# Hawke's Bay Health
# Consumer Council Meeting

**Date:** **Thursday, 14 July 2016**

**Meeting:** **4.00 pm to 6.00 pm**

**Venue:** **Te Waiora Meeting Room, District Health Board Corporate Office, Cnr Omahu Road & McLeod Street, Hastings**

**Council Members:**

Graeme Norton (Chair)
Rosemary Marriott
Heather Robertson
Terry Kingston
Tessa Robin
Leona Karauria
Jim Morunga
Nicki Lishman
Jenny Peters
Olive Tanielu
Jim Henry
Malcolm Dixon
Rachel Ritchie
Sarah de la Haye

**Apologies:** Rachel Ritchie, Sarah de la Haye, Olive Tanielu and Malcolm Dixon

**In attendance:**

Kate Coley, Director Quality Improvement & Patient Safety (DQIPS)
Tracy Fricker, Council Administrator and PA to DQIPS
Jeanette Rendle, Consumer Engagement Manager
Ken Foote, Company Secretary
Nicola Ehau, Manager Innovation & Development for Health HB
Debs Higgins, Clinical Council Representative

# HB Health Consumer Council
# Agenda

**PUBLIC**

| Item | Section 1 – Routine | Time (pm) |
|---|---|---|
| 1. | Karakia Timatanga (Opening) / Reflection | 4.00 |
| 2. | Apologies | |
| 3. | Interests Register | |
| 4. | Minutes of Previous Meeting | |
| 5. | Matters Arising - Review Actions | - |
| 6. | Consumer Council Workplan | |
| 7. | Chair's Update (verbal) | |
| 8. | Consumer Engagement Manager's Update (verbal) | |
| | **Section 2 – Presentation** | |
| 9. | Transform and Sustain Refresh – Tim Evans | 4.30 |
| | **Section 3 – For Discussion** | |
| 10. | Reducing Alcohol Related Harm - Rachel Eyre, Medical Officer of Health<br>• Position Statement example | 4.40 |
| | **Section 4 – For Endorsement** | |
| 11. | Health & Social Care Networks - Purpose and Principles - Liz & Belinda<br>Health & Social Care Networks - Geographic Localities Proposal<br>Health & Social Care Networks - Business Case – Phase One | 5.10 |
| | **Section 5 – Information only** | |
| 12. | Last Days of Life – Leigh White<br>• Care Plan<br>• Toolkit | - |
| | **Section 6 – General Business** | |
| 13. | Topics of Interest - Member Issues / Updates | 5.20 |
| 14. | Karakia Whakamutunga (Closing) | 6.00 |

**NEXT MEETING Thursday 11 August 2016, commencing at 4.00pm**
**Te Waiora (Boardroom), HBDHB Corporate Administration Building**

Tauwhiro Rāranga te tira He kauanuanu Ākina

# Interest Register

## Hawke's Bay Health Consumer Council

**Jun-16**

| Name<br>Consumer Council Member | Interest<br>eg Organisation / Close Family Member | Nature of Interest<br>eg Role / Relationship | Core Business<br>Key Activity of Interest | Conflict of Interest<br>Yes / No | If Yes, Nature of Conflict:<br>- Real, potential, perceived<br>- Pecuniary / Personal<br>- Describe relationship of Interest to |
|---|---|---|---|---|---|
| Graeme Norton | 3R Group Limited | Director/Shareholder | Product Stewardship | No | |
| | NZ Sustainable Business Council | Deputy Chair | Sustainable Development | No | |
| | HB Diabetes Leadership Team | Chair | Leadership group working to improve outcomes for people in HB with diabetes | No | Group is sponsored by HBDHB |
| | NZ Life Cycle Management Centre | Chair, Advisory Group | Advancing life cycle management thinking across NZ | No | |
| Rosemary Marriott | YMCA of Hawke's Bay | President | Youth Including health issues | No | |
| | Totara Health | Consumer Advisor | Health and wellbeing | No | |
| Heather Robertson | Restraints Committee of DHB | Committee Member | Representing Consumers on this Committee | No | |
| Terry Kingston | Central Hawke's Bay District Council | Elected Member | Local body | No | Will declare any perceived interests as they arise. |
| | Interest in all health matters, in particular - Mental Health, Youth, Rural and Transport. | | | | |
| Tessa Robin | Te Kupenga Hauora - Ahuriri | Finance and Quality Manager | Responsible for overseeing QMS for organisation and financial accountability | No | Potential - Employer holds contracts with HBDHB |
| Leonna Karauria | NZ Maori Internet Society | Chairperson | Advocacy on Maori Communities | No | |
| | Computers in Homes HB Steering Committee | Member and Regional Co-ordinator | ICT Project Management through schools and communities | No | |
| | Computers in Homes, Wairoa Steering Committee | Member and Regional Co-ordinator | ICT Project Management through homes and communities | No | |
| | Maori Party Wairoa Branch | Chairperson | Supporting Policies at a local level | No | |
| | Simplistic Advanced Solutions Ltd | Director/Owner | Information Communications Technology services. | Yes | If contracted for service, there could be a perceived conflict of interest. |
| | Hastings District Council Digital Enablement Focus Group | Member | Advisory for digital literacy and internet access initiatives for communities | No | |
| | Wairoa Wireless Communications Ltd | Director/Owner | Wireless Internet Service Provider | Yes | Approached in early 2014 by HBDHB and contracted for service to provide wireless internet service to Wairoa Rural Health Learning Centre and Hallwright House. Could be a perceived conflict of interest. |

# HB Health Consumer Council 14 July 2016 - Interest Register

| **Name**<br>**Consumer Council Member** | **Interest**<br>**eg Organisation / Close Family Member** | **Nature of Interest**<br>**eg Role / Relationship** | **Core Business**<br>**Key Activity of Interest** | **Conflict of Interest**<br>**Yes / No** | **If Yes, Nature of Conflict:**<br>**- Real, potential, perceived**<br>**- Pecuniary / Personal**<br>**- Describe relationship of Interest to** |
|---|---|---|---|---|---|
| Nicki Lishman | Employee of Ministry of Social Development | Regional Health Advisor | Liaising with health community and supporting Work and Income Staff. | Yes | Could be perceived/potential eg., situation where gaps identified regarding funding. |
| | Registered Social Worker, member of ANZASW | Professional body | Social work | No | |
| Jenny Peters | Nil | | | | |
| Olive Tanielu | HB District Health Board | Employee | Work with Pacific Island children and families in hospital and in the community | Yes | Perceived/potential conflict between employee HBDHB and roles of Consumer |
| Jim Morunga | Nil | | | | |
| Malcolm Dixon | Hastings District Councillor | Elected Councillor | | No | |
| | Sport Hawke's Bay | Board of Trustees | Non paid role | No | |
| | Scott Foundation | Allocation Committee | | No | |
| James Henry | Health Hawke's Bay Ltd | Facilitator | Part-time role. Improving lifestyles for people with chronic illness. | No | |
| Rachel Ritchie | Put the Patient First | Involved when group was active | Advocating for Diabetes Patients | Unsure | Real / potential / Perceived |
| Sarah de la Haye | Nil | | | | |

**MINUTES OF THE HAWKE'S BAY HEALTH CONSUMER COUNCIL MEETING HELD IN THE TE WAIORA MEETING ROOM, HBDHB CORPORATE OFFICE ON 9 JUNE 2016 AT 4.00 PM**

**PUBLIC**

**Present:** Graeme Norton (Chair)
Heather Robertson
James Henry
Nicki Lishman
Rosemary Marriott
Tessa Robin
Olive Tanielu
Sarah de la Haye
Jim Morunga
Terry Kingston
Leona Karauria
Jenny Peters
Rachel Ritchie

**Apology:** Malcolm Dixon

**In Attendance:** Kate Coley, Director Quality Improvement & Patient Safety
Jeanette Rendle, Consumer Engagement Manager (arrived late)
Brenda Crene, Board Administrator and PA to Company Secretary

## SECTION 1: ROUTINE

### 1. WELCOME

The Chair welcomed everyone to the meeting. Tessa Robin opened the meeting with a Karakia, sharing information around Matariki and its meaning to Māori.

### 2. APOLOGIES

An apology had been received from Malcolm Dixon and it was noted that Jeanette Rendle would be late arriving.

### 3. INTERESTS REGISTER

One new interest for Rosemary Marriott was conveyed as she was now a "Consumer Advisor" for Totara Health. **Actioned**

No members advised any conflict with items on the day's agenda.

### 4. PREVIOUS MINUTES

The minutes of the joint Hawke's Bay Health Consumer Council and HB Clinical Council **public** meeting held 11 May 2016 (at Te Taiwhenua o Heretaunga) were confirmed as a correct record of the meeting.

Moved and carried.

The minutes of the **public excluded** joint meeting between Hawke's Bay Health Consumer Council and HB Clinical Council 11 May 2016 (at Te Taiwhenua o Heretaunga) were confirmed as a correct record of the meeting.

Moved and carried.

## 5. MATTERS ARISING AND ACTIONS

Nil.

## 6. CONSUMER WORK PLAN

| | | |
|---|---|---|
| **14 Jul** | Alcohol – discussion<br>HB Integrated Palliative Care (discussion draft final in September)<br>***Monitoring***<br>Health and Social Care Networks Update | Caroline McElnay<br>Mary Wills<br><br>Liz Stockley |

Noted that the first Draft of "Developing a Person Whanau Centered Culture" will now be presented in September with the final in November 2016.

## 7. CHAIR'S UPDATE

Implementing Consumer Council structures nationally is expanding at pace. It appears the level of close support for the consumer structure by executives and board, varies greatly. A number of DHBs have asked for assistance. Consumer Councils around the country would be strengthened by working with each other, and hopefully that will come in time.

The Consumer Engagement Manager is developing a toolkit for the HB sector on consumer engagement.

## 8. CONSUMER ENGAGEMENT MANAGER'S UPDATE

In Jeanette Rendle's absence, the Chair provided an update on her behalf

a) The Recruitment process has commenced for consumer council members
   - A YOUTH advertisement had appeared in "The Zone" HB Today insert 21st May; 50 posters have been printed and distributed to community and youth organisations; schools have been emailed, with EOIs closing 20 June.
     **Action: A copy of advert(s) will be emailed to council members to distribute across their networks and to individuals who may have an interest.**

   - WOMEN & CHILDREN advertisement and poster had been issued, with expressions of interest due on 14 June. As above an email will follow for members to distribute.

b) Customer focussed bookings programme of work
   - Jacqui Mabin, Project Manager is organising a workshop regarding text to remind functionality and encouraging strong consumer involvement. A variety of patients – elderly, youth, rural, multiple conditions and, multiple family appointments etc, are being identified to enable a wide range of perspectives. Consumer Council are also welcome to attend.
     **Action: Once details have been finalised Consumer members will be advised.**

Further to the Go-Well travel plan presentation in May 2016, it would ideal to have bookings co-ordinated with available travel options. The Chair was speaking with the parties and was hopeful that customer focussed bookings and the go-well travel plan would work together in this regard.

## SECTION 2: FOR DECISION

### 9. YOUTH HEALTH STRATEGY 2016-19

Dr Caroline McElnay was in attendance and relayed Nicky Skerman's apology.

An overview was provided to Council for their feedback prior to the Strategy being presented to the HBDHB Board for final endorsement.

Feedback:

- AOD should be added in after Mental Health services, on page 19. **Actioned.**
- There were positive comments conveyed on how the feedback had been addressed in the document. Good to see a lot of feedback from Wairoa had been captured also.
- The major funder of Youth Services is the HBDHB and this should be more widely known.
- A member noted it may help if the Consumer Representative(s) were included on the front report cover for projects in future.

Consultation with youth:

- One member was concerned that adequate consultation had not occurred. It appeared that the ones who really needed this had not been consulted. It was raised by someone who houses a number of youth and they would not be able to comprehend a document like this. Advised may be talking with youth who don't have any problems.
  Assured that through this process youth from all areas had been engaged.
- Tessa – queried who in Napier had been consulted. Feedback from youth in the Napier (Maraenui) community raised concerns that no one had spoken with them. They asked "Which youth were consulted?" For a variety of reasons, there are a significant number of rangatahi that don't feel comfortable to come out of their homes and these are the ones that need help. More engagement is needed with those that are not engaging rather than with those who are already engaging with services. Over the last twenty years services have worked with whanau to firstly open their doors to accept support from community services, then services worked hard to get whanau to come into the community. After a cycle of success, the cycle has started again with rangatahi. This is similar for our Pacifica community who better engage with services that understand their language and cultural needs."
- Rosemary advised this is true but there are programmes (including YMCA) that deal with alienated youth. There is liaison and connections with directions and youth. Some need programmes delivered in their homes eg education programmes.
- Nicki advised this is about "Strategy" and the need to look more at those services and how they are delivered. The bulk of feedback just received was about those who are not receiving services. On behalf of youth, feedback has been that there are many that will not access alcohol and drug services through the DHB as they are wanting a kaupapa Maori response and service, and also that there are not enough existing Youth AOD counsellors to keep up with demand at the DHB. It is an area that is under-resourced, which then has other impacts for youth as there is not the capacity of alcohol and drug counsellors available to be able to work with people intensively and then refer into youth rehabs
- ***In summary*** *the issue is if we are going to address inequity, we need to reach the youth who are not being served and want to receive assistance.*

Consultation with Pasifika youth:

- Olive asked if Pasifika youth had been consulted, Caroline advised that it was done through Talalelei Taufale. However Olive knew that Tongan youth had not been consulted. Would need to engage with Samoan youth through the Church.
- It is all about approaching who and where, due to the different pacific cultures and languages.
- ***In summary*** *the entry point is to find where the highest trust is within these groups, and this would likely be best determined by the Pacific navigator(s) and Talalelei Taufale (a member of the DHB Population Health Team).*

In general:

- With many different strategies being developed by the DHB, all with their own consultation requirements, was there a risk of consultation saturation. Why were the dots not joined up first, instead of working in silos?
- This strategy as with other strategies must stop presenting in silos. You must look from a holistic perspective and at the whole person and the whole problem. This is where we need other services and sectors to work together and share information for the benefit of the whanau.
  Dr McElnay advised she had heard this comment before and advised when it comes to implementation all will be aligned.

Nicki and Malcolm had been involved with this project and attendance will include the youth representative when appointed to Council.

The document caters for a wider growing need of challenged youth. Overall a very good document and noting the points raised above, Council provided their approval.

**RECOMMENDATION**

**That Consumer Council**

Endorse the Youth Health Strategy 2016-19 to go to the Board for final endorsement.

**Carried**

## SECTION 3: FOR DISCUSSION

### 10. FOOD SERVICES OPTIMISATION REVIEW

The Chair welcomed Gavin Carey-Smith (acting Facilities Manager) and Deborah Chettleburgh (Nutrition and Food Manager) to the meeting.

An overview of the background and the food service review was outlined. This optimisation review had been requested by the HBDHB Board at the time of their decision to have the Nutrition Service for the HBDHB remain in-house, rather than be nationally aligned.

The resulting actions would likely take between 6-12 months to complete and included some capital spend if approved by the Board.

***Questions and Feedback:***

- Had there been any consumer input during this process, as there appeared to be areas where further improvement(s) could be beneficial? To date no consumer input had been received but management felt consumer input would be very beneficial, especially in the signage area.

- Staff and visitors would be surveyed, and points raised considered.
- A suggestion was made to consider after hours services.
- There will be interest in HBDHB's food services. We need to be well prepared and have evidence based measures in place to defend the decision to remain autonomous rather than align with other DHBs.
- For capital funding to be provided, a different process would be used.

There was full support from consumer members with the following recommendation approved.

**RECOMMENDATION**

**That HB Health Consumer Council:**

1. Support the Food Service team in investigating and implementing the recommendations.
2. Note capital applications that arise from recommendations below will be put through the capital plan process for approval.

**Approved**

## 11. HEALTH EQUITY UPDATE 2016

The Chair welcomed Dr Caroline McElnay to the meeting in her role as "Health Equity Champion".

The Health Equity Update 2016 report outlined progress made in some key areas of inequity and outlined ongoing challenges. The purpose is to promote actions and partnerships for better and equitable health and wellbeing in the HB community.

Although limited, progress had been achieved in the various areas targeted as follows:

- Health Equity Achieved 1
- Good Progress 3
- Could do better 9
- No Change / Worse 5

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The Health Equity Report was data driven (as a starting point) and the presentation provided was to prompt consumer members to provide feedback and recommendations about "what is missing?"

**Discussion:**

- Data needs to relate to patient/consumer perspective.
- The public versus the private health care route is very different regarding access and patient experiences.
- What does "Whanau Ora" mean to Maori and to others?
- Demographic appears to drive inequity.
- The deepest example of inequity is person living in poverty with a disability!
- "Disability" is behind inequity and this has not been addressed at all well.
- Pacific people are missing out and their health continues to decline. It is mentioned that Pacific people have been consulted but the majority of the Pacific community have had no consultation. Pacific people do not know what "Whanau Ora" means.
- A document would be useful to highlight pacific issues? More needs to happen in this area.
- The document raises issues and informs about what needs to develop.
- Jim Morunga was concerned at reading negative reports around Maori and would like to see where Maori have improved over the past 3-4 years. **Action Maori Health.**

- Tessa sought a holistic view of "family health" and too often families are not consulted in a range of ways.
- **"**If you know what matters to you – you can help". Health Equity could be framed around how you treat people and then relay how their health is shifting! We need to know about those who are not being treated and why.

**Action: Consumer members were asked to "make recommendations on priority actions required to further reduce health inequity in Hawke's Bay."**
**A discussion via email on Health Equity in Hawke's Bay will follow via an email discussion, prompted by Chair Graeme Norton.**

Nicki Lishman thanked Dr McElnay for her report, advising the Ministry of Social Development (MSD) see tragic inequities. There is not a lot of solid rationale at a national level so this report will open doors in HB for a lot more projects to tackle inequities.

## 12. SUICIDE PREVENTION AND POSTVENTION PLAN REPORT

Dr Caroline McElnay was supported by Penny Thompson who provided an update on what had transpired since June 2015. A year on, the network of agencies participating in suicide prevention have worked together to; link consumers to agencies and agencies to agencies, improve information sharing processes, review the support model to include prevention, provide access to training and maintain interagency commitment to suicide prevention.

