loddon mallee
regional palliative care consortium

Annual Report 2012-2013

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2. Overview

This year the Consortium progressed in its delivery of Victorian Government's "Strengthening Palliative Care: Policy and Strategic Directions 2011-2015" (SPCP)[1] across the Loddon Mallee region.

This report describes the Consortium's projects, programs, situation, achievements, directions and finances.

Consortium Chair Kathy Wright, Executive Officer Clinical Services at Swan Hill District Health

Consortium Chairperson's Report – Kathy Wright

It has been an exciting year for the Consortium as we continued to deliver on our 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."

This year the Consortium's continued the establishment of the Loddon Mallee Regional Palliative Care Consultancy Service (LMRPCCS). The service commenced operations in October 2012 with a team of palliative care specialist physicians, nurse practitioners and clinical nurse consultants, as well as administrative and managerial staff.

The achievements of the Consortium's funded projects and programs are described in this annual report. They include delivery of a detailed education gap analysis helping us to ensure that the education and training provided is as effective as possible.

This year Maggie Fernie from the Department of Health Loddon Mallee region moved from the palliative care portfolio. We wish to thank Maggie for the hundreds of hours she put into the Consortium and for her guidance and support.

We welcomed Pamela Oakley as Maggie's replacement. Pamela brings a wealth of contacts and knowledge and shares her palliative role with aged care. She also brings expertise in HACC and Aboriginal health.

Our thanks are also extended to outgoing Chair, former CEO of Boort District Health Service Veronica Jamison, for her contribution to the Consortium. Veronica was instrumental in strategic planning exercises in 2012 and in supporting the Consortium Manager. We welcomed Mara Richards, who is CEO of Robinvale District Health Service into this valuable role.

This past year also saw the resignation of two of our other longest serving Board members Michael Goodrem representing Sunraysia Community Health Service and

[1] Available at http://www.health.vic.gov.au/palliativecare/index.htm

Judy Keath from Boort District Health Service representing unfunded agencies. Both are passionate advocates for palliative care and bought a rich understanding of isolated health services into all of our work.

Special thanks to Michael for membership of the Business Group and Regional Consultancy Service Steering Committee and to Judy for all of the work she devoted to chairing this committee.

May I also say a big thank you to all of our board members our colleagues from the Department of Health and the clinicians who work tirelessly in delivering services as well as everyone else who has so generously assisted in furthering the work of the Consortium across the region.

Kathy Wright,
Consortium Chair
Executive Officer Clinical Services
Swan Hill District Health

Consortium Manager's Report

I have continued to greatly enjoy working in the Consortium with the dedicated workers delivering palliative care. I see the main role of the Consortium as helping support these people and their services. In doing this the Consortium staff have travelled over 20,000 kms to meet with members and stakeholders.

My most memorable highlight this year has been continuing to work with colleagues in the Aboriginal health sector. Particular thanks to the leadership and generosity of Cherie Waight from Victorian Aboriginal Community Controlled Health

Consortium Manager Ilana Solo in Castlemaine

Organisation (VACCHO). Cherie has helped us connect with our regional Aboriginal health services and health workers. This has assisted us in understanding just how much palliative care the Aboriginal health sector provides, and how crucial it is for links to be enhanced between our services.

Another highlight was my attendance at Castlemaine Health's Consumer Advisory Committee. This group includes former carers of palliative patients and carers of residents in aged care facilities. The Committee has agreed to assist the Consortium in an ongoing capacity through reviews of Consortium materials and attendance at some strategic planning events.

There are many supports for my role, particularly from our current Chair Kathy Wright who offers significant expertise. Thanks also to Amanda Edwards the fundholder representative the DH's Melbourne and Loddon Mallee teams and Odette Waanders from Palliative Care Victoria.

This financial year commenced with the retirement of the wonderful Anne Forden who had been the Consortium's administrative assistant for three years. I found myself temporarily in an empty office while recruiting a replacement for Anne and two Project Managers.

The only way from this point was up and up it went when we received an excellent field of candidates for all roles. We now have our full team on board and have begun to enthusiastically implement the government's Strengthening Palliative Care Policy and Strategic Directions.

A special thanks to the Consortium Board, Consortium Clinical Operations Reference Group (CORG) and the Business Group for their energy, openness and time.

Ilana Solo
Consortium Manager

Consortium membership and structure

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

In 2012-13 the Consortium consisted of the following voting and ex-officio members:

Organisation	Board member
Bendigo Health	Liz Hamilton
Boort District Health - Representing unfunded services	Judy Keath
Castlemaine Health	Amanda Edwards (Deputy Chair)
Echuca Regional Health	June Dyson
Kyneton District Health	Tracey Hynes

Driving through the region has hazards – including two near misses with emus.

Organisation	Board member
Service	
Maryborough District Health Service	Fiona Brew
Mildura Base Hospital	Angela Imms
Sunraysia Community Health Service Inc	Michael Goodrem
Robinvale District Health Services Representing CEOs	Mara Richards
Swan Hill District Health	Kathy Wright (Chair)
Ex - Officio	
Department of Health (DH) – Loddon Mallee Region	Andrew Kallaur
Consortium Manager	Ilana Solo
Consortium Administrator	Mary Crigan

Appendix 1 shows meeting attendance records for the period. **Appendix 2** contains a brief profile of each member service including the locations of each specialist palliative care service.

Diagram 1 represents Consortium structure.

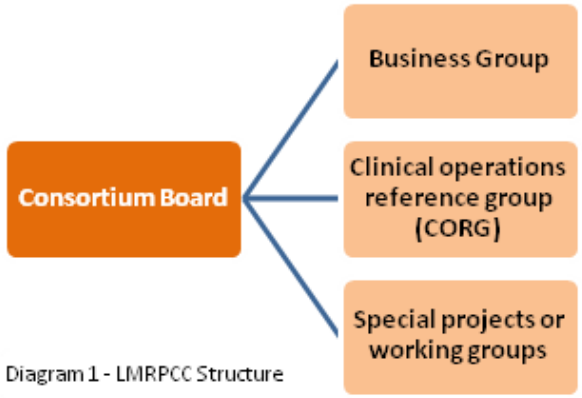


Diagram 1 - LMRPCC Structure

This structure is based on templated "Role Statements" developed and managed by the Department of Health (DH) for the purpose[2].

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, and 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.

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 includes a Chair, Deputy Chair, DH Loddon Mallee representative, Fundholder representative and two ordinary members.

The Clinical Operational Reference Group (CORG) functions as the Consortium's clinical advisory group. CORG oversees 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.

This year CORG was excited to welcome representatives from Bendigo District Aboriginal Cooperative, which has significantly deepened the clinical knowledge of the group.

