The Palliative Care Outcomes Collaboration (PCOC) wishes to acknowledge the valuable contribution made by the many staff from palliative care services who have spent considerable time collecting, collating and correcting the data and without whose effort this report would not be possible.

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If you would like more information, a detailed state report is available on the PCOC website www.pcoc.org.au.

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PCOC has made every effort to ensure that the data used in this report are accurate. Data submitted to PCOC are checked for anomalies and services are asked to re-submit data prior to the production of this report. We would advise readers to use their professional judgement in considering all information contained in this report.

Published April 2016
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In **July to December 2015** there were **21** specialist palliative care services in **Victoria** that submitted data to PCOC.

Of these:

- **11** were inpatient only services
- **9** were community only services and
- **1** was both inpatient and community

Combined, these services provided **7,636** episodes of care to **5,895** patients.

**61%** of care occurred in the home or aged care facilities.

**75%** of patients had a malignant diagnosis.

During this period **2,497** patients died.

Of these, **63%** died in hospital.

There are **4** outcome measurement areas. These are:

1. **1** benchmark on **timeliness of care** that **14** services* have met
2. **1** benchmark on **responsiveness to urgent needs** that **10** services* have met
3. **4** benchmarks on **pain management** where **10** services* have met at least one benchmark
4. **8** benchmarks on **symptom management** where **18** services* have met at least one benchmark

*Service providers with an inpatient and community setting are counted twice

For more information, a detailed Victorian state report is available at [www.pcoc.org.au](http://www.pcoc.org.au)
Section 1 - Introduction

The Palliative Care Outcomes Collaboration (PCOC) is a voluntary program partnering with palliative care services from across Australia to improve patient outcomes through benchmarking. There are 33 Victorian palliative care services participating in PCOC. Of these, 21 submitted information for the July to December 2015 reporting period. These 21 services include:

- 11 inpatient palliative care services. Inpatient services include patients who have been seen in designated palliative care beds as well as non-designated bed (in-reach and consultative).
- 9 community palliative care services (in the home or residential aged care facility).
- 1 palliative care service which provides both inpatient and community care.

The information contained in this report is based on 5,895 patients that were seen by Victorian services participating in PCOC during the reporting period July to December 2015. This report contains some national figures and Victorian figures from previous reporting periods for comparative purposes. Figure 1 summarises the volume of information included in Victoria’s six monthly reports produced by PCOC between 2013 and 2015.

**Figure 1 Volume of services, patients, episodes and phases over time for Victoria**

- **In July – December 2015:**
  - Victorian community services provided 4,625 (61%) episodes of care for 3,522 patients
  - Victorian inpatient services provided 3,011 (39%) episodes of care for 2,489 patients
Service locations

Figure 2 shows the location of Victorian services that submitted data for the July to December 2015 reporting period. There were 17 services located in major cities and four located in inner regional areas. For a full list of services in Victoria that have contributed data since January 2013, please see Appendix A.

In July – December 2015:

- 17 services are located in major cities
- 4 services are located in inner regional areas
Section 2 – Outcome measures

Timely admission to service

Time from date ready for care to episode start reports responsiveness of palliative care services to patient needs. This measure relates to the time taken for an episode to commence following the date the patient is available and ready to receive palliative care.

**Benchmark 1:** 90% of patients must have their episode commence on the day of, or the day after date ready for care.

In July – December 2015:

- 98.2% of patients in the inpatient setting had their episode commence the day of or day after date ready for care.

- 76.3% of patients in the community setting had their episode commence the day of or day after date ready for care.

For the current report period, eleven inpatient services and three community services met this benchmark (Figure 4).

![Figure 3](image1.png) Percentage of patients with episodes that commenced the day of or the day after the date ready for care – over time

![Figure 4](image2.png) National service profile for benchmark 1, July to December 2015

Inpatient services
Community services
National Profile
Benchmark

Responsiveness to urgent needs

The unstable phase alerts clinical staff to the need for urgent changes to the patient’s plan of care or that emergency intervention is required. Patients assessed to be in the unstable phase require intense review for a short period of time.

