

# Bay of Plenty Adult Palliative Care Service Plan 2011- 2016

**Author:** Sharon Hardaker, Midland Cancer Network  
**Last Updated:** 3 June 2012  
**Document Name:** Bay of Plenty Adult Palliative Care Service Plan  
**Version:** V 1.4 FINAL

## Revision history

Date	Author	Summary of Changes	Version
5/07/2011		Midland PC Work Group planning discussion and discussions with national representatives on national projects	
7 /12/2011	S Hardaker	Midland Palliative Care Work Group review of Outcomes Framework and draft of Midland PC priorities aligned to the framework.	
19/09/2011	S Hardaker	Draft sections of plan developed for discussion with BOP Palliative Care Work Group	
Oct - Feb	S Hardaker	Sections sent to 'experts' for review and completion	
23/02/2012	S Hardaker	Draft plan developed and presented for discussion and review by BOP Palliative Care Work Group	V1.0
16/03/2012	S Hardaker	Incorporating BOP Palliative Care Work Group feedback (refer to minutes of 27 February), feedback from stakeholders and general editing.	V1.3
4/06/2012	S Hardaker	Incorporating feedback from Clinical Board.	FINAL V1.4

## Distribution

Name	Title	Issue Date	Version
BOP Palliative Care Work Group	Draft for discussion	21/02/2012	V1.0
BOP Planning & Funding PHO CEOs Hospice CEOs  Copy to BOP PC Work Group	Final draft for endorsement of CPHAC/DSAC and Clinical Board	20/03/2012	V1.0  V1.3 (update)
DHB Planning & Funding for BOP DHB Board	FINAL	4/06/2012	V1.4

## Approvals

Approver	Signature	Issue Date	Version

## Table of Contents

---

Executive summary .....	5
1. Overview.....	8
1.1. Introduction.....	8
1.2. Service planning process.....	8
2. Strategic Context .....	10
2.1. Background documents .....	10
2.2. Treaty of Waitangi.....	10
2.3. What is palliative care? .....	11
2.4. Strategic vision .....	11
2.5. Defining palliative care.....	11
3. National palliative care work plan.....	15
3.1 Specialist palliative care service specifications .....	15
3.2 National health needs assessment for palliative care.....	15
3.3 Resource and capability framework (role delineation model) .....	15
3.4 Health Workforce New Zealand palliative care workforce service review .....	16
3.5 National specialist palliative care data definitions and business process .....	16
3.6 Measuring What Matters: Palliative Care .....	16
3.7 Liverpool Care Pathway (LCP).....	17
3.8 Advance care planning for adults.....	17
3.9 The Gold Standards Framework (GSF) .....	17
3.10 Palliative care education and standards.....	18
4. Midland region context.....	19
5. Local Bay Of Plenty DHB palliative care .....	20
5.1. Bay of Plenty District Health Board strategies.....	20
5.2. Bay of Plenty palliative care strategy 2003.....	21
5.3. Bay of Plenty DHB geographic and population demographics .....	22
5.4. Health needs of specific population groups.....	24
5.5. Current Palliative Care Services .....	27
5.6. Specific Bay of Plenty initiatives.....	36
5.7. Funding .....	40
6. The future .....	43
6.1. Increasing need for palliative care.....	43
6.2. Capacity to meet future demand. ....	50
6.3. Specialist palliative care workforce development .....	52
6.4. Hospital based specialist palliative care .....	56
7. Summary of key strengths and issues .....	57
7.1. Strengths .....	57
7.2. Issues and gaps.....	57
8. Vision and recommendations .....	59
8.1 Vision.....	59
8.2 Recommendations.....	59

### List of appendices

1. National documents/reviews – additional detail
2. Outcomes Framework
3. Bay of Plenty population trends
4. Service description for Waipuna Hospice
5. Service description for Hospice Eastern Bay of Plenty
6. Illness trajectories and palliative care
7. Palliative care in acute general hospitals: international examples
8. Western Bay of Plenty: Stakeholder summary
9. Eastern Bay of Plenty: Stakeholder summary

## List of Figures

Figure 1: The palliative care “system” .....	14
Figure 2: Diagnosis of hospice patients – Hospice Eastern Bay of Plenty .....	45
Figure 3: Diagnosis of hospice patients – Waipuna Hospice .....	46
Figure 4: Hospice EBOP patients – place of death .....	47
Figure 5: Waipuna Hospice Patients - Place of Death .....	48
Figure 6: Number of deaths by territorial authority – actual and projected .....	48

## List of Tables

Table 1: Characteristics of the BOP DHB by territorial authority .....	23
Table 2: Overview of providers of palliative care.....	27
Table 3: PHOs in Bay of Plenty and enrolled population as at Quarter 1, 2012 .....	28
Table 4: Bay of Plenty Residential Care Beds .....	31
Table 5: Residential care contracted beds for palliative care .....	32
Table 6: Diagnosis hospice patients 2008-2010 .....	45
Table 7: Ratio of deaths in hospital – BOP 2007-2010 .....	47
Table 8: Place of death of hospice patients - 2010 .....	47
Table 9: Mid range estimate of the number of adults who would benefit from palliative care .	49
Table 10: Waipuna Hospice referrals.....	50
Table 11: Hospice EBOP referrals.....	50
Table 12: Required specialist inpatient beds per 100,000 population / benchmarks .....	51
Table 13: BOP palliative care staff requirements .....	53

## List of commonly used abbreviations

BOP	Bay of Plenty
BOP DHB	Bay of Plenty District Health Board
DHB	District Health Board
EBOP	Eastern Bay of Plenty
EN	Enrolled nurse
GP	General practitioner
LCP	Liverpool Care Pathway
MOH	Ministry of Health
NASC	Needs Assessment and Service Coordination
NGO	Non-government organisation
PHA	Primary Health Association
PHO	Primary Health Organisation
P&F	Planning and Funding
RMO	Resident medical officer
RN	Registered nurse
WBOP	Western Bay of Plenty

## Executive summary

Palliative care is a concept of care which focuses on relieving suffering and achieving the best possible quality of life for patients with a life limiting illness and their family/whānau caregivers. It provides coordinated medical, nursing and allied health services including pastoral care services, delivered where possible in the environment of the person's choice. It includes the provision of grief and bereavement support for families, whānau and carers during the life of the patient and following his or her death.

The New Zealand Palliative Care Strategy was launched in February 2001 with the aim of setting in place a systemic and informed approach to the future provision and funding of palliative care services and to ensure that all people who are dying and their family/whānau have access to palliative care services, provided in a co-ordinated and culturally appropriate way.

The purpose of this plan is to review the current progress of palliative care service development in Bay of Plenty District Health Board (DHB) and to identify actions for local palliative care services for the period 2011 to 2016. This will be a living document and will be reviewed and updated as required, particularly when current national palliative care projects are completed and require implementation.

As the Bay of Plenty DHB population grows and ages, with an increasing incidence of cancer, a growth in chronic life-threatening disease and people with multiple co-morbidities, and changing family support structures there will be increasing demand for all levels of palliative care services and an increase in the complexity of care.

There has been considerable additional investment by the Ministry of Health in palliative care services (particularly hospices) in the past few years and so it is assumed there is unlikely to be any significant increases (if any) in funding for specialist palliative care services in the foreseeable future. In a financially constrained environment there will be challenges meeting the increasing service demands. The focus for the recommendations in this plan is on service improvement, improved relationships and building capacity and capability within the generalist level enabling the specialist services to focus on providing education and support for generalists and direct care for patients with the most complex needs. A key focus must be on prioritising the allocation of resources and how to organise or deliver services differently to live within the service's means.

The Bay of Plenty has a well developed community based model of palliative care. Specialist palliative care services receive strong community support and recognition. There are service gaps and access issues to some essential services and a collaborative approach between the PHOs, specialist palliative care services, Māori health providers and the DHB is required to find sustainable solutions. The need to develop in-hospital palliative care has been recognised as a gap and should form a major focus for the next phase of development of palliative care services in Bay of Plenty.

It is not seen as being necessary to make any major changes to the current model of care operating in Bay of Plenty DHB. However, it is acknowledged that the national project to develop a Resource and Capability Framework for delivery of palliative care services in New Zealand may require changes to be planned and implemented. This will be considered during 2012 when the outcome of the current national project is known.

There are opportunities identified to work with other palliative care services in Midland to share resources and knowledge, reduce duplication and create consistency across the Midland region. This will form the basis of the regional palliative care workplan.

The palliative care strategic vision is that all people who have a life limiting illness and their family/whānau who could benefit from palliative care have timely access to quality palliative care that is culturally appropriate and provided in a coordinated way. Three long term outcomes are considered necessary to achieve the vision.

- Access to palliative care regardless of setting
- All palliative care providers are configured to ensure a seamless care pathway
- Palliative care provision is high quality.

Each of the long term outcomes have supporting objectives and actions recommended for implementation over the next five years. These have been summarised as:

## 1. Access to palliative care regardless of setting

### 1.1 Ensure sufficient capacity within primary and specialist palliative care

*- sufficient workforce and appropriate services and infrastructure*

- (a) Scope and implement (using a phased approach) a district wide hospital specialist palliative care team/service. Consider the model of care required to improve access to palliative care medical specialist in Eastern Bay of Plenty
- (b) Investigate opportunities to implement virtual medical services e.g. video conference
- (c) Consider strengthening the palliative medicine workforce through regional co-operation
- (d) Develop a workforce plan to address identified areas of skill shortage
- (e) Implement the Hospice NZ education programme 'Fundamentals of Palliative Care'
- (f) Implement cultural competency education for health professionals in specialist palliative care services where required
- (g) Develop and implement topic specific education sessions for palliative care health professionals
- (h) Ensure access to clinical supervision
- (i) PHOs to integrate palliative care into education and training plans of primary practices
- (j) Improve consistency of access to NACS funding and other supportive care services
- (k) Explore opportunities to enable hospice medical specialist's access to diagnostic and treatment services in Tauranga Hospital
- (l) PHOs to develop and implement sustainable solutions for 24/7 access to a general practitioner
- (m) Improve patient access to primary palliative care services
- (n) Review access to grief and bereavement services in Bay of Plenty particularly for those people who are not referred to specialist palliative care services
- (o) Improve access to emergency/out of hours medication related to palliative care
- (p) Develop consistent criteria, guidelines and other resources
- (q) Develop community strategies to manage patients in their home and minimise inpatient demand
- (r) EBOP district nursing and Hospice EBOP review current nursing arrangement and look at opportunities to improve.

### 1.2 Ensure appropriate referrals to specialist palliative care services

*- awareness of palliative care referral processes and understanding of palliative care principles.*

- (a) Document access criteria and referral processes
- (b) Develop a Bay of Plenty palliative care service directory
- (c) Review and strengthen website content of Bay of Plenty DHB, hospices, Māori Health providers, PHOs and other relevant NGOs
- (d) Develop and implement a communication plan for palliative care health promotion
- (e) Develop a Bay Navigator project for palliative care
- (f) Review and standardise palliative care patient/family/whānau information
- (g) Ensure hospitals and other PHO and NGO services have policies and protocols reflecting the palliative care approach
- (h) Educate providers in the palliative care approach through the development of orientation and/or education sessions.

### 1.3 Support and align with national work programme priorities

- (a) Apply Resource and Capability Framework to the Midland region
- (b) Implement other national work programme initiatives as they become available i.e. service specifications and any new funding models.
- (c) Consider Ministry of Health EOI for the development and evaluation of a managed clinical network and submit proposal, if appropriate, for the Midland region.
- (d) Implement the HISO National Specialist Palliative Care Data and Business Process Standard when finalised.

## 2. All palliative care providers are configured to ensure a seamless care pathway

### 2.1 Ensure there is continuity and coordination of care

- *appropriate links between services*
  - *appropriate role delineation between providers*
  - *shared strategic vision across the region*
  - *appropriate information sharing.*
- (a) Refresh the Bay of Plenty Palliative Care Work Group to lead implementation of this plan
  - (b) Develop service level agreements between specialist palliative care services and others
  - (c) Develop a process to ensure every palliative patient has a nominated care coordinator and there is a plan for continuity of care after hours
  - (d) Complete the implementation of PalCare into hospices, scope system integration with (or access by) primary, hospital and other specialist services
  - (e) Bay of Plenty DHB to consider hospice staff access to relevant patient information
  - (f) Scope requirements to capture national minimum palliative care dataset
  - (g) Scope and understand how NGOs can contribute to the national initiative of shared care record.

## 3. Palliative care provision is high quality

### 3.1 Best practice is followed in delivering palliative care

*- standards for palliative care services are met; there is an interdisciplinary team approach to palliative care, and patient pathways are followed.*

- (a) Implement the Hospice New Zealand Standards
- (b) Complete implementation of Liverpool Care Pathway (LCP) and monitor utilisation
- (c) Implement the LCP reflective data cycle
- (d) Encourage and promote research opportunities
- (e) Support the implementation of Advanced Care Planning with primary and specialist services.

### 3.2 Palliative care meets the needs of patients, their families and whānau

*- culturally appropriate care, meeting the needs of specific population groups and effective treatments and support.*

- (a) Understand education and support needs for Māori health providers to inform palliative care education planning and service development
- (b) Support specialist palliative care services to carry out cultural audits of services
- (c) Participate in the development of national or regional clinical guidelines and standards
- (d) Develop relationships with other services for support with care of people with non malignant conditions, multiple co-morbidities and/or dementia
- (e) Explore strategies to improve patient transport between providers
- (f) Develop a Kaupapa Māori palliative care approach.

# 1. Overview

---

## 1.1. Introduction

---

The **New Zealand Palliative Care Strategy**<sup>1</sup> was launched in February 2001 with the aim of setting in place a systemic and informed approach to the future provision and funding of palliative care services. The focus of the strategy was on the setting up of services in New Zealand and had a 5 to 10 year vision. Since the strategy was launched considerable progress has been made in the establishment and development of the palliative care services and workforce in New Zealand. The Ministry of Health (MOH) has provided additional funding to support the implementation of the national strategy.

A number of national projects are currently underway that demonstrate progress in achieving the vision and provide clarity in areas identified as requiring further development.

The purpose of this service plan is to review the current progress of palliative care service development in Bay of Plenty DHB (BOP DHB) and to identify priorities and actions for local palliative care services for the period 2011 to 2016. This will be a living document and will be reviewed and updated as required, particularly as the national palliative care projects are completed and require local implementation.

There has been considerable additional investment by the Ministry of Health in palliative care services (particularly hospices) in the past few years and so it is assumed there is unlikely to be any significant increases (if any) in funding for specialist palliative care services in the foreseeable future. Due to increasing population and demand we expect there will be increased pressure on services. Therefore, a key focus must be on prioritising the allocation of resources and how to organise or deliver services differently to live within the service's means.

The DHB works with other Midland DHBs to advance palliative care services for both the Bay of Plenty area and the Midland region as a whole. Activities that can be facilitated by regional cooperation and are of benefit to all DHBs in Midland have been identified and will be included in a regional palliative care overview (separate to this plan).

## 1.2. Service planning process

---

This process has included:

- high level review of overarching government palliative care strategies and objectives
- high level review of international trends and priorities in developing palliative care services
- review of previous local palliative service plans or similar
- review of the recommendations from the *Gap Analysis of Specialist Palliative Care in New Zealand*<sup>2</sup>
- analysis of hospice patient demographics and trends from the palliative care monitoring returns
- estimation of some future demand implications from the population projections and what we know about current services
- discussion and consultation with stakeholders about the current model of care and services delivered. Specific sessions were held within:
  - Eastern Bay of Plenty (EBOP)
  - Western Bay of Plenty (WBOP)
  - Māori (regional session although there were no Bay of Plenty Māori present at this meeting as well as some discussion on palliative care at a local hui with Māori providers)
  - Paediatric palliative care (including representatives from Starship Hospital).

The focus of this service plan is adult palliative care services inclusive of malignant and nonmalignant life threatening disease. Currently work is happening at a national level to develop the model of care for

---

<sup>1</sup> Ministry of Health: *The New Zealand Palliative Care Strategy*, Wellington NZ, February 2001

<sup>2</sup> Ministry of Health: *Gap Analysis of Specialist Palliative Care in New Zealand – Providing a national overview of hospice and hospital-based services*, Wellington, December 2009.



paediatric palliative care in New Zealand. A separate paediatric palliative care plan for the Midland region and local networks will be prepared once the national guidance document is received.

It has been assumed that funding will be limited during this period and it is unlikely there will be any new funding for existing palliative care services from the MOH.

Implementation of agreed actions contained in the local DHB plans will be the responsibility of the DHBs using their local cancer and/or palliative care forums with programme support from Midland Cancer Network. Implementation of the agreed regional activities and projects will be the responsibility of the Midland Palliative Care Work Group.

## 2. Strategic Context

---

### 2.1. Background documents

---

The following key documents have been considered alongside the New Zealand Palliative Care Strategy:

- New Zealand Cancer Control Strategy (2003)
- New Zealand Cancer Control Strategy Action Plan 2005-2010 (March 2005)
- Primary Health Care Strategy, February (2001)
- He Korowai Oranga: Māori Health Strategy (2002)
- Health of Older Persons Strategy (2002)
- Report of the Palliative Care Expert Working Group to the Cancer Control Steering Group (February 2003)
- Specialist Palliative Care Service Specifications (Draft 2008)
- Gap Analysis of Specialist Palliative Care in New Zealand (December 2009)
- Positioning Palliative Care in New Zealand (February 2010)
- National Health Needs Assessment for Palliative Care: Phase 1 Report (June 2011)
- Bay of Plenty District Health Board District Strategic Plan 2005-2015
- Bay of Plenty Māori Health Strategic Plan 2001-2010
- Bay of Plenty DHB Health Needs Analysis (September 2008)
- Palliative Care Health Workforce Service Review, Health Workforce NZ (April 2011)
- Resource and Capability Framework for Adult Palliative Care Services in New Zealand (Draft Nov 2011)
- Measuring What Matters – Palliative Care (Draft November 2011)

### 2.2. Treaty of Waitangi

---

The Government and district health boards recognise the Treaty of Waitangi as the founding document of New Zealand and acknowledge the special relationship between Māori and the Crown under the Treaty. Central to the treaty relationship and the acknowledgement of the treaty principles is a common understanding that Māori will have an important role in developing and implementing health strategies for Māori. The relationship must be based on the following principles:

- partnership - Working together with iwi, hapū, whānau and Māori communities to develop strategies for improving the health status of Māori.
- participation - Involving Māori at all levels of the sector, in decision-making, planning, development and delivery of health and disability services that are put in place to improve the health status of Māori.
- protection – Ensuring Māori wellbeing is protected and improved as well as safeguarding Māori cultural concepts, values and practices.

He Korowai Oranga: Māori Health Strategy<sup>3</sup> sets the direction for Māori health development in the health and disability sector. The strategy provides a framework for the public sector to take responsibility for the part it plays in supporting the health status of whānau. The overall aim of He Korowai Oranga is Whānau Ora - Māori families supported to achieve their maximum health and wellbeing. This is an inclusive approach to providing services and opportunities to families across New Zealand. It empowers families as a whole, rather than focusing separately on individual family members and their problems. It requires multiple Government agencies to work together with families rather than separately with individual family members.

---

<sup>3</sup> Ministry of Health. 2002. He Korowai Oranga: Māori Health Strategy. Wellington: Ministry of Health <http://www.health.govt.nz/publication/he-korowai-oranga-maori-health-strategy>

### 2.3. What is palliative care?

---

Palliative care is a concept of care, rather than a particular mode of treatment. It is not a specialty in isolation and does not take exclusive ownership of palliative care. It is a philosophy of care to be owned by the healthcare community as a whole and delivered in all clinical settings.

Palliative care focuses on relieving suffering and achieving the best possible quality of life for patients and their family/whānau caregivers. It provides coordinated medical, nursing and allied health services including pastoral care services, delivered where possible in the environment of the person's choice. It includes the provision of grief and bereavement support for families, whānau and carers during the life of the patient and following his or her death.

Palliative care is often not well understood. In some cases it is believed to be just terminal care or end-of-life care, that it is the alternative to life-prolonging or curative care, that it is hospice care, or that it is only available for those that have cancer.

Historically the majority of people accessing specialist palliative care services have had a cancer diagnosis however there is now an increasing recognition of the value of palliative care for people with progressive nonmalignant diseases (such as cardiovascular and cerebrovascular diseases, diseases of the respiratory system, advanced organ failure and degenerative neurological diseases). We are now seeing an increasing trend of patients with this wider range of non-malignant diseases also accessing palliative care services.

There is now greater understanding that inclusion of a palliative approach should not be delayed until the end stages of an illness. There is value in a palliative approach alongside curative treatment, particularly to support people with chronic progressive illnesses over many years.

### 2.4. Strategic vision

---

The national vision for provision of palliative care services as described in the New Zealand Palliative Care Strategy is that:

*All people who are dying and their family/whanau who could benefit from palliative care services have timely access to quality palliative care services that are culturally appropriate and are provided in a coordinated way.*

Underpinning this vision is a community-based model of palliative care services.

Palliative care services are described as providing holistic care – that all aspects of people's needs, physical, psychosocial, spiritual and cultural be taken into account and seen as a whole. From a Māori perspective this is encapsulated in the philosophy 'Te Whare Tapa Wha' (four sided house). This model for wellbeing includes the components Te Taha Hinengaro (psychological health), Te Taha Wairua (spiritual health), Te Taha Tinana (physical health) and Te Taha Whānau (family health).

### 2.5. Defining palliative care

---

In 2001, the *New Zealand Palliative Care Strategy* defined palliative care as:

*'the total care of people who are dying from active, progressive diseases or other conditions when curative or disease modifying treatment has come to an end. Palliative care services are generally provided by a multidisciplinary team that works with the person who is dying and their family/whānau.'*

In 2002, the World Health Organisation (WHO) redefined palliative care for adults as:

*'an approach that improves the quality of life of individuals and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual'* (World Health Organisation, 2002)

This WHO definition reflects a fundamental shift internationally in recognising that the provision of palliative care is applicable at any stage after diagnosis of a life limiting illness<sup>4</sup>, wherever there is a need and wherever the patient is, and not just at the very end of life (terminal phase).

In 2007, the Palliative Care Subcommittee of the New Zealand Cancer Treatment Working Party further developed the definition resulting in the current working definition of palliative care. This took into consideration the fundamental place of the Treaty of Waitangi, the evolving practice of palliative care, the diversity of cultures, the importance of primary care and the need to integrate specialist and generalist palliative care.

**The New Zealand definition of palliative care** that is now widely referred to is

*Care for people of all ages with a life limiting illness which aims to:*

- 1. Optimise an individual's quality of life until death by addressing the person's physical, psychosocial, spiritual and cultural needs.*
- 2. Support the individuals family, whānau and other caregivers where needed, through the illness and after death.*

*Palliative care is provided according to an individual's need, and may be suitable whether death is days, weeks, months or occasionally even years away. It may be suitable when treatments are being given aimed at improving quantity of life.*

*It should be available wherever the person may be.*

*It should be provided by all healthcare professionals, supported where necessary, by specialist palliative care services.*

*Palliative care should be provided in such a way as to meet the unique needs of individuals from particular communities or groups. These include Māori, children and young people, immigrants, refugees, and those in isolated communities.<sup>5</sup>*

The definition identifies both generalist and specialist levels of palliative care, which should be part of an integrated framework of care provision. This may be facilitated through local and regional networks with defined formal linkages to key services including community primary care, local acute hospitals, regional cancer centres and other regional palliative providers.

**Generalist palliative care** is palliative care provided for those affected by life-limiting illness as an integral part of routine standard clinical practice by any healthcare professional who is not part of a specialist palliative care team. This is also sometimes referred to as primary palliative care.

Generalist palliative care is provided in the community by general practice teams, Māori health providers, allied health teams, district nurses, and aged residential care staff etc. It is provided in hospitals by general ward staff, as well as disease specific teams – for instance oncology, respiratory, renal and cardiac teams.

Not all patients who have a life limiting illness will need specialist care. Primary health practitioners (usually GPs, practice nurses and district nurses) appropriately care for many patients with palliative care needs. These practitioners need to be able to refer and/or seek advice from specialist palliative care services when necessary. For the majority of patients this will be for assessment or periodic review with the responsibility for ongoing care remaining with the primary health care provider. For patients with more complex care needs, care will involve a specialist palliative care service in conjunction with the primary health care service. 24 hour/7 day access to specialist palliative care advice, support and consultation is essential to ensure quality care and to build the skills and confidence of the primary health services.

---

<sup>4</sup> Life limiting illness is used to describe 'illnesses that can be reasonably expected to cause the death of the patient within the foreseeable future. This is inclusive of malignant and non-malignant illness. This differs from chronic illnesses where, even though there may be significant impact on the patients abilities and quality of life, there is less likely to be a less direct relationship between the illness and the person's death'. Palliative Care Australia. (2005). *A Guide to Palliative Care Service Development – a population based approach*.

<sup>5</sup> NZ Cancer Treatment Working Party. *The New Zealand Definition of Palliative Care*,: Wellington 2007  
[www.health.govt.nz/system/files/.../nz-palliative-care-definition-oct07.pdf](http://www.health.govt.nz/system/files/.../nz-palliative-care-definition-oct07.pdf)

**Specialist palliative care** is *palliative care provided by those who have undergone specific training and/or accreditation in palliative care/medicine, working in the context of an expert interdisciplinary team of palliative care health professionals.*

Specialist palliative care is provided through accredited services (or organisations) that work exclusively in palliative care and meet specific palliative care standards as they are developed nationally. This is usually by a hospice or hospital-based palliative care team where patients have access to at least medical and nursing palliative care specialists.

Specialist palliative care practice builds on the palliative care provided by generalist providers and reflects a higher level of expertise in complex symptom management, psychosocial support, grief and bereavement support. Specialist palliative care provision works in two ways.

1. Directly – to provide direct management and support to patients and families/ whānau where more complex palliative care need exceeds the resources of the generalist provider. Specialist palliative care involvement with any patient and the family/whānau can be continuous or episodic depending on the changing need. Complex need in this context is defined as a level of need that exceeds the resources of the generalist team. This may be in any of the domains of care: physical, psychological, spiritual, etc.
2. Indirectly – to provide advice, support, education and training of other health professionals and volunteers to support the generalist provision of palliative care.

Palliative Care is best delivered through an integrated approach that focuses on the needs of the patient and family/whānau. Such an approach recognises and defines the respective roles of all parties, both specialist and generalist, within a collaborative framework across a given geographical area. An integrated approach can occur in two ways:

**Generalist/specialist integration** – Specialist palliative care services should link with generalist services e.g. general practice, aged residential care, district nursing, Māori providers and hospital teams to ensure that palliative care need is met within a collaborative model that recognises and supports roles and responsibilities of the respective services.

**Specialist/specialist integration** – Depending on the complexity of palliative care need, smaller specialist palliative care services will at times require input from a more comprehensive service with greater specialist resources which may be geographically distant. This could occur on a regional basis with specialist services linking with other DHB specialist services utilising defined linkages and processes.

## Strategies

To support the national vision for provision of palliative care services nine strategies were developed with the aim of building a palliative care culture.

1. Ensure access to essential palliative care services.
2. Each DHB to have at least one local palliative care service.
3. Develop specialist palliative care services.
4. Implement hospital palliative care teams.
5. Develop quality requirements for palliative care services.
6. Inform the public about palliative care services.
7. Develop the palliative care workforce and training.
8. Ensure that recommendations from the Paediatric Review are implemented.
9. Address issues of income support.

## Essential services

Palliative care incorporates a wide range of different services and providers. Care is provided in a variety of settings and requires a case management approach to enable an appropriate combination of interventions by the right providers in the right place, at the right time and based on the needs for each individual and their family/whānau. A full range of essential services ensures access for people to choose the option of dying at home with access to a range of community based services and access to specialist services when required.

Essential services:

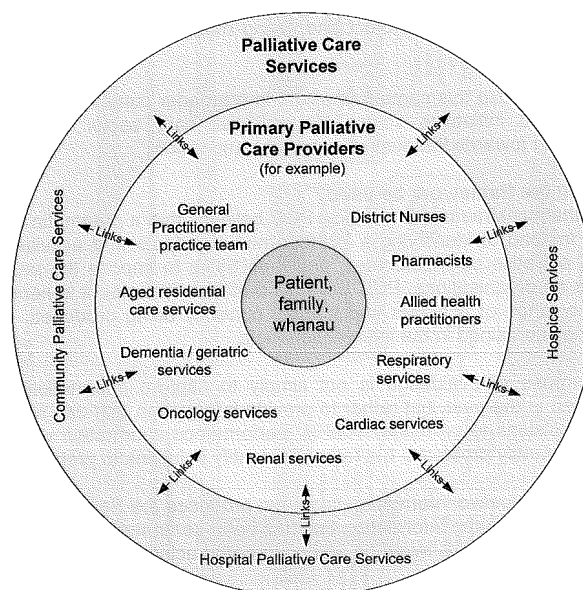
- Assessment – initial and ongoing multidisciplinary team assessment to identify needs early and establish an individualised care plan. General practice services must be included in the multidisciplinary team to ensure continuity of care to the person.
- Care coordination – each person should be allocated a care coordinator. This coordinator is responsible for appropriate information regarding options and services available to the person dying and family/whānau. Patients need to experience a seamless service with smooth and timely transition from one service to another. Timely referral to palliative care service is essential (preferably not in crisis) with smooth access to inpatient care (respite, symptom control) when required. Rapid and straight forward discharge planning and transfer from acute care to palliative care services is also required.
- Clinical care – access to medical services (primary care and specialist), nursing services and equipment to provide symptom control, 24 hours a day, seven days per week in the community. Access to inpatient care for respite and/or control of symptoms (if required or preferred), bereavement counselling and spiritual care before and after death.
- Support care – support in the home and long term residential care in an appropriate setting for people who are unable to be cared for in the home. Older people currently undergo income and asset testing to access residential care.

