

FRIENDS OF NORTHERN HOSPICE

Hospice Proposal for Launceston

September 2013 (updated February 2015)

Rationale and overview of the model proposed by Friends of Northern Hospice for the establishment of a co-located hospice facility and palliative care centre, integrated into the Launceston General Hospital.

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1. Purpose

This business case outlines the infrastructure and operational requirements of establishing a purpose built ten bed hospice and palliative care centre in Launceston, within close proximity to the Launceston General Hospital (LGH). Hospice care is a specialised and intensive form of end of life care for patients with advanced, life-threatening illnesses and support for their families. Admission will be for terminal care, symptom control and carer respite, emphasising quality of life, life-closure issues and the relief of suffering. This facility will also accommodate all specialist palliative care support services and provision for family accommodation

2. Background

Tasmania's palliative care service model is based on the 2004 Report 'Palliative Care in Tasmania: current situation and future directions' commissioned by the Tasmanian Department of Health and Human Services. The Report included an analysis of existing palliative care services and considered a range of supply and demand factors, as well as proposing a model for the future planning of palliative care services in Tasmania.

Two of the key findings of the 2004 Report 'Palliative Care in Tasmania: current situation and future directions' were:

- Tasmania has 50% of the designated palliative care beds that are recommended in the Palliative Care Australian guidelines, and there are issues with how the existing beds are distributed throughout the State.
- Based on the best available data, the Tasmanian palliative care service is currently (ie in 2004) only servicing 52% of the estimated need.

Other important observations noted in the report include:

- Demand for palliative and end of life care in Tasmania is likely to grow more rapidly than in other States due to the highest overall incidence of cancer and a rapidly ageing population.
- Between 2000 and 2003 there was a 22.4% increase in clients accessing Tasmanian palliative care services.
- "A particular issue for Tasmania is that patients who live alone are significantly more likely to require hospice/inpatient care than those who live in a supportive

family environment. Tasmania has the oldest population profile and the highest proportion of people who live alone in Australia.”¹

2.1 The data contained in the 2004 Report is the most up to data available for Tasmania. There has been no updating of supply and demand figures in the last eleven years, even as our population continues to age more rapidly than other parts of the country, and our proportion of people who live alone remains high. *There is an urgent need for the supply and demand figures to be updated.* The current government has promised \$100,000 for a Feasibility Study and updating of the 2004 Report.

Over the last four years there has been consistent support from individual medical practitioners and AMA Tasmania and GP North (prior to it transforming into Tas Medicare Local) for additional palliative care beds to address increasing demand. In August 2013 Friends of Northern Hospice conducted a survey of 61 Launceston GPs, and overwhelmingly they commented on the lack of beds available. Results are in Appendix 1.

Table 1 outlines the percentage of the population aged 65 and over and the percentage of the population who live alone for Launceston and its surrounding Local Government Areas. These figures are sourced from 2011 ABS Census data.

Table 1

LGA	% aged 65 and over	Lone person households – number	Lone person households - %	Lone person households Tasmania average - %
Launceston	15.4%	7854	30.9%	28%
Meander Valley	16.6%	1397	26.4%	28%
West Tamar	17%	1939	23.5%	28%
George Town	16%	685	26.3%	28%
Northern Midlands	16.8%	1212	25.5%	28%

These figures demonstrate there are large numbers of people living in Northern Tasmania who will find it difficult to remain in their own home should they require palliative care or end of life care. The palliative care service model in Northern Tasmania is based on the ‘hospice without walls’ approach which focuses on providing palliative care services in a range of settings, and establishing designated palliative care beds in rural hospitals. With at least 10,000 people in greater Launceston living alone, there are many people in the community who will find it difficult or impossible to remain in their own home should they require end of life care. The need for a dedicated hospice facility to service people needing palliative and end of life care in a non-acute care environment remains high. Without such a

¹ 2004 Report ‘Palliative Care in Tasmania: current situation and future directions’, page 37

facility, and with only four designated palliative care beds available to public patients in Northern Tasmania, acute beds in public hospitals will undoubtedly continue to be occupied by people requiring specialist palliative and end of life care services.