**Benchmark 2: 90% of unstable phases must last for 3 days or less.**

In July – December 2015:

- **91.0%** of unstable phases in the inpatient setting were 3 days or less.
- **69.3%** of unstable phases in the community setting were 3 days or less.

For the current report period, eight inpatient services and two community services met this benchmark (Figure 6).

---

**Figure 5** Percentage of unstable phases lasting 3 days or less – over time

**Figure 6** National service profile for benchmark 2, July to December 2015
Pain management

Pain management is acknowledged as a core business of palliative care services. The PCPSS is clinician rated and measures the severity of pain as a clinical problem. The change in pain is measured from the start of a phase to the end of the same phase. There are two benchmarks associated with this tool.

**Benchmark 3.1:** 90% of patients with absent or mild pain* at the beginning of their phase of palliative care have absent or mild pain* at the end of the phase.

In July – December 2015:

- **91.3%** of patients in the inpatient setting had absent or mild pain* at phase start, remaining absent or mild at phase end.
- **84.8%** of patients in the community setting had absent or mild pain* at phase start, remaining absent or mild at phase end.

*pain as measured by the PCPSS tool

For the current report period, six inpatient services and no community services met this benchmark (Figure 8).
**Benchmark 3.2:** 60% of patients with moderate or severe pain* at the beginning of their phase of palliative care have absent or mild pain* at the end of the phase.

In July – December 2015:

- **59.7%** of patients in the inpatient setting had moderate or severe pain* at phase start, with absent or mild pain* at phase end.

- **44.4%** of patients in the community setting had moderate or severe pain* at phase start, with absent or mild pain* at phase end.

*pain as measured by the PCPSS tool

For the current report period, seven inpatient services and no community services met this benchmark (Figure 10).
The Symptom Assessment Scale (SAS) is primarily patient rated and measures distress caused by pain. The change in distress from pain is measured from the start of a phase to the end of the same phase. There are two benchmarks associated with this tool.

**Benchmark 3.3:** 90% of patients with absent or mild distress from pain** at the beginning of their phase of palliative care have absent or mild distress from pain** at the end of the phase.

In July – December 2015:

- **89.7%** of patients in the inpatient setting had absent or mild distress from pain** at phase start, remaining absent or mild at phase end.

- **81.0%** of patients in the community setting had absent or mild distress from pain** at phase start, remaining absent or mild at phase end.

**pain as measured by the SAS tool**

For the current report period, four inpatient services and no community services met this benchmark (Figure 12).
**Benchmark 3.4:** 60% of patients with moderate or severe distress from pain** at the beginning of their phase of palliative care have absent or mild distress from pain** at the end of the phase.

In July – December 2015:

- **55.5%** of patients in the inpatient setting had moderate or severe distress from pain** at phase start, with absent or mild pain* at phase end.
- **46.3%** of patients in the community setting had moderate or severe distress from pain** at phase start, with absent or mild pain* at phase end.

**pain as measured by the SAS tool**

For the current report period, five inpatient services and one community service met this benchmark (Figure 14).
Case-mix adjusted symptoms and problems

This outcome measure includes a suite of case-mix adjusted scores used to compare the change in symptoms and problems for similar patients i.e. patients in the same phase who started with the same level of symptom. Eight symptoms and problems are included in this report and the baseline reference period is January to June 2014. The following graphs show the proportion of patient phases at or above the national average baseline.

**Figure 15** Percentage of patients at or above the national average baseline over time - PCPSS

**Figure 16** Percentage of patients at or above the national average baseline over time - SAS
Section 3 – Patient demographics

For the current reporting period, there were 5,895 patients in Victoria, who between them had 7,636 episodes of care and 16,255 palliative care phases. The community setting provided 4,625 (60.6%) episodes of care and the inpatient setting provided 3,011 (39.4%) episodes of care.

Age and sex

For the current reporting period, the average age for patients in Victoria was 72.3 years and the median was 75 years. Figure 17 shows the distribution of age for males and females in Victoria.

