HB Clinical Council Meeting

Date: Wednesday 1 December 2021

Time: 3.00pm – 5.30pm

Venue: Te Waiora Room, DHB Administration Building,
Corner Omahu Road and McLeod Street, Hastings

Members:
Dr Robin Whyman (Chair)
Brendan Duck (Deputy Chair)
Dr Andy Phillips
Dr Nicholas Jones
Dr Mike Park
Dr Russell Wills
Peta Rowden
Dr Jessica Keepa
JB Heperi-Smith
Dr Umang Patel
Dr Kevin Choy
Karyn Bousfield
Catherine Overfield
Ani Tomoana
Sarah Shanahan

Apologies:

In Attendance:
Keriana Brooking, Chief Executive Officer
Chris Ash, Chief Operating Officer
Susan Barnes, Patient Safety & Quality Manager

Minute Taker: Gemma Newland, EA Chief Allied Health Professions Officer

Public Agenda

Item	Section 1: Routine	Time (pm)
1.	Karakia, Welcome and Apologies	3.00
2.	Interests Register	
3.	3.0 Minutes of Previous Meeting (October) 3.1 Minutes from November AGM	
4.	Matters Arising – Review of Actions (public)	

5.	5.0 Annual Plan – copy for information 5.1 Workplan – copy for information 5.2 New Draft Annual Workplan for 2022 consideration – **group discussion**	3.05
6.	HB Clinical Council Board Report – October (public) – copy for information	
	Section 2: Standing Management and Committee Reports	
7.	Chief Executive Officer's Report	3.20
8.	COVID19 Vaccine and Immunisation Programme Rollout Progress Report	3.35
9.	Clinical Council Representatives and Committee Reports	3.45
10.	End of Life Choice Act – **group discussion** 10.0 End of Life Choice Act 2019 10.1 HBDHB Policy – End of Life Act – Assisted Dying Policy 10.2 HDC Assisted Dying – Practitioner Responsibilites 10.3 EOL Flowchart – Buddle Findlay 10.4 DRAFT HBDHB Procedure – Assisted Death in a Public Hospital 10.5 DRAFT HBDHB Policy – Request for Information from Patient 10.6 DRAFT HBDHB Access Agreement (not yet approved)	3.55
11.	**Section 3: Recommendation to Exclude the Public** Under Clause 33, New Zealand Public Health & Disability Act 2000	

Public Excluded Agenda

Item	Section 4: Routine	Time
12.	Minutes of Previous Meeting (October public excluded)	4.15
13.	Matters Arising – Review of Actions (public excluded)	
14.	HB Clinical Council Board Report – October (public excluded) – **no October report**	
	Section 5: Presentations / Discussions	
15.	Chief Operating Officer Report – Chris Ash	4.20
16.	Topics of Interest – Member Issues / Updates	4.35
17.	Covid in the Community – Preparedness Resurgence Plan	4.45
18.	Patient Safety and Risk Management Committee Report	5.00
19.	Patient Safety Quarterly Report – Susan Barnes	5.15
	Meeting concludes	5.30

The next Clinical Council Meeting will be held on
Wednesday 2 February 2021 commencing at 3.00pm

Our shared values and behaviours

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGA TE TIRA PARTNERSHIP
TAUWHIRO CARE

HE KAUANUANU RESPECT

*Showing **respect** for each other, our staff, patients and consumers*

	✔	✘
Welcoming	Is polite, welcoming, friendly, smiles, introduce self Acknowledges people, makes eye contact, smiles	Is closed, cold, makes people feel a nuisance Ignore people, doesn't look up, rolls their eyes
Respectful	Values people as individuals; is culturally aware / safe Respects and protects privacy and dignity	Lacks respect or discriminates against people Lacks privacy, gossips, talks behind other people's backs
Kind	Shows kindness, empathy and compassion for others Enhances peoples mana	Is rude, aggressive, shouts, snaps, intimidates, bullies Is abrupt, belittling, or creates stress and anxiety
Helpful	Attentive to people's needs, will go the extra mile Reliable, keeps their promises; advocates for others	Unhelpful, begrudging, lazy, 'not my job' attitude Doesn't keep promises, unresponsive

ĀKINA IMPROVEMENT

*Continuous **improvement** in everything we do*

	✔	✘
Positive	Has a positive attitude, optimistic, happy Encourages and enables others; looks for solutions	Grumpy, moaning, moody, has a negative attitude Complains but doesn't act to change things
Learning	Always learning and developing themselves or others Seeks out training and development; 'growth mindset'	Not interested in learning or development; apathy "Fixed mindset, 'that's just how I am', OK with just OK
Innovating	Always looking for better ways to do things Is curious and courageous, embracing change	Resistant to change, new ideas; 'we've always done it this way'; looks for reasons why things can't be done
Appreciative	Shares and celebrates success and achievements Says 'thank you', recognises people's contributions	Nit picks, criticises, undermines or passes blame Makes people feel undervalued or inadequate

RARANGA TE TIRA PARTNERSHIP

*Working together in **partnership** across the community*

	✔	✘
Listens	Listens to people, hears and values their views Takes time to answer questions and to clarify	'Tells', dictates to others and dismisses their views Judgmental, assumes, ignores people's views
Communicates	Explains clearly in ways people can understand Shares information, is open, honest and transparent	Uses language / jargon people don't understand Leaves people in the dark
Involves	Involves colleagues, partners, patients and whanau Trusts people; helps people play an active part	Excludes people, withholds info, micromanages Makes people feel excluded or isolated
Connects	Pro-actively joins up services, teams, communities Builds understanding and teamwork	Promotes or maintains silo-working 'Us and them' attitude, shows favouritism

TAUWHIRO CARE

*Delivering high quality **care** to patients and consumers*

	✔	✘
Professional	Calm, patient, reassuring, makes people feel safe Has high standards, takes responsibility, is accountable	Rushes, 'too busy', looks / sounds unprofessional Unrealistic expectations, takes on too much
Safe	Consistently follows agreed safe practice Knows the safest care is supporting people to stay well	Inconsistent practice, slow to follow latest evidence Not thinking about health of our whole community
Efficient	Makes best use of resources and time Respects the value of other people's time, prompt	Not interested in effective user of resources Keeps people waiting unnecessarily, often late
Speaks up	Seeks out, welcomes and give feedback to others Speaks up whenever they have a concern	Rejects feedback from others, give a 'telling off' 'Walks past' safety concerns or poor behaviour

Karakia

Hei Aratākina te Hui (to start)

E Io i runga i te Rangi Whakarongo mai titiro iho mai E Io i runga i te Waitai, i te Wai Moana, i te Wai Maori Whakapiri mai whakatata mai E Io i runga i a Papatuānuku Nau mai haere mai Nōu e Io te aō nei Whakatakina te mauri ki runga ki tēna taura ki tēna tauira Kia eke tārewa tu ki te Rangi Haumie Hui E tāiki e.	The waters of life connect us to all nations of this world. Sharing skills of one another and an understanding that throughout the hui we are courageous in our decisions that set and implement decisions.

Karakia whakamutunga (to finish) Unuhia

Unuhia, unuhia te uru tapu nui o Tāne Kia wātea, kia māmā te ngākau, te wairua, Te tinana, te hinengaro i te ara takatū. Koia rā e rongo, whakairia ki runga Kia wātea, kia wātea, āe rā, kua wātea!	Release, release the sacred knowledge of Tāne To clear and to relieve the heart, the spirit, The body and the mind of the bustling path. Tis Rongo that suspends it up above To be cleared of obstructions, yes, tis cleared.

Interests Register
Oct-21

Hawke's Bay Clinical Council

Name Clinical Council Member	Interest e.g. Organisation / Close Family Member	Nature of Interest e.g. Role / Relationship	Core Business Key Activity of Interest	Conflict of Interest Yes / No	If Yes, Nature of Conflict: - Real, potential, perceived - Pecuniary / Personal - Describe relationship of Interest to
Chris McKenna (Director of Nursing)	Hawke's Bay DHB - Susan Brown	Sister	Registered Nurse	Yes	Low - Personal - family member
	Hawke's Bay DHB - Lauren McKenna	Daughter	Registered Nurse	Yes	Low - Personal - family member
	Health Hawke's Bay (PHO)	Board member	HHB ensures the provision of essential primary health care services, mostly through general practices, to the population of HB.	Yes	Low
Dr Andy Phillips (Chief Allied Health Professions Officer)	Health Systems Performance Insights Programme	Chair	Improving Health System Performance	No	
	The Health Foundation (UK)	Member of College of Assessors	Improving Health System Performance	No	
	Hastings Environment Centre	Board member	Sustainable Living	No	
	Ora Taiao	Executive Board Member	Health and Climate	No	
Dr Robin Whyman (Clinical Director Oral Health)	NZ Institute of Directors	Member	Continuing professional development for company directors	No	
	Australian - NZ Society of Paediatric Dentists	Member	Continuing professional development for dentists providing care to children and advocacy for child oral health.	No	
Dr Russell Wills (Community Paediatrition)	HBDHB Community, Women and Children and Quality Improvement & Patient Safety Directorates	Employee	Employee	Yes	Potential, pecuniary
	Wife, Mary Wills employed as General Manager of Presbyterian Support East Coast	Employee	Presbyterian Support East Coast provide services within the HB and are a contractor to HBDHB	Yes	Potential, pecuniary
	Paediatric Society of New Zealand	Member	Professional network	No	
	Association of Salaried Medical Specialists	Member	Trade Union	Yes	Potential, pecuniary
	New Zealand Medical Association	Member	Professional network	No	
	Royal Australasian College of Physicians	Fellow	Continuing Medical Education	No	
	Neurodevelopmental and Behavioural Society of Australia and New Zealand	Member	Professional network	No	
	NZ Institute of Directors	Member	Professional network	No	
Dr Nicholas Jones (Clinical Director - Population Health)	NZ College of Public Health Medicine	Fellow	Professional network	No	
	Association of Salaried Medical Specialists	Member	Professional network	No	
	HBDHB Strategy & Health Improvement Directorate	Employee	Employee	No	
Karyn Bousfield	Jonathan Black Farsight Global	Partner is Director	Organisational Psychologist/ Contractor	No	Potenital percieved - no connection on a professional level
Mike Park	College of Intensive Care Medicine (CICM)	Fellow	CPO and accreditation	No	
	ASMS	Member	Trade Union	No	
	ANZICS	Member	Professional society	No	
	Central region IHT DHB Committee	Chair	DHB network for IHT	No	
	HBDHB Medical Diirector Acute & Medical	Medical Director		Yes	Potential Pecunirary - Low level
Dr Kevin Choy	The Doctors, Hastings	GP & Director	GP	Yes	Provision of Primary Care - business
Dr Umang Patel	City Medical Ltd, Napier	GP & Medical Director	GP	Yes	Provision of Primary Care - business
	HBDHB	ED SMO/Consultant Locum	Consultant	No	
Peta Rowden	Hawke's Bay DHB – Shanelle Rowden-Read	Daughter	Health Care Assistant	Yes	Low - family member
	National Directors of Mental Health Nursing (DOMHNs)	Member	Collective strategic group to positively influence nursing priorities for mental health and addiction nurses in New Zealand.	No	
	Hawke's Bay DHB Mental Health & Addictions Services – Nurse Director	Employee	Employee	No	
	Te Ao Maramatanga - College of Mental Health Nursing	Member	Professional body for practising mental health nurses in New Zealand	No	
Dr Jessica Keepa	Te Taiwhenua o Heretaunga	GP	GP	Yes	Provision of Primary Care - employee
	NZ Royal College of GPs	Member	Professional society/body	No	
	Te Ohu Rata o Aotearoa (Māori medical practitioners)	Member	Professional society		
	Francis Health	Husband is a Partner	Health consulting services to the health and public sector	No	
	Hawke's Bay Faculty of GPs	Member	Professional society		
Brendon Duck	HBDHB - Systems Lead for Medicine	Employee	Health Services	Yes	Potential
	Totara Health	Director	General Practice	Yes	Delivery of funded primary care services via back to back agreement with Health HB
	Totara Health - Pharmacist Prescriber	Employee	General Practice	No	
	Pharmaceutical Society of New Zealand	Advisor	Crown Agency	No	
	HQSC	Advisor	Crown Agency	No	

11/22/2021

Name **Clinical Council Member**	**Interest** **e.g. Organisation / Close Family Member**	Nature of Interest **e.g. Role / Relationship**	Core Business **Key Activity of Interest**	**Conflict of Interest** **Yes / No**	**If Yes, Nature of Conflict:** **- Real, potential, perceived** **- Pecuniary / Personal** **- Describe relationship of Interest to**
Catherine Overfield	Member of NZ College of Midwives	Professional Member	Professional guidance and indemnity cover	No	
JB Heperi-Smith	None delcared			No	

11/22/2021

MINUTES OF THE MONTHLY HAWKE'S BAY CLINICAL COUNCIL MEETING HELD IN THE TE WAIORA MEETING ROOM, CORPORATE OFFICE (ZOOM) ON WEDNESDAY, 6 OCTOBER 2021 at 3.00 pm

PUBLIC

Present:	Dr Robin Whyman (Chair) Chris McKenna Peta Rowden Dr Jessica Keepa Dr Kevin Choy Karyn Bousfield Dr Andy Phillips
Apologies:	Keriana Brooking, Chief Executive Officer Chris Ash, Chief Operating Officer Dr Mike Park Dr Russell Wills Brendan Duck Dr Umang Patel Catherine Overfield Dr Nicholas Jones JB Heperi-Smith
In Attendance:	Susan Barnes, Patient Safety & Quality Manager Gemma Newland, EA to Chief Allied Health Professions Officer (minutes)

SECTION 1: ROUTINE

1. WELCOME AND APOLOGIES

Dr Robin Whyman welcomed the group. Apologies were noted by Dr Whyman and accepted by Peta and Karyn. Dr Whyman recognised meeting numbers didn't make a quorum but those in attendance agreed to proceed with the Public and Public Excluded items. The AGM will be moved to the November meeting.

Dr Whyman opened the meeting by leading the group in a karakia.

2. INTEREST REGISTER

No conflicts of interest were noted for the meeting.

3. MINUTES OF PREVIOUS MEETING

The minutes of the Hawke's Bay Clinical Council public meeting held on 1st September 2021 were confirmed as a correct record of the meeting.

Moved: Karyn Bousfield
Seconded: Peta Rowden
Carried.

4. MATTERS ARISING, ACTIONS AND PROGRESS

Item 1: Clinical Council Appointments
In hand with the AGM (now in November) – appointments completed.

Item 2: Quality Framework
Karyn and Susan working on this later in the year, in hand.

Item 3: Leadership Programme for Senior Clinicians
Request to Martin Price for information on the national leadership workshops – completed, information distributed, closed.

Item 4: EMedicine Management Strategy – progress update
Activity happening in this area but date for update is still to be confirmed.

Item 5: Inpatient Survey Action – progress update
On October agenda. Closed.

Item 6: HealthPathways – progress update
February 2022 confirmed.

Item 7: HBDHB Equity Action Plan
Update due February 2022.

Item 8: Board Reporting
Discussed – closed.

Discussion around the item 8 action above: Karyn noted the previous report to board gave the incorrect view that Council is planning to report on the Equity Action plan. This is not the case so it was confirmed by the group that the view of Council is that it doesn't provide monitoring, but remains interested in the progress of this piece of work.

Action 7 to note: Clinical Council is committed to equity as part of the domains of governance and have a relationship with the Equity Action Plan. A discussion offline between Dr Whyman, Andy Phillips and Patrick Le Geyt will be had. Feedback to Council in February 2022, as per the action noted.

