Loddon Mallee

Regional Palliative Care Consortium

Annual Report 2013 - 14

www.lmrpcc.org.au

PO Box 50 Castlemaine, 3450

loddon mallee
regional palliative care consortium
Enhancing life and quality of health

Contents

Overview

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

1. Implementation of an additional 17 Palliative Care Clinical Network (PCCN endorsed tools) within the services. **Appendix 1** contains details of the increase in tools used.

2. Implementation of the Bereavement Framework in conjunction with the Loddon Mallee Regional Palliative Care Consultancy Service (LMRPCC). There was a large increase in the usage of the framework across the region, from 80 elements to 131 elements, as shown in **Appendix 2**.

3. Active coordination of regular Clinical Advisory Group meetings with managers and other key stakeholders in the region. The group discusses Department of Health (DH), PCCN and Consortium Board priorities, identifies barriers and enablers, provides networking, support and education activities as well as clinical and project advice and support.

4. Regional roll out of National Standards Assessment Program (NSAP) audits – with an increase from one to nine services now participating. NSAP enables services to assess their performance against the national palliative care quality standards and to prioritise and plan improvements.

5. Managing and/or supporting/planning a suite of projects including the Aged Care Link Nurse, Disability, After-hours Regional Framework, PCCN Tools Implementation and Bereavement Framework Implementation.

6. Influencing clinical and data processes to create a more seamless patient journey between the Community, Consultancy and In-Patient services at Sunraysia Community Health.

7. Supporting new managers in the region to understand their roles, focus on client and patient care and report appropriately

8. Providing advice and recommendations to the DH to improve palliative care service delivery in the region

9. Communicating about palliative care to generalist regional services to increase appropriate referrals and identify opportunities.

In determining what work to prioritise the Consortium:

1. Conducted a broad Strategic Planning Process to develop a Regional Plan in 2010, which is regularly reviewed.
2. Has a strong governance structure that closely monitors progress against this plan and makes changes as required as new evaluation information, data or sector requirements become available.
3. Has a project management framework that incorporates evaluations of all projects, and the ability to make changes if required.
4. Uses information shared through close and regular contact with networks across the region including service clinicians and management.

This report describes the Consortium's projects, programs, situation, achievements, directions and finances to meet our role. **Appendix 3** contains detailed information about how we have met our KPIs. **Appendix 4** describes how this maps to the Regional Plan.

Report from Consortium Chair – Kathy Wright

The Consortium spent the year focusing on investing and committing all our funds to achieve the changes required in the government's Strengthening Palliative Care Policy and Strategic Directions. A major commitment was that we initiated and supported NSAP reviews in eight specialist palliative care services. This allowed us to identify and prioritise gaps on both an individual and regional level.

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

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."*

The achievements of the Consortium's funded projects and programs are described in this annual report. These include working with the LMRPCCS to implement the Palliative Care Bereavement Framework, building networks and connections and disseminating information and resources.

This year the Consortium Board commissioned a small review to establish our successes and opportunities, and help priorities work over the next year. The review found that there is significant support for the Consortium from our eight member organisations, with wide reporting of direct value and benefits from our work.

The review confirmed that the capabilities of The Consortium include:

1. Strong governance leading to the ability to be impartial, inclusive and trusted by a wide range of stakeholders and

incorporate the views of middle, senior and executive management in decision making across agencies.

2. Systems and processes for networking and information sharing.
3. Significant stakeholder, evaluation, service planning, change, mentoring and project management staffing skills and frameworks.
4. Extensive mix of local, regional and statewide knowledge and networks pertaining to the services and the systems. For example there are active working relationships with smaller regional health agencies, consumers, carers, volunteers, CALD and Aboriginal organisations, HACC, Councils, PCPs, Medicare Locals and more.

I take this opportunity to acknowledge the contribution of all of our board members, our colleagues from the DH 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.

I would like to thank departing Board members former Chair Tracey Hynes from Kyneton and Liz Hamilton from Bendigo who have contributed so much to the Consortium and to the provision of expert quality care within our region.

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

Ilana Solo in front of a sunken paddle steamer in Mildura. It has now been refloated.

Report from Consortium Manager

I would like to begin this report with a special tribute to my friend and colleague Cherie Waight. Cherie was a proud Yorta Yorta woman who I met through her role as Senior Palliative Care Project Manager at VACCHO. Cherie was passionate about improving palliative care for Aboriginal People and was so charismatic that she brought many people along on this journey.

Cherie introduced me to many wonderful people and had so many fantastic ideas. She was truly respected and had a clear vision which I intend to carry on in my work. Cherie will be dearly missed.

XXX

A key determinant of the success of any organisation is that it understands and meets the needs of its members and stakeholders. Our stakeholders are the clients and carers in the Loddon Mallee Region who are on a palliative care journey. Our members are the Specialist Palliative Care services who work tirelessly to support these people across the health system, and the DH who provides support and sets performance requirements.

The first approach the Consortium has taken to meet the challenge of implementing the ambitious Strengthening Palliative Care Policy is to become close to our member services so that we understand and meet their needs.

The other day I was talking to one of the Managers of a Specialist Palliative Care Service (SPCS). She exclaimed that she now knows my telephone number by heart. I was thrilled: this must be an indicator that the support the Consortium has provided is needed and utilised by her.

There are key similarities and differences between member services, and what each needs differs accordingly. Some benefit greatly from direct visits and support. Others prefer telephone contacts and others funding to implement projects independently. Others like support to provide audits and data analysis services to support their planning and evaluation work.

The second way the Consortium improves the palliative care journey for clients and carers is to identify and seek to fill some of the gaps or grey spaces between the existing service systems. For example we are trying to enhance consumer engagement with the palliative care sector by working closely with a consumer leader in the region and introducing literature about consumer engagement into our CORG clinical group.

We have also mapped the various networks and systems and conduct regular visits to help link these systems up.

We have continued to try to increase culturally appropriate services provided to Aboriginal People, as described below.

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

Also thanks to Mary Crigan, our Administrative Assistant who is still unwell and we her miss dearly. Also farewell and thanks to Bertilla Campbell and Tracey Harrip, two senior clinicians and leaders who are having a (hopefully temporary) break from the palliative care sector.

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 2013-14 the Consortium consisted of the following voting and ex-officio members:

Organisation	Board member
Bendigo Health	Liz Hamilton
Castlemaine Health	Amanda Edwards (Deputy Chair)
Echuca Regional Health	June Dyson
Kyneton District Health Service	Tracey Hynes then Maree Cuddihy
Maryborough District Health Service	Fiona Brew then Karen Laing
Mildura Base Hospital	Angela Imms then Claire Eaton
Sunraysia Community Health Service Inc	Ruth Fox
Robinvale District Health Services Representing CEOs	Mara Richards
Swan Hill District Health	Kathy Wright (Chair)

Ex – Officio	
DH – Loddon Mallee Region	Andrew Kallaur
Consortium Manager	Ilana Solo
Consortium Administrator	Mary Crigan then Bronwen Machin

Appendix 5 shows meeting attendance records for the period. **Appendix 6** contains a brief profile of each member service including the locations of each specialist palliative care service. **Diagram 1** represents Consortium structure.

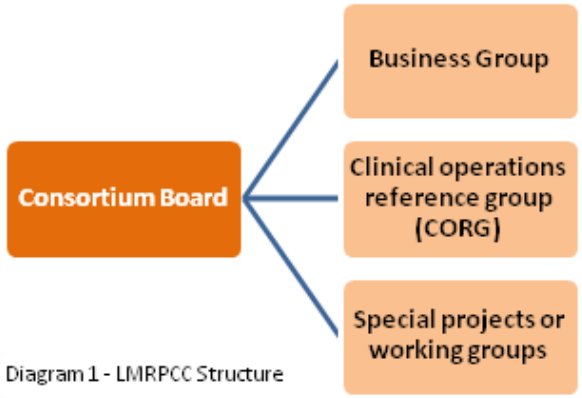


Diagram 1 - LMRPCC Structure

This structure is based on templated "Role Statements" developed and managed by DH[1].

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 included the 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.

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).

Regional Strategic Plan implementation and progress

The Consortium continued to work through its 2011-2015 Strategic Plan mapping the seven strategic directions from the Strengthening Palliative Care Policy and Strategic Directions (SPCP) into four regional priority areas.

1. Coordinating quality care across settings

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

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

Appendix 3 contains detailed information about how we have met our KPIs. **Appendix 4** describes how this maps to the Regional Plan.

Appendix 7 describes the Consortium financial position as at 30 June 2014.

The Consortium also reoriented some of its work towards meeting the DH Key Performance Indicators for Consortium developed in 2013, and more closely aligning its work towards the Department Health Role Statements.

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 23 health services. All deliver generalist palliative care services and our eight members deliver specialist palliative care services.

How demographic and research information shaped goals and priorities

The "Loddon Mallee region health status profile 2012"[2] 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	2013-14 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.	Purchased iPads and data for all Community Services so they can facilitate Telehealth sessions, and real time data and referrals in the patient's home. Commence discussions to improve discharge processes between specialist in-patient and community services. Continue Telehealth model in LMRPCCS including Aged Care and Disability programs.	Continue to support services to review models of care to accommodate distances. Continue to improve discharge processes between specialist in-patient and community services.
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.	Commence PEPA funded self care workshops for staff. Trial of Social Worker position in LMRPCCS Networking and support provided to services.	Evaluate and extend previous initiatives where valuable/possible.
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.	Support LMRPCC to continue with aged care and disability project. Support Maryborough district health to streamline documentation across its palliative, acute and aged care services. Met with ACAS services to discuss and improve referral processes.	Continue with aged care and disability project. Support services to review models of care to accommodate aged and disability services.

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

Regional profile	Impacts for palliative care	2013-14 Consortium response	Future directions
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.	Fund Mildura Aboriginal District Cooperative for a Palliative Care volunteers program. Support Echuca Regional Health to obtain funding for Aboriginal Project in Glanville Village Nursing home. Visit ACCHOs, Aboriginal Hospital Liaison Officers and HACC workers. Continue Mildura Aboriginal Reference Group.	Funding has been allocated for cultural training in region Continue Aboriginal Palliative Care Program.
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.	Jointly present with a cancer consumer to Mildura cancer consumer group with membership of people from Iran, Iraq, Sudan and Afghanistan. See the CALD Palliative Care component in the Regional Planning and Coordinating section below.	$12500 Funding has been allocated to extend PCV's culturally specific education to region. Continue to monitor and to identify other opportunities to engage with sector. Continue to monitor and consider in design of future 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.	Initiate survey of Aged Care Link nurses to understand impact of change.	Continue to monitor and consider in design of future 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.	Clients with chronic disease were considered as part of the planning processes for all projects.	Continue to monitor. Support services to review models of care to accommodate increasing chronic disease.
Death rates – there were 2674 deaths in the region in 2012. The death rate was higher than the Victorian average for all of the LGAs in the region with the exception of Macedon Ranges	Increased demand on palliative care services.	Initiate a range of activities to make services more efficient and conduct discussion with managers around how they would manage the expected increases in demand.	Support services to review models of care to accommodate regional needs. Provide benchmarking data to services to enable them to structure their work efficiently.

