

Northland Palliative Care Strategic Action Plan

Adopted by the Board May 2007

Table of Contents

Executive Summary	1
1. Introduction.....	2
1.1 Aim of the Plan	2
1.2 How the Plan was developed.....	2
1.3 What is Palliative Care?	3
1.4 Why do we need a palliative care strategy?.....	4
1.5 Guiding principles	6
2. Population	8
2.1 Population size, ethnicity, and level of deprivation	8
2.2 Population projection	9
2.3 Cancer and chronic disease in Northland	11
3. Configuration of Palliative Care Services in Northland	12
3.1 Generalist Palliative Care Services	12
3.2 Specialist Palliative Care Services	13
4. Analysis of Strengths, Gaps and Issues	16
4.1 What Northland is doing well (Strengths).....	16
4.2 Gaps and issues	16
5. Implementing the plan	19
5.1 Working in partnership.....	19
5.2 Identifying Overall Priorities	19
5.3 Evaluation, monitoring and review	19
6. Vision and Goals.....	20
The Vision	20
The Goals	20
Goal 1. Develop a seamless and integrated palliative care service delivery model to optimise delivery of cost-effective and high-quality palliative care services.....	21
Goal 2. Ensure timely referral and access to essential palliative care services for all people.....	25
Goal 3. Engage and support primary health care providers.....	27
Goal 4. Ensure an aware and informed community.....	29
Goal 5. Deliver a quality service	30
Glossary.....	31
Appendix 1: Members of the Palliative Care Steering Group.....	34
Appendix 2: Stakeholder feedback August 2006	36
Appendix 3: The Reducing Inequalities Framework an Health Equity Assessment Tool (HEAT)	42

Executive Summary

The aim of the Northland Palliative Care Strategic Action Plan is to set the strategic priorities and actions for the five year period 2006-2011. These will guide us in the achievement of equitable access to quality palliative care services that are responsive to the needs of all patients, their family and whanau across Northland.

“Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual”¹.

Palliative care service provision involves a range of providers including hospices, hospitals, general practitioners and community health services.

This palliative care strategic action plan has been developed because:

- Palliative care is effective in improving the quality of life for people who are dying and is globally recognised as a legitimate component of health care;
- There is an increasing need for Palliative Care now and increasingly into the future;
- People have a right to active and progressive care at the time of dying and there is a need to ensure equity of access to palliative care throughout Northland.
- Palliative care needs to be better understood and accepted by the community and health professionals so that people have timely access to palliative care.

The Northland Palliative Care Strategic Action Plan aims to achieve the following vision, (which has been adapted from the vision contained in the NZ Palliative Care Strategy):

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

The following goals have been developed to address the gaps and issues identified during the planning process:

- Goal 1 Develop a seamless and integrated palliative care service delivery model to optimise delivery of cost-effective and high-quality palliative care services.
- Goal 2 Ensure the timely referral and access to essential palliative care services
- Goal 3 Engage and support primary health care providers
- Goal 4 Ensure an aware and informed community
- Goal 5 Deliver a quality service.

The structure of this plan is such that Goal One must be implemented first, as all other actions follow on from the establishment of a hospital palliative care team and the provision for specialist palliative care coordination in Northland's four regions.

¹. WHO 2002

1. Introduction

1.1 Aim of the Plan

The aim of the Northland Palliative Care Strategic Action Plan is to set the strategic priorities and actions for the five year period 2006-2011. These will guide us in the achievement of equitable access to quality palliative care services that are responsive to the needs of all patients, their family and whanau across Northland.

1.2 How the Plan was developed.

This plan is informed by the NZ Palliative Care Strategy (PCS) which has a focus on people having timely access to a range of services that are provided in a coordinated and culturally appropriate way.

The first step taken to develop the Northland Palliative Care Strategic Action Plan was to carry out a stock take of the existing contracted palliative care services throughout Northland, including identifying the characteristics of palliative care service users, service activities, and outputs. This helped to identify the issues that need to be resolved.

Following an analysis of the data, a Draft Stocktake report was prepared and circulated to the providers for comment. Based on these comments, the final Stocktake was prepared.

A review of palliative care strategies from within New Zealand and Australia was undertaken to identify best practice.

Four focus group meetings with palliative care stakeholders were held across Northland (Far North, mid North, Dargaville and Whangarei) in 2006. Attendees at the meetings included hospice service providers, the Northland Palliative Care Specialist, Northland DHB staff, general practitioners, consumers, and Maori health service representatives. Participants in each group completed a S.W.O.T analysis to identify the strengths, weaknesses, opportunities and threats facing palliative care services in each area. Attendees were also asked to identify the key priorities that needed to be addressed in the Palliative Care Strategic Action Plan.

From this information a draft Strategic Action Plan was completed and sent out to all of the stakeholders seeking further input. The draft Strategic Action Plan was revised, and a Palliative Care Steering Group was formed to represent the key stakeholders and to set the planning and funding priorities within the agreed goals and actions. The members of the Palliative Care Steering Group are listed in Appendix 1.

At the time of preparing the stocktake of palliative care services, the Northland DHB also carried out a stock-take and gap analysis of cancer control services (including palliative care), and prepared the Northland Cancer Control Strategic Action Plan. Care was taken to ensure that the two strategic action plans dovetail with each other.

1.3 What is Palliative Care?

The World Health Organisation redefined palliative care in 2002, and its new definition is now in widespread international use:

“World Health Organisation Definition of Palliative Care 2002

“Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual”². It can involve a range of providers including hospices, hospitals, general practitioners and community health services.

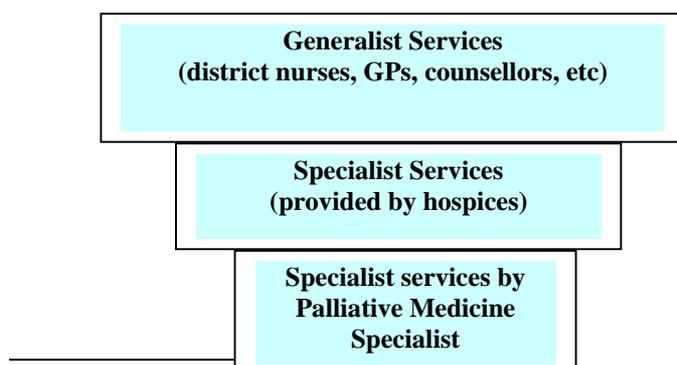
As a care concept, palliative care is considerably broader than hospice or hospital care, occurring in a range of settings with the emphasis increasingly being on community and home-based care; palliative care and hospice care are not synonymous terms. Likewise, terminal care is a part of palliative care, referring to the management of patients during the last phase of their life, which may be days or weeks, where it becomes clear that the patient is in a progressive state of decline. This is also called ‘end-of-life’ care.

The majority of palliative care is carried out by **generalists** within the primary health care sector, whose primary role is to provide generalist care, not specifically primary care. **‘Generalist Palliative Care’** incorporates the patient and family’s primary professional carers who provide palliative care as a vital and integral part of their routine clinical practice. (Tebbit, 2002).

Specialist palliative care services are those services that have a specific focus on palliative care – within Northland these services are provided via the four hospice services and the Northland Specialist in Palliative Medicine. Specialist palliative care is multi-disciplinary-medical, nursing and allied – and is provided across different care settings, with the emphasis increasingly being on community and home-based care.

Terminal care is a part of palliative care, referring to the management of patients during the last phase of their life, which may be days or weeks, where it becomes clear that the patient is in a progressive state of decline. This is also called **‘end-of-life’** care.

Figure 1: Relationship between palliative care service providers within Northland



². WHO 2002

1.4 Why do we need a palliative care strategy?

Palliative care is effective and globally recognised as a legitimate component of health care

This plan is informed by the NZ PCS (2001) which has a focus on people having timely access to a range of services that are provided in a coordinated and culturally appropriate way. It informs current palliative care service provision and future direction.

The PCS also indicates that palliative care should generally be available to people whose death from progressive disease is likely to be within 12 months. However this is not consistent with the World Health Organisation's definition of palliative care which recognises that some people live for many years with an illness or condition that is not curable and whose progressive disease and symptoms are best managed from a palliative care perspective. Early referral to palliative care services is desirable with input increasing progressively as a person's health deteriorates.

Palliative care crosses all boundaries of disease diagnosis, age, regions and culture and takes place in a variety of settings including patients' homes, hospices, rest homes, in hospitals, secondary community health, primary healthcare organisations, voluntary and community agencies.

People also have a right to active and progressive care at the time of dying.

