BARWON SOUTH WESTERN REGION

PALLIATIVE CARE CONSORTIUM

ANNUAL REPORT

2014 - 2015

Strengthening palliative care: Policy and strategic directions 2011 - 2015

Contents

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 and 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 report the activities of the consortium and detail implementation (performance measures) and outcomes (impacts) of the policy by the Barwon South Western Region Palliative Care Consortium over the last financial year. The Motor Neurone Shared Care Worker and Nurse Practitioner Candidate are now funded directly to Barwon Health so are no longer reported in the consortium annual report.

Barwon South Western Region Palliative Care Consortium Impact Reporting Template for 2014/15 as requested by the Department of Health & Human Services can be found on pages 30-41, *appendix 2*

BSWRPC Regional Demographic Palliative Care data 2014/15

	2013/14	2014/15
Total Palliative patients	1677	1727
Country of Birth (Australia)	1310 = 78%	1329 = 76.95%
Preferred Language (English)	1616 = 96.36%	1650 = 95.54%
Not Indigenous	1673 = 99.76%	1719 = 99.53%

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 Estimated Resident population (ERP) for the region at 30th June 2014 was 378,054. Estimated Resident Population (ERP) is considered to be a more accurate population figure which is updated annually not every five years as the census data is.

(profile.id.com.au)

Local Government Areas	Total Population	Increase/Decrease from 30/6/2013	% Increase/Decrease from 30/6/2013
Greater Geelong	224926	+3411	+1.51%
Surf Coast	28,481	+199	+3.25%
Queenscliffe	3,027	-31	-0.79%
Colac-Otway	20,501	-193	-0.94%
Corangamite	15,996	+2859	+17.87%
Moyne	16,344	+319	-1.95%
Warrnambool	33,501	+201	+0.59%
Southern Grampians	15,919	+207	+1.30%
Glenelg	19,357	+256	+1.32%

Geography

Figure 1: **Map of Barwon-South Western region and administrative areas, Department of Health**
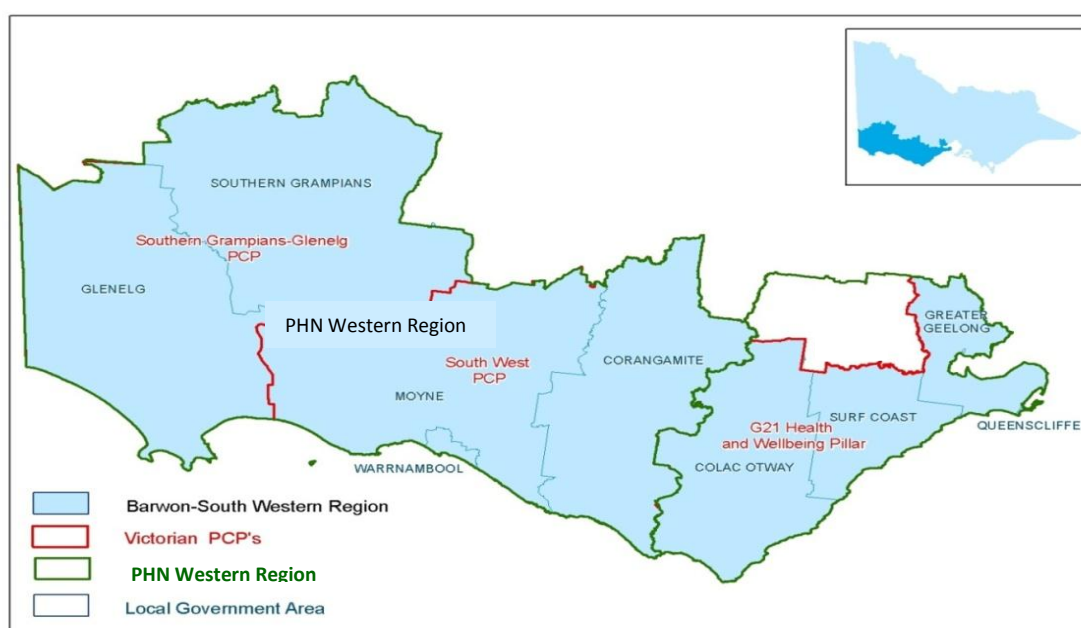
BSWRPCC ORGANISATIONAL CHART

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                              │ Barwon South Western Region Palliative Care Consortium │
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  │   Consortium Members    │                                    ┌─────────────────────┐
  └─────────────────────────┘                                    │ Executive sub-committee │
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  │ Barwon Health (Voting)  │                                        │   Consortium     │
  └─────────────────────────┘                                        │   Chairperson    │
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  │ Bellarine Community Health      │                                │ Consortium Deputy │
  │ (Voting)                        │                                │      Chair        │
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  │ Colac Area Health (Voting) │
  └─────────────────────────┘       ┌────────────────────┐
  ┌─────────────────────────────┐   │ Consortium Manager │
  │ Portland District Health (Voting) │ └────────────────────┘
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  │ South West Healthcare (Voting) │
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  ┌──────────────────────────────────┐ │ Clinical Leaders / Advisory Group │ │ Palliative Care Practitioners Group │
  │ Western District Health Service (Voting) │ └────────────────────────────┘  └──────────────────────────────────┘
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Reviewed July 2014

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 and 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 team 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 a mix of primary and secondary consultations to clients and 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 University Hospital Geelong campus of Barwon Health. The team is made up of medical and nursing personnel who provide primary and secondary consultations within the hospital. The hospital based consultancy team received eight hundred and one thousand and ninety four (1094) referrals during 2014/15.

CONSORTIUM CHAIR'S REPORT

Consortium's Chairs Report 2014-15

This is my third year as chair of the consortium. This role continues to be rewarding in terms of governance, participation and the ongoing improvements to palliative care provision across the region.

2014-15 has seen a year of consolidation of activities for the consortium. In particular, however, the highlights for the year include:

- a successful regional community forum regarding key palliative care issues and a particular focus on carer support
- the further roll out of the carer needs assessment tool (CSNAT) throughout the regional services
- a new website for the consortia that is more user friendly, easier to update and has a more contemporary feel
- increased reporting and accuracy of VINAH data (supported by the regional Data Integrity Officer)
- progression of Bellarine Community Health Palliative Care towards utilisation of the regional after-hours triage service model. They are signatories to the 2015 – 18 After-hours triage contract with St Vincent's Health together with the other five specialist palliative care services in the Barwon South Western Region

There were some initiatives that we set out to achieve but for a variety of reasons they did not occur however work will continue in 2015-16 to progress these initiatives. These include:
- completion of the exportation of Palliative Care Outcomes Collaborative (PCOC) data for benchmarking
- participation and consultation in the development of a new palliative care state-wide end of life care framework
- working towards an increase in new acute palliative care beds at the University Hospital Geelong.

It will be interesting and, no doubt, challenging to consider the role of the consortium in the coming year and beyond. The impact of the ongoing development of the state-wide end of life care framework is not yet clear. What will be our primary role and how will we contribute to the successful implementation of the framework? What expectations will the framework outline for acute services in addition to palliative care services for end of life care? How can we influence and support this potential transition? The consortium will endeavour to play an active role in this exciting phase.

Finally, as always, I would like to thank Heather Robinson, Consortium Manager, for her continued support to the consortium and its members. The successes that the consortium achieves are as a direct consequence of her knowledge, commitment and enthusiasm.

Julie Jones,
Consortium Chair

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. Agreements are in place for the remaining service in the region to commence use of the PERM software with all embedded care plans and agreed tools at the conclusion of a review by an Information Technology consultant who will make recommendations regarding the most appropriate software for Bellarine Community Health to use that will be compatible with PERM.