Consumer members were asked to provide feedback:

- Resilience crucial and this should be linked in with the Youth Strategy.
- Curious to know links with the Ministry of Education (MoE) and the ability to support schools and connections with kids at school.
  - Schools invite organisations to support them. Some do and some don't.
- How do we utilise relationships with schools more effectively – and provide a resource. Why are schools not engaged automatically?
  - Schools are autonomous and have their own governance.
- MoH Workshop held to promote the sharing of resources for suicide prevention. Schools would then understand what resources are available in the community.
- The wheels in this area do not turn fast. MoE's involvement with suicide and schools has been experienced by a consumer member, advising it has taken 5 years of focus and still no further ahead.
- Suicide is everyone's problem. Those who know the person at risk have a responsibility and should ask questions of that person. More often than not there is fear by those wanting to help – as they do not know how to ask questions. This is about enquiry learning and sharing.
- Contraception and abortion was discussed. As the law presently stands, parents don't have to be told (due to privacy) which takes away parents' rights of care as they may not know their child/young adult, is at risk / vulnerable.
- Intersectoral support - push from DHB to work alongside ACC.
- Consumer members encouraged to email ideas to Penny.thompson@hbdhb.govt.nz

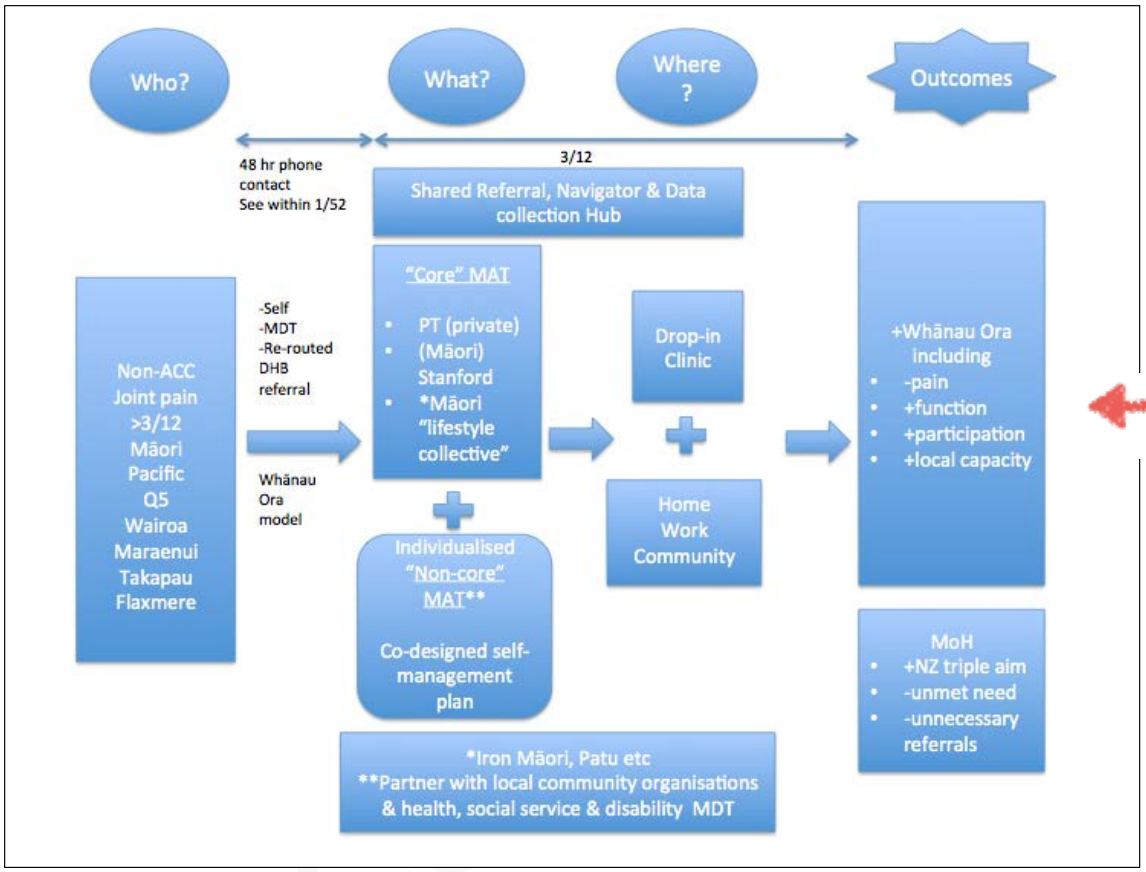
## 13. MOBILITY ACTION PROGRAMME - PRESENTATION

Dr Tae Richardson (GP) supported by Dr Andy Phillips (Chief Allied Health Professions Officer) Having worked on all things muscular skeletal issues and alternatives to orthopaedic surgery for around one year the lively presentation provided was very well received.

*"Musculoskeletal health conditions such as osteoarthritis, rheumatoid arthritis and lower back pain are the **leading cause of disability** in New Zealand and have a significant influence on health and quality of life."*

Having got through the initial round with the MoH, HB are hopeful to secure funding to undertake a two year pilot. The presentation by Tae encouraged Council to discuss and contribute to the design of a community musculoskeletal programme.

If the funding bid is successful, the two year Pilot would commence and accept onto the programme: Maori and Pacifica people over 18; who are quintile 5 (or decile 9 and 10); or those who reside in the identified area to qualify (currently Wairoa, Takapau, Flaxmere and/or Maraenui).




***Discussion and feedback:***

- Work could be done in people's homes, if necessary.
- There would be others with disabilities who will fall outside the above criteria but a line does need to be drawn in the sand.
- Why not provide to those with community services card? There had been a lot of debate around this. Over 65 universal age benefit and the community services card is means tested.
- Communication would be crucial to ensure the targeted group are made aware.
- Need all networks to be involved.
- Nicki advised that MSD have databases that can be accessed for those who need it.
- Worried if go through Doctors - they are seen as gatekeepers that provide entitlement!
- Need to build capacity for communities to self-determine.
- This represents a highly successful way of working together to support changes in the way those in need live.
- We will evaluate internally and there will be a national evaluation also.
- The open door aspect for those who need help would be welcomed.

Tae's presentation style was very appreciated with comment she was the best presenter Consumer Council had experienced.

The next step will be to present (or should we say relay "Kereama's case") to the MoH on 7 July.

**Action.** **To follow up, the Mobility Action Programme (MAP) would be included on the September 2016 Consumer agenda.**

## SECTION 4: FOR INFORMATION

### 14. TE ARA WHAKAWAIORA / ORAL HEALTH

Report taken as read. No issues discussed.

## SECTION 5: GENERAL BUSINESS

### 15. TOPICS OF INTEREST – MEMBER ISSUES / UPDATES

Issued raised / discussed included:

- Nicola Ehau briefed Council that the PHO were looking at setting up a **PHO consumer group** which was modelled around the successful whanau wellness programme. She advised this was early days of being established and asked if there was any interest to improve services going forward.

  The PHO feel they need to connect better to general practice also.

  The Chair advised that HB Health Consumer Council was meant to be across the sector and wanted to ensure that both groups did not trip over each other, or work in silos. We need to be careful to land this well or it could perpetuate something on the side and need to be careful not to have that happen. This was the first time the Chair had heard of this.
  It was acknowledged that the support of management and governance is crucial.

- **Health and Social Care Networks** was discussed by those consumer members who attended the first meeting some time ago. They felt the meeting was too process oriented and felt much had been pre-determined.

  The meetings will now be weekly on Wednesdays and there is a lot that needs to be brought to the table especially the aims and objectives. It was early days into what appears to be a likely two year programme which those attending felt had not got off to a good start.

  It was suggested that CYFS and WINZ needed to be at the table.

### 16. RECOMMENDATION TO EXCLUDE THE PUBLIC

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

**17. Minutes of Previous Meeting**
**- Public Excluded**

**18. Matters Arising – Review of Actions (nil)**
**- Public Excluded**

Carried.

The meeting closed at 6.20 pm

Confirmed: _____
Chair

Date: _____

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## HAWKE'S BAY HEALTH CONSUMER COUNCIL

### Matters Arising
### Reviews of Actions

| Action | Date Issue first Entered | Action to be Taken | By Whom | By When | Status |
|---|---|---|---|---|---|
| 1 | 10/3/16 | ***Refine Consumer Portfolios 2016/17***<br>This has been deferred until after Transform and Sustain Refresh June/July | | | Ongoing |

OURHEALTH HAWKE'S BAY Whakawateatia

# HB HEALTH CONSUMER COUNCIL WORKPLAN 2016-2017

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| Meetings 2016 | Papers and Topics | Lead(s) |
|---|---|---|
| **11 Aug** | Draft Quality Accounts<br>Travel Plan Update – verbal<br>Complementary Therapies Policy<br>***Monitoring***<br>Annual Maori Plan Q4 15/16 Dashboard<br>Te Ara Whakawaiora / Culturally Competent Workforce (local indicator)<br>Te Ara Whakawaiora / Mental Health and AOD (national and local indicators) | Kate Coley<br>Sharon Mason<br>Andy Phillips<br><br>Tracee TeHuia<br>Chris and Andy<br><br>Sharon, Alison S |
| **15 Sept** | Orthopaedic Review – closure phase 1<br>Draft – Orthopaedic Review – phase 2<br>Draft – Family Violence – Strategy Effectiveness for noting<br>Draft – Reducing Alcohol-Related Harm<br>Draft - Developing a Person Whanau Centred Culture<br>Final – Quality Accounts (co-ord with Annual Report)<br>Final – HB Integrated Palliative Care<br>Health and Social Care Networks Update<br>***Monitoring***<br>Te Ara Whakawaiora / Obesity (national indicator) | Andy Phillips<br>Andy Phillips<br>Caroline McElnay<br>Caroline McElnay<br>Kate Coley<br>Kate Coley<br>Mary Wills<br>Liz Stockley<br><br>Shari Tidswell |
| **TBA** | **HB Health Sector Leadership Forum**<br>Date, Theme and Venue to be confirmed | |
| **13 Oct** | Final – Reducing Alcohol-Related Harm<br>Draft – New Patient Safety and Experience Dashboard (reporting sequence to follow) | Caroline McElnay<br>Kate Coley |
| **10 Nov** | Travel Plan – verbal<br>Final - Developing a Person Whanau Centred Culture<br>Tobacco – Annual Update against the Plan (for noting) **<br>***Monitoring***<br>Te Ara Whakawaiora / Smoking (national indicator) **<br>Annual Maori Plan Q1 | Sharon Mason / Andrea<br>Kate Coley<br>Caroline McElnay<br><br>Caroline McElnay<br>Tracee TeHuia |
| **8 Dec** | Discussion - HB Workforce Plan<br>Health and Social Care Networks Update | John McKeefry<br>Liz Stockley |

# CHAIR'S UPDATE

Verbal

# CONSUMER ENGAGEMENT MANAGER'S UPDATE

Verbal

# TRANSFORM & SUSTAIN REFRESH

Presentation

| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Discussion paper on Reducing Alcohol-Related Harm** |
| | For the attention of: **HB Clinical Council, HB Health Consumer Council and the Māori Relationship Board** |
| Document Owner:<br>Document Author(s): | Dr Caroline McElnay, Director Population Health<br>Dr Rachel Eyre, Medical Officer of Health |
| Reviewed by: | Executive Management Team |
| Month: | July 2016 |
| Consideration: | For Discussion and Endorsement |

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**RECOMMENDATION**

**That HB Clinical Council, HB Health Consumer Council and the Māori Relationship Board:**

1. **Note** the contents of this report.
2. **Feedback** on the questions.
3. **Endorse** the proposed approach of developing a HBDHB Position Statement.

## OVERVIEW

The purpose of this paper is to facilitate discussion amongst HBDHB committees on alcohol-related harm. Alcohol-related harm is a critical issue for our DHB, creating a significant burden of harm to individuals, to communities and to our health system.

Following a first round of discussions among the committees, it is proposed that a Position Statement on alcohol-related harms be drafted for the second round. The Position Statement would outline the DHB's priorities to reduce alcohol-related health harms in the next three to five (3-5) years (this timeframe being consistent with the National Drug Policy). This would be the DHB's opportunity to develop a common agenda on alcohol harms and to outline actions to address them. A final Position Statement would be put forward to be endorsed by the HBDHB Board.

An example of a Position Statement from the combined Wellington region of three district health boards is attached.

A short film has been produced and will be presented to the committees with this discussion paper.

## BACKGROUND

### *Why we need to take alcohol-related harm seriously*

- There are a high number of hazardous drinkers[1] in New Zealand and Hawke's Bay is no exception
- Every year around 1000 New Zealanders die from alcohol-related causes
- Alcohol-related harm in New Zealand is estimated to cost an overall $6.5 billion per year
- Alcohol is a toxin, an intoxicant, a carcinogen and an addictive psychotropic drug
- Hazardous drinking patterns can create both acute and chronic health problems
- Alcohol not only affects the individual but also those around them. It has detrimental effects e.g. lifelong brain damage to young people and to the foetus when a woman drinks whilst being pregnant
- Lack of systematically collected data on 'alcohol-related harm' including 'harm to others' limits our ability to estimate the true cost to communities and prevents adequate resources and effective strategies being assigned

### *What alcohol-related harm looks like in Hawke's Bay (based on current health data[2])*

Alcohol related harm in our DHB region is demonstrated by:

- Rates of hazardous drinking in Hawke's Bay are higher than the national average (by 60%)
- Increasing rates of hazardous drinking over time (by almost 10% from 2006/07 to 2011/14)
- Highest rates of hazardous drinking among young people (41% in the 15-24 year age group)
- Higher rates of hazardous drinking and increased hospitalisations among Māori
- Increased hospitalisation rates for alcohol-related conditions among women
- Slight increase in women exceeding the alcohol and other substance legal limits while driving
- Hawke's Bay has slightly higher rates than New Zealand for alcohol related crashes resulting in non-fatal injuries but the percentage of alcohol-related crashes resulting in fatal injuries have dropped below national average

In 2015, a Hawke's Bay community survey[3] showed wide-spread recognition of alcohol harm and some pointers for change in the alcohol environment, as follows:

- Two-thirds feel the drinking of alcohol has a negative impact in their community
- Nearly 90% of people agree that alcohol affects family violence in the community and over 80% agree it affects community safety
- The majority of respondents want fewer bottle stores. Bottle stores and supermarkets selling alcohol are the most commonly identified as having the greatest impact on alcohol harm in communities
- Almost 80% want more alcohol-free entertainment options

### *What works to reduce alcohol related harm (based on the evidence) and what opportunities do we have:*

Policy:

- The strongest measures to reduce alcohol-related harm are at the policy level and involve increasing price, reducing availability and reduced advertising. The Sale and Supply of Alcohol Act (2012) requires Medical Officer of Health input and enables more community say to reduce alcohol availability at a local level e.g. via the Local Alcohol Policy (LAP) process and licensing decisions.

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1 Hazardous drinkers are defined as adults who obtained an Alcohol Use Disorders Identification Test (a validated tool) score of 8 or more representing an established pattern of drinking that carries a high risk of future damage to physical or mental health.

2 Includes latest NZ Health Survey (Ministry of Health) results, HBDHB hospitalisation data and Massey data (Environmental Health Indicators NZ programme).

3 This 2015 HBDHB led survey involved 1000 adult respondents from across Hawke's Bay.

Community:

- The next most effective and cost-effective measures at a DHB level include a range of community-level interventions that aim to delay drinking in young people, reduce harm to Māori, pregnant women, and Pasifika, encourage moderation in older adults and seek to reduce availability (limiting both demand and supply)
- Interventions need to be whānau and community focussed and not just focussed on individual choice
- A focus on settings where target groups are found allows for integrated approaches
- Community-level interventions need to be community-led but communities often lack resources to do this and to focus on alcohol harm
- It is critical to find ways to delay drinking as long as possible, especially under 18s, to prevent alcohol's harmful effects on growing brains (up to the age of 25 years old)
- The message that there is no safe amount of alcohol which can be drunk in pregnancy needs to be widely understood - including by health professionals
- Reducing the exposure of young people to alcohol promotion, marketing and sponsored events particularly associated with sport is important



Screening:

- Screening and brief intervention approaches in hospital (ED), primary care, with pregnant or reproductive age women, and in settings with a wider community reach is a proven cost-effective strategy
- A screening/data collection initiative in ED may be able to gain support from other funders, (such as from the Health Promotion Agency and ACC), to inform a business case for the DHB to undertake the next phase (brief intervention and referral)
- There is scope for improving screening and brief intervention in primary care and wider settings, to include midwives (currently being looked at under Foetal Alcohol Spectrum Disorder), and others (Police, aged care sector, etc.). Achieving the buy-in from primary care around the importance of screening and brief intervention is key

Collaboration:

- There are a range of opportunities to build on and strengthen existing initiatives in the community, for example as led by Safer Communities Networks
- The DHB is a signatory to the Joint Alcohol Strategy (by Napier City Council and Hastings District Council) and is involved in the review
- There is an opportunity to support partnerships with local Iwi to better meet Māori needs. Māori often take more notice of whānau and friends' messages and support than health professionals
- A range of frameworks and plans can help guide our actions. Our DHB's Position Statement can be used as our platform to promote our common agenda with other groups

***How can our DHB improve what it does – future actions?***

Suggested areas for future investment include:

- Enable screening (initially) and brief intervention in ED (with possible external funding)
- Improve uptake of brief intervention in primary care, encouraging greater buy-in by primary care health professionals (e.g. use of incentives)
- Investigate brief intervention training opportunities in wider community settings, including midwives
- Develop a process for communication/community engagement to facilitate conversation on alcohol health impacts and to inspire and support community action
- Enhance support for Safer Communities projects, ensuring those projects which reduce inequity are prioritised and adequately resourced (which target for example, delayed drinking/reducing social supply for Māori youth)
- Develop more Iwi partnership approaches to reducing alcohol-related harm
- Provide health leadership by being alcohol-free at health sector events such as award ceremonies and other health events
- Collaborate with other agencies, particularly councils, during development of LAPs. The DHB is working alongside Napier City and Hastings District Councils to implement their Joint Alcohol Strategy - an opportunity exists to become a signatory to the revised strategy

- Establish usefulness of a review of current Mental Health and Addiction Services and whether they are accessible, appropriate and sufficient to meet the needs of target groups
- Align alcohol strategies with other work in the area of social needs, as alcohol harm is often connected with poverty and stress e.g. vulnerable children and CYF review
- Establish a dedicated Alcohol Harm Minimisation Coordinator role to: help identify champions to promote key messages and counter resistance; develop a supportive structure including a high level steering group; write and co-ordinate a three to five (3-5) year plan with an associated monitoring framework to report back to Board level.

(Please note that the data, evidence for what works and rationale for improvement suggestions are detailed in a background report (currently in draft) available on request from the author).

## QUESTIONS FOR THE COMMITTEES

Your feedback is sought on the following questions to help guide the next steps.

1. Is there an appetite to tackle this issue of alcohol related harms?

2. What are your ideas about how we go about this e.g. the process for getting buy-in and commitment to actions from across our DHB, how we engage intersectorally and how we work with communities to bring about the necessary social change?

## ATTACHMENT

Position statement on reducing alcohol related harm from Waiarapa DHB, Hutt Valley DHB, Capital and Coast DHB, Regional Public Health (2012-13) provided as an example.


# Position statement on reducing alcohol related harm

The District Health Boards of Wairarapa, Hutt Valley and Capital and Coast and Regional Public Health are committed to reducing the alcohol-related harm. Our efforts to do so will be based on the best available evidence and we will undertake the following actions within our available resources.



1. We support the adoption of the most effective population-based strategies to reduce harmful use of alcohol, as identified by the World Health Organisation, including; reducing the availability of alcohol, increasing the purchase age, reducing the legal blood alcohol concentration for driving, increasing the price, and reducing alcohol advertising and marketing.

2. We support government policy to:
   i) Reduce excessive drinking by adults and young people;
   ii) Reduce the harm caused by alcohol use including crime, disorder, public nuisance and negative public health outcomes;
   iii) Support the safe and responsible sale, supply and consumption of alcohol;
   iv) Improve community input into local alcohol licensing decisions;
   v) Improve the operation of the alcohol licensing system.

3. We will actively work towards reducing alcohol and other drug-related harm inequalities in identified high-risk populations.

4. We will promote harm reduction strategies for alcohol and other drugs through the provision of information to health care professionals and the public.

5. We will work to increase access to treatment options for alcohol and other drugs across the region, particularly for high-risk populations.

6. We will work to increase opportunities for screening and brief interventions in appropriate health settings such as emergency departments and primary care.

7. We will actively work to increase our capacity to monitor the impact of alcohol and drug-related harm on health services.

8. We will link with Primary Health Organisations, Non-Government Organisations, Justice and Education sectors and other parts of the Health sector and communities to ensure that we have a full understanding of the alcohol and other drug issues as experienced by our population and can then determine the best interventions to address any emergent issues.

9. We will support our public health and clinical staff in their work to; plan for, promote, support and deliver alcohol and other drug harm reduction and treatment strategies appropriate for our regions' communities.

10. We will engage with local government and communities to identify alcohol issues and support the implementation of local solutions.

11. We will actively work to increase our capacity to assess the impact of our interventions.

## Background and rationale

**The impact of harmful use of alcohol on health and health services**
Hospital services face daily the outcomes of harmful consumption of alcohol across the lifespan. Emergency departments, trauma wards, operating theatres and intensive care units bear the brunt of providing care for injury, violence and acute conditions. Other services carry the burden of care for patients with mental illness or chronic disease and cancer brought about by harmful alcohol consumption over the longer term. Others deal with the developmental problems arising from alcohol use in pregnancy such as foetal alcohol spectrum disorders.

New Zealanders' pattern of drinking is of concern. We live in a society that supports harmful drinking and where consuming alcohol is seen as a normal accompaniment to our everyday activities. While there are many people who drink at low risk levels or do not drink alcohol at all, drinking at harmful levels and getting drunk is accepted. Such behaviour is frequently celebrated and glamorised. Our young people drink the way they do because they see this behaviour as "the norm". What they see and hear from adults and the community promotes this message.

It is vital then, that more people adopt the recommended guidelines for low risk drinking (see appendix 1). Following these guidelines can be difficult due to alcohol consumption being used and accepted as a means of dealing with stress, Further the social pressure to drink, the vast range of alcohol products, the way it is promoted, its availability during most hours of the day and days of the week, and the number of settings for drinking and purchase make it easy to drink large amounts.

The increasing scientific evidence regarding the health outcomes influenced by alcohol indicates the importance of tackling societal attitudes and behaviours towards alcohol. In particular historical liberalisation of policy has been accompanied by increases in the quantity of alcohol consumed[1].

