ANNUAL REPORT

Eastern Metropolitan Region
Palliative Care Consortium

2017- 2018

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MESSAGE FROM THE CHAIR

Message from the Chair

On behalf of the members of the Eastern Metropolitan Region Palliative Care Consortium (EMRPCC), I am pleased to present the 2017-18 annual report.

2017-18 has been another busy year in the palliative and end of life (EOL) care space in Eastern Melbourne. A strategic planning day was conducted in October 2017 to clarify the focus of EMRPCC's work and to ensure it is consistent with the needs of the community and stakeholder organisations. Consultation was guided by Victoria's end of life and palliative care framework and confirmed the role of the EMRPCC in promoting and supporting non-specialist palliative care, as well as specialist palliative care. Engagement of all palliative care services in an open, transparent manner was considered crucial to fostering collaborative, coordinated palliative care. Consultation with executive members identified a need to focus concerted effort to engage with private hospitals to promote access to specialist palliative care services and support end of life care.

The Consortium Executive also agreed that EMRPCC would continue to lead the work exploring the role of inpatient respite care. Early findings suggest that respite care is frequently initiated when the patient is approaching the terminal phase. Additional support for carers in the home may support patients to stay longer at home and may promote deaths at home, if preferred. The EMRPCC and its stakeholders are exploring options to provide this additional support in the home.

How we care for people at the end of life has become increasingly important as the health services within the consortia gear up to respond to the voluntary assisted dying (VAD) legislation as an option for ending one's life in compliance with the new Victorian Voluntary Assisted Dying Act (2017). While not yet enacted, it is clear that not all health services in the Eastern Metropolitan Region will actively provide VAD, however, it is expected that all services will provide pathways for patients to access VAD and ongoing care and support for their clients as they deteriorate and needs escalate. The need for high quality palliative care to be visible and accessible is very important in the light of VAD. Given that psycho-spiritual and social concerns are the most frequently cited reasons for accessing VAD in other countries, there is an imperative that these aspects of palliative care are strengthened in our community.

While the EMRPCC has been working in a changing cultural environment, we have encountered our own challenges. In February 2018 our Consortium Manager, Karen Conte, reduced her hours in that role to .5 FTE. Business continued as usual with the appointment of project officer, Emily Brasacchio, who has ably updated the EMRPCC website, conducted workshops and liaised with stakeholders.

MESSAGE FROM THE CHAIR

Implementing new aspects of Victoria’s end of life and palliative care framework such as ‘embracing diversity’, continuing to promote advance care planning, educating the community and health professionals about palliative care and implementing VAD mean that the EMRPCC will continue to be challenged in the next 12 months.

While this report provides a picture of the work conducted under the umbrella of the EMRPCC, its influence and reach is much broader as the funded services work together with other organisations in the region to promote collaboration and strengthen the delivery of palliative and end of life care in the Eastern Metropolitan Region

Professor Claire Johnson
Eastern Health end of life care Clinical Lead
Vivian Bullwinkel Chair of Palliative Care Nursing

Consortium Managers Report

It has been a privilege to work with the EMRPCC for another year. The members of our consortium are dedicated and committed to providing best practice and high quality palliative care to all people residing in the Eastern Metropolitan Region.

I would like to thank the Chair of the Consortium, Dr Margaret Bird, for her support and enthusiasm for the Consortium and the role of the Consortium Manager. We have been very fortunate to welcome Professor Claire Johnson to the EMRPCC. Claire took over the Chair role in February as Margaret was heading off on sabbatical leave.

The past year has been spent consolidating links with many stakeholders across the eastern region, including Community Aged Care Service Networks, Local councils, Eastern Melbourne PHN, Aboriginal Controlled Health Organisations and Primary Care Partnerships, just to name a few. A number of activities have been undertaken throughout the year to continue to disseminate the key messages from Victoria's end of life and palliative care framework.

A lot has happened in the palliative care sector over the last twelve months with the passing of the Voluntary Assisted Dying Bill and the implementation of the Medical Treatment and Decisions Act, which commenced in March 2018.

There is much to be achieved in the future to ensure that palliative care is everyone's responsibility as stated in the end of life and palliative care framework and the Consortium is well placed to assist with the implementation of the framework as it has the opportunity to connect specialist palliative care with the wider health, aged care and disability sectors.

Karen Conte

Consortium Manager

ABOUT US

About Us

The Eastern Metropolitan Region Palliative Care Consortium is an alliance of all funded palliative care services in the region as well as a number of associate members with a specific interest in collaboration to ensure the provision of quality palliative care.

Our partnering services are:

easternhealth

ST VINCENT'S HOSPITAL
MELBOURNE

phn
EASTERN MELBOURNE
An Australian Government Initiative

epc
Palliative care. Living well every day.

BOLTON CLARKE
Be true to you

Fernlea
Caring Flexible Respite

nemics
North Eastern Melbourne Integrated Cancer Service

Our Vision:

The Consortium's aspiration is that residents of the Eastern Metropolitan Region with a life limiting condition, their families and carers have access to a high quality palliative care system that fosters innovation and provides coordinated care and support that is responsive to their needs.

Governance

The EMRPCC consists of funded palliative care providers (voting members):

- Eastern Health (EH)
- Eastern Palliative Care Assoc. Inc. (EPC)
- St Vincent's Hospital Melbourne (SVHM)

And Associate Members:

- Eastern Melbourne Primary Health Network (EMPHN)
- Fernlea House
- North Eastern Melbourne Integrated Cancer Service (NEMICS)
- Bolton Clarke

The EMRPCC is one of eight regional palliative care consortiums and is hosted by EPC. The three funded specialist palliative care services make up the Consortium Executive and oversee the implementation of the palliative care policy direction of the Department of Health and Human Services.

The Consortium has worked towards implementing Victoria's end of life and palliative care framework: a guide for high-quality end of life care for all Victorians on a regional level.

Policy priorities:

1. Person-centered services
2. Engaging communities, embracing diversity
3. People receive services that are coordinated and integrated
4. Quality end of life and palliative care is everyone's responsibility
5. Specialist palliative care is strengthened

The role of the palliative care consortia is to:

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

The EMRPCC met on six occasions during 2017 -2018. All meetings were held at EPC.

GOVERNANCE

The number of scheduled meetings held during the year ending 30 June 2018 and the number of meetings attended by each of the member agencies is set out in the table below in Table 1. Please note that the Chair changed from Margaret Bird to Claire Johnson in February 2018 due to Margaret commencing sabbatical leave.

Figure 1 Member attendance at consortium meetings

Member Agency	**Representative**	**EMRPCC**	**Executive**
St Vincent's Health	L Stewart	6/6	3/3
	M Boughey	3/6	
Eastern Health	K Marshall	1/6	
	M Bird (Chair)	3/6	2/3
	C Johnson (Chair from Feb 2018)	5/6	1/3
Eastern Palliative Care	J Moody	5/6	3/3
	K Draper	5/6	
Fernlea House	M Carr S McIvor	0/6	
RDNS/Bolton Clarke – EMR	T Easte	5/6	
North Eastern Melbourne Integrated Cancer	K Simons M Shand	5/6	
Eastern Melbourne Primary Health Network	L Paulin	4/6	
Department of Health & Human Services- Box Hill office (ex-officio)	W Molesworth	2/6	
EMRPCC – Manager	K Conte (ex officio)	6/6	3/3
Total meetings		**6**	**3**

PALLIATIVE CARE CLINICAL NETWORK

Palliative Care Clinical Network (PCCN)

The PCCN is now under the umbrella of Safer Care Victoria (SCV)

The Consortium Manager continued as a member of the PCCN during its transformation to SCV. Several members of the EMRPCC attended the PCCN Strategic Planning Day on 31 October. By December Expressions of Interest went out to become a member of the newly formed Governance Committee and the Insight (data) Group of the PCCN.

The Consortium Manager applied to become part of the Governance Committee for the newly formed PCCN and was successful in this application. In addition both Jeanette Moody (EPC) and Claire Johnson (Eastern Health/Monash, consortium chair) were successful in their applications to become part of the Insight group. Dr. Mark Boughey remains clinical lead on the PCCN.

Victoria's End of Life and Palliative Care Framework

The Department of Health and Human Services released a new policy framework for palliative care. ***Victoria's end of life and palliative care framework*** was released in July 2016.

Principles guiding this framework

Through consultation for the framework, people and organisations contributed their thoughts and ideas to the principles. This helped establish seven guiding principles that subsequently informed the vision, goals, priority areas and aims.

Dying is part of life

Dying is a normal part of life and being human, not just a biological or medical event.

The person is central to care

A person's care is tailored and holistic; their rights, values and preferences are respected and they determine their own care whenever possible.

Carers are important

Carers receive recognition, support and are valued throughout their caring experience and after a person's death.

All people have information they discuss openly

People, their carers and families have information they understand about genuine choices that they can discuss authentically with their doctor and service providers.

Decision making is legalised and respected

People's decisions that may involve substitute decision-makers, health providers, families and carers are recognised and respected in accordance with relevant legislation.

Services are high-quality and coordinated

Individuals, their carers and families receive coordinated, integrated care from skillful staff.

Care and services are monitored

Underpinning end of life care are best practice evidence, effective monitoring, evaluation of patient-centered outcomes and supporting innovation.

THE EASTERN METROPOLITAN REGION

The Eastern Metropolitan Region

DIVERSITY

The municipalities of Manningham, Monash and Whitehorse have the greatest number of people who spoke a language other than English at home in 2016 when compared to the other 4 Local Government Areas (LGAs).