Required Impacts:	Actual 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	*Up-to-date interdisciplinary care plans that reflects the wishes of clients and carers are contained within the PERM software. A Patient Care Plan and a Health Professional Care Plan are created at the completion of each assessment. The number of completed patient care plans completed is electronic care plans is 83% and paper care plans for 17% of clients. Copies of the Health Professional care plan are provided to the client's GP and other care providers as required, these impacts are unchanged from 2013/14.*

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.

Barwon South Western Palliative Care Consortium held a regional forum in November 2014 where issues related to carer support were canvassed. The key themes from the forum then was discussed at our Strategic Planning meeting held in April 2015. There were three important areas identified: Carer Needs Identification, Educational Needs of carers and Additional Support to Carers, plans are in place for 2015/16 to progress these issues. The Palliative Care Practitioners group has respite issues on the agenda of the July 2015 meeting.

Barwon Health have introduced an in-home respite program in conjunction with multi-cultural aged care that provides palliative care trained staff to provide care in the home when there is a high need. South West Healthcare has introduced a new program to provide respite in the home

Required Impacts:	Actual 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	*In 2014/15 all (100%) of 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. As part of their interactions with respite services all (100%) palliative care services in the region all report having endeavoured to increase the level of knowledge about caring for people with life-threatening-illness within respite services by advocating on behalf of clients and ensuring their specific needs are understood by respite service staff and met wherever possible. We have no way of measuring whether respite services have increased knowledge about caring for people with a life-threatening illness. There has been no change from 2013/14.*

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; this has continued through this financial year. It was expected that Bellarine Community Health would be included from the 2014/15 financial year, however this has not occurred. Discussions regarding their use of the PERM software have been ongoing and Bellarine Community Health, after discussions with the union, have engaged the services of an IT consultant to investigate and make recommendations to the Board about preferred software options for the service. A requirement is that any preferred software be able to be linked with PERM.

All specialist palliative care service in the region have links with at least one and often more community / district nursing service. While specialist palliative care telephone triage is available to all patients/carers in the region nursing visits after-hours are available across the region. There are outlying areas where after-hours visits are not feasible or safe predominantly due to lack of mobile phone coverage or because staff on call would need to travel so far they would not be able to respond to other calls.

During this 2014/15 Barwon Health, Colac Area Health, South West Healthcare, Portland District Health and Western District Health Service have all continued to use the PERM clinical palliative care software. As the after-hours triage contract was due to end on 30th June 2015 a survey of all palliative care staff in the region was conducted in April 2015. There were 13 survey respondents, a response rate of 72.22%. The survey found that 100% of respondents indicated that it was important to be able to read the after-hours triage team notes in PERM and to view which of your clients had accessed after-hours triage when you returned to work. 30% of survey respondents indicated that problems with the service were acknowledged but continued to occur. These problems all occurred between 0700hrs and 0830hrs, so didn't involve Caritas Christi Hospice. Possible solutions were explored and a change in staffing to allow the staff member on call at this time of the morning to commence work at 0700hrs – 1530hrs. This has rectified the problems

The St Vincent's / Caritas Christ after-hours triage contract concluded on 30/6/15. During the April / May of 2015 consortium members met to discuss continuing the contract for after-hours triage, consortium members voted unanimously to re-negotiate the contract St Vincent's Health with Bellarine Community Health to be included for this contract. The contract for 2015-18 has been signed by all services. From (date) Bellarine Community Health will be providing paper-based patient data to Caritas Christi Hospice in the short term until they are using PERM software.

The process for the after-hours service is that clients telephone their local service number, where they are connected to the paging service that then pages St Vincent's/Caritas Christi. St Vincent's/Caritas Christi have access to the live PERM patient data for triage purposes, e.g. current medication, notes and assessment information. They record their advice regarding interventions within the system so that palliative care staff can view overnight activity at the start of the following day.
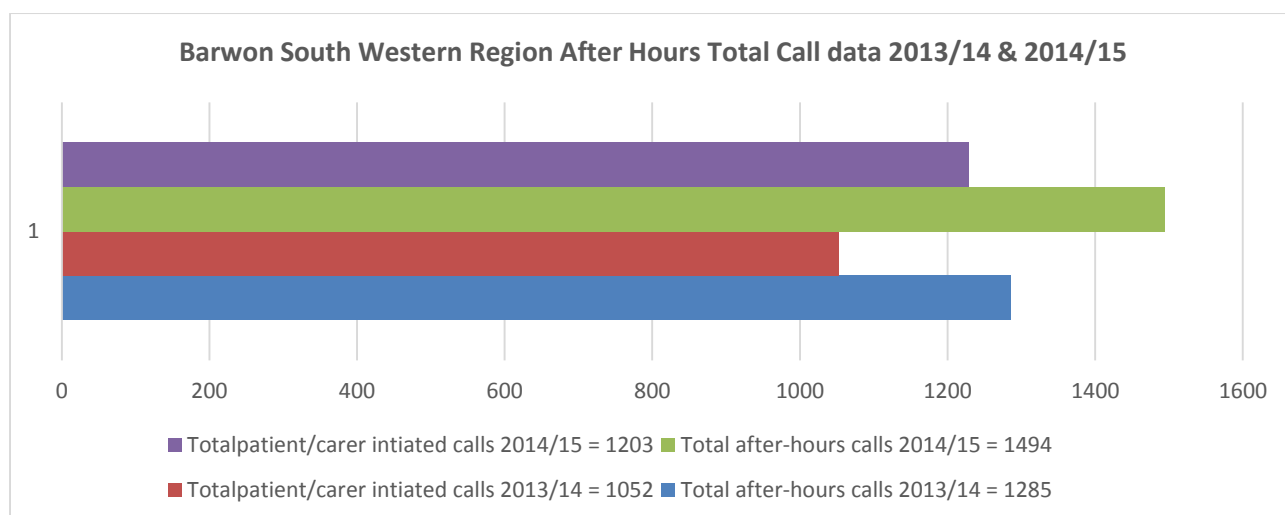
Barwon South Western Region After Hours Total Call data 2013/14 & 2014/15

Legend:
- Totalpatient/carer intiated calls 2014/15 = 1203
- Total after-hours calls 2014/15 = 1494
- Totalpatient/carer intiated calls 2013/14 = 1052
- Total after-hours calls 2013/14 = 1285

Figure 2: The impact for Strategic Direction 2.5 is an increase in the total number of after-hours calls and the total number of patient/carer initiated calls which is demonstrated by figure2.

Barwon South Western Region After Hours home visit data 2013/14 & 2014/15

- Total after-hours home visits 2014/15 = 455
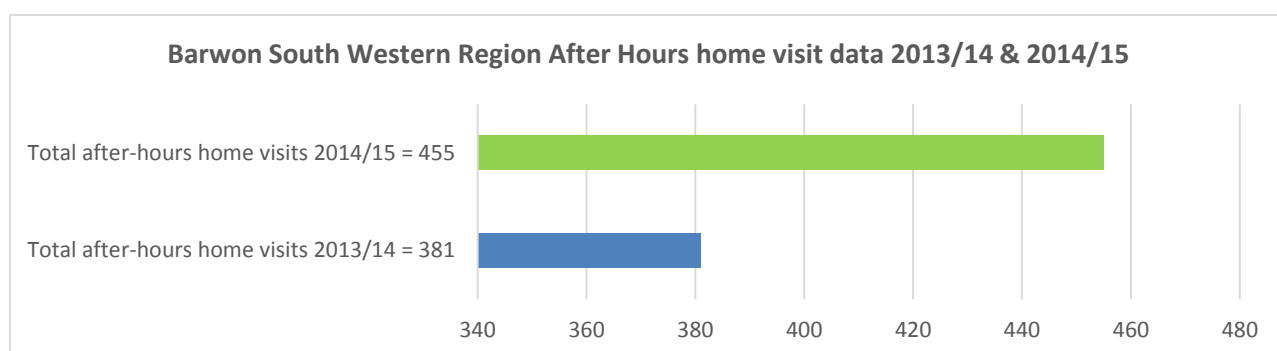- Total after-hours home visits 2013/14 = 381

Figure 3: The impact for Strategic Direction 2.5 is an increase in the number of after-hours home visits which is demonstrated by figure 3.

