



## Hawke's Bay Health Consumer Council Meeting

**Date:** Thursday, 9 February 2017

**Meeting:** 4.00 pm to 6.00 pm

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

**Council Members:**

Graeme Norton (Chair)  
Rosemary Marriott  
Heather Robertson  
Terry Kingston  
Tessa Robin  
Leona Karauria  
Jim Morunga

Jenny Peters  
Olive Tanielu  
Jim Henry  
Malcolm Dixon  
Rachel Ritchie  
Sarah Hansen  
Sami McIntosh

**Apologies:**

**In attendance:**

Kate Coley, Director Quality Improvement and Patient Safety  
Ken Foote, Company Secretary  
Tracy Fricker, Council Administrator and EA to DQIPS  
Jeanette Rendle, Consumer Engagement Manager  
Deborah Baird, Health HB  
Debs Higgins, Clinical Council Representative

## HB Health Consumer Council Agenda

### **PUBLIC**

Item	Section 1 – Routine	Time (pm)
1.	Karakia Timatanga (Opening) / Reflection	4.00
2.	Apologies	
3.	<a href="#">Interests Register</a>	
4.	<a href="#">Minutes of Previous Meeting</a>	
5.	<a href="#">Matters Arising - Review Actions</a>	
6.	<a href="#">Consumer Council Workplan</a>	
7.	<a href="#">Chair's Update (verbal)</a>	
8.	<a href="#">Consumer Engagement Manager's Update (verbal)</a>	
	<b>Section 2 – For Information / Discussion</b>	
9.	<a href="#">Orthopaedic Review phase 2 draft</a> – Andy Phillips	4.30
	<b>Section 3 – Monitoring</b>	
10.	<a href="#">Te Ara Whakawaiaora / Access (local indicator)</a>	
11.	<a href="#">Annual Maori Plan Q2 Oct-Dec 16</a> – Tracee TeHuia	4.50
	<b>Section 4 – General Business</b>	
12.	<a href="#">Topics of Interest - Member Issues / Updates</a>	
13.	Karakia Whakamutunga (Closing)	

**NEXT MEETING: Thursday 9 March 2017**

Tauwhiro Rāranga te tira He kauanuanu Ākina

## Interest Register

## Hawke's Bay Health Consumer Council

Feb-17

Name Consumer Council Member	Interest eg Organisation / Close Family Member	Nature of Interest eg Role / Relationship	Core Business Key Activity of Interest	Conflict of Interest Yes / No	If Yes, Nature of Conflict: - Real, potential, perceived - Pecuniary / Personal - Describe relationship of interest to
Graeme Norton	3R Group Limited  NZ Sustainable Business Council  HB Diabetes Leadership Team  Advancing life cycle management thinking across NZ  U Turn Trust  Integrated Pharmacist Services in the Community (National Committee)	Director/Shareholder  Deputy Chair  Chair  Chair, Advisory Group  Trustee  Steering Group Member	Product Stewardship  Sustainable Development  Leadership group working to improve outcomes for people in HB with diabetes  Advancing life cycle management thinking across NZ  Relationship and and may be contractual from time to time  Health and wellbeing	No  No  No  No  Yes  No	Group is sponsored by HBDHB       Could be a perceived conflict, however will not take part in any discussions relating to any contract matters if these arise.
Rosemary Marriott	YMCA of Hawke's Bay  Totara Health	President  Consumer Advisor	Youth Including health issues  Health and wellbeing	No  No	
Heather Robertson	Restraints Committee of DHB	Committee Member	Representing Consumers on this Committee	No	
Terry Kingston	Interest in all health matters, in particular - Mental Health, Youth, Rural and Transport. Age Concern Hawke's Bay	Board Member			
Tessa Robin	Te Kupenga Hauora - Ahuriri	Finance and Quality Manager	Responsible for overseeing QMS for organisation and financial accountability	No	Potential - Employer holds contracts with HBDHB
Leonna Karauria	NZ Maori Internet Society  Simplistic Advanced Solutions Ltd  Wairoa Wireless Communications Ltd	Chairperson  Shareholder / Director  Director/Owner	Advocacy on Maori Communities  Information Communications Technology services.  Wireless Internet Service Provider	No  Yes  Yes	If contracted for service, there could be a perceived conflict of interest.  Approached in early 2014 by HBDHB and contracted for service to provide wireless internet service to Wairoa Rural Health Learning Centre and Hallwright House. Could be a perceived conflict of interest.
Jenny Peters	Nil				

HB Health Consumer Council 9 February 2017 - Interests Register

Name Consumer Council Member	Interest eg Organisation / Close Family Member	Nature of Interest eg Role / Relationship	Core Business Key Activity of Interest	Conflict of Interest Yes / No	If Yes, Nature of Conflict: - Real, potential, perceived - Pecuniary / Personal - Describe relationship of Interest to
Olive Tanielu	HB District Health Board	Employee	Work with Pacific Island children and families in hospital and in the community	Yes	Perceived/potential conflict between employee HBDHB and roles of Consumer
Jim Morunga	Nil				
Malcolm Dixon	Hastings District Councillor Sport Hawke's Bay Scott Foundation HB Medical Research Foundation Inc	Elected Councillor Board of Trustees Allocation Committee Hastings District Council Rep	Non paid role	No No No No	
James Henry	Health Hawke's Bay Ltd	Facilitator	Part-time role. Improving lifestyles for people with chronic illness.	No	
Rachel Ritchie	Put the Patient First	Involved when group was active	Advocating for Diabetes Patients	Unsure	Real / potential / Perceived
Sarah de la Haye	Nil				
Sami McIntosh	Eastern Institute of Technology	Student Nurse	Practical placements	No	Perceived potential if applying for work.

**MINUTES OF THE HAWKE'S BAY HEALTH CONSUMER COUNCIL MEETING  
HELD IN THE TE WAIORA MEETING ROOM, HBDHB CORPORATE OFFICE  
ON 8 DECEMBER 2016 AT 4.00 PM**

**PUBLIC**

- Present:** Graeme Norton (Chair)  
Jenny Peters  
Nicki Lishman  
Terry Kingston  
Leona Karauria (4.10 pm)  
Jim Morunga  
Olive Tanielu  
Sarah Hansen  
Sami McIntosh  
Rachel Ritchie  
Heather Robertson  
Tessa Robin
- In Attendance:** Jeanette Rendle, Consumer Engagement Manager  
Deborah Baird, Health Hawke's Bay  
Tracy Fricker, EA to Director QIPS and Council Administrator
- Apologies:** James Henry, Rosemary Marriottt and Malcolm Dixon

**SECTION 1: ROUTINE**

**1. KARAKIA TIMATANGA (OPENING) / REFLECTION**

The Chair welcomed everyone to the meeting.

Malcolm Dixon is not here today as his 91 year old mother died a few days ago and Rosemary Marriott is in hospital. Our thoughts are with them.

**2. APOLOGIES**

The apologies as above were noted.

**3. INTERESTS REGISTER**

No new conflicts of interest for items on today's agenda. Terry Kingston's interest for Central Hawke's Bay District Council is to be removed as he is no longer a Councillor.

**4. PREVIOUS MINUTES**

The minutes of the Hawke's Bay Health Consumer Council meeting held on 13 October 2016 were confirmed as a correct record of the meeting. The meeting in November was joint with the Clinical Council and the combined minutes had been already dealt with.

Moved and carried.

## 5. MATTERS ARISING AND ACTIONS

**Item 1: *Interest Register***

New Interests for Terry Kingston and Graeme Norton added to the register. *Item can be closed.*

**Item 2: *Consumer Council Annual Plan for 2016/17***

Final changes made to the plan and attached to the meeting papers (item #11 on the agenda). *Item can be closed.*

**Item 3: *ID Cards for Consumer Council Members***

To be actioned.

## 6. WORK PLAN

The work plan for the beginning of 2017 appears light, but items will be added to the work plan as they come through.

## SECTION 2: WORKSHOP

### 7. CONSUMER ENGAGEMENT IN TRANSFORM & SUSTAIN PROJECTS

The Chair welcomed Kate Rawstron, Project Management Office Manager and Alex Trathen, Project Manager to the meeting to discuss Consumer Council's members' involvement with the Transform and Sustain projects and high level guidance around how we build into start-up/initiation of new projects. Transform and Sustain has been endorsed and there are a number of projects about to launch. We want to be clear from the start how members are involved with projects.

Members broke into groups to discuss the following:

1. What has worked well
2. What hasn't worked
3. What else should we consider
4. Anything else

Following discussion from the feedback provided to the questions above, Kate Rawstron will draft principles for project managers to abide by and apply to consumer engagement.

**Action:** *Draft principles to be sent to Consumer Council for review.*

## SECTION 3: FOR DISCUSSION

### 8. LONG TERM CONDITIONS

The Consumer Council noted the contents of the report presented by Leigh White, Portfolio Manager – Long Term Conditions and Jill Garrett, Strategic Services Manager – Primary Care.

**Key points:**

- The framework is based on the “Four Aka” roots (*Person-Family-Whanau Centred Care, Person centred systems and processes, Workforce development and enablement and Risk identification and mitigation*). It is not disease based, as many people have more than one condition
- Each of the Four Aka have four contributing dimensions

- Meetings were held with PAG, other consumers in the community and with Wairoa consumers on what would success look like against the Four Aka and the dimensions
- A long term conditions advisory group is to be formed to assist with implementing this strategy. The group will be made up of clinical staff from primary and secondary, nurses and GPs, business intelligence and a consumer representative
- A service review matrix has been designed as well as a consumer evaluation tool so the consumer perspective can be captured. The tool is being trialled with the Diabetes and Respiratory Services currently. There will be an expectation that services will meet certain standards based on what the consumers want, through what they have told us what they want. Services will be able to self-evaluate how well they are doing and identify areas for improvement
- We want to promote prevention, early intervention and empowering people to self-manage their conditions - not focus on the disease but on the whole person
- A snap shot tracer audit from six consumers is being completed. This type of audit maps their journey through primary and secondary and will inform the finalisation of the framework i.e. where are the gaps, what can be removed and what needs strengthening
- The document is strategic and high level. There will be a simplified version developed for the general public which will be available early next year.

Following discussion the Consumer Council members endorsed the idea of the framework. They felt it is important to look at the whole of the person's life and wellbeing and not just their health. It is important to listen to the person, as a person and not as a condition or disability. Exposure to violence and abuse, mental health, environmental factors etc need to be taken into account also. You can see the change in thought by the services, what now needs to happen is the consumers' change of thought and taking responsibility for their own health. The key to success is partnership, relationships and behaviours.

Leigh White thanked the group for their feedback and advised that workshops are being planned to get more feedback on the framework. Having heard what has been said today, she is thinking that the document should be called "Our Hawke's Bay Wellness Framework".

The Chair acknowledged the work that has gone into the document so far and looks forward to seeing the "easy read" version and the consumer evaluation tool.

## **9. COLLABORATIVE CLINICAL PATHWAYS UPDATE**

The quarterly update on progress was included in the meeting papers. No issues discussed.

## **SECTION 4: FOR INFORMATION**

### **10. ANNUAL MĀORI PLAN – QUARTER 1: JULY TO SEPTEMBER 2016**

The Annual Māori Plan, which included a summary dashboard was included in the meeting papers for information only. No issues discussed.

### **11. CONSUMER COUNCIL ANNUAL PLAN 2016/17 (FINAL)**

The final version of the Consumer Council Annual Plan was included in the meeting papers for information. No issues discussed.

## SECTION 5: GENERAL BUSINESS

### 12. TOPICS OF INTEREST – MEMBER ISSUES / UPDATES

- The Chair raised a question on behalf of Rosemary Marriott around the hospital visiting hours. How would it impact on hospital services if the start time for visiting hours were changed from 1 to 2 pm (once lunch time has finished)? General agreement that hospital management be requested to provide a response to this question, which could then be used as the basis for a full discussion in February 2017.

