Health Consumer Council Agenda

Venue: Tawa Room BOPDHB Education Centre

Date: Wednesday 11 March 2020 Time: 10.30-1.00pm

Attendees: Sue Horne, John Powell, Florence Trout, Lisa Murphy, Mere Pomana, Rosalie Crawford, Tessa Mackenzie, Theresa Ngamoki, Grant Ngatai, Terehia Biddle, Adrienne von Tunzelmann.

Item No	Item	Paper	Who	Action
1	**Opening of Meeting:** **Karakia**: Apologies: Conflict of interest			
2	**Presentations:** 2.1(10.30am)Topic is - Planned Care Programme 2.2 Jerome Ng – Introduction to HCC members 2.3 Graham Cameron - An overview of Te Toi Ahorangi - Maori Health Strategy	Planned Care Engagement Pack.pdf	• Bronwyn Anstis • Julia Braid • Dorothy Mckeown • Jerome Ng • Graham Cameron	
3	**Minutes of Meeting**: 12.02.2020 to be confirmed.			
4	**Matters Arising** : 4.1 Review of TOR – Is current format still relevant? Include process of election of Chairperson and Deputy Chairperson. ***TOR:** Terms of Reference - BOPHCC - 2019 Final(*** BOP Health Consumer Council EGM** Annual EGM.pdf	All documents are attached in this Agenda	• All	Note HCC reps to be involved (1 per visit)

	4.2 Update on Health Liaison Group interface 4.3 Drop in visits. (view on Connex)		• John • All / Averil	
5	**Correspondence:** 5.1 Letter of thanks to Arona Smith **5.2** Letter of Invitation to Dr Sarah Mitchell		• Sue	
6	**For Discussion:** 6.1 Chairperson report 6.2 **2020 Priorities Summary** • Disability Strategy update • SLM update • Complaints Policy and Protocol – *review and comment on consumer centeredness.* • Consumer Engagement Quality and Safety marker memo – *review and comment on final draft.* • Consumer Engagement Guidelines review (on hold until Person Centred lead position finalized) • "Te Toi Ahorangi future topic for consideration		• Sue • All / Averil • Grant (Point of contact)	
7	**Patient Experience**: Nil			
8	**Reports of participation in other groups** (Please email Sue, with brief details, if you have a group to feedback on, prior to meeting)		• All	
9	**General Business**:			
10	**Karakia:** **Close Meeting:** **Next Meeting**: Wednesday 8th April 2020 (Please note this meeting has been cancelled due to COVID-19) **Venue:** BOPDHB Education Centre Tawa Room,889 Cameron Road)			

Health Consumer Council
Matters Arising 2020

Meeting Date	Item	Action required	Action Taken

Attachment 1 : TOR DOCUMENT

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI	**BOP Health Consumer Council** **Terms of Reference - 2019**
Purpose:	The BOPHCC is an advisory and advocacy body which will endeavor to represent the Bay of Plenty community to advance the BOPDHB's mission of "*Enabling communities to achieve good health, independence and access to quality services".*
Functions:	The BOP Health Consumer Council will: • Promote meaningful consumer participation and maintain an overview of consumer engagement activity across the BOPDHB • Identify and advise on issues requiring consumer and community participation, including input into the development of health service priorities and strategic direction • Review and advise on reports, developments and initiatives relating to the provision of health services • Promote communication and networking with the community and relevant consumer and special interest groups as required, for specific issues and/or problem solving • Challenge planned services for any omission or disadvantage to those in most need For the avoidance of doubt, the BOPHCC will NOT: • Provide clinical evaluation of health services • Be involved in the BOPDHB's contracting processes • Be held accountable for decisions made by BOPDHB's management and/or governance whether compatible with BOPHCC's views or not • Discuss or review issues that are (or should be) processed as formal complaints, for which full and robust BOPDHB processes exist • Represent any specific consumer interest group or organisation nor enter into communication with a clear conflict of interest
Level of Influence	The BOPHCC has the authority to give advice and make recommendations to the BOPDHB senior management and Board.
Secretariat	Secretariat support will be provided by the BOPDHB Programme Manager, Consumer and Tangata Whenua Engagement and Participation.
Membership:	The BOPHCC will comprise up to 15 consumer representatives. Members will have diverse backgrounds, contacts, knowledge and skills, and must be passionate about consumers being able to access the best possible health care and services from the BOPDHB. Members will be selected to reflect a range of areas of interest e.g. Maori health, women's health, child health, long term conditions, mental health, and disability. • Although appointed to reflect the consumer voice in a particular area of interest, an individual member will not be regarded as a representative of any specific organisation or community, nor as an "expert" in that field. • When selecting members, consideration will be given to maintaining a demographic balance that reflects the Bay of Plenty population. • Inaugural members will be appointed for a one or two year term, members may be reappointed for no more than three terms; Members will be provided with training and support by the BOPDHB to undertake their role successfully as required.