The Department of Health and Human Services indicated a wish to understand the nature of the increase in Psychosocial care as an outcome of after-hours calls in the 2013/14 BSWRPCC Annual Report and any projects that may be planned in the 2015/15 financial year.

Psychosocial care as defined by the National Council for Hospice and Specialist Palliative Care Services, is care concerned with the psychological and emotional well-being of the patient and their family/carers, including issues of self-esteem, insight into an adaptation to the illness and its consequences, communication, social functioning and relationships.

Aranda and Hayman-White (2001), Worth et al. (2006) and Yardley et al. (2009) found that the reasons palliative care clients contacted an after-hours service were for advice about managing physical symptoms (especially pain), psychological support, general information on services and reassurance if anxious or about medication usage. The definition of psychosocial care used by Caritas Christi Hospice is that it is care related to escalating symptoms pain, deterioration and confusion resulting in anxiety, carer stress/burden. Whilst to date we have not conducted a detailed analysis with regard to the underlying reasons for the call outcome / psychosocial care required for BSWRPC patients, anecdotally, the ageing of patients and their carers and the increase in illness complexity of patients would correlate with the research quoted above.

Barwon South Western Region After Hours Call Outcome data 2013/14 & 2014/15
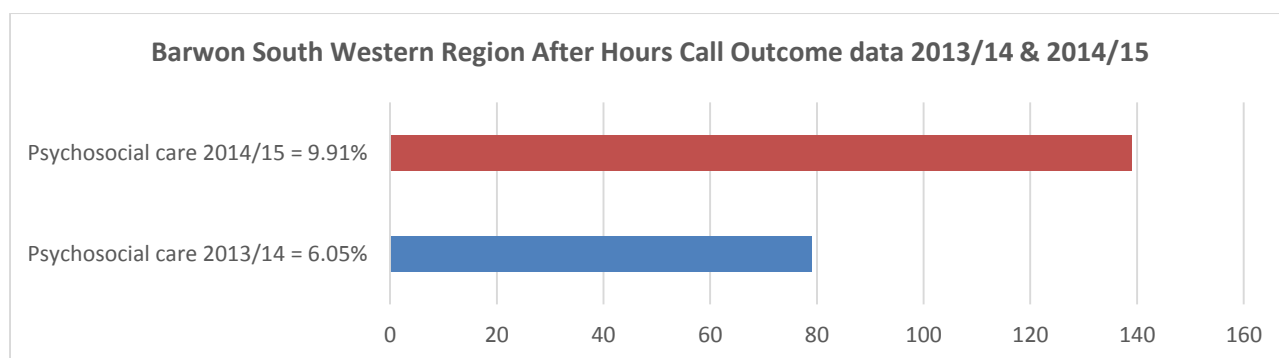
Figure 4: Psychosocial Call Outcome data for 2013/14 and 2014/15

Discussion with Caritas Christi After-hours triage staff has led to an additional classification of call outcome for Carer Burden / Stress which will be used from 2015/16. This new data field combined with the listing of specific symptoms underlying the call will allow us to determine if escalating symptoms, pain, deterioration and confusion are significant determinants of Carer Burden / Stress which result in after-hours calls.

The increase in both after-hours calls and after-hours visits is anecdotally likely to be related to the ageing of patients and their carers and the increase in illness complexity of patients would correlate with the research by Aranda et al (2001) quoted above.

Required Impacts:	Actual Impacts:
More after-hours support (including telephone support and home visits where appropriate) is available to all clients and their carers	*More after-hours support has been available to all clients and carers across the Barwon South Western Region in 2014/15. Total After-hours calls increased from 1305 (13/14) to 1372 in 2014/15. Total After-hours visits in 2013/14 were 381 and visits increased to 455 in 2014/15. See figures 2, 3 & 4.*

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 specialist palliative care services in the Barwon South Western Region are very closely linked with community nursing services, private hospitals and private community care providers and aged care providers. All training and education is focused on public and private health, community and aged care providers. Over the life of the policy training for health, community and aged care providers have been provided. Education provision has included community aged care, public and private acute care staff, community nursing and staff from residential disability services. All palliative care services in the region have developed and maintained close links with ACAS. The consortium records of pre/post education evaluations for all education provided measure any increase in knowledge and confidence of staff caring for people with a life-threatening illness. It is considered that this will then improve the number of people living and dying in their place of choice as a result of the training activities.

When considering whether specialist community palliative care patients die in their place of choice it is necessary to consider residential aged care facilities as the person's home and private residence. A key measure of ensuring that people have died in their place of choice is an increase in people dying at home, the table below indicates there has been an overall increase over the life of the policy in people dying at home across the region, there is only one service that had a reduction in patients who died at home.

Service Providers	% died at home 13/14	% died at home 14/15	Variation
Bellarine Community Health	40.77%	49.09%	+ 8.32%
Barwon Health	54%	55.58%	+ 1.58%
Colac Area Health	35%	36.36%	+1.36%
Portland District Health	42.30%	60.00%	+ 17.70%
South West Healthcare	37%	51.63%	+ 14.63%
Western District Health Service	45%	58.53%	+ 13.53%

Figure 5: CPC Separations Report - Died at home = private residence + residential aged care facility + Anam Cara Colac.

Required Impacts:	Actual 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	*Public and private health, community and aged care providers have 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 (see table above) 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* • *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*

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 has been disseminated as part of education across the region both by the sub-region palliative care teams and sub-regional palliative aged care/disability workers.
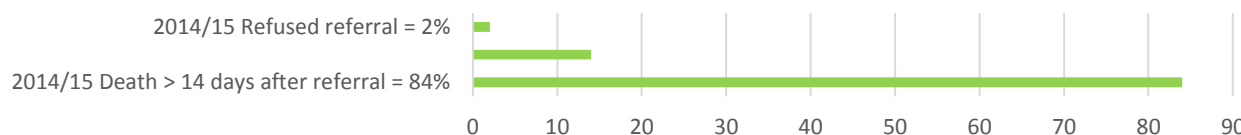
Performance measures: Health, community and aged care providers and their various networks are linked to the consortium through the consortium member organisations all of which are providers of health, community and aged care within their communities in addition to palliative care. All of the above services have been mapped by the consortium.

All palliative approach education to inpatient and community aged care workers and residential disability workers includes the key triggers for referral to specialist palliative care including the fact that a referral can be made for a one off opinion and liaison with the general practitioner. Consortium workers have been involved in promoting 'Program of Experience in the Palliative Approach' (PEPA) during palliative approach education by handing out the PEPA program brochures and encouraging staff to take part in the program. Placements within the region have involved over 100 GP's, residential aged care and residential disability staff during the last three years. Palliative Approach education for community aged care staff and Division 2 nurses at Gordon TAFE in Geelong and TAFE in Warrnambool has involved consistent education being delivered across the region. Most of the staff that complete this training then work in residential or community aged care within the region.