Regional profile	Impacts for palliative care	2013-14 Consortium response	Future directions
Lower GP rates – in some parts of the region there are significant shortages of GPs.	GPs not available, particularly for visits leading to additional pressures on nurse led services and increased reliance on GPs that may not have a good understanding of the palliative approach.	Support and promote the LMRPCCS	Continue education and training program. Continue to monitor.

The DH published a "Palliative Care Workforce Study, volunteers and employees" in 2013. [3] The following table describes some of the key findings that are particularly relevant to the region and its implication for palliative care and the Consortium.

Workforce findings	Impacts for Loddon Mallee Region	2013-14 Consortium response	Future directions
The role of a manager of volunteers is very important in enabling volunteers to support patients, carers and families. Nearly all volunteers (98 %) have a manager.	Many volunteer managers do not have detailed understanding of palliative care requirements	Commence meetings with volunteer managers in each service regarding palliative care.	Continue to support generalist volunteer managers relating to palliative care.
Most volunteers work between one and four hours per week but more than 20% work more than four hours per week. The number of hours volunteers work is equivalent to 30% of paid full-time employees. Administration support has more than doubled as a key volunteering task to 30%.	Volunteers are a large potential resource for specialist palliative care services. These are not always optimally utilised. For example several services do not have any volunteers.	Commence project with one service to reinstate volunteer program. Fund some Mildura volunteers to attend volunteer training in Bendigo.	Continue volunteer reinstatement project. Seek other participant services. Seek to promote benefits of administrative volunteers to members.
Palliative care employees are predominately female (86 %).	Some males do not like to receive care from females. This is particularly pertinent in Aboriginal organisations	Continue to promote protocol of involving male Aboriginal health workers in care of Aboriginal men if this is the preference.	Implement agreement between services for sharing of male staff members when needed.

3 http://docs.health.vic.gov.au/docs/doc/3461D52ED06DE953CA257C2A00038137/$FILE/Palliative%20care%20workforce%20study.pdf

Workforce findings	Impacts for Loddon Mallee Region	2013-14 Consortium response	Future directions
Eighty-six % of employees deem themselves to be either in the middle or at the end of their career. Thirteen % of employees are actively looking for work outside the palliative care sector.	Loss of very experienced staff from service imminent.	Fund and support training initiatives to disseminate more skills. Heavily promote PEPA program. One service has participated in active succession planning as a result of Consortium interventions.	Continue to promote education programs. Seek to instigate a culture of skills dissemination and sharing across services.
For the dissatisfied employees, increased management support followed by further education are identified as ways to increase satisfaction	There are real benefits in directly supporting and mentoring management to enable them to provide better support to staff.	Create supportive environment for CORG members.	Utilise additional PEPA funding for self care education.

Reports

Consortium Executive Report

The Business Group (Executive) 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 the changes to Consortium funding and reporting initiated by the DH.

CORG Report

CORG continued to meet and share information, practices, barriers and enablers and expertise. CORG worked on a range of projects and many members attended NSAP and PCOC training together.

CORG held a strategic planning day this year, which helped the Consortium to allocate its surplus funds.

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. The CORG were integral to the region's achievements of implementing 18 new PCCN tools and 51 elements of the Bereavement Framework.

Topics and outcomes of the meetings included:

1. Education sessions on GP engagement, bowel management, aged care and disability services, case studies.
2. Project development including PCOC working group, After-hours program

Improving connections with other services including ACAS, PCCN and VACCHO.

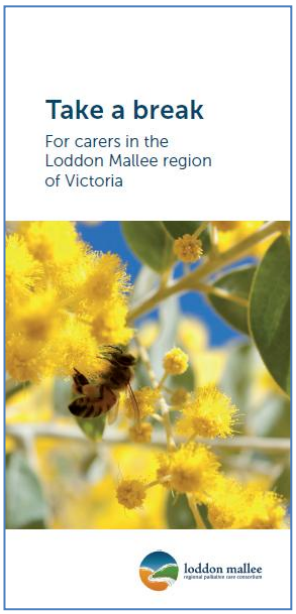


Image of the new Respite Brochure developed with CORG

Regional planning & coordinating care

Loddon Mallee Regional Palliative Care Consultancy Service (LMRPCCS)

The LMRPCCS continued to coordinate access and service provision for palliative care patients, carers and their families through referral, specialised advice and liaison with acute services, inpatient palliative care units, ambulatory care clinics and community palliative care services across the region.

The key components of The LMRPCCS are:

1. Primary and secondary complex consultations (outreach) to clients and families across the region
2. In-reach complex consultations and assessments to inpatient services for clients and families

3. Capacity building and mentoring of specialist community palliative care service, generalist community based health organisations, in-patient services, disability services, residential aged care services and general practitioners

4. Direct face to face and/or telehealth assessments and care planning across the region

5. Coordinating/facilitating access to appropriate services across the region

6. Building collaborative partnerships with multidisciplinary health care teams

7. Seeking opportunities to actively participate in formal, undergraduate and post-graduate education and training of medical, nursing and allied health staff and palliative research

8. Assisting in the implementation of end-of-life pathways in residential aged care and disability facilities

The LMRPCCS is delivered by Bendigo Health in the region south of and including the Swan Hill township. It is delivered by Sunraysia Community Health in the Greater Mildura Shire and the Swan Hill (Rural City) Robinvale area.

The LMRPCCS has a close relationship with the Consortium in that:

1. The Consortium has ratified LMRPCCS KPIs which includes an agreed reporting framework.

2. LMRPCCS staff attend CORG and are represented on the Consortium Board.

3. Bendigo Health responded to a Consortium Board request to trial a social worker in the LMRPCCS.

4. The Consortium funded iPads and data for all Palliative Care Community services to facilitate Telehealth consultations from the LMRPCCS.

Social Worker Case study

We have recently been visiting a terminally ill young woman who lives on a property in one of our outlying communities. She was married with a number of young children and had a history of mental health issues. Her illness was exacerbating her mental health problems and she had significant symptom burden from her rapidly progressing disease. Her family was also suffering in coming to terms with this very sad situation and needed increased support and guidance.

Due to her rural location, the local health service did not have a social worker we could get to attend the home.

We were able to refer this woman and her family to the LMRPCCS social worker who was able to attend the home on a regular basis and provide invaluable support. Throughout her illness and subsequent passing, we have maintained a good communication between our service, LMRPCCS, the local district nursing service to ensure we are caring for the family in the most appropriate way.

Ipad Case Study

The iPad has enabled a local family to remain at home with ongoing complex palliative care needs due to the support available directly from the Palliative Care Physician and Nurse Practitioner with the family, GP, District Nursing Service and the local palliative care service. Hospitalisation was not required and the gentleman was able to remain at home in the place of his choice despite complex needs due to being able to link all services.

This device has also been utilised to link in with other specialists and has been offered to other specialists to reduce the travel burden that has a significant impact on. Having clients and carers awareness of the ability to utilise Telehealth from home has enabled clients and carers themselves to ask their specialists if this method can be utilised for their review appointments.

Aboriginal palliative care

In response to the high Aboriginal population in the Loddon Mallee Region the Consortium continued to actively promote Palliative Care to the Aboriginal community and attempt to improve provision of culturally appropriate care.

The Consortium worked with Bertilla Campbell from the LMRPCCS in Sunraysia to maintain an Aboriginal Advisory Committee in Mildura. This included participants from the Mallee District Aboriginal Services, Mildura Base Hospital and the Medicare Local.

With the support of VACCHO, visits to three local ACCHOs and two Aboriginal Hospital Liaison Officers (AHLO) continued, and networks continued to be formed. This led to the funding of Mildura Aboriginal District Cooperative for a Palliative Care volunteers program.

The Consortium Manager worked closely with the AHLO and Director of Nursing in Echuca to successfully obtain a grant from the Victorian Aboriginal Palliative Care Collaborative (VAPCC) to improve the palliative care provided to residents of their residential aged care facility.

The region was well represented on the VAPCC with two representatives on the Steering Committee.

PEPA post-placement support activities

The Consortium again received funding to deliver the Post-PEPA support program through the DH. Rather than creating education separately from member organisations, two existing education departments were contracted to deliver sub-regional education as an initial trial.

This decision enabled the education to be delivered efficiently, utilising existing networks and simultaneously up skilling the education providers in the palliative approach.

Kyneton's Alison Lowe talking to consumers during Dying to Know Day.

The contracted agencies were invited to select from a range of topics that had been identified in the 2012 Education Gap Analysis and survey of Post-PEPA participants. Maryborough offered the following education:

1. Communicating with Carers of Patients with a Terminal Diagnosis in conjunction with Carers Victoria - two sessions
2. Loss, Grief and Bereavement in conjunction with the Centre for Grief and Loss
3. Self-care for people working with a terminal illness – two sessions.

Castlemaine offered a comprehensive full day session focusing on communication and Palliative Care which included a GP panel.

Post-PEPA recipients were invited to all of the education sessions and evaluations were positive.

At the end of the financial year the Consortium was excited to receive a further $18,000 for Post-PEPA education. This is being utilised to deliver self-care workshops hosted by each member service. This was prioritised regionally as a result of the NSAP processes that the Consortium initiated.

Health-promoting palliative care activities

The Consortium sponsored members to organise Palliative Care Week events and undertook a range of other health-promoting palliative care activities. Please refer to the section Strategic direction 7: Ensuring support from communities in **Appendix 3** for details.

Photograph of Margaret Spetting with a picture of her and her late husband Ron in an article from Riverine Herald praising the palliative care service in Echuca as part of Palliative Care Week promotions.

After-hours palliative care

The Consortium actively maintained the regions After-hours model which aligns with the DH After-hours Framework. It engaged services to review their processes, refining processes and offering three telephone triage training days for After-hours staff. It continued to develop resources to support clients and carers during hours, including a regional respite brochure and improved Carers Kit.

Protocols: The Loddon Mallee region's After-hours model utilises the After-hours staff in every service to respond to palliative care After-hours calls. These are generally senior nurses who have received the Consortium's telephone triage training and protocols to enable them to respond to specialist palliative care calls. The Consortium has met with most of these staff to encourage and support them to continue to utilise the palliative care protocols initial design of the After-hours model in 2010. This will ensure best practice advice is provided to clients, and referral processes are clearly defined and followed.

After-hours policies and procedures for each service are currently being developed, as is an After-hours induction manual for all new staff members, which was identified as a region-wide need.

