Exploring End of Life Care in New Zealand

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2.0 ABBREVIATIONS

ACP  Advance Care Planning
CCG  Clinical Commissioning Group
CM   Counties Manukau
DHB  District Health Board
EOLC End of Life Care
MCP  Multispeciality Community Provider
TED Talks Technology, Entertainment, Design
VSPA Voluntary Single Point of Access

3.0 ABOUT THE AUTHOR

Anne-Maria Olphert  RGN, RSCN, BSc (Hons), MBA.

I have worked in the NHS for over 30 years holding several roles including Ward Manager, Neonatal Sister, Children’s Intensive Care Manager, Director of Children’s Community Health Services and now as Chief Nurse for Erewash CCG in Derbyshire. In 1996 I was instrumental in setting up the first Children’s Intensive Care Unit in Leicester which included a full retrieval service, collecting children from across the country requiring an intensive care bed. I was awarded the Florence Nightingale Leadership award in 2011 and was voted Inspirational leader by the Leadership Academy in 2014. Part of my current role is as executive lead for commissioning End of Life Care in Erewash, and as such I have managed to put this important agenda on the forefront of the Trust Boards mind. After receiving the Winston Churchill Fellowship I was able to secure funding from Macmillan and recruit the first ever GPs in Erewash dedicated to End of Life and Cancer Care, as well as securing project support to implement the recommendations from this Fellowship. I’ve published widely in several journals and I’m currently on the editorial board of the British Journal of Nursing, a Clinical Trustee for Rainbows Children’s Hospice, Clinical Trustee for ADHD Solutions and an active Soroptimist.

4.0 EXECUTIVE SUMMARY

The Winston Churchill Fellowship enabled me to visit New Zealand to observe, discuss and understand their health care system specifically in relation to Palliative and End of Life Care (EOLC). The aspects of Palliative Care I chose to explore centred on the Commissioning of services, as well as the role Hospices play in the delivery of care. New Zealand is a Pacific Island nation of 4.49 million people, predominately of New Zealand European ethnicity (68%), with significant Maori (15%), Pacific island (7%) and Asian (9%) populations. About 20% of the population is aged 0-14 yrs, while the proportion of the population aged over 65 years (13%) is growing steadily (WHO 2014). Similarly in the UK our over 65 years population is 17.7% of the population and growing. Our average life expectancy is the same as New Zealand with women averaging 82 years and males 79.5 years. The need for palliative care is fast increasing as the population ages, particularly those with non-cancer diagnoses, with the number of people aged 85 years and over for example, expected to more than double by 2037 in all 4 UK countries (Dixon et al 2015).
Before visiting New Zealand I was asked why I would be visiting New Zealand to study End of Life when actually the UK is seen as a lead in Palliative and End of Life Care. The simple answer is we can always learn from others. We do not have a perfect system here which this report will show and as the executive lead for commissioning End of Life Services in Erewash Clinical Commissioning group I am continually battling to ensure EOL care can compete with all the other priorities the NHS has in commissioning services. The recent report from Dixon et al (2015) suggests that 111,700 people a year across the UK would benefit from palliative care but are not currently receiving it. We also know from the national audit of hospitals conducted by the Royal College of Physicians in England (2014), that only 21% of hospitals offered face to face access to specialist palliative care seven days a week despite national recommendations that they do so, with the majority (73%) offering access only 5 days a week.

I found across New Zealand a joined up, integrated approach to End of Life Care, the hospices and secondary care services based in hospitals were interlinked, with joint appointments and cross cover of care. The palliative care beds had been moved out of the hospitals and based in the inpatient units of the hospices, with a mixed portfolio of inpatient beds and hospice at home services.

My recommendations are based around understanding the current system and pathways we have in Derbyshire and Erewash, so that we too can have a system that offers patients the care they need at the point in time they actually need it. Our current pathway for palliative patients is defined by which GP or service they are referred to. There are several providers and some patients receive excellent care however some experience difficulties in accessing services and care appropriately. The design lab in Christchurch gave me the idea of how to approach the project in Derbyshire to develop a pathway with the patient in mind.

The research question I wanted to answer was:

- What innovative developments and programmes are in place across New Zealand specifically for EOL Care that we can learn from and introduce in Derbyshire?

5.0 MAJOR FINDINGS

- The New Zealand Health Care system lends itself to being able to provide for its populations in a holistic integrated way. The first major finding was that services are commissioned around the patient, this means there is no duplication or gaps because health and social care as staff are part of the same team. They do not have a separate social care department like we do in the UK.
The hospices I visited in Auckland, Hamilton and Wellington were all very closely linked to the big acute hospital provider, so much so that staff were employed by the acute provider and worked across the hospital and hospice and visa versa. The hospitals no longer had palliative care beds, they were all moved into the hospices inpatient facilities. The comparison in Derbyshire is that the local hospice has no inpatient facilities and the hospital has 20 palliative care beds.

There are 28 hospices in New Zealand with a 4.49 million population and the UK has 200 for a population of 64.1 million. Hospices in the UK receive approximately 15 – 30% government funding and in New Zealand they receive 60 – 75%. In fact this year the government had just announced $76.1 million (£32.8 million) will be spent on hospices and community care services over the next 4 years recurrently. The focus is to provide better support for terminally ill patients at home and in care homes.

Primary health care is coordinated through Primary Health Organisations (PHOs) of which there are 31 and they receive capitation funding for their enrolled populations. I was able to visit and receive several presentations from a large PHO in Christchurch called Pegasus (Appendix 2). Patients are free to enrol with a GP of their choice, the GP then chooses which PHO to join. Patients visiting the GP have to pay for their appointments and any subsequent tests. We in the UK have a very high ‘did not attend’ (DNA) rate in GP surgeries (11.7%) (Healthwatch 2014) which does not seem to be as much of an issue in New Zealand. GPs in New Zealand work really closely with the hospices, there are regular meetings and discussions There is also the ability to view patient records across practices, hospitals and hospices. The shared record was particularly impressive especially in Christchurch, where the earthquake had driven change quicker than had been planned.

I attended a session on Advanced Care Planning (ACP) at the APAC conference in Auckland and was inspired by the work they have done. There is work on awareness raising of ACP across the community and working with practice nurses, district nurses and general practitioners. So far they
have trained 1000 clinicians in the use of the ACP and there continuing to build on this model across New Zealand. They have launched a media campaign called ‘start the conversation’ that has gained a lot of support.

Image: Start a conversation presented at APAC conference for ACP

6.0 RECOMMENDATIONS

6.1 LOCAL

- Scope the current provision of End of Life Care across Derbyshire.
- Undertake a new audit of deaths across Erewash to benchmark current practice.
- Agree Key Performance Indicators which are shaped by patients and Carers, ensuring engagement with patient groups at all times.
- Influence workforce redesign including the integration of health and social care teams shaped by the new care models such as Multispeciality Community Providers (MCP Appendix 4).
- Review the use of current voluntary sector single point of access (VSPA Appendix 5).