To ensure people and their family/whānau have access to the essential palliative care services, a service framework is required with a network of two inter-linked levels of care. The two levels of palliative care services will be local and specialist palliative care services. It is important that where there is more than one provider, services are well coordinated to ensure that the dying person and their family/whānau receive seamless care.

## The palliative care “system”

Cancer Control New Zealand and the Palliative Care Council have developed the following diagram which demonstrates the range of providers of palliative care services and the links between them that tie each together.

**Figure 1: The palliative care “system”**



Source: *Measuring What Matters Palliative Care (Draft): Cancer Control New Zealand, as yet unpublished.*



### 3. National palliative care work plan

---

In the last ten years, since the development of the New Zealand Palliative Care Strategy, additional Ministry of Health funding has been made available to support the development of both existing and new palliative services. A number of reviews have been conducted to establish the progress made in implementing the Palliative Care Strategy and identifying gaps and areas requiring further work. A summary of these reviews is included in Appendix 1.

A number of national palliative care service development projects are currently under way which are intended to address the gaps and issues identified in previous reviews and to guide sustainable service provision in the future in the face of increasing demand for palliative care services. As these projects are completed, implications for the DHBs in Midland will be considered and this service plan will be reviewed and updated as appropriate. The current projects are outlined below:

#### 3.1 Specialist palliative care service specifications

---

In February 2008 the Ministry of Health released a draft service specification for specialist palliative care along with \$2M ongoing funding to help DHBs and hospices implement new components of the service specifications (end of life care, 24/7 telephone advice, education to generalists). After wide consultation it was recognised that further service development work was required before submitting the specifications for final approval. The following work is being undertaken:

- development of a resource and capability framework (role delineation model) for palliative care
- development of a national funding approach.

Based on the need to first complete the above work it is anticipated that the completion of the specialist palliative care service specifications will be delayed until mid 2012. It has been indicated that these might be in a more generic form rather than highly itemised.

#### 3.2 National health needs assessment for palliative care

---

The Palliative Care Council of New Zealand recognised the need for a National Health Needs Assessment to determine the need for palliative care in New Zealand on a population basis for all people who would benefit from palliative care. The Phase 1 report: *Assessment of Palliative Care Need* published by Cancer Control New Zealand in June 2011 establishes the number of people who might benefit from palliative care in New Zealand, on both a national and regional basis. Further work will follow which will make an assessment of the services required to meet the identified need and to determine how this compares with current service provision.

#### 3.3 Resource and capability framework (role delineation model)

---

It has been recognised that there are currently variations in palliative care structures and levels of service across New Zealand, with access to palliative care services being described as inequitable and inconsistent. The Ministry of Health initiated a project to develop a resource and capability framework for New Zealand which maps out a structure for palliative care services based on the patients assessed need rather than their diagnosis or locality. It is expected to provide clarity for District Health Board funders to determine the level of services they want to purchase to meet the needs of their region, so palliative care providers can plan their service development with guidance on the appropriate workforce and facilities required.

After consultation within the palliative care sector, a draft framework based on a hub and spoke approach has been proposed for final consultation in the early part of 2012. The draft framework emphasises the targeting of specialist palliative care services to support both those patients and family/whānau with the most complex need and generalist/primary providers. This means it is likely there will be an increase in the acuity of patients seen by specialist palliative care services, with less complex patients cared for by primary care providers.

The framework is expected to be finalised by mid 2012. Once the final framework is known, the impact for Midland will be assessed and a plan for implementation of any agreed changes within Midland will be developed.

Throughout this document we have included (in shaded boxes) some of the key actions recommended in the draft Resource and Capability Framework where they relate to particular issues or needs identified in the Bay of Plenty.

### 3.4 Health Workforce New Zealand palliative care workforce service review

---

Health Workforce New Zealand has recently published the results of a workforce service review to develop a vision and model of palliative care service and workforce for 2020 in a context of increasing demand and limited funding. A key recommendation of the review is the development of eight regional palliative care managed clinical networks, which are linked nationally, to manage palliative care in New Zealand. Recommendations include:

- development of a funding model for community palliative care
- utilisation of advanced nursing roles
- development of the roles of allied health professionals in palliative care.

While it is recommended that one of the eight clinical networks would align with the current Midland DHB grouping of Lakes Bay of Plenty and Waikato DHBs there could be future implications for service alignment based on the Midland five DHB model (inclusive of Taranaki and Tairāwhiti DHBs) and the recommended eight clinical network groupings.

The recommendations of the workforce service review have not yet been endorsed. It is proposed to test the concept with a demonstration pilot/s in 2012.

### 3.5 National specialist palliative care data definitions and business process

---

The specialist palliative care community in New Zealand has identified the need for nationally endorsed data standards to provide a basis of a common language for discussions between stakeholders and for understanding palliative care in New Zealand.

A draft Business Process Standard and associated Data Definition document were made available for comment during the early part of 2011. These documents are intended to ensure that minimum agreed palliative care data is collected and stored in a consistent manner whenever it is collected and stored. The finalised documents are awaiting approval and release by the Ministry of Health.

### 3.6 Measuring What Matters: Palliative Care

---

The report by Cancer Control New Zealand in 2010 identified a lack of monitoring and evaluation of the Palliative Care Strategy. The Palliative Care Council, in consultation with the Ministry of Health, Hospice New Zealand and with input from other stakeholders, has been working on developing a framework for palliative care that will generate information to inform strategic decision making across all health settings in New Zealand.

A draft document from the Palliative Care Council presents a palliative care outcomes framework using an intervention logic approach (Appendix 2). This has been developed to articulate the desired outcomes and impact of activities across the palliative care sector. Although this work is not yet complete we have used the outcomes framework to present the recommendations and actions of this service plan.



### 3.7 Liverpool Care Pathway (LCP)

---

The Liverpool Care Pathway for the Dying Patient is an evidence-based, integrated care pathway developed in the UK for the last days and hours of life. The LCP guides health care professionals to deliver best practice care to dying patients and their families/whānau in the last days and hours of life, irrespective of diagnosis or care setting. The eighteen 'goals of care' in the LCP are measurable and facilitate audit and benchmarking of end-of-life care.

The LCP has been implemented into hospitals, residential care facilities, in the individual's own home/community and into hospices in NZ. It is recognised as a best practice model for care of the dying by the Ministry of Health.

In 2008, additional funding was made available for district health boards to implement 'last days of life care programmes' which has resulted in a significant increase in the use of LCP nationally.

The National LCP Office NZ was established in November 2008 and is funded by the Ministry of Health to coordinate the sustainable implementation of the LCP in NZ. It aims to make significant improvements in the quality and consistency of LCP provision in NZ, including the development of a national database to facilitate benchmarking.

### 3.8 Advance care planning for adults

---

Advance care planning (ACP) is a process of discussion and shared planning for future care. It is patient- focussed and includes the health professionals involved in the person's care.

A National Advance Care Planning Cooperative has been formed to facilitate the development and deployment of ACP services in New Zealand. The vision of the cooperative is that *"All people in New Zealand will have access to comprehensive, structured and effective advance care planning."*

A guidance document on ACP in the New Zealand context and a number of supporting publications have been published by the Ministry of Health. While ACP is not palliative care specific, it is not included elsewhere in DHB plans in the Midland region. There is an opportunity with this planning process to consider the implementation of ACP within primary care, aged care, hospice and hospital services. A roll-out plan similar to that implemented for LCP could be considered as a collaborative project within Midland.

Elsewhere in New Zealand (Auckland, Counties Manukau and Wanganui) ACP projects have commenced and will provide additional information to inform an implementation project within Midland.

### 3.9 The Gold Standards Framework (GSF)

---

The GSF in use in the UK National Health Service is simply a way of pulling together all the good things that occur in the primary care setting in a way that supports and encourages evidence based best practice. It is concerned with helping people to live well until the end of life and includes care in the final years of life for people with any end stage illness in any setting.

GSF improves the quality, coordination and organisation of care in primary care, care homes and acute hospitals. This enables more patients to receive the type of care they want, in their preferred place, with greater cost efficiency through reduced hospitalisation.

The key goals of the framework are to improve:

- teamwork and continuity of care
- advanced planning, including out of hours
- symptom control
- patient, carer and staff support
- benefits identified from implementation of the framework are:
- better assessment and control of symptoms
- more patients dying in preferred place of choice

- better planning and fewer crisis calls and admissions through more proactive care
- improved carer support and information
- improved staff confidence, communication and co-working with hospital and specialists

The model has a community palliative care compass that has seven points aiming for better care for patients at home in the last years of life.

- Communication
- Coordination of care – nominated co-ordinator
- Control of symptoms
- Continuity - out of hours and between services
- Continued learning
- Carer support (emotional, practical, bereavement and staff support)
- Care of the dying phase – LCP.

Currently in New Zealand, there is some varied use of concepts of the GSF. While the value of the framework is generally acknowledged there is no widespread implementation into care settings.

### 3.10 Palliative care education and standards

---

In 2009, the Ministry of Health and Hospice New Zealand considered the results of the national stock-take into service provision. Nationally, there were two areas of need that required focus.

- The need for nationally consistent education programmes that support generalist palliative care providers.
- The need for revised palliative care standards and an ongoing implementation programme to ensure consistency in the quality of service regardless of locality.

Hospice New Zealand coordinated two projects to address the identified needs. Results of the projects were piloted in 2011 and implementation has commenced as follows.

#### **Education**

A *Fundamentals of Palliative Care* learning package has been developed is now released for use by hospices as a part of their education programmes offered to generalists. The initial focus for implementation is gerontology services and residential aged care; however the learning packages will be adapted over the next two years for other settings where a palliative approach is required e.g. general practice, hospital/acute care and district nursing.

The Hospice New Zealand Caregiver Assistant package will be revised and brought into alignment with the Fundamentals programme.

#### **Standards**

New standards for hospice care “*Hospice NZ Standards for providing Palliative Care*” have been developed and are being implemented across New Zealand hospices.

It is anticipated that the standards will be mandatory for member hospices of Hospice New Zealand and will be supported by an audit tool developed by Hospice New Zealand. It is not clear yet how the standards will link with district health board contracts and audit processes and whether the standards should apply to other palliative care providers such as hospitals and residential care.

## 4. Midland region context

---

The Midland region includes the Bay of Plenty, Lakes, Taranaki, Tairāwhiti and Waikato DHBs. For many years collaborative activity has occurred amongst the DHBs. To meet service and financial needs and ministerial expectations the DHB chairs and chief executives recognised the need for a more structured and coordinated regional approach to planning and delivery of services. In March 2011 the Midland Regional Cooperation Project commenced with priority given to the implementation of the Regional Clinical Services Plan, coordinating regional clinical networks (including the Midland Cancer Network) and assessing back office and support functions that could be advanced regionally.

The cancer networks are accountable to the DHBs. The geographical boundaries of the regional cancer networks in New Zealand were established on the historical non-surgical cancer treatment flow. Based on this Tairāwhiti and Taranaki currently aligns with the Central Cancer Network, but have an open invitation to the Midland Cancer Network when required. As of 1 August 2011 the Midland Cancer Network now operates from HealthShare, the regional vehicle to drive regionalisation requirements.

A Midland Palliative Care Work Group comprising Lakes, Bay of Plenty and Waikato stakeholders was established in December 2007 as a service specific work group under the umbrella of the Midland Cancer Network<sup>6</sup>. The purpose of the work group is to:

- take a proactive leadership role to oversee the implementation of agreed regional palliative care initiatives for the Midland region
- support and advise the participating organisations about issues, activities and priorities related to the delivery of palliative care services across the Midland region.

The work group membership now has wide representation including primary care, PHOs, hospices, secondary and tertiary hospital service managers, hospital based specialist palliative care, planning and funding and regional Māori Health services. This region wide, all of sector approach has worked successfully to develop palliative care services through the sharing of resources and expertise as well as by using a collaborative approach to address common issues and activities.

It was agreed in December 2009 that a co-ordinated approach to palliative care service planning would be taken and would incorporate district plans with a regional view.

---

<sup>6</sup> Palliative Care (malignant and non-malignant) is part of the Midland Cancer Network work programme.

## 5. Local Bay Of Plenty DHB palliative care

---

### 5.1. Bay of Plenty District Health Board strategies

---

The Bay of Plenty ***District Strategic Plan 2005-2015*** outlines the priorities for the DHB over the ten year period to 2015. The DHB is committed to working with it's communities to achieve greater health, remain healthy and care for people when they need care. Meeting the Government imperatives including implementing the New Zealand Cancer Control Strategy which incorporates palliative care, are a priority.

The DHB has one of the fastest growing populations of over-65 year olds in New Zealand. A key outcome in the plan which has particular relevance for palliative care is for healthy, independent and dignified ageing and recognises the need to:

- modify community norms and perceptions relating to ageing and death
- strengthen community capacity to provide resources to support older people
- develop appropriate services for older people with end-stage chronic conditions to support dying with dignity
- work with communities to develop safe environments for older people particularly those with dementia.

The DHB has recognised a number of key capacity and capability issues. These include the rurality of large portions of the DHB population, difficulty developing and maintaining consistent levels of key competencies for delivering quality services across the care continuum and coping with an increasing rate of complex and multiple chronic conditions. Each of these is applicable for the delivery of palliative care where a key focus is to provide support for people to die in their place of choice which, for most people, is at home.

In order to achieve health for Māori and act consistently with the direction set in He Korowai Oranga, the New Zealand Māori Health Strategy, BOP DHB has identified the following priorities.

- Consistent with rangatiratanga, Māori will maximise their health.
- To increase the capacity of Māori providers and communities to meet their own health and independence needs.
- To ensure responsiveness of mainstream services to Māori.

The DHB is working towards achieving by Māori for Māori services and has developed a strong participation framework for Māori throughout the DHB's governance and service provider structures. The DHB has a commitment to invest and support the following:

- Māori provider assistance
- accelerated workforce development initiatives, by Māori for Māori
- service developments that promote integration and coordination
- identification of best practice and procedure models that promote cultural values and tikanga practices.

## 5.2. Bay of Plenty palliative care strategy 2003

---

In 2003, a palliative care strategy was developed which is outlined in the document *Palliative Care in the Bay of Plenty District Health Board – Evaluation of Need and Proposed new Directions*.<sup>7</sup>

This strategy focussed on:

- developing a consistent palliative care approach
- establishing a district palliative care network
- organising a single point of co-ordination
- building provider capacity and capability
- developing a comprehensive continuum of care.

In 2007, an exercise was undertaken to review progress of the implementation of the 2003 strategy and recommendations contained therein. A draft report was prepared titled *Evaluation of the Implementation and Impact of the Bay of Plenty District Health Board Palliative Care Strategy* November 2007. There is acknowledgement that the 2007 implementation review was a less than optimal process and it is understood the document remained in draft and was not endorsed.

For the purpose of this palliative care service planning process the recommendations contained in the draft 2007 report have had a high level review to determine those that still have relevance today and to ensure these are considered in the current discussions. There has not been a detailed review against the 2007 draft report.

Areas that are considered still relevant today and where progress is required.

- Refresh the Bay of Plenty Palliative Care Network (completed 2011/12).
- The establishment of hospital palliative care services for Tauranga and Whakatane hospitals (discussions in progress, refer to section 6.4).
- Ongoing need to educate generalists on the role of palliative care, to increase their ability to provide care using a palliative approach for their patients and to promote timely referral to specialist palliative care services where required (In progress, refer to section 5.5 subtitle Education).
- Development of the palliative care concepts for supporting non-malignant conditions.
- Building mainstream service responsiveness to the needs of Māori and strengthening relationships with Māori health providers (BOP Maori palliative care hui held 2011 to start the process, refer to section 5.4).

---

<sup>7</sup> *Palliative Care in the Bay of Plenty District Health Board – Evaluation of Need and Proposed new Directions*. Produced by the Planning and Service Development, Bay of Plenty DHB, draft report May 2003.

### 5.3. Bay of Plenty DHB geographic and population demographics



The BOP DHB is made up of five territorial authorities (TAs) which, in total, cover an area of 9,666 square kilometres. These TAs are grouped into Eastern and Western Bay of Plenty and the DHB services are generally aligned to these groupings with Tauranga Hospital in the WBOP and Whakatane Hospital in the EBOP. The palliative care specialist services also align to these groupings

The BOP DHB population at the 2006 census was 200,750. In terms of population size, the DHB is 8th largest out of 20 district health boards in New Zealand. However, the DHB has the second fastest growth rate of all DHBs<sup>8</sup>.

In the five year period of this planning document (2011 to 2016) the population is predicted to grow by 5.6% (12,000). This rate of growth is higher than that for New Zealand as a whole (+4%). The majority of the growth is expected to be in the WBOP (particularly Tauranga City) with the EBOP expected to experience a static or declining population.

The characteristics of the Eastern and Western Bay of Plenty areas are considerably different. These are summarised in Table 1. Detailed demographics and graphs are provided in Appendix 3

<sup>8</sup> Bay of Plenty District Health Board Annual Plan 2011/21 Statement of Intent 2012/13, pg 7

Much of the population in the EBOP is dispersed into small rural communities many of which are isolated in terms of distance and many of these areas are of high deprivation. In the WBOP the population is more concentrated on the larger urban area of Tauranga.

**Table 1: Characteristics of the BOP DHB by territorial authority**

	<b>Eastern Bay of Plenty</b>	<b>Western Bay of Plenty</b>
Territorial Authorities	<ul style="list-style-type: none"> <li>Whakatane</li> <li>Kawerau</li> <li>Opotiki</li> </ul>	<ul style="list-style-type: none"> <li>Western Bay of Plenty</li> <li>Tauranga city</li> </ul>
Population at 2006 census % of BOPDHB region	50,850 25%	149,900 75%
Estimated population at 2011 Estimated population at 2016	50,740 50,160	163,200 175,800
Predicated population change between 2011 & 2016	-1.1% (decline of 580)	+7.7% (increase of 12,600)
Māori population	25,000 (approx 50% of the EBOP population )	25,000 (approx 17% of the WBOP population)
Population characteristics	<ul style="list-style-type: none"> <li>Young population</li> <li>High proportion of Māori</li> <li>Slow population growth</li> <li>Lower life expectancy</li> <li>More lower socio-economic communities many rurally isolated</li> </ul>	<ul style="list-style-type: none"> <li>Older population</li> <li>Lower proportion of Māori</li> <li>One of the fastest population growth rates</li> <li>Higher life expectancy</li> <li>Non Māori in these areas tend to have less family support</li> </ul>
% aged 65 years and over 2006 2011 (estimated) 2016 (estimated)	13% 14% 17%	17% 18% 20%
Number of deaths 2006 2011 (estimated) 2016 (estimated)	360 428(+18%) 457 (+6%)	1220 1290 (+5%) 1450 (+12%)

### Population ageing

Of relevance to the palliative care services is the ageing population. In general about 70% of patients who access specialist palliative care services are over 65 years so the increasing proportion of those in this age group will increase demand for both generalist and specialist palliative care services.

In 2006, 16% of the population were aged 65 yrs and over which is higher than the national rate of 12%. By 2016 this is expected to be 19% in the region and will continue to increase as the large baby boom generation begins to enter this age group. The number of people aged 65 and over is projected to increase in each of the areas with the most significant increase occurring in Tauranga which is a popular retirement destination.

The number of deaths is estimated to increase by 11% between 2011 and 2016 (189 additional deaths). The greatest increases are estimated to occur in the territorial authority areas of WBOP growth of 15% (n = 50) and Tauranga city growth of 11% (n = 110).

### Ethnicity

In 2006, 25% of the population identified as Māori, 1% Pacific people and 74% European/Other. Nationally Māori make up about 15% of the population. However, within the DHB a much higher proportion of Māori live in the EBOP area. In 2006, 50% of the people living in EBOP were Māori compared with 17% in WBOP.

The Māori population is predicted to increase by 8% (n=4,300) between 2011 and 2016.



### Socioeconomic measures

New Zealand research has shown that there is a strong association between socioeconomic deprivation and health outcomes. This is measured by the New Zealand Index of Deprivation 2006 (NZDep06). Areas with high NZDep06 scores are associated with poorer health.

In the DHB about one quarter of the population (50,000 people) live in areas with high deprivation scores. About one in seven live in areas with low scores (associated with better health).

Socioeconomic deprivation is much greater in EBOP than in WBOP. In Kawerau and Otago districts nearly 70% of the population lives in areas of high scores (quintile 5) and 40% in Whakatane district, compared to 20% in WBOP district and Tauranga city.

The areas with the highest proportions of Māori tend to correlate to the areas with high socioeconomic deprivation. Nearly 60 percent of Māori live in areas of high scores (quintile 5) compared to 20 percent of non-Māori.

## 5.4. Health needs of specific population groups

---

The DHB takes a population approach to building healthy, thriving communities. Different population groups have varying palliative care needs, which require unique interventions to enable appropriate care. This section combines the analysis of the key population characteristics and recommendations from the New Zealand Palliative Care Strategy to consider the requirements for specific groups within Bay of Plenty.

### Māori

As a population group, Māori have on average the poorest health status of any ethnic group in New Zealand. Māori aged 50 and over have higher rates across many health conditions and chronic diseases than non-Māori of the same age group. This includes rates of cancer, diabetes and cardiovascular disease. Of particular concern is that the overall cancer mortality rate for Māori is considerably higher than that of non-Māori. This is not acceptable, and the Government and the MOH have made it a key priority to reduce the health inequalities that affect Māori.

The New Zealand Palliative Care Strategy emphasised the following.

- Palliative care services are to have policies in place that recognise the specific needs of Māori.
- There are linkages between palliative care providers and Māori development organisations and that a plan for services for local Māori is developed to assist in meeting the specific needs of Māori.
- At a local level, where appropriate, each provider should employ one or more care coordinators who could meet the special needs of Māori, particularly in areas with a high Māori population. The care coordinator would coordinate services and work with the whānau to ensure that the needs of the dying person are met in a culturally appropriate way. The care coordinator could be employed in conjunction with local Māori health providers. It is important that the principles of cultural safety are recognised in the employment of Māori.

2006 Census data shows:

- BOP has a Maori population higher than the national average (Bay of Plenty 25%, national average 15%)
- within the DHB a much higher proportion of Māori live in the Eastern Bay of Plenty area (of all the Māori living in BOP, 50% are in EBOP; and 47% of the people living in EBOP are Māori compared with 17 percent in WBOP)
- the highest proportion of Māori reside in the EBOP where the socioeconomic deprivation is greatest.

In addition:

- eighteen iwi are located within the DHB area
- the DHB has the highest number of Māori providers of any DHB (50).

These unique characteristics provide both opportunities and challenges in the development and delivery of services.



Specific hui held with Māori throughout Midland identified some particular common priorities for Māori. These are summarised as the need for:

- appropriate information available for Māori to raise awareness of palliative care services
- education in palliative care for Māori health providers
- awareness and education sessions targeting specific parts of the community e.g. kaumātua, whānau as carers
- the development of Māori into palliative care careers
- specialist palliative care services to include an understanding of Whānau Ora and Tikanga in relation to palliative and end of life care in their staff orientation and education programmes
- non-Māori palliative care staff to be taught basic Te reo to enhance communication and understanding between them and their Māori patients and their family/whānau (especially in the absence of any Māori palliative care staff)
- strategies to support whānau carers to care for their relative in the community.

### People with disabilities and nonmalignant diseases

People with disabilities will often require more support care and resources such as equipment and flexible packages of care to maintain them in their home and support their family.

Traditionally specialist palliative care services have focussed on improving conditions of people who are dying from cancer. Emerging needs of people with other life limiting nonmalignant diseases can benefit from palliative care services. These include:

- heart failure
- end stage renal failure
- chronic obstructive airways disease
- liver failure
- motor neurone disease
- multiple sclerosis
- HIV/AIDS.

These illnesses are often longer in duration than a disease such as cancer and often require a higher complexity of support care. Literature indicates that people with nonmalignant diseases can have improved quality of life through access to palliative care services when required. According to the New Zealand Palliative Care Strategy, 90% of people cared for by hospices in 1998/99 had cancer and 10% had nonmalignant diseases. It was predicted that more people with non-malignant diseases would access palliative care and hospice services.

More recent data from the hospices in Bay of Plenty shows a changing proportion of their patients with a non-cancer diagnosis. Information for 2010<sup>9</sup> shows:

EBOP: 72 percent had cancer and 28 percent had other nonmalignant diseases

WBOP: 88 percent had cancer and 12 percent nonmalignant diseases.

The WBOP is experiencing a slower shift in the make-up of patient diagnoses due to the higher proportion of the very elderly residing in Western Bay of Plenty and cancer is more often associated with this age group.

Detailed analysis of the reasons has not been carried out but factors contributing to the change could include:

- an increasing prevalence of non-cancer conditions
- greater awareness of the role and value of palliative care and hospice services for those with non-malignant diseases leading to more referrals of these types of patients by GPs and hospital specialists etc
- an increased public awareness that hospice services are not just for those with cancer.

---

<sup>9</sup> Measured across all patients who died or were transferred in the calendar year.

### People in rural Bay of Plenty

According to the 2006 Census, 79% of the Bay of Plenty population lives in urban<sup>10</sup> areas compared to 86% nationally, and 21% live in rural areas compared to 14% nationally.

Most of the geographical area that is rural and remote falls into the EBOP district, with many isolated from basic primary health services and required to travel long distances to access specialist secondary or tertiary care. This rural isolation impacts on health providers and professionals servicing these populations.

In addition, just under half the population in the EBOP live in areas of high deprivation (48%). Financial hardship is common amongst residents in rural EBOP. Many do not have personal transport or cannot afford the cost of petrol to attend doctors appointments, have no access to public transport, cannot afford telephones and in some areas there is no cellphone coverage to be able to communicate easily, some cannot afford medications from the pharmacy especially when sourced on a public holiday (some pharmacies add surcharges). For many it is simply too hard or too expensive to access health services.

Patients living in rural areas face significant personal costs when needing to be transported to and/or from their home and residential care especially if ambulance transport is required due to the person's condition. The patient is charged the full cost of the ambulance transfer which can in some cases be several hundred dollars. From time to time the families choose to use alternative means of transport which can cause significant discomfort for the patient and can be particularly unsafe.

Issues also arise for palliative care service delivery to patients in remote rural areas. With long distances to travel, few patients can be seen in a day requiring more nurses to support a model of home based care for rural areas. When there is no out of hours GP in an area the ability for hospice nurses to respond to patient needs out of hours becomes complex, expensive and can be delayed if a visit is required rather than support by phone. Shared care arrangements with district nurses have been one way to minimise some of these factors. However, district nurses who do not provide palliative care as a part of their normal case load generally lack the skills to provide out of hours care for palliative patients e.g. they cannot change subcutaneous syringe drivers.

---

<sup>10</sup> Urban and rural areas are determined by Statistics New Zealand. Urban areas are centred on a major city and include neighbouring areas which are regarded as suburban and belonging to that city. Rural areas are those areas not specifically designated as 'urban' they include towns of fewer than 1000 population.

## 5.5. Current Palliative Care Services

People who are dying can receive services from a wide range of providers as described in Table 2. Access is dependent on the availability of services in each area.

**Table 2: Overview of providers of palliative care**

Level of Care	Provider	Type of care
Generalist*	Primary care practices - GPs and practice nurses	Primary care in the community
	Residential care facilities	Private hospital and rest home care
	District nursing services	Community (home based) care
	Public hospital services (e.g. ED, renal, cardiology, oncology)	Inpatient and outpatient palliative care (non-specialist)
	DHB allied health staff (e.g. occupational therapists, physiotherapists, social workers)	Assessment for equipment etc, therapy, access to support services
	NGOs and volunteer organisations e.g. home support agencies, carer support agencies, Kaitiaki Nursing Services, Cancer Society, support groups such as Alzheimer's, Multiple Sclerosis	Support care
Specialist*	Waipuna Hospice	Specialist inpatient care Day care Community care
	Hospice Eastern Bay of Plenty	Day care Community care

**\*Generalist** palliative care providers are any health professionals involved in the care of someone with a life threatening illness, often with no formal training in palliative care. Palliative care is not their primary role or function.

**\*Specialist** palliative care providers are health professionals trained specifically in palliative care working within a multidisciplinary specialist palliative care team.

### Settings

Palliative care occurs in a range of settings and requires a case management approach to enable the appropriate combination of interventions by the right providers in the right place, at the right time and based on the needs for each individual and their family /whānau.

These settings include:

- patient's home (the home of their choosing e.g. own home or family/whānau home)
- residential care facilities
- primary care
  - General practice rooms
  - General practice home visits
  - General practice after hours care facilities
- Tauranga and Whakatane hospitals
  - Emergency department
  - Inpatient wards
  - Outpatient services
- Waipuna Hospice inpatient unit, outpatient clinics and day programme facilities
- Māori health provider and marae based services
- other volunteer and supportive care services such as Cancer Society in their facilities or through home visits.

## Generalist palliative care in Bay of Plenty

- **Primary health care /general practice teams**

For people with a health need the general practice is usually the first and most frequent point of contact with the health service. All palliative patients are encouraged to have a general practitioner (GP) and the GP remains responsible for their overall care even though they may receive intermittent or episodic care from a palliative care specialist service.

Most, if not all, GPs will have a number of patients requiring palliative care each year. Many patients and family/whānau need for palliative care will be appropriately met by the general practice team and will not require the input of specialist palliative care services. Others may have more complex needs that cannot be met by the GP alone and would benefit from the additional expertise and/or wider support services of the specialist services. In most cases the need for specialist services is likely to be episodic rather than ongoing.