	• All members are responsible for ensuring their behavior reflects the BOPDHB's expected standards of conduct (Shared Expectations) and CARE values (Manaakitanga). • Remuneration shall be paid based on the BOPDHB consumer engagement payment and reimbursement of expenses guidelines. • Members must perform their functions in good faith, honestly and impartially, and avoid situations that might compromise their integrity or otherwise lead to conflicts of interest. • Members are required to declare any actual or perceived conflict of interests to be recorded in the BOP Health Consumer Council Interests Register. • Membership may be terminated or full dissolution of the BOPHCC may be undertaken by the Chief Executive Officer (CEO) of BOPDHB in consultation with the Chair of BOPHCC. Termination may be requested within 3 months from when performance is found to be unacceptable. • Members who fail to attend three consecutive meetings without an apology will be asked by the Chair to step down from the BOPHCC.
Chairperson	The inaugural Chair will be appointed by the BOPDHB CEO (or delegate) for a term of one year. Thereafter the Chair will be appointed by the CEO following consultation with BOPHCC members.
Meetings:	• A minimum of ten meetings per year will be held February to November. Should more meeting time be required this will be treated as an 'out-of-session' consultation. • A quorum will be half the current membership, including the Chair or their delegate. • Others may attend as invited persons to facilitate the business on hand by invitation of the Chair. • Minutes and agendas will be circulated at least a week prior to each meeting, with any reading material attached. • Meetings will be up to two and a half hours, held at an agreed time, to enable all members to participate. • Meeting summaries will be published on the BOPDHB website and be open to staff and the public. On occasion when there are issues of confidentiality or other risks, meetings may be closed in full or part at the discretion of the Chair.
Reporting:	The BOPHCC will report to the BOPDHB CEO. Reports and minutes will be placed on the BOPDHB website once approved by members. Minutes of those parts of any meeting held in "public" shall be made available to any member of the public, consumer group, community etc. on request to the Chair.
Terms of Reference Review:	Members will review the Terms of Reference (TOR) biannually and make any recommendations for change to the CEO.

BOP HEALTH CONSUMER COUNCIL ANNUAL ELECTION GENERAL MEETING

1. An annual election general meeting will be held each XXXXX for the election of Chair and Deputy Chair and for council members to confirm they will continue or resign for the next term of one or two years; council members will serve for no longer than three consecutive two year terms.
2. The Chair and Deputy Chair will be elected by the members present at the election general meeting; the Chair will serve for no longer than two consecutive years; the incoming Chair and Deputy Chair shall take office at the conclusion of the election general meeting and the immediate past Chair may be called upon to support his or her succeeding Chair; A retiring Chair may not be re-elected after his or her retirement.
3. Other council members may be elected at the election general meeting to the supporting positions of work plan coordinator(s) and/or communication/publicity officer(s); Nominations for all positions shall be received as written nominations, duly proposed and seconded by members of the council, and with the nominee's signed acceptance. Such written nominations shall be received by the secretariat no later than fourteen days before the date set for the election general meeting.
4. Election of all eligible council members shall be as follows:
    4.1. Where only one nomination for a position has been received, that person shall be duly elected to that position
    4.2. Where more than one nomination has been received for a position, the names of the nominees shall be put to the vote by secret ballot of council members present at the election general meeting.
5. If a position is not filled at the election general meeting, or for any reason a vacancy arises, the BOPDHB Chief Executive shall have the authority to appoint to that vacancy until the next election meeting; such co-opted members shall have the powers of elected members.

Planned Care

Engagement support pack and Frequently Asked Questions

Vision

New Zealanders experience timely, appropriate access to quality Planned Care which achieves equitable outcomes

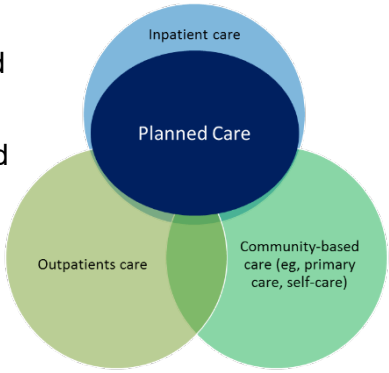
Document Name:	Planned Care Engagement support pack and Frequently Asked Questions
Version:	FINAL
Date:	24 May 2019
Author:	Julie Palmer, Electives and National Services Team

Planned Care

What is Planned Care?

