Gippsland Region Palliative Care Consortium Annual Report 2011

PALLIATIVE CARE

STRENGTHENING PALLIATIVE CARE:
POLICY AND STRATEGIC DIRECTIONS 2011-2015

GIPPSLAND REGION PALLIATIVE CARE CONSORTIUM
REPORT TO PALLIATIVE CARE, DEPARTMENT OF HEALTH

1. Contents

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Gippsland Region Palliative Care Consortium Annual Report 2011
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2. Introduction

Strengthening palliative care: Policy and strategic directions 2011–2015[1] will guide the work of palliative care services, consortia and government from 2011 to 2015. The actions outlined in the policy will equip specialist palliative care services in Victoria to meet growing demand for palliative care. The policy vision states "All Victorians with a life-threatening illness and their families and carers have access to a high-quality palliative care service system that fosters innovation, promotes evidence-based practice and provides coordinated care and support that is responsive to their needs."

In 2004, the policy supported the establishment of palliative care consortia in all departmental regions. The role of the palliative care consortia is to:

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

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.

THE GIPPSLAND REGION PALLIATIVE CARE CONSORTIUM

The Consortium is one of eight regional consortia established as part of the Victorian Government's Strengthening Palliative Care: a policy for health and community care providers 2004-09. The Consortium was formed through a Memorandum of Understanding with local health services in Gippsland. An initial Heads of Agreement, dated 18th February 1998 gave effect to the Gippsland Community Based Palliative Care Consortium. It comprised six member agencies: Central Wellington Health Service, West Gippsland Healthcare Group, Wonthaggi and District Hospital, Lakes Entrance Community Health Centre, Latrobe Community Health Service, and GSHS.

An addendum to the 1998 Heads of Agreement created the current Gippsland Regional Palliative Care Consortium (GRPCC). The current agreement is effective from 1st February 2005 to 30 June 2009.

The Heads of Agreement Addendum identifies four major roles for the Consortium:

1. Regional planning: planning services for people with a life threatening illness and implementing planned initiatives following approval by the Department of Human Services (DHS)
2. Role designation of hospitals in the region, ensuring consistent access to specialist palliative care services
3. Co-ordination of care: developing and implementing processes and systems for co-ordinated and integrated care for people with a life-threatening illness
4. Determination of priorities for future service development and funding in conjunction with DHS staff to support the implementation of the regional plans

The voting member agencies of the GRPCC include:

- Bairnsdale Regional Health Service (BRHS)
- Bass Coast Community Health Service (BCCHS)
- Bass Coast Regional Health (BCRH)
- Central Gippsland Health Service (CGHS)
- Gippsland Southern Health Service (GSHS)
- Gippsland Lakes Community Health Service (GLCH)
- Latrobe Community Health Service (LCHS)
- Latrobe Regional Hospital (LRH)
- West Gippsland Healthcare Group (WGHG)
- Yarram & District Health Service (YDHS)

Non-voting GRPCC member agencies include:

- KooWeeRup Regional Health Service (KRHS)
- Omeo District Health (ODH)
- Orbost Regional Health (ORH)
- Central West Gippsland Division of General Practice (CWGDGP)

1. Department of Health (2011). Strengthening palliative care: Policy and strategic directions 2011 – 2015. Draft policy for consultation.

3. About The Gippsland Region

The Gippsland region is extremely diverse covering an area of 41,538 square kilometres (18.3% of Victoria), from metropolitan Melbourne to the New South Wales border in the east. The distance from Mallacoota in the east to Melbourne Central Business District is approximately 516km. The 2006 census reported the resident population of Gippsland was 239,648 people or 5% of Victoria's total population (see Table 1). By 2031, the Gippsland population is predicted to increase by 14.6% to 283,767 people.

Table 1 shows the age demographics and Aboriginal and Torres Strait Islander population data collected in the 2006 Census. The percentage of population in Gippsland (30.2) aged 55 years and older is higher compared with the Victorian (24.5) and Australian (24.3) percentages.

Gippsland (1.3%) has a greater proportion of Aboriginal and Torres Strait Islander population than Victoria (0.6%), but less than the Australian proportion (2.3%).

English was the only language spoken at home by 91.3% of people in Gippsland compared with 74.4% in Victoria. In Gippsland, the most common languages other than English spoken at home were: Italian 0.9%, German 0.4%, Dutch 0.4%, Greek 0.3% and Maltese 0.2%.

In the 2006 Census, 82.3% of people in Gippsland stated they were born in Australia. The next most common places of birth were England 3.8%, Netherlands 1.0%, New Zealand 0.9%, Scotland 0.8% and Italy 0.7%.

There are nine funded community specialist palliative care services in the Gippsland Region, based at:

- BRHS
- BCCHS
- BCRH
- CGHS
- GSHS
- GLCH
- LCHS
- WGHG
- YDHS

Unfunded generalist palliative care services are also provided by KRHS, ODH, and ORH. There are also a number of smaller bush nursing services in the East Gippsland region.

There are also eleven designated palliative care inpatient beds in the region located at:

- BRHS – 1 bed
- BCRH – 1 bed
- CGHS – 2 beds
- GSHS – 1 bed
- LRH – 4 beds
- WGHG – 2 beds

TABLE 1: AGE GROUPS & POPULATIONS PROFILE

	TOTAL	A&TSI	0–14 YEARS	55+ YEARS	MEDIAN AGE
Gippsland	239,648	1.3%	19.8%	30.2%	41
Victoria	4,932,422	0.6%	19.3%	24.5%	37
Australia	19,855,288	2.3%	19.8%	24.3%	37

