

## **Chapter 7**

### **Models of service delivery**

#### **Introduction**

7.1 Funding regimes are not the only aspect of palliative care that vary from state to state, as well as locally. There are different ways that palliative care service delivery can be organised, and different kinds of organisations that are involved. Some care is delivered publicly, some privately. Some is delivered in hospitals, some in residential facilities, some in aged care, and some at home. A range of different professionals can be involved, and the way they are paid can vary too.

7.2 During its inquiry, the committee heard regularly about some particular service models that were highly regarded or were involved in important innovations. It also heard that such innovations could be placed under pressure or cut because of pilot funding or non-ongoing funding being all that was available. This chapter focusses on a small number of service delivery models, to consider what was regarded as positive about these, and what issues arise in implementing them. All of them focus on community-based care, but in each case the setting varies.

#### **Models of service delivery**

7.3 Throughout the inquiry, submitters and witnesses repeatedly referred to the model of care provided by Western Australian based Silver Chain<sup>1</sup> as being very effective in providing community based palliative care. In its submission to the committee, Silver Chain outlined and explained what it has identified as a 'best practice model of specialist community palliative care provision', <sup>2</sup> the model which it has implemented in Western Australia and is starting to extend to both South Australia and Queensland.

7.4 The best practice model through which Silver Chain operates integrates specialist community provision of palliative care with primary health care infrastructure. The model involves three specific service offerings – a metropolitan community palliative care service; a palliative nurse consultancy service; and a palliative rural telephone advisory service, all guided by the principles of building capacity within families to care for their own; integrated and coordinated services; interdisciplinary/multidisciplinary care planning; and evidence-based, client-centred care:

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1 Silver Chain, a Western Australian based not-for-profit organisation that has been providing care to people living in metropolitan, rural and remote areas for over 100 years is one of Australia's largest providers of community, clinical and health care services to the Western Australian and South Australian communities, and a growing entity in Queensland. Silver Chain provides a diverse range of services including palliative care and through its Hospice Care Service in Western Australia provides specialist community palliative care services  
Source: Silver Chain, *Submission 80*, p. 2.

2 Silver Chain, *Submission 80*, p. 2.

1. Metropolitan Community Palliative Care Service: Provision of in-home specialist palliative care to clients within the metropolitan area and to all metropolitan care facilities that do not have a registered nurse managing care 24 hours a day.

2. Palliative Nurse Consultancy Service: Provision of a palliative nurse consultancy service to metropolitan public/private hospitals and residential facilities where client care is managed by a registered nurse 24 hours each day. The service provides specialist nursing advice, assessment, procedures, specific staff education and telephone follow up to meet the care needs of a specific client. Referrals are accepted from medical practitioners, registered nurses and allied health staff that are providing care within the facility. Involvement is limited to a period of five days following which the client is separated from the service. The client can be re-referred and there is no charge to the facility or the client.

3. Palliative Rural Telephone Advisory Service: Clinical Nurse Consultants who have specialist skills and knowledge provide telephone advice to rural service providers regarding managing the palliative care needs of a specified client. This service is available via a free call telephone number 24 hours per day, seven days per week.<sup>3</sup>

7.5 Silver Chain explained that its services are delivered through an interdisciplinary team consisting of specialist nurses, medical consultants, registrars, general practitioners, allied health professionals, care aides, and volunteers.<sup>4</sup> This model enables Silver Chain to provide a whole of metropolitan service, 24 hours a day seven days a week, engaging general practitioners and providing personal and respite care.<sup>5</sup>

7.6 Silver Chain identified that their service:

...admits approximately 3,000 people annually, with more than 660 people receiving care on any given day, and an average length of stay of 84 days. Sixty per cent of admitted clients are supported to die at home (compared to national average of 25-30%). Recent analysis of Silver Chain data over the last two years demonstrates that the majority of those who died at home had no hospital admissions during their episode of care with the service.<sup>6</sup>

7.7 The services provided by HammondCare in New South Wales were also identified as a very successful and effective model:

HammondCare, a not-for-profit, aged-care provider of good reputation entered the palliative care service provision field in 2009... they opened a palliative care suite ('Bond House') within their own RACF at

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3 Silver Chain, *Submission 80*, p. 8.

