>Medicine Stream</td>
</tr>
<tr>
<td><strong>1.10</strong> Grow the joint management of patients through a partnership model of care described in 1.8 to other specialties.</td>
<td>Medicine Stream</td>
</tr>
<tr>
<td><strong>1.11</strong> Review and update the patient, family and carer experience survey to include questions regarding end of life care.</td>
<td>Consumer Engagement Team /Health Service Strategy and Planning</td>
</tr>
<tr>
<td><strong>1.12</strong> Utilise patient, family and carer survey responses to improve palliative care including transparent communication regarding what we will do differently.</td>
<td>CISS, RBWH, TPCH, Redcliffe and Caboolture Hospital Directorates</td>
</tr>
<tr>
<td><strong>1.13</strong> Enable the Queensland Government initiative to develop a repository of information, resources and programs for palliative care available beyond MNHHS for patients, their families and carers.</td>
<td>Medicine Stream</td>
</tr>
</tbody>
</table>

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Note: RBWH – Royal Brisbane and Women’s Hospital, TPCH – The Prince Charles Hospital, CISS – Community, Indigenous and Subacute Services
Service direction 2: MNHHS will develop a networked service delivery system across settings

Over the next five years MNHHS will create an integrated palliative care service system across settings for patients requiring palliative care. Recognising the important role of general practitioners, community pharmacists and other community based services in supporting care of palliative care patients to remain at home, MNHHS will remove organisational barriers, streamline policies, processes and procedures, introduce new models of care and establish a one-team culture that delivers care seamlessly across settings.

MNHHS is made up of geographic catchment areas where there is a natural population connection to HHSs. These geographic areas will be used to plan and deliver palliative care services that focus on local health needs and enables local relationships to be established with patients and the community. These catchment areas will also enable a local approach to enhancing MNHHS palliative care services that complement rather than duplicate services provided by health care partners. Three local palliative care hubs will be established where cohesive teams that cross community palliative care nursing and allied health, hospital based specialist palliative care and designated inpatient palliative care work together to provide seamless palliative care to a local population. The three palliative care hubs will align with the geographic catchments of: Redcliffe, Caboolture and Kilcoy Hospitals, TPCH and RBWH. Figure 6 below provides an overview of the palliative care hub geographic catchments. Appendix 1 provides further detail regarding each catchment.
The redesigned networked palliative care service system will include:

- home based palliative care services including personal, nursing and allied health;
- interim palliative care including respite;
- specialist palliative care support and advice to home based care (including residential aged care);
- consultation liaison and outpatient services in acute hospital;
- inpatient designated palliative care beds.

This networked service system incorporates a population approach palliative care service delivery that will be underpinned by clear governance arrangements and streamlined processes to coordinate care.

The roles and responsibilities of CISS and the hospital Clinical Directorates in delivering palliative care services will be developed and clearly documented to reduce variations, ensure improved patient access, improved responsiveness and better coordination of services across the healthcare continuum.

Objectives

- Enhance the MNHHS palliative care service network to deliver coordinated high quality care across service settings and sites.
- Improve governance, service delivery arrangements, responsibility and accountability for palliative care services across MNHHS.
- Improve monitoring and development of clinical quality system and indicators to ensure safe and effective palliative care across MNHHS.

Signs of success

- Increasing proportion of patients consider their care to be well coordinated.
- Increasing proportion of patients die in place of choice.
- All MNHHS palliative care services across settings contribute to the Palliative Care Outcome Collaboration (PCOC) data set to capture information and to benchmark outcomes.