FIGURE 1: GIPPSLAND REGIONAL PROFILE

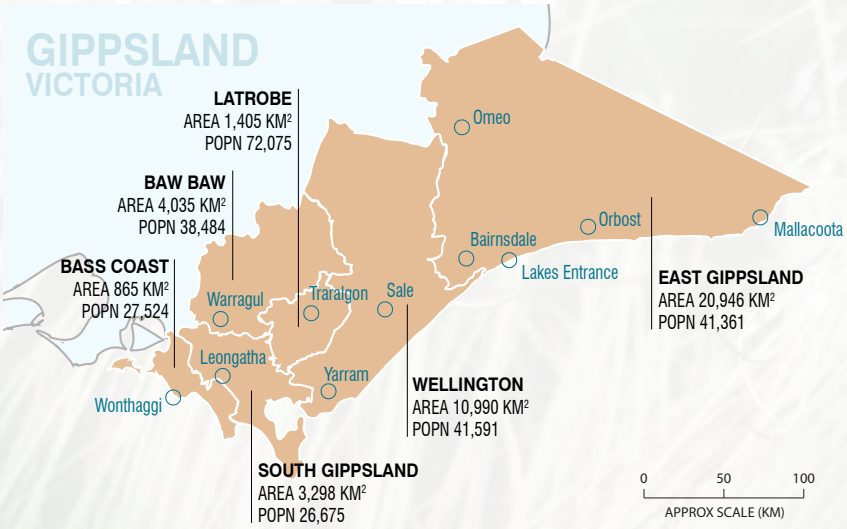
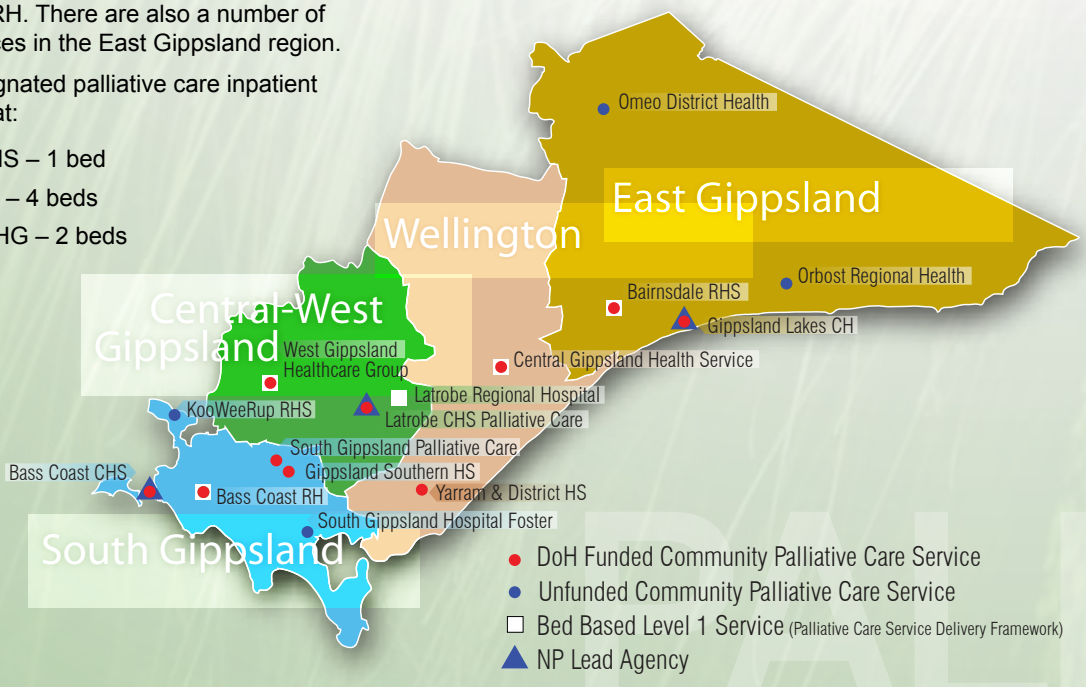


FIGURE 2: LOCATION OF PALLIATIVE CARE SERVICES - GIPPSLAND REGION



CLINICAL PRACTICE GROUP

The Department of Health has mandated that palliative care consortia establish a Clinical Practice Group (CPG) to:

- ensure that decisions that are made by the consortium are evidence based;
- facilitate collective problem solving in the implementation of the SPCP at a clinical level; and
- develop resources that promote evidence based clinical practice.

The CPG comprises representatives from community and hospital-based palliative care services from each sub region; a nurse practitioner candidate (NPC); a general practitioner (GP) from each sub region; Division of General Practice representatives and a palliative medicine specialist.

In 2010-11 the CPG membership included:

- WGHG – Maryann Bills (Motor Neurone Disease Shared Care Worker [MND SCW])
- BCCHS – Jo Kelly (NPC)
- BCRH – Rosie Steele
- GLCH – Cheryl Bush (Chair), Erin Lee (Allied Health)
- KRHS – Meagan Daley (Southern Region)
- LCHS – Rachelle McKay, Jenny Turra (NPC)
- ORH – Sandy Joiner
- GRPCC – Anthony Hooper, Mary Ross-Heazlewood, Anny Byrne, Judy Coombe
- CWGDGP – Marg Bogart
- Central West Region GPs – Vacant
- Eastern Region GPs – Dr Liz Wearne
- Southern Region GPs – Dr Bronwyn Williams
- Peninsula Palliative Care – Dr Brian McDonald
- Calvary Health Care Bethlehem – Dr Jane Fischer

CONSORTIUM MANAGEMENT GROUP

The role of the Consortium Management Group (CMG) is to drive the implementation of the Strengthening Palliative Care Policy (SPCP) in the region. The CMG is responsible for monitoring and reviewing implementation of the SPCP as well as facilitating the integration of care for people with a life threatening illness, their cares and families across the service system.

In 2010-11 the CMG membership included:

- WGHG – Anne Curtin (Chair)
- BRHS – Vicki Farthing
- BCCHS – Rae Davies/Annie Bailey
- BCRH – Kaye Beaton
- CGHS – Mandy Pusmucans
- GLCH – Cheryl Bush
- GSHS – Neil Langstaff
- KRHS – Terrona Ramsay
- LCHS – Nicole Steers
- LRH – Amanda Cameron
- ODH – Louise Vuillermin
- ORH – Bernadette Hammond
- YDHS – Marj Brosche

CONSORTIUM EXECUTIVE

The role of the Consortium Executive is to ensure the GRPCC regional plan is operationalised, ensure financial accountability and undertake staff recruitment and performance management.

In 2010-11 the Consortium Executive comprised of:

- Consortium Chair – Anne Curtin
- Consortium Manager – Anthony Hooper
- Fundholder (CGHS) – Mandy Pusmucans
- Other voting members – Vicki Farthing (BRHS), Cheryl Bush (GLCH) and Nicole Steers (LCHS).

