Palliative Care Clinical Services Plan

2017–2022

REFRESH 2020

Metro North Health

Queensland Government

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Executive summary

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 continue to have significant demand pressures and with a growing and ageing population, demand for palliative care will continue to increase. The MNHHS Palliative Care Clinical Services Plan 2017-2022 has been refreshed to guide service delivery and development for the next two years 2021 and 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. 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.

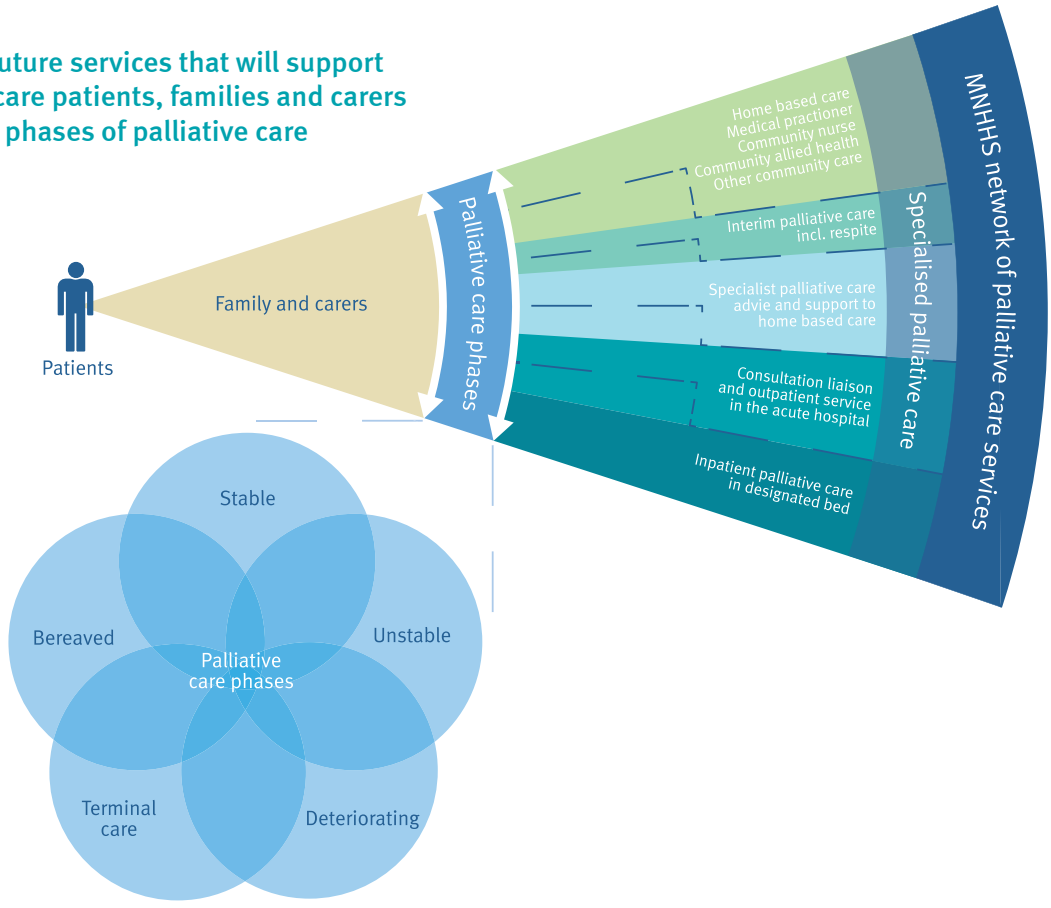
MNHHS's palliative care service network will complement services provided by private, non-government and community providers of palliative care in MNHHS. We will work in partnership with all service providers to deliver excellent care for palliative care patients, families and carers in the home, community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

The Plan outlines five service directions with corresponding actions. Significant progress has been made in implementing the priority actions over the last three years. The refreshed plan concentrates on areas of priority for the next two 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 specialties. 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



Service Direction 2: MNHHS will develop a networked service delivery system across settings

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).