Increasing need for Palliative Care

The PCS 2001 confirms that cancer is one of the main causes of death in New Zealand (140 deaths per 100,000 persons). Over 85% of people accessing palliative care have a cancer diagnosis, and cancers are more likely to have longer 'non-curative' phase than other palliative care conditions. Overall, cancer registration for the Northland region is slightly higher (1.05/100,000) than the national rate (1.00/100,000). The rate for Northland Maori compared to Maori nationally is higher in most categories, with lung cancer a particular concern. In addition, Northland has higher rates of mortality from cancer than national averages.

Northland has a population profile that is older than the national average. In 2001, 13.4% of Northland's population was over 65 years, compared to 12.1% for NZ as a whole. This population group provides a substantial proportion of those who access hospice services.

We are currently planning in an environment of population growth. Population projections are illustrated in section 2.1 of this document.

While hospice referrals are still predominantly cancer-related, over recent years there has been an increase in non-cancer referrals. With the increase in cardiovascular disease, renal disease and diabetes in Northland, these increases could have a significant impact on the number of people needing to access palliative care within the timeframe of this strategy.

This strategy provides a planned approach to meeting the changing and increasing need for palliative care services.

Implementing the strategy will enhance specialisation and expertise in palliative care. This will necessitate the review of specialist palliative care provider funding classifications.

Population based service planning

This seeks to:

- understand and plan for the health needs of a target population as a whole, defined on the basis of geography (eg Northland) or clinical need (such as terminal illness)
- implement and evaluate interventions to improve the health or wellbeing of that population

Importantly, population-based health strategies should account for all members of the targeted population, including those who may not choose to access those services or have no knowledge of them. Within any target population there will always be a small subset of people with the defined condition who require the most attention and who will consume the most resources. For palliative care there are 3 broad subgroups of dying people:

- the largest group, who do not require access to specialist care as their needs are entirely met through their own resources with the support of primary care services
- a larger group with intermittent complex requirements who require occasional input from specialist services, ‘dipping in and out’ of services provided by hospices or other specialist resources
- a small but variable group with complex symptoms and one or more of social, spiritual and psychological needs, who require specialist palliative care services.

Figure 2 depicts how different palliative patients may access generalist and specialist services during the course of their illness.

Figure 2 Possible ways a patient may access generalist and specialist palliative care services.³

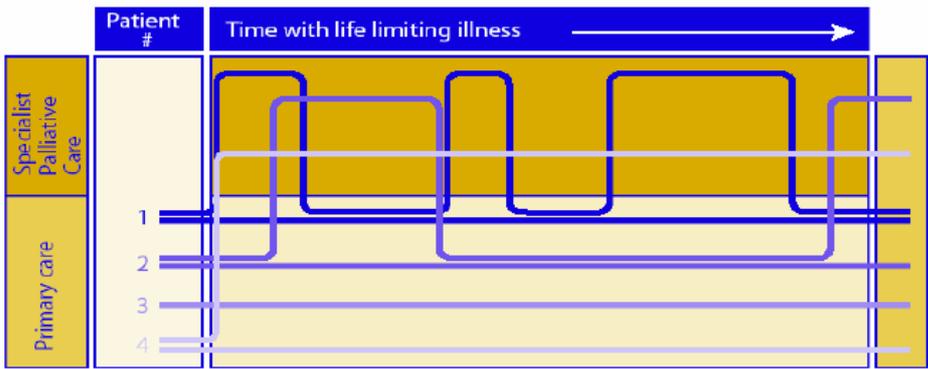


Figure 2 shows a needs-based model with formalised communication and referral links between generalist and specialist palliative care providers, while encouraging these providers to see themselves as part of a continuum of palliative care service delivery. This approach “is driven by the level and intensity of patient, primary carer and family needs as well as their strengths and limitations, rather than by organizational and service structure or objectives, or by traditional patterns of service delivery”. Significantly, this model emphasises the importance of primary care in the provision of quality palliative care, describing GPs as

³ “A Guide to Palliative Care Development: A population based approach”, Palliative Care Australia, Feb. 2005.

having “a central and critical cornerstone role” and as “full and effective partners” with specialist palliative care providers.

Recent literature emphasises the importance of mainstreaming palliative care in both acute and primary care, with a focus on structural arrangements that promote and support partnership. The impetus behind mainstreaming worldwide is to make palliative care accessible to a much wider range of patients, across a wide range of non malignant conditions and earlier in the disease trajectory.

1.5 Guiding principles

The guiding overarching principles for this plan are listed below. These principles are consistent with the approaches identified by the Northland District Health Board as being critical to the planning and delivery of its services:

- work within the framework of the Treaty of Waitangi to address issues for Maori;
- reduce health inequalities among different population groups;
- ensure timely and equitable access for all Northlanders to a comprehensive range of health and disability services, regardless of ability to pay;
- be of high quality;
- be sustainable;
- use an evidence-based approach;
- reflect a person-centred approach;
- actively involve consumers and communities;
- recognise and respect cultural diversity; and
- be undertaken within the context of a planned, coordinated and integrated approach.

Further discussion of some of the Northland DHB’s key approaches is provided below.

Treaty of Waitangi

The Treaty of Waitangi is considered the founding document of this nation and establishes the unique and special relationship between Maori and the Crown. Northland DHB participates in relationships with Maori that recognise and respect the Treaty of Waitangi principles of partnership, participation and active protection of Maori health interests, in order to improve health outcomes and reduce inequalities for Maori.

For Northland DHB, this means enabling Maori participation in funding, planning and decision making through active partnership with Maori at all levels of the health sector – in governance, operational management and workforce development, in supporting Maori health provider development, including Kaupapa Maori models of service delivery, and in acting to improve the health and wellbeing of Maori while safeguarding Maori cultural concepts and values.

Whanau Ora

To incorporate the four He Korowai Oranga (Maori Health Strategy) pathways⁴ into service planning and resource allocation decision-making, analysis of service proposals includes an assessment of their contribution to Whanau Ora. Therefore they must:

- reduce inequalities in health status for Maori
- increase Maori participation in the delivery and utilisation of health and disability support services
- improve the health status of Maori
- improve independence for Maori with disabilities
- improve opportunities for Maori to participate in wider society as well te ao Maori (the Maori world)
- consider Maori values (as well as value for money) and be culturally appropriate
- increase the level of Maori participation in service planning, implementation and delivery.

Reducing Inequalities

Reducing inequalities is one of the key strategic issues that permeate all NDHB's planning and funding processes and decisions. It is one of the main thrusts of our prioritisation policy to ensure that funding decisions are consistently driven by the need to reduce inequalities among population groups.

The most common inequalities relate to measures of health and health service usage by Maori. Pacific people also experience inequalities. Other inequalities that may be relevant to particular situations exist between rural and urban, deprived and wealthier populations, age groups, and male and female.

To ensure inequalities are being reduced NDHB uses the Health Equity Assessment Tool (HEAT) when deciding on how to allocate funding for new services. This incorporates within it the Reducing Inequalities Framework and the principles of the Treaty of Waitangi. A copy of the HEAT tool is contained in Appendix 3.

⁴ The 4 pathways are: development of whanau, hapu, iwi and Maori communities; Maori participation in the health and disability sector; effective health and disability services; and working across sectors.

2 Population

2.1 Population size, ethnicity, and level of deprivation

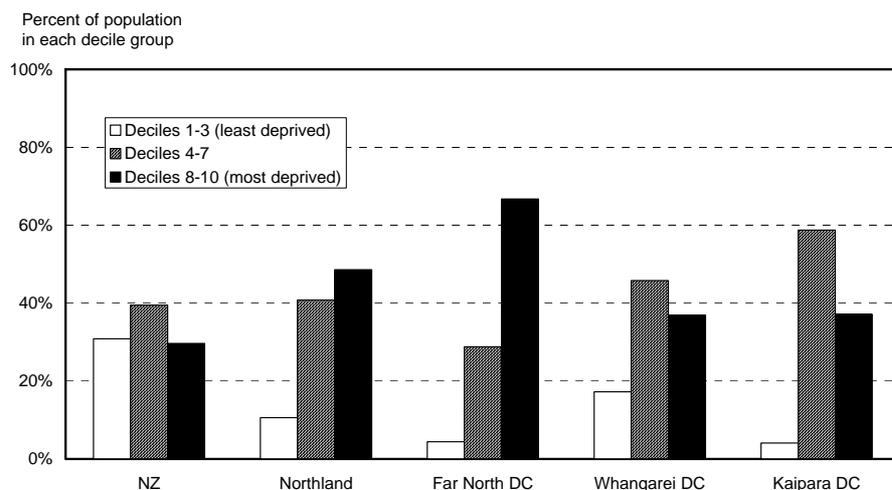
This section has been taken from the Northland DHB Strategic Plan 2005-2010⁵ and describes the wider environment in which Northland DHB and the health sector in general operates. Crucial issues for palliative care planning include:

- population size, age, ethnic makeup, growth;
- the population's geographical distribution, which affects access to services;
- health status; and
- health services configuration, which affects how needs can be best met.

