



# Level 2 Advance Care Planning Practitioner Training Review

Health Workforce New Zealand

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# 1.Disclaimer

## 1.1. Reliance on Information

In preparing this report with information as provided by Health Workforce New Zealand (HWNZ) and the Northern Regional Alliance (NRA) included in the review, we have relied upon and assumed, without independent verification, the accuracy and completeness of all information as furnished to us by the MOH and the NRA. We have evaluated this information through analysis, enquiry and examination for the purposes of providing our report. However, we have not verified the accuracy or completeness of any such information. We have not carried out any form of due diligence on the accounting or other information provided to us for this review. We do not warrant that our enquiries will identify or reveal any matter which a due diligence review or extensive examination might disclose.

## 1.2. Limited Audience

This report has been prepared solely for the use of HWNZ and the NRA for the purposes of reviewing the Level 2 Advance Care Planning Practitioner Training effectiveness, sustainability and value for money. It may be relied on solely by HWNZ and the NRA for that purpose only. This Report may not, in whole or in part, be disclosed to any other person without the prior written consent of Deloitte and we do not accept or assume any responsibility to any person other than HWNZ relation to the statements, opinions or views expressed or implied in this report.

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## 1.3. Disclaimer of Liability

Our report has been prepared with due care and diligence and the statements and conclusions in our report have been given in good faith and in the belief, on reasonable grounds, that such statements and conclusions are not false or misleading.

We will assume no responsibility arising in any way whatsoever for errors or omissions (including responsibility to any person for negligence) for the preparation of our report to the extent that such errors or omissions result from our reasonable reliance on information provided by others or assumptions disclosed in our report or assumptions reasonably taken as implicit.

## 2. Abbreviations

Abbreviations used in this report include the following:

<b>ACP</b>	<b>Advance Care Plan</b>
<b>ADHB</b>	<b>Auckland District Health Board</b>
<b>CEO</b>	<b>Chief Executive Officer</b>
<b>CME</b>	<b>Continued Medical Education</b>
<b>The Cooperative</b>	<b>The New Zealand ACP Cooperative</b>
<b>DHB</b>	<b>District Health Board</b>
<b>FTE</b>	<b>Full Time Equivalent employee</b>
<b>GP</b>	<b>General Practitioner</b>
<b>HWNZ</b>	<b>Health Workforce New Zealand</b>
<b>NRA</b>	<b>Northern Regional Alliance</b>
<b>OIA</b>	<b>Official Information Act</b>

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## 3.Executive Summary

An independent external review of the Level 2 ACP training programme was carried out to establish the effectiveness of the current programme and the financial sustainability of the programme. HWNZ provided \$350,000 of funding towards the programme over the 2014 calendar year.

The current ACP training programme comprises of a suite of training options from basic training to advanced training. The current training suite comprises 4 levels of training with 11 modules in total. This external independent review was to gain insights into the Level 2 ACP practitioner training programme (modules 6 – 8). The primary objective of the review was to consider the financial sustainability of the Level 2 ACP programme and the value for money that was received for the funding provided by HWNZ. Our secondary objective was to assess:

- The effectiveness of the Level 2 ACP training programme;
- Assess practitioner confidence levels pre and post training; and
- Identifying and assessing the on-going changed behaviours in practitioners who have received Level 2 ACP training.

The current delivery mechanism of the Level 2 ACP programme is very effective in ensuring practitioners who attend the 2.5 day course and workshop have increased confidence in practising ACP, and also in changing long term clinical practices to facilitate ACP. The overall results from our survey of attendees of the Level 2 ACP course attendees have indicated a high level of satisfaction with the course and also a high level of learned skills. However the current barriers to attending the Level 2 training have resulted in diverse uptake levels across the Northern, Midlands, Central and Southern geographic regions.

Key barriers to attending the training and practising ACP include the current course length being too long, the cost of the training is too high, and inflexibility in course minimum and maximum numbers. Our findings indicate that the current training programme, while being highly effective, does not currently cater to enough health practitioners to ensure ACP will be adopted on a widespread basis within the health sector.

Based on the financial figures presented to us, and the maximum number of health workers who have been able to attend the Level 2 training, we believe that the current delivery could be more sustainably configured. The current uptake of the Level 2 ACP training programme in terms of the primary and secondary healthcare is:

- 44% of attendees work in the secondary health care level;
- 34% of attendees work in the primary health care level;
- 10% of attendees work in both the primary and secondary health care levels; and
- 12% of attendees were unable to be classified due to their work background being either incomplete within the application form, or working in an educational role.

Our understanding is that the course is currently primarily targeted at the secondary health level; the maximum number of attendees that could have been trained during the 2014 calendar year of 300 (please note actual numbers were slightly lower due to last minute cancellations on the part of some attendees) does not take into account staff turnover rates within the secondary health sector. While 34% of attendees work in the primary health care level, we believe that going forward there should be an increased focus of ACP marketing at the primary health care level to further increase the uptake levels of ACP within the primary health care sector. In our view the primary health care level is where ACP will have the most impact within the health sector as a whole.

The feedback from attendees of the level 2 programme is very positive and we recommend that the current Level 2 ACP training programme is maintained. The programme is in essence an advanced communication course, with communication skills being the key to holding effective ACP conversations. Going forward the marketing of the level 2 ACP training programme needs to clearly reflect that the programme is an advanced communication course which helps facilitate holding ACP conversations, and that the level 2 programme is ideal for health practitioners who are planning to be advanced ACP practitioners.

