



**BARWON SOUTH WESTERN
REGION**

PALLIATIVE CARE CONSORTIUM

ANNUAL REPORT

2012 - 2013



Strengthening palliative care: Policy and strategic directions 2011 - 2015

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INTRODUCTION

The Barwon South Western Region Palliative Care Consortium was established in 1998. Its objectives were determined by the Department of Human Services policy document, *Strengthening Palliative care: a policy for health and community providers 2004-09*. This policy was reviewed in 2009-10. This led to the development and release of the Department of Health, *Strengthening palliative care: Policy and strategic directions 2011-2015* in August 2011.

The Barwon South Western region palliative care consortiums' key functions in implementing *Strengthening palliative care: Policy and strategic directions 2011-2015* (policy) include:

- Leading the implementation of relevant aspects of the policy in the region
- Monitoring and reviewing the implementation of the policy in the region
- Facilitating the integration of care for people with a life-threatening illness and their carers and families across the service system
- Working to optimise the community's access to quality palliative services
- Enabling more efficient and cooperative use of resources that supports an integrated approach to care for the patient

The role of the consortium includes:

- Undertaking regional planning in line with departmental directions
- Coordinating palliative care service provision in each region
- Advising the department about regional priorities for future service development and funding
- In conjunction with the Palliative Care Clinical Network (PCCN), implementing the service delivery framework, and undertake communication, capacity building and clinical service improvement initiatives

The policy lists the following challenges for the future:

1. Victoria's population is growing and ageing
2. The way we live in old age, the way we die, has changed
3. Meeting people's wishes to be cared for and die at home
4. Addressing unmet need

The function of this annual report is to detail implementation (performance measures) of the policy by the Palliative Care Consortium in the Barwon South Western Region and the impacts of that implementation in the Barwon South Western Region over the last financial year.

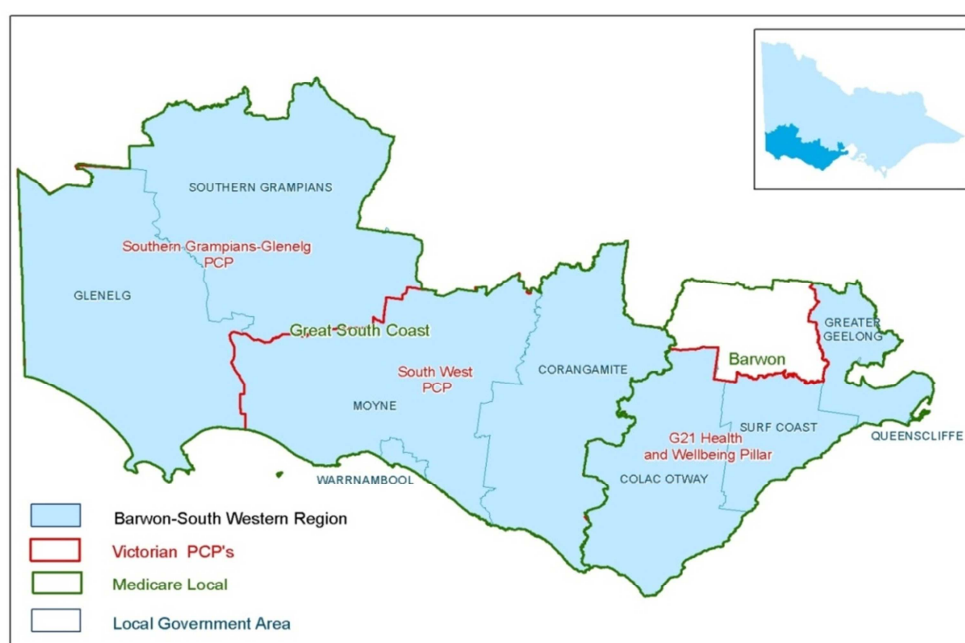
BACKGROUND ABOUT THE BARWON SOUTH WESTERN REGION

The Barwon South Western Region covers the LGA's of the City of Greater Geelong, Surf Coast Shire, the Borough of Queenscliffe, Colac-Otway Shire, Corangamite Shire, Shire of Moyne, City of Warrnambool, Glenelg Shire and the South Grampians Shire. The total population for the region in 2011 was 366,900 (source Australian Bureau of Statistics).

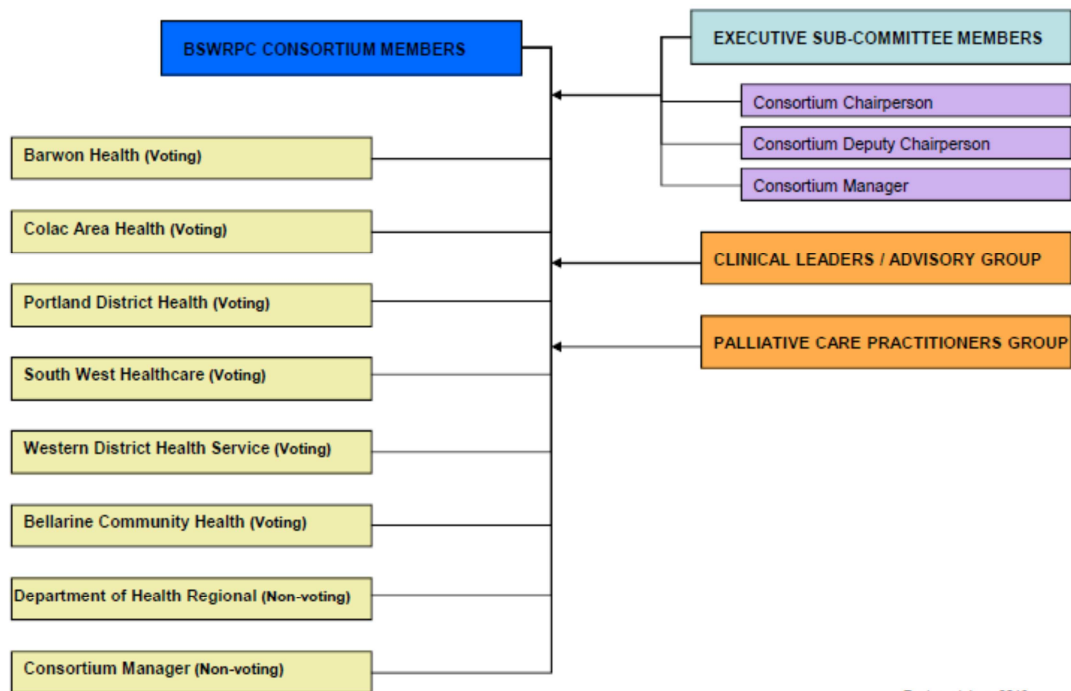
Local Government Areas	Total Population	Projected Population change 2011 – 21	% people speaking a language other than English at home
Greater Geelong	215,151	1.96%	10%
Surf Coast	26,493	2.40%	3.6%
Queenscliffe	3,054	1.22%	2.3%
Colac-Otway	20,578	1.71%	3.2%
Corangamite	16,504	0.97%	1.6%
Moyne	16,175	1.35%	1.5%
Warrnambool	32,592	1.92%	3.1%
Southern Grampians	16,510	1.01%	2.2%
Glenelg	19,843	1.14%	2.4%

Geography

Figure 1: Map of Barwon-South Western region and administrative areas, Department of Health 2012



Barwon South Western Region Palliative Care Consortium Organisational Chart



Reviewed June 2013

Barwon South Western Region Funded Palliative Care Services

Community Palliative Care services are located at Barwon Health (Geelong), Bellarine Community Health (Point Lonsdale), Colac Area Health (Colac), Portland District Health (Portland), South West Healthcare (Warrnambool) and Western District Health Service (Hamilton).

Inpatient Palliative Care beds are located as follows: Barwon Health – 16, South West Healthcare – 6, Colac Area Health – 1, Portland District Health – 1, Western District Health Services – 1

Regional Palliative Care Consultancy Teams – the teams are located as follows: Barwon sub-region team provides services to specialist palliative care teams at Bellarine Community Health, Barwon Health and Colac Area Health. South West sub-region provides services to the specialist palliative care teams at Portland District Health, South West Healthcare and Western District Health Services. Each team is multi-disciplinary, with a mix of medical, nursing, psychology and bereavement personnel making up the team. Services involve secondary consultation to palliative care team members, GP's and acute health service staff both public and private, primary consultations are also available in the form of one to one patient assessments with subsequent advice and/or an opinion being relayed to the referrer

Hospital Based Palliative Care Consultancy Team – this service is located at the Geelong Hospital campus of Barwon Health. The team is made up of medical and nursing personnel who provide primary and secondary consultations within the hospital. They receive an average of 900 referrals per year, and make an average of 1,400 contacts.

CONSORTIUM CHAIR'S REPORT

2012/13 has seen my first introduction to the Palliative Care specialty as well as the Barwon South Western Region Palliative Care Consortium. It has proved to be a steep learning curve but the immediate thing that struck me was the commitment, dedication and passion displayed by the individuals, teams, services and programs. I have worked in several other specialties but Palliative Care is the flagship for consumer-centred care and everyone involved in this fantastic work is to be commended on the work that they do. The consortium is no exception to this. Their engagement, participation and energy ensure that the systems within the region have, and will continue to, enhance and improve the patient and carer experience.

The consortium has continued implementation of actions to address requirements contained within the *Strengthening Palliative Care: Policy and Strategic Directions 2011-2015*. This second year has focussed on several key initiatives including the implementation of an after-hours model of care that is intended to provide support to patients and carers in their homes. Implementing such a model created significant challenges however, good project management, communication and regional agreement proved to be the key to its success.

Another highlight was the accomplishment of significant education and training within the region over the last 12 months. In particular it is heartening to see the uptake of education on the palliative care approach by link nurses within aged care facilities. Also worthy of note is the reception given to education within disability services and the positive feedback received on the benefits of this training in the work environment. Next year will see this education extended and enhanced.

