Palliative Care Outcomes Collaboration
Australian Health Services Research Institute
iC Enterprise 1, Innovation Campus
UNIVERSITY OF WOLLONGONG NSW 2522

Inquiry into Palliative Care in Australia

Submission by Palliative Care Outcomes Collaboration (PCOC) to Senate Standing Committees on Community Affairs

Introduction

Palliative Care Outcomes Collaboration (PCOC) is an excellent example of a national and voluntary programme using benchmarking to measure outcomes in palliative care. PCOC assists palliative care providers to improve patient outcomes by enabling their clinicians to accurately assess the quantity of car they provide to their patients.

PCOC obtains and reports on information regarding patient care and symptom management. This information supports clinicians in their treatment decisions, assists managers in their service planning and informs policy makers in funding and planning services.

Participating palliative care services submit their data sets biannually to PCOC, enabling PCOC to develop state and national data sets. These datasets are analysed and reported to services, providing them with feedback of their performance, recognition of their achievements and opportunities for quality improvement in their delivery of patient care.

With the primary aim of enhancing palliative care delivery in Australia, PCOC works to support palliative care services by providing education, report analysis and participation in research and quality improvement activities.

Integral to PCOC's success has been the ongoing support of the Australian Government, the collaboration and management of the four universities, the Chief Investigators and the members of the PCOC team including management, IT support, data analysis, Quality Improvement Facilitators and the participating services.
See Appendix A: List of services participating in PCOC.

A service can participate in PCOC when they can demonstrate that
- Palliative care patients are receiving clinical care
- After a formal clinical assessment
- By members of a multidisciplinary team
- Using PCOC assessment tools
- Which drive the care plan

- And are capable of collecting the PCOC clinical measures

PCOC works with participating services to develop national quality and outcomes benchmarks. There are currently 16 benchmark measures in relation to:

- Referral to first contact (responsiveness)
- Time (number of days) a patient is assessed as being in the unstable phase (timely management of acuity)
- Change in pain (pain management)
- Change in symptoms relative to the national average (comparison to a current agreed national average)

See Appendix B: PCOC Benchmarks & Measures

PCOC palliative care services have reported improvements in clinical practice through:

- The use of 5 standardised validated clinical assessment tools covering key palliative care domains
- The collection of information surrounding patient acuity, episodes (location) and phases of care
- The use of a common language for communicating amongst health professionals
- Identifying service performance achievements and gaps, leading to quality improvement opportunities based on best practice and evidence
- National benchmarking – enabling services to network, collaborate and share knowledge

In recognising their common goal to improve palliative care for patients and their families in Australia, PCOC has collaborated with two other National Palliative Care Programs, Caresearch and NSAP. This has been formalised through the development of a *Working Together Fact Sheet*. Appendix C: Working Together Fact Sheet

Key Messages

The health benefits from good palliative care have a broad reach across the community, which benefits patients, carers, family and community members.

1. PCOC is able to measure outcomes that demonstrate:
   a) appropriate and timely access of palliative care to those who need it, based on a sub-acute case mix model rather than the acute care model.
   b) the use of validated evidence based assessment tools to provide best practice
   c) standardised assessment tools that gives a common language for efficient communication of information between multidisciplinary team members and external organisations

2. PCOC exemplifies the need and benefit of long term investment in a commonwealth funded initiative rather than short term project funding. PCOC produced its first report in

March 2006 with 8 participating services. Report 12 will be produced within the next few weeks (March 2012) with 102 participating services. Over time PCOC has shown how outcomes in palliative care can improve by the introduction of standardised assessment tools, providing education, supporting implementation and a feedback process for improving quality care.
See Appendix D: Comparison Report 7 – 11.

Addressing the Term of Reference

The provision of palliative care in Australia, including:

(a) the factors influencing access to and choice of appropriate palliative care that meets the needs of the population, including:

- Participation in PCOC can identify appropriate palliative care through measuring palliative care outcomes
- The benchmarks and measures of PCOC include a benchmark to measure access to palliative care. Appendix B details the PCOC Benchmarks and measures.
- Review of the benchmark around time from referral to contact has resulted in some changes to this benchmark. The new version of this benchmark includes the new item of “date ready for care” which is envisaged to greatly assist in capturing the practice of early referral for palliative care patients.