Whilst the Level 2 training is very effective based on feedback received, our review identified that to further improve the uptake of ACP nationally a shorter course needs to be developed in the form of an introductory course with a length of, say, 1 day at the maximum. Feedback received from medical practitioners that have not attended the training is that there is an appetite for a shorter ACP course.

The level 2 ACP programme is CME accredited, however due to constraints on the marketing budget, there has been limited promotion of the level 2 ACP programme for CME purposes. Wider uptake of ACP as a concept and ACP training could be achieved through increased promotion of ACP at the CME level for health workers. Additionally the current ACP training programme is primarily directed at the secondary healthcare sector. In our view, ACP would be more beneficial to health workers within the primary health sector. Increased promotion coupled with a shorter introductory training course should result in a wider uptake of ACP within the health sector.

Future funding should reflect the development of an introductory ACP course or workshop. Regardless of whether an introductory course is established, funding for the subsidisation of the level 2 ACP training programme as it stands may need to be reviewed given the financial viability of course and workshop delivery.

We have reviewed the financial results of the Level 2 ACP programme. Our expectation for the revenue recorded for the course and workshop delivery results is \$600K and in line with this the actual delivery of the Level 2 ACP course and workshops should result in a small profit. Actual revenue recorded for course and workshop delivery was \$315K. We have been advised by the NRA that the difference of \$285K is due to the following:

- \$132K of funding from the NRA for Northern Region DHB staff who have received Level 2 ACP training, which has not been reflected within the numbers presented to us; and
- \$153K due to no differentiation in pricing between subsidised and non-subsidised pricing to attendees of the Level 2 ACP training programme (or 150 attendees at \$1,020 per attendee).

We have not ascertained or verified the eligibility of attendees that received subsidy, as in our view funding for course and workshop delivery has actually subsidised the training cost of all attendees of the Level 2 ACP training programme in the 2014 calendar year due to no differentiation in pricing. We have discussed the application of funding subsidies with HWNZ, and note that a greater spread of the subsidy has been achieved (i.e. a higher number of attendees have been subsidised), and as such the individual attendee subsidies are a lot lower than the contracted subsidy of \$1,020 per attendee. The difference between the contracted subsidy per attendee and the actual subsidy per attendee indicate that the costings of the level 2 programme need to be reviewed. We recommend that HWNZ should discuss with the NRA their process in assessing subsidy eligibility and how this was applied in practice.

We have assessed annual planning documents from the 5 Midland region DHB's, and have identified that ACP is only either mentioned in one page of the entire planning document or not at all. We believe that a higher focus on ACP within the regional annual plans of DHB's coupled with appropriate non-financial reporting measures for ACP should help improve the ability of regional training coordinators and Regional Health Alliances to apply for additional funding to facilitate ACP training.

Should HWNZ continue to subsidise ACP course and workshop delivery, funding should be only be released from HWNZ as and when actual courses are delivered, and when contractual reporting obligations have been met by the training provider. Commercially this will ensure that all funds are appropriately spent on approved ACP activities, and will also ensure that all expenditure incurred by the supplier is captured on a timely basis. Additionally as part of any future ACP training funding, we recommend that funding should be on the basis of the training provider being able to:

- Develop an introductory one day workshop or course in addition to the existing modules;
- Engage an independent expert to assess the use of professional actors against simulation based trainers within the level 2 training programme from a pedagogy perspective;
- Develop an achievable marketing and advertising plan; and
- Develop a financially sustainable business plan.

The primary function of ACP is to ensure that the patient's voice is heard. However given the aging population of New Zealand and the current financial constraints within the health sector, any reduction in medical intervention to terminally ill patients, and the facilitation of end of life care outside of the hospital setting should help avoid costs associated with end of life care. The ACP methodology should also help health providers in better managing terminally ill patients.

## 4. Introduction

This report describes the findings of an independent review of the Level 2 ACP Practitioner Training Programme.

The ACP methodology has been developed globally over the past decade and has gained wide recognition as a valuable tool in the care of patients facing significantly declining capacity or end-of-life. ACP is not only limited to end of life care, but is applicable to all adults in all stages of life.

The New Zealand ACP training programme was commenced in 2010 by the New Zealand ACP Cooperative (the Cooperative). The Cooperative is a grass roots collective of interested clinicians and others who wanted to have a collaborative approach to ACP for the country. Membership of the cooperative is voluntary. Cooperative founders undertook a literature search and international benchmarking and recognised that up skilling the healthcare workforce in what ACP is, the benefits of it as well as increasing their ability to initiate, participate and facilitate ACP conversations was critical. To address these learning needs an ACP and communication training programme was developed for New Zealand. In 2011 this work was further developed by the NRA (a shared services entity owned by the Northern Region District Health Boards) in the Northern Region Health Plan's Informed Patient work stream.

Since 2012 HWNZ have funded the NRA to co-ordinate the delivery of ACP training nationally. The training programme consists of five levels and utilises a 'train-the-trainer' approach. HWNZ has provided funding of \$350,000 to help support ACP training nationally. The funding is split between funding for further development of ACP training resources and infrastructure (\$185,000) and funding for course workshop delivery (\$165,000).

The current ACP training programme comprises of a suite of training options from basic training to advanced training. The current training suite comprises of 4 levels of training with 11 modules in total, with modules 1 to 5 being online eLearning based modules. This external independent review was to gain insights into the Level 2 ACP practitioner training programme (modules 6 – 8) to assess:

- Effectiveness of the Level 2 practitioner training including any barriers to participation;
- Practitioner confidence levels pre and post training; and
- On-going changed behaviours in delegates who have attended the training;

In doing so we sought to assess the effectiveness, sustainability and value for money for any future funding.