Other stakeholder representatives included a Palliative Care Physician and two Nurse Practitioners, an aged care facility (BUPA) and a private hospital (St John of God Bendigo).

In 2012-13 the following project groups were operational:

1. Steering Committee for the Loddon Mallee Regional Consultancy Service
2. PCOC Implementation Working Group
3. Mildura Aboriginal Advisory Group

The work of these groups is described further in the Reports section below.

[2] Available on www.health.vic.gov.au/palliativecare/tools.htm

Regional Strategic Plan implementation and progress

The Consortium continued to work through its 2011-2015 Strategic Plan mapping the seven strategic directions from the SPCP into four regional priority areas.

1. Coordinating quality care across settings
2. Building capacity in the palliative care workforce
3. Delivering targeted health promotions
4. Building and maintaining a sustainable Consortium.

Appendix 3 contains information on the Consortium's achievements and helps to describe how this Annual Report maps to the Regional Strategic Plan.

Appendix 4 describes the Consortium financial position as at 30 June 2013.

About the Loddon Mallee Region

The Loddon Mallee Region is one of eight DH regions and it encompasses 26% of Victoria.

The following map shows the boundaries of the region and the locations of the 25 health services. All deliver generalist palliative care services.

The "Loddon Mallee region health status profile 2012"[3] contains a comprehensive summary of health related demographic information across the region. The following table describes this demographic data and its implication for palliative care and the Consortium.

Regional profile	Impacts for palliative care	Consortium response	Future directions
Dispersed population - 308,000 people in 26% of Victoria.	Large distances to be travelled by staff and patients for service delivery.	Telehealth model in Regional Consultancy Service, after-hours and Aged Care and Disability projects.	Continue to support services to review models of care to accommodate distances.
Population movements - decline - in most of the region but growth in regional centres. Approximately half are concentrated in Mildura and Bendigo.	Loss of social capital in some regions requiring higher support needs. Rapid growth puts significant pressure on health infrastructure.	Networking and support provided to smaller service.	See above
Aged population - Higher percentages of 0-14 and 65 plus population than the Victorian average, and lower percentages of other age groups. By 2021 the percentage aged 65 plus will increase from 17% to 20.8%.	Increase in need for services and significant pressure on aged care infrastructure.	Aged Care and Disability link nurses focus supporting residential aged care facilities in palliative approach and enhancing links with specialist services.	Continue with aged care and disability project. Support services to review models of care to accommodate aged and disability services.
Aboriginal and Torres Straight Islanders (ATSI) - The ATSI population is 1.99%, nearly three times the Victorian average. Swan Hill has 4.57% and Mildura 3.79%. Very low levels of referrals to specialist palliative care services despite high mortality rates.	Significant need for palliative care and bereavement support in the ATSI community. Strong partnerships required with Aboriginal health services to provide culturally appropriate care.	See Aboriginal Palliative Care Program section above.	Continue Aboriginal Palliative Care Program.

[3] docs.health.vic.gov.au/docs/doc/F4AFE457EB4FA94CCA257BBE007495D8/$FILE/Loddon%20Mallee%20Regional%20Health%20Profile%202012.doc.pdf

Regional profile	Impacts for palliative care	Consortium response	Future directions
Cultural diversity - 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.	The need is not as high as in metropolitan areas. Lower staff awareness of culturally appropriate practices and access to interpreters.	Limited activities. See Cultural and linguistically diverse palliative care section above.	Continue to monitor and to identify other opportunities to engage with sector. Continue to monitor and consider in design of projects.
Cultural diversity - There is anecdotal evidence that the health workforce very culturally diverse in the region.	May impact on practices and views on the palliative approach.	Limited activities. See Cultural and linguistically diverse palliative care section above.	Continue to monitor and consider in design of projects.
High chronic disease rates – Diabetes and Chronic obstructive pulmonary disease rates are much higher than the state average.	Need to continue to enhance models of care towards chronic disease conditions.	Considered as part of project planning.	Continue to monitor. Support services to review models of care to accommodate increasing chronic disease.
Death rates – there were 2674 deaths in 2012 which is higher than the Victorian average for all Loddon Mallee LGAs other than Macedon Ranges.	Increased demand on palliative care services.	Not yet initiated.	Support services to review models of care to accommodate regional needs.
Lower GP rates – in some parts of the region there are significant shortages of GPs. Compared to the state average of 1.33 GPs per 1,000 population there are: .6 in Loddon and .95 and .98 in Campaspe and Swan Hill respectively.	GPs not available, particularly for visits leading to additional pressures on nurse led services. Increased reliance on GPs that may not have a good understanding of the palliative approach.	Limited education and training program. See Education Gap Analysis Steering Committee section above.	Continue education and training program. Continue to monitor.

3. Reports

Consortium Business Group's (Executive) Report

The Business Group met bi-monthly between full Board meetings to provide an additional level of consideration and support to the everyday business of the Consortium.

This year the group focused on supporting the manager in the recruitment of new staff and in reviewing and improving the financial reports, budgets, draft plans and documents.

Business Group members consisted of Kathy Wright as Chair, Amanda Edwards as Fundholder Representative, Ruth Fox, Tracey Hynes and Pamela Oakley.

CORG Report

This year the CORG continued to meet and share information, practices and expertise. They continued to work on a range of projects and many members attended Project Management, Bereavement Framework and PCOC training together.

Bi-monthly meetings include a standing Palliative Care Clinical Network (PCCN) agenda item and all PCCN publications disseminated this year have been discussed in great detail with clear follow up activities being set.

CORG has coordinated Palliative Care Outcomes Collaboration (PCOC) training for members from Maryborough, Bendigo and Castlemaine and five services have now adopted components of this national quality initiative. A PCOC working group was also established (see report below).

Regional Palliative Care Consultancy Service (LMRPCCS) Steering Committee Report

The LMRPCCS Steering Committee existed from January 2012 to June 2013 and the service commenced operations in October 2012.

The project achieved most initial objectives. Special thanks to Lee McNally from Bendigo Health for managing these achievements.

Referral numbers are encouraging and a number of services are utilising the LMRPCCS to optimise patients care. There is evidence that not all relevant "complex" cases are being referred and active steps to continue to develop service relationships and referrals are a priority for 2013-2014.

A change to the service's funding model was agreed in April 2013 due to the implementation of Activity Based Funding. The service was designed as a single auspice model, with Bendigo Health purchasing services from Sunraysia Community Health Service (SCHS) and the Peter MacCallum for the northern part of the region.