For the current reporting period, the average age for patients nationally was 71.8 years and the median was 74 years.

In July – December 2015, for Victoria:

52.0% of patients were males
Average age was 72.8 years
Median age was 75 years

48.0% of patients were females
Average age was 71.7 years
Median age was 74 years

NOTE: Age has been calculated at the beginning of the patient’s episode.

Indigenous Status

Of the 5,895 patients in Victoria for the current reporting period, 38 (0.6%) identified as Aboriginal or Torres Strait Islander. This compares to 1.3% of patients nationally across all PCOC services who identified as Aboriginal or Torres Strait Islander.
Diagnosis

In Victoria for the current reporting period, there were 4,407 (74.8%) patients with a malignant diagnosis and 1,482 (25.1%) patients with a non-malignant diagnosis.

The most common malignant diagnoses in Victoria were lung cancer (n=963), colorectal cancer (n=490) and other gastrointestinal cancers (n=418).

The most common non-malignant diagnoses were cardiovascular disease (n=254), respiratory failure (n=247) and stroke (n=128).

Figure 18 shows the percentage of malignant and non-malignant diagnosis for Victoria over the past six reporting periods.

Place of death

For the current reporting period, there were a total of 2,497 deaths in Victorian palliative care services that submit data to PCOC.

Figure 19 shows the percentage of deaths by setting over time for Victoria. In the current reporting period, there were 1,569 (62.8%) deaths in hospital and 928 (37.2%) in the community.

Nationally, for services that submit data to PCOC, 70.1% of deaths were in the hospital and 29.9% of deaths were in the community.

In July – December 2015, for Victoria:

- **37.2% of deaths occurred in the community**
- **62.8% of deaths occurred in hospital**
Inpatient setting

For the current reporting period, inpatient services provided 3,011 episodes of care to patients in Victoria. This represented 39.4% of all PCOC episodes in Victoria.

The average length of these inpatient episodes was 9.8 days and the median was 5 days. Nationally, the average length of inpatient episodes was 10.3 days.

Victorian inpatient services had an average episode length of 9.8 days

How episodes started

In Victoria for the current reporting period, the main referral sources for inpatient palliative care were; public hospitals (65.2%), community based palliative care services (20.8%) and private hospitals (9.7%).

Figure 20 shows the problems and distress from symptoms patients were experiencing on admission to inpatient palliative care units in Victoria for the current reporting period. The symptoms with the highest number of moderate / severe scores were distress from fatigue (32.7%), distress from pain (25.5%), and other symptoms (all symptoms other than pain) (23.3%).

In July – December 2015, for Victoria:

- 1,803 patients were admitted from the community
- 675 patients were admitted from another hospital
- 500 patients were admitted from acute care on another ward
How episodes ended

In Victoria, there were 2,965 inpatients that had their episode of care end in the current reporting period. Of these, 1,569 (52.9%) ended because the patient died and 1,387 (46.8%) ended because the patient was discharged.

Nationally, for the current reporting period, 53.7% of inpatient episodes ended in death and 46.3% of inpatient episodes ended in discharge.

Figure 21 shows the problems and distress from symptoms patients were experiencing on discharge from inpatient palliative care. There are very few severe scores on discharge. The symptoms with the highest number of absent scores were distress from nausea (94.2%), distress from difficulty sleeping (90.6%), and distress from bowel problems (86.9%).

Top discharge reasons from inpatient care in Victoria:

- 910 patients were discharged to the community
- 226 patients ended a consultative episode but had an ongoing inpatient episode
- 217 patients were discharged to another hospital

*as measured by the PCPSS
** as measured by the SAS
NOTE: only patients that are discharged are included in the graph. Symptoms and problems are not measured at death.
Community setting

An episode of care is a period of contact between a patient and a palliative care service that is provided by one palliative care service and occurs in one setting. Under this definition, a patient receiving palliative care is likely to have more than one episode of care.