# 5. Methodology

The key steps that were undertaken in our review of the Level 2 ACP practitioner training programme are:

## 5.1. Effectiveness of Level 2 practitioner training

We assessed effectiveness of the Level 2 training programme through:

- Review of 2014 quarterly ACP reporting to identify uptake levels of Level 2 ACP training nationally between the Northern, Midland, Central and Southern geographic regions;
- Interviewed regional ACP training coordinators and other stakeholders to identify differences in training uptake levels to identify any barriers to training; and
- Performed a survey of ACP practitioners who have received Level 2 training to further identify effectiveness of training from a practitioner perspective.

## 5.2. Practitioner confidence levels pre and post training

Practitioner confidence levels pre and post training has been assessed through:

- Surveying ACP practitioners who have received training between November 2013 and September 2014; and
- Assessing confidence data held with NRA pre and post Level 2 training.

## 5.3. On-going changed behaviours in ACP practitioners who have received Level 2 training

On-going changed behaviours have been assessed through:

- Surveying ACP practitioners who have received training between November 2013 and September 2014 to identify changed behaviours; and
- Identifying any barriers to practicing ACP.

#### **5.4. Sustainability, and value for money of funding received**

Our primary objective of the Level 2 ACP programme review was to assess the financial sustainability of the programme, and the value for money that HWNZ received for funding that has been provided for the Level 2 ACP programme. From the findings of assessing the effectiveness of Level 2 training, ACP practitioner confidence levels, and on-going changed behaviours in practitioners who have received training we reviewed the financial results of the ACP training programme against the HWNZ contractual requirements. We also assessed the underlying costs for training taking into account the financial constraints faced by the public health sector to form a view on the overall sustainability and value for money on funding received.

# 6. Review Findings

## 6.1. Effectiveness of Level 2 ACP training programme

The current Level 2 ACP practitioner training is delivered over 2.5 days with the training delivery being primarily through the use of professional actors in role playing scenarios. The course minimum and maximum numbers is 10 participants per course due to each training group being split into 2 smaller groups to facilitate role playing scenarios. The HWNZ course subsidy amounts to \$1,100 per attendee, with an additional cost to the attendee (or their employer) of \$900. The unsubsidised cost per attendee is \$2,000.

Nationally the uptake levels of the Level 2 training course varies across the Northern, Midland, Central and Southern geographic regions. The table below shows the number of delegates who have attended the Level 2 ACP training programme between November 2013 and August 2014:

	Northern	South	Central	Midland
# of Delegates	107	58	49	20
%	46%	25%	21%	8%
Underlying population base as a % of total NZ population**	37.5%	21.3%	18.2%	22.9%

\* Source- 24 10 06 Master Evaluation Spreadsheet

\*\* Source- Statistics New Zealand Subnational population estimate 30 June 2014

Whilst we would expect the Northern region to have a higher number of delegates attending Level 2 ACP training given the population base and number of medical practitioners within each region, the Central and Midland region numbers are proportionately lower than the Southern and Northern regions taking into account the population base and number of medical practitioners.

From interviews held, the key findings with regard to possible reasons for the lower training uptake levels for the Central and Midland regions were very similar. The following key barriers to training in the Midland and Central region have been identified at the secondary care level:

- Backfill for staff in the more rural and remote areas is difficult;
- ACP training is viewed as a soft skill and has a lower priority than other compulsory training for medical practitioners;
- 2.5 day course length, especially the 0.5 day;
- Inflexibility regarding minimum and maximum attendees;
- DHB budget managers view the course as expensive (i.e. 10 staff members from one department for the smaller DHB's can be a significant amount of their annual training budget);
- ACP training viewed as more beneficial to the primary care sector;
- CEO and Executive level buy in to additional funding is not at the same level as in the Northern and Southern regions; and
- Promotion of the Level 2 ACP training programme within the Midland and Central Tasman regions is too far removed from clinical leadership.

The current uptake of the Level 2 ACP training programme in terms of the primary and secondary healthcare is:

- 44% of attendees work in the secondary health care level;
- 34% of attendees work in the primary health care level;
- 10% of attendees work in both the primary and secondary health care levels; and
- 12% of attendees were unable to be classified due to their work background being either incomplete within the application form, or working in an educational role.

In our opinion, ACP training would be more beneficial to the primary care health sector, and would result in a wider uptake of ACP as a concept if the programme had a higher marketing focus toward primary care health professionals. Key barriers to training identified at the primary health level include:

- Cost of Level 2 training programme;
- Course length of 2.5 days can result in lost earnings;

- Locums and backfill is easier to cover full days but more difficult to cover for partial days, therefore actual backfill results in 3 days cover;
- Programmes are only delivered in main regional centres (except the Southern region), which results in additional accommodation costs over and above the course itself for primary care health practitioners who do not have access to the same level of employer training funding as secondary care health practitioners; and
- Limited advertising of ACP within primary care which results in ACP not being seen in a positive light by some healthcare professionals.

We have identified the following key differences in the manner in which the Level 2 ACP training is provided in the Northern and Southern regions in terms of advertising and funding:

- Higher focus on end of life care within regional health plans for the Southern Region;
- Approved “top slice” funding from Northern and Southern DHB’s to further subsidise the cost of Level 2 ACP training programme;
- Better infrastructure in the Northern and Southern regions to support ACP (I.e. Christchurch where at the time of interviews held 105 ACP plans had been lodged with the Christchurch Hospital; and
- Higher level of promotion of the Level 2 ACP training course at CME meetings by regional training coordinators;
- Proactive targeted promotion of the ACP Level 2 training programme within the Southern region for areas identified with low training uptake;
- Easier access to backfill staff within the Northern region; and
- Lower traveling distances to travel and thus avoiding additional accommodation costs for Northern region practitioners that attend the ACP level training.