Description	Data
<i>2006 Census (provisional)</i>	Total Northland population on 2006 Census night 152,200
<i>2001 Census</i>	Total Northland population 2001 Census.(usual resident population) 140,130
<i>Ethnic groups</i>	Maori a significant proportion, but Pacific and Asian small. Maori 30%, Pacific 2%, Asian less than 2%. PHO registered pop as at Sept 06: Maori 32%, PI 1%, Other 67%.
<i>Deprivation – total pop.</i>	Northland is one of the most deprived areas in the country. While 30% of New Zealand is in the lowest 3 (out of 10) deciles, 49% of Northlanders fall into this category.
<i>Deprivation – FNDC</i>	The Far North District Council is the most deprived area within Northland. 67% of the Far North DC population is in the lowest 3 deciles, compared with 37% of Whangarei DC and Kaipara DC's population.
<i>Deprivation – Maori</i>	Maori are the most deprived group within the population. 78% of Maori are in the lowest 3 deciles, compared with 47% of non-Maori.
<i>Life expectancy</i>	Northland lower than NZ. Northland 75.5, NZ 77.1. In Northland, Maori is lower than non-Maori. Females: Maori 70.3, non-Maori 84.1. Males: Maori 64.2, non-Maori 78.1

⁵ Northland DHB. 2005. *Strategic Plan 2005-2010*. pp29-38

Figure 3 Population distribution by deprivation decile, New Zealand, Northland and Northland District Councils 2001



Older Population

Northland has a population profile that is older than the national average. In 2001, 13.4% of Northland’s population was over 65 years, compared to 12.1% for NZ as a whole. This population group provides a substantial proportion of those who access hospice services.

The older (65+) population comprised 13.3% of Northland’s total population in 2001. It is projected to grow faster than the rest of the population, and the older the age group, the faster the growth (Figure 4).

2.2 Population projection

The population of Northland is estimated to be 148,000 in 2006. Northland’s projected population growth represents small numbers of people, with projections indicating growth of 5.5% by 2011 and 11% by 2026 (table 1).

For palliative care providers it is important to note that while the increase in the total population figure for Northland is projected to slow down out to 2026, the number of people aged over 65 is expected to increase dramatically. It will rise from 19,200 in 2001 to 41,000 by 2026 – a 114% increase compared to the 11% total population increase. By 2026 one-quarter of Northland’s population will be aged over 65, compared to the national average of 20%, i.e. the number of older people in Northland is projected to grow at a faster rate than the national average impacting on palliative care services.

Table 1 Northland total population projections 2006 and 2011, 2001 base

Age group	Population number			% of total population		
	2001*	2006	2011	2001*	2006	2011
65-74	11,150	12,600	14,740	7.7	8.5	9.7
75-79	3,830	4,440	4,660	2.7	3.0	3.1
80-84	2,340	2,890	3,440	1.6	1.9	2.3
85+	1,790	2,120	2,740	1.2	1.4	1.8

Figure 4 Projected total population growth by age, Northland 2006-16 (2001 base)



When the older population is analysed in more detail, it is found that in general the older the age group, the faster the rate of population increase. For example, between 2001 and 2011 the 65-74 and 75-79 age groups are projected to increase by no more than a quarter, while both the 80-84 and 85+ age groups are expected to increase by at least a third. Although the percentages in the table below may appear small, the two oldest age groups in particular consume a disproportionate amount of health resources.

2.3 Cancer and chronic disease in Northland

The characteristics of Northland’s population (in particular, the higher proportion of Maori, of older people, and a higher level of socioeconomic deprivation than the national average) have contributed to a disproportionately high disease burden. . The projected growth in these population groups means that we must plan for these disparities continuing in the future.

Cancer and cardiovascular disease together cause about two-thirds of all deaths in Northland. The proportion of deaths due to cancer over the last few years has been steady at about 32%, as shown in Table 2 below.

Overall, cancer registration for the Northland region is slightly higher (1.05/100,000) than the national rate (1.00/100000). The rate for Northland Maori compared to Maori nationally is higher in most categories, with lung cancer a particular concern. In addition, Northland has higher rates of mortality from cancer than national averages.

While hospice referrals are still predominantly cancer-related, over recent years there has been an increase in non-cancer referrals. With the increase in cardiovascular disease, renal disease and diabetes in Northland, these increases could have a significant impact on the number of people needing to access palliative care within the timeframe of this strategy.

Table 2 Causes of death in Northland, 2000 and 2003

Category	2000	2003
Number of deaths:		
Cancer	349	401
Circulatory diseases	433	445
Other causes	326	414
All deaths	1108	1260
Percentage of deaths:		
Cancer	31.4	31.8
Circulatory diseases	39.1	35.3
Other causes	29.4	32.9
All deaths	100.0	100.0

3 Configuration of Palliative Care Services in Northland

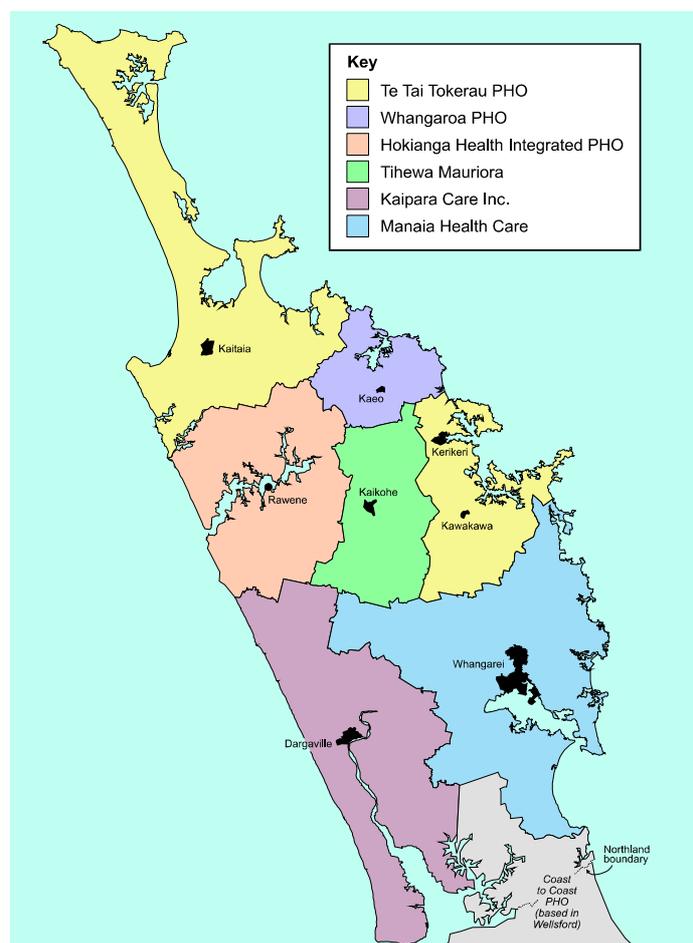
3.1 Generalist Palliative Care Services

In addition to these specialist service agreements, generalist palliative care occurs in a range of other settings including: Northland's regional hospitals, Northland DHB inpatient and outpatient services, Northland DHB Community District Nursing Service, other NGO services including Aged Residential Care Services, Iwi/Maori providers and through General Practitioner (GP) services.

A gap identified during the planning process is the lack of a hospital based palliative care team at the Northland DHB hospitals. Hospital based teams would act to enhance the capability and capacity of the various hospital based generalist services to be responsive to patients' palliative care needs and to facilitate timely access to palliative care services.

There are six Primary Health Organisations (PHOs) within Northland. The number of people enrolled with PHOs is about equal to the current estimated Northland population, and geographically they cover all of Northland, apart from part of the eastern Kaipara which is covered by a PHO based in Rodney District (Figure 5). The Te Tai Tokerau, Hokianga, Whangaroa, and Tihewa PHOs are all located within the Far North territorial local authority, and together the total Far North-based PHOs have 40% of the total registered PHO population.