4 Silver Chain, *Submission 80*, p. 2.

5 Silver Chain, *Submission 80*, pp. 8–9.

6 Silver Chain, *Submission 80*, p. 2.

Hammondville (a suburb of Sydney). This is at HammondCare's own expense and is currently not receiving any extra external funding.<sup>7</sup>

7.8 Dr Yvonne McMaster, a retired palliative care physician, spoke of the palliative care suite provided by HammondCare. Dr McMaster explained that the services provided through HammondCare's suite differ from the usual aged care situation as it provides:

1. Assessment by Specialist Palliative Care Team prior to referral, whether this assessment occurs at home/residential care or in hospital.
2. Support from the specialist palliative care team; including specialist consultation in the palliative care suite, 24 hour telephone advisory service, GP support, pharmacy access, multidisciplinary input and weekly meetings, bereavement support for families and education for nursing staff.
3. GPs with a special interest in palliative care are provided with a specific mentorship and capacity-building programme to support them.
4. In-house pharmacy licence which provides access to emergency palliative medications.
5. Designated Palliative Care Suite nursing staff.
6. All residents and their families will work with staff to plan for future care, in accordance with wishes (regularly reviewed and updated as circumstances change).
7. Tailor made palliative care education plan including the Program of Experience in the Palliative Approach (PEPA), buddy shifts and mentoring. PEPA is available to all disciplines including GPs.
8. Comprehensive education program for all staff.
9. Close links with the in-patient unit.
10. Access to HammondCare's specialist palliative care medical, nursing, allied health, pastoral care and project manager consultative services across Sydney.
11. Refurbished private rooms with ensuites.<sup>8</sup>

7.9 HammondCare further detailed the services they provide through the palliative care suite model and how this model is addressing gaps it has identified in the provision of palliative care:

The difference is firstly and foremost in the training and skill level of the staff. The staffing levels are greater within the palliative care suite. Access to specialist nursing and specialist medical support is there because of our link with Braeside Hospital and the palliative care team. We have set up a partnership where there is a 24-hour on-call telephone advice line which provides the nursing staff immediate advice about what is happening rather than waiting, which is the norm in aged care. It is really about time and

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7 Dr Yvonne McMaster, *Submission 92*, p. 22.

8 Dr Yvonne McMaster, *Submission 92*, pp. 22–23.

expertise, the gaps that we face. Time is not just that nurses in aged care are time poor; we all know that. It is more the turnaround time for a person who is deteriorating. As Dr McVey will say, the identification of that is critical in and of itself. A person is deteriorating and then the nursing staff need to call the GP, who may not be available on that particular day and it may take 24 hours before the GP arrives. The GP may write an order for symptom control of some form of medication. That needs to then go to a pharmacy, which is often off-site. That needs to then come back to the aged-care facility and it is not unrealistic to expect that 48 hours have passed from the initial determination that the person is deteriorating.

The facility has two options: either do our best to be kind and caring to a person, which we all know is not enough, or send the person through to the acute system via the accident and emergency department, and we all know that is not ideal either. So what we have tried to develop is a process and expertise level that circumvent that time issue. We have acquired a drug licence for that unit, which means we are able to hold stock within the residential aged care facility of medications that is not the norm. I have to say it was quite an interesting process getting that drug licence because I do not think there are that many requests of that nature anymore. So there was surprise coming from the pharmaceutical branch of 'Do people still do that, actually get drug licences?' That meant we could have medication on site. Specialist support and a dedicated GP that has been working with the specialists to make sure the GP is actually aligned with the treatment plans.<sup>9</sup>

7.10 HammondCare advised the committee that its costing of the program indicated an additional cost of \$50 000 per bed per annum:

At the moment it is being cross-subsidised because we are able to put that in the larger facility, so we have put that into a 124-bed facility and we dedicated nine beds, so there is cross-subsidisation. We do get Commonwealth funding for people, but the additional cost is approximately \$50,000 per bed per annum.<sup>10</sup>

7.11 When asked about their model and the inspiration for its establishment, HammondCare representatives explained to the committee:

We have known for a long time that the care of older people, particularly in nursing homes, during the dying phase is not done universally well. A lot of aged care providers will say that they do palliative care really well. That really is based on a lot of good people who care but it is not necessarily technically competent. As I said, being an organisation that had the benefit of schedule 3 hospitals, palliative care hospitals, it was an opportunity to say that the purpose of acquiring those hospitals was to be able to say, 'We want to provide older people with the right care throughout the various stages of their life and we need to make sure we can cross over those areas of expertise. So our aged care services were fabulously expert in dementia

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9 Ms Angela Raguz, General Manager, Residential Care, HammondCare, *Committee Hansard*, 2 July 2012, p. 18.

