NORTH AND WEST
METROPOLITAN REGION
PALLIATIVE CARE CONSORTIUM

Annual Report 2019-2020

North and West Metropolitan Region Palliative Care Consortium
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MESSAGE FROM OUR CHAIR

Janet Phillips
Strategy & Operations Manager | Palliative Care
Melbourne City Mission

It gives me great pleasure as Chair of the North and West Metropolitan Region Consortium to present our 2019/20 Annual Report.

Over this past year, our Consortium has demonstrated its collective commitment to Victoria's end of life and palliative care framework through a range of projects, improvement initiatives and capacity building efforts.

All members of our consortium have been very productive over the past year implementing initiatives that have improved systems, practice and coordination. Strengthened models of care in Palliative Care Units, working directly with aged care services to embed a palliative approach to care and implementing hospital to home initiatives to streamline the patient experience from in-patient units to community are examples of work undertaken by members of our consortium.

The COVID-19 pandemic presents us with significant challenges in how our consortium communicates and collaborates. We utilise a range of alternative and innovative ways of communicating, establishing and supporting collaborative improvement initiatives, capacity building and delivering education and training. Virtual meetings and forums, web-based video conferencing and education training webinars have become our new normal. As we move into the second half of 2020 and beyond, we know that COVID-19 will remain for the foreseeable future. We have planned and are implementing a range of new initiatives to reflect the different demands and pressures on palliative care services posed by this pandemic.

In these challenging times, our consortium provides a vital forum for the NW Metropolitan Region. It is an excellent mechanism for communication and collaboration, sharing information and resources and building the capacity of our workforce.

As my tenure as Chair of this Group ends and I pass the responsibility to lead this group to Amy Noble, Senior Palliative Care Clinical Nurse Consultant from the Royal Melbourne Hospital and Peter MacCallum Cancer Centre, I wish to congratulate the NW Metropolitan Region Consortium on its efforts over the previous 12 months and our ongoing commitment to working together to provide high quality palliative care across our region.

Janet Phillips
Consortium Chair

OUR CONSORTIUM

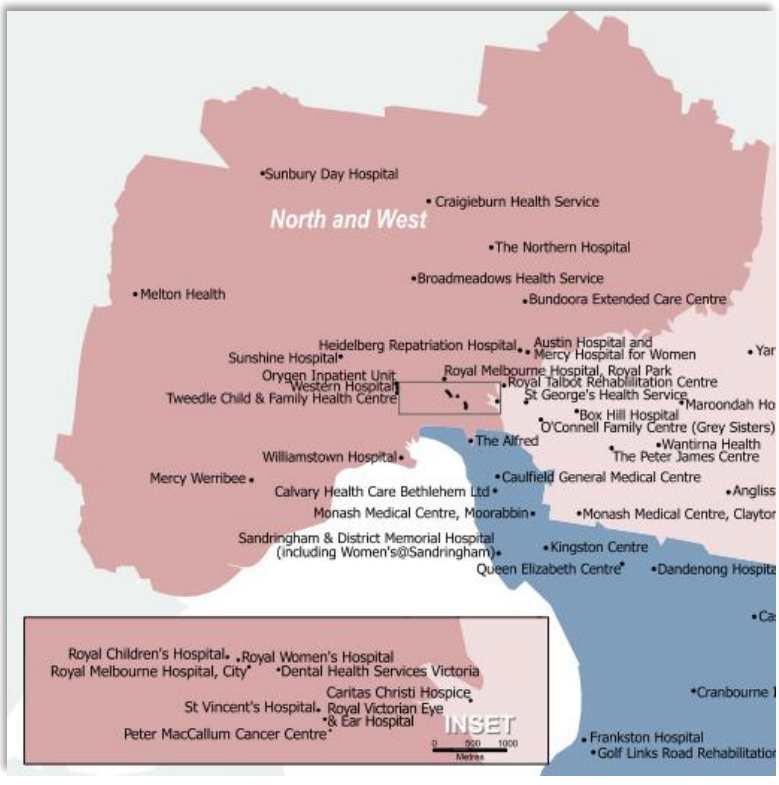
The North and West Metropolitan Region Palliative Care Consortium (NWMPCC) is one of eight regional palliative care consortia funded by DHHS. It is an alliance of services providing palliative care for people living in the north and west metropolitan region of Melbourne.

Members of the NWMPCC include hospital palliative care services, community palliative care services and the North Western Melbourne Primary Health Network (NWMPHN).

Hospital-based palliative care (wards/units and palliative care consultancy services)

Our Consortium includes five hospital based palliative care services providing care and services for Victorians across the northwest region of metropolitan Melbourne:

- Austin Health which provides specialist palliative care to enable people with a life limiting illness to live as well as possible, including symptom management, end of life care, or discharge planning enabling them to return home. Services include an inpatient Palliative Care Unit in the ONJ Centre integrating wellness and supportive care programs; a Palliative Care Consultative Service across Austin Health; a Palliative Care Clinic; and a Palliative Care Clinical Trials program.



- Melbourne Health and Peter MacCallum Cancer Centre operating together through the Integrated Palliative Care Service of the Victorian Comprehensive Cancer Centre (VCCC) providing multidisciplinary palliative care across the Parkville Precinct including nurse consultants, specialist doctors, doctors in training and nurse practitioners.