Figure 5. Geographic coverage by and current enrolment in Primary Health Organisations in Northland, September 2006



PHO	Pop Sept 06	% of region
Te Tai Tokerau	42,593	28%
Hokianga	6,428	4%
Whangaroa	3,197	2%
Tihewa	8,641	6%
Kaipara Care	11,395	8%
Manaia	78,215	52%
All 6 PHOs	148,532	

3.2 Specialist Palliative Care Services

3.2.1 Services Contracted by Northland DHB

Northland DHB has five service agreements in the NGO sector for the provision of specialist palliative care (listed below). These are made up of separate agreements with four hospice providers and one agreement for a Specialist in Palliative Medicine:

- North Haven Hospice, the largest service, based in Whangarei
- Kaipara Palliative Care, based in Dargaville
- Hospice Bay of Islands, based in Kerikeri and servicing the mid-north
- Far North Palliative and Cancer Care, based in Kaitiaki
- Specialist in Palliative Medicine, provided by a Medical Specialist based at North Haven Hospice.

Northland hospice services operate within the historical funding model and classifications that were allocated in 2000 and utilised in 2005 in a joint funding paper prepared for the Minister of Health. This paper was jointly prepared by Hospice New Zealand (HNZ), Ministry of

Health and DHBNZ, to investigate the funding of hospices by DHBs, as a result of concerns raised by HNZ with the Minister.

The hospice classifications are:

Type one: Hospices with designated inpatient units. Care is primarily in the patients' homes or other residential facility. Some patients may be admitted to an inpatient unit for symptom control or respite care. In Northland, North Haven is a type one service.

Type two: Community based hospices. Care is primarily provided in the patients' homes or other residential facility. While these hospices do not have their own inpatient facilities, they may subcontract inpatient care from other facilities.

Hospice Bay of Islands has invested in the capital outlay for a facility operating two inpatient beds. The hospice staff provide the specialist palliative care for patients admitted to these beds and other clinical and "hotel" services are subcontracted from Kerikeri Village Trust.

Far North Palliative and Cancer Care is also classified as a type two hospice and provides domiciliary care within the community. They also provide equipment and volunteer support to a bed (Shirley Crawford Haven) held within and staffed by NDHB within Kaitaia Hospital. The hospice staff provide the specialist palliative care advice for patients admitted into the Haven.

Type three: Voluntary or support services. These are primarily community based support services providing a volunteer based service. Hospices in this category do not employ clinical staff and therefore do not offer clinical services directly. Services provided are generally equipment loan and practical assistance to patients and their families.

Kaipara Palliative Care is classified as a level three service, but is not contracted to provide clinical care. The service employs both RNs and ENs as casual staff with no fixed hours, to provide respite/home based care. The Palliative Care Coordinator is a Registered Nurse, and with the Specialist in Palliative Medicine carries out clinical assessments. What needs to be explored is the scope of contract coverage and provision of clinical specialty.

Table 3 Service specifications for palliative care and their application to Northland hospice and other services

Purchase unit code and description	Code and description of services	North Haven	BOI	Far North	Kaipara
PC1 Assessment and coordination	PC1.1 Initial assessment for entry	✓	✓	✓	✓
	PC1.2 Ongoing assessment	✓	✓/NDHB	✓	✓/NDHB
	PC1.3 Care coordination	✓	✓	✓	✓
	PC1.4 Advisory and information	✓	✓	✓	✓
PC2 Clinical care	PC2.1 Domiciliary care	✓	✓/NDHB	✓	NDHB
	PC2.2 Inpatient care	✓	NGO	NDHB	NDHB
	PC2.3 Night carer relief	✓ (not RNs)	✓	✓ (not RNs)	✓
	PC2.4 Bereavement counselling and support	✓	✓	✓	✓

3.2.2 Capacity to meet Future Demand

The Stocktake of Palliative Care Services considered Northland’s specialist palliative care services’ capacity to provide future inpatient services. Table 4 on the following page shows that based on Northland’s projected population by Territorial Authorities, there is both current and future inpatient bed capacity.

Table 4 Number of available inpatient beds against 2006 District Council populations and population projections

		North Haven	BOI / Far North	Kaipara
Bed state 2006		5 (capacity 6)	BOI 2 (capacity 4) Far North 1	1 (access to 2)
2006	Proj. pop.	72,800	57,900	18,100
	Beds required ⁶	4	3	1
2011	Proj. pop.	75,100	59,600	18,100
	Beds required	4	3	1
2026	Proj. pop.	79,700	62,600	17,400
	Beds required	4	3	1

At 5.1/100,000 total population (see footnote below for explanation).

⁶ The average number of palliative care beds in Britain in the mid 90s was 5.1 per 100,000 persons (Eve A, Smith AM, Tebbit P. (1997), and this figure is widely referred to in the literature on palliative care. Australian benchmarking is higher, at 6.7 beds per 100,000persons. These ratios are however contingent on support from a well-managed community focus on delivery of palliative care services.

4. Analysis of Strengths, Gaps and Issues

4.1 What Northland is doing well (Strengths)

There are many services within Northland that are working well and should be acknowledged and celebrated. The following list of strengths is drawn from the strategic planning workshops:

- hospice services in Northland, particularly the Specialist in Palliative Care received very high feedback from all consumers and providers spoken to
- volunteers and community support
- the positive influence of the Specialist in Palliative Medicine
- established provider relationships and sharing of resources
- dedicated staff and staff retention
- strong community ownership and support of specialist palliative care services.

4.2 Gaps and issues

From the stock-take and consultation process, the gaps and issues that were identified could be classified into one or more of the following categories:

An actual gap in service

- Lack of a designated NDHB hospital or hospital liaison service. Hospital palliative care teams have an important role in ensuring that a palliative care option is available for dying people, as well as providing advice and support to hospital staff on the care of dying patients. This can involve support for decision making and symptom management during the diagnostic and/or treatment phases, or during the terminal stage of illness.
- Access to short term home help services is limited.

Gaps in the level of services available, including timeliness, which affect access to the service

- There is a need to continue to promote a highly effective relationship between specialist palliative care services and primary health care. Patient and whanau primary health contacts and relationships with their general practitioners should remain central to the delivery of palliative care, irrespective of the settings in which this occur. This is limited by knowledge gaps, accessibility, the location of patients and whether the primary providers' have an integrative health care philosophy.
- A partnership and education framework for general practice is lacking. This should encompass three main components, (taken from Arohanui Hospice's partnership plan):
 - 1 A participation framework which discusses:
 - various provider's roles and responsibilities

- how patients will move through the partnership of care (patient pathway-point of entry, referral, initial and ongoing assessment, care plan and joint decision points, admission criteria, after hours care, clinical review).
- 2 An education programme for primary health providers:
 - training workshops
 - writing and disseminating a palliative care resource folder/guidelines.
 - 3 Partnership administration:
 - provide a business / patient information framework and funding.
 - For this partnership to work to its maximum potential it is important to remove barriers to accessing general practice care such as financial concerns. The partnership of care concept therefore includes funding to reduce the financial commitment that patients have to make.
- There is an information technology gap due to lack of resources and an integrated patient information system.
 - The appropriate level of service for each stage of the palliative care services continuum is impossible to determine, because benchmarking or standards for this do not exist.

A gap in access to service occurs due to the emphasis on, and historical delivery of, specialist services

- A partnership of care is not in place and should be between:
 - ‘Specialist Palliative Care’, an essential service of quality, evidenced based, specialist care provided by a qualified interdisciplinary team (Ministry of Health, 2001), and
 - ‘Generalist Palliative Care’, the patient and family’s primary professional carers who provide palliative care as a vital and integral part of their routine clinical practice (Tebbit, 2002)

Receiving a good quality and client centred service

Many of the concerns, or barriers raised by key stakeholders related to the ‘quality’ of the service provision. Examples listed included services needing to be culturally appropriate; patients, family and whanau receiving full information that is easy to understand; limited definitions of palliative care and the need to market early intervention and service access; risk of continuing to deliver fragmented services and variable involvement of GPs.

Information sharing

With the change in the culture of the palliative care industry in New Zealand comes the need for information sharing, which is currently not integrated. There has been a shift from a cottage industry and largely volunteer organisations, to the development of professionally based services. The doctrine of palliative care is being integrated within acute hospital services, long term residential care and primary health organisations. There is also an

ongoing commitment to care for patients and their families at home and in environments of their choice, across Northland's large geographical area.

These changes are having an impact on information sharing. Given the strategic intent to build multidimensional 'teams', patient information needs to be available to as many of this team as is possible within defined timeframes. Quick and accurate exchange of information is also required during periods in the illness trajectory when patients' conditions are changing rapidly.

The availability of complete patient data is extremely important to the effective relationship between primary/generalist and specialist services, and it enhances seamless care between providers. Availability of data makes a distinct difference to the quality of advice and information available to the team.