**Action:** *Ask question of hospital services so as to enable discussion of this topic.*

- Jenny Peters has written her reflections on the Advance Care Planning forum she attended. She will email it to Consumer Council members for their information.
- Heather Robertson raised an issue on how disability impacts on people going into hospital for a procedure. Members including Heather and Sarah are aware that other DHBs are establishing ongoing roles for disability liaison people working to remove barriers and improve the quality of experience of people with disabilities within the hospital environment. General agreement that hospital management be requested to consider such a role at HBDHB.

**Action:** *Ask question of hospital services so as to enable discussion of this topic.*

### 13. KARAKIA WHAKAMUTUNGA (CLOSING)

The Chair thanked everyone for their attendance and input.

The meeting closed at 6.05 pm.

Confirmed: \_\_\_\_\_  
Chair

Date: \_\_\_\_\_



## HAWKE'S BAY HEALTH CONSUMER COUNCIL

Matters Arising  
Reviews of Actions

5

Action	Date Issue first Entered	Action to be Taken	By Whom	By When	Status
1	13/10/16	<b>ID Cards for Consumer Council Members</b> To be discussed with Company Secretary/ Security Manager.	K Coley / J Rendle		To be actioned
2	08/12/16	<b>Resignation of Consumer Council Member</b> Letter of thanks to be sent to Nicki Lishman.	Chair	Dec	Actioned
3	8/12/16	<b>Interest Register</b> Remove Central Hawke's Bay District Council interest for Terry Kingston.	Admin	Dec	Actioned
4	8/12/16	<b>Consumer Engagement in Transform &amp; Sustain Projects</b> Draft principles to be prepared and sent to Consumer Council for review	K Rawstron	Jan / Feb	
5	8/12/16	<b>Topics of Interest / Member Issues / Updates</b> <ul style="list-style-type: none"> <li>• Question raised regarding change in start time for visiting hours from 1 pm to 2 pm</li> <li>• Question raised regarding establishment of a disability liaison role</li> </ul>			





## HB HEALTH CONSUMER COUNCIL WORKPLAN 2016-2017

6

Meetings 2017	Papers and Topics	Lead(s)
<b>9 Mar</b>	HB Integrated Palliative Care Strategy Draft Annual Plan 2017 Travel Plan Update Health & Social Care Networks Adult Inpatient Experience Results (qtly March–June–Sept–Dec)  <b>Monitoring</b> Te Ara Whakawaiaora / Breastfeeding (National Indicator)	Mary / Paul and Janice Carina Burgess Sharon / Andrea Tracee / Belinda Jeanette  Nicky Skerman
<b>13 Apr</b>	New Investment Bids (ex Clinical Council for review by Consumer and MRB) Clinical Pathways Committee update (qtly)  <b>Monitoring</b> Te Ara Whakawaiaora / Cardiology (national indicator)	Peter Kennedy
<b>10 May</b> <i>Wednesday with Clinical Council</i>	Final Draft Annual Plan 2017 Best Start Healthy Eating Plan (yearly Review)	Carina TBC
<b>14 Jun</b>	Youth Health Strategy Update for information Suicide Prevention Postvention Update against 2016 Plan Adult Inpatient Experience Results (qtly)  <b>Monitoring (work in progress – incomplete)</b> Te Ara Whakawaiaora / Oral Health (national indicator)	Nicky Skerman Penny Thompson Jeanette  Robin Whyman
<b>12 July</b>	Alcohol Position Statement update	Rachel Eyre
<b>10 Aug</b>	Work in progress	
<b>14 Sept</b>	Orthopaedic Review – phase 3 draft Suicide Prevention Report (6 month update for information) Health & Social Care Networks Update (6 monthly) Adult Inpatient Experience Results Qtly TAW Healthy Weight Strategy TBC	Andy Phillips Penny Thompson Tracee and Belinda Jeanette James Dawson

<b>12 Oct</b>	TAW Smoking TBC Tobacco Annual Update against Plan	Johanna Wilson
<b>8 Nov</b> <i>Wednesday with Clinical Council</i>	Work in progress	
<b>7 Dec</b>	Work in progress	



## **CHAIR'S REPORT**

Verbal






## **CONSUMER ENGAGEMENT MANAGER'S UPDATE**

Verbal





	<b>Orthopaedic Review – Phase 2 (Draft)</b>
	For the attention of: <b>Maori Relationship Board, HB Clinical Council and HB Health Consumer Council</b>
Document Owner:	Andy Phillips and Mark Petersen
Document Author(s):	Carina Burgess, Patrick Le Geyt, Tae Richardson and Andy Phillips
Reviewed by:	Executive Management Team
Month:	February 2017
Consideration:	For Information

**RECOMMENDATION****That the Maori Relationship Board, HB Clinical Council and HB Health Consumer Council**

- Note the approach to the Second Phase of redesigning our musculoskeletal and orthopaedic pathways
- Note the three redesign goals for :  
Community Care: Addressing health inequities using Whanau ora approach delivered through Mobility Action Programme  
Primary Care: Ensuring that GPs and patients have appropriate expectations delivered by introducing dynamic hip and knee pathways  
Secondary Care: Improving patient outcomes and experience of elective surgery by fully implementing Principles of Enhanced Recovery After Surgery.

**SITUATION**

This paper gives a brief overview of the proposed approach to redesigning services for people within our community who have pain and disability resulting from Musculoskeletal and Orthopaedic conditions

**BACKGROUND**

It is evident that there are a large number of people in the community living with pain and disability caused by musculoskeletal conditions. This number is expected to rise as the population of Hawke's Bay ages and the incidence of osteoarthritis increases.

The redesign of Musculoskeletal and Orthopaedic services was set out in three phases. The first phase, now complete involved increasing surgical capacity and making conservative treatment options available. The second phase involves the co-design of a new pathway. The third phase will now be carried out within the Clinical Service Plan to effectively manage demand and align capacity over two to five years and address 'third horizon' issues over ten years that will require innovative approaches. The initiatives completed in the first phase included:

- 
- Implementing non-surgical treatment options by increasing physiotherapy and other allied health resource.
  - Implementing a new pathway for back pain patients offering an alternative non-surgical treatment option.
  - Improved patient communication and collaborative services within the DHB.
  - Reducing wait times throughout the pathway.
  - Setting thresholds for surgery based on data for orthopaedic scoring and Oxford score.
  - Increasing surgical capacity to deliver on the major joint replacement target.
  - Building a partnership between HBDHB, Health Hawkes Bay PHO and Iron Maori to gain MoH funding and deliver a Mobility Action Programme

## The Principles

The redesign of the pathway will deliver on the New Zealand triple aim

- Improved health and equity for all populations.
- Improved quality, safety and experience of care.
- Best value for public health system resources.

Within this broad purpose, the pathway redesign will be consistent with Hawkes Bay DHB vision and values

Our vision is “*healthy hawke’s bay*”, “*te hauora o te matau-a-maui*” which means excellent health services working in partnership to improve the health and well-being of our people and to reduce health inequities within our community.

Our values and behaviours are articulated as

*he kauanuanu* – showing respect for each other, our staff, patients and consumers

*akina* – continuously improving everything we do.

*raranga te tira* – working together in partnership across the community

*tauwhiro* - delivering high quality care to patients and consumers

These values and behaviours will be delivered for hip and knee pain by redesign using the following principles :

1. Equity based care, treating greatest need first
2. Do no harm
3. Doing only what is necessary to achieve the desired outcomes
4. Choosing wisely, openly together with the patient
5. Consistently apply evidence based and knowledge based clinical practice
6. Staff co creating health with the public, patients & partners.

Within these principles, the redesign will consider reliable delivery of high quality services by improving value to patients and the DHB. Value is defined as outcomes relative to costs, it encompasses efficiency. The design will consider issues such as decision making criteria and thresholds for different interventions in the context of minimising harm, waste and unwarranted variation.

There will be three clear goals of this work namely:

- Community Care: Whanau ora approach delivered through Mobility Action Programme. The first patients are expected to be enrolled by 1<sup>st</sup> March 2017 with the programme completing by 30<sup>th</sup> June 2018
- Primary Care: Dynamic hip and knee pathways to ensure GPs and patients have appropriate expectations. The learnings from this work will be disseminated by 30<sup>th</sup> June 2017.
- Secondary Care: Ensure that best practice is delivered through fully implementing Principles of Enhanced Recovery After Surgery. It is anticipated that this work will be completed by 30<sup>th</sup> June 2018

## ASSESSMENT

During a workshop on the 8<sup>th</sup> of November, a group of primary and secondary care clinicians identified current problems and challenges arising during a patient's journey related to the management of Osteoarthritis.

### 1. Appropriate referral

- a. High demand vs availability - The threshold is a reflection of capacity. Varies by month and depends on budget cycle. Formula constantly changes, lack of consistency.
- b. Location of scoring in secondary care results in unnecessary referrals to orthopaedics and a longer queue.
- c. GPs not well informed so unable to manage patient expectations
- d. Ensuring appropriate patient selection, i.e. people who will have quality of life after surgery and not life-limited after surgery.
- e. Limited capacity in allied health and surgical services to meet demand
- f. Patient's condition deteriorating while on a waiting list
- g. GPs need confidence systems work and that there is an integrated system and communications.
- h. What happens with inappropriate referral – providing management advice for primary care

### 2. Communication between services

- a. No communications from specialty services to primary care
- b. Breaking down silos
- c. Transparency of information about services offered. E.g. Joint school
- d. Disconnect with involvement of aged residential care

### 3. Patient expectations (also patient literacy)

- a. Perception that they won't get care or referred (may have heard stories from friend's experience's)
- b. Expecting surgery as the only treatment option. Patient not aware that they could be on a physio instead of a surgical pathway
- c. Patient disappointment
- d. Patient's not seeking help until they are in severe discomfort or disability.

4. **Cost to patient**
  - a. Costs for appointments and alternative therapy
  - b. Support and management for patients that don't meet criteria
5. **Management of patients who aren't appropriate for surgery**
  - a. Decreased or poor access to treatment options
6. **Pain management**
  - a. Delays in pain management
  - b. No pain services – ensure this is managed
7. **Future planning** of patients on a hip or knee pathway – know who is in early stage so they will have an idea of what future funding and services are required.
8. **Coding** - Clarity and consistency around coding (eg. SNOMED)
9. **Management of comorbidities**
10. **Monitoring outcomes** e.g. post op infection, readmission rates, quality of life, supporting data, cross reference social metrics

## ELEMENTS OF THE NEW PATHWAY

The pathway will be built on a Whānau Ora model of care. It will be specifically designed to address health inequities experienced by Māori, Pacific and quintile 5 consumers, and will be designed to meet the needs of both the working age and elderly population. The model will serve people with previous or current employment in heavy labouring jobs and those with barriers to paid work, training or caring for whānau due to musculoskeletal conditions.

The model will include self-referral (including walk in), referral by any health practitioner and invitation using MSD database matching of consumers fulfilling entry criteria. The model will include raising awareness through both informal (community) and formal (publically funded health and social services, NGOs, Pacific Churches and community centres, workplaces) networks.

Outcome/exit measures will support Whānau Ora outcomes including reduced pain, improved function, increased social and cultural participation and increased local capacity. The model will be constructed specifically to address NZ Triple Aim outcomes with particular emphasis placed on a reduction in unmet need, reducing the need for GP consultations and unnecessary referral to secondary care.

A co-design approach will build on the strengths of existing services and address access and other barriers. The model will include delivery in local communities therefore reducing the need for transport. Services will be culturally responsive and flexible around people's lifestyle e.g. work and training commitments, child care etc. The pathway will include workplace clinics for Hawke's Bay's key unskilled labour employers such as horticulture, food processing, meatworks, forestry and shearing.

A specific focus of the model will be to increase local community capacity to ensure sustainability with appropriate ongoing PHO and DHB support. The pathways will be fully aligned with Hawke's Bay Health Sector's Transform and Sustain strategic framework.