6.2 NATIONAL

- Contribute to the National CQC thematic review of End of Life Care. One of 17 CCGs across the UK to take part. (see Appendix 6)
7.0 INTRODUCTION TO THE PROJECT

In February 2015 I was delighted to be awarded a Winston Churchill Travel Fellowship, with a generous grant from the Winston Churchill Memorial Trust and Burdett Institute for Nursing, affording me the opportunity to visit New Zealand for 4 weeks to research Palliative and End of Life Care. I went out on the 17th September 2015 and arrived in Auckland, I then went to Hamilton, Wellington and finished in Christchurch from where I returned to the UK on the 19 October 2015 (see Appendix 7 for full itinerary). Whilst in Auckland I attended the APAC conference (Appendix 8), this was a thought provoking innovative conference with 1,700 delegates from the healthcare sector across the world. The opening introduction was done by Peter Jackson (Film Director) who inspires many New Zealanders as well as people from around the world. He did this via video link because he was in Gallipoli as part of the remembrance of the First World War. I was introduced to the concept of TED talks which I’d not really embraced before and was enthralled by the eight 15 minute talks by leaders in their field. I attended a session called Give it a go: Telling your story – why, what and how, and this has given me the idea to introduce it to the End of Life project in Derbyshire (Appendix 3).

Photo: slide presented at the APAC conference

New Zealand has 20 District Health Boards (DHBs) which are responsible for planning and funding health services for their geographical areas much the same as our Clinical Commissioning Groups (CCGs). There is one big difference in regard to funding, the public pay for their GP appointments and any tests the GP suggests are required.

I was inspired by the staff and public in Christchurch who suffered a devastating earthquake in February 2011 (Appendix 9), wherever I went people still spoke about what happened from taxi drivers, nurses, receptionists, hotel staff and waitresses. It’s hard not to be moved by their stories and the sheer resilience they have shown to get back on their feet following this devastation. It is important for me to acknowledge though, that a lot of the developments and projects that have been put into place following the earthquake were actually underway before 2011. Many people think that the changes were made because of the earthquake, this is not technically true, it did however help it along and give some impetus to what was needed. In the words of Anita Cox from the HealthOne Project ‘when the earthquake happened a state of emergency was declared for 6 months so the normal hoops that you have to jump through disappeared and the quake circumvented everything’.

I’m fascinated by the idea that the first person to reach 150 years old is already alive according to researcher David Sinclair (2015). An average of three months is being added to life expectancy every year at the moment and experts estimate there could be a million centenarians across the world by 2030. I consider this idea to have a major impact for care of the frail and elderly at the end of their life as we see
yet more and more people over the age of 85 years needing support. So why did I want to visit another country to study end of life care? In 2013 I commissioned an audit of deaths across Erewash (Derbyshire) which has a population of 97,000 and 12 GP practices. According to NICE (2012) approximately 1% of a population will die each year; the majority of these will be expected deaths. Whilst many of the findings gave me optimism about the provision of care for patients at the end of their life, there were some elements that were concerning and meant patients and families were suffering unduly. On examination, these results (Appendix 10) were similar to the national findings and have spurred me on to make as much of a difference as I can. Those patients that were expected to die and were taken to hospital via 999 (26) and admitted from Out of Hours (16) are of grave concern as this suggests that patients/carers may not have had the support at the end in order to stay in their usual place of residence. In receiving the Fellowship, I am making recommendations to repeat this audit once further training and awareness raising amongst the GPs and community services has been put into place. In New Zealand approximately 34% of patients die in hospital whereas in the UK 90% of patients spend time in hospital in the final year of life, and 56% of patients die in hospital (Gott 2011).

8.0 AIMS OF THE PROJECT

When we are in need of care, we can be at our most vulnerable. During this time our experience of health care services should be as positive as possible. Therefore all those involved in providing care should be continually improving standards to ensure a high quality of patient experience. The aims of this project are to bring awareness to the CCGs Governing Body, so that Palliative Care and End of Life Care (EOLC) can be commissioned effectively to improve the patient’s journey, increase awareness amongst the GPs in Derbyshire, to improve the difficult and sometimes challenging conversations with those who are dying and to ensure the voices of patients and carers are heard to both improve our services but also to help us remember why we are doing this in the first place.

When visiting the various centres in New Zealand I set the following objectives:

- Talk to clinicians delivering End of Life Care, compare their practices to the UK.
- Understand any innovative practices that can be replicated back in the UK, examples would be IT, telemedicine and telehealth.
- Talk to practitioners and commissioners of services to understand how they are helping patients to die in their place of choice. Example in the UK 79% of patients would choose to die at home however the variance is great with only 18 – 49% achieving this.
- Explore how services in New Zealand have overcome the sharing of notes and information to ensure all professionals dealing with patients have the same consistent information. Examples in the UK are Summary Care Records and EPaCCS.
- Understand how organisations and services in New Zealand are delivering 24hr 7day a week End of Life Care for people being cared for outside of hospital.
- Understand the integrated health and social care system in the Canterbury District as this model is being developed within the five year forward view ‘new models of care’ (NHS England 2014a).
9.0 PALLIATIVE CARE IN THE UK – CONTEXT

End of Life Care (EOLC) is one of the greatest challenges we face as a society and a health care system. Currently although well regarded internationally, (the UK came top of the Quality of Death Audit) Thomas & Paynton 2013, we know there are serious problems and we are not yet getting it completely right. The majority of commissioners across the UK have some type of target around EOLC/Palliative Care. For example to increase the number of patients on the supportive care/palliative register, increase the number of patients who die in their preferred place of choice, increase the number of patients on an appropriate care plan that allows for EOLC discussions and acknowledges the patient’s wishes.

Planning and purchasing of NHS services is referred to as commissioning. In England, general hospital services, urgent and emergency care, mental health and community services are commissioned at population level by 211 clinical commissioning groups (CCGs), who hold the majority of the NHS budget (65 billion in 2012/13). Each CCG is formed from the GP practices in that locality, who come together to assess the needs of their population and commission services from NHS or other provider organisations that meet those needs (Kings Fund 2013). Commissioning End of Life (EOL) Care passed to Clinical Commissioning Groups (CCGs) in April 2013. Patients who are approaching the end of their life need high-quality treatment and care that supports them to live as well as possible until they die and to die with dignity. In light of recent publicity of the Liverpool Care Pathway, do not resuscitate orders, and lack of dignity in hospitals (NHS Confederation 2012), I felt that a Fellowship to add knowledge to our current understanding of EOL could benefit the NHS system. End of life care involves a large number of third sector providers, notably hospices, and some small organisations that could be unintentionally destabilised by changes in commissioning arrangements, including the impact of potentially having to work with multiple commissioning organisations. In addition, it is now widely agreed (General Medical Council 2010) that high-quality treatment and care towards the end of life includes palliative care that focuses on managing pain and other distressing symptoms; providing psychological, social and spiritual support to patients; and supporting those close to the patient. However, it is not always recognised that palliative care can be provided at any stage in the progression of a patient’s illness, not only in the last few days of their life. Whilst there is a considerable amount we can learn from New Zealand, I found that many of the UK practices are heralded as best practice by New Zealand and they look to us for many ideas, inspirations and knowledge to improve their current practices. Whilst in Wellington, I was asked to deliver several presentations (Appendix 11) on the 6C’s, Commissioning and my leadership journey. The clinicians were really keen to learn about our Compassion in Practice strategy (NHS England 2014b) and before leaving the UK I discussed this with Jane Cummings, our Chief Nurse for England, who was really supportive of my approach to the sessions.