Figure 7: Displays the networked service model across MNHHS services based on the hub model

*Note: Planning for Caboolture Hospital redevelopment will include designated palliative care services
## Actions

<table>
<thead>
<tr>
<th>Priority actions</th>
<th>Responsibility</th>
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</thead>
<tbody>
<tr>
<td><strong>2.1</strong> Develop the service model to establish three palliative care hubs to support the delivery of connected MNHHS palliative care across primary, community and hospital settings that complement services provided by healthcare partners.</td>
<td>CISS, RBWH, TPCH, Redcliffe and Caboolture Hospital Directorates</td>
</tr>
<tr>
<td><strong>2.2</strong> Establish the MNHHS palliative care governance structure to support the networked palliative care service system.</td>
<td>CISS, RBWH, TPCH, Redcliffe and Caboolture Hospital Directorates</td>
</tr>
<tr>
<td><strong>2.3</strong> Transition TPCH and Redcliffe Hospital inpatient palliative services to the respective hospital directorates to support service connectivity.</td>
<td>CISS in partnership with TPCH and Redcliffe Hospital Directorates</td>
</tr>
<tr>
<td><strong>2.4</strong> Review and update as required the roles, responsibilities and clinical service capability of each component of the networked palliative care service system including: * domiciliary palliative care service * community based palliative care nursing and allied health team * specialist outreach service * consultation liaison service * inpatient specialist palliative care services.</td>
<td>Medicine Stream, CISS, RBWH, TPCH, Redcliffe and Caboolture Hospital Directorates</td>
</tr>
<tr>
<td><strong>2.5</strong> Consult with partner palliative care health service providers when developing and designing MNHHS palliative care services to ensure collaboration and coordination across Brisbane North.</td>
<td>Medicine Stream, CISS, RBWH, TPCH, Redcliffe and Caboolture Hospital Directorates</td>
</tr>
<tr>
<td><strong>2.6</strong> Review MNHHS patient referral and flow protocols between services across the network. Refresh (as required) to enable integrated and coordinated care across the network including smooth transitions between settings.</td>
<td>Medicine Stream, CISS, RBWH, TPCH, Redcliffe and Caboolture Hospital Directorates</td>
</tr>
<tr>
<td><strong>2.7</strong> Develop and communicate patient flow protocols regarding use of inpatient palliative care units at Redcliffe Hospital and TPCH at times of overall hospital bed capacity constraints.</td>
<td>TPCH and Redcliffe Hospital Directorates</td>
</tr>
<tr>
<td><strong>2.8</strong> In partnership with palliative care service partners review, refine and document referral processes.</td>
<td>Medicine Stream CISS, RBWH, TPCH, Redcliffe and Caboolture Hospital Directorates with service partners.</td>
</tr>
<tr>
<td><strong>2.9</strong> All MNHHS palliative care services in MNHHS will contribute to the PCOC data set to capture information and to benchmark outcomes.</td>
<td>CISS, RBWH, TPCH, Redcliffe and Caboolture Hospital Directorates</td>
</tr>
<tr>
<td><strong>2.10</strong> Actively contribute to advancing Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) across MNHHS.</td>
<td>Medicine Stream, CISS, RBWH, TPCH, Redcliffe and Caboolture Hospital Directorates</td>
</tr>
</tbody>
</table>

Note: RBWH – Royal Brisbane and Women’s Hospital, TPCH – The Prince Charles Hospital, CISS – Community, Indigenous and Subacute Services
### Actions

<table>
<thead>
<tr>
<th>Actions to be achieved over the next five years</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.11 Enable movement of palliative care specialist clinicians across MNHHS service settings.</td>
<td>CISS, RBWH, TPCH, Redcliffe and Caboolture Hospital Directorates</td>
</tr>
<tr>
<td>2.12 Strengthen service networks with other HHSs to enable patients who live outside MNHHS to have palliative care as close to home as clinically appropriate.</td>
<td>Medicine Stream</td>
</tr>
</tbody>
</table>
| 2.13 Enhance processes to ensure critically ill, frail patients are identified in a timely way to enable discussions on likely treatment pathways in terms of quality of life. Actions to achieve this include:  
  - introducing evidence-based frailty scoring tools to be administered by trained nurses on patients that are critically ill and may be frail;  
  - developing a process for patients with a high frailty score to enable discussions with all care providers (multidisciplinary team) to refer to palliative care;  
  - developing a process to discuss multidisciplinary team recommendation to refer to palliative care with the patient, family and carers for quality of life outcomes. | Medicine Stream |
| 2.14 Whilst waiting for ieMR, establish a single palliative care record including one unique record number that can follow the patient and be viewed by staff across settings. | Medicine Stream |
| 2.15 Advance discussions across service providers across service settings to investigate the establishing a minimum data set for palliative care activity. | Medicine Stream |