Primary Health Organisations (PHOs) are responsible for organising and delivering primary health care services to meet the needs of their enrolled population. They are funded by the Ministry of Health via DHBs based on the number and characteristics of their enrolled population. There are three PHOs in the Bay of Plenty area and approximately 95% of the Bay of Plenty population is enrolled with a PHO – see Table 3.

The percentage split between Māori and non Māori enrolled patients is very similar to the makeup of the general population. i.e. 25% of the BOP population is Māori and approximately 24% of the enrolled PHO population is Māori.

**Table 3: PHOs in Bay of Plenty and enrolled population as at Quarter 1, 2012**

PHO	PHO Enrolled Population				
	Total enrolled	Māori	%	Non Māori	%
Eastern Bay Primary Health Alliance (EBPHA) <sup>11</sup>	45,928	21,203	46%	24,725	54%
Western Bay of Plenty PHO <sup>12</sup>	142,974	18,793	13%	124,181	87%
Nga Mataapuna Oranga Kaupapa Māori PHO <sup>13</sup>	10,906	8,348	77%	2,558	23%
<b>TOTAL</b>	<b>199,808</b>	<b>48,344</b>	<b>24%</b>	<b>151,464</b>	<b>76%</b>

Source: Ministry of Health PHO Enrolment Demographics 2012 Qtr1 (Jan – March 2012)

<http://www.health.govt.nz/our-work/primary-health-care/about-primary-health-organisations/enrolment-primary-health-organisation> Accessed 20.01.2012

There is no specific categorisation or reporting of palliative care work undertaken by PHOs or general practices and therefore this component of work of primary practice cannot be quantified.

There is a mixed level of engagement of GPs in providing palliative care. Many GPs consider it to be an integral and valuable part of their work. Some prefer not to provide palliative care or end of life care. The varied level of commitment by GPs to providing comprehensive palliative care, including being available after hours, and willingness to do home visits or visits to patients in residential care is of significant concern. Often there is inadequate handover to GP colleagues. Some after hours cover arrangements such as the use of A&E centres do not suit the requirements of palliative patients as many patients are not ambulatory and cannot attend an out of hours clinic. Concern is also expressed at the increased use of locums where locums may not have adequate palliative care experience and lack an understanding of the patient's care plan and local support services and processes. There is anecdotal evidence that the variable access to suitable GP services after-hours results in additional demand on

<sup>11</sup> Formed on 1 October 2010 from the amalgamation of the three PHO's of the Eastern Bay Of Plenty - Eastern Bay of Plenty PHO, Kawerau PHO, Te Ao Hou PHO

<sup>12</sup> Joint venture partnership between Ngati Ranginui and Ngaiterangi Iwi and the WBOP Care Providers Inc (Provider Inc).

<sup>13</sup> The majority of the enrolled population is Māori. The PHO practices Māori values and philosophy of Te Reo, Rangatiratanga, Whakapapa and Whanaungatanga with Māori governance and management. The services are described as "By Māori for Māori but not exclusive to Māori."

emergency services such as the ambulance service and results in avoidable presentation at emergency departments and acute admissions to hospital. In some cases, it also results in palliative care medical specialist being required to provide care after hours which should be provided by the patient's GP. Residential care facilities report that some residents die in pain unnecessarily due to the difficulty in getting GPs to prescribe after-hours or in the weekend.

There is difficulty maintaining up-to-date knowledge and skills in caring for palliative patients when GPs may only care for a few palliative patients each year. The need for specialist palliative care services to give advice and support to GPs, to provide on-going education opportunities and to develop tools, clinical guidelines and quick reference information for GPs is a critical role for the specialist services.

Some GPs choose to develop a special interest in palliative care but the ability for them to access funded palliative care diploma training placements is limited.

In general, the method of funding general practice visits is not conducive to providing palliative care. The length of time given for a routine GP appointment is insufficient for providing a quality palliative care service which requires considerably more time to be spent talking with the patient and family/whānau. Many GPs are reluctant to charge the patient for the cost of the extended consultation and, in many cases, the patient could not afford to pay the actual cost.

Alternative palliative care funding schemes are being used elsewhere in New Zealand such as the MidCentral DHB Palliative Care Partnership. This is an example of palliative care primary and secondary integration which provides an alternative funding scheme which aims to reduce the barriers to primary health care for palliative patients.

The Ministry of Health Services to Improve Access (SIA) funding is available in some areas although it is not universally available or applied to reduce the cost barriers for palliative patients. The Eastern Bay PHA is currently looking at developing a scheme using SIA funding for this purpose.

- **Community (home based) care**

#### ***Nursing care***

Good home based care is required for people to be able to choose to die at home and for the patient and family/whānau to be well supported during this time.

There are two main primary palliative care nursing service delivery models in Bay of Plenty. WBOP is resourced by hospice nurses. EBOP includes district nurses in some areas but is not a full shared care model. These models have developed to address the different characteristics of Eastern and Western Bay of Plenty.

1. In WBOP, Waipuna Hospice provides care co-ordination and 24/7 nursing care to enable palliative patients to be cared for at home. Patients may be cared for in the community by the DHB district nursing service until they are considered to have reached a palliative stage at which time they are transferred to the care of Waipuna Hospice who work in conjunction with the patient's GP and other service providers. The hospice employs a team of registered nurses and health care assistants to provide home based care.

The hospice works closely with the Kaitiaki cancer support nurses who provide services and home visits for Māori patients and their whānau affected by cancer.

2. In EBOP the population is spread over a wide geographic area with small remote settlements. Economies of scale preclude a full hospice community palliative care nursing service in all parts of the district. Hospice Eastern Bay of Plenty provides palliative care coordination and 24/7 palliative nursing care in people's homes for most of the district however, in the more remote areas of Te Kaha and Murupara a shared care model with district nurses is used. With distances to travel and patient numbers it is not possible for the hospice nurse to visit every day. In these areas the hospice works closely with district nurses and GPs to provide specialist input when required.

There is also a shared care type arrangement within the hospice team. A district nursing oncology/palliative care role sits within the hospice and works as part of the hospice nursing team

with the oncology/palliative district nurses employed and funded as part of the DHB Community Services. There are two part time nurses in this role with a total of 0.6 FTE allocated for palliative care patients. During the consultation phase this arrangement was highlighted as an issue by some stakeholders.

In a mixed model of care it is difficult to develop and maintain up to date knowledge and skills in palliative care when there are small patient numbers and/or patients on an intermittent basis. While it might seem easier for palliative nurses to do all the palliative patient work it also de-skills the district nurses and takes away some flexibility in rural areas where district nurses are located throughout the community. If increasing shared care arrangements is promoted as a way of coping with increased demand for community based palliative care then issues of skill level of district nurses will need to be addressed.

The hospice works closely with Māori health providers in EBOP and works directly with family and whānau as carers to educate them on the role they have as the in-home carer and support.

### ***Home help and personal care services***

In the WBOP this service is provided through Waipuna Hospice using health care assistants for patients that have a diagnosis of cancer or end stage renal failure and who have a prognosis of less than six months. The hospice provides up to three personal care and one home help visit per week. This is designed to facilitate patients remaining at home for as long as possible and focuses on those patients who have no carer support or carers who themselves are too frail to cope. However, three visits a week are inadequate to meet the needs of many of the frail patients and because of this there is a tendency for the most frail and most vulnerable patients to be transferred from home to aged residential palliative care beds (which are funded by the DHB) when they would otherwise be able to reside at home if a seven day service was available.

In EBOP palliative care home help needs are assessed by Hospice EBOP. The services are coordinated by hospice but provided by other agencies including Disability Resource Centre and Te Puna Ora O Mataatua Health Care NZ. Funding is provided via Support Net<sup>14</sup>. During the stakeholder consultation there were no issues reported with the provision of this service. However, the need was stressed for carers employed by the home care provider organisations to have appropriate palliative care education which requires the support of their employer e.g. release time to attend education sessions.

The level of service that is provided for palliative patients under Waipuna Hospice care is inequitable when compared to the services provided by Support Net and district nursing for other patients who do not come under the Waipuna palliative contract (which covers only those that have a diagnosis of cancer or end stage renal failure). The entitlement under Support Net and district nursing is based on assessed needs for individuals and can be for up to seven days per week home help/personal care.

The New Zealand Palliative Care Strategy defines the set of essential services that dying people and their families/whānau should have access to including 'Support Care based on need'. Support care includes support in the home. The draft Resource and Capability Framework states as one of the principles underpinning the framework "Palliative care services will be provided according to need in a seamless manner, regardless of setting, diagnosis or location".

---

<sup>14</sup> Support Net provides Needs Assessment and Service Co-ordination (NASC) services for people in the Bay of Plenty. A NASC helps people with disabilities or difficulties carrying out daily activities due to age, get the support they need to be as independent as possible in their home or community.

- Residential care

Residential care is provided by rest homes and private hospitals and a small number have specialised services to cater for dementia and other mental health needs. There are total of 32 residential care facilities in Bay of Plenty providing services of different levels that are funded and contracted by the DHB. Table 4 shows the number of beds and number of facilities where these are available.

**Table 4: Bay of Plenty Residential Care Beds**

Bed level	Number of beds	Number of facilities with each bed type
Rest home	731	32
Private hospital	768	20
Dementia	113	9
Psychogeriatric	36	1
	<b>1648</b>	

Source: BOP DHB Planning and Funding

At present the occupancy rate in these facilities in Bay of Plenty is high – 92% overall in WBOP and 97% overall in EBOP. Hospital level beds in EBOP are frequently all full.

Information on the total number of deaths in these facilities has not been made available.

Rest homes generally provide care for frail, elderly people using health care assistants. A private hospital cares for the elderly who need nursing due to illness and disability and these facilities employ a mix of registered nurses and health care assistants.

Residential care facilities carry much of the burden of caring for dying patients. For many people the residential care facility is their home – they are essentially there until they die. Many die in a rest home or private hospital without the need for specialist palliative care input.

The Australian Productivity Commission's report<sup>15</sup> suggests palliative and end of life care should be core business for aged care services yet in practice the quality of care is variable and residents are transferred to hospital when the needs are beyond the resources of residential care staff. The specialist palliative care services have an important role to play in supporting staff who are predominantly caregivers rather than registered or enrolled nurses, to deliver effective palliative care.<sup>16</sup> High staff turnover which is a longstanding and common characteristic of this sector, increases the need for regular education to be available.

The Liverpool Care Pathway for care of the dying patient is being implemented in many of the residential care facilities in Bay of Plenty.

Patients under the care of the hospices may require short-term respite care in a residential care home or long term residential placement when they are unable to be cared for at home or where the caregiver at home requires a break. To support this need, the Bay of Plenty DHB purchases nine hospital level rest home beds for palliative care as detailed in Table 5.

These are dedicated beds, purchased directly by the DHB on a block basis irrespective of occupancy. There is also some flexibility to purchase additional beds in other locations if required. Access to the funded beds in Western Bay of Plenty is prioritised to patients with cancer or end stage renal failure.

<sup>15</sup> <http://www.pm.gov.au/press-office/productivity-commissions-final-report-disability-care-and-support>

<sup>16</sup> Hall B. *Resource and Capability Framework for Adult Palliative Care Services in New Zealand* – Draft for consultation, November 2011.



**Table 5: Residential care contracted beds for palliative care**

Name of facility	Location	No. of beds
<b>Western Bay of Plenty</b>		
Althorp Private Hospital	Tauranga	4 beds
Hodgson House	Tauranga	3 beds
<b>Eastern Bay of Plenty</b>		
Golden Pond Private Hospital	Whakatane	2 beds
A flexible fund (via SupportNet) exists for people in residential beds when the 9 beds are full or the patient and family are located in geographical area such as Katikati, Te Puke, Opoitiki, Kawerau or Murupara. This fund equates to approximately 3 additional beds at any one time per annum.		

Beds are fully funded for the first three months. If a patient survives beyond three months, they are transferred to long term aged residential care funding (or if under 65 then access Long Term Conditions for People with Chronic Health Conditions funding). The occupancy rate in palliative care beds varies between 85-95%.

As the population and the proportion of those aged 65+ increases, there will be additional demand for residential care beds and for beds contracted for palliative care patients. No analysis of likely increased bed numbers has been done. Suitability of beds, demand and utilisation should be regularly reviewed by the DHB to ensure there is appropriate access to sufficient beds.

Accessing suitable long term inpatient/residential care is an issue for palliative patients under 65 years of age. Placement in a residential care facility is not always suitable because of location (distance from family support) or because of the environment and skill level of the staff (most facilities are aged care with very elderly residents). This is not unique to the Bay of Plenty.

- **Local hospitals**

The acute general hospitals in BOP DHB are:

- Tauranga Hospital (WBOP) - A secondary hospital of level 4-5 services with 324 beds
- Whakatane Hospital (EBOP). A secondary hospital of level 3-4 services with 101 beds.

In addition there are Project Hope Cancer Centres based at both Whakatane and Tauranga Hospitals. These provide an oncology base for Bay of Plenty specialists and Waikato visiting medical specialists.

Generalist palliative care is provided in hospitals by general ward staff, as well as disease specific teams for instance oncology, respiratory, renal and cardiac teams who provide care for patients who are dying as a result of their illness.

An identified gap is the lack of a hospital based specialist palliative care team for the BOP DHB hospitals. Hospital based teams act to enhance the capability and capacity of the various hospital based generalist services to be responsive to patients' palliative care needs and to facilitate timely access to specialist palliative care services. Hospital based palliative care is covered more in section 6.4.

Under the current model Waipuna Hospice employs a hospital liaison nurse to assist with referrals and discharges from Tauranga Hospital. This supports the transition of patients from hospital into the hospice community care. Hospice EBOP does not have a similar role and stakeholders identified discharges of palliative patients from Whakatane Hospital are often a problem. These sometimes occur with little planning or communication with hospice; and they frequently occur late on a Friday afternoon or Saturday with no prior warning.

From time to time there will be urgent discharges where a patient wishes to return home to die and prior warning is not possible. The hospice nurse out of hours can facilitate this. However, while hospice provides a 24/7 service this is minimally resourced out of hours (usually only one nurse). Using hospice nurses out of hours to cover work that can be carried out in a more planned way during normal work hours or days is expensive. Patient/s being discharged in the weekend significantly increases the cost



to the hospice when an additional nurse needs to be employed to coordinate care. In addition, late discharges reduce the opportunity to coordinate care with other support services and to make sure all other requirements such as equipment and medications are in place. A part time discharge liaison role under Hospice EBOP would improve this situation but would require new funding. It is suggested (but not quantified at this stage) that investment in a hospital discharge liaison position within hospice would save the hospital money through facilitating early discharge.

- **Allied health services**

Allied health services including pharmacy, physiotherapy, occupational therapy, speech language therapy and social work provide valuable assessment and support for palliative patients. Waipuna Hospice employs social workers, counsellors, chaplains and (more recently) a physiotherapist/lymphodema therapist; Hospice Eastern Bay of Plenty employs a part time counsellor; the remaining allied health services are provided by the DHB and access is by referral or liaison. An exception is pharmacy input which is gained by working with DHB pharmacists but also, more often, local community pharmacists.

Allied health professions are commonly part of palliative care multi/interdisciplinary teams in other countries but their role in palliative care teams in New Zealand is under developed. In general in New Zealand they are part of DHB allied health pools with competing service demands. There are many allied health professionals who have a declared 'passion' for palliative care and have developed particular skills and knowledge in working with palliative patients even though this may form only a small part of their patient workload. However, there is a nationally recognised lack of formal training in palliative care for allied health professions, a lack of opportunities to specialise in palliative care and difficulty accessing funding for palliative care post graduate education by allied health professions.

## Specialist palliative care

Specialist palliative care practice builds on the palliative care provided by generalist providers and reflects a higher level of expertise in complex symptom management, psychosocial support, grief and bereavement support.

Bay of Plenty DHB contracts two hospices for the provision of specialist palliative care.

- Waipuna Hospice for services in Western Bay of Plenty
- Hospice Eastern Bay of Plenty for services in Eastern Bay of Plenty.

The hospices provide a single point of entry for referrals for specialist palliative care in each of their districts and coordinate care to ensure their patients and family/whānau have access to the services they require.

Detailed service profiles and patient demographics for Waipuna Hospice and Hospice Eastern Bay of Plenty are provided in Appendices 4 and 5. A summary of the hospice services is provided below.

**Waipuna Hospice** based in Te Puna, provides services for the territorial authorities of Western Bay of Plenty and Tauranga City and has a population base of around 150,000 which is three quarters of the DHB population. The hospice operates a nine bed inpatient unit and has a total paid workforce of approximately 50 FTE (90 headcount) with around 450 volunteers contributing in excess of 42,000 hours per annum.

Services offered by Waipuna Hospice interdisciplinary team include:

- Care coordination and liaison with GPs, residential care and other services
- 24/7 nursing support and care in the community
- Hospital liaison for referrals and discharges from Tauranga Hospital
- Inpatient care for symptom management, end of life care, respite care and bridging care
- 24/7 on call specialist medical support for GPs and community palliative care nurses in the Bay of Plenty region
- On site clinics (medical and nursing)
- Weekly day programme
- Biography service
- Equipment loan
- Psychosocial care and family support during illness and bereavement (bereavement counselling, bereavement groups, social work services and chaplaincy support)
- Public and professional education
- Home help and personal care services

Care for palliative patients in their own home is provided by the hospice community nursing team and does not involve shared care with district nurses. The stakeholders view is that this model works well in WBOP.

The hospice employs a medical director (palliative medicine specialist) and GPs with special interest to provide outpatient consultations, inpatient medical care and a 24/7 medical telephone support. The medical specialist undertakes home visits for assessments when required and specialist medical visits to patients in the palliative care contracted beds at Althorp private hospital.

Waipuna Hospice has been increasing the specialist medical support provided to the EBOP however growth of this service is currently constrained by resource availability.

The inpatient unit has nine beds commissioned in a 12 bed unit. There is increasing demand for additional beds however this is an unaffordable option for the hospice at this time. In response to this growth in demand the remaining three rooms are being used for an expanded day services programme including ambulatory clinics, day stay procedures and day respite care. It also provides an opportunity to work with families to educate them in caring for their family member at home.

Waipuna Hospice is the lead organisation for implementation of the Liverpool Care Pathway in Bay of Plenty and is the lead hospice in implementation of the PalCare patient management system for the five hospices in Midland.

From January to December 2010 Waipuna Hospice cared for 417 people who died during the year, provided 6192 domiciliary nursing visits and undertook 4330 nursing and medical assessments. The hospice cares for around 190 people at any one time. Around 90% of their patients have cancer. 85% of those who died during 2010 were European and 13% Māori.

**Hospice Eastern Bay of Plenty** based in Whakatane, provides services for the territorial authorities of Whakatane, Kawerau and Opotiki and has a population base of about 50,000 which is one quarter of the DHB population. The hospice has a paid workforce of 8.6 FTE as at July 2010 with around 50 volunteers contributing in excess of 7,000 hours per annum.

Services offered by Hospice Eastern Bay of Plenty include:

- Care co-ordination and liaison with GPs, residential care, hospitals, pharmacists and other services
- 24/7 palliative care community nursing service provided by hospice nurses and in conjunction with district nurses for patients in Te Kaha and Murupara
- Weekly day stay programme
- Specialist equipment loan
- Psychosocial care and family support during illness
- Grief and bereavement counselling and support groups, access to social work services and chaplaincy support
- Public and professional education
- Assessment for home help and personal care services
- Coordination of palliative beds in local rest home for respite or end-stage care
- Biography service

The hospice works closely with GPs, some district nurses, residential care facilities and Māori provider services. LCP is being implemented as a part of a Bay of Plenty wide project under the leadership of Waipuna Hospice.

Access to a palliative medicine specialist is improving via links with Waipuna Hospice. One-off education sessions for generalists and patient consultations for some EBOP patients have been provided but this is not yet formalised in terms of the degree of regularity. On occasions Eastern Bay of Plenty patients have been admitted to the inpatient unit at Waipuna Hospice however given the distance to travel this presents problems for them. Many patients and/or their family/whānau lack access to reliable transport or cannot afford the cost of travel. Transfer by ambulance is a prohibitive cost for patients. Because of this, admission to the Waipuna Hospice inpatient unit is not seen as a widely acceptable option for Eastern Bay residents.

From January to December 2010 Hospice Eastern Bay of Plenty cared for 160 people who died during the year, provided 1968 domiciliary nursing visits and undertook 2476 nursing assessments (including giving phone advice). The hospice cares for around 50 people at any one time. About 72% of their patients have cancer. The next most common are respiratory and cardiovascular diseases. 62% of those who died during 2010 were European and 35% Māori.

The criteria for access and admission to the specialist services of both hospices are based on the Leeds eligibility criteria for specialist palliative care services which is needs based and not diagnosis based for patients with an extraordinary level of need (i.e. their needs exceed the resources of the primary care team). Acceptance of referral into the service is determined following a comprehensive assessment.

The draft Resource and Capability Framework recommends the development and adoption of national eligibility criteria for access to specialist palliative care services.

Representatives of Waipuna Hospice and Hospice Eastern Bay of Plenty actively participate in the Midland Palliative Care Workgroup and have developed relationships with hospices within Midland and in other parts of New Zealand. They are members of Hospice New Zealand and involved in national activities.

The Hospices are accredited under EQUIP4 standards and undergo HealthShare audits against the Bay of Plenty DHB contract.

## 5.6. Specific Bay of Plenty initiatives

---

### **End of life Liverpool Care Pathway for the dying patient**

It is widely quoted that most people, given a choice, would prefer to die at home. In order to support this it is essential to provide comprehensive palliative care services within the community.

Considerable effort has been made to put resources in place to support palliative patients who are dying to remain at home or in residential care. This has been further enhanced by the introduction of the end of life Liverpool Care Pathway (LCP) to guide the care of patients in their last days of life. The LCP has been endorsed by the Ministry of Health as the End of Life Care Pathway for use in New Zealand. The LCP is an integrated care pathway that guides healthcare professionals to deliver evidence-based best practice care to dying patients and their families in the last days and hours of life, irrespective of diagnosis or care setting.

Waipuna Hospice is the lead organisation for implementation of the LCP. An implementation programme commenced in the WBOP in 2008 and is 79% complete (as at December 2011). Implementation began in EBOP in 2010 and is 45% complete (as at December 2011).

One of the aims of the LCP is to avoid unnecessary hospital admissions by anticipating and planning for the possible needs of palliative patients who are dying, usually resulting in them being able to remain at home.

### **Clinical guidelines**

In Bay of Plenty, clinical guidelines are generally available within the hospices for the services they provide. There is a gap in the availability of documented best practice clinical guidelines and referral pathways for use by generalists and the hospices recognise the need for further work in this area.

There should be consistency across Midland and therefore consideration given to developing region wide best practice guidelines supported by local referral pathways and service descriptions.

The draft Resource and Capability Framework recommends the adoption of national evidence based symptom management guidelines to reduce duplication and resource required for review.

### **Bay Navigator**

The DHB in association with the Western Bay of Plenty Primary Health Organisation, Nga Mataapuna Oranga and the Eastern Bay Primary Health Alliance, has embarked on a project to develop care pathways for the improvement of the patients overall journey. Care pathways look at the continuity of care across different disciplines and sectors, with the aim of reducing duplication and improving the efficiency of resources within a constrained financial setting and medical workforce.

Bay Navigator provides online support to enable hospital clinicians and general practitioners to work together to improve the coordination of patient care from the community, into hospital and back into the community. A care pathway development approach brings together clinical staff from a range of disciplines to design and agree care processes. This has resulted in "boundary-crossing", and the strengthening of clinical networks to share knowledge, produce efficiencies and reduce errors.

The four health groupings initially chosen are diabetes, respiratory, cardiology and child health. It is recommended that palliative care be considered as an option for development on the Bay Navigator.

### **Information management**

There are a range of services contributing to the care of palliative patients (hospital, hospice, GPs, district nursing etc). Each service maintains their own information and patient records and there is little, if any, integration of systems and limited sharing of information. Obtaining information for this plan has been difficult because the information is either manually held, fragmented or simply not available.

The availability of complete patient information, quickly and accurately, is extremely important to the effective relationships between primary/generalist and specialist services, and it enhances seamless care between providers.

The two hospices have historically used a combination of Medtech and other paper or spreadsheet based records. Medtech is a modular practice management solution used by many medical practices throughout both New Zealand and Australia. Although it enabled some improved communication and information sharing between hospices and primary practice, it did not provide an overall information solution for the hospices. Many of their other information management requirements remained very manual, labour intensive and prone to error.

Waipuna Hospice has recently led a project with the Midland hospices<sup>17</sup> to purchase and implement PalCare an electronic patient care information management solution for the delivery of palliative care and support services at the point of care. This has been made possible by community grant funding for both software licences and communications equipment.

In addition to the benefits of shared patient information PalCare makes a wide range of other business related activities of the hospices such as monitoring and reporting more accurate and efficient.

The implementation of PalCare in the Midland hospices is currently in progress and will follow a staged roll out. Phase one is implementation within the hospices (and for district nurses in some areas) with some capability for GPs to access information via web access. Phase two will expand access to a wider group such as primary, hospital and other specialist services and will explore the integration with other systems.

There will be a requirement for DHBs and hospices to implement the HISO National Specialist Palliative Care Data and Business Process Standards when finalised.

Consideration also needs to be given to PalCare's relationship with the regional data repository which is a wider Midland DHB regional information systems project.

The draft Resource and Capability Framework identifies several enablers of care across all services to facilitate the integration of care. This includes an integrated electronic record shared across formal care providers (with patient consent).

## Research

Very little palliative care research has been carried out in Bay of Plenty. Some projects associated with staff undertaking tertiary study have been completed but the results are not widely available.

In 2010 Hospice Eastern Bay of Plenty was successful in gaining funding to support a research project with Māori recording patient journeys of isolated rural Maori palliative patients. The project report has not yet been finalised. When available there should be consideration of the report findings relative to service improvements for the Eastern Bay of Plenty and possibly could be applied to other areas in Midland.

## Education

- **Generalist level**

Palliative care education is provided for generalists by Waipuna Hospice and Hospice EBOP. In general, each hospice provides education within their districts although there are now some whole of BOP and wider Midland regional approaches e.g. a recent Māori Health provider hui on Palliative Care and a Midland Palliative Care Education work group to facilitate sharing of resources and to promote consistency of approach throughout Midland.

There is no Bay of Plenty wide education plan. Each hospice delivers the range and number of programmes in response to perceived local need and within their available resources.

The Midland Palliative Care Nurses and Carers Education Strategy provides a view of the programmes available to build palliative care understanding and knowledge within the nursing and

---

<sup>17</sup> There are five hospices in the Midland area - Waipuna Hospice, Hospice Eastern Bay of Plenty, Hospice Waikato, Rotorua Community Hospice and Lake Taupo Hospice

carer workforce. A Midland education calendar is made available via the hospices and the Midland Cancer Network website.

Additional Ministry of Health funding to implement new services defined in the National Palliative Care Service Specifications (Draft, 2008) and 'Access to Care' pressure funding for Bay of Plenty hospices targeted (amongst other things) the improvement of education to generalists and implementation of end of life care which includes an education component. Both hospices increased their staffing to meet the requirement for increased education and for implementing LCP. This enabled a dedicated focus on education as opposed to an add-on amongst other competing demands.

Hospice New Zealand is actively involved in education and workforce development and has developed a range of education packages that can be used by member hospices. This provides a cost effective approach to the development and delivery of consistent palliative care education programmes and resources throughout New Zealand and are used by the BOP hospices.

Details of the range of education programmes and sessions offered within Bay of Plenty are listed in the individual hospice service outlines – Appendices 4 and 5.

Traditionally, Bay of Plenty specialist palliative care services have not had any involvement in delivering palliative care education for medical students, RMOs or advanced trainees. This is changing with the appointment of a palliative medicine specialist at Waipuna Hospice which has enabled:

- agreement with Waikato Palliative Care Service for registrars/advanced trainees in palliative medicine to undertake part of their training at Waipuna Hospice
- site accreditation of Waipuna Hospice by the Royal Australian College of Physicians for trainees to undertake core components of advanced training.

The benefits of Waipuna Hospice increasing involvement in formal education for palliative medicine trainees includes enhanced recruitment opportunities for BOP, growing the number of specialists in New Zealand and a resource to support the development of hospice services.

Medical education would be further enhanced by the development of a Midland regional medical education strategy to identify a whole of region approach to providing education and placement opportunities for doctors.

Particular gaps identified in education for generalists in BOP.

- Education of acute hospital staff on palliative care. Suggest a formal understanding be developed with hospitals for the hospices to:
  - have a regular slot on orientation programmes
  - deliver grand round session/s on palliative care
  - present palliative care topics in nursing study days
  - have undergraduate nurse placements with hospice services
  - have medical student and RMO rotations through Waipuna Hospice as part of their training.
- Palliative care education for allied health. Palliative care is not covered at undergraduate level or in any allied health training and so some are underprepared in dealing with palliative patients. Some allied health staff find it difficult to develop skills in palliative care as an area of specialisation or special interest.
- Medical education for GPs. This is currently limited by the lack of availability of palliative medical resource to provide this throughout BOP and would be enhanced by the appointment of additional specialist palliative medicine resource.

The draft Resource and Capability Framework identifies several enablers of care across all services to facilitate the integration of care. Education and training for generalist providers, including practice based education to support a palliative approach, is identified as an enabler.

Included in the recommendations contained in the draft R&C Framework is:

- the development of qualifications appropriate for the allied health workforce to maximise the potential for the discipline specific skill they bring to the provision of palliative care services; and



- work with university and other education providers to develop e-learning opportunities which will enable staff who live outside of main centres to access training and qualifications.

