2020/2021 Annual Report

Hume Region Palliative Care Consortium

HUME REGION
Palliative Care
Consortium

www.humepalliativecare.org.au

2020/2021

OUR PARTNERS

OUR VISION

Provide Palliative Care leadership in the Hume Region

OUR MISSION

The Hume Region Palliative Care Consortium are committed to working with each other, governments and the community so all Victorians with a life limiting illness and their families and carers will have access to a high quality palliative care service system that fosters innovation, provides coordinated care and support that is responsive to their needs.

This report has been collated by Elizabeth Jenkins, HPCC Manager with content contributed from Community Palliative Care Services and Palliative Care Consultancy Services in the Hume Region.
September 2021
www.humepalliative care.org.au
Copies of this report are available by contacting Elizabeth Jenkins
elizabeth.jenkins@gvhealth.org.au

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2020/2021

ABOUT HPCC

2020/2021

The Palliative Care Consortia were developed by the Victorian Department of Health in 2008. There are eight Consortia across the State. Three covering metropolitan Melbourne and four covering Regional Victoria.

Palliative care consortia bring together senior management representatives and clinicians from all healthcare services funded to provide specialist palliative care. The HPCC membership comprises of representation from 7 specialist palliative care organisations and, representation from the Hume Region Department of Health.

The Consortia members are:

- Albury Wodonga Health
- Benalla Health
- Goulburn Valley Health
- Goulburn Valley Hospice Care Service
- Northeast Health Wangaratta
- NCN Health
- Seymour Health
- Hume Region Department of Health
- Hume Region Palliative Care Care Consortium Manager

The HPCC focus is to work collaboratively within the Hume Region to deliver and develop palliative care services.

Palliative care consortia support palliative care providers to:

- Raise awareness of palliative care amongst health care providers, ancillary services, community groups and organisations including residential facilities.
- Foster collaboration amongst service providers to maximize designated palliative care resources, reduce duplication of effort and promote consistency of practice.
- Promote end of life and palliative care education and training.
- Inform improvements to practice through their Clinical Advisory Group and broader clinical engagement activities, including liaison with Safer Care Victoria's Palliative Care Clinical Network.
- Advise the Department about regional priorities for future service development and funding.

The HPCC is guided by a 3 year strategic plan 2019 - 2022. The plan aligns with the Victorian palliative and end of life framework. In line with the Department of Health Consortium Role Statements there is also a Regional Consortium Executive Group, and Clinical Advisory Group. Members of the HPCC group have delegated authority from their CEO to represent their organisation. A Consortia Memorandum of Understanding is signed bi-annually by all members.
The Hume Region Palliative Care Consortia (HPCC) meet bi-monthly and the Hume Region Clinical Advisory Group meet on the alternate months. Meetings for this reporting period have all been via video conference.

Consortium Group Members	Consortium Group	Clinical Advisory Group
Albury Wodonga Health	✓	✓
Benalla Health	✓	✓
Clinical Advisory Chair	✓	✓
Consortia Manager	✓	✓
Goulburn Valley Health	✓	✓
Goulburn Valley Hospice Care	✓	✓
Hume Region DH	✓	N/A
NCN Health	✓	✓
Northeast Health Wangaratta	✓	✓
Seymour Health	✓	✓

Consortium (6 meetings held)
Chair:
2020 - Erica Anderson, Northeast Health Wangaratta
Deputy Chair: Sue Wilson, Benalla Health
2021 - Robyn Sprunt, NCN Health
Deputy Chair: Anne Daley, Seymour Health

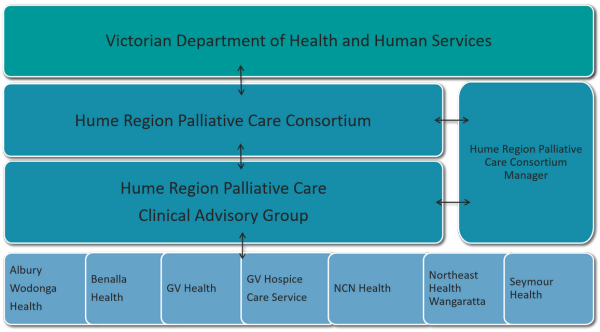
Clinical Advisory Group (6 meetings held)
Chair:
2020 - Jackie Creek, Northeast Health Wangaratta
Deputy Chair: Robyn Sprunt, NCN Health

2021- Annette Cudmore, Goulburn Region Consultancy Service
Deputy Chair: Jackie Creek, Northeast Health Wangaratta

ABOUT HPCC

Location

HPCC Organisational Structure



The Victorian Department of Health fund the following services and roles in the Hume Region:

Albury Wodonga Health
- Community Palliative Care Service
- East Hume Regional Consultancy Palliative Care Service
- 2 funded palliative care in-patient beds

Benalla Health
- Community Palliative Care Service

Goulburn Valley Health
- Goulburn Region Palliative Care Consultancy Service
- 8 funded palliative care in-patient beds
- Hume Region Palliative Care Consortium Manager employing agency

Goulburn Valley Hospice Care Service
- Community Palliative Care Service

NCN Health
- Community Palliative Care Service

Seymour Health
- Community Palliative Care Service
- West Hume Palliative Care Aged and Disability Resource Nurse

Northeast Health Wangaratta
- Community Palliative Care Service
- 2 funded palliative care in-patient beds
- East Hume Palliative Care Aged and Disability Resource Nurse
- MND Shared Care Worker
- HPCC Project Officer employing agency
- Fund holder for the Consortium

REGIONAL OVERVIEW

Demographic snapshot

Population

Population in the Hume Region is 297,894 (1)
The projected population by 2036 will be 368,778 (3)

The fastest growing population in the Hume Region (and rural Victoria) will be in the Mitchell Shire - projecting a 4.5% increase from 2018 - 2036. Second in the Region is Wodonga (2.0%) then Mansfield (1.1%) (3)

It is projected that by 2036, 23% of people living in the Hume Region will be aged 65 and over. (3)

Aboriginal Population

There is over 5,600 Aboriginal and Torres Strait Islander people living in the region which is 2.0% of total population. The percentage of Aboriginal and Torres Strait Islanders is considerably higher in the Hume region than for Victoria (0.8%). (4)

Cultural Diversity

11% of the population were born overseas.
6.8% of people aged 65+ have a preferred language other than English.
The top 5 languages other than English spoken at home are Italian, Arabic, Punjabi, Mandarin and German. (4)