It is exciting to consider the year ahead and to be a part of a shared vision to continue to strengthen the palliative care focus within our services. This year will not be without further challenges (an obvious mention goes to activity based funding) but I am confident that with the support of the consortium members, the Department of Health, the Consortium Manager and all other key stakeholders we will endure and improve.

Finally, I would like to thank Heather Robinson, Consortium Manager, whose skills, knowledge, standards, commitment and attention to detail are second to none. I am sure that the consortium members will agree when I say that we couldn't have done it without her.

Julie Jones
September 2013

Strategic Direction 1: Informing and involving clients and carers

Priority: Actively involve clients and carers in the planning and delivery of their care

1.2 Ask clients and carers how they would like to be involved in the planning and delivery of their care. Work with clients, carers and other clinicians, particularly the client's GP, to develop an interdisciplinary care plan that reflects clients' and carers' wishes

Performance Measure: The response to this priority is dictated by a regional agreement to use consistent tools, as endorsed by the Palliative Care Clinical Network (PCCN), Palliative Care Outcomes Collaborative (PCOC) and Victorian Integrated Non-Admitted Health (VINAH) minimum data sets across inpatient, community and consultancy services.

There is also regional agreement to embed the reporting of Resource Utilisation Groups – Activities of Daily Living (RUG ADL), Australian-modified Karnofsky Performance Status (AKPS), Problem Severity Scores, Edmonton Symptom Assessment Score, Phase and a Distress Thermometer into the palliative care software (PERM) used by 83% of community palliative care services in the region.

Required Impacts:

- All clients have an up-to-date interdisciplinary care plan that reflects their wishes for how they would like to be involved in the planning and delivery of their care
- Where appropriate, a copy of the completed care plan is provided to the client (and carer) and to other care providers, including the client's GP

Actual Impacts:

An up-to-date interdisciplinary care plan that reflects the wishes of clients and carers are contained within the PERM software. Currently electronic assessments are completed for 83% of clients, and on paper for 17% of clients. A completed copy of the care plan is generated for the client to keep at home for community clients in 100% of cases. Copies of the care plans are sent to the client's GP and other care providers as necessary.

Strategic Direction 2: Caring for carers

Priority: Strengthen practical and psychological, social and spiritual support for carers of people with a life-threatening illness, acknowledging that their needs may change

- 2.3 Ensure access to a range of respite options to meet the needs of clients and carers by:
- Mapping available respite services
 - Strengthening links between palliative care services and respite services
 - Providing specialist consultation and advice to respite services about how to meet the needs of clients with a life-threatening illness

Performance measures: Lists of respite services that may be appropriate for clients with life-threatening illness have been developed and are available in each palliative care service in the region. Information and education on respite availability, including provision of care for children with a life-threatening condition is provided to families and carers by all (100%) community, palliative care services across the region as part of standard admission packages for all new clients. All services have access to the eligibility criteria of the respite services available to clients allowing them to offer tailored advice to clients

Required Impacts:

- A range of respite services established
- Respite services have increased knowledge about caring for people with a life-threatening illness
- Clear and consistent eligibility criteria are developed and adopted by palliative care and respite providers

Actual Impacts:

All (100%) palliative care program staff in the Barwon South Western region received education about appropriate respite services and eligibility criteria as part of palliative care induction programs and ongoing education. We will consider developing on-line education using the learning portal for ongoing education of staff across the region. As part of their work with respite services all (100%) palliative care services in the region have endeavoured to increase the level of knowledge about caring for people with life-threatening-illness within respite services but we have no way of measuring this at this time.

Priority: Increase the availability of after-hours support to clients and carers in their homes, particularly in rural areas

- 2.5 Implement an after-hours model of care across the region

Performance measure: An after-hours model which is aligned with the After-hours palliative care framework (Department of Health 2012) was implemented across the Barwon South Western region in 2012/13 (with the exception of Bellarine Community Health).

During this financial year Barwon Health, Colac Area Health, South West Healthcare, Portland District Health and Western District Health Service have all been using PERM clinical palliative care software. This has proved to be a useful tool to assist with appropriate triage responses to after-hours calls by providing the necessary live clinical information on which to base clinical decision-making. All staff

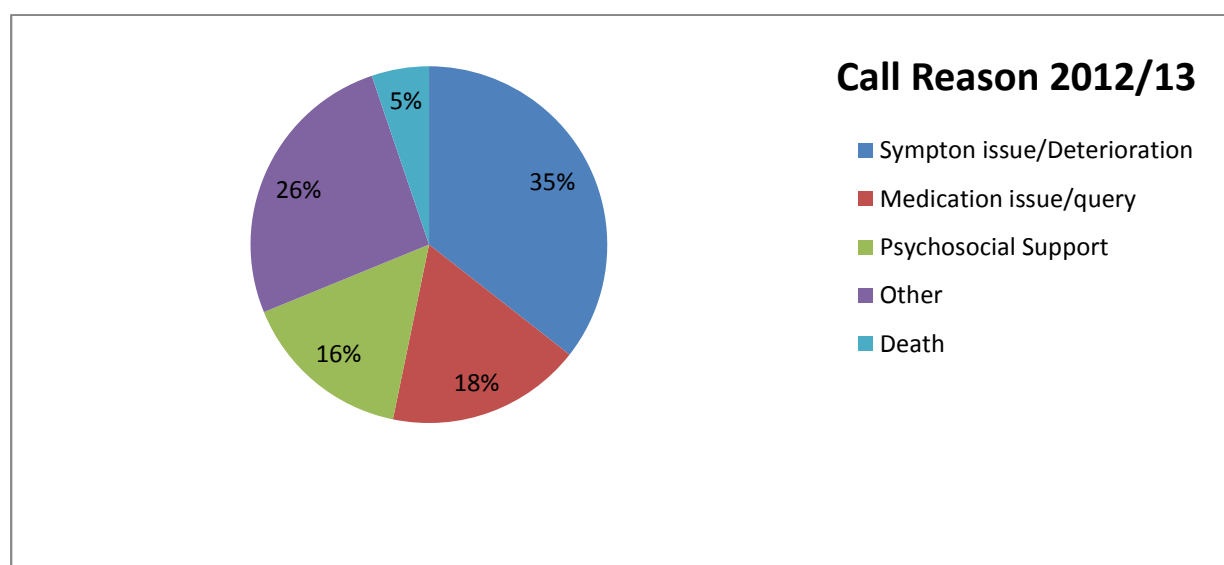
of each service has been involved in developing the protocols for after-hours triage as it applies to their service.

The process for after-hours service is that clients ring into their local service and they are seamlessly connected to the paging service that then pages St Vincent's/Caritas Christi. To enable this process St Vincent's/Caritas Christi also have access to the live PERM patient data after-hours for triage purposes, this includes: current medication, notes and assessment information. They can record their advice regarding interventions within the system so that palliative care staff can view overnight activity at the start of the following day.

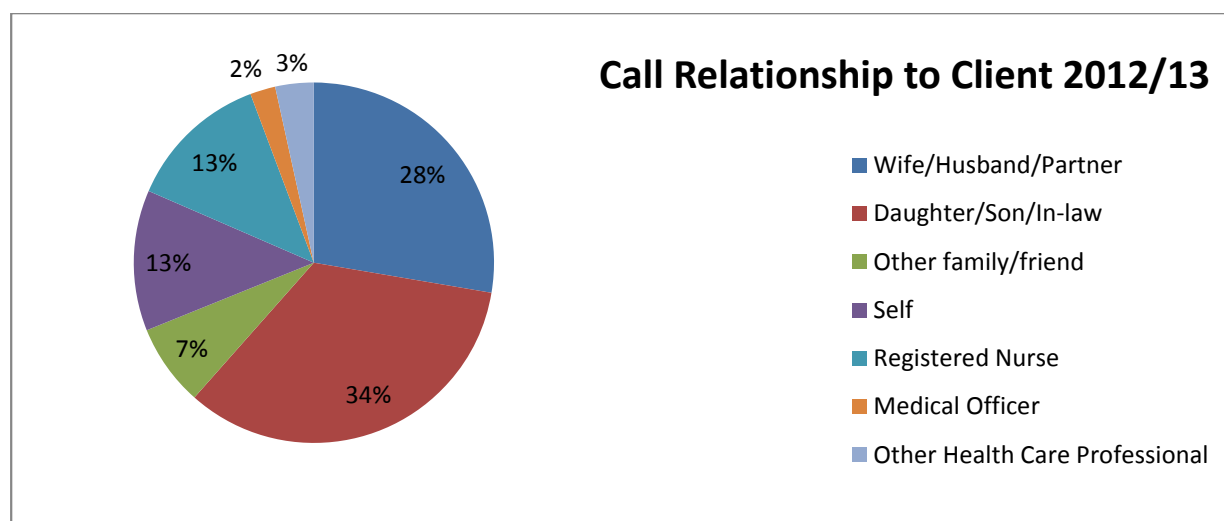
Total after-hours triage calls during 2012/13 for the Barwon South Western Region are made up of:

Bellarine Community Health	113
All other health services	1502
Total	1615

This led to a total 352 after-hours nursing call-outs by community/district nurses across the region during the financial year to June 30th 2013. Please see a breakdown of call elements below.



Call reason data



Caller relationship to client data

Required Impacts:

More after-hours support (including telephone support and home visits where appropriate) is available to all clients and their carers

Actual Impacts:

More after-hours support (including specialist telephone support and community nursing home visits where appropriate) is available to all clients and carers in the Barwon South Western region. Whilst in the preceding year Barwon Health had a triage relationship with St Vincent's / Caritas Christi, in the past after-hours telephone support to clients and carers of South West Healthcare, Portland District Health Service, Colac Area Health and Western District Health Service were not always provided by specialist palliative care staff. Protocols have been developed with community/district nursing services in the region to provide call-outs for clients when requested by Caritas Christi and if it is safe to do so.

