Workforce for quality care at the end of life

Position statement

Palliative Care Australia

Palliative Care Australia is the national peak body established by the collective membership of eight state and territory palliative care organisations and the Australian and New Zealand Society of Palliative Medicine. Together the Palliative Care Australia members network to foster, influence and promote local and national endeavours to realise the vision of quality care at the end of life for all.[1]

PCA believes

- The profile, skills and capabilities of the Australian health workforce is being shaped by changing patterns of disease, increasing demands for quality care at end of life, system-wide shortages of health professionals, and reforms to systems of care.

- Population based approaches, together with an understanding of differing care pathways that are responsive to the needs of specific populations, should provide an organising framework for development of models of care and health service delivery plans. A workforce with skills and capabilities to support emerging models of care is needed to meet community expectations of safe and quality care for all.[2]

- Quality end-of-life care is required for people at all ages and across all settings of care. In practice, health professionals will provide services for people who are dying to varying extents, depending on their specialty and practice setting. An integrated and person-centred system of care for people at end of life requires all health care professionals to have the level of knowledge, skills, attitudes, and behaviours appropriate for their context of practice.

- All health professionals must be appropriately prepared for providing end-of-life care, to ensure they can deliver care consistent with national palliative care standards. The nature and scope of such preparation will vary between primary and specialist settings, and between disciplines, but must enable health professionals to meet a level of competence necessary for their scope of practice.

- Health professionals working in specialist palliative care services need to demonstrate specialised knowledge, skills and competence as defined by relevant professional and disciplinary standards.

- A well distributed, accessible and appropriately trained and skilled[3] specialist and primary care workforce is required to meet the needs of people at end of life. Specific incentives and alternate models may be required to match the service challenges in regional, rural and remote locations.

- A systematic strategy for developing capabilities in end-of-life care for the whole health workforce is integral to the provision of high quality and sustainable services for people who are dying. This strategy requires appropriate educational responses at all levels, including courses which prepare health professionals for entry to practice and continuing professional development, as well as specialist training programs.

- Access to sufficient numbers of specialist training positions and educational programs is required to meet the growing demand for quality end-of-life care. The number of such training positions should be determined on the basis of a robust workforce planning model.

- Continuing professional development in palliative care requires flexible approaches to meet the needs of health professionals in various practice contexts to promote accessibility and to enable ongoing learning.

- A knowledge-led culture that supports opportunities for health professionals providing end-of-life care to engage ongoing learning and continuous improvement is integral to quality end-of-life care.

- Inter-professional learning, combined with appropriate discipline specific learning opportunities, are emerging as effective approaches for preparing health professionals to provide quality end-of-life care.

- Cultural competence and culturally safe practice needs to be integrated into learning at all levels. Of particular importance will be the need to effectively address the delivery of end-of-life care services to Indigenous communities, requiring a fundamental shift in the ability of the health workforce to meet their needs.

PCA calls for

- The promotion and valuing of capabilities required to provide quality end-of-life care amongst health professionals working in all health care settings.

- Health professionals to be appropriately qualified and competent for the level of service offered. This means:
    - all undergraduate and entry to practice courses in the health professions should meet the benchmarks established by the Palliative Care Curriculum for Undergraduates (PCC4U) project, to enable all health professionals to develop core capabilities in end-of-life care
    - continuing professional education programs be underpinned by a nationally consistent set of core competencies in end-of-life care, and be able to be delivered flexibly to meet differing needs and changing circumstances
    - all health professionals working in specialist palliative care services have access to training programs to enable them to demonstrate specialised knowledge, skills and competence as defined by relevant professional and disciplinary standards.

- A systematic analysis of the palliative care workforce to identify gaps between population need and workforce availability (both for staff type and geographical distribution), and the implementation of appropriate strategies to ensure sufficient numbers of training positions to meet current and future needs of the specialist palliative care workforce.

- A national approach to implementing the competency standards for specialist palliative care nursing practice.[4]

- The development of national, state or local workforce development plans that are aligned with a population based model of service delivery and which reflect advances in practice.

- The implementation and appropriate resourcing in each of the states and territories of a role delineation framework based on PCA's national palliative care standards to ensure that health professionals are working within a supportive, high quality service structure, and that clinical and academic education and training programs are adequately resourced to ensure achievement of such standards.