(i) People living in rural and regional areas

Access to palliative care services will be enhanced through the systemic roll out of PCOC assessment tools across primary care. Primary care providers are recognised as community based providers such as general practitioners, community nurses, allied health, residential aged care providers and public/private hospital staff in acute, sub acute and rural/remote areas.

The roll out of the PCOC assessment tools across primary care providers is currently delivered on a voluntary basis at the request of participating services. Multiple opportunities exist to broaden the participation of primary care providers across Australia. For example in Western Australia, Western Australia Health has commenced the rollout of PCOC assessment tools in all regional health services. South Australia has commenced the rollout of these tools in country SA. Rural and remote regions in NSW are currently not participating in PCOC. Rural and remotes areas of Queensland vacillate between participation and non participation due to resource allocation. There are no Northern Territory palliative care or primary care services participating in PCOC. (See Appendix A).

It is envisaged that the systemic roll out of PCOC assessment tools and participation in PCOC would greatly enhance access to palliative care for people living n rural and regional areas of Australia.

PCOC is well positioned with Quality Improvement Facilitators across Australia to deliver the education for the use of the PCOC assessment tools and interpretation of palliative care outcomes against benchmarks and measures.

(ii) Indigenous people : The PCOC Strategic Plan for 2011-13 (See Appendix E) has identified the need to enhance the capacity of indigenous health service providers to utilise PCOC assessment tools and participate in the collaboration

(iii) People from culturally and linguistically diverse backgrounds: PCOC will seek to partner with CALD service providers/peak bodies to review current assessment tools

(iv) People with disabilities: services participating in PCOC do not identify patients who are disabled. There is no specific disability benchmark.

(v) Children and adolescents: PCOC has a deliverable under the current funding agreement to develop a paediatric dataset. PCOC is currently negotiating with Australian Rehabilitation Outcomes Collaboration (AROC) to look at opportunities to establish a joint project to develop a paediatric data set for rehabilitation and palliative care

b) the funding arrangements for palliative care provision, including the manner in which sub-acute funding is provided and spent;

PCOC has within its data set the variables required for determining the activity based funding and the acuity for funding.

PCOC is one of the programs funded under the National Palliative Care Program. The PCOC Strategic Plan 2011 – 2013 recognises the National Strategy and details KPIs that can be measured to demonstrate connection to the national strategy (Appendix E). The National Palliative Care Programs have the capacity to meet the priority areas identified in the national strategy.

PCOC and other members of the National Palliative Care Program have the capacity to lead and contribute to priority areas of the national strategy action areas including:

- collaboration across PCOC, NSAP and Caresearch
- reviewing national outcome data
- engagement and linkages throughout the palliative care sector
- improving the skill level of primary care and specialist palliative care providers.

c) the efficient use of palliative, health, and aged care resources;

PCOC is currently undertaking a project in Residential Age Care to implement the five PCOC assessments tools for residents within those facilities to achieve better palliative care outcomes.

d) the effectiveness of a range of palliative care arrangements, including hospital care, residential or community care and aged care facilities;

Services participation in PCOC represents palliative care service provision in hospital care, consultancy, community care and ambulatory care. *PCOC Outcomes in Palliative Care* biannual reports capture the effectiveness of outcomes for palliative care across all settings at individual service level, state and national levels. The reports also demonstrate the levels of improvement of across the Palliative Care Problem Severity Score and the Symptom Assessment Scale.

(e) the composition of the palliative care workforce, including:
  (i) its ability to meet the needs of the ageing population, and
  (ii) the adequacy of workforce education and training arrangements;

PCOC delivers PCOC assessment workshops to up-skill primary service providers and specialist service providers in the use of the PCOC assessment tools. The workshops attract 5.75 CPD hours for nursing staff. There is capacity for PCOC to investigate CPD hours for medical and allied health as the composition of attendees at these workshops includes multidisciplinary participation. PCOC has also identified the need to develop an advanced element of training to incorporate the strategic use of *PCOC Outcomes in Palliative Care* reports for service planning and service delivery. An example of the evaluation of Assessment Workshops is attached.
Appendix F: Report on NSW PCOC Assessment Workshops 2011.

