Hawke's Bay Clinical Council Meeting

Date: **Wednesday, 7 December 2016**

Meeting: **3.00 pm to 5.30 pm**

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

Council Members:

Chris McKenna
Dr Mark Peterson
Dr John Gommans
David Warrington
Billy Allan
Dr Andy Phillips
Dr Robin Whyman
Dr Caroline McElnay
Jules Arthur
Dr Kiri Bird
Dr Tae Richardson
Dr David Rodgers
Dr Russell Wills
Debs Higgins
Anne McLeod

Apologies: Drs Peterson and McElnay

In Attendance:

Kate Coley, Director Quality, Improvement & Patient Safety
Ken Foote, Company Secretary
Tracy Fricker, Council Administrator and EA to Director QIPS
Graeme Norton, Chair HB Health Consumer Council
Kerri Nuku, Māori Relationship Board

PUBLIC MEETING

Item	Section 1 – Routine	Time (pm)
1.	Apologies / Welcome	3.00
2.	Interests Register	
3.	Minutes of Previous Meeting	
4.	Matters Arising – Review Actions	
5.	Clinical Council Workplan	
	Section 2 – For Decision	
6.	Long Term Conditions Report – Leigh White and Jill Garrett 6.1 Framework 6.2 Appendicies	3.15
	Section 3 – Presentations	
7.	Gastro Outbreak Update – Kate Coley	4.15
8.	Quality Improvement Programme – Chris McKenna, John Gommans & Andy Phillips	3.45
9.	Relationship Centred Practice – Andy Phillips & Anne McLeod	4.00
	Section 4 – For Discussion or Information	
10.	Annual Maori Plan Q1 Jul-Sept 16 – For information only	-
11.	Final Complementary Therapies Policy – For information only	-
	Section 5 – Reporting Committees / Monitoring	
12.	Clinical Advisory & Governance (CAG) Committee – Dr T Richardson	4.30
13.	Collaborative Clinical Pathways Update (4 monthly) – Leigh White	4.40
14.	**Recommendation to Exclude the Public**	

PUBLIC EXCLUDED

Item	Section 6 – Routine	
15.	Minutes of Previous Meeting	4.50
16.	Matters Arising - Review Actions	
17.	Member Topics of Interest	
	Followed by Christmas Cheer at Vidals	

Next Meeting: Wednesday, 8 February 2016 at 3.00 pm
Te Waiora (Boardroom), HBDHB Corporate Administration Building

Tauwhiro Rāranga te tira He kauanuanu Ākina

Interests Register

Hawke's Bay Clinical Council

Dec-16

Name Clinical 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
Chris McKenna (Director of Nursing)	Hawke's Bay DHB - Susan Brown	Sister	Registered Nurse	Yes	Low - Personal - family member
	Hawke's Bay DHB - Lauren McKenna	Daughter	Registered Nurse	Yes	Low - Personal - family member
	Health Hawke's Bay (PHO)	Board member	HHB ensures the provision of essential primary health care services, mostly through general practices, to the population of HB	Yes	Low
Dr Mark Peterson (Chief Medical Officer - Primary Care)	Taradale Medical Centre	Shareholder and Director	General Practice - now 20% owned by Southern Cross Primary Care (a subsidiary	Yes	Low
	Royal New Zealand College of General Practitioners	Board member	GP training and standards	Yes	Low
	City Medical Napier	Shareholder	Accident and Medical Clinic	Yes	Contract with HBDHB
	Daughter employed by HBDHB from November 2015	Post Graduate Year One	Will not participate in discussions regarding Post Graduates in Community Care	Yes	Low
	PHO Services Agreement Amendment Protocol (PSAAP)	"Contracted Provider" representative	The PHO services Agreement is the contract between the DHB and PHO. PSAAP is the negotiating group that	Yes	Representative on the negotiating group
	Health Hawke's Bay Limited (PHO)	Board member	HHB ensures the provision of essential primary health care services, mostly through general practices, to the population of HB.	Yes	Low
	Council of Medical Colleges	Royal New Zealand College of General Practitioners representative and Council of Medical Colleges Executive	May impact on some discussions around medical training and workforce, at such times interest would be declared.	Yes	Low
Dr John Gommans (Chief Medical Officer - Hospital)	Stroke Foundation Ltd	Chairman of the Board of Directors	Provides information and support to people with a stroke. Has some contracts to the MOH	Yes	Low
	Internal Medicine Society of Australia and New Zealand (IMSANZ)	Immediate Past President and a current Director of IMSANZ	The IMSANZ represents the interests of specialist General Internal Medicine physicians throughout Australia and New Zealand	Yes	Low
	Royal Australasian College of Physicians (RACP), Adult Medicine Division Committee (AMDC)	Member and Chair elect of NZ Committee	RACP represents Physicians in all Adult Medicine specialties across Australasia; the NZ AMD representing those based in NZ	Yes	Low
Dr Caroline McElnay (Director Population Health & Health Equity Champion)	NZ College of Public Health Medicine	President until October 2017	NZCPHM represents the interests of Public Health Medicine specialsits in NZ, provides training of registrars, ongoing accrediation of specialists and advocacy on public health matters.	No	
	RNZ Plunket Society	National Board member	Provision of heath and social services to children under 5 years, advocacy for children	No	
William Allan (Chief Pharmacist)	Pharmaceutical Society of New Zealand	Executive member	Pharmacy advocacy, professional standards and training	Yes	Low
	Pharmaceutical Management Agency (PHARMAC)	Member, Tender Medical Subcommittee of PTAC (Pharmacology & Therapeutics Advisory Committee)	Provide advice to PHARMAC on the clinical suitability of tenders for subsidised medicines for inclusion in the Pharmaceutical Schedule and Hospital Medicines List (HML)	Yes	Low. Influences the cost of subsidised medicines to the DHB's combined pharmaceutical budget
	Executive User Group for eMedicines programme (ITHB/HQSC)	Member (Central Region's representative)	Provide leadership and guidance to the HITB and HQSC on the eMedicines (Hospital) programme (electronic prescribing & administration; eMedicines	Yes	Low
	Pharmacy Steering Group (MoH)	Member	Provide advice to the Ministry on the utilisation of pharmacists within the health workforce	Yes	Low
Jules Arthur (Midwifery Director)	National Midwifery Leaders group	Member	Forum for national midwifery and maternity issues	No	
	Central Region Midwifery Leaders report to TAS	Member	Regional approach to services	No	
	National Maternal Wellbeing and Child Protection group	Co Chair	To strengthen families by facilitating a seamless transition between primary and secondary providers of support and care; working collaboratively to engage support agencies to work with the mother and her whanau in a culturally safe manner.	No	
	NZ College of Midwives	Member	A professional body for the midwifery workforce	No	
	Central Region Quality and Safety Alliance	Member	A network of professionals overseeing clinical governance of the central region for patient quality and safety.	No	
Dr Kiri Bird (General Practitioner)	Te Timatanga Ararau Trust (Iron Maori)	Partner (Lee Grace) is a Trustee	Health and Wellbeing	Yes	Low - Contract with HBDHB
	Gascoigne Medical Raureka	General Practitioner	General Practice	Yes	Low
	Royal NZ College of General Practitioners	Member	Health and Wellbeing	No	
	Royal NZ College of General Practitioners	Lead Medical Educator in HB	Health and Wellbeing	No	
	Te Ora Board (Maori Doctors)	Deputy Chair	Health and Wellbeing	No	
	Te Akoranga a Maui (Maori chapter for RNZCGP)	Member	Health and Wellbeing	No	

Name **Clinical 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**
David Warrington (Nurse Director - Older Persons)	Havelock North Chiropractic	Wife is Practitioner and Co-owner	Chriopractic care and treatment, primary and preventative	Yes	Low
	Pilates Works	Wife is CE and Co-owner	Rehabilitation, Primary and preventative.	Yes	Low
	National Directors of Mental Health Nursing	Member		No	Low
Dr Tae Richardson (GP and Chair of Clinical Quality Advisory Committee)	Loco Ltd	Shareholding Director	Private business	No	
	Dr Bryn Jones employee of MoH	Husband	Role with Ministry of Health as Chief Advisor in Sector Capability and	Yes	Low
	Clinical Quality Advisory Committee (CQAC) for Health HB	Member	Report on CQAC meetings to Council	No	
	HQSC / Ministry of Health's Patient Experience Survey Governance Group	Member as GP representative		No	
	Life Education Trust Hawke's Bay	Trustee		No	
	Dr Bryn Jones employee of MoH	Husband	Deputy Chief Strategy & Policy Officer (Acting)	No	
	Pacific Chapter of Royal NZ College of GPs	Secretary		No	
Andrew Phillips (Director Allied Health HBDHB)	Nil	Not Applicable	Not Applicable	No	Nil
Dr David Rodgers (GP)	Tamatea Medical Centre	General Practitioner	Private business	Yes	Low. Provides services in primary care
	Tamatea Medical Centre	Wife Beth McElrea, also a GP (we job share)	Private business	Yes	Low. Provides services in primary care
	Directions Youth Health	Wife Beth involved	Assisting youth in HB	No	
	City Medical	Director and Shareholder	Medical Centre	Yes	Low. Provides services in primary care
	NZ Police	Medical Officer for Hawke's Bay	Provider of services for the NZ Police	No	
	Health Hawke's Bay (PHO) initially - from 1 July 2015 under HB District Health Board	Collaborative Clinical Pathways development	Was the Champion for the initial work, however on 1 July this moved under the HBDHB umbrella (with a community focus).	No	
	Advanced Care Planning	Steering Group member	Health and Wellbeing	No	
	Urgent Care Alliance	Group member	Health and Wellbeing	Yes	Low. Ensure position declared when discussing issues around the development of urgent care services.
	National Advisory Committee of the RNZCGPs	Member	Health and Wellbeing	No	
	Health Hawke's Bay (PHO)	Medical Advisor - Sector Development	Health and Wellbeing	Yes	Low. Ensure position declared when discussing issues in this area relating to the PHO.
Debs Higgins (Senior Nurse)	The Hastings Heatlh Centre	Practice Nurse Family Violence Intervention Coordinator	Delivery of primary health care - General Practice and training of Clinicians in family violence intervention.	No	
	The NZ Nurses Society	Member of the Society	Provision of indemnity insurance and professional support.	No	
	LIVE (Local Initiative for Violence Elimination)	Member of management Committee	Network of agencies that provide family violence intervention services.	No	
	Eastern Institute of Technology (EIT)	Lecturer - Nursing	Education.	No	
Anne McLeod (Senior Allied Health Professional)	Aeotearoa NZ Association of Social Workers	Member		Yes	Low
	HB DHB Employee Heather Charteris	Sister-in-law	Registered Nurse Diabetic Educator	Yes	Low
	Directions Coaching	Coach and Trainer	Private Business	Yes	Low: Contracts in the past with HBDHB and Hauora Tairawhiti.
Dr Robin Whyman (Clinical Director Oral Health)	NZ Institute of Directors	Member	Continuing professional development for company directors	No	
	Australian - NZ Society of Paediatric Dentists	Member	Continuing professional development for dentists providing care to children and advocacy for child oral health.	No	
Dr Russell Wills	HBDHB Community, Women and Children and Quality Improvement & Patient Safety Directorates	Employee	Employee	Yes	Potential, pecuniary
	HBDHB employee Mary Wills	Spouse	Employee	Yes	Potential, pecuniary
	Paediatric Society of New Zealand	Member	Professional network	No	
	Association of Salaried Medical Specialists	Member	Trade Union	Yes	Potential, pecuniary
	New Zealand Medical Association	Member	Professional network	No	
	Royal Australasian College of Physicians	Fellow	Continuing Medical Education	No	
	Neurodevelopmental and Behavioural Society of Australia and New Zealand	Member	Professional network	No	
	NZ Institute of Directors	Member	Professional network	No	

MINUTES OF MEETING FOR THE HAWKE'S BAY CLINICAL COUNCIL and JOINT MEETING WITH HAWKE'S BAY HEALTH CONSUMER COUNCIL HELD IN THE EDUCATION CENTRE, HAWKE'S BAY DISTRICT HEALTH BOARD ON WEDNESDAY, 9 NOVEMBER 2016 AT 1.00 PM

PUBLIC

Present:
Dr Mark Peterson (Chair)
Chris McKenna (Co-Chair)
Dr Kiri Bird
Dr John Gommans
Dr Russell Wills
Dr Robin Whyman
Dr David Rodgers
Dr Caroline McElnay
Andy Phillips
Debs Higgins
William Allan
David Warrington (3.20 pm)
Jules Arthur

In Attendance:
Dr Kevin Snee, Chief Executive Officer (2.25 pm)
Ken Foote, Company Secretary
Kerri Nuku, Māori Relationship Board Member
Tracy Fricker, Council Administrator and EA to DQIPS

Apologies: Dr Tae Richardson and Anne McLeod

SECTION 1: ROUTINE

1. WELCOME AND APOLOGIES

Dr Mark Peterson (Chair) welcomed everyone to the meeting. He advised that the Consumer Council members will join the meeting at 2 pm and that a workshop on Palliative Care and Advanced Care Planning will be held from 4 pm.

Apologies were noted as above. David Warrington will be late and David Rogers, Caroline McElnay and Kerri Nuku have advised they will need to leave before the workshop.

2. INTERESTS REGISTER

No conflicts of interests for agenda items.

3. CONFIRMATION OF PREVIOUS MINUTES

The minutes of the meeting held on 12 October 2016, were confirmed as a correct record of the meeting.

Moved and carried.

4. MATTERS ARISING, ACTIONS AND PROGRESS

Item 1: **Workshop for Joint Meeting with Consumer Council**
Planning for workshop completed. On agenda for today's meeting items #26 and #27. *Item can be closed.*

Item 2: **Reporting Committees / Monitoring**
The new report template is yet to be developed. This will be part of the work with the clinical committees review. *Item can be closed.*

Item 3: **Laboratory Committee**
Information on EasyCheck kits has been resent to GPs by the PHO. *Item can be closed.*

Item 4: ***RMO Strike Update***
Dr John Gommans, Chief Medical & Dental Officer - Hospital (CMDO) advised that the RMO Strike in October was managed well, but around 200 outpatient appointments and 43 operations were postponed. Feedback was that there was no real reduction in attendances in ED or referrals in from primary care. Not sure what could be done different, communication was sent out to primary care. A further strike notice has been issued for 23-25 November. It is hoped that we will not have to postpone as many procedures and day cases as last time. A further complication is that key clinical staff have been approved leave for professional development/ conferences during this time and this notice also clashes with the new house officers' orientation. Contingency planning for this latest notice is underway.

Correspondence In

Chris McKenna (Co-Chair) advised that with regret she accepted Robyn O'Dwyer's resignation after five years of good work for the Clinical Council. Recruitment for another primary care nurse representative is underway.

Action: ***Letter of thanks to be sent to Robyn O'Dwyer.***

5. CLINICAL COUNCIL WORK PLAN

The work plan was included in the meeting papers for information. Reminder that the Health Awards is on 24 November, it was noted that this is during the RMO Strike.

The Chair commented that if members have additional items they wish to be added to the work plan that he and Chris McKenna were happy to receive suggestions.

SECTION 2: FOR DISCUSSION / UPDATE

6. LEARNINGS FROM ICU REVIEW 2013 – PROGRESS UPDATE

Report accepted as read. The CMDO advised that processes for reviews have changed so there is now a much better oversight of report recommendations and action plans. Regular updates will come to Clinical Council until all recommendations have been completed.

7. CLINICAL GOVERNANCE STRUCTURE UPDATE

Dr Andy Phillips, Chief Allied Health Professions Officer (CAHPO) advised that the work around the clinical governance structure has been going on for around 18 months and is has been a team effort. The framework allows the Clinical Council to provide assurance to the Board about

governance of the organisation. An updated draft structure with principles and timelines was tabled. A meeting has taken place with the chairs of the advisory groups which will report to the five committees, to do some co-design and discussion around terms of reference. The draft structure does not include all of the advisory groups, there are some that sit under those on the draft structure which need to be populated.

The Co-Chair advised that it is also part of the work of Clinical Council to have representation on the committees and advisory groups. It was noted that some Clinical Council members are already involved with several of the groups, and this is an opportunity for members to express an interest in particular advisory groups.

The CAHPO asked for feedback on the draft document:

Feedback:

- The Patient Experience Committee should report directly to the Clinical Council, but still have involvement with Consumer Council
- There will be a considerable administrative burden, it is important to think about processes, the reports of the advisory groups to the committees and the committees to the Clinical Council, how this is going to be done, how frequently, who is going to organise the meetings, secretarial support etc. This needs to be put in place otherwise it will fall over because it has not been administered properly
- It is timely that the terms of reference are being refreshed, so that everyone knows what is expected of them if they are on one of these committees/advisory groups
- Need to develop a standard reporting template for the advisory groups and committees to use. The Clinical Council does not need to see everything, we need to be informed about any risks to the organisation and achievements
- Clarify the role of the Maori Relationship Board (MRB) on the structure. Possibly some of the committees could provide a report to MRB as well. The Company Secretary noted that extracts of reports from the committees will form part of the Clinical Council minutes which are available to MRB. You do not want to overburden MRB with management clinical information, it is a governance group
- The CMO and MDQIPS have discussed system design/processes and the MDQIPS is happy to take the lead on this work and will meet with the DQIPS on how this will work, workflow management, templates for reporting, terms of reference, agendas and minutes and well as role descriptions and expectations etc
- There is an opportunity to relook at the work plan, when you look at the work plan and see what is reporting through, there may be things that can fall away.

The Chair commented there is still work to be done including confirmation of Clinical Council member representation on the five committees and some of the advisory groups.

8. ALLIED HEALTH PROFESSIONS FORUM

The CAHPO advised that the paper highlights the main issues allied health have been working on including staffing capacity of Allied Health Services, training and support of current staff, developing new staff and new service models. Person and Whanau Centred care is a principle of how allied health work.

The Co-Chair noted that one of the challenges for allied health is the ability to free up study time and funding for that. The CAHPO commented that they are working on developing a training hub as part of the workforce development strategy. Part of this is looking at funding and the ability to back fill for the allied health professions.

9. LABORATORY SPECIMENS LABELLING IMPROVEMENT INITIATIVE

The Co-Chair advised that at the October Board meeting there was a query from a Board Member on where we were up to with this initiative? Around 18 months ago the Finance Audit & Risk Committee (FRAC) wanted to know how we were addressing the number of laboratory errors. This paper is an evaluation on where we have got to and the results to date. A small group meet every two months to look at new learnings and support for staff. A consequences process has been implemented for repeated errors and a new laboratory form developed, which has different steps around identifying patients, getting the correct test, the correct patient and accountability for sign-off.

This was a topical piece of work around harm and unwarranted waste. Harm was repeated tests on an individual because of wrong labelling and unwarranted waste is repeat sampling going to the laboratory, being sent back, trying to get IDs and duplication. There is still error to be concerned about, the main one being wrong test/wrong patient, which put patients at risk.

We can be pleased with the work of the group and the results achieved to date, they are going in the right direction. We have seen some sustainable change.

The CMDO commented this is an example of good progress in a hard to achieve area. Getting the message imbedded with staff that shortcuts have serious consequences. There are synergies with Pharmacy looking at medication errors, wrong patient/wrong drug is still a major risk and Radiology when patients are sent for incorrect radiology investigations. This is part of a whole package we are trying to work on. This is the first time we have seen significant change in the trends.

SECTION 3: REPORTING COMMITTEES / MONITORING

10. HB CLINICAL RESEARCH COMMITTEE

The CMDO advised that the last meeting was postponed due to the RMO Strike. A research forum was held on 2 August focused on research in primary care with Di Vicary and Helen Francis speaking to the groups. There are no new issues or risks to report. At the next meeting they will be looking at their terms of reference and membership.

11. LABORATORY SERVICE COMMITTEE

Dr Kiri Bird provided a quarterly update on the last quarter from the Committee. There have been a few resignations (midwife, acting laboratory manager and administrator) for the committee. The terms of reference for the committee state that the Clinical Council appoints the midwife. There was an Accreditation visit about 3 weeks ago, she asked for a summary. There were no issues anticipated, but she has not received an update.

The CAHPO apologised for this oversight and advised that at the last audit we received 19 corrective actions and 81 recommendations. We have successfully dealt with all of the recommendations and corrective actions and there were no new corrective actions from the latest visit. Work still in progress is the building of the new histology laboratory which has now received approval from the Board and the provision of clinical pathology expertise to the Laboratory. Ross Boswell has been appointed as the Clinical Director to provide strategic leadership in the Laboratory, but we still need clinical input in microbiology. There are plans for a further review for microbiology.

The terms of reference (TOR) and membership need to be revised. The Company Secretary advised that any changes to the TOR or membership need to come back to Clinical Council for approval.

SECTION 4: RECOMMENDATION TO EXCLUDE THE PUBLIC

12. RECOMMENDATION TO EXCLUDE THE PUBLIC

The Chair moved that the public be excluded from the following parts of the meeting:

13. Minutes of Previous Meeting (Public Excluded)
14. Matters Arising – Review of Actions (Public Excluded)
15. Letter received from CAG on Governance Matters

SECTION 5: JOINT MEETING DISCUSSIONS / DECISIONS

The Consumer Council members joined the meeting at 2.10 pm. The Chair welcomed them to the meeting and round table introductions were made.

Consumer Council members in attendance were: Heather Robertson, Nicki Lishman, Terry Kingston, Rosemary Marriott, Jim Morunga, Tessa Robin**,** James Henry, Sarah Hansen, Sami McIntosh and Tessa Robin (2.25 pm). Apologies were received from Graeme Norton, Leona Karauria, Jenny Peters, Malcolm Dixon and Olive Tanielu. Jeanette Rendle attended in her support capacity as Consumer Engagement Manager.

16. 13-17 YEAR OLD PRIMARY CARE ZERO RATED SUBSIDY

The Chair welcomed Patrick Le Geyte, Programme Manager, Maori Health to the meeting.

Patrick advised that this proposition came out of the Health Sector Leadership Forum. The District Health Board (DHB) worked up a number of options and presented to the Clinical Council in November/December 2014. The Clinical Council advised that a universal approach to all of the population was not affordable and to focus on Wairoa and other depravation 8, 9 and 10 areas. Universal approaches to heath care are easier to implement than targeted with the difficulties around the funding mechanisms and allocation in primary health care which are funded through practices based in localities.

The proposition is about a zero fees approach with an equity focus on Maori and Pacific populations. During the consultation period with GP practices, the PHO and groups of young people in deprived areas the feedback was similar. GPs acknowledged that cost was a factor but that the model of care was not always responsive to young people, and youth advised the same. The proposition removes cost as a barrier but is also asking primary care practices to change their model of care to be more “youth friendly”.

Primary Care advised they preferred Option 1. The cost to implement the proposition is just over $60,000 more than what the Clinical Council allocated, however not all practices would participate, therefore it was likely to come in under budget.

Following discussion the Clinical and Consumer Council members endorsed the content of the report and supported recommendation Option 1.

17. SYSTEM LEVEL MEASURES (DRAFT)

The Chair welcomed Carina Burgess, Acting Head of Planning and Wayne Woolrich, Business Services Manager, Health Hawke’s Bay to the meeting.

Carina Burgess gave an overview of what system level measures were and advised that there are four that the DHB and Health Hawke’s Bay working together need to achieve:

1. Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0–4 year olds (i.e. Keeping children out of the hospital)
2. Acute hospital bed days per capita (i.e. Using health resources effectively)
3. Patient experience of care (i.e. Person centred care)
4. Amenable Mortality rates (i.e. Prevention and early detection)

Two joint primary and secondary workshops were held to brainstorm ideas and subsequent meetings were held to refine the plan. The plan was submitted to the Ministry of Health for review and some changes were required including the ASH 0-4 target which needed to be confirmed, readmission rates will be included, the amenable mortality rates will include ethnicity data and a change is required to the patient experience of care measure where we had the definition wrong. Some of the language in the report was also changed to be consistent with the rest of the country.

Wayne Woolrich commented that we have a great opportunity to develop a framework for Hawke's Bay which is more valuable and meaningful for our population. We have come from the IPIF (integrated performance and incentive) framework which is five national set targets monitoring general practice and incentive payments based on performance. The Ministry have launched the system level framework with not a lot of time for us to get ready for it and the challenge has been getting the right people around the table on what this means for Hawke's Bay. Year one is around educating primary and secondary on what system level measures are. The Ministry have provided a framework and they want to see primary and secondary working together developing the plan for Hawke's Bay. The PHO are proposing in their payment structure to general practice in year 1 that they monitor attendance and incentivise general practice to get around the table.

Questions / Feedback:

- Was changing immunisation rates for dental discussed? It was brought up and is under discussion to include an oral health measure next year
- Access to GP visits within 24 hours, Hawke's Bay appears to have the worst performance in the county. Should we consider a measure about access to a GP appointment within 24 hours? Like this idea, data may be better already and hopefully will improve with the urgent care alliance
- When this initiative first came out we thought it could be used as a tool to drive improvement, but the response from the Ministry has been underwhelming
- There a lot of different funding streams which don't add up to a lot, if you put them together they do
- We want general practice to approve sharing data across primary and secondary
- Building and mapping good networks will give us a better outcome, it is a culture change
- Trying to incentivise people to do the right things
- Too much talk about money and not enough talk on what is good for the patient. For too long GPs have been receiving funding for what is the success rate, for Maori it is not good. We have already been paying them for to not succeed. We should not be talking about incentives for them to continue not to succeed. Agree with getting primary sitting around the table and talking with everybody who is involved in the care of whanau, not just secondary. The interest is about the health and wellbeing of whanau and not money. Secondary has been doing some positive work moving forward putting the patient/whanau first, would like to see the same from GPs
- As an example, feedback from the community is that GPs won't do the smoking target without an incentive. GPs as a rule do not see the current target as being the right target, should the right target be developed GPs will fully support it. The new system level measure of Smokefree households for children at 6 weeks will be strongly supported as it makes sense and can be easily measured
- The smoking target was badly designed. If you get a target that makes a difference it will be easier to get GPs engaged

- With smoking you need to reduce the uptake, that is where the money needs to go. The uptake rates for Maori between the ages of 24-50 was 1% different in the 2006 census (50%) to the 2013 census (51%)

Wayne Woolwich commented that the system level measures framework it is a great opportunity to get primary and secondary around the table to focus on how we improve health outcomes for our population of Hawke's Bay. That is the intent of the framework.