Bellarine Community Health continues to provide an on-call service using their own generalist staff and is expected to join the other consortium members using the PERM software and the St Vincent's/Caritas Christi after-hours triage service within the coming financial year 2013/14.

As this is the first year for the regional after-hours service the data provided here forms the baseline data against which impacts for future years can be measured.

Client and carer satisfaction with the availability of after-hours support in the Barwon South Western region as measured in the 2013 Victorian Palliative Care Satisfaction Survey (VPCSS) remains consistent, 2011 – mean of 4.1, 2012 – 4.1 and 2013 – 4.1 of a possible total of 5.

Strategic Direction 3: Working together to ensure people die in their place of choice

Priority: Raise the awareness of health, community and aged care providers about palliative care to ensure people are cared for and die in their place of choice

3.1 Palliative care services provide consultation and support to health, community and aged care providers that are caring for clients with palliative care needs

Performance measures: All training and education is focused on public and private health, community and aged care providers. Over the last year a number of training activities have been held, these have been open to residential and community aged care, public and private acute care staff, community nursing and staff from residential disability services. The consortium records pre/post education evaluations for all education they provide, to measure any increase in knowledge and confidence of staff caring for people with a life-threatening illness. It is hoped that this will then improve the number of people living and dying in their place of choice as a result of training activity.

The consortium manager and palliative aged/disability worker met with the manager of the Aged Care Assessment Service (ACAS) at the Barwon Health, McKellar Centre campus to discuss the range of education being delivered to residential aged care facility staff across the region and the likelihood that aged care staff would now be more likely to appropriately refer residents to community palliative care. The value of formal protocols was discussed but it was felt that they were not necessary at this time as ACAS already has a very strong relationship with palliative care and refers patients to palliative care as necessary. ACAS personnel are also able to access PERM software to make referrals or record their opinion after assessment.

Required Impacts:

Public and private health, community and aged care providers have increased knowledge about how to care for people with a life-threatening illness and how to support someone with a life-threatening illness at home

Actual Impacts:

Public and private health, community and aged care providers having an increased knowledge about how to care for people with a life-threatening illness and how to support someone with a life threatening illness within a facility or at home if that is their choice is affected by a number of factors:

- The provision of ongoing education to all sectors about a palliative approach for people with a life-threatening illness*
 - Promotion of PEPA palliative approach education as and when it becomes available*
 - Increases in education about appropriate referrals to community and inpatient palliative care and the number and appropriateness of referrals to community palliative care services*
 - The presence of willing/able carer/s makes a significant difference to the clients ability to die in their place of choice, even though the use of available services can significantly increase time spent at home*
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- *The work of Palliative Care Consultancy Teams in acute health facilities in the region increases the knowledge of staff caring for someone with a life-threatening illness working within that facility, the team are also available to advocate and facilitate on the client's behalf regarding appropriate care choices*
 - *The availability of supportive services in the community including community/district nursing, local government home care services, respite services and volunteers support all contribute to clients being more likely to be care for and/or die in their place of choice*
 - *Evaluations are conducted before and after all education, see results of education in sections 3.4 and 3.6*
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3.2 The palliative care sector develops consistent and clear information for health, community and aged care providers about when and how to refer clients to palliative care; information will be developed for GP's as a priority.

Performance measures: Health, community and aged care providers and their various networks are linked to the consortium through the consortium member organisations all of which provide a variety of other services within their communities in addition to palliative care.

Barwon Medicare Local: A Barwon Health organisational project was undertaken that has streamlined referral of patients to Barwon Health clients using common GP software programs e.g. Medical Director. Specialist Palliative Care Services also took part in this project to simplify palliative care referrals. GP's can select a palliative care referral from a generic referral pick-list, the referral fields have been pre-determined and the majority of fields are auto-populated. The referrals are then sent electronically to the specialist palliative care program. This has improved the quality of referrals, the majority of which are now electronic with past history, medications, reason for referral and co-morbidities included. The timeliness of referrals to specialist palliative care has improved as a consequence of continuous liaison with medical staff and their experience of its benefits.

The Medicare local employs staff with palliative care and aged care portfolios, consortium staff have met with these staff to make them aware of palliative care activities of interest to general practitioners. Articles about these activities are for inclusion the Medicare local newsletter. The Barwon Medicare local is the auspice for the GP Palliative Care Special Interest Group which has a monthly breakfast meeting. This group consists of GP's, members of the specialist palliative care team and invited guest speakers as necessary. They arrange an annual palliative care seminar to which all GP's and specialist palliative care staff are invited.

The Palliative/Aged Care Support nurse wrote an article for the newsletter about the aged care link nurse program and the related education, she also attended the GP palliative care special interest

group meeting to discuss issues raised as part of the education and received some valuable feedback from them.

Great South Coast Medicare Local: Links will be developed with this Medicare Local in 2013/14 as this group is still developing its services due to receiving funding much later than the Barwon group.

Consortium staff have been involved in promoting 'Program of Experience in the Palliative Approach' (PEPA) palliative approach education sessions and placement within the region to over approximately 100 GP's, residential aged care and residential disability staff during the last year.

Required Impacts:

- Clients receive timely and appropriate referral to palliative care
- Information and referral processes promoted by the palliative care sector are consistent with referral and coordination strategies across health, community and aged care providers

Actual Impacts:

Clients across the Barwon South Western region receive timely and appropriate referral to specialist palliative care. There is a high level of stability amongst the medical community and specialist palliative care services are well known and highly respected in the region which facilitates appropriate referral processes being promoted by the palliative care sector. Referral strategies are based on Service Coordination Tool Templates (SCTT) across health, and community and aged care. In the 2013 the Barwon South Western Region Victorian Palliative Care Satisfaction Survey (VPCSS) conducted by Ultrafeedback reported client and carer satisfaction with the ease of referral to palliative care scored a mean of 4.52/5 in 2013 (an increase from 4.42 in 2011).

3.4 Improve palliative care capacity in disability accommodation services

Performance measures: Two part-time disability/palliative care project officers were employed in the Barwon South Western region, one to service the Barwon sub-region, the other to service the South West sub-region. This consortium decision was based on the model used for regional palliative care consultancy services which divided into the Barwon sub-region covering Geelong, Colac and Bellarine and the South West sub-region covering Hamilton, Portland and Warrnambool.

Relationships have been developed across the region with regional Department of Health disability officers and public disability accommodation services and also with private disability accommodation services.

Activities in the South West sub-region

Meetings were held across the sub-region during February and March 2013 with representatives from the above named organisations. Some of the common perceived barriers to keeping residents in disability accommodation raised were: lack of skill of staff, lack of knowledge, fear of the unknown (staff), grieving of other residents, self-care and grief, meeting the needs of other residents when one resident requires more attention and a lack of resources and funding for 24 hour nursing care if the client is unable to attend day centre.

A two session palliative approach education program was delivered based on the Palliative Care Toolkit. The palliative approach toolkit describes the palliative approach, referral to specialist palliative care, the clinical domains of pain, dyspnoea, nutrition and hydration, oral care and delirium, case conferencing, communication and advance care planning. This event was held in April 2013, 12 disability accommodation staff attended. Staff evaluations results were excellent with 96% believing that Palliative Care and Disability accommodation services should have closer ties and 97% believing that advance care planning would be of assistance to them.

Activities in the Barwon sub-region

Meetings were held with the Geelong Regional Action Network Disability (GRAND) in 21st March 2013 and with Colac Otway Disability Accommodation (CODA) on the 8th April 2013, at which a pilot proposal was presented which included the following:

- Education workshops for disability staff in Geelong and Colac- including an introduction to palliative care, palliative approach, referring to specialist palliative care, recognising when someone is deteriorating, common signs and symptoms in the final days of life, common changes that occur when death is imminent, managing symptoms, family meetings, advance care planning and self-care/grief
- Individual education to group homes on request when a resident has been diagnosed with a life-limiting illness, or concerns from staff regarding the care of the resident

The proposal was well received at each meeting and it was unanimously agreed to trial this proposal for the next twelve months then to review it.

Residential Disability accommodation personnel were invited to a Dementia education session in June which they found very useful; the key issue for those attending was Advance Care Planning. The development of disability specific plans was thought to be useful in identifying preferred place of care and death and acting as a trigger for appropriate conversations with families or guardians. This group indicated they would like to be invited to any future education.

Further education sessions have been booked for Colac on 7th August and Geelong 11th November 2013

There have been many learning's from the discussions across both the public and private disability accommodation services:

- The preferred place of care and preferred place of death for residents is not recorded and this would need to occur if a baseline measure is to be in place from which it can then be extrapolated if an improvement has occurred
- The need for a disability specific advance care plan was agreed and a funded pilot project has commenced in Geelong, Dr Charlie Corke is the chair of the advisory committee which includes a consultant, staff from the Summer Foundation, residential disability staff, respecting patient choice staff, a disabled client, parents of a disabled client and the Disability/Palliative Care project officer from the Barwon sub-region
- Some baseline palliative approach education is likely to be beneficial to disability accommodation staff but there is also a need for education to staff around the deterioration of individual residents
- An understanding of the effect legislative requirements specific to the residential disability sector have on disability staff e.g. mandatory cardio pulmonary resuscitation and notification of the Coroner for all deaths create significant staff stress and often result in residents being transferred to acute hospitals for their final days
- Difficulty accessing funding for overnight active care for deteriorating clients
- Lack of funding for active care by staff during the day as residents would normally go to day programs

- Referrals of clients from residential disability services to specialist palliative care services cannot be measured as there is no Victorian Integrated Non-Admitted Health (VINAH) data item (referral in service type) for residential disability services that would allow this data to be recorded. Specialist palliative care services in the region have indicated that they do receive referrals for clients in residential disability but this data is not quantifiable

Required Impacts:

People living in disability accommodation services who have a life-threatening illness are supported to be cared for and die in their place of choice

Actual Impacts:

The impact of the above measures to improve palliative approach capacity in disability accommodation will, if implemented, increase the likelihood that people living in disability accommodation services will be able to be cared for, and die in, their place of choice. As discussed above, we cannot identify at this time what the preferred site of care and death is for residents of residential disability services. We will report on these impacts in future years as this work progresses.