A web based patient information system that integrates acute and community care information into a single view of the patient is being developed in Northland for hospice and wider use. It enables the sharing of information across providers, and the promotion of service integration. Also, it will not be dependent on individuals, so will support sustainable and consistent service provision. Being a web based system there are no capital costs required to join the system apart from those needed to ensure an appropriate internet connection.

Research and best practice

Professionalism requires services to be aligned to best practice, international and national standards. There is growing international literature but little produced in New Zealand. Systems therefore have to be put in place so that clinical data can be collected, extracted and compared in a manner not detracting from essential clinical activity.

5. Implementing the plan

5.1 Working in partnership

Health status and outcomes is affected or determined by many social and economic influences outside the direct control of health service providers. Working with other agencies enables the health sector to better address needs that affect and underlie health status. It can also be a way of reaching the most deprived populations, particularly as they form the client base for agencies such as MSD and Housing NZ.

The potential improvements documented in the Palliative Care Strategic Action Plan summarise the findings from the regional key stakeholder focus groups. The issues and potential improvements relate to four key system changes:

- enhancing the level of acceptance and understanding of palliative care as active health care by patients, their families and whanau, and the community
- ensuring the adequacy of information exchange about patient care
- supporting the inclusion, capability and capacity of general practitioners and secondary health services to participate in the palliative care of patients
- supporting the capability and capacity of acute services to recognise and refer patients to Specialist Palliative Care Services.

5.2 Identifying Overall Priorities

Priorities have been identified following a prioritisation process. The structure of this strategy is such that goal one must be implemented first, as all other actions follow on from the establishment of a hospital palliative care team and the provision for specialist palliative care coordination in Northland's four regions.

5.3 Evaluation, monitoring and review

Information is vital to identify needs, determine patterns across population groups and trends over time, monitor needs over time and assess how well health services are meeting them. Information is essential to reducing inequalities. Health services cannot meet all needs so we must focus on the highest priorities first. Without accurate and complete information we cannot prioritise, target intervention and monitor outcomes. Without such information we cannot set appropriate quality assurance measures.

We also need to develop a comprehensive and planned approach to the collection and analysis of the information collected that is tied to the measuring the goals of this strategic plan.

Information flow between health and disability service providers is frequently mentioned as a source of frustration because inadequate information handicaps the ability of providers to provide quality care.

6. Vision and Goals

The Vision

The Northland Palliative Care Strategic Action Plan aims to achieve the following vision, which has been adapted from the vision contained in the NZ Palliative Care Strategy.

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

The Goals

The following goals have been developed to address the gaps and issues identified during the planning process:

- Goal 1 Develop a seamless and integrated palliative care service delivery model to optimise delivery of cost-effective and high-quality palliative care services.
- Goal 2 Ensure the timely referral and access to essential palliative care services.
- Goal 3 Engage and support primary health care providers.
- Goal 4 Ensure an aware and informed community.
- Goal 5 Deliver a quality service.

Specific service gaps and issues that were identified in the feedback from stakeholders have been grouped and listed under the relevant palliative care goal in this section. This is followed by a list of actions to be taken to address the issues during the first three years of implementation of this strategy.

As noted above, the structure of this plan is such that Goal One must be implemented first, as all other actions follow on from the establishment of a hospital palliative care team and the provision for specialist palliative care coordination in Northland's four regions.

Goal 1. Develop a seamless and integrated palliative care service delivery model to optimise delivery of cost-effective and high-quality palliative care services.

Goal one is the critical goal for the achievement of improvements in palliative care in Northland. The actions listed should be implemented first. The actions in the subsequent goals follow on from the achievement of goal one.

Issues and priorities that this goal seeks to address:

- Four models of specialist palliative care service delivery are operating in Northland with no clear framework for promoting generalist provision.
- The challenge of supporting and sustaining the delivery of quality paediatric palliative care across Northland.
- No formalised palliative care consultancy capacity or integrated palliative care practice between NDHB's acute services and community including aged related care services.
- Variable referral and discharge planning.
- No documented clinical pathways or local best practice guidelines for those (adults, young persons or children) who are dying. Practical guidelines for end of life care are more likely to be in place for those with cancer rather than a non cancer progressive illness. This relates particularly to those who are younger.
- Information technology gap due to lack of resources, with insufficient capacity to develop an integrated patient information system.
- The availability of patient data is extremely important to the effective relationship between primary/generalist and specialist services. Complete and timely patient data that is not dependent on individuals would make a distinct difference to the quality of advice and information available to palliative care teams, and support sustainable and consistent service provision.
- The Aged Residential Care sector provides a number of beds for older people with palliative care needs. The structure of age related care services and funding creates an imbalance in access to the full range of palliative care services and inconsistent support.
- Reduced access to quality end of life care for people over 65 years. The daily bed day rate does not always cover high cost treatments, specialist supplies, specialist equipment, increased number of medical visits or increased need to access local or regional specialist services.
- Correctional facilities present unique challenges for palliative care, especially with no direct 24/7 registered nurse cover at Northland's Regional Corrections Facility, and systemic difficulties getting approval for alternative care solutions.
- Barriers to accessing the full range of palliative care services need to be identified.

What we are going to do

Actions	Agencies involved	Measures/milestones	Resources required
1.1 Create a hospital based palliative care team to provide improved access to palliative care services at the time of diagnosis and treatment.	NDHB Provider Contracted hospice providers NGOs	Whangarei Hospital palliative care team in place, with allocated FTEs for Palliative Care Physician, Clinical Nurse Specialist, and access to allied health and Maori health services. The hospital palliative care team has formal links to secondary services clinical governance processes.	New with links to NDHB cancer Control Strategy.
1.2 Establish specialist care coordination roles/ palliative care liaison team for all regional hospitals.	As above	Specialist care coordination roles defined and established in Kaitaia, Bay of Islands and Dargaville.	As above
1.3 Establish specialist palliative Care Coordination positions with FTEs either from within or sub contracted from existing specialist palliative care services. (also refer 1.2)	As above	Capacity and capability established in Northland's four regions, and responsive to Maori. FTEs match projected population, service utilisation and configuration data. Links established between primary and secondary care; specialist and generalist care; quality research and education.	New/extended.
1.4 Establish systems for early referral, between treatment services, community support services and palliative care.	As above	Referral procedures and response times for the service established.	Also refer 1.1

What we are going to do (continued)

Actions	Agencies involved	Measures/milestones	Resources required
1.5 Develop and promote standardised clinical pathways for patients for whom palliative care or a palliative approach would be appropriate.	As above	<p>Clinical pathways and regional palliative care protocols, with performance indicators, are established for all age groups.</p> <p>Standardised palliative care referral form implemented, discharge summaries and client reports in use.</p> <p>Patient management information is integrated and accessible.</p> <p>All patients have patient-held care plans.</p> <p>Education and promotion strategy implemented.</p>	Also refer 1.3
1.6 Integrate community based services with acute services' professional development and training initiatives.	As above	<p>Provision of formal and informal training including joint professional development and training in place.</p> <p>Palliative Care nursing forum established.</p> <p>Integrated CNE/CME framework and timetable in place.</p> <p>Increase in specialist palliative care skills, reduced 'palliative care' terminology barrier.</p>	New/existing
1.7. Research and develop integrated patient information systems.	As above	Integration of a web based patient information and reporting system into general practice, hospice and secondary services.	Existing
1.8 Quality end of life care services are accessible wherever people are dying e.g general practice services, smaller regional hospitals, PCOs, Age Related Residential Care Services and the Regional Corrections Facility.	NDHB MAPOs NGOs PHOs	<p>End of Life Care is documented using the Liverpool Care Path Way⁷.</p> <p>The incremental development or adaptation of 'end of life care contracts' for age related residential care services, recognising cost.</p>	New: SIA funding PHO development funding and Specialist Palliative Care and Aged Residential Care Service Agreements.

⁷ www.lcp-mariecurie.org.nz

What we are going to do (continued)

Actions	Agencies involved	Measures/milestones	Resources required
1.9 Reduce barriers for people with terminal illness accessing palliative treatment in Auckland.	As above	Scoping report on transport and accommodation solutions for people with terminal illness receiving services in Auckland.	Increased/ new (considered in context with NTA eligibility). Phase 1 Cancer Control Strategy

Goal 2. Ensure timely referral and access to essential palliative care services for all people.

