



PALLIATIVE CARE

*Progress Report 2006
Action Plan 2006-2007*

NGĀ PEEHITANGA TĀNGATA O TE AO HURUHURI
NGĀ WHAKARITENGA MO TE TIKĀ ME TE ORA MORIMORIMATAWHAI

THE TRIALS PEOPLE FACE IN A CHALLENGING WORLD
CAN BE OVERCOME BY CARING FOR AND LOVING ONE ANOTHER

Waikato Palliative Care Operations Network

Progress Report 2005 – 06

&

Action Plan 2006 – 07

Report Prepared by Jan Hewitt, Project Manager
Development & Support Unit, Waikato DHB
September 2006

Acknowledgments

Special acknowledgment to the people on the Waikato Palliative Care Operations Network whose contribution has been valued. It is recognised that much of the progress is as a result of formation of this forum and the individual's commitment and contribution.

Acknowledgment and thanks to the people inside and outside the Waikato District Health Board who have contributed to the development of palliative care services within the Waikato DHB.

Recognition and thanks to Judy Fitness and Jackie White, Project Officers that assisted with one off projects or DSL and Collaborative Care.

Executive Summary

The purpose of this report is to summarise:

- The Waikato palliative care progress between November 2005 and June 2006 that aim to enhance service provision to patients with a life limiting illness and their family / whānau
- Outline the Waikato Palliative Care Operations Network 2006-07 action plan.

The Waikato District Health Board Palliative Care Strategy Plan 2005 – 2010 (Strategy Plan) was endorsed in August 2005. The purpose of the Strategy Plan was to assist guiding local service delivery developments.

The Waikato palliative care goal is to ensure that all providers of palliative care in the Waikato work together with the community to ensure that the New Zealand Palliative Care Strategy is implemented in the most optimal way for the Waikato district. This is to ensure that all people with palliative care needs and their family / whānau have access to essential palliative care services, provided in a co-ordinated and culturally appropriate way.

The progress report section summarises developments to date and work in progress since the endorsement of the Strategy Plan. Components of this section include:

- The establishment of the Waikato Palliative Care Operations Network which is the vehicle for guiding the implementation of the Strategy Plans recommendations
- An overview of new target funds invested into palliative care
- An update of key focus areas:
 - Collaborative care review project
 - Review project of the palliative care support services administered by Disability Support Link
 - Pilot project to implement the Liverpool Care Pathway (LCP) for the dying person
 - Joint initiative to appoint a 3rd palliative care physician between Hospice Waikato and Health Waikato which will include longer term development of a 24 hour / 7 day consultancy service, outreach service in Te Kuiti and long term appoint a clinical director for an integrated palliative care service
 - Development of a palliative care link nurse initiative working with resthomes/continuing care organisations
 - Other key developments
- An overview of national developments:
 - Palliative care definitions
 - Service specifications
 - New Zealand palliative care work group priorities
 - Proposal to establish a Palliative Care New Zealand organisation

The 2006-07 action plan builds on progress made over the last six months and details the Waikato Palliative Care Operations Network key focus areas for 2006-07.

Key focus areas include:

- Development of an integrated palliative care directory of services and providers
- Recruitment of the third palliative care physician and development of 24 hour / 7 day consultancy service, outreach service in Te Kuiti and appointment of clinical director
- Implement recommendation of the palliative care support services review project within allocated resources
- Implement recommendation of the palliative collaborative care review project within allocated resources
- Develop and implement the specialist palliative care link nurse initiative in partnership with resthomes / continuing care organisations
- Scope and identify requirements of palliative care services and links for Waikato DHB District Hospitals
- Scope implications of a single point of entry for specialist palliative care services
- Continue LCP pilot project and evaluate rolling out to other settings
- Formalise training and development programmes for the specialist palliative care nurses and general practice within the Waikato
- Continue to actively participate in the development of the national palliative care definitions and service specifications
- Identify a timeframe for developing a transition pathway from youth services to palliative care adult services.

Contents

Executive Summary	3
Part One - Introduction	6
Part Two - Progress Report.....	8
Waikato Palliative Care Operations Network.....	8
2005 – 06 Target Funding.....	8
Palliative Care Physician Joint Initiative	10
Palliative Care Link Nurse Initiative	10
Collaborative Care Review Project.....	11
Disability Support Link Palliative Support Services Review Project.....	14
End of Life Liverpool Pathway.....	17
Hospice Waikato.....	17
Other Update Points.....	18
National Palliative Care Work Group.....	18
National Palliative Care Definitions	18
Palliative Care New Zealand	19
Service Specifications.....	19
Part Three – Action Plan 2006 – 2007.....	20
References.....	25
Appendix 1- Waikato Palliative Care Operations Network Terms of Reference.....	26
Appendix 2 – Prioritisation of Recommendations.....	29
Appendix 3 - The Liverpool Care Pathway – Bringing a Model of Excellence for Care of the Dying	30

Part One - Introduction

The Waikato Palliative Care Strategy Plan (Hewitt, 2005) as developed to provide strategic direction for an integrated and co-ordinated Waikato District Health Board (Waikato DHB) palliative care services. The plan will guide service delivery and development between the years 2005 –2010.

The Waikato palliative care goal is to ensure that all providers of palliative care in the Waikato DHB work together with the community to ensure that the New Zealand Palliative Care Strategy (2001) is implemented in the most optimal way for the Waikato district. This is to ensure all people with palliative care needs and their family / whānau have access to essential¹ palliative care services, provided in a co-ordinated and culturally appropriate way.

The goal encompasses four key result areas:

- Integrated and collaborative care
- Patient focus on improved access and equity to palliative care services based on identified needs and informed choices
- Workforce development to ensure a skilled and competent workforce committed to the palliative care approach
- Quality systems

Each of the key results areas have supporting objectives and strategic initiatives recommended for implementation over the next five years. The supporting objectives are:

Integrated and Collaborative Care

- 1.1. To establish the Waikato DHB Palliative Care Network
- 1.2. To promote the palliative care approach and inform the public and providers
- 1.3. To establish formal links between the various service levels and providers
- 1.4. To ensure there is palliative care clinical leadership

Patient Focus on Improved Access and Equity of Services

- 2.1. To provide access to culturally appropriate palliative care services
- 2.2. To continue to improve palliative care services through review, analysis and improvement to the patient journey and parallel processes
- 2.3. Waikato rural communities to have improved access to palliative care services
- 2.4. To strengthen the palliative care links and partnership with general practice

¹ Essential services include: assessment, care co-ordination, clinical care and support care.

- 2.5. To provide specialist palliative care advice and support to palliative care patients in resthomes and continuing care organisations
- 2.6. To establish assessment single point of entry
- 2.7. To improve clinical care through the development and implementation of clinical pathways
- 2.8. To maximise scarce specialist palliative care resource and reduce duplication

Workforce and Resource Development

- 3.1. To ensure all palliative care service providers practice within the palliative care approach
- 3.2. To ensure there are adequate levels of appropriate trained palliative care staff
- 3.3. To ensure there are adequate Hospice community inpatient beds for respite and symptom control
- 3.4. To ensure there is adequate, safe and appropriate equipment to support people in the community

Quality Systems

- 4.1. To foster a culture of continuous quality improvement that enhances best practice and improves quality of care and services provided
- 4.2. To develop and implement a transition pathway and process between child and youth services to adult services
- 4.3. To establish adult and child and youth baseline data, appropriate performance indicators, benchmarks and reporting mechanisms to ensure achievement of the Palliative Care Strategy
- 4.4. Participate in national initiatives to improve the quality palliative care and establish benchmarking
- 4.5. Waikato DHB planning and funding service should review the Disability Support Link palliative care administrative function for night relief and respite care to resthomes / continuing care organisations
- 4.6. Waikato DHB planning and funding service should review all palliative care service specifications, rationalise, integrate and establish reporting and monitoring systems

Part two provides an overview of progress towards implementing the Strategy Plan recommendations and work in progress.

