Grampians Region
Palliative Care **Consortium**

Annual Report 2012

Members:

Ballarat Health Services
Ballarat Hospice Care Inc.
East Grampians Health Service
Djerriwarrh Health Services
Wimmera Health Care Group
St John of God Hospital Ballarat
Department of Health (non voting)

This report was prepared by:
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Copies of this report can be downloaded from the Grampians Region Palliative Care Consortium website at http://www.grampianspaliativecare.com.au or by contacting Pete Marshall – Consortium Manager, Grampians Region Palliative Care Consortium at the above email address.

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Overview of 2011-12 from the Chair of the Grampians Region Palliative Care Consortium

Circumstances have meant that our incumbent chair, Ms Helen Watt was unable to carry out the role since late 2011. After stepping up from deputy chair for several months, the consortium decided to officially endorse the changeover of my role to chair as from March 2012.

I would like to take this opportunity to thank Helen Watt, the retiring chair, for her contributions and oversight of the consortium. I am sure that I speak for all consortium members in wishing Helen well for the future.

June 2011 saw the appointment of Mr Pete Marshall as the Consortium Manager. Many of Pete's efforts have concentrated upon setting up sustainable systems and processes to ensure appropriate governance and strategic direction for the consortium in the future. The launch of the new Strengthening Palliative Care policy, and the substantial budget allocation for 2011-15, has resulted in a threefold increase in funding and workload for the Grampians Region Palliative Care Consortium. Taking these increases into account, Consortium Members decided to invest in more staff directly employed by the consortium in order to effectively manage future operational and strategic demands. Thanks to the efforts of Pete and Consortium Members we are now in a position to build upon our existing capacity and meet the needs of our various stakeholders.

Many of our stakeholders were present for our annual Strategic Planning Day which cumulated in a number of key priority areas. These included better partnerships and strategic alliances, improved communication strategies and integrated Information Technology software. Improvements in all of these areas have ensued thanks to the efforts of many. Overall, it has been a year of significant change and challenges involving consortium structure and administration, the GRPCC Clinical Group and strategic planning for the future.

Denise Hooper
Grampians Region Palliative Care Consortium Chair

Grampians Region Palliative Care Consortium History

In anticipation of the need to expand palliative care services and provide educational opportunities for health professionals working in palliative care, a Grampians Regional Palliative Care Service Strategic Alliance was formed in 1998. Members of the alliance came from existing providers of community palliative care services, funded by the Victorian Department of Human Services (DHS). The alliance provided direction and advice to DHS in regard to funding allocation, service requirements and priorities of palliative care services within the Grampians Region.

In November 2004 DHS launched *Strengthening Palliative Care: A Policy for Health and Community Providers 2004 – 09.* The policy identified the need to review membership of the Grampians Regional Palliative Care Strategic Alliance to ensure appropriate representation from specialist palliative care services across the region.

In December 2004, the Grampians Region Palliative Care Consortium (the Consortium) replaced the alliance, with the addition of the inclusion of St John of God Healthcare, Ballarat. Palliative care consortia comprise voting members from all funded palliative care services in each departmental region as well as other stakeholders from health and community services in a non-voting capacity.

In 2009 a Memorandum of Understanding (MOU) was developed between the Consortium and its agency partners for the period July 2009 – to June 2011. This year saw a new MOU developed for the period July 2011 – June 2015.

The Consortium is integral to the development of strategic direction for palliative care within the Grampians Region. It consists of key representatives from specialist palliative care services, both inpatient and community, and is responsible for the strategic regional planning for people with life threatening illness. It also determines priorities for service development and funding as well as participating in the development of a service delivery framework and funding model.

To enable the Consortium to be a more effective resource to members, a restructure took place in 2010 that produced a clear delineation between clinical advisors, and Consortium members, enabling the Consortium to more clearly focus resources and implement policy across the region. The clinical group deal with practice issues, and the Consortium meetings focus on region wide priorities and allocation of resources.

The Grampians Region Palliative Care Consortium (GRPCC) is guided by the policy and strategic directions as set out in *Strengthening palliative care: Policy and strategic directions 2011–2015*, with a stated role to:

- undertake regional planning in line with departmental directions
- coordinate palliative care service provision in each region
- advise the department about regional priorities for future service development and funding
- in conjunction with the Palliative Care Clinical Network:
- implement the service delivery framework
- undertake communication, capacity building and clinical service improvement initiatives.

Implementation of the strategic directions requires broad based consultation and collaboration with both services and communities across the Grampians region, however the GRPCC has a primary focus on the core members, which are the services that provide specific palliative care within the Region.

About the Grampians Region

The total area of land in the Grampians is 48,618 sq km, and only 1% (approx.) of land region is zoned for residential, business or industrial use, with most being rural (approx. 79%) or public reserve (approx. 20%).

Population growth in Grampians Region has been lower than average since 2000, and this trend is projected to continue to 2022. There are higher than average percentages of children under 14 years, and persons aged 45 plus, while the 15 to 44 age group is under-represented. The Aboriginal population is higher than average, but levels of cultural diversity are low.

The rate of volunteering is the highest of all regions. Grampians has higher than average low income individuals and households and the highest percentage of unemployed throughout Victoria, but low levels of housing stress. The year 9 educational attainment is the lowest of all regions.

Grampians Region has the lowest GP ratio per 1,000 population, but the highest rate primary care occasions of service at over twice the Victorian average. Grampians Region ranks 2nd among regions

for HACC clients aged 0–69 per 1,000 target population, and for those over 70 years of age, 26.3% are HACC clients.

In terms of health indicators, rates of asthma are higher than average across most of the region, as are rates of drug and alcohol clients and mental health clients. Some LGAs in the Wimmera have particularly high rates of overweight and obesity.

