MARTIN JENKINS

HOSPICE WAIKATO SERVICE MASTER PLAN

Final Report

25 September 2020

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PREFACE

This report has been prepared for Hospice Waikato by Sarah Baddeley, Michelle Hancock, and Sam Ponniah from MartinJenkins (Martin, Jenkins & Associates Limited) and Marianne Scott from Scott Health Consulting.

MartinJenkins advises clients in the public, private and not-for-profit sectors. Our work in the public sector spans a wide range of central and local government agencies. We provide advice and support to clients in the following areas:

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EXECUTIVE SUMMARY

Hospice Waikato provides a freely available, holistic, and essential health service for people in their community facing a life-limiting illness

Hospice Waikato provides specialist palliative care services to people and their families/whānau who are facing a life-limiting illness. Hospice Waikato services include paediatric and adult services across specialist community palliative care within an overarching hospice philosophy of care for the whole person and their family/whānau - physical, emotional, spiritual, and social needs.

All care and support provided by the hospice is completely free of charge. As an essential community-based health service, hospice services receive most funding from central government, with fundraising playing an important part in keeping services free of charge.

The holistic approach to palliative care has an affinity with a wider Te Ao Māori world view and specifically with Te Whare Tapa Whā (the four-sided whare/house) – all four sides are interlinked and necessary to ensure strength and symmetry. Most important, this model is also consistent with Hospice Waikato's commitment to reducing health inequity and recognises the principles, rights, and interests of iwi/Māori under Te Tiriti o Waitangi[1].

Feedback from patients, family and whānau shows that Hospice Waikato is viewed extremely positively by those it serves. Hospice paediatric palliative care services, when reviewed in 2011, also received overwhelmingly positive feedback from family and whānau in relation to the services it provided and the way in which staff operated. Since that time, services and facilities have evolved to expand the scope of services provided and an increasing proportion of rural home care support.

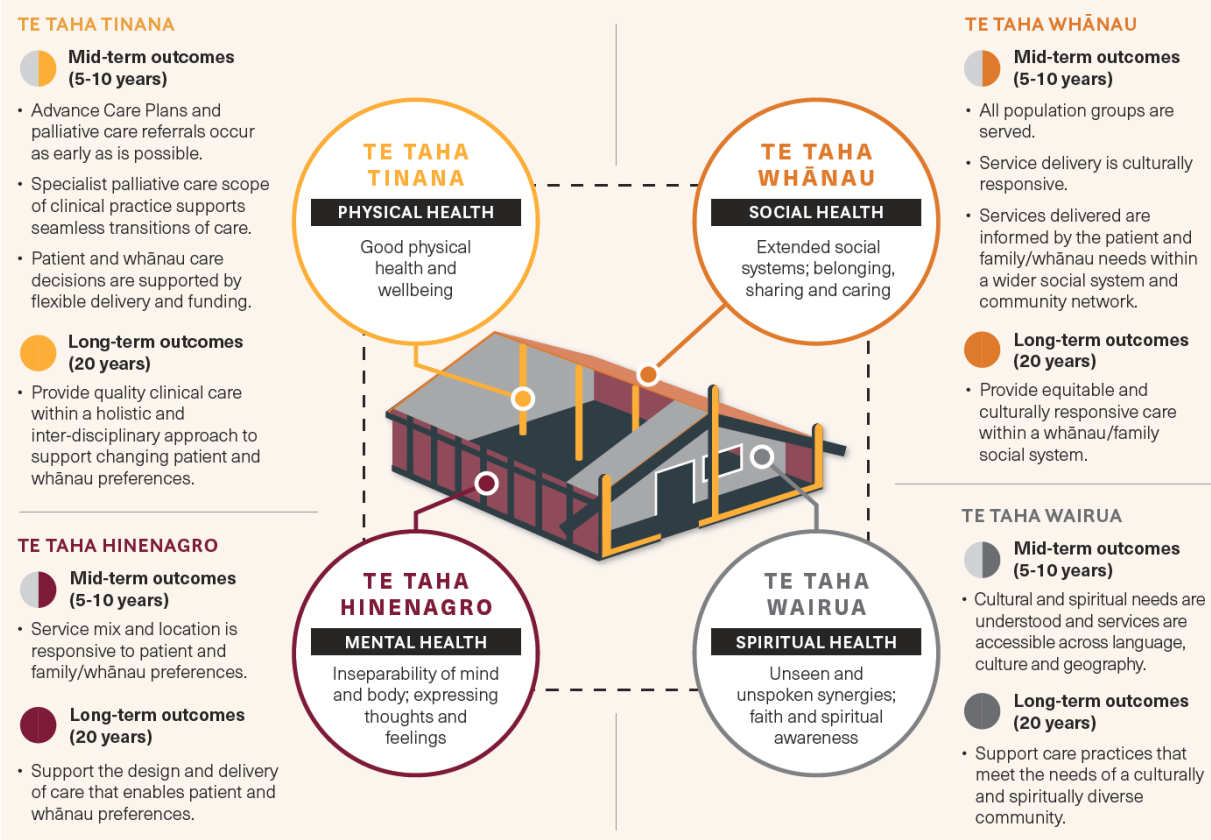
A holistic set of long-term outcomes has been developed to guide this Service Master Plan

The following strategic outcomes have been developed with members of the Hospice Waikato executive and board. These have been used to identify and evaluate the options for future development of services and models of care.

These outcomes are based on the Te Whare Tapa Whā model for understanding the Māori view of health and wellness, developed by Mason Durie in 1982.

[1] The definition of health equity is the subject of rich academic literature, both internationally and in New Zealand. Here we use the Ministry of Health's own broad working definition on equity in health outcomes: 'In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage may require different approaches and resources to get equitable outcomes' (Ministry of Health 2018).

Figure 1: Hospice Waikato Service Master Plan Outcomes Framework



The most direct strategic alignment for the Hospice Waikato Service Master Plan (SMP) is with the Waikato District Health Board (DHB) health system plan and palliative care strategy. The long-term impacts outlined in the Waikato DHB statutory planning and performance system[2] and related strategies are used to evaluate the effectiveness and quality of the services the DHB funds and provides.

Hospice Waikato contributes to the Waikato DHB long term impact related to specialist care for people with end-stage (life-limiting) conditions where *'…it is important that they and their families are supported, so that the person can live comfortably, have their needs met and die without undue pain and suffering.'* The current Waikato DHB Palliative Care Strategic Plan (2016-2021)[3] long term outcomes (equitable access, seamless care pathway and meeting whānau/family needs) may change when the strategy is updated in 2021. This was under review at the time of SMP development.

2 Waikato District Health Board 2019/20 Statement Of Performance Expectation. Available from https://www.waikatodhb.health.nz/assets/Docs/About-Us/Key-Publications/Plans/Waikato-DHB-Annual-Plan-2019-20.pdf

3 Available from https://waikatodhb.cwp.govt.nz/assets/Docs/About-Us/Key-Publications/Plans/5625f7ceb7/Waikato-DHB-Palliative-Care-Strategic-Plan-2016-21.pdf

As the needs of its community changes, Hospice Waikato will need to adapt to whom, where and how its services are delivered

A comprehensive needs assessment was undertaken to support the development of this SMP. This took a locality approach to understanding community needs, consistent with the Waikato DHB strategic planning approach.

Underlying trends for the Waikato show a region that is rapidly growing, diversifying and ageing:

- The Waikato[4] is the third fastest growing region in the country, having grown by 13.5% between the 2013 and 2018 Census and forecast to increase by a further 30% (137,500 people) over the next 20 years
- The population mix is changing too, seeing an increase in Māori, Pacific peoples, and Asian populations
- The population is ageing, as the number of people over 65 years of age in the Waikato has been growing over the last 12 years by 3.5% each year, higher than the national rate of 3.1%. A large proportion of this increase is occurring outside of Hamilton city.

These trends are likely to require changes to Hospice Waikato's existing service models and orientation, adapting to be more culturally accessible and responsive. While care in the home is a priority for many, selected stakeholder feedback indicated a general openness to receive expert advice and support, provided these are based on established relationships of mutual trust, respect and responsiveness. New models of delivery will also need to be considered to achieve cultural responsiveness, given health and social services more generally are employing a kaupapa Māori approach, that is – by Māori for Māori.

Hospice Waikato will also need to consider how it will adapt its services to serve an increasingly older population in rural parts of the region. Particularly given these areas experience additional socioeconomic challenges compared with urban areas (highest proportion of quintile 5 deprivation areas are in the South Waikato, Ruapehu, Hauraki, South Waikato, and Waitomo districts)[5].

A growing younger population in the city centre, with longer life expectancies for congenital diseases

While the population is forecast to age considerably, the child and youth population aged 0 to 19 years is likely to experience modest growth. This mostly impacts the main urban areas as the working age

[4] For demographic assessment purposes, we have expanded the Waikato DHB district to include the additional Waikato regional council boundaries of Rotorua and Taupō.

[5] Waikato DHB Palliative Care Strategic Plan 2016-2021 (Table 3). Available from https://waikatodhb.cwp.govt.nz/assets/Docs/About-Us/Key-Publications/Plans/5625f7ceb7/Waikato-DHB-Palliative-Care-Strategic-Plan-2016-21.pdf

population increases and young families locate themselves closer to Hamilton city. Notably, in almost all areas outside of Hamilton city, the younger population is forecast to decline. This suggests that demand for paediatric palliative care is more likely to come from the main urban area but with an ongoing need to support children and their whānau in both rural and urban communities.

As a specific cohort of focus, children are living longer with life-limiting conditions due to advances in technologies and therapies.[6] This will place increased pressure on Hospice Waikato to meet the increasingly complex needs of affected children, young people, their family and whānau over a longer period of time. The current duration of Hospice Waikato service support is estimated to be about 50% longer for paediatric patients than for adults.[7]

Shift in epidemiology and an increase in prevalence of comorbidities (including those living with cancer as a chronic condition) will create different demands for hospice services

The causes of death are changing, with circulatory disease and other chronic conditions (dementia in older people and cystic fibrosis in children) outnumbering cancer as the leading cause of death. As adults and children are living longer with chronic and congenital diseases, and a wider range of conditions are leading to death (e.g. renal failure, respiratory issues, motor neurone disease), high quality palliative care will grow in importance for a wider proportion of the population than is served now. In addition, the duration of time people will receive services will also continue to increase. The under-utilisation of Hospice Waikato services by non-cancer patients (only 21% of its referrals) suggests a significant unmet need for non-cancer patients living with life limiting conditions.

Statistics NZ population projections suggest there will be a significant increase in deaths across the region over the upcoming two decades when compared to the previous two. The Waikato is projected to experience 98,700 deaths between 2018 to 2043 compared to 55,000 between 1996 and 2018. While the absolute number of deaths is projected to increase, the age at which those deaths occur is also likely to increase. National projections suggest the proportion of deaths occurring over age 85 are expected to increase significantly. This means that not only will there be a substantially higher number of deaths in the region, but those deaths are expected to occur at much older ages. This is likely to mean longer time spent in care, and an increase in people with co-morbid conditions as they live longer. This will increase the prevalence of people dying at home and in residential care with chronic health conditions such as dementia, heart, and respiratory diseases.

6 McLeod, H. (2016). The Need for Palliative Care in New Zealand. Available from https://tas.health.nz/assets/Health-of-Older-People/Technical-Report-Need-for-Palliative-Care-vF2-June-2016-H-McLeod.pdf

7 Based on a 3-month sample from (Jul-Sep 2019) of Hospice staff contacts(direct ad indirect) recorded in PalCare, data indicated on average for adults and paediatric respectively, 35 day and 55 day duration (time from first to last contact).

There are broader challenges for Hospice Waikato to consider

Lack of integration across the palliative care ecosystem

In the broader Waikato palliative care ecosystem, there is limited evidence of integration and clarity of roles across providers. This lack of integration risks fragmented delivery of services and poor transitions between providers, which challenges the provision of a seamless experience of care for patients living with life-limiting illness, and their family and whānau. As more people are forecast to choose to spend their last years of life at home, in aged care facilities and other community settings, there is a need to ensure providers across the system are working together in effective ways to provide a holistic and seamless experience that meets the psychological, social, spiritual, and physical needs of patients and their whānau.

This applies equally to adult and paediatric services. High demand (and long respite wait times) for children and young people for in-patient unit beds may suggest an unmet need in paediatric palliative care due to capacity and/or capability constraints, i.e. paediatric palliative care nursing is a specialty area where not all adult nurses would have sufficient experience.

A more integrated and community-based model of care could provide improved support for patients and their family/whānau. As Hospice Waikato is a referral-based service with relatively low referrals rates from general practice and community providers, this would require even more Hospice Waikato senior staff time and energy for service provider relationship development both in the community and key Waikato DHB services. Quality care for patients and their whānau will also require the system to provide more integrated health care services in the home complementary manner. Critical to receiving specialist palliative care within the home is access to home-based general nursing, personal care, and home help. To be successful, integration needs to be a guiding principle across the palliative care ecosystem that is technology enabled for effective sharing of patient information and care plans across all settings.

The needs of sponsors and donors

Understanding the needs of current and future sponsors is critical for financial sustainability and also to maintain the deep connection Hospice Waikato has to the community it serves. Donated funds constitute 30% of annual revenue (with 70% funding through the Waikato DHB service contract). Over the years, prior to 2019/20, Hospice Waikato's Marketing and Fundraising team has successfully increased fundraising targets year on year. It has developed several iconic and key events in the marketplace, while increasing engagement with the community, brand awareness, new technologies and fundraising platforms.

Hospice Waikato's 2020/21 marketing and fundraising strategies identify significant challenges and opportunities for sustainable charitable funding channels. Revenue sources are broadly from a mix of community fundraising, major events, Hospice Shops and committed (regular) giving. A survey of sponsors is planned later in 2020 that will focus on their needs and will inform ongoing marketing and fundraising strategies.

The ongoing economic impacts of the recent Covid-19 pandemic further drive the importance of diversified charitable funding streams that leverage technologies and grow successful channels. This means building on the established Hospice Waikato brands (including Rainbow Place and Hospice Shops), growing communications with major sponsors and supporters and an increased focus to regular giving approaches. This SMP indicates the need to develop a long term fundraising strategy that is more strongly aligned to services rather than physical infrastructure that has traditionally been the case.

The immediate and long-term impacts of COVID-19

Every aspect of Hospice Waikato's services have experienced immense disruption during the nationwide lockdown. Positive developments included greater collaboration and information sharing with the Waikato DHB, strong recent investment in digital technologies enabling greater ease of moving people off-site and maintaining connectivity with staff, patients, families and other providers, a much greater use of virtual consults and the strength of staff to adapt to the changing environment.

Challenges included persistent connectivity issues with the Waikato DHB information technology systems and the community acting as a barrier to communication at times, significant financial impacts (albeit cushioned by the Government wage subsidy and rent relief from landlords), a much higher workload for community nursing as patients preferred to be cared for at home.

These challenges present many of the opportunities that exist for future growth and development, including improving integration across the palliative care ecosystem and expanding the community nursing service. Over the medium to longer-term, Hospice Waikato will need to be agile to respond to the ambiguity and uncertainty that is likely to characterise the economic and social environment post-COVID-19.

Hospice Waikato will need to make six strategic shifts to meet the holistic needs of its community and address broader system challenges

A four-step process was used to identify the strategic shifts Hospice Waikato would need to make as part of this SMP. This started with:

1 the needs assessment that has been summarised above; followed by

2 a long-listing exercise to identity model of care components most likely to deliver against the desired outcomes; then

3 a short-listing exercise to group the model of care components; and finally

4 assessing the short list against assessment criteria.

The analysis was informed by stakeholders and tested with staff and leadership at various points to ensure their views and perspectives were captured.

At the end of the process, 6 strategic shifts were identified to enable Hospice Waikato to achieve each of its desired outcomes across the four dimensions of Te taha whānau (Social Wellbeing), Te taha wairua (Spiritual Wellbeing), Te taha hinengaro (Mental Wellbeing) and Te taha tinana (Physical Wellbeing).

While these are presented as a set of potential strategic shifts, they are not mutually exclusive and are in many cases overlapping and complementary to one another. Overlapping components largely relate to population coverage across different community groups (e.g. frail older people with chronic health problems) that Hospice Waikato serves and enablers of service delivery (e.g. cultural responsiveness).

In any scenario, there are certain areas that can be improved over the immediate term. These include:

- focusing on maximising use of available resources and infrastructure to optimise outcomes, e.g. paediatric respite waiting times, and other operational efficiencies
- consideration of commitment to establishing key roles to lead strategic change that supports multiple shifts and leverages regional resources
- critical improvements in Māori leadership, provider relationships and change management capabilities.

Further detail contrasting the shifts is provided later in the full report. The measures of changing Hospice services demand are reflected in the number of referrals received and of these, the number of accepted referrals reflect increased service utilisation and related resource requirements.

Shift 1: Reduce rural service inequities

What is required?

Rural residents do not receive the same scope of Hospice Waikato services than those living in urban areas[8] and requires positive provider relationships to reduce inequities. [9]

This shift will require a focus on the scope of services (especially Family Services) rather than increased volume of referrals, as 2018/19 data indicates 46% of estimated people dying in rural areas accessed Hospice Waikato services compared to 36% in Greater Hamilton.

An increased scope of social work and counselling services will be needed to better support those living in the most deprived areas, and areas with higher Māori populations.

What are the financial and resource implications?

Preliminary estimates identify an increase by 1.0 FTE social worker and 0.6 FTE counsellor resources (from 2.5 and 2.2 FTE respectively) assigned to rural teams to support people in their homes supported by more formal volunteer support roles.

8 Landers A, Dawson D, Doolan-Noble F. (2018). Evaluating a model of delivering specialist palliative care services in rural New Zealand. J Prim Health Care. 2018;10(2):125–131. doi:10.1071/HC18004 (Abstract only)

9 Thiel V, Sonola L, Goodwin N, Kodner DL. (2013). Midhurst Macmillan Community Specialist Palliative Care Service Delivering end-of-life care in the community. The King's Fund. 2013 (Funded by Aetna and the Aetna Foundation)

This has an estimated 32% (860) increase in Family Services contacts compared to the base case.

Shift 2: Grow cultural responsiveness

What is required?

The person-centred hospice model of care was developed based on a western worldview and this needs to be adapted to better meet the perspectives, values, and needs of Māori[10] and an increasingly diverse population. [11]

Hospice Waikato will need to focus on increasing Māori, Pacific and Asian service access and experience of care through working in partnership, workforce diversity, Māori leadership, cultural competency training, cultural advice (vacant Kaiāwhina role in 2020), attention to health literacy and cultural appropriateness of published information and minor facilities refurbishment.

Working with community Māori, Pacific, and Asian providers to grow workforce diversity and cultural responsiveness. Opportunity for sharing of knowledge, community networks and community-based volunteer support.

What are the financial and resource implications?

Results in 0.4 FTE increase in Kaiāwhina resource (current 0.6FTE vacancy) and small increase in referrals (65 people or 5% increase compared to the base case) and of these, assume two thirds might benefit from specialist consultation and home care support.

Shift 3: Rebalance holistic care and extend community reach

What is required?

Effective holistic care engages not only with patients and whānau, but with the broader community as well. There is growing evidence that a more ‘compassionate community’ will better support community outcomes[12] and health system sustainability.

A more comprehensive increase in holistic services is required that further expands social worker and counselling support alongside spiritual care and other therapies for those people already referred to Hospice Waikato. The focus is on increasing the scope of holistic services offered for those referred to Hospice Waikato.

There is a need to also reach new communities of people living rough and offenders. While the overall numbers are smaller, perhaps less than 30 referrals (2% increase compared to the base case), this

10 Moeke-Maxwell T, Waimarie Nikora L, Te Awekotuku N. (2014). End-Of-Life Care And Mäori Whänau Resilience. Mai Journal, Vol 3 (Issue 4): 140-152

11 Frey, R., Gott, M., Raphael, D., Black, S., Teleo-Hope, L., Lee, H., & Wang, Z. (2013). 'Where do I go from here'? A cultural perspective on challenges to the use of hospice services. Health & social care in the community, 21(5), 519–529. https://doi.org/10.1111/hsc.12038

12 Abel J, Sallnow L, Murray S, Kerin M. Each Community is Prepared to Help: Community Development in End of Life Care – Guidance on Ambition Six. The National Council for Palliative Care, 2016

would require Waikato DHB and Department of Corrections support for cross-sector engagement and model of care development.

This shift also presents opportunities for community-based volunteer support of people with limited social networks as part of a system-wide 'Compassionate Communities' strategy.

What are the financial and resource implications?

Preliminary estimates suggest the most significant workforce increase of 5 FTE. This includes 1.25 FTE for social work, 1.25 FTE counselling and 2 FTEs for other therapies plus a new 0.5 FTE co-ordinator role to support the 'Compassionate Communities' strategy. Estimated 83% (2,194) increase in Family Services contacts compared to the base case.

Shift 4: Reduce inequities for people dying with chronic health problems

What is required?

Earlier engagement[13] (home and team based) of palliative care support for people with life-limiting chronic health conditions can significantly improve quality of life but requires strong relationships with general practice as the lead health providers.[14]

This is a significant change in Waikato DHB (hospital) and primary care referral practice and there will be financial implications for primary care without specific funding streams to support expanded service coverage.

Opportunity for community-based volunteer support of people with limited social networks as part of a system-wide 'Compassionate Communities' strategy.

What are the financial and resource implications?

If fully implemented, this shift results in an estimated 18% (209 people) increase in referrals accepted for Hospice services. This change will potentially require 3- 5 years to reach these numbers and is highly dependent on general practice referrals.

Preliminary estimates suggest 2.2 FTE increase will be required for advice and education support for primary care (Hospice SMO/CNS), Home Care nursing and Family Services.

Hospice IPU impact may be relatively small as the significant majority of care is typically home or residential care facility based.

13 Gardiner, C., Ingleton, C., Gott, M. et al. Exploring the transition from curative care to palliative care: a systematic review of the literature. BMJ Supportive and Palliative Care 2015; 5 (4). 335 - 342. ISSN 2045-435

14 De Vleminck A, Pardon K, Beernaert K, et al. Barriers to advance care planning in cancer, heart failure and dementia patients: a focus group study on general practitioners' views and experiences. PLoS One. 2014;9(1):e84905. Published 2014 Jan 21. doi:10.1371/journal.pone.0084905

Potential increase to home equipment needs (number and strength the cater for unhealthy weight earlier in the disease trajectory) related to increasing age, mobility and frailty problems associated with chronic conditions.

Shift 5: Grow paediatric palliative services and extend community reach

What is required?

An early joined up approach to paediatric palliative care for children with life-threatening conditions and their families enhances the provision of holistic care. Care duration is typically longer than needed for adults and results in higher population coverage needs due to overlapping years of existing and new patients.

This shift focuses on expanding population coverage (from 33% to 68% of deaths aged 0-19 years), expanded Hospice Waikato IPU based respite support and potentially expanded scope of services to include perinatal palliative care.

Paediatric community-based teams are well positioned to support this, through increased collaborative team working with the DHB neonatal and paediatric teams in hospital and home settings.

What are the financial and resource implications?

This shift results in a 97% increase in paediatric respite bed days in the Hospice Waikato IPU and related paediatric palliative care nursing support. As almost half of deaths under 1 year of age are Māori, expanded service access coverage for this group requires attention to cultural responsiveness.

Compared with the base case, the greatest resource impact is on home and respite support with 43% (9) more children and young people for home care support and estimated new referrals for 12 babies (parents/whānau) for perinatal support. In total, this represents a 100% increase in referrals.

Long term opportunity (15-10 years) for a standalone Paediatric facility a model of care, i.e. better outcomes for children separated from adult services with paediatric trained staff, rather than capacity driver.

Shift 6: More age-attuned palliative care

What is required?

The population is living longer and dying later in life creating both service demand pressures and requiring alternative models of care. Best practice indicates the need for integrated approaches (rather than silo approaches) to palliative care services, through engaging with aged residential care facilities and the wider health system.[15]

15 Smets T, Onwuteaka-Philipsen BBD, Miranda R, et al. (2018). Integrating palliative care in long-term care facilities across Europe (PACE): protocol of a cluster randomized controlled trial of the 'PACE Steps to Success' intervention in seven countries. BMC Palliat Care. 2018;17(1):47. Published 2018 Mar 12. doi:10.1186/s12904-018-0297-1

This requires a focus on increasing Hospice Waikato referrals for people dying with (not from) dementia and frailty. This is an estimated 66% increase (812 people) in base case Hospice Waikato referrals and potentially 21% (increase (236 people) requiring specialist palliative care consultation support.

To be successful, this shift requires a change in Aged Residential Care and GP referral practices. Resource impacts mostly related to Aged Residential Care liaison (CNS), medical advice to GPs and home care team relationships/ education with general practice and Family Services support for families.

Opportunity for community-based volunteer support of people with limited social networks as part of a system-wide 'Compassionate Communities' strategy.

What are the financial and resource implications?

The IPU impact is negligible as support for this shift is largely through aged residential care, assuming the current Hospice Waikato IPU configuration continues (as this is not suitable for advanced dementia care).

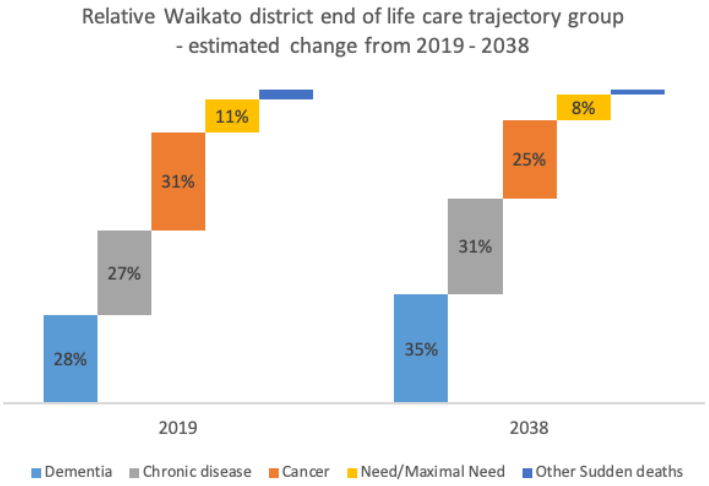
Estimates suggest 1 FTE increase for Aged Residential Care liaison nurse liaison and 0.2 FTE senior medical resources.

There is a potential increase to home equipment needs for home care.

Predicting care requirements

Broad-order projections based on McLeod & Atkinson (2019) national projections of increased deaths of end of life trajectory groups (2019-2038) has been applied to indicative Waikato DHB district deaths. The majority (77%) of Hospice Waikato services are currently utilised by people dying with cancer. To retain the population health principle, Hospice Waikato needs to consider how best to balance service coverage for non-cancer populations.

Figure 2: Relative Waikato District End of Life Trajectory Groups



Assumptions were defined across possible referral process scenarios for each strategic shift

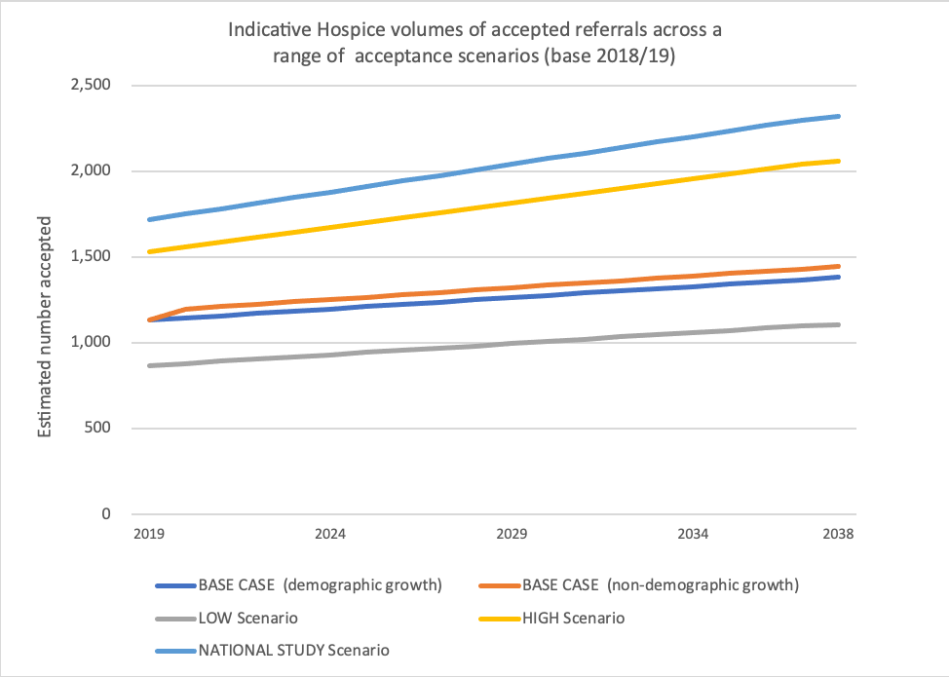
Without detailed time and motion data for Hospice Waikato staff and related resources, five scenarios were defined to test the potential resource impacts, outcome benefits and risks with increased Hospice Waikato capacity and capability. Current resource utilisation was estimated based on a 3-month (Jul-Sep 2019) Hospice Waikato contacts data extract segmented by:

- adult and paediatric service, then
- disease group (end of life trajectory groups defined in the 2015 national study), then
- hospice discipline (nursing, family services, medical[16] and volunteer).

