

# Community specialist palliative care services in New Zealand: a survey of Aotearoa hospices

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## ABSTRACT

**AIM:** Community specialist palliative care (SPC) in Aotearoa New Zealand is provided by independent hospices. Substantial increase in demand for palliative care is projected in the next 20 years. We aimed to describe the current landscape of SPC services across Aotearoa whilst incorporating an equity lens.

**METHODS:** A descriptive cross-sectional survey was undertaken to describe aspects of hospice service and populations served. Survey links were emailed to clinical, or service leads of hospices identified via Hospice New Zealand Website.

**RESULTS:** All eligible hospices (n=32) completed the online survey. All hospices provided care at home, with 94% (n=30) also providing care for patients in aged residential care facilities. All 32 hospices provided symptom management, family and carer support and bereavement care. Six hospices (19%) did not provide afterhours cover. Fifteen (47%) hospices did not have Māori cultural position and median full time equivalent across all hospices for such position was one day per week. Only nine (28%) hospices provided palliative medicine specialist training.

**CONCLUSION:** Areas of inconsistency were highlighted including afterhours access and cultural support for Māori. The capacity of the present system to address current and future shortages of palliative medicine specialist is questioned.

With Aotearoa New Zealand's ageing population, demand for palliative care is projected to increase substantially in the next 20 years, whilst equitable access to palliative care services is emphasised in the Ministry of Health's Palliative Care Action Plan.<sup>1,2</sup> Like other well-resourced countries, community palliative care in New Zealand is delivered via a primary-specialist model.<sup>3</sup> The Ministry of Health has based their definitions of specialist and primary palliative care on providers' degree of training or experience and those who work exclusively in palliative care. Primary palliative care is provided by any health professional who is not part of a specialist palliative care team as an integral part of their standard practice, e.g., a general practice team.<sup>4</sup> Community specialist palliative care (SPC) services deliver or support home-based care for those who have life limiting condition and in New Zealand, is currently delivered by 33 hospices. Hospices in New Zealand are independent, charitable organisations that provide support to people with life-limiting conditions and their whānau at no cost to patients.<sup>5</sup> These hospices provide care both directly to patients with complex needs and indirectly by supporting primary palliative care teams to care for their patients with palliative care needs.<sup>2</sup>

Health disparities in New Zealand are well documented, and Māori experience both higher cancer incidence and higher mortality rates than non-Māori regardless of education level or occupation.<sup>6,7</sup> Moreover, palliative care services have not historically been developed to specifically meet the needs of Māori. Māori have not accessed palliative services at similar levels as non-Māori, possibly due to low levels of awareness or misconceptions of palliative care services.<sup>8,9</sup> Recent calls for more equitable healthcare delivery have included consideration of palliative care.<sup>10</sup> To develop a sustainable and equitable model for the future requires starting with a stocktake of the status quo, including areas of gaps and inequity.

Criteria for defining models of specialist palliative care remains a developing area of research; furthermore, the term "model of care" is used inconsistently in studies and policy documents.<sup>11</sup> Up until recent work by Firth et al., there has been no consensus on core components of a specialist care service model both internationally or in New Zealand, which poses challenges for making comparisons between models of care and development of evidence based health policy.<sup>12</sup> Research examining models of specialist community palliative care in New Zealand is very limited.<sup>11</sup> Ser-

vice models differ across the country, and studies in New Zealand have generally been limited to individual services and certain aspects of the palliative care services.<sup>13,14</sup> Unlike other well-resourced countries, benchmarking or stocktake of SPC services has not yet been conducted in New Zealand.<sup>15</sup> Moreover, provision of quality SPC services in rural communities remains a challenge and under-resourcing of SPC services in remote areas in New Zealand is well recognised.<sup>16</sup>

The objective of this study is to describe the current landscape of specialist community palliative care services across New Zealand whilst incorporating an equity lens on these services.

## Methods

### Study design

This study used a descriptive cross-sectional survey to describe and summarise aspects of hospice services. The survey design was based on the Firth et al.'s conceptual framework that sets out core components of specialist palliative care service, with the addition of questions on equity and service provision for Māori populations.<sup>12</sup> An online survey was created using Qualtrics software (Version [July 2021] of Qualtrics, Qualtrics, Provo, UT, USA). Paper-based surveys were also available on request. There were 31 service-related questions with five additional demographic questions about the respondent who completed the survey. Examples of aspects of services of interest were related to care settings, staffing, number of referrals, demographics of serviced population, types of care provided, out-of-hours (See Appendix 1 for the full set of survey questions). The survey was peer reviewed by three senior clinicians before dissemination.