This report summarises the various organisations I visited across New Zealand and extracts any learning that can be transferred to the UK systems. Whilst several recommendations have been made, I’ve begun to make some changes within the CCG and the commissioning landscape I’m currently working in as follows:

- Appointed 2 GPs to lead on EOL and Cancer Care in collaboration with Macmillan for 2 years.
- Appointed a project lead for the Derbyshire wide EOL project to support me in the dissemination and learning from New Zealand.
- Presented my high level findings to the CCG senior management team.
- Commissioned a GP to undertake a further EOL audit of all deaths across Erewash.
- Delivered an awareness raising session with GPs, Practice Nurses and Practice Staff.
- Hosted the CQC for their thematic review of palliative care services.
10.0 FINDINGS
10.1 Advance Care Planning (ACP)

It’s interesting that we don’t plan for the one thing that is definitely going to happen – dying. New Zealand have progressed advanced care planning otherwise known as ‘conversations that matter’ and it has been in use for several years now (Ministry of Health 2011). There is also access to an on-line programme for nurses to do on ACP. I attended an excellent session at the APAC conference on the use of ACP delivered by Dr Barry Snow, Helen Mason and Leigh Manson. They suggest that 70% of people think about dying, and yet in the UK only 45% have discussed what their wishes would be in relation to one or more aspects if they didn’t have long to live, and only 5% report having a living will or advance care plan. Even more remarkable only 11% have written plans in place for their funeral (Shucksmith et al 2012). Shucksmith et al also suggests that there is a growing body of research that shows that planning for and talking about end of life (essentially ACP) is associated with a ‘better quality’ death and less emotional stress for bereaved family members. A lovely analogy for the ACP was ‘the patient was the captain in the Waka’ (large New Zealand canoe) which New Zealanders can really relate to.

Photo: slide from ACP session at APAC conference - patient in control original Waka vessel

Helen Mason also suggested at the conference that end of life used to be very quick whereas now we have ‘prolonged dwindling’ which lends itself to having an ACP to ensure our wishes are considered and understood.
It didn’t matter where I visited in New Zealand both North and South Island everyone had access to the same high quality information in the form of websites, leaflets and documentation. The Ministry of Health is very good at providing material for the healthcare workforce. We have a tendency to produce local information which has varying levels of quality, often photocopied several times.

In October 2015 the UK Department of Health (DH 2015) responded to the House of Commons Health Select Committee Report on End of Life Care and made clear the recommendation for Advance Care Planning. They suggest ‘there remains significant work to be done, particularly at the local level, where implementation will ultimately be driven’. They recommend the following: ‘that all staff who provide palliative and end of life care to people with life limiting conditions should receive training in advance care planning, including the different models and forms that are available and the legal status of different options. Training should be developed in partnership with the National Council for Palliative Care and other non-government bodies with relevant expertise’. In Christchurch they rolled out ACP slightly differently by targeting the GPs, so they have 80% of ACPs generated by the GP and GPs are then reimbursed ($172.62 per ACP) much the same way as we use Locally Enhanced Services (LES) to introduce new quality initiatives amongst GP practices.

10.2 Volunteers

In my travels I met several volunteers doing a wide variety of roles from cook, gardener, odd job man, making toys specific to that child, and holding a child that was dying as she had no parents. In fact many of the hospices in New Zealand had huge amounts of volunteers, Hospice Waikato in Hamilton had 680 and Mary Potter Hospice in Wellington had 700. Waikato had worked out that volunteers saved them approximately $140,000 (£60,460) per month and unlike the UK volunteers are allowed to be used in any roles as long as they are trained and have the relevant updates. They seemed to be able to integrate so sensitively into the patient and families lives. They offered compassionate caring to support families in the remaining months and weeks of life and make it as meaningful and comfortable as possible. They came
from all walks of life such as students, retired, ex-nurses and much more. They went through the same strict application and screening process and had to complete a specialised training programme before spending time with patients and families. The volunteer who sat with the dying child had lost a granddaughter some years previously and it was something she felt she could give back.

Similarly to the UK, the hospices run several retail charity shops which have been integrated into the local communities and are run by volunteers. I visited the one in Wellington which was being run out of an old warehouse and had plenty of customers when I was shown around. Where these shops are placed is hugely important and can decide its success or downfall.

![Photo: Mary Potter charity shop](image)

Another successful role used widely at Waikato and Mary Potter Hospice was that of volunteer biographers; Vivienne Pender at Mary Potter said ‘I enjoy stories, listening to the ordinary everyday lives of people resonating personality. I enjoy those unique times in life when I am truly listened to by someone who is free of their own stories, willing to give full attention. It is this experience, this deep listening, that we bring to people who are dying when they record their life stories in biography. We want the dying person to be in charge of what they express. It is not unusual to hear the words: “My life is not interesting to anyone else. I can’t think of anything to say”. Then, with rapport established and the ability of the volunteer biographer to truly listen, people are often surprised by the memories and experiences that pour forth’. I was really touched by the idea of biographers who can capture a person’s thoughts, feelings and experiences as a memento for the family left behind. Waikato Hospice explained the training that these volunteer biographers go through from listening, scribing, and the use of rapport.
The recent framework written by the National Palliative and End of Life Care Partnership (2015) suggest that volunteers contribution can be used to far greater effect. To achieve their ambition, more needs to be done locally and nationally to recruit, train, value and connect volunteers into a more integrated effort to help support people, their families and communities. The Derbyshire wide EOL project will explore the use of the voluntary sector, which services are available and how people get sign posted to the right services through the use of the voluntary single point of access (VSPA).

10.3 Hospice and residential support

The New Zealand Government will pay for 28 days residential care for any patient classed as palliative to give carers respite. Mercy Hospice top this funding up as it equates to $70 (£36) a day. One of the reasons they choose to do this is because it would cost $1000 (£517) a day if the patient came into the hospice for respite. This system seems to work really well with the hospice social worker negotiating with the community nurses, family and the residential home for a bed. The community hospice teams go into residential homes (which are all private) to provide care, support and education. One of the reasons this can happen is because the government pays 70% of the hospice funding and so can determine what provision they want for its population. In the UK commissioners have to negotiate with the hospices and cannot tell hospices what to do as they only fund a maximum of 30% for the care of those patients, everything else is fund raised from the public. As a Clinical Trustee for a Children Hospice in the UK, the hospice receives a maximum of 15% funding from commissioners. Patients are allowed to have $200,000 (£86,400) in the bank plus their house before they have to pay for residential care. The government pays $120 (£51) a day for residential care. In the UK its all means tested and you pay for your residential/nursing care home if you have assets and savings of more than £23,250. New Zealand residential care homes receive training both face to face but also innovatively via large TV screens where hospital and hospice staff deliver training via this medium. This would certainly be something we should consider in the UK because staff struggle to be released to attend training but if it was on site this would ease the pressures.