10 Ms Angela Raguz, HammondCare, *Committee Hansard*, 2 July 2012, p. 18.

care and we had hospitals that were expert in palliative care. So how do we bring the two together?...It was only about creative thinking; it was a good idea.<sup>11</sup>

7.12 HammondCare further explained to the committee that although their applications for funding were declined they decided to 'do it anyway' and have commissioned the unit for the coming year to demonstrate 'not just the cost-effectiveness but the better outcome for the people and families.'<sup>12</sup>

7.13 HammondCare informed the committee that although they had again approached the Commonwealth seeking funding to expand their model, the complexities of providing aged and palliative care prove to be barriers to further future investment:

...it [palliative care] is an area that we do not think can be ignored. I think we need to be looking at innovative models, and there are opportunities through flexible funds programs and whatnot to get these things up and running and off the ground. We just started that before that was actually open—the flexible funds round last year.

...The response [from government] is that absolutely there is a need, but like any response the government is saying, 'We think we are putting enough into aged care so there is not really an option for a lot more top-up'. It costs more than aged care but it costs less than subacute care, and so it is that in-between land. In the state health system there is that very real truth that, even if a person is out of that subacute bed or acute bed and in an aged-care bed, another person very quickly fills that, so there is not a real dollar saving. It is just that the cost of care for this person is less than what it would have been there. So it is hard to actually get people to come on board.<sup>13</sup>

7.14 Another example of a service model delivering effective palliative care was Eastern Palliative Care Association Incorporated. Eastern Palliative Care is the largest community based palliative care service in Victoria. In the 2010-11 year Eastern Palliative Care 'supported over 1260 new clients... 83 per cent of whom has malignant disease and 36 per cent who were under the age of 69.'<sup>14</sup>

7.15 Eastern Palliative Care do not have access to hospital beds but rather work with hospices and inpatient palliative care units to support clients to 'die in their place of choice with symptoms well managed'.<sup>15</sup> Representatives of Eastern Palliative Care explained how its services are effectively targeted and delivered:

Every client in the region who gets referred for specialist palliative care comes into our intake team, and our intake team go through an assessment

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11 Ms Angela Raguz, HammondCare, *Committee Hansard*, 2 July 2012, p. 22.

12 Ms Angela Raguz, HammondCare, *Committee Hansard*, 2 July 2012, p. 22.

13 Ms Angela Raguz, HammondCare, *Committee Hansard*, 2 July 2012, pp. 22–23.

14 Eastern Palliative Care Association Inc., *Submission 42*, p. 1.

15 Eastern Palliative Care Association Inc., *Submission 42*, p. 1.

process where we look at whether they have generalist needs or specialist needs.<sup>16</sup>

7.16 EPC explained that in the case of generalist needs, where the patient is 'relatively stable and has no particular issues; the family is all on board and the aged care facility is on board,' they would not provide ongoing support, rather:

[EPC] would provide advice on the phone to the aged-care facility. They may be referred off for RDNS, the Royal District Nursing Service, in case they need extra support, but we would not keep going with those.<sup>17</sup>

7.17 To determine the care that will be provided, Eastern Palliative Care's intake team perform an assessment. Those who have symptom issues that are not being managed are then provided with care services.<sup>18</sup>

7.18 Eastern Palliative Care explained that referrals to their service are generally made by doctors although families can make referrals and aged-care facilities are increasingly referring patients for assessment.<sup>19</sup> EPC informed the committee that they do not have a waiting list, rather they have a process in place which enables their intake team to assess the patient's need and see urgent clients within four hours:

Ms Hogan: We do not have a waiting list...our intake team, they triage and so the people who are very urgent get seen within four hours and the people whose needs are not so urgent might have to wait 10 days, but they are still on the books and we are still making contact with them and so there is still that ongoing contact. So that whole concept of the waiting list is something that we do not have at all.

