Barwon South Western Region Palliative Care

BARWON SOUTH WESTERN REGION

PALLIATIVE CARE CONSORTIUM

ANNUAL REPORT

2015 - 2016

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

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This annual report was prepared by: Heather Robinson and Myra McRae
On behalf of: Barwon South Western Region Palliative Care Consortium
Telephone: 03 42155661
Email: myra.mcrae@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 and led to the development and release of the Department of Health, Strengthening palliative care: Policy and strategic directions 2011-2015 in August 2011. This policy continues until the release of the End of Life Care Framework in 2016.

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.

Barwon South Western Region Palliative Care Consortium Impact Reporting Template for 2015/16 as requested by the Department of Health & Human Services can be found on *appendix 2*

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 Queenscliff, 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 2015 was 380,470. 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 30/6/2014	% Increase/Decrease from 30/6/2014
Greater Geelong	229,420	+4494	+1.95%
Surf Coast	28,941	+460	+1.58%
Queenscliff	3,017	-10	-0.03%
Colac-Otway	20,255	+1754	+7.88%
Corangamite	15,671	-325	-0.02%
Moyne	16,229	-105	-0.06%
Warrnambool	32,028	-1023	-0.003%
Southern Grampians	15,751	-168	-0.01%
Glenelg	19,158	-199	-0.01%

Figure 1: Data from profile.id.com.au

Geography

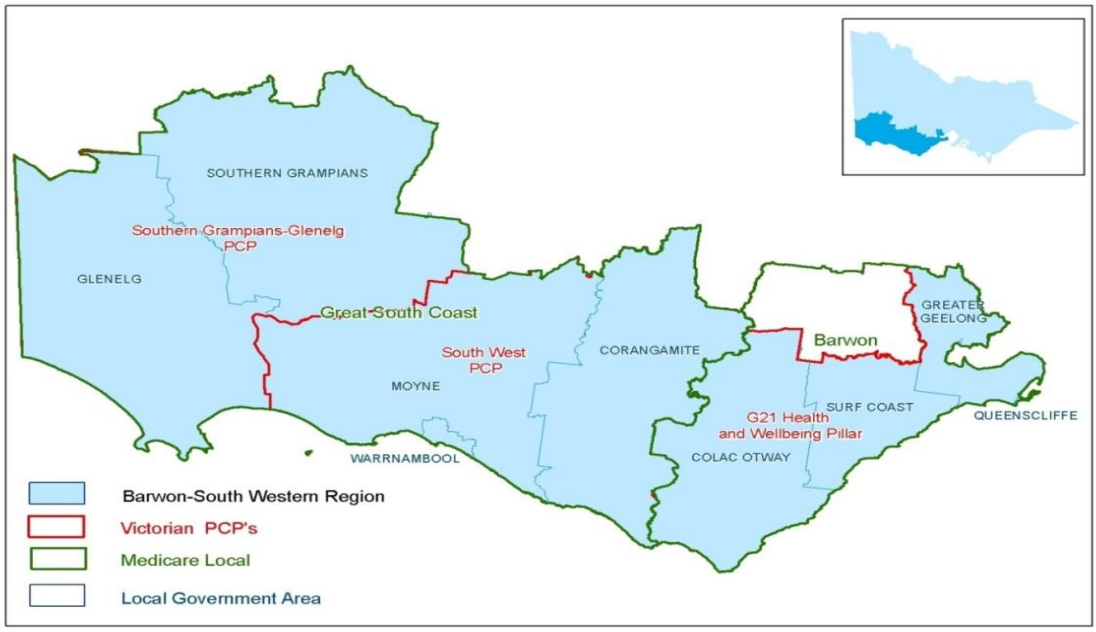

Figure 2: Map of Barwon-South Western region and administrative areas, Department of Health

