

**Grampians Region
Palliative Care Plan
2004-2009**

Final report

prepared for

**Grampians Region Palliative Care
Consortium**

by

Atkinson Kerr and Associates

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Tel (03) 9415 6500 Suite 6, 10 Hoddle Street, Abbotsford 3067
Mobile 0417 500 394 Fax (03) 9419 9033
akaadmin@alphalink.com.au

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1. Introduction and terms of reference

The Grampians Region Palliative Care Consortium is required to develop a plan for how palliative care services are to be delivered across the region, including details of how the consortium will work together with other health and community care providers to strengthen patients' access to the palliative care approach as well as appropriate access to specialist services.

The Grampians Regional Palliative Care Plan will cover a 5-year span from 2004 to 2009 and will identify and prioritise the palliative care needs of the communities within the Grampians Health Region of Victoria. The plan will support the Victorian Department of Human Services policy: *Strengthening palliative care: a policy for health and community care providers 2004-2009*.

An integrated services system is outlined under this policy. In each region, specialist palliative care providers have formed the regional consortia to enable an 'efficient and cooperative use of resources while supporting an integrated approach to care for the patient' (Department of Human Services 2004).




The Department of Human Services *Guide to developing your regional plan* (Department of Human Services 2004a) has provided the template for planning. Local communities' needs are to be identified and meaningful input is to be obtained from people with life-threatening illnesses, families and carers. The regional palliative care plan will also complement existing planning frameworks, such as the Primary Care Partnerships, the Integrated Cancer Services Framework, Home and Community Care and other relevant service frameworks. (ibid.: 2)

The Grampians Regional Palliative Care Plan 2004-2009 is structured as follows:

- the methodology or approach;
- the regional context;
- gaps and priorities;
- the strategic plan addressing these priorities.

2. Methodology

The following lists the tasks in the left column and charts the progress in the right column.

Stage and Tasks	Progress
<p>1. Preliminary</p> <ul style="list-style-type: none"> In consultation with the Consortium, finalise the process of consultation and identify who is to be consulted. 	 <ul style="list-style-type: none"> Stakeholders for consultation were identified with area representatives and Consortium Meetings with Consortium 3rd Feb, 3rd Mar and 8th April 2005
<p>2. Literature and policy review</p> <ul style="list-style-type: none"> DHS Guide to developing regional palliative care plan and relevant policy DHS palliative care initiatives Successful models of palliative care delivery in other rural communities Relevant major national, state and regional palliative care studies and reviews Recent federal and state government policy relating to rural palliative care services 	 <ul style="list-style-type: none"> Commonwealth and DHS Policy documentation reviewed Brief literature review completed on rural palliative care services Regional submission to Government and funding bodies relevant to Palliative Care 
<p>3. Data Collection and analysis</p> <p>Review, analyse and synthesise data and information available on the population and specified palliative care data related to the facilities of the Grampians region.</p> <p>Service profiles of current Palliative Care providers</p>	<ul style="list-style-type: none"> Demographic data by LGA and region identified. Inpatient palliative care data provided by DHS Community palliative care data provided by DHS Budget allocation for palliative care providers provided by DHS Surveys of current palliative care providers completed Data provided by palliative care providers to regional DHS gathered

4. Key Stakeholder consultation	<ul style="list-style-type: none">• See list of stakeholders consulted (Appendix 1)
5. Wider Stakeholder consultation	<ul style="list-style-type: none">• Workshop forums arranged in 3 centres to access wider consultation from professional bodies/organisations• See Forum Notice Appendix 2• See questionnaire Appendix 3
6. Progress Report	Presented 28/02/05
7. Draft Final Report for circulation	Presented 4/04/05
8. Consortium Meeting to discuss draft	Discussed and revised at meeting on 08/04/05
9. Presentation of Final Report	17/04/05

3. Policy context

'Australia leads the rest of the world in developing the relatively new medical discipline of palliative care' (Maddocks, 2003: S4).

The Commonwealth Department of Health and Ageing, with Palliative Care Australia, sponsored a supplement to the *Medical Journal of Australia* in 2003. The 14 articles discussed a range of issues in palliative care to inform health professionals and to stimulate interest in the philosophy of palliative care. Introducing the supplement, Professor Ian Maddocks praised the mutually supportive relationship among the diverse providers of palliative care, the high level of government support for palliative care initiatives over the past two decades and the teamwork evident in palliative care management.

The National Palliative Care Strategy

Palliative care in Australia follows the goals of the *National palliative care strategy: a national framework for palliative care service development*, endorsed by the Australian Health Ministers' Advisory Council (AHMAC) in October 2000. Governments at Commonwealth and state level along with palliative care service providers and advocacy groups in all States and territories are committed to the development and provision of best practice palliative care to those who need it, 'so that people who are dying have access to an appropriate service, at the right time, and in the right place' (Department of Health and Aged Care 2000: 9).

The goals of the Strategy are:

1. Awareness and understanding

To improve community and professional awareness and understanding of, and professional commitment to, the role of palliative care practices in supporting the care needs of people who are dying and their families of care.

2. Quality and effectiveness

To support continuous improvement in the quality and effectiveness of all palliative care service delivery across Australia.

3. Partnerships in care

To promote and support partnerships in the provision of care for people who are dying and their families, and the infrastructure for that care, to support delivery of high quality, effective palliative care across all settings.

The National Palliative Care Strategy has been supported by per capita funding to States and territories, through Australian Health Care Agreements, as well as funding of national initiatives under six priority areas:

1. Better access to medications for palliative care in the community;
2. Assistance for families and increased support to other care networks;
3. Education, training and support for the workforce;
4. Increasing access to palliative care services;
5. Supporting research into palliative care;
6. Performance information development.

(National Palliative Care Program 2005: 2)

Palliative Care Australia

Under priority area 2, the Commonwealth also supports Palliative Care Australia (PCA) as the peak national non-government organisation representing the palliative care sector. PCA has developed three documents to assist in planning palliative care services.

- *Standards for palliative care provision* (Palliative Care Australia 1999)

PCA is currently revising the national standards, most recently revised for the 3rd edition in 1999. This standards revision project (under priority area 4, increasing access to palliative care services) is expected to be completed by December 2005.

The present standards are grouped into six domains for application in specialist palliative care services.

Table 1: Standards for palliative care provision

Domain 1: Physical	
Standard 1.1	A comprehensive, interdisciplinary assessment of the patient and their family is undertaken to develop a plan of care.
Standard 1.2	A care plan based on the identified and expressed needs of the patient and family is established and regularly reviewed.
Standard 1.3	The management of the patient's symptoms is directed by best available evidence applied systematically and skillfully.
Standard 1.4	The terminal phase of illness is recognised and sensitive care is provided.
Standard 1.5	The importance of the environment in which care is provided is recognised and patient and family wishes are considered.
Domain 2: Psychological	
Standard 2.1	The psychological impact of terminal illness on the patient and family is assessed and responded to appropriately.
Standard 2.2	Where identified psychological need exceeds the available capacity of the palliative care service, the patient and/or family are referred to external specialist services.
Standard 2.3	A bereavement program is available to families and carers based on best available evidence and assessed need.
Standard 2.4	The palliative care service recognises the impact on staff of providing care to dying patients and their families.
Domain 3: Social	
Standard 3.1	A comprehensive interdisciplinary assessment is undertaken to identify the social needs of the patient and family.
Standard 3.2	An individualised, integrated care plan is developed in consultation with patient and family to address social needs.
Standard 3.3	The importance of raising and maintaining community awareness of palliative care is recognised and acted upon.
Standard 3.4	Palliative care services are actively involved in social policy formation.
Domain 4: Spiritual	
Standard 4.1	The spiritual dimensions of the patient and family are acknowledged, explored and responded to appropriately.
Standard 4.2	The religious beliefs of the patient and family are recognised and respected.
Standard 4.3	Appropriate spiritual and religious support for patients, families and carers is provided.
Domain 5: Cultural	
Standard 5.1	The palliative care service meets the cultural needs of the patient and family and reflects the cultural diversity of the community it serves.
Domain 6: Structural standards	
Standard 6.1	An interdisciplinary team approach exists to provide coordinated medical, nursing and allied services to the patient and family.
Standard 6.2	The interdisciplinary team will incorporate appropriately trained volunteers.
Standard 6.3	Specialist palliative care education is provided to the interdisciplinary team and other health professionals.
Standard 6.4	The palliative care service is committed to quality improvement and research in clinical and management practices.

(Palliative Care Australia, 1999)

- *Palliative care service provision in Australia: a planning guide* (Palliative Care Australia 2003)

This guide is a consensus document between PCA members, key stakeholders and other organisations. It discusses the minimum staffing and bed requirements for specialist palliative care provision. For example, it recommends a minimum of 6.7 designated inpatient palliative care beds per 100,000 population, supplemented with more such beds in rural and remote areas to give equity of access in these geographic areas (ibid.: 18). Staffing levels of medical palliative care specialists are recommended to be 1.5 EFT per 100,000 population or per 125 acute hospital beds or per 6.7 palliative care designated beds (ibid.: 26).

- *A guide to palliative care service development: a population based approach* (Palliative Care Australia 2005)

This guide recognises the existing networks of palliative service care provision and offers a framework for service planning. It explores the role of specialist palliative care services and describes three levels of specialist care. The role of primary care providers is recognised, while the delineation of roles is seen as an ongoing area for development by the appropriate health jurisdictions.

Victorian Palliative Care Policy

Policy for palliative care in Victoria is outlined in *Strengthening palliative care: a policy for health and community care providers 2004-09* (Department of Human Services 2004). The vision of this policy is that 'all Victorians with a progressive life-threatening illness and their families and carers will have access to a high quality service system which fosters innovation and provides coordinated care and support that is responsive to their needs' (ibid.: 3).

The guiding principles of the Victorian policy are:

1. People with a life-threatening illness and their carers and families have information about options for their future care and are actively involved in those decisions in the way that they wish.
2. Carers of people with a life-threatening illness are supported by health and community care providers.
3. People with a life-threatening illness and their carers and families have care that is underpinned by the palliative approach.
4. People with a life-threatening illness and their carers and families have access to specialist palliative care services when required.
5. People with a life-threatening illness and their carers and families have treatment and care that is coordinated and integrated across all settings.
6. People with a life-threatening illness and their carers and families have access to quality services and skilled staff to meet their needs.
7. People with a life-threatening illness and their carers and families are supported by their communities.

The Palliative Approach as defined in the Victorian policy is an approach which improves the quality of life by providing pain and symptom relief, spiritual and psychological support from diagnosis to the end of life and bereavement.

Specialist Palliative Care, also defined in the Victorian policy, builds on the palliative approach and reflects a higher level of expertise in complex symptom control, loss, grief and bereavement.

Among earlier policy documents in Victoria were *Palliative care services in Victoria: a vision* (1995) and *Palliative care services in Victoria: the way forward* (1996).

