



# PALLIATIVE CARE

*Progress Report 2007  
Action Plan 2007-2008*

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

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May 2007

## **Acknowledgements**

Special acknowledgements 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 individuals' commitment and contribution.

Acknowledgement and thanks to the Waikato District Health Board for recognising the Waikato Palliative Care Operations Network for the Simply the Best summer quality award for its contribution to quality and demonstrated commitment to working collaboratively.

Acknowledgement and thanks to WebHealth who have worked in partnership to develop the palliative care service directory.

A big thank you to Ward 5, 23 and 25 staff who have embraced the End of Life Liverpool Care Pathway (LCP) and lead the pilot. The pilot demonstrated significant improvements to patient care. A special thanks Theresa MacKenzie who has demonstrated strong leadership and commitment to implementing LCP within the Waikato.

Acknowledgement and thanks to the many other people within and external to the DHB that have contributed to the development of palliative care services within the Waikato.

## **Cover Citation:**

Ngā Peehitanga Tāngata o te ao Hurihuri, ngā whakaritenga mo te tika me te ora morimori atawhai.

The trials people face in a challenging world, can be overcome by caring for and loving one another.

Reverend Buddy Te Whare for the support and citation on the cover page.

## Executive Summary

This is the second annual Waikato Palliative Care Operations Network progress report.

The purpose of this report is to summarise:

- The Waikato palliative care progress between 1 July 2006 and 30 June 2007 that aims to enhance service provision to patients with a life limiting illness and their family / whānau
- Outline the Waikato Palliative Care Operations Network 2007-07 action plan.

The Waikato 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 over 2006-07 and work in progress since the endorsement of the Strategy Plan. Components of this section include:

- Development of an integrated palliative care directory of services and providers
- Joint recruitment initiative for a third palliative care physician
- Implement recommendations of the palliative care DSL review project
- Implement recommendations of the palliative care collaborative care review project
- 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 rural hospitals
- Liverpool Care Pathway pilot project and evaluation
- Training and development programmes for the specialist palliative care nurses and general practice within the Waikato
- Waikato DHB 2006-07 target palliative care funding initiatives
- Audit
- Donny Trust Fellowship
- Link with Midland Cancer Network and proposed regional initiatives
- National developments including continuing to actively participate in the development of the national palliative care definitions and service specifications.

The 2007-08 action plan builds on progress to date and details the Waikato Palliative Care Operations Network key focus areas for 2007-08.

Key focus areas include:

- Recruitment of the third palliative care physician and development of a 24 hour / 7 day consultancy service and appointment of clinical leadership
- Continue with implementation roll out of the End of Life Liverpool Care Pathway
- To promote and develop the Donny Fellow position
- To promote and support primary education and support (explore links and developments with the HealthRight Chronic Care Management Framework)
- To continue to promote and develop the link nurse concept with resthomes / continuing care organisations
- To scope and develop requirements for Waikato Hospice community inpatient service, including service framework, workforce requirements, quality processes and systems and funding implications
- Pilot a 24 hour / 7 day integrated specialist palliative care nurse on-call service with PCU and Hospice Waikato
- To project manage implementation of the Collaborative Care review quality recommendations
- To promote implementation of the palliative care DSL review recommendations
- To project manage development of a rural hospital / community palliative care role delineation model, complete stock take and review
- To promote palliative care by working in partnership with Maori Health providers to complete a stocktake identifying education and support requirements
- To establish a Midland region palliative care service specific group under the umbrella of the Midland Cancer Network
- To actively participate and support Lakes DHB request for proposal to develop specialist palliative care outreach services in the Lakes DHB
- To actively participate and support national initiatives.

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## Part One – Introduction

This is the second annual Waikato Palliative Care Operations Network progress report.

The Waikato Palliative Care Strategy Plan (Hewitt J, 2005) was developed to provide strategic direction for an integrated and co-ordinated palliative care service for the Waikato district. The plan guides service delivery and development until 2010. This builds on the 2006 Progress Report (Hewitt J, 2006) and highlights 2007 advancements and outlines the action plan for 2007-08.

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 (Ministry of Health, 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 essential<sup>1</sup> 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 four years. The supporting objectives are:

### **Integrated and Collaborative Care**

- 1.1 To establish the Waikato 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 partnerships with general practice
- 2.5 To provide specialist palliative care advice and support to palliative care patients in resthomes and continuing care organisations

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<sup>1</sup> Essential services include: assessment, care co-ordination, clinical care and support care.

- 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 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 initiative to improve the quality of 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 - 2007**

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

- An overview of the Network and new targeted funding investment into palliative care;
- An update of key focus areas from the 2006-07 Action Plan and;
- Overview of national developments.

### ***Waikato Palliative Care Operations Network***

The Waikato Palliative Care Operations Network (Operations Network) was established in November 2005 and has proven to be an effective mechanism for advancing the Palliative Care Strategy. There has been some changes to the membership of the group over the last twelve months (refer to appendix 1 terms of reference) these include:

- Chair is now the Manager, Midland Cancer Network
- Palliative Care Specialist
- PHO representative – CEO Hauraki PHO with interest in Maori, rural and primary care.

The Operations Network won the Waikato DHB ‘Simply the Best Summer Award’ for demonstrating collaboration and quality improvements.

The 2006-07 action plan focus areas were:

- Development of an integrated palliative care directory of services and providers
- Recruitment of a third palliative care physician and development of 24 hour / 7 day consultancy service, outreach service in Te Kuiti and appointment of clinical leadership
- Implement recommendations of the palliative care Disability Support Link (DSL) review project within allocated resources
- Implement recommendations of the palliative care 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 rural hospitals
- Scope implications of a single point of entry for specialist palliative care services
- 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.



The following provides more detail on progress made on key concepts over 2006-07.

### **2006-07 Target Funding**

In December 2006 the Minister of Health<sup>2</sup> announced \$4 million nationally allocated of palliative care in an effort to address cost pressures (including wage cost pressures due to increased rates of pay for Hospice nurses) for hospices in the first instance, and secondly to further develop the full range of palliative care services, which may include hospital palliative care services.

Waikato DHB was allocated \$338,402 and was incorporated into baselines in February 2007. This funding was fully allocated to Waikato Community Hospice Trust.

Waikato DHB also allocated the following unsustainable cancer control target funding<sup>3</sup> to the following palliative care initiatives:

- Nurse resource for three months to assist with the LCP development. PCU is the lead for this initiative \$22,500, April – 30 June 2007
- Palliative care essential community support programme, including provision of equipment for low socio-economic communities (Huntly, Ngaruawahia, Whitianga, Tairua and Coromandel town). Waikato Community Hospice is the lead for this one off initiative; investment is \$100,000 to be implemented between April – 30 June 2007.
- In addition funding was allocated to develop an integrated psycho-oncology model of care framework and business case which includes services to address palliative care needs.

### **Waikato Palliative Care Service Directory Initiative**

The Waikato Palliative Care Operations Network worked jointly with WebHealth to develop and implement a palliative care directory of providers and services. This went live in May 2007 and will continue to be reviewed and updated. The public and health organisations can access the web based information.

### **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 services
- 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

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<sup>2</sup> 20 December 2006. Media Statement Additional funding for palliative care & 21 January 2007 Ministry of Health letter to DHB CEOs and email from Ministry of Health dated 29<sup>th</sup> March 2007.

<sup>3</sup> Waikato DHB Executive Group endorsement March 2007.

- h) as required increase support to district hospitals and communities in terms of outreach clinics
- i) development of the palliative care approach with other specialties and district hospitals.

The majority of the above strategies cannot be implemented until achievement of recruitment of the third physician. The Progress Report – 2006 highlighted that a funding stream had been identified and recruitment had commenced. Unfortunately Waikato has not been able to attract a new physician to fill the vacancy. There is a national and international shortage of palliative care physicians. Both services have reviewed and changed the emphasis of the advert and in the process of advertising. Currently there are six palliative care physician vacancies within New Zealand.

The current palliative care physicians participated in the change management process of developing this service, which has now been completed.

In the interim, PCU has managed to utilise funds to employ a locum palliative care specialist (Dr Kirk effective 1<sup>st</sup> November 2007) for three months and an additional registrar for three months (June – August 2007).

### **End of Life Pathway Pilot Project**

The Strategy Plan recommendation:

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

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

The LCP is seen as a key component and best practice concept in improving delivery of end of life care to patients and family / whānau. For further detailed information please refer to the Waikato Palliative Care Progress Report 2006 appendices.

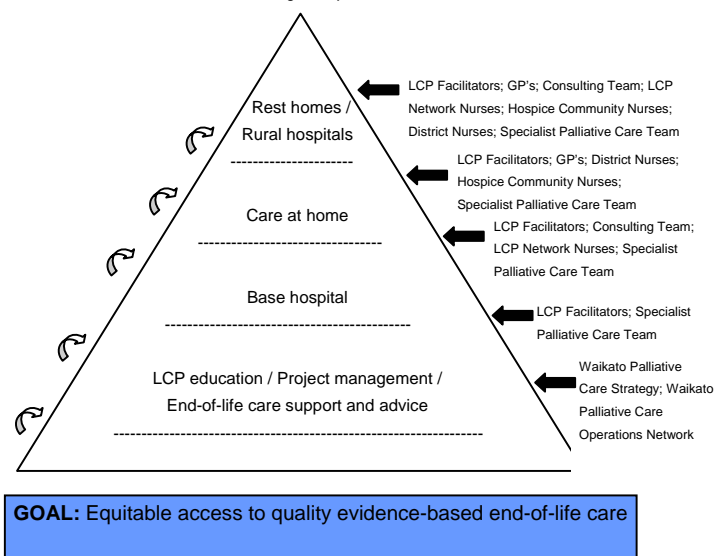
Waikato has embraced the concept of the LCP and is registered with the LCP project, Royal Liverpool Hospital, UK (lead centre). The Palliative Care Unit (PCU) led the LCP pilot in an acute setting, Waikato Hospital. PCU recruited a part time LCP nursing resource. A locally adapted care pathway was lodged with the lead centre in July 2006. The pre implementation audit was completed in July 2006. The General Medical consultant group agreed to pilot the LCP in general medicine, Waikato Hospital.

The pilot was launched 10 October 2006 in three wards – two general medical (ward 5 & 23) and one combined oncology / haematology / palliative care ward (ward 25). LCP network nurse groups were established (July – September 2006) supported with intensive staff education sessions (August – October 2006). The LCP network groups will ensure future sustainability of the LCP in each ward. House surgeons receive LCP training during their orientation programme and registrars suggested LCP training be delivered at their journal club. In addition LCP presentations were made at the Grand Round.

The pilot demonstrated in the pre and post implementation audit (appendix 2) significant improvements in the use of the pathway. The Waikato pathway does consider cultural needs (6b) and an ethnicity data audit was completed (appendix 2).

The LCP nurse following attendance at the 4<sup>th</sup> Annual LCP conference including a LCP International Collaborators Day (November 2006) developed a LCP implementation plan model for the Waikato. In particular this model addresses the need to take the LCP into the primary and community setting. Findings suggest it is more beneficial to implement the LCP with general practice prior to resthomes. General Practices in collaboration with Hospice will be better positioned to support resthome staff in the delivery of evidence based end of life care. The Waikato Palliative Care Operations Network have endorsed this model and this forms the way forward for implementation across the district and is incorporated into the 2007-08 action plan section.