BSWRPCC

Organisational Chart

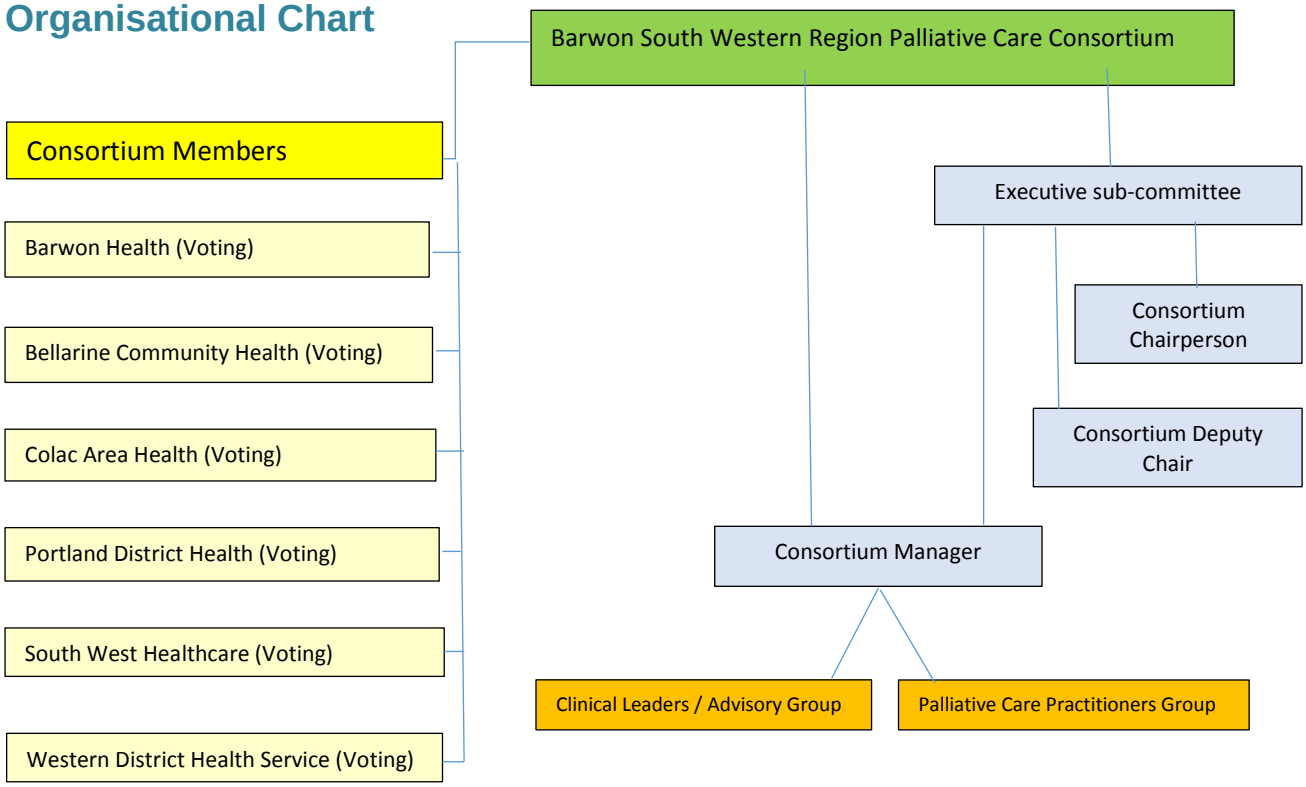

Figure 3: Barwon South Western Region Palliative Care Consortium Organisational Chart (Reviewed July 2015

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 one thousand and ninety (1090) referrals during 2015/16.

CONSORTIUM CHAIR'S REPORT

Consortium Chair Report 2015-16

This is my fourth and final report as chair of the consortium as I will be leaving for pastures new at the end of August 2016. This role has been extremely rewarding as I watch and participate in continued improvements to the palliative care provision across the region.

2015-16 has seen a further year of consolidation of activities for the consortium. In particular the highlights for the year include:

- increased after hours support in the region with the completion of Bellarine Community Health in joining the other consortium services in utilising the regional after hours service provided by Caritas Christi
- a successful partnership between Barwon Health and Multi-Cultural Aged Care Services (MAC's) to provide care in the home by palliative care trained staff by patients and carers who require additional respite support at home
- almost 45% of palliative care patients dying in their preferred place of choice
- regional PEPA education attracting 695 attendees to relevant palliative approach events
- continued improvements to the regional Palliative Electronic Record Management (PERM) system and consequently improvements to reporting of activity data incrementally as a result.

There were a few initiatives that we set out to achieve but for a variety of reasons they did not occur, however further work will continue in 2016-17 to progress them. These are:

- the ability to be able to externally benchmark our data via the Palliative Care Outcomes Collaborative (PCOC)
- an increase in new acute palliative care beds at the University Hospital Geelong.

