

Banksia Palliative Care Service Inc.



Annual Report 2014/15

Home based care for children and
adults living with a progressive
terminal illness





1. Banksia CoM Member Damian Neylon and Banksia Life Member Alan Johns
2. Original Banksia Steering Group Members Dr Michael (Taffy) Jones and Katherine Kingsbury and Banksia Life Member Ann Francis
3. Staff Member and supporters from The Patchwork Gallery Quilt Group
4. Banksia CoM Members left to right Paul Zanatta, Therese Desmond, Jane Picton, Damian Neylon, Paul Adcock and Paul Oppy
5. Banyule "Citizen of the Year" Banksia Volunteer, Maria Welsh
6. Special guests at the 2014 AGM, Kayoko and Hiro Kinoshita representing the Japanese Education Clinical Cardiology Society (JECCS), Osaka, Japan
7. Members of the Heidelberg Warringal Lions Club

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Year in Review

On behalf of the Committee of Management, staff and volunteers of Banksia Palliative Care Service (Banksia) we are pleased to present the Annual Report for the year ending 30 June 2015. Our Annual Report is designed to feature our achievements and provide insight into the future goals of the organisation.

This year represents our 25th Year of providing specialist palliative care and support. We encourage you to read pages 5 to 8 which details the speech Dr. Michael (Taffy) Jones gave to our AGM in 2014 which highlights our beginnings and the significance of Banksia achieving 25 years of caring for our community.

We were very privileged one of our patients Lawrie Carter and his wife Linda agreed to work with us to develop a DVD which discussed their journey and experience with Banksia. The DVD is being used as a promotional tool for community presentations and also symbolises the support we aspire to provide to every patient, carer and their family.

We are very pleased to report our Volunteers were recipients of the City of Banyule Community Recognition Award.

Banksia is extremely proud to have one of our volunteers Maria Welsh awarded the 2015 City of Banyule "Citizen of the Year", based on her contributions to the community as an active volunteer for Banksia and a range of other services.

We have continued our partnerships with Goulburn Valley Hospice Care and Wodonga Hospital and provided specialist palliative training in their local communities.

Over the last 12 months we have spent considerable time conceptualising and implementing some of the changes we will need to make from an operational and governance perspective as we move to accreditation under the National Quality and Safety Standards.

We have also spent time developing a new strategic plan for the period 2015 – 2018 with a focus on ensuring we can meet increased demand for community palliative care and provide a sustainable model of service.

This year has also been a sad year for our team with the death of our staff member Jenny Lumsden. Jenny first worked at Banksia in a casual nursing role for approximately 4 years and then as a permanent staff member for 10 years. She was admired for her dedication to Banksia and for the care and support she gave to patients and their families. Jenny will be greatly missed by the team.

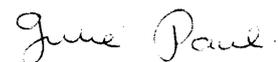
We continue to work in collaboration with the North and West Melbourne Metropolitan Palliative Care Consortium, North East Primary Care Partnership and the Royal District Nursing Service.

We thank the many people and organisations who have contributed to our achievements in the 2014/15 financial year, either through donations, grants or non-financial support when needed.

Our achievements would not be possible without the vision and leadership from our Committee of Management and the commitment and dedicated service from our staff, volunteers and support from our members. We also thank the Department of Health and Human Services (Vic) for their ongoing funding.



Paul Oppy
President



Julie Paul
Executive Officer

Celebrating 25 Years: Reflections by Dr Michael (Taffy) Jones



It gives me real pleasure to be able to look back on the past 25 years of the Banksia Palliative Care Service. At the risk of telling this audience what they already know, let me just remind you that the history of hospice or palliative care, the two terms are interchangeable, is a comparatively recent one worldwide and in Australia in particular.

The term hospice is derived from the medieval religious house which helped weary and desperate travellers, but the modern concept has, of course, become much wider. Hospice or palliative care means a concept of care for those people who are dying and has come to particularly refer to those who are dying from cancer and, more recently, from AIDS. It is different from acute care in that it has come to mean looking after every aspect of a patient in providing care comprehensively for all their needs - physical, psychological, emotional, social, spiritual and cultural.

I am sure most of you will recall what a lot of us grew up with - that is, the surgical open and shut, nothing else can be done approach, leaving no-one to pick up the pieces.

The palliative care movement began in the late nineteen sixties in England and North America and came to Victoria in the late nineteen seventies. Ms. Katherine Kingsbury, who is here tonight, was a member of our Steering Committee and was instrumental in providing a very significant stimulus to the commencement of palliative care services in Victoria when she published her book "I Want to Die at Home".

There are three basic models of palliative care which have been developed:

1. An independent service - a free standing hospice which enables people to die in an institution which cares only for terminally ill patients such as, for example, the Caritas Christi Hospice in Kew.
2. A hospital based service which is either in a dedicated area within a hospital or else a consultative service which uses hospital resources and staff with particular skill and experience in palliative care either in a dual capacity or as a dedicated team.

3. A community based service organisation which is run by and within the community and cares for people wishing to die in their own homes.

Why, then, is there a need for these services?