Barwon Health (53.89% of population) Timely Referrals 2013/14

2013/14 Death < 14 days after referral = 8.86%

2013/14 Death > 14 days after referral = 91.14%

0   10   20   30   40   50   60   70   80   90   100

Barwon Health (53.89 % of population) Timely Referrals 2014/15

2014/15 Refused referral = 2%

2014/15 Death > 14 days after referral = 84%

0   10   20   30   40   50   60   70   80   90
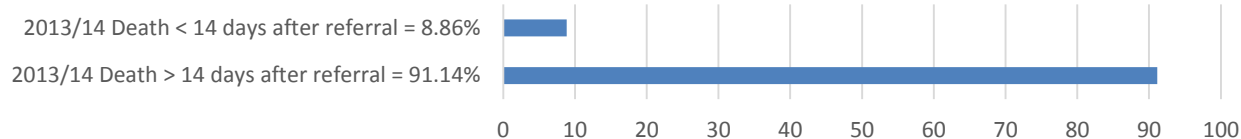
Required Impacts:	Actual Impacts:
• Clients receive timely and appropriate referral to palliative care • Information and referral processes promoted by the palliative care sector are consistent with referral and coordination strategies across health, community and aged care providers	Clients across the Barwon South Western region receive timely and appropriate referral to specialist palliative care. Barwon Health Palliative Care which has 53.89% of the regions' population is used as an example as this data is not available from all services. Referral data for 1/7/14 – 30/6/15 indicates the following: 1. 84% of those clients referred to specialist palliative care died after more than 14 days after admission or were referred appropriately 2. 9% died less than 14 days after referral 3. 7% refused admission, these clients were referred predominantly from oncology services There continues to be 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. Barwon Health Palliative care has worked collaboratively with Western Victoria Primary Health Network to develop Health pathways to improve access to information for GPs regarding Palliative Care. To date, we have developed pathway information addressing issues of referral to Palliative Care, incorporating referral information for both Bellarine and Colac Palliative Care programs, along with specific information relating to Cachexia and Breathlessness clinics. We are planning further work in this area, in particular we plan to explore the development of a pathway for new palliative care patients which will incorporate links to the Palliative Care Carers online toolkit.

3.4 Improve palliative care capacity in disability accommodation services

Performance measures: Two part-time disability/palliative care project officers are 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.

Palliative approach education provision to disability accommodation service workers has needed to be tailored to their specific needs. They have specified that their education priorities are as follows:
- When requested by disability accommodation services in response to having a client with a life-threatening illness
- Invitations to attend all palliative approach training whenever it is offered to personal care workers across the region
- Invitations to all palliative approach post PEPA education in the region.

Update on Barwon Disability Palliative Approach Advisory Committee (BDPAAC)
- In Geelong an Advisory Committee was formed in 2013/14 with Dr Charlie Corke as the Chair to progress the use of advance care planning in disability services. This Quality Improvement Project is now in stage 3: assessing the efficacy of existing Advanced Care Planning processes for people with a disability

Project process
- Aim to recruit up to 30 participants with a disability and their significant others to take part in the project
- The 30 project participants will ideally be made up of 10 people deemed competent, 10 people deemed non-competent and 10 people who require supported decision making
- General Funding Update – none to date, currently seeking funding opportunities
- Currently investigating awareness

Required Impacts:	Actual 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	*The Barwon sub-region disability/palliative care project officer is a member of the above mentioned BDPAAC advisory committee who will report progress to the Consortium. If funding is received for this project it will likely increase the likelihood this impact will be achieved. It is expected that at the conclusion of this project there will be an established process for ascertaining disability clients preferred place of care and death. A clear time frame for this cannot be predicted as it is outside of the control of the consortium.*

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 plan is can be found on page 46, a*ppendix 4*.

Required Impacts:	Actual 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	• *The regional palliative/aged care action plan was reviewed by the Consortium in Dec 2014/15 (see appendix 4)* • *Palliative Approach Education continues to be delivered across the region to link nurses, community aged care nurses, aged care personal care workers and disability workers. The region continues to use the Palliative Approach toolkit developed by the University of Queensland/Blue Cross Research and Practice Development Centre.* • *Residential Aged Care Facilities are encouraged to request on site education of staff for specific topics and this is regularly accessed.*

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

Performance measure: Part-time palliative/aged care support nurses are employed in the Barwon sub-region and the South West sub-region. *There are now 541 link nurses from 110 facilities, this includes Division 1 and 2 Registered Nurses, Medication Endorsed Division 2 nurses and Personal Care workers from Community and Residential Aged Care who have been trained in a Palliative Approach over the life of the policy by the palliative aged care support nurses in this region.*

- Education of link nurses has continued across region
- A Palliative Approach education program was developed for aged care personal care workers (residential and community).
- Palliative care of people with dementia workshops were held in Geelong and Warrnambool during 2013 - 2015
- Ongoing secondary consultations and regular newsletters are provided by both palliative/aged care support nurses.
- Information was given to all participants about support available from the following: 'Care Search', PEPA placements and PEPA education.

Barwon South Western Region Palliative Care Education evaluations for 2014/15:

Evaluation Questions	Agree		Strongly agree	Neither Agree or Disagree
The education increased my confidence and skills in taking a thorough pain history from a patient	47%		53%	
I am confident the knowledge and skills gained from this workshop will help improve end of life care for residents in Residential Aged Care facilities.	46%		54%	
The workshop increased my confidence and skills to help improve end of life care to my residents	31%		65%	4%
The workshop increased my skills and confidence in developing communication strategies with people living with dementia and their carers	37%		56%	7%

Main Role of Education attendees		% of total attendees
Registered Nurses, Endorsed Enrolled Nurses, Enrolled Nurses	198 attendees	49%
Personal Care Workers & Disability Service Workers	54 attendees	13%
PEPA sponsored workshops x 2, RN's, EEN's, EN,s PCW's & Disability workers	105 attendees	26%
Medical Education (Fellow) RN's, Medical Staff	45 attendees	11%

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:
South West Healthcare (Merindah Lodge) data indicates that of permanent residents (non respite) during 2014/15 95% died in their place of choice, aged care facility.
Barwon sub-region:
Barwon Health Residential Aged Care data indicates that of permanent Barwon Health aged care residents (non respite) during 2014/15, 96% died in their place of choice, aged care facility with the remainder dying in University Hospital Geelong (acute).
End-of-life pathways were utilised in 52.54% of aged care facilities in the Barwon South Western region. There has been a reasonably large turn-over of managers and staff of aged care facilities over the life of the policies which means the palliative Aged Care Support workers will continue to reinforce the important of this at all education.

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

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, South West Healthcare, 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. Barwon health are in the process of collating accurate data but early indications suggest that primary consultations are higher than the 50% previously presumed.

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

Required Impacts:	Actual 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	*Impacts for 2014/15 remain unchanged from previous years and are:* • *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 using an accepted triage tool.* • *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 and has residential aged care beds, five of the six consortium members also have acute hospital beds and 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 and Geelong Private Hospital has strong links with the palliative care program at Barwon Health and Bellarine Community Health.
- 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.

On 1 July 2015, the Federal Government made further commitments towards achieving an organised primary healthcare system through the establishment of 31 new primary health networks across Australia, including six in Victoria. Western Victoria Primary Health Network (PHN) has replaced the Grampians, Barwon and Great South Coast Medicare Locals. Continuity of patient services will be a key focus in 2015/16. This new, not for profit organisation is responsible for delivering on the following two objectives set by the Federal Government:

- Increasing the efficiency and effectiveness of health services for patients, particularly those at risk of poor health outcomes.
- Improving coordination of care to ensure patients receive the right care, in the right place, at the right time.