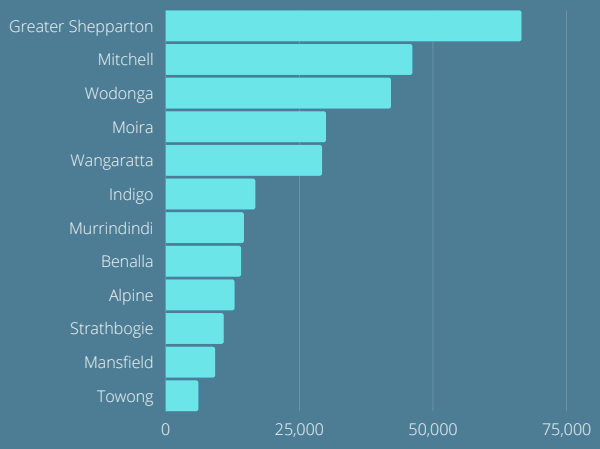
Leading cause of death

The top 5 leading underlying causes of death in Australia in 2019

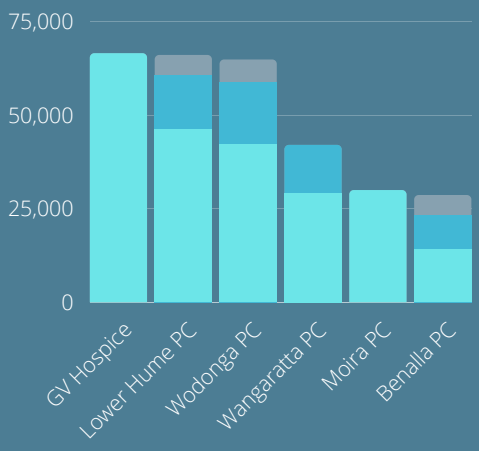
1. Coronary heart disease
2. Dementia inc. Alzheimer disease
3. Cerebrovascular disease (which includes stroke)
4. Lung cancer
5. Chronic obstructive pulmonary disease (COPD) (2)

Life expectancy in Australia (born 2017-2019) Male 80.9 years; Female 85 years. (2)

Population by Local Government Area (LGA's) (1)



Population by Community PC Service based on the LGA's they service (1)



Source:
1. PHN Exchange - Murray. Estimated resident population (ERP) - PHIDU 2019
2. Australian Institute of Health and Welfare (AIHW)
3. Victoria in Future 2019 (VIF2019)
4. ABS

MESSAGE FROM OUR CHAIR

Robyn Sprunt, NCN Health

On behalf of the Hume Region Palliative Care Consortium I am pleased to present the 2020/21 Annual Report. Nominated as Chair early in 2021, I would like to acknowledge and thank Erica Anderson for her leadership and contribution as Chair in the previous 12 months.

Over the past year, the COVID -19 pandemic has presented us with significant challenges in how we communicate, collaborate and provide services for our communities. Despite this, our palliative care teams have risen to these challenges and have shown a continued commitment to Victoria's end of life and palliative care framework, providing high quality end of life care to our communities.

In these challenging times, our consortium provides a vital forum for the Hume Region, supporting communication, collaboration, sharing of information and resources, and building the capacity of our workforce.

This year, several innovation and development projects were undertaken. GV Health and Northeast Health Wangaratta supported transition from hospital to home initiatives; Seymour Health and GV Health developed processes for earlier engagement with palliative care services, and NCN Health and Seymour Health implemented a multidisciplinary team approach to service provision.

Hume Region Palliative Care Consortia members continued to support a collaborative project aimed to provide a dedicated palliative care patient management system across the region.

The joint efforts of our Project Officer, Consortium Manager, the Executive and Clinical teams and our Regional Information Technology Manager to bring this together has been encouraging. We look forward to the next stage of the project in the coming months and realising the benefits that is will bring.

A focus on workforce development has seen two new Advanced Trainee in Palliative Medicine Registrars complete their first term in Wodonga and Shepparton supported by the Goulburn Region and East Hume Consultancy Services.

The Hume Region Palliative Care Consortium partnered with Hume Regional Nurse and Midwifery Educators Group to support 24 Nurses to complete the Banksia Palliative Care Course via a scholarship program.

The Australian Centre for Grief and Bereavement delivered two online courses which saw a multidisciplinary audience with 38 participants across our region.

Our Regional Aged Care and Disability Palliative Care Resource Nurses, Karen Richards and Heather Wickham both retired at the end of 2020 after being in their roles for the past 8 years. The HPCC welcomed Rose Sexton and Samantha Moorhouse to these roles in 2021. Together they have developed a best practice framework to guide and support the palliative approach in the aged care and disability sectors across the Hume Region.

This year our Clinical Advisory Group continued to work on developing processes and guidelines, and supported the implementation those developed by State and National bodies to support best practice clinical care in the region.

Two of the community palliative care services in the Hume Region have representation on the Safer Care Victoria WAVE project focussed on improving the engagement between community palliative care services and paramedics in the provision of end of life care across Victoria.

We continue to work with our State and National partners - Palliative Care Victoria, Safer Care Victoria, PEPA, the Centre for Palliative Care and the new Palliative Care Advice Service to implement programs and best practice resources in our region where possible.

THANK YOU

I would like to take this opportunity to acknowledge and thank the many people who have supported Hume Region Palliative Care Consortium through their ongoing commitment to providing high quality end of life care in our communities.

Firstly to our clinical community palliative care teams and volunteers, the After Hours Triage Team and the many Hume Region District Nursing Services that work in partnership to provide a coordinated approach to end of life care providing vital continuity of care for people at home.

The Palliative Care Consultancy teams for their ongoing commitment to person centred care, both acute and community based, with particular mention to the East Hume Consultancy team who pivoted with each border closure to maintain the sub-regional service.

Executive Members of the HPCC, the Clinical Managers and leads in the Clinical Advisory Group, for their support and guidance in leading palliative care in the Hume Region. I would like to acknowledge and thank Jackie Creek and Annette Cudmore for their roles as Clinical Advisory Group Chair in 2020/21.

I would like to recognise Michelle Burns in her role as HPCC Project Officer for her persistence to coordinate and progress the dedicated palliative care patient management system project bringing us to the final stages of this key project.

The Consortium Manager, Elizabeth Jenkins for maintaining and coordinating the partnerships across the region and for her focus on educational opportunities and other projects in the region to support the continued success of the HRPCC.

Last but not least, I would like to wish both Heather Wickham and Karen Richards all the best in their retirements and thank them for their outstanding contribution to palliative care in the aged care and disability sectors in the Hume Region.

Robyn Sprunt

Hume Region Palliative Care Consortium Chair
Executive Manager Community Health and Wellbeing, NCN Health.

"Our consortium provides a vital forum for the Hume Region, supporting communication, collaboration, sharing of information and resources, and building the capacity of our workforce.

CLINICAL ADVISORY GROUP REPORT

Working as a sub-committee of the Hume Region Palliative Care Consortium, The Clinical Advisory Committee (CAG) met for 6 meetings over 2020/21. The role of the CAG is to oversee, monitor and report on clinical and operational service initiatives and processes as they relate to the implementation of Victoria's end of life and palliative care framework and the HPCC Operational Plan.

