loddon mallee
regional palliative care consortium

Annual Report 2014 / 15

Enhancing life and quality of health

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Loddon Mallee Regional Palliative Care Consortium (LMRPCC)

Vision

Working collaboratively with stakeholders and the community, so that people in the Loddon Mallee Region with a progressive life-limiting illness and their families/carers, have access to high quality, innovative, responsive and coordinated services.

Our role

Our role is to help deliver and facilitate the Victorian Government's *Strengthening palliative care: Policy and strategic directions 2011-2015*[1], and the relevant *Implementation Strategy2* across the Loddon Mallee region.

Our values

- Open, respectful and transparent communication.
- Commitment to consumer, carer & stakeholder participation.
- Collaborative planning underpinned by a social model of health.
- Evidence based quality care.

Strategic Directions[3]	*Strengthening palliative care: Policy and strategic directions 2011-2015*
1. Coordinating Quality Care Across Settings	1. Informing and involving clients and carers 3. Working together to ensure that people die in their place of choice 4. Providing specialist care when and where it is needed 5. Coordinating care across settings 6. Providing quality care supported by evidence
2. Building capacity in the palliative care workforce	4. Providing specialist care when and where it is needed 5. Coordinating care across settings
3. Delivering targeted health promotions	1. Informing and involving clients and carers 2. Caring for carers 3. Working together to ensure that people die in their place of choice 5. Coordinating care across settings7. Ensuring support from communities
4. Building and maintaining a sustainable Consortium	5. Coordinating care across settings

1 Herewith referred to as the state policy. ,

2 Available at http://docs.health.vic.gov.au/docs/doc/Strengthening-palliative-care-implementation-strategy

[3] Complete Loddon Mallee Regional Palliative Care Consortium Strategic Plan 2012-15 Appendix 1

Messages

Consortium Chair – Ms Kathy Wright

2014-15 was a busy and successful year for the Loddon Mallee Consortium. Service capacity increased across our services supported by small grants made available from the Consortium Budget.

Board Members signed a new Memorandum of Understanding for the period 2015-18 and this will enable us to continue to work together across the Loddon Mallee Region supporting our residents to die in their place of choice.

The Board also voted to move the Consortium Secretariat from Castlemaine Health to Bendigo Health (commencing 1 July 2015) and I would like to take this opportunity to acknowledge Castlemaine Health for all of its support to the Consortium over the preceding years.

As a region we also came to a consensus to fund a Service Improvement Officer role, to be based out of the Consortium Secretariat to provide technical support to each member in designated priority areas. This role commenced on 1 July 2015.

We also welcomed several new Board Members during this period: Ms Chloe Keogh representing unfunded services, Ms Debbie Gervasoni representing Maryborough District Health Services and also Ms Karen Laing representing Kyneton. I would like to thank the previous members for all of their support to Palliative Care in the Loddon Mallee.

In December 2015 our Consortium Manager Ms Ilana Solo left us to take a position with the Loddon Mallee Integrated Cancer Services. The Board and all Palliative Care Services join me in thanking Ilana for her dedicated service to our region over the last 3 years.

We recruited a new Consortium Manager, Susan Morgan, who has a radiotherapy background and significant project management experience, which will ensure the Consortium is well positioned to progress evidence based palliative care for the region.

I would like to briefly highlight the upgrade of the Carers Kit, a truly innovative tool which aims to support Carers in a very practical sense. The Kit has been distributed across the region and to several other areas in the State. During this financial year the Board has agreed to now develop a Carers Kit App and we anticipate testing in late 2015.

We are also proud of the work done to progress Aboriginal Palliative Care in our region. During 2014-15 the Consortium has been supporting 3 key projects and will continue to support partnerships between our mainstream services and our local ACCHOs.

Finally, as the existing state wide palliative care policy comes to an end the LMRPCC Board looks forward to informing the next steps for Palliative Care in our region and in Victoria.

Kathy Wright
Consortium Chair
Executive Officer Clinical services
Swan Hill District Health

Consortium Manager

As the current state wide palliative care policy comes to an end, the Consortium Secretariat team would like to acknowledge the specialist community palliative care services across the Loddon Mallee for their hard work and commitment to enabling people to die in their place of choice

Our region is vast and we need to be creative in terms of service provision to people from more rural and remote locations. Our use of technology is increasing, as well as development of tools and resources to share across the region.

This year we have supported 3 projects to strengthen culturally appropriate palliative care for our Aboriginal populations. The Consortium has also been cooperating effectively with our regional Consultancy and together we are tackling specialist service provision and capacity building. We are also investing in supportive tools and networks for our Carers and also building capacity in our communities to support people dying at home.

The Consortium team and our members look forward to working with colleagues across the state to further strengthen palliative care services by articulating further with health and community partners.

Susan Morgan
Consortium Manager

Members of the Bendigo Palliative Care Auxiliary

Overview

The Consortium continued to increase the accessibility, efficiency and effectiveness of palliative care received by patients and carers across the Loddon Mallee Region. It achieved this by supporting specialist palliative care services to implement a range of targeted and appropriate quality initiatives and working outside the sector to build understanding, linkages and processes. Highlighted achievements include:

Aboriginal Palliative Care: Two projects supporting the improvement of Aboriginal Palliative Care in the Echuca region are currently underway: "Providing Culturally Safe and appropriate Palliative Care to Aboriginal Aged Care Residents in Echuca"; and "To enhance the palliative care experience of the Aboriginal People who live in Glanville Village Residential Aged Care Facility (RACF), providing culturally safe and appropriate care for residents with a life limiting condition. To also capture learnings that can be disseminated to the sector".

Another Aboriginal Palliative Care project is underway in Mallee District Aboriginal Service Region (Mildura): To conduct a literature review re advanced care plans, engage the community, undertake service mapping exercises to establish an optimized palliative care service plan for the Mallee region and build capacity across relevant workforces.

In **recognition of the importance Carer's** in enabling people to die in their place of choice, the Consortium has undertaken several significant activities to support Carers in our region: we have redesigned the Carers Kit and made it available to each of our services as well as on the website. Several other Victorian regions have requested access to the Kit. We have also commenced the development of a Carer's Kit App for mobile devices and this will begin beta testing late September 2015. We have also entered in to a partnership with Carer Support Services to undertake a scoping project to design a Loddon Mallee Palliative Care Carers Support Network.

2014-15 also saw a renewed focus on **data management** in the Loddon Mallee. PCOC audits were conducted in Kyneton and Maryborough areas and significant improvement in accuracy was determined in both services. After Hours Call data was also automated at Bendigo Health.

An application was made to the Australian Bureau of Statistics for access to 3 years of death data for Victoria and New South Wales and work has commenced on developing a death profile for the Loddon Mallee service providers. This will enable us to recognise areas requiring priority action (e.g burden of non-malignant palliative care deaths, and/or burden of Aboriginal deaths that could benefit from appropriate palliative care). This regional profile will be ready October 2015. It is anticipated that next steps will be service planning and a workforce planning profile for the region. LMRPCC is also providing profile reports for each of the other Consortiums (state wide), the local Primary Health Network and the Loddon Mallee Integrated Cancer Services (LMICS)

Service Improvement Grants (Small Grants) were issued to members during 2014-15 to the total value of $77, 965 (see Appendix 3). These grants were utilised to improve local capacity and spanned activities such as: developing palliative care resources for Motor Neurone Disease, implementation of a Bereavement Programme, NSAP auditing and subsequent improvements and optimisation of service coordination between local service providers.