As I write this report the Victorian End of Life and Palliative Care Framework has been released. This document provides structure, focus and, no doubt, challenges for the palliative care services within the region but it also heralds an exciting time of innovative and forward thinking strategies. I wish the consortium well in this new era and know that the services and people within it are as committed as always to ensuring that all patients and families receive the best possible end of life care and are genuinely able to make choices about the care they receive as they approach that stage in their lives.

Finally, as always, I would like to thank Heather Robinson, Consortium Manager, for her support to the consortium and its members during 2015-16. Heather retired in July 2016 and we wish her well. I would also like to thank Myra McRae, who stepped into the breach as Acting Consortium Manager, and who has worked hard to complete this report in Heather's absence.

Julie Jones,
Consortium Chair

BSWRPC Regional Palliative Care data 2015/16

	BCH	BH	CAH	PDH	SWH	WDHS
Total Accepted Referrals	122	644	67	39	128	53
Total Patient Episodes	Not avail	8675	786	998	1936	786
Total Episodes Ended	101	403	58	28	44	28
Total Contacts	2327	16,871	1326	3418	3694	2159

Strategic Direction 1: Informing and involving client s 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. A patient care plan is developed for Bellarine Community Health clients at assessments which is also shared with the client's GP. Agreements are in place for Bellarine Community Health to move to use of the PERM software with all embedded care plans and agreed tools at the conclusion of a service wide Information Technology review. This is expected to occur within the 2016/17 financial year.

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 reflect 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 care plans within the region is 100% of all clients. These are a mix of 83% electronic and 17% paper care plans covering all clients. All care plans are provided to the client's GP and other care providers as required, these impacts are virtually unchanged from 2014/15.*

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 were 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. During 2015/16 Care Needs Identification was introduced across the region with all specialist palliative care services using the CSNAT tool to assess Carer Needs, it has been decided to continue the use of this tool.
Barwon Health have maintained an in-home respite program in conjunction with Multi-cultural Aged Care Services that makes available palliative care trained staff to provide care in the home when there is a high need. South West Healthcare have maintained their respite in the home service.

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 2015/16 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 significant change to these impacts from 2014/15.*

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 in five palliative care services across the Barwon South Western region in 2012/13; In the 2015/16 financial year the sixth service, Bellarine Community Health Ltd (BCH) joined the Barwon South Western Region Palliative Care After-hours triage program, commencing in February 2015. The result of this is that all community palliative care patients and carers in the Barwon South Western Region now have access to specialist palliative care telephone triage advice and support after-hours.

All specialist palliative care services 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 not available across the whole 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 2015/16 Barwon Health, Colac Area Health, Portland District Health, South West Healthcare and Western District Health Service have all continued to use the PERM clinical palliative care software. During 2015 discussions were held between Barwon Health, Bellarine Community Health and St Vincent's/Caritas Christi to establish the guidelines for BCH to join the after-hours triage program. This has been successfully achieved and staff, patients and carers at BCH have been satisfied with the service. The St Vincent's / Caritas Christi After-hours triage contract was renewed in 2015 for a further three years (2015/18) and now includes Bellarine Community Health Ltd.

The process for the after-hours service is that clients telephone their local service number; they are then connected to the call centre of the paging service, which answers with a specific script and asks some predetermined questions. St Vincent's/Caritas Christi is then paged the information which allows them to have the patients information ready when they ring the client back. St Vincent's/Caritas Christi have access to the live PERM patient data or paper based patient report for BCH which can then be used 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. For BCH clients triage staff send a report each morning listing all clients who have called and the call content.