The objectives of the CAG are to:

- Promote consistent adoption of evidence-based palliative care practice throughout the Hume region.
- Identify regional clinical issues and opportunities for improvement and ways to address these issues.
- Where feasible, standardise clinical protocols and tools and assessment and care planning approaches across palliative care agencies in the Hume region.
- Contribute to the development of the HPCC Operational Plan.
- Establish and promote service improvement initiatives and reporting mechanisms to address the clinical practice-related items within the Framework and HPCC Operational Plan.

6 meetings were held in 2020/21. All via video conference.

Our focus in 2020/21 included:

- Regional guideline development for consistent user access and information management for the new PalCare software system.
- Development of a regional palliative care workforce development plan and implementation of regional education
- Development of the MND NIV Guideline - Considerations when a request to discontinue NIV is made.
- Supported a consistent approach to implementing the Caring Safely @ home resources and processes.
- Support for the implementation of the Palliative Care Advice Service in the Hume Region.
- Development of palliative care promotional information for consumers and health care professionals including website content.
- Shared activity data and resources/processes to support service demand and patient management.
- Sub-working group provided input to a discussion paper and development of regional consistent policy and process's for domiciliary oxygen.
- Peer support and shared resources for service provision through Covid-19 restrictions.
- Shared practice and resources for telehealth
- Promotion of new and updated clinical resources developed by Safe Care Victoria's Palliative Care Clinical Network inc. Anticipatory prescribing guidelines, update opioid conversation,
- Safer Care Victoria's WAVE project representation

Guest speakers at our CAG meeting were:
Claire Johnson - RACF PCOC Wicking model

Esther Denrdal - Palliative Care Advice Service

Chair 2020: Jackie Creek, Northeast Health Wangaratta

Chair 2021: Annette Cudmore, Goulburn Region Palliative Care Consultancy Service

Community Care

2020/2021

Palliative care teams work with clients, carers, families and a multidisciplinary team striving to support a person to be cared for and to die in their preferred place which could be in a hospital or in their home, including residential aged care facility. Continuous care and coordination means that clients preferences and wishes can be supported as much as possible.

2020/2021 community palliative care service data from the Hume Region indicates that:

1206 referrals were made to community palliative care services. 67 more than the previous year. Referrals to community palliative care services have increased by about 6% per year over the past 3 years.

All referrals are assessed and some people are referred on to other more appropriate services. Of the 1206 referrals received, 895 of the referrals were accepted and admitted by the community palliative care teams. Admissions to our community palliative care services in 2020/21 increased by 4% from the previous year.

Community palliative care services will often discharge clients from their service when symptoms are under control and they are assessed as being stable for a period of time. Clients are informed they can an re-enter the service when they require more support. 262 clients were discharged from the services in 2020/21. This is 78 more clients than the previous year.

The community palliative care teams supported 648 clients and their carers through end of life. 70% of their clients, had their goal to die in their preferred place of death met. This is a 12% increase from the previous year.
54% of deaths were in a hospital. This is the same as the previous year. Whilst hospital deaths is in the majority, data demonstrates a 21% increase of home deaths in 2020/21 from the previous year.
The number of deaths the palliative care services have supported in the community increased by 2% each year from 2018/19 to 2020/21.

Community palliative care services provide a bereavement care service for carers or family which continues after a clients death for a period of time determined by the bereaved, their needs and offered for approximately 12 months. The number of bereaved clients in the bereavement phase of care across the region at any given time is on average 481 people per month. This in an increased of 6% from 2019/20 to 2020/21.

Community Care

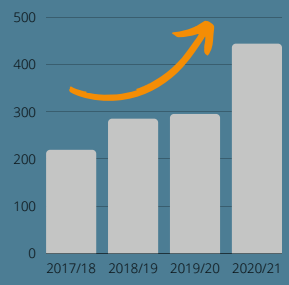
Palliative Care is by nature multidisciplinary, supporting clients with palliative and end of life needs and their carers and families. The performance outcomes from the community palliative care services are also attributed to the collaborative relationships with the General Practitioners, Medical Specialists, District Nursing Services, staff in residential aged care facilities, Hume Region Palliative Care care Consultancy services, the After Hours Triage Teams, rural and regional hospitals and Ambulance Victoria.

AFTER HOURS TRIAGE AND ADVICE

Palliative Care teams in the Hume Region all provide an after hours triage phone number to clients receiving palliative and end of life care and their carers. Goulburn Valley Hospice Care Service provide 24 hours phone access to clients and carers. Five Community Palliative Care Services are supported by the After Hours Triage Team at St Vincent's Health, Caritas Christi Hospice. They are:

- Benalla Health Palliative Care Service (Benalla Health)
- Lower Hume Palliative Care (Seymour Health)
- Moira Palliative Care Service (NCN Health Numurkah Campus)
- Northeast Health Wangaratta Palliative Care (Northeast Health Wangaratta)
- Wodonga Palliative Care Service (Albury Wodonga Health)

No. of calls over 4 years



There were 444 phone calls made to the After Hours Triage Team from the Hume Region* . This is a 34% increase from the previous year.

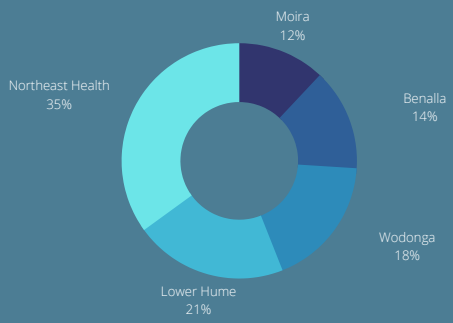
The main reason for calls was for advice to manage symptoms.

Symptom advice, medication plans, education and psychosocial support were the majority of call outcomes.

The Hume Teams meet quarterly with the Triage Team Manager and After Hours Coordinator(s) to maintain good communication and opportunity for quality improvement.

*This data does not include Goulburn Valley Hospice Care Service who provide a different after hours model.

Percentage of calls by service 2020- 2021



CONSULTANCY SERVICES

The Victorian Department of Health funds two Palliative Care Consultancy Services in the Hume Region. Each team covers a sub-regional area proving support for Community Palliative Care Teams, General Practitioners, Hospital medical treating teams, and Specialists.

The East Hume Palliative Care Consultancy Service

Covers the area of Ovens Murray catchments incorporating the local government areas of Alpine, Benalla, Indigo, Mansfield, Towong and Wodonga. They cross over into Albury to support the Albury Campus of Albury Wodonga Health (a Victorian Health Service) and the Border Cancer Centre. The geographical area covers approximately 25,458 sq km.

The Team provide both hospital based and community sub-regional consultancy service. Referrals are received from hospital based medical teams inc. from metropolitan and rural hospitals, specialists, oncology teams, community palliative care teams and general practitioners.

The team provide an outreach service to the community palliative care teams in the Ovens Murray catchment. This includes the Benalla, Wangaratta and Wodonga teams. The services include onsite consultation, joint home visits, and telehealth case reviews.