- **Specialist level**

Education and development of specialist nurses and others in the hospices is generally achieved through a combination of comprehensive in service activities, access to learning resources, agreed individual development plans, and CME arrangements for medical staff. There are a number of postgraduate training programmes available through a range of providers in New Zealand. There is some access to Health Workforce New Zealand funding to support staff post graduate training/education in palliative care (mostly targeting nursing and medical staff) and BNI Palliative Care Scholarships through Hospice New Zealand (for hospice staff or Hospice NZ individual members).

A priority gap identified for knowledge and skill development of the existing palliative care workforce is in caring for an increasing range of nonmalignant diseases and those with dementia. It was also identified that allied health professions lack access to funding to support their development of specialist knowledge and skills in palliative care.

Waipuna Hospice has entered into an agreement with BOP DHB to enable Waipuna Hospice to utilise the Moodle<sup>18</sup> online learning platform. Initially this will be used to make the mandatory training more accessible to staff e.g. fire safety, however it is intended to expand this over 2012/2013 to include other online palliative care learning packages.

Waipuna Hospice is increasing the number of undergraduate nursing student clinical placements offered to include placements for transition students. All students will have the opportunity to experience inpatient, hospice at home and day services. These placements will be available to students with an interest in palliative care and it is anticipated that from 2013 Waipuna Hospice will be in a position to employ new graduates from amongst those students who have had a placement at Waipuna Hospice.

## **Volunteers**

Hospices rely on the significant input of volunteers to support many of the services and fundraising efforts of hospices. Formal induction and training programmes are required for volunteers and are delivered regularly by the hospices.

## **Public**

Bay of Plenty does not have a specific strategy around raising public awareness of palliative care services. In general, public promotion of palliative care and hospices is achieved through:

- national campaigns under the umbrella of Hospice New Zealand
- hospice newsletters, websites, information brochures
- local hospice promotion, events and fundraising
- speaking engagements
- word of mouth 'marketing'.

---

<sup>18</sup> Moodle is an Internet based system for delivering e-Learning programmes for educational and training organisations.



## 5.7. Funding

---

### Generalist palliative care services

- Primary Health Organisations (PHOs)  
PHOs are funded at a population level, based on the characteristics of a practice's enrolled population. Community palliative care services delivered through PHOs for their enrolled populations do not have defined funding streams or specified services. They are considered to be a component of essential primary health care services.

The Ministry of Health has provided funding (via DHBs to PHOs) to develop specific programmes to improve the provision of primary care. Examples are services to improve access (SIA) funding, Coordinated Primary Options (CPO) services and CarePlus. PHOs have flexibility to decide how these programmes will be developed in their areas to meet the unique needs of their population. The BOP DHB doesn't specifically fund any palliative care initiatives through SIA or CarePlus funding. However, the PHOs have developed programmes that are available to groups which might include palliative patients (but there is no specific recording of patient by type of care). Examples include:

- BOP DHB provides funds to the three PHOs for CPO services. The PHOs choose what components are to be covered under the CPO service. The PHOs have a 'Rest Home' component which funds a temporary stay (maximum 3 nights) for a person over 65 years of age. The service is to cater for patients that are too ill to be discharged home. The PHOs do not record if the patient is palliative or otherwise.
- WBOP PHO funds the Kaitiaki Nursing Services through SIA funding. This includes a Whānau Cancer Support nursing service for Māori clients and their whānau affected by cancer. Three Māori nurses carry out home visits and support extends through treatment and palliative/end of life stages. This service is available to the enrolled population of the PHO.
- WBOP PHO uses CPO funding for grief support arising from depression. There is a grief support agency in Tauranga (Grief Support Inc).
- Hospital based palliative care  
Palliative care is considered a part of usual treatment and care across a range of specialties within the hospital environment. There is no identifiable funding within the hospital service specifically for palliative care.
- District nursing and allied health services  
District nursing and allied health services are funded as a part of the DHB community services. There was no information provided on the funding of these services or volumes of workload for palliative care patients.

There is a DHB funded district nurse position with a 0.6 FTE palliative care component in EBOP. This role is positioned with the Hospice Eastern Bay of Plenty team.

- Residential care  
The DHB directly purchases nine hospital level residential care beds for palliative care as detailed previously. These are dedicated beds, purchased on a block basis irrespective of occupancy. There is also some flexibility to purchase additional beds in other locations if required.

Waipuna Hospice provides a specialist medical visiting service to Althorpe private hospital for patients in the palliative care contracted beds.

- Home help and personal care  
In the WBOP Waipuna Hospice provides limited home help and personal care service in patient's homes. The service was initially provided by the hospice with \$67,500 of DHB funding in 2006. Currently the hospice tops up the funding by an additional \$30,000 per annum to provide for up to three personal cares and one home help visit per week for those that require it.

In EBOP, funding for home help and personal care is provided through Support Net.

- Other NGOs including Māori health provider services, Cancer Society etc receive funding from the DHB to provide a range of care and support services. None have identifiable components of palliative care although they may be providing care or support for people who are dying.

### **Specialist palliative care**

BOP DHB funds services through annual agreements between the hospice and the DHB. In the past these were multi-year agreements but have changed to annual contracts because the hospices are experiencing high growth. The contracts are based on a volume of referrals which is capped. Currently the volume cap is less than the expected actual volume for both hospices. The hospices received increases for demographic growth and a price adjustment in the 2011/12 contracts.

National Palliative Care Service Specifications (NPCSS) were developed in 2001 by the Ministry of Health as part of the Nationwide Service Framework. Purchase units (PUCs) are allocated to them and DHBs use them to contract regional/local clinical services. These PUCs are still broadly used today by DHBs but PUC values and processes to determine volumes and annual changes are not consistent between DHBs.

In 2006, a review of the NPCSS was initiated and resulted in the first draft of new service specifications being released on February 2008. These service specifications currently remain in draft.

From time to time funding has been allocated by the Ministry of Health to the hospices for specific initiatives. In recent years these were:

- 2008/09 - funding for the implementation of end of life care, education to generalists, 24/7 telephone advice. These were new services defined in the National Palliative Care Service Specifications (draft, MOH 2008)
- 2009 - \$60M boost hospice funding nationally over four financial years (2009/10 to 2012/13) to expand care and services and to help hospices meet their current financial challenges. The amount each hospice receives was determined on national hospice and DHB surveys, and was expected to ensure 70% of hospice costs (based on 2008 calculations) are covered by MOH/DHB funding. Boost Hospice Funding is confirmed for 4 years from 1 July 2009.
- \$1.3 million of the total 'Boost Hospice' funding was allocated to some selected hospices to help address difficulties in accessing palliative care services. This 'Access to Care Pressures' funding was to be used to address key gaps in the hospice services as identified in the qualitative results of the national stocktake of specialist palliative care services<sup>19</sup>. This allocation was provided for the 2009/2010 and 2010/2011 years and has been confirmed for the 2011/12 and 2012/13 years.

Both hospices received Access to Care Pressure funding targeted towards education for generalists and developing a 'hub and spoke' model within BOP. In particular this has enabled Waipuna Hospice to provide Hospice EBOP with some palliative care medical specialist support and some access to the Waipuna Hospice inpatient unit where appropriate. These aspects of service require further development.

'Boost Hospice' funding is paid to the hospices in 12 even monthly payments. This does not attract any volume or price increases because it is passed on directly from the amount received from the Ministry of Health. It is not yet known whether the Boost Hospice Funding will continue. Currently the additional funding is expected to cease on 30 June 2013. This poses specific challenges for hospices as this funding supports their current level of services.

In 2009, after the 'Boost Funding' allocation, public funding was expected to cover 70% of hospice costs. However, with no adjustment for inflation this now represents approximately 63% contribution for Waipuna Hospice and remains at around 70% for Hospice EBOP. The shortfall of at least 30% is raised

---

<sup>19</sup> *Gap Analysis of Specialist Palliative Care in New Zealand – Providing a national overview of hospice and hospital-based services*, Ministry of Health, December 2009.

by hospices through hospice shops, community fundraising activities and from sponsorship, bequests and donations from individuals and organisations.

Donations of services 'in kind' and unpaid volunteers make a significant contribution the running of hospice services. Hospices would not provide their current range and level of services without these contributions.

### **Inter district flows**

There are patients who live on or close to the boundaries between different DHBs, and it may be more appropriate for them to receive service/s from an alternate DHB area. An example is the boundary between EBOP and Lakes DHB around the Murupara/Ruatahuna district. In this example Hospice EBOP provides services but the residents may prefer residential care in Rotorua. In the past there have been only a few instances of this so hospices have not tended to recharge for their services. Equipment is usually supplied by arrangement between the hospices and/or hospital service. Inter district flow agreements provide for transfer of costs in residential care facilities for these patients.

A precise map or description or has not been able to be located to identify exactly where the boundaries between DHBs exist. This does cause some operational issues around who should provide services especially in remote rural locations where providing nurse visits is resource intensive and more expensive. A detailed map would provide clarification and reduce confusion for the services. For Bay of Plenty DHB this would involve defining and agreeing the precise boundaries between Lakes and Waikato DHBs.

### **Governance**

The allocation of funding and performance against contract of palliative care service providers in BOP DHB is the responsibility of the Planning and Funding Portfolio Manager for Health of Older People and the Portfolio Manager for Cancer. Elements of funding for primary care fall under the Portfolio Manager for Primary.

The hospices submit quarterly returns of patient and activity data in a format prescribed by the Ministry of Health (MoH monitoring returns) and any other reports required by Planning and Funding. Portfolio managers meet regularly with the hospice managers to review performance against contract and identify issues.

### **Identified funding issues**

Currently the way that specialist palliative care services are funded by the Midland DHBs is different in each DHB and this is also the case throughout New Zealand. The funding is fragmented and in general, there is a high degree of funding services based on predicted costs from previous year's activities. This approach supports the funding of services based on historical activities rather than assessed need and can perpetuate inequities.

DHB Planning and Funding managers have identified the lack of national service specifications for palliative care as an issue. The need for a new national funding model for specialist palliative care has been highlighted in a number of the current national initiatives. Work on the new national specialist palliative care service specifications and associated documents has not proceeded as quickly as originally planned. These were intended to provide a greater level of clarity to the planning, provision and purchasing of palliative care services. Included in the MoH current national work plan for palliative care is work on a discussion document on the national funding model. It is expected that a new national funding model will be developed following completion of the Resource and Capability Framework and Service Specifications.

Included in the recommendations contained in the draft Resource and Capability Framework is the need to change the current funding models to incentivise effective palliative care outcomes (at both a patient and systems level) instead of on the basis of historical services delivery.

## 6. The future

---

### 6.1. Increasing need for palliative care

---

The population's need for palliative care is being driven by a range of factors which increase the need for care delivered by both specialists and generalists including:

- population growth and a growth in the number of deaths.
- ageing population – a greater proportion of people in the older age group means more people will require palliative care
- people living longer – likely to see a rise in chronic diseases such as heart disease, cerebrovascular disease, respiratory disease and cancer
- increasing complexity of care – more people with co-morbid conditions including more with dementia
- increase in rates of cancer and deaths from cancer – cancer has had the biggest influence on need for palliative care because most cancer deaths involve a period when palliative care is required

Based on the New Zealand Cancer Registry and the MoH's Mortality Collection data, cancer is the leading cause of death in New Zealand accounting for 29% of all deaths. While age-standardised cancer incidence rates are falling, the growth in the older population will increase overall cancer registrations substantially

- increase in referral of patients with nonmalignant diseases due to an increased awareness that people with nonmalignant diseases can benefit from palliative care services
- increase in referrals overall as result of improved awareness of the services available and the benefits
- increase in utilisation by Māori, Pacific People and other ethnic groups as a result of services being more responsive to cultural needs leading to greater acceptance by these groups.

In addition, the hospices report additional demands being placed on their services because of the changing family structures. They observe more patients living alone with little or no family support as families are smaller, more dispersed or are elderly themselves. This increases demand for supportive services such as home help and personal care and makes it more difficult for people to stay in their own home and to die at home.

Changes in clinical practice and policy in other clinical specialties (e.g. aged care and oncology) will also influence patterns of referral and demand for services. New models of care are being developed for other specialties and palliative care is increasingly being included as a key component in patient pathways. There is a need to ensure both the availability of palliative care and good integration of palliative care with other services to support these new models.

The Bay of Plenty specialist palliative care services recognise the need to strengthen relationships with other specialty services, in particular aged care services, to ensure palliative care is an accepted part of mainstream healthcare and that other specialties receive the education and support they require to meet the needs of their patients and family/whānau. Palliative care should be infused into other clinical specialties and all clinical settings.

The Medical Oncology Cranleigh Report (2011)<sup>20</sup> concludes that “overall, the increase in numbers of people with cancer, survivorship, treatment duration, the changing care complexity and funding pressures are likely to significantly impact workloads and service sustainability.” The Ministry of Health recognises that in implementing new models of care for medical oncology there will be impact on other services provided by district health boards and non-government organisations. The report outlines that service and capacity pressures in other cancer related services, particularly palliative care, are affecting medical oncology capacity. It states “the sector consensus is that 10-20% of patients occupying medical

---

<sup>20</sup> Report to the Ministry of Health - New Models of Care for Medical Oncology, Cranleigh Health, 5 October 2011.

oncology inpatient beds may not need specific medical oncology input and could be better managed in a specialist palliative care facility.”

The New Zealand Lung Cancer Standards<sup>21</sup> released in August 2011 include the availability of palliative care as a specific standard, i.e. Standard 12: *Patients who cannot be offered curative treatment, as well as those with a significant symptom burden, should be offered early access to palliative care services.*

The key to caring well for people who will die in the (relatively) near future is to understand how they may die, and then plan appropriately. Since diseases affect individuals in different ways, prognosis is often difficult to estimate. None the less, it seems that patients with specific diseases and their carers often have common patterns of experiences, symptoms, and needs as the illness progresses<sup>22</sup>. Three typical trajectories have been developed so far and are increasingly used to conceptualise palliative care needs – refer to Appendix 6.

Physical, social, psychological and spiritual needs of patients and their carers are likely to vary according to the trajectory they are following. Specialist palliative care services that traditionally have cared for those with cancer are being challenged to meet the varied needs of those with other chronic conditions and especially those with dementia.

## **Cancer and chronic disease**

Overall in New Zealand, cancer is now the leading cause of death in New Zealand accounting for 29% of deaths from all causes. Seventy-two percent of all deaths from cancer in 2008 occurred in people aged 65 and over.

According to the Ministry of Health, for the period 2006-2008 Bay of Plenty had the highest age-standardised cancer registration rate of all DHBs (370 per 100,000) and was significantly higher than the national rate (344 per 100,000). Bay of Plenty age standardised death rate from cancer (140.4 per 100,000) is higher than the national average (132.3 per 100,000) and is the eighth highest across all DHBs.

The Bay of Plenty DHB had the same leading causes of death for older people (65+) as those nationally (2005-07):

- ischaemic heart disease
- stroke
- chronic obstructive pulmonary disease
- diabetes
- lung cancer

The leading causes of death were similar across ethnic groups.

The Bay of Plenty District Strategic Plan 2005-2015 recognises the increasing rates of chronic conditions, including multiple chronic conditions, as a key issue requiring new approaches to preventing, detecting and managing new outcomes.

Recent data in Table 6 from the hospices in BOP shows a changing proportion of patients with a non-cancer diagnosis. This could be attributed to an increasing prevalence of non-cancer conditions, awareness of the role and value of palliative care and hospice services for those with nonmalignant diseases and an increased public awareness that hospice services are not just for those with cancer.

---

<sup>21</sup> National Lung Cancer Working Group. 2011. Standards of Service Provision for Lung Cancer Patients in New Zealand. Wellington: Ministry of Health.  
[http://www.MoH.govt.nz/MoH.nsf/Files/cancer/\\$file/lung-cancer-service-standards-aug11.pdf](http://www.MoH.govt.nz/MoH.nsf/Files/cancer/$file/lung-cancer-service-standards-aug11.pdf)

<sup>22</sup> Murray SA, Kendall M, Boyd K, Sheikh A. *Illness trajectories and palliative care*. BMJ April 2005; vol 330, pp 1007-1011.

**Table 6: Diagnosis hospice patients 2008-2010**

		2008	2009	2010
<b>Cancer</b>	Hospice EBOP	79%	80%	72%
	Waipuna Hospice	91%	90%	88%
<b>Non Cancer</b>	Hospice EBOP	21%	20%	28%
	Waipuna Hospice	9%	10%	12%

Source: Hospice MoH monitoring returns

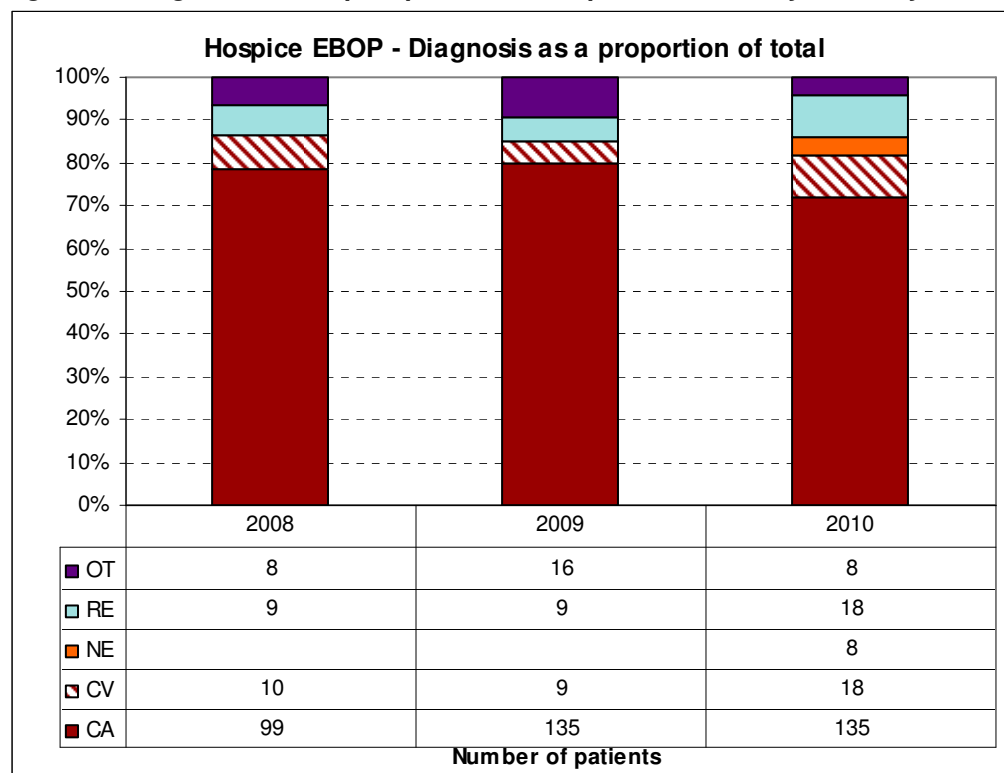
Note this data is based on the primary diagnosis of the patient which may or may not be the exact cause of death i.e. a patient with cancer as a primary diagnosis may have died of another cause.

Figures 2 and 3 show a breakdown of the number of patients by diagnosis and shows the overall makeup of diagnosis groups for patients who died or were transferred within each calendar year.

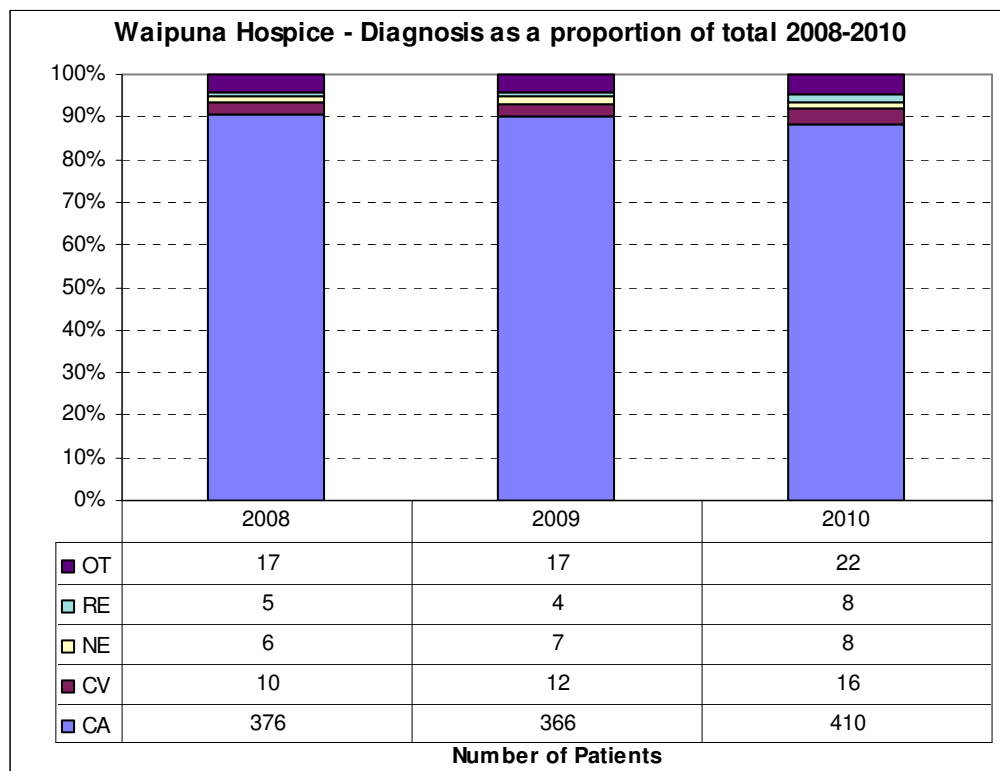
EBOP is experiencing a marked increase in the number of people with respiratory, neurological and cardiovascular disease.

Key to the diagnosis groups in the charts:

OT	Other
RE	Respiratory
NE	Neurological
CV	Cardiovascular
CA	Cancer

**Figure 2: Diagnosis of hospice patients – Hospice Eastern Bay of Plenty**

**Figure 3: Diagnosis of hospice patients – Waipuna Hospice**



## Deaths in Bay of Plenty

### Place of death

In UK, despite most people (56-74%) expressing a preference to die at home, only 35% actually achieve this aim (National Audit Office NAO, 2008)<sup>23</sup>. The majority of deaths in England occur in an acute hospital setting following prolonged, chronic illness. In Australia only 16% of people die at home. Twenty percent of people die in hospices and 10% in nursing homes. The rest (around 54%) die in hospitals.<sup>24</sup>

The *National Health Needs Analysis for Palliative Care*<sup>25</sup> indicates that on a national basis most deaths in New Zealand occurred in a hospital setting (34%) followed by residential care (31%) and private residence (22%). A small number of deaths were in a hospice inpatient unit.

In BOP, the proportion of those who die in hospital is less than Australia, UK and New Zealand as a whole. During the 4 year period 2007 to 2010, an average of 28% died in Tauranga or Whakatane Hospitals. See Table 7.

<sup>23</sup> End of Life care, 2010, Vol 4 No 3

<sup>24</sup> CareSearch Preferred Place of Death [www.caesearch.com.au](http://www.caesearch.com.au) Accessed 24 August 2011.

<sup>25</sup> National Health Needs Analysis for Palliative Care, Cancer Control Council, June 2011.

A full copy of the National HNA for Palliative Care is available from the publications section on the Cancer Control New Zealand website <http://www.cancercontrolnz.govt.nz/about-us/publications>



**Table 7: Ratio of deaths in hospital – BOP 2007-2010**

	Whakatane Hospital deaths	Tauranga Hospital deaths	Total deaths in Hospital	All deaths in BOP	Deaths in hospital as a % of all deaths
2007	107	345	452	1714	26%
2008	101	341	442	1669	26%
2009	105	428	533	1728	31%
2010	100	391	491	1723	28%

Source: Bay of Plenty DHB and Statistics New Zealand

It is not known how many of the total deaths in BOP occur at home or residential care facilities etc, nor do we have information of where people would prefer to die. However, we do have information on where people who are patients of the hospice services die, see Table 8 below.

**Table 8: Place of death of hospice patients - 2010**

	Eastern Bay of Plenty	Western Bay of Plenty
Home	60%	34%
Hospital	21%	16%
Residential care home*	19%	22%
Hospice inpatient unit	-	27%

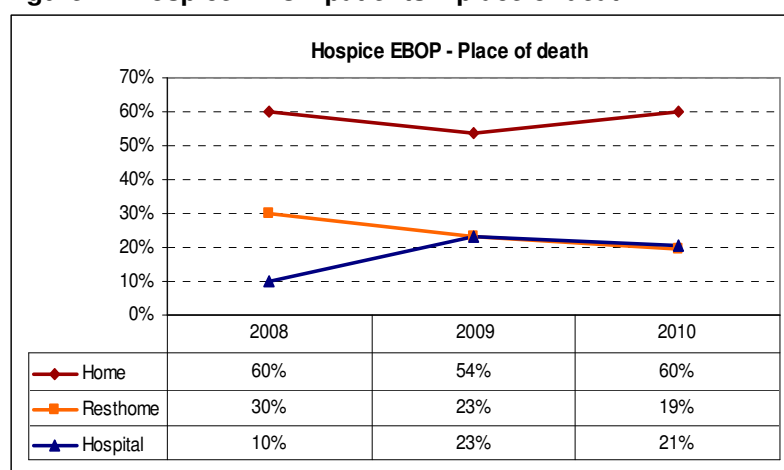
\*Includes those where the ARC is their 'home'

Source: Hospice MOH monitoring returns

EBOP has a high proportion of Māori and high socioeconomic deprivation. The palliative care model of care in the region is predominantly community based and has developed to support both the socioeconomic situation of the population and the cultural preference of Māori to remain at home to die. Success of this is demonstrated in the high proportion of hospice patients who die at home (60%).

Between 2008 and 2010, the proportion of deaths in residential care in EBOP declined and the proportion dying in hospital increased – see Figure 4. The exact reason for this trend is unknown but could be attributed to:

- o difficulty placing residents in suitable local residential care facilities
- o patients becoming more sick and not being able to be cared for at home
- o less family support available in the home
- o increasing referrals resulting in more pressure on hospice and district nurses and not able to maintain the level of care in the home for some.

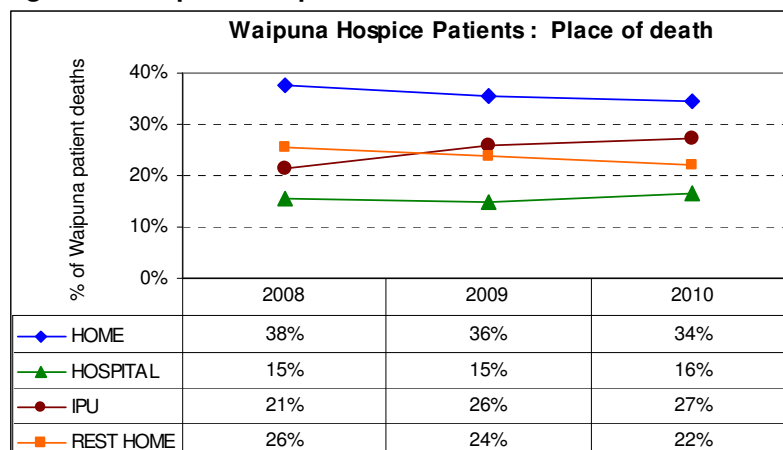
**Figure 4: Hospice EBOP patients – place of death**

Source: Hospice Ministry of Health monitoring returns

In contrast to EBOP, the percentage of Waipuna Hospice patients who die at home has declined since 2008 with an increasing trend of patients dying in the hospice inpatient unit. The number of hospice patients dying in residential care is also declining – see Figure 5. This could also reflect a higher

complexity of care required and patients being unable to be supported to die at home or in residential care facilities, and for whom the hospice inpatient unit is a suitable alternative.

**Figure 5: Waipuna Hospice Patients - Place of Death**

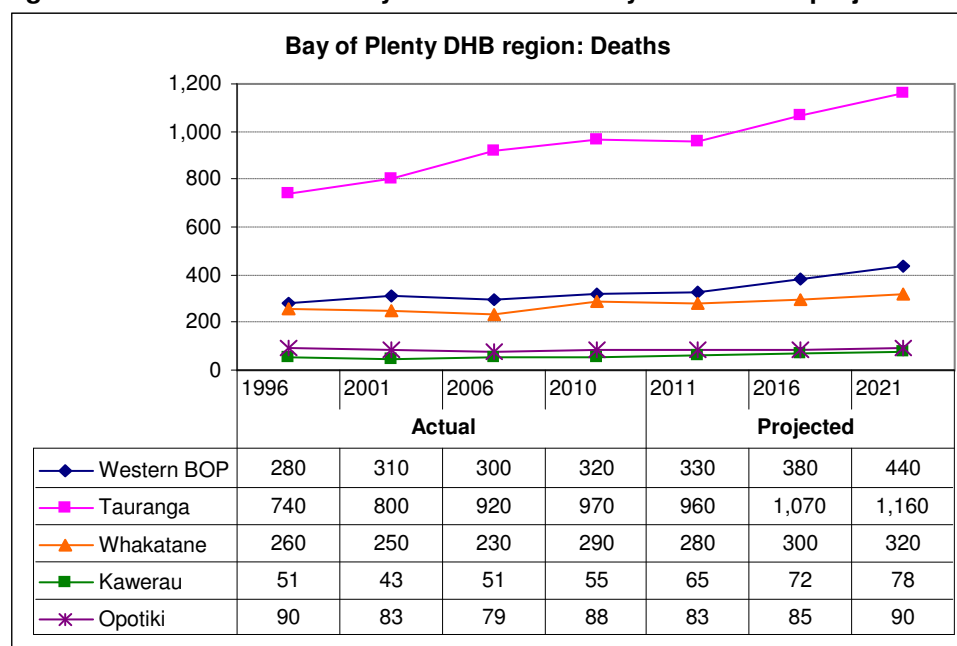


Source: Hospice Ministry of Health monitoring returns

### Projected number of deaths

According to projections by Statistics New Zealand the number of deaths in BOP is estimated to reach 1907 by the year 2016, with the most significant increases in Tauranga and WBOP territorial authorities – see Figure 6.