Waikato End of Life Pathway Implementation Plan 2006-2010



The implementation plan has commenced, the agreed plan that will carry on into 2007-08 includes implementation of LCP in the following areas:

- Ward 2 & 12 (surgical)
- Ward 22 (respiratory)
- Scope and develop for community hospice home care with GP involvement
- Resthomes – Eventhorpe as part of Waikato Hospice community inpatient service
- Thames Hospital pilot area – hospital followed by community
- Scope and develop plans and processes to implement LCP into primary in Thames.

### Palliative Care Link Nurse Programme

One of the main issues identified in the Strategy Plan is fragmentation of services with and between providers resulting in variations 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 are 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, primary health 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 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. Relationships have been developing to introduce the specialist nurse as a resource. This nursing position has been able to offer advice and support, from this will the relationships which will facilitate the introduction of LCP once the General Practitioners have embraced LCP into the community. By taking this approach there will be a group of GP and Hospice staff who will have the ability to support the pathway within individual resthomes / continuing care facilities. The time developing these relationships will give the specialist nurse a strong base to launch the pathway and will assist in identifying key personnel who will be the link people within the facility.

## **DSL Project Recommendations**

In November 2005, the Waikato DHB Board endorsed one-off funding for the formal review of the current Disability Support Link (DSL) palliative care support service. In February 2006 the Operations Network led 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

The DSL Review Report (Fitness J. Hewitt J., 2006) provides an overview of the project findings and recommendations for improvement initiatives. The project recommended that DSL remain the lead provider that manages and administers the palliative care support services contract for the Waikato DHB. The report also recommended improvements to the current systems and processes to 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.

The Waikato DHB Planning and Funding and DSL have not been able to reach a solution regarding the recommendation of supporting the administration component of service co-ordination. Due to not advancing the recommendation for service co-ordination, no development has been made on any of the remaining quality system and process recommendations.

### **Collaborative Care Project Recommendations**

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 led 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.

A number of recommendations were made to be phased over 2006-2010 within current existing resource with the exception of the establishment of a 24hr/7day integrated specialist palliative care nursing on call service. If the pilot recommends continuation then associated cost for this service would need to be prioritised through the DHB process.

The Network providers have not been able to make progress with implementing the recommendations, therefore options to address have been considered in the 2007-08 Action Plan with resourcing to support implementation.

## **Rural Hospitals Review**

The Waikato Palliative Care Strategy Plan recommendation;

2.3 Waikato rural communities to have improved access to palliative care services included the strategy (2.3b) to review and evaluate the current rural hospitals and make recommendations for the future in relation to palliative care. This aspect of work has strong links with the collaborative care review.

In March 2007 a rural hospital manager's workshop was held to agree a way forward and these recommendations from the workshop are included in the 2007-08 action plan section. The key recommendation was to commission a project to develop a role delineation model for the rural hospitals / community, stocktake of services and providers and identify future needs.

## **Hospice Waikato**

Hospice Waikato completed purchase of a motel / conference centre, based in Hamilton in 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

In addition to purchasing the facilities Hospice Waikato has launched a capital fund raising programme<sup>4</sup> to upgrade the administration service facilities and new build for the inpatient facility. Planning requirements have commenced.

This development has meant that the Waikato Palliative Care Operations Network has had to reprioritise the recommendations (appendix 3) and this is further discussed in the 2007-08 Action Plan section.

As of 1<sup>st</sup> July 2006, Hospice Waikato commenced an extension of services which were already available in Thames, Waihi and Paeroa to include Coromandel town, Whitianga, Whangamata and Tairua. A Hospice nurse who lives on the Coromandel was appointed to work collaboratively with the District Nurses and other providers of palliative care to

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<sup>4</sup> Target \$7million

provide holistic support to patients and their families / whanau. The nurse works closely with Rainbow Place, Hospice services for children.

## **Supporting General Practice**

A key recommendation of the Strategy Plan is:

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

The Palliative Care physicians have actively supported this recommendation through providing support and educational opportunities for general practice. Following consultation with the Waikato primary health organisations the aims are;

1. To develop an optimal relationship with individual general practitioners. This relationship is between the specialist providers and primary providers. It was important to identify PCU medical physicians as a resource for general practice (clinical guidelines accessible on the web, telephone access for quick opinions, referral for consultation of patients with difficult problems and more rarely for complex admissions under palliative care, Waikato Hospital). Supportive service to general practice is a key recommendation.
2. To respond to general practitioner request for information and independent review regarding the use of new analgesics<sup>5</sup>.

These aims were met through a series of twelve medical presentations across the Waikato district. Waikato Primary Health supported general practice to attend these presentations. Attendance was outstanding in terms of numbers. The inclusion of district nurses and pharmacists at these meetings added to building the knowledge base and the strengthening of team work in local areas.

Outreach clinics in the south Waikato area included lunch time education component to which general practitioners were invited and is an ongoing forum for discussion.

## **PCU Discharge Audit**

As a quality initiative, PCU has completed a discharge planning audit cycle. Discharge planning was identified as area of concern, as a result of phone calls to PCU following discharges from Waikato Hospital. Although these discharges were from across the hospital it was agreed to work to implement a solution within the base ward (Ward 25) and if successful, to consider whether it could be applied across a wider setting. The aim is to audit the documentation and transfer of information between inpatient and community staff, to determine effectiveness of current discharge planning processes. The method used was a retrospective audit of patients notes of discharged under palliative care from ward 25. PCU with ward 25 developed a palliative care discharge checklist to assist with the audit.

The audit process involved PCU, ward 25 staff, allied health, Hospice Waikato and district nursing services. The first audit demonstrated what is or not documented, and was inclusive to as what was actually carried out.

Subsequently in September 2006 a meeting was held between above agencies;

- Brain storming, agreement to do audit of notes for discharge documentation

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<sup>5</sup> Note: these drugs were being heavily marketed

- Audit completed utilising staff from areas being audited; results demonstrated that there was very little record of planning. Feedback to ward staff
- Further meeting where it was decided to develop discharge check list, the trial form was distributed to ward and community for feedback
- Education session in ward prior to putting form out as pilot.

This quality improvement initiative is ongoing. There are a group of staff in the ward supporting this initiative; they have surveyed colleagues and find wide spread support for the checklist. The implementation is taking longer than planned, however a re-audit will occur within the next three months to review progress.

### **Eventhorpe Audit**

An audit was undertaken by PCU in September 2006 to identify the level of, and improve the medical management of, specialist palliative care patients at Eventhorpe hospital. The audit report was tabled and accepted by the Waikato Palliative Care Operations Network and noted some possible gaps / concerns with service.

There were four key recommendations;

1. Discuss findings at the Waikato Palliative Care Operations Network
2. Discuss findings at GP Peer Support Groups
3. Re-audit
4. Involve Hospice Waikato and Eventhorpe hospital in any future audit.

It was also noted that this audit linked with the development of Hospice Waikato's community inpatient facility and noted there are three stages;

1. Now and until employment of third physician
2. Following employment of third physician
3. Third physician and commissioning of Hospice Waikato community inpatient facility.

It was endorsed by the Waikato Palliative Care Operations Network that a sub group be formed to identify the pathway and processes for optimising the utilisation of Eventhorpe Hospice community inpatient respite/symptom beds for each of the above three stages.

### **Palliative Care Unit Processes and Associated Funding**

PCU completed a review of its processes to identify outputs considered to have no attached revenue stream. Refer to appendix 4 for PCU inpatient / outpatient referral processes, education / phone consults processes.

The Operational Policy Framework requires funders to use national purchase unit codes from the national service framework where an appropriate purchase unit exists. In regards to PUC this approach has been adopted.

Development of national service specifications and funding model should address most of the issues raised in the future.



### **Donny Trust Fellowship**

The Clinical Director has led the process to work with key stakeholders to develop a more attractive package for an advanced GP trainee. The School of Medicine has been involved to develop programme of research projects for this trainee. The Royal New Zealand College of General Practitioners has approved this position as part of accreditation.

### **Psycho-Oncology Service**

Waikato DHB utilising unsustainable cancer control target funding has supported the Psychology Centre to lead the development of a Psycho-Oncology model of care and service framework for the Waikato district. This initiative includes the palliative care continuum. The project report is due July / August 2007.

### **Midland Cancer Network**

The Midland Cancer Network was endorsed and established in 2006 with supporting management infrastructure. As part of the work programme Lakes DHB, utilising the Service Planning and New Health Intervention Assessment (SPINA framework for collaborative decision making) tabled a proposal for change to develop a specialist palliative care outreach service in Lakes DHB utilising Waikato specialist palliative care services. This initiative is linked to the national specialist palliative care service specifications (draft). Lakes DHB will be the lead with support from the Midland Cancer Network to developing the business case to support development of this initiative.

In addition Bay of Plenty DHB completed an evaluation and review of their Palliative Care Strategy Plan. The BOP team visited (March, 2007) Waikato as part of the evaluation phase.

The Waikato Palliative Care Operations Network recommends a regional service group be established to look at regional palliative care initiatives, this is further discussed in the 2007-08 Action Plan section.

### **Adolescent / Young Adult Oncology / Haematology Service**

The Ministry of Health has developed draft Adolescent / Young Adult Oncology / Haematology Service Specifications (tier 2). The aim of the service specifications is to optimise care directed to the specific needs of adolescent and young adult (AYA) patients by partnering the paediatric and adult oncology / haematology tertiary services.

In addition the service specifications recommends care co-ordination and AYA advisory group be established, this will be under the umbrella of the Midland Cancer Network.

Waikato DHB has new funding (May 2007) to support the implementation of a regional AYA care coordinator.

This service includes the palliative care continuum.

## **National Work Programme**

The Ministry of Health Cancer Control work programme includes palliative care, and the following is a summary of work in progress or about to commence.

### **National Palliative Care Definitions**

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

### **National Specialist Palliative Care Service Specification**

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. The first draft service specifications have completed a consultation round and it is anticipated that the final draft specifications will be released for review early in 2007-08.

### **Improving Access to Specialist Education for Nurses**

A specialist cancer / palliative care nursing education work group has been formed. A Request for Proposal is due to go out from the Ministry of Health for a cancer / palliative care nursing education stocktake. Palliative Care Nurses NZ inaugural conference is in November 2007 to support palliative care nurses and assist with education.

### **Establish a National Approach to Palliative Care Medical Training**

An analysis of current workforce levels and requirements is in progress with a planned national approach to palliative care medical training draft completed and national approach to be agreed with CTA.

### **Addressing Community Palliative Medicine Supply Limitations**

A paper has been prepared and presented to the national Palliative Care Working Group. PCU members attended a meeting in Wellington 12-13<sup>th</sup> May to agree a national way forward; this will be released in the near future.

## **Part Three – Action Plan 2007-2008**

This section takes a planned and phased approach towards achieving the Waikato Palliative Care Strategy Plan goal and recommendations (refer to appendix 3 - prioritisation of recommendations).

The Waikato Palliative Care Operations Network 2007-08 Action Plan builds on progress made over the last eighteen months.