5. CLINICAL COUNCIL ANNUAL PLAN AND WORK PLAN 2020/21

Taken as read.

6. HB CLINIAL COUNCIL BOARD REPORT – SEPTEMBER (Public)

No significant discussion. The Board thanked Council for engaging in the systems performance measures workshop in the September meeting.

SECTION 2: STANDING MANAGEMENT COMMITTEE REPORTS

7. CHIEF EXECUTIVE OFFICER REPORT

Keriana was an apology.

8. COVID-19 VACCINE AND IMMUNISATION PROGRAMME ROLLOUT PROGRESS REPORT

Chris McKenna shared the celebration that as of today, 50% of the Hawke's Bay community are double vaccinated with 76% having had at least one dose. Now the COVID team is working on the 'hard to reach' groups with a campaign promoting to "get a mate vaccinated". There will be a national drive, named "Super Saturday" on 16th October asking all vaccination providers to open and get as many people vaccinated as possible. The latest update from Ministry of Health is that there is no need to wait six weeks between vaccinations, the recommended time frame is now three weeks between doses.

A Hawke's Bay campaign, Ū Tonu, meaning keep striving, will be used to promote vaccination locally especially for Māori. It uses real life, Hawke's Bay people in the images, focussing on the 20 – 40-year-old age group and those that are vaccine resistant. Incentives of vouchers and tradie breakfasts are some of the methods that groups are using. Chris noted the connection of low vaccination levels to issues with those in transitional housing and transient people. The COVID workforce are working to bring forward resurgence planning. There is a strong plan to increase testing if and when needed, within Hawke's Bay.

The COVID teams are working to connect with gangs..Incentivising General Practice and hard to reach areas to vaccinate are part of a multipronged approach to increase the vaccination rates in Hawke's Bay.

Chris thanked General Practices and pharmacies that have taken up the opportunity to be vaccination providers. Recent statistics have booking data showing more interest in vaccinations. There is a big drive in Wairoa tomorrow to push their rate up. The DHB are holding a vaccination clinic tomorrow from 12pm – 6pm which is open to staff and their family.

Kevin Choy spoke about the primary care workforce. Staffing vaccination rates are generally high, patient rates are as high, with the hard to reach groups being targeted now. Incentive payments have been provided to these organisations to assist with the drive to vaccinate. Kevin asked about future planning and Chris acknowledged this, commenting resurgence is the current focus. Development of future tiered approach planning and health pathways were all discussed.

Chris McKenna was presented with flowers in recognition of her 11 years on Clinical Council. She recognised the hard work of Clinical Council and what it achieves in its governance within the DHB and that this was reflected in the great dialogue that occurs at the meetings. The Board has always relied on the views of and feedback from Clinical Council and that it remains so important to keep that relationship. Chris thanked Robin for his work as Chair. This is to be Chris' last meeting with Council and we wish her well as she remains as a COVID Lead for the DHB.

9. CLINICAL COUNCIL REPRESENTATIVES AND COMMITTEE REPORTS

None noted.

Kevin noted that the Clinical Advisory and Governance Committee (CAGC) meeting is now to be held every three months for the PHO and that there is a new Chair.

SECTION 3: RECOMMENDATION TO EXCLUDE THE PUBLIC

10. The Chair moved that the public be excluded from the following parts of the meeting:

11. Minutes of Previous Meeting (public excluded)
12. Matters Arising – Review Actions (public excluded)
13. HB Clinical Council Board Report – No September report (public excluded)
14. Chief Operating Officer Report
15. Topics of Interest – Member Issues/Updates

16. Risk Management Governance Report
17. Inpatient Survey Update
18. DAA – Corrective actions report

The meeting closed at 3.39pm

Confirmed: _____
Chair

Date: _____

MINUTES OF THE HAWKE'S BAY CLINICAL COUNCIL ANNUAL GENERAL MEETING
HELD IN THE TE WAIORA MEETING ROOM, CORPORATE OFFICE
ON WEDNESDAY, 3 NOVEMBER 2021 at 3.00pm

PUBLIC

Present:	Dr Robin Whyman (Chair) Brendan Duck Peta Rowden Dr Jessica Keepa Dr Kevin Choy Karyn Bousfield Catherine Overfield Dr Nicholas Jones Ani Tomoana Sarah Shanahan
Apologies:	Dr Andy Phillips Dr Russell Wills
In Attendance:	Chris Ash, Chief Operating Officer Susan Barnes, Patient Safety & Quality Manager Gemma Newland, EA to Chief Allied Health Professions Officer (minutes)

ANNUAL MEETING

1. WELCOME AND APOLOGIES

Dr Robin Whyman opened the meeting by leading the group in a karakia.

Dr Whyman welcomed the group and explained that the decision was made to hold the Annual General Meeting on its own and take the opportunity to discuss forming a workplan for 2021/22 year. The apology of Andy Phillips was noted by Dr Whyman then all members introduced themselves.

Welcomes were extended to Ani Tomoana, Sarah Shanahan as new members.

Clarification on nominations of Chair and Deputy process – one nomination received for Chair and one for Deputy Chair.

2. MINUTES OF PREVIOUS MEETING

The minutes from the previous Annual General Meeting of the Hawke's Bay Clinical Council meeting held on 7 October 2020 were confirmed as a correct record of the meeting.

Moved: Peta Rowden
Seconded: Karyn Bousfield
Carried.

3. MATTERS ARISING FROM PREVIOUS ANNUAL MEETING

The only action noted was to revise the terms of reference which was signed off in April 2021.

4. ANNUAL REPORT 2020

Dr Whyman tabled the Annual Report for 2020/2021, noting the report summarised what Council had achieved during the year, with a focus on quality and capturing the key themes from the directorate presentations. He thanked all members for their contributions during the year and acknowledged the input of Jules Arthur as Co-Chair, who left employment with the DHB a few months ago.

Moved: Peta Rowden
Seconded: Brendan Duck
Carried.

5. REVIEW OF CLINICAL COUNCIL ANNUAL PLAN 2020/21

Included in the papers was a table showing the Annual Plan progress. The summary of this was described as a mixed report card by Dr Whyman. He believed Council struggled to progress the work plan as greatly as hoped in the area of consumer engagement, and access to data for some metrics that describes ethnicity continued to create challenges when considering equity.

The progress in the area of an engaged and effective workforce was positive and a promise of more work in the workforce development area was expected in 2022. A new Clinical Governance framework \ while not finalised had progressed and would be an ongoing activity for 2021/22. The delay was in part a result of structural changes at Hawke's Bay District Health Board as well as the Health and Disability Systems review. Clinical effectiveness was covered well throughout the last 12 months of meetings.

Dr Nick Jones wanted to understand how Council's work programme fits in the wider HBDHB work plan (for example the Equity Action Plan). Dr Whyman noted Clinical Council had clear responsibilities on clinical governance.
Member representation of Health Hawke's Bay (PHO) was not currently being met due to the Medical Director's unavailability and current vacancy of its Nurse Director position. Health Hawke's Bay has been in communication with the Chair on its non-representation.

Dr Jones asked about a localities approach for governance and Karyn Bousfield noted this was unknown given the formation of Health New Zealand and localities were still to be determined/advised. Chris Ash explained locality data should be mapped when presenting information. Opportunities for future clinical governance meetings which included locality updates would be discussed.

6. ELECTION OF CHAIR /DEPUTY CHAIR / CO-CHAIRS 2021/22

Karyn Bousfield assumed the Chair and Dr Robin Whyman and Brendan Duck vacated the room**.**

Two nominations were received: Dr Robin Whyman as Chair and for Brendan Duck as Deputy Chair. Dr Jones suggested a treaty partnership consideration for Māori representation as a Chair or leadership position on Council. Council agreed on this being a positive move for the future but no nominations were made. It was also discussed that leaders (and those wanting to become leaders) should be provided governance training.

No other nominations were forthcoming and Clinical Council unanimously endorsed the nominations:
Dr Whyman – continue as Chair
Brendan – nominated Deputy Chair

It was noted that Sarah Shanahan and Ani Tomoana had accepted their nominations to Clinical Council which were approved by Keriana Brooking, CEO HBDHB and Phillipa Blakey, CEO PHO.

7. REVIEW OF TERMS OF REFERENCE

There was a brief discussion on the Terms of Reference and Membership which were updated in April 2021. The group were happy to keep these in place.

Terms of Reference could be reviewed as the structure of the health system changes in the future.

The incorrect version of the Terms of Reference (September 2019) were included in the papers. Gemma Newland will circulate the current Terms of Reference (March 2021) to the group.

8. CLINICAL COUNCIL'S ANNUAL WORKPLAN 2021 / 2022

Karyn spoke of the preparation that is underway for when Health New Zealand begins in July 2022 and that there will be a transition period in terms of governance structure. Currently, primary care has Clinical Advisory Governance Committee (CAG) but there needs to be a clinical governance structure for Provider Services to support Clinical Council which currently reports to the HBDHB CEO and Board. Wairoa has their own clinical governance group. Central Hawke's Bay doesn't have any specific governance structures in place. Clinical governance comes under the patient safety area in health services. This is a work in progress with the aim of finalising a new framework in the New Year.

Consideration is being given to all the sub groups that sit under Clinical Council. Currently, the data dashboard and reporting structures are not balanced across localities and groups. The new health system should encourage good governance with localities. Karyn confirmed that HBDHB stills need to tidy and align its governance systems to be ready for the new health authority. Clinical Council shouldn't become provider services and endeavour to maintain a health system focus.

The recent internal restructure of Health Services was to improve the operational leadership and clinical leadership and to ensure HBDHB aligned with the new framework for Health NZ. Health services is now four main groups rather than six directorates.

Sarah Shanahan shared an example of how pathways don't always instigate operational change. Karyn explained the overarching view of Clinical Council should be receiving information from all relevant groups.

Dr Jones raised that COVID response was likely to impact Clinical Council over the next six months with the areas of focus being resurgence, readiness and resilience. Dr Whyman noted COVID could be a theme within Council's workplan but its ability to cover multiple topics within the timeframe could be difficult. It was important Clinical Council maintained its function in clinical governance not operational decision making.

A proposal was made by Dr Whyman to consider Clinical Council's meeting frequency. Dr Whyman suggested every two months with the next Clinical Council meeting to be in December 2021. This had been discussed with Keriana Brooking and supported by her because of reporting timelines to Board and FRAC meetings.

The four quadrants of clinical governance described by the HQSC (Health Quality and Safety Commission) will still form the basis of Council's workplan. Equity was added to this framework in 2020/21 and Council also needs the capability to add to the workplan as issues / topics arise from reporting groups. Members agreed that equity should be woven into the four quadrants rather than being separate. Brendan Duck, Karyn Bousfield, Susan Barnes and Dr Whyman will lead the design of the new workplan.

Consumer Council will be framed using localities and members should consider this for Clinical Council. What tangible functions will Clinical Council provide with governance?

It was agreed to schedule discussion of the annual plan objectives for 2021/2022 within the December Clinical Council meeting.

The meeting closed with a karakia at 4.17pm

Confirmed: _____

Chair Deputy Chair

Date: _____

HAWKE'S BAY CLINICAL COUNCIL
MATTERS ARISING / ACTIONS

(Public)
As at October 2021

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1.	Dec-20	***Quality Framework*** Introduce framework to DLTs Launch framework	Susan Barnes	Late 2021	
2.	July-21	***EMedicine Management Strategy*** Progress review	Di Vicary / Brendan Duck	TBC	
3.	July-21	***HealthPathways*** Update from Team Leads	Tania Page and Donna Armstrong	Feb 2022	
4.	Aug-21	***HBDHB Equity Action Plan*** • Report back for information on progress with the Plan	Nick Jones and JB Heperi-Smith	Feb 2022	
5.	Sept-21	***Board Reporting*** Provide Board with information regarding Clinical Council's workplan 21/22 following AGM	Robin Whyman	November 2021	

HAWKE'S BAY CLINICAL COUNCIL
ANNUAL PLAN 2020/2021

AREA OF FOCUS	ACTIVITIES	TIMEFRAME	PROGRESS
Clinical Effectiveness	1 HRT Quarterly Report 2 System Performance Measures 3 Te Ara Whakawaiora	Quarterly Quarterly TBC	1 and 2 on September agenda
Patient Safety & Quality	1 Implementation of the clinical governance framework 2 Implementation of Safety1st 3 Patient Safety and Risk Management Report	April 2021 August 2021 September 2021	On hold post structure review Reported in August 2021 Completed
Engaged & Effective Workforce	1 Safe Staffing / CCDM 2 Clinical Council Newsletter development 3 Meeting with newly appointed ED People and Culture	April 2021 Mid-year July 2021	August, November 2021 Removed Completed
Equity	1 Review of Terms of Reference 2 Revision of the HRT dashboard for ethnicity data in the indicators 3 Membership of other committees and groups	April 2021 August 2021 October 2021	Completed – consider membership AGM September Discuss at AGM, October
Consumer Engagement	1 Pātaka Kōrero 2 Consumer engagement framework 3 Inpatient survey	TBC August 2021 July 2021	 Completed Completed, follow up October

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Clinical Council Workplan 2020 / 2021

As at October 2021

Meeting	Clinical Council	Area of Focus from CC Annual Plan	FRAC	BOARD
May	HRT dashboard – Q4 2020 data System Performance Measures Patient Safety quarterly report DAA corrective actions update COVID vaccination update Clinical Committees Updates	Clinical Effectiveness Patient Safety and Quality Clinical Effectiveness Patient Safety and Quality	Dashboard (May) + Short Report (including narrative from CC)) forms part of Patient Safety Report	Summary of conversations/key topics discussed
June	DAA corrective actions update COVID vaccination update Clinical Committees Updates	Equity Consumer Engagement Clinical Effectiveness Patient Safety and Quality		**No meeting held due to lack of quorum**
July	Presentation – Inpatient survey Martin Price, ED People & Culture eMedicine Management Strategy COVID vaccination update Clinical Committees Updates	Consumer Engagement Engaged & Effective Workforce Clinical Effectiveness Patient Safety and Quality Clinical Effectiveness		Summary of conversations/key topics discussed

Clinical Council Workplan 2020 / 2021

As at October 2021

Meeting	Clinical Council	Area of Focus from CC Annual Plan	FRAC	BOARD
August	Equity action plan DAA corrective actions update CCDM Safe Staffing (core data set) Patient Safety quarterly report DAA corrective actions update COVID vaccination update Clinical Committees Updates Community/Consumer Council & Localities/Community Networks Safety1st – progress report	Equity Patient Safety and Quality Clinical Effectiveness Clinical Effectiveness Patient Safety and Quality	Report (2) Dashboard (August) + Short Report (including narrative from CC) forms part of Patient Safety Report	Summary of conversations/key topics discussed
September	HRT dashboard – Q1 2021 data System Performance Measures Discussion Risk Management Governance report DAA corrective actions update COVID vaccination update Clinical Committees Updates ED expansion case	Clinical Effectiveness Patient Safety and Quality Equity Engaged & Effective Workforce Consumer Engagement		Summary of conversations/key topics discussed
October	DAA corrective actions update Risk Management Governance report (next Jan 2022) Inpatient Survey Update	Clinical Effectiveness Equity Patient Safety and Quality Clinical Effectiveness Engaged & Effective Workforce		Summary of conversations/key topics discussed