Priority: Assist aged care services to care for people at the end of life

3.5 Undertake a project to establish protocols and strengthen relationships between palliative care and aged care services, including residential, community and aged care assessment services

Performance measure: A regional palliative/aged care action plan was developed by the consortium and implemented. A copy of the aged care action plan is attached at *Appendix 3*. The plan will be reviewed in August 2013 by the Barwon South Western Palliative Care Consortium

Required Impacts:

- State and regional palliative/aged care action plans developed
- Joint resources to support the provision of end-of life care in aged care services developed

Actual Impacts:

A regional palliative/aged care action plan was developed which is to be reviewed annually. Resources were developed to support the provision of end-of-life care in aged care services. The Palliative Approach toolkit developed by the University of Queensland/Blue Cross Research and Practice Development Centre was reproduced in its entirety to enable palliative/aged care support nurses to deliver consistent education to the residential aged care services across the region and to provide at least one toolkit per aged care facility as a resource across the Barwon South Western Region. This toolkit has a module with a focus on end-of-life care provision.

3.6 Establish a palliative/aged care support nurse in each region

Performance measure: Part-time palliative/aged care support nurses were employed in the Barwon sub-region and the South West sub-region. The palliative/aged care support nurses visited all (100%) of the managers of aged care facilities to discuss the aged care link nurse program. Managers were given a copy of module 1: 'Integrating a palliative approach' from the palliative approach toolkit. They were then asked to discuss the program with their staff and to nominate at least two Division 1 Registered nurses to join the link nurse training program. Education programs were then developed based on the toolkit at each end of the region.

In the *South West sub-region* 25 facilities sent a total of 62 link nurses for training based on the palliative approach toolkit. Education was held at Cobden District Health Service, Terang Hospital, and Abbeyfield in Mortlake, Camperdown, Port Fairy, Hamilton, Casterton, Warrnambool and Glenelg Community Aged Care. End of life care pathways were used in 17% of facilities in the pre-education survey, this increased to 62% of facilities in the post-education survey. Between the pre/post education surveys aged care link nurse confidence in the following areas is reflected here:

	Pre	Post	% increase
Reacting to reports of pain	87%	88%	1%
Reacting to reports of terminal delirium	60%	76%	4%
Reacting to reports of dyspnoea	72%	81%	9%
Reacting to reports of nausea	70%	88%	18%
Reacting to reports of constipation	75%	88%	13%
Changes in resident decision making capacity	75%	83%	8%

In the *Barwon sub-region* 35 facilities sent a total of 113 link nurses for training based on the palliative care toolkit. Education was held in Geelong, Colac and Bellarine. End of life care pathways were used in 15% of facilities in the pre-education survey, this increased to 50% in the post education survey. Between the pre/post education surveys aged care link nurses confidence in the following areas is reflected here:

	Pre	Post	% increase
Reacting to reports of pain	57%	66%	9%
Reacting to reports of terminal delirium	41%	41%	-
Reacting to reports of dyspnoea	52%	54%	2%
Reacting to reports of nausea	58%	70%	18%
Reacting to reports of constipation	61%	66%	5%
Changes in resident decision making capacity	45%	58%	13%

Ongoing secondary consultations and regular newsletters are provided by both palliative/aged care support nurses. At the 30th June 2013 there are only 7 facilities in the Barwon South Western region not involved with the aged care support nurse program.

All staff of aged care facilities have been reminded of the dangers of using the out-dated Graseby syringe drivers. A reduction in the price of NIKI T34 syringe driver was arranged by the palliative/aged care support worker through the company representative from REM systems, saving \$650. A number of facilities took up this offer and also the free education that went with it.

Information was given to all participants about support available from the following: 'CareSearch', PEPA placements and PEPA education.

Key learning's from the palliative/aged care program to consider for inclusion in the program for 2013/14 include:

- A regular ongoing education with topics selected by link nurses included dementia, self-care/grief, difficult conversations and having an understanding of multicultural issues.
- Some aged care facilities had a length of stay of 21 days which was clearly causing stress for staff, increased sick leave and a significant grief burden.
- Palliative Care Worker specific palliative approach training is required as in some facilities these staff makes up a significant proportion of their EFT.
- To date the theory behind the Link nurse model in aged care has had varying success. In some facilities it has worked well but in others the link nurses don't feel comfortable or confident to educate other staff in the facility or to try and facilitate process change.

Required Impacts:

- End-of-life care pathways in residential aged care facilities implemented
- More aged care facility residents are supported to die in their place of choice

Actual Impacts:

South Western sub-region: End of life care pathways were used in 17% of residential aged care facilities in the pre-education survey, this increased to 28% in the post-education survey.

Barwon sub-region: End of life care pathways were used in 15% of facilities in the pre-education survey, this increased to 50% in the post education survey. We do not have access to preferred place of choice to die in residential aged care or the actual place of death data, therefore we cannot report on this impact at the present time.

Strategic Direction 4: Providing specialist palliative care when and where it is needed

Priority: Ensure people who need access to specialist palliative care are receiving care appropriate to their needs at the right time, in the place of their choice

Implement the palliative care service delivery framework Service Delivery Framework (SDF) across Victoria, with advice from the Palliative Care Clinical Network (PCCN). As part of this implementation: the service delivery framework will be used by the palliative care consortium in regional service planning

Performance measures: Regional service planning is aligned with the Service Delivery Framework and supported with a signed memorandum of understanding between all the consortium members listed below.

- Barwon Health
- Colac Area Health
- Bellarine Community Health
- Western District Health Service
- South West Healthcare
- Portland District Health

Specialist palliative care community services are placed in appropriately sized population centres across the region, see the list above.

Inpatient Palliative Care Beds are located in the following centres:

Barwon Health (McKellar Centre campus), South West Healthcare (Warrnambool Hospital), Portland District Health Service, Colac Area Health and Western District Health Service

Regional Palliative Care Consultancy Team: Each team is made up of specialist palliative care medical, nursing and supportive care staff. One team is located in the South West sub-region and supports the palliative care services at Portland District Health, Western District Health Service and South West Healthcare, 50% of team activity is primary consultation and the remainder of the team activity is secondary consultation. The other team is located in Barwon sub-region and supports the palliative care services at Colac Area Health, Bellarine Community Health and Barwon Health; it also has 50% of team activity as primary consultation and the remainder as secondary consultation.

Acute Hospital Consultancy Team: the acute hospital team is located at Barwon Health, Geelong.

Required Impacts:

- Clients have access to an appropriate level of specialist palliative care in their region
- There is clear information about the palliative care services that are available across regions and the capabilities of these services

Actual Impacts:

Clients have access to an appropriate level of specialist palliative care in their region. There are no waiting lists for community palliative care services and all referrals are assessed as soon as possible.

There is clear information about the palliative care services that are available across the region

and the capabilities of these services are available from a number of sources including the palliative care services, the health services in which they are based, general practice, medical specialists, local government and community health centres.

The Barwon South Western Region Palliative Care consortium website lists services, their locations and their services available across the region www.bswrpc.org.au. Information is also available online from Palliative Care Victoria, Palliative Care Australia and the Department of Health.

Strategic Direction 5: Coordinating care across settings

Priority: Strengthen the role of the palliative care consortium in coordinating palliative care service provision and leading policy implementation in the region

5.2 Develop stronger links between the palliative care consortium, the PCCN and all other relevant stakeholders

Performance measures: Identify the health, community and aged care networks in each region and how they link with palliative care.

Each consortium member in the region employs community/district nurses, five of the six consortium members also have acute hospital beds and residential aged care beds five of the six consortium members also have funded palliative care inpatient beds.

Other links include:

- St John of God Hospital in Warrnambool has strong links with the palliative care services at South West Healthcare.
- St John of God Hospital in Geelong has strong links with the palliative care program at Barwon Health. Palliative care patients in Geelong Private Hospital can be assessed by members of the Barwon Health palliative care consultancy team as requested.
- Through the Palliative/Aged Care Support Nurse Program links have been established with public and private residential aged care facilities across the Barwon South Western Region.
- Through the Disability/palliative care project officers links have been established with public and private residential aged disability services across the Barwon South Western Region.

A Memorandum of Understanding exists with regional health services all of whom are consortium members who provide funded specialist palliative care service. These services also provide residential and community aged care, district/community nursing, acute care services and a range of other health and community services.

With reference to strengthening/developing links between consortium and networks see Strategic Direction 3.2 Medicare Locals.

Addition collaboration is also undertaken via the Clinical Leaders and Practitioners Groups (as outlined in the 'Background about the Barwon South Western Region'.

Required Impacts:

Broadened the number and type of partnerships between palliative care consortia and other health, community, aged care and other providers and structures per region including Primary Care Partnerships and Medical Locals

Actual Impacts:

The number and types of partnerships between the consortium and other health, community, aged care and other providers has increased over the last financial year. The key driver of this increase has been the amount of liaison within the residential aged care and residential disability services. Meetings were held with the managers of all residential aged care facilities and most residential disability service coordinators/managers.

Added to this has been the significant amount of education offered throughout all of the sectors including post PEPA education.

Excellent links have been developed with the Barwon Medicare Local including regular meetings with their specialist portfolio holders and regular updates from the Primary Care Partnership G21.

