



Reshaping palliative care for the future

**Palliative Care
Strategy to 2026**

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Disclaimer: Information is current as of March 2022.

Executive summary

Everyone deserves to die with dignity. Yet many don't get to choose where and how they live during the last days or months of their lives.

Palliative care respects people's needs and preferences at the end-of-life and offers compassionate and tailored care to those at their most vulnerable. Overcoming barriers to accessing quality palliative care requires a strategic and collaborative approach, especially with Australia's increasing ageing population.

Covid-19 has ignited conversation around death and dying, with a spotlight on the importance of caring for at-risk and older populations. The 2021 Royal Commission into Aged Care, Quality and Safety has identified palliative care as one of four areas for immediate attention.¹

We aim to empower and respect people's choices at the end-of-life and make sure they have access to quality care at the right time, no matter where they are.

Our 2026 Strategy outlines our four critical goals. We want to:

- 1. Enable people to die with dignity.**
- 2. Improve palliative care equity and access for vulnerable communities.**

- 3. Improve knowledge, skills and confidence in palliative care for the workforce and community.**
- 4. Lead the health and aged care sector in palliative care services and research.**

Over the next five years we will embed our expertise wherever the person we are caring for is located – in the community, in residential aged care homes or in hospital. We will continue to tailor care to the individual and support our patients, clients, residents and their families/carers with compassion, understanding and evidence-based practice. We will focus on improving the sector through collaboration with strategic partners and fellow thought leaders and by sharing our knowledge and skills through education, support, training and resources.

Through our strategy and model of care we want to improve quality of life for people in need – in particular those that others can't or won't.

Our commitment – Statement from the CEO

**There's nothing more universal than death.
But when it comes to understanding or
accessing quality care when it matters
most, our experiences are quite different.**

Demand for palliative care is expected to double by 2050 due to a rapidly ageing population and increased chronic illness, sparking a need to ensure equitable access to services at the right time and in the right place.²³

Palliative care is about living life to the very end with peace and dignity. But sadly many people, from healthcare providers to the general public, think it is about just seeing out final days and without the support and care they really need.⁴

This might be why up to 75% of people dying in Australia miss out on palliative care. In residential aged care this is even worse, with only 6% of those dying assessed as needing palliative care – even though 53% approach their last days with complex health needs.⁵⁶⁷

Access to palliative care in rural and remote areas is at times described as a postcode lottery – if you happen to live in the bush or in regional Australia, you are likely to have just a quarter of the level of service as you might have in the city.⁸

It's time for this to change, and HammondCare is ready to be part of the answer.

Our team has worked tirelessly to develop a comprehensive five-year strategy that amplifies our leadership position in palliative care and uses it to improve understanding and access to quality care wherever we can.

In this strategy, we renew our commitment to palliative care by bringing our expertise to wherever the person is – in the community, in residential care or in hospital.

We are exploring new ways of offering palliative support and relationship-based care where others can't or won't.

We aim to empower and respect the choices of people at the end-of-life and to offer timely and quality care wherever they are.

To achieve this, we'll deepen our engagement, strengthen integration and partnerships, and enhance our sector leadership.

During our consultation with families, staff and external experts, we were told, "HammondCare is very trusted – it can use its credibility to influence at a national, social and political level, which would be very useful and benefit the whole sector."

We will continue to set global standards in care for people in need, particularly vulnerable communities. We lead research and also share our expertise through education and consultancy through the Palliative Centre. Whether you are a policy maker, aged or healthcare professional, peak body, academic or consumer, we appreciate your interest and contribution to palliative and end-of-life care.

We'll strive to meet people's final wishes and walk the journey alongside them, helping bring comfort and peace at the end-of-life. We invite you to partner with us in achieving our goals.

Yours faithfully,



Mike Baird
Chief Executive Officer

What is Palliative and End-of-Life Care?

“Palliative Care is an approach that improves the quality of life of patients and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial and spiritual.”⁹

— World Health Organisation

By 2031, approximately 5.7million Australians will be 65 years and over, with the number of First Nations peoples in the same age bracket increasing from 3% of the population to 7%.¹⁰ Equitable access to quality palliative care services for those living with life-limiting illnesses is an increasing imperative.

Palliative care

In Australia, patients with life-limiting illnesses have a range of rights and expectations, including effective pain management and palliative care (see Appendix 1). But every person is different – and so are their needs. They may be at a different age or stage of their disease or have different cultural, social, emotional, physical and spiritual needs. They may need care for a short time, at intermittent intervals or consistently over months or years.

Regardless of individual circumstances, palliative care supports people and their families/carers living with life limiting illnesses. The focus of this care includes maximising quality of life, care planning, facilitating end-of-life conversations and management of symptoms in partnership with the person and their family/carer.¹¹

Guiding Principles for Quality Palliative Care.¹²

- **Palliative Care is person-centred care.**
- **Death is a part of life.**
- **Carers are valued and receive the care they need.**
- **Care is accessible.**
- **Everyone has a role to play in palliative care.**
- **Care is highly valued and evidence-based.**

See Figure 1 on the following page:
Patient-centred palliative care.



Figure 1: Patient-centred palliative care¹³

End-of-life care

When a person is reaching end-of-life, whether it be a matter of months, days or hours, end-of-life care¹⁴ provides physical, spiritual and psychosocial assessment, care and treatment. A multidisciplinary team supports people and their families with:

- progressive and incurable conditions,
- general frailty,
- significant existing conditions that could cause a sudden acute crisis, and
- life-threatening acute conditions caused by a sudden catastrophic event.



A supported, respectful final journey

Our Community Palliative Care team supported 62-year-old Rebecca to live life as independently as possible right to the end. She had two main wishes: to die at home and have her daughter Lissa, who lives in Tel Aviv, by her side.

Rebecca's house was full of love, laughter, connection, respect and joy, as her siblings, partner and two children supported her during her final journey. Our care team answered questions, kept Rebecca informed of her choices and gave her and her family the time to accept her changing situation as her illness progressed.

Deeply connected to their Jewish faith, Friday night Sabbath dinners were important gatherings for the family. Six days before she died, unable to actively participate anymore, the family gathered around her bedside to celebrate the weekly event to help keep her connected.

After her death, while incredible sadness remains, her colourful clothes, family stories and photos serve as treasured memories for the family.

"While I held my sister, I felt held by the team at HammondCare. Rachael and staff provided a continuity of care for all of us. The support we received was remarkable – sensitive, caring, knowledgeable."

Shoshana, Rebecca's sister

Strategic Environmental Context

As the population ages, chronic diseases will lead to increasingly complex needs at the end-of-life for more people. The impact across the health and aged care sectors will be significant. We as an industry need to act urgently to prepare for the decades ahead.

