# Hospice Waikato Service Master Plan

SEPTEMBER 2020

## OUR MISSION

To provide the best possible specialist community palliative care, that enhances the quality of life for those facing end of life and bereavement.

## OUR VISION

Quality end of life care for all.

## OUR 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.

## STRATEGIC CHALLENGES

1. Shift in epidemiology and an increase in prevalence of comorbidities will create different demands for hospice services.
2. Need to improve service coverage due to growth in rural areas, diversity, and variation in socio-economic deprivation.
3. Currently experience variable primary care engagement, limited provider partnerships, unclear service referral pathways.
4. Workforce faces low cultural diversity, wage pressure and is under resourced in medical and allied health.
5. Inflexible funding rules, with insufficient funding of holistic services and pressure on philanthropic sources.

## DESIRED OUTCOMES – TE WHARE TAPA WHĀ

This model of care is consistent with Hospice Waikato's commitment to reducing health inequity and to Te Tiriti o Waitangi.

### TE TAHA TINANA

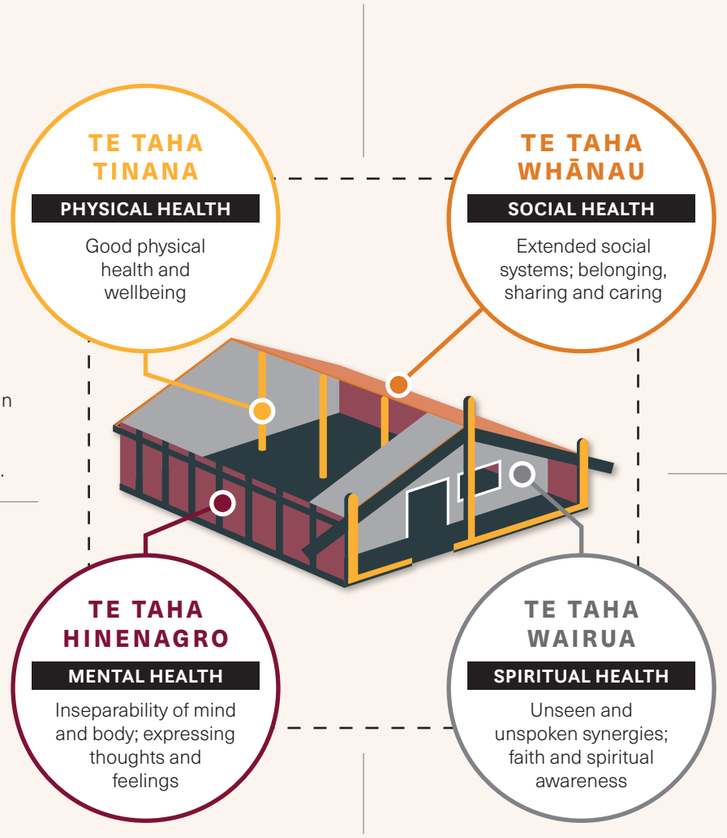
**Mid-term outcomes (5-10 years)**
- Advance Care Plans and palliative care referrals occur as early as is possible.
- Specialist palliative care scope of clinical practice supports seamless transitions of care.
- Patient and whānau care decisions are supported by flexible delivery and funding.

**Long-term outcomes (20 years)**
- Provide quality clinical care within a holistic and inter-disciplinary approach to support changing patient and whānau preferences.

### TE TAHA HINENAGRO

**Mid-term outcomes (5-10 years)**
- Service mix and location is responsive to patient and family/whānau preferences.

**Long-term outcomes (20 years)**
- Support the design and delivery of care that enables patient and whānau preferences.




### TE TAHA WHĀNAU

**Mid-term outcomes (5-10 years)**
- 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.

**Long-term outcomes (20 years)**
- Provide equitable and culturally responsive care within a whānau/family social system.

### TE TAHA WAIRUA

**Mid-term outcomes (5-10 years)**
- Cultural and spiritual needs are understood and services are accessible across language, culture and geography.

**Long-term outcomes (20 years)**
- Support care practices that meet the needs of a culturally and spiritually diverse community.

## KEY CONSIDERATIONS

| 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 service system. | 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. | Strategic decisions will balance realistic limitations to Hospice Waikato strategic priorities while being ambitious about more aspirational options that will require a system response. | 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. |

## HOSPICE WAIKATO VALUE DRIVERS

**WHO**
Value-aligned with the Hospice population health approach to drive service access equity, includes communities not currently reached and the scope of available Hospice services.

**WHERE**
Value-focused on service delivery location that drives value related to convenient access and experience of care that best meet patient and whānau needs.

**HOW**
Factors that enable effective and efficient service delivery. Significant focus on workforces, ICT, businesses processes and other infrastructure.

**HOW**
Optimising health outcomes through more integrated and timely ways of working with service providers across the Waikato palliative care ecosystem.

