Advance Care Planning Programme Steering Group
Terms of Reference
January 2018

1. PURPOSE OF THE GROUP

The national advance care planning (ACP) steering group is established by the Health Quality & Safety Commission (the Commission) to provide advice and support for the effective delivery of the advance care planning 2018-2022 strategy and five-year roadmap of actions (attached as Appendix One).

This includes:

- promotion of ACP
- development of resources including for Māori, Pacific and Asian populations
- education and training
- monitoring and evaluation
- implementation of ACP at DHB level
- determining priority and pace of projects for national consistency
- fostering regional and national collaboration.

The role of the group is to:

- provide advice to the Commission's ACP team on the local and regional implementation of ACP, including issues and challenges
- act as a communication and feedback channel between DHBs and others involved in ACP and the Commission's ACP team
- report on the local and regional delivery of the ACP plan and roadmap of actions, to be part of the evaluation of the programme.

There is no formal accountability framework for the group.

2. BACKGROUND

The Commission is managing the national ACP programme until the end of December 2019, with funding from DHBs. It is currently developing a work plan for the next two years, in consultation with DHBs.

Having national funding for ACP for the next two years is an exciting opportunity to support the national direction for ACP, update existing resources and develop new ones and undertake wider promotion of the programme. There will be a strong focus on supporting DHBs to continue to implement ACP locally, and to train their own staff in having ACP conversations.

3. MEMBERSHIP OF THE STEERING GROUP

The term of the steering group membership will be from appointment to 31 December 2019. The group will continue beyond this point subject to the future funding of the programme.

Membership of the group will be reviewed in December every year.

Any member may at any time resign as a member by advising the Chair in writing.

The steering group membership will include:

- Consumer representatives, including Māori and Pacific representation
- Regional ACP representative for each of the 4 regions
- A representative from each region's DHB ACP implementation managers/facilitators
- Training subject matter expert
- Aged care representative
- Clinical leads from regions
- Māori and Pacific health professionals
- Primary care representative, eg, GP or practice nurse
- A secretariat consisting of up to seven Commission staff members, including the Director of Communications, Snr Programme Manager, Implementation Manager, ACP Promotions Coordinator and representatives from the Partners in Care and Deteriorating Patient programmes.

Required skills and attributes

As a collective, steering group members will have these skills and attributes:

- strong regional networks of those interested in and working with ACP, and existing communication channels with those networks
- understanding of ACP needs of consumers, including Māori, Pacific and Asian populations.
- operational knowledge of ACP in the health sector
- strategic knowledge of ACP at a regional level
- clinical application of ACP, and insight from the frontline.

Duties of the chair

The Chair shall be elected from within the membership at the first meeting.

The chair is responsible for guiding the work of the group and meetings, and for ensuring all committee members and advisors are able to contribute fully to the group's work.

Each committee also has a deputy chair appointed by the group. The deputy chair takes the chair's place when they are unavailable for meetings.

4. WAYS OF WORKING

- The steering group's way of working is through collaboration and consultation.

- The steering group will meet/teleconference five times in the 2018 calendar year. The aim is for:

    - Monthly teleconferences starting mid-February 2018
    - one face-to-face meeting by end April 2018

- Face-to-face meeting will be held in Wellington and last a maximum of four hours
- Teleconferences will last a maximum of 1.5 hours.
- Steering group members will receive relevant information at least a week before each meeting
- Steering group members are expected to participate fully in meetings, including reading circulated documents and contributing to discussions
- Experts may be invited to advise the group, as required. For example, to discuss evaluation and monitoring.
- Minutes of the meeting will be kept by the secretariat and agreed by all members of the steering group who participated in the meeting
- Members may be contacted between meetings for advice, should the need arise.

Relationship between the ACP advisory group and ACP steering group

The ACP steering group will focus on operational aspects of ACP and delivery within the health sector, while the ACP advisory group will think strategically about the future of ACP and opportunities across sectors.

- The advisory group's ideas and thinking will feed into the thinking of the steering group – particularly when undertaking operational planning for future years.
- The steering group will provide advice on the practical implementation of the suggested directions for ACP from the advisory group.
- The Commission will ensure each group is aware of the thinking of the other by providing updates at meetings and sharing minutes.

5. ATTENDANCE FEES

Members may be entitled to be paid fees for attendance at meetings, including time spent on teleconferences.

Fees are set and reviewed in accordance with State Services Commission guidelines ("Fees and allowances for statutory and other bodies") and in accordance with *Cabinet Office Circular CO (12) 6,* dated December 2012[1]. Fees are not negotiable.

The fee for a half day face-to-face meeting is $320 for members and $450 for the Chair. Payment for teleconferences is calculated at the rate of one eighth of the relevant daily rate per hour.

There is an expectation that members are remunerated for their time, but not if they are already receiving payment for that time from another source. The onus is on members to alert their employers and/or the secretariat to ensure that double payment does not occur.

[1] See http://www.dpmc.govt.nz/cabinet/circulars/co12/6#_tocSection_C_

Fees are subject to withholding tax, which is deducted from the fees at a rate of 33 cents in the dollar. Members are required to fill in an IR330 form and forward it to the secretariat, together with a bank account number to which fees and expense reimbursements are to be paid, or, where appropriate, an IR331 exemption form.

Individuals who are GST registered or organisations who are claiming the fee payments on behalf of a member may send a tax invoice for payment of fees.