- A composite of incentives that are both financial and non financial to be provided for health professionals to provide end of life services to people in under-served communities, and be supported by well integrated service networks and linkages.

- State and territory governments to collaborate in the development of evidence based guidelines for staffing of inpatient/hospice and community services.

- A greater recognition of and support for the key role of Aboriginal and Torres Strait Islander health workers and increasing the representation of Indigenous people in the health workforce, including through appropriate education and training opportunities.

- A commitment by governments to education and training that builds the cultural competence of Australia's health workforce through undergraduate, postgraduate, vocational, and continuing professional education.

Background

> *We … need to train, develop and empower clinical and health service leaders to mould a culture of continuous reflection and self-improvement which will inspire the generations of health professionals to come. Promoting a culture of mutual respect and patient focus through shared values and educational experiences, collegiality between leaders of clinical and corporate governance, and appropriate recognition and compensation arrangements is intrinsic to job satisfaction and retention of our precious workforce.*[5]

Developing a Strategic National Framework

The challenges associated with ensuring a health workforce capable of providing quality care to people approaching the end of life, can be considered to be a subset of the broader challenges associated with developing a sustainable, skilled and adaptable workforce to meet the health needs of the Australian community. The drivers of health workforce innovation and reform in end-of-life care are likely to be:

- significant increases in demand
- changing patterns of disease
- changing models of care
- system-wide health professional shortages across health.

The National Health Workforce Strategic Framework sets out seven underlying fundamentals that need to guide future health workforce strategy:

- national self-sufficiency in workforce supply
- distribution to optimise equitable access
- health care environments where workforce is valued, supported and operates with mutual collaboration
- cohesive action among health, education and regulatory bodies to create a workforce that is knowledgeable, skilled and engaged in life-long learning
- optimal use of workforce skills, involving realignment of workforce roles and workforce redesign to address health needs, sustainable quality care and required competencies
- workforce policy that is population and consumer focussed, informed by best available evidence
- workforce policy development and planning undertaken collaboratively with all key stakeholders[6]

The NHHRC is recommending a new framework for education and training of health professionals that:

- moves towards a flexible, multi-disciplinary approach to how we educate and train health professionals, and
- incorporates an agreed competency-based framework as part of a broad teaching and learning curriculum for all health professionals.[7]

Such principles need to be reflected in education and training initiatives for health professionals in end-of-life care.

Needs-based planning

> *A population based service planning approach seeks to understand and plan for the health needs of the target population as a whole, and to implement and evaluate interventions to improve the health and wellbeing of the population.*[8]

Changing demographics and patterns of disease require workforce planning and development strategies that are grounded in evidence based population needs approaches (socio-economic, health status, disease and risk factors, age, ethnicity, geography), and which are responsive to more consumer focussed contemporary models of care.[9] [10]

The PCA service development frameworks and national standards are based on these principles of needs-based planning. The PCA Frameworks specify the levels of resources and capabilities, including human resources, that are required to deliver quality end-of-life care for the entire population. These PCA Frameworks are consistent with role delineation frameworks in a number of States and Territories which provide important planning, resource allocation and system-wide accountability functions.[11] Together with the PCA Frameworks, the workforce resource profiles that are associated with the various role delineations across various levels of service provide the broad framework for workforce planning.

Workforce distribution, retention and attraction

A major challenge to equitable access to palliative care services is the poor distribution of health professionals, particularly in rural and remote regions. System-wide issues such as inability to take leave, limited availability of locums, lack of inter-professional support and other lifestyle and professional considerations all impact on workforce availability. There is strong anecdotal evidence that specialist palliative care services are not available when and where required, particularly where the only service that is provided is through a single palliative care provider. This situation has significant detrimental impacts for the quality of care and the choices that people at the end of life and their families can access.

Australia has about half the palliative medicine specialists it needs under current referral patterns, with unmet need being by far the greatest outside of metropolitan areas. Data for New South Wales shows that the number of palliative medicine specialists outside of the greater Sydney metropolitan area is about one third per 100,000 of the state average.[12] This has significant implications about the ability to develop flexible models such as shared care or hub and spoke models in non metropolitan areas as they rely on specialist medical care to be proximate within a geographical service region.