**Figure 6: Number of deaths by territorial authority – actual and projected**



Source: Statistics New Zealand

In 2010, of the 1290 deaths in WBOP 415 (32%) were patients of Waipuna Hospice and of the 433 deaths in EBOP 160 (37%) were patients of Hospice EBOP. The cause of death for the remaining two thirds of deaths would include:

- sudden/unexpected death e.g. heart attack, major trauma
- natural death e.g. old age or other illnesses where specialist palliative care was not required
- child and infant deaths.

And it is likely there would be a percentage that died without specialist palliative care input who may have benefited from it. The reasons could include:

- non referral – lack of recognition that the person was dying
- lack of awareness of palliative care/hospice services
- declined referral to hospice by patient/family/whānau.

However, there are no sources of information on which to base an estimate of what this percentage might be.

## National Palliative Care Health Needs Assessment (HNA) - estimate of need.

The *National Health Needs Analysis for Palliative Care* published in 2011 provides estimates of the number of people who would benefit from palliative care. Mortality Collection and Hospital Admission data for 2005, 2006 and 2007 was analysed to establish how many people might have benefited from palliative care and future estimates made based on population growth.

The mid-range estimate for adults in BOP DHB (those aged 20 yrs+) indicates 57.1% of all deaths would benefit from palliative care. This was projected in the HNA to an estimate of the likely numbers of people based on population growth.

**Table 9: Mid range estimate of the number of adults who would benefit from palliative care**

<b>BAY OF PLENTY</b>	<b>Midrange estimate number likely to benefit from palliative care p.a.</b>	<b>Increase between periods (number of people and % increase)</b>
Baseline (2006)	913	
Projected 2016	1069	156 (17%)
Projected 2026	1195	126 (12%)

Source: *National Health Needs Assessment for Palliative Care Phase 1 report*,  
Palliative Care Council of New Zealand, June 2011 p. 34

The HNA states there is limited evidence available on how the number of people who could benefit from palliative care can be allocated into the following groups:

- those requiring specialist palliative care
- those who could be cared for adequately by generalist palliative care providers.

Because of the difficulty identifying the likely split of patients between the two service levels the estimation is of limited use in relating to current services in Bay of Plenty and planning future service volumes.

The HNA states that although research is limited to date, there is some evidence showing that palliative care for people in more deprived areas requires more resources than in most affluent areas. A study undertaken by St Christopher's Hospice in London found that people in the most deprived district of their catchment required, on average, twice as many home visits as people from more affluent districts. After the annual incidence of deaths, deprivation is therefore considered the second most important factor affecting palliative care resource needs in a population.

## 6.2. Capacity to meet future demand.

### Referrals

The specialist services currently report an increasing trend of referrals beyond what they had expected, and that referral numbers exceed the capped volume they are funded for – see Tables 10 and 11.

**Table 10: Waipuna Hospice referrals**

Financial year	Funded volume cap	Actual referrals	Difference	% above funded level
2008/09	450	470	+20	4.4%
2009/10	465	472	+7	1.5%
2010/11	473	524	+51	11%
2011/12 (current)	489	293 (6/12 actual) <i>Estimate full year * 586</i>	+96	20%

**Table 11: Hospice EBOP referrals**

Financial year	Funded volume cap	Actual referrals	Difference	% above/below funded level
2008/09	144	134	-10	-7%
2009/10	146	172	+26	18 %
2010/11	148	199	+51	34%
2011/12 (current)	150	116 (6/12 actual) <i>Estimate full year* 232</i>	+82	55%

\* estimate is based on average of first 6 months multiplied by 12.

There is no data available to demonstrate workload volume or trends for generalist providers such as GPs, district nurses, allied health. However, in stakeholder discussions generalist services talked about the need to prioritise palliative patients amongst other competing demands and expressed the feeling that they were compromising the level/standard of care they should be providing for those patients and family/whānau. Their time is prioritised to clinical care and felt they simply “do not have enough time” to spend with the palliative patient, family and whānau.

Hospice services report that with the increasing referrals and patient numbers they too are having to reprioritise activities. Clinical care is a priority and time for social support and other activities of holistic care is declining.

### Specialist palliative care inpatient beds

The *New Zealand Palliative Care Strategy* listed the number of palliative care beds in New Zealand in 1998/99 per 100,000 population. This ranged from 0.64 to 7.8 beds per 100,000 with an average of 4.3 beds per 100,000 population. At the time BOP was reported as 0.77 beds per 100,000 however since then the Waipuna inpatient unit has been developed.

Palliative Care Australia recommends 6.7 beds per 100,000 population, based on an 85% occupancy rate<sup>26</sup>. In Ireland, the recommended level in 2007 was 10 inpatient hospice beds per 100,000 population<sup>27</sup> however it is recognised that palliative care services in Ireland are more developed than other countries.

Table 12 provides a review of specialist inpatient (hospice) beds against Australia and UK benchmarks. These figures have been widely referred to in literature on palliative care however they are contingent on support from a well-managed community focus on delivery of palliative care. Also included is the NZ 1998/99 average beds per 100,000 population.

<sup>26</sup> Palliative Care Australia 2003. *Palliative Care Service Provision in Australia: A Planning Guide*. 2<sup>nd</sup> edition: Palliative Care Australia

<sup>27</sup> Staffing Levels and Bed Numbers in Specialist Palliative Care in Ireland, 2007. Update of baseline study (2005) data. [http://www.hospice-foundation.ie/index.php?option=com\\_content&task=view&id=240&Itemid=157](http://www.hospice-foundation.ie/index.php?option=com_content&task=view&id=240&Itemid=157)

**Table 12: Required specialist inpatient beds per 100,000 population utilising international benchmarks** (rounded to whole number)

		<b>Australia</b>	<b>UK</b>	<b>NZ</b>
<b>Basis</b>	<b>Population</b>	<b>6.7 per 100,000</b>	<b>5.1 per 100,000</b>	<b>4.3 per 100,000</b>
<b>Western BOP</b>				
2006	150,000	10	8	7
2016 projected	175,800	12	9	8
<b>Eastern BOP</b>				
2006	50,850	4	3	2
2016 projected	50,160	4	3	2
<b>Total BOP</b>				
2006	200,750	14	10	9
2016 projected	226,000	15	12	10

Waipuna Hospice inpatient unit currently operates 9 beds. This equates to 4.3 beds per 100,000 population for the whole of Bay of Plenty (or 5.7 beds per 100,000 if measured against the WBOP population only). The building has provision to expand to 12 beds if necessary. During 2010/2011, there has regularly been pressure to commission a minimum of 10 beds however this has not been possible due to a lack of funds available for the required increase in staff and related expenses.

Based on past utilisation rates and changing patterns of demand for inpatient services, Waipuna Hospice believes the Australian benchmark would most realistically reflect the likely future need in BOP i.e. 15 beds estimated for all of the Bay of Plenty region in 2016. The key issues around increasing to 15 beds would be:

- suitability of the location of beds - if all the specialist inpatient beds were developed at Waipuna Hospice these may not be suited to the needs of the EBOP community (given the distance and the cost of travelling which would be prohibitive for many families). The economies of scale prohibit a dedicated hospice inpatient unit for EBOP based on the projected requirement of 3 to 4 beds. Alternatives might be to purchase additional beds in local hospital level residential care in EBOP with the most complex care going to Whakatane Hospital or Waipuna Hospice.
- building projects are expensive. Securing adequate funding to expand the inpatient unit and to resource the additional beds would be very difficult.

In response to growing demand for services and in an effort to delay/minimise the need to commission additional inpatient beds, Waipuna Hospice is implementing an increased day services programme. Over a 6 to 12 month period in 2011/12 the following services are being progressively introduced or expanded:

- nurse and doctor led outpatient clinics (including some procedures)
- access to specialist physiotherapy
- day respite
- art therapy
- young person groups
- caregiver education.

It is not known what impact establishing a specialist palliative care team in Tauranga Hospital would have on the hospice inpatient unit. It is possible that current demand will increase due to identification of patients in hospital that might better be managed in the hospice inpatient unit rather than remaining in the acute hospital. If a hospital palliative care service is implemented, the effect on the hospice inpatient unit would need to be carefully monitored.

### 6.3. Specialist palliative care workforce development

This section explores workforce requirements for Bay of Plenty based on international recommendations. These relate to specialist palliative care services inclusive of allied health. There is no information available on which to base workforce requirements for generalist palliative care services (e.g. district nurses, GPs, registered nurses in residential care).

The increasing demand in palliative care services is an international phenomenon with recognised workforce issues. Improving the quality of health services depends on adequate levels and availability of appropriate trained workforce including the important group of volunteer workers.

Key issues for development of a sustainable workforce include:

- To ensure adequate staff levels to address the growing demand
- Staff recruitment and retention strategies
- To ensure a multidisciplinary team approach
- To have a focused approach to training and development of undergraduate, graduate and post graduate health professionals, health care assistants, volunteers, carers and families/whānau
- Promotion of palliative care approach and services to general health professionals and providers
- Promotion of cultural learning
- To address the needs of the palliative care workforce in rural areas
- To increase Māori palliative care workforce
- To provide support and supervision of the workforce

In 2011, Health Workforce New Zealand published the results of a workforce service review<sup>28</sup> to develop a vision and model of palliative care service and workforce for 2020 in a context of increasing demand and limited funding. Included in the report was a calculation of workforce and patient ratios (medical and nursing FTEs per 1000 patients in 2008). In the review, BOP is grouped with Waikato and Lakes DHBs as one of eight network groupings. The Waikato/Bay of Plenty/Lakes ratio of 21.6 FTEs per 1,000 patients was the second lowest (next to the upper South Island) of all eight regions. The range was 42.2 FTEs per 1,000 patients to 20.7 FTE per 1,000 patients.

#### Workforce calculations

Internationally there is no consensus about population size or appropriate specialist-generalist service volumes for resourcing palliative care services. Most research and policy development in this area originates in the UK, Ireland and Australia where inpatient palliative care is more common than in NZ and there are differences in the models of care. Therefore using overseas estimations should be treated with caution in the NZ setting. However, in the absence of agreed national benchmark standards in NZ, we have used the guidelines published by Palliative Care Australia in 2003.<sup>29</sup>

The planning guide provides population-based specialist palliative care clinical staffing guidelines to support an integrated palliative care system. There is some variation in the Australian model when applying it to the BOP situation. The Australian guidelines do not provide for hands on nursing care in the community and relies on this being provided by generalist community nurses (not accounted for in the resource calculations). The Waipuna Hospice community nursing team provides hands on care and Hospice EBOP has a mix of hands on care for some patients and shared care with district nurses for others. Therefore a direct comparison of all nursing components will not be possible.

It is acknowledged that the current BOP DHB resourcing and funding will not meet the predicted staff level requirements stated. However the BOP DHB and hospices can prioritise where scarce resources are allocated for development of palliative care services as funds become available.

The staff levels recommended by Palliative Care Australia have been applied to the BOP region as a whole - see table 13. Assumptions of the model are:

- |                                   |                  |                                                        |
|-----------------------------------|------------------|--------------------------------------------------------|
| • Palliative care designated beds | FTE per 6.7 beds | BOP DHB palliative care beds = 9                       |
| • Acute hospital beds             | FTE per 125 beds | BOP DHB beds = 425<br>(324 Tauranga and 101 Whakatane) |

<sup>28</sup> Health Workforce New Zealand, *Palliative Care Workforce Service Review*, 2011  
<http://www.healthworkforce.govt.nz/our-work/workforce-service-reviews/palliative-care>

<sup>29</sup> Palliative Care Australia, *Palliative Care Service Provision in Australia: A Planning Guide 2<sup>nd</sup> Edition*, 2003

- Community

FTE per 100,000 pop. BOP DHB population = 210,100<sup>30</sup>

**Table 13: BOP palliative care staff requirements**

Position	Community based service levels	Acute hospital consultative service levels	Palliative care designated bed levels	Estimated Current FTE (excluding admin & management FTEs)
Palliative care specialist <sup>1</sup>	← 3.15 →	3.15	→	0.9 Waipuna Increasing to 1.1 from April 2012
Registrar	← 2.10 →	2.10	→	0.9 Waipuna <sup>2</sup>
Resident medical officer	-	-	0.34	1.2 Waipuna <sup>3</sup>
Liaison psychiatry	← 0.53 →	0.53	→	Referral to mental health
Nurse consultant/specialists <sup>4</sup> Clinical nurses  Registered and enrolled nurses <sup>6</sup>	2.1 4.2 <sup>5</sup>	2.55	6.5 hrs per pt day	Community teams: 11.45 RN/1.68 HCA Waipuna 3.6 EBOP  Waipuna IPU RN 9.6 EN 2.2 HCA 2.2
Discharge liaison <sup>7</sup>	← 0.53 →	0.53	→	Included in community RN
Psychology	0.53	0.34	0.13	Hosp. referral
Social work	1.05	0.85	0.34	1.48 Waipuna EBOP links with DHB community service
Bereavement support	0.53	0.34	0.13	1.46 Waipuna 0.5 EBOP
Pastoral care	0.53	0.85	0.34	0.5 Waipuna and community churches
Speech therapy	0.42	0.68	0.27	Hosp. referral
Dietitian	← 0.42 →	0.42	→	Hosp. referral
Physiotherapy	0.84	0.68	0.27	0.1 Waipuna Hosp. referral
Occupational therapy	0.84	0.68	0.27	Hosp. referral
Pharmacist	-	0.85	0.13	Hosp. or community pharmacists
Music, art therapist	1.05	-	0.56	
<b>TOTAL</b>	<b>12.09</b> Dedicated plus shared roles	<b>7.82</b> Dedicated plus shared roles	<b>2.78</b> Dedicated plus shared roles	
Volunteers <sup>8</sup>	1 per 65	1 per 65	1 per 65	1 per 450 Waipuna 1 per 50 EBOP (0.5FTE)

Notes:

- Specialist and registrar positions have both community and inpatient responsibilities

<sup>30</sup> The population used for these calculations is 210,100 based on the information from Statistics NZ for District Health Board populations at 30 June 2010 (Subnational population estimates). Approx split WBOP 160,000 & EBOP 50,000).



2. Shared arrangement with Health Waikato Palliative Care Service (late 2011)
3. These are Waipuna Hospice IPU non specialist doctors (0.2 FTE employee and 1.0 FTE contracted GPs)
4. Community and acute care consultation teams require consultant/specialist level nurses to act independently, provide consultation to primary carers and to coordinate, monitor and review patient care. Clinical nurses are senior nurses who work under the direction of the consultant/specialist.
5. The Australian model excludes the direct hands on care of community nurses. Waipuna Hospice and Hospice EBOP community nurses provide hands on care in the patient's home. Waipuna community team HCAs carry out home help and personal care for patients.
6. Designated palliative care beds require a mix of direct care including specialist & clinical nurses, RN and EN level staff, with a predominance of RNs over ENs. Patient carers may also be a part of the mix.
7. The Australian model indicates the discharge liaison could be included in a nursing or social work position
8. Based on recommendation for "process" volunteers (e.g. routine practical tasks)

In the current services there are a number of significant gaps, in particular these relate to medical staff, allied health staff and resources for an acute hospital consultative service.

Priorities for the BOP DHB palliative care workforce planning include:

- **Palliative medicine specialist** - It has been long recognised there is an international and national shortage of specialist palliative care physicians and the lead in time for recruitment can be significant. To recognise this issue, additional Ministry of Health funding has been provided since 2009 to establish up to nine palliative medicine advanced training positions throughout New Zealand. The scheme provides an additional \$30,000 for each year of training during the three year training programme, additional to the usual funding for trainees. As trainees from this scheme qualify it is expected this will reduce some of the previous recruitment difficulties.

It is recommended, as funding comes available, that recruitment of additional palliative medicine specialists would enable:

- timely patient access to palliative medicine assessment, consultation and input to care planning due to increasing number of referrals for patients with complex clinical needs
- development of the palliative care approach with other specialist services especially in the acute hospitals (the model of a hospital based specialist service to support Tauranga and Whakatane Hospitals is to be developed)
- increased delivery of palliative care education programmes
- increased support for GP's in palliative care
- additional support for the 24 hour/7 day week palliative medicine acute on-call service for general practitioners, other specialists and for assistance and advice to the specialist palliative care nurse on-call service
- increase support to Bay of Plenty hospitals and communities in terms of outreach clinics
- reduce the risks if there is a resignation and to enhance coverage for leave.

It is recommended that the development of specialist medical resources be done in a collaborative way within Midland to maximise the opportunity for sharing knowledge and expertise within the region. It is envisaged that while palliative medicine specialists will be employed by particular DHBs or hospices, they will collaborate and provide support across organisational boundaries to enhance palliative medicine in the region. This would require palliative care medical staff to be credentialed by each of the DHBs across the region. Further work needs to be carried out to fully develop this concept.

Hospice EBOP requires formalised regular specialist medical input into service provision and development.

- **Registrars** – Waipuna Hospice has recently gained accreditation as a core training site for advanced palliative medicine trainees. As funding becomes available it is intended to have an advanced trainee and/or have increased involvement in the rotation of advanced trainees from Waikato DHB. The benefits of this initiative would be an opportunity to support increasing the number of specialists in New Zealand and an interim solution to assist the existing palliative medicine specialist with workload.

- **General practitioners** – The GP workforce in general is ageing and there is a mixed level of engagement of GPs (particularly younger GPs) in providing palliative care and after hour's services. The GP's knowledge of palliative care and clinical literacy will be encouraged and strengthened by provision of educational programmes in palliative care, supported by prompt access to specialist palliative care services and community support services. Sustainable solutions to address the issues of GP availability and out of hours cover, especially for rural areas, needs to be developed as a part of PHO initiatives to deliver on the Government's Primary Health Strategy. The opportunity to develop GPs with a special interest in palliative care should be explored.
- **Nursing** – If the future sustainability of specialist palliative care is dependent on increasing the capacity and capability of generalists to care for palliative patients and their family/whānau thus enabling specialist services to deal with more complex cases, then the provision of education is a critical role for specialist palliative care. The Hospice New Zealand Fundamentals of Palliative Care education package has recently been released and provides a nationally consistent tool for delivery of education across the group of generalist nurses (developed with an aged care focus in the first instance but is intended to be modified for other groups).

The specialist services need to develop an education plan for these groups in their region with timeframes and resources assigned. A commitment of support from the generalists employing organisation for release time and financial support, where required, should be considered as part of the planning process.

The *New Zealand Palliative Care Strategy* described specialist palliative care services as employing “a majority (over 60 percent) of their registered nursing staff with a recognised palliative care qualification and the rest working towards completed palliative care qualifications”. Currently Waipuna Hospice has 30 percent of RNs<sup>31</sup> with post graduate qualifications (with a further 5 undertaking study – when completed will increase the ratio to 42.5%) and Hospice Eastern Bay of Plenty has 66 percent.

The Ministry of Health and the Nursing Council have identified palliative care as one of the scopes of practice for nurse practitioner role development in New Zealand. For a registered nurse to meet the Nursing Council criteria they must have a clinical masters degree, at least four years experience in palliative care and pass a Nursing Council assessment of competencies. Registration as a nurse practitioner with prescribing rights can also be obtained. Nurse practitioners are expert nurses, have advanced levels of assessment and treatment skills to manage complex situations, promote evidence based practice to influence standards in health practice and have the ability to order, conduct and interpret diagnostic and laboratory tests and administer therapies for the management of potential or actual health needs. The nurse practitioner role has the flexibility of practice to work across a large range of settings and has the potential to contribute significantly to service provision in rural areas where access to specialist medical support is limited.

The Bay of Plenty palliative care workforce plan should promote a pathway for development of a nurse practitioner in palliative care. There may also be value in developing a higher level of knowledge and skills in palliative care within the group of practice nurses (particularly those within larger general practices).

- **Allied health** – Allied health professionals are an essential component of a comprehensive and quality palliative care service. More work needs to be carried out in BOP to determine how well allied health is meeting to the needs of palliative patients when accessed through the centralised DHB model and if there is a need to have a greater range of allied health professionals specifically trained and designated as part of the specialist palliative care team. Insufficient information is available at this time to make a recommendation on this.
- **Carers** – The important role of carers, especially in the home, is widely acknowledged. These are the family/whānau or other carers that are most often with the patient and providing day to day care and support. There is a need to ensure they have an appropriate level of understanding and knowledge to support the patient and to be able to identify when help is needed and how to access help. Both specialist and generalist palliative care service providers have a role to play in education of carers and programmes and resources need to be developed to support this learning.

---

<sup>31</sup> The percentage of RN's is measured as a headcount of nurses (not FTE).

## 6.4. Hospital based specialist palliative care

The *New Zealand Palliative Care Strategy* describes hospital palliative care teams as necessary to educate and advise all hospital services on the palliative care approach and the need to provide palliative care as an option for people who are dying. They would also assist in ensuring people access the appropriate palliative care services in their communities on a timely basis.

Irish guidelines recommend a consultant-led multidisciplinary palliative care team in each acute hospital of 150 beds or more. Resourcing is recommended to include a specialist palliative care nurse, a social worker and a secretary, led by the palliative medicine specialist working across the range of settings and who was available in the hospital for a defined minimum number of sessions per week. The guidelines suggest that for smaller general hospitals, where it may not be feasible to employ a full-time specialist palliative care team, the specialist palliative care team serving the community should provide a service to patients in the hospital.

Currently there is no hospital palliative care team or palliative care specialist medical or nursing resource in Tauranga or Whakatane Hospitals other than a hospice discharge/liaison nurse role in WBOP who works with Tauranga hospital staff. Access to specialist palliative care for a hospital inpatient is by referral to Waipuna Hospice or Hospice EBOP on discharge from hospital.

Currently, there is only one palliative medicine specialist in the Bay of Plenty. This role sits with Waipuna Hospice and has a community and hospice inpatient focus. Although Waipuna Hospice works closely with the oncology service at Tauranga Hospital the palliative medicine specialist has no formal role in either hospitals (other than being available to hospital doctors as a part of the 24/7 medical telephone support service for BOP).

BOP DHB has for some time identified the need to improve palliative care in the hospital setting and has indicated a desire to establish a specialist palliative care service/team at least in Tauranga Hospital in the first instance, with consideration of an appropriate service level and model of care for Whakatane Hospital. Waipuna Hospice has previously considered, and promoted, the establishment of a specialist palliative care team that serves both hospitals in the region. The hospice believes this could be a partnership between Waipuna Hospice and the DHB, but development would require a long term commitment by the DHB.

The 2008 plan to develop Resident Medical Oncology and Haematology services based in Tauranga<sup>32</sup> identified that a resident service requires access to specialist palliative care services including access to consultation service with palliative care physicians.

Radiation oncology service plan work is under way for BOP. The DHB has indicated the possible establishment of a private provider for a radiation oncology service at the Tauranga Cancer Centre. International role delineation models require radiation oncology services to be part of a comprehensive cancer service including on site specialist palliative care. One of the principles that apply to a radiation oncology service is that all patients receiving radiotherapy should have access to the same level of care and support. This will not be achieved for patients in BOP if there is no on site specialist palliative care.

In addition to staffing a hospital-based service there will need to be the development of referral guidelines, clinical protocols, patient information, as well as access to support systems and resources including diagnostic services.

There is an opportunity to use technology to improve access to specialist medical consultations throughout the region using videoconferencing. This was trialled recently between Waikato and Thames hospitals with a palliative care patient follow-up consultation and worked well. This would be dependent on access to appropriate videoconferencing equipment and facilities at suitable locations in the BOP.

Some key points relating to palliative care in acute general hospitals in Ireland and Australia and evaluating hospital palliative care is provided in Appendix 7.

---

<sup>32</sup> Hewitt J. *Plan to Develop Resident Medical Oncology and Haematology Services based in Tauranga, Bay of Plenty DHB*. Midland Cancer Network, Hamilton NZ, 2008.

## 7. Summary of key strengths and issues

---

Detailed stakeholder feedback is included in Appendix 8 and 9.

### 7.1. Strengths

---

There were many comments of support for the palliative care services provided during the stakeholder meetings. A wide range of people who provide generalist and specialist level palliative care services in the BOP are very dedicated and skilled and displayed significant commitment to improving the quality of life for their patients and their family/whānau/carers.

There is wide acknowledgement of the progress made to date in Bay of Plenty, particularly in the development of the specialist services and the work of the hospices. However there are gaps and issues that require ongoing attention.

Key strengths of current services include:

- Single point of access and assessment by hospices as the specialist palliative care services in their districts.
- Co-ordination of care works well for patients within the specialist services.
- Strong philosophy of home based care and support.
- Specialist services available 24/7.
- Dedicated and knowledgeable palliative care staff.
- Low staff turnover in the specialist palliative care services.
- Links and integration with generalist services e.g. GPs, residential care, Support Net, Kaitiaki nurses, Māori Health providers, Mental Health services.
- Strong community support for hospices (fundraising and volunteer resources).
- Well developed hospice facilities for staff, patients, family and whānau.

### 7.2. Issues and gaps

---

The following summarises issues and gaps identified during the planning process. These are not presented in any priority order.

- Service level gaps mean access to essential services is variable.
  - Lack of a hospital specialist palliative care service for Tauranga and Whakatane hospitals.
  - Lack of formalised access to specialist medical consultations and education in EBOP.
  - There are gaps accessing suitable out of hours primary care support for palliative patients throughout the region<sup>33</sup>.
  - Lack of suitable long term inpatient/residential care facilities for palliative patients under 65 years of age.
  - Difficulty accessing medications especially after hours in EBOP.
- There are issues of access to palliative care services for people in remote rural areas. These are predominantly related to economies of scale for service provision and the socioeconomic status of patients, family and whānau.

---

<sup>33</sup> Note: The lack of primary coverage 24/7 is outside the scope of this plan.

- There is no regular forum in BOP for generalist and specialist services to collectively discuss the development of palliative care services or discuss issues of concern to improve the integration of services.
- There is fragmentation of services between providers resulting in variations in standards of practice. There is a lack of clarity and understanding of roles and responsibilities between some services.
- There is a lack of integrated patient information.
- The lack of a palliative approach and/or providers unsure of services available often results in late referral.
- There is inequitable access to home help, personal care and funded residential care beds based on diagnosis, care provider and/or age. There are multiple pathways to services. Inequitable access is a risk for the DHB.
- Funding of services is based on historical activities rather than assessed need and can perpetuate inequities. Funding is fragmented and difficult to identify. The method of funding general practice is not conducive to providing quality palliative care.
- There is a lack of documented palliative care clinical guidelines and pathways for generalist services.
- There is a lack of quality standards and performance indicators for palliative care across the generalist providers (primary practice, residential care, district nurses and other providers). There is poor availability of information to understand or monitor the amount of palliative care provided by generalists.
- There is forecasted growth in referrals due to population growth and change in population characteristics, increasing incidence of cancer and nonmalignant diseases and increased awareness of palliative care services. Private and public funding to expand palliative care services is limited and changes to current service delivery models will need to be considered.
- There is a need to work more closely with Māori, especially in the WBOP, to identify and reduce the cultural barriers for Māori accessing palliative care and to build mainstream service responsiveness to the needs of Māori. There is a lack of formal education and development with Māori health providers.
- Workforce development and education across the whole continuum of care is viewed as a critical area for future sustainability of services.
  - There is under representation of Māori within the palliative care workforce.
  - It is difficult for generalists to maintain palliative care skills and up to date knowledge when the numbers of patients are small and/or the need occurs infrequently.
  - The high use of locum staff reduces local palliative care knowledge of services and pathways.
  - The access that specialist palliative care services have to the hospitals to provide education is limited.
- The role of allied health in the specialist service multidisciplinary teams is underdeveloped and limited by competing patient demands. Allied health professions lack access to funding to support professional development in palliative care.
- Patients who are referred to the specialist palliative care services and their family/whānau have access to grief and bereavement support. Western Bay of Plenty PHO funds some grief support arising from depression which may include some palliative patients/family/whānau. It is not known the scope of services available for those people who do not access specialist palliative care services, and if there is an unmet need.

## 8. Vision and recommendations

### 8.1 Vision

This section provides specific actions for BOP to 2016 using the framework provided in the draft report by the Palliative Care Council *Measuring What Matters: Palliative Care* (see Appendix 2 for the framework overview).

The updated national palliative care strategic vision is:

*All people who have a life limiting illness and their family whānau who could benefit from palliative care have timely access to quality palliative care that is culturally appropriate and provided in a coordinated way.*

Three long term outcomes are considered necessary to achieve the vision. These are indicated below along with the system outcomes that form the area of focus for the actions recommended in BOP palliative care service plan.