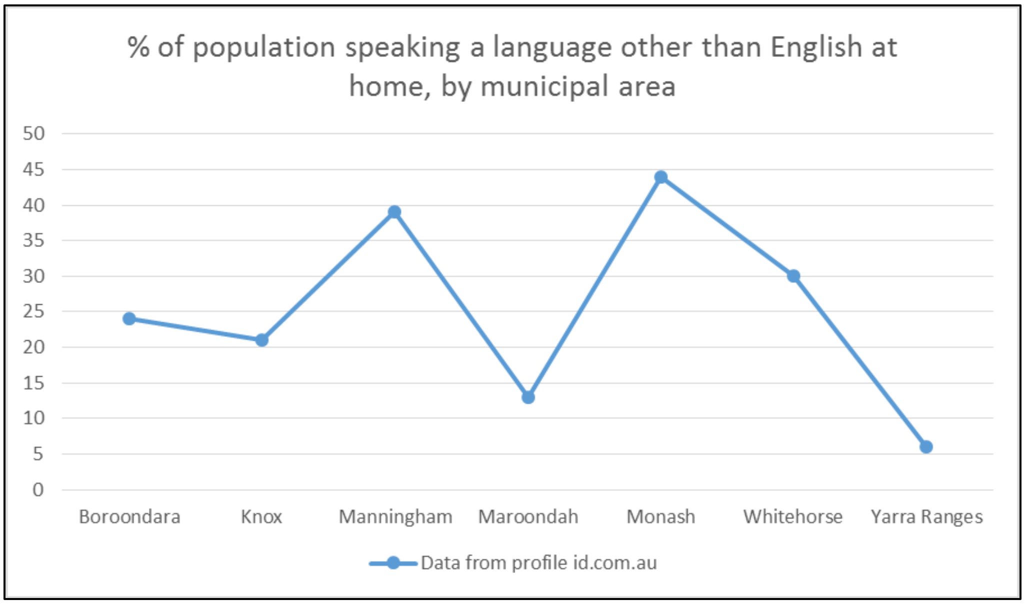
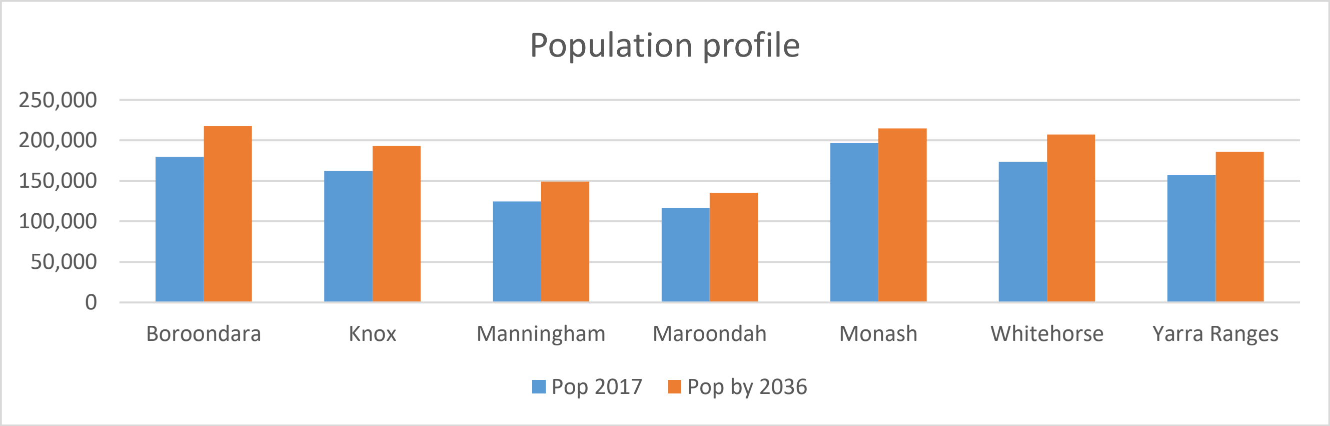


Figure 2

As the region extends from inner city suburbs to outer rural areas, the demographics vary across communities

POPULATION GROWTH

Figure 3: The current estimated population total is 1,086,201. This is expected to increase by 177,874 people over the next 19 years (2036) to 1,264,075 people.

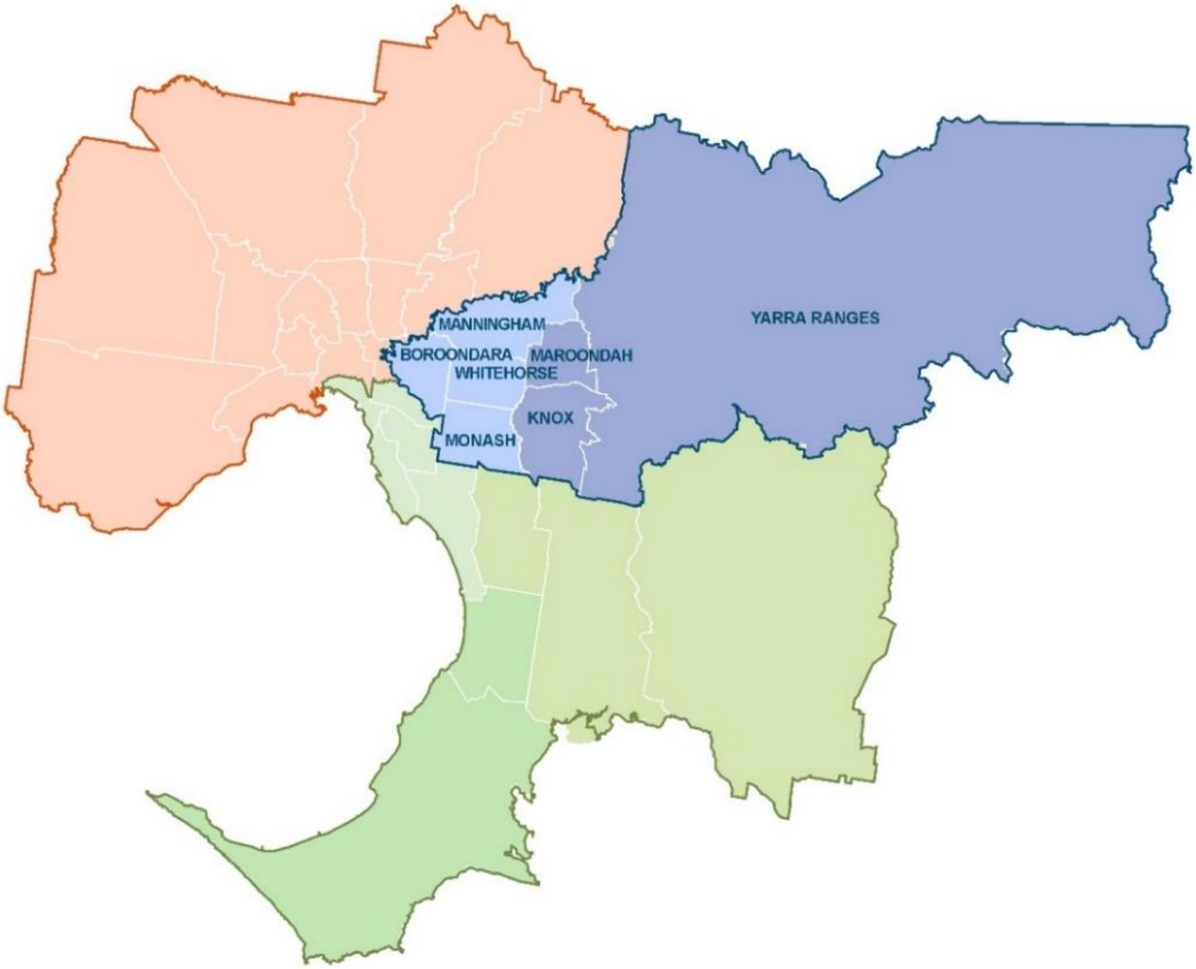


THE EASTERN METROPOLITAN REGION

REGIONAL PROFILE

The Eastern Metropolitan Region comprises seven Local Government Areas (LGAs):

Boroondara, Knox, Manningham, Maroondah, Monash, Whitehorse, Yarra Ranges



Metropolitan Regions		Eastern Metropolitan Planning Areas	
▭	Eastern Metropolitan Region	🟦	Inner East Area
▭	Northern & Western Metropolitan Region	🟪	Outer East Area
▭	Southern Metropolitan Region		

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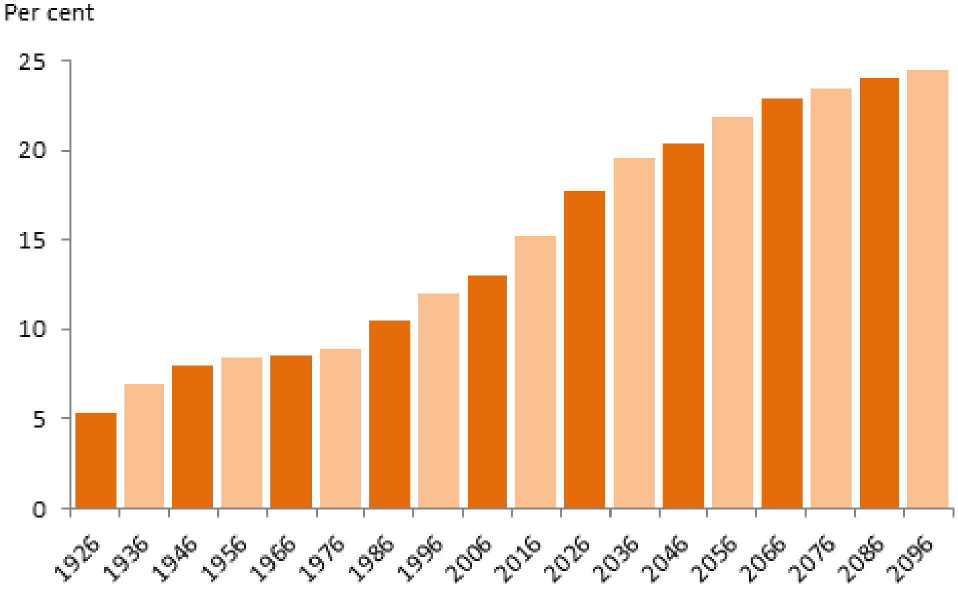
THE EASTERN METROPOLITAN REGION

POPULATION DATA

The Ageing Population

In 2016, there were 3.7 million (15%) Australians aged 65 and over-increasing from 319,000 (5%) in 1926 and 1.3 million (9%) in 1976 (Figure 4). The number and proportion of older Australians is expected to continue to grow. By 2056, it is projected there will be 8.7 million older Australians (22% of the population); by 2096, 12.8 million people (25%) will be aged 65 years and over. (ABS)

Figure 4: Australian population aged 65 and over, at 30 June, over time (per cent)



THE EASTERN METROPOLITAN REGION

More than 15 per cent of Victoria's population are older

The number of Victorians aged 65 and above is set to treble by 2058

PEOPLE AGED 65 YEARS AND OVER

At June 2014, there were 865,100 people aged 65 years and over living in Victoria, representing 15% of the population. Of these, 118,300 people (2.0% of the state's total population) were aged 85 years and over. In line with the continuing ageing of the Victorian population, the number of people aged 65 years and over grew by 18% between 2009 and 2014.