Locations of Australian deaths in 2017.¹⁵

- **Almost half were admitted hospital patients.**
- **36% were in residential aged care.**
- **4% in home care.**
- **3% in emergency departments.**

With the number of Australians who die each year expected to double in the next 25 years, demand for quality services and support will increase significantly.¹⁶

Between 50% and 90% of people may benefit from palliative care, with even conservative estimates putting the figure of those whose final stages of life could be improved at around 80,000 per year.¹⁷ We need greater investment in integrated supportive care services to complement medical care. Too much of a curative focus on healthcare can lead to an over-medicalisation of death and ignore the overall experience of everyone involved – from those who are ill to their friends and family.

The Commonwealth Government's National Palliative Care Strategy¹⁸ aims to make sure people affected by life-limiting illnesses get the care they need to live well to the end – and that evidence-based, quality palliative care is available to everyone who requires it.

Changing attitudes about death

Death is an uncomfortable topic. But this reluctance to talk openly about death, dying and grief creates a barrier for clinicians to start timely conversations with patients about their end-of-life care preferences.¹⁹

Public conversations about death and dying have increased especially through the Covid-19 pandemic. This may lead to a resurgence

of community initiatives and services like Death cafes,²⁰ ‘Death Over Dinner’, and death education (see Appendix 2).

With a focus on public education, building support networks and engaging communities to care for those who are dying, these initiatives strengthen community capacity, local interconnectedness and overall knowledge.

We can change the narrative by sharing stories of people in our care and show what a ‘good death’ looks like – encouraging the public to adopt a more proactive and confident approach to these difficult discussions.

Changing context on voluntary assisted dying

Voluntary assisted dying (VAD) is the assistance a health practitioner provides to a person to end their life. In recent years, different state parliaments across Australia have been debating VAD, and as of March 2022, five Australian states have passed relevant legislation including Queensland, South Australia, Tasmania, Victoria and Western Australia. The legislation is only in effect in the last two states, with Tasmania due to commence in October 2022. The VAD Bill was tabled in NSW Parliament in October 2021, and is due to be debated in 2022 by the Legislative Council.

We at HammondCare believe changes in legislation regarding VAD don’t consider the circumstances that might influence a person’s decision or ability to provide informed consent. They place vulnerable people at greater risk of having their lives ended without their consent. We oppose the legalisation of VAD and instead endorse palliative care as the appropriate service for people who are dying.

Barriers to accessing palliative care

Palliative care has historically been outside of the residential care sectors ‘core business’. With chronic underfunding, staff shortages and structural barriers, accessing best practice end-of-life care within the sector has been challenging.

There is a shortage of non-clinical end-of-life care skills for people in both residential care homes and community settings which is also limiting access to quality care. Exponential growth in the number of people needing support to live well at home means the sector is facing a lack of available care workers.

Australia’s metropolitan areas are fortunate to be among a relatively small number of cities with access to high quality, comprehensive palliative care. But there are many persistent barriers and gaps to overcome – including a historical focus on supporting only people with cancer, complex funding models, structural barriers, skills shortages and poorly resourced regional areas (see Appendix 3).

Royal Commission into Aged Care, Quality and Safety findings

One of the four areas the Royal Commission identified for immediate attention in 2021 was palliative care.²¹ This includes better access to specialists, health practitioners and health services, a new primary care model with accredited aged care GPs, collaboration between federal and state governments for a better residential aged care model, and specialised training for aged care workers (see Appendix 4).

Changing care landscape

The lack of common understanding around palliative care and its benefits leads to inconsistent healthcare. Historically, palliative care services have focused on supporting people with cancer, but in recent years other disciplines such as renal medicine are also increasingly adopting the approach.





Palliative care by numbers:

- **There were 83,430 palliative care related hospitalisations across Australia in 2018-19.²²**
- **Almost 40,500 people died in sub-acute hospital care in 2017, equivalent to half of the estimated palliative care needs of 82,000.²³**
- **In 2008-09, only 10% people in residential aged care had highly complex needs, increasing exponentially to 53% over the following 10 years.²⁴**
- **16,159 individuals received palliative care services in primary care in 2017, accounting for 10% of deaths that year, with an estimated additional 10% who would have benefited.²⁵**

(See Appendix 5 for more information)

Hospital Care

Palliative care generalists and specialists are also in short supply, which makes hospital resourcing challenging.

In fact, specialists are at half the levels required to deliver a minimum model of care.²⁶

Hospices could provide a useful alternative for patients in the last few weeks of life, alleviating pressures on hospital beds. Hospices are yet to receive any substantial funding in Australia, but State governments may consider this approach in the future.

Residential Aged Care

Our \$30billion Australian aged care sector is predicted to increase by 6%+ long-term due to our ageing population.

Changing industry regulations will likely reduce structural barriers to care and improve economic alignment to meet the increasing needs of residents (see Appendix 6).

But a lack of adequate support for ageing Australians in aged care environments will lead to a significant growth of residential-based complex dementia over the next five years.²⁷ The sector urgently needs more staff and skills to identify residents who are deteriorating and respond to their care needs quickly and appropriately.

Primary Care

General practitioners (GPs) play an important role across the healthcare system, particularly for aged care residents.

Currently, Medicare Benefits Schedule (MBS) items limit GPs from working cohesively with residential aged care homes to support palliative care residents. However, the Royal Commission's recommendations around accrediting GPs and new financial incentives aims to resolve this.

In smaller regional communities, a GPs role is critical during a very challenging time for both patient and their family. Often, they provide the only clinical care for patients at the end-of-life who wish to remain close to home and an important interface with Specialist Palliative Care clinicians.

Without nationally consistent, routinely collected primary healthcare data that reports on GPs' role in palliative care, offering consistently optimal care across the country remains a challenge.²⁸ The Palliative Care Outcomes Collaboration (PCOC) is working with practitioners to address this situation by developing new benchmarks in care.

Community Care

Less than 2% (or 2,500) of individuals who died in 2017-18 received a palliative care visit at home funded through the MBS.²⁹

There is a growing need for home-based nursing services available 24/7 to support patients and families. Sharing the caring role across community-based health services has significant benefits, such as reducing unnecessary hospitalisations. And it creates opportunities to better engage and collaborate with organisations like the Ambulance Services.

Evidence shows that people with life-limiting illnesses often prefer to die at home. We need to shift our focus on comfort and psychosocial approaches to care that complements medical treatment.

A 64% increase in funding for home care over the next two years will focus on eliminating the existing waitlist for the service. While a large proportion of home care focuses on domestic tasks such as shopping and cleaning, trained care workers can also deliver non-clinical end-of-life support.



Strategic Environmental Context Continued



Respecting Mary's wishes

Moving to Australia after her divorce, Mary lived on a rural NSW property with her son for 30 years. She was deeply religious and spoke very little English. She slept on the floor of her house and used a bucket toilet. Her domestic role cleaning and cooking for her family kept her busy.

As Mary's mobility declined, her son started caring for her. He would use a wheelbarrow to transfer her outdoors, which she loved. Despite her increasingly frailty, Mary and her son didn't access local services or Medicare to meet Mary's health needs. Eventually the Government's Aged Care Assessment Team (ACAT) got involved. Mary did not want to go to residential aged care, so ACAT referred her to HammondCare's Home Care team to support her to live well at home.