We have just introduced telehealth into 6 care homes in Erewash this is often referred to as the Airedale model because the consultations are provided by staff based at Airedale NHS Trust. I was able to observe several telehealth consultations whilst at Christchurch hospital with John Garrett Senior, Medical Officer
in paediatrics (www.nztrc.org.uk). This was set up by Christchurch because there were no paediatricians able to cover the West Coast of the South Island so instead of having to travel several hours in a car, John set up the telehealth system and has had great success and received wide interest in his successful model. There are now 400 units across New Zealand for this network which started in 2001. The system has been expanded to include MDT meetings, and they are experimenting using patients own mobile devices. Currently 10% of all follow ups are seen in this way. They also have the units in GP practices on the West Coast which is something we are considering in the UK.

Hospices in New Zealand also provide a 24hr telephone support to all their patients no matter where they are. The Sue Ryder Charity (2014) found that 92% of CCGs failed to provide a 24 hour support telephone help line for patients at the end of life, this means only 8% actually offer a 24 hour helpline for patients and carers at the end of life. The National Palliative and End of Life Care Partnership (2015) suggests that every person at the end of life should have access to 24/7 services, as needed, as a matter of course and that all commissioners and providers have to engage in defining how their services will operate to ensure expert responsiveness to needs, at any time of day or night.

The Hospices across New Zealand received support from the Ambulance Trust and were not charged for journeys made to and from the hospice. The Ambulance Trust in New Zealand is run by St Johns Ambulance and is a charitable funded organisation, which means everyone has to pay an amount for the use of the ambulances even in certain emergencies (Appendix 12). You will see that if I had needed an ambulance, because I’m from the UK I would have had to pay. Ambulance staff are also able to view hospital and general practice notes on the patient, thus removing the problems we have with ambulance crews having to resuscitate a patient because the ‘Do Not Resus’ paperwork cannot be found where the patient is living.

Photo: St John’s Ambulance outside Middlemore hospital

10.4 ‘Don’t waste the patient’s time’

In Christchurch I saw an example of a campaign they had undertaken over the last 12 years, to address how in the healthcare system we waste the patient’s time in a variety of ways. Examples of the patient having to tell their story several times to many different professionals, how many extra days in hospital they spend, how they are bought back to hospital for outpatient appointments with different professionals but never on the same day. I was shown around the Design Lab which has taken large groups of people from different disciplines and undertook a programme of finding what mattered to them, their roles and responsibilities they could subscribe to. They were given innovative role playing
exercises whereby they got rid of their preconceived ideas and ‘baggage’ and were asked to think about what legacy they will leave for the healthcare system (in 30 years’ time), given the projected aging population and aging workforce. An excellent idea they came up with was taking everyone’s photo when they attended the first day on an iPad and then 30 minutes later they gave them their name badges with their aged appearance showing them 30 years older. This really focussed the attendees mind on the task at hand considering this prospect of being much older themselves as they said ‘they could own being old’. The guiding principle they came up with was

‘Don’t waste the patient’s time’

This in turn leads to the construction of a more productive and less wasteful healthcare system that has a patient (not cost reduction) focus. Not wasting the patients time had led to not wasting the healthcare workers time and health care resources. Examples are one stop clinics, when previously they would have attended several times including any investigations in between and triage of patients in 10 minutes at 24 hour GP clinics instead of waiting for up to 4 hours in A&E. The ‘Don’t waste the patient’s time’ philosophy, also takes away conflicts of interest with people who were fighting for their share of the money for their organisation, and instead has a focus on patient services for the population. It looks at patient experience and flows, and reduces wasted staff time and resources. There were three strategic goals as part of this exercise 1. People take greater responsibility for their own health 2. People stay well in their own home and communities, 3. People receive timely and appropriate complex care and support.

The Multi-Disciplinary Team meetings at Mercy Hospice, Waikato and Mary Potter were all about sharing information across community, secondary and hospice staff. They had teleconference facilities for everyone to dial in and contribute to individual patients needs and care plans.

PHOTO: MDT meeting at Mercy Hospice Auckland (including George the Labrador)

To meet the predicted increase in demand for beds at the Middlemore Hospital Auckland they set out on a journey to give patients back healthy days to live well in the community, this journey started in 2011 and was completed by July 2013. What they did was:

- Give back to the community 20,000 healthy and well days so reducing bed days by 20,000
• Reduce by 5,000 unnecessary hospital admissions

They planned to do this by:

• Helping people to live well in the community
• Keeping people at risk well in the community
• Rapid response in the community to acute events
• A coordinated and rapid care in Emergency Care
• Safe and timely care for those who need in-hospital care

This 20,000 days programme has now gone into its second phase and we can see a further drive to give patients valuable time back in their own communities and homes.

Photo: 20,000 day campaign and beyond

What became very apparent in my visits across New Zealand is they have really got to grips with longer term planning and places like the Design Lab in Christchurch allowed this to happen. Staff were given recognition for working many years in an organisation (long service achievement). We of course have this in the UK but it’s more about staying in the NHS than staying at a given organisation. New Zealand had long term ‘campaigns’ with on-going work and co-designing systems, rather than short term ‘pilot projects’ to be scaled up later. Examples for this long term thinking were the Campaign for one shared computerised record for all organisations including hospitals and GPs (working with private sector providers) and creating Health Care Pathways (with secondary care clinicians and GPs). The Accident Compensation Corporation (see Appendix 13) were thinking of collecting and investing funds to meet the liabilities of this generation (including earthquakes) rather than leaving a debt legacy for the future.
I saw many excellent examples of patient records being shared and used across organisations where GPs, hospices and secondary care could not only see, but also access patient records, thus reducing the times the patient has to re-tell their story. The ‘patient portal’ campaign was co-designed with stakeholders to create an e-platform for basic patient data accessible by all health staff and more importantly by social services, out of hours and ambulance crews too. The system in Christchurch had been accelerated due to the earthquake where many thousands of notes were destroyed. Pegasus the community and GP provider network, set in motion an electronic system to share notes and patient information. Whilst they had the work underway pre the earthquake this disaster accelerated the implementation plan.

**Photo: Christchurch New Zealand February 2011**

The National Palliative and End of Life Care Partnership (2015) have suggested there should be ambitious local targets for the rollout of systems for sharing digital records and widespread use of electronic systems should be encouraged across health and social care providers in the statutory, voluntary and private sector.

The Design Lab encourages experimentation but equally it encourages the idea of ‘Fail Fast’. Secondary to the investment of future ideas, was an acceptance that all projects will not succeed. In fact the Ministry of Health have said ‘expect 30% of your projects will fail’. So they accept ‘fail fast’ and move on, this is not something we in the NHS encourage, embrace or acknowledge. It’s almost as though we’ve spent the budget on this idea and it must succeed. How they have got around this in New Zealand is to put early evaluation into place so that if it’s going to fail it can be identified early and stopped quickly when small sums are at stake. However the point is organisations must not be afraid to try things out.
10.5 Nursing Challenge

Similarly to the NHS, New Zealand also has an impending issue of an aging workforce. They used to have to go overseas to attract nurses and in fact I was really surprised at the amount of ex- UK nurses and doctors working in New Zealand who have been there from 2 – 20 years. About 3 years ago they changed their model and they now have 6 students per ward as opposed to 1-2 students they used to have. They have increased their new grad intake to 160 just for Princess Margaret Hospital in Christchurch and this has started to have a positive impact on their nursing numbers. They also still have the new students go through generalist training first, which means there is no direct entry for nursing apart from midwifery. The student does 3 years training then once qualified they work on the wards/community. After 2 years they choose which post grad training they want to do and specialise for example in children’s and mental health. New Zealand wants a generalist workforce and Jenny Gardner (Nurse Coordinator at Princess Margaret Hospital Christchurch) said that because New Zealand has a small workforce due to its size, they need nurses to be able to move around and be generalist. In fact nurses in rural areas are also first responders, as we would use paramedics. Before a nurse can start a Masters Programme (specialise,) they have to have a career plan in place first signed off by their manager. I was lucky enough to be invited to one of the post graduate award ceremonies for a group of nurses and also met with New Zealand’s Chief Nurse, Jane O’Malley.