Based on available published recommendations, a number of referral management scenarios were assessed regarding the base case, low, high and national study (McLeod & Atkinson, 2019) scenarios. The following graph contrasts the relative impacts across the various scenario assumptions.

[16] Advice from Hospice Waikato leadership that the medical contacts data is inconsistently recorded therefore appropriate to use these data to assess medical resource impacts

Figure 3: Indicative Hospice Waikato Volumes



The following table outlines which end of life trajectory groups are most impacted by the strategic shifts compared with the high scenario[17] for the respective adult populations served.

Table 1: Strategic Shift Impacts on Trajectory Groups

Strategic Shift	Population targeted	Hospice service most impacted	Est. high scenario growth
0. Base case	No change	Leadership capability focus Annual increase in home care service demand	Current referral base Demographic growth 0.9% pa but current rate (non-demographic) is 5.5%[18] pa
1. Rural services	Serving the same number of referred patients and whānau differently Focus on rural areas of high socioeconomic deprivation	Increased family services (social workers, counsellors)	Current referral base + Family services contacts 32% increase
2: Cultural responsiveness	Māori, Asian, Pacific peoples (est. 65 additional referrals to establish equitable ethnic group coverage)	Staff education, cultural support Hospice Home Care and Family services to absorb within budgets	Referrals received 5% increase Referrals accepted 4% increase

17 The high scenario was adapted from the 2011 palliative care recommendations (low scenario) and national study published in 2019

18 Based on Hospice 5-year average service volumes increase (2014-2019). This is considered a non-demographic forecast assumption as it is higher than the current mortality rate increases of 0.9% pa

Strategic Shift	Population targeted	Hospice service most impacted	Est. high scenario growth
3. Holistic care	Largely serving the same number of referred patients and whānau differently Focus on district wide areas of high socioeconomic deprivation and those with psychosocial needs	Family services (complete range of disciplines)	Referrals received 2% increase Referrals accepted 3% increase Family services contacts 83% increase
4. Chronic care	People dying with chronic and other palliative care need (not cancer, dementia or sudden deaths)	Home Care Services Some IPU service impact (but lower utilisation compared with cancer care)	Referrals received 56% increase Referrals accepted 18% increase
5. Paediatric care	Babies, children and young people. Focus on respite waiting list inequities compared with adults and new perinatal support	Hospice IPU respite care Home and hospital team support	Referrals received 100% increase IPU respite days 97% increase
6. Age attuned care	People dying with dementia	Aged Residential Care liaison, education and general practice advice Negligible IPU service impact	Referrals received 66% increase Referrals accepted 18% increase

Strategic shifts 4 and 6 are particularly sensitive to referrals criteria and related management assumptions. We tested potential impacts on accepted referrals using the national study recommendations.

If successful, strategic shifts 4 and 6 would significantly increase the number of referrals received – requiring inter-disciplinary assessment and communication back to the referrer particularly given the likely increase in decline rates.

Paediatric specialist palliative care services

The relatively small number of deaths each year (est. 64 in 2019) for those aged 0-19 years of age is important from a population health and community support perspective.

Although there is low growth forecast for this group, there is unmet specialist palliative care need related to the **scope of services** available and increasing **duration and complexity** of home-based care for families.

Inpatient Unit

The impact on the Inpatient Unit was carefully examined against high and low scenarios. Overall it was assessed that the 11-bed unit has physical capacity to enable an increase to 2 resourced paediatric beds for the next 20 years if there is no increase in adult patient average length of stay or additional chronic care patients in both 85 % and 90% occupancy models.

A horizons-based approach to implementation will enable resources to be used more effectively

We have broken down the SMP into three distinct time horizons to enable a meaningful level of detail to guide investment choices at each stage. The level of uncertainty around the key drivers impacting on care will be higher in the longer term, while the operating environment will be quite stable in the short term.

The three horizons are characterised as follows:

1 **2020 to 2021 – strengthen foundations**. Due to scarce resources and the contracts in place, this phase will be focused on making the most of existing resources, making incremental changes where possible, and planning and preparing for changes to be made in the period to follow.

2 **2020 to 2025 – service pilots and standardisation**. As new contracts and partnerships begin to come into play, this period will allow for Hospice Waikato to begin to branch out and pilot new models and services with a focus on understanding specific service and system wide impacts.

3 **2025 to 2028 – larger scale service model change**. This period will see successful pilots rolled out at scale, the potential for greater change, evaluation and adaptation, and the start of work to scope the next waves of improvement both within the service, and across the system particularly focussed on system wide enablement of care in the home.

Addressing challenges around the key enablers of the strategic shifts

Implementation of the SMP will require a focus on the key enablers of the strategic shifts outlined. The three key enablers, critical to the success of Hospice Waikato are the same as those that have been identified across the wider health system[19]:

- **Workforce** – Hospice Waikato is dependent on a kind, caring, compassionate and clinically competent and skilled workforce. Challenges include low cultural diversity, cultural competence and an ageing workforce, poor quality information to understand utilisation, indications of an under-resourced workforce, an emerging wage pressure
- **Data and digital technologies** – Hospice Waikato currently have an appropriate suite of tools to enable digital connectivity. Current challenges facing the delivery of an improved model of care include growing digital literacy amongst the workforce, patients and their whanau and supporting new ways of working, particularly amongst the medical and family services workforce
- **Facilities and equipment** – Safe, fit-for-purpose facilities and equipment are essential to support the outcomes identified for Hospice Waikato. The quality of the facilities and equipment at Hospice Waikato has been assessed by leaders as fit for purpose and of a high quality particularly when compared to other similarly funded and provider community health services. No expansion of the IPU was identified under high and low growth scenarios. This means that any future facilities will likely be a strategic choice related to paediatric care in the long term, and to

[19] Health and Disability System Review. 2020. Health and Disability System Review – Final Report – Pūrongo Whakamutunga. Wellington: HDSR

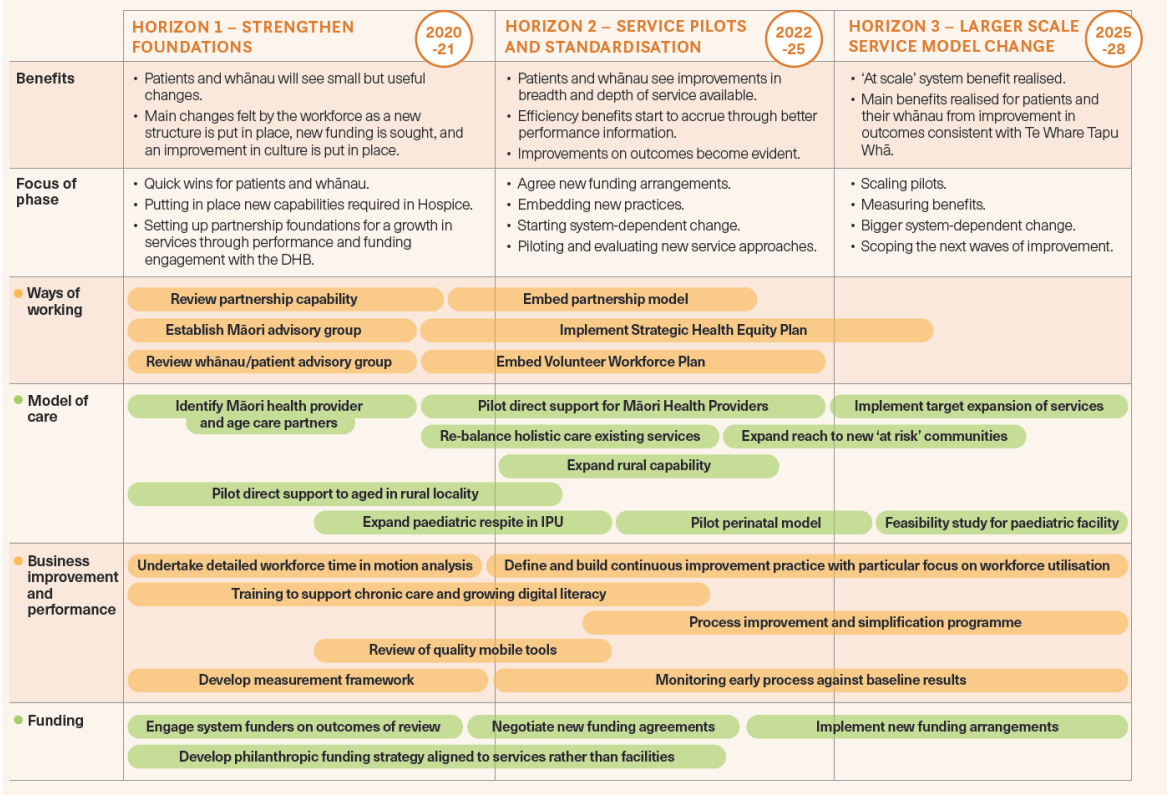
support a greater location of the workforce in rural communities (though this should be considered in partnership with Waikato DHB (as part of their localities strategy) and other community providers including Māori health providers.

The recommended implementation pathway

While the SMP is intended to support the next 10-20 years of demographic change, Hospice Waikato has also sought a high-level implementation pathway focus on outcomes for the next 5-8 years. Successful implementation of the SMP will require:

- **Strategic alignment** – a strategic alignment of the outcomes sought in the SMP between the Hospice Waikato Board, executive, workforce and critical funders and partners including Waikato District Health Board, Primary Health Providers (including Māori Health Providers) and Age and Residential Care Providers
- **Skilled and competent workforce** - including the adoption of some new ways of working
- **Performance, measurement, and feedback** – the adoption of a more continuous system of performance measurement feedback with better understanding of the use of resources (particularly staff time), and greater involvement of patients, their family and key strategic partners.

Key phases of the SMP Implementation Pathway are set out below implemented across three strategic horizons.



Immediate next steps

The immediate priorities for implementing the SMP are:

- Repurposing two of the existing IPU beds to meet the needs of paediatric respite care
- Developing or appointing the capability to drive a more strategic approach to change and partnerships with a priority Māori providers and rural aged and residential care
- Continuing to monitor the progress of the End of Life Choice Act and associated referendum outcome to assess any implications this may have to workforce needs, patient care and service delivery
- Revisiting both philanthropic funding and volunteer workforce strategies to align the SMP including orientating the strategy toward service-based activity such as compassionate communities
- Demonstrate the value of new models of care through pilot and evaluation to inform the contract renegotiation in 2022
- Reaching agreement with the DHB at contract renewal in September 2022 focussed on the expansion of rural nursing care and more holistic care (social work and counselling) across the palliative service.

INTRODUCTION

Who is Hospice Waikato?

Hospice Waikato provides specialist palliative care services to people and their families/whānau who are facing a life-limiting illness.

All care and support provided by the hospice is completely free of charge. As an essential health service, hospice services receive most funding from central government, with fundraising playing an important part in keeping services free of charge.

Brief history of Hospice Waikato

Hospice Waikato was founded in 1981 by Margaret Broad, whose interest in the Hospice movement grew out of her own personal family tragedy. Margaret lost her husband Jon, and their daughter Philippa, who were both among the 257 people killed in the Erebus disaster where an Air New Zealand flight plunged into the second-highest volcano in remote Antarctica. She used the challenge of her own loss and grief to start an organisation dedicated to caring for people through the hardest of times.

Margaret's hospice vision was for qualified staff and volunteers to provide free, holistic care for terminally ill patients who preferred to remain at home. This would be supported by a small, comfortable property with a few beds to be available when people could no longer cope at home, or for short stays to give respite for carers and patients.

Her philosophy of care and vision lives on to this day and are embedded in the values and mission of Hospice Waikato.

What is palliative care?

Palliative care is a specialist medical service for people who are dying or whose illness is no longer curable. It is an active and holistic approach to care with the goal of providing quality of life, managing pain and symptoms to enable people to live every moment in whatever way is important to them.

While physical needs like managing pain and symptoms are a priority, equal importance is placed on cultural, emotional, spiritual, and social needs as the end of life approaches. Support is also provided for family and whānau both before and after the death of their loved one.

The holistic approach to palliative care has an affinity with a wider Te Ao Māori world view and specifically with Te Whare Tapa Whā (the four-sided whare/house) – all four sides are interlinked and necessary to ensure strength and symmetry.

Te Whare Tapa Whā model of care underpins the seven principles of care identified in Te Ara Whakapiri: Principles and guidance for the last days of life that are concerned with the total wellbeing of the person and their family/whānau. It is a statement of guiding principles and components for the

care of adults in their last days of life across all settings, including the home, residential care facilities, hospitals, and hospices.[20]

Hospice New Zealand acknowledges that hospices have a responsibility to ensure that quality, compassionate care is available and delivered to Māori patients/tūroro and whānau, alongside the care delivered to all members of the community.

What are Hospice Waikato's values?

Figure 4: Hospice Waikato Vision and Values

Mission	To provide the best possible specialist community palliative care, that enhances the quality of life for those facing end of life and bereavement.	
Vision	Quality end of life care for all.	
Values	*Community - Hapori*	United by heart, we walk alongside our people, near and far, working in partnership to provide quality holistic care
	Advocacy - Akiaki	Honouring the cycle of life and death, ensuring our people have a voice, insisting that all have equal access to quality care
	Respect - Whakarangatira	We have respect for our people, our diversity, and in our communication through safe and holistic practice
	Empathy - Aroha	Being with our people, acknowledging uniqueness, and supporting with dignity, respect, and compassion

What is Hospice Waikato's role?

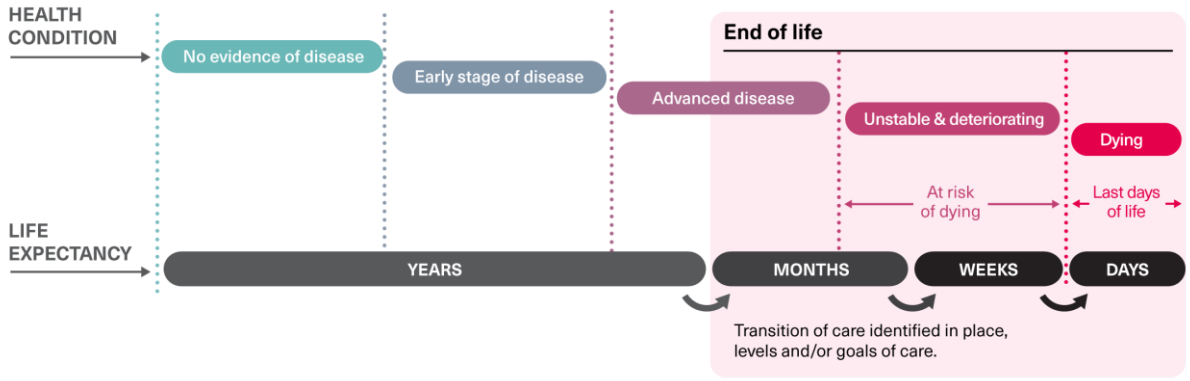
Hospice Waikato services include paediatric and adult services across specialist community palliative care within an overarching hospice philosophy of care for the whole person - their physical, emotional, spiritual, and social needs.

Palliative care should be provided in a personalised way that meets the unique individual needs. This standard of care applies whether death is days, weeks, months or, when appropriate, years away. Hospice services collaboratively support across the full palliative care continuum that is longer than the last months and days of life. Treatments and other patient, carer and whānau support can be aimed at improving either or both quantity and quality of life.

The system to enable this standard of care comprises specialist palliative care services, primary palliative care providers and other health and social services. These services are equally dependent on other community, patient and caregiver contributions linked together in different ways and at different times along a patient and whānau's journey.

20 Ministry of Health. 2017. Te Ara Whakapiri: Principles and guidance for the last days of life. (2nd edn). Wellington: Ministry of Health. Available from https://www.health.govt.nz/publication/te-ara-whakapiri-principles-and-guidance-last-days-life

Figure 5: End of life and last days of life



Source: Ministry of Health (2015)

Broader context of the review of the health and disability system

The Government has recently commissioned a comprehensive and integrated review of the New Zealand Health and Disability System.[21] The review was charged with recommending system-level changes that would be sustainable, lead to better and more equitable outcomes for all New Zealanders and shift the balance from treatment of illness towards health and wellbeing.

The findings are grouped around the following four key themes:

- Ensuring **consumers, whānau and communities** are at the heart of the system. The system must understand the needs of individuals, whānau and communities in much more detail and must design and deliver services to address the identified needs. The review proposes a much more networked environment where the full range of primary and community services are planned with the community. Home-based support should be assessed by need rather than having eligibility determined by diagnosis.
- **Culture change** and more **focused leadership**. The system needs a clearer definition of functions and structures, more collective responsibility, and more deliberate upskilling throughout the sector, from kaiāwhina to DHB board members. Recommendations include setting up a new agency, Health NZ, responsible for leadership of health service delivery and a Māori Health Authority to provide advice on hauora Māori issues and lead the development of a strengthened Māori workforce and growth of kaupapa Māori services around the country.
- Developing more effective **te Tiriti based partnerships** within health and disability and creating a system that **works more effectively for Māori**. The fact that Māori health outcomes are significantly worse than those for other New Zealanders represents a failure of the health and disability system and does not reflect te Tiriti commitments. In addition to the establishment of a Māori Health Authority, the review recommends that Governance in other parts of the system

21 Health and Disability System Review (2020). Health and Disability System Review – Final Report – Pūrongo Whakamutunga. Available from www.systemreview.health.govt.nz/final-report.

needs to reflect te Tiriti partnerships. It also suggests changes to funding for Māori communities to better reflect need and be protected from being diverted to broader treatment programmes.

- Ensuring the **system is integrated** and **deliberately plans ahead** with a longer-term focus. There is a lack of structured planning within the system, which the reviewers see as a fundamental flaw. They propose legislating a properly integrated planning system which requires the system to cooperate and plan within an agreed framework.

While there are uncertainties around the future structure of the health and disability system, these themes are consistent with opportunities identified in the palliative care needs assessment that will inform Hospice Waikato's strategic long-term service master planning (SMP) ambitions. This SMP seeks to align with the four themes from the Health and Disability System review.

Previous Strategic Plan

Hospice Waikato's previous Strategic Plan 2016-2021, set out its desired long term outcomes, including the provision of equitable access to palliative care, ensuring all palliative care services and providers are configured as a seamless care pathway and delivering effective services that meet the needs of patient and whanau.

The following intermediate outcomes outline how these long-term outcomes would be achieved.[22]

Table 2: Hospice Existing Intermediate Outcomes

Outcome	Intermediate outcomes
Care	• Specialist community palliative care services are continually developed to meet increasing demand while also addressing changing needs and ways of accessing services. • Access to the complete range of Hospice services and support for Māori is improved. • Access to the complete range of Hospice services and support in rural and other diverse communities is improved. • Access to specialist community palliative care for children, adolescents and young adults is strengthened. • Continuous quality improvement philosophy and related research capabilities are strengthened. • There is continued development of infrastructure to provide seamless, holistic, high quality end of life care.
People	• Hospice Waikato staff and volunteers are equipped to meet current and future needs of our increasingly diverse communities. • Hospice Waikato is a healthy and safe workplace and service. • Hospice Waikato is recognised as an employer of choice. • Hospice Waikato has established partnerships that enable the development of the specialist community palliative care workforce. • Hospice Waikato staff function as a high-performing interdisciplinary team. • Hospice Waikato staff and volunteers are proud of being part of the Hospice Waikato team

22 Hospice Waikato (2016). Strategic Plan 2016-2021. Available from https://www.hospicewaikato.org.nz/file/strategic-plan-201621/open

Outcome	Intermediate outcomes
Partners	• Primary palliative care providers are equipped to provide high quality generalised palliative care. • Hospice Waikato demonstrates an ongoing focus on research, to build a community of excellence. • Hospice Waikato is actively engaged with local iwi. • Hospice Waikato has a high level of engagement with the community. • Hospice Waikato works in collaboration with community health providers, across all cultures. • Hospice Waikato works in partnership and collaboration with the DHB and other health providers to enable seamless palliative care to our community. • Hospice Waikato is the charity of choice for philanthropic giving.
Community	• Promotion of our brand ensures that our diverse community has a high level of awareness as to who we are, what we are about, and how they access our services. • Partnerships are established with iwi to deliver seamless care to Māori. • Sustainable relationships are established that help us to understand the needs of and provide for our rural and diverse community. • There is a culture at Hospice Waikato of being aware and engaged with all cultures and communities. • Hospice Waikato's care is driven by our knowledge and understanding of the diverse communities and cultures of the region
Finances	• Funding is enabling the delivery of high-quality contracted care. • Commercial activities are supplementing Government/DHB funding. • The Hospice Foundation has made progress in building a sustainable generational endowment fund. • Hospice Waikato has established an effective asset management structure. • Hospice Waikato's infrastructure and equipment is meeting and exceeding organisational needs. • An effective risk management strategy is in place. • Business services are provided that reflect best practice principles

Source: Hospice Waikato, 2016

The context and structure for this Service Master Plan

This report aims to provide a strategic plan or blueprint for the future development of Hospice Waikato models of care / services and infrastructure investment, to ensure the sustainability of Hospice Waikato to deliver specialist community palliative care to the people of the Waikato DHB area. It is intended to be directional in nature rather than prescriptive and will be used to inform detailed planning and decision-making.

The report is set out in four parts:

1 An assessment of the needs of the communities Hospice Waikato serves, and how these are forecast to change over time and how well Hospice Waikato is placed to meet these needs now and into the future

2 The strategic outcomes that Hospice Waikato seeks to achieve over time, including how these align with regional and national strategies and how options for this SMP should be assessed

3 The recommended strategic shifts Hospice Waikato will need to implement to deliver on its desired outcomes

4 The steps Hospice Waikato will need to take to implement those shifts.

WHO DOES HOSPICE WAIKATO SERVE?

How are the needs of the community changing?

The Waikato is growing and diversifying rapidly

The Waikato[23] is the third fastest growing region in the country, having grown by 13.5% between the 2013 and 2018 Census. This growth is forecast to continue, with a further 30% increase (137,500 people) expected by 2043.

The population mix is changing too. Over the last 12 years, the ethnic composition of the population has shifted from being close to 90% European in 2006 to around 75% at present. The area has seen an increase in Māori, Pacific peoples, and Asian populations, and this is forecast to continue with the size of the population that is European remaining relatively static.

The Waikato's population is ageing, particularly outside the urban centre

The population over 65 years of age in the Waikato has been growing over the last 12 years by 3.5% each year, higher than the national rate of 3.1%. When considering the last 5 years, this growth is even higher, at 4.2% compared to the national rate of 3.3%. This ageing population trend is forecast to continue. In fact, around half (75,000) of the projected increase in the regional population by 2043 is anticipated in the over 65 age group.

While Hamilton city has the highest proportion of people aged over 65, the growth in this age group over the last 5 years is among the lowest in the region. Other areas, particularly Thames-Coromandel, Waikato, Waipa, Otorohanga and Taupō have experienced growth in the over 65 age group that is close to or above the regional average. This suggests relatively more people are ageing outside of the Waikato's central urban areas, but the significant increase number of older people means demand for palliative care is likely to grow into the future in both rural areas and urban centres.

23 For demographic assessment purposes, we have expanded the Waikato DHB district to include the additional Waikato regional council boundaries of Rotorua and Taupō.

There is significant variation in socio-economic deprivation within the Waikato

The Waikato region does not experience, at the regional level, the highest deprivation [24] in New Zealand but is still amongst the six regions with the most deprivation challenges.

The region has higher than average overall deprivation, with 48.1% of its zones either of the most deprived areas (quintile 4 and 5). The strongest drivers of deprivation in the Waikato Region are education, access, and income. These factors impact palliative care service needs of the individual and their whānau as those living in areas of high socioeconomic deprivation may have fewer resources to cope with health problems and end of life care. For example, they more likely to have access to poor quality drinking-water, live with higher levels of stress, poor quality or overcrowded housing.[25] This potentially impacts Hospice Waikato allocation of psychosocial resources such as social workers and counsellors in addition to home based nursing services.

The least deprived territorial authority is Waipa District and the most deprived is South Waikato District. Significant changes in government social and economic policy, geopolitics and economic cycles are likely to have a factor in the changes over time but the impact of these cannot be forecast.

For Hospice Waikato service planning purposes, the current distribution of socioeconomic deprivation will be assumed. As the Waikato Region is made up of very disparate communities, no two communities have the same mix of drivers and some experience significant deprivation. This variation suggests that Hospice Waikato, together with other palliative care providers, need to consider the different drivers in each locality and how best to target interventions to address the unique needs in each community. This aligns with the developing Waikato District Health Board locality strategic approach.

More young people are expected in the main urban area, with increasingly longer life expectancies for congenital diseases

While the population is forecast to age considerably, the child and youth population aged 0 to 19 years is likely to experience modest growth. This mostly impacts the main urban areas as the working age population increases and young families locate themselves closer to Hamilton city. Notably, in almost all areas outside of Hamilton city, the younger population is forecast to decline. This suggests that demand for paediatric palliative care is more likely to come from the main urban area but with an ongoing need to support children and their whānau in both rural and urban community.

24 New Zealand Deprivation Index (NZDep) ranks small areas across New Zealand from least deprived to most deprived. NZDep can be displayed as deciles. The deciles rank from 1 to 10. NZDep 9 and 10 equate to high deprivation or low socio-economic status. A score of NZDep 1 and 2 is an area of low deprivation and relates to high socio-economic status. NZDep can also be presented as quintiles for ease of display. A NZDep quintile of 5 will contain the areas that are ranked as NZDep 9 and 10. A NZ Dep quintile of 4 will contain the areas that are ranked as NZDep 7 and 8 and so on.

25 McMillan, R. and Exeter, D. (2018). Socioeconomic Deprivation in the Waikato Region. Using the Index of Multiple Deprivation to understand drivers of deprivation. Waikato Plan Discussion Paper, Waikato Plan, Hamilton. Available from https://waikatoplan.co.nz/assets/Waikato-Plan/About-the-plan-/Our-people-files/Waikato-Plan-Waikato-Region-Index-of-Multiple-Deprivation-report-FINAL-3.pdf

As a specific cohort of focus, children are living longer with life-limiting conditions due to advances in technologies and therapies.[26] This will place increased pressure on Hospice Waikato to meet the needs of affected children, young people, their family and whānau over a longer period of time. The current duration of Hospice service support is estimated to be about 50% longer for paediatric patients than for adult.[27]

Shift in epidemiology and an increase in prevalence of comorbidities will create different demands for hospice services

The causes of death are changing, with circulatory disease and chronic conditions (dementia in older people and cystic fibrosis in children) outnumbering cancer as the leading cause of death. As adults and children are living longer with chronic and congenital diseases, and a wider range of conditions are leading to death (e.g. renal failure, respiratory issues, motor neurone disease), high quality palliative care will grow in importance for a wider proportion of the population than is served now. In addition, the duration of time people will receive services will also continue to increase. The under-utilisation of Hospice Waikato services by non-cancer patients (only 21% of its referrals) suggests a significant unmet need for non-cancer patients living with life limiting conditions.

Statistics NZ population projections suggest there will be a significant increase in deaths across the region over the upcoming two decades when compared to the previous two. The Waikato is projected to experience 98,700 deaths between 2018 to 2043 compared to 55,000 between 1996 and 2018. While the absolute number of deaths is projected to increase, the age at which those deaths occur is also likely to increase. National projections suggest the proportion of deaths occurring over age 85 are expected to increase significantly. This means that not only will there be a substantially higher number of deaths in the region, but those deaths are expected to occur at much older ages. This is likely to mean longer time spent in care, and an increase in people with co-morbid conditions as they live longer. This will increase the prevalence of people dying at home and in residential care with chronic health conditions such as dementia, heart, and respiratory diseases.

How well does Hospice Waikato and the wider ecosystem respond to community needs?

Hospice Waikato services are held in high regard, and the challenge is to ensure these are available to all

Feedback from patients, family and whānau shows that Hospice Waikato is viewed extremely positively by those it serves. Hospice paediatric palliative care services (Rainbow Place), when reviewed in 2011, also received overwhelmingly positive feedback from family and whānau in relation

26 McLeod, H. (2016). The Need for Palliative Care in New Zealand. Available from https://tas.health.nz/assets/Health-of-Older-People/Technical-Report-Need-for-Palliative-Care-vF2-June-2016-H-McLeod.pdf

27 Based on a 3-month sample from (Jul-Sep 2019) of Hospice staff contacts(direct ad indirect) recorded in PalCare, data indicated on average for adults and paediatric respectively, 35 day and 55 day duration (time from first to last contact).

to the services it provided and the way in which staff operated. Since that time, services and facilities have evolved to expand the scope of services provided.