Mary's living situation was complex, and our team helped her with personal care, meals and used a translation app to communicate. Staff supported her by tailoring care around her preferences. Rather than use a bed, she chose to remain sleeping on the floor, so they bought soft mats to protect her skin. She particularly enjoyed when carers played music to invoke joy and fond memories.

Mary continued to deteriorate. She was in pain, and she stopped eating and drinking. In partnership with her GP, she was referred to a local palliative care service. We built trust and rapport with her son and worked closely with him, Mary's GP and local palliative care services.

She started pain medication, after the team assured her son that this would not hasten her death, and Mary became more comfortable. Her two adult children visited from Malaysia, giving them an opportunity to resolve a lifetime of experiences and mend relationships. Mary passed away peacefully the day after her daughter returned home.

Mary's son expressed much appreciation to HammondCare for his mother's journey, and he was extremely grateful he had the chance to tell his mother he loved her for the first time.

Investment and resources

With health professionals and care providers funded by different governments, there is limited combined funding for palliative care services for people with dementia. This has led to a lack of integrated care in communities – and consumers having to navigate complex health systems.

New federal and state and territory funding commitments to improve aged care services (see Appendix 7) should help in developing more locally appropriate services and initiatives.

Informing best practice palliative care

We intend to contribute to industry expertise through our strategy (see Appendix 8). We want to adopt a consistent approach in applying frameworks, using validated assessment tools and collaborating to help grow the body of evidence around best practice palliative care. To make sure systems are sustainable, the industry needs to invest in and train practitioners to understand how to use these tools in the real world – and deepen their knowledge and skills in caring for a person at the end-of-life.



A digital future

People will always be at the heart of excellent patient care. But with the help of technology, we'll be able to create innovative new models of care and greater efficiencies in the way we provide – and receive – health and aged care services. It will help speed up healthcare decisions, keep individuals more informed about their options and empower them to work closely with their health professional.

Digital tools and dashboards will allow us to guide excellence in clinical care and continuous improvement. Aligned with the Aged care Standards, ELDAC's Digital Dashboard³⁰ is a good example. Organisations can integrate this tool within their clinical data management system in aged care settings, to help track, provide prompts and visually report on resident data in a meaningful way to support their palliative and end-of-life care.

There are also significant opportunities to expand the use of telehealth, link eHealth datasets and increase the use of frontline tools such as iPads to optimise care in real time.

“A cultural change is needed to deliver a holistic approach to palliative care, reframing the solution with more continuity of care across providers.”

– External stakeholder

A more peaceful end-of-life for Alan

Ninety-one-year-old Alan loved when his wife came to visit him at a regional care home. But living with Lewy Body dementia had its challenges, and Alan had frequent episodes of physical and verbal aggression. Despite repeated requests by staff, his GP still hadn't visited, so Alan was referred to Dementia Support Australia (DSA). After DSA's assessment, he was identified as having terminal agitation, demonstrating distressing hallucinations, delusions and restlessness.

The Consultant supporting Alan through the DSA palliative care service recommended tailored non-pharmacological strategies to reduce his distress and helped the care home team build their confidence and capacity to support Alan's needs. DSA helped the care staff engage with their local palliative care services, sought interim medical advice from DSA's Palliative Care Specialist and purchased resources to assist in providing the best care.

DSA worked closely with Alan's wife to understand his end-of-life wishes and made appropriate psychosocial support available to her to support her with her grief. Alan died a comfortable and peaceful death.

Our impact

At HammondCare, our mission is to improve quality of life for people in need. We care for those who others won't or can't. And as experts in palliative care and complex dementia, we are uniquely placed to help lead the sector in re-shaping care across residential aged care, sub-acute hospitals and the community.

Our Palliative Care Strategy to 2026 supports this mission. It is also closely aligned with The National Palliative Care Strategy 2018, which outlines seven Australia-wide goals for action focused on: Understanding; Capability; Access and Choice; Collaboration; Investment; Data and Evidence; and Accountability.³¹

This section outlines our goals and how we'll achieve them. We will focus on growing community care while maintaining our hospitals, new models of care through embedding research into practice, complex dementia, education and mentoring in situ, and advocacy for sector-wide improvements.

**Our Palliative Care Aim:
to empower and respect the choices of people at the end-of-life and to deliver timely and quality care wherever the client is.**

Our Palliative Care Goals:

- 1. Enable people to die with dignity** by providing an enhanced model of care and supporting their decisions and preferences;
- 2. Improve palliative care equity and access** for vulnerable communities, particularly those with complex dementia;
- 3. Improve knowledge, skills and confidence in palliative care**
 - for staff across health, home care and residential aged care environments and
 - for the general community to increase death literacy; and
- 4. Lead the health and aged care sector** by providing integrated palliative care services and in delivering world-class research.



Our goals will be underpinned by:

- integrated service delivery pathways;
- leveraging our geographic hubs;
- pastoral care;
- extending knowledge and reach, growing strong partnerships;
- sustainable investment;
- use of technology;
- and improving impact measurements.

Across our business, our focus will be on:

- **Hospitals** – maintain our footprint and grow our grief and bereavement services.
- **Care in the community** – increase services and programs to support people to live well at home through our health and homecare teams, grow palliative care knowledge and education, and improve access and equity.
- **Complex dementia** – grow integrated services with access to palliative care and support for people living with complex dementia.
- **Residential Care** – embed a new model of care in our services and train and mentor our teams to better support residents at the end-of-life.
- **Resources and education** – grow our consumer-focused resources and deliver training internally and externally to upskill the workforce.
- **Thought leadership** – deliver world-class research, share our expertise and advocate for sector-wide improvements.

We will impact four key areas, which are aligned with domains outlined in our strategic directions:

1. Best people, highly valued

Increase staff and volunteer skills and knowledge in palliative care, and establish new career pathways and opportunities to meet growing sector needs.

2. Data-driven evidence based

Use evidence to inform practice, invest in innovation and better measure our impact.

3. Operational excellence

Provide relationship-based care through proven models of care and holistic services in supportive environments.

4. Shaping the sector

Re-shape the sector through leadership and advocacy, collaborating for system-wide improvements.



Best people, highly valued

Increase staff and volunteer skills and knowledge in palliative care, and establish new career pathways and opportunities to meet growing sector needs.