### Study population and recruitment

A total of 33 hospices were identified via Hospice New Zealand website. One hospice does not provide direct clinical care and hence was excluded from the study. Clinical or service leads of each of the 32 remaining hospices were emailed individualised links to the online survey, participant information sheet and consent form. Hospice New Zealand assisted with recruitment by emailing out an introductory letter about the research project to all hospices in April 2021, which was followed by survey links two weeks later. Participants were asked to give consent electronically prior to undertaking the survey. The study was approved by the University of Otago Ethics Committee (D20/024).

## Data analysis

Responses were recorded in Qualtrics and downloaded to an Excel spreadsheet and statistical analysis was conducted using statistical computing software R 4.1 (R Institute, Vienna, Austria). Questionnaire responses were reported using descriptive analysis, e.g., frequencies, means and standard deviation to determine the general patterns in the data. As the respondent frame covered the entire set of Hospices operating in New Zealand at the study date, no inferential statistics were calculated or reported.

## Results

### Clinical and psychosocial services

All 32 invited hospices completed the online survey. Most hospices provided direct hands-on care (n=31) and all hospices provided face to face care whilst just over half (n=16; 53%) also offered telehealth. All hospices provided care at home, with 94% (n=30) also providing care for patients in aged residential care facilities. All 32 hospices provided symptom management, family and carer support and bereavement care. Most hospices also provided psychological care (n=30; 94%) and spiritual care (n=30; 94%) with a smaller number providing respite care (n=17; 53%) and rehabilitation (n=8; 25%).

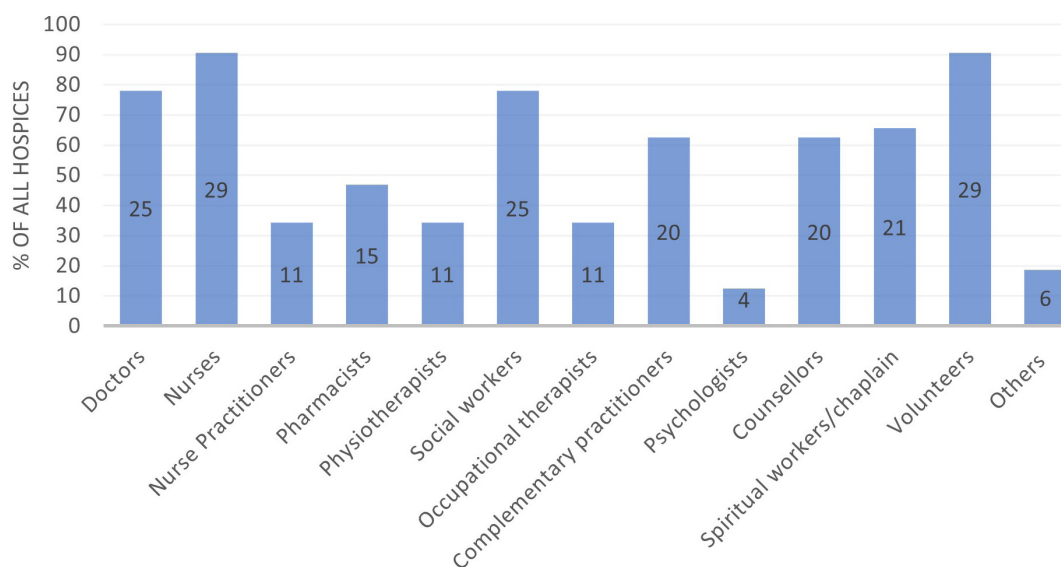
Fewer than half of all hospices (n=13) had inpatient units, with the majority of these having between six to ten beds (n=11). The most frequent number of referrals accepted were in the range of 200 to 499 per year, with only a minority of hospices (n=6; 19%) receiving more than 1,000 referrals per year. Almost all hospices reported having standardised acceptance criteria (n=31; 97%).

The most frequently employed professions were nursing (n=29; 91% of hospices), followed by medical professionals and social workers (both n=25; 78%), spiritual workers (n=21; 66%), complementary practitioners and counsellors (n=20; 63%) (see Figure 1). Within medical personnel, the most commonly employed roles were palliative medicine specialists (n=21; 66%), followed by medical officers (n=19; 59%) and general practitioners (n=11; 34%). Only nine hospices (28%) had positions for palliative medicine advance trainees.

