Barwon South Western Region
Palliative Care

BARWON SOUTH WESTERN REGION

PALLIATIVE CARE CONSORTIUM

ANNUAL REPORT

2013 - 2014

COLAC AREA Health

wdhs Western District Health Service

South West Healthcare

Barwon Health

PORTLAND DISTRICT HEALTH

Strengthening palliative care: Policy and strategic directions 2011 - 2015

Contents:

This annual report was prepared by: Heather Robinson
On behalf of: Barwon South Western Region Palliative Care Consortium
Telephone: 03 42155661
Email: heathrob@barwonhealth.org.au

Web: www.bswrpc.org.au
Copies of this report can be downloaded from the website

INTRODUCTION

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

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

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

The role of the consortium includes:

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

The policy lists the following challenges for the future:

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

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

BACKGROUND ABOUT THE BARWON SOUTH WESTERN REGION

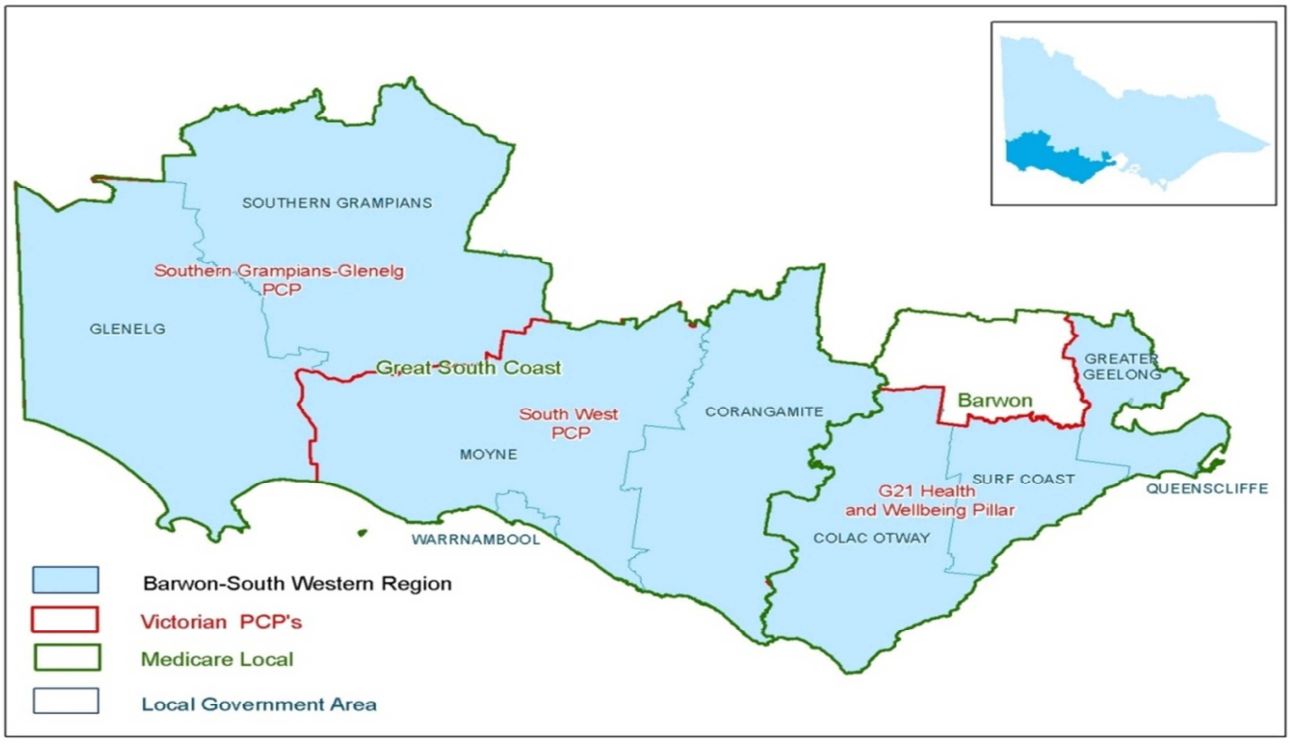
The Barwon South Western Region covers the LGA's of the City of Greater Geelong, Surf Coast Shire, the Borough of Queenscliffe, Colac-Otway Shire, Corangamite Shire, Shire of Moyne, City of Warrnambool, Glenelg Shire and the South Grampians Shire. The total Estimated Resident population (ERP) for the region at 30th June 2013 was 371,929. 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.