Note: RBWH – Royal Brisbane and Women’s Hospital, TPCH – The Prince Charles Hospital, CISS – Community, Indigenous and Subacute Services
Service direction 3: MNHHS will enhance patient access to home and community based palliative care services

MNHHS recognises most people receiving palliative care prefer to be cared for at home (including residential aged care). We also recognise that many people do not achieve this goal. Our priority is to change this and enable more people to receive palliative care in the home. We recognise families and carers provide the mainstay of care for many people who receive palliative care at home. Ensuring families and carers are supported in the community to undertake this role is a priority.

MNHHS will do this by working collaboratively with other Brisbane North providers of palliative care to provide complementary community based services. Our care will be provided through a range of modalities including telehealth. We will enhance our home and community palliative care service capacity and capability over the next five years to provide comprehensive home and community care.

We will improve information resources available to support patients, families and carers to understand the palliative care phases, common care pathways, symptom management and bereavement support.

Objectives

- Enhanced access to home based nursing and allied health care that is responsive, coordinated and flexible to meet the patients changing needs.
- Improved access to specialist palliative care expertise for advice and information to general practitioners and other home based care providers including residential aged care services (including after hours).
- Investigate the establishment of an interim palliative care service between care in the hospital and the home (including respite).
- Enhanced partnerships with Queensland Ambulance Service including the Low Acuity Response Unit to provide collaborative responsive care.

Signs of success

- Increase number of palliative care patients who are largely cared for at home by 50 per cent.
- Increased number of palliative care patients that have a shared care treatment plan accessible by multidisciplinary team members, the general practitioner and the patient.
- 10 per cent increase in patient experience survey response rates across MNHHS.
- Number of quality improvements implemented in response to patient experience data.
## Actions

<table>
<thead>
<tr>
<th>Priority actions</th>
<th>Responsibility</th>
</tr>
</thead>
</table>
| 3.1 Continue to enhance community based palliative care capacity through a range of modalities including telehealth by:  
- extending hours of operation from 7.00 am - 6.30 pm to 7.00 am – 9.30 pm;  
- growing domiciliary care, nursing and allied health workforce capacity;  
- reviewing current equipment stock volumes to ensure timely access for palliative care patients;  
- advancing implementation of quality and safety standards for palliative care. | CISS |
| 3.2 Strengthen partnerships with private, non-government and primary care providers including GPs and community pharmacies at a local level to establish sustainable models of care including a shared care plan. | Medicine Stream, CISS |
| 3.3 Review, document and communicate the role, responsibilities and reporting lines of specialist community based palliative care nurses including nurse practitioners in supporting complex patients cared for at home. | CISS |
| 3.4 Maximise use of telehealth and other technologies to support patients to be cared for at home. | CISS |
| 3.5 Develop and/or review protocols to support rapid discharge for the dying patient to be cared for at home. | Medicine Stream, CISS, RBWH, TPCH, Redcliffe and Caboolture Hospital Directorates |
| 3.6 Review, refresh and communicate care pathways including the rapid escalation pathway to support patients at home who deteriorate to remain in the home. | Medicine Stream, CISS, RBWH, TPCH, Redcliffe and Caboolture Hospital Directorates |
| 3.7 Partner with Queensland Ambulance Service to advance care protocols of first line of support to home based palliative care patients including investigation of medication management and initiation of escalation pathways. | Medicine Stream, Queensland Ambulance Service |
| 3.8 Enhance access to grief and bereavement support for patients and families cared for at home. | CISS, RBWH, TPCH, Redcliffe and Caboolture Hospital Directorates |
| 3.9 Document and communicate processes to enable ease of access to palliative care beds particularly during exacerbations of symptoms and during the terminal care phase. | CISS, RBWH, TPCH, Redcliffe and Caboolture Hospital Directorates |
| 3.10 Strengthen partnerships with residential aged care services to co-design model/s of care to enable palliative care in the aged care residential service advice reducing the need to present to emergency departments. | Medicine Stream, CISS, RBWH, TPCH, Redcliffe and Caboolture Hospital Directorates |
| 3.11 Working with Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds and peak bodies to co-design palliative care models to better tailor care for people from diverse backgrounds. | Medicine Stream and CISS |

