

Resource and Capability Framework for Integrated Adult Palliative Care Services in New Zealand

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Executive summary

Purpose

The Resource and Capability Framework for Integrated Adult Palliative Care Services in New Zealand (the Framework) is designed to provide guidance to funders and policy makers. The Framework informs strategic planning and the purchasing of accessible and equitable palliative care services for New Zealanders.

Context

A common lack of understanding about what makes up specialist palliative care services has affected the strategic development of palliative care services, contributing to variable access to services for people with palliative care needs. Also, the allied health workforce's contribution to palliative care is not clearly defined, and there are opportunities for this group to provide palliative care services as part of a multidisciplinary team approach.

The Ministry of Health (the Ministry) developed the Framework using a structured role delineation approach, which involved differentiating services by their level of complexity in order to clarify how to support more consistent access to and purchasing of palliative care services. Delineating the roles in palliative care gives clarity to providers about which components of palliative care should be provided and by whom (Palliative Care Council 2012).

The health sector currently faces the challenge of an ageing population living with chronic disease, which increases the demand for many services, including palliative care. In an environment of constrained funding, meeting this challenge requires robust planning and strategic development of palliative care services in order to meet future population needs.

The recent National Health Needs Assessment for Palliative Care (Palliative Care Council 2011) established the number of people on a national and regional basis who might benefit from palliative care, noting that most people who would benefit are aged over 65 years.

The Framework

The Framework presented here clarifies the composition and requirements of palliative care services that are appropriate for the New Zealand context. The Framework is a necessary step in finalising the Specialist Palliative Care Service Specifications, which are used by district health boards (DHBs) to purchase services.

The Framework is based on the principle that all people with palliative care needs have access to an appropriate level of care, regardless of diagnosis or location.

The recommendations included in the Framework should, however, be considered in the context of current funding and available resources.

Sector views

The development of the Framework is strongly informed by the palliative care sector's views. Input into the Framework was provided through a widely distributed consultation questionnaire in August 2011 and a workshop attended by sector representatives in November 2011. Those who attended the workshop agreed to a single level of specialist palliative care, delivered by integrated providers working collaboratively, as the service model most appropriate for New Zealand. Working collaboratively is formalised through a partnership model referred to as a 'hub-and-spoke'. The Ministry sought further sector feedback on the draft Framework during May and June 2012.

Recommendations

There are two main recommendations arising from this process. It is recommended that DHBs:

- use the Framework to inform planning and strategic development of palliative care services
- consider population palliative care need during regional clinical service planning.

1 Introduction

1.1 Purpose

The Resource and Capability Framework for Integrated Adult Palliative Care Services in New Zealand (the Framework) is designed to provide guidance to funders and policy makers. The Framework informs the strategic planning and purchasing of accessible and equitable palliative care services for New Zealanders.

The Framework describes a structured approach to the delivery of palliative care to support more consistent access to, and purchasing of, palliative care services across the country. It describes the levels of care and staffing resources appropriate for the New Zealand context, and the formal links between all providers of palliative care so that the needs of the patient, family and whānau are met.

The Framework is based on the concept that, for many people, the need for palliative care can be met by their existing primary care provider (eg, their general practitioner). The need for specialist palliative care services may be episodic or shared rather than required on an intensive basis. The Framework also promotes a collaborative and integrated approach to service delivery.

For an explanation of the terms used in this document, see the Glossary.

1.2 Definition of palliative care

The Palliative Care Subcommittee of the New Zealand Cancer Treatment Working Party (2007) developed a working definition of palliative care for New Zealand, the Framework adopts this definition. Palliative care is the care for people of all ages with a life-limiting illness, which aims to:

- optimise an individual's quality of life until death by addressing the person's physical, psychosocial, spiritual and cultural needs
- support the individual's family, whānau, and other caregivers where needed, through the illness and after death.

The principles of palliative care service provision are that it should be:

- provided according to an individual's need, and may be suitable whether death is days, weeks, months or occasionally even years away
- available wherever the person may be
- provided by all health care professionals, supported (where necessary) by specialist palliative care services

- provided in such a way as to meet the unique needs of individuals from particular communities or groups, including Māori, children and young people, immigrants, refugees, and those in isolated communities.

1.3 Commissioning the Framework

The Ministry of Health (the Ministry) commissioned the development of a palliative care framework appropriate to the New Zealand context in May 2011. The Framework was developed in close collaboration with the sector and with guidance from the Ministry's Palliative Care Advisory Group (PCAG).

The development of the Framework was based on a role delineation approach, which involves differentiating services by their level of complexity. The Framework provides a way to describe how to support more consistent access to and purchasing of palliative care services across the country. The Ministry developed the Framework in response to the PCAG's concern that there is variation in access to palliative care and a lack of common agreement as to what constitutes specialist palliative care services.

Links to the development of Specialist Palliative Care (SPC) Service Specifications

The Framework is required before the Ministry can progress the SPC Service Specifications through the joint Ministry and DHB formal service specification approval process. The PCAG recommended that this work be undertaken following the sector's feedback on the February 2009 draft SPC Service Specifications. In particular, DHBs were concerned about the uncertainty of the resource implications of implementing the SPC Service Specifications.

Links to other resource and capability frameworks

Palliative care services in New Zealand vary in their structure and resourcing. The finalised Framework distinguishes the levels of palliative care required and supports DHBs to develop a service plan for palliative care that focuses on sustainable and equitable services.

After the Ministry initiated the Framework with the PCAG, both Hospice New Zealand and Hospital Palliative Care Services both identified the need to develop capability frameworks specific to their own organisations.

These organisations have now developed the Hospice New Zealand Capability Framework and the Hospital Palliative Care Service Capability Framework. These additional frameworks are provided in Appendices A and B.

1.4 Project methodology

The draft Framework was presented to key stakeholder groups including DHB General Managers Planning and Funding and DHB Chief Operating Officers seeking their initial thoughts and feedback prior to wider consultation. The consultation process was endorsed through these early discussions.

A questionnaire was widely distributed to the sector in August 2011 to capture feedback on the draft Framework and to gauge the sector's views on the issues, including qualifications, eligibility criteria for specialist services and team composition.

A response rate has not been calculated because the distribution process encouraged the questionnaire to be circulated to all interested groups and individuals.

In November 2011 the Ministry hosted a workshop to consult with representatives from key organisations and groups in the palliative care sector on selected findings from the questionnaire. The purpose of the workshop was to reach consensus on an approach to those parts of the questionnaire where the responses varied or were contradictory. The outcome of the workshop was a Framework that reflects the New Zealand context.

2 Challenges for palliative care

New Zealand faces the challenge of an ageing population with people living longer as the result of more effective health interventions. The Framework uses a ‘right service, right place, right time’ approach, supporting competency development and maximising the skills of all providers.

2.1 An increasing number of people with chronic conditions can benefit from palliative care

Health Workforce New Zealand (2011) predicts that the number of people requiring palliative care will increase by nearly 25 percent over the next 15 years, and will be just over double the current level by 2061. This includes an increasing recognition of the number of people who could benefit from palliative care to improve their quality of life.

Changes in clinical practice have influenced the trajectories of illness, and an increasing number of people are living with chronic conditions such as renal failure over a longer period of decline than seen in patients with cancer (Lynn and Adamson 2003).