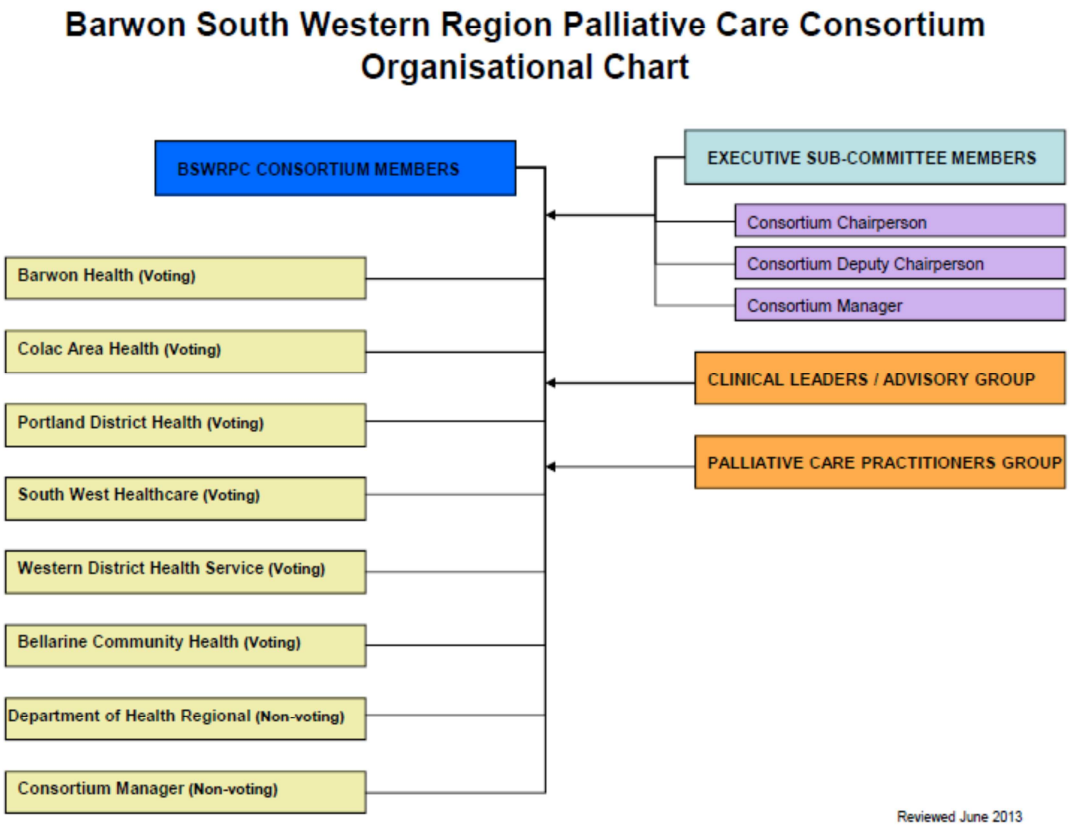
Local Government Areas	Total Population	Increase/Decrease from 30/6/2012	% Increase/Decrease from 30/6/2012
Greater Geelong	221,515	+3390	+1.55%
Surf Coast	28,282	+808	+2.94%
Queenscliffe	3,058	-27	-0.88%
Colac-Otway	20,694	-73	-0.35%
Corangamite	13,137	-250	-1.53%
Moyne	16,277	+51	+0.31%
Warrnambool	33,300	+296	+0.90%
Southern Grampians	16,145	-227	-1.39%
Glenelg	19,521	-237	-1.20%

(profile.id.com.au)

Geography

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





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 eighty two (882) referrals during 2013-14.

CONSORTIUM CHAIR'S REPORT

2013/14 has been the second year of my role as Consortium Chair. This has allowed me to consolidate some of my learning about the consortium, the region in general and palliative care in particular.

This year has seen the consolidation of activity based funding and the requirement for regular mandatory reporting to the Department of Health via the Victorian Integrated Non-Admitted Health (VINAH) dataset. This has proved a challenge for all services within the consortia. However, with persistence from the services and the recent employment of a Data Integrity Officer, this requirement has now been met.

As always, there have been great achievements in the area of aged Care and disability. The ongoing education program continues to reap rewards and the evaluations illustrate that all the hard work is having good effect.

Another highlight of the year includes a request by the Victorian Department of Health that the Barwon Health Palliative Care Program undertake a project to develop a concept model of care that will meet the changing and growing needs of the Greater Geelong and Barwon South West Region. This model of care, whilst considering all aspects of the program, particularly incorporates and prepares for the new acute palliative care beds currently being built at The Geelong Hospital site. The paper was completed in June 2014. It builds on the principles of the Victorian Department of Health's Strengthening Palliative Care: Policy and strategic directions 2011-2015 and whilst accommodating the change that the new beds will bring, also aims to achieve patient-centric goals (dying in the place of choice and accessing care as close to home as possible). This provided a unique chance to change the way we think about and plan services, and the opportunity to develop a new and innovative model of care that is sustainable through current and future challenges. The next stage will be the realisation of this vision where the support from the Department of Health is paramount.

The coming year (2014/15) brings some exciting initiatives and will see the implementation of such things as:

- a regional community forum regarding key palliative care issues
- 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
- the inclusion of Palliative Care, Bellarine Community Health on the PERM database and utilisation of the regional after hours service
- the ability to be able to externally benchmark our data via the Palliative Care Outcomes Collaborative (PCOC)
- participation and consultation in the development of a new palliative care state-wide strategy
- an increase in new acute palliative care beds at the University Hospital Geelong.

Finally, I would like to thank Heather Robinson, Consortium Manager, whose consistent hard work and dedication to the regional role, ensures that the members are well equipped, knowledgeable and motivated to continue to implement relevant initiatives that benefit palliative care staff, patients and families alike.

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 by December 2014.

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	*An up-to-date interdisciplinary care plan that reflects the wishes of clients and carers are contained within the PERM software. This care plan is then available to after-hours triage staff to inform their practice. As stated in the 2012/13 report, electronic assessments are completed for 83% of clients, and on paper for 17% of clients. A completed copy of the care plan is generated for the client to keep at home for community clients in 100% of cases. Copies of the care plans are sent to the client's GP and other care providers as necessary. The percentage of services using the PERM software to complete assessments and therefore generate care plans remains unchanged for 2013/14. There were some difficulties achieving ANF agreement for Bellarine Community Health to commence usage of PERM software. This issue has been resolved at the time of writing this report, Bellarine Community Health can now proceed with implementation of the electronic palliative care record after which 100% of clients will have electronic care plans generated or amended after each assessment.*

Strategic Direction 2: Caring for carers

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

2.3 Ensure access to a range of respite options to meet the needs of clients and carers by:

- Mapping available respite services
- Strengthening links between palliative care services and respite services
- Providing specialist consultation and advice to respite services about how to meet the needs of clients with a life-threatening illness

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

Required Impacts:	***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 2013/14 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.*

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 throughout 2013/14. It is expected that Bellarine Community Health will be included from December 2014 as discussions regarding their use of the PERM software have been ongoing for the last six months of this financial year and a clear implementation plan has been developed

During this 2013/14 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 a consequence more appropriate triage responses to after-hours calls can be facilitated with access to the most up to date clinical information on which to clinical decision-making.