In Greater Melbourne, 14% of the population were aged 65 years and over in 2014, compared with 19% in the rest of Victoria.

Health status

In the Eastern Metropolitan Region:

- The percentage of the population aged 65 and over is expected to grow from 15.5% in 2011 to 18.4% in 2021.
- Residents of Eastern region have the highest life expectancies when compared with any other region in Victoria
- 45% of the population are overweight or obese.
- 61% of the population are non-smokers.

TOTAL DEATHS IN AUSTRALIA

Leading Causes of Death

In 2016, there were 158,504 deaths in Australia (81,867 males and 76,637 females).The leading cause of death was Ischaemic heart disease with 19,077 deaths, or 12.0% of all deaths. People who died from Ischaemic heart diseases in 2016 had a median age at death of 85.1 years. Ischaemic heart disease is a condition that affects the supply of blood to the heart, and includes acute myocardial infarction, angina and chronic ischaemic disease.

Dementia, including Alzheimer's disease, remains the second leading cause of death in 2016, with 13,126 deaths. Dementia accounted for 8.3% of all deaths in 2016, up from 5.3% of all deaths in 2007. Cerebrovascular diseases (6.6%), Cancer of the trachea, bronchus and lung (5.3%) and Chronic lower respiratory diseases (5.1%) complete the top five leading causes of death. The top five leading causes of death remain unchanged from 2015 and in total these causes accounted for more than one-third (37.3%) of all deaths registered in 2016.

While leading causes for the whole population are unchanged, there has been a change in the leading cause for females. Dementia, including Alzheimer's disease has replaced heart disease as the leading cause among women following a small decrease in heart disease numbers and a further increase in dementia numbers.

Leading Causes of Aboriginal and Torres Strait Islander Death

Measures of mortality relating to Aboriginal and Torres Strait Islander people are key inputs into the Closing the Gap strategy, led by the Council Of Australian Governments (COAG).

Analysis of Aboriginal and Torres Strait Islander deaths included in this section refers only to those that occurred in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory. Data for Victoria, Tasmania and the Australian Capital Territory are excluded in line with national reporting guidelines.

In 2015, the standardised death rate for Aboriginal and Torres Strait Islander persons was almost double that of non-Indigenous Australians (999.9 compared with 578.8 deaths per 100,000 people respectively). There were also significant differences in the leading causes of death. Causes including Intentional self-harm, Cirrhosis and other liver diseases and Land transport accidents feature prominently among leading causes of Aboriginal and Torres Strait Islander deaths. Diabetes is the second leading cause of death among Aboriginal and Torres Strait Islander people, but is ranked sixth for all Australians.

THE EASTERN METROPOLITAN REGION

Causes of death in the Eastern Metropolitan Region

Overall, people living in the Eastern Metropolitan Region (EMR) enjoy a life expectancy slightly higher than that of any other region in Victoria.

The top ranking causes of death and disability in the EMR are:

- Ischaemic heart disease, diabetes, stroke, mental illness (depression, generalised anxiety disorder, suicide and dementia), cancer (lung, prostate, colon, rectum and breast) and chronic obstructive pulmonary disease (emphysema and chronic bronchitis)

Other main causes of death and disability include:

- Asthma, road and traffic accidents, dental caries, arthritis and other mental illnesses such as schizophrenia and borderline personality disorders

Yarra Ranges has the lowest perceived health status within the EMR. It has the highest incidence of all causes of ill health and disability, communicable diseases and injuries in the EMR.
Maroondah has a relatively low health and wellbeing status and a high rate of accidents, injuries, suicide, poisonings, substance abuse and problem gambling.

Tobacco is the leading risk factor amongst males and obesity is the leading risk factor amongst females within the EMR.

Sources: ABS and profile.id.com

MOTOR NEURONE DISEASE

MOTOR NEURONE DISEASE

- **Currently in Australia there are about 2,100 people with MND – 60% male and 40% female**
- **58% are under 65 years**
- **Average length of time from diagnosis to death is 2.5 years**
- **1 in 11,500 Australians have MND**

Figure 5 People Living With MND by DHHS Palliative Care Consortium Region in 2017/2018

	BARWON SOUTH WEST	EMR	**GIPPSLAND**	**GRAMPIANS**	**HUME**	**LODDON**	**NWMR**	**SMR**	**VIC**
Number of new MND diagnoses	12 (21)	39 (29)	18 (9)	11 (9)	18 (10)	12 (13)	49 (52)	45 (51)	**204** **(194)**
No. of deaths from MND	20 (12)	32 (29)	12 (4)	7 (8)	12 (10)	8 (8)	49 (44)	38 (38)	**178** **(153)**
No. of people registered with MNDV at 30/6/2018	**34** **(42)**	86 (76)	**23** **(20)**	**17** **(13)**	**24** **(19)**	**35** **(30)**	**99** **(105)**	**100** **(94)**	**417** **(399)**

Figures in brackets are comparative numbers from the previous financial year.

The number of people diagnosed, living and dying with MND in the EMR has increased since last year.

EPC data:

1. Number of New EPC MND referrals	11
2. Number of EPC Deaths of MND clients	24
3. Number of EPC clients with MND as of 30/06/2018:	16
4. MND Top Up Funding grants total for clients	$37,000

Consortium Activities

Research

Respite admissions to specialist palliative care units - the issues for future service delivery.

Background:

Palliative care services recognise the need to support the caregivers of palliative care patients. The inpatient specialist palliative care units (PCUs) in the Eastern Metropolitan Region of Melbourne (Caritas Christi and Wantirna Health) both offer planned respite inpatient admissions, designed to provide short-term relief for carers. Increasingly, however, both services have noted requests for 'urgent respite' which does not conform to the commonly understood definition of a respite patient.

A detailed review of the literature by the Victorian State Government Department of Health and Human Services in 2015 found that respite in the palliative care setting had no clear definition, although the general consensus is that it should be a break, time-out or relief for the caregiver. It was also recognized that there is confusion regarding the use of the term 'respite' in palliative care which may more accurately indicate symptom management issues or functional deterioration with disease progression. The need for further policy development in the area of palliative care respite was recognized by the DHHS's report.

Aims:

To explore the characteristics and outcomes of the patients admitted for planned and unplanned respite care in the two PCUs in the Eastern Metropolitan Region between 1 July 2015 and 30 June 2016.

Method:

Participants were identified by referrals documenting 'respite' as a reason for the PCU admission. Patient records were retrospectively reviewed to determine the planned or unplanned nature of the admission. The data from the patient record review and symptom and functional data from Palliative Care Outcome Collaboration (PCOC) reports were used to conduct a between group comparison of characteristics and outcomes of planned and unplanned admissions (Chi square test for categorical variables and Mann-Whitney U test for continuous variables).

Ethics approval was provided by St Vincent's Health, Eastern Health and Eastern Palliative Care Human Ethics Committees.

Results:

Unplanned respite was provided to 109 patients and planned respite was provided for 56 patients during the study period. Patients admitted for unplanned respite were older (median 77 years, *IQR:*68-84 vs 71 years, *IQR:* 60-81, *p* .017), were more likely to have cancer (79% vs 65%,χ^2: 3.63 *p*.045) and had higher levels of symptom distress (i.e. an amalgamated PCOC Symptom Assessment Scores for pain, dyspnoea, nausea and constipation. Maximum score=40) (median 8; *IQR:* 4-13 vs 4; *IQR:* 2-9, *p* .006) than the planned admissions. The unplanned cohort was also more likely to die during the admission than the planned cohort (47% vs 24%; χ^2: 7.65; *p .004*).

Conclusion:

This study supports the literature in that the term ‘respite admission’ is ambiguous in clinical practice. Our results show that these admissions are being used frequently when there is disease progression and increasing care needs. Emergency ‘respite’ was strongly correlated with inpatient mortality, higher symptom severity scores and older age. Hence, the greater incidence of ‘urgent respite’ may be a reflection of the burden of symptom instability and/or pre-terminal disease being managed in the community.

Carer fatigue or the inability to cope with a palliative patient at home needs careful monitoring. The subtle increase in symptoms or disease progression can be enough to destabilise the care being provided at home. This highlights the importance of community clinicians looking behind the carer story and unmasking the need for close patient review.

Potentially, unplanned respite admissions do not prepare the family or patient for the likelihood of death, or a different preferred place of death. Symptoms of dyspnoea and delirium are known to increase the likelihood of admissions to hospitals and PCUs, as noted in our study. Although community palliative care services predominantly see cancer patients with a predictable disease trajectory, it is important to note that not all cancers follow the same trajectories. Planning for care demands a recognition of disease trajectory, prognosis and the limitations of home care.

