Palliative Care Services Plan*
2009-2016

Summary Document for
Allied and Scientific Health Workforce

* Please note this is a Summary Document only. For a complete version of the plan go to
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Overview

South Australia’s Health Care Plan 2007-2016 identified an increasing demand for palliative care services in the coming years. Planning to meet this increase in demand presents a series of challenges which include the community’s expectations of access to quality end of life care services, particularly for the growing population of older people who increasingly are living alone and with fewer available family members able to provide support. Compounding this challenge, is a workforce that is itself ageing and retiring, and cannot be readily replaced.

South Australia has a well established and well regarded palliative care sector. Palliative care services for many years have championed holistic approaches to care and delivering integrated services across in-hospital and out-of-hospital settings. In developing this new plan for palliative care, emerging knowledge about caring for the dying has been merged with the strengths of SA current palliative care service delivery program.

The Plan positions the work of palliative care services within the broader context of all the end of life care needed and provided across the state and directs palliative care services towards those people with the most complex end of life care needs. It expands the focus on building the capacity of generalist providers to ensure continuity and their active participation in care through to the end of life.

Ageing workforce

Like the rest of the nation, South Australia is facing a health care workforce crisis as its workforce ages. Many of today’s health workers will be retiring in the foreseeable future and the health care sector is competing against many other industries for the small pool of young people and migrants entering the workforce.

SA Health modelling of future workforce supply indicates a complete inability to maintain workforce groups at current numbers into the future. For example, it is predicted that the number of Registered Nurses in SA will drop from approximately 16,000 to around 12,000 by 2020.

The crisis in the country workforce is of even greater concern:

- Nurses in the country are on average older than the state mean, and the nursing workforce in country SA is anticipated to shrink by up to 30% in the next 20 years.
- Increased turn over of General Practitioners in country South Australia will continue to be a problem; currently 40% of General Practitioners have less than five years experience working in rural SA and over the next five years international medical graduates are expected to constitute around 40% of the rural medical workforce.
Planning end of life care

Consideration of end of life trajectories helps broaden the scope of planning beyond a focus on the relatively small proportion of people who die with involvement from a palliative care service.

This palliative care plan recognises three typical or characteristic end of life trajectories (excluding sudden death) and seeks to appropriately position palliative care services across these trajectories to ensure the input and resources of services are most effectively utilized. The trajectories include:

1. Short period of evident decline
2. Long-term limitations with intermittent serious episodes
3. Prolonged decline.

Along these trajectories, a series of key points or triggers representing interventional opportunities that can change the nature, direction and outcomes of care can be anticipated. Triggers come in many forms and may include a new diagnosis or revision of prognosis, the advent of a frightening or overwhelming symptom, an escalation of symptoms or an indication of increasing distress or despair. Across these end of life trajectories, a number of triggers can be predicted.

Expanding and reshaping palliative care services

To expand and reshape palliative care services to meet the trajectory demand and workforce challenges ahead the following directions have been identified:

- Consolidation of palliative care services into regionalised teams for enhanced integration and sustainability
- Formalising links and partnerships between metropolitan and country services
- Recasting the balance of end of life care that takes place in the in-hospital and out-of-hospital settings to give increased opportunity for people who want to receive end of life care at home
- Building the capacity of generalist providers to effectively contribute to high quality end of life care
- Developing a palliative care quality agenda which supports understanding, planning for, and reporting on the needs and the outcomes of care for all those at end of life across each service catchment and across the state
- The regionalised palliative care services will provide an integrated service for people and their families across in-hospital and out-of-hospital sites.
i. Palliative care services in metropolitan Adelaide

Metropolitan Adelaide will be served by three public adult Level 6 palliative care services. Consistent with the health system architecture underpinning the SA Health Care Plan, these Level 6 services will be based at the metropolitan General Hospitals: The Queen Elizabeth Hospital, the Repatriation General Hospital and the Modbury Hospital.

Existing palliative care services will be consolidated within these services to ensure the long-term viability and sustainability of the palliative care sector in the state. Level 6 palliative care services will provide services across spine and other hospitals/health care facilities within their catchment area. The three Level 6 services will each serve as a tertiary level resource to a designated number of Level 4 and Level 2 services based in country South Australia to ensure equitable access and consistent specialist coverage across the whole state.

The paediatric palliative care service based at the Women’s and Children’s Hospital will maintain and develop its focus as a Paediatric Level 6 service providing quality end of life care of infants, children and adolescents across the state. This requires partnering with all adult services across metropolitan, periurban and rural South Australia.

ii. Palliative care services in country South Australia

The service architecture of the SA Health Plan provides for expanded clinical services at four Country General Hospitals and with this comes an enhanced capacity to develop end of life care services at these sites. Palliative care services based in the four population centres of Mt Gambier, Pt Lincoln, Berri, and Whyalla will be developed to become Level 4 palliative care services by 2016.

Over time, and with analysis of trends in demand and flow, this may include expanded inpatient capacity and incorporate a cluster of specialist inpatient medical and nurse-led care options in these four hospitals.