Clinical Council Workplan 2020 / 2021

As at October 2021

Meeting	Clinical Council	Area of Focus from CC Annual Plan	FRAC	BOARD
	COVID vaccination update Clinical Committees Updates			
November – no meeting, just AGM	COVID vaccination update Clinical Committees Updates	Clinical Effectiveness Equity Patient Safety and Quality Clinical Effectiveness Engaged & Effective Workforce	Dashboard (November) + Short Report (including narrative from CC) forms part of Patient Safety Report	Summary of conversations/key topics discussed
December	COVID vaccination update Adverse Event Management Policy (delayed) Clinical Committees Updates HRT dashboard – Q2 2021 data Patient Safety Quarterly Report	Clinical Effectiveness Equity Patient Safety and Quality Clinical Effectiveness Engaged & Effective Workforce		Summary of conversations/key topics discussed

Clinical Council Annual Workplan 2022

DRAFT

COVID

System Level Measures

Consumer Engagement

- Work with new Consumer Council on localities structure of future clinical governance
- End of Life Choice Act implementation

Clinical Effectiveness

- Clinical outcome—HRT, HQSC data DASHBOARD
- Health Pathways
- HSCGG—Monitor development of Clinical Governance Board Provider Services

OURHEALTH HAWKE'S BAY Whakawateatia

Engaged and Effective Workforce

- Credentialing
- Staff experience surveys
- Quarterly invitation to People and Culture (Dashboard)

Quality Improvement and Patient Safety

- Adverse Event Policy

DRAFT

Equity

OURHEALTH HAWKE'S BAY Whakawateatia	**REPORT FROM HB CLINICAL COUNCIL (Public) OCTOBER 2021** For the attention of: **HBDHB Board**
Document Author(s) Document Owner	Gemma Newland (Executive Assistant to Chief Allied Health Professions Officer) Dr Robin Whyman (Chair)
Date	October 2021
Purpose/Summary of the Aim of the Paper	Provide Board with an overview of matters discussed at HB Clinical Council meeting on 6 October 2021.
Health Equity Framework	The Hawke's Bay Clinical Council works in partnership with a whole of system approach to ensure Hawke's Bay health services are achieving equity in health outcomes through the provision of services that are culturally safe, appropriate in addressing inequities and accessible to Tangata Whenua.
Principles of the Treaty of Waitangi that this report addresses:	The Hawke's Bay Clinical Council is the principal clinical governance, leadership and advisory group for the Hawke's Bay health system; committed to Te Tiriti o Waitangi and achieving equity for Tangata Whenua and other populations, in the provision of health care in the Hawkes' Bay District.
Risk Assessment	Risks associated with the issues considered by the Clinical Council include the COVID-19vaccination uptake, risk management governance and quality of care.
Financial/Legal Impact	
Stakeholder Consultation and Impact	Stakeholder engagement is the basis of discussion of issues at the Clinical Council
Strategic Impact	None identified
Previous Consideration / Interdependent Papers	None identified
RECOMMENDATION: It is recommended that the Board: *1.* **Note** the contents of this report	

1. COVID-19 Vaccination Programme

Council received an update on the progress of the COVID-19 vaccination programme noting in particular

- Rollout at the time of the meeting was 50% of the Hawke's Bay community are double vaccinated with 76% having had at least one dose.
- Now the COVID team are working on the 'hard to reach' groups with a campaign promoting to "get a mate vaccinated"
- National immunisation promotion - "Super Saturday" on 16th October
- Reduced timeframe between doses from six weeks to three weeks between doses. Public health teams are currently arranging stand-up planning meetings for future cases, given heightened concerns around cases in Auckland.
- A Hawke's Bay campaign, Ū Tonu, meaning keep striving, will be used to promote vaccination locally especially for Māori.
- Ongoing specific focus groups including people in transitionary housing, transient populations and gang populations
- Feedback from the primary care sector noting generally high staff vaccination rates and improving patient uptake

Forward planning for managing COVID in the community was discussed including planning with clinical leads and development of health Pathway to implement within the health Pathways tool particularly for use in primary care.

2. Community Nurse Prescribing

Council were pleased to note the successful endorsement from the Nursing Council of New Zealand of the Registered Nurse Prescribers in Community Health (RNPCH) programme for HBDHB. This process was started in 2016 when there were changes to the Medicine Act. The process relies on qualified Nurses using standing orders – with most of these being relevant to paediatrics and monitored by a prescribing governance group.

3. Inpatient Survey Update

Council discussed a paper from the Patient Safety and Clinical Quality team with the areas of the inpatient survey that were highlighted from the most recent survey as the areas for improvement. The four highlighted areas were: Low uptake of the survey is still an issue (more of an administration issue), pronunciation of Māori names, involvement of family / whānau in patient care and side effects of medication. Council agreed all four areas are core issues to address with the clinical teams / group leadership teams – and should be followed up by audits, with results monitored.

4. Risk Management Governance

Council met with Andrew Boyd, Executive Director Financial Services, Darren Horsley (Mid-Central DHB) and Jared McGillicuddy (TAS) work alongside Andrew with the risk management improvement initiative for the HBDHB. Council discussed the planned work to enhance risk management within the organisation and the role of Clinical Council in risk governance.

Council noted that risk can be grouped into eight risk domains: operational, clinical / patient safety, strategic, financial, human capital, legal / regulatory, technology and hazard. Good governance of risk is considering how we balance risk with cost and strategic direction.

Council agreed its role in clinical governance of risk and agreed to participate in the framework and document development. Council were supportive of the approach being taken and clarity of the presentation.

5. DAA Corrective Actions Report

Council noted progress reports continue to be provided to the Ministry of Health on implementation of actions following the last DAA Certification Audit. The high-risk actions related to management of risk and the risk management governance discussion indicated clear action on that item. The second related to staffing and while good progress has been made with implementation for action including CCDM implementation supporting nursing recruitment. High turnover rates do continue to mean that staffing levels are challenging,

Council was pleased to note that one low risk corrective action related fridge monitoring has now been closed.

6. Council AGM

The AGM of Clinical Council was not held at the October meeting as the meeting lacked a quorum due to sick leave, annual leave and high clinical demand in the sector. The AGM is now planned for November.

7. Retirement of Chris McKenna from Clinical Council

Council were pleased to recognise the tremendous contribution that Chris McKenna has made to Clinical Council over the past 11 years. Chris was an inaugural member of Clinical Council in 2010. She spoke of the hard work of Clinical Council, what it achieves in its governance within the DHB and that this was reflected in the informed dialogue that occurs at the meetings.

Council wished her well as she remains as a COVID Lead for the DHB. Chris was presented with flowers in recognition of her roles with Council as Chief Nursing and Midwifery Officer, member and past Chair.

CHIEF EXECUTIVE OFFICER REPORT

KERIANA BROOKING

COVID-19 VACCINE AND IMMUNISATION PROGRAMME ROLLOUT

NICK JONES

CLINICAL COUNCIL REPRESENTATIVES AND COMMITTEE REPORTS

End of Life Choice Act 2019

Public Act	2019 No 67
Date of assent	16 November 2019
Commencement	see section 2

Contents

The Parliament of New Zealand enacts as follows:

1 Title

This Act is the End of Life Choice Act 2019.

2 Commencement

(1) If a majority of electors voting in a referendum respond to the question in subsection (2) supporting this Act coming into force, this Act comes into force 12

months after the date on which the official result of that referendum is declared.

(2) The wording of the question to be put to electors in a referendum for the purposes of subsection (1) is—

"Do you support the End of Life Choice Act 2019 coming into force?"

(3) The wording of the 2 options for which electors may vote in response to the question is—

"Yes, I support the End of Life Choice Act 2019 coming into force."

"No, I do not support the End of Life Choice Act 2019 coming into force."

(4) This section overrides any other enactment to the extent that the enactment specifies any wording of the question or the options for the referendum that is different from the wording in subsections (2) and (3).

(5) If this Act does not come into force under subsection (1) within 5 years after the date on which it receives the Royal assent, this Act is repealed.

(6) In this section, **referendum**—

(a) means a referendum providing electors with an opportunity to decide whether this Act should come into force; and

(b) includes any fresh referendum required to be held if the High Court, on a petition, declares the referendum under paragraph (a) to be void.

Section 2(1): this Act brought into force, on 6 November 2021, see the 2020 End of Life Choice Referendum Declaration of Official Results (*Gazette* 2020-au5132).

Part 1
Preliminary provisions

3 Purpose of Act

The purpose of this Act is—

(a) to give persons who have a terminal illness and who meet certain criteria the option of lawfully requesting medical assistance to end their lives; and

(b) to establish a lawful process for assisting eligible persons who exercise that option.

4 Interpretation

In this Act, unless the context otherwise requires,—

approved form means a form approved and issued under section 40

assisted dying, in relation to a person, means—

(a) the administration by an attending medical practitioner or an attending nurse practitioner of medication to the person to relieve the person's suffering by hastening death; or

(b) the self-administration by the person of medication to relieve their suffering by hastening death

attending medical practitioner, in relation to a person, means the person's medical practitioner

attending nurse practitioner means a nurse practitioner who is acting under the instruction of an attending medical practitioner (or replacement medical practitioner)

authority has the meaning given to it by section 5(1) of the Health Practitioners Competence Assurance Act 2003

Code of Health and Disability Services Consumers' Rights means the Code of Health and Disability Services Consumers' Rights prescribed by regulations made under section 74(1) of the Health and Disability Commissioner Act 1994

competent to make an informed decision about assisted dying has the meaning given to it in section 6

conscientious objection means an objection on the ground of conscience

Director-General means the Director-General of Health

eligible person has the meaning given to it in section 5

health practitioner has the meaning given to it by section 5(1) of the Health Practitioners Competence Assurance Act 2003

independent medical practitioner means a medical practitioner who,—

(a) in relation to a person who has requested to exercise the option of receiving assisted dying, is independent of the person and of the person's attending medical practitioner (and any replacement medical practitioner); and

(b) has held, for at least the previous 5 years, a practising certificate, or the equivalent certification from an overseas authority responsible for the registration or licensing of medical practitioners

medical practitioner means a health practitioner who—

(a) is, or is deemed to be, registered with the Medical Council of New Zealand continued by section 114(1)(a) of the Health Practitioners Competence Assurance Act 2003 as a practitioner of the profession of medicine; and

(b) holds a current practising certificate

medication, in relation to assisted dying, means a lethal dose of the medication

Minister means the Minister of the Crown who is responsible for the administration of this Act—

(a) under the authority of a warrant; or

(b) under the authority of the Prime Minister

Ministry means the Ministry of Health

nurse practitioner means a health practitioner who—

(a) is, or is deemed to be, registered with the Nursing Council of New Zealand continued by section 114(1)(a) of the Health Practitioners Competence Assurance Act 2003 as a practitioner of the profession of nursing and whose scope of practice permits the performance of nurse practitioner functions; and

(b) holds a current practising certificate

person who is eligible for assisted dying has the meaning given to it in section 5

pharmacist means a health practitioner who—

(a) is, or is deemed to be, registered with the Pharmacy Council established by section 114(5) of the Health Practitioners Competence Assurance Act 2003 as a practitioner of the profession of pharmacy; and

(b) holds a current practising certificate

psychiatrist means a medical practitioner whose scope of practice includes psychiatry

Registrar means the Registrar (assisted dying) nominated under section 27

Review Committee means the committee appointed under section 26

SCENZ means Support and Consultation for End of Life in New Zealand

SCENZ Group means the body established under section 25.

5 Meaning of person who is eligible for assisted dying or eligible person

(1) In this Act, **person who is eligible for assisted dying** or **eligible person** means a person who—

(a) is aged 18 years or over; and

(b) is—

(i) a person who has New Zealand citizenship as provided in the Citizenship Act 1977; or

(ii) a permanent resident as defined in section 4 of the Immigration Act 2009; and

(c) suffers from a terminal illness that is likely to end the person's life within 6 months; and

(d) is in an advanced state of irreversible decline in physical capability; and

(e) experiences unbearable suffering that cannot be relieved in a manner that the person considers tolerable; and

(f) is competent to make an informed decision about assisted dying.

(2) A person is not a person who is eligible for assisted dying or an eligible person by reason only that the person—

(a) is suffering from any form of mental disorder or mental illness; or

(b) has a disability of any kind; or

(c) is of advanced age.

6 Meaning of competent to make an informed decision about assisted dying

In this Act, a person is **competent to make an informed decision about assisted dying** if the person is able to—

(a) understand information about the nature of assisted dying that is relevant to the decision; and

(b) retain that information to the extent necessary to make the decision; and

(c) use or weigh that information as part of the process of making the decision; and

(d) communicate the decision in some way.

7 Act binds the Crown

This Act binds the Crown.

Part 2
Assisted dying

8 Conscientious objection

(1) A health practitioner is not under any obligation to assist any person who wishes to exercise the option of receiving assisted dying under this Act if the health practitioner has a conscientious objection to providing that assistance to the person.

(2) Subsection (1)—

(a) applies despite any legal obligation to which the health practitioner is subject, regardless of how the legal obligation arises; but

(b) does not apply to the obligation in section 9(2).

(3) An employer must not—

(a) deny to an employee any employment, accommodation, goods, service, right, title, privilege, or benefit merely because the employee objects on the grounds of conscience to providing any assistance referred to in subsection (1); or

(b) provide or grant to an employee any employment, accommodation, goods, service, right, title, privilege, or benefit conditional upon the employee providing or agreeing to provide any assistance referred to in subsection (1).

(4) A person who suffers any loss by reason of any breach of subsection (3) is entitled to recover damages from the person responsible for that breach.

(5) In subsection (3), **employee** includes a prospective employee.

9 Effect of conscientious objection by attending medical practitioner

(1) This section applies if—

(a) a person informs the attending medical practitioner under section 11(1) that they wish to exercise the option of receiving assisted dying; and

(b) the attending medical practitioner has a conscientious objection to providing that option to the person.

(2) The attending medical practitioner must tell the person—

(a) of their conscientious objection; and

(b) of the person's right to ask the SCENZ Group for the name and contact details of a replacement medical practitioner.

(3) If the person chooses to have a replacement medical practitioner, all subsequent references in this Act to the attending medical practitioner (except in section 11(1)) are to the person's replacement medical practitioner.

10 Assisted dying must not be initiated by health practitioner

(1) A health practitioner who provides any health service to a person must not, in the course of providing that service to the person,—

(a) initiate any discussion with the person that, in substance, is about assisted dying under this Act; or

(b) make any suggestion to the person that, in substance, is a suggestion that the person exercise the option of receiving assisted dying under this Act.

(2) Subsection (1) does not prevent a health practitioner from—

(a) discussing with a person, at that person's request, assisted dying under this Act; or

(b) providing information to a person, at that person's request, about assisted dying under this Act.

(3) A health practitioner who contravenes subsection (1)—

(a) is not to be treated as having committed an offence under section 39(1); but

(b) may under the Health and Disability Commissioner Act 1994 be found by the Health and Disability Commissioner or held by the Human Rights Review Tribunal to have acted in breach of the Code of Health and Disability Services Consumers' Rights by providing services that do not comply with relevant legal standards; and

(c) may be the subject of disciplinary proceedings for professional misconduct under the Health Practitioners Competence Assurance Act 2003.

(4) In this section, **health service** has the meaning given to it by section 5(1) of the Health Practitioners Competence Assurance Act 2003.

11 Request made

(1) A person who wishes to exercise the option of receiving assisted dying must inform the attending medical practitioner of their wish.

(2) The attending medical practitioner must—

(a) give the person the following information:

(i) the prognosis for the person's terminal illness; and

(ii) the irreversible nature of assisted dying; and

(iii) the anticipated impacts of assisted dying; and

(b) personally communicate by any means (for example, by telephone or electronic communication) with the person about the person's wish at intervals determined by the progress of the person's terminal illness; and

(c) ensure that the person understands their other options for end-of-life care; and

(d) ensure that the person knows that they can decide at any time before the administration of the medication not to receive the medication; and

(e) encourage the person to discuss their wish with others such as family, friends, and counsellors; and

(f) ensure that the person knows that they are not obliged to discuss their wish with anyone; and

(g) ensure that the person has had the opportunity to discuss their wish with those whom they choose; and

(h) do their best to ensure that the person expresses their wish free from pressure from any other person by—

(i) conferring with other health practitioners who are in regular contact with the person; and

(ii) conferring with members of the person's family approved by the person; and

(i) record the actions they have taken to comply with paragraphs (a) to (h) in the first part of the approved form that requests the option of receiving assisted dying.