Increasing the number of designated palliative care beds for public patients in Northern Tasmania will relieve pressure on the LGH by reducing the use of expensive acute care beds for patients who will not require acute care services. Historically many terminally ill patients have had repeated presentations to the LGH Emergency Department where they have been subjected to numerous unnecessary tests, treatments and/or procedures. Availability of beds in a hospice setting will allow for direct admissions by clinicians who are familiar with the patient's clinical status.

2.3 Tasmania has high levels of chronic and cancer related disease, which is expected to increase as the population continues to age. For example, rates for treated End Stage Kidney Disease increased from 4.8 per 100 000 population in 1989 to 10.5 in 2009. Rates are expected to increase to 19 per 100 000 people by 2020.

The increasing prevalence of chronic disease in Tasmania will result in greater demand for palliative care services in the years ahead.

2.4 Recently reported figures indicate palliative care hospital admissions in Australia increased 50% between 2001 and 2010.

“And demand keeps soaring. Palliative care hospital admissions in Australia rose by more than 50 per cent between 2001 and 2010 - there were 56,000 reported in public and private hospitals in 2009-10. People aged over 75 years made up about half of all admissions, with only about one in 10 younger than 55.”²

2.5 The current availability of designated beds for end of life care in Launceston is three private beds and four public beds. Prior to 2007 there were three private beds at Calvary, three private beds at Philip Oakden House and three public beds at Philip Oakden House. Therefore the current availability in 2015 is less than 2007. Should this hospice proposal be accepted there would be immediate endeavours to restore the three private beds which were removed when Philip Oakden closed. Therefore if those private beds are restored, there would already be seven beds funded for the hospice, and the funding would be required to construct the building and provide three additional public beds.

² Reported in The Age Newspaper, 31 July 2013, retrieved from <http://www.theage.com.au/victoria/in-death-theres-a-lot-of-living-20130720-2qbdu.html>

3. Overview of proposed facility

The model proposed is for the development of a purpose built hospice as part of the Launceston General Hospital (LGH), which would be the parent hospital. The model is for a partially integrated unit which shares aspects of service provision with the LGH.

Key features:

- located within close proximity to the LGH;
- purpose built facility which enables all specialist palliative care services to be co-located in one building;
- facilities to include a specialist, public, ten bed inpatient hospice, clinical and office accommodation, consulting rooms and a training room;
- multidisciplinary staffing team that includes medical, nursing, allied health, chaplaincy/spiritual care and volunteer support;
- 24 hour access
- single rooms with ensuite facilities;
- separate entrance to the hospice unit;
- access to outdoor or tranquil garden area;
- family room;
- condolence room;
- prayer or reflection room;
- provision for the facility to be extended to accommodate a further 5 beds should it be required in the future.

The hospice will cater for people whose condition has progressed beyond the stage where curative treatment is effective and cure is attainable.

4. Model proposed for a specialist palliative care service

4.1 Co-location of all palliative care services in Launceston

It is proposed all existing palliative care services and the ten bed in-patient facility would be co-located in this facility. This would enable the facility to operate as a knowledge hub for the region, and a centralised resource for other providers such as residential aged care facilities and community care providers. Therefore facilities such as training rooms and consulting rooms would be provided in the centre, and the existing palliative care consultants, the community palliative care service and any palliative care allied health professionals would be co-located within the facility.

Co-location provides a range of important benefits to patients and the service.

- It will strengthen the linkages between community palliative care and in-patient care.

- It supports improved planning and pathways between palliative care settings.
- It is a cost effective option.

4.2 GPs to be able to admit patients to hospice beds and continue care once admitted

The model proposed will provide general practitioners (GPs) with the option of directly admitting their patients to the facility, and continuing to provide care to them once admitted. This is strongly supported by GPs in the Launceston area, and is similar to what occurs at the Whittle Ward in Hobart. GPs have little opportunity for continuing to care for their patients once they are admitted to the Melwood Unit at Calvary Health St Luke's in Launceston. In a survey undertaken by Friends of Northern Hospice in August 2013³, 85.2% of the 61 GPs who responded indicated they would admit and continue to care for patients in a hospice should one be built within close proximity to the LGH.

This would also enable existing palliative care Consultant/s to practice as the name suggests, in a consulting capacity. Currently the palliative care Consultant/s undertake all admissions to the designated beds at the Melwood Unit at Calvary Health St Luke's in Launceston. As one GP commented "... more availability of places for GP care would be good. Palliative care at Melwood Unit has been hijacked by palliative care specialists."