A key deliverable will be improving patient experience, clinical outcomes and value for money. Growing evidence tells us that consumer experience is a good indicator of the quality of health services. Better experience, stronger partnerships with consumers, and consumer and family-centred care have been linked to improved health, clinical, financial, service and satisfaction outcomes.

The pathway will ensure a consistent approach to collection, measurement and use of consumer experience information on a regular basis including measures of communication, partnership, co-ordination and physical and emotional needs.

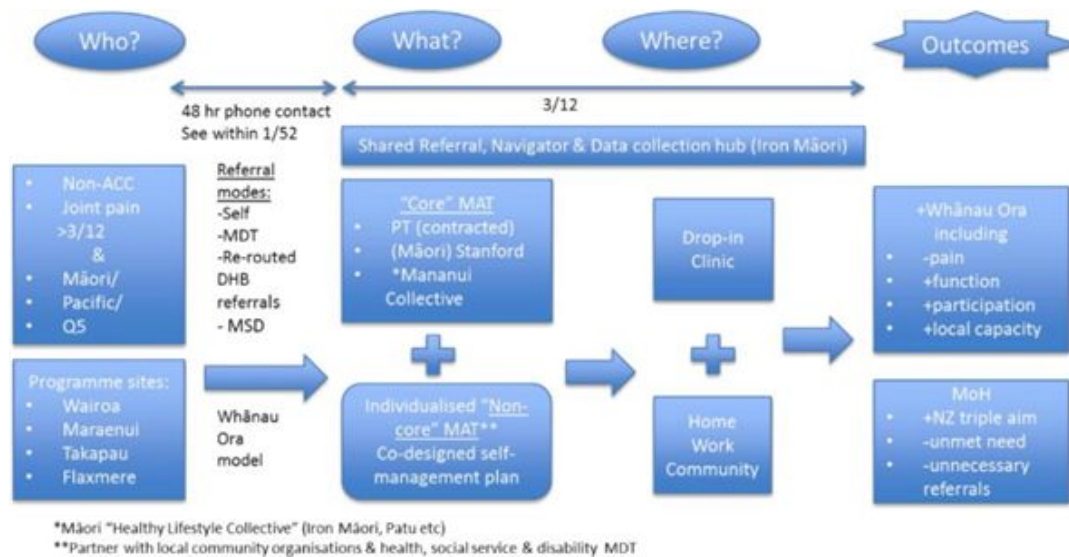
The pathway will address education and training needs of staff including relationship centred practice and cultural competency. Verbal and written communication will be in a consumer's preferred language (using translators if necessary). A health literacy "universal precautions" approach to communications will be implemented, given our understanding of health literacy levels in NZ, particularly for Māori. The system will support health literacy with services being easily accessible and navigable. The Whānau Ora model of care requires a partnership approach between consumer and service. In a Whānau Ora model of care, experience of care extends beyond supporting physical and emotional needs to cultural ones. The Stanford and Whariki Long Term Condition programme will further enhance consumer experience by developing, amongst other things, the person's own communication and decision making skills as well as dealing with the physical and emotional needs of their condition. The programme covers long term conditions in general therefore the pathway has the potential to improve the management of coexisting morbidities as well as musculoskeletal pain and disability.

Clinical outcomes will be enhanced not only by improved consumer experience of care, but also by a reduction in unmet need and inequity and through an emphasis on early intervention. It is recognised that early intervention for prevention and treatment is very important, especially around maintaining physical activity, as activity itself is evidenced to be beneficial for osteoarthritis.

As experience of care, quality (clinical effectiveness) and equity are cross cutting dimensions of the NZ Triple Aim, it can be argued that value for money cannot be achieved without them. The pathway will deliver value for money by equitable and improved health outcomes due to early intervention, and by a reduction in unnecessary referral to orthopaedic clinic. This will obviously free up orthopaedic outpatient capacity to focus on those most likely to benefit from this resource. Improved economic contributions would also be expected as people become able / better able to participate in work/ training and social obligations. These contributions are likely to be considerable given that musculoskeletal conditions are the leading cause of disability in NZ. With a wider lens, inequity itself has an uncontested effect on economic growth with evidence suggesting that in the decade 1990-2010, NZ experienced the largest impact of inequality on GDP growth of any OECD country.

The pathway will comprise physiotherapy, Stanford and Whariki Long Term Condition programme and a Māori Lifestyle Collective (a suite of kaupapa Māori healthy lifestyle services including Iron Māori and Patu programmes). In addition, the pathway will include an individualised, co- designed self-management programme and all existing publically funded health, social service and disability services and those provided by local community organisations.

The pathway will build on the Mobility Action Programme pathway shown above as well as existing hip/knee pathways.



### ESTABLISHING A 'DYNAMIC' PATHWAY

At its meeting of 10<sup>th</sup> January, EMT agreed to work in partnership with NEXXT to develop dynamic pathways. Subsequently a sub-group agreed that dynamic hip/knee pathways would be the exemplars for this development. The purpose will be to develop a Patient Centric journey that encourages;

- the sharing of information
- the delivery of consistent best practice care and
- the measurement of outcomes.

The Key Benefit Areas will be:

- The generation and communication of appropriate referrals
- Improved communication and transparency of information between providers across both primary and secondary care
- The systematic collection of information to assist in planning and funding and to understand gaps in patient care.
- To identify in advance from the condition of the existing patients on chronic care pathways, if there is a likely to be an increase or decrease in demand
- Supporting patient literacy
- Reducing ASH rates

The hip and knee osteoarthritis pathways provided in both primary and secondary care settings will:

- Allow scoring or aspects of scoring in primary care to prevent inappropriate referrals
- Provide guidance when a patient's condition does not meet the threshold for a referral - management, in particular physiotherapy

- Provide the ability to build a moving threshold aspect into the pathway
- Facilitate and manage the criteria for appropriate patient selection
- Deliver transparency between health providers as to who is doing what and how long the patient has been managed for
- Enable the coordination of services and health care providers involved in patient care, e.g. GP, hospital orthopaedic team, physiotherapy, allied health

This will increase provider efficiency by reducing inappropriate referrals, improving communication and speeding up the delivery of care for patients.

Non-surgical management/checklists will be monitored and reviewed, pre and post op, according to the point the patient is at within a pathway, for example: pain management,

This will help to set the right patient expectations and help them to feel their on-going care is being managed. This will lead to better patient outcomes.

Possible inclusion of patient questionnaires to monitor their wellness, mental health, outcomes and social factors.

This will provide an insight into the wider well-being of the patient, allowing for appropriate care to be referred, leading to an overall better patient outcome.

Monitoring outcomes for hip or knee replacement surgery.

This will provide background data that can be used to optimise the care delivery and assistance provided to patients. Over time this will lead to better patient outcomes and a more effect use of resources.

Data on hip and knee osteoarthritis pathways will guide future planning and funding of services or points of low or high demand.

Data will be provided that can be used to forecast forward demand by patients. Over time this will lead to a more effect use of resources and a more consistent service for patients.

## **CO-DESIGN OF THE COMMUNITY/PRIMARY CARE PATHWAY**

It has been agreed that this work will be undertaken by the Collaborative Pathways group. A partnership will be agreed with NEXXT to design the dynamic pathway. A steering group of primary and secondary care clinicians will be established. Initial work will be undertaken to describe the approach which will be discussed with a variety of stakeholders including patients with musculoskeletal conditions, patient groups such as greypower, primary and secondary care clinicians. Learnings from these discussions together with an initial design will be presented by the end of June 2017.

## **SECONDARY CARE PATHWAY**

There has already been much work done in secondary care in HBDHB to implement the best practice principles of surgery to acute and elective orthopaedic pathways. Enhanced recovery after surgery ensures that patients : -

- Are in the optimal condition for treatment
- Are better informed about their care
- Are exposed to extensive pre-habilitation

- Experience a more streamlined, standardised care pathway
- Are exposed to evidence-based methods of enhancing care
- Experience optimal post-operative rehabilitation


The work will ensure that for each patient:

- Patients receive extensive Pre-Op Information
- Joint School is delivering appropriate patient expectation and preparation
- Anaesthetic Regime is optimised
- Pain Relief is provided without using opiates wherever possible
- Appropriate early mobilisation is provided
- Staff have appropriate expectations of patient early recovery

The aim of the next phase of this work will be to:

- Improve Patient Experiences
- Deliver standardised treatment pathways for all patients, all of the time
- Deliver Process Improvement resulting in Outcome Improvement



	<b>Te Ara Whakawaiaora:</b> <b>Access (ASH Rates 0-4 &amp; 45-64 years)</b>
	For the attention of: <b>Māori Relationship Board, HB Clinical Council and          HB Health Consumer Council</b>
Document Owner:	Dr Mark Peterson, Chief Medical Officer - Primary
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Reviewed by:	Executive Management Team
Month:	February 2017
Consideration:	For Monitoring

**RECOMMENDATION**

**That Māori Relationship Board, HB Clinical Council and HB Health Consumer Council:**  
 Note the contents of this report.

**OVERVIEW**

Te Ara Whakawaiaora (TAW) is an exception based report, drawn from AMHP quarterly reporting, and led by TAW Champions. Specific non-performing indicators are identified by the Māori Health Service which are then scheduled for reporting on progress from committees through to Board. The intention of the programme is to gain traction on performance and for the Board to get visibility on what is being done to accelerate the performance against Māori health targets. Part of that TAW programme is to provide the Board with a report each month from one of the champions. This report is from Dr Mark Peterson, Champion for the Access Local Indicator.

**UPCOMING REPORTS**

The following are the indicators of concern, allocated EMT champion and reporting month for each.

Priority	Indicator	Champion	Reporting Month
Access Local Indicator	Reducing acute admissions of Ambulatory Sensitive Hospitalisations (ASH): 1. 0-4 year olds - dental decay, skin conditions, respiratory and ear, nose and throat infections 2. 45-64 year olds - heart disease, skin infections respiratory infections and diabetes	Mark Peterson	February 2017

## **MĀORI HEALTH PLAN INDICATOR:**

This report provides an update on programmes related to Ambulatory Sensitive Hospitalisations (ASH) for 0-4 and 45-64 years of age in Hawke's Bay.

Ambulatory Sensitive Hospitalisations (ASH) reflect hospital admissions for conditions which could potentially be prevented by early access to treatment in care. In many countries ASH is used as a means to assess the performance of primary care and to identify potential barriers to access. However, while ensuring early access to effective primary care is still likely to be of considerable value in reducing ASH, in countries such as New Zealand, where large socioeconomic and ethnic disparities in child health exist, a greater emphasis may need to be placed on addressing those factors, often outside of the health sector, which drive the underlying burden of disease (e.g. household income, housing, nutrition, exposure to second hand cigarette smoke). This is because, even with optimal access, the ability of a general practitioner to prevent a paediatric pneumonia admission after the first crucial hours may be limited, but the opportunities available for a DHB to prevent paediatric respiratory infections via e.g. healthy housing projects and parental smoking cessation programmes may be considerable.

The Hawke's Bay DHB is committed to non-differential targets and significant inequality is seen in this indicator. Our work programmes focus on targeting vulnerable populations to reduce hospitalisation, improving the home environment and improving consistency of practice and early access to primary care programmes and reducing inequities.

## **WHY IS THIS INDICATOR IMPORTANT?**

### ***System Level Measures***

The Introduction of the System Level Measures; targeted performance measures, came into effect beginning 2016-17. The measures include some previous health targets included in the Integrated Performance Incentive Framework and a set of newly introduced, nationally agreed performance measures. Ambulatory Sensitive Hospitalisation (ASH) rates are included in two System Level Measures.

- ASH 00-04yrs is reported against under the SLM-Ambulatory Sensitive Hospitalisation (ASH)
- ASH 45-64yrs is reported under the SLM-Acute Hospital Bed Days.