This is because cancer is the second commonest cause of death in our community after heart disease and has been for some considerable time, and is actually still on the increase with an ageing population. Hospitals by definition are acute places and are geared towards curing, hence it is actually impossible, no matter how well motivated the staff are, to spend the time that is necessary and desirable for the proper care and comfort of the dying patient. Having said that, I hasten to add that people who die in an acute situation are, I believe, extremely well looked after in a hospital, but for those who have a little time it is generally accepted that a hospital is not the best place for them to be leading up to their death. In a study that we did at the Austin Hospital in the first half of 1989, out of 110 cancer patients only 16% died in their own homes.

Hospitals often have a problem in facilitating communication, and it is often difficult for relatives to make reasonable contact at this unique time when much needs to be said - emotions are strained and there is a desire to strengthen those close bonds of affection and kinship that will soon be broken. The observance of quietness is often obtrusive and there is frequently a problem fitting in the special requirements of adequate pain relief with the normal required drug routines in an acute ward.

There has for some time been a worldwide trend towards palliative care at home, and extensive research has shown that most people wish to stay at home if at all possible and to die there when the time comes.

At home the patient remains a more dominant and singular individual than they can ever be in a hospital or a hospice. In the presence of a caring family, the desires and needs of a dying person are most readily noted and alleviated. Most people prefer a familiar environment in times of stress and hence, given the chance, prefer to be surrounded by people and things which are familiar to them. It is, of course, illogical to remove people from their own gardens, pets, neighbours and the myriad of things that make a place home at the very time when they need these things most.

When I spoke at a local service club (I think it was either Lions or Rotary) in 1990, I told them that we were planning to establish a domiciliary based hospice care program and that meant that we would be aiming to meet the physical, emotional, social, spiritual and cultural needs of those who were dying and to support the family as the primary care givers both before and after they were bereaved. I went on to say that we would be seeking a close relationship with hospitals in our region so that there would be back up provided, with inpatient beds for those people who were unable to stay at home or who needed temporary admission to hospital for pain control or to give the family a little respite. At that time, we predicted that in 1991 some 600 people in the areas of Heidelberg, Eltham, Diamond Valley and Whittlesea would require palliative care.

We spelt out the principles that were going to be fundamental in looking after our patients as being:

1. Palliative care services of the highest quality.
2. Providing a service to our terminally ill patients and their families as care givers regardless of their gender, age, ethnicity, religious background or diagnosis.
3. We believe that terminally ill patients and their families and care givers should have the right to choose the kind of support they needed and participate in decisions about the services they required.
4. Palliative care service systems should enhance coordination of related services.
5. Palliative care should be delivered in a culturally responsive manner.

When I first arrived at the Austin in 1987, I was surprised to find that there was no palliative care service either within the hospital or in the community and, after all, the Austin used to be known, not so long ago, as the "Hospital for Incurables". I had come from Geelong, where we had started a domiciliary palliative care service in 1982, so I knew what was required to get such a service off the ground.

Now for some reason, the establishment of palliative care services has caused a great deal of enmity and criticism from many involved in the care of patients right across the board. I guess this can be explained to some extent because doctors are primarily geared to curing and generally speaking find the concept of admitting that nothing curative can be done for a particular patient as being an admission of failure. Many health care professionals seem to regard the establishment of these services as being an insult to the services they already

provide. For example, at a public meeting in Geelong in 1981 I was launching the Geelong service when I was interrupted by a nurse who told everyone "I have been looking after dying people for many years and they don't need any additional support". However, this sort of comment completely misses the point of what palliative care is all about, which is the total care of every aspect of a patient that I have already referred to, and this cannot possibly be done by a single or even two or three health care professionals. Furthermore, research that I did many years ago in Geelong showed that many patients were admitted to the hospital for extended periods before they died because of lack of support to keep them at home.

Dr. Roger Woodruff said in his excellent book on palliative medicine published in 1993 and I quote

"The practice of palliative medicine is progressing rapidly. The traditional division between active treatment of the disease and the care of the dying is disappearing and the importance of providing comprehensive symptomatic and supportive care long before the terminal phase of the illness is now accepted. All aspects of the patient already referred to must be addressed not as an elaborate or fashionable form of practice, but as a clinical necessity and a multi-disciplinary approach to patient management is a pre-requisite for successful patient care."

Looking back now to the time when I decided we needed to establish a community based palliative care service, we were exceptionally fortunate in the people that were around and available to help us in so many ways. Dr. Woodruff was one of these, and he started an inpatient palliative care service at the Austin about this time and strongly supported the establishment of the community based service.

We held a public meeting in the Heidelberg Town Hall in March, 1989 and before this, of course, had to establish a Steering Committee. Mrs. Jean McCaughey, the then Governor's wife, agreed to be our Patron and Katherine Kingsbury, to whom I have already referred, readily accepted the invitation to help us with advice and to be one of the Steering Committee members, and took on the arduous role of secretary. She also chaired the first meeting of the Steering Committee on 20th March, 1989 before we were incorporated and had duly elected office bearers.

I believed that it was most important that the Service was seen as community based and not Austin based, and hence we needed a Chairperson who was well known and widely respected in the community, and when I approached John Shilliday, who was at that time the Principal of the Ivanhoe Girls' Grammar School, he immediately accepted and did a marvellous job in all sorts of ways over our initial few years. I took on the role of Deputy Chair.