Following discussion the Clinical and Consumer Council members endorsed the content of the report and supported the recommendations.

18. ALCOHOL HARM REDUCTION POSITION STATEMENT

The Chair welcomed Dr Rachel Eyre, Medical Officer of Health to the meeting. Dr Eyre advised that since she last spoke with the Clinical and Consumer Councils in July, a draft position statement had been prepared. They are now seeking endorsement from the councils for the statement to be adopted by the Board.

It was noted that there has been unanimous support for a position statement on reducing alcohol related harm. There was the desire that it be "punchy and positive", the vision was whanau and community oriented and was an opportunity for engagement and further collaboration. Working in partnership with the community, iwi lead strategies, consistent messaging and integrating with other work like fetal alcohol, youth strategy, family violence and with councils around the alcohol strategy. It was acknowledged that this is a societal issue and there would be no quick fixes. This is an opportunity for the DHB to take the lead and be part of the solution to move forward on this issue.

Following discussion it was felt that the first sentence was a mixed message and suggested a minor change, remove the first part of the sentence and start with "Hawke's Bay District Health Board recognises that…"

The Clinical and Consumer Councils fully endorsed the position statement and the recommendation for the Board to adopt the position statement.

19. TRANSFORM AND SUSTAIN PROGRAMME REFRESH

The Chair welcomed Kate Rawstron, Project Management Office Manager to the meeting. The content of the report was noted.

Kate Rawstron advised that this paper articulates the outputs of the projects from the transform and sustain refresh process. They have been brought together in a series of workstreams. We want to work collectively and in an integrated fashion. Feedback received was that we needed to get leadership and partnership coming through a lot stronger than what we had previously. While the document shows as a workstream structure, which suggests silos, we know that there is a lot more fluidity across workstreams, particularly around person and whanau centred care and investing in staff, these two will be very much integrated.

Endorsement is now being sought from the Clinical and Consumer Councils on the 19 projects proposed in the paper.

Questions/Feedback:

- Query regarding "School Ready" (page 6) does this include before school checks? This project is building on the work already being done and integration across services and whole of public sector delivery

- Pleased that clinical leaders have been involved, without this things will not change. It is also about how we support consumers to change
- There is an IS project on the shared health record in maternity that is not on the plan, it is across section and includes GPs and LMCs
- In the diagram (page 3), need to identify the patient experience survey as "local" so it is not confused with the national patient experience survey
- Under person and whanau centred care we are not demonstrating all the ways we engage with our consumers, we need to look at the other areas and mediums used to communicate with our consumers, joining up the dots
- There is a considerable amount of work going on outside of this framework, the greater use of social media to communicate etc. There are a lot of things happening that may not be a specific project
- Good to see clinical leadership, we are starting to lose those people who could transform and sustain
- There is a lot of organisational fatigue out there and competing priorities, what can we do to get people re-engaged? Suggestion of a quarterly meeting of all project leads
- Sometimes it can be difficult to get away to attend the transform and sustain seminars
- Recognising the time it takes to successfully lead these projects is important. People don't have time and have to shuffle commitments and project work can get de-prioritised. Being mindful of the commitment it takes to be a project lead. Staff may need to be released from other duties
- Suggestion to use Livestream for those who do not work or live in Hastings or webinar so that staff can access at any time. Then you are sharing information at a time they are able to access it.

The Clinical and Consumer Councils noted the content of the report and endorsed the new projects being proposed.

20. URGENT CARE ALLIANCE PROJECT END REPORT

The Chair advised that the paper noted the current status of the project work. The GP after hours Request for Proposal (RFP) work is currently in abeyance at the request of the parties that put in the RFPs and they are working together to come up with a proposal to co-locate a GP after hours service in Hastings close to the Emergency Department.

The remaining two workstreams, the advanced practitioner workforce and aged residential care have options identified in the paper for approval.

The Co-Chair advised that until the model of care is finalised the advanced practitioner workforce is in abeyance. We are moving towards advanced clinical nurse specialists and nurse practitioner development in primary and emergency care. This was part of the original business case around changes to ED A lot of work has also been done around mobilising allied health services. We are reliant on what the model is and how can we participate going forward.

It is noted that allied health needs to be involved in both these projects, there is a lot of synergy between nursing and allied health.

Aged residential care is work to be progressed. We are not at that point yet. The GP after hours needs to be sorted first. The timeframe for the GP after hours to be in place is April 2017.

SECTION 6: FOR INFORMATION – NO DISCUSSION

21. TRAVEL PLAN UPDATE

The report provided an update on the Go Well Travel Plan since August 2016. No issues discussed.

22. ORTHOPAEDIC REVIEW – CLOSURE OF PHASE 1

The report provided an overview of the work that has been carried out to re-design musculoskeletal and orthopaedic Services and the closure of phase one. No issues discussed.

23. REGIONAL TOBACCO STRATEGY FOR HB (2015-2020)

The report provided an annual update of the regional tobacco strategy for Hawke's Bay with focus on progress towards the three objectives through monitoring of the six key indicators. No issues discussed.

24. TE ARA WHAKAWAIORA / SMOKING (NATIONAL INDICATOR)

The report was provided for information only. No issues discussed.

25. ANNUAL MAORI PLAN Q1 JUL-SEP 2016

The report was a late withdrawal from the agenda and will be provided at a later date.

SECTION 6: WORKSHOP – PALLIATIVE CARE AND ADVANCED CARE PLANNING

Chris McKenna (Co-Chair) facilitated the workshop. A welcome was extended to the additional attendees from Cranford Hospice, Health Hawke's Bay and other DHB staff.

Feedback from those present was captured, however with further consultation planned with stakeholders. A final report will go to the Board in early 2017 for consideration.

The combined meeting closed at 5.30 pm

Confirmed: _____
Chair

Date: _____

HAWKE'S BAY CLINICAL COUNCIL
Matters Arising – Review of Actions
(PUBLIC)

Action No	Date issue raised	Action to be Taken	By Whom	By When	Status
1	12/10/16	RMO Strike Update	Dr J Gommans	Dec	No strike action taken in November
2	12/10/16	Clinical Council Annual Workplan 2016/17. • Review of the plan to take place between meetings (Mark Peterson, Chris McKenna, Andy Phillips and Russell Wills). • Required Governance structures finalised and clinical services plan underway.			
3	9/11/16	Resignation of Clinical Council member - letter of thanks to be sent to Robyn O'Dwyer. • Replacement Senior Nurse representative on Council.	Co-Chairs Co-Chairs	Nov	Actioned.
4	9/11/16	Clinical Governance and Committee Structures • Progress and Council representation on five committees and some advisory groups TBC • Timeline for the document in final form TBC			
5	9/11/16	Laboratory Services Committee Review of TOR to come through Council for sign off.			
6	9/11/16	Following on from the WORKSHOP on Palliative Care and Advanced Care Planning – where to from here?			

5

HB CLINICAL COUNCIL WORKPLAN 2016-2017

Meeting Dates	Papers and Topics	Lead(s)
8 Feb 17	Orthopaedic Review phase 2 Draft (from Sept) Fracture Clinic – Orthopaedic Dept near ED (investigation) ICU Learnings – Action Plan update (quarterly) Quality Dashboard Concept Paper MRI Target Achievement (board request Sept 2016) HB Integerated Palliative Care (Final) ***Monitoring*** Te Ara Whakawaiora / Access Annual Maori Plan Q2 Oct-Dec 2016 CAG	Andy Phillips Sharon Mason Kate Coley Kate Coley / Russell Sharon / Mark Mary Wills Mark Peterson Tracee TeHuia
8 Mar 17	Travel Plan Update ***Monitoring*** Maternity Clinical Governance Group Update (6 monthly) Falls Minimisation Committee Te Ara Whakawaiora / Breastfeeding (national indicator) Laboratory Services Committee Radiology Servcies Committee Health & Social Care Networks (6 monthly) CAG	Sharon / Andrea Beattie TBC (previously Caroline) TBC TBC Kiri Bird Mark Peterson Tracee / Belinda Sleight
12 Apr 17	Draft Health Equity Update Draft Youth Health Strategy Draft Suicide Prevention Postevetion Update against 2016 plan ***Monitoring (work in progress – incomplete)*** Collaborative Clinical Pathways HB Nursing Midwifery Leadership Council Update & Dashboard 6mthly Te Ara Whakawaiora / Cardiology (national indicator) CAG	TBC (previously Caroline) TBC TBC Mark / Leigh White Chris McKenna John Gommans
10 May 17	ICU Learnings Report – Action Plan update (qtly) Best Start Healthy Eatng Plan *yearly review" ***Monitoring (work in progress – incomplete)*** HB Clinical Reasearch Committee Update (6 monthly) Infection Control Committee (6 monthly) CAG	Kate Coley TBC (previously Caroline) John Gommans Chris McKenna

Meeting Dates	Papers and Topics	Lead(s)
14 Jun 17	Orthopaedic Review – closure of phase 2 Orthopaedic Review – closure of phase 3 Quality Improvement Programme (6 monthly) Draft Health Equity Update Final Youth Health Strategy Final Suicide Prevention Postvention Update against 2016 Plan ***Monitoring (work in progress – incomplete)*** Te Ara Whakawaiora / Oral Health (national indicator) CAG	Andy Phillips Andy Phillips Kate Coley Caroline McElnay Caroline McElnay Caroline McElnay Robin Whyman

HAWKE'S BAY District Health Board Whakawāteatia	**Hawke's Bay District Health Board Long Term Conditions Framework**
	For the attention of: **Maori Relationship Board, Clinical and Consumer Council**
Document Owner: Document Author(s):	Tim Evans and Mark Peterson Jill Garrett, Strategic Services Manager and Leigh White
Primary Care Sponsor(s)	Mark Peterson Chief Medical Officer Primary Chris McKenna – Chief Nursing Officer Primary and Secondary
Date:	December 2016

Purpose:

1. Acknowledge and endorse content of draft Framework

2. Provide feedback regarding;
- implementation stages and their timing
- trial with diabetes and respiratory services to inform final document
- identification of members for a LTC Advisory Group (inclusive of primary care – secondary services – allied health - Māori health providers and consumers)

1. BACKGROUND

Long term conditions have become the most significant cause of death and disease. Hawke's Bay is above the national prevalence[1] in 6 out of 11 chronic disease risk factors for adults aged 15 years and over. The financial burden of this equates to 15% of the total health spend.

Currently 81% of funds associated with Long Term Conditions is spent on acute management and rehabilitation services, and only 19% on early intervention and prevention.

The framework is aimed at shifting the focus towards early intervention and prevention within the next 5 years. Within that time frame it is anticipated that shifting the spend ratio to a 60% acute management-rehabilitation and 40% early intervention and prevention could be achieved. This would equate to approximately a 4% change in budget allocation per annum over a 5 year period.

To date Hawke's Bay DHB has not had a strategic document that provides a framework against which the planning and reporting for Long Term Conditions can be aligned and monitored. In 2015 it was identified as a priority by both primary and secondary care services. In April 2016 the Strategic Services Manager – Primary Care and the Portfolio Manager Long Term Conditions commenced the development of the framework in consultation with consumer, primary, secondary and allied health teams.

[1] [1] NZ Burden of disease study 2013. Chronic Disease: Current Situation Analysis (Prevalence, Morbidity and Mortality)-Lisa Jones Business Intelligence HBDHB.

The HBDHB Long Term Conditions Framework is generic in its approach. It is not disease specific. Nationally and internationally effective Long Term Conditions approaches focus holistically on the person and/or whānau, listening to 'what matters to you" rather than asking "what's the matter with you".

Many of our whānau have more than one long term condition which has an impact on, or can be a result of, mental health and un-wellness. Threaded throughout the framework is recognition that mental wellness/illness impacts greatly on effective self-management of long term conditions.

2. FRAMEWORK STRUCTURE

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. Each of the Four Aka have four contributing dimensions (see pages ….. of the Framework). Where appropriate the outcome attached to each of the dimensions is linked to both System Level Measures and the outcomes (currently draft) of Transform and Sustain.

The methodology for change on which the framework is based is IHI Improvement Methodology. This is an outcomes based methodology that works through setting up manageable (small) change environments that lead to system wide improvements.

Implementation tool – to achieve system wide improvement –. The Long Term Conditions Service Review Matrix **(LTC**-**SRM**) is a self-review tool, against which services can evaluate their achievement against the Four Aka.

The SRM is structured around a continuum of excellence (see Appendix One of the Framework). With the support of QIPS facilitators et.al, services will;

- be invited to work within a multi-disciplinary approach to addressing Long Term Conditions
- assess where they sit on the LTC-SRM using agreed sources of evidence
- utilise service planning and reporting mechanisms to work towards shifting performance within the continuum towards excellence.

- The **LTC-SRM** serves also as a global assessment tool - for where services across the sector (both primary and secondary) sit in relation to performance against LTC outcomes. *(see page 11 of appendix one).* This will provide a helicopter view of where areas need to be strengthened and
- additional resources and support placed to move performance from entry level to excellence.

3. FRAMEWORK PURPOSE

- Address equity through a focus on consumer (whānau) focused services
- Achieve optimised health outcomes for the population of Hawke's Bay
- Ensure that evaluation does not rest solely with measuring clinical outcomes but includes quality of life, patient activation measures, confidence measures based on researched self-care and self-management methodologies[2]
- Shift from individual service to integrated service models of delivery (MDT and IDT)

[2] Self-Care and Self-Management programs of work currently in practice within Hawke's Bay include the Stanford Model (recognised in over 43 countries), WHO, Brief Quality of Life Tool and at its inception phase Clinical and Patient Activation measures based on Relationship Centred Care.

- Evaluate the spend (total) for long term conditions and how focusing on risk mitigation, prevention and early intervention will have a positive impact on reducing demand on; ED Presentations, ED Admissions and Length of Stay.
- Provide a tool against which services can evaluate their effectiveness[3] against the four Akas of the framework and measure progress towards achieving excellence over time.
- Use an interdisciplinary approach in the design and ongoing evaluation and modification of the services to improve health outcomes
- Challenge the status quo and provide opportunity for innovative practice based on co- design models of care

4. IMPLEMENTATION

Stage 1:

April – Nov 2016 (completed)

- Consultation with a wide range of consumers (groups and individuals), service providers both secondary and primary, Health Hawke's Bay Population Priority Committee, members of the HBDHB Clinical Council and Service Directorates
- Alignment: with NZ Health Strategy, Transform and Sustain, HBDHB Equity Report, MoH Long Term Conditions Dimensions (currently under development)
- Financial analysis of current spend in relation to: the triple aim, live well, get well, stay well strategy in line with generic spend and spend on the top 5[4] Long Term Conditions inclusive of mental health and wellness across the board.
- Iterations x 16 of framework in response to findings
- Development of the Long Term Conditions Service Review Matrix
- First Draft presented to EMT and CAG (8th & 9th November)

Nov- Dec (in progress)

- First Draft presented to committees; Clinical Council, MRB[5], Consumer Council
- Revision of documents in response to committees feedback

Stage 2: Jan – Mar 2017

- Develop easy read version written with a health literacy lens so that consumer may engage with the framework and provide feedback
- Completion of patient x 5 tracer audits by QIPS team member (Val Guay)
- Advisory group formed (MDT)
- Analysis of tracer audits
- Review modification and finalising of Service Review Matrix (SRM)
- Trial of Framework and LTC - SRM with Respiratory and Diabetes Services
- Develop program of workshops for the socialisation of the framework and utilisation of the SRM with service planning and reporting cycles

Stage 3: April 2017

- Finalise Document
- Finalise the easy read version
- Develop a consumer evaluation tool

[3] The evaluation tool – LTC Service Review Matrix has been developed in draft conceptual form – awaiting formation of the LTC Advisory Group to inform its final content.

[4] The Top Five Long Term Conditions are; Cardiovascular Disease, Cancers, Respiratory, Musculoskeletal, and Diabetes.

[5] Māori Relationship Board

Stage 4: May 2017

- Launch document
- Socialise with MoH
- Commence program of implementation developed in Stage 2:

Stage 5: Ongoing

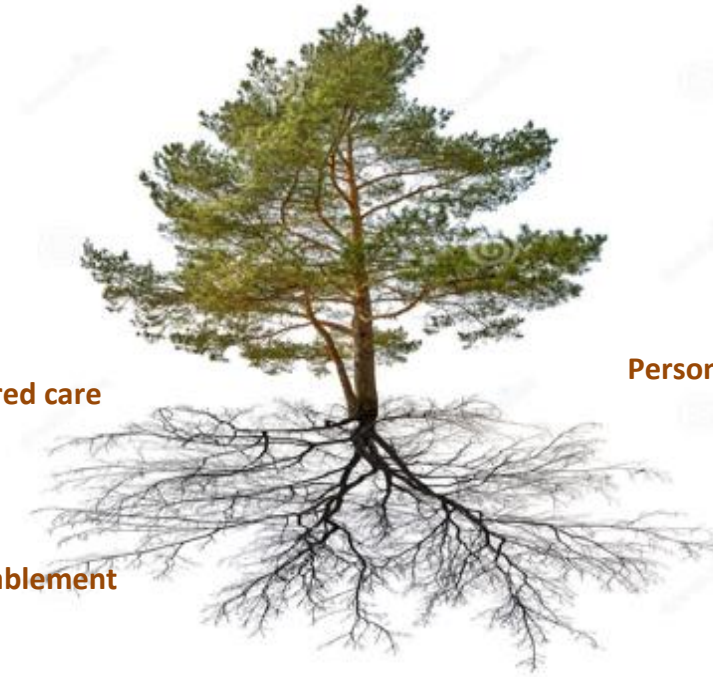
- Monthly to quarterly meetings of Long Term Conditions Advisory Group
  Function:
  - Evaluation of current trends (qualitative and quantitative data analysis – cross sector)
  - Form recommendations to services against findings
  - Monitor progress against findings
  - Provision of leadership and management advice
  - Connect regionally and nationally to inform current and future planned work practices

5. THE FRAMEWORK:

Contents List

Long Term Conditions Framework

Hawke's Bay DHB
Long Term Conditions (LTCs) Framework



Person- family - whānau centred care

Person centred systems and processes

Workforce development and enablement

Risk identification and mitigation

The Kahikatea[1]

[1] The Kahikatea – or white pine is native to New Zealand. Significant for its extensive and intertwining root system indicating interdependencies support.

Content

Executive Summary:

Why do we need a Hawke's Bay Framework - Long Term Conditions have become the most significant cause of death and disease contributing to; to 80% of deaths and 80% of the health budget spend. Hawke's Bay is above the national prevalence level in 6 out of 11 chronic disease risk factors for adults aged 15 years and over2. This has a significant impact on individuals, whanau and the wider community.

The structure of 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. Each of the Four Aka have four contributing dimensions (see pages 8-11 below). Where appropriate the outcome attached to each of the dimensions is linked to both System Level Measures and the outcomes (currently draft) of Transform and Sustain. The methodology for change on which the framework is based is IHI Improvement Methodology. This is an outcomes based methodology that works through setting up manageable (small) change environments that lead to system wide improvements.

System wide improvement – implementation tool. The Long Term Conditions **Service Review Matrix (LTC-SRM - Appendix One)** is a self-review tool, against which services can evaluate their achievement against the four Aka. The SRM is structured around a continuum of excellence
With the support of QIPS facilitators et.al, services will;

- be invited to work within a multi-disciplinary approach to addressing Long Term Conditions
- assess where they sit on the LTC-SRM using agreed sources of evidence
- utilise service planning and reporting mechanisms to work towards shifting performance within the continuum towards excellence.

The LTC-SRM serves also as a global assessment tool - for where services across the sector (both primary and secondary) sit in relation to performance against LTC outcomes. *(See page 11 of Appendix One).* This will provide a helicopter view of where additional resources and support need to be placed within the sectors to move performance from entry level to excellence.

The framework is NOT disease specific – People often experience more than one chronic condition and associated mental health challenges. We need to promote holistic care of the person and their whānau in a stay well – get well – be well model.

Prevention vs intervention – the framework is focused on prevention, early intervention and management as a strategy for reducing the increasing demand on acute hospital based services. Self-care and self-management underpins the framework so that people choose well in relation to addressing their own health needs. Based on business intelligence modelling of population trends coupled with a shift of emphasis to early intervention, it is anticipated that a reduction of up to 4% demand on acute services can be achieved. This will be evidenced through; reduced ED presentations, reduced ED admission rates and reduced length of stay. Over a 5 year period that will equate to resource economies of 20%.

[2] Chronic Disease: Current Situation Analysis-Prevalence, Morbidity and Mortality. Lisa Jones HBDHB Business Intelligence Team.

Vision

Your Health in Your Hands with Our Help and Support

Kei a koe te tikanga [3]

Mission statements[4]

Our people and systems respect and support self-management

Ka whakamiha, ka tautoko hoki ō tātou tāngata, ā tātou pūnaha i te whakahaere whaiaro a te tangata.

people powered – people and whānau centred care[5]

We are a connected collaborative team involved in your care

He tira tūhono, he tira mahi tahi mātou ka tiaki i a koe.

one team – whole public sector delivery

We value quality, effectiveness and innovation

Ka matapopore mātou ki te kounga, te whaihua, te auaha hoki

value and high performance - smart system – information system connectivity

We strive to be responsive and flexible

Ka whakarīrā mātou kia rarata ai, kia urutau ai hoki

closer to home – health and social care networks

[3] Kahungungu Hikoi Whenua

[4] The mission statements connect with the **NZ Health Strategy priorities** and **Transform and Sustain refresh priorities**. Te Reo translation provided by HBDHB translation team.

[5] These statements align with the NZ Health Strategy and the Refresh Transform and Sustain Program

The Four Aka

Person - Family - Whānau Centred Care

- Consumer voice
- Health Literacy
- Self-Care
- Understanding the determinants of health

Person Centred Systems and Processes

- Health and Social Care networks
- Models of care development
- Collaborative clinical pathways
- Integrated IT systems and enablement

Workforce Development and Enablement

- Clinical Leadership
- Clinical expertise
- Workforce capacity and capability
- Inter-sectoral development

Risk Identification and Mitigation

- Population health
- Equity
- Continuous quality improvement
- Governance and advisory support

Section One: Why do we need a strategy?

What do we know?

Context and definition: Long term chronic conditions are defined by the **World Health Organisation** as having one or more of the following characteristics: they are permanent, leave residual disability, are caused by non-reversible pathological alteration, require special training of the person for rehabilitation, or may be expected to require a long period of supervision and care (WHO. 2005. Preventing Chronic Disease) refer: https://www.rnzcgp.org.nz/assets/documents/Training-and-Beyond/Curriculum-Documents-2014/Long-term-Conditions-CS.pdf . Not all LTCs are precipitated by lifestyle factors, some are genetic, such as cystic fibrosis. LTCs can originate at birth or in childhood and persist into adulthood.[6] Minimising the impact of Long Term Conditions on our populations' health requires of us attention to what can be prevented and or minimised through mitigation of risk, minimisation of harm and early and effective intervention and management strategies.

The effects of LTCs for the Individual: Long term conditions impact greatly on quality of life, independence and economic wellbeing. The psychological aspects of dealing with long term conditions can be considerable, varying from dealing with personal response to the disease; coping with treatment; feeling of lack of personal control and handling the responses of others. People with multiple morbidities risk experiencing poor coordination of treatments primarily designed to address single conditions.

For the health and care system: It is predicted by the World Health Organisation that chronic conditions will be the leading cause of disability by 2020 and that if not successfully managed will become the most expensive problem for health care systems.

Chronic disease is a major contributor to the life expectancy gap between Māori and Pasifika and Non Māori and Pasifika peoples[7]

15% of the population of Hawke's Bay have one or more Long Term Condition[8]

An estimated **80%** of health care funds are spent on chronic disease[9]

80% of all deaths in NZ result from chronic conditions.[10]

Getting serious about eliminating health inequity: Māori and Pasifika should not be disproportionately represented within this population group[11]. They should not expect to have much higher levels of chronic disease at a much earlier stage in life [12] than Non Māori. Māori and Pasifika have the right to expect the same life expectancy, morbidity and mortality rates as Non Māori.

[6] Referenced to the developing draft Long Term Conditions Service Specifications – Ministry of Health.

[7] Ajwani S, Blakely T, Robson B, Tobias M, Bonne M. 2003. *Decades of Disparity: Ethnic mortality trends in New Zealand 1980-1999*. Wellington: Ministry of Health and University of Otago.

[8] Chronic Disease: Current Situation Analysis-Prevalence, Morbidity and Mortality. Lisa Jones HBDHB Business Intelligence Team.

[9] New Zealand Guidelines Group. 2001. *Chronic Care Management: Policy and Planning Guide*. Compiled by the Disease Management Working Group

[10] Ministry of Health. 1999. *Our Health Our Future: Hauora Pakari, Koiora Roa*. Wellington: Ministry of Health

[11] This population group refers to those with a long term condition.

[12] Ajwani S, Blakely T, Robson B, Tobias M, Bonne M. Decades of disparity: Ethnic mortality trends in New Zealand 1980-1999. Wellington: *Ministry of Health and University of Otago; 2003.*

My Challenge - Your Challenge - Our Challenge

The health of our population changes dramatically when we approach 35yrs of age.
To make a difference we need to begin at birth, working with our partners across all sectors, all disciplines

Starting now

Our way of working will be sustainable.
Our focus will shift from curative to preventative practices in all aspect of our work and care.