From July 2012 most northern service funds will flow directly to SCHS. The Consortium is seeking to address any implications of this change by working closely with all stakeholders to develop appropriate Key Performance Indicators (KPIs) and processes.

The Consortium maintains reporting responsibilities for some elements of the LMRPCCS, particularly for the aged care, nurse practitioner, disability and Rural Medical Purchasing Fund components as they utilise Consortium funding. Such reports are found throughout this document.

KPIs for the service have been drafted, and **Appendix 5** contains a report against these.

Steering Group members comprised: Judy Keath (Chair), Ilana Solo, Lee McNally, Liz Hamilton, Maggie Fernie and then Pamela Oakley, Michael Goodrem, Veronica Jamison and then Kathy Wright.

Education Gap Analysis Steering Committee Report

The project concluded delivering a comprehensive education gap analysis that is now:

1. Assisting those designing education and training programs by providing detailed information about gaps in palliative care education and ways to meet these gaps in line with best-practice.
2. Informing a range of strategies to meet needs identified.

The recommended strategies of better promoting educational opportunities in the region and in-sourcing education to Consortium members is expected to bring the following benefits:

1. Enhanced understanding of the palliative approach by educators across the region with improved transfer of capacity to audiences.
2. Increased attendance at existing sessions as higher awareness and forward planning from target audience.

The education gap analysis results are the main example of research in the Consortium. Results have been widely promoted inside and outside the region including acceptance at the 12th Australian Palliative Care Conference.

Palliative Care Outcomes Collaborative (PCOC) working group report

Part of the Consortium's role is to assist services to implement PCOC and PCCN endorsed tools. As many PCCN tools are used by PCOC the CORG group prioritised a working group to identify ways that PCOC can be optimised in the region.

The first achievement was a retrospective audit of three of the services using PCOC to identify what opportunities for improvement may exist.

Two of the three services, showed embedded and consistent practices with the recording of PCOC assessments on each face to face visit. The next step for these services would be to consider submitting their data to PCOC for benchmarking.

The third service is extremely small and only involved one worker at the time. The benefits of the PCOC program as implemented appear marginal. The Consortium will work with this service and others to help make PCOC more successful.

4. Highlights

Rural Medical Purchasing Fund (RMPF) Program

In 2012-13 the Consortium allocated its RMPF funding to Bendigo Health to enhance the LMRPCCS. This fund aims to:

1. Provide rural regions with funding to purchase additional specialist medical palliative care in order to address gaps in access to specialist medical palliative care.

2. Build capacity for rural regions to become self-sufficient in providing specialist medical palliative care.

RMPF funds were used to partially fund full time Palliative Care Physician Dr Tiffany Shaw in Bendigo Health and to purchase services of Dr Odette Spruyt and Dr Corry De Neef from the Peter MacCallum Cancer Centre (PMCC).

Video links and/or site visits and were provided to clients of the all funded palliative care services in the region. Referrals were also received from a wide range of other services including GPs, aged care and disability facilities. Education, mentoring and on-call support were also provided.

The RMPF funds have not yet been successful in building self-sufficiency in the northern region of the Loddon Mallee. The main barriers are isolation and lack of funding to cover a full-time equivalent position. **Appendix 6** contains further details of the RMPF funded Mildura services.

Aged care and disability projects

The Consortium allocated most of its Disability and Aged Care funding to Bendigo Health as well as some surplus funding. Clinical Nurse Consultants Kate Cozens and Bertilla Campbell were then given the responsibility of delivering this program.

In November 2012 the Consortium approved the Loddon Mallee Regional Palliative Care Aged and Disability Funding Plan, which incorporated action plans and KPIs for the roles.

Achievements to date include:

1. Establishment of palliative link nurses in residential aged facilities and disability worker champions in disability facilities across the region. They 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 63 aged care facilities in the region and all ten disability facilities have participated.
2. Utilisation of the Commonwealth government-funded Palliative Approach Toolkit for Residential Aged Care to train and support these workers.
3. Networking and support activities including completion of a reverse PEPA placement into Cohuna and delivery of education sessions to PEPA participants and other RACF workers.
4. Establishment of Telehealth in 30% RACFs Evaluation and monitoring activities.
5. Training to all regional Department of Human Services Disability Accommodation Services Managers regarding the support available through the Consortium and local palliative care services and ascertain the training needs of their staff.

As a direct result of the project there were three referrals of palliative care clients from disability accommodation services to specialist palliative care services.

Identified learnings have been incorporated into a more detailed Project Plan which is near completion.

Motor Neurone Disease (MND) Program

Following collaboration between DH and the Motor Neurone Disease Association of Victoria a shared-care MND nurse has provided education to allied health, medical and nursing staff as well as volunteers and community carers across the region.

Eilish Whelan from the Bendigo Health Community palliative care service works six hours a week supporting clients and visiting clients.

After-hours palliative support

The Consortium receives recurrent funding from the DH to implement a regional after-hours framework. In November 2012 Project Manager Robert Maio was employed for three days a week for a period of three years to progress this work.

An After-Hours Project Plan with the following objectives has been developed:

1. Maintain the existing after-hours processes as delivered in the 2009-12 Pilot Project.
2. Improve the existing after-hours processes including education and capacity building, data collection and reporting.

Achievements include

1. Audit of status of after-hours model. Provision of four after-hours Telephone Triage training days with sixty participants from twelve different services.
2. Patient Planners were further developed, printed and submitted to the Palliative Care Clinical Network Endorsement Sub-Committee for review.
3. Support to Kyneton, Maryborough and Sunraysia to bring their after-hours calls back 'in-house' in response to changes to Medicare Local which meant purchased telephone service ceased.
4. Reinstatement of processes in Castlemaine Health and support to Bendigo Health to fully implement model.
5. Improved forms and data collection processes for after hours which will support move to ABF.

Since introducing the after-hours program in its current form, there has been a decrease in the number of after-hours calls made by carers, and anecdotal evidence of a decrease in admission to hospital emergency departments.

This is viewed as project success as each of these calls represents a carer or patient in distress whose symptoms are being effectively managed and anticipated during business hours. For example there were 429 after hours phone calls received in 2012-13. Of the four fully participating services with measureable data, there was a 47% drop in calls from 2009 project baseline data.

2013 results from the Victorian Palliative Care Satisfaction Survey (VPCSS) indicated a 10% increase in carer satisfaction in the Loddon Mallee region. However a review of individual data indicates there is room for refinements in some of the services. This will be the next priority for the project.

Case study

The following case study highlights some of the complex issues involved in providing after-hours support, and the changes made to procedures as a result. It demonstrates how the After-Hours process supported one family to achieve "Maria's" wish to die at home.