(f) the adequacy of standards that apply to the provision of palliative care and the application of the standards for Providing Quality Care to all Australians;
PCOC recognises the *PCA Standards for Providing Quality Care to All Australians* need to be reviewed for currency.

(g) advance care planning, including:

- (i) avenues for individuals and carers to communicate with health care professionals about end-of-life care
- (ii) national consistency in law and policy supporting advance care plans, and
- (iii) scope for including advance care plans in personal electronic health records;

PCOC is collaborating with Respecting Patient Choices (another National Palliative Care Program) to undertake a snapshot study to measure the extent of advanced care planning across palliative care services participating in PCOC. It is envisaged this snapshot study will inform the development of specific advanced care planning questions in the assessment process of PCOC. Under the collaboration, discussion continues around the possible future role of the PCOC Quality Improvement Facilitators delivering advanced care planning training and education.

(h) the availability and funding of research, information and data about palliative care needs in Australia;

PCOC has commenced dialogue with the Department of Veterans Affairs to seek possible funding to research the palliative care outcomes for veterans in Australia. Currently veterans are not specifically identified by palliative care services participating in PCOC and PCOC is unable to determine if the palliative care outcome for veterans differs from the palliative care outcomes of the general population.

PCOC is a strategic and collaborative approach to data collection and data repository which focuses on palliative care patient outcomes. PCOC is liaising with AIHW to assist with queries around publication of a national picture of palliative care across the country.

Submission enquiries:

Professor Kathy Eagar
Executive Director
Palliative Care Outcomes Collaboration

Wendy Gain
National Director
Palliative Care Outcomes Collaboration

Appendix A: List of services participating in PCOC

Palliative Care Services Submitting Data for PCOC Report 12 (July – December 2011)

Palliative Care Service	State
Calvary Health Care Canberra (Clare Holland House)	ACT
Baringa Private Hospital	NSW
Calvary Health Care Sydney	NSW
Calvary Health Care Riverina	NSW
Calvary Mater Newcastle	NSW
Camden Hospital	NSW
Canterbury Hospital	NSW
David Berry Hospital	NSW
HammondCare - Braeside Hospital	NSW
HammondCare - Greenwich Hospital	NSW
HammondCare - Neringah Hospital	NSW
Lourdes Hospital	NSW
Manning Rural Referral Hospital	NSW
Mercy Care Centre - Young	NSW
Mercy Health Service Albury	NSW
Mt Druitt Hospital	NSW
Nepean Hospital	NSW
Port Kembla Hospital	NSW
Sacred Heart Palliative Care Service	NSW
St Joseph's Hospital	NSW
St Vincent's Hospital Lismore	NSW
St Vincent's Hospital, Sydney - Palliative Care Consult Service	NSW
Tamworth Base Hospital	NSW
Westmead Hospital	NSW
Blue Care Toowoomba Community	QLD
Bundaberg Palliative Access	QLD
Cairns and Gordonvale Hospital	QLD
Caloundra Hospital	QLD
Canossa Private Hospital	QLD
Gladstone Hospital	QLD
Gympie Hospital	QLD
Hervey Bay & Fraser Coast Palliative Care Service	QLD
Hopewell Hospice	QLD

Palliative Care Service	State
Ipswich Hospice	QLD
Ipswich Hospital	QLD
Karuna Hospice Services	QLD
Mater Adult's Hospital Brisbane	QLD
Mater Private Brisbane	QLD
Mater Private Bundaberg	QLD
Mater Private Mackay	QLD
Nambour Hospital	QLD
Rockhampton Base Hospital	QLD
Royal Brisbane and Women's Hospital	QLD
St Vincent's Hospital Brisbane	QLD
Sunshine Coast and Cooloola Community Palliative Care Service	QLD
The Prince Charles Hospital	QLD
Toowoomba Hospital	QLD
Townsville Palliative Care Centre	QLD
Wesley Private	QLD
Wynnum Hospital	QLD
Adelaide Hills Community Health Service	SA
Calvary Health Care Adelaide (Mary Potter Hospice)	SA
Lower North (Clare) Palliative Care Service	SA
Lyell McEwin Palliative Care Service	SA
Modbury Hospice SA	SA
Port Lincoln Health Service	SA
Port Pirie Regional Health Service	SA
Riverland Palliative Care Service	SA
Royal Adelaide Hospital	SA
South East Regional Community Health Service	SA
Southern Adelaide Palliative Services	SA
Stirling District Hospital	SA
Whyalla Palliative Care Service	SA
Yorke Peninsula Palliative Care	SA
Calvary Health Care Tasmania - St John's	TAS
JW Whittle Palliative Care Unit	TAS
Tasmania Community North	TAS
Tasmania Community North West	TAS
Tasmania Community South	TAS
Banksia Palliative Care Services	VIC