Improving After-hours data: The Consortium developed an improved method and form to collect data about After-hours calls. This includes better demographic information about clients, specific reason for the call, what advice was offered, and how the caller responded to the advice. **Appendix 8** shows the data collected from three of the four services who had implemented this in 2013.

Better data collection processes gives clearer information about why clients call After-hours services. This will help inform better palliative care practices during business hours. For example, data reveals people are having problems with syringe drivers. The Consortium has reviewed the syringe driver component of the Carers Kit and promoted syringe driver training as a result.

Training: Telephone triage training sessions are integral to the maintenance of the After-hours framework. Three telephone triage training days have been provided to twenty-six generalist nurses. Consistently positive feedback has been received.

Carer Kit review: 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.

Re-developing the kit involved consulting with carers and members of consumer groups (approximately 20 people) to obtain their feedback and suggestions for improvement. These recommendations were then discussed with the relevant clinicians such as occupational therapists, physiotherapists and clinical nurse consultants to determine the best way of presenting the information.

The kit includes 16 different information and equipment cards covering a range of different topics including: how to use a bath chair; using a portable nebulizer; giving sub-cutaneous injections and how to prevent bed sores.

Carers are shown face to face how to use equipment by a nurse, physiotherapist or OT, and the information cards are left behind for the carer to refer to once the health team has gone.

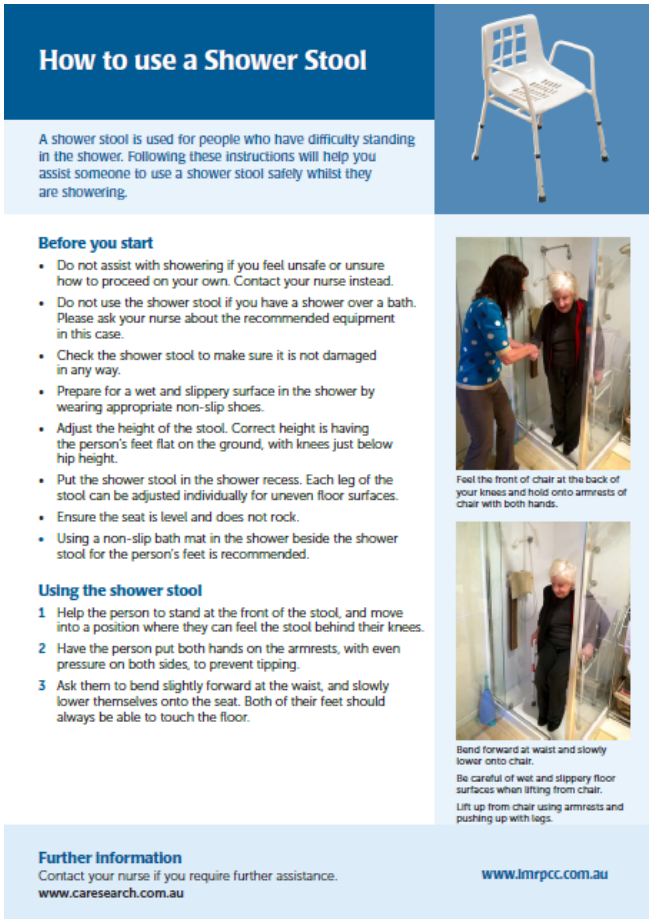


Image of the Shower Stool page of the Carers Kit. There are to be 16 cards in total.

Photos and captions depicting the specific steps of using the equipment were taken and then sent to a professional editor and designer to arrange in the most visually appealing way. The Kit will be printed and distributed to palliative care services within the Loddon Mallee towards the end of this year and submitted to the PCCN for endorsement as a statewide resource.

Evaluation and transition

After-hours funding will transition directly to services in 2015. Services will be fully responsible for ensuring ongoing maintenance of the model. The Consortium is conducting a comprehensive evaluation of the After-hours services and model to support this transition. This will include analysis of data and of interviews of carers and specialist and generalist staff.

The report will make recommendations for refining the model and making it more sustainable into the future.

CALD palliative care

The Consortium supported a consumer to attend a Cancer Consumer CALD meeting in Mildura and present about palliative care.

Relevant training opportunities have been heavily promoted on the website.

The Consortium maintained its 2010 *Outline of Different Cultural Beliefs at the time of Death* document on the website. This was re-printed in the national newsletter of the Australian Funeral Director's Association.

CALD Cancer Consumer group in Mildura.

MND regional worker activities and RMPF funding

Bendigo Health receives MND regional worker funding and continued to employ a worker to provide training and support to clients in the region.

Bendigo Health and Sunraysia Community Health Service receive RMPF funding. It supported the employment of Dr Tiffany Shaw in Bendigo Health who was located in the LMRPCCS.

It supported 10 clinics and a Telehealth service in Mildura delivered by Dr Corey DeNeef from the Peter MacCallum Cancer Centre. 85 patients were seen in total, with 33 of these being via Telehealth.

Other achievements

Bereavement support standards

As part of its responsibilities to help implement PCCN initiatives the Consortium implemented a Bereavement Standards project.

A baseline audit of existing bereavement support initiatives in all services was undertaken. Members were also asked to nominate the standards that required

assistance to implement. All services requested some level of support to enhance the level of bereavement support they offer to clients, including help with:

1. Bio-psychosocial assessment tools
2. Basic bereavement training for clinical and non-clinical staff
3. Protocols for supporting staff
4. Protocols for dealing with at-risk clients
5. Protocols for making referrals to specialist bereavement services
6. Position descriptions for bereavement coordinators.

The Consortium Board requested that a social worker be employed in the LMRPCCS whose role would include working with the Consortium staff to deliver the project jointly.

A joint Project Plan was created and has been actively progressed. This has delivered:

1. Education on implementing the PG13 tool for complicated grief in three services.
2. Generic position descriptions for bereavement coordinators were circulated and have been implemented by two services.
3. Protocols for supporting staff, dealing with at-risk clients and for making specialist bereavement referrals are being drafted by the Consortium.
4. Education and direct support for services to implement the standards.

The project has been extremely successful in implementing the standards, as shown in **Appendix 9** which demonstrates that 51 improvements have been made as a result of the project.

In-patient beds in Echuca

As part of the redevelopment of Echuca Regional Health, funding was received to open two brand new in-patient beds. The service is to be formally launched shortly.

Nurse Unit Manager Denise Gowty on the new balcony.

Respite beds in Kyneton

Kyneton Health initiated two new respite beds for palliative care clients. As a small rural health service, Kyneton Health is able to take such initiatives due to its more flexible funding.

Peter Matthews, Board President opening the two new respite beds in Kyneton Health.

Future directions

Consortium plans for the immediate future will centre on evaluating the After-hours program ready for handover to services, and continuing to support services to implement the Strengthening Palliative Care Policy.

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. This includes supporting the $21,000 project with MDAS to train and support Aboriginal Palliative Care Volunteers in the Mildura region.
3. Support 14 new projects in member services, as described in the table below.

Location	Funded projects
Bendigo	NSAP Audit including subsequent improvements
Castlemaine	To restructure palliative care service and develop new Model of Care
Echuca	Implement Bereavement Framework Establishing model of care for in-patient unit. Implementation of care plans for community palliative care patients
Kyneton District Health	Implement PCOC Palliative Care Client Assessment Motor Neurone Disease education Best practice Service Coordination between services providers Implement Bereavement Framework
Maryborough	Identification of most suitable evidence-based tools to support a consistent model for the provision of a palliative approach to the care across the hospital for community clients, hospital inpatients and residents in RAC facilities with a life-limiting illness.
Mildura (Base Hospital)	NSAP Audit including subsequent improvements
Mildura (Sunraysia)	Communication and coordination project
Swan Hill	Research and replace service software due to inability to accurately report mandatory data to VINAH despite data collection and input.
Total Grant allocation	$77,965

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

Bendigo 107kms, Mildura 308kms.

Appendix 1 – Usage of PCCN tools

The Consortium and CORG group worked to implement PCCN tools. The table below shows the current usage compared to the baseline collected in 2012/13.

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

Please also see Appendix 2 for implementation of the Bereavement Framework which is also endorsed by the PCCN.

Appendix 2 – Implementation of Bereavement Framework

The Consortium and LMRPCCS worked to implement the PCCN endorsed Bereavement Framework. The table below shows the current usage compared to the baseline collected in 2012/13. The data pertains to the LMRPCCS and seven Community Palliative Care Services in the region.

Standard	Measure	2012/2013	2013/14
Pre-death Screening	Bio-psycho-social spiritual assessment	3	5
	Education resources – literature/ brochures, re grief process & specialist support available	4	5
At Death	Courtesy phone call	4	6
	Informal/formal assessment	3	6
12 Weeks	Telephone assessment	4	3
6 Months	PG13 for at-risk clients	1	3
12 Months	Bereavement Card	3	2
	Memorial Service	4	3
Staff Training	Bereavement Coordinator	3	3
	Position Description	2	4
	Budget for bereavement follow-up (larger services)	1	1
Access	Basic cultural training for staff on local social groups	4	4
	Multi-faith resource file	2	3
	Professional development planner (bereavement support)	2	2
Training	Basic bereavement training for all clinical & non-clinical staff	3	4
	Professional development opportunities regularly documented	2	4
Volunteers	Undertake Pal Care Vic training modules	0	3
	Ongoing supervision scheduled and documented	0	5
Staff Support	Protocols for supporting staff are clearly identified	2	5
	Staff access ongoing supervision & support	0	4
	Death reviews conducted & staff debriefings organised for complex deaths	1	3
Clinical handover	Documented protocols for dealing with at-risk clients	2	3
	Documented protocols for making referrals to specialist services	3	4
	Documented protocols for actively supporting clients to access specialist services	2	3
Health promotion	Participation in community education & health promotion (eg, Pal Care week, Grief-awareness week)	3	6
	Development of effective inter-agency networks	2	5
	Staff are aware of range of other local support resources available to clients	4	6
Quality improvement	Evaluation strategy developed	1	5
	Relevant datasets established & collected from clients	3	4
	Bereavement service undergoes ongoing evaluation & continuous improvement	0	4
Resources	Grief brochures	5	5
	Information sheets	5	5
	Other (please stipulate)	2	2
TOTAL		**80**	**131**

Appendix 3 - KPI reporting against strategic directions

Statewide Consortia are required to report against relevant components of the SPCP Implementation Plan. Metrics have been agreed with the DH. What follows is information about what the Consortium has delivered, how it has met it's KPI and describes some of the impacts of this work.

Strategic Direction 1: Informing and involving clients and carers

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

Actions: 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.

Required impacts: All clients have an up-to-date interdisciplinary care plan that reflects their wishes for how they would like to be involved in the planning and delivery of their care.

Where appropriate, a copy of the completed care plan is provided to the client (and carer) and to other care providers, including the client's GP.