Service Improvement Officer Role: Members also voted to equitably support the funding of a service improvement role. Board Members voted during 2014-15 for each service to proportionally

fund, based on PCRAM figures, 0.5 EFT of a programme officer to support the services in priority areas for a period of 3 years. The role was advertised and commenced out of the Consortium Secretariat on 1 July 2015. The position description and service agreement are available from the Consortium Secretariat

Latrobe Disability Project – Health Promotion Framework

A total of $11,000 was contracted to Latrobe University Palliative Care Unit (LTUPCU) to deliver a consultancy and research project for the LMRPCC. The aim of the project was to support people living in Loddon Mallee Region disability accommodation services who have a life-threatening illness to receive best practice palliative approach and end of life support and care. The objectives of the LMRPCC Disability Health Promoting Palliative Care (HPPC) Regional Project were to:

1) Develop a regional plan, within a Health Promoting Palliative Care (HPPC) framework, for the LMRPCC Disability Project

2) Support, guide and mentor the palliative care nurses responsible for implementing the disability project in the Loddon Mallee Region

3) Develop and implement a research project that supports the implementation of a Disability HPPC approach in the Loddon Mallee Region.

See Appendix 5 for the **'Health Promoting Palliative Care Framework'**. The complete project report is available from the Consortium Secretariat.

Finally, during 2014-15 the Consortium Members signed a new memorandum of understanding (2015-18) agreeing to cooperate together to strengthen palliative care services in the Loddon Mallee Region. This overarching MoU enabled the Board to agree to move the Consortium Secretariat from Castlemaine Health to Bendigo Health on 1 July 2015.

Aged Care

Capacity building activities continued across the region's 64 Aged Care Facilities. In July a video conference program commenced and delivered targeted education around the 'Palliative Approach' Toolkit but also supernumerary topics, including: 'diagnosing dying', 'management of nausea and vomiting' and 'delirium management'. PCA study days were also delivered in Maryborough, Echuca and Bendigo, focussing on the Toolkit and also general palliative care. The Aged and Disability Link Nurse also attended the public sector RAC Manager meeting, as well as the Victorian Palliative Care Aged Care Network Meetings every 2 months.

About Us

The Loddon Mallee Region is one of eight DH regions and it encompasses 26% of Victoria. The population as recorded in 2012 is 308,000 and is predicted to grow by 21.5% by 2031. Approximately half the population are concentrated in Mildura and Bendigo.

The map shows the boundaries of the region and the locations of the 23 health services. All deliver generalist palliative care services and our eight members deliver specialist palliative care services.

The percentage of Aboriginal and Torres Strait Islanders is much higher for Loddon Mallee Region than for Victoria. The highest percentages are in Swan Hill (4.57%), Mildura (3.79%) and Campaspe (2.35%).

The culturally diverse population is well below the Victorian average, with 8.3% born overseas and 4% speaking a language other than English at home. There are significant pockets of ageing diverse communities E.g. ageing Italian and Greek communities in Mildura and Swan Hill.

Compared to the state average of 1.33 GPs per 1,000 populations there are: 0.6 in Loddon and 0.95 and 0.98 in Campaspe and Swan Hill respectively.

Consortium Organisational Structure and Profile

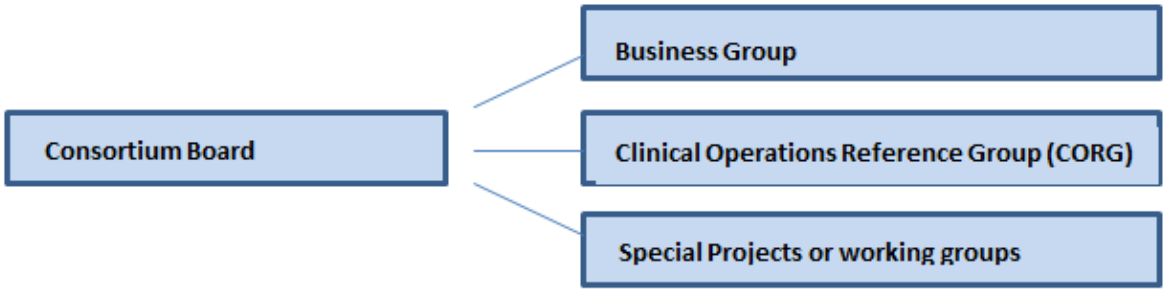
Profile of Consortium members

State wide palliative care consortia have voting members from all funded palliative care services as well as other stakeholders from health and community services.

In 2014-15 the Consortium consisted of the following voting and ex-officio members:

Agency	Service Profile	Staffing (EFT)	Key initiatives
Bendigo Health Care Group	Community Palliative Care Service including Chum House Day Hospice	7.7	PCOC working group Data optimisation
	Specialist Inpatient Palliative Care Service	15.3	PCOC
	Loddon Mallee Regional Consultancy Service (LMRPCCS)	3	Aged Care / Disability Link Telehealth Strengthened outreach
Castlemaine Health	Community Palliative Care Service	1	PCOC After Hours Framework Data optimisation
Echuca Regional Health	Community Palliative Care Service Palliative Care IP Beds	3.7	Bereavement Project Aboriginal Aged Care Care Planning Project
Kyneton District Health Service	Community Palliative Care Service	3.3	MND Service Coordination PCOC
Maryborough District Health Services	Community Palliative Care Service	0.2	Review Palliative Care Assessment Forms Review PCOC data EOL and Advanced Care
Mildura Base Hospital	Palliative Care IP Beds	3.3	Process Improvement Mapping ongoing
Sunraysia Community Health Service	Community Palliative Care Service	3.5	Process Improvement ongoing
	LMRPCCS	1.0	Aged Care Link Nurse Disability Project (c Latrobe)
Swan Hill District Health Service	Community Palliative Care Service	2.0	NSAP

Loddon Mallee Regional Palliative Care Consortium Structure



The Structure is based on template "Role Statements" development and managed by DHHS. The peak governance group for the Consortium is the Board. Its primary responsibilities are to set and monitor the delivery of the Strategic Plan, ensure that the financial affairs of the Consortium are managed, promote and enable the work of the Consortium across the region.

The Board is supported by the Business Group, the Clinical Operations Reference Group (CORG), and special projects or working groups. These groups do not have individual decision making or delegation responsibilities, but make considered recommendations for Board ratification.

Consortium Board

State wide palliative care consortia have voting members from all funded palliative care services as well as other stakeholders from health and community services. In 2014-15 the Consortium consisted of the following voting and ex-officio members:

Organisation	Name	Position
Bendigo Health Care Group	Mr Paul Rumpff	
Castlemaine Health	Ms Amanda Edwards	Deputy Chair
Echuca Regional Health	Ms June Dyson	
Kyneton District Health Service	Ms Karen Laing	
Maryborough District Health Services	Ms Deb Gervasoni	
Mildura Base Hospital	Ms Clare Hammerton	
Sunraysia Community Health Service	Ms Ruth Fox	
Swan Hill District Health Service	Ms Kathy Wright	Chair
Kerang District Health (Small Rural Health Services)	Ms Chloe Keogh	
Ex-Officio		
DHHS – Loddon Mallee	Ms Pamela Oakley	
Consortium Manager	Ilana Solo Susan Morgan	
Consortium Administrator	Bronwen Machin	

Consortium Secretariat

The Consortium Secretariat moved from Castlemaine Health to Bendigo Health on 1 July 2015. The LMRPCC Board would like to take this opportunity to formally thank Castlemaine Health for all of the services provided to the Consortium prior to this date.

