

Response to the Draft Report: Reforms to Human Services: July 2017

About HammondCare

Established in the 1930s, HammondCare is an independent Christian charity specialising in aged and dementia care, palliative care, rehabilitation, pain services and older persons' mental health services.

HammondCare provides end-of-life care through a range of specialist palliative and supportive care services. These services include inpatient care (Greenwich, Braeside and Neringah Hospitals in Sydney); community palliative care; palliative care clinical in-reach to public and private acute hospitals; end-of-life care in our residential aged care homes; the Palliative Care Home Support Program (PCHSP) in seven NSW Local Health Districts; education and training services; and an online educational resource website (www.palliativecarebridge.com.au). HammondCare either directs, or partners in, a large number of palliative and supportive care research and service development projects.

Introduction

HammondCare welcomes the opportunity to comment on the draft report on Reforms to Human Services. This response focuses primarily on Chapter 3: Reforms to end-of-life care and considers the recommendations made on:

- Community-based end-of-life care
- End-of-life care in residential aged care
- Advance care planning
- Training clinicians to talk about and provide end-of-life care

It is critical that high quality, individually tailored end-of-life care (EOLC) is available for all people who require it and that it is delivered by suitably trained clinicians and care staff regardless of the location or service type where care is provided.

Community-based end-of-life care

HammondCare reaffirms that a substantial increase in the availability of community-based palliative care is required, drawing on the experience and expertise of service providers, service users and representative organisations to assess that need. We support the need to design services that address identified gaps and prepare for future increase in demand for EOLC.

HammondCare believes it is critical to work towards providing consistent and equitable access to palliative care services in all metropolitan and rural areas throughout Australia. As the Palliative Care Home Support Program in NSW demonstrates, competitive processes to select providers with expertise in EOLC – either individually or through consortium arrangements – can produce significantly improved outcomes for patients and their families.¹ This approach should be encouraged and built on throughout Australia.

¹ See HammondCare's submission to the Reforms to Human Services Issues Paper.

End-of-life care in residential aged care

HammondCare agrees that high-quality EOLC needs to become core business in residential aged care. We agree that the Australian and state and territory governments should work together to address misconceptions about eligibility for EOLC services for aged care residents.

As the draft report notes, a significant factor impacting the quality of EOLC in residential aged care is the design of the Aged Care Funding Instrument (ACFI), which limits access to and the duration of additional subsidies for EOLC. We support the recommendation to remove these restrictions.

HammondCare's palliative care model at Lavender House has proven to be successful in providing integrated palliative care within an existing residential aged care setting.² Despite its success, there is no routine funding to support such models. Additional funding should be provided to encourage the ongoing development and sustainable implementation of innovative approaches to palliative care in residential aged care, especially when there is evidence that demonstrates they are successfully achieving improved outcomes for residents.

Advance care planning

HammondCare affirms that advance care planning is an essential component of putting people's needs and choices at the heart of EOLC services and because of this, support to prepare an advance care plan should be routine for people with life-limiting illnesses. To normalise discussions about advance care planning and to ensure a person's preferences are known when a sudden health event occurs, these discussions should begin well before the diagnosis of a life limiting illness or admission to an aged care home.

We therefore support the recommendation to include advance care planning conversations as a core component of the Medicare item number for the '75 plus' health check, along with the introduction of a new Medicare item number to enable practice nurses to facilitate advance care planning. We reaffirm that general practitioners and practice nurses could play a much more significant role in helping people articulate their preferences for EOLC through advance care planning, particularly older people and people with chronic and debilitating illnesses.

This is in line with the Advance Project,³ led by HammondCare, which is empowering general practice nurses to initiate conversations about advance care planning during routine health assessments for these two target groups. We agree that facilitating general practitioners and general practice nurses to introduce the concept of advance care planning and provide written material on the purpose and content of an advance care plan is a positive step forward.

At or soon after the time of admission to a residential aged care facility, it is important that any existing advance care plan is reviewed and that residents are given the opportunity to discuss advance care planning. HammondCare's model of care in residential aged care

² See HammondCare's submission to the Reforms to Human Services Issues Paper.

³ See HammondCare's submission to the Reforms to Human Services Issues Paper.

promotes collaboration and consultation with residents and their family, enabling them to partner in care. We support the Productivity Commission's desire to see increased conversations about future care needs and advance care planning in residential aged care. We also support inclusion of conversations about future care needs and advance care planning in the Quality of Care Principles.

It is worth noting that work is already underway to achieve that end. The Australian Government is currently engaged in a collaborative process to develop a Single Aged Care Quality Framework based on consumer outcomes, rather than prescriptive processes. The draft standards, released in March 2017, stated that assessment and planning within aged care services should "[include] advance care planning and end of life planning if the consumer wishes".⁴ HammondCare supports this approach.

However, we believe the timeframe included in Draft Recommendation 4.4 goes beyond the outcomes-focus of the draft standards. Given that admission to residential aged care can be an emotionally stressful time, we do not believe that a two-month timeframe for developing or updating advance care plans will always be practicable or appropriate. We also believe that such parameters are better suited to guidelines, rather than being 'enforced' through regulatory standards in a manner that encourages 'tick-a-box' compliance.

We agree that discussions about end of life treatment choices and the formalisation of advance care plans need to be led by appropriately trained clinical staff. However, we also believe that a team approach to end of life care is critical in residential aged care and this approach must be supported by the standards. Some aspects of discussions about future care needs could be initiated by staff who do not have clinical training, such as pastoral care staff and care staff, and they should be supported to do so.

While we support the inclusion of advance care planning and discussions about end-of-life care in the standards for aged care, we do not believe it is the role of the standards to prescribe how or when they occur. This would be inconsistent with the proposed approach for the development of future standards.

Training clinicians and health professionals to talk about and provide end-of-life care

The draft report recognised that clinicians are often reluctant to initiate end-of-life conversations and notes the evidence that this reluctance can be reduced through targeted training. HammondCare reaffirms the importance of training and believe that a specific recommendation should be included to address the need for training to improve EOLC and the uptake of advance care planning in all settings.

HammondCare believes that education on end-of-life care should be available more broadly throughout the health and aged care sectors. There are many excellent educational resources available that are worthy of further investment, including:

- The Palliative Care Curriculum for Undergraduates (PCC4U) program, which targets undergraduate health students.
- The online training modules, practical workshops and screening and assessment tools developed as part of the Advance Project, which currently targets practice

⁴ Department of Health, 'Single Aged Care Quality Framework: Draft Aged Care Quality Standards Consultation Paper 2017', 18.

nurses but could be extended to general practitioners, nurses working in other settings, including aged care, as well as allied health professionals.

- The Program of Experience in the Palliative Approach (PEPA), which provides free palliative care workshops and placements in palliative care services.

We also support more opportunities and resourcing for education on EOLC for non-university trained health professionals including care staff in residential and community aged care services.

Conclusion

HammondCare supports the approach of the draft report on Reforms to Human Services in relation to EOLC. We agree that competitive processes should be used to enable non-government agencies with experience and expertise in EOLC to support more people to die at home. We agree that EOLC in residential aged care should be better resourced. We agree that advance care planning should be made part of routine practice, especially in primary care and residential aged care settings. However, we believe that in addition to regulatory reform, more education throughout the health and aged care sectors is required to effect change, and this should be acknowledged the final report.

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