There is a need to ensure these services can be experienced by all, with gaps around availability and access to services for:

- **Rural areas** – there were fewer than expected referrals from rural parts of the region in the 12 months to June 2019. Hospice Waikato significantly increased the number of rural home care services (22% increase in referrals between 2017/18 to 2018/19 compared with only a 2% increase in urban home care referrals). Hospice Waikato will need to continue to reduce this rural service inequity in targeted communities, particularly as the population is forecast to age and experience additional socioeconomic challenges in rural compared with urban areas (highest proportion of quintile 5 deprivation areas in the South Waikato, Ruapehu, Hauraki, South Waikato and Waitomo districts)[28]
- **Non-European ethnicities** – Hospice Waikato will need to strengthen its service coverage for underserved communities and cultural responsiveness as the population becomes more ethnically diverse.

Services will also need to consider where different ethnic communities choose to live. A higher proportion of Asian people are expected to live in Hamilton city and surrounding urban areas, while Māori and Pacific peoples are expected to reside more evenly across the region.

Additional gaps in the population have been identified where palliative care services are required, including those in prison and people living rough who are also living with life limiting illnesses and would potentially benefit from specialist community palliative care services.

There are service equity issues

As noted above, the population in the Waikato has grown and is forecast to become increasingly diverse. A comparison of the ethnic profile of the resident DHB population with the Hospice Waikato patient profile in 2018 suggests a roughly similar distribution of Asian, Māori and Pacific patients when compared to the DHB population aged 40 and over.

[28] Waikato DHB Palliative Care Strategic Plan 2016-2021 (Table 3). Available from https://waikatodhb.cwp.govt.nz/assets/Docs/About-Us/Key-Publications/Plans/5625f7ceb7/Waikato-DHB-Palliative-Care-Strategic-Plan-2016-21.pdf

Table 3: Hospice Waikato Ethnic Profile

Ethnicity	Waikato DHB		Hospice Waikato patients
	Full population	Population aged 40 and over	
Pacific Peoples	**5%**	**2%**	**2%**
Asian	**10%**	**6%**	**3%**
Māori	**24%**	**15%**	**16%**
European	**74%**	**80%**	**72%**
Other	**2%**	**2%**	**8%**

Source: Census data, Statistics NZ, Hospice Waikato, 2018[29]

However, access is only one component of health equity and the experience of care matters. There is also a need to ensure that the care provided to Māori, Pacific and Asian communities is **responsive and culturally sensitive.** Hospice Waikato has identified this as a gap in their own analysis. Staff engagement surveys conducted in 2017 identified the need to expand the Hospice's cultural focus to better support the spiritual and cultural needs of more diverse patients. Furthermore, interviews with selected Māori and Pacific providers confirmed that these communities do perceive a cultural responsiveness barrier in accessing services. This is because Hospice Waikato is currently thought of as a place where loved ones are left, which goes against cultural values around caring for family members, making them feel comfortable in the home, and relying on the extended family for care and support.

While care in the home was a priority, selected stakeholder feedback indicated a general openness to receive expert advice and support, provided these are based on established relationships of mutual trust, respect and responsiveness. New models of delivery will also need to be considered to achieve cultural responsiveness, given health and social services more generally are employing a kaupapa Māori approach, that is – by Māori for Māori.

Integration across the ecosystem will be important as more people choose to die in their community

In the broader Waikato palliative care ecosystem, there is limited evidence of integration and clarity of roles across providers. This lack of integration risks fragmented delivery of services and poor transitions between providers, which challenges the provision of a seamless experience of care for patients living with life-limiting illness, and their family and whānau. As more people are forecast to choose to spend their last years of life at home, in aged care facilities and other community settings, there is a need to ensure providers across the system are working together in effective ways to provide a holistic and seamless experience that meets the psychological, social, spiritual, and physical needs of patients and whānau.

29 Annual Report 2017-2018. Available from https://www.hospicewaikato.org.nz/file/annual-report-201718-1/open

This applies equally to adult and paediatric services. High demand (and long respite wait times) for children and young people for in-patient unit beds may suggest an unmet need in paediatric palliative care due to capacity and/or capability constraints, i.e. paediatric palliative care nursing is a specialty area where not all adult nurses would have sufficient experience.

A more integrated and community-based model of care could provide improved support for patients and their family/whānau. As Hospice is a referral-based service with relatively low referrals rates from general practice and community providers, this would require even more Hospice senior staff time and energy for service provider relationship development both in the community and key Waikato DHB services. To be successful, integration needs to be a guiding principle across the palliative care ecosystem.

Sponsor needs

Health currently enjoys around 10% (compared to 15% in Australia) of total donations and bequests. This represents almost $180m annually made to charities in New Zealand and has been a consistent share of total donations with dollar values rising steadily as the total level of giving has grown. [30]

Compared with other countries, New Zealand has a high number of charities per capita of population (lowest population per charity) with the most support coming from many people giving smaller amounts of dollars. This means high competition for local donor funding.[31]

Understanding the needs of current and future sponsors is critical for financial sustainability and to main Hospice Waikato's deep connection to the community it serves. Donated funds constitute 30% of annual revenue (with 70% funding through the Waikato DHB service contract). Over the years, prior to 2019/20, Hospice Waikato's Marketing and Fundraising team has successfully increased fundraising targets year on year. It has developed several iconic and key events in the marketplace, while increasing engagement with the community, brand awareness, new technologies and fundraising platforms.

The Hospice Waikato marketing and fundraising strategies (2020/21) identify significant challenges and opportunities for sustainable charitable funding channels. Revenue sources are broadly from a mix of:

- community fundraising from supporters/clubs and organisations who fundraise on behalf of Hospice Waikato with minimal assistance, e.g. Give a little, quiz nights, head shaves, sporting events and festivals/galas etc.
- major fundraising events, e.g. Chef's Night Out, Schick Golf Day
- Hospice Shops that provide a physical presence across the district and more recently establishment of an online platform
- committed (regular) giving, which provides the most predictable revenues.

30 McLeod, J (2020). The New Zealand Support Report. The current state and significance of giving in New Zealnd and the outlook for recipients. JBWere in collaboration with Philanthropy New Zealand, February 2020. Available from https://philanthropy.org.nz/wp-content/uploads/2016/03/jbwere-nz-support-report-digital.pdf

31 McLeod, J (2017). The New Zealand Cause Report. Shape of the Charity Sector. JBWere, March 2017. Available from: https://www.jbwere.co.nz/media/41bhoesn/the-jbwere-nz-cause-report.pdf

Lessons from Covid-19 and strategic advice from CCS Fundraising consultants highlight the importance of communication and relationships with donors. The importance of understanding donor and supporter needs, communications and engagements is a focus of the 2020/21 strategies.

Informal discussions with existing long-term supporters of Hospice Waikato highlighted the importance of localised community involvement, unique distinguishable community linkages and commitment to involving whānau and families. This is reflected in the free services provided, presence close to where people live (home care service, Hospice Shops and volunteers) and stories that have local meaning to communities, whānau and families across the Waikato. It matters that Hospice Waikato is distinguished from the role of other charities, e.g. the Cancer Society, and the full suite of Hospice Waikato services, and by its unique geographical differentiation.

How could this change?

The ongoing economic impacts of the recent Covid-19 pandemic further drive the importance of diversified charitable funding streams that leverage technologies and grow successful channels. This means building on the established Hospice Waikato brands (including Rainbow Place and Hospice Shops), growing communications with major sponsors and supporters and an increased focus to regular giving approaches.

A survey of sponsors is planned later in 2020 that will focus on their needs and will inform ongoing marketing and fundraising strategies.

The immediate and longer-term impacts of COVID-19

It is difficult to underestimate the impact that COVID-19 and the Government response to the pandemic has had on communities, industries, and the nation as a whole.

Immediate impacts and response

Every aspect of Hospice Waikato's service experienced immense disruption during the nationwide lockdown, with the following key developments and insights to come out of the 3-month period from 26 March when the lockdown began:

- Greater collaboration and information sharing with the Waikato DHB, including the opportunity to provide education to nurses at Anglesea Hospital
- There were persistent issues with connectivity between the Waikato DHB IT system and the community that was a barrier to communication
- Significant financial impacts that were cushioned by the Government wage subsidy and rent relief from landlords
- Strong investment in IT over the past three years made it much easier to move staff off-site and maintain connectivity with patients, families, other providers, and each other
- A much higher workload for community nursing with patients preferring to be cared for at home due to stringent visiting restrictions at hospital and in the Hospice Inpatient Unit
- A much greater use of virtual consults across community nursing, family, and paediatric services, although this has to be counterbalanced with the limitations of rural wi-fi accessibility
- Staff were quick to adapt to the changing environment, keeping the wellbeing of patients and their families front of mind.

Longer term impacts

Over the medium to longer term, Hospice Waikato will need to be agile to respond to the ambiguity and uncertainty that is likely to characterise the economic and social environment post-COVID-19. This includes:

- the risk of further outbreaks
- financial challenges, including increased competition for charitable donations, reduced financial contributions from long-time supporters and reduced income from traditional fundraising activities
- a constrained fiscal environment for health funding, notwithstanding the funding likely to be required to respond to the findings of the Health and Disability system review
- reduced net migration (by both New Zealand and overseas residents) and the potential changes to the make-up of the communities served.

WHAT OUTCOMES DOES HOSPICE WAIKATO SEEK TO ACHIEVE?

Hospice Waikato strategic outcomes

The following strategic outcomes have been developed with members of the Hospice Waikato executive and board.

These outcomes have been developed using the Te Whare Tapa Whā model for understanding the Māori view of health and wellness, developed by Mason Durie in 1982. This model is also consistent with Hospice Waikato's commitment to reducing health inequity and recognises the principles, rights, and interests of iwi/Māori under Te Tiriti o Waitangi.

Figure 6: SMP Strategic Outcomes

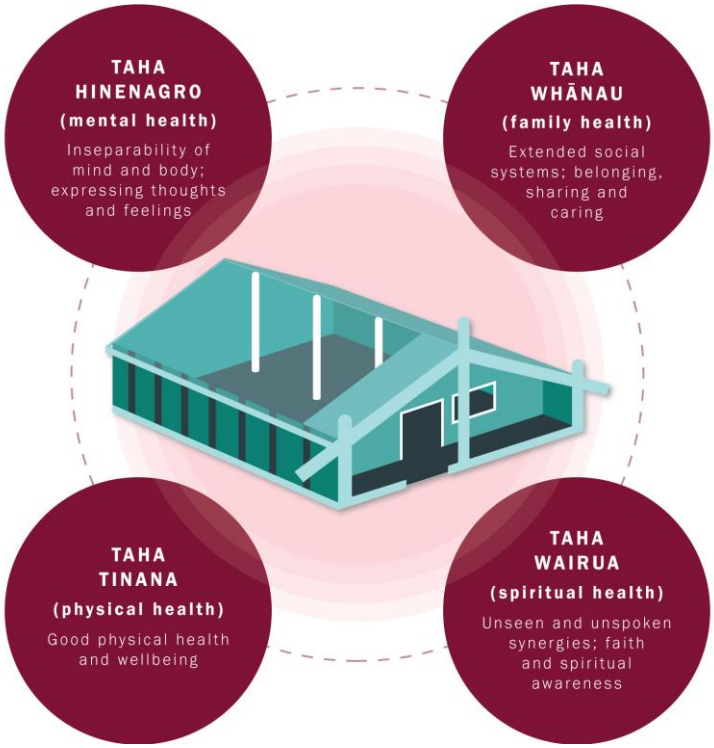
	**Long term outcomes (20 years)**	**Medium term outcomes/design principles (5-10 years)**	**National hospice standard alignment[32]**
Te taha whānau (Social Wellbeing)	Provide equitable culturally responsive care within a whānau /family social system	• All population groups are served • Service delivery is culturally responsive • Services delivered are informed by the patient and family/whānau needs within a wider social system and community network	Standard 1: Assessment of needs Standard 3: Providing the care Standard 4: Supporting and caring for the family, whānau and carers Standard 9: Staff qualifications and training
Te taha wairua (Spiritual Wellbeing)	Support care practices that meet the needs of a culturally and spiritually diverse community	• Cultural and spiritual needs are understood, and services are accessible across language, culture and geography	Standard 1: Assessment of needs Standard 3: Providing the care Standard 9: Staff qualifications and training
Te taha hinengaro (Mental Wellbeing)	Support the design and delivery of care that enables patient and whānau preferences	• Service mix and location is responsive to patient and family/whānau preferences	Standard 1: Assessment of needs Standard 3: Providing the care Standard 6: Grief support and bereavement care Standard 9: Staff qualifications and training

32 Note that Standards 2 (developing the care plan) and 5 (transitions between services) apply across all four strategic outcomes.

	**Long term outcomes** **(20 years)**	**Medium term outcomes/design principles** **(5-10 years)**	**National hospice standard alignment[32]**
Te taha tinana **(Physical Wellbeing)**	Provide quality clinical care within a holistic and inter-disciplinary approach to support changing patient and whānau preferences	• Advance Care Plans and palliative care referrals occur as early as is possible • Specialist palliative care scope of clinical practice supports seamless transitions of care • Patient and whānau care decision are supported by flexible delivery and funding	Standard 1: Assessment of needs Standard 3: Providing the care Standard 7: Culture of the organisation Standard 8: Quality improvement and research Standard 9: Staff qualifications and training

Figure 6 outlines the four dimensions of this model: taha wairua (spiritual health), taha hinengaro (mental health), taha tinana (physical health) and taha whānau (family health)[33]. Different parts of a wharenui (meeting house) represent each dimension (see Figure 6). Together, all four are necessary and in balance, represent 'best health'. Each taha is also intertwined with the other.

Figure 7: Te Whare Tapa Whā model of health



33 Summary available via Ministry of Health at https://www.health.govt.nz/system/files/documents/pages/maori_health_model_tewhare.pdf

Te Whare Tapa Whā can be applied to any health issue (physical, spiritual, psychological or connections with family) affecting Māori. It is an influential model for describing concepts of health and wellbeing from a Māori perspective that has been endorsed as a guiding framework by the Ministry of Health and the wider palliative care professional community.[34] It is also well aligned with Pacific health and wellbeing principle that *'Pacific families are 'ola manuia' mentally, spiritually, culturally and socially.'*[35]

Hospice Waikato stakeholders widely endorsed the continued relevance of this framework.

The Hospice Waikato Māori Health Plan (2019-2020) outlines goals aligned to the Te Whare Tapa Whā model of care, which include:

- improving the quality of ethnicity data
- improved and equitable access
- timely and coordinated care
- meeting the cultural and spiritual needs of patients and their whānau
- ensuring Hospice Waikato's employees, volunteer body and board are reflective and responsive to the needs of Māori.

Advancing the Te Whare Tapa Whā model aligns with national and Hospice NZ expectations

Two of the four proposed New Zealand Health and Disability System change themes strongly align with this Māori world view model for health, i.e:

- Ensuring consumers, whānau and communities are at the heart of the system (personalised services)
- Creating a system that works more effectively for Māori (partnership and whānau-centred).

It also underpins the long-established holistic care philosophy of the hospice movement internationally and enshrined in the Hospice New Zealand standards (refer Hospice New Zealand Standards). By nature, these long-term outcomes are interrelated and are unlikely to be successful with silo strategic approaches. An integrated SMP approach that acknowledges the relative contribution of change activities towards these long-term outcomes is recommended.

Strategic alignment

Hospice Waikato operates within a broader health and social system with complex relationships across services and settings that impact patient and whānau experience and quality of care. It matters that this SMP clarifies where and how Hospice Waikato long term services developments fit

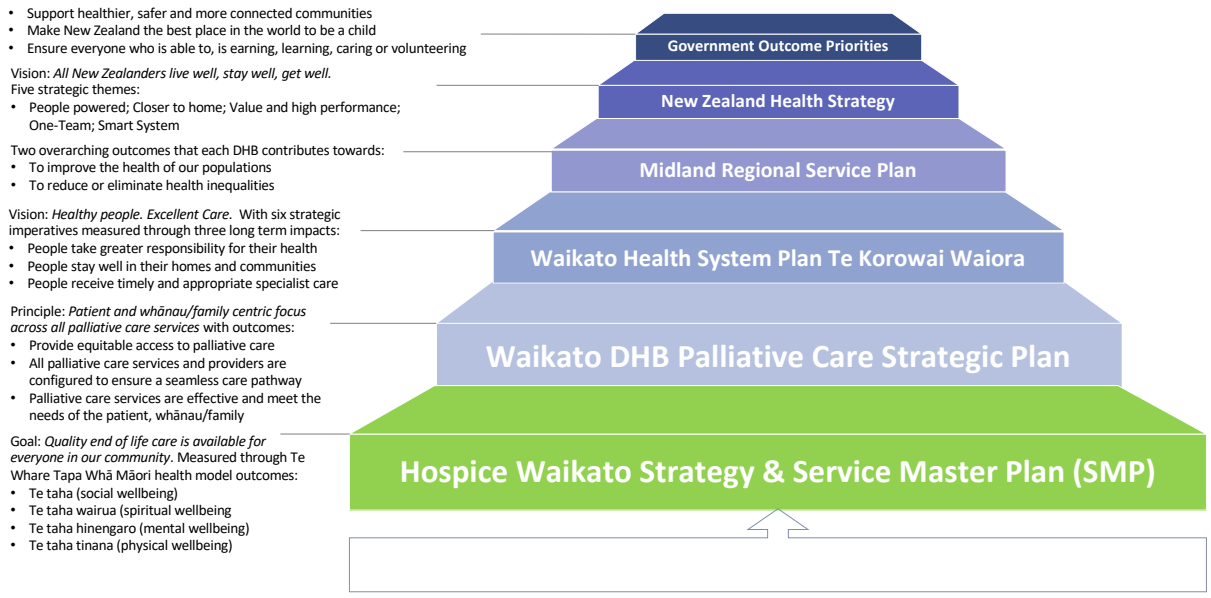
34 Ministry of Health (2017). Te Ārā Whakapiri: Principles and guidance for the last days of life (Second edition) Wellington, Ministry of Health

35 Ministry of Health (2020). 'Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025. Wellington: Ministry of Health. Available from https://www.health.govt.nz/system/files/documents/publications/ola_manuia-phwap-22june.pdf

within this system to leverage (not duplicate) available resources and enable a seamless palliative care journey for patient, carers and whānau where and when they need it.

Strategic line of sight for Hospice Waikato extends through local, regional, and national levels within a foundational set of service standards and guided by the philosophy of holistic hospice care. This is summarised in the diagram below and further detail provided in the section on Government priorities.

Figure 8: Hospice Waikato strategic alignment



The most direct strategic alignment for the Hospice Waikato SMP is with the Waikato DHB health system plan and palliative care strategy. The long-term impacts outlined in the Waikato DHB statutory planning and performance system[36] and related strategies are used to evaluate the effectiveness and quality of the services the DHB funds and provides.

Hospice Waikato contributes to the Waikato DHB long term impact related to specialist care for people with end-stage (life-limiting) conditions where *'…it is important that they and their families are supported, so that the person can live comfortably, have their needs met and die without undue pain and suffering.'* The current Waikato DHB Palliative Care Strategic Plan (2016-2021)[37] long term outcomes (equitable access, seamless care pathway and meeting whānau/family needs) may change when the strategy is updated in 2021. This was under review at the time of SMP development.

36 Waikato District Health Board 2019/20 Statement Of Performance Expectation. Available from https://www.waikatodhb.health.nz/assets/Docs/About-Us/Key-Publications/Plans/Waikato-DHB-Annual-Plan-2019-20.pdf

37 Available from https://waikatodhb.cwp.govt.nz/assets/Docs/About-Us/Key-Publications/Plans/5625f7ceb7/Waikato-DHB-Palliative-Care-Strategic-Plan-2016-21.pdf

Strategic assessment

The SMP long term outcomes have been integrated into the following assessment criteria to support decisions around service development priorities. These criteria have similarities with the critical success factors the New Zealand Treasury recommends for business case analysis. The business case framework is a widely accepted tool for investment decision-making for assets and/or service delivery including in the health sector.

Assessment Criteria	Perspective	Hospice NZ Standards & Health Sector Priorities Alignment (indicative only and not exhaustive)
Success factors		
Strategic fit Alignment with strategic objectives and the broader objectives of other health system and community partners, funders, and forecast demand.	Population (District)	• Meets forecast demand across the system • Enhanced capability of primary and community health care
	Health Sector (National)	• Meets forecast demand across the system • Grows a population-based approach • Improving health equity outcomes • More effective relationships with Māori • Better palliative care system integration • Longer term planning focus
	Funders (District)	• Meets strategic objectives of the Waikato DHB and Hospice Waikato Foundation • Meets community donor needs and expectations
Capacity and capability Ability to deliver services to support patients and their family/whanau including in partnership with others	Organisation (Hospice Waikato)	• Cultural responsiveness • Safe and efficient transitions of care (Std 5) • Access to grief support and bereavement care (Std 6) • Person-centred palliative & end of life organisation culture (Std 7) • Quality improvement and research (Std 8) • Staff & volunteers competent & qualified (Std 9)
	Individual (patient & whānau/carer)	• Comprehensive holistic person-centred, assessment (Std 1) & Care Plan (Std 2) • Care provided meets person's preferences (Std 3) • Care provided meets person's family, whānau and carers' needs (Std 4)
Potential affordability How well the service can be met from likely available funding and matches other funding constraints	Organisation (Hospice Waikato)	• Financial viability

Assessment Criteria	Perspective	Hospice NZ Standards & Health Sector Priorities Alignment (indicative only and not exhaustive)
Potential achievability How well the service responds to the changes required and is able to access the skills and capability required	Population (District)	• Service coverage across populations and geography • Collaborative working/productive linkages with service providers and care settings (working in partnership)

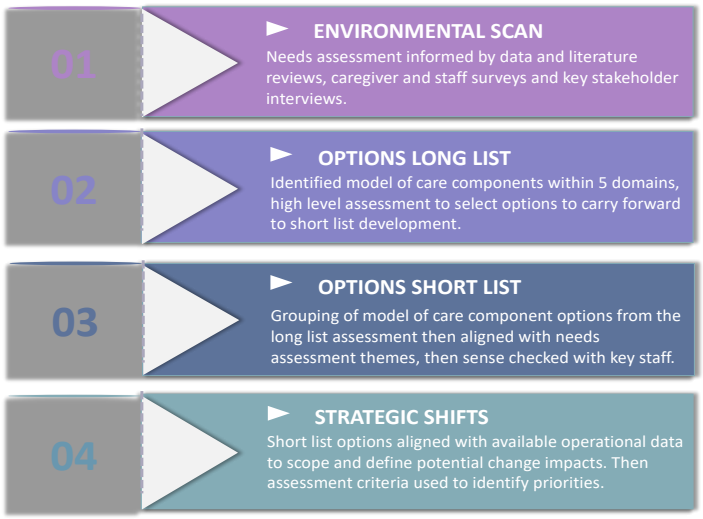
Assessment Criteria	Perspective	Hospice NZ Standards & Health Sector Priorities Alignment (indicative only and not exhaustive)
SMP Long Term Outcomes		
1. Provide equitable **culturally responsive** care within a whānau/family social system		
2. Support care practices that meet the needs of a culturally and **spiritually** diverse community		
3. Support the design and delivery of care that enables patient and **whanau preferences**		
4. Provide **quality clinical care** within a holistic and inter-disciplinary approach to support changing patient and whānau preferences		

WHAT ARE THE STRATEGIC SHIFTS HOSPICE WAIKATO NEEDS TO MAKE?

Options and strategic shift development approach

To define recommended strategic shifts for Hospice Waikato, we undertook a four-step process as outlined below.

Figure 9: Four step process



Key domains

In order to identify the strategic choices Hospice Waikato faces as part of the development of its Service Master Plan, we have sought to define the key drivers of value highlighted in the palliative care needs assessment and published literature (Appendix 5 provides a summary of published palliative care studies and reviews).

This has led us to develop a set of key strategic questions related to various components of care (aspects of future service delivery) below. A summary of long list options considered against each domain is outlined below to highlight the range of potential strategic considerations for Hospice Waikato.

Table 4: Summary of long list options

Domain	Critical questions	High level outline of long list options identified
Scope	What geographic reach should Hospice Waikato have?	• Hospice alignment within or beyond Waikato DHB district boundaries
	Which communities should Hospice Waikato serve?	• Population health options related to community reach, i.e. those underserved or excluded currently
	What ages and health conditions should Hospice Waikato provide care for?	• Population health options related to service access inequities for specific patient groups services now
Solution	What should Hospice Waikato's core services be?	• Options related to the mix of services, i.e. targeting services for enhanced capability and/or capacity across all age groups
	Where should services be located?	• Consideration of expanded scope of current care settings and new opportunities, e.g. other community provider locations for outreach services
	What is the right balance/focus of direct and indirect services?	• Options that consider the focus of Hospice services within the broader palliative care ecosystem and relationship with other providers.
	What changes are required to people and culture?	• Workforce (employed and volunteer) and role development options as the most critical enabler of service delivery
	What changes are required to other enablers?	• Internal and external enabler options that would contribute to improved outcomes.
Delivery	What role should Hospice Waikato and other providers play in delivering services?	• Options for how (lead or supporting role) and where Hospice could take a with other providers and organisations.
Implementation	What are the timeframes for implementation?	• Integrated planning approaches that optimise alignment with short to longer term strategic directions (1-20 years)
Funding	What funding sources are available?	• Opportunities within and outside existing funding and revenue streams

A more detailed long list options description and high-level assessment of outcomes is provided in Appendix 2 and Appendix 3.

Key considerations

The following key considerations have influenced development and assessment of the strategic options. These are important to the scope of the potential options considered and the practical realities of Hospice Waikato's scope of influence within a complex health and disability system.

Table 5: Key consideration impacting SMP

Consideration	1. Hospice is a philosophy of care – not a building	2. Broader system of care and social support influences strategic choices	3. System wide provider performance accountabilities, capacity and capability is unclear	4. Hospice will always require public health funding for financial sustainability
	Hospices provide care for the whole person, not just their physical needs but also their emotional, spiritual, and social needs consistent with Te Whare Tapa Whā. They also care for families and friends, both before and after a death.	Delivery of holistic specialist community palliative care services is inherently impacted by the structure, capacity, capability and policies of the broader public and private health and disability services.	The national service specifications are limited to adult specialist palliative care with inconsistent overlap with more general personal and home care services.	Hospice Waikato's current service contract with the Waikato DHB expires in Sep 2022. This contract has fixed monthly funding linked to available national service specifications for specialist palliative care (MoH, 2015).
Implications for the Service Master Plan	A holistic model of care is an assumed framework across all service settings and workforces. Hospice Waikato must sustain a longstanding presence and linkages in the community as a community health provider and with benefactors.	Strategic decisions will acknowledge realistic limitations to Hospice Waikato strategic priorities while committing to identification of aspirational options that require a larger or whole of system response to change.	Hospice Waikato working with the Waikato DHB to clarify system-wide provider responsibilities at a whole of system level and how this flows onto support services access. Improving outcomes will require whole of system changes which may slow the pace of change.	This impacts the scope of Hospice Waikato service volume change over the contract period, unless there is a mutually agreed contract variation. This potentially constrains model of care changes that require significant workforce investment without agreed contract variations and/or uplift in charitable funding.

Recommended strategic shifts

The identified strategic shifts represent potential focus areas for major change for Hospice Waikato. These reflect a broad spectrum ranging from minimal change to existing form and function (base case) through to ambitious options that require significant, potentially transformative changes highlighted in the palliative care needs assessment. Refer to Appendix 5 for a summary of published literature themes in relation to palliative care challenges and opportunities to improve. Available best practice literature and available operational data (e.g. service coverage, referrals patterns, sample service contact data) were considered as we refined and tested the short list options with key Hospice Waikato staff.

While these are presented as a set of potential strategic shifts, they are not mutually exclusive and are in many cases overlapping and complementary to one another. Overlapping components largely relate to population coverage across different community groups (e.g. frail older people with chronic health problems) that Hospice Waikato serves and enablers of service delivery (e.g. cultural responsiveness).

Further detail contrasting the shifts is provided in Appendix 3.