Regional consortia

To achieve an integrated palliative care service system DHS is establishing regional consortia to be responsible for:

- Regional planning;
- Designating hospital roles within the region;
- Coordinating care;
- Determining priorities for future service development and funding.

The *Guide to developing your regional plan* (Department of Human Services 2004a) outlines the particular focus of regional planning as follows:

Each regional palliative care consortium will develop a plan for how palliative care services are to be delivered across their region. The plan will also detail how the consortium will work together with other health and community care providers to strengthen patients' access to the palliative approach and appropriate access to specialist services.

In particular, each regional palliative care plan will identify the priority palliative care needs of the local communities and describe how the consortium is working together with meaningful input from people with life-threatening illnesses, families and carers.

The regional palliative care plan should:

- *be simple, practical and regionally focused*
- *be forward looking*
- *support and drive Strengthening palliative care: a policy for health and community care providers 2004–09, outlining regional priorities and what agencies will do to achieve these*
- *complement existing planning frameworks, such as the Primary Care Partnerships, the Integrated Cancer Services Framework, Home and Community Care and other relevant service frameworks.*

(ibid.: 2)

The regional plans are to include:

1. the methodology or approach
2. the regional context
3. gaps and priorities
4. addressing the priorities – the strategic plan (ibid.: 3).

This regional approach is the key policy platform (Department of Human Services 2004: 12). The *Cancer Services Framework for Victoria* (Barton, 2003) found that access to palliative care services for cancer sufferers was 'variable and not necessarily related to institutional or population size' (ibid.: v) and that there was a shortage of palliative care physicians. Barton et al. noted that 'greater demands are placed on hospital services when deficiencies exist in community-based services' (ibid.: 41). The *Cancer Services Framework* recommended that 'efforts should be made to ensure that all Victorians who require palliative care have access to high quality services' (ibid.: x) and also recommended the establishment of metropolitan and rural/regional services.

The DHS policy recognises that palliative care can be beneficial to all people with a life-threatening disease and is not limited to people with cancer (op. cit.: 13). While bearing this in mind, the Victorian Cancer Services Improvement Program (CSIP) funds Integrated Cancer Services (ICS) to develop initiatives for service improvement, and has identified links to palliative care for patients with advanced disease among its priority areas for service improvement (Department of Human Services, 2004b).

The ICS philosophy is based on integrated care with defined referral pathways, and depends on effective collaboration between hospitals and community based services (Victorian Government Cancer Initiatives, 2005).

Rural Palliative Care Service Provision

An initiative for rural palliative care services funded under National Palliative Care Program priority area 4 (increasing the range and reach of palliative care services) was piloted in 2001-2003 by the Griffith Area Palliative Care Service (GAPS), southern New South Wales. The project in Griffith identified all the key issues that have also been revealed in this Grampians Region Palliative Care planning review.

The GAPS initiative was a community-focused model with an integrated team of primary care providers including GPs (National Palliative Care Program 2005: 15). Hatton et al. (2003) evaluated the GAPS project. It was also evaluated by Cromwell et al. (2003).

Some existing deficiencies in palliative care provision prior to the project had been identified as:

- inequity of access services and support between oncological and non-oncological patients;
- After hours primary care medical services were uncoordinated and from the GP's perspective, the job was exhausting and demanding;
- No formal out-of-hours system for domiciliary nursing support existed.
- There were no dedicated palliative care beds at Griffith Base Hospital;
- Patient medical records for admissions to acute care failed to reflect the chronicity and complexity of medical problems;
- There were no operational links between the Griffith Base Hospital Oncology/Palliative Care Unit, District Nursing and private community nursing agencies;
- Data collection on the incidence, scope and tracking of palliative care cases was incomplete and inconsistent between local service providers. This clearly failed to meet national standard requirements for a minimum data set; and
- There was no formal volunteers' network to support patients and carers, except that provided by the local branch of the Cancer Patients Assistance Society.

(Hatton et al.: 12)

Key elements of the service model developed for the GAPS project were:

GOVERNANCE AND STAFFING

- Administration of the project by a board of governance including senior management from the regional Health Service and local Division of General
- Practice plus representatives from pastoral care and the community;
- Appointment of a Project Coordinator jointly funded by the regional Health Service and local Division of General Practice for the initial term of funding.

24-HOUR ACCESS

- Provision of a 24-hour 1800 number for advice, intake, referral and coordination of out-of-hours call-outs as required;
- Formal nursing on-call roster after hours including registered nurses from all agencies;
- Formal GP on-call roster out-of-hours funded solely through Medicare Benefit Schedule claims (organised and managed by the Division of General Practice). This included an agreement that attendance for ED presentations

will be encompassed within an MBS claim, and not levied against Griffith Base Hospital as a GP-Visiting Medical Officer (VMO) call-back; and

- Formal agreement with Griffith Base Hospital visiting Medical Officers on-call for the transfer of GAPS-registered patients to a palliative care team medical officer next day following an emergency admission.

CASE MANAGEMENT AND REVIEW

- Joint agreement from all agencies on a single set of policies, procedures and clinical guidelines for the management of patients registered with the GAPS service;
- Joint intake options by the case management team;
- An integrated patient-centred medical record that traverses all services involved in the patient's care;
- Weekly case management review involving oncology/palliative care nurses, community nurses, private nursing agency nurses, GP representatives, and allied health, in liaison with Griffith Base Hospital Emergency Dept and Pastoral Care;
- Accredited volunteer screening and training program, provided by the Mercy Hospital, Albury; and
- Education programs for Medical Officers, Registered Nurses, pastoral care and volunteers.

ENHANCED PRIMARY CARE

- Following the weekly case reviews, coordinated, systematic uptake of Enhanced Primary Care (EPC) items.

INFORMATION MANAGEMENT

- Trial of the palliative care information system (PaCIS) for patient registration and clinical information;
- Establishment of a Minimum Data Set that satisfies National Standards for Palliative Care;
- Trial of palm pilots to collect the minimum data set at the point-of-care; and
- Routine collection of baseline data, monthly monitoring and progressive evaluation against nominated Key Performance Indicators.

(Hatton et al.: 13)

Hatton et al. found that this innovative system for joint inter-agency and community governance ensured the proper administration of the objectives of the service without impeding the routine operational management of the participating agencies (ibid.: 17).

The West Victoria Division of General Practice is currently undertaking a rural palliative care project, in conjunction with the Central Grampians Palliative Care Service and Wimmera Hospice Care at Wimmera Health Care Group. Objectives of this project include provision of a high quality service to the rural community (through enhanced after hours care, access to medicines for isolated patients), increased understanding by health service providers of palliative care principles, therapeutic issues and effective communication processes (through educational activities) and increasing the Koori community's awareness of, access to and benefits from palliative care services (WestVic Division of General Practice website).

Provision of palliative care in regional Victoria should include recognition of the palliative care needs of Aboriginal Victorians. A review conducted for the Grampians Region Palliative Care Alliance (GRPCA) in 2003 found there was a low demand for community-based palliative care from Koori people in the Grampians region and recommended a three-year action plan based around awareness of cultural needs, access to and understanding of Palliative Care services and a model for service delivery and promotion (Atkinson and Kerr, 2003).

4. Regional Context

4.1 Regional Demographic Information

The Grampians health region of Victoria includes the Shires of Ararat, Golden Plains, Hepburn, Hindmarsh, Horsham, Moorabool, North Grampians, Pyrenees, West Wimmera, Yarriambiack and Ballarat City. The Grampians Region covers an area of 47,980 square kilometres and extends from the Melbourne metropolitan area in the east to the South Australian border in the west and has a population of approximately 208,226.

