loddon mallee
regional palliative care consortium

Regional Strategic Plan 2012-15

Vision

Working collaboratively with stakeholders and the community, so that people in the Loddon Mallee Region with a progressive life-limiting illness and their families/carers, have access to high quality, innovative, responsive and coordinated services.

Our role

Our role is to help deliver and facilitate the Victorian Government's *Strengthening palliative care: Policy and strategic directions 2011-2015*[1], and the relevant *Implementation Strategy*[2] across the Loddon Mallee region.

Our values

- Open, respectful and transparent communication.
- Commitment to consumer, carer & stakeholder participation.
- Collaborative planning underpinned by a social model of health.
- Evidence based quality care.

[1] Herewith referred to as the state policy.
[2] Available at http://docs.health.vic.gov.au/docs/doc/Strengthening-palliative-care-implementation-strategy

Our Major strategic directions

There are seven strategic directions in the state policy as follows:

The Loddon Mallee Palliative Consortium (LMPCC) has mapped these directions into four regional priority areas, as shown in the adjacent table:

Our strategic direction	Relevant Strengthening Palliative Care strategic direction
1. Coordinating Quality Care Across Settings	1. Informing and involving clients and carers 3. Working together to ensure that people die in their place of choice 4. Providing specialist care when and where it is needed 5. Coordinating care across settings 6. Providing quality care supported by evidence
2. Building capacity in the palliative care workforce	4. Providing specialist care when and where it is needed 5. Coordinating care across settings
3. Delivering targeted health promotions	1. Informing and involving clients and carers 2. Caring for carers 3. Working together to ensure that people die in their place of choice 5. Coordinating care across settings 7. Ensuring support from communities
4. Building and maintaining a sustainable Consortium	5. Coordinating care across settings

The Consortium will deliver on these initiatives within our resources and structures via our strategic plan.

Major delivery areas

The table below shows how the LMPCC intends to deliver each of the strategic directions in alignment with the Department of Health's *Strengthening Palliative Care: Policy and Strategic Directions 2011-2015* document.

Goals	Objectives	Strategies
Strategic direction 1 - Coordinating Quality Care Across Settings		
Ensure people who need access to specialist palliative care are receiving care appropriate to their needs at the right time, in the place of their choice.	Drive the establishment of, and monitor, a consultancy level palliative care service across the whole Loddon Mallee Region. The service delivery will be in line with the government's Palliative Care Service Capability Framework[3] in so far as this can be met within available resources.	Steer and support the establishment of an efficient and effective Multi Disciplinary Team (MDT)[4] within Bendigo Health, including being party to a written guideline as developed by Bendigo Health, Department of Health and the Consortium. Receive and monitor regular reports of MDT activities from Bendigo Health and report these in line with Department of Health requirements. Evaluate the MDT model within two years of establishment, determining and implementing refinements to the MDT model.

[3] Available as part of the state policy.
[4] Often also referred to as a Consultancy or a level 3 service.

Goals	Objectives	Strategies
	Continue to work with the Victorian Aboriginal Palliative Care Program (VAPCP)[5] to develop Aboriginal peoples' awareness of and access to palliative care services and enable palliative care services to provide culturally appropriate palliative care.	Work closely with VAPCP to help increase the linkages, partnerships and relationship between aboriginal health organisations and Consortium members across the region.
	Identify areas where access to palliative care for people from a CALD can be improved.	Link with bodies representing and working with people from CALD backgrounds and Palliative Care Clinical Network (PCCN) CALD projects to identify issues and projects to improve access regionally.
Increase the availability of after-hours support to clients and carers in their homes.	Establish, evaluate and govern an ongoing program to improve after-hours support.	In conjunction with key stakeholders, plan an ongoing sustainable After Hours Program. This will align with the Department of Health's *After Hours Palliative Care Framework*[6] and strengthen the structures delivered through the 2009-11 After Hours Pilot Project. Evaluate the After Hours Program in year three of the strategy and regularly report program activities in line with program plan, Consortium member expectations, and Department of Health requirements.

[5] This is auspiced through the Victorian Aboriginal Community Controlled Health Organisation (VACCHO).
[6] http://docs.health.vic.gov.au/docs/doc/After-hours-palliative-care-framework

Goals	Objectives	Strategies
Ensure all Victorian palliative care services provide quality care that is assessed against national standards and supported by a quality improvement culture.	Use tools, measures and initiatives from the National Standards Assessment Program (NSAP), Palliative Care Outcomes Collaboration (PCOC) and Palliative Care Clinical Network to improve the quality of care provided by Consortium members.	Operate a clinical group within the Consortium (CORG[7]). Members will work together and within their services to help implement: • An appropriate degree of PCOC. • NSAP as directed by the Department of Health. • Other tools and initiatives developed by the Palliative Care Clinical Network and the Department of Health as appropriate.
Use technology to enhance service coordination for all palliative care services.	Opportunities to enhance use of technology across Consortium members are identified and utilised.	Identify and scope IT projects that can enhance service coordination and quality. Seek funding and deliver IT projects where possible, in alignment and partnership with LMRHA[8], as appropriate. Maintain communication with the LMRHA and awareness of ICT initiatives including the Transition Care telemedicine project, levering off existing initiatives where possible. Consider opportunities for a single integrated data base of registered Palliative Care clients in the Loddon Mallee Region. Utilise telemedicine as part of the MDT model.