Part Two - Progress Report

Part two summarises developments to date and work in progress since the endorsement of the Strategy Plan. Components of this section include:

- The establishment of the Waikato Palliative Care Operations Network (Operations Network) which is the vehicle for guiding the implementation of the Strategy Plans recommendations
- An overview of new targeted funding invested into palliative care
- An update of key focus areas and
- Overview of national developments.

Waikato Palliative Care Operations Network

The Operations Network has established in November 2005 with terms of reference (appendix 1) and meets on a monthly basis. The Operations Network prioritised the Strategy Plan recommendations (appendix 2) and developed an action plan for 2005-06.

The 2005-06 action plan focus areas are:

- Allocation of new hospice funding that included recruitment of a joint 3rd palliative care physician and additional Palliative Care Unit (PCU) clinics
- Collaborative Care Review Project
- Review of Palliative Care Support Services administered by Disability Support Link (DSL)
- Palliative care 'Link' nurse to work with resthomes/continuing care organisations
- Pilot project to develop and implement the Liverpool Care Pathway (LCP) for the dying person
- National development of service specifications.

These are discussed briefly.

2005 – 06 Target Funding

There were two specific allocations of new target palliative care funding for 2005-06:

1. Hospice related palliative care
2. New funding that included Non-hospice palliative care, support and rehabilitation as a target area

A joint project between the Ministry of Health, District Health Boards New Zealand (DHBNZ) and Hospice New Zealand was established in July 2004 to investigate the funding of hospices by DHBs. This project reported to the Minister of Health. In July 2005 the Minister verbally confirmed an additional \$5.9 million nationally for palliative care services, this sustainable funding allocated to DHBs on a population based funding formula basis. The 2005-06 Waikato DHB allocation was \$501,169 (\$445,483 gst excl.) per annum.

The first call on this funding was to address shortfalls in hospice funding for the two essential palliative care services, which are assessment and care co-ordination and clinical care. Any residual funding was to be used for other palliative care priorities.

The Waikato DHB Community and Public Health Advisory Committee (CPHAC) endorsed the following:

- The funding for Hospice Waikato is provided to meet current volume costs of essential service components. Waikato Community Hospice contract volumes for palliative assessment and co-ordination and clinical care increase from 343.47 to 420.75 effective 1 July 2005. This was an increase of \$350,591 per annum. Where Hospice Waikato was not the lead carer the lower level of service rate would apply. Funding adjustments will be made as a result of reconciliation between the volumes contracted for and those actually delivered by 30 June 2006. Any wash-up funds would be used toward implementation of recommendations made in the Waikato Palliative Care Strategy Plan. Within Hospice Waikato's funding allocation it included a joint appointment with PCU, Health Waikato of 1.0 fte palliative care physician. This will allow clinical governance, standards of care and deliver best practice services through out Waikato. This option will ensure that Hospice Waikato has clinical leadership to support strengthening links and partnership with general practice.
- Health Waikato increased funding was \$90,093 effective 1 July 2006. The increased funding was for:
 - Palliative care community services – volume increase of 36
 - Outpatient first specialist assessment – volume increase 189
 - Outpatient subsequent attendance – volume increase of 75

This funding included the joint appointment with Hospice Waikato of a 3rd palliative care physician to fulfil the goals of the Strategy Plan of providing leadership, collaboration, education and 24/7 access for health professionals supporting palliative care patients. With this option it is expected that a specialist outreach service will commence in Te Kuiti and that current community based services will be extended and formally co-ordinated.

It was recognised that recruitment of a physician would take time and that PCU's funding would be used for funding project resource to undertake the collaborative care and DSL review projects.

- Tokoroa and District Community Hospice palliative assessment and co-ordination funding was increased by 5.75 volumes.

In February 2006 funding of \$111,135 (gst excl.) was made available to Waikato DHB by the Ministry of Health for Cancer Control Strategy implementation for 2005-06. On 1 July 2006 sustainable funding of \$266,724 (gst excl.) per annum, is available for the following target areas:

- Non-hospice palliative care, support and rehabilitation
- Cancer workforce development
- Supporting multidisciplinary teams
- Establishing regional cancer networks

The Waikato DHB CPHAC endorsed (March 2006) the appointment of a palliative care link nurse 1.0 fte. This is discussed later in the report.

Palliative Care Physician Joint Initiative

The Strategy Plan recommendation:

3.2 To ensure there are adequate levels of appropriate trained palliative care staff

Strategies:

- b) employ a third palliative care physician
- c) appoint a Clinical Director 0.2 fte
- d) implement a 24 hour / 7 day week on-call consultancy roster and service
- e) specialist palliative care physician to have sessional time in Hospice Waikato service
- g) promote and develop medical staff education and training programmes in palliative care
- h) as required increase support to district hospitals and communities in terms of outreach clinics
- i) development of the palliative care approach with other specialities and district hospitals

As discussed 2005-06 target funding section recruitment of the third palliative care physician is in progress. The aim was to recruit 1 July 2006, however there is a national and international shortage of palliative care physicians and the timeframe has been extended.

The current palliative care physicians are actively participating in the change management process of moving towards the new model of service delivery. Hospice Waikato and Health Waikato have agreed that Health Waikato will employ the physician on behalf of both organisations. Both organisations will be involved in the advertising and recruitment process.

A position description has been developed and advertising process commenced. The operational detail is work in progress.

Development of the Te Kuiti outreach clinic has commenced, but will not be fully operational until appointment of the third physician.

Palliative Care Link Nurse Initiative

One of the main issues identified in the Strategy Plan is fragmentation of services with and between providers resulting in variation in standards of practice. A particular area of concern is the delivery of quality palliative care to patients in resthomes and continuing care organisations.

The majority of people requiring palliative care are older people. Approximately 80% of Waikato DHB palliative care patients are aged 65 years or more and the growth of older people is projected to continue. This is likely to increase demand for palliative care. People admitted and dying in residential care is increasing and is expected to continue to grow because of the ageing population and less support due to changing family structure. The Waikato Operations Network and resthomes / continuing care organisations need to work together on strategies to improve the quality of palliative care services and reduce the impact on scarce resources with this anticipated growth.

Another issue identified is the need to develop and implement end of life care pathways. The palliative care link nurse position has strong links with the end of life

pathway nurse. Discussions with Hospice Waikato and PCU recommended that PCU employ and manage this new initiative.

The Strategy Plan recommendation:

2.5 To provide specialist palliative care advice and support to palliative care patients in resthomes and continuing care organisations.

This initiative promotes community based care co-ordination and workforce development for generalist palliative care providers in resthomes and continuing care organisations, by a specialist palliative care nurse co-ordinator.

A specialist palliative care nurse has been employed into this new position.

Over 2006-07 the Operations Network and resthomes / continuing care organisations will jointly develop a community based palliative care co-ordination service for identified palliative care patients in resthomes and continuing care organisations. This service will be supported through the palliative care nurse educator 1.0 FTE.

The main objectives of the services include:

- Conduct a baseline assessment, including training needs analysis of current palliative care provision in resthomes / continuing care organisations
- Raise profile of specialist palliative care services including directory of specialist palliative care services
- Establishment of referral and discharge criteria
- Work in partnership to further develop staff orientation processes
- Work collaboratively with other education providers and develop resource file and palliative care education programmes
- Introduce integrated care pathways for the dying (i.e. Liverpool pathway) as appropriate
- Prevent inappropriate acute admissions to hospital.