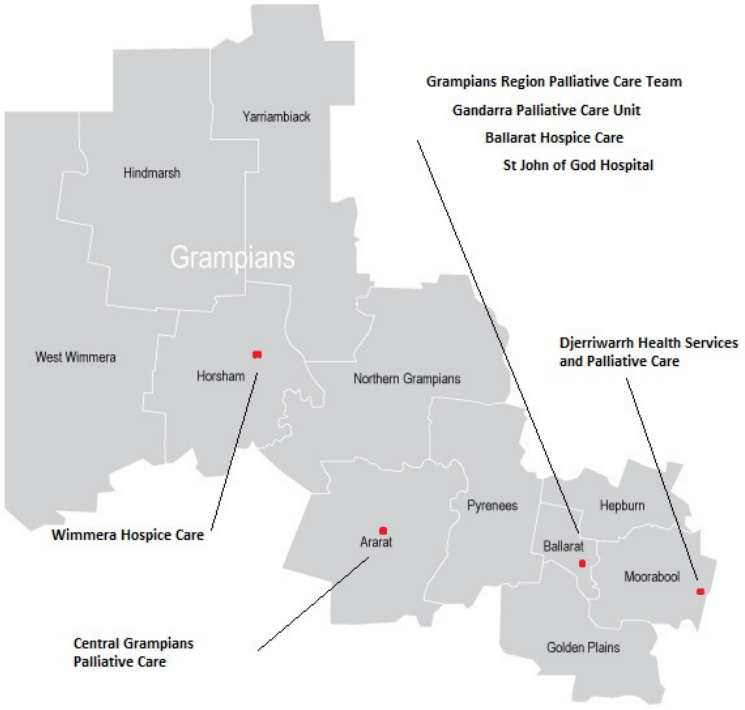
However, a breakdown into the broad areas of Wimmera (Horsham, West Wimmera, Hindmarsh and Yarriambiak LGAs), Central (Northern Grampians, Ararat and Pyrenees LGAs) and Ballarat (Ballarat, Hepburn, Moorabool and Golden Plains LGAs) shows significant disparities in local demographics.

Table 1: *Population density and proportions of aged residents*

	Grampians Region	Wimmera	Central	Ballarat
Total population	220,878	16.5%	13.4%	70.1%
65+ (as % of popn)	16.4%	20.8%	20.6%	14.6%
Area sq. kms	48,618	28,222	13,370	7,026
% of Grampians area	100%	58.0%	27.5%	14.5%
Popn density (persons/sq km)	4.5	1.3	2.2	22.0

The Ballarat area has a vastly higher population density, accounting for 70.1% of the total population, but only 14.5% of the total land mass.

The Central area in particular has higher than average rates on disability indicators, with each of the LGAs having higher than average persons with severe or profound disabilities, and higher rates of those needing assistance with core activities.



Grampians region does not stand alone on many of these indicators, as numerous studies have shown high levels of health inequality across areas of rural Australia. The challenge is exacerbated by limited resources spread across large geographical areas, and well recorded difficulties in attracting skilled health care professionals.

The palliative care services in the Grampians region are committed to offering a high level of care, and the consortium is committed to supporting them in this regard.

Projected future population distribution

Future planning for the Consortium needs to take account of possible changes in the population distribution across the region. Population growth for the region to 2022 will be well below the Victorian average. However, the growth in population is heavily skewed to the LGAs closest to the Melbourne Metropolitan Area to the East of the region, and the Golden Plains LGA is projected to become a significant growth area.

Table 2:*Current and projected resident population by Local Government Area (LGA), 2009 and 2022*

LGA	2009	2022	% Increase/decrease
West Wimmera (S)	4,613	3,664	-20.6
Yarriambiack (S)	7,681	6,522	-15.1
Hindmarsh (S)	6,202	5,305	-14.5
Northern Grampians (S)	12,340	11,205	-9.2
Ararat (RC)	11,913	12,091	1.5
Horsham (RC)	20,042	20,527	2.4
Hepburn (S)	14,803	16,559	11.9
Grampians	**224,636**	**252,315**	**12.3**
Pyrenees (S)	6,885	7,759	12.7
Victoria	**5,443,228**	**6,409,575**	**17.8**
Moorabool (S)	27,896	32,959	18.1
Ballarat (C)	94,088	112,782	19.9
Golden Plains (S)	18,173	22,943	26.2

The Aged Population

The number of people over the age of 65 will rise from 34,971 to 52,832 by 2022, an increase of 51%. A higher proportion of the current population in the Wimmera and Central areas are over 65 years of age compared with the Ballarat area, but importantly for palliative care, the projected increase in the aged population will be more heavily concentrated in the East of the region, as illustrated in Table 2, below.

Table 3: *Current and projected resident population by Local Government Area (LGA), Age 65+, 2009 and 2022*

LGA	2009	2022	% Increase/Decrease
Yarriambiack (S)	1,874	1,989	6.1
Hindmarsh (S)	1,542	1,644	6.6
West Wimmera (S)	946	1,060	12
Ararat (RC)	2,254	2,973	31.9
Horsham (RC)	3,391	4,504	32.8
Northern Grampians (S)	2,359	3,145	33.3
Hepburn (S)	2,658	3,852	44.9
Victoria	**738,131**	**1,072,540**	**45.3**
Grampians	**34,971**	**52,832**	**51.1**
Pyrenees (S)	1,395	2,115	51.6
Ballarat (C)	13,477	21,900	62.5
Moorabool (S)	3,300	6,043	83.1
Golden Plains (S)	1,775	3,608	103.3

Aboriginal and Torres Strait Islander

Data regarding the Aboriginal and Torres Strait Islander population can be found in the recent Department of Health publication - *Grampians Closing the Indigenous Health Gap Plan, 2009–13.*

Approximately 0.8 per cent of the region's population is Aboriginal or Torres Strait Islander, which equates to approximately 1,762 people (ABS 2006 Census), with numbers being broadly distributed across the region in a similar proportion as the general population. Table 3 shows approximate numbers associated with each of the Aboriginal community-controlled organisations (ACCOs).

Table 4: *Aboriginal and Torres Strait Islander population in the Grampians Region*

ACCO name	Catchment area local government areas	Number of Aboriginal persons (approx)
Ballarat and District Aboriginal Cooperative	Ballarat City Council, Golden Plains Shire, Moorabool Shire, Hepburn Shire	1,200
Goolum Goolum Aboriginal Cooperative	West Wimmera Shire, Horsham Rural City Council, Hindmarsh Shire, Yarriambiack Shire	350
Budja Budja Aboriginal Cooperative	Ararat Rural City Council, Pyrenees Shire, Northern Grampians Shire	200

Other data shows that the Grampians Aboriginal and Torres Strait Islander population is significantly younger than that of the non-Aboriginal and Torres Strait Islander population. Approximately 79% of the Aboriginal and Torres Strait Islander population is under 44 years compared to approximately 56% of the non-Aboriginal and Torres Strait Islander population.