Focusing on Māori and Pasifika

Getting it right for Māori and Pasifika will mean everyone benefits.
Find the gap and take action to reduce it.

Not just one but multiple conditions present challenges for the individual and the health system: Increasing numbers of people present with more than one LTC. The rise in the incidence of long term conditions can be attributed to an increase in lifestyle risk factors (refer snap shot one – page 5) an ageing population with associated increased levels of frailty, and the socioeconomic determinants of health. People with multiple long-term conditions have markedly poorer quality of life, poorer clinical outcomes and longer hospital stays, causing them to be the most costly group of patients.[13]

Mental health and well-being is a challenge faced by all with a long term condition. It is a long term condition that will impact significantly on the health outcomes of our population.

Prevention and early intervention need to be the focus of the Long Term Condition Framework; the majority of long term conditions are preventable or could be better managed. Elimination of modifiable risk factors would prevent 80 percent of premature heart disease, 80 percent of premature stroke, 80 percent of type 2 diabetes and 40 percent of cancer.[14]

Prevention should be the focus of all aspects of Long Term Condition Management; prevention of expectation of occurrence, prevention of occurrence, prevention of exacerbation of risk factors, prevention of deterioration in health and wellbeing, prevention of increasing levels of acuity.

Prevention is about the individual and the health system working in partnership to fund and provide appropriate access to resources, activities and expectations that promote self-care – self management from a cradle to the grave. It is supporting a system that "empowers the patient to take a lead role in managing their health and ensuring access to the range of services and resources required to achieve optimal outcomes (WHO, 2002)

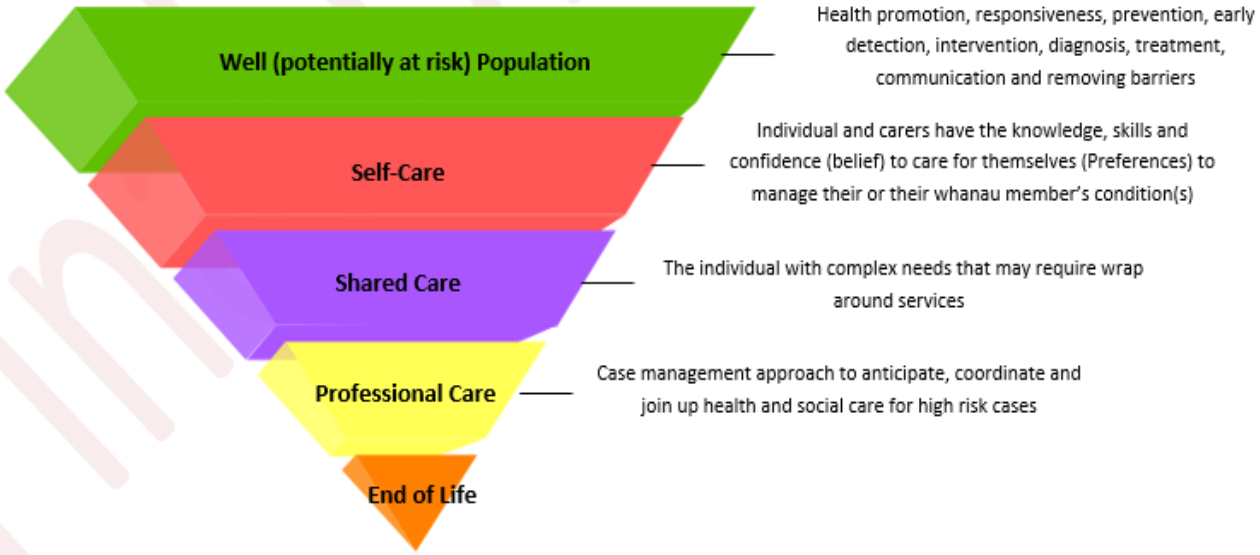
[13] Goodwin, N., Curry, N., Naylor, C., Ross, S., Dulig, W., Managing People with Long Term Conditions (2010), *The King's Fund*.
[14] World Health Organization, 2009. Interventions on Diet and Physical Activity: What Works: Summary Report

A non-disease person centred framework - The need to reduce health inequalities is a priority. Considerable health inequalities occur between population groups due to many factors including; historical, cultural, socio-economic status, geographical place of residence, ethnic identity, and gender. Long term chronic conditions account for a higher proportion of illness and deaths among Māori, people on low incomes and Pacific peoples than among the general population. New Zealand studies have identified organisational, human resource, and person-community issues in access to health care as barriers for care[15].

Less focus on disease (medical diagnosis) and greater focus on the person as a whole: Current service provision, is still weighted towards disease diagnostics but there needs to be a shift from reactive to managed care within a social, cultural and economic context. There needs to be a greater emphases on prevention, early intervention, self-management and improved cross sector integration (inclusive of social services, education, housing and justice) and relationships. The emphasis needs to be on the person and their families/whānau being partners in their care.

Model of care delivery is now gearing up to meet the needs of the population by stratifying it by risk rather than by disease. This predicates the requirements for care and will determine the design of workforce capacity and capability.

Figure 1.1 – Population Care Stratification



[15] *Discussion paper, Improving Responsiveness to Māori with Chronic Conditions May 2010*

Section Three: The Four Aka

Key: SLM – System Level measures | c-SLM – Contributing Measure

	Components of each aka	Objectives	Process measures	Outcome (Draft) Transform and Sustain
Person - Family - Whānau centred Care	**Consumer voice**	Consumers are integral to the design and evaluation of services	**Consumer input is demonstrated in service level planning and reporting** • Consumer feedback mechanisms in place *(number + variety)* • Complaints trends analysis *(utilising the WHO[16] taxonomy of categories)* • Service level plans demonstrate response to consumer voice	**Power balance shifted more in favour of consumers**
	Health Literacy	Health literacy improvements enhance access and navigation to health services by the consumer	**Health information is consumer / user focused** • Utilisation of consumer experience surveys (c-SLM) • GP practices offering an e-portal • Consumers engaged in self-management/rehabilitation programs • DNA rates-Outpatients / GP LTC consults	**Consumers access understandable information & enabled to take action**
	Self-Care	Consumers are supported to self-manage to their highest level of confidence	**Proactive Utilisation of Health services** • *+7 ED presentations (acute)* • Referral rates to accredited self-management programs • **Reduction in ASH rates** (SLM) • **Reduction in readmission rates** (SLM)	**Consumers equal partners in their health care and engaged in their own treatment** *(management)*
	Understanding the determinants of health	Health professionals implement clinical and cultural competence[17] health strategies based on an understanding of the determinants of health	**Completion rates of Mandatory training** • Treaty of Waitangi Responsiveness • Cultural competency • ACE assessment • Health Literacy modules (Primary) • Relationship Centred care training • Utilisation of Patient and clinical activation measures[18]	**Services are aligned to community need**

[16] http://www.who.int/patientsafety/taxonomy/icps_full_report.pdf

[17] Cultural competence is a set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations. Refer: Cross T, Bazron B, Dennis K, Isaacs M. Towards a Culturally Competent System of Care, Volume I. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center, 1989. Ewen S. Cultural Literacy: An Educational Approach for Health Professionals to Help Address Disparities in Health Care Outcomes. Journal of Australian Indigenous Issues 2010; 13(3); 84-94.

[18] Reference Andy's documents / Relationship Centred Care.

	Components of each Aka	Objectives	Process measures	Outcome (Draft) Transform and Sustain
Person centred clinical systems and processes	**Health and Social Care networks**	Collaborative networks developed providing services closer to home utilising a MDT[19] and inter-professional approach.	**Consumer/community focused outcomes aligned to all contracts** • Establishment of Service Level Alliance Agreements • Establishment of Health Network Leadership Teams • Health Sector aligned to Results Based Accountability • Outcomes based evaluation framework attached to all contracts • Multi agency performance reporting	**Joint leadership between DHB, providers, community and (government) agencies**
	Models of care development	Building health services around the person using a whānau ora model of care and whole of workforce approach.	**Inter disciplinary whole of sector model of care** • HBDHB Workforce framework completed • Individual workforce strategies align to population health needs[20] • Interdisciplinary teams involved in patient care planning • Transfer of care process results in reduced (re) admission rates (c-SLM) • **Reduction in Amenable Mortality** (SLM)	**Consumers access quality care which enables them to manage their own health needs**
	Collaborative Pathways	Providing consistency and equity in the delivery of care for our consumers based on best practice	**Ongoing development, implementation and review of collaborative pathways** • Timely access to services (diagnostics, FSAs, ...) (c-SLM) • Clinical utilization rate of pathways/referrals • Referral decline rates • (timely) Transfer of care • Reduced Bed days (save 4000 beds) (c-SLM) • Disease detection and follow up rates (c-SLM)	**Consistent timely provision of services results in enhanced health outcomes and efficient use of resources**
	Integrated IT systems and enablement	Information Systems, and IT are easy to use, accessible and utilised at all levels for the purpose of system wide improvement.	**IT supports efficiencies** • Utilisation rates of IT patient /population information systems e.g. Dr Info – Karo Reports – Disease registers – population stratification – Service Utilisation statistic • Utilisation of shared patient care records • Utilisation of e-referrals (internal to DHB- Primary care) •	**Appropriate and easy access to information for patients clinicians and management**

[19] MDT: Multi-Disciplinary Approach (Health, social and community based services)

[20] Population health profiling is used to proactively stratify the population to enable effective preventative and early intervention management.

	Components of each Aka	Objectives	Process measures	Outcome (Draft) Transform and Sustain
Workforce Development and Enablement	**Workforce capacity and capability**	The capacity and capability of the work force aligns with the population health needs and demand.	**Workforce able to respond to health service needs** • Population stratification data utilised for service design • Service workforce mapped – capacity and capability current and future state • Recruitment and retention rates • Professional development alignment to service needs	**Workforce able to respond to the needs of the Hawke's Bay Population**
	Clinical leadership	Identified clinical leaders provide direction, support and accountability for the uptake and dissemination of best practice models to optimise patient care.	**Services are supported with expert and innovative clinical leaders** • Membership of clinical bodies / leadership forum • Participation in LTC regional-national - international congress • Delivery at LTC fora • Publication and research	**Recognition nationally as Leaders in Long Term Conditions prevention and early intervention methodology (Māori)**
	Clinical expertise	Clinical staff, medical and nursing and allied health, provide services to the top of their scope supported by best practice guidelines under the direction of identified clinical leaders.	**Clinical best practice and expertise is supported** • Service workforce strategy in place • Alignment of workforce strategy with IDT approach • Clinical lead pathway identified and utilised for staff development / incentives • Consistent management and skills sets supported by new training.	**Clinical expertise is recognised within the organisation**
	Inter-sectoral development	Patient care is maximised through the utilisation of an Interdisciplinary Team (IDT) approach to individualised care inclusive of the lay workforce.	**Coordinated partnership approach to patient care** • Care teams utilising a shared record • Customer focused performance reporting • Aligned models of care and funding models • Care teams extend outside the health sector (patient determined)	**Coordinated partner approach to deliver of services with consumer (across agencies)**

	Components of each Aka	Objectives	Process measures	Outcome Transform and Sustain
Risk identification and mitigation	**Population health**	Validated risk profiling is used to support and understand the needs of the population and manage those at risk.	**The system is responsive to the population** **To be completed by Population Health Teams including…** • Determinants of health • Population risk stratification • Service utilisation • Co design models in place	**Elimination of the Health Equity Gap**
	Equity	The gap in consumer health outcomes is addressed actively through targeted approaches to the delivery of care.	**The system is responsive to the population** **To be completed by Māori / Pasifika Health Teams including…** • IDT planning and reporting demonstrate tailored responses to Māori health needs • ….. • …..	
	Continuous quality improvement	Innovative practice is supported. Recognised improvement methodologies are used to achieve evidence based enhanced patient outcomes.	**Change is supported by agreed methodology for improvement** **To be completed by QIPS Teams including…** • IDTs collectively using agreed methodologies for planning and monitoring improvement • Celebration of innovative best practice that is evidence based • Uptake of research and development initiatives • Quality Improvement initiatives cross service boundaries	**Quality improvement cycles imbedded within and across all teams of practice**
	Governance / advisory support	The support of an advisory group is used to evaluate services and advise on service design and improvement	**Change is supported by an Interdisciplinary Advisory** **To be completed by yet to be formed Advisory Team** • ….. • ….. • …..	

Section Four: The Methodologies that Informed the Framework

The Hawke's Bay District Health Board – Long Term Conditions Framework aims to operate from a strengths based approach. This involves looking at and for opportunities to change and improve through utilising existing expertise, systems and relationships. Highlighting high functioning, customer focused coordinated responsive care. What the framework aims to do through the **Service Review Matrix** (Appendix 4) is identify areas of excellence for the purpose of disseminating best practice within our local context, and utilise the following methodologies to effectuate change.

Appreciative Inquiry (AI) – creating a positive atmosphere for change.

Appreciative inquiry is a change management approach that focuses on identifying what is working well, analysing why it is working well and then doing more of it. The basic tenet of AI is that an organization will grow in whichever direction that people in the organization focus their attention

Appreciative Inquiry is about the co-evolutionary search for the best in people, their organizations, and the relevant world around them. AI involves the art and practice of asking questions that strengthen a system's capacity to apprehend, anticipate, and heighten positive potential. AI paves the way to the speed of imagination and innovation; instead of negation, criticism, and spiralling diagnosis, there is discovery, dream, and design. AI seeks, fundamentally, to build a constructive union between past and present capacities: achievements, assets, unexplored potentials, innovations, strengths, elevated thoughts, opportunities, benchmarks, high point moments, lived values, traditions, strategic competencies, stories, expressions of wisdom, insights into the deeper corporate spirit or soul-- and visions of valued and possible futures. Taking all of these together, AI seeks to work from accounts of a "positive" change core.

Results Based Accountability: Not just measuring results – partnering up with those who contribute to a collective (agreed) outcome

Results-Based Accountability™ (RBA), also known as Outcomes-Based Accountability™ (OBA), used by organisations to improve the performance of their programs or services. It recognises that 'trying hard' outputs driven models, do not always result in anyone being 'better off'. RBA uses a data-driven, decision-making process to help (communities and) organisations get beyond talking about problems to taking action to solve problems. The strength of the framework is identifying partnerships and working together for the achievement of a common goal.

IHI Improvement methodology: Testing ideas-theories in controlled environments vs whole of system change

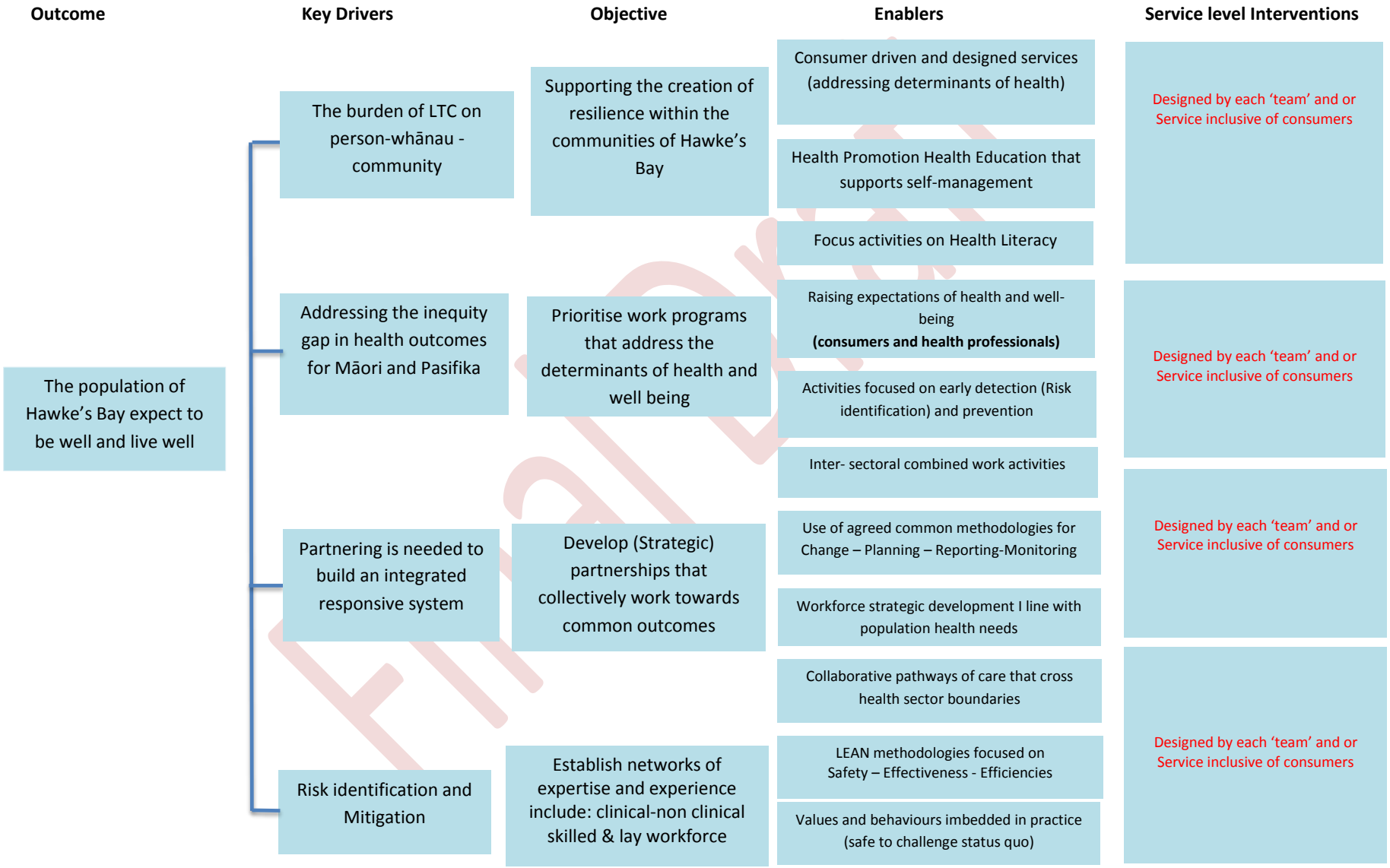
The Model for Improvement, developed by Associates in Process Improvement [21] , is a simple, yet powerful tool for accelerating improvement. This model is not meant to replace change models that organizations may already be using, but rather to accelerate improvement. The model has two parts; three fundamental questions which can be addressed in any order (refer Service Review Matrix[22]); What are we trying to accomplish, How do will we know a change is an improvement and What change can we make that will result in improvement? The strength of this cycle is it identifies specific aims, establishes quantitative measures associated with an agreed outcome (improvement) using those who use and work in the system. It does not call for whole of system change- but tests environments and builds on successes that have been achieved.

[21] http://www.apiweb.org/ (W. Edwards Demming)

[22] Long Term Conditions - Service Review Matrix (LTC-SRM) includes summary of the IHI methodology Plan Do Study Act model and questions. (Appendix Two of the SRM)

Driver Diagram (IHI Improvement Methodology)

(For - consultation)



Bibliography:

References - Local Documents:

HBDHB Transform and Sustain (Refresh), Māori Health Plan, Equity Report 2016, Healthy Eating Strategy, Draft Youth Strategy, Primary Care Strategic and Annual Plans

References - Key NZ Documents

- The 2016 NZ Health Strategy- Future direction and its Roadmap of Actions,[23] in particular Action 8 Tackle long term conditions and obesity
- Te Korowai Oranga[24]
- Equity of Health care for Māori: a Framework
- Primary Health Care Strategy
- New Zealand Disability Strategy: make a world of difference[25] (to be revised 2016)[26]
- Disability Support Services, Strategic Plan 2014-2018[27]
- Health of Older People Strategy 2002[28] (update in progress due 2016)
- Positive Aging Strategy[29]
- 'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018
- The Crown Funding Agreement and its schedules, the Operational Policy Framework and the Service Coverage Schedule and the Nationwide Service Specifications.[30]

[23] http://www.health.govt.nz/system/files/documents/publications/new-zealand-health-strategy-future-direction-apr16.pdf

[24] http://www.health.govt.nz/our-work/populations/Māori-health/he-korowai-oranga this link provides a description of its various elements – including its aim: Pae Ora– Healthy futures for Māori. Pae Ora (Healthy Futures) is the Government's vision and aim for the refreshed strategy. It builds on the initial foundation of Whānau Ora (Healthy Families) to include Mauri Ora (Healthy Individuals) and Wai Ora (Healthy Environments).

[25] http://www.health.govt.nz/publication/new-zealand-disability-strategy-making-world-difference

[26] Revising the New Zealand Disability Strategy http://www.odi.govt.nz/nzds/

[27] The Disability Support Services' (DSS) Strategic Plan, reflects commitment to the United Nations Convention on the Rights of Persons with Disabilities 2008, which aims to 'promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity'. http://www.health.govt.nz/publication/disability-support-services-strategic-plan-2014-2018

[28] The Health of Older People Strategy sets out a framework for improving health and support services for older people. http://www.health.govt.nz/publication/health-older-people-strategy

[29] The Office for Senior Citizens https://www.msd.govt.nz/what-we-can-do/seniorcitizens/positive-ageing/strategy/

[30] http://nsfl.health.govt.nz/

Specific Links

Obesity

http://www.health.govt.nz/our-work/diseases-and-conditions/obesity/childhood-obesity-plan
http://www.health.govt.nz/our-work/diseases-and-conditions/obesity/obesity-related-publications
http://www.health.govt.nz/our-work/diseases-and-conditions/obesity/weight-management-hiirc
http://www.health.govt.nz/our-work/diseases-and-conditions/obesity
http://www.health.govt.nz/our-work/eating-and-activity-guidelines
http://www.health.govt.nz/our-work/eating-and-activity-guidelines/current-food-and-nutrition-guidelines
http://www.health.govt.nz/publication/guidance-healthy-weight-gain-pregnancy

Smoking

http://www.health.govt.nz/our-work/preventative-health-wellness/tobacco-control/smokefree-2025

Health Literacy

Health Literacy Review: a guide http://www.health.govt.nz/publication/health-literacy-review-guide 2015

Evidence based research

http://www.health.govt.nz/publication/health-loss-new-zealand-1990-2013
http://www.health.govt.nz/our-work/life-stages/child-health/child-health-publications
http://www.health.govt.nz/publication/food-and-nutrition-guidelines-healthy-children-and-young-people-aged-2-18-years-background-paper
http://www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/new-zealand-burden-diseases-injuries-and-risk-factors-study-2006-2016

Disease specific groups – best practice guidance

Cancers

http://www.health.govt.nz/publication/new-zealand-cancer-plan-better-faster-cancer-care-2015-2018 http://www.health.govt.nz/our-work/diseases-and-conditions/cancer-programme
http://www.health.govt.nz/our-work/diseases-and-conditions/cancer-programme/faster-cancer-treatment-programme/national-tumour-standards

Cardiovascular

http://www.health.govt.nz/our-work/diseases-and-conditions/cardiovascular-disease
http://www.health.govt.nz/publication/new-zealand-primary-care-handbook-2012

Chronic Kidney Disease

http://www.health.govt.nz/your-health/conditions-and-treatments/diseases-and-illnesses/kidney-disease
http://www.health.govt.nz/publication/managing-chronic-kidney-disease-primary-care

Chronic pain

http://www.ncbi.nlm.nih.gov/pubmed/21946879
Blythe, F. Dominick, C Nicholas, M. NZ Medical Journal (NZMJ) 24 June 2011, Vol 124 No 1337; ISSN 1175 8716

Chronic Respiratory Disease

http://asthmafoundation.org.nz/news-and-events/publications/
https://www.thoracic.org.au/
http://asthmafoundation.org.nz/wp-content/uploads/2012/03/COPDguidelines.pdf

Dementia

http://www.health.govt.nz/publication/new-zealand-framework-dementia-care

Diabetes

Living Well with Diabetes is the Ministry's plan for 2015 to 2020. It builds on this work already underway and seeks to improve outcomes for people with diabetes
http://www.health.govt.nz/our-work/diseases-and-conditions/diabetes
http://www.health.govt.nz/our-work/diseases-and-conditions/diabetes/quality-standards-diabetes-care
http://www.health.govt.nz/our-work/diseases-and-conditions/diabetes/diabetes-publications

Gout

http://www.health.govt.nz/publication/health-literacy-and-prevention-and-early-detection-gout

Mental Health and Addiction

https://www.rnzcgp.org.nz/assets/documents/Training-and-Beyond/Curriculum-Documents-2014/Mental-Health-CS.pdf
http://www.health.govt.nz/publication/rising-challenge-mental-health-and-addiction-service-development-plan-2012-2017
http://www.tepou.co.nz/outcomes-and-information/knowing-the-people-planning/31 http://www.health.govt.nz/our-work/mental-health-and-addictions
http://www.depression.org.nz/
https://thelowdown.co.nz/
http://www.health.govt.nz/our-work/mental-health-and-addictions/mental-health-publications

Musculoskeletal Disorders

http://www.arthritis.org.nz/wp-content/uploads/2012/09/fitforwork.pdf
http://www.arthritis.org.nz/wp-content/uploads/2011/07/economic-cost-of-arthritis-in-new-zealand-final-print.pdf
http://osteoporosis.org.nz/resources/health-professionals/fracture-liaison-services/
http://www.health.govt.nz/our-work/preventative-health-wellness/mobility-action-programme
http://www.health.govt.nz/publication/family-doctors-methodology-and-description-activity-private-gps refer
https://www.rnzcgp.org.nz/assets/documents/Training-and-Beyond/Curriculum-Documents-2014/Musculoskeletal-CS.pdf