Photo: Post graduate award ceremony

Photo: Myself with Jane O’Malley Chief Nurse for New Zealand
Students pay for their own training via loans and there is only a 2-3% drop out rate, in comparison to the UK dropout rate of 20% (Nursing Times 2015). At the CNO summit (Dec 2015), Jeremy Hunt announced that NHS England are also thinking of stopping the bursary process in the UK and replacing it with a loan system, there is considerable concern over this proposal.

In April 2016 nurses in England will start a new revalidation system, having to provide evidence in hours of learning, reflection, patient care and feedback. This has been established in New Zealand for several years now and the system seems to work really well. Nurses there can also undertake an additional post development recognition programme that means they will not be spot check audited, as they have already provided evidence of reflection. If ward nurses take up the additional development programme, they are paid additional monies each year ($3,000), senior nurses don’t receive this. If you want any post graduate funding for courses, you have to have undertaken the additional post development recognition programme.

Photo: expert portfolio contents page from the recognition development programme
11.0 CONCLUSIONS

The Winston Churchill Fellowship enabled me to travel to New Zealand to see if there were developments and pathways that could be replicated back in Derbyshire. My research question was: What innovative developments programmes are in place across New Zealand specifically to EOL Care, we can learn from and introduce in Derbyshire. There was so much to learn and I’ve not been able to capture it all in this report, but I intend to publish my findings and recommendation so that other organisations can learn from my experiences. On the back of receiving this Fellowship I submitted a proposal to Macmillan to appoint 2 GPs for the first time across Erewash to lead on EOL care and Cancer and they started in post in June 2015. I’ve also secured funding for a project manager to support the implementation of the recommendations, as set out in section 12, which will start November 2015 for 18 months.

New Zealand has managed to integrate both health and social care together as well as integrate hospices and secondary care services. My recommendations build strongly on this ethos and the direction of travel the MCP Vanguards are taking will support this work.

Before going to New Zealand, I felt strongly that patients in Derbyshire were not always getting a ‘great’ service and I heard many stories from both staff and patients saying that

‘sometimes I get ‘night sitting’ and sometimes I don’t’.

‘the agency rang at 9 at night to say they couldn’t send anyone’

‘The Erewash care team are great but they sometimes have a waiting list they’re so busy’

‘There isn’t a helpline at night and I get scared, I’m not sure I will be able to cope’

These quotes are from staff, patients and families and the aim of this project is to make sure all patients at the end of life have access to the care and services they need. The EOL audit, (Appendix 9), showed that patients were still attending A&E via ambulance, when they were known to be at the ‘end of life’ and this is what this project aims to prevent happening.

There are some huge inequalities in funding of the voluntary sector and hospices compared to New Zealand, ours being an average of 30% and theirs being 70%, I’m not sure the funding streams across England will ever compare to New Zealand but I’m hoping this report will at least highlight the issue.

Creating individualised person centred care means ensuring palliative and end of life care is part of the new models of integrated health and social care. Such systems are being promoted, supported and developed across the NHS, the voluntary sector and the wider health and social care system over the next 5 years, with Erewash at the forefront being a Vanguard for the MCP model.
12.0 RECOMMENDATIONS

Erewash CCG has a registered population of 97,000 and the Palliative and End of Life Services are currently delivered by a range of different providers, Derby Teaching Hospitals FT, Nottingham University Hospitals, Macmillan, Treetops Hospice, Marie Curie Services, Derbyshire Community Health Services and a range of voluntary sector providers. Whilst the services provided are extensive, I want to explore fully whether the individual and collective services are providing the care required to support End of Life for patients and their carers. Following my successful application for the Winston Churchill Fellowship I decided to submit a proposal to Macmillan to fund a project lead to support me in implementing my findings from New Zealand, which I was successful in doing. The following recommendations are part of that project:

LOCAL

- Scope current provision of End of Life Care across Derbyshire, to include statutory and voluntary sector provision.
- Explore fully whether the individual and collective services are providing care required to support end of life for patients and their carers.
- Undertake a new audit of deaths in Erewash to benchmark current practice and outcomes with future provision (last done in 2013).
- Develop agreed outcomes and Key Performance Indicators shaped by patient/carers and stakeholders.
- Engage with patients and carers through patient and participation groups (PPGs) to provide case studies that can influence future provision and highlight any gaps. Introduce the 15 second video ‘message of improvement’ concept I took part in at the APAC Conference (Appendix 3).
- Develop a commissioning plan for the 16/17 contracting round.
- Influence workforce redesign to include integration of social and healthcare staff as part of the Vanguard project for MultiSpeciality Community Provider (MCP) (see Appendix 4).
- Review the Voluntary Single point of access (VSPA) service (Appendix 5) to see if it ensures value for money, patients are receiving timely and appropriate advice and services.
- Promote the use of Advanced Care Planning (ACP) working with stakeholders set up awareness raising sessions, promote the use of ACP through the CCG website.

NATIONAL

- Contribute to the National CQC thematic review of End of Life Care. One of 17 CCGs across the UK to take part (see Appendix 6).
12.1 ACTION PLAN

