



Hawke's Bay Health Consumer Council Meeting

Date: Thursday, 13 October 2016

Meeting: 4.00 pm to 6.00 pm

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

Council Members:

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

Apologies: Jim Morunga, Tessa Robin

In attendance:

Kate Coley, Director Quality Improvement and Patient Safety
Ken Foote, Company Secretary
Tracy Fricker, Council Administrator and EA to DQIPS
Jeanette Rendle, Consumer Engagement Manager
Nicola Ehau, Acting CEO 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 – For Discussion	
9.	Draft - Palliative Care in HB 2016-2026 – Mary Wills	4.30
10.	Working together for Tamariki in Hawke's Bay – Russell Wills	4.55
11.	Quality Dashboard – Kate Coley	5.20
12.	Draft Consumer Council Annual Plan 2016/17	5.35
	Section 3 – Presentation	
	Section 4 – General Business	
13.	Topics of Interest - Member Issues / Updates	5.45
14.	Karakia Whakamutunga (Closing)	

NEXT MEETING: - note date change to Wednesday 9 November 2016

Extended meeting likely to join with Clinical Council

Venue: HBDHB Education Centre, Canning Road, near ED

Tauwhiro Rāranga te tira He kauanuanu Ākina

Interest Register**Hawke's Bay Health Consumer Council**

Oct-16

Name Consumer Council Member	Interest eg Organisation / Close Family Member	Nature of Interest eg Role / Relationship	Core Business Key Activity of Interest	Conflict of Interest Yes / No	If Yes, Nature of Conflict: - Real, potential, perceived - Pecuniary / Personal - Describe relationship of Interest to
Graeme Norton	3R Group Limited	Director/Shareholder	Product Stewardship	No	Group is sponsored by HBDHB Could be a perceived conflict, however will not take part in any discussions relating to any contract matters if these arise.
	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	
	Advancing life cycle management thinking across NZ	Chair, Advisory Group	Advancing life cycle management thinking across NZ	No	
	U Turn Trust	Trustee	Relationship and and may be contractual from time to time	Yes	
	Integrated Pharmacist Services in the Community (National Committee)	Steering Group Member	Health and wellbeing	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	If contracted for service, there could be a perceived conflict of interest. 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.
	Simplistic Advanced Solutions Ltd	Shareholder / Director	Information Communications Technology services.	Yes	
	Wairoa Wireless Communications Ltd	Director/Owner	Wireless Internet Service Provider	Yes	
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.

HB Health Consumer Council 13 October 2016 - Interest Register

Name Consumer Council Member	Interest eg Organisation / Close Family Member	Nature of Interest eg Role / Relationship	Core Business Key Activity of Interest	Conflict of Interest Yes / No	If Yes, Nature of Conflict: - Real, potential, perceived - Pecuniary / Personal - Describe relationship of Interest to
	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 Sport Hawke's Bay Scott Foundation HB Medical Research Foundation Inc	Elected Councillor Board of Trustees Allocation Committee Hastings District Council Rep	Non paid role	No No No 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				
Sami McIntosh	Eastern Institute of Technology	Student Nurse	Practical placements	No	Perceived potential if applying for work.

**MINUTES OF THE HAWKE'S BAY HEALTH CONSUMER COUNCIL MEETING
HELD IN THE TE WAIORA MEETING ROOM, HBDHB CORPORATE OFFICE
ON 15 SEPTEMBER 2016 AT 4.00 PM**

PUBLIC

Present: Graeme Norton (Chair)
Rosemary Marriott
Malcolm Dixon
Jenny Peters
Nicki Lishman
Tessa Robin
Jim Morunga
James Henry
Terry Kingston
Leona Karauria
Rachel Ritchie
Olive Tanielu
Sarah Hansen
Sami McIntosh

In Attendance: Ken Foote, Company Secretary
Jeanette Rendle, Consumer Engagement Manager
Tracy Fricker, EA to Director QIPS and Council Administrator

Apology: Heather Robertson

SECTION 1: ROUTINE

1. KARAKIA TIMATANGA (OPENING) / REFLECTION

The Chair welcomed everyone to the meeting and expressed sympathy on the passing of Terry Kingston's wife. He welcomed Sami McIntosh to the meeting and round table introductions followed. Sami thanked everyone for their welcome and gave a brief introduction of her background.

2. APOLOGIES

The apology as above was noted.

3. INTERESTS REGISTER

No new interests registered. No conflicts of interest for items on today's agenda.

Sami McIntosh will provide her interests to be recorded on the register.

Action: *Record interests for new member when received.*

4. PREVIOUS MINUTES

The minutes of the Hawke's Bay Health Consumer Council meeting held on 11 August 2016 were confirmed as a correct record of the meeting.

Moved and carried.

MATTERS ARISING AND ACTIONS

Item 1: **Refine Consumer Portfolios 2016/17**

To be discussed under item #14 Action Plan 2016/17.

Item 2: **Interests Register**

Changes for Lenora Karauira actioned. *Item can be closed.*

Item 3: **Te Ara Whakawaiaora / Mental Health**

The Maori Relationship Board and Clinical Council are also wanting to discuss the mental health topic. There may be an opportunity for discussion at the combined quarterly meeting with the Clinical Council in November.

5. WORK PLAN

The work plan is included in the papers. The October meeting does not look too bad. Discussions are being had about the joint meeting in November and items for that agenda. Following the discussions previously held around the transform and sustain refresh and the 6 key issues, investing in staff and changing culture is one of the issues and we may need to have practical contribution to. If we want to transition to a Person and Whanau Centred Care Culture, then staff need to be invested to change the culture and we need to join those two together. We need to ask, as consumers, what education do we think should take place to get us to a culture which is person and whanau centred?

6. CHAIR'S UPDATE

The Chair advised that the first meeting of the National Collective of Consumer Councils is being held in Auckland on 29 September, he and Jeanette Rendle will be attending. There are 12 DHBs involved in the meeting, four that have consumer councils in place and others are on the journey towards this. He will provide feedback on the meeting in October.

The Manage My Health system was discussed at the Clinical Council yesterday. It is being used as a portal to enable District Nursing to share and update the patient health record within MedTech. There is a pilot currently underway in two practices in Napier. Following the HealthOne presentation last year, he is concerned that we might start down a path of reinventing the wheel. HealthOne is being used in the South Island and will be available for other DHBs next year, whether this is taken up by other DHBs is for them to decide. What is coming is a national platform for a shared record. Some concern was raised from member experience that the information on the Manage My Health system needs to be managed by the GP or specialist and cannot be accessed by the patient first; when this happens it can cause unnecessary anxiety for patients.

7. CONSUMER ENGAGEMENT MANAGER'S UPDATE

Jeanette Rendle, Consumer Engagement Manager advised that she recently had a telephone call from Davanti who are looking for some solutions for the organisation regarding our telephone services and how consumers would prefer, in the future to interact and communicate with the DHB.

Feedback:

- Getting information electronically via email
- Electronic would be great. Day Surgery and the Villas telephone patients regarding appointments, but this does not always work
- Have a question in the contact form, what is your preferred method for communication
- We need a system which enables us to communicate in multiple ways
- Like the idea of Manage My Health, it is self-empowering

- Would like to have a more personal touch and speak to a person rather than a message with options to choose from

Any further feedback email by 21 September jeanette.rendle@hbdhb.govt.nz

SECTION 2: FOR DECISION

8. QUALITY ACCOUNTS

The Chair commented that we have seen the Quality Accounts on a couple of occasions now for feedback. Jeanette Rendle advised that we have a communication plan developed using social media, posters, information in the newspapers etc. We are trying to spread the messages as wide as we can through different means.

Members felt overall that it is a great improvement on last year and they are getting better each time and more consumer orientated.

Recommendations in paper approved. Quality Accounts and the Communication Plan endorsed by the Consumer Council.

SECTION 3: DISCUSSION

9. GASTRO OUTBREAK HAVELOCK NORTH

Ken Foote, Company Secretary advised that the presentation summarises the health aspects of the gastro outbreak, how it unfolded and how we responded. It was used by the CEO at the public meetings held.

We are now in recovery phase. The Public Health Unit are still looking at surveillance and getting the epidemiology data and working with the Hastings District Council to ascertain the source. A lot of reviews and debriefs are underway with stakeholders. It is the biggest water borne disease outbreak in New Zealand history and we want to take learnings from the event.

There have been two public meetings in Havelock North. The focus of those meetings was the Hastings District Council and Hawke's Bay Regional Council on the issue was on the water itself. We are interested in feedback regarding health response that we provided to the community. The question we have for the Consumer Council is how do you think we should engage with the community on getting feedback on how the outbreak was dealt with?

Feedback:

- When there is more information available would be the right time for further public meetings
- Issue with how it was communicated with in the wider community, not just Havelock North
- Appreciated that the Hastings District Council and DHB put information on their websites – this was seen as a trusted source
- There weren't enough public meetings, this was an extreme case. They should have gone to rugby clubs or other different environments, and don't be afraid to use old fashion methods of publicity
- Admiration for the care in the hospital, ED and the wards. Protocols were in place and done brilliantly. The DHB handled the situation magnificently
- Newspapers, radio communication
- The collaboration between health and the Hastings District Council was great.

There will be an internal review regarding the health response as well as the Government Inquiry. The Consumer Council will be provided with these reports when they are available.

Recommendation by the Consumer Council that we need to do more debriefing in the community when new information is available.

SECTION 4: FOR INFORMATION ONLY

10. HEALTH & SOCIAL CARE NETWORKS

Report provided for information only.

The Chair provided an update on feedback from the Maori Relationship Board and the Clinical Council that this needed to be bottom up and from the community and they are not sure that this is working like this in Wairoa and Central Hawke's Bay. Tracee Te Huia, General Manager Maori Health Service has taken over as sponsor for this piece of work. She is developing a paper for the Executive Management Team (EMT) to set the boundaries for this work. Unless this is owned by the community it is just another version of what service providers think it should look like. The Maori Relationship Board and the Clinical Council are both looking at this from a strong consumer perspective.

11. TE ARA WHAKAWAIORA – HEALTHY WEIGHT STRATEGY

Report provided for information only. No issues discussed.

SECTION 5: CONSUMER COUNCIL PLANNING 2016-17

12. QUALITY IMPORVEMENT AND PATIENT SAFETY PLAN

The first draft of the plan is included in the papers for information and can be included in the discussion under item #13 below.