In terms of effectiveness of the course from the perspective of attendees, an online survey was sent to participants who had attended the Level 2 training between the 4 November 2013 and 3 September 2014. The online survey was sent to 244 recipients, with 133 recipients completing the survey and 111 recipients who did not respond to the online survey. The overall response rate to the online survey was 55%. In our view the response rate is sufficient enough to draw conclusions regarding the ACP Level 2 training programme.

Key qualitative questions asked to survey recipients to assess effectiveness and also any barriers to participation included the following questions:

- Would you recommend the course to others? (Yes/ No question supplemented with qualitative responses)
- With regard to the course content, are there any areas/items which could be removed? (Qualitative question)
- Are there any other areas which are needed to be covered in greater depth? (Qualitative question)
- Is there any other feedback to take into account in future courses? (Qualitative question)

90% of survey participants would recommend the course to others, 5% of survey participants would not recommend the course to others, and 5% of survey participants did not answer the question in relation to recommending the course to others. Positive feedback received included:

- *“Absolutely, best course I have ever done;*
- *I am systematically making sure that every social worker attend this course;*
- *This was a fantastic course;*
- *For an older Doc the course exposed me to learning in communication and testing new skills..... always valuable and hence should benefit all participants;*
- *It was not at all what I was expecting but it was better than I was expecting. It was simply excellent.*
- *Everyone should do this course – it has re energised my practice and amazing outcomes since attending (and I thought I had it pretty sussed before); and*
- *Absolutely! I would like to see this type of education made compulsory for doctors and nurses.”*

Negative feedback received (which in our view is the key points to take on board in future ACP training courses) included the following general comments:

- *“ Level 1 training was more beneficial from a practical learning point;*
- *The course was overly long for the skills imparted;*
- *The course may be useful for undergraduates and new grads to be taught how to talk to clients but experienced staff do not need to spend 2 days learning how to talk to clients;*
- *There would be resistance to paying course and time away from work for some workplace, I self-funded myself for course costs, accommodation, travel and unpaid leave;*
- *The length of the course puts GPs off as it is hard to make time to attend;*
- *More a communication course rather than ACP; and*
- *The course was not advertised as an advanced communication course and is expensive for an advanced communication course.”*

59% of survey participants responded to the question “are there any areas/items which could be removed?” Only 15% of respondents who provided a qualitative response, with regard to areas of the course that could potentially be improved (85% of respondents provided positive responses). The positive responses (85% of survey participants that answered the question) identified the following:

- *I found all areas/items useful;*
- *I feel it was all very relevant;*
- *No, as the course progressed it tied together well; and*
- *I don't believe anything should be removed.*

15% of survey participants provided comments for areas/items which could be improved, and in our view the negative responses received with regard to areas/items of the training programme which could be improved should be taken on board by the current training provider to further improve the level 2 ACP training programme. The general comments for areas which could be improved include:

*“The course was too long, and repetitive in areas;*

- *Length of time spent on role plays was too long;*
- *2 days of communication training is too long;*

- *Too much emphasis on communication; and*
- *Clinical situations were presented within the role plays, but not related to doing actual ACP.”*

70% of survey participants provided responses to areas that needed to be covered in greater depth, with 73% of respondents providing positive feedback. The main themes identified as needing to be covered in greater depth by the residual 27% of survey respondents were:

- *“The legalities of ACP and the level of documentation required needs to be clearer;*
- *How to write an ACP and the items which should be considered;*
- *Additional coverage of how to introduce ACP in a professional manner?*
- *Additional coverage on ethical considerations; and*
- *Different cultural considerations.”*

50% of survey participants provided feedback to amend future courses, with 83% of respondents providing positive feedback. The feedback provided was along the general themes identified earlier within this report.

In terms of overall effectiveness of the course, based on feedback provided from healthcare professionals that have attended Level 2 training, the current training is very effective. Based on interviews held and the results from surveying course attendees, the actual Level 2 training is an advanced communication course and not solely related to ACP, and is due to communication being such an integral part of applying ACP methodologies.

While the training is highly effective, a key issue for the programme is increasing the number of healthcare professionals which attend the Level 2 ACP training programme, with several barriers to attending the Level 2 Training being identified. Please refer to section 7 of this report for proposed recommendations to further improve the uptake level of the training programme.

## **6.2. Practitioner confidence levels pre and post training**

Attendees of the Level 2 training programme complete a survey before and after attending the training, with a standardised set of questions being asked which assesses attendees overall confidence with practising ACP. Each question is rated on a scale of 1 to 10, with 1 being not very confident and 10 being very confident. We have assessed the confidence of course attendees in working with ACP from data held with the NRA for courses delivered between 4 November 2013 and 3 September 2014. Please note that this timeframe is based on data originally provided by the NRA at

the commencement of this review. We acknowledge that there have been level 2 courses which have been delivered subsequent to the commencement of our review, which have not been captured in the online survey. We performed tests on the underlying data worksheet against physical completed surveys. No material differences were identified within the worksheet, and we have been able to assess the pre course confidence data as accurate and therefore we were able to rely on the data for the purpose of this review.