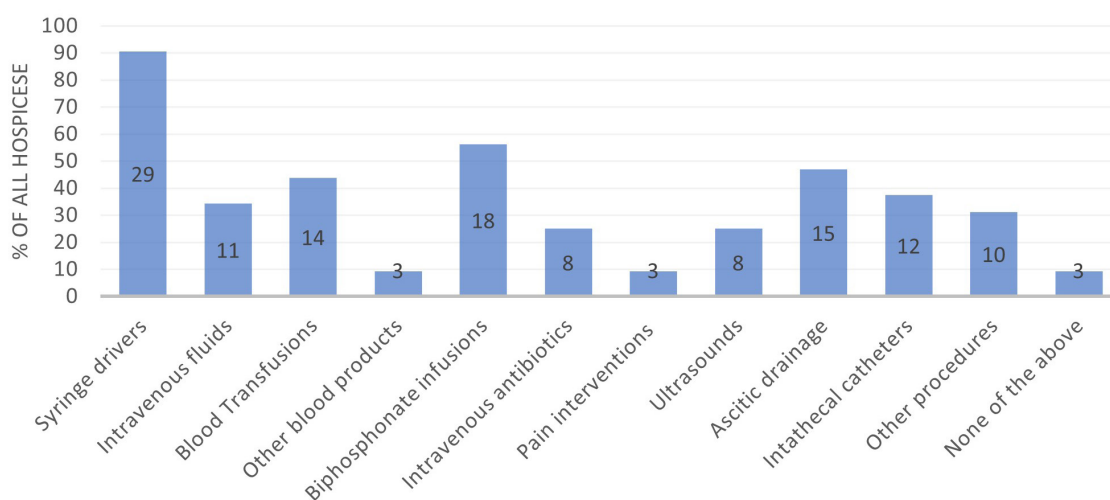
Hospices offer a range of procedures with syringe drivers (91%) being the most common (see Figure 2).

Most hospices provide spiritual care (n=29; 91%) and care is delivered by a staff spiritual carer (n=20; 63%), visiting spiritual carer (n=11; 34%) and by "others" (n=9; 28%).

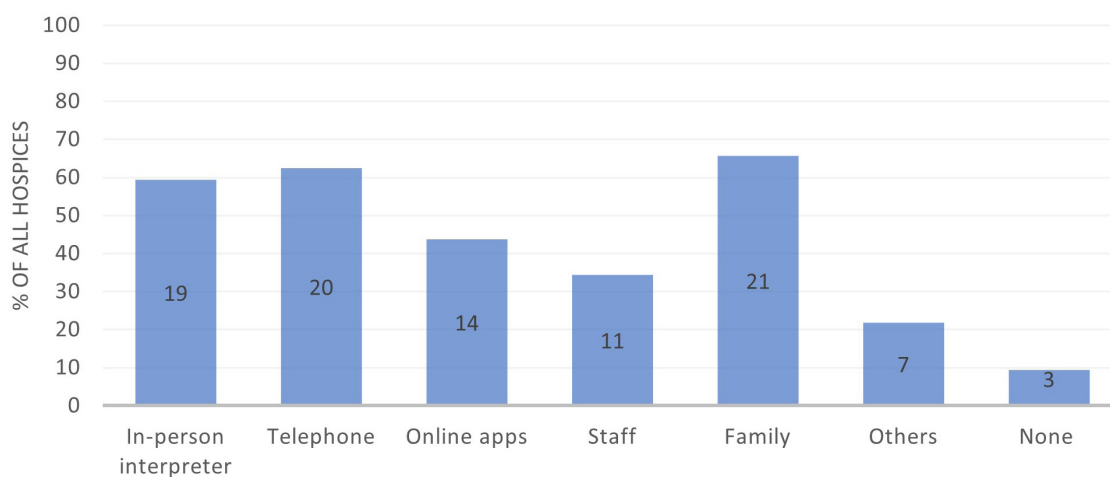
**Figure 1:** Professions employed by New Zealand Hospices (n=32 total).