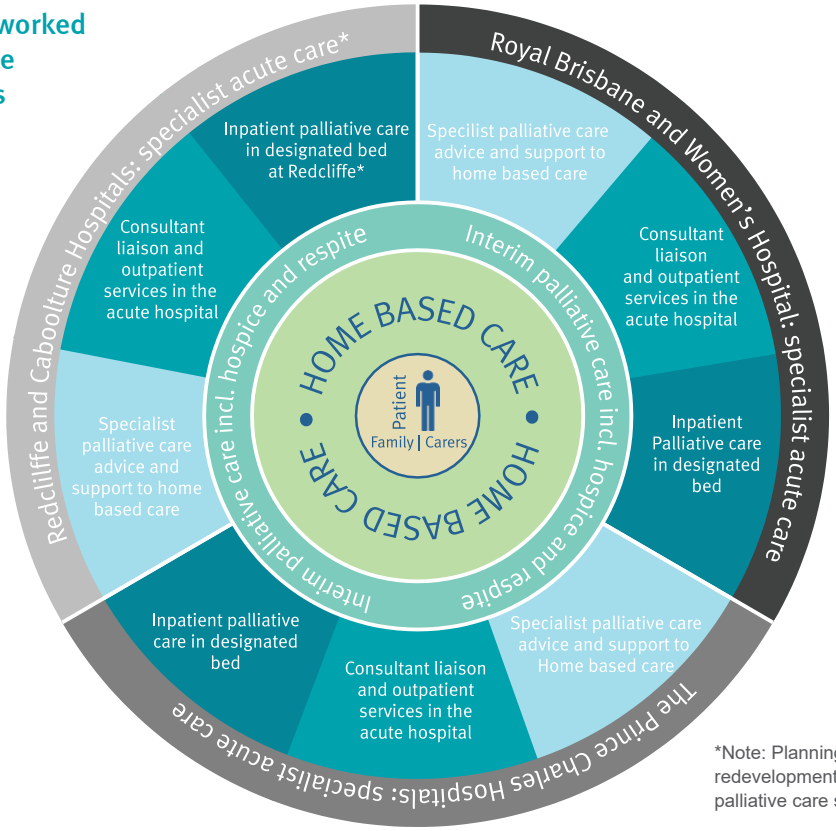
Service Direction 4: MNHHS will grow specialist palliative care capacity

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.

Figure 2: Proposed palliative care networked service model to be established across MNHHS



*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: September 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 more than 1,045,000 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
- medical, nursing and allied health support in the home
- consultation liaison services in the acute ward setting
- specialist palliative care outpatient services
- 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), Redcliffe Hospital and Caboolture and Kilcoy hospitals and respite care at Brighton Health Campus.

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 ensure equitable access to palliative care services 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

This plan considers community (home), ambulatory and inpatient 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.