What the Consortium has delivered:	Performance Measure	KPI Metric	Actual impacts
Continued promotion of the PCCN tools. Support to services to implement these. The Consortium gained agreement from all of its members to perform a self assessment against the National Palliative Care Standards. NSAP participation has increased from one to nine of the eleven specialist services. A Consortium project officer assisted. The NSAP reviews revealed that most services create and update interdisciplinary care plans using progress notes rather than a validated template that can be explicitly agreed and shared. Cultural change is required to change this in some services. The Consortium has circulated several validated tools and policies for services to select from and funded training and implementation for some services.	Regional agreement to use consistent tools, as endorsed by the PCCN, across inpatient, community and consultancy services.	**# &/or % palliative care providers using PCCN endorsed tools.** 100% of SPCSs in Loddon Mallee Region are using at least one PCCN endorsed tool. Usage rates have increased in 2013-14 from 25 to 42 tools used as described in Appendix 1. Compliance with the Bereavement framework has increased as described in Appendix 2.	Large increase in use of validated tools has a clear impact on quality of service provided. For example four new services are using the Carer Support Needs Assessment Tool to rigorously assess the needs of their clients. Some of the increase in use of PCCN tools has been due to NSAP which requires the use of validated tools.. As part of NSAP services have prioritised and committed to: • Implementation of the 'Bereavement Framework' (5 services) • Implementation of a Care Plan template (6 services) • Advance Care Planning (4 services) • ISBAR – Handover Tool (4 services) • Documentation of place of care/death (4 services) • Improve documentation of phase change (4 services) • Validated assessment tools

What the Consortium has delivered:	Performance Measure	KPI Metric	Actual impacts
			(PCCN or other) (5 services) • Capacity building/support for carers (1 service) • Referral and Admission Policy (4 services) • Formal agreements/improved communication other service providers (4 services) • Safety and risk assessment policies and review (1 service) • Education for staff National Palliative Care Standards (4 services) • Utilisation of demographic data and community needs (3 services) • Incorporation of research, quality initiatives and/or audits (5 services) • Mentoring, relationship building, self care (5 services) Each of these will have benefits to clients and carers. For example introducing Care Plan templates will enable them to improve more explicitly reflecting the wishes of clients and carers.
The Consortium supported Bendigo Health to successfully implement PCOC into the in-patient unit.	Regional agreement to use consistent tools, as endorsed by the PCCN, across inpatient, community and consultancy services.	Many elements of PCOC are endorsed by the PCCN.	PCOC will enable the service to better understand and improve care provided and focus on regular and accurate assessments of clients.

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.

Increase the availability of After-hours support to clients and carers in their homes, particularly in rural areas.

Actions: Ensure access to a range of respite options to meet the needs of clients and carers by: Mapping available respite services; Strengthening links between palliative care services and respite services; Providing specialist consultation and advice to respite services about how to meet the needs of clients with a life-threatening illness; Implement After-hours model of care across Victoria.

Required Impacts: A range of respite services established, Respite services have increased knowledge about caring for people with a life-threatening illness, Clear and consistent eligibility criteria are developed and adopted by palliative care and respite providers.

What the Consortium has delivered:	Performance measure	KPI Metric	Actual impacts
The Consortium developed and distributed a respite brochure for clients of all services to enhance the documented policies and procedures relating to respite. The brochure clearly describes the respite options available in the region and the referral processes. The brochure is available on the Consortium website and will be distributed as part of admission processes for each service. The brochure was originally based on a Southern Metropolitan Consortium brochure. It was tailored for use in the region and widely tested with clients.	Information and education on respite, including providing care for children with a life-threatening condition, available regionally	**# &/or % services with respite education as part of documented policy & procedures**. Six of eight (75) Community Palliative Care Services have respite education as part of documented policy and procedures.	All new clients and carers will have clear and up to date information about accessing respite in the region. The brochure was discussed at both the CORG and Board level increasing knowledge around what is available and how the changes to aged care underway are impacting respite in the region.
The Consortium invited ACAS providers to attend a CORG meeting and discuss the ACAS requirements for entry including how to access respite in a timely manner.	Services use criteria to assess respite service eligibility		Service capacity to make accurate and timely ACAS referrals enhanced. May lead to faster and more appropriate respite for clients.
An After-hours model which is aligned with the After-hours palliative care framework (DH 2012) was implemented across the Loddon Mallee Region in 2009/10. The Consortium maintained this framework during this year. This included reviewing policies and processes, reinstating processes in some services, offering After-hours nursing education	After-hours model of care implemented in each region	**# After-hours phone calls (interpret impact, compare with baseline data)** The Consortium was planning to utilise VINAH data to count After-hours calls however this data is not accurate. Detailed data was collected about 174 calls from three services, which is described in Appendix 8. **% satisfaction reported in VPCSS**	Four services have now adopted the new telephone triage record form developed by the Consortium. Using consistent record forms, protocols and communication channels with the SPCS ensures best practice advice and processes are followed. Evaluations Triage Training revealed

<table>
<tr><th>What the Consortium has delivered:</th><th>Performance measure</th><th>KPI Metric</th><th>Actual impacts</th></tr>
<tr><td>on processes, adding better data collection forms, running three telephone Triage training sessions with 26 participants, assisting services to analyse and take action on their data.

See the After-hours report in the Regional Planning and Coordinating Care section of this report.</td><td></td><td>Loddon Mallee improved for the following VPCSS measure - Availability for After-hours support:

<table><tr><th>Year</th><th>Region</th><th>State</th></tr><tr><td>2013</td><td>4.09</td><td>4.45</td></tr><tr><td>2014</td><td>4.31</td><td>4.44</td></tr></table>
The following VPCCSS measure describes results for Assistance for After-hours or unanticipated situations

<table><tr><th>Year</th><th>Region</th><th>State</th></tr><tr><td>2013</td><td>4.42</td><td>4.41</td></tr><tr><td>2014</td><td>4.42</td><td>4.33</td></tr></table></td><td>comments like:

“(The training) has given me insight into how to use protocols and has helped in answering phone calls”.

“It has helped me to be more aware of how I listen to callers and asking the right question. Using the protocols makes workplace practices less stressful and takes legal worry away”.</td></tr>
<tr><td>After-hours project was communicated through the website and CORG and Board members.

Services all communicate their model directly to their clients via discussions and templated information.</td><td>After-hours model of care implemented in each region</td><td>Knowledge of After-hours model of care (e.g. pre/post education evaluation)

100% knowledge of After-hours model of care was reported amongst triage education participants and CORG members.</td><td>Clear information provided about model of After-hours care in the region.</td></tr>
</table>

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.

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

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

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 will be developed for GP’s as a priority.

Improve palliative care capacity in disability accommodation services.

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.

Establish an aged care palliative care link nurse in each region.

Required impacts: Clients receive timely and appropriate referral to palliative care, Information and referral processes promoted by the palliative care sector are consistent with referral and coordination strategies across health, community and aged care providers, 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.

<table>
<tr><th>What the Consortium has delivered:</th><th>Performance Measure</th><th>KPI Metric</th><th>Actual impacts</th></tr>
<tr><td>The Consortium continues to implement the recommendations from its 2013 Education Gap Analysis report, which mapped the wide service network and the education and training it required. Three member services were contracted to deliver education on agreed topics in 2013/14.</td><td>Training, education and workforce development is focused on public and private health, community and aged care providers</td><td># &/or % providers receiving education sessions

LMRPCC funded/led programs continued to directly deliver training/education/networking with staff across the region being:

11 Health Services
5 Aboriginal Health Organisations
2 Primary Care Partnerships
2 Medicare Locals.
4 Local Governments
1 CALD group
1 Consumer Advisory group
5 other health providers.

This does not include education provided by Bendigo Health and Sunraysia Community Health as part of the Aged Care and Disability Projects and the LMRPCCS team.</td><td>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><td>Item</td><td>RM*</td><td>SM**</td><td>RM</td><td>SM</td></tr><tr><td>I knew where to enquire about palliative care</td><td>3.59</td><td>3.41</td><td>3.65</td><td>3.47</td></tr><tr><td>I found it easy to be referred to palliative care</td><td>4.53</td><td>4.38</td><td>4.54</td><td>4.45</td></tr></table>*RM – Region Mean
** SM – State Mean</td></tr>
<tr><td>Respondents to the Education Gap Analysis project advised us to publicise education in advance and both on websites and on noticeboards in facilities.

The Consortium responded by creating quarterly “Palliative Care</td><td>Training, education and workforce development is focused on public and private health, community and aged care providers</td><td>In 2013/14 there were 3,524 unique visitors to the web site and 7,354 views on the homepage where 80 education opportunities were displayed.

Each edition of the Pinboard was distributed to 260 locations.</td><td>Anecdotal evidence of increased participation in education by staff in region. For example Consortium has received many telephone calls seeking information about promoted courses.</td></tr>
</table>

What the Consortium has delivered:	Performance Measure	KPI Metric	Actual impacts
Pinboard" Newsletters which were distributed to every aged care facility and health service in the region. The Consortium also maintained an up to date calendar of educational opportunities in the region on its website.			
LMRPCC heavily promoted the PEPA program to members	Training, education and workforce development is focused on public and private health, community and aged care providers.	Wide PEPA participation in the region, particularly for Rehabilitation and district nurses.	As one nurse stated: "We had five District Nurses take place in the PEPA program which they all found very beneficial in building knowledge and experience. Also provided paperwork and policy to review in relation to relevance to our service".
All education and training offered by the Consortium is evaluated for satisfaction. This has resulted in minor changes to the venues, content and ordering of courses to improve impacts, and confirmation that the training is of appropriate quality.	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	**Knowledge of & increased confidence In, palliative care approach (e.g. pre/post education evaluation)** 98% of evaluations received reported increased confidence in palliative care approach. Of those training sessions run by the LMRPCCS, 100% of participants indicated that much information had been gained about palliative care approaches.	Significant increase in confidence and skill level in caring for people to live and die in their place of choice.
The Consortium invited ACAS providers to attend a CORG meeting and discuss the ACAS requirements for entry including how to access respite in a timely manner.	Closer links with ACAS.	**# &/or % palliative care providers with formal protocols with ACAS** 0 providers have formal protocols with ACAS but all are trained in using generalist ACAS protocols for referrals	Service capacity to make accurate and timely ACAS referrals enhanced. May lead to faster and more appropriate respite for clients.