Key focus areas for 2007-08 are:

- Recruitment of the third palliative care physician and development of a 24 hour / 7 day consultancy service and appointment of clinical leadership
- Continue with implementation roll out of the End of Life Liverpool Care Pathway
- To promote and develop the Donny Trust Fellow position
- To promote and support primary education and support (explore links and developments with the HealthRight Chronic Care Management Framework)
- To continue to promote and develop the link nurse concept with resthomes / continuing care organisations
- To scope and develop requirements for Waikato Hospice community inpatient service, including service framework, workforce requirements, quality processes and systems and funding implications
- Pilot a 24 hour / 7 day integrated specialist palliative care nurse on-call service with PCU and Hospice Waikato (refer Collaborative Care Review)
- To project manage implementation of the Collaborative Care review quality recommendations
- To promote implementation of the DSL recommendations
- To project manage development of a rural hospital / community palliative care role delineation model, complete stock take and review
- To promote palliative care by working in partnership with Maori health providers to complete a stocktake identifying education and support requirements
- To establish a Midland region palliative care service specific group under the umbrella of the Midland Cancer Network
- To actively participate and support Lakes DHB request for proposal to develop specialist palliative care outreach services in the Lakes DHB
- To actively participate and support national initiatives.

Key Results Areas	Medium to Long Term Objective	Annual Objective 2007/2008	2007/2008 Performance Measures
<b>Integrated and Collaborative Service</b>	1.1 Palliative Care Network	<ul style="list-style-type: none"> <li>a) Establish under the MCN a Midland regional Palliative Care service specific group</li> <li>b) Actively participate and support Lakes DHB to develop specialist palliative care outreach service business case</li> </ul>	<p>MCN palliative care service groups established by 30-6-07</p> <p>Waikato implications for service are understood by 30-7-08</p>
	1.2 To promote the palliative care approach and inform the public and providers	<ul style="list-style-type: none"> <li>a) Promote and continue to keep directory updated</li> </ul>	<p>Raise awareness of directory through community health forums and Outreach by 30 June 2008</p>
	1.4 To ensure there is palliative care clinical leadership	<ul style="list-style-type: none"> <li>a) Appointment of third physician appoint a Clinical Director</li> <li>b) Development of medical staff education and training plan</li> </ul>	<p>Third physician appointed asap</p>
<b>Patient Focus on Improved Access and Equity of Services</b>	2.1 To provide access to culturally appropriate palliative care services (links to 3.1)	<ul style="list-style-type: none"> <li>a) To promote palliative care by working in partnership with Maori Health providers to complete a stocktake identifying education and support requirements</li> </ul>	<p>Stocktake completed and action plan developed by 30 June 2008</p>

Key Results Areas	Medium to Long Term Objective	Annual Objective 2007/2008	2007/2008 Performance Measures
Patient Focus on Improved Access and Equity of Services continued	2.3 Waikato rural communities to have improved access to palliative care services	a) Project to implement recommendations from collaborative care project review within allocated resources	Project completed and implementation plan of recommendations developed by 30 June 2008 (within allocated resources)
	(1.3) To establish formal links between the various service levels and providers a) To develop a role delineation model that describes the various levels of service, delineates expected resources & capability of generalist and specialist services (links to 2.4 f)	b) Project to develop a palliative care role delineation model and framework for the rural hospitals / community c) Complete stocktake of services/ providers d) Identify areas for improvement and plan	Project completed and implementation plan of recommendations developed by 30 June 2008 (within allocated resources)
	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 (b) PCU engage in discussions with Waikato Post Graduate Medical Programme to provide palliative care continuing education (c) Incorporate clinical pathways (2.7) into chronic care management framework	4 Primary CME sessions by 30 June 2008  PCU participate in Post Graduate Medical Programme during 2007-08

<b>Key Results Areas</b>	<b>Medium to Long Term Objective</b>	<b>Annual Objective 2007/2008</b>	<b>2007/2008 Performance Measures</b>
<b>Patient Focus on Improved Access and Equity of Services continued</b>	2.5 To provide specialist palliative care advice and support to palliative care patients in resthomes and continuing care	(a) 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 2008
	2.7 To improve clinical care through the development and implementation of clinical pathways - Liverpool Care of the Dying Pathway Implementation Plan (links with 2.4 and 2.5 concepts)	(a) Implement Wards 2,12,22 (b) Scope and develop implementation plan for community Hospice Waikato homecare area, with involvement of GPs (c) Eventhorpe – Hospice Waikato rollout (d) Thames Hospital	Implementation roll out plan achieved by 30 June 2008
<b>Workforce and Resource Development</b>	3.1 To ensure all palliative care service providers practice within the palliative care approach	(a) Educate Māori health providers in the palliative care approach to build capacity and capability (links to 2.1)	Maori health providers education on palliative care approach completed by 30 June 2008
	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 <sup>rd</sup> physician	Appointment of joint Clinical Director asap (dependant on recruitment of 3 <sup>rd</sup> physician) Medical on call service implemented

<b>Key Results Areas</b>	<b>Medium to Long Term Objective</b>	<b>Annual Objective 2007/2008</b>	<b>2007/2008 Performance Measures</b>
<b>Workforce and Resource Development continued</b>	Donny Fellow	(a) Continued development and promotion of the Donny Fellow programme	Donny Fellow position filled asap
	Nursing	(a) Project manage development of a framework, pilot an integrated 24/7 specialist palliative care nursing on-call service with PCU and Hospice Waikato	Project and pilot completed by 30 June 2008 Review and written report with recommendations presented to Operations Network by 30 June 2008
		(b) 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 2008
	Allied Health	(a) Palliative Care Operations Network participate in development of Waikato DHB psycho-oncology service	Psycho-Oncology business case incorporates the requirements of palliative care within model of care and framework
	3.3 To ensure there are adequate Hospice community inpatient beds for respite and symptom control (Hospice Waikato lead for project management of the process)	(a) To scope and develop requirements for Waikato Hospice community inpatient service, including service framework, workforce requirements, quality processes and systems and funding implications	Hospice community inpatient service model of care, service delivery framework and implementation / change management plan is developed by 30 June 2008

Key Results Areas	Medium to Long Term Objective	Annual Objective 2007/2008	2007/2008 Performance Measures
<b>Quality Systems</b>	4.1 To foster a culture of continuous quality improvement that enhances best practice and improves quality of care and services provided	a) Continue with PCU / Ward 25 discharge audit b) Within allocated resources complete Eventhorpe audit	Improved discharge planning and communication demonstrated Eventhorpe audit completed within allocated resources by 30 June 2008
	4.2 (& 1.3b) To develop and implement a transition pathway and process between child and youth services to adult services	a) Child services identify a timeframe to develop the transition pathway and process b) Link in with Adolescent / Young Adult Oncology service development under umbrella of the MCN	Child Services identify timeframe by 30 June 2008
	4.5 Waikato DHB should review the DSL palliative care administration function for night relief and respite care to resthomes / continuing care	a) DSL and Planning and Funding implement recommendations of DSL review	DSL recommendations implemented by 30 June 2008
	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 (b) Actively participate in any other national initiatives (c) Regular feedback to network following national meetings	Participate in development of national service specifications



## **References**

- Fitness J. Hewitt J. (2006). *Waikato DHB Palliative Care Disability Support Link Review*. Hamilton: Waikato District Health Board.
- Hewitt J. (2005). *Waikato DHB Palliative Care Strategy Plan 2005 - 2010*. Hamilton: Waikato District Health Board.
- Hewitt J. (2006). *Waikato Palliative Care Progress Report 2006 & Action Plan 2006-07*. Hamilton: Waikato District Health Board.
- Ministry of Health. (2001). *The New Zealand Palliative Care Strategy*. Wellington: Ministry of Health.

## Appendix 1: Waikato Palliative Care Operations Network Terms of Reference



### Terms of Reference for the Waikato Palliative Care Operations Network

#### 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 –Manager Midland Cancer Network	Jan Hewitt
Clinical Director, Regional Cancer Centre	Dr Jeremy Long
Chief Executive Officer, 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
CEO Hauraki PHO	Hugh Kininmonth
Paediatrician	Dr Dave Newman
Māori Health Representatives	Maata McManus

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 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 Hewitt, Manager, Midland Cancer Network  
**Administration:** as above

### **Meeting Schedule**

**Frequency:** 4<sup>th</sup> Tuesday of the month 11 – 12md  
**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.
- Annual progress report 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 – EOL LCP Pilot Project Post Audit Report**