Palliative care

http://www.health.govt.nz/our-work/life-stages/palliative-care
http://www.tepou.co.nz/initiatives/equally-well-physical-health/37

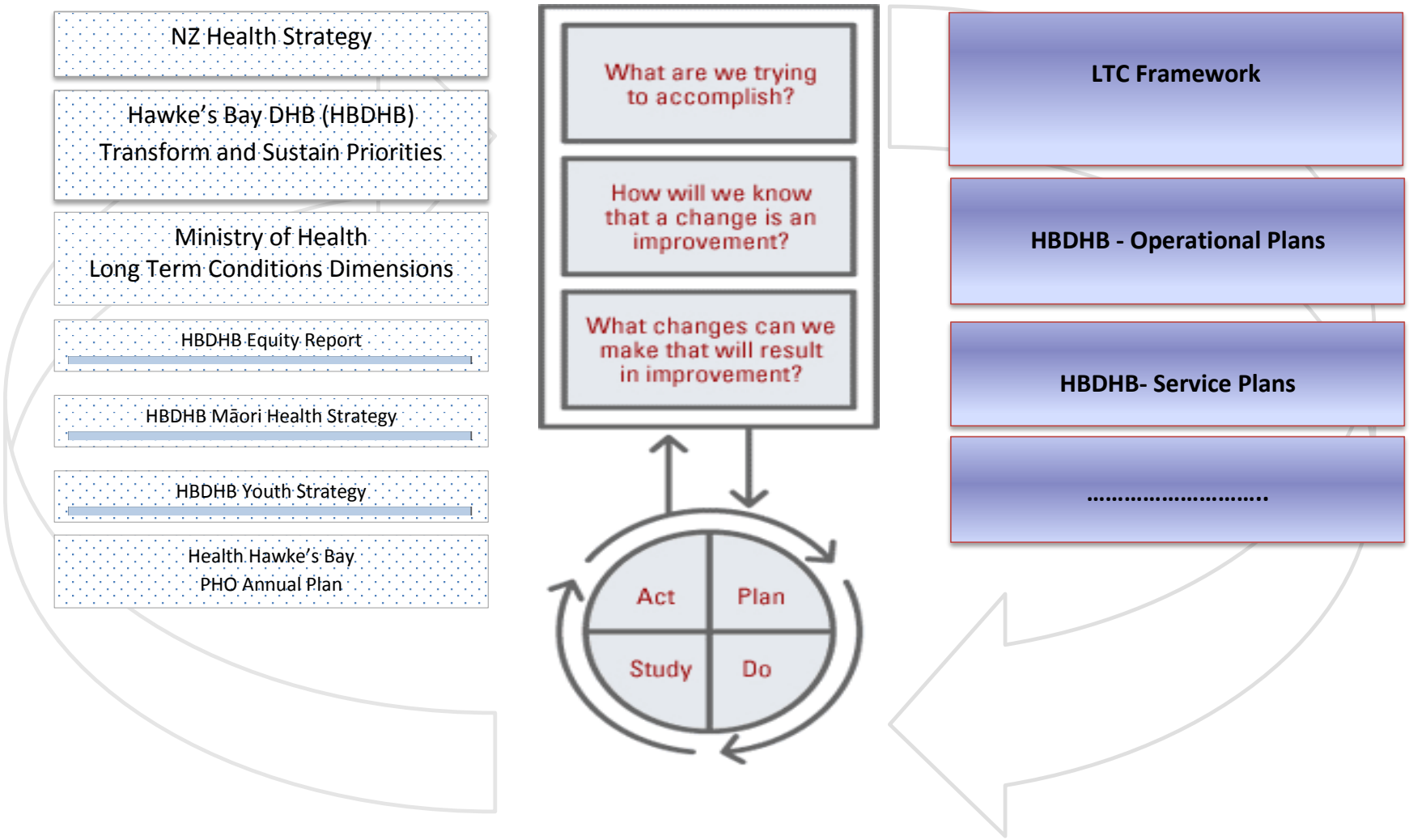
Stroke

http://www.health.govt.nz/publication/new-zealand-clinical-guidelines-stroke-management-2010

Hawke's Bay DHB
Long Term Conditions (LTCs) Framework – Appendices

Appendix One: Long Term Conditions –Service Review Matrix (LTC-SRM)

(DRAFT) completion and development by LTC Advisory Group



Strengthening an Integrated Approach to Patient Care

Background

This matrix has been developed in alignment with the Long Term Conditions Framework and in response to the need to provide an evaluative framework on which to base decision making when a service/provider:

a) evaluates performance against the Four Akas,
b) maps service capacity inclusive of both strengths and areas for development
c) economically and strategically aligns the distribution of resources and support

The Purpose

The self-review matrix is to build internal capacity within an organisation/service to self-evaluate and self-design areas for improvement. By using internal expertise with the assistance of critique of an external provider (in this instance the PHO quality leader and quality support team members or in DHB QIPS team). The process of self-evaluation and review follows the plan, do, study act model (Appendix 1) and is underpinned by results based accountability i.e. outcomes focused.

Suggested methodology

The quality review matrix is designed as a proactive evaluation framework based on evidence based thinking methodologies; results based accountability and the PDSA cycle of review.

1. **Champion Resources (CR)** are identified within each work area but should consist of no less than; x 1 GP/Consultant, x 1 Service Nurse/Registered Nurse x 1 Service Manager/Clinical Nurse Manager. **A Quality Leader (QL)** from the PHO/DHB QIPS are identified for each Service.

2. **Resources** - change management, facilitation, interview skills can be utilised to host learning conversations http://www.infed.org/thinkers/argyris.htm

3. **Suggested steps for CR and QL**
   - Work through the quality review matrix, using resources above in particular having the conversations where they feel what best fits against the component parts of the four akas.
   - Assign evidence to substantiate conclusions in line with evidence that has been identified in the matrix.
     Identify and prioritise areas for improvement. Each performance indicator; competent, proficient and excellent are divided into two levels by a number. The **lesser** number indicates **working towards** achieving at this level and the **greater number** indicates **working at this level**.
   - Findings are mapped for each work area. The results can be used to strategically and economically allocate resources, determine both individual service support and support to be provided collectively to groups of services with areas in common for development.
   - Develop an action plan to address the areas for improvement, resources needed, support required, and time frames to achieve success against the identified indicators.

The Four Aka		Components of each Aka	Notes
Aka Tahi	Person-Family-Whanau centred Care	Consumer Voice	Consumer Council and Clinical Advisory Group (PHO)
		Health Literacy	QIPS
		Self-care	Imbed work
		Understanding Determinants of health	Public Health Unit, Maori Health
Aka Rua	Person centred clinical systems and processes	Health and Social Care Networks	MOH Priorities
		Models of care development	PHO
		Collaborative Pathways	Between Providers. Integration/Outcomes
		Integrated IT systems and enablement's	IT, Business Analyst
Aka Toru	Workforce Development and Enablement	Workforces capacity and capability	Workforce Development – unregulated, careers
		Clinical Leadership	Attraction and retention of high performing staff – Nursing workforce development
		Clinical Expertise	
		Intersectoral development	Integration work with NHSP – DHB-PHOs
Aka Wha	Risk Identification and mitigation	Population Health	Public Health Unit
		Equity	HEAT
		Continuous quality improvement	Between Providers. Outcomes Focus. Show casing the 'success – bright spots' in achieving area based integration.
		Governance/advisory support	Advisory group

Definitions:

Service Generic identifier of a range of health provision agents which include hospital based services – community services – general practice

Performance Indicators:

Table 1.0 - Global Indicators (vs Individual Indicators in Table 1.1 – below)

Excellence		Improvement		Entry	
6	5	4	3	2	1
Services exhibit a systems wide approach and can be recommended as champions **to lead in ALL Akas**.		A service that is functioning at this level exhibits good practice in most areas and has evidence to support their **working towards a systems based approach - in ALL Four Akas**		A service that is functioning at this level exhibits areas of **good practice but this is reliant on individual staff vs. a systems based approach**	
Service can provide a body of evidence to support: Highly responsive to both person and population health outcomes. Strategies that have a focus on person/family/whanau centred care. Proactive engagement with external health providers enhancing outcomes (through a whanau ora approach). Seamless vertical and horizontal integration in place, with dedicated CQI activities. Attainment of 100% of System Level Measures/Operational Targets. Provision of an integrated range of services (both clinical and support, including total engagement with e-referrals, benchmarking etc.). Demonstrates an inter-professional model – of engagement and membership of professional bodies. Serious and sentinel events are managed and reported. Shared learnings conducted internally (IDT) and within external forum.		**Service can provide a body of evidence to support:** Responsive to the person's voice and demonstrates a proactive approach to gaining feedback. Some integrated models of care being used, e.g. interdisciplinary teams with appropriate utilisation of all services. Some vertical and horizontal integration in place, with dedicated CQI activities. Attainment of 80% of System Level Measures/ Operational Targets (DHB). Engagement and utilisation of clinical and support E-tools. Workforce and service planning is being developed. Able to provide and support professional student placement. Serious and sentinel events are managed and reported and used for in-service improvements.		**Service can provide a body of evidence to support:** Responsive to the person's voice and demonstrates a approach to gaining feedback. Has plans in place to develop integrated models of care to support consumer access. Minimum standard sets that have been externally validated have been achieved e.g. Cornerstone Accreditation (Primary Care), QA Health Standards Secondary Care). Attainment of 70% of System Level Measures/ Operational Targets (DHB). Engagement and utilisation of clinical and support E-tools. Provides qualified and experienced workforce at a ratio able to meet the needs of registered population. Serious and sentinel events are managed and reported	

Table 1.1 – Individual Indicators (vs Global Indicators in Table 1.0 above)

Aka One	Person-Family-Whanau Centered Care						Evidence
	Excellence		Improvement		Entry		
	6	5	4	3	2	1	
Consumer Voice	• The service has developed a range of methods to capture feedback • Information gathered relates to both generic service and specific areas of work needing a greater focus • Causal link between feedback and change within the Service is evidenced - "good ideas"		• The service has more than three ways to capture feedback. • Information from all methods is fed back to the team and used to instigate change. • There is growing evidence to show that feedback is linked to change within the service (not solely complaints)		• Basic questionnaires generating generic feedback is in place. • Evidence exists to support feedback being used to implement change. • Complaints register content discussed at Service meetings and formative actions taken		**Current surveys Consumer engagement in feedback CQI projects Meeting agendas/ action points Complaints register**
Health Literacy	• Staff qualified in providing (health) literacy training • Information developed and provided for consumers and staff is critiqued by same • Complaints do not include lack of understanding or insufficient information provision • Q &A opportunities based on the PDSA cycle - Options grids available for a range of conditions and treatments		• Planning is evident to ensure all staff are qualified in health literacy • Literacy and cultural awareness evident in all health information provided (oral and written) • Specific information caters to all population – literacy, culture, age, ethnicity • Consumer input is sought when developing (some) forms • Q &A opportunities provided and used to inform frequently asked questions – Options Grids		• Evidence exists to support planning is underway for staff to be trained in health literacy • Health Information is provided in a range of formats • Input from consumers sought when developing forms etc. • System in place that identifies and caters for differing (Health) literacy levels of ALL clients (pictorial, literary, oral)		**Patient / health information and documentation Feedback / feed forward from consumers**
Self Care	• Tailoring self-care models to meet consumers • Specific projects/programmes/initiatives demonstrate inclusiveness of consumer • MDT staff utilise individual planning e.g. care planning in primary and discharge planning in secondary care		• Demonstrating ways to ensure that people are actively involved in planning their self-management • A shared MDT understanding of what self-management support means.		• Evidence exists to support planning of the development of models of self-care • Isolated evidence where MDT have been formed and utilised		**Individual Planning/Discharge Planning Cycles of CQI**
Determinants of health	• Staff are able to articulate what cultural competence looks and feels like: for staff, for the person and evidenced in feedback mechanisms used. • Cultural perspectives are a component in all aspects of planning and analysis. • Language is not a barrier to engagement • Increased life expectancy for high needs population is identified as an outcome		• Feedback developed to explore the level of cultural competence within the work place, staff and environment • Barriers created by the health Service culture are identified and being addressed proactively e.g. social support systems		• On-going staff training in place for communication skills - culture specific. • At a glance – environment is culturally sensitive (location and use of space & information and presentation available)		**Māori Health Plan Environment Consumer focus groups Feed forward mechanisms Use of language line**

Aka Two	Person centred clinical systems and processes						Evidence
	Excellence		Improvement		Entry		
	6	5	4	3	2	1	
Health and Social Care Networks	• Partnerships in health care is evident • The Networks meet & exceeds all targets on a quarterly basis. • The Networks have proactively determined further priorities. • Outcomes for each priority are clearly identified and a plan of action is in place. • A review process can be demonstrated with the capacity for change		• Achieves within 5-10% of all System Level Measures/Targets in all four quarters. • Planning is underway in content, method of delivery, duration and target population to form an integrated approach		• Archives (inconsistently) against system level measures • Identifies areas for development and addresses recommendations. • Works proactively with guidance to develop an Action Plan. • Demonstrates improvement over time in areas identified in Service reports		**System Level Measures/Targets results** **Service Quarterly reports** **Action Plan**
Models of Care development	• All data inclusive in planning • Partnerships in health care evident • Total workforce involvement in achieving outcomes • Using principles as a basis for tests of changes e.g. implement a Stanford Model for all conditions – a model that can be promoted from all sectors		• Gaps known to staff and data is being used to analysis and plan strategies for addressing the gap • Limited links to other providers • Demonstrates fundamental transformation of the relationship between a person/carer and provider e.g. consumer satisfaction		• Gaps not known to Service staff • Few links to other providers		**Data analysis** **Consumer satisfaction** **What is working well – lean and embed**
Collaborative Pathways	• Service provides clinical leadership to assist with the development, publishing and socialising of pathways		• Service provides clinical staff to assist with the development, publishing and socialising of pathways		• Identifies staff for potential assistance with collaborative pathways		**Number of pathway participation**
Integrated IT systems	• Improvement cycles well evidenced to embrace new technology e.g. patient portal, patient held records, telehealth care (remote via phones, mobiles, internet, videoconferencing)		• Planning processes are in place to align to technological changes to support telehealth care		• No planning to keep abreast with technology changes		**IT systems- Patient Portal,**

Aka Three	Workforce Development and Enablement						Evidence
	Excellence		Improvement		Entry		
	6	5	4	3	2	1	
Workforce capacity and capability	• There is a process for the team to measure their competency (advanced) with their consumers and peers. • Staff turnover / staff rejuvenation are considered as part of sustainability planning. • Staff development, education and support are mechanisms used to promote a culture of continuous improvement.		• Team and individual performance is analysed to inform areas for improvement and effective use of skill base. • The culture of the team is forward thinking and achievement focused (e.g. use of unpaid careers/volunteers to assist with caring)		• All staff have a current job description, employment agreement and current annual performance appraisal. • Performance appraisal & performance management systems are established and utilised to enhance performance and professional development. • Areas for development are identified and actioned to ensure staff qualifications and experience is commiserate with population health needs		**Staff training programs Qualification and registration records Performance appraisals and monitoring Business continuity planning and sustainability of workforce Team functionality analysis**
Clinical Leadership	• Members of the service are involved in local, regional or national governance. • The team search out challenging opportunities to change, grow, innovate and improve. • Research and risk analysis are explored		• The service has a voice that influences clinical direction external to the Service. e.g. writing submissions, business cases. • The service has clinical leadership that is a role model to others in the team and external.		• The service has a clinical leadership structure, recognises individual contributions and celebrates team success.		**CQI initiatives Staff recognition methods Publication of evidence based articles Governance membership**
Clinical expertise	• Clinical and administration staff are supported in working to their scope of practice • Initiatives are supported and evidence based on population health needs • Senior Nurses and Nurse practitioners have clinical lead roles.		• Both clinical and admin teams utilise all electronic tools effectively and efficiently. • Systems and processes are standardised across the team and their adherence audited by clinical and admin leaders. • There is a direct link between population health needs and professional development plans of staff members. • Staff to patient ratios are managed effectively (numbers and staff competency)		• All clinical staff belong to a professional body. • Professional body competencies are met. • Induction & orientation programs in place • Reorientation of existing staff carried out as required. • Support systems are in place for new graduates, locums, newly appointed staff.		**Compliance audits Professional Dev. Plans and Education attendance records. Audits of staffing & appointment management Orientation Induction plans**
Inter-sectoral development	• The service is represented at a range of professional forums • Staff present at seminars, workshops and conferences • Staff research is published • Demonstrated goal-setting and motivational processes have created positive effects on health behaviours		• Staff attend local and national seminars and conferences pertaining to their role and share the learning at Service and network level		• Staff attend local network meetings on a regular basis to support and share learnings across their network; - Peer review teams - Service nurse forums - Service Manager forums		**Professional network membership Service meeting agendas-minutes Publications**

Aka Wha	Risk identification and mitigation						Evidence
	Excellence		Improvement		Entry		
	6	5	4	3	2	1	
Population health	• The service meets & exceeds all targets on a quarterly basis • The service proactively determines further population based priorities (risk) • Outcomes for each priority are clearly identified and a plan of action is in place • A review process (CQI) can be demonstrated with the capacity for change		• The service has designed implemented and reviewed a number of strategies • Service knows specific population (registration, risk stratification, recalls) health outcomes and are monitoring		• Data collection is set up correctly to be able to record and retrieve population and individual health data (e.g. read codes, classifications, recall systems, length of stays etc.) • Health data is reviewed routinely by the multi-disciplinary team • Strategies are being developed to address population health outcomes		**Data captures** **Dr Info access and use** **Equity Data – Maori Health data** **SLM measures** **Risk stratification Models** **CAP**
Equity	• ≥ 3% gap between MPI and NMPI in System Level Measures/Health Targets • Improvement cycles well evidenced • Partnerships in health care evident • Total workforce involvement in achieving outcomes		• ≥ 5% gap in MPI and NMPI System Level Measures/Health Targets • Service data is used to analysis and plan strategies for addressing the gap • Limited links to other providers		• ≥ 10% in MPI and NMPI health targets • Few links to other providers		**MPI vs. NMPI analysis** **(Not** Total vs. Maori
Cycle of Continuous Quality Improvement	• Proactively reviews risk factors and uses a range of risk calculators • Uses tracer (or other) audit processes to identify areas for improvement • Experiences and outcomes are shared with other providers e.g. at professional network meetings / forum • Leader in Service Continuity Planning		• Both electronic audits and internal audit processes are undertaken in an organised plan • The whole team or multi-disciplinary quality group is involved in the investigation of all incidents • Recommendations following events are used as Quality Improvement activities • Management of Major incidents – Emerging Infectious Diseases and Fire are all part of the Services continuity planning and are reviewed and updated 6-12 monthly as required.		• Accidents, incidents and near misses are recorded routinely and reviewed • Meeting agendas/ minutes demonstrate that reduction of harm forms part of CQI cycles (patients and staff) • Clinical audit is undertaken and a PDSA is undertaken • Best Practice Guidelines form the basis of all programmes and can easily be accessed.		**Incident reporting** **Trend analysis** **Action plans – CQI** **Service meeting agendas/minutes** **Action research** **Peer reviews** **Clinical audits** **Compliance audits**
Governance and Advisory	• A culture of continuous improvement exists in all areas and is not reliant on one area or one person for its progression. • Achieves and exceeds all targets • Self-managing Project Planning • Provides leadership in the development of effective programmes that address population health needs		• Business continuity/service/operational plans are current and review mechanisms in place • Achieves within 5-10% of all Health Targets in all four quarters. • Self-managing action planning based on recommendations		• Governance and advisory group formed and meet regularly • Achieves (inconsistently) against health targets but within 20% of target • Identifies areas for development and addresses recommendations. • Demonstrates improvement over time in areas identified in reports.		**Service meeting agendas/minutes** **Action research** **health target results** **Reports** **Action Plan** **Corrective Action Reports**

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Mason Durie (2006) *Measuring Māori Wellbeing.* Massey University. Wellington.

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Appendix One: LTC - Service Evaluation Summary

Purpose: The Service Evaluation Summary is tool to be utilised to summarise the analysis of the service evaluations. It acts to provide a strategic view; mapping both areas of strength and areas for development. The purpose of which is to globally look at where expertise can be shared across the 'network of services', where resources need to be allocated to strengthen capabilities.

					Excellence				Proficient							Competent							
					6		5		4			3				2		1					
	Service Improvement Team				Aka Tahi				Aka Rua				Aka Toru				Aka Wha				Service visits			
					Person Family -Whanau Centred Care				Person Centred Systems and Processes				Workforce Development and Enablement				Risk Identification and Mitigation							
Service	Quality Improvement Facilitator	Clinical	Consumer	Administration	Consumer Voice	Health and Literacy	Self Care	Understanding the Determinants of Health	Health and Social Care Networks	Model of Care Development	Collaborative Clinical Pathways	Integrated IT Systems and Enablement	Clinical Leaderhip	Clinical Expertise	Workforce Capacity and Capability	Inter-Sectoral Development	Population Health	Equity	Coninutous Quality Improvement	Governance and Advisory Support	Date last visited	Date last visited	Date last visited	Date last visited

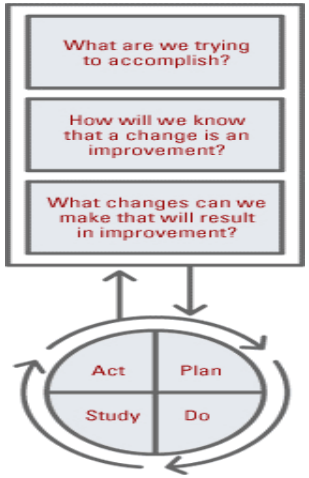
Appendix Two: LTC- Service Review Matrix – IHI Methodology

Methodology:
IHI Improvement Methodology

1. PLAN

Develop a framework on which to base the evaluation using a rubric of performance indicators.

- Use a three-scale model with each performance indicator divided into two levels.
- The higher number indicates achieved. The lesser number indicates working towards achievement.
- **Competent** is to be viewed as covering the minimum requirements to achieve the health outcomes.



2. DO

Try out an Improvement Theory
The report and the action plan

- The report should include:
  - performance in relation to each system measures/health targets
  - recognition of Best Practice that has contributed to high performance
  - recommendations for actions to improve service performance in specific areas
- Following the report being complied staff should discuss and identify areas for improvement and prioritised. **An action plan** is then developed to address the areas for improvement, resources needed, support required and time frames
- **After a period of 2-3 months the resulting outcomes are reviewed**

3. Study / Act (is a continuous review cycle)

Review the results and standardise the improvement
The action plan and reports are reviewed and assessed:

- which component parts have addressed areas that needed strengthening and **need sustaining as part of business as usual**
- Which component parts have not addressed low performance and therefore need to be revised
- What are the new areas of focus (if any) that need to be added to the action plan
- **After a period of 2-3 months the resulting outcomes are again reviewed**

Appendix Two: HEAT Assessment

Management of Long Term Conditions:

Background[1]: Key findings from the burden of disease study 2013 tells us that people are living longer with chronic long term conditions which contributes to associated disability and or challenges that face individuals needing to access care or manage their own self-care. Hawke's Bay, has significantly higher risk factors associated with the development of a chronic condition. Māori and Pasifika are over represented within this statistic.

Understanding Health Inequalities

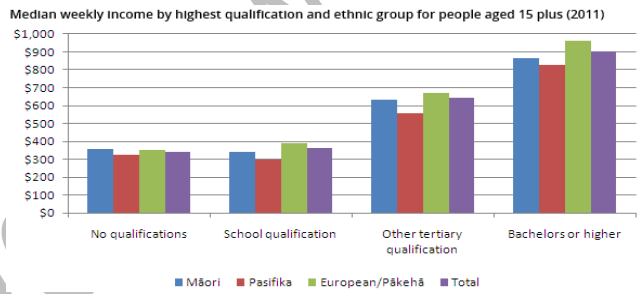
Type of Inequality	1. What inequalities exist?	2. Who is most advantaged and how?	3. Why did the inequality occur?
Consider the range of inequalities	**What do you know about inequalities in relation to this health issue?**	**Who is advantaged in relation to the health issue being considered and how?**	**What causal chain(s) lead to this inequality?**
Ethnicity[2]	Currently Māori and Pasifika peoples are over represented in all of our Health Risk Factors[3] which are listed in order of risk; Tobacco use, high body mass index, high blood pressure, high blood glucose level and low levels of physical activity. All of these risk factors contribute to premature mortality, increased incidence long term condition and co-morbidity rates. The disparity gap is greatest for smoking and high body mass index.	Female Non- Māori Pasifika (NMPI[4]) are least represented in the LTC (Generic) cohort, followed by Male NMPI, however this is dependent on the specific condition(s).	Educational levels of females (mothers) is identified as having a high impact on future population outcomes inclusive of health. A 15% gap exists between Māori (70%) and European females (85%) 18yr+ leaving school with NCEA L2 or above. The gap for males is 16%. Education leading to improved choice re employment, housing, lifestyle etc. Influence directly the determinants of health as identified below in this table.

[1] Adapted and taken from "Chronic Disease: Current Situation Analysis- (Prevalence, Morbidity and Mortality)" – Lisa Jones HBDHB Business Intelligence Team

[2] Ethnicity inequality – not counted twice – each separate component…

[3] Risk Factors listed are those identified in the Chronic Disease: Current Situation Analysis(Prevalence, Morbidity and Mortality) – Lisa Jones HBDHB Business Intelligence Team taken from the NZ Burden of Disease Study 2013 and the Health Equity Report – 2016.

[4] MPI-Maori Pasifika peoples vs Non Maori Pasifika (NMPI). This comparison is used to identify that the gap between MPI and NMPI is where health effort needs to be concentrated the most. By comparing MPI with total population we lose sight of the real difference that exists within population health outcomes.