- Northern Health Inpatient Palliative Care Unit caring for patients who require symptom assessment and management and future planning options, end of life care and inpatient specialist palliative care; the Palliative Care Consultation Service, a multidisciplinary team working together with other teams to look after inpatients of The Northern Hospital Epping, Broadmeadows Hospital or Northern Health Bundoora, or who are attending a specialist clinic at the hospital.

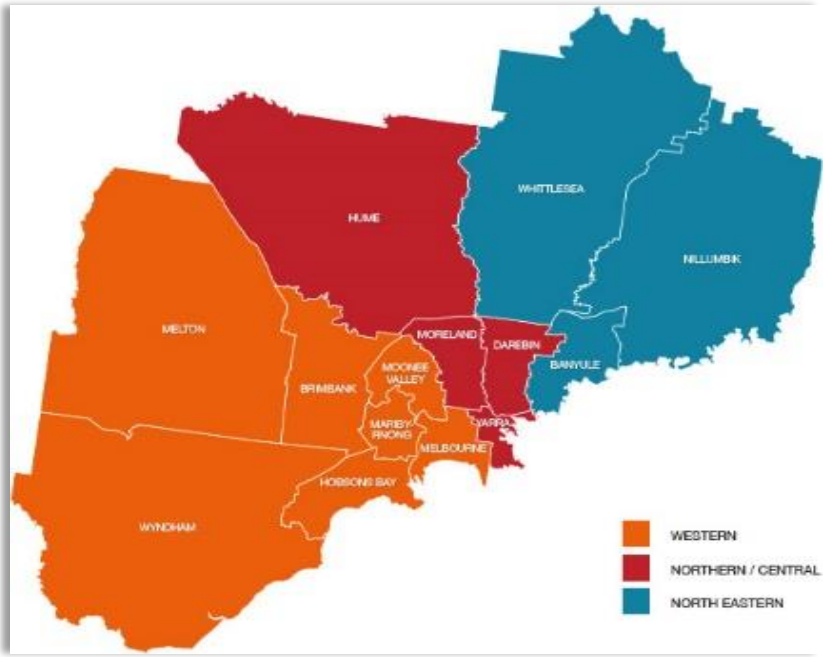
- Werribee Mercy Hospital (Mercy Health) providing inpatient palliative care and end of life care at the Gabrielle Jennings Centre for Palliative Care and palliative care consultancy service for the hospital.

- Western Health Palliative Care Consultancy Service providing expertise and advice to patients, carers and health professionals; Outpatient Clinics including the SMART (Symptom Management and Referral Team) Clinic, a multi-disciplinary Palliative Care outpatient clinic which is a partnership between Western Health Palliative Care and Pharmacy Teams and Mercy Palliative Care and Palliative Care in patient.

Our Community Palliative Care Services

Our three palliative care services provide care to specific local government areas (LGAs) across our region include:

- Mercy Palliative Care, a community-based palliative care service offering support in the NW metro region of Melbourne servicing seven municipalities including Brimbank, Maribyrnong, Melbourne, Melton, Moonee Valley, Hobsons Bay and Wyndham offering 24-hour support and advice. According to the Australian Bureau of Statistics, the population for this catchment at 2018 was estimated at 1,106,450.



- Melbourne City Mission (MCM) Palliative Care covering the north central part of the region with a total estimated population at 2018 of 666,249. MCM provides in-home palliative care services seven days a week in the cities of Hume, Moreland, Darebin and Yarra. It offers a range of nursing, medical, allied health and consulting services to help people experiencing a life-limiting illness to have the best possible quality of life.

- North-eastern part of the region is the catchment area for Banksia Palliative Care Service with a total estimated population of 418,500 at 2018. Banksia provides specialist palliative care and practical support including coordinated expert nursing, medical and allied health services for people who have been diagnosed with a progressive terminal illness residing in the local government areas of Banyule, Nillumbik and Whittlesea.

Key Demographics

The Australian Bureau of Statistics estimated population for the north and west metropolitan region of Melbourne in 2018 was 2,191,199 representing just over one third (33.9%) of the population of Victoria. The most recent Census data (2016) identified our catchment as:

- having an expected growth of over half a million people (521,478) in the ten years to 2026

- representing an ageing population where the population of people aged 70 years or older is expected to increase by more than half (50.6%) in the ten years to 2026

- including one quarter (24.8%) of Victoria's Aboriginal and Torres Strait Islander population

- being culturally diverse, with three out of every ten residents in the region (29.8%) being born in a non-English speaking country

- having a projected growth rate of persons with a diagnosis of dementia of 420% to 2050 (26,101 in 2017 to 118,192 persons by 2050) Source: NATSEM, University of Canberra, January 2016. Commissioned by Alzheimer's Australia Vic.

OUR FOCUS FOR 2019-2020 AND COVID-19

We began 2019 – 2020 focusing on three key priorities:

- Continuing to strengthen governance processes and operational practices

- Planning, promoting and supporting the implementation of collaborative palliative care improvement initiatives with member agencies and strengthening workforce capacity. Each activity needed to be consistent with one or more of the priorities of Victoria's end of life and palliative care framework:
  - delivering person-centred services
  - engaging communities, embracing diversity
  - coordinating and integrating services
  - making quality end of life and palliative care everyone's responsibility
  - strengthening specialist palliative care.