Course attendees are required to also complete the confidence survey directly after the course. We were interested in ACP confidence levels of Level 2 ACP course attendees greater than 4 weeks after attending the Level 2 ACP training. We surveyed Level 2 ACP course attendees who attended the course between 4 November 2013 and 3 September 2014 to assess confidence levels after practising ACP in the workplace. The questions asked to survey participants are exactly the same questions asked pre and post the Level 2 ACP training programme.

The table below summarises the average confidence scores for course attendees before completing the Level 2 training programme, the average confidence level directly after attending the training programme, and the confidence level of attendees between 4 weeks and 1 year after attending the training programme.

	Pre Level 2 ACP training	Confidence score directly after training	Confidence score <u>up to 52 weeks after training</u> **
Average confidence score*	5.88	8.25	8.11

\* Confidence scores are based on 1 being "Not very confident" and 10 being "Very confident."

\*\* Based on 133 survey respondents.

Based on the results of training delegate's confidence scores directly before and after the training, and up to 52 weeks post training, there is material improvement in delegate confidence with practising ACP.

### **6.3. On-going changed behaviours in practitioners who have received Level 2 training**

We have attempted to ascertain on-going changed behaviours in practitioners through surveying ACP practitioners who have received training between November 2013 and September 2014 to identify changed behaviours, and to also identify any barriers to practicing ACP. Key questions asked to survey participants included the following questions:

- Has the ACP Level 2 Practitioner training changed your clinical practice, if yes, please provide at least one example?
- Are there any barriers to implementing ACP in your workplace? (If yes please describe)
- What are you doing differently as a consequence of attending the course (professionally and personally)?

82% of survey respondents identified that the Level 2 ACP practitioner training has changed their clinical practice. 18% of respondents identified that there has been no change in their clinical practice since attending the Level 2 ACP training. A summary of the qualitative responses provided with regard to examples of how clinical practice has changed include:

- Improved communication of ACP with patients;
- Better listening to patients wishes instead of discussing standard clinical options;
- Increased introduction of ACP with patients; and
- Easier to initiate ACP conversations with patients.

Additionally 81% of survey respondents have identified things that they do differently subsequent to attending the Level 2 ACP Practitioner training. Key examples include:

- Better at listening to patients;
- More aware of legal requirements; and
- More open to holding ACP discussions with patients, and colleagues.

89% of survey participants provided a response with regard to the identification of barriers to practising ACP. 28% of participants that answered the question did not find any barriers to practicing ACP. The key barriers to practicing ACP as identified by 72% of respondents include:

- Lack of time to hold ACP conversations;
- Limited understanding of ACP by colleagues;
- Lack of privacy in open wards;
- No formal guidance within the workplace to documenting ACP;
- Lack of infrastructure to store ACP;
- Patients being seen are in an acute setting; and
- Do not see patients on a regular enough basis.

Based on the results of the survey, over 80% of course attendees have changed clinical practice up to 1 year after attending the Level 2 ACP Practitioner programme. However some of the responses from survey participants with regard to barriers to practicing ACP indicate that the training is being primarily directed at the secondary care level rather than a higher focus on the primary care sector. Key barriers to practising ACP also include a lack of understanding by fellow healthcare workers, limited infrastructure to support ACP, and formal guidance and systems not being present to support on-going ACP practices.

#### **6.4. Sustainability and value for money of funding received**

From the findings of assessing the effectiveness of Level 2 training, ACP practitioner confidence levels, and on-going changed behaviours in practitioners who have received training, we then reviewed the financial results of the ACP training programme against the HWNZ contractual requirements. We also assessed the underlying costs for training taking into the financial constraints faced by the public health sector.

HWNZ has provided funding of \$350,000 in the 2014 calendar year to help support ACP training nationally. The funding is split between funding for further development of ACP training resources and infrastructure (\$185,000) and funding for course workshop delivery (\$165,000). The funding for ACP training resources and infrastructure costs also takes into account work performed by the NRA in the 2013 calendar year for the development of ACP training materials which was funded directly by the NRA. The 2014 financial results for the ACP training programme split between development and infrastructure costs and course and workshop delivery are summarised on the next page:

Profit and loss line item	Development & Infrastructure	Course & Workshop delivery	Total
<b>Revenue:</b>			
Revenue - HWNZ Funding	185,000	165,000	350,000
Revenue - Course Fees	-	150,121	150,121
<b>Total Revenue</b>	<b>185,000</b>	<b>315,121</b>	<b>500,121</b>
<b>Expenses:</b>			
Outsourced Admin Staff	(-275,458)	-	275,458
Outsourced Clinical Staff	-	-	-
Corporate Administration	-	(-18,000)	18,000
Course Fees - Staff	(-3,187)	-	3,187
Taxis	-	(-4,322)	4,322
Travel Local	-	(-65,851)	65,851
Travel International	-	(-9,363)	9,363
Accommodation & Meals	-	(-36,780)	36,780
Software - Minor Purchases	(-6,695)	-	6,695
Mobile Phones	(-65)	-	65
Consultants Actors Training Camps	-	(-216,057)	216,057
Consultants - Christie (UK)	-	(-26,824)	26,824
Printing	(-4,166)	-	4,166
Stationery & Office Supplies	(-8,862)	(-401)	9,263
Couriers & Freight	0	(-330)	330
Reception & Catering	(-88)	-	88
Conference Organising Costs	-	(-49,223)	49,223
Sundry	-	(-5,250)	5,250
Northern Region Specific Costs	(-27,181)	-	27,181
<b>Total Expenses</b>	<b>(-325,702)</b>	<b>(-432,401)</b>	<b>(-758,103)</b>
<b>Net (Deficit)/ Surplus</b>	<b>(-140,702)</b>	<b>(-117,280)</b>	<b>(-257,982)</b>

Please note that the above accounts do not include the NRA funding for courses delivered within the Northern region. Funding is allocated for the Northern Region courses based on the net deficit of course and workshop delivery. For the 2014 Calendar year the NRA has also provided \$132K in funding which has not been included within the accounts presented above. This was confirmed with a member of the NRA finance team.