We needed to become incorporated for funding and donation purposes as well as legal recognition and, having been through this in Geelong, I knew what needed to be done to establish the association as a company limited by guarantee, but it was terrific to have Brian McMahan, a local solicitor, agree to join the Steering Committee and to do all the necessary bureaucratic legal work gratis.



The early tasks that had to be sorted fairly rapidly were not only being incorporated but the establishment of the proposed catchment area for the service, fundraising and community awareness raising. In 1989 we obtained funding from the Health Department for a feasibility study to be conducted and engaged the consulting firm of Wyse, Wannan and Morris, and I think this came about because I knew Lyn Wannan when we had both chaired regional consultative councils for community services previously. They produced a very comprehensive report and addressed the objectives of defining the catchment area, identifying staffing and other resources required, documenting the principles and philosophies of care, identification of the required links with other health provider agencies, including most importantly the Royal District Nursing Service and the Austin Hospital, and negotiation with local agencies about the potential to contribute to a network of palliative care services with a view to establish protocols for working relationships and contracts where appropriate. A discussion paper was developed outlining a model for the delivery of palliative care, structure and process for improving the coordination and cooperation between agencies involved in caring for terminally ill patients and their families, which was distributed to key agencies for comment.

The coordination model involved the following key features:

- Banksia Palliative Care Service having overall responsibility for the coordination of all agencies and services involved with patient/family/care giver care.
- A coordinated patient/family assessment process.
- Agreement between agencies for the service to take responsibility for day to day monitoring of the patient/family and service needs.
- Agreements about processes for referral to Banksia and for involvement of other agencies.

This model was supported by all those consulted with, including public and private hospitals, Royal District Nursing Service, local government, home and community care managers and community health centres. The report emphasised the philosophy underlying the development of palliative care, involving total care of a person with a terminal illness, recognising a patient's right to have some control over the service they receive and that service also being responsive to the needs of the patient's family and other care givers.

The report concluded that our service was underway at a very exciting time when palliative care was finally finding its footing in the health and community service sector in Victoria and the recognition of this as a specialty in its own right and depending on allowing patients, their families and care givers to be responsible for their own care. The report concluded "It is within this climate that the people in the North East of Melbourne can expect a new and exciting palliative care service".

The feasibility study also identified some service gaps and in particular the need to establish a volunteer program and a Bereavement Program, and so we set about rectifying this, establishing these two programs in February 1993 and October 1992 respectively. However, funding of course was the major issue for us.

I had received a phone call from the Health Department in April 1989 saying that funding was to be made available but nothing materialised.

At the first AGM in June 1990, I was the speaker and the president reported that we had been unable to obtain funding despite lobbying and taking a deputation to the Minister

At the next AGM on 9th September 1991, the chair bemoaned the fact that no funding had been made available to us to run the service in 1991 or 1992 but we had invited Dr Chris Brook who was the Regional Director for the Health Department to be our guest speaker, and he announced at the meeting a grant of \$50,000 per annum to be not a once off but a recurring grant to enable us to get the Service off the ground.

To become fully operational we needed to appoint a Project Officer and this advertisement was placed in the Age on 2nd of November 1991. Although there were some three applicants interviewed, the stand out was Trudi Wyse who was one of the team who conducted the feasibility study so she was duly appointed in December 1991

We were then able to conduct a one year pilot project commencing April 1992 and an Initial Operation phase which overlapped to some extent from the first patient being accepted 31 August 1992 to the last patient accepted in this phase at the end of March 1993.

The conclusion of the retrospective review of these two initiatives was and I quote:

"BPCS has complimented existing resources through facilitation and coordination of client centred holistic care – a vital and integral aspect of palliative care"

I referred earlier on to how fortunate we were in the understanding and support we got from such a wide spectrum of people, and I have already referred to the support of John Shilladay, Katherine Kingsbury and Roger Woodruff. All members of the steering committee made valuable contributions but it was particularly useful to have Vin Heffernan the local State member, Ian Berry from the Health Department and Frank Evans who was the central CEO of RDNS on side and helping as well as being allowed to use the RDNS Rooms at Diamond Creek, and Vin Heffernan's rooms, Ivanhoe Girls Grammar, and the Ivanhoe RSL rooms for various meetings. Lorraine Jordan at the Austin and Ann Turley at Melbourne City Mission were also most supportive I must also thank most profusely my PA Lyn Robertson, who not only did a lot of typing and spent a lot of time on Banksia business but kept my office going whilst I was swanning off speaking at service clubs, lobbying ministers and so forth.

A significant milestone for us was the signing of a definitive collaborative working agreement with RDNS in June 1993 following an initial agreement before we commenced the pilot and initial operation phases in 1992.

Finally, there is often nothing very funny about death and dying, but, ever since my days as Admitting officer in a metropolitan hospital as a young doctor when the wonderful ambos would feel sorry for me and bring the patients who had died (the so called DOAs) to my house next to the hospital to save me having to walk over there in the middle of the night I have had a horror of pronouncing someone dead when in fact they are not and when I was still in private practice down on the Bellarine peninsula I had a patient etc

I think that the whole matter of domiciliary palliative care was beautifully summed up in a letter I received when I was in Geelong which said

“You gave us the most precious gift of time, and most important spending the time solely together. We were able to have so many good times and unlike hospital able to see the outside world and still enjoy it. Through all the sad things there were so many good ones. Through all the pressure of a hospital I would have missed so much – a hospital day can’t be 24 hours but a home day is”.