Issues and priorities that this goal seeks to address:

- The need to continue to extend to and engage with patients who have non-cancer life-limiting diseases.
- Increased life limiting disease processes in younger people.
- The people of Northland experience variable service delivery, with Maori in some areas not accessing palliative care services at the same level as non Maori.
- Reducing barriers to early referral such as family/patient reluctance or denial of prognosis, and general lack of knowledge and understanding of palliative care among health professionals and the community.
- Northland has high deprivation and low socio-economic status which affects peoples’ ability to access primary /non specialist services.
- Limited access to funded support services.
- Training for palliative care specialty has a lag time of 3-5 years. There is a high level of training uptake within contracted specialist services and a low level of training within primary health and age related care services.
- Developing culturally appropriate eservices.

What we are going to do

Actions	Agencies involved	Measures/milestones	Resources required
2.1 Promote palliative care to relevant acute care clinicians/nurses, general practice and community practitioners as a benefit to clinical practice and to patient care and wellbeing.	NDHB acute and community /Maori services General Practices Community support agency fieldworkers NGOs	Palliative care education strategy and resources developed and implemented through designated professional education network or appointed nurse specialists for Northland.	Also refer 1.6 Existing/ new
2.2 Increase access to palliative care for all Northlanders and deliver services in a culturally appropriate manner.	NDHB MAPOs NGOs	Increased utilisation of palliative care services by those with a progressive non-cancer illness.	New

What we are going to do (continued)

Actions	Agencies involved	Measures/milestones	Resources required
2.3 Carry out research to identify barriers for Maori to access palliative care services and methods for improving access.	As above	Completion of research (linked to Cancer Control Strategic Action Plan). Implement recommendations. Increased utilisation of palliative care services by Maori.	New
2.4 Remove 6 month prognosis as a criterion for admission to palliative care, promoting earlier access to palliative care services.	NDHB MAPOs	Common eligibility established and consistent with national palliative care service specifications, eligibility framework and funding.	Service enhancement based on national review. A national review of the palliative care service specifications is currently occurring with sector and DHB representation.
2.5 Ensure each person who is dying and their primary carers have access to support care, based on needs assessment and service coordination.	NDHB MAPOs NGOs	Access to long term support needs.	National eligibility and funding decisions for providing long term support needs to those with chronic / complex care needs (pending).

Goal 3. Engage and support primary health care providers.

Issues and priorities that this goal seeks to address:

- Financial barriers for palliative care patients needing to access GP services, particularly after hours.
- There is limited General Practitioner support after hours, and reduction of GP service.
- Loss of GP support and engagement in palliative care (as a general principle, and with specific tensions in some areas).
- Each New Zealand GP only sees about 5 terminally ill patients each year, with a predominance of those with a cancer diagnosis.
- Risk of fragmented service provision, information and confusion for patients and their carers.
- The different working / treatment cultures between GPs and palliative care teams need to be acknowledged and managed.
- The cultural context of dying and available treatment choices needs to be addressed to ensure timely access to appropriate palliative care support.
- Poor or limited discharge information.
- Risk of GPs and other primary health care providers being left 'out of the loop'.
- The need to increase palliative care awareness and collaboration.

What we are going to do

Actions	Agencies involved	Measures/milestones	Resources required
3.1 Develop a general practice partnership framework including:		General practice partnership framework completed.	
(a) Support for GP attachments or sessional attachments to community palliative care services promoting lead GPs;	GP practices. Specialist palliative care providers.	Attachments in place.	Service enhancement through CME/ new.
(b) Promote clinical outreach with GPs and general practice teams through specialist palliative care coordination position(s) and regional Specialist in Palliative Medicine.	As above.	Specialist palliative care coordinators in position, advancing collaborative care. (Refer 1.3).	New
3.2 Reduce financial and service barriers for patient access to relevant GP services.	NDHB MAPOs PHOs	Increased access. GP availability.	SIA funding.
3.3 Develop GP roles and responsibilities, scope of practice, patient pathway and after hours care.	PHOs GPs Palliative Care Specialists	GP engagement, pathways and after hours care in place.	Existing

Goal 4. Ensure an aware and informed community

Issues and priorities that this goal seeks to address

- The need for a common understanding of palliative care and marketing its benefits to patients, family and whanau, and communities.
- The cultural context of dying and available treatment choices needs to be addressed to ensure timely access to appropriate palliative care support.
- Continued support of volunteer involvement.
- Maintaining effective intersectoral relationships, facilitating access to community support services and personal funding support.

What we are going to do

Actions	Agencies involved	Measures/milestones	Resources required
4.1 Develop and implement a community awareness strategy to inform the public about palliative care services.	NDHB MAPOs Palliative care providers	Key messages developed and promoted. Positive community / promotional reports. Additions made to NDHB website.	Existing

Goal 5. Deliver a quality service

Issues and priorities that this goal seeks to address (as identified in goals 1 to 4)

- Promoting an evidence based approach.
- Developing best practice guidelines for both cancer and non cancer patients.
- Developing performance indicators.
- Developing data quality, particularly regarding case and age definition, as it affects NDHB's current capability to plan across services.
- Monitoring provider contract performance, informing NDHB service agreements.
- Regional and national benchmarking using integrated service utilisation data.

What we are going to do

Actions	Agencies involved	Measures/milestones	Resources required
5.1 Develop data systems to integrate patient and service utilisation data.	NDHB MAPOs Contracted providers National professional body	Standardised patient information systems. Reporting from shared patient information system Improved data to inform funding decisions National, regional and local benchmarking	New (Cancer Control phase 1 funding).
5.2 Continue to develop service agreements, and service specifications to ensure palliative care services are responsive to local needs, and there is consistency and sustainability in the range and quality of services across Northland.	NDHB NGOs PHOs	Service specifications in contracts. Data definition. Funding methodology considers trends in service volumes for core contracted services. Funding equity achieved for Northland and service classifications reviewed	Increased/ new

Glossary

Terms *in italics* have their own entry.

Term	Explanation
acute	Used to describe an illness or injury, either mild or severe, which lasts for a short time. (See also <i>chronic</i> .)
benchmarking	The process of comparing one organisation's service data with another. For DHBs this is typically with national data or other DHBs.
cancer registration	A system run by the Ministry of Health which contains a record of every cancer diagnosed in NZ. Once laboratories have diagnosed a cancer they must, under a special act, report it to MoH.
cardiovascular disease (CVD)	Related to the heart (cardio) and circulatory (vascular) system. The term includes both <i>coronary heart disease</i> and <i>stroke</i> .
decile	See <i>deprivation</i> .
deprivation, deprived	Describing those with high, often multiple, needs (often used loosely to mean 'poor', though income is only one of the factors considered). The most widely quoted source of data on deprivation is the NZ Deprivation (NZDep) scale which analyses 5-yearly Census data to describe deprived populations. Once 'deprivation index' scores are calculated across the whole of New Zealand, the data is divided into deciles, 10 population groups of equal number. (These deciles are calculated differently, and use a different scale to the school deciles used by the education system.)
FTE	Full-time equivalent
HEAT	Health Equity Assessment Tool. A series of questions designed by the Ministry of Health that enable a service or plan to be assessed for its effectiveness in <i>reducing inequalities</i> .
He Korowai Oranga (HKO)	The national Maori health strategy published by the Ministry of Health (see also <i>Whakatataka</i>).
hospice	A facility that provides a programme of specialist palliative and supportive services to dying persons and their families / whanau, in the form of physical, psychological, social and spiritual care.
Hospitalisation	The process of attending hospital as a patient. It includes 3 main types: inpatient, a patient who stays at least one night in hospital outpatient, a person who is seen in a non-inpatient setting, or 'clinic', by a specialist after referral from a GP daypatient, a patient who undergoes an operation or other procedure in hospital and able to return home without staying overnight. The term 'hospitalisation' is often used loosely to mean one or any combination of the 3 types.
inequality	See <i>reducing inequalities</i> .
inpatient	See <i>hospitalisation</i> .
intersectoral	Used to describe relationships between health and other sectors, often other government organisations, <i>TAs</i> .
mainstreaming	A term used internationally within palliative care circles to describe the provision of services by providers who are not specialists in palliative care. This includes