Palliative Care Service	State
Cabrini Prahran	VIC
Calvary Health Care Bethlehem	VIC
Caritas Christi - Fitzroy	VIC
Caritas Christi - Kew	VIC
Eastern Health Wantirna	VIC
Eastern Health Yarra Ranges Clinic	VIC
Eastern Palliative Care	VIC
Gandarra Palliative Care Unit - Ballarat	VIC
Goulburn Valley Hospice Inc.	VIC
Lower Hume Palliative Care	VIC
McCulloch House - inpatient unit	VIC
Melbourne Citymission Palliative Care	VIC
Mercy Palliative Care - Medical Consultant	VIC
Mercy Palliative Care - Sunshine	VIC
Northern Health Broadmeadows Palliative Care Unit	VIC
Northern Health Palliative Care Consult Team	VIC
Peter MacCallum Cancer Centre	VIC
Royal Melbourne Hospital Palliative Care Unit	VIC
South East Palliative Care	VIC
St John of God - Geelong	VIC
Sunraysia Community Palliative Care Service Clinic	VIC
Werribee Mercy Hospital	VIC
Armadale Hospital	WA
Bethesda Hospital	WA
Northam Palliative Care	WA
Palliative Ambulatory Service North (Bethesda Hospital)	WA
Royal Perth Hospital	WA
Royal Perth Hospital - Nurse Practitioner	WA
Silver Chain Hospice Care Service	WA
St John of God Hospital - Bunbury	WA
St John of God Hospital - Geraldton	WA
St John of God Murdoch Community Hospice	WA

Appendix B: PCOC Benchmarks & Measures

NATIONAL BENCHMARKS AND TARGETS

PCOC worked with participating services in 2009 to develop our first set of national quality and outcomes benchmarks. These were the subject of extensive consultation at three workshops held in Brisbane, Sydney and Adelaide in May and June 2009 to which all participating services were invited.

The measures are included and explained in the PCOC national report but are summarised below. In December 2009, national ***benchmarks*** (standards of performance that all services will be measured against) were formally adopted for each measure.

Benchmark Measures

1. TIME FROM REFERRAL TO FIRST CONTACT

Time from referral to first contact is calculated as the time in days between the referral date and the date of first contact or episode start date (whichever occurs first) and is calculated for all episodes of care and across all settings of care. Although definitional issues around this measure have been identified it was decided that it is still a useful measure of service responsiveness and that changes to be incorporated into the next (Version 3) dataset will improve the collection, quality and understanding of the items required for this measure.

Benchmark 1.1: 90% of patients are contacted by a member of the clinical team (face-to-face or by phone) either the day of, or the day following referral

2. TIME IN THE UNSTABLE PHASE

Time in the unstable phase is calculated as the difference between the phase start date and the phase end date and is analysed by episode type and the occurrence of the unstable phase during the episode.

Benchmark 2.1: 85% or more of patients in their first palliative care phase remain in the unstable phase for less than 7 days.

Benchmark 2.2: 90% or more of patients in a subsequent palliative care phase remain in the unstable phase for less than 7 days.

Benchmark 2.3: The median time in the unstable phase is 2 days or less.

3 - CHANGE IN PAIN (BOTH PCPSS AND SAS)

Change in pain is calculated by the difference in pain score from the beginning of a phase to the end of phase and is calculated using both Palliative Care Problem Severity Score (PCPSS) pain and Symptom Assessment Score (SAS) pain measures. It is also reported by setting of care.