- In 2007 in New Zealand alcohol is estimated to have been responsible for 802 deaths (5.4% of all deaths) and 13,769 years of life lost (YLLs) under 80 years of age. Much of the harm (43%) was due to injury (unintentional, violence and self-harm), but alcohol also contributed to a range of chronic non-communicable diseases, including cancers, liver disease and cardiovascular diseases[2].

- Alcohol related admissions to hospital transition from injury as the primary cause to increasing presentations of chronic conditions such as cancer, cardiovascular disease and digestive disorders[3] as age increases.

- Men have roughly twice the rate of death and hospital admissions attributable to alcohol. Deaths from injury were more common in men, contributing to 73% of all years of life lost from drinking in men and 42% in women[4].

- 82% of New Zealand women report consuming alcohol prior to conception and 34% report drinking during pregnancy[5].



[1] Huckle, T., R. Q. You, et al. (2011). "Increases in quantities consumed in drinking occasions in New Zealand 1995â€"2004." *Drug and Alcohol Review* 30(4): 366-371.
[2] Connor J, Kydd R, Shield K, Rehm J. (2012) *Alcohol-attributable burden of disease and injury in New Zealand:* 2004 and 2007. Wellington: Alcohol Advisory Council of New Zealand
[3] Connor, J., Kydd,R.,Rehm, J.,Shield,K. (2013). *Alcohol-attributable burden of disease and injury in New Zealand:* 2004 and 2007. Research report commissioned by the Health Promotion Agency. Wellington, Health Promotion Agency.
[4] Connor, J., Kydd,R.,Rehm, J.,Shield,K. (2013). Alcohol-attributable burden of disease and injury in New Zealand: 2004 and 2007. Research report commissioned by the Health Promotion Agency. Wellington, Health Promotion Agency.
[5] Mallard S, Connor J, Houghton L. 2013 Maternal factors associated with heavy periconceptional alcohol intake and drinking following pregnancy recognition: A post-partum survey of New Zealand women. Drug and Alcohol review vol 32 issue 3

- Hazardous drinking is more common in the most deprived areas of New Zealand[6] and there is a clear association between overall alcohol outlet density and socioeconomic deprivation, with more alcohol outlets situated in deprived areas[7]

- In the Wellington Region 22% of men and 11% of women have a hazardous drinking pattern scoring 8 or more on the 10-question AUDIT test[8].



## Legislative and Policy Environment

**National Drug Policy**
Government policy recognises that no single strategy can address the harms from drug and alcohol use and that multiple strategies are needed. The strategies are captured in a single framework of three core areas[9]:

- Supply control – control or limit the availability of drugs, including alcohol
- Demand reduction – limit the use of drugs and alcohol by individuals, including abstinence
- Problem limitation – reduce the harm from existing drug and alcohol use

**The Law Commission**
In 2008 The Law Commission was engaged to evaluate the existing laws and policies relating to the sale, supply and consumption of alcohol. The final report released in 2010 - *Alcohol In Our Lives, Curbing the Harm* made 153 recommendations to government for change in law.[10]

Major recommendations included: raising the purchase age to 20, sweeping reform to the self-regulation of advertising and marketing, an immediate increase in the tax on alcohol and the introduction of a minimum pricing regime, and regulations to allow restriction on the supply of alcohol. Of these major recommendations government chose to implement significant change to the supply of alcohol allowing for greater restrictions predominantly through control of hours, density and location. Communities were given some control over licensing matters with councils able to adopt Local Alcohol Policies.

**The Sale and Supply of Alcohol Act 2012**
In December 2012, the government introduced a new act regulating the supply of alcohol. This act has significant changes from the previous Sale of Liquor Act 1989. Particularly pertinent to health services are:

- A broader definition of alcohol related harm

  *"alcohol related harm –*
  *(a) means the harm caused by the excessive or inappropriate consumption of alcohol; and*
  *(b) includes –*



[6] Connor, J. L., K. Kypri, et al. (2010). Alcohol outlet density, levels of drinking and alcohol-related harm in New Zealand: a national study. *Journal of epidemiology and community health* 65(10): 841-846
[7] Connor, J. L., K. Kypri, et al. (2010). Alcohol outlet density, levels of drinking and alcohol-related harm in New Zealand: a national study. *Journal of epidemiology and community health* 65(10): 841-846
[8] Ministry of Health (2013) Regional results from the 2011/12 New Zealand Health Survey http://www.health.govt.nz/publication/regional-results-2011-12-new-zealand-health-survey
[9] Ministry of Health (2007) *National Drug Policy 2007-2012*, Downloaded from http://www.ndp.govt.nz
[10] The NZ Law Commission (2010) NZLC R114 *Alcohol in our lives: Curbing the harm.* Downloaded from http://www.lawcom.govt.nz/project/review-regulatory-framework-sale-and-supply-liquor

*(i) any crime, damage, death, disease, disorderly behaviour, illness, or injury, directly or indirectly caused, or directly or indirectly contributed to, by excessive or inappropriate consumption of alcohol: and*
*(ii) any harm to society generally or the community, directly or indirectly caused, or directly or indirectly contributed to, by crime, damage, death, disease, disorderly behaviour, illness, or injury of a kind described in subparagraph (i)"*[11]

- An increased role for the medical officer of health

  (a) The medical officer of health is required to enquire into all licensing applications and report on those of concern
  (b) All territorial authorities must consult with the medical officer of health while drafting their local alcohol policies.

  *Local alcohol policies are implemented through local council (they are voluntary, not compulsory) and guide all alcohol licensing applications in the district. They can place restrictions on the availability of alcohol by stipulating controls on the hours of operation, density of premises, the types of premises etc for given locations. The policy is both a tool for harm reduction and enables a community to have a say in licensing matters.*

- A requirement to respond to territorial authorities request for alcohol related health information, particularly the health of the districts residents and the nature and severity of the alcohol-related problems arising in the district.

The district health boards of Wairarapa, Hutt Valley and Capital and Coast and Regional Public Health are committed to playing an active role in informing local alcohol policies as part of their efforts to reduce alcohol-related harm.

**Evidenced based strategies**
Alcohol problems are not restricted to a small proportion of heavy/dependent drinkers or to the young. Therefore action at all levels of society by all means is required to bring a societal change in attitudes to consumption. There is no single factor that contributes to the development of alcohol-related problems and a multi strand evidenced based approach addressing supply control, demand reduction and harm minimisation is required.

As a member state of the World Health Organisation, New Zealand health services are expected to demonstrate commitment to advancing alcohol harm reduction both locally and nationally. This includes advocating for more effective policy and intervention strategies suitable for the New Zealand context.

The most effective strategies for reducing the harmful use of alcohol include population based strategies such as reducing the availability of alcohol, increasing the purchase age, lowering the blood alcohol concentration for driving, increasing the price and reducing alcohol marketing and advertising[12]. At the individual level brief interventions are of assistance[13].

[11] *Sale and Supply of Alcohol Act 2012*. Public Act 2012 No. 120
[12] World Health Organization (2010). Sixty-third world health assembly. Strategies to reduce the harmful use of alcohol: draft global strategy
[13] World Health Organization (2010). Sixty-third world health assembly. Strategies to reduce the harmful use of alcohol: draft global strategy

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| OURHEALTH HAWKE'S BAY Whakawateatia | **Health and Social Care Networks – Purpose and Principles** |
| | For the attention of: **Māori Relationship Board, Clinical and Consumer Council** |
| Document Owner:<br>Document Author(s): | Liz Stockley, GM Primary Care<br>Belinda Sleight, Project Manager Strategic Services |
| Reviewed by: | Executive Management Team |
| Month: | July 2016 |
| Consideration: | For Decision |



**RECOMMENDATION**

**That the Māori Relationship Board, Clinical and Consumer Council:**

1. Review and endorse the purpose set out for the development of networks.
2. Review and endorse the principles against which networks will be developed.

## OVERVIEW

In February the Health and Social Care Networks Programme was presented to EMT, Clinical Council, Consumer Council, MRB, Priority Populations Committee (HHB) and the HBDHB Board, and in March 2016 to the Health Hawke's Bay Board and Clinical Advisory Group. In general, the vision and direction of the progamme were supported by management and governance, with feedback given, particularly regarding health consumer involvement and the need to improve readability (essentially a request to better communicate the initiative as we roll it out).

This current paper seeks to more clearly articulate the purpose of a network (i.e. what a network is set up to achieve) and the principles by which each network will be designed and implemented.

## BACKGROUND

Under the umbrella of Transform and Sustain, the goals within the Primary and Community Strategic Health Care Framework (the framework) drafted in 2014 were set out to enable a primary and community health care sector that is:

- Well positioned to respond to the growth in demand from long term conditions and increasing numbers of older people
- Capable and has capacity to contribute to improving equity in access and outcomes
- Pulling together as a single system, so that people who use services find them seamless and easy to navigate.

The opportunities that are being targeted by the development of networks (why are we doing this) are:

- Collectively making a greater impact on health and well-being outcomes – especially for those most in need
- Redesigning services to be more appropriate and accessible to patients against defined outcomes that matter
- Ensuring services are delivered in the most appropriate setting

- Sustainability of services – ensuring resources are appropriately used, and fit to meet future population demands (such as aging and chronic disease)
- Supporting local clinical and consumer driven decision making
- Collectively raising standards of service to meet quality expectations
- Improving communications and the co-ordination between services
- Allowing us to do more with the resources we have.

**NETWORK PURPOSE AND PRINCIPLES**

The purpose and design principles of Health and Social Care Networks are presented in the attached two-page document.

**PREREQUISITES**

In order to successfully establish a series of networks, EMT recognises the need for the following:

- Support to identify what matters to communities
- Improved communication and collaboration between organisations and individuals in the health and social care communities
- Shared electronic care record and access to information at the right time for the care of the patient
- Review of facilities for each network – infrastructure may need to be developed
- Those involved in network development will need support and access to evidence about models of care that work and translate these into local services
- There is a culture of tolerance for not getting things right the first time, provided those mistakes are learned from

**RECOMMENDATION**

EMT is being asked to do two specific things:

1. Review and endorse the purpose for the development of networks.
2. Review and endorse the principles against which networks will be developed.

# Health and Social Care Networks

## Vision

Consumers accessing a wide range of coordinated services closer to home.

## Purpose

To empower and support people to keep themselves and their whānau well
To ensure services are well co-ordinated and aligned to local need
To eliminate population inequities experienced by groups within our communities
To provide sustainably for today whilst preparing to meet future demands
To enable care as close to home as possible



## What does success look like? A phased approach

| Phase One<br>2016-2018 | Phase Two<br>2018-2020 | Long Term<br>2020- |
|---|---|---|
| • More health services are community-based within appropriate geographic networks<br>• Communities are engaged<br>• Providers are collaborating<br>• Primary care models of care are developed<br>• Services focused on appropriateness and access<br>• Tools and infrastructure development underway<br>• Individuals and whānau decide care plans | • Health and social care providers work together<br>• Primary care workforce is more sustainable<br>• Scopes of practice have increased in the community<br>• All appropriate services are delivered in community<br>• Individuals more engaged with care<br>• Whole workforce is culturally responsive<br>• Individuals are health literate and can access services as and when they need | • Local governance frameworks are established<br>• Shared funding pools exist across health and social budgets<br>• Co-design is used to redesign services<br>• Voluntary services are included<br>• More community involvement in health and social care<br>• Community drives agenda and priorities<br>• Community ownership of some services<br>• Individuals and whānau drive their whole health journey |
| **What this looks like for consumers (examples)** | | |
| Consumers are working with providers to develop and implement a plan to improve community wellness.<br>People with complex conditions have a care plan, developed by them, their whānau, and the professionals that support them.<br>It is easy to book an appointment online or by phone, and appointments are available when needed. | People are able to self-manage because they are supported, can understand health information, and know who to ask for help when they need it.<br>Fewer trips to hospital are required as more services are available close to home.<br>People don't repeatedly explain their symptoms or history because providers can access this information. | Services are linked up so that a person seeking help for a medical issue will also be offered assistance to improve other aspects of their health and wellness, including the socio-economic determinants of health.<br>Health and social care is under the leadership of a community-owned and directed organisation; people can easily have their say and get involved. |

## Design principles

| Network Structure | Focus | Governance and decision making | Service |
|---|---|---|---|
| Networks are geographic-based, however cross-boundary service provision is also allowed where this is existing or makes sense to develop.<br><br>Led by a Network Leadership Team, consisting of consumer, provider and funder stakeholders, which is the key conduit between the sector, the network and the community.<br><br>Each network will be supported by a lean management and administration team.<br><br>Network drivers are determined by consumers, providers, and sector advisors.<br><br>The population is supported by effective and efficient delivery of services: providers may be internal or external (e.g. visiting services).<br><br>Provider-partners include, but are not limited to, general practice, Māori providers, NGOs, voluntary, and broader public sector organisations (i.e. inter-sectoral).<br><br>Network partners will work as an integrated, cohesive whole, within a high-trust environment; not just co-location. | Focusing on prevention, early intervention, and self-management.<br><br>Strengthening resilience of individuals, whānau, and communities (supported by clinical and organisational expertise).<br><br>Promoting sustainable practices: resources, funding, and workforce.<br><br>Promoting health literacy – consumers and providers speaking a shared language.<br><br>Utilising the skills sets and passion that sits within the network (working on principles of sustainability), seeking out champions to spearhead action (enablement and empowerment).<br><br>The network will reflect the Treaty principles of partnership, protection and participation.<br><br>Eliminating health inequity is a central focus of all network operations; this will be reflected in the KPIs developed to report on and monitor impact across the triple aim dimensions.<br><br>Networks will commit to continuously improving quality, shared learning, and effective change management. | The Network Leadership Team (or Alliance) will be responsible to the community and DHB for agreed outcomes.<br><br>The Leadership Team will initially recommend approaches and activities to the DHB for implementation. As expertise and experience is built, the Team will gain further operational control and exert greater influence across the health sector.<br><br>Partners will align with the overall vision, and must be willing to develop their services to contribute to collaborative models (work with the willing).<br><br>Each network will link directly with the community it serves to define outcomes that matter.<br><br>Membership will include consumers, clinicians, sector leadership, and community leaders.<br><br>Input from the health and social care sectors will provide advice to the Network Leadership Team.<br><br>Leadership will be legitimised by meaningful provider engagement and partnership with consumers. | The network understands the needs of the local community and reflects this through the services it provides (a population health approach).<br><br>Services must be accessible to the community and be evidence based and outcomes focused.<br><br>Services will be provided by the most appropriate provider (e.g. clinician, allied health or social care professional, community volunteer), in the most appropriate place and at the right time for the consumer or whānau.<br><br>Where appropriate, services will be multi-disciplined and integrated vertically and horizontally across health and social care / community sectors.<br><br>Quality of services will be standardised, delivery will be locally tailored to each network as appropriate.<br><br>Data will be used to stratify consumers in each practice so that proactive, relevant interactions promote wellness, and prevent illness.<br><br>Technology will be utilised to augment and expand the services available by more traditional means. |

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| OURHEALTH HAWKE'S BAY Whakawateatia | **Health and Social Care Networks – Geographic localities proposal** |
| | For the attention of: **Māori Relationship Board, Clinical and Consumer Council** |
| Document Owner:<br>Document Author(s): | Liz Stockley<br>Belinda Sleight |
| Reviewed by: | Executive Management Team |
| Month: | July 2016 |
| Consideration: | For Decision |



**RECOMMENDATION**

**That the Māori Relationship Board, Clinical and Consumer Council:**

1. Review and endorse the proposed basis for network localities.

## OVERVIEW

The Health and Social Care Networks programme will cluster community-based health and social services that serve a geographically defined location. The purpose of which is to promote and support; collaboration, information sharing and joint initiatives to enable better health outcomes for the population.

Four such networks are proposed across Hawke's Bay; one for each of Wairoa, Napier, Hastings, and Central Hawke's Bay. The geographic boundaries for the networks will be those of the territorial authorities (District and City Councils).

This approach builds upon the existing sense of community that is apparent in Hawke's Bay, a region which recently confirmed the continuing relevance of its four-district structure. We will work with each network locality to determine local priorities, including working with the two larger urban localities to identify areas of interest/need in which to focus specific actions with smaller, more targeted stakeholder sub-groups (e.g. youth health, mental health).

Work to establish networks will be staggered, such that we learn from the early adopters. Wairoa will be the first network to set up, as it is the locality in which the population is most ready and willing to engage. Progress in each locality will also proceed at different rates, again depending on stakeholder readiness. For example, in Central Hawke's Bay, we are proposing to set up a network, but will not establish a leadership structure until some collaborative projects and priority setting activities have built the relationships and trust in that community. For Napier and Hastings, we consider that the network structure will have merits for these larger localities, but we will delay the start of establishment activities until we have crystallised the learnings from the rural –based networks and can see that expected benefits are being achieved.

## BACKGROUND

In February, we presented a proposal to establish a series of networks, consisting of services that collaborate (are joined up) to provide care for patients that they have in common. The intent of these

networks is to facilitate the coordinated and collaborative activity that is necessary to achieve our vision. The direction of travel signalled by this proposal was supported by EMT and the various governance groups.

In this paper, we are further defining key aspect of the networks, that is, the geographic area encompassed in each. Governance feedback on the previous paper has been incorporated into this document.

## PROPOSAL – FOUR NETWORKS

*Wairoa and Central Hawke's Bay* (CHB) – for both of these districts, rurality and relative isolation are defining features which set them apart from the urban areas and tend to shape the concerns of community members (e.g. transport issues, lack of locally-available services, population decline). From discussions with stakeholders in each location, it is clear that a sense of community readiness exists in Wairoa, whereas in Central Hawke's Bay a range of shared priorities for change is emerging.

- *Wairoa*: 7,890 population (2013 census); ~7,676 enrolled with general practices located in Wairoa, ~184 enrolled elsewhere.
- *Central Hawke's Bay*: 12,720 population (2013 census; a June 2015 estimate suggests 13,450); ~10,717 enrolled with general practices located in Waipukurau and Waipawa, ~2,241 enrolled elsewhere.

*Hastings and Napier* – Initial discussions regarding Health and Social Care Networks indicated that these urban areas could be divided up based on general practice locations, much like the clusters developed for the EngAGE initiative currently being rolled out. However, the wider scope of the networks initiative, which is envisioned to incorporate health and wellness providers across a range of organisations and contracts, suggests that a simpler overarching structure would better serve the stakeholders involved. In particular:

- Strategic partnerships: the health and social care networks initiative seeks to build collaboration across health services, Ministry of Social Development (MSD) - funded social services, WINZ, CYFS, some services of the justice and education sectors, related NGOs, and various council initiatives (e.g. community and business development activities). Many of these organisations base their operations on territorial authority boundaries and/or have strong links with their relevant District or City Council. Using the territorial authority model will also facilitate integrated action by the Hawke's Bay Intersectoral Leadership Group, currently consisting of health, MSD and council leaders.
- Secondary services delivered in the community: a number of secondary services are delivered in the community, and we want to preserve the way workloads are currently divided across team members, as this brings consistency for patients and primary care staff who gain assistance or interact with these services. Most services pursue a geographic division of workloads, with the Wairoa/Napier/Hastings/ Central Hawke's Bay groups being most common (see Appendix 1).
- Building collaboration cross general practices is likely to be challenging, as they are private businesses competing for customers (enrolled patients). Therefore, it makes sense to build upon existing relationships where these exist. For example, in Napier, the provision of after-hours services is an example of city-wide coordination/collaboration.
- Splitting each urban area into smaller localities would potentially require assigning to different networks the separate branches of a multi-location practice (e.g. The Doctors Napier and The Doctors Greenmeadows). This is likely to cause difficulties if each network requires of the individual branches different service specifications or funding models in response to the needs of their local population.
- Within the Napier and Hastings networks, we propose to encourage formation of 'communities of interest' that wrap services around particular consumer groups. For example, a 'neighbourhood alliance' of local providers and the community could work together to achieve the specific aspirations of people living in Camberley and Flaxmere. Providers with

specific expertise could work with consumers to develop 'centres of excellence' for a condition or life stage; the multi-disciplinary EngAGE clusters are prototypes of this model focusing on improving outcomes for older people. A number of whānau or hapu could work with community providers to develop a wellness approach that incorporates their kaupapa.

- The larger network geographies could better support professional development via mentoring and secondment activities between providers in the network. Some clinicians had voiced concern for colleagues working in the relative isolation of a few general practices within the smaller network geography model.
- Averaging across the urban practices, around 13% of the enrolled population lives greater than 10km (as the crow flies) from their practice[1]. Defining smaller network geographies makes it more likely that these people will live outside of the area in which services collaborating and sharing information with that practice will be focused.