Collaborative Care Review Project

In November 2005, the Waikato DHB Board endorsed one-off funding for the formal review of collaborative care services. In February 2006 the Operations Network lead the review of the Waikato Palliative Collaborative Care (Collaborative Care) Model. This was in response to the Strategy Plan recommendation:

- Waikato rural communities to have improved access to palliative care services
- To formally review and evaluate the current collaborative care service and make recommendations for the future.

The Network set four project objectives for the review:

1. To identify the current level of palliative collaborative care service, including strengths, weaknesses and opportunities
2. To review other palliative care models both nationally and internationally
3. To recommend the model for the future
4. To develop a collaborative care action plan.

The project report was presented to the Network (White, 2006) and this report summarises what is collaborative care, the project findings and way forward.

Currently in rural Waikato the district nursing service provides generalist care for adult palliative patients together with Hospice Waikato who provide specialist non clinical services. This model of care is known as collaborative care. Palliative patients who live in rural Waikato can choose to either receive care solely from district nursing services or participate in the collaborative care model.

In 2003, the Waikato Community Hospice Trust (Hospice Waikato), and Rural Hospitals and Community Based Services (RHCBS) Family Health Team (FHT) district nursing service and the PCU, initiated the current collaborative care model.

The collaborative care model was developed to introduce Hospice Waikato palliative care service components to the Waikato rural community. The collaborative care model was first piloted in the Te Kauwhata, Huntly, Te Awamutu and Raglan. This model has now been expanded to other Waikato DHB rural areas excluding Coromandel town, Whitianga, Whangamata, Tairua and Tokoroa.²

Currently within the Waikato DHB there are four palliative care nursing service delivery models. The models are either a mixture of specialist palliative care; combination of generalist and specialist palliative care³ or generalist palliative care nursing service. While the review was cognisant of all four models the focus of the project is the collaborative care model.

In the collaborative care model district nursing service provides palliative nursing care across the Waikato district with the exception of Hamilton, Cambridge and Ngaruawahia. When a patient who lives outside of Hamilton, Cambridge and Ngaruawahia chooses the palliative collaborative care model they receive multidisciplinary palliative care input through Hospice Waikato and district nursing service. The district nurse is the 'key worker' and provides all clinical care for the patient in their home. Hospice Waikato provides specialist emotional support for the patient/whānau.

Hospice Waikato provides a package of home based palliative care services for patients in Hamilton, Cambridge and Ngaruawahia that includes the delivery of nursing care and access to the multidisciplinary team and services.

The review found that efficiencies are possible and following table outlines the goals and actions recommended.

The implementation of the recommendations are to be phased over 2006 – 2010 and within current existing resources with the exception of the establishment of a 24/7 day a week integrated specialist palliative care nursing on call system. It is proposed that there is a six-month pilot for the integrated specialist palliative care nursing on call system to identify requirements and costs. Funding for 2006-07 will come from the current vacant palliative care physician.

If the pilot recommends continuation then associated cost for this service is to be prioritised through the DHB process for 2007-08.

² As of 1st July 2006, Hospice Waikato commenced developing services in Coromandel town, Whitianga, Whangamata, and Tairua

³ Refer to Waikato DHB Palliative Care Strategy Plan for definitions of generalist and specialist palliative care providers / services. Development of national definitions is in progress.

<p>1. Integrated Service</p> <p>Goal: All palliative care services delivered in rural Waikato will be co-ordinated between providers.</p> <p>Actions:</p> <ul style="list-style-type: none"> • Develop a process to ensure all patients receiving collaborative care have an identified care co-ordinator • Review, standardise and integrate information and documentation between the providers of palliative collaborative care • Inform the public and providers on what to expect from the Waikato DHB palliative collaborative care service • Determine the Regional Referral Centre (RRC) as the single point of entry for collaborative care services • Review and update the Memorandum of Understanding (1996) between RH&CBS and Hospice Waikato
<p>2. Improved Access of Service</p> <p>Goal: All people throughout rural Waikato district have access to collaborative care services.</p> <p>Actions:</p> <ul style="list-style-type: none"> • Hospice Waikato and RH&CBS work collaboratively to support the extension of the collaborative care model to Coromandel Town, Whitianga, Tairua and Whangamata • Consider the options and implications of introducing a full range of specialist palliative care service components to the Tokoroa community • Develop a formal understanding of when, if ever, collaborative care may be considered within the Hamilton and hinterland areas for complex palliative care patients under the care of DNS
<p>3. Workforce and Resource Development</p> <p>Goal: All stages of collaborative care workforce development are aligned to service needs and available resources</p> <p>Actions:</p> <ul style="list-style-type: none"> • Develop within the collaborative care model a 24 / 7 day a week specialist palliative care nurse on-call telephone consultancy service for health provider use only • Improve clinical care through the development and implementation of clinical pathways / guidelines and tools • Develop specialised educational packages for staff working within palliative care teams
<p>4. Implementation of Quality Monitoring Systems</p> <p>Goal: Information is available so reporting of collaborative care activities can be accurately monitored</p> <p>Actions:</p> <ul style="list-style-type: none"> • Develop and implement a baseline data set that captures relevant data from integrated palliative care services • Develop a suitable collaborative care reporting and monitoring systems with agreed frequency of auditing

Disability Support Link Palliative Support Services Review Project

In November 2005, the Waikato DHB Board endorsed one-off funding for the formal review of the current DSL palliative care support service. In February 2006 the Operations Network lead the review. This was in response to the Strategy Plan recommendation:

“4.5 Waikato DHB planning and funding service should review the Disability Support Link (DSL) palliative care administration function for night relief and respite care to rest homes/ continuing care” (p26).

The purpose of this report is to provide an overview details of the project findings and make recommendations for improvement initiatives (Fitness, 2006).

DSL palliative care support services are provided to patients during the last six weeks of life. The support services are:

- Palliative carer support night/day relief (carer support) - two nights per week or the funding equivalent of \$150 to be used as desired by the client to meet the family / whānau need for carer support at other times of the day
- Respite/end of life rest home/continuing care bed (respite care) - for a maximum of six weeks where the patient is deemed to be in the terminal phase.

Palliative carer support and/or respite care funding commenced 1997-8 to meet a ‘gap’ in the services. At the time palliative care funding commenced, it was deemed that DSL was the most appropriate service to manage the funds because they had an invoicing mechanism and already provided a range of support services for disabled people and their families/whānau. At the time no eligibility criteria for accessing palliative care support services were provided to DSL and although some have subsequently been developed (in 1999), they have never been formally recognised.

Historically, DSL palliative care support services funding has been based on previous expenditure rather than need. Expenditure over the last four financial years has averaged \$384.5k annually and it is likely that this will be inadequate in the future with the forecasted increasing numbers of palliative care patients. The 2006-07 budget is \$429,455 fee for service and \$1,634.38 management fee.

Analysis of DSL data for the 2001-06 financial years indicates an average of six referrals per month for palliative carer support and seven referrals per month for respite care. The last three financial years indicate a proportionally higher demand for rest home/continuing care beds for and decreasing demand for palliative carer support.

The key strengths of the current service are:

- DSL knowledge and ability to administer (single point of entry, invoicing mechanism) the palliative support services, including the availability and knowledge of the DSL manager
- DSL has formed relationships with rest home and continuing care organisations and agencies that provide carer support
- Palliative Care Unit provides specialist palliative clinical advice and guidance to DSL and district nursing as required.