Well in conclusion, it is just terrific to be here and thanks very much to Julie Paul who went to a lot of time and trouble finding the source documents I needed and her husband who very kindly delivered them to my house. Congratulations on sticking to the original philosophy of a domiciliary service and not bowing to pressure and being swallowed up by a mega hospital or health service because of the petty jealousies of short sighted health professionals and administrators.

A guy called Leo Rosten said and I quote in part:

“There is a myth to which many of us are addicted that the purpose of life is to be happy. I know of nothing more demeaning than this narcotic pursuit of fun. Where was it ever written that life can always be easy or free of conflict or of pain? The purpose of life is not to be happy but to matter, to be productive, to be useful, and to have it make some difference that we lived at all”

Well BPCS has certainly mattered and made a huge difference for the better in countless peoples' lives so Congratulations and I wish you every success for the future.

Dr Taffy Jones

Vision, Mission & Values

Our Vision is to provide and promote specialist home based palliative care, which is accessible, responsive and in partnership with the community.

Our Mission

As people experience progressive terminal illness, death and bereavement Banksia Palliative Care Service will:

- Provide specialised health care to clients and their carers in their place of residence
- Enable clients to access a range of services to address physical, social, emotional, spiritual and cultural needs
- Achieve best practice through a commitment to excellence in client care, research and education
- Partner with consumers and the community to optimise client care
- Embrace internal and external review for the benefit of our client centred practice.

Our Values

We show **RESPECT** as we uphold the unique personality, dignity, situation and choice of all our clients.

We demonstrate **COMPASSION** and **EMPATHY** to all as they travel the journey of a progressive terminal illness and bereavement.

Our work is done in **PARTNERSHIP** and we build and maintain effective relationships.

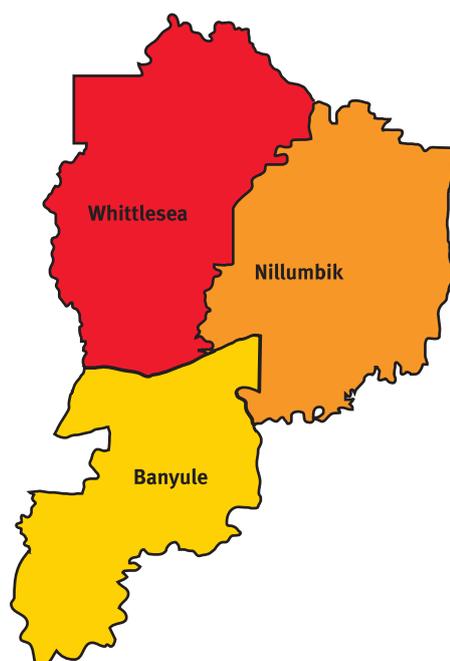
We aim for **EXCELLENCE** and continually strive towards **BEST PRACTICE**.

We aspire to be **INNOVATIVE** and actively seek, develop and implement creative new ideas.

We act with **INTEGRITY** by implementing honest, transparent and ethical practice at all times.

Service Area & Client Statistics

Service Area



Client Statistics	2012/13	2013/14	2014/15
Number of Clients Referred	606	611	600

Source of Referrals

Hospitals	433	391	418
GP's and Specialists	81	101	73
Community Agencies	26	42	28
Aged Care Facilities	27	22	15
Families and Self referrals	39	55	66
Total	606	611	600

Clients Admitted by Local Government Areas

Banyule	224	245	192
Nillumbik	78	83	82
Whittlesea	201	212	225
Darebin			6
Total	503	540	515*

Age of Clients

0-30	5	9	9
31-60	93	98	97
61-80	233	259	245
81+yrs	172	174	164

Place of Death

Home	118	131	102
Aged Care Facility	27	33	29
Inpatient Setting Designated Palliative Care Unit	124	143	168
Inpatient Setting Other Than Palliative Care Unit	94	73	61
Total	363	380	360

Our Team

Staff (EFT – effective full-time equivalent)

Administration	7 (4.7 EFT)	7 (4.7 EFT)	7 (4.8 EFT)
Clinical Services & Learning Centre	13 (8.6 EFT)	14 (9.3 EFT)	14 (9.3 EFT)
Client Support Services	7 (4.2 EFT)	7 (4.2 EFT)	7 (4.2 EFT)

Total	27 (17.5 EFT)	28 (18.2 EFT)	29 (18.3 EFT)
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Volunteers	28	28	29
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* The number of clients admitted includes 6 patients from the City of Darebin which is a one off occurrence when we assisted our colleagues at Melbourne City Mission when demand exceeded their resources

Partnering with Consumers

Our Consumer Advisory Group provides a strong partnership between consumers and our service and assists us in ensuring we are providing a client centred approach to care. They provide advice, guidance and direction in relation to safety and quality improvement opportunities.