2.2 Access to palliative care services is variable

Access to services across the country varies and is influenced by the availability of existing services, geographical location and diagnosis rather than the patients’ assessed need for palliative care. Access to palliative care services is more limited for some population groups, including Māori, Pacific and rural populations, residents of aged-care facilities, and those with chronic illness.

The Framework provides guidance on how to improve access to all components of specialist palliative care services through formal arrangements to improve areas where access is currently limited.

2.3 Aged-care facilities have an increasing role in providing palliative care

Aged-care facilities are increasingly important in the delivery of primary palliative care. The *National Health Needs Assessment for Palliative Care* (Palliative Care Council 2011) estimated that the proportion of people aged over 65 years was 12.2 percent in 2006, and predicts this will increase to 19 percent by 2026.

The Australian Productivity Commission (2011) report *Caring for Older Australians* suggests that palliative and end-of-life care should be core business for aged-care facilities. In practice, the quality of care is variable and residents may be transferred to hospital when their needs are beyond the resources of aged-care staff. The Framework provides guidance on how aged-care facility staff can be supported by specialist palliative care services.

2.4 Lack of shared understanding of palliative care services affects service planning

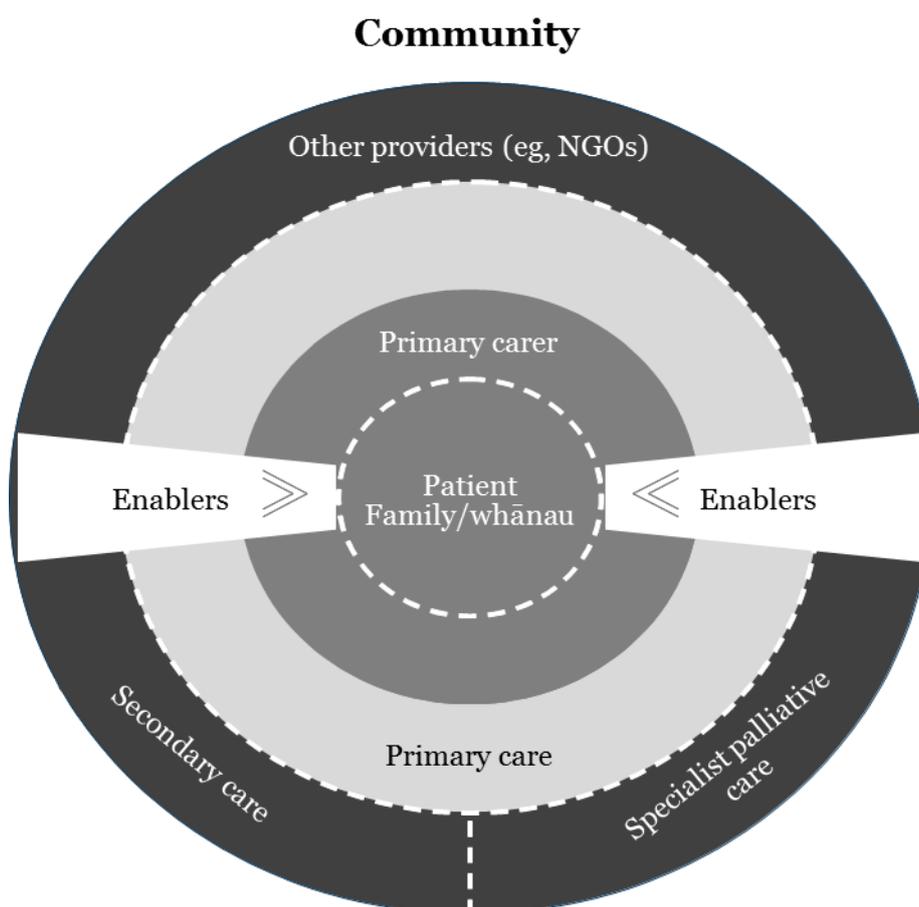
A common lack of understanding of what makes up specialist palliative care services has affected the strategic development of palliative care, contributing to variable access to services for people with a palliative care need. The Framework provides guidance on the expectations for service arrangements and the level of staffing resource required to deliver these arrangements.

3 The Framework

3.1 Understanding the Framework

The Framework that was agreed following stakeholder consultation is represented in Figure 1.

Figure 1: Framework for integrated adult palliative care services



The **patient, family and whānau** are at the centre of the Framework, with the **primary carer** providing the first level of care. In many cases a family member takes this primary role of coordinating and delivering care and supporting the patient. The primary carer as a family and whānau member is both a provider of care and a recipient of supportive care.

Primary palliative care providers, usually general practice teams, are the main providers of palliative care. Primary palliative care providers work in an ‘integrated approach’ with **secondary care services, specialist palliative care services and other providers** of care, such as aged-care facilities and home-based support services. The context of all care is that the patient, family and whānau are members of a community.

Enablers of an integrated approach include:

- a shared electronic record across formal care providers (with patient consent)
- formalised shared-care arrangements, such as a template for documenting shared care to foster collaborative links and assist integration between specialist palliative care services and primary palliative care providers, such as general practice teams
- use of care pathways and shared clinical management guidelines
- cultural support and cultural competency
- clarity of roles and responsibilities, underpinned by formal agreements
- a purchasing framework
- education and training for primary palliative care providers, such as practice-based education to support general practice teams to provide a palliative approach.

3.2 Principles underpinning the Framework

The following principles underpin the Framework.

- Patient, family and whānau comprise the unit of care.
- An integrated system approach is applied to the entire pathway of care.
- The majority of palliative care is provided by primary palliative care providers (both in the community and in secondary care), supported by specialist services.
- There is one level of specialist palliative care, which may be provided using a hub-and-spoke model (see section 3.5 for an explanation of this).
- Palliative care will be provided according to need in a seamless manner, regardless of setting, diagnosis or location.
- A regional planning approach will be implemented, allowing for local flexibility.
- Specialist palliative care services will target their direct care service provision at those patients, families and whānau with complex needs that cannot be met, or met alone, by primary palliative care providers.
- Patients will access specialist services through nationally agreed eligibility criteria.
- Access to specialist palliative care advice and support will be 24/7.
- The aim is to work towards 24/7 access to general practice services.
- Development of the role of allied health workforce in palliative care.
- Enablers, including a shared electronic record for patients, are supported and formalised partnership agreements detailing roles and responsibilities put in place.