Goal	How
Strengthen recruitment opportunities in palliative care by positioning ourselves as an Employer of Choice.	<ul style="list-style-type: none">Showcase our palliative care credentials in job advertisements, through online channels and at career events.Recruit skilled professionals with expertise and interest in palliative care.Consider new and expanding staff roles to support quality front-line service delivery, such as employing GPs and more nurse practitioners.
Nurture internal talent and develop career pathways to improve retention.	<ul style="list-style-type: none">Develop new approaches to improve staff wellbeing and satisfaction to ensure people feel highly valued for their skills, commitment and expertise in end-of-life care.Offer new career pathways and opportunities to enhance skills and share expertise across the sector.Provide scholarships for staff to complete postgraduate qualifications in palliative care at partnering universities.Strengthen the learning culture through blended learning models including training, mentoring and modelling to put new knowledge into practice with better outcomes and greater sustainability.
Develop new industry qualifications and support residential and home care workers to upskill in palliative care and dementia care.	<ul style="list-style-type: none">Create new Australian Skills Quality Authority (ASQA) accredited content in Certificate 3 in Individual Support, with new optional units of competency in dementia and palliative care.Consider how this new Certificate 3 accredited content could be delivered more broadly across the sector.

Goal	How
Upskill staff and volunteers in HammondCare's differentiators of dementia and palliative care.	<ul style="list-style-type: none"> • Create a framework to define the knowledge and skills needed for dementia and palliative care, guide staff development and identify the learning resources needed for implementation. • Apply consistent language, terms and approach to facilitate a common understanding of palliative and end-of-life care with staff. • Support our Care Workers to complete Certificate 3 (and/or complete two mandatory units on a palliative approach and dementia care) through our internal Registered Training Organisation. • Increase our volunteer numbers and provide optimal training in end-of-life support to complement the care staff provide and enhance the capacity of our workforce. • Promote Program of the Experience in the Palliative Approach (PEPA) placements to observe and learn through our specialist palliative care teams.
Expand our workforce capabilities and capacity across residential aged care to support people at the end-of-life.	<ul style="list-style-type: none"> • Understand service barriers, navigate complexity and support readiness to improve end-of-life care for our residents. • Embed tools in practice to prompt the earlier identification of deteriorating residents in the last six months of life, particularly for those with dementia. • Support teams to implement routine assessment of palliative care needs and advance care planning preferences using the Advance Project (see page 31) processes and tools.
Expand our workforce capabilities and capacity across Home Care to support people to remain at home at the end-of-life.	<ul style="list-style-type: none"> • Understand service barriers, navigate complexity and support readiness to improve end-of-life care for our clients. • Support teams to implement routine assessment of palliative care needs and advance care planning preferences using the Advance Project processes and tools. • Work closely with primary healthcare services as part of a shared care approach to support wishes to die at home.
Contribute to building a sustainable palliative care workforce across the sector.	<ul style="list-style-type: none"> • Offer undergraduate and postgraduate multi-disciplinary team placements across all disciplines within HammondCare in collaboration with relevant academic institutions. • Better understand the lived experience by engaging with people with dementia or who are accessing our palliative care services to develop our approach. • Support the workforce to integrate best practice tools and resources. • Influence research, policy and practice through evidence-based innovation and implement a plan of action.



Data-driven evidence based

Use evidence to inform practice, invest in innovation and better measure our impact.

Goal	How
Foster a palliative care research culture.	<ul style="list-style-type: none">Support early career researchers by offering scholarships to complete master's degrees and/or PhDs in relevant topics.Develop and mentor staff to use critical thinking skills to cultivate evidence-based practice.Undertake small scale end-of-life pilot projects to grow the evidence base.
Strengthen our academic and cross sector collaborations to achieve mutually agreed strategic outcomes and pool resources towards achieving common goals.	<ul style="list-style-type: none">Enter formal partnership agreements with one or more Australian universities for a consortium approach to palliative care.Strengthen and expand international collaborations.Host a Palliative Care Roundtable to identify end-of-life priority focus via a collaborative model.
Build greater integration and practice across complex dementia and palliative care.	<ul style="list-style-type: none">Develop new advance care planning and palliative care needs assessment approach and tools tailored for primary health and aged care professionals.Define a clearer pathway and greater integration for clients to progress from home care to residential care as needed.Measure benefits of an integrated approach to care.
Identify, develop and/or integrate technology to embed palliative care into systems and processes to improve data collection, tracking, sustainability and reporting.	<ul style="list-style-type: none">Review options and invest in suitable and integrated technological tools to drive best practice in palliative care.

Goal	How
Implement existing validated palliative care research and tools into operational practice.	<ul style="list-style-type: none"> Apply the Advance Project tools and framework from Phases 1 and 2 into service delivery and practice across multiple settings. Ensure consistency and sustainability across our services in the selection of appropriate tools, templates and processes.
Goal	How
Measure impact and changes to practice to quantify the real difference we can make.	<ul style="list-style-type: none"> Develop a framework with agreed indicators to measure the quality of palliative care across different settings (residential aged care, hospital and community). Enhance feedback processes and our communication with families. Develop a consumer-facing <i>Our Palliative Care Commitment</i> statement on HammondCare's principles to deliver best practice palliative care based on these indicators. Apply a health economics lens to service delivery to define the financial benefits of an integrated approach to care and strengthen our case for upfront investment in our services.



Operational excellence

Provide relationship-based care through proven models of care and holistic services in supportive environments.

Goal	How
Provide seamless palliative care, clinical and psychosocial services and support across a range of services based on needs – offering a specialist approach for complex conditions, and a generalist approach for non-complex cases.	<ul style="list-style-type: none"> Integrate palliative and end-of-life care within our current model of care. Provide exceptional quality end-of-life care to patients, residents or clients using a holistic approach, validated tools and staff expertise. Improve services for a more integrated end-of-life approach and pathway to care at the right time, in the right setting, at the right dose, based on a person's needs and preferences. Increase the non-clinical supportive offerings to better care for the person and their family at the end-of-life. Use technology to drive consistent best practice and support quality of care metrics.



Operational excellence continued

Goal	How
Strengthen integration between palliative care and complex dementia through shared expertise, relevant frameworks, assessment tools and best practice service delivery.	<ul style="list-style-type: none">Improve the health service interface between people with severe dementia (with behaviour and psychological symptoms) and access to palliative care, to reduce over-prescribing and use of antipsychotics and increase personalised management strategies.Grow expertise and impact for integrated care across different settings for early identification of deterioration of people with complex dementia.
Enhance our best practice relationship-based models of care, based on the cultural, spiritual, practical and clinical needs and preferences of the person and their family.	<ul style="list-style-type: none">Develop integrated consumer resources and programs to improve decision making and increase understanding about death and dying, and provide links to existing end-of-life resources.Enhance our residential model of care to take a holistic person-centred approach at the end-of-life, making sure non-clinical care and clinical approaches complement each other.Strengthen our Mission-led pastoral care and volunteering approach to support people at the end-of-life, with consideration of a <i>Compassionate Communities</i> approach.Strengthen our cultural approaches to end-of-life care for vulnerable populations such as First Nations peoples and culturally and linguistically diverse communities.Expand the Dreams Project to create lasting memories for the families at the end-of-life.
Improve the physical environment and tailor aids for the care of patients, clients and residents in existing facilities.	<ul style="list-style-type: none">Ensure the right environment for supporting people at the end-of-life and their families.Use best practice evidence when investing in building upgrades and new facilities.Provide appropriate equipment to better meet the needs of clients and patients.