The Consumer Advisory group:

- Drives consumer participation
- Contributes to the development and review of Banksia's service and strategic planning
- Reviews consumer feedback and identifies opportunities for improvement
- Ensures diverse and hard to reach consumer perspectives are included
- Collaborates and reviews Banksia's service design of program initiatives
- Participates in the analysis and review of Safety Quality Performance data and identifies opportunities for improvement
- Promotes health literacy by driving the feedback and review process of consumer information publications and communication to the community
- Participates in workforce training to build capacity of Banksia staff and volunteers in client centred care.

We continue to seek opportunities to increase the involvement of our Consumer Advisory Group members throughout the organisation. In the last 12 months the Consumer Advisory Group have reviewed, advised and provided guidance in the following areas:

- A framework for partnering with consumers based on the National Safety and Quality Health Care Standard for consumer participation
- Bereavement letters sent to carers
- Privacy statement which is distributed to clients and is displayed on our webpage
- New quality framework
- Recruitment letter sent to past carers seeking interest to join the Consumer Advisory Committee
- Survey sent to clients on discharge from our service when they no longer require a specialist palliative care service
- New survey seeking client feedback at 1 month post admission to our service
- Introduction of our new carer assessment tool to families and carers

- New pressure injuries information sheet
- New health literacy policy
- A bumper sticker to promote our service
- Training for new consumer advisory members
- Terms of reference

The Consumer Advisory Group was represented in the following areas:

- Participated in interview panels for prospective new staff
- Attended staff strategic planning days
- Attended Quality, Safety and Risk Committee meetings

We would also like to thank:

- Nicky Barry the Coordinator for Consumer Participation from the Health Issues Centre for reviewing the Terms of Reference for the Consumer Advisory Group, Partnering with Consumers Framework protocol and providing staff education on the benefits of consumer participation in service delivery.
- Our Consumer Advisory Group for volunteering their time to work in partnership with Banksia to enable us to plan, design and provide services that are more likely to meet the needs of clients and carers.



Consumer Advisory Group Members
Left to Right: Lynne Clarke, Margaret Clancy, Andrew Glide

Client Services

Key Achievements

1. Improving internal systems for Quality, Risk and Safety

We have reviewed our internal meeting structure to ensure quality risk and safety is “everyone’s business”. All staff are members of the Quality Risk and Safety Committee. The aim of the committee is to support and promote a culture of quality and continuous improvement and safety in the delivery of care. The committee receives data and information which evidences our achievements against an extensive list of key performance indicators. The new structure is comprehensive and includes all areas of the organisation.

2. Increasing opportunities to receive feedback about our service

We encourage and welcome feedback from our patients, families, carers, staff, volunteers and stakeholders to enable us to provide a service that meets the expectations of the community .

We have conducted an extensive review of our framework for seeking feedback which includes how we:

- receive, review and respond to compliments and complaints
- review and report trended data
- identify and implement systems and processes for improvement

Refer to chart below for an overview of how we actively seek feedback.

Individual/Group	Mechanisms	Timing	Frequency
Clients	Written Surveys Telephone surveys Face to face consultation	1 month post admission At 2 months post admission As requested Discharge of client (excludes RIP)	
Carers/Family	Written Surveys Telephone surveys Focus Groups Face to face consultation	1 month post admission Discharge of client At 2 months post admission As requested	
GPs	Written Surveys (review current) Face to face consultations	Immediately post client discharge Target to visit each GP practice annually	At client discharge Annual
Other Health & Community Practitioners	Written Surveys Face to face consultations	Immediately post client discharge Target to visit annually	At client discharge Annual
Referring health services	Written Surveys Face to face consultations	Annually Visit each health service 6/12	Annual Annual
Partnering services	Face to face meetings Satisfaction Survey	January, April, August November July each year	Quarterly/as required Annual
Alliance agencies	Face to face meetings Attendance at Network meetings Satisfaction Survey	February, October July each year	Twice yearly Annual
Consumer Advisory Group	Committee meetings Direct consultation	At meetings	As required
Staff	Satisfaction survey Opportunity for Improvement suggestions	April each year As identified by staff member	Annual
Volunteers	Satisfaction survey Opportunity for Improvement suggestions	April each year As identified by staff member	Annual

3. GP Forum

We held a GP forum to review our processes for communication with GPs on admission to our service, during care on discharge and notification of death. Based on the discussion the communication tools have been revamped and preliminary data indicates the new tools are working much better and have improved satisfaction from GP's with communication from our service.

4. Providing a timely service for new clients

We have continued to build flexibility into our clinical model to ensure we are able to manage the variations in demand for new clients requiring our service. Overall we know that the majority of new referrals were seen within their triage time frame (< 7 days). This flexibility enabled us to support our colleagues at Melbourne City Mission Palliative Care Service during the year when they required assistance to ensure that clients in their catchment area were seen in a timely manner.