3.3 Levels of need

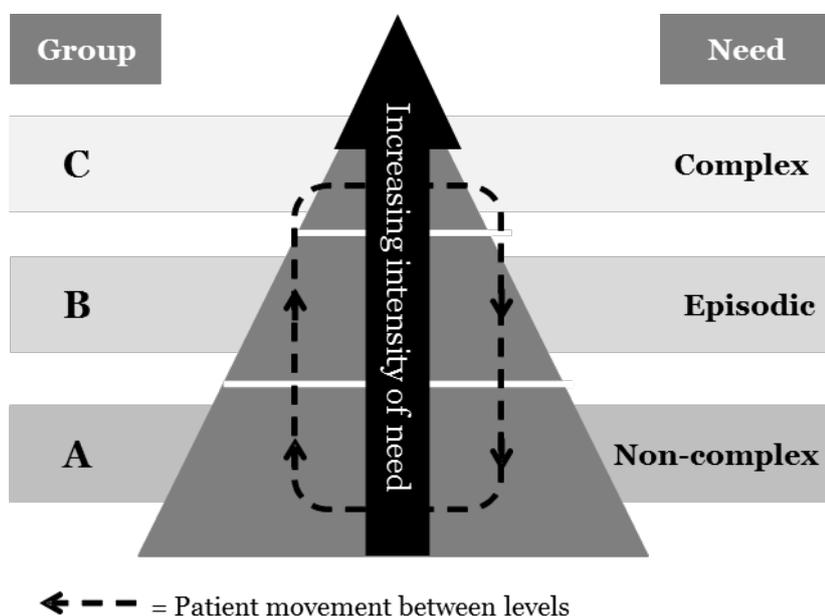
The Framework supports a dynamic approach to specialist palliative care, based on the concept that for many people the need for palliative care can be appropriately met by their existing primary palliative care provider. Research shows that the level of need can be used to classify patients into three groups, as illustrated in Figure 2.

Group A, the largest group, comprises patients whose needs are met by their primary palliative care providers, and these patients do not need to access specialist palliative care.

Patients in Group B require episodic access to specialist services, although these patients continue to have their care managed by their primary palliative care provider in a shared care model.

The smallest group is Group C. The needs of these patients are complex and do not respond to standard palliative care clinical practice guidelines. Group C patients are likely to require ongoing care by specialist services.

Figure 2: Three levels of patient need



Source: Adapted from Palliative Care Australia 2005

3.4 Implementing the Framework

The Framework emphasises the role of both primary palliative care providers and specialist palliative care services to ensure sustainable and comprehensive health care that meets the population's need. The Framework recommends that patients access specialist services based on assessed need rather than diagnosis or locality. This means there is likely to be an increase in the acuity of patients seen by specialist palliative care services, with primary palliative care providers caring for patients with less complex needs.

Implementation of the Framework has implications for existing service configuration and service planning, including opportunities to:

- identify population need and map this against existing services
- promote the development of collaborative links between primary palliative care providers in all settings (eg, general practice teams, geriatricians, aged-care facilities) and specialist palliative care providers
- develop agreed referral and assessment protocols to meet the population's palliative care need
- ensure the contribution of the allied health workforce is included in the development of future models of care
- determine workforce configuration
- consider service development at the local, district, regional and national levels.

3.5 A hub-and-spoke approach

After consultation, the palliative care sector has agreed that there should be one level of specialist palliative care provided to a population, using a hub-and-spoke approach. This approach involves one site, (the hub) acting as a base and providing services to support satellite sites (the spokes). Arrangements can vary depending on the configuration of the organisations involved and the types of service provided. In rural areas this model provides an identifiable local presence while facilitating access to services that are difficult to deliver locally.

The principle of partnership underpins the hub-and-spoke model. This partnership includes primary palliative care providers, in particular general practice teams, who provide the majority of care to patients with palliative care needs.

The hub-and-spoke approach is based on one level of palliative care, not a hierarchy. The hub-and-spoke model represents horizontal integration of services, ensuring that the local population has access to *all* the components of specialist palliative care (as defined by the SPC Service Specifications), even if the components of specialist palliative care are not delivered by one contracted provider. This enables the best use of existing resources within a region where the required expertise is not available from a single provider.

3.6 The Framework capability matrix

The Framework capability matrix uses a hub-and-spoke approach based on one level of palliative care.

Table 1: Specialist palliative care services

Specialist palliative care: the hub	Capability
Services provided	<ul style="list-style-type: none"> • Provides services, including physical, psychological, social and spiritual care for patients wherever they reside, including patients in aged residential care facilities, and family and whānau where assessed needs exceed the capability of the primary palliative care providers (specialist care may be episodic, shared or ongoing for a small group of patients) • Provides specialist assessment of the patient and their family/whānau • Provides consultation services and support to primary palliative care providers • May provide a care coordination function • Provides, or has access to, dedicated inpatient palliative care beds • Provides symptom management of complex and/or unstable medical conditions • Provides management for complex grief, social and spiritual problems • Provides 24/7 telephone advice and support • Supports the implementation of end-of-life care pathways • Provides consultation for services outside the district through formalised network arrangements • Engages in advance care planning and supports planning initiated in primary palliative care
Geographical coverage	<ul style="list-style-type: none"> • Local, district and regional

Specialist palliative care: the hub	Capability
Indicative staffing profile	<ul style="list-style-type: none"> • A comprehensive interdisciplinary team, which may be from a range of providers rather than employed by a single agency • Medical specialist(s) with specialist qualifications in palliative medicine (Fellow of Chapter of Palliative Medicine) • Registered medical practitioners with specialist qualifications in palliative medicine (eg, recognised diploma in palliative medicine) • Specialist nursing (this may include a nurse practitioner or clinical nurse specialist), with a postgraduate diploma in palliative care as the minimum qualification • Specialist allied health staff (eg, occupational therapist, social worker, physiotherapist, pharmacist, speech–language therapist) with specific training (or postgraduate qualifications) in palliative care • Psychosocial staff (eg, psychologist, psychotherapist, counsellor) with specific training (or postgraduate qualifications) in palliative care • Cultural advisors with specific training and experience in palliative care • Spiritual advisors with specific training and experience in palliative care
Service links	<ul style="list-style-type: none"> • Formal links with primary palliative care providers (eg, general practice teams and aged-care facilities) • Formal links with ‘spoke’ specialist palliative care services • Formal links with other tertiary/secondary services or specialties (eg, pain service, dementia service) • Formal links with regional clinical networks
Education/training	<ul style="list-style-type: none"> • Participates in undergraduate and postgraduate teaching • Provides education about a palliative approach and formal training programmes for health professionals across a range of settings • May provide registrar or general practitioner with special interest¹ (GPwSI) training • May have formal links with academic units
Infrastructure	<ul style="list-style-type: none"> • Access to tele-health facilities • Access to equipment loan • Shared electronic record
Performance improvement	<p>Leads research and quality activities at the regional level</p> <p>Participates in benchmarking and continuous quality improvement</p>

¹ Specialist palliative care services based within the hub may provide education or training to a general practitioner who has a special interest in palliative care medicine.