5.3 Strengthen consortium governance and accountability processes and document them consistently

Member agencies:	Voting Delegates	Attendance
Barwon Health (Chair)	Julie Jones	100%
Colac Area Health	Jennifer Levine	66%
Bellarine Community Health	Kathy Day	66%
Portland District Health	Annette Hinchcliffe	66%
South West Healthcare	Julianne Clift	100%
Western District Health Service (Deputy Chair)	Janet Kelsh	83%

Executive Committee:

The Executive committee is made up of the Chairperson, Deputy Chairperson and the Consortium Manager.

The Clinical Leaders Group (Clinical Advisory) is chaired by the Consortium Chairperson or the Colac Area Health voting delegate.

The consortium workers for the region include:

- Consortium Manager (Heather Robinson)
- Palliative/Aged Care Supports workers x 2
- Disability/Palliative Care Project officers x 2

Performance measures: A role statement audit carried out in June 2013 found that:

- Role statements for Consortium, Consortium Chair, Consortium Deputy Chair, Consortium Manager and employing agency, Consortium Executive, Consortium Fundholder, Consortium members (voting) and Consortium member (non-voting) have all been implemented and are current.
- Links with the Department of Health are maintained through circulation of monthly palliative care project updates, attendance at statewide meetings, consortium manager meetings and other meetings as necessary e.g. in this year a series of meetings related to ABF funding of the sector, Department of Health staff attended the June 2013 consortium meeting to discuss ABF issues specifically.
- All voting members of the consortium understand the consortium role and champion palliative care in their own health service; they participate in budget and resource allocation decisions.
- All consortium member agencies have current accreditation status, five with ACHS and one with QICSA.

Required Impacts:

Palliative care consortia have documented governance and accountability processes in place that are understood by consortia members

Actual Impacts:

- *A record is maintained of all meeting minutes, reports, agenda's, for the consortium, the clinical leaders group and the practitioners group.*
 - *Progress of all aspects in the consortium regional plan are reviewed as standing items at each consortium meeting.*
 - *Terms of reference for the Consortium, Executive and Clinical Leaders have all been reviewed in 2013.*
 - *Procedures are in place for orientation of new consortium members.*
 - *A quality and risk management framework has been developed for the consortium, see Appendix 4.*
 - *The fundholder for the next two years is Barwon Health elected in 2013 and the Consortium Chair is Julie Jones (Manager of Palliative Care at Barwon Health) also re-elected in 2013.*
-

Priority: Use technology to enhance service coordination for all palliative care services

5.4 Encourage consistent equitable IT solutions that facilitate coordination and consultation across all palliative care services

Performance measures:

- Partnerships and opportunities to promote IT connectivity were explored and developed as part of the development of the 'Palliative Electronic Record Management' (PERM) software which was part of a project funded by the Department of Health and Ageing..
- The Barwon South Western Region Palliative Care Consortium (BSWRPCC) developed a specialist palliative care medical record based on an agreed assessment model and a variety of clinical tools. These tools includes: Problem Severity Score, Edmonton Symptom Assessment Score, the Australian Modified Karnofsky Performance Scale, RUG/Activities of Daily Living, Phase, Distress Thermometer and Palliative Prognostic Indicator.
- The regional software system (PERM) was developed for community palliative care to support the population needs based model of care, the agreed common assessment tools, collect data for the Palliative Care Outcomes Collaborative (PCOC), the Victorian Integrated Non-admitted Health (VINAH) minimum datasets, to provide evidence for the National Standards Assessment Program (NSAP) and to provide internal data for service and workforce planning. This software is now in place at Barwon Health, South West Healthcare, Western District Health Service, Portland District Health and Colac Area Health. Through 2012 discussions have continued with Bellarine Community Health to explore how the software may be of benefit to them.
- Carer Support Needs Assessment Tool (CSNAT) is being trialled at three community palliative care programs at the moment and it might in future be appropriate to consider adding it to the suite of tools in PERM

Required Impacts:

IT solutions are in place to support quality initiatives and connectivity

Actual Impacts:

- *Palliative Care Electronic Record Management (PERM) software is internet based which allows St Vincent's/Caritas Christi to access live data for after-hours triage. They are also able to record their activity overnight and this is then flagged for community palliative care staff the next morning.*
- *There are a number of internal data reports available using PERM data that can be used by the services who use the software to design quality initiatives.*
- *BSWRPCC took part in a telehealth project in early 2013 which involved assessing the hardware capability of community palliative care services in the region, hardware was then ordered to allow many more telehealth activities to take place in the region.*
- *At Portland District Health a clinic is being planned for complex patients where the medical staff will have access to the patients live palliative care notes, this will be followed by a multidisciplinary team meeting.*
- *Palliative Care workers across the region are being encouraged to use the purchased iPad to access patient information while they are out with the patient and to record key components of the assessment while they are in the client's home.*
- *Accurate data reports of VINAH data are being finalised once this work is complete internal reports will be available for use in benchmarking and quality initiatives.*
- *The Barwon South Western Region now has a PCOC test extraction report ready to be submitted. When this report is sent the reports back from PCOC will form the basis of benchmarking analysis and the development of appropriate quality project.*

Strategic Direction 6: Providing quality care supported by evidence

Priority: Develop consistent clinical care protocols that are informed by research and evidence

6.1 Quality improvement opportunities are identified and actioned

Performance measures:

Victorian Palliative Care Satisfaction Survey (VPCSS): All palliative care services within the Barwon South Western region participated in the 2013 round of the VPCSS. Key data is included below:

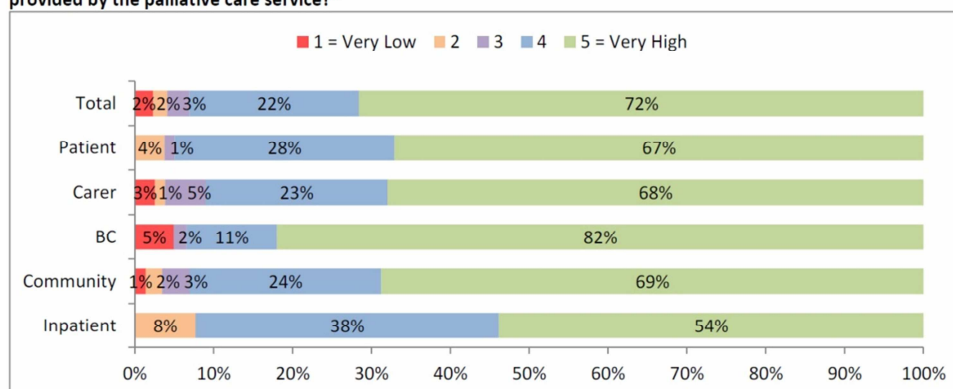
Top five *Priority to Improve* items:

Item	mean
Satisfaction with support received for planning ahead for funeral arrangements (if applicable)	3.67
Satisfaction with activities to help you pass the time	3.25
Satisfaction with ongoing support to minimise financial burden	3.64
Satisfaction with ongoing support, level of access to psychological support services	3.77
Satisfaction with ongoing support, opportunities to talk with other carers about your own situation (as a carer)	3.23

Top five performing items:

Item	mean
Satisfaction with the level of respect shown towards you as an individual	4.86
Satisfaction with the response from nurses	4.79
Overall satisfaction with the care delivered by your palliative care team	4.77
Satisfaction with the level of expertise of the people involved in your care	4.72
Satisfaction with the way your physical needs are supported	4.71

Figure 1: Distribution of responses for the question, "How satisfied were you with the overall standard of care provided by the palliative care service?"



NSAP Support for Carers Collaborative Project: As a result of consistent carer concerns registered in the Victorian Palliative Care Satisfaction Survey over the last three years three consortium members in the Barwon South Western Region are taking part in the Support for Carers Collaborative Project. Barwon Heath, Western District Health Service and Portland District Health

Clinical tools implemented at the service and regional level: Refer to 5.4 for a list of the clinical tools implemented across the Barwon South Western region palliative care services

Other initiatives: The PCCN consortia representative acts as a conduit between the services, the consortium, the clinical advisory group and PCCN. The PCCN consortia representative attended 83% of PCCN meetings and 100% of Clinical Leaders group in the last financial year. A PCCN report is a standing agenda item at all consortium meetings, clinical leaders meetings and palliative care practitioners meetings. The PCCN consortium representative attends consortium meetings, clinical advisory group and palliative care practitioners meetings at which she reports on the activities of the

Palliative Care Clinical Network. The Consortium representative is then in a position to be able to put issues raised within the region to the PCCN for review.

Required Impacts:

- Established statewide program of work for the update of evidence into clinical practice
- Palliative care service delivery is more consistent and evidence based

Actual Impacts:

Palliative care service delivery is more consistent and evidence based through its use of a standardised initial assessment tool and a number of clinical tools.

Preparation for implementation of the bereavement framework in the Barwon South Western region has commenced, impacts will be able to be reported in future annual reports.

Discussion of suitable carer assessment tools as part of the NSAP Support for Carers Collaborative Project and then implementation of any chosen tool will assist with more consistent and evidence based practice leading to improved impact reporting.

Priority: Ensure all Victorian palliative care services provide quality care that is assessed against national standards and supported by a quality improvement culture

6.6 Provide ongoing support to palliative care consortia and their member services to develop region-wide clinical service improvement programs that link with the work of the PCCN

Performance measures: The Clinical and Advisory groups are combined in the Barwon South Western region. The Clinical Advisory (Clinical Leaders) group role statement, membership, meeting format and frequency were reviewed in February 2013. Membership was broadened to include bereavement, social work and pastoral care workers based on the specific issues to be discussed, the format will be a mix of standing items and continuing work on issues supported by the PCCN, meetings will be quarterly.