CALD

A relatively small proportion of the Grampians Region has come from non-English speaking backgrounds. Community members now living in the Grampians Region, but born overseas, include people from Chile, China, Croatia, Egypt, Germany, Greece, Holland, India, Iraq, Iran, Japan, Kenya, Lebanon, Malaysia, New Zealand, Nigeria, Pakistan, Philippines, Poland, Somalia, South Africa, Sri Lanka, Sudan, Thailand, Togo, United Kingdom and Vietnam, Yugoslavia.

Consortium Membership and Structure

Committee of Management as at 30 June 2012

Chair: Denise Hooper, Primary Care Manager, Wimmera Health Care Group (from March 2012)

Members:
Julia Meek, Director of Nursing, Djerriwarrh Health Services
Michelle Veal, Manager Community Programs, Ballarat Health Services
Liz McEncroe, Nurse Unit Manager, Medical Oncology Unit, St John of God Ballarat Hospital
Carita Potts, Executive Officer, Ballarat Hospice Care Inc
Peter Armstrong, Clinical Director, East Grampians Health Service (from March 2012)
Melanie Hahne, Coordinator, Wimmera Hospice Care (Clinical Group representative)
John Koopmans, Department of Health
Pete Marshall, GRPCC Manager

Retired:
Helen Watt, Clinical Director, East Grampians Health Service (Chair until February 2012)

Member Services

Ballarat Health Services (BHS) **-** Drummond Street North, Ballarat 3350. The catchment area consists of the whole of (but not limited to) the Grampians Health Region.

Gandarra Palliative Care Unit is a nine-bed inpatient palliative care facility providing end stage care and symptom management for patients and their families who have been diagnosed with a terminal illness. The multidisciplinary team comprises of medical, nursing, pastoral and volunteer support as well as allied health professionals such as occupational therapy, dietetics and social workers.

Patients and families are encouraged to actively participate in all aspects of the patient focussed multidisciplinary care and planning. The environment enables patients and families to maintain as much as possible their normal routine within a specialised setting.

The Grampians Regional Palliative Care Team (GRPCT) facilitates the ongoing development of palliative care services in the Grampians Region through education, collaborative strategic planning, preparation of written materials, policies and procedures, quality improvement processes and consultation. The GRPCT is committed to providing a variety of quality education to a broad range of health professionals who strive for better palliative care practices.

Accreditation
In 2010 BHS received a four-year accreditation from the Australian Council on Healthcare Standards (ACHS).

Ballarat Hospice Care Inc (BHCI) - 312 Drummond Street South, Ballarat 3350. The catchment area consists of the City of Ballarat, Hepburn Shire, Golden Plains Shire, Moorabool – West SLA, and west of the Ballan-Daylesford Road and Geelong-Ballan Road within the Moorabool – Ballan SLA.

Ballarat Hospice Care Inc provides home-based palliative care services that are patient-focused for people living with a life threatening illness. A multidisciplinary team of specialist health professionals and trained volunteers deliver quality end of life care with understanding and compassion through symptom management and medication. BHCI continues to support families following a death at a time when people are emotional and feel vulnerable.

Experienced palliative care staff provide expert pain and symptom management as part of any ongoing treatment, with emotional and other practical support services for patients and families. The focus is on providing quality of life, to end of life care, with palliative care an adjunct to ongoing treatment, which can be delivered from diagnosis to bereavement.

Accreditation
In 2011 BHCI was accredited by Quality Improvement Council Standards (QICSA) and Palliative Care Australia Standards.

Wimmera Health Care Group (WHCG) **-** Baillie Street, Horsham 3400. The catchment area consists of the Statistical Local Areas (SLA) or the Rural City of Horsham and the Shires of Hindmarsh, Yarriambiack and West Wimmera.

Wimmera Hospice Care, auspiced by WHCG, is a palliative care service that supports people living with life limiting illnesses and their families and carers. The WHC team supports patients at home, in aged care facilities and in hospital. The team works closely with patients' local doctors, nurses and allied health care teams. The focus is not just on physical problems but also the emotional, spiritual and social issues that can occur as a result of illness. A bereavement support program is offered to families and carers and funding can be made available for specialist bereavement counselling.

Accreditation
Since 1975 WHCG has met the stringent patient care standards and is currently in a four year accreditation cycle with ACHS.

East Grampians Health Service (EGHS) - Girdlestone Street, Ararat 3377. The catchment area consists of the Shire of Northern Grampians, the Rural City of Ararat and the Shire of Pyrenees including Skipton (ie. Beaufort and Skipton Health Service).

Central Grampians Palliative Care (CGPC) is a community-based service auspiced by EGHS, delivering health care and emotional support to patients, and their carers, living with life threatening illnesses. CGPC aims to work with patients, their families and carers to achieve a level of care that optimises an individual's quality of life and to enhance dignity and independence. The service liaises with a number of local health and community services to assist in personal care, symptom management, home help and transport. It also loans equipment and aids to enable independence to be maintained and to make home nursing care easier. EGHS has one inpatient palliative care bed.

Accreditation
EGHS was surveyed by ACHS during 2010 – 2011, resulting in continued accreditation until 2013.

Djerriwarrh Health Services (DHS) - Grant Street, Bacchus Marsh 3340. The catchment area consists of the Moorabool – Bacchus Marsh SLA and east of the Ballan-Daylesford Road and Geelong-Ballan Road with the Moorabool – Ballan SLA.

Djerriwarrh Palliative Care (DPC) is a community-based service, auspiced by DjHS. The palliative care program offers co-ordinated care services for people with a terminal illness and support for their family at home. Care and support is offered including pain relief and management of other symptoms. It aims to be flexible and sensitive to the wishes and needs of clients and their families. A range of allied health services are available and a counsellor co-ordinates volunteer and bereavement services. DjHS has two inpatient palliative care beds.

Accreditation
DjHS had their accreditation with ACHS renewed until 2015.

St John of God Ballarat Hospital (SJOG) - Drummond Street North, Ballarat 3350. The catchment area consists of the whole of (but not limited to) the Grampians Health Region.