- *Napier*: 57,240 population (2013 census)
- *Hastings*: 73,245 population (2013 census)

**Issues**

As with any mechanism for defining network geographies, the four-locality model does not solve all issues, and brings forth others. As we establish the networks, we need to be aware of the following:

- There will still be some people resident in one locality but enrolled at a practice elsewhere; this could potentially lead to a situation in which they gain services from two networks. For example, a person living in Wairoa may habitually visit a general practice that is close to their workplace in Napier however, for other services (e.g. district nursing or a budget advisor meeting with the family as a group) the Wairoa network would be better placed to help. We need to understand how these inter-network interactions would work, including any flow of funding that is needed to support the right service/right place approach for these people.
- The four locality model still requires the splitting of The Doctors Hastings across two networks (Hastings and Central Hawke's Bay).
- Each network may need an 'anchor' location that acts as a focal point and at which a wide range of services and providers may be accessed. Similar to the South Central Foundation's Nuka headquarters at Anchorage, or Counties Manukau's 'super centres', Wairoa has the IFHC, and the Napier and Central Hawke's Bay Health Centres could act as hubs for each of these networks. We need to consider the options for Hastings, particularly now that the "Kauri" initiative is no longer progressing.
- Community of interest activities could potentially add complexity to network management and operations; any such initiatives would need to be written into business plans and budgets of the wider network as part of the annual and forecast planning. A range of network structures could facilitate these initiatives and options need to be considered by the DHB (Ken Foote's expertise).
- Community of interest activities must not result in inequities between networks (we need to ensure the same quality and availability of services to avoid 'poorer' networks).

**RECOMMENDATION**

That EMT:

1. Review and endorse the proposed basis for network localities.

1. Information supplied by Adrian Rasmussen, Health Intelligence Team, Health Hawke's Bay.

## APPENDIX 1

Division of workloads across team members – secondary services delivered in the community

| Service | Alignment structure | Notes |
|---|---|---|
| Respiratory services, pulmonary rehabilitation, Māori health, cardiac rehabilitation, physiotherapy, occupational therapy, child development services | Four clusters (Wairoa, Napier, Hastings (incl. Havelock North), and Central Hawke's Bay). | Some specialists work across all four clusters. Education-based services may be only offered online to Wairoa and CHB residents. |
| Dieticians, speech-language therapy (SLT) | Two clusters (Wairoa and Napier / Hastings and Central Hawke's Bay). | SLTs cycle between community and hospital-based work to ensure skills currency. Also practice-based dieticians at Totara Health. |
| EngAGE | Six clusters, three in each of Hastings and Napier. Central HB and Wairoa not covered currently. | Roll out to Wairoa and Central HB would involve one cluster in each area. |
| District nursing | Four clusters (Wairoa/Napier/Hastings/CHB), but the urban ones are each split into three sub-clusters, with multiple staff (nurses and assistants) covering each. | Napier cluster split as per EngAGE although Napier Central locality is too big to service; Hastings cluster split Hastings Health Centre; Totara Health plus Havelock North; rest of Hastings. |
| Ostomy service, continence service, antenatal, neonatal (nurses and social workers) | Small number of staff and FTEs cover all of Hawke's Bay. | |
| Social work | Mix of general practice employees working in specific practices and DHB employees working broadly across Hawke’s Bay. Wairoa and Central Hawke's Bay have dedicated DHB staff domiciled in those localities. | General practice employees work with practice only (e.g. HHC). Māori Health social worker (DHB employee) works across four practices. Other DHB social workers tend to support specialist areas (e.g. renal, cancer, paediatrics). |
| Clinical pharmacy | Linked to individual practices, but groupings are likely to follow EngAGE cluster format. | One staff member is currently positioned across two engAGE clusters; likely to be several pharmacists associated with each cluster, especially where these include large practices. |
| Diabetes service | No clear geographic approach. | Six Diabetes CNS are active across Hawke's Bay. |




# Business Case

## Health and Social Care Networks
## Phase One

**June 2016**

**Prepared by Belinda Sleight**
**Project Manager, Strategic Services**

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## 1.0 EXECUTIVE SUMMARY

This business case recommends that a budget of $130,000 p.a. be approved to support establishment of collaborating networks of health and social service care providers. The purpose of these networks is to provide holistic, joined up care focused on patients/consumers and their family/whānau as partners in their health journeys.

Currently, the health system in Hawke's Bay is not well positioned to respond to emerging challenges and, therefore, we need to design new ways of working that will enable care that is person-centered, sustainable, and effective. Particular challenges include providing care for the growing number of frail older people and those people living with complex long term conditions. Further effort is required to deliver equitable outcomes or access to services for Māori and Pacific populations, and those who are unable to afford, access or navigate the health sector.



The concept of Health and Social Care Networks, as a vehicle for addressing these challenges has been discussed in a range of health governance, management and community forums, and there is now support for networks as a change vehicle under the auspices of Transform and Sustain strategic framework. A programme team is now developing overarching principles by which the networks will be designed, and is working with providers and service users in two early-adopter communities to scope projects that will establish networks in their communities.

Key benefits of the programme include:

- Consumers and their families/whānau get the assistance they need from the right person, right time, right setting.
- Closing gaps between services so that people experience joined up care – not having to explain history to each provider, being able to group interventions to single visits, a holistic approach to wellness that addresses health and the social determinants to health.
- Redesigning services so that they suit consumers and are able to be provided sustainably. Also moving services into the community where they are closer to where people live.
- Building upon existing community strengths; not just current services and infrastructure, but also community spirit, individuals with influence and local knowledge.

Sustainable service provision is a key principle of this programme and, therefore, the focus is on lean managerial structures and redesigning services that fit within current budgets despite the growing demand. This funding will support change leadership, stakeholder engagement and input required for a collaborative community-up programme, and seed funding towards the early activities (initial small collaborative projects that will deliver quick wins and buy-in to the collaborative process). The intention is not to build permanent cost increases into the sector, but to work with what we have in more effective and creative ways.

The establishment of Health and Social Care Networks requires a significant programme of activity and of change management. It is also an opportunity to revitalise our sector and increase sustainability through service affordability, infrastructure and workforce. This collaborative environment will be challenging as it will requires us to work differently, listening to diverse points of view, building and delivering a shared vision (future state) and devolving decision making. This will not happen in one step- we will take a staged approach and build capability within the networks so that the DHB, PHO have confidence in their contractual partners.

## 2.0 PURPOSE

This business case recommends a budget of $130,000 p.a. be approved to support establishment of collaborating networks of health and social service care providers (termed 'Health and Social Care Networks'). The paper is presented to Executive Management and Clinical Council for approval and release of funds.

## 3.0 BACKGROUND

In December 2013, the Hawke's Bay health sector released *Transform and Sustain*, which set a strategic direction for health service provision over the next five years. In *Key Intention 8 Transforming Primary Care*, the strategy describes a need to redesign primary and community services so that they become fully integrated, provide care closer to the person's home and are able to provider higher quality through more expansive services. Subsequently, a strategic framework *Transforming Primary and Community Health Care in Hawke's Bay* was developed, in which the concept of clustered service provision and collaboration across providers was first presented.

A Steering Group of senior DHB and PHO management and clinicians, has since spent approximately six months developing the network concept and determining how it could be implemented. Related projects and activities have also begun, that have informed the Group's thinking. These include:

- The HBDHB Health Services Directorates considered services that could be provided in the community and the consideration of some models from elsewhere (e.g. Nuka).
- The Hastings Health Centre and Totara Health joint development included a survey of community requirements, and engaged consumers in consideration of the general practice model of care. Whilst the joint development will now not go ahead, learnings will inform the programme regarding consumer requirements and also how to gain consumer viewpoints.
- The key Wairoa providers are now meeting regularly and have agreed to work together to improve population outcomes. A community meeting in March has solidified support for a network, and a leadership group is now being formed.
- Several stakeholder meetings in Central Hawke's Bay have resulted in a collective of provider and consumer representatives that is now meeting regularly to prioritise service development.
- The EngAGE, District Nursing and Pharmacy Facilitator projects are essentially trialling networks of services in Napier and Hastings. Lessons will be learned from these.
- The DHB and PHO are currently considering how primary care infrastructure should be developed. A single shared care record will be a priority and some research has been undertaken for solutions that may work in Hawke's Bay.
- Training courses in co-design and quality improvement, plus ongoing work by QIPS staff, are increasingly focusing on collaborative models and tools for service redesign.

We are now seeking to identify and secure funding to support a coordinated programme of work that will bring together the learnings and facilitate change projects. This budget will consist of new investment, business as usual, and redirection of existing spend, plus cash and in-kind contributions from other organisations as partners with us in the networks.

## 4.0 SITUATIONAL ANALYSIS

### *4.1 Current Situation / Problem*

The health system in Hawke's Bay, like the rest of New Zealand will experience a significant growth in the population of frail older people and a further growth in the numbers of people living with complex long term conditions. The health system is currently not designed to deliver equitable outcomes or access to services for Māori and Pacific populations and there are

groups of people who are unable to afford, access or navigate the health sector. This problem is not unique to health. There is a lack of co-ordination between health and social care services that can be frustrating for individuals and lead to lack of engagement and wasted resources.

There is a need for primary care to be better positioned to address acknowledged challenges, to be more connected and collaborative, and to deliver services that are accessible and appropriate for the Hawke's Bay population.

We have proposed to establish a number of networks of collaborating health and social care services that are clustered around geographical communities that work closely together to care for patients that they have in common. Implementation of this proposal will lead to a health service in which the right clinician is delivering an appropriate service in the most sensible location, supported by a network of providers who understand and respond to the needs of the patient and their whānau, who in turn are empowered to manage their own health and social wellness.



A programme of work is now underway, using a phased approach that will enable us to learn as we go and work with those communities and stakeholders that are most ready to engage. Initially the networks, with community input, will focus on delivering current services most appropriately in a manner which is responsive to each community and engages community based resources and facilities effectively. This is the focus of Phase One. This vision will grow over time to support devolved decision making over service design and investment in resources and facilities to clinicians, professionals and community leaders. The time frame to achieve this expanded vision may be different for different communities - this is a long term vision.

### *4.2 Requirements to be met by this project*

Key requirements of Phase One are:

- The DHB, Health Hawke's Bay and each community will have a shared view of the outcomes required of networks and how we will achieve them. This will involve an agreed 'standard' approach to network development, and appropriate tailoring to fit population needs.
- A variety of channels will be in place for stakeholder engagement, and stakeholders (providers and consumers) are co-design partners in vision, planning, service redesign and delivery.
- The communities of Wairoa and Central Hawke's Bay are supported to establish the first Health and Social Care Networks. This includes channelling resources into the networks and developing tools to assist establishment and operation.
- A range of organisations providing services that impact health or the social determinants of health (e.g. education, justice) will be partners in the networks. These organisations will increasingly commit resources to the collaborative networks.
- Progress towards a collaborative environment – a model of care that supports self-care, multidisciplinary teams working with people and families with complex needs, sharing of information across providers to facilitate joined-up care.

**High-level time line**

In Phase One of the programme (2016-2018) we will:

1. Background work – review examples of good practice from other places to avoid reinventing the wheel; align various projects, existing and new initiatives; review services and considering the most appropriate delivery models; review systems and processes to reflect the collaborative working environment; develop a standard pathway, tools and templates to guide establishment of networks throughout Hawke's Bay.
2. Establish a network in Wairoa
3. Motivate collaboration in Central Hawke's Bay

4. Support the identification of sensible network groupings in Napier and Hastings
5. Initiate the development of the technology platform in primary care.

Each of the individual pieces of work will be subject to appropriate project management rigour and business case processes. Some of these initiatives will be concurrent and will inform each other.

**What success will look like?**
Successful implementation of Phase One means:

- People find it easy to identify and access the help and services they need because they are health-literate, the services have been designed to be easily understood, and there is additional navigation and kaiawhina assistance if required.
- Existing services will be configured in ways that improve the patient experience and respond better to communities.
- Community resources and facilities are evolving to provide a broad range of services.
- Multi-disciplinary, multi-provider case-management is the established approach for working with people and/or whānau with complex health and social needs.
- General practice clinicians have the time to work with patients who need it. Patients at risk are proactively identified and supported.
- Primary care clinicians have opportunities to increase scopes of practice and develop additional expertise.
- Technology and information is increasingly used for joined up service delivery and to support self-management.
- Networks are supported by nimble, responsive management, using existing resources where possible. Organisations are working collaboratively to get the best value from all publicly funded resources.

### *4.3 Stakeholders Requirements*

Stakeholders grouped as:
Health Consumers / community: This project must deliver better access to a comprehensive range of health services that are joined up, so that health and socio-economic determinants of health are approached holistically. The work must focus on health equity across our population, as significant groups (particularly Maori) are over-represented in our poor health statistics. Tackling these issues must include working with the people (individuals, family/whānau, communities) to design and deliver services that work for them and address the things that matter to them.

Providers of health and social care (primary and secondary health care, community social care): This project must enable providers of health and social care to innovate, so that they are able to better provide for the current needs of our population and anticipate and respond to expected future requirements. We must work with providers to effect sustainable change.

Funders: This stakeholder group requires ways of meeting increasing demand for health care within an environment of constrained budgets. This means that networks must be robust vehicles for change that will deliver the required outcomes in a sustainable manner. To this end, we have designed a staged approach, in which responsibility (devolved decision making) will be stepped up as networks gain experience in managing and commissioning services.

First-mover networks: These communities each have a core group of people (providers and consumers) who recognise that change is needed and who are willing to engage in the change process, albeit to varying extents. These communities (individuals, groups) require support such as managerial expertise, seed funding, tools and systems for collaboration.

### *4.4 Strategic Alignment*

The programme has been established under the auspices of Transform and Sustain, particularly contributing to *Key Intention 8: Transforming primary health care*, and *Key Intention 7 Transforming through integration of rural services*. It has been designed to implement the *Transforming Primary and Community Health Care in Hawke's Bay Strategy*.
To deliver outcomes across the three health triple aim dimensions, the programme will:

- Use a population health approach to identify the needs and aspirations of each community, then design and deliver services that are tailored to meet those requirements.
- Work with health consumers to ensure that services are co-designed to meet their needs, both in terms of the type of care available (the services offered), and also the approach to care (e.g. the model of care).
- Develop and enable smarter working within available funding levels.



The programme is broadly aligns with initiatives and strategic directions nationally. Aspects will be informed by activities achieved by other DHBs – for example, the locality-based grouping of services from Counties Manukau, progressive general practice models of care led by Midlands, and the focus on data and information sharing from Canterbury. The programme's focus on joining up health and social care anticipated the recently refreshed Health Strategy's call for better alignment and collaboration for services working across health and the social determinants of health.

## 5.0 OPTIONS ANALYSIS

### 5.1 *Funding an Existing Initiative*

This business case has been developed to support a funding allocation for an existing initiative.

Options for funding the initiative include using business as usual funds, redirecting existing spend, and identifying other sources of funding (particularly cash and in-kind support from potential or actual network partners). We will use each of these sources for various parts of the work programme. However, as there is considerable project-based work to be done, we are requesting investment to support the early-stage innovation and community engagement aspects.

## 6.0 PROPOSAL RELATED TO IMPLEMENTING THE RECOMMENDED OPTION

### *6.1 Objectives*

The objective of this programme is to support services to work collaboratively across the health and social care spectrum to cluster existing services around geographical communities and to reshape services so that:

- Services are appropriate to prevent ill health, enable people to keep themselves well and independent for as long as possible
- Support the development of quality services that are provided in the community
- Ensure services provided by a wide range of health and social care professionals in the community are better co-ordinated and respond to local need
- Improve communication and information sharing between different health, social care and voluntary sector professionals and community groups
- Facilitate closer working between community based and hospital services, ensuring that patients receive a smooth and safe transition from hospital services to community based services and vice versa.

### *6.2 Benefits*

| Benefit | Value or Measure |
|---|---|
| Delivering more health services in the community | Consumer satisfaction from improved access<br>Multi-disciplinary teams are in place to work with people with complex needs |
| Services are working collaboratively with other organisations across health and social care | Providers find it easy to refer clients to other relevant services across health and social determinants of health |
| People find it easy to identify and access the help they need | There are improvements in health outcomes and equity of health outcomes because assistance is holistic and there are less gaps to fall through |
| Improved sustainability of the primary care workforce | Better staff satisfaction<br>Greater variety of 'generalist' roles that help people navigate services<br>Clinicians have more time available to work with those people who need it most |
| Technology and information is used effectively to support new ways of working | Greater use of technology for accessing expertise (e.g. teleconference FSAs)<br>Individuals and families/whānau are risk stratified and offered help proactively |
| Sector-wide improvement in which providers and communities are pulling in the same direction towards improved wellness and equitable health outcomes | Communities are actively engaged in prioritising, planning and delivering wellness initiatives<br>Providers are sharing information that enables holistic, timely intervention and assistance across health and social determinants of health |

### *6.3 Assumptions*

1. This is the first phase in a series of activities which will result in establishment of health and social care networks in Hawke's Bay. This is a long term (5+ years) programme of work.
2. The DHB and PHO are philosophically willing to change and are willing to embrace a process of co-design to effect that change.
3. This programme will affect a number of existing projects, initiatives and business-as-usual; these will need to align with the change direction established by this programme.
4. We will work with stakeholders to confirm requirements and relevant models for Hawke's Bay Health and Social Care Networks that empower each community; whilst there will be a 'minimum standard' of requirements (e.g. services offered, reporting requirements) to meet sector and national expectations, tailoring to fit the needs of the locality is a key principle of this initiative.

### *6.4 Business Impact*

Successful implementation of the programme as a whole will have wide-ranging effects across the DHB as a business unit and the health and social care sectors. It will also impact other sectors that provide services that contribute to health and wellness (e.g. education, justice).

Business Management: review of a range of business processes to ensure that they are aligned with collaborative actions. Examples could be those processes used for contracting, human resources planning and recruitment, and budget allocation

People and human resources: movement of service delivery into the community setting, seven-day services, working at top of scope, recruitment of more 'generalists' and enabling roles (case managers, social workers, behaviourists, navigators, primary care assistants). Many of these would be associated with general practice rather than within the hospital/DHB remit, but interacting with the broader range of 'health care professionals' will become normal.

Infrastructure and operation support: A focus on community service delivery/care closer to home and information sharing will create the need for investment in infrastructure, particularly IT tools for collaboration.

Consequential: it is possible that the proposed proactive identification of people at risk may increase demand for services in the short-to-medium term. The programme's premise is that earlier intervention will decrease demand for higher-acuity services, however it may take some time to achieve this state.



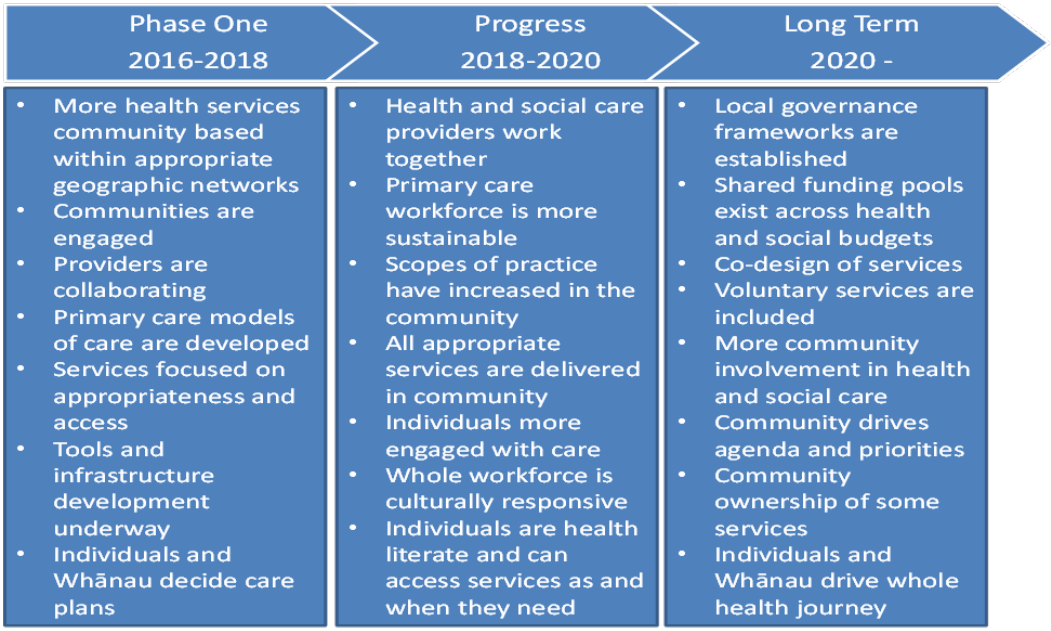
### *6.5 Approach*

This is a programme of work involving a number of projects, namely the high-level design of a standard network configuration (the "Core Network Expertise' project) plus network establishment projects in each of the localities (four in total). Additional work will centre on better aligning primary care IT (patient management systems) with collaborative activity.