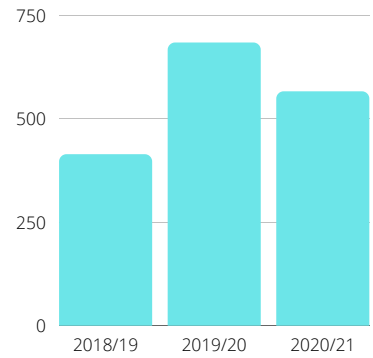
The East Hume Palliative Care Consultancy Service have a representative on the Hume Palliative Care Consortium and Clinical Advisory Group.

East Hume Consultancy Palliative Care Service and Oncology Multi-disciplinary Team (MDT) Meetings

As a cross border area with large specialist catchment areas, lines of communication between agencies can be impeded. The East Hume Regional Consultancy Service noted that information and plans from the Oncology MDT did not always transfer to regional palliative care teams, especially those in outlying areas.

An innovative communication line has been established by the East Hume Consultancy Service throughout the East Hume and Southern NSW area to ensure patient handover and pertinent clinical information is available to support continuity of care and timely engagement of palliative services. This has enabled improved and consistent care with our regional palliative care clients.

East Hume Consultancy referrals received over 3 years



Services:
- Out patient clinics
- Hospital based consultancy
- Community based consultations inc. RACF
- Multidisciplinary team consults
- Case review meetings
- Tele-health appointments

East Hume Consultancy provides palliative care consultancy services to the community teams at:
- Benalla Palliative Care Service
- Northeast Health Wangaratta Palliative Care Service
- Wodonga Palliative Care Service

Weekly rostered outreach consultancy services to the community palliative care teams and their service areas.

CONSULTANCY SERVICES

The Goulburn Region Palliative Care Consultancy Service

The Goulburn Region Palliative Care Consultancy Service covers the (West Hume) Goulburn Region incorporating the local government areas of Greater Shepparton, Mitchell, Moira, Murrindindi and Strathbogie. This is approx. 14,936 sq km.

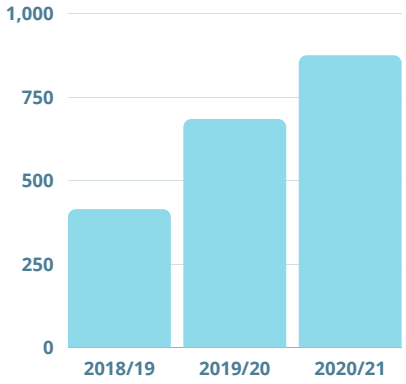
The Consultancy Service is is based at GV Health in Shepparton. Their model of care incorporates hospital based in-patient consultancy at GV Health and community sub-regional consultancy service, the provision of education and quality improvement. Referrals are received from hospital based medical teams inc. from metropolitan and rural hospitals, specialists, oncology teams, community palliative care teams and general practitioners.

The team provide an outreach service to the community palliative care teams in the Goulburn Region. This includes the Benalla Palliative Care Team as palliative care service and shire boundaries overlap. The services include onsite consultation, joint home visits, and telehealth case reviews.

The Goulburn Region Palliative Care Consultancy Service have a representative on the Hume Palliative Care Consortium and Clinical Advisory Group.

GV Health also facilitate a Palliative Care Governance Group who meet quarterly to provide a forum for consultation between GV Health, GV Hospice Care Service, NCN Health and Seymour Health. The forum enables governance and leadership for the provision of integrated palliative care service development, coordination and evaluation in the Goulburn Region catchment including palliative care consultancy, inpatient, and community palliative care services.

Goulburn Region Consultancy Referrals received over 3 yrs



Services:
- Out patient clinics
- Hospital based consultancy
- Community based consultations inc. RACF
- Multidisciplinary team consults
- Case review meetings
- Tele-health appointments

Provides palliative care consultancy services to the community teams at:

- Goulburn Valley Hospice Care Service
- Lower Hume Palliative Care Service
- Moira Palliative Care Service
- Benalla Health

Weekly rostered outreach consultancy services to the community palliative care teams and their service areas.

CONSULTANCY SERVICES

Motor Neurone Disease Shared Care Worker

The Hume Region Motor Neurone Disease (MND) Shared Care Worker (SCW) works from Northeast Health Wangaratta Palliative Care (0.2 EFT).

In collaboration with the Motor Neurone Disease Association of Victoria, the SCW supports MND patients who are receiving palliative care through education with care providers and acts as a resource person to patients, families, carers and staff.

Over the last year approaches to education has changed to incorporate more virtual sessions and telephone conversations. An introduction to the MND SCW role is incorporated in the induction of new palliative care staff across the Region to ensure there is awareness of the supports available to patients, carers and health professionals, .

The pandemic has forced increasing engagement with MND Victoria through on-line meetings, and serendipitously this has increased the frequency with which we can meet.

A number of creative solutions to improve people's quality of life has been enabled through access to Top Up funding from the Victorian Department of Health. It is a timely reminder that acute health care facilities can also access additional funding to care for people with MND.

A new Guideline was developed in conjunction with the Hume Region Palliative Care Clinical Advisory Committee to provide guidance of the considerations for health practitioners working with patients with Motor Neurone Disease, and their families, when a request to discontinue non-invasive ventilation is made. It is not a guideline to the process of withdrawal of non-invasive ventilation but considerations prior to the process.

The Hume Region MND SCW is partnering with Calvary Health Care Bethlehem, the palliative care teams at Albury Wodonga Health (Wodonga CPC & East Hume Regional Consultancy) and Northeast Health Wangaratta, in a research project funded by the Victorian Department of Health called 'My Neuro-Palliative Care Project'.

By engaging with patients and carers living with a progressive neurological disease and other stakeholders, the project is focused on gaining increased understanding of the key elements of effective neuro-palliative care support. A new model of care will then be proposed, trialled and evaluated in a few selected metropolitan and rural palliative care services in Victoria. The My Neuro-Palliative Care Project should be completed later this year.

CONSULTANCY SERVICES

Palliative Approach
Residential Aged Care and Disability Accommodation Services

The Hume Region Aged and Disability Link Resource Nurse program works as part of the Regional Palliative Care Consultancy Teams. Commencing in 2012, Heather Wickham and Karen Richards worked across the East Hume and West Hume sub-regions. Their substantive role at that time was to establish a 'Palliative Care Link Nurse (or nurses) in Residential Aged Care Facilities within the Hume Region. The Link Nurse role in RACF was supported by the implementation of the Aged Care Palliative Approach tool kit developed by Queensland University. The second part of the role was to support and build capacity within the Supported Disability Accommodation Services to maintain the care for their clients to receive palliative and end of life care in their home.

In 2020, both Heather and Karen retired after their long standing, committed and valued contribution to the Aged Care and Disability Service sectors.