Note: RBWH – Royal Brisbane and Women’s Hospital, TPCH – The Prince Charles Hospital, CISS – Community, Indigenous and Subacute Services
## Actions

<table>
<thead>
<tr>
<th>Actions to be achieved over the next five years</th>
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</tr>
</thead>
<tbody>
<tr>
<td>3.12 Enhance MNHHS volunteer program to support companionship of patients with a life-limiting illness and their families in the home, in the acute setting and in designated palliative care units.</td>
<td>Medicine Stream, CISS, RBWH, TPCH, Redcliffe and Caboolture Hospital Directorates</td>
</tr>
<tr>
<td>3.13 Investigate establishing day respite and overnight hospice/interim palliative care at Zillmere Health Campus.</td>
<td>CISS</td>
</tr>
<tr>
<td>3.14 Work with other agencies to investigate opportunities to develop interim palliative care service including respite services in MNHHS.</td>
<td>CISS, Medicine Stream</td>
</tr>
<tr>
<td>3.15 Enhance palliative care pharmacy capacity to develop a palliative care community pharmacy network that can provide a crucial point of contact for patients and their families.</td>
<td>CISS, RBWH, TPCH, Redcliffe and Caboolture Hospital Directorates</td>
</tr>
</tbody>
</table>

Note: RBWH – Royal Brisbane and Women’s Hospital, TPCH – The Prince Charles Hospital, CISS – Community, Indigenous and Subacute Services,
Ensuring people with a life-limiting illness live their lives as comfortably as possible in the setting of choice will be enabled through improved access to multidisciplinary specialist palliative care teams. Specialist teams will include palliative care trained medical, nursing and allied health staff. These teams will support the care of complex palliative care patients in all settings complementing and enhancing already established specialist palliative care teams.

Specialist palliative care teams will work with specialist treatment teams to ensure patients receive the highest quality evidence-based care. Sensitive timely conversations with patients, families and carers about the burden of treatment that is not likely to bring benefit or prolong life to an acceptable quality will also be enhanced through the establishment of specialist palliative care teams.

To enable access to care close to home inpatient specialist palliative care beds will be established at all hospitals overtime. RBWH will grow capacity over the next five years. Establishing local palliative care consultation liaison services at Caboolture Hospital will be investigated. Longer term it is anticipated Caboolture Hospital will become the fourth palliative care hub with comprehensive palliative care services outlined above including inpatient designated specialist care beds.

Objectives
- Improve timely access to specialist multidisciplinary care 24/7 for palliative care patients cared for at home.
- Improve access to consultation liaison services at TPCH and Redcliffe, Caboolture and Kilcoy Hospitals.
- Create designated inpatient beds at RBWH.

Signs of success
- Improved access to specialist palliative care services locally across MNHHS’s service settings.
- Care protocols established to support patients from other HHSs to receive care and to return home with documented care plan in a timely clinically appropriate way.
- 10 per cent increase in patient experience survey response rates across MNHHS.
- Number of quality improvements implemented in response to patient experience data.
## Actions

