



# Comprehensive Palliative Care in Aged Care (CPCiAC) Measure – Interim Report

Palliative care

14 February 2024



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This artwork was developed by Marcus Lee Design to reflect Nous Group's Reconciliation Action Plan and our aspirations for respectful and productive engagement with Aboriginal and Torres Strait Islander peoples and communities

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# 1 Executive summary

## 1.1 The Comprehensive Palliative Care in Aged Care Measure

### **The Measure aims to improve palliative care in residential aged care facilities (RACFs)**

The Comprehensive Palliative Care in Aged Care (CPCiAC) Measure (the Measure) aims to strengthen national efforts to improve access to quality palliative care as a key component of an integrated health-aged care system. The Measure provides \$57.2 million in federal funding over six years from 2018-19 to 2023-24 through the Project Agreement for CPCiAC Measure (Project Agreement), with funding to states and territories commencing from 2019-20. The Measure is a matched funding arrangement, with the Australian Government matching the contribution of states and territories. States and territories implement initiatives suited to local needs.

Nous Group (Nous) has been engaged by the Australian Government Department of Health and Aged Care (the Department) to undertake a national evaluation of the Measure between July 2020 and October 2023.

## 1.2 Purpose and scope of this Interim Report

### **This report provides an interim assessment of progress up to August 2023 towards the Measure's aim**

This report assesses the extent to which the Measure, as of August 2023, is achieving its aims to inform policy advice on the future of the Measure beyond June 2024. It outlines activities being implemented by states and territories to-date, and emerging evidence related to the Measure's successes and challenges. It is informed by qualitative and quantitative data collected directly from states and territories, and national datasets where available.

It builds on the findings and information contained in the Baseline evaluation report, delivered September 2021, and the Mid-point evaluation report, delivered September 2022, and highlights progress since the Mid-point report.

Evaluation findings have been developed with reference to the ten national outcomes grouped under the goals of the National Palliative Care Strategy as listed in Table 1.<sup>1,2</sup> Interim findings measure the progress and impact and the Measure.

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<sup>1</sup> Australian Government Department of Health, National Palliative Care Strategy 2018.

<sup>2</sup> Goal 5 (Investment) and Goal 7 (Accountability) of the National Palliative Care Strategy are not necessary to be included as national outcomes for this evaluation.

Table 1 National outcomes for the Measure

Outcome number	Outcome description
1	More discussions focused on end-of-life care decision making between residents, families, carers, General Practitioners (GPs) and specialist palliative care services including use of Advance Care Plans (ACPs).
2	Improved access to information that informs end-of-life care decisions for residents and families.
3	A higher proportion of clinical and non-clinical staff in RACFs have skills and confidence appropriate to their roles to recognise and respond to the holistic palliative care needs of residents, in a culturally safe way.
4	Improved access to quality palliative care in RACFs including: <ul style="list-style-type: none"> <li>increased use of assessments to establish residents' palliative care needs</li> <li>decreased health service use related to clinically futile or non-beneficial treatments and inpatient bed days</li> <li>decreased healthcare expenditure arising from decreased service use.</li> </ul>
5	Improved quality of palliative care provided in RACFs including: <ul style="list-style-type: none"> <li>reduced symptom burden</li> <li>improved quality of life for residents during the period they access palliative care</li> <li>better experience of death and dying for residents, families/carers and staff, including meeting physical, psychosocial, cultural and spiritual needs.</li> </ul>
6	Greater resident choice in palliative care including: <ul style="list-style-type: none"> <li>more people dying where they want</li> <li>increased person-centred care informed by an individual's choice.</li> </ul>
7	Improved care coordination with GPs/primary care, acute care services and specialist palliative care services.
8	Improved integration between the health and aged care systems.
9	More palliative care services and health planners are informed by performance information on appropriateness, effectiveness, efficiency and outcomes.
10	Improved clinical governance to identify and implement quality improvement initiatives and evaluation of outcomes within RACFs.

### 1.3 The needs of residents, families, carers and staff

Nous conducted a literature review as part of the early stages of this evaluation.<sup>3</sup> It identified eight common palliative care needs for RACF residents, as well as common needs of families, carers, staff and the broader system (summarised in Table 2). 'System needs' refer to needs at the Australian Government (predominantly related to the aged care system and primary care system) and state and territory government level (predominantly related to health care systems).

Table 2 Summary of needs of residents, families, carers and staff<sup>4</sup>

<b>Resident needs</b>	<p>Across supports and services, evidence indicates that RACF residents need care that is <b>culturally appropriate, coordinated and flexible</b> to meet their individual needs and preferences.</p> <ul style="list-style-type: none"> <li>• Nursing and medical support.</li> <li>• Pain and symptom management.</li> <li>• Multidisciplinary and specialist medical support to manage complex medical needs.</li> <li>• Avoidance of unnecessary hospitalisations and procedures.</li> <li>• Involvement in decision-making including advance care planning.</li> <li>• Case conferencing and care coordination.</li> <li>• Counselling and psychosocial support.</li> <li>• Spiritual support.</li> </ul>
<b>Families/carer needs</b>	<ul style="list-style-type: none"> <li>• Education and access to information.</li> <li>• Emotional, spiritual and psychological support.</li> <li>• Respectful support and involvement including bereavement.</li> </ul>
<b>Staff needs</b>	<ul style="list-style-type: none"> <li>• Access to clinical staff when needed.</li> <li>• Training, support and supervision to identify palliative care needs.</li> <li>• Appropriate referral pathways.</li> <li>• Education in symptom management.</li> <li>• Time and resources to deliver care.</li> <li>• Training to engage with residents and families.</li> </ul>
<b>System needs</b>	<ul style="list-style-type: none"> <li>• Ability to communicate with patients, carers and families about palliative care needs, death and dying.</li> <li>• Appropriate facilities, workforce and funding to provide care.</li> <li>• Communication channels across the health system, including with other RACF staff and hospitals.</li> </ul>

<sup>3</sup> Nous Group. Literature review summary report – National Evaluation of the CPCiAC, 2020.

<sup>4</sup> Ibid.

- Appropriate education and training options underpinned by competency and capability frameworks.

## 1.4 Interim evaluation findings

### **States and territories have continued to progress implementation of Measure activities.**

- Since mid-2022, jurisdictions have made further progress with recruitment and projects.
- All states and territories consulted in July and August 2023 reported ongoing implementation progress of CPCiAC activities. To date, the Measure has funded 54 projects and 99 full-time equivalent (FTE) and has impacted over 1,250 RACFs across Australia.
- At the Mid-point report, Tasmania was in the early stages of the General Practitioner (GP) Registrar program, which aims to enhance medical input into palliative care into RACFs. Only one registrar was recruited as of May 2022. Since then, a total of five six-month rotations for GP registrars in palliative care have been completed or commenced.
- In South Australia, the Eldercare traineeship pilot has been expanded beyond the original end date in February 2023 due to high demand. The traineeship aimed to improve the education and recruitment of personal care workers in RACFs. So far, the program has seen 23 trainees achieve a Certificate III in Individual Care (Aged Care), with another two cohorts of trainees recruited in February and April 2023. See Case Study 1, page 30.
- Western Australia has also commenced an additional four small pilot projects across metropolitan RACFs since mid-2022, following a consultation period to inform the planning and design of each project. Many of these pilots aim to improve the transition for residents between hospitals and RACFs, including coordinating care and advanced care planning.

### **Measure activities are showing evidence of increasing access to palliative care services, encouraging genuine collaboration and responding to significant palliative care needs.**

- Multiple jurisdictions report increased access to palliative care within RACFs due to improved capabilities of RACF staff to assess needs and deterioration, and to appropriately escalate care. In some RACFs, an increase in referrals to specialist services has indicated increased identification of palliative care needs and subsequent referrals to appropriate care.
- All jurisdictions continue to report greater involvement of specialist care services in RACFs and further evidence that care coordination has improved in some jurisdictions. For rural and regional locations across Queensland, South Australia and Northern Territory, virtual care has been essential in facilitating care coordination across multi-disciplinary teams.
- There is ongoing evidence of improved discussions and information regarding advance care planning for residents, families and carers, although there is still variability in the rate of completion of Advance Care Plans (ACPs) across jurisdictions. South Australia has commenced ACP workshops in partnership with local councils, with the purpose of increasing education and awareness of end-of-life decision-making for older adults prior to entering RACFs (see Case study 2, page 38).



- South Australia and the Australian Capital Territory (ACT) highlighted that the Measure has enabled collaboration across sectors that would not have otherwise occurred, particularly between the non-government organisation (NGO) sector and state government.

**There is ongoing evidence that the Measure funding has enabled states and territories to explore new and innovative approaches to palliative care, addressing existing palliative care needs and service gaps.**

- South Australia, Tasmania, Queensland and Western Australia all reported that the Measure funds have been used to explore and implement innovative approaches to palliative care not previously funded or that otherwise would not have occurred.
- In South Australia, the partnership with Eldercare has established a new standard for end-of-life care in RACFs, and the 'Hospice in the RACF' project won the Innovation in Palliative Care award at the National Palliative Care Awards 2023. The traineeship portion of this project has been an innovative approach which resulted in 16 additions to the aged care workforce in February 2023 who all had relevant education and training to deliver palliative care to residents (see Case study 1, page 30).
- Tasmania reported the value of the Measure in enabling a proactive in-reach approach to identifying and addressing palliative care needs across the state. This has led to increased identification of palliative care needs in RACFs that otherwise may have been undetected, and subsequent referral to specialist care.
- Western Australia and the Torres and Cape Hospital Health Service (HHS) in Queensland were able to invest a portion of the Measure funding into early consultation with key stakeholders and communities to develop creative solutions to service gaps through a pop-up model of care implementing new resources, a needs rounds model of palliative care and a bereavement model for families.

**States and territories have used the flexible nature of funding to implement context-specific models and adapt models to mitigate constraints.**

- Queensland and New South Wales (NSW) have benefited from the flexibility of the Measure funding to implement devolved models across HHS and Local Health Districts (LHDs) respectively. Representatives from both jurisdictions indicated that this has allowed for tailored approaches in each region that best suits local needs and processes.
- Both NSW and Tasmania reported the need to adapt the needs rounds models due to resourcing constraints. Tasmania has, in some RACFs, pivoted to mini needs rounds while some LHDs in NSW have adopted a more consultative, bedside approach to needs assessments for RACF residents.
- Other jurisdictions also noted the need to adapt their models of care as implementation of activities progressed based on varying levels of engagement with clinicians and RACFs, COVID-19 challenges and other learnings that arose throughout the implementation process. Western Australia adapted their major education program from an in-person format to online delivery, due to challenges accessing RACFs in the COVID-19 environment and changing RACF education needs identified through consultation with providers. based on low engagement rates from

RACFs. The flexibility of the Measure allowed this pivot and ultimately led to cost savings that were able to be redirected to expand other programs with higher demand.

**There is ongoing evidence that the Measure has improved coordination between the health and aged care sectors and enhanced provision of multidisciplinary palliative care.**

- Jurisdictions that have implemented needs rounds and/or multidisciplinary case conferences report that they have fostered collaboration between aged care, medical and allied health staff to deliver better quality care for residents. These jurisdictions report they have led to increased resident access to nursing and primary care staff, as well as GPs and specialist teams.
- In Tasmania, Measure-funded GP registrars attend needs rounds led by Measure-funded Clinical Nurse Consultants (CNCs). A newly recruited social worker is also attending needs rounds to provide resources to residents and their families in a pilot program, which is showing early success.
- In Western Australia, GP case conferencing coordinators are supporting primary care coordination between GPs and RACFs to provide an additional resource to RACFs and reduce administration burden on GPs.
- In Queensland, South Australia and the Northern Territory, virtual care delivery has enabled improved coordination across multidisciplinary teams. Virtual care models are being used in some jurisdictions to facilitate care coordination, particularly in regional and rural areas where it is challenging to have all care providers physically in the same location.
- Jurisdictions also reported that care coordination between aged care, specialist care and GPs remains an ongoing challenge, particularly GP engagement, especially where GP services are provided online.

**There are ongoing successes across all models of care being implemented by states and territories, in particular access to specialist palliative care and needs rounds.**

- Several jurisdictions report that needs rounds enable more proactive identification of residents' palliative care needs and deterioration including earlier referrals to specialist palliative care services. They also contribute to increased awareness of residents' ACPs and how to enact them, or where an ACP may be required. They are helping to improve GP engagement within RACF palliative care, especially where needs rounds are run by specialist palliative care consultants.
- Specialist palliative care access has been a key focus for most jurisdictions and is often facilitated through needs rounds. Increasing access to specialist care within the RACFs is ensuring that residents are provided with the appropriate care without having to be transferred to external facilities in their end-of-life period. Western Australia has expanded their Metropolitan Palliative Care Consultancy Service (MPaCCS) to increase the reach and accessibility of specialist clinicians across RACFs. Tasmania and Queensland have also reported increased referrals to specialist teams for RACF residents, enabling improved access to care.
- All jurisdictions have taken varied approaches to education and training that cut across the residential aged care and palliative care sectors. While some jurisdictions such as South Australia, Queensland, the Northern Territory and Tasmania have had success with on-the-job

traineeships and in-person education sessions, others reported challenges with engagement for in-person delivery and have had to pivot to virtual formats.

- Several case studies on models of care have been provided in this report, including:
  - In South Australia, on the Eldercare traineeship pilot program to upskill aged care workers, a partnership between government bodies to run community-based workshops to improve local awareness for end-of-life planning and an app-based learning platform for aged care workers.
  - In Tasmania, on GP registrar rotations to build capability for GPs in providing palliative care.
  - In NSW, on a partnership between Murrumbidgee LHD and End of Life Direction for Aged Care (ELDAC) to deliver programs to improve the confidence and capability of RACF staff.

**Regardless of the model of care, some common factors enable their success.**

In the Mid-point report, Nous identified some common enabling factors that support models of care to be successful, regardless of which model is being implemented. These broadly align to the success factors identified in the literature review conducted as part of this evaluation in 2020.

Based on consultation and data collection in July 2023, the following common factors that support ongoing success of models of care include:

- **The quality and capacity of the surrounding health system.** In consultations, stakeholders emphasised the importance of effective primary and acute health system infrastructure in facilitating access to palliative care.
- **Open communication between families/carers and RACF staff.** Families and carers need communication to understand their family member is being cared for.
- **Mechanisms and processes to support and educate staff to identify residents needing palliative care.** High workforce turnover limits the effectiveness of one-off education and training for RACF staff.
- **Working collaboratively with stakeholders, including RACF leadership.** Stakeholders reported that engagement with RACFs to ensure buy-in was essential to the implementation of new models of care.

### 1.4.1 Challenges and Limitations

**There are ongoing workforce challenges, due to staff turnover and recruitment challenges and residual impacts of COVID-19. These challenges undermine the sustainability of training and education initiatives.**

- All jurisdictions continued to report workforce challenges both in recruiting and retaining staff in RACFs, as well as clinicians in the palliative care service system (see section 5.1.3). ACT noted the burdensome nature of palliative and end-of-life care and how this contributes to burnout for staff who are not appropriately supported.
- Queensland, Western Australia and Tasmania reported that constant staff turnover in RACFs is a significant barrier to capacity building (see section 5.1.3). Queensland and Western Australia

reported the need for ongoing, embedded training to mitigate the impacts of turnover and ensure a baseline skillset. Jurisdictions also reported that the time-limited funding for specific roles in-part contributed to higher rates of staff turnover, due to lack of certainty.

- Several jurisdictions reported that workforce shortages have also been contributed to by residual impacts of COVID-19, including furloughs, workforce exits and challenges replacing staff, and residual burnout. Queensland also reported that high turnover of specialist staff undermines the long-term relationships built between the health and aged care sectors.
- Jurisdictions also reported ongoing challenges in recruiting to clinical roles, particularly in regional, rural and remote areas.

### **Data and evidence limitations continue to be a challenge.**

- All jurisdictions are undertaking internal evaluations or monitoring processes, though they are at varying levels of completeness, and some do not focus specifically on the CPCiAC Measure (such as NSW). NSW is undertaking a statewide evaluation of the NSW Health End of Life and Palliative Care Framework 2019-24, which covers broader state funding. Only a small portion of the NSW evaluation will cover palliative care delivered in aged care and the focus will not be on Measure activities.
- Jurisdictions continue to face difficulties in accessing data that can be used for monitoring and evaluation from RACFs, hospital or community-based services. Nous requested administrative data from jurisdictions to inform this report, however the data received in response was variable, with significant gaps and no clear trends across measures. All jurisdictions reported challenges in responding to the data request, especially in reliably identifying RACF residents in their administrative datasets. While some jurisdictions' data showed an increase in specialist palliative care referrals, and a decrease in transfers to hospital for RACF residents, this was not the case for all.
- The Palliative Care Outcomes Collaboration (PCOC) dataset did inform this report; however, it is limited in that it only captures information from 51 specialist palliative care services providing in-reach to RACFs across Australia, over 88 per cent of which are based in metropolitan locations.
- The primary dataset used in this evaluation and included in the Mid-point report, the National Integrated Health System Information-Analysis Asset (NIHSI-AA), has not informed this Interim report as it does not cover implementation of the Measure due to a time lag of two years. At this stage, NIHSI-AA only covers data up to June 2021. It was decided that this would not be used to inform this Interim report given it covers such a limited period of Measure implementation.

### **There is significant interest from states and territories to extend the Measure beyond June 2024, however there are concerns about time-limited funding and time required to plan.**

- All states and territories (Health Department representatives) are supportive of an extension to the Measure. Several jurisdictions reported that the Measure has enabled them to implement or expand palliative care services that would not have otherwise been possible. All jurisdictions reported they were considering ongoing implementation of selected models of care, though

some, including South Australia, noted benefits in further considering existing capabilities and needs within RACFs to inform how funding is used in the future.

- States and territories have reported ongoing challenges with the time limited nature of the funding, and lack of advance notice about funding requirements. Multiple states and territories raised the issue of temporary funding as a concern, due to the uncertainty it creates for staff whose positions are funded by Measure funds and challenges with retaining skilled staff in time-limited contracts. Jurisdictions noted that they would need adequate notice and time to seek support from jurisdictional Treasury Departments and notify teams delivering the CPCiAC activities.

## **1.5 Activities being implemented under the Measure**

To date, the Measure has funded 54 projects and 99 FTE, and has impacted over 1,250 RACFs.

## 2 Introduction

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This section describes the Measure, and the purpose and scope of the national evaluation.

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### 2.1 Overview of the Measure

**The Measure aims to improve palliative care in RACFs.**

The Measure provides \$57.2 million in federal funding over six years from 2018-19 to 2023-24 through a Project Agreement, with funding to states and territories commencing from 2019-20. The Measure aims to help older Australians living in residential aged care who are nearing the end of their life. Its goals are to:

- improve palliative and end-of-life care for older people living in residential aged care
- further enable people to die where they want, supported by increased aged care services.

The Measure is provided through a matched funding arrangement model, with the Australian Government matching the contribution of states and territories. States and territories implement initiatives suited to local needs, with the suggestion being that the initiatives focus on:

- **in-reach models of care**, that include assessments to establish residents' palliative care needs.
- **models that support end-of-life care decision making** that aim to deliver quality, person-centred care to dying residents through the development of agreed goals of care.
- **education and training initiatives**, that aim to build the capacity of the RACF workforce and other clinicians involved in the delivery of care to residents of RACFs.<sup>5</sup>

### 2.2 Purpose and scope of the national evaluation

**The national evaluation of the Measure is assessing whether its aims are achieved.**

Nous has been engaged by the Department to evaluate the Measure between July 2020 and October 2023.<sup>6</sup> The evaluation objectives are to:

- assess implementation, appropriateness, effectiveness and cost-effectiveness of the Measure
- measure and analyse the impact of state and territory activities in relation to the Measure's objectives
- identify the barriers and enablers to achieving the intended outcomes

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<sup>5</sup> Commonwealth of Australia. National Project Agreement for Comprehensive Palliative Care in Aged Care. 21 July 2020.

<sup>6</sup> At the time of writing, Nous and the Department of Health and Aged Care are exploring an extension to the evaluation to mitigate the impacts of the time lag for the availability of the NIHSI-AA data, and the delays in Measure implementation caused by the COVID-19 pandemic, as reported in the Mid-point evaluation report.

- assess the effectiveness of the governance model of the Measure
- identify issues to inform future priorities, consider demographics, and health and aged care reforms
- analyse the achievements of the program in relation to the National Palliative Care Strategy
- develop recommendations to inform palliative care policy development.

The national evaluation will not evaluate:

- Individual models implemented by the states and territories nor compare palliative care outcomes across states and territories. Some jurisdictions are undertaking local evaluations of their activities, which the national evaluation will draw on.
- Palliative care activities in residential aged care settings that are not funded under the Measure. For example, if an in-reach service is expanded under the Measure, then expansion activities only will be considered in this evaluation.

## 2.3 Purpose of this report

This Interim Report provides an updated assessment of implementation and effectiveness of the Measure to 30 May 2023, since the Mid-point Report delivered in 2022 and the Baseline Report in 2021. Both of these reports are available on the Department's website:

<https://www.health.gov.au/our-work/comprehensive-palliative-care-in-aged-care-measure>.

This Interim report is intended to inform the federal Mid-Year Economic and Fiscal Outlook (MYEFO) 2023-24. This report structures findings against the key evaluation questions (KEQs) provided in 0. It provides:

- an assessment of the impact of policy and operating context on implementation of the Measure
- updated evaluation findings on:
  - activities being delivered in each state and territory as of June 2023
  - whether the Measure is being implemented as planned and lessons from implementation to date
  - the extent to which it is appropriate to meeting the needs of residents, families and carers
  - the effectiveness of the joint funding and delivery arrangements
  - alignment to the National Palliative Care Strategy
  - the emerging success of models of care (based on available data at this stage).

## 3 Evaluation methodology

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This section provides a broad overview of the evaluation approach and the methodology used for the preparation insights for this report.

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### 3.1 Evaluation approach

**The national evaluation has process, outcome and economic components.**

An Evaluation Framework, agreed by the Department and states and territories in 2021, outlines the methodology undertaken for the national evaluation. The evaluation has three components:

1. Process component. This examines the process of implementation and delivery of the Measure, including the effectiveness of joint funding and delivery arrangements between the Australian Government and states and territories. An update on the emerging findings for this component is provided in section 5.
2. Outcome component. This examines the extent to which intended outcomes and goals were achieved. The Evaluation Framework identified ten national outcomes by which to assess progress towards goals. An updated assessment against the national outcomes is provided in section 5.3.
3. Economic component. This examines the cost-effectiveness of the Measure. This will be provided in the Final Report in 2024.

Eight KEQs structure the evaluation (see the Data collection plan, page 94 of the Mid-point evaluation report).

### 3.2 Methodology

This report draws on a range of qualitative and quantitative inputs to build on the findings presented in the Mid-point Report.<sup>7</sup> Data sources for this report include:

- implementation updates from state and territory health departments
- consultations and qualitative data collections from states and territories in October 2022 and August 2023
- quantitative data from state and territory ambulance, emergency, admitted patient, non-admitted patient datasets and other CPCiAC activity-based data where available
- National quantitative datasets related to palliative care, including from the ELDAC, PCOC, Australian Healthcare and Hospitals Association (AHHA) and the Aged Care Quality and Safety Commission (ACQSC).

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<sup>7</sup> Nous Group, National Palliative Care in Aged Care Measure- Mid-point Report, September 2022.



**Some states and territories provided additional quantitative data on palliative care related services to inform this report, however data availability was varied.**

Nous developed a quantitative data collection template with input from states, territories and the Australian Institute of Health and Welfare (AIHW) to collect data from states and territories covering the time period from one year prior to implementation of the Measure, through to May 2023. The data provided by states and territories was intended to be comparable, but there are differences in data collection methodologies across jurisdictions that limits comparability. For this reason, the data is presented as aggregate data and used only to observe broad trends in palliative care service delivery across Australia. Caveats, definitions and data specifications have been provided in footnotes where appropriate and in Appendix C.

The quantitative data request was designed to mitigate challenges in the availability of up-to-date quantitative at the time of writing this report. These challenges included:

- The two-year time-lag of NIHSI-AA data, meaning that as of June 2023, only data up to June 2021 was available, which does not cover a sufficient period of CPCiAC Measure implementation to draw any meaningful insights about the Measure's impact.
- NIHSI-AA not including Western Australia hospital data and not capturing specialist palliative care service events outside hospital.
- Challenges associated with extracting and interpreting ambulance transfer data. The evaluation had planned to incorporate analysis from a pilot leveraging Ambulance Tasmania data, however due to very low sample sizes of transfers prior to CPCiAC Measure implementation in Tasmania, the pilot was ceased as it was not likely to produce results that would enable us to meaningfully compare transfers prior to and following the Measure implementation.

## 4 Policy and operating context

This section describes the context in which the Measure is being implemented.

The Measure was introduced amongst significant reforms within the health and aged care sectors. The implementation of recommendations from the Royal Commission into Aged Care Quality and Safety, which the Measure responds to, will continue to impact the health and aged care systems. There is significant pressure on the sector due to ongoing reforms.

As reported in the Mid-point evaluation report, ongoing initiatives and reforms across health and aged care impact implementation of the Measure. These include:

- ongoing implementation of recommendations from the Royal Commission
- new voluntary assisted dying legislation in all states and territories, and implementation underway
- residual and ongoing impacts of COVID-19, including RACF lockdowns and workforce shortages
- broader workforce shortages, particularly for roles that are key to palliative care, such as GPs, nurses and nurse practitioners (NPs), and in regional, rural and remote area.

Table 3 outlines the current policy, stakeholder and operating context of the Measure. Activity across these domains impacts the ability of the evaluation to contribute to observed changes.

**Table 3 Policy and operating context of the Measure**

<b>Policy context</b>	<ul style="list-style-type: none"> <li>• Comprehensive Palliative Care in Aged Care Measure</li> <li>• National Palliative Care Strategy</li> <li>• End-of-Life Direction for Aged Care</li> <li>• Australian National Aged Care Classification (AN-ACC)</li> <li>• Aged Care Quality Standards</li> <li>• Jurisdictional strategies and policy frameworks</li> <li>• AHHA Palliative Care Online Training</li> <li>• Mandatory Quality Indicator Program</li> <li>• Program Of Experience in the Palliative Approach</li> <li>• National Safety and Quality Health Standards</li> <li>• Palliative Care Standards</li> <li>• Palliative Care Outcomes Collaboration</li> </ul>
<b>Stakeholder environment</b>	<ul style="list-style-type: none"> <li>• Australian Government</li> <li>• State and territory governments</li> <li>• Residential aged care facilities</li> <li>• Specialist and non-specialist palliative care providers</li> </ul>

	<ul style="list-style-type: none"> <li>• Aged care and palliative care peak bodies</li> </ul>
<b>Operating environment</b>	<ul style="list-style-type: none"> <li>• Royal Commission into Aged Care Quality and Safety</li> <li>• 2023-24 Budget</li> <li>• Aged care labour market reforms</li> <li>• COVID-19 related impacts</li> <li>• Voluntary assisted dying legislation implementation</li> <li>• High workforce mobility, turnover and shortages</li> <li>• Shifting community expectations for person-centred and holistic care</li> <li>• Trends in the health and aged care sector towards integrated care, values-based care and digital health</li> </ul>

#### 4.1.1 Recent reforms may also impact the context of the Measure

Since the Mid-Point Report in July 2022, there have been key national reforms that have had, and are expected to have, an impact on health and aged care sectors, and the Measure. These include:

##### **Implementation of the Australian National Aged Care Classification (AN-ACC) funding model.**

The AN-ACC funding model is the primary funding model of residential aged care in Australia and was implemented in October 2022, replacing the Aged Care Funding Instrument (ACFI).<sup>8</sup> Independent assessors consider residents' care needs and assign aged care providers with funding based on the residents' assessment.<sup>9</sup> The new model separates funding assessments from care planning, enabling the RACFs to focus on understanding the resident's needs, goals and preferences.<sup>10</sup> Unlike ACFI, AN-ACC is not prescriptive in the specific care activities that are funded.