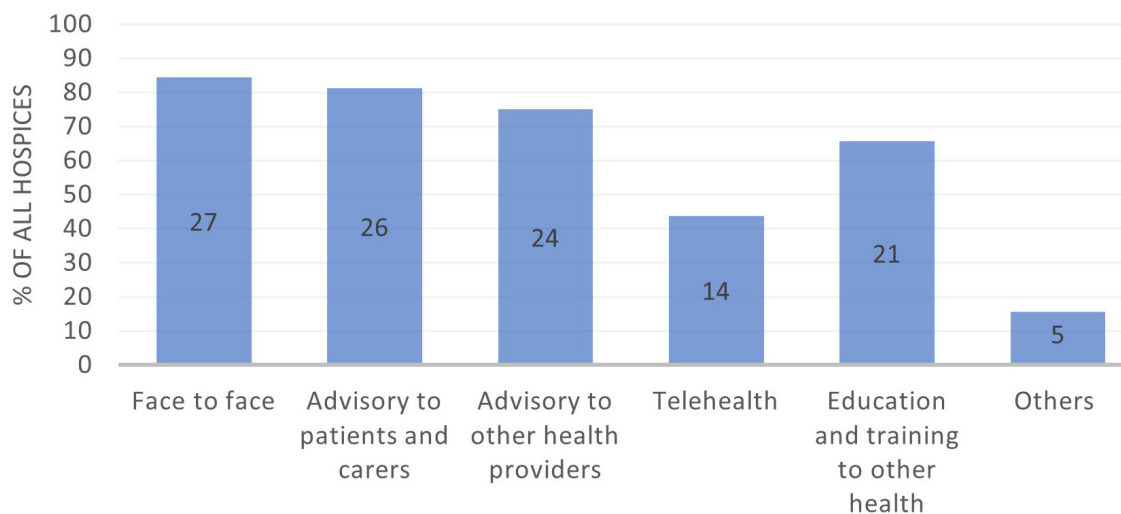


**Figure 2:** Procedures provided by New Zealand Hospices (n=32).



**Figure 3:** Types of interpreting services used in hospices.



**Figure 4:** Types of care provided in rural areas by hospices.

About two-thirds of all hospices (n=22; 69%) had implemented patient reported outcome measures in their clinical services, with most (n=19) having adopted the Outcome Assessment and Complexity Collaborative's (OACC) suite of measures (either Palliative care Outcome Scales [POS]; or Integrated Palliative care Outcome Scales [IPOS]).<sup>17</sup> Another suite of measures used were Palliative Care Outcomes Collaboration (PCOC) (n=4) and four hospices reported use of other measures.<sup>18</sup>

Provision of afterhours nursing and medical service was reported for 22 and 20 hospices respectively, with four of these hospices offering "telephone advice only". Six hospices reported that no routine afterhours care, either directly or via telephone, was available for their patients. Only a minority of hospices provide afterhours psychological (n=3; 9%) and spiritual care (n=6; 19%).

The mean percentage of cancer and non-cancer patients across all hospices were 64% and 36%, respectively. Ten hospices only provided care to adults, and there was no paediatric-only hospice.

### Education and integration with other health providers

Most hospices offered specific education sessions to outside professionals (n=28; 88%) with most of these same hospices also delivering onsite professional (n=26) and student training (n=25). Of note, only nine hospices (28%) were found to be specialist palliative medicine training sites. Most hospices offered liaison staff in other settings: hospital (n=14; 44%), primary care (n=10; 31%), aged residential care (n=20; 63%) and other settings (n=6; 19%). Seven hospices (22%) had no liaison staff in other settings.

### Bereavement care

All hospices provided non-complex bereavement care for adults, and a majority (n=21; 66%) extended that care to bereaved children. Many hospices also provided complex bereavement care for adults (n=22; 69%) and just under half (n=14; 44%) offered complex paediatric bereavement care. Modes of routine contact following death were telephone (n=29; 91%), letter (n=20; 63%), face-to-face (n=24; 75%) and in a group (n=20; 75%).

### Equity in care

About three-quarters of hospices reported keeping ethnicity data for their patients (n=23; 72%) and these hospices were asked to give the estimated percentage of patients seen by their service. The median percentages of NZ European, Māori and Pasifika peoples were 70%, 17% and 1%, respectively. Percentage of Māori seen ranged between 3 to 17% across the 23 hospices.

### Māori population

Māori cultural competency staff training was reported by most hospices, covering topics of Te Tiriti o Waitangi (n=25; 78%), Māori customs (n=18; 56%), Te Wairuatanga (n=14; 44%) and other topics (n=10, 31%). Three hospices reported no staff training in Māori cultural competency (9%). All hospices reported having knowledge of local Iwi and/or Māori providers, with 10 hospices (31%) having partnership agreements and 19 (59%) engaged regularly with Māori providers. Types of regular engagement reported were hui (n=10; 31%), written correspondence (n=9; 28%),

social media (n=1; 3%) and others (n=9; 28%). Fifteen (47%) hospices do not have a cultural, or liaison position designated for Māori and median full time equivalent (FTE) across all hospices for such position was 0.2 FTE (i.e., one day per week equivalent).

