# Text, letter Description automatically generatedMō te hōtaka whakamahere tiaki i mua i te wā taumaha me te hōtaka whakawhiti kōrero ā-haumanu 2022–28 |

# Strategy and road map of actions for advance care planning and clinical communication programme 2022–28

## Tā mātau matakitenga | Our vision

*Te whakamana i ngā tāngata o Aotearoa kia uru mai ki ngā mahi whakariterite i ngā manaakitanga ā muri ake mō rātau | Empower New Zealanders to participate in planning their future care*

## Ā mātau kaupapa rautaki matua | Our strategic priorities

Improving experiences for consumers and whānau.

* Embedding and enacting Te Tiriti o Waitangi, supporting mana motuhake.
* Achieving health equity.
* Strengthening systems for high-quality services.

## Mātāpono | Core values

*Wairuatanga | Spirituality –* the recognition and expression of wairuatanga is valued and encouraged within all processes and domains of advance care planning.

*Whakapapa me te tuakiritanga | Genealogy and identity –* the unique and full expression of identity is encouraged and valued. The unique mana, whakapapa and ancestry of everyone is respected and accepted through the process of advance care planning. Whānau are the centre of a Māori world view.

*Kaitiakitanga | Holistic multi-generational guardianship to keep whānau safe –* an advance care plan is a whānau taonga. Advance care planning combines spiritual, cultural and practical processes to guide and strengthen whānau across generations.

*Kotahitanga | Unity through consensus, collective decision-making –* advance care planning encourages whanau- and person-centred decision-making processes and supports mana motuhake.

[See page 2 for a summary of the six advance care planning workstreams and objectives.](#p2)

[See page 3 onwards for the full strategy and road map of actions for each workstream.](#_Strategy_and_road)

# Summary of six advance care planning workstreams and objectives

See [page 3 onwards](#_Mana_whakahaere_|) for the full strategy and road map of actions for each workstream. Click on any workstream heading to go straight to the detail.

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| [Mana whakahaere | Governance and leadership – Tā te tirohanga Māori | Supporting cultural safety](#_Mana_whakahaere_|) | [Ngā whakatairanga | Promotion – Kia mana te tangata me te whakamahere tauwhiro ā whānau | Normalise person- and whānau-centric care planning](#_Ngā_whakatairanga_|) | [Ngā rauemi | Tools and resources – Kia wātea katoa mai te whakamahere tiaki i mua i te wā taumaha | Advance care planning is available to all](#_Ngā_rauemi_|) |
| A commitment to cultural safety that increases health equity is fundamental to support a health system that works for all communities, and particularly Māori as tangata whenua. The leadership, management and delivery of advance care planning services is done in partnership with Māori. Services and resources specifically for Māori are created and delivered by Māori. People working in advance care planning enact the principles of Te Tiriti in their work. | Consumers talk about what matters to them and their whānau; they are supported to think about what that means for their current and future wellbeing; they can easily capture and share that as they choose.  Health care professionals are planning and delivering person- and whānau-centric care.  [**View Whainga hou 2022–24 | New actions 2022–24 for this workstream**](#_Whainga_hou_2022–24) | New Zealanders are supported by tools and resources that make it easy for them to engage in advance care planning.  [**View Whainga hou 2022–24 | New actions 2022–24** **for this workstream**](#_Whainga_hou_2022–24_1) |
| [Whakangungu | Education and training – He ohu mahi, he hapori hoki e rite ana | A prepared workforce and community](#_Whakangungu_|_Education) | [Aroturuki me te aromatawai | Monitoring and evaluation – Mā te kiritaki te tauwhiro e arataki | Care is based on what matters to consumers](#_Aroturuki_me_te) | [Whakakaupapa | Implementation – Kia nui te hua | Maximising value](#_Whakakaupapa_|_Implementation) |
| The health care workforce is confident and skilled to support people and their whānau to safely and effectively think, talk and plan for their care.  People who want to support members of their whānau or wider community to engage in advance care planning are confident and supported to do so.  [**View Whainga hou 2022–24 | New actions 2022–24** **for this workstream**](#_Whainga_hou_2022–24_2) | Measurement and evaluation show the programme is meeting the needs of consumers, health care workers and providers.  [**View Whainga hou 2022–24 | New actions 2022–24** **for this workstream**](#_Whainga_hou_2022–24_3) | What is important to each person and their whānau is recorded, shared, valued and used to inform health care planning and delivery for them.  Background pattern  Description automatically generated with medium confidence[**View Whainga hou 2022–24 | New actions 2022–24** **for this workstream**](#_Whainga_hou_2022–24_4) |