5. Promoting palliative care to diverse communities

We continue to seek opportunities to promote our service to the multicultural and Aboriginal and or Torres Strait Islander communities within our catchment area. This year we have:

- o Presented to Chinese and Turkish groups and
- o Translated our general brochure into Indian and Chinese

We commenced a project funded by a grant from the Department of Health and Human Services, Palliative Care Program (VIC) to enable us to provide culturally safe palliative care to Aboriginal and/or Torres Strait Islander communities. The project enabled us to employ a project worker and will cover the following aspects:

- Review of our policies and procedures
- Development of a cultural framework for providing appropriate care
- Education for staff and volunteers
- Development of Aboriginal and/or Torres Strait Islander specific resources
- Review of our client information kit
- Networking and formalising partnerships with Aboriginal specific health services and
- Review of our client information sheets to ensure they are culturally safe

We would like to thank the following people for assisting us with this project:

- Carleen Miller, Project Worker
- Jason King, CEO Victoria Aboriginal Health Service (VAHS)
- Belinda Stevens, Director | Workforce & Wellbeing, Victorian Aboriginal Community Controlled Health Organisation (VACCHO)
- Steve Kirkbright, Project Manager, Victorian Aboriginal Palliative Care Collaborative

We have reviewed our website to ensure it meet health literacy principles and meets the needs of a diverse community - www.banksiapalliative.com.au

6. Meeting service targets

We continue to exceed our annual target set by the Department of Health (Vic) for Service Events. Service Events are defined as an "interaction between one or more healthcare provider(s) with one client (patient), which must contain therapeutic/clinical content and result in a dated entry in the patients medical record. The patient must be present at the interaction. The service may be delivered by telephone or face to face and the client must not be in hospital at the time.

Service Events by month: Actual Vs Target



Staff & Volunteers



- 1. Banksia Volunteers at the City of Banyule Volunteer Awards
- 2. Banksia Volunteers with the City of Banyule Mayor and Councillor
- 3. Banksia Staff
- 4. Banksia Staff
- 5. Banksia Volunteers
- 6. Banksia Staff



Planning for the Future

The Planning Context

The staff, volunteers and Committee of Management dedicated significant time and effort towards attaining the objectives of the 2011-2014 Strategic Plan.

Our achievements enable us to enter a new period of strategic planning with a high level of confidence in the quality of our services. This confidence is supported by:

- an external accreditation process of practice and service standards,
- feedback from our clients and carers and other stakeholders,
- self-assessment against national palliative care standards,
- participation in a national palliative care outcomes collaborative and
- an external review of financial management systems.

The 2015 - 2018 Strategic Plan aspires to consolidate these outcomes, build on our successes and stretch us to further improvement. Strategic challenges facing Banksia over the next few years include:

- providing clear messages to the community about the role of home-based palliative care;
- meeting increasing demand with current resources;
- providing access to palliative care for people who are socially disadvantaged or isolated ;
- recruiting highly skilled and experienced staff and
- being responsive to the changes in the way government funds community-based palliative care.

Strategic Direction 1:

Ensure clients living with a progressive terminal illness and their carers feel well supported.

Banksia's success depends on providing our clients and their caregivers with choice and confidence in the quality and availability of Banksia's services.

Goals

- 1.1 Ensure Banksia's services are delivered equitably across all three municipalities in Banksia's catchment
- 1.2 Expand the role of consumers within the service
- 1.3 Ensure client and carer feedback is used to improve service provision
- 1.4 Transition to accreditation under National Safety and Quality Health Service Standards
- 1.5 Investigate opportunities to use telecare / telehealth facilities to support clients and their carers
- 1.6 Identify and eliminate any gaps within current core service provision that will make a difference to clients and carers

Strategic Direction 2:

Promote the choice to use home-based palliative care.

Banksia's success depends on reaching out to more people in our community who choose home-based palliative care.

Goals

- 2.1 Promote and market BPCS value to our diverse stakeholder groups
- 2.2 Increased referrals from specific target populations

Strategic Direction 3.

Successfully adapt to a changing environment.

Banksia's success depends on maintaining a professional and innovative organisational culture, efficient business processes and modern data and telecommunications systems which support a highly competent and committed workforce capable of adapting to the needs of the population and changes in government policies.

Goals

- 3.1 An organisational culture that is responsive to service needs and embraces our workplace values
- 3.2 Increase learning and educational opportunities for individuals, community groups and service providers supporting those living with a progressive terminal illness
- 3.3 Financial management systems reduce the administrative load on Banksia's staff without compromising existing financial controls
Effective financial controls provide confidence to our stake holders
- 3.4 Review Banksia's existing client information system to ascertain if it will continue to meet service demands
- 3.5 Long term financial sustainability
- 3.6 Explore opportunities to enable Banksia to provide services beyond those funded by government

Committee of Management

The Committee of Management oversee the governance aspects of the organisation. Members of the committee are volunteers who support the work of Banksia and come from within the community.

Our current Committee of Management consists of eight members from diverse backgrounds, who bring a variety of skills to ensure Banksia remains community focussed with the right business approaches to guarantee the organisation remains viable and meets the demand of palliative care clients living within our catchment area. We have interviewed members of the committee to find out a little more about them and why they volunteer.



Row 1. From left: Paul Oppy, Therese Desmond, Debra Ward

Row 2: John Richardson, Jane Picton, Morgan Waters

Row 3: Paul Adcock, Paul Zanatta

Paul Oppy

Paul joined the Committee of Management in 2009 after retiring as Director of Information Technology at Austin Health. He brings to Banksia many years of experience in managing information systems and computer technologies, mostly in the acute health sector. His interests include risk management, corporate governance and electronic health records.