Planned Care encompasses medical and surgical care traditionally known as Elective or Arranged services that are delivered in hospitals. It also includes a range of treatments funded by District Health Boards (DHBs) delivered in primary or community settings.

Planned Care considers more than just hospital-based care and admissions, it includes all appointments and support people need during their healthcare journeys.



Planned Care generally begins from the point a person is referred from their primary care provider or another health professional for specialised care. Care is delivered by the most appropriate health professional in the most appropriate setting.

Planned Care is about providing a pathway of care based on people's clinical needs to achieve improved health outcomes, within the publicly-funded resources available. It's about understanding a person's situation, working together with them so they understand the options available to them and can make informed decisions based on their needs, priorities and values.

Planned Care is not intended to replace existing terms and concepts such as 'acute', 'arranged' and 'elective' admissions. These concepts will continue to exist. The intention of Planned Care is to take more deliberate steps toward considering these concepts collectively and in the context of quality of services, service user's experience and equitable health outcomes.

Delivering Planned Care will require close partnerships between the Ministry of Health (MOH), DHBs, Primary Health Organisations (PHOs), general practice and other primary care providers, individuals and whānau, to adopt innovative and evidence-based approaches.

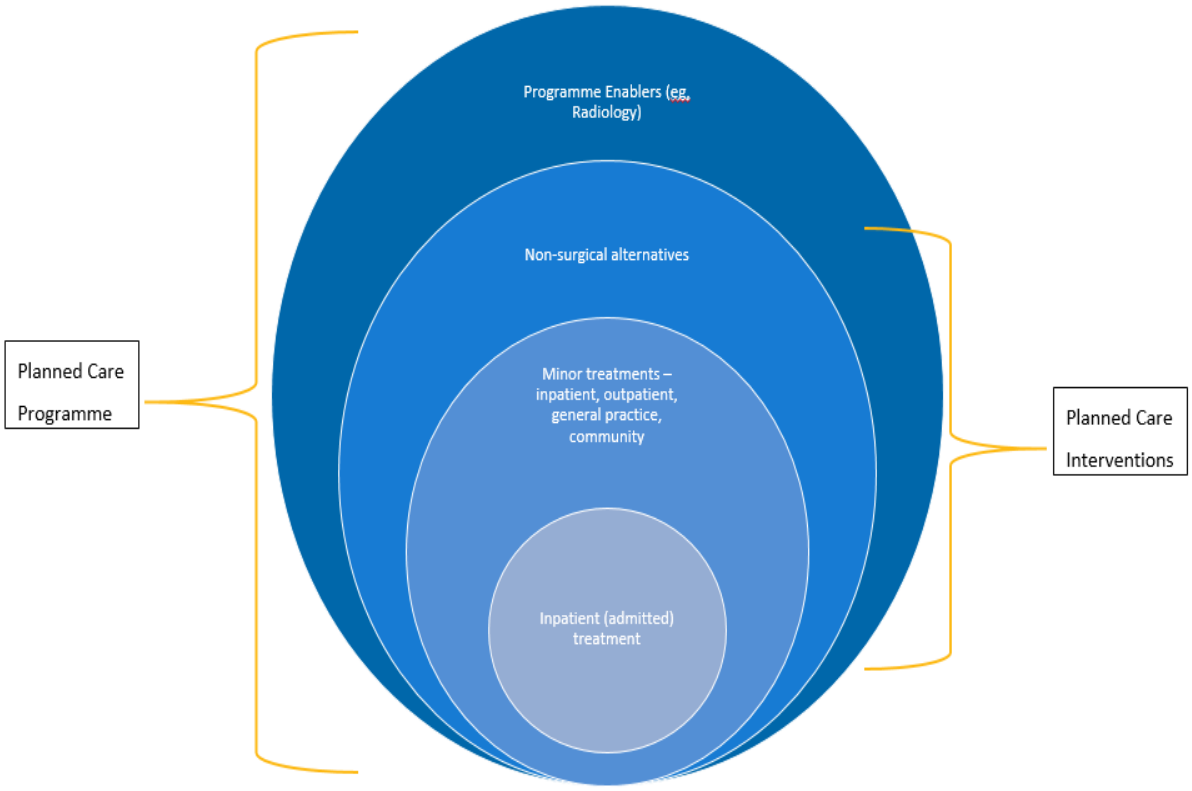


Figure One: Planned Care programme and interventions

Why do we need a new approach?

The previous Reduced Waiting Times Strategy was established in 2000. The challenges facing our health system have evolved and changed since then. An ageing, more co-morbid population, increasing expectations by service users and funding/ capacity constraints are some of the drivers placing increased pressure on Planned Care services.