Shaping the sector

Re-shape the sector through leadership and advocacy, collaborating for system-wide improvements.

Goal	How
Influence policy development for sector-wide improvements at a national and state / territory level.	<ul style="list-style-type: none">• Seek opportunities to showcase organisational excellence and share expertise with governments and policy decision makers.• Collaborate with partners to amplify our voice on identified palliative care priorities.• Engage in shared decision-making opportunities by becoming members of governance groups or attending key forums.• Leverage the United Nations Decade of Healthy Ageing 2021-2030 as the backdrop to drive the case for palliative care improvements.
Strengthen areas where HammondCare has clear market differentiation and a competitive advantage.	<ul style="list-style-type: none">• Strengthen The Palliative Centre to build on core focus areas of research and education.• Focus on greater integration across our core programs in complex dementia and palliative care and seek enhancement funding to operationalise.• Collaborate with external stakeholders to address system-wide issues of fragmented care for people with dementia.• Explore opportunities to deliver a Palliative Support Australia service, to complement the existing Dementia Support Australia model.• Develop a new approach to support people at the end-of-life in residential care homes, and with a life-limiting illness who wish to stay at home - using internal expertise and published evidence which aligns with the HammondCare Model of Care.
Influence investment in best practice models of care for vulnerable populations.	<ul style="list-style-type: none">• Explore options with state and federal governments to establish Hospice-like models in Australia, for seamless transition to dedicated beds in non-hospital high care settings based on need.• Seek combined funding investment for palliative care for vulnerable populations such as those who are homeless or at risk of homelessness, Aboriginal and Torres Strait Islander, rural/remote communities, and cultural and linguistically diverse populations.



Shaping the sector continued

Goal	How
Scale up selected programs to meet community demand and expectations.	<ul style="list-style-type: none">Establish a Community Program with partners to better integrate consumer-focused initiatives, including help navigating care pathways, more tailored resources, enhanced volunteer liaison and grief and bereavement support.Focus on services and supports to rural and remote and/or Aboriginal and Torres Strait Islander communities, using the DSA service delivery footprint.Increase scope and reach to deliver timely bereavement programs to support families through their grief and loss, and enable stronger pathways to link into other service providers.Engage with the HammondCare Foundation to inspire and connect to new funders to resource innovative approaches to end-of-life care.
Share expertise by growing our palliative care resources, consultancies and education offerings.	<ul style="list-style-type: none">Scale-up offerings based on our expertise and meet increasing industry demand for a workforce skilled in end-of-life care and dementia care.Use multiple platforms and formats to reach our health and aged care stakeholder audiences.Expand our reach and build capacity in other providers and potentially other countries by working with our strategic partners.
Help support people's wishes to die at home.	<ul style="list-style-type: none">Work with state governments to identify opportunities to roll-out a proven model of palliative care support into other states and territories.Develop a new model of care using insights and experiences from the Palliative Care Home Support program / Out of Hospital program.Increase service delivery capabilities to support Home Care clients from the admission stage through ensuring end-of-life resources and support are available, in collaboration with local palliative care services.Expand grief and bereavement care to better support families and carers.

Goal	How
Strengthen end-of-life efforts in the primary care sector with general practice, to support families and communities.	<ul style="list-style-type: none"> Expand service offerings in priority locations of NSW, Victoria, Queensland and South Australia, with an emphasis on existing HammondCare locations, through collaborations with Primary Health Networks. Deliver palliative care education to local GPs to support people to die at home by recognising clinical deterioration and managing symptoms such as pain.
Showcase innovation and best practice in palliative care.	<ul style="list-style-type: none"> Seek opportunities to showcase who we are, what we stand for and what we offer, differentiating us from other services and programs. Inspire philanthropists and donors through the HammondCare Foundation to fund innovative palliative care initiatives.
Benchmark patient and family expectations for end-of-life care in residential care, home care and in the community.	<ul style="list-style-type: none"> Partner with other stakeholders to improve industry standards. Better understand what community expectations are for care at the end-of-life. Apply new models ourselves, share with others, collect impact measures, use results to influence decision making and publish outcomes.

Our Current Service Delivery

We are a trusted organisation with a solid reputation for expertise, innovation and results.

HammondCare at a glance



33,811

people cared for
in FY2021³²



87

locations across
Australia



4,807

dedicated staff



650

volunteers³³

Multiple settings

Sub-acute hospitals,
acute hospital in-reach
services, residential care
and the community.

Multidisciplinary team

Palliative care physicians,
nurses, allied health
professionals, pastoral care
coordinators, dementia
consultants, care workers
and trained volunteers.

Our Key Differentiators

- **Focus on the person, their family and carers through our holistic, relationship-based approach.**
- **Complex dementia and palliative care expertise.**
- **Care across multiple settings in home care, community, residential aged care and hospitals.**
- **Best-practice replicable models of care including cottage-like environments.**
- **Multidisciplinary team of professionals.**
- **World-class research, practice and expertise.**
- **Focus on spiritual wellbeing and vulnerable populations.**
- **Can lead, innovate and influence industry, societal perceptions and policy directions.**

Why Palliative Care?

Palliative care is a key priority that aligns with our mission, providing a “compassionate hand during life’s most challenging time.”³⁴

Our unique, tailored approach and model of care allow us to care for people at the end-of-life, across multiple settings – supporting them with their medical, psychosocial, spiritual and environmental needs.

The HammondCare model of care provides a blueprint for excellence across all our services. It focuses on six domains including individualised care, a relationship and comfort focus, engaging people in our care, optimal use of the environment and empowering staff. All elements are inextricably intertwined and make us uniquely placed to provide quality care to our clients, patients and residents.



Figure 2: HammondCare's model of care

We have decades of experience providing best practice specialist and generalist palliative care to communities in need and supporting people with complex dementia. We have built a reputation for leading world-class research to build evidence and capabilities.

Our Current Service Delivery Continued

Like most similar organisations, we have many challenges in our way. Significant skilled and experienced worker shortages make it difficult to meet growing aged care demands. Balancing staff training with operational demands can create conflicting priorities. So, too, can managing multiple funding sources with different requirements. We also need to integrate defined business units and keep up with technological advances.



Making Mick's final dream come true

The Dreams Project supports patients with a life-limiting illness and their families to create memories and reignite purpose and hope at the end-of-life. Mick's dream became reality when three 2005 West Tigers Grand Final players – Robbie Farah, John Skandalis and Pat Richards – visited him at Greenwich Hospital. With a beaming smile from ear to ear and a sparkle in his eye, the experience brought him great joy. He was truly grateful for this special 'Dream' and especially pleased to get Pat's signature on his Tigers jersey.

A message from Pat later to let Mick know, "*that the boys were still thinking of him,*" brought one final smile from their life-long fan. The visit was very meaningful for Mick and has become a treasured memory for his family now that he's gone.