The key weaknesses of the current service are:

- Current contract definitions and eligibility criteria for palliative care support services (DSL for six weeks and Hospice for six months) are not congruent with either the:

- The New Zealand Cancer Control Strategy Action Plan (MOH, 2005) that aligns with the World Health Organisation (WHO, 2002) definition that “the provision of palliative care is applicable at any stage after diagnosis of a life-threatening illness, and not at the very end of life (terminal phase)” or the
- New Zealand Palliative Care Strategy (2001) recommendation that palliative care should generally be available to people whose death from progressive disease is likely within 12 months
- Current eligibility criteria for accessing palliative support services are not formalised, creating uncertainty for referrers
- Inequity of services – DSL patients not registered with Hospice Waikato can only access support services through DSL. Hospice Waikato patients are able to access palliative support services through Hospice (non-DHB contracted) and DSL Waikato DHB contracted services
- Service specifications are out of date and not reflecting the services provided
- Access to services, particularly palliative carer support night/day relief is not equitable across the Waikato DHB district due to variable availability of carers
- Waikato DHB contracts for the administration function only for palliative care carer support night/day relief. Inconsistencies with provision of palliative care carer support night/day relief i.e. DSL approves the funds but does not provide the personnel (although will advise) whereas Hospice Waikato will organise the carer
- Funding level does not always meet the full cost of carer support. There are known issues with palliative patients with complex, high cost needs
- Data collection is incomplete with minimal monitoring services
- Nationally it is known there is fragmentation, gaps and issues related to the boundaries of personal health and disability support services and the needs of people with long-term, chronic illnesses

A number of options have been identified within this document. The options in the report discussed are:

1. DSL continues to manage palliative care support services (i.e. approval of services and administration of funds)
2. DSL continues to administer funds with approval given by palliative care co-ordinator
3. PCU manages palliative care support services
4. Hospice Waikato manages palliative care support services
5. Acute Home Care Support Services expands to manage palliative care support services
6. A ‘one stop shop’ service co-ordination concept that integrates personal health (palliative care support services and acute home care support services and Disability Support Services (DSS) run through DSL

While outside the scope of the project consideration should be given as progress is made in relation to the:

- Waikato DHB service and campus redevelopment ambulatory Referral Co-ordination Centre. Should the Referral Co-ordination Centre concept be expanded to include support services?
- National boundary issues between personal health and disability support services for people with chronic medical illnesses
- Longer term options related to addressing the issues related to patients who want to remain / die in their home accessing regulated and / or non-regulated carers within the community
- Review of national palliative care services specifications.

Option six was considered to be the preferred longer-term option for the Waikato DHB, but this option is outside the scope of the project and would require further analysis. The option would combine all support services which are available to a palliative care patient and their family/whānau based on need, thus providing a more timely and seamless provision of service, reducing duplication of administration and creating a single point of entry for referrers. It is recognised that this option requires a long-term approach since it will necessitate the review of current contracts, funding and service provision arrangements and development of a change management plan.

The recommended option is option one where DSL remains the lead provider that manages and administers the palliative care support services contract for the Waikato DHB. Improvements to the current systems and processes will be implemented to enhance the quality of the services. The following recommendations can occur with a small additional investment.

The quality improvements will include:

- The proposed eligibility criteria, assessment and referral tool and guidelines are approved and implemented. Training and information is provided to referrers on the new tools and guidelines. These tools / guidelines will reduce the need for DSL to refer back to the referred and / or make contact with PCU for advice
- DSL utilise increased contracted funds to employ a 0.5 fte for administration of the service co-ordination. Funding would come from the sustainable funding increase of 2006-07
- PCU continue to provide DSL clinical support and guidance
- Improved data collection through the development of a minimal data set
- Waikato DHB planning and funding clarify with DSL contractual reporting and monitoring requirements in relation to palliative care support services
- DSL explore the option of referrals routed through the Referral Co-ordination Centre.

A longer-term recommendation to increase access to palliative care support services firstly to meet the timeframes of:

- The New Zealand Palliative Care Strategy (MOH, 2001) of twelve months and
- The New Zealand Cancer Control Action Plan (MOH, 2005) timeframe of any stage after diagnosis of a life-threatening illness

will require significant investment. Additional funding would need to go through the Waikato DHB prioritisation process and be phased in over a 5 – 10 years.

End of Life Liverpool Pathway

The Strategy Plan recommendation:

2.7 To improve clinical care through the development and implementation of clinical pathways.

Strategies:

a) End of Life Liverpool pathway is implemented. Initially pilot in one or more settings.

Waikato DHB has embraced the concept of the Liverpool Care Pathway (LCP) and is registered with the LCP project, Royal Liverpool Hospital, UK. The LCP is seen as a key component in improving delivery of end of life care to patients and family / whānau. The Palliative Care unit (PCU) is leading the Liverpool Care Pathway Pilot in an Acute Setting, Waikato Hospital.

The pilot will occur in two wards of Waikato Hospital. It is well known that implementation of the LCP is resource intensive and time consuming. The pilot is expected to take approximately a year.

A Waikato DHB Executive Group paper (appendix 3) provides further information to on the Liverpool Care Pathway for care of the dying.

Hospice Waikato

Hospice Waikato takes possession of a motel / conference centre, based in Hamilton effective 15 December 2006. The aim of this strategic initiative is to bring all Hospice Waikato services onto one site and enable Hospice the flexibility to develop inpatient services as recommended in the Strategy Plan. This long-term initiative will provide foundation for enhancing Hospice services to align with the Strategy Plan recommendation:

3.3 To ensure there are adequate Hospice community inpatient beds for respite and symptom control.

Strategies:

- a) Waikato DHB and Hospice Waikato need to consider and address the current level of community Hospice inpatient beds, 4 is inadequate and strategies to increase to 10 should be explored as the Waikato DHB model of care is developed
- b) Explore long term facility / management options for community inpatient respite and symptom control beds for the Waikato district
- c) Develop and strengthen Hospice community inpatient respite and symptom control services to ensure best practice and excellence in standards

As of 1st July 2006, Hospice Waikato commenced developing services in Coromandel town, Whitianga, Whangamata, and Tairua.

Other Update Points

The Strategy Plan recommendation:

2.4 To strengthen the palliative care links and partnership with general practice.

Strategies:

e) Waikato PHO Hamilton Local Management Group consider implementation of the Palliative Care Home Visit Programme.

His strategy has been implemented. The Waikato PHO Palliative Care Home Visiting Project was implemented in Hamilton City 1st January 2006. This project provides up to 12 free GP home visits (which can include 2 visits to the surgery) in late stages of terminal illness to ensure patients and whānau are well supported and the patient is able to stay in their home as long as possible.

Hospice NZ developed a syringe driver education programme for resthomes. Waikato has taken a collaborative approach to implementing this initiative. Hospice Waikato and the Palliative Care Unit are jointly implementing this programme across the Waikato DHB.

National Palliative Care Work Group

The Ministry of Health Cancer Control Implementation team informed the sector of the Improving Palliative Care Project (Project Sponsor Deborah Woodley, MOH and Project Manager Nick Polaschek, MOH)

A palliative care work group has been established under the auspices of the NZ Cancer Treatment Working Party (NZCTWP). The work groups purpose is to ensure the implementation of the NZ Palliative Care Strategy and the relevant objectives of the Cancer Control Strategy:

- To set in place a systematic and informed approach to the provision and funding of palliative care services
- To reduce the incidence and impact of cancer, and to reduce inequalities with respect to cancer from a palliative care perspective.

The Improving Palliative Care Project three priorities identified are:

- A national definition of palliative care produced
- Service requirements for generalist and specialist palliative care (including hospital, inpatient units, and community services) developed and implemented through national service specifications
- Palliative care workforce needs assessment completed.

National Palliative Care Definitions

A subcommittee of the National Cancer Treatment Working Party (NCTWP) are developing a national definition for palliative care, including generalist and specialist. Work is in progress.

Palliative Care New Zealand

The Palliative Care Advisory Committee was tasked to develop a national umbrella organisation to bring together the entire principal interests in palliative care across New Zealand. The proposed organisation will be named Palliative Care New Zealand (PCNZ).

As of June 2006 the Committee has determined PCNZs mission statement, communications network, Board structure and organisational scope. Work and consultation on establishment of this organisation is ongoing.