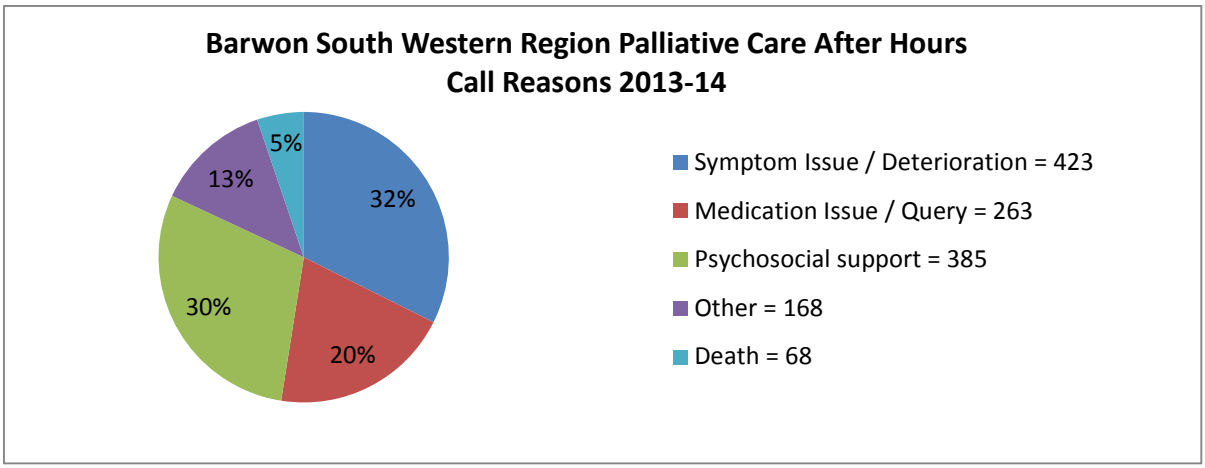
The process for after-hours service is that clients telephone their local service number, where they are seamlessly connected to the paging service that then pages St Vincent's/Caritas Christi. To enable this process St Vincent's/Caritas Christi also have access to the live PERM patient data for triage 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.

Total after-hours triage calls during 2013/14 for the Barwon South Western Region are made up of:

Bellarine Community Health	92
All other health services	1276
Total after-hours calls	1368

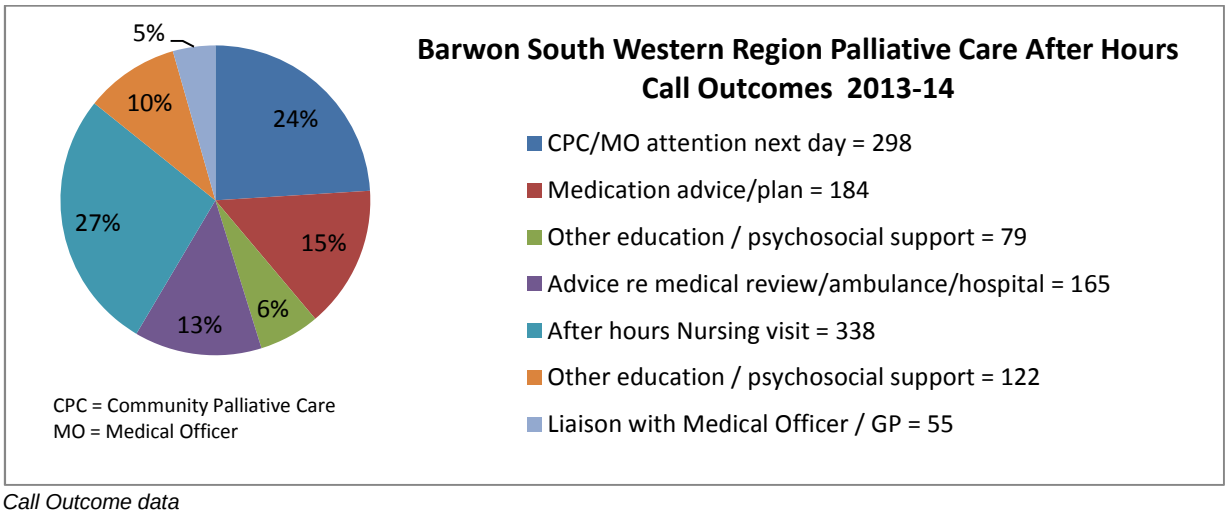
The fact that the consortium doesn't have access to total registrations for services across the region contributes to making it difficult to explain the reduction in after-hours triage calls during this financial year. A drop in total patients or a decrease in patients with high complexity could explain this decrease. Alternatively it may reflect improved patient/carer education. However this is only speculation.

The after-hours calls led to a total 338 after-hours nursing call-outs (visits) by community/district nurses across the region during the financial year to June 30th 2014. Please see a breakdown of call elements below.



Call reason data

The after-hours call reason 'Psychological support' has had an increase of 14% in 2013/14 from the previous year despite 'Deaths' remaining at 5%. While it is not possible to definitively identify the cause it can be speculated that the most likely cause/s would be an increase in client complexity and/or carer stress.



Call Outcome data

Required Impacts:	***Actual Impacts:***
More after-hours support (including telephone support and home visits where appropriate) is available to all clients and their carers	• *As reported last year after-hours support (including specialist telephone support and community nursing home visits where appropriate) is available to all clients and carers in the Barwon South Western region. Clients and carers of Barwon Health, South West Healthcare, Portland District Health Service, Colac Area Health and Western District Health Service were able to access specialist palliative care advice and support from St Vincent's/Caritas Christi. Protocols are well established to provide call-outs for clients when requested by Caritas Christi and if it was safe to do so.* • *Bellarine Community Health continues to provide an on-call service using their own generalist staff. Discussions with Bellarine Community Health have commenced and an implementation plan has been developed. The first steps in implementation involve: ANF sign off regarding the implementation, support from SWARH to set up the electronic platform into which PERM will be added, and staff education prior to roll out of the software. Once this is complete BCH is expected to join other consortium members using the PERM software and the St Vincent's/Caritas Christi after-hours triage service by December 2014.* • *Carer satisfaction ("Experiences as a Carer") with after hours in the Barwon South Western region as measured in the Victorian Palliative Care Satisfaction Survey (VPCSS) are as follows: 2012 community mean 4.58/5, 2013 mean 4.42/5, 2014 mean 4.50/5. From 2013 onwards Portland District Health, Western District Health Service and Colac Area Health palliative care services joined the after-hours triage service which may account for some variation in the year to year results. There have been some technical issues on occasion with the paging service which affect carers' perceptions of after-hours service availability. These technical issues mainly resulted in slowed response times.*

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

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

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

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

When considering whether people die in their place of choice it is necessary to consider residential aged care facilities as the person's home. A key measure of ensuring people die in their place of choice is an increase in people dying at home, the table below indicates there has been an overall increase in people dying at home across the region.