Specialist palliative care: spoke	Capability
Services provided	<ul style="list-style-type: none"> • Provides access to support and services, including physical, psychological, social and spiritual care for patients wherever they reside, including patients in aged residential care facilities, and family and whānau where assessed needs exceed the resources of the primary palliative care provider • Provides bereavement support • May provide a care coordination function • Provides 24/7 on-call coverage (this may be through a regional hub) • Engages in advanced care planning
Geographical coverage	<ul style="list-style-type: none"> • Local
Staffing profile	<ul style="list-style-type: none"> • Registered medical practitioners with specialist qualifications in palliative medicine (eg, recognised diploma in palliative medicine) • Nursing staff with a minimum of a postgraduate certificate in palliative care • Staffing includes access to psychological, social, cultural and spiritual care, and allied health staff who have completed formal training in palliative care (may be from a range of providers rather than employed by a single agency)
Service links	<ul style="list-style-type: none"> • Formal agreements, links and referral arrangements with primary palliative care providers (eg, general practice teams and aged-care facilities) and hub specialist palliative care services
Education/training	<ul style="list-style-type: none"> • Provides formal training and clinical practice teaching sessions for local primary palliative care providers
Performance improvement	<ul style="list-style-type: none"> • Participates in benchmarking and data collection
Infrastructure	<ul style="list-style-type: none"> • Shared electronic record • Access to inpatient beds • Access to tele-health facilities • Access to equipment loan

Table 2: Primary palliative care providers

Primary palliative care providers delivering a palliative approach may be located in either primary or secondary care settings	Capability
Services provided	<ul style="list-style-type: none">• Delivers a palliative approach to patients with life-limiting or life-threatening conditions supported by specialist palliative care services and psychosocial support as required• Engages in advance care planning• May perform a care coordination/key worker function• Engages in and utilises an end-of-life pathway programme
Geographical coverage	<ul style="list-style-type: none">• Local
Staffing profile	<ul style="list-style-type: none">• Health care professionals or health care providers who are not part of a specialist palliative care team (see the glossary for a definition of primary palliative care)
Service links	<ul style="list-style-type: none">• Formal links with specialist palliative care services• Consultation with specialist palliative care services when standard guidelines do not meet patient and family/whānau needs• Allied health workforce• Awareness of services available and access to services
Education/training	<ul style="list-style-type: none">• Participates in palliative care education programmes provided by specialist palliative care services
Performance improvement	<ul style="list-style-type: none">• Participates in accreditation programmes as applicable
Infrastructure	<ul style="list-style-type: none">• Shared electronic record• Access to tele-health facilities• Access to equipment loan

3.7 Suggestions to support implementation of the Framework

Comprehensive resource material, such as palliative care guidelines, will need to be made available to support primary palliative care providers, including nursing services, general practitioners, aged-care facilities, the allied health workforce and acute hospitals. National guidelines may need local adaptation to ensure a fit with local and regional services. Many resources have already been developed and could be shared with other services nationally (eg, the Hospice New Zealand Standards for Palliative Care).

Involving users in the development of health services is one way of ensuring the needs of the patient and family and whānau are understood and services are developed to include their perspective. Involving users also provides an opportunity to treat patients and carers as stakeholders in the service. They can make an important contribution to service planning and decision-making and help keep the service centred on the patient, family and whānau. A toolkit to involve users in the design of health services sponsored by the Ministry of Health is available at www.healthcodesign.org.nz.

Glossary

Sourced from the New Zealand Palliative Care Glossary (Palliative Care Council 2012).

Advance care planning (ACP)	A process of discussion and shared planning for future health care. ACP is focused on the individual and involves both the person and the health care professionals responsible for their care. It may also involve the person's family and whānau and/or carers if that is the person's wish. ACP provides individuals with the opportunity to develop and express their preferences for care, informed not only by their personal beliefs and values but also by an understanding of their current and anticipated future health status and the treatment and care options available.
Chronic condition	A biological or physical condition where the natural evolution of the condition can have a significant impact on a person's overall quality of life, including an irreversible inability to perform basic physical and social functions. Serious and persistent chronic conditions are multidimensional, interdependent, complex and ongoing. Chronic conditions are characterised by persistent and recurring health consequences lasting for three months or more.
End-of-life care	End-of-life care is the provision of supportive and palliative care in response to the assessed needs of the patient and family/whānau during the end-of-life phase. It focuses on preparing for an anticipated death and managing the end stage of a life-limiting or life-threatening condition. This includes care during and around the time of death, and immediately afterwards. It enables the supportive and palliative care needs of both the person and their family and whānau to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms, and provision of psychological, social, spiritual and practical support and support for the family.
Family	Those who are closest to the patient in knowledge, care and affection. The family may include the biological family, the family of acquisition (related by marriage/contract), and the family of choice and friends (including pets). See also <i>whānau</i> .
Hospice	<p>Hospice is not only a building; it is a philosophy of care. The goal of hospice care is to help people with life-limiting and life-threatening conditions make the most of their lives by providing high-quality palliative and supportive care.</p> <p>Hospices provide care for the whole person: not just their physical needs but also their emotional, spiritual and social needs. They also care for families and friends, both before and after a death. Irrespective of where a hospice service is, this philosophy of care does not change. In New Zealand all aspects of hospice care are provided free of charge.</p>

Interdisciplinary team

A group of individuals with diverse training and backgrounds who work together as an identified unit or system. Team members consistently collaborate to solve problems that are too complex to be solved by one discipline or many disciplines in sequence.

Membership of the team varies depending on the services required to identify and address the expectations and needs of the patient, caregiver and family. A palliative care interdisciplinary team typically includes one or more doctors, nurses, social workers, spiritual advisers, pharmacists, allied health workers and personal care workers. Other disciplines will be part of the team as resources permit.

Primary carer

The primary carer is generally in the close kin network of the patient and is usually self-identified. The primary carer can be the patient's spouse, child, another relative, family member or friend. They may be supported by other carers, but will generally take a primary role in the coordination and delivery of care and support to the patient. This person provides for the practical needs of the patient and takes on additional tasks that may be of a technical nature, to provide ongoing care for the patient (eg, the administration of medications). They provide the primary support role for the patient at all levels of need.

Primary palliative care (generalist)

Care provided by all individuals and organisations that deliver palliative care as a component of their service, but whose substantive work is not the care of people who are dying. It is palliative care provided for those affected by a life-limiting or life-threatening condition as an integral part of standard clinical practice by any health care professional who is not part of a specialist palliative care team.

In the context of end-of-life care, a primary palliative care provider is the principal medical, nursing or allied health professional who undertakes an ongoing role in the care of patients with a life-limiting or life-threatening condition. A primary palliative care provider may have a broad health focus or be specialised in a particular field of medicine. This care is provided in the community by general practice teams, Māori health providers, allied health teams, district nurses and residential care staff, etc. It is provided in hospitals by general ward staff, as well as disease-specific teams (eg, oncology, respiratory, renal and cardiac teams).

Primary palliative care providers assess and refer patients to specialist palliative care services when the patient's needs exceed their services capability.

Quality care at the end of life is realised when strong networks exist between specialist palliative care providers, primary palliative care providers, support care providers and the community – working together to meet the needs of all people.

Note: this terminology is in a transitional phase, moving from the term 'generalist palliative care' to 'primary palliative care'. Only the term 'primary palliative care' is used in the Framework.

Specialist palliative care

Palliative care provided by health professionals 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 may be provided by hospice- or hospital-based palliative care services where patients have access to at least medical and nursing palliative care specialists.

Specialist palliative care will be provided through accredited services (or organisations) that work exclusively in palliative care and meet specific palliative care standards as they are developed nationally. Specialist palliative care practice builds on the palliative care provided by primary palliative care providers and reflects a higher level of expertise in complex symptom management, psychosocial support, grief and bereavement. Specialist palliative care provision works in two ways.

1. *Directly* – to provide direct management and support of patients, their families and whānau, where more complex palliative care need exceeds the resources of the primary palliative care provider. Specialist palliative care involvement with any patient and the family/whānau can be continuous or episodic depending on changing need. Complex need in this context is defined as a level of need that exceeds the resources of the primary palliative care 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 provision of primary palliative care.

Whānau

The extended family, or family group. In the modern context the term is sometimes used as a familiar term of address to a number of people, including friends who may not have any kinship ties to other members.