Table 6: Summary of Strategic Shifts

Ref.	Strategic Shift	High level description
-	Base Case 	Enhanced status quo. Focus on maximising use of available resources and infrastructure (Hospice Anywhere) to optimise outcomes, e.g. paediatric respite waiting times, and other operational efficiencies. Consideration of commitment to establishing key roles to lead strategic change that supports multiple shifts and leverages regional resources. Critical developments include Māori leadership, provider relationships and change management capabilities.
1	Reduce rural service inequities 	Rural residents do not receive the same scope of Hospice services than those living in urban areas[38] and requires positive provider relationships to reduce inequities. [39] Focus on the scope of services (esp. Family Services) rather than volumes as referrals (proxy for coverage) in rural areas in 2018/19 is c. 46% of estimated rural and 36% of Greater Hamilton deaths. Difficult to accurately scope need for Family Services, but increased scope of social work and counselling services has been included in this shift to better support those living in the most deprived areas - generally in rural Waikato and high Māori populations. • Preliminary estimate to increase by 1.6FTE social worker and counsellor resources assigned to rural teams to support people in their homes supported by more formal volunteer support roles. • Estimated 32% (860) increase in Family Services contacts compared to the base case.
2	Grow cultural responsiveness 	Recognises the person-centred Hospice model of care was developed based on a western worldview and this needs to be adapted to better meet the perspectives, values, and needs of Māori[40] and an increasingly diverse population. [41] Focus on increasing Māori, Pacific and Asian service access and experience of care through working in partnership, workforce diversity, Māori leadership, cultural competency training, cultural advice (vacant Kaiāwhina role in 2020), health literacy and cultural appropriateness review of published Hospice information and minor facilities refurbishment. • Results in small increase in referrals (c. 65 people or 5% increase compared to the base case) and of these, assume two thirds might benefit from home care support. • Additional 0.4 FTE kaiāwhina to grow cultural competency • Expanded cultural competency training to include e-CALD[42] (this is free to DHB contracted providers) Working with community Māori, Pacific, and Asian providers to grow workforce diversity and cultural responsiveness. Opportunity for sharing of knowledge, community networks and community-based volunteer support.

38 Landers A, Dawson D, Doolan-Noble F. (2018). Evaluating a model of delivering specialist palliative care services in rural New Zealand. J Prim Health Care. 2018;10(2):125–131. doi:10.1071/HC18004 (Abstract only)

39 Thiel V, Sonola L, Goodwin N, Kodner DL. (2013). Midhurst Macmillan Community Specialist Palliative Care Service Delivering end-of-life care in the community. The King's Fund. 2013 (Funded by Aetna and the Aetna Foundation)

40 Moeke-Maxwell T, Waimarie Nikora L, Te Awekotuku N. (2014). End-Of-Life Care And Mäori Whänau Resilience. Mai Journal, Vol 3 (Issue 4): 140-152

41 Frey, R., Gott, M., Raphael, D., Black, S., Teleo-Hope, L., Lee, H., & Wang, Z. (2013). 'Where do I go from here'? A cultural perspective on challenges to the use of hospice services. Health & social care in the community, 21(5), 519–529. https://doi.org/10.1111/hsc.12038

42 Culturally and Linguistically Diverse. Further information on e-learning resources is available from https://www.ecald.com

Ref.	Strategic Shift	High level description
3	Rebalance holistic care and extend community reach 	Effective holistic care engages not only with patients and whānau alone, but with the broader community as well. There is growing evidence that a more 'compassionate community' will better support community outcomes[43] and health system sustainability. Focus on reaching new communities of people living rough and offenders. Small numbers perhaps less than 30 referrals (c.2% increase compared to the base case) but would require DHB and Department of Corrections support for intersectoral engagement and model of care development. A more comprehensive increase in holistic services that further expands social worker and counselling alongside spiritual care and other therapies for those people already referred to Hospice. The focus is on increasing the scope of holistic services offered for those referred to Hospice. Opportunity for community-based volunteer support of people with limited social networks as part of a system-wide 'Compassionate Communities' strategy. • Preliminary estimate to increase by 1.25 FTE for social work, 1.25 FTE counselling and 2 FTEs for other therapies • New 0.5 FTE co-ordinator role to support the 'Compassionate Communities' strategy to support those with limited social networks. • Estimated 83% (2,194) increase in Family Services contacts compared to the base case
4	Reduce inequities for people dying with chronic health problems 	Earlier engagement[44] (home and team based) of palliative care support for people with life-limiting chronic health conditions can significantly improve quality of life but requires strong relationships with general practice as the lead health providers.[45] In reality this is a significant change in Waikato DHB (hospital) and GP referral practice and there will be financial implications for primary care without specific funding streams to support expanded service coverage. If fully implemented, this shift results in an estimated 56% (681 people) increase in base case Hospice referrals and 18% (209 people) increase in consultation services. Potentially requires 3- 5 years to increase to these numbers. Most impacts will be on indirect advice for primary care (SMO/CNS), Hospice, education, and Home Care services. • Preliminary estimates suggest 2.2 FTE increase will be required for advice and education support for primary care (Hospice SMO/CNS), Home Care nursing and Family Services. • Hospice IPU impact may be relatively small as the significant majority of care is typically home or residential care facility based. Potential increase to home equipment needs (number and strength the cater for unhealthy weight earlier in the disease trajectory) related to increasing age, mobility and frailty problems associated with chronic conditions. Opportunity for community-based volunteer support of people with limited social networks as part of a system-wide 'Compassionate Communities' strategy.

43 Abel J, Sallnow L, Murray S, Kerin M. Each Community is Prepared to Help: Community Development in End of Life Care – Guidance on Ambition Six. The National Council for Palliative Care, 2016

44 Gardiner, C., Ingleton, C., Gott, M. et al. Exploring the transition from curative care to palliative care: a systematic review of the literature. BMJ Supportive and Palliative Care 2015; 5 (4). 335 - 342. ISSN 2045-435

45 De Vleminck A, Pardon K, Beernaert K, et al. Barriers to advance care planning in cancer, heart failure and dementia patients: a focus group study on general practitioners' views and experiences. PLoS One. 2014;9(1):e84905. Published 2014 Jan 21. doi:10.1371/journal.pone.0084905

Ref.	Strategic Shift	High level description
5	Grow paediatric palliative services and extend community reach 	An early joined up approach[46] to paediatric palliative care for children with life-threatening conditions and their families enhances the provision of holistic care. Community based teams are well positioned to support this.[47] This shift focuses on expanding population coverage (from 33% to 68% of deaths 0-19 years), the scope of services to include perinatal palliative care and expanded Hospice respite support included in the base case model. Care duration is typically longer than needed for adults and results in higher population coverage needs due to overlapping years of existing and new patients. Increase collaborative team working with the DHB neonatal and paediatric teams in hospital and home settings. As almost half of deaths under 1 year of age are Māori, expanded service access coverage for this group requires attention to cultural responsiveness. • This shift results in 97% increase in respite bed days to Hospice IPU based respite and related paediatric palliative care nursing support. • Greatest impact on home and respite support with 43% (9) more children and young people for home care support and estimated 12 babies for new perinatal support. • In total, this is a 100% increase in referrals for the paediatric service. Long term opportunity (15-10 years) for a standalone Paediatric facility a model of care, i.e. better outcomes for children separated from adult services with paediatric trained staff, rather than capacity driver.
6	More age attuned palliative care 	The population is living longer and dying later in life creating both service demand pressures and requiring alternative models of care. Best practice indicates the need for integrated approaches (rather than silo approaches) to palliative care services engaging with aged residential care facilities and the wider health system.[48] Focus on increasing Hospice referrals for people dying with (not from) dementia and frailty with: • an estimated 66% increase (812 people) in base case Hospice referrals, and • potentially 21% (increase (236 people) requiring consultation support. To be successful, this shift requires a change in Aged Residential Care and GP referral practices. Resource impacts mostly related to will be on Aged Residential Care liaison (CNS), medical advice to GPs, home care team relationships/ education with general practice and Family Services support for families. Negligible IPU impact as support is largely Aged Residential Care based, assuming current Hospice IPU configuration (not suitable for advanced dementia care). Potential increase to home equipment needs for home cares. Opportunity for community-based volunteer support of people with limited social networks as part of a system-wide 'Compassionate Communities' strategy.

These recommended strategic shifts represent significant change for Hospice Waikato and require heightened integration with service providers across the district to realise outcome benefits for patients and their whānau.

[46] A Guide to Children's Palliative Care (Fourth Edition), 2017. Together for Short Lives, England. Accessible online from: https://www.togetherforshortlives.org.uk/wp-content/uploads/2018/03/TfSL-A-Guide-to-Children's-Palliative-Care-Fourth-Edition-5.pdf

47 Kaye EC, Rubenstein J, Levine D, Baker JN, Dabbs D, Friebert SE. Pediatric palliative care in the community. CA Cancer J Clin. 2015;65(4):316–333. doi:10.3322/caac.21280

48 Smets T, Onwuteaka-Philipsen BBD, Miranda R, et al. (2018). Integrating palliative care in long-term care facilities across Europe (PACE): protocol of a cluster randomized controlled trial of the 'PACE Steps to Success' intervention in seven countries. BMC Palliat Care. 2018;17(1):47. Published 2018 Mar 12. doi:10.1186/s12904-018-0297-1

Recognising the need to be **aspirational and pragmatic** in terms of achievability, each strategic shift was assessed against criteria including Hospice Waikato Board endorsed long term Te Whare Tapa Whā long term outcomes.

Assessment against long term outcomes

Assessment results highlight the need for a **combination of strategic shifts** to achieve these long-term ambitions. In addition, the scale of population (number of people) potentially impacted will vary considerably between strategic shifts, e.g. approximately 22 paediatric patients each year for one shift compared with potentially 209 adults a year to increase service coverage for people dying with chronic health problems. These factors were considered against the SMP success factors for strategic change.

Further, as the general practitioner is the lead community health provider, advanced Hospice **engagement with general practice** to enhance referrals is critical to the strategic shifts most significantly associated with service access inequities. Most changes are amenable to phased implementation with pilot or proof of concept approaches advisable where development of provider relationships is essential to achieving the outcomes sought.

Table 7: Strategic shift assessment results

SMP LONG-TERM OUTCOMES

STRATEGIC SHIFTS	Assessment criteria →	1. Provide equitable culturally responsive care within a whānau/family social system.	2. Support care practices that meet the needs of a culturally and spiritually diverse community.	3. Support the design and delivery of care that enables patient and whānau needs.	4. Provide quality clinical care within a holistic and inter-disciplinary approach to support changing patient and whānau preferences.
1	Rural care	PARTIAL	PARTIAL	OPTIMAL	PARTIAL
2	Cultural care	OPTIMAL	OPTIMAL	PARTIAL	PARTIAL
3	Holistic care	PARTIAL	OPTIMAL	OPTIMAL	PARTIAL
4	Chronic care	PARTIAL	PARTIAL	PARTIAL	OPTIMAL
5	Paediatric care	PARTIAL	NEGLIGIBLE	OPTIMAL	PARTIAL
6	Aged care	NEGLIGIBLE	PARTIAL	PARTIAL	OPTIMAL

SMP SUCCESS FACTORS

STRATEGIC SHIFTS	Assessment criteria →	**Strategic fit** How well the service aligns with strategic objectives, broader objective of other health systems, community partners and forecasts.	**Capacity and capability** How well the service can be delivered to support patients and whānau, including in partnership with others.	**Potential affordability** How well the service can be met from likely available funding and within other funding constraints.	**Potential achievability** How well the service responds to changes and is able to access required skills and capability.	**Success factor ranking**
1	Rural care	●●●	●●●	●●●	●●●	2
2	Cultural care	●●●●	●●●	●●●●	●●●	1
3	Holistic care	●	●●●	●●	●●●	5
4	Chronic care	●●●●	●	●	●●	6
5	Paediatric care	●●	●●●	●●	●●●●	3
6	Aged care	●●●	●●	●●●	●●	4

INDICATIVE ASSESSMENT OUTCOME

STRATEGIC SHIFTS		Key advantages	Key disadvantages	Conclusions
1	Rural care	• Extends existing model of care.	• Funding reliance on donations.	• Focus on rural areas of high deprivation.
2	Cultural care	• Te Tiriti and national priority.	• Internal cultural change for success.	• Organisation wide change to reduce inequities.
3	Holistic care	• Meets community expectations.	• Funding reliance on donations.	• Builds on rural access - focus of shift 1.
4	Chronic care	• Reduces access inequity.	• Highly primary care dependent.	• High value but complex provider model.
5	Paediatric care	• Whānau focused improvements.	• Super specialty workforce needs.	• Initial respite access then pilot perinatal model.
6	Aged care	• Focus on indirect support.	• Aged residential care variability.	• Amendable to pilot model approach to test feasibility.

Potential implications of the recommended strategic shifts

The shifts outlined above will have implications for demand for services as more patients are referred to and receive care from Hospice Waikato. It will also have implications for where Hospice Waikato's services are located, as its geographic reach changes over time.

Demand for services

The identification of potential strategic directions for Hospice Waikato was significantly informed by a palliative care needs assessment, published literature and available Hospice utilisation data. Scoping the impacts of service master plan strategic options was based on two key service need references:

- End of Life Care Trajectory study based on 2015 mortality and related reports undertaken by Atkinson and McLeod (2019)[49]
- Assessment of Palliative Care Need by Cancer Control New Zealand (2011)[50].

The trajectory study identified the scope of unmet demand for specialist palliative care services that encompassed services in all settings from the hospital to community facilities and private homes. A related report[51] explored potential impacts for different care settings and providers of specialist palliative care based on a model of care that remained **unchanged** from that studied in 2015. This provides an excellent baseline scenario and assumptions of the setting of care impacts, i.e. hospice in the home compared with aged residential care and hospital settings.

Further informed by the insights and experience of key stakeholder interviewed, these data and information were used to estimate preliminary service and resource demand impacts for each identified strategic shift that aim to address different groups of unmet specialist palliative care need.

These should be considered indicative for strategic direction purposes, as patient cohort data was constructed from available information where the data was incomplete.

Waikato specific mortality data is important as it differs from the national average

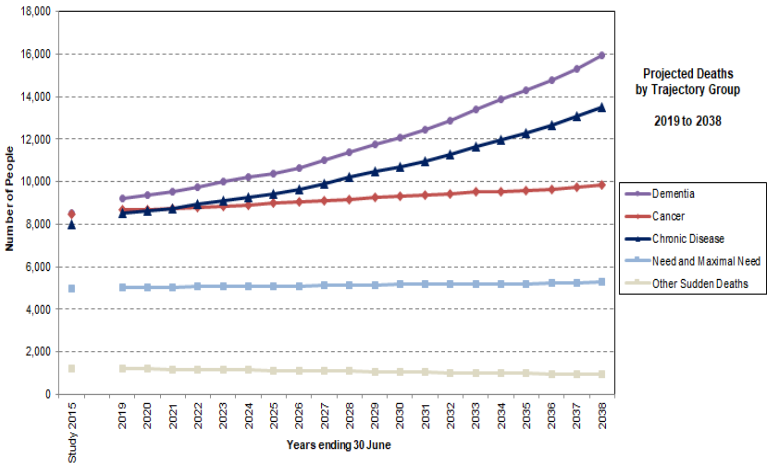
A key difference between the forecast national and Waikato district death profile relates the relatively high proportion of people dying with cancer in the Waikato (31% in 2016) compared to the national average of 26.6% (McLeod and Atkinson 2019).

49 McLeod, H., & Atkinson, J. (2019). Policy Brief on Trajectories of Care at the End of Life in New Zealand. Available from https://www.interrai.co.nz/assets/News/Presentations/Research/e2ecf0fb35/Policy-Brief-on-Trajectories-of-Care-at-the-End-of-Life-in-New-Zealand-vF.pdf

50 Naylor, W (2011). National Health Needs Assessment for Palliative Care. Phase 1 Report: Assessment of Palliative Care Need, Cancer Control New Zealand, Wellington. Available from https://www.health.govt.nz/system/files/documents/publications/national-health-needs-assessment-for-palliative-care-jun11.pdf

51 McLeod, Heather & Atkinson, June. (2019). Policy Brief on Place of Care and Time in the Community at the End of Life in New Zealand. 10.13140/RG.2.2.36166.22082. Available from https://www.researchgate.net/publication/335405036

Figure 10: Projected Deaths by Trajectory Group



From a projection's perspective, adopting national mortality trends without adjustment for Waikato specific data will significantly underestimate the current number of deaths related to cancer.

Palliative care value drivers of strategic change

These data informed development of six recommended strategic shifts for short to longer term planning purposes. The table below highlights the associated with one or more value drivers and related implementation issues or challenges of each strategic shift.

Table 8: Drivers of Strategic Change

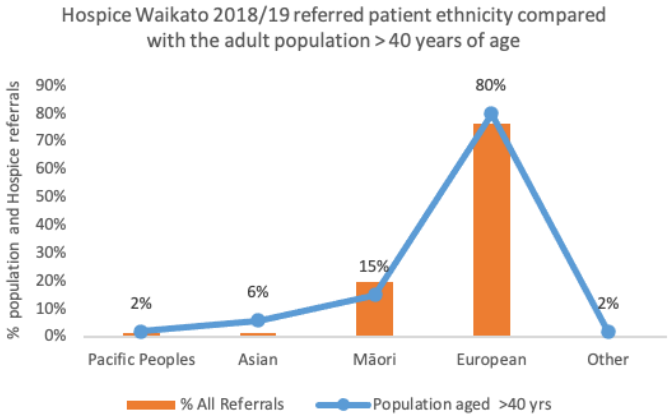
Strategic Shift	Value Driver: Access equity	Value Driver: Experience equity	Value Driver: Service efficiency	Key Challenge	Potential timeframe
0. Base case			●●	Budget allocations	Short term
1. Rural services	●●	●●	●	Holistic services not fully funded under DHB contract	Short to medium term
2: Cultural responsiveness	●	●●●	●●	Investing in provider relationships	Short term and ongoing
3. Holistic care	●●	●●	●	Holistic services not fully funded under DHB contract	Medium to longer term
4. Chronic care	●●●	●●	●	Growing primary care relationships and clinical complexity requiring robust DHB services engagement	Medium to longer term
5. Paediatric care	●●	●●●	●	Growing paediatric nursing capabilities and (new) highly specialist perinatal service	Short to medium term
6. Age attuned care	●●●	●●	●	Variability of ARC facility nurse ratios, skills mix and growing GP relationships	Medium to longer term

Population health equity drivers of strategic change

Communities of different ethnicity

Equity of health outcomes and service access across communities of different ethnicity is a national, regional, and local priority. For Hospice, people aged over 40 years are the appropriate comparator group. The graph below highlights **service access inequities** for Asian and Pacific peoples.

Figure 11: Referrals by Ethnicity



In addition, the combined Māori, Asian and Pacific communities represent almost a quarter of the population with significant growth forecast for Asian communities.

Service access and **experience of care** are the drivers of the *Cultural Responsiveness* strategic shift to uplift Asian and Pacific referrals and grow organisation wide Māori, Pacific and CALD cultural responsiveness.

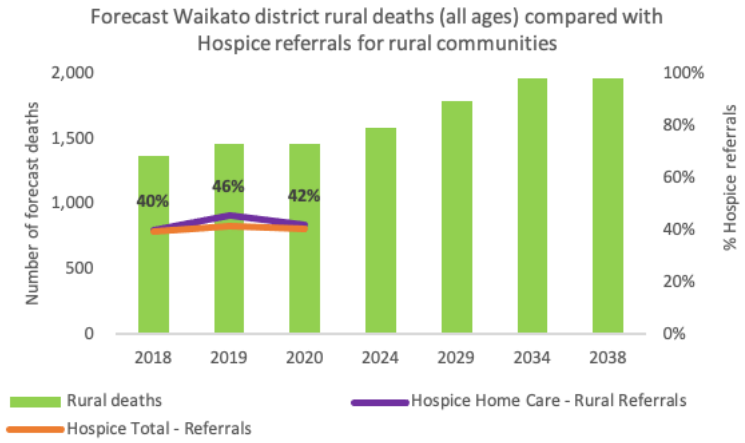
Rural communities

One of Waikato DHB strategic priorities is to *'Eliminate health inequities for people in rural communities*. The graph below highlights Hospice Waikato rural home care service referrals are similar, and in 2019 slightly higher, than the overall referrals rates.

The focus for Hospice Waikato relates to inequity of rural whānau access to the complete suite of Hospice services, notably **Family Services** which was a concern expressed by for Hospice Waikato staff interviewed.

Service access and experience of care (convenience and increased access) are the drivers of the *Rural Inequities* strategic shift to improve Hospice Waikato Family Services. More equitable access is focused on providing better psychosocial support for people living in rural areas of high socioeconomic deprivation.

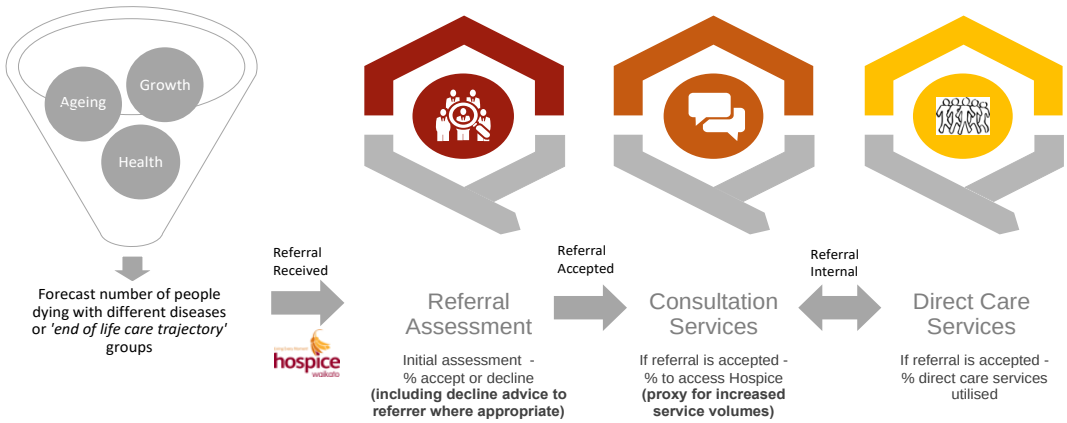
Figure 12: Forecast Rural Deaths



Translating population changes into service demand impacts

The high-level Hospice Waikato referral process flow outlined in the figure below underpins the 'funnel' assumptions for service demand, i.e. proportion of the population that are referred for specialist palliative care, accepted for consultation and/or direct Hospice Waikato services.

Figure 13: Hospice Waikato Referral Process Flow



The proportion of those referred for specialist palliative care (including Hospice) are the key differences between the national end of life trajectory study (McLeod & Atkinson 2019) and actual referral patterns. Notably, relatively high cancer referrals compared to those for people with chronic health problems and dementia.

Adult specialist palliative care services

Indicative change to adult service demand without a planned change in the model

Broad order projections based on McLeod & Atkinson (2019) national projections of increased deaths of end of life trajectory groups (2019-2038) has been applied to indicative Waikato DHB district deaths. The majority (77%) of Hospice Waikato services are currently utilised by people dying with cancer which will be impacted by the increasing proportion of the population dying with chronic diseases and dementia.

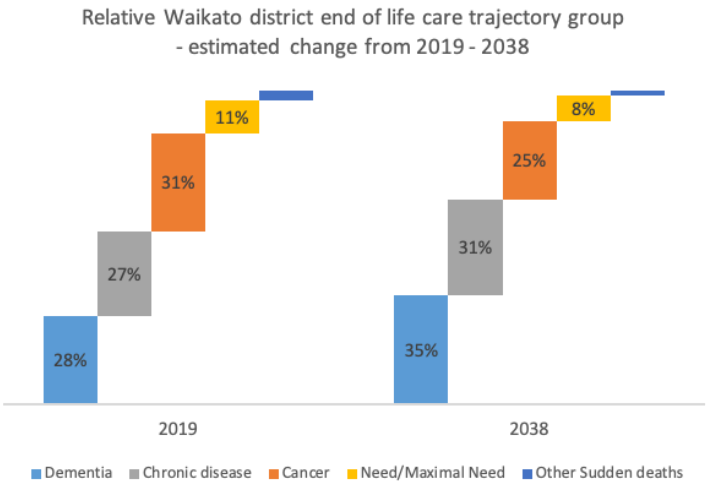
To retain the population health principle, Hospice Waikato needs to consider how best to **balance service coverage for non-cancer populations.**

People dying with chronic diseases most impacts hospice home care, as national estimates that Hospice home care demand (without change in care model) will increase by 126% from 2019-2018.

Dementia care demand increases most impacts aged residential care as on average, only 32% of time is spent at home in the last year of life.

The strategic consideration for Hospice Waikato is growing relationships with general practice and aged residential care facilities.

Figure 14: Relative Waikato District End of Life Care Trajectories



Assumptions were defined across possible referral process scenarios for each strategic shift

Without detailed time and motion data for Hospice Waikato staff and related resources, five scenarios were defined to test the potential resource impacts, outcome benefits and risks with increased Hospice Waikato capacity and capability. Current resource utilisation was estimated based on a 3-

month (Jul-Sep 2019) Hospice Waikato contacts data extract segmented by:

- adult and paediatric service, then
- disease group (end of life trajectory groups defined in the 2015 national study), then
- hospice discipline (nursing, family services, medical[52] and volunteer.

The following assumptions were compared and applied to the relevant strategic shift population groups, notably forecast number of people dying with chronic diseases and dementia. As the population **dying with cancer are well served currently**, scenarios assumed nil change to the population coverage (only annual population growth) for this group.

Recognising the lack of national service specifications for levels of specialist palliative care services across community care settings, the following table outlines the range of scenarios to test a range of potential strategic shift impacts for each end of life care trajectory group.

ADULTS	BASE CASE (est. num) [53]	LOW SCENARIO (Naylor 2011)			HIGH SCENARIO (Adapted Naylor & McLeod)			NATIONAL STUDY SCENARIO (McLeod 2019)[54]		
% Assumptions	Consult & Direct	Assess	Consult	Direct	Assess	Consult	Direct	Assess	Consult*	Direct**
Dementia	11	50%	30%	10%	100%	30%	10%	100%	30%	10%
Cancer	871	90%	70%	20%	100%	90%	20%	100%	90%	20%
Chronic disease	204	50%	30%	10%	100%	50%	10%	100%	65%	10%
Need/ Maximal	45	50%	30%	10%	65%	30%	10%	65%	65%	10%
Other Sudden deaths	0	0% (not appropriate for specialist palliative care across all scenarios)								
Total	**1,131**									

The lack of detailed Hospice Waikato service utilisation data for this planning process does not enable a useful comparison of 'direct care impacts'. The following scenario assessment therefore focused on the 'consult' estimates as a proxy for the volume of referrals that are accepted by Hospice Waikato.

52 Advice from Hospice Waikato leadership that the medical contacts data is inconsistently recorded therefore appropriate to use these data to assess medical resource impacts

53 Actual rate of declining referrals is on average 7% that is very different from recommended rates from published literature (see low, high and national study scenarios above). Therefore, estimated base case numbers for referrals accepted by Hospice (for consultation and/or direct services) with forecast growth based on McLeod & Atkinson forecast of hospice home care service demand growth 2019 – 2038.

54 Consultation percentages for the national study scenario is based on estimated proportion within each group living in the community in their last year of life (McLeod & Atkinson, 2019). No specific recommendations or data was included regarding direct services therefore the Naylor (2011) rates were used.

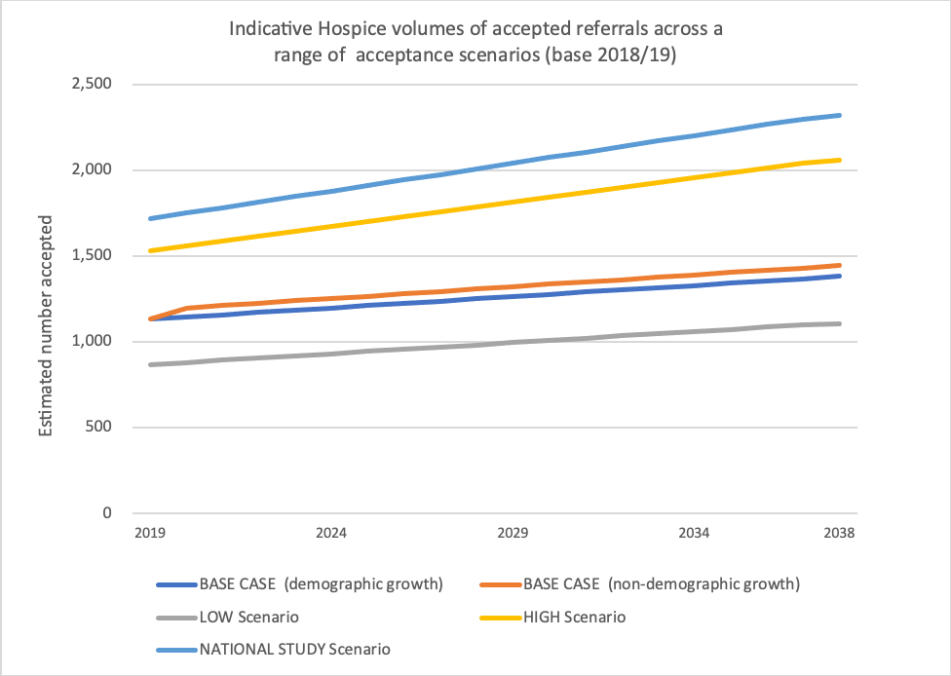
Estimated referrals receipt and acceptance scenario differences

Estimating the range of scenario impacts compared with the base case service volumes and working assumption that **'consultation' volumes are a proxy for accepted referrals.** This provides only as indicative assess the impact on direct service resources.

There is no national guidance for referral acceptance rates in specialist palliative care. As a result, the management of referrals is likely influenced by local referral criteria, referrer knowledge and relationship with service providers and availability of local hospital and community resources.