What the Consortium has delivered:	Performance Measure	KPI Metric	Actual impacts
Relevant stakeholders in the service system were mapped and prioritised for ongoing networking and liaison which was then delivered.	Health, community and aged care providers/networks linked with palliative care consortia	**Committee membership Attendance at meetings / events** The Consortium has attended and presented at over thirty meetings and travelled 18,000 km's within the region as part of its networking responsibilities. This has included diverse groups such as the Aboriginal Hospital Liaison Officer Group, HACC Workers Group and Southern Mallee Primary Care Partnership Health and Wellbeing Group. The Consortium manager is a member of the Loddon Mallee Integrated Cancer Service Board and the Heathcote Community Capacity Builders Project (Chair).	Promote palliative care services to increase referrals, networks and understanding. Palliative care representation explicitly added to two LMICS Advisory Groups. This strategy should contribute to increased numbers of appropriate referrals to services. From VINAH 2013/14 data a baseline for the region is 630 referrals to six of the seven Community Palliative Care Services.
The Consortium has developed links with Medicare Locals	Develop links with Medicare Locals	**Examples of joint work/collaborations with Medicare Locals** Loddon Mallee Murray Medicare Local has trained Consortium staff member to obtain better demographic data and promoted palliative care education. Consortium has supported Lower Murray Medicare Local in establishment of their pain clinic to seek to improve efficiency and processes for palliative patients. Consortium is closely following the changes to Medicare Locals and advising members of any issues and opportunities with this.	Improved data analysis in Consortium leading to more accurate planning. Promotion of education to GPs in the region.
The LMRPCCS receives the Disability funding. Clinical Nurse Consultants with dual	Disability/palliative care project officer employed in each region	**Disability/palliative care project officer employed** Clinical Nurse Consultants with dual responsibilities for the Disability and Aged Care roles	See items below for impacts of the project.

What the Consortium has delivered:	Performance Measure	KPI Metric	Actual impacts
responsibilities for the Disability and Aged Care roles were employed in Bendigo and Mildura in October 2012. The Consortium allocated an additional $75,000 in surplus funds to extend the hours available for this work.		were employed in Bendigo and Mildura in October 2012. Consortium surplus funds doubled the hours spent on the project for the Disability and Aged Care roles.	
There are 27 disability accommodation services managed directly by DHS and 28 facilities managed by 10 Community Service Organisations. All of these facilities were visited in 2012/13 and relationships initiated. Regular contact was maintained with managers and some staff of these facilities through email and telephone. The project staff provided individual education to group homes on request when a resident has been diagnosed with a life-limiting illness, or concerns from staff regarding the care of the resident.	Project officers develop relationships with regional DH disability officers / accommodation services and encourage palliative care referrals to align with the Disability residential services palliative care guide	**Identified learnings / issues re: disability residential services using a palliative care approach** Learnings identified in 2012/2013 were supplemented with evaluation feedback. Reinforced themes are that Disability staff aren't familiar with the difference between a palliative approach and end stage care and have appreciated information about recognising deterioration and when to refer on to a GP. **# referrals to palliative care providers** **increase in referrals to palliative care from Disability residential services** This data is not tracked in VINAH and accurate information has been difficult to obtain. Service managers across the region can recall six disability clients this financial year. **Awareness in the disability sector of information on, and access to, palliative care** Education provided has increased awareness as	Identified learnings have been incorporated into the project plan and communicated with specialist palliative care staff. Phone advice has been given by the project worker in Bendigo on four occasions for generic support related to whether referrals are appropriate and on the "palliative approach". Positive education evaluation results indicate an increased likelihood that people living in disability accommodation services will be able to be cared for, and die in, their place of choice. For example one participant said: "I can look for triggers for referral to palliative care and the GP"

What the Consortium has delivered:	Performance Measure	KPI Metric	Actual impacts
		evidenced by positive evaluation results.	
The Consortium identified a need to enhance the health promotion aspects of the disability roles in line with the achievements of other Consortia. It contracted LaTrobe University to review the Project Plan and mentor and support the two nurses responsible for the project.	Project officers develop relationships with non-government disability accommodation services Disability services' capacity to provide palliative care improved	**# &/or % disability services with contact with palliative care** 100% of disability services have had contact with palliative care via the disability role. **# &/or % disability services with education sessions** 79 staff from 18/53 (33%) disability services attended education sessions. **# participants in education knowledge of & increased confidence in, palliative care approach (e.g. pre/post education evaluation)** Four disability specific day long education sessions were run in Bendigo, Swan Hill and Echuca with 79 participants. Pre and post education evaluations demonstrate knowledge of and increased confidence in the palliative care approach. **# disability services, contacted by project officers, who are aware of Disability Palliative Care Guide** 100% disability services were contacted by project officers and Disability Palliative Care Guide was disseminated to them.	Awareness in the disability sector has risen as evidenced by evaluations at the end of each session. Comments including: "I have a better understanding for when there is a need for palliative care". "'Palliative care is not just for people who are dying now and with cancer". Best-practice reference guide promoted.

What the Consortium has delivered:	Performance Measure	KPI Metric	Actual impacts
A regional palliative/aged care action plan was developed by the Consortium in conjunction with the relevant LMRPCCS staff. Goals were approved by the Consortium Board.	Regional Palliative care action plans developed and implemented	**Goals of action plan evaluated** The Aged Care Action Plan was approved by the Consortium Board. Included review of the goals and KPI/evaluation metrics. An evaluation survey was conducted with project participants to identify the success of the project and the barriers to implementing End of Life Care Pathways into RACFs. The results are contained in Appendix 9. Results are being used to tailor future project initiatives.	Impacts identified in the evaluation survey of RACF participants include: 1. Improved GP's writing preemptive orders in at least four facilities 2. "Positive attitude developed within staff about their abilities to deliver first class care" 3. "Setting up a booklet/ brochure stand for the residents families to access." 4. "All residents have advanced care plan wishes documented on entry now. We are now having discussions with families more regularly on end of life progression" 5. "Improve the terminal care with comfort care charting, care plan consultation discuss terminal and palliative phase in more depth" 6. "Greater awareness of pre emptive orders and confidence to speak to families with any of their questions".
The LMRPCCS receives the Aged Care Link Nurse funding. Clinical Nurse Consultants with dual responsibilities for the Disability and Aged Care roles were employed in Bendigo and Mildura in October 2012. The Consortium allocated an additional $75,000 in surplus funds to extend the hours available for this work. The project also delivered an additional PEPA funded Aged Care Extension workshop with 51 attendees.	Aged care/palliative care link (support) nurse employed in each region	Clinical Nurse Consultants with dual responsibilities for the Disability and Aged Care roles were employed in Bendigo and Mildura in October 2012. **# &/or % RACF visited by project officer** 40/64 (62.5%) RACFs were visited by the project officers. **# &/or % RACF receiving education by project officer** 60/64 (93%) RACF received education by project officer. Five workshops with 129 participants were delivered across the region. 6 x ½ hour videoconference education sessions were delivered with participants from 30 facilities. **knowledge of & increased confidence in, palliative care approach (e.g. pre/post education evaluation)**	See items above and below for impacts of the project.

What the Consortium has delivered:	Performance Measure	KPI Metric	Actual impacts
		Pre and post education evaluations demonstrate knowledge of and increased confidence in the palliative care approach.	
The LMRPCCS conducted a baseline survey of RACFs in 2012/13 which found that 5 were using an EOLCP. In 2014 a follow up survey was conducted with 27 responses. A question about the barriers to implementing EOLCPs was asked. Full results are contained in Appendix 9. Implementing EOLCPs was a key goal of the education program provided to RACFs.	Increase in number of residential aged care facilities supported to implement end of life care pathways	**# &/or % RACF using end-of-life care pathways** There was an increase in facilities known to be using end-of-life care pathways from five in 2012/13 to nine in 2013/14. However reliable data on this is difficult to obtain due to respondents having different understanding of what an EOLCP is. Barriers to implementing EOLCPs as identified in the evaluation survey include: "Not supported by management" "No consistency". "Lack of time allowed to implement pathway. "Lack of understanding of need for this pathway by senior staff." "No supernumery time to implement". "Lack of policies and procedures".	Education evaluations demonstrate an increased understanding of the benefits of EOLCPs amongst RACF staff. The project evaluation reveals an improvement in EOLCP care provided through increased conversation and more active medication management. There has been an known increase in use of EOLCPs in the region. The next challenge is to influence management to support the pathways.

Strategic Direction 4: Providing specialist palliative care when and where 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: Implement the palliative care service delivery framework Service Delivery Framework (SDF) across Victoria, with advice from the Palliative Care Clinical Network (PCCN). As part of this implementation: the service delivery framework will be used by the palliative care consortium in regional service planning.

Impacts: Clients have access to an appropriate level of specialist palliative care in their region; There is clear information about the palliative care services that are available across regions and the capabilities of these services.

What the Consortium has delivered:	Performance measure	KPI Metric	Actual impacts
The Consortium reviewed and ratified KPIs for the LMRPCCSs in Bendigo and Mildura which are directly based on the SDF. The Consortium explicitly built the SDF into its regional planning and Project Management frameworks. It initially promoted the framework heavily to service staff and managers and encouraged services to resolve any gaps. A change of tact was required in response to the release of the DH's DRAFT Palliative care service capability framework Self-assessment audit results. The focus shifted towards promoting the Sub-Acute Planning framework and on individual service priorities. The Consortium provided advice about how to optimise services towards the goals of "patients dying in their place of choice" and "patients receiving care in their preferred setting". The Consortium did some work to confirm that Sunraysia Community Health Service is the optimal location for the Consultancy Service in the North, and to better align it with the two other specialist palliative care services in the region.	Regional service planning is aligned with the Service Delivery Framework.	**# formal MOUs (or similar) between entities aligned with SDF** One formal MOUs (or similar) between entities aligned with SDF being the Guideline and KPIs for Loddon Mallee LMRPCCS **% projects aligned with the SDF** 100% LMRPCC projects are aligned with SDF which is explicitly built into The Consortium's project management frameworks. Key examples include: 1. KPIs for Loddon Mallee LMRPCCS. The KPIs align directly with the SDF. 2. After-Hours project. 3. Palliative Aged Care Link Nurse Project. 4. Disability Palliative Care. In anticipation of the changes to the SDF to better align with the Sub-acute Planning Framework the CORG and Consortium Board discussed the framework and identified implications.	There are clear and agreed KPIs for the LMRPCCS. Any concerns raised by the members can now be assessed and understood in relation to this agreement and the regular metrics that are provided. Service success can be monitored and the interaction between Community, Inpatient and Consultancy services can be continuously improved. Evidence of more client focused care practices. For example faster response to referrals from in-patient services.

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; Strengthen consortia governance and accountability processes and document them consistently; Use technology to enhance service coordination for all palliative care services.

Actions: Develop stronger links between the palliative care consortia, the PCCN and all other relevant stakeholders. Strengthen consortia governance and accountability processes and document them consistently. Palliative care consortia have documented governance and accountability processes in place that are understood by consortia members. Encourage consistent and equitable IT solutions that facilitate coordination and consultation across all palliative care services.

Impacts: Broadened the number and type of partnerships between palliative care consortia and other health, community, aged care and other providers and structures per region including Primary Care Partnerships and Medical Locals; Identify the health, community and aged care networks in each region and how they link with palliative care. IT solutions are in place to support quality initiatives and connectivity.