Each ASH band for total population is divided into; Māori, Pacific, Other<sup>1</sup>. Targets are derived from the DHB ASH rates for the Māori population. The base line rates for the DHB will be compared with national total population rates and targets set accordingly. These are expressed in rates per 100,000.

The Hawke's Bay District Health Board recognises that comparing Māori against national-total population data masks the equity gap. Therefore all Māori and Pasifika data reported against for ASH will include ..... vs Other to adequately examine the equity gap.

Targets are to be set to work towards eliminating the gap within a 2-5 year period dependent on the base line. Using the base line as a measure, reducing the equity gap by half each year. If below 10% the aim is to eliminate the gap. Rates within 5% would be considered equitable (e.g. HBDHB Māori ASH rates to be at or below national total population rates)<sup>2</sup>

To September 2016, the Top Three ASH conditions for Māori in the 0-4 year age group were; Dental Conditions, Asthma and Respiratory Infections- Upper and ENT.

For the 2017 year the contributory measures regarding the System Level Measure of Reduced ASH rates for 0-4 years as agreed by Health Hawkes Bay and the Hawke's Bay DHB are:

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<sup>1</sup> MoH-System Integration S11: Ambulatory sensitive hospitalisations.

<sup>2</sup> MoH-System Integration S11: Ambulatory sensitive hospitalisations.

- Paediatric respiratory training
- Increased Immunisation Health Target
- Oral Health Initiative

#### 45-64 years

As of September 2016 the Top Three conditions contributing to the ASH rate for 45-64yrs were; cardiac conditions, respiratory (including COPD and Pneumonias) and Cellulitis.

For the 2017 year the target areas as identified in the SLM-Improvement Plan will be;

Acute Hospital Bed Days (SLM)

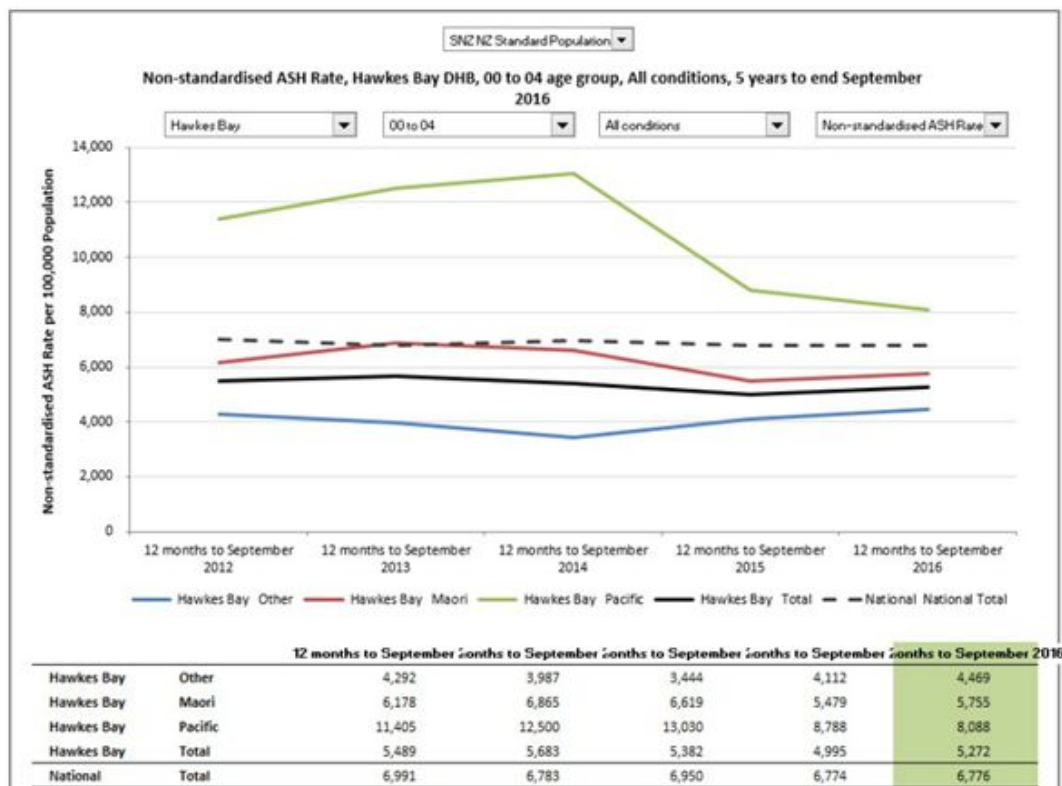
Contributory Measures

- ASH rates 45-64yrs
- Collaborative (Clinical) Pathways implementation for Cellulitis and Congestive Heart Failure
- Ed Admission rates; Cellulitis and Congestive Heart failure

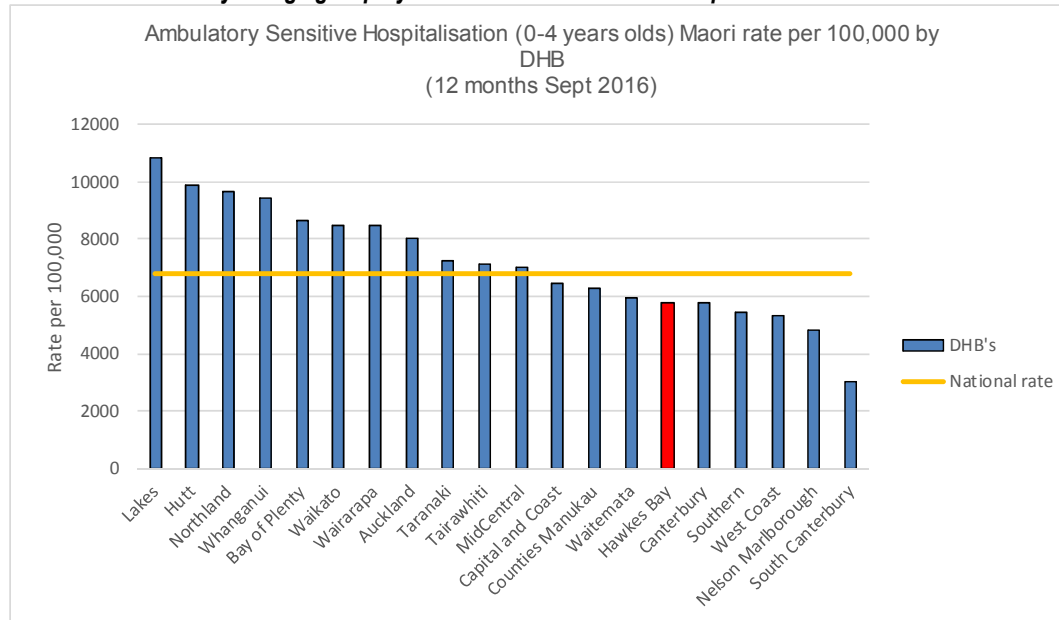
## HAWKE'S BAY DISTRIBUTION AND TRENDS

### TARGET 0-4 YEAR AGE GROUP

*Hawke's Bay Māori ASH rates 0-4 year age group – 12 months to end Sept 2012-2016*

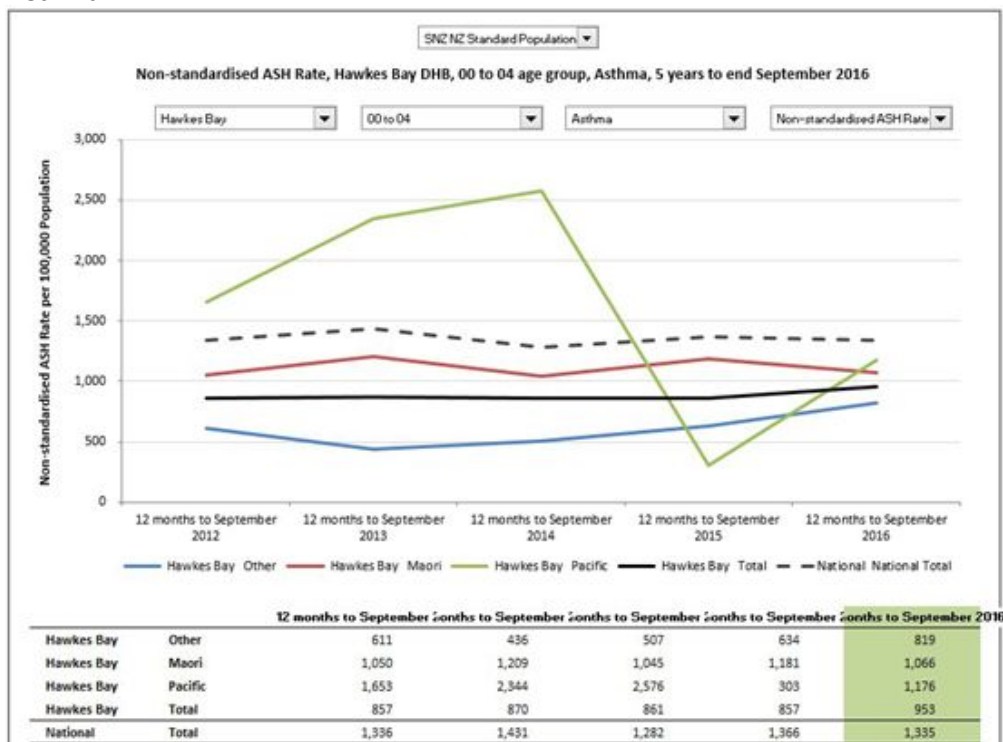


As at September 2016 Hawke's Bay tamariki have lower rates of ASH compared to national rates for Māori and similar rates of ASH compared to national non-Māori. There has been a reduction in the gap between the Māori ASH rate and the national rates with a slight increase in the 12 month period to September 2016.

**Māori ASH rates 0-4 year age group by DHBs – 12 months to end Sept 2016**

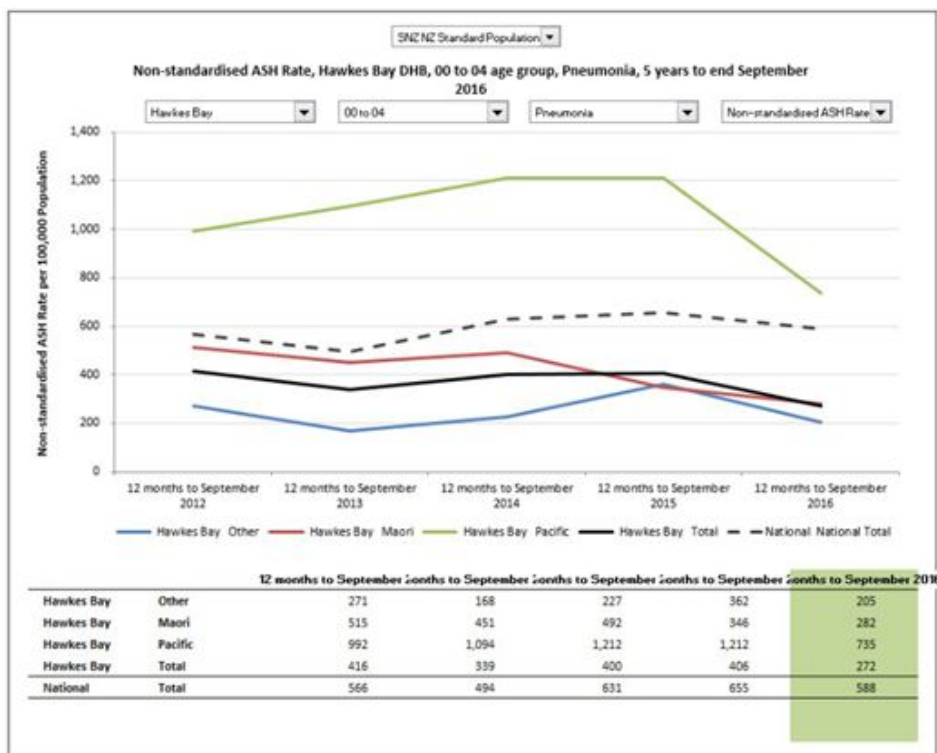
In the 12 months to September 2016 the Hawke's Bay Māori rate was 84.9% of the national rate and Hawke's Bay DHB was the 6<sup>th</sup> best performer of all DHBs with Māori rates substantially lower than national rates in this age group.