Paul has lived in the local community for many years. He was drawn to volunteer at Banksia after reflecting on his parents' journeys through terminal illnesses and an encounter with the Respecting Patient Choices program at Austin Health.

Paul currently serves as Banksia's President.

Therese Desmond

Therese commenced on the Banksia Committee in 2012. With a strong interest in the provision of high quality community based support she has extensive experience in the provision of community services at operational, strategic management and governance levels. She is a registered nurse with tertiary qualifications in community health and management. Therese became more aware of community based palliative care services when she and her family were able to support her father to die peacefully at home with the assistance from a palliative care organisation.

Therese is currently the Chief Executive Officer of the Oakleigh Centre, an organisation that provides supports to people living with an intellectual disability. Therese currently serves as Vice President.

Debra Ward

Debra joined Banksia Palliative Care Services Committee of Management in 2014 after a colleague recommended she apply for the recently vacated Treasurer's role.

Debra recently resigned from her position as Executive Manager Corporate Services at VincentCare Victoria after 11 years of service to pursue other interests. She brings a wealth of experience to Banksia having managed the finance, infrastructure/purchasing and information technology & communication departments for VincentCare Victoria which included aged care, community & disability services.

Debra looks forward to contributing to Banksia's strategic direction ensuring the ongoing viability of the organisation as a member of the Committee of Management.

John Richardson

John joined the Committee of Management in 1994 and brings to Banksia over 30 years experience in Human Resources Management gained in both the public and private sectors, including over ten years as Executive Director of Human Resources at Austin Health. John is currently General Manager of Human Resources for RACV. He holds a Bachelor of Business Degree from RMIT University and is a Chartered Member of the Australian Human Resources Institute.

John has also served as Vice President and President on Banksia's Committee of Management.

Paul Adcock

Paul joined the Committee of Management in 2006. Paul currently works at Alfred Health in the position of Director Technology Services and Transformation, responsible for Health Information Management, IT Infrastructure and Service Delivery. Since graduating as a Nurse and specializing in Critical Care, Paul has held a number of clinical and management roles in Public Health, Government and Private Consulting.

Paul's interests include workforce leadership and change management.

Paul lives in the local community with his wife and three teenage children and was drawn to volunteer at Banksia in support of the local community and the valuable services provided by Banksia.

Paul has served Banksia in both Vice President and President positions in the past.

Jane Picton

Jane joined Banksia Committee of Management in 2009.

Jane is a qualified Social Worker & mediator. For many years she worked in the Family Court & later with Victorian Legal Aid with separated or divorced couples to assist them to resolve their relationship issues. Additionally she worked at La Trobe University assisting International students with their degree course in Social Work.

Jane sees a parallel in some ways with the Banksia service & her work with separated couples, who experience grief & loss in their lives.

As well as being a Committee of Management member, Jane is involved with several organisations including U3A and a Refugee & Asylum seeker centre.

Morgan Waters

Morgan joined the Committee of Management in 2014 and is currently employed as Senior Associate at Russell Kennedy Lawyers. He brings many years of legal experience to the Banksia Committee of Management and enjoys working with clients to achieve positive outcomes.

Morgan joined the Committee of Management to help Banksia continue to provide much needed services to those in their final stages of life.

Paul Zanatta

Paul joined the Committee of Management in early 2014 to fill a casual vacancy. Paul's professional career spans thirty years in roles broadly scoping policy advocacy, senior strategic and operational management, research and health practice (nursing). He is currently the Executive Manager for Social Policy and Research at VincentCare Victoria, where he has been working since 2011 with responsibilities for program evaluation, research, social policy advocacy and strategic business development. Paul has long standing community and population health interests as well as strong interests in organisation strategy and good governance in "purpose-based" (not for profit) organisations. Paul and his family had lived in the Eltham Montmorency area for almost 30 years before moving to Preston for proximity to the city. His experience of his own teenage daughter's death 10 years ago underscores the value he places on specialist palliative care.

Staff Values

Communication

Banksia staff strive for constructive and responsible communication. We value open, mindful communication as a means of enhancing our work environment.

Professionalism

Banksia staff are committed to ethical practice, accountability and the pursuit of excellence.



Respect

Banksia staff acknowledge and value the individuality and contribution of each person; recognising that diversity is crucial to a dynamic and successful environment.

Collaboration

Banksia staff recognise that effective team work requires a shared vision, flexibility and collegial teamwork.



Wellbeing

Banksia staff work together to create an enjoyable, healthy and safe work environment and celebrate achievements by recognition and affirmation.