##### **Introduction of additional indicators in the National Aged Care Mandatory Quality Indicator Program.**

In April 2023, in response to recommendations in the Royal Commission, the National Aged Care Mandatory Quality Indicator Program (QI Program) was expanded.<sup>11</sup> The QI program requires residential aged care providers to report every three months on key areas of aged care, and aims to improve quality of aged care services and achieve better health outcomes for residents.<sup>12</sup> It was expanded to include six additional indicators related to daily living activities, incontinence care, hospitalisation, workforce, consumer experience and quality of life.<sup>13</sup> The additional indicators aim

<sup>8</sup> Australian Department of Health and Aged Care, Residential Aged Care Funding Reform, 2022. Accessed at <https://www.health.gov.au/topics/aged-care/aged-care-reforms-and-reviews/residential-aged-care-funding-reform>

<sup>9</sup> Ibid.

<sup>10</sup> Ibid.

<sup>11</sup> Australian Department of Health and Aged Care., New residential aged care quality indicators, 2022. Accessed at <https://www.health.gov.au/news/new-residential-aged-care-quality-indicators>

<sup>12</sup> Ibid.

<sup>13</sup> Ibid.

to improve data quality and increase coverage of data across key elements of care but may also create additional data collection and reporting requirements for RACF staff.<sup>14</sup>

### **Introduction of aged care labour market reforms aim to mitigate workforce challenges.**

Reforms have been implemented recently to mitigate workforce shortages and attract and retain skilled staff. These include:

- A 15 per cent pay increase for three quarters of residential aged care workers covered by certain awards, as of 30 June 2023.<sup>15,16</sup> This includes personal care workers, nursing assistants, enrolled nurses, registered nurses, NPs working in aged care and home aged care workers.<sup>17</sup>
- The introduction of the Aged Care Industry Labour Agreement to reflect the contemporary role that migration can play in investing in skills and training in the aged care sector.<sup>18</sup> The Agreement promotes recruitment by allowing employers to sponsor direct care workers on skilled visas, including an expedited two-year pathway to permanent residency.<sup>19</sup>

### **Commencement of Voluntary Assisted Dying (VAD) laws in all states.**

The implementation of VAD legislation promotes patient autonomy which has potential to complement improved palliative care quality and safety to offer people more choice around how, and when, they die.<sup>20</sup> VAD legislation has been passed in all states but remains prohibited in the ACT and the Northern Territory.<sup>21</sup> In Victoria, Western Australia, Tasmania, Queensland and South Australia, VAD is operating and available to those that meet the eligibility criteria. VAD laws in NSW will commence on 28 November 2023.

It is unclear how VAD and palliative care services will interact. The peak body for palliative care in Australia, Palliative Care Australia (PCA), notes that VAD is separate to palliative care, however people may choose to receive palliative care while undertaking the VAD process. They also acknowledge that palliative care health professionals can choose whether to become authorised practitioners who can provide VAD to patients.<sup>22</sup> In NSW the peak body for palliative care has

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<sup>14</sup> Australian Department of Health and Aged Care, National Aged Care Mandatory Quality Indicator Program (Qi Program) Manual Part A – Version 3. 2022.

<sup>15</sup> United Workers Union, Aged Care Workers' Pay Rise Addresses Neglect., 2023.

<sup>16</sup> Australian Department of Health and Aged Care. A tripartite approach to address workforce shortages in aged care, 2023. <https://www.health.gov.au/ministers/the-hon-anika-wells-mp/media/a-tripartite-approach-to-address-workforce-shortages-in-aged-care>

<sup>17</sup> The Aged Care Award 2010, Nurses Award 2020 and Social, Community, Home Care and Disability Services Industry Award 2010

<sup>18</sup> Australian Department of Health and Aged Care. Skilled migration program, 2023.

<https://immi.homeaffairs.gov.au/what-we-do/skilled-migration-program/recent-changes/new-aged-care-industry-labour-agreement>

<sup>19</sup> Ibid.

<sup>20</sup> RACGP, (2019) Will palliative care and voluntary assisted dying clash – or collaborate?. NewsGP.

<sup>21</sup> ELDAC. (2023) Overview of Voluntary Assisted Dying.

<sup>22</sup> Palliative Care Australia, VAD Position Statement, available at:

<https://palliativecare.org.au/statement/palliative-care-and-voluntary-assisted-dying-position-statement-2022/>

released a statement asserting that voluntary assisted dying is not part of palliative care practice.<sup>23</sup> Further consideration will be given to this contextual factor in future data collection and as VAD models of care mature.

## 4.1.2 There are other significant challenges facing the aged care sector

### **Workforce shortages are a major concern in the aged care sector.**

Significant workforce shortages in the aged care sector affect the implementation and success of the Measure. The Skills Priority List labels direct care occupations in the aged care sector in national shortage.<sup>24</sup> In 2021, the aged care worker shortage doubled in less than 12 months, increasing from 17,000 to 35,000.<sup>25</sup> Reasons for workforce shortages reported by states and territories in 2022 include:

- Ongoing staff furloughs related to the COVID-19 pandemic, creating extra demand on specific roles or teams.
- Other residual impacts of the COVID-19 pandemic on the workforce including staff exits during the pandemic (and a lack of recovery of staff that left) and ongoing burnout of staff that remained in the sector.
- Ongoing high turnover of staff within the residential aged care sector, due in part to the burden and complexity of the work relative to remuneration, and time-limited funding for specific roles.
- Challenges in recruiting to clinical roles, particularly in regional, rural and remote areas.

### **The aged care sector is experiencing financial strain, reportedly due to residual effects of the COVID-19 pandemic and implementing reforms in response to recommendations from the Royal Commission.**

Despite having made progress recovering after COVID-19, the aged care sector has reported significant financial strain. Residual debts from expenses incurred for infection control measures and additional staffing and reporting requirements are reported to be continuing causes of financial pressure for RACFs. In July 2023, 54 per cent of RACFs in Australia were reported as operating at a loss.<sup>26</sup> Some stakeholders suggest this is compounded by additional costs of implementing reforms in response to Royal Commission recommendations – particularly the 15 per cent pay increase for three aged care awards and the requirement to have a registered nurse on site at RACFs 24 hours a day, seven days a week.

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<sup>23</sup> Palliative Care NSW Inc (PCNSW) Position Statement, available at: <https://palliativecarensw.org.au/wp-content/uploads/2021/11/Position-Statement-VAD-Palliative-Care-NSW.pdf>

<sup>24</sup> Australian Department of Health and Aged Care. (2023) A tripartite approach to address workforce shortages in aged care.

<sup>25</sup> CEDA (2021) Duty of Care: Meeting the Aged Care Workforce Challenge.

<sup>26</sup> ABC, (2023) VIDEO: Aged Care sector under pressure due to COVID-19 grant payment delays.

## 5 Interim evaluation findings

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This section provides interim evaluation findings on:

- Progress in implementing the Measure and lessons from implementation to date (section 5.1).
  - The appropriateness of the Measure in meeting the needs of residents, families, carers and staff (section 5.2).
  - Interim progress against the national outcomes where possible (section 5.3). The Final Report in 2024 will provide a detailed assessment of progress against national outcomes.
  - Models of care being implemented in states and territories (section 5.4).
  - The extent to which the Measure is addressing interface issues at this stage (section 5.5).
  - The effectiveness of the joint funding and delivery arrangements (section 5.6).
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### 5.1 Implementation progress and lessons to date

#### 5.1.1 Key findings

- At this stage, the Measure has funded 54 projects and 99 FTE, and has impacted over 1,250 RACFs.
- All jurisdictions have been delivering on the Project Agreement responsibilities to date.
- All jurisdictions signed up to the Measure, with some significantly delayed in doing so.
- All states and territories have commenced implementation; those that were delayed at the Mid-point evaluation report have made significant progress.
- Implementation has been enabled by collaboration across the health and aged sectors, flexible funding and governance support.
- Aged care workforce shortages and high turnover have created challenges, and difficulty with recruitment has impeded implementation.

#### 5.1.2 Delivery against Project Agreement responsibilities to date

**The Project Agreement outlined responsibilities for the Australian Government, states and territories.**

As reported in the Mid-point report, the Project Agreement outlined the Measure aims, financial arrangements and responsibilities of governments.<sup>27</sup> States and territories subsequently signed

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<sup>27</sup> National Project Agreement for Comprehensive Palliative Care in Aged Care. 21 July 2020. Commonwealth of Australia.

specific schedules that outlined their individual funding arrangements, planned projects, and outputs and reporting milestones.

**All jurisdictions have been delivering on the Project Agreement responsibilities to date.**

The Australian Government and states and territories have been delivering on responsibilities in the Project Agreement. An assessment of delivery against responsibilities was provided in section 4.1.1 and Appendix E of the Mid-point report. Table 4 provides an updated assessment.

**Significant progress in implementation has been made since the Mid-point report.**

- South Australia has completed piloting the Eldercare Hospice in Aged Care pilot model and commenced the roll out of needs rounds at all their facilities. Eldercare has been contracted as a system leader to support four non-Eldercare facilities to implement PCNRs, to promote workforce capability sustainability.
- The ACT has continued to implement the PCNR model. All 29 facilities in the ACT are implementing at least one component of the PCNR model (needs rounds, case conferences or referrals to specialist palliative care clinical work).
- At the Mid-point Report, Tasmania was in the early stages of the GP Registrar program, with only one registrar recruited at that point in time. Since then, a total of five six-month rotations for GP registrars in palliative care have been completed or commenced. They have also continued rolling out the CNC in-reach services model with needs rounds in all three CPCiAC program regions.
- The Northern Territory and Western Australia have continued implementation. In the Northern Territory, services have been expanded to additional RACFs and in Western Australia, new models of care have commenced in some projects.

**Table 4 Interim assessment of delivery against responsibilities in the Project Agreement<sup>28</sup>**

Stakeholder	Responsibilities	Delivery on responsibilities
Australian Government	<ul style="list-style-type: none"> <li>• Monitoring and assessing achievement against milestones in the delivery of projects to ensure that outputs are delivered within the agreed timeframe.</li> <li>• Providing a consequent financial</li> </ul>	<p>As reported in the Mid-point report, the Australian Government continues to meet the responsibilities outlined in the Project Agreement and support the Measure’s implementation. The Department:</p> <ul style="list-style-type: none"> <li>• has been monitoring achievement against jurisdictional milestones through assessing specific performance reports, received April each year</li> <li>• has provided funds to jurisdictions on sign-up to the Measure</li> <li>• has commissioned an independent national evaluation which started in 2020</li> </ul>

<sup>28</sup> Commonwealth of Australia. Responsibilities as outlined in the National Project Agreement for Comprehensive Palliative Care in Aged Care. 21 July 2020.

	<p>contribution to states.</p> <ul style="list-style-type: none"> <li>Delivering a national evaluation by 2023-24.</li> </ul>	<ul style="list-style-type: none"> <li>has conducted five Project Implementation Group meetings.</li> </ul>
<b>States and territories</b>	<p>Financial contribution matched by Australian government, project proposal, delivering project outputs and reporting.</p>	<p>As reported in the Mid-point report:</p> <ul style="list-style-type: none"> <li>All states and territories are providing matched financial contributions to support implementation of the Project Agreement to date.</li> <li>All states and territories submitted proposals and supporting evidence after signing up to the Measure.</li> <li>All states and territories are working towards delivering project outputs set out in the Project Agreement. Implementation progress has improved since the Mid-point report, due to progress in recruitment and reduced impacts of COVID-19.</li> </ul> <p>As of August 2023, all states and territories have been reporting on the delivery of outputs set out their agreements. All states and territories provided annual milestone performance reports to the Department in 2021, 2022 and 2023. Payments were made to all jurisdictions in 2022-23.</p>
<b>States and territories</b>	<p>Evaluating their agreed projects, to contribute to the overarching evaluation of the Measure.</p>	<p>The national Project Agreement outlines a responsibility for states/territories to evaluate their projects, however jurisdictional evaluations vary in status:</p> <ul style="list-style-type: none"> <li>South Australia – completed, report provided.</li> <li>Queensland, ACT – in progress. Interim evaluation report currently undergoing internal approvals.</li> <li>Tasmania, Victoria, Western Australia, NSW – in progress.</li> <li>Northern Territory – not conducting an evaluation but conducting monitoring activities.</li> </ul> <p>To date, all states/territories have contributed to the national evaluation through input on the Evaluation Framework, completion of six-monthly data collection templates and participation in six-monthly consultations with evaluators.</p>



	All jurisdictions except Victoria contributed to July 2023 data collection to inform the Interim Report.
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**At this stage, the Measure has funded 54 projects and 99 FTE, and has impacted over 1,250 RACFs.**

All states and territories consulted in July 2023 reported ongoing implemented progress of CPCiAC activities. Projects funded by the Measure are described in Table 5 and Table 6 and further detail on approaches in each jurisdiction is provided overleaf and in Appendix A.

**Table 5 Projects funded by the Measure, by jurisdiction**

Jurisdiction	Projects	Count
ACT	One Palliative Care Needs Rounds (PCNR) model incorporating needs rounds, case conferences and specialist palliative care referrals.	1
NSW	Each of the 16 LHDs have been funded to design and implement their own projects.	16
VIC	Five workstreams are being implemented across Victoria including to enhance existing models of care, build local capacity, improve assessment tools, resources on goals of care and a resident Elders program providing access to culturally safe palliative care.	5
WA	Nine projects across three workstreams, including an expansion of specialist in-reach support for metropolitan RACFs, developing RACF workforce capability and capacity, and seven smaller projects including to improve the transition for residents between hospitals and RACFs.	9
SA	Three projects implemented by two providers, Eldercare (one) and Regional Support Services (RSS) (two).	3
Tas	Three workstreams including CNC led in-reach into RACFs to conduct needs rounds, palliative care focused registrar training positions for GP registrars, and funding brokerage for allied health on an as-needs basis.	3
NT	Two projects implemented, one in Central Australia focused on education for RACFs, including site visits and referrals, and one in the Top End providing regular needs rounds and education for RACFs.	2
QLD	Each of the 15 HHS have been funded to design and implement their own projects, with central support.	15
Total		54

Table 6 Projects planned and implementation progress by jurisdiction

State/territory	Total funding	Implementation progress	Early insights	Evaluation
<b>Australian Capital Territory</b>	\$2.2million 29 RACFs 4.6 FTE	ACT has implemented the Palliative Care Needs Rounds (PCNR) model to all RACFs. PCNR is business-as-usual. At least one component of the model is implemented in all 29 RACFs in the ACT. Recruitment of Nurse Practitioners has been challenging. Implementation is on track.	The PCNR model is improving the ability of RACF staff ability to respond to resident needs. The case conferences promote collaboration from across the health and aged sector. Staff burnout can be attributed to the burden of clinical supervision.	Yes, complete.
<b>New South Wales</b>	\$20million 404 RACFs 13 FTE	NSW has a devolved approach, where each Local Health District (LHD) have developed initiatives to reflect local needs. Most LHDs are doing some variation of enhanced in-reach care or needs rounds. Implementation is on track.	Some LHDs have adapted from a needs rounds model to a more consultative, bedside approach on an as-needed basis, to account for resourcing constraints.	Yes, not focused on the Measure. Annual reporting
<b>Northern Territory</b>	\$1million 13 RACFs 1.2 FTE	NT is conducting in-reach needs rounds or screening rounds at RACFs and education and training through weekly visits and case debriefs. COVID-19 initially put these projects on hold, but they are now operating as planned. Top End: Implementation is on track. Central Australia: Implementation is on track.	A strong relationship has been built between the RACFs, community nurses and the specialist palliative care team. Education sessions have been well received and have equipped RACF nursing staff with skills to manage symptoms and residents.	No. There is ongoing monitoring.

<b>Queensland</b>	\$18million 433 RACFs 40.3 FTE	QLD has a devolved approach where each Hospital and Health Service (HHS) has a Specialist Palliative Care in Aged Care project team who developed appropriate service models. Recruitment to specialist roles in many HHSs are a challenge.  Implementation is on track.	Proactive models of care (such as needs rounds) are enabling issues to be pre-empted and referrals to specialist services reduced, particularly “in crisis” referrals. Though it takes more time, RACFs report being less overwhelmed.	Yes, commenced.
<b>South Australia</b>	\$7.7million 22 RACFs 18.9 FTE	SA have developed three projects including Hospice in Aged Care, Hospice in the RACF and GP Education and Engagement. Regional areas are a focus. The Hospice in Aged Care pilot project has finished and is now being expanded to more RACFs.  Implementation is on track.	The traineeship program, part of the Hospice in Aged Care project, has increased capacity and improved palliative care knowledge, and confidence among staff by triggering conversations of PC and embedding processes at an operational level.	Yes, complete.
<b>Tasmania</b>	\$2.3million 67 RACFs 5.5 FTE	TAS projects are progressing well. They are designed to provide case-based education through discussion at needs rounds, encourage GP involvement in palliative care and facilitate access to allied health support. Implementation is on track.	Case-based education is being encouraged at needs rounds, led by the CPCiAC clinical nurse consultants. Collaboration with GP registrars is showing benefits, with one GP registrar becoming a palliative care consultant.	Yes, commenced but delayed.

<b>Victoria</b>	\$28.4million	Progressing well after significant implementation delays. Victoria's five workstream activities have commenced. Implementation is on track.	GP engagement has been supported through information sessions and establishing local network with palliative care providers and clinicians. Projects have built on existing procedures and infrastructure.	Yes, commenced.
<b>Western Australia</b>	\$11.4million 285 RACFs 15.2 FTE	WA has eight of their nine projects implemented, with the one remaining project currently being finalised with a provider. Implementation is on track.	CPCiAC projects that built on infrastructure and relationships of existing projects have been more effective than new initiatives. Stakeholder needs were identified through consultation prior to implementation.	Yes, commenced.

### 5.1.3 Lessons from implementation to date

#### **Flexible Measure funding has enabled an effective context-specific approach.**

- The flexible approach to use of funds has enabled jurisdictions to develop and implement models of care relevant to their unique local contexts and demographics.
- In Queensland, decision-making authority has been delegated to each HHS to use funding to design and deliver individual models of care. A central team with the Health Department worked with each HHS to develop service profiles and appropriate models of care. This effectively enabled vastly different areas (e.g., metropolitan Brisbane, Torres Cape and Central West) to tailor models of care to be best suited to their service needs.
- In Queensland, South Australia, Tasmania and Western Australia, the central Measure-focused staff within the state health departments have played a significant role in providing coordination support to Measure funded teams. In South Australia, this has included providing significant oversight to RSS, one of the providers of the Measure funded activities, due to their challenges with staffing and project coordination. Jurisdictions reported that funding these central roles has been a challenge due to the lack of designated funding for them in the Measure.

#### **The Measure has enabled genuine collaboration between GPs and RACFs, NGOs and government service providers to provide better support to residents.**

- Case conferencing and needs rounds across multiple jurisdictions have reportedly increased resident access to nursing and primary care staff, as well as GPs and specialist teams. Jurisdictions that have implemented needs rounds and/or multidisciplinary case conferences report that they have fostered collaboration between aged care, medical and allied health staff to deliver better quality care for residents.
  - In Tasmania, Measure-funded GP registrars attend needs rounds led by Measure-funded CNCs.
  - In Western Australia, GP case conferencing coordinators are supporting primary care coordination between GPs and RACFs to provide an additional resource to RACFs and reduce administration burden on GPs.
  - In the ACT, case conferences bring together RACF and GPs (as well as the resident and their relatives) to discuss how to improve the resident's quality of life, including completing an ACP.
  - South Australia reported the Measure has fostered collaboration across sectors, including between service providers, Eldercare and RSS, who have provided staffing support to each other when required, despite running separate projects.

#### **Jurisdictions and local health networks have adapted their approaches to address resourcing constraints.**

- NSW reported local approaches have been re-designed and/or refocused to accommodate for staff shortages and turnover, such as shifting from a formalised needs rounds model to a more consultative approach via referral pathways.
- Tasmania has developed mini-needs rounds to simplify the process for RACF staff and promote more engagement, mitigating staffing shortages. This also includes phone support and video conferencing when staff are unable to attend face-to-face.

**Staff shortages and workforce turnover continue to be a challenge, with the long-term impact of training inhibited due to staff turnover.**

- All jurisdictions reported challenges with implementing the Measure due to ongoing high staff turnover in the aged care sector. South Australia, Tasmania and Queensland in particular reported ongoing issues with turnover that impact the ability to retain an adequately and appropriately skilled workforce in those jurisdictions.
  - Queensland reported the biggest challenge is maintaining a trained regional workforce, both in RACFs and in the local Specialist Palliative Care in Aged Care (SPACE) representatives. Each HHS in Queensland has at least one Measure-funded SPACE representative to support locally developed models of care for activities funded by the Measure.
  - Staff shortages in Tasmania have impacted the ability of facilities to prepare for and attend needs rounds, adapting this model (as described above). They also reported that capacity building programs in RACFs often have to restart as staff leave the facility.
  - The ACT reported that the psychological burden of providing palliative care, particularly compounded by residual burnout from the COVID-19 pandemic, is a major contributor to workforce turnover and burnout among RACF staff.
- Queensland reported that they initially funded training in a way that assumed less workforce mobility, focusing on larger training initiatives in the middle of their implementation timeline. A key lesson identified from this was that a lower level of smaller, more consistent funding for ongoing training would be more effective, given high workforce turnover and the importance of maintaining skills.

**Recruitment into Measure-specific roles has been challenging, especially in regional areas and where roles require supervision.**

- The Northern Territory have been unable to recruit to a specific role in the Central Australia palliative care team, leading to work being shared among existing staff to ensure it is still delivered.
- In the ACT, ongoing implementation is dependent on the recruitment to NP positions. The ACT reported barriers to recruitment being insufficient mentors to support NP candidates and a transition NP role not being covered by the ACT Public Sector Nursing and Midwifery Enterprise Agreement 2020-2022.
- Western Australia reported difficulty recruiting a Transition Support Officer (TSO), causing delays in implementation of their TSO pilot program.

### **Jurisdictions reported that more detailed assessment of the RACF need and upfront planning could help to better target palliative care services in the future.**

- Multiple jurisdictions reported that the success of Measure activities would benefit from a better baseline understanding the state of RACF staff capability, and that this could help target future efforts to where they are really needed.
- Western Australia reported one of their education providers undertook broad consultation to understand need and found it beneficial in informing the redesign of their training course when pivoting from face-to-face to virtual delivery.
- Victoria also conducted a scoping review in 2021-22 prior to Measure implementation to identify staff knowledge gaps and test the level of interest of RACF management staff to support their employees to participate in CPCiAC projects.
- South Australia identified a major challenge was the lack of time and resources at the outset of Measure implementation dedicated to organisational preparedness, planning and time to set up governance structures, recruit staff and engage with key stakeholders.
- The ACT plans to focus the next phase of their evaluation on understanding the barriers to RACFs to engagement in the PCNR model, and to inform strategies to improve engagement and sustainability.

### **There is ongoing evidence that the unweighted funding design has led to implementation challenges.**

- Some evidence suggests that the current funding distribution method for CPCiAC activities may not align equitably with the needs or barriers faced by rural and regional areas across jurisdictions. Queensland reported that it bases its funding distribution on the number of RACF beds, without considering specific regional challenges. Meanwhile, South Australia is using remaining CPCiAC funds to conduct a benchmarking exercise, seeking to understand existing capabilities and needs in RACFs across the system. This will guide better targeting of future funding to areas with identified needs.

## **5.2 Appropriateness of the Measure**

### **By design, the Measure is an effective mechanism to meet the needs of residents, families, carers, staff and the system.**

As described in the Mid-point report (see section 4.2) there are three ways in which the design of the Measure is appropriate to meet the needs of residents, families, carers and staff:

1. **The design of the Project Agreement defined aims that matched evidence on needs** by suggesting that funded initiatives focus on models of care that 'include assessment to establish palliative care needs'<sup>29</sup> and on education and training for 'the RACF workforce and other

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<sup>29</sup> Nous Group, Literature review summary report – National Evaluation of the CPCiAC, 2020.

clinicians’.<sup>30</sup> Despite this, in practice this assessment could have been done better and could have better anticipated what was needed to achieve it.

2. **The funding mechanism facilitates greater collaboration at the health and aged care interface** by providing funding and delivery support. Section 5.6 of the Interim report explores the effectiveness of the joint funding and delivery mechanism.
3. **The Measure allows for flexible approaches to meet local needs**, allowing states and territories to design activities that respond to local contexts and flexibility to either implement new approaches to palliative care, or expand existing models of care.

Nous conducted a literature review as part of the early stages of this evaluation.<sup>31</sup> It identified eight common palliative care needs for RACF residents, as well as common needs of families, carers, staff and the broader system (summarised in Table 7). ‘System needs’ refer to needs at the Australian Government (predominantly related to the aged care system and primary care system) and state and territory government level (predominantly related to health care systems).

**Table 7 Summary of needs of residents, families, carers and staff<sup>32</sup>**

<b>Resident needs</b>	<p>Across supports and services, evidence indicates that RACF residents need care that is <b>culturally appropriate, coordinated and flexible</b> to meet their individual needs and preferences.</p> <ul style="list-style-type: none"> <li>• Nursing and medical support.</li> <li>• Pain and symptom management.</li> <li>• Multidisciplinary and specialist medical support to manage complex medical needs.</li> <li>• Avoidance of unnecessary hospitalisations and procedures.</li> <li>• Involvement in decision-making including advance care planning.</li> <li>• Case conferencing and care coordination.</li> <li>• Counselling and psychosocial support.</li> <li>• Spiritual support.</li> </ul>
<b>Families/carer needs</b>	<ul style="list-style-type: none"> <li>• Education and access to information.</li> <li>• Emotional, spiritual and psychological support.</li> <li>• Respectful support and involvement including bereavement.</li> </ul>
<b>Staff needs</b>	<ul style="list-style-type: none"> <li>• Access to clinical staff when needed.</li> <li>• Training, support and supervision to identify palliative care needs.</li> <li>• Appropriate referral pathways.</li> <li>• Education in symptom management.</li> </ul>

<sup>30</sup> Commonwealth of Australia, National Project Agreement for Comprehensive Palliative Care in Aged Care. 21 July 2020.

<sup>31</sup> Nous Group, Literature review summary report – National Evaluation of the CPCiAC, 2020.

<sup>32</sup> Nous Group. Literature review summary report – National Evaluation of the CPCiAC, 2020.