CONSORTIUM ACTIVITIES

Death Audit – reviewing all deaths in one month from outside the PCU

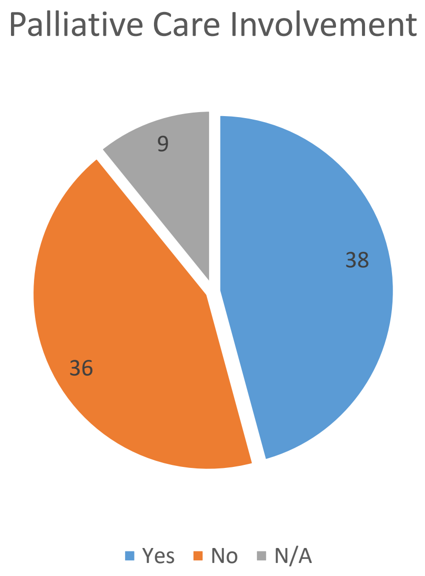
What did we audit?

- All deaths that occurred **outside PCU** at Eastern Health during October 2017
- Was the palliative care consult team involved in the care?
- Was bereavement support or information offered to the family?
- How many days elapsed between ‘diagnosis of dying’ and death?
- Was the prognosis/diagnosis of dying discussed with the family?
- Was an end of life care pathway used?
- What was the length of stay for this final admission?
- Was social and/or spiritual support offered?
- How old was the person who died?
- Was an advance care plan available?

Results:

- 72% of people were over the age of 70
- 82% of admissions were under 9 days
- 85% of patients did not have an ACP
- In 80% of deaths the prognosis/dying was discussed with the family
- In 69% of cases social work/pastoral care was offered

46% of people who died in October 2017 had an assessment attended by the palliative care consult team



- In 94% of cases there was no evidence of any bereavement support being offered or information for families about how to find support once they left the hospital

This audit will be repeated in 2018 to gauge the impact of the Victorian Care Plan for the Dying Implementation process at Eastern Health

Identifying and supporting patients with complex palliative care needs in the community with additional services from Eastern Health palliative medicine specialists

Background/rationale/literature review

It is known many people choose to receive care at home through to the end of life if support is adequate. The published Victoria government's end of life and palliative care framework aims to ensure right care in the right place, including developing new models of home based palliative care. Shared care models promoting service provision and information exchange of both specialists and general practitioners have been identified as effective in palliative care settings. Palliative medicine specialist input is beneficial for patients with complex conditions, symptoms and for advisory support for general practitioners and other specialist services. Avoidance of unnecessary hospital emergency department visits and inpatient admissions and achieving home death for those who prefers to be cared for and die at home remains important indicators for palliative care services. Additional services from palliative medicine specialists for patients in the community may help improving these outcomes and enhance integration in the existing multidisciplinary service model for the patients in the overlapping Eastern Health (EH), Eastern Palliative Care (EPC) and Eastern Melbourne PHN (EMPHN) locale.

Aim

To examine the benefits of a pilot service model providing additional services from Eastern Health palliative medicine specialists for patients in the community with complex palliative care needs in the existing multidisciplinary service model provided by EH inpatient palliative care services, EPC, EMPHN and general practitioners (GPs).

Methods

Study design

The before and after study design is used. The intervention is the provision of additional services from EH palliative medicine specialists for patients in the community over a period of

4 weeks after the patient with complex palliative care needs is discharged from EH inpatient units back into the community. The additional services will be provided by a designated EH palliative medicine specialist, who is also the research clinician, while the patient is in the community. This encompasses liaison and advisory services with all treatment teams (in particularly EPC and the GPs) and clinician initiated additional patient assessment and management through phone contacts and home visits. Unable or refusing to participate to have data collected for the research component of this project does not affect the patient's eligibility for this additional service provision.

A. Community Service Feedback – semi-structured interviews with GPs

Feedback about the service will be sought from the GPs of all patients who received additional palliative medicine specialists' service after discharge.

B. Community Service Feedback – focus group sessions with EPC multi-disciplinary team members

Feedback about the service will be sought from the EPC multi-disciplinary team members of all patients who received additional EH palliative medicine specialists' service after discharge.

This research project is still in progress and results will be available in next year's annual report.

Eastern Public Health Palliative Care (PHPC) Collaborative (La Trobe)

EMRPCC were invited to participate in a planning day to commence a collaborative process using our collective assets in the east, and to make the most of all our resources, respective networks and expertise. It was a great opportunity to meet and get to know all the key players in the area, and their planned work in public health palliative care. We spent a full day together to share plans, identify common goals and touchpoints in our work, map gaps and potentiate our outcomes. The stakeholders included:

- Palliative Care Victoria
- Yarra Ranges Council
- CHAOS (Neighbourhood House Collective)
- Eastern Melbourne Primary Health Network
- Eastern Metropolitan Region Palliative Care Consortium

CONSORTIUM ACTIVITIES

All are planning new work in public health palliative care (PHPC) and contribute different networks, expertise and assets to a potentially regional collaborative approach, and state-wide opportunities. For example, we may share the development and roll out of a PHPC (HELP) volunteer training program, and decide to set up regular collaborative meetings. All the of stakeholders are interested in the principles of the HELP framework, so that provides us with a common community development approach, but also an opportunity with the PHN to bring the local health networks together on palliative care in the community as well, and draw upon the expertise and networks of the EMRPCC

Networking Activities

Inner East Primary Care Partnership – The consortium manager attended the Service Coordination Practitioners Network meetings.

Primary Care Partnerships (PCP) are funded by the state government to support local health and community support service providers to work together to improve the health and wellbeing of the community. The Inner East PCP (IEPCP) has four local government areas within its catchment – Boroondara, Manningham, Monash and Whitehorse.

The IEPCP Service Coordination Practitioners Network (SCPN) commenced more than 10 years ago to support health and community service practitioners to implement service coordination in the IEPCP catchment. The Network currently has over 130 members from more than 45 organisations.

The Inner East PCP Service Coordination Practitioners’ Network provides health and community service practitioners with an opportunity to discuss and share best practice in the coordination of services that enhance the health, wellbeing and independence of people living in the IEPCP catchment.

The consortium manger was also a member of the IEPCP Reference Group which coordinated the SPCN. This allowed a focus on advance care planning and palliative care within several of the meetings held throughout the year. The IEPCP strategic planning forum was also attended.

The below list of regular meetings attended illustrates the reach of the consortium across the EMR:

Hospital Based Palliative Care Consultation-Team Business Meeting at Eastern Health: this meeting allowed networking with the hospital based consult team.

CONSORTIUM ACTIVITIES

Community Aged Care Service Providers Network of Whitehorse (CASPNOW)
Homestyle Aged Care Services: palliative care presentation to staff
Wantirna Health Palliative Care Journal Club
EMR Alliance meetings
NEMICS annual forum
Asia Pacific Prostate Cancer Conference – presentation: Palliative care in advanced prostate cancer. Melbourne Exhibition and Conference Centre
Advance Care Planning Special Interest Group –Executive Committee
EMR Aboriginal Health and Wellbeing Network
Palliative Care Research meeting-Wantirna Health
Eastern Disability Services Network Quarterly Forums
Eastern Melbourne Primary Health Network End of Life Care Working Party
Boorondara Aged Care Service Providers network meetings attendance and advance care planning and palliative care presentation to attendees.
Eastern Dementia Network Meeting
Outer East Aged Care Network-palliative care presentation
State-wide Palliative Care Collaboration Meeting

In addition to the above networking activities, the consortium manager based herself at sites across the EMR to increase collaboration across the three member sites. One day per week was spent at Caritas Christi in Kew, one day per week was spent at Wantirna Health in Wantirna and the remainder of the week was spent at Eastern Palliative Care in Mitcham.

CONSORTIUM ACTIVITIES

COMMUNICATION SKILLS TRAINING

Workshop – Eliciting and responding to emotional cues. Communication Skills training for staff of any discipline caring for palliative care patients was offered across the EMR utilizing the Victorian Cancer Clinicians Communication Program (VCCCP) developed by Cancer Council Victoria.

Seminar – Communication Skills training based on the SMRPCC Palliative Care Conversations Program was offered to any health professional working within the EMR and was aimed at non-specialist palliative care staff.

	Date	Venue	Number of participants	Disciplines attending	Organisations represented
Workshop VCCCP	August 21, 2017	Eastern Palliative Care	Four	Registered nurses x2 Advanced trainee doctors x2	Eastern Health x3 EPC x 1
Seminar	November 22, 2017	Eastern Palliative Care	Forty	Various health disciplines	Community health, aged care, acute hospitals, Aboriginal health service, Local councils

Comments from participants of the seminar:

What is your key take-home message from today's program?

Not to be afraid of the 'D' word

Be more in tune with where patient is at with their prognosis and acceptance

Palliative care is not as scary as I believed before this training. It is really about human contact, caring, empathy and providing support.

Allow more time to answer. Open and closed questions.

Be more sensitive and caring for patients of palliative care needs

Listen to patient before asking too many questions. More confident to discuss options to patients and family.

Confidence

Communication, listening are key to PC conversation

Early palliative care conversations can make later conversations easier

Don’t be afraid to be honest and frank with words/actions of dying

Good to learn about communication skills and how to prepare and have meaningful and informative conversations

Planning communication and having the communication skills using ‘PREPARED’

CONSORTIUM ACTIVITIES

PALLIATIVE CARE FORUMS

Palliative Care Forums were targeted at health professionals working across all sectors including health, aged care and disability. Two forums were conducted and were kindly sponsored by PEPA. The forums were conducted in September 2017 and June 2018 and were organized by the Consortium Manger and project officer. These days would not be possible without the assistance and support provided by volunteers offered through Eastern Palliative Care- assisting with registrations, afternoon tea and packing up. A very big thankyou to these volunteers; Laura Chandler, Lisa Martin and Angelia Reidy, and to the fabulous speakers listed below who volunteered their time to prepare and present at the forums. It was a great opportunity to showcase our talented staff and spread some important messages about palliative care to our colleagues from many different sectors.