In 2016 the largest differences between Hawke's Bay Māori rates and national rates in the 0-4 year age group are in the conditions Cellulitis and Asthma - improvements have been made in the rates for Asthma over the last 12 months but there has been a decrease in the performance for Cellulitis.

**Hawke's Bay Māori ASH rates 0-4yrs - improving****Asthma**

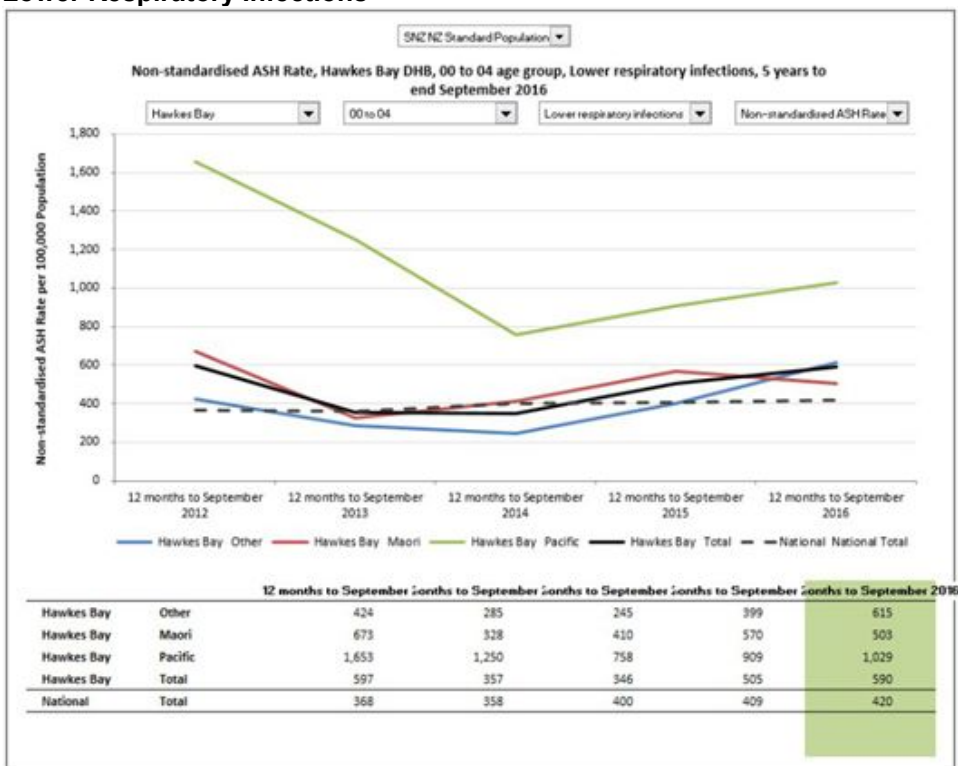
Asthma is the 2<sup>nd</sup> ranked ASH condition for Māori 0-4 years yet rates have decreased slightly compared to the end of September 2015. There is also a reduction in the gap between Māori and non-Māori. By 12 months to end of September 2016 Māori rates were 23 % higher than rates for Other.

## Pneumonia

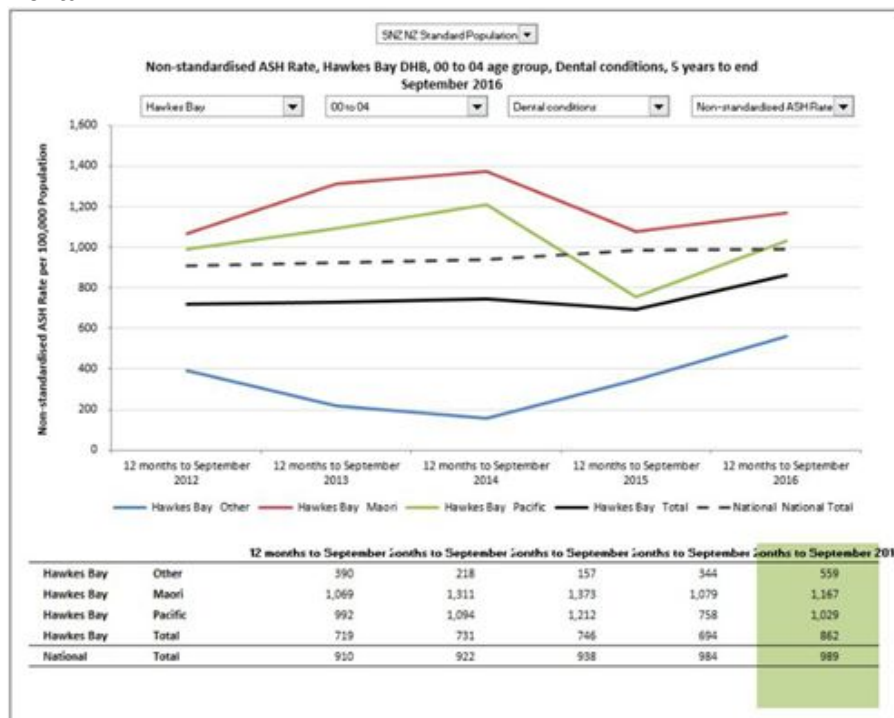


Pneumonia rates in the 0-4 years have decreased in the last two years. The Hawke's Bay Māori 0-4 year rate is half the national rate.

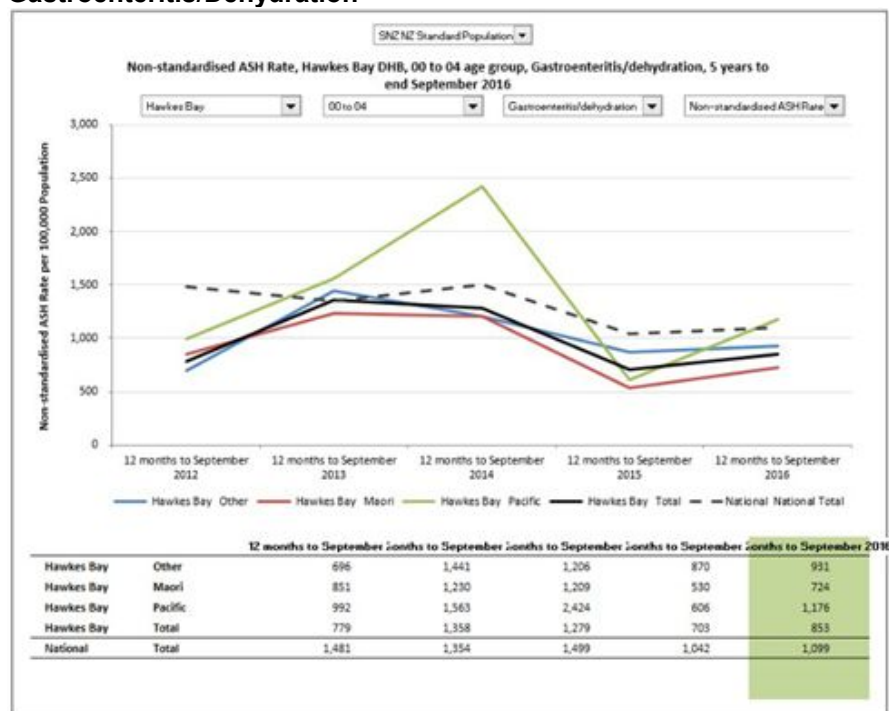
## Lower Respiratory Infections



Lower Respiratory Infections are 1.2 times the total national rate. In Hawke's Bay Māori 0-4 year olds are now the best performing ethnicity and is also below the rate for Hawke's Bay Other.

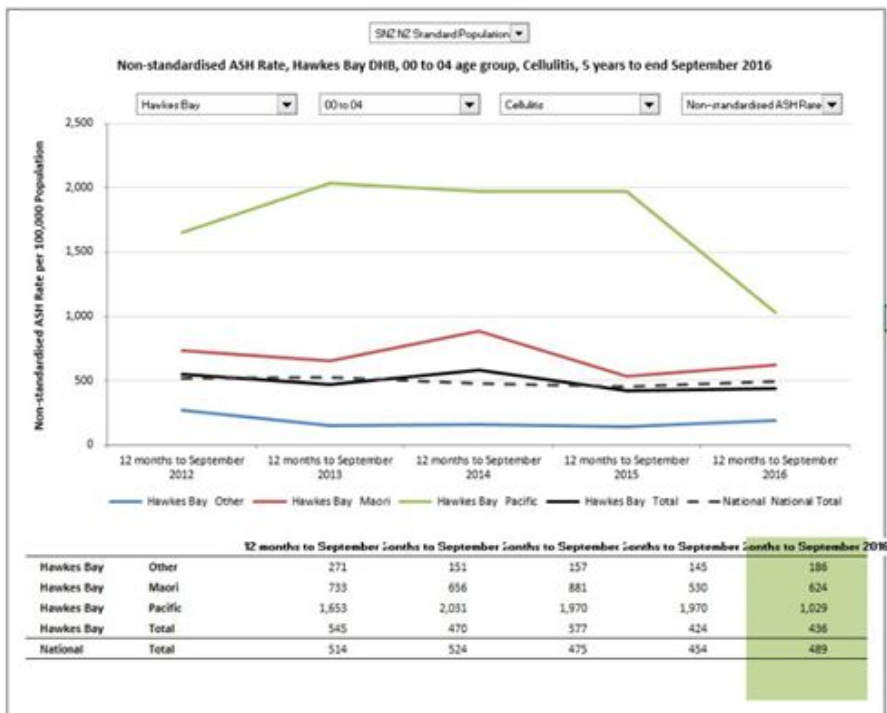
**Hawke's Bay Māori Ash Rates 0-4yrs - Not Improving****Dental**

Dental is the top ranked Māori ASH condition in the 0-4 year olds. Rates have increased in the last 12 months to September 2016 and Hawke's Bay Māori rates are 2 times the Hawke's Bay rate for Other and 1.2 times the total national rate.

**Gastroenteritis/Dehydration**

Ranked 4<sup>th</sup> for ASH conditions for Hawke's Bay Māori 0-4, Gastroenteritis/Dehydration increased over the current period 12 months to September 2016. Māori rates are lower than the Hawke's Bay non-Māori and below the national rates for total and Māori.

## Cellulitis



Cellulitis is the 6<sup>th</sup> ranked ASH condition for Hawke's Bay and is 1.3 times the national rate. There has been an increase from 530 per 100,000 for the period 12 months to September 2015 to 624 per 100,000 for the period 12 months to September 2016. It is also 3.4 times higher than the rate for Hawke's Bay Other.