Figure 1: Map of Grampians Region

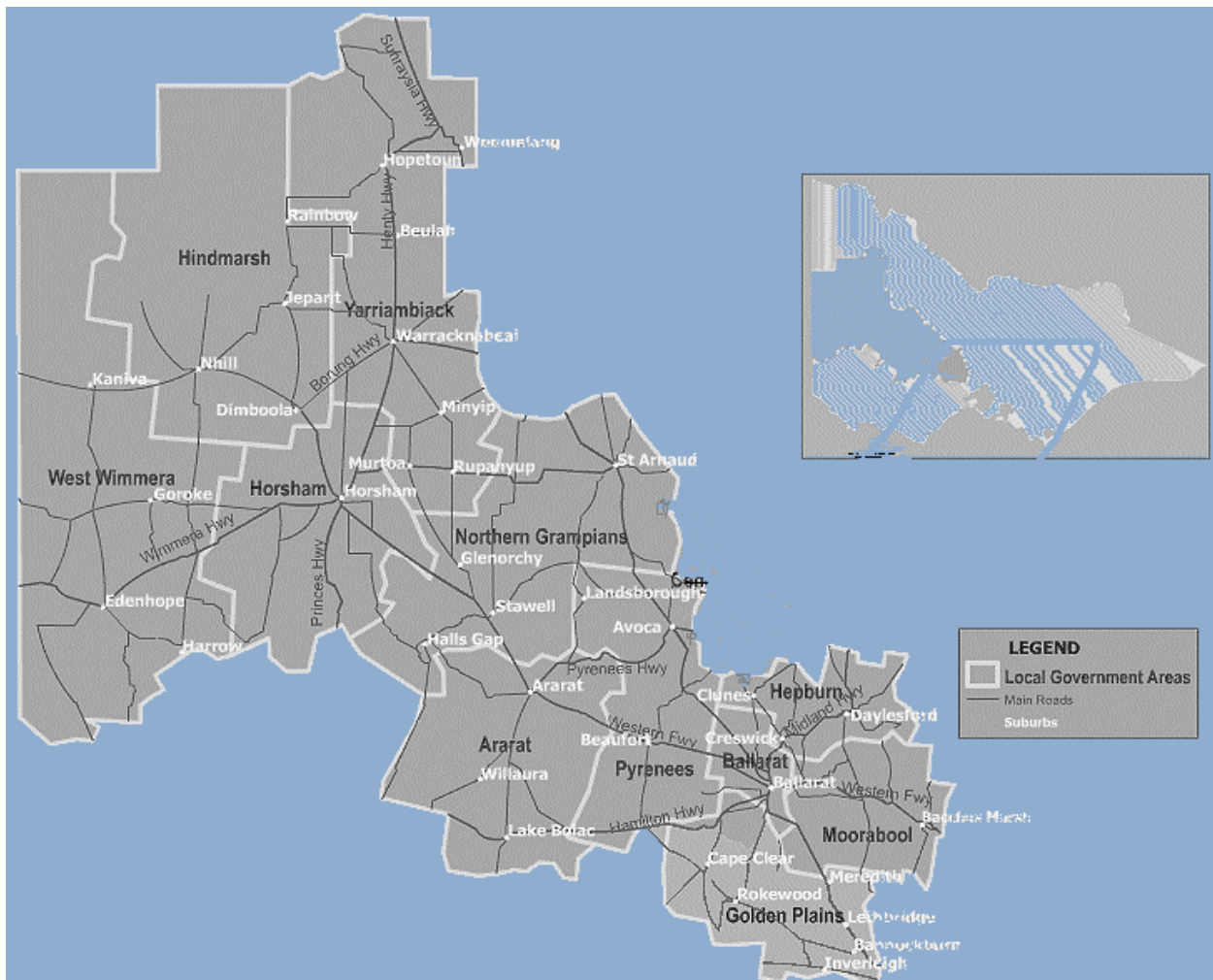


Table 2: Projected Populations by Local Government Area

Local Government Area	Population 2001	% of Total Region	Projected Population 2011	Average Rate of Increase p.a. 2001-2011 %	Population aged 60+ 2001 %	Projected Population aged 60+ 2031 %
Ararat	11,721	5.63	11,571	- 0.10	23.00	45.00
Ballarat	83,599	40.18	93,817	+ 1.20	18.00	31.60
Golden Plains	15,101	7.26	17,588	+ 1.50	12.50	33.30
Hepburn	14,488	6.96	15,349	+ 0.60	21.60	43.00
Hindmarsh	6,596	3.17	6,023	- 0.95	27.20	46.90
Horsham	18,586	8.93	19,657	+ 0.60	20.70	43.00
Moorabool	25,087	12.06	29,254	+ 1.55	13.30	30.90
Northern Grampians	13,055	6.28	12,853	- 0.15	22.10	40.10
Pyrenees	6,641	3.19	6,298	- 0.55	23.00	44.10
West Wimmera	4,882	2.35	4,416	- 1.00	24.70	37.90
Yarriambiack	8,311	3.99	7,429	- 1.15	27.50	40.60
TOTAL	208,067	100.00	224,255	+ 0.78	19.05	35.29

Table 2 shows the current population of the region by local government area. Reading from left to right, the columns show: the population as recorded in the 2001 ABS census; the proportion of the regional population in each LGA; the projected population for each LGA in 2011; and the projected per annum rate of increase for the ten years commencing 2001.

The final two columns provide the percentage of the population over 60 years of age in 2001 and the projections for the percentages aged over 60 years in 2031. The age group over 60 years has been identified as this group makes up approximately 80% of all palliative care patients based on current figures.

It can be seen that the region is growing as a whole and this will continue into the future, however the growth is very uneven. Local government areas on Melbourne's fringe (Moorabool and Golden Plains) will experience the strongest growth and will almost double the Victorian regional average. Growth in the regional centres of Ballarat and to a lesser extent Horsham will also be quite strong. Hepburn will benefit from both growth in Melbourne and Ballarat. The more westerly rural LGA will continue to decline in population as a result of young

adults moving to the larger centres and the restructuring of traditional rural industries. This trend is more pronounced the further west the LGA is located. Regional Victoria's population aged 60 years and over is calculated to rise from 19.5% of the population in 2001 to 35.9% in 2031. The aged population of the Grampians region will mirror this rise, going from 19.05% to 35.29%. This trend can be expected to lead to a significant demand in increase for palliative care services as the population ages and sudden and unexpected deaths decrease. As can be anticipated the areas with the strongest growth patterns will continue to have the younger age profiles, however all LGAs are experiencing a rapid ageing of the population.

4.2 Service Mapping

Currently the Department of Human Services Victoria funds four Community Palliative Care Services and ten inpatient palliative care beds at 80% occupancy within the Grampians Region. Each service provider has representation on the Grampians Region Palliative Care Consortium.

Palliative Care Service Providers within the Grampians Region are as follows:

Grampians Regional Team funded by DHS

Ballarat Health Services	Based at Gandarra Unit at the Queen Elizabeth Centre site, Ballarat.
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Designated inpatient bed days funded by DHS at 80% occupancy

Ballarat Health Services	6 at the Gandarra Unit based at the Queen Elizabeth Centre site, Ballarat. (Unit also has 3 WIES funded beds).
Djerriwarrh Health Services	2 at Bacchus Marsh
East Grampians Health	1 at Ararat
Wimmera Health Care Group	1 at Horsham
Unassigned Bed	1 Distributed between the four Community Palliative Care Services

Community Palliative Care Services funded by DHS:

Ballarat Hospice Care	Owned and operated independently at Ballarat
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Djerriwarrh Health Services	Djerriwarrh Community Palliative Care Service
East Grampians Health	Central Grampians Palliative Care Service
Wimmera Health Care Group	Wimmera Hospice Care

Each Community Palliative Care Service within the Grampians Region of Victoria provides professional support and coordination of services to patients, carers and other health professionals within the scope of their resources.

Budget

DHS Budget (\$) for Community Palliative Care Service Providers

Table 3: Community Palliative care services funding by population

	2004/05 \$K	% of regional community-based funding	% of regional population
Djerriwarrh Health Services	119	10	9
Ballarat Hospice Care	623	53	58
Central Grampians Health Service	194	17	15
Wimmera Health Service	235	20	18
Subtotal	1171	100%	100%
Regional Palliative Care Team	230	n/a	n/a
Total	1401		

Source: Department of Human Services Victoria 2003-2004

Not surprisingly (as the consortium has been allocating funds on this basis) there is a good match between population distribution and the distribution of funding across the four services.

In addition to the above funding, the four Community Palliative Care Services receive a proportion of funds from one regional unassigned bed. These funds are utilised in accordance with the DHS Unassigned Bed Fund (UBF) Guidelines. "The primary aim of the UBF is to fund the hire or purchase of equipment or services which will allow palliative care clients to remain at home without compromising their quality of care when they would otherwise require admission to an inpatient setting. The UBF is designed to fund services or equipment which a CPCS would not normally provide as part of its standard service or which are above the usual level of service provision." (DHS Palliative Care Website)

DHS Budget for the designated inpatient bed days

Table 4: Inpatient Palliative care services funding by population

Palliative care Inpatient Services	2004/05 bed days	Funding \$K	% of regional inpatient	% of regional population
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			funding	
Djerriwarrh Health Services	584	255	20	9
Gandarra (BHS)	1752	737	59	58
Central Grampians Health Service	300	131	11	15
Wimmera Health Service	292	127	10	18
Total	2928	1250	100%	100%

Source: Department of Human Services Victoria 2003-2004

DHS funding to the providers outlined above for 2004-2005 was \$436 *per diem*.
(Note: Ballarat Health Services allocated \$527 per diem for 177 DVA bed days in addition.)

It can be seen that the distribution of inpatient funding is not as well matched to population as the community based funds.

Table 5: Total Palliative care services funding by aged population

Palliative Care Community and Inpatient Services	2004/05 Funding \$K	% of regional funding	% of regional population 60 years and over
Djerriwarrh Health Services	374	16	6
Gandarra/ Ballarat hospice	1360	57	53
Central Grampians Health Service	315	13	18
Wimmera Health Service	349	15	23
Total	2398	100%	100%

The use of the over 60 years as the population is arguably a much better measure than the total population, given that 80% of palliative clients are drawn from that age group. If we combine both community based and inpatient palliative care funding to each sub-regional area, and then match against the aged (over 60 years) population distribution, an even greater imbalance of the ratio of funds to population emerges the further west in the region.

Palliative Care requirements broadly align with the aged care population in the region and the distribution of services, particularly inpatient services, does not currently reflect this. Therefore, prior to any further distribution of designated palliative care bed days within the region, this should be reviewed.

Service Models and Linkages

The Community Palliative Care Services established in three of the four areas within the Grampians Region have service models which are aligned and administered by a public inpatient health facility in their area. The public health facility also manages the inpatient designated palliative care bed days to their area. This synergy of service provision enables and promotes care coordination and integration as well as cost and operational efficiencies. The fourth Community Palliative Care Service, a not for profit community organisation,

historically has operated independently within the larger regional base in the region. It has changed its' model of care away from personal care delivery to the broader coordinated and supported care role, with close linkages with the public inpatient facility, comparable to the other three services.

The service models applied to the Community Palliative Care Services have commonality in that they integrate closely with their local District Nursing Services and Home and Community Care Services to provide the personal care to their clients. The four Community Palliative Care Services all co-ordinate the clients care and provide education to the carers. This then allows the service to provide a patient care plan and to coordinate or case manage the palliative care. The 'generalist' clinical and personal care services e.g. District nursing and HACC continue to provide the day to day treatment and care within the care plan. Palliative care services can also provide a range of other assistance from pain management to specialist equipment to purchase of additional in home care. According to the stakeholders consulted, the Community Palliative Care providers have strong linkages to numerous network agencies including (but not limited to) Palliative Care Victoria, District Nursing Services, In reach Palliative Care Services, Local General Practitioners, Division of General Practices, Primary Care Partnerships, Home and Community Care Services, Residential Care facilities, Pastoral Care services, Community Health Services, Acute Healthcare facilities. It is noted that there are no formal agreements or protocols with the linkage services.

Patient contacts

Table 6: Palliative Care Patient Contacts 2003 - 2004

	Patients	% of regional total	% of regional population 60 years and over	Total Contacts	Average no. contacts/patient
Djerriwarrh	76	9	6	1962	25.8
Ballarat Hospice	405	48	53	12185	30.1
Central Grampians Health Service	130	15	18	5433	41.8
Wimmera Health Service	240	28	23	6322	26.3
Regional Total	851	100%	100%	25902	30.44
State	10782			349618	32.4

Source: Department of Human Services Victoria 2003 - 2004

Djerriwarrh (3%) and Wimmera (5%) both have a higher proportion of patients than their proportion of the aged population, conversely Ballarat (5%) and Central Grampians (3%) have proportional fewer patients per head of aged population.

All of the Palliative care services except the Central Grampians region are below the average number of contacts when compared to the state average. The four Community Palliative Care Services in the Grampians Region recorded approximately 26,000 client contacts for 2003-2004 consisting mainly of nurse contacts.

Table 7: Client Contacts

	Allied Health	Pastoral	Counsellor, bereavement	Medical Officer	Nurse	Volunteer	Other	Total
Djerriwarrh	252	2	293	4	1241	170		1962
Ballarat Hospice Care	572	910	1015		9294	387	7	12185
Central Grampians Health Service					5433			5433
Wimmera Health Service		1	331	1	5458	531		6322
Total	824	913	1639	5	21426	1088	7	25902

Source: Department of Human Services Victoria 2003-2004

Staffing Resources

Staffing EFT to provide the above services varies according to allocated budget and volunteers are utilised in some services.