## KEY SHIFTS – OVERVIEW

1. **Reduce rural service inequities**
   Improving the mix and accessibility of specialist palliative care services for rural residents with a short-term focus on expanding the scope of services particularly social work and counsellors.
2. **Grow cultural responsiveness**
   Maturing organisational cultural competency and building collaborative partnerships including with Māori health providers, improved cultural capability, and a stronger visual identity.
3. **Rebalance holistic care and extend community reach**
   Rebalancing holistic care aligned with Te Whare Tapa Whā and target new communities.
4. **Reduce chronic care inequities**
   Earlier and extended specialist palliative care access for people with life-limiting chronic health problems.
5. **Grow paediatric services and extend community reach**
   Expanding the range and scope of paediatric services to improve equity of access including expanding respite care and, potential expansion of scope of services to include prenatal palliative care and a long-term opportunity to consider a standalone paediatric facility.
6. **More age-attuned palliative care**
   Enhancing specialist palliative care service access for older people in all residential settings with a focus on increasing referrals for people dying with (not from) dementia and frailty by working with aged care and primary care.

# Hospice Waikato Service Master Plan

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## KEY SHIFTS – DETAILS

**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 |

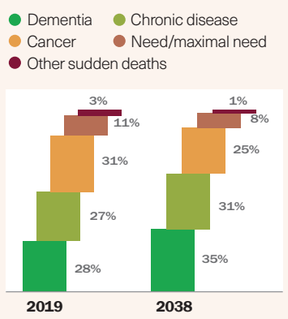
**INDICATIVE ASSESSMENT OUTCOME**

| 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. |

## PREDICTING CARE REQUIREMENTS

The composition of those requiring support and care from Hospice Waikato will need to change to balance service for non-cancer patients.

**Relative Waikato District end-of-life care trajectory group, estimated change**

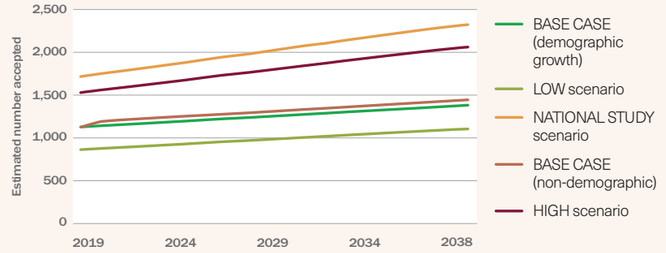



*Broad-order projections based on McLeod & Atkinson (2019) national projections of increased deaths of end of life trajectory groups (2019-2038) has been applied to indicative Waikato DHB district deaths. The majority (77%) of Hospice Waikato services are currently utilised by people dying with cancer.

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)[1].
- Assessment of Palliative Care Need by Cancer Control New Zealand (2011)[2].

**Indicative Hospice volumes of accepted referrals across a range of acceptance scenarios (base 2018-19)**




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 this is current unmet need related to the scope of services available.

1. 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
2. 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

## IMPLEMENTATION PATHWAY

| | HORIZON 1 – STRENGTHEN FOUNDATIONS 2020-21 | HORIZON 2 – SERVICE PILOTS AND STANDARDISATION 2022-25 | HORIZON 3 – LARGER SCALE SERVICE MODEL CHANGE 2025-28 |
|---|---|---|---|
| **Benefits** | • Patients and whānau will see small but useful changes.<br>• Main changes felt by the workforce as a new structure is put in place, new funding is sought, and an improvement in culture is put in place. | • Patients and whānau see improvements in breadth and depth of service available.<br>• Efficiency benefits start to accrue through better performance information.<br>• Improvements on outcomes become evident. | • 'At scale' system benefit realised.<br>• Main benefits realised for patients and their whānau from improvement in outcomes consistent with Te Whare Tapu Whā. |
| **Focus of phase** | • Quick wins for patients and whānau.<br>• Putting in place new capabilities required in Hospice.<br>• Setting up partnership foundations for a growth in services through performance and funding engagement with the DHB. | • Agree new funding arrangements.<br>• Embedding new practices.<br>• Starting system-dependent change.<br>• Piloting and evaluating new service approaches. | • Scaling pilots.<br>• Measuring benefits.<br>• Bigger system-dependent change.<br>• Scoping the next waves of improvement. |
| **Ways of working** | Review partnership capability<br>Establish Māori advisory group<br>Review whānau/patient advisory group | Embed partnership model<br>Implement Strategic Health Equity Plan<br>Embed Volunteer Workforce Plan | |
| **Model of care** | Identify Māori health provider and age care partners<br>Pilot direct support to aged in rural locality | Pilot direct support for Māori Health Providers<br>Re-balance holistic care existing services<br>Expand rural capability<br>Expand paediatric respite in IPU<br>Pilot perinatal model | Implement target expansion of services<br>Expand reach to new 'at risk' communities<br>Feasibility study for paediatric facility |
| **Business improvement and performance** | Undertake detailed workforce time in motion analysis<br>Training to support chronic care and growing digital literacy<br>Develop measurement framework | Define and build continuous improvement practice with particular focus on workforce utilisation<br>Process improvement and simplification programme<br>Review of quality mobile tools<br>Monitoring early process against baseline results | |
| **Funding** | Engage system funders on outcomes of review<br>Develop philanthropic funding strategy aligned to services rather than facilities | Negotiate new funding agreements | Implement new funding arrangements |