Type of Inequality	1. What inequalities exist?	2. Who is most advantaged and how?	3. Consider the contributing factors that caused the inequity.
Levels of literacy [5]	Currently only 1:5 New Zealanders are operating at a highly effective level of literacy. The majority of Māori, Pasifika and those from other ethnic minority groups are functioning below the level of competence in literacy required to effectively meet the demands of everyday life.	Research suggests that people with high (health) literacy: • are more likely to use prevention services (such as screening) • have more knowledge of their illness, treatment and medicines • are more likely to manage their long-term/chronic condition • are less likely to be hospitalised due to a chronic condition • are more likely to use emergency services • are less vulnerable to (workplace) injury because they understand safety (precautionary) messages.	 *Source: Education Counts* Education initiatives in the last 10yrs have focused on improving literacy (numeracy) levels with a particular focus for Māori and Pasifika as they are overly represented in the low academic achievement stats, unskilled or low skilled labour workforce, unemployment and involvement with the justice services and utilisation of assisted social services. The inclusion of non-mainstream schools; Kura Kaupapa Māori and charter schools, introduction of NCEA and NZQA standards, and literacy benchmarking attempt to address the disparity that exists going forward, however the legacy of low literacy has had an impact on our current health and quality of life indicators. Low literacy levels can contribute to a lack of confidence in navigating the health systems and social support networks. This in turn contributes to the inability to access the care and support that exists and that one is entitled to.
Health literacy[6]	56% of adult New Zealanders have poor health literacy skills, scoring below the minimum required to meet the needs of the demands of everyday life. Māori who live in a rural location have on average the poorest health literacy skills, closely followed by Māori who live in an urban location. The findings in the **Korero Marama** report show that overall the majority of New Zealanders are limited in their ability to obtain, process and understand basic health information and services		

[5] Health Literacy is defined as; 'the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions' (Kickbusch et al 2005). Statistics NZ – level of Adult Literacy and http://www.healthliteracy.org.nz/about-health-literacy/health-literacy-statistics

[6] Korero Marama (2010)

Health Literacy (cont.)	in order to make informed and appropriate health decisions.		Systems and processes that have been set up without consumer input in their design, use of consumer feedback post design and analysis of data that demonstrates consumer engagement with services contributes to lack of institutional awareness of the level of (health) literacy of their client base.
Socio economic factors inclusive of wider determinants of health	The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution and accessibility of resources at a personal (individual) and population health level. Addressing equity is about unequal distribution of resources in order to advantage the disadvantaged in order to create as close to a level playing field as possible.	Those who enjoy economic wellbeing and resilience gained through, stable and supportive family dynamics, good to excellent educational achievement, employment, and participation as a contributor to local and regional community (networks)	Limiting or limited access to education, employment and or social supports, at a personal or population level contributes to disadvantaged individuals and populations. Continuous and exponential increases in compromised quality of life indicators will directly impact on the 'resilience' of a family and or community to address, self-manage, create opportunity and work their way out of adversity. Lack of understanding around compounding factors that influence levels of resilience can contribute to inappropriate 'care and or self-care' being prescribed or expected of the person affected by compromised health.
Disability	With the onset of the development of a long term condition the level of ability to manage everyday life activities is affected. Those with one or more comorbidities have the greater challenges to face. Age will impact on the ability of the individual, partner and or whanau to manage the compromised health state of the consumer	Those with good family support, an able bodied partner, access to transportation to access care assistance, financially able to 'buy' assistance required or modify lifestyle to accommodate the condition(s). Those who have built resilience over time to cope with change and or changes in circumstance. Those who have developed self-managing skills that enable they or their family, network to problem solve presenting issues. Those who are not at saturation point in regard to the compromises they are having to make in-order to maintain a level of wellness that is acceptable to them.	By treating the person/family as a whole and addressing the items that 'matter to the person' instead of the 'condition or what is the matter with them' we will begin to mitigate, minimise and hopefully eliminate the impact that their change in health status has on their ability to enjoy the lifestyle of their choosing.

Type of Inequality	1. What inequalities exist?	2. Who is most advantaged and how?	3. Consider the contributing factors that caused the inequity.
Age - 65+	At the age of 35yrs the prevalence and onset of Long Term Conditions increases. This is particularly relevant to Māori (Female).		Contributing factors that lead to the onset of Long Term Conditions is believed to begin as early as pregnancy. Lifestyle influenced or compromised by low education levels, which contribute to economic well-being impact on the capacity of individuals and whanau to choose well in in terms of health choices.
Gender	There is approximately a 10% differential between (Māori) Male and female risk factors within the HBDHB demographic	Females are advantaged	Screening programs for females and the incidence of attendance of general practice by females presenting with whanau who are unwell has had an impact on female visibility to health professionals. On average attendance differentials between male and females is a 75:25 ratio. Screening is the first point of prevention, risk identification and management. Lack of screening impacts on both the identification of risk factors and the timeliness (acuity) of the person's health status when they engage in and access active management.
Mental wellness[7]	Many people with long term physical health conditions also have mental wellness issues. This can lead to significantly poorer health outcomes and reduced quality of life.	Those with a single long term condition (1:5 of the 4:5 adults who have a Long Term Condition. Those with high levels of resilience, low acuity, early stages and highly skilled in self-management. Those with high health literacy Those with good whanau support	In providing disease specific health care we overlook the holistic approach that should be engendered with Long Term Conditions. People with long term conditions and co morbid mental health problems disproportionately live in deprived areas and have access to fewer resources of all kinds. The interaction between co-morbidities and deprivation make a significant contribution to generating and maintaining equalities.
Access to health care services[8]	Those living in rural communities.	Those living within easy driving distance to services required. Those living in an area with good mobile / outreach services. Ability and desire of people to have residences in areas with easy access to services.	Residence of choice or determined by full range of health determinants. Economies of scale –as determined financially viable by the DHB Attraction and retention of staff.

[7] The King's Fund and Centre for Mental Health 2012 - https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf

[8] This section ONLY covers physical access as all other barriers to access have been identified above e.g. socio economic section/health literacy, gender et. al.

Level	Determinants with associated possible interventions (May or may not be the responsibility of the health system)
Structural:	**Based on consumer and service feedback gathered in the consultation process (See Appendix 2 – LTC Framework)** **Education -** Healthy families, confident in their own identity, able to make choices that suit their own individual context is the focus of Ka Hikitia – Māori education strategy, designed for the purpose of Māori achieving success as Māori. Literacy and numeracy project have been introduced to the education system to address underperformance of all students. Valuing kaupapa Māori education – within a Te Ao Māori framework has also been identified as mechanisms to ensure that tailored responses to differing needs within our population are needed instead of the 'one size fits all' model of thinking. **Access points – multiple and varied –** consumers consistently repeated the same messages. They want multiple access points to health care/support at varying levels. This included; hours including late nights, early mornings, weekend clinics, and the ability to – phone – email – visit or have someone visit them were needed. The use of IT – web based patient portals were seen as only being advantageous. This was reaffirmed in Wairoa – by and 82yr old male who said "My patient portal is the best thing out – time saver and ease of access to all the information I need. I'm not that stable on my feet so coming in to town can be a real issue." A recently unemployed forestry worker was quick to mention that he had no time off if working in Forestry to get to the doctor – early morning starts – long hard days – relying on forestry transport all were factors contributing to intermittent access to care. **Utilisation of regulated health and non-health/non-regulated workforce –** the consumers wanted the right people with the right skills to support them in taking care of themselves but what was most important was the right fit of person. Diversification of our workforce (bi and multicultural) was identified as a need. The right fit also extended to what level of expertise was needed and the use of non – regulated workforce to provide levels of care appropriate to the consumer. Youth for example are wanting to engage with people with an affinity for youth issues and do not need to see a GP when their needs can be managed and or coordinated by a range of other staff – Nurse practitioner – Youth social worker – Youth counsellor. Navigation of the system was identified as a need. This can be achieved through advocating for an interdisciplinary team approach to care / support. **Interdisciplinary approach to care/support – using a wellness model –** the Long Term Conditions Framework advocates for an holistic wellness approach to care based on the Four Aka. In order for care not to be focused solely on the condition but on the consumer and whanau leads to the need to have an interdisciplinary approach. - **Generic approach not disease specific –** the incidence of consumers with co morbidities dictated to the framework that what is needed is a generic approach to care. The consumer wants a primary – centralised coordinator of their care that can provide access points to specialist care as and when needed. - **Mental health focus:** Care for large numbers of people with long-term conditions will improved by better integrating mental health support with primary care and chronic disease management programmes, with closer working between mental health specialists and other professionals. Service commissioning groups should prioritise integrating mental and physical health care more closely as a key part of their strategies to improve quality and productivity in health care.

Intermediate Pathways: *Material, psychosocial and behavioural factors. The impact of structural factors on health*	**Patient and relationship centred care –** is the response that is needed to tailor care and support for consumers that will engender ease of access to all stages in ones' healthy development. Taking into consideration quality of life measures as well as clinical measures to guide the health workforce and consumer as to 'what matters to them most' as a means of directing what type of care is needed – against an agreed set of priorities dictated by the consumer but advised and supported by the health professional. **Raising consumer expectations –** By not accepting that health inequities is an expectation if you are Māori or Pasifika and or in a group that is not experiencing equitable health outcomes (aged , disabled, living in remote areas, male) we address the issue from the consumer demand perspectives. This can be achieved through; - **Dis-establishing myths -** that exist about conditions that you should or should not expect if you fall into a particular population or age group. - **Raising health literacy -** becoming a focus of all information that is shared in a transformational vs transactional manner with the first step of finding out what is 'known to the consumer' before exchanging information that is intended to grow that information that will lead to greater understanding and self-determination in decision making - **Creating multiple avenues to enhance self-management –** by examining and evaluating the paternal aspect to health care provision, based on the level of acuity required of the consumer at any given time, we create the opportunity for the consumer to be the decision maker in their own care. If all the above is considered in the determination of the care and support that is needed then we create the right environment to implement – co designed models of care that have had the receiver and provider of care involved in its design process.
Health and Disability Services	**Flexible services** that can respond to variability in baseline health status and needs (mental and physical) - (see interdisciplinary teams above) **Risk mitigation**- Promotion of CQI initiatives that focus on snap shot tracer auditing that examine the pathway / care journey of the patient to identify routinely areas for improvement without them being attached to or a response to an incident – accident or death **Promoting the use of the Health and Disability advocacy service** – and taking learnings from any investigations or cases
Impact: *the impact on socioeconomic position*	Work with national, regional and local health promotion teams Work with ACC and other funding bodies that support employment and understanding of the determinants of health for those with a disability Cross-sector initiatives to co-fund tailored packages of care inclusive of MSD as a funder of subsidies and benefits for consumers Fund existing community providers to care for consumers building capacity and capability within our available work force Work with local education providers to inform curricular content, education pathways and career pathways Ensure step-up, step down options and the flexibility to do so within the patient journey of wellness and un wellness.

Pathway (AKA)	Questions	Responses
Tuatahi – *Developing whānau, hapū, iwi and Māori communities*	*How have Māori been involved in the use of HEAT?* *Have Māori health inequalities been fully considered?*	The focus of the framework is to address equity and gap in health outcomes Consumer consultation was representative of our demographic profile for Hawke's Bay. Wairoa – consultation group – 70% Māori and chosen due to its high Maori population as well as high needs in relation to Long Term Conditions. PAG included 3 Māori members Consumer council members represented our rural isolated communities (Parangahau)
Tuarua – *Māori participation in the health and disability sector*	*How will you involve Māori in the health and disability service interventions?* *How will you build Māori workforce capability?*	Health and disability service: engage the 'right fit of person to work with the individual engaged in any service intervention. Utilise the kaitakwaenga who have recently been appointed within the Maori health team. Ensure consumers know they can request a change of person – should the right fit not be achieved (Code of Rights) Workforce development forms part of Aka toru – workforce development and enablement.
Tuatoru – *Effective health and disability services*	*How will you ensure that the health and disability service intervention(s) proposed are timely, high-quality, effective and culturally appropriate for Māori?*	Identify this in the service plans and use the driver diagram (LTC Framework figure 1.0) to ensure that activities engaged in by services align to high level outcomes and objectives; example provided is – addressing the inequality gap in health outcomes for Maori and Pasifika with the enabler identified as – prioritising work programs that address the determinants of health
Tuawhā – *Working across sectors*	*How will you work collaboratively with other sectors to reduce Māori health inequalities?*	The inter sectoral approach of the health and social care networks in conjunction with the multidisciplinary approach to providing non disease specific care to those with or at risk of having a Long Term Condition.

Questions	Responses
Health inequality outcomes	System level measures and contributing measures identified in Aka Tahi Use of quality of life tools to measure non clinical outcomes for consumers Reduction to within 5% of gap between Māori and non-Māori
Groups Benefiting	Those with long term conditions – who are then able to access interdisciplinary teams and increase their confidence in their self-management.
Unintended Consequences	By focusing on generic approach – specialised care may be impacted on. The time frame leading up to high functioning IDTs may impact on patient care coordination. Workforce capacity and capability to work in a generic approach will need lead in time and to be managed well.
Risk Mitigation	Establish a LTC advisory group inclusive of Māori and Pasifika members Support and monitor service plans and operational management Work closely with the QIPS team to ensure systems for improvement are in place Ensure clinical leads are in place to manage care and coordination of care

How will you know if inequalities have been reduced?

By ensuring that all data is presented in MPI vs NMPI (not MPI vs Total population which masks the gap)

- Outcomes measures identified and monitored against each of the "Teams of Practice" or Service targets
- Utilisation of the System Level Measures and the contributing measures to map progress towards agreed outcomes

Reduction in the gap between MPI and NMPI

- Across the board

Appendix Three: Consultation Record - Long Term Conditions Framework

Health Faculty / Area	Person	Date	Version	Resulting modification to the document
GM – Primary Care CEI- PHO	Mark Petersen / Liz Stockley	July 2016	5	Include MDT approaches (in particular community pharmacies), thread through mental health wellness and youth.
QIPS	Jeannette Rendle/Adam MacDonald	July 2016	5	Resonance consumer voice and health literacy
Maori Health	Patrick LeGeyt	July 2016	5	Meaning of the tree: • (White pine – roots intertwined/interdependencies) Need to include HEAT Data to reflect Maori Link Social connectedness
Strategic Services/CFO	Mary Wills, Tim Evans	Aug. 2016	6	On track – aligns Transform and Sustain/Links to Annual Plan/Clinical Service Plans
Medical Directorate	Paula Jones, Colin Hutchinson, David Gardner	Aug. 2016	6	Keep it generic/Link it to Service Plans – Key areas: LTC/CP/Discharge Planning and E-Referrals/People to take ownership
PHO Boards	PPC CAG Innovation & Development Team	August 2016 To be presented August 2016	4 7	Instead of consults – make sure use engagement/ Preventative Model Focus on self-management Data to be inclusive of Pacifica
PHO	Trish Freer, Faye Milner	August 2016	8	Comments: - supportive to work on next phases
Nursing Leadership	Chris McKenna	September 2016	8	Portray engagement with Primary care Workforce
Consumers	Mental Health - PAG		9	Comments captured and documented - Refer to Appendix 2
Consumer	Husband and wife (both with LTCs)	September 2016	10	Comments captured and documented – Refer to Appendix 2
Executive Management	Andy Phillips/Sharon mason	October 2016	12	Relationship Centred Care – Staff Resilience
GP-medical Advisors	Kerryn Lum, KJ Patel, Jane Nash	October 2016	13	Finished product – easy read for all – watch the language and use of it – e.g. SLM? – What does this mean to GPs? /align the funding with diagnostics/capabilities – how will document remain responsive – how will it become real?

Nursing	Hastings Health Centre Taradale Health Centre	October 2016	12	Framework is structured
QIPS Team	Team members	October 2016	13	Will link to their work – 4000 days campaign
Hauroa Heretaunga – Nursing	Julia Ebbett	October 2016	13	What will success look like, definitions of self-care/self-management/thread through ACP/Not more but better/Right language or otherwise will disengage/ use of workforce capabilities in differing ways new roles e.g. navigator.
Consumers - Wairoa	14 consumers attending hui	October 2016	15	Comments captured and documented - Refer to Appendix 3
EMT	Executive Management Team	November 2016	16	Length of document. Order in which information presented. Generalist statements around burden of disease.
EMT	Clinical members of EMT	November 2016	17	Remove snap shot views. Include executive summary. Reframe statements to reflect better utilisation of upstream services vs cost reductions that will lead to reduced; ED Presentations, ED Admissions and Length of Stay.

Generic feedback gained through conversations and interactions with:

- Community members / consumers from Parangahau - Central Hawke's Bay

Appendix Four: Consumer Feedback Summaries

Aka Tahi	Components of each Aka	Objectives	What would success look like to you if this was done well?
Person - Family - Whanau centred Care	**Consumer voice**	Consumers are integral to the design and evaluation of services	**We want to be:** • Updated regularly – either verbally or in written material • Represented on DHB Committees and encouraged to be active and contribute • Valued for their contributions. Reponses to the voice to be immediate and appropriate. • Compensated for our contribution • Right person/right fit and to be listened to (there are differing ways to communicate) • When making changes they reflect on the consumer – we want to be involved with decision making • What is the first language/Te reo
	Health Literacy	Health literacy improvements enhance access and navigation to health services by the consumer	**We want:** • No jargon, simple language e.g. "Pertussis versus whooping cough" or "Influenza – why not just say flu" • Talk back concept and sometimes we may want to be in pairs • If the literacy is to our level we are more willing to ask for help • More assistance with navigator's e.g. Kaitakawaenga/WINZ/Social Services • Knowledge of what other providers can do for us • Language line/Health Internet that is readable • Up to date information provided for us that includes; - Welcome packs – informing of length of stays, information for family/whanau, consumer rights, - Information about our personal health e.g. medications, our key worker and our key physician and choices if we don't like the people we are to be cared for etc. - Simplistic language about medication management – if you take this, it will do this so what happens
	Self-Care	Consumers are supported to self-manage to their highest level of confidence	**We want:** • We need to take self-responsibility, manage our own care and be less dependent on health system and make our own choices • What matters to me • Needs to be holistic • Needs to have an outcome

Aka Rua	Components of each Aka	Objectives	What would success look like to you if this was done well?
Person Centred Clinical Systems and Processes	**Understanding the determinants of health**	Health professionals implement health strategies based on an understanding of the determinants of health	**We want:** • To be treated as a whole person not broken down into departments e.g. medical, mental health etc • Acknowledgement that just because I have a mental health issue that it may not be this issue that brings me to care • Reassurance that some medical problems are not dismissed or overlooked when seeking help e.g. pain, chronic fatigue, skin problems • Reassurance that communication is occurring between Providers of my care – right team of people - is there ethical dilemmas over confidentially? • Take health into the workplace – "we cannot get off work for a day to have a blood test" • "No more form" filling – lets us do it once only • To connect and have one system – health, social and education • Transport – cost of Ambulances • Hubs of services together under one roof e.g. NGOs/Heart Foundation/Breathe HB
	Health and Social Care networks	Collaborative networks developed providing services closer to home utilising a MDT[9] and inter-professional approach.	
	Models of care development	Building health services around the person using a whanau ora model of care and whole of workforce approach.	**We want to be:** • Linked up immediately with other agencies that support the healing of a person and plus supports our family • Agencies would work as a whole and not in iodation – this means we don't need to repeat our stories • Agencies have the same access to personal records – no replication of information • Access, independence and "free" • Face to face is important • At 82 years I support and can use the patient portal • Extended hours of services, not only GPs but pharmacy, laboratory • Don't want to be the "click the ticket" or check for check sake • Someone to help us navigate through – so it is seamless
	Collaborative clinical pathways	Development, implementation and review of clinical pathways that demonstrate integration of care	**We think:** • Bringing the Agencies together with the person at the centre – share resources, knowledge and information.

[9] MDT: Multi-Disciplinary Approach (Health, social and community based services)

	Integrated IT systems and enablement	Information Systems, and IT are easy to use, accessible and utilised at all levels for the purpose of system wide improvement.	**We want:** • Single person record • All to have access to our records in shared way. • Records need to be constantly updated especially when one Agency has information and the other does not know yet • Accuracy of data e.g. READ codes

Aka Toru	**Components of each Aka**	**Objectives**	**What would success look like to you if this was done well?**
Workforce Development and Enablement	**Clinical leadership**	Identified clinical leaders provide direction, support and accountability for the uptake and dissemination of best practice models to optimise patient care.	**We think:** • Constant personal development should take place for all staff • Training to be mandatory and staff be on full pay when up-skilling • Clinicians to travel worldwide to conferences and have full access and support to do technical, scientific, medical and humanities training
	Clinical expertise	Clinical staff, medical and nursing, provide services to the top of their scope supported by best practice guidelines under the direction of identified clinical leaders.	**We think:** • Staff should have access and training to alternatives therapies • Staff should be exposed and supported to learn from other cultures, countries and societies • Clinical leaders should be accountable to consumers groups e.g. PAG and to be flexible and adaptable
	Workforce capacity and capability	The workforce, inclusive of the lay workforce are able to work at the top of their scope with adequate support from the sector to achieve optimal patient care.	**We think:** • Supervision would be compulsory every 4 weeks for staff working in mental health including nurses, care associates, key workers and clinical team • Supervision should be tailored fit i.e. staff could chose who they would like as supervisor and the supervisor "constant" for contact • On demand supervision would be available when requested by staff
	Inter-sectoral development	Patient care is maximised through the utilisation of a MDT approach to individualised care.	**We think:** • Every shift should have time for debrief – not only crisis but day to day events • Regular staff meetings • Integration of all Teams (rural not working in isolation)

Aka Wha	Components of each Aka	Objectives	What would success look like to you if this was done well?
Risk Identification and Mitigation	**Equity**	Addressing the gap in patient outcomes is addressed actively through targeted approaches to the delivery of care.	**We want:** • Maori decision making • Recognise the treaty and reflect this in workforce • Funding to address the equity gaps • Wairoa's fit is unique • Address access issues • Better transport for our disability – e.g. a bus that travels to Napier is fit for disabilities
	Continuous quality improvement	Innovative practice is supported. Recognised improvement methodologies are used to achieve evidence based enhanced patient outcomes.	**We want:** • Person and relationship centred care • Advertise technology to support health needs e.g. "time reminders in phones for insulin"
	Governance and or advisory support	The support of an advisory group is used to evaluate services and advise on service design and improvement	No Comments recorded

***Consumers consulted in this exercise were:** Patient Advisory Group (Mental Health), HBDHB. Consumer Group from Wairoa. Consumer Council members: Graeme Norton. Consumers of services: Rosemary and Terry Marriot, CHB consumer and consumer council members, feedback from Parangahau in relation to CHB Network.

Appendix Five: Financial Summary

Purpose: To provide an indicative base line figure for the current spend in relation to Long Term Conditions. In a strategic landscape – what shift in spending needs to be planned for move the ratio of spending away from acute (Get well) Hospital and (Stay Well) Rehabilitation and Support Services and move towards (Start Well) Prevention and Detection and Management Services over time. **Figures quoted below are - $000s**

Shifting resource to support diminished demand on acute services through greater utilisation of up-stream services

The Current State - Long Term Conditions				
Start Well		**Get Well**		**Stay Well**
Prevention	**Detection and Management Services**	**Intensive Assessment and Treatment**		**Rehabilitation and Support Services**
Public Health	**Primary Care**	**Hospital**	**Out of District**	**Community**
$5,311	**$7,810**	**$22,082**	**$27,701**	**$6,555**
8%	**11%**	**32%**	**40%**	**9%**

Future State			
20%	**20%**	**60%**	**10%**

Financial Assumptions: (Provided by financial accountant)

Long Term Conditions costings have been based on a 15% calculation of the total health spend. This is based on the % population with one Long Term Condition. It is estimated that the prevalence of co morbidities would affect up to 35%. Assumptions therefore had to be made when estimating the costs. See full list of assumptions below:

The top five long term conditions; CVD, Respiratory, Cancers, Diabetes and Musculoskeletal have been used to gauge spend.

Long term Conditions - Primary, Hospital, and Community costings:
A % relating to LTC based on LTC Hospitalisations for HB domiciled patients for 2011 to 2013 as documented in Lisa Jones Report (2015) QIPP LTC Supporting the local implementation of the Year of Care Funding. Model for people with long-term conditions (2012).

Total LTC Hospitalisations for HB domiciled patients 2011 to 2013, Per Chronic Conditions dataset from Business Intelligence
Includes the following: Musculoskeletal Disease, Diabetes Complications- Renal Failure, Diabetes, Ischaemic Heart Disease, Stroke, Asthma, COPD, Cancer (No=17479)
Total Discharges for HB domiciled patients for 2011-2013 (dataset from Business Intelligence) (no=118971)
Note these figures are per HB domicile of patient rather than per location of service which the $ are based on.
Equates to – estimated 15% of total spend.

Out of district costs are based on IDF data. A full summary is provided in Appendix Five for IDF
Public Health spend is calculated at 100% of budget due to it being too difficult to determine which are LTC and all are preventative and general in nature.
IDFs are classified between various LTC conditions, and therefore no further apportionment is required.

As information is captured at a higher level it is difficult to itemise costs to specific conditions. Therefore, only costs which can be clearly attributed to a specific condition e.g. Haemodialysis to Diabetes are shown under specific conditions. Generic amounts capture costs not able to be itemised.

Exclusions
Residential Care costs are excluded as typically relate to people over +65 and are difficult for the DHB to control.
Paediatrics (Hospital & IDFs) excluded from analysis as unable to confirm conditions are long term at this stage.