# Strategy and road map of actions for each workstream

## Mana whakahaere | Governance and leadership – Tā te tirohanga Māori | Supporting cultural safety

### Ngā tino whāinga | Objectives

A commitment to cultural safety that increases health equity is fundamental to support a health system that works for all communities, and particularly Māori as tangata whenua. The leadership, management and delivery of advance care planning services is done in partnership with Māori. Services and resources specifically for Māori are created and delivered by Māori. People working in advance care planning enact the following principles of Te Tiriti in their work:

**Wairuatanga** – the advance care planning and clinical communication training programme prioritises Māori world views, values and beliefs into care and treatment planning. Wairua informs the leadership, management and delivery of services. It is understood that wairuatanga is the core of the Māori world and supports Māori to live, thrive and flourish as Māori and can support all peoples to do the same.

**Kāwanatanga** – in advance care planning, shared decision-making is used to plan care and make health care treatment decisions. This ensures power is shared and that the care and treatment decisions align with what matters most to the person and their whānau.

**Tino rangatiratanga** – advance care planning provides for Māori autonomy and mana motuhake in the design, delivery and monitoring of services and resources. It enables the right for Māori to exercise authority over their lives according to te ao Māori (the Māori world) view. Te ao Māori is expressed through tikanga and kawa. It encompasses spirituality, cosmology, whakapapa, history, knowledge, cultural values and beliefs, and is encapsulated within mātauranga Māori.

**Ōritetanga** – advance care planning contributes to equity for Māori by including specific actions that support access and equitable outcomes for whānau Māori, enhancing mana of people over their life course and contributing to the overall health and wellbeing of Māori.

### Ngā rautaki | Strategies

* Increase Māori representation at governance level nationally and influence an increase at local level.
* Support Māori in the workforce to apply for positions in advance care planning leadership, implementation and training.
* Increase Pacific peoples’ representation at governance level nationally and influence an increase at local level.

## Ngā whakatairanga | Promotion – Kia mana te tangata me te whakamahere tauwhiro ā whānau | Normalise person- and whānau-centric care planning

### Ngā tino whāinga | Objectives

Consumers talk about what matters to them and their whānau; they are supported to think about what that means for their current and future wellbeing; they can easily capture and share that as they choose.

Health care professionals are planning and delivering person- and whānau-centric care.

### Ngā rautaki | Strategies

* Engage people to think and talk about what matters most and consider how that might impact on their health choices now and in the future, with a specific focus on supporting whānau Māori and Pacific peoples.
* Engage the health and social workforce to design and deliver person- and whānau-centric services.
* Engage organisations and groups beyond health to support people to think and talk about what matters most.

### Mahi ā motu | National action by the national programme

* Develop a promotion plan that engages all New Zealanders to do advance care planning for themselves or support whānau to think and talk about what matters most.
* Run promotion campaigns designed to reach whānau Māori and Pacific peoples.
* Identify organisations and groups that could support the promotion of advance care planning. Build relationships and understanding about how they might do that and what tools, relationships and resources they might need. In partnership with local organisations, develop the tools and resources organisations and groups need.
* Support and encourage health care providers/organisations to prioritise person- and whānau-centricity in the design and delivery of health care services.
* Support health workers to value the uniqueness of each person they provide care for and to ensure no care or treatment is offered that does not align what matters most to that person and their whānau.

### Mahi ā rohe | Local action

* Create an expectation that what matters to people and whānau informs care planning and delivery.
* Promote the benefits of person- and whānau-centric health care delivery to providers, non-governmental organisations, aged residential care facilities, primary health organisations, general practices and community groups.
* Support local promotion activities including providing resources and local infrastructure for community activities and champions.
* Collect and share consumer and health care workforce stories.