There have been many lessons learnt from the case and the Castlemaine Health is refining these processes.

Special thanks to Nurse Practitioner Merrill Cole for collating this case study.

"Maria"

Maria was a patient of the palliative care service diagnosed with lung and bone cancers. It was Maria's wish to stay at home through the terminal phase of her illness.

In the early hours of the morning, Maria appeared visibly distressed by an increase of pain. A syringe driver for opiates was in place and her carer had been trained by the Community Palliative Care Service how to give breakthrough injections for pain two days prior, when Maria was no longer able to swallow tablets. Her GP also agreed to take out-of-hours calls when needed.

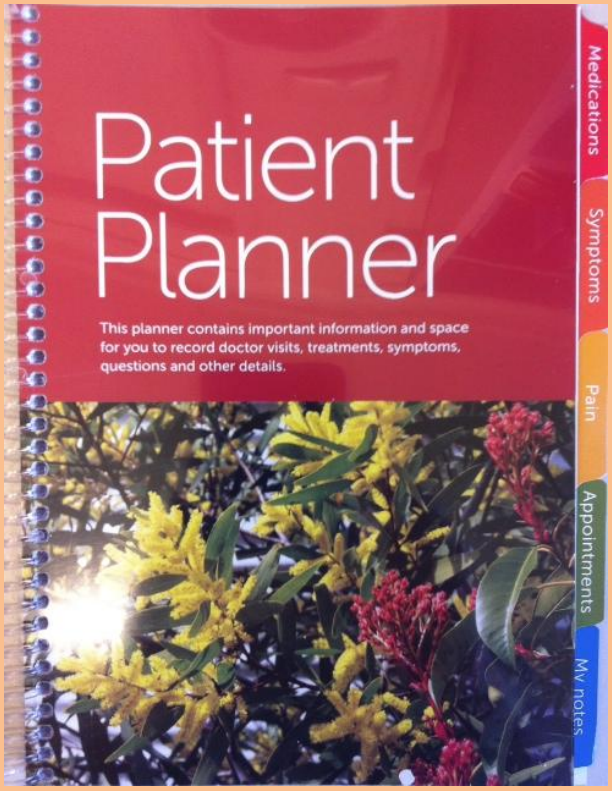
Due to increased pain, and not being confident with having used all the available breakthrough doses of analgesia, her husband decided to call for an ambulance for more medications.

Shortly after arrival the ambulance officer called the after-hours contact number at Castlemaine Health to establish the full context of Maria's medical history. The after-hours service, staffed by generalist nurses, has access to a list of all locally registered palliative clients with relevant medical information.

The ambulance officers were made aware of Maria's wish to remain at home during the end stages of her illness. They were also given the GPs after-hours contact number. They were able to confirm the dose of Maria's breakthrough medication (as prescribed by the doctor). They then drew up the new dose of medication for the carer to inject, and after ensuring this relieved Maria's pain, they left again, with Maria able to remain at home.

Later that same morning, Maria died peacefully at home accompanied by her family.

In situations during a crisis when it is necessary to call an ambulance, ambulance personnel who are not aware of all the relevant medical information, or after administering medications, are obliged to take patients to hospital. In this example this transfer was avoided leading to better outcomes for Maria.



CORG enhanced and re-printed the Patient Planners in conjunction with the LMRPCCS. These were originally adapted by Consortium member Bertilla Campbell from a Division of General Practice product.

This planner provides a means for recording important information given to patients by different members of their health care team. It can be used as an up to date record of a patient's medical treatment, enabling them to share the latest information with different medical staff. It is one of the Consortium's products that will "support clients and carers during hours to reduce after-hours needs".

PEPA post-placement support and other training, education, research and workforce activities

The Consortium receives funding to implement a program for post-PEPA participants. This year's work was informed by the education gap analysis (see Education Gap Analysis Steering Committee report above) and a survey of post-PEPA participants which had 24 respondents.

Respondents listed the top priorities for education as medication management, symptom management, advance care planning and communications skills. 55% also indicated an interest in project management training when asked.

Significant work was put into outsourcing such training to the education departments of three Consortia member agencies. These are to commence in 2014 and will be offered to all post-PEPA participants.

The Education Gap Analysis Report identified that promotion and information surrounding training was a priority. PEPA funds were used to invest in a training calendar for the Consortium's website which is now updated several times a week.

PEPA funds were again used this year to sponsor services to host events during Palliative Care week. This included:

1. A screening of the "Life Before Death" film in Castlemaine which received extensive press and over 100 attendees.
2. Promotional press and education on Advanced Care Directives (ACD) in Kyneton.

3. Education events in Echuca, Mildura and Maryborough.

Post PEPA participants were invited to participate in all of these events.

Consortium funded programs have delivered training/education to staff from at least 122 facilities/providers being:

- 60 Aged Care facilities
- 6 Disability facilities
- 31 Health Services
- 5 Aboriginal Health Organisations
- 2 Primary Care Partnerships
- 2 Medicare Locals.
- 3 Local Governments
- 5 other health providers.
- 1 CALD group
- 1 Consumer Advisory group
- CORG.

Not included are other education and training provided by the LMRPCCS and other funded services.

In response to a CORG request the Consortium provided copies of the 2012 Volunteer Training Resource Kit to all member services. The resource kit is being used to train the current tranche of volunteers.

Project Manager Robert Maio presenting in Italian in Mildura

Cultural and linguistically diverse palliative care

The Consortium has collected data to show that the referral rates to palliative care are lower than population levels in CALD communities. In order to commence a CALD project it was decided to take advantage of Consortium Project Manager Robert Maio's fluency in Italian.

Robert organised a presentation on palliative care to the local Italian community in Mildura and conducted the session in Italian. Approximately 50 people participated. They also received information in Italian on palliative care and advance care planning, and gave feedback surrounding their palliative care needs and how to meet them which will inform future sessions.

Robert was accompanied by Bertilla Campbell from SCHS, so audience members could put a local face to the service. Both received true Italian hospitality of fine Italian coffee and sweets.

Another of these sessions is planned for Swan Hill in the Italian language later in 2013.

Aboriginal Palliative Care Program

In 2012 Consortium set aside $21,000 in surplus funds to support Aboriginal palliative care. Contacts in the Department of Health and of Human Services in the Loddon Mallee assisted the Consortium to secure invitations to:

1. the important Loddon Mallee Aboriginal Reference group- composed of CEO or representative from each of the Aboriginal community controlled orgs in the region, and
2. The regional Aboriginal HACC Workers Network meetings.

Consortium staff was able to seek advice on how best to work with the sector in allocating these funds during these meetings.