Generic Spend **LONG- TERM CONDITIONS GENERIC**
Excludes Paediatrics

Be Well				Get Well		Stay well		
Prevention		Detection and Management Services		Intensive Assessment and treatment		Rehabilitation & Support Services		
PUBLIC HEALTH	$'000	PRIMARY	$'000	HOSPITAL	$'000	COMMUNITY	$'000	OUT of DISTRICT
services delivered to HB Population		*first Level of care or entry point*		*specialist services lead by consultant*		*services support individual live independently*		*service provide out of district*
School Based Health Services	$524	Immunisation (by Pharmacies) eg Flu	$182		% LTC			
B4 School Checks	$414				15			
Directions (YOSS)	$282							
PUBLIC HEALTH		PRIMARY		HOSPITAL		COMMUNITY		OUT of DISTRICT
Services delivered to HB Population		*First Level of care or entry point*		*Specialist services lead by consultant*		*Services support individuals to live independently*		*Service provide out of district*
Population Health		**General Practice**		**Emergency**		**General Practice**		Inpatient
Healthy Families	$171	Capitation Funding (% w/b LTC clients)	$4,547	Hastings Emergency Dept.	$1,991	CPD Funding	$113	Ambulatory
Obesity Programmes	$200	VLCA & Free under 13yr (% w/b LTC clients)	$511					NTA (Ambulatory)
Green Prescription	$288			**Inpatient**		**PHO**		Mental Health - Provider
Rheumatic Fever	$186			Acute Assessment Unit (incl nurses)	$66			Mental Health - NGO
Immunisation	$1,101			CCU (incl nurses)	$579	Nurse Lead Clinics	SIA ? PHO to provide number	
Smoking Cessation	$470			ICU/HDU (incl nurses)	$1,373	Counselling Packages	SIA ? PHO to provide number	
House Insulation	$125			Mental Health Unit (incl nurses)	$579	Whanau Wellness Program	SIA ? PHO to provide number	
Maternal Nutrition	$241			Other In-patient Wards (incl nurses)	$969	**HBDHB**		
				Medical Staff	$1,090	Pharmaceutical	Pharmaceutical	
Early Childhood Education Centres	?	**After Hours**		Psychiatrist Medical	$691	Mental Health (Community)	$1,077	
Well Child/ Tamariki Ora	$838	City Medical (incl Nurse)	$117	**Outpatients (Napier/Hastings)**		District Nursing	$768	
				Specialist Villas (FSA/F/Ups)	$428	Home Based Supports	$1,775	
PHO						Allied Health (Physio, Ots)	included in hosp	
Risk Screening (under capitation)	$0			Nurse Led Clinics	refer OPD	Clincial Pharmacists	$79	
						NASC (Options HB)	$336 Service	
Others		**Community Diagnostics**		**Allied Health Services**				
Internet Health Navigator Provider		Community Laboratory	$941	Occupational Therapy	$246			
		Radiology Public limited	$870	Physiotherapy	$262			
				Social Workers	$163	**Maori Services**	$768	
				SLT	$46	**Pacific Services**	$15	
						Disability Services	Funded by MoH $22m	
				Pharmaceuticals	$258	**Migrant Community Workers**	$0	
		Health Literacy	$0	**DHB Diagnostic Procedures**				
				(elective & acute)		**Ambulance Services**	$515 IHT	
				Radiology	870	**National Transport & Accommodati**	$314	
				Laboratory (Blood)	382			
				Laboratory	$1,152			
				Imaging Services	refer Radiology			
				Angiography Suite	refer Radiology			
				Health Literacy / QIPS	38			
$4,840		$7,169		$11,181		$5,760		$5,772

DRAFT

Long Term Conditions Cardiovascular (refers to conditions that involve narrowed or blocked blood vessels that can lead to a heart attack, chest pain (angina) or stroke).

adult heart disease(Leigh to defn) & WvS $

Be Well		Get Well	Stay well	
Prevention	Detection and Management Services	Intensive Assessement and treatment	Rehabilitation & Support Services	
			$'000	$'000
PUBLIC HEALTH *services delivered to HB Population* **Population Health** Screening **Others** Heart Foundation Stroke Foundation Te Hotu Manawa Māori Patu (one off)	**PRIMARY** *first Level of care or entry point* **General Practice** Echocardiograms (primary) Heart (CVRA) Check Target Funding **Comm Diagnostics** ECG (private)	**HOSPITAL** *specialsit services lead by consultant* **Emergency** Thrombolysis Amputations (PVD) **Inpatient** Medical Day Ward Blood Transfusions) Stroke Unit **Outpatient** Neurovascular Clinic (Stroke) **DHB Diagnostic Procedures** Imaging Services (CT) Angiography Suite Echocardiography Holter Monitoring Stress Test & Cardioversions CCU / interventions	**COMMUNITY** *services support individual live independently* **HBDHB** Cardio Rehab Oxygen Therapy Rehab. Services Nurse Practitioner (CHF) Clinical Nurse Specialist (CHF) **PHO** Stanford Model **Maori Services** Maori Diabetes and CVD Funding	**OUT of DISTRICT** *service provide out of district* Inpatients $10,752 Ambulatory $48
???				
Costings: (Estimated Costs) $0	$0	$0	$0	$10,800

Research/Literature Report on NZ Cost of Illness Studies on LTC 2009

Coronary Heart Disease

Direct cost $179 million (Scott: 1993)
Direct included: ambulance, hospital, diagnostic tests, private consultation costs, medicine and dispensing costs)
Hospital stays main contributor of direct costs
Direct outnumbered indirect by 10:1
Indirect $14-$24 million
Indirect included: lost productivity, medical research and health promotion
Intangible costs: $114 -$264 million - calculated by costing the loss of lie
Under willingness-to-pay approach, intangible costs increased to $14,568 million

Ischaemic Stroke
Direct costs $93-$140 million (1992) (Scott and Scott 1994)
Direct costs 10 times more than indirect
Hospitial and continuing care account 90% of all costs

DRAFT

Long Term Conditions Musculoskeletal (to restore and/or maintain the function of the musculo-skeletal system, due to trauma, congenital developmental abnormalities, and degenerative or disease processes)

Be Well		Get Well	Stay well
Prevention	Detection and Management Services	Intensive Assessement and treatment	Rehabilitation & Support Services

PUBLIC HEALTH *services delivered to HB Population*	PRIMARY *first Level of care or entry point*	HOSPITAL *specialsit services lead by consultant*	COMMUNITY *services support individual live independently*	OUT of DISTRICT *service provide out of district*	$'000
Health Promotion	**General Practice**	**Emergency**	**HBDHB**	Inpatients	$1,548
Falls		Spinal Injuries	Orthotics	Ambulatory	$19
		Chronic Pain	Clinical Nurse Specialist	Queen Victoria Hospital	$53
		Inpatient	District Nursing (wound mang)		
			Rehab. Services		
Falls & Fracture Working Group		Spinal Urodynamics			
ACC Provider		Wound Costs: Pressure Area Management	**ARC**		
			Additional Pressure Aream wound consumables		
		AT&R Services			

Costings: (Estimated Costs)				
$0	$0	$0	$0	$1,620

Research/Literature Report on NZ Cost of Illness Studies on LTC 2009

Arthritis

NZ Direct costs $564 million (Arthritis NZ and Access Economics 2005)
Direct: Health costs represented 1/3 of above
Indirect costs: $1,788 million - out weigh direct health costs more than 3:1
Intangible costs: $2,560 million

Osteoporosis
Direct costs $1, 159 million (Brown et al (2007)
Costs dominated by treatment - musculoskeletal, back problems and curvature of spine
Immediate # treatment and after $300million - dominated by pharmaceuticals

DRAFT

Long Term Conditions Respiratory

Be Well | **Get Well** | **Stay well**

Prevention | **Detection and Management Services** | **Intensive Assessement and treatment** | **Rehabilitation & Support Services**

PUBLIC HEALTH	PRIMARY	HOSPITAL	COMMUNITY		OUT of DISTRICT	$'000
services delivered to HB Population	*first Level of care or entry point*	*specialsit services lead by consultant*	*services support individual live independently*		*service provide out of district*	
PHO	General Practice	Inpatient	HBDHB		Inpatients	$241
GASP Assessments	Flexible Funding Respiraotry Project	Bronchoscopy	Pulmonary Rehab	$251	Ambulatory	$40
	Dietitian	Dietitian	COPD	$35		
Breathe HB	203 (suggest commu	Outpatients (Napier/Hastings)	Home Oxygen			
	Contract	Sleep Apnoea Assessments	Clinical Nurse Specialists			
	Breathe HB	Sleep Apnoea Equipment (short and long term) - CPAP, BIPAP & Humdifier	Dietitian			
Costings: (Estimated Costs)						
$203	$0	$0	$286		$281	

Research/Literature Report on NZ Cost of Illness Studies on LTC 2009

Asthma

NZ Direct costs: $102 million 1998/99 (Mitchell 1989)
$17 million - Hospitial (did not include oupiateitn or ED attendances)
$85 million pharmaceutical

COPD
NZ Direct costs: $103-$192 milion (2002)
Hospitalisations were the highest costs items - 63%
Pharmaceuticals account 15% of costs

Lung Cancer
NZ Direct costs $18-$28 million
Hospitalisations were 2/3 of costs
Palliative care costs more expensive than pharmaceuticals

Obstructive Sleep Apnoea
Direct cost $29 million (Scott 2007)
Direct accounted fr hoostal, outpatient, GP visits, surgery, appliacne, tansport
Indirect $10 million
Indiect mainly loss of productivity and 1/3 of direct costs
Intangilbe costs $1.3 million (loss of life)

DRAFT

Long Term Conditions Cancer (Management of a person with a malignant disease)

Be Well

Prevention

PUBLIC HEALTH
services delivered to HB Population

Health Promotion
National Screening Programmes — ok

PHO

Screening

Cancer Network
Cancer Society
Cancer Services
Kia Ora e Te Iwi Programme
Cervical & Breast Screening Pro — 268

Detection and Management Services

PRIMARY
first Level of care or entry point

General Practice

National Screening Programmes

Get Well

Intensive Assessment and treatment

HOSPITAL
specialist services lead by consultant

Palliative Care	3,346
Gastro/Endo	1482

Outpatients (Napier/Hastings)

Medical Day Ward (IV Chemotherapy) — in generic

Equipment/supplies
Subcutaneous Continuous infusions (Syringe Drivers)

Dietitians

Stay well

Rehabilitation & Support Services

COMMUNITY
services support individual live independently

General Practice

Palliative Care Initatiatve Programme

HBDHB
Pharmaceutical (Cytotoxic chemotherapy, targeted hormones, molecular therapy or immunotherapy)

Oxygen Therapy
Nurse Practitioner @ $115k each
Clinical Nurse Specialist @ $95k each
Psychologist
ARC — 0
Syringe drivers

Equipment/supplies
Subcutaneous infusions
Lymphedema bandages/support hosiery
Stoma consumables
Long-term aids

Cranford
Specialist Education

Dietitians

OUT of DISTRICT — *service provide out of district* — **$'000**

Inpatients	$1,660
Ambulatory	$6,936
NTA (include Genetic)	

Costings: (Estimated Costs)			
$268	$0	4,828	$0	$8,596

IDF Coding

Purchase U	Description	Group
D01001	Inpatient Dental treatment	
M00.01	General Internal Medical Services - Inpatient Services (DRGs)	Generic
M05.01	Emergency Medical Services - Inpatient Services (DRGs)	Generic
M10.01	Cardiology - Inpatient Services (DRGs)	CVD
M10.05	Specialist Paediatric Cardiac - Inpatient Services (DRGs)	
M15.01	Dermatology - Inpatient Services (DRGs)	
M20.01	Endocrinology & Diabetic - Inpatient Services (DRGs)	Diabetes
M25.01	Gastroenterology - Inpatient Services (DRGs)	
M30.01	Haematology - Inpatient Services (DRGs)	Cancer
M34.01	Specialist Paediatric Haematology	
M40.01	Infectious Diseases (incl Venereology) - Inpatient Services (DRGs)	
M45.01	Neurology - Inpatient Services (DRGs)	
M49.01	Specialist Paediatric Neurology	
M50.01	Oncology - Inpatient Services (DRGs)	Cancer
M54.01	Specialist Paediatric Oncology	
M55.01	Paediatric Medical Service (Inpatient)	
M60.01	Renal Medicine - Inpatient Services (DRGs)	Diabetes
M65.01	Respiratory - Inpatient Services (DRGs)	Respiratory
M70.01	Rheumatology (incl Immunology) - Inpatient Services (DRGs)	Orhto
M80.01	Palliative Medical Services - Inpatient Services (DRGs)	Cancer
S00.01	General Surgery - Inpatient Services (DRGs)	
S05.01	Anaesthesia Services - Inpatient Services (DRGs)	
S15.01	Cardiothoracic - Inpatient Services (DRGs)	CVD
S25.01	Ear, Nose and Throat - Inpatient Services (DRGs)	
S30.01	Gynaecology - Inpatient Services (DRGs)	
S35.01	Neurosurgery - Inpatient Services (DRGs)	
S40.01	Ophthalmology - Inpatient Services (DRGs)	
S45.01	Orthopaedics - Inpatient Services (DRGs)	Orhto
S55.01	Paediatric Surgical Services	
S60.01	Plastic & Burns - Inpatient Services (DRGs)	
S70.01	Urology - Inpatient Services (DRGs)	
S75.01	Vascular Surgery - Inpatient Services (DRGs)	Diabetes
W06.03	Maternity inpatient (DRGs)	
W10.01	Maternity inpatient (DRGs)	
Grand Total		

Grouped into link with LTC

Generic (based only on Medical)
CVD
Diabetes
Cancer
Respiratory
Ortho

Sourced from IDF Calculation Files (16/17 IDF Forecast)

Inpatient

Row Label:	Sum of Amount
Cancer	1,660,283
CVD	10,751,507
Diabetes	872,389
Generic	1,129,028
Orhto	1,547,895
Respirat	241,112
(blank)	11,220,733
Grand Tota	27,422,946

Ambulatory

Row Labels	Sum of Amount
Cancer	6,935,582
CVD	48,129
Diabetes	61,402
Generic	980
Ortho	18,508
Respiratory	39,596
(blank)	3,128,562
Grand Total	10,232,759

GASTRO OUTBREAK UPDATE

PRESENTATION

QUALITY IMPROVEMENT PROGRAMME UPDATE

RELATIONSHIP CENTRED PRACTICE

PRESENTATION

HAWKE'S BAY District Health Board Whakawāteatia	**Annual Māori Health Plan Q1 (July-Sept 2016) Non-Financial Exceptions Report**
	For the attention of: **Māori Relationship Board, HB Clinical Council, HB Health Consumer Council and the HBDHB Board**
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; and Peter Mackenzie, Operational Performance Analyst
Reviewed by:	Executive Management Team
Month:	November 2016
Consideration:	For Monitoring

10

RECOMMENDATION

MRB, Clinical and Consumer Council and HBDHB Board:

Note the contents of this report.

OVERVIEW

The purpose of this paper is to provide MRB, HB Clinical Council, HB Consumer Council and the HBDHB Board with exception report for Quarter 1 on the implementation of the 2016 – 2017 Annual Māori Health Plan. A quick reference summary dashboard will be supplied prior to the meeting and 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 indictors. 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

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

Table of Contents

2017-2017 ANNUAL MĀORI HEALTH PLAN PERFORMANCE HIGHLIGHTS

Achievements

1. Cervical screening

Cervical Screening for 25-69 year old Māori women (72.7%) for this quarter is slightly lower than the 73.2% in the last 2015-2016 quarter (Page 5). However, HBDHB continues to be on the top list on Cervical Screening performance in New Zealand. This performance also narrows the disparity gap between Māori and non- Māori by 5.5%.

The performance is attributed to the HBDHB integrated service approach across the screening pathways in working together towards a common goal of attaining the national target for Māori women and addressing inequity. Māori women have access to free cervical smear tests and support services across the district. We have been working closely with GP practices to improve participation of NCSP priority group women in screening e.g. Best Practice in Primary Care project and data-matching. In addition, we have been contacting Māori and Pacific women who have never had a cervical smear or have not had one for over five years by phone or home visits, and offering outreach smears. The uptake has been positive.

Recent population projections released by the National Screening Unit show that in the next five years (2016-2021) Hawke's Bay's NCSP eligible Māori and Pacific populations will increase by 7% and the Asian population will increase by 16%. This is a challenge our sector need to prepare for.

2. Immunisation

HBDHB ranks 3rd nationally for immunisation rates for 8 months old Māori and has remained above or very near the target of ≥ 95% with a 94.4% in Quarter 1 (Page 6).

This success is attributable to a number of factors ranging from having a champion in the executive management team; a committed, appropriate, experienced workforce; and an action plan with sound tracking and tracing processes with NIR to ensure that children are referred to outreach if needed in sufficient time to locate them. Attempts are made to contact all families with overdue children to offer immunisation and information / resources if hesitant.

Efforts will be focused on fostering collaborative relationships with all immunisation providers to promote immunisation within the community at antenatal sessions monthly and PEPE groups (first time parents) run through Plunket.

Areas of progress

1. Mental Health and Addictions

Māori under Mental Health Act compulsory treatment orders has decreased from 201.6 per 100,000 population in Quarter 4 of 2015/16 to 183.9 per 100,000 population in Q1 2016/17. There still remains a significant inequality between Māori and non-Māori of 94.2 per 100,000 population down from 104.9 per 100,000 population in Quarter 4 (Page 7).

2. Access to Care

The number of Māori enrolled in the Health Hawke's Bay PHO increased slightly by 1% from 95.6% in Quarter 4 of 2015-2016 to 96.6% in Quarter 1 in 2016-2017 and remains slightly below the expected performance target of 97% (Page 8). Currently HBDHB ranks 4th among all DHBs in the country for Māori PHO enrolments.

3. Rheumatic Fever

Acute Hospitalisation for Rheumatic Fever has decreased from 7.33 in Quarter 3 of 2015-2016 to 4.82 in Quarter 1 of 2016-2017 (6 monthly data) (Page 9).

4. Alcohol and Other Drugs

Access to services for 0-19 Year Olds within 3 weeks of referral increased by 4.2% from 66.4% in Quarter 4 of 2015-2016 to 70.6% in Quarter 1 of 2016-2017 but still below the expected target of 80%. Similarly, 0-19 Year Olds seen within 8 weeks of referral increased slightly from 91.4% to 91.7% but less than the target of 95% (Page 10).

The decreased wait times has been a focus over 2016 and is a product of collaborative work with referrer (e.g., schools, CYF) in ensuring that we provide most seamless service possible for Māori.

Areas of focus

The above achievements notwithstanding, we are challenged to put more efforts in the following areas to gain traction towards targets:

1. Ambulatory Sensitive Hospitalisations

ASH Rates in 2015/16 and presented a significant narrowing of disparity gap for 0-4 year old group between Māori and Other and HBDHB has 3rd best results for all DHBs for 0-4 year old group. However in Quarter 1 of 2016/17 they have risen 13.1% to from 78.6% in Quarter 4 to 91.7% in Quarter 1. Similarly, ASH Rates for 45-64 year old group have increased from 170% in Quarter 4 to 196.0% in Quarter 1 presenting a significant inequality between Māori and non- Māori of 87% (Page 11).

2. Breast Screening

Breast screening services for (50-69yrs) has decreased slightly from 67.9% in Quarter 4 of 2015-2016 to 67.1% in Quarter 1 of 2016-2017 and remains just below the expected target of ≥70% (Page 12).

3. Workforce Development

Staff completed cultural training is making slow progress from 77.5% in Quarter 4 to 78.8% in Q1. Medical staff (39.9%) and Support staff (63.3%) have progressed the slowest of all occupational groupings. Medical staff, despite a 25.6% increase in 2015/16, have only increased 0.3% from Quarter 4 to 39.9% in Quarter 1 (Page 13).

Māori Workforce did not grow in Quarter 1 and remained static at 12.5%; the same result noted in Quarter 4 of 2015-2016 (Page 14). Whilst the 2016-2017 annual target of 13.8% is only an additional 10% on 2015-2016 result, it remains a significant challenge.

4. Obesity

The B4SC data for Quarter 1 of 2016-2017 (6 monthly data) shows that only 18% of Māori Children with BMI in 98th percentile were referred to a health professional for nutritional advice, which is a 2% decrease from 20% reported in Quarter 3 of 2015-2016 (Page 15).

QUARTERLY PERFORMANCE AND PROGRESS UPDATE

Cancer Screening

Outcome: Achieve the National Cervical Screening Programme (NCSP) national – Target: 80% of 25-69 years

Key Performance Measures	Baseline[1]	Previous result[2]	Actual to Date[3]	Target 16-17	Trend direction
Māori	74.1%	73.2% (U)	72.7% (U)	≥80%	▼
Pacific	71.2%	71.4% (U)	74.2% (U)	≥80%	▲
Other	76.5%	77.8% (U)	78.2% (U)	≥80%	▲
Total	75.8%	76.6% (U)	76.9% (U)	≥80%	▲

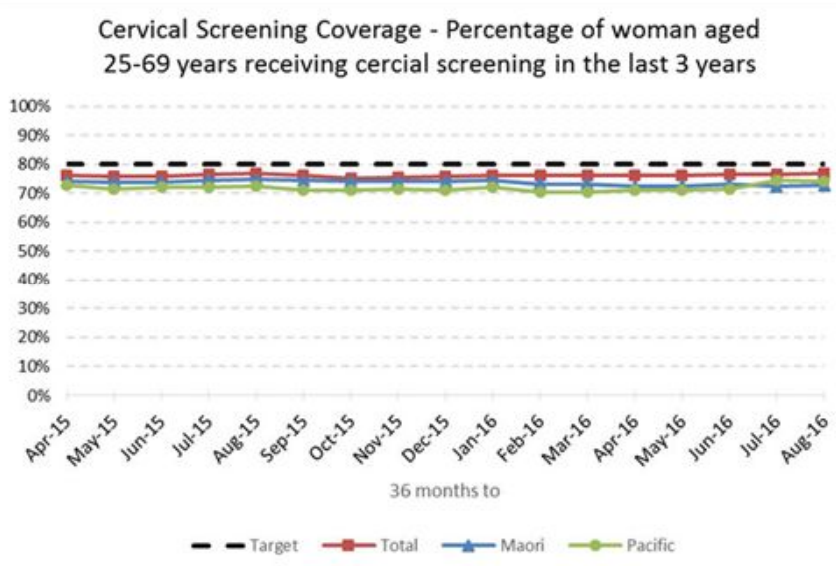
Comments:

Continuing to work with GP practices to improve participation of NCSP priority group women in screening e.g. Best Practice in Primary Care project and data-matching. In addition, contacting Māori and Pacific women who have never had a cervical smear or have not had one for over five years by phone or home visits, and offering outreach smears. The uptake has been positive.

Continuing to ensure accuracy of participant ethnicity data held on National Cervical Screening Programme Register and ethnicity data on NHI

Recent population projections released by the National Screening Unit show that in the next five years (2016-2021) Hawke's Bay's NCSP eligible Māori and Pacific populations will increase by 7% and the Asian population will increase by 16%. A challenge to the sector.

Time series



Source: National Screening Unit

13 years to December 2015

23 years to June 2015

33 years to August 2016

Increasing Immunisation

Outcome: 95% 8 month olds completing primary course of immunisation

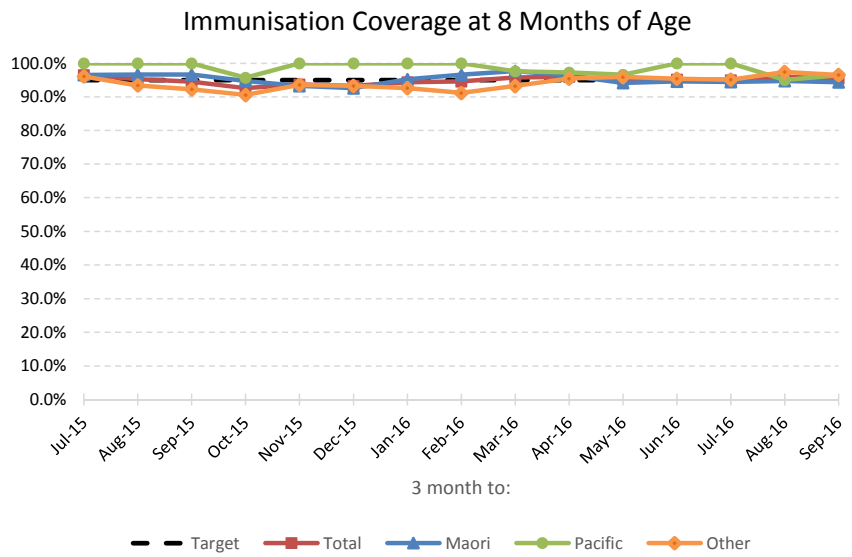
Key Performance Measures	Baseline[4]	Previous result[5]	Actual to Date[6]	Target 16-17	Trend direction
Māori	92.6%	94.6% (F)	94.4% (U)	≥95%	▼
Pacific	100.0%	100% (F)	96.4% (F)	≥95%	▼
Other	93.3%	95.4% (F)	96.5% (F)	≥95%	▲
Total	93.3%	95.2% (F)	95.4% (F)	≥95%	▲

Comments:

Implementing the Immunisation Action Plan and continuing to be systematic in our approach. Sound tracking and tracing processes in place with NIR to ensure that children are referred to outreach if needed in sufficient time to locate them. Attempts are made to contact all families with overdue children to offer immunisation and information / resources if hesitant.

Continue to foster collaborative relationships with all immunisation providers and promote immunisation within the community at antenatal sessions monthly and PEPE groups (first time parents) run through Plunket.