Maintaining an ongoing involvement for a patient's GP when palliative and end of life care is required is an important aspect of providing care within a person-centred model of care. Many GPs in Launceston are willing to admit patients to a hospice and may also be willing to extend this to include:

- maintaining a level of care, with the support of a palliative care team, once admitted; and/or
- being kept informed of the patient's progress once admitted

If a patient is subsequently discharged back home or to another community based setting, the GP is informed and able to resume the person's care.

³ In August 2013 the Friends of Northern Hospice distributed a survey to all GP practices in Launceston. The questions and results are listed in Appendix 1.

4.3 Hospice unit to provide care for a range of reasons

A palliative care client is a person whose condition has progressed beyond the stage where curative treatment is effective and cure is attainable, or who chooses not to pursue curative treatment.

The client must have:

- been diagnosed as having a terminal illness, or
- a progressively deteriorating condition.

The role of the hospice unit is to provide:

Respite Care

A patient may be admitted to the unit for a short term basis to provide the family or carer respite time, and to introduce and familiarise the patient to the facility for later admission.

Symptom Management

A patient may be admitted for assessment, diagnosis, consultation and treatment of symptoms. When the symptoms are stabilised or treatment completed, the patient can return to their home and family or carer with the ongoing care and support of their GP and the community palliative care service.

End of Life Care

End of Life Care will be provided when it is not appropriate or possible for a person to remain at home until they die.

Typically, patients being admitted to the hospice unit may have been diagnosed with diseases such as cancer, motor neuron disease, dementia or end stage renal, cardiac or respiratory disease.

4.4 The hospice service model

The service model adopted here is not a stand-alone hospice. It will be a purpose built unit, integrated into the Launceston General Hospital. This offers the following advantages.

- Use of existing hospital infrastructure, including hospital accountability and peer review processes, accreditation processes.
- Use of existing ancillary services such as accounting, housekeeping, laundry and catering services.
- Opportunity to integrate clinical leadership.
- Ease of access to other specialist services.
- Continuity of holistic patient care.

- Opportunity for staff to work within the unit, and to educate a wide range of hospital staff in the principles and practice of palliative and end of life care.
- More effective use of resources.
- Fewer, and more appropriate, emergency presentations and hospital admissions.
- Reduced incidence of medical interventions and tests for those at the end of their, which also increases the cost effectiveness of the hospice option.
- The calmer, less interventionist approach patients receive in hospice care can also result in reduced need for grief and bereavement counselling for families and loved ones.

5. Next Steps

In order to progress this proposal into a full business case a number of further steps need to occur.

- Demand figures need to be updated so that current, accurate data is available as the basis for future planning.
- There needs to be economic modeling undertaken in relation to palliative care admissions into public hospitals, and a cost benefit analysis on freeing up acute care beds in the region by increasing the number of designated palliative care beds. A health economist would need to be engaged to undertake this work.
- Data needs to be collected on specific population groups and their need for access to palliative care beds, for example children, Aborigines, refugees and humanitarian entrants, culturally and linguistically diverse community members.
- An indicative cost for developing the dedicated centre needs to be undertaken, and potential sources of funding identified.