Ms Moody: My board have given directions, if for some reason we cannot see that person within 10 days, that we are to put on extra staff and meet the community's needs. It is the board's responsibility to find funding for that.<sup>20</sup>

### **Common issues faced by these models of service provision**

7.19 It is clear from the examples provided that levels of funding, and availability of workforce, are hurdles that face service providers in providing effective and efficient care. However, there are also other important factors.

7.20 Palliative Care Australia attributed the success of the Silver Chain model to its nurse-led coordinated multidisciplinary workforce:

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16 Ms Jeanette Moody, Chief Executive Officer, Eastern Palliative Care Association Inc., *Committee Hansard*, 4 July 2012, p. 5.

17 Ms Jeanette Moody, Eastern Palliative Care Association Inc., *Committee Hansard*, 4 July 2012, p. 5.

18 Ms Jeanette Moody, Eastern Palliative Care Association Inc., *Committee Hansard*, 4 July 2012, p. 5.

19 Eastern Palliative Care Association Inc., *Committee Hansard*, 4 July 2012, p. 5.

20 Ms Louise Hogan, Manager Human Resources and Public Relations; Ms Jeanette Moody, Chief Executive Officer, Eastern Palliative Care Association Inc., *Committee Hansard*, 4 July 2012, p. 8.

At the moment where it is working well in terms of coordination of care, such as the Silver Chain model that I mentioned before, it is usually a nurse-led model in terms of case coordination. But it really does include an entire multidisciplinary team that sits down and meets. So there is all that back-end work that goes into ensuring somebody receives the best possible care.<sup>21</sup>

7.21 Similarly, Palliative Care Queensland suggested that the success of the Victorian model, as demonstrated by Eastern Palliative Care's service, could be attributed to their governance arrangements where a consortium within a region coordinates service provision:

The Victorian model of having a consortium within a region where you try to pull together the paediatric, adult, disability or whatever other services and get them talking to each other and sorting out the problems... is absolutely vital. If you sat in Brisbane on a hotline you would have no idea what Roma offered or what Cairns had, even though you might have a list of services.<sup>22</sup>

7.22 The Victorian Healthcare Association echoed this view and explained that the 'devolved model of governance' in place in Victoria enables innovation in service delivery and the allocation of funds:

...through the devolved model of governance there has been a capacity for local solutions to be put in place. Our funding model here in Victoria is reasonably complex. It has been based loosely on an activity based funding system for 18 or 19 years now, so we are well established in the playground. Activity based funding to hospitals in Victoria still counts for only about 65 per cent of hospital funding. There is a range of other different funding mechanisms as well that come into play. Then each of those hospitals have their own board of governors. Therefore they have their own chief executive and the creation of strategy, while it needs to be consistent with state government policy directions, can still be intuitive to the way in which that policy direction is interpreted at the local level. That creates opportunity for innovation.<sup>23</sup>

7.23 Silver Chain in Western Australia informed the committee that it received approximately 95 per cent of its funding from the Western Australian state government:

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21 Dr Yvonne Luxford, Chief Executive Officer, Palliative Care Australia, *Committee Hansard*, 24 April 2012, p. 25.

22 Professor Rohan Vora, President, Palliative Care Queensland, *Committee Hansard*, 2 July 2012, p. 28.

23 Mr Trevor Carr, Chief Executive, Victorian Healthcare Association, *Committee Hansard*, 4 July 2012, pp. 15–16.

...It would probably be 95 per cent or a little bit above. There are donations and bequests we receive, but the majority of funding is through the state government with a small amount of DVA funding.<sup>24</sup>

7.24 Through Palliative Care Queensland's description of the fragmented provision of services in that state, the barriers that have been overcome by Silver Chain, Eastern Palliative Care and HammondCare become clear:

Obviously, under the new health arrangements—we have talked before about the divide between the Commonwealth and the states—there are also the issues around what happens about out-of-hospital care. Within a state, you get caught up with the systems manager, the 17 health and hospital services and a statewide paediatric service that goes across the state, so it will be interesting to see how that develops and that will hopefully help with some of these issues, but what happens about the other 17?