13. CONSUMER COUNCIL ANNUAL PLAN FOR 2016/17

Ken Foote, Company Secretary facilitated a session asking the Consumer Council what they wanted to focus on for the 2016/17 year. What do they want to drive? Discussion held on the items identified below:

Consumer Voice

- Health & Social Care Networks (Wairoa and CHB)
- Integration
- Youth
- Older Persons
- Mental Health

Quality & Safety

- Health Literacy
- Person and Whanau Cantered Care
- Staff Culture
- Disability issues
- Patient experience

Consumer Engagement

- Customer focused booking
- Consumer engagement strategy – database, register, youth
- Liaison – MRB and Clinical Council (Graeme Norton)
- Technology

Everything interlinks and is important, need to be grouped more so they are not looked at separately.

Action: *Graeme Norton and Ken Foote to meet and draft the plan, to be emailed to the Consumer Group for feedback prior to the next meeting.*

SECTION 6: GENERAL BUSINESS

14. TOPICS OF INTEREST – MEMBER ISSUES / UPDATES

- **Rosemary Marriott** - had a conversation with Anna Kirk, Communications Manager about the Health Awards as they appeared to have been split into two categories NGO/PHO and DHB. There will still only be one award for each category but there are two ways of applying for it either via the NGO/PHO or DHB. The other change is that people have to get the permission of their executive team to put in an application for the health awards, so the DHB ones have to be vetted by EMT on the grounds that some of the things put forward in the past were trivial and the judges hadn't realised this and they had received awards. The objective is for quality control and to increase the number of entries.
- **Tessa Robin** – concerned expressed with the decision by the Ministry regarding raising the age of cervical screening to 25 years, particularly for our Maori and Pacific communities. The Chair advised he will confer with Clinical Council colleagues about this. Nothing has come to Clinical Council or Board about this yet.
- **Jim Morunga** - apology for October meeting.

15. KARAKIA WHAKAMUTUNGA (CLOSING)

The meeting closed at 6.10 pm.

Confirmed: _____
Chair

Date: _____

HAWKE'S BAY HEALTH CONSUMER COUNCIL

Matters Arising
Reviews of Actions

5

Action	Date Issue first Entered	Action to be Taken	By Whom	By When	Status
1	10/03/16	<i>Refine Consumer Portfolios 2016/17</i> To be discussed as part of work under Consumer Council Annual Plan for 2016/17.	Ken / Graeme		Item 10 on agenda
2	11/08/16	<i>Te Ara Whakawaiora / Mental Health</i> To be included on agenda for joint meeting with Clinical Council in November	Graeme	November	Noted on workplan
3	15/09/16	<i>Interests Register</i> Interests to be recorded for Sami McIntosh when received.	Admin	October	Actioned
4	15/09/16	<i>Consumer Council Annual Plan for 2016/17</i> Meet to draft plan following discussion at September meeting. Circulate for feedback prior to October meeting.	Ken / Graeme	October	Item 10 on agenda



HB HEALTH CONSUMER COUNCIL WORKPLAN 2016-2017

6

Meetings 2016	Papers and Topics	Lead(s)
Wed 9 Nov Joint Mtg	<p>Mental Health topic for joint Clinical/Consumer Meeting in Nov Venue to be confirmed</p> <p>Travel Plan – verbal Event / Complaint / Hazard / Risk Management System Tobacco – Annual Update against the Plan (for noting)** Final – Reducing Alcohol-Related Harm Draft – Family Violence – Strategy Effectiveness Draft - HB Integrated Palliative Care Long Term Conditions (information only) 13-17 Year Old Primary Care Zero Rated Subsidy Project Transform & Sustain Refresh System Level Measures Bariatric Surgery Investigations paper Monitoring Te Ara Whakawaiaora / Smoking (national indicator) ** Annual Maori Plan Q1</p>	<p>Sharon Mason / Allison</p> <p>Sharon Mason / Andrea Kate Coley Caroline McElnay Caroline McElnay Caroline McElnay Mary Wills Leigh White / Jill Garrett Tim Evans / Patrick Tracee TeHuia Carina Burgess Mary Wills</p> <p>Tracee TeHuia Tracee TeHuia</p>
24 Nov	HB Health Awards presentation evening	Venue to be confirmed
8 Dec	<p>Discussion - HB Workforce Plan Health and Social Care Networks Update Orthopaedic Review – Phase 2 Draft</p>	<p>Kate Coley Tracee / Belinda Andy Phillips</p>
January 2017	No Meeting	
9 Feb 17	<p>Orthopaedic Review – phase 3 Draft Finalt - HB Integrated Palliative Care Annual Maori Plan Q2 Te Ara Whakawaiaora / Access</p>	<p>Andy Phillips Mary Wills Tracee TeHuia Mark Peterson</p>
9 Mar 17	<p>Travel Plan Update Te Ara Whakawaiaora / Breastfeeding (National Indicator) Health & Social Care Networks</p>	<p>Sharon / Andrea Nicky Skerman Tracee / Belinda</p>
13 Apr 17	<p>Draft Health Equity Update Draft Youth Health Strategy Draft Suicide Prevention Postevetion Update against 2016 plan Te Ara Whakawaiaora / Cardiology (national indicator)</p>	<p>Caroline McElnay Caroline McElnay Caroline McElnay John Gommans</p>



CHAIR'S UPDATE

Verbal



CONSUMER ENGAGEMENT MANAGER'S UPDATE

Verbal

All people who are dying and their family/whānau who could benefit from palliative care have timely access to quality palliative care services that are culturally appropriate and are provided in a coordinated way

(NZ Palliative Care Strategy 2001)

Palliative Care in Hawke's Bay

Our vision and priorities for
the future 2016 – 2026

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

Executive Summary

*"You matter because you are you, and you matter to the last moment of your life.
We will do all we can, not only to help you die peacefully, but also to live until you die"*

Dame Cicely Saunders

Dying is a normal part of the human experience and affects people regardless of age. Whenever a person dies in Hawke's Bay, there are impacts for their family/whānau, friends, work colleagues and the community in which they live. Many people would prefer to die in their own home, cared for and surrounded by their loved ones. ²⁴ Others will die in hospice, hospital or aged residential care, by choice or by necessity.

The experience of dying, and of caring for loved ones at the end of life, can have a deep and lasting impact on those involved. Poorly supported dying, with inadequate symptom control and failure to meet the needs of those who are dying as well as those who care for them, may lead to a complicated bereavement process for those left behind. In contrast, high quality and well-co-ordinated care at the end of life provides a setting for a healthy experience of death for both family/whānau and surrounding community.

The quality of care provided in the Hawke's Bay region to those at the end of life is everyone's responsibility. Death is not a subject that should be avoided or concealed. It is one of the great certainties of life, and involvement in caring for those people who are dying can, not only strengthen family relationships, encourage compassion and resilience, and promote positive connections in the community, enhance respect for health and life, and reduce community fears about death and dying.

We will extend the ways we receive patient feedback and hear what is important to patients and family/whānau. As the numbers of people needing palliative care grows rapidly over the next 10 years, we will need to be culturally responsive in our practice. This will be supported by shared leadership, working as one team and with agreed priorities for the next 10 years.

We will recruit and train staff in palliative care. This includes sustainable medical staff and replacement of our retiring nursing workforce. Allied health and family support team members will work with primary care to provide a multidisciplinary response for patients with dementia and who are frail. Our focus on education and training will develop the next generation of palliative care practitioners in primary and specialist palliative care.

We will agree how services provide access 24 hours a day 7 days a week. As the national strategies for Health of Older people and Palliative Care are implemented in Hawke's Bay, we will invest in sustainable specialist palliative care services and education and training. This will be supported by technology, shared information across services and using information to inform service improvement.

Our six priorities for the future will improve care for people and their family/whānau. To achieve this requires us to work together as one team to strengthen the foundations on which our vision is built.

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

Our six priorities:

1

Each person and their family/whānau will have their individual needs as the centre of care

2

Each person gets fair access to high quality individualised care

3

Comfort and wellbeing maximised

4

Care is seamless

5

The community is involved

6

People are prepared to care

9

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

Introduction

In today's society, people are increasingly expressing the importance of choice and independence as major components of dignity in advancing illness and old age. Most of us expect to make decisions, not only on how we live our last years, months, weeks and days of life but also on how and where we die. With advances in chronic disease management, single disease approaches for planning end of life will make less sense as functional decline towards end of life could be very hard to predict. This will have wide reaching implications for the co-ordination of care, health and social needs, predictions of future outcomes, referrals and patient, family/whānau experience and choice.

Increasing numbers of people with neurodegenerative conditions like dementia suggests an increasing need for early participation in planning for, and conversation about dying if we are going to be able to provide quality care to those at end of life.

Palliative care is recognised as a speciality that focuses on patient centred care, but as future demands for services increase, more than ever we will need to ensure we continue to place the patient and their family/whānau needs and goals at the centre. Our response to needs will have to be tailored so that we are providing just the right amount of support to empower and enable individuals to achieve their goals and to live their lives until they die. Services will need to ensure that they are providing a culture of enablement alongside our care. This will enable people greater choice, independence and dignity in advancing illness and/or old age.

For Hawke's Bay the level of need for palliative care is hard to predict. There is literature stating that for most people their palliative care needs can be met through good primary palliative care provided by general practitioners, hospitals, aged residential care, district nurses and Māori health providers without the need for direct care provision of specialist palliative care. [18;20](#). Providing palliative care needs to be a core part of everyone's practice.

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

What is palliative care?

Palliative care is the care of people who are dying from active, progressive diseases or other conditions that are not responsive to curative treatment. Palliative care embraces the physical, social, emotional and spiritual elements of wellbeing—tinana, whānau, hinengaro and wairua – and enhances a person's quality of life while they are dying. Palliative care also supports the bereaved family/whānau. ¹³.

The principles of palliative care are that it:

- provides relief from pain and other distressing symptoms
- affirms life and regards dying as a normal process
- intends neither to hasten or postpone death
- integrates the psychological and spiritual aspects of patient care
- offers a support system to help patients live as actively as possible until death
- offers a support system to help the family cope during the patient's illness and in their own bereavement
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated
- will enhance quality of life, and may also positively influence the course of illness
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Palliative care is provided according to an individual's need, and may be suitable whether death is days, weeks, months or occasionally even years away. It may also be suitable sometimes when treatments are being given aimed at extending quality of life.

It should be available wherever the person may be located. It should be provided by all health care professionals, supported where necessary, by specialist palliative care services.

Palliative care should be provided in such a way as to meet the unique needs of people from particular communities or groups. This includes but is not limited to: Māori, children and young people, immigrants, those with intellectual disability, refugees, prisoners, the homeless, those in isolated communities and lesbian, gay, transgender and intersex people. ¹⁶.