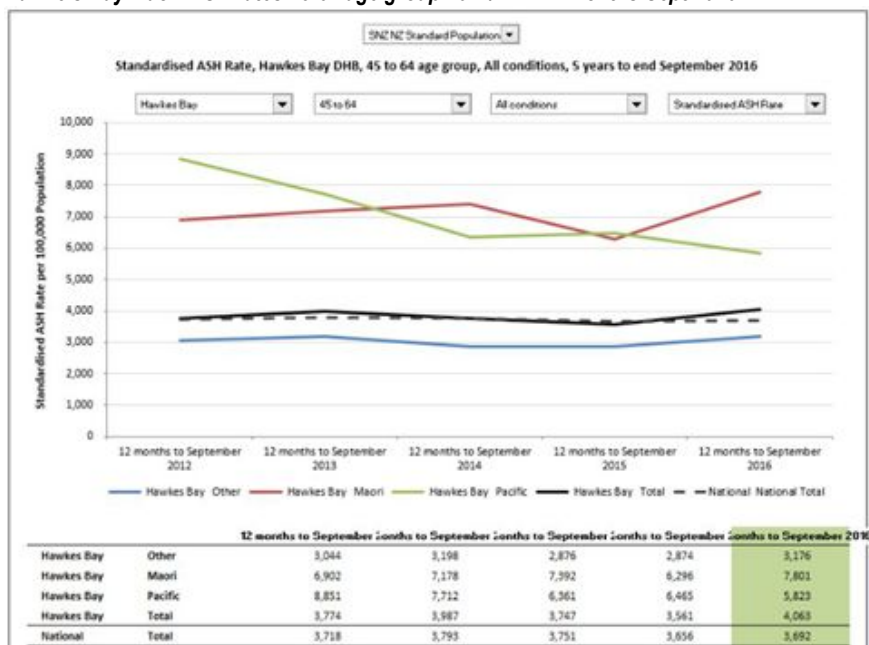


### ASH RATES 45-64 AGE GROUP

The expectation for ASH 45-64 is that there will be a minimum reduction by half of the equity gap between Māori and national total population base line data over a period of 2.5 years. Within 5% would be considered equity.<sup>3</sup>

### Hawke's Bay Distribution and Trends

#### Hawke's Bay Māori ASH rates 45-64 age group 2011/12 – 12 months Sept 2016



In period Sept 15-Sept 16	Increase in ASH rates Sept 15-Sept 16	Decrease in ASH rates Sept 15-Sept 16
Māori	1505	
Other	303	
Pasifika		642

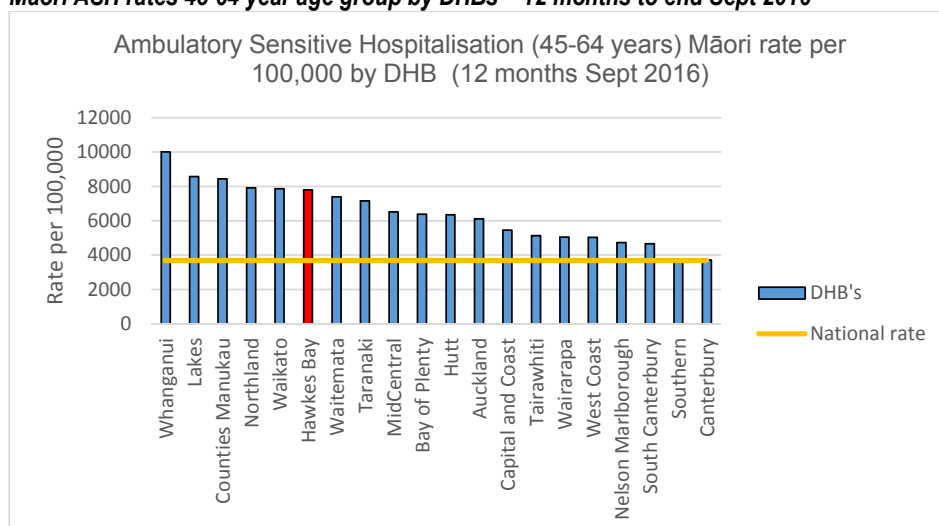
The top 3 ASH conditions for Māori in this age group are; Cardiac Conditions (Angina, Chest Pain, Myocardial Infarction), Respiratory (including COPD and Pneumonias) and Cellulitis.

There has been a decline in Hawke's Bay ASH rates in the 45-64 year age group in both Māori and non-Māori. In the 12 months to September 2016 the Hawke's Bay Māori rate was 1.9 times the Hawke's Bay non-Māori rate and 2.1 times the national rate.

The gap between the Hawke's Bay Māori rate and the Hawke's Bay non-Māori rate has widened between 2012 and 2016.

<sup>3</sup> As indicated by the MoH specifications for ASH rates.



**Māori ASH rates 45-64 year age group by DHBs – 12 months to end Sept 2016**

In the 12 months to September 2016 the Hawke's Bay Māori rate was 90% higher than the national rate and Hawke's Bay DHB is ranked 15<sup>th</sup> out of 20 DHBs. Māori rates are substantially higher than national rates in this age group across the majority of DHBs.

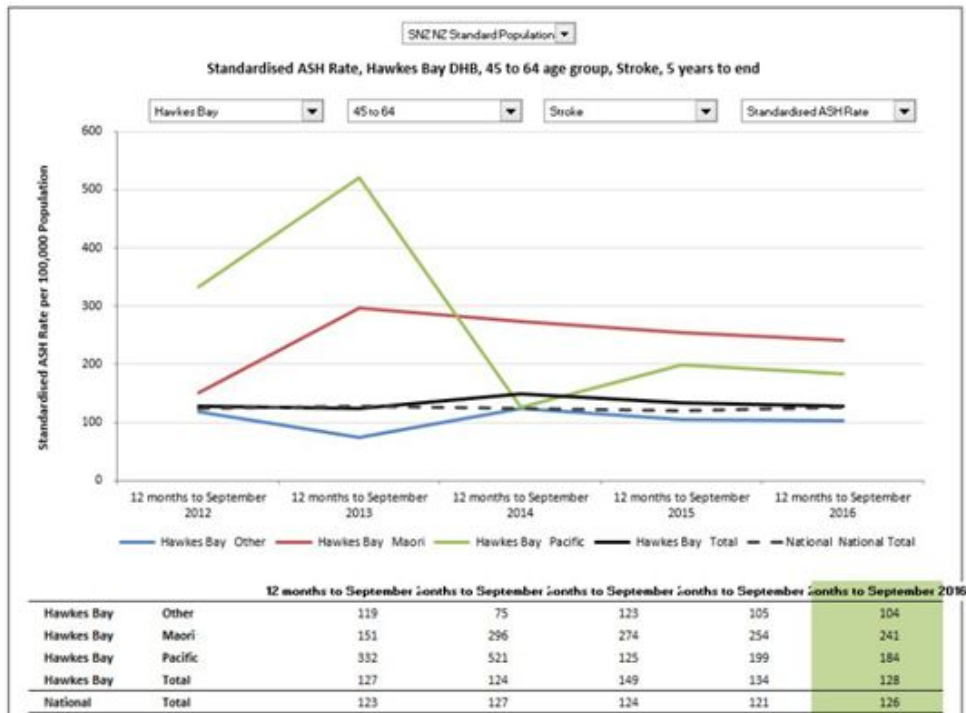
The largest differences in Māori rates and national rates by ASH condition in this age group are Congestive Heart Failure and Respiratory infections-COPD.

**Hawke's Bay ASH rates 45-64yrs - conditions where Māori rates are - *improving*****Congestive Heart Failure**

Ranked 5<sup>th</sup> for ASH conditions Congestive heart failure has improved over the period 12 months and is now 0.3 times lower than 2015.

There is still a substantial gap between Hawke's Bay Māori and Hawke's Bay Other with the Māori rate being 6.1 times higher.

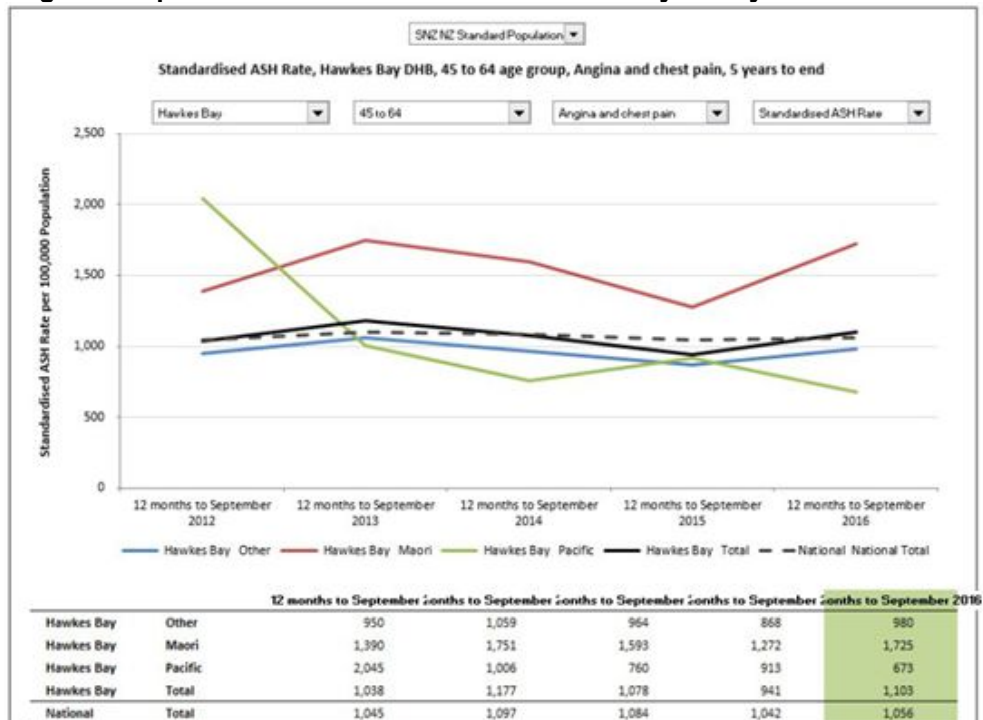
## Stroke



Stroke has improved slightly over the period 12 months to September but is currently 1.9 the total national rate.

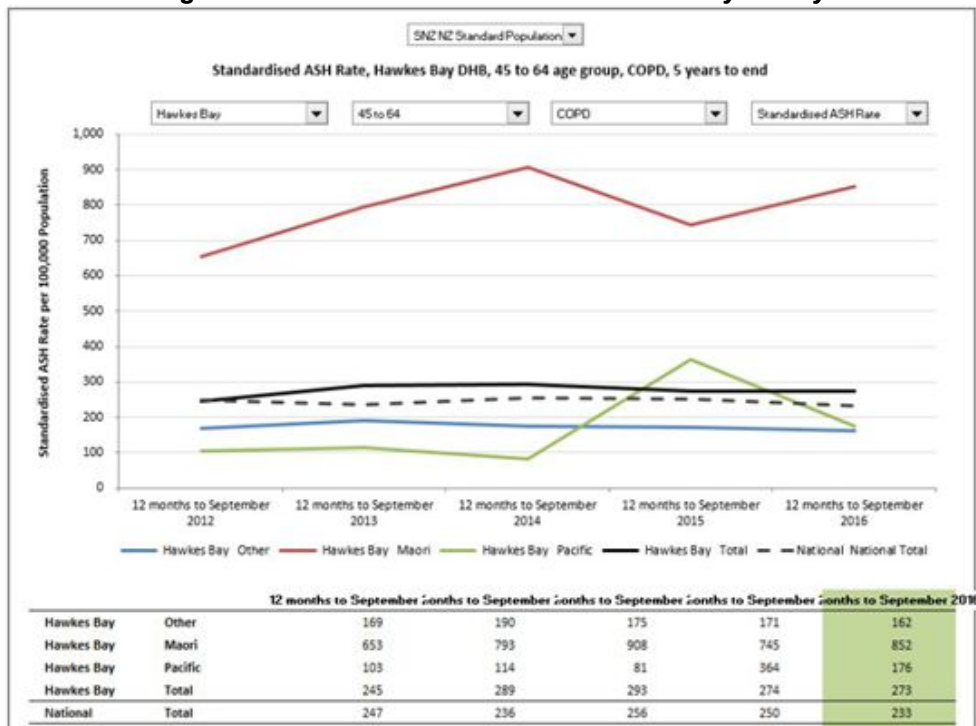
**Hawke's Bay ASH rates 45-64yrs - conditions where Māori rates are - *not improving***