Table 8: Staffing EFT & Volunteer Numbers: Grampians Region Community Palliative Care Services (current)

	Nursing	Medical	Allied health	Administrative	Volunteer Numbers
Djerriwarrh	0.9*		0.80		
Ballarat Hospice Care	4.41	0.10	2.04	1.94	17
Central Grampians Health Service	1.84				1
Wimmera Health Service	1.6			0.70	33
Regional team	N/Avail	N/Avail		N/Avail	
Total	8.75	0.10	2.84	2.84	51

* Djerriwarrh advise that an additional 0.7 EFT Clinical Nurse Consultant Palliative Care works with its Community Palliative Care Service but is funded separately.

Nursing staff comprise the main component of staffing within the community palliative care services. Ballarat Hospice Care operates independently whilst the other three services have access to their aligning health facilities for some governance and administrative functions.

Table 9: Palliative Care contacts per Staffing EFT

	Total EFT	Total Contacts	Contacts per EFT
Djerriwarrh	1.7	1962	1154
Ballarat Hospice Care	8.49	12185	1435
Central Grampians Health Service	1.84	5433	2953
Wimmera Health Service	2.3	6322	2749
Region Total	14.33	25902	1809

The contacts per equivalent full time staff varies between community palliative care services. The services in the west of the region show substantially higher numbers of contacts per staff member compared to the services in the east of the region. It should be noted that the services in the west of the region cover a larger geographical area whilst the services in the east of the region have a higher density of population.

Djerriwarrh Community Palliative Care Service contracts their services out to provide visits to clients within the Melton area which is in Western Metropolitan Palliative Care Region and is equivalent to approximately 0.4 EFT of their staffing resources. Service fees for these services have not been included in the previous budget tables

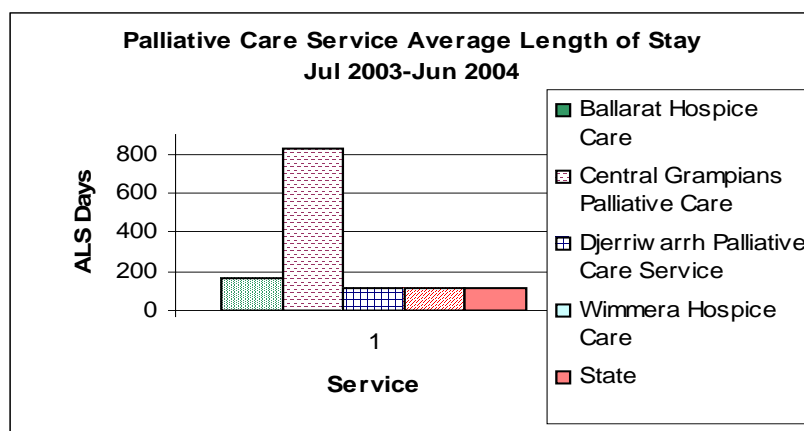
Out-of-hours services are provided formally only by Ballarat Hospice Care (24 hour coverage); however each provider has alternative arrangements for their clients to access the acute health facility out of hours. The acute facility and/or district nursing service can access out of hours consultative assistance from Gandarra Staff at Ballarat Health Services.

The Regional Team provides support and education to the region through their Palliative Care Physician and Clinical Nurse Consultant. The Palliative Care Physician also provides case conferencing and after hours services medical practitioners and palliative care nurses within the region. At present there is only one palliative care physician and he has advised that there is immediate need for an addition Palliative Care Physician to assist him in meeting the demand for specialist palliative care medical services throughout the region.

Client Length of Stay (registration)

The Community Palliative Care Services provide ongoing care for their clients throughout their palliative phase and most clients require repeated contacts over several months. The average length of stay (registration) for clients within the Grampians Region is largely within the benchmark of State average with the exception of Central Grampians Palliative Care Service which attributes its marked variance to incomplete care planning and lack of resources to monitor the client register. The 2004-2005 Central Grampians average length of stay is currently being reduced.

Figure 2: Palliative care service average length of stay



Source: Department of Human Services Victoria 2003-2004

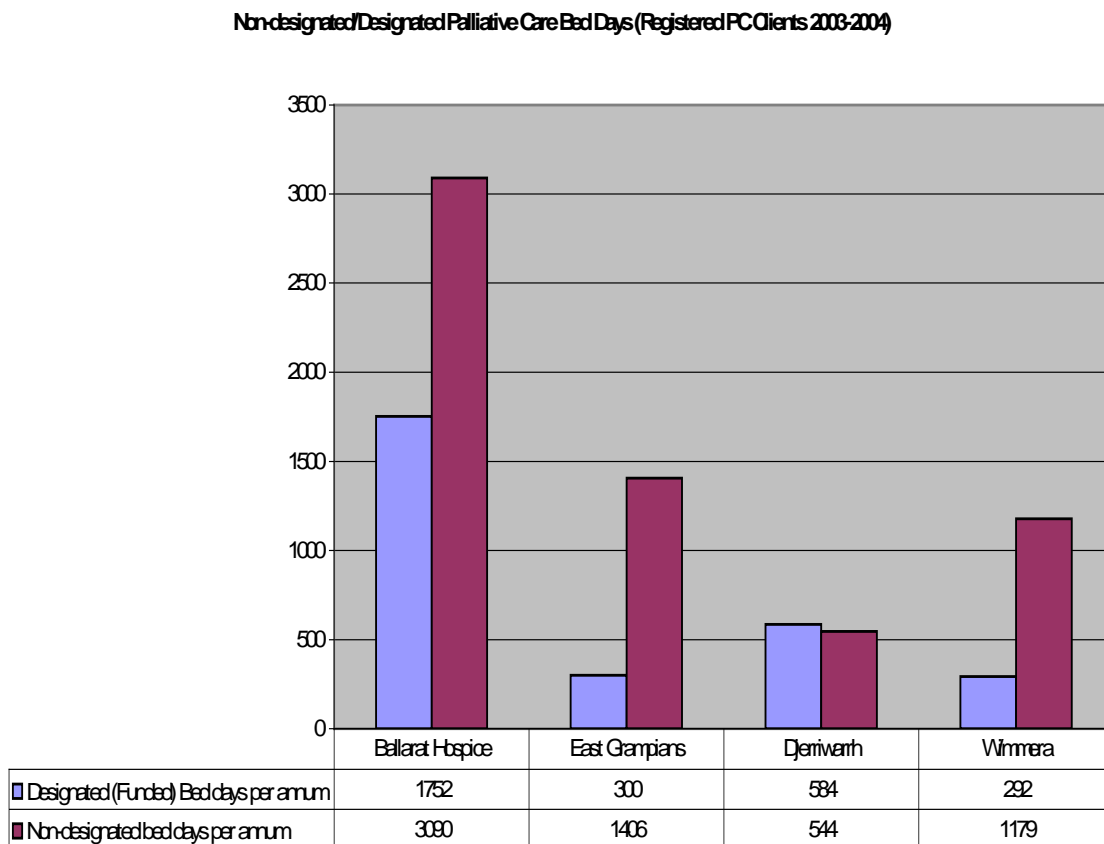
Designated Inpatient Beds

Most health facilities in the Grampians Region provide inpatient care for patients in the palliative phase of their illness and this is largely provided in non-designated palliative care beds. The designated or palliative care funded Health facilities (10 beds in 4 facilities in the region plus 1 unassigned bed) provide care for registered palliative care patients (i.e. those registered with a Community Palliative Care Service). The funded or designated palliative care beds should have access to nursing, medical and allied health palliative care staff who are experienced and trained, and are able to deliver the palliative approach in their care.

Limitations apply to the data discussed here as it is collected manually and some admissions will therefore not be recorded. The recorded inpatient bed days for registered palliative care patients in all four funded Community Palliative Care Services are far in excess of the funded designated bed days in their affiliated health facilities. (See Fig. 3).

If the ratio of designated to non-designated beds using the graph below is calculated Central Grampians has 1 designated bed to 4.5 undesignedated beds, Wimmera 1:4, Ballarat 1:1.8 and Djerriwarrh 1:0.9, giving a regional ration of 1:2.1 all of which is higher than the State's average of 1:0.6. Care is needed in interpretation of this finding given the higher use of hospital as opposed to home care as demonstrated later in this section (see Site of Death).

Figure 3: Non-designated/designated palliative care bed days

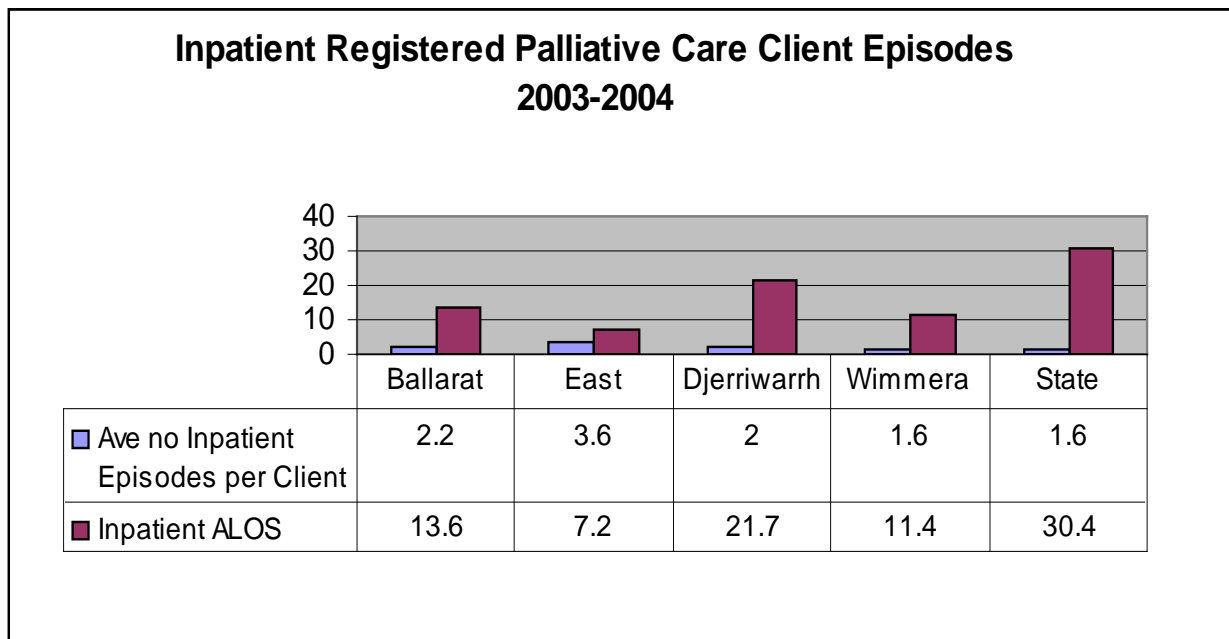


Source: Department of Human Services Victoria 2003-2004

As shown in Fig. 4 inpatient episodes per client (other than East Grampians) for the Grampians Region are in line with the State average and average length of stay for Grampians Region patients are well below the State average. The collection of this data has only become mandatory in the last 12 months, therefore accuracy of State data is questionable.