### **Other cultural groups**

Four hospices (12.5%) reported of having cultural liaison staff specific for other cultural groups with two of these hospices having support staff for more than one ethnic groups. Ethnic groups catered for by support staff were Pasifika (n=2; 6%), East Asian (n=3; 9%) and South Asian (n=1; 3%). About two-thirds (n=22; 69%) hospices reported having a budget for interpreter services. Common types of interpreting services used were reported to be via family, telephone and in person professionals (see Figure 3). Only seven (22%) hospices reported having a specific policy for patients with a disability.

### **Rural communities**

Most hospices (n=28; 88%) reported providing care in rural areas, defined in the survey as more than 30 minutes travel time from the nearest base hospital.<sup>19</sup> Figure 4 displays the types of care offered.

## **Discussion**

This study surveyed all hospices in New Zealand regarding the populations they serve and services they provided and is the quantitative part of a mixed method study for determining a future model for community specialist palliative care in New Zealand. This study found areas of similarity and variability in services provided by hospices. Areas of similarity include a holistic approach to care, a cornerstone of palliative care; and hands-on care including end-of-life care delivered at home by multi-disciplinary teams.<sup>20</sup> Such a finding is noteworthy as home base palliative care programmes have been shown to improve quality of life, increase home deaths, reduce hospital service utilisation and to be cost-effective.<sup>21-23</sup> Another commonality was that hospices commonly engage in education for people in primary palliative care roles. Education and training are known to facilitate collaboration between primary and specialist palliative care; however, previous studies found effective education models may vary between professionals.<sup>24</sup> A previous study in New Zealand evaluating a palliative education programme in the form of workshops, that

aligns with clinical practice, resulted in sustained improvement in knowledge, skills and confidence in general practitioners.<sup>25</sup> Similar research should extend to other professional groups to identify elements of effective education model. The last Ministry of Health Workforce Stocktake, published in 2009, identified palliative care medical specialists as one of the biggest workforce issues for both hospices and hospitals. One could argue whether the small number of advanced training hospices found in the present study is adequate to remedy the workforce shortage issue and meet future demand.<sup>4</sup>

As a contrast, the study identified many areas of variability between hospices, some of which may lead to inconsistent care across settings and population groups, a concern previously voiced by the New Zealand palliative care sector.<sup>1</sup> A key element of providing end of life care at home is to have round-the-clock access to palliative care including SPC; the fact that 19% of hospices were unable to provide any afterhours care (direct or via telephone) is potentially concerning, although it is unclear from this survey whether alternative arrangements with other out-of-region SPC providers exist to fill that gap. This finding suggests hospices are more limited to provide after-hours care to their patients than previously reported.<sup>4</sup> Conversely, comparing with the Ministry of Health's report in 2009, the number of hospices with an inpatient unit has increased by one, although it is not known whether this led to changes in the total number of hospice beds in New Zealand.<sup>4</sup>

The New Zealand Palliative Care Strategy highlighted Māori as a group requiring specific policies, community linkages and care coordinators to ensure "culturally appropriate" and "coordinated" service implementation.<sup>26</sup> Although the majority of hospices were found to offer Māori cultural competence training, the varying availability of Māori liaisons or their equivalent suggests inconsistent access to appropriate cultural support. Similarly, this study also found varying levels of support for other cultural groups including Pasifika peoples. Health equity is a priority in New Zealand and the relatively small number of hospices engaging actively with local Māori providers indicates that further work in this area is needed. Future efforts can be guided by Hospice New Zealand's recently published Mauri Mate that sets out a Māori Palliative Care Framework for hospices, including one recommendation for the need for hospices to develop good engage-



ment and relationships with local Māori communities. These relationships could help to dispel myths about hospices (as only a place for people to die) and reveal insights into traditional Māori values, customs and local resources.<sup>27</sup>

This survey also highlights a potential gap for hospices in meeting the palliative care needs of people with disabilities as only a minority of hospices have policy specific for this frequently overlooked group. The rising number of people with disability living into old age will see increasing age related illnesses requiring palliative care, ideally delivered by a workforce that are equipped and confident to meet their unique needs.<sup>28</sup>