Benchmark 3.1:	At least 90% of patients with absent or mild PCPSS pain at the beginning of their phase of palliative care have absent or mild PCPSS pain at the end of the phase
Benchmark 3.2:	At least 60% of patients with moderate or severe PCPSS pain at the beginning of their phase of palliative care have absent or mild PCPSS pain at the end of the phase
Benchmark 3.3:	At least 90% of patients with absent or mild SAS pain at the beginning of their phase of palliative care have absent or mild SAS pain at the end of the phase
Benchmark 3.4:	At least 60% of patients with moderate or severe SAS pain at the beginning of their phase of palliative care have absent or mild SAS pain at the end of the phase

4 - CHANGE IN SYMPTOMS RELATIVE TO THE NATIONAL AVERAGE

Change in symptoms relative to the national average measures the mean change in symptoms on the PCPSS/SAS that are adjusted for both phase and for the symptom score at the start of each phase. This measure allows services to compare the change in symptom score for ‘like’ patients i.e. patients in the same phase who started with the same level of symptom. Eight symptoms were included in the last report (PCPSS pain, other symptoms, psychological/spiritual, family/carer; SAS pain, nausea, bowels, breathing).

Zero is the baseline national average. A positive score indicates that a service is performing above the baseline national average and a negative score that it is below the baseline national average.

The baseline national average has been calculated based on the period July to December 2008 and this will be reviewed mid 2012. Each service will be measured against this baseline national average for each 6 month reporting period. This will allow each service to measure any change in their symptom management over time.

This is a relative rather than an absolute measure and so we propose targets rather than service benchmarks.

Target 4.1:	75% of participating services are performing at or above the baseline national average for PCPSS Pain by the end of 2011.
Target 4.2:	75% of participating services are performing at or above the baseline national average for PCPSS Other Symptoms by the end of 2011.
Target 4.3:	75% of participating services are performing at or above the baseline national average for PCPSS Psychological/Spiritual by the end of 2011.
Target 4.4:	75% of participating services are performing at or above the baseline national average on PCPSS Family/carer by the end of 2011.

Target 4.5: 75% of participating services are performing at or above the baseline national average for SAS Pain by the end of 2011.

Target 4.6: 75% of participating services are performing at or above the baseline national average for SAS Nausea by the end of 2011.

Target 4.7: 75% of participating services are performing at or above the baseline national average for SAS Bowels by the end of 2011.

Target 4.8: 75% of participating services are performing at or above the baseline national average for SAS Breathing by the end of 2011.

Appendix C: Working Together Fact Sheet

WORKING TOGETHER

EVIDENCE : STANDARDS : OUTCOMES

CareSearch, NSAP and PCOC are working together to develop an aligned approach to change management in palliative care. All three projects are funded by the Australian Government Department of Health and Ageing with a collaborative interest in enhancing practice in palliative care and, as a result, improving care for patients and their families.

ABOUT THE PROJECTS

CareSearch is an online resource providing health professionals and patients, their carers and families with access to palliative care information and evidence. Evidence is important in quality improvement and change management as it can help services learn about what has been shown to be effective.

The National Standards Assessment Program (NSAP) is a national quality improvement framework that enables services to engage in a structured process of self-assessment against the Palliative Care Australia *Standards for Providing Quality Palliative Care for All Australians* using all available sources of evidence and data, supports the development and implementation of improvement actions, and encourages participation in peer mentoring and collaborative improvement effort.

The Palliative Care Outcomes Collaboration (PCOC) is the only national voluntary program utilising validated clinical assessment tools to benchmark and measure outcomes in palliative care. Participation in PCOC assists service providers to improve practice and meet Palliative Care Australia's *Standards for Providing Quality Palliative Care for All Australians.*

Together, the three projects offer a unique opportunity for those who provide palliative care to review their performance, identify areas for improvement and draw upon evidence to develop their services and teams.

HOW WE CURRENTLY WORK TOGETHER

The three projects are already working together to ensure that resources are shared and used within the individual projects. For example, PCOC data can be used as evidence of meeting standards for NSAP assessments. Services use CareSearch to enter NSAP self-assessment data. PCOC Quality Improvement Facilitators provide services with information about CareSearch resources that relate to symptom and care issues.