What the Consortium has delivered:	Performance Measure	KPI Metric	Actual impacts
Relevant stakeholders in the service system were again mapped and prioritised for ongoing networking and liaison. The Consortium has attended and presented at over thirty meetings and travelled 18,000 km's within the region as part of its networking responsibilities.	Identify the health, community and aged care networks in each region and how they link with palliative care Strengthen/develop links between consortia and networks	**# partnerships in region** **List/describe the type of partnerships in region** **# links with networks examples of joint initiatives & improved outcomes** The formal partnerships directly involving the Consortium are: 1. Consortium MOU with eight regional health services who provide specialist palliative care service as well as residential and community aged care, district/community nursing, acute care services and a range of other health and community services. 2. Contract with LaTrobe University to review the Disability Project Plan and mentor and support the two nurses responsible for the project. 3. Loddon Mallee Integrated Cancer Service through participation of Consortium Manager in their Board of Management. 4. Victorian	There is clear information about the specialist and generalist palliative care services that are available across the region and the capabilities of these services are available from a number of sources including the palliative care services, the health services in which they are based, general practice, medical specialists, local government, community health centres and Consortium website. All funded services are participating in Consortium and receive its services. La Trobe project - beginning to increase quality of disability project. Keep promoting palliative care to cancer sector. Influence Integrated Cancer Service. Incorporate Palliative Care positions into Advisory groups. Developing more networks with Aboriginal People to lead to better care and more referrals. Echuca Regional Health obtained VAPCP grant for RACF project.

What the Consortium has delivered:	Performance Measure	KPI Metric	Actual impacts
		Aboriginal Palliative Care Project (VAPCP) through participation of Consortium Manager in their Steering Group. 5. With Telstra to provide iPads and data for services over a two year period 6. With St John God of Hospital and BUPA via membership of CORG. 7. With PCCN through the regional representative 8. With two members services to deliver education utilising Carers Victoria and Centre for Grief and Loss educators. Informal partnerships include: 1. With Aboriginal Hospital Liaison Officers, and Aboriginal Controlled Community Health Organisations including VACCHO to promote palliative care. 2. With the ACAS and Carer Support Services to share information and referral pathways. 3. With the PCP's and Medicare Locals to promote palliative care and for consultation and data support. 4. With the Palliative Care Clinical Studies	Incorporate private sector organisations into CORG education, planning, advice.

What the Consortium has delivered:	Performance Measure	KPI Metric	Actual impacts
		Collaborative for four services to begin to participate in their Rapid Phase IV Pharmacovigilance Program.	
A record is maintained of all meeting minutes, reports, agenda's, for the consortium, the clinical leaders group and the practitioners group. Progress of all aspects in the Consortium Regional Plan are reviewed in standing items at each consortium meeting. Terms of reference for the Consortium, Executive and Clinical Leaders have all been reviewed in 2014. Procedures are in place for orientation of new consortium members. A quality and risk management framework has been developed for the Consortium. The fundholder for the Consortium will shift from Castlemaine Health to Bendigo Health in 2015.	Clinical advisory groups role statement identifies formal links with the PCCN. Role statements are implemented regionally Palliative care consortia have documented governance and accountability processes in place that are understood by consortia members.	**Role statement audit** A role statement audit carried out in June 2014 found that there was wide compliance with the requirements.	Confidence and trust in the Consortium is high, enabling it to progress the Government's strategy, to implement projects and culture change and to improve connections throughout the region.
See Strategic Direction 3 above relating to: Examples of joint work/collaborations with Medicare Local	Develop strong and sustained links with Medicare Locals	**# links with Medicare Locals** **examples of joint initiatives & improved outcomes** See Strategic Direction 3 above relating to: Examples of joint work/collaborations with Medicare Local	See Strategic Direction 3 above relating to: Examples of joint work/collaborations with Medicare Local
The Consortium purchased and installed iPads and data for all Community Palliative Care Services so they can facilitate Telehealth sessions, and real time data and referrals in the patient's home. It funded an IT worker in the LMRPCCS to implement this project.	Partnerships and opportunities to promote IT connectivity are explored and developed	**Examples of projects where IT connectivity is identified/promoted** iPads and data for all Community Palliative Care Services provided More than a third of RACS in the region now participate in VC education sessions.	Any client who lives within mobile telephone range now has access to Telehealth in the home if required, via referrals to the LMRPCCS and other services. See Case Study in the LMRPCCS Report above which demonstrates direct client benefits as a result of the iPad.

What the Consortium has delivered:	Performance Measure	KPI Metric	Actual impacts
The Consortium purchased and installed cameras and speakers on the desktops of all Board members who didn't already have this.	Partnerships and opportunities to promote IT connectivity are explored and developed	All Board members now have access to VC from their desktops.	These regional executive staff can now directly dial into VC meetings and contact each other and other clinicians in the region. Reduced problems in logging into Consortium and other regional VC meetings.
Aged care link nurses have continued to deliver regular video conferencing sessions which will shortly be published on the Consortium website.	Partnerships and opportunities to promote IT connectivity are explored and developed	Six half hour video conferencing sessions on symptom management are run monthly across the region	Increase capacity of aged care staff in provision of palliative care.
The Consortium worked with services to increase the accurate reporting of the VINAH data element regarding preferred place of death		Decrease of proportion of clients without a preferred place of death by 42%	Enable DH and services to better monitor how successful services are at supporting clients to die in their place of choice.

Strategic Direction 6: Providing quality care supported by evidence

Priority: Develop consistent clinical care protocols that are informed by research and evidence; Ensure all Victorian palliative care services provide quality care that is assessed against national standards and supported by a quality improvement culture.

Actions: Implement a program of work for the PCCN including:

1. providing clinical advice to the department on the implementation of the policy and the SDF
2. reviewing quality indicators and identifying quality improvement opportunities as part of monitoring quality data collection
3. endorsing and adopting evidence-based clinical guidelines and protocols
4. implementing evidence-based clinical tools at a service level.
5. identifying service delivery research priorities.

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.

Work with the Commonwealth Government, Health Workforce Australia and the Workforce Unit in the DH 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.

Impacts: Established statewide program of work for the update of evidence into clinical practice, Palliative care service delivery is more consistent and evidence based.

What the Consortium has delivered:	Performance Measure	KPI Metric	Actual impacts
As mentioned in Strategic Direction 1 the Consortium heavily promoted NSAP and nine services participated and prioritised a range of quality projects. The Consortium also supported and encouraged services to apply for funding for quality initiatives.	Quality improvement opportunities are identified and actioned, Clinical tools implemented at the service and regional levels	**# projects listed on PCV's quality projects website** Nine projects are listed on quality projects database, an increase of 3 from last year.	See response to Strategic Direction 1.
PCCN tools discussed and heavily promoted. Demonstrated increase in use of tools.	Quality improvement opportunities are identified and actioned, Clinical tools implemented at the service and regional levels	**Discussion/promotion of PCCN tools** **# clinical tools used with evidence based (PCCN) endorsed** See response to Strategic Direction 1.	See response to Strategic Direction 1.
The Consortium has been represented at the PCCN meetings and information has been actively fed back to the Consortium Board and Clinical Group	A PCCN consortia representative acts as a conduit between services, consortia clinical advisory group and the PCCN. Consortia representative attends PCCN to report on clinical service improvement activities	**% attendance at PCCN & CAG meetings** 100% attendance at PCCN and 100% attendance of CORG, the region's CAG meetings by the regional representative Alison Lowe, Nurse Unit Manager at Kyneton District Health Service. Dr. Tiffany Shaw, Palliative Care Physician, Loddon Mallee Regional Palliative Care Consultancy Service also attends both meetings. **PCCN standing consortia meeting agenda item** PCCN is a standing Consortia Board and CORG meeting agenda item. **PCCN items circulated** 100% PCCN items circulated to both LMRPCC Board and CORG. **PCCN information on consortia website** All relevant PCCN information is contained on LMRPCC website.	All regional services members are aware of PCCN requirements and directions. See response to Strategic Direction 1 demonstrating significant increases in PCCN endorsed tools utilised

The Consortium convenes 6 CORG (equivalent of CAG) meetings per year. The Consortium functions as a data and information clearinghouse, regularly disseminating information, research and grant opportunities to members.	Each region has an active clinical advisory group	**# &/or % services with representation on CAG** 100% services with representation on CAG (11/11 services) **Examples of CAG initiatives / outcomes** 1. Networking and support for participants 2. Implement Bereavement framework 3. Participate in NSAP 4. Develop regional referrals criteria 5. Significantly revise Carers Kit 6. Receive information, research, education and case studies 7. Provide advice to the Board 8. PCOC working group looking at how to optimise PCOC implementation so that different assessments impact patient care.	CORG is a strong group with representation of the NUMs or most senior nurses in all funded services. This means regional decisions can be made and implemented and the group is an excellent way to communicate with the sector.
		# submissions to PCCN for endorsement The Patient Planner received provisional endorsement in 2013 and the requested changes have been agreed. Extensive preparation of the Carers Kit which will be submitted by November 2014.	The submission of the Patient Planner to the PCCN will increase the quality and authority of the product, which will assist the carers and clients who will utilise it.
		% attendance at PCCN meetings 100% attendance at PCCN	

What the Consortium has delivered:	**Performance Measure**	**KPI Metric**	**Actual impacts**
See response to Strategic Direction 3	Regional workforce training and education initiatives	**Changes in knowledge, confidence & skills reported in education/training evaluations** All education was evaluated and there were demonstrated changes in knowledge, confidence and skills. **# &/or % staff undertaking consortia-led training** 100% of clinical staff working in Specialist Palliative Care services received some form or consortia-led or funded training in 2013/14. **increased knowledge & confidence (pre/ post**	The capacity of the health, community, aged care and disability services workforce to care for people with a life-threatening illness has been enhanced through the education provided to residential aged care and residential disability workers specifically and to health and community more generally.

What the Consortium has delivered:	Performance Measure	KPI Metric	Actual impacts
		training evaluation) See above.	

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: 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, community and aged care.

Impacts: Victorians are better able to support people with life-threatening illness and their carers.

What the Consortium has delivered:	Performance Measure	KPI Metric	Actual impacts
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. The approach was to seek opportunities to build awareness and understanding of death, dying and loss in the community by integrating this into the Consortium funded work and core business. 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 • Continued to build and enhance regional networks and relationships across the region including Medicare Locals, PCPs and aboriginal and council based	Links between palliative care consortia/palliative care services and health promotion officers (local councils, community health centres, PCPs) established or enhanced ; Regional activities undertaken to build community capacity to support people who are referred to palliative care	**# &/or examples of links** **# &/or examples of joint activities** The LMRPCC has promoted its activities and programs through the following: • Advertising of all LMRPCC events via website, email newsletter and Palliative Care Victoria Newsflash • Numerous stakeholder meetings which included health promotions workers from one council, two PCPs and two community health services. The Consortium sponsored four services to deliver Palliative Care Week activities. These were targeted at clients, carers and the general public. Media was received.	It is anticipated that these activities would have increased appropriate referrals to specialist services. Newspaper articles generated in Echuca, Swan Hill, Kyneton and Bendigo as a direct result of Consortium funded activities.