Palliative care nurses have the same aged profile issues as the rest of the workforce.[13] [14] There is however some evidence to support the anecdotal view that sector turnover is low and that new recruits are being drawn into the available palliative care nurse workforce pool.[15] While this may auger well for the short term, there is a larger risk that the overall growth in the available workforce may be insufficient to meet needs, or that industry dynamics, such as the enormous growth in GP practice nurses over the last decade may impact on availability. The emerging role of nurse practitioners in palliative care in providing a model of care that reflects changing needs of the health system is evident, with a small number of palliative care nurse practitioners now accredited in Australia. To date, analysis of the potential for such roles, and the training and support requirements for them to reach their potential is limited.

The availability of general practitioners is a generic problem with about half the number being available to regional, rural and remote areas compared to metropolitan areas (although availability in some outer metropolitan areas is an issue as well). These shortages are further exacerbated by logistical challenges of servicing highly dispersed populations.[16]

For end-of-life care, the workforce situation is further exacerbated for other health professionals that are a key part of the specialist and non-specialist interdisciplinary team. People living in outer regional centres have access to about a half as many allied health professionals as people in metropolitan centres.[17]

Ameliorating the shortage of health professionals in under-served communities requires a composite of incentives that are both financial and non financial and well integrated 'hub and spoke' health service networks.[18]

Workforce roles and changing delivery models

Models incorporating shared roles and responsibilities are recognised as being conducive to palliative care, with members sharing information and working interdependently.[19] The benefits of such approaches are now being recognised in broader health service delivery contexts with the greatest shift occurring in primary care settings.[20] While palliative care has been at the leading edge of interdisciplinary approaches, there will need to be greater utilisation of referral pathways between acute, sub-acute and primary care sectors to consolidate the real benefits to be gained from person centred team approaches. Such team approaches will require significant communication as well as flexibility and responsiveness to meet complex needs.

A number of factors are also increasingly leading to a re-examination of roles, responsibilities and scope of practice of health care professionals, including:

- inherent relationship changes caused by new team based and shared care models[21]
- workforce shortages and support for better utilising the full capacity of existing health professionals.[22]

This will also require the proactive but sensitive management of barriers to change, and in particular professional resistance and poor interpersonal relationships.[23]

Emerging models of care will also require targeting of workforce development in specific sectors:

- ensuring a high level of competency among specialist palliative care nurses to support and in some cases lead interdisciplinary teams in primary care settings
- integrating the extended clinical role of palliative care nurse practitioners
- ensuring that residential aged care staff have appropriate and accessible training and support

- supporting GPs in further developing their lead/coordination/collaborative roles in working with primary care and specialist interdisciplinary teams
- ensuring an increased recognition of specific Indigenous health workforce needs and in particular the need to raise the profile and skills of Aboriginal and Torres Strait Islander Health Workers in supporting palliative care as part of community controlled or mainstream health care services. [24]

Education and training

As death is a normal part of the life cycle and an important part of our health system is providing services for those at the end of life, a baseline goal is that all health care professionals require as a minimum, knowledge and skills to provide competent, safe and effective care of people approaching the end of life. This means that some preparation in the knowledge, skills and competencies required to provide care to people approaching the end of life should be built into all undergraduate and postgraduate courses that prepare health professionals for entry to practice, and for practice in the various specialties.

The national palliative care standards require that staff are appropriately qualified for the level of service offered. In practice, health care professionals will be involved with people who are dying to varying extents depending on which part of the health care continuum, specialty or setting they operate within. As a result a range of post graduate and continuing professional education and training approaches are required to flexibly cater for differing circumstances. This will require different levels of competency and knowledge with appropriate minimum competencies being applied to match the requirements at each level.

There are four common core learning domains that need to be applied across all professional groups, undergraduate, postgraduate and continuing education and all settings – end-of-life care principles; communications skills for end of life; assessment of a person's needs and preferences; symptom control. Common core learning domains are important to workforce development in that they assist in developing a consistent approach to cross-sectoral and cross-discipline learning. Learning and teaching of palliative care should also reflect the core values that underpin the national standards.[25]

The growing complexity of care provided in the community requires education and training of students and health professionals to be better incorporated at all levels, in appropriately resourced interdisciplinary community based settings.[26] This involves the adequate availability of clinical training and experience in the community as well as acute and subacute care settings at undergraduate, postgraduate and continuing professional education.