Service Providers	% died at home 12/13	% died at home 13/14	Variation
Bellarine Community Health	N/A	N/A	N/A
Barwon Health	42.65%	54%	+11.35%
Colac Area Health	57%	35%	-22%
Portland District Health	29%	42.30%	+13/3%
South West Healthcare	37%	37%	+/-0
Western District Health Service	38%	45%	+7%

CPC Separations Report, Died at home = private residence + residential aged care facility. N/A = Not available

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 having an increased knowledge about how to care for people with a life-threatening illness and how to support someone with a life threatening illness within a facility or at home if that is their choice is affected by a number of factors:* • *The provision of ongoing education to all sectors about a palliative approach for people with a life-threatening illness* • *Promotion of PEPA palliative approach education twice during this financial year* • *Increases in education about appropriate referrals to community and inpatient palliative care and the number and appropriateness of referrals to community palliative care services* • *The presence of willing/able carer/s makes a significant difference to the clients ability to die in their place of choice, even though the use of available services can significantly increase time spent at home* • *The work of the sub-regional Palliative Care Teams at*

	each end of the region supports clients/carers and specialist palliative care staff increasing the likelihood that people will die in their place of choice • *The work of the acute Palliative Care Consultancy Team in University Hospital Geelong increases the knowledge of staff caring for someone with a life-threatening illness working within that facility, the team are also available to advocate and facilitate on the client's behalf regarding appropriate care choices* • *The availability of supportive services in the community including community/district nursing, local government home care services, respite services and volunteers support all contribute to clients being more likely to be care for and/or die in their place of choice* • *Evaluations are conducted after all education, see results of education in sections 3.4 and 3.6*

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 provide a variety of other services within their communities in addition to palliative care.

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.

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. As an example of timely and appropriate referrals the Barwon Health Community Palliative Care information regarding all deaths from 1/7/13 – 30/6/14 indicates that 91.14% were on the program more than 14 days, 9.85 % died less than 14 days after referral. There is a high level of stability amongst the medical community and specialist palliative care services are well known and highly respected in the region which facilitates appropriate referral processes being*

promoted by the palliative care sector. Referral strategies are based on Service Coordination Tool Templates (SCTT) across health, and community and aged care. The Barwon South Western Region Victorian Palliative Care Satisfaction Survey (VPCSS) conducted by Ultrafeedback reported client and carer responses to 'I found it easy to be referred' to palliative care as follows:

- *2012 mean 4.53*
- *2013 mean 4.52*
- *2014 mean 4.45*

Anecdotally, it is perceived that the variation across the region to refer to palliative care is related to GP preparedness.

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.

Activities in the Barwon South Western region

- Three education workshops has occurred in 2013/14 for disability staff including information an introduction to palliative care, palliative approach, referring to specialist palliative care, recognising when someone is deteriorating, common signs and symptoms in the final days of life, common changes that occur when death is imminent, managing symptoms, family meetings, advance care planning and self-care/grief.
- Residential Disability accommodation personnel were invited to all personal care worker education in a Palliative Approach (5 sessions in total) and all post PEPA palliative care education (3 sessions).
- In Geelong an Advisory Committee has been formed with Dr Charlie Corke as the Chair to progress the use of advance care planning in disability services. A trial is being conducted with 10 – 15 clients/carers using the existing Community Advance Care Plan. Once the trial is complete recommendations will be made regarding its wider use in the Geelong area.

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 impact of the above measures, together with the trial of advance care plans in Geelong, increases the likelihood that people living in disability accommodation services will be able to be cared for, and die in, their place of choice. Until advance care plans are introduced more widely in this sector it will not be possible to record preferred place of choice for care or death for residents of residential disability services and thus then to try to facilitate care and death in the place of choice. The Barwon sub-region disability/palliative care project officer is a member of the advisory committee who will report progress to 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 attached at *Appendix 3*.

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 July 2013.* • *Resources were developed to support the provision of end-of-life care in aged care services. The region continues to use the Palliative Approach toolkit developed by the University of Queensland/Blue Cross Research and Practice Development Centre. This toolkit has a module with a focus on end-of-life care provision; in February 2014 the updated toolkit roll-out occurred and all aged care facilities in the Barwon South Western Region were invited to the education provided on behalf of the Commonwealth Depart of Social Services. All aged care facilities have been made aware that they need to request a copy of the updated toolkit for their facility.*

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 489 link nurses from 110 facilities that have been trained between 2012 and 2014 by the palliative aged care support nurses in this region.**

In the *Barwon sub-region* - Education of link nurses continued in the region, a further sixty five (65) link nurses were trained from Geelong, Colac and the Bellarine peninsula during this financial year, from February 2014 this was based on the updated toolkit. Two workshops for link nurses originally trained in

2012/13 were held during the year with on-going education delivered as requested; these workshops were attended by 21 link nurses. Palliative Approach education, often with a focus on a specific issue, as requested was also delivered to four aged care facilities during the year.