<table>
<thead>
<tr>
<th>Outline</th>
<th>Findings</th>
<th>Lead</th>
<th>Timescales</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Project resources</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recruit interim project Lead</td>
<td></td>
<td>AMO</td>
<td>Completed Oct 2015</td>
</tr>
<tr>
<td>EOL audit of deaths across Erewash for 2014 to act as benchmark for change</td>
<td></td>
<td>PL</td>
<td>Dec 2015</td>
</tr>
<tr>
<td><strong>Phase 1 – Detailed scoping of the current EOL service across Erewash linking with North Derbyshire</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A health service by service review across Erewash</td>
<td>10.3 10.4</td>
<td>ZB</td>
<td>Nov 15 – March 16</td>
</tr>
<tr>
<td>Social Care and Voluntary sector – a service by service review</td>
<td>10.2</td>
<td>PN</td>
<td>Nov 15 – March 16</td>
</tr>
<tr>
<td>Patient and user experience – feedback on current provision of services</td>
<td>10.3</td>
<td>RM</td>
<td>Nov 15 – March 16</td>
</tr>
<tr>
<td>Drawing together the information from all providers to review and understand any areas of overlap and gaps</td>
<td>10.3 10.4</td>
<td>ZB</td>
<td>Feb 16 – April 16</td>
</tr>
<tr>
<td><strong>Phase 2 – Design of a platinum service</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engagement work with key stakeholders to identify what a platinum service should look like</td>
<td>10.4</td>
<td>ZB</td>
<td>Feb 16 – April 16</td>
</tr>
<tr>
<td>Patient and Carer engagement for the Service redesign</td>
<td>10.4</td>
<td>RM</td>
<td>Feb 16 – April 16</td>
</tr>
<tr>
<td><strong>Phase 3 – Development of a commissioning Plan</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Using the outcomes of phases 1 and 2, a sustainable commissioning plan will need to be developed</td>
<td>10.4</td>
<td>ZB/AW</td>
<td>April 16 – June 16</td>
</tr>
<tr>
<td>Further review of the plan with stakeholders/patients and carers will be required</td>
<td>10.4</td>
<td>ZB</td>
<td>May 16 – June 16</td>
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<tr>
<td>The plan should allow sufficient time to influence contracts for 2017/18. This would enable discussions with providers during the 16/17 year, prior to the more formal contracting round</td>
<td></td>
<td>CCG Contracts team</td>
<td>August 16 – Dec 16</td>
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<tr>
<td><strong>Phase 4 – Implementation of a commissioning plan</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Implementation of the commissioning plan</td>
<td></td>
<td>AW</td>
<td>April 2017</td>
</tr>
<tr>
<td>Contract/Outcome/KPI monitoring</td>
<td></td>
<td>CCG Contracts team</td>
<td>April 2017 onwards</td>
</tr>
<tr>
<td>Development of framework for evaluation</td>
<td></td>
<td>ZB</td>
<td></td>
</tr>
<tr>
<td><strong>Phase 5 – Monitoring and evaluation</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Patient and Carer experience feedback and evaluation</td>
<td>10.1 10.4</td>
<td>RM</td>
<td>Feb 17 – Oct 17</td>
</tr>
<tr>
<td>Service Pathway Evaluation</td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Project Outputs/Benefits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Development of a CCG End of Life Strategy</td>
<td></td>
<td>ZB</td>
<td>Apr 16 – June 16</td>
</tr>
<tr>
<td>A single point of access for all service users for palliative and EOL care</td>
<td>10.2 10.4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please note phase 4 and 5 can run concurrently.

In reviewing the quality of the current services and designing the platinum model of care, the following points will be considered:

- Identification of people who are at the end of their life – does that happen in a timely way? Are services accessed when they should be? What improvements can be made?
• The role of the voluntary services – with particular focus on the local vSpa – are the carers in Erewash assessing the services they require? Can this be improved?
• How well are we doing in helping people to die well? Review of the achievement of preferred place of care, patient experience feedback. Are services responsive? Is there sufficient service provision 24/7?
• Are the services communicating and engaging with patients and carers? Do they feel well informed, empowered and able to make decisions?

The plan will be to evaluate and review the current service arrangements to determine where and what change will need to take place, therefore the evaluation framework will be developed at the start of the second year. The outcomes and KPIs will be shaped by patient/carers and stakeholders as part of the engagement work, to determine the platinum pathway.

The CCG is part of the first wave of Vanguards on the MultiSpeciality Community Provider (MCP) (Appendix 4) and this project will complement the Vanguard model.

12.2 FURTHER ACTIONS AND DISSEMINATION

<table>
<thead>
<tr>
<th>PLAN</th>
<th>ACTION</th>
<th>TIMESCALES</th>
</tr>
</thead>
<tbody>
<tr>
<td>CQC thematic review</td>
<td>Contribute to thematic review and incorporate findings and recommendations into this project</td>
<td>November 2015 – March 2016</td>
</tr>
<tr>
<td>Report for WCMT</td>
<td>Complete report for WCMT within 3 months</td>
<td>December 2015</td>
</tr>
<tr>
<td>Newsletter articles</td>
<td>Send press release for Palliative Care Nurses NZ</td>
<td>Completed November 2015</td>
</tr>
<tr>
<td></td>
<td>Send press release to WCMT</td>
<td></td>
</tr>
<tr>
<td>Publish findings from Fellowship</td>
<td>Approach peer review journals to publish findings and recommendations</td>
<td>February – June 2016</td>
</tr>
<tr>
<td>Secure funding for a project manager</td>
<td>Submit proposal to Macmillan to fund project manager to scope services across Derbyshire</td>
<td>Completed – Nov 2015</td>
</tr>
<tr>
<td>Influence commissioning intentions for 17/18</td>
<td>Present report and findings to Erewash Governing Body</td>
<td>February – October 2016</td>
</tr>
<tr>
<td>Disseminate report</td>
<td>Send report to relevant stakeholders including contributors from New Zealand</td>
<td>February 2016</td>
</tr>
</tbody>
</table>
Appendix 1

Burdett Trust for Nursing

The Burdett Trust for Nursing jointly funds 10 Fellowships with the Winston Churchill Memorial Trust. The aim of the partnership is to improve the health and well-being of patients, a key element of the Medicine, Health & Patient Care category. The Burdett Trust makes grants in support of nurse-led projects, using its funds to empower nurses and make significant improvements to the patient care environment. The Burdett Trust for Nursing is an independent charitable trust named after Sir Henry Burdett KCB, the founder of the Royal National Pension Fund for Nurses (RNPFN). The Trust was set up in 2002 in recognition of the foundation, philosophy and structure of the RNPFN.

Nurses, midwives and the allied health professions make up the majority of the healthcare workforce and play a pivotal role in direct care to patients. The Trust makes grants in support of nurse-led projects, using its funds to empower nurses and make significant improvements to the patient care environment.

Appendix 2

Pegasus

Primary Care network federation of 245 GP practices (for GP collaboration and support). Pegasus provides back office functions such as IT help desk, clinician education programme, budget holding, pharmacy support, after hours cooperative, Health pathway delivery programme, and GP software development. They help individual practices reorganise themselves through workshops to build capability. There are very few home visits most are done by acute domiciliary nursing teams. Telehealth, telephone and email consultations are done. GPs are motivated by 1. Help and deliver a better service, 2. Have a better work life balance, 3. Leave a legacy for the next generation. Across England, GPs are part of the CCG as they are members but they are forming what we call federations and this has the capability of forming functions that can be done for all practices, thus reducing cost and duplication. In Erewash the federation has just begun to take form and has been called Erewash Health (12 practices), following wide consultation with patients and public.
Appendix 3

Give it a go – ‘telling your story’

Exploring the experience of people who have received or delivered health and disability services is one way of understanding how these services can be improved. Story telling is a mechanism by which people can reflect on their experiences. It is a powerful tool for challenge and change. Stories take a number of forms and come naturally to some people. Stories designed to communicate messages benefit from careful preparation. This workshop will engage participants in ways to do this and offer the opportunity to film some of the participants’ stories.

- Peoples experiences in health and disability services are a valid measure of quality and inform improvement.
- Negotiating understanding and meaning in peoples stories can improve health services.
- Preparation of your story helps to communicate your message.