We come from an area where the services are already really fragmented and vary hugely, even within a metro area, let alone the rest of the state. We are worried that we will have 17 totally different services developing with different priorities on palliative care. People may have to travel from one district to another if they want to have certain services, even in end-of-life care. Firstly, we asked for improved coordination of services across Queensland and the development and implementation of a state-wide service plan. We note the South Australian plan and the strategy in Victoria, and hope that with the new state government—who have, wonderfully, called an inquiry into the whole state of affairs there—we might start getting some traction. We are very hopeful that we can work with the new government on reversing some of the issues.<sup>25</sup>

7.25 In addition to interdisciplinary teams and effective governance, some inquiry participants were concerned that Australia has a medical model of care, resulting in the use of relatively high-cost, hospital based care, with less use of holistic and home-based care than might be desirable:

The community hospice model of care which is still very prominent in the UK, USA, Canada, New Zealand, Europe and parts of Asia, has in Australia been superseded by very sophisticated Palliative Care based on a strong medical model. While quality Palliative Care is undeniably important, it is of some concern that the hospice model of care, which can support and underpin home care has virtually been abandoned in Australia. With the strong “medicalisation” of palliative care in Australia, the concept of holistic and person centred end-of-life care has at times been compromised and people’s right to choice in place of care and type of care thereby discounted. This fact I would suggest, is in part represented in the low statistics of home deaths in Australia.<sup>26</sup>

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24 Mr Mark Cockayne, General Manager, Health; and Director, Hospice Care Service, Silver Chain, *Committee Hansard*, 5 July 2012, p. 32.

25 Professor Rohan Vora, Palliative Care Queensland, *Committee Hansard*, 2 July 2012, p. 24.

26 Anam Cara House Geelong and Colac, *Submission 54*, p. 2.



7.26 The Victorian Healthcare Association raised a similar issue:

International research suggests that up to 90 per cent of people with a life-threatening illness would prefer to die at home, or in a home-like environment. The capacity to meet a person's wish to die at home is important as it allows them to spend time with their families and friends and maintain their own routines and preferences in a safe and familiar environment. Despite this preference however, only 26.5 per cent of Victorians die at home, while 56 per cent died in hospital.<sup>27</sup>

7.27 Silver Chain (noted above) provide a contrast with this Victorian result: sixty per cent of their clients were able to die at home.

### *Committee view*

7.28 The committee concludes that for service delivery to be both cost-effective and achieve positive outcomes for the dying, their carers and families, there must be a focus on 'dying in place'. The committee is not indicating that dying at home is better than in hospital, and it recognises that choices around the place where palliative care occurs must also depend on carers' availability and capacity (see chapter 5).

7.29 The committee is concerned that people's preferences are not being met. Furthermore, the cost of care in a hospital-centred system is higher than that based around 'dying in place', where appropriate. Thus Australia effectively risks running a system that is relatively expensive, and does not meet people's needs or preferences around death.

7.30 The committee concluded that regardless of where care is delivered, multi-disciplinary teams and good coordination were critical to effectiveness. Regional service delivery organisations were often praised for their work, and it was clear that effectiveness 'on the ground' and at the local level was important. However, what was not clear was the extent to which governance should be devolved to achieve good community service delivery. The committee heard that there was a strong sense that devolved organisation is a feature of success in Victorian palliative care. In contrast however, Silver Chain, one of the most highly regarded services in the field, is a very large organisation that does not appear to operate with a particularly devolved or decentralised organisational structure.

7.31 The committee takes the view that the most important consideration in service delivery reform at present is to increase the capacity to support palliative care in the home (including residential aged care), or specialised hospice facilities where that is the preference, and reduce unnecessary (and often unwanted) transfer into the hospital system. This is likely to have the effect of saving money. Most important however, is that it will provide a better experience to patients and those around them.

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27 Victorian Healthcare Association, *Submission 57*, p. 1.

**Recommendation 11**

**7.32** The committee recommends that service delivery models include a greater emphasis on community-based care, 'dying in place', and a reduction in unnecessary hospital admissions.