Long term outcome	Palliative Care System Outcome
Access to palliative care regardless of setting	<ul style="list-style-type: none"><li>• Sufficient capacity within primary and specialist palliative care</li><li>• Appropriate referrals to specialist palliative care services</li></ul>
All palliative care providers are configured to ensure a seamless care pathway	<ul style="list-style-type: none"><li>• There is continuity and coordination of care</li></ul>
Palliative care provision is high quality	<ul style="list-style-type: none"><li>• Best practice is followed in delivering palliative care</li><li>• Palliative care meets the needs of patients, their families and whānau</li></ul>

### 8.2 Recommendations

#### Access to palliative care regardless of setting

##### 8.2.1 Ensure sufficient capacity within primary and specialist palliative care

*Achieving this outcome requires sufficient workforce and appropriate services and infrastructure*

##### **Actions**

- (a) Scope and implement (using a phased approach) a district wide hospital specialist palliative care team/service to provide improved access to palliative care in Tauranga and Whakatane hospitals and in the EBOP community, which integrates well with other specialist and generalist services.
- (b) Investigate opportunities to implement virtual medical services e.g. use of video conference for consultations and education to improve access for remote/rural areas, including a scope of infrastructure support requirements.

- (c) Strengthen the palliative medicine workforce
  - Work with other specialist services in Midland to scope a hub and spoke regional medical team concept including a whole of region approach to medical education.
  - Scope the feasibility of operating a single 24/7 regional medical telephone support service i.e combine BOP with Waikato/Lakes.
  - Continue to develop the palliative medicine advanced training programme by providing trainee placements in Bay of Plenty. Make application to the Palliative Medicine Trainee Coordinating Committee (PAMTRACC) for a funded training position.
  - Support GPs in palliative care by providing ongoing education and 24/7 specialist support.
  - Encourage local GPs to undertake formal study in palliative care – investigate the establishment of a Clinical Diploma in Palliative Medicine programme (linking with regional training hubs).
- (d) Develop a workforce plan to address identified areas of skill shortage in palliative care (specialist medical, allied, Māori in palliative care). This would include exploring the opportunities for further new roles in palliative care e.g. nurse practitioner, palliative care pharmacist.
- (e) Implement the Hospice NZ programme 'Fundamentals of Palliative Care' for identified groups starting with the residential care sector.
- (f) Implement cultural competency education for health professionals in specialist palliative care services.
- (g) Develop and implement topic specific education sessions for palliative care health professionals in caring for patients with nonmalignant conditions and dementia.
- (h) Ensure access to clinical supervision to monitor and support nurses and allied staff who are providing palliative care.
- (i) PHOs to integrate palliative care into education and training plans of primary practices.
- (j) Improve equity and consistency of approach to access NASC funding and other supportive care services and facilities for all palliative patients:
  - have clearly defined referral pathways for each category.
  - P&F to identify opportunities to standardise and improve access based on need as opposed to age, diagnosis, or location.
  - Monitor and evaluate utilisation to inform DHB P&F.
- (k) Explore opportunities to enable hospice medical specialists to access diagnostic and treatment services in Tauranga Hospital to reduce the need for patients to be referred to emergency department to enable access.
- (l) PHOs to develop and implement sustainable solutions which ensure all palliative patients have access to a general practitioner 24/7 and ensure processes allow for the GP to be familiar with the patient's condition and care plan.
- (m) Identify strategies to improve patient access to primary services and refer to DHB P&F.
- (n) Initiate a project to scope access to grief and bereavement services in BOP particularly for those people who are not referred to specialist palliative care services but who may benefit from grief and loss support. Identify any gaps and refer to DHB P&F.
- (o) Review access to emergency/out of hour's medication in BOP and contribute to the development of a Midland regional standard. Ensure all stakeholders understand how to access medication.



- (p) Contribute to the development of nationally consistent palliative care access criteria, guidelines and other resources, where possible, and implement in BOP where necessary.
- (q) Support specialist palliative care services to develop community strategies to manage patients in their home and minimise inpatient demand.
- (r) EBOP district nursing and Hospice EBOP review current nursing arrangement and look at opportunities to improve.

### **8.2.2 Ensure appropriate referrals to specialist palliative care services**

*Achieving this outcome requires awareness of palliative care referral processes and understanding of palliative care principles.*

#### **Actions**

- (a) Ensure that access criteria and referral processes for all BOP palliative care and support services are clearly documented.
- (b) Develop a BOP palliative care service directory including service description, access criteria and referral processes and communicate to stakeholders.
- (c) Review and strengthen website content of the DHB, hospices, Māori health providers and PHOs and other relevant NGOs to link with the service directory and clinical guidelines.
- (d) Develop and implement a communication plan for palliative care health promotion to increase public understanding of palliative care. Monitor and evaluate impact of actions.
- (e) Develop a Bay Navigator project for palliative care to clarify and strengthen primary and secondary relationships, referral pathways and clinical guidelines.
- (f) Review and standardise palliative care patient/family/whānau information and ensure it is presented in an appropriate manner for target groups.
- (g) Ensure that hospitals and other PHO and NGO services have policies and protocols reflecting the palliative care approach.
- (h) Educate providers in the palliative care approach through the development of orientation and/or education sessions for:
  - general practice teams
  - residential care sector
  - Māori health providers
  - other NGOs and/or support groups
  - specialist clinical services of the acute hospitals
  - community and allied health services
  - volunteers.

### **8.2.3 Support and align with national work programme priorities**

- (a) Apply Resource and Capability Framework to the Midland region when published (estimated April 2012)
- (b) Implement other national work programme initiatives as they become available i.e. service specifications and any new funding models.
- (c) Consider the Ministry of Health EOI for the development and evaluation of a managed clinical network and submit proposal, if appropriate, for the Midland region.
- (d) Implement the HISO National Specialist Palliative Care Data and Business Process Standard when finalised.

## All palliative care providers are configured to ensure a seamless care pathway

### Outcome

#### 8.2.4 Ensure there is continuity and coordination of care

*Achieving this outcome requires integration throughout the health sector and services/providers to be coordinated with each other. This includes the need for*

- *appropriate links between services*
- *appropriate role delineation between providers*
- *shared strategic vision across the region*
- *appropriate information sharing.*

### Actions

- (a) Refresh the BOP Palliative Care Work Group to oversee implementation of this plan and provide leadership for progress the development of palliative care services within the DHB:
  - elect a chair
  - confirm terms of reference
  - agree and prioritise the palliative care service plan recommendations
  - develop an annual implementation plan and monitor progress
  - identify project resources as required.
- (b) Develop and document service level agreements between specialist palliative care services and generalists who provide services for care of the palliative patient. Monitor to ensure continuity of care is maintained. (also links with 8.2.3 (a))
- (c) Develop a process to ensure every palliative patient has a nominated care coordinator and there is a plan for continuity of care after hours. A care co-ordinator is required for all palliative patients not just those that access specialist palliative care services.
- (d) Complete the implementation of PalCare into hospices and scope PalCare system integration with (or access by) primary, hospital and other specialist services. Implement as agreed. Also consider interface with a regional data repository and shared care record.
- (e) BOP DHB to consider hospice staff access to relevant patient information.
- (f) Scope requirements to capture regional minimum palliative care dataset for planning and monitoring (also linked to 8.2.3 (d)).
- (g) Scope and understand how NGOs can contribute to the national initiative of a shared care record and data repository.

## Palliative care provision is high quality

### Outcome

#### 8.2.5 Best practice is followed in delivering palliative care

*Achieving this outcome requires that standards for palliative care services are met; there is an interdisciplinary team approach to palliative care, and patient pathways are followed.*

### Actions

- (a) Implement the Hospice New Zealand Standards in hospices and hospital services (where relevant). Consider relevance of HNZ Standards to other generalist services.
- (b) Complete implementation of LCP in BOP and monitor utilisation to ensure sustainability.

- (c) Implement the LCP reflective data cycle as the quality improvement cycle of LCP.
- (d) Encourage and promote research opportunities relevant to the BOP palliative care population and services. Apply the learnings to BOP services.
- (e) Scope and support the implementation of Advanced Care Planning with primary and specialist services.

## **Outcome**

### **8.2.6 Palliative care meets the needs of patients, their families and whānau**

*Achieving this outcome requires culturally appropriate care, meeting the needs of specific population groups and effective treatments and support.*

## **Actions**

- (a) Carry out a stocktake/hui to understand education and support needs for Māori health providers in BOP to inform the palliative care education planning and palliative care service development.
- (b) Support specialist palliative care services to carry out cultural audits of services. Develop and implement service improvement plans in conjunction with local Māori health services.
- (c) Participate in the development of national or regional clinical guidelines and standards that support a range of treatments and implement across Midland.
- (d) Develop relationships with other services for support with care of people with nonmalignant conditions, multiple co-morbidities and/or dementia, and to provide input into service planning of other services where palliative care is identified as a part of the care pathway.
- (e) Scope and explore strategies to improve patient transport between providers.
- (f) Scope and implement a Kaupapa Māori palliative care approach including initiatives to support carers to care for their whanau in the community.

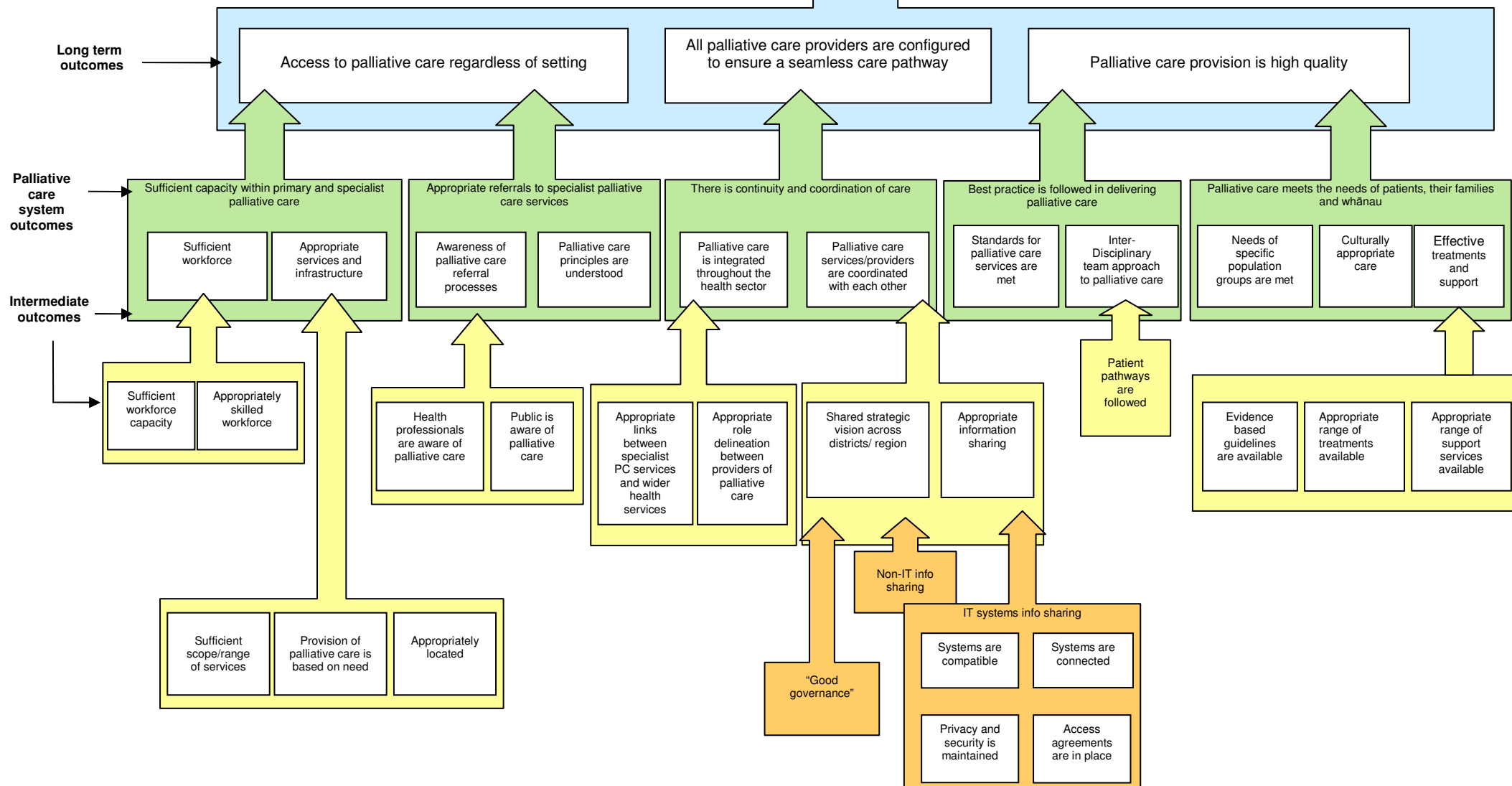
## NATIONAL DOCUMENTS / REVIEWS – ADDITIONAL DETAIL

Title	Summary
<p><b><i>Report of the Palliative Care Expert Working Group to the Cancer Control Steering Group</i></b></p> <p>Ministry of Health: 2003</p>	<p>Recognised the implementation of the New Zealand Palliative Care Strategy had gone some way to increasing access to palliative care services. However, a number of remaining areas that required further action were identified. These were:</p> <ul style="list-style-type: none"> <li>• To continue to improve access to a defined set of essential palliative care services for people dying of cancer in each DHB</li> <li>• To ensure that a seamless service is provided for patients with cancer who require palliative care, no matter where they live</li> <li>• To ensure that the palliative care workforce continues to be developed so that it can meet the needs of current and future populations especially in relation to cultural diversity.</li> </ul>
<p><b><i>Gap Analysis of Specialist Palliative Care in New Zealand</i></b></p> <p>Ministry of Health: December 2009</p>	<p>Provides an overview of the current provision of specialist palliative care services in New Zealand and highlights gaps against the draft service specifications. The gap analysis confirmed anecdotal evidence that there are wide variations in the provision of hospice and other specialist palliative care both at local and regional levels.</p>
<p><b><i>Positioning Palliative Care in New Zealand</i></b></p> <p>Cancer Control New Zealand: Feb 2010</p>	<p>Provided a review of Government Health Policy in relation to the provision of palliative care services in New Zealand.</p> <p>The report concluded that New Zealand was still some way behind other countries in recognising palliative care as an integral part of the health care continuum; and that while there was progress across the country in setting up palliative care services and in workforce development, there were still significant gaps. It also identified a lack of monitoring and evaluation of the strategy implementation.</p> <p>Remaining challenges:</p> <ul style="list-style-type: none"> <li>• Inequality of access; particularly based on diagnosis, but also in relation to ethnicity, age and geographic location</li> <li>• Lack/absence of data on population need, service provision and service utilisation</li> <li>• Lack of awareness/utilisation of palliative care services among the general public and health care professionals</li> <li>• Lack of inclusion in national health policy and strategic planning</li> <li>• Lack of a national strategic approach to research in palliative care.</li> </ul> <p>Seven recommendations were made to address what was considered to be a “relatively poor understanding of the need for palliative care and a lack of information on services currently being provided and how they are accessed by people with life limiting illnesses” (p. 18).</p> <p>The recommendations form a basis for the current work programme of the Palliative Care Council and will, over the next few years, provide further information to inform the development of palliative care services in NZ.</p>

**Outcomes Framework – next page**

# Palliative Care Strategic Vision

All people who have a life limiting illness and their family/whānau who could benefit from palliative care have timely access to quality palliative care that is culturally appropriate and provided in a co-ordinated way.

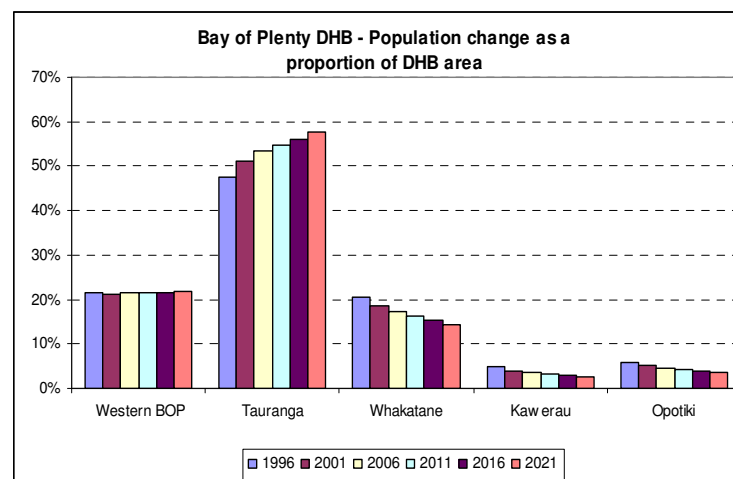
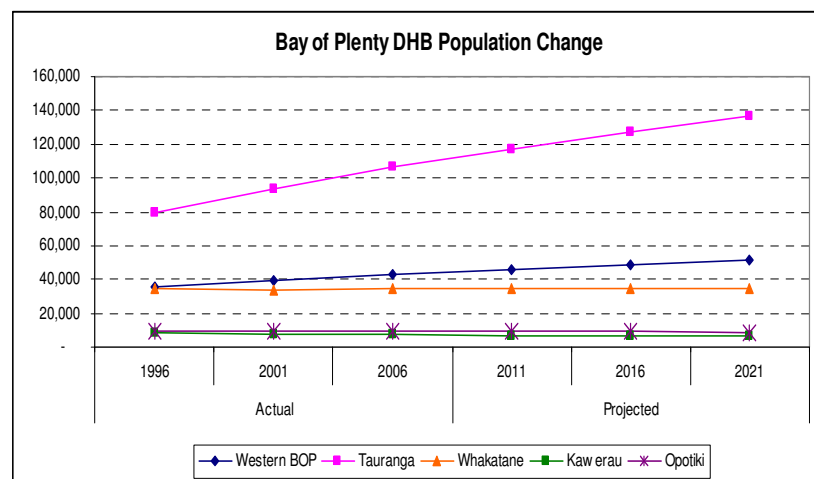


## Bay Of Plenty: Population Trends

	Actual			Projected			% change
	1996	2001	2006	2011	2016	2021	2011-2016
Western BOP	115,400	132,500	149,900	163,200	175,800	188,000	7.7%
Eastern BOP	52,000	50,880	50,850	50,740	50,160	49,260	-1.1%
<b>Total BOP DHB</b>	<b>167,400</b>	<b>183,380</b>	<b>200,750</b>	<b>213,940</b>	<b>225,960</b>	<b>237,260</b>	<b>5.6%</b>

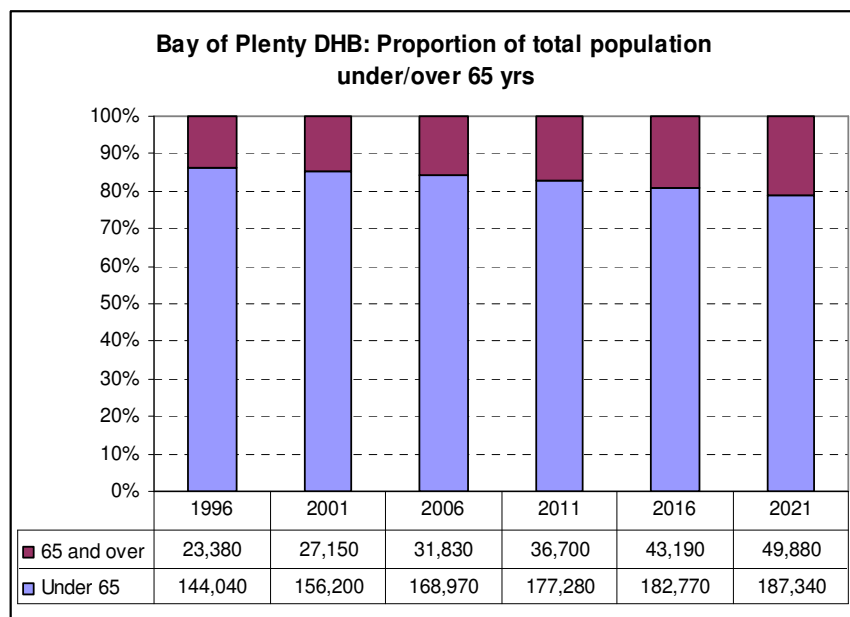
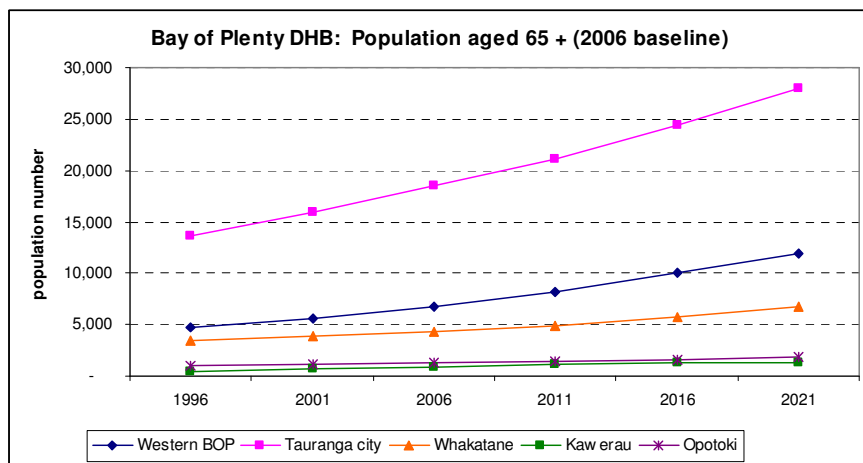
### By Territorial Authority

	Actual			Projected			% change	
	1996	2001	2006	2011	2016	2021	2011 to 2016	2011 to 2021
Western BOP	35,800	39,000	43,000	46,100	48,900	51,500	6.1%	11.7%
Tauranga	79,600	93,500	106,900	117,100	126,900	136,500	8.4%	16.6%
Whakatane	34,200	34,100	34,500	34,700	34,600	34,300	-0.3%	-1.2%
Kawerau	8,120	7,290	7,150	6,950	6,640	6,260	-4.5%	-9.9%
Opotiki	9,680	9,490	9,200	9,090	8,920	8,700	-1.9%	-4.3%
	<b>167,400</b>	<b>183,380</b>	<b>200,750</b>	<b>213,940</b>	<b>225,960</b>	<b>237,260</b>	<b>5.6%</b>	<b>10.9%</b>





## Bay of Plenty: AGE



### Eastern BOP

	2006	2011	2016	2021
Under 65	44,290	43,370	41,450	39,240
65 yrs +	6,520	7,350	8,720	9,990
<b>Total</b>	<b>50,810</b>	<b>50,720</b>	<b>50,170</b>	<b>49,230</b>
% under 65 yrs	87%	86%	83%	80%
% 65 yrs +	13%	14%	17%	20%

### Western BOP

	2006	2011	2016	2021
Under 65	124,680	133,910	141,320	148,100
65 yrs +	25,310	29,350	34,470	39,890
<b>Total</b>	<b>149,990</b>	<b>163,260</b>	<b>175,790</b>	<b>187,990</b>
% under 65 yrs	83%	82%	80%	79%
% 65 yrs +	17%	18%	20%	21%

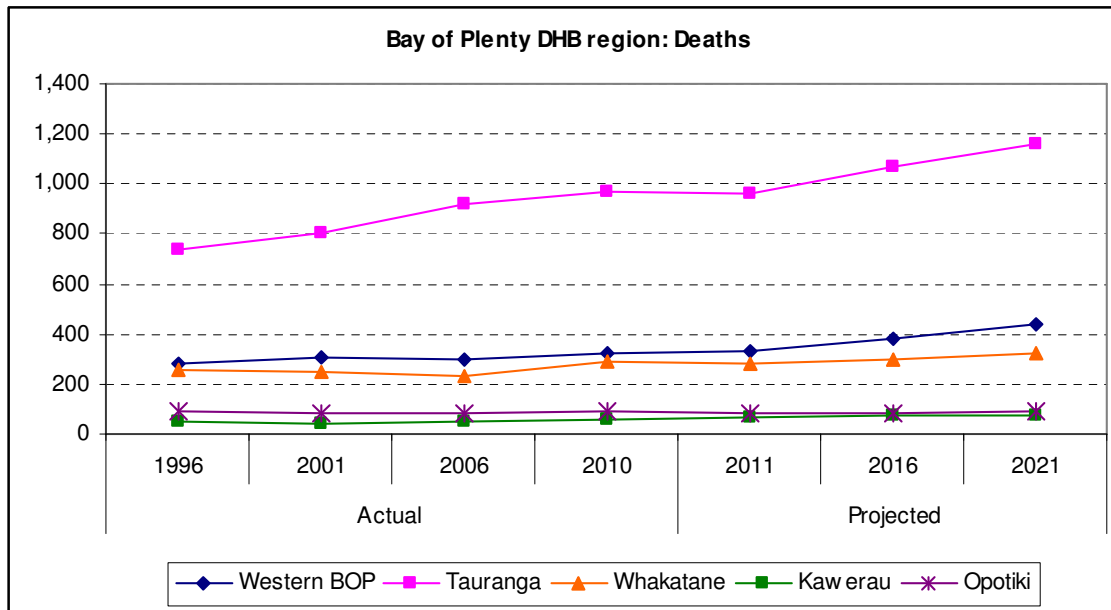
### All BOP DHB

	1996	2001	2006	2011	2016	2021
Under 65	144,040	156,200	168,970	177,280	182,770	187,340
65 yrs +	23,380	27,150	31,830	36,700	43,190	49,880
<b>Total</b>	<b>167,420</b>	<b>183,350</b>	<b>200,800</b>	<b>213,980</b>	<b>225,960</b>	<b>237,220</b>
% under 65	86%	85%	84%	83%	81%	79%
% 65 yrs +	14%	15%	16%	17%	19%	21%

## Bay of Plenty – Deaths

### By Territorial Authority

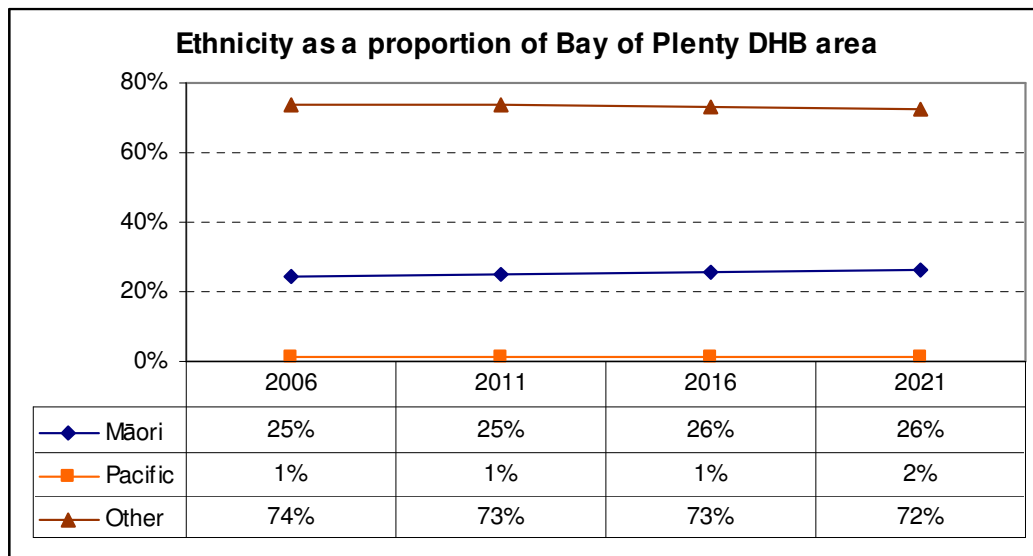
	Actual				Projected			% change	
	1996	2001	2006	2010	2011	2016	2021	2011/16	2011/21
Western BOP	280	310	300	320	330	380	440	15%	33%
Tauranga	740	800	920	970	960	1,070	1,160	11%	21%
Whakatane	260	250	230	290	280	300	320	7%	14%
Kawerau	51	43	51	55	65	72	78	11%	20%
Opotiki	90	83	79	88	83	85	90	2%	8%
<b>TOTAL</b>	<b>1,421</b>	<b>1,486</b>	<b>1,580</b>	<b>1,723</b>	<b>1,718</b>	<b>1,907</b>	<b>2,088</b>		



## Hospital Deaths

Site	Discharge HSC	2007	2008	2009	2010
Tauranga	ATR <6WEEKS-ACTIVE	10	13	14	17
	GEN MEDICINE GP LED	2	5		
	GEN MEDICINE SPEC	238	212	274	216
	EMERG/INTENSIVE MED		5	8	12
	CARDIOLOGY GEN		1		
	CARDIOLOGY SPEC	14	12	25	39
	DERMATOLOGY SPEC	1			
	GASTROENT. GEN		2		
	GASTROENT. SPEC	6	7	28	17
	INFECT. DISEASE GEN	1			
	ONCOLOGY SPEC				2
	PAED MED SPEC	1	1	1	2
	RESPIRATORY SPEC	1	3	3	4
	RHEUMATOLOGY SPEC				4
	PALLIATIVE CARE GEN	20	13	8	
	ENDOCRINOLOGY			3	4
	MA POSTNATAL-MOTHERS		1		
	MA SPEC CARE NURSERY	1	1	1	
	MA BABY WITH COM LMC				2
	GEN SURGERY GEN	2	1	1	
	GEN SURG SPEC	25	37	27	36
	GASTRO SURGERY GEN		1		
	OTOLARYNGOLOGY SPEC			1	
	GYNAECOLOGY SPEC	1		1	
	ORTHOPAEDIC SPEC	16	11	18	12
	UROLOGY SPEC		2	3	2
	VASC. SURG SPEC	5	4	4	5
	MH MHSOP INPT ST	1	9	8	17
<b>TGA Total</b>		<b>345</b>	<b>341</b>	<b>428</b>	<b>391</b>
Site	Discharge HSC	2007	2008	2009	2010
Whakatane Hosp	ATR <6WEEKS-ACTIVE	1			1
	GEN MEDICINE GP LED		5	3	
	GEN MEDICINE SPEC	89	72	78	80
	EMERGENCY SERVICES		1		1
	EMERG/INTENSIVE MED		1	2	
	PALLIATIVE CARE GEN	10	6	6	2
	MA SPEC CARE NURSERY		1	2	3
	GEN SURGERY GEN		2		2
	GEN SURG SPEC	6	10	13	8
	GYNAECOLOGY SPEC	1			
	ORTHOPAEDIC SPEC		3	1	3
<b>WHK Total</b>		<b>107</b>	<b>101</b>	<b>105</b>	<b>100</b>
<b>Grand Total</b>		<b>452</b>	<b>442</b>	<b>533</b>	<b>491</b>