Based on available published recommendations, a number of referrals management scenarios were assessed. The following graph contrasts the relative impacts across the scenario assumptions.

Figure 15: Scenarios of Indicative Hospice Volumes of Accepted Referrals



By testing these scenarios, the following key differences are relevant for Hospice Waikato consideration given the scale of difference between published recommendations and current referral management processes.

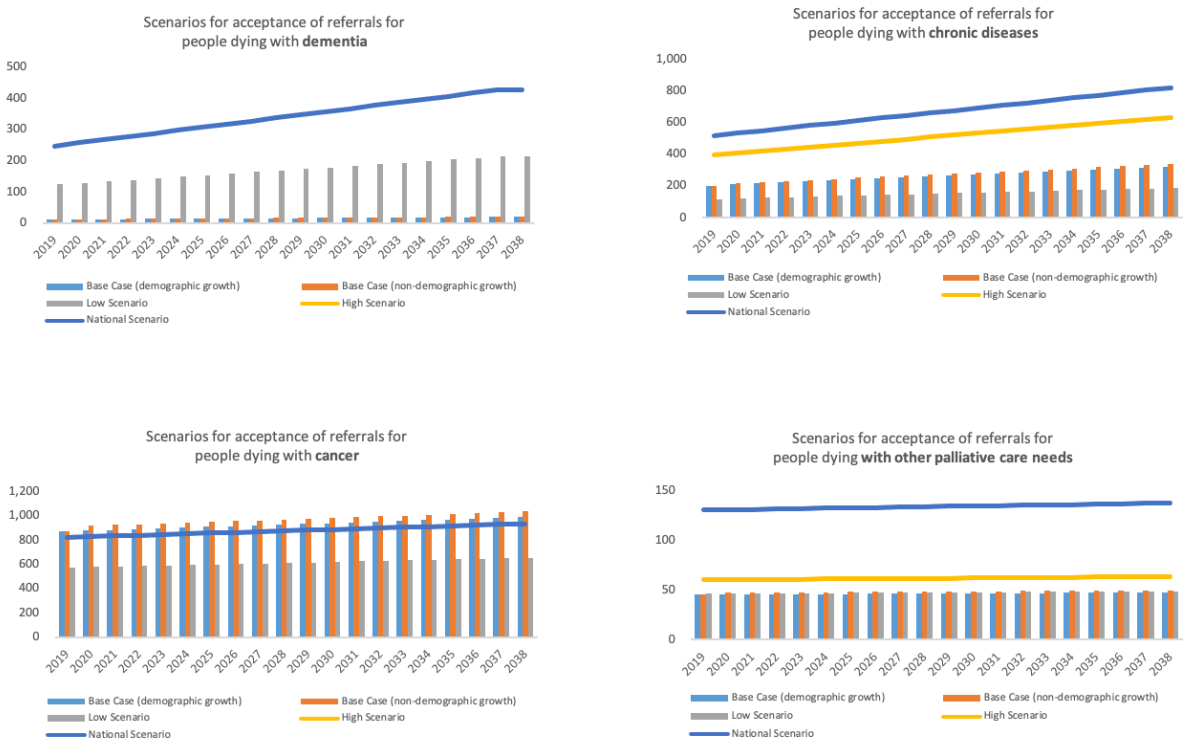
- without changing the service delivery, there is potentially a 4.6% difference between demographic growth based projected deaths (0.9% pa) and the average of 5.5% per annum growth that Hospice Waikato has experienced in the last 5 years
- the current Hospice referral decline rate varies but averages at 7% of referrals received

- all strategic shifts involve increasing the number of referrals to meet better address unmet demand and inequities and will significantly increase the decline rate if the published recommendations of referral acceptance (from assessment to consultation)
- this could be viewed negatively by referrers unless there is an increased focus/resources to provide a robust process of supportive feedback for referrers.

Scenarios potentially have varying impacts for people dying with difference health conditions

When we disaggregated these scenarios by the four end of life trajectory groups there were major scenario differences compared with the base case.

Figure 16: System Demand Scenarios



The graphs above highlight the following potential change management considerations should Hospice Waikato seek to influence referrer practices and progress different referral management processes.

- **Dementia care** - the potential magnitude of service change (10-20 fold increase) means it would be prudent to take a collaborative planning with aged residential care and general practice providers with a focus on advice and education support. A proof of concept or pilot process would be beneficial to assess the value and potential scalability of where and how Hospice Waikato services can add the greatest value and are affordable.

- **Chronic diseases** – scenarios result in a 2 - 2.5 fold increase in the number of accepted referrals. This could mean increased engagement and support of general practice teams at the time of advance care planning (CNS, medical advice). As the national end of life care study indicates suggest 65% will spend their last year of life in the community (home or home with hospice care), this will likely increase Hospice Waikato home care support. In addition, patients with advanced respiratory and circulatory diseases may have complicated home care needs. Unhealthy weight is a predisposing condition for many chronic diseases, therefore an increased need for larger home-based equipment and other supports should be considered.
- **Cancer care** – is the group best served by Hospice Waikato services currently with very high referral rates (> 90% of estimated deaths in 2019). Caring for these patients remains important across all scenarios but become a decreasing proportion of the population dying each year and is estimated that by 2030 is surpassed by dementia and chronic disease.

The following table outlines which end of life trajectory groups are most impacted by the strategic shifts with a **high scenario** for the respective **adult populations** served.

Table 9: Impact on End of Life Trajectory Groups

Strategic Shift	Population targeted	Hospice service most impacted	Est. high scenario growth
0. Base case	No change	Leadership capability focus Annual increase in home care service demand	Current referral base Demographic growth 0.9% pa but current rate (on-demographic) is 5.5%[55] pa
1. Rural services	Serving the same number of referred patients and whānau differently Focus on rural areas of high socioeconomic deprivation	Increased family services (social workers, counsellors)	Current referral base + Family services contacts 32% increase
2: Cultural responsiveness	Māori, Asian, Pacific peoples (est. 65 additional referrals to establish equitable ethnic group coverage)	Staff education, cultural support Hospice Waikato Home Care and Family services to absorb within budgets	Referrals received 5% increase Referrals accepted 4% increase
3. Holistic care	Largely serving the same number of referred patients and whānau differently Focus on district wide areas of high socioeconomic deprivation and those with psychosocial needs	Family services (complete range of disciplines)	Referrals received 2% increase Referrals accepted 3% increase Family services contacts 83% increase
4. Chronic care	People dying with chronic and other palliative care need (not cancer, dementia or sudden deaths)	Home Care Services Some IPU service impact (but lower utilisation compared with cancer care)	Referrals received 56% increase Referrals accepted 18% increase

[55] Based on Hospice 5-year average service volumes increase (2014-2019). This is considered a non-demographic forecast assumption as it is higher than the current mortality rate increases of 0.9% pa

Strategic Shift	Population targeted	Hospice service most impacted	Est. high scenario growth
6. Age attuned care	People dying with dementia	Aged Residential Care liaison, education and general practice advice Negligible IPU service impact	Referrals received 66% increase Referrals accepted 21% increase

Strategic shifts 4 and 6 are particularly sensitive to referrals criteria and related management assumptions. We tested potential impacts on accepted referrals using the national study recommendations. This scenario would further increase the **estimated number of accepted** referrals for chronic care referrals accepted from 18% (constructed high scenario) to 35% (national scenario).

Consideration of resources to manage increased referral assessment and decline rates

If successful, strategic shifts 4 and 6 would significantly increase the number of referrals received – requiring inter-disciplinary assessment and communication back to the referrer. There was no data for the review to scope the potential resource impacts but would be important to consider as part of detailed business case development, i.e. the high scenario estimates:

- strategic shift 4 chronic care potential 56% increase
- strategic shift 6 aged care potential 66% increase.

Paediatric specialist palliative care services

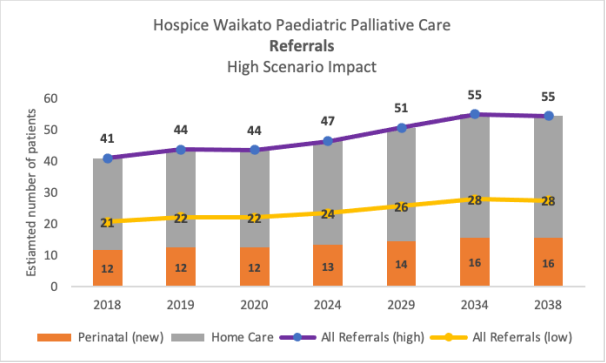
The relatively small number of deaths each year (est. 64 in 2019) for those aged 0-19 years of age is important from a population health perspective and less complicated to forecast service change than for adults.

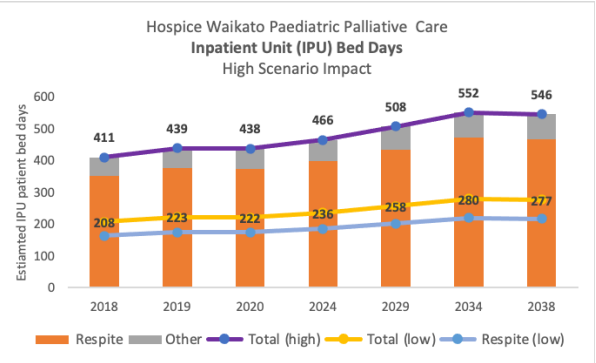
Although there is low growth forecast for this group, there is unmet specialist palliative care need related to the **scope of services** available and increasing **duration and complexity** of home-based care for families.

Actual Waikato DHB deaths in this age group were sourced from a related trajectories of paediatric and congenital deaths data set.[56] These assumptions and actual Hospice Waikato IPU utilisation data were used to estimate a high and low service change scenarios for strategic shift 5 that aims to 'grow paediatric palliative services and extend community reach'. Greatest impact on home and respite support.

[56] Atkinson (2018). Trajectories of Paediatric and Congenital Deaths in New Zealand; based on 2015 Mortality and Trajectory data.

Figure 17: Impact on Paediatric Care





The high scenario assumes new Hospice Waikato referrals to provide perinatal palliative care to **expand population coverage**. This expands the established collaborative team relationship with the DHB paediatric teams to neonatal services in hospital with a focus home settings. The new perinatal service involves an estimated 12 babies a year that die within the first 1-2 days of birth and doubles the total number of referrals overall to extend community reach. As almost half of deaths under 1 year of age are Māori, expanded service access coverage for this group requires attention **to cultural responsiveness.**

The IPU high scenario tested the increased capacity for inpatient respite support as that was a strong area of need from parents interviewed as part of the SMP consultation process. The scenario **doubles the respite access** (bed days) per referred patient to the Hospice Waikato IPU.

This could be managed with increased IPU resourcing **2 beds for paediatric patients**. There is existing physical bed capacity within the IPU to accommodate this change and requires a review of the nursing skills mix and capabilities to support this change.

Long term opportunity (15-10 years) for a standalone paediatric facility a model of care rather than capacity driver.

Consideration of Family Services demand

Over a 3-month sample of 50 paediatric patients (3 with cancer and 47 with non-cancer conditions), Family Services provided on average over 210 minutes of time per patient and their whānau.

In this sample, a there was a significantly higher average resource time to support cancer care. However, this is a very small sample and highly influenced by individual case variation.

Figure 18: Paediatric Resource Demand and Contacts by Discipline

For chronic care, there was a similar resource commitment across counsellors, social workers, and music therapies. Spiritual care services were infrequently utilised (2 chronic care patients only in the sample data provided). Together with counsellors, spiritual care demand may increase if a perinatal palliative care service is developed.

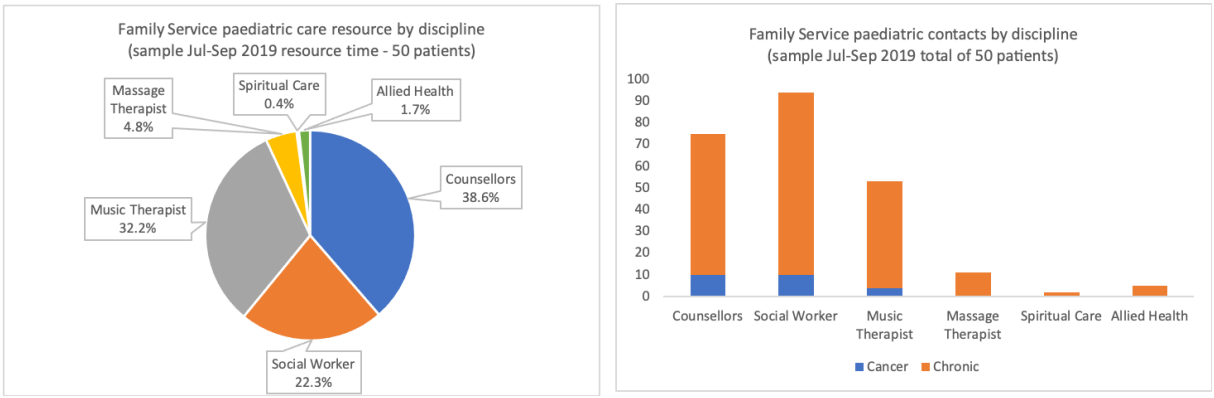
Potential strategic shift impacts on the Hospice Inpatient Unit

Resourced bed occupancy of the Hospice Inpatient Unit (IPU) has been reducing since 2018 with seasonal variations over December and average occupancy of 66% (range 49% - 81%). Currently, the IPU has 11 physical beds and is resourced for 10 adult beds and 1 paediatric bed that is open 4 days a week (Tuesday – Friday).

This low overall use of IPU by palliative care patients (4% of contacts recorded in PalCare) is not unique to Hospice Waikato - national average of 10% in their last year of life access Hospice inpatient beds. McLeod and Atkinson forecast no increase in IPU capacity if the current model of care remains. This is consistent with preliminary scenario testing as part of this SMP development.

However, the IPU remains an important service for Hospice Waikato for symptom control (73%), end of life (14%) and respite care (11%). The median length of stay is trending downwards but due to the small size of the unit, average length of stay of almost 10 days varies from month to month.[57]

Paediatric use of the IPU is different to adults, with a lower average length of stay (4 days) and predominant use for respite (79%) than symptom control (19%). The limited resourced bed days for



children and young people means there is an inequitable waiting time compared to adults. This was a key area for improvement identified by the parents engaged as part of the SMP consultation process.

[57] Hospice Waikato 2018/19 utilisation data and graphs kindly provided by W.Naylor, August 2020

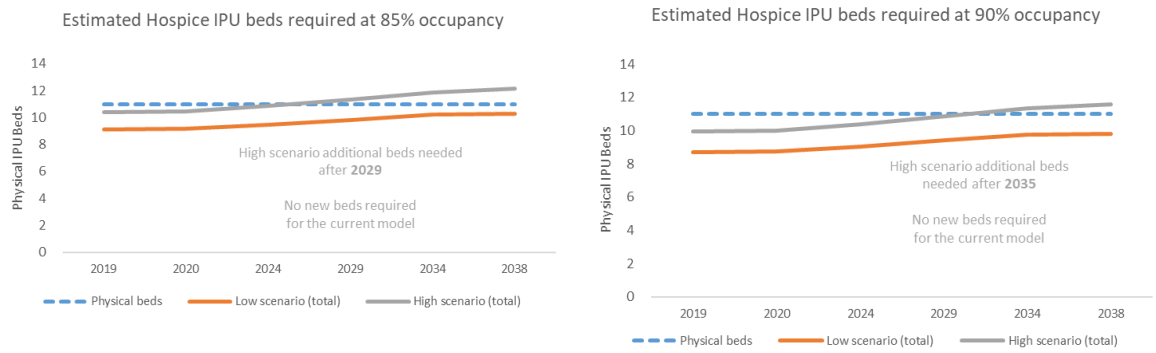
Preliminary estimates of IPU beds needed

Forecasting potential IPU beds requires consideration of a number of factors, notably:

- population growth and changing health needs in their last year of life
- individual patient and family preferences and expectations
- IPU referrer practices, knowledge and expectations of Hospice services
- staff admission and discharge processes impacting the average length of stay
- target occupancy rates that allow management of peak admission periods, i.e. an 85% occupancy provides more spare capacity to manage bed turnover than a 90% occupancy (the planned nature of non-acute admissions means higher occupancy rates are appropriate).

The following graphs highlight the high and low scenario demand pressures on total IPU beds.

Figure 19: Inpatient Unit High and Low Demand Scenarios



Key high scenario differences

The high scenario includes doubling paediatric access to respite days as the majority use of paediatric IPU beds. For adults, this scenario includes a small increase in the average length of stay for cancer care (the majority of patients) compared to the national average (9.5 and 9.2 days respectively) and significantly longer stay for chronic care (high scenario 4 days and low is 1.1 days), but is a much smaller group.

The 11-bed unit has physical capacity to enable an increase to 2 resourced paediatric beds for the next 20 years if there is no increase in adult patient average length of stay or additional chronic care patients in both 85 % and 90% occupancy models.

Assuming all models enable increased paediatric respite as a key area of unmet need for whānau, the pressure for new beds will occur with increased adult length of stay with:

- an 85% occupancy by 2029
- an 90% occupancy after 2035

Identified challenges for the IPU

These relate to admission decisions by medical staff in IPU, minimal after-hours admissions, declining respite requests and nurse-initiated admissions that has potentially led to community nurses not considering admission to IPU. Further, respite admissions very minimal and senior leader advice is that Hospice should be operating 2 beds for respite.

With the growing complexity of patient medical conditions, there is a need to consider how acuity and related care needs are effectively identified and managed.

These are issues that would be further explored and included in the change management process as part of implementation.

Potential financial impacts

Summary of the potential financial impacts

To understand the financial implications of the shifts, we have estimated the order of magnitude for the costs of each shift over 10 years. We have then compared the costs of each shift against the enhanced status quo to highlight the impact of the changes over time. Table 10 and Figure 20 and **Error! Reference source not found.** compare the financial impact of each shift over the 10-year period. The impact on cost is tied to the additional FTEs required in each scenario. Strategic shift 3 has the most additional resources and therefore is the most expensive, as illustrated in Figure 20 and **Error! Reference source not found.**. Shift 4 requires the second greatest financial investment. Shift 5 has no significant impact. The tables in Appendix 6 provide more detail of the estimated financial impact of each shift by year.

Figure 20: Strategic shifts - additional operating expenses in comparison to the enhanced status quo

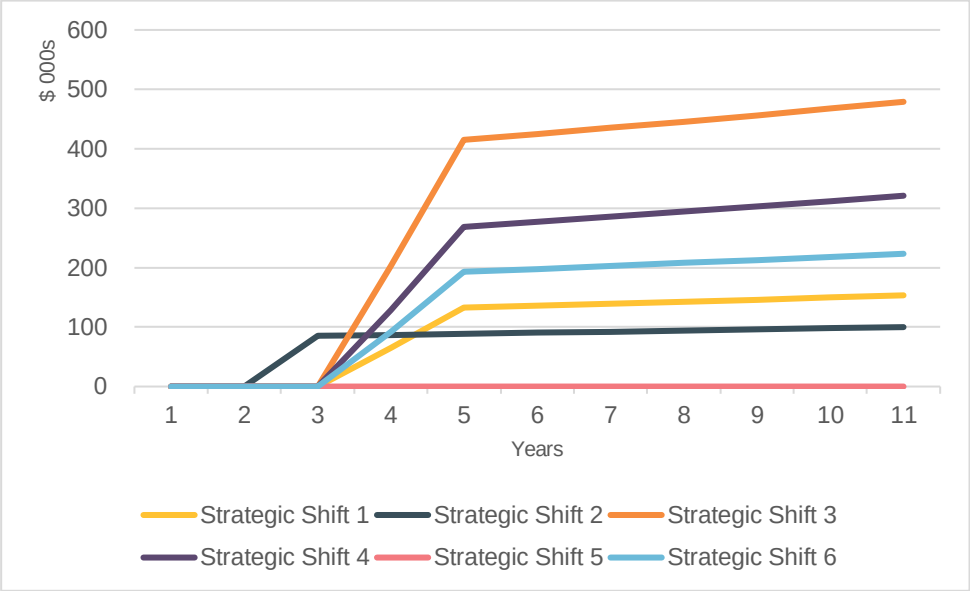


Table 10: Assumptions, FTEs and key risks

	Assumption	FTEs	Key Risks
Enhanced Status Quo	Revenue • DHB base contract revenue increases by 2% pa • Hospice shops income increases by 2% pa • Fundraising and donation revenue increases by 10% until it reaches 2018/19 levels and then increases by 2% Expenses • Nursing and Family Service wages increase by 10.5% on 1 July 2021 • Wages for all clinical roles increase by 2.5% • Wages for non-clinical roles increase by 2% pa • General expenses increase by 2% pa • Required vacant roles have been included in the 2020/21 budget Other • Year 0, the base year is the actual financial performance in the 2019/20 financial year	1 FTE • Strategic relationship/change leader starting 1 July 2021	Revenue • DHB reduces base contract funding • The post COVID-19 economic environment reduces funding and donation revenue or the recovery in these revenue streams is slower than forecast Expenses • Family services wages need a substantial jolt to retain and attract staff • Further increases are needed for nurses to retain and attract staff • Medical wages need further increases to retain and attract staff
Strategic Shift 1	All enhanced status quo assumptions	1.6 FTE starting from 1 January 2023 • Social worker -1.0 FTEs • Counsellor - 0.6 FTEs	• Family service wage increases are more than 2.5% pa due to industrial outcomes across the state sector (social work/mental health) • More resources are required to support the shift
Strategic Shift 2	All enhanced status quo assumptions plus: • Additional opex of $50,000 pa from 1 July 2021 for cultural advisory services • Minor capex of $50k pa for three years starting from 1 July 2021. This capex is for building improvements, so asset increases and depreciation impacts the Foundation, not the Trust. The Foundation is assumed to fund this capex.	An additional 0.4 of an FTE for the mana āwhina resource from 1 July 2021.	• Additional resources are not enough to meet the needs of all cultural groups using Hospice Waikato's services

	Assumption	FTEs	Key Risks
Strategic Shift 3	All enhanced status quo assumptions plus: • Other non-wage family service expenses increase from 2022/23. They increase to be 15% of wage and ACC costs (% based on historic and budgeted ratio).	5 additional FTEs from 1 January 2023: • Social worker - 1.25 FTEs • Counsellor – 1.25 FTEs • Other therapies – 2 FTEs • Compassionate communities co-ordinator – 0.5 FTEs	• Additional resources are not enough to meet the needs of the extended community. • Family service wage increases are more than 2.5% per annum.
Strategic Shift 4	All enhanced status quo assumptions plus: • Other non-wage community nursing expenses increase from 2022/23. They increase to be 22% of wage and ACC costs (% based on historic and budgeted ratio adjusted for wage jolt). • Minor capex of $25k pa to fund additional in-home equipment from 1 July 2022. The Foundation is assumed to fund this capex.	2.2 additional FTEs from 1 January 2023: • Nurse Specialist – 1.0 FTEs • Medical SMO – 0.2 FTEs • Social Worker – 1.0 FTEs Note that the Social Worker FTE resource could be shared allocated amongst the Family Services team where needed most (eg 0.5 of an FTE for a Social Worker and 0.5 of an FTE for a Counsellor)	• Additional FTEs are not enough to meet the increased volume of referrals
Strategic Shift 5	All enhanced status quo assumptions. Our preliminary analysis suggests that this shift will have no significant financial impacts as changes can be absorbed by reallocating and optimising existing resources.		• The change in staff mix to support increased paediatric palliative services increases costs
Strategic Shift 6	All enhanced status quo assumptions plus: Other non-wage community nursing expenses increase from 2022/23. They increase to be 22% of wage and ACC costs (% based on historic and budgeted ratio adjusted for wage jolt).	1.2 additional FTEs from 1 January 2023: • ARC Nurse Liaison – 1.0 FTEs Medical SMO – 0.2 FTEs	• Potential for increased home equipment investment

Enhanced Status Quo

The base year for the Enhanced Status Quo option is Hospice Waikato's 2020/21 forecast statement of financial performance. Table 10 summarises the key assumptions used in modelling this scenario. The biggest impact on costs is the assumed 10.5% pay increase to nursing[58] staff that we have modelled from 1 July 2021.[59]

Assumptions to revenue growth can also make a significant impact on the overall profit/deficit position. We have taken a conservative position on revenue modelling, as the longer-term impact of COVID-19 is unknown. We note that the budgeted increase in Hospice Shop income for the 2020/21 year is 28% greater than in 2019/20. It is unlikely that growth can continue at this level over the next 10 years. We therefore assumed a more conservative 2% per annum increase.

As highlighted in Table 10, the Enhanced Status Quo has only one additional FTE in comparison to the status quo. This is the addition of 1 FTE in a Strategic Relationship/Change Leader role to support strategic shifts and leverage regional resources. We have assumed that there are no significant financial impacts from optimising available resources and infrastructure. The Enhanced Status Quo option forecasts a deficit of $840,000 in 2022/23 which we would expect to be the subject of a negotiation with Waikato DHB regarding long term sustainable funding arrangements.

There are a number of risks to the potential financial impacts forecast for the enhanced status quo options (and consequently for the forecasts for all other shifts). The key risks are captured in Table 10. Base contracted income is a significant risk. We have assumed that this income increases by 2% per annum, but the actual amount received will depend on the DHB's strategic priorities and available funding. Staff costs are another significant risk. While we have factored in a wage jolt for nurses arising from uncertain outcomes from the current MECA negotiations, we have not factored in the same jolt for other services. Labour market pressures may mean that Family Services staff also face upward wage pressure as a result of collective settlements within the public sector (health and social services). However the impact of COVID on collective bargaining outcomes are unclear. Regardless, an appropriately remunerated workforce will be important to ensure skilled and experienced staff are retained. Critically, we have not incorporated a significant salary adjustment for medical officers.

Strategic shift 1 – Reduce rural service inequities

To better support those living in the most deprived areas, we have added 1.6 additional resources in strategic shift 1. This is broken down into 1 additional FTE for a social worker and 0.6 of an FTE for additional counselling resources. The additional resources are assumed to be in place from 1 January 2023. In 2023/24[60], this increases operating costs by $133,000 in comparison to the enhanced status quo.

58 Nursing staff includes all staff in Community Nursing Services, Day Hospice, Education and Quality and Nursing and HCA staff in the Inpatient Unit. Note that we made an allowance for non-medical staff in this unit and their wages are assumed to increase by 2%.

59 The current contract is due to roll off in August. This means that there is a risk of increased wages being back-dated to the current 2020/21 financial year. However, as only a 2% increase was factored into the budget for this year, we have made the increase from the start of the 2021/22 financial year.

60 We have used 2023/24 to compare operating costs as this provides for a full year of the additional resource costs. Using 2022/23 would only factor in half a year of additional resource costs in comparison to the enhanced status quo. This is also the case for strategic shift 3, 4 and 6.

The key risk to this shift is that staff in Family Services receive a wage jolt sometime in the near future. This impacts strategic shift 1 more than the enhanced status quo because of the additional resources in Family Services. The wage costs for the additional Family Services are based on average wages we would expect existing staff to be paid in January 2023, without a wage jolt.

Because of the inequity of service for those living in rural areas, we have assumed that the additional funds for these positions will be provided by the DHB.

Strategic shift 2 – Grow cultural responsiveness

Strategic shift 2 increases resources to better meet the needs of an increasingly diverse population. To do this, we have modelled an additional $50,000 per annum in opex for cultural advisory services. The currently vacant 0.6 Kaiāwhina role is increased to 1 FTE from 1 July 2021. In 2021/22, operational expenses are $85,000 greater than the enhanced status quo.

We have also allowed for $50,000 in capex over three years for minor refurbishment to make facilities more culturally welcoming. We assume that this funding would be provided by the Foundation.

Strategic shift 3 – Rebalance holistic care and extend community reach

This shift focuses on delivering more comprehensive increases in holistic services, which has the greatest increase in FTEs of all the shifts. Family Services increase by 5 FTEs from 1 January 2023 – 1.25 FTE for social work, 1.25 FTEs for counselling services, 2 FTEs for other therapies and 0.5 of an FTE as a co-ordinator to support the 'Compassionate Communities' strategy. As this shift increases the size of the Family Services team substantially, we have also provided for one of the additional resources to act as the deputy leader of the team. We have increased other expenses in the Family Services unit to reflect the increased size of the team, the subsequent increase in workload and the need for supporting resources.

Because this shift has the greatest increase in FTEs, it is also the most expensive. In 2023/24, operational expenses are over $400,000 greater than the enhanced status quo.

The key risk to this shift is the same as that for strategic shift 1, that staff in Family Services receive a wage jolt sometime in the near future. This risk is even greater than for strategic shift one because of the substantially increased team size.

Strategic shift 4 – Reduce inequities for people dying with chronic health problems

Strategic shift 4's increased focus on reducing inequities for people with chronic health problems means that Hospice Waikato will need additional resources to provide indirect advice for primary care and homecare services. Our preliminary estimates suggest that Hospice Waikato will need an additional 2.2 FTEs from 1 January 2023 – an additional nurse specialist, 0.2 of an FTE in senior

medical officer resource and an additional social worker.[61] We have also made an allowance for increased community nursing expenses to support the work of the additional nurse.