This demonstrates the effectiveness of the Community Palliative Care Services to provide care within their home environment; however it also adds increased pressure on their resources and discharge planning to care for their clients at home rather than in hospitals.

Figure 4: Inpatient registered palliative care client episodes 2003-2004



Source: Department of Human Services Victoria 2003-2004

The following tables list the episodes of inpatient care in both designated and non-designated beds for registered palliative care patients for each community-based service. Campuses with designated beds are in bold.

Table 10: Ballarat Hospice Care: Hospice inpatient episodes 2003-2004

Ballarat Hospice Care - Hospital Inpatient Episodes 2003 - 2004	No. of Episodes
Ballarat Health Services – Base Campus	96
Ballarat Health Services– Queen Elizabeth Campus	122
Hepburn Health Service – Creswick District hospital	6
Hepburn Health Service – Daylesford District Hospital	12
St John of God Health Care - Ballarat	111
<i>Others (fewer than 5 episodes per hospital)</i>	9

Total	356
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It is notable that nearly one third of all episodes for registered patients of the BHC were at the SJOG Ballarat. This vindicates the inclusion of SJOG in the Consortium. There are high numbers of registered palliative care patient admitted to BHS base campus both from this catchment and Central Grampians catchment.

Table 11: Central Grampians Palliative Care: Hospital inpatient episodes 2003-2004

Central Grampians Palliative Care – Hospital Inpatient Episodes 2003 - 2004	No. of Episodes
Ballarat Health Services – Base Campus	52
Ballarat Health Services– Queen Elizabeth Campus	8
Beaufort & Skipton Health Service - Beaufort	5
East Grampians Health Service - Ararat	44
East Wimmera Health Service – St Arnaud Campus	17
St John of God Health Care - Ballarat	21
Stawell District Hospital	75
<i>Others (less than 5 episodes per hospital)</i>	15
Total	237

It is notable that there were more episodes of register patients to the Stawell Regional Hospital than in the Ararat Hospital who have the designated bed. This matter is discussed in Section 5.9.

Table 12: Djerriwarrh Palliative Care Service: Hospital Inpatient Episodes 2003 – 2004

Djerriwarrh Palliative Care Service – Hospital Inpatient Episodes 2003 - 2004	No. of Episodes
Ballarat Health Services – Base Campus	5
Ballarat Health Services– Queen Elizabeth Campus	5
Bacchus Marsh & Melton Memorial Hospital	28
St John of God Health Care - Ballarat	7
<i>Others (less than 5 episodes per hospital)</i>	7
Total	52

Djerriwarrh had far fewer inpatient episodes than the other services despite having two designated beds. This reflects that they had only 9% of the registered patients in the region in the past year. See section 5.9 for further discussion

Table 13: Wimmera Hospice Care: Hospital Inpatient Episodes 2003 – 2004

Wimmera Hospice Care– Hospital Inpatient Episodes 2003 - 2004	No. of Episodes
Dunmunkle Health Services	5

Edenhope & District Hospital	18
Rural Northwest Health – Warracknabeal	10
West Wimmera Health Service - Jeparit	5
West Wimmera Health Service - Nhill	9
WHCG - Dimboola District Hospital	5
WHCG -Wimmera Base Hospital	65
<i>Others (less than 5 episodes per hospital)</i>	<i>12</i>
Total	129

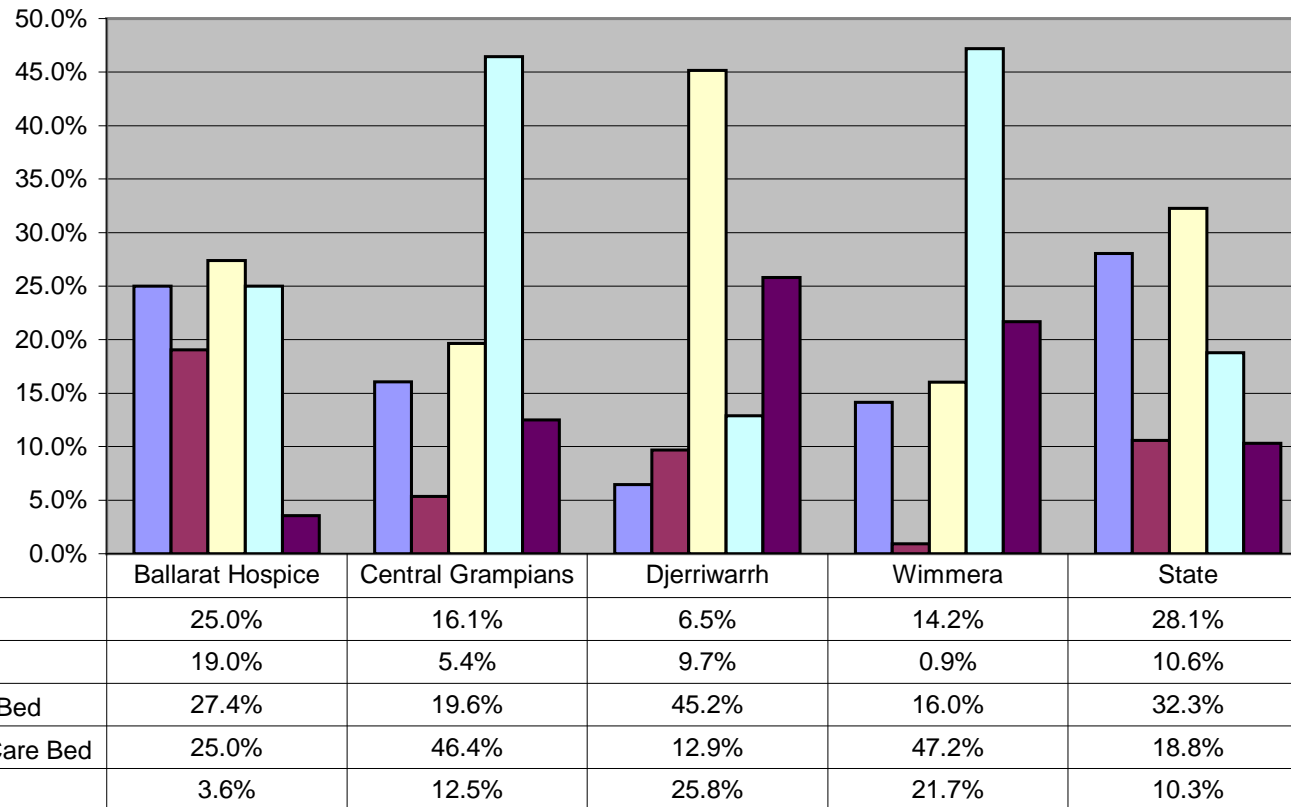
WHC has the most widespread distribution of inpatient episodes across the acute hospitals in their catchment reflecting the very large area of the catchment and the number of small rural hospitals in the area.

Site of Death

Data from the Grampians region demonstrates that clients' site of death is predominantly within a hospital facility and varies substantially from the State average. It is significant to note the high percentage of deaths occurring in non-designated public and private hospital palliative care beds within the Grampians Region (see Figure 5, following).

Figure 5: Comparison of site of death
 Source: Department of Human Services Victoria 2003-2004

Site of death comparison



Quality

The Community Palliative Care Services within the Grampians Region benchmark their services against performance criteria set out by the Department of Human Services Victoria. The four criteria measured are:

1. Assessment: persons with a documented assessment within 72 hours of admission
2. Care Planning: number of patients for whom documented care plan was reviewed within 10 days of assessment
3. Implementation of Care – GP Notification: number of written notifications to nominated GP within 3 working days of admission
4. Implementation of Care – 24 hr service: patients and families informed of 24 hour service

The 2003-2004 results (Table 14) demonstrate the capability of the services once referrals are received.

Table 14: Palliative Care Performance Indicators % of Compliance 2003 – 2004

	Patients	Assessment	Care Planning	Implementation of Care GP Notification	Implementation of Care 24 Hr service
Djerriwarrh	76	97.14	80	91.43	94.29
Ballarat Hospice Care	405	98.74	98.11	96.23	99.37
Central Grampians Health Service	130	100	98.57	90	94.29
Wimmera Health Service	117	98.29	95.73	82.91%	95.73

Source: Department of Human Services Victoria 2003-2004

Summary

The highest concentration of population of the region is centred around Ballarat and those LGAs on the fringe of Melbourne. The region is experiencing growth but this is uneven and largely in the aforementioned areas while the rural LGAs are continuing to decline in population.

The ABS views the ageing of the population as the most significant trend in the population. This is true for the Grampians region and also true Australia-wide. The rural LGA in the region are already experiencing a significant proportion of

their population above the age of sixty. This means that Wimmera and Central Grampians have additional demands on their services.

The service model provides a comprehensive service across the whole region via four community based palliative care services, supported by designated inpatient beds (and access to non-designated beds) and a small regional team including a Palliative Care Physician.

A total of 851 clients were registered in 03/04 and some 26,000 episodes of care delivered.

Approximately \$2.5 million is provided by DHS for services specific to palliative care. Additional services are provided via the general health system including access to non-designated acute beds, district nursing, HACC services, etc.

The balance of funding appears to have more resources per capita closer to Melbourne rather than further away. Given that access to services is important, this balance requires review.

Registered palliative care patients occupy several times the number of acute beds as are designated for palliative care. The proportionate usage of non-designated beds is far higher than the state average. These are spread across a wide range of hospitals in the region and some in Melbourne.

Proportionally fewer palliative care patients die at home in the Grampians compared to the state average. Apart from this on most indicators the GPC services appear to be close to state benchmarks for performance.

4.3 Overview of Stakeholder Consultations

The consultative process for this plan was comprehensive and involved in excess of 50 consultations throughout the Grampians Region and wider area over a three month period (refer to Appendix 1 for a list of consultations). A common theme was portrayed by stakeholders that the current community palliative care services provided by the four services was of a high quality, delivered the palliative approach (as defined in the literature review), was well known and linked to most professional health and care bodies within the region. Of special note was the availability of a specialist palliative care physician in the region. All stakeholders consulted expressed their appreciation of this resource and need for this service to continue and grow.

All health facilities consulted requested consideration for additional funded designated palliative care beds and explained that anecdotally the number of unregistered palliative care patient episodes in their facilities was as high as the registered palliative care patient bed days.

All stakeholders consulted advised the urgent need for more comprehensive and ongoing staff education for all levels of staff throughout the health and residential aged care facilities and other care organisations.

The increased need for grief and bereavement counseling was also strongly stated by most users of the palliative care services. Although this service is already being provided by the four community palliative care services, demand appears to be at least double what was currently provided.

Key stakeholders also articulated their desire for improved communication, particularly early palliative care referrals from all medical oncologists to the community palliative care services.