- Supporting the successful implementation of initiatives funded through innovation grants from the Victorian government including but not limited to Telehealth capability; Community In-Reach and Review Program; Aged Care In-reach Program, and Hospital 2 Home initiatives.

While these priorities remained our focus, COVID-19 presents Consortium member agencies with new challenges in how we provide palliative care in the context of a pandemic. In response our Consortium Management Group have directed resources towards:

- additional Palliative Care Consultant, Nurse Consultant, administration and pastoral care support
- staff training and education
- equipment including syringe drivers for end of life care; iPads and other devices to support telehealth consultations, and
- personal protective equipment.

We have sought alternative and innovative ways of communicating, establishing and supporting collaborative improvement initiatives, capacity building and delivering education and training including:

- virtual consortium management group meetings using integrated audio and video applications
- web-based video conferencing for education, training and working group meetings
- web-based information forums and interactive webinars
- regular on-line contact with other consortia managers to share insights and solutions to issues raised by COVID-19 in consortia operations

- maintaining regular on-line contact with networks and key stakeholders
- attendance at key network meetings using on-line platforms
- circulating key resources and information including Health Alerts and resources published by DHHS and Safer Care Victoria.

GOVERNANCE AND OPERATIONAL PRACTICES

Over the past 12 months we have further strengthened our governance processes and operational practices through:

- ✓ Revision of the Management Group Terms of Reference to include more explicit objectives regarding governance and monitoring responsibilities of the Group.
- ✓ Increased member engagement and involvement as demonstrated by:
  - all scheduled meetings being conducted (10 meetings scheduled for the period - no meeting scheduled September 2019 due to national Palliative Care Conference and no scheduled meeting January 2020)
  - 83% meeting attendance with representatives from at least six of the eight member agencies attending each meeting.
- ✓ Systematised Management Group meeting practices including:
  - standing agenda items (e.g. project status reports, innovations, capacity building, communication and updates from key agencies, financial performance and member agency feedback
  - comprehensive reporting of the status of projects, improvement initiatives and capacity building initiative
  - transparent decision-making processes to support robust financial management of Consortium funds.
- ✓ Ensuring all consortium activities and initiatives are consistent with priorities set out in Victoria's end of life and palliative care framework.
- ✓ Tools to support reporting of project outcomes and use of education and training funds.
- ✓ Implementation of practices to ensure effective use and management of Consortium staff:
  - enabling remote working access
  - scoping workload for both staff
  - development and use of detailed work plans to ensure efficient and effective use of Consortium Manager and Project Coordinator resources
  - Regular staff supervision and outcomes monitoring.

COLLABORATIVE IMPROVEMENT INITIATIVES AND PROJECTS

Members of our consortium have been very productive over the past year implementing initiatives that have improved systems, practice and coordination.

The following are some examples of the work undertaken over the past 12 months, funded internally by the organisation, funded by the Consortium or through innovation grants from the state government or via the north West Metropolitan PHN.

Project title: Targeted implementation to improve after-hours access to palliative care in seven Doutta Galla Aged Services (DGAS) in north west metropolitan Melbourne.

Project aim: Implement improved palliative care systems and processes in the six DGAS metropolitan RACFs.
Timeline: August 2019 to October 2019

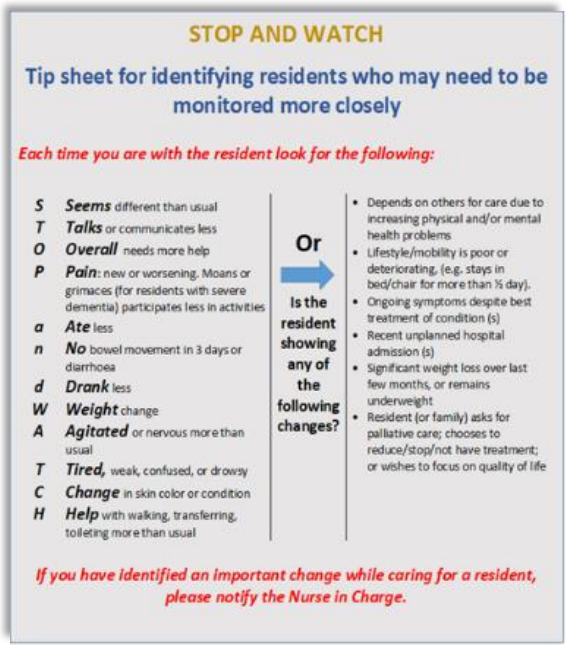
Collaborating agencies:
- Doutta Galla Aged Services
- Mercy Palliative Care
- NWMPHN and GPs

Outcomes achieved:

- DGAS model of Palliative Care developed and policies and procedures revised and strengthened.

- Stop & Watch system (S&W); early warning communication process for PCAs, housekeeping services, family, volunteers alerting RN if they notice something different in a resident's daily status/care needs. Requires RN to complete resident assessment to inform next steps, includes reporting pathways; strengthens communication keeping 'whole team' focused on changes to residents' status/care needs.

- Strengthened ACP processes including medical goals of care completed on admission with resident and family and promoted ACP information for staff, residents and relatives.