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Appendix A: Hospice Capability Recommendations

1 October 2012

Hospice capability: what should our community expect of us?

The underlying intentions to this piece of work are equity of access, quality of care and fairness of hospice care for the people of New Zealand. Alongside this is the certainty that each hospice is very important to its local community, but what we also know is that patients and families are not necessarily concerned if the care they receive is delivered by generalist or specialist providers. What is important is that the right services are delivered by the right people, at the right time, in the place that is right for the patient and their family.

We acknowledge and honour the range of services, the diversity of models and the locally driven adaptations to meet communities' needs. We have taken the best of this, agreed the core of local community hospice care, and developed a way to strengthen and position hospices to lead palliative care in the future.

By working together to define hospice care as it stands now, we can ensure that the founding values of hospice continue to underpin the care delivered by hospices throughout New Zealand in the future.

It is acknowledged that we are facing demographic changes in communities, an ageing population, and an increase in chronic conditions, which will contribute to an increase in demand for hospice services – which will be challenged by workforce shortages and funding constraints.

As an organisation, we felt it was timely to actively lead and participate in sector developments that will change the face of health care and palliative care delivery in New Zealand. By leading the future shape of hospice, we will positively influence the development of policy, service and funding models, and service planning.

We strongly believe, as do our communities, that hospices have an important and valid role to play both now and in the future.

Hospice capability key questions

- What is it that people in our communities need?
- What needs to be in place to meet the expectations of people?

Hospice capability key assumptions

- That the majority of New Zealanders want to choose where they live during their illness and where they die.
- That people and their families and whānau will need access to skilled people who take responsibility for ensuring their care is coordinated and appropriately linked to other health providers and social agencies.
- That people have appropriate access to clinicians who can provide expert symptom management, assistance with practical matters, psychosocial and spiritual support (or a team who sees them as a whole person – social, spiritual, member of a family and community), carer respite, education of carers, night care, equipment, etc.
- That criteria for entrance to a service be based on patient need, not on diagnosis or what services offer.
- That families want the problem sorted and are not so concerned by whom, but they do expect a quality service, delivered by professionals who are able to effectively solve their problem.
- That the unit of care is the person and their family and whānau.
- That care should be delivered in a culturally appropriate manner.
- That hospices review their services against the Hospice NZ Standards for Palliative Care and use the quality review programme tools to guide quality improvement.

What should all hospices be capable of providing?

To ensure consistent and quality care is delivered within all communities, each hospice will have:

Clinical functions

- Community palliative care services delivered by the interdisciplinary team to meet the needs of the patient and family (hands on community nursing care will be offered or accessible, when needed).
- Advanced assessment and care planning – medical, nursing, psychosocial and spiritual.
- Care coordination / case management in place.
- Liaison – cultural, community, aged care, hospital and social services, where necessary.
- Education – both of the public and health workforce.
- Counselling and support programmes during illness and into the bereavement phase.
- End of life pathway and or alternate model of sector wide training.
- Quality improvement and management.
- Clinical data collection; accurate and timely.

See also, clinical functions that are accessed as a minimum standard of care.

Non-clinical functions

- Effective governance and leadership.
- Volunteer management and systems.
- Responsible and ethical fundraising.

All hospices will employ or contract people for each of these roles, with subsequent required competencies depending on profession.

Nurses

The majority of specialist palliative care is delivered through the nursing workforce, most of whom will have postgraduate qualifications in palliative care. Inpatient units will have a mix of experienced and specialist qualified staff. The following outlines the minimum requirements.

Consistent with current PDRP*	Graduate	Competent	Proficient	Expert (EN at this level called accomplished)	Senior TL CNS CNE	Nurse practitioner
IPU RNs	Yes	Yes	Yes	Yes	Yes	Optional
IPU ENs	Yes	Yes	N/A	Yes	N/A	N/A
IPU HCAs	N/A	Yes	N/A	N/A	N/A	N/A
Community care coordinator	No	No	No	Minimum	Yes	Optional
Community nursing	No	No	Minimum	Yes	Yes	Optional

RNs – at least 60% with relevant qualifications (PG cert in PC) and proficient/expert

ENs – at least 60% proficient/expert within scope of practice

Senior nurses – competencies plus qualification, minimum PG diploma (PC endorsement), preferably master's

* See appendix for abbreviations.

Doctor

Hospices will need general practitioners and/or medical officers on staff, who are vocationally registered and preferably have a postgraduate diploma or clinical diploma in palliative care. These staff will also need access to, and supervision from, a palliative medicine specialist.

Cultural liaison/advisor

Each hospice team will include cultural support staff, competent in palliative care. These competencies are yet to be developed, but this will be done in partnership with hospice cultural advisors currently delivering this care and drawing on international best practice.

Social work, counselling and spiritual care

The psychosocial team is pivotal to the delivery of comprehensive and holistic patient, family and whānau care. The following outlines the registration, qualifications and competencies of these staff that all hospices will be working towards.

	Membership required	Registration required	Qualification required	Competency required To be developed
Social work	ANZASW*	SWRB	PG cert in PC	Yes
Counselling	NZAC	Application with HPCA	PG cert in PC	Yes
Spiritual care	Does not currently exist	Does not currently exist	PG cert in PC	Yes

* See appendix for abbreviations.

Educators

Educators are from a wide range of professions, although the lead is often taken by nurses. The qualifications and competencies are as laid out for the CNE role; educators will demonstrate competencies to an expert level, plus have or be working towards a minimum qualification of PG Diploma (PC endorsement) and preferably a Master's degree in an area relevant to palliative care provision.

Volunteer services

All hospices will have a volunteer workforce, undertaking roles that enhance services. This workforce will be managed by trained managers who will demonstrate competencies in palliative care. These competencies are yet to be developed, but this will be done in partnership with experienced hospice managers of volunteer services.

All hospice services will either provide or have access to:

- inpatient care (eg, hospice inpatient unit, aged residential care, hospital – dedicated palliative care beds)
- equipment for patients and families at home
- respite – night and day nursing and carer relief
- home help for personal cares
- 24/7 medical and nursing advice and care, in the home

- paediatric and young person palliative care services
- specialist teams – such as renal, respiratory, cardiac, and mental health services, health of older people services, children and young people services, disability services, etc
- interpreter services, including deaf interpreter.

Specific expertise/roles and their competencies

Specialist medical

Some hospices will employ specialist medical staff who will then support, advise and supervise medical officers. They will also provide support and advice to local general practitioners and in some cases provide services to other hospices. These staff will be vocationally registered in palliative medicine with MCNZ (and Fellows of the RACP or Chapter of Palliative Medicine).

A smaller group of hospices will provide advanced training opportunities for registrars in Palliative Medicine and other specialities. These hospices must meet RACP criteria to become a training site.

Occupational therapy, physiotherapy, clinical pharmacist, dietician, speech–language therapist

Role	Registration required	Qualification	Competency
Occupational therapy	Occupational Therapy Board	PG* cert in PC	Yes
Physiotherapy	Physiotherapy Board	PG cert in PC	Yes
Clinical pharmacist	Pharmacy Council	PG cert in PC	Yes
Speech–language therapy	New Zealand Speech–Language Therapists’ Association (not covered by HPCA)	PG cert in PC	Yes
Dietician	Dieticians Board	PG cert in PC	Yes

* See appendix for abbreviations.