The net financial result for the funding received was a net deficit of \$258K. Taking into account the \$132K in additional funding from the NRA for Northern region courses which has not been included in the accounts provided, the net result for the ACP programme in the 2014 calendar year decreases to a deficit of \$126K.

The table below represents expenses which we have identified which could be minimised in the future to make the ACP programme more financially sustainable:

Expense Item	Amount \$000	Deloitte Comment
Outsourced administration staff	275	Expense relates to the staff outsourced from the NRA and ADHB to help facilitate administrative tasks associated with the ACP programme. The FTE numbers relating to this expense item amount to 2.4 FTE, being 0.4 for the ACP programme manager, 1.0 for the ACP Project Manager, and 1.0 for the ACP Administrator, and a small amount of finance time. The average cost per FTE equates to \$115K per FTE. In our view this expense is relatively high for administrative and project management related activities, and could be further reduced.
Consultant Actors Training Camps	216	This expense relates to principally to actors used in the delivery of the Level 2 ACP course and workshop.
Consultants- Christie (UK)	27	This is the payment made to Christie School of Oncology in April 2014. In essence this relates to the cost of staff coming to NZ to cover courses in the first quarter of 2014. This cost was part of the establishment of the programme.
Travel International	9	This is the actual costs of travel for trainers from the Christie School of Oncology for their visit in the first half of the 2014 calendar year.

Within the HWNZ contract with the NRA, the HWNZ funding for course and workshop delivery of \$165,000 is capped to a maximum of 150 people that can receive subsidised training. The subsidy per eligible attendee is \$1,100 per attendee, with a maximum cost to an eligible attendee not to

exceed \$900. This indicates that the gross cost to course attendees amounts to \$2,000. Taking into account that 30 courses have been delivered during the year, the total revenue presented within the accounts does not appear to be complete (based on 300 course attendees during the year). We have discussed this with NRA finance staff, who have identified that the difference is due to no differentiation in the amount charged for the Level 2 ACP training programme for subsidised and unsubsidised attendees.

Please refer below for our calculation, where we have calculated an alternative scenario based on revenue we would have expected to be received from the delivery of the Level 2 ACP training programme and the ACP programme for which funding has been received from HWNZ as a whole.

Expected revenue from subsidised training	\$ and numbers
Maximum number of subsidised attendees	150
Subsidy per attendee	\$1,100
<b>Total HWNZ Subsidy</b>	<b>\$165,000</b>
Costs to be borne by employer or attendee	\$900
<b>Total amount to be paid by DHB's or subsidised attendees</b>	<b>\$135,000</b>
<b>Total expected revenue from subsidised training</b>	<b>\$300,000</b>

Expected revenue from attendees who did not receive subsidy	\$ and numbers
Number of attendees that were not subsidised	150
Maximum amount to be charged (based on subsidised workings)	\$2,000
<b>Total course fees to be received from unsubsidised attendees</b>	<b>\$300,000</b>
<b>Total expected revenues</b>	<b>\$600,000</b>

<b>Total Expected revenue</b>		<b>\$</b>
Total revenue from subsidised training		\$300,000
Total revenue from attendees that did not receive subsidy		\$300,000
<b>Total expected revenues</b>		<b>\$600,000</b>

<b>Reconciliation of revenue presented in accounts</b>		<b>\$</b>
Total revenue presented within accounts for course and workshop delivery		\$315,121
NRA Funding not reflected as revenue		\$132,000
<b>Total revenue accounted for</b>		<b>\$447,121</b>

Total expected revenue		\$600,000
<b>Difference</b>		<b>\$(152,879)</b>

Based on the financial figures presented, the difference in revenue recorded of \$153K indicates that the net amount that has not been charged to unsubsidised attendees is \$1,020 per attendee.

Taking into account the amount of revenue that has not been reflected within the accounts, it would appear that the ACP training programme is profitable, with the net result for all activities being a surplus of \$27K. Please see below for the details of our calculations.

Reconciliation of net result	Amount \$(000)
Net result presented within the accounts for course and workshop delivery	(\$117,280)
Plus NRA funding not included in accounts	\$132,000
Plus difference in revenue between Deloitte expectation and amounts presented	\$152,879
<b>Amended workshop and course delivery result</b>	<b>\$167,599</b>
Development and infrastructure net result	(\$140,702)
<b>Amended net result (surplus)</b>	<b>\$26,897</b>

Please note that we have not verified the accuracy of the figures presented to us, or verified if the actual amounts that have been charged to attendees of the Level 2 ACP training programme nor have we performed an audit of the underlying financial records due to being outside the scope of this review. We have reviewed several different versions of financial results for the ACP programme and based on initial questions posed regarding the financial results, it would appear that financial oversight over the ACP programme is not satisfactory given the level of funding received. We recommend that HWNZ should discuss with the NRA their process in assessing subsidy eligibility and how this was applied in practice.