Historically, hospices in New Zealand and overseas have had a strong focus in caring for cancer patients.<sup>8</sup> Although there is an increasing recognition of the value of palliative care for people with non-malignant diagnoses,<sup>1</sup> this study found the profile of patients continues to weigh heavily towards cancer. One explanation could be that the unpredictable trajectory of non-malignant diseases makes appropriate timing of referral to palliative care difficult.<sup>29</sup> As the burden of non-malignant disease increases with the ageing population, changes in the model of care may be required. For instance, this might include SPC services providing episodic instead of the usual round-the-clock care for chronic conditions to support primary care teams via shared patient electronic records and, in the event of patients' sudden deterioration, enhanced responsiveness to enable home deaths.

Community SPC access for children continues to be challenging due to the small number of paediatric patients seen in general. The current model of Starship Hospital, Auckland being the national resource service to collaborate with patient's primary paediatric team and local adult specialist palliative care services is likely to continue in the foreseeable future.<sup>4</sup>

There were several strengths to this study. To the authors' knowledge, this is the first comprehensive study to describe community SPC services

in New Zealand. All eligible hospices responded which provides an excellent snapshot of populations served and current service provision. The survey utilised an existing robust framework specifically designed for describing specialist palliative care services.<sup>12</sup> The survey covered a range of areas of relevance for future planning in Aotearoa New Zealand, including a focus on Māori population and equity.

There were several limitations to this study. Qualitative responses were limited to free-text boxes with a lack of details to clarify responses especially when respondents chose the "others" option. Although most hospices reported providing services to rural communities, due to the service provider framework utilised in this study, comparison between rural and urban services was not feasible and a future study from a service population perspective that specifically examines inequity in access to SPC in rural areas is warranted. There is considerable overlap in the catchment areas covered by hospices which precludes subgroup analysis according to geographical areas and population size. Financial data collection was outside the scope of this study and the extent to which variations found between hospice services attributable to funding levels was not examined.

## Conclusion

The present study demonstrated hospices in New Zealand provide holistic care at home by multi-disciplinary teams. Areas of inconsistency were highlighted, particularly in afterhours access to SPC and cultural support for Māori and other ethnic groups. The number of advanced training hospices remains small and the capacity of the current system to address shortages in the previously identified palliative medicine specialists is questioned. Future studies comparing SPC services between rural and urban communities in New Zealand is warranted to identify other areas of inequity.

**COMPETING INTERESTS**

Nil.

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**Appendix 1**

A1. What is the purpose of the care provided in your service? (please tick as many as apply)

- Symptom management
- Family and carer support
- Psychological care
- Bereavement care
- Care of the dying (last few days of life)
- Respite care
- Spiritual care
- Rehabilitation
- Others (please specify in textbox below)

A2. Does your service accept patient or family self-referrals directly (i.e., not via another service providers, e.g., primary care team)?

- Yes
- No

A3. Within which setting is your service delivered? (please tick as many as apply)

- Inpatient hospital
- Inpatient hospice
- Home based care at patient's own home
- Aged residential care home
- Outpatient
- Day care
- Prison
- Others (please specify in textbox below)

A4. What type of care does your service provide? (please tick as many as apply)

- Direct "hands on, face-to-face" care
- Advice and support to patients and family e.g., phone advice or providing prescription to patients and families
- Consult advice and support to other professionals caring for individual patients e.g., primary care or other specialties
- Education and training to professionals (not in relation to specific individual patients)
- ☒Other (please specify in textbox below)

B1. How many new referrals are accepted and seen annually by your service?

- <200
- 200–499
- 500–999
- 1000–3499

- 3500–5000
- >5000

B2. How many inpatient beds does your service have?

- No inpatient bed
- 1–5
- 6–10
- 11–15
- 16–20
- >20

B3. Which DHB(s) does your service catchment area come under? (please tick as many as apply)

- Auckland DHB
- Bay of Plenty DHB
- Canterbury DHB
- Capital and Coast DHB
- Counties Manukau DHB
- Hawkes Bay DHB
- Hutt Valley DHB
- Lakes District DHB
- MidCentral DHB
- Nelson–Marlborough DHB
- Northland DHB
- South Canterbury DHB
- Southern DHB
- Tairāwhiti DHB
- Taranaki DHB
- Waikato DHB
- Wairarapa DHB
- Waitematā DHB
- West Coast DHB
- Whanganui DHB