Health and Specialist Palliative Care

In FY21, 849 palliative patients and their families received specialist multidisciplinary care in our three hospitals – and we supported 2,542 Northern Sydney based patients to die at home. One of our hospitals was also named in the top four Palliative Care Outcomes Collaboration (PCOC) Australian hospitals.

- **Three HammondCare hospitals in NSW** provide palliative care in Northern and South-West Sydney, and we support five other acute Sydney hospitals.
- **Community specialist palliative care teams** support people at home in Northern and South-West Sydney.
- **Specialist Medical Outreach services** are delivered in Southern NSW.
- **A multidisciplinary team** provides spiritual guidance and palliative rehabilitation care to improve function and wellbeing.
- **A free 24-hour advice and support telehealth service** is available in Northern Sydney.
- **Medibank and BUPA partnerships** support members to remain at home during their final days, with 148 Medibank patients and 182 BUPA patients (as of 30 June 2021).
- **Bereavement Support Program, Biography Program and Last Days Program** focus on supporting families and creating lasting memories.
- **Quality End-of-Life pilot program** supported nine residential aged care sites in 2021 through new tools, resources and monthly webinars.
- **Volunteers provide** supportive care to patients and their families in multiple settings.
- **Dreams Project initiatives** supported by the HammondCare Foundation bring patient wishes to life, creating lasting memories for loved ones.



Dementia Centre

Dementia Support Australia (DSA) supported 45,018 clients with behaviours related to their dementia between October 2016 and August 2021.

- **DSA is a national federally funded program** providing support and care to clients with dementia and their families in residential aged care and in the community.
- **A pilot program launched in May 2021** to help the carers of clients who are dying to navigate end-of-life and engage local palliative care services. Referrals are made to **The Violet Initiative** to provide grief and bereavement support to families of DSA clients.
- The Violet Initiative and Professor Rod MacLeod ran a **professional development program** at HammondCare to increase staff skills, knowledge and confidence in identifying and supporting clients who have terminal agitation or are dying.



Residential Care

We work with 23 residential aged care homes across metro and regional NSW and metro Victoria, with residents staying an average of 2.5 years.

- Our model of care ensures quality pain management, and we're working to **improve early identification for residents** who are approaching end-of-life and have increased symptom management needs.
- **We work with different local health services** in proximity to aged care facilities to access palliative care clinical support and resources.
- The **nine-bed Lavender Suite in South-Western Sydney** provides dedicated end-of-life care to frail residents.
- We are currently developing a new South Australia care home with a dementia care village due to open in 2023.



Home Care

We supported clients across 26 locations in NSW, Melbourne and Brisbane, including end-of-life care through the Palliative Care Home Support Program (PCHSP) in NSW.

- NSW Health Out of Hospital Care funding supported 3,448 homes and trained 1,067 workers to deliver the PCHSP across seven NSW Local Health Districts between 2013-21. It also supported 73% of patients' preferences to die at home. We provided 6,023 packages to 5,509 patients.



Pastoral Care

HammondCare's pastoral care team offers complementary support to the people we care for and their families.

- Focusing on an individual's own emotional journey and tailoring spiritual care to help find peace and meaning.
- Navigating changing physical, mental or emotional needs.
- Building deep connections through art, music, nature or other interests.

Service Locations

Figure 3: Map of HammondCare's service locations to 30 June 21

Residential Care

Cardiff **NSW**
Erina **NSW**
Horsley **NSW**
Scone **NSW**
Sydney **NSW**
 Darlinghurst
 Hammondville
 Miranda
 North Turramurra
 Wahroonga
Waratah **NSW**
Woy Woy **NSW**
Melbourne **VIC**
 Caulfield

HammondCare At Home

Canberra **ACT**
Batehaven **NSW**
Bathurst **NSW**
Broken Hill **NSW**
Cardiff **NSW**
Coffs Harbour **NSW**
Dubbo **NSW**
Erina **NSW**
Goulburn **NSW**
Horsley **NSW**
Kyogle **NSW**
Merimbula **NSW**
Narara **NSW**
North Gosford **NSW**
Nowra **NSW**
Picton **NSW**
Port Macquarie **NSW**
Scone **NSW**
Sydney **NSW**
 Hammondville
 Manly
 Miranda
 North Turramurra
 St Leonards
 St Marys
 Wahroonga
Tweed Heads **NSW**
Wentworth Falls **NSW**
Brisbane **QLD**
 Chermside
 North Lakes
Melbourne **VIC**
 Footscray

HammondCare Health

Sydney **NSW**
 Greenwich
 Mona Vale
 Prairiewood
 Wahroonga

The Dementia Centre

Canberra **ACT**
Bathurst **NSW**
Cardiff **NSW**
Coffs Harbour **NSW**
Dubbo **NSW**
Horsley **NSW**
Nowra **NSW**
Port Macquarie **NSW**
Sydney **NSW**
 Greenwich
 Hammondville
 North Turramurra
 Miranda
 St Leonards
 St Marys
Tamworth **NSW**
Waratah **NSW**
Alice Springs **NT**
Darwin **NT**
Brisbane **QLD**
 Chermside
 Brookwater **QLD**
 Cairns **QLD**
 Gold Coast **QLD**
 Sunshine Coast **QLD**
 Toowoomba **QLD**
 Townsville **QLD**
 Adelaide **SA**
 Daw Park
 Devonport **TAS**
 Hobart **TAS**
 Ballarat **VIC**
 Bendigo **VIC**
 Drouin **VIC**
 Geelong **VIC**
 Melbourne **VIC**
 Footscray
 Malvern
 Wodonga **VIC**
 Perth **WA**
 Wembley

Research

Sydney **NSW**
 Greenwich
 Hammondville
 St Leonards
Melbourne **VIC**
 Malvern
 Perth **WA**
 Wembley

Palliative Care Home Support Packages

Seven Local Health Districts across rural and remote towns within NSW

● ● PERTH

DARWIN

CAIRNS

TOWNSVILLE

ALICE SPRINGS

We champion the care of
33,811
people across Australia

ADELAIDE

DAW PARK

SUNSHINE COAST

BRISBANE

TOOWOOMBA

BROOKWATER

GOLD COAST

TWEED HEADS

KYOGLE

COFFS HARBOUR

PORT MACQUARIE

SZONE

BROKEN HILL

WARATAH

CARDIFF

NARARA

NORTH GOSFORD

ERINA

WOY WOY

WENTWORTH FALLS

SYDNEY

PICTON

HORSLEY

GOLDBURN

NOWRA

BATEHAVEN

WODONGA

MERIMBULA

BENDIGO

BALLARAT

YARRA VALLEY

CANBERRA

GEELONG

DROUIN

MELBOURNE

DEVONPORT

HOBART

Our Thought Leadership

Our best practice services and proven model of care are based on cutting-edge research. As a sector leader, we work with governments, universities and partners to drive innovation and share our learnings. Through investment in research, education and international partnerships, we play a key role in helping shape the future of the Australian healthcare sector to meet increasing health and aged care needs.

