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

Overview

Purpose

This document outlines a Resource and Capability Framework for adult palliative care services in New Zealand. The Resource and Capability Framework:

- defines the different levels of palliative care services
- describes the support services and staff capability required at each level.

Audience

The Resource and Capability Framework has been primarily developed for District Health Boards (DHBs) and hospices to guide and assist service planning and funding. It complements the service specifications for specialist palliative care services.

This plan is relevant to the following groups:

- DHB funders
- DHB providers
- Non-government organisations who provide palliative care services (hospices)
- Regional Cancer Networks
- Ministry of Health officials.

Exclusions

This document covers adult palliative care services. It does not cover paediatric palliative care services.

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Background

Palliative Care Advisory Group

The Palliative Care Resource and Capability Framework was developed to support the implementation of the Specialist Palliative Care Service Specifications, which were developed as part of the Palliative Care Strategy (Ministry of Health 2001). The Framework was developed by the Palliative Care Advisory Group.

The Palliative Care Advisory Group provides advice to the Ministry of Health and DHBs (via the Cancer Control Steering Group) on palliative care as part of the Cancer Control Programme.

The Palliative Care Advisory Group provides advice on:

- palliative care service development and improvement
- priorities for palliative care, and
- other areas as requested by the Cancer Control Steering Group.

Palliative Care Strategy

The Palliative Care Strategy was released in 2001. It resulted in a more common understanding of what constituted a modern palliative care service. The Strategy introduced the concept of six tertiary centres for national palliative care provision. It also encouraged service development to follow the generalist and specialist model of palliative care as described by the Working Definition of Palliative Care in New Zealand (Ministry of Health 2007).

Palliative Care Service Specifications

Following the release of the Palliative Care Strategy, palliative care service specifications were developed, with drafts presented to the sector in 2008 and 2010. These service specifications describe common minimum operating environment elements and requirements that both the Ministry of Health and DHBs must use when funding services. They describe varying levels of detail for services in a hierarchical set of tiers one to three; from a high level generic description through to describing a particular service. The services specifications are awaiting further service development work (which includes the finalisation of this framework) before being submitted for final approval

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Background, Continued

Palliative Care Gap Analysis

To support the implementation of the specialist palliative care service specifications a Gap Analysis of Specialist Palliative Care Services in New Zealand (Ministry of Health 2009) was completed. The Gap Analysis revealed a high degree of variability in the structure and resourcing of palliative care services in New Zealand.

The variability is understandable given the history of palliative care development in New Zealand. Services were often developed in response to local need and available resources in an effort to provide local access to palliative care services.

Need for the Resource and Capability Framework

The current difference in the structure, organisation, and level of service makes it difficult to ascertain consistency in patient, family, and whanau access to services. The findings of the Palliative Care Gap Analysis supports the need to develop a consistent and common approach to describing and defining palliative care services in response to population need, hence the development of the Palliative Care Resource and Capability Framework.

Budget 2009 boost hospice funding initiative

As part of Budget 2009 the Government committed $15 million to Boost Hospice Funding. Of this funding $1.3 million was allocated to address Access to Care Pressures. The Access to Care Pressures funding has been used to address hospice and district service gaps based on the results of the Gap Analysis of Specialist Palliative Care in New Zealand (Ministry of Health 2009).

Palliative Care Services

Generalist and specialist palliative care services

The Working Definition of Palliative Care in New Zealand (Ministry of Health 2007) defined generalist and specialist palliative care services. It recommended that generalist and specialist services need to be part of an integrated framework of care provision which may be facilitated through local and regional networks, with defined formal linkages to key services including community primary care, local acute hospitals, regional cancer centres, and other regional palliative providers.

Generalist palliative care is available throughout the course of a life limiting illness, with specialist palliative care provided on the basis of assessed need, rather than simply diagnosis or prognosis. Further information on the distinction between generalist and specialist palliative care is provided below.

Generalist palliative care

Generalist palliative care is palliative care provided for those affected by life limiting illness as an integral part of standard clinical practice by any healthcare professional who is not part of a specialist palliative care team. It is provided in the community by general practice teams, Maori health providers, allied health teams, district nurses, and residential care staff etc. It is provided in hospitals by general ward staff, as well as disease specific teams – for instance oncology, respiratory, renal and cardiac teams.

Some of the generalist providers, e.g. general practice teams, will have ongoing contact with a family throughout and following illness. Others, such as district nurses or ward nurses will have episodic contact, depending on the needs of the patient and family.