C1. Which of the following professionals does your service employ? (please tick as many as apply)

- Doctors
- Registered nurses
- Nurse practitioners
- Healthcare assistants
- Social workers
- Pharmacists
- Complementary practitioners e.g. music/art/lymphoedema (please specify in textbox below)
- Physiotherapists
- Occupational therapists
- Psychologists
- Counsellors

- Spiritual workers/Chaplains
- Volunteers
- Other (please specify in textbox below)

*Display This Question:*

*If C1 = Doctors*

C2. Which of the following types of doctors does your service employ (excluding relieving or locum staff)? (please tick as many as apply)

- Palliative medicine specialist
- Medical officers
- General practitioners
- Palliative medicine advance trainees
- Registrars
- House surgeons
- Others types of doctors (please specify in textbox below)

C3. How is care provided by your service? (please tick as many as apply)

- Face-to-face
- Telephone advice or support
- Telehealth other than telephone advice or support
- Others (please specify in textbox below)

C4. Which of the following procedures does your service provide to your patients? (please tick as many as apply)

- Syringe driver
- Ultrasound
- Ascites drainage
- Pain intervention procedures e.g., nerve block
- Intravenous fluids
- Other procedures (please specify in textbox below)
- Blood transfusions
- Biphosphonate infusions
- Other blood products
- Intravenous antibiotics
- Domiciliary management of intrathecal catheters
- ☒None of the above

D1. Does your service accept afterhours referral?

- Yes

- No
- Yes, but only in exceptional circumstances (please comment in textbox below)

D2. Does your service provide any afterhours care by **medical staff** for patients already known to this service?

- Yes – direct hands-on care, face-to-face care
- Yes – telephone advice and support only
- Yes – both hands on and telephone advice/support
- No afterhours medical service
- Yes, only in exceptional circumstances (please comment in textbox below)

D3. Does your service provide any afterhours care by **nursing staff** for patients already known to this service?

- Yes – direct hands-on care, face-to-face care
- Yes – telephone advice and support only
- Yes – both hands on and telephone advice/support
- No afterhours nursing service
- Yes – only in exceptional circumstances (please comment in textbox below)

*Display This Question:*

*If D2 = Yes – direct hands-on care, face-to-face care*

*Or D2 = Yes – telephone advice and support only*

*Or D2 = Yes – both hands on and telephone advice/support*

*Or D3 = Yes – direct hands-on care, face-to-face care*

*Or D3 = Yes – telephone advice and support only*

*Or D3 = Yes – both hands on and telephone advice/support*

D4. When is afterhours care service available? (please tick as many as apply)

- Weekdays evenings
- Weekdays overnight
- Weekends daytime
- Weekends evenings
- Weekends overnight

D5 Does your service provide any afterhours spiritual care?

- Yes
- No

D6. Does your service provide any afterhours psychological care e.g., counselling?

- Yes
- No

E1. Does your service offer education and/or training to professionals outside your organization?

- Yes
- No

*Display This Question:*

*If E1 = Yes*

E2. What kind of training or education does your service provide? (please tick as many as apply)

- Specific education sessions
- On-site training
- On-site student training
- Other (please specify in textbox below)

E3. Does your service have liaison staff designated in any of the following settings? (please tick as many as apply)

- Hospital
- Primary care
- Aged residential care
- Others (please specify in textbox below)
- No liaison staff in other settings

E4. Does your service routinely have joint clinics/home visits with other specialties? (please tick as many as apply)

- Primary care
- Respiratory
- Cardiology
- Geriatrics
- Renal
- Oncology
- Psychiatry
- Others (please specify in textbox below)
- No routine joint clinics/visits with other specialties

F1. Is there a standardized palliative care pathway in your region to advise other clinicians on patient care?

- Yes

- No
- Not sure

F2. Does this service use any patient reported outcome measures (PROMs) e.g., Palliative Care Outcome Scales (POS), Integrated Palliative Care Outcome Scale (IPOS) or Palliative Care Care Outcomes Collaboration symptom assessment scale (PCOC)?

- Yes
- No

*Display This Question:*

*If F2 = Yes*

F3. Which patient reported outcome measures (PROMs) does your service use? (please tick as many as apply)

- POS/IPOS
- PCOC
- Others (please specify in textbox below)

F4. Does your service have standardized referral criteria for acceptance of patients?

- Yes
- No

F5. Does your service have standard criteria for discharging patients from the service?