Person	Role	Date
Ms Ilana Solo	Consortium Manager	LOA December 2014
Ms Susan Morgan	Consortium Manager	Commenced 23 February 2014
Ms Julie Misson	Project Officer	
Ms Robert Maio	Project Officer	
Ms Bronwen Machin	Admin Officer	

Business Group

The Business Group plays an 'executive' role in the Consortium including oversight of the Consortium Manager, the budget and all financial reports. Business Group membership included the Chair, Deputy Chair, Fund holder representative and one ordinary member.

Organisation	Person	Role
Swan Hill District Health Service	Ms Kathy Wright	Chair
Bendigo Health Care Group	Mr Paul Rumpff	
Castlemaine Health	Ms Amanda Edwards	
Sunraysia Community Health Service	Ms Ruth Fox	

Clinical Operations Reference Group (CORG)

The Clinical Operations Reference Group (CORG) functions as the Consortium's clinical advisory group. CORG overseas the implementation of the *Strengthening Palliative Care: Policy and Strategic Directions 2011-2015* at a clinical level and develops resources and processes.

CORG members include senior staff from the region's funded consultancy, community and in-patient palliative care services and representatives from other stakeholders (including Small Rural Health Services, Aged Care and Private Hospital).

Organisation	Name	Position
Bendigo Health Care Group	Ms Elizabeth Loughnan	
Castlemaine Health	Mr Ian Morelli	
Echuca Regional Health	Ms Denise Gowty Ms Katherine Formica	
Kyneton District Health Service	Ms Alison Lowe	Chair
Maryborough District Health Services	Ms Ann Marie Jones	
Mildura Base Hospital	Ms Kathryn Drysdale	
Sunraysia Community Health Service	Ms Mel Livens	
Swan Hill District Health Service	Ms Catherine Kemp	
Kerang District Health (Small Rural Health Services)	Ms Sue Gray	
Ex-Officio		
Consultancy - Southern	Ms Merrill Cole	
Consultancy - Northern	Ms Lisa O'Connor	
St John of God	Mr Les McLennan	
Consortium Manager	Ilana Solo Susan Morgan	
Consortium Project Officers	Robert Maio Julie Misson	
Consortium Administrator	Bronwen Machin	

Meeting Log

Present in Person or via Electronic Link (P), Apology (A)

Board	Aug 14	Oct	Dec	Feb	April	Jun 15	%
Bendigo Health	P	P	P	P	P	P	100
Castlemaine Health	A	A	P	A	A	P	33
Echuca Regional Health	P	P	P	P	P	P	100
Kyneton District Health	P	P	P	P	P	A	83
Maryborough District Health	P	A	A	A	A	P	33
Mildura Base Hospital	P	P	A	A	P	A	50
Sunraysia Community Health	P	A	A	P	P	P	66
Swan Hill District Health	P	P	P	P	P	P	100
Small rural health services	A	A	A	A	A	P	17
Average attendance rate							63
Ex-Officio Representatives							
CEO Representative	A	A	A	A	A	A	0
DH	P	P	P	P	P	P	100
Consortium Manager	P	P	P	P	P	P	100
Consortium Administrator	P	P	P	P	P	P	100

Present in Person or via Electronic Link (P), Apology (A)

CORG	Jul 14	Sep	Nov	Feb	Mar	May 15	%
Bendigo Health	P	P	P	P	P	P	100
Castlemaine Health	P	P	P	P	P	P	100
Echuca Regional Health	P	A	A	P	P	P	66
Kyneton District Health	P	P	P	P	P	P	100
Maryborough District Health	P	P	A	A	A	P	50
Mildura Base Hospital	P	A	A	A	P	P	50
Sunraysia Community Health	P	A	A	A	P	P	50
Swan Hill District Health	A	P	A	P	P	P	66
Average attendance rate							70
Ex officio representatives							
Consortium Admin Assistant	A	P	P	P	P	P	83
Consortium Manager	P	P	P	P	P	P	100
BUPA	A	A	A	A	A	A	0
Bendigo District Aboriginal Cooperative	A	A	A	A	A	A	0
St John of God (Bendigo)	A	A	A	A	A	A	0
Southern Consultancy service	P	P	P	A	P	P	100
Northern Consultancy service	P	A	P	P	P	P	83

Reports

CORG Report

Small Grants were issued to CORG members during 2014-15 to the value of $77, 965 (see Appendix 3). These grants were utilised to improve local capacity and spanned activities such as: developing palliative care resources for Motor Neurone Disease, implementation of a Bereavement Programme, NSAP auditing and subsequent improvements and optimisation of service coordination between local service providers.

Building off the recommendations of the April 2015 VAGO Report, the CORG met for a strategic planning day in Swan Hill in May 2015. The major output from the day was a list of priority actions areas for the Loddon Mallee, including inter alia:

- Focus on upskilling Community Palliative Care Service staff to maximise opportunities to extend service provision, via use of technology (tele-health)
- Supporting and extending community control of death and dying (non- medicalisation of death)
- Focus on improving VINAH data across the region
- Focus on supporting Carers across the Loddon Mallee
- Efforts to increase understanding of a palliative approach across the regions health, aged care and disability sectors

It was agreed by the Board to use these priorities to inform capacity building efforts in 2015-16.

During 2014-15 the CORG also reviewed the After Hours Palliative Care Telephone Support Orientation Manual and edited the Carers Kit, leading to the release of Version 2. The CORG have also supported the development of a Carers Kit App which will be available for testing in the 4th quarter of 2015.

Palliative Care Week celebrations Sunraysia Community Health 2015

Loddon Mallee Regional Palliative Care Consultancy Service (LMRPCCS) Report

The LMRPCCS has continued to focus on complex symptom management and support to generalist and specialist community palliative care providers.

In-reach and outreach consultations are delivered to patients and families across the region, by providing primary (direct) and secondary (indirect) consultations and assessments. Direct face-to-face consultations remain the significant majority of contacts, with the use of Telehealth progressing, but often limited by factors out of the control of the Consultancy.

Capacity building and mentoring continues to be foremost in service provision. Formal education has been provided through study days and workshops, with acknowledgement of the extent of informal education related to each consultation which occurs between Consultancy workers and other health care workers.

The LMRPCCS is delivered by Bendigo Health in the following LGA's: Buloke Shire, Loddon Shire, Campaspe Shire, Macedon Ranges Shire, Central Goldfields Shire, Mount Alexander Shire, Gannawarra Shire, Swan Hill Rural City (excluding Robinvale area), City of Greater Bendigo.

The LMRPCCS is delivered by Sunraysia Community Health in the Greater Mildura Shire and the Swan Hill Rural City (Robinvale area).

Hospice Case Study: Bendigo

April was admitted to Hospice on 20 March 2015 for symptom management. She had recently spent a period of respite in Melbourne Hospice as it was close to her friends to enable them to visit and take her out. She had been home only a few days and was struggling to cope.