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<tbody>
<tr>
<td><strong>4.1</strong> Develop a workforce plan for medical, nursing and allied health staff across all hub sites with skills in delivering safe and effective palliative care across care continuum.</td>
<td>CISS, RBWH, TPCH, Redcliffe and Caboolture Hospital Directorates</td>
</tr>
<tr>
<td><strong>4.2</strong> Establish local grief and bereavement services at TPCH, RBWH, Redcliffe and Caboolture /Kilcoy Hospitals to support people through loss and grief.</td>
<td>Medicine Stream, CISS, RBWH, TPCH, Redcliffe and Caboolture Hospital Directorates</td>
</tr>
<tr>
<td><strong>4.3</strong> Investigate establishing local palliative care consultation liaison services at Caboolture Hospital.</td>
<td>Caboolture Hospital Directorate</td>
</tr>
</tbody>
</table>
| **4.4** Design and establish a specialist multidisciplinary palliative care service that provides specialist advice and support across care settings including home and community. This service could be provided via a range of modalities including telehealth and include:  
  - 24/7 access to specialist symptom management, support and admission if required  
  - access to specialist medical, nursing, allied staff  
  - access to pharmacy  
  - bereavement care  
  - rapid response service.  
These services will be designed in partnership with diverse community stakeholders, non-government and private palliative care services providers with an emphasis on coordinated connected service provision. | Medicine Stream, CISS, RBWH, TPCH, Redcliffe and Caboolture Hospital Directorates |
| **4.5** Benchmark consultation liaison services at Redcliffe Hospital (including support to Caboolture and Kilcoy Hospitals) and TPCH against the RBWH consultation liaison service and consider comparable access to resources. | TPCH and Redcliffe Hospital Directorates |
| **4.6** Advance joint outpatient clinics with specialty teams and palliative care specialists to enable timely conversations regrading palliative care. This model should build on the joint clinic for renal patients and be provided by a range of modalities including telehealth. | CISS, RBWH, TPCH, Redcliffe and Caboolture Hospital Directorates and Streams |
| **4.7** Develop systems and processes to reduce interventions that are not likely to benefit quality of life. | CISS, RBWH, TPCH, Redcliffe and Caboolture Hospital Directorates |
| **4.8** Improve capture of data of palliative care service activity through increasing education regarding the use of International Classification of Disease code Z51.5. | CISS, RBWH, TPCH, Redcliffe and Caboolture Hospital Directorates |

Note: RBWH – Royal Brisbane and Women’s Hospital, TPCH – The Prince Charles Hospital, CISS – Community, Indigenous and Subacute Services,
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<tbody>
<tr>
<td>4.9 Investigate opportunities to re-establish access to spiritual care and expand pastoral care across the MNHHS palliative care service network.</td>
<td>Medicine Stream, CISS, RBWH, TPCH, Redcliffe and Caboolture Hospital Directorates</td>
</tr>
<tr>
<td>4.10 Redesign outpatient service model for palliative care to include access to nursing, allied health, bereavement and administrative support.</td>
<td>Medicine Stream, CISS, RBWH, TPCH, Redcliffe and Caboolture Hospital Directorates</td>
</tr>
<tr>
<td>4.11 Establish inpatient palliative care beds at RBWH through redesigning model of care by cohorting existing activity in a dedicated unit.</td>
<td>RBWH</td>
</tr>
<tr>
<td>4.12 Develop a dedicated palliative service at Caboolture Hospital starting with consultation liaison services with the responsibility of providing support to Kilcoy hospital patients.</td>
<td>Caboolture Hospital</td>
</tr>
<tr>
<td>4.13 Improve quality of care for patients admitted to specialised palliative care inpatient beds in MNHHS by:</td>
<td>CISS, RBWH, TPCH, Redcliffe and Caboolture Hospital Directorates</td>
</tr>
<tr>
<td>• redesigning the Redcliffe Hospital palliative care unit to have a mix of single rooms and double bedded bays and improved access to family space</td>
<td></td>
</tr>
<tr>
<td>• redesigning Redcliffe Hospital and TPCH palliative care units to create more restrooms for staff and visitors.</td>
<td></td>
</tr>
</tbody>
</table>

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Service direction 5: MNHHS will advance research, education and training to deliver innovative evidence based palliative care

Palliative care research and education will contribute to improving care to patients, their families and carers both locally and elsewhere. Efforts in research and education will directly benefit patients receiving care in MNHHS, their families and carers and contribute to a larger body of evidence statewide, nationally and internationally.