While the Western Victoria Primary Health Network (PHN Western Victoria) is new it retains a number of staff who has had significant links with palliative care over the life of the policy. They have a Palliative Care Program with the following aims:
- Coordination of monthly meetings of GP's and regional palliative care
- Promote the use of technology for communication and telehealth
- Improve GP knowledge of cancer and palliative care to support GP's

They provide information to GP's about bereavement resources, Advance Care Planning, Decision Assist, Health Pathways, community resources and maintain links with Primary Care Partnerships and Local

Government, and annual Palliative Care Forum is held. Through the PHN and G21 we are kept informed of activities and events across the region and disseminate these to palliative care providers.

Additional collaboration is also undertaken via the quarterly Clinical Leaders meetings and the six monthly Practitioners Group meetings (as outlined in the 'Background about the Barwon South Western Region').

Required Impacts:	Actual 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	• *The number and types of partnerships between the consortium and other health, community, aged care and other providers has continued to increase over the 2014/15 financial year. The key drivers of this increase have been:* • *Liaison with residential aged care facilities, residential disability services, and community aged care service providers.* • *Regular communication is maintained with the managers of all residential aged care facilities and most residential disability service coordinators / managers.* • *Significant education has been offered throughout all of the sectors over the life of the policy. Post PEPA education has been valued by all attendees.* • *The move from Medicare Locals in the region to PHN Western Victoria with regular liaison from the Primary Care Partnerships in particular G21 has been brought advantages. There is a high level of palliative care interest and expertise in the Primary Health Network which is now shared region wide.*

5.3   Strengthen consortium governance and accountability processes and document them consistently

Member agencies:	Voting Delegates	Attendance
➢ **Barwon Health (Chair)**	**Julie Jones**	**85.71%**
➢ **Bellarine Community Health**	**Helen Nikolas**	**42.85%**
➢ **Colac Area Health**	**Jane Robertson**	**71.42%**
➢ **Portland District Health**	**Fiona Heenan**	**42.85%**
➢ **South West Healthcare (Dep. Chair)**	**Julianne Clift**	**100%**
➢ **Western District Health Service**	**Usha Naidoo**	**71.42%**

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)
- Data Integrity Officer (on behalf of the services as part of the regional After-hours model. Each service contributes funds for the after-hours model which includes the role of the Data Integrity Officer).

Performance measures:

A role statement audit carried out in June 2015 found that:

- Role statements for Consortium, Consortium Chair, Consortium Deputy Chair, Consortium Manager and employing agency, Consortium Executive, Consortium fund holder, Consortium members (voting) and Consortium member (non-voting) have all been implemented and are current.
- Links with the Department of Health have been maintained through circulation of monthly palliative care project updates, attendance at state wide meetings, consortium manager meetings and other meetings as necessary.
- All voting members of the consortium understand the consortium role and champion palliative care in their own health service; they participate in strategic planning, budget and resource allocation decisions.
- The BSWRPCC Strategic Plan for 2014/15 can be found on pages 42-45, *appendix 3.*
- A consortium financial report can be found on page 29, see *appendix 1.*
- A Quality Risk and Assessment Plan can be found on pages 47-48, see *appendix 5.*

Consortium member accreditation status is as follows:

Organisation	Status	Organisation	NSAP
Barwon Health	Feb 2015	SIA Global	Cycle 3
Bellarine Community Health	Aug 2015	QIC & NSQHS	Cycle 1
Colac Area Health	Sept 2015	ACHS	Cycle 1
Portland District Health	Aug 2014	ACHS	Cycle 2
South West Healthcare	May 2014	ACHS	Cycle 4
Western District Health Service	Oct 2013	ACHS	Cycle 3

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.*
- *Aspects of 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 2014*
- *Procedures are in place for orientation of new consortium members.*
- *A quality and risk management framework has been developed for the consortium, see Appendix 5.*
- *The fund holder for the next two years is Barwon Health and the Consortium Chair is Julie Jones (Manager of Palliative Care at Barwon Health).*

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 completed in 2009.
- 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: Use of a validated pain scale, Assessment of pain for all new patients, Regular Pain Assessment, Prescribing guidelines for breakthrough pain, Recommendation of a bowel regime with opioids, Regular pain medication for severe pain, 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. Bellarine Community Health has employed an IT consultant to advise them regarding the most appropriate software to provide a patient master index which will support PERM clinical palliative care software.
- Carer Support Needs Assessment Tool (CSNAT) has been implemented in all community palliative care programs in the region.

Required Impacts:	Actual Impacts:
IT solutions are in place to support quality initiatives and connectivity	*• IT solutions including Internet based clinical palliative care software are in place which promote more appropriate after-hours triage responses across the region. This has also enabled implementation of the Population Needs Based model of care across the region.* *• Through South West Alliance of Rural Health (SWARH) all services in the region have access to telehealth teleconferencing and video conferencing.* *• For regional palliative care patients presenting at University Hospital Geelong referrals from the Acute Palliative Care Consultancy Team can be made directly to the appropriate palliative care service through the software (PERM). This allows for much more rapid response and follow-up.* *• The above activities support connectivity and quality initiatives across the region.*

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 2014 round of the VPCSS. This program has now concluded.

Consistent carer support themes identified in the Victorian Palliative Care Satisfaction Survey over the three years to 2013/14 in the Barwon South Western Region and also at the November 2015 Regional Palliative Care Forum has led to all specialist palliative care services implementing the CSNAT tool. Regular audits are conducted to assess ongoing themes.

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 75% of Clinical Leaders group meetings 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 provides a report for consortium meetings, clinical advisory group and palliative care practitioners meetings reporting 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:	Actual Impacts:
Established state-wide program of work for the update of evidence into clinical practice Palliative care service delivery is more consistent and evidence based	*All palliative care services within the region within the region have a continuing commitment to NSAP and regular audits of CSNAT results.*
	All evidence-based clinical tools recommended by the Palliative Care Clinical Network have been implemented by palliative care services in the Barwon South Western Region. The most recent in the last financial year has been the Carer Needs Assessment (CSNAT) tool.
	The regional PCCN consortia representative is a nurse practitioner candidate based at Barwon Health. This representative attends BSWRPC Clinical Leaders Group meetings and reports on the activities of the PCCN.
	During 2014/15 there have been no recommendations for the update of evidence into clinical practice from the PCCN. Palliative Care service delivery is more consistent and evidence based in the region. The work plan of the Clinical Leaders Group has ensured implementation of the Bereavement Framework and a review of the ongoing validity of the evidence based clinical tools used by palliative care services across the region and PCCN issues is a standing item on the Clinical Leaders Group meeting agenda's.

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 2014. Membership includes bereavement, social work and pastoral care workers in relation to the specific issues to be discussed, the format is a mix of standing items and continuing work on issues supported by the PCCN, meetings are quarterly. Agenda standing items are:
- 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 - plan regional implementation of these guidelines**
> ✓ **Implement Carer Needs Assessment Tool at all palliative care services in the region**
> ✓ **Carer Support Information**
> ✓ **Pain tools and policies, review of all clinical tools**
> ✓ **Review admission and discharge guidelines for all services**

The region also has a Palliative Care Practitioners Group that now meets three times per year. 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:	Actual Impacts:
Rigorous and ongoing clinical service improvement is undertaken by palliative care consortia and their member services	• *In the Barwon South Western Region this group is called the Clinical Leaders Group, it is multidisciplinary and it meets quarterly.* • *As stated previously all palliative care services are accredited and are involved with NSAP.* • *Barwon South Western Region Consortia PCCN representative attends PCCN and reports on clinical service improvement activities. Regional Admission and Discharge policies reviewed, all clinical tools reviewed, End of Life Pathways reviewed and preparation for PCOC data extraction has occurred.*

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 continues to include the registrar and advance trainees in Specialist Palliative Care at Barwon Health. Dr Peter Martin remains the Clinical Director for Barwon Health Palliative Care Service. Dr Emma Greenwood, a GP with an interest and post graduate qualification in palliative care provides services to South West Healthcare and Portland District Health, the Department of Health & Human Services indicated these arrangements should be reviewed annually. It is understood by the Department of Health & Human Services that in the longer term Dr Greenwood is required to increase her qualifications. It remains difficult to recruit to specialist palliative care nursing positions in the region.