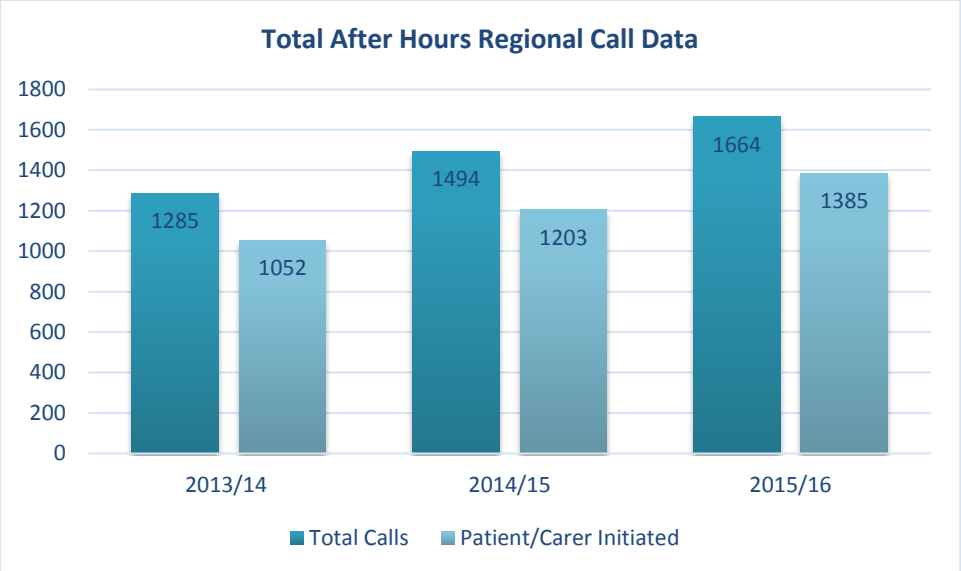

Figure 4: The impact for Strategic Direction 2.5 is an increase in the total number of after-hours calls and the total number of patient/carer initiated calls which are demonstrated by figure 4.

Total Regional After-hours Home Visits

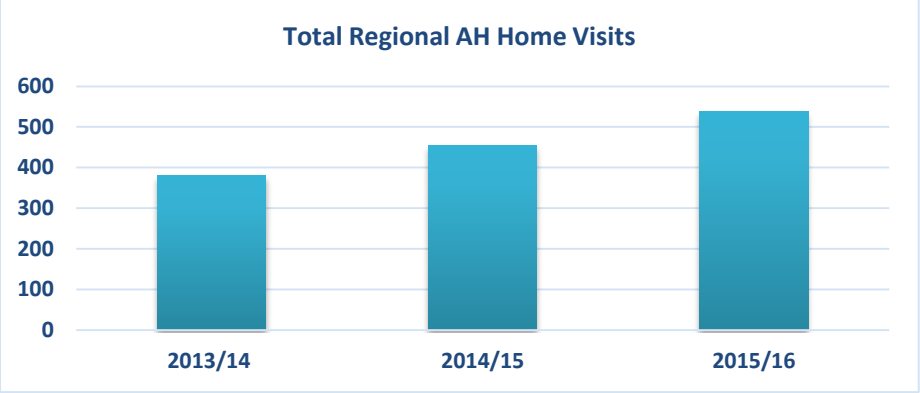

Figure 5: The impact for Strategic Direction 2.5 is an increase in the number of after-hours home visits, this is demonstrated by the graph above.

Call Reason

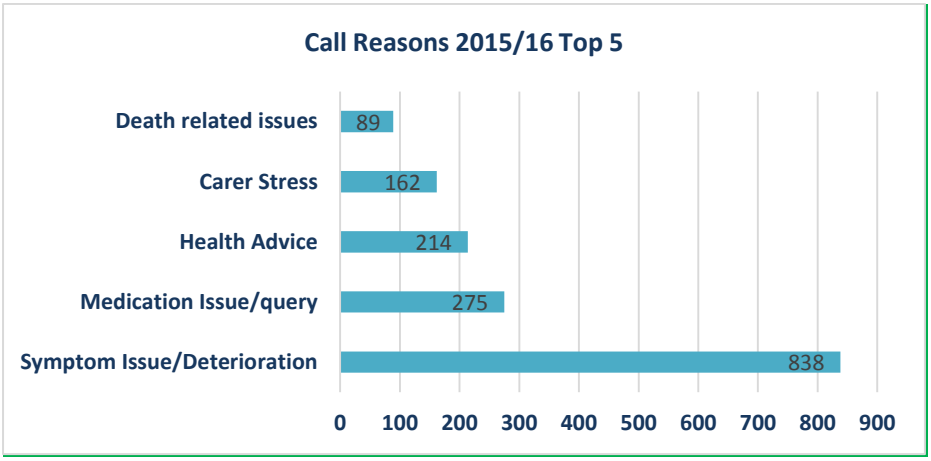

Figure 6: As can be seen by the graph above by far the most common call reason for 2015/16 is symptom issues/deterioration which is consistent with the increased complexity of community palliative care clients.