The secretariat will automatically pay the prescribed meeting fee following the meeting, unless the member is invoicing through an individual company or organisation. Expense claims, which are discussed below, need to be lodged manually with the secretariat.

6. EXPENSES

Steering group members' travel arrangements will be made by the ACP secretariat, and funded by the Commission.

The following may be claimed, where appropriate, and are not subject to withholding tax:

- Vehicle mileage (calculated at 77c/km)
- Taxi expenses
- Domestic airport departure tax
- Parking fees at airports and hotels.

If there is any doubt about the validity of claims, please contact the secretariat for advice, preferably before incurring any costs.

All reimbursable committee expenditure is to be submitted on a Commission claim form, with supporting tax invoices or receipts, and submitted to the secretariat for processing.

Claim forms should be sent to the secretariat as soon as possible after each meeting. Please ensure the advisory group name and date of the meeting is on the claim form/invoice.

7. THE SECRETARIAT

The steering group will have a secretariat to provide administrative and analytical support, provided by the Commission.

This includes preparing and distributing agenda and associated papers at least five days prior to meetings; recording and circulating of minutes no later than a fortnight following the meeting date; managing the organisational arrangements for meetings including provision of rooms and audiovisual equipment.

Appendix One: Five-year strategy for ACP

PROMOTION **Normalise future healthcare planning**	**Objective**	**Strategies**
	Consumers and health care professionals are routinely talking about future healthcare planning, recognising different cultures and experiences. Death is considered a natural process – the conclusion of the life cycle and not a 'failure' of care.	▶Promote future healthcare planning to the public, health and social workforce. ▶Discuss and network across the health, social and wider sectors. ▶Ensure ACP and person-centric values-based care planning is on the national health and social care agenda. ▶ACP interactions are culturally and socially appropriate
	Local action by DHBs	**National action by the Commission**
	Create an expectation that what matters to consumers informs care planning	Promote future health care planning using a mix of public relations, networking events, and stakeholder engagement
	Promote the benefits of future healthcare planning within the DHB, to providers, NGOs, ARC facilities, PHOs, GP and community groups	Develop resources to support local awareness raising Respond to strategies, initiatives and actions nationally that impact on ACP Network at senior level within health and social care, with a specific focus on ARC, Health of Older People, Palliative Care and Long Term Conditions
	Collect and share consumers and healthcare workforce stories	Engage and build relationships with organisations outside health that could support the societal cultural change required
RESOURCES **ACP is available to all**	**Objectives**	**Strategies**
	New Zealanders can develop an ACP, no matter where in the country they are, their ethnicity or socioeconomic status.	▶Resources are developed with our communities to ensure utility & cultural appopriateness ▶Resources support healthcare workers, community volunteers and consumers ▶Resources are consistent, widely available and useful to all
	Local action by DHBs	**National action by the Commission**
	Identify the resource needs of local groups	Evaluation of available of ACP Guide and Plan
	Modify national resources to meet local cultural needs	Identify and develop resources and cultural tools to increase ACP access for Maori, Pacific and Asian populations using co-design
EDUCATION AND TRAINING **A prepared workforce and community**	**Objectives**	**Strategies**
	The health care workforce is skilled in communicating and working with patients, families/whānau to make shared decisions about health care. *There is a skilled volunteer workforce able to support people to have conversations and develop their ACP*	▶Support DHBs to deliver ACP and clinical communication education locally ▶Provide evidence-based advanced clinical communication training ▶Support DHBs to train and maintain a volunteers workforce
	Local action by DHBs	**National action by the Commission**
	Recruit skilled staff interested in facilitating training; providing time and support for facilitators to be trained and to deliver training within the DHB district	Develop a Train-the-trainer programme to train facilitators locally Develop standardised training course content to be delivered by local facilitators - for health workforce and volunteers
	Develop the infrastructure to support their trained staff to effectively deliver ACP and clinical communication training	Evaluate faciltators and training quality and support facilitators to ensure sustained quality and skill
	Recruit a team of volunteers and train them locally	Support DHBs in the development of infrastructure, processes and policies to maximise the value of the training
	Support volunteers to work with the community and consumers	Maintain a team of advanced communication trainers and professional actors
MONITORING & EVALUATION **Care is based on what matters to consumers**	**Objective**	**Strategies**
	Measurement and evaluation show the programme is meeting the needs of consumers, healthcare workers and providers	▶Measurement approach is developed, and baseline measures taken ▶A continuous improvement approach is undertaken
	Local action by DHBs	**National action by the Commission**
	Data is collected	National measures for process and impact are developed in consultation with DHBs Data is analysed and reports generated
	Run projects to address local opportunities for improvement	Improvements made to programme based on monitoring and evaluation findings
IMPLEMENTATION **Maximising value**	**Objectives**	**Strategies**
	Systems and processes maximise the investment in ACP and training *What is important to consumers is recorded, shared and valued*	▶Processes and policies ensure that the value of training, resources and care planning is maximised ▶ACP conversations are consistently recorded ▶ACP plans are easily stored, retrieved and used by consumers and healthcare workers
	Local action by DHBs	**National action by the Commission**
	Build systems and processes into existing structures that ensure ACP deployment is successful	Develop a model of care to support DHB's integration of their systems to ensure ACPs are recorded, retrieved and used, including a how-to guide for DHBs
	Provide appropriate support and resource	Work with electronic health record (EHR) leads to ensure ACP is considered in the design and implementation of a national EHR
	Make recording, storing and retrieving advance care plans and notes of ACP conversations easy for consumers and clinicians through DHB systems.	