In 2023/24, operational expenses are almost $270,000 greater than the enhanced status quo.

The increase in home-based care under this shift is also likely to require investment in additional equipment. We have estimated that an additional $25,000 in annual capital expenditure will be needed. This estimate is based on the current capital spend and the increased referral volumes.

Strategic shift 5 – Grow paediatric palliative services and extend community reach

Strategic shift 5 requires a rebalancing of current resources to support enhanced paediatric palliative services. Our preliminary analysis suggests that this shift will not have any substantial financial impacts. There is therefore no difference in operating expenses and the forecast deficit to that of the enhanced status quo.

Strategic shift 6 – More age attuned palliative care

This scenario requires additional resources to support Aged Residential Care and GP referral practices. We have estimated that Hospice Waikato will need an additional FTE in an Aged Residential Care Nurse Liaison role and an additional 0.2 of an FTE in senior medical officer resource from 1 January 2023. We have also made an allowance for increased community nursing expenses to support the work of the additional nurse.

The shift results in operational expenses being more than $190,000 greater than the enhanced status quo in 2023/24.

There is a risk that an additional investment in equipment to support in-home care will need to be made. We have not increased capital expenditure in this shift in our preliminary estimates.

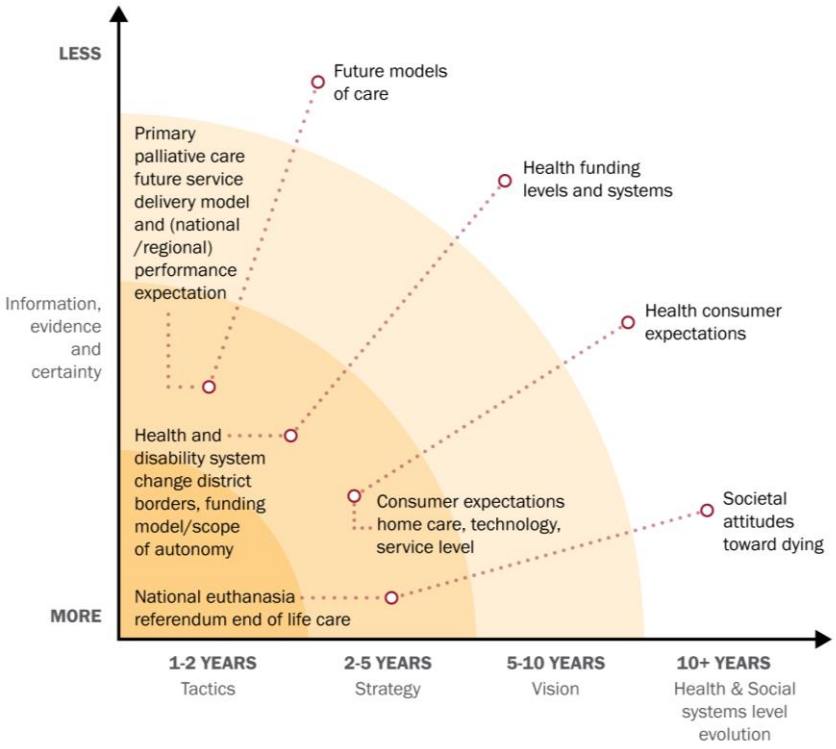
Managing strategic risks and uncertainties

This section sets out the uncertainties facing Hospice Waikato over the next 20 years (broken down into the short, medium and long-term horizons). It will identify the key risks associated with these uncertainties and what impact it could have on the shifts Hospice Waikato needs to make as identified in the previous section.

Managing risk and uncertainty within the SMP requires a balance of tactical management with gathering of greater information, evidence, and certainty.

[61] It is likely that a broader range of Family Services support staff will be needed. For modelling purposes, we have made a simplifying assumption that the FTE will be a social worker. However, in reality this additional resource could be split a number of ways – eg 0.5 of an FTE for social work and 0.5 of an FTE for additional counselling services – without substantially changing the financial outcome.

Potential uncertainties



Dependencies

Dependencies' are any actions or developments required of others and outside the scope of this SMP, and on which the success of the SMP depends.

National dependencies
Health and Disability System Change including any flow on implications to funding of community specialist palliative care or change in relevant standards
Review of National Standards of Palliative Care that may result in the evolution of different models of care or different funding arrangements
Negotiation of the national Hospice multi-employer collective agreement may give rise to workforce funding challenges

Regional dependencies
Waikato District Health Board Waikato DHB is undertaking a review of current palliative care services to ensure alignment with the direction set for Waikato health services by Te Korowai Waiora (the DHB's Health System Plan), and that a future

National dependencies
focussed model of integrated palliative care for the Waikato is clearly defined, with implementation pathways developed.

Strategic risks

Table 11: Strategic risks

Risk	Description	Mitigation	Impact	Likelihood
Overtaken by system wide review	A national review of the Health System has been proposed a fundamental change to the way community-based health services are commissioned and funded. While the direction of change is likely to be beneficial, there may be contracting disruption and uncertainty.	Provide input and strategically influence consideration of the review directly as well as through Hospice New Zealand. Ensure that contracting periods provide flexibility to cater for prolonged periods of uncertainty.	Low	Low
Waikato District Health Board Review of Palliative Care	The District Health Board is undertaking a Review of Palliative Care in parallel. It is unclear as to whether this will result in more funding flowing into the sector or greater optimisation within existing funding	Ensure underlying demographic and model of care changes are shared to create a common understanding. Manage relationship with review and DHB closely.	High	Medium
Strengthening relationship with iwi/Māori and Māori health providers	It may take longer than anticipated to establish quality relationships with Iwi/Māori given competing demands on their time. This could impact on the timeframes within which we are able to begin making ground on the improvements to expand services and help support health equity.	Pilot and target a particular Māori health provider and expand from that core. Suggest considering approaching both Tainui health services and Te Kohao health given proximity to Hospice Waikato IPU.	Low	Medium
Lack of buy-in from system participants	Support and buy-in from others in the social support and health system is not achieved to the extent needed to effect change, particularly in the timeframes needed.	Continue high level discussions with the wider system and focus on strong population health analysis, performance-based information and a pilot and evaluation change model More substantive discussions will take place	Medium	Medium

Risk	Description	Mitigation	Impact	Likelihood
		in the lead up to contract renewal with the DHB		
Workforce shortages	Sector wide difficulties in attracting key groups including medical and allied health. This may include challenges in the retention of skilled workforce to meet proposed model of care needs.	Participation in national MECA negotiations and seeking additional funding to meet any wage increases. Measures to support strengthening capacity and capability of staff. Succession plans for key staff	High	Medium
Funding shortfalls	Failure to renew DHB contract on favourable terms	Engage with DHB through Palliative Care Review. Influence National Palliative Care Policy Development	Medium	Medium
	Significant decline in philanthropic revenues	Develop more modern revenue strategy that moves away from physical asset fund raising to service-based offering. Consider social impact analysis to support.	Medium	Medium

WHAT STEPS SHOULD HOSPICE WAIKATO TAKE TO IMPLEMENT THESE SHIFTS?

Applying a horizons approach

We have broken down the SMP into three distinct time horizons to enable a meaningful level of detail to guide investment choices at each stage. The level of uncertainty around the key drivers impacting on care will be higher in the longer term, while the operating environment will be quite stable in the short term.

The three horizons are characterised as follows:

- **2020 to 2021 – strengthen foundations**. Due to scarce resources and the contracts in place, this phase will be focused on making the most of existing resources, making incremental changes where possible, and planning and preparing for changes to be made in the period to follow.
- **2020 to 2025 – service pilots and standardisation**. As new contracts and partnerships begin to come into play, this period will allow for Hospice Waikato to begin to branch out and pilot new models and services.
- **2025 to 2028 – larger scale service model change**. This period will see successful pilots rolled out at scale, the potential for greater change, evaluation and adaptation, and the start of work to scope the next waves of improvement.

Enablers

Implementation of the SMP will require a focus on the key enablers of the strategic shifts outlined. The three key enablers, critical to the success of Hospice Waikato are the same as those that have been identified across the wider health system[62]:

- **Workforce** – the critical workforce comprising volunteers, retail staff, mana āwhina, nurses, nurse specialists, social workers, counsellors, play and musical therapists, spiritual counsellors, doctors, and leadership required to support the organisation.
- **Data and digital technologies** – the ways of working and platforms required to support a modern model of care with tools that are easy to use, inclusive and provide confidence to patients, their whānau/caregivers, and clinicians.
- **Facilities and equipment** – the equipment, physical infrastructure and buildings required to ensure that care is delivered safely and effectively.

[62] Health and Disability System Review. 2020. Health and Disability System Review – Final Report – Pūrongo Whakamutunga. Wellington: HDSR

Each of these enablers is dependent on the other and will require careful planning and management that is well informed by the strategic choices set out in the SMP. Each of these enablers needs to be properly catered for in supporting planning processes including strategic and business planning to ensure dependencies are well understood and adequately resourced.

Workforce

Like all aspects of health care delivery, Hospice Waikato is dependent on a kind, caring, compassionate and clinically competent and skilled workforce. Improving outcomes from the Hospice Waikato workforce will be critical to improving outcomes for patients and success in delivering on the strategic shifts identified in this report. Current challenges facing the Hospice Waikato workforce include:

- low cultural diversity and cultural competence and ageing (average age 48-51 yrs)
- poor quality information to understand utilisation, and indications of an under-resourced workforce especially medical and allied health
- an emerging wage pressure that is likely to grow with forthcoming wage and pay equity settlements.

Data and digital technologies

Increasing the reach of specialist community palliative care to new communities will require investment in solutions that support sharing of data (patient information), connectivity between clinical staff and patients particularly in isolated and remote communities, and increased levels of digital literacy (both clinicians and patients and their whānau).

Hospice Waikato currently has an appropriate suite of tools to enable digital connectivity. Feedback from stakeholders and leaders is that the current challenges facing the delivery of an improved model of care include:

- growing digital literacy amongst the workforce, patients and their whānau
- supporting new ways of working, particularly amongst the medical and family services workforce.

Facilities and equipment

Safe, fit-for-purpose facilities and equipment are essential to support the outcomes identified for Hospice Waikato. The quality of the facilities and equipment at Hospice Waikato has been assessed by leaders as fit for purpose and of a high quality particularly when compared to other similarly funded and provider community health services. The implementation pathway and preferred options reflect some of the strategic investments that will be required to support successful implementation in the period identified by the SMP.

The key facilities development question relates to any future IPU expansion and use of the neighbouring land acquired. The former is sensitive to Hospice Waikato's SMP decisions on future services change and response of primary palliative care providers to increase referral volumes. Rural

bed capacity is likely to leverage existing rural hospital and other community provider capacity (including Māori health providers) rather than a Hospice investment.

If there is to be major facilities investment, it is more likely to be a paediatric unit development and that will release capacity in the existing IPU for bed growth demands. From a funding perspective, the Rainbow Place brand is more amenable to community/donation funding than adult services.

With the available land, there could be opportunity to partner with another organisation to develop health related facilities. This latter point should be actively explored particularly with Māori health providers.

Priority focus – Health Equity for Māori

System wide measures, including those related to Palliative Care and services provided by Hospice Waikato highlight the critical need to make improvements in health outcomes and delivery of care for Māori. Health equity will require priority to be provided to the design of service for Māori communities. While traditional health service design has been informed by the principles of the Treaty of Waitangi, increasingly the achievement of healthy equity is being informed by rights and interests analysis and the view, as presented in the contemporary health claims before the Waitangi Tribunal, that quality palliative care is a right. This perspective is reflected in the recent Mauri Mate: A Māori Palliative Care Framework for Hospices[1]. As a priority, Hospice Waikato should consider Mauri Mate and develop a more strategic Māori Health Equity Plan that recognises the strategic significance of health equity for Māori in their community. Consistent with the roadmap provided by Mauri Mate, priorities to support the SMP should include:

- Inclusion of understanding of Te Tiriti o Waitangi and the rights and interest of iwi/Māori as a core competence within the Hospice Waikato Board, senior leadership team and staff.
- Establishment a Māori advisory group to guide the Board, executive and workforce to a more culturally competent and community connected health service
- Strengthening relationships with Māori health providers with a focus on provision of specialist palliative care education services. In addition, such relationships will contribute to the strengthening of more holistic family and allied health services including rongoā Maori practice such as mirimiri massage.
- Preparation of a specific workforce strategy that focusses on lifting the cultural capability of the current workforce and practical steps to make Hospice Waikato a more attractive employer to a more culturally diverse workforce, particularly Māori workforce
- Improvement of cultural design, visual identity and culturally relevant information that is more appropriate for Māori including written information, physical visual elements in facilities, social media, and digital stories.

Implementation pathway

While the SMP is intended to support the next 10-20 years of demographic change, the Board has also sought a high-level implementation pathway focus on outcomes for the next 5-8 years. Successful implementation of the SMP will require:

- **Strategic alignment** – a strategic alignment of the outcomes sought in the SMP between the Hospice Board, executive, workforce and critical funders and partners including Waikato District Health Board, Primary Health Providers (particularly Māori Health Providers) and Age and Residential Care Providers.
- **Skilled and competent workforce** - including the adoption of some new ways of working see below.
- **Performance, measurement, and feedback** – the adoption of a more continuous system of performance measurement feedback with greater involvement of patients, their family and key strategic partners.

Figure 21: Ways of Working

Ways of working to support the SMP

Building a high-performance culture and team

- Use leadership to communicate and reinforce expectation and communicate the vision outlined in the SMP
- Provide training in core skills to develop new skills required particularly digital literacy and confidence in working remotely from the patient and their whanau
- Develop a volunteer workforce strategy
- Review recruitment to emphasise the skills that are valued in the new model

Patient and whānau focussed

- Embed a more strategic health equity plan supported by a more culturally confident workforce
- Place patients and whānau at the centre of service design rather than funding and system

Working smarter

- Drive improved information about levels of service, care, demand, and staff utilisation to better understand performance

Partnership and collaboration

- Improve connections, relationships, and partnerships within the wider Waikato social system.

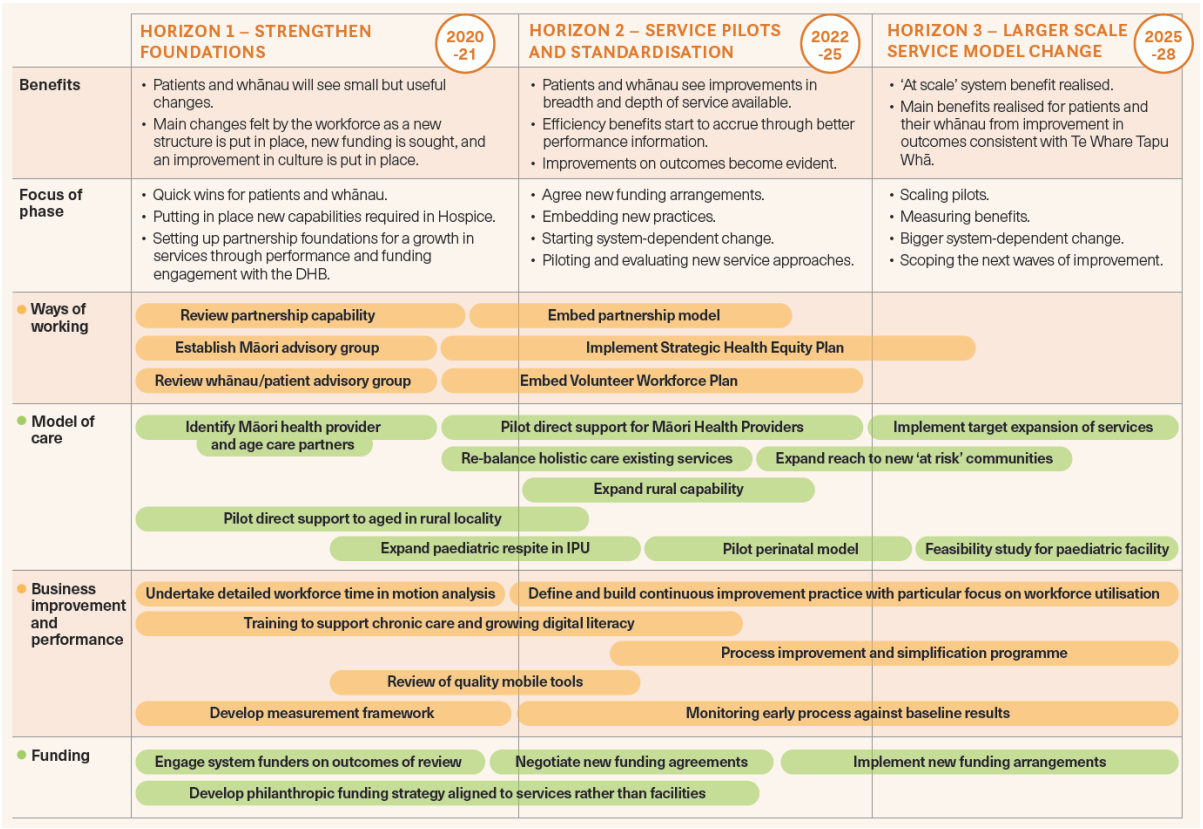
Immediate implementation priorities

Priority focus for implementing the SMP will include:

- Repurposing two of the existing IPU beds to meet the needs of paediatric respite care
- Demonstrate the value of new models of care through pilot and evaluation to inform the contract renegotiation in 2022
- Continuing to monitor the progress of the End of Life Choice Act and associated referendum outcome to assess any implications this may have to workforce needs, patient care and service delivery
- Reaching agreement with the DHB at contract renewal in September 2022 focussed on the expansion of rural nursing care and more holistic care (social work and counselling) across the palliative service
- Developing or appointing the capability to drive a more strategic approach to partnerships with a priority Māori providers and rural aged and residential care
- Revisiting both philanthropic funding and volunteer workforce strategies to align the SMP including orientating the strategy toward service-based activity such as compassionate communities.

Key phases of the SMP Implementation Pathway are set out below implemented across three strategic horizons.

Table 12: SMP Implementation Pathway



Measuring success

Successful implementation of the shifts identified in the SMP will result in core stakeholders noticing the following differences

Table 13: Measuring Success

Patients and whānau will notice	Workforce will notice	Board and funders will notice
• More holistic care delivered where they choose to receive it • Greater support in navigating the wider health and social system of support for palliative care • Care that reflects their cultural and spiritual needs	• Better use of skills and greater skill development • Ability to work remotely in the field, enabled by mobile technology • More focus on patients and their whanau, and less rigidity, but within clear boundaries of	• Better feedback about the breadth of high-quality care received by a broader range of patients and their whānau. • A greater connection between Hospice Waikato and the wider Waikato health and social system

Patients and whānau will notice	Workforce will notice	Board and funders will notice
• Ability to manage information related to their care through a lead provider that is well supported by a multidisciplinary team • Consistent quality services on different locations	discretion/extended scope of practice • A greater multi-disciplinary approach, with the ability to draw on a wider team to support holistic patient and whānau needs • Stronger focus on partnering with other organisations and directly communities to improve quality of care. • Active empowerment to think about service improvement, and receptiveness to ideas • More thinking about the connections across multi-disciplinary teams • Consistent approach to similar services across geographic areas – more ability to help other areas when the pressure is on or to manage rosters	• Improved performance reporting across a wider variety of outcomes • A more sustainable cost structure

APPENDIX 1: STRATEGIC OUTCOMES LINE OF SIGHT

Government priorities

The health and disability system outcomes framework elements below contribute to three of the Government's twelve priority outcomes: Support healthier, safer and more connected communities, Make New Zealand the best place in the world to be a child and Ensure everyone who is able to, is earning, learning, caring or volunteering and to the Government's theme Improving the well-being of New Zealanders and their families. The New Zealand Health Strategy[63] and the New Zealand Disability Strategy[64] set out the Government's strategic direction for the health and disability sectors in New Zealand and highlights the priorities Government considers to be most important. These are then translated at regional and local levels by crown entities like the District Health Boards (DHBs) and providers alongside local priorities.

New Zealand Health Strategy

The future vision for this strategy is that *'All New Zealanders live well, stay well, get well'.* This acknowledges that people want not just a long life, but also quality of life. The five interconnected strategic themes to achieve this vision aim for a more integrated and cohesive system that works in the best interests of New Zealanders at individual and population levels, and what is affordable and possible. The themes are people focused and consistent with the person-centred hospice model.

Midland Regional Services Plan Strategic Direction

The Midland region stretches from Cape Egmont in the West to East Cape and encompasses five District Health Boards (Bay of Plenty, Lakes, Hauora Tairāwhiti, Taranaki, and Waikato). The 2019-2022 strategic direction[65] represents a collaborative DHB commitment to achieve equity in health outcomes and wellbeing for the people living in this region. This plan includes a Midland Cancer Network commitment to review and update of the Midland Palliative Care Services Development plan and to commence implementation of the specialist palliative care workforce plan.

Waikato Health System Plan Te Korowai Waiora

The Waikato DHB 2016 strategy *'Healthy people. Excellent care.'*[66] identifies a vision for the district as part of a wider health and social system. The focus of this strategy is on the community and more integrated, coordinated, and cohesive health and social services. The 2019 Waikato Health System

63 Minister of Health (2016). New Zealand Health Strategy: Future direction. Wellington: Ministry of Health.

64 New Zealand Disability Strategy 2016–2026, Wellington: Ministry of Social Development, 2016.

65 Available from the Health Share website: https://healthshare.health.nz/sites/default/files/images/2019-2022%20Midland%20RSP%20Strategic%20Direction.pdf

66 Waikato Health System Plan Te Korowai Waiora, Waikato DHB, 2019. Available from https://waikatodhb.cwp.govt.nz/assets/Docs/About-Us/Key-Publications/Plans/7bf3d1e7ca/Waikato-Health-System-Plan-Te-Korowai-Waiora.pdf

Plan Te Korowai Waiora seeks to advance the Waikato DHB's Iwi Māori Health and Healthy people. Excellent care strategies with a whānau and family focussed approach to health and wellbeing.

The third long term impact related to specialist care is most closely aligned to future service development as it relates to people with end-stage (life-limiting) conditions where *'…it is important that they and their families are supported, so that the person can live comfortably, have their needs met and die without undue pain and suffering.'* This is further defined in the Waikato DHB Palliative Care Strategic Plan (2016-2021) focus on equitable access, seamless care and person-centered services.

Figure 22: Waikato DHB performance framework (2019)

National performance story

Health system future direction	All New Zealanders live well, stay well, get well, we will be people-powered, providing services closer to home, designed for value and high performance, and working as one team in a smart system				
Strategic themes	People-powered	Closer to home	Value and high performance	One team	Smart system

Regional performance story

Midland vision	All New Zealanders live well, stay well, get well					
Regional strategic outcomes	To improve the health of the Midland populations			To eliminate health inequalities		
Regional strategic objectives	Health Equity for Māori	Integrate across continuums of care	Improve quality across all regional services	Improve clinical information systems	Build the workforce	Efficiently allocate public health system resources

Waikato DHB performance story

Our vision	Healthy people. Excellent Care					
Our strategic imperatives	Achieving health equity for high needs populations	Ensuring safe, quality health services for all	Providing people centred services	Delivering effective and efficient care and services	Becoming a centre of excellence in learning, training, research and innovation	Developing productive partnerships

Service performance

Long-term impacts	People take greater responsibility for their health	People stay well in their homes and communities	People receive timely and appropriate specialist care
Intermediate impacts	Fewer people smoke Reduction in vaccine preventable diseases Improving health behaviours	An improvement in childhood oral health Long term conditions are detected early and managed well Fewer people are admitted to hospital for avoidable conditions More people maintain their functional independence	People receive prompt acute and arranged care People have appropriate access to ambulatory, elective and arranged services Improved health status for those with severe mental illness and/or addictions More people with end stage conditions are supported appropriately
Outputs	Percentage of eight months olds will have their primary course of immunisation on time	Percentage of the eligible population will have had their cardiovascular risk assessed in the last five years	Percentage of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours

Stewardship

Stewardship	Workforce	Organisational Performance Management	Clinical Integration / Collaboration / Partnerships	Information

Source: Waikato District Health Board 2019/20 Statement of Performance Expectations

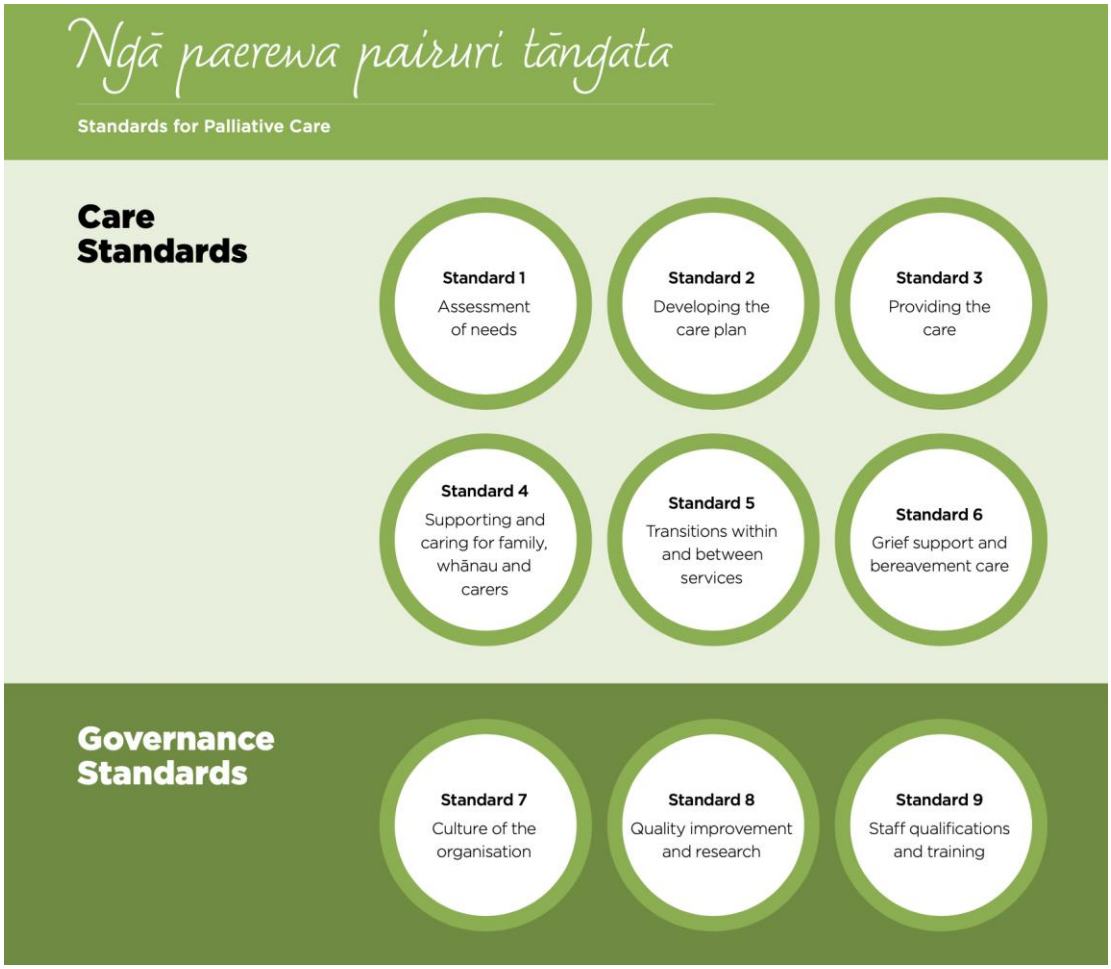
Hospice New Zealand Standards

These outcome focused standards have been developed to support all Hospice services to deliver quality palliative care for the person and their family, whānau and carers.

The interrelated nine standards (see below) are consistent with the people and whānau centered model of care. They are divided into two categories:

- Clinical Standards (1-6) describe systems and enablers for the delivery of clinical care.
- Governance Standards (7-9) describe expectations of the organisation, quality and research and support for staff and volunteers.