April was bedbound, alert, orientated and frustrated with her illness. She was known to the team. She lived alone, and her parents living approximately 30 minutes away.

April was 27 years old, single, qualified as a social worker before diagnosis of a glioblastoma multiforme. She gained spiritual and religious comfort from her faith and was visited frequently by her Pastor and they held services for her in the unit on a Sunday.

April's condition stabilised and the discussions commenced regarding her place of discharge. Her mother June was involved in family meetings with Social Work and the Hospice team and a decision was made for nursing care in an Aged Care facility. Discharge planning was ACAS and DHHS approved.

This was a very distressing time for April, her mother and the staff involved. June had promised April that she would never put her into a Nursing Home and changed her mind at the prospect of her daughter living with much older age group. They decided to go back home to April's house with support and they were both supported with this decision.

April died suddenly before discharge date. June was distraught at the thought she almost 'put' her daughter in an aged care facility. June contacted the DHHS and hoped to raise awareness of the lack of facilitates for people of similar age within Bendigo and continues with her campaign.

Usage of PCCN Tools

PCCN endorsed Tool	No. of LMRPCC Services using tool 2012/13	2013/14	2014/15
Carer Support Needs Assessment Tool	3	4	3
Distress Thermometer	0	2	1
FACIT (Pal)	0	0	0
FICA Spiritual Assessment Tool	0	1	0
General Health Questionnaire	0	1	3
Initial Pain Assessment Score	2	8	8
Karnovsky Score	6	8	8
Liverpool Care Pathway	0	0	0
Modified Liverpool Care Pathway	1	1	1
Palliative Prognostic Index (PPI)	0	1	1
Palliative Prognostic Scale (PaP)	0	1	1
Problem Severity Scale (PCOC)	6	7	7
Symptom Assessment Scale (PCOC)	7	8	8
TOTAL	25	42	41

Implementation of Bereavement Framework

STANDARD	MEASURE	Baseline 2012/2013	2013/14	2014/15
Pre-death Screening	Bio-psycho-social spiritual assessment	3	5	3
	Education resources – literature/ brochures, re grief process & specialist support available	4	5	8
At Death	Courtesy phone call	4	6	8
	Informal/formal assessment	3	6	8
12 Weeks	Telephone assessment	4	3	5
6 Months	PG13 for at-risk clients	1	3	3
12 Months	Bereavement Card	3	2	5
	Memorial Service	4	3	5
Staff Training	Bereavement Coordinator	3	3	5
	Position Description	2	4	2
	Budget for bereavement follow-up (larger services)	1	1	0
Access	Basic cultural training for staff on local social groups	4	4	4
	Multi-faith resource file	2	3	3
	Professional development planner (bereavement support)	2	2	4
Training	Basic bereavement training for all clinical & non-clinical staff	3	4	5
	Professional development opportunities regularly documented	2	4	5
Volunteers	Undertake Pal Care Vic training modules	0	3	2
	Ongoing supervision scheduled and documented	0	5	1
Staff Support	Protocols for supporting staff are clearly identified	2	5	3
	Staff access ongoing supervision & support	0	4	3
	Death reviews conducted & staff debriefings	1	3	4

	organised for complex deaths			
Clinical handover	Documented protocols for dealing with at-risk clients	2	3	2
	Documented protocols for making referrals to specialist services	3	4	5
	Documented protocols for actively supporting clients to access specialist services	2	3	1
Health promotion	Participation in community education & health promotion (eg, Pal Care week, Grief-awareness week)	3	6	7
	Development of effective inter-agency networks	2	5	7
	Staff are aware of range of other local support resources available to clients	4	6	8
Quality improvement	Evaluation strategy developed	1	5	3
	Relevant datasets established & collected from clients	3	4	5
	Bereavement service undergoes ongoing evaluation & continuous improvement	0	4	3
Resources	Grief brochures	5	5	8
	Information sheets	5	5	8
	Other (please stipulate)	2	2	2
TOTAL		80	131	145

Regional Planning & Coordinating Care

PEPA in the Loddon Mallee

The following PEPA placements were supported by DHHS in the Loddon Mallee region during this reporting period:

Type	No.	Organisations involved
GP	1	Mallee District Aboriginal Health Service (Bendigo Health inpatient and consultancy)
Nursing	5	2 Bendigo Health (Bendigo Health inpatient, community & regional consultancy) 1 Heathcote Health (Bendigo Health inpatient, community & regional consultancy) 1 Echuca Health (Bendigo Health inpatient/Echuca Health community) 1 Mallee Track Com. Health (Peter Mac, Bendigo IP & Reg. Cons., Sunraysia Com. Health)
Speech Pathology	1	Swan Hill (Peter Mac, Melbourne City Mission community, Bendigo Health inpatient and community)

Aboriginal Palliative Care

During 2014-15 the Consortium continued to work towards improving Palliative Care for Aboriginal people in the Loddon Mallee Region.

The Consortium has supported the Mallee District Aboriginal Service with a $21,000 Grant to conduct a project throughout 2015 to develop a model for palliative care for Aboriginal people in the Mildura region and to undertake training of their Aboriginal Health Workers and also mainstream workforce in Sunraysia Community Health Service and Mildura Base Hospital.

The Consortium is also supporting Echuca Regional Health project workers with project governance assistance for their two projects: 1) Commonwealth sponsored Decision Assist project entitled: Improving the palliative care provided to Aboriginal Residents of Glanville Village Nursing Home; and the VAPPC Project 2) Providing Culturally Safe and appropriate Palliative Care to Aboriginal Aged Care Residents in Echuca.

The Consortium Manager has regularly participated in regional Aboriginal health meetings and has been invited to provide a death profile for Loddon Mallee Aboriginal populations at the next Loddon Mallee Aboriginal health Liaison Officer and Aboriginal Health Promotion and Chronic Care Regional Forum.

Feedback received during this financial year also indicated a general gap in understanding by mainstream community palliative care services about the cultural specifics on death and dying for Aboriginal people in our region. A focus of 2015-16 will be some capacity building in partnership with VACCHO for a community palliative care mainstream service providers.

Health Promoting Palliative Care Activities

As per previous years the Consortium sponsored members to organise Palliative Care Week events and undertook a range of other health-promoting palliative care activities.

The Consortium also engaged Latrobe University to work with local stakeholders to develop a Health Promoting Model for Palliative Care in our Disability Sector (See project detail in 'Overview section'.

Project officers also developed relationships with regional DH disability officers / accommodation services and encourage palliative care referrals to align with the Disability residential services palliative care guide

Carer Kit review & APP development

The Carers Kit is a regional resource developed by the CORG to help carers when at home. Significant work has gone into rewriting and designing the kit to make it as user-friendly and as visually appealing as possible.

In 2014-15 the Consortium Board agreed to support the development of the Kit into an App suitable for phones and tablets. Testing of the App is anticipated for October 2015. It should be noted that there has been multiple approaches from regions outside of Loddon Mallee to access the Carers Kit Resource, which we have made freely available.

After Hours

During 2014-15 the Consortium reviewed and redistributed the After Hours Orientation Manual to all members.

The Consortium also worked with Bendigo Health to develop a web-based database to record After Hours calls received by the after-hours managers from palliative care patients and/or carers. This database both streamlined the previous process by allowing both the palliative care service and the

after-hours managers to have access to the calls. It also enabled the palliative care service to provide timely follow-up and record the outcome of this follow-up so it was available to the after-hours managers, should the same client call back. Following the successful implementation at Bendigo, it will be rolled out across the region.