The current Level 2 ACP training programme is effective in increasing attendees confidence in practising ACP and also effective in changing course attendee behaviour. In addition taking into account the barriers to attending the course; the fact that the course is an advanced communication course; the barriers to practising ACP; and only 300 attendees at the most being able to attend the Level 2 ACP training programme, we do not believe that the manner in which the course is currently delivered represents value for money in terms of funding received. The basis for this conclusion is that we cannot identify a return on funds invested or a payback period on the funds invested by HWNZ. The value for money of funding received is further put into question in light of alternative funding options that HWNZ could potentially invest in, with the potential for a wider training outcome.

Based on the financial figures presented to us, and also the maximum number of health workers who have been able to attend the Level 2 training, we believe that the current delivery configuration is also unsustainable. The course is currently primarily targeted at the secondary health level; the maximum number of attendees that could potentially be trained during the year of 300 does not take into account staff turnover rates within the secondary health sector. As such, widespread knowledge and adoption of ACP will not occur within the Health Sector given the level of staff turnover within the New Zealand public health sector. Please refer to section 7 of this report for recommendations to improve the sustainability and value for money of HWNZ funding going forward.

# 7. Recommendations

We understand that the current level 2 ACP programme delivery is supported through the results of international research in terms of the effectiveness of didactic training. However, due to the level 2 ACP programme being funded through HWNZ, the programme can be seen to be funded through public monies. As such, we recommend that alternative options are investigated to reduce the cost base of training delivery, whilst also increasing the uptake of ACP training. To further improve the uptake of ACP nationally, we recommend that the following options are investigated in further detail:

- Introducing an introductory 1 day workshop to improve uptake levels;
- Reviewing the current pricing and marketing of the level 2 ACP training programme to make the programme more financially sustainable;
- Reducing the use of professional actors and replacing with health trainers who specialise in simulation based training;
- Increasing the promotion of ACP at the CME level for health workers;
- Introducing and/or developing an introductory ACP communication course; and
- Higher levels of promotion at the primary care sector (being GP's, Practice Nurses, community based care, allied health etc.).

We acknowledge that the current Level 2 delivery mechanism is effective in increasing practitioners confidence with ACP and also in on-going changed behaviours of practitioners, however given the current barriers to attending the Level 2 training programme and to increase awareness of ACP nationally the current delivery mechanism needs to be reassessed. In terms of improving ACP awareness within the health sector we recommend the following:

- Reducing the cost of the training to reflect a reduced course length;
- Higher focus on ACP within the regional health plans to increase the level "top slice" funding for all regions to facilitate ACP training; and
- Increased development of non-financial reporting measures to hold DHB's accountable for increasing awareness and uptake of ACP.

We have included the business case that has been prepared by the Southern Health Alliance to obtain top slice funding from South Island DHB's in Appendix B of this report, which we believe is a good example of an effective business case. We recommend that the Midland and Central regional health alliances review this business case and make provision for a similar arrangement.

To remove the barriers to practising ACP, we recommend the following:

- Further development of ACP infrastructure to facilitate the storage and access of completed plans to facilitate the smooth transition of information between primary care and secondary care;
- Increased promotional material to increase awareness of ACP at the primary care level; and
- Use of non-financial measures to remove the excuse of “time pressure barriers” by health practitioners opposed to practising ACP.

Should HWNZ continue to subsidise ACP course and workshop delivery, funding should be only be released from HWNZ as and when actual courses are delivered, and when contractual reporting obligations have been met by the training provider. Commercially this will ensure that all funds are appropriately spent on approved ACP activities, and will also ensure that all expenditure incurred by the supplier is captured on a timely basis. Additionally as part of any future ACP training funding we recommend that funding should be on the basis of the training provider being able to:

- Develop an introductory one day workshop or course;
- Engage an independent expert to assess the use of professional actors against simulation based trainers within the level 2 training programme from a pedagogy perspective;
- Develop an achievable marketing and advertising plan; and
- Develop a financially sustainable business plan.

We would like to highlight that we are not recommending to remove the level 2 ACP training programme all together, merely we have identified that the current delivery mechanism of the programme needs to be reassessed, with the key items being the 2.5 day length, and the current cost management of the programme and also the pricing of the programme for all attendees.

The recommendations we have raised above should be considered carefully as to their full commercial impact. We highly recommend that the current course length needs to be re-assessed. Any changes to the current training programme need to be weighed against a reduction in the current effectiveness of the training programme and an increase in uptake of ACP, to ensure an optimal balance between effectiveness and uptake numbers. We also recommend that HWNZ perform further investigation into the revenue discrepancies identified within the accounts presented.

## 8. Conclusion

The current concern with end of life care is focussed on where and when people pass away with limited consideration to a patient's wishes. Medical intervention may not always be in the patient's best wishes. The ACP methodology helps facilitate patient communication at end of life care. ACP is not only limited to end of life care, but is applicable to all adults in all stages of life.

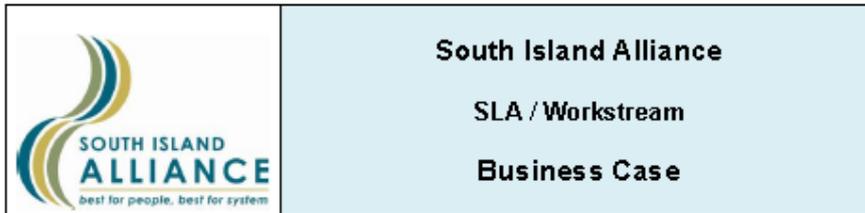
Given the aging population of New Zealand and the current financial constraints within the health sector, any reduction in medical intervention to terminally ill patients, and the facilitation of end of life care outside of the hospital setting should help reduce the current financial burden placed within the health system. The ACP methodology should help health providers in better managing terminally ill patients and also help reduce the current financial pressures within the health sector, through cost avoidance.