Time series



Source: National Immunisation Register, Ministry of Health

4 October to December 2015

5 April to June2016

6 July to September 2016

Mental Health

Outcome: Reduced rate of Māori under compulsory treatment orders to < 81.5 per 100,000 (total population)

Key Performance Measures	Baseline[7]	Previous result[8]	Actual to Date[9]	Target 15-16	Trend direction
Māori (per 100,000)	196	201.6 (U)	183.9 (U)	≤81.5	▲
Other (per 100,000)	93.4	64.5 (F)	60.1 (F)	≤81.5	▲
Total (per 100,000)	97	97.3 (U)	89.7 (U)	≤81.5	▲

Comments:

Some recent trending down for Māori CTO rates is positive but more work needed to reduce in longer term. Activity in the table below indicate moves to better understand complexities of this issue and greater connection with our communities and whānau, which is imperative. Community Mental Health vision is to have a greater Whānau Ora type approach to our treatment and service provision with a more holistic approach to needs, including social and economic factors, to support whānau aspirations for improved wellness and lifestyle. Supporting Parents Healthy Children (was COPMIA) and Pregnancy Parenting Support initiatives are examples of how and where we will be resourcing this work.

A Te Ara Whakawaiora paper was presented and discussed at MRB in August. Subsequently, the Mental Health directorate and Māori Health Services have organised a wananga that will be held in Q2 with a wide group of stakeholders to discuss the complexities of compulsory treatment orders.

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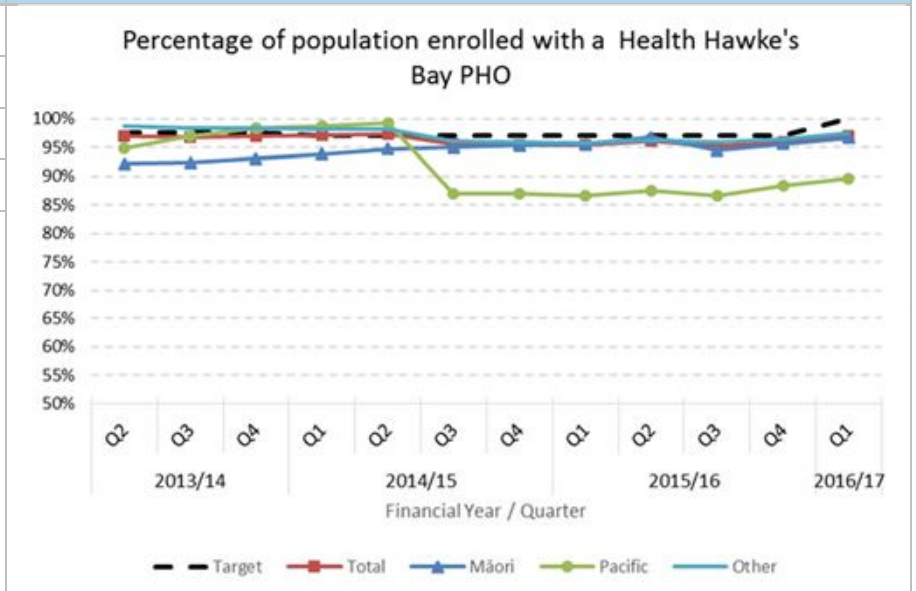
7

8*April to June 2016*

9*July to September 2016*

Access to Care						
Outcome: Increase enrolment in the PHO – Target: % of the population enrolled in the PHO						
Key Performance Measures	Baseline[10]	Previous result[11]	Actual to Date[12]	Target 16-17	Trend direction	Time series
Māori	97.2%	95.6% (U)	96.6% (U)	≥100%	▲	
Pacific	88.7%	88.4% (U)	89.6% (U)	≥100%	▲	
Other	96.5%	96.5% (U)	97.4% (U)	≥100%	▲	
Total	96.4%	95.9% (U)	96.9% (U)	≥100%	▲	
Comment:						



10 October 2015

11 April 2015

12 July 2016

Reducing Rheumatic Fever						
Outcome: Reduced incidence of first episode Rheumatic Fever						
Key Performance Measures	Baseline [13]	Previous result [14]	Actual to Date[15]	Target 16-17	Trend direction	
Māori	2.48	7.99 (U)	4.82 (U)	≤1.5	▲	**Comments:** Work continues on refreshed rheumatic fever plan
Pacific	-	-	16.47 (U)	≤1.5	*	
Total	0.6	1.87 (U)	1.86 (U)	≤1.5	▲	

10

13 July 2014 – June 2015

14 July 2015 – June 2016

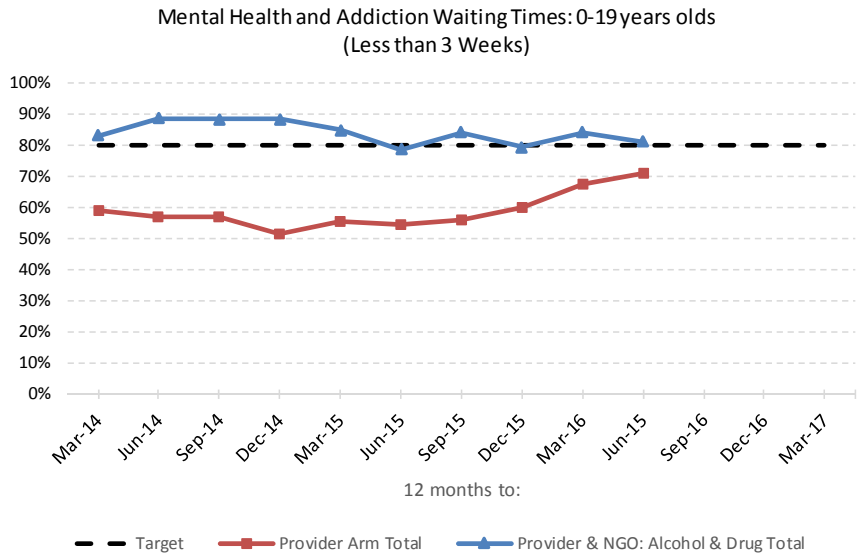
15 July 2016 – September 2016

Alcohol and Other Drugs

Outcome: % of 0-19 year olds seen within 3 weeks of referral

Key Performance Measures	Baseline[16]	Previous result[17]	Actual to Date[18]	Target 16-17	Trend direction
Mental Health Provider Arm: Seen within 3 weeks Ages 0-19					
Māori	63.2%	66.4% (U)	70.6% (U)	≥80%	▲
Pacific	75.0%	71.4% (U)	72.7% (U)	≥80%	▲
Other	56.9%	68% (U)	71.3% (U)	≥80%	▲
Total	60.1%	67.4% (U)	71.2% (U)	≥80%	▲
Decreased wait times has been a focus over 2016 and is trending positively, although there has been an increase in referrals over time.					
Provider Arm and NGO: Seen within 3 weeks Ages 0-19					
Māori	90.5%	88% (F)	81.6% (F)	≥80%	▼
Pacific	-	-	-	≥80%	*
Other	61.5%	80% (F)	80% (F)	≥80%	—
Total	84.2%	84% (F)	81.2% (F)	≥80%	▼

Time series



16 January 2015 to December 2015

17 April 2015 to March 2016

18 July 2015 to June 2016

Ambulatory Sensitive Hospitalization (ASH)

Outcome: Reduction in Ambulatory Sensitive Hospitalisation (ASH) rates in 0-4 year olds.

Key Performance Measures	Baseline [19]	Previous result[20]	Actual to Date[21]	Target 16-17	Trend direction
Māori	82.1%	78.6% (F)	91.7% (U)	≤85.3%*	▼
Other	66.1%	55.5% (U)	63.8% (U)	-	▼
Total	73.0%	69.6% (U)	80.3% (U)	-	▼

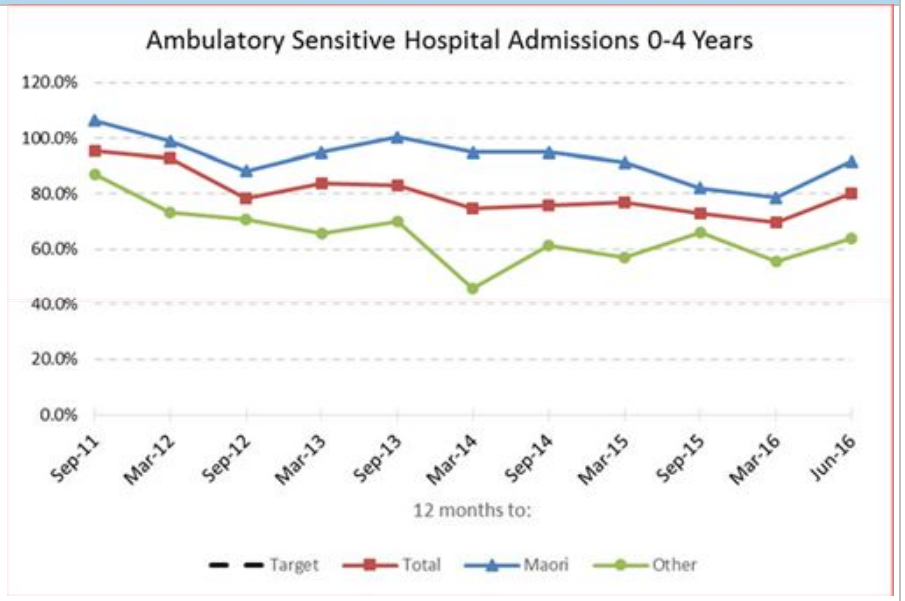
** To focus on equity the Māori target has been set at 'within 5% of the Total'*

Planning is underway to employ a Kaiawhina, as part of the HBDHB Public Health team as part of the skin programme, within local Te Kohanga Reo. This role will support the Te reo skin resources developed and rolled out into ECE and Te Kohanga reo in 2015, which focus on preventing skin infections.

The Māori health Programme manager is working with Plunket to provide a facilitation and advocacy role initiating oral health appointments and attendance by whānau who may have barriers to accessing services. WCTO services as well placed to perform this role as they have established relationships with whānau, as well as WCTO checks aligning with key oral health checks.

The HBDHB Respiratory programme has been extended to cover children, work is being planned to up skill Primary care staff around child specific respiratory conditions and pathways. Other opportunities being scoped are; development of clinical pathways; flu injections for children with respiratory conditions; looking at support post discharge for children presenting to ED with respiratory conditions. Activities focus on improving management of respiratory conditions and follow up at primary care/community level to reduce the possibility of hospital admissions.

Time series



Source: Ministry of Health

1912 months to September 2015

2012 months to September 2015

2112 months to March2016

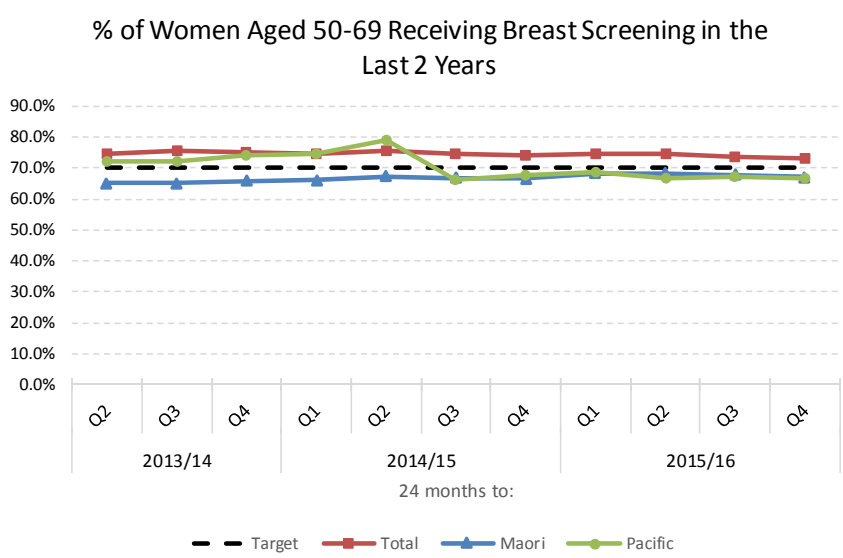
Breast Screening

Outcome: Achieve the National Breast Screen Aotearoa (BSA) national – Target: 70% of 50-69 years

Key Performance Measures	Baseline[22]	Previous result[23]	Actual to Date[24]	Target 16-17	Trend direction
Māori	68.4%	67.9% (U)	67.1% (U)	≥70%	▼
Pacific	66.5%	67.2% (U)	66.6% (U)	≥70%	▼
Other	76.0%	74.5% (F)	74.5% (F)	≥70%	—
Total	74.7%	73.4% (F)	73.2% (F)	≥70%	▼

Comments:

Time series



Source: National Screening Unit

22 24 months to December 2015

23 24 months to March 2016

24 24 months to June 2016

Māori Workforce and Cultural Competency

Outcome: All staff working in the health sector have completed an approved course of cultural responsiveness training.

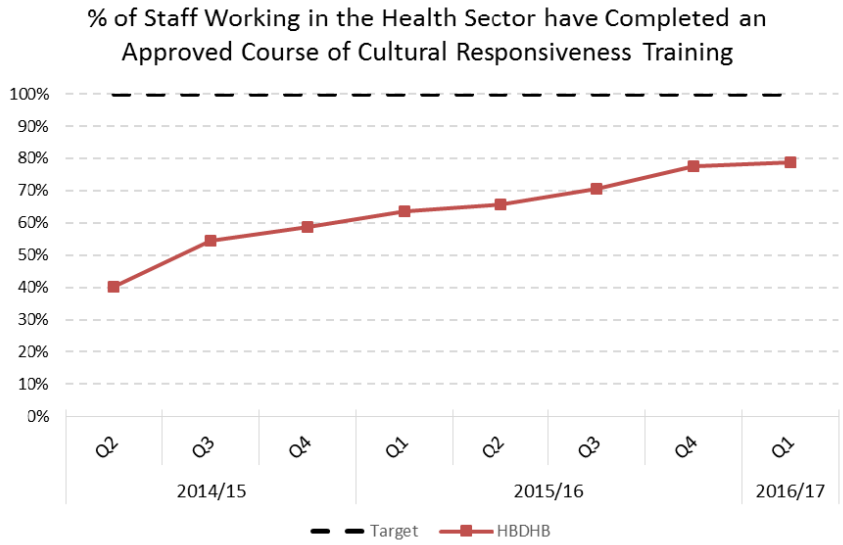
Key Performance Measures	Baseline[25]	Previous result[26]	Actual to Date[27]	Target 16-17	Trend direction
Medical	19.20%	39.6% (U)	39.9% (U)	-	▲
Management & Administration	79.10%	85.6% (U)	87% (U)	-	▲
Nursing	70.00%	81.4% (U)	82.9% (U)	-	▲
Allied Health	77.30%	85.2% (U)	86.2% (U)	-	▲
Support Staff	35.60%	60.1% (U)	63.3% (U)	-	▲
HBDHB	65.60%	77.5% (U)	78.8% (U)	≥100%	▲

Comments:

Current report shows DHB staff who have completed EEWM training or other cultural training.

Managers now have access to reports within PAL$ to monitor staff completion rates of EEWM and Treaty of Waitangi.

Time series



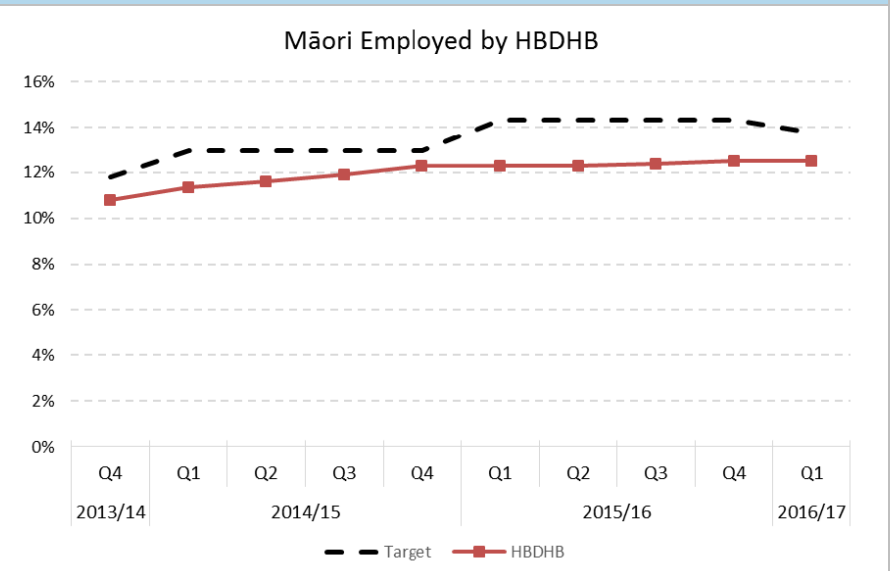
25 December 2014

26March 2016

27June 2016

Māori Workforce and Cultural Competency						
Outcome: Increased proportion of Māori employed by 10% yearly across HBDHB. Target 16/17 year 13.75%						
Key Performance Measures	Baseline[28]	Previous result[29]	Actual to Date[30]	Target 16-17	Trend Direction	Time series
Medical	2.90%	3.2% (U)	3.4% (U)	-	▲	
Management & Administration	16.50%	16% (F)	16.5% (F)	-	▲	
Nursing	10.60%	10.8% (U)	10.8% (U)	-	—	
Allied Health	12.60%	13.2% (U)	13.2% (U)	-	—	
Support Staff	28.20%	29.3% (F)	27.4% (F)	-	▼	
HBDHB	12.30%	12.5% (U)	12.5% (U)	≥13.75%	—	

Comments:
Gap to 30 September is 38 made up as follows:
30 Medical
44 Nursing
3 Allied Health
(26) Support
(13) Management and Admin



28 December 2014

29March2016

30June2016

Obesity						
Outcome: Reduce the incidence of Obesity in Hawke's Bay – Target: 95 percent of children with BMI ≥98th percentile identified in the Before School Check (B4SC) programme will be referred on for nutrition, activity and lifestyle interventions.						
Key Performance Measures	Baseline [31]	Previous result [32]	Actual to Date [33]	Target 15-16	Trend direction	Comments
Māori	30.0%	20% (U)	18% (U)	≥95%	▼	We currently do not have this data as this is a new target and the first quarter are only just completed – data checking is underway. It will come from the B4 School Check programme
Other	23.0%	21% (U)	22% (U)	≥95%	▲	
Total	27.0%	21% (U)	21% (U)	≥95%	—	

10

31 6 months to September 2015

32 6 months to March 2016

33 6 months to June 2016

COMPLEMENTARY THERAPIES POLICY

HAWKE'S BAY DISTRICT HEALTH BOARD	**Manual:**	Clinical Practice Guidelines
	Doc No:	(To be inserted)
Complementary Therapies Policy	**Date Issued:**	November 2016
	Date Reviewed:	
	Approved:	Clinical Council
	Signature:	Andy Phillips, CAHPO
	Page:	1 of 9

PURPOSE

- To ensure that complementary therapies are practiced safely on Hawke's Bay District Health Board (HBDHB) premises.
- To ensure that patients and Whanau access complementary therapies in an informed and appropriate way.
- To provide a robust framework to support practitioners to provide complementary therapies safely and appropriately.

PRINCIPLES

1. The policy applies to all complementary therapists practicing on HBDHB premises and to all patients receiving complementary therapies within HBDHB premises
2. All complementary therapists are bound by the Health and Disability Act and Code (2014)
3. The complementary therapist must have written evidence of a qualification in their area of practice recognised by the sector regulator, or the relevant professional association
4. The Manager of the HBDHB premises will be responsible for ensuring complementary therapists are current members of their relevant professional body and have up to date personal liability insurance
5. HBDHB will maintain a register of complementary therapists who meet the agreed criteria to practice on HBDHB premises
6. All complementary therapists must have the necessary knowledge or skills
7. Individual complementary therapists are responsible for - ensuring confidentiality of client information; maintaining adequate up to date indemnity insurance; ensuring a current knowledge base of treatments and their own area of therapy
8. Documentation of consent **must** be recorded by the practitioners in the client's records and stored by complementary therapists in accordance with Information Governance requirements
9. Written information on the complementary therapies must be provided to clients to help inform their decision
10. Consumers have the right to access any complementary therapists they wish
11. It is expected that complementary therapists and HBDHB staff offering conventional treatment will collaborate effectively in the treatment and care of consumers
12. HBDHB does not accept any liability for any patient harm occurring to consumers accessing complementary therapies that are not provided by a HBDHB employee.

INTRODUCTION

HBDHB recognises that there is increasing interest in the practice of complementary therapies in health care and that many patients and whanau report significant benefit. The purpose of these guidelines and protocols for specific complementary therapies is not to limit either practice or patient choice, but to ensure professional standards and high quality service.

These guidelines offer areas of good practice when a consumer decides to contract with a non-DHB employee for complementary therapy services.

In developing these guidelines HBDHB is not making any claims on the validity or evidence base of these procedures. It is the responsibility of each individual complementary therapist to ensure they discuss fully with the service user the evidence base of the proposed treatment and any potential risks.

The DHB is not yet persuaded that the evidence base is sufficiently strong to support the use of public funding to support these complementary therapies

In accordance with the above guidelines the complementary therapy:

- Must work alongside existing medical treatment without compromising existing care.
- Must be based on current evidence and best practice.
- Must be based on consultation, planning, education and demonstrable competence.
- Must comply with local policies.

The main purpose in the use of complementary therapies is to help:

- Promote relaxation.
- Reduce anxiety.
- Ease symptoms such as pain, nausea, poor sleep patterns.
- Help the patient find coping mechanisms and strategies.

SCOPE

This policy covers the following complementary therapies:

- Aromatherapy
- Reflexology
- Indian head massage
- Reiki
- Yoga
- Hypnotherapy
- Osteopathy
- Chiropractic treatment

DEFINITIONS

Complementary Therapies

Complementary therapies are used alongside orthodox treatments with the aim of providing psychological and emotional support through the relief of symptoms. The following therapies are within scope of this document:

Aromatherapy – is the use of pure essential oils generally applied in the form of massage, but can also be used in special aromatherapy diffusers. Their main use in this situation is to calm and relax the individual. Blends, usually of three different oils are chosen in conjunction with the client, which take account of their preferences and medical history.

Reflexology- Reflexology is based on the principle that certain points on the feet and hands, called reflex points, correspond to various parts of the body and that by applying pressure to these points in a systematic way, a practitioner can help to release tensions and encourage the body's natural healing processes.

Indian Head Massage - has been practiced for over a thousand years, easing tension and promoting a sense of relaxation and well-being. Other parts of the body may respond to this relaxed state. A head massage takes 30-40 minutes and covers the upper back, shoulders, neck, face, scalp, arms and hands.

Reiki - Reiki (pronounced ray-key) was developed in Japan in the early 1900's. Reiki can produce a feeling of deep relaxation, a boost in energy levels and a reduction in tension and anxiety. During a treatment a reiki practitioner lays their hands on a recipient in a series of positions over head, torso and legs.

There are different levels of reiki practitioners; level one is for people who have learnt reiki to treat themselves, or use informally with friends; level two is practitioner level, to give reiki treatments to patients; level 3 is reiki master or teacher. Practitioners should have attained level 2 as the minimum to practice in accordance with this policy.

Yoga – Is an ancient tradition of mental and physical exercises, which started in India over 5,000 years ago and is now widely practiced in NZ. There are many different styles of yoga. It includes physical exercises, breathing techniques and relaxation.

Hypnotherapy - Hypnosis describes an interaction between a therapist and client. The therapist attempts to influence perceptions, feelings, thinking and behaviour by asking the client to concentrate on ideas and images that may evoke the intended effect. Hypnotherapy can help reduce stress and anxiety, improve quality of sleep and help prepare for investigations and treatments.

Osteopathy - is a health care system of diagnosis and treatment that emphasises the relationship between structure and function in the body, and the ways it can be affected through manipulative therapy and other treatment modalities

Chiropractic Treatment – is concerned with the diagnosis and treatment of mechanical disorders of the musculoskeletal system, especially the spine, under the belief that such a disorder affects general health via the nervous system. The main chiropractic treatment technique involves manual therapy, especially manipulation of the spine, other joints, and soft tissues, but may also include exercises and health and lifestyle counselling.

Complementary and Alternative Medicines (CAM)

CAM is an 'umbrella' term used to describe a range of health systems, modalities and practices that may have little in common other than that they are practised alongside or as an alternative to mainstream medicine. There may however be similarities in philosophy and approach – for example, the need to take a holistic approach to health care, including the interactions between physical, spiritual, social and psychological aspects.

CAMs are considered to be any non-medically prescribed substances that a person uses with the belief that they will improve health or well-being. The term includes but is not limited to:

- Herbal medicines; herbalism
- Nutritional therapy (vitamins and minerals)
- Health food supplements (e.g. royal jelly)
- Colloids / cell salts
- Chinese medicine

The use of Rongoa Māori as well as Complementary and Alternative Medicines is out of scope of this policy and is covered by a separate HBDHB policy: HBDHB/IVTG/144.

ROLES AND RESPONSIBILITIES

HBDHB Management Responsibilities:

The DHB recognises that service managers have a responsibility to implement this policy and monitor/audit the use of the Complementary Therapies protocols within their area of management. These responsibilities include:

- Where appropriate, negotiating and agreeing with local complementary therapists the place of a complementary therapy as outlined in the protocols to support normal clinical activities, and ensuring where appropriate this is reflected in a written care plan.
- Final agreement prior to therapies being commenced on DHB premises. The management team will be responsible for the monitoring of any therapies practised.
- Ensuring that details held on the DHB register are up-to-date and correct. They will also maintain a list of practising complementary therapists.
- Auditing complementary therapists compliance with this policy

Complementary Therapists Responsibilities

Assessment

- The patient or carer will be assessed by individual complementary therapists at the first visit to ensure the referral is appropriate and any preferred choice of therapy is suitable
- Specific complementary therapies may have contraindications relevant to them
- Any concerns about contraindications including those arising from conventional treatment must be discussed with a HBDHB health professional closely involved in the patient's care.