Hospice services could offer, depending on local community needs

It is widely acknowledged that the provision of day programme, group support, supportive therapies and a range of other services greatly contributes to the care provided to a patient and their family and whānau. However, due to financial and human resource limitations there are often challenges involved in providing these therapies. Therefore where possible, a hospice could choose to offer:

- hospital in-reach services, multidisciplinary with psychosocial and spiritual care components
- day programme and therapies
- group support for patients, carers, families, etc
- family carer information and bereavement services, etc
- complementary therapies.

Specific expertise/roles and their competencies may include:

- music therapy
- art therapy
- massage therapy
- aromatherapy.

Hospices who offer complementary therapies will ensure these services are delivered by qualified and registered staff with competencies in palliative care. Hospices may encourage staff to undertake palliative care-specific qualifications and these staff would then be specialist in their respective role.

Regional collaboration for service provision

Looking to the future, with increased demand on services and funding constraints it is not realistic or necessary for each hospice to provide all services to their communities. The sharing of services through a regional collaborative approach/network will ensure all patients and families receive care and support through effective partnerships among hospice providers.

Within this model hospices may collaborate on:

- standardised policies and audit processes
- shared medical specialists
- shared quality systems
- clinical leadership support
- centralised administration, technology and other backroom functions.

The cornerstones of regional collaboration:

- the configuration of services will require strong governance
- a strong caution against another layer of bureaucracy
- flexible services to meet community needs
- cannot impact on community funding or support
- community relationships remain vital to the local hospice.

The model could be described as follows (note: hospices x, a, z, b and y are situated within one region.)

An example of a regional collaborative network			
	Services:	Services:	Services:
	<ul style="list-style-type: none"> • Community palliative care services • Advanced assessment and care planning • Care coordination/case management • Liaison • Education • Bereavement support • End of life care pathway • Quality improvement • Clinical data collection • Effective governance and leadership • Volunteer management and systems • Responsible fundraising 	<ul style="list-style-type: none"> • Inpatient care • Equipment • Respite • Home help, personal cares • 24/7 medical and nursing advice and care • Paediatric and young person palliative care • Specialist teams • Interpreter services, including deaf interpreter 	<ul style="list-style-type: none"> • Hospital in-reach (or there will be a hospital palliative care team in place) • Day programme • Group support • Family carer education, rehabilitation, etc
Local hospice x	Will have	Will have access to	May offer
Local hospice a	Will have	Will have access to	Do offer
Regional hospice z	Will have	Will have	Will have
Local hospice b	Will have	Will have access to	Do offer
Local hospice y	Will have	Have	May offer

Where to from here – for Hospice New Zealand and members?

There is a need for local and regional impacts to be identified prior to any new models, agreements or partnerships being established. Hospice NZ and members will participate in Ministry of Health service planning and funding model development. Additionally, stemming from the hospice capability development and consultation process, we have multiple areas for future discussion and development. These can be broadly grouped into five areas.

Core services definition

1. Defining what is meant by each of the core clinical and non-clinical functions as listed in the hospice capability recommendations above, so that there is a shared understanding and standard across all hospice services.

Competency definition

2. Describing the levels of psychosocial competency required for all staff, those carrying out advanced assessment and lead psychosocial professionals.
3. Clearly identifying where one role of expertise finishes and where access and referral to another expert is required.
4. Development of allied health and psychosocial palliative care competencies.
5. Development of spiritual care competencies.
6. Development of 'all staff' and 'expert staff' guidelines for cultural competencies.
7. Development of agreed quality capability and competencies.

Volunteer support

8. Development of an agreed description of volunteer functions and roles, defining how these hospice services work alongside all palliative care.
9. Development of competencies for managers of volunteer services.

Qualifications development

10. Partner with HWNZ and universities to develop training options for all hospice professions.
11. Defining 'equivalent' postgraduate qualifications.

Palliative care as part of the wider health sector

12. Defining how hospice services work alongside all palliative care providers and describing how hospice services are integrated into the whole population health sector.

The background to this project

Hospice NZ identified the need for a framework that clearly defined all services that should be offered by hospices, and the staffing skills and experience required to deliver these services. This was endorsed at a membership and governance level of the organisation.

The project was overseen by a specifically convened governance group, with a separate working group contributing their time and expertise.

Hospice Capability Governance Group

Mary Schumacher (Chair)	Hospice NZ CEO
Rod MacLeod	Honorary Clinical Professor University of Auckland and Palliative Care Development Manager Hospice North Shore
Kevin Nielsen	Hospice Taranaki CEO
Peter McIntyre	Hospice NZ board member, Otago Community Hospice board member
Jan Nichols	Mercy Hospice CEO

Hospice Capability Working Group

Suzie Kuper	Lake Taupo Hospice	Nursing representative
Karen Talbot	Hospice West Auckland	Nursing representative
Paul Ranby	Arohanui Hospice	Psychosocial representative
Clare Greensmith	Otago Community Hospice	Allied health representative
Diane Greenwood-Havea	Te Omanga Hospice	Psychosocial representative
Marion Taylor	Hospice Wanganui	GPwSI representative
Brian Ensor	Mary Potter Hospice	Medical specialist representative
Deb Peters	PCAG	Consumer representative
Wayne Naylor	Cancer Control Council	Senior analyst
Richard Thurlow	Waipuna Hospice	CEO representative

The first work of the governance group was to clarify the scope of this project. Additionally, they assisted the project team to further identify risks, assumptions and interdependencies that might impact on the project. The working group developed the core service description, identified the professional qualification and recommended palliative care competency specific to their specialist role.

Abbreviations used in this document

ANZASW	Australia New Zealand Association of Social Workers
CNE	clinical nurse educator
CNS	clinical nurse specialist
EN	enrolled nurse
FTE	full-time equivalent
GP	general practitioner
HCA	health care assistant
HPCA	Health Practitioners Competence Assurance Act
HWNZ	Health Workforce New Zealand
IPU	inpatient unit
MCNZ	Medical Council New Zealand
MOSS	medical officer
NZAC	New Zealand Association of Counsellors
PC	palliative care
PDRP	professional development and recognition programme
PG	postgraduate
PM	palliative medicine
RACP	Royal Australian College of Physicians
RN	registered nurse
SWRB	Social Worker Registration Board
TL	team leader

Appendix B: Hospital Palliative Care Service Capability Framework

4 June 2012

Introduction

The strategic vision for palliative care in New Zealand 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'.² In order to achieve this vision, there are three key long-term outcomes that the palliative care sector and wider health sector must work towards. These are:

1. access to palliative care regardless of setting
2. all palliative care providers are configured to ensure a seamless care pathway
3. palliative care provision is high quality.

These outcomes are important because together they constitute the things that are necessary to achieve the palliative care strategic vision. Achieving these longer term outcomes will require a number of system-level approaches that result in changes to important short-term outcomes.

The system-level areas that need to be addressed include: *sufficient capacity* (workforce, services and infrastructure), *appropriate referrals* (awareness of palliative care referral processes, palliative care principles are understood), *continuity and coordination of care* (palliative care is integrated throughout the health sector, palliative care services/providers are coordinated with each other), *best practice is followed* (standards for palliative care service provision are met, interdisciplinary team approach to palliative care), and *palliative care meets the needs of the patient, their family and whānau* (needs of specific population groups are met, culturally appropriate care, effective treatments and support).