A Palliative Care of People with Dementia workshop was held in Geelong in March 2014. One hundred and forty people attended from residential aged care, community aged care and residential disability services.
A Palliative Approach education program was developed for aged care personal care workers (residential and community), five workshops were delivered with 120 personal care workers attending. The palliative aged care support nurse also provided education to Division 2 nursing students at the Gordon TAFE as part of the palliative care stream.

In the *South West sub-region* – On-going education has been provided quarterly to the 62 existing link nurses in the region this included the changes from the updated toolkit, these link nurse come from 25 facilities. Education was provided to the staff of an aged care facility not previously involved in the link nurse program, they have set up a steering committee to oversee implementation of the palliative approach within their facility A questionnaire to all aged care facilities regarding their education needs indicated there is a significant need for Palliative Approach education for personal care workers. This education program has been developed and will commence in October 2014.

A workshop that had Palliative Care for People with Dementia as its theme was held in Warrnambool late in 2013, the workshop was well attended (90 people), with all aged care facilities represented.

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: 'CareSearch', PEPA placements and PEPA education.
Key learning's from the palliative/aged care program to consider for inclusion in the program for 2014/15 include:

- Maintain regular ongoing education with topics selected by link nurses included dementia, self-care/grief, difficult conversations and having an understanding of multicultural issues.
- Some aged care facilities had a length of stay of 21 days which was clearly causing stress for staff, increased sick leave and a significant grief burden.
- Palliative Care Worker specific palliative approach training is required as in some facilities these staff make up a significant proportion of their EFT.

To date the theory behind the Link nurse model in aged care has had varying success. In some facilities it has worked well but in others the link nurses don't feel comfortable or confident to educate other staff in the facility or to try and facilitate process change as a result of this variability the Link nurse education will continue to be provided in each sub-region.

Barwon South Western Region Palliative Aged Care Education evaluations for 2013/14:

Evaluation Questions	**Agree**	**Strongly agree**	**Neither Agree or Disagree**
The workshop increased my understanding of the a palliative approach, specialist palliative care and end-of-life care	52.94%	47.05%	
The workshop increased my understanding my understanding of the benefits of implementing a palliative approach (PA) and the PA toolkit in my RACF	50%	50%	

Evaluation Questions	Agree	Strongly agree	Neither Agree or Disagree
I understand my role in the care of people with a life-limiting illness	50%	50%	
I am confident to identify the needs of people with a life-limiting illness	50%	50%	
I feel more confident with having difficult conversations with residents/clients and their families/carers	42.85%	48.57%	8.57%
I feel confident that I can use the knowledge gained from this workshop to help improve the care I provide to residents/clients at the end of life	54.54%	45.45%	

Most useful workshop topics nominated by attendees	
Advance Care Planning	20.97%
End of life care pathways	30.67%
Palliative care case conferences	14.68%
10 steps to implement a palliative approach	20.27%
Recognising deteriorating health in residents	13.28%

Main Role of Education attendees	RN Div1	RN Div2	PCW
100% work in Residential Aged Care Facilities	44.74%	23.68%	31.57%

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 South West Healthcare residents (non respite) during 2013/14 100% died in the aged care facility. This data indicates that aged care facility staff are more confident and competent to manage palliative care residents within the facility which is effectively their home. End-of-life pathway information from aged care facilities in the sub-region is not available as there is no uniform pathway used by all facilities.

Barwon sub-region:

Barwon Health Residential Aged Care data indicates that, of permanent Barwon Health aged care residents (non respite) during 2013/14, 95.84% died in the aged care facility with the remainder dying in Geelong Hospital (acute).

This data indicates that aged care facility staff are more confident and competent to manage palliative care residents within the facility which is effectively their home. End-of-life pathway information from aged care facilities in the sub-region is not available as there is no uniform pathway used by all facilities.

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

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

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

Required Impacts:	**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 2013/14 remain the same as the previous year 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 has strong links with the palliative care program at Barwon Health and Bellarine Community Health. Palliative care patients in Geelong Private Hospital can be assessed by members of the Barwon Health palliative care consultancy team as requested.
- Through the Palliative/Aged Care Support Nurse Program links have been established with public and private residential aged care facilities across the Barwon South Western Region.
- Through the Disability/palliative care project officers links have been established with public and private residential aged disability services across the Barwon South Western Region.

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

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

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 increased over the 2013/14 financial year. The key drivers of this increase have been the amount of 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.* • *A significant amount of education has been offered throughout all of the sectors including post PEPA*

	education. • *Excellent links have been developed with Medicare Locals and regular updates from the Primary Care Partnership G21.*

5.3 Strengthen consortium governance and accountability processes and document them consistently

Member agencies:	Voting Delegates	Attendance
➢ Barwon Health (Chair)	Julie Jones	80%
➢ Colac Area Health	Jennifer Levine	60%
➢ Bellarine Community Health	Kathy Day	20%
➢ Western District Health Service	Usha Naidoo	100%
➢ South West Healthcare (Dep. Chair)	Julianne Clift	100%
➢ Portland District Health	Fiona Heenan	60%

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

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

The consortium workers for the region include:

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

Performance measures: A role statement audit carried out in June 2014 found that:

- Role statements for Consortium, Consortium Chair, Consortium Deputy Chair, Consortium Manager and employing agency, Consortium Executive, Consortium Fundholder, Consortium members (voting) and Consortium member (non-voting) have all been implemented and are current.
- Links with the Department of Health are maintained through circulation of monthly palliative care project updates, attendance at statewide meetings, consortium manager meetings and other meetings as necessary
- All voting members of the consortium understand the consortium role and champion palliative care in their own health service; they participate in budget and resource allocation decisions.