With the Reduced Waiting Times Strategy services were delivered in line with the Strategy's principles of clarity, timeliness and fairness. After many years of consistent focus and investment, there have been significant increases in the number of first specialist assessments and procedures delivered as well as reductions in waiting times. This has been enabled by hospitals' use of prioritisation and urgency tools so that people who have the greatest clinical needs and potential to benefit get their care first.

However, there is general consensus across the Sector that it's time to build on the improvements delivered over the past decades and mature our view of Planned Care. This means reassessing what we mean and expect when it comes to fairness, equity, and timeliness, and broadening our focus to include service quality and peoples experience of care.

Planned Care strategic vision, principles and priorities

Vision

New Zealanders experience timely, appropriate access to quality Planned Care which achieves equitable health outcomes.

The vision and priorities outline at a high level what we're aiming to achieve for the population of New Zealand and the principles that will support this direction. Taking steps towards the vision will be iterative and evolving. Open engagement across all parts of the system and with communities will be needed to understand how we might all contribute to creating change, develop sustainable improvements both in how services are delivered and the quality of care people receive.

Principles

- **Equity** – You'll get the healthcare that safely meets your needs, regardless of who you are or where you are.
- **Access –** You can access the care you need in the right place, with the right health provider.
- **Quality -** Services are appropriate, safe, effective, efficient, and respectful and support improved health.
- **Timeliness –** You will receive care at the most appropriate time to support improved health and minimise ill-health, discomfort and distress.
- **Experience** – You and your family or whanau work in partnership with healthcare providers to make informed choices and get care that responds to your needs, rights and preferences.

Strategic priorities

- **Understanding health need -** Understand health need, both in terms of access to services and health preferences, with a focus on understanding inequities that we can change.
- **Balancing national consistency and local context -** Ensuring consistently excellent care, regardless of where you are or where you are treated.
- **Simplifying pathways for service users'** providing a seamless health journey, with a focus on providing person-centred care in the most appropriate setting.
- **Optimising sector capacity and capability -** Optimising capacity, reducing demand on hospital services and intervening at the most appropriate time.
- **Fit for the future -** Planning and implementing system support for long term funding, performance and improvement.

Planned Care Key messages

The following key messages have been prepared to support DHB staff in their engagment and planning activities related to implementation of Planned Care.

1. The Planned Care Strategic approach builds on the principles of the Reducing Waiting Times Strategy (Timeliness, Clarity and Fairness). The principles of Planned Care reflect a maturing of the Strategy and include equity, access, quality, timeliness and experience of care.

2. Changes are being made to the way Planned Care is counted, monitored and funded by the Ministry. This is to provide a broader perspective on the range of interventions delivered, expand the dimensions of quality that are monitored and remove disincentives that existed within the previous framework.

3. People will continue to be at the centre of Planned Care. Individuals and whānau will be supported to make informed choices about their health care needs and actively engaged as partners with their health care team. Peoples' experience of Planned Care will be that they are person-centred, enabling them to be easier to navigate.

4. Planned Care services will be designed and delivered based on robust understanding of population health needs, priorities and preferences, including where there are inequities in access to services and health outcomes. A key feature of Planned Care will be demonstated committment to actively identifying and prioritising solutions to address health inequities.

5. Planned Care will enable the design and provision of contemporary models of care, including early and preventive non-surgical pathways where appropriate, to be delivered in the community or primary care settings.

6. The measurement suite is iterative and a starting point for a more holistic view of Planned Care performance. Future 'ideal' measures will be confirmed with the sector over a three to five year pathway of evolving measures. Further information on measures that make up the framework are outlined in Appendix 4.

Frequently asked questions

1. What is the definition of Planned Care

Planned Care generally begins from the point a person is referred by their primary care provider for specialised care. It encompasses medical and surgical services that aren't required as an emergency or funded through the Accident Compensation Corporation (ACC). It includes all appointments and support people may need during their healthcare journey.

The programme of Planned Care covers a wide range of activities including surgery and other interventions, as well as enablers such as Radiology and First and Follow Up Specialist assessments.

2. Why has this new approach to Planned Care been established?

Changes are needed to enable the health sector to respond to an increasing and ageing population and changing public expectations of our health system. Maintaining the status quo will not support us to achieve equity and sustainability.

The previous approach has been criticised for the emphasis on counting hospital discharges which created a disincentive to making appropriate changes to deliver services outside of operating theatres or invest in earlier non-surgical interventions. Similarly, a focus on counting and reporting First Specialist Assessments led to some services giving less priority to other important or urgent activity.

It was also recognised that measuring the quality of Planned Care services should be expanded to provide a more comprehensive view of quality.