STOP AND WATCH

Tip sheet for identifying residents who may need to be monitored more closely

Each time you are with the resident look for the following:

S	***Seems*** different than usual	Or → Is the resident showing any of the following changes?
T	***Talks*** or communicates less	
O	***Overall*** needs more help	
P	***Pain***: new or worsening. Moans or grimaces (for residents with severe dementia) participates less in activities	
a	***Ate*** less	
n	***No*** bowel movement in 3 days or diarrhoea	
d	***Drank*** less	
W	***Weight*** change	
A	***Agitated*** or nervous more than usual	
T	***Tired,*** weak, confused, or drowsy	
C	***Change*** in skin color or condition	
H	***Help*** with walking, transferring, toileting more than usual	

- Depends on others for care due to increasing physical and/or mental health problems
- Lifestyle/mobility is poor or deteriorating, (e.g. stays in bed/chair for more than ½ day).
- Ongoing symptoms despite best treatment of condition (s)
- Recent unplanned hospital admission (s)
- Significant weight loss over last few months, or remains underweight
- Resident (or family) asks for palliative care; chooses to reduce/stop/not have treatment; or wishes to focus on quality of life

If you have identified an important change while caring for a resident, please notify the Nurse in Charge.

- ‘Comprehensive Health Assessment of Older Person’ training conducted by Latrobe University to ensure competent assessment of S&W residents.
- Video of palliative care training day and ACP education to ensure access for all DGAS staff including night staff.
- GP Directions Form for after-hours locums and other visiting clinicians to ensure ready access to information to inform decision making.
- Referral pathway flow chart to support consistent and appropriate decision making when referring to Residential-In-Reach, GPs, Palliative Care, Locums.
- Redesigned Community Palliative Care referral forms using ‘ISBAR’ framework to aid communication/decision making.
- On-site pharmacy system for timely after-hours access to key medications.
- Performance monitoring and reporting for all DGAS RACFs. Data trended to assess impact of initiatives to support ongoing system and practice improvement.

Project title: H2H (Hospital to Home) Project

Project aim: Enhance client, family and carer outcomes for palliative clients across our catchment.
Timeline: July 2019 - ongoing

Collaborating agencies:
- Banksia Palliative Care Service
- Northern Health

Achievements to date:

- Providing structured introduction to community palliative care staff and services whilst inpatient at Northern Health through an in-reach arrangement that includes a partial admission to Banksia allowing immediate access to after-hours expertise on discharge.
- Facilitating streamlined, effective, delay-free discharge from inpatient units (particularly those without palliative care expertise).
- Strengthened communication and collaboration across and between inpatients units, palliative care Consultancy Team and community palliative care service.
- Increased access to integrated specialist care and supports in community via specialist palliative care out-patient clinics located at Bundoora Extended Care Centre.

Project title: CIRP (Community In-reach and Review Program)

Project aim: Enhance client, family and carer outcomes for palliative clients across our catchment.
Timeline: July 2019 - ongoing

Collaborating agencies:
- Banksia Palliative Care Service
- Austin Health
- Melbourne Health / Peter Mac
- Warringal Private Hospital, North Park Private

Achievements to date:

- Providing structured introduction to actual Community Palliative Care staff and services whilst in hospital through an in-reach arrangement that includes a partial admission to Banksia that allows immediate access to after-hours expertise on discharge;
- Facilitating streamlined, effective, delay-free discharge from all inpatient units (particularly those without PC expertise), and
- Increased access to integrated specialist care and supports in the community via specialist Banksia out-patient clinics.

Project title: Aged Care In-reach Program Project

Project aim: Develop and implement a person-centered pathway of palliative care for residents with diagnosed life limiting illnesses from entry into RACF to end of life.
Timeline: July 2019 and ongoing

Collaborating agencies:
- Banksia Palliative Care Service
- Blue Cross RACFs - Banksia's catchment

Achievements to date:

- Enhancing resident and family outcomes with provision of expert, holistic, multidisciplinary palliative care organised and implemented in the home by the 'right' people and service, at the 'right' time.
- Decreasing need for hospital resource investment. Residents less likely to need hospitalisation due to advanced, anticipatory care options (including emotional and psychosocial) being delivered in the RACF.
- Enabling resident and family access to additional services, e.g. music therapy, counselling and bereavement support.
- Increasing capacity of RACF workforce with dedicated and on-the-spot palliative care education and training.

- Addressing needs of generally frail and declining residents as they progress into palliative-approach treatment.
- Encouraging successful, collaborative management of palliative care and end of life care between RACFs and community palliative care services.

Project title: CCSP (Client and Carer Support Program)

Project aim: Provide additional supports at either end of the client's disease trajectory supporting development of trusting relationships to optimise clients and carers experience.
Timeline: Julv 2019 to November 2021

Collaborating agencies:
- Banksia Palliative Care Service
- Eastern Melbourne PHN

Achievements to date:

- Provide dedicated and specifically structured education and support to carers who become responsible for client care in the home, including hygiene support, sourcing and use of medical equipment, and managing oral intake and medications
- In home respite, for clients who need support from a person with knowledge and skills.