This document, the *Hospital Palliative Care Service Capability Framework*, has been developed to give direction to hospital palliative care services (HPCS), other palliative care service providers, district health boards, the Ministry of Health and the wider health sector on how hospital palliative care services should be configured to achieve the vision for palliative care.

² Palliative Care Council of New Zealand. 2012. *Measuring What Matters: Palliative care*. Wellington: Cancer Control New Zealand.

The framework has attempted to address each of the system-level outcomes by detailing what is expected of a highly functional in terms of workforce, resources and infrastructure, clinical and non-clinical functions, and key working relationships.

Background

In 2001 the New Zealand Palliative Care Strategy identified the need for hospital palliative care services and recommended the establishment of hospital palliative care services in all hospitals.³ It was recognised then that many people were dying in hospitals without ready access to palliative care. Current mortality data shows that this continues to be the case, with approximately one-third of all deaths in New Zealand occurring in hospital.⁴ Many of these deaths are sudden and unexpected, but there are a large number where death can be expected and where palliative care would be of benefit.

An analysis of mortality data from 2005–2007 estimated that around 57% of all deaths in New Zealand (15,724 individuals) could have benefited from palliative care. Of this estimate group, 47% of adult deaths and 78% of deaths in 0–19 year olds occurred in hospital. These figures suggest that the need for palliative care is present to a high level in the hospital setting. In addition, people who would benefit from palliative care and who die in hospital are more likely to be Māori or Pacific people (or other ethnic minority), come from a more deprived area, and have a non-cancer diagnosis.

One of the key aspects of HPCS is enhancing the capability and capacity of primary palliative care providers (ie, those health care providers that deliver palliative care as a component of their service, but their substantive work is not in the care of people who are dying) to ensure they can deliver high-quality palliative care within the limits of their knowledge and ability.

HPCS also provides specialist palliative care when the needs of a patient/family exceed the capability of the patient's principle care team. To achieve this dual role, HPCS provide advice on symptom management; patient, carer and staff support; technical expertise; and bereavement support. Their involvement with individual patients may range from giving advice and information to the patient's principle care team, to conducting patient consultation and assessment, offering short-term interventions, or providing complex ongoing care.⁵

³ Ministry of Health. 2001. *The New Zealand Palliative Care Strategy*. Wellington: Ministry of Health.

⁴ Palliative Care Council. 2011. *National Health Needs Assessment for Palliative Care Phase 1 Report: Assessment of palliative care need*. Wellington: Cancer Control New Zealand.

⁵ National Council for Palliative Care. 1996. *Palliative Care in the Hospital Setting (Occasional Paper 10)*. London: National Council for Palliative Care.

HPCS provides multidisciplinary education, both formal and informal, through one-to-one encounters, ward rounds, study days, courses and formal lectures. HPCS should also be involved in audit and research within a framework of clinical governance and provide strategic direction to their employing DHB in relation to palliative care.⁶

Framework development

The Ministry of Health is developing a national Resource and Capability Framework for Integrated Adult Palliative Care Services in New Zealand. The purpose of the Framework is to 'provide guidance to health service providers, funders and policy makers to inform planning and strategic development of palliative care services'.⁷ This includes the resources and capability required to support service delivery. As a result of this work, Hospital Palliative Care New Zealand identified the need to clearly articulate what hospital palliative care services are in New Zealand from the perspective of the services themselves.

This Framework is intended to set a minimum standard for hospital palliative care service provision in New Zealand, and also to inform the Ministry's Resource and Capability Framework project.

The Palliative Care Council (PCC) offered to support HPCNZ with this piece of work by providing secretariat support, and invited HPCNZ to a meeting to begin developing a hospital palliative care capability framework. A call for members of HPCNZ to form a working party and participate in this meeting was made to the HPCNZ membership. Four representatives from HPCNZ agreed to sit on the working group along with Dr Kate Grundy, Chair of PCC, and staff from the Palliative Care Council and Ministry of Health.

Hospital Palliative Care Service Capability Framework Project Working Group

Dr Kate Grundy	Palliative Care Physician, Canterbury DHB; Chair, Palliative Care Council
Dr Mike Harris	Palliative Care Physician, Auckland DHB
Dr Jean Clark	Clinical Nurse Specialist Hospital Palliative Care Team, MidCentral DHB
Tania Helyer	Clinical Nurse Specialist Hospital Palliative Care Team, Waitemata DHB
Debbie Wise	Clinical Nurse Specialist Hospital Palliative Care Team, Hutt Valley DHB

⁶ NHS Scotland. 2002. *Clinical Standards: Specialist palliative care*. Edinburgh: Clinical Standards Board for Scotland.

⁷ Ministry of Health. 2012. *Resource and Capability Framework for Integrated Adult Palliative Care Services in New Zealand: Consultation document*. Wellington: Ministry of Health.

Craig Tamblyn General Manager, Cancer Control New Zealand and Palliative Care Council

Wayne Naylor Senior Analyst, Palliative Care Council

Kate Thomason Advisor, Cancer Programme, Ministry of Health

The working group identified the core workforce, functions (clinical and non-clinical) and essential working relationships required for HPCS, including staff qualifications. These are referred to as the *will have* components of the framework.

There are a number of staff members and functions and facility requirements that are not always a part of the core HPCS, but which the service regularly requires access to and support from. These are referred to as the *will have access to* components of the framework.

Given the diversity of HPCS configurations, service delivery models and funding streams, the Working Group also identified a number of service components that HPCS *could offer*, including other specialist staff positions.

An underlying principle of the framework is that Hospital Palliative Care Services are delivered by a specialist interdisciplinary team to meet the needs of all patients who are referred and their family/whānau. Education and staff support are also essential functions.

The draft Framework was sent to the Hospital Palliative Care New Zealand (HPCNZ) membership for consultation and was then discussed at a national meeting of HPCNZ on 25 May 2012. This meeting resulted in further refinement of the Framework.

Hospital Palliative Care Service Capability Framework

While the Framework describes a minimum standard for HPCS, it is recognised that many services are not currently configured or resourced in line with the Framework and so a realistic timeframe will need to be set for these services to develop to an appropriate level. This will need to be accompanied by a commitment from DHBs to invest in service development and ongoing resourcing.

In addition, HPCS need to be configured and resourced at an appropriate level to meet local need, and they may not need to provide all components of the Capability Framework. For example, HPCS in a smaller provincial hospital may have some components provided by regional HPCS (for example, 24/7 telephone advice) and may not require full-time staff.

It is recommended that hospital palliative care services should be configured as follows:

Hospital Palliative Care Services will have:

Staff

- Specialist nursing
- Specialist medical
- Administration/data management.

Clinical functions

- Five-day on-site service (with after-hours telephone cover)
- Consultation, advice and liaison with referring team (MDT)
- Advanced assessment (initial and ongoing) and care planning – medical, nursing, psychosocial, spiritual
- Liaison – community (primary care), aged care, hospital teams, hospice (inpatient and community services), pain services
- Input into family meetings
- Input into discharge planning
- Input into advance care planning
- Input into end-of-life care pathway implementation.