A statewide centre for Aboriginal and Torres Strait Islander Health will be established in Pt Augusta. Leadership in the provision of culturally safe end of life care for Aboriginal people will be an important function of this centre.

Periurban areas of the northern Adelaide plains, the Adelaide hills and the Fleurieu Peninsula are all facing rapid and extensive population growth. The Strategy for Planning Country Health Services in SA recognises that service planning and service delivery in these areas will increasingly integrate with that of the metropolitan area. This will facilitate the coordinated distribution of resources to the growth areas of greater Adelaide with these periurban services moving toward Level 4 palliative care service delineation by 2016.
The development of small hospices at Mt Barker and at Gawler Hospitals are in recognition of population size and demand flowing from outer metropolitan and periurban areas. This will include expanded inpatient care capacity, and may include a cluster of nurse-led beds within the compliment of dedicated palliative care beds. The development of a similar unit for the Southern Fleurieu remains an option for the future and will be reviewed in the light of population demand and inpatient flow data in 2012.

**iii. Statewide access to specialist expertise and support**

The considerable resources invested in palliative care services are utilised to maximum effect through a system of relationships called ‘service partnering’. With varying degrees of formality, these partnerships ensure that every primary care provider involved in the care of a person at end of life can access a local palliative care provider if required.

If the local specialist service is resourced at Level 2 or Level 4, then that service can access support from their Level 6 partner, if required. The development of a statewide clinical network for palliative care has been identified as the most appropriate mechanism to enable this and other outcomes.

**Model of palliative care in SA**

Palliative care will be provided through a service model that operates across a geographical catchment area, integrates the provision of care across in-hospital and out of hospital settings, involves collaborative links with other primary care providers and includes partnering arrangements between Level 6, 4 and 2 services across the state.

Within this model, palliative care retains its integral relationship with the acute care sector in recognition of the complex care needs of its patient base and the importance of its role in assisting those patients transitioning from curative care streams. The model is structured to facilitate the person on an end of life care pathway to access the range of services available.

Complexity of need should not be the primary factor in determining the setting of care at end of life. Most people who have complex needs can be cared for in a community setting if they so wish, provided they have around the clock access to expert advice and support. While the bulk of care at end of life occurs in peoples’ own homes, hospice care plays a crucial role by providing short episodes of inpatient care for symptom control, rehabilitation, terminal care, respite, and continuing care in instances where care at home cannot be sustained.
An important challenge in this Plan has been to strike the right balance between resource allocation that adequately supports inpatient care and also ensures optimisation of care in out-of-hospital settings. A regionalised service model and a consistent approach to palliative care will be adopted across the state. This will be supported by:

- A single palliative care Unique Record Number to support once only referral.
- The statewide development and uniform use of common tools, medical history & clinical record, standardized instruments, protocols and admission, discharge and referral criteria to increase efficiency and uniformity of care.
- Increased use of evidence-based guidelines and the tailored use of standardised and optimised clinical pathways.
- A consultation-liaison service construct with active partnerships with direct care providers.
- The provision of the bulk of inpatient palliative care in dedicated hospice units.
- The incorporation of Advanced Practice roles across disciplines contributing to the palliative core team
- Enhanced capacity for the regional team to work across multiple sites, providing an in-reach service to other health facilities in the catchment area
- Improved performance measurement through shared use of quality indicators and a shared quality framework for service outcome measurement and reporting
- Consolidated coordinated training and support to volunteers and paid staff across services
- Shared education and research programs.

### i. Streamlining access and referral

A number of steps will be required to consolidate and streamline access to palliative care services and enhance their profile amongst service users and referrers. They include:

- Development of a centralised point of contact process, to ensure ‘once only’ referral
- Ready access to after-hours phone support and advice
- The promotion of the new and established online service directories, including the Palliative Care Australia services directory, the Palliative Care Council of SA directory of services, the Divisions of General Practice, the Directory of Cancer Services in South Australia, and the Health Provider Registry, to enhance community awareness of and access to relevant information about providers and services for those at end of life
- Direct promotion of new regionalised services to all referrers and via webpage and other existing forums or media.

The Plan also incorporates the development of a self-sustaining SA Palliative Care Community Pharmacy Network to facilitate a quality use of palliative medicines approach across community, aged care settings, ensure the optimal
prescription and dispensing of palliative care medications around the clock to those who need them and the safe disposal of those drugs when no longer required. Accessibility to medications after hours in the community setting remains a continuing challenge that undermines successful care at home for people with complex or fluctuant symptoms.

**ii. Palliative care services in the out-of-hospital setting**

From international experience and with the benefit of the GP Plus Health Care Strategy, it is anticipated that South Australia can achieve a much higher rate of supported death at home. By 2012, between 30-40% of those people referred to a palliative care service should be supported to die at home.

The principle enabler of success will be the optimal use of the expanded palliative care teams through the consistent application of the model of care set out in this plan.