12 Request confirmed

(1) This section applies after the attending medical practitioner complies with section 11.

(2) If the person requesting to exercise the option of receiving assisted dying (**A**) wishes to proceed, the attending medical practitioner must give A the approved form referred to in section 11(2)(i).

(3) A must—

(a) sign and date the second part of the form; or

(b) be present when the second part of the form is signed and dated as described in subsection (4).

(4) The second part of the form may be signed and dated by another person (**B**) if—

(a) A cannot write for any reason; and

(b) A requests B to sign and date it; and

(c) B notes on the form that they signed the second part of the form in the presence of A; and

(d) B confirms on the form that B is not—

(i) a health practitioner caring for A; or

(ii) a person who knows that they stand to benefit from the death of A; or

(iii) a person aged under 18 years; or

(iv) a person with a mental incapacity.

(5) The attending medical practitioner must—

(a) be present when—

(i) subsection (3)(a) is complied with; or

(ii) subsections (3)(b) and (4) are complied with; and

(b) collect the form; and

(c) send the completed form to the Registrar.

13 First opinion to be given by attending medical practitioner

(1) This section applies after the attending medical practitioner complies with section 12(5)(c).

(2) The attending medical practitioner must reach the opinion that—

(a) the person requesting the option of receiving assisted dying is a person who is eligible for assisted dying; or

(b) the person requesting the option of receiving assisted dying is not a person who is eligible for assisted dying; or

(c) the person requesting the option of receiving assisted dying would be a person who is eligible for assisted dying if it were established under section 15 that the person was competent to make an informed decision about assisted dying.

(3) The attending medical practitioner must—

(a) complete an approved form recording their opinion; and

(b) send the completed form to the Registrar.

14 Second opinion to be given by independent medical practitioner

(1) This section applies if the attending medical practitioner reaches the opinion described in section 13(2)(a) or (c).

(2) The attending medical practitioner must—

(a) ask the SCENZ Group for the name and contact details of an independent medical practitioner; and

(b) ask the independent medical practitioner for their opinion on whether the person requesting the option of receiving assisted dying is a person who is eligible for assisted dying.

(3) The independent medical practitioner must—

(a) read the person's medical files; and

(b) examine the person; and

(c) reach the opinion that—

(i) the person is a person who is eligible for assisted dying; or

(ii) the person is not a person who is eligible for assisted dying; or

(iii) the person would be a person who is eligible for assisted dying if it were established under section 15 that the person was competent to make an informed decision about assisted dying.

(4) The independent medical practitioner must—

(a) complete an approved form recording their opinion; and

(b) send the completed form to the Registrar; and

(c) send a copy of the completed form to the attending medical practitioner.

15 Third opinion to be given by psychiatrist if competence not established to satisfaction of 1 or both medical practitioners

(1) This section applies if—

(a) the following situation exists:

(i) the attending medical practitioner reaches the opinion described in section 13(2)(a); and

(ii) the independent medical practitioner reaches the opinion described in section 14(3)(c)(iii); or

(b) the following situation exists:

(i) the attending medical practitioner reaches the opinion described in section 13(2)(c); and

(ii) the independent medical practitioner reaches the opinion described in section 14(3)(c)(i); or

(c) the following situation exists:

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(i) the attending medical practitioner reaches the opinion described in section 13(2)(c); and

(ii) the independent medical practitioner reaches the opinion described in section 14(3)(c)(iii).

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(2) The medical practitioners must jointly—

(a) ask the SCENZ Group for the name and contact details of a psychiatrist; and

(b) ask the psychiatrist for their opinion on whether the person requesting the option of receiving assisted dying is competent to make an informed decision about assisted dying.

(3) The psychiatrist must—

(a) read the person's medical files; and

(b) examine the person; and

(c) reach the opinion that—

(i) the person is competent to make an informed decision about assisted dying; or

(ii) the person is not competent to make an informed decision about assisted dying.

(4) The psychiatrist must—

(a) complete an approved form recording their opinion; and

(b) send the completed form to the Registrar; and

(c) send a copy of the completed form to—

(i) the attending medical practitioner; and

(ii) the independent medical practitioner.

16 Opinion reached that person is not eligible for assisted dying

(1) Subsection (2) applies if the attending medical practitioner reaches the opinion described in section 13(2)(b).

(2) The attending medical practitioner must explain the reasons for their opinion to the person requesting the option of receiving assisted dying.

(3) Subsection (4) applies if—

(a) the independent medical practitioner reaches the opinion described in section 14(3)(c)(ii); or

(b) the following situation exists:

(i) a psychiatrist is asked for their opinion under section 15(2)(b); and

(ii) the psychiatrist reaches the opinion described in section 15(3)(c)(ii).

(4) The independent medical practitioner or the psychiatrist, as appropriate, must explain their reasons for their opinion to the person requesting the option of receiving assisted dying and the attending medical practitioner.

(5) The attending medical practitioner must—

(a) complete an approved form recording the actions taken to comply with subsection (2) or (4); and

(b) send the completed form to the Registrar.

17 Opinion reached that person is eligible for assisted dying

(1) This section applies if—

(a) the following situation exists:

(i) the attending medical practitioner reaches the opinion described in section 13(2)(a); and

(ii) the independent medical practitioner reaches the opinion described in section 14(3)(c)(i); or

(b) the following situation exists:

(i) a psychiatrist is asked for their opinion under section 15(2)(b); and

(ii) the psychiatrist reaches the opinion described in section 15(3)(c)(i).

(2) The attending medical practitioner must—

(a) advise the person requesting the option of receiving assisted dying that the person is a person who is eligible for assisted dying; and

(b) discuss with the person the progress of the person's terminal illness; and

(c) discuss with the person the likely timing for the administration of the medication; and

(d) give the person an approved form for the person to complete by choosing the date and time for the administration of the medication; and

(e) advise the person that at any time after completing the approved form referred to in paragraph (d) the person may decide—

(i) not to receive the medication; or

(ii) to receive the medication at a time on a later date that is not more than 6 months after the date initially chosen for the administration of the medication.

(3) The attending medical practitioner must—

(a) complete an approved form recording the actions taken to comply with subsection (2); and

(b) send the completed form to the Registrar.

18 Eligible person to choose date and time for administration of medication

(1) If an eligible person wishes to receive assisted dying, the person must—

(a) complete the approved form referred to in section 17(2)(d); and

(b) return the completed form to the attending medical practitioner.

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(2) After receiving the completed form, the attending medical practitioner must send the form to the Registrar.

(3) Each time (if any) that an eligible person decides under section 17 or 20 to receive the medication on a date later than the date initially chosen and specified in the approved form referred to in section 17(2)(d),—

(a) the eligible person must complete a new approved form to replace the form initially or most recently completed under section 17(2)(d) (a **replacement form**); and

(b) references in sections 19 and 20 to the date chosen or chosen time are references to the date and time chosen in the replacement form.

19 Provisional arrangements for administration of medication

(1) This section applies after the attending medical practitioner complies with section 18(2).

(2) Before the date chosen by an eligible person for the administration of the medication, the attending medical practitioner must—

(a) advise the person about the following methods for the administration of the medication:

(i) ingestion, triggered by the person:

(ii) intravenous delivery, triggered by the person:

(iii) ingestion through a tube, triggered by the attending medical practitioner or an attending nurse practitioner:

(iv) injection administered by the attending medical practitioner or an attending nurse practitioner; and

(b) ask the person to choose one of the methods; and

(c) ensure that the person knows that they can decide, at any time before the administration of the medication, not to receive the medication or to receive the medication at a time on a later date that is not more than 6 months after the date initially chosen for the administration of the medication; and

(d) make provisional arrangements for the administration of the medication on the chosen day and time.

(3) At least 48 hours before the chosen time for the administration of the medication, the attending medical practitioner, or an attending nurse practitioner, must—

(a) write the appropriate prescription for the eligible person; and

(b) advise the Registrar of the method and of the date and time chosen for the administration of the medication.

(4) The Registrar must check that the processes in sections 11 to 18 have been complied with.

(5) If the Registrar is satisfied that the processes in sections 11 to 18 have been complied with, the Registrar must notify the attending medical practitioner accordingly.

20 Administration of medication

(1) This section applies after the attending medical practitioner has received notification from the Registrar under section 19(5).

(2) At the chosen time for the administration of the medication, the attending medical practitioner, or an attending nurse practitioner, must ask the eligible person if they choose—

(a) to receive the medication at that time; or

(b) not to receive the medication at that time, but to receive the medication at a time on a later date that is not more than 6 months after the date initially chosen for the administration of the medication; or

(c) not to receive the medication at that time, and to rescind their request to exercise the option of assisted dying.

(3) If the eligible person chooses not to receive the medication at the chosen time, the attending medical practitioner, or an attending nurse practitioner, must—

(a) immediately take the medication away from the eligible person; and

(b) complete an approved form recording the action taken to comply with paragraph (a); and

(c) send the completed form to the Registrar.

(4) If the eligible person chooses to receive the medication, the attending medical practitioner, or the attending nurse practitioner, must—

(a) provide the medication to the person, for administration by either of the methods described in section 19(2)(a)(i) and (ii); or

(b) administer the medication by either of the methods described in section 19(2)(a)(iii) and (iv).

(5) The attending medical practitioner, or the attending nurse practitioner, must—

(a) be available to the eligible person until the person dies; or

(b) arrange for another medical practitioner or attending nurse practitioner to be available to the person until the eligible person dies.

(6) For the purposes of subsection (5), the attending medical practitioner or attending nurse practitioner **is available to the eligible person** if the medical practitioner or attending nurse practitioner—

(a) is in the same room or area as the person; or

(b) is not in the same room or area as the person but is in close proximity to the person.

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21 Death to be reported

(1) Within 14 working days of a person's death as a result of the administration of medication under section 20, the attending medical practitioner, or the attending nurse practitioner who provided or administered the medication on the instruction of the attending medical practitioner, must send the Registrar a report in the approved form containing the information described in subsection (2).

(2) The information is—

(a) the name of the attending medical practitioner or attending nurse practitioner; and

(b) the person's name; and

(c) the person's last known address; and

(d) the fact that the person has died; and

(e) which of the methods described in section 19(2)(a) was used; and

(f) a description of the administration of the medication; and

(g) whether any problem arose in the administration of the medication and, if so, how it was dealt with; and

(h) the place where the person died; and

(i) the date and time when the person died; and

(j) the name of the medical practitioner or nurse practitioner who was available to the person until the person died; and

(k) the names of any other health practitioners who were present when the person died.

(3) The Registrar must send the report to the Review Committee.

22 Destruction of prescription if no longer required

(1) Subsection (2) applies if—

(a) an attending medical practitioner, or an attending nurse practitioner, holds a prescription written under section 19(3)(a); and

(b) the medication is no longer required.

(2) The attending medical practitioner, or the attending nurse practitioner, must—

(a) immediately destroy the prescription; and

(b) complete an approved form recording the action taken to comply with paragraph (a); and

(c) send the completed form to the Registrar.

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23 No further action to be taken if person rescinds request to exercise option of receiving assisted dying

(1) This section applies if, at any time, an eligible person rescinds their request to exercise the option of receiving assisted dying.

(2) The attending medical practitioner or attending nurse practitioner must—

(a) complete an approved form recording that the person has rescinded their request; and

(b) send the completed form to the Registrar; and

(c) take no further action in respect of the person's request (other than under section 22, if applicable).

(3) If at any subsequent time the person wishes to exercise the option of receiving assisted dying, the person may make a new request under section 11.

24 No further action to be taken if pressure suspected

If, at any time, the attending medical practitioner or attending nurse practitioner suspects on reasonable grounds that a person who has expressed the wish to exercise the option of receiving assisted dying is not expressing their wish free from pressure from any other person, the medical practitioner or nurse practitioner must—

(a) take no further action under this Act to assist the person in exercising the option of receiving assisted dying; and

(b) tell the person that they are taking no further action under this Act to assist the person in exercising the option of receiving assisted dying; and

(c) complete an approved form recording—

(i) that they are taking no further action under this Act to assist the person in exercising the option of receiving assisted dying; and

(ii) the actions taken to comply with paragraph (b); and

(d) send the form completed under paragraph (c) to the Registrar.

Part 3
Accountability

25 SCENZ Group

(1) The Director-General must establish the SCENZ Group by appointing to it the number of members that the Director-General considers appropriate.

(2) The Director-General must appoint members who the Director-General considers have, collectively, knowledge and understanding of matters relevant to the functions of the SCENZ Group.

(3) The functions of the SCENZ Group are—

(a) to make and maintain a list of medical practitioners who are willing to act for the purposes of this Act as—

(i) replacement medical practitioners:

(ii) independent medical practitioners:

(b) to provide a name and contact details from the list maintained under paragraph (a), when this Act requires the use of a replacement medical practitioner or independent medical practitioner, in a way that ensures that the attending medical practitioner does not choose the replacement medical practitioner or independent medical practitioner:

(c) to make and maintain a list of health practitioners who are willing to act for the purposes of this Act as psychiatrists:

(d) to provide a name and contact details from the list maintained under paragraph (c), when this Act requires the use of a psychiatrist, in a way that ensures that neither the attending medical practitioner nor the independent medical practitioner chooses the psychiatrist:

(e) to make and maintain a list of pharmacists who are willing to dispense medication for the purposes of section 20:

(f) to provide a name and contact details from the list maintained under paragraph (e) when section 20 is to be applied:

(g) in relation to the administration of medication under section 20,—

(i) to prepare standards of care; and

(ii) to advise on the required medical and legal procedures; and

(iii) to provide practical assistance if assistance is requested.

(4) The Ministry must service the SCENZ Group.

26 Review Committee

(1) The Minister must appoint an end-of-life Review Committee consisting of—

(a) a medical ethicist; and

(b) 2 health practitioners, one of whom must be a medical practitioner who practises in the area of end-of-life care.

(2) The Review Committee has the following functions:

(a) to consider reports sent to it under section 21(3) (**assisted death reports**); and

(b) to report to the Registrar whether it considers that the information contained in an assisted death report shows satisfactory compliance with the requirements of this Act; and

(c) to direct the Registrar to follow up on any information contained in an assisted death report that the Review Committee considers does not show satisfactory compliance with the requirements of this Act.

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27 Registrar (assisted dying)

(1) The Director-General must nominate an employee of the Ministry as the Registrar (assisted dying).

(2) The Registrar must establish and maintain a register recording the following:

(a) approved forms held by the Registrar; and

(b) the Review Committee's reports to the Registrar; and

(c) the Registrar's reports to the Minister.

(3) The Registrar must consult the Privacy Commissioner—

(a) before establishing the register; and

(b) at regular intervals while maintaining the register.

(4) If the Registrar receives a complaint about the appropriateness of the conduct of any health practitioner under this Act that the Registrar considers relates to a matter within the jurisdiction of any of the following persons, the Registrar must refer the complaint to that person:

(a) the Health and Disability Commissioner, if it appears that the complaint alleges that the conduct of the health practitioner is, or appears to be, in breach of the Code of Health and Disability Services Consumers' Rights; or

(b) the appropriate authority, if it appears that the complaint relates to a health practitioner's competence, fitness to practise, or conduct; or

(c) the New Zealand Police.