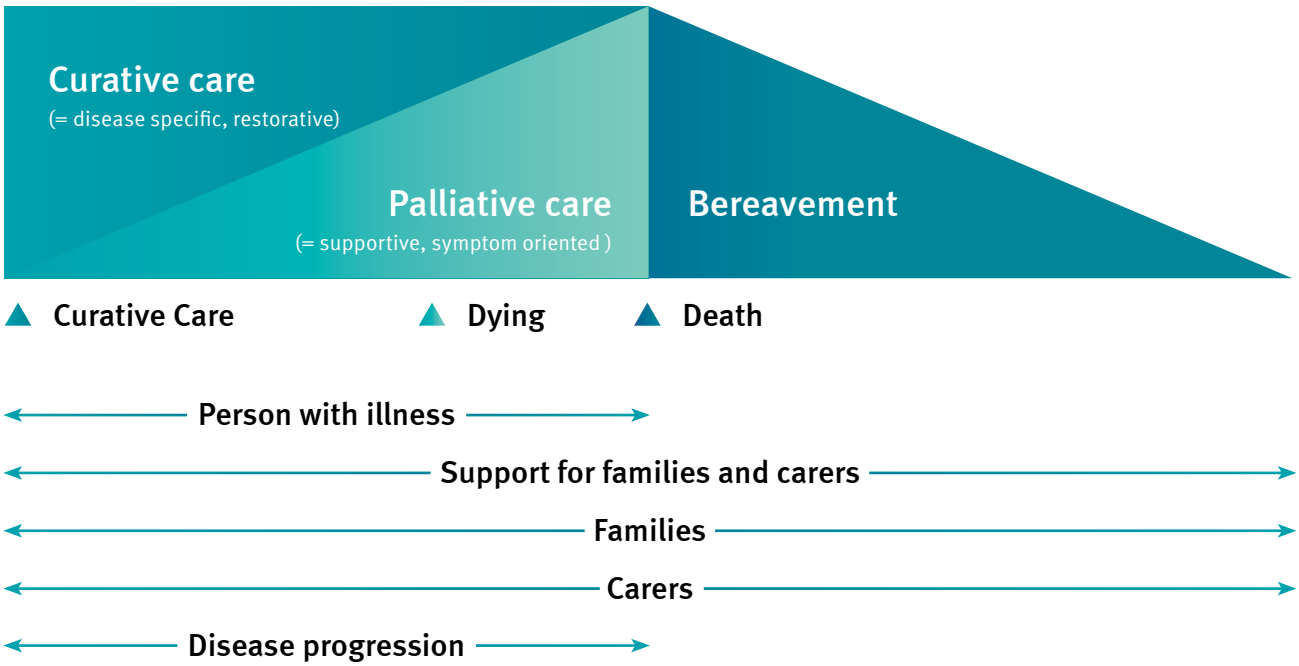
3.1 Definitions

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.

Figure 3: Palliative Care definition



Source: Adapted from Australian and New Zealand Society of Palliative Medicine (2008), Submission 430 to the National Health and Hospitals Reform Commission.

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/carers circumstances change suddenly impacting on patient care.

Deteriorating

The care plan is addressing anticipated needs but requires periodic review because the patient's overall functional status is declining and the patient experiences a gradual worsening of an existing problem and/or experiences a new but anticipated problem. The family/carers experience a gradual worsening distress that impacts on the patient's care.

Terminal

Death is likely within days and no acute intervention is planned or required. The use of frequent, usually daily, interventions aimed at addressing physical, emotional and spiritual issues is required.

Bereaved

The patient has died and bereavement support is provided to family/carers.

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[1].

[1] A Guide to Palliative Care Service Development: A population based approach [Internet]. 1st ed. ACT: PCA; 2005 [cited 12 October 2016]. Available from: http://palliativecare.org.au/wp-content/uploads/2015/05/A-guide-to-palliative-care-service-development-a-population-based-approach.pdf

Context

This Plan has been developed within the context of a range of national, state and local directions and frameworks for palliative care. Consideration of the growing and ageing population, increasing incidence of disease, a changing service system together with a review of literature and evidence-based practice informed the development of this Plan. The Plan was reviewed in 2020 and updated to reflect the current environment and priorities.

4.1 Policy

The *'National Palliative Care Strategy 2018'* continues to represent Commonwealth, State and Territory Governments' commitment to palliative care. The strategy describes seven goals that aim to support a coordinated and consistent approach to the delivery of high quality palliative care to all. The seven goals are shown below:

Table 1: National Palliative Care Strategy 2018

Goal Number	Goal
Goal 1: Understanding	People understand the benefits of palliative care, know where and how to access services, and are involved in decisions about their own care
Goal 2: Capability	Knowledge and practice of palliative care is embedded in all care settings
Goal 3: Access and choice	People affected by life-limiting illnesses receive care that matches their needs and preferences
Goal 4: Collaboration	Everyone works together to create a consistent experience of palliative care across care settings
Goal 5: Investment	A skilled workforce and systems are in place to deliver palliative care in any setting
Goal 6: Data and evidence	Robust national data and a strong research agenda strengthen and improve palliative care
Goal 7: Accountability	National governance of this Strategy drives action

Source: National Palliative Care 2018

Palliative Care Australia also developed '*National Palliative Care Standards 5th Edition'*. The 9 standards are broken into care standards. which describe the systems and enablers necessary to deliver high quality care. and governance standards which describe expectation in regards to quality management, quality improvement and benchmarking.

The standards are based on a set of core values necessary to ensure high quality, person centered and evidence based services that meet peoples' needs across the continuum.

The Australian Commission on Safety and Quality in Health Care *National Consensus Statement: Essential Elements for Recognising and Responding to* provides an endorsed national approach for identifying 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 1.04 million people. By 2026 our local population is anticipated to grow at a compound annual growth rate of 1.5% to almost 1.14 million, with the population growth for older people aged 65 years and over projected to increase by 3.5 per cent annually. 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 16 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 (accounts for roughly 8 per cent).