Consortium member accreditation status is as follows:

Barwon Health	July 2013	SAI Global
Bellarine Community Health	Oct 2013	QIC & NSQHS
Colac Area Health	Sept 2013	ACHS
Portland District Health	August 2014	ACHS
South West Healthcare	May 2014	ACHS
Western District Health Service	Oct 2014	ACHS

Required Impacts:	***Actual Impacts:***
Palliative care consortia have documented governance and accountability processes in place that are understood by consortia members	• *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 4.* • *The fundholder for the next two years is Barwon Health elected in 2013 and the Consortium Chair is Julie Jones (Manager of Palliative Care at Barwon Health) also re-elected in 2013.*

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

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

Performance measures:

- Partnerships and opportunities to promote IT connectivity were explored and developed as part of the development of the 'Palliative Electronic Record Management' (PERM) software which was part of a project funded by the Department of Health and Ageing.
- The Barwon South Western Region Palliative Care Consortium (BSWRPCC) developed a specialist palliative care medical record based on an agreed assessment model and a variety of clinical tools. These tools includes: 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. Through 2013/14 discussions have continued with Bellarine Community Health to explore how the software may be of benefit to them.
- Carer Support Needs Assessment Tool (CSNAT) is being used at three community palliative care programs and it might, in future, be appropriate to consider adding it to the suite of tools in PERM, for review in November 2014.

Required Impacts:	***Actual Impacts:***
IT solutions are in place to support quality initiatives and connectivity	• *Palliative Care Electronic Record Management (PERM) software is internet based which allows St Vincent's/Caritas Christi to access live data for after-hours triage. They are also able to record their activity overnight and this is then flagged for community palliative care staff the next morning.*

	• *There are a number of internal data reports available using PERM data that can be used by the services who use the software to design quality initiatives.* • *At Portland District Health a palliative care clinic is being held regularly where complex patients can access the medical staff, they in turn can access the electronic patient record. This is followed by a multidisciplinary team meeting.* • *Palliative Care workers across the region are being encouraged to use the purchased iPad to access patient information while they are out with the patient and to record key components of the assessment while they are in the client's home.* • *Accurate data reports of VINAH data are being finalised. A Data Integrity Officer has been employed part-time to correct errors and ensure VINAH data is accurate. When this work is complete internal reports will be developed for use in benchmarking and quality initiatives.* • *The Barwon South Western Region now has a PCOC test extraction report available and it is anticipated that initial data will be submitted via this report in November 2014. When a formal benchmark report has received from PCOC benchmarking analysis may begin and the development of appropriate quality project will occur.*

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. Key data is included below:

Top five *Priority to Improve* items:

Item	2014 mean	2013 mean
Satisfaction with ongoing support, opportunities to talk with other carers about your own situation (as a carer)	3.37	3.23
Satisfaction with activities to help you pass the time	3.19	3.25
Satisfaction with ongoing support to minimise financial burden	3.81	3.64
Agreement with 'I knew where to enquire about palliative care	3.64 (New)	
Satisfaction with ongoing support to minimise your own psychological burden	3.99 (New)	

For the three items that have a mean 2013 recorded most have improved slightly, for the one item where the mean has decreased slightly, this was not statistically significant. The items marked (New) have not appeared in the top five 'priority to improve' items prior to this year. The consortium will discuss the above results at its next meeting and consider any necessary quality improvement strategies.

Top five performing items:

Item	2014 mean	2013 mean
Satisfaction with the level of respect shown towards you as an individual	4.83	4.80
Satisfaction with the response from nurses	4.72	4.69
Satisfaction with the privacy of your room	4.63 (New)	
Overall satisfaction with the care delivered by your palliative care team	4.63	4.68
Satisfaction with ongoing support 'necessary equipment to provide care safely to the patient	4.64 (New)	

For the three items that were noted in 2013 most have improved slightly, for the one item where the mean has decreased slightly but this was not statistically significant. The items marked (New) have not appeared in the 'top five performing' items prior to this year

NSAP Support for Carers Collaborative Project: As a result of consistent carer support themes registered in the Victorian Palliative Care Satisfaction Survey over the last three years three consortium members in the Barwon South Western Region have taken part in the Support for Carers Collaborative Project. Barwon Heath, Western District Health Service and Portland District Health have trialling and are currently using the CSNAT tool. Audit results have been favourable therefore the Consortium has decided that it will be introduced region wide in 2014/15.

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 72% of PCCN meetings and 75% of Clinical Leaders group in the last financial year. A PCCN report is a standing agenda item at all consortium meetings, clinical leaders meetings and palliative care practitioners meetings. The PCCN consortium representative attends consortium meetings, clinical advisory group and palliative care

practitioners meetings to report 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. The current PCCN consortia representative resigned and the Consortium will endorse a replacement representative at its October 2014 meeting.

Required Impacts:	***Actual Impacts:***
Established statewide program of work for the update of evidence into clinical practice Palliative care service delivery is more consistent and evidence based	• *Palliative care service delivery is more consistent and evidence based through its use of a standardised initial assessment tool and a number of clinical tools.* • *Preparation for implementation of the bereavement framework in the Barwon South Western region has commenced, Barwon Health are currently developing implementation guidelines for the bereavement framework. This will be presented at the November 2014 Clinical Leaders meeting. Impacts will be able to be reported in future annual reports.* • *CSNAT has been selected as the most appropriate carer assessment tool as part of the NSAP Support for Carers Collaborative Project, implementation of the chosen tool will assist with more consistent and evidence based practice leading to improved impact reporting.*

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

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

Performance measures: The Clinical and Advisory groups are combined in the Barwon South Western region. The Clinical Advisory (Clinical Leaders) group role statement, membership, meeting format and frequency were reviewed in February 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 - discuss regional implementation of these guidelines**
- ✓ **NSAP Support for Carers Collaborative project - Barwon Health, Portland District Health and Western District Health are all taking part in this**
- ✓ **Carer Support Information**
- ✓ **Pain tools and policies, review of all clinical tools**