(5) If the Registrar does not refer a complaint under subsection (4), the Registrar must notify the complainant of that fact and of the reason why a referral was not made.

(6) The Registrar must take any action directed by the Review Committee under section 26(2)(c).

(7) The Registrar must report to the Minister by the end of 30 June each year on the following matters for the year:

(a) the total number of deaths occurring under section 20:

(b) the number of deaths occurring through each of the methods described in section 19(2)(a):

(c) the number of complaints received about breaches of this Act:

(d) how those complaints were dealt with:

(e) any other matter relating to the operation of this Act that the Registrar thinks appropriate.

(8) The Registrar must perform any other functions that this Act requires the Registrar to perform.

28 Persons to provide information to Registrar

(1) This section applies to—

(a) the Health and Disability Commissioner; and

(b) an authority; and

(c) the New Zealand Police.

(2) A person to whom this section applies must provide to the Registrar each year any information that the Registrar may require to enable the Registrar to report to the Minister on the matters referred to in section 27(7)(c) and (d).

(3) The information must be provided within the time and in the manner specified by the Registrar (which must be reasonable in the circumstances).

29 Minister must present to House of Representatives copy of report under section 27

As soon as practicable after receiving a report under section 27(7), the Minister must present a copy of the report to the House of Representatives.

30 Review of operation of Act

(1) The Ministry must, within 3 years after the commencement of this Act and then at subsequent intervals of not more than 5 years,—

(a) review the operation of this Act; and

(b) consider whether any amendments to this Act or any other enactment are necessary or desirable; and

(c) report on its findings to the Minister.

(2) As soon as practicable after receiving a report under subsection (1)(c), the Minister must present a copy of the report to the House of Representatives.

Part 4
Related matters

31 Regulations

The Governor-General may, by Order in Council, make regulations providing for any matters contemplated by this Act, necessary for its administration, or necessary for giving it full effect.

32 Other rights and duties not affected

(1) Nothing in this Act affects a person's rights to—

(a) refuse to receive nutrition:

(b) refuse to receive hydration:

(c) refuse to receive life-sustaining medical treatment.

(2) Nothing in this Act affects a medical practitioner's duty to alleviate suffering in accordance with standard medical practice.

33 Advance directive, etc, may not provide for assisted dying

(1) A person who wishes to request to exercise the option of receiving assisted dying under this Act must sign and date the approved form referred to in section 12(3) (the **request form**), and to the extent that any provision expressing such a wish is included by the person in an advance written or oral directive, will, contract, or other document that provision is invalid.

(2) A person who, after signing and dating the request form, wishes to rescind a request to exercise the option of receiving assisted dying under this Act must communicate that wish to the attending medical practitioner or the attending nurse practitioner orally, in writing (a **rescind document**), or by gesture and to the extent that any provision expressing such a wish is included by the person in an advance written or oral directive, will, contract, or other document (not being a rescind document) that provision is invalid.

(3) No particular form of words is required to rescind orally or in writing a request to exercise the option of receiving assisted dying under this Act.

34 Welfare guardians have no power to make decisions or take actions under this Act

A welfare guardian appointed under the Protection of Personal and Property Rights Act 1988 for a person does not, in that capacity, have the power to make any decision, or take any action, under this Act for that person.

35 Effect on contracts of death under this Act

A person who dies as a result of assisted dying is, for the purposes of any life insurance contract, or any other contract,—

(a) taken to have died as if assisted dying had not been provided; and

(b) taken to have died from the terminal illness referred to in section 5(1)(c) from which they suffered.

36 Restrictions on making public details of assisted dying deaths

(1) This section applies in respect of a death that was, or appears to be, the result of assisted dying under this Act.

(2) No person may make public in respect of any death to which this section applies—

(a) the method by which the medication was administered to the deceased:

(b) the place where the medication was administered to the deceased:

(c) the name of the person who administered the medication to the deceased, or the name of that person's employer.

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(3) A person who contravenes this section commits an offence and is liable on conviction—

(a) to a fine not exceeding $20,000, in the case of a body corporate:

(b) to a fine not exceeding $5,000, in any other case.

(4) Nothing in this section applies in respect of court or tribunal proceedings or to reports or publications of those proceedings.

(5) In this section, **make public** means publish by means of—

(a) broadcasting (within the meaning of the Broadcasting Act 1989); or

(b) a newspaper (within the meaning of the Defamation Act 1992); or

(c) a book, journal, magazine, newsletter, or other similar document; or

(d) an audio or a visual recording; or

(e) an Internet site that is generally accessible to the public, or some other similar electronic means.

37 Immunity from criminal liability

(1) A health practitioner who does all or any of the following is immune from criminal liability under section 179 of the Crimes Act 1961 or any other enactment:

(a) discusses with a person, at that person's request and in accordance with sections 10 and 11 of this Act, assisted dying under this Act:

(b) provides to a person, at that person's request and in accordance with sections 10 and 11 of this Act, information about assisted dying under this Act:

(c) gives a person the approved form referred to in section 11(2)(i) of this Act in accordance with section 12(2) of this Act and complies with section 12(5) of this Act:

(d) takes any other action that this Act authorises or requires them to take in respect of a person who requests to discuss, requests information about, or wishes or requests to exercise the option of receiving, assisted dying under this Act, and who has not yet been advised in accordance with this Act whether the person is a person who is eligible for assisted dying.

(2) The rest of this section applies if a person (**A**) is eligible to exercise the option of receiving assisted dying under this Act and wishes or requests to exercise that option.

(3) A has the right to request to exercise the option of assisted dying under this Act and does not commit an offence under any enactment by exercising that option.

(4) If another person (**B**) knows, or has reasonable grounds for believing, that A has requested to exercise the option of assisted dying under this Act, B is not justified—

(a) in using any force, under section 41 of the Crimes Act 1961, to prevent A from exercising that option; or

(b) in using any force, under section 48 of the Crimes Act 1961, to defend A from an action being taken in respect of A and that this Act authorises or requires to be taken in respect of A.

(5) B, or any other person, is immune from criminal liability if B or that person, in good faith and believing on reasonable grounds that A wishes to exercise the option of assisted dying under this Act,—

(a) takes any action that causes, assists, or facilitates the death of A in accordance with the requirements of this Act (for example, an attending medical practitioner who, under section 20(4)(a), administers medication to A in accordance with the requirements of this Act is immune from liability under the Crimes Act 1961 for the death of A); or

(b) fails to take any action and that failure causes, assists, or facilitates the death of A in accordance with the requirements of this Act (for example, an attending nurse practitioner who, under section 20(5)(a), is available to A, and takes no action to revive A, is immune from liability under the Crimes Act 1961 for the death of A).

(6) Subsection (5) applies—

(a) even if taking that action, or failing to take that action, would, but for subsection (5), constitute an offence under any enactment; and

(b) notwithstanding section 63 of the Crimes Act 1961.

38 Immunity from civil liability

(1) A person (**A**) is immune from civil liability if A, in good faith and believing on reasonable grounds that another person (**B**) wishes to exercise the option of assisted dying,—

(a) takes any action that assists or facilitates the death of B in accordance with the requirements of this Act; or

(b) fails to take any action and that failure assists or facilitates the death of B in accordance with the requirements of this Act.

(2) Nothing in this section affects the right of any person to—

(a) bring disciplinary proceedings against a health practitioner under the Health Practitioners Competence Assurance Act 2003; or

(b) bring proceedings under section 50 or 51 of the Health and Disability Commissioner Act 1994; or

(c) apply for judicial review.

39 Offences

(1) A person who is a medical practitioner, nurse practitioner, or psychiatrist commits an offence if the medical practitioner, nurse practitioner, or psychiatrist wilfully fails to comply with any requirement of this Act.

(2) A person commits an offence if the person, without lawful excuse,—

(a) completes or partially completes an approved form for any other person without that other person's consent; or

(b) alters or destroys a completed or partially completed approved form without the consent of the person who completed or partially completed the form.

(3) A person who commits an offence under this section is liable on conviction to either or both of the following:

(a) imprisonment for a term not exceeding 3 months:

(b) a fine not exceeding $10,000.

40 Director-General may approve forms

The Director-General may approve and issue forms for the purposes of this Act.

41 Amendments to other enactments

Amend the enactments specified in the Schedule as set out in that schedule.

Schedule
Amendments to other enactments

s 41

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Part 1
Amendments to Acts

Burial and Cremation Act 1964 (1964 No 75)

In section 2(1), definition of **certificate of cause of death**, replace "or 46C" with ", 46C, or 46CA".

After section 46C, insert:

46CA Certificate of cause of death in relation to assisted dying

(1) This section applies if a person dies as a result of assisted dying under the End of Life Choice Act 2019.

(2) The medical practitioner or nurse practitioner who was available to the person until the person died must, immediately after the person's death, give a certificate of cause of death.

(3) However, a certificate of cause of death must not be given under this section if the coroner has decided to open an inquiry into the death under Part 3 of the Coroners Act 2006.

In section 46D, replace "or 46C" with "46C, or 46CA".

Coroners Act 2006 (2006 No 38)

After section 13(2), insert:

(2A) However, subsections (1) and (2) do not apply in any case in which the death was a result of assisted dying under the End of Life Choice Act 2019.

In section 60(1)(a), after "self-inflicted", insert "(other than as a result of assisted dying under the End of Life Choice Act 2019)".

After section 71(3), insert:

(4) In this section, **self-inflicted**, in relation to a death, does not include a death that was the result of assisted dying under the End of Life Choice Act 2019 (*see* section 36 of that Act, which restricts making public details of assisted dying deaths).

Crimes Act 1961 (1961 No 43)

In section 41, insert as subsection (2):

(2) This section is subject to section 37 of the End of Life Choice Act 2019.

In section 48, insert as subsection (2):

(2) This section is subject to section 37 of the End of Life Choice Act 2019.

Crimes Act 1961 (1961 No 43)—*continued*

After section 179(3), insert:

(4) This section is subject to section 37 of the End of Life Choice Act 2019.

10

Health Act 1956 (1956 No 65)

In section 112B, replace the definition of **health information** with:

> **health information** has the meaning set out in paragraphs (a) and (c) of the definition of that term in section 22B, but does not include information about assisted dying services provided under the End of Life Choice Act 2019.

Health and Disability Commissioner Act 1994 (1994 No 88)

In section 2(1), definition of **health services**, replace paragraph (a)(vii) with:

(vii) diagnostic services:

(viii) services provided to a person who has requested assisted dying under the End of Life Choice Act 2019; and

New Zealand Public Health and Disability Act 2000 (2000 No 91)

In section 6(1), replace the definition of **services** with:

> **services** means—
>
> (a) health services; and
>
> (b) disability support services; and
>
> (c) services provided to a person who has requested assisted dying under the End of Life Choice Act 2019

Protection of Personal and Property Rights Act 1988 (1988 No 4)

After section 18(1)(f), insert:

(g) to request, on behalf of the person, the option of receiving assisted dying under the End of Life Choice Act 2019.

Part 2
Amendments to legislative instruments

Births, Deaths, Marriages, and Relationships Registration (Prescribed Information) Regulations 1995 (SR 1995/183)

Replace regulation 7(1)(a)(xiii) with:

(xiii) the cause or causes of the person's death, subject to subparagraph (xiiia):

(xiiia) in respect of a person who died as a result of assisted dying under the End of Life Choice Act 2019, the terminal illness that gave rise to the person's eligibility for assisted dying:

Births, Deaths, Marriages, and Relationships Registration (Prescribed Information) Regulations 1995 (SR 1995/183)—*continued*

(xiiib) in respect of a person who died as a result of assisted dying under the End of Life Choice Act 2019, the fact that the person died as a result of assisted dying under that Act:

(xiiic) the interval between the onset of the cause of death and the death, in respect of each cause of death, subject to subparagraph (xiiid):

(xiiid) in respect of a person who died as a result of assisted dying under the End of Life Choice Act 2019, the interval between the onset of the terminal illness that gave rise to the person's eligibility for assisted dying and the person's death by assisted dying:

Cremation Regulations 1973 (SR 1973/154)

In regulation 7(1)(a), replace "or 46C(1)" with ", 46C, or 46CA".

In Schedule 1, form B, replace "or 46C(1)" with ", 46C, or 46CA".

In Schedule 1, form B, replace items 6 and 7 with:

6 Did you attend the deceased before the deceased's death?

If so, for how long? [*state how many weeks, months, or years*]

7 If you attended the deceased before the deceased's death, when did you last see the deceased alive? [*state how many hours or days before death*]

In Schedule 1, form B, replace item 9(a) with:

(a) immediate cause—the disease, injury, or complication that caused the death, or assisted dying? [*specify*]

In Schedule 1, form B, replace item 10 with:

10 What was the mode of death if other than by assisted dying? [*specify*]

In Schedule 1, form B, replace item 14 with:

14 In view of your knowledge of the deceased's habits and constitution, do you feel any doubt whatever as to the cause of the deceased's death? [*specify*]

In Schedule 1, form B, replace the paragraph immediately following item 17 with:

I certify that the answers given above are true and accurate to the best of my knowledge and belief, and that there is no circumstance known to me that can give rise to any suspicion that the death was due wholly or in part to any other cause than that stated that makes it desirable that the body should not be cremated.

Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 (SR 1996/78)

In the Schedule, after clause 5, insert:

Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 (SR 1996/78)—*continued*

5A End of Life Choice Act 2019

(1) This clause sets out how this Code operates with the End of Life Choice Act 2019 (the **EOLC Act**).

(2) For Right 4(2) of this Code, contravening section 10(1) of the EOLC Act may be found or held to be providing services that do not comply with relevant legal standards.

(3) Right 6(1)(b) and (c), and (2) of this Code is overridden by section 10 (assisted dying must not be initiated by health practitioner) of the EOLC Act.

(4) Right 7(2) to (5) of this Code is overridden by section 6 (meaning of competent to make an informed decision about assisted dying) of the EOLC Act.

(5) Under clause 5 of this Code (and without limiting that clause), nothing in this Code requires a provider to act in breach of any duty or obligation imposed by the EOLC Act or prevents a provider from doing an act authorised by the EOLC Act.

Legislative history

8 June 2017	Introduction (Bill 269–1)
13 December 2017	First reading and referral to Justice Committee
9 April 2019	Reported from Justice Committee (Bill 269–2)
26 June 2019	Second reading
23 October 2019	Committee of the whole House (Bill 269–3)
13 November 2019	Third reading
16 November 2019	Royal assent

This Act is administered by the Ministry of Health.

Wellington, New Zealand:

Published under the authority of the New Zealand Government—2019

End of Life Choice Act (Assisted Dying) Policy				
HBDHB/CPG/147				
Approved by:	Executive Director - Patient Safety & Quality	**First Issued:**	November 2021	HE KAUANUANU RESPECT ĀKINA IMPROVEMENT RARANGA TE TIRA PARTNERSHIP TAUWHIRO CARE
Signature:	Karyn Bousfield	**Review Date:**		
		Next Review:	November 2027	

10

Purpose

This document covers the specific requirements of the End of Life Choice Act 2019 (Assisted Dying) to support compliance.

For purposes of this policy, the provision of information refers to the carrying out of Sections 8, 9, 10, 18, 19 and 20 of the End of Life Choice Act 2019.

Principles

All HBDHB documents are based on and link back to our values; **He Kauanuanu** (respect), **Ākina** (improvement), **Raranga Te Tira** (partnership) and **Tauwhiro** (care), and are detailed so all persons are provided with clear information on the way they are expected to practice and undertake tasks.