Call Outcome

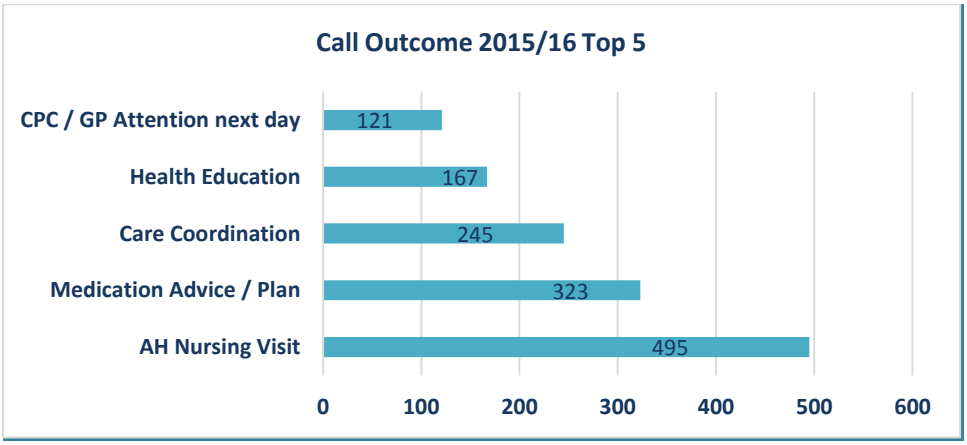

Figure 7: As can be seen by the graph above by far the most common call outcome for 2015/16 was an after-hours nursing visit and as for call reason medication advice and planning is also a significant issue.

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 2015/16. Total After-hours calls increased from 1494 (2014/15) to 1664 in 2015/16. Total After-hours visits in 2014/15 were 455 and visits increased to 537 in 2015/16.* *Call Reason indicates the significant role that symptom issues and medication issues play for patients/carers. Increasingly we are seeing increases in the need for health/care advice, reported carer stress and death related issues.* *Call Outcome indicates the actual outcome of the call. Apart from after-hours nursing visits, medication advice and plan consistently is a factor as is care coordination, health education and the flagging of the need for CPC/GP attention the next day. See figures 4, 5, 6 & 7.* *Some additional 2015/16 call outcome data fields that are now being collect include advised to call an ambulance (70) and advised to present to emergency department (37). These are trends that will be monitored into the future.*

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 BRACAS. 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 we now have access to a specific report which records this information, see below. In future years it is expected that the percentage of patients dying in their place of choice will continue to increase. The report below enables services to educate their palliative care staff regarding the need to update preferred place of Death and Preferred Site of Care as these change during the patient journey.

Service Providers	% Patients Died in Preferred Place of Choice	Total Deaths 2015/16	Deaths at home or RACF
Bellarine Community Health	48.5%	101	49
Barwon Health	41.4%	399	173
Colac Area Health	46.7%	45	14
Portland District Health	60%	25	10
South West Healthcare	41.4%	99	30
Western District Health Service	31.4%	51	29

Figure 8: Actual Place of Death versus Recorded Preferred Place of Death

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 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 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 thus increasing the likelihood that people will die in their place of choice* • *The work of the acute Palliative Care Consultancy Team in Barwon Health, University Hospital Geelong increases the knowledge of hospital 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 and personal care services, respite services and volunteers support all contribute to clients being more likely to be cared for and/or to die in their place of choice* • *Evaluations are conducted after all education, see results of education in sections 3.4 and 3.6* • *See table 8 above regarding proportion of palliative care patients dying at home.*

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. Aged and Disability Support workers in the Barwon and South West sub-regions 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.

Barwon sub-regional workshop attendance during 2015/16:

Registered nurses/Endorsed Enrolled nurses/Enrolled nurses	13 workshops	129 attendees
Personal care workers, Disability services	2 workshops	28 attendees
Registered Nurses and Medical staff, workshops by C Murtagh	4 workshops	130 attendees
PEPA sponsored workshops: 1 x general, 1 x disability, 1 x aged care, 1 x GP		109 attendees
Residential Aged Care Facilities education	17 in-services	184 attendees

PEPA education was held in the region in March (General session), May (Disability session), GP session in May and in June (Aged care session). All were well attended and evaluations.