Emotional Support in Palliative Care Forum- September 2017
Speakers & Topics
Held at Wantirna Health

Alison Mapleson
Music Therapist,
Eastern Palliaitve Care

Gillian Jackson
Remedial Massage Therapist
specialising in Palliative Care Massage,
Eastern Palliative Care

Libby Byrne
PhD, LecturerAssociate Lecturer
Master of Art Therapy
Department of Public Health
School of Psychology and Public Health

Kathryn Bennett &
Annabel Bakes
Nurse Practitioner-Palliative Care and
Family Support Worker,
Eastern Palliative Care

Carol Pyke
Victorian Manager, PEPA
PEPA clinical placements

Evaluation:

There were 80 registrations for the forum with 65 attending on the day.

An evaluation survey was developed and distributed via Survey Monkey with a 53.8% response rate.

The session was rated very highly and 100 % of respondents said they would recommend future forums to their colleagues.

Participants were asked for their three **take home messages** from attending this forum:

"Importance of effective communication, support for families and carers, holistic care for every individual and respect their wishes, do not prejudge."

"There are lots of supports for patients and carers. Consider the benefits of complementary therapies. Ask for help when you need it."

"Use of music, creative arts and pets for people in palliative care."

Who attended the forum?

24 attendees answered this question:

Nurses	7
Client Advisor	2
Social Worker	2
Pastoral Care/ Spiritual Care Worker	10
Home Support Assessor	2
Other	2

CONSORTIUM ACTIVITIES

Grief and Bereavement Forum -June 2018 – Speakers & Topics Held at Eastern Palliative Care

Christine Oosthuizen
Senior Bereavement
Family Support Worker,
Eastern Palliative Care

Hayley Russell
Bereavement Family Support Worker,
Eastern Palliaitve Care

Megan McLean
Bereaved Carer

Evaluation:

There were 80 registrations for the forum with 54 attending on the day.

An evaluation survey was developed and distributed via Survey Monkey with a 51.8% response rate.

Majority of participants rated highly the presentation of a bereaved carer and 60.7 % of respondents said they would recommend future forums to their colleagues.

Below are some of the comments and feedback received from participants who attended the forum:

“The presentation by the carer was the most interesting / useful part of the session for me. It was interesting to hear from a carer what service providers can do to enhance carers' experience.”

CONSORTIUM ACTIVITIES

“A very valuable, concise and well-presented session. I would highly recommend to my colleagues to attend in the future.”

“Fantastic session - very informative, great to hear some of the newer models of grief, helpful to hear from a carer's perspective. Thanks for arranging.”

Organisations represented at the forums:

Benetas	*Mecwa Care*
BlueCross	*North Richmond community health*
Boroondara Council	*Peter James Centre*
Brotherhood of St Lawrence	*Pronia*
Call on Clare	*St Vincent’s Private Hospital*
EACH	*St Vincent Health*
Eastern Health	*The Haven*
Home Instead Senior Care	*Villa Maria Catholic Homes*

EMRPCC Strategic Planning Forum

The consortium held a half day forum with all members of the consortium plus relevant other stakeholders to identify the way forward for the consortium over the next two years on a background of uncertainty around the future of the consortium. This planning forum confirmed the direction to be taken whilst awaiting the review from DHHS.

The forum was facilitated by an external facilitaor.

CONSORTIUM ACTIVITIES

Presentations to inform the planning forum and to avoid duplication included the End of Life working party from the Eastern Melbourne Primary Health Network and recent work undertaken by the EMRPCC.

The forum participants then explored what the consortium had achieved and done well as well as anything that the consortium could have done but hadn't. The group then discussed what the value add of the consortium was and what its role should be in the future and given limited resources - DHHS funds manager salary only - what can the consortium realistically do in the next two years to fulfil that role?

The group identified gaps and priorities being mindful of work being done by the PHN

Knox Active Ageing Expo 2018

The Consortium was successful in being selected to exhibit at the Knox Ageing Expo 2018- held on Wednesday 30th May at Knox Civic Centre, from 10.00 am to 4.00 pm. The purpose of the Knox Active Ageing Expo was to inform, educate and also provided an opportunity for community members to learn about all aspects of Active Ageing. The day included a combination of exhibitor stands and information sessions. The Expo consisted of 40 stallholders from the local area with a focus on promotion of active ageing, social inclusion and participation, having equal access to all seniors.

The Consortium Manager and project officer had written information available with a focus on advance care planning and were available to answer general questions around this and other end of life care topics. The Consortium's stall was themed around "Things to do before you kick the bucket", asking participants to offer a desired wish or activity they would want to complete before they "kicked the bucket", in exchange for entering a free raffle and also receiving a consortium logoed cupcake. The raffle prize was kindly donated by Basile Imports, in Bayswater and assisted in attracting a large number of community members to the stall.

Some of the comments or wishes that attendees offered for the Bucket List board were:

- Tandem Skydive
- Ride in a Helicopter
- Learn Aboriginal words
- To be able to keep up with Grandkids
- Live long and happy
- Visit the pyramids
- To write my life story
- To see the Barrier Reef with my husband

Advance Care Planning Education

As a result of the new legislation affecting advance care planning in Victoria - Medical Treatment Planning and Decision Act 2016, the Consortium assisted in disseminating these new changes through presenting at various local special interest group meetings such as Outer East Aged Care Network and also an education workshop with local home care providers and their staff, such as Home Instead.

In addition EMRPCC held a free forum on the Medical Treatment Planning and Decisions Act 2016 featuring a guest speaker from the Office of the Public Advocate; Claire McNamara, Legal Officer to present to health professionals across the EMR in December 2017. 27 staff registered for the event.

Newsletter

The EMRPCC e-newsletter went out monthly. The target audience was primarily the non-specialist palliative care health professional working anywhere across the EMR. The newsletter was distributed to 241 subscribers each month. Figure 6 shows the percentage of subscribers that opened and clicked through to the newsletter.

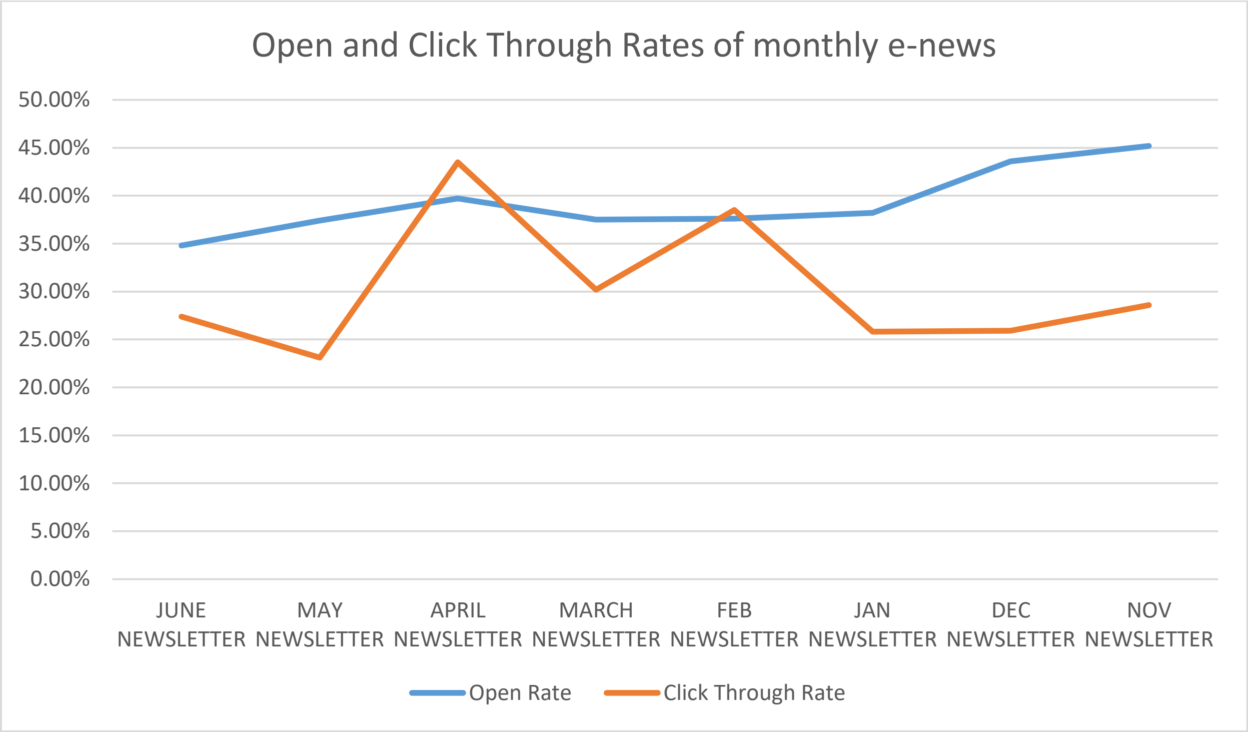


Figure 6 Monthly newsletter statistics

Dying To Know Day 2017

The EMRPCC hosted a Dying to Know Day event in the foyer of Wantirna Health. The event was kindly supported by Heritage & Heritage Funerals which allowed us to offer a free coffee from the café to visitors who came to our information stalls to chat about death & dying. We were also able to purchase resources for the day from The Groundswell Project which instigated these events.

It was a very successful day with over 50 visitors to our stall. They were able to collect resources and talk to experts in advance care planning, palliative care, funeral planning and grief and bereavement.

The consortium is very grateful to the following helpers on the day who included:

Margaret Watkinson	Volunteer	EPC
Maree Pane	Volunteer	EPC
Carol Russell	Funeral Director	Heritage & Heritage Funerals
Fiona McLeod	HARP NP	Eastern Health
Sam Brean	ACP clinical lead	Eastern Health
Laura Chandler	Volunteer	EPC
Pamela	Registered Nurse	Fernlea House
Lynne	Enrolled nurse	Fernlea House
Leonie	Volunteer Coordinator	Fernlea House
Wendy Miles	Community Engagement Manager	Home Instead Senior Care
Karen Philippzig	Coordinator	Compassionate Friends Victoria
Sue Stebbins	Volunteer	Compassionate Friends Victoria
Jo Wade	Volunteer	Compassionate Friends Victoria
Andrew Weatherhead	Volunteer	Compassionate Friends Victoria

Palliative Care Education Scholarship Program

The EMRPCC was pleased to offer scholarships for attendance at a palliative care course or study day for non-specialist palliative care health workers across the Eastern Metropolitan Region (EMR) kindly supported by PEPA.