	<ul style="list-style-type: none"> <li>• Time and resources to deliver care.</li> <li>• Training to engage with residents and families.</li> </ul>
<b>System needs</b>	<ul style="list-style-type: none"> <li>• Ability to communicate with patients, carers and families about palliative care needs, death and dying.</li> <li>• Appropriate facilities, workforce and funding to provide care.</li> <li>• Communication channels across the health system, including with other RACF staff and hospitals.</li> <li>• Appropriate education and training options underpinned by competency and capability frameworks.</li> </ul>

### 5.2.1 Resident needs

- **All states and territories have funded activities focused on addressing residents' clinical needs.** This includes through improved nursing and medical support, case conferencing and care coordination, and specialist medical support to manage complex medical needs through Measure-funded activities.
- **Three states have funded activities to meet cultural needs.** Western Australia has been delivering cultural education for RACF staff relating to communications for Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse (CALD) communities. Queensland has had success developing a community-informed model of care through consultation with Aboriginal and Torres Strait Islander communities in their Torres and Cape SPACE project (see Case study 4, page 41). As reported through Project Implementation Group updates, Victoria is partnering with Aboriginal and Torres Strait Islander organisations to develop models of care to support access to culturally safe palliative and end-of-life care.
- **Activities are less likely to address the psychosocial and spiritual needs of residents.** States and territories were less likely to indicate that activities provided counselling or psychosocial supports. Tasmania has commenced an allied health project whereby a social worker has been engaged to support residents, carers and families.
- **All states and territories have projects that seek to improve the quality of or discussions about ACPs.** ACT conducts case conferences with residents and families that target ACP completion and Western Australia, under the nurse liaison role, aims to improve a resident's access to ACPs once referred to the MPaCCS. South Australia has been working with local councils to deliver workshops to increase understanding and awareness of ACPs in the community (see Case study 2, page 38).

### 5.2.2 Family and carer needs

- **Three jurisdictions have funded activities to meet the educational needs of families and carers.** South Australia have developed resources to support staff to manage grief and bereavement informed by existing end-of-life resources adapted to suit the aged care context and through the engagement with a bereavement social worker. The Northern Territory and

ACT are including family members and carers in case conferences with residents, where appropriate, to increase their inclusion and understanding of the end-of-life planning process. In other states, family and carer needs are indirectly focused on through Measure activities. For example, those implementing needs rounds build staff capacity to respond to family and carer needs through ACP review for residents.

### 5.2.3 Staff needs

- **All states and territories are seeking to meet the capability building needs of clinical and non-clinical staff.** At least three jurisdictions (Queensland, South Australia and Western Australia) have funded either formal or one-off education and training or more informal 'case-based' education (e.g., Northern Territory) for clinical staff and personal care workers in RACFs. Six jurisdictions are conducting needs rounds, which incorporate an education component for personal care workers, nurses and clinical staff. South Australia has piloted a successful personal care worker traineeship program to improve capacity of RACF staff (see Case study 1, page 30).

**The following evidence was reported in the Mid-point report, and no updated or conflicting evidence arose in recent reporting to the national evaluation:**

- **Two states have funded specific roles to address medication management needs.** The project pharmacist has invited community pharmacists in local regional areas to attend needs rounds to discuss residents. Future work will engage community pharmacists to address medication challenges. ACT has NPs who attend needs rounds to prescribe appropriate medications pre-emptively to support after-hours access to medications. South Australia has employed a project pharmacist to attend needs rounds to identify and reduce medication mismanagement.

#### **Case study 1: In South Australia, Eldercare's traineeship pilot program had notable success with overwhelming demand.**

South Australia used part of their CPCiAC funding to contract Eldercare to conduct their 'Hospice in the RACF project'. Part of this project included a 12-month traineeship to upskill aged care workers who would ultimately earn a Certificate III in Individual Support (Aged Care)<sup>33</sup>, awarded through an external registered training organisation. The traineeship program aimed to improve the knowledge and skills of personal care workers in identifying deterioration and palliative care needs in residents.

The pilot included a total of 27 participants over two cohorts, commencing in February and April 2022. Through the program, 23 trainees completed the Certificate III (awarded after six months) and the 16 who completed the full traineeship were offered an ongoing employment contract within Eldercare facilities. During their course, the trainees completed 120 hours of paid placement and on-the-job training and mentorship within RACFs for 12 months.<sup>34</sup>

Due to the recognised value of the traineeship and education support, South Australia Health approved the redirection of underspent funds to extend palliative care training to non-pilot Eldercare sites. Eldercare subsequently continued the traineeship model and have built this into

<sup>33</sup> Research Centre for Palliative Care, Death & Dying, Flinders University, Comprehensive Palliative Care in Aged Care (CPCiAC) Pilot Projects in South Australia: Final Evaluation Report. May, 2023.

<sup>34</sup> Eldercare, Hospice in the RACF Final Report – Internal, Version 1.0 Final. 2023.

business as usual. Eldercare have since used their own funding to support another cohort of trainees commencing in April 2023.

Eldercare's Hospice in the RACF program won the Innovation in Palliative Care award at the National Palliative Care Awards 2023.

## 5.3 Reporting against national outcomes

### 5.3.1 About the Mid-point assessment

The Mid-point assessment was conducted in 2022. It included an updated baseline assessment against the ten national outcomes of the evaluation, and emerging findings against the outcomes and the KEQs. The Mid-point evaluation report drew on the following data sources:

- NIHSI-AA and other national datasets, including ELDAC, PCOC, AHHA and ACQSC
- Qualitative data collected from states and territories
- Consultations with state and territory governments, RACF representatives, specialist and generalist clinicians, and peak bodies.

This report provides updated emerging findings against the national outcomes of the evaluation and the KEQs based on qualitative and quantitative data collected from states and territories, and other national datasets, including ELDAC, PCOC, AHHA and ACQSC.

### 5.3.2 Updated interim assessment against national outcomes

A summary of the interim assessment against the national outcomes is provide in below..

The following pages provide an updated assessment against each national outcome. These provide:

- a summary of the baseline, mid-point and interim assessments for each outcome
- updated emerging insights on progress being made against national outcomes, supported by evidence collected through quantitative and qualitative data analysis, consultation with jurisdictions since April 2022 and national datasets where available.

Each outcome aligns to a component of the National Palliative Care Strategy, identified by the Strategy goals of: Understanding, Access and choice, Collaboration, and Data and evidence.

#### Summary of interim assessment against the national outcomes

In summary, the emerging insights indicate that at the time of this report:

- **End-of-life decision making:** There is some evidence of improved advance care planning across jurisdictions through greater use of documentation, increased involvement of GPs and more proactive conversations with families. Some evidence still suggests that not all RACFs are proactively providing information, although there is an increased focus on resident-centered discussions and a request from providers for more generalised and consistent resources for staff. (Outcome 1, Outcome 2)

- **Capability:** Training programs are embedded into practice in many RACFs including through needs rounds and targeted onsite palliative care and clinical deterioration training programs. There is emerging evidence to suggest that RACFs are more equipped to identify and escalate responses for residents with palliative care needs and deliver palliative care. (Outcome 3)
- **Access to palliative care:** There is evidence that activities funded under the Measure are leading to improved accessibility and availability of palliative care to RACF residents. There is also early progress in improving residents' choice to receive palliative care in the place of their choosing, by providing more options to access palliative within RACFs. (Outcome 4)
- **Quality of palliative care:** While Measure activities are improving the quality of palliative care in some RACFs including with specific programs for Aboriginal and Torres Strait Islander residents, there is significant variability. (Outcome 5)
- **Greater resident choice:** There is still variability in the use of ACPs, however their effectiveness may be improving. Additional evidence suggests a potential increase in cultural safety and consideration of dignity for RACF residents receiving end-of-life care and improved ability of RACFs to provide palliation. (Outcome 6)
- **Care coordination:** All jurisdictions continue to report greater involvement of specialist care services in RACFs and further evidence that care coordination has improved in some jurisdictions. Continued focus is being placed on GP participation including through virtual care models to facilitate care coordination across multidisciplinary teams. (Outcome 7)
- **Health and aged care interface:** There is evidence in some jurisdictions that relationships are being strengthened between RACFs and healthcare providers. (Outcome 8)
- **Performance information:** Most jurisdictions are conducting their own evaluations related to the Measure all at varying states of completeness. Jurisdictions continue to face difficulties in accessing data that can be used for evaluation, including the limited reporting to PCOC's and the delay of NIHSI-AA. (Outcome 9)
- **Clinical governance:** There is emerging evidence of Measure activities improving clinical governance and quality improvement initiatives. Complaints related to palliative care continue to be low in 2023 (~one per cent) however there is still an opportunity for RACFs to improve governance systems, frameworks and risk management, based on Aged Care Quality Standards data. (Outcome 10)

### Outcome 1: More discussions focused on end-of-life care decision making between residents, families, carers, GPs and specialist palliative care services including use of ACPs.

**Baseline assessment:** The majority of RACFs reported that most residents have ACPs in place and the majority of RACFs are compliant with Aged Care Standards relating to ACPs. However, plans may not be regularly updated or used in RACFs.

**Mid-point assessment:** There was emerging evidence of increased discussions around end-of-life care decision making, although there remain some system-level challenges that impede regular discussions around Advance Care Planning.

## Outcome 1: More discussions focused on end-of-life care decision making between residents, families, carers, GPs and specialist palliative care services including use of ACPs.

**Interim assessment:** There is some evidence of improved advance care planning across jurisdictions through greater use of documentation, increased involvement of GPs and more proactive conversations with families. Evidence in the Northern Territory suggests that the use and effectiveness of ACPs may be impacted by cultural differences.

### Outcome 1: Emerging interim findings

#### **There is ongoing evidence of more discussions being conducted that focus on end-of-life care decision making.**

Evidence of emerging progress against this outcome includes:

- **Measure activities are helping to improve the effectiveness of ACPs and GP's involvement in discussions in South Australia, Western Australia and Northern Territory.**
  - In Western Australia, advance care planning discussions and records are increasing, as a result of higher clinician to resident ratios under the MPaCCS model. In the period between April 2022 to October 2022, Western Australia reported that 89 per cent of all resident episodes of care had an ACP in place or advance care planning discussion.<sup>35</sup> As reported in July 2023, pilot projects across North, South and East Metropolitan Health Services are focusing on increased support for ACP documentation for residents in RACFs and transitional care.
  - In South Australia, clinicians reported that needs rounds led by specialist palliative care consultants are improving GP engagement and coordination with RACFs. Routine analysis of ELDAC After Death Audits revealed a 30 per cent increase in case conferences held to discuss residents' palliative care needs, to 52 per cent of all deceased patients across regional sites over the course of the project<sup>36</sup>
  - Needs rounds in the Northern Territory are encouraging collaboration between GPs and RACFs to develop plans for residents' end-of-life preferences using ACPs and Goals of Care plans. The Northern Territory reported that one RACF ensures that all residents have ACPs on arrival into the RACF, this is either conducted by the clinical NP or referred on to the appropriate parties.
- Queensland reported a significant increase in ACP documentation since commencement of the Measure activities but noted the COVID-19 context was a relevant factor which likely prompted residents and families to be more proactive in their end-of-life care planning.

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<sup>35</sup> Reported in the April 2022 to October 2022 six-monthly data collection round and in the Nous Progress Report 6.

<sup>36</sup> Comprehensive Palliative Care in Aged Care (CPCiAC) Pilot Projects in South Australia: Final Evaluation Report. May (2023). Research Centre for Palliative Care, Death & Dying, Flinders University

- Northern Territory stakeholders reported that the use and effectiveness of ACPs may be impacted by cultural differences. Northern Territory RACFs reported some difficulties in completing ACPs with Aboriginal and Torres Strait Islander residents and their families due to differences in cultural views around death and dying, and difficulties in achieving family engagement. Efforts have been made to recruit Aboriginal and Torres Strait Islander personal care workers, however this has been challenging due to high demand for Aboriginal healthcare workers in the community.
- In Tasmania, there are targeted activities to support ACP development, though it is too early to assess the extent of the impacts of these activities. Although implementation is in the early stages, in-reach CNC are supporting RACF staff in the implementation of needs rounds, including the development and re-evaluation of palliative care plans for residents in collaboration with RACF staff to ensure that symptom management and psychosocial needs are being met.

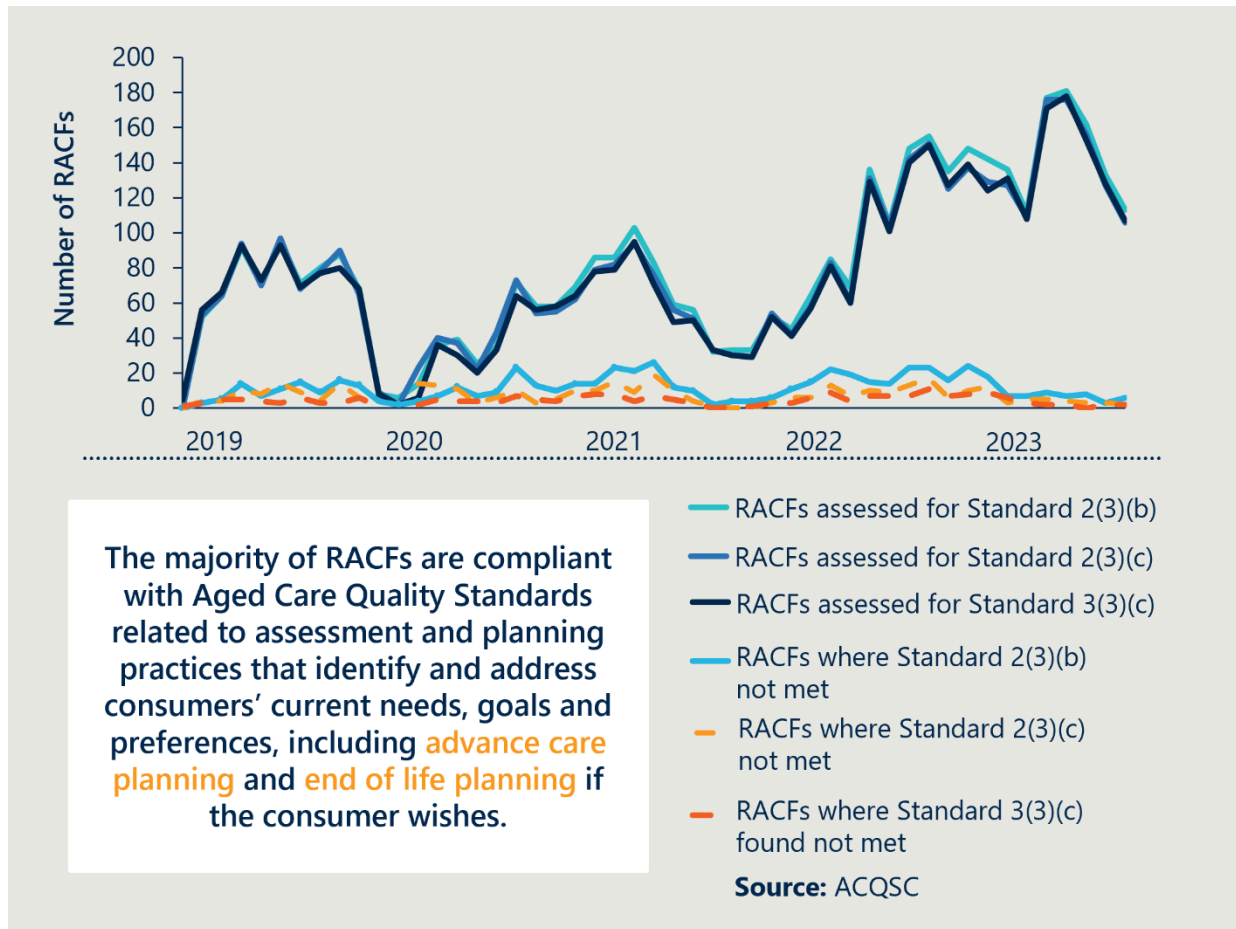
**The majority of RACFs continue to be compliant with Aged Care Standards for assessment and planning practices related to ACPs.**

- Between 2019 to 2023, the majority of RACFs met the Aged Care Quality Standards related to having adequate assessment and planning practices in place to identify and address consumers' current needs, goals and preferences, including ACPs. Of those assessed by the ACQSC, between 85 to 90 per cent met Aged Care Quality Standards 2b, 2c and 3c (see Figure 1).<sup>37</sup> As reported in the Mid-point evaluation report, the proportion of non-compliant facilities increased temporarily during 2020 to 2021, however analysis of 2022 and 2023 data shows that compliance has improved significantly since this period. Nous had previously reported that this drop in compliance may be due to the COVID-19 pandemic. Consultation with the ACQSC has revealed that risk profiling informs when performance assessments are scheduled. During the COVID-19 pandemic, the Commission prioritised services for audit based on relative risk, especially risks associated with COVID-19. Most of the services due for reaccreditation and assessed as higher risk had a site audit in the 2020-21 and 2021-22 financial years (FYs), and a greater proportion of lower risk sites were audited in the 2022-23 FY. This would have affected the number of RACFs assessed as not meeting the standards in those years.

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<sup>37</sup> This is based on the rate of RACFs assessed as 'met' or 'not met' Aged Care Quality Standards 2b, 2c and 3c which relate to assessment and planning that addresses consumer needs, goals and preferences (including ACPs) and which is based on partnership with the consumer and involves who they wish to be involved in the process.

Figure 1 RACFs accessed for Aged Care Quality Standards 2b, 2c, 3c



These emerging findings are evidence of the contribution of Measure-funded activities to the National Palliative Care Strategy Goal 4 (collaboration). They demonstrate early progress in strengthening the funding mechanisms that facilitate advance care planning.

## Outcome 2: Improved access to information that informs end-of-life care decisions for residents and families.

**Baseline assessment:** The majority of RACFs are compliant with Aged Care Standards that require them to involve residents in care planning and services.

**Mid-point assessment:** Early progress was being made in improving the accessibility of information for residents and families relating to end-of-life care, although some evidence showed that not all RACFs were proactively providing information.

**Interim assessment:** Further progress has been made in improving the accessibility of information for residents and families relating to end-of-life care, and while some evidence still suggests that not all RACFs are proactively providing information, there is an increased focus on resident-centered discussions and a request from providers for more generalised and consistent resources for staff.

## Outcome 2: Emerging interim findings

### **Case conferences in the ACT, South Australia and the Northern Territory include family members in decision-making conversations between clinicians and residents.**

- Eldercare sites in South Australia organise family case conferences as recommended through needs rounds. These case conferences focussed on advance care planning, with involvement from the resident's chosen GP and, at times, state-based palliative care services. South Australia reported that they are recording a reduced number of residents with conflict within the family around treatment and care options, from 16 per cent (n=13) to two per cent (n=1).<sup>38,39</sup> Although this reduction cannot be directly attributed to the CPCiAC project activities, it may indicate an improvement in engagement with families through formal and informal meetings.
- In the ACT, case conferences are facilitated by the CPCiAC team or RACF staff, and include facility staff, residents, relatives acting as the legal decision-maker and relevant health care providers. These case conferences focus on concerns from the resident and relative, improving quality of life, goals of care and the completion of an ACP. The ACT reports that case conferencing is performing well and the CPCiAC team are gaining positive engagement.
- In the Top End, Northern Territory, family meetings are held in conjunction with GP case conferences to increase support in the understanding of residents' palliative care needs and establish goals of care. These conferences are also increasing access of family members to information and decision-making surrounding end-of-life care.

### **Resources to inform end-of-life decision-making are providing increasing support for conversations between RACF staff and residents, families and carers in the Northern Territory and Western Australia.**

- RACFs in the Northern Territory use Goals of Care discussion flow charts to guide RACF staff in their conversations with families of residents regarding the palliative care approach in the Top End.
- Western Australia has established a Residential Goals of Care (RGoC) Working Group which includes the WA Country Health Service Coordinator for Aboriginal Health Workers in palliative care. They are providing expertise on the development of staff resources to support culturally safe RGoC discussions with Aboriginal and Torres Strait Islander residents and families including the 'Aboriginal End-of-Life and Palliative Care Framework' and 'Advance Care Planning; Planning Ahead for Your Healthcare' and 'Taking Care of Dying Time' resources.
- Tasmania reports a need for more consistent and generalised resources for care staff, families and residents, which are currently shared on an ad hoc basis. However, the in-reach CNC role is having success in building communication channels between RACF staff and family members regarding resident care (see Outcome 1).

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<sup>38</sup> From the first three months to the final three months of the Eldercare project.

<sup>39</sup> Research Centre for Palliative Care, Death & Dying, Flinders University, Comprehensive Palliative Care in Aged Care (CPCiAC) Pilot Projects in South Australia: Final Evaluation Report. May, 2023.



## **There is an increased focus on resident-centered discussions and ACPs due to CPCiAC Measure activities.**

- In Tasmania, there has been an increase in resident-focused discussions through needs rounds, however residents are not attending needs rounds. Since CPCiAC activities have been implemented (from April 2022 to March 2023) there have been 1,144 resident-focused discussions in needs rounds, discussing 426 unique residents. This has occurred in a total of 251 needs rounds conducted. Prior to CPCiAC implementation in Tasmania, from April 2021 to March 2022, there were no needs rounds and no discussions recorded.
- In South Australia, the use of needs rounds in metropolitan areas has contributed to an increase in the proportion of residents with ACPs and a focus on palliative care case conferences (PCCCs). Between October 2021, when the Eldercare CPCiAC project started, and December 2022, there was a significant improvement in the number of residents in Eldercare sites with an ACP or Advance Care Directive (ACD) completed – from 399 to 621. The Eldercare Hospice in the RACF Final Report stated that while the Palliative Care Services Team was established prior to CPCiAC, the introduction of needs rounds provided an opportunity for training clinical staff in Advance Care Planning. Data collection on PCCCs is limited by Eldercare systems, however between November 2021 to December 2022, at Eldercare CPCiAC project sites, 51 PCCCs were completed and 18 were attended by the GP.<sup>40</sup>
- In South Australia’s rural and regional CPCiAC funded project, there was an increase in the commencement of end-of-life Care Pathway/Care Plans, from 52 per cent to 70 per cent,<sup>41</sup> although the proportion of those who died with a care plan in place decreased. It is not clear why only commencement has increased in these Rural Support Services project sites and not completion. However, South Australia did report some challenges with data collection, particularly in regional areas, due to less mature systems of the service provider.
- South Australia has also partnered with local councils to conduct community-based ACP workshops to increase general awareness and support older adults in the community in developing ACPs prior to entering RACFs. Reporting from the project identified a significant demand for these workshops (see Case study 2, page 38).
- Analysis of quantitative data from ACQSC indicates that RACFs have improved compliance with the standards related to aged care residents’ choice and independence in decision-making surrounding their care, the way its delivered and when to include family and carers in their care.<sup>42</sup> For the period July 2019 to July 2023, compliance against this standard has varied, although a general increase in compliance has been recorded following 2020. In July 2019, 93.5

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<sup>40</sup> Eldercare, Hospice in the RACF Final Report – Internal, Version 1.0 Final. 2023

<sup>41</sup> Research Centre for Palliative Care, Death & Dying, Flinders University, Comprehensive Palliative Care in Aged Care (CPCiAC) Pilot Projects in South Australia: Final Evaluation Report. May, 2023.

<sup>42</sup> Aged Care Quality Standard 1(3)(c): Each consumer is supported to exercise choice and independence, including to: i) make decisions about their own care and the way care and services are delivered; and ii) make decisions about when family, friends, carers or others should be involved in their care; and iii) communicate their decisions; and iv) make connections with others and maintain relationships of choice, including intimate relationships.

per cent of the RACFs that were assessed were compliant with this standard, this decreased to 74.8 per cent in 2020, however this has since recovered and improved to the 98.4 per cent as of July 2023, the highest rate of compliance recorded for this period.

These emerging findings are evidence of contribution of Measure-funded activities to the National Palliative Care Strategy Goal 1 (understanding). They demonstrate early progress in improving families/carers' understanding of the benefits of palliative care and better involvement of them in decisions about the care of their family members.

### **Case study 2: South Australia have been delivering community-based workshops to improve local awareness for end-of-life planning.**

South Australia Health has been working closely with the Office for Ageing Well and local councils to deliver educational community-based workshops to improve education and awareness of ACD/ACPs for older people (50+ years) in the community, prior to these people becoming residents in RACFs. Prior research contracted by South Australia Health indicated that, in many cases, many people already have reduced decision-making capacity upon entering care at a RACF. As a result, they are unable to complete an ACD/ACP in the RACF.

The pilot program was conducted by the City of Onkaparinga,<sup>43</sup> and funded through a combination of the CPCiAC Measure, Commonwealth Home Support Programme (CHSP) funding and state-based grants.

A community survey was released to identify understanding, awareness and engagement with ACDs among older people in SA. The survey revealed that 73 per cent of respondents (most of whom were aged between 65-75 years) did not have an ACD in place. The survey also identified a strong preference among the respondents for an in-person presentation or workshop to support the community in establishing ACDs.

Two co-design pilot workshops were run with 18 community participants to inform the design of the final workshop and free resources to support the ACD process. Peer facilitators were also recruited as volunteers to lead workshop delivery. Workshops were promoted by each Council through internal newsletters to CHSP clients, databases for council volunteers and a dedicated external website.

As of November 2022, ten workshops have been delivered to over 125 attendees. Of the attendees, 83 per cent indicated that they felt the workshop would help them complete an ACD and 96 per cent felt the resources were beneficial.

By targeting the broader community, the program is aiming to increase the rates of ACD/ACP completion before people are admitted into RACFs and have the direction in place to receive end-of-life care in the way that they choose. Reporting from this initiative has shown a high demand in the community for these workshops.

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<sup>43</sup> Lowe, J. City of Onkaparinga . Advance Care Directive Peer-led Workshop Project Interim report December 2022.

### Outcome 3: A higher proportion of clinical and non-clinical staff in RACFs have skills and confidence appropriate to their roles to recognise and respond to the holistic palliative care needs of residents, in a culturally safe way.

**Baseline assessment:** Palliative care training is often not mandatory in RACFs; however, nurses and care workers are the most common users of the Palliative Care Online Training portal run by the AHHA.

**Mid-point assessment:** Embedded training into RACF work practices was demonstrating success in capability building, rather than focusing on training individuals. Training programs were requiring strong relationships between clinicians and RACFs in order to be successful.

**Interim assessment:** Training programs are embedded into practice in many RACFs including through needs rounds and targeted onsite palliative care and clinical deterioration training programs. There is emerging evidence to suggest that, as a result, RACFs are more equipped to identify and escalate responses for residents with palliative care needs and deliver palliative care. RACFs are reporting success in varied modes of training, including through smaller more frequent sessions to mitigate staff turnover, with further demand for online training resources.

#### Outcome 3: Emerging interim findings

##### **Needs rounds are an effective platform for upskilling clinical staff in the ACT, South Australia and Tasmania.**

- Tasmania has reported great success with their GP registrar traineeships whereby registrars attend needs rounds led by CNCs, resulting in increased comfort and capability for GPs to address palliative care needs within RACFs. Tasmania reported that one GP registrar who went through this program, continued their training in palliative care and is now operating as a specialist palliative care consultant (see Case study 3, page 41). The Tasmanian CPCiAC model comprises of CNC-led needs rounds, GP registrar training posts and funding for allied health support in RACFs brokered as required. Since implementation of the Measure in April 2022, Tasmania has reported a 3.7 per cent decrease in the number of patients admitted to a palliative care facility, suggesting an improvement in palliative care provision in RACFs.<sup>44</sup>
- South Australia reported that specialist-led needs rounds are perceived as a valuable learning opportunity by GPs at regional sites, who encourage attendance from their registrars. This was more successful in increasing GP attendance than financial incentives. In the Eldercare model, implemented in metropolitan sites, needs rounds were led by palliative care NPs. As noted in Outcome 2 above, needs rounds provided an opportunity for the existing Eldercare Palliative Care Services Team to provide one-on-one training and modelling for clinical staff in Advance Care Planning and PCCCs.<sup>45</sup>

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<sup>44</sup> This is the total number of patients admitted to RHH Whittle ward or purchased LGH beds in Calvary St Luke's, including all admissions, not just from RACFs. This excludes private admissions to Calvary St Luke's as Tasmania were unable to obtain this data.