OPERATIONAL REFERENCE GROUP

The aim of the Operational Reference Group (ORG) is to:

- Provide a forum for coordination of service standards and quality initiatives across the region as directed by the GRPCC Strategic Plan 2005 – 2009;
- Facilitate integration of service initiatives across the region, with a view to sharing knowledge and skill resources amongst consortium members;
- Provide a forum for learning about best practice initiatives in palliative care; and
- Provide a forum where the range of stakeholders can raise service delivery issues both within the group and to the GRPCC.

In 2010-11 the ORG membership included:

- CGHS – Mandy Pusmucans (Chair), Therese Smyth
- BRHS – Lesley Fenton
- BCCHS – Jo Kelly
- BCRH – Julie Clements
- GRPCC & GLCH – Maggie Goss
- GLCH – Barb Phillips
- South Gippsland Palliative Care Service – Mary Ross-Heazlewood, Lyn Yeomans
- LCHS – Rachelle McKay
- LRH – Kerry Sibson, Marg Warne
- MND & WGHG – Toine Boville
- Consortium Manager – Anthony Hooper
- Very Special Kids – Maria Bradford

CONSORTIUM PERSONNEL

The consortium personnel assist implementation of the SPCP by providing regional education and training; project, volunteer and administrative support; and coordinating communication activities. In 2010-11, the GRPCC personnel included:

- Anthony Hooper - Consortium Manager
- Mary Ross-Heazlewood – Regional Education Officer
- Anny Byrne – Project Officer, Pathway for Improving the Care of the Dying (PICD)
- Sandy Scholes – Project Officer, Specialist Services
- Maggie Goss - Regional Volunteer Support & Education
- Steve Kirkbright – Information and Communications Coordinator
- Toine Bovill & Maryann Bills – Motor Neurone Disease (MND) Shared Care Workers (SCW)

4. Year Highlights

NURSE PRACTITIONER PROJECT

The Rural Palliative Care Nurse Practitioner project will offer Gippsland the opportunity to achieve one of its prime objectives for palliative care in the region – increased access to consistent specialist care. The nurse practitioner will be an integral part of the Specialist Palliative Care Teams proposed for the three sub-regions in Gippsland. The aim for the regional model is to have consistency in care across the region (access, quality of service).

A palliative care nurse practitioner candidate is a registered nurse engaged by a service/organisation as they work toward meeting the academic (eg approved Master of Nursing Practice {Nurse Practitioner}) and clinical requirements for endorsement as a nurse practitioner. The actual period of candidature varies in length according to the individuals requirements in attaining and consolidating competence at the level of a nurse practitioner.

Nurse practitioner candidates Jo Kelly from Southern region, and Jenny Turra from Central West region were appointed in 2010-11. Eastern region has also committed to appointing a nurse practitioner candidate in 2011-12.

Care provided by the nurse practitioner candidates in Gippsland includes:

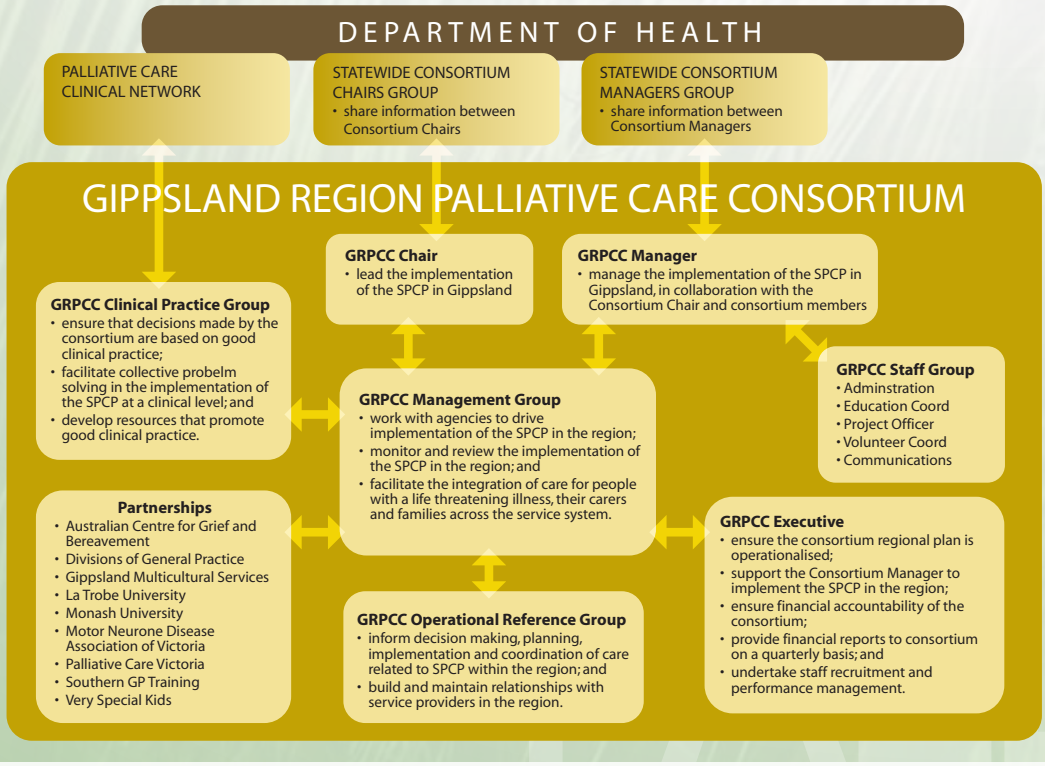
- Supporting the community palliative care teams (Level 1) and District Nursing Services currently in place;
- Providing care coordination of the complex palliative patient in collaboration with the specialist palliative care physician thus improving the service pathway for these patients;
- Increasing access to specialist palliative care services (perceived to be a major gap in palliative care in the region);
- Providing clinical leadership in palliative care in the sub region; and
- Being involved in education and research for palliative care within the region.