Project title: Hospital Nurse Liaison Project

Project aim: Strengthen discharge planning, communication and referral of patients between acute and community settings.
Timeline: October 2019 to October 2020

Collaborating agencies:
- Northern Health
- Melbourne City Mission Palliative Care

Achievements to date:

- Appointment of Melbourne City Mission Palliative Care Liaison Nurse (PCLN).
- Strengthened discharge planning practices including referral to appropriate services, coordination of inpatient elements to facilitate transit to home, i.e. Medication orders via treating team, equipment and care needs via OT, Physiotherapy, notifying client's GP of discharge and commencing / updating documentation within electronic client record.
- Supporting client transition to home via scheduled home appointments in the immediate period after discharge.
- Preparation of first quarter report (March 2020-May 2020) demonstrating improved referral responsiveness by NH Palliative Care Consultancy Service, improved referral and

assessment responsiveness due to on-site presence and practice of the Melbourne City Mission PCLN and reduction in number of unscheduled presentations to Northern Health.

Project title: Non-Malignant Symptom Management Clinic

Project aim: To ensure access to palliative care for patients with non-malignant disease nearing the end of their life to improve quality of life for patients with COPD or other life limiting respiratory conditions

Timeline: September 2019 – Project on hold due to COVID-19 – plan to recommence when lockdown restrictions ease

Collaborating agencies:

- Werribee Mercy Hospital – collaboration between Palliative Care Consultancy Team and HIP, Renal, Medical Units and ED
- Referring GPs

Context:

The Non-Malignant Symptom Management clinic will accept referrals from within Werribee Mercy Hospital, with a particular focus on chronic disease sufferers who are part of the Health Independence Program, patients of Werribee Mercy Renal and Medical Units and patients who attend the Emergency Department. Referrals will also be encouraged and accepted from GPs.

Once the COVID-19 pandemic stabilises, Werribee Mercy will start the weekly clinic conducted by a palliative care consultant and a palliative care nurse with involvement of social worker. Key objectives of the initiative will be to:

- reduce distress from symptoms for patients in end stage of their malignant disease
- improve seamless transition to palliative care for patients with non-malignant disease
- provide specialist palliative support to non-malignant outpatient clinics
- provide access to specialist palliative care support for GPs providing symptom management to patients with non-malignant disease through referral to the clinic
- create a long-term sustainable clinic model that can be scaled to include all cohorts of patients with non-malignant disease.

Achievements to date:

- A robust communication plan has been developed to engage internal and external stakeholders and promote uptake of the initiative.
- Symptom management tools/information sheets have been developed
- Initiatives to support carers.

Project title: PalCare Go Project

Project aim: Develop a telehealth capability that will expand the palliative care service response.
Timeline: December 2019 to March 2022

Collaborating agencies:
- Melbourne City Mission Palliative Care
- PalCare (encrypted, web-based patient information management system)

Context:

Collaboration between Melbourne City Mission and *PalCare*,

Whilst the *PalCare* GO project was originally envisaged to target people with longer-term chronic illness, it is now agreed that *PalCare* Go may be utilised more broadly, given the challenges that the COVID-19 pandemic presents. Project objectives include:

- Improved access for clients, carers and families to MCM palliative care services
- Increased capacity for clients to manage their own symptoms and gain access to information that may prevent the need for hospital admissions
- Address needs of people with chronic illness who do not, generally meet the criteria for palliative care but still need to manage chronic diagnosis with long term trajectories.

Achievements to date:

- Final stages of product development and testing the *PalCare* GO capability in August 2020.

- Following the testing phase and pending approval of the product, Melbourne City Mission Palliative Care will pilot *PalCare* GO by introducing the capability to a specified number of clients. *PalCare* GO will:
    - be made available through the *PalCare* Home application that allows people to self-assess against specific symptoms, to maintain records in a diary page format, and to access up to date information on palliative care, with links to relevant websites
    - provide the capability to interact with the service via video conference
    - use its telehealth capability to potentially be used as a communication mechanism with clients in lieu of scheduled face to face visits where it is safe and appropriate to do so. This capability is not intended to replace face to face visits.

Project Title: **Austin Palliative Acute Transition Home (PATH) Service**

Project Aim: Provide a timely and coordinated response to acute palliative care needs of clients within Austin Health and Melbourne City Mission catchment area
Timeline: January 2020 to December 2020

Collaborating agencies:
- Austin Health Palliative Care Service
- Melbourne City Mission Palliative Care

Outcomes achieved to date:

- PATH model between the two services established that will:
  - assist in transition process to expedite early discharge from hospital for palliative care clients who wish to receive care at home
  - provide timely, responsive specialist palliative care to support clients to stay in the community and prevent admission into hospital
  - prevent readmissions and ED presentations by bridging gaps in service delivery.
- Memorandum of understanding finalized.
- Baseline data collection and Phase 1 underway.

Project Title: **Palliative Care Unit Harmonisation at Peter MacCallum & Royal Melbourne**

Project Aim: Integration of workforce and care protocols to support coordinated care, particularly for patients and carers moving between hospital organisations and from hospital to home settings.
Timeline: January 2020 to November 2020

Collaborating agencies:
- Peter MacCallum Cancer Centre
- Royal Melbourne Hospital
- Melbourne City Mission Palliative Care

Context and outcomes achieved to date:

A new 12 bed palliative care unit has been established at Peter MacCallum Cancer Centre opening September 2020. While the COVID-19 pandemic has impacted the rate at which objectives have been progressed, the following has been achieved:

- Collaboration between social work, pastoral and MCM counsellors has supported the development of bereavement support resources and guidelines. The bereavement assessment based on the DHHS Bereavement Support Guidelines will be part of Electronic Medical Record.