# Health Waikato Hospital

**BASE  
FEEDBACK**

**REVIEW**

**May – July 2006**

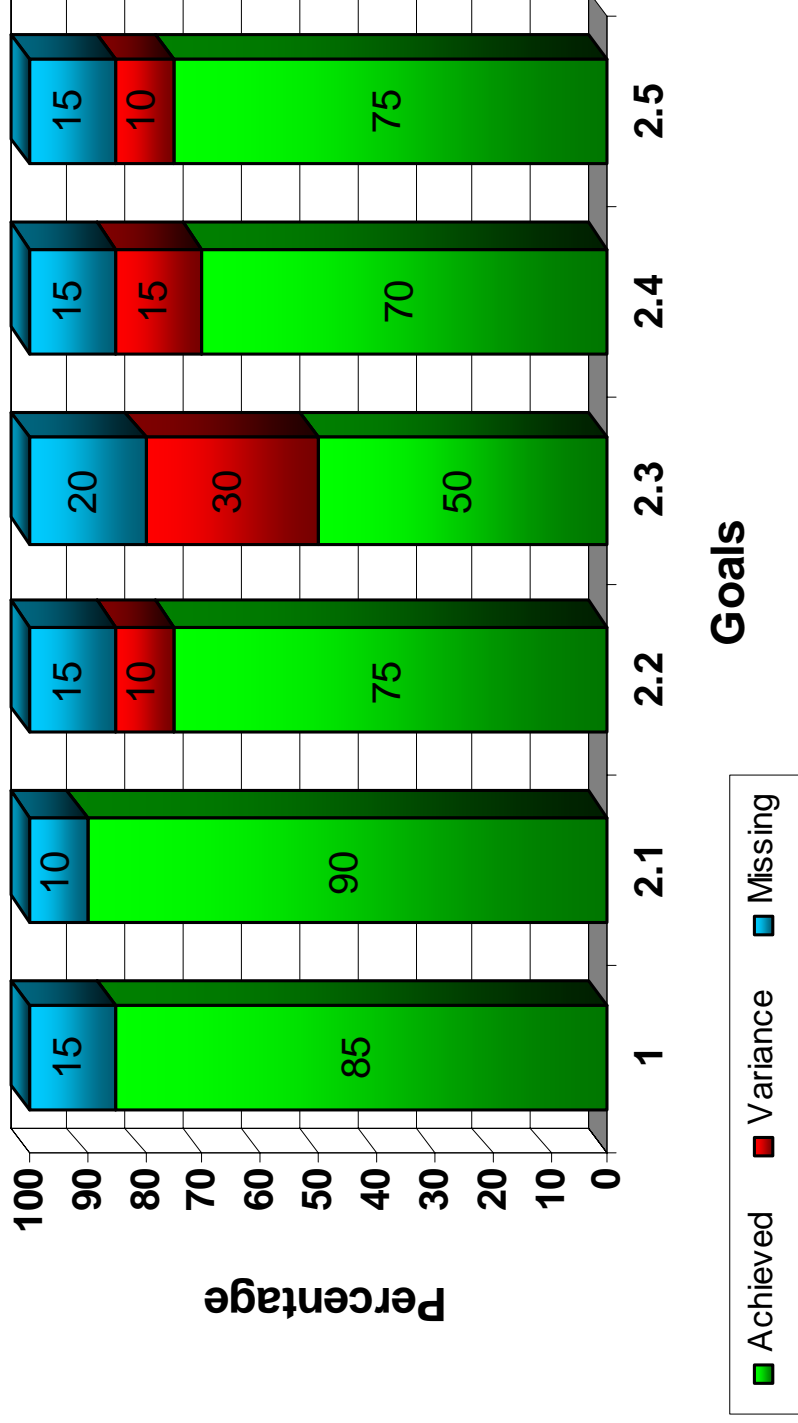
**POST PATHWAY FEEDBACK**

**October – December 2006**

# Comfort Measures

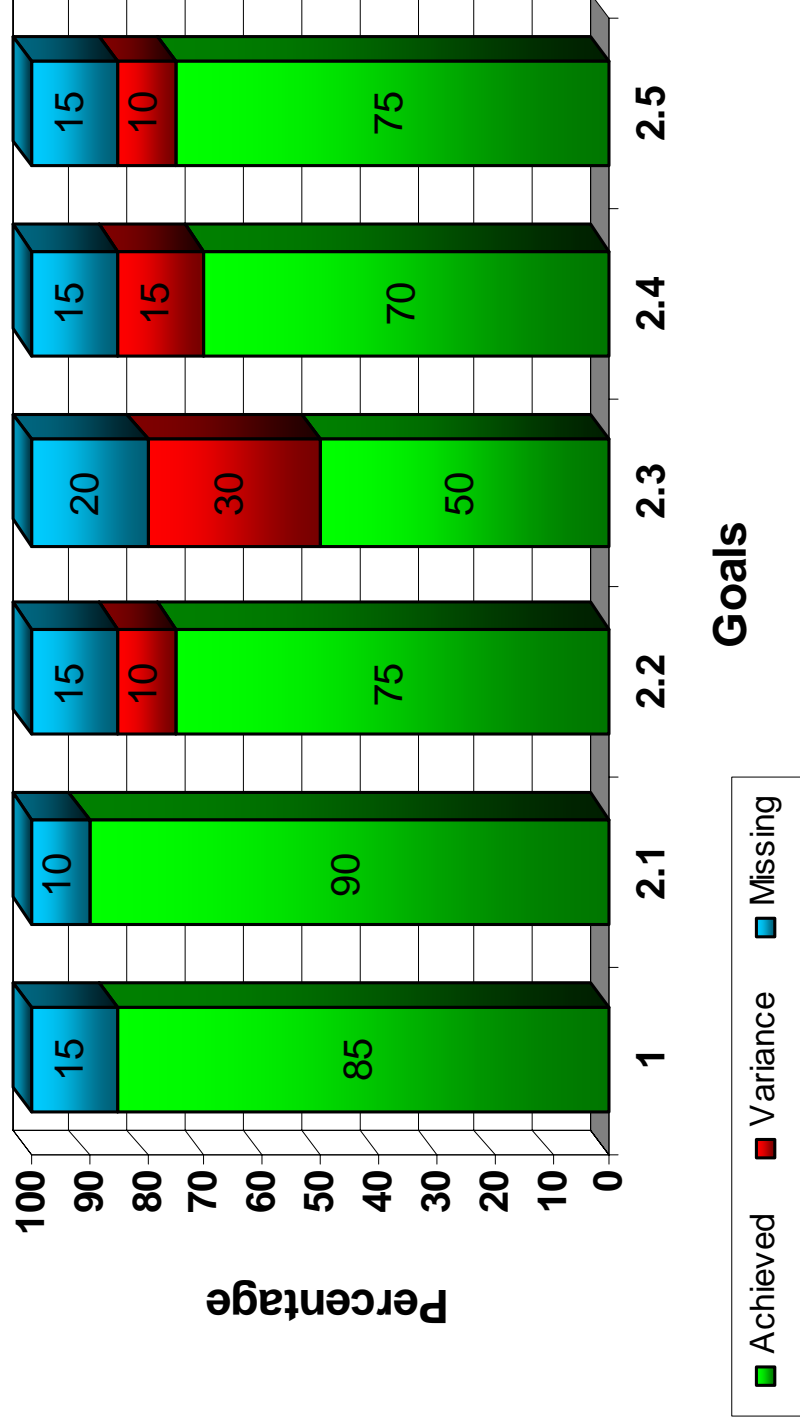
- Goal 1*      Current medication assessed and non-essentials discontinued
- Goal 2*      As required subcutaneous drugs written up according to protocol
- 2.1      Pain
  - 2.2      Agitation
  - 2.3      Respiratory tract secretions
  - 2.4      Nausea and vomiting
  - 2.5      Dyspnoea

## Post: Comfort Measures (n=20)





## Post: Comfort Measures (n=20)



# Comfort Measures

*Goal 3* Discontinue inappropriate interventions

3.1 Blood tests

3.2 Antibiotics

3.3 IV fluids or drugs

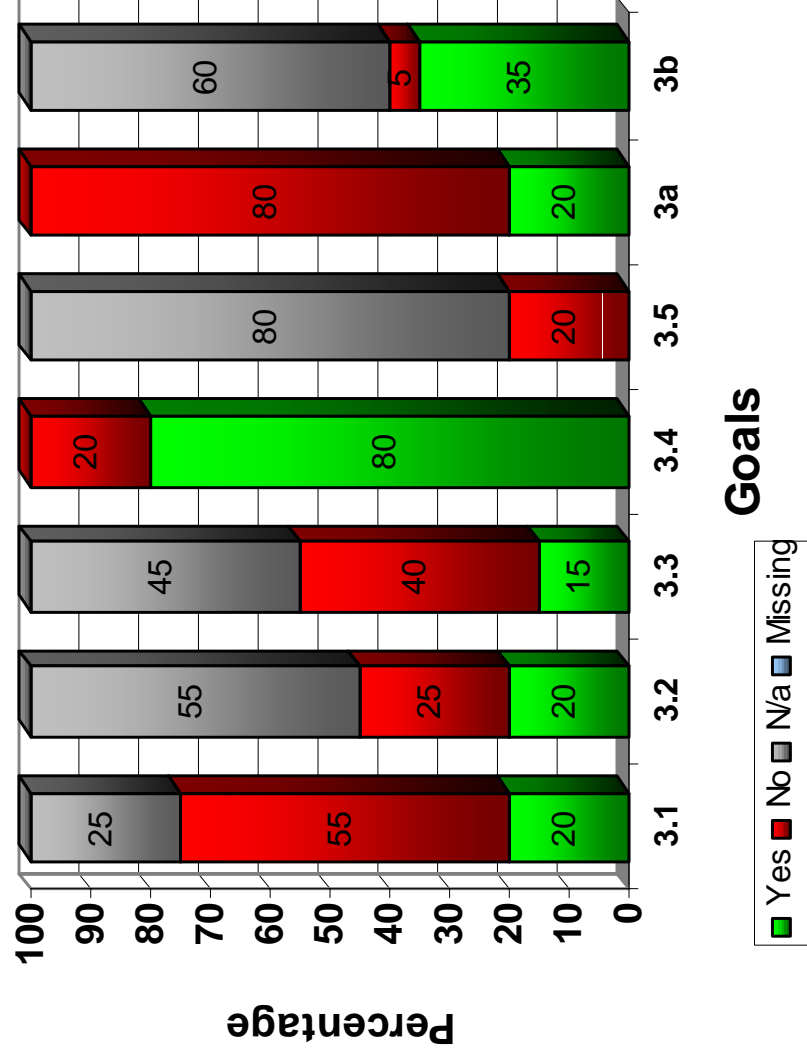
3.4 Not for CPR

3.5 Deactivate Cardiac Defibrillators

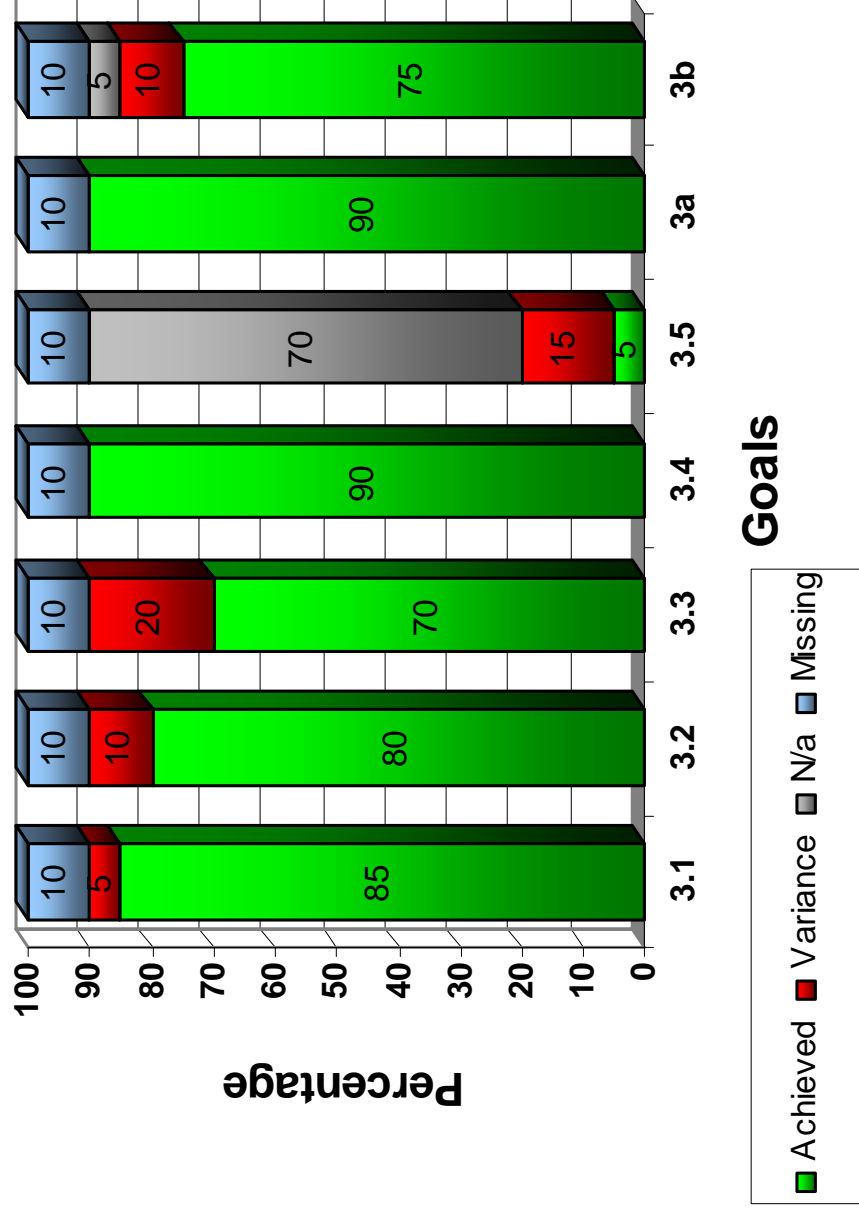
*Goal 3a* Discontinue inappropriate nursing interventions

*Goal 3b* Syringe Driver set up within 4 hours

## Pre: Comfort Measures (n=20)



## Post: Comfort Measures (n=20)



# Psychological / Insight & Religious/Spiritual

*Goal 4* Ability to communicate in English assessed  
as adequate:

- 4.1 Patient
- 4.2 Family/Other

*Goal 5* *Insight into condition assessed:*

Aware of Diagnosis

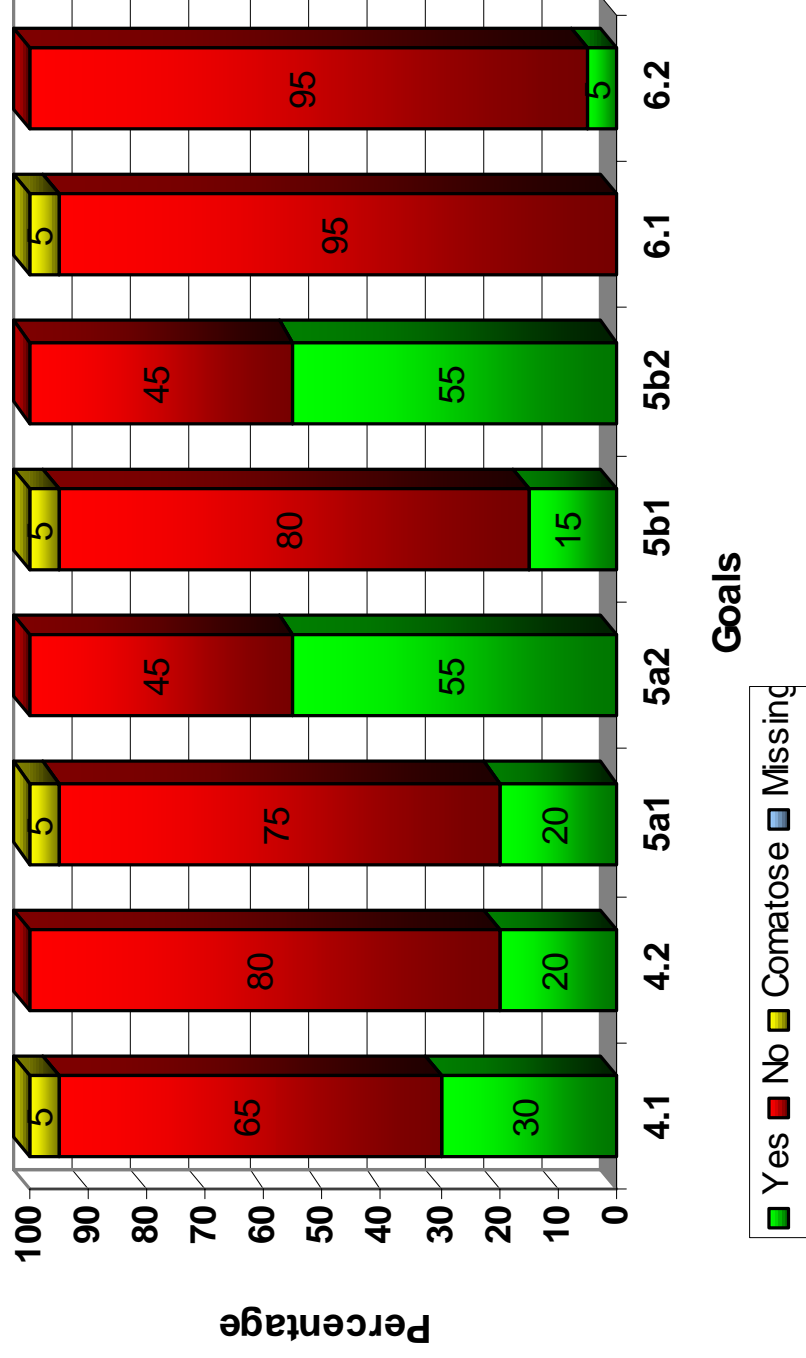
- 5a1 Patient
- 5a2 Family/other

Recognition of Dying

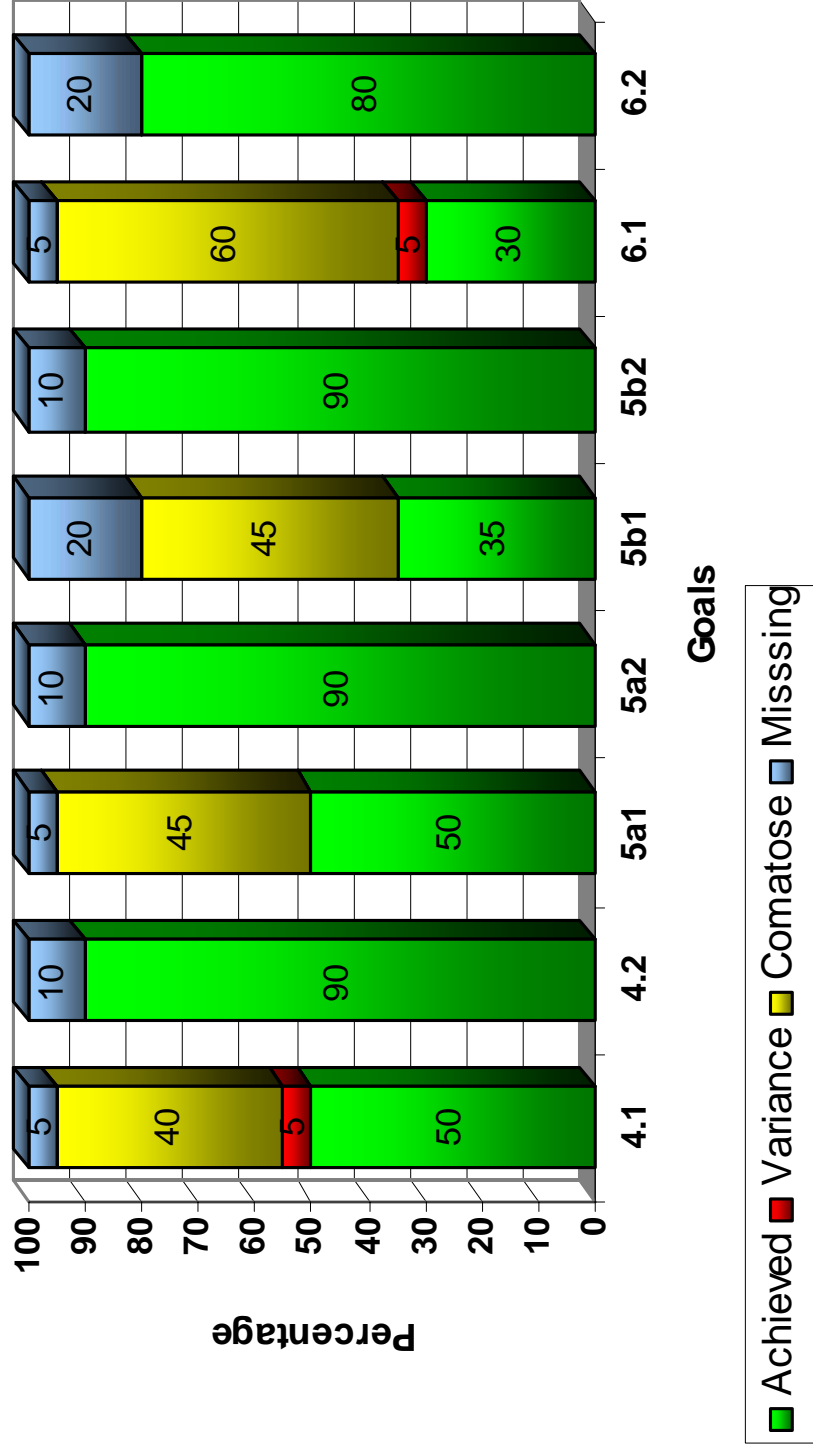
# Psychological / Insight & Religious/Spiritual

*Goal/ 6* Religious / spiritual needs assessed  
with:  
6.1 Patient  
6.2 Family/other