MND regional worker activities

Bendigo Health receives MND regional worker funding and continued to employ a worker to provide training and support to clients in the region. Meanwhile Kyneton was also supported with a small Grant from the Consortium to develop up an extensive MND reference, which has been distributed across the region.

Aged Care in Loddon Mallee

The Aged Care and Disability Link Nurse positions continued in the north and south of the region during the 2014-15 financial year and ongoing education and capacity building sessions were delivered across the 64 Aged Care facilities.

A targeted education initiative involving video conference enabled a further 6 sessions to be delivered across the region from 1 July 2014 – 30 December 2014. These sessions focussed on the Palliative Approach Toolkit and also extra topics such as ‘diagnosing dying’ and ‘management of delirium’.

Future Directions

Building from our CORG strategic planning day, held in Swan Hill in May the Consortium has identified five clear areas of focus for 2015-16:

1. Loddon Mallee Palliative Care Carers Support Network

Funding from Bendigo Carer Support Services will be used to design a Loddon Mallee Palliative Care Carers Support Network. This scoping work will be undertaken by Carers Victoria and will also be followed by training around carer's needs.

2. Changing perceptions of Community on death & dying

The Consortium is working with an external consultant and our palliative care experts to modify existing 'No Bull' Programme previously used in Rural Communities during drought, to present a 3 hour programme in 7 locations in Loddon Mallee engaging around 'death and dying' and opportunities to strengthen support for people dying and / or caring for dying in the community. Course development is underway and sessions will commence in Q1 to targeted community leaders (Local Government, Sporting Clubs, Service Clubs etc.),

3. Aboriginal 'Death & Dying' Cultural Safety Training

Based on feedback from local Aboriginal stakeholders, the Consortium is working with VACCHO to develop a training package around cultural considerations in death and dying in Aboriginal Communities.

4. Strengthening the use of Technology across our region

Building upon the delivery of iPads to our palliative care teams across Loddon Mallee, our Service Improvement Officer will routinely work with the CORG members and our Consultancy throughout 2015 – 16 to build technology capacity to optimally maximise Consultancy support to clients in the community.

5. Conduct innovative service planning for the region

Building on ABS death data regional profile and working with our members and the Consultancy, undertake a service planning exercise for the region, considering workforce and technology as key enablers.

Appendix 1

Regional Strategic Plan 2012-15

Our Major strategic directions

The Loddon Mallee Regional Palliative Consortium (LMPRCC) has mapped these directions into four regional priority areas, as shown in the adjacent table:

Our strategic direction	Relevant Strengthening Palliative Care strategic direction
1. Coordinating Quality Care Across Settings	1. Informing and involving clients and carers 3. Working together to ensure that people die in their place of choice 4. Providing specialist care when and where it is needed 5. Coordinating care across settings 6. Providing quality care supported by evidence
2. Building capacity in the palliative care workforce	4. Providing specialist care when and where it is needed 5. Coordinating care across settings
3. Delivering targeted health promotions	1. Informing and involving clients and carers 2. Caring for carers 3. Working together to ensure that people die in their place of choice 5. Coordinating care across settings 7. Ensuring support from communities
4. Building and maintaining a sustainable Consortium	5. Coordinating care across settings

Major delivery areas

The table below shows how the LMRPCC intends to deliver each of the strategic directions in alignment with the Department of Health's *Strengthening Palliative Care: Policy and Strategic Directions 2011-2015* document.

Goals	Objectives	Strategies
Strategic direction 1 - Coordinating Quality Care Across Settings		
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.	Drive the establishment of, and monitor, a consultancy level palliative care service across the whole Loddon Mallee Region. The service delivery will be in line with the government's Palliative Care Service Capability Framework4 in so far as this can be met within available resources.	Steer and support the establishment of an efficient and effective Multi Disciplinary Team (MDT)5 within Bendigo Health, including being party to a written guideline as developed by Bendigo Health, Department of Health and the Consortium. Receive and monitor regular reports of MDT activities from Bendigo Health and report these in line with Department of Health requirements. Evaluate the MDT model within two years of establishment, determining and implementing refinements to the MDT model.

4 Available as part of the state policy.

5 Often also referred to as a Consultancy or a level 3 service.

Goals	Objectives	Strategies
	Continue to work with the Victorian Aboriginal Palliative Care Program (VAPCP)6 to develop Aboriginal peoples' awareness of and access to palliative care services and enable palliative care services to provide culturally appropriate palliative care.	Work closely with VAPCP to help increase the linkages, partnerships and relationship between aboriginal health organisations and Consortium members across the region.
	Identify areas where access to palliative care for people from a CALD can be improved.	Link with bodies representing and working with people from CALD backgrounds and Palliative Care Clinical Network (PCCN) CALD projects to identify issues and projects to improve access regionally.

6 This is auspiced through the Victorian Aboriginal Community Controlled Health Organisation (VACCHO).

Goals	Objectives	Strategies
Increase the availability of after-hours support to clients and carers in their homes.	Establish, evaluate and govern an ongoing program to improve after-hours support.	In conjunction with key stakeholders, plan an ongoing sustainable After Hours Program. This will align with the Department of Health's *After Hours Palliative Care Framework*[7] and strengthen the structures delivered through the 2009-11 After Hours Pilot Project. Evaluate the After Hours Program in year three of the strategy and regularly report program activities in line with program plan, Consortium member expectations, and Department of Health requirements.
Ensure all Victorian palliative care services provide quality care that is assessed against national standards and supported by a quality improvement culture.	Use tools, measures and initiatives from the National Standards Assessment Program (NSAP), Palliative Care Outcomes Collaboration (PCOC) and Palliative Care Clinical Network to improve the quality of care provided by Consortium members.	Operate a clinical group within the Consortium (CORG[8]). Members will work together and within their services to help implement: • An appropriate degree of PCOC. • NSAP as directed by the Department of Health. • Other tools and initiatives developed by the Palliative Care Clinical Network and the Department of Health as appropriate.

7 http://docs.health.vic.gov.au/docs/doc/After-hours-palliative-care-framework

8 The Clinical Operations Reference Group which is made from Consortia members and other invited participants.

Goals	Objectives	Strategies
Use technology to enhance service coordination for all palliative care services.	Opportunities to enhance use of technology across Consortium members are identified and utilised.	Identify and scope IT projects that can enhance service coordination and quality. Seek funding and deliver IT projects where possible, in alignment and partnership with LMRHA9, as appropriate. Maintain communication with the LMRHA and awareness of ICT initiatives including the Transition Care telemedicine project, levering off existing initiatives where possible. Consider opportunities for a single integrated data base of registered Palliative Care clients in the Loddon Mallee Region. Utilise telemedicine as part of the MDT model.

Goals	Objectives	Strategies
Strategic Direction 2: Building capacity in the palliative care workforce		
Increase the capacity and specific knowledge of those in the healthcare workforce encountering palliative care clients.	Develop and deliver an appropriate education plan and strategy across the Loddon Mallee Region.	Complete an educational gap analysis to identify the need in the region and a strategy to meet this need. Within the constraints of funding and other priorities, build appropriate educational activities into MDT and Consortium activities and report these to Department of Health as appropriate. Support the practice of Palliative Care Nurse Practitioners within the Region as part of the MDT. Seek opportunities for the introduction of a new practitioner in the Northern part of the Region.