If staff worked in any health related field within the EMR, they were eligible to apply. They could apply to attend courses available within the region or a relevant course being held anywhere in Victoria.

There were six scholarships available each valued at up to $500.

We know that many people require a palliative approach to their care and may not necessarily need to be referred to a specialist palliative service. These scholarships aimed to encourage health workers working outside the specialty of palliative care to increase their knowledge and skills to take back to their workplace.

The participants needed to commit to the following scholarship components:

- If being considered for acceptance of a scholarship, the participant was required to successfully complete the free online training: ‘Palliative Care: Getting Started’ or similar depending on their discipline. The certificate of completion was submitted to the Consortium Manager prior to final scholarship approval.

- The participant then attended the approved course and provided their certificate of attendance to the Consortium Manager.

- The participant then needed to commit to arranging a clinical placement via PEPA. This placement into a palliative care service within the EMR was included to consolidate their learning and provide vital connections with specialist staff in the EMR.

Figure 7 below shows the information about the participants including their discipline and the course completed through the scholarship program.

Applicants n=8

Discipline	Sector	Online course completed	Course requested	PEPA application completed
RN	Acute	√	CPC Masterclass- Care of the imminently dying- completed	√
RN	RACF	√	Banksia -Palliative Care Resource Nurse course- August 9- completed	√
RN	RACF	√	EPC short course	x
RN	RACF	√	Introduction to palliative care for registered nurses- EPC	√
RN	Bolton Clarke	√	Introduction to palliative care for registered nurses- EPC	√
Lifestyle coordinator	RACF	x	Banksia-Palliative Care Essentials-	√
EEN	Community care	√	Introduction to palliative care for registered nurses- EPC	√
PCA	Community care	√	Intro to palliative care for PCAs EPC	√

Figure 7 Scholarship participants

CONSORTIUM ACTIVITIES

The DHHS Client Experience Survey Reference Group

The consortium manager and the EPC CEO were part of the DHHS reference group to assist in the development of the new Client Experience survey.

DHHS contracted Ipsos Social Research Institute (Ipsos) to assist with the development of palliative care client and carer experience questions.
These questions were incorporated into the department's Victorian Health Experience Survey (VHES) as an annual module (survey).

A sector reference group was established to advise on question development across multiple care settings.

Ipsos conducted a literature review and an environmental scan of palliative care/end of life research and survey tools.
Survey domains and groups were identified and agreed by the reference group.
Five survey instruments were identified:
– In-home (community) client survey
– In-home (community) carer survey
– Hospital (inpatient) client survey
– Hospital (inpatient) carer survey
– Bereaved carer survey
Experience questions were formulated by Ipsos based on literature review/environmental scan finding and other survey instruments

- Questions were presented, debated and refined with the reference group
- Ethics approval granted for cognitive testing process with clients, carers and bereaved carers
- Cognitive testing was completed in February 2018; final report was delivered to VAHI in late March 2018
- VAHI and the department met to finalise the cognitive testing report on 30 April 2018

CONSORTIUM ACTIVITIES

PALLIATIVE CARE CONVERSATIONS JOURNAL CLUB

A monthly journal club (supported by PEPA and Menarini Australia) was commenced this year. This group of health professionals comes together once per month from a variety of health settings across the EMR. An article relevant to palliative care is circulated and discussed each month.

The journal club is based on the following definition of evidence based practice: “the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating induvial clinical expertise with the best available clinical evidence from systematic research” (Sackett et al, 1996)

The aim is to engage health professionals from non-specialist palliative care (primary palliative care) settings in thinking about how good palliative care can be achieved in a variety of different settings. High quality palliative care is increasingly recognized as essential for seriously ill patients, caregivers, and the health care system. The core work of palliative care, a collaborative team-based approach for improving the quality of life of all patients with serious illness, drives better performance in the elements of improving patient experience and population health, while addressing clinician experience and resource use. Additionally, it is becoming increasingly clear that delivery of high quality palliative care is the responsibility of all clinicians.

Reviewing articles and discussing how the subject matter could be translated into their own organisation, helps the participants to keep palliative and end of life care at the front of their mind and take back the issues raised to their colleagues to discuss potential systems changes to improve the delivery of end of life care.

The following articles have been discussed this year:

- Care of dying adults in the last days of life
- Patient values informing medical treatment: a pilot community and advance care planning survey
- A Literature Review of Western Bereavement Theory: From Decathecting to Continuing Bonds
- Current Best Practices for Sexual and Gender Minorities in Hospice and Palliative Care Settings
- End-of-life decision making by family caregivers of persons with advanced dementia: A literature review of decision aids
- Views on cardiopulmonary resuscitation among older Australians in care: A cross-sectional survey
- Communicating with children when a parent is dying

CONSORTIUM MEMBER ACTIVITIES

Consortium Member Activities

EASTERN HEALTH

Eastern Health Supportive and Palliative Care Service

Eastern Health's Supportive and Palliative Care services support patients and their families across the spectrum of End of Life care. A 32 bed inpatient Specialist Palliative Care Unit, located at Wantirna Health, provided interdisciplinary care for 748 patients in 2017/18. A further 2145 patients were referred to the Hospital Based Palliative Care Consultancy Service (HBPCCS) from general services throughout Eastern Health.

In response to Eastern Health's End of Life Care Expert Advisory Committee's (EAC) development of an End of Life Care Standard to guide the provision of end of life care throughout the health service that is consistent with the National Consensus Statement and the Victorian End of Life and Palliative Care Framework, an extensive education program was initiated and supported by the EAC and the HBPCCS. More than 76 education sessions were conducted throughout Eastern Health to introduce the Standard and the new Care Plan for the Dying Person-Victoria. Ongoing work will support inpatient units embed these tools in the care of all people who die within Eastern Health and an annual audit will be conducted to evaluate their effectiveness in promoting the best possible end of life care.

Eastern Health has worked to build on the Memorandum of Understanding signed with EPC in 2016/17, with a collaborative research project to support patients to fulfil their wish to die at home. Selected patients were discharged from Wantirna Health with enhanced palliative medicine input, in conjunction with support from EPC and the patients' GP. This project has seen an increased rate of home deaths in the last 12 months for people with complex symptoms and has been well received by patients, their families and GPs providing their medical care. Final analysis of data from this project is in-progress.

CONSORTIUM MEMBER ACTIVITIES

EASTERN PALLIATIVE CARE

EPC has had a very busy year with client number up 10% and referrals up 7%. In total we had 2336 people referred to EPC and 1418 new clients admitted to the program. With around 450 client on the book at any one time this total 1868 clients over the 12 months. When you add at least one carer per client you can see how the number of people we care for escalates.

EPC continues to be actively involved with the Consortia as the fund holder and employing agency.

Palliative Support Nurse / Disability Services Report

In May 2017 the Aged Care / Disability Care (ACDC) team was created. The team consists of the existing Palliative Support Nurse and two Registered Nurses operating Monday to Friday for 7 hours per day. The ACDC team also has the support of a Family Support Worker (FSW) five shifts per fortnight. The Palliative Support Nurse role was a pre-existing role, which has now been integrated into the ACDC team.

The team manages:

- Their own Intake calls, client assessment and follow up for some clients who are either terminal of only need a short tern=m on our program
- Support with managing Advanced Care Planning and Medical Power Of Attorney. The team also organise, facilitate and attend family meetings where appropriate.
- Offers advice and support to GPs in managing their palliative clients as required.
- Provide education and mentoring to staff in residential care facilities.

Their aim is to prevent unnecessary hospital admissions, and to support staff in providing optimal palliative care for residents at the end of life. Goals of care are tailored to the individual and their family, respecting each client's wishes and care needs.

Aboriginal and Torres Strait Islander (ATSI) clients

EPC has provided care to 8 people who have identified as of either Aboriginal or Torres Strait Islander descent. One of these clients was cared for by the Central Team, one client was cared for by the Inner team and the remaining 6 clients were cared for by the Outer Team. Two clients were discharged from the program, one client remains on the program and five clients have died on the program.

EPC continues to promote palliative care to clinicians in the Eastern Metropolitan region. The Manager of Nursing and Medical services attends the Aboriginal Health and Wellbeing Network meeting quarterly. This meeting is attended by clinicians from community health, Aboriginal services, council, aged care and other relevant clinicians. EPC hosts this meeting annually.

CONSORTIUM MEMBER ACTIVITIES

EASTERN MELBOURNE PHN

EMPHCC End of Life Care Working Group

Eastern Melbourne PHN, through its involvement with the Eastern Melbourne Primary Health Care Collaborative, has established an End of Life Care working group, which includes the EMPHCC and other hospital, primary care and consumer representatives. The group meets regularly and is working to establish projects to fill gaps in the system with the goal of increasing the number of people who are able to die in their place of choice.

HealthPathways

HealthPathways Melbourne is a website developed for General Practice to be used at point of care with the aim to assist health professionals to appropriately assess, manage and refer patients to secondary, tertiary and community health services. It aims to promote better health outcomes for local patients by improving access to the right care, in the right place at the right time. Palliative related pages include palliative care, caring for dying patient at home and in a RACF, certification of death, emergencies in palliative care, new palliative care patient, pain management and pain medications, symptom control, terminal phase management, GP palliative care resources and referral to palliative care services.