**iii. The community palliative care team**

To support the shift to increased numbers of people supported to die at home, more will be asked of palliative care community teams and more resources will be provided to support them. Palliative care services are provided:

- to people requiring care at end of life and their caregivers and families when the level of nursing, medical and psychosocial care needed exceeds the capacity of primary care teams and community-based chronic care and aged care services
- are based on need and informed by a comprehensive palliative care assessment
- in homes and in residential aged care, transition care and community disability support facilities
- at an agreed and consistent level across the state, as delineated by the resources and capabilities of each level of specialist service (Level 2, 4 and 6).

In the community setting, palliative care services will provide:

- palliative care assessment, care planning, advice and support for people and their families/kinship groups
- 24 hour consultative advice to providers of primary and community-based chronic end of life care services to support them in their work and systematically build and extend their skills, confidence and clinical capacity in the care of people at end of life
- 24 hour advice and support to palliative care patients and their caregivers, either remotely or at the point of care, based on need
- ongoing assessment of risk from complicated grief from time of referral, early therapeutic intervention to positively alter grief trajectory and timely referral to primary and specialist loss and grief services, wherever possible
A range of high-quality and regularly evaluated programs of clinical teaching and capacity building to all providers of community-based end of life care, across health and disabilities sector.

Palliative care services often ‘share’ the care of people with complex needs with community agencies such as Royal District Nursing Service who also employ palliative care nurse consultants to provide advice and support in the home. To avoid duplication of services, providers will work together to ensure a quality, coordinated, sustainable approach to care.

**iv. Palliative care packages**

One of the new components of service arising from statewide reforms in health will be a targeted suite of palliative care packages to support community-based care of people at end of life, their caregivers and their families. The scoping and development of these packages for use across South Australia will be undertaken as a priority and funding for these packages will be identified through a number of state and federal health reform initiatives.

**v. Day hospice**

The Plan makes provision for the piloting and evaluation of a variety of ‘day support’ options, for use by clients of Level 6 and 4 services. The day hospice setting may prove a suitable venue for a range of planned activities such as the performance of therapeutic procedures and interventions, assessment and rehabilitative activities, carer education, carer respite and support and to mitigate social isolation.

**vi. Rapid response teams**

In recognition of the impact of managing increasing numbers of people with complex care needs in the community, Level 6 palliative care services will develop and pilot the use of rapid response teams. These teams will bring expanded emergency and out of hours multidisciplinary response to the home or site of care at short notice and may comprise, nursing, palliative medicine and allied health staff depending on need. These teams will respond to situations that would otherwise result in presentation and management in the Emergency Department, or admission to an acute care bed or hospice.

**vii. Ambulatory care services**

Across the GP-Plus Health Care Centres and in the outpatient settings of public hospitals within their service catchments, palliative care services will provide a range of ambulatory care services including:

- multidisciplinary palliative care outpatient consultation and review clinics
- contribution to multi-specialty clinics (e.g. multidisciplinary cancer and Motor Neurone Disease clinics)
- psychosocial assessment and individual, family and group counselling services
- bereavement support and counselling services.
A number of innovative clinics may also be piloted and evaluated including:

- symptom specific clinics (e.g. dyspnoea, anxiety/depression and cachexia/asthenia)
- discipline-specific clinics (e.g. physiotherapy, occupational therapy, pharmacy, nursing).

**Palliative care services in the hospital setting**

*i. The place of hospices in integrated service delivery*

Dedicated hospice units play a critical role in meeting the needs of people at end of life who require periods of intensive inpatient care. The bulk of inpatient care provided by palliative care services will take place in hospices. Admission to all publicly funded hospice beds is based on need as determined by a palliative care assessment.

Hospices require a minimum cluster of 16 beds to ensure a critical mass of patients and skilled staff with qualifications and expertise. Dedicated hospice units will be located in each of the Level 6 palliative care services. To meet the needs of South Australians requiring overnight admitted care in a hospice setting through to 2016, a reconfiguration and expansion of hospices beds is needed.

The following section makes provision for increasing the number of palliative care beds across metropolitan and greater Adelaide areas to 104 by 2016. Palliative care bed numbers in country areas are more difficult to quantify but this Plan identifies the need for 8-16 beds spread across the country General hospitals, at least two beds in the centre for Aboriginal health.

   **i. For the greater northern Adelaide area**

Based in the Modbury Hospital, this unit will serve as the main centre of inpatient care in the Northern suburbs of Adelaide. The current hospice at Modbury Hospital will need to increase from its current 14 to 22 beds over the next few years. A second hospice will soon need to be established at Gawler Hospital, configured initially as a small satellite unit of the Modbury hospice with a cluster of 4-6 palliative care beds.

   **ii. For the western, inner and eastern Adelaide areas and the Mt Lofty Ranges**

The development of a hospice unit at The Queen Elizabeth Hospital is a priority. This unit will be part of the Level 6 palliative care service based at QEH and will need to have the capacity to provide 24 palliative care beds within the next 4 years. This hospice will serve as the main centre of inpatient palliative care in the western, central and eastern suburbs of Adelaide.
Some hospice care for public patients will continue to be accessed from Mary Potter Hospice in North Adelaide. A small satellite hospice unit will need to be established at Mt Barker Hospital in the immediate future with an initial cluster of 4-6 palliative care beds. The size and the capacity of this unit will be expanded to reach a fully sustainable unit of 10 beds by 2016.