The overall programme is summarised in the diagram below; this business case relates to Phase One activities, broken into two stages aligned to the planning calendar as follows:

1. Stage One: Jan 2016 – June 2017 (18 months)
2. Stage Two: July 2017 – June 2018 (one year)

The focus of Phase One will be to cluster existing services around geographical communities and use the design of these services as a lever to engage providers, other public services, Iwi, NGOs and voluntary organisations in the concept of community networks. We will begin with health services and social care providers that are ready to act, and will invite other community partners to also review their services through an aligned approach.



### *6.6 Estimated Timeline (Stage One, Phase One)*

| High Level Milestone | Finish Date |
|---|---|
| **1. Programme Start up and planning**<br>• Project Manager appointment / TOR signed off/ Steering Group established<br>• Stakeholder analysis and Comms Plan/ Website completed<br>• Project Planning documentation created: Risk Plan, Benefits Plan; Quality Plan; Project Budget<br>• Project Plan acceptance | March – April 2016 |
| **2. Core Network Expertise Project: Project Management**<br>• Agree TOR – Establish project groups – communication plan etc.<br>• Engagement and communication with Stakeholders<br>• Complete work required and confirm acceptability of deliverables / Monitor and demonstrate benefits<br>• Project closure including Project Completion Evaluation | Mar – Sep 2016 |
| **3. Establishing a network project in Wairoa** | Jul – Dec 2016 |
| **4. Motivating collaboration in Central Hawke's Bay** | March – Dec 2016 |
| **5. Supporting the identification of sensible network groupings in Napier and Hastings** | Aug – Dec 2016 |
| **6. Initiating the development of the technology platform in primary care.** | March – Dec 2016 |
| **7. Review work to date and develop plan for Jan – Dec 2017.** | Nov 16 – Jan 17 |
| **8. Complete Work as outlined in plan for Jan – Dec 2017.** | Jan – Dec 2017 |
| **9. Phase Close - Next Phase Plan**<br>Review work to date and develop / approve next steps action plan e.g. programme completion evaluation or refreshed TOR | Oct – Dec 2017 |

### *6.7 Interrelated Projects*

| Project Name | Interdependency description |
|---|---|
| Patient Experience | Will inform this project by providing patient insight to service requirements and information on patient profiling by geographic practice area |
| EngAGE; DN GP Alignment; Clinical Pharmacy Facilitators | Information on existing models of service delivery and potential geographical networks |
| Urgent Care | Some of these services, co-designed with primary care stakeholders, may become part of one or more networks. This may motivate collaboration |
| Customer Focused Booking | Influenced by, and influences, models of care that could be adopted by practices within a network |
| Health Literacy | Health literacy will be a key component of models of care implemented by general practices within networks |
| Model of Care support in Primary Care | PHO project to develop a centre of knowledge regarding general practice models of care. Will inform and assist general practices |

### *6.8 Risk Analysis*

| Risk | Risk Mitigation Approach |
|---|---|
| Lack of primary care engagement | Early and clear communication to sell benefits, address concerns; gain their involvement in co-design through workshops, feedback opportunities. |
| Lack of engagement with secondary care | Senior clinicians to act as champions for the initiative; keep them fully informed of/involved in the project's work programme. Regular communications and opportunities to contribute in the co-design process. |
| Project doesn't adequately address consumer priorities | Ensure there are ways to gather the consumer voice in each locality. Ensure that there is good consumer representation on the Stakeholder Group; this group must be representative of our population and/or have strong networks into our population. |
| Project, programme and change fatigue | Communicate the vision and engage stakeholders at an early stage so that they own the solutions. |
| Scale of what we're trying to achieve | Low impact for this current project stage, but recognised as considerably higher likelihood and impact for network implementation. Stage implementation projects, concentrating on those groups most able to move forward as early adopters, so that we can learn from mistakes. Recognise the need to learn from experience. |
| Too busy keeping the current state afloat | Adequately resource the project (staff time, cash) to ensure that there is enough 'space' to effect change. |
| New ways of working/new relationships (as equal partners) that parties are not used to (working in partnership with consumers | Conduct activities to address gaps in knowledge/skills/experience. Be clear that this is change behaviour and all parties need to take responsibility for engagement and the resulting outputs. |
| Governance of networks; how do we account for them? | Build robust processes based on best practice. |
| Duplication of efforts across other T&S projects (e.g. patient experience, urgent care, AIM 24/7, etc) | Project Manager to get a good understanding of results from other projects, and synthesise the lessons. |

### *6.9 Financing the Project*

The requested funding allocation of $130,000 will be used to support (a) across-programme enablers and (b) specific activities within the network establishment projects. An indicative budget of Phase One (covering two years) is presented below.

| | 2016/17 | 2017/18 |
|---|---|---|
| Programme enablers | | |
| Consumer engagement tools | $ 15,000 | $ 15,000 |
| Communications, meeting costs, travel | $ 15,000 | $ 15,000 |
| Wairoa establishment | | |
| Backfill / project lead | $ 50,000 | $ 50,000 |
| Meeting costs (e.g. koha, facilitation, catering) | $ 5,000 | $ 5,000 |
| Initial projects/ quick wins | $ 20,000 | $ 20,000 |
| Central Hawke's Bay establishment | | |
| Meeting costs (e.g. koha, facilitation, catering) | $ 5,000 | $ 5,000 |
| Initial projects/ quick wins | $ 20,000 | $ 20,000 |
| Napier establishment | | |
| Meeting costs (e.g. koha, facilitation, catering) | | $ 5,000 |
| Initial projects/ quick wins | | $ 20,000 |
| Hastings establishment | | |
| Meeting costs (e.g. koha, facilitation, catering) | | $ 5,000 |
| Initial projects/ quick wins | | $ 20,000 |
| | $ 130,000 | $ 180,000 |

Assumptions/notes:

- All other costs associated with this programme will be met by redirection of existing spend (including staff) into the networks.
- We propose to second 0.5 FTE to act as Wairoa change leader for the establishment phase. This commitment is proposed 2 years (24 months), beginning as soon as possible. A position description for the Change Leader role is attached (Appendix 1); responsibility for the backfill position resides with the Acting Service Director Rural Oral & Community.
- Direct employment costs of staff involved in the programme will be covered from existing budgets and redirection of resources.
- In year 2, we will cover the additional spend either through further redirection of resources or a further investment bid.

### *6.10 Next Steps*

The next steps for implementation include:

- Recruiting back-fill for the Wairoa Integrated Family Health Centre Manager, so that resource is available for leading Network establishment activities.
- Establishing Network Leadership teams in each of Central Hawke's Bay and Wairoa, to lead the early-stage activities (e.g. identifying priorities, analysing data (needs/gaps and strengths/assets), community engagement, shared locality-based vision and values).
- Establishing various stakeholder groups as required by the community (this may be a provider group, a consumer liaison group, special interest groups (e.g. youth health collective); these groups will inform priorities for action, will be key channels for communication with stakeholders, and will be partners in co-design activities.

# APPENDICES

Appendix 1: Position Profile – Wairoa Network Establishment Change Leader

**Hawke's Bay**
**District Health Board**
**Position Profile / Terms & Conditions**



| | |
|---|---|
| **Position holder (title)** | Wairoa Network Establishment Change Leader<br>0.5 FTE for 2 years |
| **Reports to (title)** | Head of Strategic Services<br>Work plan accountability to Wairoa Network Leadership Team |
| **Department / Service** | Strategic Services; Planning, Informatics and Finance |
| **Purpose of the position** | ▪ To use relationship, motivation and negotiation skills to build trust between stakeholders and drive change within the health and social care sectors that serve the Wairoa community.<br>▪ To lead and project manage transformational change projects, including the planning, delegating, monitoring, and motivating functions, to achieve the required outcomes and benefits within the expected targets for time, cost, and quality.<br>▪ To lead the development of the leadership model and programme plan that will set up and implement a Health and Social Care Network for Wairoa.<br>▪ To recognise and support the Transform and Sustain Strategy by delivering real change in service delivery in Wairoa, through innovative leadership, business model development, and models of care that will improve health and wellness outcomes for the population. This work in Wairoa will directly inform the design and implementation of similar models across Hawke's Bay.<br>▪ To embed across Wairoa's health sector providers a culture of person and whānau centred care as per the agreed model of care and business model.<br>▪ To build and maintain relationships across the stakeholder community, including consumers, providers and funders, ensuring that stakeholder partnership is central to all redesign efforts, identification of priorities, and decision making.<br>▪ To work intersectorally, being recognised as a leader of positive transformation across a range of sectors and organisations that impact health and wellness; examples are social care, education, and justice sectors, iwi groups, and community groups (NGOs, churches, etc). |

## Working Relationships

| Internal | External |
|---|---|
| ▪ Chief Executive Officer<br>▪ Chief Operating Officer<br>▪ Company Secretary<br>▪ HBDHB and Health Hawke's Bay leadership teams as sponsoring groups for the project.<br>▪ Health and Social Care Programme Manager<br>▪ Project sponsors, steering committees and stakeholders<br>▪ HBDHB Programme Management Office Manager<br>▪ Project Support service staff including: Finance, Quality and Patient Safety, Communications, Information Services, Business Intelligence; Facilities, Procurement, Planning, Strategic Services, Consumer groups, Human Resources<br>▪ Māori Health<br>▪ Committees, teams and groups involved in the governance of the health sector & related Project Managers (DN GP Alignment; Urgent Care; engAGE; Clinical Pharmacy Facilitators; Patient Experience)<br>▪ Wairoa Health Centre | ▪ Wairoa Network Leadership Group<br>▪ Wairoa project team members and support resources<br>▪ Stakeholders of the development of Health and Social Care Networks, specifically general practice teams, Māori and other community providers, rangatahi advisory group, whānau and the community.<br>▪ Taiwhenua o te Wairoa |

## Dimensions

| | |
|---|---|
| **Expenditure & budget / forecast for which accountable** | None currently. However, the Change Leader will be expected to competently manage any resources allocated to the projects during their lifecycle. This will include effective processes associated with project budget management including development of funding applications for resource outside any allocated project budget. |
| **Challenges & Problem solving** | Challenges for the role include:<br>▪ To work autonomously with minimum supervision but within a clear project process (maintained by the Project Management Office), and a strategic framework and direction (the "Transform & Sustain" strategy).<br>▪ To be a dynamic change agent, getting things done with a sound application of change management methodologies.<br>▪ To deal with complexity and diversity across the varying stakeholder views.<br>▪ To have excellent interpersonal skills as the approach involves achieving things through the coordination and alignment of staff both internal and external to the organisation, without direct line management authority.<br>▪ To have sufficient gravitas, and authority to gain the respect of senior managers and clinicians who will be involved in, or affected by, project delivery. To be able to communicate clearly and effectively in writing (including business case development) and in presentation to audiences.<br>▪ To be methodical, systematic, and persistent in working through problems issues, and obstacles to achieve progress.<br>▪ To have the intellectual capacity and flexibility to move between, and lead or facilitate complex change and projects covering a diverse range of issues and services.<br>▪ To be able to work to deadlines in delivering project milestones, progress reports, and evaluations. |
| **Number of staff reports** | No Direct Reports but requires coordination of many staff both internal and external to the organisation and the wider community through the project process. |
| **Delegations & Decision** | ▪ Delegated authority may be transferred to this role.<br>▪ Must be confident to make decisions or recommendations relating to the project as per agreed delegated authority.<br>▪ Discretion is required to be exercised in releasing confidential information to the appropriate parties. |
| **Other Indicators** | Works with formal, informal and virtual teams in a collaborative structure.<br>With stakeholders, establish a workplan for Wairoa network that includes outcome measures to assess results end of year one and end of year two. |


Our vision
HEALTHY
HAWKE'S BAY
TE HAUORA O
TE MATAU-Ā-MĀUI
Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community.
Our values
Tauwhiro – delivering high quality care to patients and consumers
Rāranga te tira – working together in partnership across the community
He kauanuanu – showing respect for each other, our staff, patients and consumers
Ākina – continuously improving everything we do

## Key Accountabilities

| CORE ROLE | |
|---|---|
| **Tasks (how it is achieved)** | **How it will be measured (KPI):** |
| Relationships and Leadership:<br>▪ Build and maintain relationships across the varied stakeholder groups.<br>▪ Use relationship and negotiation skills to gain buy-in and partnership across diverse stakeholder groups.<br>▪ Is available to engage with stakeholders at all levels to gain alignment, progress projects and initiatives, and champion a collaborative working environment.<br>▪ Resolve issues proactively and sensitively.<br>▪ Act as the first point of contact for the Network Establishment work programme. | Is recognised as the leader of the programme of work that will establish a Health and Socail Care Network in Wairoa.<br>Maintains a positive working environment in which stakeholder partnership is recognisable in all processes, outputs and outcomes.<br>Effective relationships and risk management processes ensure that the project remains on track despite the complexity of the changes envisaged by the work plan. Effective escalation processes are followed when required.<br>Programme stakeholders understand and buy into the programme plan. Successful delivery of the programme is accomplished<br>Programme benefits are demonstrated in the organisation and communicated across the sector. |
| Lead change:<br>• Work with service providers, consumers and funders to develop an implementation and change management strategy based on population health and asset mapping approaches.<br>• Work with stakeholders to foster participation in the project to ensure their on-going ownership of the change. This will include championing co-design and appreciative inquiry methodologies as key tools for change.<br>• Use influence appropriately to champion and progress positive change.<br>• Communication strategies demonstrate effective engagement of all key stakeholders in an appropriate way including: effective meetings / minutes, formal communications and adhoc communications.<br>• Timely and smooth transition from the old systems to the new. | Robust stakeholder analysis and implementation of a communication plan has resulted in a community of varying viewpoints actively engaged in the project, and contributing to the work plan.<br>Stakeholders requirements for effective service and service delivery change are identified, documented and signed off.<br>Positive feedback from stakeholders on participation opportunities.<br>A commitment to person and whānau-centred care is perceptible in all project processes and outputs.<br>Use of change impact analysis is evident during project planning, such that impacts are known and can be mitigated to facilitate smooth transition. |
| Deliver project implementation:<br>• Manage project resources effectively including engagement, delegation, and performance management.<br>• Ensure delivery of the expected project deliverables on time, within budget and meeting the requirements that have been agreed.<br>• Effective communication with project sponsor, steering group and all project stakeholders through coordinated implementation of the agreed communication plan.<br>• Managers the day to day work delivery and provides timely reporting of progress as per HBDHB project management standards. | Demonstrates application of evidence based approaches in preparing project implementation plans.<br>Project resources work effectively or performance management is in place.<br>Reporting requirements are met.<br>Expected benefits accruing throughout the project and after its completion are identified in the project planning process, and realisation of these benefits is achieved according to the timeframes envisaged by the benefit realisation plan.<br>Implementation timelines are met. |

| | |
|---|---|
| | Establishes measures to monitor and demonstrate success of the project throughout its duration. |

| **OCCUPATIONAL HEALTH & SAFETY** | |
|---|---|
| **Tasks (how it is achieved):**<br><br>Displays commitment through actively supporting all health and safety initiatives.<br><br>Ensures all staff/colleagues maintain adequate safety standards on the job through consultation, training and supervision.<br><br>Ensures own and others safety at all times.<br><br>Complies with policies, procedures and safe systems of work.<br><br>Reports all incidents/accidents, including near misses in a timely fashion.<br><br>Is involved in health and safety through participation and consultation. | **How it will be measured (KPI):**<br><br>Evidence of participation in health and safety activities.<br><br>Demonstrates support of staff/colleagues to maintain safe systems of work.<br><br>Evidence of compliance with relevant health and safety policies, procedures and event reporting. |

## Key Competencies

| DRIVE FOR RESULTS | |
|---|---|
| **Tasks (how it is achieved):**<br><br>Demonstrates the ability to drive self and others to deliver results e.g. MOH targets, KPI's, service plans<br><br>Consistently and constantly fosters joint problem solving and decision making across the team and wider<br><br>Manages the balance between meeting both organisational wide targets and budget requirements<br><br>Demonstrates the following:<br>▪ Strong prioritisation skills<br>▪ Communication skills (both verbal and written) and<br>▪ The running of effective meetings | **How it will be measured (KPI):**<br><br>Organisation meets the defined targets within budget<br><br>Team meetings held on a monthly basis are effective and results focused<br><br>Monthly reports and business case's presented professionally, with effective decision making |

| BUILDING EFFECTIVE TEAMS | |
|---|---|
| **Tasks (how it is achieved):**<br><br>Staff performance development plans are aligned with the approved service/continuum plan.<br><br>Creates strong morale and spirit in his/her team to foster a feeling of belonging.<br><br>Demonstrates the ability to blend people into teams when needed to work autonomously e.g. leading project teams, participation in projects, forums.<br><br>Fosters open dialogues and joint problem solving and decision making.<br><br>Defines success in terms of the whole team and shares wins and successes.<br><br>Demonstrates the ability to effectively lead and participate in organisational wide project teams as required. | **How it will be measured (KPI):**<br><br>90% of performance appraisals are completed on time with objectives and plans incorporated.<br><br>Team meetings are run on a monthly basis.<br><br>Successes are recognised and celebrated on both an individual and team level.<br><br>Projects are implemented effectively within the parameters of the terms of reference. |

| CUSTOMER SERVICE | |
|---|---|
| **Tasks (how it is achieved):**<br><br>Open and responsive to customer needs.<br><br>Demonstrate an understanding of continuous quality improvement. | **How it will be measured (KPI):**<br><br>Demonstrates a commitment to customer service and continuous quality improvement, through interaction with patient/clients and other customers.<br><br>Identifies customer needs and offers ideas for quality improvement.<br><br>Effective management of customers/situations. |

| HONOURING TREATY OF WAITANGI OBLIGATIONS | |
|---|---|
| **Tasks (how it is achieved):**<br><br>Demonstrates understanding of the principles of the Treaty of Waitangi.<br><br>Ensure the principles of partnership, protection and participation are applied to day to day work.<br><br>Ensures procedures do not discriminate against Māori. | **How it will be measured (KPI):**<br><br>Evidence of the principles applied in work practice. |

## Essential and Desirable Criteria: Qualifications / Skills / Experience

| **Essential** | |
|---|---|
| **Treaty of Waitangi Responsiveness** (cultural safety) | Demonstrates the ability to engage with people in manner that the person(s) determines to be culturally safe.<br><br>Demonstrates ability to apply the Treaty of Waitangi within the Service. |
| **Qualifications** (e.g. tertiary, professional) | ▪ Tertiary level qualification (minimum BA level)<br>▪ Formal training or qualification in Project Management (prefer PMI PMP, PRINCE2 Practitioner, MSP) |
| **Business / Technical Skills** (e.g., computing, negotiating, leadership, project management) | ▪ Ability to write coherent meaningful project briefs, project implementation documents; business cases and other relevant documents.<br>▪ Good Facilitation Skills (Vision development etc.).<br>▪ Competent User of Microsoft Office applications especially: Word; Excel; Outlook<br>▪ Evidence of applied skills and successful outcomes in negotiating, and leadership roles.<br>▪ Evidence of strong written and presentational skills.<br>▪ Evidence of managing complex programmes to time and budget to deliver required outcomes.<br>▪ Evidence of self-awareness, and emotional and political intelligence.<br>▪ Good level of numeracy and evidence of working with financial and informatics analysis.<br>▪ Evidences awareness of project lifecycles for construction, IT and service improvement or redesign projects. |
| **Experience** (technical and behavioural) | Shows commitment to, and demonstrates the behaviours of the health sector:<br>▪ Tauwhiro (delivering high quality care to patients and consumers)<br>▪ Rāranga te tira (working together in partnership across the community)<br>▪ He kauanuanu (showing respect for each other, our staff, patients, and consumers)<br>▪ Ākina (continuously improving everything we do)<br><br>A track record of leading and delivering projects and change in a complex environment.<br><br>Familiarity with project management software. |

| Desirable | |
|---|---|
| | ▪ Formal Training or qualification in Change management<br>▪ Experience of working with other agencies on the wider determinants of health Previous experience in leading and delivering projects and change in a health environment<br>▪ Experience of working with other agencies on the wider determinants of health. |

## Recruitment Details



| | |
|---|---|
| **Position Title** | Change Leader |
| **Hours of Work** | 40 hours per fortnight. Fixed term 2 years (24 months) |
| **Salary & Employment Agreement Coverage** | Secondment. |
| **Date** | June 2016 |

| | |
|---|---|
| OURHEALTH HAWKE'S BAY Whakawateatia | **Last Days of Life Care Plan and Toolkit** |
| | For the attention of: **Māori Relationship Board (MRB) and Clinical and Consumer Council** |
| Document Owner:<br>Document Author: | Mark Peterson<br>Leigh White |
| Reviewed by: | Paul Malan (Strategic Services Manager Older Health and Mental Health Services) and Mary Wills (Head of Strategic Services), Executive Management Team |
| Month: | July 2017 |
| Consideration: | For Information |

**RECOMMENDATION**

**That the Māori Relationship Board, Clinical Council and Consumer Council:**

1. **Review** and Provide Feedback.
2. **Endorse** Ongoing Work

## EXECUTIVE SUMMARY

Last days of life care planning is an integral component of aged care services, medical and surgical care, management of chronic and complex illness. It is imperative that all health professionals should be competent to provide care to people who are approaching the end of their life and the tools (attached) are to be used as a guide. Last days of life care planning is a replacement for the phasing out of the Liverpool Care Pathway.