The Mildura Aboriginal Advisory Group continued with representation from Mallee District Aboriginal Services, Sunraysia Community Health Service, Mildura Base Hospital and the Consortium Office.

In Swan Hill and Bendigo the Consortium arranged and attended a meeting between the manager of the palliative care service and their hospital's Aboriginal liaison officer. As a result one manager was invited to attend an Aboriginal community event and promote the service and made changes to the way the service was marketed to make it more culturally appropriate.

PEPA and reverse PEPA placements into and from Aboriginal Health Services have been heavily promoted; however only one such placement has been achieved.

Case Study – Josie

In 2011 a young Aboriginal woman, Josie, returned to the Northern Mallee region area having been diagnosed with life limiting illness. Her condition was unstable with major symptoms. These included physical issues such as pain and nausea, psychosocial impacts of the recent diagnosis and concerns about guardianship of her infant, and spiritual issues related to Josie's 'return to country' needs.

As a first point of call Josie contacted the local Aboriginal health service and was allocated a primary HACC worker. The HACC worker had completed a PEPA placement during the year and established relationships with palliative care services. The worker was able to identify that palliative care services would be appropriate for Josie and make a referral.

The referral succeeded and the HACC worker and palliative care service have met regularly to collaborate on a management plan to meet Josie's specific needs including planning for end of life care. They gathered a network of key service providers and initiated multidisciplinary meetings to address the complicated support required.

Two major outcomes resulted in this case;

1. The initial response by the Aboriginal HACC worker set the scene for establishing a cohesive team effort. The worker initiated a referral to a mainstream palliative care service and this resulted in the establishment of a support plan to address Josie's specific needs.

2. Physical needs were often overshadowed by psychosocial need and an understanding and respect for cultural was imperative. Key services were targeted and introduced to Josie by

the HACC worker, including, a general practitioner, home pharmacy services, social support services related to financial affairs, maternal and child health care, accommodation support workers, and additional community nursing staff.

3. In the Northern Mallee, the current referral system from Aboriginal health service to main stream palliative care remains strong as relationships have been established and are fostered through regular case management meetings. Primary service providers are encouraged to increase their knowledge and PEPA is fostered as an opportunity to build relationships. Specialist Palliative Care services continue formal and informal education sessions and tailor these to primary health service needs.

Health-promoting palliative care activities

This year the Consortium developed a Capacity Building Strategy describing how the Consortium will help to build awareness and understanding of death, dying and loss in the Loddon Mallee community. The Consortium will continue to:

1. Maintain sponsorship of Palliative Care Week activities held by member agencies.
2. Deliver a series of non-clinical education topics through existing educational programs of Consortium members.
3. Maintain and promote a high-quality website which includes an educational calendar and electronic newsletter.
4. Continue to build and enhance regional networks and relationships across the region including Medicare Locals, PCPs and Aboriginal and council based services.
5. Ensure 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.
6. Build the Consortium brand through provision of consistent, clear and professional information.

Improving patient flows

Assistance from the Consortium was requested to improve patient flows between Sunraysia Community Health Palliative Care Service (community) and Mildura Base (inpatient).

Interviews and two focus group sessions were held to determine the current and the ideal patient flow between the two services. Swim-lane diagrams were used to identify the current patient flow **(Figure 1)** between the two services and identify the ideal patient flow processes.

Patient flow improvements	
Action	**Progress**
Laminated cards provided to community patients for presentation to staff on admission to hospital to allow them to be identified as palliative care patients	Completed
Letter sent to Medical Director requesting increased use of the "palliative care" rather than "acute" classification	Letter sent. Awaiting reply
Community palliative care (CPC) to provide patients with realistic information on what to expect when admitted to hospital	Ongoing education provided
Review of guidelines instructing patients or carers in the use of breakthrough medication	Reviewed new guidelines in use
Improved information protocols including CPC faxing "SCTT consent to share information" forms to hospital in advance	Completed Resulted in improved flow of information
Regular booking for patients requiring Pleurocentesis	For consideration in 2015

Advance Care Planning in Echuca

The Consortium has provided limited funding to Echuca Regional Health Service to conduct an Advance Care Planning (ACP) project using surplus funds. The project objectives are as follows:

1. Implement ACP based on the Respecting Patient Choices (RPC) program including tools, templates and processes.

2. Embed the new systems and processes within participating services so that they can be self sustained. This will include convincing senior decision makers of the benefits of an ongoing program and is in recognition of the limited life span of the project.

3. Develop a report on the project that can be used by the Consortium as a model for future projects.

Figure 1 Consortium Project Manager Julie Misson demonstrating the swim lane diagram technique. Actions that could help achieve the improved patient flow were identified and disseminated. Assistance continues to be provided to follow up on progress.

The following project benefits are expected

1. A marked increase in the number of adult patients which have conversations surrounding advance care planning or an Advance Care Plan developed.

2. All Advance Care Plans developed clearly articulate the patients preferences and are specific to each person and are available when needed.

3. All Advance Care Plans are complied with in a thoughtful and respectful way.

To date the project has:

1. Appointed a Steering Committee and project worker.

2. Established interest and support from medical, nursing and allied health staff within the organisation.
3. Reviewed RPC documentation and endorse/advise of changes required.
4. Engaged Health Information Services, to establish advanced care planning documentation processes.
5. Developed policy and procedures.
6. Implemented staff education and training.

Outstanding project deliverables are based on sustainability of the processes, development of a report and suggested model for Consortium and evaluation.

Bendigo Health and Castlemaine Health have also commenced Advance Care Planning projects into acute services this year.

Consortium quality database

The Consortium has a mandate to assist services to implement various frameworks and standards as found in the Strengthening Palliative Care: Policy and Strategic Directions 2011 – 2015 and produced by the PCCN.

Many of these processes overlap and initial analysis showed that most of the Consortium services had in place some or many components; however, this could not be demonstrated in a systematic way.

A quality database was developed and populated to capture the current status of Consortium members and to track any improvements made.

This database has enabled the Consortium to produce reports and identify gaps. It will greatly assist the three services who elected to undergo the NSAP self assessment in 2014.

5. Future directions

Consortium plans for the immediate future will centre on continuing the after-hours program as well as completing and implementing findings of the Education Gap Analysis. Additional work will be conducted to support services with their models of care, in preparation for the continued implementation of activity based funding.

Consortium surplus funding will continue to be used to:

1. Employ the Project Manager who supports CORG to implement PCCN and quality initiatives.
2. Continue work to improve access to palliative care for the Aboriginal community.
3. Extend aged care and disability programs.

Other future directions are also contained in the regional profile section of this report.