Service Specifications

The Ministry of Health created the national palliative care service specifications in 2001 as part of a nationwide service framework. The palliative care community agrees that the current service specification do not adequately define the appropriate scope of palliative care services. New service specifications need to describe a full range of services, incorporating community care, hospital care, hospice care and their interrelation with one another.

A national Palliative Care Service Specifications Review Group (PCSSRG) was established (March 2006) under the umbrella of the National Cancer Treatment Working Party (NCTWP).

In summary there are numerous anomalies with palliative care service specifications both from a local and national and generalist and specialist perspectives. National review and development of services specifications is in progress.

Part Three – Action Plan 2006 – 2007

Palliative care is a young speciality and continues to evolve. Until 2001 with the release of the New Zealand Palliative Care Strategy Plan (2001) and more recently at a local level with the Strategy Plan palliative care services have developed in an adhoc way.

As palliative care has evolved, the World Health Organisation definition of palliative care has changed substantially. In recent years the community expectations for palliative care have grown. These changes challenge those who are involved in planning, funding and provision of services to meet new expectations.

This section takes a planned and phased approach towards achieving the Strategy Plan goal and recommendations.

The Waikato Palliative Care Operations Network 2006-07 Action Plan builds on progress made over the last six months.

Key focus areas for 2006-07 are:

- Development of an integrated palliative care directory of services and providers
- Recruitment of the third palliative care physician and development of 24 hour / 7 day consultancy service, outreach service in Te Kuiti and appointment of clinical leadership
- Implement recommendation of the palliative care support services review project within allocated resources
- Implement recommendation of the palliative collaborative care review project within allocated resources
- Develop and implement the specialist palliative care link nurse initiative in partnership with resthomes / continuing care organisations
- Scope and identify requirements of palliative care services and links with Waikato DHB District Hospitals
- Scope implications of a single point of entry for specialist palliative care services
- Continue LCP pilot project and evaluate rolling out to other settings
- Formalise a training and development programmes for the specialist palliative care nurses and general practice within the Waikato
- Continue to actively participate in the development of the national palliative care definitions and service specifications
- Identify a timeframe for developing a transition pathway from youth services to palliative care adult services.

Key Results Areas	Medium to Long Term Objective	Annual Objective 2006/2007	Annual Objective 2006/2007 Performance Measures
Integrated and Collaborative Service	1.2 To promote the palliative care approach and inform the public and providers	a) Develop an integrated palliative care directory b) Define responsibility for maintaining directory	Directory developed by 30 June 2007. Work in progress, will be constantly ongoing
	1.4 To ensure there is palliative care clinical leadership	a) Following appointment of CD development of medical staff education and training plan	Identify training requirements, then develop a plan by 30 June 2007
	2.3 Waikato rural communities to have improved access to palliative care services	a) Implement recommendations from collaborative care project review within allocated resources b) Waikato DHB district hospital review to ensure linking with collaborative care review project	Approved recommendations implemented by December 2006 within allocated resources District hospital review project completed by 30 June 2007
Patient Focus on Improved Access and Equity of Services			

Key Results Areas	Medium to Long Term Objective	Annual Objective 2006/2007	Annual Objective 2006/2007 Performance Measures
Patient Focus on Improved Access and Equity of Services continued	2.4 To strengthen the palliative care links and partnerships with general practice	(a) PCU engage in discussions with the 4 PHOs to develop a palliative care continuing education plan for primary	4 Primary CME sessions by 30 June 2007
		(b) PCU engage in discussions with Waikato Post Graduate Medical Programme to provide palliative care continuing education	PCU participate in Post Graduate Medical Programme during 2006-07
		(c) To explore with IS development of communication links for referral and electronic discharge summary	IS requirements considered in SCR development
	2.5 To provide specialist palliative care advice and support to palliative care patients in resthomes and continuing care	(a) Employ palliative care link nurse to develop and implement programme with aged care (b) Incorporate clinical pathways (2.7) into programme framework	Palliative care link programme with aged care organisations scoped, developed and implemented by 30 June 2007

Key Results Areas	Medium to Long Term Objective	Annual Objective 2006/2007	Annual Objective 2006/2007 Performance Measures
Patient Focus on Improved Access and Equity of Services continued	2.6 To scope the requirements to establish an assessment single point of entry	(a) Scope and define requirements to ensure fit with SCR requirement, consider OPRS and regional referral centre models (b) Develop standardised referral and assessment tools and guidelines	Requirements and Plan agreed by 30 June 2007 Tools and guidelines developed by 30 June 2007
	2.7 To improve clinical care through the development and implementation of clinical pathways - Liverpool Care of the Dying Pathway Project (links with Link Nurse concept)	(a) Formal review of Health Waikato pilot project (b) Implement recommendations of review within allocated resources	Pilot in place by Sept 2006 Formal Review process to commence late 2007
	3.2 To ensure there are adequate levels of appropriate trained palliative care staff Medical	(a) Call for EOI for CD (b) To implement 24 hour / 7 day week specialist on-call consultancy service on confirmation of start date of 3 rd physician	Appointment of joint Clinical Director by 30 June 2007 Medical on call service implemented
Workforce and Resource Development	Nursing	(a) Training and development plan is developed for all specialist palliative care nurses.	60% of target workforce have or are working towards post graduate palliative qualification by 30 June 2007

Key Results Areas	Medium to Long Term Objective	Annual Objective 2006/2007	Annual Objective 2006/2007 Performance Measures
Quality Systems	4.1 To foster a culture of continuous quality improvement that enhances best practice and improves quality of life (Research and evidence based standards should be developed parallel to national palliative care sub committee project plan)	a) Implementation of national referral protocols for access to palliative care as developed under the auspices of the proposed Guidelines Steering group within NZCTWP.	Ongoing
	4.2 To develop and implement a transition pathway and process between child and youth services to adult services	b) Child services identify a timeframe to develop the transition pathway and process	30 June 2007
	4.5 Waikato DHB should review the DSL palliative care administration function for night relief and respite care to resthomes / continuing care	a) Implement recommendations of review within allocated resources	30 June 2007
	4.6 Waikato DHB should review all palliative care service specifications, rationalise, integrate and establish reporting and monitoring systems	(a) Actively participate in development of national service specifications (community and hospital) (b) Regular feedback to network following national meetings	Participate in development of national service specifications

References

- Fitness, J. H., J., (2006). *Waikato DHB Palliative Care Disability Support Link Review*. Hamilton: Waikato District Health Board.
- Hewitt, J. (2005). *Waikato District Health Board Palliative Care Strategy Plan 2005-2010*. Hamilton: Waikato District Health Board.
- MOH. (2001). *The New Zealand Palliative Care Strategy*. Wellington: Ministry of Health.
- MOH. (2005). *New Zealand Cancer Control Strategy Action Plan 2005 - 2010*. Wellington: Ministry of Health.
- White, J., Hewitt, J., (2006). *Waikato DHB Palliative Collaborative Care Review*. Hamilton: Waikato District Health Board.

Appendix 1- Waikato Palliative Care Operations Network Terms of Reference

Overview

Cancer control is a strategic health priority for the Waikato DHB and palliative care comes under the umbrella of cancer control. The Waikato DHB palliative care network will be the approach and mechanism to bring all providers together to work on implementation of the Waikato DHB Palliative Care Strategy Plan 2005 – 2010. A philosophy of broad-based community service is the optimal way to accommodate and address the projected demand in palliative care needs.

The network formalises relationships with generalist and specialist palliative care providers as well as the community. There will be two groups that will form the Waikato DHB palliative care network, they are:

- Waikato DHB palliative care operations network (generalist and specialist stakeholders)
- Waikato DHB palliative care advisory group (community stakeholders)

Palliative Care Operations Network

Palliative care providers will work in a collaborative and co-ordinated manner to ensure equitable provision of high quality, clinically effective, culturally appropriate palliative care service throughout the Waikato DHB.