4TH GIPPSLAND REGION PALLIATIVE CARE CONFERENCE

GRPCC again collaborated with the Gippsland Region Integrated Cancer Services (GRICS) and the three Gippsland Divisions of General Practice in staging the two day conference *'Life and Death Matters – the whole person'*. 142 health professionals attended the two day event which included a tour of the William Buckland Radiotherapy Centre. Dr Odette Spruyt gave the keynote address *'Palliative Care – the fourth arm of cancer care'* on the Friday evening. The two keynote speakers on Saturday were Dr. Catherine Crock who spoke on *'Patient and Family Centred Care'* and Dr Michael Barbato *'Unconscious Perception – The evidence and implications for care'*. There were two concurrent sessions held Saturday afternoon giving participants access to six interactive and instructive workshops. Selected responses from evaluations include:

- "Very informative. Helped put yourself in the patient's shoes"
- "Excellent. Ask the parents and families for ideas. See them as people. Respect them"
- "Interesting presentation. Intuitively know this makes sense but good to see some tools/indicators of altered conscious states"
- "A better understanding of methadone use in nerve pain"
- "The importance of the environment/personal space in relation to a persons' well being"

FIGURE 3: GRPCC ORGANISATIONAL STRUCTURE



QUALITY MEASURES

Table 2 indicates participation in quality and monitoring processes namely the National Standards Assessment Program (NSAP), Victorian Palliative Care Satisfaction Survey (VPCSS) and the Palliative Care Outcomes Collaborative (PCOC). Where available, a brief summary of results is provided for each measure.

NATIONAL STANDARDS ASSESSMENT PROGRAM

Seven services across Gippsland participated in the NSAP. Table 3 lists regional priorities identified for improvement.

PALLIATIVE CARE OUTCOMES COLLABORATIVE

There are currently no services in the Gippsland region that systematically use PCOC tools. There are however some services that are and/or intending to trial the tools available, including GLCH.

VICTORIAN PALLIATIVE CARE SATISFACTION SURVEY

2010-11 was the second year of the VPCSS. The survey captured feedback from adult patients (30%), carers (26%) and bereaved carers (25%) from both community and inpatient palliative care settings. The survey was conducted between 25 February and 13 May 2011. There were a total of 144 respondents across the region (all services) in 2011. Items were rated from 5 (high) to 1 (low). Overall results of satisfaction for all respondent types increased compared with 2010 results. The top five performing and priorities for improvement are provided in Table 4 and Table 5 respectively.

Source: Ultrafeedback. http://www.ultrafeedback.com/a.asp?s=1067&u=report16&p=irkear

TABLE 2: QUALITY MEASURES PARTICIPATION

MEMBER SERVICE	NSAP	VPCSS	PCOC
WGHG	✓	✓	
BRHS	✓	✓	
BCCHS	✓	✓	
BCRH	✓	✓	
CGHS		✓	
GLCH	✓	✓	partly
GSHS		✓	
KRHS		✓	
LCHS		✓	
LRH	✓	✓	
ODH	✓	✓	
ORH		✓	
YDHS		✓	
TOTAL number	7	13	0

TABLE 3: NSAP IDENTIFIED PRIORITIES FOR IMPROVEMENT

AREA OF IMPROVEMENT	GRPCC RESPONSE
Standard 5 - The primary caregiver is provided with information, support and guidance about their role according to their needs and wishes.	'Caring for Carers' is a key area of the new policy direction. Elements of this standard will also be addressed in the proposed After hours Project.
Standard 6.7 - Plans are in place for the certification of death, including plans for certification after hours.	CPG is currently developing policy/ guideline. PICD rolled out across the region.
Standard 8.4 - Clinical assessment is undertaken to identify those family members suffering depression, anxiety and sadness associated with loss, grief or bereavement.	Work is currently being undertaken by the Victorian Palliative Care Clinical Network with regards to this element. The CPG will review outcome of this work.
Standard 10.3 – Policies for prioritizing and responding to referrals in a timely manner are documented.	The CPG is to obtain and review copies of prioritization tools that have been developed by services in other regions and interstate.
Standard 11.5 – There is a robust and rigorous clinical audit review	The CPG is to determine whether there is an exsiting framework for this standard or whether this needs to be developed.

TABLE 4: TOP FIVE PERFORMING ITEMS FOR GIPPSLAND REGION

RANK	ITEM	MEAN
1	Experience in palliative care - [Satisfaction with] The level of respect shown towards you as an individual	4.83
2	People involved in the delivery of care - [Satisfaction with] How well the team responds to your needs	4.76
3	People involved in the delivery of care - Overall satisfaction with the care delivered by your palliative care team	4.75
4	People involved in the delivery of care - [Satisfaction with response to needs from] Nurses	4.74
5	People involved in the delivery of care - [Satisfaction with] The level of expertise of people involved in your care	4.73

TABLE 5: TOP FIVE PRIORITY ITEMS TO IMPROVE FOR GIPPSLAND REGION

RANK	ITEM TO IMPROVE	MEAN
1	Experiences as a Carer - [Satisfaction with ongoing support] Opportunities to talk with other carers about your own situation (as a carer)	3.03
2	Experiences as a Carer - [Satisfaction with ongoing support] Support you received from volunteers	3.71
3	Experiences as a Carer - [Satisfaction with ongoing support] To minimise financial burden	3.23
4	Experiences as a Carer - [Satisfaction with ongoing support] Level of training provided to carry out specific care functions (such as massaging, moving or bathing the patient)	3.91
5	Experiences as a Carer - [Satisfaction with ongoing support] Level of access to psychological support services (e.g. to deal with issues such as loss, grief and bereavement)	3.65

5. Reports

CONSORTIUM CHAIR

ANNE CURTIN
CHAIR, GRPCC

2010-11 has seen major achievements in delivering the integrated palliative care services first identified at the formation of the Consortium five years ago. Partnerships with patients, families and carers together with a team approach to patient care by health professionals has seen the rollout of Pathway for Improving the Care of the Dying (PICD) and the establishment of the Clinical Practice Group to implement common clinical practice procedures and policies across Gippsland. These are both major achievements in improving care and access to services for patients and their families in the region.

Visits from Southern Metropolitan Regional consultancy teams further strengthened regional palliative care services by supporting Gippsland general practitioners with training and education, secondary consultancy advice and case conferencing services. Nurse practitioner candidates were appointed at BCCHS and LCHS and the Nurse Practitioner proposal for East Gippsland was developed. Linking the nurse practitioner candidates with the specialist program will be a major focus for 2011-12.