The following New Zealand Legislation and Standards are also applicable to this document:

- End of Life Choice Act 2019
- Code of Health and Disability Services Consumers' Rights
- NZS 8134.1.2:2021 Ngā Paerewa Health and Disability Services (Core) Standard
- Health Practitioners Competence Assurance Act 2003
- New Zealand Public Health and Disability Act 2000 (section 88)
- Privacy Act 2020
- Ministry of Health Policy Guidance for Assisted Dying Services Information for district health boards – public hospitals

Scope

This policy applies to all staff who are responsible for patients / clients and their families / whanau within HBDHB (including community-based staff).

Definitions

Term/Abbreviation	Meaning
Assisted dying	(a) The administration by an attending medical practitioner or attending nurse practitioner of medication to a person to relieve the person's suffering by hastening death; or (b) the self-administration by the person of medication to relieve their suffering by hastening death.

Term/Abbreviation	Meaning
Attending medical practitioner (AMP)	The medical practitioner who provides end-to-end care throughout the assisted dying service, including carrying out the first eligibility assessment and preparing and administering the medication for assisted dying.
Attending nurse practitioner (ANP)	The nurse practitioner who administers the medication for assisted dying (under the instruction of the attending medical practitioner)
Conscientious objection	An objection on the ground of conscience
Health practitioner	As defined by section 5(1) of the Health Practitioners Competence Assurance Act 2003
SCENZ	Support and Consultation for End of Life in New Zealand
SCENZ Group	Support and Consultation for End of Life in New Zealand Group (SCENZ Group). The statutory body for assisted dying service that is responsible for maintaining lists of practitioners who are willing to provide assisted dying services; as well as providing practical help in relation to assisted dying.

Roles and Responsibilities

Role	Responsibility
Chief Medical & Dental Officer (CMDO)	Overall responsibility and is the single point of contact for the DHB regarding assisted dying, in particular for approval of request for DHB as a location for an assisted death
Chief Nursing & Midwifery Officer (CNMO), Chief Allied Health Professions Officer (CAHPO), Chief Operating Officer (COO)	To support the decision making by the CMDO for the DHB to be used as a location for an assisted death, the CNO will provide input and as required, the COO and CAHPO (or their delegates).
All Health Practitioners (as outlined in the scope of this document)	To read and comply with the standards as outlined in this policy

HBDHB Standards

Initial Response

1 It is possible that a person may ask any DHB staff member about assisted dying services, which may include a request for information about assisted dying or for help to access this service.

2 Under the End of Life Choice Act 2019, assisted dying can only be requested by the person wanting the intervention for themselves. The person must raise the topic of assisted dying first. A health practitioner is not able to suggest it as an option.

3 A person cannot use an advance directive to request assisted dying. Assisted dying cannot be requested or consented to by an enduring power of attorney for health and welfare.

4 A family member cannot ask for assisted dying on behalf of a person.

Role Response

5 The DHB staff member's response to a person who raises the topic of assist dying will depend entirely on what their role is within the organisation i.e. medical practitioner, other health care professional, unregulated health care worker.

a. **Medical practitioners (doctors)** do not have to be involved in providing assisted dying services if they have a conscientious objection or lack the necessary skills and training to offer the assisted dying service. However, they have a legal minimum requirement to inform the person of their objection and to advise the person of the right to contact the SCENZ Group to get the name and contact details of a doctor who is willing to provided assisted dying.

b. **Other health professionals** with a conscientious objection are not legally required to disclose their conscientious objection. However, they must not stop a person from getting information about or access to assisted dying services.

c. **Unregulated health care worker** should acknowledge the request and advise the person they will inform their nurse / medical practitioner of the request and ask for them to follow up with the person.

6 The DHB staff member's response may also depend on their personal beliefs, however no matter of personal beliefs, responses to a person who raises the topic of assisted dying should be done in a respectful and professional manner.

7 Staff should avoid directly or indirectly discouraging a person from choosing assisted dying.

Ongoing Standards of Care

8 Staff should carry out their responsibilities under the Code of Health and Disability Services Consumer Rights and ensure that a person is not prevented from accessing lawful medical care.

9 Assisted dying does not replace the care a person is already receiving. Instead it provides another option in some circumstances.

10 If a person chooses to access assisted dying services, this option will most likely be in addition to the care they are already receiving, such as palliative care.

11 There is continuation of a person's wider care so that their other health needs are addressed while the assessment for whether they are eligible (including competence) for assisted dying occurs and/or up until their assisted death takes place.

12 Continuing this care also means that if the assessment finds that a person is not eligible for assisted dying or the person chooses not to have an assisted death, service providers are still meeting their wider health needs.

13 Cultural and spiritual practices / beliefs and involvement of whānau will be respected at all times.

14 HBDHB staff must be aware of their obligations under the Privacy Act 2020 and s36 of the End of Life Choice Act 2019 to keep details of assisted deaths private.

Location for Assisted Dying

15 Assisted dying services are expected to generally be provided in home and community settings. However, DHB hospital staff may be involved in assisted dying services in certain situations. These may include:

a. A person in the DHB hospital's care requests assisted dying while in a public hospital

b. A DHB hospital staff member chooses to provide assisted dying services or to play a supporting role in the process

16 In rare situations, parts of the dying process, including the assisted death, may take place in a public hospital. These may include where:

a. A patient who has already started the assisted dying process is admitted to a public hospital and certain circumstances apply, such as that:

i. The assessment process must take place while the person is in a public hospital

ii. An assisted death must take place in a public hospital because the person is not able to leave the hospital

b. A person who is found to be eligible for assisted dying is living or currently residing in a facility that does not permit assisted deaths to take place there. In this case, a public hospital is expected to be the place of last resort for the assisted death to occur

17 Where an assisted death is to occur within the hospital setting, an access agreement between the external AMP and attending ANP and the DHB is required prior to any planned assisted death request.

18 Formal agreement for the assisted death process to take place in the DHB is required from the Chief Medical & Dental Officer (CMDO) with input from the Chief Nursing & Midwifery Officer (CNMO), and as required, the Chief Operating Officer (COO) and Chief Allied Health Professions Officer (CAHPO), or their delegates.

Employment Obligations and Education

19 HBDHB employees wishing to become an AMP or ANP will do so under section 88, New Zealand Public Health and Disability Act 2000 and not as part of their DHB employment agreement.

20 All health practitioners are required to complete the Ministry of Health e-learning module End of Life Choice Act 2019: Overview module (this can be done either individually or as a group).

Measurable Outcomes

Nil complaints recorded in Safety1st (Event Report System)

Reporting of completion of Ministry of Health e-learning module – End of Life Choice Act 2019: Overview Module

Related Documents

HBDHB/PPM/098 - Privacy Policy

References

End of Life Choice Act 2019

Key Words

Assisted dying
End of Life Choice Act

For further information please contact the Chief Medical & Dental Officer

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

This guide is to help health practitioners understand their responsibilities to people who choose to receive assisted dying. It outlines how the Code of Health and Disability Services Consumers' Rights (the Code) applies under the End of Life Choice Act 2019 and how the Health and Disability Commissioner (HDC) will manage related complaints.

Assisted dying: Practitioners' responsibilities under the Code

From November 7 2021, assisted dying will become part of the health and disability system. The Code of Health and Disability Services Consumers' Rights will apply, and people choosing to receive the service will be able to complain to the Health and Disability Commissioner.

The End of Life Choice Act 2019 (EOLC Act) changes some aspects of the Code in important ways. Even if you will not be involved in providing this service, it's important to understand your responsibilities under the Code to people who request it.

The EOLC Act sets out the specific eligibility criteria, assessment process and safeguards for the assisted dying service and informs appropriate standards of care. The Ministry of Health has developed information on the Act and resources for health professionals working in different settings, available on its website **www.health.govt.nz**

Just like other forms of health care, people requesting assisted dying services have certain rights under the Code.

These include the right to be treated fairly and with respect, to care and support that meets their needs and is culturally appropriate, to make choices about their care, to discuss their care in a way that they understand, and to receive good quality services. If they do not receive care of an appropriate standard, then they have the right to complain to HDC. The full Code can be found on the HDC website **www.hdc.org.nz**

The patient-first principles that inform your practice now, continue to apply in this space. However, the EOLC Act changes people's rights under the Code in a few areas.

Providing information to those in your care

Normally under the Code, a person has the right to all the information they need to make an informed decision about their care, including all of the options available to them. But under the Act, you cannot initiate any discussion with a person that is substantially about assisted dying unless the person requests that you do so. That is, your patient must start the conversation about assisted dying.

This does not mean you cannot discuss end of life care. It is essential that people can express what's important to them and their whānau, and make decisions about their care at the end of life. Advanced care planning continues to be part of good practice and assisted dying may well come up as part of those conversations. Practitioners just need to be sure that they do not present the option of assisted dying if it has not been raised by their patient first.

This requirement also supports cultural safety for your patients and upholds their right to services that meet their needs. Assisted dying remains a sensitive topic for many in our communities and talking about it without prompting from your patient may impact upon your therapeutic relationship.

Once the person has raised assisted dying, Right 6 of the Code applies in full. They have the right to all relevant information, including an explanation of all of their options and the risks. Given the many steps involved in the assisted dying process, it is important that people are provided with enough information at every step to be able to make an informed choice.

Conscientious objection

Under the EOLC Act, medical practitioners do not have to be involved in providing assisted dying if they have a conscientious objection to doing so. However, they still have a responsibility to inform the person requesting the service of their objection, and their right to contact the Support and Consultation for End of Life in New Zealand Group (SCENZ) for the name and details of a medical practitioner who is willing to participate. Other health practitioners with a conscientious objection can also follow these steps.

Your obligations under the Code are broader. Even if you are not prepared to provide assisted dying, you are still responsible for providing quality care for that person. For example, under Right 5 of the Code the person has the right to effective communication, including an environment that enables open, honest and effective discussion. Right 4 (5) also requires that you cooperate with any medical practitioner assisting the person, to ensure quality and continuity of care.

Competence to make decisions

According to Right 7 (2) of the Code, a person is presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that they are not competent. But, under the EOLC Act a person's competency to make an informed decision must be assessed in order to be eligible for assisted dying, as set out in the legislation.

The use of advance directives

Right 7 (5) of the Code states that a person may use an advance directive in accordance with the common law. But under the EOLC Act an advance directive cannot be used to determine the wishes of the patient with respect to assisted dying.

These provisions in the Act are about preserving people's autonomy while protecting them from harm. The HDC will be monitoring how they impact on consumers.

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TE TOIHAU HAUORA, HAUĀTANGA

Issues and challenges

Involving family and carers

Whānau and carers can play an important role in supporting a person through the process, if the person wants them to. The person who chooses to receive assisted dying does not have to discuss it with their whānau, **and** the attending medical practitioner cannot raise it with the family without the person's consent. The Act does require that attending medical practitioners encourage people to talk to their whānau or other support people and there should be opportunity for the person to do so.

Where whānau are involved, you should help them to understand the process, discuss their support needs, and enable them to contribute to care planning where appropriate.

The individual's choice

Some complaints may allege coercion – by family members, caregivers or health professionals. The Act is clear that assisted dying will be an individual and personal choice, to consider and make. It includes a number of safeguards to ensure that the person reaches that decision independently, without influence from anyone else.

Medical practitioners are expected to be alert to any signs indicating the person is being pressured about their choice. If you are concerned you should talk to other people involved in that person's care, including family members (where you have the person's permission). Whānau, carers, welfare guardians or those who hold enduring power of attorney, cannot request assisted dying on behalf of another person.

Recordkeeping

The Act requires that medical practitioners complete a number of forms and records when a person requests assisted dying, when the request is confirmed, for determining eligibility and so on. But good recordkeeping will be essential in any situation where assisted dying is discussed. This documentation will be an important record and something that HDC will refer to when responding to complaints.

There may be complaints about how a doctor has determined competence. The Act is clear about what makes a person competent and about the process required to determine competence. It is essential, if you are determining competency, that you follow and document this process.

Access to the service

Access may also be the subject of complaints by people wanting the assisted dying service. Some health providers – such as residential care homes and hospices - may not permit assisted dying on their premises. If you are an attending medical practitioner or attending nurse practitioner, you will need to provide advice on what options the person may have.

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How complaints will be addressed

HDC's approach to addressing complaints about assisted dying will be similar to how we address complaints about other health services.

Anyone may make a complaint to HDC - including whānau, family, friends or caregivers of the person choosing to receive assisted dying. Depending on the circumstances, we may suggest the person making the complaint raises it with the health provider(s) concerned as they may be able to sort out the problem quickly.

They might also work with an advocate from the Nationwide Advocacy Service, who can help them understand their options and support them to raise concerns with the health provider(s). Where advocates identify serious issues, or where the health provider(s) is not cooperating, they can refer complaints on to HDC.

The person can also approach HDC directly, or the Registrar (assisted dying) at the Ministry of Health. The Registrar can refer them to HDC, the Medical Council, Nursing Council, or other relevant agency.

Full details of how HDC resolves complaints are on our website: **www.hdc.org.nz**

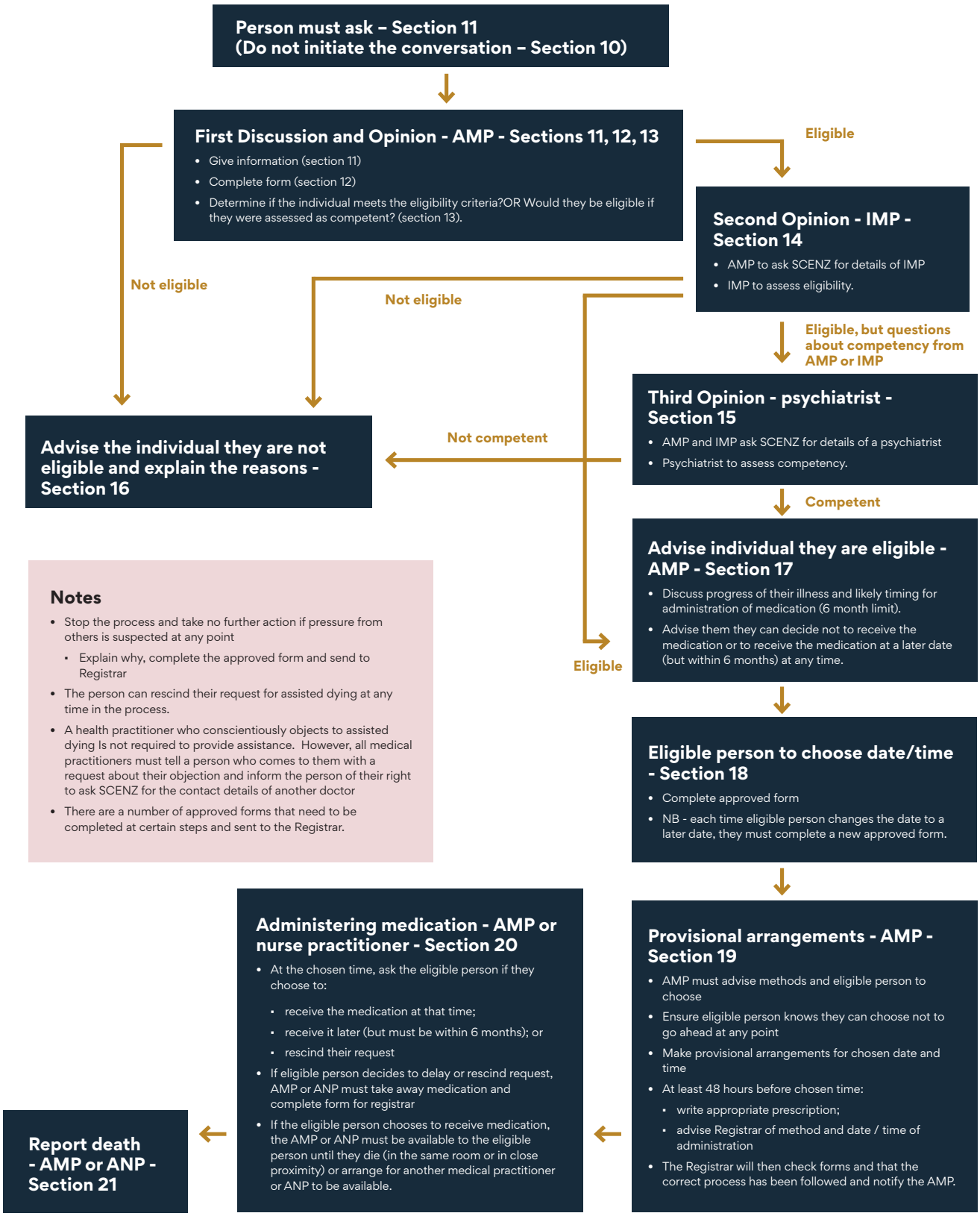
What you can expect from HDC

Our focus is on ensuring the rights of people using any health and disability service are upheld – including at the end of life. If you are the subject of a complaint, we will let you know and give you an opportunity to present your view. You can expect we will resolve the issue fairly and efficiently, and keep you informed of how the complaint is progressing. Where we decide to undertake a formal investigation, we will notify you.

