**If you could change one thing for rural palliative care service delivery what would it be?:**

1. **Locally**
2. **Nationally**

1.
The resources to enable people to die in their own communities
**Locally**
Palliative care beds in Wingecarribee Shire

**Nationally**
Palliative care beds servicing discreet communities
Greater allocation of CNC nursing staff
Dedicated palliative care section in public hospital or purchase bed days from the private system

2.
Improved access to Palliative Care specialists and Level 3 services
Better communication to provide an improved awareness for the role of palliative care in the community.

3.

**Locally**
Communication between GPs Nurses and services

- if everyone communicated more effectively it would make a difference to the way people experienced health care
- using documentation that is user friendly for all health professionals working in Palliative care

**Nationally**

- Prevention education
- Mindfulness, awareness education
- Promoting lifestyles of health and wellbeing

4.
**Locally**
Increased resources particularly GP and allied health to visit patients in their homes in rural areas

**Nationally**
The Australian Primary Care Collaborative has now extended to cardiac disease and will probably continue to be expanded to toher chronic conditions. The focus of the Collaborative is on management of chronic diseases. It would be ideal if a continuum of care was promoted instead – to manage the disease progresses and eventually having a palliative care as the burden of the condition increases and life expectance shortens.

5.
**Locally**
Establish a Hospice

**Nationally**
Availability of a Hospice in all regional areas

6.
**Locally**
- Too much reliance on the local palliative care support group, a volunteer organisation. State Health/Government needs to allocate adequate funding through home care etc
- Better, more equitable access to the whole range of services
- Cease the closing of dedicated pain clinics

**Nationally**
- Uniform standards across the country

7.
**Locally**
Locally based palliative care physician/consultant

**Nationally**
Enhanced and tangibly supported education opportunities for health care professionals proving direct care for those facing a life limiting illness, delivered through specialist palliative care services

8.
**Locally**
Equity of access

**Nationally**
Equity of access

9.

**Nationally**
The current remuneration system for GPs does not encourage Quality Palliative care. The quick 15 minute claimable item does not allow for the GP to fulfill a thorough assessment including psychosocial needs or spend the time to really listen to what the patient is saying.
Long consultations are closely scrutinized by the MBS auditors making the GP fearful to use them- patients have to return as not all issues are dealt with and it makes the GP practice extremely busy.
Remuneration needs to be changed to outcome based system. Where symptoms are resolved in 24-48 hours, where patients and families are satisfied with the care they have been given. Where patients do have a comprehensive TCA and Care Plan, where ACA has been approached and where the hard conversations have been had in a timely manner.

10.
**Locally**
The need to travel to a provincial area to receive radiotherapy treatment! The availability of palliative care services

**Nationally**
More funding for services

11.
**Locally**
- More in-patient beds located where there is a palliative care physician to provide support for complex patients/ symptoms
- Funded palliative care consultation team for the acute hospital
- Increased hospice beds for the region

12.
**Locally**
Palliative care services to provide on-going education and resources that empowers the broad community to support their family members and neighbours so that patients can remain at home

**Nationally**
24hour phone support available to all palliative care patients and their families wherever they are in Australia at the cost of a local phone call

13.
**Locally**
Integrate more resources to Community based palliative care services ie

- Recurrent funding
- Incentives for community based PC Nurse Practitioners
- Increased family/carer support networks
- Streamlined referrals

**Nationally**
Make permanent changes to the curriculum in which all new GP registrars are involved in more intense PC training either in community based services or in acute health care settings. Currently they are spending around 2 weeks studying palliative care over the whole of their training – definitely not enough!

14.
**Locally**
24/7 service provision to include nurse practitioner

**Nationally**
Medicare items for PC/ Advance Care Planning and medical provision in RACF with a uniform funding approach for palliative care.

15.
**Locally**
Establish a governance board to provide strategic direction for end of life care in the region eg review model of care and set priorities

**Nationally**
Planned national approach to implementing priority strategies that support end of life care eg identification of the palliative population; a common language; implementation of a national referral document

16.
**Locally**
Co-locate SPCS with oncology service

**Nationally**
Incentives and promotion of more PC Specialists in rural areas

17.
**Locally**
Funding to enable a 1.0FTE Bereavement coordinator to be appointed to the Yorke Peninsula Region who could complement the existing 1.0 FTE Palliative Care Coordinator Position

**Nationally**
Increased support in the provision of service at the local level

18
**Locally**
24hour access

**Nationally**
Access to Palliative Care Specialists
19.
**Locally**
More complementary therapies

**Nationally**
A greater awareness of what PC is at all levels, GPs, carers patients etc
More education – beyond the funded RPCP projects

20.

**Locally**
Regular education sessions for GP Practice nurses facilitated by PC specialist nurses

**Nationally**
Lobby for improved PC project funding and realistic timeframes

21
**Locally**
Access to bereavement service and 24 hour palliative service on Kangaroo Island

**Nationally**
Greater access to specialist palliative care hospices in larger rural centres

22.
**Locally**
Fulltime Palliative Care Consultant

**Nationally**
Recognition that palliative care is not just for cancer patients

23.
**Locally**
GPs to recognize the value of early referral to palliative care service

**Nationally**
Funding of palliative care projects for a realistic period of time ie 3-5 years to allow improvements to be embedded in practice

24.
**Locally**
The provision of more nursing staff to provide after hours services

**Nationally**
Greater recognition of the role of the rural GP (possibly making Rural General Practice as specialisation to attract more doctors to rural areas)

25.
**Locally**
- Resources for Gp to join regional pallitve care team
- Access to medications

**Nationally**
Care of dying is responsibility of all health professionals. Inclusion in all undergraduate studies – medical nursing and allied health.

26.
Enhance communication
- Primary providers
- SPC providers
- Patients and families

All are companions on the patient's journey!

27.
**Locally**
Facilitate equal access to palliative care providers and services across the region

**Nationally**
Implement Palliative care standards across the country and increase awareness of the meaning of "palliative".

28.
**Locally**
More consultation and integration with local and interconnecting services to avoid confusion and ensure good collaborative care; making it easier for GPs and community members to access quality care

**Nationally**
More consultation with service providers ie many agencies are offering the same service

29.
**Locally**
24hour specialist palliative support

**Nationally**
Good use of communication systems connecting MDT

30.
**Locally**
Skilled dedicated PC workforce and resources

**Nationally**
Ambulance policy to change re narcotics and transportation