Greater Choices for At Home Palliative Care

Eastern Melbourne PHN is one of 12 Primary Health Networks to receive funding under the Greater Choice for At Home Palliative Care measure. Using a Compassionate Communities approach, it aims to improve current services to allow people to die in their place of choice. This two and a half year project provides two full time equivalent staff at the PHN to participate in activities to strengthen integration across the palliative care sector.

ST VINCENT’S HEALTH

National Palliative Care Week activities

In May 2018, EPC held a session “Discussing Deterioration & Dying with Families”. Two speakers Tricia Delaney, Family Support Worker and Lee-Anne Henley, Palliative Support Nurse discussed in detail how to have conversations with families who had relatives approaching end of life in Aged Care Facilities. Topics centred on communication skills, trajectories in palliative approach, key stages to have conversations, how to hold a family meeting, explaining to families the changes in nutrition, hydration and respiratory patterns, describing how pain is managed and the myths of Morphine. Discussion also focussed on how to answer the question families often ask “How long does she/he have?” More than 30 Aged Care managers and registered nurses attended with very positive feedback.

After Hours Report

The relationship between EPC and Caritas Christi remains strong with Caritas staff as a key assistance to clients of EPC who call overnight.

In total 2737 calls were made to Triage which is an average of 228 calls per month. The busiest month was April at 268 calls and with quietest month being January with 189 calls.

Calls came mainly from a Partner (38%) or a son or daughter (36%). The times of calls varied but most (49%) of calls were received between 5 PM and 9 PM.

Figure 8 Twelve percent of all calls needed a visit to visit and the reasons were:

Death	29%
General Deterioration	10%
Injection	17%
Other symptoms	3%
Uncontrolled symptoms	40%

SVHM Palliative Care Services 2017/2018

Palliative Care Services at SVHM provides inpatient beds at Caritas Christi Hospice (CCH) Kew and at Fitzroy to patients in the terminal phase of care, requiring symptom control or respite. Coupled with this is the palliative care consultancy which provides service across all of SVHM and St Vincent’s Private, palliative care medical clinics at Fitzroy, two day a week day respite program at CCH, after hours telephone triage service to community palliative care clients, and VMO clinics and telephone support to the Hume Region.

End of Life Care

The End of Life Care (EoLC) working group at SVHM is an organization wide representative committee. The main achievements have included developing an EoLC policy and framework for SVHM within the context of the Department of Health definitions and informed by the Australian Commission on Safety and Quality in Healthcare’s Essential Elements for Safe and High-Quality End-of-Life care (Consensus Statement), and now the new accreditation standards. A major piece of work has been the governance around and implementation of the

Care Plan for the Dying Person – Victoria (DHHS endorsed) to ensure all those dying at SVHM consistently receive the best care possible. Implementation is progressing well (will be complete by end of 2018) and we are working to evaluate and monitor the implementation to ensure the tool is maximally effective and maintained by engaging staff and embedding it in morbidity and mortality practice.

Advance Care Planning

The approach to ACP at SVHM is in line with DHHS strategy whereby it is everyone's responsibility. The new legislation supports this, by making all APHRA registered clinicians accountable to make reasonable efforts to find out if patients have an Advance Care Directive (ACD). The ACP approach among many Victorian hospitals which SVHM have adopted is:

A Appoint a Medical Treatment Decision Maker

C Chat and Communicate.

P Put it on Paper

Since the introduction of Advance Care Planning at SVHM, there has been an significant increase of documented Advance Care Plans/Directives (ACPs) in Medical Records Online (MRO) from 2014 (pre-implementation) to 2017 (third year of implementation).

We acknowledge that developing one's ACP can take time and involve multiple conversations, so the ACP discussion record was developed, which is an e-blog style form located in the legal tab of MRO. This allows patients to have their values recorded centrally – a one stop shop. This record of conversations and progression of conversations is a vital component.

The graph below demonstrates a program such as ACP takes time to grow. For 2017 there were 526 ACPs and 228 ACP discussion records in our medical record, marked increases on the previous year.

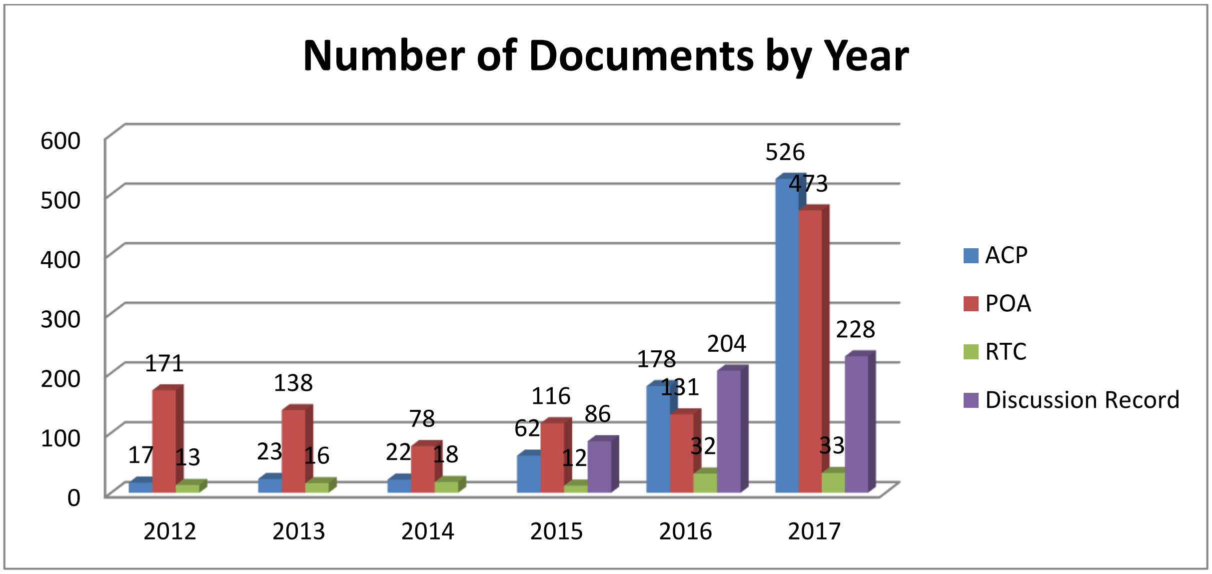


Figure 9

The Advance Care Planning program continues to develop resources for staff and patients, with all resources recently being reviewed earlier this year with the introduction of the *Medical Treatment Planning and Decisions Act 2016*.

After Hours Support

2017-218 After Hours Report

Eastern Palliative Care Association Incorporated (EPC) and Caritas Christi Hospice (CCH), Kew, developed a specialist After Hours Triage support model in the 1990's. Through continuous refinement, review and development this is now a very supportive and well run model with excellent client/carer satisfaction.

The service is provided by SVHM and now covers 4 regions of Victoria encompassing rural, regional and metropolitan services, receiving at total of 4647 calls for the year with 98% call received within 15 minutes.

EPC clients and carers are provided with an After Hours phone number which connects them to Caritas Christi inpatient palliative care unit. The senior nurses (Triage Nurses) at Caritas Christi receive and respond to calls backed up by access to the client's electronic medical record. The Triage Nurse adds to the record when phone calls are received providing integrated support to the client and carer. The Triage Nurses at Caritas Christi are very experienced in supporting clients and carers on the phone and have available a number of agreed protocols and procedures to follow. They also have access to telephone interpreters when required.

In the Eastern Region this is backed up with on call specialist palliative care nurses employed by EPC who will visit clients in their homes, out of hours, if the issue cannot be resolved over the phone. In the past 12 months 1505 calls were received by the Triage Service for clients on the Eastern Palliative Care program of which 19% of calls required a nurse to visit. All calls to the Triage Nurse are followed up next day by Eastern Palliative Care nurses.

Generally, there are multiple issues when clients and families ring the Triage Nurse. Most times there will be a combination of advice given, medication instruction/advice, education or a request for specific follow up the next day. Where symptoms are complicated the Triage Nurse may ring the EPC Nurse who will in turn contact either the GP or the EPC Doctor on call. Contact with medical practitioners usually occurs while the nurse is in the home supporting the client.

Triage Impacts

The purpose of the Triage Nurses and On Call Nurses are:

- To provide a 24-hour response to clients and carers
- To answer questions that arise outside business hours for clients of EPC
- To explain medications, particularly when medications have changed or symptoms have changed
- To support clients and their carers as symptoms progress/change or there is general deterioration
- To advise on unexpected medial issues that arise

The Triage Service is designed to prevent clients and carers from calling an ambulance or attending a hospital emergency department where they may or may not be known. It also provides education and support.

Data analysis

A total of 1505 calls were received by the After Hours Triage Service for EPC clients from the 1st of July 2017 to the 30th June 2018, out of which of 99% of calls were answered within 15 minutes (Table 9) There may be multiple phone calls required to be made to resolve the initiating call which resulted in 2732 calls being made over the year, (*Table 9)* equaling 28250 minutes. The median duration of a call was 19 minutes (*Table 9*).

A total of 19% of calls required a nurse to visit (*Table 9*).

The majority of calls were related to uncontrolled symptoms, followed by death of a client.

Further to this, a small proportion of clients 7% are required to attend the **Emergency Department** (*Table 9*). The main reasons for an emergency department attendance were symptoms not able to be managed in the home and family /client preference.

Figure 10: Data Analysis

1 July 2017 to 30 June 2018	Year to date
% calls answered within 15 mins	99%
Total no phone calls to complete episodes	2732
Mean length of episodes	19 mins
% of episodes with ambulance+/- ED recommendation	7%
% of AH nurse call outs	19 %

Sixty two percent of calls occurred between the hours of 5 PM and midnight. This is down from 75% in the previous year.

The main reasons for a **nursing visit** include:

- Client death, verification of the death and support for the family
- Uncontrolled symptoms: for example the client has taken several oral doses of "breakthrough" analgesic or anti-nausea medication with little relief of symptoms
- To administer an injection or commence a s/c device: for example, a syringe driver
- Client deterioration and family request a visit

Bolton Clarke

In 2018 Bolton Clarke expanded their service offerings and their footprint, providing more services for more people in more places. They are building on the heritage, legacy and long held values that support growth, innovation and expansion for the benefit of those they serve.