For more information

The End of Life Choice Act (2019) sets out the legal framework and a high-level process for accessing assisted dying, including strict eligibility criteria and safeguards. You can read more about the End of Life Choice Act on the New Zealand Legislation website: **www.legislation.govt.nz**

The Ministry of Health is leading the implementation of the End of Life Choice Act 2019. Full information for the public, health professionals and service providers can be found on the Ministry's website: **www.health.govt.nz**



Please note this flowchart is a summary only and does not constitute legal advice. For more detailed information, please review the Act here or see the Ministry of Health's guidance here.

BUDDLE FINDLAY

Procedure - Assisted Death in a Public Hospital (End of Life Choice Act)				
Reference Number (if new document, will be assigned by Policy Control)				
Approved by:		**First Issued:**		
Signature:		**Review Date:**		
		Next Review:		

Purpose

This purpose of this document is to outline the practices for implementation of the End of Life Choice Act (Assisted Dying) 2019 requirements if this occurs in the DHB premises.

For purposes of this procedure, the intervention of assisted dying refers to the carrying out of Sections 18, 19 and 20 of the End of Life Choice Act 2019.

This procedure must be read in conjunction with the End of Life Choice (Assisted Death) Policy.

Scope

These procedures must be followed in all cases where the intervention of assisted dying is requested to occur within a Hawke's Bay District Health Board (HBDHB) facility, including Wairoa, Napier, Hastings and Central Hawkes Bay.

The DHB is the location of last resort for the intervention of assisted dying. It is expected most interventions will occur in a person's home or at another community location. The Attending Medical Practitioner (AMP) or Attending Nurse Practitioner (ANP) will have explored all non-DHB options and have formally applied to the DHB to use DHB premises for the intervention.

If approval is given, a signed access agreement between the AMP / ANP and HBDHB will be required in advance of any assisted death occurring within the HBDHB facility.

Definitions

Term/Abbreviation	Meaning
Assisted dying	The administration by an attending medical practitioner or attending nurse practitioner of medication to a person to relieve the person's suffering by hastening death; or the self-administration by the person of medication to relieve their suffering by hastening death.
Attending medical practitioner (AMP)	The medical practitioner who provides end-to-end care throughout the assisted dying service, including carrying out the first eligibility assessment and preparing and administering the medication for assisted dying.
Attending nurse Practitioner (ANP)	The nurse practitioner who administers the medication for assisted dying (under the instruction of the attending medical practitioner)
Hospital / Inpatient Facility	This refers to either HB Hospital, Napier, Wairoa or Central Hawke's Bay Health Centre.
Registrar	The Registrar (assisted dying) nominated under section 27

SCENZ Group	Support and Consultation for End of Life in New Zealand Group (SCENZ Group). The statutory body for assisted dying service that is responsible for maintaining lists of practitioners who are willing to provide assisted dying services; as well as providing practical help in relation to assisted dying.

Roles and Responsibilities

Role	Responsibility
Chief Medical Officer	

Procedure – Eligible Person Not Currently an Inpatient (Location of Last Resort)

1 All options for assisted dying to take place in a home / community setting must have been explored and exhausted **prior to** considering a DHB facility as the last resort for location of choice.

2 Formal agreement for the assisted death process to take place in the DHB is required from the Chief Medical Officer (CMO) with input from the Chief Nursing & Midwifery Officer (CNMO), and as required, the Chief Operating Officer (COO) and Chief Allied Health Professions Officer (CAHPO), or their delegates.

3 **Readiness to undertake assisted dying in a HBDHB facility e.g. HB Hospital, Napier, CHB or Wairoa Health Centre**

a. Completion of the requirements of Section 18 and 19 of the End of Life Choice Act is required prior to progressing with the assisted dying in the DHB facility.

b. Prior to the completion of the form described in Section 17(2)(d) of the End of Life Choice Act regarding time and date for the administration of the medication for assisted death, the AMP must work with the HBDHB CMO to ensure a date and time that is mutually agreed by the DHB and the person eligible for assisted dying.

c. The CMO must confirm to the AMP in writing or by email that the assisted death can take place in the hospital prior to any discussion of the time or date with the eligible person. This will take into consideration the anticipated capacity and operational demands of the preferred HBDHB facility preference.

d. The AMP must demonstrate to the satisfaction of the CMO that all possible non-hospital-based options for the intervention have been explored and exhausted.

e. The eligible person is expected to be domiciled in the HBDHB area. Consideration of assisted dying for an eligible person who is not domiciled in the DHB area will only be under exceptional circumstances and agreed by the CMO and relevant Executive Leads as required.

f. The eligible person cannot be considered ready to complete assisted dying until the requirements of Section 19 are met, particularly that the Registrar is satisfied that the processes in sections 11 to 18 of the Act have been complied with and has notified the attending medical practitioner of that.

g. After agreement and the sending of the form to the Registrar, the assisted death will be booked into ECA for that time and date as an outpatient encounter (see Appendix 1 for booking process)

h. No less than 48 hours prior to the agreed date and time of the assisted death, the AMP will confirm in writing to the CMO that the requirements of Section 19 have been fulfilled, and provide evidence that the Registrar has advised that sections 11 through 18 of the Act have been met.

i. The DHB will ensure the location for the assisted death is in a suitable private space, with provision for the attendance of whānau or friends as requested by the eligible person.

4 **The day of planned assisted death**

a. The booking will be reconfirmed by the DHB (via Bed Manager) to the AMP/ANP by 1000 hours on the morning of the agreed date, including:

i. The location,

ii. Arrival time,

iii. Location to report to,

iv. Maximum capacity for whānau or friends to attend

v. Estimation of available time in the location on the date of the assisted death. Who should the person / whānau report to on arrival?? Who would meet them?

b. The DHB reserves the right to postpone or reschedule the booking for unforeseen capacity or emergency requirements.

c. The AMP is required to be present in the hospital no later than 30 minutes prior to the arrival of the eligible person and their whānau or support persons.

d. DHB staff will only assist at the discretion of the DHB and as the DHB determines the situation requires. No DHB staff will be obligated to assist in the intervention. Assistance from DHB staff may include activities such as transport of the deceased to the mortuary as required, provision of a tea trolley for family / whānau, arranging cleaning / blessing of the room following the death.

e. No admission or discharge documentation will be completed by DHB clinical staff for the planned intervention. The patient's arrival time and time of death will be recorded on ECA by DHB administration staff (as per booking process).

f. If the eligible person rescinds the request for assisted dying (Section 23) while in hospital for the intervention, the AMP will arrange (at the patients cost) for the patient's return to their place of residence unless admission is required for clinical reasons, as determined by the relevant DHB acute admitting service.

5 **Completion of the Death Certificate and Statutory Documentation**

a. The AMP/ANP is solely responsible for the completion of the Death Certificate and other end of life documentation, as required by the Act.

6 **Care and Removal of the Deceased**

a. The AMP/ANP is responsible for ensuring that arrangements are made for the removal of the deceased from the specified location of assisted death. Arrangements should be agreed prior to the AD intervention taking place.

b. The DHB is responsible for appropriate Tikanga and cleaning of the location prior to and following an assisted death.

Procedure – Eligible Person Currently an Inpatient

1 **The eligible person is currently an inpatient in the DHB (i.e. assessment has already been completed)**

a. The patient and/or AMP/ANP must advise the lead clinical team responsible for the patient's inpatient care of the patient's wish to consider assisted dying in the hospital.

b. Discussion is held between the lead DHB clinical team, the AMP/ANP and the patient to consider if appropriate / safe to discharge patient back to place of residence / community location for assisted death to occur.

c. If discharge is not possible, follow **step 3 (a-i)** as above for approval for assisted death to occur within the DHB facility.

2 **The day of planned assisted death**

a. The booking will be reconfirmed by the DHB (via Bed Manager) to the ward / location of patient and the AMP/ANP by 1000 hours on the morning of the agreed date, including the location, capacity and maximum available time in the location on the date of the assisted death.

b. The DHB reserves the right to postpone or reschedule the booking for unforeseen capacity or emergency requirements.

c. The DHB will ensure the location for the assisted death is in a suitable state of readiness.

d. The AMP/ANP is required to be present in the ward where the patient located, no later than 30 minutes, prior to the agreed time for the procedure for handover from lead clinical team.

e. The lead clinical team will formally complete a handover of the patient to the AMP/ANP, and the person will be transferred to the location prepared with the AMP/ANP in attendance. The AMP/ANP will be responsible for all clinical care following the completion of the handover by the lead clinical team. The lead clinical team will complete a written discharge summary, noting the transfer of care to the AMP/ANP (this must be done in a timely manner to enable the assisted death outpatient encounter to be initiated in ECA).

f. DHB staff will only assist at the discretion of the DHB and as the DHB determines the situation requires. No DHB staff will be obligated to assist in the intervention. Assistance from DHB staff may include activities such as transport of the patient to the specified location for the assisted death, or transport of the deceased to the mortuary as required, provision of a tea trolley for family / whānau, arranging cleaning / blessing of the room following the death.

g. If the eligible person rescinds the request for assisted dying (Section 23) prior to the assisted death, they will return to the care of the lead clinical team at an available ward bed, or could be discharged to their place of residence / community location if clinically appropriate.

3 **Completion of the Death Certificate and Statutory Documentation**

a. The AMP/ANP is solely responsible for the completion of the Death Certificate and other end of life documentation, as required by the Act.

4 **Care and Removal of the Deceased**

a. The AMP/ANP is responsible for ensuring that arrangements are made for the removal of the deceased from the specified location of assisted death. Arrangements should be agreed prior to the assisted death intervention taking place.

b. The DHB is responsible for appropriate Tikanga and cleaning of the location prior to and following an assisted death.

Procedure – AMP / ANP Responsibilities

1 **The Attending Medical Practitioner (AMP) or Attending Nurse Practitioner (ANP)**

a. The AMP/ANP must be registered with SCENZ Group (being the body established under s25 of the Act) to undertake assisted dying in the hospital and that registration must be active.

b. The AMP/ANP will undergo any credentialing specified by the SCENZ Group for practitioners providing assisted dying services.

c. The AMP/ANP must have a signed Access Agreement in place with HBDHB prior to planning an assisted death within a HBDHB facility.

d. The AMP/ANP must meet the requirements of Section 20, in particular that they must be available to the eligible person in the hospital until the person dies, or arrange for another medical practitioner or nurse practitioner to be available.

e. The AMP/ANP is solely responsible for the intervention of assisted death in the hospital.

f. It is the responsibility of the AMP to ensure all relevant supports e.g. cultural, spiritual, social etc has been provided to the eligible person prior to the procedure

2 **Responsibility of the AMP or ANP for the medication**

a. The AMP/ANP is solely responsible for all aspects of transporting, safeguarding, administering and disposing of the medication and additional consumables provided by the SCENZ process that are used in the assisted dying intervention.

b. The DHB will keep no record of the medication administration, and will not provide the facility for disposal or destruction of the medication (s22 End of Life Choice Act).

Related Documents

References

https://www.health.govt.nz/our-work/life-stages/assisted-dying-service

Responding when a person raises assisted dying: A handbook for registered health professionals

Responding when a person raises assisted dying: A conversation guide for registered health professionals

Policy guidance for Assisted Dying Services: Information for district health boards – public hospitals

Keywords

Assisted dying
End of Life Choice

For further information please contact the Chief Medical Officer

APPENDIX 1

BOOKING PROCESS

If the assisted death is to occur within the DHB facility, a patient encounter must be generated in ECA as an Assisted Death Outpatient Department appointment

Outpatient Department Name: Assisted Death

1. To book patient into the 'Assisted Death Service' the following information is required:
    a. Patient NHI
    b. Responsible AMP / ANP name, including their HCP number (see note below)
    c. Date and time of planned procedure
    d. Location of procedure i.e. HB Hospital, Wairoa Health Centre, CHB Health Centre, Napier Health Centre
2. Send booking request to the Outpatient Booking Manager and Outpatient Booking Team Leader prior to the planned date to create the outpatient encounter
3. The booking staff will create a one-off clinic under the Outpatient Dept given the details provided:
    a. Create an 'Other&AlliedHealth' referral, with a priority of 4 Routine and a Must Be Seen By date of the day of the procedure
    b. They will book the patient in to the clinic slot for the one-off clinic.
    c. The clinic slot will be New Patient.
4. On the day the AMP/ANP will record the arrival/attendance time and the time of death. As the responsible clinician will most likely not be a DHB employee & therefore have access to ECA, the time of arrival & finish time will need to be manually recorded by the AMP/ANP and those details provided to Outpatient Bookers to put in retrospectively
5. This information will be provided to the bookers who will record this against the appointment and outcome the appointment of 'Service Complete'.
6. If the patient changes their mind and leaves alive, then the same information needs to be recorded but the appointment outcome is "Self Discharge".
7. Need to add in a third destination – 'treated acutely' (or words to that effect) to cover if for some reason, the Assisted Death does not occur and the patient needs urgent treatment through ED
8. Regardless of whether the patient comes from the wards (as an existing in-patient) or comes specifically into the DHB facility for the assisted death, the referral will be an 'Other&AlliedHealth' referral. However, it is important that if the patient was an existing in-patient, that they are fully discharged in ECA before attending this booked outpatient appointment.

Note:
When the Access Agreement is signed between the DHB and the relevant AMP/ANP, the confirmation of HCP Code is provided.
If the AMP/ANP does not have an HCP number, then this needs to be formally requested through Digital Enablement prior to planned procedure date.

APPENDIX 2

BOOKING CHECKLIST

Text ….

Date Request Received by CMO		
Access Agreement Signed	Yes ❑	

Patient Name		
Patient NHI Number		
Preferred Date		
Patient Location (at time of request)	Inpatient ❑ Bed #	Community/Home ❑
Planned Time of Arrival		
Preferred Location (circle)	HB Hospital ❑	Napier Health Centre ❑
	CHB Hospital ❑	Wairoa Health Centre ❑
Booking Request to Outpatients		
Bed Manager notified of booking		
Confirmation by AMP to CMO section 19 fulfilled		
Day of AD Intervention	Bed availability, location & time of arrival confirmed to AMP/ANP	
	Access / swipe for AMP/ANP	
	Time of patient arrival	
	Time of death	
	Confirmation of planned arrangements for collection of deceased	

Assisted Dying – Request for Information from Patient				
Reference Number (if new document, will be assigned by Policy Control)				
Approved by:		**First Issued:**		HE KAUANUANU RESPECT ĀKINA IMPROVEMENT RARANGATETIRA PARTNERSHIP TAUWHIRO CARE
Signature:		**Review Date:**		
		Next Review:		

Purpose

This purpose of this guideline is to provide guidance to medical practitioners who are not providing assisted dying services and to health practitioners (not including medical practitioners) for requests for information about assisted dying services. The document is to be read in association with the End of Life Choice Act (Assisted Dying) Policy.