The Consortium's education program continues to encourage informal and ongoing conversations recognising the diversity in patients' needs, values and beliefs. Delivery of further education across the region will feature as a key objective in 2011-12. Our volunteers' enthusiasm, attendance and thirst for education is gratefully acknowledged and the Consortium has delivered more forums to accommodate demand.

The Fourth Annual Gippsland Palliative Care Conference *'Life and Death Matters – The Whole Person'* was a highlight of 2010-11 with over 150 delegates attending. Expert keynote speakers included Dr Odette Spruyt, Dr Michael Barbato, Dr Catherine Crock and Dr Ben Hindson.

2010-11 also saw the first presentation ceremony for graduates of the Introduction to Palliative Care Short Course at Monash University, which was developed in collaboration with the GRPCC in response to the needs of member services in the region.

After five years as the Consortium's manager, Anthony Hooper left to return to his other passion, the environment, and the business he runs on his farm with his wife. Anthony set solid foundations for the Consortium that will be sustained in the future and is a testimony to him. Anthony added great measure to the Palliative Care Service and quality of life of our community in Gippsland and we thank him very much and wish him well in the future.

CONSORTIUM MANAGER

VICKI DOHERTY
CONSORTIUM MANAGER

It is my pleasure to report on the work of the GRPCC on behalf of Anthony Hooper, who resigned as the GRPCC Manager at the end of June 2011. Before I report on the outcomes of 2010-11, I would like to acknowledge the major achievements of the GRPCC over the past five years.

Building relationships with key stakeholders has been an effective strategy to improve the coordination and access to palliative care services in the region. The GRPCC has developed partnerships with the three Divisions of General Practice and established links with the aged care sector to promote an integrated approach to palliative care. The GRPCC has also developed partnerships with Aboriginal community controlled health organizations and linked with Gippsland Multicultural Services to improve access to palliative care by Aboriginal and CALD communities.

The GRPCC obtained recurrent funding to provide health services with access to palliative medicine specialists. Partnerships with Southern Health Supportive and Palliative Care unit, Calvary Health Care and Peninsula Palliative Care were developed to provide a visiting palliative medicine specialist consultancy service to the region. With assistance from Southern Health, the GRPCC implemented the Pathway of Improving the Care of the Dying (PICD) in acute, community and aged care facilities across the region.

The vastness of the Gippsland region and reduced access to specialist services required the GRPCC to think outside the proverbial square of service provision. Meeting this challenge, the GRPCC was the first consortium to appoint a nurse practitioner candidate to provide a sub-regional palliative care consultancy service. Nurse practitioner candidates will be appointed in each sub-region and once endorsed as a nurse practitioner will provide clinical leadership, support the community palliative care teams, coordinate the care of complex patients and provide education and research in palliative care.

The GRPCC has developed innovative ways to provide quality professional development opportunities. Scholarships for GPs to obtain post graduate qualifications in palliative care have been provided and education sessions by palliative medicine specialists have been coordinated and provided across the region. A major achievement of the GRPCC was partnering with Monash University to develop a Short Course in Palliative Care with 90 graduates to date. The GRPCC has hosted four annual conferences with expert keynote speakers and workshops. The GRPCC also worked hard to ensure that GPs have access to Continuing Professional Development points for attending the conference.

The Volunteer Support Program is a testament to the GRPCC's acknowledgement of the importance of volunteers in the provision of palliative care. The GRPCC developed and distributed the Volunteer Training Manual in partnership with Palliative Care Victoria and is now used nationally. In addition to the volunteer training program, the GRPCC also provides an annual volunteer education forum and annual volunteer retreat.

The GRPCC has also staged a number of health promoting palliative care initiatives in the region. The play '*Four Footprints'* was performed in eight locations throughout Gippsland. *'Café Conversations'* have also been conducted in a number of locations across the region. These forums provided a unique opportunity for people in the community to talk about death and dying.

The ORG was established to support clinicians and provide

feedback and recommendations on the implementation of the Regional Plan. The CPG was also established to develop and promote good clinical practice and advise the GRPCC on clinical issues in the region. The CPG has been successful in developing and distributing evidence based clinical practice guidelines and referral pathways to enhance consistency of care throughout the region.

Finally, the GRPCC has developed and reviewed a constructive and coordinated communication strategy. The strategy includes production and distribution of a quarterly newsletter and maintenance of a comprehensive website with events calendar, service directory, education portal and publications. The GRPCC also developed and distributed over 1000 copies of the *'Growing Through Loss'* publication, featuring experiences of carers, families and health care workers.

The exemplary achievements of the GRPCC over the past five years have helped to improve the access to and quality of palliative care in Gippsland. The work of the GRPCC has also assisted in raising the profile of palliative care in the community. The innovative and dedicated work of the GRPCC continued into 2010-11 and is summarized below.

GRPCC CLINICAL PRACTICE GROUP

In 2010-11, the CPG met nine times and focused on developing specialist referral pathways, multi-disciplinary team meeting procedures and developing prioritised clinical practice guidelines. The specialist service access and management pathways for GPs were endorsed by the GRPCC and an implementation strategy for the pathway is currently being developed.

Evidence based Clinical Practice Guidelines published and distributed include:

1. Opioid Conversion Guidelines.
2. Oxygen Use in Palliative Care.
3. Subcutaneous Drug Infusion Compatibility Guideline.
4. Criteria for Referral to Palliative Care Services.

The CPG conducted an emergency medication audit of Gippsland palliative care services. The audit sought to establish a policy and procedure for management of emergency medications. The audit will inform development of a consistent policy on the storage and supply of emergency palliative care medication throughout the region.

REPRESENTATION ON OTHER RELEVANT COMMITTEES

The GRPCC is represented on the Palliative Care Clinical Network by Southern region nurse practitioner candidate, Jo Kelly. Mary Ross-Heazelwood represents the GRPCC on and co-chairs the Palliative Care Victoria Interdisciplinary Research, Education and Advanced Practice Special Interest Group, which meets quarterly. Maggie Goss represents the GRPCC on the Palliative Care Victoria Volunteer Management Special Interest Group, which also meets quarterly. Maggie also represents the managers of palliative care volunteers from Victoria's rural and remote regions on the National Network of Palliative Care Managers of Volunteers, run by Palliative Care Australia.

CONSORTIUM EXECUTIVE GROUP

The Department of Health requires Consortia Executive to meet at least twice per annum. In 2010-11, the GRPCC Executive met three times.