Palliative Centre

Our Palliative Centre, launched in May 2020, conducts research, shares vital resources with health professionals and consumers and provides education and training. It also advocates for sector-wide improvements and helps us improve our services.

For more information, please visit www.hammond.com.au

Research

We have world-class research expertise and can develop frameworks, assessment tools and best practice care for clinicians and carers supporting people at the end-of-life. We collaborate with universities and service-focused organisations to drive innovation and increase the evidence base – and translate these into practice.

Some of our efforts include:

- Lead the Australian Government funded Advance Project to develop free, practical resources and training based on research for primary care professionals. These will help initiate advance care planning conversations and assess patients' and carers' palliative and supportive care needs. New funding in 2021-23 focuses on supporting people with dementia and their families in residential care homes and in community care settings.
- Support people with life-limiting illnesses through initiatives such as the roll-out of the National Cancer Pain guidelines in cancer centres around Australia.
- Conduct research studies including '*Understanding palliative care patients and caregivers views and requirements for spiritual care*', '*Communication-related experiences and needs of families for older people living with advanced dementia receiving end-of-life care*', '*Designing early engagement and wellbeing in palliative*

- care' and 'Telehealth for palliative care services in residential aged care'.*
- Award PhD Scholarships for innovative initiatives such as '*Palliative Paramedicine: Broadening the role of paramedics delivering palliative and end-of-life care in Australian Communities*' (in progress).
 - Publish in reputable international journals, including the Journal of Clinical Oncology and Palliative Medicine and Dementia, and deliver conference presentations.

The Advance Project

The program's training and resources facilitate a team-based approach to advance care planning (ACP) and palliative care in primary care settings. In 2019-20, over 1,100 participants attended 29 face-to-face workshops, 38 brief in-practice training sessions and 3 webinars. By 30 June 2020, over 1,800 participants from general practices across Australia registered for the Advance Project online training.

The project's resources include tools to help clinicians initiate ACP and palliative care and help them get patients to think about future healthcare preferences, symptoms and concerns. There are also resources for carers.

Evaluation feedback from GPs, nurses, practice managers, patients and their carers has been highly positive.

"I thought the video examples were very helpful for modelling future conversations with patients. The flow charts and assessment guides are very helpful and will also guide set up of systems in general practice. The patient resources help ask questions in a non-threatening manner – love it."

Nurse participant

Education and resources

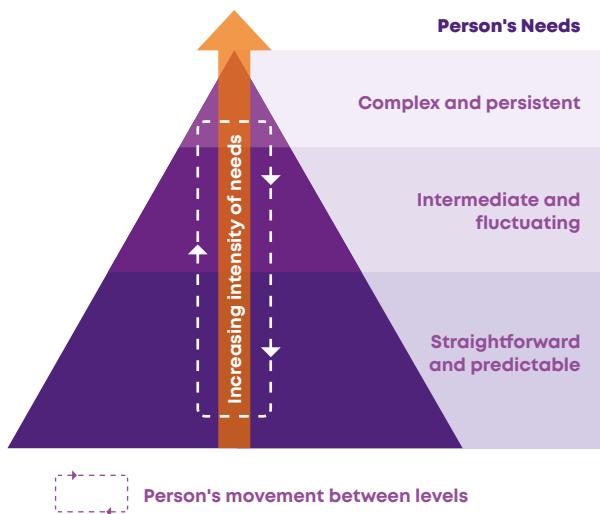
We provide accredited and non-accredited education and develop evidence-based publications and resources for health and aged care professionals and consumers.

- Developed and ran palliative care courses and training packages through Hammond College, HammondCare Registered Training Organisation and specialist palliative care professionals. Courses include *Palliative Care Essentials, Advance Care Planning, Palliative Care Case Conferencing and Recognising the Deteriorating Patient*.



Our Thought Leadership Continued

Figure 4: Level of need for people living with a life-limiting illness³⁵



- Ran a tele-education series to expand reach and accessibility of quality end-of-life to 39 residential aged care sector organisations, with 800+ staff included in this Community of Practice.
- An external consultancy will deliver the *Behaviour and Psychological Symptoms of Dementia (BPSD) Series*, including a palliative care module.
- Published evidence-based resources across a range of formats including books, webinars, videos and podcasts, such as *The Palliative Care Handbook, End-of-Life Flipchart and Resource Book, Palliative Care Bridge* and podcast *Talking Palliative Care: Normalising the Conversation* (www.dementiapodcast.com).
- Develop consumer [resources on terminal agitation in dementia](#).

Partnerships

We collaborate with numerous academic and service delivery organisations and networks to ensure we utilise global best practice palliative care frameworks, tools and evidence.

- **Australian:**

- Federal & state health departments, Northern Sydney Local Health District (LHD) and South-West Sydney LHD, Primary Health Networks (including Sydney North Health Network and Coordinare) across multiple jurisdictions, Palliative Care Australia, Palliative Care NSW and other state affiliates, Academic and University partners at University of Sydney, University of Wollongong (PCOC), UNSW (DCRC), Flinders University (CareSearch), ELDAC, UTS (IMPACCT) and the Violet Initiative.

- **International:**

- Hospice NZ.
- Northern Ireland Hospice (UK).
- St Giles (UK).
- St Christopher's (UK).
- Topaz (The Netherlands).

Palliative care clinical services

The Northern Sydney Local Health District contracts HammondCare to provide palliative care, older person's mental health and ambulatory rehabilitation services at our Greenwich and Neringah Hospital sites. An outreach team provides Specialist Community

Palliative Care services to support people to live well at home in the Northern Sydney region, supported by 24/7 telehealth advice and support.

Our Braeside Hospital site at Prairiewood provides palliative care

and rehabilitation to the residents of South-West Sydney funded by the Local Health District. People are cared for at home through PEACH, the local community outreach palliative care service.

Next steps

We will develop an Implementation Plan to execute the Strategy. We will prioritise actions over the next five years after outlining the scope of each piece of work and determining resources needed and timeline to implement. There will be governance in place to monitor progress and make sure we achieve our plans.

We will define clear outcome measures for each action as part of the implementation process.

The measures of success will focus on five key outcomes which align with our overarching strategy:

1. Lives impacted.
2. Quality of care.
3. Quality (end) of life.
4. Financial sustainability.
5. Social dividend.

Key performance indicators will measure progress towards achieving these outcomes.

We will strengthen and enhance the Palliative Centre to build on current initiatives and extend our footprint through research, education and training, resource development and advocacy for sector-wide improvements.

Thank you

Thanks to everyone who contributed to the development of this Reshaping palliative care for the future strategy.

Our consultation from July to September 2021 included perspectives from 118 staff and volunteer survey respondents, five staff focus groups and two consumer consultations. Eleven external stakeholders participated in separate interviews representing academia, peak bodies, regional and remote perspectives, primary care, community, aged care and local health districts. Quotes from these consultations are included in this document.