5. Discussion and recommendations

The following section discusses matters to be considered in the future palliative care plan for the region. These issues are derived from stakeholders' consultations and also informed by the policy, literature and data analysis presented in the preceding two chapters. The issues raised below need to be seen in the context of improving a well-recognised and highly utilised service system. The Palliative care services were observed to be working well together and are well respected within the broader health and aged care sectors. The regional support provided by the Palliative Care Physician is highly valued and widely used across the region.

5.1 The Grampians Regional Palliative Care Consortium

The Grampians Regional Palliative Care Service Alliance was formed in 1998 by the services then funded by DHS. It was one of the earliest of the Victorian regions to form a regional alliance. It operated for a number of years, providing a forum for cooperative decision-making and regional support. Funding for a regional team to support the work of the community-based services was obtained. In November 2004 DHS launched *Strengthening Palliative Care: a policy for health and community providers 2004-09* prompting the Alliance in the Grampians to agree to a more formal arrangement under the title of the Grampian Regional Palliative Care Consortium. Included in the regional consortium for the first time was St. John of God Healthcare, Ballarat (SJOG).

The Consortium, like the alliance before it, continues to operate without a paid secretariat. A Memorandum of Understanding (MOU) was developed and then signed by the four community based palliative services and Ballarat Health (responsible for Gandarra and the Regional team) and SJOG Ballarat. In summary the MOU commits to each service to:

- Facilitate the provision of specialist palliative care services across the Grampians Region;
- Participate in regional planning of services and implementing planned initiatives following Department approval;
- Identify role designation of hospitals within the Region;
- Review current processes and systems for coordination and integration of care;
- Participate in prioritising future service development and funding in conjunction with Departmental staff to support the implementation of the Grampians Region Palliative Care Plan;
- Ensure a mechanism exists to collect data for reporting ;

- Monitor the effectiveness of the Grampians Region Palliative Care Plan;
- Identify mechanisms for involving consumers, health professionals and other interested parties in advising Regional Consortium members.

In practice the consortium has had little time to test the effectiveness of the new organisational arrangements however given the now lengthy history of cooperative decision-making this new arrangement is likely to be successful.

An issue with regard to membership may arise from services which seek to gain funding and recognition as part of the palliative care network. Already some of the larger health services not currently funded to provide palliative care services are requesting a more broadly-based distribution of resources. Some of these services may feel not only the lack of current resources but also that they are locked out of any decisions about future planning. This matter is further considered in the next section (section 5.2)

A further issue that has been evident is the status of the regional team. Historically the funding of the regional team has been by way of a direct service grant to the Ballarat Health Service (BHS). A number of questions now arise out of this approach with regard to the management and resource allocation within the Team. There is little transparency in the funding of the regional team, partially as the funding appears to be combined with funding for the inpatient beds at Gandarra. Furthermore the allocation of the regional team's time across the various sub-regions has been neither discussed nor agreed upon by the Consortium members. With this in mind it is unlikely that the Consortium members will approve any future funding being pooled with the regional team funding without greater transparency.

The above issue applies to the allocation and resource allocation of the regional physicians and the nurse educator. The PCA guidelines suggest that there is a need for at least one more physicians in the region -depending on how the guidelines are interpreted- and a registrar position. As previously mentioned it is not clear as to what contribution Gandarra is making to the funding of the physician, arguably all the allocation to these inpatient beds should be funded from the bed day payments and not the regional team. This should be explored prior to seeking additional funding. The inadequacy of the funding for the education program is discussed in Section 5.4.

It is recommended that the Consortium, working with Ballarat Health Service, put in place greater transparency on future governance and resource allocation arrangements of the Regional team.

5.2 Community Involvement

The requirements of the regional planning process suggest that *'The plan will ... detail how the consortium will work together with other health and community care providers to strengthen patients' access to the palliative approach ... and describe how the consortium is working together with meaningful input from people with life-threatening illnesses, families and carers.'*

The Western Vic Division of General Practice as part of its Commonwealth funded project on rural palliative care services, and in conjunction with the RACGP, has developed a proposal for the Central Grampians to establish a 'network' of locally based services and carers with an involvement in palliative care. Geographically based around the current boundaries of the Central Grampians Palliative Care service it will provide opportunities to:

- Network with others with an interest in palliative care;
- Examine local issues of importance;
- Provide a venue for multi-disciplinary education;
- Promote awareness of palliative services to the broader community.

The proposal is to invite the following groups to participate:

- GPs (or the Division of GPs);
- Local health services (district nursing, inpatient services, etc)
- HACC services;
- Residential aged care services;
- Volunteers groups (if available);
- Carers' representatives.

It is proposed that the Consortium members monitor the progress of the Central Grampians Palliative Care network with regard to the value of adopting such an approach in the other three community-based palliative care services. Secondly it is proposed that once local networks are established the Regional Consortium consider membership/representation from one or more of these local networks onto the regional consortium. Such representation could be either a representative as a member of the consortium or having a representative from each of the four networks on an advisory committee to the Consortium. The value of such networks will therefore be both local and regional in effect, giving a voice to the broader community of carers and service providers.

It is recommended that the Consortium consider the development and representation of local networks.

5.3 Access to Inpatient Beds

Analysis of bed day utilization and palliative care patient admission/episode characteristics demonstrates that the demand for inpatient hospital palliative care services is substantially above the dedicated funded allocation to the Grampians Region. At the moment, the funding for this additional work comes out of the acute sector payment which is usually funded under WIES funding.

As palliative care patients have specific needs, this substantial gap in provision of services is of concern as it means that palliative care patients will be widely dispersed in all the hospitals and may receive 'patchy' support and service delivery.

It will not be possible to deliver the principles of the State Palliative Care Policy, in particular principles four, five and six which require that people with a life threatening illness and their carers and families should have 'access to specialist palliative care services when required', 'treatment and care that is coordinated and integrated across all settings', and 'access to quality services and skilled staff to meet their needs' (*Department of Human Services 2004*), unless the dedicated number of palliative care beds is substantially increased within the Grampians Region.

It is important to note the high percentage of bed days utilised for registered palliative care patients in non-designated public hospital beds throughout the Grampians Region and in particular the East Grampians Health Services and Wimmera Health Care Group which are 82.5% and 81% respectively. It should be further noted that within the Central Grampians Palliative Care service, inpatient episodes for 2003-2004 were 18.5%, or 44 episodes, at East Grampians Health Service – Ararat (*which has the designated palliative care bed*) and 31.6%, or 75 episodes, at Stawell Regional Health. Application for conversion of Nursing Home Type bed days to Designated Palliative Care bed days has been made by Stawell Regional Health to the Department of Human Services in September 2004. This application has not been successful to date.

Rural Northwest Health – Warracknabeal Campus do not have any allocation of designated palliative care bed days, however they have recently announced their intention to develop a palliative care inpatient area. In 2003-2004, Rural Northwest Health – Warracknabeal Campus inpatient episodes for registered palliative care patients were 7.75%, or 10, of the total inpatient episodes for the Wimmera Hospice Care patients.

It should be noted that in the Grampians Region, a large proportion of palliative care patients die in the hospital setting as opposed to the home setting. This practice differs from the State average and could be related to the average age of the patient as well as the geographical distances within the rural areas.

It is important that designated palliative care bed days are focused on areas where the breadth of the service and support is sufficient for the complex and sometimes chronic needs of this patient group. In light of this principle, and given the widespread distribution of palliative care patient admissions to non designated beds it is recommended that priority be given to utilising non assigned bed day funding in preference to designated bed day funding. Unassigned bed day funding is a more flexible funding model allowing the money to follow the patient rather than the patient following the money. Furthermore this funding system ensures that actual additional services are provided and not simply that bed day funding is substituted. It provides greater control for the palliative care services.

Palliative Care Australia recommends a minimum of 6.7 designated palliative care beds per 100,000 population. Given this ratio, the Grampians Health region population of well over 200,000 supports the need for a minimum 13.4 designated beds.

It is recommended that the Consortium apply to DHS to increase the number of designated palliative care beds for the region from 11 (10 designated inpatient and 1 unassigned bed) to 13.4 (10 designated inpatient and 3.4 unassigned beds) and that the western half of the Grampians Region receive priority in the allocation of the additional beds.

5.4 Regional Education

All stakeholders consulted throughout the consultative process strongly indicated the need for increased educational resources to the Grampians Region. provided This needs to be addressed as a priority in the future. The Community Palliative Care Services currently provide educational support to health and care professionals utilising their services, however this is limited due to lack of staffing and funding. The Regional Palliative Care Team attempts to provide a regional education program to doctors, nurses and primary care workers from very limited resources. However, it is unclear as to the composition of the staffing resources of the Regional Team as EFT and role delineation of team members was not able to be obtained from Ballarat Health Services notwithstanding a number of requests.

Consultations revealed a very broad range of service settings and providers that need to be considered if such a program is to be comprehensive. These include GPs, inpatient services, community health and district nursing, residential aged care and local government services including HACC. In addition, the regional team report that most of the target audience are restricted in their ability to attend educational sessions due to rostering and other commitments.

The Commonwealth's PEPA program has proven beneficial for the minimal number of staff who have been able to access it, however all services have expressed concern that they have not been able to access the program.

Currently, the Grampians Rural Health Alliance Network (GRHANet) is responsible for rolling out the information technology throughout the region and includes developing video conferencing facilities in all hospitals. Access and utilisation of these facilities should be considered for palliative care educational activities.

All services consulted expressed challenges in providing 'backfill' staffing to enable staff to attend educational programs. The capacity to release staff for ongoing professional development is very limited due to inadequate allocation within most of the funding models. This issue applies to all categories of staff in the community, hospitals, residential care and home environments. However it is unlikely that the palliative care budget will be able to afford to meet 'back-fill' requirements nor is it necessarily good policy. It is suggested that the cost of back-filling positions involved in palliative care professional development continue to be met as part of the ongoing responsibility of the health sector employer.

This study has found that the need for professional development in palliative care to the health sector is the highest priority for the regional plan. As this involves a wide range of services across a wide range of clinical and personal care categories, further study of the nature and delivery model for professional education is required. Such a study will also assist services to incorporate palliative care training into their broader professional development program.

Accordingly it is recommended the consortium allocate funding for a training needs assessment and the development of a multi disciplinary training plan.

5.5 Grief and Bereavement Services

Grief and bereavement counselling is a critical part of the palliative care services. Qualified counselling for this is only available in one of four services within the Grampians Region (Ballarat Hospice Care). Nursing staff are widely called upon to provide counselling in the rural areas of the Grampians Region where access to qualified counsellors are not available. Each of the four community based palliative care services advised that they provide regular access for their staff to attend personal counselling consultations.

Most persons and groups consulted advised the need for increased grief and bereavement counselling services in their area even though they are largely within the State average for counselling contacts. Pastoral care contacts

however, are well below the State average for the rural areas of the Grampians Region.