Term	Explanation
	general practitioners, hospitals and community services.
MoH	Ministry of Health.
NDHB	Northland District Health Board, which has 2 parts, <i>NDHB Funder</i> and <i>NDHB Provider</i> . The NDHB Funder is that part of NDHB that has been legislated to carry out the funding function for health services in Northland. The funder assesses needs, sets priorities for services, allocates funds, lets contracts to providers, and monitors performance. The NDHB Provider is that part of NDHB that provides health services (as distinct from the <i>NDHB Funder</i>). The majority of the Provider Service's funding goes on <i>Secondary care services</i> . In the strategy documents, 'NDHB' refers to the whole organisation with involvement as relevant in each case from the funder or from the provider arm.
NGO	Non-government organisation, any organisation which is not part of the public sector. In the health sector it usually refers to health service providers, though it applies more widely than that. It encompasses the private and voluntary sectors, therefore including many organisations which are funded wholly or partly from the public purse but are not part of a formal government structure. Major NGOs include hospices, PHOs and Maori providers and aged residential care services.
outcome	The result of an action. As distinct from an output, which is a measure of an activity rather than the result it has. An operation to mend a broken leg is an output, while the return to full function of the leg is the outcome. In a bigger picture sense, a focus on outcomes aims to analyse how effectively health services are provided and how well they work together.
outpatient	See <i>hospitalisation</i> .
palliative care	According to WHO, an approach that improves the quality of life of patients and their families facing the problems of a life-threatening illness. It aims to prevent and relieve suffering by means of early identification and assessment and treatment of pain and other problems physical, psychosocial and spiritual. It can involve a range of providers including hospices, hospitals, general practitioners and community health services.
PCC	Palliative Care Coordinator, a new position proposed in the Palliative Care Strategic Action Plan to work with subregional community palliative care services.
PCO	Primary Care Organisation.
PCS	Palliative Care Strategy for New Zealand 2001.
primary health care	Health services provided in the community which people can access themselves. The most well known are those provided by general practitioners, though they also include pharmacy services, private physiotherapists and, increasingly, nurse practitioners. (See also <i>secondary services</i> , <i>tertiary services</i>).
Primary Health Organisation (PHO)	A group of providers of <i>primary health care</i> services whose responsibility is to look after the people who enrol with them (those who are 'on the register'). PHOs include GPs as well as a whole range of primary health care providers and practitioners (Maori and community health service providers, nurses, pharmacists, dietitians, community workers, and many others). As well as providing traditional primary health care services, PHOs must improve access to services for those with higher needs (such as Maori or those with chronic health conditions), have a focus on preventing ill health (rather than waiting till they are visited by sick people) and improve the way services work together.
progressive disease	An incurable disease whose symptoms become gradually more severe over time, often resulting in disability and eventual death. Treatment is limited to lessening

Term	Explanation
	the effects of the disease and its symptoms. See also <i>terminal</i> .
reducing inequalities	Inequalities in the health status of populations exist by <i>socioeconomic status</i> , <i>ethnicity</i> , gender, age and geographical areas. The reducing inequalities approach is about recognising these and proactively planning, funding and delivering services to reduce these differentials.
registration	See <i>cancer registration</i> .
secondary services, secondary care	Hospital services which people can access only through a referral from a primary health care worker. (See also <i>primary health care</i> , <i>tertiary services</i>).
socioeconomic status (SES)	Social position along a scale (which runs, in everyday terms, from 'rich to 'poor'), as measured by criteria such as income level, occupational class or educational attainment.
specialist	A physician or surgeon, usually based in a hospital, who has undertaken extra training on top of the normal medical degree to specialise in a particular type of service or disease. Also called a consultant.
target population	A group of people within a larger population which has been identified for special attention, usually because they have higher needs. Target populations are most commonly defined by ethnicity, age, gender or geography, or any combination thereof.
terminal	Describing a condition which results inevitably in death. Also used to describe the final stages of such a condition. See also <i>progressive disease</i> .
Whanau Ora	A Ministry of Health-driven process aimed at supporting healthy Maori families which emanates from He Korowai Oranga. It aims to identify and extend whanau strengths and build them into initiatives throughout the health sector.

Appendix 1

Members of the Palliative Care Steering Group

The Palliative Care Steering Group

Far North Palliative and Cancer Care.

Hospice Bay of Islands.

North Haven Hospice.

Specialist in Palliative Medicine.

Kaipara Palliative Care.

PHO Representative

Manaia Health PHO.

Aged Care sector representative.

Ngati Hine Health Trust Iwi liaison.

Te Tai Tokerau MAPO.

General Manager Chronic and Complex Care, Northland DHB.

Portfolio Manager, Health of Older Persons, Palliative Care, Disability Services, Northland DHB.

Population Health Strategist, Northland DHB.

Appendix 2

Stakeholder feedback August 2006

Whangarei	Far North	Bay of Islands	Kaipara
Weaknesses			
Financial support for GPs. (6)	Referrals being made in Whangarei for short term home help, assessment process occur through telephone (eligibility criteria). (7)	Access to new drugs – availability and cost. (7)	Restriction of home support staff – personal care, short-term/long-term from DSS. (9)
Little after-hours GP support in greater Whangarei District. (6)	Nurses using/ maintaining own vehicles – remoteness geographic area and long travel times as well as cost of fuel. (6)	No incentives to work in rural areas. (4)	Inpatient care: the importance of earlier intervention. (5) <i>[In both weaknesses (3) and opportunities (2).]</i>
Current funding model. (5)	Information technology: gap due to lack of resources, lack of compatible systems and the needs to have an IT platform. (4)	Non-existent hospital liaison team: no hospital liaison team from NDHB to palliative care providers compared to other hospitals in Auckland. There are currently no specific palliative care team at the hospital. (4)	Not enough involvement of Maori and fewer Maori volunteers (4 out of 66). Thus enough or the right services for Maori population? (3) <i>[In both weaknesses (1) and threats (2).]</i>
Build support for medical specialist, palliative care team with medical involvement. Hospital based services stretched, particularly in rural areas. (4) <i>[In both weaknesses (2) and opportunities (2).]</i>	Staff recruitment and retention. (4) <i>[In both threats (1) and weaknesses (3).]</i>	Difficulty in access and lack of diagnostic services in rural areas. (3)	Communication between different health disciplines, notes and databases. (3)
No discharge planning out of hospital on occasions. (4)	‘Mainstream’ services and Maori being ignored. Not dovetailing, misunderstandings and different levels of perceived professionalism. (1)	Low socioeconomic status and high deprivation, no transport and money to access the services. (2)	We don’t know whether we are doing well or not. (2)
Lack of psychological/ personal support for whanau, eg in going to WINZ. (2)	Communication. (1)	No funding for specialist palliative care in rural areas. (2)	District nurses and GPs, generalist and specialist care. (1)
Lack of knowledge of palliative services. (1)		Public awareness of palliative care. (2)	Lack of future financial planning and lack ability to plan. (1)
		Isolation and rurality. (1)	
		Funding not fairly	

Whangarei	Far North	Bay of Islands	Kaipara
		shared. (1)	
		Transport funding in rural areas. (1)	
		Competition of funding with other organisations. (1)	
		Marketing. (1)	
Opportunities			
Nurse specialist >1 to help Warrick and the team. (7)	Flexibility in sharing of resources (skills, protocols, workforce, physical resources). (7)	Higher palliative care profile to community through education and marketing. (5)	Building on the team we have (moving forward), eg providing specialist support for our district nurses in order to enable them to increase their services to the community. (11)
Little after-hours GP support in greater Whangarei District. (6)	Training of palliative care staff and families of clients across all providers with common language and understanding as well as common service marketing. (7)	Regional educator for nurses / carers and GPs. (5)	Increased in use of technology. (6)
Increased link with the hospital (6).	New model for palliative care and the chance to rewrite the strategy (5).	Non-existent hospital liaison team. No hospital liaison team from NDHB to palliative care providers compared to other hospitals in Auckland. There are currently no specific palliative care team at the hospital. (4)	Raising awareness through external service, media and the hospice's shop (marketing of services). (5)
IT system and hospices website to enable patients and their families in accessing information (5)	lack of marketing – limited definition of palliative care and the importance of marketing services from an early stage <i>[In both threats (1) and opportunities (2).]</i>	IT development (3)	Improve coordination thru palliative care. (5)
Hospices to have control over home help funding for faster services. To explore funding that support patients and ↑ responsiveness. (5)	Earlier intervention. (3)	Regional protocols / systems / guidelines. (2)	Regional and national standards of consistency. (3)
Enhance relationship with GPs and more education for GPs about palliative care. (5)	Work more closely with allied health. (2)	Enhance what we've got, strengthen relationships. (1)	Provide more specialist services than at present. (3)
Marketing of palliative	Shared professional	Increased scope of	Inpatient care, the