MEMBER SERVICE/STAKEHOLDER ATTENDANCE AT CONSORTIUM MEETINGS

The Department of Health mandates that the Consortium members meet at least six times per annum. In 2010-11, the CMG met 11 times. The attendance (percentage) of each member service is listed in Table 6.

TABLE 6 – MEETING ATTENDANCE

MEMBER SERVICE	ATTENDANCE (%)
WGHG	91
BRHS	91
BCCHS	55
BCRH	64
CGHS	64
GLCH	73
GSHS	27
KRHS	45
LCHS	91
LRH	64
ODH	45
ORH	36
YDHS	82
Consortium Manager	100
CWGDGP	55

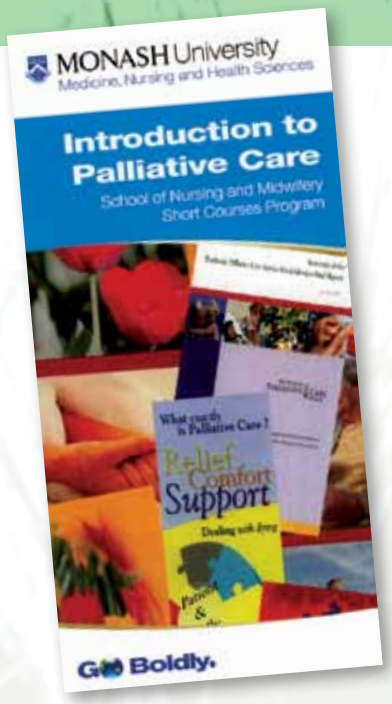
ACCREDITATION STATUS OF MEMBER AGENCIES

All member agencies are accredited with details provided in Table 7.

TABLE 7 – MEMBER AGENCY ACCREDITATION

MEMBER SERVICE	STATUS	AUTHORISING AGENCY
WGHG	current	ACHS
BRHS	current	ACHS
BCCHS	current	Quality Improvement Council
BCRH	current	ACHS
CGHS	current	ACHS
GLCH	current	Quality Improvement Council
GSHS	current	ACHS
KRHS	current	ACHS
LCHS	current	Quality Improvement Council
LRH	current	ACHS
ODH	current	ACHS
ORH	current	ACHS
YDHS	current	ACHS

TRAINING, EDUCATION, RESEARCH AND WORKFORCE ACTIVITIES



The GRPCC coordinates regular visits by palliative medicine specialists to provide education, secondary consultations and participation in multi-disciplinary team (MDT) meetings. The visiting specialist consultancy service is provided by Southern Health, Calvary Health Care Bethlehem and Peninsula Health.

In 2010-11, the visiting consultancy services attended:

- WGHG (5 visits)
- BRHS /GLCH (6 visits)
- LRH/LCHS (10 visits)
- CGHS (3 visits)
- YDHS (2 visits)
- GSHS, BCCHS, BCRH (8 visits)
- SGH (2 visits)
- Mirboo Nth (1 visit)

Education activities provided in 2010-11 are listed in Table 8.

TABLE 8 - TRAINING ACTIVITIES

TITLE	PARTNERS	PARTICIPANTS	DETAILS
Introduction to Palliative Care Short Course	Monash University	64 during 2010 and 2011 (90 since 2009)	13 week course. GRPCC advice, support and financial subsidy available.
PEPA placement	DH	20 (4 GPs; 15 nurses, 1 allied health)	Promotion of PEPA by GRPCC and post placement network via Operational Reference Group.
Pathway for Improving Care of the Dying	Southern Health	46 Health Care Professionals (HCP)	Provided 3 sessions to staff at BRHS, ORH, GSHS, SGH
Pain Assessment in Palliative Care	Southern Health	8 HCP	WGHG September 2010
Complex Pain in Palliative Care	Southern Health	29 HCP	WGHG October 2010
Palliative Care in the non cancer setting	Southern Health	35 HCP	WGHG August 2010
Pain assessment	CHCB	15 HCP	LRH October 2010
End of life symptom management	CHCB	30 HCP	LRH November 2010
Nausea and vomiting & subacute bowel obstruction	CHCB	30 HCP	LRH July 2010
Palliative Care Emergencies – Spinal Cord Compression/ Superior Vena Cava Syndrome/ Hypercalcaemia	Southern Health	25 HCP	WGHG November 2010
Complex pain management in palliative care	CHCB	27 HCP	August 2010
Palliative care emergencies	CHCB	17 HCP	LRH December 2010
Constipation	CHCB	6 Ward Level Staff	LRH April 2011
Delirium	CHCB	11 Ward Level Staff	LRH may 2011
VOLUNTEER TRAINING			
Palliative Care Volunteer Training		15 Volunteers 2 Managers	Lakes Entrance /Bairnsdale /Orbost April - June 2011
Memoir Writing /Scrapbook workshop		32 Volunteers 8 Managers	1 session LCHS 1 session LRH
Palliative Care Volunteer Weekend Retreat		40 Volunteers 5 Managers	Rawson December 2010
MDT MEETINGS			
MDT Case Review and Discussion	CHCB	GPs and CGHS PC Team Staff	Maffra November 2010
MDT Teleconferences	CHCB	Monthly teleconference for GPs and palliative care team	LCHS (11 meetings) CGHS (4 meetings)
MDT Case Reviews	Peninsula Health	GPs and BCRH palliative care team, South Gippsland palliative care team, BCCHS	6 meetings

6. Consortium Role

PATHWAY FOR IMPROVING THE CARE OF THE DYING

PROJECT OFFICER – ANNY BYRNE

The PICD was developed by the Supportive and Palliative Care Unit of Southern Health and is an adaptation of the Liverpool Care Pathway. The PICD aims to import the principles of palliative care into generalist health and aged care. In 2010-11, the GRPCC and Southern Health have worked together to implement the PICD in health services across Gippsland. To date more than 250 patients in Gippsland have had their care managed through the PICD. Medical and nursing staff have reported that using the PICD is straightforward and empowering and helps them to meet patient's needs at end of life. An evaluation of the PICD will be produced in 2011-12.

Listed below is PICD activity across the region and the number of participating health services including aged care facilities.