Appendix 1 – Meeting attendance

Legend

Present in person: P Apology A

Consortium Board 2012- 13 financial year

Voting agencies	August '12	October	Dec.	Feb. '13	April	June '13	%
Bendigo Health	P	P	P	P	P	P	100
Boort District Health	P	P	P	P	A	A	66
Castlemaine Health	P	A	P	P	P	P	83
Echuca Regional Health	P	P	P	P	P	P	100
Kyneton District Health	A	P	P	A	P	P	66
Maryborough District Health	A	A	A	P	P	P	50
Mildura Base Hospital	A	P	A	A	A	P	33
Sunraysia Community Health	A	P	A	A	A	P	33
Swan Hill District Health	P	A	P	P	P	P	83
Average attendance rate							68%
Ex-Officio Representatives							
CEO Representative	P	P	A	P	P	P	83
DH	P	P	A	P	A	P	66
Consortium Manager	P	P	P	P	P	P	100
Consortium Administrator	P	P	P	P	P	P	100

CORG 2012-13 financial year

Members	July '12	Sept.	Nov.	Feb. '13	March '13	May '13	%
Bendigo Health	P[	P	P	P	P	P	100
Castlemaine Health	P	P	P	P	P	P	100
Echuca Regional Health	A	P	P	P	P	P	83
Kyneton District Health	A	P	P	P	P	P	83
Maryborough District Health	P	P	P	A	A	A	50
Mildura Base Hospital	P	P	P	A	A	P	66
Sunraysia Community Health	A	P	P	P	P	P	83
Swan Hill District Health	P	P	P	P	P	P	100
Ex officio representatives							
Consortium Admin Assistant	P	P	P	P	P	P	100
Consortium Manager	P	P	P	P	P	P	100
BUPA	A	A	A	P	P	P	50
Bendigo District Aboriginal Cooperative	P	P	P	A	A	P	66
St John of God (Bendigo)	P	P	P	P	A	A	66

Appendix 2 - Profile of Consortium members

Voting members	Service Profile	Staffing (EFT)*	Key initiatives
Bendigo Health	Community Palliative Care Service	6.72	PCOC working group CORG Chair
	Specialist Inpatient Palliative Care Service	15.3	After-hours framework
	Regional Consultancy Service		Aged Care Link Nurse Disability Link Nurse Telehealth Patient planner redesign
Castlemaine Health	Community Palliative Care Service	1	PCOC working group After-hours framework
Echuca Regional Health	Community Palliative Care Service	2	Education project working group Advance Care Planning
Kyneton District Health Service	Community Palliative Care Service	1.85	Palliative Care Clinical Network representative After-hours framework
Maryborough District Health Service	Community Palliative Care Service	.4	Maintain Liverpool Pathway PCOC working group
Mildura Base Hospital	Specialist Inpatient Palliative Care Service.	3.3	Process improvement mapping
Sunraysia Community Health Service	Community Palliative Care Service	3.5	Process improvement mapping
	Regional Consultancy Service		Aboriginal project Patient Planner redesign
Swan Hill District Health	Level 2 Community Palliative Care Service	3	Maintain EOLCP

*The EFT data contained in the above table was correct as at December 2012. Minor changes may have occurred since then.

Appendix 3 - Strategic Plan progress

The table below contains additional information on Consortium achievements and helps to describe how this Annual Report maps to the Consortium's Regional Strategic Plan and to DH funding requirements.

Strategic plan goals	Strategic plan objectives/DH funding requirements	Achievements
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 entire Loddon Mallee Region.	Consultancy service established in Bendigo Health. For details see Highlights section above.
	Employ nurse practitioners across the region using relevant DH funds.	Two nurse practitioners engaged.
	Continue to work with the Victorian Aboriginal Palliative Care Program (VAPCP)[4] .	Aboriginal working group in Mildura continued and work promoted. For details see the Highlights section above.
	Identify areas where access to palliative care for CALD people.	Education session provided to Mildura Italian community in Italian.
Increase the availability of after-hours support to clients and carers in their homes.	Establish, evaluate and govern an ongoing program to enhance after-hours supports.	Continued to work on after-hours model across region For details see Highlights section above.
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 such as Palliative Care Outcomes Collaboration (PCOC) and PCCN outputs.	Promotion and introduction of many tools. See Highlights section above.
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.	Education Gap Analysis delivered. See Training, Education, Research and Workforce Activities section above.

[4] This is auspiced through the Victorian Aboriginal Community Controlled Health Organisation (VACCHO).

Strategic plan goals	Strategic plan objectives/DH funding requirements	Achievements
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. Employ aged-care link nurse to deliver range of DH KPIs across region.	Initial scoping and planning work for the use of these funds within the LMRPCCS has commenced. The program will be delivered by the nurse practitioners and clinical nurse consultants employed in the service.
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. Employ worker to deliver range of DH KPIs across region.	Initial scoping and planning work for the use of these funds within the LMRPCCS has commenced. The program will be delivered by the nurse practitioners and clinical nurse consultants employed in the service.
Strategic Direction 3: Delivering targeted health promotions		
Raise awareness of palliative care.	Develop and deliver an agreed palliative care health promotions strategy across the Loddon Mallee Region.	The Consortium allocated funding for Palliative Care Week activities across the region to raise awareness and understandings in the community. See health promotions section above for details.
Provide information on palliative care tailored to the needs of clients and carers.	Carers and clients receive targeted information.	The CORG have developed a Carers Kit that will support services when working with Carers. See CORG and after-hours sections above.

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.	There has been ongoing networking and liaison both between Consortium members and the office and relevant health, community, aged care and other bodies. The Consortium has attended and presented at over thirty meetings and travelled 20,000 km's within the region as part of its networking responsibilities.
Continue to enhance the governance of the Consortium.	Consortium runs efficiently and effectively, with the right mix of strategic, stakeholder and operational input.	The Consortium conducted a Board review to assess satisfaction with its progress. The results were overwhelmingly positive and proactive steps were taken to action all feedback. The Consortium made contact with Castlemaine Health's Consumer Advisory Group who agreed to perform this role for the Consortium.
Efficiently and effectively deliver Consortium core business, small projects and programs.	Plan, deliver, evaluate and acquit against Consortium funding streams in an efficient and effective manner.	See the Highlights section above for project reports.

Appendix 4 - Financial Statements

During the reporting period the Consortium approved a deficit budget as part of its plan to continue to spend down surplus funds in an appropriate manner.

The Profit and Loss statement below shows detailed transactions over the 2012/2013 fiscal year.