They are an organisation built on more than 200 years of shared experience helping people live enriched and fulfilled lives – they are one of Australia's most experienced providers of independent living services, including specialist nursing services that meet the changing needs of our diverse client base at home and in their retirement living and residential communities.

Bolton Clarke is a forward thinking social enterprise enabling people to live a life of fulfilment with tailored, integrated quality of life solutions. They are committed to delivering a comprehensive service continuum that promotes personal choice, genuine health, wellbeing and care leadership. Working within the communities they serve and maintaining local autonomy within the organization provides programs and services which are aligned to local need.

FERNLEA

Fernlea Community Care Inc is a not-for-profit community-based organisation, serving the eastern and southern regions of Melbourne. They provide centre-based day respite in Emerald and Berwick, for people with a life-limiting illness, chronic condition or dementia, as well as an in-home care service that supports people to stay independent in their own homes for longer. They also have an op shop that helps raise money for our community work that is not funded.

Over the past year, they have been working to expand the continuum of services they provide, from diagnosis to end of life. This year, they were fortunate to receive a state government grant to develop end of life services. They are now working on developing those services, which will include a carer support group, a memoirs program and trained volunteers who will go into people’s homes at the very end stages of life, to provide respite and support. They will also develop some resources that will help open up the public conversation about death and dying.

PEPA in the Eastern Metropolitan Region

In December 2017 a new contract was established for delivery of the Commonwealth funded Program of Experience in the Palliative Approach (PEPA) program in Victoria for 2017-20. The Centre for Palliative Care manages the Victorian PEPA contract. This works well as both PEPA and CPC are able to benefit from the experience of the team in delivering various palliative care education programs.

Carol Pyke returned to her role with the Department of Health and Human Services in mid-2017. Tracey Mander commenced as the PEPA Victoria manager in December 2017.

Due to the new PEPA contract commencing late in 2017, many Victorian workshops and placements are weighted towards the end of 2018.

The following PEPA workshops were completed in the EMR during the 2017-18 year:

Workshop	Venue	Date	Number of attendees
Palliative Approach in Aged Care	St. Vincent's Health	6th June 2018	17

The following workshops are planned in the EMR for the remainder of 2018:

Workshop	Venue	Date
Palliative Approach – Indigenous Perspectives	Mary McKillop Heritage Centre, East Melbourne	17th July 2018
Palliative Approach – Culturally Responsive Palliative Care	Eastern Palliative Care, Mitcham	25th July 2018
PEPA Mentor Workshop	Mary McKillop Heritage Centre, East Melbourne	25th July 2018
Keeping Contemporary in Palliative Care - Post PEPA Placement Workshop	Karralyka, Ringwood East	22nd August 2018

A total of 8 PEPA placements occurred across the EMR during 2017-18 year:

- Registered Nurses: 2
- Personal Care Attendant: 1
- Psychologist: 2
- Social Workers: 2
- General Practitioner: 1

EMRPCC Website Activity 2017/2018

The website contains relevant and up to date information for specialist palliative care and non-specialist services and service users. As can be seen by the comparisons in the tables below, there has been a steady increase in visits to the EMRPCC website compared to the previous financial year.

Figure 11 July –December 2016

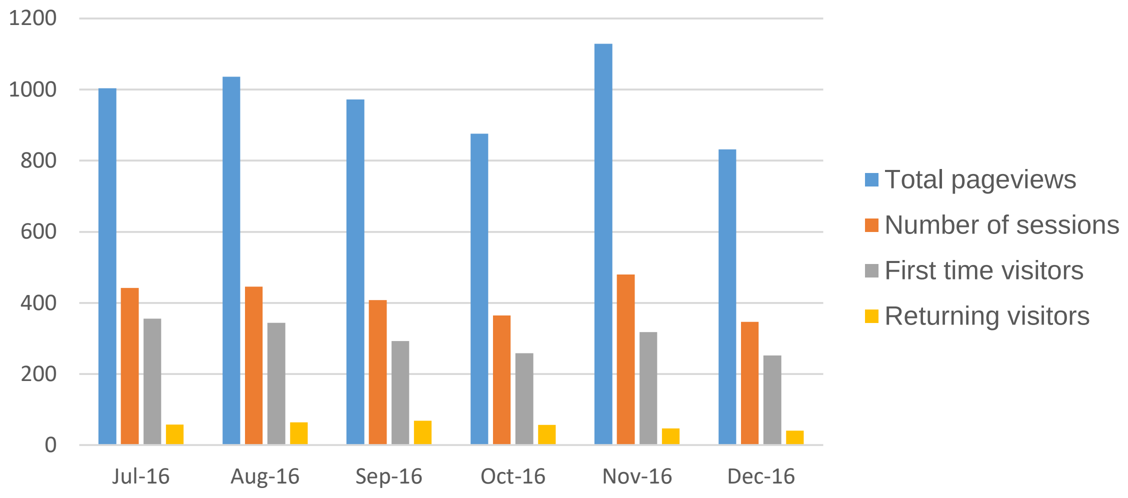


Figure 12 January-June 2017

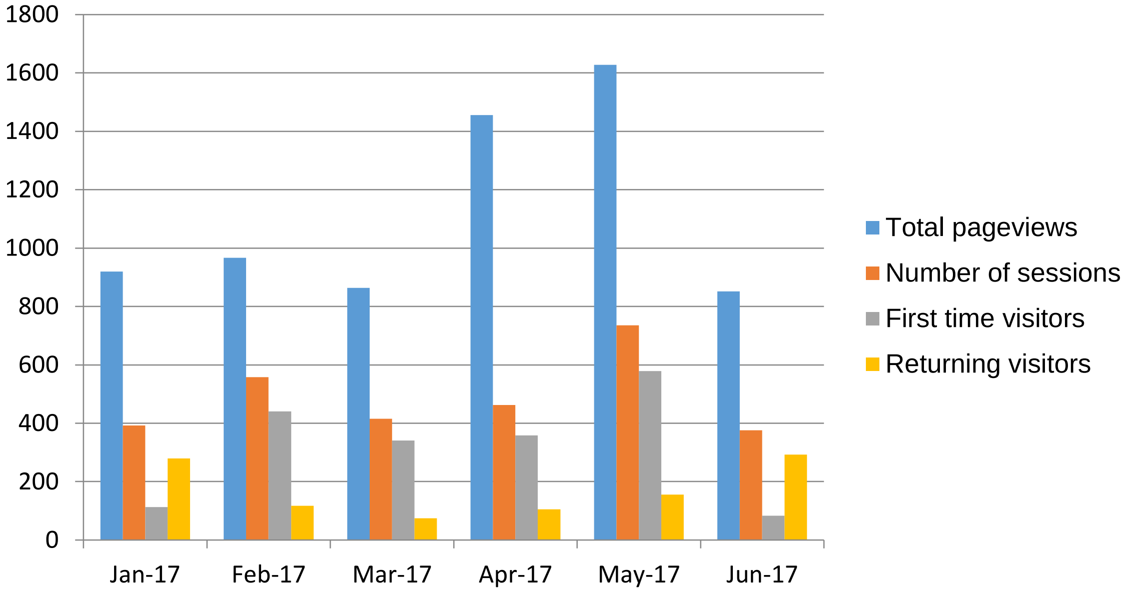


Figure 13 July- December 2017

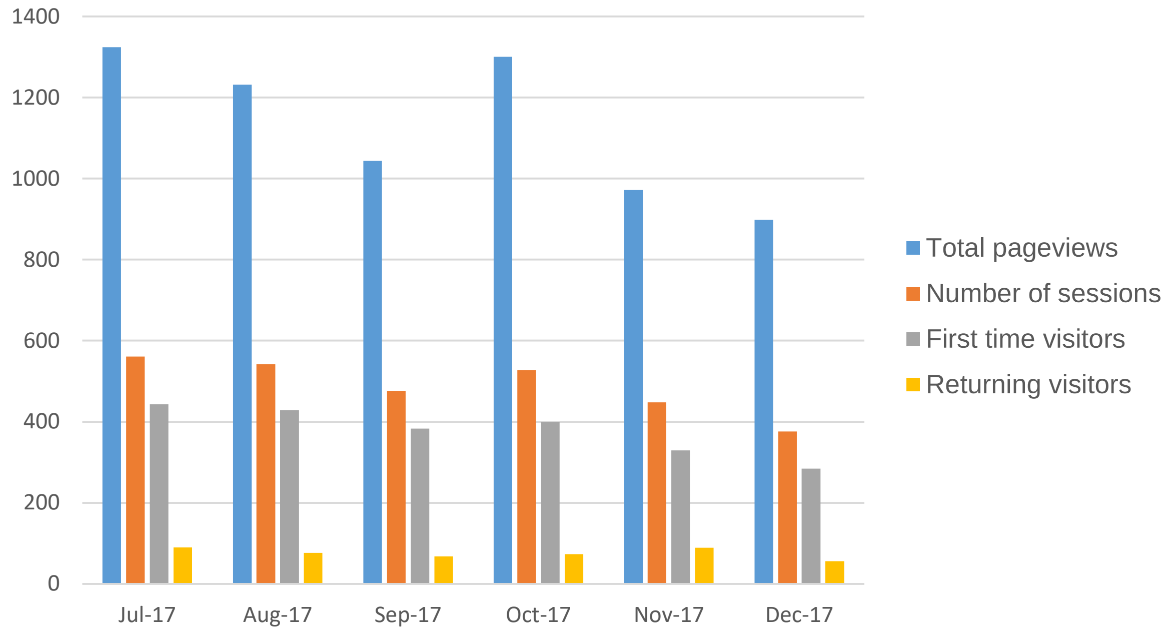


Figure 14 January-June 2018