<sup>45</sup> Eldercare, Hospice in the RACF Final Report – Internal, Version 1.0 Final. 2023

- In the ACT, case-based education is integrated into the PCNR model, attended by RACF staff and a specialist palliative care clinician from CPCiAC team. The biopsychosocial status of each resident is discussed to promote symptom management and identify opportunities to extend and reinforce knowledge of RACF staff. This model aims to build the confidence and capability of RACF clinical and care staff to lead needs rounds on an ongoing basis without the involvement of the CPCiAC team.

### **NSW, South Australia and Victoria have had success with targeted onsite palliative care and clinical deterioration training programs**

- South Australia have held onsite training programs in regional and metropolitan sites, targeted at nurses, GPs, senior clinical RACF staff and some non-clinical staff. The evaluation of the on-site training showed a major increase in knowledge about palliative and end-of-life care in aged care (from 35 per cent to 94 per cent) and confidence in recognising signs of deterioration (from 11 per cent to 76 per cent).<sup>46</sup>
- In NSW, some LHDs have focussed on basic capability building, such as syringe driver education for RACF nursing staff. South Eastern Sydney LHD reported the improved rate of syringe driver competency has resulted in a 260 per cent increase in the use of syringe drivers in the Sutherland area (from April 2022 to October 2022), compared to six-months prior to the Measure activities commencing, which enables residents discharged (back from hospital) to the RACF to commence care without delay.
- In NSW, Murrumbidgee LHD partnered with ELDAC with a focus on improving the capability and confidence of RACF staff across two cohorts of facilities across the district. The cohorts completed the ELDAC Linkages Program (formerly known as 'Working Together'). Assessments revealed improved capability and confidence for aged care workers and clinical staff across a number of skill sets related to cultural safety and end-of-life planning when comparing before and after involvement in the program (see Case study 4, page 41).
- Victoria have reported success with the utilisation of the STOP and WATCH approach – an early warning communication system that helps non-clinical RACF staff communicate when a resident appears out of character and inform the clinical staff member in charge.

### **There is emerging evidence that RACFs are becoming better equipped to provide palliative care.**

- Three jurisdictions provided quantitative data on the number of patients discharged from the emergency department (ED) back to a RACF (where stay is less than 24 hours in ED) prior to and during CPCiAC Measure implementation. In two jurisdictions,<sup>47</sup> this number has steadily decreased since implementation, suggesting that RACF residents are not inappropriately or prematurely being transferred to ED, suggesting that RACF staff are better equipped to provide palliative care.

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<sup>46</sup> Research Centre for Palliative Care, Death & Dying, Flinders University, Comprehensive Palliative Care in Aged Care (CPCiAC) Pilot Projects in South Australia: Final Evaluation Report. May, 2023.

<sup>47</sup> The third jurisdiction that provided this data did not display any clear trend.

- Two jurisdictions have reported decreases in the number of patients admitted to palliative care facilities since the commencement of Measure activities.<sup>48</sup> Although this data is not specific to RACF residents, it reflects broader capability of community services to provide palliative care, including in RACFs.
- Analysis of ACQSC data on compliance with the Aged Care Standards indicates that from July 2019 to July 2023, ~75 per cent of RACFs met the standard on providing each consumer with safe and effective personal care and/or clinical care. This is comparatively lower than other standards however compliance has improved significantly in 2023. This may be because during the COVID-19 pandemic, assessments were focused on higher-risk RACFs and may have focused on one or more Quality Standards for services rated as higher risk.

### **Case study 3: GP registrar rotations in Tasmania are contributing to capability building for GPs to better meet the complex needs of palliative residents in RACFs.**

Tasmania's GP Registrar program is showing emerging success building interest and buy-in from training GPs in the palliative care specialty. The Registrar, under the direction of the Medical Specialist Palliative Care, provides high quality, evidence-based and complex care to palliative residents in RACFs. The Registrar provides comprehensive assessment of palliative residents with complex symptoms and end-of-life care needs, and can provide advice and support to other treating GPs specific to palliative care.

The program operates through six-monthly rotations and has recruited 2.5 FTE between November 2022 and May 2023. Two previous registrars are now palliative care advanced trainees and three are current candidates.

One previous trainee who was involved in the program has continued study in palliative care and is now practicing as a specialist medical consultant in the region.

### **Case study 4: In NSW, Murrumbidgee LHD is working closely with ELDAC to deliver programs to improve the confidence and capability of RACF staff.**

Murrumbidgee LHD has focussed their use of the Measure funding on education and capability building through the Murrumbidgee Mentor Model (MMM), conducted in partnership with ELDAC's Linkages Program (formerly the 'Working Together' program). The program aims to expand RACF capacity to provide end-of-life care, improve staff confidence, skills and knowledge about palliative care and advance care planning, and increase access to palliative care advice and support.

The Linkages Program involves engagement with an ELDAC facilitator who uses evidence-based linkage strategies to build connections between aged care, primary care and specialist palliative care providers specific to the regions and services that they are working with. Other external services relevant to the delivery of end-of-life care are also included in this linkage network.

The program was initially delivered over a six-to-nine-month period to two cohorts of 13 RACFs in the LHD. Participating RACFs completed five ELDAC audits in the pre-implementation period and repeated these audits following the program's closure (post-implementation).<sup>49</sup> The pre-implementation audits revealed gaps in knowledge, skills and confidence of RACF staff. As part of

<sup>48</sup> Other jurisdictions did not provide this data.

<sup>49</sup> Only 12 of the 13 RACFs completed the post-implementation audits, one was considered lost to follow-up.

the program, Linkage Facilitators worked with services to focus on addressing these gaps and meeting the educational and clinical care needs of the aged care staff.

Personal Learning Assessments (PLAs) were conducted by aged care workers and clinical staff in the RACFs to assess their confidence and skills over the course of the program. Aged care workers reported increases in confidence across all assessment areas including assessing end-of-life and palliative care needs, and development of subsequent care plans, recognising deterioration, care in the last week of life and bereavement needs of families. To a lesser extent, clinical RACF staff reported increased confidence in understanding ACP legislation, assessing end-of-life and palliative care needs, and when to initiate specialist palliative care.

### **Tailored training programs for aged care workers is increasing capacity and confidence to identify and escalate residents with palliative care needs**

Personal care workers make up the majority of the aged care workforce.<sup>50</sup> In the Midpoint Report, PCA consumer representatives reported that training may not adequately equip them for the complexity of their roles, particularly for discussions around ACPs. During Mid-point data collection, stakeholders in Tasmania and the ACT reported personal care worker training needs to be low burden given capacity constraints and accessible in many languages to reflect the diversity of the personal care workforce.

- Eldercare’s traineeship model in South Australia has shown significant cultural benefits of a peer mentorship approach including increased skills, confidence and ability to internally escalate palliative care needs. A total of 27 trainees were recruited into the program and are now, as of July 2023, trained in a Certificate III in Individual Support (Aged Care) (see Case study 1, page 30).
- South Australia have also partnered with Flinders University and GPEx to develop short educational videos to be accessible through the PalliAGED app. The videos are designed to support aged care workers in the delivery of palliative care to residents at the end of life (see Case study 5, page 44).
- Western Australia found that pivoting to online delivery for the Residential Aged Care Excellence in Palliative Care (RACEPC) project made the training and education delivery more accessible to RACF staff who were able to access the training when their workload was low.

“Without this traineeship I would not have been able to afford to take the time off work, pay for study and lose money doing placement ... Without this I wouldn't have been able to be working in my dream job and I never knew if it was my dream job until I got it.” -Eldercare trainee, SA<sup>51</sup>

### **Western Australia, Northern Territory and Victoria have identified that smaller, more frequent education sessions embedded in work practices are more appropriate for mitigating the impact of staff turnover in RACFs**

<sup>50</sup> Australian Department of Health. Aged Care Workforce Action Plan: 2022–2025: Growing a skilled workforce to deliver high quality care for senior Australians. 2022

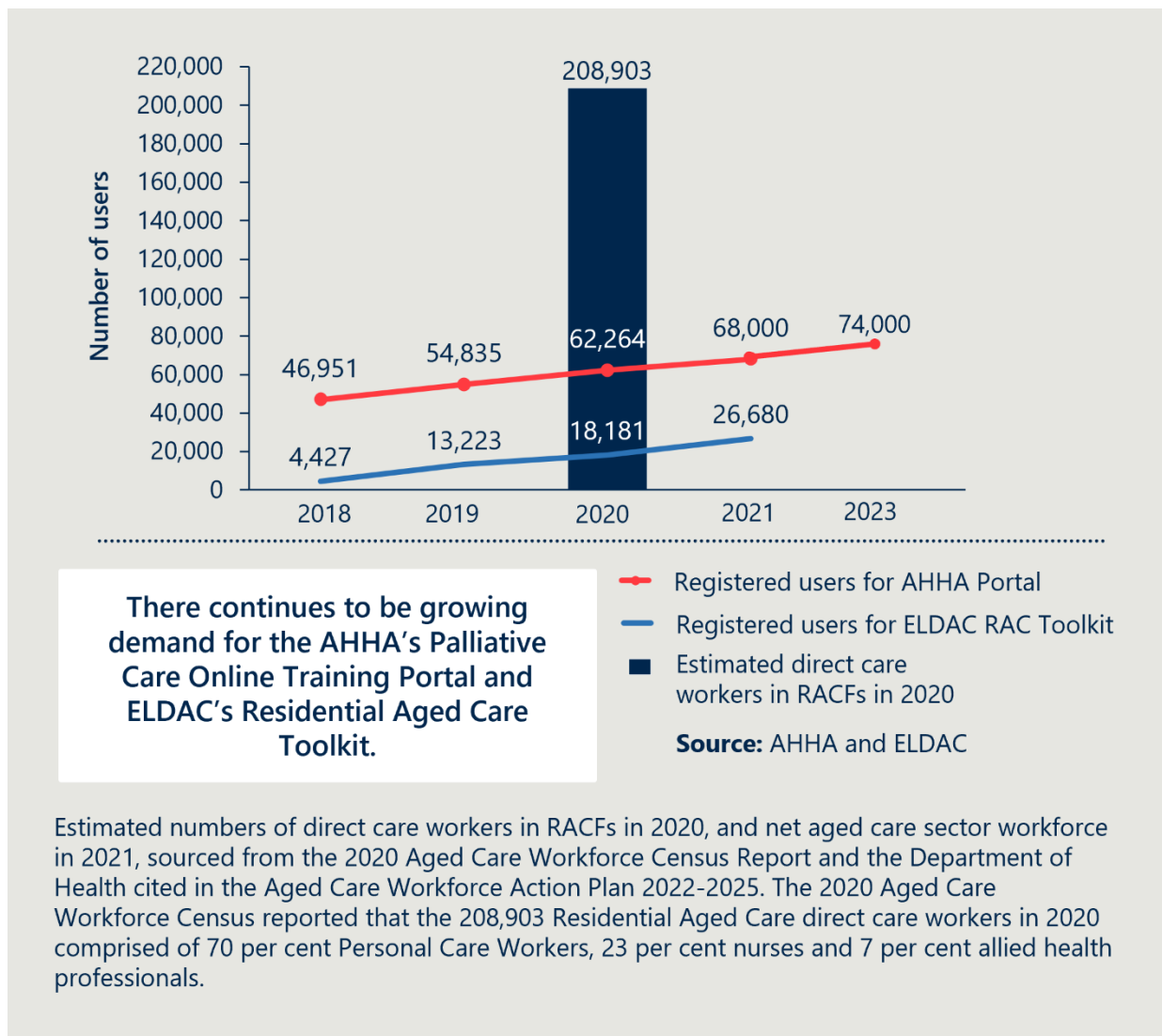
<sup>51</sup> Research Centre for Palliative Care, Death & Dying, Flinders University, Comprehensive Palliative Care in Aged Care (CPCiAC) Pilot Projects in South Australia: Final Evaluation Report. May, 2023.

- In Western Australia, MPaCCS teams have been facilitating regular short, informal education sessions (“toolbox sessions”) for RACF staff, the delivery of which had increased almost 300 per cent in the period from April 2022 to October 2022. During this period, 381 “toolbox” education events were provided to RACF staff during this period (compared to 120 in the previous six months). WA has also reported success in their Residential Care Line expansion project, in the delivery of their ‘Clinical Deterioration’ education package to upskill RACF staff on recognising and responding to the residents with deteriorating health.
- Similarly to Western Australia, Victoria reported in the Mid-point report having implemented “short, sharp, practical” education sessions to mitigate the “limited bandwidth” of staff. This was reported as being more effective than delivering extended education sessions. They are providing education and training through multiple CPCiAC activities.
- Central Australia in the Northern Territory have also reported that regular palliative care education and tools to RACFs appears to have impacts on improving confidence of RACF staff to implement processes that lead to effective end-of-life care for residents.
- While Queensland had invested in fewer large education components, they have since identified that funding smaller, more frequent education sessions embedded in work practices are more appropriate for mitigating the impact of staff turnover in RACFs.

**There continues to be a demand for online palliative and aged care training resources, particularly among nurses and care workers**

- The number of users of AHHA Palliative Care Online Training Portal has continued to increase since it was established in 2018, with the portal providing training to 6,801 new participants since January 2022 (to a total of 74,000 users, see Figure 2). In 2020, there were 208,903 direct care workers in Residential Aged Care – so this number represents approximately 35 per cent of that work force. The vast majority of AHHA Palliative Care Online Training Portal users reported their level of knowledge and/or skills in palliative care had improved since undertaking the training (89 per cent). Of the users that reported an improvement, 83 per cent described themselves as being either ‘confident’ or ‘extremely confident’ in delivering best-practice palliative care services after completing the training. This is compared to only 37 per cent of participants beforehand.
- The majority of users of the AHHA Palliative Care Online Training Portal are based in NSW, Queensland, Victoria, WA and South Australia. Registered nurses are the most common user group (33 per cent of users) followed by students (16 per cent) and care workers (14 per cent).
- Funding for the AHHA Palliative Care Online Training Portal ends in June 2023, so it will not be possible to monitor ongoing usage beyond this point.

Figure 2 Users registered for the AHHA Palliative Care Online Training portal and ELDAC Residential Aged Care Toolkit, 2018 to 2023



These emerging findings are evidence of contribution of Measure-funded activities to the National Palliative Care Strategy Goal 2 (capability). They demonstrate early progress in improving the capability of personal care workers, nurses and GPs working in aged care to identify and address resident’s needs.

**Case study 5: South Australia have leveraged partnerships to develop an app-based learning platform for aged care workers.**

South Australia Health has used part of the Measure funding to contract GPEx, in conjunction with Eldercare, to develop ten educational videos to support aged care workers with palliative care service delivery. GPEx collaborated with Eldercare to identify relevant topics to include in the videos and provided support to screenwriters. The videos were filmed in June 2023.

The videos will be uploaded to the PalliAGED App, operated by Flinders University, which will be used as an educational tool and learning platform for aged care workers to access via mobile phone, to support them in delivering and recognising palliative care needs for residents.



Once finalised, the app will be shared nationally and support palliative care education and capability building for RACF care workers across all jurisdictions.

#### Outcome 4: Improved access to quality palliative care in RACFs including:

- increased use of assessments to establish residents' palliative care needs
- decreased health service use related to clinically futile or non-beneficial treatments and inpatient bed days
- decreased healthcare expenditure arising from decreased service use.

**Baseline assessment:** Approximately only seven per cent of RACF residents accessed palliative care services from 2014-19. An average of 55 per cent of RACF residents who died in 2018-19 may have received medicines associated with palliative care, but access to palliative care can be improved. In a majority of PCOC care episodes in 2021, care was provided by the specialist palliative care in-reach service within two days of the resident being ready.

**Mid-point assessment:** There was emerging evidence that activities funded under the Measure were leading to increasing accessibility and availability of palliative care to RACF residents. Jurisdictions reported increased referrals to palliative care teams, improved confidence for RACF staff and care partners, and better access to palliative care related medicines.

**Interim assessment:** There is further evidence that activities funded under the Measure are leading to improved accessibility and availability of palliative care to RACF residents. There is also early progress in improving residents' choice to receive palliative care in the place of their choosing, by providing more options to access palliative within RACFs.

#### Outcome 4: Emerging interim findings

**There is emerging evidence that the Measure-funded activities are contributing to an increase in access to and availability of palliative care.**

Emerging evidence from states that are further progressed in implementation includes:

- Queensland Specialist Clinicians and the Queensland Department of Health reported an increase in referrals to the SPACE team. Queensland reported that the Measure has enabled improved coordination of the Specialist Palliative Rural Telehealth service (SPaRTa). Local, on-the-ground SPACE team members are trained to operate the equipment and provide increased access to virtual palliative care in regional and rural RACFs.
- In Western Australia, RACFs reported that MPaCCS involvement has contributed to increased confidence for staff and care partners to deliver palliative care. An independent review and consultation process regarding the MPaCCS program has informed the decision to expand the program's service hours, staffing and reach across metropolitan Perth and trialling other services recommended in the review.
- In South Australia, the virtual care service delivered at Eldercare sites has reportedly "revolutionised" access to care planning, by enabling residents to be assessed by care teams through virtual channels without having to be transferred between facilities. South Australia has

reported an increase in the average length of time between hospital visits for patients receiving palliative care, from 29 days (reporting period July 2019 to June 2020) to 43 days (reporting period July 2022 to June 2023),<sup>52</sup> since the Measure's implementation in July 2021, which would suggest improved access to care within RACFs.

- The ACT reported that their PCNR are a useful model for proactively identifying needs and scheduling case conferences between residents and care providers. Improved access to overall care in RACFs is reflected in ambulance transfer data which indicates a 13 per cent reduction in transfers to emergency department from 3,014 transfers in financial year 2019/2020 to 2620 transfers in financial year 2021/2022.<sup>53</sup>
- In the Northern Territory, high demand for the Measure activities has meant that the number of RACFs accessing projects has increased from seven (since April 2022) to 13 (June 2023). In the Top End, the NP role is directly contributing to improving access to palliative care for residents in RACFs and increasing the confidence of RACF staff to respond to palliative care needs internally. Telehealth has been an essential tool in facilitative needs rounds, providing access to GPs and avoiding delays in reviewing patients, ultimately preventing unnecessary admission to Royal Darwin Hospital.
- Tasmania have adapted needs rounds model of care into 'mini needs rounds' that provide access to clinical care for residents, with fewer resourcing constraints. Since the commencement of activities funded under the Measure in April 2022, a total of 251 needs rounds have been conducted and the number of residents referred to specialist palliative care has almost tripled, from 34 to 92 residents. This reflects the increased identification of palliative care needs through improved access to general clinical care and implies greater access to specialist palliative care services for RACF residents. GP registrar attendance at needs rounds is also increasing the capabilities of GPs trainees to improve the quality of palliative care that they can deliver to residents in RACFs.

**Increased accessibility of palliative care in RACFs may be reflected in some service use data across jurisdictions, although further investigation is required.**

- Two jurisdictions reported a reduction in the average length of palliative care related stays in a hospital for residents referred by a RACF, since implementation of the Measure, although the trend is unclear across other jurisdictions and requires further investigation in the future. There is also no clear trend in the number of and average length of palliative care related stays in a specialised facility for residents referred by a RACF, since implementation of the CPCiAC Measure.
- As reported in Outcome 9, while the number of specialist palliative care in-reach services reporting into PCOC decreased slightly from 2021 (57 services) to 2022 (51 services), the number of episodes of care increased by 18 per cent and the number of RACF staff making referrals to these services also increased slightly.

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<sup>52</sup> This data refers to all patients receiving palliative care, it is not specific to RACF residents.

<sup>53</sup> The number of call outs that resulted in transport from a RACF to ED. This data is not specific to residents transferred for palliative care needs.

These emerging findings are evidence of contribution of Measure-funded activities to the National Palliative Care Strategy Goal 3 (access and choice). They demonstrate early progress in improving residents' choice to receive palliative care in the place of their choosing, by providing more options to access palliative within RACFs.

#### **Outcome 5: Improved quality of palliative care provided in RACFs including:**

- reduced symptom burden
- improved quality of life for residents during the period they access palliative care
- better experience of death and dying for residents, families/carers and staff, including meeting physical, psychosocial, cultural and spiritual needs.

**Baseline assessment:** RACFs are the most common referrer to specialist palliative care residential care in-reach services reporting to PCOC. RACF residents most commonly attend ED for reasons other than their primary illness.

**Mid-point assessment:** Jurisdictions reported that needs rounds and similar models had increased involvement of specialist palliative care services in RACFs, although there remained some challenges in accessing non-medical support.

**Interim assessment:** The evidence suggests that while Measure activities are improving the quality of palliative care in some RACFs including with specific programs for Aboriginal and Torres Strait Islander residents, there is significant variability.

#### **Outcome 5: Emerging interim findings**

##### **There is emerging evidence that Measure activities are improving the quality of palliative care in some RACFs, although there is significant variability**

- There is continued evidence that the MPaCCS model in Western Australia and needs rounds models in the ACT, South Australia, Tasmania and Queensland, are improving the quality of palliative care through increased involvement of specialist palliative care services in RACFs. Two jurisdictions provided quantitative data that indicated increasing referrals to specialist palliative care services from RACFs, suggesting improved access to care in RACFs. More detail is included in Outcome 7 below.
- In South Australia, the Flinders University evaluation found that, in RSS sites, symptom management as the principal reason for transfer to hospital has reduced significantly from 57 per cent to zero per cent<sup>54</sup> over the course of implementation period for Measure funded activities. This indicates that residents are accessing improved symptom management within the RACF and are therefore not requiring transfer to hospital for this type of care.
- Tasmania are using a multidisciplinary team to delivery holistic, wraparound care. They have recruited a social worker in one region to build relationships with residents and families and provide information about the care that RACFs can provide. Other regions continue to support

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<sup>54</sup> Research Centre for Palliative Care, Death & Dying, Flinders University. Comprehensive Palliative Care in Aged Care (CPCiAC) Pilot Projects in South Australia: Final Evaluation Report. 2023.

brokerage of allied health as needs are identified through RACF staff or CNC. A music therapist is providing in-reach services into RACFs in the south.

- Analysis of PCOC data from 2021 to 2022 indicates a slight increase in the proportion of referrals from RACFs to specialist palliative care in-reach services<sup>55</sup> from 43.1 per cent to 44.1 per cent.<sup>56</sup> Increasing referrals from RACFs indicates improved identification of palliative care needs in the RACFs and subsequent access to in-reach care.

### **Some jurisdictions have developed tailored programs to suit the needs of Aboriginal and Torres Strait Islander residents.**

- The Torres and Cape HHS in Queensland combined the Measure funding with other sources to undertake an extensive consultation process involving Aboriginal and Torres Strait Islander communities in the region to co-develop a pop-up model of care, incorporating additional resources, and a needs round and bereavement model to support palliative care provision and families following death. The measure is intended to acknowledge and respect the needs of Aboriginal and Torres Strait Islander residents in their end-of-life care. The program plays a coordination role between palliative care services and residents.
- Victoria has implemented the Resident Elders project to promote culturally safe palliative and end-of-life care for Aboriginal and Torres Strait Islander Elders, and a mentor program for aged care registered nurses across some metropolitan and regional areas. Victoria employed a Measure-funded cultural advisor as a core member of the Palliative Care Victoria project team and reported that this fostered engagement with Aboriginal Community-Controlled Organisations (ACCOs), after having initial challenges with building trust.

### **There are ongoing challenges that inhibit the ability of RACFs to provide quality palliative care.**

- Although needs rounds have reportedly increased the quality and accessibility of palliative care in RACFs, some jurisdictions reported that they are one of the first processes to be deprioritised when RACFs are overwhelmed with workload or staffing constraints.
- There remain challenges in recruiting allied health workers available to RACF staff who can provide non-pharmacological aspects of palliative care to maximise residents' function, independence, and psychosocial wellbeing. RACFs with a religious affiliation have chaplains and other supports in place.
- There are also challenges related to the high proportion of CALD workers in the personal care workforce, regarding differing views of death and subsequent unease with certain palliative care related procedures and medications (as reported in consultations with RACFs in 2022).

### **Quantitative data on deaths of RACF residents while in hospital show unclear trends across jurisdictions and require further investigation in the future.**

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<sup>55</sup> Only 51 palliative care in-reach services are reflected in this data, more than 88 per cent of which are located in a major city.

<sup>56</sup> Analysis of PCOC data from the periods January 2022 to December 2022 and January 2021 to December 2021, provided by PCOC, University of Wollongong.

- Over the CPCiAC implementation period, two jurisdictions observed decreases in the number of deaths for RACF residents while admitted to hospital to receive palliative care, while another jurisdiction reported an increase for the same indicator. The number of deaths for RACFs residents within 24 hours of admission to hospital for care related to palliative care increased in two jurisdictions, to varying degrees. This may suggest that palliative patients are spending longer in residential aged care prior to being admitted. However, other jurisdictions observed decreases. Further investigation is required to extrapolate any conclusions from this data.

**PCOC data provides an assessment of symptom management using benchmarking scores for palliative care patients at the commencement of their episode of care.**

- While there has been an increase in the episodes of care provided specialist palliative care in-reach services reporting in to PCOC,<sup>57</sup> as noted in Outcome 4 and illustrated Figure 3, analysis of PCOC data indicates that residents' state (at the time of care) have worsened slightly. In 2022, compared to 2021, RACF residents are less stable, more deteriorated, are more dependent at the commencement of the episode of care<sup>58</sup> and have worse outcomes of care.<sup>59</sup> This could suggest that residents are receiving palliative-related care for longer from the RACF staff prior to them calling the specialist in-reach teams, however given Nous did not receive 'place of death' in the PCOC data, nor is the PCOC data linked to hospital transfers, we cannot confirm this hypothesis. These trends require further investigation and corroboration against other data points in the future.
- PCOC data from 2021 to 2022<sup>60</sup> indicates the proportion of patients meeting benchmarks for Symptom Assessment Scores (SAS) for pain, fatigue and breathing problems all decreased from 2021 to 2022. This trend was also observed for the Palliative Care Problem Severity Scores (PCPSS) for pain and family/carer problems (see Figure 3).
- As noted in Outcome 9, from 2021 to 2022, there was also a slight increase in the number of residents who were a less stable condition when the specialist palliative care in-reach service commenced the episode of care.<sup>61</sup>

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<sup>57</sup> Analysis of PCOC data from the periods January 2022 to December 2022 and January 2021 to December 2021, provided by PCOC, University of Wollongong.