South Western sub-regional workshop attendance during 2015/16:

Registered nurses/ Endorsed Enrolled nurses/Enrolled nurses	8 workshops	23 attendees
Personal care workers and Disability services	8 workshops	26 attendees
Residential Aged Care Facilities education	11 in-services	66 attendees

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. There continues to be a high level of stability amongst the medical community and specialist community 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. So as previously discussed the work of the Aged and Disability Support workers ensure that referral processes and eligibility for palliative care services are well known across the region.*

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 the services 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 been tailored to the specific needs of these services. 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)

- Currently working on an Ethics submission and documentation to support it. Once the submission is approved another meeting will be held to discuss the next step in the project.

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 *Appendix 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 December 2015 (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 693 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 since March 2012 by the palliative aged care support nurses in this region.*

- Education of link nurses in a palliative approach has continued across region
- A Palliative Approach education program was developed for aged care personal care workers residential / community.
- 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.

Main Role of Education attendees		**% of total attendees**
Registered Nurses, Endorsed Enrolled Nurses, Enrolled Nurses	152	21.87
Personal Care Workers & Disability Service Workers	54	7.78
PEPA sponsored workshops x 2, RN's, EEN's, EN,s PCW's & Disability workers	109	15.68
Medical Education (Palliative Care Fellow) RN's, Medical Staff	130	18.70
In services at Residential Aged Care Facilities (38 facilities)	250	35.97
Totals	695	100%

Barwon South Western Region Palliative Care Education evaluations for 2015/16:

Evaluation Questions	Agree	Strongly agree	Neither Agree or Disagree
The workshop increased my understanding of the benefits of implementing a palliative approach utilising the palliative approach toolkit	26%	74%	0
I feel more confident in my knowledge of the non-pharmacological management of the five clinical care domains in the palliative approach toolkit.	40%	60%	0
The workshop increased my knowledge and awareness of the different anti-emetic medications used to treat the different causes of nausea.	26%	74%	0

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 2015/16 95% died in their place of choice, aged care facility.

End-of-life pathways were utilised in 16.66% of aged care facilities in the South Western sub-region.

Barwon sub-region:

Barwon Health Residential Aged Care data indicates that of 107 permanent Barwon Health aged care residents (non respite) during 2015/16, 96.27% 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 48.71% of aged care facilities in the Barwon sub-region.

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/or 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. 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.

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 2015/16 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 have 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. In 2016/17 this will include Epworth Hospital in Geelong and Warrnambool.

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 have 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 reduced during the 2015/16 financial year. This has been due to the change of Medicare Locals to Primary Health networks* • *Liaison continues 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* • *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**	**83.33%**
Bellarine Community Health	**Helen Nikolas**	**66.66%**
Colac Area Health	**Bronwyn McPherson**	**66.66%**
Portland District Health	**Fiona Heenan**	**50%**
South West Healthcare (Deputy Chair)	**Julianne Clift**	**100%**
Western District Health Service	**Anne-Maree Simonds**	**50%**

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 Deputy Chairperson.

The consortium worker for the region is:

- Consortium Manager (Heather Robinson for 2015/16)

Performance measures:

A role statement audit carried out in June 2016 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 2015/16 can be found on *Appendix 3.*
- A consortium financial report can be found on *Appendix 1.*
- A Quality Risk and Assessment Plan can be found on *Appendix 5.*

Consortium member accreditation status is as follows:

Organisation	Accreditation	Organisation	Participate in NSAP
Barwon Health	Yes	SIA Global	Yes
Bellarine Community Health	Yes	QIC/NHQHS	Yes
Colac Area Health	Yes	ACHS	Yes
Portland District Health	Yes	ACHS	Yes
South West Healthcare	Yes	ACHS	Yes
Western District Health Service	Yes	NHQHS	Yes

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 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), elected June 2016.*

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 was 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 with the exception of Bellarine Community Health.* • *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 integration, 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:

***Clinical tools implemented at the service and regional level*:** Refer to *Appendices 5.4 – 6.1.5* 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 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 based at Barwon Health. This representative attends BSWRPC Clinical Leaders Group meetings and reports on the activities of the PCCN.* *During 2015/16 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 ongoing implementation of the Bereavement Framework and a regular review of the ongoing validity of the evidence based clinical tools used by palliative care services across the region and the PCCN issues are 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, terms of reference, membership, meeting format and frequency were reviewed in 2015. 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 Palliative Care Policy until a new policy is released 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 any specific issues from 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 have been reviewed, all clinical tools have been reviewed, End of Life Pathways are awaiting decisions at a more international level and preparation for PCOC data extraction has occurred. It is expected that those services with sufficient clients for PCOC will be reporting from 2016/17 onwards.*