**iii. For the southern Adelaide areas**
Hospice facilities at Repatriation General Hospital will need to expand to a 22 bed unit. This unit will continue to serve as the main centre of hospice care in the southern suburbs of Adelaide. Additional planned bed capacity will also be required at Repatriation General Hospital to absorb demand until the 22 bed unit is established. The development of a hospice at Noarlunga Hospital with a base capacity of 10 beds by 2016, configured initially as a small satellite unit with a cluster of 4-6 palliative care beds.

**iv. Within the catchment of the paediatric palliative care service**
Paediatric palliative care service has a commitment to supporting children and younger adolescents with palliative care needs to remain at home. Paediatric inpatient palliative care will continue to be provided at Women's and Children's Hospital in hospital wards relevant to the child's underlying diagnosis or in adult hospices.

**v. Within the catchments of Country General Hospitals**
The volume of inpatient palliative care needed across country areas varies according to population demographics. Each Country General Hospital will be developed to have a 2-4 bed capacity in purpose-designed single palliative care rooms. The Palliative Care Coordinator will lead each rural and periurban palliative care service.

**vi. Palliative care services in the residential aged care setting**
Palliative care services currently provide a consultancy service to residents in aged care facilities. This service will continue and be expanded as the community palliative care teams are increased. The development of community packages of care will further assist aged care providers in meeting the care needs of their residents.

**Working within the new care model**

**i. Types of palliative care beds**
The Plan also develops the concept of differentiated types of palliative care bed. Nurse-led care options will be explored and developed to enhance the flexibility of services as they strive to be more responsive to the needs and preferences of
people who require admitted overnight care or supported community residential care.

**ii. Acute palliative medicine in hospitals**
The provision of an Acute Palliative Medicine Service, Level 6 adult palliative care services will maintain a presence in the all metropolitan hospitals within their respective catchments.

**iii. Optimising the influence of palliative medicine**
The model of care supports palliative medicine specialists to achieve high levels of integration and influence in a range of medical specialty services (including oncology, neurology, renal, thoracic and general medicine) to ensure that each acute specialty service integrates quality end of life medical care into their clinical practice.

These teams will help facilitate acuity-based care planning and timely responses to need in the Acute Medical Units of Adelaide’s three adult major metropolitan hospitals. They will collaborate with other contributing medical specialist services and nursing and allied health staff working in this setting. The Paediatric Palliative Care service will provide this function at the Women’s and Children’s Hospital.

**iv. Equipping teams for change**
A considerable emphasis of this plan hinges on the use of a single shared model of palliative care to support the quality and consistency of service delivery across the state. Expanding the capacity and the disciplinary diversity of the specialist team to enhance the sustainability of services over the long-term presents as both a challenge and an opportunity.

To achieve the vision of a dynamic modern palliative care service structured for long-term efficacy, flexibility and sustainability requires an integrated strategy of team diversification and role design, within a team culture characterised by ‘interdisciplinary’ rather than ‘multidisciplinary’ approaches and ‘collaborative’ rather than ‘cooperative’ work practices.

Exploring the impact of new and emerging roles will also be an important feature of the workforce strategy. The three Level 6 adult palliative care services in metropolitan Adelaide will be expanded by the inclusion of a number of new and emerging roles, each designed to add to the capacity of services to achieve enhanced community care outcomes for people at end of life, their caregivers and families. A significant emphasis will also be placed on extending the concept of ‘advanced practice roles’ beyond nursing into other areas including social work, pharmacy, and a range of allied health and other psychosocial support roles.
v. **Supporting end of life care providers**

To further improve the quality of this care, in the face of an overall increase in the demand for end of life care requires:

- an informed community
- an informed health sector the ‘right’ support for generalist providers of end of life care by the palliative care sector
- a particular focus on supporting living-in-place/dying-in-place in the residential aged care setting
- the whole of population evaluation of end of life care.

Underpinning the directions for palliative care is an end of life health literacy program. Advance Care Planning and Advance Directives play an important role in enhancing the health literacy of South Australians. The key strategy in this area involves the roll out of an Informed Choices Program across primary, chronic and aged care services in each health region. This program will train and equip key frontline workers positioned to respond to triggers along patient pathways to optimise the timely initiation of advance care planning and the completion and utilisation of advance care plans.

The Palliative Care Council of SA has a significant role in advancing health literacy for people at the end of life. The Council is recognised as an effective community representative peak-body advocating quality end of life care for all, supporting caregivers, and promoting health and health literacy.