2020 also saw the end of the Palliative Approach Toolkit retiring in June 2020 as new evidence based approaches emerged. Alternate resources were reviewed and mapped against the toolkits elements by individuals who were part of the original development. The alternative quality sources of palliative care information and resources identified were PalliAGED, End of Life Directions for Aged Care (ELDAC) and Care Search.

2021 the Consortia members welcomed Rose Sexton and Samantha Moorhouse to the East and West Aged Care and Disability Resource Nurse roles. Both work in the Community Palliative Care Sector as Clinical Nurse Specialists in their respective sub-regions.

Working collaboratively, they have developed a strategic vision, values and objectives for providing support and building the palliative approach capacity in residential Aged care facilities and the Disability Accommodation Services.

Like so many sectors working throughout 2020 and 2021 the Residential Aged Care Facilities and Disability Services have worked though challenges and experiences never encountered before. Their commitment to provide high quality care to their residents, clients and families has not wavered.

The inability to engage in the traditional face to face and onsite education and support activities meant that Sam and Rose have developed a 'hybrid' model based on both face to face (when able to) and an online presence to engage with facility staff. The engagement in their programs to date from staff within RACF is proving to be a success and will continue to evolve as the COVID-19 situation continues to be navigated.

VISION
We aim to build the capacity of Residential Aged Care Facilities and Disability Accommodation Services in the Hume Region to provide high quality care which meets individual needs/preferences of clients with life limiting illnesses.

VALUES
- All people receive care that preserves their dignity and quality of life
- Residents of RACF and clients of Disability Accommodation Services receive high quality palliative care which meets their needs and preferences
- Staff are empowered to confidently deliver palliative and end of life care
- Residents/Clients culture identity and diversity is respected

PALLIATIVE APPROACH

Residential Aged Care and Disability Accommodation Services

Palliative Approach outcomes

- Onsite visits to RACF were able to be conducted in the early part of 2021. There were **30** RACF site visits for introductions and an opportunity to discuss palliative approach educational and program support needs with the site Managers and Link Nurses. Onsite education sessions also commenced briefly before covid restrictions returned.

- In 2020/21, the Hume Region Palliative Care Website pages for the Residential Aged Care and the Supported Disability Accommodation Services were updated to reflect new resources and contact details

- A Monthly Newsletter has been established. Each month there is a new theme based on the ELDAC care model domains. The first edition launched in July 2021 focused on 'Recognizing Deterioration'. August covered 'Advance Care Planning' and September's topic is 'Work Together'.

- Monthly 'Questions and Answers' (Q & A's) online sessions were established based on the monthly newsletter theme. The first session was attended by **19** RACF staff. Based on feedback received, the monthly Q & A has changed to an education session based on a selected topic and a Q& A session at the end.

- An audit program was introduced with Facility staff being offered support to complete deceased record audits or being provided with appropriate tools to support a self audit processes. This quality improvement process identifies strengths and challenges in end of life care provision and opportunities to implement quality improvement.

- In line with the ELDAC tool kit terminology the Link Nurse role is referred to as a 'Palliative Care Champion'. A Hume Region 'Champion Mentorship Program' has been initiated and there are currently **25** Champions signed up to complete the online program. The first program starts in September 2021.

- **4** nurses working in RACF's completed the virtual Banksia Palliative Care Course in 2020/21 supported by the HPCC.
- 15 applications from Nurses working in RACF applied for and were successful in receiving a HPCC supported place in the Banksia Palliative Care Course (for either October 2021 or February 2022).

- Expressions of Interest for Reverse PEPA have been received from RACF's. it is anticipated that these will be conducted in 2021 or 2022 depending on covid restrictions.

- Development of palliative and end of life information packs has commenced and will be distributed to facilities once complete.

- Disability Service Sector: Relationship Building has been developed with Disability Accommodation Services and their Clinical Practice Advisors. This has gone a long way in identifying gaps in learning objectives at these facilities and where resources would be most appreciated. The primary objective is to direct workers to reliable and up to date resources and support services. Identifying goals of care and utilising the Specialist Palliative Care Services in their area.

SERVICE INNOVATION

The palliative care services in the Hume Region continue to strive for the best care outcomes providing support to clients and their carers and/or family members to receive palliative and end of life care in their place of choice.

In 2019 the Hume Region palliative care services applied for and were successful in receiving a number of palliative care innovation and development grants provided by the Victorian Department of Health. The Department's grant program focussed on the development and testing of new models of care, workforce models and support systems to enable more efficient service provision aimed at improving the continuity of care across multiple care settings for Victorians with life-limiting illnesses who would benefit from palliative care.

From 2019 to 2021 project teams have been working on planning, implementing and evaluating new initiatives and models in the regional palliative care sector. All projects were undertaken against the unanticipated backdrop of the COVID-19 pandemic which had an effect on each project in different ways.

Continuity of care across multiple care settings - in patient hospital to home projects

Hospital to Home for End of Life Care - GV Health

Von Sison, Project Manager

GV Health, received an innovation and development grant from the Victorian Department of Health to develop the Hospital to Home for End of Life Care Service.

This was a quality improvement activity focused on patient centred care and undertaken over 12 months. The aim was to support clinicians, clients and carers in end of life care planning and discharge to their preferred place of care.

The Hospital to Home for End of Life Care Service provides a systematic approach in:

- Symptom assessment and management
- Identifying psychosocial and spiritual domains and augmenting existing supports
- Involvement of community services to support patients
- Supporting clinicians with patient discharge
- Supporting carers and/or facilities by providing education regarding end of life care and follow up

With well defined metrics, the Service was successful in meeting what it had set out to achieve.

- During the project 11 patients were identified and referred for the Hospital to Home for End of Life Care Service.
- 10 patients were successfully discharged within 48 hours from time referral was accepted.
- No patients re-presented to hospital 72 hours post discharge.
- On follow up all patients met their preferred place of care and death.

Patient Flow Project - Albury Wodonga Health

Rebekah Clutterbuck, Manager Palliative Care

Albury Wodonga Health received a service innovation and development grant from the Victorian Department of Health to improve patient flow at AWH.

AWH is utilising this grant to fund a 12 month Patient Flow Project which will work with cross border agencies to promote client choice regarding site for care and end of life . The focus is on timely patient flow and access to the right services and venue for their palliative or end of life care.

This will be achieved by

- developing an understanding of the multiple cross border and Eastern Hume Region Community Palliative Care Services and their catchments;

- the development of a guideline/tool to guide referral to the right community palliative care service from the inpatient setting;

- development of orientation tools/education packages to support the use of the guideline/tool and improve the knowledge of palliative care within cross border agencies

- working closely with staff within Albury Wodonga Health, the Border Cancer Hospital, Mercy Health, Northeast Health Wangaratta and Benalla Health.

