From: Stacey O'Hara - Griffith AMS
Sent: Wednesday, 20 October 2021 2:00 PM
To: Portfolio Committee 2
Subject: RE: Health outcomes and access to health and hospital services in rural, regional and remote New South Wales - Post-hearing responses - 6 October 2021{HIGH RISK}
Attachments: 20210601_MPHN Response_Palliative care.pdf

Hi Vanessa
AS part of the Aboriginal Health Consortium, I have asked the MPHN to have input into my response. They have summed it up perfectly and I really don't need to add anything else. Therefore, please find attached responses to the questions raised.
I would like to thank the Portfolio Committee for the opportunity to participate in the inquiry.
Kind Regards,

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INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NEW SOUTH WALES

HEARING – Thursday 29 April 2021

SUPPLEMENTARY QUESTIONS

Response: Ms Julie Redway, Acting Chief Executive, Murrumbidgee Primary Health Network

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In addition to what is contained in your submission and evidence provided at the public hearing, do you have any further comments regarding the current provision of palliative medicine, nursing and care in rural, regional and remote New South Wales?

1.1 Background

Thank you for the opportunity to provide feedback on palliative care in the Murrumbidgee region. As a significant proportion of palliative care services in regional and rural areas is provided in primary care, MPHN works with GP providers and mental health providers, residential aged care facilities, state funded specialist palliative care services and private palliative care services delivered to identify ways to improve primary care support and access to care across the region.

Since 2018 MPHN has delivered the Commonwealth funded At Home Palliative Care program which has enable a focus on increasing capacity and capability in primary care in a limited number of pilot sites to provide palliative and end of life care. Activities have included:

- Facilitating GP establishment of multidisciplinary meetings across three sites of Cootamundra, Corowa and Hay, which includes engagement with State funded palliative care services.
- The implementation of the PCOC (Palliative Care Outcomes Collaborative) program in general practice which facilitates better care coordination, through the use of a set of validated palliative care assessment tools across care setting. MPHN has implemented PCOC into general practice, which has the benefit of a shared language in multidisciplinary team meetings and referrals to specialist palliative care by primary care.
- Implementing a compassionate communities approach across two communities to build community capacity to support carers of palliative care patients.
- Provision of training in aged care to support advance care planning.
- Improving RACF imprest systems for better access to palliative care medications which has recently been commissioned to work with a number of RACFs and primary care across the region.

Through MPHNs work in palliative care and links with both primary, community and palliative care services, we are able to provide feedback on where we see the needs across the region regarding access to palliative medicine, nursing and care.

1.2 Provision of palliative care medication

Access to medications across the region is not consistent or equitable.

Issues are experienced where pharmacists do not stock an extensive range of palliative care medicines, due to the risk of these going out of date before they can be sold. In conjunction with this, the need for improved anticipatory prescribing in primary care can result in patients having no access to specific palliative care medications when they are most needed.

In addition, there are no 24 hour pharmacies in the Murrumbidgee region and therefore access to palliative care medicines in the afterhours is an issue.

Whilst local rural hospitals present as an opportunity for access to medications, particularly in the after-hours period, there are no formal arrangements between GPs and the local hospital for this to occur. This can lead to patients presenting to ED to be able to access the appropriate care.

Issues also arise when patients are discharged from hospital with either insufficient medicine supplies to enable continuum of therapy or no discharge plan is provided. This can make it particularly difficult for the GP to continue the therapy / treatment that they did not initiate.

1.3 Provision of primary and specialist care

While specialist palliative care services are available in many regional centres, rural and remote communities rely on primary care-led palliative care models. Patients of lower socio-economic status are less likely to receive specialist palliative care in regional area, or if they have a non-malignant condition.

MPHN has been working with GPs and MLHD to facilitate establishment of palliative care MDT meetings, with very few meetings currently occurring across the region. This is hampered by no one service or provider being funded for administration and coordination to facilitate MDT meetings.