1. Banksia Volunteers
2. Banksia Volunteers and Staff
3. Banksia Volunteers and Consumer Advisory Group Members



Our Team

Permanent Staff

Administration

Julie Paul, Executive Officer
Kellie-Ann Blackman, Administrative Coordinator
Kathleen Menzies, Quality & Risk Manager
Carleen Miller, Project Worker
Angela O'Toole, Receptionist
Christina Robertson, Administration Coordinator
Jane Matthes, Book- Keeper
Tim Paul, Community Liaison Coordinator
Claudia Wilson, Receptionist
Robyn Wright, Quality & Risk Coordinator
Julie Mannix, Administration Project Worker
Monique Balfour, Project Worker Consumer Participation
Jill Smith, Casual Receptionist

Clinical Services and Learning Centre

Priscilla Reilly, Manager
Andrea McGee, Manager
Andrea Davy, CRN
Paul Rosenquist, CRN
Mary McGowan, CRN
Jac Bongiovanni, Intake Nurse
Nerida Morton, Educator
Robyn Gamilis, PCNS
Jenny Gunn, PCNS
Nicollette Powell, Massage Therapist
Jenny Lumsden, PCNS
Alex Ralty, Intake Worker
Fiona Wilson, PCNS
Nicky Goymer, PCNS
Catherine Hayes, PCN
Sonya Herbert, PCN
Melinda Breen, PCNS
Belinda Harper, PCNS
Helen McLennan, PCNS

Client Support Services

Linda Espie, Manager
Steve Crump, Spiritual Care Practitioner
Leigh Ford, Bereavement Coordinator
Laura Medcalf, Music Therapist
Rosslyn Lyall, Counsellor
Monique Balfour, Volunteer Coordinator
Fiona Tischmann, Social Worker
Gilliam Moseley, Casual Counsellor
Francis Bhathal, Casual Social Worker

Volunteers

Bev Boulter
Colin Blanch
Anne Chomiak
Pam Quinton Randall
Jill Simeoni
Jill Smith
Margaret Butler
Samantha Hou
Bev Anthony
Angie Seoh Sughito
Margaret Birthisel
Jenny Cocks
Maryanne Freeman
Lyn Geer
Leonie Lorenz
Jan Merkel Stol
Margaret Rentoul
Mary Mazurczuk
Gabrielle Mac Tiernan
Eric Morgan
Nicki Zorotheos
Irene Sidrak
Lorraine Taylor

Cheryl Wayman
Mary Vratsis
Maria Welsh

Service Recognition Awards

10 Years of Service

Jenny Lumsden
Bev Boulter

5 Years of Service

Maria Welsh
Pam Quinton-Randall
Bev Anthony
Jane Picton
Robyn Wright

2 Years of Service

Monique Balfour
Nerida Morton

Committee of Management

Paul Oppy, President
Therese Desmond, Vice President
Debra Ward, Treasurer
John Richardson
Paul Adcock
Jane Picton
Morgan Waters
Paul Zanatta

Finance Sub-Committee

Debra Ward, Chair
Paul Adcock
John Richardson
Paul Oppy
Julie Paul

Life Members

John Shilliday
Ann Francis
Alan Johns
Tim Paul
Noel Paine
Maureen Glover
Yvonne Mee
Marion Cooper

Consumer Reference Group

Andrew Glide, Consumer
Margaret Clancy, Consumer
Lyn Clark, Consumer
Katherine Menzies
Robyn Wright
Julie Paul
Monique Balfour

Volunteer Reference Group

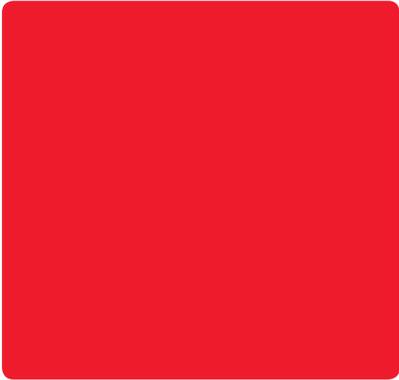
Pam Quinton-Randall, Volunteer
Julie Paul, Staff
Bev Boulter, Volunteer
Maria Welsh, Volunteer
Monique Balfour, Staff
Tim Paul, Staff
Jenny Cox, Volunteer

Banksia & Royal District Nursing Service

Middle Management Group
Leanne Davey (RDNS)
Kerry Oates (RDNS)
Robyn Wright
Andrea McGee
Julie Paul
Maggie Scott (RDNS)
Julie Wilson (RDNS)

Footnote:

CRN: Clinical Resource Nurse
PCNS: Palliative Care Nurse Specialist
PCN: Palliative Care Nurse



- 1. Banksia President, Paul Oppy
- 2. Students from Ivanhoe Girls Grammar who assisted at the 2014 AGM
- 3. Banksia CoM and Staff Member
- 4. Banksia CoM Member John Richardson receiving his 20 Year Award, CoM Damian Neylon and Paul Oppy
- 5. Banksia Volunteers



Banksia Palliative Care Service Inc.

Whilst the Annual Report is an opportunity and commitment to report to our members and other stakeholders, it is also constructed as a marketing and public relations document to ensure Banksia's programs and services are known to the broader community. We welcome your enquiries and interest on any of the programs and services outlined in the Annual Report.

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Detour Design, Adelaide.

For further enquiries in relation to
the work of Banksia please contact

Julie Paul, Executive Officer

472 Lower Heidelberg Road
Heidelberg VIC 3084 Australia
T (03) 94550822

E juliep@banksiapalliative.com.au
www.banksiapalliative.com.au