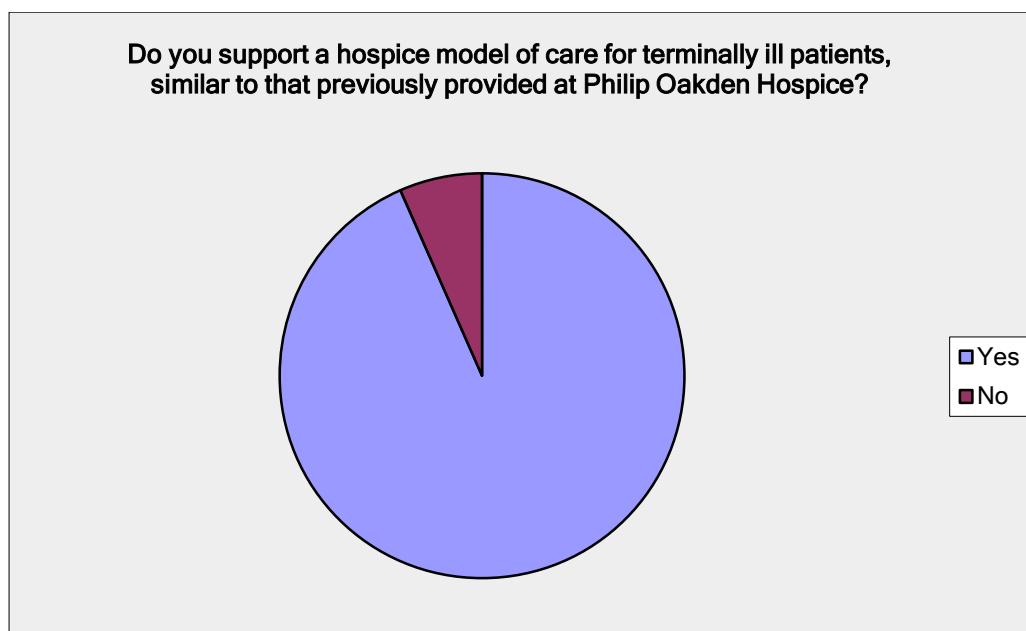
6. Conclusion

An exciting opportunity exists for Northern Tasmania to lead the way with a fresh innovative approach to palliative and end of life care. Northern Tasmania could lead the way with a state of the art modern hospice, purpose built and operating under best practice guidelines, servicing the community in coping with the challenges of an ageing population.

Appendix 1 – Survey of Launceston General Practitioners

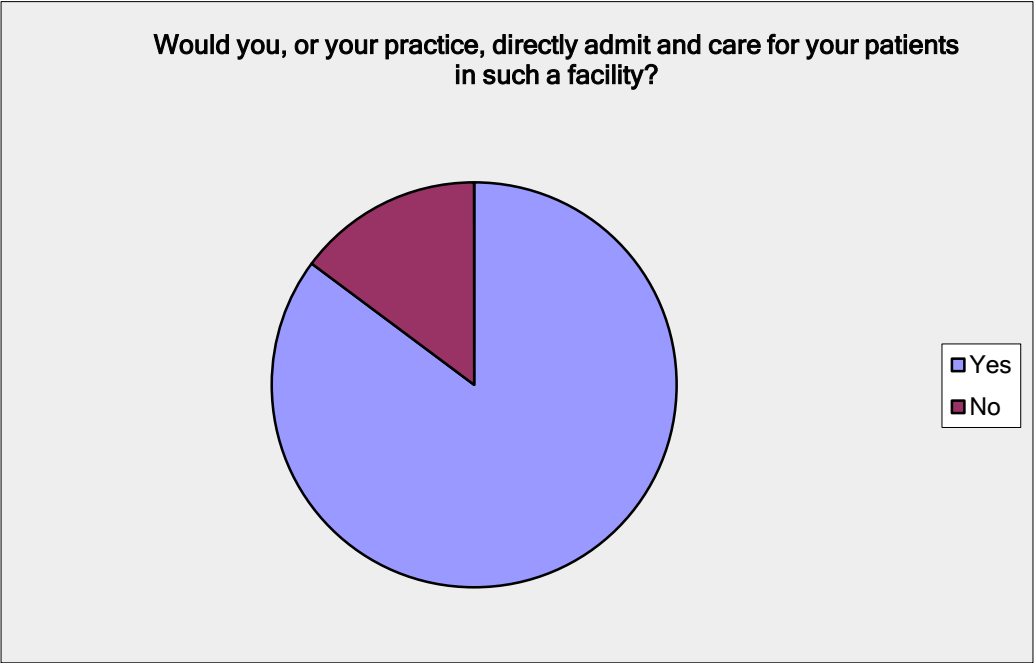
Question 1 – Do you support a hospice model of care for terminally ill patients, similar to that previously provided at Philip Oakden Hospice?

Answer Options	Response Percent	Response Count
Yes	93.4%	57
No	6.6%	4
<i>answered question</i>		61
<i>skipped question</i>		0



Question 2 – Would you, or your practice, directly admit and care for your patients in such a facility?

Answer Options	Response Percent	Response Count
Yes	85.2%	52
No	14.8%	9
<i>answered question</i>		61
<i>skipped question</i>		0



Question 3 – Do you think there are deficiencies in palliative care services in Launceston?

Answer Options	Response Percent	Response Count
Yes	81.8%	45
No	18.2%	10
<i>answered question</i>		55
<i>skipped question</i>		6