It is noted that the Central Grampians Community Health Services has received an increase in funds for grief and bereavement services. However, Community Palliative Care Services remain unable meet the demand for grief and bereavement services in their areas.

Table 15 shows the percentage of counselling and pastoral care contacts from the total number of contacts per service.

Table 15: Counselling and pastoral care contacts

Service	% Counselling Contacts	% Pastoral Care Contacts
Djerriwarrh	19.93	0.1
Ballarat Hospice Care	8.33	7.47
Central Grampians Health Service	0	0
Wimmera Health Service	5.24	0.02
State	6.29	2.95

Source: Department of Human Services 2003-2004

Consideration needs to be given to the allocation of funding grief and bereavement services to all four services. Each service will need to consider whether the counselling services are provided from within the services' resources or purchased through outsourcing. Consideration also should be given to the provision of grief and bereavement education for in-home staff, e.g. HACC staff, caring for palliative care patients.

It is recommended that additional funding be made available for the Community Palliative Care Services to purchase grief and bereavement services.

5.6 Equity and Access for Private Patients

A significant number of private patients are registered with the palliative care services in the Grampians Region. Private patients receive appropriate community palliative care in the Grampians region but find it difficult in gaining equal access to designated palliative care beds. Consequently a large percentage of registered patients utilise the private hospital system for care in their terminal phase.

The main private health facility in the Grampians Region is St John of God Health Care, Ballarat, which is a significant referral and palliative care service provider. This includes Radiotherapy services provided for the region. There were 142

inpatient episodes at St John of God Health Care, Ballarat, for patients registered with the four community palliative services from within the Grampians Region for 2003-2004. This equates to 18.35% of all inpatient episodes throughout the region.

St John of God, Ballarat are not included in any funding arrangements for palliative care in the Grampians Region. Clinical needs should be the determining feature for access for palliative care patients, not insurance status.

It is noted that St John of God Healthcare, Ballarat, has recently been appointed as a member of the Grampians Region Palliative Care Consortia.

It is recommended that private patients have equity of access to all publicly funded palliative care services in the region.

5.7 Volunteers

Palliative Care Services routinely link with volunteer programs, which are sometimes configured as 'wellness programs' or 'survivor programs'. It is now well recognized that support groups play a vital role in assisting people through a difficult time. However, volunteers need to be appropriately trained, supervised and supported to undertake this role. It is most important they work within the system that is structured and not provide conflicting or competing information that can confuse patients and their carers.

It is noted that the volunteer programs are highly variable within the Grampians Region. It is suggested that a generic 'support and training program' be established in each of the areas but stay closely linked to central resources.

Ballarat Hospice Care is currently undertaking a project funded by the William Buckland Foundation Grant which involves developing and implementing a model for increased utilisation of Volunteer Services in community palliative care programs. The project will extend for a two-year period at which time it will be evaluated by the University of Ballarat. Outcomes of the project will be "By the conclusion of the project palliative care volunteer service provision across the state will have been reviewed and recommendations made as to ongoing expansion of volunteer services at Ballarat Hospice Care. At least three discreet teams of volunteers, bereavement, fundraising and patient/family support workers will have been developed. The recruitment, selection, training and ongoing support of these volunteers will be supported by adequate policy and infrastructure." (*William Buckland Foundation Grant Application, Ballarat Hospice Care 2004*)

It is recommended that the consortium considers the outcomes of the Volunteer project with a view to extend this throughout the region.

5.8 Standardization of Documentation

Community palliative care services expressed a common desire to standardize the information requirements within the documentation that is used for palliative care patients. This includes referral forms, clinical progress notes, care plans and discharge plans, policies and protocols.

It is noted that DHS have developed, through their Primary Care Partnerships, Service Coordination Tool Templates “to support Service Coordination practice by assisting with identifying the initial needs of clients and providing a vehicle to collect and share core client information in a consistent way” (*DHS Primary Care Partnerships Website*). The SCoTT templates include such forms as referral, service coordination plan, psychosocial and health behaviour.

It is recommended that a working party be established by the Grampians Palliative Care Consortium to oversee the implementation of the Service Coordination Tool Templates (SCoTT), as per the DHS Guidelines.

5.9 Patient-centred Records

Stakeholders consulted advised that patients often presented to health professionals with no documented medical history. This poses issues of duplicating or omission of care and treatments, safety of staff and patients and efficiency and effectiveness of services.

Whilst health professionals take detailed records for their own records, dispersal of information and communication to the other professionals within the care team can always be improved. Case management conferencing often overcomes this issue but is not always possible in the rural areas due to distances of travel involved.

It needs to be highlighted that a nationwide pilot project, funded by the Commonwealth Government, and undertaken by the West Vic Division of General Practice, has prepared a comprehensive patient held medical record and information package.

It is recommended that following the successful evaluation of the pilot patient medical record and information package this be extended across the Grampians region.

If this proves successful after evaluation, it may be of interest to other services.

5.10 Inpatient Beds in Residential Aged Care Facilities

Designated palliative care beds have historically been sited in the acute hospital setting, however statistics demonstrate that a high percentage of patients are aged. Residential care staff in high care facilities are regularly providing care for patients with life threatening illnesses and anecdotal evidence suggests that non-registered palliative care patients occupy a significant number of high care places in residential care facilities. Siting the palliative care beds is best close to aged care beds although access to acute facilities should be easily achieved.

Stakeholders consulted confirmed that high care residents were often not registered with a palliative care service although was in effect receiving care in accordance with the palliative care principles.

Table 16 demonstrates the high percentage of registered palliative care clients within the Grampians Region aged 70 years and over. It should be noted that all four service areas have significantly higher percentage of aged persons than the State average.

Table 16: Proportion of palliative care clients aged over 70 years

Palliative Care Service	% clients 70 yrs +
Ballarat Hospice	61.57
Djerriwarrh	68.75
Central Grampians	55.1
Wimmera Hospice	67.79
State	34.48

Source: Department of Human Services Victoria 2003-2004

It is recommended that models of purchasing/supporting palliative care bed days in high care aged residential settings using unassigned bed days funding be considered. A pilot model could be established in the Wimmera Health Care Group which has a high care facility which is geographically located adjacent to the acute care facility.

5.11 After-hours Access

Providing after hours services in large geographical areas with small population base will always be a challenge. It is here that the linkages with acute services and emergency services need to be formalised and widely known.

All rural stakeholders consulted commented the difficulty in providing and accessing 24-hour services. However, given the distances required to be covered in the rural areas it is physically challenging to provide a face-to-face 24-hour service. Ballarat Health Services – Gandarra, provide a telephone advice service and health professionals in most areas within the Grampians Region access this service. District Nursing Services also provide 24-hour access in most areas or will direct the patient to acute emergency facilities where appropriate.

To provide staffing resources for 24-hour access is cost prohibitive, and so a compilation of measures may need to be actioned depending on the resources and arrangements in place within the individual communities.

It is recommended that the Consortium develop treatment plans for the most common palliative care emergencies in conjunction with each hospital's clinical reference group for use by all emergency departments and divisions of general practitioners. These plans should highlight how contact with the appropriate services can be optimized at the earliest possible time.

It is also recommended that an after hours telephone advice service be formalised. This service could be provided by specialist palliative care units such as Ballarat Health Services Queen Elizabeth Centre – Gandarra Unit or St Vincent's Caritas Christi.

5.12 Discharge Planning

Internationally, best practice in palliative care and oncology services is truly multidisciplinary. These include medical, surgical and radiation services, but more importantly, supportive care services. This last group represents a diversity of treating professionals and in particular a nurse care co-ordinator role. Equity of access to specialist palliative care services is required to build effective and efficient links between hospitals, community health and specialist palliative care services.

A common and persistent theme in feedback from all stakeholders was the importance of discharge planning to commence in a timely manner and thus ensuring patients have access to the full range of specialist palliative care services and also avoid patients presenting to the palliative care service in the end stage of their illness.

Registering the patient to a community palliative care service needs to be stressed and it should be considered mandatory that all patients entering the clinical service, who may finish with palliative care, should be assessed by a nurse or case co-ordinator within the initial consultation period. At this stage, the

broader range of support services can be detailed and patients appropriately registered for ongoing services. Funding should be made within the budget model to ensure this is achieved.

Assessment from our literature review revealed that:

- Weekly case management review involving oncology/palliative care nurses, community nurses, private nursing agency nurses, GP representatives, and allied health, in liaison with Griffith Base Hospital Emergency Dept and Pastoral Care;
- Joint agreement from all agencies on a single set of policies, procedures and clinical guidelines for the management of patients registered

It is recommended that the Consortia discuss with the Regional Integrated Cancer Service a policy that all patients entering treatment, who may require palliative care, be assessed by a nurse or case coordinator within the initial consultation period.

It is further recommended that regular case management consultative meetings be conducted within all palliative care services.

5.13 Regional Integrated Cancer Service

The *Cancer Services Framework for Victoria* outlines an integrated service model for metropolitan and regional cancer services based on the following principles:

- services will be population based;
- individuals will have access to the full range of services from prevention, screening, diagnosis, treatment, rehabilitation, supportive care and palliative care;
- referral pathways are clearly defined for the range of services required
- care is multidisciplinary and coordinated;
- high quality care requires a 'critical mass' of expertise and leadership.

The integrated service model to be adopted involves the establishment of three metropolitan and five regional Integrated Cancer Services (ICS), based on specified geographic populations. The philosophy of an ICS is that hospitals and primary and community health services develop integrated care and defined referral pathways for the populations they serve. This requires effective collaboration between hospitals and community based services including General Practitioners. This will promote more effective local coordination of care for cancer patients, and a more rational, evidence-based approach to cancer service planning and delivery. (*Victorian Government Cancer Initiatives Website 2005*)

The Grampians Palliative Care Consortia are now represented on the Regional Integrated Cancer Services committee. It is essential that the strategic direction for both the palliative care and cancer services within the region are integrated to ensure appropriate coordinated care between hospitals, health professionals and the community.

The parallel development of cancer and palliative care policies within the region provides an opportunity to build links and address the roles of specialist oncology and palliative care services.

Stakeholders consulted advised that palliative care patients would benefit from more frequent case conferencing between their medical oncologist and specialist palliative care providers and early registration with their palliative care service from their medical oncologist.

It is recommended that all future Palliative Care and Integrated Cancer Service Planning in the region acknowledge the interdependence of the two service systems and that for these services to be properly responsive, clinical guidelines highlighting the linkages, referrals and communication should be mandatory.

5.14 Indigenous Palliative Care

The National Palliative Care Program is currently funding the Indigenous Palliative Care Project which is being undertaken by the Victorian Aboriginal Community Controlled health Organisation (VACCHO) of behalf of DHS. This program follows on from the development of the National Indigenous Palliative Care Resource Kit and Practice Principles.