4.3 Mortality

It is estimated the total number of deaths of MNHHS residents will grow from approximately 5690 people per year to over 6000 per year by 2026. This represents approximately 19 per cent of all deaths in Queensland.

Current environment

The palliative care service system in MNHHS includes:

- **Specialist community palliative care** is provided in patients home (including residential aged care facility). Specialist community palliative care includes advising, educating and triaging ongoing clinical management of palliative care patients with complex care needs in the community 24/7 by the multidisciplinary team.
- **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 week days from 5pm to 8am and 24 hours a day on weekends. RBWH provides seven days roster with nurse on-call 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.

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 MNHHS. 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

- Specialist community palliative care services have provided approximately 793 individual patients, totaling over 11,560 occasions of service in 2019-20.
- Inpatient palliative care services (public and private) for MNHHS residents increased 24.9 per cent over three year period 2016-17 to 2018-19;
- A large proportion of palliative care patients die in hospital. This is consistent with other HHSs;
- over 88 per cent of all inpatient palliative care separations at MNHHS public hospitals in 2019-20 were people aged 65 years and over;
- over 50 per cent of all palliative care separations in 2019-20 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.

Issues and challenges

Issues and challenges facing the services include:

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 by 3.3 per cent over the next two years.

Access to inpatient palliative care services close to home in MNHHS is challenging due to the number and location of designated palliative care beds.

Meeting patient expectations of having choice in end of life care - the appropriateness of care, preferred places of care and death, as well as equity of access to care are important and people wish to be involved in decision making about their end of life care.

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.

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.

Grief and bereavement support for carers and families is lacking in MNHHS. 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.

Care tailored to diverse populations - there is support for palliative care needs of Aboriginal and/or Torres Strait Islander populations and those from different cultural and religious backgrounds.

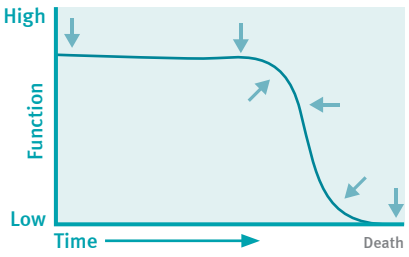
Provision of specialist palliative care services to residents in aged care facilities.

Figure 4: Typical patterns of chronic illness leading to death

Trajectory A:

Short period of evident decline

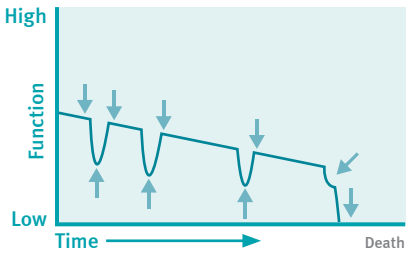
Mostly cancer



Trajectory B:

Long-term limitations with intermittent serious episodes

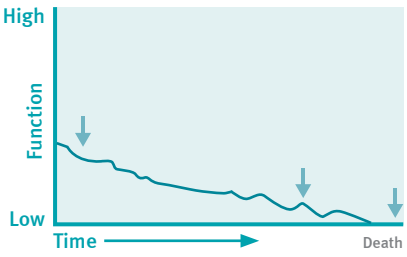
Mostly heart and lung failure



Trajectory C:

Prolonged decline

Mostly frailty and dementia



Source: White Paper: Living Well at the End of Life (Lynne and Adamson 2003)

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.

"I was diagnosed with life-limiting cancer. EVERYONE, without exception was wonderful. I was provided with masses of information about support services, about next treatment steps, palliative care, Blue Care, wound management, estate planning etc. All excellent information delivered by wonderful people but given my state of mind and recent surgery making me fuzzy, it would have been really helpful to have the information in document form, to take way, in addition to the info sessions provided by each person. Not a criticism, just a suggestion. The information is hugely important and I fear I may have forgotten some of it."

"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."

"I want to thank my cancer care team and the team at palliative care. They care not only for me but for my whole family. They listen and try to make my journey smooth"

"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."

Palliative care services in MNHHS over the next two years

Over the next two years MNHHS will continue its commitment to palliative care as 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 commit to partnering with others to connect care, strengthen care coordination and explore opportunities to co-design care.

MNHHS will continue to 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.w

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.