- Workforce harmonisation has commenced including options around work experience in each area of palliative care practice and undergraduate programs and potential collaborative research opportunities.

- Development of procedures and guidelines relevant to end of life for Royal Melbourne and Peter MacCallum and extensive guidelines to guide palliative care practice across the precinct and with Melbourne City Mission Palliative Care including admission guidelines and protocols and discharge planning.

Project title: **Strengthening Western Health model of care in Palliative Care Unit**

Project aim: Review existing model of care from referral to discharge and implement strategies to enhance and strengthen systems and practices.
Timeline: May 2020 to August 2020

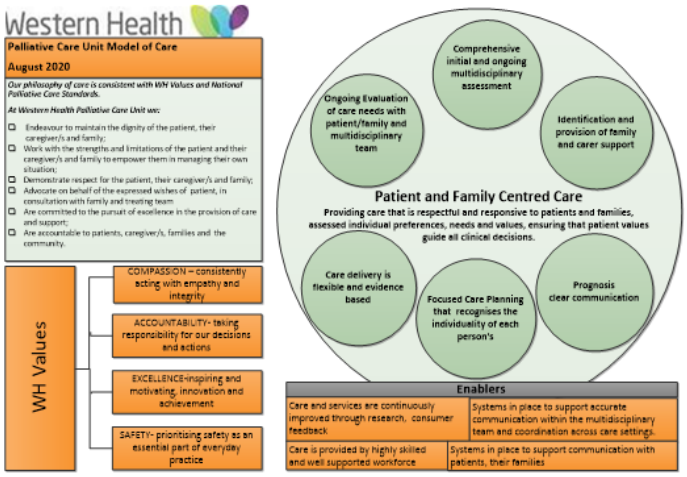
Collaborating agencies:
- Western Health Palliative Care Unit
- Mercy Palliative Care

Outcomes achieved:

- Key elements of best practice models of palliative care researched, current Model of Care mapped and SWOT analysis completed.

- Consultation with internal and external stakeholders identified expectations of care.

- Philosophy of care explored and agreed.



- Referral practices and pathways between Palliative Care Unit and community palliative care revised and streamlined.

- Improving communication through goals of care, multidisciplinary case conferencing.

- Key Performance Measures and audit systems to evaluate the effectiveness of practice and outcomes over time.

- Revised and strengthened model of care.

- Staff education and training on the strengthened model of care.

Initiative title: Palliative Care Advisory Service

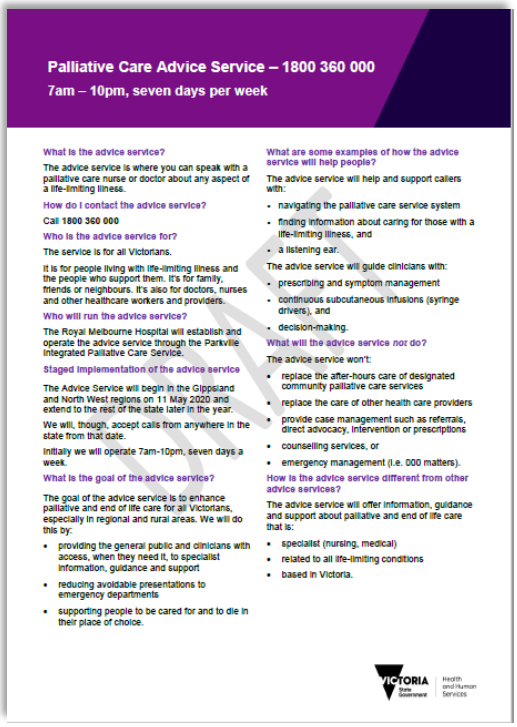
Aim: Phone advice service for people with life-limiting illness and families or health care providers to speak with a palliative care nurse or doctor about any aspect of the life limiting illness.
Timeline: May 2020 (3-year project)

Collaborating agencies:
- DHHS
- Royal Melbourne Hospital

Overview of the service:

The goal of the advice service is to enhance palliative and end of life care for all Victorians, especially in regional and rural areas by:

- providing the general public and clinicians with access, when they need it, to specialist information, guidance and support
- reducing avoidable presentations to emergency departments
- supporting people to be cared for and to die in their place of choice.



Palliative Care Advice Service – 1800 360 000

7am – 10pm, seven days per week

What is the advice service?

The advice service is where you can speak with a palliative care nurse or doctor about any aspect of a life-limiting illness.

How do I contact the advice service?

Call 1800 360 000

Who is the advice service for?

The service is for all Victorians.

It is for people living with life-limiting illness and the people who support them. It's for family, friends or neighbours. It's also for doctors, nurses and other healthcare workers and providers.

Who will run the advice service?

The Royal Melbourne Hospital will establish and operate the advice service through the Parkville Integrated Palliative Care Service.

Staged implementation of the advice service

The Advice Service will begin in the Gippsland and North West regions on 11 May 2020 and extend to the rest of the state later in the year.

We will, though, accept calls from anywhere in the state from that date.

Initially we will operate 7am-10pm, seven days a week.

What is the goal of the advice service?

The goal of the advice service is to enhance palliative and end of life care for all Victorians, especially in regional and rural areas. We will do this by:

- providing the general public and clinicians with access, when they need it, to specialist information, guidance and support
- reducing avoidable presentations to emergency departments
- supporting people to be cared for and to die in their place of choice.