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

Required Impacts:	***Actual Impacts:***
Rigorous and ongoing clinical service improvement is undertaken by palliative care consortia and their member services	*The clinical leaders group have developed a work plan for the next year. There will be a review of the work plan items with actions due at each meeting. Part of the work plan involves a review of all clinical indicators before the end of the 14/15 financial year. At each meeting consideration is given to issues that have come up at the last PCCN meeting. As indicated earlier a new regional PCCN representative will be selected at the October Consortium meeting. Any significant issues and the associated recommendations are taken to the next consortium meeting for discussion. The palliative care practitioner's group aims are to disseminate information on issues relevant to the field including issues from the clinical leaders group. Both Palliative Aged care support nurses report at these meetings and discussion of issues related to PERM software are also on the agenda of each six monthly meeting. These meetings also act as a support mechanism for palliative care staff that are often quite isolated from other palliative care practitioners.*

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

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

Performance measures: Regional workforce training and education initiatives including the registrar and advance trainees in Specialist Palliative Care at Barwon Health. 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 indicated these arrangements should be reviewed annually. It is understood by the Department of Health 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	• *The palliative workforce growing sufficiently to meet demand is an issue that is frequently outside of our control. We have the same ageing issues as the health workforce in general and the specific issues of attracting suitably qualified staff to regional and rural areas.* • *The capacity of the health, community, aged care*

and disability services workforce to care for people with a life-threatening illness has been enhanced through the education provided to residential aged care and residential disability workers specifically (see 3.4 & 3.5) and to health and community more generally.

- *Ongoing support the Palliative Care medical staff member at South West Healthcare was agreed by the staff member and the consortium. Consequently a review was undertaken in August 2014 between Barwon Health and South West Healthcare resulting in consideration of a documented supervision schedule and an education plan for the forthcoming 12 months*
- *The Palliative Care workforce is being considered within the development and framework of the Barwon Health Workforce Strategic Plan with the intention that strategies will be developed overtime to address any capacity issues.*

Strategic Direction 7: Ensuring Support from Communities

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

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

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

Required Impacts:	***Actual Impacts:***
Victorians are better able to support people with life-threatening illness and their carers	• *Work towards the achievement of impact measures for this strategic direction have commenced during 2013/14 and will continue into the future.* • *Discussions have been held with staff from Portland District Health, South West Healthcare and Western District Health Service to establish the activities that already occur on a regular basis in their communities that are connected to palliative care. Significant activities already take place including planning for each annual Palliative Care Awareness Week. Planning is already underway for 2015 activities.* • *All palliative care service providers have teams of trained volunteers who act as ambassadors in the community.* • *Educational strategies have included the significant amount of palliative approach education provided to aged care staff and residential disability staff across the region in the last financial year.* • *Barwon Health undertook a palliative care model of care project during 2014 which involved consultation with key community stakeholders including GP's, consumers and carers. As a result of this consultation the completed model of care report includes specific recommendations regarding increasing community capacity, specific programs for marginalised groups, as well as shared care agreements with specialist*

	services and primary care. The document is aspirational in its intent but it is anticipated that implementation of elements of the model will occur on an incremental basis as resources will allow. • *Barwon Health has convened an End-of-Life-Care Steering Committee with the aim of developing an organisational-wide EOLC Strategy and Framework. As part of this process stakeholder and community awareness and consultation is essential and is planned over the course of the strategy development.*

Other Activities

Motor Neurone Disease (MND) Shared Care Worker

People living with MND in the Barwon South Western Region in Victoria in 2013/14

	Region	Statewide
Patients at the beginning of the period	10	262
No. of patients newly diagnosed	4	52
No. of deaths	4	40
Total patients in the region during 2013/14	28	255

Data courtesy of MND Victoria

The MND Shared Care worker retired from her role on the 13th July 2014, and despite two efforts at advertising and subsequent recruitment, the position remains unfilled. The MND Shared care worker role is a diverse one despite being the equivalent of one day per week. The purpose of the role is to establish and maintain supportive networks, clear communications between service providers and to provide care to improve the pathways to effective palliative care provision for people with MND throughout the Barwon South Western region. A significant part of the role has, as a result, involves engaging with other service providers working with MND clients in the region such as GPs, the Progressive Neurology Clinic, Home Based Rehabilitation Team and Community Nursing. As a condition of receiving funding for this role there is an expectation that the Shared Care Worker will undertake the following:

- Actively provide education about MND and the services offered to palliative care staff and people with MND
- Support other palliative care workers and community providers within our region to provide best practice care for a client with MND
- Promote the need for early referral to palliative care
- Be an integral part of the palliative care team at Barwon Health
- Liaise with the Barwon South Western MND Victoria Regional Advisor where necessary to address individual client needs and community education
- Continue to provide quarterly reports to MND Victoria
- Attend MND Shared care worker meetings on a regular basis and
- Attend the biannual MND National Conference.

Author:
Jacqui White, Community Palliative Care Coordinator

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

The 2013/14 workshop was held in Geelong in March 2014 titled 'Updating Skills in a Palliative Approach'. The workshop was presented by Professor Fran McInerney, Cathy Donahue and Nurse practitioner Regina Kendall. There were 120 attendees, the majority of those attending had a background in residential aged care, others were from the residential disability sector and community aged care. The feedback from the session was excellent:

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

Sub-Regional Palliative Care Consultancy

In the Barwon South Western Region the rural medical purchasing fund has been used to enhance palliative medical support to the South West and Colac areas of the sub-regional Palliative Care Consultancy teams.

Palliative Care Nurse Practitioner Candidate

My main focus of my nurse practitioner candidature has been to improve the quality of life with patient's life limiting illnesses with a focus on the symptom management of breathlessness and cancer cachexia. I am one of the team members in the multidisciplinary clinics and continue to develop and extend my advanced practice role.