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

Palliative care will be delivered by both primary palliative care and specialist palliative care providers working together as one team.

Primary palliative care (PPC) refers to care provided by general practices, Māori health providers, allied health teams, district nurses, aged residential care staff, general hospital ward staff as well as disease specific teams e.g. oncology, respiratory, renal and cardiac teams. The care provided is an integral part of usual clinical practice. Primary palliative care providers assess and refer people to specialist palliative care services when the needs of the person exceed the capability of the primary palliative care provider.^{7.}

Specialist palliative care (SPC) is palliative care provided by those who have undergone specific training or accreditation in palliative care/medicine, working in the context of a multidisciplinary team of palliative care health professionals.

Specialist palliative care may be provided by hospice or hospital based palliative care services where people have access to at least medical and nursing palliative care specialists.

Specialist palliative care is delivered in two key ways:

- Directly – direct management and support of the person and family/ whānau where more complex palliative care needs exceed the physical, spiritual or social resources of the primary provider. SPC involvement with any person and the family/ whānau can be continuous or episodic depending on the changing need.
- Indirectly – to provide advice, support, education and training for other health professionals and volunteers to support the primary provision of palliative care.

Future need

Like all of New Zealand, and the World, the increasing numbers of people dying and the changing patterns of illness means the number of people who could benefit from a palliative approach to care is increasing. We will need to manage resources and ensure that we have the right people equipped to care and support the needs of those with a life limiting condition.

Evidence is showing us that in the next 20 years we will have more people dying. They will be living with and dying from not only malignant conditions such as cancer, but chronic conditions and multiple comorbidities, including dementia. Their longevity will be frequently compromised by fragility and disability.^{10.}

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

For New Zealand the estimates are:

- Projected deaths will increase by almost 50 percent (from 30,000 to 45,000 per annum in 2038).
- Deaths will reach 55,500 per annum by 2068. This is the result of people living longer than before, coupled with an absolute increase in numbers due to the “baby boom” generation (born between 1946 – 1965) entering their older years.
- There will be rapid ageing of those deaths. In 20 years over half of the deaths will be in the age group 85 years and older. Deaths at the oldest ages will be predominantly women.
- Over the last decade deaths from circulatory system conditions have been declining and deaths from other conditions, including respiratory conditions, dementia and frailty, have been proportionally increasing.

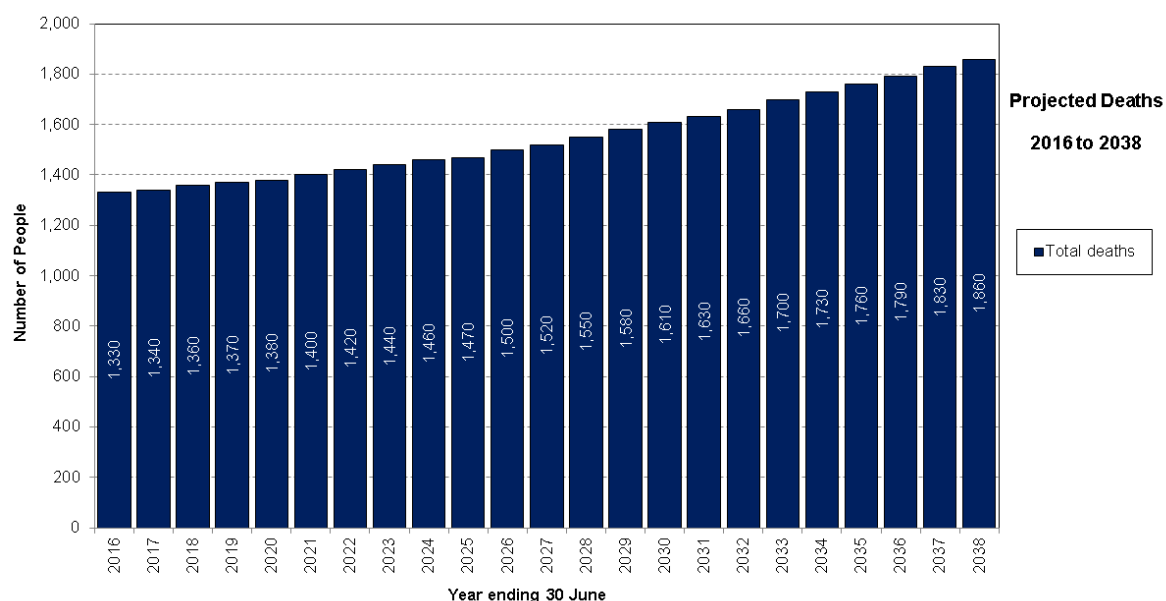
For Hawke's Bay our data is showing us:

- The number of deaths per year will increase by over 500 people. From 1,330 predicted for 2016 to 1,860 by 2038. See graph 1.
- People in the 84-94 age group will more than double from 420 in 2016 to 870 by 2038. See graph 2.
- We will also see an increase in the 95 years and over age group with increases from 100 in 2016 to 200 by 2038.
- The number of Māori and Pasifika people dying will increase and whilst the numbers are relatively small per annum, the increased incidence of poverty plus barriers to access caused by cultural differences and lack of resources means that they are likely to require more support to achieve equitable outcomes.
- The estimated number of people dying who are likely to benefit from palliative care services is 822 in 2015 rising to 927 in 2025.
- The Hospice NZ Palliative Care Demand Model suggests that Cranford Hospice could possibly have been involved with 822 deaths in 2015 based on population data. They were actually involved in 663 deaths. There may be an unmet need of approximately 160 patients currently per annum.

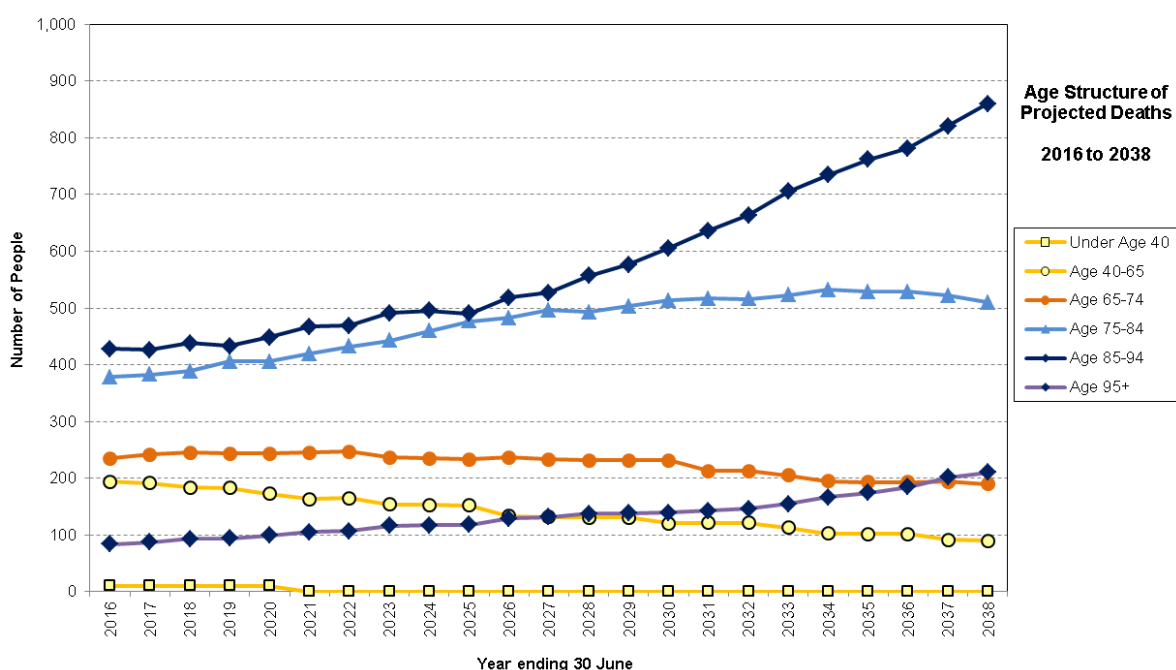
Uptake of specialist and primary palliative care services by Māori (15.8%) and Pasifika (1.1%) was in line with their younger population profiles in 2014. However, it is not known whether the experiences of those groups is equitable, or whether they receive similar number of contacts per person as other non-Māori, non-Pasifika people.

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

Graph 1 : Number of projected deaths in Hawke's Bay 2016 to 2038



Graph 2 : Estimated change in age of death in Hawke's Bay from 2016 to 2038



Acknowledgement: This document was developed using the National Palliative and End of Life Care Partnership. Ambitions for Palliative and End of Life Care; A national framework for local action 2015-2020. www.endoflifeambitions.org.uk.

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

Foundations on which our vision is built

“All people who are dying and their family/whānau who could benefit from palliative care have timely access to quality palliative care services that are culturally appropriate and are provided in a coordinated way”¹³.

To realise our vision we have identified eight foundations that need to be in place to meet our commitments to palliative care in Hawke's Bay. They are necessary for each and underpin the whole. These foundations are prerequisites for success in providing quality palliative care to our community now and into the future.



1. Patient, Whānau and Community Voice

Systems for palliative care are best designed in collaboration with people who have had personal experience of death, dying and bereavement. We need to ensure that we are listening to the voices of patients, family/whānau, carers and communities in all that we do.³ We need to engage communities in their own care design and how health services are delivered. Patients and whānau have told us they need better information so they are aware of support and can access it when they need it.²¹

2. Cultural responsiveness

We will provide culturally responsive care that is mindful of the beliefs and values of patients, family/whānau. This will include considering how to provide palliative care for the growing numbers of Māori and Pasifika who will need these services. Whānaungatanga, kanohi ki te kanohi, wairuatanga, and the availability of Māori kaitakawaenga are all important for effective communication with Māori patients and their family/whānau. ¹¹.

3. Education and Training

To have palliative care as everybody's business there is a large education programme that needs to be implemented. We will need to educate patients, family/whānau, carers and primary palliative care providers in palliative care. With increasing demands on time we will need to look at a range of methods to teach appropriate knowledge and skills in end of life care. They include face-to-face, e-learning, simulation, reflective learning, health promotion, telemedicine, case studies, death reviews, mentoring and supervised clinical practice. We also need to look at ways to educate and train our informal workforce, unpaid volunteers and carers so they too are well equipped to provide hands on care and support. We will need to understand death and dying and advance care planning.

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For PPC providers core elements will include:

- Identifying patients who need palliative care
- Breaking bad news
- Conversations with patients and their family/ whānau around advance care planning
- Providing care according to patient and family/whanau needs
- Basic symptom management
- Psychosocial support
- Knowledge of when to refer to specialist palliative care

These should be routine aspects of care delivered by any PPC health practitioner.