The *specific role* of the Waikato DHB palliative care operations network is to be actively involved in planning, developing, implementing, monitoring and evaluating health related initiatives and services for people with palliative care needs within the Waikato DHB.

Membership

Membership for this group will comprise of the following:

Chair – General Manager Health Services	Jan Adams
Clinical Director, Regional Cancer Centre	Dr Jeremy Long
Project Manager, Development & Support Unit	Jan Hewitt
CEO, Hospice Waikato	Elizabeth Bang
Palliative Care Specialist	Dr Des Swanevlder
Palliative Care Specialist	Dr Alan Farnell (Sept 2006)
Planning & Funding Portfolio Manager	Rachel Poanaki
Operations Manager, Palliative Care Unit	Kim Holt
Regional Co-ordinator Palliative Care Unit	Margaret Stevenson
Waikato GP Liaison	Dr Linda Rademaker
Manager, Rural Hospitals & Community Based Services	Jill Dibble
PHO representative – CEO Hauraki PHO	Hugh Kininmonth
Paediatrician	Dr Dave Newman
Māori Health Representative	Maata McManus
	Dr Nina Scott

The network will co-opt other key stakeholders and support staff as necessary.

Key Objectives

- To deliver on the goals of the Waikato DHB Palliative Care Strategy Plan, which aims to achieve the national Palliative Care and Cancer Control Action Plan strategies.
- To build relationships to promote providers of palliative care services within the Waikato DHB to communicate new initiatives and / or service developments to the Waikato DHB Palliative Care Operations Network. This will enable the Network to be kept informed and consider palliative care initiatives / developments within the Waikato DHB to inform planning and alignment with the Waikato DHB Palliative Care Strategy Plan. The Network as required provide expert advice and support to providers as required.
- To direct and oversee palliative care workstream projects as required.
- To focus on local service co-ordination and ensure provision of generalist and specialist services and support as required.
- Development of an annual service delivery plan to include planning priorities, which reduce inequalities, quality service improvement, workforce development, education and training. To prepare business cases as required.
- To monitor the implementation of the annual service delivery action plan.
- To monitor and evaluate service provision including reporting of data to inform and shape future service development.
- To ensure participation of all key stakeholders through the Waikato DHB Palliative Care Advisory Group which takes account of the views of other providers, patients, families / whānau and / or carers.
- To promote the development of collaboration and integration, including intersectoral linkages between services.
- Effective and efficient communication links among health professionals / providers.
- To participate in national initiatives and communicate developments.
- Members may also be invited to participate or lead additional working groups as required.

Chair and Administration Function

The administration function entails the preparation and circulation of agenda, recording and circulating the minutes, coordinating meeting arrangements and the distribution of information among members.

Chair: Jan Adams, Acting General Manager, Health Services

Administration: Project Manager, Jan Hewitt, Waikato DHB Development & Support

Meeting Schedule

Frequency: 4th Tuesday of the month 11 – 12am

Venue: Bryant Education Centre (to be confirmed on agenda)

Minutes and Agenda

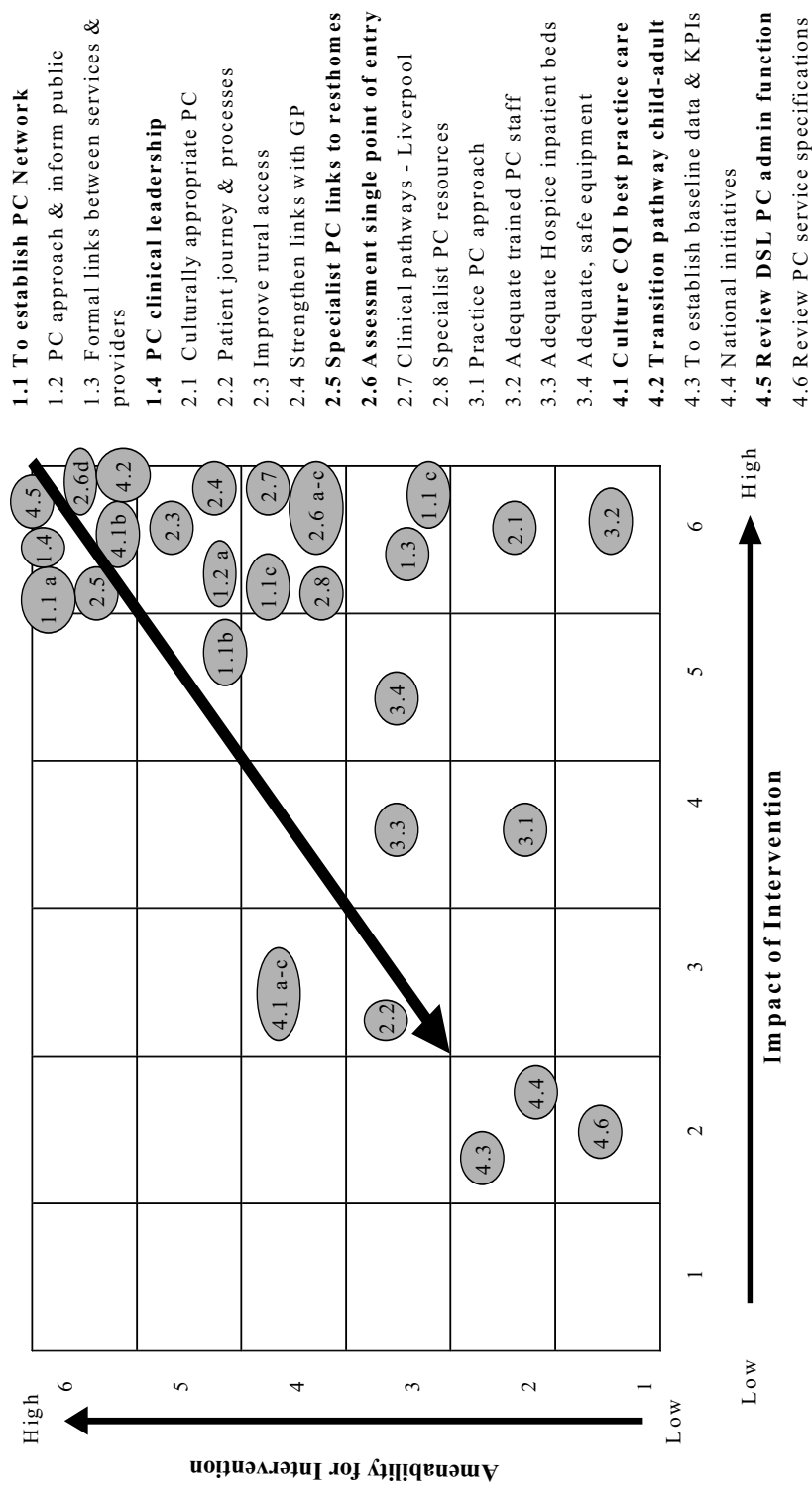
- Minutes are circulated to members within seven days after the meeting via email
- Agenda items are sought ten days preceding each meeting
- The agenda is circulated one week prior the scheduled meeting including all papers.
- Briefing/background papers will be prepared and circulated prior to the meeting. If a decision is required a recommendation will be clearly stated at the end of the paper.

Reporting and Communication

- The Network Chair reports directly to the Waikato DHB CEO.
- Quarterly progress reports to the Chair from the project manager.
- Minutes will be made available to the Waikato DHB palliative care advisory group chair and other stakeholders as requested.
- The process for managing any correspondence from the network will be directed by the Chair.