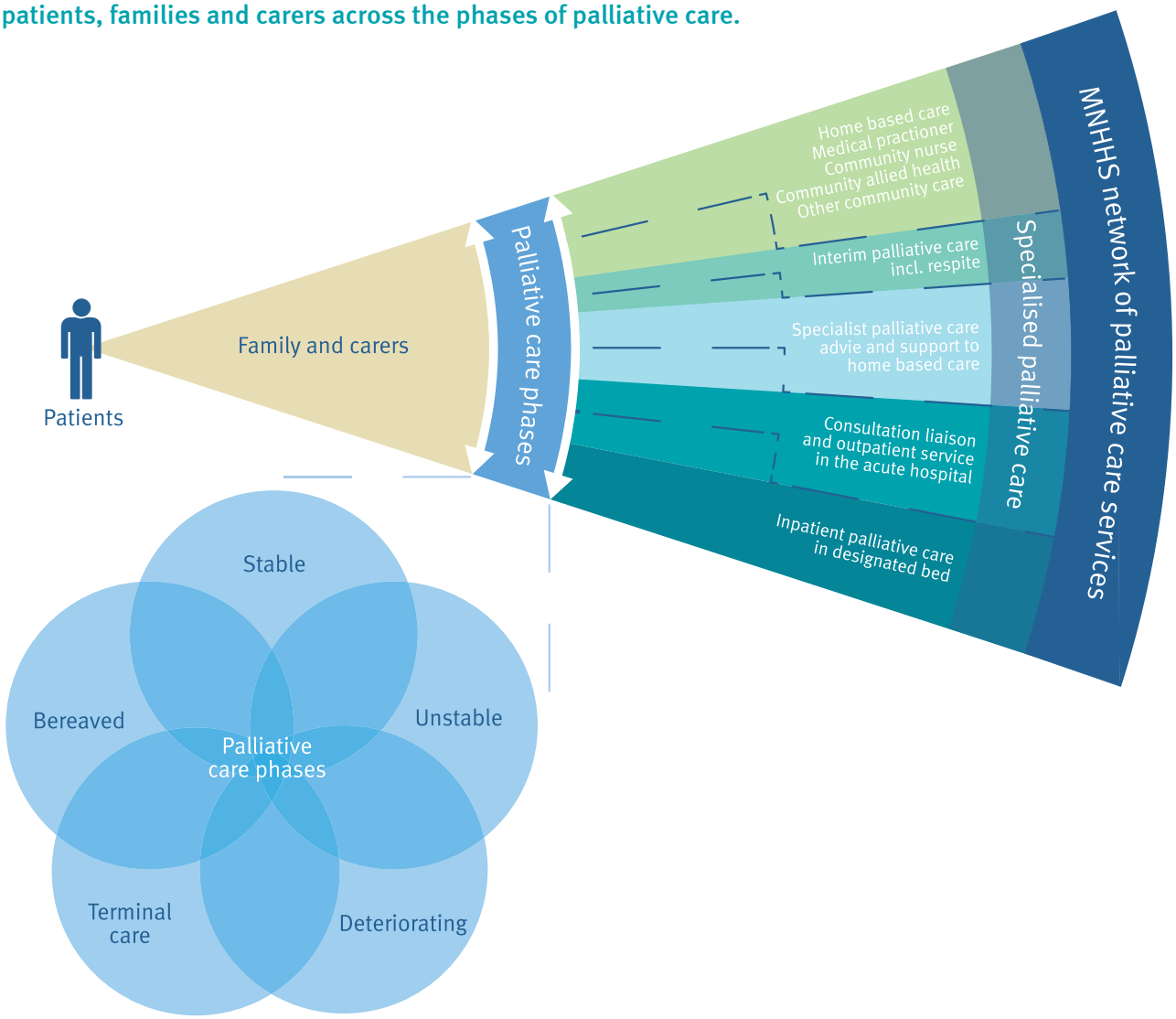
Families and carers will be recognised as having a key role in supporting all aspects of patient care. This role will be supported through timely access to information, support and advice.

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 two 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). 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.



Source: MNHHS Health Strategy and Planning, 2017

Service directions

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*.

Some actions in the Plan will be delivered by doing things differently within existing resources. Some actions will require resources to progress.

The actions completed in the first three years of the plan are listed in Appendix 1. The actions that are priorities for the next two years listed in each service direction.

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. 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.