Required Impacts:	Actual Impacts:
• The palliative care workforce grows sufficiently to meet demand • The capacity of the health, community, aged care and disability services workforce to care for people with a life-threatening illness is enhanced	• *There has been a program of palliative care education conducted throughout the year by a Palliative Care fellow from Barwon Health.* • *The Palliative Care Aged Care and Disability Support workers in the region have continued to support aged care and disability staff personnel.* • *Through education in a palliative approach thus increasing their capacity. Specialist Palliative Care services provide support and education to acute and community health staff in this region.*

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 state-wide level between palliative care stakeholders across health, community and aged care

Required Impacts:	Actual Impacts:
Victorians are better able to support people with life-threatening illness and their carers	• *Barwon South Western Region Palliative Care Consortium and its member services have excellent links with local government, community health and primary care partnerships. Local government links are most commonly with Home and Community Care programs which are most relevant for palliative care services. All consortium member services have community health as part of their health services which supports excellent relationships.*
	• *Palliative Care Services in the region were encouraged by the consortium to become involved in Palliative Care Awareness Week activities. The play "Four Funerals in One Day" was stage by Bay Street Productions between 25th and 30th May 2015. This palliative care awareness raising production was sponsored by Barwon Health, Colac Area Health, South West Healthcare and Western District Health Service. Each service provided staff to join a panel discussion at the conclusion of the play. This activity was very well attended and was supported by the media.*
	• *All specialist palliative care services have volunteers working within the services and these together with clinical staff act as ambassadors in the community helping to ensure people with life-threatening illnesses are better supported in the Barwon South Western region.*
	• *In rural and regional communities knowledge of palliative care and supportive services for*

people with life-threatening illness is often higher due to a high degree of stability across medical practitioners and palliative care providers.

- *Educational strategies have included a significant amount of palliative approach education provided to community nursing, community and residential aged care staff and residential disability staff across the region in the last financial year thus increasing community awareness and understanding of palliative care.*

- *The Barwon Health End of Life Care Strategy was endorsed by the Board in May 2015. This strategy includes an element of community awreness and education. It is intended that the strategy will be implemented over the next five years.*

Appendix 1: BSWRPCC Financial Statement 2014 /15

Barwon South Western Region Palliative Care Consortium		Full year
Funding		
PEPA funding		4,000
After Hours Service		132,650
BSW Consortium funding + indexation		125,704
Total Revenue		262,354
Operating Labour Costs:		
Data Integrity Officer		44,893
BSW Consortia Manager: including on costs		90,825
Total Operating Labour Costs		142,664
Operating Non labour costs		
After hours provision		64,000
Conferences & Meetings (including flights & accommodation)		1,375
Training Costs		5,010
Admin costs (including MV. Telephone etc.)		29,645
Total Operating Non Labour costs		120,030
Total Costs		262,694
Net surplus/*deficit*		*-340*

Appendix 2: BSWRPCC Impact Reporting Template 2014-15

Strengthening palliative care: Policy and strategic directions 2011-2015 – <u>impact</u> reporting template

Strategic Direction 1: Informing and involving clients and carers

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

Actions	Impacts	Performance measure	Progress	Key achievements / evidence of impact	Year commence reporting impact
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	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	Regional agreement to use consistent tools, as endorsed by the PCCN, across inpatient, community and consultancy services	Completed Completed	Electronic assessments are completed for 83% of clients, and paper assessments 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 health professional care plan are provided to the client's GP and other care providers as necessary.	2012/13 2012/13

Not commenced	In progress	Completed

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 over time

Actions	Impacts	Performance measure	Progress	Key achievements / evidence of impact	Year commence reporting impact
2.3 Ensure access to a range of respite options to meet the needs of clients and their 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 • developing consistent state-wide eligibility criteria for palliative care clients accessing respite	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	Information and education on respite, including providing care for children with a life – threatening condition, available regionally	Completed Completed Ongoing Completed Ongoing	In 2014/15 all (100%) of 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. As part of their interactions with respite services all (100%) palliative care services in the region all report having endeavoured to increase the level of knowledge about caring for people with life-threatening-illness within respite services by advocating on behalf of clients and ensuring their specific needs are understood by respite service staff and met wherever possible. We have no way of measuring whether respite services have increased knowledge about caring for people with a life-threatening illness. There has been no change from 2013/14.	2012/13

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

Actions	Impacts	Performance measure	Progress	Key achievements / evidence of impact	Year commence reporting impact
2.5 Implement after-hours models of care across Victoria	• More after-hours support (including telephone support and home visits where appropriate) is available to all clients and their carers	• After-hours model of care implemented in each region	Completed	More after-hours support has been available to all clients and carers in 2014/15. After-hours calls increased from 1305 (13/14) to 1372 in 2014/15. After-hours visits In 2013/14 were 381 and visits increased to 455 in 2014/15. See pages in Annual Report for further information	2012/13

Not commenced	In progress	Completed

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

Actions	Impacts	Performance measure	Progress	Key achievements / evidence of impact	Year commence reporting impact
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	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	Training, education and workforce development is focused on public and private health, community and aged care providers	Completed Ongoing	Public and private health, community and aged care providers have 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 (see table above) if that is their choice	2012/13
		Training, education and workforce development activity records participant's confidence and skill level in caring for people to live and die in their place of choice and the changes as a result of the training activity	Completed Ongoing	Evaluation following training has been very positive and the impacts are as follows: Between 2013/14 and 2014/15 deaths at home including deaths in residential care facilities have changed by the following margins: Barwon Health + 1.58%, Bellarine Community Health + 8.32%, Colac Area Health -1.67%, Portland District Health + 17.70%, South West Healthcare + 14.63% and Western District Health Service + 13.53%.	2012/13
		Closer links with ACAS (possible protocol development explored)	Completed Ongoing	Regular liaison with ACAS staff, they refer clients and assess clients on request.	2012/13
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 GPs will be developed as a priority	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 | Health, community and aged care providers/networks linked with palliative care consortia

Develop links with Medicare Locals, now Replaced by Primary Health Network Western Region. | Completed Ongoing | Clients across the Barwon South Western region receive timely and appropriate referral to specialist palliative care. Barwon Health Palliative Care which has 53.89% of the regions' population is used as an example as this data is not available from all services. Referral data for 1/7/14 – 30/6/15 indicates the following: 84% of those clients referred to specialist palliative care died after more than 14 days after admission or were referred appropriately 9% died less than 14 days after referral 7% refused admission, these clients were referred predominantly from oncology services and were having ongoing cancer treatment. Information and Referral processes are promoted by the palliative care sector. Referral strategies are based on Service Coordination Tool Templates (SCTT) across health, and community and aged care. | 2012/13 |