### Whainga hou 2022–24 | New actions 2022–24

1. Develop a significant public promotion strategy and plan. Identify key audiences, messages and channels. Create resources to catch audience attention with clear calls to action.
2. Create resources to strengthen health professionals’ cultural responsiveness in working with whānau Māori.
3. Increase familiarity of the new advance care planning branding. Develop a pūrākau (story/myth) to enhance the mana of the kuaka (godwit) as a symbol of advance care planning.
4. Target specific strategies for Māori, Pacific peoples and disabled people as our key priority communities.
5. Look for opportunities to link advance care planning and messaging to life events, high-risk professions and recreational activities.
6. Use social media and existing communication channels in and beyond health.
7. Develop a health workforce engagement strategy to build awareness about advance care planning (including shared goals of care) and support each person to see their role in planning and delivering person- and whānau-centric services.

Raise awareness of palliative care as an option for consideration in the process of planning for symptom management and end of life.

## Ngā rauemi | Tools and resources – Kia wātea katoa mai te whakamahere tiaki i mua i te wā taumaha | Advance care planning is available to all

### Ngā tino whāinga | Objectives

New Zealanders are supported by tools and resources that make it easy for them to engage in advance care planning.

### Ngā rautaki | Strategies

* Develop useful, useable and culturally appropriate tools and resources in partnership with communities. This reflects the priority to use a cultural safety approach in all advance care planning activities and processes including the development of tools and resources.
* Resources support shared decision-making.

### Mahi ā motu | National action by the national programme

* Develop and co-design resources and tools to increase access to advance care planning by Māori, Pacific peoples and disabled people.
* Maintain and increase the use of the advance care planning website by consumers and clinicians.
* Support shared decision-making during episodes of care in hospitals, aged residential care and in the community. Support the adoption of the principles of shared goals of care in these settings. Develop resources and tools for clinicians and consumers that support shared decision-making.
* Develop community engagement tools.

### Mahi ā rohe | Local action

* Identify the resource needs of local groups.
* Adapt national resources to meet local need and meet the needs of key priority communities such as Māori, Pacific peoples and disabled people.
* Distribute tools and resources locally.

### Whainga hou 2022–24 | New actions 2022–24

1. Evaluate usability and acceptability of the advance care plan and guide. Understand the barriers and concerns for whānau Māori and other key priority communities about sharing ‘what matters most to me and my whānau’ with the health system. Explore what key health-related information is useful to include in an advance care plan and what other important information is best held separately by whānau. Act on the recommendations from the evaluation.
2. Help people understand what information about them and their whānau would support quality person- and whānau-centric decision-making.
3. Promote the whānau resource *Whenua ki te whenua* and work with Pacific communities to adapt/translate it for Pacific peoples.
4. Adopt and promote the Easy Read advance care plan being developed in Canterbury for people with learning disability.

Explore the feasibility and relevance of community engagement tools like those developed overseas for use in Aotearoa (for example, card games to encourage conversation and   
promote thinking).

## Whakangungu | Education and training – He ohu mahi, he hapori hoki e rite ana | A prepared workforce and community

### Ngā tino whāinga | Objectives

The health care workforce is confident and skilled to support people and their whānau to safely and effectively think, talk and plan for their care.

People who want to support members of their whānau or wider community to engage in advancecare planning are confident and supported to do so.

### Ngā rautaki | Strategies

* Training supports the activation of Te Tiriti o Waitangi principles and the health outcomes identified in *Whakamaua Māori Health Action Plan 2020-2025*.
* Training supports culturally safe practice.
* Advance care planning is nationally consistent and locally adaptable.

### Mahi ā motu | National action by the national programme

* Develop and maintain nationally consistent and effective advance care planning education and training for the health workforce.
* Train and support local trainers to deliver the national training locally. Influence local organisations to identify and support Māori staff to be trained as trainers.
* Support local health organisations and teams to build systems and processes to deliver training and education.
* Work with local organisations to appropriately fund and build systems and processes to support community-based advance care planning activities.
* Influence colleges and education institutions to have advance care planning as part of relevant under- and postgraduate courses; also providers to include it in orientation programmes.
* Develop and maintain nationally consistent and effective advance care planning education and training for community champions and activators.