With a greater focus on primary palliative care, we will need a sustainable and sufficient specialist workforce to provide advice, support and education to PPC providers. They will also be educated, trained and equipped to manage and care for those who will need complex palliative care management including those with dementia and frailty.

There needs to be a focus on increasing opportunities for introducing and training students in all disciplines in palliative care.

4. Leadership

Shared leadership with clear responsibilities will deliver our vision and priorities. A business case will describe the priorities for investment so that services are planned to meet Hawke's Bay population needs.

Clinical leadership must be at the heart of this strategic vision to ensure that each person and their family/whānau receives the care they need, at the right time, by the right people. They must be committed to the priorities and are key in ensuring outcomes are met. As the Ministry of Health finalises the Palliative Care Strategy and Health of Older People Strategy, we will link new national priorities to our agreed local priorities.

5. Access 24 hours, 7 days a week

Every person at the end of life should have access to services 24 hours, 7 days per week (24/7). In times of distress, uncontrolled pain and other symptoms cannot wait for office hours. People need to know who to contact, no matter what the time. PPC providers, especially GPs, are providing the majority of care. They need to be resourced to meet the demands, with access to 24/7 advice and support from SPC. For those who experience complex symptoms, the SPC nursing and medical team needs to be able to provide advice, care and support to those in need.

In Hawke's Bay we have a PPC programme that is intended to support patients who have a life limiting condition. The funding allocated to this programme is focussed on providing patients with dedicated care led by their primary health care team that works to moderate symptoms, pain, physical stress and the mental stressors associated with serious illness. The goal of this programme is to support planned care to improve the quality of life for both patients and their families.

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A patient is offered access to this programme when they meet criteria and when there is a sense of need to provide palliative care therapies when no cure can be expected and when there is an expected length of life of six months or less. We will plan for sustainable funding past 30 June 2017.

6. Sustainable Specialist Palliative Care Service

Specialist palliative care is a vital foundation if we are to realise our vision and our priorities. Our specialist service needs to be equipped and resourced to meet the needs of complex patients, family/whānau, increased education needs, support of primary palliative care providers, advice and support 24/7.

There is a national shortage of palliative medicine specialists, an ageing nursing workforce and the low use of allied health teams.²⁴ Allied health professionals are commonly part of the palliative care multidisciplinary team in other countries (e.g. United Kingdom) but are not always in New Zealand.

SPC has been working hard since 2011 to build its workforce for the future needs with the introduction of advanced trainee positions, the introduction and expansion of clinical nurse specialists in hospice and hospital and the development of a nurse practitioner role. There is still work to do to ensure that we have a sustainable workforce that is well educated and equipped to meet needs.

In 2016 Cranford Hospice was successful in its submission for Ministry of Health innovation funding. The following roles have been established, based on feedback from General Practice and Aged Residential Care.

The existing Aged Residential Care Palliative Care Resource Nurse position increased from 0.6 to 1.2 full time equivalent. The Aged Residential Care liaison nurse will support and teach skills in palliative care.

A new 0.9FTE Palliative Care Nurse Practitioner supports primary care and rural services. This role works within General Practice with an emphasis in the first instance on rural populations in Central Hawke's Bay and Wairoa. The focus of this role will be to develop the skills, capacity and systems/processes required in primary care to deliver high quality primary palliative care. The Nurse Practitioner will support a primary care training programme and establish a process for regular case review with practices.

A new Caregiver Support Coordinator provides support to family/whānau caring for palliative patients by mobilising existing support services and volunteer networks.

Alongside new innovation and new roles the core clinical team positions need development to meet current and future demands.

Our specialist medical workforce is an urgent priority. We do not have a sustainable medical workforce to meet required needs. With increasing complexity of patient and family/whānau needs and population growth we need to plan to increase resources.

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This is not unique to Hawke's Bay. In 2014 the national Palliative Medicine and Training Coordination Committee surveyed District Health Boards and reviewed work force projections for Senior Medical Officer positions. They found 12 Senior Medical Officer positions were vacant and over the next five years to 2019, vacancies due to retirement would increase this to 30.¹⁰

The current medical, nursing, allied health, family support workforce is summarised in Appendix 1. Proposed roles and FTEs are described for 2026, to be able to cope with an increased demand for clinical care provision, advice, mentorship, supervision, rural support and education.

Over 50% of our SPC nursing workforce are eligible for retirement in the next 2 to 5 years. In the last few years we have been successful in recruiting for positions, as more nurses are considering palliative care as a speciality. These nurses will need time (2 to 3 years) to specialise and train. As half of our experienced workforce retires in the next 5 years providing support, mentorship and training will be challenging.

We have proposed increases in the nursing workforce to meet the increased need for complex care provision, an increase in inpatient beds at Hospice from 8 to 10, increased education and mentorship of primary care providers and training new specialist nursing staff. Staff, services and facilities will respond to the growing numbers of people with dementia and frailty.

To provide a holistic approach to care, SPC has also been growing its family support team and allied health team. This team will almost double to be able to meet demands in the community, especially with increased frailty, the need for a rehabilitative approach and patients living for longer with multiple comorbidities. As interdisciplinary teams develop further with primary care we will improve our communication and systems so we coordinate with new services such as engAGE services for frail older people.

To respond to the needs of the Hawke's Bay population, we will integrate Cranford Hospice and the Hospital Specialist Palliative Care team (HPCT) to form one specialist palliative care service for Hawke's Bay. This integrated service will provide quality clinical care at Cranford Hospice, within the community, and an in-reach consultation liaison service to the Hawke's Bay Fallen Soldiers Memorial Hospital. The service will use the same management support, human resources and clinical guidelines across all care settings. There will be one single point of entry to SPC, and care will be more seamless no matter what bed you are in or which setting that bed is placed in. SPC will be delivered equitably, with greater care coordination and with opportunities for workforce development. There will be rotation of staff across hospice, community and hospital areas.

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7. Technology

Care planning conversations need to be effectively recorded and appropriately shared through electronic systems. Electronic systems will need to support wider access to information, extended information context and new functions, such as write access by multiple sources. Access to Advanced Care Plans, pre-emptive charting and crisis plans must be maximised. ¹⁹

8. Evidence and Information

We need to ensure that data and evidence, including people's accounts of their experience of care are used effectively to inform learning, improvement. We will improve the collection, analysis, interpretation and dissemination of data related to palliative and end of life care. This will include evidence relating to needs, provision, activity, indicators and outcomes. ¹⁹

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Palliative Care in Hawke's Bay: Our vision and priorities for the future.

1

Each person and their family/whānau will have their individual needs as the centre of care

"On one occasion the hospice nurse arrived after he was discharged from hospital and worked through the discharge summary to make sure we understood the plan"

Wife of patient

What we already know

- People are unique, they want to be listened to, respected and involved in their care.
- People and their family/whānau require care. The needs of all individual members need to be identified and addressed.
- Leaders and care professionals need to be innovative in how they ask, record and work to support choices, particularly with limited resources.
- People, family/ whānau want to be involved in their care. They should be given all the information, advice and support they need to make decisions about it.
- Advance care planning gives everyone a chance to say what is important to them, ahead of time. It helps people understand what the future might hold and to say what treatment they would and would not want. It helps people, their families and healthcare teams plan for the future and end of life care ^{.14}.
- Having conversations about death, dying and end of life requires compassion, knowledge, experience, sensitivity and skill on the part of the health professional involved. A series of conversations may be needed to determine the goals, values and wishes of the person and their family/ whānau in order to reach decisions about the appropriate plan of care.

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The building blocks we need in place

<p>Enablers for person centred care</p> <p>Care must be delivered by systems that are carefully and consciously designed to ensure people retain control and are active participants in their care. Whenever possible care must be respectful of the person's values and preferences 16.</p>	<p>Access to social support</p> <p>There is a mix of health, personal and social need at the end of life and afterwards which requires skilled assessment and available resources, delivered in an appropriate environment.</p>
<p>Meaningful conversations</p> <p>People should have the opportunity to say what's important to them and be well informed about dying, death and bereavement by the right people in the right way at the right time 14.</p>	<p>Clear expectations</p> <p>People and their family/whānau should know what they are entitled to expect as they reach the end of their lives.15.</p>
<p>Integrating the philosophy</p> <p>The philosophy of person centred care is promoted and integrated into models of care across the health and social sectors.</p>	<p>Good end of life care includes bereavement</p> <p>Caring for the individual includes understanding the need to support the unique set of relationships between family, friends, carers, other loved ones and their community, and includes preparations for loss, grief and bereavement.</p>

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2

Each person gets fair access to high quality care

"The hospital palliative care team explained what 'hospice' meant, communication was great. Once this had been explained they were happy to accept a referral"

Consumer feedback

What we already know

- The number of Māori and Pasifika people dying will increase and whilst the numbers are relatively small per annum, the increased incidence of poverty in this population and the barriers to access caused by cultural difference and lack of resources means that they are likely to require more support to achieve equitable outcomes .11.
- We cannot identify and predict when every person will die. The population is ageing and chronic conditions and co-morbidities will increase, making this even more difficult.
- Adults living in Wairoa and Central Hawke's Bay had fewer face to face contacts with SPC than in urban areas. They did not receive a corresponding increase in GP contacts, suggesting an inequity between urban and rural service delivery. 22.
- There is substantial data available regarding the palliative population. This needs to be standardised and used appropriately to identify the needs of the Hawke's Bay population and inform decision making. 23.
- Access to good and early palliative care can improve outcomes, not only with regards to quality of life, but also life expectancy 15; 18
- The way messages relating to the likely outcomes of medical conditions are communicated to people, affect their transition from curative to palliative care and willingness to accept referral to specialist palliative care.
- A public health approach recognises and plans to accommodate those disadvantaged by the economy, including rural and remote populations, tangata whenua, the homeless, lesbian, gay, bisexual, transgender and intersex communities.
- "Until recently, almost all assessments of the quality of palliative care focused on care structures and processes rather than on outcomes. Outcome measures are widely used in palliative care research to describe patient populations or to assess the effectiveness of interventions, but they are not, as yet, always incorporated into routine clinical practice". 2.

