



Submission to the Ministry of Health on Palliative Care Services

The National Council of Women of New Zealand (**NCWNZ**) is an umbrella organisation representing 51 nationally organised societies and national members. It has 23 branches throughout the country attended by representatives of those societies and some 150 other societies as well as individual members. NCWNZ's function is to represent and promote the interests of New Zealand women through research, discussion and action.

This submission has been prepared by the NCWNZ Social Issues Standing Committee after consultation with the membership of NCWNZ.

INTRODUCTION

NCWNZ made a submission in 2002 to the New Zealand Palliative Care Strategy Discussion Document. Since that time (2006) we have also adopted a supporting resolution, that "NCWNZ requests the government to fund the total cost of the three core health services by Hospices, those services being Assessment and Co-ordination, Clinical Care and Support Care."

Thank you for further opportunity to again make a submission. Many of our members throughout New Zealand gave personal experiences of using Palliative care services.

Many members have also been involved with Hospice as volunteers, employees and service users. While the public perception of using Hospice services is for cancer patients it must be noted that the service is for all with terminal illnesses. Members felt that this needed to be more widely highlighted that the service is also available for all cultures similarly requires greater promotion.

Q1. The draft Resource and Capability Framework proposes three levels of specialist Palliative care services. How many levels of specialist care services do you recommend are required in New Zealand?

A1. One level, or two at the most. This is seen as the beginning of care and referrals can be made to the appropriate specialist from the point of entry. Not all people referred for Palliative care need to see a specialist and other services can be recommended at this stage. Having one point of entry can provide clarification in regard to immediate and long term treatments.

A definition of what is within 'specialist services' is needed as this could be medical, nursing or Allied Health services. At times the only care needed will be by caregivers with GP support.

Q2. An alternative approach to role delineation, as described by the recent Palliative Care Funding Review in the United Kingdom, has also been presented during the consultation forums.

Do you consider this model has merit as an appropriate framework for New Zealand?

A2. Agree. This model needs to allow flexibility so smaller services are not cut and the Holistic care model is retained. All roles within the framework need to be clearly defined with families included in this.

Q3. Formalised linkages between generalist and specialist providers are essential to ensure appropriate services are available to meet the continuum of needs from uncomplicated to complex.

A3. Agree. Linkages are necessary. This is where the single entry point would be foremost in ensuring that service users are advised about all services available. Trust rather than formal agreements between services is seen as more useful as this will allow for greater flexibility of service use. This would also provide clarity of the roles of primary and secondary service providers.

Q4. The United Kingdom National Council for Palliative Care and the National Health Services (NHS) National Institute for Clinical Excellence (NICE) 'Guidelines for Improving Supportive and Palliative Care for Adults with Cancer (2004)' recommends specialist palliative care teams should include palliative medicine, consultants and palliative care nurse specialists together with a range of expertise provided by physiotherapists, occupational therapists, dieticians, pharmacists, social workers and those able to give spiritual and psychological support. Specialist palliative care teams in New Zealand should reflect this team composition.

A4. Strongly agree. This should also include cultural support as New Zealand is a multicultural society. This could be formal or informal agreements depending on each individual DHB and will need to be clearly defined.

Influencing Policy for Women to Thrive

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Q5. A. To reduce variability and increase equity to services, national eligibility criteria for access to specialist services need to be defined.

A5 A. Strongly agree. New Zealand's rural and urban populations have differing requirements and equity of care is essential

Q5 B. An example of eligibility criteria for specialist care services is the Leeds Eligibility Criteria (Bennett 2002) . This includes three key criteria:

1. The patient has active progression and advanced disease.
2. The patient has an extraordinary level of need (those which exceed the resources of the primary team).
3. The patient has been assessed by a Specialist Palliative care team.

Patients are required to be reviewed and the criteria serve as both entry and exit criteria and on a needs basis patients will be referred back to their original health care team.

A5 B. Services should reflect individual needs. Access should be automatic if needed and referrals given for the required services.

Q6. The Working Definition for Palliative Care in New Zealand (2007) states that, "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."

What form should this specific training take/what minimum qualification for specialist teams are required for?

Medical staff

Nurses

Social Workers

Councillors

Allied Health staff

A6. Training and qualifications for specialist teams should be regularly audited to ensure they keep pace with current care standards. Funding is available for medical staff but needs to be available for other team members.

Q7. At least 60% of staff in specialist services described above as requiring specialist palliative care qualifications will hold the agreed qualification in order that the service may meet the criteria for the specialist service level. The remainder of staff will be actively engaged in gaining qualifications in specialist palliative care.

A7. Agree. Levels of Specialist qualifications can depend on geographical areas and the availability of funding for training. This needs to be made available, especially for Nursing staff who are with patients 24 hours a day. Support from individual hospitals/places of care is necessary to maintain qualification levels.

Q8. All specialist palliative care services will have a continuous quality and audit programme applicable to palliative care.

A8. STRONGLY agree. These are needed to improve the quality of care and to ensure up to date data and research is available and used. It is essential for future planning in relation to continued high quality care, training, availability of service and improved outcomes.

Q9. Specialist palliative care advice for health professionals must be available in all areas of New Zealand on a 24 hour /seven days a week basis. This may be accessed via regional linkages.

A9. Strongly agree. Rural areas need funding for up to date technology and training to use it. Availability of Pharmacy and other essential services must be available in rural areas as well.

Q10. Specialist palliative care teams will be required to be actively involved in the provision of training and education on palliative care.

A10. Strongly agree. This will enhance the knowledge and education of other teams and make them aware of the available services.. This will also ensure equity in the level of care and provision of service throughout New Zealand, whether rural or urban. It will also help with research and planning for future services and funding.

Q11. Please identify any other issues you feel require consideration in the implementation of the framework.

A11. Transport from rural areas, accommodation for families from out of area, funding for family/children's counselling, more home based carers training/support for families, increased funding for respite care/more beds available.