MNHHS hosts the Centre for Palliative Care Research and Education (CPCRE) which was established to enhance palliative care services in Queensland through education and research. MNHHS will continue to actively partner with the CPCRE and other organisations to foster a stronger education, innovation and research culture in MNHHS.

Objectives
- Increase capability and capacity of the MNHHS palliative care clinicians to participate in research activities.
- Investigate opportunities for joint appointments with universities and the CPCRE.
- Partner with universities to develop curriculum to include palliative care for medical, nursing and allied health students.

Signs of success
- Increase numbers of staff participating in research activities relevant to palliative care.
- Increase the number of publications prepared by MNHHS staff in peer reviewed literature.
- Increase the number of presentations across disciplines at national forums on palliative care.

Actions

<table>
<thead>
<tr>
<th>Priority actions</th>
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</tr>
</thead>
<tbody>
<tr>
<td>5.1 Actively pursue education and training actions described in service direction 1.</td>
<td>Medicine Stream</td>
</tr>
<tr>
<td>5.2 Encourage advanced training in palliative care medicine through growing the number of training positions in palliative care across MNHHS.</td>
<td>Medicine Stream</td>
</tr>
<tr>
<td>5.3 Partner with CPCRE to refresh the current palliative care beginning level education package and roll out training and education across MNHHS and potentially to other partners including GPs.</td>
<td>Medicine Stream</td>
</tr>
<tr>
<td>5.4 Foster a research culture within palliative care in MNHHS to include a coordinated framework for knowledge translation from research to practice.</td>
<td>Medicine Stream, CISS, RBWH, TPCH, Redcliffe and Caboolture Hospital Directorates</td>
</tr>
<tr>
<td>5.5 Engage with CPCRE to provide advice and assistance to new researchers in MNHHS.</td>
<td>Medicine Stream</td>
</tr>
<tr>
<td>5.6 Partner with universities to establish joint clinician appointments including medical, nursing and allied health.</td>
<td>Medicine Stream, CISS, RBWH, TPCH, Redcliffe and Caboolture Hospital Directorates</td>
</tr>
<tr>
<td>5.7 Increase research participation and outputs among all disciplines and service settings.</td>
<td>Medicine Stream</td>
</tr>
</tbody>
</table>

Note: RBWH – Royal Brisbane and Women’s Hospital, TPCH – The Prince Charles Hospital, CISS – Community, Indigenous and Subacute Services.
Where to from here

MNHHS is committed to implementing the MNHHS Palliative Care Clinical Services Plan 2017-2022 over the next five years and will actively work in partnership with private, community and non-government providers to establish a network of palliative care services across settings across Brisbane North. An implementation plan will be developed to progress actions over time and will guide the priorities of MNHHS Clinical Directorates and Clinical Streams. Some actions will require resourcing over time through normal budgetary processes.

Monitoring, reporting and review

The Plan will be monitored and reported on an annual basis. These processes will allow changes in health needs or service developments during implementation of the Plan to be identified and ensure the Plan can be reviewed and updated if required.
## Appendix

### Appendix 1: Proposed MNHHS palliative care hubs and associated catchments

<table>
<thead>
<tr>
<th>Palliative Care Hub</th>
<th>Hospital catchment</th>
<th>Geographical catchment by SA2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HUB 1</strong></td>
<td>Caboolture/Kilcoy</td>
<td>Beachmere - Sandstone Point, Bribie Island, Burpengary, Burpengary – East, Caboolture, Caboolture – South, Elimbah, Kilcoy, Morayfield, Morayfield – East, Narangba, Upper Caboolture, Wamuran, Woodford - D’Aguilar.</td>
</tr>
<tr>
<td></td>
<td>Hospital’s catchment</td>
<td>Redcliff Hospital catchment Brighton, Clontarf, Dakabin – Kallangur, Deception Bay, Margate - Woody Point, Murrumba Downs – Griffin, North Lakes - Mango Hill, Redcliffe, Rothwell - Kippa-Ring, Scarborough – Newport.</td>
</tr>
</tbody>
</table>