What the Consortium has delivered:	Performance Measure	KPI Metric	Actual impacts
services • 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.			
	Statewide model/templates developed, endorsed by PCCN and implemented	**Discussion/promotion of PCCN model/template** There were no relevant endorsed PCCN models/templates available in 2013-14	

Appendix 4 - 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.	**Complete -** Consultancy service established. KPIs agreed with Consortium and regularly reporting against these has commenced
	Employ nurse practitioners across the region using relevant DH funds.	.7 EFT of Nurse Practitioner employed in LMRPCCS.
	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 Aboriginal Palliative Care component of the Regional Planning section above.
	Identify areas where access to palliative care for CALD people can be enhanced.	Education session provided to Mildura cancer consumer group with membership of people from Iran, Iraq, Sudan and Afghanistan. For details see the CALD Palliative Care component of the Regional Planning section above.
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 the After-Hours component of the Regional Planning 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 PCCN outputs.	Consortium has actively promoted and supported members to implement many tools. See the response in the Strategic Direction 1 section of Appendix 3.
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.	Continued to implement recommendations of Education Gap Analysis. See the response in the Strategic Direction 2 section of Appendix 3.

[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.	Aged Care Link Nurse Program moving into “business as usual”. See the response in the Strategic Direction 2 section of Appendix 3.
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.	Disability Program moving into “business as usual”. See the response in the Strategic Direction 2 section of Appendix 3.
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 the response in the Strategic Direction 7 section of Appendix 3.
Provide information on palliative care tailored to the needs of clients and carers.	Carers and clients receive targeted information.	Extensive testing of Carers Kits with carers and services. Complete review. See the After-Hours component of the Regional Planning section 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.	See the response in the Strategic Direction 4 section of Appendix 3.
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 Strategic review to assess satisfaction with its progress. The results were overwhelmingly positive and proactive steps were taken to action all feedback.
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.	All projects have approved project plans and governance and reporting frameworks .

Appendix 5 – Meeting attendance

Legend
Present in person or via electronic link: P Apology A

Consortium Board 2013-2014 financial year

Voting agencies	August '13	October	Dec.	Feb.	April	June '14	%
Bendigo Health	A	P	A	P	P	P	67
Boort District Health	A	A	A	A	A	A	0
Castlemaine Health	P	P	P	A	P	A	67
Echuca Regional Health	P	A	P	P	P	P	83
Kyneton District Health	A	A	A	A	A	P	16
Maryborough District Health	A	P	A	P	A	P	50
Mildura Base Hospital	A	A	P	P	A	A	33
Sunraysia Community Health	P	A	P	P	P	P	83
Swan Hill District Health	P	P	P	P	P	P	100
Average attendance rate							44
Ex-Officio Representatives							
CEO Representative	P	A	P	A	A	A	33
DH	P	P	P	A	P	P	83
Consortium Manager	P	P	P	P	P	P	100
Consortium Administrator	P	P	P	P	P	P	100

CORG 2013-14 financial year

Members	July '13	Sept.	Nov.	Feb.	March '13	May '14	%
Bendigo Health	P	P	P	P	P	P	100
Castlemaine Health	P	P	P	P	P	P	100
Echuca Regional Health	P	P	P	P	P	A	83
Kyneton District Health	P	P	P	P	P	P	100
Maryborough District Health	P	P	P	P	P	P	100
Mildura Base Hospital	P	P	P	P	P	A	83
Sunraysia Community Health	P	P	P	P	P	P	100
Swan Hill District Health	A	A	P	A	A	P	33
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	A	A	A	0
Bendigo District Aboriginal Cooperative	P	A	A	A	A	A	16
St John of God (Bendigo)	P	P	A	A	P	A	50

Appendix 6 - Profile of Consortium members

Voting members	Service Profile	Staffing (EFT)*	Key initiatives
Bendigo Health	Community Palliative Care Service including Chum house day hospice	7.27	NSAP PCOC PCCN endorsed assessment tools Advance Care Planning Bereavement Framework
	Specialist Inpatient Palliative Care Service	20.68	NSAP PCOC Advance Care Planning Bereavement Framework
	Loddon Mallee Regional Consultancy Service (LMRPCCS)	3	NSAP Aged Care Link Nurse Disability Link Nurse Telehealth Social Worker
Castlemaine Health	Community Palliative Care service	1	Restructuring service PCOC working group
Echuca Regional Health	Community Palliative Care service	1.8	NSAP Aboriginal palliative care project Advance Care Planning Bereavement Framework
Kyneton District Health Service	Community Palliative Care Service	1.85	NSAP Palliative Care Clinical Network representative
Maryborough District Health Service	Community Palliative Care Service.	.4	NSAP Evidence based tools for consistent palliative approach across MDHS
Mildura Base Hospital	Specialist Inpatient Palliative Care Service	3.3	NSAP
Sunraysia Community Health Service	Community Palliative Care Service	3.55	NSAP Communication and coordination project
	LMRPCCS	.83 EFT plus contract with Peter MacCallum Institute	Aboriginal palliative care steering committee KPI development
Swan Hill District Health	Community Palliative Care Service	2.0EFT	NSAP Maintain EOLCP Advance Care Planning

Appendix 7 – 2013-14 Fiscal Year 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.

Profit and Loss Statement

Account	Actuals	Comments
Expenditure		
Combined Salaries and wages	$214,062	
22091 Grants Received on Behalf of and Paid to Other Agencies	$173,210	Education, Palliative Care Week, extend IT and Aged Care Disability roles in LMRPCC, small grant projects
32006 Domestic Cleaning etc	$920	
35202 Marketing	$150	Yearly website hosting
35616 Professional Membership	$670	
35636 Printing & Stationery	$12,786	Patient planners and respite brochures
35701 Telephone Expenses	$245	
35856 Conferences Registration	$2,590	
35872 Travel, Accomm. & Meals	$5,733	
35881 Computer Consumables	$17,296	iPads for services plus two years of data. Headsets for services to access desktop videoconferencing
35952 Contract Administration Service 35301 and 35326 Consultancy costs	$17,750	
36102 Miscellaneous Expenses	$451	
36125 Corporate Overheads	$41,168	12.5% of revenue
and 36565 Education and Development	$11,475	Includes $5000 Telephone Triage Training
61802 Internal Transfers - Fleet Veh	$5,747	
Expenditure Grand Total	**$504,253**	
Revenue		
Palliative Care - consortia	$121,777	
Palliative Care - LMRPCCS	$20,901	Aged Care + Disability projects
Palliative Care - Non Admitted	$155,666	After-hours Regional Framework
PEPA Post Placement Support	$31,000	
57806 Miscellaneous Revenue (Interest)	$11,872	From fundholder
Total revenue	$341,216	
Total Operating Result	**-$163,037**	

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

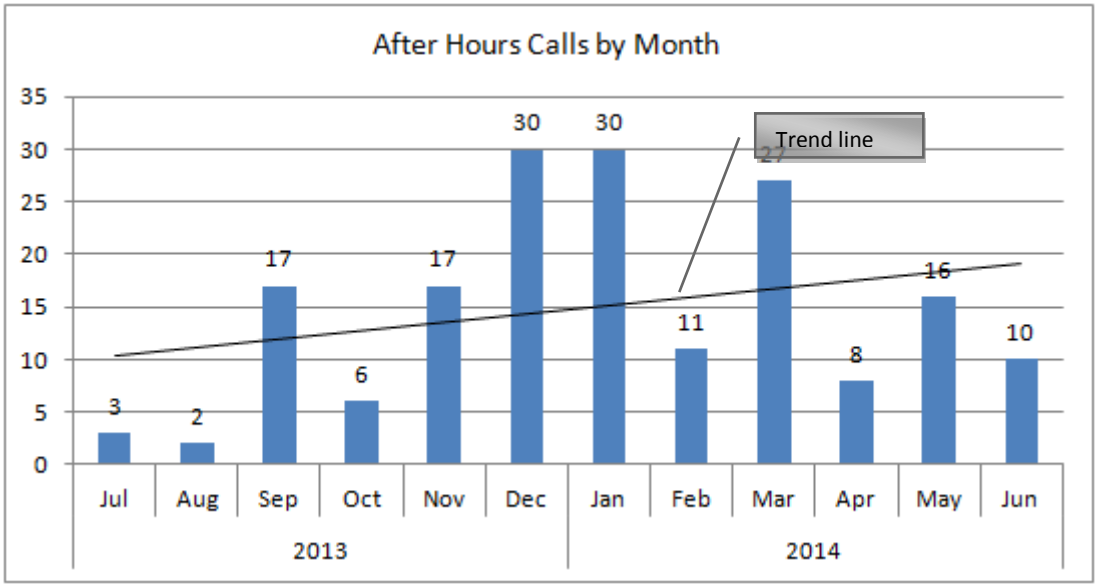
Balance statement

Consortium balance sheet as at June 30 2013	Amount $
Net cash inflow (outflow) from operating activities	-163,037
Prior Year Adjustment	$200
Cash and cash equivalents at beginning of period	$450,504
Cash and cash equivalents at end of period	**$287,466**

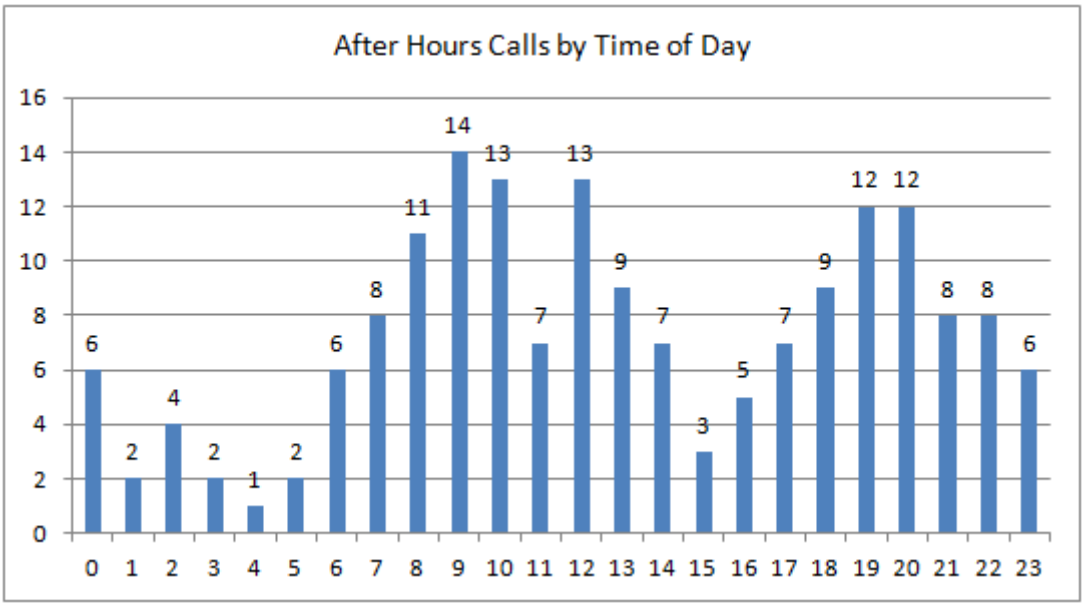
Appendix 8 – Detailed analysis of After-hours calls

After-hours calls were tracked using a Consortium developed form and process in four services. This section contains an analysis of the data in three of these services. For one of these services data only commenced in September 2013.