Specialist palliative care

Specialist palliative care is palliative care provided by those who have undergone specific training and/or accreditation in palliative care/medicine, working in the context of an expert interdisciplinary team of palliative care health professionals. Specialist palliative care may be provided by hospice or hospital based palliative care services where patients have access to at least medical and nursing palliative care specialists.

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

Specialist palliative care provision works in two ways:
1. Directly – to provide direct management and support of patients and families/whānau where more complex palliative care need exceeds the resources of the generalist provider. Specialist palliative care involvement with any patient and the family/ whānau can be continuous or episodic depending on the changing need. Complex need in this context is defined as a level of need that exceeds the resources of the generalist team – this may be in any of the domains of care – physical, psychological, spiritual, etc.

2. Indirectly – to provide advice, support, education and training of other health professionals and volunteers to support the generalist provision of palliative care provision.

Resource and Capability Framework

About the Framework

The Resource and Capability Framework:

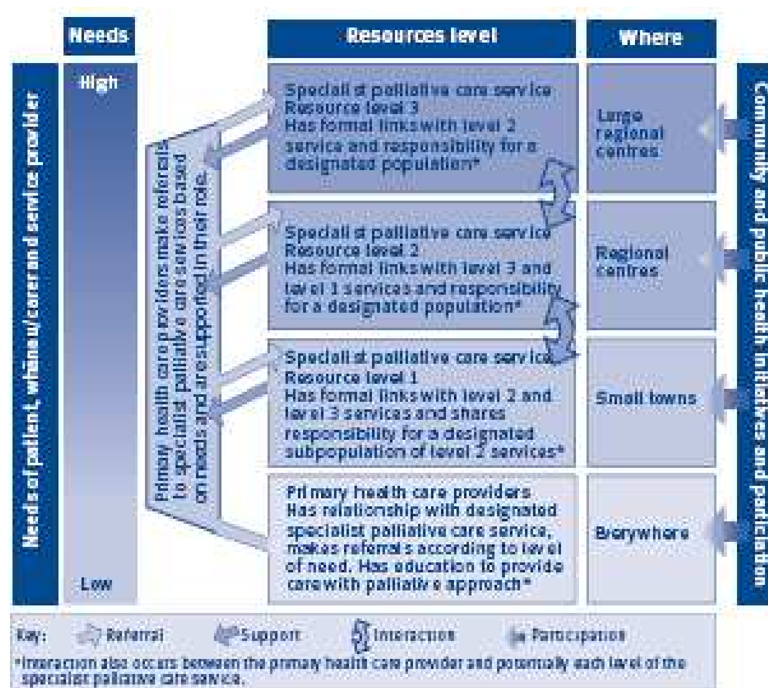
- defines the different levels of palliative care services
- describes the support services and staff capability required at each level.

Palliative care service providers (both generalist and specialist) provide palliative care across a range of levels. The level of palliative care provided should be based on the assessed needs of the patient and their family and whanau. The level of response will also be influenced by the overall capacity and capability of an individual service.

The Resource and Capability Framework

The resource and capability framework, see figure 2, is based on the following three components:

1. **patient need -** any given patient population will have a range of needs, from simple to complex. This need is dynamic,
2. **capability level -** across the range of needs, the response to the needs will be provided by a number of services with differing capabilities
3. **regional locality -** across a the range of needs within a regional locality different services will need to develop linkages and collaborative ways of working enabling equity of access and service provision based on need.



Adapted from *A Guide to Palliative Care Service Development: A population based approach.* Palliative Care Australia (2005)

Collaborative approach

Working together to **improve care is a core component** within the model. The Resource and Capability Framework provides a collaborative inclusive model that incorporates all resource levels. The framework describes the relationships between the multiple providers of palliative care, from generalist through to specialist, based on a population needs approach.

Within the framework, it is expected that formalised links between generalist and specialist providers of palliative care service will ensure the provision of services is appropriate for the patient, family and whanau's needs. It is important to note that this framework is descriptive and not designed to determine service delivery structures or to make decisions in isolation of critical factors such as safety and access.

Capability requirements

The capability required of the various levels of service, generalist and specialist, to meet the needs of the population requiring palliative care is described in table 1.