The impact of delayed last days of life planning can lead to a number of adverse outcomes:

- continued aggressive, unwanted and/or unwarranted life-sustaining measures instigated;
- poor experiences for families where distraught family members are called on at a time of grieving to engage in last days of life decisions;
- potentially avoidable conflicts between families and the health care team, or within the health care team; about the best course of treatment and care for the dying person;
- care being delivered in acute settings when better outcomes could be delivered in supported community or home environments;
- stress for health professionals balancing their obligation to act in the best interests of the dying person, sometimes differing views amongst treating clinicians and families.

The purpose of the enclosed document is to provide an update on the progression of work.

## SUMMARY UPDATE

- Last Days of Life Care Plan with supporting documents (Toolkit) are in final draft (attached) and signed off by the HBDHB Working Group (Refer to Arttachment 3) to support a trial.
- Trial of documents in Aged Residential Care to be completed.
- Last Days of Life Care Plan with supporting documents (Toolkit) sent to MoH for example of.
- HBDHB LTC Portfolio Manager to participate in the National Advisory Group for implementation of Te Ara Whakapiri - The Principles and Guidance for the Last Days of Life.

## CONSULTATION UPDATE



A cross-sector representative group was formed to collectively document updates: Trish Freer & Faye Milner (PHO), Jill Garrett (HBDHB Primary Strategic Service Manager), Janice Byford-Jones, Karen Franklin, Sarah Nichol, Jo Loney (Cranford Hospice) and Anne Gray (Secondary Care Services). The group has developed documents, informed their stakeholders and presented (or will present) to the following committees:

| Committee | Date | Feedback |
|---|---|---|
| Consumer Council | Consumer input has been received with regard input into the documents (refer enclosed Attachement - Appendix 2) | |
| PHO I'ND | June 2016 | Acknowledged paper |
| PHO Leadership Team (PHOLT), | June 2016 | Presenting Monday 4 July 2016 |
| PHO Clinical Advisory Governance Group | | To present July 2016 |
| Palliative care Sector Integration | 4 July 2016 | To present 4 July 2016 |
| Maori Relationshiop Board | 13 July 2016 | To present July 2016 |
| Clinical Council | 13 July 2016 | To present July 2016 |
| Consumer Council | 14 July 2016 | Included in Documents as Information |

## EXPECTED ROLE OF HBDHB

The Last Days of Life Care Plan and Toolkit are at the point of a trial and this has been agreed within five Aged Residential care facilities. Trial will commence post consultation – aiming for end of July 2016. Funding for the development of the tools and 500 copies for the trial will be provided by Strategic Services.

## EXPECTED ROLE OF HEALTH HB

To endorse the work and support implementation of the HBDHB Last Days of Life Care Plan document and toolkit as a replacement for LCP based on Te Ara Whakapiri: Principles and Guidance. To support the introduction and adoption in primary care. Note: Symptom Management for last days of life Algorithms are currently well embedded into general practice and these will not change.

Note:

- during the trial phase, General practice will be business as usual except for those GPs who are providing oversight for the trial in ARC.
- assumption of expected costs will be evaluated post trial and further consultation will occur with regard to wider implementation. It is expected the cost implication for PHO will be socialisation and education at CME sessions.

## EXPECTED ROLE OF SECONDARY SERVICES

Because of internal changes occurring in secondary care, a trial at this point is delayed.

## EXPECTED ROLE OF CRANFORD

In consultation with Cranford no trial will need to occur in the community as the forms will not be used in this area of practice at this time. Trial implementation, oversight in ARC and findings may be supported by Cranford (funding and date of commencement to be confirmed). To ensure the workforce is educated and skilled to provide quality care for people in their last days/hours of life. Cranford will ideally undertake workforce development in ARC, secondary care and present to Primary Care in CME sessions.

## EXPECTED ROLE OF RESIDENTIAL CARE

A proposed trial of 3 months (dates and timeframes not as yet agreed).

- ARC Facilities: Mary Doyle, Brittany, Masonic and Atawhai/Gracelands
- GP support: Dr M. Peterson, Dr P. Henley, Dr L. Whyte and Dr J. Eames

## EXPECTATION OF TRIAL OUTCOMES

Even though the aim of the trial is to trial the documents it is hoped that use will result in:

- improved decision making;
- a positive impact on multi-professional team communication and working;
- increased confidence of nurses about when to approach medical colleagues to discuss treatment plans;
- people being treated with greater dignity and respect;
- greater clarity around preferences and plans about how these can be met.

Will await national approach with regard to audit process – but early thoughts:

- Determine how death audits will be reviewed at a local level, based on predicted, as well as unexpected, hospital deaths.

## WHAT WILL SHOW IMPROVEMENT

Health records will better reflect a holistic approach to care in the last days of life. This includes evidence of communication and consideration of the individual needs of the person and family/whanau. It is expected that staff working with the document will show high level of confidence in planning and providing care. Having a consistent approach to the delivery and management of care will allow for effective evaluation and subsequent improvement to services provided through evaluation. This will be inclusive of the family/ whanau experience.

## ATTACHMENT(s)

Appendix 1 Heat Tool
Appendix 2: Copy of Consumer Feedback
Appendix 3: Working Group Members
Appendix 4: Care Plan
Appendix 5: Toolkit

## Appendix 1

### Key Performance Indicators against the Health Equity Assessment Tool (HEAT)

| Health Equity Assessment Tool - Questions | Assessment of the proposal using the Health Equity Assessment tool |
|---|---|
| *What health issue is the policy/programme trying to address* | That people are aware of the essential components and considerations required to promote quality care at the end of life for all adults in New Zealand.<br><br>Feedback will be taken into account from a consumer review:<br>(e-mail)- *"I spoke with whanau from a range of cultural backgrounds such as Māori, Samoan, Cook Island, Tongan, mixed European and those that were not raised within their cultural heritage. The key area of concern for all was "trust". Trust in the system, trust in the people and trust in the word (written and verbal)."*<br><br>The tool is to provide consistency and quality of care taking into consideration the individual person's/whanau choice.<br><br>It is a tool that is worked through with the person/whanau, vs a process that is "done to" the person(s) receiving care. (see email below)<br>*"Whereby some whanau have felt they have been pushed into making a decision due to the need to free up a bed; lack of staffing support; and implied costs of maintaining life in a hospital setting."* |
| *What inequalities exist in this health area?* | The Planning for Last Days of Life Care Plan is for care for adults and excludes children. This is being addressed in another process.<br><br>Without a standardised tool, the risk of substandard, fragmented care, and or variations in care is a risk.<br><br>The tool caters to the individual and eliminates the risk of 'stereotypical applications of care to ethnicities- see comment below.<br><br>*email - "Also acknowledging that the tool is for all cultures*<br>*- Another important aspect is to ensure that health workers do not assume that because of the ethnicity of the whanau that they fit within the expected cultural criteria. For example, not every Māori whanau are connected to their whanau, hapu, marae, iwi or cultural heritage. It must be what is acceptable and applicable to the individual (whanau) rather than their ethnicity alone."* |
| *Who is most advantaged and how?* | The Planning for Last Days of Life Care Plan is for care for adults and the advantage is to have a better quality of care experience in their last phases of life. It also empowers the work force to work individually with the person to ensure care and management meets their individual needs |
| *How did the inequality occur? (What are the mechanisms by which this inequality was created is maintained or increased?)* | The equity has occurred with the national consensus of the removal of the LCP leaving a gap in standardisation of care services. Removing the LCP without replacement of a suitable alternative that is endorsed centrally would lead to multiple variation, and the absence of agreed standards. |
| *What are the determinants of this inequality?* | (Lack of) Participation in decision making by providers<br>Attitudes of Care Planning for last days of Life |

| | |
|---|---|
| *How will you address the Treaty of Waitangi in the context of the New Zealand Public Health and Disability Act 2000?* | The Last Days of Life Care Plan is underpinned by Te Whare Tapa Whā, an holistic approach to care that addresses a person's physical, family/whānau, mental and spiritual health. It is person centred tool based on a partnership and full participation by the person and whanau in care management.<br><br>Providing an individualised care plan helps to guide and prompt the care of the person who is dying and support for their families/whanau and other people who are significant to them. The individual nature of the tool allows for culturally appropriate care to be provided. A core purpose of the document is to support consistent care across organisations regardless of the setting.<br><br>It is predicted that it may become evident that those that die in their own homes may also benefit from the use of the care plan document, this is particularly important when considering the higher percentage of Maori that die in the community. This factor will be considered after the trial?? |
| *Where/how will you intervene to tackle this issue?* | Adopting the seven overarching principles outlined in Te Ara Whakapiri: Principles and Guidance for the last days of life will truly reflect the needs of a person and their family/whānau at the end of life. In essence, the plan, path or guidance encompasses the fundamentals of Te Whare Tapa Whā, namely the mental, physical, spiritual and social principles of well-being.<br><br>The Last Days of Life Care Plan provides guidance, instructions and prompts to clinicians and the wider multi-disciplinary team that will assist them with their assessment and decision making regarding a person's deterioration and the possible outcome/s and indicated management. The plan ensures all necessary assessment, planning and monitoring are documented in line with the person's preferences. This provides evidence of appropriate care and communicates individualised care to all involved. |
| *How could this intervention affect health inequalities?* | Champions within providers of services.<br>Agreed competencies and standards.<br>Consistency in the implementation of the last days of life management. |
| *Who will benefit most?* | Adults and whanau in HB and health care providers supported in their management of care by a reputable and endorsed tool. |
| *What might the unintended consequences be?* | Lack of adoption of the tool and default to the previous LCP |
| *What will you do to make sure it does reduce/eliminate inequalities?* | Develop a process of monitoring outcomes for diverse population groups represented in the HB demographic.<br>Monitoring uptake and engagement with the tool by providers.<br>Attendance of ongoing CME-CNE. |
| *How will you know if inequalities have been reduced/ eliminated?* | Evaluations of outcomes for patients / whanau inclusive of case studies – whanau stories. |

## Appendix 2

-----Original Message-----
From: [redacted]
Sent: Wednesday, 25 May 2016 12:07 p.m.
To: 'Graeme Norton Hme'
Subject: FW: Last days of Lire documents for comment

Kia ora Graeme

Well I have had some very interesting conversations and feedback, but the email below covers off the feedback from others very well.

I spoke with whanau from a range of cultural backgrounds such as Maori, Samoan, Cook Island, Tongan, mixed European and those that were not raised within their cultural heritage.

12

The key area of concern for all was “trust”. Trust in the system, trust in the people and trust in the word (written and verbal). The past experiences of our whanau have left some lasting “bad” impressions. However, some advise that there has been some definite improvements over the years. There is some cynicism that in today’s hospital environment, whereby some whanau have felt they have been pushed into making a decision due to the need to free up a bed; lack of staffing support; and implied costs of maintaining life in a hospital setting. Whanau have been told that it is more cost effective for the hospital if they took their whanau member home to look after themselves.

Another important aspect is to ensure that health workers do not assume that because of the ethnicity of the whanau that they fit within the expected cultural criteria. For example, not every Maori whanau are connected to their whanau, hapu, marae, iwi or cultural heritage. It must be what is acceptable and applicable to the whanau rather than their ethnicity alone.

In sharing these examples there were also a number of “happy” examples shared, but of course it is the bad experiences we remember and voice.

I hope this helps with development of the final plan.

Nga mihi,
[redacted]

## Appendix 3

**Acknowledgement of the HB Integrated Working group:**

Dr Carol McCallum *(Palliative Physician*)
Karyn Franklin *(Clinical Services Manager, Cranford Hospice*
Sarah Nichol *(Quality Co-Ordinator Cranford Hospice)*
Sue- Mary Davis *(Palliative care nurse Liaison with Aged Residential Care)*
Anne Gray/Lorna Hulkes *(shared) (Palliative CNS Secondary Care)*
Joan McAsey (*Practice Nurse, Hastings Health Centre*)
Irene O'Connell (*Clinical Manager, Eversley Aged Residential Care*)
Jo Loney (*Education Service Manager, Cranford Hospice*)
Liz Beattie (*Clinical Manager, Masonic Aged Residential Care*)
Trish Freer (*Health Programmes Manager – HHB*)
Faye Milner (*Secretarial Support – PHO*)

**Request critique of documents:**

Dr Mark Peterson
Graeme Norton (sent to the Consumer Council)
Dr Liz Whyte
Dr Eames
Mrs Jacqui Thomas (*Consumer*)

APPENDIX 4

OURHEALTH HAWKE'S BAY
Whakawāteatia

*Fill in only if person label is unavailable*

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

.....

# LAST DAYS OF LIFE CARE PLAN

Identifying the Dying Person

## Flowchart

### RECOGNITION OF PERSON DETERIORATION

**DOES THE PERSON SHOW 2 – 3 OF THE FOLLOWING SIGNS/SYMPTOMS?**

- ☐ Profound weakness
- ☐ Reduced intake food/fluids
- ☐ Difficulty swallowing/taking oral medications
- ☐ Drowsy or reduced cognition – semi conscious with lapses into unconsciousness
- ☐ Bed bound after progressive decline over days and weeks
- ☐ Peripherally shut down

**Is this deterioration acute or unexpected?** YES → **Are there reversible cause(s) of deterioration?** YES → **Is investigation or new intervention appropriate and/ or wanted by the person/ family/whānau/ carer?** YES → **Treat Causes**

YES

NO

NO

- Family notified (if not already aware of person's condition); family involvement in care and allowances made for them to remain with person.
- Psychological support: plan of care discussed with person(if able) and family/whānau /carer
- Spiritual/religious/cultural beliefs: addressed with person (if able) and family/whānau /carer – facilitate any identified rituals around death. Referral to cultural/spiritual/religious support people if required.
- Medication: non essential medications discontinued, anticipatory PRN medication prescribed - consider route (refer to your organisation's symptom management algorithms)
- Discontinue unnecessary interventions: e.g. IV antibiotics, blood tests, observations/Early Warning Symptoms Score
- Ensure DO NOT RESUSCITATE order is documented.

**DOCUMENT ABOVE INFORMATION AND COMMENCE END OF LIFE CARE PLANNING**

**As with all clinical guidance this document aims to support but does not replace clinical judgement**

BrebnerPrint TRIAL 16/06/16

LAST DAYS OF LIFE CARE PLANNING TOOLKIT

12.1

INSTRUCTIONS

OURHEALTH HAWKE'S BAY
Whakawāteatia

*Fill in only if person label is unavailable*

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

.....

# INSTRUCTIONS

This plan is an integrated care document that can be used across all settings, including the home, aged residential care, hospital and hospice

The term "last days of life" defines the period of time in which a person has been assessed and diagnosed as dying by a multi-disciplinary team and that death is expected within hours or days.

The goals of care are optimal symptom management and support for the person/family/whanau. The person should be assessed and a individualised care plan developed in line with the person (if able), family/whanau wishes and needs.

## CRITERIA FOR THE USE OF THE CARE PLAN

A health practitioner undertakes assessments when recognising a person may be entering their last days of life, planning priorities of care and continually assessing care needs. Any changes in condition act as a prompt to ensure conversations occur with the person and with their family/ whānau.

## INSTRUCTIONS FOR USE

This document is organised in three parts and must link with the person's clinical records. It is imperative to clearly communicate all decisions leading to a change in care, and document these conversations.

| | |
|---|---|
| **Preparing for last days of life:** *Pages 3 to 5* | Baseline assessment to identify priorities of care |
| **Planning for care:** *Pages 6 to 7* | Person centred priorities of care |
| **Ongoing assessment:** *Pages 8 to 11* | Regular assessments *(recommend 4 hourly or more often if required)* of the persons condition to ensure that changes are addressed in a timely manner. |
| **Care after death:** *Page 12* | Checklist |

## LEAD HEALTH PRACTITIONER/S

Doctor: ..... Page contacts (HBDHB): .....

*If GP - See Page 3 for Contact Details*

Nurse Practitioner: .....

Work number: ..... After hours number: .....

Primary Nurse: .....

## THIS PLAN SHOULD BE REASSESSED EVERY THREE DAYS

Date of Life Care Plan commencement ..... Signed .....

Reassessment date: ..... Reassessment time: ..... Signed .....

Reassessment date: ..... Reassessment time: ..... Signed .....

Reassessment date: ..... Reassessment time: ..... Signed .....

OURHEALTH HAWKE'S BAY
Whakawāteatia

*Fill in only if person label is unavailable*

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

.....

## CONTACTS

| FAMILY/ WHĀNAU | |
|---|---|
| | **1st Contact:** |
| If the person's condition changes, who should be contacted first? | Name: .....<br>Relationship: .....<br>Telephone Number: .....<br>Mobile Number: ..... |
| If the person's condition changes, when should they be contacted? | At any time ☐<br>Not at night time ☐ |
| | **2nd Contact:** |
| If the first contact is unavailable, who should be contacted? | Name: .....<br>Relationship: .....<br>Telephone Number: .....<br>Mobile Number: ..... |
| When to contact | At any time ☐<br>Not at night time ☐ |
| Next of Kin if different from above | Name: .....<br>Relationship: .....<br>Telephone Number: |
| **KEY SERVICE PROVIDERS** | |
| | **1st Contact:** |
| Name of General Practitioner<br>Notified of change in person's condition<br>☐ Yes ☐ No | Name: .....<br>Mobile Number: .....<br>At any time ☐ Not at night time ☐ |
| In what circumstances do they want to be contacted? | **2nd Contact:** |
| If unavailable, which GP should be contacted? | Name: .....<br>Mobile Number: .....<br>At any time ☐ Not at night time ☐ |
| Community Providers are notified of "Last Days of Life" if applicable | Cranford Hospice ☐ Yes ☐ No ☐ N/A<br>District Nurses ☐ Yes ☐ No ☐ N/A<br>NASC Agency ☐ Yes ☐ No ☐ N/A<br>Home Support Agency ☐ Yes ☐ No ☐ N/A<br>Other ☐ Yes ☐ No ☐ N/A<br>.....<br>.....<br>..... |

PREPARING FOR LAST DAYS OF LIFE

OURHEALTH HAWKE'S BAY
Whakawāteatia

*Fill in only if person label is unavailable*

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

.....