WHAT IS PLANNED

CareSearch, PCOC and NSAP have signed a Memorandum of Understanding recognising the organisations' shared interest in improving palliative care in Australia by up-skilling palliative care services, facilitating quality improvement, and encouraging the use of evidence in practice.

The projects will work together to:

- Expand linkages between the existing projects and their activities and responsibilities,
- Collaborate on workshops, conference presentations, reports and analysis,
- Provide evidence-based advice to policy makers as appropriate, and
- Develop aligned approaches to communicating and supporting change management.

Appendix D: Comparison Report 7 – 11

PERCENTAGE OF SERVICES MEETING BENCHMARKS

Comparison from Report 7 to Report 11

Benchmark measure 1 - Time from referral to first contact

Benchmark 1.1: 90% of patients are contacted by a member of the clinical team (either face to face or by phone) the day of, or the day following of referral (including weekends).

	Jan-Jun 09 (Report 7)	Jul-Dec 09 (Report 8)	Jan-Jun 10 (Report 9)	Jul-Dec 10 (Report 10)	Jan-Jun 11 (Report 11)
Episodes meeting benchmark	81%	81%	80%	75%	76%
Services meeting benchmark	49%	45%	49%	41%	42%

Benchmark measure 2 - Time in the unstable phase

Benchmark 2.1: 85% or more of patients in their first palliative care phase remain in the unstable phase for less than 7 days.

	Jan-Jun 09 (Report 7)	Jul-Dec 09 (Report 8)	Jan-Jun 10 (Report 9)	Jul-Dec 10 (Report 10)	Jan-Jun 11 (Report 11)
Phases meeting benchmark	62%	66%	67%	72%	77%
Services meeting benchmark	17%	23%	29%	40%	47%

Benchmark 2.2: 90% or more of patients in a subsequent palliative care phase remain in the unstable phase for less than 7 days.

	Jan-Jun 09 (Report 7)	Jul-Dec 09 (Report 8)	Jan-Jun 10 (Report 9)	Jul-Dec 10 (Report 10)	Jan-Jun 11 (Report 11)
Phases meeting benchmark	72%	73%	74%	78%	80%
Services meeting benchmark	13%	20%	23%	39%	44%

Benchmark 2.3: The median time in the unstable phase is 2 days or less.

Services meeting benchmark	Jan-Jun 09 (Report 7)	Jul-Dec 09 (Report 8)	Jan-Jun 10 (Report 9)	Jul-Dec 10 (Report 10)	Jan-Jun 11 (Report 11)
First phase	15%	19%	28%	37%	42%
Subsequent phase	21%	41%	48%	59%	55%

Benchmark measure 3 - Change in pain (both PC PSS and SAS)

Benchmarks 3.1 and 3.3: At least 90% of patients with absent or mild pain at the beginning of their phase of palliative care have absent or mild pain at the end of the phase.

	Jan-Jun 09 (Report 7)	Jul-Dec 09 (Report 8)	Jan-Jun 10 (Report 9)	Jul-Dec 10 (Report 10)	Jan-Jun 11 (Report 11)
PSS Pain					
Phases meeting benchmark	82%	81%	78%	77%	80%
Services meeting benchmark	20%	25%	12%	7%	20%
SAS Pain					
Phases meeting benchmark	82%	81%	79%	78%	80%
Services meeting benchmark	19%	13%	12%	9%	16%

Benchmarks 3.2 and 3.4: At least 60% of patients with moderate or severe pain at the beginning of their phase of palliative care have absent or mild pain at the end of the phase.

	Jan-Jun 09 (Report 7)	**Jul-Dec 09 (Report 8)**	**Jan-Jun 10 (Report 9)**	**Jul-Dec 10 (Report 10)**	**Jan-Jun 11 (Report 11)**
PSS Pain					
Phases meeting benchmark	38%	41%	47%	49%	50%
Services meeting benchmark	20%	23%	32%	35%	43%
SAS Pain					
Phases meeting benchmark	41%	41%	44%	48%	49%
Services meeting benchmark	12%	16%	24%	9%	35%

Benchmark measure 4 - Change in symptoms relative to the national average

Target: 75% of participating services are performing at or above the baseline national average on each measure by the end of 2011.