## Bay of Plenty: Ethnicity



**Source:** Bay of Plenty DHB Health Needs Assessment, Sept 2008

## PALLIATIVE CARE SERVICE PLANNING – Service description for Waipuna Hospice

<b>DHB</b>	<b>Bay of Plenty</b>
<b>Hospice</b>	<b>Waipuna Hospice Incorporated</b>
<b>Description</b>	<p>Waipuna Hospice provides a specialist hospice palliative care service and the co-ordination of palliative care services for the WBOP area. This incorporates direct service provision and advice and support to other health service providers.</p> <p>Waipuna Hospice is the sole provider of community and inpatient palliative care in the WBOP district.</p>
<b>Population Served</b>  <b>Population characteristics</b>	<p>Population base at 2006 census: 149,000 Geographical area covers the territorial authorities of Tauranga City and Western Bay of Plenty.</p> <p>WBOP is 75% of the total BOPDHB population 17% Māori Population predicted to increase by 7.7% (12,560) between 2011 and 2016 Greatest growth in population will be in Tauranga city Increasing proportion of 65 years and over</p> <ul style="list-style-type: none"> <li>• 2006 = 17% of total</li> <li>• 2016 = 20% of total</li> </ul>
<b>Key Services</b>	<p><b>Nursing</b></p> <ul style="list-style-type: none"> <li>• Specialist nursing team provides 24/7 support and care in the community.</li> <li>• Care coordination and liaison with GPs and other services</li> <li>• Care coordination and nursing visits are provided by the same person who is employed by hospice.</li> <li>• Hospital liaison nurse to assist with referrals and discharges from Tauranga Hospital (employed by Waipuna Hospice)</li> <li>• Co-ordinates placement in residential care beds for respite or end of life care</li> </ul> <p><b>Medical</b></p> <ul style="list-style-type: none"> <li>• 24/7 medical service with doctors on call out of hours.</li> <li>• 24/7 medical telephone service for the full BOP region.</li> <li>• On site clinics for community patients including pain clinic.</li> <li>• Objective is to maintain GP lead for patients with hospice specialist support as required.</li> </ul> <p><b>Specialist inpatient services</b></p> <ul style="list-style-type: none"> <li>• 9 beds utilised in the 12 bed inpatient unit.</li> <li>• Symptom management, respite care, end of life care where care at home is not possible.</li> <li>• The additional rooms are currently being set up for expansion of day services programme.</li> </ul> <p><b>Day services programme</b> Social networking, art therapy, physiotherapy, massage, respite, education and outpatient clinics including some procedures.</p> <p><b>Equipment loan</b></p> <ul style="list-style-type: none"> <li>• Short term loan of equipment to support care at home</li> <li>• Example syringe drivers, wheelchairs, electric beds, nebulizers, shower stools, commodes, pressure mattresses, Lazy boys, oxygen concentrators.</li> </ul>

	<p>Family support</p> <ul style="list-style-type: none"> <li>• Bereavement counselling and bereavement groups</li> <li>• Social work</li> <li>• Chaplaincy</li> <li>• Biography service</li> </ul> <p>Education</p> <ul style="list-style-type: none"> <li>• Syringe driver</li> <li>• LCP</li> <li>• RN and EN study days</li> <li>• Health care assistant study days</li> <li>• Practice nurse study sessions</li> <li>• Caregiver study days</li> <li>• Ad hoc topic specific sessions for generalists</li> <li>• GP education/CME</li> <li>• Undergraduate medical training and education</li> <li>• Undergraduate nurse placements</li> <li>• Access to Genesis Oncology Trust breakfast lectures</li> <li>• Public education via invited speaking engagements</li> <li>• Hospice NZ palliative care for generalists education</li> </ul> <p>Volunteer support services</p> <ul style="list-style-type: none"> <li>• Formal volunteer training programme.</li> <li>• Trained volunteers support day programmes, practical support such as driving, shopping), companionship, carer relief, biography service, equipment management/delivery.</li> </ul> <p>Other support services</p> <ul style="list-style-type: none"> <li>• Home help and personal care</li> </ul> <p>Also available within BOP but not a Waipuna Hospice service is Kaitiaki Nursing Services (Whānau cancer support nurses for Māori clients and their whānau affected by cancer). Supports Māori patients of Waipuna Hospice but also many who are not registered with Waipuna. Three Māori nurses carry out home visits. The Māori nurses are able to encourage whānau to go to the hospice or arrange for the hospice nurse to visit the patient along with the Māori nurse. This partnership model works well. This is a service specific to cancer patients in WBOP funded by the Western BOP PHO.</p>
<b>Workforce</b>	<p>Waipuna Hospice has a total paid workforce of 50.4 FTE (approx 90 headcount ) as at June 2011.</p> <ul style="list-style-type: none"> <li>• Management / admin 10.75 FTE</li> <li>• Medical director/specialist 0.9 FTE</li> <li>• GPs with special interest 1.2 FTE</li> <li>• Registered nurse with post graduate qualifications 6.4 FTE</li> <li>• Registered Nurses without post graduate qualifications 16.95 FTE</li> <li>• Enrolled Nurses 2.2 FTE</li> <li>• Health care assistant 3.23 FTE</li> <li>• Social work/counsellors/chaplains 3.44 FTE</li> <li>• Cooks 0.93 FTE</li> <li>• Retail 4.41 FTE</li> </ul> <p>Volunteers – Around 450 volunteers contribute approximately 42,000 hours per annum. They are considered an integral part of the efficient functioning of Waipuna Hospice supporting all components of hospice services.</p>
<b>LCP</b>	<p>Waipuna Hospice is the lead organisation for implementation of end of life LCP in the DHB. 2 years</p>

	into the implementation project. 75% complete.
<b>Information/patient management systems</b>	<p>Waipuna Hospice has historically managed its patient data using MedTech and a paper based system.</p> <p>Currently implementing Palcare as a part of a regional initiative. Waipuna Hospice is the lead organisation for this project.</p>
<b>Quality standards</b>	Accredited under EQUIP4 standards.
<b>Key Linkages</b>	<p>Local and BOP</p> <ul style="list-style-type: none"> <li>• General practice teams and PHO teams</li> <li>• WBOP residential care providers</li> <li>• Tauranga (and Whakatane?) hospital services</li> <li>• BOP DHB district nurses, physiotherapists, occupational therapists, social workers</li> <li>• Māori Health providers</li> <li>• Cancer Society and other support groups</li> <li>• Kaitiaki cancer support nurses</li> <li>• Hospice EBOP</li> </ul> <p>Regional / national:</p> <ul style="list-style-type: none"> <li>• Hospices in other DHB areas</li> <li>• Midland Palliative Care Work Group</li> <li>• Midland Cancer Network</li> <li>• Hospice New Zealand</li> <li>• Palliative Care Advisory Group</li> </ul>

**Gaps identified in the 2009 Ministry of Health Gap Analysis of services provided by specialist palliative care providers in New Zealand.**

*Extracted from the summary findings from Gap Analysis: Waipuna Hospice*

	<b>Identified gap</b>	<b>Comments / Actions to address</b>
1	Home visits by medical personnel (specialist /GP) outside of normal working hours are not provided – this is not necessarily a gap	Lack of GP home visits remains an issue. Hospice specialist does home visits for assessments when necessary.
2	Provision of a limited number of education courses for generalists, given the size of the population served by the hospice	Improved with new structure and additional FTE for education team since June 2010.
3	Absence of explicit and agreed processes to ensure those with specialist palliative care needs have access to the following equipment: home oxygen, continence, IV, enteral and parenteral supplies, lymphodema bandages and hosiery.	Continues to be an issue largely due to funding being held by district nursing and considered for DN patients only. With rising patient numbers there is pressure on the supply of equipment. (Issue also includes consumables).
4	An absence of effective and appropriate linkages with some services and organisations – but these may not be applicable for Waipuna Hospice	Not considered an issue



## Waipuna Hospice – Patient demographics

Calendar Year	2008	2009	2010
<b>Patients</b> (deaths and discharges)			
Total patient numbers	416	406	464
Deaths	371	367	417
Transfers/discharges	45	39	47
Active patients – average per month			
<b>Age</b> (deaths and discharges)			
Average age (years)	73.0	72.3	73.0
< 65yrs	100 24%	106 26%	111 24%
65 yrs and over	316 76%	300 74%	353 76%
<b>Gender</b> (deaths and discharges)			
Male	237 57%	208 51%	250 54%
Female	179 43%	198 49%	213 46%
<b>Ethnicity</b> where stated (deaths and discharges)			
European	314 84%	326 85%	360 85%
Maori	51 14%	50 13%	53 13%
Other	9 2%	7 2%	9 2%
<b>Place of death</b>			
Home	140 38%	130 36%	143 34%
Hospital	57 15%	54 15%	68 16%
IPU	79 21%	95 26%	113 27%
Residential care home	95 26%	87 24%	91 22%
<b>Diagnosis</b> (deaths and discharges)			
Cancer	376 91%	366 90%	410 88%
Non-cancer	38 9%	40 10%	54 12%
<b>Length of stay (days)</b>			
Average all patients	153 *	137*	132*
Average LOS cancer diagnosis	158	145	140
Average LOS all non-cancer	107	62	69
<b>Number of assessments</b>			
Initial assessments	494	388	399
Ongoing nursing assessments	1175	1349	1285
Ongoing medical assessments	2292	2310	2646
Domiciliary nursing visits - home	7217	6447	6192
Admissions to inpatient unit	273	245	247
Bed days	2147	2217	2480
Bereavement/grief and loss visits	524	491	673
<b>Residential care</b> (respite & end of life)			
Number of days (financial year data)			
Average bed days per patient			

Source: Ministry of Health monitoring returns as completed by Waipuna Hospice

\* Adjusted to exclude patients with average LOS in excess of 5 years

2008: 3 patients – 5.2, 6.3 and 6.6 years

2009: 1 patient – 12.36 yrs ? data issue

2010: 1 patient – 5.9 years

## PALLIATIVE CARE SERVICE PLANNING – Service description for Hospice EBOP

<b>DHB</b>	<b>Bay of Plenty</b>
<b>Hospice</b>	<b>Eastern Bay of Plenty (Hospice EBOP)</b>
<b>Description</b>	Hospice BBOP provides single point of entry specialist palliative care services in the EBOP community. The model of care is care coordination provided by the hospice with nursing visits provided either by hospice nurses or via links with district nursing services depending on the location of the patient (e.g. for patients in Te Kaha and Murupara).
<b>Population Served</b>  <b>Population Characteristics</b>	<p>Population base at 2006 census: 50,850</p> <p>Geographical area covers territorial authorities of :</p> <ul style="list-style-type: none"> <li>• Whakatane</li> <li>• Opotiki</li> <li>• Kawerau</li> </ul> <p>EBOP is 25% of total BOP DHB population</p> <p>50% Māori</p> <p>Population predicted to decline by 1% (580) between 2011 and 2016</p> <p>Increasing proportion of 65 yrs and over</p> <ul style="list-style-type: none"> <li>• 2006 = 13% of total</li> <li>• 2016 = 17% of total</li> </ul> <p>Rural/remote patients/families</p> <p>Low socioeconomic status in rural areas</p> <p>Lower life expectancy compared with WBOP</p>
<b>Key Services</b>	<p><b>Nursing</b></p> <ul style="list-style-type: none"> <li>• Specialist nursing team provides community based nursing care mainly in the patient's own home.</li> <li>• 24/7 nursing support and advice for patients/whānau/carers and other generalists. Out of hours support is via phone and nurses on call.</li> <li>• Care coordination and liaison with GPs and other services.</li> <li>• Weekly patient review team meeting and family meetings as required.</li> <li>• Coordinates placements in palliative beds for respite or end-stage care.</li> <li>• In-reach service to Whakatane Hospital.</li> </ul> <p><b>Medical</b></p> <ul style="list-style-type: none"> <li>• Access to 24/7 specialist medical advice (telephone support) from Waipuna specialist (not formalised).</li> <li>• GP remains primary medical lead for patients.</li> </ul> <p><b>Equipment loan</b></p> <ul style="list-style-type: none"> <li>• Short term loan of equipment to support care at home.</li> <li>• Example syringe drivers, wheelchairs, electric beds, nebulizers, shower stools, commodes, pressure mattresses, lazy boy chairs.</li> </ul> <p><b>Day programme</b></p> <ul style="list-style-type: none"> <li>• Once weekly for social networking, respite and relaxation, massage.</li> </ul> <p>Grief and bereavement / family support :</p>

	<ul style="list-style-type: none"> <li>• Counselling or support for patient and whānau encountering the grief of a terminal illness.</li> <li>• Contact and support after death for all bereaved families.</li> <li>• Bereavement support group and acknowledgment of the anniversary of the patient's death.</li> <li>• Biography service.</li> </ul> <p>Education</p> <ul style="list-style-type: none"> <li>• Caregivers training.</li> <li>• Syringe driver.</li> <li>• Palliative care education days.</li> <li>• LCP.</li> <li>• In-service sessions for generalist s e.g. delirium.</li> <li>• Address orientation sessions at Whakatane Hospital (nurses?).</li> <li>• Provides access to Genesis Oncology Breakfast Lectures.</li> <li>• Public education via invited speaking engagements.</li> </ul> <p>Volunteer support service</p> <ul style="list-style-type: none"> <li>• Trained family support volunteers provide companionship, advocacy, practical support (driving, shopping), carer relief, day programme support, biography service.</li> </ul> <p>Inpatient services/ beds</p> <ul style="list-style-type: none"> <li>• Hospice has access to two rest home beds (for end of life or respite) funded via Support Net. Also has access to another bed via a floating fund for non-Whakatane residents.</li> <li>• Access to Waipuna Hospice inpatient unit beds if necessary</li> </ul>
<b>LCP</b>	<p>Implementation of LCP is a Midland regional initiative. Waipuna Hospice is the lead organisation for implementation of end of life LCP in the DHB, including Eastern Bay of Plenty.</p> <p>Education and implementation completed for version 12 with</p> <ul style="list-style-type: none"> <li>• Hospice EBOP community team</li> <li>• residential care facilities in Whakatane</li> <li>• Whakatane Hospital.</li> </ul>
<b>Workforce</b>	<p>Total paid workforce 8.6 FTE as at 1 July 2010.</p> <ul style="list-style-type: none"> <li>• Management/admin/public relations 4.0 FTE</li> <li>• Registered nurses 3.6 FTE</li> <li>• Family support /Volunteer co-ordinator 0.5 FTE</li> <li>• Counsellor 0.5 FTE</li> </ul> <p>Volunteers – Around 50 volunteers contributed approx 3500 hours per annum on 2009/10 year (excludes shop hours). Increased to approx 7000 hrs in 2010/11. Volunteers are considered an integral part of the efficient functioning of Hospice EBOP.</p>
<b>Information/patient management systems</b>	<p>Hospice EBOP has historically managed its patient data using MedTech32, excel spreadsheets and a paper based system.</p> <p>Currently implementing PalCare as a part of a regional initiative. Waipuna Hospice lead organisation.</p>
<b>Quality standards</b>	<p>Accredited under EQUIP4 standards.</p>
<b>Key Linkages</b>	<p>Local and BOP</p> <ul style="list-style-type: none"> <li>• General practice teams / PHO teams</li> <li>• EBOP residential care providers</li> </ul>

	<ul style="list-style-type: none"> <li>• Home help &amp; personal cares providers</li> <li>• Whakatane Hospital services</li> <li>• BOP DHB district nurses, physiotherapists, occupational therapists, social workers</li> <li>• Māori health providers</li> <li>• Cancer Society and other support groups</li> <li>• Support Net</li> <li>• Waipuna Hospice</li> </ul> <p>Regional / national:</p> <ul style="list-style-type: none"> <li>• Hospices in other DHB areas</li> <li>• Midland Palliative Care Work Group</li> <li>• Midland Cancer Network</li> <li>• Hospice New Zealand</li> </ul>
--	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

**Gaps identified in the 2009 Ministry of Health Gap Analysis of services provided by specialist palliative care providers in New Zealand.**

*Extracted from the summary findings from Gap Analysis: Hospice Eastern Bay of Plenty*

	<b>Identified gap</b>	<b>Comments / Actions to address</b>
1.	No medical specialist resource in Whakatane.  No established medical specialist clinics.	Improving with support provided from Waipuna Hospice palliative medicine specialist. Arrangement not formalised.
2.	Home visits by GPs out of normal working hours are limited.	Access to GPs out of hours and availability of GPs to do home visits remains inconsistent and is an issue.
3.	Provision of a limited number of education courses (2007/08) although the hospice anticipates this area to grow with the recent appointment of an experienced nurse educator.	This has improved with appointment of additional nursing staff.
4.	No definite plans regarding when an end of life care programme (LCP) will be implemented.	Implementation in progress, 45% complete as at June 2011
5.	An absence of effective and appropriate linkages with some services and organisations but these may not be applicable for Hospice EBOP.	Not considered an issue.
6.	No access to after hours pharmacist or GP.	Continues to be an issue.

## Hospice Eastern Bay of Plenty – Patient demographics

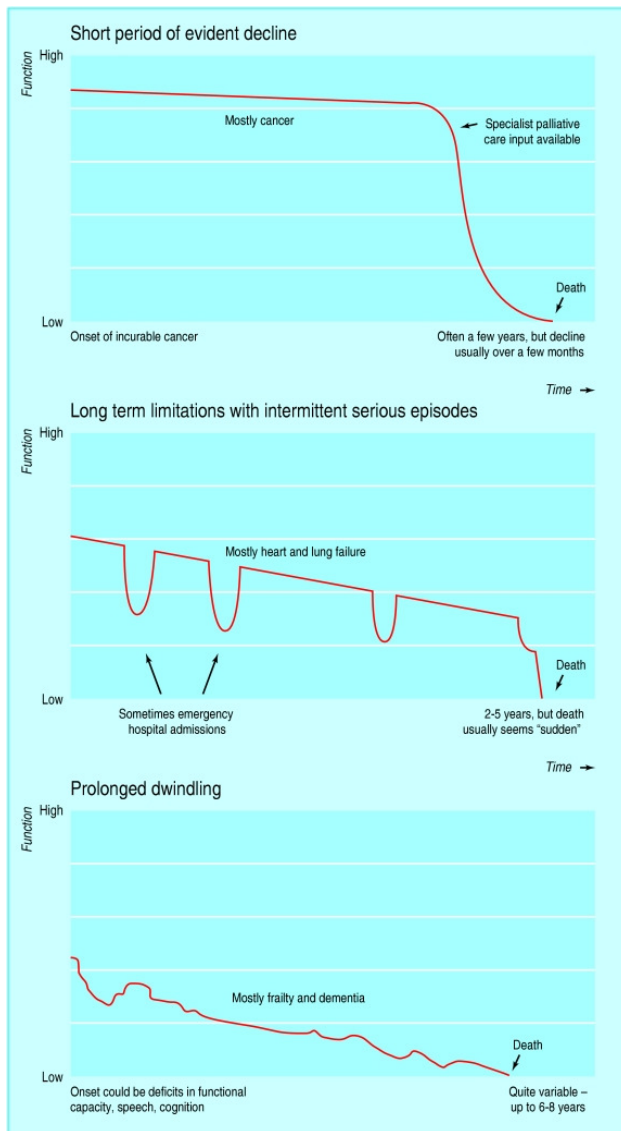
	2008	2009	2010
<b>Patients</b> (deaths and discharges)			
Total patient numbers	126	169	187
Deaths	115 91%	143 85%	160 86%
Transfers/discharges	11 9%	26 15%	27 14%
Active patients – average per month	54	51	50
<b>Age</b> (deaths and discharges)			
Average age (years)	71.2	70.3	71.7
< 65yrs	37 29%	53 31%	62 33%
65 yrs and over	89 71%	116 69%	125 67%
<b>Gender</b> (deaths and discharges)			
Male	69 55%	87 51%	101 54%
Female	57 45%	82 49%	86 46%
<b>Ethnicity</b> (deaths and discharges)			
European	84 67%	96 57%	116 62%
Maori	41 33%	72 43%	65 35%
Other	1 1%	1 1%	6 3%
<b>Place of death</b>	6/12 months data		
Home	24 60%	77 54%	96 60%
Hospital	4 10%	33 23%	33 21%
Residential care home	12 30%	33 23%	31 19%
<b>Diagnosis</b> (deaths and discharges)			
Cancer	99 79%	135 80%	135 72%
Non-cancer	27 21%	34 20%	52 28%
<b>Length of stay (days)</b>			
Average all patients	92	125	108
Average LOS cancer diagnosis (369pts)	107	142	130
Average LOS all non-cancer (113pts)	38	57	50
<b>Number of assessments</b>			
Nursing assessments – phone calls	1202	1884	2476
Domiciliary nursing visits - home	1918	1313	1968
Bereavement/grief and loss visits	124	30	91
<b>Residential care</b> (respite & end of life)			
Number of days***			
Average bed days per patient			

Source: Ministry of Health monitoring returns as completed by Hospice Eastern Bay of Plenty

\*\*\* Note this is supplied as financial year

## Illness trajectories and palliative care

Figure 1



**Source:**

**Figure 1.**

Lynn J, Adamson DM. *Living well at the end of life. Adapting health care to serious chronic illness in old age*. Washington: Rand Health, 2003.

**Source article:**

Murray SA, Kendall M, Boyd K, Sheikh A. *Illness trajectories and palliative care*. BMJ April 2005; vol 330, pp 1007-1011.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC557152/>

### Trajectory 1: short period of evident decline, typically cancer

This entails a reasonably predictable decline in physical health over a period of weeks, months, or, in some cases, years. This course may be punctuated by the positive or negative effects of palliative oncological treatment. Most weight loss, reduction in performance status, and impaired ability for self care occurs in patients' last few months. With the trend towards earlier diagnosis and greater openness about discussing prognosis, there is generally time to anticipate palliative needs and plan for end of life care. This trajectory enmeshes well with traditional specialist palliative care services, such as hospices and their associated community palliative care programmes, which concentrate on providing comprehensive services in the last weeks or months of life for people with cancer. Resource constraints on hospices and their community teams, plus their association with dying, can limit their availability and acceptability.

### Trajectory 2: long term limitations with intermittent serious episodes

With conditions such as heart failure and chronic obstructive pulmonary disease, patients are usually ill for many months or years with occasional acute, often severe, exacerbations. Deteriorations are generally associated with admission to hospital and intensive treatment. This clinically intuitive trajectory has sharper dips than are revealed by pooling quantitative data concerning activities of daily living. Each exacerbation may result in death, and although the patient usually survives many such episodes, a gradual deterioration in health and functional status is typical. The timing of death, however, remains uncertain. In one large study, most patients with advanced heart failure died when expected to live for at least a further six months. Many people with end stage heart failure and chronic obstructive pulmonary disease follow this trajectory, but this may not be the case for some other organ system failures.

### Trajectory 3: prolonged dwindling

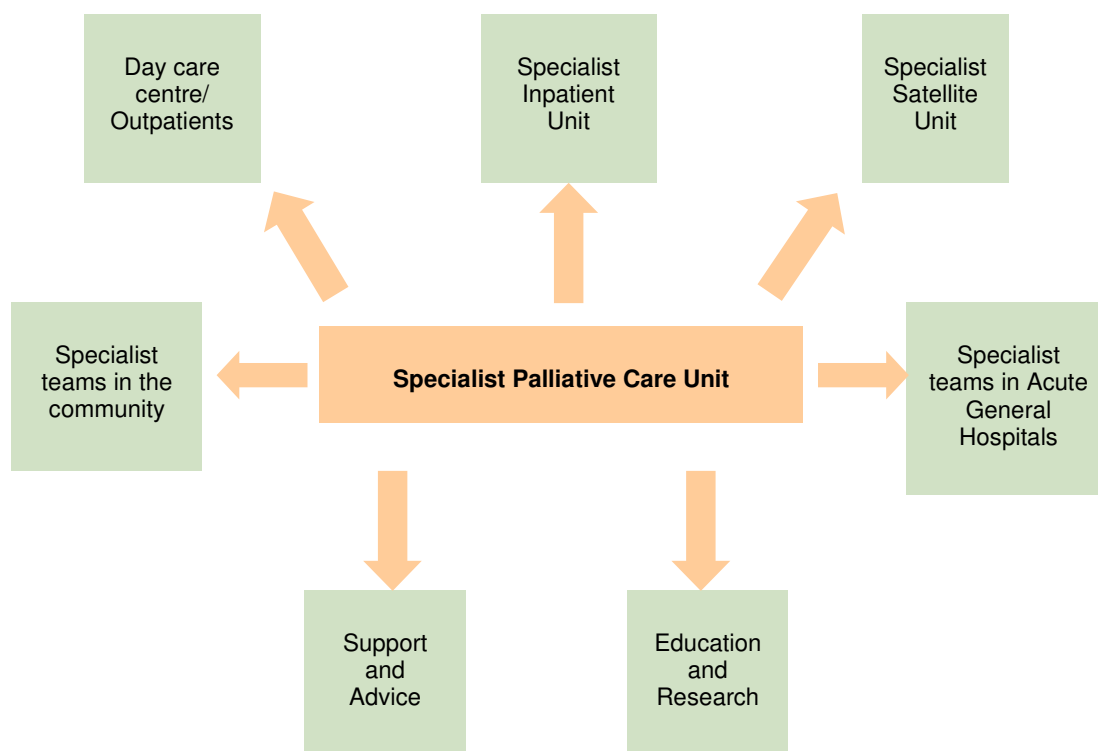
People who escape cancer and organ system failure are likely to die at an older age of either brain failure (such as Alzheimer's or other dementia) or generalised frailty of multiple body systems. This third trajectory is of progressive disability from an already low baseline of cognitive or physical functioning. Such patients may lose weight and functional capacity and then succumb to minor physical events or daily social "hassles" that may in themselves seem trivial but, occurring in combination with declining reserves, can prove fatal. This trajectory may be cut short by death after an acute event such as a fractured neck of femur or pneumonia.

## Palliative care in acute general hospitals: international examples

The following provides a description of palliative care in acute general hospitals in Ireland and Australia.

### Ireland<sup>34</sup>

In Ireland, the focus has been on establishing specialist palliative care (SPC) inpatient units as the core essential element of the SPC service in each health board area. It should be the “hub” of the service, around which all components of the specialist service revolve. SPC services in all other settings, including the community and hospital settings, should be based in or have formal links with the SPC unit.



The report has seven key recommendations for specialist palliative care in acute general hospitals in Ireland.

1. All acute general hospitals should have a consultant-led SPC service, offering advice and support to health care professionals in the hospital.
2. The SPC team should work alongside other hospital teams, complementing their work, rather than taking over care of the patient.
3. The SPC team in an acute general hospital should consist of at least a consultant in palliative medicine, a specialist palliative care nurse, a social worker and a secretary.
4. Joint outpatient clinics should be established in acute general hospitals, allowing the SPC team to become involved in inpatient care at an early stage in the disease process.
5. Arrangements should be made to “fast-track” outpatient appointments for patients receiving palliative care.

<sup>34</sup> Department of Health and Children: *The Report of the National Advisory Committee on Palliative Care*, Ireland. 2001



6. There should be one point of entry to hospital services for palliative care patients, and subsequent referrals should be speedily organised.
7. In A&E, the patient's condition should be rapidly assessed, and the patient should be referred to the appropriate team without delay.

Irish guidelines recommend a consultant-led multidisciplinary palliative care team in each acute hospital of 150 beds or more. Resourcing is recommended to include a SPC nurse, a social worker and a secretary, led by the palliative medicine specialist working across the range of settings and who was available in the hospital for a defined minimum number of sessions per week.

Consultant specialists may have joint appointments between inpatient SPC units and acute general hospitals. Also consultant appointments that are regionally based covering hospital and community services are emerging.

The Irish guidelines suggest that for smaller general hospitals, where it may not be feasible to employ a full-time specialist palliative care team, the SPC team serving the community should provide a service to patients in the hospital.

### **Australia<sup>35</sup>**

A significant proportion of anticipated deaths still occur in acute hospitals and many patients are identified as needing palliative care while in acute hospital. The availability of specialist palliative care practitioners within hospital and clinic settings is likely to increase the timeliness and rate of referral to palliative care services and to improve the symptomatic management of these patients.

Australian guidelines are based on staffing a consultative service for an acute hospital of 125 beds

Specific roles for palliative care in the acute setting include:

- assessment, symptom management and consultation;
- discharge planning for all palliative patients; and
- education of health care providers throughout the hospital.

In Australia, to be considered as providing comprehensive cancer care, every cancer centre must have active, interdisciplinary specialist palliative care service participation.

### **In-hospital palliative care delivery methods**

There are three methods most frequently referred to in literature and various guides. The Centre to Advance Palliative Care (Australia) gives a concise description which is amended below<sup>36</sup> :

- **Consultative approach**  
Primarily operates as a consultative service. Consultant or clinical nurse specialist (CNS) undertakes an initial assessment and refers to other services as needed. Work is undertaken with family on plans for the future. Referrals received from doctors, patient or family. All units within the hospital deliver palliative care. The palliative care consultant or CNS develops protocols with treatment team and educates staff.
- **Inter or multidisciplinary team approach**  
This is a consultative service with a team of professionals from different disciplines (e.g. doctors, nurses, social workers) assessing and following through with patients. May be primarily advisory to referring physician or may assume part of the care of the patient. This approach may include a case management component by a palliative care social worker. All hospital units should deliver palliative care as a part of their function.
- **Inpatient approach**  
This involves an inpatient unit (ward) within the hospital with designated beds and specially trained staff. The palliative care team assumes responsibility for patient management and discharge planning.