3. In what way is Planned Care different to Electives?

By recognising a broader range of activity, Planned Care will enable DHBs to deliver services in the most appropriate setting including services that can best be delivered in primary care and community settings.

Some non-surgical interventions will also be funded such as early intervention programmes for musculoskeletal conditions. These programmes will include education, physiotherapy, exercise programmes and multi-disciplinary advice that has not previously been publicly funded. Successful programmes will delay or even avoid the need for later hospital interventions.

Changes to the Ministry of Health's funding and monitoring frameworks are key to supporting this and are different to the previous model. This will reduce barriers to enable:

- delivery in less resource-intensive settings
- support non-surgical care alternatives
- support more contemporary models of care
- provide more flexibility on what services can be funded

4. How will Planned Care interventions be counted?

There needs to be a robust and reliable measure of the non-acute activity that DHB's are delivering. This is important as it is this non-acute (Planned) activity that can be seen as less urgent and deferrable. So measuring this activity provides insight into how the system is performing generally.

We will be measuring the 'count' of Planned activity by including the volume of inpatient, outpatient and some defined community interventions. This is to give a better indication of the level of activity that DHBs are delivering and does not dis-incentivise them from providing services in the most appropriate setting using more efficient and convenient delivery models.

This is one aspect of the new measurement suite for Planned Care

5. How will Planned Care be measured?

The new set of measures for Planned Care provide a more balanced and broader view across a range of measures. Each measure is linked to one of the five principles of Planned Care: equity, access, quality, timeliness and experience.

The measures span a range of areas from waiting times to volumes, while also including measurement of areas that enable Planned Care, such as Radiology services. The framework also links to measurement from other programmes closely aligned to Planned Care such as timely access to Cancer Services.

The intention is that Planned Care measurement will no longer be considered a barrier to DHBs implementing new models of care in less resource-intensive settings.

The Planned Care measurement suite is iterative. This is the starting point for taking a more holistic view of Planned Care performance. Future 'ideal' measures will be identified and developed with the sector over a 3-5 year pathway of evolving measures.

6. Will Elective Service Patient Flow Indicators (ESPIs) still be used?

Yes, ESPIs will continue to play a key role in the Planned Care measurement suite. Timely access to care is a measure of quality and it's important we continue to monitor and measure that commitments made to service users are being met.

7. Who was involved in the refresh of the Planned Care strategic approach?

The Ministry worked in partnership with a Sector Advisory Group (SAG) to develop the refreshed approach to Planned Care. The Ministry also sought feedback from DHB Consumer Councils on the draft principles and priorities of the strategic approach. Members of the SAG included:

- Jill Lane, previous Director, Service Commissioning, Ministry of Health (until October 2018)
- Michelle Arrowsmith, Deputy Director General, DHB Performance, Support and Infrastructure, Ministry of Health (from January 2019)
- Dr Andrew Simpson, Chief Medical Officer, Ministry of Health
- Dr Peter Bramley, Chief Executive, Nelson Marlborough DHB
- Kathryn Cook, CEO, MidCentral DHB (until October 2018)

- Fepulea'i Margie Apa, Chief Executive, Counties Manukau DHB (from December 2018)
- Mr Andrew Connolly, Head of Department, General Surgery, Counties Manukau DHB
- Carolyn Gullery, General Manager, Planning, Funding & Decision Support, Canterbury DHB
- Dr Jeff Lowe, Chair, General Practice New Zealand (GPNZ)
- Prof Chris Cunningham, Professor of Research, Centre for Maori Health and Development, Massey University
- Jess Smaling, Acting Group Manager DHB Performance and Support, MOH
- Simon Duff, Acting Manager, Electives and National Services, MOH

8. How will Planned Care help improve health equity?

The Government is committed to improving equity in access to services and health outcomes by ensuring the health system is delivering sustainably for all New Zealanders. To achieve equity the health sector needs to better understand the causes of inequities and identify actions needed to be prioritised to address these.

With Planned Care while the focus remains on timeliness and growing service capacity to meet growing population needs. It's also designed to address inequities in access to care and health outcomes. Planned Care will enable DHBs to design contemporary models of care including preventive and early intervention approaches that can lead to improved outcomes and reduced demand on hospital services.

In the updated Planned Care measurement suite, where applicable for all measures, information will be collected and reported on by key variables, age, gender, ethnicity and deprivation.

This information will be made available to DHBs for the first time. Through the accountability arrangement with the Ministry DHBs will be required to take action and report on improvements to health equity.