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

The building blocks we need in place

Person centred outcome measurement <p>With a consistent data set, improvement can be tracked and action taken to ensure all providers are accountable for enabling fair access to quality care.</p>	Using data <p>"Well-organised data collection can help us to target different population groups and track their progress towards better outcomes, access and wider goals shared with other agencies. Information we collect can improve our understanding of the cause and effect relationships between health and other social services, the effectiveness of different ways of working, and the value for money offered by different interventions" ¹³</p>
Unwavering commitment <p>To achieve equity and access, provision and responsiveness requires unwavering commitment to local contracts and sustainable funding.</p>	Referral criteria <p>A clear referral process is designed to ensure limited resources are appropriately allocated to serve those most in need. Other barriers to access are proactively evaluated and reduced to ensure an equitable service.</p>
Community partnerships <p>Local plans should include partnerships between different faith groups and cultural communities, as well as the diverse organisations that support children and young adults, people living with different life shortening illness, and those managing the difficulties of older age.</p>	Population based needs <p>Palliative care needs for the Hawke's Bay population should inform service design and resource allocation.</p>

3

Comfort and wellbeing maximised

“The hospice doctor was the first to look at my whole picture, she asked “what sort of person are you? Do you want to know anything? She was the first to work with my interest in other therapies”

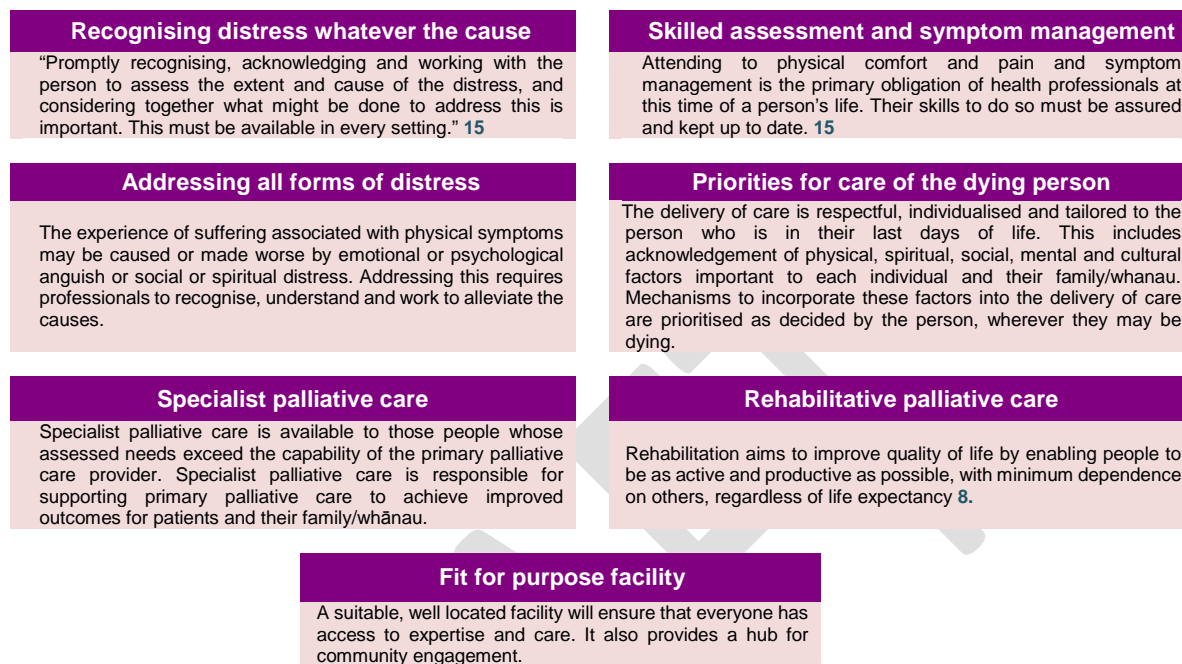
Patient feedback

What we already know

- What matters most to people at the end of life is good control of pain and other symptoms and being accompanied by but not a burden to their family/whānau. [10](#).
- People want to be considered as a whole. We need to care for physical, spiritual, family and mental health needs.
- Many people approaching death are fearful of being in pain or distress. Dying and death can be a powerful source of emotional turmoil, social isolation and spiritual or existential distress. [15](#)
- The experience of dying, and of caring for loved ones at the end of life, can have a deep and lasting impact on those involved. Poor support and inadequate symptom control may mean we fail to meet the needs of those who are dying, as well as those who care for them. This may lead to a complicated bereavement process for those left behind.
- A rehabilitation approach to palliative care is central to the person-centred ethos of hospice care, and promotes a culture that helps patients to thrive, not just survive, when faced with uncertainty and serious illness. [8](#).
- “The benefits of this rehabilitative approach are huge, not only for patients and their families but for hospices too, as they seek to respond to the challenges of supporting more people living longer with chronic conditions”. [8](#).
- Members of the interdisciplinary team offer a diverse range of skills in the provision of emotional, social, psychosocial, cultural, religious and spiritual support, and it is recognised that all team members play a vital role.

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

The building blocks we need in place



Palliative Care in Hawke's Bay: Our vision and priorities for the future.

4

Care is seamless

"It feels like the nurses are all up with the play, we don't have to repeat the story each time, it quickly felt like they really know us"

Patient feedback

What we already know

- People report not having a clear understanding of the role of the multiple health services involved in their care.
- Feedback indicates that lack of coordinated care and services increases the stress experienced by the patient, their carer/s, family and whānau. The alleviation of this would add significantly to their quality of life.
- People feel supported and safe with 24 hour advice available. The quality of the advice directly influences the level of trust people have with a service as a whole.
- Poor communication and failure to share information about the person who is dying is a recurrent theme when care is not good enough. [15](#).
- Primary palliative care professionals, including aged residential care staff report the increased confidence and increased ability to provide quality of care when access to specialist advice is available.
- High quality and well-co-ordinated care at the end of life provides a setting for a healthy experience of death for both family/whānau and the surrounding community. [19](#).
- People at the end of life with high levels of health, support and palliative needs require flexible packages of quality home nursing and support services to enable them to die at home, and to support their family and whānau at this time.

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

The building blocks we need in place

<p>Systems for shared records</p> <p>Health records for all people living with a life-limiting condition must include documentation of their assessed needs, as well as their preferences for end of life care. The person must have given their informed consent and the records should be shared electronically with all those involved in their care.</p>	<p>Clear roles and responsibilities</p> <p>People living with life limiting conditions may have different services involved in their care. It is essential that people and their families know who and where to turn to for advice in times of change or crisis.</p>
<p>A system-wide response</p> <p>Coordinated services need to be responsive to need in the community. These systems must include enabling dying people and their family/whānau access to 24/7 advice and support.</p>	<p>Continuity in partnership</p> <p>Communication between service providers and consistent knowledge across settings, facilitates the smooth and timely delivery of quality care.</p>

5

The community is involved

What we already know

- Talking about death, dying and bereavement is avoided in most community groups.
- Many members of the community do not understand what palliative care is.
- People who are dying and bereaved people often feel disconnected or isolated from their communities and networks of support. ¹⁵
- Globally there is much known about helping to nourish compassionate and resilient communities, and how to build capacity to provide practical support. ¹⁵
- Death, dying and loss affect everybody.
- The majority of people living and eventually dying from life-limiting conditions spend the greater part of their time at home being cared for and supported by family members, friends and neighbours.
- Many people feel unprepared when faced with the experiences of life-limiting conditions, death and bereavement and are uncertain about how to offer support and assistance.
- The experience of death, dying and bereavement can bring additional personal, health and social costs to those left behind. Much of this is preventable and/or relievable if the right supports are available in the right place at the right time. ⁹.
- The use of volunteers maximises community engagement and promotes partnerships between agencies and the community. Volunteers add value to the patient and family experience and complement the work of paid staff.

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The building blocks we need in place

<p>Compassionate and resilient communities</p> <p>In a compassionate community, people are motivated by compassion to take responsibility for and care for each other with collective benefit. http://www.charterforcompassion.org/index.php/shareable-community-ideas/what-is-a-compassionate-community</p>	<p>Public awareness</p> <p>A community will be in the best position to care when they are comfortable with death and dying, can understand the difficulties people face, and know what help is available.</p>
<p>Practical support</p> <p>Practical support, information and training are needed to enable families, neighbours and community organisations to help.</p>	<p>Volunteers</p> <p>To meet our commitment, more should be done locally to recruit, train, value and connect volunteers into a more integrated effort to help support people, their family/whanau and communities. 15.</p>

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6 People prepared to care

“People didn’t focus on physical symptoms – hospice staff were able to see the whole picture”

Consumer feedback

What we already know

- The recruitment and retention of palliative care medicine specialists in urban and provincial areas is a major issue. ¹² This is also an issue for Hawke's Bay. ¹²
- We have an ageing specialist palliative care nursing workforce.
- The demand for palliative care services, and thus workforce, will increase slowly over the next ten years but thereafter will increase more rapidly in line with the ageing population. ¹²
- There is a growing need for a workforce that is culturally competent to accommodate diverse personal, cultural and spiritual customs and values. ¹⁰
- Feedback suggests that the relationship people have with their GP and practice nurse is extremely important.
- The ageing population and emphasis on integrated care means that home and personal caregiver roles are becoming an increasingly critical part of the palliative care multidisciplinary team.
- Much of palliative care is provided by family members as informal carers. Reliance on informal carers and the volunteer workforce will only increase and we will need to support them to undertake potentially more complex roles. ¹⁰
- A primary palliative care workforce works best when it is well-informed, educated and supported by specialist palliative care in caring for those with life-limiting conditions.
- Specialist palliative care services will need the capability and capacity to be able to provide care, support and educate others to meet projected demands and complexities of care.
- In order to meet identified needs of patients and their family/whanau we need a diverse range of skill and expertise within the interdisciplinary team.
- Staff can only compassionately care when they are cared for themselves. They must be supported to sustain their compassion so that they can remain resilient. This allows them to use their empathy and apply their professional values every time. ¹⁵

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

The building blocks we need in place



HOW WE PLAN TO STRENGTHEN OUR FOUNDATIONS AND MEET OUR PRIORITIES

OUR PRIORITIES

Each person and their family/whānau will have their individual needs as the centre of care						
Enablers for person centred care	Access to social support	Meaningful conversations	Clear expectations	Integrating the philosophy	Bereavement Support	
Each person gets fair access to high quality care						
Using data	Unwavering commitment	Person centred outcome measurement	Population based needs	Referral criteria	Community partnerships	
Comfort and wellbeing is maximised						
Recognising distress	Skilled assessment & symptom management	Priorities for care of the dying person	Addressing all forms of distress	Specialist palliative care	Rehabilitative palliative care	Fit for Purpose Facility
Care is seamless						
Systems for shared records		Clear roles and responsibilities		System-wide response	Continuity in partnership	
The community is involved						
Compassionate communities		Public awareness		Practical support	Volunteers	
All staff are prepared to care						
Knowledge base		Support and resilience	Using technology	Sustainable workforce	Clinical governance	

FOUNDATIONS

Patient, whānau and community voice	Cultural responsiveness	Education and training	Leadership	24/7 access	Sustainable specialist palliative care service	Evidence and information	Technology
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ACTIONS REQUIRED

- Patients and family members know where to go for palliative care and are connected to services
- Information, education and visibility in the community on innovative ways to increase awareness and community culture around death and dying.
- Health and support workforce is skilled and informed to be able to support conversations around death and dying.
- Integration of Cranford Hospice and Hospital Palliative Care Team to form one specialist palliative care service.
- Specialist medical workforce developed to meet minimum recommended requirements.
- Training and supervision systems in place to support the development of SPC workforce.
- Confirm sustainable and responsive after hours primary palliative care arrangements
- Specialist palliative care provide education and support the efforts of primary palliative care providers in delivering patient care.
- Develop and expand nurse-led initiatives and expert roles such as the Nurse Practitioner.
- Last Days of Life (Te Ara Whakapiri) Pathway is developed and implemented across the region.
- Increase the role and size of the allied health and family support services.
- Research and evaluation outcomes are used to inform best practice.
- New purpose built facility for specialist palliative care. Increase from 8 to 10 inpatient beds as per recommendations (MOH 2013).
- Information technology systems accessible across primary and specialist settings. Palcare or other system.
- Look for opportunities to expand volunteer and informal support services in the community.
- Continued involvement in national data work – to develop measurable patient outcomes.
- Implementation of a rehabilitative approach to palliative care.