**Improving access and equity**

*Opportunities for collaboration*

Health in grief and loss is an area that extends well beyond palliative care and will require a statewide and whole of health approach. Equitable access to primary care bereavement support for all, based on need, can be achieved by working with:

- GP Plus Health Care Networks and other providers of primary care across the state to configure appropriate community-based primary care support and interventions strategies.
- key stakeholders and champions within a range of health services (such as peri-natal, intensive care, mental health, and a range of chronic disease as well as trauma and emergency response teams) to explore and optimize system-wide responses.
- a range of community agencies and educators to raise awareness of the need for and enablers of community-wide health in grief and loss.
A statewide Health in Grief and Loss Plan will be developed. The expected long-term outcomes from this plan will include:

- enhanced equity of access to appropriate interventions for all people at risk of complicated grief regardless of the service pathway they take
- a reduction in the incidence and severity of bereavement related mortality and morbidity across SA
- reduced reliance on palliative care services to meet the bereavement needs of people who would not otherwise need or benefit from referral to a palliative care service
- the repositioning of palliative care service focus back onto consultative, educational and direct service for complex bereavement in palliative care clients only.

Supporting regional older people’s health services
Key members of each palliative care team will work with the new Regional Older People’s Health Services to systematically establish and refine referral pathways, clinical support protocols, shared learning opportunities, and quality and evaluation of care at end of life in the aged care sector (both residential and community). Mechanisms will need to be in place to ensure formal relationships and referral pathways between tertiary level aged care services and palliative care services are optimized and lead to integration, coordination and continuity of contributions by these teams in both community and residential aged care settings.

Working alongside pain teams
Palliative care and pain services will work with other key stakeholders to support population-based improvement in outcomes related to prevention, intervention and control of acute, chronic and complex pain across South Australia. This suggests a need for a close clinical working relationship between procedural pain teams and palliative care team.

Enhancing quality

Demonstrating performance and continuous improvement
There will be a number of elements that together form a comprehensive quality framework for all palliative care services funded through SA Health. These elements include:

- the fostering of innovation and practice improvement, clinical and health service research, and a culture that seeks always to learn from mistakes, expand and share knowledge and improve the safety and quality of care
- the performance of audit, quality feedback loops, and ‘plan-do-study-act’ cycles by individual practitioners, teams and services
- regular service self-assessment against the national standards using a suite of validated assessment tools, with an emphasis on the experience of people at end of life, their caregivers and family as they traverse the health system.
the adoption of the Competency Standards for Specialist Palliative Care Nursing Practice as a shared statewide approach in the recruitment, professional practice development and performance management of specialist palliative care nurses

- service benchmarking and peer assessment – each Level 2, 4 and 6 Service will undergo benchmarking with comparable benchmark partners identified locally or nationally and utilise peer assessment to critically review all aspects of service delivery to ensure quality national palliative care specific accreditation. All Level 6 services will undergo specialty-specific accreditation by 2012 and all Level 4 services

Implementation

**Strengthening partnerships**
The integrated service delivery model described in this Plan draws on a whole of population approach and develops a sharper focus on the outcomes of people receiving end of life care across a range of care settings. The partnering relationships between palliative care services of varying levels across the state will be systematically consolidated over the life of the Plan.

**Managing the transition**
The formation of the regional services will require a period of transition as components of the model are expanded and reshaped. The Regions have established processes and mechanisms to manage this complex implementation. Service providers are actively participating in the design of the new service arrangements consistent with reform plans.

The transition is further supported by the new Aged Care Funding Instrument (ACFI) which has been implemented by the Australian Government in recognition of the increasing level of care required to meet the needs of some aged care residents. This instrument specifically recognises the increasing complexity of people’s care needs at end of life and allows the aged care sector to maximise the resources available to them to more adequately these needs.

**Leadership and change**
Further planning at the regional level will lead to the development of integrated service plans for each region and it will be through this mechanism that the directions of this and other statewide services plans will be operationalised.

Underpinning this will be a framework of statewide quality improvement, reporting, information technology, workforce and population-based surveillance programs. South Australia’s Health Care Plan makes use of statewide clinical networks. This approach represents the preferred clinical leadership mechanism for the palliative care sector in South Australia. A Statewide Palliative Care Clinical Network will support the development of a single model of care and a standardized approach to
service delivery across the state and also have oversight of a number of key statewide projects that will contribute to the roll out of this Plan.

Expanding the vision

**Health Promotion**
The palliative care sector has an evolving interest in the promotion of health through the normalisation of death. Through a range of targeted public health promotional approaches designed to shift the level of community anxiety about death and dying.

**Developing and supporting the workforce**
A statewide palliative care workforce strategy will be developed. Using a systematic approach to recruitment, retention and role innovation, a workforce strategy will be implemented to build the capacity and the sustainability of palliative care teams, including the early incorporation of a range of specialist roles in each adult Level 6 service including consultant physiotherapists, occupational therapists, pharmacists, clinical psychologists and the caregiver network facilitator.

A 2009-2010 palliative care workforce profile will be produced as a priority. The Plan anticipates the need for a workforce of approximately 23 Nurse Practitioners by 2016. Consistent with the County Health workforce strategy some of the nurse practitioners working in Level 4 palliative care services may have a scope of practice that incorporates aged care or chronic disease care and work in roles that focus on a dual specialty population. Growing this workforce will require the preparation of Nurse Practitioner candidates using a staggered cohort approach.