GPs in some communities report limited access to palliative care nurses, with remote visiting services occurring 2-3 monthly. Recruiting specialist palliative care staff is a challenge for regional areas. Due to low staff levels, nurses are required to travel long distances to see patients face to face, or use telehealth, which is not always the patient preference. There is significant variation in after-hours support provided by the specialist palliative care team across the region, with no after-hours support in some areas.

GPs report they are often not advised when their patient has been admitted to or discharged from hospital, with inadequate or no discharge plan given to the GP when advice is provided. In addition, GPs are often not kept informed by oncologists / treating specialists regarding their patient’s status, and when the patient’s returns back to the Residential Aged Care Facility or regional town for end of life care, they are not provided with patient care information. Palliative patients and carers do not always have access to the care information or plans they require and health literacy among patients and carers is variable.

There is a lack of publicly available, qualified counselling providers who have specific training in end of life care, including bereavement qualifications. There is currently one public specialist palliative care bereavement worker for the whole Murrumbidgee region, with the patient needing to have been registered with the service before dying for the bereaved carer to be eligible for support. There is one public palliative care social worker who provides face to face assistance in Wagga. There is no other public social work available for community palliative care patients. Palliative care volunteers are only available in Wagga. As far as MPHN are aware there are no palliative care specific support group’s options for carers and patients.

Poor access to screening for existential and spiritual distress by all providers is experienced, despite its inclusion in the national palliative care standards.

The travel required to access services and treatment can be a major challenge for people living in rural and remote areas. Community transport only operates in business hours and often only travel to major towns on particular days of the week, requiring overnight accommodation. While VIPTASS and IPTASS travel reimbursement forms are available, some patients and carers report it is too overwhelming to complete.

Section 2: In addition to what is contained in your submission and evidence provided at the public hearing, do you have any further comments regarding ways to improve both the access and availability of palliative medicine, nursing and care in rural, regional and remote New South Wales?

2.1 Improving access to palliative care medication

There is a need to develop a standardised palliative care pharmacopoeia recognised by all providers, across all settings of care. Pop-up imprest medication systems as required for RACFs and for patients in the community, either at hospitals or community pharmacies would improve access to medication for palliative patients.

2.2 Improving provision of primary care

Private primary care providers are not funded by a model that facilitates integrated, coordinated care for people with complex conditions such as people approaching end-of-life. System reform at a national level is required to adequately remunerate primary care for this important and complex work. This includes a review of payment mechanisms, and investment in training and support to develop systems whereby clinicians can work at the top of their scope of practice, including primary care nurses and allied health. The COVID-19 response has demonstrated the effectiveness of telehealth. Access to MBS telehealth item numbers for specialists, GPs, nurse practitioners and allied health service providers is vitally important to facilitate access to effective and timely integrated care.

Health literacy can be improved by delivery of patient and carer education sessions to improve understanding of conditions, symptoms and self-management, and access to tailored, multimodal resource packages offered by a platforms such as GoShare.

Development and adoption of an electronic patient-led care plan which, with consent can be shared with and updated by those involved in the care of a palliative patient is required if we are to develop an effective integrated system. Such a platform could also be used to monitor symptoms and pain management and evaluate the quality of care, and life from a patient perspective. It could also allow for enrolment onto a local palliative register to fast track patients when there is a presentation to ED and/or an admission, and facilitate timely discharge summaries back to general practice and RACFs with an integrated accountability system included. Access to a regional telehealth nursing, community palliative care or hospital triage systems under an enrolled patient program with access to comprehensive and up to date care plans, and patient access to medication locally would likely result in less unplanned presentations to ED, less admissions and decreased length of stay.

NSW Ambulance are also important providers of palliative care in the after-hours period in rural and remote communities. The NSW Ambulance Service patient management system requires upgrade to provide the ability to access the patients' My Health Record, the NSW Ambulance Palliative Care Plan, and communicate with the patients regular GP on their own electronic system. Ideally, it would be interoperable with the electronic patient-led shared care plan. Processes to approve NSW Ambulance Palliative Care Plans need to be implemented in a timely manner, ideally less than 24 hours.

Finally, a funded cross-sector palliative care regional governance mechanism is required if we are to achieve a one system approach to improving patient, carer and clinician experience during palliation and system efficiencies and effectiveness.