OUTCOME MEASUREMENTS

1. Increase in satisfaction with care by family members surveyed after death using a standard questionnaire relating to comfort and wellbeing. Measure baseline then increase by x to y by 2026.
2. National palliative care outcome measures are implemented and used for data collection and evaluation by 31 December 2017.
3. 95% of referrals to specialist palliative care are accepted, reflecting appropriateness.
4. 70% of GP practice have access to the electronic patient management system Palcare by 1 July, 2018 and 70% of hospital by 1 July 2021.
5. Monitor access to SPC compared to our population profile & then adapt services to respond:
 - Death by ethnicity in HB.
 - Access by area reflects deaths in each area.
 - Access by condition reflects deaths by condition.
6. The proportion of people dying in their preferred setting will be 90% by 31 December, 2018.
 - The proportion of people dying in hospital will decrease by one third from 34% to 21% by 31 December 2018
7. 100% of aged residential care facilities and hospital wards have implemented the Last Days of Life Care (Te Ara Whakapiri) Plan supported by Specialist Palliative Care services.
8. People with palliative care needs living in aged residential care facilities have care plans reflecting individual needs and best practice via documentation peer review.
9. New SPC facility built by 31 December 2019.
10. One specialist palliative care team for Hawkes Bay providing hospice, community and hospital in-reach consultation-liaison services by 1 July 2018
11. 20% nursing staff under the age of 50 by 2021.
12. Increase the proportion of Maori nurses to reflect the population in Hawke's Bay from 8% to 24 by 2026.
13. SPC FTE medical staff increased from 3.2 to 6.4 by 31 December 2018

Appendix 1

Table 1: Current & Proposed Medical Workforce

Role 2016	Full Time Equivalent (FTE)	Proposed Roles 2026	Full Time Equivalent (FTE)
Palliative medicine specialist (Hospital 0.5; Hospice 0.5)	1.0	Palliative medicine specialist	2.0
Medical officer special scale Advanced trainee (currently in Hospital)	1.8 0.4	Medical officer special scale or GP with special interest, or advanced trainee or registrar physician training. (Covering community, hospice inpatient unit and hospital services)	3.0
		House officer trainee Hospital & Hospice	1.0
Medical Director	0.4	Medical Director	0.4
TOTAL	3.6		6.4

This FTE does not include 30% non-clinical time as per contracts or leave requirements.

Table 2: Current & Proposed Nursing Workforce

Roles 2016	Full Time Equivalent (FTE)	Proposed Roles 2026	Full Time Equivalent (FTE)
Nurse Practitioner Candidate	0.9	Nurse Practitioner	0.9
Clinical Nurse Specialists Hospital 2.0; Hospice 2.8	4.8	Clinical Nurse Specialists Hospital 2.0; Hospice 3.0	5.0
Aged Care Liaison Nurses	1.2	Aged Care Clinical Nurse Specialist	2.0
Registered Nurses inpatient unit and community nurses	18.2	Registered Nurses inpatient unit and community nurses, new graduate position	21.8
Education	0.5	Education	2.0
	0.8	Enrolled Nurse	0.8
		Health care assistants	3.0
TOTAL	26.4		35.5

Table 3: Current & Proposed Allied Health & Family Support Workforce

Roles 2016	Full Time Equivalent (FTE)	Proposed Roles 2026	Full Time Equivalent (FTE)
Counsellor	1.0	Counsellor	2.0
Social Worker	1.0	Social Worker	2.0
Pastoral Care	0.8	Pastoral Care	1.0
Carer Support Coordinator	1.0	Carer Support Coordinator	1.6
Music Therapist	0.4	Music Therapist	0.6
Kaitakawaenga	0.8	Kaitakawaenga	1.0
Cultural Advisor	0.2	Cultural Advisor	0.2
Pharmacist	0.5	Pharmacist	0.8
Occupational Therapist	0.6	Occupational Therapist	1.0
		Physiotherapist	1.0
TOTAL	6.3		11.2

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Consumer feedback 2015 – 2016

This information is from written and verbal feedback. Quotes are adapted to maintain confidentiality

PRIMARY PALLIATIVE CARE

Almost all mentioned their GP – always expressed strongly, whether good or bad. This is a very important relationship. Majority spoke positively about their GP, the sense of support, advocacy and availability. Practice nurses mentioned occasionally, positive addition to sense of support.

Criticisms related to communication:

- of prognosis and introduction of the idea of referral to Hospice
- availability, the need to be able to access as needed and not to have to see other GPs who don't know them
- concentration on physical / medical needs of the patient

I can tell my GP anything, she is a great advocate

It is hard to get the same GP so we have to "start again" each time - this stopped us talking about Long Term Care like we wanted to. GP is there for/focuses on "medical matters"

My out-patient appointment made all the difference, they linked everything together

When we ask for a visit – the response is always "yip, no problem"

SECONDARY PALLIATIVE CARE

Some people reported satisfaction with the service they were provided if/when admitted. Of those that met with the HPCT, all but one was positive and the communication provided relief and more confidence and understanding of hospice.

Several negative experiences expressed of communication from specialists / doctors regarding diagnosis and prognosis. These were all expressed with quite a bit of emotion. Mostly related to 'abruptness' or suddenness of the message. Some felt that this was even "rude" and left them with negative feelings including an inability to ask questions. Many left not knowing what 'palliative care' was and afraid to accept the referral.

Many felt the doctors at the hospital were only interested in one aspect of them and this was a barrier to quality care.

The Hospital Palliative Care Team explained what 'hospice' meant, communication was great. Once this had been explained they were happy to accept referral

When they decide they can't do anything medically for you, you are off on your own, they don't want to know you....

Cranford people are non-intrusive; responsive and great for advice

The doctor was the first to look at the "whole picture"

SPECIALIST PALLIATIVE CARE

The majority of those visited described having strong beliefs about Hospice as a 'place to die' and were unhappy about the referral, some saying that this meant they refused referral initially and later regretted this once they learned what it is really about.

All felt that Cranford Hospice staff were great and there were no complaints or criticism about this. Often people felt supported and safe with the 24 hour advice available.

People didn't focus on physical symptoms – most were more interested in talking about the general feeling of psychosocial support and several mentioned that the Hospice staff were able to see the 'whole picture'.

Actually coming into the Hospice building for an appointment was universally a positive experience and reduced fears / barriers to accepting admission if needed.


People talked about the need to keep 'living' and things like vague appointment times were interruptions to that.





WORKING TOGETHER FOR TAMARIKI IN HB

Dr Russell Wills

	Quality Dashboard
	For the attention of: HB Clinical Council and HB Health Consumer Council
Document Owner:	Kate Coley, Director – Quality Improvement and Patient Safety
Document Author(s):	Kate Coley, Director – Quality Improvement and Patient Safety
Reviewed by:	Executive Management Team
Month:	October 2016
Consideration:	For Discussion

RECOMMENDATION**That Clinical and Consumer Council:**

- Endorse the establishment of a Quality Dashboard.
- Note that feedback is sought from EMT, Clinical Council and Consumer Council before being presented to FRAC.
- Note that over time this dashboard will evolve once the cross sector event reporting system is rolled out.
- Note that the dashboard will be reported on a quarterly basis and shared across the sector

OVERVIEW

The governance of clinical quality and patient safety occurs within the context of the broader governance roles of boards, which includes financial governance, health & safety, managing risk, setting strategic direction and ensuring compliance with statutory requirements. Governance of an organisation occurs at all levels and requires a program of review and improvement of internal processes and outcomes at every level.

Clinical Governance is defined as

“the system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimizing risks and fostering an environment of excellence in care for consumers, patients, community”

An effective system of clinical governance at all levels of the health system is essential to ensure continuous improvement in the safety and quality of care. Good clinical governance makes certain that there is accountability and creates a ‘just’ culture that is able to embrace reporting and support improvement.

The DHB has both a stated commitment to quality and safety and a well-established patient safety and quality management system in place. With the establishment of the new Quality Improvement & Patient Safety Service however, there is now an opportunity to give more prominence to this commitment and refresh this system by aligning it more to the objectives of the Working in Partnership for Quality Framework, the national and regional priorities, and the priorities identified in Transform & Sustain. It also provides an opportunity to review and enhance the effectiveness of the governance structures with responsibilities for clinical quality and patient safety. This refinement and

evolution has been underway for the past year and will continue over the coming year, with the implementation of the Quality Annual Plan.

The key challenge as an organisation is to continue to maintain and embed the quality framework so as to ensure that patient safety and quality of clinical care is part of everyone's business and is embedded in the culture of the organisation. The focus going forward is on continuous improvement and further development of the quality framework.

The purpose of this report is to seek approval for the establishment of a quality dashboard to provide assurance to the Board, EMT, Clinical and Consumer Councils in regards to the core dimensions of quality – centred around patient safety, clinical effectiveness and patient experience. In addition to providing this assurance it also gives greater transparency and visibility to trends, evolving issues and provides the opportunity for greater sharing of learnings across the organisation. Prior to being approved by Board, feedback will be sought from Clinical Council and Consumer Council around the indicators presented.

This dashboard reinforces the endorsed new clinical governance committee structure which is currently being implemented, and will be better supported in the future with the rollout of a new cross sector event management reporting system.