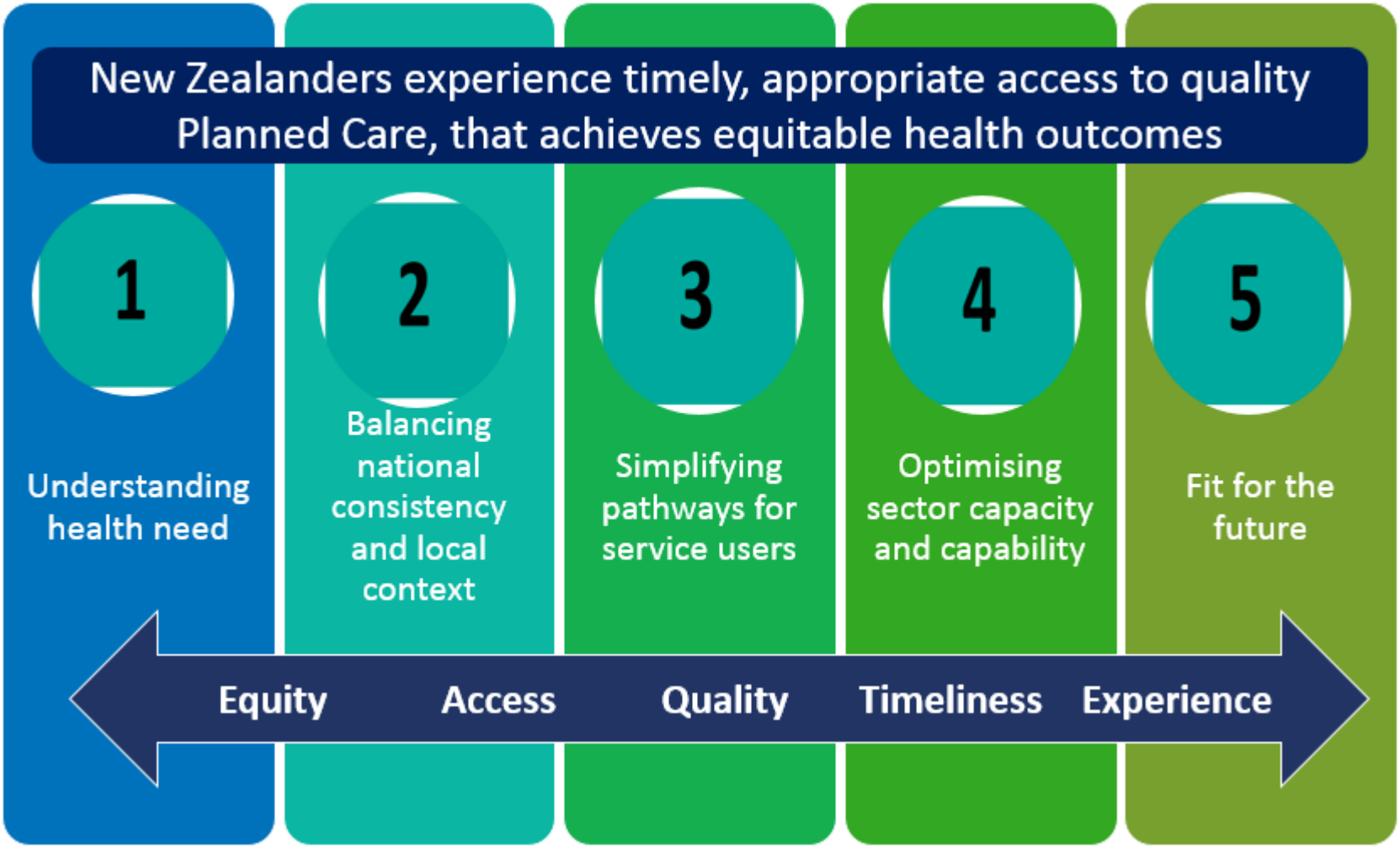
9. What support is available to help DHBs implement Planned Care?

The Ministry will continue to work with DHBs to support implementation of Planned Care. Following the regional engagement workshops, DHBs and the Ministry will have a much better idea on the ways Planned Care can be best implemented. Some areas may require local, regional or national responses. The Ministry will work with the sector to ensure it supports DHBs in the most appropriate way possible.

There are a range of resources available on QUICKR (The Planned Care website) that DHBs can access to support their improvement programmes. Further information about who to contact for these programmes and resources is attached in Appendix 5.

Appendix 1 - Planned Care Strategic Priorities
Appendix 2 - Planned Care Principles
Appendix 3 - Planned Care Interventions
Appendix 4 - 2019/20 Planned Care Measurement suite
Appendix 5 - Ministry contacts

Appendix 1: Planned Care Strategic priorities



Appendix 2: Planned Care Principles

How will planned care work?