- Pre Audit – 8 (services)
- GRPCC visit – 7
- Southern health visit – 10
- Working group formed – 7
- Action Plan – 6
- Documentation reviewed – 6
- Implementation package received – 6
- Education commenced – 6
- Implemented – 6

SPECIALIST PALLIATIVE CARE SERVICES

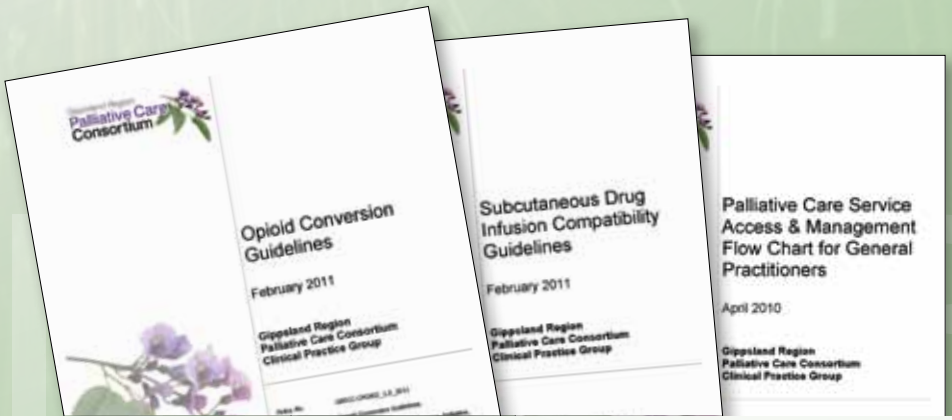
PROJECT OFFICER – SANDY SCHOLES

Building on the significant work already undertaken by the GRPCC with Southern Metropolitan Region palliative medicine specialists and with the assistance of recurrent funding, the Regional Palliative Care Consultancy Service Project focuses on supporting consultancy team visits, integrated with the nurse practitioner model and dovetails with the referral pathway.

The Consortium's success in securing funding for the project enables the full implementation of a comprehensive Regional Palliative Care Consultancy Service model to support improvements to patient care

The GRPCC has:

1. Obtained recurrent funding to implement a Regional Palliative Care Consultancy Service;
2. Drafted a strategic plan for 'Delivering a Specialist Palliative Care Consultancy Service to Gippsland' for the Department of Health;
3. Facilitated credentialing of participating palliative medicine specialists by CGHS on behalf of the GRPCC to allow the direct assessment of patients;
4. Developed plans for the consultancy service that integrates the nurse practitioner role with palliative medicine specialists.
5. Continued partnerships with the Southern Metropolitan Region palliative medicine specialists from Southern Health Supportive and Palliative Care Unit, Calvary Health Care Bethlehem and Peninsula Health to provide:
   - Regular MDT meetings with palliative care services across Gippsland;
   - Case reviews with community palliative care services;
   - Clinical attachments for health professional's education across the region;
   - Continuation of the secondary consult service;
   - Development and establishment of a primary consult service;
   - Participation in GRICS MDT lung tumour stream meetings;
   - Monthly attendance at William Buckland Radiotherapy Centre for MDT meetings and case review; and
   - Support and training to palliative care nurse practitioner candidates in Central/West Gippsland and South Gippsland.
6. Collaborated with the Divisions of General Practice to facilitate visits by the palliative medicine specialist to general practices in Gippsland.



REGIONAL VOLUNTEER SUPPORT

PROJECT OFFICER – MAGGIE GOSS

In 2010-11, the GRPCC continued to provide support to the managers of palliative volunteers across Gippsland, with information about education and training opportunities for their volunteers. The GRPCC hosted a meeting with volunteer managers to look at introducing Health Promoting Palliative Care activities for volunteers. This resulted in a few services conducting *Café Conversations* in their area.

To assist volunteers in providing bereavement support, the GRPCC conducted a Bereavement Support Volunteer Education Program. The GRPCC also facilitated a Memoir Writing Workshop, Scrapbooking a Memoir Workshop and with support from BCCHS, the regional volunteers were offered a workshop on Boundaries for Volunteers.

One of the highlights of 2010-11 was the Annual Weekend for managers of volunteers and the regional palliative care volunteers at Rawson. The weekend provided education, relaxation, networking opportunities as well as discussions about the needs of managers and the volunteers. The 2011-12 Annual Weekend is currently being planned to be held in Cowes and an Art Therapist has been engaged to undertake a number of workshops for regional volunteers.

CONVERSATIONS ABOUT DYING – PALLIATIVE CARE FORUM

PROJECT OFFICER – MARY ROSS-HEAZLEWOOD

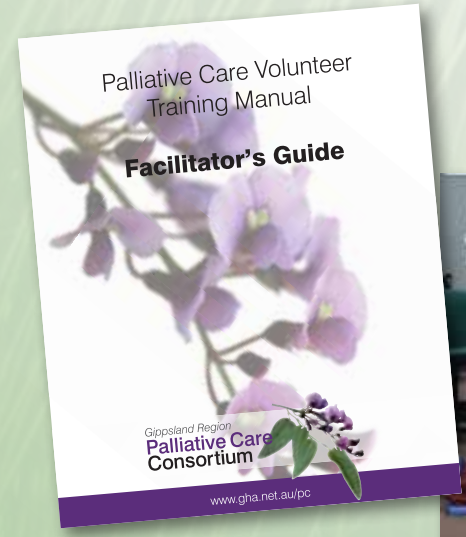
Seventy participants, including volunteers, nurses, GPs and palliative care workers attended the most recent GRPCC forum, *Conversations about Dying*. Participants explored issues relating to the role and needs of carers, when addressing the needs of the patient. The discussion was challenging but an empowering message for the carer, leading to enriching end-of-life experiences for both carer and patient.

Keynote speaker palliative care physician Michael Barbato OAM opened the day with discussion about communication including advice on attentive listening. The participants learned that one-on-one conversations are best and that 95% of communication is non-verbal. Dr Barbato's practical advice included key points in providing help to sick and dying people.

Dr Barbato highlighted the differences between healing and curing, outlining the factors that contribute to healing. Michael suggested 'healing' can come from within oneself, and involves the psychological/social/spiritual domains. On the other hand 'curing' comes from outside oneself, usually as an intervention and involves almost solely the physical domain. Supporting his thoughts on healing and curing, Dr Barbarto explained the holistic and biomedical models of care.