## Pre: Psychological/Insight Issues Religious Needs (n=20)



# Post: Psychological/Insight & Religious needs (n=20)

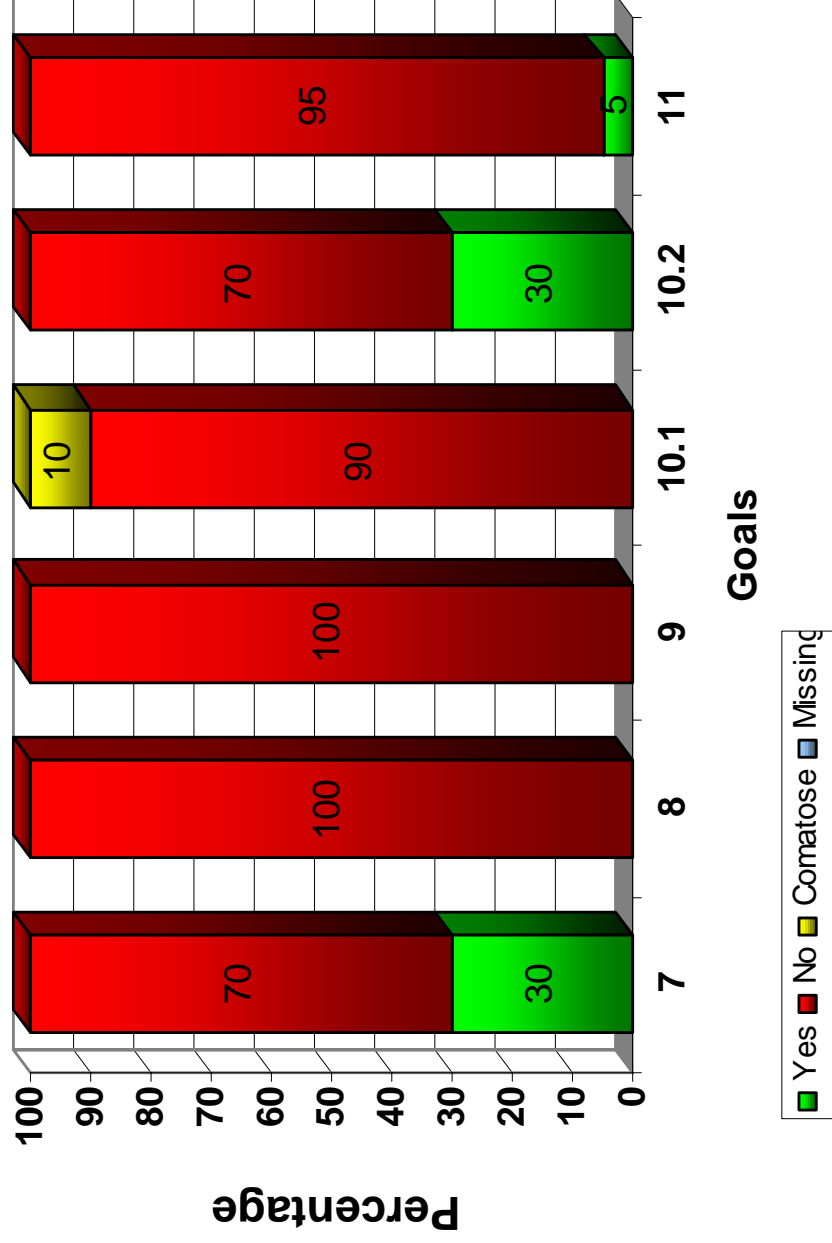




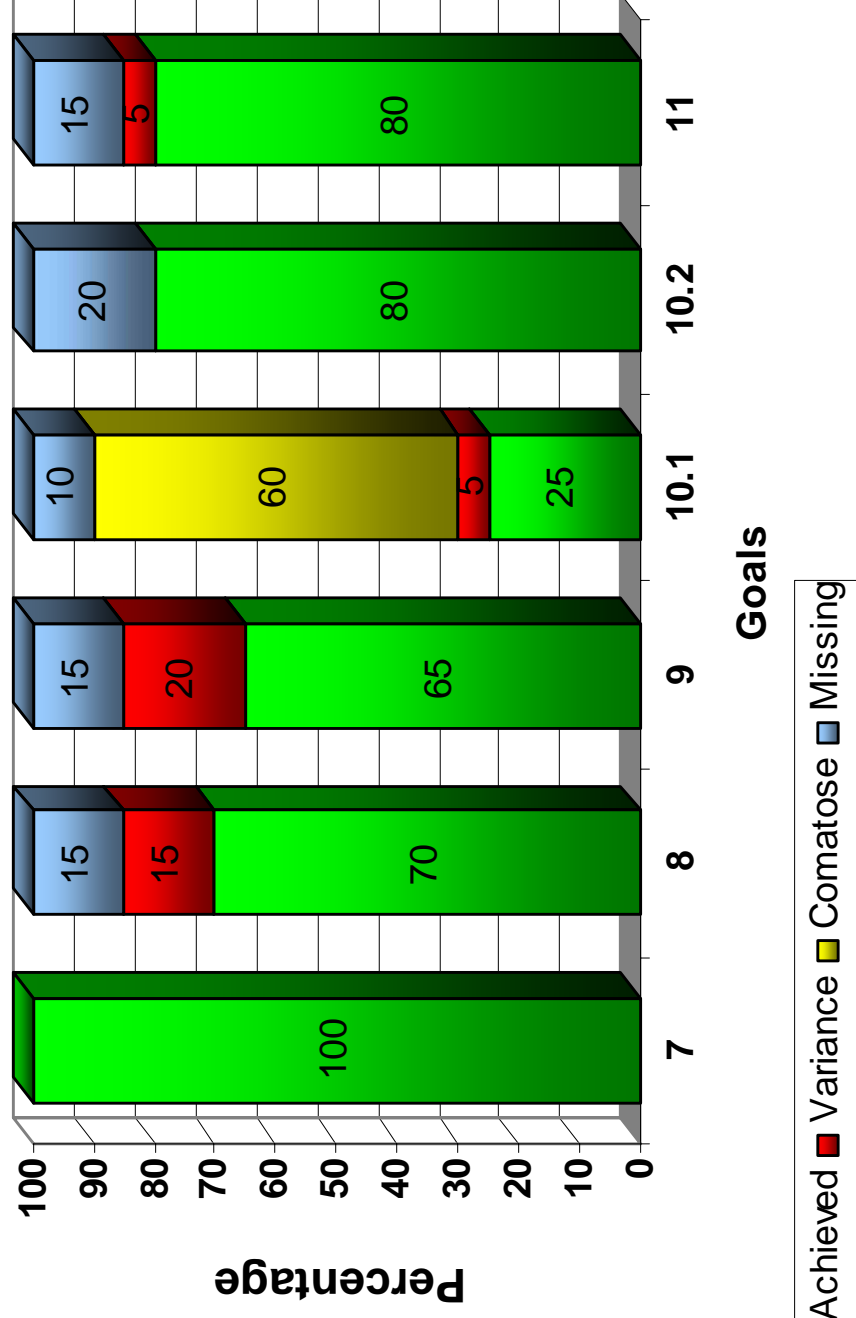
# Communication

- |                |  |  |
|----------------|--|--|
| <i>Goal 7</i>  | <i>NOT APPLICABLE TO COMMUNITY SAMPLE</i>            | How family/other to be informed of patient's impending death   |
| <i>Goal 8</i>  | <i>NOT APPLICABLE TO COMMUNITY SAMPLE</i>            | Family/other given hospital/hospice information leaflets<br>(Accommodation, car parking, dining room facilities etc) |
| <i>Goal 9</i>  | General Practitioner is aware of patient's condition |  |
| <i>Goal 10</i> | Plan of care explained to:                           |  |
|                | 10.1 Patient   |  |
|                | 10.2 Family/other                                    |  |
| <i>Goal 11</i> | Family/other understanding of plan of care           |  |

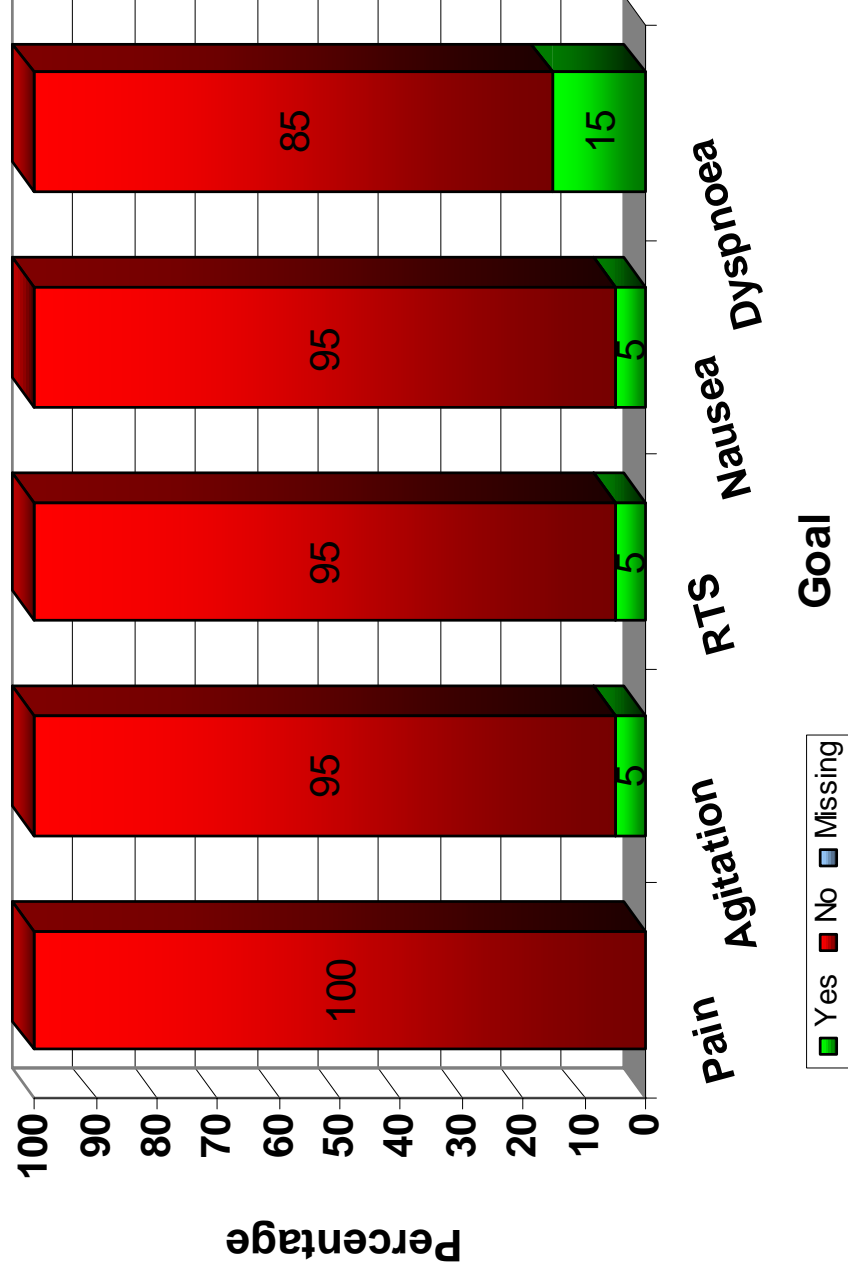
## Pre: Communication (n=20)



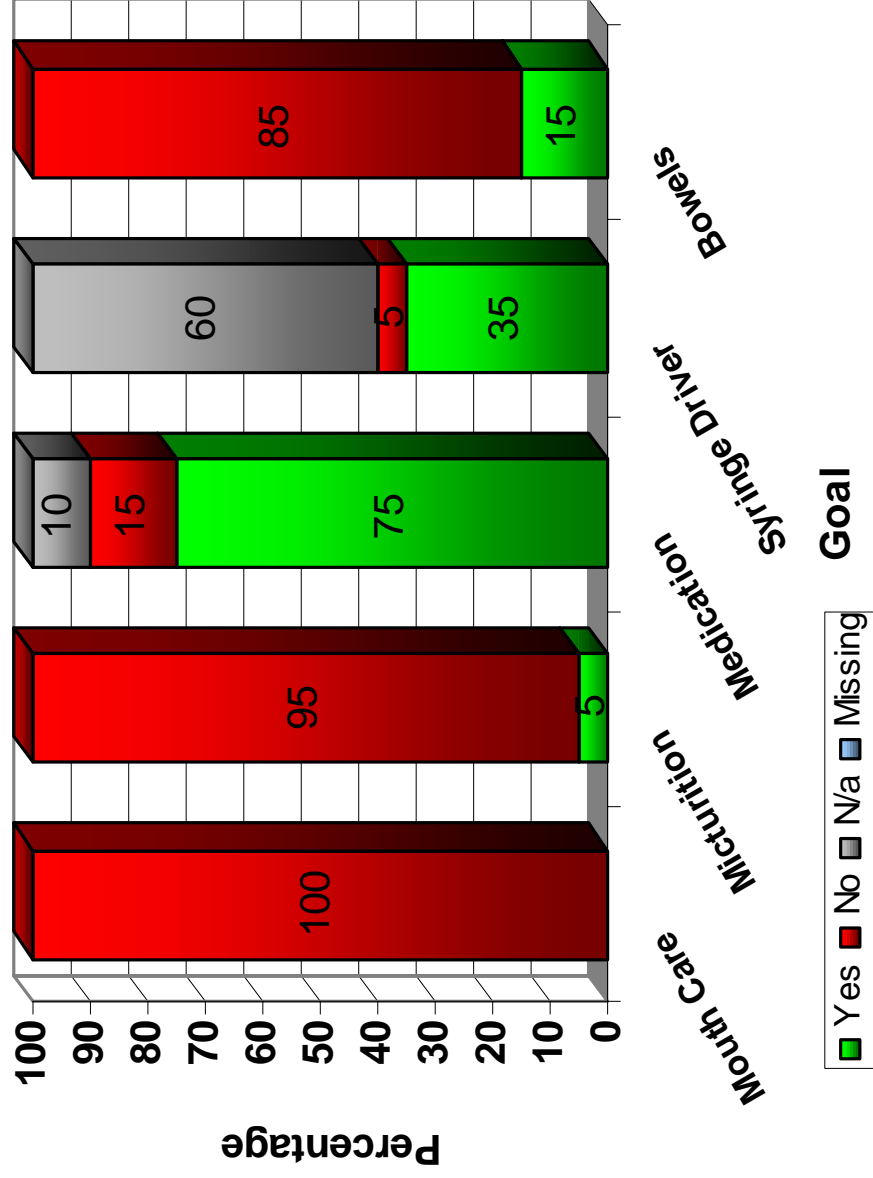
## Post: Communication (n=20)