Appendix 2 – Prioritisation of Recommendations

The Decision Matrix Grid Showing Prioritisation of Palliative Care Recommendations (Nov. 2005)



Appendix 3 - The Liverpool Care Pathway – Bringing a Model of Excellence for Care of the Dying

July 2006

Introduction

The Waikato Palliative Care Operations Network progress report 2005-06 and implementation plan 2006-07 (draft) was tabled at Waikato DHB Executive Group (17-7-06) by the Acting GM Health Services.

The purpose of this paper is to provide further information to the Executive Group on the Liverpool Care Pathway (LCP) for care of the dying.

The Waikato Palliative Care Strategy Plan was endorsed in November 2005. The Strategy Plan recommended the need to improve the quality of care for the dying patient and family / whānau (Waikato Palliative Care Strategy Plan, 2005 p22).

Integrated clinical care plans / pathways are not a new concept, they are part of clinical care within Waikato DHB, ie. cardiac bypass surgery. The LCP is an integrated clinical care plan / pathway based on evidence based best practice standards for the multidisciplinary team that guides care of the individual patient and family / whānau in the last days of life. The LCP aims to improve care for the dying person and family / whānau within the primary, acute or a home care setting. Waikato DHB has commenced implementation of the Strategy Plan recommendation with a pilot project in an acute hospital setting.

The paper provides a background to the development of the LCP, what is the pathway, LCP fit with Waikato DHB approach, objectives and benefits of implementing LCP within Waikato DHB, progress to date, planned timeline, resource and cost implications. A copy of the Waikato LCP pathway is attached.

The Executive group are invited to a Waikato LCP presentation on Monday 14th August, BEC auditorium.

Background

The NHS Cancer Plan (2000) highlighted the need for improvement in the care of the dying and challenged the palliative care community “too many patients still experience distressing symptoms, poor nursing care, poor psychological and social support and inadequate communication from healthcare professionals during the final stages of illness. The care of all dying patients must improve to the level of the best.”

The NHS (2000) key themes of outcomes of care of the dying patient were:

- Poor outcome data for care of the dying
- No minimum standards for care of the dying
- No opportunity for benchmarking / learning
- Clinical governance agenda poorly developed
- Education strategies unfocused
- Research limited in this area.

The LCP for the dying patient was jointly developed and piloted in 1997 by the Royal Liverpool University Trust and the Marie Curie Centre Liverpool, UK to enhance education programmes for care of the dying. The LCP framework has gained UK and international recognition and in 2000 was awarded National Beacon Status⁴ for palliative care.

The NHS aim was to build on the existing Beacon Dissemination Programme and co-ordinate a national model of spread and sustainability of the LCP across the NHS Cancer Networks linked with the Cancer Services Collaborative Improvement Partnership⁵ and supported by Marie Curie Cancer Care. A key initiative / focus of the Cancer Services Collaborative for the palliative care is the LCP in the last days or hours of life (and the other focus area is the Gold Standards Framework in community palliative care in the last months or year of life at home). The LCP is a key recommendation in the National Institute of Clinical Evidence (NICE) guidelines for supportive and palliative care (refer www.nice.org.uk).

Dr J Ellershaw, Medical Director, Marie Curie Centre Liverpool leads the NHS LCP programme with The Royal Liverpool Universities Hospital specialist palliative care team. There is a structure to support the programme (www.lcp-mariecurie.org.uk). The LCP programme provides affiliated organisations with tools, resources and framework for qualitative analysis and reporting of audit data by their research team. The research team aims to report in hard and electronic form within one month of receipt of the audit forms. At this point in time there is no cost to Waikato DHB and other participating organisations to access tools, resources and participate in audit.

The LCP programme team at Liverpool state that “a major cultural shift is required if the needs of dying people are to be met and the workforce is to be empowered to take a leading role in this process. Dying patients are an integral part of the population of general hospitals. Their death must not be considered a failure; the only failure is if a persons death is not as restful and dignified as possible. Often the complexity of the measurement of palliative care intervention has thwarted effective outcome measures being developed. We believe the Liverpool care of the dying pathway has the ability to change practice, promote multi-professional collaboration and articulates evidence-based practice” (www.lcp-mariecurie.org.uk). Caring for dying patients requires sensitive handling and an attitude of compassion and understanding and health professionals need knowledge and support to achieve this.

What is the LCP?

The LCP for the dying patient was developed to transfer the hospice model of care into other care settings⁶. It is a multiprofessional framework supported by a pathway process and document that provides evidence-based care for the dying phase. The pathway provides guidance on the different aspects of care required including comfort

⁴ The NHS Beacon Programme identifies centres of excellence and supports the delivery of high quality patient centred care by spreading good practice across the NHS (NHS, 2003).

⁵ The Cancer Services Collaborative Improvement Partnership is a national NHS programme designed to improve the way in which cancer services are provided. It is lead by the National Cancer Control Director and National Manager. The aim is to improve the experience and outcomes for patients with suspected or diagnosed cancer by optimising care delivery systems across the whole pathway of care.

⁶ Other settings examples are hospital, hospice, resthomes, home based services

measures, anticipatory prescribing of medication, and discontinuation of inappropriate interventions. Additionally psychological and spiritual care and family support is included. The LCP is applicable in hospital, hospice, nursing home and community settings.

The LCP empowers health professionals to deliver high quality care to dying patients and their family, with measurable improvement in care. It facilitates multiprofessional communication and documentation and integrating national guidelines into clinical practice. It promotes the education and empowerment role of the specialist palliative care team to bridge the theory practice gap, as palliative care is a relatively new speciality. The NHS Liverpool programme team have pathways for various settings – hospital, hospice, nursing homes and community.

The key elements that constitute an integrated care pathway:

- It organises the process
- There is a timeline element
- There is supportive evidence of practice
- There is an element of multidisciplinary collaboration
- There are elements of care identified usually within an agreed timeframe
- There is continuous review of practice
- There is an assessment of variance
- It is outcome focused
- It constitutes part of the clinical record
- The pathway should inform risk and benefit

It has been acknowledged (NZ Palliative Care Strategy, 2001; Waikato Palliative Care Strategy Plan, 2005) that specialist palliative care providers cannot care for all palliative patients in the dying phase. If a pathway was introduced for the last days of life this would support generalist palliative care providers such as the ward, nursing home and community teams to manage the episode of care for the dying, which will meet the needs of the patient, carer and staff.

LCP Fit with Waikato DHB Approach

Strategies underpinning the need to provide equitable access and quality care to all dying patients and their family / whānau are:

- New Zealand Palliative Care Strategy (2001)

“Palliative care is globally recognised as a legitimate component of health care. Evidence shows that palliative care is effective in improving the quality of life for people who are dying and that it should be a central feature of good clinical practice” (p 3).

“Hospitals mainly provide services to dying people as a component of other services (for example acute care or general care). This is generally not tailored for dying people” (p 35).

- New Zealand Cancer Control Strategy (2003)
- New Zealand Cancer Control Strategy Action Plan 2005 – 2010 (2005)

- Waikato DHB District Annual Plan (2005)

The principles of quality improvement⁷ align with the principles of the LCP(p 72) and supports multidisciplinary approach to care, evidence based care standards, guidelines and care plans / pathways. Collaborative approach to care for patients and family / whānau in all settings

Why does Waikato DHB want to implement the LCP?

- Waikato Palliative Care Strategy Plan 2005 – 2010 (2005)

The findings of the Waikato Palliative Care Strategy project steering group (Waikato DHB, 2005) regarding the care of the dying were similar to the previously mentioned NHS key themes of outcomes for care of the dying and for Waikato there was an opportunity for improvement. The number of deaths within Health Waikato hospitals are increasing⁸ (Waikato Palliative Care Strategy Plan, 2005).

The initial recommendation of the Waikato Palliative Care Strategy Plan 2005 – 2010 (2005) was the establishment of the Waikato Palliative Care Operations Network to lead and facilitate implementation of the Strategy Plans recommendations within allocated resources.