Figure 23: Hospice New Zealand Standards



Source: Hospice Zealand (2019)

APPENDIX 2: SMP OPTIONS LONG LIST SUMMARY

Long list assessment outcome key: Discount Carry forward Preferred

	Subset	Status Quo	Option 1	Option 2	Option 3	Option 4	Option 5
1. SCOPE							
Reach	Geographic	Waikato DHB district	(1.1) Waikato district	(1.2) + Lakes DHB Taupō Hospice	(1.3) + other Lakes DHB locations	(1.4) + other DHB populations	
Who	Community	Waikato resident coverage	(1.5) + beyond equity for Māori	(1.6) + equitable Asian & Pasifika access	(1.7) + new access for people living rough	(1.8) + new access for offenders (prison, parole, post-release)	
Who	Age & Health condition	All ages, service focus on adult cancer + complex PPC	(1.9) + more care for adults with chronic disease (e.g. heart etc)	(1.10) + sudden deaths at all ages (stillborn to adult)	(1.11) + expanded care for infant/child with life-limiting disabilities	(1.12) + perinatal & neonatal babies (pre-birth up to 6mthsold)	(1.13) + increased volumes based on existing condition mix
2. SOLUTION							
What	Core Service	Home Care, Paediatric (PPC), Family Service, Education, IPU, OP	(2.1) + enhanced PPC services and capacity (IPU/respite, outpatient)	(2.2) + expanded rural psychosocial and other Family Services capacity	(2.3) + expanded Home Care capacity and capability	(2.4) + expanded primary care provider education	(2.22) + expanded Hamilton IPU
Where	Location/ Facility	Hospice IP/OP/Day, home, limited ARC	(2.5) + increased ARC coverage	(2.6) + use of other community locations	(2.7) + regional Hospital support	(2.8) + dedicated/ new PPC IPU	(2.23) + new Hospice PPC respite service
How	Service Category	Direct and indirect	(2.9) + earlier SPC input from time of diagnosis	(2.11) + iwi, Māori & Pacific provider collaboration	(2.12) + more indirect primary care support	(2.13) + broader non-SPC home care for all ages	
How	People & Culture	Clinical, non-clinical, volunteer, other support	(2.14) + integrated Paediatric MDT and Lead liaison roles	(2.15) + grow cultural responsiveness across workforces	(2.16) + more CNS roles to lead ARC & primary capability growth	(2.17) + grow role of Family Services and volunteers	(2.24) + greater scope of non-SPC home care roles
How	Other enablers	Governance, ICT, budget, quality assurance	(2.18) + Board representation for Māori & consumer	(2.19) + maximise virtual IDT service delivery model	(2.20) + collaborative DSL referral pathway definition and equity	(2.21) + operational efficiencies/targeted quality improvement	
3. DELIVERY							
Who	Delivery lead	Hospice Waikato + other providers	(3.1) + increase alliances / strategic partnerships	(3.2) + grow compassionate communities with DHB	(3.3) + grow informal networks and provider relationships	(3.4) devolve/ outsource opportunities	
4. IMPLEMENTATION							
How	When	Pending SMP	(4.1) + maximise current resources (1-2yrs)	(4.2) + core business priorities (2-3yrs)	(4.3) + leveraging emerging opportunities (5-10yrs)	(4.4) + new directions (15-20yrs)	(4.5) risk appetite
5. FUNDING							
How	Source	Waikato DHB (70%); donations (30%)	(5.1) + targeted MOH funding	(5.2) + new contracts, e.g. corrections, MSD	(5.3) + new charitable sponsor/s	(5.4) + other revenue opportunities	

Key acronyms:

ARC – Aged Residential Care
CNS – Clinical Nurse Specialist
DSL – Disability Support Link
IDT – Interdisciplinary team
IP – Inpatient (community or hospital setting)
IPU – Hospice Waikato Inpatient Unit
MSD – Ministry of Social Development
MDT – Multidisciplinary team
OP - Outpatient
PPC – Paediatric palliative care
SMP – Hospice Waikato Service Master Plan
SPC – Specialist Palliative Care

APPENDIX 3: SMP OPTIONS LONG LIST ASSESSMENT

Dimension	Subset	Status Quo	Option 1	Option 2	Option 3	Option 4	Option 5
1. SCOPE							
Reach	**Geographic**	Waikato DHB only	**(1.1) Waikato DHB district**	**(1.2) + Lakes DHB Taupō Hospice**	**(1.3) + other Lakes DHB locations**	**(1.4) + other DHB populations**	
	Key advantages		Meets community & DHB funder expectation	Leverage specialist experience for Midlands region	Further leverage specialist experience for Midlands region	Shared SCPC expertise to improve health sector performance/capability	
	Key disadvantages		Does not leverage specialist expertise for Midlands	Donor/funder perception of focus outside the community they support	Donor/funder dissatisfaction with resource focus outside the community they support	Donor/funder dissatisfaction with resource focus outside the community they support	
	Conclusion		Core community expectation	Support Hospice expertise for regional + collegial benefit	Potential regional benefit; but no DHB need identified	Risks overstretching senior staff; loss of community identity	
Who	**Community**	Waikato resident coverage	**(1.5) + expand Māori access**	**(1.6) + expand Asian & Pasifika access**	**(1.7) + new access for people living rough**	**(1.8) + new access for offenders (prison, parole, post-release)**	
	Key advantages		Improves Te Tiriti Māori outcome equity goal	Addresses current service access	Supports population with multiple health inequities	New model of care partnership with DHB	
	Key disadvantages		Nil if conducted in partnership & consultation	Nil if conducted in partnership & consultation	Access more difficult as GP enrolment is low	Model reliant on DHB MDT service development/funding	
	Conclusion		Core community and sector expectation	Core community and sector expectation	Vulnerable group worthwhile exploring with DHB	Vulnerable group worthwhile exploring with the DHB	
Who	**Age and health condition**	All ages Adult cancer + complex paediatrics	**(1.9) + more care for adults with chronic disease (e.g. dementia heart, respiratory, CNS)**	**(1.10) + sudden deaths at all ages (stillborn to adult)**	**(1.11) + expanded care for infant/child with life-limiting disabilities**	**(1.12) + perinatal & neonatal babies (c. 22 weeks gestation < 6mths)**	**(1.13) + increased volumes based on existing condition mix**
	Key advantages		Address unmet need for adults dying with non-cancer conditions (>80% no hospice – McLeod 2019)	Address unmet need for psychosocial support for parents/whānau in DHB maternal services	Expand service scope to better support parents of children with life-limiting disabilities, e.g. respite	Address unmet need for access to palliative care options for parents/whānau early in prognosis. Proactive DHB NICU champion and Hospice PPC relationships	Path of least change for workforces and processes of care across Hospice and broader palliative care system.

Dimension	Subset	Status Quo	Option 1	Option 2	Option 3	Option 4	Option 5
	Key disadvantages		Significant resource require resources beyond DHB contract remuneration. Requires significant increase in primary care provider / direct referrals	Palliative care is best delivered prospectively and continuity of support more logically the domain of the DHB and related public agencies to offer support	Need to grow expertise and resources for children with complex CNS support 24/7. Would require a more effective/clear referral process with DSL	Potential for significant increase in referrals and requirement for onsite support at Waikato Hospital and new relationship to build with O&G services	Enduring inequities for people dying with long term health conditions and other community groups experiencing palliative care disparities.
	Conclusion		The most significant population inequity by volume and amenable to current Hospice service mix	Not a strong fit with palliative care services relative to other community groups/cohorts.	Builds on the existing Rainbow Place expertise and resources	Addresses a gap in population coverage and builds on established model	A short term option while agreed SMP changes are explored and resourced
2. SOLUTION							
What	**Core Service**	Home Care, PPC, Family Service, Education, IPU, OP	**(2.1) + enhanced PPC services and capacity (IPU/ respite, OP)**	**(2.2) + expanded rural psychosocial and other Family Services capacity**	**(2.3) + expanded Home Care capacity and capability**	**(2.4) + expanded primary care provider education**	**(2.22) + expanded Hamilton IPU**
	Key advantages		Address parent/caregiver feedback for better respite access. More equitable PPC coverage	Addresses core inequity of holistic service options across rural/urban areas; and caregiver priorities for counselling & social support	Focus on the service with the greatest growth (22% on the last year); aligns with health policy primary and community care priorities and caregiver preferences	Reduces inequity of palliative care for people with chronic health conditions; early engagement to improve patient care options	Ability to manage long term demand increase due to long term demographic growth
	Key disadvantages		Competition with adult IPU requiring new facilities; expanded/new workforce with complex paediatric care competencies	Require a significant budget shift to allied health; Hospice masking/taking the burden of inadequate funding/access to primary care psychosocial services	Unclear / inconsistent provider responsibilities for non-specialist home care support risks financial and resource sustainability. Geographical spread needs more robust IDT model and reliance on virtual options. Potential barriers in rural areas and people living in areas of high socioeconomic deprivation.	Current GP and practice nurse uptake is low; significant time to further grow relationships. Requires PHO/DHB alliance to be successful. Relies on DHB to drive primary palliative care capability and capacity.	Support Hamilton based residents and alone does not well support rural population growth and higher growth rates/demand for home based care demand
	Conclusion		Builds on strong service foundation and likely strong community support	Aligned with Hospice philosophy of holistic care, patient/caregiver priorities	Strong community demand / preference for home care support options 24/7	Whole of system responsibilities and response opportunity	A longer term option dependent on RP expansion and home care services

Dimension	Subset	Status Quo	Option 1	Option 2	Option 3	Option 4	Option 5
Where	**Location/ Facility**	Hospice IP/OP/Day, home, limited ARC	**(2.5) + more ARC coverage**	**(2.6) + use of other community locations**	**(2.7) + regional Hospital support**	**(2.8) + dedicated/new PPC IPU**	**(2.23) + new Hospice PPC home respite service**
	Key advantages		Contributes to addressing current and forecast unmet needs of older people and growth of more people dying over 85yrs. Enhances primary care capability	Leverage established community resources and local relationships; increases community presence. Amenable to pilot approach	Aligns with and leverages proposed DHB locality model; builds stronger primary care and DHB relationships	Supports accepted best practice to separate adult and paediatric care; addresses bed block for respite care	Supports parents and caregivers that are experiencing growing complexity of home care. Enables parents to cope better at home rather than admission to IPU/hospital.
	Key disadvantages		Significant resource require resources beyond DHB contract remuneration. Requires robust integrated primary care and nursing workforce training/ mentoring, CNS roles	Will take time to establish relationships before expanding service delivery. Potentially increases Hospice staff travel time (dep. on potential offset to local home visits)	The DHB locality strategy is in the early implementation phases and timeframe for regional hospital model and infrastructure development is unclear	Duplication of resources with significant operational cost uplift relative to occupancy in medium term. New facilities funding and build lead time potentially 5+ years	Current disability funding streams do not provide for this level of home care complexity (staff, training, equipment, provider). Requires a change in DSL provider specifications
	Conclusion		Significant opportunity to address unmet need and build strategic partnerships	Advances strategic provider relationships to increase reach/reduce inequities	Leverages available rural infrastructure and aligns with DHB locality priorities	Model worthwhile exploring with the DHB, community and donors	Model worthwhile exploring with the DHB and MSD funders.
How	**Service Category**	Direct and indirect	**(2.9) + earlier SPC input from time of diagnosis**	**(2.11) + iwi, Māori & Pacific provider collaboration**	**(2.12) + more indirect primary care support**	**(2.13) + broader non-SPC home care for all ages**	
	Key advantages		As for (1.9) + improve patient care options and care	As for (2.6). Leverage established community resources and local relationships; increases community presence.	Builds on earlier engagement with opportunity for increased virtual SPC consultation with primary providers	Aligns with integrated care closer to home and community care policies and patient/ whānau preferences.	
	Key disadvantages		As for (1.9) + requires DHB and PHO partnership to incentivise / encourage GP referrals	Will take time to establish relationships before expanding service delivery. Current funding model does not incentivise or support expanded palliative care	As for (2.9).	More complex integration of disability and personal care support services. This requires clarification with the DHB or risks Hospice underfunding	
	Conclusion		Significant opportunity to improve equity and quality of health care	As for (2.6). Advances strategic provider relationships to increase reach/reduce inequities	As for (2.9).	Significant opportunity to further support patient/ whānau preferences building on current model	

Dimension	Subset	Status Quo	Option 1	Option 2	Option 3	Option 4	Option 5
How	**People & Culture**	Clinical, non-clinical, volunteer, other support	**(2.14) + integrated Paediatric MDT and Lead liaison roles**	**(2.15) + grow cultural responsiveness across workforces**	**(2.16) + more CNS/NP roles to lead ARC & primary capability growth**	**(2.17) + grow role of Family Services and volunteers**	**(2.24) + greater scope of non-SPC home care roles**
	Key advantages		Mitigates risk of service gaps and transitions of care problems across specialties and providers of care. Aligns with international and national recommendations	Potential to reduce access inequities and improve experience of care outcomes for Māori, Asian and Pasifika communities. Opportunity for Hospice staff to learn from Māori, iwi and Pasifika providers	As for (2.5).	Improves access equity to a complete suite of holistic services. Grows community based 'compassionate care' support skills, role modelling and capacity expansion of volunteers	Improves continuity and experience of care for patients and whānau. Increases flexibility of roles performed by each MDT member thereby reducing the number of people entering homes.
	Key disadvantages		Lack of national service specifications to underpin funding and system wide performance challenges ability to grow the model	Requires whole of organisation leadership support, significant HR management processes and workplace culture change to be successful	As for (2.5).	Not fully scoped in current contract and significantly dependent on charitable funding.	Expands scope of non-specialist cares performed by Hospice staff requiring larger workforce. Potential professional dissatisfaction at not 'working to top of skillset/license'
	Conclusion		Aligned with 2012 national recommendations to explore with the DHB	Essential to meeting and exceeding patient and whānau needs	As for (2.5).	Worthwhile exploring with DHB alongside locality model and SPC provider scope. Significant dependency on donor funding	An important conversation to have with Waikato DHB due to current inconsistencies across general home/personal care service access.
How	**Other enablers**	Governance quality assurance, ICT, budget	**(2.18) + Board representation for Māori & consumer**	**(2.19) + maximise virtual IDT service delivery model**	**(2.20) + collaborative DSL referral pathway access equity**	**(2.21) + operational efficiencies/targeted quality improvement**	
	Key advantages		Improved community insights and participation	More efficient use of staff time; reduced travel time	Reduced service gaps and improved quality of care	Be more effective/smarter within current resources	
	Key disadvantages		Candidate availability and experience	Not suitable for initial relationship building / some staff and patient/whānau preferences	Complex funding criteria and inconsistent local referral assessments	Initiatives are likely to be reliance on other system providers	
	Conclusion		Quality of decision making through participation	Key workforce sustainability enabler	Important to collaborate with DHB for Hospice role	Important concurrent approach alongside SMP changes	

Dimension	Subset	Status Quo	Option 1	Option 2	Option 3	Option 4	Option 5
3. DELIVERY							
Who	**Delivery lead**	Hospice Waikato + other providers	**(3.1) + increase alliances / strategic partnerships**	**(3.2) + grow compassionate communities**	**3.3) + grow informal networks and provider relationships**	**(3.4) devolve/outsource opportunities**	
	Key advantages		As for (2.11) Māori & Pacific (2.5) Aged residential care (2.4) PHO & DHB (1.8) MSD & DHB	As for (2.7) + increased community awareness, social networks and potential charitable funding support	The first step in growing more integrated services across providers. Enhanced informal networks of health and social services staff working together	To be discussed	
	Key disadvantages		Uncertain health and disability sector structure and funding change	Uncertain directions for the DHB locality and community strategy	Largely based on goodwill between individuals and benefits gained are at risk of legacy system disincentives/conflicts.	To be discussed	
	Conclusion		Significant local sustainability options	Long term benefits that complement DHB localities	Considered a foundation step towards a more integrated system of care and support	To be discussed	
4. IMPLEMENTATION							
How	**When**	Pending SMP (project mix/prog.)	**(4.1) + maximise current resources (1-2yrs)**	**(4.2) + core business priorities (2-3yrs)**	**(4.3) + leveraging emerging opportunities (5-10yrs)**	**(4.4) + new directions (15-20yrs)**	
	Key advantages		Almost certain financial and resource availability and (likely) minimal change stress from current model	Focused change to motivate people, culture and system changes; proof of concept/ pilot for long term directions.	Build on pilot/proof of concept and foundation changes made in years 1-4. agility to manage unplanned changes. Facilitates cohesive short to long term planning	Aspirational target state directions that enables communication to current and future stakeholders	
	Key disadvantages		Short term options unlikely to enable long term sustainability and change	Financial risks with DHB contract expiry (Sep 22) within this period	Broader health and disability system changes and DHB funder impacts likely to impact success/scope of planned SMP ambition	Uncertain external forces for change	
	Conclusion (SMP Programme)		Manage through operational planning aligned with longer term SMP priority directions	Align with medium to long range change directions where there is reasonable control of changes needed	Establishes the foundation for long term sustainability changes and change course as needed	Important for SMP cohesion leverages change effort and resources	

Dimension	Subset	Status Quo	Option 1	Option 2	Option 3	Option 4	Option 5
5. FUNDING							
How	**Source**	Waikato DHB (70%); donations (30%)	**(5.1) + targeted MOH funding**	**(5.2) + new contracts, e.g. corrections, MSD**	**(5.3) + grow DHB and charitable sponsor/s**	**(5.4) + new revenue opportunities**	
	Key advantages		Targeted funding for specified services	Potential to diversity funding sources while addressing unmet need	Opportunity to leverage DHB review process to clarify scope of Hospice revenue	Potential to capitalise on Hospice innovations for new business offering, e.g. management systems, joint ventures	
	Key disadvantages		Unlikely given typical DHB funder for district services	As for (1.8)	Risk of reduced DHB funding; negative charitable funding economic impacts of Covid19	Not core business for Hospice; potential need for new commercial resources	
	Conclusion		Unlikely option in the short-medium term	Opportunity worthwhile exploring with the DHB	Explore and assess feasibility of funding channel options	Explore and assess feasibility of options	

APPENDIX 4: STRATEGIC SHIFT SUMMARY

	STATUS QUO	BASE CASE Enhanced status quo	Strategic Shift 1 Reduce rural service inequities	Strategic Shift 2 Grow cultural responsiveness	Strategic Shift 3 Rebalance holistic care and extend community reach	Strategic Shift 4 Reduce inequities for people dying with chronic health problems	Strategic Shift 5 Grow paediatric palliative services and extend community reach	Strategic Shift 6 More age attuned palliative care
Summary Description	Current service coverage, mix and resource utilisation	Assumptions for the status quo service model (no change) with core service efficiencies achievable within current resources and infrastructure footprint	Improve the mix and accessibility of specialist palliative care services for rural residents	Mature organisational cultural competency of staff, leadership and organisational enablers	Rebalance holistic specialist palliative care aligned with Te Whare Tapa Whā and target new communities	Earlier and extended specialist palliative care for people with life-limiting chronic health problems	Expand the range and scope of paediatric palliative care services to improve equity of access	Enhance specialist palliative care service access for frail older people in all residential settings
Out of scope (system-wide /DHB issue)	Change to the Waikato DHB contract.	Waikato DHB total funding of palliative care services (outside of annual cost pressure increases) is unlikely to change within the current contract term (expiring September 2022).	Development rural hospital physical bed capacity for palliative care as this will form part of the broader DHB locality strategy (unless part of new/funded strategic partnership). Primary care funding of psychosocial support.	Comprehensive district wide community network engagement as this would form part of the WDHB locality model development.	DHB team engagement / leadership from mental health, allied health, general medical and nursing. Changing DSL funding and access criteria management. Primary care funding of psychosocial support.	Primary care leadership in Advance Care Planning, funding of primary palliative care services and psychosocial support. DHB funding for increased district nursing support of people living at home.	DHB funding and workforce capacity for psychosocial and cultural support of maternity and neonatal service patient and whānau. Home based respite care (unless Hospice becomes an approved DSL provider).	Primary care leadership in Advance Care Planning, medical support of Aged Residential Care and funding of primary palliative care services and psychosocial support.
Key risks	Limited growth of Waikato DHB Income. Slow down and reversal of traditional fundraising and donation income streams. Staff health and safety in community and home settings.	Internal trade offs required to potentially shift resources between business units to accommodate efficiencies	Possible pressure on Hospice to take on psychosocial support outside palliative care scope (e.g. beyond the last year of life and for general support needs) due to primary care funding constraints for home and palliative care services. DHB locality development, community services and rural hospital model uncertainties. WDHB clinical workstation interoperability with PalCare to support 'one-team' working and integration.	Major change to organisational culture that requires support at all levels from governance to service delivery and support functions. DHB relationship directions with local iwi and Māori health providers could confuse/divert from direct Hospice relationships. WDHB clinical workstation interoperability with PalCare to support 'one-team' working and integration.	Tension with DHB DSL processes and barrier to timely referrals to enable effective and safe transition of care. Lack of national specifications and funding for psychosocial services pressure to afford increased family services access. DHB locality development and community services model uncertainties. Waikato DHB clinical workstation interoperability with PalCare to support 'one-team' working and integration.	Tension with DHB DSL processes and barrier to timely referrals to enable effective and safe transition of care. Lack of national specifications and funding for primary palliative care constrains resource availability. DHB locality development and community services model uncertainties. Waikato DHB clinical workstation interoperability with PalCare to support 'one-team' working and integration.	Lack of national specifications and funding for paediatric palliative care to afford increased respite and perinatal palliative care service access. WDHB clinical workstation interoperability with PalCare to support 'one-team' working and integration.	Tension with DHB DSL processes and barrier to timely referrals to enable effective and safe transition of care. Lack of national specifications and funding for primary palliative care constrains resource availability. National Aged Residential Care contract change uncertainties. Waikato DHB clinical workstation interoperability with PalCare to support 'one-team' working and integration.
KEY CHANGE FOCUS								
Change focus	Hospice Anywhere ICT mobilisation and ongoing efficiencies	Operational efficiencies - optimising available resources	Service access equity - rural psychosocial services	Service access and experience of care equity - Māori, Pacific, Asian patients and whānau	Service access equity - vulnerable communities and whānau	Service access equity - adults with chronic health problems	Service access equity - babies, children and young people	Service access equity - frail older people
Who - service coverage	-	-	-	Increase - Pacific and Asian access	Increase - new offenders/people living rough	Increase - chronic conditions care	Increase - new perinatal / neonatal support	Increase - dementia care
Where - location of services	-	Optimise - offering telehealth and indirect advice for referrers, patients and family where appropriate	Increase - family services service scope Increase - rural hospital support Increase - telehealth and indirect advice	Increase - home care Increase - telehealth and indirect advice	Increase - family services scope Increase - telehealth and indirect advice New - social sector support	Increase - home care Increase - telehealth and indirect advice	Increase - Hospice IPU bed access Increase - Waikato DHB hospital support of neonatal and paediatric services	Increase - aged residential care Increase - telehealth and indirect advice
How - service mix	-	Optimise - appropriate virtual contacts methods	Increase - Family Services home care	Increase - Hospice Home Care Increase - Family Services Increase - Volunteer Support (in collaboration with community providers)	Increase - Family Services home care Increase - Volunteer support	Increase - Hospice Home Care Increase - Volunteer Support	Increase - Paediatric IPU respite New - Perinatal palliative care	Increase - Hospice Home Care Increase - Family Services Increase - Volunteer Support
How - referrals	-	Enhance - integration of referral triage process for early family services review/planning	Earlier - general practice referrals to Hospice Improved - timeliness of DSL home and personal cares referrals	Increase - health care provider referrals to Hospice Improved - timeliness of DSL home and personal cares referrals	Earlier - general practice referrals to Hospice Improved - timeliness of DSL home and personal cares referrals	Increase - earlier general practice and WDHB referrals to Hospice Improved - timeliness of DSL home and personal cares referrals	Increase - earlier referrals from WDHB neonatal and paediatrics Improved - timeliness of DSL home and personal cares referrals	Increase - earlier referrals from general practice and Aged Residential Care Improved - timeliness of DSL hone and personal cares referrals
How - workforce mix	-	No specific changes identified	Increase - social workers/counselling Change - Home and Family Services staff living in/close to rural areas Change - increase frequency of home care nursing liaison with general practice nurses Increase - volunteers (direct support)	Increase - liaison and support of Māori and Pacific health workforces in the community Target - workforce diversity Increase - Māori cultural advisory lead	Increase - counsellors, social workers Increase - volunteers supporting patients in their homes New - Compassionate Communities Coordinator	Increase - Family Services across disciplines Increase - volunteers (direct support) Increase - nursing	Increase - nursing (paediatric palliative senior RN) for expanded IPU beds and perinatal palliative care service support	Increase - Counsellors, social worker, OT, physio Increase - volunteers supporting patients in their homes Increase - ARC liaison nurse
How - workforce training	-	Maximise - volunteer patient supports	New - rural hospital medical and nursing staff training by Hospice	New - tikanga and e-CALD training and competencies (organisation-wide)	Change - volunteer training/peer support model of care	Increase - home care team clinical support of people with complex needs	Increase - paediatric palliative care nursing and counsellor education	Increase - home care team clinical support of people with complex needs
How - facilities	-	-	-	Review - Māori world view reflected in Hospice facilities	-	-	Reconfigure - Hospice IPU rooms Long term - option for standalone facility	-
How - ICT	-	Maximise - utility and use of virtual technologies	Update - ICT devices to improve mobile team efficiencies	Update - ICT devices to improve mobile team efficiencies Review - Māori world view & CALD reflected in website and information	Update - ICT devices to improve mobile team efficiencies	Update - ICT devices to improve mobile team efficiencies	Update - ICT devices to improve mobile team efficiencies	Update - ICT devices to improve mobile team efficiencies
How - partnerships	-	Increase - focus on strategic provider relationship and change management	Expand - PHO and rural GP relationships	Increase - Māori & Pacific provider relationships and Asian community network	Increase - PHO and GP relationships New - social sector agencies	**Increase - PHO and GP relationships**	**Increase - DHB neonatal and paediatric service linkages**	**Increase - PHO and GP relationships**
How - governance	-	New - provider relationships (and change) lead	New - provider relationships (and change) lead	New - provider relationships (and change) lead	New - provider relationships (and change) lead	New - provider relationships (and change) lead	New - provider relationships (and change) lead	New - provider relationships (and change) lead

APPENDIX 5: LITERATURE REVIEW SUMMARY

Snapshot of recommended strategic shift alignment with published literature.

Population health approach with a focus on inequities and growing local social networks

- Intersectoral team approaches for communities that miss out on services now due to complex other issues and are outside standard referral pathways, e.g. people living rough and offenders
- Community development (compassionate communities) alongside other public health approaches deliver benefits to people at end of life, their families and carers and communities

Culturally responsive support to reduce experience of care inequities

- Supporting the right of whānau to actively participate in caring for their dying relatives, maintaining the mana and self-determination connected and supportive whānau relationships
- Value of addressing language barriers, workforce diversity and patient and whānau/family awareness of services, establishing relationships of trust, community outreach and networks, creating political and cultural space for Māori kaumātua and whānau to take cultural leadership

Integrated professional networks and earlier access to palliative care support

- Earlier engagement (home and team based) of palliative care support for people with life-limiting chronic health conditions improves quality of life and satisfaction with care
- Enhanced specialist palliative care support of general practice as the ideal initiators of advance care planning where they have established relationships with patients and families.

More age attuned palliative care

- Differences in opinion on the needs and timing of services older people, their whānau and families supports the need for integrated, personalised, and holistic care planning and delivery
- Need for integrated approaches to palliative care services engaging with care facilities and the wider health system as silo approaches, e.g. staff training, have limited success alone.

Expanding the scope of community based paediatric palliative care

- International paediatric palliative care models stress the importance of joined up approach between health, disability and social care, children's, and adult services
- Comprehensive interdisciplinary and holistic perinatal palliative care should be initiated early that includes advocating for families, family centred goals and psychosocial support

Interdisciplinary rural palliative care

- Leadership is considered essential for integrated models to flourish with clear professional boundaries and positive GP and service partnerships
- Nurse-led model focus on symptom management, teaching, referrals, psychosocial and spiritual support, advance care planning, home care and telephone-based support shows benefits.
- Model of care including volunteers to support the holistic component of the care coordination model matched to patients with opportunity for training in bereavement counselling.

Expanded reach through enabling technologies

- Telehealth and remote monitoring benefits have not been well established in palliative care but likely reflects the early stage of technology use in palliative care rather than lack of outcome benefits
- GP video consultation support of aged residential care facilities can be challenged by technical infrastructure, repeated staff training, new clinical procedures, and relationship development
- Web-based platforms and telephone calls for informal caregivers (usually family members or close friends) can result in significant (but small) improvements in some aspects of care.

Introduction

From a health system perspective, palliative care and relief of end of life suffering are essential elements of universal health coverage.[67] A solely clinical model of palliative care is inadequate to address the challenges of inequitable access, continuity and fragmentation of care.[68] This is well recognized in the current Hospice New Zealand standards[69] and guidance for the last days of life.[70] Demand pressures due to population growth and ageing, and magnitude of rising unmet need for palliative care services[71] means the health system needs to plan, implemented and evaluate different ways of working.

Published studies and reviews support many of the key findings of the palliative care needs assessment developed to inform the Hospice Waikato Service Master Plan. A snapshot is outlined here with further information available on request.

We need to focus on population inequities of those who are being missed

Adopting a population health approach aims to improve the health of the entire population and to reduce health inequities among population groups. This is a general objective of District Health Boards (DHBs) and is a national specialist palliative care service specification objective that services will *'…ensure equitable access to all the components of the Service for their DHB resident population'*.

The draft needs assessment identified several community groups currently experiencing palliative care inequities in the Waikato district. Some of these groups include people dying with chronic diseases, dementia, children, and infants and under 5 years of age (esp. in the first year of life).[72]

In addition to these groups, there are specific communities where mainstream services struggle to meet their needs due to lack of access through standard health service referrals pathways, are insecurely housed or have complex other issues, e.g. people living rough[73] and offenders living in prison[74] that are increasingly older with disproportionately high health needs. Examples of British models for people living rough include St Mungo's and St Luke's Hospice that use recovery based approaches including accommodation, outreach teams and services (health, housing, social care, drug and alcohol), community education and advocacy. Published toolkits available to support multi-agency care and other practical advice.