## INITIAL ASSESSMENT PAGE 1 OF 2

| | |
|---|---|
| **RECOGNITION OF DYING:** *Goal: Both the person/family/whānau have awareness and understanding of the diagnosis* | |
| The person is aware they are dying?<br>***See guidelines on "Identifying the dying person"*** | ☐ Yes ☐ No ☐ Unconscious<br>Date: ..... Signature: ..... |
| Is the family/whānau aware their family member is dying?<br>***See guidelines on "Breaking Bad News" and "W.H.A.N.A.U" tool*** | ☐ Yes ☐ No<br>Date: ..... Signature: .....<br>**Document clearly in PROGRESS NOTES what was said and by whom.** |
| **Advance Care Plan:** *Goal: Both the person/family/whānau are given the opportunity to discuss what is important to them* | |
| Does the person have an existing Advance Care Plan?<br>***If Yes – where is it located*** | ☐ Yes ☐ No<br>Located: .....<br>Date: ..... Signature: ..... |
| Does the person have an existing Directive/ Do Not Resuscitate Order documenting their wishes at end-of-life?<br>***If Yes – where is it located*** | ☐ Yes ☐ No<br>Located: .....<br>Date: ..... Signature: ..... |
| Does the person have nominated Enduring Power of Attorney (EPOA) for Health? | ☐ Yes ☐ No<br>Name: .....<br>Relationship: ..... Contact No.: ..... |
| Has the EPOA been activated?<br>Copy sighted? | ☐ Yes ☐ No<br>☐ Yes ☐ No<br>**Document clearly in PROGRESS NOTES what was said and by whom.** |
| **Preferred Place of Care:** *Goal: person and family/whānau choice if appropriate* | |
| Person's preferred place of care | ☐ Home ☐ Hospital<br>☐ Hospice ☐ Aged Residential Care |
| Family/whanau preferred place of care<br>***If going home or to Aged Residential Care from HBDHB see "Discharge Checklist"*** | ☐ Home ☐ Hospital<br>☐ Hospice ☐ Aged Residential Care |
| **Information and Explanation:** *Goal: Both the person/family/whānau are given the opportunity to discuss what is important to them.* | |
| Family/whanau given information of facilities available e.g. visiting times, parking, tea and coffee, quiet area, toilets.<br>***Information brochure "What to expect when someone is dying" explained and given to family/ whānau if appropriate.***<br>***Give "Bereavement Information" brochure and list of Funeral Directors if appropriate time.*** | ☐ Yes ☐ No<br>☐ Yes ☐ No Brochure given ☐ Yes ☐ No<br>☐ Yes ☐ No Brochure given ☐ Yes ☐ No<br>Name of Funeral Director (if known) .....<br>If for cremation/burial .....<br>Specific death certificate questions:<br>Previous occupation.....<br>Ethnicity..... Marital Status..... |

OURHEALTH HAWKE'S BAY
Whakawāteatia

*Fill in only if person label is unavailable*

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

.....

## INITIAL ASSESSMENT PG 2 OF 2

### Cultural:

| | |
|---|---|
| If able, the person is given the opportunity to discuss their cultural needs e.g. needs now, at death and after death.<br><br>Family/whānau is given the opportunity to discuss their cultural needs at this time e.g. needs now, at death and after death.<br><br>***Refer to appropriate cultural support e.g. Maori Health Service, Asian Support, Pacific Island Support. See W.HA.N.A.U: Personalising care at end of life.*** | Date and time of conversation: .....<br>.....<br><br>Date and time of conversation: .....<br>.....<br><br>Names of services involved: .....<br><br>**Document clearly in PROGRESS NOTES what was said and by whom.** |

### Religious and Spiritual:

| | |
|---|---|
| If able, the person is given the opportunity to express what is important to them at this time eg. wishes, feelings, faith, beliefs, values (needs now, at death and after death) | ☐ Yes ☐ No<br><br>Date and time of conversation: ..... |
| The family/whānau is given the opportunity to express what is important to them at this time eg. wishes, feelings, faith, beliefs, values (needs now, at death and after death)<br><br>***Refer to Chaplain Service or contact person's preferred support person if required. See Spiritual care assessment tool based on FICA approach.*** | ☐ Yes ☐ No<br><br>Date and time of conversation: .....<br><br>Names of services involved: .....<br><br>**Document clearly in PROGRESS NOTES what was said and by whom.** |

### MUST BE COMPLETED BY MEDICAL PRACTITIONER

| | | | | |
|---|---|---|---|---|
| • Active acute medical treatment is no longer in the person's best interest | ☐ Yes | ☐ No | Date: ..... | Signature: ..... |
| • Non-essential medications discontinued and current medications reviewed | ☐ Yes | ☐ No | Date: ..... | Signature: ..... |
| • PRN subcutaneous anticipatory medications charted.<br>***See Symptom Management Algorithms*** | ☐ Yes | ☐ No | Date: ..... | Signature: ..... |
| • Inappropriate interventions discontinued e.g blood tests, routine observations, blood glucose monitoring, oxygen therapy | ☐ Yes | ☐ No | Date: ..... | Signature: ..... |
| • The need for artificial hydration/nutrition has been discussed | ☐ Yes | ☐ No | Date: ..... | Signature: ..... |
| • Not for Resuscitation status recorded | ☐ Yes | ☐ No | Date: ..... | Signature: ..... |
| • Implantable Cardioverter Defibrillator (ICD) is deactivated | ☐ Yes | ☐ No | Date: ..... | Signature: ..... |
| • Organ donation considered and information given to person/family<br>***See Tissue Donation brochure*** | ☐ Yes | ☐ No | Date: ..... | Signature: ..... |

### Individual/Specific Requests

.....

.....

.....

PLANNING CARE

OURHEALTH HAWKE'S BAY
Whakawāteatia

*Fill in only if person label is unavailable*

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

.....

## ALL PERSONNEL COMPLETING THE LAST DAY OF LIFE - *CARE PLAN* - PLEASE SIGN BELOW

You should also have an understood the 'Health Care Professional' leaflet

| Name (print) | Full Signature | Initials | Professional Title | Date |
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OURHEALTH HAWKE'S BAY
Whakawāteatia

*Fill in only if person label is unavailable*

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

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PLANNING CARE

12.1

## CARE PLAN PAGE 1 OF 2

***Plan of care developed using information from initial assessment; any known ACP documentation; input from person/ family/whānau.***

| Person PROBLEM / FOCUS | GOAL | ACTIONS |
|---|---|---|
| **Te Taha Tinana** | | |
| **PAIN** | Person is pain free<br>• Verbalised by person if conscious<br>• Pain free on movement<br>• Appears peaceful | e.g. Consider need for positional change ☐<br>.....<br>.....<br>..... |
| **AGITATION** | Person is not agitated<br>• Person does not display signs of delirium, terminal anguish, restlessness (thrashing, plucking, twitching) | e.g. Exclude retention of urine as cause ☐<br>e.g. Consider need for positional change ☐<br>.....<br>..... |
| **RESPIRATORY TRACT SECRETIONS** | Excessive secretions are not a problem | e.g. Medication to be given as soon as symptoms arise ☐<br>e.g. Consider need for positional change ☐<br>e.g. Symptom discussed with family/other ☐<br>.....<br>..... |
| **NAUSEA AND VOMITING** | Person does not feel nauseous or vomits<br>• Person verbalises if conscious | .....<br>.....<br>..... |
| **DYSPNOEA** | Breathlessness is not distressing for person<br>☐ Person verbalises if conscious | e.g. Consider need for positional change ☐<br>.....<br>..... |
| **OTHER SYMPTOMS (E.G. OEDEMA, ITCH)** | ..... | .....<br>.....<br>..... |
| **MOUTH CARE** | Mouth is moist and clean<br>• See mouth care guidelines | e.g. Ensure mouth is kept moist ☐<br>e.g. Family/whānau/other involved in care given ☐<br>.....<br>..... |
| **MICTURITION DIFFICULTIES** | Person is comfortable | e.g. Urinary catheter if in retention ☐<br>e.g. Urinary catheter or pads, if general weakness creates incontinence ☐<br>.....<br>..... |
| **MEDICATION** | All medication is given safely and accurately | e.g. If syringe driver in progress check rate and site ☐<br>..... |

**Plan of care continued onto next page**

PLANNING CARE

OURHEALTH HAWKE'S BAY
Whakawāteatia

*Fill in only if person label is unavailable*

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

.....

## CARE PLAN PAGE 2 OF 2

***Plan of care developed using information from initial assessment; any known ACP documentation; input from person/ family/whānau.***

| Person PROBLEM / FOCUS | GOAL | ACTIONS |
|---|---|---|
| **MOBILITY / PRESSURE AREA CARE** | Person is comfortable and in a safe environment | Mattress: .....<br>Position changes: .....<br>Personal Hygiene needs: ..... |
| **BOWEL CARE** | Person is not agitated or distressed due to constipation or diarrhoea | ..... |
| **Taha hinengaro** | | |
| **PSYCHOLOGICAL SUPPORT** | Person becomes aware of the situation as appropriate | e.g. Person is informed of procedures ☐<br>e.g. Touch, verbal communication is continued ☐<br>..... |
| | Family/whānau / other are prepared for the person's imminent death with the aim of achieving peace of mind and acceptance | e.g. Check understanding of nominated family/whānau/ others/younger adults / children ☐<br>e.g. Check understanding of family/whānau/others not present at initial assessment ☐<br>e.g. Ensure recognition that the person is dying and of the measures to ensure comfort ☐<br>..... |
| **Te Taha Wairua** | | |
| **RELIGIOUS/ SPIRITUAL SUPPORT** | Appropriate religious / spiritual support has been given | e.g. Support from Chaplaincy team may be helpful ☐<br>e.g. Consider cultural needs ☐<br>..... |
| **Te Taha Whānau** | | |
| **CARE OF THE FAMILY/ WHANAU/ OTHER** | The needs of those attending the person are accommodated | e.g. Consider health needs and support ☐<br>..... |
| **CULTURAL SUPPORT** | Consider the cultural needs of the person/ family/whānau | ..... |
| **OTHER**<br>E.G. COMMUNICATION | | ..... |

**Health Professional Name:** .....

**Signature:** ..... **Date:** .....

**Please turn over for on-going assessment / outcome monitoring chart**

OURHEALTH HAWKE'S BAY
Whakawāteatia

*Fill in only if person label is unavailable*

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

.....

# ONGOING ASSESSMENT - OUTCOMES

**The goals and action plan must be monitored a minimum of 4 hourly and more often if necessary. Each entry in this monitoring chart indicates the previous 4 hour.**

**Use the following code to indicate if in the past 4 hours the goals were achieved:** Codes (please enter in columns(not a signature))
A= Achieved – The Goal was achieved and no additional interventions were required in the previous 4 hours
C = Change – Use this if the goal was not achieved and / or if additional actions were required to maintain the goal
If code C is used – details MUST be provided in the persons progress notes – including (PIE) Problem, Intervention and Evaluation

| GOALS FROM CARE PLAN | Date: | | | Day: | | | Date: | | | Day: | | | Date: | | | Day: | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TIME | | | | | | | | | | | | | | | | | | |
| **PAIN**<br>*Person is pain free*<br>• Verbalised by person if conscious<br>• Pain free on movement | | | | | | | | | | | | | | | | | | |
| **AGITATION**<br>*Person is not agitated*<br>• Person does not display signs of delirium, terminal anguish, restless (thrashing, plucking, twitching) | | | | | | | | | | | | | | | | | | |
| **RESPIRATORY TRACT SECRETIONS**<br>*Excessive secretions are not a problem* | | | | | | | | | | | | | | | | | | |
| **NAUSEA AND VOMITING**<br>*Person does not feel nauseous or vomits*<br>• Person verbalises if conscious | | | | | | | | | | | | | | | | | | |
| **DYSPNOEA**<br>*Breathlessness is not distressing for the person*<br>• Verbalised by person if conscious | | | | | | | | | | | | | | | | | | |
| **OTHER SYMPTOMS (E.G. OEDEMA, ITCH)** | | | | | | | | | | | | | | | | | | |
| **MOUTH CARE**<br>*Mouth is moist and clean* | | | | | | | | | | | | | | | | | | |
| **MICTURITION DIFFICULTIES**<br>*Person is comfortable* | | | | | | | | | | | | | | | | | | |
| **MEDICATION**<br>*All medication is given safely and accurately* | | | | | | | | | | | | | | | | | | |
| **MOBILITY / PRESSURE AREA CARE**<br>*Person is comfortable and in a safe environment* | | | | | | | | | | | | | | | | | | |
| **BOWEL CARE**<br>*Person is not agitated or distressed due to constipation or diarrhoea* | | | | | | | | | | | | | | | | | | |
| **PSYCHOLOGICAL SUPPORT**<br>*Person becomes aware of the situation as appropriate* | | | | | | | | | | | | | | | | | | |
| *Family/whanau/other are prepared for the person's imminent death with the aim of achieving peace of mind and acceptance* | | | | | | | | | | | | | | | | | | |
| **RELIGIOUS / SPIRITUAL SUPPORT**<br>*Appropriate religious / spiritual support has been given* | | | | | | | | | | | | | | | | | | |
| **CARE OF THE FAMILY /WHANAU/OTHER**<br>*The needs of those attending the person are accommodated* | | | | | | | | | | | | | | | | | | |
| **CULTURAL SUPPORT**<br>*Consider the cultural needs of the person/ family/whānau* | | | | | | | | | | | | | | | | | | |
| **OTHER** E.G. COMMUNICATION | | | | | | | | | | | | | | | | | | |
| **HEALTH PROFESSIONAL INITIAL** | | | | | | | | | | | | | | | | | | |
| **DESIGNATION** | | | | | | | | | | | | | | | | | | |

ONGOING ASSESSMENT

OURHEALTH HAWKE'S BAY
Whakawāteatia

*Fill in only if person label is unavailable*

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

.....

## ONGOING ASSESSMENT - OUTCOMES

**The goals and action plan must be monitored a minimum of 4 hourly and more often if necessary. Each entry in this monitoring chart indicates the previous 4 hour.**

**Use the following code to indicate if in the past 4 hours the goals were achieved:** Codes (please enter in columns(not a signature))
A= Achieved – The Goal was achieved and no additional interventions were required in the previous 4 hours
C = Change – Use this if the goal was not achieved and / or if additional actions were required to maintain the goal
If code C is used – details MUST be provided in the persons progress notes – including (PIE) Problem, Intervention and Evaluation

| GOALS FROM CARE PLAN | Date: | | | Day: | | | Date: | | | Day: | | | Date: | | | Day: | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TIME | | | | | | | | | | | | | | | | | | |
| **PAIN**<br>*Person is pain free*<br>• Verbalised by person if conscious<br>• Pain free on movement | | | | | | | | | | | | | | | | | | |
| **AGITATION**<br>*Person is not agitated*<br>• Person does not display signs of delirium, terminal anguish, restless (thrashing, plucking, twitching) | | | | | | | | | | | | | | | | | | |
| **RESPIRATORY TRACT SECRETIONS**<br>*Excessive secretions are not a problem* | | | | | | | | | | | | | | | | | | |
| **NAUSEA AND VOMITING**<br>*Person does not feel nauseous or vomits*<br>• Person verbalises if conscious | | | | | | | | | | | | | | | | | | |
| **DYSPNOEA**<br>*Breathlessness is not distressing for the person*<br>• Verbalised by person if conscious | | | | | | | | | | | | | | | | | | |
| **OTHER SYMPTOMS (E.G. OEDEMA, ITCH)** | | | | | | | | | | | | | | | | | | |
| **MOUTH CARE**<br>*Mouth is moist and clean* | | | | | | | | | | | | | | | | | | |
| **MICTURITION DIFFICULTIES**<br>*Person is comfortable* | | | | | | | | | | | | | | | | | | |
| **MEDICATION**<br>*All medication is given safely and accurately* | | | | | | | | | | | | | | | | | | |
| **MOBILITY / PRESSURE AREA CARE**<br>*Person is comfortable and in a safe environment* | | | | | | | | | | | | | | | | | | |
| **BOWEL CARE**<br>*Person is not agitated or distressed due to constipation or diarrhoea* | | | | | | | | | | | | | | | | | | |
| **PSYCHOLOGICAL SUPPORT**<br>*Person becomes aware of the situation as appropriate* | | | | | | | | | | | | | | | | | | |
| *Family/whanau/other are prepared for the person's imminent death with the aim of achieving peace of mind and acceptance* | | | | | | | | | | | | | | | | | | |
| **RELIGIOUS / SPIRITUAL SUPPORT**<br>*Appropriate religious / spiritual support has been given* | | | | | | | | | | | | | | | | | | |
| **CARE OF THE FAMILY /WHANAU/OTHER**<br>*The needs of those attending the person are accommodated* | | | | | | | | | | | | | | | | | | |
| **CULTURAL SUPPORT**<br>*Consider the cultural needs of the person/ family/whānau* | | | | | | | | | | | | | | | | | | |
| **OTHER** E.G. COMMUNICATION | | | | | | | | | | | | | | | | | | |
| **HEALTH PROFESSIONAL INITIAL** | | | | | | | | | | | | | | | | | | |
| **DESIGNATION** | | | | | | | | | | | | | | | | | | |

OURHEALTH HAWKE'S BAY
Whakawāteatia

*Fill in only if person label is unavailable*

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

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PROGRESS NOTES

12.1

## PROGRESS NOTES

If code C is used IN THE ON-GOING ASSESSMENTSECTION – details MUST be provided in the persons progress notes – including (PIE) Problem, Intervention and Evaluation

| DATE | PROGRESS NOTES | SIGNATURE AND DESIGNATION |
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PROGRESS NOTES

OURHEALTH HAWKE'S BAY
Whakawāteatia

*Fill in only if person label is unavailable*

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

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## PROGRESS NOTES

If code C is used IN THE ON-GOING ASSESSMENTSECTION – details MUST be provided in the persons progress notes – including (PIE) Problem, Intervention and Evaluation

| DATE | PROGRESS NOTES | SIGNATURE AND DESIGNATION |
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OURHEALTH HAWKE'S BAY
Whakawāteatia

*Fill in only if person label is unavailable*

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

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# CARE AFTER DEATH

**NOTE: This section is to be used if advised by your organisation. It may be more appropriate to use your services Care of the Deceased Checklist or Forms**

| TIME OF DEATH | |
|---|---|
| Person has died | Date/ Time/ Signature: ..... |
| People in attendance at time of death | ..... |
| Person has been verified dead | Date/ Time/ Signature: ..... |
| Person certified (Medical) | Date/ Time/ Signature: ..... |
| **AFTER DEATH CARE** | |
| Discussed as appropriate with family/whānau procedures following death, e.g. funeral arrangement, viewing of the body/tūpāpaku | ☐ Yes ☐ No |
| Bereavement support has been discussed<br>***See Organisation Policy on Care at death and after death*** | ☐ Yes ☐ No |
| **ACTIONS COMPLETED** | |
| Notify Next of Kin | ☐ Yes ☐ No |
| Notify Attending Doctor | ☐ Yes ☐ No |
| Clinical records complete | ☐ Yes ☐ No |
| Ensure body correctly identifiable | ☐ Yes ☐ No |
| Sign off Release of Body form (if applicable) | ☐ Yes ☐ No ☐ N/A |
| WINZ notified/form printed (if applicable) | ☐ Yes ☐ No ☐ N/A |
| Ministry of Health (MoH) notification/form printed (Death only) | ☐ Yes ☐ No ☐ N/A |
| Options HB notified (if applicable) | ☐ Yes ☐ No ☐ N/A |
| Community Providers are notified of Death (if applicable) | Cranford Hospice ☐ Yes ☐ No ☐ N/A<br>District Nurses ☐ Yes ☐ No ☐ N/A<br>NASC Agency ☐ Yes ☐ No ☐ N/A<br>Home Support Agency ☐ Yes ☐ No ☐ N/A<br>Other ☐ Yes ☐ No ☐ N/A<br>.....<br>.....<br>.....<br>.....<br>.....<br>.....<br>.....<br>..... |

APPENDIX 5

OURHEALTH
HAWKE'S BAY
Whakawāteatia

# TOOLS AND RESOURCES TO GUIDE THE CARE OF PEOPLE IN THEIR LAST DAYS OF LIFE

OURHEALTH HAWKE'S BAY Whakawāteatia

# ADDITIONAL TOOLS

**to assist with decision making and providing information to ensure the physical (tinana), psychological (hinengaro), spiritual (wairua) and family (wairua) wellbeing for all people is upheld.**



| TOOL | WHERE TO ACCESS |
|---|---|
| 1. Identifying the dying person - Flowchart | Information Pack<br>In hospital: Via Nettie<br>Map of medicine |
| 2. Symptom Management Algorithms<br>Hawkes Bay Algorithms | Information Pack<br>In-hospital – via Nettie<br>General practice – via HHB website<br>Aged Residential care - Information Pack<br>Map of medicine |
| 3. Hospital Discharge checklist | In-hospital – via Nettie<br>General practice – via HHB website<br>Aged Residential care - Information Pack<br>Map of medicine |
| 4. W.H.Ā.N.A.U: personalising care | Information Pack<br>In-hospital – via Nettie<br>General practice – via HHB website<br>Aged Residential care - Information Pack<br>Map of medicine |
| 5. Spiritual care assessment tool (FICA) | Information Pack<br>In-hospital – via Nettie<br>General practice – via HHB website<br>Aged Residential care - Information Pack<br>Map of medicine |
| 6. Breaking bad news flow chart (SPIKES) | Information Pack<br>In-hospital – via Nettie<br>General practice – via HHB website<br>Aged Residential care - Information Pack<br>Map of medicine |
| 7. List of cultural support | Access organisations own resources |

| BROCHURES AVAILABLE | WHERE TO ACCESS |
|---|---|
| What to expect when someone is dying<br>- information for family/whanau | For supplies of brochure contact :<br>?? Cranford Hospice<br>Telephone 06 8787047 |
| Tissue Donation<br>- information for persons and family/ whānau | For supplies of brochure contact:<br>Donor Co-Ordinator<br>Organ Donation of New Zealand<br>Ph 09 630 0935 |
| What to do after death, grief and bereavement support<br>- practical information for family/ whānau | For supplies of brochure contact:<br>Funeral Directors Association of NZ (Inc)<br>P O Box 10888 Wellington 6143<br>Email: info@fdanz.org.nz<br>Website: www.funeralsnewzealand co.nz |

OURHEALTH HAWKE'S BAY
Whakawāteatia

# BREAKING BAD NEWS FLOWCHART

BREAKING BAD NEWS FLOWCHART

## PREPARATION

Check the person's notes to assess what has already been discussed *(don't assume prior discussions have been remembered or understood)*
Check who should be present e.g. family, other health professionals
**Set time aside with no distractions e.g. pager, mobile phone**
Set the scene and ensure privacy

## WHAT DOES THE PERSON KNOW?

It would help me to know what you understand about your illness, how did it all start, what is happening now?
*(this is about gaining the person's level of understanding and engagement, ACP and EPOA)*

## IS MORE INFORMATION WANTED?

"Would you like me to give you more details about your illness?"