Profit and Loss Statement

Revenue	Amount $	
DH - Palliative Care Strategic Framework	107,132	
DH - Palliative Care Strategic Framework top up	12,604	
DH - PEPA Post Placement Support	11,500	
DH - Disability Palliative Care	5,000	
DH - Palliative Care Aged Care link nurse	15,550	
DH - After–hours palliative Care	170,755	
58518 Interest Received	20,623	
75062 Salary Recoveries	1,702	
57806 Miscellaneous Revenue	1,215	
Total Revenue	**$346,081**	
Expenditure	**Amount**	**Comments**
Combined Salary and Wages	196,591	
22091 Grants Received on behalf of and Paid to another agency	95,050	Extension of Aged Care and Disability Project for Bendigo Health and Sunraysia. Palliative Care Week grants to members. Advance Care Planning Pilot project in Echuca.
35002 General Administrative Expense	3,564	
35952 Contract administration services	8,124	
35004 Administrative Expenses	10,000	
28001 Food Expenses + 60600 Food transfers	588	
33101 Replacement & Additions Other Equip	115	
34003 Maintenance Furniture & Fittings	360	
35201 Advertising & 35202 Marketing	2120	
35401 Publications (Books/Journals/Videos)	85	
35616 Membership Fees/Professional Fees	763	
35636 Printing & Stationery	9,043	
35661 Motor Vehicle Expenses – Other plus 35871 Travel	4329	
35806 Staff Training and Development	68	
35851 Scholarships	-1314	

Expenditure	Amount $	Comments
35856 Conferences - Registration and Accommodation	4,002	
35881 Computer Consumables	215	
36102 Miscellaneous Expenses	2,559	
36125 Corporate Overhead	42,655	Set at 12.5% of revenue
37201 External Audit Fees	600	
61920 Transfer (Equipment)	2,457	
Total Expenditure	$381,080	
Operating surplus/deficit	**-$34,999**	

The table below shows the Consortium balance at the end of the financial year.

Balance statement

Consortium balance sheet as at June 30 2013	Amount $	Comment
Net cash inflow (outflow) from operating activities	-34,999	Balance includes assets worth $2247 held by fundholder
Net increase/decrease in cash held	-34,999	
Cash and cash equivalents at beginning of period	485,503	
Cash and cash equivalents at end of period	**$450,504**	

The table below provides a more detailed financial breakdown of the RMPF program.

RMPF Expenditure	Amount $
Peter MacCallum Institute – clinics in Mildura	24,234
Bendigo Health – Employ Physician for regional consultancy services	103,993
Bendigo Health - Additional Physician Hours using Consortium surplus funds as agreed with DH via Extension to Aged Care and Disability program	53,750
Total expenditure 2012/13	181,977
Total income 2012/13	128,227
Profit (Loss)	**-53,750**

RMPF balance held by Consortium fundholder as at June 30 2013	Amount $
Net cash inflow (outflow) from operating activities	-54,000
Cash and cash equivalents at beginning of period	129,000
Cash and cash equivalents at end of period	75,250
Balance – Consortium funds carried forward	**$75,250**

Appendix 5 - Performance of Loddon Mallee Regional Palliative Care Consultancy Service

The LMRPCCS is utilising draft Key Performance Indicators (KPIs) to structure and report on its work. As the service is still in its infancy not all of the KPIs can yet been reported. This Appendix contains reports against those KPIs for which information was available. The report covers the entire consultancy service – including the Southern service delivered by Bendigo Health and the Northern service delivered by Sunraysia Community Health Service with the Peter MacCallum Institute.

<table>
<tr><th>Key Performance Indicator</th><th>Result</th></tr>
<tr><td colspan="2">KPI 1 – Role description and range of services</td></tr>
<tr><td>Number of occasions of service of ‘in-reach’ consultancy to hospital based staff as a percentage of the consultancy service</td><td>Southern region (Bendigo Health)
43%

Northern region (Sunraysia Community Health Service)
15.25%</td></tr>
<tr><td>Number of ‘outreach’ occasions of service as a percentage of the consultancy service</td><td>Southern region (Bendigo Health)
57%

Southern region (Sunraysia Community Health Service)
84.75%</td></tr>
<tr><td colspan="2">KPI 2 – Catchment</td></tr>
<tr><td>Record of the distribution of the service/funding across the catchment by postcode ensuring equitable access across the region</td><td>Direct clinical services provided.

Southern region (Bendigo Health)<table><tr><th>Location</th><th>Patients</th><th>Patients %</th><th>Contacts %</th><th>Episodes %</th></tr><tr><td>Bendigo</td><td>132</td><td>62</td><td>64</td><td>59</td></tr><tr><td>Castlemaine</td><td>13</td><td>6</td><td>6</td><td>6</td></tr><tr><td>Echuca</td><td>16</td><td>8</td><td>7</td><td>6</td></tr><tr><td>Kyneton</td><td>5</td><td>2</td><td>3</td><td>3</td></tr><tr><td>Maryborough</td><td>5</td><td>2</td><td>3</td><td>5</td></tr><tr><td>Swan Hill</td><td>23</td><td>11</td><td>11</td><td>12</td></tr><tr><td>Mallee District</td><td>4</td><td>2</td><td>2</td><td>3</td></tr><tr><td>Outside Loddon Mallee region</td><td>14</td><td>6</td><td>6</td><td>7</td></tr></table>Northern region (Sunraysia Community Health Service)<table><tr><th>Location</th><th>Patients</th><th>Contacts %</th></tr><tr><td>Mallee District</td><td>56</td><td>323</td></tr></table>Information in this report is provided in PCRAM catchments - Future data will be grouped into local government areas (LGAs) for future reporting purposes.</td></tr>
<tr><td colspan="2">KPI 3 – Staffing profile</td></tr>
<tr><td>EFT report provided annually with details of staffing numbers</td><td>Consultancy Team - 5.29 EFT in total being:
Admin Officers – 1.72EFT (.37EFT ICT project worker, .53EFT</td></tr>
</table>