9 Loddon Mallee Rural Health Alliance, an IT joint-venture that most Consortium members belong to.

Goals	Objectives	Strategies
Assist aged care services to care for people at the end-of-life	Assist residential care facilities across the Loddon Mallee Region to implement end-of-life care pathways.	The MDT will work with the various regional aged care agencies to implement end of life care pathway services and programs10. The Consortium will receive and monitor regular reports of MDT aged care activities from Bendigo Health and report these to the Department of Health.
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.	The MDT will work with the various regional disability stakeholders to improve the capacity of this sector to provide palliative care in line with relevant Department of Health implementation plans. The Consortium will receive and monitor regular reports of MDT disability activities from Bendigo Health and report these to the Department of Health.

10 In line with best practice as identified by the Centre for Palliative Care http://centreforpallcare.org/index.php/resources/end_of_life_care_pathways/

Goals	Objectives	Strategies
Implement the palliative care service delivery framework (SDF) across Victoria, with advice from the PCCN.	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.	Work with Department of Health to identify appropriate actions the Consortium can do to help regional service planning become more aligned with the SDF. Deliver any appropriate actions, most likely commencing from 2013-14.
Strategic Direction 3: Delivering targeted health promotions		
Raise awareness of palliative care by other health, community, and aged care providers to ensure that people are cared for and die in their place of choice. Strengthen the Loddon Mallee communities' 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.	Develop and deliver an agreed palliative care health promotions strategy across the Loddon Mallee Region.	Develop a realistic and achievable health promotions strategy in line with stakeholder expectation and best-practice promotions standards. Evaluate Consortium health promotion activities in year three of the strategy and regularly report the activities in line with Consortium member and Department of Health expectations.

Goals	Objectives	Strategies
Provide information about palliative care that is tailored to the needs of clients and carers.	Carers and clients receive targeted information.	Continue to identify, share, streamline and improve client and carer information through the CORG in line with PCCN and Department of Health initiatives. Work with relevant stakeholders to review, finalise, publish and distribute the Carers' Kit developed by the CORG in 2011/12. Disseminate further copies of the Patient Planner11 across the region.
Strategic Direction 4 - Building and maintaining a sustainable Consortium		
Strengthen links between stakeholders in palliative care	Influence and impact of the Consortium is strengthened by solid networks and connections across the region and in relevant statewide settings.	Engage with relevant health, community, aged care and other bodies including but not limited to Palliative Care Victoria, Motor Neurone Disease regional workers, VACCHO, primary care partnerships and medicare locals. Actively participate in the Palliative Care Clinical Network, Loddon Mallee Integrated Cancer Service, and statewide Consortium Managers Meetings.

11 Published by the Central Victorian GP Network as an outcome of a federally funded project.

Goals	Objectives	Strategies
Continue to enhance the governance of the Consortium	Consortium runs efficiently and effectively, with the right mix of strategic, stakeholder and operational input.	Ensure there is an appropriate framework in place to meet all Department of Health reporting requirements. Improve budgeting and reporting processes within the Consortium. Develop and sign a detailed agreement between Consortium and fundholder about treatment and reporting of funds. Maintain and update the following documents in line with Department of Health role statements and strategies: • Consortium MOU • Terms of Reference (which will be developed for the Board and all sub-committees) • Any additional role statements. Develop and implement annual work plans for the Board and Sub-Committees and monitor and report their progress.

Goals	Objectives	Strategies
		Undertake an annual review of the functioning of the consortium and the sub-committees and make changes as appropriate.
Efficiently and effectively deliver our core business and small projects and programs.	Plan, deliver, evaluate and acquit against our funding streams in an efficient and effective manner.	Maintain the post-PEPA12 program of educational activities targeted at health professionals while it is funded. Maintain a sponsorship program to help enhance palliative care knowledge and experience across the region. Utilise Consortia surplus funds to deliver against the Strategic Plan.

12 Program of Experience in the Palliative Approach.

Appendix 2

Financial statement

Profit & Loss Statement

Account	YTD actuals	Comments
Expense		
Salaries and Wages	$ 207,003	(inclusive of Superannuation, Workcover premium)
Grants Received on Behalf of and Paid to Other Agencies	$ 66,144	
Food Supplies	$ 371	
Consultancy Costs	$ 19,857	
Printing & Stationery	$ 8,621	
Professional Membership	$ 782	
Publications (Books/Journals/V	$ 1,029	
Telephone Expenses	$ 1,296	
Conferences Registration and Accommodation	$ 4,501	
Travel, Accommodation & Meals	$ 11,910	
Miscellaneous Expenses	$ 552	
Computer Consumables - Other	$ 331	
Motor vehcile expenses	$ 7,532	
Corporate Services	$ 26,338	Corporate charge (12.5% of grant revenue)
Total Expenses	**$ 356,267**	
Revenue		
54103 DH Grant - Palliative Care - Non Admitted	$ 87,219	
54118 DH Grant - Palliative Care Consortia	$ 124,846	
58502 Interest from Investments	$ 13,726	
Total Revenue	**$ 225,791**	
Total Operating Result	**-$ 130,476**	
BALANCE SHEET		
Consortium, Balance Sheet as at June 30th 2015		
Net cash inflow(Outflow) from Operating activities	-$ 130,476	Draw down on the Trust 14/15
Cash and Cash equivalents at beginning of period (Jul 2014)	$ 287,464	
Cash and Cash equivalents at end of period (Jun 2015)	**$ 156,989**	Trust Balance

Note: Accrued Leave expenses for staff completing contracts on 30 June 2015 recovered from Trust balance July 2015.

Appendix 3

Small Grants to Members

During 2014-15 financial year small grants were finalised to the LMRPCC Members to strengthen palliative care in key local priority areas.

Who	What	$
Castlemaine Health	To restructure & integrate the District Nursing & Palliative care services to form a Model of Palliative Care	$11,500
Bendigo Health	NSAP Audit including subsequent improvements	$4,864
Echuca Regional Health	Design and implementation of bereavement program	$4000
Echuca Regional Health	Establishing model of care for palliative patients within the in-patient rehabilitation unit.	$4000
Echuca Regional Health Community Palliative Care	Implementation of care plans for community palliative care patients	$4000
Mildura Base Hospital	NSAP Audit including subsequent improvements	$5000
Maryborough Regional Hospital	Identification of most suitable evidence-based tools to support a consistent model for the provision of a palliative approach to the care across MDHS for community clients, hospital inpatients and residents in RACS facilities with a life-limiting illness.	$6331
Kyneton District Health	Bereavement support standards	$5000
Sunraysia Community Health Services	Communication and coordination project	$6000
Kyneton District Health	Palliative Care Client Assessment	$5000
Kyneton District Health	Understanding Motor Neurone Disease	$5000
Kyneton District Health	Best practice Service Coordination between services providers	$5000
Swan Hill District Health	Research and replace PJB data software program due to inability to accurately report mandatory data to VINAH despite data collection and input	$7000
TOTAL		**$77, 965**

Appendix 4

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

<table>
<tr><th>Actions</th><th>Impacts</th><th>Performance measure</th><th>Progress</th><th>Key achievements / evidence of impact</th><th>Year commence reporting impact</th></tr>
<tr>
<td>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</td>
<td>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</td>
<td>Regional agreement to use consistent tools, as endorsed by the PCCN, across inpatient, community and consultancy services</td>
<td>Completed</td>
<td>Regional processes ensure that all services are aware of all PCCN endorsed clinical tools and in a position to trial and use as appropriate for their services. (Consortium has sourced permission, where appropriate for use of tools). Consortium has also audited services around correct use of tools, enabling benchmarking within the region.