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

- 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

	Priority actions	Responsibility
1A	Work with Queensland Ambulance Service regarding protocols to support the care wishes of palliative care patients cared for at home.	COH
1B	Undertake patient, family and carer experience survey across MNHHS service settings to capture feedback and implement improvements in response to survey results.	All Directorates
1C	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.	All Directorates

Note: RBWH – Royal Brisbane and Women's Hospital, TPCH – The Prince Charles Hospital, COH – Community and Oral Health.

Service direction 2: MNHHS will develop a networked service delivery system across settings

Over the next two years MNHHS will continue to support 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 address barriers, streamline policies, processes and procedures, to work in 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. Four local palliative care hubs will be established where cohesive teams that cross community palliative care and hospital based palliative care to work together to provide seamless palliative care to a local population.

The networked palliative care service system will include:

- home based palliative care services
- palliative care respite
- specialist palliative care support and advice to home based care (including residential aged care)
- consultation liaison services
- outpatient services
- 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.

Objectives

- Enhance the MNHHS palliative care service network to deliver coordinated high quality care across service settings and sites.
- 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.

	Priority actions	Responsibility
2A	Maintain the roles, responsibilities and clinical service capability of each component of the networked palliative care service system to improve patient outcomes including: • advocacy for domiciliary care to support patients in their homes • expanded specialist community based palliative care health teams • expanded consultation liaison services • expanded inpatient specialist palliative care services.	All Directorates
2B	Continue to implement and communicate patient flow protocols regarding use of inpatient palliative care beds at Redcliffe Hospital and TPCH and community based care to optimise access to beds for patients requiring palliative care.	All Directorates
2C	Enable movement of palliative care specialist clinicians across MNHHS service settings.	All Directorates
2D	Continue to develop palliative registry functionality until ieMR implemented in Metro North.	All Directorates and Medicine Clinical Stream
2E	Develop respite model of care, pilot, evaluate and expand.	All Directorates, Medicine Clinical Stream and Health Service Strategy and Planning

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 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 virtual care. We will enhance our home and community palliative care service capacity and capability 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 palliative 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.

	Priority actions	Responsibility
3A	Continue to enhance community based palliative care capacity through a range of initiatives including: • expansion of telehealth/virtual care use • extending hours of operation from 7.00 am – 6.30 pm to 7.00 am – 9.30 pm • growing nursing and allied health workforce capacity • using available resources efficiently.	COH
3B	Strengthen partnerships and communication with private, non-government and primary care providers to establish sustainable models of care with: • GPs • community and hospital pharmacies	Medicine Stream and Directorates
3C	Develop and/or review protocols to support rapid discharge for the dying patient to be cared for at home.	All Directorates
3D	Review, refresh and communicate care pathways including the rapid escalation pathway to support patients at home who deteriorate to remain in the home.	All Directorates
3E	Establish a grief and bereavement service for patients and families cared for at home.	COH

Service direction 4: MNHHS will grow specialist palliative care capacity

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 available at all hospitals.

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.
- Increase bed capacity across MNHHS.

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.

	Priority actions	Responsibility
4A	Develop a workforce plan for medical, nursing and allied health staff across all services with skills in delivering safe and effective palliative care across care continuum.	All Directorates and Professional Leads
4B	Document consultation liaison service model of care and resources to support model at all facilities.	All Directorates and Health Service Strategy and Planning
4C	Participate in programs and processes to reduce interventions that are not likely to benefit quality of life e.g. INTERACT	All Directorates
4D	Redesign outpatient service model for palliative care to include access to nursing, allied health, bereavement and administrative support.	All Directorates
4E	Enhance palliative services at Caboolture Hospital.	Caboolture Hospital
4F	Improve quality of care for patients admitted to specialised palliative care inpatient beds in MNHHS by: a. redesigning the Redcliffe Hospital palliative care unit to have a mix of single rooms and double bedded bays and improved access to family space b. redesigning Redcliffe Hospital and TPCH palliative care units to create more rest space for staff and visitors.	Redcliffe and TPCH and Infrastructure and Assets
4G	Increase dedicated inpatient bed numbers for specialised palliative care in all facilities in line with need.	All Directorates and Health Service Strategy and Planning
4H	Establish grief and bereavement services for patients and families cared for in hospitals.	Directorates

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 MNNHS.