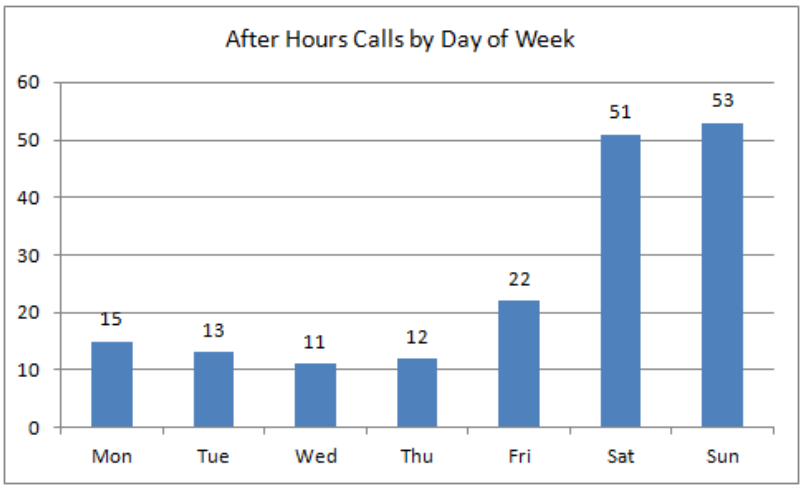
After-hours Calls by Month



After-hours Calls by Time of Day



After-hours Calls by Day of Week

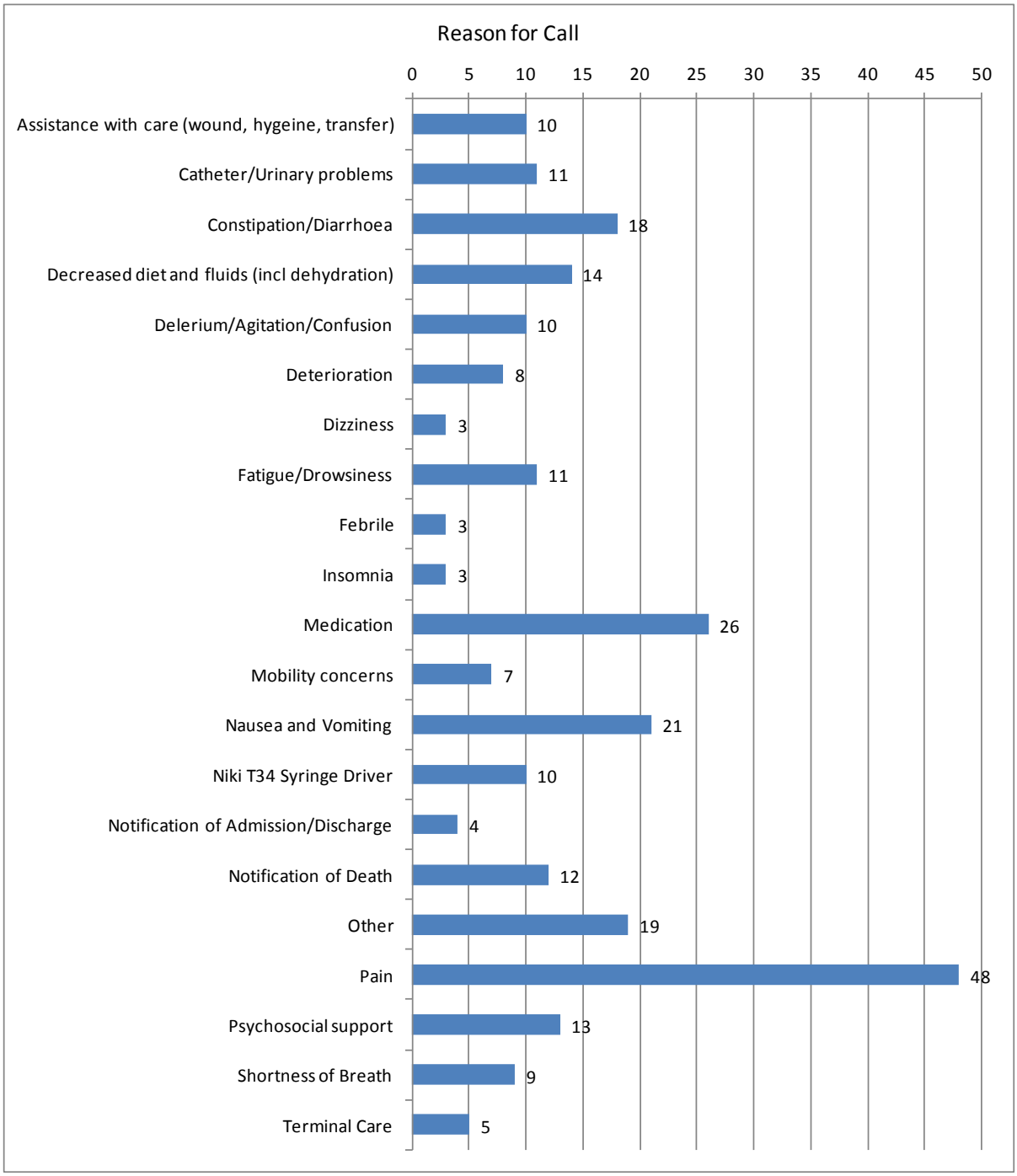


The majority of the calls occurred on the weekend.

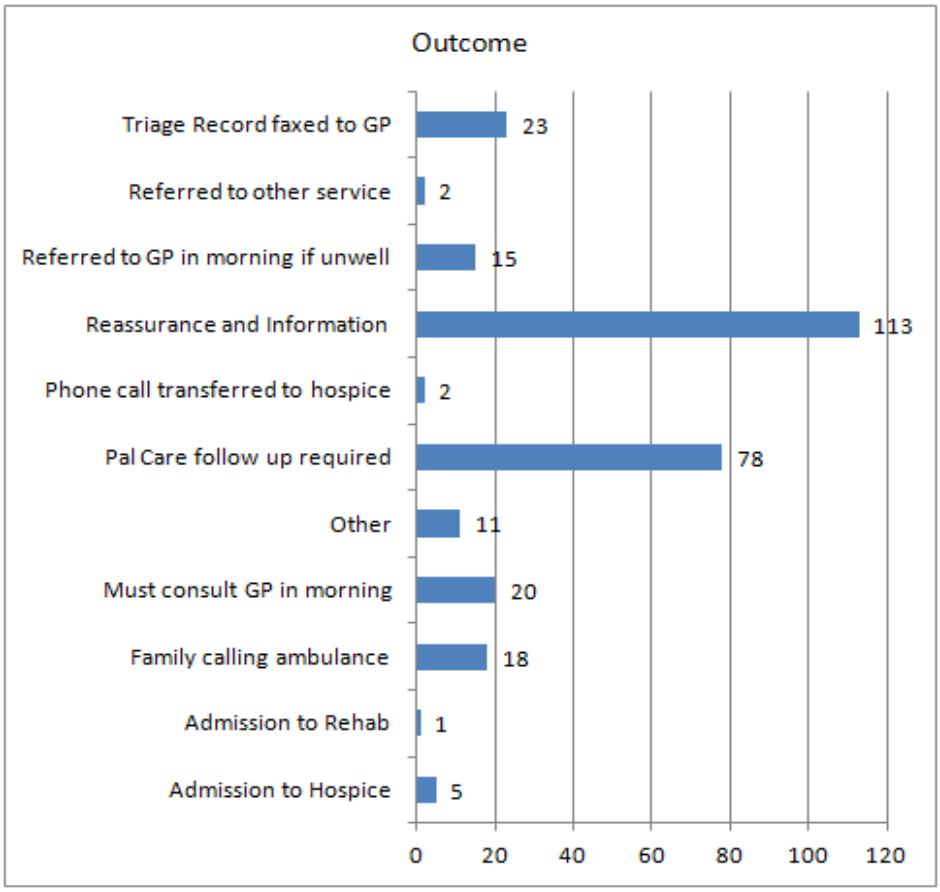
Relationship of Caller to Patient

Relationship	Count
Carer	12
Child	45
Other	28
Parent	10
Partner	52
Patient	27
Total	**174**

Reason for Call - Note: Each Reason was able to be chosen more than once.



Outcome of Call



Appendix 9 – Aged Care survey respondents

The LMRPCCS conducted a survey of staff in RACF facilities who they have been closely working with. Here is a summary of responses.

Total respondents = 27.

Facilities using an EOLCP = 7

Barriers to facility using EOLCP:

6 Time, including supernumerary time
2 Lack of policy and procedure
2 Not supported by management
19 Skipped question

Pathways used:

1 Manad
1 Trajectory A B C TERMINAL CARE WISHES
2 Residential aged care end of life care pathway Brisbane South
3 Unsure

What positive changes has your facility made to improve a Palliative Approach for your residents since attending this training?

7 Education of staff including EN's, link nurses including succession planning
4 GP's writing preemeptive orders
4 More confidence conducting family discussions on palliative care
3 Availability Palliative Care Tool Kit
2 Improved documentation including charting, care plans, advance care plans
2 Starting a Palliative approach team, working party
1 Aromatherapy lamp
1 Enabling time off to attend education session including video link, and implement ideas.
1 Improved information (brochures) for residents and families to access.

Has your facility contacted your Community Palliative Care Service since your training?

13 Skipped question
6 Yes
5 No
3 Unsure

Why did you contact the Community Palliative Care Service?
2 For phone advice about symptom management
1 For advice about social issues a resident was having

2 We referred a resident to the Community Palliative Care Service
2 To come and deliver an education session
1 Support and reinforcement that we were giving the best care
2 To touch base with the service.

What reasons would you say you have not made contact with the local Community Palliative Care Service?

2 Lack of time
2 No staff assigned responsibility
2 Have not needed to
1 Too late in implementing the palliative approach

Glossary of acronyms used

ABF	Activity Based Funding
ACAS	Aged Care Assessment Service
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