SJOG is a member of the St John of God group, which operates an organisation-wide Palliative Care Strategy that embodies an holistic approach to palliative care as an integral component of inpatient, outpatient and community services. The focus is on building confidence and capacity to equip caregivers with the knowledge and skills to manage and care for people at the end of life. The ultimate aim is to offer patients, with the support of their families and other carers, the opportunity to die with dignity and respect wile minimising pain and suffering.

The implementation of its Pastoral Services Strategic Plan 2010-2014 took place during the year. The main focus is on strengthening professional practice, information and education, and data collection. The Murdoch hospital developed bereavement resource packages for carers, which have been introduced across all hospitals within the SJOG group.

Accreditation - In 2010 – 2011 SJOG was accredited by ACHS.

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Consortium Manager's Report

The consortium was without a manager for 3 months just before this (2011 – 12) financial year, and in many ways the current year has been spent setting up the processes and structures for the consortium to more effectively and sustainably acquit its responsibilities into the future.

Compared with 2 years ago, funding coming through the consortium has tripled, and the work and expectations associated with the funding is closer to five-fold. The launch of the new Strengthening palliative care policy, and the substantial budget allocation for 2011-15, come with a clear message that consortia have a more significant role to play going forward. Over the same time, the sole employee of the consortium throughout the 2011-12 financial year was the Manager, working 0.6 EFT.

A combination of coming in to a new role, a change of auspice and a gap in having a manager in place has meant that many systems and processes were not in place. Although some of limitations on what has been achieved in the past year have to do with being new and setting up systems, it will remain the case that the administrative functions will consume a large and essentially immovable part of the consortium business. What gets consigned to 'the rest of the time' in this case are the functions that are potentially more important for the members and palliative care in general in the longer term – components of the strategic planning, implementation and evaluation, and components of service and community communication.

Consortium capacity became a major obstacle to effective management of the new funding streams, but rather than either haphazardly engaging new staff, or distributing funds without thorough processes, the consortium has taken a conservative approach to both. While this has meant that implementation of new initiatives has been slower than anticipated, the approach has been to 'do it once and do it properly' so that we do not have to keep re-visiting areas into the future.

We believe that the approach of attending to systems and capacity is now beginning to pay dividends, with consortium capacity building initiatives being put in place, and new approaches to projects being thoroughly implemented. The section below highlights some of the structural and administrative changes that have taken place in 2011-12, and although some are seemingly minimal, they all go towards clearer and more functional management and oversight.

Pete Marshall, Consortium Manager

Consortium structure and administration

Decision to employ consortium staff, set up an office in Ballarat and to allocate a proportion of project funding to consortium capacity building

The consortium considered and endorsed the employment of an additional 0.8 project worker, and the setting up of an office in Ballarat. The project worker will be over and above any specifically funded program – the focus will be to assist the Consortium Manager to enable the consortium to fully support palliative care across the region. Specific allocation of tasks for the project worker to pick up would be determined on the basis of priorities and the skills and experience of the worker.

Funding for consortium capacity building over and above the core administrative funding will come from an allocation of 10% of all project funding coming through the consortium. While decided at the end of the 2011-12 financial year, these changes will not take effect until the 2012-13 financial year.

Funding and service agreements

The new funding coming through to augment the *Strengthening palliative care: Policy and strategic directions 2011-2015*, and the need to be responsible for funding that went to other services and programs highlighted to this consortium the need to have a basic funding and service agreements in place so that there would be a clear record of what each party was agreeing to. Agreements were developed for all major projects that the consortium contributes funding, outlining:

- Amount of funding and breakdowns for the term of the agreement.
- Clear start and finish dates
- Agreed timelines and outcomes
- Sign off by consortium exec and Health Service exec
- Able to be varied with agreement of all parties

Conflict of Interest

The consortium did not have a process for members to declare if they had a real or potential conflict of interest with any of the items on the agenda. It was decided that there would be a statement regarding conflict of interest at the top of the agenda, and that the chair would call on members to declare any conflict of interest before the start of the official meeting.

Decision making via email

There was a recognised need to enable some form of decision making between formal meetings, and the consortium discussed adopting an electronic decision making guideline based upon that used by the state-wide Palliative Care Clinical Network (PCCN). The decision was to adapt the PCCN guideline, which was then circulated for comment, with final endorsement at the June meeting.

New Memorandum of Understanding (MoU)

Faced with an out-dated existing MoU, and the need to make some changes, the consortium undertook the task of developing a new MoU. One of the issues that has disrupted the meeting schedule has been the lack of a quorum on occasions for the consortium meetings. Although it may seem a minor point, it was an arrangement that had the potential to delay important consortium business. The consortium decided to focus on the sections of the MoU that deal with nominating a proxy, and these are set out below:

- *A quorum consists of a majority of voting members, that is, a minimum of four out of six voting members.*
- *Agencies may nominate a proxy voting representative in the event that their designated voting representative is unable to attend. Proxy voting rights must be made by way of written (including email) notification by the designated representative, or in exceptional circumstances by an officer of equal or higher status to the designated representative from the funded agency.*
- *Permanent changes to the designated role assigned to the delegation of a representative must be received in writing by the CEO (excluding email) at least 24 hours before the next consortium meeting that the representative will attend.*

Consortium meetings can make significant decisions about how resources are utilised across the region, and so it is important that a nominated proxy is in a position to understand the operations of both the service and the consortium, and is capable of making decisions based on that.

All services were involved in reviewing the development of the MoU, and all signed off at CEO level.

The consortium understands that since this MoU was developed, a new template has been developed by the Department, and this will be reviewed in light of changes that may be required in the Grampians version.

GRPCC Clinical Group

The Grampians palliative care clinical services share a total commitment to the provision of high quality palliative care, together with an ability to design and implement practical and innovative ways to make the best use of scarce resources spread over a large geographic area. In many ways, these services exceed expectations, which was highlighted at the Palliative Care Victoria conference in August 2012 with a number of excellent presentations, posters and overall attendance.

These services are also keen to share resources and ideas, and to collaborate in initiatives. During the course of the reporting year, the clinical group have been used more frequently as the first port of review for new initiatives, which in turn allows for more informed and balanced proposals to be taken to the consortium meetings for approval. As such, a number of the items mentioned below are reported in more detail in other sections of the report, but are included here as they were significant items of business for the clinical group while being worked up and reviewed.