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

	Priority actions	Responsibility
5A	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.	All Directorates
5B	Foster a research culture within palliative care in MNHHS to include a coordinated framework for knowledge translation from research to practice.	All Directorates
5C	Engage with CPCRE to provide advice and assistance to new researchers in MNHHS.	All Directorates
5D	Partner with universities to establish joint clinician appointments including medical, nursing and allied health.	All Directorates
5E	Increase research participation and outputs among all disciplines and service settings.	All Directorates

Note: RBWH – Royal Brisbane and Women's Hospital, TPCH – The Prince Charles Hospital, COH – Community and Oral Health.

Where to from here

MNHHS will continue to implement the MNHHS Palliative Care Clinical Services Plan 2017-2022. 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 identifies and ensure the Plan can be reviewed and updated if required.

Appendix

Appendix 1: Actions from Palliative Care Plan 2017-22

Completed actions

Action	Initiative
1.2b	Develop and/or review and update information to support families and carers in caring for a person with a life-limiting illness
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.
1.4	Establish support structures for all staff working in palliative care to have opportunities to debrief, reflect and receive support as needed.
1.5	Continue to promote the uptake of advance care planning. All staff will be encouraged to lead discussions supported by current ACP coordinators to: a. discuss in the community end of life decisions with patients who are unable to be seen in the hospital setting; b. provide education to clinicians to support respectful and timely communication with patients, families and carers.
1.12	Utilise patient, family and carer survey responses to improve palliative care including transparent communication regarding what we will do differently.
2.3	Transition TPCH and Redcliffe Hospital inpatient palliative services to the respective hospital directorates to support service connectivity.
2.5	Consult with partner palliative care health service providers when developing and designing MNHHS palliative care services to ensure collaboration and coordination across Brisbane North.
2.6	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.
2.8	In partnership with palliative care service partners review, refine and document referral processes.
2.9	All MNHHS palliative care services in MNHHS will contribute to the PCOC data set to capture information and to benchmark outcomes.
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.
2.15	Advance discussions across service providers across service settings to investigate the establishing a minimum data set for palliative care activity.
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.
3.4	Maximise use of telehealth and other technologies to support patients to be cared for at home.
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.

Completed actions *(continued)*

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.

Action	Initiative
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.
3.13	Investigate establishing day respite and overnight hospice/interim palliative care at Zillmere Health Campus.
3.14	Work with other agencies to investigate opportunities to develop interim palliative care service including respite services in MNHHS
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.
4.3	Investigate establishing local palliative care consultation liaison services at Caboolture Hospital
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: a. 24/7 access to specialist symptom management, support and admission if required b. access to specialist medical, nursing, allied staff c. access to pharmacy d. bereavement care e. rapid response service.
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

Actions progressed through another avenue or reframed

Action	Initiative
1.1a/e	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: • 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 • fact sheets to debunk common myths regarding palliative care
1.2a	Develop and/or review and update education and information for patients, families and carers regarding patient journeys including management of common symptoms, pain and escalation pathways
1.2c	Develop and/or review and update education information regarding be tailored to diverse communities
1.8	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.
1.10	Grow the joint management of patients through a partnership model of care described in 1.8 to other specialties.
1.11	Review and update the patient, family and carer experience survey to include questions regarding end of life care.
1.12	Utilise patient, family and carer survey responses to improve palliative care including transparent communication regarding what we will do differently.
1.13	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.
2.2	Establish the MNHHS palliative care governance structure to support the networked palliative care service system.
2.10	Actively contribute to advancing Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) across MNHHS.
2.13	**a.** 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: **b.** introducing evidence-based frailty scoring tools to be administered by trained nurses on patients that are critically ill and may be frail; **c.** developing a process for patients with a high frailty score to enable discussions with all care providers (multidisciplinary team) to refer to palliative care; **d.** developing a process to discuss multidisciplinary team recommendation to refer to palliative care with the patient, family and carers for quality of life outcomes.
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.
4.2	Establish local grief and bereavement services at TPCH, RBWH, Redcliffe and Caboolture /Kilcoy Hospitals to support people through loss and grief.
4.6	Advance joint outpatient clinics with speciality 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.
4.9	Investigate opportunities to re-establish access to spiritual care and expand pastoral care across the MNHHS palliative care service network
5.1	Actively pursue education and training actions described in service direction 1.

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