OVERVIEW OF THE DASHBOARD

Currently there are a variety of mechanisms that are provided in various governance meetings which provide information around key performance indicators e.g. Clinical Council Indicators, Performance Framework. These reports have been in place for a period of time and whilst they provide measures of performance they are limited in regards to better transparency and visibility of quality improvement activities and actions that are in place to improve performance.

This new dashboard will report against the three pillars of quality – safety, clinical effectiveness and experience. This aligns with the newly defined clinical governance committee structure which is currently being implemented and is cross sector wide.

The dashboard, which is attached identifies a number of indicators and measures. Each of the indicators will have an agreed definition and target (which align to either MOH, HB Health sector or HQSC requirements) and commentary will be provided on an exceptions basis.

It is proposed that we utilise a simple RAG analysis approach so that this provides a very visual and simple tool so that drilling down into areas of non-performance can be easily done by the relevant governance groups.

The RAG analysis will be defined as follows:

- Green – Current period exceed, meets or is within 0.5% of the agreed target/baseline
- Amber – Current period is below by 0.5% to 5%
- Red – Current period is below by more than 5%

The dashboard will also show the trend direction from the previous quarter. Commentary will be focused on the reasons for below target performance and identify mitigation and quality improvement activities to get the indicator back on track.

This is a first draft of the dashboard and it will evolve over time with the establishment of a new cross sector event reporting system, which will take a period of time to implement, however it is hoped that in the long term this dashboard will be a cross sector reporting and monitoring tool.




Appendix 1 provides an overview of the dashboard visual.

Quality Improvement and Patient Safety Dashboard



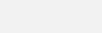

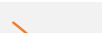

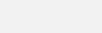
Clinical Effectiveness

		Baseline	Previous	Current	Target	Trend
Patient Movements	Number of ward movements during an episode of care	31%	31%	28%	≥ tbc	
Outliers	Medical Specialty in Surgical ward and vice versa	7%	6%	6%	≤ tbc	
Length of Stay	Average length of stay for entire hospital (admission to discharge)	2.9	2.57	2.78	≤ tbc	
Long Stay Patients	Patients with a length of stay greater than 10 days					
Hand Hygiene						
Reduced readmissions	Readmission Rate	8%	8%	8%	≤ tbc	
Cornerstone	Practices achieving cornerstone accreditation	64%	86%	86%	≥ 80%	
Enrolments	Patients enrolled with a GP practice	95%	95%	96%	≤ 97%	
Hospital Demand	Average Hospital Status for the quarter					
Cancelled Surgeries	Surgeries cancelled on the day of surgery for non-clinical reasons					

Patient Safety

		Baseline	Previous	Current	Target	Trend
Patient ID Errors	Number of errors due to miss patient ID e.g. labs, radiology, pharmacy					
Patient Events	Number of patient events/incidents per 1,000 admissions	105.5	90.9	99.5	≤ tbc	
Deteriorating Patients	Rapid response patients success rate					
SAC1 and SAC2 Events	Days since last event					
Outstanding Risks	Significant number of risks outstanding	26	16	13	≥ tbc	
Standardised Hospital Mortality Rate		108	108	103	≤ 100	
Infection Rates	CLAB and SSI from HQSC					
Pressure Ulcers						
Falls Resulting in Harm						
Family Violence Intervention Training	Attendance and completion of Family Violence Intervention Training					

Patient Experience

		Baseline	Previous	Current	Target	Trend
National Patient Experience	Communication	8.7	8.6	8.7	≥ 8.4	
	Partnership	8.9	8.8	9	≥ 8.4	
	Co-ordination	8.7	8.8	8.8	≥ 8.4	
	Physical and Emotional Needs	8.9	8.8	9	≥ 8.4	
Number of Complaints		136	147	138	≤ tbc	
Number of Compliments		232	164	126	≤ tbc	
Patients Presenting to ED enrolled with GP Practise with	Enrolled with a GP Practice with an A&M clinic	0.35	0.35	0.35	≥ tbc	
Number of Privacy Breaches						
Relationship Centred Practice Training	Attendance and Completion of relationship centred practice training					

HAWKE'S BAY HEALTH CONSUMER COUNCIL

DRAFT ANNUAL PLAN 2016/17

Purpose	Provide a strong viable voice for the community and consumers on health service planning and delivery	Advise and encourage best practice and innovation in the areas of patient safety, consumer experience and clinical quality	Promote and support the enhancement of consumer engagement
FUNCTIONS	<ul style="list-style-type: none"> Identify and advise on and promote, a 'Partners in care' approach to the implementation of 'Person and Whanau Centred Care' into the Hawkes Bay health system, including input into: <ul style="list-style-type: none"> Development of health service priorities Strategic direction The reduction of inequities Participate, review and advise on reports, developments and initiatives relating to health service planning and delivery. Seek to ensure that services are organised around the needs of all consumers 	<ul style="list-style-type: none"> Identify and advise on issues that will improve clinical quality, patient safety and health literacy. Seek to enhance consumer experience and service integration across the sector. Promote equity of access/treatment Seek to ensure that services are responsive to individual and collective consumer needs. 	<ul style="list-style-type: none"> Facilitate and support the development of an appropriate Consumer Engagement Strategy for the Hawkes bay health system Ensure, coordinate and enable appropriate consumer engagement within the health system <ul style="list-style-type: none"> across Hawke's Bay within the Central region at National level Receive, consider and disseminate information from and to HBDHB, Health Hawke's Bay, Consumer groups and communities. Ensure regular communication and networking with the community and relevant consumer groups. Link with special interest groups as required for specific issues and problems solving.
STRATEGIES	<ul style="list-style-type: none"> Proactively raise and promote issues of importance and/or concern to consumers generally, for consideration and/or resolution by relevant organisations within the health system. Engage early with project and planning teams, and standing committees, to ensure the consumer perspective is included in all outcomes and recommendations. Review and comment on all relevant reports, papers, initiatives to the Board. Ensure robust complaint/feedback systems are in place and that consumers are well informed and easily able to access these Consumer Council members to be allocated portfolio/areas of responsibility. 	<ul style="list-style-type: none"> Work with Clinical Council to develop and maintain an environment that promotes and improves: <ul style="list-style-type: none"> Putting patients / consumers at the centre Patient safety Consumer experience Clinical quality Health literacy Equity Promote initiatives that empower communities and consumers to take more responsibility for their own health and wellness. Promote a clinical culture which actively engages with patients / consumers at all levels, as 'partners in care'. Advocate / promote for Intersectoral action on key determinants of health. 	<ul style="list-style-type: none"> Raise the profile and community awareness of Consumer Council and the opportunities / options for enhanced consumer engagement in decision making. Ensure good attendance and robust discussions at monthly Consumer Council meetings Co-ordinate consumer representation on appropriate committees and project teams: <ul style="list-style-type: none"> Within Hawke's Bay At Central Region and National levels Engage with HQSC programmes around consumer engagement and 'partners in care'. Maintain current database and regular communications with all Hawke's Bay health consumer groups/organisations. Provide regular updates on both the HBDHB and Health Hawke's Bay websites Ensure Consumer Council members continue to be well connected and engaged with relevant consumer groups and communities
OBJECTIVES 2015/16	<ul style="list-style-type: none"> Actively promote and participate in' co-design processes for: <ul style="list-style-type: none"> Youth Mental Health Older Persons Participate in the development of Health and Social Care Networks Provide consumer perspective into Customer focussed Booking 	<ul style="list-style-type: none"> Promote and assist initiatives that will improve the level of health literacy within the sector and community. Facilitate and promote the development of a 'person and whanau centred care' approach and culture to the delivery of health services, in partnership with the Clinical Council. Promote the provision of consumer feedback and 'consumer stories'. Monitor all 'Patient Experience' performance measures/indicators as co-sponsor of the 'patient experience Committee' within the clinical governance structure. Facilitate a focus on disability issues 	<ul style="list-style-type: none"> Facilitate and support the development and implementation of a consumer engagement strategy and principles in Hawkes Bay Establish a connection with Youth within the community Influence the establishment and then participate in regional and national Consumer Advisory Networks.