SERVICE INNOVATION

Continuity of care across multiple care settings - in patient hospital to home projects

Palliative Care Liaison Project - Northeast Health Wangaratta

Sue Box , Heather Wickham and Kate Stratton.

In 2019 NHW secured temporary funding from DHHS Palliative Care Service Innovation and Development Grant under Victoria's end of life and palliative care framework to commence the Acute Palliative Care Liaison Nurse role.

The project sought to improve palliative care service provision in NHW's acute facility by improving outcomes for patients in regard to Advance Care Planning, symptom assessment and management, end of life care, and advocacy for client choice in regard to site of care and death.

The role of the Palliative Care Liaison Nurse is to support and achieve optimal palliative care outcomes for clients with a life limiting disease admitted to NHW. The program provides an essential link between the Acute Care and community services including, but not limited to community palliative care services, district nursing, residential aged care and disability sector to assist clients to be cared for and die in their site of choice.

The Liaison Nurse works in collaboration with emergency, acute and palliative care staff in the Acute Care setting and Community Services to achieve effective working relationships across organisations.

In the year 2020-21 the Palliative Care Liaison project continued for the full twelve months.

During this time we have achieved the following outcomes:

- Provided oversight to the care of all patients admitted with a Palliative diagnosis, whether they were admitted to a community Palliative Care program or not.
- This included 276 episodes of care to 214 individual patients.
- Implemented 8 new policies, procedures and new forms, aimed at improving the care of the Palliative Care patient cohort.
- Reviewed many policies, procedures and forms as they come due for review.
- Reformed and attended the Care of the Dying Person Committee, including writing new terms of reference.
- Provided both formal and informal education sessions to the Medical, Acute Nursing and Allied Health Staff.
- Maintained a visible and open presence in the acute sector, encouraging learning, communication, support and promoting excellence in patient care.
- Clip audits show an improvement in the management and recording of symptoms of pain at end of life.
- Financial reports show an increase in funding received for palliative care patients, also an improvement in the number of bed days which were utilised by palliative care patients.

SERVICE INNOVATION

New models of care - Early referral clinics

Early Referral Clinic, Lower Hume Palliative Care - Seymour Health

Samantha Moorhouse Project Officer.

The Victoria's end of life and palliative care framework recognises that failure to talk about and plan for death is one of the most significant obstacles to improving the quality of dying. It also recognises that early referral to palliative care significantly improves people's quality of life, their mood and improves their survival time.

Currently significant inconsistencies exist in services offered depending upon the place of residence and inadequate timeliness of response to referrals.

The Lower Hume Palliative Care - Early referral clinic for supportive and symptom care project was developed for clients with malignant or chronic disease who are stable but are starting to have some symptoms, or are looking for advice on services in their area.

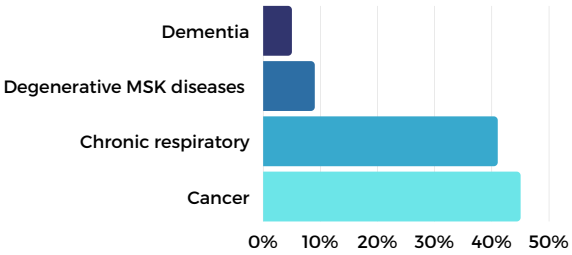
The expected outcomes were:

- Increased uptake of advanced care planning
- Better symptom management
- Earlier awareness of support services available
- Reduced carer stress
- Preferred place of care and death known to carers and members of the clients multidisciplinary team

The project data to date indicates:

- Referrals to the clinic have been well received.
- 50% of clients have completed their Advance Care Directive and 20% are in progress.
- 63% of clients have received Symptom management outcomes
- 16% of clients were identified as requiring a referral to community palliative care
- The referral source includes GP's, Specialists, HARP, Nurse and Allied Health professionals.

Health condition of clients referred



The PERFECT Clinic, Goulburn Region Palliative Care Consultancy Service - GV Health

Von Sison, Project Manager

The aim of the PERFECT Clinic project (Palliative Early Referral, Follow up to Enable Care Timely (PERFECT)) is to establish a robust referral system for oncology patients to palliative care services. Early referral to palliative care not only leads to better symptom management, but also provides psychosocial and spiritual support leading to an improved quality of life overall.

The project ran from March 2020 – Jan 2021.
The aims of the clinic are to:

- Increase referrals to palliative care
- Introducing concept of palliative care
- Reduce hospital presentations and admissions for symptoms related to disease.

The process involved screening using the Symptom Assessment Scale (SAS) of patients presenting to oncology for symptom concerns early on in their disease trajectory and referral to palliative care for those who met the PERFECT Clinic referral criteria.

ERC provided:

- Symptom assessment and management
- Identifying psychosocial and spiritual domains and augmenting existing supports
- Involvement of community services to support patients
- Early discussions regarding advance care planning
- Conversations regarding preferred place of care and death

Data both quantitative and qualitative indicate the clinic and processes were successful in

- Introduction and completion of advance care directives
- Improved consumer engagement and rapport to palliative care later on their disease trajectory
- Improved symptom management in the community which resulted in fewer hospital presentation and admission
- Encouraged conversations regarding nature of disease, treatment, goals of care and care preferences

SERVICE INNOVATION

New models of care - Multidisciplinary Service Model

Expanding the scope of the specialist multidisciplinary community palliative care team. Moira Palliative Care Service - NCN Health (Numurkah)

NCN Health – Moira Palliative Care Service received an innovation and development grant from the Victorian Department of Health to explore, develop and trial a workforce model that integrates dedicated allied health services, in particular Occupational Therapy and Social Work, directly within Moira Palliative Care Service.
The project aimed to:

- Increase access and range of specialist Occupational Therapy services offered across palliative care services, including introduction of new therapeutic supports.
- Increase access to specialist palliative care Social Work and social wellbeing support for all palliative care clients.
- Increase in early referral of clients for support by specialist palliative care services.
- Embed a consistent approach to multidisciplinary team-based assessment, coordinated care plan development and review for all palliative care clients.

There were three project domains undertaken - a review and scoping of workforce models of care; review and implementation of best practice and processes; and development and trial of a multidisciplinary model of care to support the Moira Palliative Care Service.

The review and scoping of multidisciplinary workforce models in palliative care services involved a literature review; a staff and Volunteers survey; consultation with the regional palliative care teams and participation in a Safer Care Victoria webinar on the role of allied health in palliative care.

To support the second project domain (implement best practice and process) the community were engaged to provide an understanding of their current knowledge of the palliative care service. New referral pathways were developed and patient information updated. The use of technology was used to support patient flow, complete assessments and to inform key outcomes via PCOC data (Palliative Care Outcomes Collaboration).

The model of care was developed in conjunction with staff. The roles, responsibilities and referral pathways for each specific discipline were developed. Multidisciplinary case conference and reviews were embedded into practice, extending the reach with the Goulburn Region Consultancy Service.