In 2014 – 15 the use of PCCN Tools across each service in the Loddon Mallee is represented below:

<table>
<tr><th>PCCN endorsed Tool</th><th>2014/15</th></tr>
<tr><td>Carer Support Needs Assessment Tool</td><td>3</td></tr>
<tr><td>Distress Thermometer</td><td>1</td></tr>
<tr><td>FACIT (Pal)</td><td>0</td></tr>
<tr><td>FICA Spiritual Assessment Tool</td><td>0</td></tr>
<tr><td>General Health Questionnaire</td><td>3</td></tr>
<tr><td>Initial Pain Assessment Score</td><td>8</td></tr>
<tr><td>Karnovsky Score</td><td>8</td></tr>
<tr><td>Liverpool Care Pathway</td><td>0</td></tr>
<tr><td>Modified Liverpool Care Pathway</td><td>1</td></tr>
<tr><td>Palliative Prognostic Index (PPI)</td><td>1</td></tr>
<tr><td>Palliative Prognostic Scale (PaP)</td><td>1</td></tr>
<tr><td>Problem Severity Scale (PCOC)</td><td>7</td></tr>
</table>
</td>
<td>2012 - 13</td>
</tr>
</table>

				Symptom Assessment Scale (PCOC) 8 TOTAL 41	

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	IN Progress	'Take a break' Respite brochure for carers in the Loddon Mallee Region distributed to all services Partnership entered into with Carer Support Services to scope out a Loddon Mallee Regional Palliative Care Carers Support Network (to be completed in 2015 -16)	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	- More after-hours support (including telephone support	- After-hours model of care implemented in each	Completed	An After Hours service model has been introduced across the region.	2011-12

care across Victoria	and home visits where appropriate) is available to all clients and their carers	region		Bendigo Health conducts automate electronic reporting of all calls. Other services have adopted the telephone triage reporting form Telephone Triage training conducted across the region annually The After Hours Telephone Triage Orientation manual reviewed during 2014-15 and re-released across services	

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

<table>
<tr><th></th><th>Impacts</th><th>Performance measure</th><th>Progress</th><th>Key achievements / evidence of impact</th><th>Year commence reporting impact</th></tr>
<tr><td rowspan="2">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</td><td rowspan="2">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</td><td>Training, education and workforce development is focused on public and private health, community and aged care providers</td><td>Ongoing</td><td>Each of the 64 public and private aged care facilities in Loddon Mallee receives ongoing access to education and training on the palliative approach toolkit. Including access to video conferencing / online training modules which staff have ongoing access

PCA study days have been conducted across the region

The Consortium is supporting a project in Echuca which looks to strengthen palliative care for Aboriginal clients within Aged Care facility</td><td>2011-12</td></tr>
<tr><td>• 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</td><td>Ongoing</td><td>Training records demonstrate increased uptake in palliative care related courses. Evaluation results indicate increased understanding of key concepts and willingness to support residents to die in their chosen place of care.

Loddon Mallee Regional VPCSS Data shows the Loddon Mallee Region is performing better than the state average and has increase in the following questions:

<table><tr><th></th><th colspan="2">2013</th><th colspan="2">2014</th></tr><tr><th>Item</th><td>RM*</td><td>SM**</td><td>RM</td><td>SM</td></tr><tr><th>I knew where to enquire</th><td>3.59</td><td>3.41</td><td>3.65</td><td>3.47</td></tr></table></td><td>2011-12</td></tr>
</table>

				about palliative care I found it easy to be referred to palliative care 4.53 4.38 4.54 4.45 *RM – Region Mean ** SM – State Mean	
		Closer links with ACAS (possible protocol development explored)	Completed	Regional links with ACAS developed including strengthened relationships with CORG members Service capability to make accurate and timely ACAS referrals enhanced.	2012-13
3.2 The palliative care sector develops consistent and clear information for health, community and aged care providers about when and how to refer clients to palliative care; information for GPs will be developed as a priority	Clients receive timely and appropriate referral to palliative care Information and referral processes promoted by the palliative care sector are consistent with referral and coordination strategies across health, community and aged care providers	Health, community and aged care providers/networks linked with palliative care consortia	Completed	Aged Care is represented on the Clinical Operations Reference Group (CORG) Focus Group established to sustainably support Aged Care Link Nurses across the region (TOR include: to work together to facilitate best practice in Palliative Care in RACs)	2011-12
		Develop links with Medicare Locals	Completed	The Consortium has healthy links with the: Murray Primary Health Network Western Victoria Primary Health Network (which include Maryborough and District)	2012-13

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	In Progress	KPI's for the roles (north and south) were developed by a Consortium Steering Committee in a document called the "Aged and Disability Funding Plan". Disability/ palliative care project work undertaken in north and south Loddon Mallee including regular attendance at the disability sector meetings. Loddon Mallee Region Palliative Care Consortium (LMRPCC), Bendigo Health, Sunraysia Community Health Services (SCHS): *Health Promoting Palliative Care (HPPC) Disability Project: 2015 – 2018*	2011-12
		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	In Progress	We have engaged with Disability stakeholder groups across the region and difficulties with regular engagement still exist	2011-12
		Project officers develop relationships with non-government disability accommodation services	In Progress	Work still needs to be completed in this area	2011-12
		Disability services' capacity to provide palliative care improved	In progress	Work still needs to be completed in this area	2011-12

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	"Regional palliative/aged care action plan" developed in 2013	2011-12
3.6 Establish an aged care palliative care link nurse in each region)	▯ 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	▯ Aged care/palliative care link (support) nurse employed in each region	Completed	Aged care / palliative link nurse employed in north and south	2011-12
		▯ Increase in number of residential aged care facilities supported to implement end-of-life care pathways	In progress	Each service in the region designated a nurse with a palliative care portfolio, leading to the establishment of a new Palliative Link Nurses (PCLNs') responsibility in residential aged facilities (RACFs) to act as key contacts for the program and implement changes in their facilities. To date 127 of these roles have been established in 60 of the 64 facilities in the region. Work still to be completed in implementing 'End of Life Care Pathway' in Residential facilities	2011-12

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

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

Actions	Impacts	Performance measure	Progress	Key achievements / evidence of impact	Year commence reporting impact
4.2 Implement the palliative care service delivery framework (SDF) across Victoria, with advice from the PCCN As part of this implementation: services will undertake self-assessment against the service capabilities detailed in the framework the service delivery framework will be used by palliative care consortia in regional service planning	Clients have access to an appropriate level of specialist palliative care in their region There is clear information about the palliative care services that are available across regions and the capabilities of these services	Regional service planning is aligned with the SDF	Completed	Consortium service planning and implementation are closely aligned with the SDF, including the following projects: Palliative Care Services Summary (ensuring there is clear information about the services that are available across the region and the capabilities of these services). After Hours Model of Care (creating increased capacity and coordination of specialist palliative care after hours service in line with expressed client needs). Aged Care Project and Disability Project (ensuring aged care and disability providers can draw on the resources of the specialist palliative care sector when appropriate as well as improve their own approach to palliative care).	2013-14