Principles	what can I expect?	What will my healthcare provider do?
Equity *You'll get the healthcare that safely meets your needs and preferences, regardless of who you are or where you are.*	• I will be respected, regardless of who I am or where I am. • I will receive the same quality of care as other health users.	• Your provider will purposefully take steps to reduce health inequities. • Your provider is committed to ensuring people referred for Planned Care are treated fairly and consistently using appropriate assessment tools and locally agreed access criteria. • Your provider will organise and deliver services that are fit for their population's health needs, delivered in clinically appropriate timeframes.
Access *You can access the care you need in the right place, with the right health provider.*	• I get the right care, in the right place, from the right people to minimise ill-health, discomfort and distress. • I will be fairly assessed, based on my health needs and the impact on my life. • Information about access criteria and thresholds will be made available and understandable to the public.	• Your provider will ensure all people are treated based on need and potential to benefit from care. • Providers will work with you to develop an appropriate plan of care. • Providers will ensure you know who you can contact to get accurate, timely information about your care. • Providers will offer a range of services for people with different levels of need, assessing people fairly and communicating clearly.
Quality *Services are safe, effective, appropriate, and respectful and support improved health.*	• I will receive high quality care from skilled health care providers. • I will get the information I need in a timely manner so I understand what's happening at all stages of my healthcare journey and am empowered to make informed decisions.	• Providers will work within communities to help keep them as healthy, well and able as possible. • They will provide a culturally competent workforce that is connected to your community. • They will provide evidence-based care that reduces unnecessary variation and complications of care. • They will design services that are coordinated, reducing fragmentation, miscommunication and unnecessary hospital visits and appointments.
Timeliness *You receive care at the most appropriate time to support improved health.*	• I get the most appropriate care at the time when it can do the most good. • I know when I will be treated or next seen. • I know who to contact if plans change or I have questions about my care. • If I cannot be treated at the scheduled time, my provider will work with me to reschedule as soon as possible.	• Your provider will provide timely, clear communication about your plan of care. • They will care for you within agreed timeframes based on your preferences and needs. • Every effort will be made to avoid unnecessary delays in your healthcare journey. • When changes to plans need to be made, DHBs will make every effort to communicate promptly with you so you know what is happening and why.
Experience *You and your family or whānau work in partnership with healthcare providers to make informed choices about Planned Care which responds to your needs, rights and preferences.*	• I will work with my providers to agree my plan of care and outcomes. • I am supported to make my own choices and to set health goals and plans that are important to me. • My family or whānau are given information and support so they can support me.	• Your provider will work in partnership with you and your family or whānau to provide care that responds to your needs and preferences. • They will work you towards your health goals, including returning to activities that are important to you. • They will value your time and experiences and work to continuously improve care.

Appendix 3: Counting Planned Care Interventions

PLANNED CARE INTERVENTION	DEFINITION
Inpatient Surgery	Inpatients Surgery that is casemix included elective and arranged discharges from a surgical specialty, or from a medical specialty where a surgical procedure has been provided. Procedures are coded to National Minimum Data Set (NMDS).
Inpatient Minor Procedures:	Elective or arranged non-casemix surgical procedures, which are completed in an inpatient setting and coded to NMDS.
Outpatient Minor Procedures:	Selected range of minor procedures, which are completed in an outpatient or community setting and coded to National Non –Admitted Patient Collection (NNPAC).
Community Minor Procedures:	Minor operations, which are completed in a community setting and coded to National Non-Admitted Patient Collection (NNPAC).
Alternative Models of Care:	Alternative Models of Care completed and coded to NNPAC, based on purchase units to be confirmed.

Further detailed definitions for Planned Care Interventions will be place on the NSFL.

Appendix 4: 2019/20 Planned Care Measurement Suite

Principle:	**Access -** Patients can access the care they need in the right place, with the right health provider.
Measures:	• Planned Care Interventions, regardless of setting, inpatient, outpatient, community and provision of alternative models of care. • Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT) (ESPI 3) • The proportion of patients who were prioritised using approved nationally recognised processes or tools (ESPI 8)

Principle:	**Timeliness -** Patients receive care at the most appropriate time to support improved health.
Measures:	• DHB services that appropriately acknowledge and process more than 90% of referrals in 15 calendar days or less (ESPI 1) • Patients waiting longer than four months for their first specialist assessment (FSA) (ESPI 2) • Patients given a commitment to treatment but not treated within four months (ESPI 5) • Diagnostic Waiting Times - Coronary Angiography, Computed Tomography (CT), and Magnetic Resonance Imaging (MRI) • Ophthalmology Follow up Waiting Times – Proportion of patients seen for ophthalmology follow-up within clinically intended timeframes. • Faster Cancer Treatment – 31 day indicator (***Note:*** *this measure will be linked to the existing reporting through the cancer programme)* • Cardiac Wait times – proportion of patients seen within clinical urgency timeframes for cardiac surgery.