The cost effective incorporation of salaried sessional General Practitioners with a Special Interest in Palliative Care will be explored. Based on service need and level of uptake by general practitioners the role will be incorporated into Level 4 and Level 6 services across the state. Other key role innovations include:

- A repositioning of palliative medicine roles within the acute sector and a workforce replenishment strategy to ensure the supply of palliative medicine specialists.
- The recruitment of accredited pharmacists for each adult Level 6 service in 2009 and the launch of a community pharmacy network in 2009.
- The emergence of the palliative psychological medicine specialist role within the specialist medical complement of each adult Level 6 service.
- The incorporation of a welfare officer in each integrated Level 6 service to provide information and assistance to families with welfare, legal, financial, housing, placement and transport issues.
- The utilisation of a business manager in each adult Level 6 service to assist in the executive, financial and administrative functioning of each regionalised, integrated service.
**Widening the concept of advanced training in Level 6 services**

Each adult Level 6 service will meet the criteria for and maintain accreditation as a training site for advanced training in palliative medicine and will also serve as training sites for the clinical diploma in palliative medicine and the specialist skill attachment for general practice training.

All Level 6 services will take up a principle role in support of the role transition and clinical supervision of Nurse Practitioner candidates, and **advanced training roles in social work, pharmacy and key allied health disciplines**. Supporting the advanced practice training of others will be a key distinguishing feature of all specialists working in Level 6 services.

**Service level leadership and accountability**

The expanded scope of the three adult Level 6 palliative care services as outlined in this Plan will require skilled executive leadership oversight and capacity an adequate level of business manager support for each Level 6 service will also be required. Health regions will develop, through review and revision of all job and person specifications, a shared clinical governance structure for each adult Level 6 service that accounts for a contemporary construction of medico-legal liability and accountability within collaborative interdisciplinary practice models.
Directions at a glance

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Timeframe for action

The following action timeframe will be implemented by regional health services and the statewide palliative care clinical network over the life of the plan.

Priority first actions
The anticipated program of work required in 2009 includes the following areas.

i. Statewide
- The establishment of the statewide clinical leadership framework for palliative care (Statewide Palliative Care network).
- Develop and implement palliative care packages in both metropolitan and country areas. This work will be supported by a statewide project funded from a grant from the National Palliative Care Program.
- Workforce initiatives to recruit and develop palliative care clinicians, commencing with the Palliative Care Nurse Practitioner Role Transition Program, and the development of pharmacist consultant positions and the associated SA Palliative Care Community Pharmacy Network as well as a range of other advanced practice roles.

ii. Metropolitan specific
- The formation of the 2 Level 6 services in CNAHS. This will require bringing together the separate teams currently located in different hospitals to form regionalised services
- Develop processes needed to enable clinicians to work across multiple care facilities
- Establishment of the hospice at The Queen Elizabeth Hospital
- Extend the capacity of the hospice at Modbury Hospital
- Determine the resource impact on primary care services of supporting more people with palliative care needs to die at home.

iii. Country specific
- Development of services in country level 4 sites, with a particular focus on achievement of equity of access across country South Australia
- Develop the Aboriginal palliative care service based in Pt Augusta.
Other components of palliative care service

The scope of palliative care services extends well beyond clinical service provision, and includes a number of domains and activities that are summarised in the section below.

i. Research
The palliative care community is charged with the primary responsibility for asking and answering a range of questions related to clinical, philosophical, technical and operational issues related to end-of-life care and the needs of the palliative care population. This community bears the responsibility for building the knowledge- and evidence-base that frames future practice and innovation. Level 6 services have particular research responsibilities and are expected to develop a purposeful targeted program of research which both achieves a ‘best fit’ between the skills, interests and capacity of expert clinicians within that service and the targeted areas of established need or knowledge deficit.

ii. Education and teaching

Undergraduate
Curriculum offered in health sciences courses that prepare the health workforce that will provide end of life care in the future will, as a minimum, need to incorporate an introduction to the principle and philosophy of palliative care. National curriculum initiatives are available to support this.

Palliative care services demonstrate their contribution to education through the development of relationships with undergraduate faculty at University and TAFE to design, deliver, review and evaluate palliative care-related curriculum, and by recognition of participation through membership of academic faculty. Palliative Care services provide clinical placements opportunities for undergraduate students and have established agreements that support the development of shared teaching and learning relationships and activities with faculty partners.

Postgraduate
A range of postgraduate topics and awards are already available to provide for the entry-in-specialty and advanced practice needs of the specialist workforce. The Department of Palliative and Supportive Studies at Flinders University and the Discipline of General Practice at Adelaide University both offer different but well-established graduate programs.

Experienced expert clinicians working in Level 6 services contribute to the continuing design, delivery, review and evaluation of both graduate-level palliative care-related curriculum and discipline-specific graduate curriculum. They also gain recognition for their contributions by way of academic status and in some instances joint appointments. Their profile and their activities within the teaching faculty of
universities is indicative of the extent to which Level 6 services are recognised for their tertiary level expertise.