What are some examples of how the advice service will help people?

The advice service will help and support callers with:

- navigating the palliative care service system
- finding information about caring for those with a life-limiting illness, and
- a listening ear.

The advice service will guide clinicians with:

- prescribing and symptom management
- continuous subcutaneous infusions (syringe drivers), and
- decision-making.

What will the advice service *not* do?

The advice service won't:

- replace the after-hours care of designated community palliative care services
- replace the care of other health care providers
- provide case management such as referrals, direct advocacy, intervention or prescriptions
- counselling services, or
- emergency management (i.e. 000 matters).

How is the advice service different from other advice services?

The advice service will offer information, guidance and support about palliative and end of life care that is:

- specialist (nursing, medical)
- related to all life-limiting conditions
- based in Victoria.

VICTORIA State Government | Health and Human Services

- The advice service:
  - helps and support callers with navigating the palliative care service system, finding information about caring for those with a life-limiting illness, and a listening ear.
  - guides clinicians with prescribing and symptom management, continuous subcutaneous infusions (syringe drivers), and decision-making.

Promotion of the service:

The advice line has been widely promoted across north west metropolitan Melbourne through attendance of the Nurse Unit Manager of the advice service key forums including the Consortium Management Group meeting and NW Aged Care Skype forums. The flyer, describing the advice service has also been distributed by the convenor of the NW Residential Aged Care Network meeting to all aged care service providers in the north west metro catchment.

2019-20 CAPACITY BUILDING

Education and Training

September/November 2019: Mindfulness Meditation Workshops: 3 x 1hr sessions
Facilitated by Meditation Solutions.
***18 participants** from Austin Health Palliative Care Services attended.*

3-day practical workshop upskilling RNs on 'Comprehensive health assessment of the older person' - *Conducted October 2019 by Australian Centre for Evidenced Based Aged Care - Latrobe University.*
***20 RNs** from Doutta Galla Aged Services and Community Palliative Care Services attended.*

October 2019, presentation on Voluntary Assisted Dying: Implementation Challenges and Solutions - *Presented by Janet Phillips from Melbourne City Mission Palliative Care.*
***38 clinicians** from NW PC Consortium organisations attended.*

End of Life Law for Clinicians Workshop conducted by the Office of Public Advocate conducted February 2020.
3 clinicians from NW PC consortium organisations attended.

VAD Expert Panel Q&A Session: February 2020 - *Drew an audience of **48 clinicians** from across NW PC consortium organisations. Panellists included Dr Cameron McLaren, Professor Margaret O'Connor, Amy Noble, Michelle Wood and Susan Jury.*

Introduction to Mindfulness for Self-Care: 6-week program (1.5 hrs x 6 sessions) from February 2020 to March 2020
Facilitated by Clinical Educator, Suzanne Peyton from Melbourne City Mission Palliative Care.
***12 participants** from NW PC consortium organisations attended.*

Videos for carers on Saf-T intima insertion and preparing and giving medications.
Produced April 2020 and made available to all Consortium Members in July 2020 via YouTube.

Skills to enhance Telephone and Telehealth Consultations - 90 Minute Webinar skills development interactive session - May 2020
Conducted by Dr Peter Martin and Meg Chiswell from Centre for Organisational Change in Person Centred Healthcare, Deakin University.
***27 clinicians** from NW PC consortium organisations attending.*

Bad, Sad and Difficult News Telehealth Webinar June 2020
Conducted by Dr Peter Martin and Meg Chiswell from Centre for Organisational Change in Person Centred Healthcare, Deakin University.
***20 clinicians** from NW PC Consortium organisations attended.*

Examples of Conference Presentations and Posters

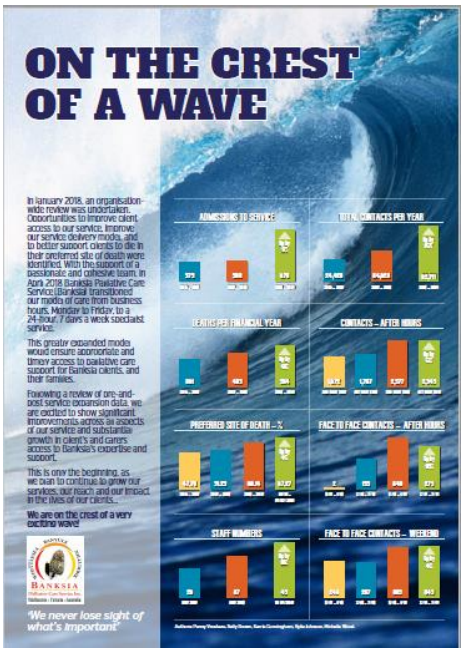
September 2019: Oceanic Palliative Care Conference:

- Banksia Palliative Care Service
  - *Oral and Poster presentation: 9-5 to 24/7: the evolution of a community palliative care service model.*

- Austin Health:
  - Oral presentation: *'Is there a doctor in the house? A firsthand experience of Toronto community palliative care'*
  - Poster presentation: *'Seizing the opportunity: Developing a vision and strategic plan for our Palliative Care Service'*
  - Poster presentation: *'Seeing the opportunity: Eye donation in palliative care'*
  - Poster presentation: *'Introducing mindfulness as a self-help tool in the palliative care unit'*