## GIVE AN ALERT!.... AND…….PAUSE!

"I am afraid that it looks more serious than we hoped"

## ALLOW PERSON TO REFUSE INFORMATION AT THIS TIME

"It must be difficult to accept this?" *(Determine how much they want to know at this time)*

## GIVE EXPLANATION (IF REQUESTED)

A narrative of events may be helpful

## ELICIT AND LISTEN TO ANY CONCERNS

"What are the main things that you are worried about?" *(Reassure that support is paramount)*

## SUMMARISE AND PLAN

"Your main concerns at the moment seem to be…."

## OFFER AVAILABILITY AND SUPPORT

Offer follow up discussion, e.g. social work referral, church minister, chaplain, cultural support services

## COMMUNICATE WITH MULTIDISCIPLINARY TEAM AND DOCUMENT

Clearly document conversation in clinical notes and who was present at this discussion

OURHEALTH HAWKE'S BAY Whakawāteatia

# ADAPTATION OF SPIKES*



| | | |
|---|---|---|
| **S** | **SETTING** up the discussion | • read notes/test results<br>• check who should be present ; involve significant others; is a translator needed?<br>• arrange privacy; think of tissues/water<br>• set time aside with no distractions e.g.pager<br>• mentally prepare self how news will be shared and how to respond to reaction<br>• sit down and make a connection with person/family/whanau |
| **P** | Assessing the **PERCEPTION** of condition/ seriousness | • use open ended questions to gather how person perceives the situation e.g. What have you been told so far?<br>• listen to their level of comprehension, accept denial but do not confront at this stage; this can correct any misinformation and tailor breaking news to what they already understand |
| **I** | **INVITATION** from person to give information | • how much do they want to know "Are you the sort of person who likes to know everything?"<br>• accept the person's rights not to know -"Would you like me to give you all the information or sketch out what has happened and spend more time discussing the treatment plan?" |
| **K** | **KNOWLEDGE:** giving facts and information to person | • warning the person that bad news is coming lessens the shock and can facilitate information processing "I'm sorry to tell you that…" "The results are not as good as we hoped"<br>• use language intelligible to person; use diagrams if helpful<br>• consider their emotional state<br>• give information in small chunks; avoid jargon and acronyms<br>• Avoid excessive bluntness and avoid "There is nothing more we can do" as this maybe inconsistent with their own goals such as good pain relief and control |
| **E** | **EXPLORE** emotions and empathize | • observe and identify emotions expressed by person "You appear sad" "I can see how upsetting this is for you"<br>• what strategies/mechanisms have they used in the past to deal with bad news?<br>• do they have a particular outlook on life/cultural/spirituality that helps<br>• who are the important people in their life |
| **S** | **STRATEGY & SUMMARY** | • draw up plan with person "Your appointment to see Mrs Brown the oncologist is on…" "You are going to contact the funeral director…"<br>• consider immediate plans – what are you doing next; who will you tell/ how will you tell them; how will they cope?<br>• have person repeat key points to ensure that they have understanding<br>• does anything need to be clarified or any other questions?<br>• by understanding person's goals, hope can be fostered to help them accomplish their goals<br>• offer other professional support e.g. Chaplain, cultural support, social work referral, funeral director<br>• document/communicate discussion/plan with other professionals that need to know<br>• close the meeting |


- Baile WF, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP. SPIKES-A six-step protocol for delivering bad news: application to the person with cancer. Oncologist 2000;5(4):302-311.
- Kayleigh Steel, Michael Kennedy, Sean Prendergast, Christina Newton, Andrew MacGillivray and Aileen D'Arcy
- www.physio-pedia.com/File:SPIKES_Table.jpg

OURHEALTH HAWKE'S BAY
Whakawāteatia

*Fill in only if person label is unavailable*

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

.....

# DISCHARGE CHECKLIST FOR A PERSON IN THEIR LAST DAYS OF LIFE

| CHECKLIST | YES | NO | N/A | SIGNED | DATE | COMMENT |
|---|---|---|---|---|---|---|
| Does the person have a preferred place of care | | | | | | |
| Person/family are aware of prognosis | | | | | | |
| Person's main nominated contact supports decision for discharge | | | | | | |
| Not for Resuscitation complete | | | | | | |
| Ambulance booked – aware of Not for Resuscitation | | | | | | |
| GP or nominated other aware of discharge and arrangements made for GP to visit. | | | | | | |
| Hospice is aware of discharge | | | | | | |
| District Nurse updated of care needs and discharge date and time (inclusive of Rural/CHB and Wairoa) | | | | | | |
| Aged Residential Care updated of care needs and discharge date and time | | | | | | |
| Assessment completed by Needs Assessment Co-Ordination Agency (Options HB) and individual care package in place | | | | | | |
| Other MDT members aware e.g. social worker, OT, physio | | | | | | |
| Current medication assessed and non essential medication discontinued | | | | | | |
| Discharge medication/s ordered:<br><br>Appropriate subcutaneous AND anticipatory medication prescribed and faxed to pharmacy. | | | | | | |
| If person is being discharged with a continuous infusion pump. Complete appropriate Discharge Checklist. | | | | | | |
| Person/family understand the discharge medication | | | | | | |
| Equipment delivered/planned e.g. electric bed, mattress, | | | | | | |
| Oxygen arranged if applicable. | | | | | | |
| Circle of Support has been completed and documented who is the first point of contact. | | | | | | |

DISCHARGE CHECKLIST FOR A PERSON IN THEIR LAST DAYS OF LIFE

12.2

OURHEALTH HAWKE'S BAY
Whakawāteatia

# W.H.A.N.A.U: PERSONALISING CARE AT END-OF-LIFE

**This has been designed as a prompt card providing potential conversation starter questions to guide conversations about end of life. The background image of Te Whare Tapa Whā (Durie 1985) reminds of the need for a holistic approach to care and W.H.A.N.A.U. guides conversations to ensure that care for people can be personalised.**

## 'W.H.Ā.N.A.U' - PERSONALISING CARE AT END-OF-LIFE

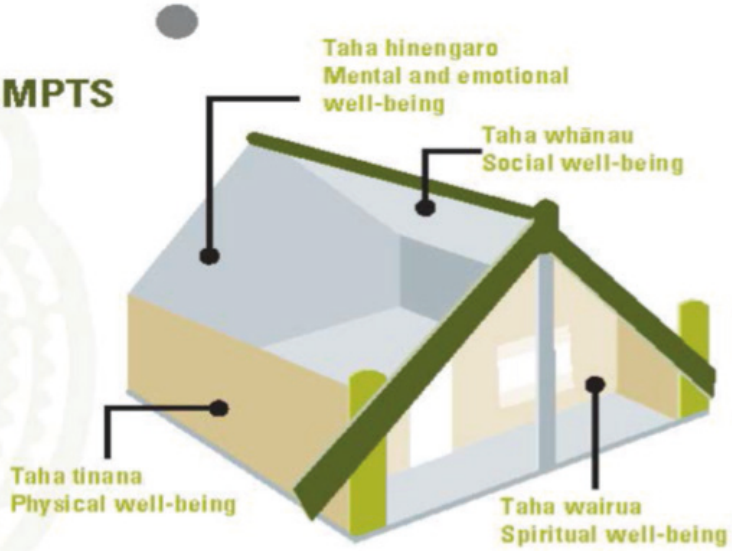
- ✓ **WHO TO ASK?** It may be better to talk with a whānau spokesperson, or with the whānau or family all together
- ✓ **HAVE** *time* and *space* to talk and *offer* thinking time
- ✓ **ASK** - don't assume what's important to you is the same for others
- ✓ **NEED** others to join these conversations? – friends, whānau
- ✓ **AGAIN** - people's needs change, so ask again
- ✓ **UNCOMFORTABLE** asking or responding to these questions? Ask for help – colleagues, chaplains, cultural advisors

## SOME USEFUL PROMPTS

What can we do now to help you and those people important to you to feel safe and comfortable?

Do you have beliefs and family traditions that are especially important to you?

What are the important things about you and your whānau that we need to know right now?




Source: Batten et al (2014)

12.2

OURHEALTH HAWKE'S BAY
Whakawāteatia

# SPIRITUAL CARE ASSESSMENT TOOL BASED ON FICA APPROACH

## BACKGROUND

The FICA Spiritual History Tool was developed by Dr Puchalski and a group of primary care physicians to help physicians and other healthcare professionals address spiritual issues with persons. Spiritual histories are taken as part of the regular history during an annual exam or new person visit, but can also be taken as part of follow-up visits, as appropriate. The FICA tool serves as a guide for conversations in the clinical setting.

## SUGGESTED QUESTIONS

These should be adapted to suit each person and revisited as person circumstances change.

| | |
|---|---|
| **Faith** | What things do you believe in that give meaning/value to your life?<br>**and/or:** Do you consider yourself spiritual or religious? **and/or:**<br>**and/or:** What is your faith or belief? |
| **Importance** | In what ways are they important to your life?<br>**and/or:** What influences do they have on how you take care of yourself? |
| **Influence** | **and/or:** How are your beliefs/values influencing your behaviour during your illness?<br>**and/or:** In what ways do your beliefs/values help you in regaining your health/ wellbeing? |
| **Community** | Is there a person or group of people who you love or who are very important to you?<br>**and/or:** How is this supportive to you?<br>**and/or:** Do you belong to a religious/cultural community? |
| **Address** | Is there anything we can do to help you while you are with us?<br>**and/or:** Would it help to talk to someone about these issues? |

**An example of a spiritual assessment in a non-religious person**

| | |
|---|---|
| **F** | Naturalist |
| **I** | Feels at one with nature. Each morning she sits on her patio looking out over the trees in the woods and feels 'centered and with purpose" |
| **C** | Close friends who share her values |
| **A** | After discussion about belief, she will try to meditate, focusing on nature, on a daily basis to increase her peacefulness |

**You can refer to the faith leader or Chaplaincy Department at any time, but some specific situations may include:**

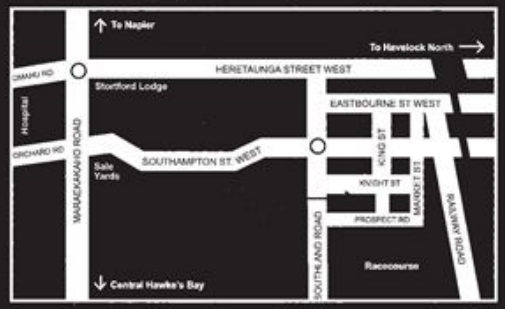
- When one's own belief system prohibits involvement in the spiritual/religious/cultural care of the person
- When spiritual or religious/cultural issues seem particularly significant in the person's suffering
- When spiritual or religious/cultural beliefs or values seem to be particularly helpful or supportive for the person
- When spiritual or religious/cultural beliefs or values seem to be particularly unhelpful for the person
- When addressing the spiritual or religious/cultural needs of a person exceeds your comfort level
- When specific community spiritual or religious/cultural resources are needed
- When you suspect spiritual or religious/cultural issues which the person denies
- When the person or family have specific religious needs e.g. Confession, Holy Communion, Sacrament of the Sick, needs a prayer mat or private space to pray, sacred texts, etc
- When the person's family seem to be experiencing spiritual/emotional pain or trauma
- When members of staff seem to be in need of support.

Source: Puchalski and Larson (1998)

SPIRITUAL CARE ASSESSMENT TOOL BASED ON FICA APPROACH

12.2

"You may want a friend, someone from your family or whānau or a minister to be with you now."




# WHAT TO EXPECT WHEN SOMEONE IS DYING

## What to do when your loved one dies

You don't have to do anything straight away. There's no need to call the police or an ambulance. You will need to call the hospice nurse or your GP at some stage to tell them your loved one has died. A doctor will need to prepare a death certificate. If death occurs at night and you are comfortable being at home with your loved one, make these calls in the morning – usually after 7am.

Your loved one's body can stay at home for several hours for relatives and friends to visit and pay their respects. Phone the hospice nurse if you need help at this time. If not, you'll need to lie your loved one on their back. Cover them only with a light sheet. Make sure electric blankets and heaters are off and the room is cool. You may want a friend, someone from your family or whānau or a minister to be with you now.

## Cranford Hospice 24 hour contact number 06 878 7047

300 Knight Street
Hastings 4122

**P** 06 878 7047
**F** 06 878 3799
**E** reception@cranfordhospice.org.nz
**W** cranfordhospice.org.nz

Cranford hospice hawke's bay

*A Service of:* Presbyterian Support East Coast

This brochure describes some of the typical features of the process of dying. It may help to reduce anxiety about the unknown.

The dying process is unique to each person, but in most cases there are common characteristics or changes that help to indicate that a person is imminently dying.

Death usually comes gradually and peacefully, and there are many changes that signal life is coming to an end. Most that occur at this time are normal and don't need any special treatment, hospitalisation, or professional help.

If you are unsure about anything, please call Cranford Hospice or the health professional supporting you at this time.

## Here are some of the changes that may occur when someone is dying:

### Not eating or drinking

As people get closer to dying, the body does not need fluid to function. Your loved one is likely to lose interest in food and drink to the point that they're not eating or drinking anything at all. They may have lost the ability to swallow, so don't try to give them drinks at this stage because liquid will only pool at the back of their throat. Moistening the mouth with ice chips or a wet cloth may be all that is needed.

### Increased confusion and restlessness

It is common for dying people to be quite restless or agitated in the last 24 to 48 hours before they die. Try to reassure them by talking calmly and telling them who you are. Don't make sudden noises or startle them. Constant touching or stroking may be disturbing, try gently holding their hand. Playing their favourite music may help to calm them.

### Breathing

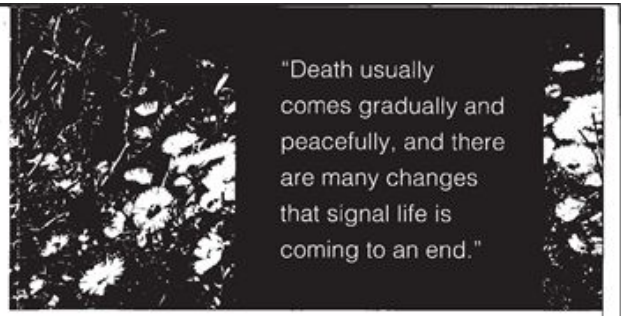
As your loved one finds it harder to swallow, saliva and secretions may collect at the back of their throat and make a noise when they breathe – it's sometimes called the 'death rattle'. This isn't distressing for them, but it might be to you. Raising the head of the bed with pillows may help.

As death approaches, you'll notice your loved one's breathing pattern changes. There may be gaps of seconds or minutes between breaths. When the gaps between breaths get longer and longer, it's a sign that death is close.

Sometimes when a person is taking their last breaths, they may seem to grimace. This isn't because they're uncomfortable, it's just the muscles in the upper part of their body and face contracting and relaxing.

### Changing colour

As blood circulates more slowly, your loved one's arms and legs will start to feel cool and may look patchy/mottled and dark. Their face may be pale and pinched, their nose may feel cold and the beds of their fingernails and toenails may turn blue. You may notice their skin is clammy and marks easily where they're touched. There's no need to put on



"Death usually comes gradually and peacefully, and there are many changes that signal life is coming to an end."

a lot of extra bedding or an electric blanket – this might just make them restless. Depending on the weather, a sheet and a few warm blankets should be enough.

### Incontinence

Sometimes there is a loss of control of bowels or bladder. It will be important to discuss this with your nurse in order to get appropriate supplies.

## How to tell if your loved one has died:

- Their breathing stops
- Their chest stops moving up and down
- They will have no heartbeat or pulse
- They don't respond when you shake them or talk loudly
- Their eyes are fixed and their pupils are dilated – sometimes their eyelids stay open
- Their jaw relaxes – sometimes their mouth stays open
- They may have lost control of bladder or bowels

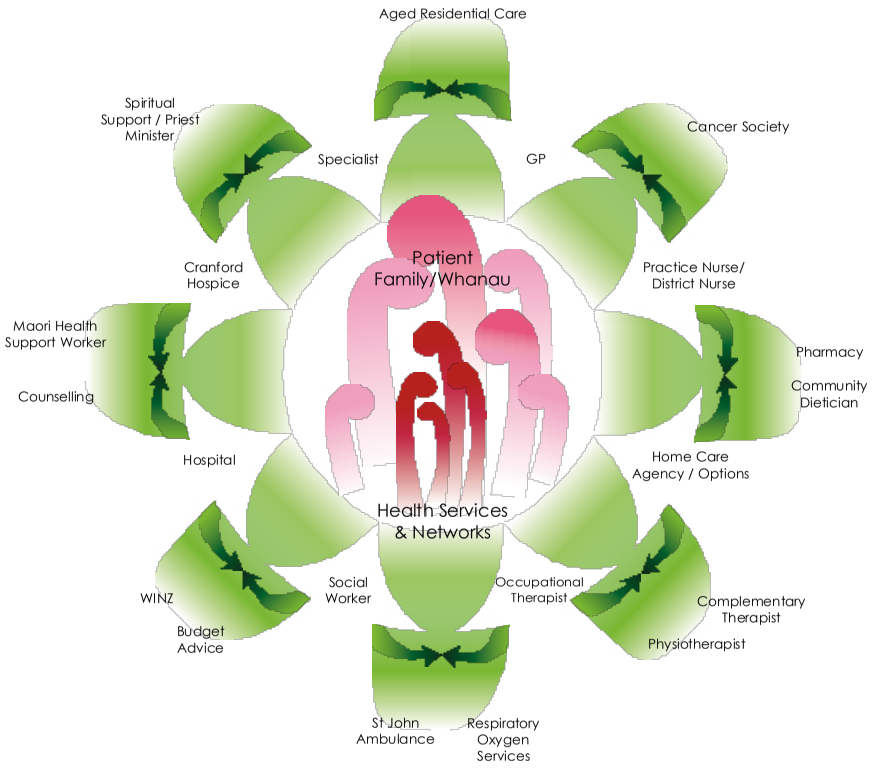
## Appointments

## Notes

‘Palliative care is a sacred encounter for any culture’

# Palliative Circle of Support

For Hawkes Bay




Referral into

## Partnership of Care Services

Acknowledgement: This resource was produced in Wairoa by Gae Redshaw RN- Hawkes Bay District Health Board





| Important Contact People: | Phone Numbers: |
|---|---|
| GP Practice | |
| Doctor | |
| Practice Nurse | |
| Hospital / Acute Ward | |
| District Nurse | |
| Pharmacy | |
| Cranford Hospice | |
| Nurse / Kaitakawaenga | |
| Social Worker | |
| Maori Health Provider | |
| Cancer Society Support Care | |
| Spiritual Support | |
| Occupational Therapist | |
| Home Care Agency | |
| Care Person | |
| Physiotherapist | |
| Ambulance<br>*(Are you a member of St Johns Ambulance?)* | |
| Other | |
| | |
| | |

***(Keep this information inside your diary)***

12.2