The project concluded in June 2021, and has provided the opportunity to undertake many important activities to support improved service provision and clinical best practice while exploring alternatives for a new model of care that includes specialist Allied Health Professionals within the Moira Palliative Care Service. Many of these activities require commitment to embed and integrate project achievements into ongoing clinical practice, and require continued focus.

SERVICE INNOVATION

New models of care - Care for Carers

Care for Carers - Implementation of CSNAT, Goulburn Valley Hospice Care Service

Supporting the carers of palliative patients in the community is an essential element for palliative care services. In 2020 Goulburn Valley Hospice Care Service commenced a quality improvement activity to improve the responsiveness of the Service in identification and planning with carers to meet their individual needs. This was through systematically embedding an effective assessment tool known as Carer Support Needs Assessment Tool (CSNAT).

The aim of the quality improvement activity was to implement a process to provide 'better support for carers' reflected within the carer-led documented care plan (assessment, intervention, and evaluation of needs). Change of practice to a process in which the carers' perspectives are central to identifying support needs as well as potential solutions and to improve practice and delivery of palliative care services in a community setting.

Introducing the CSNAT during the admissions process, carers are able to complete it in their own time and prior to the next scheduled visit. Joint visits with a Nurse and the Family Support Worker were then scheduled as part of the admission process. The tool was important in assessing the level of need for carers to identify 'complex', 'medium' or 'addressed' needs. Through this process, care planning is a shared activity led by the carer. Based on needs, the Service was able to develop the appropriate level of support by the Family Support Worker who was introduced as part of the larger team of support during initial assessment, and establishing a rapport with carers and clients early on.

Adaption of CSNAT process occurred from previous face to face activity to also encompass an 'over the phone' assessment process due to COVID-19 restrictions. With the identification of greater resources required to meet the needs of increasing client numbers and associated carers, GV Hospice increased the FTE of the Supportive Care Practitioner.

Carers and Staff provided feedback on the process and the tool. PCOC data was also valuable in measuring and demonstrating improvements via Case Mix adjusted outcomes for Family/Carer; and Anticipatory Care Family/Carer. Each phase of the quality improvement activity was reviewed and adjustments were made accordingly. Carer feedback suggests that they felt more supported, where able to acknowledge that their role had its challenges but were aware of the supports available.

HPPC Website

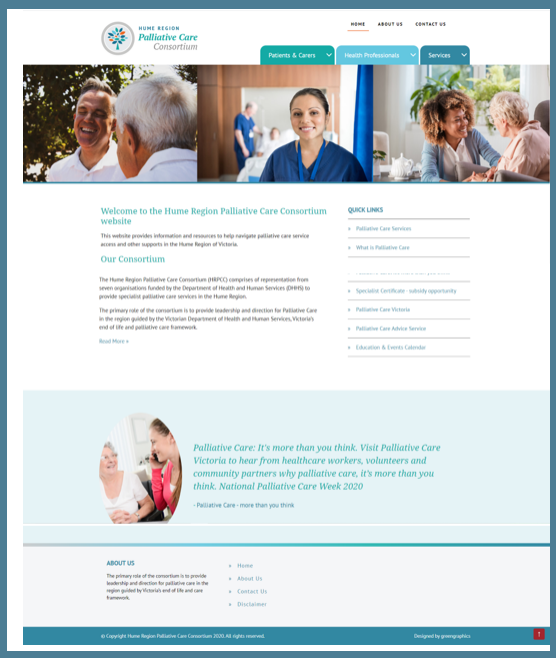
In 2020/21 the Hume Region Palliative Care Consortium website was given a facelift.

Our hosts at Green Graphics supported the process to creating a more user friendly experience on all devices. The Consortia Manager Elizabeth Jenkins updated the content as required.

Website data indicates that over a 30 day period - there were 318 individual visits to the website; 668 page views. 81% of visitors were new, and 19% returning. Amongst the top ten page views were all the community palliative care service pages; contact us; About the HPCC and Residential Aged Care page.

Green Graphics also assisted in refining our new logo in 2019.

www.humepalliativecare.org.au



SERVICE INNOVATION

Support systems to enable more efficient service provision

Regional dedicated palliative care system integration

Michelle Burns - Project officer

In July 2019, in conjunction with the Hume Region palliative care services, the Consortium were successful in a joint submission to the Department of Health for a palliative care services innovation and development grant to implement a consistent, dedicated palliative care patient management system.

The purpose of the project is to improve client outcomes by supporting continuity of care across community, consultancy, in-patient settings and after-hours palliative care.

'PalCare' PMS, is already used by Goulburn Valley Hospice Care Service in the Region and many other services in Victoria.

The project with all its moving parts was coordinated by Michelle Burns, engaging with multiple stakeholders throughout the project. Collaboration was key as we worked through scoping, governance and now the implementation stages of the project.

The project-scoping phase recommended the implementation of PalCare progress, concluding the change would assist in; consistent practice across the region in receiving referrals; improved communication using one system accessible to consultants and other integral health professionals; and improved client outcomes based on validated assessment tools.

We believe that transitioning Hume teams across to using PalCare aligns with Victoria's palliative care and end of life framework, and the Hume Region Palliative Care Consortium Strategic Plan 2019 – 2021, to address:

- Delivering person-centred service
- Coordinating and integrating services
- Standardise clinical frameworks across community palliative care services, and
- Strengthen palliative care service delivery in the Hume Region.

Now in the final project phase, palliative care teams are planning for the transition, focussing on workflow and process change. While project staff and the vendor develop and approach the site transition schedule, staff training is about to commence.
We are working toward all Hume Region palliative care teams transitioned and using PalCare by the end of 2021.

Tele-health, Lower Hume Palliative Care Service - Seymour Health

Samantha Moorhouse Project Officer.

The Lower Hume region has geographical areas where there are very limited services available to patients whose preference is to be cared for and die at home. This includes places where District Nurses can only visit weekly, there is no available home care staff, where the ambulance functions Monday to Friday 9-5pm and the GP clinic may not have a GP every day. These limited services impact on the patient achieving their preference for having end of life care in their home.

The Telehealth Project implemented the Provision of a Digital Health infrastructure enabling clinical consultancy with Lower Hume Clinical Nurse Specialists throughout the Lower Hume region

The introduction of Telehealth to a regional community palliative care had some unexpected benefits. The multidisciplinary approach to client care became a more central model and nurses were able to assist clients with access to specialists in a timely manner.

Staff benefitted from the support of a team approach to client care and regular supervision. This was able to take place despite COVID-19 restrictions and large distances between clinicians as is typical in regional community services across Victoria.

Hume Region Palliative Care Services participating in the Safer Care Victoria's WAVE project

- Goulburn Valley Hospice Care Service
- Lower Hume Palliative Care Service

The WAVE project (We are Ambulance Victoria Engaged is a project that seeks to improve the engagement between community-based palliative care services and paramedics in the provision of end-of-life care across Victoria.