Within the scope of this project, the Koori community are seeking to explore how Koori palliative care issues can be integrated and supported across both Koori and mainstream specialist palliative care services and how Koori communities can be supported to provide care for palliative care clients in their communities.

A review conducted for the Grampians Region Palliative Care Alliance (GRPCA) in 2003 found there was a low demand for community-based palliative care from Koori people in the Grampians region and recommended a three-year action plan based around awareness of cultural needs, access to and understanding of Palliative Care services and a model for service delivery and promotion (Atkinson and Kerr, 2003).

It is recommended that the Grampians Palliative Care Consortia establish links with the Indigenous Palliative Care Project to explore further development of palliative care for the Koori communities of the region.

6. Implementation Plan

Recommendation	Responsibility	Date to commence	Date to be completed	Performance Indicator
1. That the Consortium, working with Ballarat Health Service, put in place greater transparency on future governance and resource allocation arrangements of the Regional team.	Consortia Executive/ Project Consultant	Jun 2005	Aug 2005	
2. That the Consortium consider the development and representation of local networks	Consortia Executive/ Project Consultant	Jun 2005	Jul 2005	
3. That the Consortium apply to DHS to increase the number of designated palliative care beds for the region from 11 (10 designated inpatient and 1 unassigned bed) to 13.4 (10 designated inpatient and 3.4 unassigned beds) and that the western half of the Grampians Region receive priority in the allocation of the additional beds.	Consortia Executive/ Project Consultant	Jun 2005	Sep 2005	
4. That the consortium allocate funding for a training needs assessment and the development of a multi disciplinary training plan.	Consortia Executive/ Project Consultant	Jul 2005	Oct 2005	
5. That additional funding be made available for the Community Palliative Care Services to purchase grief and bereavement services.	Consortia Executive/ Project Consultant	Jul 2005	Dec 2005	

Recommendation	Responsibility	Date to commence	Date to be completed	Performance Indicator
6. That private patients have equity of access to all publicly funded palliative care services in the region.	Consortia	Jul 2005	Ongoing	
7. That the consortium considers the outcomes of the Volunteer project with a view to extend this throughout the region.	Consortia	2006 (when project completed)		
8. That a working party be established by the Grampians Palliative Care Consortium to oversee the implementation of the Service Coordination Tool Templates (SCoTT), as per the DHS Guidelines.	Consortium Executive	Jul 2005	Feb 2006	
9. That following the successful evaluation of the pilot patient medical record and information package this be extended across the Grampians region.	Consortia	2006 (when project completed)		
10. That models of purchasing / supporting palliative care bed days in high care aged residential settings using unassigned bed days funding be considered.	Consortia	2006		
11. That the Consortium develop treatment plans for the most common palliative care emergencies in conjunction with each hospital's clinical reference group for use by all emergency departments and divisions of general practitioners.	Consortia	Sep 2005	Mar 2006	

Recommendation	Responsibility	Date to commence	Date to be completed	Performance Indicator
12. That an after hours telephone advice service be formalised.	Consortia	Sep 2005	Dec 2005	
13. That the Consortia discuss with the Regional Integrated Cancer Service a policy that all patients entering treatment, who may require palliative care, be assessed by a nurse or case coordinator within the initial consultation period. It is further recommended that regular case management consultative meetings be conducted within all palliative care services.	Consortia Executive	Jul 2005	Dec 2005	
14. That all future Palliative Care and Integrated Cancer Service Planning in the region acknowledge the interdependence of the two service systems and that for these services to be properly responsive, clinical guidelines highlighting the linkages, referrals and communication should be mandatory.	Consortia	Jul 2005	Feb 2006	
15. That the Grampians Palliative Care Consortia establish links with the Indigenous Palliative Care Project to explore further development of palliative care for the Koori communities of the region.	Consortia Executive	Jul 2005	Mar 2006	

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Appendix 1: Consultations

Department of Human Services

Mr John Koopmans Program Advisor, Palliative Care
Grampians Region, Ballarat

Mr Michael Bramwell Project Officer, Palliative Care and Specialist
Programs Metropolitan Health and Aged Care
Services

Ms Glenda Stanislaw Manager, Primary and Community Health
Grampians Region

Ballarat Health Services

Dr David Brumley Clinical Director of Palliative Care
Gandarra Palliative Care Unit

Ms Marian Hubbard Director Community Programs

Ms Maree Kewish Nurse Unit Manager
Gandarra Palliative Care Unit

Mr Lawrence Harbeggar Clinical Nurse Specialist
Gandarra Palliative Care Unit

Ms Meg Clinical Nurse Specialist
Gandarra Palliative Care Unit

Ms Jade Odgers Regional Palliative Care Nurse

Ballarat District Nursing Service

Ms Michelle Veal Nursing Services Manager

Ballarat Hospice Care

Ms Heather Robinson Co-ordinator

Ms Jill Clinical Nurse Consultant

City of Ballarat

Ms Robyn Stevens Team Leader, Assessment

Djerriwarrh Health Services

Mrs Jane Cape Manager Community Nursing Services

Ms Robyn Tucker Clinical Nurse Consultant

Dunmunkle Health Services

Ms Vicki Jenkin District Nurse

East Grampians Health Service

Mr Darren Clark Coordinator, Central Grampians Palliative Care

Ms Maria Stickland Director of Patient Services

East Wimmera Health Service

Ms Josephine Hennessy St Arnaud Campus

Hepburn Health Service

Ms Gabrielle Bence Executive Director of Nursing

Stawell Regional Health

Mr Michael Delahunty Chief Executive

Ms Claire Letts Director of Clinical Services

St John of God Health Care – Ballarat

Ms Nola Poulter Nurse Unit Manager

Ms Annie Rivett Director of Nursing

Ms Lyn Stonehouse Discharge Planner

West Wimmera Health Service

Executive Director

Grampians Community Health Centre

Ms Ann Manager

Rural North West Health

Ms Bronwyn Clayton District Nurse

Ms Melissa Cook Registered Nurse

Ms Coral Schmidt Nurse Unit Manager

Wimmera Health Care Group

Ms Anne Hayes Coordinator Wimmera Hospice Care

Ms Wendy Lewis Director of Clinical Services

Ms Janette McCabe Nurse Unit Manager, Acute Care

Ms Cathy Newell District Nurse

Ms Jill Roberts Nurse Unit Manager, Aged Care

Mr Chris Scott Chief Executive Officer

Ms Helen Tory District Nursing Unit Manager

Ms Denise Wickham Nurse Unit Manager, Acute Care

Dr Alan Wolf Director Medical Services

Medical Oncologist

Dr Rodney Bond Ballarat Oncology & Haematology Services

Primary Care Partnerships

Ms Tracy Wilson Executive Officer, Central Highlands PCP

Regional Integrated Cancer Services

Dr Stephen Vaughan Medical Oncologist

Ms Colleen O'Hara

Division of General Practice

Dr Rob Grenfell	GP Consultant, West Vic Division of General Practice
Ms Catherine Mackay	Project Officer, West Vic Division of General Practice
Ms Jane Measday	Senior Projects Manager

Yariambiack Shire Council

Ms Olinda Poulton	Community Services Manager
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Appendix 2: Wider stakeholder forum notice

Suite 6/10 Hoddle Street Abbotsford 3067
Tel (03) 9419 1255 skerr@alphalink.com.au

Grampians Region Palliative Care Plan 2004 - 2009

Consultations with Stakeholders

The Grampians Region Palliative Care Consortium is developing a plan for how palliative care services are to be delivered across their region. The Palliative care Plan will cover a 5 year span from 2004 – 2009 and will determine the community's palliative care needs, assess future demands, describe the current services and identify current and future service requirements.

Atkinson Kerr and Associates Pty Ltd have been engaged to develop this plan. They have completed a number of similar reviews. The plan will support the Department of Human Services Victoria policy: *Strengthening palliative care: a policy for health and community care providers 2004-2009*.

Atkinson Kerr and Associates will be conducting three stakeholder forums in Ararat, Horsham and Ballarat to discuss these matters and also distribute a short questionnaire to participating groups.

	<u>Horsham</u>	<u>Ararat</u>
DATE:	WEDNESDAY 2nd March, 2005	THURSDAY 3rd March, 2005
TIME:	12.30PM Onwards <i>(Light Lunch Provided)</i>	1400 <i>(Refreshments Provided)</i>
VENUE:	Board Room Wimmera Health Care Group Baillie street, Horsham	Meeting Room East Grampians Health Service Ararat
RSVP:		

Appendix 3: Survey

atkinson kerr and associates

Suite 6/ 10 Hoddle Street 3067

Telephone (03) **9419 1255**

Mobile **0417500394**

Facsimile (03) **9486 7911**

E-mail skerr@alphalink.com.au

PO Box 238 Clifton Hill 3068

RE : Grampians Regional Palliative Care Plan 2004-2009

The Grampians Region Palliative Care Consortium is developing a plan for how palliative care services are to be delivered across their region. The Palliative care Plan will cover a 5 year span from 2004 – 2009 and will determine the community's palliative care needs, assess future demands, describe the current services and identify current and future service requirements.

Atkinson Kerr and Associates Pty Ltd have been engaged to develop this plan. They have completed a number of similar reviews. The plan will support the Department of Human Services Victoria policy: *Strengthening palliative care: a policy for health and community care providers 2004-2009*.

Attached is a questionnaire that we would like you to look at and either fill it out and return by email (make sure you save before sending), fax or post or bring along to the Workshop Forum with you.

The process is confidential and none of your comments will be directly identifiable Many thanks

Yours sincerely

Stephen Kerr
Project Co-ordinator.

GRAMPIANS REGION PALLIATIVE CARE PLAN 2004 - 2009

Date:

Service name:

Name and title of the person completing the questionnaire:

NB: use the yes/no column if it is a yes/no question, otherwise use the detailed response column.

You can fill this survey out electronically, then save it under your service's name prior to returning by email. Alternatively you can fax or post.

	yes/no	detailed response
1. Do you: a) provide any Palliative Care Services? If so please list. b) access Palliative Care Services? If so please list. c) refer clients to Palliative Care Services? If so please list.		
2. Who does your service target? 3. Are your patients/clients drawn from a particular geographic area?		
4. What links are there between your service and the Palliative Care Service Providers in your area?		
5. What gaps or weaknesses do you see there are in the Palliative Care Services in your area?		
6. What could be provided to enhance the Palliative Care Services in your area?		
7. What are the 3 most urgent priorities you see regarding Palliative Care Service Planning in your area?		
8. What is your vision for Palliative Care in your area?		

	yes/no	detailed response
9. How do you think the providers will work together to achieve this?		
10. What mechanisms do you see necessary to facilitate the integration of the Palliative Care Service delivery in the region?		
11. What resources do you think are needed to achieve above?		
12. Any other comments?		

Thank you. ***If you have filled this out electronically, remember to SAVE THE FILE under your services' name prior to returning it by email to skerr@alphalink.com.au***