For purposes of this procedure, the provision of information refers to the carrying out of Sections 8, 9 and 10 of the End of Life Choice Act 2019.

Scope

This guideline applies to all staff who are responsible for patients / clients and their families / whanau within HBDHB (including community-based staff).

Definitions

Term/Abbreviation	Meaning
Assisted dying	The administration by an attending medical practitioner or attending nurse practitioner of medication to a person to relieve the person's suffering by hastening death; or the self-administration by the person of medication to relieve their suffering by hastening death.
Conscientious objection	An objection on the ground of conscience.
Health practitioner	A health professional who must be registered and hold a practising certificate in line with the Health Practitioners Competence Assurance Act 2003.
Request for assisted dying	The clear request that a person would like to start the assisted dying process, noting that they may already have had some conversations related to assisted dying before making this request.
Support and Consultation for End of Life in New Zealand Group (SCENZ Group)	The statutory body for the assisted dying service that is responsible for maintaining lists of practitioners who are willing to provide assisted dying services, as well as providing practice help in relation to assisted dying

Roles and Responsibilities

Role	Responsibility
All staff	To read and practice within the guidance

Guideline

Information on Assisted Dying

1 Information in print or accessible form to provide to the patient making the enquiry is available

   a. Our Hub https://ourhub.hawkesbay.health.nz/our-place/end-of-life-choice-act/

   b. Ministry of Health website – Information for the Public https://www.health.govt.nz/our-work/life-stages/assisted-dying-service/information-public

   c. Ministry of Health About the Assisted Dying Service Overview Information https://www.health.govt.nz/system/files/documents/pages/assisted_dying_service_-_general_information_sheet.pdf

   d. Ministry of Health Considering Assisted Dying https://www.health.govt.nz/system/files/documents/pages/assisted_dying_service_-_general_information_sheet.pdf

   e. Ministry of Health Secretariat phone 0800 223 852 (also contact for SCENZ Group)

2 All health practitioners must be informed and prepared, and this includes completing the e-learning modules for health professionals on the Ministry of Health learning platform https://learnonline.health.nz

   a. End of Life Choice Act 2019: Overview (mandatory as per HBDHB End of Life Choice Act (Assisted Dying) Policy)

   b. Assisted dying care pathway: Overview (highly recommended)

   c. Responding when a person raises assisted dying (highly recommend)

For medical practitioners (not providing assisted dying services)

No matter what your personal beliefs or role, you should respond respectfully and professionally to the patient who raises the topics of assisted dying. These raising of the topic and request for information regarding assisted dying by the patient is prior to the process outlined from section 11 onwards of the Act (that is the request being made for assisted dying). You must:

1 Ensure you are informed about the topic of assisted dying and are prepared if a request is made to you for information regarding assisted dying

2 Respectfully respond to a patient raising the topic of assisted dying

If you have a conscientious objection as a medical practitioner OR, as a medical practitioner, you lack the appropriate skills or experience to provide assisted dying services (reasons of competency), the minimum legal requirement states that you must:

1 Inform the patient of your objection OR advise the patient of the reason for not providing assisted dying services (e.g. for reasons of skill and/or knowledge)

2 Advise the patient of their right to contact the SCENZ Group for a name and contact details of a medical practitioner who is willing to provide assisted dying services. The SCENZ Group can be contacted on 0800 223 852

3 Provide the patient with printed public information sheets from the Ministry of Health's website https://www.health.govt.nz/our-work/life-stages/assisted-dying-service, e.g. Assisted Dying Service, Considering assisted dying information sheets

4 Document the conversation in the patient's health record and advise the lead clinical team

5 Continue the duty of care to the patient and their whānau

Hyperlink care pathway - https://www.health.govt.nz/system/files/documents/pages/care_pathway_for_medical_practitioners.pdf

For health practitioners (other than medical practitioners)

No matter what your personal beliefs or role, you should respond respectfully and professionally to the patient who raises the topics of assisted dying. Whilst medical practitioners are legally obliged to disclose a conscientious objection, other health practitioners are not obliged to, but they may choose to.

These raising of the topic and request for information regarding assisted dying by the patient is prior to the process outlined from section 11 onwards of the Act (that is the request being made for assisted dying). You must

1 Ensure you are informed about the topic of assisted dying and are prepared if a request is made to you for information regarding assisted dying

2 Respectfully respond to a patient raising the topic of assisted dying

3 Advise the patient you are unable to provide assisted dying services

4 Suggest that the patient speaks with their lead medical practitioner / general practitioner or they can contact the SCENZ Group for a name and contact details of a medical practitioner who is willing to provide assisted dying services. The SCENZ Group can be contacted on 0800 223 852.

5 You can advise the patient, they can find further information about assisted dying on the Ministry of Health's website https://www.health.govt.nz/our-work/life-stages/assisted-dying-service/information-public or provide the patient with printed public information sheets from the Ministry of Health's website https://www.health.govt.nz/our-work/life-stages/assisted-dying-service, e.g. Assisted Dying Service, Considering assisted dying information sheets

6 Document the conversation in the patient's health record and advise the lead clinical team

7 Continue your duty of care to the patient and their whānau

If there is not a conscientious objection, as a health practitioner you may provide information about assisted dying services to the patient who raises the topic of assisted dying within the scope of your professional role.

In addition to the steps 1 – 7 above, this may include:

1 Asking clarifying questions

2 Consider the setting and whether this is the right time to have a discussion

3 Refer to the Ministry of Health *'Responding when a person raises assisted dying – conversation guide and handbook' to* support further conversation about assisted dying. Hyperlink document - https://www.health.govt.nz/system/files/documents/pages/responding-when-a-person-raises-assisted-dying-a-conversation-guide-for-registered-health-professionals-sep21-v2_0.pdf

Hyperlink care pathway - https://www.health.govt.nz/system/files/documents/pages/care_pathway_for_health_practitioners.pdf

For medical and nurse practitioners providing assisted dying services

These practitioners will need to follow the specific care pathway as described by the Ministry of Health.

Hyperlink care pathway - https://www.health.govt.nz/system/files/documents/pages/care_pathway_for_medical_and_nurse_practitioners.pdf

For all other HBDHB staff

No matter what your role, you may be asked by a patient for information on the topic of assisted dying. If this happens:

1 Respond respectfully and professionally to the patient who raises the topics of assisted dying

2 Advise the patient you are unable to provide any information about assisted dying services, and that you will advise the patient's care team of the request as soon as possible

3 Suggest that the patient speaks with their lead medical practitioner / nurse caring for them

4 Ensure that you speak as soon as practicable to the clinical team / nurse caring for the patient to advise them of the request for information about assisted dying

5 Continue your duty of care to the patient and their whānau

Related Documents

End of Life Choice Act (Assisted Dying) Policy

References

https://www.health.govt.nz/our-work/life-stages/assisted-dying-service/information-health-professionals/resources-guidance-and-information-health-professionals

End of Life Choice Act 2019

Responding when a person raises assisted dying: A handbook for registered health professionals
https://www.health.govt.nz/system/files/documents/pages/responding-when-a-person-raises-assisted-dying-a-handbook-for-registered-health-professionals-sep21_0.pdf

Responding when a person raises assisted dying: A conversation guide for registered health professionals
https://www.health.govt.nz/system/files/documents/pages/responding-when-a-person-raises-assisted-dying-a-conversation-guide-for-registered-health-professionals-sep21-v2_0.pdf

Policy guidance for Assisted Dying Services: Information for district health boards – public hospitals
https://www.health.govt.nz/system/files/documents/pages/policy_guidance_for_assisted_dying_services_-_information_for_district_health_boards_-_public_hospitals.pdf

Keywords

End of Life Choice Act 2019
Assisted Dying

For further information please contact the Chief Medical Officer

Access Agreement for Medical or Nurse Practitioner providing Assisted Dying Services at Hawke's Bay District Health Board

Date: _____

Practitioners Name: _____

Address: _____

_____

Contact Details:

Mobile _____

Email _____

Professional Qualifications _____

_____

Professional qualifications:

Currently employed by Hawke's Bay District Health Board? Yes / No

The Practitioner must attach to this access agreement:

(a) the names and addresses of two referees who verify the identity of the Practitioner;

(b) a copy of their current annual practising certificate; and

(c) confirmation of their medical / nursing indemnity protection coverage.

(d) confirmation of their HCP Code

The Practitioner confirms that:

- All the information provided above is true and correct and agrees to be bound by the terms and conditions of this access agreement.
- Provides evidence of vaccination as per COVID-19 Public Health Response Order.

The information provided in this access agreement is collected for the purpose of issuing and maintaining the agreement, and will not be used for any other purpose.

Practitioners Signature: _____

Signed for and on behalf of Hawke's Bay District Health Board (HBDHB):

_____

Terms and conditions of access to Hawke's Bay District Health Board for Private Practitioners

1 Purpose

(1) The Practitioner requires access to Hawke's Bay District Health Board (**HBDHB**) to provide assisted dying services pursuant to the End of Life Choice Act 2019 (**the Act**).

(2) This access agreement provides the Practitioner with access to HBDHB for the purpose of providing assisted dying services as specified in the service specifications for those services issued by the Ministry of Health.

2 Clinical safety

Assisted dying services will be provided in a clinically safe manner and in accordance with HBDHB policies, both administrative and clinical, and its values. All relevant policies and a statement of HBDHB values will be made available to the Practitioner.

3 Cultural safety

Assisted dying services will be provided in a manner that recognises cultural differences and is sensitive to cultural traditions, protocols and customs, in particular those of Māori.

4 Access to HBDHB

(1) HBDHB shall provide the Practitioner with an orientation to its facility at a time mutually agreeable to both parties.

(2) HBDHB has obligations under the Health and Safety at Work Act 2015 to secure the health and safety of workers within its workplaces. The Practitioner must observe all relevant health and safety and security requirements notified to the Practitioner by HBDHB.

(3) The Practitioner will wear an identification card approved by HBDHB visibly affixed to his/her clothing at all times while in HBDHB.

5 Relationship between HBDHB and the Practitioner

(1) The Practitioner is fully responsible and accountable for his/her professional practice.

(2) The Practitioner will explain to the patient the relationship between him/her and HBDHB is that of an independent practitioner in respect to assisted dying services; the relationship between HBDHB and the Practitioner is not to be construed as one of employment or a contract for service by the Practitioner.

6 Qualifications

(1) The Practitioner is, and shall at all times be, a health practitioner who registered with the Medical Council of New Zealand, or is registered with the Nursing Council of New Zealand as a practitioner of the profession of nursing and whose scope of practice permits the performance of nurse practitioner functions and in both cases holds an annual practicing certificate.

(2) The Practitioner will inform the facilities of any change in their practising status or any conditions attached to their annual practising certificate.

(3) The Practitioner will maintain registration with SCENZ Group, being the body established under s25 of the Act, as a medical practitioner willing to act for the purposes of the Act.

(4) The Practitioner will undergo any credentialing specified by the SCENZ Group for practitioners providing assisted dying services.

(5) The Practitioner will provide any information regarding his/her training and qualifications; experience and practice as is reasonably required by HBDHB.

(6) The Practitioner agrees to notify HBDHB immediately if he/she is subject to a competence review, complaint or other process that may reflect upon their ability to provide assisted dying services. This will include any complaint made to the Health and Disability Commissioner or to any other agency or statutory body in relation to or arising out of assisted dying services provided by the Practitioner.

7 Practitioner Compliance with Statutes and Regulations

(1) The Practitioner must ensure the Act and other regulatory, legal and professional requirements that apply to assisted dying services are complied with.

(2) The Practitioner shall provide assisted dying services:

(a) with all reasonable care, skill and diligence;

(b) in accordance with clinical best practice;

(c) in accordance with legal, professional and ethical standards; and

(d) in accordance with all applicable regulatory and statutory requirements, in particular those specified by SCENZ Group pursuant to s20 and s25(g) of the Act in respect to the administration of medication.

8 Indemnity Protection and Indemnity

(1) The Practitioner shall maintain appropriate professional indemnity protection at all times during the term of this agreement.

(2) The Practitioner indemnifies HBDHB against any and all claims or complaints made against HBDHB that arise from or are in respect of the assisted dying services provided by the Practitioner and are attributable in whole or in part to any act or omission of the Practitioner.

9 Administrative Requirements

(1) The Practitioner will meet any reasonable administrative requirements of HBDHB to the extent necessary to enable to the parties to co-ordinate services.

(2) HBDHB shall facilitate the Practitioner's compliance with its administrative requirements.

(3) The Practitioner shall notify HBDHB of any changes in his/her contact details.

10 Complaints management

(1) Where a complaint is made in respect to the assisted dying service, the party receiving the complaint will advise the family of the appropriate avenues for complaint management.

(2) If the Practitioner and HBDHB both have responsibilities in respect of the service complained about then, the party who receives the complaint shall discuss the issue with the other party.

(3) If there is:

(a) a material, or a repeated breach after notice, of a term or terms of this access agreement;

(b) performance concerns relating to the Practitioner's clinical practice;

(c) behavioural issues which would on the face of the concern expressed, be considered to risk damage to the reputation of HBDHB or the Practitioner, or result from alleged criminal behaviour, or health and safety concerns for staff and patients

(together "**serious concerns**"), HBDHB shall investigate fairly, thoroughly and as quickly as reasonably possible those serious concerns, following a fair and reasonable process and recognising the right to natural justice of the Practitioner.

(5) Pending the results of the investigation of serious concerns, HBDHB Chief Medical Officer or Chief Nursing and Midwifery Officer may impose restrictions on the Practitioner's clinical practice at HBDHB, including suspending the Practitioner's access to HBDHB. Reasons for any restrictions or for suspension are to be provided to the Practitioner by HBDHB immediately.

(4) HBDHB shall have no liability for pecuniary harm to the Practitioner as a consequence of these investigations and any restriction to practice that may occur.

11 Term

(1) This agreement is continuous will the Act is in force, subject to an annual sighting of the Practitioner's annual practising certificate and indemnity protection.

(2) The Practitioner may terminate this access agreement by giving written notice to HBDHB.

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

11

That the public now be excluded from the following parts of the meeting, namely:

12. Confirmation of Previous Minutes (Public Excluded)
13. Matters Arising – Review of Actions (Public Excluded)
14. Clinical Council Board Report (was no Report in October for Public Excluded)
15. Chief Operating Officers Report (Public Excluded)
16. Topics of Interest (Public Excluded)
17. Covid in the Community – Preparedness (Public Excluded)
18. Patient Safety and Risk Management Committee (Public Excluded)
19. Patient Safety and Quarterly Report (Public Excluded)

The general subject of the matter to be considered while the public is excluded, the reason for passing this resolution in relation to the matter and the specific grounds under Clause 32(a) of the New Zealand Public Health and Disability Act 2000 for the passing of this resolution are as follows:

- Official Information Act 1982 9(2)(ba) to protect information which is subject to an obligation of confidence.
- Official Information Act 1982 9(g)(i) to maintain the effective conduct of public affairs through the free and frank expression of opinions between the organisation, board and officers of the Minister of the Crown.
- NZPHD Act 2000, schedule 3, clause 32(a), that the public conduct of the whole or relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i) of the Official Information Act 1982).