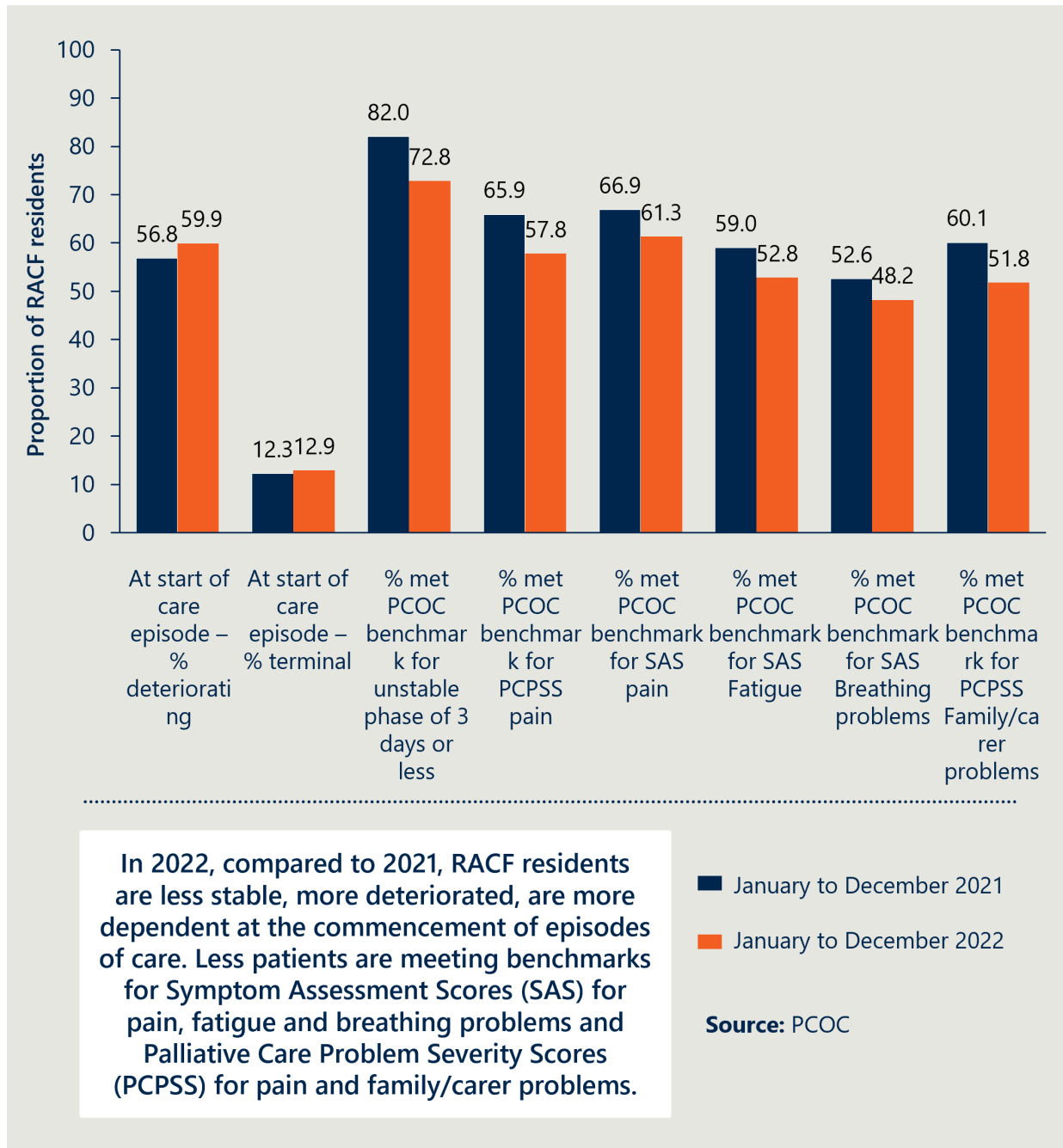
<sup>58</sup> Assessed using Australia-Modified Karnofsky Performance Scale (AKPS) and Resource Utilisation Group-Activities of Daily Living (RUG-ADL) scores

<sup>59</sup> Assessed using benchmarks for Symptom Assessment Scores (SAS) for pain, fatigue and breathing problems and Palliative Care Problem Severity Scores (PCPSS) for pain and family/carer problems.

<sup>60</sup> Analysis of PCOC data from the periods January 2022 to December 2022 and January 2021 to December 2021, provided by PCOC, University of Wollongong.

<sup>61</sup> Ibid.

Figure 3 RACF resident conditions and outcomes of care, for specialist palliative care in-reach into residential aged care reporting into PCOC in 2021 and 2022



**Outcome 6: Greater resident choice in palliative care including:**

- more people dying where they want
- increased person-centred care informed by an individual’s choice.

**Baseline assessment:** The majority of RACF residents who died in 2018-19, died in a RACF; however, a substantial proportion of RACF residents in 2021 did not have their preferred place of death recorded by the RACFs.

## Outcome 6: Greater resident choice in palliative care including:

- more people dying where they want
- increased person-centred care informed by an individual's choice.

**Mid-point assessment:** There was still significant variability in the use of ACPs, although there was anecdotal evidence that this was improving in some jurisdictions, this was not the case for all.

**Interim assessment:** There is still variability in the use of ACPs, however their effectiveness may be improving. Additional evidence suggests a potential increase in cultural safety and consideration of dignity for RACF residents receiving end-of-life care and improved ability of RACFs to provide palliation.

## Outcome 6: Emerging interim findings

**At this stage, ACP use is still variable, however their effectiveness may be improving.**

- During the Mid-point data collection period, stakeholders across jurisdictions reported that having discussions associated with ACPs, in addition to having the ACPs in place, helps enable staff to be better prepared, pre-empt needs and medications and facilitate a better experience of dying for the resident and their family.

**Assessment against the Aged Care Quality Standards indicates potentially increasing cultural safety and consideration of dignity for RACF residents receiving end-of-life care.**

- Since July 2019, the proportion of RACFs meeting the standard that relates to consumers being treated with dignity and respect, with their identity, culture and diversity valued<sup>62</sup> has varied significantly. Although, the rate of compliance was highest for this period, at 94.7 per cent as of June 2023. In the beginning of this period, compliance against this standard was at 92.2 per cent, decreasing to 73.2 per cent in 2020 and remained within the 86 to 88 per cent range over 2021 and 2022.
- Over the same period, there was slightly less variability in compliance with the standard relating to consumers being treated with dignity and respect, with their identity, culture and diversity valued.<sup>63</sup> 2019 data indicates that 95.4 per cent of RACFs were compliant with this standard, in comparison to a compliance rate of 99.3 percent reported in July 2023. This is the highest rate of compliance recorded for this period, with a steady increase shown over 2022 and 2023.

**Some jurisdictions are reporting increased rates of death within RACFs, suggesting improved ability of RACFs to provide palliation and reduced need for transfers to external facilities in the last days of life.**

- An independent evaluation of South Australia's CPCiAC Measure activities, conducted by Flinders University,<sup>64</sup> found that since the commencement of Measure activities, the proportion

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<sup>62</sup> Aged Care Quality Standard 1(3)(a): each consumer is treated with dignity and respect, with their identity, culture and identity valued

<sup>63</sup> Ibid.

<sup>64</sup> Research Centre for Palliative Care, Death & Dying, Flinders University, Comprehensive Palliative Care in Aged Care (CPCiAC) Pilot Projects in South Australia: Final Evaluation Report. May, 2023.

of residents who died in their preferred place of death increased from 66 per cent to 77 per cent. The percentage of residents who died in residential aged care increased from 85 per cent to 93 per cent.

- In October 2022, the Northern Territory reported that deaths in nursing homes in the Top End had increased by 175 per cent since the beginning of the CPCiAC project,<sup>65</sup> indicating improved access to end-of-life care within the RACF.
- Tasmania reported that, since the commencement of the Measure, 98 per cent of RACF residents in RACFs impacted by the Measure have died in their place of choice.<sup>66</sup>

### Outcome 7: Improved care coordination with GPs/primary care, acute care services and specialist palliative care services.

**Baseline assessment:** 8.5 per cent of RACF residents attended a multidisciplinary case conference in 2018-19. This suggests that GPs are involved in coordinating care in RACFs, but there is an opportunity for further improvement. This accounts for an estimated 50 per cent of the total estimated number of RACF residents who accessed palliative care or were dispensed with medicines related to palliative care.

**Mid-point assessment:** All jurisdictions reported greater involvement of specialist palliative care services in RACFs, along with some anecdotal evidence of improved care coordination. Case conferences and needs rounds within RACFs had reported benefits for increasing clinician engagement, although GP participation remained a challenge across jurisdictions and some strategies were being explored to incentivise increased GP involvement.

**Interim assessment:** All jurisdictions continue to report greater involvement of specialist care services in RACFs, and further evidence that care coordination has improved in some jurisdictions. Continued focus is being placed on GP participation including through virtual care models to facilitate care coordination across multidisciplinary teams.

### Outcome 7: Emerging interim findings

**All jurisdictions have reported greater involvement of specialist palliative care services; there is anecdotal evidence that care coordination has improved in some jurisdictions.**

- ACT have reported benefits of needs rounds in RACFs as an integrated and collaborative model that involves all members of a resident's care team.
- In South Australia, specialist-led needs rounds in regional sites are increasing GP engagement in RACFs (see Outcome 3) and fostering collaboration between GPs and RACFs. The Eldercare needs rounds have acted as a catalyst for case conferencing between GPs, residents and specialist palliative care services.
- In Western Australia, the MPaCCS expansion has increased palliative care medical consultant support to GPs and the Liaison Nurse has increased engagement with hospital-based clinicians

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<sup>65</sup> Using monthly data reported by Top End palliative care nurse practitioner.

<sup>66</sup> During the period from 1 April 2022 to 31 March 2023.



and GPs. The introduction of a Nurse Liaison role has increased palliative care referrals to the MPaCCS team by 239 per cent since the Measure's commencement (reported October 2022).

- Tasmania has used Measure funds to hire GP registrars who have had active participation in needs rounds, working in collaboration with RACF staff and specialists. One GP registrar was reported to have continued further training in palliative care and is now operating as a specialist consultant in the region (see Case study 3, page 41).
- Telehealth and virtual care have facilitated communication channels between GPs, hospital clinicians and RACFs in Central Australia. This has led to the development of very strong working relationships that contribute to improve care coordination and planning for residents.
- In NSW, LHDs reported to the NSW Ministry of Health in the October 2022 reporting period that the Measure activities, in particular needs rounds, have led to more appropriate patient referrals to specialist palliative care services and, subsequently, an improved quality of life for residents.
- In quantitative data collected from two jurisdictions in August 2023, the number of specialist palliative care referrals (from RACFs) since CPCiAC Measure implementation have increased. This suggests greater involvement of specialist palliative care services in responding to needs within RACFs. In these two jurisdictions, there has also been a decrease in the number of patients receiving palliative care through public outpatient services. In two other jurisdictions that reported on outpatient palliative care services, there was not a clear trend, suggesting that further investigation is required.

**Across jurisdictions, new roles (i.e., additional FTE) have contributed to improved care coordination.**

- In the Mid-point data collection period, Central Australia reported increased staff confidence to respond to palliative care needs and decision-making, rather than sending residents straight to hospital, due to education within the RACFs.
- In this data collection period, Queensland reported the value of the central SPACE team in encouraging collaboration between GPs, local SPACE clinicians and RACF staff, particularly when disagreements occur regarding the status of a particular resident. SPACE teams reported that GPs can, at times, be reluctant to declare a resident as palliative. Some SPACE teams are reporting improvement in GP attitudes and cooperation as their involvement with them progresses. Further information is provided in section 4.5.

**There are ongoing challenges to care coordination between GPs/primary care and specialist palliative care services.**

- All jurisdictions continue to report that high staff turnover in RACFs is a barrier in progressing Measure activities and inhibits the positive impact of newly developed relationships. Western Australia reported that programs with existing reach and relationships with RACFs, such as MPaCCS, had more success and implementation was less impacted by RACF staff turnover due to having existing processes in place. In South Australia, Eldercare and RSS shared resources between programs when staffing was low.

- Limited accessibility of GPs to specialist or allied health teams increases the difficulty in care coordination. In particular, online GP services make it especially challenging to identify a resident's regular practitioner and engage to coordinate care. Virtual care models are being used in some jurisdictions to facilitate care coordination across multidisciplinary teams, particularly in regional and rural areas where it is challenging to have all care providers physically in the same location.

These emerging findings are evidence of contribution of Measure-funded activities to the National Palliative Care Strategy Goal 4 (collaboration). They demonstrate early progress in improving communication between and across national, state/territory and local palliative care networks and stakeholders.

## Outcome 8: Improved integration between the health and aged care systems.

**Baseline assessment:** Approximately one third of RACF residents had a presentation to ED or one hospitalisation from 2018-19. Only three per cent of hospitalisations related to palliative care and these were more likely to be overnight stays. Residents are more likely to receive palliative care medicines in the RACF, but some residents may not have access to the palliative care services they need.

**Mid-point assessment:** At mid-point, COVID-19 was a major contextual factor that contributed to an increase in urgent transfers from RACFs to EDs for many jurisdictions, due to restricted access to RACFs to conduct needs rounds. Other jurisdictions found that specialist teams and GPs reduced the need to admit RACF residents to hospitals in this time.

**Interim assessment:** There is evidence in some jurisdictions that relationships are being strengthened between RACFs and healthcare providers. Anecdotal evidence of an initiative in QLD suggests reduced need for hospital admissions and three pilot projects in WA are supporting residents at the point of transition between hospitals and RACFs.

### Outcome 8: Emerging interim findings

#### **Working relationships are being strengthened between RACFs and healthcare providers in Western Australia, Northern Territory, Queensland and Tasmania.**

- Western Australia's MPaCCS team continue to build supportive relationships with RACFs and GPs across the metropolitan regions. The Liaison Nurse role within the MPaCCS team works with a range of stakeholders across the health and residential aged care systems to improve the interfaces between hospitals and RACFs with the objective of smoothing the transitions of individual residents between these settings. In a separate project, the GP case conference coordinator role supports primary care coordination between GPs and RACFs, to provide an additional resource to RACFs and reduce administrative burden on GPs. Other pilot projects funded by the Measure are working to strengthen relationships between hospitals and RACFs, however are still in their first year of implementation.
- Northern Territory reported that the Measure is supporting collaboration between RACFs and GPs in end-of-life care planning. There is also work underway within different policy areas of Northern Territory Health to develop resources for all RACFs to increase education and

understanding relating to the documentation of goals of care and resuscitation status for RACF residents. The resources will be distributed and available to all facilities across the Territory to improve the delivery of care within the wishes of residents.

- In Queensland, local SPACE teams support regional RACFs to connect with centrally located palliative care specialists through facilitating access to the SPaRTa service. See Outcome 4.
- In Tasmania, RACFs are working with the CPCiAC team to broker allied health services to residents in need across the state, as identified through needs assessments.

**In Queensland, there is early evidence of increased referrals to the SPACE team and anecdotal evidence that their support helps to reduce the need for hospital admissions.**

- In Queensland, specialist clinicians reported an increase in referrals to the SPACE teams. Anecdotal evidence suggested that this may be related to increased awareness of death during the COVID-19 pandemic and the increased salience of vulnerability of aged care residents during this time. Clinicians reported that the involvement of the SPACE teams and GPs reduced the need to admit RACF residents to hospitals. The Measure has reportedly led to HHSs and RACFs working together very well, with high RACF engagement with state-based health services.
- As reported in Outcome 7, two jurisdictions reported that the number of specialist palliative care referrals (from RACFs) has increased since CPCiAC Measure implementation.

**Western Australia has three pilot projects focused on supporting residents at the point of transition from hospital to RACFs to receive palliative care.**

- These projects are designed to provide support to palliative care patients in hospitals who are entering a RACF or transitional care facility for the first time, or returning to their RACF. The Measure funds transition support navigator and care coordinator roles across three metropolitan regions which offer a range of supports including Advance Care Planning and liaising between clinical teams and RACF staff.

**There is early evidence that the CPCiAC Measure activities are contributing to a decrease in the number of transfers from RACFs to hospitals for palliative care, however further investigation is required.**

- In August 2023, four jurisdictions provided quantitative data on the number of patients transferred from a RACF to a hospital for palliative care, prior to and during implementation of Measure activities. Analysis of this data indicates no clear trend: two jurisdictions observed a decrease in the number of transfers and a third observed a very slight decrease in a small sample size. One jurisdiction observed an increase in transfers. Further investigation in the final data collection period will be required to understand the impact of the Measure on this indicator.
- Three jurisdictions also provided data on the number of patients transferred by ambulance from a RACF to ED and the number of transfers. Again, analysis found no clear trend, with two jurisdictions observing an increase and a third observing a decrease in both number of patients and transfers. Further investigation is required to understand the extent to which Measure

activities may be contributing to a change in the rate of transfers, and adjust for RACF population size, in the final data collection period.

## **Outcome 9: More palliative care services and health planners are informed by performance information on appropriateness, effectiveness, efficiency and outcomes.**

**Baseline assessment:** Approximately one third of RACF residents had a presentation to ED or one hospitalisation from 2018-19. Only three per cent of hospitalisations related to palliative care and these were more likely to be overnight stays. Residents are more likely to receive palliative care medicines in the RACF, but some residents may not have access to the palliative care services they need.

**Mid-point assessment:** At mid-point, COVID-19 was a major contextual factor that contributed to an increase in urgent transfers from RACFs to EDs for many jurisdictions, due to restricted access to RACFs to conduct needs rounds. Other jurisdictions found that specialist teams and GPs reduced the need to admit RACF residents to hospitals in this time.

**Interim assessment:** There is evidence in some jurisdictions that relationships are being strengthened between RACFs and healthcare providers. Anecdotal evidence of an initiative in QLD suggests reduced need for hospital admissions and three pilot projects in WA are supporting residents at the point of transition between hospitals and RACFs.

### **Outcome 9: Emerging interim findings**

#### **Internal evaluations are occurring in most jurisdictions to inform future planning, although they are currently at varying states of completeness.**

- South Australia's internal evaluation, conducted by Flinders University, is now complete with the final evaluation report published in May 2023.<sup>67</sup>
- ACT, Tasmania, Queensland and Victoria are currently undergoing evaluations of their activities funded by the Measure, final results are projected to be available within the next 12 months.
- NSW is undergoing an evaluation of the broader palliative care service system, of which the CPCiAC Measure and aged-care specific delivery plays a small role.
- Western Australia is in the early stages of setting up a 'deep dive' impact evaluation of their nine projects, the evaluation will explore RACF consumer and provider perspectives and is projected to be complete by August 2024.

#### **Early evidence in Tasmania suggests that dedicated Departmental resources help with information sharing between the PHN and the Tasmanian Department of Health.**

- In Tasmania, the recruitment of the 'CPCiAC team' within the Tasmanian Department of Health has reportedly led to more and improved interaction with the PHN, Primary Health Tasmania (PHT) and enabled PHT to share information with the Department.

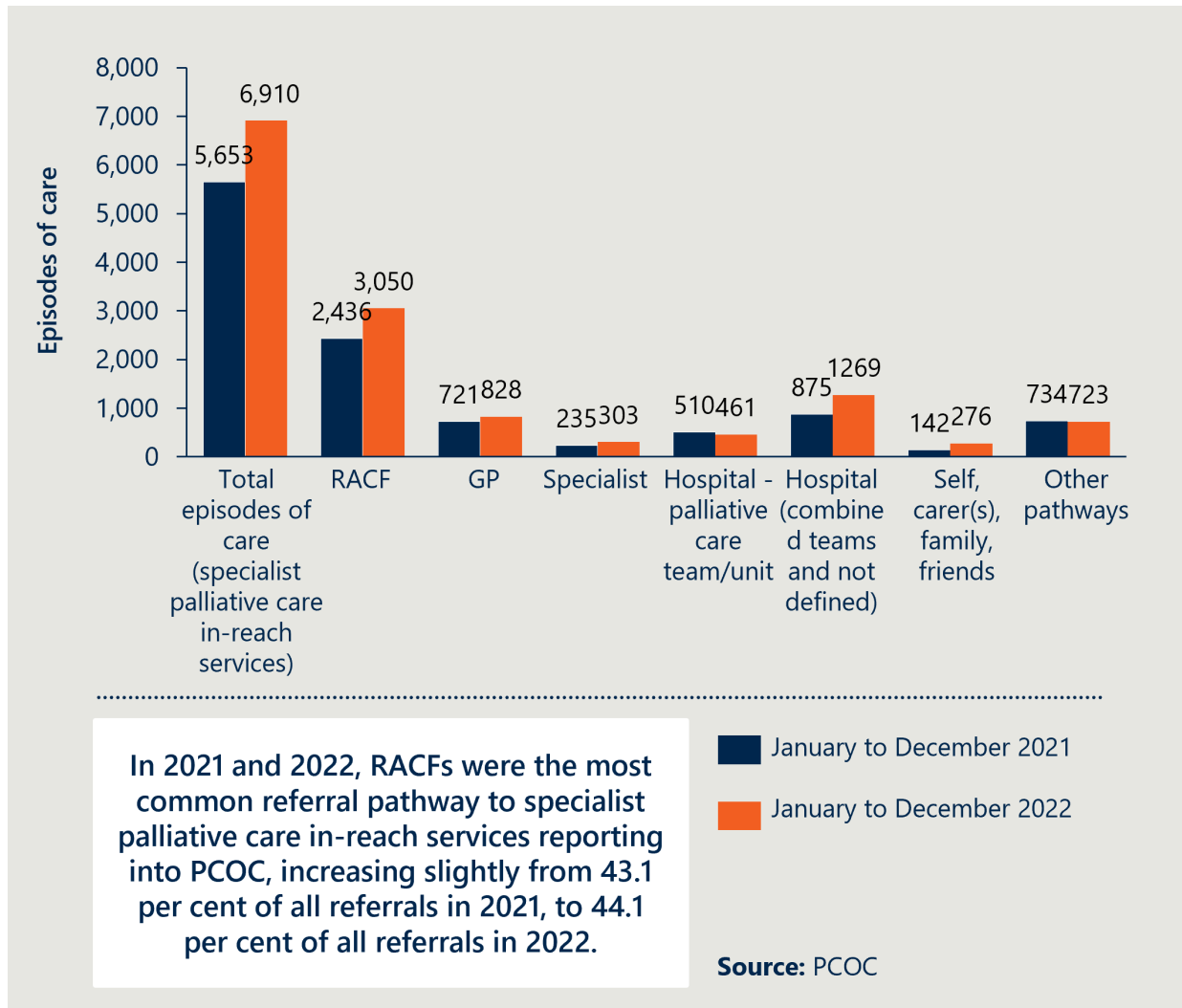
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<sup>67</sup> Research Centre for Palliative Care, Death & Dying, Flinders University, Comprehensive Palliative Care in Aged Care (CPCiAC) Pilot Projects in South Australia: Final Evaluation Report. May, 2023.

**PCOC provides performance information to palliative care services and health planners; however, its use continues to be limited and it does not capture information about RACFs.**

- PCOC collects information on palliative care outcomes alongside other information about the resident and support provided. The use of PCOC is voluntary but well established in palliative care services, some of which provide services to residents in RACFs. From January to December 2022, there were 51 specialist palliative care services conducting in-reach to residential aged care and reporting to PCOC, accounting for 6,910 episodes of care. This is a slight reduction from 57 services between January to December 2021, but an increase on the 5,653 episodes of care in that period.
- Of the 6,910 episodes of care, from January to December 2022, most referrals came from RACFs, which comprised of 44.1 per cent of all referrals to PCOC-reporting specialist palliative care services conducting in-reach services to RACFs, a slight increase from 43.1 per cent in 2021. Other major referral sources were hospital teams (25.1 per cent), GPs (12 per cent), specialist practitioners (4.4 per cent). These rates were similar between 2022 and 2021. There was also an increase in referrals from 'residents (self), carer(s), family, friends' from 2.5 per cent in 2021, to four per cent in 2022, suggesting there may be growing awareness of specialist palliative care in-reach services among this group. See Figure 4.
- From 2021 to 2022, there was also a slight increase in the number of residents who were a less stable condition when the specialist palliative care in-reach service commenced the episode of care. There was an increase in the proportion of residents identified as 'deteriorating' (from 56.8 per cent to 59.9 per cent) or 'terminal' (from 12.3 per cent to 12.9 per cent), suggesting that residents are further progressed in their palliative care episodes when the specialists team commence care (see Figure 3 on page 50).
- PCOC has developed a new model that RACFs can implement to capture similar information. This was piloted in 2021 and received some additional funding in the 2021-22 Australian Government Budget; however, data is not available on this program yet. Nous will aim to include this data in the final evaluation report.

Figure 4 PCOC-reporting specialist palliative care in-reach into residential aged care, by referral source, 2021-2022



**States and territories face significant challenges using administrative health data to understand palliative care services for RACF residents. NIHSI-AA provides a comprehensive data source across health and aged care but continues to be delayed.**

- During July-August 2023 data collection, all states and territories reported significant challenges in extracting and providing reliable administrative data to inform the evaluation. Nous requested a range of palliative care related indicators, drawing on jurisdictional administrative data from ambulance, hospital and outpatient systems. States and territories reported challenges in reliably identifying RACF residents in this data, with at least two jurisdictions undertaking a manual matching process based on patient and RACF address details as a compromise. States and territories also reported challenges with the timeframes for the request, and with strict internal approval processes, noting that data teams are under significant pressure with multiple priorities, and any findings published (based on quantitative data provided) would need additional clearance from the jurisdiction.
- As noted in the mid-point evaluation report, NIHSI-AA provides an accurate picture of RACF residents health service utilisation across RACFs, acute and primary care settings. However, the

time required for data collation, processing and linkage means that the data availability is delayed by two years, which presents a challenge for health planners seeking to use NIHSI-AA to inform decisions.

## Outcome 10: Improved clinical governance to identify and implement quality improvement initiatives and evaluation of outcomes within RACFs.

**Baseline assessment:** Only one per cent of aged care complaints since 2018 related to palliative and end-of-life. In 2021, 65 per cent of RACFs had recently implemented quality improvement initiatives. Complaints and the Royal Commission may have prompted these initiatives.

**Mid-point assessment:** Most jurisdictions are conducting their own internal monitoring and evaluation processes focused on systemic information collection, including activity and outcomes measurement within RACFs. Digital infrastructure in some jurisdictions is enabling improved data collection and sharing.

**Interim assessment:** There is emerging evidence of Measure activities improving clinical governance and quality improvement initiatives. Complaints related to palliative care continue to be low in 2023 (~one per cent) however there is still an opportunity for RACFs to improve governance systems, frameworks and risk management, based on Aged Care Quality Standards data.

### Outcome 10: Emerging interim findings

#### **There is some early evidence of Measure activities improving clinical governance and quality improvement initiatives.**

- Local evaluations being undertaken by three jurisdictions have focused on systematic information collection. South Australia, Tasmania and Queensland, through their evaluations which either solely or in part focus on CPCiAC activities, are systematically monitoring activities and outcomes within RACFs where the RACFs are implementing Measure activities. This monitoring and evaluation of activities implemented by RACFs would most likely not have occurred without the Measure. Western Australia is also conducting a 'deep dive' impact evaluation exploring RACF consumer and service provider perspectives that commenced 1 July 2023, with the final report due August 2024. This will rely on consultation and survey data and will not be informed by the state's administrative data.
- The internal evaluation in Tasmania is overseen by the CPCiAC Implementation Group, which includes representation from RACF management, and meets regularly to discuss progress and address emerging challenges relating to the evaluation.
- Western Australia has established multiple clinical governance groups that contribute to the ongoing performance and improvement of the activities funded under the Measure. These groups have laid the foundation for ongoing collaboration and service improvement across the palliative care and aged care service systems.
- The Northern Territory is utilising monitoring and reporting to inform quality improvement processes, as well as conducting reviews of existing educational resources in RACFs. In Central

Australia, education resources to support palliative care management in RACFs are being reviewed and updated to ensure that they are supporting the provision of high-quality care. Evaluation forms are also being distributed in some RACFs to understand resident, family and satisfaction with the quality of care. Both regions are monitoring emergency department data and conducting case reviews to understand if particular admissions were preventable.