November 2019: Tasmanian Palliative Care Conference

- Banksia Palliative Care Service:
  - Oral Presentation: *Have Education, will travel!*

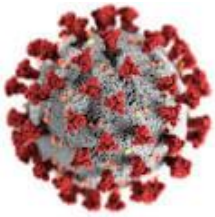


EXAMPLES OF HOW WE ARE ADAPTING IN THIS COVID-19 WORLD

Telehealth sessions for clients and their carers/families

In response to the COVID-19 outbreak, Banksia clients and their carers/families continue to access Banksia services via telehealth including but not limited to:

- *Nursing assessments and reviews*
- *Medical assessments and reviews*
- *Grief and Bereavement Counselling*
- *Social Work assessments and supports*
- *Music therapy sessions*
- *Group Bereavement Information sessions*



Regular Aged Care Skype Forums: Practice in COVID-19 environment

Aged Care Skype forums continue to provide an opportunity for palliative care clinicians within the Consortium who provide support for aged care services to come together to:

- *share issues of concern and challenges around the provision of services in the context of COVID-19*
- *discuss and share initiative and solutions to these issues and challenges*
- *support capacity building in aged care around end of life care*
- *share project ideas, tools, resources, practice models etc.*

Development and implementation of external palliative care education and training via virtual platforms such as Zoom and MS Teams

Banksia Palliative Care Service providing education and training for external health care providers such as RACFs, Support Houses, Allied Health Services and Health Care Professionals. Sharing palliative care knowledge and expertise to ensure colleagues across our catchment and beyond have access to continued education to help deliver the best community palliative care services possible.

Regular on line meetings with other Consortium Managers and aged care interest group

In response to the COVID-19 outbreak Consortium Manager met regularly to:

- *share issues of concern and challenges around the provision of services in the context of COVID-19*
- *discuss and share initiative and solutions to these issues and challenges*
- *support capacity building in aged care around end of life care*
- *share tools, resources, practice models etc.*

Austin Health Palliative Care Services adapted services by:

- *converting the Palliative Care Clinic to Telehealth for continued outpatient medical and nursing consultations*
- *providing a specialist Palliative Care Consultative service to the inpatient COVID wards, and the Residential In-reach Team supporting local Residential Aged Care Facilities, and*
- *providing support to families and carers to remain connected with their loved ones during inpatient visitor restrictions*

WHAT'S HAPPENING NOW AND REST OF 2020

Aged Care:

- Aged Care Capacity Building Stategy
- Aged Care Skype Forums: Membership includes representatives from in-reach services, Community Palliative Care and inpateint consultancy servcies. Supporting communication and information sharing in the context of COVID-19
- Aged Care COVID-19 Bereavement focus group
- Supporting the implementation of ELDAC Improvment Program and PCOC in Residential Aged Care Program in aged care facilities in our catchment

Capacity Building:

- Webinars: Communication in Telehealth environment, Self Care for health care communities programs
- Disability Support Workers: strengthening palliative care awareness and knowledge

Supporting CQI Projects:

- Mercy Palliative Care Model of Care - scope includes Patient Journey from admission to discharge and including bereavement and transitions across settings; Workflows; Processes and tools for Referral, Triage, Admission, Care Planning documentation and Discharge; Procedures related to care delivery Complete continuum of care settings - Community, Werribee Mercy GJC, Consultancy at Werribee Mercy Hospital
- NWMPHN and Community Pallaitive Care Service initiaitve that enhances interdisciplinary care between general practices and community palliative care services
- Explore opportunities to work with Western & Central Melbourne Integrated Cancer Service around a rapid access model of care/referral process for comunity care

Remaining connected and communicating in a COVID-19 world

- Continue to share information, resources and strategies with other Consortium Managers and Aged and Disability Link Nurses
- Publish monthly newsletter and upgrade our website increasing its interactivity and functionality
- Continue to actively contribute to key NW region groups including Western & Central Melbourne Integrated Cancer Service Governance Committee and Inner North West Primary Care Partnership Governance Group and the NW Aged Care Network Group

FINANCIAL REPORT

Statement of Income & Expenditure 2019-20

North and West Metropolitan Region Palliative Care Consortium
Re: Funding Agreement with the Victorian Department of Health and Human Services (DHHS) For the year ending 30 June 2020

Consortium Core Profit / Loss Statement	2019/2020	2018/2019
Balance c/f from prior year	399,253	488,833
DHHS Core Consortium	226,531	221,553
DHHS Regional Consultancy Aged / Disability	246,114	122,110
DHHS Other Regional Consulting		105,188
Other Income		125,000
Sub-total Operating Income	***472,646***	***573,851***
Total Income, including prior year balance c/f	**871,899**	**1,062,684**
Expenditure		
Salaries & on-costs	154,007	237,377
Service Delivery Enhancement Grants	629,031	338,959
Non-salary costs	49,279	87,095
Total Expenditure	**832,317**	**663,431**
Operating Surplus (Deficit)	**-359,671**	**-89,580**
C/f Surplus Total	**39,582**	**399,253**

Notes on monies carried forward	***$***	***$***
Operating surplus (deficit) for year	*-359,671*	*-89,580*
Add previous year C/f	*399,253*	*488,833*
Total Carried forward into next year (1)	***$39,582***	***$399,253***

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