The importance of this role and the willingness of members to contribute cannot be over-emphasised. The section below outlines some decisions and initiatives of the clinical group, and other service initiatives that used the clinical group for discussion and/or review.

Election of new chair

The chair of the clinical group had been held by Jade Odgers (Grampians Regional Palliative Care Team) for well over her allotted time as she carried the load until new arrangements could be put in place. There was a general consensus that the chair should rotate around services, and after a general discussion about availability and responsibilities, Melanie Hahne (Coordinator, Wimmera Hospice Care) was approached by the group to act as the new chair. Melanie had concerns about particular short term workloads, and asked to be given time to consult her team. Jane Cape (Djerriwarrh health Services) took on the role of vice-chair, and with the assurance that back up would be available if required, Melanie took on the role of chair.

Our thanks go to Jade Odgers for the significant contribution that she has made and continues to make in the clinical group

Clinical meeting procedures

Following the election of the chair, there were a number of procedural issues discussed and decided:

- The chair will preside for two years, with the periods overlapping with the 2 years of the consortium chair role. This will ensure better continuity of experience.
- Quorum for a meeting will be 4 members, but not including consortium staff.
- Two out of every three meetings will be by videoconference, and one face to face.

Regional Renal Project

Ballarat Hospice Care Inc. used the clinical group to work through future implementation for this consortium supported initiative, and later presented a project plan for feedback and review before being presented to the consortium meeting to secure funding. This initiative will be discussed more fully in another section of the report.

Admission criteria, referral processes and discharge review

The clinical group undertook a project to benchmark and have consistent criteria for admission and referral across the Grampians region. Ballarat Hospice Care reviewed each of the services admission and discharge protocols and procedures, collated them and brought them back to the clinical group for review. The review indicated that criteria and procedures were reasonably consistent across the region, and the clinical group agreed to put further development of these processes on hold as they were also being reviewed at a state-wide level.

RHCE Round Two applications

These Commonwealth grant were administered National Rural Health Alliance, and two submissions were presented from the region. Wimmera Hospice Care applied for funding to trial a palliative care orientation program for overseas trained nurses in the Wimmera, and the Grampians Regional Palliative Care Team applied for funding to continue their twilight training sessions. Wimmera Hospice Care was successful in their application, and is piloting an orientation program for overseas trained nurses in the Wimmera region.

Palliative Care Equipment Loans Scheme (PCELS)

The Department of Health and Ageing made one-off funding available under the National Palliative Care Scheme for the purchase of equipment to support the provision of palliative care for people who are dying in settings of their choice. This was administered in Victoria by Palliative Care Victoria, and the Grampians region was allocated $26,321.00. As a clinical group it was decided to take a regional approach to this application, and subsequently the consortium worked to achieve a collaborative agreement on how the funds would be split, and then with each service to share information and prioritise their equipment needs. Subsequently, the consortium made one application on behalf of all services.

Due to this collaborative approach, a second round of unused funding was made available for the Grampians region, and again a consensus approach to individual distribution enabled all available funding to be utilized. It is a credit to all services involved that they at all times maintained a focus on ‘fairness’ in this process.

The Mentoring Program

The consortium provided funding support for the GRPCT to develop a mentoring program, and the regional team in turn used the clinical group as a forum for discussion of ideas and for distribution of information. Mentoring is to be targeted for new staff and for others with an associated role to palliative care, including post grad students. A facilitator was engaged for three training sessions (half day 19/4, full days 10/7 & 9/10).

Informing and involving clients and carers

At the November meeting services discussed State-wide Priority 1 “Informing and involving clients and carers”. Information regarding what each service has implemented to meet this priority was discussed. It was agreed that at the next face to face meeting all services would bring information currently used to share ideas. An informal time was allocated at the end of the core business for services to view and discuss the resources of others, and this was a lively session which will be followed up at a later date to enhance clarity, simplicity and standardization of information across the region.

Quality Initiative Register

Palliative Care Victoria has developed a Quality Initiative Register on their website. This was taken to a clinical meeting, and subsequently the consortium members have contributed to this register with the renal project and orientation program for overseas trained nurses.

A later meeting has been scheduled to include building upon this register and supporting better access to and utilization of PCV resources.

Big Breakfast

The Big Breakfast initiative is a major annual project of the clinical group, run to promote Palliative Care Week, and funded and supported by the consortium. The initiative was first run in May 2011, and the intention of the group is to improve and expand the reach of the initiative each year, and in particular to review both the positives and negatives of each event to ensure that lessons are learned and incorporated into future events. This review was the major item of the April meeting, and made the following recommendations:

- Continue to keep the format informal
- Have a short quiz (with prizes) focusing around understanding of what palliative care is and morphine myths. This was done in Horsham last year and this year will have a regional collation.
- Invite two other health services in the region to video link and participate (Rural North West Health and Daylesford). This was suggested following interest in 2011 from other services.

A submission for funding for the event was put to and agreed to by the consortium.

It was also decided to use the June meeting for a more timely review of this year's event, so ensuring that lessons for improvement were more likely to be understood and adopted.

Regional Training Re-Imbursement Initiative

The consortium developed draft guidelines for this initiative, and the clinical group was used as a key source of review and feedback on guideline clarity and applicability. This initiative will be discussed more fully in another section of the report.

Other Activities

- Discussion around the Master Class for palliative care services which was organized by the regional team in May.
- Discussion amongst services throughout the region about submission of abstracts for the Palliative Care Victoria conference in August.
- More discussion around the Renal Project, which has gained ethics approval, and a paper has been accepted for the Australian Clinical Networks Conference.

Setting the agenda for the future

The clinical group also proactively set important agenda items for future meetings:

- The agenda for the July meeting was adjusted to give Odette Wanders (Chief Executive Officer, Palliative Care Victoria) time to speak about projects across the region. Each service will also be able to provide a brief overview of core activities and initiatives as part of this meeting.
- In addition, the July meeting will also give the Clinical Group an opportunity to say farewell to Jane Auchettl, After Hours project worker. Jane will provide a summary of the project to date and distribute the Carer Information Kit (An information kit developed for carers in the Loddon Mallee region).
- Catherine Duck (Project Manager for the Victorian End of Life Care Pathways Coordinating Program) will attend the August meeting and provide an overview of this project.