- Infrastructure such as Digital Health Records and My Health Record can enable better data collection and sharing. In ACT, the Health Directorate reported a focus in the coming months on improved data governance and collection to assist with evaluating Measure activities. Also in the ACT, the PHN reported that improved systems, technology and infrastructure (as well as processes and individual capabilities) were needed to enable better communication and collection of data. This included rolling out Digital Health Record and promoting better use of My Health Record. The Tasmanian PHN also reported that implementing My Health Records could improve data sharing and care transitions.

**The vast majority of complaints to the ACQSC are not relating to palliative care, however there is still an opportunity in RACFs to improve governance systems, frameworks and risk management.**

- The total number of complaints received by the ACQSC has increased since 2018, however an extremely small proportion of these complaints are related to palliative care. From January 2018 to July 2023, only one per cent of all complaints to the ACQSC were about palliative care (see Figure 5).
- From July 2019 to July 2023, between 20-25 per cent of all RACFs assessed against the Aged Care Standards 8(3)c-e were found to have not met the standards (see Figure 6). While this rate has decreased in 2023, the overall rate is still higher than the majority of other standards and suggests that there continues to be improvements required in the governance systems, frameworks and risk management approaches in RACFs. As reported in Outcome 1, a greater proportion of higher risk sites were assessed during FYs 2020-2022. This could impact the number of RACFs found to have not met certain standards. Further investigation in the future is required.



Figure 5 Total, and palliative care related, complaints to the ACQSC from January 2018 to July 2023

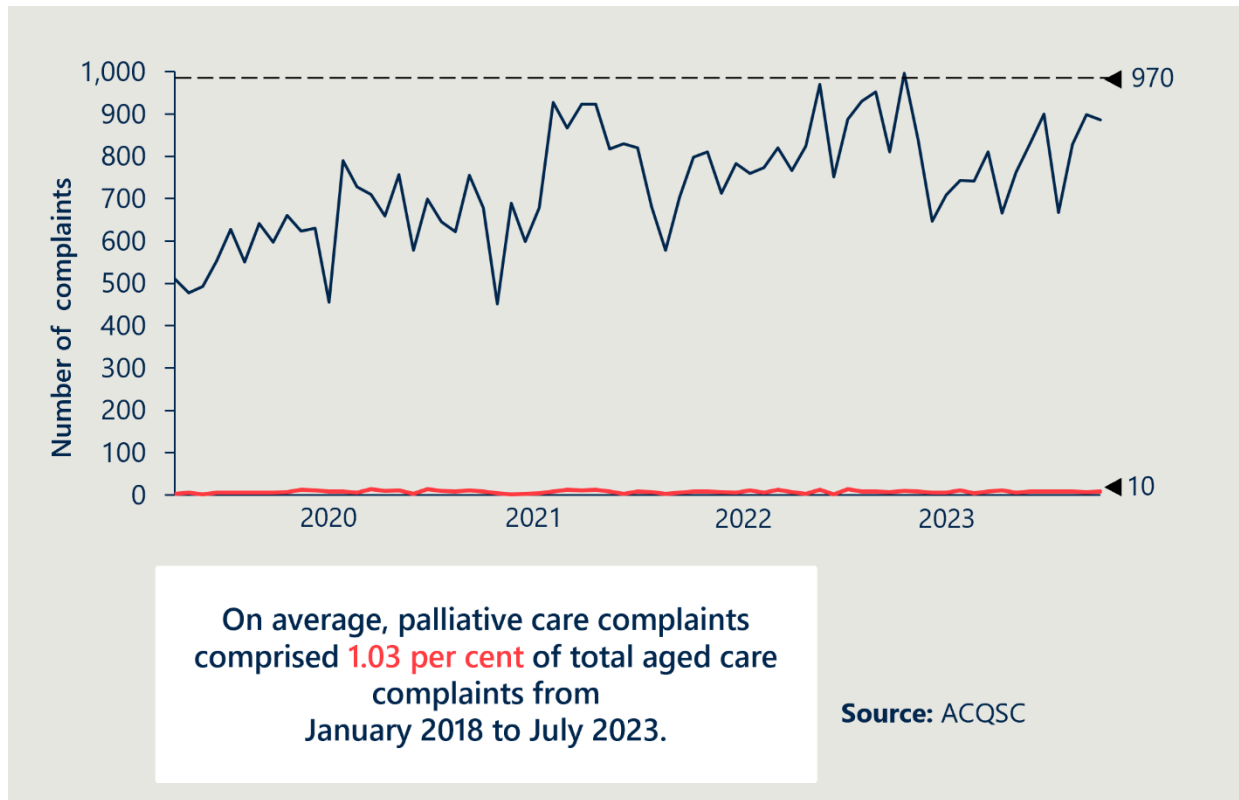
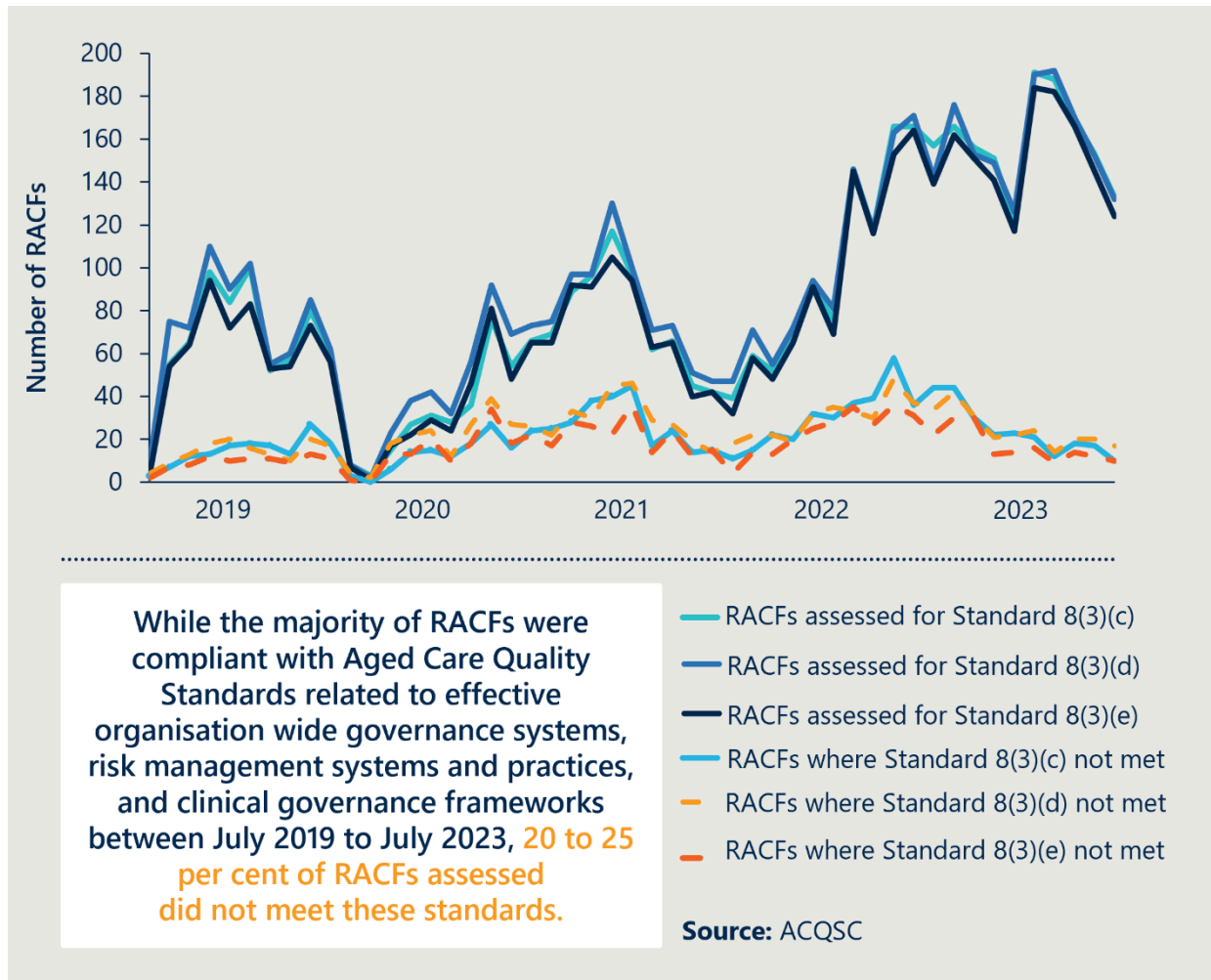


Figure 6 RACFs assessed for Aged Care Quality Standards 8c, 8d and 8e, from July 2019 to July 2023



## 5.4 Early success of models of care being implemented

Section 4.4.3 in the Mid-point Evaluation Report<sup>68</sup> defines seven key models of care that have been identified through a literature review of best practice palliative care service delivery<sup>69</sup> and consultation with states and territories. These models of care have been adopted to varying degrees across all jurisdictions using funding provided by the Measure. Table 9 provides updated progress and emerging findings related to these models of care across jurisdictions since the Mid-point report (reporting conducted in April 2022).

The models of care outlined in Table 9 below are not mutually exclusive, some have overlapping components. For example, needs rounds include access to specialist palliative care support, have education and training components and foster collaboration across multidisciplinary teams.

**Table 8 Summary of progress for models of care implemented across states and territories**

Model of care	Progress and emerging evidence for success	Implemented in
<b>Needs rounds</b>	<p>In consultations, jurisdictions reported some emerging outcomes including:</p> <ul style="list-style-type: none"> <li>improved ability of RACF staff to identify and respond to residents' palliative care needs and deterioration including earlier referrals to specialist palliative care services</li> <li>increased awareness of residents' ACPs and how to enact them, or where an ACP may be required</li> <li>improved GP engagement, confidence and coordination within RACFs to deliver palliative care.</li> </ul> <p>However, there have been some challenges with maintaining the model for some jurisdictions.</p> <ul style="list-style-type: none"> <li>South Australia and ACT reported that while valuable, needs rounds were one of the first activities to stop when RACF workload becomes overwhelming, even when embedded into business as usual.</li> </ul> <p>NSW highlighted that the needs rounds model, including full wraparound support, is resource intensive and multiple LHDs have pivoted to a more consultative, bedside approach to needs assessments.</p>	SA, TAS, QLD, NT, NSW, ACT

<sup>68</sup> Nous Group. National evaluation of the Comprehensive Palliative Care in Aged Care Measure- Mid-point Report. 2022.

<sup>69</sup> Nous Group. Literature Review Summary Report- National Evaluation of the Comprehensive Palliative Care in Aged Care Measure. 2020.

<p><b>Access to specialist palliative care support</b></p>	<p>In general, jurisdictions reported that RACF staff are better equipped to:</p> <ul style="list-style-type: none"> <li>• identify the palliative care needs of residents and address deterioration earlier</li> <li>• deliver palliative care and to hold conversations with residents and their families</li> <li>• enable improved communications with families and carers.</li> </ul> <p>In Western Australia, the MPaCCS program has been expanded under a 12-month trial to increase service hours and geographical reach across metropolitan RACFs. The MPaCCS model has improved collaboration between GPs and RACF staff, including the ability of RACF staff to advocate to GPs and families on behalf of residents with complex needs.</p>	<p>ACT, SA, QLD, TAS, NSW, NT, WA</p>
<p><b>Education and training</b></p>	<p>While some stakeholders reported that education and training they had received or available resources were useful, many commented on that staff capacity and turnover is a challenge to building staff capability in the long-term.</p> <ul style="list-style-type: none"> <li>• Queensland commented that in the future, they would have conducted smaller, more frequent training sessions to mitigate this issue, instead of investing in large one-off blocks of training.</li> <li>• Tasmania and ACT also commented on workforce turnover, however mentioned that often staff move between RACFs in similar regions. As a result, the jurisdictions did not see this as a complete loss, given that the skills that staff would have acquired would remain within the sector.</li> </ul> <p>Western Australia pivoted their RACEPC Communicate education program to an online delivery format due to reduced accessibility to RACFs during the COVID-19 pandemic and changing RACF education needs identified through consultation with providers. The pivot allowed for greater accessibility for RACF staff to access small pieces of education and training.</p>	<p>WA, VIC, SA, NT, NSW, QLD</p>
<p><b>Traineeships</b></p>	<p>South Australia's reported some benefits to their traineeship model (see Case study 1, page 30), including:</p>	<p>SA, TAS</p>

	<ul style="list-style-type: none"> <li>expanded workforce capacity</li> <li>improved confidence and palliative care specialist skillset among personal care workers through access to mentoring opportunities</li> <li>greater recognition and feeling valued among personal care attendants.</li> </ul> <p>Tasmania has had two GP registrars complete the palliative care rotations enabled by the Measure, who are now palliative care advanced trainees, and another three candidates have been recruited. As outlined in Case study 3 (page 41), the program is showing success in building buy-in and interest in the palliative care specialty from GP trainees.</p>	
<b>Incentivising shared care</b>	<p>Reports from clinicians and RACF staff from South Australia in consultations for the Mid-point report indicated that providing financial incentives to GPs may be associated with better GP participation in needs rounds. Since then, South Australia have found that having specialist-led needs rounds was more successful in encouraging GP involvement than financial incentives.</p> <p>Western Australia is piloting a model for Case-Conferencing Coordinators located in metropolitan RACFs whose role is to support primary care coordination between General Practice and RACFs, coordinate case conferencing aided by Medicare Benefits Schedule (MBS) items, and develop systems and processes to be sustainable for GPs and RACFs.</p>	SA, WA
<b>Access to multidisciplinary resources</b>	<p>Case conferencing and needs rounds across multiple jurisdictions has reportedly increased resident access to nursing and primary care staff, as well as GPs and specialist teams. Queensland, South Australia and the Northern Territory highlighted that virtual care delivery has enabled improved coordination across multidisciplinary teams.</p> <p>Tasmania has recruited a social worker in the North-West and broker allied health services across the other regions to support holistic, wraparound care for residents.</p>	NSW, SA, WA, QLD, NT, ACT, TAS, VIC
<b>Culturally safe and</b>	<p>In Western Australia, a major education provider has incorporated cultural education for all RACF staff relating to Aboriginal and Torres Strait Islander and CALD</p>	VIC, NT, WA

<p><b>appropriate models of care</b></p>	<p>community communication in all e-learning modules and exists in all virtual delivery options. The provider employs Aboriginal actors to play patient roles in simulation-based education on communicating Advance Care Planning and Goals of Care education sessions.</p> <p>Victoria is also implementing a model of care that supports Elders to access culturally safe and effective palliative and end-of-life care.</p>	
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**Regardless of the model of care, some common factors enable their success**

In the Mid-point report, Nous identified some common enabling factors that support models of care to be successful, regardless of which model is being implemented. These broadly align to the success factors identified in the literature review conducted as part of this evaluation in 2020.

Based on consultation and data collection in July 2023, the following common factors that support ongoing success of models of care include:

- The quality and capacity of the surrounding health system. In consultations, stakeholders emphasised the importance of effective primary and acute health system infrastructure in facilitating access to palliative care. For example, the effectiveness and ability to deliver needs rounds relies on the availability of NPs (or other specialist palliative care practitioners), local GPs and the capacity of RACF staff. In the Northern Territory and rural areas of Queensland, there is a lack of GPs and allied health staff which inhibits the success of multidisciplinary models of care.
- Open communication between families/carers and RACF staff. Families and carers need communication to understand their family member is being cared for. For example, the Northern Territory and South Australia developed resources for RACF staff to communicate with families and carers and encourage conversations relating to the end-of-life process for their loved ones.
- Mechanisms and processes to support and educate staff to identify residents needing palliative care. High workforce turnover limits the effectiveness of one-off education and training for RACF staff. An ongoing finding is the need to embed education policies and procedures into RACF settings, to ensure a more sustainable investment of education and training initiatives. Several jurisdictions highlighted the value of embedding small blocks of training into their existing procedures and struggled to get engagement for education programs that required more significant time commitments. Jurisdictions also emphasised the importance of ACPs to support shared and integrated care for residents and their families and carers.
- Working collaboratively with stakeholders, including RACF leadership. Stakeholders reported that engagement with RACFs to ensure buy-in was essential to the implementation of new models of care. There is some evidence that leveraging existing relationships is an effective strategy. Western Australia reported that existing programs that had been expanded using the Measure funding, had more success due to their existing relationships with RACFs, compared to new programs that struggled to gain traction in the implementation stage.

## 5.5 Extent to which the Measure addresses interface issues

**Health system interface issues continue to be a challenge, however there is ongoing evidence that the Measure is addressing these issues.**

The literature review conducted by Nous in 2020 at the outset of the evaluation identified the key health interface issues that RACFs, primary care and acute care sectors are seeking to address.<sup>70</sup> The Mid-point report outlined the emerging evidence that the Measure is an effective mechanism to address health-aged care interface issues, though implementation was in its early stages in many states and territories.

In this reporting period, Nous heard ongoing evidence of the Measure helping to address interface issues, as well as challenges that continue to persist.

**Multidisciplinary teams bolster collaboration through case-by-case discussions.**

There is evidence of improvements to coordination between GPs/primary care, acute care services and specialist palliative care services. The Measure has enhanced collaboration by supporting the establishment of multidisciplinary teams in RACFs to provide valuable care for residents and their families.

- South Australia reported that where Specialist Palliative Medicine Consultants lead the needs rounds, particularly in the RSS CPCiAC sites in regional and rural parts of the state, this fosters collaboration with RACF staff and builds interest in the palliative care speciality amongst GPs and GP registrars. SA have observed the GPs bringing registrars to the needs rounds because they view it as a valuable learning opportunity.
- In Tasmania, GP registrars attend CNC-led needs rounds. The CPCiAC team have reported that engagement between GPs and RACF staff has had a significant positive impact on Measure projects. Tasmania have also recruited to 0.2 FTE social workers to attend needs rounds with the CNC and GP registrar to provide social work resources to residents and their families in a pilot program, showing early success.
- In Western Australia, the GP case conferencing coordinators support primary care coordination between GPs and RACFs to provide an additional resource to RACFs and reduce administration burden on GPs.
- The Northern Territory report that care is most effective when needs rounds teams, including a GP, discuss individual cases together.

**Coordination issues can be mitigated by dedicated positions and structures that support collaboration.**

South Australia, Western Australia, Queensland and the Northern Territory have reported that multidisciplinary collaboration can occasionally cause friction and have implemented strategies to mitigate this, with emerging success. Having a dedicated CPCiAC support team, establishing linkage roles, and strengthening communication pathways can help address potential conflict.

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<sup>70</sup> Nous Group. Literature Review Summary Report- National Evaluation of the Comprehensive Palliative Care in Aged Care Measure. 2020.

- In Western Australia, the Liaison Nurse role in the MPaCCS project works with stakeholders across the health and residential aged care sector to improve the interface issues between hospitals and RACFs, aiming to smooth the transitions of residents between the two and minimise the use of acute hospital resources. Additionally, specific roles within other projects have been established to improve interface issues between hospitals and RACFs for specific regions, these include the Transition Support Navigator (North Metropolitan Health Service), Care Coordinator (South Metropolitan Health Service) and Transition Support Office (East Metropolitan Health Service).
- In Queensland, the SPACE team, comprising of clinical leads and coordination staff within Queensland Health, reported making in-person visits to facilities experiencing friction between medical and nursing staff. The SPACE team help to improve communication and collaboration between facility staff and the multidisciplinary teams, and report that this hands-on approach has been effective.
- Similarly, the SPaRTa telehealth model in regional areas connects a local RACF staff member to the SPACE team for support, which can also add legitimacy when the staff contact the GP.
- In the Northern Territory, the Central Australia project created a communication channel between key GPs, hospital clinicians and RACF management staff. This was done mainly by advisory links via phone and telehealth, and has led to the development of strong and supportive relationships.
- South Australia is developing a framework for regional RACFs to recruit Link Nurses to attend professional development and then facilitate education sessions for staff, or stream sessions from metro facilities. Link Nurses are designed to play more of an educator role than a clinical role, to build capability in regional RACFs and connect with metro facilities. It is a pilot program at this stage.

**Jurisdictions reported that care coordination between aged care, specialist care and GPs remains an ongoing challenge.**

- The ACT reported that factors impacting low engagement with GPs centre around payment and time. RACFs visits occur after business hours, requiring the GPs to attend outside of contracted hours. This is reportedly not supported by the Medicare Benefits Schedule (MBS) billing items, resulting in inadequate remuneration, which disincentivises GP engagement.
- Tasmania also reported challenges with GP engagement and coordination, stating that ongoing communication and relationship building with GPs is an effective mitigation strategy to address this.
- In Queensland, online GP services have acted to both address health system interface issues and create challenges. GP coordination through online GP services has been difficult, as continuity of care is minimal. The Queensland CPCiAC team reported that continuous and persistent engagement with GPs has mitigated this to an extent. The team also reported that GPs often deny their patient is palliative, though this has reportedly improved through ongoing engagement with palliative care services.



## 5.6 Effectiveness of joint funding and delivery arrangements

**At the Mid-point of the evaluation, there was evidence that the Measure was improving collaboration and the health-aged care interface, despite some implementation challenges.**

The Mid-point evaluation report highlighted that the Measure is demonstrating success at improving collaboration at the health-aged care interface. Mid-point data collection found evidence that:

- Joint funding has enabled greater scale and scope of jurisdictions to respond to palliative care in aged care that otherwise would not have occurred, by providing additional resources and enabling specialist palliative care services to focus on palliative care outside community and hospital settings.
- Joint funding has strengthened collaboration to improve palliative care between health and aged care stakeholders, by helping to address siloed ways of working and align staff around a common purpose.
- Joint funding and delivery arrangements have enabled design of innovative models of care by states and territories, including South Australia's Eldercare traineeships and Western Australia's hospital transition support roles.

**There is ongoing evidence that the Measure funding has enabled states and territories to explore new and innovative approaches to palliative care, addressing existing palliative care needs and service gaps.**

- South Australia, Tasmania, Queensland and Western Australia all reported that the Measure funds have been used to explore and implement innovative approaches to palliative care not previously funded or that would not have occurred otherwise.
  - While the Measure funds enabled South Australia to expand an existing service delivered by Eldercare, left-over funds have been used to explore how to expand this model and ensure it is sustainable within non-Eldercare sites, by focusing on providing the resources used to build other provider's capabilities.
  - In Tasmania, the Measure funds have enabled the palliative care service to implement a proactive in-reach model which the state reported was not previously possible. The proactive nature of the service has improved confidence of RACF staff to understand when and how to seek support from the specialist service. Tasmania reported that there was 'no way' to absorb this model into the existing services they had prior to the Measure.
  - In Queensland, all but two HHS reportedly had nothing similar to the current specialist palliative care team service that has been established in the SPACE model through Measure funds.
  - Western Australia reported that the funding has enabled collaboration across providers and teams within the Department of Health that would not have happened otherwise, while also allowing effective services (such as MPaCCS) to enhance their existing in-reach services.

- Tasmania and South Australia reported that Measure activities are enabling palliative care teams in those states to identify more palliative care needs and be equipped to respond to these. In Tasmania, specialist palliative care referrals by RACFs have increased by 51 per cent since the CPCiAC Measure was implemented.

**There is emerging evidence that some jurisdictions have established effective governance structures to support Measure implementation, shape delivery of activities and maintain accountability.**

- Tasmania, Western Australia and Queensland reported establishing a range of governance structures and approaches to support Measure implementation, including internal governance groups and communities of practice (both internal and with key service partners) to shape the delivery of Measure activities and maintain accountability across devolved models of care.
- Queensland reported that oversight from the state health department is helpful to provide governance and facilitate a community of practice. Tasmania's health department has also facilitated a community of practice with GPs and used this forum to promote CPCiAC activities. Queensland noted however that a pure 'top down' approach would likely not have been effective, and that the funding enabled a good balance for HHSs to design their models of care, while the Department holds them accountable to an agreed set of service principles.
- South Australia reported the need to be more hands on with one provider than another, due to the staff shortages and organisational maturity of that provider.

**The Mid-point evaluation report also highlighted some challenges in Measure implementation, including with engagement between the Commonwealth and jurisdictions, the time limited nature of the funding and the lack of specific data collection requirements.**

- Greater engagement between the Australian Government and states and territories in developing the Measure would have prevented some of the implementation delays. Due to budget confidentiality, there was no opportunity to partner with the jurisdictions in the development of the Measure, meaning that jurisdictions were not informed in advance about funding requirements or the nature of the contributions, contributing to delays in Measure implementation to allow jurisdictions time to find funding.
- The time limited, unweighted funding allocations limited the impact delivered by states and territories to certain regions. The Measure funding was allocated based on a per-capita distribution, and not weighted by the additional costs and care needs for priority populations, such as rural or Aboriginal and Torres Strait Islander populations. Northern Territory noted the financial and time costs of accessing RACFs in remote areas to provide education and care, reporting that the current funding distribution does not reflect the needs of the Northern Territory to provide equitable services.
- Lack of clear accountability and specificity for data collection and reporting makes it more challenging to understand the national impact of the Measure.

**States and territories have reported ongoing challenges with the time limited nature of the funding, and lack of advance notice about funding requirements.**

- States and territories requested further clarity on the intentions of the Department to seek an extension to the CPCiAC Measure and when a decision could be expected. Multiple states and territories raised the issue of temporary funding as a concern, due to the uncertainty it creates for staff whose positions are funded by CPCiAC Measure funds and challenges with retaining skilled staff in time-limited contracts.
- All states and territories (Health Department representatives) are supportive of an extension to the Measure, but noted they would need adequate notice and time to seek support from jurisdictional Treasury Departments and notify teams delivering the CPCiAC activities. For example, NSW noted that in order to have adequate time to notify LHDs and organise matched funds at the state-level, they would need to know the decision of the Measure extension by November 2023.

**There is ongoing evidence that the unweighted funding design has led to implementation challenges.**

- There is some evidence that the unweighted design of how funding is distributed has meant that the distribution of CPCiAC activities is not necessarily proportional to need or system barriers experienced in rural and regional areas. Queensland reported that funding distribution across HHSs is decided based on number of RACF beds and does not consider the systemic access challenges faced by certain populations/regions.