Agenda standing items:

- Consortium decisions will be based on good clinical practice
- Facilitate collective problem solving in the implementation of the Strengthening Palliative Care Policy
- Develop resources that promote good clinical practice
- Report of issues raised by the Palliative Care Clinical Network
- Report of issues raised by the Clinical Pain Network of the PCCN

Align all topics for discussion during the year with the current Strengthening Palliative Care Policy including:

- ✓ Bereavement guidelines - discuss regional implementation of these guidelines
- ✓ NSAP Support for Carers Collaborative project - Barwon Health, Portland District Health and Western District Health are all taking part in this
- ✓ Carer Support Information
- ✓ Pain tools and policies

The region also has a Palliative Care Practitioners Group that meets twice yearly. This group is supported by the consortium and provides an opportunity for broader discussion by staff from all disciplines of issues arising in palliative care more generally, the palliative care software in use in the

region, educational opportunities for staff and issues for each of the palliative care services in the region.

Required Impacts:

Rigorous and ongoing clinical service improvement is undertaken by palliative care consortia and their member services

Actual Impacts:

The clinical leaders group have decided to consider appropriate ways to implement the bereavement framework in the region; there is ongoing discussion at each meeting about this issue. There is discussion of any findings from the network in relation to pain indicators and whether there are additional pain tools we need to consider having embedded into the software at each clinical leader's group meeting. At each meeting consideration is given to issues that have come up at the last PCCN meeting. Any significant issues and the associated recommendations are taken to each consortium meeting for discussion.

The regional decision to have several services involved in the NSAP Support for Carers Collaborative is likely to form the basis of a quality improvement project in an area where we know there is considerable need. It is expected there will be substantial gains in this area in the next twelve months.

Priority: Continue to build and support the palliative care workforce to meet increasing demand for palliative care

6.7 Work with the Commonwealth Government, Health Workforce Australia and the Workforce Unit in the Department of Health to develop innovative strategies to educate, train and recruit more specialist palliative care clinicians (medical, nursing and allied health) and to build the capacity of the general health, community, aged care and disability workforce

Performance measures: Regional workforce training and education initiatives including the registrar and advance trainees in Specialist Palliative care at Barwon Health. The retirement of a senior medical consultant from South West Healthcare in mid June 2013 led to the need to negotiate interim new arrangements for South West Healthcare and the South West Palliative care Consultancy Team. Dr Emma Greenwood, a GP with an interest and post graduate qualification in palliative care has been appointed by South West Healthcare into this position. The Department of Health has indicated these arrangements will need to be reviewed annually and that in the longer term Dr Greenwood is required to increase her qualifications.

Required Impacts:

- The palliative care workforce grows sufficiently to meet demand

Actual Impacts:

The palliative workforce growing sufficiently to meet demand is an issue that is frequently outside

-
- The capacity of the health, community, aged care and disability services workforce to care for people with a life-threatening illness is enhanced *of our control. We have the same ageing issues as the health workforce in general and the specific issues of attracting suitably qualified staff to regional and rural areas.*
The capacity of the health, community, aged care and disability services workforce to care for people with a life-threatening illness has been enhanced through the education provided to residential aged care and residential disability workers specifically (see 3.4 & 3.5) and to health and community more generally.
-

Strategic Direction 7: Ensuring Support from Communities

Priority: Strengthen Victorians' awareness, capacity and resilience in relation to dying, death, loss and bereavement, and their ability to support people with life-threatening illness and their carers

7.1 Develop and implement a strategy that helps to build awareness and understanding of death, dying and loss across Victorian communities through:

- communication
- partnerships
- practical methods, tools and educational strategies targeted to meet the needs of specific communities
- strategies to ensure people who are referred to palliative care are more prepared and are supported by their communities
- links and communication mechanisms at a statewide level between palliative care stakeholders across health, community and aged care

Required Impacts:

Victorians are better able to support people with life-threatening illness and their carers

Actual Impacts:

Work towards the performance measures and impacts for this strategic direction will commence in December 2013 and will be reported at the end of the next financial year.

Sub-Regional Palliative Care Consultancy

In the Barwon South Western Region the rural medical purchasing fund has been used to enhance palliative medical support to the South West and Colac areas of the sub-regional Palliative Care Consultancy teams. The key activities of the Barwon South Western sub-regional Palliative Care Consultancy teams fall into the following categories:

Community Palliative Care Support	Patient Assessment, Advice and Support	Support to General Practitioners and Palliative care Education
48%	50%	2%

PEPA (Program of Experience in a Palliative Approach) post-placement support activities

The 2013 workshop was held at Truffleduck in Geelong on June 24th 2013; it was titled 'A palliative approach for people with Dementia'. The workshop was presented by Professor Fran McNerney. There were 120 attendees, the majority of those attending had a background in residential aged care, others were from the residential disability sector and community aged care. The feedback from the session was excellent:

- ✓ Information in the presentation will be useful to me in the future = 100%
- ✓ I will change my practice as a result of the learning I have gained in this session = 92%

Motor Neurone Disease (MND) Shared Care Worker

Author Jenny Graham

The past year has seen a steady number of MND clients across the region but predominantly in the Geelong area. Referrals have most commonly come from the Motor Neurone Disease (MND) regional advisor but several general practitioners have made referrals over the past year so it has been the palliative care teams that have encouraged registration with MND Victoria to gain the benefits of additional support from the organisation and the Regional Advisor. Additionally, some of these people have not had the usual assessment and support of allied health which is vital in their ongoing care in the community. The late referrals provide greater challenges as there is an urgent need to encourage trust in service providers and then subsequent acceptance of the necessary interventions offered to improve the overall quality of life for clients and carer/s. There were 17 referrals in total for the Barwon South Western Region for the year and there are 7 current clients at 30/6/13.

Education: Several sessions of education have been provided to the following range of carers: aged care facility staff, local government workers, rehabilitation/allied health teams, community nurses and hospice workers. Education is offered to any team or individual involved in the care of someone with MND as soon as possible after admission to palliative care. The support is ongoing throughout the episode of care and I encourage health workers to call me for advice at any time. In April this year MND Victoria convened a seminar in Geelong for health professionals entitled "A Community Responds". Over 100 people attended this very informative day. The feedback was excellent.

Once again support to community based MND clients through Top-Up Funding has not occurred this past year due to the short term involvement in palliative care of most clients. The funding has been offered to some clients but declined. There has been one enquiry about In-patient Top Up funding for a recently diagnosed client.

The benefit of small client numbers is that it gives me the opportunity for more frequent direct client involvement and one on one support to the care team as required. I continue to enjoy the role of MND Shared Care Worker, the diversity of clients/families I meet and the variety of health teams throughout the region combine to make the role very rewarding. The success of this role is now evident across the region. I no longer see apprehension in staff caring for MND patients. All clients are getting access to specialist knowledge as required and local teams are providing quality support in the client's home community.

Palliative Care Nurse Practitioner Candidate

Author Meg Harrison

Qualification being completed 'Masters of Nursing Practice: Nurse Practitioner'. Five units have been completed towards my masters in 2012-2013:

- Ethical Dimensions of Nursing (1unit)
- Leadership and Management in Nursing (1unit)
- Advanced clinical Practice: Clinical assessment (0.5 unit)
- Cancer Care: Body systems and assessment (0.5 unit)
- Cancer Care: Psychosocial Perspectives (0.5 unit)
- The Pathophysiology of Diabetes (1unit)
- Advanced Clinical Nursing: Clinical Management (0.5 unit)
- Management of Diabetes (current) (1unit)

Pain Clinical Indicators Working Group with The Department of Health:

An audit consisting of 20 community palliative care patients and 20 palliative care unit patients was completed. I presented audit findings at Clinical pain indicators Workshop on 31st May 2013 at Banksia Palliative Care. I have attended 2nd monthly meeting with this group, collating results, the outcome of the workshop and how to move forward with getting these indicators implemented across state of Victoria.

Working towards my scope of practice with dyspnoea and cachexia as a focus:

Developing Dyspnoea Clinic: I am currently collecting clinical evidence worldwide and will have discussions with Dr Ian Grant after his conference overseas. I am regularly attending pulmonary rehabilitation for clinical experience with Dr Rob Mellon. Arrangements are still to be concluded regarding the medical input for this clinic. We are not sure as yet when this clinic will. This work will be ongoing.

Cachexia clinic: I am working on promoting the Cachexia clinic that runs at the Barwon Health, McKellar campus, currently in discussions with Dr Helen Farrell regarding presenting on the clinic at a conference in Melbourne.

Aboriginal Palliative Care

The Consortium Manager in the Barwon South Western Region is a member of the Victorian Aboriginal Palliative Care Advisory Group. There has been planning for some time for the development of a message stick which will be presented to each region with the aim of facilitating communication. The handing over of the message stick is planned for the 25th July 2013 at the VACCHO members meeting. The Palliative Care personnel at South West Healthcare, Western District Health Service, Portland District Health and Barwon Health have undergone Aboriginal Cultural Awareness training. This training will be offered again in the 2013/14 financial year and services will be encouraged to ensure that all staff have attended this training.