PROFESSIONAL DEVELOPMENT

In 2020 the HPCC and CAG created a workforce development plan to support increase palliative care knowledge and skill for staff working in dedicated palliative care services and staff providing palliative care as part of general care. The plan followed the Centre for Palliative Care's 'novice clinician to expert clinician' framework drawing on the existing and planned programs to continually develop palliative care knowledge and skill within the Region.

Palliative Medicine Training

- Victorian Palliative Medicine Training - 3 Registrars supported in 2020/21
- Support for Medical Student training from the Universities of NSW and Melbourne. Consultants provide lectures and host clinical placements

Palliative Care Nurses Training

- Two Nurse Practitioner Candidates with East Hume Consultancy Service
- 24 Nurses completed the Banksia Palliative Care Course
- 10 regional monthly case discussion with the specialist PC teams and St Vincent's Health Physicians - 10 held

Loss, Grief & Bereavement

- Australian Centre for Grief and Bereavement delivered 2 online courses
- Multidisciplinary audience of 38

Residential Aged Care

- Monthly online education sessions
- Monthly newsletter based on ELDAC Clinical Care Domains
- Palliative Care Champion Training to commence

PROFESSIONAL DEVELOPMENT

A little more detail.....

- **Victorian Palliative Medicine Training**

Both Palliative Care Consultancy Services in the Hume Region support six-month registrar positions. In 2020/2021, Goulburn Region Palliative Care Consultancy (GV Health) and East Hume Consultancy Services (Albury Wodonga Health) supported a total of 3 Registrars.
Accredited by The Royal Australasian College of Physicians (RACP), the East Hume Consultancy support the Community Palliative Care and the Hospital Consultancy terms and the Clinical Diploma. The Goulburn Region Consultancy support a Cancer Care term and the Clinical Diploma.

- **Medical Student Training**

Physicians Dr Chi Li and Dr Siva Subramaniam support medical student palliative care training by providing lectures and hosting clinical placements for medical students from the University of New South Wales and the University of Melbourne.

- **Palliative Care Nurse Practitioner Candidate training**

The East Hume Palliative Care Consultancy Service currently has **two** Palliative Care Nurse Practitioner Candidates under the mentorship of Dr Chi Li.

- **Monthly Case Presentations**

The Community and Consultancy Palliative Care Services (7 services) along with a different Palliative Care Physician from St Vincent's Health meet virtually once per month for a professional development case discussion. The cases are deidentified and have a level of complexity that is worked through by the group and led by the Palliative Care Physician. Cases are chosen based on the expertise of the Physician supporting the discussion each month. **10** case conferences are held every year.

- **Banksia Palliative Care Course**

The Hume Region Palliative Care Consortium and the Hume Region Nurse and Mid-Wifery Educators Group have supported students to complete the Banksia Palliative Care Nurse Training over a number of years. This has in the past been a face to face delivery in one of the larger regional towns - Shepparton, Wangaratta or Wodonga. In 2020 the course was moved online enabling greater flexibility for participants to join the training. In 2020 and 2021 to date, **24** nurses in the Hume Region completed the Banksia Palliative Care Nurse Course (all 8 sessions). Banksia Palliative Care Service evaluate each session and report very good feedback from participants.

- **Loss, Grief and Bereavement**

The Australian Centre for Grief and Bereavement facilitated two virtual workshops supported by the Hume Region Palliative Care Consortium. Bianca Lavorgna, Anita Hoare and Chris Hall delivered an introductory level workshop and a more advanced workshop.

1. Effective brief contact and single session grief support
2. Expanding the therapist toolkit and creative interventions

A multidisciplinary audience of **38** attendees participated in the workshops collectively.

- **Program in the Experience of the Palliative Approach**

One face to face workshop was held in the region in May 2021, facilitated by Dr Hung Nguyen in conjunction with Palliative Care Victoria. The Culture Centred Care Workshop - CALD was held in Benalla with approximately 20 participants. There were no Reverse PEPA's completed in Residential Aged Care Facilities (RACF) in the Hume Region in 2020 and 2021 to June 30th, however expressions of interest are now coming in from RACF's in the Region and our Palliative Care Aged Care and Disability Resource Nurses are about to commence with this program in the 2021/22 financial year.
One Nurse completed a PEPA Clinical Placement this year .
COVID-19 has had a major impact on how the PEPA program is run in the Hume Region. Previously workshops and Reverse PEPA's have been very popular however these have understandably been on hold. We continue to promote the online courses and are in discussions with the Victorian PEPA Manager about how best to run the program in our Region in the coming year.

REFLECTIONS AND THE NEXT TWELVE MONTHS

Planning planning planning.....

The previous few years has seen enormous innovation applied in the region to improve client centred care. With limited resources, the growing service utilisation and projected population growth, it is timely that our current Regional Plan is coming to its end. The Hume Region Palliative Care Consortium is planning to develop a new plan for 2022.

Many foundations have been laid in the palliative care services providing a backdrop for embracing all that this has to offer. Implementation of the PalCare system is a real win for the Region. The roll on effects will strengthen continuity of care, underpinned by the common secure electronic infrastructure and regional processes, effectively reducing duplication.

The Consultancy Services have developed supportive sub-regional models. Their flexibility to pivot across multiple care settings to provide patient centred care is a credit to them. Of course this is not without its challenges as they navigate hospital and community based consultancy service alongside large geographic areas with finite resources.

During the COVID-19 pandemic, the palliative care teams supported more clients choosing to receive their end of life care at home than in the past. Greater use of telehealth was also implemented and although it does not replace home visits, it does provide an opportunity to embed telehealth as another mode of contact to 'see' the client and carer in their home and to facilitate multidisciplinary case reviews.

The innovation projects supported by the Victorian Department of Health have provided a pathway for our services to achieve timely and multi-disciplinary palliative care. The projects will provide great background, learnings and opportunities as move to the next regional plan.

Workforce development and training will remain a focus and feature predominately in the new regional plan. Support for the dedicated palliative care sector through succession planning and generalist health professionals where palliative and end of life care is part of their role.

We will continue to be part of the State Consortia Managers Group. This group was Chaired by Tanja Bahro (Southern Metro) in 2020 and Elizabeth Jenkins (Hume) in 2021 and provided a platform for bi monthly meetings with representation from some of our State and National programs. They included Palliative Care Victoria, The Centre for Palliative Care, PEPA, Safer Care Victoria (PCCN) and the Palliative Care Advice Service. This forum is important in sharing information, ideas and resources across the sector.

The Hume Region Palliative Care Consortium, The Clinical Advisory Group and member agencies, will continue to work with our State and National partners including the Victorian Department of Health and Human Services, St Vincent's Health, The Centre for Palliative Care, PEPA, Palliative Care Victoria and Safer Care Victoria - Palliative Care Clinical Network.