For the current reporting period, community services provided 4,625 episodes of care to patients in Victoria. This represented 60.6% of all PCOC episodes in Victoria.

The average length of these community episodes was 38.3 days and the median was 26 days. Nationally, the average length of community episodes was 37.8 days.

Victorian community services had an average episode length of 38.3 days

How episodes started

In Victoria for the current reporting period, the main referral sources for community palliative care were; public hospitals (59.1%), residential aged care facilities (9.1%) and general medical practitioners (7.9%).

Figure 22 shows the problems and distress from symptoms patients were experiencing on episode start for community palliative care in Victoria for the current reporting period. The symptoms with the highest number of moderate / severe scores were distress from fatigue (49.8%), family / carer problems (31.4%), and other symptoms (all symptoms other than pain) (28.6%).

At the beginning of community episodes:

- 3,770 patients were living in a private residence
- 321 patients were living in residential aged care facilities
How episodes ended
In Victoria, there were 4,185 community patients that had their episode of care end in the current reporting period. Of these 928 (22.2%) ended because the patient died and 3,257 (77.8%) ended because the setting or intent of care changed (discharge).

Nationally, for the current reporting period, 26.6% of community episodes ended because the patient died and 73.4% of community episodes ended in discharge.

Figure 23 shows the problems and distress from symptoms patients were experiencing on discharge from community palliative care. The symptom with the most moderate / severe distress was fatigue (64.4%), followed by other symptoms (all symptoms other than pain) (49.7%) and family / carer problems (46.5%).

Top discharge reasons from community care in Victoria:

- 1,789 patients were admitted for inpatient palliative care
- 1,043 patients were admitted for inpatient acute care
Appendix A – List of Victorian services

The following table lists the Victorian services that have been participating in PCOC reporting over the past three years.

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### Appendix B – Glossary

**Episode**
An episode of care is a period of contact between a patient and a palliative care service that is provided by one palliative care service and occurs in one setting. An episode of care ends when either; the patient is formally separated from the current setting of care; the patient dies; or the principal clinical intent of the care changes and the patient is no longer receiving palliative care. Under this definition, a patient receiving palliative care is likely to have more than one episode of care.

**Patient**
PCOC defines a patient as a person for whom a palliative care service accepts responsibility for assessment and/or treatment as evidenced by the existence of a medical record. Family / carers are included in this definition if interventions relating to them are recorded in the patient medical record. As a result, if a patient is seen in two different services with different medical record systems they will be counted twice in the total number of patients.

**PCPSS**
Palliative Care Problem Severity Score (PCPSS) is a clinical tool used for initial screening and ongoing coordination of specialist palliative care. Clinician rated, it facilitates the global assessment of four palliative care domains: pain, psychological / spiritual, other symptoms and family / carer.

**Phase**
Palliative care phase identifies a clinically meaningful period in a patient’s condition. The palliative care phase is determined by a holistic clinical assessment which considers the needs of the patients and their family and carers. The phases provide a framework for referrals, triage and care planning.

**SAS**
Symptom Assessment Scale (SAS) describes the patient’s level of distress relating to individual physical symptoms. The symptoms in the scale are the seven most commonly experienced by palliative patients; difficulty sleeping, appetite problems, nausea, bowel problems, breathing problems, fatigue and pain. The instrument is designed to be a patient rated tool but also allows for rating by proxy (e.g. family, carer or clinician).
Appendix C – How to interpret the national profile graphs

The national profile graphs present Victorian services in comparison to other palliative care services participating in PCOC. In each graph, the shaded region describes the national profile for that outcome measure. Victorian inpatient services are highlighted as black dots on the graph. Victorian community services are highlighted as grey triangles on the graph.

If the number of dots or triangles does not correspond to the number of services on a particular graph, this means that a service(s) has not met the criteria for inclusion in this measure. This may be caused by insufficient data item completion, or the service not having any data falling into a particular category, for example, no phases starting with moderate or severe pain.

The red line on the graph indicates the benchmark for that outcome measure.

![Figure 24 National service profile for benchmark 1, July to December 2015](image-url)