**Clinical teaching across settings**

Beyond ad hoc and ongoing clinical teaching, Level 6 services provide a targeted range of clinical teaching opportunities and take responsibility for the continuing teaching/learning needs of their own team members, as well as contributing to formal teaching opportunities (such as grand-rounds, clinical teaching and tutorial calendars) within the acute care hospitals and community agencies with which they have service agreements.

A statewide approach to training support, continuing professional education and practice development across palliative care services will assist in enhancing the quality and diversity of opportunities that can be provided to, and by the palliative care community of practice.

**iii. Health promotion**

The palliative care sector has an evolving interest in the promotion of health through the ‘normalisation of death’. Through a range of targeted public health promotional approaches designed to shift the level of community anxiety about death and dying, palliative care services seek to redress the concerns of those that feel that assisted suicide is a more dignified response to impending death than the path that lies through illness and dependence on others.

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**The new and emerging roles within palliative care teams**

A range of new and emerging roles will be incorporated into expanded palliative care teams.

**i. The palliative psychological medicine specialist and the palliative care clinical psychologist**

This plan anticipates the need for Level 6 services to enhance their capacity to provide psychological and psychiatric support to better assess and meet the needs of people with emergent or continuing mental health needs at end of life, those whose mental health is at risk, and to caregivers and families experiencing anxiety, distress, psychological dysfunction or mental health crises.

Palliative Psychological Medicine Specialists will be incorporated into the specialist medical complement of each adult Level 6 service to achieve this.

Each Level 6 service will also utilise a clinical psychologist specialising in psychological support and therapeutic counselling to people, caregivers and families experiencing anxiety, existential distress and difficult adjusts that are common at end of life.
ii. The GP with a special interest

The use of the general practitioner with a special interest in palliative care have been identified as a potential source of medical practitioners who can ‘fortify’ the provision of palliative medical services, particularly across community settings. The varying distribution of general practitioner services and after hours locum service cover across the community setting leaves large structural gaps in primary medical care services. This will limit the capacity of SA Health services to increase the amount of adequately supported end of life care in the outer suburbs of Adelaide.

The use of the GP with a special interest in palliative care will be explored:
- in the hospice setting and in GP Plus Centres
- when working alongside nurse practitioners in the community, and with a particular focus on supporting people at end of life with multi-system illness
- as a key component of palliative care service provision in country general hospitals
- to extend specialist skills and expertise into the general practitioner workforce.

iii. The caregiver network facilitator

This novel role utilises a health visiting approach to engage with caregivers to assist them to identify and mobilise their own local network of friends, relatives, neighbours, work colleagues and acquaintances to assist with caregiver support. A key aspect of the role involves addressing social barriers as well as knowledge deficits that inhibit the utilisation of a willing and able network of people and local organisations to provide material and practical assistance to caregivers. The facilitator maintains extensive knowledge and entree to the full spectrum of local community resources that exist (including local government, community groups, sporting associations and the faith or cultural communities that are relevant and significant to the caregiver).

iv. The personal care worker in community palliative care

This plan anticipates the need for a workforce of personal care workers with accredited skills and training in the provision of end of life care. The palliative care sector will have a leadership role in the development of training, accreditation and supervision of practice of this workforce.

This strategy will need to incorporate not just recruitment and role promotion, but will also require a careful mapping of opportunities for workers to progress through a well-described career path involving role consolidation and progression though an articulated program of training and credentialing opportunities.
Optimising contributions through advanced practice roles

Advanced practice roles:
- have extended and expanded scopes of practice
- incorporate innovative, non-traditional tasks
- take responsibility for aspects of care previously undertaken by other health professionals.

What makes a practice role ‘advanced’ is the application of advanced knowledge required to safely perform those services or tasks. The other requirement for these roles is the maintenance of high-level collaborative interdisciplinary model of teamwork and a shared approach to clinical governance.

An advanced practice professional is a recognised expert in their field. They have special knowledge, skills, and years of experience related to the care of a specific patient population and in the delivery of expert, specialised clinical services. Their roles involve expanded practice, across multiple domains related to clinical practice, education, research, professional development and leadership, and they have a pre-established minimum level of post-basic education, and an appropriate level of clinical supervision required for safe practice at an advanced level. A number of advanced practice roles have been planned for palliative care services in South Australia.

i. The palliative care consultant physiotherapist and occupational therapist

Rather than seek additional allied health workers, the intent of this strategic plan is to utilise the contribution of therapists for higher-level effect. A physiotherapist and an occupational therapist will be employed by each Level 6 service with the expectation that these clinicians will engage in graduate level palliative care education, develop advanced clinical expertise and serve as clinical leaders within their respective disciplines.

These clinical leadership roles will serve as consultant clinicians. Through the development of their own roles, and engaging a shared program of advanced practice and role development, they will fully explore and optimise the contribution that physiotherapy and occupational therapist roles can make to:
- the comprehensive functional assessment
- community-based support of palliative care patients (including in the GP Plus Health Care setting)
- maintenance of functional independence
- palliative rehabilitation from reversible decline in function
- the management of asthenia.