Breathlessness/Dyspnoea Clinic:
Dyspnoea is described as 'distressful subjective sensations of uncomfortable breathing that may be caused by many disorders' (Mosby's Medical dictionary) other definitions are uncomfortable sensation, shortness of breath. Dyspnoea is the patient's interpretation of their difficulty in breathing. Breathlessness is frequently associated with anxiety which may not always be related to the underlying disease severity. It may be influenced by physiological, psychological and environmental factors, and it is these factors that the Breathlessness Clinic will focus on.
The Breathlessness clinic has now been operating for 9 months now since completing the pilot in January 2014. The majority of patients have chronic respiratory and cardiac failure and are deteriorating in their condition, however not requiring our specialist Community Palliative Care (CPC) team at present. The aim of the clinic is improving the quality of life and managing the symptom of breathlessness to enable them to stay at home by developing a breathlessness action plan, stress management and coping strategies to try and avoid hospital admissions and emergency department reviews. Another focus is towards goal setting and introducing palliative care and Advanced Care Plans (ACP). The clinic has just introduced Telehealth for patients that are too breathless to leave the house; we aim to increase this service in particular with patients in the Bellarine and the Colac region.

Cachexia Clinic:
My other main focus will be on symptom management of patients with cancer cachexia (anorexia and loss of weight with cancer). Cachexia is a very common syndrome affecting over 80% of patients with advanced cancer. The cachexia clinic aims to maximise function and quality of life in patients with advanced cancer through a Medical review and examination; Dietician review for nutritional assessment and advice; Physiotherapy review for strength training and exercise.
I am already involved with the cachexia clinic and see patients in the clinic as well as follow them up at home in the community, which gives them continuity of care. Focusing on cachexia education will be part of my focus towards my scope of practice as a Nurse Practitioner. Currently we see a lot of patients with advanced cachexia and our clinic will in the future aim to provide education so that patients with early or pre-cachexia would be referred at diagnosis. There is also evidence that patients with non-malignant cachexia such as cardiac cachexia would also benefit from this clinic and I would also like to extend this clinic to include this cohort of patients.

Other Activities:
Attended:

- Nurse Practitioner Forum at VPNPC quarterly
- Deakin University Master Class for NPC
- VPMTP/VPCNPC leadership workshop

Ongoing education/Supervision:

- Monthly leader mentorship with Director of Aged Care
- Weekly supervision with Regional Director Palliative Care at Cachexia clinic

- Bi annual reviews by Chief Nursing and Midwifery Officer
- Fortnightly radiology reviews
- Monthly journal club and registrar training

Education:

- Continuing education in the Community Nurse teams, HARP and HBR
- Completed Cachexia and breathlessness clinic brochure's,
- Completed patient information and medication advice sheets
- Completed breathlessness clinic Action Plan for patients
- Completed Prompt document for Opioid conversion

Deakin University Study:

- Currently: Completed 8 units towards my Masters Nursing Practice Nurse Practitioner
- Will have completed 10 by the end of 2014, with 2 units to be completed by 2015

Author: Meg Harrison, Nurse Practitioner Candidate

Aboriginal Palliative Care

The Consortium Manager in the Barwon South Western Region was a member of the Victorian Aboriginal Palliative Care Advisory Group which has now been disbanded. There was a message stick presentation to each region by VACCHO in Mooroolbark on 25th July 2013 with the aim of facilitating communication in each region between ACCHO staff and the consortium. The Palliative Care personnel at South West Healthcare, Western District Health Service, Portland District Health and Barwon Health have undergone Aboriginal Cultural Awareness training. This training will be offered again in the 2014/15 financial year and services will be encouraged to ensure that all staff has attended this training. Services have also been encouraged to have palliative care staff meet with Aboriginal Liaison Officers to improve relationships and help facilitate an understanding of palliative care and an understanding of the issues of Aboriginal people.

Appendix 1: BSWRPCC Financial Statement 2013/14

Barwon South Western Region Palliative Care Consortium	Full year
Funding	
Nurse Practitioner Grant	80,000
MND Shared worker	18,000
PEPA funding	34400
Link Nurse	50,693
Disability Support Funds	12,500
After Hours Service	150,000
Rural Medical Purchasing Fund	34,283
BSW Consortium funding + indexation	123,777
Total Revenue	503,653
Operating Labour Costs:	
Palliative/Aged Care Support (Link) nurse	50693
Disability Support worker	12500
BSW Consortia Manager: including on costs	100,630
Total Operating Labour Costs	163,823
Operating Non labour costs	
Bellarine Community Health - After hours	16515
After hours provision	91,100
Rural Medical purchasing costs	34,283
Barwon Health Nurse Practitioner Candidate	80,000
Conferences & Meetings (including flights & accommodation)	14,164
Computer equipment	10,000
Training Costs	9,115
MND Shared care worker	18,000
Admin costs (including MV. Telephone etc.)	38,565
Costs still to pay	
Website upgrade & fees	5,632
Palliative Approach extension costs	7,000
14/15 post PEPA education costs	14,000
Total Operating Non Labour costs	338,374
Total Costs	502,197
Net surplus/*deficit*	1,456

Appendix 2: Future Directions - Strategic/Operational Plan for 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 L Kelly	SWH & BH to report through Consortium Manager at meeting	Ongoing
	3.2 The palliative care sector develops consistent and clear information for health, community and aged care providers about when and how to refer clients to palliative care; information for GP's will be developed as a priority	Health, community and aged care providers/networks are linked with the palliative care consortium. A regional Palliative Care Forum will be held in November 2014. All health, community, aged care, Medicare locals will be invited.	All consortium members Consortium Manager	Report in Annual Report Report in Annual report	Ongoing
	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 L Kelly	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.			Achieved 2011

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

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	Dec 2014	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 statewide 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. Statewide 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	In progress	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 3: Barwon South Western Region Palliative Care Consortium Aged Care Action Plan 2013/14

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, in 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 2013/14

- 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 10/7/13

Appendix 4: Barwon South Western Region Palliative Care Consortium 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 5: Acronyms

ABF	Activity Based Funding
ACAS	Aged Care Assessment Service
ACHS	Australian Council on Healthcare Standards
BH	Barwon Health
BCH	Bellarine Community Health
BSWRPCC	Barwon South Western Region Palliative Care Consortium
CSNAT	Carer Support Needs Assessment Tool
EFT	Effective Full Time
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