Appendix 1: BSWRPCC Financial Statement 2012/13

BSW Pall Care Consortium	Full year
Funding	
Nurse Practitioner Grant	80,000
MND Shared worker	18,000
PEPA funding	11500
Link Nurse	77,750
Disability Support Funds	25,000
After Hours Service	150,000
Rural Medical Purchasing Fund	128,557
BSW Consortium funding + indexation	117,449
BSW Consortium Top up	12604
Total Revenue	620,860
Operating Labour Costs:	
Palliative/Aged Care Support (Link) nurse	74849
BSW Consortia Manager:	86,269
On costs	8,523
Total Operating Labour Costs	169,641
Operating Non- Labour costs	
Southwest Healthcare (Link Nurse, Disability support , & RMPF)	133,836
After hours (including setup)	116,544
Rural Medical purchasing costs	34,283
Telehealth project costs	14,000
Barwon Health Nurse Practitioner Candidate	80,000
Conferences & Meetings Inc. flights etc.	18,176
Printing & Stationery	5,800
Training	6,115
MND Shared care worker	18,000
Admin costs (Inc. MV. Telephone etc.)	28,565
Total Operating Non Labour costs	455,319
Total Costs	624,960
Net surplus/deficit	-4,100

Appendix 2: Future Directions - Strategic/Operational Plan for 2013/14

Strategic Direction 2:	Actions	Performance measures	Responsible	Timeframe	Progress
Caring for Carers	2.3 Ensure access to a range of respite options	Information and education on respite, including providing care for children with a life-threatening condition is available regionally. Respite eligibility is known by palliative care services	Consortium & all services	Annual Report	Ongoing
	2.5 Increase the availability of after-hours support to clients and carers	Provide a palliative care after hours advice and support for all patients registered with community palliative care services across the region	All services Consortium Manager to report at each meeting	Standing agenda item	Ongoing

Strategic Direction 3:	Actions	Performance Measures	Responsible	Timeframe	Progress
Working together to ensure people die in their place of choice	3.1 Palliative care services provide consultation and support to health, community and aged care providers that are caring for clients with palliative care needs	Training, education and workforce development is focused on public and private health, community and aged care providers. This education and workforce development records increases in skill & confidence level of participants working to ensure people die in their place of choice	M McRae B King	SWH & BH to report through Consortium Manager at each meeting	Ongoing
	3.2 The palliative care sector develops consistent and clear information for health, community and aged care providers about when and how to refer clients to palliative care; information for GP's will be developed as a priority	Health, community and aged care providers/networks are linked with the palliative care consortium. Links will be developed with Medicare Locals. Barwon Medicare Local	Consortium Manager	Report in Annual report	Ongoing
		Great South Coast Medicare Local	Consortium Manager	Report in Annual Report	Begin in 2013/14
	3.4 Improve palliative care capacity in disability accommodation services.	Disability/palliative care project officers appointed. Relationships developed with all (public/private) residential disability services to encourage palliative care referrals. Improve disability services capacity to provide palliative care is improved	M McRae B King	SWH & BH to report through Consortium Manager at each meeting	Ongoing
	3.5 Undertake a project to strengthen relationships between palliative care, aged care services, community and aged care assessment	Regional palliative/aged care action plans developed and implemented	Consortium & Consortium Manager	Review September 2013	Ongoing
	3.6 Assist aged care services to care for people at the end-of-life	Employ palliative / aged care palliative support nurses.	M McRae (BH) B King (SWH)	Reports by Consortium Manager to each meeting	Ongoing

Strategic Direction 4:	Actions	Performance measures	Responsible	Timeframes	Progress
Providing specialist palliative care when and where it is needed	4. 2 Implement the palliative care service delivery framework (SDF) across the Barwon South Western region, with advice from the PCCN. As part of this implementation: Services will undertake self-assessment against the service delivery framework	Regional service planning is aligned with the SDF	Consortium & Individual services	Services will be asked to submit the data yearly to the Dept. of Health	PIAT and SDF docs to be done annually

Strategic Direction 5:	Actions	Performance measures	Responsible	Timeframes	Progress
Coordinating care across settings	5.2 Develop stronger links between the palliative care consortium, the PCCN and other relevant stakeholders.	Identify the health, community and aged care networks in each region and how they link with palliative care. Strengthen/develop links between consortia and networks. Clinical advisory group identifies formal links with the PCCN. Develop strong and sustained links with Medicare Locals	Consortium & Consortium Manager	Report at each BSWPCC meeting See 3.2	Ongoing
	5.3 Strengthen consortium governance and accountability processes and document them consistently.	Role statements are implemented regionally	Consortium & Consortium Manager	Terms of Reference reviewed annually. Elections every two years	ongoing
	5.4 Encourage consistent and equitable IT solutions that facilitate coordination and consultation across all palliative care services.	Partnerships and opportunities to promote IT connectivity are explored and developed. Use of PERM / TRAK at Barwon Health, South West Healthcare, Western District Health Service, and Portland District Health and Colac Area Health.	Individual services	Report at each consortium meeting	Ongoing
		Continue to work towards IT solution for Bellarine Community Health.	BCH staff and Consortium	2013/14	Yet to be achieved

Strategic direction 6:	Actions	Performance measures	Responsible	Timeframes	Progress
Providing quality care supported by evidence	6.1 Implement a program of work for the PCCN. Ensure all palliative care services provide quality care that is assessed against national standards and supported by a quality improvement culture	Palliative care services will maintain accreditation and participate in national palliative care outcomes and standards assessment processes. NSAP, PCOC and ACHS or QICSA. Quality improvement opportunities are identified and actioned. Clinical tools implemented at the service and regional levels A PCCN consortia representative acts as a conduit between services, consortium clinical advisory group and the PCCN	Individual services, reported in BSWPCC Annual Report	Report at each Consortium meeting	Ongoing
Ensure all Victorian palliative care services provide quality care that is assessed against national standards and supported by a quality improvement culture	6.6 Provide ongoing support to palliative care consortia and their member services to develop region-wide clinical service improvement programs that link with the work of the PCCN	Each region has an active clinical advisory group Consortium representative attends PCCN to report	Consortium & PCCN rep	Report at each Consortium meeting	Ongoing
Continue to build and support the palliative care workforce to meet the increasing demand for palliative care	6.7 Work with government to develop innovative strategies to educate, train and recruit more specialist palliative care clinicians (medical, nursing and allied health) and build the capacity of the general health, community, aged care and disability workforce	Regional workforce training and education initiatives. Count non-palliative care providers undertaking training to increase knowledge or skills. Record changes in knowledge and confidence and improved skills annually	Sub-regional educators & Consortium Manager	Report in Consortium Managers report and Annual Report	Ongoing

Strategic direction: 7	Actions	Performance measures	Responsible	Timeframes	Progress
Ensuring support from communities	<p>7.1 Develop and implement a strategy that helps to build awareness and understanding of death, dying and loss across Victorian communities through:</p> <ul style="list-style-type: none"> Communication Partnerships Practical methods and tools Increase palliative care volunteer engagement with the community Strategies to ensure people who are referred to palliative care are more prepared and are supported by their communities Links and communication mechanisms at a statewide level between palliative care stakeholders across health, community and aged care 	<p>Links between palliative consortium/palliative care services and health promotion officers (local councils, community health centres, PCP's) established or enhanced. Describe links.</p> <p>Statewide model/templates developed, endorsed by PCCN and implemented. Discussion and promotion of PCCN model and template</p> <p>Regional activities undertaken to build community capacity to support people who are referred to palliative. Give examples of joint activities</p>	Consortium & consortium manager	<p>Establish in 2013/14</p> <p>Establish in 2013/14</p> <p>Establish in 2013/14</p>	<p>Report at each meeting from Dec 2013 onwards</p> <p>"</p> <p>"</p>

Traffic Light Reporting

This system is intended to enable reporting to be efficient, effective, timely and accurate, and is based on reporting on progress in achievement of **Performance measures/Impacts** within agreed **Timelines**.

Green	Orange	Red
On track; appropriate efforts are being made to continue to achieve these goals, it is a standing agenda item at Consortium meetings	Yet To be commenced. Goals and issues will be reported separately by the Consortium Manager	Not to be commenced at this time or concluded/completed

Appendix 3: BSWRPCC Palliative Aged Care Action Plan

Step 1

Develop position descriptions for the palliative aged care support nurses based on desired policy performance measures and impacts.

Advertise for Palliative aged care support nurses

Employ palliative aged care support nurses to be situated within the same organisation as the sub regional palliative care consultancy team's e.g. South West Healthcare and Barwon Health.

Step 2

Decide on a project model based on a review of other similar projects that may inform the options for our region considering issues of consistency across the region and possibly the state.

Planning the palliative care aged care project is to include regular meetings between support nurses and managers to plan consistent education content, palliative approach toolkits, pre and post education evaluation and reporting requirements.

Step 3

Order printing of toolkit modules and order other toolkit components for collation sufficient for the number of aged care facilities in the region. Plan the education venues, dates, education plans and book venues.

Step 4

Contact all managers of aged care facilities by email to explain the project and invite their participation. The project will involve palliative approach education for link nurses using the palliative approach toolkit, ongoing education, secondary consultations and provision of a support network for link nurses.

Step 5

Meet all aged care facility managers face to face, give them a copy of Module 1 of the toolkit and ask them to nominate at least two (2) nurses, this is a minimum, Division 1 or Division 2 for high care facilities or Division 1 nurse and personal care workers for low care facilities to attend the training. Nominated link nurses would preferably have a pre-existing interest in palliative care.

Step 6

Delivery of education sessions, certificates are provided to link nurses who completed all modules of the training. All link nurses advised to complete the self-directed learning package and then promote its use within the facility for all existing staff and all new staff within three (3) months of commencement.