[7] The Clinical Operations Reference Group which is made from Consortia members and other invited participants.
[8] Loddon Mallee Rural Health Alliance, an IT joint-venture that most Consortium members belong to.

Goals	Objectives	Strategies
Strategic Direction 2: Building capacity in the palliative care workforce		
Increase the capacity and specific knowledge of those in the healthcare workforce encountering palliative care clients.	Develop and deliver an appropriate education plan and strategy across the Loddon Mallee Region.	Complete an educational gap analysis to identify the need in the region and a strategy to meet this need. Within the constraints of funding and other priorities, build appropriate educational activities into MDT and Consortium activities and report these to Department of Health as appropriate. Support the practice of Palliative Care Nurse Practitioners within the Region as part of the MDT. Seek opportunities for the introduction of a new practitioner in the Northern part of the Region.
Assist aged care services to care for people at the end-of-life	Assist residential care facilities across the Loddon Mallee Region to implement end-of-life care pathways.	The MDT will work with the various regional aged care agencies to implement end of life care pathway services and programs[9]. The Consortium will receive and monitor regular reports of MDT aged care activities from Bendigo Health and report these to the Department of Health.
Improve palliative care capacity in disability accommodation services	People living in disability accommodation services who have a life-threatening illness are supported to be cared for and die in their place of choice.	The MDT will work with the various regional disability stakeholders to improve the capacity of this sector to provide palliative care in line with relevant Department of Health implementation plans. The Consortium will receive and monitor regular reports of MDT disability activities from Bendigo Health and report these to the Department of Health.

[9] In line with best practice as identified by the Centre for Palliative Care http://centreforpallcare.org/index.php/resources/end_of_life_care_pathways/

Goals	Objectives	Strategies
Implement the palliative care service delivery framework (SDF) across Victoria, with advice from the PCCN.	Clients have access to an appropriate level of specialist palliative care in their region. There is clear information about the palliative care services that are available across regions and the capabilities of these services.	Work with Department of Health to identify appropriate actions the Consortium can do to help regional service planning become more aligned with the SDF. Deliver any appropriate actions, most likely commencing from 2013-14.
Strategic Direction 3: Delivering targeted health promotions		
Raise awareness of palliative care by other health, community, and aged care providers to ensure that people are cared for and die in their place of choice. Strengthen the Loddon Mallee communities' awareness, capacity and resilience in relation to dying, death, loss and bereavement, and their ability to support people with a life-threatening illness and their carers.	Develop and deliver an agreed palliative care health promotions strategy across the Loddon Mallee Region.	Develop a realistic and achievable health promotions strategy in line with stakeholder expectation and best-practice promotions standards. Evaluate Consortium health promotion activities in year three of the strategy and regularly report the activities in line with Consortium member and Department of Health expectations.

Goals	Objectives	Strategies
Provide information about palliative care that is tailored to the needs of clients and carers.	Carers and clients receive targeted information.	Continue to identify, share, streamline and improve client and carer information through the CORG in line with PCCN and Department of Health initiatives. Work with relevant stakeholders to review, finalise, publish and distribute the Carers' Kit developed by the CORG in 2011/12. Disseminate further copies of the Patient Planner[10] across the region.
Strategic Direction 4 - Building and maintaining a sustainable Consortium		
Strengthen links between stakeholders in palliative care	Influence and impact of the Consortium is strengthened by solid networks and connections across the region and in relevant statewide settings.	Engage with relevant health, community, aged care and other bodies including but not limited to Palliative Care Victoria, Motor Neurone Disease regional workers, VACCHO, primary care partnerships and medicare locals. Actively participate in the Palliative Care Clinical Network, Loddon Mallee Integrated Cancer Service, and statewide Consortium Managers Meetings.
Continue to enhance the governance of the Consortium	Consortium runs efficiently and effectively, with the right mix of strategic, stakeholder and operational input.	Ensure there is an appropriate framework in place to meet all Department of Health reporting requirements. Improve budgeting and reporting processes within the Consortium. Develop and sign a detailed agreement between Consortium and fundholder about treatment and reporting of funds.

[10] Published by the Central Victorian GP Network as an outcome of a federally funded project.

Goals	Objectives	Strategies
		Maintain and update the following documents in line with Department of Health role statements and strategies: • Consortium MOU • Terms of Reference (which will be developed for the Board and all sub-committees) • Any additional role statements. Develop and implement annual work plans for the Board and Sub-Committees and monitor and report their progress. Undertake an annual review of the functioning of the consortium and the sub-committees and make changes as appropriate.
Efficiently and effectively deliver our core business and small projects and programs.	Plan, deliver, evaluate and acquit against our funding streams in an efficient and effective manner.	Maintain the post-PEPA[11] program of educational activities targeted at health professionals while it is funded. Maintain a sponsorship program to help enhance palliative care knowledge and experience across the region. Utilise Consortia surplus funds to deliver against the Strategic Plan.

[11] Program of Experience in the Palliative Approach.