<sup>35</sup> Palliative Care Australia *Palliative Care Service Planning in Australia: A Planning Guide*, 2003

<sup>36</sup> From Waitemata DHB In-hospital Adult Palliative Care Strategy and Service Development Plan, 2006-2010  
Waitemata DHB

## Cost effectiveness of hospital palliative care

There is little research in New Zealand on the cost effectiveness of hospital palliative care. A literature review undertaken by the University of Dublin Centre for Health Policy and Management (2007) *Cost-Effectiveness of Palliative Care in Hospital: A Review of Literature* found that hospital-based palliative care can cost less than conventional care by:

- decreasing the intensity of treatment
  - a reduction in unnecessary resource utilisation (tests and drugs) and spare expensive technological resources
  - improvement in communication among patients, their families, and the primary treating physician about goals of care.
- implementing structured planning. The palliative care services can be paid for from cost savings which include:
  - shortened length of stay in general
  - decreased “bounce back” and emergency admissions on recently discharged patients who return because of symptom management problems
  - decreased stays in intensive care units by, but not limited to, dying people
  - direct admission to palliative care unit
  - prevented transfers between units
  - death outside the hospital.

One study suggested that depending on how well referral sources are educated and informed in advance of the initiative, these substantial cost savings can be documented often within one to two years.

A number of studies included in the literature review concluded that hospitals have begun to invest in palliative care services to enhance quality of care and because of their measurable impact on reducing ICU and total bed days but also for their efficacy in supporting transitions from high intensity, high cost hospital settings to more appropriate and desired care settings, such as home.

## WESTERN BAY OF PLENTY - Stakeholder summary

STRENGTHS	COMMENTS
1. Model of care <ul style="list-style-type: none"> <li>single point of entry for specialist palliative care services in WBOP</li> <li>care coordination</li> <li>continuity of care</li> </ul>	<ul style="list-style-type: none"> <li>Continuity of care – no mixed model of nursing care (district nurses not involved in care of patients at home)</li> <li>Specialist medical home visits when necessary</li> </ul>
2. Waipuna Hospice facilities	<ul style="list-style-type: none"> <li>Inpatient unit 9 beds with ability to increase to 12</li> <li>On site clinics for community patients</li> <li>Scope for further development on site</li> </ul> <p>But lack of space in current building limits ability to expand day programme.</p>
3. Workforce and services – Waipuna Hospice	<ul style="list-style-type: none"> <li>Strong leadership / organisational structure</li> <li>Good internal staff mix</li> <li>Good medical staff support (mix of specialist and GP/MO) but light on specialist resource for region-wide service</li> <li>24/7 medical and nursing support – mix of on duty/on call</li> <li>24/7 medical advice (telephone support) for full BOP region</li> <li>hospital liaison nurse to assist with referrals and discharges (employed by Waipuna Hospice)</li> <li>Good aged care liaison with dedicated liaison nurse position</li> <li>Social work, counselling, chaplain and bereavement support resources directly employed by Waipuna Hospice</li> <li>Dedicated LCP and education resource gives focus for these activities</li> <li>Good volunteer structure and training programmes in place.</li> <li>Strong volunteer support</li> </ul>
4. Good grief and loss support in district	<ul style="list-style-type: none"> <li>Hospice family support team including counselling, social work, bereavement support programmes and groups</li> <li>Hospice strength working with families and providing young family support</li> <li>Community - some PHO access to counselling/psychologist. Western PHO grief support funding</li> <li>Private grief counselling – 6 free sessions (DHB funded). Anyone can access via GP or hospice</li> </ul>
5. Kaitiaki Nursing Services (Whānau cancer support nurses for Māori clients and their whānau affected by cancer)	The partnership model with hospice nurses works well. However this is a service specific to cancer patients. There is no single non-oncology parallel.
6. Palliative care education/training	<ul style="list-style-type: none"> <li>Dedicated education resources at hospice</li> <li>Increasing range of programmes</li> <li>Relationship with Polytech - nursing student visits/placements</li> <li>Waipuna Hospice accredited for medical advanced trainees and</li> </ul>

	trainee placements provided																																				
7. LCP implementation	<p>Good progress on implementation of LCP</p> <table><tr><td></td><td colspan="3">As at 30 June 2011</td></tr><tr><td></td><td>Total Possible</td><td>LCP education/implemented</td><td>%</td></tr><tr><td><b>WBOP</b></td><td></td><td></td><td></td></tr><tr><td>GP practices Tga</td><td>28</td><td>22</td><td>79%</td></tr><tr><td>ARCs Tga</td><td>16</td><td>13</td><td>81%</td></tr><tr><td>Tga Hospital</td><td>10</td><td>6</td><td>60%</td></tr><tr><td>Waipuna inpatient</td><td>1</td><td>1</td><td>100%</td></tr><tr><td>WBOP comm team</td><td>1</td><td>0</td><td>0%</td></tr><tr><td></td><td><b>56</b></td><td><b>42</b></td><td><b>75%</b></td></tr></table>		As at 30 June 2011				Total Possible	LCP education/implemented	%	<b>WBOP</b>				GP practices Tga	28	22	79%	ARCs Tga	16	13	81%	Tga Hospital	10	6	60%	Waipuna inpatient	1	1	100%	WBOP comm team	1	0	0%		<b>56</b>	<b>42</b>	<b>75%</b>
	As at 30 June 2011																																				
	Total Possible	LCP education/implemented	%																																		
<b>WBOP</b>																																					
GP practices Tga	28	22	79%																																		
ARCs Tga	16	13	81%																																		
Tga Hospital	10	6	60%																																		
Waipuna inpatient	1	1	100%																																		
WBOP comm team	1	0	0%																																		
	<b>56</b>	<b>42</b>	<b>75%</b>																																		
8. Community support for Waipuna Hospice	<ul style="list-style-type: none"><li>Well supported and respected by community</li></ul> See also issue – level of community funding difficult to sustain																																				
9. Strong regional relationships	<ul style="list-style-type: none"><li>Between service providers within BOP</li><li>With Waikato specialist palliative care services</li></ul>																																				
10. Residential care	<ul style="list-style-type: none"><li>7 fully funded dedicated palliative care beds</li></ul> See also issue – access to beds prioritised to those with cancer or end stage renal failure.																																				
11. Links with district nursing	Linkages between district nurses and hospice for cross over of care for complex patients.																																				
12. Good level of support from mental health services for people with dementia, including support for caregivers	Severe dementia – specialised work for specific age group																																				
13. Tauranga Hospital model of care for Māori.	Appropriate supportive care environment e.g. Kaupapa Māori ward, patient navigators.																																				
14. PalCare information system	Implementation enabling single electronic patient record. 2 <sup>nd</sup> phase opportunity will be GP access to see patient record. Need to look at how PalCare can link with Bay Navigator information technology (website) which gives GPs access to information.																																				
15. BOP have resident medical oncology service																																					
16. Support Net – strong relationships across sector	However, see issues below																																				

ISSUES	COMMENTS
1. No hospital-based specialist palliative care team in BOP	
2. Hospital discharges with poor medication planning and prescribing	Waipuna Hospice usually has to sort out the problems. Out of hours pharmacies are available up to about 9pm 7 days.
3. Out of hours availability and home visits by GPs for palliative patients	<ul style="list-style-type: none"> <li>• A lot of GP practices don't provide after hours services. The out of hours service in Tauranga is run from a single company – not sure if patients go there.</li> <li>• Home visit by GP = \$400. This is prohibitively expensive for patients.</li> <li>• Some aged care facilities report issues with access to GP after hours. Difficulty getting GP to prescribe after hours or in weekends. Some residents die in pain unnecessarily.</li> </ul> <p>Waipuna medical and nursing support is available 24/7 - challenge for Waipuna Hospice doctors/specialist is to decide whether extra scans/xrays are needed and to advise if hospital ED is the best first point of call (e.g. there is a significant proportion of calls out of hours to do with falls)</p>
4. Education	Medical students and RMOs don't go through Waipuna Hospice as part of their education/training.
5. Māori cultural issues	<p>Recognised gap for Waipuna. Requires the input of Māori to help develop cultural aspects of palliative care and end of life care. Issue is not about diagnosis or clinical aspects but Māori cultural aspects that should fit alongside other inputs. This is not exclusive to Māori but applies to other cultures as well, especially for end of life care. Need to establish links with iwi to get input/partnership:</p> <ul style="list-style-type: none"> <li>• establish what hospice needs to do to be patient focussed for Māori</li> <li>• raise awareness of the needs of Māori as opposed to the needs of the disciplines delivering service/s</li> <li>• develop specific packages of education for disciplines – medical, nursing, allied health.</li> <li>• the coming generation all speak Māori - how will services prepare/respond?</li> </ul> <p>Acknowledged that this is improving but still a work in progress.</p>
6. Documented clinical guidelines and pathways	<ul style="list-style-type: none"> <li>• Those applying within Waipuna are available.</li> <li>• Not much for generalists, more for specialists.</li> <li>• Opportunity to improve/develop.</li> </ul> <p>Need consistency across Midland DHBs</p>
7. Community palliative care access to hospital based procedures	<p>Access to some interventions (x-ray, MRI) is more difficult if the medical specialist is outside the DHB. Currently can have some problems getting access to these interventions as hospice medical specialist has no privilege access to any imaging.</p> <p>Example: Hospice cannot book an MRI appointment for a patient with possible spinal cord compression. End up sending patient via ED or GP just to get an MRI.</p>

	This is a huge limitation –opportunity to build linkages with DHB/hospital based palliative care.
8. Transportation costs	<ul style="list-style-type: none"> <li>Cost of nurse-escorted ambulance journey for transfer of patient from Waikato to Waipuna (Waipuna is charged).</li> <li>Cost of ambulance transport between Waipuna Hospice and patient's home – patient pays.</li> </ul>
9. Access to respite beds	<ul style="list-style-type: none"> <li>High occupancy rate for the current fully funded beds (7 beds).</li> <li>Ring fenced dedicated beds are prioritised to patients with cancer and ESRF and are all located in Tauranga – no equity of access. Some flexible funding exists to help address bed location issue.</li> <li>Young adults are not dealt with very well. Placed in residential care with old people.</li> <li>No equity in current system – within areas of BOP and between DHBs.</li> </ul>
10. Support Net (NASC) funding	<ul style="list-style-type: none"> <li>Support Net works with prognosis &gt;6 months. This impacts on ability for patient to remain at home, need to go to institution to get support (model of care/ inputs to keep people in their homes). Assessment should be based on need as opposed to prognosis.</li> <li>Current criteria excludes those in WBOP with cancer or end stage renal failure if prognosis is &lt; 6 months – services are provided by Waipuna Hospice (see 11. below).</li> <li>Those with other chronic conditions and if considered to be at end stage (no prognosis required) come under Support Net for assessment and funding. Can get up to 7 days/week support.</li> <li>Younger people not eligible?</li> </ul>
11. Package of care for home support/personal care reduces when a patient moves from DN (Support Net funded) to hospice care.	<ul style="list-style-type: none"> <li>Patient who moves from elderly (frail) to elderly (palliative) level of support reduces from 7 days per week fully funded to 3 days per week (part funded Waipuna Hospice 50%/DHB 50%).</li> <li>Younger people not eligible ?</li> </ul>
12. DHB allied health services in the community are fragmented and not funded particularly well	<p>e.g. dietitians, speech language therapy, social work, occupational therapy, physiotherapy.</p> <ul style="list-style-type: none"> <li>Need closer links with hospice as the specialist service – especially for hospice outpatient clinics. Allied professions have a lot of skill to bring to services.</li> <li>Allied health in community is built around historical funding – difficult mechanism to grow AH input/role in the community.</li> </ul>
13. Need to grow the palliative care philosophy in the BOP	<ul style="list-style-type: none"> <li>Community awareness/perception of hospice (current focus is end of life vs palliative)</li> <li>Other health professionals understanding of palliative care (increase awareness around timeliness of referral)</li> <li>Grow understanding of palliative care for nonmalignant/chronic illnesses</li> <li>Need training around having the difficult conversations.</li> </ul>
14. Meeting needs of younger patients in palliative care	<ul style="list-style-type: none"> <li>Younger patients don't receive as much access to support as those who are 65+ e.g. Younger patients who require long-term hospital level care can't go into aged residential care, and do not have the same access to NASC funding.</li> </ul>
15. Funding	<ul style="list-style-type: none"> <li>Inconsistent funding approach nationally (there is to be work on a new national funding model)</li> </ul>

	<ul style="list-style-type: none"> <li>Funding is fragmented - multiple organisations involved</li> <li>Demand estimated to grow – pool of public funding is not</li> <li>Income from bequests, donations and community funding to support the gap in public funding for hospices is increasingly difficult to secure.</li> <li>Current model of funding not very supportive of how palliative care is delivered i.e. does not support GP visits for patient &amp; family whānau or intermittent nature of input by specialist PC services.</li> <li>Silo funding doesn't work - not patient centred. Doesn't fit disease process. Needs to change.</li> <li>National issue – medication costs incl ketamine. Makes a difference between patient being at home and having to go to hospital.</li> <li>Palliative patients miss out on Enable funding for equipment and housing modifications because criteria requires assessment that they are expected to live in their own home for more than 2 years.</li> <li>No consistency across the country for people to access palliative care funding.</li> </ul>
16. Equipment / consumables	<ul style="list-style-type: none"> <li>Waipuna Hospice supplies equipment for their patients.</li> <li>If not a Waipuna patient, access to equipment is via the DHB community services or hospital inpatient services.</li> <li>Rising patient numbers puts pressure on equipment supplies.</li> </ul>
17. Carer support	<ul style="list-style-type: none"> <li>Need to have good carer support especially to make home environment more viable in the model of care.</li> </ul>

OPPORTUNITIES	COMMENTS
---------------	----------

**Current projects under way and others identified as useful for the future**

1. National palliative care projects in progress	<ul style="list-style-type: none"> <li>Development of: <ul style="list-style-type: none"> <li>role delineation model/resource and capability framework (2011)</li> <li>models of care (2011)</li> <li>national funding model (begin 2011/2012)</li> <li>specialist palliative care service specifications (2012)</li> </ul> </li> <li>MOH consideration of Gold Standards Framework</li> <li>Palliative Care HNA work</li> <li>Health Workforce NZ palliative care workforce service review</li> <li>Hospice NZ Standards project</li> <li>Hospice NZ education package development</li> </ul>
2. Advance Care Planning (ACP)	<ul style="list-style-type: none"> <li>New Zealand national guidance document and tools for ACP now available</li> <li>Regional project opportunity for rollout (similar to LCP rollout). Will require project resource &amp; funding.</li> </ul>
3. Implementation of PalCare	<p>Phase one implementation into hospices in Midland in progress under the leadership of Waipuna Hospice.</p> <p>Significant opportunity to:</p> <ul style="list-style-type: none"> <li>improve patient information management</li> <li>improve reporting accuracy &amp; consistency and create efficiencies</li> <li>improve access by others to patient information for provision of care</li> </ul>



	Phase 2 will consider access by others (non hospice) and integration with other systems.
4. PHO / primary practice - "Better, sooner, more convenient" initiatives	<ul style="list-style-type: none"> <li>• Opportunity for improved integration of services</li> <li>• Development of palliative care pathways in Bay Navigator</li> </ul>
5. Improvements in technology / availability of technology	<p>Example</p> <ul style="list-style-type: none"> <li>• Videoconferencing palliative care consultations to improve access to medical specialists and improve efficiency in use of medical specialist time. Comment- BOP DHB does not currently have very good MDT/videoconference facilities set up with appropriate technology. It is improving and hospital to hospital access should be available by end of 2011).</li> <li>• Expand use of videoconferencing education sessions to improve access.</li> <li>• PalCare – what elements can be linked to Tauranga Hospital 'Bay Navigator' site.</li> </ul>
6. Education /training	<ul style="list-style-type: none"> <li>• Site accreditation for advanced trainees has been achieved at Waipuna Hospice. Opportunity to apply for an Advanced Training position – part funded by HWNZ &amp; PaMTraCC.</li> <li>• Include Waipuna Hospice rotations/placements as part of education/training of medical students/RMOs.</li> <li>• Training to have the difficult conversations.</li> <li>• Carer education programme - Care for the carer, developing the skills needed in the home. (Note Waipuna carer programme starts November)</li> </ul>
7. Assessment tool InterRAI	How does it relate to palliative patients? Duplication of information from families. Consider relationship with PalCare – some information may be able to be linked between the systems. Hospices may be able to get read only access to InterRAI.

## EASTERN BAY OF PLENTY – Stakeholder summary

STRENGTHS	COMMENTS
17. Model of care <ul style="list-style-type: none"> <li>single point of entry for specialist palliative care services in EBOP</li> <li>care co-ordination</li> </ul>	<p>Palliative care nursing in the home working in conjunction with district nurses in some rural areas and Māori provider services as required.</p> <p>Good relationships between services. Good communication between district nurses and hospice.</p>
18. Recently extended hospice facilities	<p>Additional property purchased to accommodate hospice's growing need.</p> <p>Hospice EBOP strategic plan includes developing inpatient beds 10 plus years out. Not on current building programme. Is dependent on population need for inpatient beds and ability to secure capital and operational funding in the future, reviewed on an ongoing basis.</p>
19. Workforce & services –Hospice EBOP	<ul style="list-style-type: none"> <li>Strong leadership &amp; experience in hospice</li> <li>Very low staff turnover rate</li> <li>24/7 nursing support – well known and used by generalist, patient and whānau.</li> <li>24/7 medical advice (telephone support) available from Waipuna Hospice (but needs to be formalised)</li> <li>Counselling resources directly employed by Hospice EBOP</li> <li>Good volunteer support from community</li> </ul>
20. Strong relationships with local Māori	<ul style="list-style-type: none"> <li>Hospice EBOP has worked hard to establish good relationships and services for Māori. High proportion of patients are Māori (43% in 2009 and 35% in 2010, YTD 2011 44%) relative to:               <ul style="list-style-type: none"> <li>BOPDHB population (25%)</li> <li>NZ (14.7%)</li> </ul> </li> <li>Māori Liaison position in 2008/2009 funded through DHB Innovation Funding. Number of Māori patients went up during this time. Has now ended. MOH funded service development project followed in 2010 – interviewing Māori</li> </ul> <p>Continue to strengthen relationships with Māori providers and Whānau Ora group.</p>
21. Good grief and loss support	<ul style="list-style-type: none"> <li>Hospice counsellor and bereavement support group available to non-hospice as well</li> <li>Access to hospital chaplain and social worker</li> <li>Kaumātua &amp; Māori advocates</li> <li>Biography service valued</li> </ul>
22. Palliative care education for generalists	<ul style="list-style-type: none"> <li>Range of programmes available is increasing</li> </ul>
23. Strong relationships	<ul style="list-style-type: none"> <li>Very good linkages between hospice and inpatient service at Whakatane Hospital</li> <li>Hospice has good access to and relationships with home based</li> </ul>

	<ul style="list-style-type: none"><li>support agencies to support people to stay at home.</li><li>Hospice EBOP and Waipuna Hospice have developed strong alliance and regional networks.</li><li>Hospice relationship with Golden Pond works well (2 funded beds)</li></ul>																												
24. Liverpool Care Pathway implementation	<ul style="list-style-type: none"><li>Good progress on implementation of LCP</li></ul> <table><tr><td></td><td colspan="3">As at 30 June 2011</td></tr><tr><td><b>EBOP</b></td><td><b>Total Possible</b></td><td><b>LCP education/implemented</b></td><td><b>%</b></td></tr><tr><td>GP practices Whaka</td><td>15</td><td>6</td><td>40%</td></tr><tr><td>ARCs Whak</td><td>4</td><td>1</td><td>25%</td></tr><tr><td>Whakatane Hosp</td><td>2</td><td>2</td><td>100%</td></tr><tr><td>EBOP comm team</td><td>1</td><td>1</td><td>100%</td></tr><tr><td></td><td>22</td><td>10</td><td>45%</td></tr></table>		As at 30 June 2011			<b>EBOP</b>	<b>Total Possible</b>	<b>LCP education/implemented</b>	<b>%</b>	GP practices Whaka	15	6	40%	ARCs Whak	4	1	25%	Whakatane Hosp	2	2	100%	EBOP comm team	1	1	100%		22	10	45%
	As at 30 June 2011																												
<b>EBOP</b>	<b>Total Possible</b>	<b>LCP education/implemented</b>	<b>%</b>																										
GP practices Whaka	15	6	40%																										
ARCs Whak	4	1	25%																										
Whakatane Hosp	2	2	100%																										
EBOP comm team	1	1	100%																										
	22	10	45%																										
25. Community support for Hospice EBOP	<p>Well supported and respected by community.</p> <p>See also issue – level of community funding difficult to sustain.</p>																												

Note: Keep access to services simple (simplify the pathways)

ISSUES	COMMENTS
<p>1. Workforce –</p> <ul style="list-style-type: none"> <li>Lack of palliative care specialist medical resource</li> <li>Sustainable funding for education and building competency</li> <li>Need for palliative care social work position in the community</li> </ul>	<ul style="list-style-type: none"> <li>Lack of palliative care specialist medical resource for regular clinics and education of GPs &amp; hospital doctors. Could be achieved with an MOU with Waipuna but issue is shortage of palliative care specialist FTE.</li> <li>Hospice EBOP casemix is now about 30% nonmalignant. Issue is the skill base of the staff to deliver care for nonmalignant case mix as growth occurs.</li> </ul>
<p>2. Differences between district nursing palliative/oncology nurse and Hospice nurse positions</p>	<ul style="list-style-type: none"> <li>There is a DHB district nurse position with a 0.6 palliative component, located at hospice but not part of the on-call palliative nursing roster. There are issues including participation in on call roster, palliative care training, cover for leave. Filled by 2 nurses oncology/palliative care 1.2 FTE total.</li> <li>DN capacity impacts on Hospice EBOP capacity. If priority is given to oncology patients, hospice nurse picks up extra visits.</li> </ul>
<p>3. Out of hours availability and home visits by GPs for palliative patients</p>	<p>Access to GPs can be a problem.</p> <ul style="list-style-type: none"> <li>Some rural areas do not have on call GP services. No after hours access in Kawerau.</li> <li>Locality of GP after hours (many GPs don't live in Eastern Bay area).</li> <li>Out of town rest homes struggle to get GPs to visit during work hours – travel time is an issue. Some won't visit.</li> </ul>
<p>4. Access to pharmacy out of hours</p>	<ul style="list-style-type: none"> <li>Need GPs to pre-empt everything.</li> <li>Whakatane - GPs can't get Whakatane Hospital Pharmacy to issue any drugs</li> <li>Opotiki - Opotiki Health Centre 24/7 has a small pharmacy</li> </ul>

	<ul style="list-style-type: none"> <li>• Murupara - no pharmacy in town. Drugs delivered twice daily by courier from Te Ngae Pharmacy Rotorua – scripts need to be received at pharmacy by 9am to ensure delivered next day. Rotorua Hospital often discharges Murupara patients home without medication(s) – a significant issue.</li> <li>• Te Kaha - GP does a lot of pre-emptive scripting from Opotiki pharmacies– has not been an issue.</li> </ul>
5. Access to Whakatane Hospital staff for palliative care education	<ul style="list-style-type: none"> <li>• Need to improve opportunities for hospice to educate Whakatane Hospital staff on hospice services etc e.g. participate in orientation sessions and hold palliative care education sessions. Includes need to provided orientation for new doctors. Challenge is the high reliance on locums bringing high turnover – need MOU with BOPDHB.</li> </ul>
6. Lack of documented clinical guidelines and pathways	<ul style="list-style-type: none"> <li>• LCP only</li> <li>• Need to improve/develop</li> </ul>
7. Access to suitable residential/respite care	<ul style="list-style-type: none"> <li>• Two fully funded beds at Golden Pond in Whakatane for palliative end stage or respite is good but often not in location of need. Non preferred provider fund managed by Support Net is available for beds in Kawerau and Murupara if required. Opotiki hospital beds only used if GP can oversee patient.</li> <li>• Shortage of hospital level beds in EBOP</li> <li>• Difficulty accessing suitable long term residential care for those under 65 yrs.</li> </ul>
8. Ambulance transport costs	<p>Cost of St Johns ambulance transport payable by patient in some cases – expensive. Low socioeconomic group – can't afford the cost. Applies within Whakatane and to Hamilton.</p> <p>Positive aspects:</p> <ul style="list-style-type: none"> <li>• hospital pays if palliative patient is discharged home to die. If not end of life, hospital has ½ price arrangements.</li> <li>• If St Johns member home to hospital is free.</li> </ul>
9. Package of care for home support/personal cares	<ul style="list-style-type: none"> <li>• Social work used to pick up the cost of home support for 6 weeks post discharge from hospital but not any more. Hospice now has to pick this up for palliative patients. Change in policy interpretation – needs to be looked at.</li> </ul>
10. Need to grow the palliative care philosophy in the BOP	<ul style="list-style-type: none"> <li>• Community awareness/perception of hospice (current focus is end of life vs palliative)</li> <li>• Other health professionals understanding of palliative care esp hospital services (earlier referral)</li> <li>• Grow understanding of palliative care for nonmalignant/chronic illnesses</li> </ul>
11. Funding	<ul style="list-style-type: none"> <li>• Inconsistent funding approach nationally (there is to be work on a new national funding model)</li> <li>• Funding is fragmented - multiple organisations involved</li> <li>• Demand estimated to grow – pool of public funding is not</li> <li>• Income from bequests, donations and community funding to support the gap in public funding for hospices is increasingly difficult to secure.</li> <li>• Current model of funding not very supportive of how palliative care is delivered i.e. does not support GP visits for patient &amp; family whānau or intermittent nature of input by specialist PC services.</li> <li>• Ability of EBOP community to fund shortfall of DHB contract</li> </ul>

	<p>funding for operational costs is currently difficult.</p> <ul style="list-style-type: none"> <li>Inequity in funding - SIA funding for palliative patients only available in Kawerau. However, there is to be a change in how SIA funding is to be managed. Flexible funding pool will result in how GPs provide support for palliative patients in Kawerau.</li> </ul>
12. Equipment	<p>Good sharing of equipment between hospital and hospice but</p> <ul style="list-style-type: none"> <li>challenge is ensuring equipment is appropriate to the person's level of need</li> <li>sometimes time delays for assessments to be done in the community (palliative is given priority). Usually done within 2 weeks.</li> </ul>
13. Some confusion for patients and generalists aligning across boundary to Lakes DHB	<ul style="list-style-type: none"> <li>GPs and some patients/families align to Rotorua for services. Murapara is in BOPDHB area so hospice provides services.</li> <li>Lack of clear understanding of where the boundary is between the DHBs. Need detailed map agreed.</li> </ul>
14. EBOP requires more formal palliative care input at Whakatane Hospital.	<ul style="list-style-type: none"> <li>Formalise 24/7 medical telephone support with Western BOP</li> <li>Specialist medical support from Waipuna to EBOP – clinics/consultation and education</li> <li>Hospice EBOP nursing role &amp; activities in Whakatane Hospital need to be formalised - MOU.</li> </ul>

OPPORTUNITIES	COMMENTS
<b>Current projects under way and others identified as useful for the future</b>	
1. National palliative care projects in progress	<ul style="list-style-type: none"> <li>Development of: <ul style="list-style-type: none"> <li>role delineation model/resource and capability framework (2011)</li> <li>models of care (2011)</li> <li>national funding model (begin 2011/2012)</li> <li>specialist palliative care service specifications (2012)</li> </ul> </li> <li>MOH consideration of Gold Standards Framework</li> <li>Palliative Care HNA work</li> <li>Health Workforce NZ palliative care workforce service review</li> <li>Hospice NZ Standards project</li> <li>Hospice NZ education package development</li> </ul>
2. Advance Care Planning (ACP)	<ul style="list-style-type: none"> <li>New Zealand national guidance document and tools for Advance care Planning now available</li> <li>Regional project opportunity for rollout (similar to LCP rollout). Will require project resource &amp; funding.</li> </ul>
3. Implementation of PalCare	<p>Phase one implementation into hospices in Midland in progress under the leadership of Waipuna Hospice.</p> <p>Significant opportunity to:</p> <ul style="list-style-type: none"> <li>improve patient information management</li> <li>improve reporting accuracy &amp; consistency and create efficiencies</li> <li>improve access by others to patient information for provision of care</li> </ul> <p>Phase two will consider access by others (non-hospice) and integration with other systems.</p>
4. PHO/primary practice - "Better, sooner, more convenient"	<ul style="list-style-type: none"> <li>Opportunity for improved integration of services</li> <li>Development of palliative care pathways in Bay Navigator</li> </ul>

initiatives	
<p>5. Improvements in technology / availability of technology</p>	<p>Example</p> <ul style="list-style-type: none"> <li>• Videoconferencing palliative care consultations to improve access to medical specialists and improve efficiency in use of medical specialist time. Comment- BOP DHB does not currently have very good MDT/videoconference facilities set up with appropriate technology. It is improving and hospital to hospital access should be available by end of 2011).</li> <li>• Expand use of videoconferencing education sessions to improve access</li> </ul>
<p>6. Māori Health services and Te Pou Kokiri, based at Whakatane Hospital.</p>	<p>Potential to formalise and strengthen linkages between the hospital based team and Hospice EBOP.</p>