Actions	Impacts	Performance measure	Progress	Key achievements / evidence of impact	Year commence reporting impact
3.4 Improve palliative care capacity in disability accommodation services	• 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	Disability/palliative care project officer employed in each region	Completed	Disability/palliative care project officers x 2 employed in the Barwon South Western Region located at Barwon Health and South West Healthcare	2012/13
		Project officers develop relationships with regional Department of Health disability officers / accommodation services and encourage palliative care referrals to align with the Disability residential services palliative care guide	Completed Ongoing	Impact: The Barwon sub-region disability/palliative care project officer is a member of the above mentioned BDPAAC advisory committee who will report progress to the Consortium. If funding is received for this project it will likely increase the likelihood this impact will be achieved. It is expected that at the conclusion of this project there will be an established process for ascertaining disability clients preferred place of care and death. A clear time frame for this cannot be predicted as it is outside of the control of the consortium.	2012/13
		Project officers develop relationships with non-government disability accommodation services	Completed Ongoing		2012/13
		Disability services' capacity to provide palliative care improved	Completed Ongoing		2012/13

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

Actions	Impacts	Performance measure	Progress	Key achievements / evidence of impact	Year commence reporting impact
3.5 Undertake a state-wide project to establish protocols and strengthen relationships between palliative care and aged care services, including residential, community and aged care assessment services	• 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	• Regional palliative/aged care action plans developed and implemented	Completed Ongoing	Regional aged care action plan (see appendix 4) developed and implemented	2012/13
3.6 Establish an aged care palliative care link nurse in each region		• Aged care/palliative care link (support) nurse employed in each region	Completed	Aged care/palliative care support nurses x 2 employed in the region.	2012/13

	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	• Increase in number of residential aged care facilities supported to implement end-of-life care pathways	In progress Continuing	End-of-life pathways were utilised in 52.54% of aged care facilities in the region. There has been a reasonably large turn-over of managers and staff of aged care facilities over the life of the policies which means the palliative Aged Care Support workers must continue to reinforce the important of this at all education.	
			In Progress Continuing	South Western sub-region: South West Healthcare (Merindah Lodge) data indicates that of permanent residents (non respite) during 2014/15 95% died in their place of choice, aged care facility. Barwon sub-region: Barwon Health Residential Aged Care data indicates that of permanent Barwon Health aged care residents (non respite) during 2014/15, 96% died in their place of choice, aged care facility with the remainder dying in University Hospital Geelong (acute).	

Not commenced	In progress	Completed

35

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

Actions	Impacts	Performance measure	Progress	Key achievements / evidence of impact	Year commence reporting impact
4.2 Implement the palliative care service delivery framework (SDF) across Victoria, with advice from the PCCN As part of this implementation: • services will undertake self-assessment against the service capabilities detailed in the framework • the service delivery framework will be used by palliative care consortia in regional service planning	• 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	• Regional service planning is aligned with the SDF	Completed Completed	*There is no change in the impacts from 2013/14* *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 using an accepted triage tool.* *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.*	2012/13 2012/13

Not commenced	In progress	Completed

Strategic direction 5: Coordinating care across settings

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

Actions	Impacts	Performance measure	Progress	Key achievements / evidence of impact	Year commence reporting impact
5.2 Develop stronger links between the palliative care consortia, the PCCN and all other relevant stakeholders	• 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	• Identify the health, community and aged care networks in each region and how they link with palliative care	Completed Ongoing	The number and types of partnerships between the consortium and other health, community, aged care and other providers has continued to increase over the 2014/15 financial year. The key drivers of this increase have been: Liaison with residential aged care facilities, residential disability services, and community aged care service providers. Regular communication is maintained with the managers of all residential aged care facilities and most residential disability service coordinators / managers. Significant education has been offered throughout all of the sectors over the life of the policy. Post PEPA education has been valued by all attendees.	2012/13
		• Strengthen/develop links between consortia and networks	Completed Ongoing	All palliative care services have positive links with primary care partnerships, local government services and Aboriginal Community Controlled Health organisations in their areas.	2012/13
		• Clinical advisory groups role statement identifies formal links with the PCCN	Completed Ongoing	Terms of reference for the Clinical Leaders (Advisory) Group identifies the role of the regional representative in the PCCN reporting to the clinical leaders group and also passing information from clinical leaders back to PCCN.	2012/13
		• Develop strong and sustained links with Medicare Locals	Completed Ongoing	The Medicare Locals in the Barwon South Western region have been replaced by the Primary Health Network Western Region. They have a high level of skill and commitment to palliative care and offer a number of services to GP's. Strong links are maintained.	2012/13

Actions	Impacts	Performance measure	Progress	Key achievements / evidence of impact	Year commence reporting impact
5.3 Strengthen consortia governance and accountability processes and document them consistently	• Palliative care consortia have documented governance and accountability processes in place that are understood by consortia members	• Role statements are implemented regionally	Completed Ongoing	A record is maintained of all meeting minutes, reports, agenda's, for the consortium, the clinical leaders group and the practitioners group. Aspects of 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 2014 Procedures are in place for orientation of new consortium members. A quality and risk management framework has been developed for the consortium, see Appendix 5. The fund holder for the next two years is Barwon Health and the Consortium Chair is Julie Jones (Manager of Palliative Care at Barwon Health).	2012/13

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

Actions	Impacts	Performance measure	Progress	Key achievements / evidence of impact	Year commence reporting impact
5.4 Encourage consistent and equitable IT solutions that facilitate coordination and consultation across all palliative care services	• IT solutions are in place to support quality initiatives and connectivity	• Partnerships and opportunities to promote IT connectivity are explored and developed	Completed Ongoing	Impacts: IT solutions including Internet based clinical palliative care software are in place which promote more appropriate after-hours triage responses across the region. This has also enabled implementation of the Population Needs Based model of care across the region. Through South West Alliance of Rural Health (SWARH) all services in the region have access to telehealth teleconferencing and video conferencing. For regional palliative care patients presenting at University Hospital Geelong referrals from the Acute Palliative Care Consultancy Team can be made directly to the appropriate palliative care service through the software (PERM). This allows for much more rapid response and follow-up.	2012/13

Not commenced	In progress	Completed

Strategic direction 6: Providing quality care supported by evidence

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

Actions	Impacts	Performance measure	Progress	Key achievements / evidence of impact	Year commence reporting impact
6.1 Implement a program of work for the PCCN including: 6.1.1 providing clinical advice to the department on the implementation of the policy and the SDF 6.1.2 reviewing quality indicators and identifying quality improvement opportunities as part of monitoring quality data collection 6.1.3 endorsing and adopting evidence-based clinical guidelines and protocols 6.1.4 implementing evidence-based clinical tools at a service level 6.1.5 identifying service delivery research priorities	• Established state-wide program of work for the update of evidence into clinical practice • Palliative care service delivery is more consistent and evidence based	• Quality improvement opportunities are identified and actioned	Completed Ongoing	All palliative care services within the region within the region have a continuing commitment to NSAP and regular audits of CSNAT results	2012/13
		• Clinical tools implemented at the service and regional levels	Completed Ongoing	All evidence-based clinical tools recommended by the Palliative Care Clinical Network have been implemented by palliative care services in the Barwon South Western Region. The most recent in the last financial year has been the Carer Needs Assessment (CSNAT) tool.	2012/13
		• A PCCN consortia representative acts as a conduit between services, consortia clinical advisory group and the PCCN	Completed Ongoing	The regional PCCN consortia representative is a nurse practitioner candidate based at Barwon Health. This representative attends BSWRPC Clinical Leaders Group meetings and reports on the activities of the PCCN. During 2014/15 there have been no recommendations for the update of evidence into clinical practice from the PCCN. Palliative Care service delivery is more consistent and evidence based in the region. The work plan of the Clinical Leaders Group has ensured implementation of the Bereavement Framework and a review of the ongoing validity of the evidence based clinical tools used by palliative care services across the region and PCCN issues is a standing item on the Clinical Leaders Group meeting agenda's.	2012/13