Strategic Planning

The Grampians consortium planning day was held in Ballarat on Thursday 20th October. Staff from palliative care head office ran the 16 participants through a presentation on the *Strengthening palliative care: Policy and strategic directions 2011-2015*. This and the associated *Implementation strategy* and *Implementation plan* form the basis of strategic direction for all consortia across the state, but over and above this, the planning day identified a range of priorities, with the top three being:

Service Coordination

- Helping agencies with consistency of practice
- Sharing of resources
- Increase of understanding knowledge of palliative care across other agencies
- Conduct a mapping exercise of partnerships and links, identify gaps and fill these, strengthen existing links
- Support consistency of tools
- Support integration of IT systems

Aged care

- Aged care link nurse – regional position
- Care planning – support greater understanding and consistency
- Training/increasing HACC workers understanding and knowledge around palliative care specifics.
- Building on existing relationships and projects
- Funding to support service initiatives between palliative care and HACC
- Identify gaps over and above the link nurse project.

Community understanding and awareness.

- Continual community education
- Clear and consistent messaging
- Strategic plans and daily practice to reflect talking about death and dying.
- Share opportunities to promote common messages
- Placing Pall Care 'up front' with other services / health promotion
- Normalising death and dying - real life stories
- Health promotion
- Identify and market difference between palliative care and end of life care.
- Marketing strategy for the region

Victorian Palliative Care Satisfaction Survey (VPCSS)

It was mentioned earlier in the report that the Grampians palliative care clinical services share a total commitment to the provision of high quality palliative care, and this is reflected in the results from the 2012 VPCSS where the Grampians region scored higher than the state-wide average on all of the major domains surveyed.

Table 5: *Overall satisfaction for total Grampians Region and the State-wide sample Item*

Domain	Region mean	State-wide mean
Mean scores for “Satisfaction with overall standard of care”	4.78	4.67
mean scores for the “Accessing Palliative Care”	4.30	4.14
mean scores for the “Experience of admission to this service”	4.66	4.57
mean scores for the "People involved in the delivery of care"	4.65	4.53
mean scores for the "Delivery of care by this service"	4.52	4.38
mean scores for the "Experience in Palliative Care"	4.68	4.54
mean scores for the "Experiences as a Carer"	4.18	3.99
mean scores for "Experience of inpatients in palliative care"	4.80	4.26

It is fitting that this annual report should highlight the value of our palliative care staff, and there is no more fitting tribute than the comments of patients and carers themselves:

- *“Empathy from staff. Patience in explaining things. No question was too trivial. Proactive staff i.e. things in place before they were needed. Always a smile and looking at positives.”*
- *“Excellent care for patients needs 24/7 family away felt welcomed and well informed.”*
- *“Exceptional people with exceptional skills.”*
- *“Experience of staff and understanding.”*
- *“I was completely overawed and extremely comforted by the outstanding level of care given and the expertise shown by all the doctors, nurses, volunteers at the [Health Service] and[Health Service]. They were absolutely marvellous.”*
- *“I would give 10 out of 10 to all members of the palliative team. They could not do enough to help me. They were all so helpful.”*

At the same time, the members of the Grampians consortium are keenly aware that there is room for improvement. The VPCSS identified the following five items as the region-wide priorities for improvement, and it will be major focus of both the clinical and consortium meetings to develop, fund and manage initiatives for continual quality improvement across the board.

Table 6: *VPCCS identified improvement priorities*

Priority to Improve Ranking	Item	mean
1	[Satisfaction with ongoing support] Opportunities to talk with other carers about your own situation (as a carer)	3.46
2	[Satisfaction with support received for] Planning ahead for funeral arrangements (if applicable)	3.89
3	[Satisfaction with support received for] Legal issues (e.g. advance care planning, medical power of attorney)	4.11
4	[Satisfaction with ongoing support] Support you received from volunteers	4.04
5	[Satisfaction with ongoing support] Level of training provided to carry out specific care functions (such as massaging, moving or bathing the patient)	3.94

After Hours

The original After Hours Pilot Project in Loddon Mallee and Grampians regions was funded for the period 2009 – 2011. The project's objective was to develop an after-hours palliative care service model appropriate for rural areas. A final report, an overview of which was presented at the Australian Palliative Care Conference in Cairns in September 2011, highlighted two main elements of the Community Palliative Care Regional Service Delivery model:

- Education, symptom management and support processes for patients and carers through the development of Guidelines for Patients and Carers.
- An after hours nursing telephone triage service that provides local solutions to a complex problem through different delivery options.

The project successfully demonstrated the viability of an effective, equitable after hours service for community palliative care patients that is both sustainable and local.

A small amount of surplus funding allowed for the pilot to continue until the end of September 2011, and the announcement of new after hours funding for all consortia for 2012 – 15 provided the Loddon Mallee and Grampians Consortia the opportunity to extend the current project manager's contract to consolidate and expand the after hours project in regard to:

- Consolidating the after hour processes implemented during the original project conducted in 2009 – 2011.
- Ensuring sustainability across all services of after hours care and support of patients and carers.
- Integrating the after hours processes across all elements of patient care and support between acute and community.
- The scope for capacity building opportunities around after hours support
- Review current educational delivery programs and resources for patients and carers with a view to developing and / or collaborating with them to develop an integrated education plan and strategy.
- Linking in with the strategies and recommendations of the 'Strengthening Palliative Care 2011 – 2015' state-wide initiatives
- Scoping the potential of collaboration with aged care facilities

Both consortia agreed to provide funding to continue the implementation of this successful project with the result that the Community Palliative Care After Hours regional model is currently operating in the Grampians and Loddon Mallee regions through the implementation of:

- Telephone Triage after hours support currently provided to community palliative care clients and carers by:
  - 12 Hospitals
  - 2 Regional after hours services
  - 2 Community palliative care teams
- The Guidelines for Patients and Carers symptom management care plans implemented by:
  - 90 % community palliative care services
  - 60% district nursing teams
- Expansion into regional hospitals has commenced.
- Implementation into aged care facilities is being explored.
- Development of regional projects is continuing.

Early in 2012, the release of the Department of Health state-wide framework endorsed and incorporated the pilot project recommendations. The *After-hours palliative care framework* ('the framework') is informed by the findings of the pilot projects. It is designed to assist palliative care consortia and palliative care services to develop models of after-hours support for their region.