Percentage of services (with 10 or more valid observations) currently at or above the baseline national average:

	Jan-Jun 09 (Report 7)	**Jul-Dec 09 (Report 8)**	**Jan-Jun 10 (Report 9)**	**Jul-Dec 10 (Report 10)**	**Jan-Jun 11 (Report 11)**
PCPSS Pain-CAS	54%	63%	66%	73%	76%
SAS Pain-CAS	49%	45%	69%	63%	73%
Other symptoms	67%	68%	76%	78%	80%
Psychological/spiritual	53%	57%	71%	72%	73%
Family/carer	56%	55%	63%	75%	76%
Nausea	46%	51%	58%	67%	76%
Bowels	46%	48%	55%	63%	67%
Breathing	61%	57%	71%	73%	80%

Percentage of phases with a change in symptom score that was better than the baseline national expected change:

	Jan-Jun 09 (Report 7)	**Jul-Dec 09 (Report 8)**	**Jan-Jun 10 (Report 9)**	**Jul-Dec 10 (Report 10)**	**Jan-Jun 11 (Report 11)**
PCPSS Pain-CAS	68%	68%	64%	65%	66%
SAS Pain-CAS	68%	66%	62%	63%	64%
Other symptoms	51%	49%	53%	56%	57%
Psychological/spiritual	59%	58%	61%	64%	65%
Family/carer	48%	48%	50%	54%	56%
Nausea	79%	78%	79%	80%	81%
Bowels	63%	61%	63%	66%	67%
Breathing	68%	66%	70%	71%	72%

Appendix E: PCOC Strategic Plan 2011-2013

	STRATEGIC PLAN 2011 – 2013 ***Improving palliative care patient outcomes through benchmarking***
VISION	Improvement in palliative care patient outcomes
MISSION	To improve patient outcomes through systematic and continuing assessment of patients and benchmarking with other services
ROLE	PCOC utilises standardised and validated clinical assessment tools to measure patient outcomes in palliative care and benchmark with other services
OBJECTIVE 1 IMPROVING PATIENT OUTCOMES & PEER PERFORMANCE	
Strategies	KPIs
Identify opportunities for systematically improving patient outcomes through service improvement using change management principles	- Utilise outcome data for peer performance projects for palliative care services - Undertake validation studies for phase assessment and Palliative Care Problem Severity Score (PCPSS) - Evaluate PCOC initiatives 1. Assessment tool kit 2. Bi-annual report evaluation - Create a national QI register of projects initiated in response to PCOC data and systematically evaluate improved outcomes that can be traced to these projects. Create communities of practice for services doing QI projects - Rotating national leadership role for Quality Improvement Facilitators in PCOC benchmarks
OBJECTIVE 2 ALIGN WITH THE NATIONAL PALLIATIVE CARE STRATEGY 2010	
Strategies	KPIs
Collaborate with members of the Palliative Care Working Group (PCWG) and other National Palliative Care Programs to increase integration of successful models of service delivery across the palliative care sector	- Provide state and national reports to Palliative Care Working Group and other relevant stake holders to inform palliative care policy development - Enhance the capacity of aged care, indigenous, paediatric, adolescent and health service providers to utilise PCOC assessment tools - Improve alignment of PCOC, NSAP and CareSearch - Work to incorporate PCOC assessment tools into all palliative care undergraduate and relevant post graduate curricula - Investigate opportunities for co-facilitation of education sessions and projects with other national palliative care programs

OBJECTIVE 3 BENCHMARK PALLIATIVE CARE OUTCOMES	
Strategies	KPIs
Define core activity and realign resources and processes to the strategic plan	- Annual PCOC Benchmarking workshops: 1. Multi-modal services – Consultative, Community and Inpatient 2. Community Services 3. Inpatient Services - Bi-annual *Outcomes in Palliative Care* Reports: 1. National 2. State 3. Service
OBJECTIVE 4 INCREASING PCOC AWARENESS	
Strategies	KPIs
Build our reputation as an outcomes improvement program	- Submission and publication of peer reviewed journal articles evaluating the PCOC program - PCOC presentations at relevant state and national conferences - Joint exhibition stands (CareSearch, NSAP, PCOC) at state and national conferences - Contributions to newsletters including PCA, ANZSPM, PCNA, State Palliative Care associations and other peak bodies