A HammondCare Steering Group guided the final Strategy development and the priorities for inclusion. This Group will continue to provide oversight during the implementation phase.

Glossary

Advance Care Plan

States preferences about health and personal care and preferred health outcomes. They may be made by, with or for the person. When made on the person's behalf, they should be prepared from the person's perspective to guide decisions about care. Advance care plans can nominate a preferred decision-maker, but they may not be legally recognised.

End-of-Life care³⁶

Includes the physical, spiritual and psychosocial assessment, care and treatment delivered by health professionals and ancillary staff. It also includes support of families and carers and the care of the person's body after death. People are approaching the end-of-life when they are likely to die within the next 12 months.

Palliative care

An approach that improves the quality of life for people and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other physical, psychosocial and spiritual needs.

Psychosocial care

Psychosocial denotes both the psychological, spiritual and social aspects of a person's life and may describe the way people make sense of the world. Psychological characteristics include emotions, thoughts, attitudes, motivation and behaviour, while social aspects denote the way in which a person relates to and interacts with their environment.

Quality of life

The degree to which an individual is healthy, comfortable and able to participate in or enjoy life events.

Relationship-based care

Healthcare that focuses on four types of provider relationships for the delivery of services; the relationship with the patient, resident or client relationships with other providers, relationships with the patient's family and community and the provider's relationship to themselves linked to their professional development and self-awareness.

Specialist palliative care

Services provided by clinicians who have advanced training in palliative care. Specialist palliative care providers deliver direct care and/or consultative care to patients with complex palliative care needs, and work with multidisciplinary teams to support patient needs.

Supportive care

Care that improves the quality of life of patients who have a serious or life-threatening disease. The goal of supportive care is to prevent or treat as early as possible the symptoms of a disease, side effects caused by treatment of a disease, and psychological, social and spiritual problems related to a disease or its treatment.

Appendices

Appendix 1.

Palliative Care Australia stipulates in its ‘Palliative Care 2030 Report’ that “All Australians have a human right to high quality palliative care” and “Australia will maintain the universal health system, and equity of access remains a priority for all levels of government.”³⁷

Appendix 2.

During the Covid-19 pandemic, we saw the impact of lockdowns and the importance of caring for at-risk and older populations play out in mainstream media. This, combined with heightened community expectations at the end-of-life, has increased interest in and visibility of what a ‘good death’ is.

Initiatives that focus on normalising and promoting conversations about end-of-life care, death and loss have been around for many years. But with increased awareness, we might see a resurgence of Death cafes,³⁸ ‘Death Over Dinner’, ‘Dying to Talk’ and ‘Dying to Know Day’ and death education. For example, public health model *Compassionate Communities* focuses on building social capital within local communities to support individuals who are living with advanced illness.³⁹

Appendix 3.

Barriers to accessing palliative care include:

- Palliative care’s historical focus on supporting people with a cancer diagnosis means others with life-limiting illnesses such as heart failure, kidney disease and dementia have had limited access – despite clear benefits such care could have.
- Complex funding models for palliative care have led to inequitable access to services. This is exacerbated for the growing number of patients with complex conditions like dementia, leading to significant delays in referrals.
- Structural barriers to accessing best practice end-of-life care in the residential care sector amid decades of chronic underfunding and workforce shortages means palliative care is not recognised as ‘core business’.
- A skill shortage and lack of care workers means the sector can’t meet the growing demand for non-clinical end-of-life care. There are also shortages in experienced palliative care nurses and generalist clinical professionals, specifically nurses and GPs, to support palliative care in residential aged care homes.
- Poorly resourced regional and remote regions have inadequate support for vulnerable communities like First Nations peoples.

Appendices Continued

Appendix 4.

The Royal Commission into Aged Care, Quality and Safety delivered its recommendations in early 2021, following a two-year process accepting 10,574 public submissions, assessing 1,074 aged care provider responses and hearing from 600 witnesses.

“Four areas that require immediate attention in quality and safety ... food and nutrition, dementia care, the use of restrictive practices and palliative care.”

The recommendations⁴⁰ linked to palliative care include the need for:

- Improved access to specialists and other health practitioners through multidisciplinary outreach services – expansion of the *Greater Choice for at Home Palliative Care* measure through the Primary Health Networks.
- A new primary care model with accredited aged care GPs – boosting existing aged care incentives for GPs to practice in aged care to support residents’ palliative care needs.
- Government to work with states and territories to develop an appropriate multidisciplinary service model for residential aged care, to avoid unnecessary hospitalisations.
- Improved access to state and territory health services for people in aged care.
- Dementia and palliative care training for aged care workers – new accredited Certificate III courses are required.

Appendix 5.

A 2018 Australian Institute of Health and Welfare Report⁴¹ looked at how 245,000 older Australians who died between 2012-14 used aged care program funding.

Eighty percent used at least one program to support the most prevalent diagnoses of heart disease, dementia and cerebrovascular disease. Most people accessing Permanent Residential Aged Care (PRAC) funding had dementia, with the highest group accessing Home and Community Care (HCAC) funding having a heart disease or cancer diagnosis.

Appendix 6.

The Australian Institute of Health and Welfare reported that only 1 in 77 aged care residents had an Aged Care Funding Instrument (ACFI) appraisal indicating the need for palliative care.⁴² This number is expected to increase substantially. A new funding instrument, Australian National Aged Care Classification (AN-ACC) will include a separate classification for palliative care and provide a new incentive for aged care providers to identify residents’ end-of-life needs and take a palliative approach to their care.

Appendix 7.

As part of the 2021-22 Budget, the federal government has committed \$119 billion over four years⁴³ to invest in aged care. This includes \$37.3 million over the next three years to enable all Primary Health Networks to design and implement locally appropriate initiatives as part of the *Greater Choices for At Home Palliative Care* measure. Some states and territories have also committed additional funding to palliative

care services.

Medicare spent \$7.1million on Specialist Palliative Care services in 2019-20, up from \$5.3million in 2013-14,⁴⁴ showing increasing demand over a six-year period.

KPMG's 2020 health economics analysis into palliative care called for an "overhaul of the palliative care system in Australia." It calculated that an additional annual upfront investment of just over \$350million would reduce unnecessary and costly emergency department visits, hospital stays and intensive care admissions, saving the broader healthcare system \$450million annually.⁴⁵

Appendix 8.

There are four Australian expert organisations offering evidence-based education and resources:

- Palliative Care Outcomes Collaboration (PCOC)⁴⁶ through the University of Wollongong.
- End-of-life Directions for Aged Care (ELDAC).⁴⁷
- Program of the Experience in the Palliative Approach (PEPA).⁴⁸
- Care Search.⁴⁹ run by Flinders University.

Various state health departments have developed Palliative Care Frameworks and Plans to help people and services work together and create consistency across health systems. The End-of-Life and Palliative Care Framework 2019-2024⁵⁰ outlines how NSW can do this to deliver high quality person-centred end-of-life care.

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