**There is evidence of ongoing issues with data collection and evaluation requirements impacting the quality of data collected for evaluation purposes.**

- There is variability in the extent to which states and territories are conducting evaluations, the detail with which these consider CPCiAC Measure activities and the timing for when they will be available to inform the evaluation. While Tasmania, ACT, South Australia, Western Australia and Victoria are conducting evaluations, it is not clear whether these will be finalised in time to inform the final national evaluation report. NSW has advised their evaluation, which is broader than the CPCiAC Measure, will not provide any relevant insights to the national evaluation. The Northern Territory is not conducting an evaluation.
- A quantitative data request was sent to states and territories to inform this Interim Report, however the data received in response was variable, with significant gaps. Jurisdictions reported challenges in responding to the indicator request without standardised national specifications, coordinating timely data extraction with their data custodians and reliably identifying RACF residents in their administrative datasets. There is limited administrative data available directly from states and territories to inform the evaluation and a reliance on standardised, linked national datasets such as NIHSI-AA which is delayed in its availability.
- As reported in the Mid-point evaluation report, there is opportunity to specify requirements for states and territories about the type (and timing) of data to collect and share and/or specific funding for state/territory evaluations to enable more rigorous monitoring of success of models of care.

**There is an opportunity to clarify roles and responsibilities across aged care, health and primary care to support collaboration across these sectors and implementation of the Measure.**

One state reported that local health networks had reported some concerns that they were conducting activities that were the responsibility of RACF staff. The ACT reported that although some RACF staff build capability and take leadership in palliative care activities, such as needs rounds, this can be personality dependent and there can be a reliance on specialist palliative care teams by RACF staff. Clearly articulated responsibilities of staff across aged care and primary care roles could support effective collaboration and implementation of the CPCiAC Measure, particularly among multi-disciplinary teams and service provision at the interface of health-aged care.

## Appendix A Jurisdictional summaries

This appendix provides detailed information on state and territory approaches to implementing the Measure. For each state/territory, the summary provides:

- key statistics, such as total Measure funding and the number of RACFs and residents
- key policy priorities and/or contextual information related to palliative care in aged care
- activities originally planned under the Measure
- progress made in implementation to June 2023 and any early benefits reported.

### A.1 Australian Capital Territory

ACT has rolled out the PCNR model out across the Territory. Implementation of Measure-funded activities is now 'business-as-usual', however there are ongoing challenges in recruiting for funded roles.

**Table 9 Implementation approaches and activities in the ACT**

<p><b>Summary</b></p>	<ul style="list-style-type: none"> <li>• Total funding: \$2.2 million</li> <li>• Population in RACFs: 2,334</li> <li>• Number of RACFs: 29</li> <li>• Number of RACFs impacted by Measure activities: 29</li> <li>• Evaluation being undertaken: Yes</li> <li>• Delivery approach: centralised delivery. Coordinated by the PEACE team at Calvary Public Hospital Bruce, Clare Holland House</li> </ul>
<p><b>What is the policy and operating context?</b></p>	<ul style="list-style-type: none"> <li>• ACT is predominantly using Measure funds to expand the INSPIRED model across the ACT, which was previously evaluated through a randomised controlled trial and is now referred to as the PCNR model. The trial of needs rounds in</li> </ul>

	<p>the ACT started in February 2017, conducted by the Palliative Aged Care Specialists (PEACE) and North Canberra Hospital (formerly Calvary Public Hospital Bruce) and was funded by ACT Health.</p> <ul style="list-style-type: none"> <li>• ACT also has a Geriatric Rapid Acute Care Evaluation (GRACE) team who sit alongside the PCNR model and help to manage the transfer of aged care patients to and from hospital (not necessarily aged care patients). The GRACE service provides clinical care to RACFs residents to better manage their conditions, preventing a trip to hospital.</li> </ul>
<p><b>What did ACT plan to implement?</b></p>	<ul style="list-style-type: none"> <li>• Nurse Practitioners and needs rounds – Recruit 4.3 FTE palliative care nurse practitioners to roles to support the delivery of specialist palliative care services, both in-reach and out-reach, to all RACFs across the ACT through a PCNR model of care.</li> <li>• Education and training for RACFs to build capacity and capability in all RACFs and workforce succession planning.</li> <li>• Expand and build on existing in-reach models of specialist palliative care within RACFs across the ACT with care being delivered based on the risk stratification and clinical need of residents, identified through PCNR, case conferences and clinical work through referrals.</li> <li>• The PCNR model consists of three components:             <ol style="list-style-type: none"> <li>1. PCNR</li> <li>2. Case conferences</li> <li>3. Clinical work with residents</li> </ol> </li> </ul>
<p><b>What has been progressed as at June 2023?</b></p>	<p>Implementation progress includes:</p> <ul style="list-style-type: none"> <li>• The PCNR model has been rolled out across the ACT and is now considered business-as-usual. At least one component of the PCNR model is being implemented in each RACF in the ACT. All facilities contact the in-reach specialist team if needed but there are varying levels of consistent engagement with the model as a whole.</li> <li>• The major barrier to implementation has been the recruitment of Nurse Practitioners to the funded positions. Ongoing training to transition experienced nurses to specialist palliative care roles and succession planning is pivotal to the model's success. Recruitment to the roles is an ongoing challenge, including through the absence of the Transition Nurse Practitioner role in the ACT nursing enterprise agreement.</li> </ul>

	<ul style="list-style-type: none"> <li>The CPCiAC team hope to meet with each RACF to discuss their internal evaluation findings to help improve engagement.</li> </ul>
<b>What evidence exists of early benefits?</b>	<p>Early benefits of the Measure activities include:</p> <ul style="list-style-type: none"> <li>The PCNR model has seen such success it is now business-as-usual in all RACFs in the ACT.</li> <li>The case conferences model has high engagement across the health and aged care sectors, coordinating GPs, RACF staff, specialist palliative care nurses and others as required (such as pharmacists). The CPCiAC team report often having to run the case conferences but that they are more effective when led by the registered nurses or RACF care teams, as they provide a greater level of trust and are more person-centric.</li> <li>PCNRs have allowed the CPCiAC team to assess the RACF staff's literacy of death, to inform where to target training and education about death, deteriorating residents and escalation pathways.</li> <li>Needs rounds and the PEPA program have provided support to RACF staff. The ACT CPCiAC team shared that one RACF manager reported they had gained confidence from completing the PEPA program and has shared their newfound knowledge with their staff, to further educate about monitoring and managing signs of distress and deterioration in residents.</li> </ul>

**Table 10 Models of care implemented in the ACT**

<b>Model of care</b>	<b>Description</b>	<b>Model of care category</b>
<b>PCNR</b>	Monthly 60-minute triage (and risk stratification) meetings, where up to ten residents with a short prognosis and high symptom burden are presented.	Needs rounds
<b>Case conferences</b>	Case conferences between RACF, the resident, relatives and relevant health care providers (e.g., the GP) are facilitated by either the PCNR team or RACF staff.	Needs rounds
<b>Clinical work with residents</b>	Both needs rounds and case conferences may lead to referrals for direct specialist palliative care clinical work with residents.	Access to specialist palliative care support

## A.2 New South Wales

LHDs in NSW have each received equal Commonwealth funding and developed local plans to implement the Measure. Implementation is progressing across LHDs.

**Table 11 Implementation approaches and activities in NSW**

<p><b>Summary</b></p>	<ul style="list-style-type: none"> <li>• Total funding: \$20 million</li> <li>• Population in RACFs: 61,094</li> <li>• Number of RACFs: 916</li> <li>• Number of RACFs impacted by Measure activities: 404 (across the 14 LHDs that provided data in this reporting period)</li> <li>• Evaluation being undertaken: External evaluation of broader framework</li> <li>• Delivery approach: de-centralised delivery. LHDs received equal funding to develop local plans that reflect local needs.</li> </ul>
<p><b>What is the policy and operating context?</b></p>	<ul style="list-style-type: none"> <li>• The NSW Health End of Life and Palliative Care Framework 2019-24 has influenced reviews of local services. The NSW Ministry of Health has contracted an external evaluation of the Framework, across five priorities. As part of this evaluation, CPCiAC will be covered. There has also been state budget commitments (in 2017, 2019, 2020 and 2021) on workforce enhancements, use of virtual care, education and training, refurbishments, medical specialists, and regional and rural services.</li> <li>• The Voluntary Assisted Dying Act 2022 (NSW) was passed in May 2022 and will come into effect on 28 November 2023. The NSW peak body for palliative care have asserted that VAD is not and should not impact palliative care services.</li> </ul>
<p><b>What did NSW plan to implement?</b></p>	<ul style="list-style-type: none"> <li>• All LHDs and St Vincent’s Health Network received equal funding to develop local plans that reflect local needs. The plans outline appropriate models of care to address gaps and indicates where workforce will be enhanced. 16 LHDs have commenced implementation of local projects.</li> <li>• Across the LHDs, varying models of care have been implemented. These models include:             <ol style="list-style-type: none"> <li>1. Needs rounds model</li> </ol> </li> </ul>



	<ol style="list-style-type: none"> <li>2. In-reach model</li> <li>3. Adapted Decision Assist linkages model</li> <li>4. Older persons project</li> <li>5. ELDAC Linkages Program</li> <li>6. Improved pathways and virtual care model</li> <li>7. Education and training focus</li> </ol> <ul style="list-style-type: none"> <li>• Education and training approaches include the Palliative Approach Framework (PAF) resource embedded in facilities and used during needs rounds discussions, PEPA education sessions and pop-up training sessions from district nurses.</li> </ul>
<p><b>What has been progressed as at June 2023?</b></p>	<ul style="list-style-type: none"> <li>• Many LHDs are recruiting designated roles, including Clinical Nurse Specialists, NPs, Network Managers, Allied Health and a Palliative Care Medical Registrar. Several LHDs have a particular focus on training, in particular Far West, Murrumbidgee, Nepean Blue Mountains, Northern NSW and Western NSW LHDs.</li> <li>• Six LHDs have adapted their palliative care needs rounds models to a more active in-reach consultative approach to mitigate the high resourcing demands of needs rounds and subsequent wraparound care required.</li> <li>• All districts report high RACF staff turnover as the most common barrier to effective implementation on the ground. This impacts sustainability and limits the impact of in-reach services, partnership development and efforts to build capacity and capability across the sector.</li> </ul>
<p><b>What evidence exists of early benefits?</b></p>	<p>Early benefits of the Measure activities include:</p> <p>Benefits of the Measure are variable across NSW due to high variability across approaches adopted by LHDs.</p> <ul style="list-style-type: none"> <li>• In Western Sydney LHD, the transitional nurse practitioner (TNP) provides palliative care clinical expertise and support, in conjunction with a multidisciplinary team. Since commencement of the TNP role (March 2023), 114 residents have been supported.</li> <li>• Murrumbidgee LHD has worked closely with ELDAC to deliver training programs to a total of 26 RACFs with the aim of increasing confidence and capabilities of clinical and non-clinical staff. In the most recent cohort of RACFs to undergo the training, personal care workers reported improvements across all skills.</li> </ul>

- Hunter New England has purchased new equipment and reported that the consultancy and partnership approach between Palliative Care and Aged Care services has been received positively.
- Southern NSW LHD (SNSWLHD ) has a formal agreement with an external provider Palliative Aged Care Consultancy Service (PACCS) to provide 672 hours of service by a Clinical Nurse Consultant per annum to specific aged care facilities within SNSWLHD between February 2022 and 30th June 2024.

Table 12 Models of care implemented in NSW

Model of care	Description	Model of care category
<b>Needs rounds model</b>	Four districts are implementing needs rounds which provide direct clinical support for residents and monthly one-hour triage meetings.	Needs rounds
<b>In-reach model</b>	An adaptation of needs rounds, led by CNCs, CNS' or NPs to be delivered as a consultative model to oversee palliative care delivery for residents.	Access to specialist palliative care support
<b>Adapted Decision Assist linkages model</b>	Specialist Palliative Care Link-Nurse to embed systems and clinical frameworks for a sustainable palliative approach to care in RACFs and RAC beds.	Access to specialist palliative care support
<b>Older persons project</b>	Using a redesign methodology to understand local context, issues and readiness of RACFs. Emphasis is on patient and family journey, data systems, and building workforce capacity.	Access to specialist palliative care support
<b>ELDAC Linkages Program</b>	Working with ELDAC to build capacity within all RACFs across an LHD. Focuses on capacity building, technology, information sharing, improved partnerships.	Education and training

<b>Improved pathways and virtual care model</b>	Education/training development for RACF clinicians and primary care providers. Focus on partnerships, sharing policy/guidelines and virtual care.	Education and training
<b>Education and training focus</b>	All districts have incorporated capacity building of RACF staff into their models and/or positions. Five districts are focusing on education and training.	Education and training

### A.3 Northern Territory

The Northern Territory has two projects underway in Central Australia and Top End. The Measure is being used to establish in-reach screening rounds and provide additional education, training and support to the RACF workforce.

**Table 13 Implementation approaches and activities in the NT**

<b>Summary</b>	<ul style="list-style-type: none"> <li>• Total funding: \$1 million</li> <li>• Population in RACFs: 514</li> <li>• Number of RACFs: 13</li> <li>• Number of RACFs impacted by Measure activities: 13</li> <li>• Evaluation being undertaken: Monitoring</li> <li>• Delivery approach: Centralised delivery. Managed and coordinated by the Department of Health, two project teams operating in Central Australia and Top End.</li> </ul>
<b>What is the policy and operating context?</b>	<ul style="list-style-type: none"> <li>• Stakeholders in the Northern Territory identified structural and system-wide issues that have hindered implementation, particularly in the Central Australia Region. These included limited capacity of RACFs to provide palliative care, limited capacity in the clinical health workforce (including GPs) and challenges retaining RACF staff.</li> </ul>

	<ul style="list-style-type: none"> <li>Stakeholders have reported difficulties providing consistently high-quality and holistic palliative care in the RACF settings across the Northern Territory given the structural issues and workforce challenges. COVID-19 exacerbated these challenges.</li> </ul>
<b>What did NT plan to implement?</b>	<ul style="list-style-type: none"> <li>Project 1: Central Australia Palliative Care Coordination</li> <li>Project 2: Top End Palliative Care Coordination</li> </ul>
<b>What has been progressed as at June 2023?</b>	<p>Implementation progress includes:</p> <ul style="list-style-type: none"> <li>Services provided by the Measure have expanded to impact six additional RACFs since the Mid-point report.</li> <li>Top End implementation is progressing well. Weekly needs rounds screening has been continued. Targeted case reviews occur with attendant GPs on a case-by-case basis and include family members where appropriate.</li> <li>Central Australia was delayed in implementation, due to COVID-19 challenges and associated issues with staffing. Videoconference meetings are facilitating needs rounds with RACF senior nursing staff as required. Tennant Creek regular visits have resumed.</li> <li>A two-day education course was held in Tennant Creek (Central Australia), Juninga Centre and Terrace Gardens (Top End) with the Program of Experience in the Palliative Approach (PEPA) with the focus of increasing capabilities across clinical and non-clinical RACF staff.</li> <li>Staffing is a major barrier across the health and aged care workforces in the Northern Territory. COVID-19 contributed to large reductions in workforce capacity, caused by staff redeployment to hospitals and people leaving the sector all together. The latter has left significant gaps in the workforce, many of which have remained unfilled.</li> </ul>
<b>What evidence exists of early benefits?</b>	<ul style="list-style-type: none"> <li>Central Australia has reported improved communication channels between GPs, hospital clinicians and RACF management in Alice Springs and Tennant Creek, mainly by advisory links via phone and telehealth. This includes improved follow-up communication with clinicians regarding advance care planning.</li> <li>In the Top End, there is an improved data collection and review process in Royal Darwin Hospital and Palmerston Regional Hospital. ED admissions for residents are being reviewed to identify if the admission was preventable. Additional data capture is also being conducted on new referrals, deaths and place of death for RACF residents.</li> </ul>

- There is a focus on reviewing resources available to RACF staff to ensure that they align with up-to-date best practice, and appropriately support them in engaging in conversations relating to palliative care and end-of-life care planning with residents and families. This includes referral criteria to be used as a guide across four RACFs to improve the referral process for residents to specialist services.

Table 14 Projects implemented in the NT

Project	Description	Model of care category
<b>Project 1: Central Australia Palliative Care Coordination</b>	<p>Project 1 has shifted from the initial model of care, which was the Palliative Needs Assessment approach. This approach included PCNRs and additional support for RACFs and attending GPs to develop a plan for end-of-life preferences.</p> <p>Project 1 now consists of a regular cycle of basic palliative care education for RACFs. This includes site visits, patient referrals, support for care staff, debriefing of deaths. Project 1 has focused on the Tennant Creek RACF, due to identification of significant needs.</p>	<ul style="list-style-type: none"> <li>• Access to specialist palliative care support</li> <li>• Education and training</li> </ul>
<b>Project 2: Top End Palliative Care Coordination</b>	<p>Project 2 aims to establish and formalise relationships with RACF GPs nursing staff and clinical leads of the four RACFs in Top End Northern Territory.</p> <p>Project 2 provides regular palliative care screening rounds and includes the development of education schedules for RACF staff and Palmerston Regional Hospital staff. Telehealth methods are being used by Palmerston Regional Hospital to avoid delays in seeing patients, hence preventing unnecessary admissions to Royal Darwin Hospital.</p>	<ul style="list-style-type: none"> <li>• Needs rounds</li> <li>• Access to specialist palliative care support</li> <li>• Education and training</li> </ul>

## A.4 Queensland

Queensland have taken a devolved but collaborative approach, with each HHS on track to implement a model of care aligned to local need.

**Table 15 Implementation approaches and activities in the Queensland**

<p><b>Summary</b></p>	<ul style="list-style-type: none"> <li>• Total funding: \$18 million</li> <li>• Population in RACFs: 37,872</li> <li>• Number of RACFs: 507</li> <li>• Number of RACFs impacted by Measure activities: 433</li> <li>• Evaluation being undertaken: Yes, internal evaluation.</li> <li>• Delivery approach: Decentralised delivery, managed and coordinated by a central team in the health department but with decision-making authority delegated to each HHS to use funding to design and deliver individual models of care.</li> </ul>
<p><b>What is the policy and operating context?</b></p>	<ul style="list-style-type: none"> <li>• The state-wide Strategy for End-of-Life Care (2015) describes the components of end-of-life care across all levels of care and identifies key service directions to guide planning and service development, though does not explicitly reference RACFs. The Parliamentary Inquiry into Aged Care, End-of-Life and Palliative Care in Queensland presented 35 recommendations related to palliative care in March 2020. In 2022, Queensland Health released an updated Palliative and End-of-Life Care Strategy.</li> <li>• The Voluntary Assisted Dying Act 2021 came into effect from 1 January 2023. In 2020, \$171 million of additional funding for palliative care services was also announced over six years.</li> </ul>
<p><b>What did Queensland plan to implement?</b></p>	<ul style="list-style-type: none"> <li>• Each Queensland HHS has developed and implemented a service model appropriate to their local context based on engagement with local RACFs and centrally defined service principles. The Central SPACE Project Team facilitates a monthly community of practice meeting to link clinical leadership with operational experience.</li> <li>• Example projects include:             <ul style="list-style-type: none"> <li>• Needs rounds in the Gold Coast</li> <li>• Telehealth in West Moreton</li> <li>• Community consultation in the Torres Strait</li> </ul> </li> </ul>
<p><b>What has been progressed as at June 2023?</b></p>	<p>Implementation progress includes:</p>

- In 2020, Queensland established statewide and HHS project governance in the form of SPACE Project Teams in all 15 eligible HHSs. SPACE Project Teams engaged with local RACFs to determine the most appropriate model of care for their region. Engaging RACFs as partners in care, communicating benefits and tailoring to the local context helped to build trust and strong relationships, and proactive engagement were key to gaining support for the project.
- Recruitment delays in many HHSs have been the biggest barrier to implementation and baseline data collection, particularly with workforces being re-deployed to respond to COVID-19. There is concern that there are not enough palliative care practitioners to deliver promising in-reach models at scale across the state (currently at 50 per cent), particularly in regional areas however, this is intended to be addressed through the \$102 million workforce plan to increase Queensland’s palliative care workforce by 2025-26.
- The Central SPACE Project Team are conducting an evaluation due to complete in 2024. The final evaluation report is expected to be released in the 2023-24 FY.

**What evidence exists of early benefits?**

- Early benefits of the Measure activities include:
- SPACE teams are connecting RACF staff with education, training and resources and building relationships with GPs. The SPACE team plays a linkage and leadership role which helps mitigate staff turnover.
  - In some HHSs, there is emerging evidence that activities funded under the Measure are improving the confidence and capability of RACF staff (e.g., needs rounds in the Gold Coast) and reducing hospitalisations (e.g., 24/7 nurse hotline in West Moreton HHS).
  - In others, SPACE teams have observed increasing referrals to specialist palliative care services. Queensland Health representatives hypothesised that this increase may be related to improved confidence, greater engagement with the SPACE teams and COVID-19.
  - Clinicians and RACF staff have reported greater benefits where Measure funding was used to expand or enhance existing palliative care initiatives. Queensland Health representatives suggested this represents the localised approach whereby on-the-ground knowledge and buy-in supports success and ensures culturally appropriate and community-specific care.
  - Two HHS (Gold Coast, and Torres and Cape) have been listed as finalists for the National Palliative Care Awards 2023.

Table 16 Example projects implemented in Queensland

Project	Description	Model of care category
<b>Needs rounds on the Gold Coast</b>	Specialist Palliative Care teams participate in monthly needs rounds with RACFs to identify and support residents' palliative care needs.  To encourage a multidisciplinary approach, the PHN has established a Steering Group consisting of local PHN, Hospital Network and RACF representatives, GPs and GEDI to ensure guidance and collaboration from the right people.	Needs rounds
<b>Telehealth in West Moreton</b>	Ipswich Nurses has used Measure funding to expand their telehealth consults and support lines and virtual assessment clinics to ensure RACF staff have 24/7 access to specialist palliative care support and advice.	Access to specialist palliative care support
<b>Community consultation in the Torres Strait</b>	The SPACE team have used Measure funding to establish pop-up palliative care project focused on community consultation in the Torres Strait and Cape Tribulation. Consultation has been completed and the HHS have established their own specialist palliative care team, needs rounds and bereavement supports.	Culturally safe and appropriate models of care

## A.5 South Australia

The South Australia projects are progressing well – CPCiAC funding has enabled the development of innovative models of workforce education and training.

Table 17 Implementation approaches and activities in SA

<b>Summary</b>	<ul style="list-style-type: none"> <li>• Total funding: \$7.7 million</li> <li>• Population in RACFs: 16,443</li> </ul>
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	<ul style="list-style-type: none"> <li>• Number of RACFs: 263</li> <li>• Number of RACFs impacted by Measure activities: 22</li> <li>• Evaluation being undertaken: Yes, independent evaluation.</li> <li>• Delivery approach: Centralised delivery, managed and coordinated by a central team in the health department; providers contracted.</li> </ul>
<p><b>What is the policy and operating context?</b></p>	<ul style="list-style-type: none"> <li>• South Australia Health published the end-of-life Care Strategic Plan (2018) to support implementation of South Australia's end-of-life Care Strategy, which covers end-of-life decision making in RACFs.</li> <li>• South Australia Department of Health Grants project (2020) invested \$16 million over four years into palliative care services.</li> <li>• The voluntary assisted dying Bill was passed in 2021. The Voluntary Assisted Dying Act 2021 (the Act) commenced 31 January 2023.</li> </ul>
<p><b>What did SA plan to implement?</b></p>	<ul style="list-style-type: none"> <li>• There are three main projects being rolled out across SA: <ul style="list-style-type: none"> <li>• Hospice in Aged Care (Rural Support Service)</li> <li>• Hospice in the RACF (Eldercare)</li> <li>• GP Education and Engagement</li> </ul> </li> <li>• Smaller projects have been implemented in partnership with external providers: <ul style="list-style-type: none"> <li>• Educational videos available via the PalliAGED app, in partnership with Flinders University, GPEx and Eldercare.</li> <li>• Peer-led community ACP workshops with local councils.</li> </ul> </li> </ul>
<p><b>What has been progressed as at June 2023?</b></p>	<p>Implementation progress includes:</p> <ul style="list-style-type: none"> <li>• South Australia's Project 2 (Hospice in the RACF) pilot managed by Eldercare ended in February 2023 with great success. Underspent funds from the pilot was put towards expanding Eldercare's Palliative Care Needs Rounds into four non-Eldercare sites, supported by the Eldercare palliative care nurse practitioner.</li> </ul>

	<ul style="list-style-type: none"> <li>• Eldercare’s palliative care traineeship program saw 23 trainees complete the Certificate III in Individual Support (Aged Care). 16 FTE trainees completed the whole 12-month program and remain employed by Eldercare ongoing employees.</li> <li>• Project 1 and Project 3 have combined under the RSS programs. GPs and their registrars are attending needs rounds led by Palliative Medicine Consultants as they recognise this as a valuable opportunity for learning and skills development.</li> <li>• The RSS have successfully received a grant to recruit palliative care link nurses at each of the 15 project sites.</li> <li>• An independent evaluation has been completed by Flinders University, as of May 2023.</li> </ul>
<p><b>What evidence exists of early benefits?</b></p>	<p>Early benefits of the Measure activities include:</p> <ul style="list-style-type: none"> <li>• The traineeship for personal care attendants is showing emerging benefits of increased palliative care conversations and confidence of personal care attendant mentors. Eldercare have embedded traineeships into business as usual and have recruited additional waves of trainees. One cohort was recruited in February 2023 using leftover CPCiAC funding, and the following cohort was recruited in April 2023, without additional funding from the CPCiAC Measure.</li> <li>• The Regional Hospice in Aged Care project is being piloted across 15 sites. <ul style="list-style-type: none"> <li>• A whole-day workshop on palliative care was held at each regional site by the nurse educator, followed by site visits for mentoring. Sixteen GP educational series were facilitated by the palliative care medical consultant.</li> <li>• Flinders University evaluation reported the following evidence, compiled from After Death Audit data from RSS sites: <ul style="list-style-type: none"> <li>• Transfer to hospital in the last week of life reduced from 16 per cent to nine per cent.</li> <li>• Symptom management as the principal reason for transfer to hospital reduced significantly from 57 per cent to zero per cent.</li> <li>• The percentage of residents who died in residential aged care increased from 85 per cent to 93 per cent.</li> <li>• The percentage of residents who died in their preferred place of death increased from 66 per cent to 77 per cent.</li> </ul> </li> </ul> </li> </ul>

**Table 18 Projects implemented in SA**

Project	Description	Model of care category
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<b>Hospice in Aged Care (Rural Support Service)</b>	<p>This project aims to support rural and remote residents of state-funded RACFs and MPS to internally manage end-of-life care within the facilities. The project includes:</p> <ul style="list-style-type: none"> <li>• escalation of care pathways</li> <li>• specialist palliative care support (from dedicated palliative care nurse educators, GPs and palliative care pharmacist)</li> <li>• workforce education.</li> </ul>	<ul style="list-style-type: none"> <li>• Access to specialist palliative care support</li> <li>• Needs rounds</li> <li>• Education and training</li> </ul>
<b>Hospice in the RACF (Eldercare)</b>	<p>This pilot project aims to build capacity of hospice care in the RACF, to reduce ED transfers at end-of-life. The project includes:</p> <ul style="list-style-type: none"> <li>• provision of hospice model of care coordinated by palliative care nurse practitioners, supported by GPs</li> <li>• education supported by Palliative care Nurse educators</li> <li>• testing the traineeship model for palliative care workers</li> <li>• grief and bereavement resources.</li> </ul>	<ul style="list-style-type: none"> <li>• Access to specialist palliative care support</li> <li>• Needs rounds</li> <li>• Traineeships</li> </ul>
<b>GP Education and Engagement</b>	<p>This project aims to establish links and networks between GPs and metropolitan specialist palliative care services, so residents benefit from shared care under case management of the GP. The project is mapped to the Project 1 sites. The project includes:</p> <ul style="list-style-type: none"> <li>• incentivised GP attendance to needs rounds</li> <li>• GP skill development in palliative and end-of-life care</li> <li>• shared care support through telehealth consultations, case management.</li> </ul>	<ul style="list-style-type: none"> <li>• Needs rounds</li> <li>• Education and training</li> <li>• Incentivising shared care</li> </ul>
<b>Additional projects</b>	<p>Smaller projects have been implemented in partnership with external providers:</p> <ul style="list-style-type: none"> <li>• Educational videos available via the PalliAGED app, in partnership with Flinders University, GPEx and Eldercare.</li> </ul>	<ul style="list-style-type: none"> <li>• Education and training</li> </ul>

- Peer-led community ACP workshops with local councils

## A.6 Tasmania

Tasmania has three major projects centred around expanding in-reach models of care, and education and training initiatives. Implementation is showing early success.