The new financial year (2012-13) will see the end of the formal Loddon Mallee and Grampians partnership as both regions build separately on future initiatives. This step was hastened by the resignation of the project manager, Jane Auchettl, who has accepted a new and exciting challenge. Jane was a significant factor in the success of this project, and it is fitting that the annual report should recognise this and include a tribute made at the time of her resignation:

> *Jane has grabbed hold of the after hours project and made it into a strong and viable model that allows individual services and populations to adapt solutions according to relevant and local circumstances. This in turn creates individual ownership of the outcomes, and I believe that this is one of the major strengths of this project. To do this, she has demonstrated both a strong and realistic understanding of rural communities, and the persistence and patience to support local solutions to develop. Jane has worked across the Loddon Mallee and Grampians regions with significant autonomy combined with a very high level of professionalism and reporting. She relished the challenges of the role, and always looked to the wider application of what she was doing. While we will miss Jane's valuable contribution to the consortium, we must also thank her very much for what she has done, and wish her all the best in her new role.*
>
> Pete Marshall, June 2012

Aged Care and Disability

As part of the Government's commitment to meet growing demand and address gaps in palliative care service delivery, the Department of Health has provided new funding to establish a region wide palliative care link nurse position and a region wide disability palliative care position.

The Grampians Region Palliative Care Consortium (the consortium) called for an Expression of Interest (EoI) from funded palliative care services within the Grampians region to manage these initiatives for a period of three years from July 1st 2012 to June 30th 2014. The documentation detailed that the EoI may be made by a service alone, or by more than one service in collaboration. A funded service may partner with another not for profit service (ie. non palliative care specific) within the Grampians region to enable more effective coverage either geographically or across service fields, or both, but in this situation the palliative care funded service will be the lead agency.

The request for an EoI needed to be read in conjunction with the Department of Health discussion paper - *Aged care palliative care link nurse and Disability palliative care position for consortia*, which was sent out as an attachment to the email regarding the call for an EoI.

<u>Main points that arose in consortium discussions</u>

- The position needs to set up the structures that will maximize ongoing and sustainable change. This has led to highlighting both clinical palliative care experience and well developed change management skills in being important when choosing staff for the roles.
- Some consortium members feel that in order to maximise the ability to recruit and retain skilled staff, and given the limited amount of recurrent funding, the aged care and disability roles would be better to be combined. The most recent consortium clinical meeting however expressed the view that balancing the two roles may be very difficult, and that the consortium should be flexible around this issue.
- The consortium needs to be presented with and agree to a model that will be effective in developing the initiatives over the first three years. Realistically, developing the model itself will require considerable research and consultation, and it may be that this initial scoping is a separate process.

- Both the position/s and the overall consortium approach to palliative aged care and palliative disability care will be guided by the Palliative Aged Care Steering Committee and the Disability Palliative Care Steering Committee respectively. These regional committees do not currently exist, and will be established jointly by the consortium and the funded service, and resourced by the funded service.

Disability Palliative Care

Given that two consortium members applied for this funding, an executive made up of non-applying service representatives considered applications and decided that the Disability position would go to East Grampians Health Service (EGHS), who had placed an EoI for that role only. Apart from previous experience with another project involving the health needs of the disability sector, this initiative also targeted an area of high levels of disability in the community, as detailed in the demographic data set out at the start of this document.

Given the intent of the consortium to put funding agreements for all major projects, an agreement for the disability palliative care funding was drawn up between the consortium and EGHS, and signed off by all parties in time for a start in the new financial year.

A small amount of additional funding is available for disability palliative care, which will be targeted to small projects that support the overall aim of the core funding.

Aged Care Palliative Care

The other service involved in the EoI declined to go ahead on the basis of the aged care role alone, and as set out in the conditions of the EoI, the consortium will undertake a scoping project during 2012-13, and on the basis of the outcomes of that scoping project, set up another EoI for the aged care funding over the 2013-15 financial years.

Again, some additional funding is available for aged care palliative care, which will be targeted to small projects that support the overall aim of the core funding.

Nurse Practitioner Funding

The consortium meeting of March 2012 decided that funding provided to the consortium for the support and development of Palliative Care Nurse Practitioner (NP) and Nurse Practitioner Candidate (NPC) resources would be used to support expanded capacity in the Grampians Regional Palliative Care Team (GRPCT), who already have a nurse practitioner in place working in a regional capacity. Up until this point, this position has been funded by Ballarat Health Services (BHS) from other sources.

Finding balance in the agreement

The consortium set up an agreement that gives some certainty for the position, but at the same time also accommodates the broader need to support the development of NP and/or NPC skills within the region in the future. An arrangement that meets that need was a 2 year funding agreement that has a 12 month notice period.

The agreement was set up in that fashion for the consortium to have flexibility around the final (2014-15) years funding under the current arrangement. In the meantime, the consortium will undertake a review to build upon earlier work undertaken in the Grampians region, and will consider ways in which a future nurse practitioner workforce can be nurtured and developed in the Grampians region. Development of the nurse practitioner workforce, is a core ongoing task of the consortium clinical group.

The Nurse Practitioner agreement was drawn up and signed by all parties.

State-wide Clinical Network

Grampians region is the only consortium that did not have representation on this network during 2011-12. This is core representation for the consortium to have, and the funding has allowed the nurse practitioner incumbent within the regional team to take up this representation into the future.

Rural Medical Purchasing Fund

Before the establishment of the RMPF, the region had one 0.8 EFT Palliative Medicine Specialist. The workload was such that there was a reduced capacity to visit outlying areas in the region. The Consortium used the Medical Fund to support contributions from BHS to fund an additional full time Palliative Medical Specialist in the Grampians Region. This arrangement continues, meaning that an effective palliative care specialist service operates throughout the region with in-reach and consultancy services at BHS, and monthly visits to regional palliative care services in Bacchus Marsh, Horsham and Ararat.

The Palliative Medical Specialists reported that the new workforce arrangements have provided:

- Improved response times to new assessments, resulting in more Ballarat patients being seen on the same day as they were referred.
- Greater equity of services across the region
- A more collegial working environment for specialists
- A more sustainable working environment
- Regional capacity building through increased upskilling of General Practitioners
- Improved continuity of care for patients and families.