The closing section of Dr Barbato's presentation included useful and specific points including the challenge to empower participants to remove the barriers around talking about dying and change the paradigm by asking:

- what is it like for you?
- what do you fear most?
- what is your greatest hope?
- how has the illness changed your life?



Volunteer Bereavement Program Workshop participants

6.2 Coordinating Care

AFTER-HOURS CARE INITIATIVES

The Department of Health has provided funding to the GRPCC in 2011-12 to develop an after-hours palliative care model for Gippsland. Development of this model will be a focus for 2011-12.

CULTURALLY AND LINGUISTICALLY DIVERSE & ABORIGINAL PALLIATIVE CARE

The GRPCC has partnered with Gippsland Multicultural Services to develop a systematic approach to developing culturally appropriate palliative care pathways. In 2011-12, the GRPCC will build on previous work including two regional forums on health promoting palliative care (2006) and Health and Community Care (HACC) services for Aboriginal People (March 2009). The GRPCC newsletter will continue to provide information on Culturally And Linguistically Diverse (CALD) palliative care and Aboriginal issues, such as Aboriginal Cultural Safety and cultural awareness which was produced in Newsletter No.5, 2009.

MOTOR NEURONE DISEASE SHARED CARE WORKER

PROJECT OFFICERS – TOINE BOVILL & MARYANN BILLS

The MND Shared Care Worker role is shared by WGHG staff and covers all of Gippsland. Education sessions as well as one-to-one contact is undertaken including telephone support provided on an ongoing basis to all health professionals in Gippsland. Key activities include:

- Two MND Forums were held and well attended;
- Two MND Information sessions for Monash Medical students were provided; and
- Presentation: "Gippsland MND Shared Care Worker" at Palliative Care Nurses Australia Conference in Brisbane 2010 and published in CareSearch 2010.

Toine and Maryann were also awarded the Nina Buscombe Award by MND Victoria to assist them to attend the MND International Symposium in Sydney in November.

ADVANCE CARE PLANNING

PROJECT OFFICER – ANNY BYRNE

The GRPCC has partnered with the CWGDGP and liaised with Northern Health to develop and implement a consistent approach to advance care planning (ACP). Initial service mapping of ACP activities throughout the region has commenced in preparation for the project.

The GRPCC website, quarterly newsletter and 'Stories' book are major publications of GRPCC

7. Future Directions

The future strategic directions of the GRPCC align with the Department of Health SPCP and will be developed in detail at a regional planning day. The key future directions for 2011-12 will include:

1. Informing and involving clients and carers
   a. The GRPCC will continue to work closely with Northern Health and the Divisions of General Practice to improve and standardise advance care planning throughout the region.
   b. The GRPCC will revise the GRPCC website to ensure information is appropriate and accessible for clients and carers.
2. Caring for carers
   a. The GRPCC aims to increase access to respite services.
   b. The GRPCC will develop a model for after hours palliative care support in clients' homes.
   c. The GRPCC will report on the findings of the Bereavement Pilot Program.
3. Working together to ensure people die in their place of choice
   a. The GRPCC will evaluate and make recommendations on implementation of the PICD in aged care facilities.
4. Providing specialist care when and where it is needed
   a. The GRPCC will expand the palliative medicine specialist visits to the region.
   b. The GRPCC will continue to support the nurse practitioner model in the region.
   c. The GRPCC will investigate ways to provide bereavement support to the region.
5. Coordinate care across settings
   a. The GRPCC ORG and CPG will continue to develop and recommend policies and programs to enhance care coordination throughout the region.
   b. The GRPCC will assist services to participate in video and teleconferencing.
6. Providing quality care supported by evidence
   a. The GRPCC will continue to assist services to monitor and address their palliative care provision against NSAP.
   b. The GRPCC CPG will continue to develop and implement evidence based clinical care protocols throughout the region.
7. Ensuring support from communities
   a. The GRPCC will take a health promoting approach to strengthen the community's awareness and understanding of death, dying and loss.

8. Financial Statement

YEAR ENDING 30 JUNE 2011

GRPCC

REVENUE	2010/11 TOTAL
Government Grants:	
Department of Health	270,716
Other (54101) income	63,576
Balance brought forward 2009-10	9,982
TOTAL REVENUE	344,274
EXPENDITURE	
Salaries Recoveries	0
Beverages	173
Food Supplies-Other	0
Special Function	53,079
Repl/Add-Computer Equip<$100	172
Advertising	0
Manager /Staff /Consultancy Costs	240,764
Printing & Stationery	4,743
Staff Training Development	10,318
Conference Registration & Accommodation	12,627
Travel Expenses-Car Allowance	0
Accommodation –Other	0
Other Admin Exp-Other Expenses	0
Other Expenses	22,398
Total Other Expenses from Operations	
TOTAL EXPENDITURE	344,274

YEAR ENDING 30 JUNE 2011

MEDICAL PURCHASING - GRPCC

REVENUE	2010/11 TOTAL
Government Grants:	
Department of Health	123,643
Medical Specialist Funding Income	400,000
TOTAL REVENUE	523,643
EXPENDITURE	
Salaries Recoveries	4,995
Beverages	924
Food Supplies-Other	6,583
Special Function	0
Consultancy Costs	202,939
Printing & Stationery	22
Conference Registration & Accommodation	4,275
Travel Expenses-Car Allowance	3,085
Accommodation –Other	191
Other Admin Exp-Other Expenses	5,000
Other Expenses	0
Total Other Expenses from Operations[1]	16,640
TOTAL EXPENDITURE	244,654
Surplus/(Deficit) for the year[2]	278,989

Notes

1. Administration coordination fee departmental report F0735
2. the net surplus has been obtained from CGHS departmental reports (F0736 and F0735) which provide supporting documentation for this statement

PALLIATIVE CARE

Gippsland Region

Gippsland covers an area of 41,538 square kilometres, extending from metropolitan Melbourne to the New South Wales border in the east. The Gippsland estimated resident population is projected to increase from 247,929 in 2006 to 262,270 in 2016, an average annual increase of 0.6% per annum. Gippsland has 4.9% of the estimated Victorian population.

www.gha.net.au/grpcc