**Table 19 Implementation approaches and activities in Tasmania**

<p><b>Summary</b></p>	<ul style="list-style-type: none"> <li>• Total funding: \$2.3 million</li> <li>• Population in RACFs: 4,582</li> <li>• Number of RACFs: 74</li> <li>• Number of RACFs impacted by Measure activities: 67</li> <li>• Evaluation being undertaken: Monitoring and evaluation</li> <li>• Delivery approach: Centralised delivery, managed and coordinated by a central team in the health department.</li> </ul>
<p><b>What is the policy and operating context?</b></p>	<ul style="list-style-type: none"> <li>• The Compassionate Communities Palliative Care Policy Framework 2017-2021 provided a comprehensive framework for the delivery of palliative care in Tasmania. A new Tasmanian Palliative Care Policy Framework was released in November 2022.</li> <li>• In 2020, legislation was drafted to provide a legislative base for ACDs within the Guardianship and Administration Act 1995.</li> <li>• Voluntary assisted dying services are now in effect and regulated by the End-of-Life Choices (Voluntary Assisted Dying) Act 2021.</li> </ul>
<p><b>What did Tasmania plan to implement?</b></p>	<p>There are three projects being rolled out across Tasmania:</p> <ul style="list-style-type: none"> <li>• Project 1: Specialist Palliative Care in-reach into RACFs</li> <li>• Project 2: Training posts for GP registrars in palliative care</li> <li>• Project 3: RACF funding for allied health support</li> </ul>

<p><b>What has been progressed as at June 2023?</b></p>	<p>Implementation progress includes:</p> <ul style="list-style-type: none"> <li>• A total of 67 RACFs have been impacted by the Measure so far – 15 in the Northwest, 23 in the North and 29 in the South. A total of 51 RACFs originally registered interest in participating in the Measure across Tasmania.</li> <li>• All CNC positions (one in each region) have been recruited and roles commenced. GP Registrar rotations in all regions have commenced. Five registrars have completed six-month rotations so far.</li> <li>• A social worker has been recruited (0.2 FTE) to provide specialist palliative care social work services to proactive support residents and families within the RACF setting in the North-West region.</li> <li>• COVID-19 and resourcing constraints have contributed to some regions and RACFs adapting needs rounds to ‘mini rounds’ and leveraging telehealth.</li> <li>• A working group has been established to support data collection and monitoring process.</li> </ul>
<p><b>What evidence exists of early benefits?</b></p>	<p>Early benefits of the Measure activities include:</p> <ul style="list-style-type: none"> <li>• Between November 2023 and May 2023 there were 115 needs rounds held, which provided the opportunity for 660 cased based discussions.</li> <li>• Anecdotally, Tasmania Health representatives indicated that needs rounds have been useful to build awareness of holistic palliative care in aged care, establish relationships and mechanisms of collaboration through the Implementation Advisory Group.</li> <li>• There has been a reported increase in referrals to specialist palliative care services thanks to the proactive, in-reach model and needs rounds. The role of the social worker and CNC have been increasing the identification of palliative care needs and referrals to appropriate services.</li> <li>• The creation of a CPCiAC Implementation Advisory Group has supported knowledge sharing about how generalist and specialist palliative care providers can work together in the delivery of palliative care.</li> <li>• The CPCiAC team at the Tasmanian Department of Health, as reported by the Tasmanian PHN, has improved capacity for collaboration and coordination in palliative care and reduce the risk of duplication (such as between the Measure activities and Greater Choices initiatives).</li> </ul>

Table 20 Projects implemented in Tasmania

Project	Description	Model of care category
<b>Specialist Palliative Care in-reach into RACFs</b>	This project aims to deliver dedicated and proactive specialist palliative care in-reach services in targeted RACFs, led by CNCs. This will include on-site clinical assessment, treatment and care coordination for residents. The CNCs will also deliver education and capacity building to RACFs to provide better care beyond the life of the Measure.	<ul style="list-style-type: none"> <li>Needs rounds</li> <li>Access to specialist palliative care relationships</li> </ul>
<b>Training posts for GP registrars in palliative care</b>	This project aims to support the establishment of GP registrar training positions in palliative medicine within the Specialist Palliative Care Service and/or the Tasmanian rural medical generalist pathway to expand the skilled workforce available to provide quality palliative care to residents in RACFs.	<ul style="list-style-type: none"> <li>Traineeships</li> </ul>
<b>RACF funding for allied health support</b>	This project will provide brokered allied health services to ensure the palliative care needs of residents in RACFs are met in a holistic way.	<ul style="list-style-type: none"> <li>Access to multidisciplinary resources</li> </ul>

## A.7 Victoria

Victoria has recommenced all five workstreams following delays. These focus on enhancing existing models of care, providing culturally safe care and building local capacity. Victoria did not provide an update to the national evaluation in this reporting period (November 2022 to June 2023). Information in this summary is based on data provided by Victoria on the previous reporting period (May to October 2022) and the 2022-2023 Performance Milestone report provided to the Department of Health and Aged Care in 2023.

Table 21 Implementation approaches and activities in Victoria

<b>Summary</b>	<ul style="list-style-type: none"> <li>Total funding: \$28.4 million</li> <li>Population in RACFs: 48,501</li> </ul>
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	<ul style="list-style-type: none"> <li>• Number of RACFs: 765</li> <li>• Number of RACFs impacted by Measure activities: 35</li> <li>• Evaluation being undertaken: Yes, internal evaluation.</li> <li>• Delivery approach: Centralised delivery, managed and coordinated by a central team in the health department; providers contracted.</li> </ul>
<p><b>What is the policy and operating context?</b></p>	<ul style="list-style-type: none"> <li>• In-reach models of care (res-in-reach) to RACFs existed prior to the Measure in the Victorian health service in metropolitan, regional and sub-regional hospitals. These teams have not historically targeted palliative care, they provide time critical care aimed at preventing ED presentations and unplanned admissions of aged care residents. Throughout the COVID-19 pandemic these teams encountered an increase in palliative and end-of-life care referrals. To reduce duplication of services and maximise workforce availability there has been a focus on coordination between residential-in-reach teams and community palliative care providers.</li> </ul>
<p><b>What did Victoria plan to implement?</b></p>	<p>There are five workstreams being rolled out across Victoria:</p> <ul style="list-style-type: none"> <li>• Enhance existing models of care</li> <li>• Resident elders program</li> <li>• Build local capacity</li> <li>• Improve assessment tools</li> <li>• Supporting goals of care</li> </ul>
<p><b>What has been progressed as at June 2023?</b></p>	<ul style="list-style-type: none"> <li>• Victoria has recommenced their CPCiAC workstreams after implementation delays. A total of 4.5 FTE have been engaged in the last six months to support project delivery. Staff are principal project leads and project officers external to the Victorian Department of Health. Approximately 30 RACFs are currently directly impacted by the CPCiAC measure in Victoria, a reduction from 35 during the last reporting period.</li> <li>• Significant progress has been made on CPCiAC workstream implementation, however no benefits have been reported as yet:</li> </ul>

	<ul style="list-style-type: none"> <li>• The Resident Elders project to promote culturally safe Aboriginal and Torres Strait Islander palliative and end-of-life care for elders, has re-commenced in partnership with Palliative Care Victoria (PCV) and the Victorian Aboriginal Community Controlled Health Organisation (VACCHO).</li> <li>• The aged care registered nurse mentor program has recommenced across metropolitan and regional Victoria. Six specialist palliative care providers have been engaged. The program reportedly has the potential to build resilience and sustainable palliative and end-of-life care practices, however it is too early to determine benefits.</li> </ul>
<p><b>What evidence exists of early benefits?</b></p>	<p>Early benefits of the Measure activities include:</p> <ul style="list-style-type: none"> <li>• In the last reporting period (April 2022 to October 2022), Victoria’s workstreams had only recently recommenced following delays caused by COVID-19. At this point, it was too early to observe the benefits of the programs. No update has been provided on the emerging outcomes of Victoria’s programs since.</li> <li>• Based on information provided by Victoria in the 2022-2023 Performance Milestone Report, there is continued implementation progress across all workstreams, including: <ul style="list-style-type: none"> <li>• Workstream 4: Goals of Care – Undertaking focus groups with families with lived experience and commencing a Consumer Advisory Group.</li> <li>• Workstream 5: Resident Elders – Employing a cultural advisor as a core member of the Palliative Care Victoria project team and to help foster engagement with Aboriginal Community-Controlled Organisations (ACCOs).</li> </ul> </li> </ul>

**Table 22 Workstreams implemented in Victoria**

Project	Description	Model of care category
<p><b>Enhance existing models of care</b></p>	<p>Explore models to strengthen integration across providers:</p> <ul style="list-style-type: none"> <li>• resourcing for community palliative care providers</li> <li>• palliative care rounding in a small number of metropolitan RACFs</li> <li>• coordination between community palliative care providers and residential-in-reach teams.</li> </ul>	<ul style="list-style-type: none"> <li>• Needs rounds</li> </ul>



<b>Resident Elders program</b>	Partner with Aboriginal and Torres Strait Islander organisations to develop and implement a model of care that supports Elders to access culturally safe and effective palliative and end-of-life care.	<ul style="list-style-type: none"> <li>• Culturally safe and appropriate care</li> </ul>
<b>Build local capacity</b>	Build capacity in RACF staff to recognise residents' clinical deterioration and establish processes and pathways to specialist palliative care providers. Including mentor programs for aged care registered nurses to promote resilience and sustainable palliative and end-of-life care.	<ul style="list-style-type: none"> <li>• Education and training</li> </ul>
<b>Improve assessment tools</b>	Review of RACF assessment and frailty tools to incorporate palliative care components and enhance early recognition of decline, reduce unnecessary deterioration, functional decline and more.	<ul style="list-style-type: none"> <li>• Education and training</li> </ul>
<b>Supporting goals of care</b>	Test, refine and implement resources to support families of residents without decision-making capacity to identify and record goals of care.	<ul style="list-style-type: none"> <li>• Education and training</li> </ul>

## A.8 Western Australia

Table 23 Implementation approaches and activities in WA

<b>Summary</b>	<ul style="list-style-type: none"> <li>• Total funding: \$11.4 million</li> <li>• Population in RACFs: 16,867</li> <li>• Number of RACFs: 285</li> <li>• Number of RACFs impacted by Measure activities: 285</li> <li>• Evaluation being undertaken: Yes, independent evaluation.</li> <li>• Delivery approach: Centralised delivery, managed and coordinated by a central team in the health department; providers contracted.</li> </ul>
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<p><b>What is the policy and operating context?</b></p>	<ul style="list-style-type: none"> <li>• Western Australia End-of-Life and Palliative Care Strategy 2018-2028 and Implementation Plan One 2020-2022 detail key priorities and actions for palliative care that includes RACFs, such as improving access to and delivering quality palliative care.</li> <li>• The Sustainable Health Review 2019 (2020) set out Western Australia’s intention to prioritise the delivery of patient-centered, high-quality and financially sustainable healthcare, including to achieve respectful and appropriate end-of-life care and choices.</li> <li>• My Life, My Choice Report of the Joint Select Committee on Palliative Care (2020), that made 25 recommendations to improve end-of-life and palliative care, AHDs/Advance Care Planning and VAD. VAD came into effect in July 2021.</li> </ul>
<p><b>What did WA plan to implement?</b></p>	<ul style="list-style-type: none"> <li>• Project 1: MPaCCS expansion</li> <li>• Project 2: RACEPC Communicate</li> <li>• Workstream 3: Additional projects</li> </ul>
<p><b>What has been progressed as at June 2023?</b></p>	<p>Implementation progress includes:</p> <ul style="list-style-type: none"> <li>• All nine projects are in operation. The RACEPC Communicate project, which was originally designed to be delivered in person, has pivoted to online delivery due difficulties in accessing RACFs during the COVID-19 pandemic and changing education requirements. The unspent funds from this pivot were reallocated to further expand the MPaCCS service to increase service hours and reach across metropolitan Perth. <ul style="list-style-type: none"> <li>• Part of the MPaCCS expansion includes the recruitment of a Liaison Nurse role to work with a range of stakeholders across the health and residential care systems to improve the interfaces between hospitals and RACFs with the objectives of smoothing the transitions of individual residents between these settings, and minimising the use of acute hospital resources. Since commencing, the liaison nurse reported 277 completed episodes of care.</li> </ul> </li> <li>• All seven projects under Workstream 3 have commenced with some slight variations to original project designs and delays caused by recruitment challenges and COVID-19. Between 1 September 2022 and 28 February 2023, 5.5 FTE have been recruited to positions in these projects.</li> </ul>
<p><b>What evidence exists of early benefits?</b></p>	<p>Early benefits of the Measure activities include:</p>

- Improved collaboration between GPs and RACF staff (by providing more palliative care support and conducting in-reach and out-reach education to RACFs), under the MPaCCs project and GP Case Conferencing Coordinator pilot.
- Improved end-of-life care planning as a result of the three hospital transition support pilots and WACHS RGoC pilot.
- A high volume of sustained interest by RACFs for RCL’s clinical deterioration education package.
- Increased access to specialist palliative care through increased referrals to MPaCCS from RACFs, indicating improved identification of need by RACF staff.
- An additional palliative care medical consultant under MPaCCS has improved the quality of relationships between the specialist consultant and GPs working in aged care, due to increased availability.
- The role of the MPaCCS Liaison Nurse enables discussions with treating teams in acute and tertiary hospitals, to facilitate smoother transitions to RACF settings. The Liaison Nurse is improving access and uptake of ACPs and goals of care documentation on referral to MPaCCS, as well as improving the quality of ACP discussions with patients and families. Since commencing, the liaison nurse has completed 277 episodes of care.

Table 24 Projects implemented in WA

Model of care	Description	Model of care category
<b>MPaCCS expansion</b>	This project aims to expand MPaCCS in metropolitan Perth. MPaCCS facilitates sustained, coordinated and timely access to needs-based quality palliative care for RACF residents. Project 1 has included additional education and training, and specialist in-reach support for metropolitan RACFs. Project 1 includes the addition of two Clinical Nurses, a social worker and additional system-wide roles.	<ul style="list-style-type: none"> <li>• Access to specialist palliative care support</li> <li>• Access to multidisciplinary resources</li> <li>• Education and training</li> <li>• Culturally safe and appropriate models of care</li> </ul>
<b>PaSCE Residential Aged Care Excellence in Palliative Care</b>	<p>This project aims to develop RACF workforce capability and capacity to provide quality end-of-life and palliative care services to residents and families.</p> <p>This project is a virtual program of education, training and mentorship to upskill metropolitan and regional staff on the RACEPC approach.</p>	<ul style="list-style-type: none"> <li>• Education and training</li> </ul>

<p><b>Additional projects</b></p>	<p>Seven projects under Workstream 3 have commenced:</p> <ul style="list-style-type: none"> <li>• NMHS Transition Support Navigator pilot (metropolitan)</li> <li>• SMHS Care Coordinator pilot (metropolitan)</li> <li>• EMHS Transition Support Officer pilot (metropolitan)</li> <li>• WA Primary Health Alliance GP Case-conferencing Coordinator pilot (metropolitan)</li> <li>• Residential Care Line (RCL) expansion (metropolitan)</li> <li>• GP information resources (state-wide)</li> <li>• WA Country Health Service Goals of Residential Care pilot (state-wide)</li> </ul>	<ul style="list-style-type: none"> <li>• Access to specialist palliative care support</li> <li>• Incentivising shared care</li> <li>• Access to multidisciplinary resources</li> <li>• Education and training</li> <li>• Culturally safe and appropriate models of care</li> </ul>
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## Appendix B Key evaluation questions

Table 26 outlines the KEQs and research questions, mapped to the three evaluation components (process, outcome and economic). The highlighted KEQs have been covered in the Interim Report. The remaining KEQ will be covered in the Final report.

Research questions:

1. Has the Measure been implemented as planned and what are the implementation lessons from the Measure?
2. How appropriate is the Measure to meet the needs of residents, families and carers in the RACF setting?
3. How effective have the joint funding and delivery arrangements been for implementing and achieving the aims of the Measure? How could governance arrangements be more effective?
4. To what extent has the Measure achieved its intended outcomes?
5. How cost-effective is the Measure?
6. Is there a specific model of care that has been implemented that has proven to be more successful than others?
7. How well does the Measure align and contribute to the National Palliative Care Strategy? Are there opportunities for improvement?
8. Does the Measure and the models adopted in each jurisdiction help to address health system interface issues?

**Table 25 Data collection plan**

KEQ	Research question	Process evaluation	Outcome evaluation	Economic evaluation
1	What is important to understand about the policy and operating contexts in which the Measure is delivered?	✓		
1	What is the aim of the Measure?		✓	
1	Has the Measure been implemented as planned?	✓		
1	How could the implementation process have been improved?	✓		
2	What are the palliative care needs of residents, families/carers and staff in RACF settings?		✓	

KEQ	Research question	Process evaluation	Outcome evaluation	Economic evaluation
2	How well did the Measure meet those needs?		✓	
3	What evidence exists on best practice approaches to funding and delivery arrangements?	✓		
3	To what extent do the joint funding and delivery arrangements enable the Measure to achieve its aims?	✓		
3	How could the funding and delivery arrangements be improved?	✓		
4	What are the intended outcomes?		✓	
4	How can outcomes be measured?		✓	
4	What is the baseline for the evaluation?		✓	
4	How have outcomes changed over the life of the Measure?		✓	
5	What are the costs of the 'do nothing scenario' across the RACF, hospitals, transport, medication and elsewhere?			✓
5	What are the costs of the Measure across the RACF, hospital, transport, medication and elsewhere?			✓
5	What is the difference in costs between the 'do nothing scenario' and the Measure?			✓
5	What activities undertaken through the Measure are the most cost efficient?			✓
5	What processes for implementing the Measure were the most cost efficient?	✓		✓
6	Which models of care implemented under the Measure have been most successful?		✓	
6	What models of care exist elsewhere that have proven successful?		✓	

KEQ	Research question	Process evaluation	Outcome evaluation	Economic evaluation
7	How do the Measure's listed outcomes align with the goals and priorities of the National Palliative Care Strategy?	✓		
7	How has the Measure contributed to the goals and priorities of the Strategy?		✓	
7	How could the Measure be better aligned to the Strategy?		✓	
8	What are the key interface issues?	✓		
8	How have the models adopted within the Measure acted to address interface issues?		✓	
8	How have other palliative care in RACF initiatives outside of the Measure sought to address health interface issues?		✓	



## Appendix C Notes on quantitative data

This Appendix provides notes, caveats, definitions and other data specifications for jurisdictional data provided directly by states and territories, as requested by the Nous evaluation team, to inform the Interim Report.

Nous requested quantitative data for 23 indicators starting from 12 months prior to commencement of implementation of the Measure and at continued 12-month intervals following implementation. Most jurisdictions noted challenges with identifying a cohort of RACF residents in administrative hospital data. While some navigated this challenge with cross referencing processes to match patient address with RACF locations, others were unable to provide data with this specification (where requested).

Table 27 includes the full list of indicators requested from states and territories. Table 28 lists the specific notes, caveats and definitions for specific indicators where provided by each jurisdiction.

**Table 26 Quantitative indicators requested from states and territories in June 2023**

Number	Indicator
1	Number of patients transferred by ambulance from a RACF to ED (and number of ambulance transfers from a RACF to ED).
2	Number of patients that are transferred from a RACF to a hospital for palliative care.
3	Number of patients admitted to a palliative care facility.
4	Number of and average length of palliative care related stays in a hospital for residents referred by a RACF.
5	Number of and average length of stay for hospital admissions for RACF residents.
6	Number of and average length of palliative care related stays in a specialised facility for residents referred by a RACF.
7	Length of time between recurring visits to hospital for a RACF resident, related to palliative care.
8	Length of time between recurring visits to a specialised facility for a RACF resident.
9	Number of deaths for RACF residents within 24 hours of admission to hospital, for care related to palliative care.
10	Number of deaths for RACF residents while admitted to hospital to receive palliative care.
11	Number of patients receiving palliative care through public outpatient services.
12	Number of patients receiving palliative care through palliative care outreach services/number of outreach episodes.
13	Number of specialist palliative care referrals (from RACF).

14	Number of RACF residents seen by the CPCiAC funded project(s).
15	Number of RACF residents who received specialist palliative care services.
16	Number of RACF residents who attend needs rounds.
17	Number of needs rounds conducted in total.
18	Number of RACF residents who have an Advance Care Plan (ACP)/Advance Care Directive (ACD) in place.
19	Number of RACF residents who are deceased in their chosen place of death.
20	Number of RACF residents who are referred to a specialist palliative care provider from ED.
21	Number of ED presentations for RACF residents to receive urgent palliative care.
22	Number of patient deaths within 24 hours of presentation to ED

**Table 27 Quantitative data specifications by jurisdiction**

Jurisdiction	Indicator	Notes
ACT	Number of and average length of stay for hospital admissions for RACF residents.	The data provided represents all patients and is not specific to RACF residents. ACT are unable to identify RACF residents in hospital admissions data.
Tasmania	Number of patients that are transferred from a RACF to a hospital for palliative care.	This excludes those who were not RACF residents prior to the admission.
Tasmania	Number of patients that are transferred from a RACF to a hospital for palliative care.	The total number of patients who are admitted to Royal Hobart Hospital Whittle ward or purchased Launceston General Hospital beds in Calvary St Luke's. This data includes all admissions, not just RACF residents, excludes private admissions to Calvary St Luke's as this data is not obtainable
Tasmania	Number of and average length of palliative care related stays in a specialised facility for residents referred by a RACF.	The length of stay data in the pre-implementation period is likely to be skewed by a small number of people with extended stays (i.e., More than 100 days).
Tasmania	Number of specialist palliative care referrals (from RACF).	The data provided represented the total number of referrals, not just those from RACFs.

South Australia	Number of patients that are transferred from a RACF to a hospital for palliative care.	The data provided reflects the number of palliative care patients where the source of referral was recorded as a RACF.
South Australia	Number of and average length of palliative care related stays in a hospital for residents referred by a RACF.	Nous has used the number of referrals as a proxy to transfers to hospital, given that referrals from RACFs are likely to result in a transfer to hospital.
South Australia	Number of patients who are discharged from ED back to RACF (where stay is <24hours)	The data provided only reflects the average lengths of stay and does not include the number of stays.
Western Australia	Number of patients receiving palliative care through palliative care outreach services/number of outreach episodes.	Definition used for 'specialist palliative care': Specialist palliative care is undertaken by a professional palliative care team or service with recognised qualifications or accredited training in palliative care. They provide direct care to people, and their family/carer with complex palliative care needs and/or provide consultation services to support, advise and educate specialist and non-specialist teams providing end-of life care.
Western Australia	Number of RACF residents who are referred to a specialist palliative care provider from ED.	Definition used for 'outreach services': reflects the use of hospital or community-based palliative care services provided within the RACF.
Northern Territory	Number of patients admitted to a palliative care facility.	Data collected from the hospice facilities at Royal Darwin Hospital and Alice Springs Hospital. These are situated on hospital premises but are considered separate wards/units.
Northern Territory	Number of and average length of palliative care related stays in a hospital for residents referred by a RACF.	Includes specialised and non-specialist palliative care delivered in hospital.
Northern Territory	Number of specialist palliative care referrals (from RACF).	Data provided for this represents the Top End only.

## C.1 Australian Capital Territory

The ACT provided quantitative data for two of the requested data points. Other data was unable to be provided for the following reasons:

- The implementation of a new digital health record in the ACT in November 2022 impacted the availability of data for this evaluation.
- ACT Health are unable to identify RACF residents in data available at the time of this evaluation.
- ACT Health is unable to provide data on place of residence (e.g., RACF), referral to specialist palliative care provider and reason for presentation (palliative care) is not currently present in sufficient detail in administrative data sets available at the time of evaluation.
- Data on palliative care patients receiving palliative care through public outpatient services or outreach could not be provided but the number of services provided in a palliative care related outpatient clinic could be provided in the future.
- ACT Health does not record data on RACF recruitment, RACF models of care, RACF referrals to specialist palliative care, RACF ACPs or RACF residents deceased in chosen place of death.

## C.2 Tasmania

Tasmania provided some state-level quantitative data. RACF residents were identified within the data through a manual process to cross reference the address of patients within hospital data with known addresses of RACFs.

Given Tasmania's delayed sign-up and subsequent commencement of activities under the Measure, data could only be provided for two time periods; from 1 April 2021 to 31 March 2022 (pre-implementation) and from 1 April 2022 to 31 March 2023 (post-implementation). Much of the pre-implementation activity data (i.e., Number of needs rounds conducted in total) was therefore not possible to report on for the period prior to April 2022. Other data regarding ACP/ACDs and residents' chosen place of death were not recorded prior to the Measure activities.

## C.3 South Australia

South Australia Health provided some state-level quantitative data, including the period 12 months prior to implementation. Data for some activity-based indicators was reported on in an independent evaluation<sup>71</sup> of South Australia's projects which have been used to inform parts of the national evaluation.

## C.4 Western Australia

Western Australia provided yearly data starting from 12 months pre-implementation. The process of identifying RACF residents within hospital data involved matching patient addresses with known addresses of RACFs (n=284) using Jaro-Winkler methodology.

Some activity data was provided by community-based service providers, MPaCCS and Silverchain. The data provided by MPaCCS was provided in percentage figures, as opposed to total counts of

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<sup>71</sup> Research Centre for Palliative Care, Death & Dying, Flinders University (2023). Comprehensive Palliative Care in Aged Care (CPCiAC) Pilot Projects in South Australia: Final Evaluation Report

patients or residents accessing services. This meant that the data was difficult to contextualise and generate a fulsome picture of service usage.

## **C.5 Northern Territory**

Northern Territory were able to provide some of the requested data points for the requested time periods. A small number of indicators were able to be captured, however were omitted in the reporting to Nous where the count of residents or episodes of care was less than ten. This was due to concerns for privacy and identification of patients.

## **C.6 Queensland**

Queensland were not able to provide quantitative data at the time of this report. The quantitative data was held up in the approval stages prior to sharing with Nous to include in this reporting.

## **C.7 NSW**

NSW were not able to provide quantitative data to inform the evaluation, due to concerns about the reliability of identifying RACF residents, given the lack of markers for this population in their administrative data.

## **C.8 Victoria**

Victoria did not provide quantitative data to inform the evaluation and did not respond to requests.