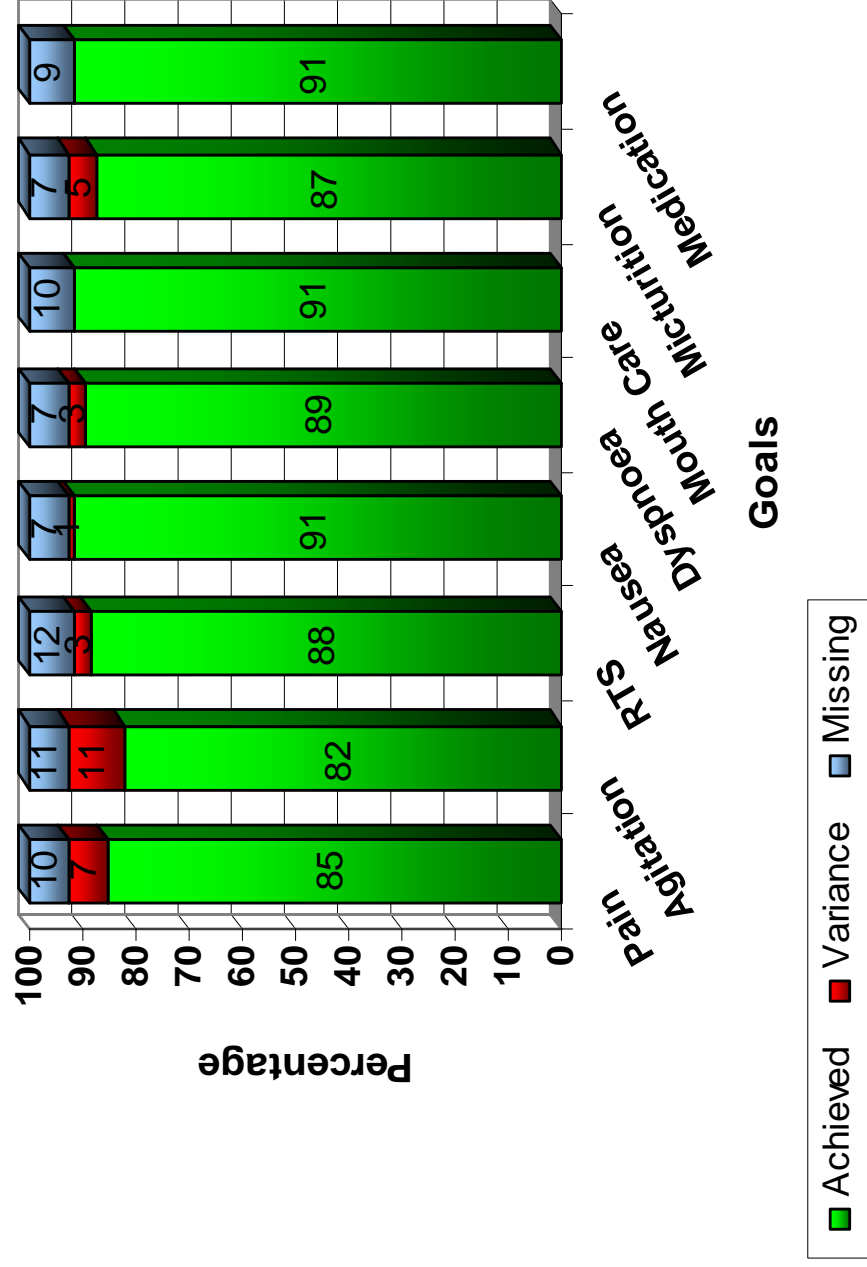
## Pre: Assessment of documentation of ongoing care (4/12 hourly)



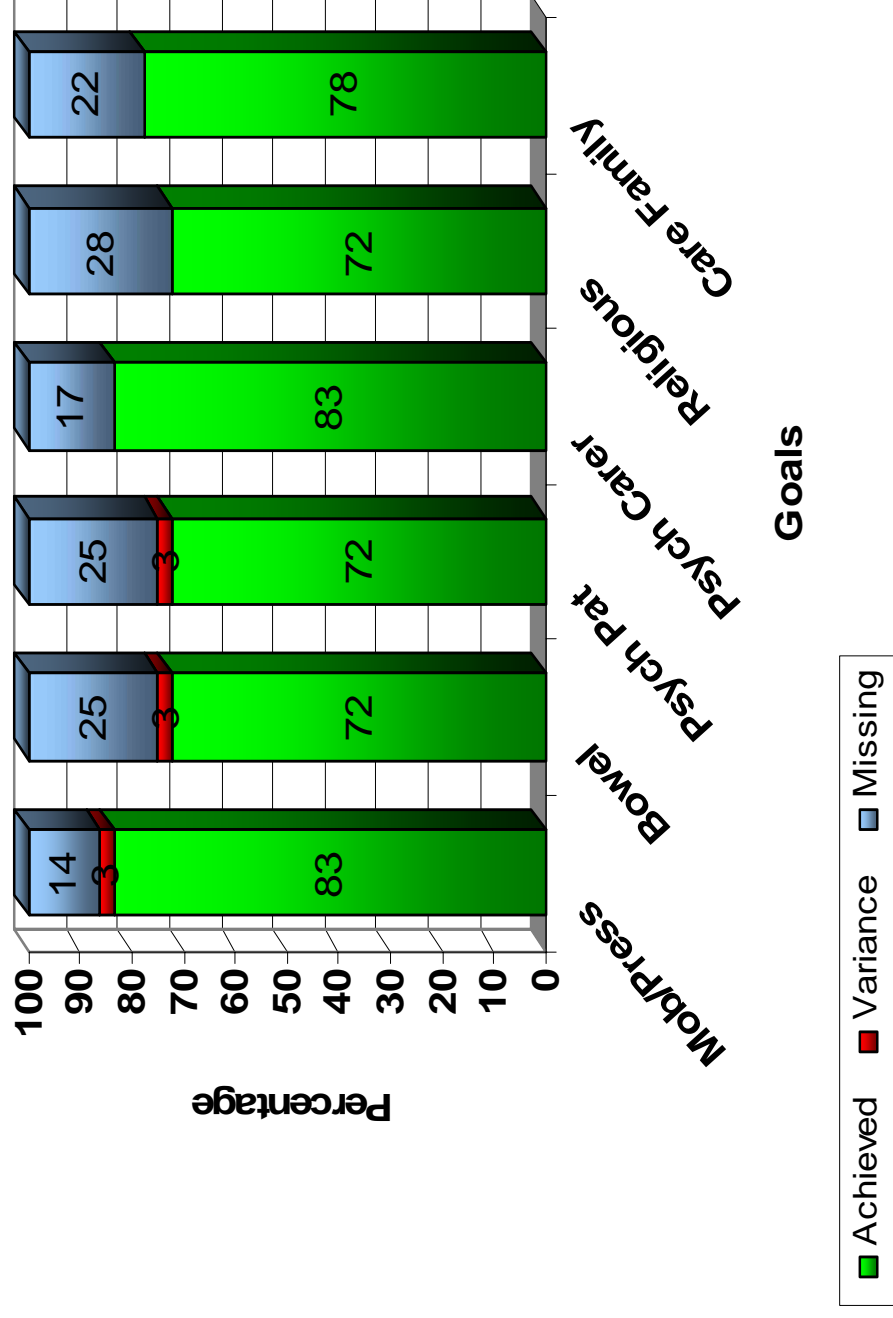
## Pre: Assessment of documentation of ongoing care (4/12 hourly)