**Angina – Top ranked ASH Condition for Hawke's Bay 45-64yrs**

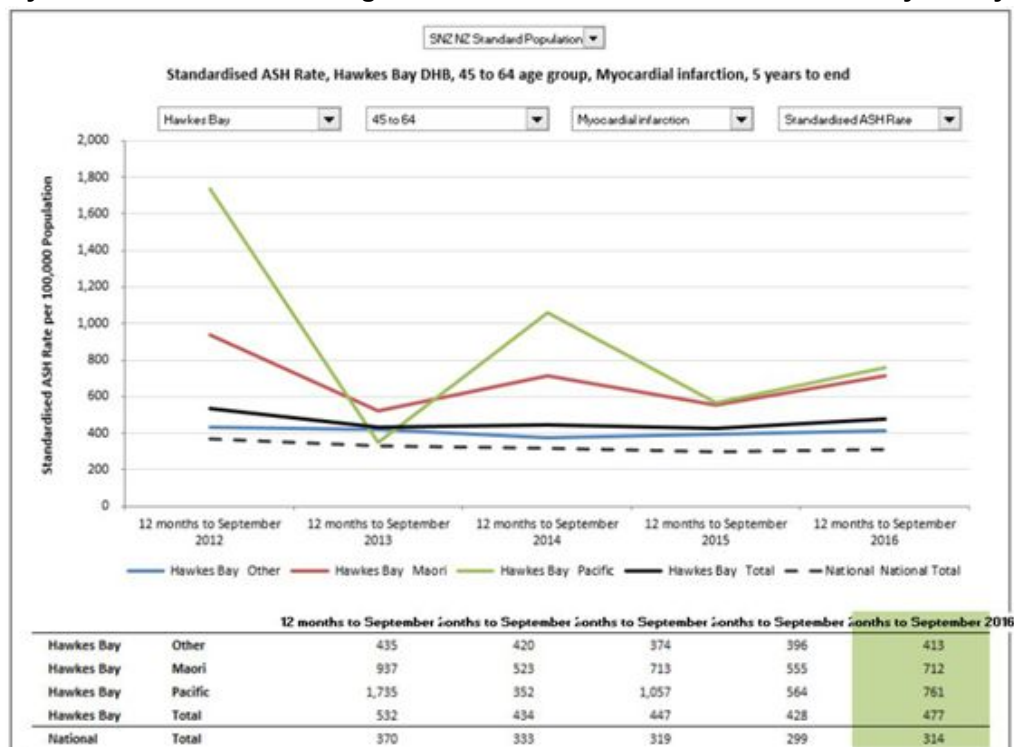


Angina and chest pain is the top ranked ASH condition for Hawke's Bay Māori 46-64 and it has increased at a rate of 1.3 from the period 12 months to September 2015.

The rate is currently 1.6 times the national rate and 1.8 times the rate for Hawke's Bay Other.

**COPD – 2<sup>nd</sup> Highest ranked ASH condition of Hawke's Bay 45-64yrs**

COPD is ranked 2<sup>nd</sup> for ASH conditions for Hawke's Bay Māori in the age group 45-64 years. There has been a 1.1 increase in the rate compared to the period 12 months to September 2015. Of greater significance however is that the Māori rate currently sits 5.3 times higher than the rate for Hawke's Bay Other.

**Myocardial Infarction - 3<sup>rd</sup> Highest ranked ASH condition of Hawke's Bay 45-64yrs**

Myocardial Infarction is ranked 3<sup>rd</sup> for ASH condition for Hawke's Bay Māori in the age group 45-64 years. The rate has increased at a rate of 1.2 in the period 12 months to September 2016 and has also widened against Hawke's Bay Other.

It is currently 1.7 times higher than the Hawke's Bay rate for Other.

## **REVIEW OF CURRENT AND PLANNED ACTIVITY RELEVANT TO SUPPORT THESE INDICATORS**

### **0-4 YEAR OLDS**

#### ***Paediatric respiratory training for Practice Champions***

Paediatric respiratory training underway, 13 nurses from nine practices have currently completed. Health Hawkes Bay are working on a communication strategy out to general practice. Two further respiratory training sessions are scheduled.

The existing respiratory pathway has been modified to include children and a process is in place to support notification through to Practice Champions by CNS Paediatric Respiratory of all paediatric patients that have been admitted to hospital for asthma and wheeze.

#### ***Increased immunisation Health Target***

Focus is on the measure: % of eight month olds who will have their primary course of immunisation (6 weeks, 3 months and 5 month immunisations events) on time. Hawke's Bay achieved target throughout the 2016 year. Concentrated efforts continue to ensure a targeted outreach service, provision of alternative venues and opportunistic immunisations in secondary services. Critical to the continued success of achieving the measure is a well-functioning NIR database which shares information between various child health databases.

#### ***Oral Health Initiative***

The recommendations and findings report on 'Improving access to Community Dental Services for Tāmariki Māori' initiated by Population Health Service, Community Dental Service and Māori Health Service was released in July 2016. Key recommendations included; reinvesting resources with Well Child/Tāmariki Ora providers to manage children who are failing community dental appointments, introducing a patient focused booking system and revision of the 'hub and spoke' model of care.

#### ***Healthy Homes Programme***

Hawke's Bay DHB and Health Hawkes Bay continue to fund a programme providing insulation and a range of interventions for households living in low socioeconomic areas who have significant health need. The greatest percentage of referrals into the Healthy Homes programme are for Māori and Pacific whānau. The MoH has expanded the criteria (and funding out to 2020) for the Healthy Homes Initiative which now includes pre-schoolers hospitalised for an indicator condition, at risk pregnant women/new mothers, and priority families with pre-schoolers for whom at least two of the following risk factors apply: CYF finding of abuse or neglect; caregiver with a Corrections history; mother has no formal qualification; and long-term benefit receipt

#### ***Work in Kohanga Reo***

The re-establishment of DHB service provision within Hawke's Bay kohanga reo is now fully operational and enables the provision of education and advice to whānau, tamariki and kohanga around the management and treatment of skin conditions. As a result of a successful budget bid and investment, a new public health nurse was employed at the end of 2016, to continue to expand this programme.

The 'Clean it, Cover it, Treat it, Love it' skin resource has been translated for use in local Kohanga. This supports parents and Kaiako around best practice in recognition and management of skin issues. This aims to lead to earlier recognition and treatment of skin infections, avoiding the need for admission. Currently building feedback mechanisms for use of the resource into the action plan for 2017.

### **45-64 YEAR OLDS**

#### ***Collaborative Pathways***

Health Hawke's Bay and Hawke's Bay DHB are developing collaborative pathways across a range of conditions to improve practice by promoting the integration of services so that patients experience timely and consistent quality care that is coordinated in its approach within Hawke's Bay and reflects care that would be experienced elsewhere nationally.

Measuring the efficacy of the pathways is twofold. Firstly through analytics that would detail the current uptake and use of pathways within clinical practice and individual patient care and secondly through clinical patient / population health indicators.

Without both components, measuring the contribution that pathways make to patient outcomes is unreliable. The current platform on which the pathways are hosted does not currently provide this level of analytics.

An interactive application is going to be trialled with the anticipation that a fully interactive pathway can be developed. This would map how a pathway is being used by individual providers, link directly to patient information and ultimately be able to demonstrate the causal link between use of pathways to improve patient and population health outcomes.

Two pathways are being developed for a proof of concept. The cost of 35K has been approved by EMT (January 2017). The findings from the trial will be evident in June 2017 at which time the decision to extend to further pathways will be made by clinical council and EMT. It is anticipated that if the trial is successful all current pathways developed will be provided with the interactive function.

To date 30 pathways have been developed and GPs are increasing their use. From anecdotal evidence we can estimate that the most accepted pathways to date have been Respiratory (COPD), Dementia, Cellulitis and Last days of Life.

The new cellulitis pathway is reducing medication prescribing. This pathway was published and implemented into General Practice in November 2016 with the intent to change prescribing practice e.g. prescribe oral antibiotics and less use of intravenous antibiotics. However, if intravenous is required it is now a once daily administration rather than previous management which was twice daily – this saves the person time and cost to travel e.g. instead of two visits per day can be one. This pathway has been mirrored with slight changes and will be implemented into the Emergency Department, published date for February 2017. Consultants and nursing staff have received education and the change management is being led by the IV Clinical Nurse Specialist. Having this pathway in both primary and secondary care will endorse consistency of practice across both sectors.

The Congestive Heart Failure pathway aims to lead to improvements in consistency of practice not only in general practice but in aged residential care in the attempt to reduce and avoid hospital admissions. This is a very detailed prescribed pathway led by one of our dedicated Cardiologist and since publication has been reviewed with changes made due to national changes. This demonstrates the support from Clinical leads to ensure pathways are current within practice.

Promotion of all pathways is led by a small team that continues to socialise by visiting individual practices, promotion at CME/CNE training and quarterly newsletters.

### ***Continuation of the Nurse-Led Respiratory Program***

#### **(Responding to Māori COPD rates-5.3 times the rate of Other)**

Nurse led respiratory (including asthma and Chronic Obstructive Pulmonary Disease-COPD) clinics have been operating in General Practice since Sept 2014. Significant improvement and stabilisation of COPD rates for Pasifika and Other has been achieved.

This has not been the same for Māori, which currently sit at 5.3 time that of other with an annual increase of 1.2

Funding has been approved for the continuation of the pilot into a program of work that includes joint funding commitments from PHO and DHB. The focus of the program in its continued form will be addressing the high COPD rates of Māori

The service specifications are being developed currently and are being designed to intensify the focus on Māori outcomes and diversify the approaches whilst still repeating the proven work achieved with Other and Pasifika. The program methodology will follow an outcomes based framework.

Outcomes to date have seen decreases in ED presentations, hospitalisations and length of stay.

These outcomes can be attributed to the following key elements within the program:

- Emphasis on co-ordination and streamlining of client healthcare, with a strong Primary Health Care ethos focusing on early detection and timely management of chronic conditions at the primary care level.
- Nurse-led clinics are effective in co-ordination and self-management.
- Focus on Q4 and 5 patients representing 45% Māori accessing from quintile 5, and 65% Pacific) reflecting improved access to healthcare for high-needs clients
- Increased autonomy of nursing workforce with strengthened career pathway to CNS and Nurse Practitioner levels of competency
- Working in tandem with first line emergency services and pharmacy to provide patient management that reduces ED presentations for stabilisation.

Newly introduced elements to improve Māori Health outcomes are:

- Greater focus on whānau wellness vs the individual, supported by referral by Respiratory Clinical Nurse Specialist (R-CNS) to the whānau wellness program (PHO)
- Shift of emphasis on review rather than initial diagnosis allowing more people to be seen and more concentrated follow up
- The R-CNS to work with practice nurse champions alongside Māori health workers to improve capacity within the sector of specialist knowledge – management of respiratory conditions
- The R-CNS is working with exercise and health literacy teams to provide expert advice to improve program delivery and information
- Direct liaison by St John service with primary care for the management of patients instead of being transported to ED

Challenges:

- Disinvestment in secondary services with expectation of primary care to meet patient needs has not been accompanied by equivalent resources
- Non integration of primary and secondary service IT Patient Management Systems hinder real time transfer and visibility of clinical notes

The respiratory service will be used to trial the newly developed Draft Long Term Conditions Framework and the evaluation tool that has also been developed to support services in their planning reporting and implementation activities. The service has been selected to its focus on whānau based care, self-management focus and improved health outcomes for Māori.

### ***Sharing Primary Care Practice Information***

Business Intelligence has produced reports for a selection of general practices on their ED presentation and admission rates for consumers who had been identified as presenting 7+ times. The pilot initiative was set up to help determine the causative factors. Initial findings have demonstrated a range of influences and the most informative was that the patients identified in the trail were both high users of ED and General Practice, with high to complex needs and or awaiting surgical intervention.

Sharing of practice level data – pertaining to consumer utilisation of hospital based services has proven to be effective in identifying opportunities for service integration and coordination of patient centred care.

The initiative is continuing and work is underway to extend to additional data sharing with an ever greater number of general practice involvement with the appropriate oversight for a confidentiality and IT governance perspective.