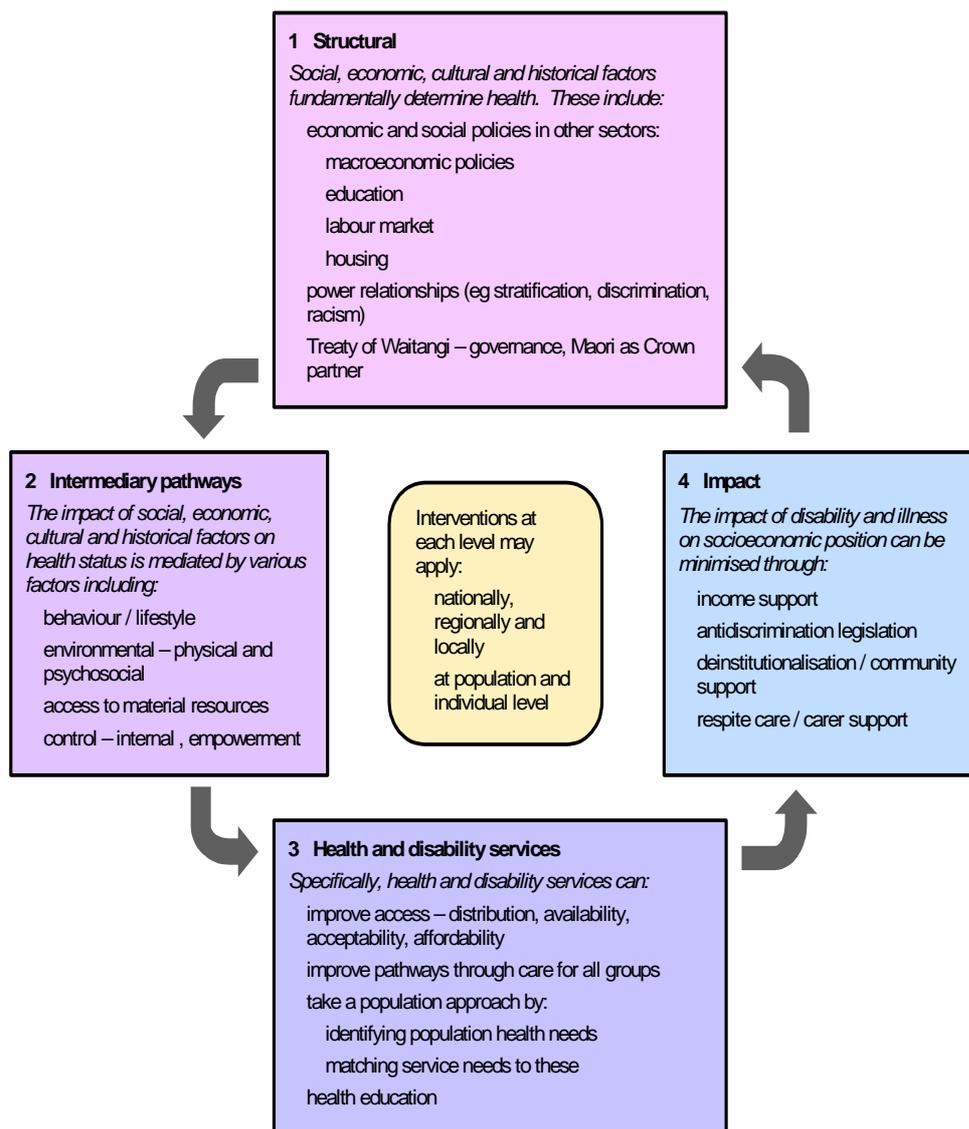
Whangarei	Far North	Bay of Islands	Kaipara
care and hospices' services through handouts. (5)	development across all funded agents. (1)	practice. (1)	importance of earlier intervention, (5) <i>[In both weaknesses (3) and opportunities (2).]</i>
Develop regional protocols. (5)	Multidisciplinary owning of palliative care. (1)		Investing tools to assist those delivering care. (1)
Increase bed space for long term stay of younger patients and their families. (4)			Build on delivery of clinical care, raise the benchmark with education. (1)
Build support for medical specialist, palliative care team with medical involvement. Hospital based services stretched, particularly in rural areas. (4). <i>[In both in weaknesses (2) and opportunities (2).]</i>			Show Kaipara model of care as the most appropriate for the area. (1)
Education for carers. (3)			Shared systems, policies and procedures in place, eg for new staff. (3)
Growth of services with the increasing number of patients. (1)			
A link between hospices and rest homes. (1)			
Threats			
Diminished relative funding. (4)	Lack of marketing. Limited definition of palliative care and the importance of marketing services from an early stage. (3) <i>[In both in threats (1) and opportunities (2).]</i>	Funding, sufficient and ongoing. (10)	Risk of increased fragmentation of service providers. (5)
Loss of GPs support – the “Y” generation. (2)	Staff recruitment and retention. (4) <i>[In both threats (1) and weaknesses (3).]</i>	Staff – retaining and recruiting. (8)	Increased costs. (5)
Pay parity. (1)	Cost of complex chronic care. (3)	Potential lack of carers. (3)	Ignorance, we don't know what we don't know. (3)
	Increasing workload. (1)	Travel costs. (3)	Threats of losing the good reputation currently held within the community. (2)
	Out of date funding model. (1)	Law changes to Charities Act. (1)	Staff recruitment and retention. (1)
		Centralisation of services. (1)	Not enough involvement of Maori and fewer

Whangarei	Far North	Bay of Islands	Kaipara
			Maori volunteers (4 out of 66). Thus enough or the right services for Maori population? (3) [In both weaknesses (1) and threats (2).]
		Increased disease processes in young people. (1)	Housing standard: houses in rural areas with no running water and electricity. However, most don't want to move out from their home. (1)
Strengths			
Reinforced the great work we are doing	know each other – relationships and networking between the staff	accessible Specialist in Palliative Medicine–(1)	highly regarded services by the community
The people, cooperation, willingness	skills and expertise of palliative care staff	good relationship with other agents (1)	collaboration
Client-focussed care	GPs are readily available	facilities and resources, including human, assets and equipments	coordination
Boundaries flexible	volunteers are valued	cooperation under current system	personnel
Warrick as the Palliative Care Specialist – highlighted the positive influence of the Palliative Medicine Specialist.	Partial funding modes are valuable.	Localised identities within each area.	External involvement with education and care (eg education of staff from North Haven).
Community support – volunteers.	Community ownership of the Far North palliative care.	Existing model must be working even though might not be the best model.	Dedication, goodwill and faithful staff. Stable workforce (average length of employment for inpatients nurses 18.2 years).
Support from nurses.	Locally run.	Good communication.	Accessible services.
Good Iwi providers relationships.	Commitment of staff.	Information and resources sharing.	What happens behind the scenes, eg managing volunteers. Individual dedication in the team involved behind the scenes.
Support from media.	Unique	Staff.	Strong community and volunteers (some volunteers also paid to work night shift).
Good relationship between organisation.	Strong community – people bringing in expertise to the community.	Commitment.	Strong local knowledge.

Whangarei	Far North	Bay of Islands	Kaipara
Ease of access, guidance, quick processes.	Staff easy to get hold of.	Volunteers.	High quality of services.
24 hr response in Whangarei, FN and BOI.	Marketing is done through the local newspaper.	Locally based.	Long history of service provision.
Coordination between borders.	Great location geographically.	Goes the extra mile in providing the services.	Strong community support.
Oncology support.	Good system / process is available.	Support for service users and family.	Inpatient care.
Counselling services.	Great facility.	Accessible Specialist in Palliative Medicine.	Have everything on one site.
Palliative care leadership in Northland.	Good community support.	Good relationship with other agents.	Local ownership.
Shared care.	Access to services of Medical Specialist.	Good knowledge based.	Ability to access other hospices.
Good communication within the team.	Education.	Multiple providers.	District nurses have established relationship with family members.
Support from GPs.	Manager is able to support the team and patients in a number of areas.	Increased scope of practice.	PHOs and GPs visits availability, continuity of care.
Most non-North Haven Hospice participants very pleased with the informal personal communication that they receive from the staff.			Night nursing.

Appendix 3

**The Reducing Inequalities Framework an
Health Equity Assessment Tool
(HEAT)**



The following set of questions has been developed to help in considering how particular inequalities in health have come about, and where the effective intervention points are to tackle them.

- 1 What health issue is the policy / programme trying to address?
- 2 What inequalities exist in this health area?
- 3 Who is disadvantaged most and how?
- 4 How did the inequality occur? What are the mechanisms by which it was created, and is it being maintained or increased?
- 5 What are the determinants of the inequality?
- 6 How will the programme address the principles of the Treaty of Waitangi (specifically partnership, participation and protection)?

- 7 Where / how will the programme intervene to tackle this issue? (Use the MoH Intervention Framework and the ToW to guide thinking.)
- 8 How could this intervention affect health inequalities?
- 9 Who will benefit most?
- 10 What might the unintended consequences be?
- 11 What will you do to make sure the programme reduces or eliminates inequalities?
- 12 How will reduction in inequalities be measured?