Principle:	**Quality -** Services are safe, effective, efficient, appropriate and respectful and support improved health outcomes.
Measures:	• Acute readmissions

Principle:	**Experience -** You and your whānau work in partnership with healthcare

	providers to make informed choices about Planned Care, which responds to your needs, rights and preferences.
Measures:	• Health Quality and Safety Commission (HQSC) inpatient experience survey • HQSC primary care experience survey (focus on specialist care and hospital service questions) ***Note:*** *these measures will be link to the existing System Level Measures.*

Principle:	**Equity -** You'll get the healthcare that safely meets your needs and preferences, regardless of who you are, or where you are.
Measures:	Where applicable for all measures above information will be collected and reported on by key variables, age, gender, ethnicity and deprivation. **Developmental measure:** Did Not Attends (DNAs) for FSA – *this measure will be developed from NPF during 2019/20.*

Appendix 3: Ministry contacts

Ministry leads for resources and information related to Planned Care

In the first instance, please contact the Lead contact for your DHB about any queries you have about Planned Care.

DHB	Lead Contact	Email
Auckland	Jane Potiki	Jane.Potiki@health.govt.nz
Bay of Plenty	Sue Morgan	Sue.Morgan@health.govt.nz
Canterbury	Simon Duff	Simon.Duff@health.govt.nz
Capital and Coast	Sylvia Watson	Sylvia.Watson@health.govt.nz
Counties Manukau	Mark Rahman	Mark.Rahman@health.govt.nz
Hawkes Bay	Hayden Luscombe	Hayden.Luscombe@health.govt.nz
Hutt Valley	Nik Straugheir	Nik.Straugheir@health.govt.nz
Lakes	Nik Straugheir	Nik.Straugheir@health.govt.nz
MidCentral	Sylvia Watson	Sylvia.Watson@health.govt.nz
Nelson Marlborough	Hayden Luscombe	Hayden.Luscombe@health.govt.nz
Northland	Loren Shand	Loren.Shand@health.govt.nz
South Canterbury	Annette Pack	Annette.Pack@health.govt.nz
Southern	Loren Shand	Loren.Shand@health.govt.nz
Tairawhiti	Hayden Luscombe	Hayden.Luscombe@health.govt.nz
Taranaki	Sylvia Watson	Sylvia.Watson@health.govt.nz
Waikato	Loren Shand	Loren.Shand@health.govt.nz
Wairarapa	Nik Straugheir	Nik.Straugheir@health.govt.nz
Waitemata	Mark Rahman	Mark.Rahman@health.govt.nz
West Coast	Simon Duff	Simon.Duff@health.govt.nz
Whanganui	Mark Rahman	Mark.Rahman@health.govt.nz

Speciality area contact

TOPIC	MINISTRY CONTACT
• **Funding and Monitoring of Planned Care** • **Diagnostics (Radiology)**	**Loren Shand** Team Leader, Funding & Monitoring, Electives & National Services DDI: 04 496 2312 / Mobile: 021 817 784 **Loren.Shand@health.govt.nz**
Prioritisation • Development and implementation of national prioritisation tools to provide an ethical, objective, consistent process for ranking patients by their clinical need and ability to benefit from surgery. • **Acuity tool** – a mechanism for determining the order of patient scheduling, based on clinical urgency and time waiting	**Mark Rahman** Senior Advisor, Electives & National Services, DHB Performance and Support DDI: 04 816 3520 / Mobile: 027 497 4992 **Mark.Rahman@health.govt.nz**
National Ophthalmology Collaborative	**Sue Morgan** Portfolio Manager, Service Improvement, Electives & National Services, DHB Performance and Support DDI: 04 816 2543 / Mobile: 021 223 7699 **sue.morgan@health.govt.nz**
Speciality-specific Improvement projects • Orthopaedics, vascular, plastics & reconstructive services • Patient Focussed Booking • Production planning • Streamlined preadmission processes • Reducing unnecessary follow ups • Musculoskeletal Early intervention programmes	**Simon Duff** Acting Manager, Electives and National Services DDI: 04 4962263 / Mobile: 021786145 **Simon.Duff@health.govt.nz** or **Julie Palmer** Acting Team Leader, Service Improvement Team, Electives and National Services DDI: 04 8163627 / Mobile: 021 221 6973 **Julie.Palmer@health.govt.nz**