### Mahi ā rohe | Local action

* Recruit skilled staff interested in facilitating training; provide time and support for trainers to attend training and then deliver training locally; and provide training administration support for trainers.
* Support staff to deliver advance care planning services effectively.
* Provide the funding, systems and support to recruit and train community champions and activators.
* Support community champions and activators to work with their communities, consumers   
  and whānau.

### Whainga hou 2022–24 | New actions 2022–24

1. Evaluate all current training material to check it promotes and supports cultural safety, person- and whānau-centricity, the principles of Te Tiriti o Waitangi and the desired health outcomes set out in *Whakamaua Māori Health Action Plan 2020-2025*.
2. Support advance care planning trainers to educate health care workers attending L1A training on how to respond when assisted dying is raised during advance care planning conversations.
3. Explore alternative approaches and resources for local trainers to use to continue training during COVID-19 restrictions.
4. Work with medical, nursing and allied health undergraduate programmes to incorporate shared goals of care, the serious illness conversation guide and advance care planning.
5. Pilot an approach to support local community champions for whānau Māori.

Develop and pilot an online training package for community organisers.

## Aroturuki me te aromatawai | Monitoring and evaluation – Mā te kiritaki te tauwhiro e arataki | Care is based on what matters to consumers

### Ngā tino whāinga | Objectives

Measurement and evaluation show the programme is meeting the needs of consumers, health care workers and providers.

### Ngā rautaki | Strategies

* Measurement approach is used to assess quality of advance care planning.
* A continuous improvement approach is used nationally and encouraged locally.

### Mahi ā motu | National action by the national programme

* Use national measures to monitor the quantity and quality of advance care planning services, training and systems.
* Analyse data and generate reports.
* Any improvements made to the programme are based on monitoring and evaluation findings.

### Mahi ā rohe | Local action

* Collect, analyse and use data to support improvement of local services.
* Run projects to address local opportunities for improvement.

### Whainga hou 2022–24 | New actions 2022–24

1. Workforce survey to measure awareness and engagement with shared goals of care and advance care planning.
2. Patient experience survey questions to measure patient experience of shared decision-making and person- and whānau-centricity of care planning and delivery.
3. Adapt the national advance care planning stocktake to include system maturity measures.

Collect, monitor and evaluate accurate ethnicity data from training attendees in order to influence the increase of Māori participation in advance care planning training.

## Whakakaupapa | Implementation – Kia nui te hua | Maximising value

### Ngā tino whāinga | Objectives

What is important to each person and their whānau is recorded, shared, valued and used to inform health care planning and delivery for them.

### Ngā rautaki | Strategies

* People and their whānau are supported before, during and after advance care planning conversations.
* Advance care planning conversations are consistently recorded.
* Advance care plans are easily stored, shared and used by people and their whānau.
* Advance care plans are easily stored, retrieved and used to support health care treatment, planning and delivery.
* Processes and policies maximise the value of training, resources and care planning.

### Mahi ā motu | National action by the national programme

* Support and influence models of local system integration for the recording, retrieval and use of advance care plans.
* Work with IT vendors to explore the viability of digital solutions for the storing and sharing of advance care plans.
* Work with electronic health record (EHR) leads to consider advance care planning in the design and implementation of a national EHR.
* Support health providers to consider advance care planning as a whole-of-system intervention that includes thinking, talking and planning care and treatment across a person’s lifetime and across health settings.

### Mahi ā rohe | Local action

* Build systems and processes to support local advance care planning services.
* Appropriately resource local advance care planning services.
* Make recording, sharing, storing and retrieving advance care plans and notes of advance care planning conversations within local services easy for consumers and clinicians.
* Integrate advance care planning, serious illness conversation guide, share goals of care and assisted dying services across health care settings.

### Whainga hou 2022–24 | New actions 2022–24

1. Explore the viability and potential functionality of an advance care planning app.
2. Explore the viability and potential functionality of audio recording advance care plans.

Demonstrate the integration of advance care planning, the serious illness conversation guide, shared goals of care and assisted dying, and support local integration.

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