PEPA post placement support

The uncertainty and late arrival of the PEPA funding has meant that activity in this area has been restricted to the focus of attention at clinical meetings throughout the year. The Grampians region has a history of training and workforce development, and a number of initiatives developed and described in this report point to the priority of this issue. The consortium is committed to ensuring that this funding is used to gain maximum benefit for palliative are patients and their carers throughout the region.

Motor Neurone Disease (MND) Funding

The MND funding in the Grampians region is used to support a 1 day/week regional role situated with Wimmera Health Care Group (WHCG). The incumbent acts as a resource/support person for people living with MND and other workers and services across the region, conducts training and provides information and updates on current resources and clinical approaches. A good example of this was the Identification and dissemination of new material around cognitive change with MND.

This role demonstrates the difficulties of small roles with a large regional responsibility. The funding available does not fully cover that role, quite apart from the broader issue of also providing funding for the role to effectively provide a regional service, ie, funding for travel and other associated expenses.

The consortium values the fact that there is specific funding available to support MND patients across the region, and has agreed that it will continue to meet the shortfall between funding available and funding required to fulfil the role.

Integrating Renal and Palliative Care – Framework for Implementation

The consortium supplied funding for this innovative project being undertaken by Ballarat Hospice Care Inc. The ultimate aim of this project is to create a supportive environment for patients and families to make informed decisions focusing on quality of life, and the project is a response to an identified lack of consistency and response to these care needs.

Renal services are particularly receptive to these initiatives as they develop long term relationships with their patients, and they are well placed to see the deterioration.

The project will clearly determine and continue to develop a framework for implementation, is ongoing, and has so far achieved:

- Completed planned visits and engagement of Renal Nurses and Palliative Care Services.
- Meetings with University of Ballarat to prepare research project and abstract with intention of presenting at the Australian Clinical Networks Conference.
- Clinician champions identified
- Preparation of Research and Ethics approval
- Resources Packs prepared

The consortium looks forward to ongoing collaboration and support for this innovative and ultimately far reaching project.

Working with the Grampians Medicare Local

The Grampians Medicare Local is part of the third tranche of Medicare Locals being established, and as such will not officially begin operation until July 1st 2012. However the Grampians Medicare Local will largely cover the same geographic area as the consortium, and will essentially be a roll-over of two pre-existing Divisions, Ballarat and WestVic, with which the consortium has well established and productive working relationships.

Discussions have already taken place regarding areas of common interest and possible joint projects, and the consortium is well placed to build upon the existing established relationships.

Support for up-skilling palliative care staff in the Grampians Region.

The consortium meeting in April decided to support better access for community palliative care staff working with palliative care patients throughout the region to attend conferences, seminars or educational workshops to further their knowledge and skills in palliative care.

The consortium has done this in the past by responding to particular events or circumstances, but has not had a documented process in place. The consortium established guidelines for accessing support, with the aim of speeding up the process and making more training opportunities viable, and taking away the need for individual decision making.

The consortium also decided that cover for backfill should be included in the policy, as this was often the most critical factor in decisions to release staff.

The aim of the policy is not to cover all of the costs associated with undertaking training – it is part of the responsibility of individual agencies to provide training for their staff, and individuals have a responsibility for themselves to maintain their skills. The aim is provide support such that both staff and agencies, particularly those with less immediate access to training opportunities, take up a greater range of options.

Support for research preparation and conference presentations

In addition to the previous initiative, a proposal was developed to support palliative care staff across the region to undertake research associated with their work, and to present that research in public forums and/or relevant publications.

The Board gave in principle support to develop this proposal further, and bring back to a later meeting.

Financial Statement

Palliative Care Consortium Consolidated Projects	30-Jun-12
	2011-12 June YTD Actuals
Income	
GOVERNMENT GRANTS	
DH GRANT - AFTER HOURS PALLIATIVE CARE (CONSORTIUM SHARE)	100,000.00
DH GRANT - DISABILITY PALLIATIVE CARE	25,000.00
DH GRANT - PALLIATIVE AGED CARE LINK NURSE	18,500.00
DH GRANT - PALLIATIVE AGED CARE LINK NURSE	77,750.00
DH GRANT - PALLIATIVE CARE CONSORTIUM INDEXATION TOP-UP	12,604.00
DH GRANT - PALLIATIVE CARE NURSE PRACTITIONER	80,000.00
DH GRANT - PALLIATIVE CARE STRATEGIC FRAMEWORK	106,065.00
DH GRANT - RURAL MEDICAL PURCHASING	127,275.00
Total GOVERNMENT GRANTS	**547,194.00**
OTHER INCOME	
F8502- 54105 Feb 12 DHS Grant - Community Palliative Care - Wimmera funds	237,889.00
Y7503- 57849 Oct 11 MND Share Care Wkr - Motor Neuron Disease	10,000.10
10% From Other Projects Income to fund Consortium Administrative Expenses	41,002.50
Total OTHER INCOME	**288,891.60**
Total Income	**836,085.60**
Expenditure	
Transfer 10% of Income to Consortium for Administrative Funding	41,002.50
EXTERNAL CONTRACT STAFF	
GRANTS RECEIVED & PAID TO OTHER AGENCIES	171,859.83
REPLACEMENT AND ADDITIONS- Furniture and Fittings <$1,000	623.00
REPLACEMENT AND ADDITIONS- Computers and Comms <$1,000	1,279.01
OTHER ADMINISTRATIVE EXPENSES	2,675.18
COMPUTER - OTHER COSTS	970.00
ADVERTISING	399.18
CONSULTANCY COSTS	5,386.00
PUBLICATIONS - (BOOKS/JOURNALS) INC SUBSCRIPTIONS	50.00
PRINTING & STATIONERY	569.55
MOTOR VEHICLE FUEL AND OIL	634.14
STAFF TRAINING AND DEVELOPMENT	182.09
CONFERENCES REGISTRATION AND ACCOMM	600.00
TRAVEL EXPENSES- OTHER	7,393.36
ADMINISTRATION FEE	7,500.00
Total Direct Expenses	**240,325.48**
Salaries & Wages	
SALARIES	54,997.93
SUPERANNUATION EXPENSE	4,648.85
WORKCOVER - PREMIUM	1,286.73
Total Salaries & Wages	**60,933.51**
Surplus / (Deficit)	**534,826.61**
Total Program Surplus as at 30/6/2012	**534,826.61**