Non-clinical functions

These functions are considered critical to enhancing the knowledge and skills of primary palliative care providers and ensuring leadership and strategic direction for palliative care:

- clinical education – both formal/structured and informal
- supervision/training (medical and nursing)
- leadership and strategic planning
- quality improvement
- research/audit
- clinical data collection
- access to clinical supervision
- appropriate networks and engagement (local, regional and national).

Effective working relationships with:

- other specialist palliative care services (within DHB and beyond as required)
- bereavement support services
- hospital medical and nursing staff
- allied health staff (eg, social workers, physiotherapists, occupational therapists, chaplaincy and spiritual support services)
- liaison psychiatry, psych-oncology services
- pain service – acute and chronic
- specialist teams – oncology, children and young people services, mental health services, renal, cardiac and respiratory services, health of older people services, wound, disability services, etc
- discharge coordinator
- other services as appropriate to ensure good patient/family/whānau outcomes.

Hospital Palliative Care Services will not always offer directly, but will have access to:

- private/quiet spaces for consultations and family meetings
- single rooms for dying or distressed patients/family
- interventional pain services/techniques
- paediatric specialist palliative care support/advice
- hospice inpatient care
- residential care beds
- equipment.

Staff

- physiotherapy
- occupational therapy
- speech–language therapy
- dietetics
- pharmacy and clinical pharmacology
- cultural liaison
- interpreter services.

Hospital Palliative Care Services could offer:

- inpatient care (ie, dedicated inpatient palliative care beds)
- outpatient clinics
- on-site, after-hours services
- family carer education, rehabilitation
- public education
- complementary therapists – including art, music, massage, aromatherapy, etc.

Hospital Palliative Care Services could also include the following staff

These roles are particularly important in HPCS with a high level of need, such as a tertiary-level hospital with a cancer centre. These ‘high need’ services would be expected to at least include the roles marked ‘*’:

- registrar / palliative medicine advanced trainee*
- nurse practitioner / nurse practitioner candidate*
- clinical psychologist*
- specialist palliative care social worker*
- end-of-life care pathway facilitator*
- bereavement support worker
- palliative care nurse specialist trainee
- advance care planning facilitator.

Staff qualifications and competencies required in a Hospital Palliative Care Service

	Position	Registration required	Relevant qualification(s)	PDRP level
Nursing	Nurse practitioner™	NCNZ	Master’s	n/a
	Senior nurse / CNS	NCNZ	PG Diploma	Expert
	RNs	NCNZ	PG cert in PC	Proficient – expert
Senior nurse/CNS – competencies plus qualification, minimum PG Diploma (PC endorsement), preferably Master’s RNs – <i>all</i> will have relevant qualifications (PG cert in PC) and be proficient/expert Nurse educator and LCP / end of Life care pathway facilitator will be at least RN with PG Cert in PC RN PDRP levels – graduate, competent, proficient, expert (Levels of competence should be based on the National Professional Development Framework for Palliative Care Nursing in Aotearoa New Zealand)				

	Position	Registration required	Relevant qualification(s)
Medical	Palliative medical specialist	MCNZ Vocational registration in palliative medicine	FRACP, FACHPM (or equivalent)
	Registrar / palliative medicine advance trainee	MCNZ	MBCChB
	MOSS / general practitioner	MCNZ	Clinical Diploma in Palliative Medicine
	Some services may employ a house surgeon as well as a registrar.		
Allied health	Occupational therapy	Occupational Therapy Board	Not applicable as allied health are employed by other services.
	Physiotherapy	Physiotherapy Board	
	Clinical pharmacist	Pharmacy Council	If employed specifically by HPCS then they require a PG Cert in PC.
	Speech–language therapy	New Zealand Speech–Language Therapists’ Association (not covered by HPCA)	
	Dietician	Dieticians Board	
	Cultural liaison	None exist	
Psycho-social	Social work	Social Workers Registration Board (SWRB)	Not applicable as allied health are employed by other services.
	Counselling	New Zealand Association of Counsellors (NZAC – application with HPCA)	If employed specifically by HPCS then they require a PG Cert in PC.
	Spiritual care	None exist	

Notes:

PG cert in PC = Postgraduate Certificate in Palliative Care

HPCA = Health Practitioners Competence Assurance Act 2003

Appendix C: Stakeholders consulted

- District health boards – planning and funding
- District health boards – provider arm
- Hospice New Zealand
- Palliative Care Council
- Hospital Palliative Care New Zealand
- Primary health care organisations
- College of General Practitioners
- Regional cancer networks
- Australian and New Zealand Society of Palliative Medicine Incorporated
- Palliative Care Nurses New Zealand
- New Zealand Nurses Organisation
- College of Nurses Aotearoa
- District health boards – allied health directors
- New Zealand Aged Care Association
- Bupa Care Services
- Metlifecare
- Oceania Group
- Presbyterian Support National Office
- Ryman Healthcare
- Summerset
- National Council of Women
- Māori Women’s Welfare League
- Grey Power
- Age Concern
- Cancer Voices

Appendix D: Selected literature review

A selected literature review focusing on differentiating levels of care was completed as part of developing the Framework.

Australia

In 2005 Palliative Care Australia published *A Guide to Palliative Care Service Development: A population approach*, which set out a service planning framework. The service planning framework was based on role delineation outlining the relationship between specialist and primary care services. Role delineation provides a consistent and common language describing and differentiating health care services in terms of their complexity.

The service planning framework described three levels of specialist palliative care services relating to level of resources, capability and linkages. The service planning framework defined primary care services as services whose substantive work was not in palliative care, matching the New Zealand definition of primary palliative care provider.

Each state in Australia has subsequently developed its own role delineation model or resource and capability framework as a component of planning the delivery of palliative care services. The following list provides some examples:

- New South Wales (Department of Health, NSW 2007) has adopted three levels of specialist palliative care. The model has three components: the relationships and roles of primary care services and specialist care providers; the classification of specialist palliative care services into three levels in terms of resources and capability; and access to community support services required by both primary and specialist services.
- Western Australia (Department of Health, WA 2005) has mapped the levels described in the Palliative Care Australia framework against the six levels of the Western Australian Health Clinical Services Framework and is in the process of implementing a new model of palliative care.
- Tasmania (Department of Health and Human Services, TAS 2008) has adopted a service delivery model with four levels of care – two primary and two specialist. The roles and responsibilities for primary and specialist providers are defined at each level.

- Most recently the state of Victoria (Department of Health, VIC 2011) has adopted a palliative care service capability framework that includes three types of services (inpatient, community and consultancy) and three levels of inpatient categories (two levels of community-based services and one level of consultancy). Each of the inpatient categories is mapped against seven dimensions that measure and describe capability.

United Kingdom

The National Institute for Clinical Excellence manual *Improving Supportive and Palliative Care for Cancer* (2004) differentiates generalist and specialist palliative care services. The manual notes that many services specialise in providing palliative care services but are not full specialist palliative care services because the focus of their care is not on complex problems. The recent palliative care funding review (Hughes-Hallett et al 2011) differentiated the elements of dedicated palliative care as specialist palliative care services (delivered by specialist providers), core palliative care services (delivered by people whose primary focus is palliative care) and universal palliative care services delivered by generalists.