- Yes
- No

G1. What is the standard follow-up routinely offered to families after death? (please tick as many as apply)

- Letter
- Telephone
- Face to face visit/meeting
- Group support
- Others (please specify in textbox below)
- No routine follow up after death

G2. Does your service offer bereavement care?

- Yes
- No

*Display This Question:*

*If G2 = Yes*

G3. Does your service offer specialist bereavement care to bereaved adults at risk of complex grief?

- Yes
- Only standard (non-specialist) bereavement care is available

*Display This Question:*

*If G2 = Yes*

G4. Does your service offer bereavement care to children?

- Yes
- No

*Display This Question:*

*If G4 = Yes*

G5. Does your service offer specialist bereavement care to bereaved children at risk of complex grief?

- Yes
- No

G6. Does your service offer spiritual care?

- Yes
- No

*Display This Question:*

*If G6 = Yes*

G7. Which of the following provides spiritual care at your service? (please tick as many as apply)

- Staff spiritual carer/Chaplain
- Visiting spiritual carer/Chaplain
- Others (please specify in textbox below)

H1. What Māori Cultural Competence staff training does your service provide or facilitate, including training by external providers e.g., DHB? (please tick as many as apply)

- Te Tiriti o Waitangi (Treaty of Waitangi) with a focus on health
- Traditional Māori customs e.g., te reo Māori, rongoā (traditional healing), protocols of tapu (sacred) and noa (ordinary)
- Te Wairuatanga - Māori spirituality
- Others (please specify in textbox below)

- Content of training is not known
- No training is provided

H2. Does your service have knowledge of local Iwi and/or Māori providers?

- Yes
- No

*Display This Question:*

*If H2 = Yes*

H3. Does your service have partnership agreements with local Iwi and/or Māori providers?

- Yes
- No

*Display This Question:*

*If H2 = Yes*

H4. Does your service have regular engagement with local Iwi and/or Māori providers?

- Yes
- No

*Display This Question:*

*If H4 = Yes*

H5. What regular engagement does your service have with local Iwi and/or Māori providers? (please tick as many as apply)

- Regular hui (meetings)
- Written correspondence e.g. emails, newsletters
- Social media
- Others (please specify in textbox below)

H6. What is the total Full Time Equivalent (FTE) of Liaison or Cultural position designated for Māori? (please enter as a number e.g., 0.8 and write "0" if no FTE)

I1. What percentage (%) of patients (estimated: should add up to 100%) known to your service fall under the following primary diagnoses

Cancer :  
Non-cancer :  
Total :

I2. Does your service offer care to:

- Adult patients only

- Paediatric patients only
- Both adult and paediatric patients

13. Do you know the ethnic profile of patients seen by your service? (e.g., what percentage are Māori)

- Yes
- No

*Display This Question:*  
*If I3 = Yes*

14 What is the ethnic composition of patients known to your service? (estimated percentages, should add up to 100%)

- NZ European/European
- Māori
- Pacific Islander
- Asian
- Others

15. Does your service have cultural liaison staff other than Māori cultural support?

- Yes
- No

*Display This Question:*  
*If I5 = Yes*

16. If yes to above, please tick as many as apply:

- Pacific Island
- East Asian
- South Asian
- Muslim community
- Others (please specify in textbox below)

17. What interpreting services do you use for patients with limited English? (please tick as many as apply)

- In person
- Telephone
- Online apps e.g., Google Translate
- Staff
- Family members
- Others (please specify in textbox below)

- None of the above

18. How well do you think your service caters for patients with limited English?

- Very well
- Well
- Satisfactory
- Below satisfactory
- Poorly

19. Does your service have a budget for interpreters?

- Yes
- No

110. Does your service have policy specific for patients with disability?

- Yes
- No

111. Does your service provide care to patients in rural area – i.e. more than 30-minutes travel time from the nearest base hospital? (*definition according to Rural-urban Classification for NZ Health and Research policy: University of Otago*)

- Yes
- No

*Display This Question:*  
*If I11 = Yes*

112. What type of care does your service provide in rural area – i.e., more than 30-minute travel time from the nearest base hospital? (Please tick as many as apply)

- Direct “hands-on, face-to-face” care
- Advisory (may include telephone advice, support and prescribing) to patients and families
- Advisory to other health care providers
- Telehealth to patients (other than telephone advice and support)
- Education and training to professionals (not in relation to specific individual patients)
- Others (please specify in textbox below)