We formed into groups of 8 and shared our stories and experiences. From these stories we chose a theme that we felt was important to get our message across in a 15 second video. Our theme was ‘communication’ as we all had a poor experience to relay. We then identified someone to be filmed, and someone to be a sign writer (creating 1-2 word written sign that captures the essence of each story). The 15 second video became our snapshot of a ‘message for improvement’. At the end all the videos were put together and shown as a 2 minute video. It was really compelling and an excellent media to use. We are going to use this in our Derbyshire wide project to get patient stories to inform our understanding of the current services and to see what patients want for the future.

The topics suggested were:

- When I was told I had........
- The treatment I had ........
- While I was in hospital .........
- When my GP told me..........
- When I left hospital..........
Appendix 4

Multi Speciality Provider (MCP)

Patients in Ilkeston and the wider Erewash area are to benefit from extra investment in local health services, after being chosen to pilot a new way of organising NHS care locally.

Erewash CCG’s partnership with community health providers and GPs has been recognised as one of only 29 Vanguard sites across the country to be exemplars of better care. As such they have received a share of £200 million Department of Health funds to help drive forward improvements in health and community care across the areas they serve.

The bid was chosen for the partnership’s innovative plans to transform care for patients by improving the way GPs, healthcare professionals and local authorities work together to support people to stay well, live independent lives and avoid hospital admissions. The bid outlines plans to forge even strong links with voluntary groups, health and mental health care providers, to deliver more joined up and integrated care. The partnership has also committed to providing personalised care plans for people with long term conditions.

Appendix 5

VSPA

The VSPA is accessed by a single telephone number, for those working with patients/clients who are registered to a North Derbyshire, Hardwick or Erewash GP practice (excluding Children under the age of 18, self-referrals from general public, patients/clients with an acute mental health problem, Patients/clients with acute dental problems, patients/clients with life threatening emergencies needing acute hospital admission).

The VSPA worker agrees with the referrer the nature of the voluntary sector service/s required, contacts the patient to discuss what they feel they need, and then liaises between the patient and voluntary sector to arrange the service. It is essential that the patient agrees that their information can be shared with VSPA. The referrer will be advised of the outcome, with the patient’s/client’s consent.

- The VSPA is responsible for ensuring the appropriate organisation contacts the patient/client and the service commences in line with the agreed timescales.
- The VSPA transfers patient information to the voluntary sector organisation to enable the provision of care in a seamless and timely manner.
- If Derbyshire Community Health Services (DCHS) SPA/Clinical Navigation Service identifies an additional need that can be provided by the voluntary sector they can refer directly into the VSPA.
  This supports the resilience of the local health and social care system in North Derbyshire, Hardwick and Erewash.
- The VSPA is delivered by staff with appropriate levels of training and understanding of the local voluntary and community sector to enable them to deliver a safe and effective service.
- The VSPA utilises an information system to enable easy electronic capture of patient/client demographics, referrer, needs and organisations referred to.
- The VSPA provides to commissioners monthly performance monitoring data.
Appendix 6

CQC Thematic Review

The CQC are undertaking a thematic review of inequalities and variation in the quality of End of Life Care (Nov 2015 – March 2016). Evidence shows that people in particular groups, including people with the most complex conditions and those who are vulnerable because of their circumstances, experience end of life care which is poorer quality and does not always meet their needs, and that variations in care, and coordination of care, at local level contribute to this. There are examples of good practices and the review aims to identify and document to enable others to learn from what works well. The work will inform commissioners and national and local stakeholders how they can address inequalities based on these findings. The key lines of enquiry for this review aim to explore how well services work together and the effectiveness of care pathways from the perspective of someone who has experience of end of life care, rather than the quality and safety of care of one provider. The focus for the review is inequalities and variation in relation to four aspects:

- Identification and communication
- Coordination of care across services
- Timely access to good care
- Care in the last few days and hours of life.

This national review will inform the CCGs commissioning intentions as well as feed into the Erewash specific EOL pathway.
## ITINERARY OF TRAVEL

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<thead>
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<th>Date</th>
<th>Location</th>
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<td>18th Sept</td>
<td>Arrive Auckland</td>
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<tr>
<td>22nd Sept</td>
<td>Auckland</td>
<td>Denise Kivell CNO then Eastern Health Study Tour</td>
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<tr>
<td>23rd Sept</td>
<td>APAC conference, Auckland</td>
<td>Professor Jonathon Gray</td>
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<tr>
<td>24th Sept</td>
<td>APAC conference, Auckland</td>
<td>Professor Jonathon Gray</td>
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<tr>
<td>25th Sept</td>
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<td>Professor Jonathon Gray</td>
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<tr>
<td>27th Sept</td>
<td>Auckland</td>
<td>Spend afternoon with Jenny Thurston Nurse Lead</td>
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<td>28th Sept</td>
<td>Mercy Hospice Auckland</td>
<td>Jenny Thurston - Nurse Leader</td>
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<td>29th Sept</td>
<td>Travel to Hamilton</td>
<td>InterCity Coachlines</td>
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<td>Zoe Fairbrother, Caren Barnett, Sandy Haggar, Gordon Giddings Medical officer</td>
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<td>Jude Pickthorne - palliative Care CNS, Dr Jonathon Adler, Dr Maureen Coombs</td>
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<td>6th Oct</td>
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<td>Bruce Wilson - Project Lead Palliative care managed clinical network</td>
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<td>7th Oct</td>
<td>Wellington Mary Potter Hospice</td>
<td>Wendie Ayley CNS, Vanessa Eldridge Maori Liaison</td>
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<td>Wellington Te Omanga Hospice</td>
<td>Heather Spence CNS, Mary Death DON, Ian Gwynne Consultant, Eleanor Barratt OT</td>
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<td>9th Oct</td>
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<td>Andrea McCance DON Canterbury DHB and Emma Hickson DON PHO</td>
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<td>Design Lab, Brian Dolan, Richard Hamilton, Mary Gordon DON, Jane O’Malley DON for NZ</td>
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<td>13th Oct</td>
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<td>Michael McIlhone DON Pegasus, Nurse Maud, John Garratt, Kate Gibb</td>
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<tr>
<td>17th Oct</td>
<td>Travel home</td>
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</table>
- Visited Middlemore Hospital
- APAC Conference Auckland
- Mercy Hospice

- Visited Waikato Hospice and Rainbow Place Hamilton

- Wellington General Hospital
- Mary Potter Hospice
- Te Omanga Hospice

- Design Lab Christchurch
- Princess Margaret Hospital
- Christchurch Hospital
- Pegasus (PHO)
- Nurse Maud
Appendix 8

APAC CONFERENCE (Asia Pacific Healthcare Conference)

APAC Forum, managed by Ko Awatea, the centre for health system innovation and improvement at Counties Manukau Health. I attended this conference from the 23rd September until the 25th September 2015 and went to the following sessions: the conference was opened up by Film Director Peter Jackson:

23rd September – Masterclass on Large Scale Change to achieve best care everywhere.
- Lisa Schilling from Kaiser Permanente
- TED talks

24th September – Plenary session by Dr Jonathon Gray
- Theatre company delivered stories from patients
- Workshop – Give it a go: Telling your story why what and how! (see Appendix 7)
- Key note inspirational speaker Itay Talgam (excellent session and thought provoking equating leadership to conductors in an orchestra)
Photo: Itay Talgam inspirational key note speaker

25th September – Plenary session by Charles Vincent on patient safety
- Building resilience in front line healthcare Jo Soldan Debbie Minton
- Conversations that matter Dr Barry Snow, Helen Mason and Leigh Manson

The conference was closed by an inspiring session from Ruby Wax who was able to get the audience of 1,200 to undertake a few minutes of mindfulness.