We can see the value of the ACP methodology, however our review has identified that the current delivery mechanism does not facilitate widespread uptake of the ACP practices. Further, the lack of knowledge of ACP by medical practitioners is also a barrier to practicing ACP. Increased knowledge and recognition of ACP practices and a reduction in barriers to attending ACP training will help ensure the long term sustainability of the ACP programme nationally.

# Appendix A- Interviews Held

Name	Title
Andrew Boyd	Chief Executive Officer- Healthshare
Bala Newton	General Practitioner- Hamilton East Medical Centre
Bob Bishop	Management Accountant- Auckland District Health Board
Gary Lees	Director of Nursing- Lakes District Health Board
Hannes Schoeman	Human Resources Manager- Lakes District Health Board
Jane Goodwin	Board Advance Care Plan Coordinator- Canterbury District Health
Jane Large	Facilitator, Health of Older Persons Service Level- South Island Health Alliance
Kate Grundy	Palliative Care Physician- Canterbury District Health Board
Kate Rawlings	Programme Director- South Island Health Alliance
Leigh Manson	Northern Regional ACP Programme Director
Michael Bland	Midland Regional Training Director- Healthshare
Nicola Smith	Regional Director Workforce Development Central Tasman
Ron Dunham	Chief Executive Officer- Lakes District Health Board
Shona Muir	National Advance Care Plan Training Programme Manager, Northern Region ACP Project Manager
Tony Phemister	Portfolio Manager Regional Planning and Service Delivery- Northern Regional Alliance

# Appendix B- Effective Business Case for “top slice” funding



**Recommendation/s**

- **That GM P&F discuss and approve the recommendation/s of HOPSLA:**
  1. To fund 70 L2 education places in 14/15 year
  2. To support Conversations that Count education and awareness in 14/15
  3. Support ACP Champion Group  
Total needed for 14/15 \$78k

**1. Project Name**

Advance Care Planning

**2. Background**

HOPSLA support the SI planning for Advance Care Planning (ACP) and have worked over the last 2 years to promote training and system design so that ACP can become standard practice for those who will benefit. Awareness needs to encompass the health workforce across the continuum and the communities who reside in the South Island. HOPSLA works with the national ACP co-operative to strive for consistency of approach.

**3. Description of project**

Continuing to build a network of L2 trained health professionals from all health disciplines.

Promote the uptake of L1 e-learning resource.

Ensure the IS system can support an electronic ACP (Acute care, Primary Care, Ambulance)

Participate in National ‘Conversations that Count’ awareness raising and education.

**4. Expected Outcome/s**

Advance care planning gives everyone a chance to say what’s important to them. It helps people understand what the future might hold and to say what treatment they would

and would not want. It helps people, their families and their healthcare teams plan for future and end of life care.

This is likely to result cost savings through less inappropriate presentations to acute services when people are in the end stage of care and improve the experience for all – the person, their family and the health care team.

#### 5. Timeline include dates

July 2014 – June 2015 Train further health professions in L2 in SI

April 2015 Conversations that Count – education, awareness raising and includes a SI Communication plan in place by Feb 2015

#### 6. Cost and Budget

Description	Year 1	Year 2	Year 3
L2 Training	70 places \$63k*	80 places \$72k*	90 places \$81k*
Conversations that Count	\$10k	\$10k	\$10k
Support ACP Champion Group	\$5K	\$5K	\$5K
total	\$78k	\$87k	\$96k

\*Based on \$900 per person which includes support from National ACP Co-operative & Workforce NZ. Values may change but are accurate at 29 January 2014

#### 7. Context

Making an 'End of Life' plan is still a new concept for NZ society. An advance care plan is a way to help people think about, talk about and share their thoughts and wishes about their future health care. However it takes time and expertise to inform a well considered plan that expresses an informed choice. It also takes a society who knows about the advantages and drawbacks of ACP and understands that ACP is not euthanasia. It requires health system changes and education of the workforce. The SI ACP work is designed to address these needs.

#### 8. SI Health Service Plan - Item no. & Activity (business case relates to)

To be confirmed

#### 9. Linkages this project will have with:

SLAs & Workstreams	Dementia, InterRAI, Stroke
MoH	
Other SI DHBs	Chronic Conditions Management, Dementia, InterRAI, Stroke

Other SI Alliance projects	SIRTH, SCN
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### 10. Prioritisation

SIA Strategic goals	Contribute to meeting Population Health Goal, Sustainability Goal and Experience of Care Goal.
Effectiveness	ACP is evidence based
Equity	This initiative is aimed at improving access for those in most. The processes are being designed to achieve national and regional consistency.
Implementation	Implementation is achievable.
Value for money	Regional approaches to work in a consistent manner are demonstrated to be value for money.

### 11. Risks

Risk	Mitigation
SI falls behind national progress	Ensure there is planned progress for SI each year in regional plan
Lack of engagement of health professionals	Use champions to influence change Communication plan
Lack of understanding of ACP in communities/society	Use champions to influence change Communication plan
IS system is unable to support ACP	Integrated planning with ISSLA

### 12. Recommendation

That GMP&F discuss and agree:

1. To fund 70 L2 education places in 14/15 year
2. To support Conversations that Count education and awareness in 14/15
3. Support ACP Champion Group  
Total needed for 14/15 \$78k

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