The Strategy Plan recommends:

“2.7 To improve clinical care through the development and implementation of clinical pathways

Strategies:

- (a) End of Life Liverpool pathway is implemented. Initially pilot in one or more of the following settings:
 - Hospice Waikato community inpatient facility
 - Hospice Waikato home based care
 - Waikato Hospital speciality services
 - Resthomes/continuing care organisations
- (b) Employ dedicated resource initially to lead and facilitate development of the clinical pathways. It is recognised that there are numerous barriers to implementation of the Liverpool pathway. Resource is required for ongoing training and continuous improvement.” (p 22)

⁷ Focus on the patient / consumer; planning; total involvement of all healthcare personnel; systems and processes; measurement; continuous improvement

⁸ Death statistics for Health Waikato (data source, decision support) show: 2003 - 619 deaths, 2004 - 628 deaths, 2005 - 658 deaths.

The Strategy Plan also recommends

2.5 To provide specialist palliative care advice and support to palliative care patients in resthomes and continuing care organisation's (p 22)

A palliative care link nurse concept was endorsed by CPHAC in March 2006. The longer-term aim is to introduce the principles and supporting tools of the LCP to relevant resthomes / continuing care organisations.

Anticipated Key Benefits of Implementing the LCP within the Waikato DHB

- Improved care and support for dying patients and family / whānau
- Empowers the clinical team to deliver optimum care of the dying
- Guidance for clinical staff on different aspects of care required including comfort measures, anticipatory prescribing of medicines and discontinuation of inappropriate interventions
- Facilitates multidisciplinary communication
- Supports measurable improvements in the documentation of end of life care
- Supports local DHB policies on care of the dying
- Informs and influences education programmes and the role of the specialist palliative care team
- Informs standard setting and benchmarking of end of life care
- Promotes cost effective healthcare by appropriate prescribing, and when rolled out ultimately aims to avoid crisis interventions in the community and inappropriate hospital admissions
- Utilise expertise and learning of the NHS Liverpool project team, including increased opportunity for collaborative research utilising the Marie-Curie LCP programme research section.

Waikato DHB Progress

The General Manager Health Services (Chair of Waikato Palliative Care Operations Network) on 19th December 2005 endorsed affiliation with NHS national LCP project. Waikato DHB is a registered organisation with the NHS LCP national project. As previously mentioned there is currently no cost associated with this affiliation.

Palliative Care Unit, Waikato Hospital is leading the pilot project of implementing the Liverpool Care Pathway in an acute hospital setting. The Palliative Care Unit, Waikato Hospital has appointed a LCP Project Co-ordinator.

The Waikato Palliative Care Operations Network reviews and monitors progress of the Liverpool Care Pathway pilot in an acute hospital setting, Waikato Hospital on a monthly basis.

The pilot for Waikato Hospital aims to introduce the LCP into two inpatient wards, (one ward that has patients with malignant conditions and one ward with patients with non-malignant conditions). The decision on the non-malignant ward is in discussion with the medical team.

The Waikato Hospital Palliative Care team along with the Te Puna Oranga (Māori Health Unit) and chaplaincy team have been working on the development of the LCP. The UK LCP has been adapted for Waikato Hospital to address the local needs, such as linking with organisational policy and cultural appropriateness.

Introduction to the pilot and education on the LCP has commenced with staff.

The draft Waikato LCP is attached, due to the length of the document a summary of the LCP is outlined. The framework of the LCP document is in three sections:

- Initial assessment and care
- Ongoing care
- Care after death

Section 1 : Initial assessment covers:

- Comfort measures
- Psychological needs
- Religious / spiritual / cultural support
- Communication with family
- Communication with primary care
- Pharmacological recommendations for symptom management + anticipatory prescribing attached

Section 2: Ongoing assessment covers:

- Multi-disciplinary team
- 4 hrly nursing review of physical comfort and symptom control
- 12 hrly nursing review of psychological, spiritual, religious, cultural and social care
- Variances recorded – useful for future discussion and review / audit of care

Section 3: Care after death includes:

- Specific to Health Waikato's procedures and policies.

If all goes according to plan the Palliative Care Unit team proposes to pilot implementation of LCP care of the dying pathway in the nominated wards mid October 2006.

Continuous Quality Improvement

LCP continuous quality improvement activities of the pilot include:

- A pre-implementation retrospective audit of documentation of 20 sets⁹ of clinical notes. This audit is in progress.
- Training and education on the pathway for health professionals has commenced. This needs to be completed two weeks prior the pilot beginning
- The pilot will identify ongoing training needs of staff
- The pilot will facilitate reflective practice
- Pathway format has demonstrable outcomes that will expedite clinical audit and inform future practice
- A post implementation audit of the pathway to evaluate whether the LCP made a difference to the care of dying patient and their family / whānau (benchmarking)
- Contribute to New Zealand specific evidence and research. The first Liverpool Care Pathway New Zealand Newsletter was published in April 2006. The aim of the newsletter is to develop a national network of support and a platform for the sharing of ideas and experiences. Waikato has contributed to this initiative.

Staff Perceptions

As previously mentioned introduction and education on the pathway is in progress. Some nursing staff comments / perceptions obtained to date of using the LCP have been:

“We can become caught up in nursing documentation, but this pathway means that we spend more time with the patient.”

“We were carrying out the best care that we could but with the LCP we have the knowledge behind what we are doing.”

“My communication has improved and I’m not as scared to communicate with families.”

“The LCP is a caring way for the multi-disciplinary team to work on common goals for the interest of the patient/family.”

“I found the pathway excellent and specific to the needs of the dying patient, helpful as a guide to nurses as well.”

Roll out of LCP within Waikato

The Waikato Palliative Care Strategy Plan identifies that implementation of the principles and concept of the LCP is time and resource intensive. The Waikato Palliative Care Operations Network supports a phased approach over the next five years to the implementation of the LCP within allocated resources.

2005-06

⁹ 5 patient records from Ward 25, 5 patient records from Ward 5 / or Ward 23 and 10 patient records from elsewhere in Waikato Hospital.

- Dedicated resource has been invested in PCU with the LCP project co-ordinator.
- Development of a pilot project for implementation of LCP in Waikato Hospital.

2006 - 2008

- Waikato Hospital pilot project continues with evaluation
- Consider roll out to other parts of Waikato Hospital and District Hospitals
- Following the LCP pilot project evaluation consideration will be given to implementation of LCP into resthomes / continuing care organisations.

2008 - 2010

- Hospice Waikato strategic plan aligns with the Waikato Palliative Care Strategy Plan. Hospice has announced that they have purchased a site / facility within Hamilton to bring all services to one site, including Hospice community inpatient beds. The longer-term aim is to staff this facility with hospice nurses using the LCP tools.
- Consider opportunities with community providers and primary care. Other strategy plan recommendations are required to be implemented prior to consideration of implementing LCP in primary care, ie fully established specialist palliative care team to provide support and educational packages for community providers and primary care.

Resources and Cost

The Waikato Palliative Care Strategy Plan recognises that implementation of the LCP is resource intensive and takes time.

As previously mentioned the Palliative Care Unit has a nurse that holds a portfolio for implementation of the LCP. A component of the role of the palliative care link nurse will be to support resthomes in the education of the LCP.

For any clinical pathway being introduced education and training of staff is required.

If any opportunities arise requiring additional investment, the initiative will be considered via the Waikato DHB prioritisation process.

Conclusion

The Waikato Palliative Care Strategy Plan endorsed the implementation of the LCP to improve care of the dying within the Waikato DHB. The LCP is viewed as evidence based best practice. Waikato DHB is taking a long-term phased approach to implementation. International experience has demonstrated that the process of implementation is ongoing, time and resource intensive. Waikato DHB has limited resources and implementation of the LCP is structured to utilise resources that we currently have.