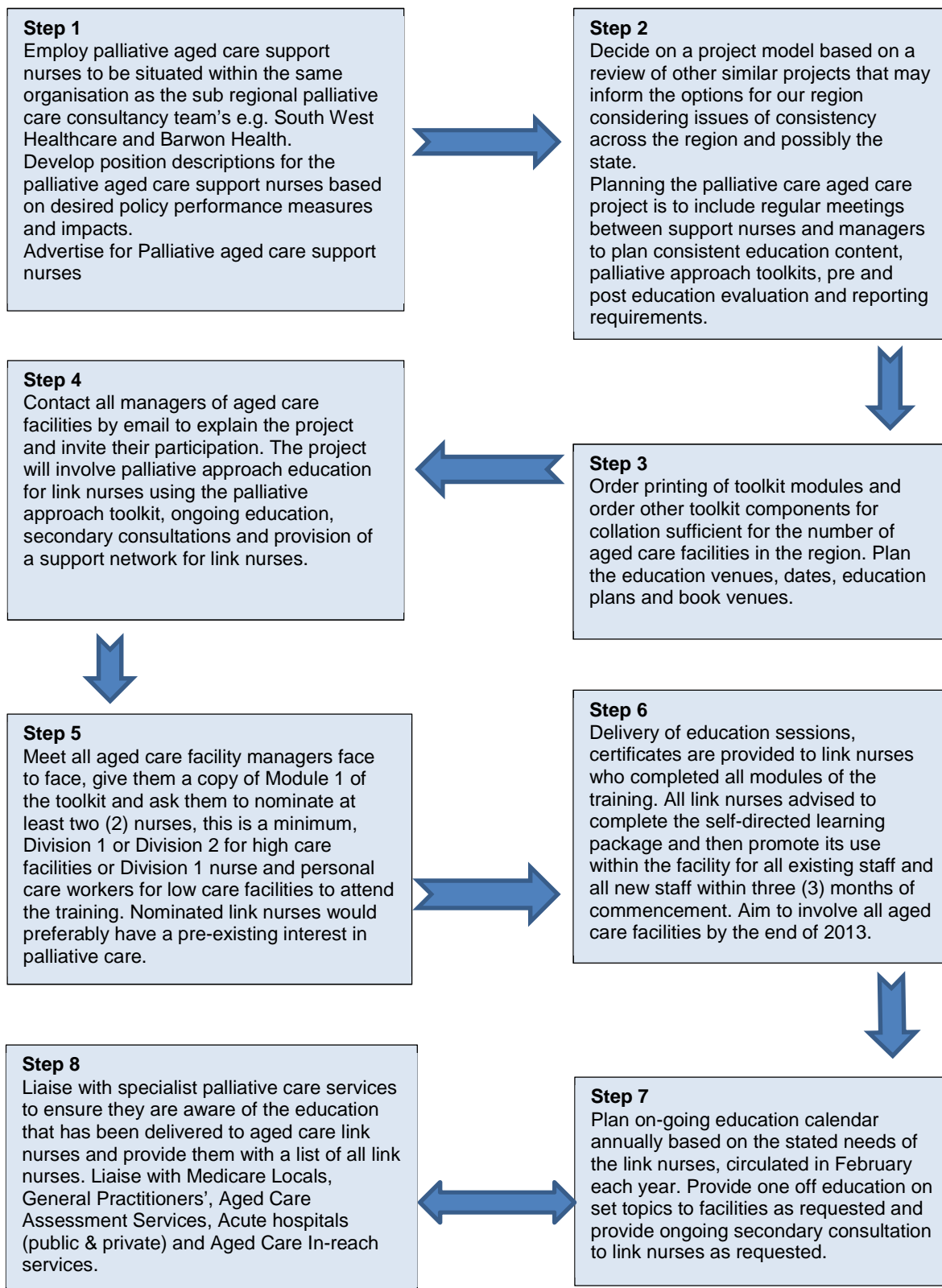
Step 7

Plan on-going education calendar annually based on the stated needs of the link nurses, circulated in February each year. Provide one off education on set topics to facilities as requested and provide ongoing secondary consultation to link nurses as requested.

Step 8

Liaise with specialist palliative care services to ensure they are aware of the education that has been delivered to aged care link nurses and provide them with a list of all link nurses. Liaise with Medicare Locals, GP's, Aged Care Assessment Services, Acute hospitals (public & private) and Aged Care In-reach services.

Barwon South Western Region Palliative Aged Care Action Plan Flowchart



Appendix 4: Barwon South Western Region Palliative Care Consortium Quality & Risk Assessment Plan

Governance - Strategic

	Risk Observed or Potential Risk	Probability	Consequence	Risk Rating	Implication	Risk Treatment Strategies	Responsible	Residual Risk
1	Limited ability to demonstrate benefit of Consortium role	Unlikely	Moderate	Moderate	Reduction in support for the Consortium by agencies.	Related objectives and implementation strategies in the Strategic Plan & annual operational plans.	Chair/CM	Low
2	Capacity to ensure awareness and effective management of Strategic and Operational Risk	Possible	Major	High	Failure to effectively manage risks could result in staff, financial and reputational losses or negative impacts.	Related objective and implementation strategies in Strategic Plan and annual operational plans	CM	Moderate
3	Reduced capacity to maintain effective communication between Consortium members and other Stakeholders	Unlikely	Minor	Low	Limiting Consortium capacity to take opportunities to grow	Related objective and implementation strategies in the Strategic Plan and annual operational plans	CM & Consortium	Low
4	Reduced capacity to develop mutually beneficial partnerships	Possible	Minor	Moderate	Limited capacity to ensure that patients / carers receive a integrated service.	Related objective and implementation strategies in the Strategic Plan.	CM	Moderate
5	Ineffective relationship with Dept. of Health or other funding bodies	Unlikely	Moderate	Moderate	Poor response to requests for funding, unwillingness to assist with problems.	Related objective and implementation strategies in the Strategic Plan	CM and Consortium	Low

Governance - Processes

	Risk Observed or Potential Risk	Probability for Consortium	Consequence	Risk Rating	Implication	Risk Treatment Strategies	Responsible	Residual Risk
1	Lack of suitable Consortium Members	Unlikely	Moderate	Moderate	Lack of community input, lack of opportunity for advice, lack of support for CM.	Consortium members recommend new members as required to meet skill profile.	CM and Consortium	Low
2	Reduced capacity to enhance professional development of Consortium members	Possible	Low	Low	Poor strategic decisions, lack of capacity to interpret operational reports and provide oversight of the organization.	Proposed formal induction for all new Consortium members.	CM and Consortium	Moderate
3	Consortium does not meet regularly or frequently enough	Rare	Moderate	Moderate	Lack of control	Consortium meets	CM and Consortium	Low
4	Consortium does not have appropriate committees	Unlikely	Low	Low	Consortium members are overworked, difficult decision making.	Proposed establishment of necessary sub-committees with appropriate terms of reference.	CM and Consortium	Moderate
5	Poor relationship between Consortium and CM	Unlikely	Moderate	Moderate	Poor decision making, waste of effort, uncertainty of service delivery.	Annual performance appraisal of the Consortium Manager by the Consortium Chairman and a third party. Regular meetings with the Chair quarterly.	Chair and CM	Low

Governance - Monitoring

	Risk Observed or Potential Risk	Probability for Consortium	Consequence	Risk Rating	Implication	Risk Treatment Strategies	Responsible	Residual Risk
1	Inadequate reporting of activity and/or financial position provided to Consortium	Unlikely	Major	High	Loss of control, poor decision making, exposure to numerous risks.	All Consortium members to have knowledge of activities and financial position. Financial reports provided at each Consortium meeting	Fundholder and CM	Moderate

Operational – Quality / Customer Services

	Risk Observed or Potential Risk	Probability for Consortium	Consequence	Risk Rating	Implication	Risk Treatment Strategies	Responsible	Residual Risk
1	Inability to respond appropriately to complaints about consortium	Possible	Minor	Moderate	Unresolved complaints can affect costs, staff and reputation	Annual feedback from stakeholders at Strategic Planning day. Maintain effective networks	CM and Consortium	Low

Operational – Quality / Financial

	Risk Observed or Potential Risk	Probability for Consortium	Consequence	Risk Rating	Implication	Risk Treatment Strategies	Responsible	Residual Risk
1	Poor financial systems & reporting	Unlikely	Major	High	Lack of data for decision making, possibility of financial crisis, poor asset management, loss of control	Ensure ability of Fundholder to produce appropriate bi-monthly reports and annual report to Department of Health	Consortium	Low

Operational – Quality / Learning and Growth

	Risk Observed or Potential Risk	Probability for Consortium	Consequence	Risk Rating	Implication	Risk Treatment Strategies	Responsible	Residual Risk
1	Inadequately supported staff	Likely	Major	High	High work cover claims, inappropriate behaviour and poor service delivery	Regular meeting with Chair	CM & Consortium	Low
2	Complaints about staff / organisation	Possible	Moderate	Moderate	Compensation costs, management time, poor publicity.	Complaints procedure policy to be reviewed by Consortium	CM & Consortium	Moderate
3	Inadequate and/or ineffective recruitment and appointment system	Unlikely	Moderate	Moderate	Poor service delivery and risk to patient and family safety	Fundholder / Employer has appropriate Human resource policies and procedures	CM & Chair	Low

Appendix 5: Acronyms

ABF	Activity Based Funding
ACAS	Aged Care Assessment Service
ACHS	Australian Council on Healthcare Standards
BH	Barwon Health
BCH	Bellarine Community Health
BSWRPCC	Barwon South Western Region Palliative Care Consortium
CODA	Colac Otway Disability
CSNAT	Carer Support Needs Assessment Tool
EFT	Effective Full Time
GRAND	Geelong
LGA's	Local Government Areas
MND	Motor Neurone Disease
NSAP	National Standards Assessment
PCCN	Palliative Care Clinical Network
PCOC	Palliative Care Outcome Collaborative
PCP	Primary Care Partnerships
PEPA	Program of Experience in the Palliative Approach
PERM	Palliative Electronic Record Management
PIAT	Policy Implementation Audit Tool
QIC	Quality Improvement Council
RUG ADL	Resource Utilisation Groups – Activities of Daily
SCTT	Service Coordination Tool Template
SDF	Service Delivery Framework
TRAK	TrakCare™
SWH	South West Healthcare
VINAH	Victorian Integrated Non-Admitted Health
VPCSS	Victorian Palliative Care Satisfaction Survey