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, palliative care medical services are also provided to Colac Area Health and Bellarine Community Health. 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. 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 on an adhoc basis 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 in May 2016. This palliative care awareness raising involved Barwon Health, Colac Area Health in a range of activities., Portland District Health held an afternoon tea for palliative care carers and families, South West Healthcare (SWH) involved local primary schools in palliative care education and then they made butterflies representing patients, carers and families who had experienced a loss. There was a fantastic butterfly display at SWH and good media coverage.* • *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 informed about Palliative Care services 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 awareness and education. It is intended that the strategy will be implemented over the next five years.*

Appendix 1: BSWRPCC Financial Statement 2015/16

Barwon South Western Region Palliative Care Consortium	Full year
Funding	
PEPA funding	10,455
BSW Consortium funding + indexation	125,084
Total Revenue	135,539
Operating Labour Costs:	
BSW Consortia Manager: including on costs	98,895
Total Operating Labour Costs	98,895
Operating Non labour costs	
Conferences & Meetings (including flights & accommodation)	10,087
Training Costs	2,112
Admin costs (including MV. Telephone etc.)	12,282
Corporate Overhead	9,271
Total Operating Non Labour costs	33,751
Total Costs	132,647
Net surplus/*deficit*	*2,892*

Appendix 2: BSWRPCC Impact Reporting Template 2015-16

Strengthening palliative care: Policy and strategic directions 2011-2015 – impact 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 Ongoing Completed Ongoing Completed Ongoing	In 2015/16 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 2014/15.	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 2015/16. After-hours calls increased from 1494 (14/15) to 1664 in 2015/16. After-hours visits In 2014/15 were 455 and AH visits increased to 537 in 2015/16. 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:	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	Health, community and aged care providers/networks linked with palliative care consortia	Completed Ongoing	All Palliative Care services across the region operate an appropriate triage system in order that patients are seen in a timely manner and any potential delays are minimised.	2012/13
	Information and referral processes promoted by the palliative care sector are consistent with referral and coordination strategies across health, community and aged care providers	Develop links with Medicare Locals, now Replaced by Primary Health Network Western Region.		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.	

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 developed and implemented. Refer page 47, appendix 4.	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 In Progress Continuing	End-of-life pathways were utilised in 65.37% 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 importance of this at all education. 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 2015/16, 96% died in their place of choice, aged care facility with the remainder dying in University Hospital Geelong (acute).	

Not commenced	In progress	Completed

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	No longer relevant	Completed Completed	There is no change in the impacts from 2015/16 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 the Western Primary Health Network	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 reduced slightly during 2015/16 The key driver of this increase have been the merging of Medicare locals into the Primary Health Network. Liaison with residential aged care facilities, residential disability services, and community aged care service providers continue. 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. 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.	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

			Completed Ongoing		
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		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 2015/16. Procedures are in place for orientation of new consortium members. A quality and risk management framework has been developed for the consortium, see pages 48-49, 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), elected in June 2016.	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 based at Barwon Health. This representative attends BSWRPC Clinical Leaders Group meetings and reports on the activities of the PCCN. During 2015/16 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 ready for the next scheduled extraction.	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 in May 2016. This palliative care awareness raising involved Barwon Health, Colac Area Health in a range of activities., Portland District Health held an afternoon tea for palliative care carers and families, South West Healthcare (SWH) involved local primary schools in palliative care education and then they made butterflies representing patients, carers and families who had experienced a loss. There was a fantastic butterfly display at SWH and good media coverage. 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 2015/16

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 June 2016	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

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	Not relevant

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 Western Region Primary Health Network.	Consortium & Consortium Manager	Report at BSWPCC meeting	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 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, see page 22.	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 2015/16

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 2015/16

- 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 if there is sufficient funding.
- Focus on ongoing Individual facility education based on specific patient issues or family issues
- Provide PEPA Palliative Approach education as funding becomes available.

Reviewed by BSWRPCC, June 2016

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 was reviewed by Consortium in 2015	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