Not commenced	In progress	Completed

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

Actions	Impacts	Performance measure	Progress	Key achievements / evidence of impact	Year commence reporting impact
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	• Rigorous and ongoing clinical service improvement is undertaken by palliative care consortia and their member services	• Each region has an active clinical advisory group	Completed Ongoing	In the Barwon South Western Region this group is called the Clinical Leaders Group, it meets quarterly. As stated previously all palliative care services are accredited and are involved with NSAP.	2012/13
		• Consortia representative attends PCCN to report on clinical service improvement activities	Completed Ongoing	Barwon South Western region Consortia PCCN representative attends PCCN and reports on clinical service improvement activities. Regional Admission and Discharge policies reviewed, all clinical tools reviewed, End of Life Pathways reviewed and preparation for PCOC data extraction has occurred to commence in July 2015.	2012/13

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

Actions	Impacts	Performance measure	Progress	Key achievements / evidence of impact	Year commence reporting impact
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	• The palliative care workforce grows sufficiently to meet demand • The capacity of the health, community, aged care and disability services workforce to care for people with a life-threatening illness is enhanced	• Regional workforce training and education initiatives	Completed Ongoing	There has been a program of palliative care education conducted throughout the year by a Palliative Care fellow from Barwon Health. The Palliative Care Aged Care and Disability Support workers in the region have continued to support aged care and disability staff personnel Through education in a palliative approach thus increasing their capacity. Specialist Palliative Care services provide support and education to acute and community health staff in this region. The workforce is growing sufficiently to meet demand within the east and centre of the region but in the far west of the region it is increasingly difficult to recruit when palliative care positions become vacant.	2012/13

Not commenced	In progress	Completed

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 a life-threatening illness and their carers

Actions	Impacts	Performance measure	Progress	Key achievements / evidence of impact	Year commence reporting impact
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 education strategies targeted to meet the needs of specific communities • strategies to enhance opportunities for palliative care service volunteers to engage with their 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 state-wide level between palliative care stakeholders across health, community and aged care	• Victorians are better able to support people with life-threatening illness and their carers	• Links between palliative care consortia/palliative care services and health promotion officers (local councils, community health centres, PCPs) established or enhanced	Completed Ongoing	Barwon South Western Region Palliative care Consortium and its member services have excellent links with local government, community health and primary care partnerships. Local government links are most commonly with Home and Community Care programs which are most relevant for palliative care services. All consortium member services have community health as part of their health services which supports good relationships.	2013/14
		• State-wide model/templates developed, endorsed by PCCN and implemented	Completed Ongoing	No new models or templates have been developed or endorsed by the PCCN in this financial year. Those developed in previous years were implemented.	2013/14
		• Regional activities undertaken to build community capacity to support people who are referred to palliative care	Completed Ongoing	Palliative Care Services in the region were encouraged by the consortium to become involved in Palliative Care Awareness Week activities. The play "Four Funerals in One Day" was stage by Bay Street Productions between 25th and 30th May 2015. This palliative care awareness raising production was sponsored by Barwon Health, Colac Area Health South West Healthcare. Each service provided staff to join a panel discussion at the conclusion of the play. This activity was very well attended and was supported by the media. All specialist palliative care services have volunteers working within the services and these together with clinical staff act as ambassadors in the community helping to ensure people with life-threatening illnesses are better supported in the Barwon South Western region. In rural and regional communities knowledge of palliative care and supportive services for people with life-threatening illness is often higher due to a high degree of stability across medical practitioners and palliative care providers. Educational strategies have included a significant amount of palliative approach education to community nursing, community and residential aged care staff and residential disability staff across the region thus increasing community awareness and understanding of palliative care.	2014/15

Not commenced In progress Completed

Appendix 3: BSWRPCC Strategic Plan 2014-15

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 G Wallwork	SWH & BH to report through Consortium Manager to consortium	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.

A regional Palliative Care Forum to be held in November 2014. All health, community, aged care, Medicare locals and Primary Care Partnerships to be invited. | All consortium members

Consortium Manager | Report in Annual Report

Report in Annual report | Achieved |
	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 G Wallwork	SWH & BH to report at Consortium 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 July 2014	Ongoing
	3.6 Assist aged care services to care for people at the end-of-life	Employ palliative / aged care palliative support nurses.	Consortium		Achieved 2011

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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 Service delivery Framework	Consortium & Individual services	Services requested to submit the data yearly to the Dept. of Health	PIAT completed annually, except 2014/15

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 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 consortium meeting	Ongoing
		Continue to work towards IT solution for Bellarine Community Health.	BCH staff and Consortium Manager	Ongoing, report annually	Progressing

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 the like. 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 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 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	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 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 state-wide level between palliative care stakeholders across health, community and aged care	Links between palliative consortium/palliative care services and health promotion officers (local councils, community health centres, PCP's) established or enhanced. Describe links. State-wide model/templates developed, endorsed by PCCN and implemented. Discussion and promotion of PCCN model and template Regional activities undertaken to build community capacity to support people who are referred to palliative. Give examples of joint activities	Consortium & consortium manager		Ongoing

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 4: BSWRPCC Aged Care Action Plan 2014/15

Rationale: The aged care action plan has been reviewed as one of the fundamental underpinning beliefs on which it was based has been shown to be inaccurate.
It was expected that the education of link nurses would lead to them providing education to other staff in their facilities. While this did occur successfully in some facilities, for the majority of facilities link nurses did not feel comfortably or competent to educate other staff in their own facilities.
There were a number of factors that affected link nurses which contributed to this.
They included: lack of time to provide education, perceived lack of credibility, lack of confidence, beyond their skill and capability level, unwillingness to take any initiative.

Other consortia within the state have had similar responses from aged care staff.

Aged Care Actions Planned for 2014/15

- Ongoing group palliative approach education directed at Division 1 & 2 nurses

- Ongoing group palliative approach education directed at Personal Care Workers

- Continuing regrouping sessions with staff that have previously completed palliative approach education, these may be linked to the annual calendar of education.

- Ongoing Individual facility education based on specific patient issues or family issues

- Pilot projects to be conducted if sufficient funding can be sourced

Reviewed by BSWRPCC, Dec 2014

Appendix 5: BSWRPCC Quality & Risk Assessment Plan

Governance - Strategic

	Risk Observed or Potential Risk	Probability	Conse-quence	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 implementation strategies in the Strategic Plan.	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 and or carers receive an 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	Conse-quence	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.	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 Chairperson and the Deputy Chairperson (e.g. Julianne). Regular meetings with the Chair monthly.	Chair and CM	Low

Governance - Monitoring

	Risk Observed or Potential Risk	Probability for Consortium	Conse-quence	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	Conse-quence	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 Annual Palliative Care Forum Maintain effective networks	CM and Consortium	Low

Operational – Quality / Financial

	Risk Observed or Potential Risk	Probability for Consortium	Conse-quence	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 employing agency produce appropriate monthly reports and annual financial report to Department of Health	Consortium	Low

Operational – Quality / Learning and Growth

	Risk Observed or Potential Risk	Probability for Consortium	Conse-quence	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.	Employing agency complaints procedure to be reviewed by Consortium in 2014	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	Employing agency has appropriate Human resource policies and procedures	CM & Chair	Low

Appendix 6: 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
CSNAT	Carer Support Needs Assessment Tool
EFT	Effective Full Time
EQuIP	Evaluation and Quality Improvement Program
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