## RECOMMENDATIONS FROM TARGET CHAMPION

As the Champion for the TAW ASH rate report there were two things that stood out for me.

- 1 For ASH rates 0-4 we are doing well, both with national comparisons and with the closing of the equity gap. We are now well in the lower half of the league table of DHB ASH rates in this age group and, pleasingly, the gap between the Maori rates and the total population is small and closing. Dental admissions is the one issue that does need to be highlighted where the rates are still high, however the work done with getting younger children engaged with the dental service should lead to improvements over the next 1-2 years.
- 2 For ASH rates in the 45-64 age group the HBDHB is at the wrong end of the league table with rates higher than the national average and some very large discrepancies between Maori and non-Maori. COPD and Heart Failure stand out as issues that need to be addressed.


## CONCLUSION

There is significant work with COPD by the Respiratory Pilot which has now become BAU and for CHF the appointment of a CNS to work between primary and secondary care should help with this. It is interesting that CVD rates are much closer to the national average and have a much lesser equity gap. This could represent a time gap with improvements in primary prevention still to come through but could also indicate a treatment gap where Maori are not being treated as successfully for their CVD and therefore going on to develop CHF.

Dr Mark Peterson  
**Chief Medical Officer - Primary**





	<b>Annual Māori Health Plan Q2 (October - December 2016)</b>
	For the attention of: <b>HB Clinical Council and HB Health Consumer Council</b>
Document Owners:	Tracee Te Huia, General Manager Māori Health
Document Author(s):	Patrick Le Geyt, Programme Manager Māori Health Justin Nguma, Senior Health & Social Policy Advisor Peter Mackenzie, Operational Performance Analyst
Reviewed by:	Executive Management Team
Month:	February 2017
Consideration:	For Monitoring

**RECOMMENDATION**

**That the Clinical and Consumer Councils:**

Note the contents of this report.

**OVERVIEW**

The purpose of this paper is to providing MRB, HB Clinical Council, HB Consumer Council and the HBDHB Board with exception report for Quarter 2 on the implementation of the 2016 – 2017 Annual Māori Health Plan. A quick reference summary dashboard will be supplied prior to the meeting which shows our position as at the end of Quarter 1 for all indicators. The dashboard uses traffic light methodology with detailed information and symbols for all indicators. For example, in a situation where the performance of the indicator for the current quarter is higher than the previous quarter this symbol '▲' will be used to show an upward trend while an opposite symbol '▼' will be used to show a downward trend. In cases where the variance to the annual target for the indicator is greater than 0.5% this symbol 'U' (indicated on the dashboard in red) will be used to indicate unfavourable trend and 'F' for favourable trend (indicated on the dashboard in green colour) toward the annual target (see the table below).

**KEY FOR DETAILED REPORT AND DASHBOARD**

<b>Baseline</b>	Latest available data for planning purpose
<b>Target 2015/16</b>	Target 2016/17
<b>Actual to date</b>	Actual to date
<b>F (Favourable)</b>	Actual to date is favourable to target
<b>U (Unfavourable)</b>	Actual to date is unfavourable to target
<b>Trend direction ▲</b>	Performance is improving against the previous reporting period or baseline
<b>Trend direction ▼</b>	Performance is declining
<b>Trend direction -</b>	Performance is unchanged

## 2016-2017 ANNUAL MĀORI HEALTH PLAN QUARTER 2 PERFORMANCE HIGHLIGHTS

### Achievements

1. Access to referral services for alcohol and other drugs for 0-19 year old Māori within 3 weeks has slightly decreased from 81.6% in Q1 to 80.5% in Q2, but still tracking positively above the expected target of  $\geq 80\%$ .



### Areas of progress

1. Immunization rates for 8 months old Māori for Q2 has remained unchanged from 94.6% in Q1, tracking positively towards the expected target of  $\geq 95\%$ . This rate lowers the disparity gap between Māori and non- Māori from 2.1% in Q1 to 1.8 in Q2.
2. The number of Māori enrolled with HHB PHO increased slightly from 96.6% in Q1 to 96.8% in Q2 and trending positively towards the target of  $\geq 100\%$ . This brings the disparity gap between Māori and non- Māori for Q2 to less than 1%. Currently HBDHB ranks 4th among all DHBs in the country for Māori PHO enrolments
3. The ASH rates for Māori 0-4 year old group has dropped from 91.7% in Q1 to 84.9% in Q2 and trending positively towards the expected rate of  $\leq 83\%$ . This lowers the disparity gap between Māori and non- Māori from 11.4% in Q1 to 7.1% in Q2. HBDHB ranks 3rd among the best DHBs in the country for ASH rates among the 0-4 year olds.
4. Cervical screening for 25-69 year old Māori women for Q2 is 72.8% up slightly from 72.7% in Q1 with a disparity gap of 6% between Māori and non- Māori compared to 5% recorded in Q1. Nonetheless, this indicator continues to trend positively towards the target of  $\geq 80\%$  putting HBDHB ahead of all other DHBs in the country.
5. Māori Workforce grew by less than 1% from 12.5% in Q1 to 13% in Q2 trending towards the expected target of 13.8% or 22 employees to the target of 409 Māori staff.
6. Access to referral services for alcohol and other drugs for 0-19 year old Māori within 8 weeks has increased slightly from 91.7% in Q1 to 93.6% in Q2, tracking positively towards the expected target of  $\geq 95\%$ . This lowers the disparity gap between Māori and non- Māori from 1.1% in Q1 to 1% in Q2.



### Challenges

1. Acute hospitalization for Rheumatic Fever has steadily remained at 7.3% from Q1 and tracking more than 20% away from the expected target of  $\leq 1.5$ .
2. Māori under Mental Health Act compulsory treatment orders (CTO) has decreased from 183.9 per 100,000 population in Quarter 1 to 179.9 per 100,000 population in Q2. However, the indicator is tracking behind the target of  $\leq 81.5$  with a disparity gap of 117.8 between Māori and non- Māori in Q2 compared to 94.2 in Q1.
3. ASH rates for Māori 45-64 years went up slightly to 211.3% in Q2 from 196% in Q1 trailing behind the target of  $\leq 123\%$  with a significant disparity gap of 101.3% between Māori and non- Māori.
4. Breast screening for 50-69 Māori women dropped from 67.1% in Q1 to 64.7% in Q2 tracking positively towards the target of  $\geq 70\%$ . This rate presents a disparity gap of about 11% between Māori and non- Māori compared to 7.4% in Q1.



5. The Māori staff cultural competency training shows some slight increase from 78.8% in Q2 to 80.7% in Q2. While the numbers of staff training across professions went up slightly across the service, the number of staff training among the medical staff dropped by 2.2% from 39.9% to 39.7% in Q2.





National ranking by Trendly.

**Please note:**

- Unless otherwise stated the results presented in this dashboard are for Māori.
- The approximated gap to achieving target numbers stated may only be one of a range of possible values that could deliver the targeted level/result.



## ANNUAL MĀORI HEALTH PLAN, QUARTER 1 SEPTEMBER – DECEMBER 2016 DASHBOARD REPORT

Immunisation								
Indicator	Baseline	Prior period result	Actual to date		Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
Immunisation at 8 Months (3m)	92.6%	94.4%	94.4%	96.2%	≥ 95%	-2		↑
65+ Influenza (3m)	68.0%	56.5%	Update available in Q4		≥ 75%	-		↑


Rheumatic Fever								
Indicator	Baseline	Prior period result	Actual to date		Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
Hospitalisation rate (6m)	2.48	7.3	7.3	2.48	≤ 1.5	-1		↓


Breastfeeding								
		Prior period result	Actual to date		Individual Numbers to Target (approx)	Time Series Trend	Desired Trend	
Indicator	Baseline		Maori	Total	Period target			
QIF Data (6m)								
At 6 Weeks	58.0%	67.0%	Update available in Q3		≥ 75%	-		↑
At 3 months	46.0%	39.0%			≥ 60%	-		↑
At 6 months	46.0%	48.0%			≥ 65%	-		↑

SUDI								
Indicator	Baseline	Prior period	Actual to date	Maori Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Rate per 100,000 (12m)	2.09	2.1	Update expected Q4		≤ 0.4			↓
Caregivers given SUDI Prevention Info (12m)	72.8%	72.8%			≥ 100%			↑

Oral Health								
Indicator	Baseline	Prior period	Actual to date	Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Pre-school enrolment rate (3m)	65.3%	74.1%	Update available in Q3		≥ 95%	-		↑
% Caries Free at 5yrs (3m)	36.0%	36.0%			≥ 67%	-		↑

Tobacco								
Indicator	Baseline	Prior period	Actual to date		Period target	Individual Numbers	Time Series Trend	Desired Trend
Smokefree 2 weeks postnatal (6m)	53.0%	65.6%	Update expected Q3		≥ 95.0%	-		↑

Mental Health & Addictions								
Indicator	Baseline	Prior period	Actual to date		Period target	Individual Numbers	Time Series Trend	Desired Trend
Mental Health Act community treatment orders (per 100,000) (3m)	196.0	183.9	179.9	62.1	≤ 81.5	-		↓



Access to Care								
Indicator	Baseline	Prior period result	Actual to date		Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
PHO Enrolment (3m)	97.2%	96.6%	96.8%	97.5%	≥ 100%	-1310		↑

The number in brackets identifies the frequency at which data is updated:

(3m) 3 months


(6m) 6 months

(12m) 12 months

ASH Rates								
Indicator	Baseline	Prior period result	Actual to date		Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
			Maori	Other				
0-4 years (6m)	82.1%	91.7%	84.9%	77.8%	≤ 83%	-145		↓
45-64 years (6m)	172.0%	196.0%	211.3%	110.0%	≤ 138%	-2706		↓

Cancer								
Indicator	Baseline	Prior period	Actual to date Maori	Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Cervical screening (25-69 yrs) (3m)	74.1%	72.7%	72.8%	78.9%	≥ 80%	-656		↑
Breast screening (50-69 yrs) (3m)	68.4%	67.1%	64.7%	75.0%	≥ 70%	-93		↑

Maori Workforce								
Indicator	Baseline	Prior period result	Actual to date		Individual Numbers to Target (approx)	Time Series Trend	Desired Trend	
			Maori	Period target				
Medical	2.9%	3.4%	4.2%	≥ 13.8%				
Management & Administration	16.5%	16.5%	17.2%	≥ 13.8%				
Nursing	10.6%	10.8%	11.2%	≥ 13.8%				
Allied Health	12.6%	13.2%	13.5%	≥ 13.8%				
Support Staff	28.2%	27.4%	28.2%	≥ 13.8%				
Māori staff - HBDHB (3m)	12.3%	12.5%	13.0%	≥ 13.8%	-		↑	

Cultural Responsiveness								
Indicator	Baseline	Prior period result	Actual to date	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend	
Medical	19.2%	39.9%	37.7%	≥ 100.0%				
Management & Administration	79%	87.0%	88.4%	≥ 100%				
Nursing	70%	82.9%	85.4%	≥ 100%				
Allied Health	77%	86.2%	89.2%	≥ 100%				
Support Staff	36%	63.3%	64.9%	≥ 100%				
HBDHB (3m)	66%	78.8%	80.7%	≥ 100%	-		↑	

Obesity								
		Prior period result	Actual to date		Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Indicator	Baseline		Maori	Other				
Referred for Nutrition (3m)	30%	26%	44%	40%	≥ 95%	-		↑
Bariatric Surgery (3m)	7	0	0	0	-	0.00		-

Alcohol and Other Drugs								
Indicator	Baseline	Prior period result	Actual to date		Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
% of 0-19 year olds seen within 3 weeks of referral (3m)	91%	81.6%	80.5%	81.1%	≥ 80%	Numbers available in Q3		↑
% of 0-19 year olds seen within 8 weeks of referral (3m)	100%	91.7%	93.6%	94.6%	≥ 95%			↑



## TOPICS OF INTEREST / MEMBER UPDATES

12

Verbal