All education and training needs to be based on effective learning methodologies and will need to provide for flexible approaches that reflect the "real world". [27] [28] These will vary between professions and settings but are likely to encompass elements of experiential learning and reflection, self directed learning, mentoring,[29] scenario analysis and role playing[30] and interdisciplinary learning.

The role of specialist palliative care providers is crucial in facilitating both specialist and generalist teaching and learning. However, significant concern exists about the capacity of specialist services to provide meaningful clinical placements, and this is a generic issue that has been recognised as in need of support as part of national health reform processes.

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[1] The following definitions of end of life, end-of-life care and palliative care are used throughout this position paper. Source: Palliative Care Australia (PCA), *Palliative and End-of-Life Care – Glossary of Terms,* PCA, Canberra, 2008.
End of life: That part of life where a person is living with, and impaired by, an eventually fatal condition, even if the prognosis is ambiguous or unknown.
End-of-life care: End-of-life care combines the broad set of health and community services that care for the population at the end of their life. Quality end-of-life care is realised when strong networks exist between specialist palliative care providers, primary generalist providers, primary specialists, and support care providers and the community – working together to meet the needs of the people requiring care.
Palliative care is specialist care provided for all people living with, and dying from an eventually fatal condition and for whom the primary goal is quality of life.
[2] Australian Health Workforce Advisory Committee *A Models of Care Approach to Health Workforce Planning* Health Workforce Information Paper 1, March 2005
[3] Department of Health and Ageing *Primary Health Care Reform in Australia* (2009) p.113
[4] Canning D et al (2005) *Competency Standards for Specialist Palliative Care Nursing Practice* Brisbane; QUT
[5] National Health and Hospitals Reform Commission (NHHRC) *A healthier future for all Australians Final Report June 2009* p.140
[6] Australian Health Workforce Advisory Council March 2005
[7] National Health and Hospitals Reform Commission *A healthier future for all Australians Final Report June 2009*
[8] Palliative Care Australia (2005) A guide to palliative care service development: A population based approach

[9] Segal L: "Issues facing the future health care workforce: the importance of demand modelling" *Australia and New Zealand Health Policy* 2009, 6:12
[10] Australian Health Workforce Advisory Committee: *A Models of Care Approach to Health Workforce Planning*
[11] See SA Health *Palliative Care Services Plan 2009-2016*; NSW Health *Palliative Care Strategic Framework 2010-2013*
[12] ANZSPM Position Statement *Benchmark Number of Specialists in Palliative Medicine* (June 2009)
[13] Department of Human Services *Palliative Care Workforce A supply and demand study* (2006)
[14] SA Health *Palliative Care Services Plan 2009-2016*
[15] DHS (2006) p.44
[16] Department of Health and Ageing 2009 op cit. p.31
[17] Department of Health and Ageing 2009 op cit.
[18] Scott IS Health care workforce crisis in Australia; too few or too disabled? *MJA* 2009; 190 (12): 689-692
[19] Crawford GB Price SD Team working: palliative care as a model of interdisciplinary practice *MJA* 2003: 179 (6 Suppl): S32-S34
[20] DoHA 2009 Primary Care Strategy p 116
[21] Crawford & Price op cit.
[22] See Scott op cit.; Department of Health and Ageing 2009 op cit. p.115
[23] Tang M Multidisciplinary teams in cancer care: pros and cons *CancerForum* 33 (3) 2009
[24] Department of Health and Ageing *Primary Health Care Reform in Australia Report to Support Australia's First National Primary Health Care Strategy* 2009a p.126
[25] National Palliative Care Program (2005) *Principles for including palliative care in undergraduate curricula* p.9
[26] Department of Health and Ageing 2009 p 117
[27] Cairns W Yates PM Education and training in palliative care *MJA* 2003; 179 (6 Suppl): S26-S28
[28] Scott IS op cit.
[29] Cairns W Yates PM op cit.
[30] Scott IS op cit.