Consultant therapists will serve as statewide resources and lead their services in the capacity building of other therapists who work in primary and acute care settings to
support quality end of life care. They will be expected to contribute to curriculum development, education and training within and beyond their own disciplines, and will bring new focus and capacities to the research agenda.

**ii. The palliative care consultant pharmacist**

Through the Pharmacy Reform Program, accredited consultant pharmacists will be positioned in each Level 6 service and in Country Health SA to take up leadership roles in clinical practice, teaching/education curriculum development, and clinical research within the field of palliative care pharmacotherapeutics.

A fully optimised advanced practice pharmacy role in palliative care would play a critical role in the ongoing management, monitoring and titration of complex drug regimens, and serve as an expert resource for all prescribers providing end of life care. These roles will facilitate a program of close engagement and capacity building between Level 6 services and community and hospital pharmacies across the state, and through the development of a statewide community palliative care pharmacy network. The pharmacist based in country will work across all country areas. A self-sustaining SA Palliative Care Community Pharmacy Network will:

- Facilitate a quality use of palliative medicines approach across community, aged care, disabilities and acute care settings.
- Expand the number and the capacity of community pharmacists across the state providing home medicine reviews for palliative care patients in the community.
- Ensure the optimal prescription and dispensing of palliative care medications around the clock to those who need them, and the safe disposal of those drugs when no longer required.
- Explore and overcome barriers that inhibit greater contribution to the planning and delivery of coordinated multidisciplinary palliative care by community pharmacists in the community setting.
- Bring together community pharmacists with an interest in palliative care to explore and develop opportunities for increased community pharmacy involvement in quality end of life care in the community.

**iii. The palliative care nurse practitioner**

The number of nurse practitioners working in Level 4 and 6 palliative care services will need to rise from two to 20 or more by 2016 in order to meet the projected demand. When fully optimised, these advanced practice roles will enable comprehensive clinical assessment care coordination and clinical management for people at end of life with complex needs.

**iv. The advanced practice social worker**

The palliative care workforce strategy will need to overcome the underdeveloped social work career path to ensure a fuller utilisation of the range of skills and contributions inherent in the social work role through the development of advanced practice social worker roles.
This plan recognises that experienced social workers with additional qualifications, training and skills (beyond that of entry level social work practice) can be more fully utilised within palliative care services in particular aspects of service delivery such as:

- therapeutic one-on-one and group counselling and interventions
- community capacity building, health promotion at end of life, and partnership development
- the coordination, education, training and support of volunteers, and bereavement programs
- a clinical leadership role to provide advocacy, policy development, academic and clinical teaching, and research to build the evidence, design curriculum and change practice in psychosocial care at end of life.

**Demonstrating performance and continuous improvement**

National Standards Assessment Program funded by the Australian Government Department of Health and Ageing under the National Palliative Care Program provides a national approach to continuous quality improvement in palliative care service delivery.

This program will form a critical element in the SA palliative care quality framework. It is also a means by which palliative care services in South Australia can contribute to the national quality agenda. The plan sets out a timeframe for the national palliative care specific accreditation for Level 6 services (by 2012) and Level 4 services by 2016. The Palliative Care Outcomes Collaborative also provides South Australian palliative care services with an opportunity to participate in a national continuous quality improvement project by the standardised collection and analysis of routine outcome measures which support a national benchmarking system designed to improved palliative care outcomes.

**i. Research and development**

The palliative care sector continues to benefit from a national program of research and development funded through the National Palliative Care Program. The directions of this program will guide the research and development agenda for palliative care services in South Australia. Through the upcoming Australian Health Care Agreements and a range of intergovernmental forums, those elements of the local end of life care reform agenda that benefit from a national approach will be addressed.
The workforce profile

Each year a three year rolling workforce profile will be generated to guide the palliative care workforce strategy through to 2016. The workforce strategy will also be informed by ongoing analysis of the impact and efficacy of new roles and the optimization of others (both those inside and those outside palliative care services). The level of uptake of new roles and their impact on others within the team, along with the overall performance and responsiveness of teams will also be monitored.

Additional work has been planned that will refine the 2009 three year workforce profile and ensure it accounts for the differing levels of out-of-region activity that each service participates in to meet their respective partnering obligations. With specific reference to the planned incorporation of 20 or more nurse practitioners with palliative care services by 2016, a coordinated program of preparation and role transition involving three cohorts of six Nurse Practitioner candidates is proposed.

Workforce planning to align the disciplinary roles to the needs of services is an ongoing challenge that will be taken up by the palliative care clinical network as it pilots and evaluates role innovations and monitors trends in retention, recruitment and workforce supply.

i. Workforce Issues

Some new or advanced practice roles will be built into the first workforce profile at 1.0 full time equivalent per service. This approach is calculated to ensure sufficient minimum full time positions to embed them into each service, facilitate their optimisation and to support their capacity to develop as whole-of-state resources.

Roles in this category include the caregiver network facilitator, the advanced practice roles in pharmacy, physiotherapy, occupational therapy, and the welfare officer and business manager positions.