Portfolios and areas of interest	HB Health Consumer Council Members:																																																																						
<p>AREAS OF INTEREST</p> <table border="0"> <tr><td>- Women's' health</td><td>Sami, Olive and Leona</td></tr> <tr><td>- Child health</td><td>Sami, Malcolm and Rachel</td></tr> <tr><td>- Youth health</td><td>Malcolm, Rosemary and Jim</td></tr> <tr><td>- Older Persons health</td><td>Jenny, Heather</td></tr> <tr><td>- Chronic conditions</td><td>Rosemary, Terry, James and Rachel</td></tr> <tr><td>- Mental Health</td><td>Nicki and Terry</td></tr> <tr><td>- Alcohol and other drugs</td><td>Nicki and Rosemary</td></tr> <tr><td>- Sensory and physical disability</td><td>Heather and Tessa</td></tr> <tr><td>- Intellectual and neurological disability</td><td>Heather and Olive</td></tr> <tr><td>- Rural health</td><td>Leona (Wairoa) and Terry (CHB), Heather, Jim,</td></tr> <tr><td>- Maori health</td><td>Tessa, Leona, Jim and James</td></tr> <tr><td>- Pacific health</td><td>Olive and Tessa</td></tr> <tr><td>- Primary health</td><td>Jenny and Rachel</td></tr> <tr><td>- High deprivation populations</td><td>Nicki, Jenny and Leona</td></tr> </table> <p>2016-17 PORTFOLIOS</p> <ul style="list-style-type: none"> - Co-Design Youth - Malcolm, Rosemary & Jim plus youth reps - Co-Design Mental Health - Nicki, Terry & PAG - Co-Design Older persons - Jenny, Heather, Rosemary - Health and Social Care networks - Tessa, Rachel, Jenny, Leona - Customer Focussed Booking – Tessa, Sarah - Health Literacy – James, Leona, Olive - Person and Whānau Centred Care - Rosemary - Patient Experience Committee (of Clinical Council) - Sami - Disability – Sarah, Heather, Terry - Consumer Engagement Strategy - ALL - Connections with Youth – same as co-design for youth group above <p>Support:</p> <p>Operational and Minutes</p> <table border="0"> <tr><td>Kate Coley</td><td>(Director Quality Improvement and Patient Safety)</td></tr> <tr><td>Tracy Fricker</td><td>(Council Secretary and PA to DQIPS)</td></tr> <tr><td>Jeanette Rendle</td><td>(Consumer Engagement Manager)</td></tr> </table> <p>Clinical Council Liaison</p> <p>Debs Higgins</p> <p>Governance</p> <table border="0"> <tr><td>Ken Foote</td><td>(Company Secretary)</td></tr> <tr><td>Brenda Crene</td><td>(Board Administrator and PA to Co-Sec)</td></tr> </table> <p>Communications</p> <table border="0"> <tr><td>Anna Kirk</td><td>(Communications Manager)</td></tr> </table>	- Women's' health	Sami, Olive and Leona	- Child health	Sami, Malcolm and Rachel	- Youth health	Malcolm, Rosemary and Jim	- Older Persons health	Jenny, Heather	- Chronic conditions	Rosemary, Terry, James and Rachel	- Mental Health	Nicki and Terry	- Alcohol and other drugs	Nicki and Rosemary	- Sensory and physical disability	Heather and Tessa	- Intellectual and neurological disability	Heather and Olive	- Rural health	Leona (Wairoa) and Terry (CHB), Heather, Jim,	- Maori health	Tessa, Leona, Jim and James	- Pacific health	Olive and Tessa	- Primary health	Jenny and Rachel	- High deprivation populations	Nicki, Jenny and Leona	Kate Coley	(Director Quality Improvement and Patient Safety)	Tracy Fricker	(Council Secretary and PA to DQIPS)	Jeanette Rendle	(Consumer Engagement Manager)	Ken Foote	(Company Secretary)	Brenda Crene	(Board Administrator and PA to Co-Sec)	Anna Kirk	(Communications Manager)	<table border="1"> <tr> <td>Graeme Norton (Chair) HASTINGS</td><td>graeme.norton@clear.net.nz</td></tr> <tr> <td>Nicki Lishman (MSD Rep) WESTSHORE</td><td>nicki.lishman004@msd.govt.nz</td></tr> <tr> <td>Jim Henry NAPIER</td><td>jimbhenry@hotmail.co.nz</td></tr> <tr> <td>Jim Morunga NAPIER</td><td>jim.morunga@tkh.org.nz</td></tr> <tr> <td>Jenny Peters NAPIER</td><td>peters.jenny26@gmail.com</td></tr> <tr> <td>Olive Tanielu HASTINGS</td><td>olivetanielu@rocketmail.com</td></tr> <tr> <td>Heather Robertson NAPIER</td><td>Heather.hb@xtra.co.nz</td></tr> <tr> <td>Leona Karauria NUHAKA</td><td>Info@s-a-s.co.nz</td></tr> <tr> <td>Rosemary Marriott HASTINGS</td><td>roseandterry@xtra.co.nz</td></tr> <tr> <td>Terry Kingston WAIPAWA</td><td>terrykingston@xtra.co.nz</td></tr> <tr> <td>Tessa Robin NAPIER</td><td>tessa.robin@tkh.org.nz</td></tr> <tr> <td>Malcolm Dixon HAVELOCK NORTH</td><td>dixonmj24@icloud.com</td></tr> <tr> <td>Rachel Ritchie HAVELOCK NORTH</td><td>andyrach@xtra.co.nz</td></tr> <tr> <td>Sarah Hansen HASTINGS</td><td>hansennorsemen@xtra.co.nz</td></tr> <tr> <td>Samitioata (Sami) McIntosh HASTINGS</td><td>smkoko@live.com</td></tr> </table>	Graeme Norton (Chair) HASTINGS	graeme.norton@clear.net.nz	Nicki Lishman (MSD Rep) WESTSHORE	nicki.lishman004@msd.govt.nz	Jim Henry NAPIER	jimbhenry@hotmail.co.nz	Jim Morunga NAPIER	jim.morunga@tkh.org.nz	Jenny Peters NAPIER	peters.jenny26@gmail.com	Olive Tanielu HASTINGS	olivetanielu@rocketmail.com	Heather Robertson NAPIER	Heather.hb@xtra.co.nz	Leona Karauria NUHAKA	Info@s-a-s.co.nz	Rosemary Marriott HASTINGS	roseandterry@xtra.co.nz	Terry Kingston WAIPAWA	terrykingston@xtra.co.nz	Tessa Robin NAPIER	tessa.robin@tkh.org.nz	Malcolm Dixon HAVELOCK NORTH	dixonmj24@icloud.com	Rachel Ritchie HAVELOCK NORTH	andyrach@xtra.co.nz	Sarah Hansen HASTINGS	hansennorsemen@xtra.co.nz	Samitioata (Sami) McIntosh HASTINGS	smkoko@live.com
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MEMBER TOPICS OF INTEREST

GLOSSARY OF COMMONLY USED ACRONYMS

A&D	Alcohol and Drug
AAU	Acute Assessment Unit
AIM	Acute Inpatient Management
ACC	Accident Compensation Corporation
ACP	Advanced Care Planning
ALOS	Average Length of Stay
ALT	Alliance Leadership Team
ACP	Advanced Care Planning
AOD	Alcohol & Other Drugs
AP	Annual Plan
ASH	Ambulatory Sensitive Hospitalisation
AT & R	Assessment, Treatment & Rehabilitation
B4SC	Before School Check
BSI	Blood Stream Infection
CBF	Capitation Based Funding
CCDHB	Capital & Coast District Health Board
CCN	Clinical Charge Nurse
CCP	Contribution to cost pressure
CCU	Coronary Care Unit
CEO	Chief Executive Officer
CHB	Central Hawke's Bay
CHS	Community Health Services
CMA	Chief Medical Advisor
CME / CNE	Continuing Medical / Nursing Education
CMO	Chief Medical Officer
CMS	Contract Management System
CNO	Chief Nursing Officer
COO	Chief Operating Officer
CPHAC	Community & Public Health Advisory Committee
CPI	Consumer Price Index
CPO	Co-ordinated Primary Options
CQAC	Clinical and Quality Audit Committee (PHO)
CRISP	Central Region Information System Plan
CSSD	Central Sterile Supply Department
CTA	Clinical Training Agency
CWDs	Case Weighted Discharges
CVD	Cardiovascular Disease
DHB	District Health Board
DHBSS	District Health Boards Shared Services
DNA	Did Not Attend
DRG	Diagnostic Related Group
DSAC	Disability Support Advisory Committee
DSS	Disability Support Services
DSU	Day Surgery Unit
DQIPS	Director Quality Improvement & Patient Safety
ED	Emergency Department

ECA	Electronic Clinical Application
ECG	Electrocardiograph
EDS	Electronic Discharge Summary
EMT	Executive Management Team
Eols	Expressions of Interest
ER	Employment Relations
ESU	Enrolled Service User
ESPIs	Elective Service Patient Flow Indicator
FACEM	Fellow of Australasian College of Emergency Medicine
FAR	Finance, Audit and Risk Committee (PHO)
FRAC	Finance, Risk and Audit Committee (HBDHB)
FMIS	Financial Management Information System
FSA	First Specialist Assessment
FTE	Full Time Equivalent
GIS	Geographical Information System
GL	General Ledger
GM	General Manager
GM PIF	General Manager Planning Informatics & Finance
GMS	General Medicine Subsidy
GP	General Practitioner
GP	General Practice Leadership Forum (PHO)
GPSI	General Practitioners with Special Interests
GPSS	General Practice Support Services
HAC	Hospital Advisory Committee
H&DC	Health and Disability Commissioner
HBDHB	Hawke's Bay District Health Board
HBL	Health Benefits Limited
HHB	Health Hawke's Bay
HQSC	Health Quality & Safety Commission
HOPSI	Health Older Persons Service Improvement
HP	Health Promotion
HPL	Health Partnerships Limited
HR	Human Resources
HS	Health Services
HWNZ	Health Workforce New Zealand
IANZ	International Accreditation New Zealand
ICS	Integrated Care Services
IDFs	Inter District Flows
IR	Industrial Relations
IS	Information Systems
IT	Information Technology
IUC	Integrated Urgent Care
K10	Kessler 10 questionnaire (MHI assessment tool)
KHW	Kahungunu Hikoi Whenua
KPI	Key Performance Indicator
LMC	Lead Maternity Carer
LTC	Long Term Conditions
MDO	Māori Development Organisation
MECA	Multi Employment Collective Agreement
MHI	Mental Health Initiative (PHO)
MHS	Māori Health Service
MOPS	Maintenance of Professional Standards

MOH	Ministry of Health
MOSS	Medical Officer Special Scale
MOU	Memorandum of Understanding
MRI	Magnetic Resonance Imaging
MRB	Māori Relationship Board
MSD	Ministry of Social Development
NASC	Needs Assessment Service Coordination
NCSP	National Cervical Screening Programme
NGO	Non Government Organisation
NHB	National Health Board
NHC	Napier Health Centre
NHI	National Health Index
NKII	Ngati Kahungunu Iwi Inc
NMDS	National Minimum Dataset
NRT	Nicotine Replacement Therapy
NZHIS	NZ Health Information Services
NZNO	NZ Nurses Organisation
NZPHD	NZ Public Health and Disability Act 2000
OPF	Operational Policy Framework
OPTIONS	Options Hawke's Bay
ORBS	Operating Results By Service
ORL	Otorhinolaryngology (Ear, Nose and Throat)
OSH	Occupational Safety and Health
PAS	Performance Appraisal System
PBFF	Population Based Funding Formula
PCI	Palliative Care Initiative (PCI)
PDR	Performance Development Review
PHLG	Pacific Health Leadership Group
PHO	Primary Health Organisation
PIB	Proposal for Inclusion in Budget
P&P	Planning and Performance
PMS	Patient Management System
POAC	Primary Options to Acute Care
POC	Package of Care
PPC	Priority Population Committee (PHO)
PPP	PHO Performance Programme
PSA	Public Service Association
PSAAP	PHO Service Agreement Amendment Protocol Group
QHNZ	Quality Health NZ
QRT	Quality Review Team
Q&R	Quality and Risk
RFP	Request for Proposal
RHIP	Regional Health Informatics Programme
RIS/PACS	Radiology Information System
	Picture Archiving and Communication System
RMO	Resident Medical Officer
RSP	Regional Service Plan
RTS	Regional Tertiary Services
SCBU	Special Care Baby Unit
SLAT	Service Level Alliance Team
SFIP	Service and Financial Improvement Programme
SIA	Services to Improve Access

SMO	Senior Medical Officer
SNA	Special Needs Assessment
SSP	Statement of Service Performance
SOI	Statement of Intent
SUR	Service Utilisation Report
TAS	Technical Advisory Service
TAW	Te Ara Whakawaiora
TOR	Terms of Reference
UCA	Urgent Care Alliance
WBS	Work Breakdown Structure
YTD	Year to Date