The table provides further detail on the differentiation between the levels of service shown in the Resource and Capability Framework (figure 2). This sets out the expected capabilities of the primary care providers and the variously resourced specialist palliative care services. The New Zealand context, both overall population size and geography sets out challenges in providing access to interdisciplinary specialist palliative care services. Reflecting the need to ensure efficient use of resources, the table details how the Resource and Capability Framework enables networks of services within the different resource and capability profiles.

Capability table

Table 1. Capability matrix supporting the Resource and Capability Framework

Level	Capability	Resources	Linkages
Primary care and generalist providers	Clinical management and care coordination including assessment, triage and referral using a palliative approach for patients with uncomplicated needs associated with life limiting conditions and / or end of life care.	General practitioner, nurse practitioner, registered nurse, community (district) nurse, Maori health workers, allied health staff, specialist health care providers in other disciplines.	Has formal links with a specialist palliative care provider for the purposes of referral, consultations and access to specialist care based on need

Specialist palliative care Level 1	Provide palliative care for patients, families and whanau whose needs exceed the capability of primary care and other generalist providers. Provides assessment and case consistent with needs, provides consultative support, information and advice to primary care and other generalist providers. Has quality and audit programme.	Multi-disciplinary team including medical practitioner, clinical nurse specialist and psychosocial professionals with skills and experience in palliative care, allied health staff, pastoral care and volunteers. A designated staff member coordinates a volunteer service.	Has formal links with primary care providers and other generalist providers and level 2 and/or level 3 specialist palliative care providers to meet the needs of patients, families and whanau with complex problems.
Specialist palliative care level 2	As for level 1, able to support higher resource due to population size. Provides formal education programs to primary care, other generalist providers and for level 1 providers and the community.	Interdisciplinary team including medical practitioner, clinical nurse specialist / practitioner, and psychosocial professionals with specialist qualifications. Includes designated allied health and pastoral care staff.	Has formal links with primary care providers and other generalists providers and level 3 services for patients, families and whanau with complex needs.
Specialist palliative care level 3	Provides comprehensive care for patients and families and whanau with complex needs. Provides local supports to primary care providers, other generalist providers, regional level 1 and / or 2 services including education and standards. Comprehensive research and teaching role.	Interdisciplinary team including medical director and clinical nurse specialist / practitioner, psychosocial professionals and allied health staff with specialist qualifications in palliative care.	Has formal links with local primary care providers, and other generalist providers, with specialist palliative care providers level 1 and 2 and relevant academic units including professional chairs where available.

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Resource and Capability Framework, Continued

Capability in practice

Typically a level 1 specialist palliative care service would exist in a smaller population area where higher levels of resources are not warranted on an ongoing basis. However, it is expected that the larger regional centres and areas would have a level 2 specialist service available.

Level 3 specialist services would be readily available as part of the whole system but will be fewer in number and exist to cover their local area with additional responsibility for a large region including regional and rural areas through formal links with level 1 and 2 services. It is expected that level 3 services will also have a responsibility for a designated local population in addition to the supportive and specialist consultation roles.

A number of specialist palliative care services have volunteer services. Clear protocols should exist within specialist palliative care services about the utilisation and management of volunteer services, including access to volunteer services by primary care providers and other generalist providers without the ongoing need for specialist palliative care support.

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Implementation

Implementation implications

The implementation of such a model will have implications for service development across the board. This will include:

1. review of ways in which both generalist and specialist services see their strategic development
2. influence development of individual services in line with an integrated model
3. promote the development of collaborative linkages between generalists and specialists, as well as between different levels of specialist services
4. development of agreed referral and assessment protocols for the levels of palliative care need within the population.

The Resource and Capability Framework emphasises the refinement of the role of primary care providers and the various specialist palliative care services to ensure sustainable and comprehensive health care that meets the populations' needs. The Resource and Capability Framework emphasises that the distribution of patients across the levels should be based on assessed need rather than diagnosis or locality. This means that there may potentially be an increase in the acuity of patients seen by specialist palliative care services, with less complex patients cared for by primary care providers.

Comprehensive resource material will need to be developed to support primary care providers including resources for generalist nursing services, general practitioners, residential aged care facilities and acute hospitals. Some resources have already been developed, and should be shared nationally.

The Resource and Capability Framework is not intended to be a cost shifting exercise It is anticipated that full implementation of this model of palliative care provision will provide access to an appropriate level of care for all those with palliative care need. It will take some time with some initial blurring between the levels as services reconfigure to support the intent of the Resource and Capability Framework and specialist palliative care service specifications.

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