## Post: Assessment of documentation of ongoing care (4/12 hourly)



## Post: Assessment of Ongoing Care Last 24 hours - 12 hourly observations

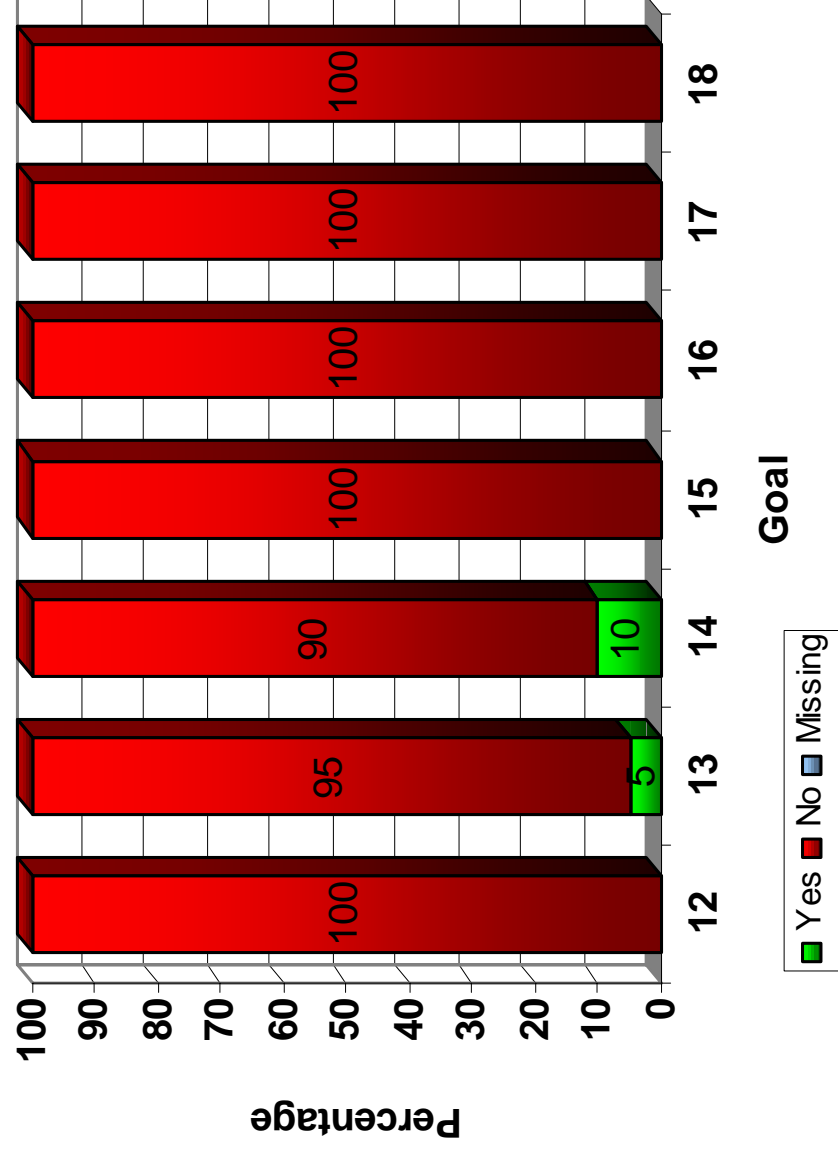


# Care After Death

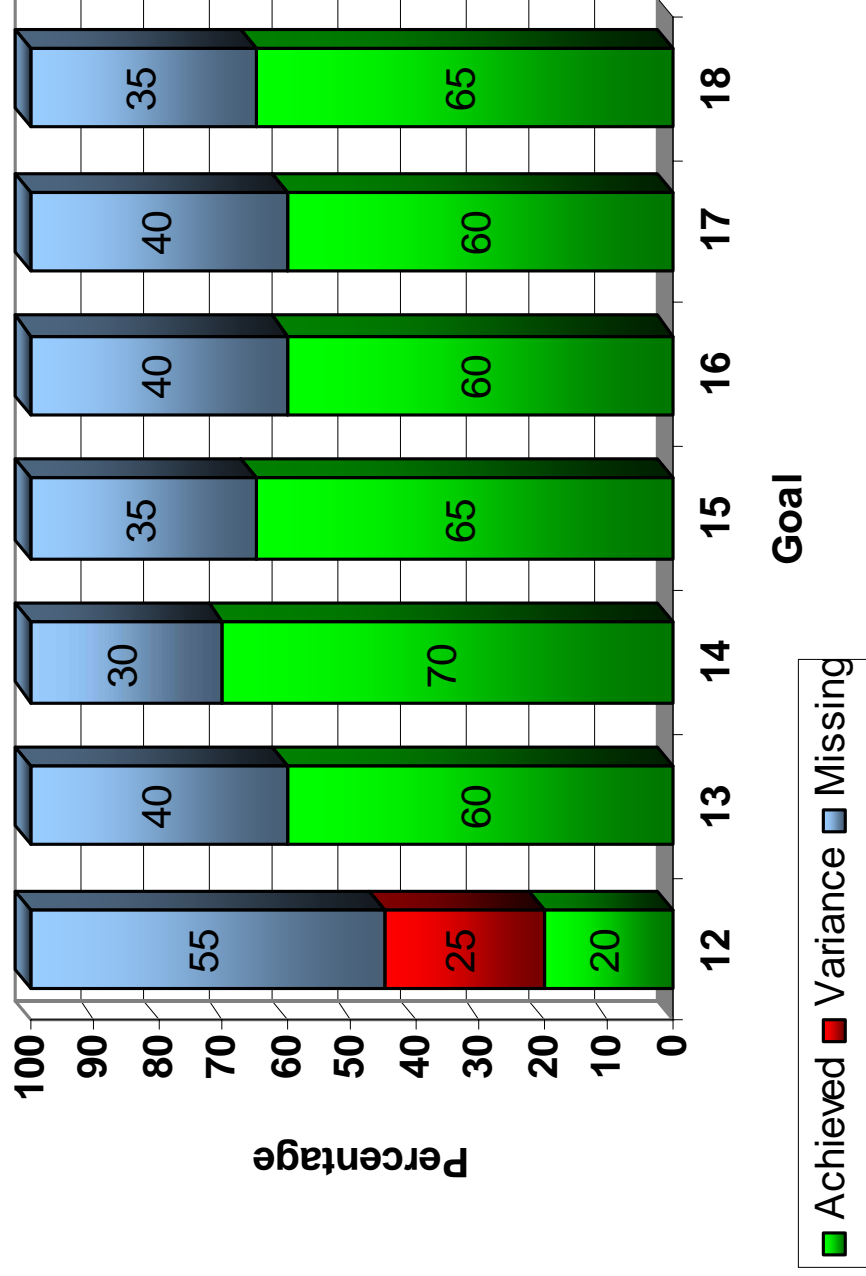
- Goal 12**      GP Practice contacted re: patients death
- Goal 13**      Procedure for laying out followed
- Goal 14**      Procedure following death discussed or carried out.
- Goal 15**      Family/ other given information on procedures
- Goal 16**      ***NOT APPLICABLE TO COMMUNITY SAMPLE***  
*Hospital/Hospice Policy followed for patients valuables & belongings*
- Goal 17**      Necessary documentation and advice is given to the appropriate person
- Goal 18**      Bereavement leaflet given



## Pre: Care after Death (n=20)



## Post: Care after Death (n=20)



# Waikato Hospital Ethnicity Data

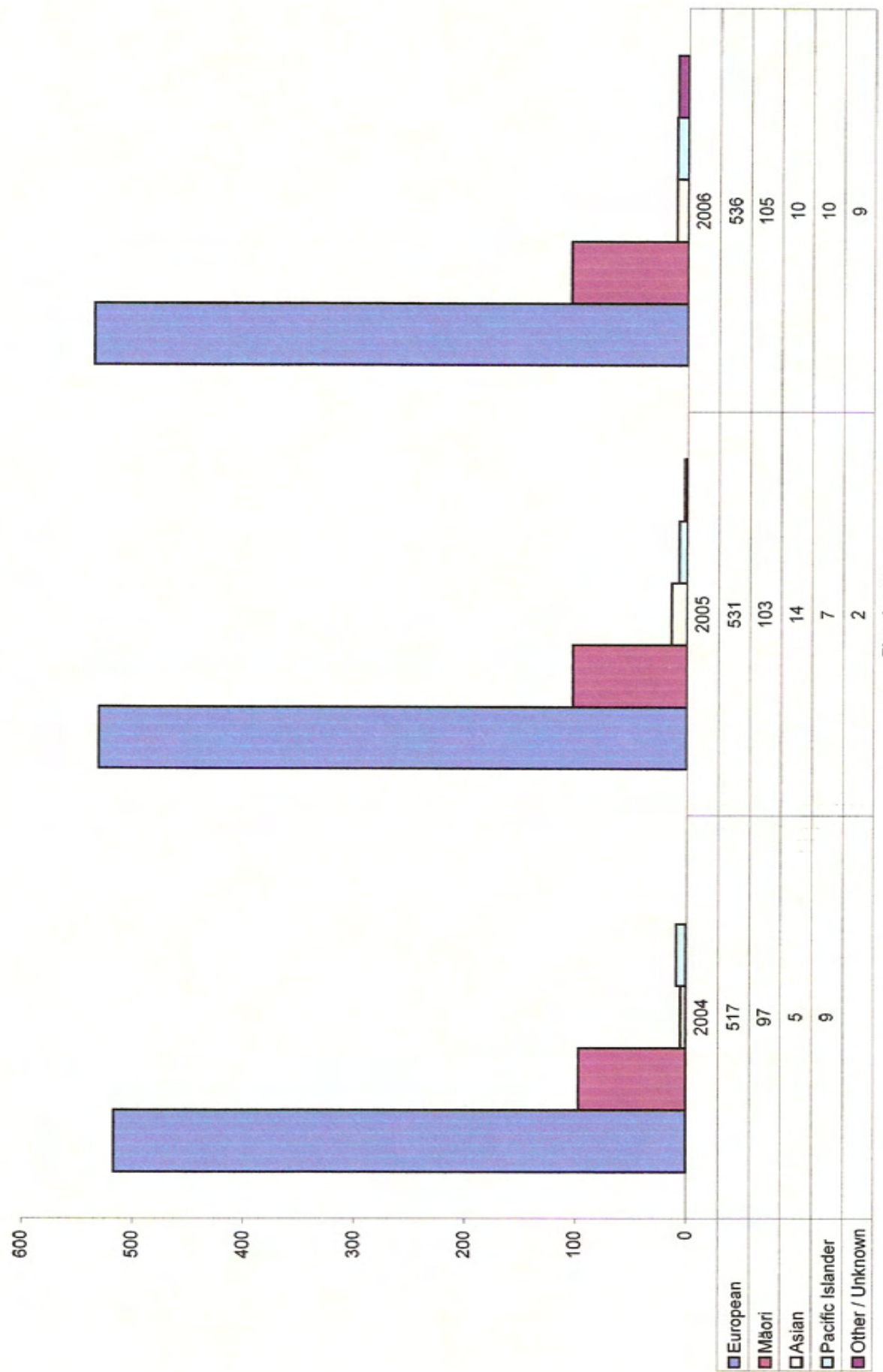
BASE REVIEW

May – July 2006

POST PATHWAY

October – December  
2006

## Waikato Hospital Deaths Ethnicity group and Fiscal year



## Demographics (n=20)

<b>Audit</b>	<b>Pre-LCP</b>	<b>Post-LCP</b>
<b>Gender</b>	<b>50/50</b>	<b>50/50</b>
<b>Ethnicity</b> (non-NZ European : NZ European)	<b>8 : 12</b>	<b>6 : 14</b>
<b>Mean age</b>	<b>79yrs</b>	<b>80yrs</b>
<b>Cancer</b>	<b>8</b>	<b>15</b>
<b>Non-cancer</b>	<b>12</b>	<b>5</b>

# Cultural needs/support requirements

*Goal 6B*      Cultural tradition identified

- a) with patient
- b) with family/whanau

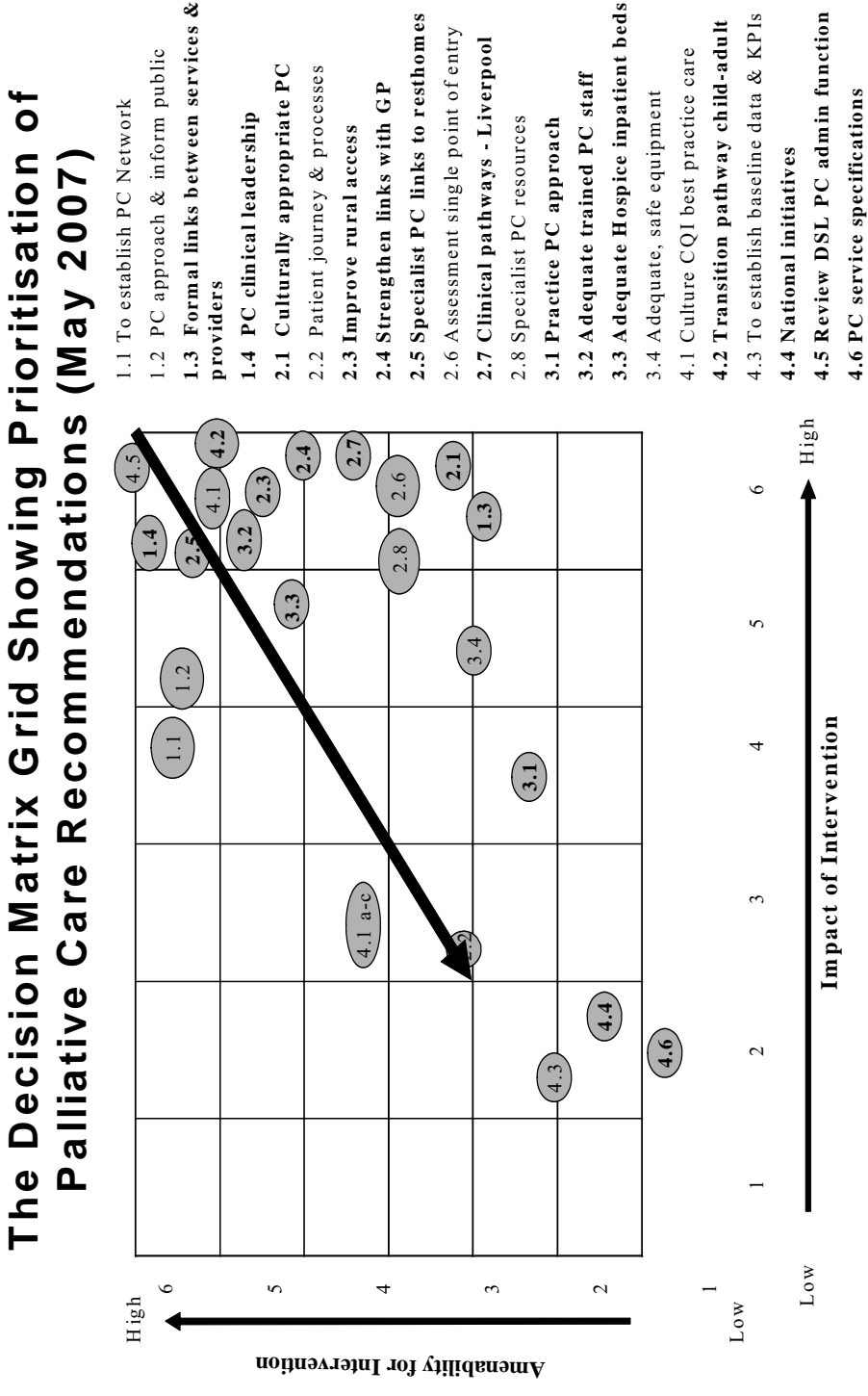
# Cultural Needs Assessment (n=20)

<b>Ethnicity</b>	<b>Pre-LCP audit</b>	<b>Post-LCP audit</b>
<b>NZ European / Pakeha</b>	12	14
<b>Maori</b>	3	1
<b>Other European</b>	3	4
<b>Chinese</b>	1	-
<b>Tongan</b>	1	-
<b>Other Asian</b>	-	1
<b>Total:</b>	<b>20</b>	<b>20</b>





Appendix 3 – Prioritisation of Recommendations



# Appendix 4 – PCU Processes