Strategic direction 5: Coordinating care across settings

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

Actions	Impacts	Performance measure	Progress	Key achievements / evidence of impact	Year commence reporting impact
5.2 Develop stronger links between the palliative care consortia, the PCCN and all other relevant stakeholders	Broadened the number and type of partnerships between palliative care consortia and other health, community, aged care and other providers and structures per region including Primary Care Partnerships and Medical Locals	Identify the health, community and aged care networks in each region and how they link with palliative care	Completed	The Consortium has identified key health, community and aged care networks in the region (and how they link to palliative care, e.g. Carer Support Services that can provide palliative care related respite) and assists with information exchange	2011-12
		Strengthen/develop links between consortia and networks	Completed	Links have been established with the relevant Primary Health Networks, the Loddon Mallee Aboriginal health Liaison Officer and Aboriginal Health Promotion and Chronic Care Group, the Bendigo Aboriginal Inter Agency Group, and the Loddon Mallee Rural Health Alliance	2011-12
		Clinical advisory groups role statement identifies formal links with the PCCN	Completed	Consortium representation on the PCCN - directly feeds to our Clinical Operations Reference Group (CORG)	2011-12
		Develop strong and sustained links with Medicare Locals	Completed	The Consortium has healthy links with the: Murray Primary Health Network Western Victoria Primary Health Network (which include Maryborough and District)	2011-12
5.3 Strengthen consortia governance and accountability processes and	Palliative care consortia have documented governance and accountability processes in	Role statements are implemented regionally	Completed	Role statements are implemented regionally: Board CORG	2012-13

document them consistently	place that are understood by consortia members			Business Group Consortium Secretariat	

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	Ongoing	iPads distributed to services. Ongoing training from the Consortium to support optimal links with Consultancy services and local clinical stakeholders Video conferencing and telephone conferencing routinely used to facilitate clinical service provision In 2015-16 plans in place to implement tele-health clinics as appropriate	2013-14

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		PCCN endorsed LM Patient Planner Implemented After Hours MoC for the region A suite of education modules for Aged Care Services have been implemented e.g. 'diagnosing dying' PCCN Pain Audit conducted across the region Implemented the PCCN Bereavement Framework	2012-13
		Clinical tools implemented at the service and regional levels		PCCN tools recommended to services and Consortium assistance to monitor accuracy of implementation. Auditing of PCCN tools undertaken by Service Improvement Officer enabling benchmarking across the region.	2012-13
		A PCCN consortia representative acts as a conduit between services, consortia clinical advisory group and the PCCN	Completed	Yes	2012-13

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	Yes: Clinical Operations Reference Group, meets bi-monthly	2012-13
		Consortia representative attends PCCN to report on clinical service improvement activities	Completed	YES	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	Regional Education Needs Analysis completed Regional Focus on Aged Care / palliative care capacity building Regional Focus on Grief and Bereavement across general workforce Awareness building across CALD and Aboriginal groups LMRPCC Website (including regional education calendar) LMRPCC Pin Board Newsletter – advertises training	2012-13

				opportunities to those not connected to internet, and to provide useful information on education and services	

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 statewide level between palliative care stakeholders across health,	• 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	The Consortium developed and ratified a Regional Capacity Building Strategy for 2013-2015 to provide guidance on how best to acquit its responsibilities under Strategic Direction 7. Under the guidance of this strategy, the Consortium: • Maintained sponsorship of Palliative Care week activities held by member agencies • Delivered a series of non-clinical education topics through existing educational programs of our members • Maintained and promoted a high-quality website which includes an educational calendar and electronic newsletter • Ensured that health promotions principles are considered in the design of all regional projects and programs including the After-hours, aged care/disability and quality improvements • Built the Consortium brand through provision of consistent, clear and professional information Linked two services to the "Marmalade Ashes" Health Promotion Initiative initially funded by the Grampians Consortium.	2013-14
		• State wide model/templates developed, endorsed by PCCN and implemented		Nil	

community and aged care		Regional activities undertaken to build community capacity to support people who are referred to palliative care	Completed	Continued to build and enhance regional networks and relationships across the region including Medicare Locals, PCPs and aboriginal and council based services	2012-13

Appendix 5 LMRPCC Health Promoting Palliative Care Disability Framework

Loddon Mallee Region Palliative Care Consortium (LMRPCC), Bendigo Health, Sunraysia Community Health Services (SCHS)

Health Promoting Palliative Care (HPPC) Disability Project: 2015 – 2018

Aspirational Goal	People living in disability accommodation services who have a life-threatening illness in the Loddon Mallee Region receive best practice palliative approach and end of life support and care

BUILD CAPACITY IN THE DISABILITY SECTOR	BUILD CAPACITY IN COMMUNITY PALLIATIVE CARE SERVICES
Use organisational community development approaches to build capacity in the disability sector to provide end of life support to dying residents ❖ Facilitate opportunities and support the development of a disability palliative care working group to build internal organisational capacity in the disability sector on end of life issues for residents. ❖ Invite palliative care and other relevant services and stakeholders to this group. ❖ Develop a Work Plan with the group to guide implementation and collectively identify priority areas to progress ❖ Identify useful end of life resources to guide implementation ❖ Embed Palliative Approach in disability services documentation, in particular the Specific Health Management Plans ❖ Support the working group to build a workforce and organisational environment that fosters staff confidence on death and dying ❖ Provide education and training on issues identified by the group and: ✓ Build capacity in staff to effectively communicate on issues relating to dying, death, loss and bereavement ✓ Recognise deterioration and implement referral steps ✓ Support the disability sector to provide leadership and direction on a social model of dying for their residents ✓ Support the sector & stakeholders to develop systematic early identification of LLI for improved end of life planning and ACP ❖ Identify mechanisms with the working group to embed sustainable changes into policy and practice ❖ Explore with the working goup community development projects with residents on end of life issues	**Partner with palliative care services to examine & review models of service provision to disability services** ❖ Seek partnership with the CORG as a collective and with individual member services ✓ Include the HPPC Disability Project regularly on the CORG agenda ✓ Disability project workers build individual relationships with CORG members and organisations in their region. Track services providing care to disability accommodation services and their experiences. ✓ Invite guest speakers to CORG to improve clinical skills in the area of working with people with intellectual disability (PWID). E.g. specific disability conditions, pain management, communication challenges, palliative care in the home ✓ Seek opportunities for the disability and palliative care sectors to partner to build collaborative approaches and promote shared knowledge ✓ Improve understanding of disability services workplace culture, structure and protocols to provide palliative care plans that are tailored, relevant and achievable for staff (Specific Health Management Plans) ❖ Improve referral processes between disability, palliative care and community services ✓ Map services in the LMR who deliver care to disability accommodation services. Determine baseline at CORG, and discuss ongoing referrals & service provision in meetings ▪ NB: CPSC, DNS, HARP, HITH, TCP, ACAS, RACF, hospital, acute, sub-acute, HIP, PAC, ✓ Referral Criteria and Processes – examine how PWID are currently screened at Intake, and explore prioritising PWID as a vulnerable population for community services and end of life care needs ✓ Develop process resources (flowcharts) in consultation with both palliative and disabilty sector to improve outcomes for residents