Key Performance Indicator	Result
including disciplines, qualifications and experience	administrative worker, .83EFT project manager, .05 EFT Mildura) • Medical Officers - .91EFT • Nursing Services – 1.71EFT in North and .8 EFT in Mildura. (Includes .9 EFT Nurse Practitioners).
KPI 4 – Education, training and research	
Number of regional education program activities undertaken by the LMRPCCS and the number of attendees. Evaluation forms to be given to all participants and reviewed after each education session.	The core Consultancy team conducted the following education and training as part of the introduction of the new service: Southern region (Bendigo Health) 32 sessions with 202 attendees Northern region (Sunraysia Community Health Service) 23 sessions with 150 attendees In addition they conducted the following as part of the Aged Care Link Nurse and disability programs: Southern region (Bendigo Health) 43 sessions with 582 attendees in Aged Care facilities 10 sessions with 115 attendee in disability services Northern region (Sunraysia Community Health Service) – disability and aged care combined. 14 sessions with 164 attendees Evaluation forms are reviewed at the end of each session and used for quality improvements.
Number of presentations/forums/PCCN meetings/conferences/CORG meetings attended by LMRPCCS staff.	Consultancy team presented at three CORG meetings and one PCCN meetings. Three PCCN meetings were attended. All six CORG meetings were attended.
Record of participation and membership of LMRPCCS staff in consultancy service statewide groups.	Both Nurse Practitioners hold membership with the Victorian Palliative Care Nurse Practitioner Collaborative. Physician involved in Palliative Care Clinical Network and Palliative Care Research Network. Clinical Nurse Consultant involved in Pain Clinical Indicator Working Group (PCIwg) and Aboriginal Palliative Care Collaborative, Consortium Aged Care and Nurses Group and Disability Group and Aged Care COP.
KPI 5– Quality framework	
Accredited with appropriate accreditation agency (currently ACHS).	Bendigo Health is accredited with ACHS. Sunraysia Community Health Service is accredited under ISO9001. Peter MacCallum Cancer Centre is accredited with ACHS.
Evidence of participation in clinical	NSAP was considered in design of service.

Key Performance Indicator	Result
improvement program and assessment against National Standards.	NSAP assessment to commence in 2014.
VINAH data submission on a monthly basis including additional data collection of 'delivery mode' and 'client present status' reported annually to the Department of Health .	VINAH date submission will commence shortly. Current financial year data was collected manually.
100% clinicians are credentialed.	All clinical staff are registered with AHPRA. In the Southern Region all clinicians are credentialed within Bendigo Health and eleven health services have accepted these credentialing arrangements. Work is progressing to achieve credentialing in the remaining services. In the Northern Region the Peter MacCallum Institute staff are credentialed with Sunraysia Community Health Service and Mildura Base Hospital.
KPI 6 – Service integration and linkages	
List of occasions and purpose of contact made with other specialist palliative care services	The services were located with Bendigo and Sunraysia specialist palliative care services. In the Southern Region - fortnightly teleconferences were offered by the Consultancy team to all specialist palliative care services.
Activity reports provided to the Loddon Mallee Consortium. The report will include operational activity, collaborative partnerships and educational activities.	Activity reporting has commenced.
KPI 7– Infrastructure, faculties and supporting services	
Formal protocols with community/acute services for access and referrals will be in place.	A referral form was designed and promoted heavily. Referral protocols are also described in the approved Guideline between the LMRPCCS and the Consortium. All outside referral are obtained via the SCTT tool or phone referral.
Evidence of use of tele-health facilities.	Videoconferencing consults have occurred at several hospitals including Cohuna, Heathcote, Donald, Kyneton and Swan Hill, Mallee Track Health and Community Services, Robinvale District Health Services and an aged care facility. These have occurred with patients that are inpatients or who are being supported by their local Community Palliative Care Service. One consult has been conducted with a patient at home in Maryborough with more of these being planned and another to a woman who is travelling around the country in a camper trailer.

Appendix 6 - RMPF Clinics in Mildura

RMPF funding continued to fund visits by physicians from the Peter MacCallum Cancer Institute to Mildura. The Peter MacCallum service also includes teleconferencing on specific cases as required and phone advice and support to Sunraysia Community Health Service staff in relation to specific (specialist) palliative care issues that arise on an ad-hoc basis.

This year Dr Odette Spryte took an oversight and support role, while most of the visits were conducted by Dr Corry De Neef.

In the following table the number of monthly tele-conferences is under reported. An improved recording system is under development for 2013 with enhanced compliance with DH reporting requirements (VINAH).

Site of visit	Jul 2012	Aug	Sept	Oct	Nov	Dec	Jan 2013	Feb	Mar	Apr	May	June 2013	Total
Mildura Regional Clinical School – Monash University	N/A	4	1	4	3	3	2	3	4	4	2	3	**33**
Home	-	-	2	1	1	1	1	2	-	1	-	1	**10**
Mildura Base Hospital	-	2	-				3	-	-	-	1	-	**6**
Mildura Private Hospital	-		-	-	1		-	-	-	-	1	-	**2**
Residential Aged Care Facility	-	-	-	-			1	2	-	1	1	2	**7**
Tele-health / case management	-	-	1	1	2	2	1	2	1	2	3	3	**18**
Patient status													
New patients seen	-	2	3	1	2	3	2	4	2	3	1	4	**27**
Patients reviewed	-	4	1	5	5	3	6	5	3	5	7	5	**49**
Total patients per month	-	6	4	6	7	6	8	9	5	8	8	9	**76**
Monthly Tele-conferences *number under reported*	-	2	1	1	1	1	2	2	3	2	2	4	**21**
Education session/attendees	-	5		-	-	-	-	-	16	-	-	10	**31**

6. Glossary of Acronyms Used

Glossary of Acronyms Used	
ABF	Activity Based Funding
ACD	Advance Care Directives
ACHS	Australian Council on Healthcare Standards
AHPRA	Australian Health Practitioner Regulation Agency
ATSI	Aboriginal and Torres Straight Islanders
CALD	Cultural and Linguistically Diverse Palliative Care
CEO	Chief Executive Officer
CORG	Clinical Operations Reference Group
CPC	Community Palliative Care
DH	Department of Health
EFT	Equivalent Full Time
EOLCP	End of Life Care Pathway
GP	General Practitioner
HACC	Home and Community Care
KPIs	Key Performance Indicators
LGAs	Local Government Areas
LMRPCC	Loddon Mallee Regional Palliative Care Consortium
LMRPCCS	Loddon Mallee Regional Palliative Care Consultancy Service
MND	Motor Neurone Disease
NSAP	National Standards Assessment Program
PCCN	Palliative Care Clinical Network
PCIwg	Pain Clinical Indicator Working Group
PCOC	Palliative Care Outcomes Collaboration
PCP	Primary Care Provider
PEPA	Program of Experience in the Palliative Approach
PMCC	Peter MacCallum Cancer Centre
RACF	Residential Aged Care Facility
RMPF	Rural Medical Purchasing Fund
RPC	Respecting Patient Choices
SCTT	Service Coordination Tool Templates
SCHS	Sunraysia Community Health Service
SPCP	Strengthening Palliative Care: Policy and Strategic Directions 2011-2015
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
VAPCP	Victorian Aboriginal Palliative Care Program
VINAH	Victorian Integrated Non-Admitted Health Minimum Dataset
VPCSS	Victorian Palliative Care Satisfaction Survey