Photo: Ruby Wax at the APAC conference talking about mental health, how our brains work and mindfulness
Appendix 9

CHRISTCHURCH EARTHQUAKE

On 22 February 2011 Christchurch was struck by an earthquake that devastated its centre and caused immense damage to other parts of the city. It killed 185 people and injured some 6,600 more. Christchurch Hospital itself survived, but most health buildings including all the hospitals, were damaged in varying degrees of severity. On the day, five general practices were completely destroyed – with 11 clinicians among the dead – and many other practices and pharmacies were severely disrupted as power and water supplies disappeared. Around 14 per cent of the city’s residential care beds were destroyed.

More than four years later, as the city regenerates, buildings in its centre are still being demolished. Some general practices and pharmacies will still have to relocate, as structural surveys show they are insufficiently sound to withstand another shock. Parts of Christchurch Hospital remain unusable. It lost 103 inpatient beds in the quake – though all but 33 of those were later provided at Princess Margaret Hospital in Christchurch. Parts of Burwood, an elective orthopaedic centre in the north-east of the city, are also still unusable, as are parts of the mental health facility at Hillmorton in the city’s south-west, and Ashburton Hospital, an hour’s drive south of Christchurch. As a tiny but stark reminder of what happened, the clock on the shored-up memorial to Queen Victoria’s jubilee stands frozen at 12.51, the moment the earthquake struck. Despite the earthquake, the improvements to Canterbury’s system of health and social care outlined above have continued. Indeed, the response to the quake accelerated some changes that were already in place and introduced several new ones – a classic demonstration of the rule that good can come out of crisis. But it would be a mistake to believe that the earthquake is largely responsible for the progress that has been made. The response would not have been what it was without the foundations already laid to move to a more integrated, patient centred health and social care system. Canterbury provides much food for thought for the many clinicians, funders and managers interested in better demand management in primary care, allied to significant improvements in hospital efficiency that in turn have an impact on the use of social care.
Appendix 10

END OF LIFE AUDIT 2013

Sudden/unexpected death by place of death

<table>
<thead>
<tr>
<th>Place of death</th>
<th>Totals</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home/Usual place of residence</td>
<td>32</td>
<td>36%</td>
</tr>
<tr>
<td>Hospital</td>
<td>46</td>
<td>52%</td>
</tr>
<tr>
<td>Elsewhere</td>
<td>11</td>
<td>12%</td>
</tr>
</tbody>
</table>

Expected deaths

<table>
<thead>
<tr>
<th>Age of death</th>
<th>Number of deaths</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;40</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td>41-50</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td>51-60</td>
<td>13</td>
<td>5.6%</td>
</tr>
<tr>
<td>61-70</td>
<td>33</td>
<td>14.3%</td>
</tr>
<tr>
<td>71-80</td>
<td>63</td>
<td>27.3%</td>
</tr>
<tr>
<td>81-90</td>
<td>73</td>
<td>32%</td>
</tr>
<tr>
<td>&gt;90</td>
<td>47</td>
<td>20%</td>
</tr>
<tr>
<td>Total</td>
<td>231</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Place of death</th>
<th>Totals</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home/usual place of residence</td>
<td>113</td>
<td>49%</td>
</tr>
<tr>
<td>Hospital</td>
<td>94</td>
<td>41%</td>
</tr>
<tr>
<td>Hospice/Community hospital</td>
<td>20</td>
<td>8%</td>
</tr>
<tr>
<td>No place recorded</td>
<td>4</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td>231</td>
<td>100%</td>
</tr>
</tbody>
</table>
Admission route of those (expected) dying in hospital that was recorded in records.

<table>
<thead>
<tr>
<th></th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted by 999</td>
<td>26</td>
</tr>
<tr>
<td>Admitted by OOH</td>
<td>16</td>
</tr>
<tr>
<td>Admitted by GP</td>
<td>7</td>
</tr>
</tbody>
</table>

Anticipatory medicines prescribed

<table>
<thead>
<tr>
<th>Anticipatory meds prescribed</th>
<th>Totals</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full 5</td>
<td>42</td>
<td>52%</td>
</tr>
<tr>
<td>Part &lt; 5</td>
<td>34</td>
<td>42%</td>
</tr>
<tr>
<td>None</td>
<td>5</td>
<td>6%</td>
</tr>
<tr>
<td>Total on PC register</td>
<td>81</td>
<td>100%</td>
</tr>
</tbody>
</table>

The full 5 anticipatory medications consist of: Diamorphine, Midazolam, Haloperidol, Hysocine, Water

Appendix 11

PRESENTATIONS

Leadership and Values of a Quality Culture Presentation
Wednesday 7th October 2.00 - 3.00
Easthope Seminar Room, Ward Support Block Wellington Hospital

You are invited to spend an hour with Anne-Marie Olphert Chief Nurse and Quality Officer who will share her experience on the role of nurses in leadership and ensuring a quality health care service.
Appendix 12

ST JOHNS AMBULANCE TRUST

Please read below for an explanation of our ambulance charges:

For emergencies and accidents

Do I need to pay a part charge?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If I have a medical emergency</td>
<td>If you’re treated by an ambulance officer and/or transported in an ambulance because of a medical emergency, there is a part charge you have to pay – even if someone else calls the ambulance for you.</td>
</tr>
<tr>
<td>If I have an accident</td>
<td>If you have an accident related injury, that is covered by the Accident Compensation Corporation (ACC) for ambulance transport within 24 hours of the injury and if the injury meets ACC criteria.</td>
</tr>
<tr>
<td>If my injury did not occur today</td>
<td>If you have an accident related injury that is more than 24 hours old or injuries that do not meet ACC criteria, you need to pay the part charge.</td>
</tr>
</tbody>
</table>

How much do I pay? **Charges across the country (GST inclusive)**: $88.00

*St John does not provide emergency ambulance services in Wellington or the Wairarapa.*

Do I pay a part charge if I am from overseas?

- Yes: If you are from the Cook Islands, Niue or Tokelau.
- Yes: If you are a work visa holder eligible to be in NZ for two years or more.
- Yes: If you are a UK citizen normally living in the UK and visiting NZ.

**Charge for non-eligible visitors (GST inclusive)**: $800.00

How do I pay? We will post you an invoice and details of how you can pay it.
Appendix 13

Accident Compensation Corporation (ACC)

The ACC is unique to New Zealand and was set up in 1974 with monies from various sources. It covers the treatment, rehabilitation and compensation for patients who have had an accident. This includes medical mistreatment. Compensation can be up to 80% of wages. There is no fault finding and no ability (or need) to sue for damages. Treatment is comprehensive and includes hospital, GP, dental and pharmacy costs and death compensation. Funds for this scheme are raised from employers, employees (PAYE), annual car registration, petrol tax, and the government for the non-earners. They also get significant investment income from their reserves which they use.

14.0 References