Relationships are important to prisoners at the end of life (both inside and outside of prison) and inmate hospice volunteers can build close bonds with the prisoners in their care (but can also experience a great deal of grief as a result of their job). [75] The Rimutaka Prison High Dependency Unit model is supported by a multi-disciplinary DHB team including the palliative care team, provides

67 Knaul FM, Farmer PE, Krakauer EL, et al. Alleviating the access abyss in palliative care and pain relief-an imperative of universal health coverage: the Lancet Commission report [published correction appears in Lancet. 2018 Mar 9;:]. Lancet. 2018;391(10128):1391–1454.

68 Abel J, Kellehear A, Karapliagou A. Palliative care-the new essentials. Ann Palliat Med. 2018;7(Suppl 2):S3–S14. doi:10.21037/apm.2018.03.04

69 Standards for Palliative Care 2019. Hospice New Zealand, 2019.

70 Ministry of Health. 2017. Te Ara Whakapiri: Principles and guidance for the last days of life. (2nd edn). Wellington: Ministry of Health.

71 McLeod H, Atkinson J. (2019). Policy Brief on Trajectories of Care at the End of Life in New Zealand. 10.13140/RG.2.2.34488.49925.

72 McLeod H, Atkinson J. (2019). Policy Brief on Trajectories of Care at the End of Life in New Zealand. 10.13140/RG.2.2.34488.49925.

73 Klop HT, de Veer AJE, van Dongen SI, Francke AL, Rietjens JAC, Onwuteaka-Philipsen BD. Palliative care for homeless people: a systematic review of the concerns, care needs and preferences, and the barriers and facilitators for providing palliative care. BMC Palliat Care. 2018;17(1):67. Published 2018 Apr 24. doi:10.1186/s12904-018-0320-6

74 McParland C, Johnston BM. Palliative and end of life care in prisons: a mixed-methods rapid review of the literature from 2014-2018. BMJ Open. 2019;9(12):e033905. Published 2019 Dec 23. doi:10.1136/bmjopen-2019-033905

75 McParland C, Johnston BM. Palliative and end of life care in prisons: a mixed-methods rapid review of the literature from 2014-2018. BMJ Open. 2019;9(12):e033905. Published 2019 Dec 23. doi:10.1136/bmjopen-2019-033905

patients assessments and education sessions for health staff on those needs. The unit provides a safe and secure environment where people can be supported to either transition out of prison or age (and die) with dignity within the prison.

Truly holistic care benefits from 'compassionate communities' that provide social network support

The optimal practice model is based on a close partnership between clinical services and communities/civic institutions.[76] There is a growing body of research and best practice[77] which shows that compassionate communities, when implemented with other public health approaches, deliver substantial benefits to people at end of life, their families and carers, communities and health systems. These benefits include improved quality of life, community cohesion and bereavement outcomes and reduced health care costs.[78] Part of adopting a community development approach to hospices services involves planning a programme of organisation-wide culture change.[79]

Identified success factors include listening and aligning to community needs, building capacity of the communities using community development approaches, connecting with GPs, palliative care services and other health services. Challenges include low existing community cohesion, difficulty in shifting mindsets away from medicalised views of care, and funding constraints.

Culturally responsive support to reduce experience of care inequities

The Waikato has grown and is forecast to become increasingly diverse. This requires Hospice Waikato to look closely at equity of service access and experience of care for Māori, Pasifika, and Asian communities. Qualitative studies highlight the value of addressing language barriers, workforce diversity and patient and whānau/family awareness and knowledge of hospice services. [80]

Local and national research highlights significant scope for improvement to reach 'quality end of life for all' for Māori at end of life with a focus on cultural resources that support Māori carers resilience.[81] This includes creating political and cultural space for Māori kaumātua and their whānau to take cultural leadership. Identified priorities in palliative care include centring family connections and local capacity-building to improve cultural relevance of services. Involvement from whānau, continuity of care and after-hours care with a greater Māori workforce and a further emphasis on culturally safe care are key to improving access and experience. [82] Flexibility and multi-sectoral partnerships in palliative care delivery may be most effective at addressing complex cultural barriers.[83] Importance of supporting the right of whānau to actively participate in caring for their dying relatives, maintaining the mana and self-

76 Abel J, Kellehear A, Karapliagou A. Palliative care-the new essentials. Ann Palliat Med. 2018;7(Suppl 2):S3–S14. doi:10.21037/apm.2018.03.04

77 The Australian Government commissioned a review of 12 case studies across Australia, the United Kingdom and New Zealand.

78 Final Report: Compassionate Communities Feasibility Study. Australian Department of Health, 6 July 2018 (Nous Group ©)

79 Abel J, Sallnow L, Murray S, Kerin M. Each Community is Prepared to Help: Community Development in End of Life Care – Guidance on Ambition Six. The National Council for Palliative Care, 2016

80 Frey R, Gott M, Raphael D, et al. 'Where do I go from here'? A cultural perspective on challenges to the use of hospice services. Health Soc Care Community. 2013;21(5):519–529. doi:10.1111/hsc.12038

81 Moeke-Maxwell T, Waimarie Nikora L, Te Awekotuku N. End-Of-Life Care And Mäori Whänau Resilience. Mai Journal, 2014; Vol 3 (Issue 4): 140-152, Volume 3, Issue 2, 2014

82 Slater T, Matheson A, Ellison-Loschmann L, et al. Exploring Māori cancer patients', their families', community and hospice views of hospice care. Int J Palliat Nurs. 2015;21(9):439–445. doi:10.12968/ijpn.2015.21.9.439

83 Caxaj CS, Schill K, Janke R. Priorities and challenges for a palliative approach to care for rural indigenous populations: A scoping review. Health Soc Care Community. 2018;26(3):e329–e336. doi:10.1111/hsc.12469

determination of palliative care patients while meeting needs for a deeply connected and supportive relationship with whānau.[84]

For Asian communities, involvement of family members and provision of palliative care service information at the time of advance care planning improves family satisfaction.[85] Access to interpreters, establishing relationships of trust and community outreach alongside engagement with Asian community networks are recommended quality improvement approaches.[86]

Grow integrated professional networks and earlier access to palliative care support

Incorporating palliative care earlier in the disease trajectory and implementing a phased transition are key components of optimum care.[87] Earlier engagement (home and team based) of palliative care support for people with life-limiting chronic health conditions such as heart failure demonstrated significant improvements including quality of life and satisfaction with respect to dyspnoea, sleep quality and depression and anxiety.[88] Family and carers of people with dementia experience grief and loss multiple times with several of these losses likely to occur before their loved one dies of the disease or co-existing health conditions.[89] Case conferencing for people with advanced dementia can improve medication management, advance care planning, psychological support, family support and terminal care.

The ideal time for preliminary engagement of palliative care services is at the stage of advance care planning. The long-term and often lifelong relationship of general practitioners (GPs) have with their patients and family makes them the ideal initiators of advance care planning. Some of the barriers to achieving this reported include lack of knowledge about treatment options and familiarity with the terminal phase, the patient's lack of awareness of their diagnosis and prognosis (e.g. dementia) and lack of structural collaboration between the GP and specialist.[90] In aged residential care settings staff turnover and lack of individual and family feedback/ experience of care resulted in variable advance care planning outcomes.[91]

84 Ministry of Health. 2014. Palliative Care and Māori from a Health Literacy Perspective. Wellington: Ministry of Health.

85 A total of 30 articles were included: qualitative (24), quantitative (5), and mixed methods (1). Three main themes were discovered: 1) palliative care practice within the family, 2) trust as a precondition of palliative care, and 3) the importance of knowledge and cultural competency.

86 Shabnam J, Timm H, Nielsen DS, Raunkiaer M. Palliative care for older South Asian migrants: a systematic review [published online ahead of print, 2019 Jul 8]. Palliat Support Care. 2019;1–13. doi:10.1017/S1478951519000397 (Abstract only)

87 Gardiner, C., Ingleton, C., Gott, M. et al. Exploring the transition from curative care to palliative care: a systematic review of the literature. BMJ Supportive and Palliative Care 2015; 5 (4). 335 - 342. ISSN 2045-435

88 Methods: A systematic PubMed search was conducted from inception to June 2016 for studies of palliative care interventions for HF patients. Studies of humans with a HF diagnosis who underwent a palliative care intervention were included. Data were extracted on study design, participant characteristics, intervention components, and in three groups of outcomes: patient-centred outcomes, quality-of-death outcomes, and resource utilization.

89 Parker D, Lewis L. Gourlay K. Palliative Care and Dementia. Dementia Australia 2017; Paper Number 43

90 De Vleminck A, Pardon K, Beernaert K, et al. Barriers to advance care planning in cancer, heart failure and dementia patients: a focus group study on general practitioners' views and experiences. PLoS One. 2014;9(1):e84905. Published 2014 Jan 21. doi:10.1371/journal.pone.0084905

91 Gilissen J, Pivodic L, Wendrich-van Dael A, et al. Implementing the theory-based advance care planning ACP+ programme for nursing homes: study protocol for a cluster randomised controlled trial and process evaluation. BMC Palliat Care. 2020;19(1):5. Published 2020 Jan 8. doi:10.1186/s12904-019-0505-7

More age attuned palliative care

Older people with multi-morbidities are projected to be the main recipients of palliative care in the coming decades and persistent pain can limit older adults' quality of life (health and function).[92] National data highlights significant palliative care inequities for older people including those living in aged residential care (villa, rest home or hospital levels).

Best practice indicates the need for integrated approaches to palliative care services engaging with care facilities and the wider health system. Individual targeted interventions targeting a specific element within a facility, such as training of care staff, appear ineffective if not embedded in a broader organizational approach. [93] Key barriers identified included staff beliefs in their capabilities to face dying residents, their attitudes to changes at work as well as the resources and time required. Factors that functioned as either facilitators or barriers related to considerable variation in staff competence and confidence, motivation, and attitudes to work in general, as well as the managers' plans and decisional attitude concerning efforts to develop evidence-based palliative care. Leadership was a facilitator to implementing evidence-based palliative care.[94]

There are reports of different expectations across older people and carers (earlier access to services) compared to health professionals (assignment of a key worker to coordinate care), with differences in opinion on the optimal timing and indications for this service.[95] This highlights the importance of integrated, personalised and holistic care planning and delivery with older people, their whānau and families.

Expanding the scope of community based paediatric palliative care

Early integration of paediatric palliative care for children with life-threatening conditions and their families enhances the provision of holistic care, addressing psychological, social, spiritual, and physical concerns, without precluding treatment with the goal of cure. Community based palliative care teams are well positioned not only to provide continuity of care to children and families but also to facilitate communication among numerous subspecialty services and to help prevent unwanted readmission to the hospital.[96]

The 2012 guidance for integrated paediatric care in New Zealand[97] was informed by consultation with paediatric providers and palliative care service providers in eight DHBs over 6-weeks plus literature reviews. The proposed framework included regional nurse co-ordinators and lead paediatricians linking local health and social service providers with the national specialist service at Starship Hospital. The recommendations have not been formally endorsed nationally as reflected in a lack of national paediatric service specifications. The British children's paediatric palliative care model

92 Morrissey MB, Herr K, Levine C. Public health imperative of the 21st century: innovations in palliative care systems, services, and supports to improve health and well-being of older Americans [published correction appears in Gerontologist. 2015 Dec;55(6):1067]. Gerontologist. 2015;55(2):245–251. doi:10.1093/geront/gnu178

93 Smets T, Onwuteaka-Philipsen BBD, Miranda R, et al. Integrating palliative care in long-term care facilities across Europe (PACE): protocol of a cluster randomized controlled trial of the 'PACE Steps to Success' intervention in seven countries. BMC Palliat Care. 2018;17(1):47. Published 2018 Mar 12. doi:10.1186/s12904-018-0297-1

94 Nilsen P, Wallerstedt B, Behm L, Ahlström G. Towards evidence-based palliative care in nursing homes in Sweden: a qualitative study informed by the organizational readiness to change theory. Implement Sci. 2018;13(1):1. Published 2018 Jan 4. doi:10.1186/s13012-017-0699-0

95 Bone AE, Morgan M, Maddocks M, et al. Developing a model of short-term integrated palliative and supportive care for frail older people in community settings: perspectives of older people, carers and other key stakeholders. Age Ageing. 2016

96 Kaye EC, Rubenstein J, Levine D, Baker JN, Dabbs D, Friebert SE. Pediatric palliative care in the community. CA Cancer J Clin. 2015;65(4):316–333. doi:10.3322/caac.21280

97 Guidance for Integrated Paediatric Palliative Care in New Zealand. Report to the Ministry of Health, New Zealand. September 2012.

similarly stresses the importance of joined up approach between health and social care, children's, and adult services and with services for disabled children.[98]

The significant numbers of deaths under 20 years are in the first year of life and New Zealand data suggests that a considerable unmet need for palliative care in this group. Perinatal palliative care includes options for obstetric and newborn care with a dual focus on palliative care and life-prolonging treatment that can ameliorate suffering and honour patient and family values.[99] Comprehensive and holistic perinatal palliative care should be planned and initiated before birth, initiated early and be integrative and when necessary.[100]

The interdisciplinary approach includes advocating for families, family centred goals and a focus on parent satisfaction with decision making and psychosocial support. Service outcomes include parental satisfaction with physical and psychosocial support, help with the decision-making process, opportunity to parent their infant, infant comfort, and positive personal and family growth.[101]

Interdisciplinary rural palliative care

Several interrelated factors influence rural palliative care provision, in particular an increasingly ageing population, volunteer and health professional workforce and differences between rural communities.[102] A New Zealand survey of rural specialist palliative care service stakeholders (including staff in primary care, aged residential care and the hospital) reported feeling the specialist palliative care teams were under-resourced and that additional educational opportunities were essential.[103] Leadership was considered essential for integrated models to flourish with clear professional boundaries and positive GP and service partnerships.[104]

A nurse-led navigation model[105] including visits bi-weekly to facilitate symptom management, teaching, referrals, psychosocial and spiritual support, advance care planning, community support for practical tasks, and telephone-based support for individuals indicated potential benefits. These related to smooth transitions and enhanced quality of life along the disease trajectory and across locations of care by providing a consistent source of support and education.[106] Other primary care providers can support improved rural palliative care services such a community pharmacist in medicine related decisions and communications.[107]

98 A Guide to Children's Palliative Care (Fourth Edition), 2017. Together for Short Lives, England. Accessible online from: https://www.togetherforshortlives.org.uk/wp-content/uploads/2018/03/TfSL-A-Guide-to-Children's-Palliative-Care-Fourth-Edition-5.pdf

99 Perinatal Palliative Care: ACOG COMMITTEE OPINION, Number 786. Obstet Gynecol. 2019;134(3):e84-e89. doi:10.1097/AOG.0000000000003425

100 Balaguer et al. BMC Pediatrics 2012, 12:25 http://www.biomedcentral.com/1471-2431/12/25

101 Denney-Koelsch E, Black BP, Côté-Arsenault D, Wool C, Kim S, Kavanaugh K. A Survey of Perinatal Palliative Care Programs in the United States: Structure, Processes, and Outcomes. J Palliat Med. 2016;19(10):1080-1086. doi:10.1089/jpm.2015.0536 [Abstract only]

102 Whittall D, Lee S, O'Connor M. Factors affecting rural volunteering in palliative care - an integrated review. Aust J Rural Health. 2016;24(6):350–356. doi:10.1111/ajr.12313 (Abstract only)

103 Landers A, Dawson D, Doolan-Noble F. Evaluating a model of delivering specialist palliative care services in rural New Zealand. J Prim Health Care. 2018;10(2):125–131. doi:10.1071/HC18004 (Abstract only)

104 Thiel V, Sonola L, Goodwin N, Kodner DL. Midhurst Macmillan Community Specialist Palliative Care Service Delivering end-of-life care in the community. The King's Fund. 2013 (Funded by Aetna and the Aetna Foundation)

105 The research included two co-located rural communities, each with a population of approximately 10 000 persons. These communities are located 30 minutes from one another and 4 hours by car from a specialist palliative treatment centre, a commute that entails navigating three mountain passes that often have difficult driving conditions due to weather.

106 Pesut B, Hooper BP, Robinson CA, Bottorff JL, Sawatzky R, Dalhuisen M. Feasibility of a rural palliative supportive service. Rural Remote Health. 2015;15(2):3116.

107 Akram G, Corcoran ED, MacRobbie A, Harrington G, Bennie M. Developing a Model for Pharmaceutical Palliative Care in Rural Areas-Experience from Scotland. Pharmacy (Basel). 2017;5(1):6. Published 2017 Feb 16. doi:10.3390/pharmacy5010006

Benefits for families receiving extended rural palliative care to support dying at home included increased familiarity with dying and a positive impact on bereavement. The palliative care nurses were equally positive, but also commented on the need to debrief and on the heavy emotional toll the work takes.[108] The Midhurst Macmillan Community Specialist Palliative Care Service model of care includes volunteers to support the holistic component of the care coordination model and are matched to patients and some are trained in bereavement counselling. [109]

Expanded reach through enabling technologies

Teleconsultation can enhance communication among patients, families and palliative care teams, reinforces partnership and decreases the burden on families and use of the emergency services.[110] Interprofessional consultation (e.g. indirect specialist palliative service) can contribute to symptom control for home-based palliative care patients and improve advance care planning.

The impact of telehealth and remote patient monitoring has not been well established in palliative care. Remote monitoring using TapCloud indicated improved symptom management and patients in the model and positive patient experiences relate to three main advantages: 1) access to clinicians, 2) quick responses, and 3) improved efficiency and quality of care.[111]

Video consultations to enhance general practitioners (GPs) support of aged residential care facilities can be challenged by facility technical infrastructure, need for repeated staff training, new clinical procedures, and the time to develop the relationships. Video consulting was clinically useful and avoided hospital attendance on a small scale. [112] Specialist palliative care team-patient teleconsultation led to collaboration between primary care and specialist palliative care teams, but interdisciplinary teleconsultations with real-time contact between patient and both professionals were less common but stimulated patient-centred care dialogues.[113]

Telemedicine tools such as Web-based platforms and telephone calls for informal caregivers (usually family members or close friends) can result in significant improvements in some aspects of care. However, they often reported small effect sizes[114,115] and seem to suggest that we are in an exploratory phase.

108 Spelten E, Timmis J, Heald S, Duijts SFA. Rural palliative care to support dying at home can be realised; experiences of family members and nurses with a new model of care. Aust J Rural Health. 2019;27(4):336–343. doi:10.1111/ajr.12518 (Abstract only)

109 Thiel V, Sonola L, Goodwin N, Kodner DL. Midhurst Macmillan Community Specialist Palliative Care Service Delivering end-of-life care in the community. The King's Fund. 2013 (Funded by Aetna and the Aetna Foundation)

110 Pinto S, Caldeira S, Martins JC. e-Health in palliative care: review of literature, Google Play and App Store. Int J Palliat Nurs. 2017;23(8):394–401. doi:10.12968/ijpn.2017.23.8.394

111 Bonsignore L, Bloom N, Steinhauser K, et al. Evaluating the Feasibility and Acceptability of a Telehealth Program in a Rural Palliative Care Population: TapCloud for Palliative Care. J Pain Symptom Manage. 2018;56(1):7–14. doi:10.1016/j.jpainsymman.2018.03.013

112 Wade V, Whittaker F, Hamlyn J. An evaluation of the benefits and challenges of video consulting between general practitioners and residential aged care facilities. J Telemed Telecare. 2015;21(8):490–493. doi:10.1177/1357633X15611771

113 Van Gurp J, van Selm M, van Leeuwen E, Vissers K, Hasselaar J. Teleconsultation for integrated palliative care at home: A qualitative study. Palliat Med. 2016;30(3):257–269. doi:10.1177/0269216315598068 (Abstract only)

114 Marzorati C, Renzi C, Russell-Edu SW, Pravettoni G. Telemedicine Use Among Caregivers of Cancer Patients: Systematic Review. J Med Internet Res. 2018;20(6):e223. Published 2018 Jun 18. doi:10.2196/jmir.9812

115 Zheng Y, Head BA, Schapmire TJ. A Systematic Review of Telehealth in Palliative Care: Caregiver Outcomes. Telemed J E Health. 2016;22(4):288–294. doi:10.1089/tmj.2015.0090 (Abstract only)

APPENDIX 6: FINANCIAL ANALYSIS

Financial forecasts

Operating expenses

	2019/20 Year 0	2020/21 Year 1	2021/22 Year 2	2022/23 Year 3	2023/24 Year 4	2024/25 Year 5	2025/26 Year 6	2026/27 Year 7	2027/28 Year 8	2028/29 Year 9	2029/30 Year 10
Enhanced Status Quo	$11,984,009	$12,591,504	$13,348,329	$13,656,327	$13,973,595	$14,300,461	$14,637,281	$14,964,893	$15,300,923	$15,645,584	$15,991,067
Strategic Shift 1	$11,984,009	$12,591,504	$13,348,329	$13,721,247	$14,106,448	$14,436,544	$14,776,675	$15,107,677	$15,447,180	$15,795,400	$16,144,527
Strategic Shift 2	$11,984,009	$12,591,504	$13,433,629	$13,743,333	$14,062,341	$14,390,982	$14,729,613	$15,059,072	$15,396,985	$15,743,567	$16,091,009
Strategic Shift 3	$11,984,009	$12,591,504	$13,348,329	$13,858,715	$14,388,257	$14,725,216	$15,072,377	$15,410,582	$15,757,464	$16,113,243	$16,470,116
Strategic Shift 4	$11,984,009	$12,591,504	$13,348,329	$13,784,375	$14,242,502	$14,577,919	$14,923,326	$15,259,575	$15,604,306	$15,957,748	$16,312,103
Strategic Shift 5	$11,984,009	$12,591,504	$13,348,329	$13,656,327	$13,973,595	$14,300,461	$14,637,281	$14,964,893	$15,300,923	$15,645,584	$15,991,067
Strategic Shift 6	$11,984,009	$12,591,504	$13,348,329	$13,748,526	$14,166,873	$14,498,454	$14,840,105	$15,172,665	$15,513,765	$15,863,620	$16,214,424

Net Deficit

	2019/20 Year 0	2020/21 Year 1	2021/22 Year 2	2022/23 Year 3	2023/24 Year 4	2024/25 Year 5	2025/26 Year 6	2026/27 Year 7	2027/28 Year 8	2028/29 Year 9	2029/30 Year 10
Enhanced Status Quo	-$20,460	-$400,687	-$851,225	-$840,452	-$825,583	-$805,978	-$780,939	-$808,354	-$835,768	-$862,983	-$913,902
Strategic Shift 1	-$20,460	-$400,687	-$851,225	-$905,372	-$958,436	-$942,062	-$920,332	-$951,138	-$982,025	-$1,012,799	-$1,067,362
Strategic Shift 2	-$20,460	-$400,687	-$936,525	-$927,459	-$914,329	-$896,499	-$873,271	-$902,533	-$931,830	-$960,966	-$1,013,844
Strategic Shift 3	-$20,460	-$400,687	-$851,225	-$1,042,840	-$1,240,245	-$1,230,734	-$1,216,035	-$1,254,043	-$1,292,309	-$1,330,642	-$1,392,951
Strategic Shift 4	-$20,460	-$400,687	-$851,225	-$968,500	-$1,094,490	-$1,083,437	-$1,066,984	-$1,103,036	-$1,139,151	-$1,175,147	-$1,234,938
Strategic Shift 5	-$20,460	-$400,687	-$851,225	-$840,452	-$825,583	-$805,978	-$780,939	-$808,354	-$835,768	-$862,983	-$913,902
Strategic Shift 6	-$20,460	-$400,687	-$851,225	-$932,651	-$1,018,861	-$1,003,971	-$983,762	-$1,016,126	-$1,048,609	-$1,081,019	-$1,137,259

Unfunded Net Deficit

The unfunded net deficit assumes that the additional costs of strategic shift 1 and 4 are funded by the DHB in base contract funding. Therefore, these strategic shifts have the same net deficit as for the enhanced status quo.

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30
	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Enhanced Status Quo	-$20,460	-$400,687	-$851,225	-$840,452	-$825,583	-$805,978	-$780,939	-$808,354	-$835,768	-$862,983	-$913,902
Strategic Shift 1	-$20,460	-$400,687	-$851,225	-$840,452	-$825,583	-$805,978	-$780,939	-$808,354	-$835,768	-$862,983	-$913,902
Strategic Shift 2	-$20,460	-$400,687	-$936,525	-$927,459	-$914,329	-$896,499	-$873,271	-$902,533	-$931,830	-$960,966	-$1,013,844
Strategic Shift 3	-$20,460	-$400,687	-$851,225	-$1,042,840	-$1,240,245	-$1,230,734	-$1,216,035	-$1,254,043	-$1,292,309	-$1,330,642	-$1,392,951
Strategic Shift 4	-$20,460	-$400,687	-$851,225	-$840,452	-$825,583	-$805,978	-$780,939	-$808,354	-$835,768	-$862,983	-$913,902
Strategic Shift 5	-$20,460	-$400,687	-$851,225	-$840,452	-$825,583	-$805,978	-$780,939	-$808,354	-$835,768	-$862,983	-$913,902
Strategic Shift 6	-$20,460	-$400,687	-$851,225	-$932,651	-$1,018,861	-$1,003,971	-$983,762	-$1,016,126	-$1,048,609	-$1,081,019	-$1,137,259

Note that this table does not include capex. Strategic shift 2 has minor capex of $50k pa for three years from 1 July 2021. Strategic shift 4 has an additional $25k pa of capex from 1 July 2022. We assume that additional capex needs will be funded by the Foundation.

Difference from the enhanced status quo

The following tables illustrate the additional costs of each strategic shift over the cost of the enhanced status quo.

Operating expenses

	2019/20 Year 0	2020/21 Year 1	2021/22 Year 2	2022/23 Year 3	2023/24 Year 4	2024/25 Year 5	2025/26 Year 6	2026/27 Year 7	2027/28 Year 8	2028/29 Year 9	2029/30 Year 10
Strategic Shift 1	$0	$0	$0	$64,920	$132,853	$136,084	$139,393	$142,784	$146,257	$149,815	$153,461
Strategic Shift 2	$0	$0	$85,300	$87,006	$88,746	$90,521	$92,332	$94,178	$96,062	$97,983	$99,943
Strategic Shift 3	$0	$0	$0	$202,388	$414,662	$424,755	$435,096	$445,689	$456,541	$467,659	$479,049
Strategic Shift 4	$0	$0	$0	$128,048	$268,907	$277,459	$286,045	$294,682	$303,383	$312,164	$321,037
Strategic Shift 5	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Strategic Shift 6	$0	$0	$0	$92,199	$193,278	$197,993	$202,823	$207,772	$212,842	$218,036	$223,357

Net deficit

	2019/20 Year 0	2020/21 Year 1	2021/22 Year 2	2022/23 Year 3	2023/24 Year 4	2024/25 Year 5	2025/26 Year 6	2026/27 Year 7	2027/28 Year 8	2028/29 Year 9	2029/30 Year 10
Strategic Shift 1	$0	$0	$0	-$64,920	-$132,853	-$136,084	-$139,393	-$142,784	-$146,257	-$149,815	-$153,461
Strategic Shift 2	$0	$0	-$85,300	-$87,006	-$88,746	-$90,521	-$92,332	-$94,178	-$96,062	-$97,983	-$99,943
Strategic Shift 3	$0	$0	$0	-$202,388	-$414,662	-$424,755	-$435,096	-$445,689	-$456,541	-$467,659	-$479,049
Strategic Shift 4	$0	$0	$0	-$128,048	-$268,907	-$277,459	-$286,045	-$294,682	-$303,383	-$312,164	-$321,037
Strategic Shift 5	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Strategic Shift 6	$0	$0	$0	-$92,199	-$193,278	-$197,993	-$202,823	-$207,772	-$212,842	-$218,036	-$223,357

Unfunded net deficit

	2019/20 Year 0	2020/21 Year 1	2021/22 Year 2	2022/23 Year 3	2023/24 Year 4	2024/25 Year 5	2025/26 Year 6	2026/27 Year 7	2027/28 Year 8	2028/29 Year 9	2029/30 Year 10
Strategic Shift 1	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Strategic Shift 2	$0	$0	-$85,300	-$87,006	-$88,746	-$90,521	-$92,332	-$94,178	-$96,062	-$97,983	-$99,943
Strategic Shift 3	$0	$0	$0	-$202,388	-$414,662	-$424,755	-$435,096	-$445,689	-$456,541	-$467,659	-$479,049
Strategic Shift 4	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Strategic Shift 5	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Strategic Shift 6	$0	$0	$0	-$92,199	-$193,278	-$197,993	-$202,823	-$207,772	-$212,842	-$218,036	-$223,357