Safe Practice

- The complementary therapist should provide written evidence of a qualification in their area of practice recognised by the sector regulator - or the relevant professional association
- Complementary therapists will be required to practice using guidelines based on the current evidence of best practice. Any concerns that arise during treatment should be referred to the appropriate HBDHB health professional
- All complementary therapists will be required to have indemnity insurance and be a member of an appropriate professional body
- Any complementary therapist using products and oils on patients must ensure that they have the up to date information as to whether the patients' condition would be harmed or worsened as a result of their use (for example this could be in the form of contra indicators to patients and their disease. There are many information sources available to obtain this advice).

Consent

- Complementary therapists must obtain appropriate consent
- Consent for the therapy must be obtained before the complementary therapist carries out the complementary therapy
- Documentation of consent **must** be recorded in the client's records and stored safely by the complementary therapist in accordance with Information Governance requirements
- Written information on the complementary therapies must be provided to clients to help inform their decision.

Written Information

Written information must be provided including the following;

- A description of the therapy and what that entails for the patient.
- A statement to the effect that the therapy is not an alternative to conventional therapies.
- A statement explaining that all complementary therapists have completed relevant qualifications appropriate to their practice

Record keeping

Complementary therapists will keep all records of treatments/interventions provided and these will be kept by the complementary therapist in secured storage according to information governance requirements. As part of the records information on age, sex, ethnicity and address of patient will be documented.

Training Requirements

All complementary therapists who wish to practice complementary therapies must hold a qualification in their area of practice recognised by the sector regulator - or the relevant professional association.

They must also:

- Be able to show how they keep themselves updated
- Be able to demonstrate they have personal liability insurance that would cover them for practice within the DHB Premises
- Understand and acknowledge the boundaries they have with accountability for their own practice
- Adhere to these guidelines.

REFERENCES

NICE Supportive and Palliative Care Improving Outcomes Guidance (2004)

RELATED DOCUMENTS

Complementary and Alternative Medicines - HBDHB policy - HBDHB/IVTG/144

KEYWORDS

Complementary Therapies
Aromatherapy
Reflexology
Indian head massage
Reiki
Yoga
Hypnotherapy
Osteopathy
Chiropractic treatment

For further information please contact the Chief Allied Health Professions Officer

Appendix 1

HBDHB REGISTER OF COMPLEMENTARY THERAPISTS OFFERING THERAPY AND CONSULTING WITH PATIENTS ON HBDHB PREMISES

Name	Qualifications	Therapies Offered	Professional Body	Indemnity Insurance	Review Meeting

Appendix 2

COMPLEMENTARY THERAPIST AGREEMENT TO COMPLY WITH THE POLICY

I have received, read and understood the policy and will adhere to it.

Complementary Therapist: …… Dated: ……

Centre Manager: …… Dated: ……

Appendix 3

CONSENT FORM FOR COMPLEMENTARY THERAPY

Patient Name: ……...

Date of Birth: ……

Leaflet/Literature Provided to the Patient: YES ☐ NO ☐

I sign to confirm that:

- I have received the information provided by the therapist YES ☐ NO ☐
- I have understood this information YES ☐ NO ☐
- I consent to the therapy YES ☐ NO ☐
- I have an existing medical problem and my GP consents to the therapy YES ☐ NO ☐ N/A ☐

1. Signed: ……... Date: ……
   (Patient)

   Signed: …… Date: ……
   (Complementary Therapist)

   Therapy Offered: ……..

2. Signed: ……... Date: ……
   (Patient)

   Signed: …… Date: ……
   (Complementary Therapist)

   Therapy Offered: ……..

3. Signed: ……... Date: ……
   (Patient)

   Signed: …… Date: ……
   (Complementary Therapist)

   Therapy Offered: ……..

4. Signed: ……... Date: ……
   (Patient)

   Signed: …… Date: ……
   (Complementary Therapist)

   Therapy Offered: ……..

CLINICAL ADVISORY & GOVERNANCE (CAG) COMMITTEE

12

HAWKE'S BAY District Health Board Whakawāteatia	collaborative clinical pathways **Collaborative Pathways (CP) Update**
	For the attention of: **HB Clinical Council and Consumer Council**
Document Owner: Document Author(s):	Mark Peterson, Chief Medical Officer Primary Care Leigh White, Portfolio Manager, Strategic Services
Reviewed by:	Mary Wills, Head of Strategic Services Belinda Sleight, Project Manager, Health and Social Networks
Month:	November 2016
Consideration:	For Information

RECOMMENDATION

That Clinical Council and Consumer Council:

- **Note** that 30 pathways are completed and GPs are increasing their use.
- **Note** the team continues to socialise by visiting individual practices, CME training and quarterly newsletters
- Clinical Council continues to promote the development and use of the current pathways.

EXECUTIVE SUMMARY

The primary purpose of the enclosed documents is to provide an outline of work to date.

OVERVIEW

A recommendation from Clinical Council was to focus on three key work areas in 2016/17. Three key intentions (pathway development, marketing and embedding work) have been outlined in the following documents:

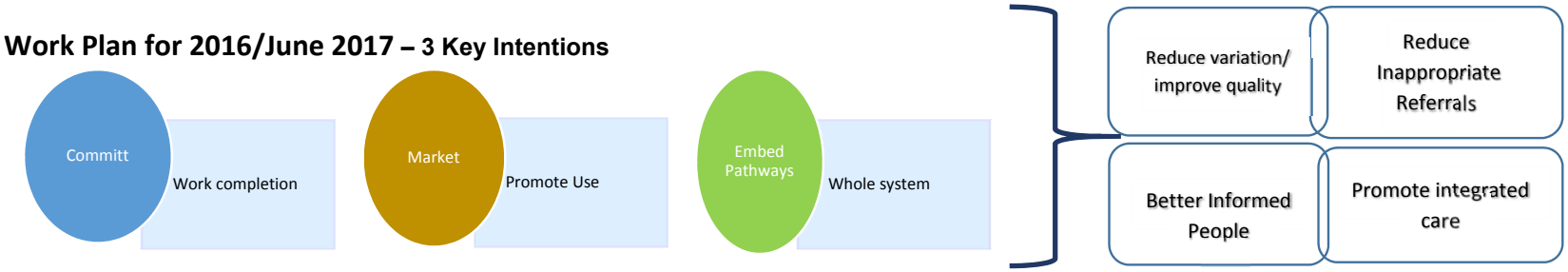
IN SUMMARY:

The new cellulitis pathway is reducing medication prescribing and administration. Last days of life pathway is leading to improvements in consistency of practice in aged residential care.

There are clear expectations of what needs to be done however there are numerous roadblocks to be able to achieve the work programme. This is despite a small committed team. Visible clinical support is still required from Clinical Council.

The team is talking with Auckland, Canterbury and MidCentral DHB to link e referrals to pathways. This doesn't seem to have been achieved elsewhere to date.

Work Plan for 2016/June 2017 – 3 Key Intentions



Activities	Task/Action	Resources
1. COMMITT Pathway development **Outcome** To complete	**Task:** **Pathway Development: (**either requested as Expression of Interest (EOI) or aligned to Annual Plan). Note: New Pathways are approved by CCP Committee prior to work commencement. Note there may be 5 pathways within one. **Action:** **Committed – in development (refer to dashboard)** **EOI - planned to commence/no date confirmed**: Toothache, Osteoarthritis Mobility Action, Falls with Fractures, Frailty, Gestational Diabetes, Midwifery Pathways, mental health Pathways. **Alignment to key National/DHB goals:** Faster Cancer Treatments – Colorectal, Breast, Prostrate, GI, Hep C. **As per Annual Plan:** • Development of Clinical Pathways for high prevalence conditions (e.g. depression, anxiety) collaboratively with NGOs, with opportunities for increased efficiency and collaborative working identified. • Develop Clinical Pathways for better collaboration between primary and secondary care • Fully implement and socialise the Diabetes Clinical Pathway across the sector by December 2016 • Standardise clinical practice and through the development of a Cellulitis Clinical Pathway by Q1 and the implementation and socialisation of the CHF Clinical Pathway by Q2	**Responsibilities** CMO LTC Portfolio Manager **Staffing** LTC Portfolio Manager CP Editors Co-Op – Clinical Leaders Health professional participation to develop Pathways **Completion Date** Review June 2017 **Monitoring** Usage – back-end monitoring Feedback IT support to monitor change **Resources** Existing budget

Activities	Task/Action	Resources
	• Implement and socialise the Clinical Pathway 'Wheeze in Preschool Children' to primary care, Breathe HB and Central Health • Agreeing Clinical Pathways for palliative care • Localise Central Region Pathways for colorectal and lung cancer by Q1. Work with the Central Region to develop Clinical Pathways for bowel and breast cancer and localise by Q4 • Complete and implement a Clinical Pathway for Primary Care Management of TIA • Complete design and Implementation of Map of Medicine Pathway for Colonoscopy and CT Colonoscopy. The Pathway will promote the use of National Referral Criteria for direct access outpatient colonoscopy and standardise the triage process for surgical and medical colonoscopy referrals • Review Clinical Pathway for Hip and Knee Pain to improve self-management and non-surgical intervention in the community and better alignment of primary and secondary care • Promote and implement the Hepatitis C Clinical Pathway	
2. MARKET. Development and Socialisation **Outcome** Usability	**Task:** **Raise profile** **Actions:** • Continue to build relationships with providers, GP Visits, Face to Face, Internet , Advertising , PHO Portal, CEO news • Remuneration for pathway participation for health professionals • Employ dedicated GP on a 4 hours (0.1 FTE) basis with specific duties. Work on Job description (include: compulsory attendance in 2 working group meetings to develop Pathway content, apply local region specifics and determine data measures for evaluation, 2-3 electronic reviews via email or teleconferences (mainly final phases), compulsory champion with their peers and wider local group, lead education session to launch the Pathway in the chosen education forum)	**Responsibilities** LTC Portfolio (0.5 FTE of current role) **Staffing** LTC Portfolio Manager CP Editors Co-Op – Clinical Leaders Health professional participation to develop Pathways Support from Strategic Services Interlink with MidCentral and Whanganui Existing staff Utilisation of the PHO Clinical Pharmacists/Facilitators

Activities	Task/Action	Resources
	• CME/CNE sessions • CME/CNE attainment recognised through MoM • Work with adopters/champions • Positive consumer stories (work with QIPS Team) • Investigate opportunities to support Pathway with regards change of prices or new innovation e.g. paying for private echoes for small group of population	PHO Medical Advisors **Completion Date** Ongoing reviews **Monitoring** Usage – back-end monitoring Feedback **Resources** Remuneration – supported in existing budget Dedicated GP – ON HOLD as per CMO decision
3 **EMBED.** Usability and availability **Outcome** Right IT Platforms to support practice	**Task:** **Socialise and integrate Clinical Pathways for use in primary care and other key providers (e.g. Aged Residential Care).** **Actions:** • Understand the Inter-relationship with Map of Medicine/Med-Tech/My Practice (IT Platforms/Vendors Business rules). • Keep abreast with funding (£.00) can be subject to exchange rate fluctuations. • Investigate the current tool. Is it responsive and easily used as this will encourage use that will therefore support best practice; workflows will be improved meaning less duplication and lost opportunities for gaining better outcomes for the person. • It is recognised that there is some work to be done in order to gain integration between e-referrals (Healthlink forms) and the practice	**Responsibilities** LTC Portfolio (0.5 FTE of current role) CMOs Head of Strategic Services **Staffing** LTC Portfolio Manager Support from IT Department **Completion Date** Recommendation by end of June 2017 **Monitoring** Feedback

Activities	Task/Action	Resources
	management system (Medtech, My Practice) in general practice. This challenge exists with other Pathway applications being used in New Zealand; however we are currently negotiating MoM's involvement in finding solutions and looking at other Vendor opportunities • Develop new QA process - Achieving benefits requires a clear understanding of what we are trying to achieve by developing Pathways, and a means of measuring this.	**Resources** No budget

Collaborative pathways - Monitoring Plan for 2016/June 2017– key: 1 + 2 + 3 = 4 1: Planning, 2: Implementing, 3: On track, 4: On track with significant issues

Activities	Narrative
1. COMMITT **Task: Pathway Development** 1 + 2 + 3 = 4	**Updates** • Refer dashboard and newsletter attached **Clinical Leadership:** • Support by CMO Primary Care (M. Peterson), D. Rodgers (PHO Medical Advisor) and D. Gardner (Rheumatologist) **Pathway Team** • Meet fortnightly – planning **Budget** • On track – see attached **New planning (not confirmed or signed off by CP Steering Group to date except** Osteoarthritis Mobility Action**)** • Toothache, Falls with Fractures, Frailty, Gestational Diabetes and Diabetes in the Elderly, Mental Health **Alignment to National/DHB goals** • MidCentral DHB is developing standard faster cancer pathways (FCT) for Whanganui, Midcentral & Hawke's Bay. This requires more work by our team to localise with clinicians for use in Hawke's Bay. We have discussed issues with MidCentral DHB to improve this. **Annual plan:** • LTC Portfolio Manager needs to be involved with System level Measures (SLM) and contributory measures so the work is aligned to outcomes • **Specific to Annual Plan**

Action wording	Section of AP	Comments
Begin development of Clinical Pathways for high prevalence conditions (e.g., depression, anxiety) collaboratively with NGOs, with opportunities for increased efficiency and collaborative working identified	PM Youth Mental Health Project	Early discussions with PHO/Mental health Services
Develop Clinical Pathways for better collaboration between primary and secondary care	PM Youth Mental Health Project	Ongoing – Inter-related with CPO
Fully implement and socialise the Diabetes Clinical Pathway across the sector by December 2016	Living Well with Diabetes	Review underway – sign off before Endocrinologist leaving

Activities	Narrative		
	Standardise Clinical Practice and through the development of a Cellulitis Clinical Pathway by Q1 and the implementation and socialisation of the CHF Clinical Pathway by Q2	ASH 45-65	Cellulitis – Implemented/Socialised CHF – need to socialise
	Implement and socialise the Clinical Pathway 'Wheeze in Preschool children' to primary care, Breathe HB and Central Health	ASH 0-4	Implemented/Socialised
	Agreeing Clinical Pathways for palliative care	Service Configuration – Palliative Care	Last Days of life – in Trial in 5 ARC Facilities. Await completion of Strategy Consultation
	Localise Central Region Pathways for colorectal and lung cancer by Q1. Work with the central region to develop Clinical Pathways for bowel and breast cancer and localise by Q4	Cancer Services	Lung/Colorectal done Breast – planning stage
	Complete and implement a Clinical Pathway for Primary Care Management of TIA	Stroke	Done
	Complete design and Implementation of Map of Medicine Pathway for Colonoscopy and CT Colonoscopy. The Pathway will promote the use of National Referral Criteria for direct access outpatient colonoscopy and standardise the triage process for surgical and medical colonoscopy referrals.	Diagnostics	No work to date
	Review clinical pathway for Hip and knee pain to improve self-management and non-surgical intervention in the community and better alignment of primary and secondary care.	Elective	Plan to review link in Mobility Action Plan
	Promote and implement the Hepatitis C Clinical Pathway	Actions to Support Delivery of Regional Priorities	Aim publish December/January

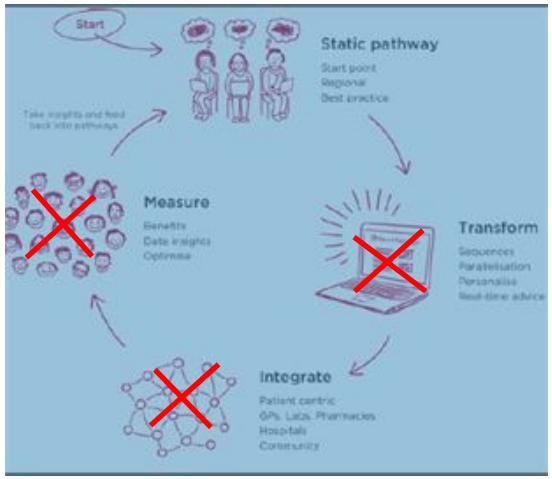
Activities	Narrative
2. MARKETING 	**Data Updates** • refer to data monitoring sets **GP interfaces** • 16/28 Practices visited to date (excludes Wairoa) – still awaiting GP Practices to confirm available visit times • communication is out there but support not a high priority against other competing workloads • **Major issue**: E-referral systems electronically needs to work both ways – this piece of work is not part of the CP work programme but has an influence to assist with change.

Month	FSA	eReferral	Total	eReferral%	Other Referral %
Sep-15	2613	1092	3705	29%	71%
Oct-15	2371	945	3316	28%	72%
Nov-15	2694	1053	3747	28%	72%
Dec-15	2442	1033	3475	30%	70%
Jan-16	2135	894	3029	30%	70%
Feb-16	2501	1172	3673	32%	68%
Mar-16	2782	1176	3958	30%	70%
Apr-16	2568	1071	3639	29%	71%
May-16	2705	1265	3970	32%	68%
Jun-16	2587	1229	3816	32%	68%
Jul-16	2360	1119	3479	32%	68%
Aug-16	2669	1411	4080	35%	65%
Total	**30427**	**13460**	**43887**	**31%**	**69%**

***Comment**: This shows that e referrals increased in August. Uptake may be higher than this as the query that collates data is being updated. Actual use could be higher.*

- Newsletter (example enclosed) – 3 monthly updates - sent via PHO Portal and direct to Practice Managers
- CME/CNE Sessions – average 30-35 attendances – predominantly attended by Practice Nurses. This is despite GPs MoPs points. There is good attendance by GPs in practice for face to face visit.

Activities	Narrative
	Secondary care • communication is out there but support is not a high priority against other competing workloads – discussion takes place about 'push back' – if referral does not meet criteria however there has been limited uptake from secondary care to look and/or change E-referral. Unsure what needs to happen? • updates via Staff News – well received with feedback at times • Involving ED – Met with Consultants with regards to Secondary Care Cellulitis Pathways – trial - when published • Easy access through Nettie **Other Providers** • Connecting with many other providers – Pharmacies, District Nurses, Cranford, Home care Services - ongoing **External to HB** • Established fortnightly teleconferences with Whanganui/MidCentral – with regards FCT relationship • Governance Meetings – quarterly • Established monthly meetings with Map of Medicine Senior Programme Consultant Challenges to get GPs to develop pathways • GPs not available despite funding for their time. Competing against direct patient time. This is not unique to HB. **Example of Consumer story**: **Consumer feedback – Thyroid Pathway** This Pathway has been interesting and timely. I am a locum Pharmacist with hypothyroidism (diagnosed 18 months ago). I found the Pathway useful and despite knowing much of the information it filled in a few gaps. I will continue to read the saved Pathways and information/links.

Activities	Task/Action
3. EMBED **Task: I**T process 1 + 2 + 3 = 4	**IT Inter-relationship and functionality** • Single sign on through MedTech system has been accomplished in Practices with Medtech/other practices can access MoM through desktop applications • Marketing issues still remain – trying to sell capacity and benefits with tools not supporting processes is very difficult. **What is our current gap** Simply defining and publishing a static Pathway does not typically lead to the reduction in variation of care and the improvements anticipated. This is generally related to the habits and practices of the clinical care providers and the systems they have available. **In the ideal world** *To make a GP's job easier:* What they want is to go through a pathway and the outcome maybe to create a referral letter, maybe radiology and laboratory requests and/or maybe an administrative tool (links in with advanced forms payments) that link – not going in/out of different IT platforms – if the system is easy to use then it will benefit the person as there will be more time to spend with them  This is where we are today

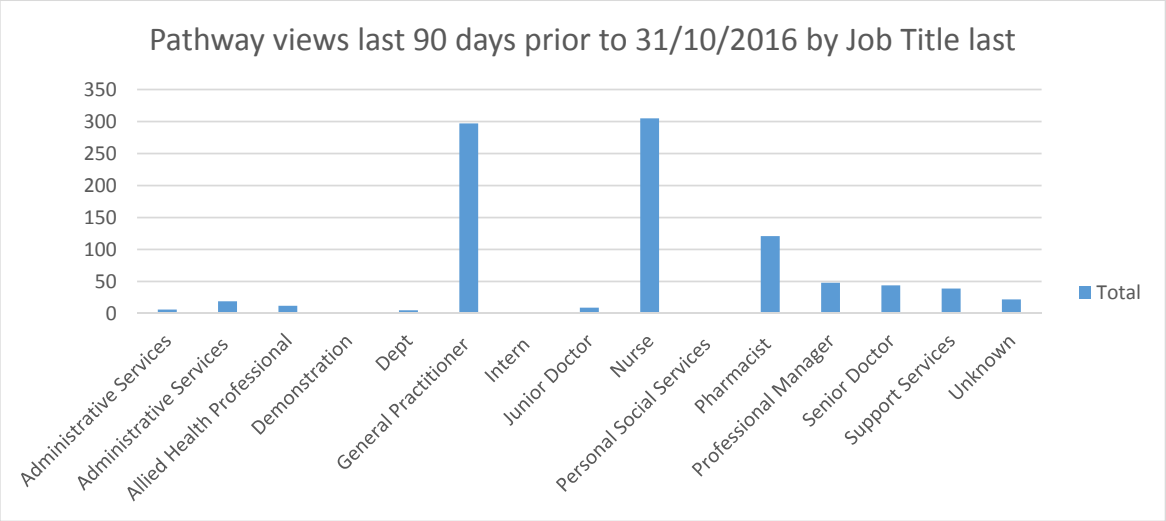
13

Activities	Task/Action
	Work to date We have been exploring other Vendor capabilities as our experience in understanding the current IT systems demonstrates that they are not provider centric, not integrated, and do not coordinate a patient-centric journey that encourages; • the sharing of information • the delivery of consistent best practice care and • the measurement of outcomes What we are asking is: **a full person's journey (person-centred) mapped, and where the user has the ability to access differing processes within one central (application) point.** **More work is required before presenting to EMT and Clinical Council – but below is a snapshot to date of Vendors** **1. Map of Medicine** o robust tool but static o formats – flowchart o rigid QA processes e.g. links to NICE Guidelines o does not interface with referral systems and/or administrative process o does not link to the person patient management system **2. Health pathways (3D)** o static tool that needs localising o content appears to be mostly derived from practice-based knowledge, although senior clinicians provide an over-viewing function and content reflects New Zealand guidelines o formats – narrative o does not link to the person event o secondary users perceive can be overly focused on primary care, perceiving that an appreciation of the whole patient journey was lost and leaving little functionality for hospital-based staff **3. Pathway Navigator Limited - Next** o new developers o pathways are dynamic and linked to the person (they deliver transformed versions of existing static pathways) o travels the person journey – can link to the person event (PMS) **MORE WORK TO DO……**

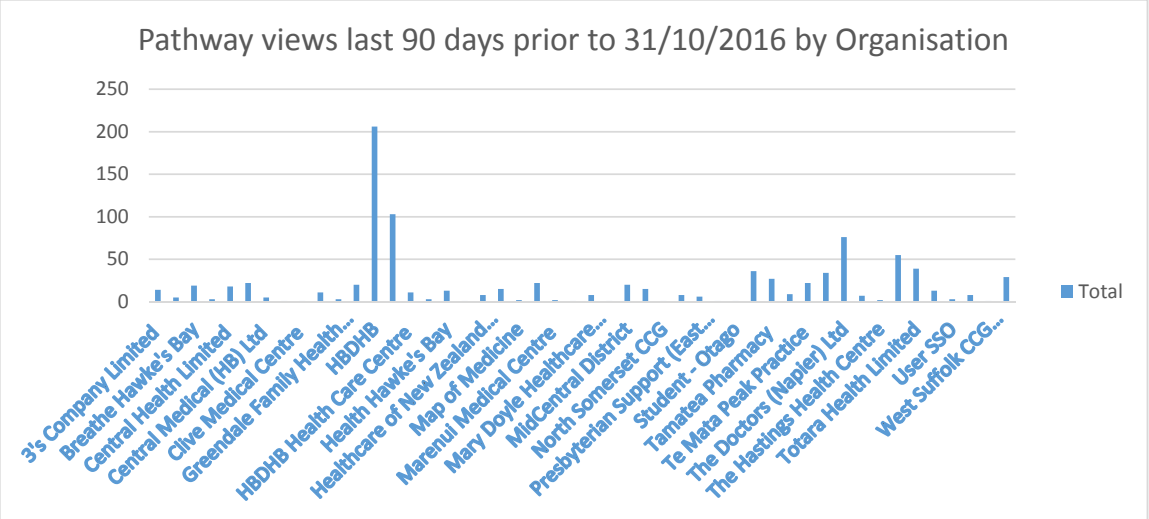
Collaborative Pathway		Budget 16/17	Spend to date
	Internal Costs	Programme Costs	Programme Costs
Leadership and Management			
Clinical Pathways Project Lead	1.0 FTE		Internal costs
Internal Staff Support & Other Costs		6,500	9,962
GP Champion (0.1 FTE) (Outsourced)			
Project Support Costs		5,000	0
		11,500	**0**
Maintenance			
Editing (0.2 FTE)		26,991	6,667
Editing (outsourced)		38,400	0
External Facilitator/Editor (Fee for Service)		8,000	1,328
Ongoing Training		3,500	
		76,891	**7,995**
Infrastructure			
Map of Medicine Licence Fees		60,000	19,733
Publishing Fees		26,250	5,037
Map of Medicine Annual Fee	Publishing & Support		2,671
Software changes (Med Tech/My practice)		45,000	
		131,250	**27,443**
Clinical Engagement			
Pharmacy, Allied Health, ARC	MDT		
Hospital Staff			
Facilitation & Catering		**5,000**	**156**
Venue Hire	Hosp or Community		
Education and Socialisation		5,000	330
		10,000	**330**
Innovation			
Redesign, service development*		100000 - **ON HOLD**	0
		0	**0**
TOTAL		**229,641**	**45,883**

13

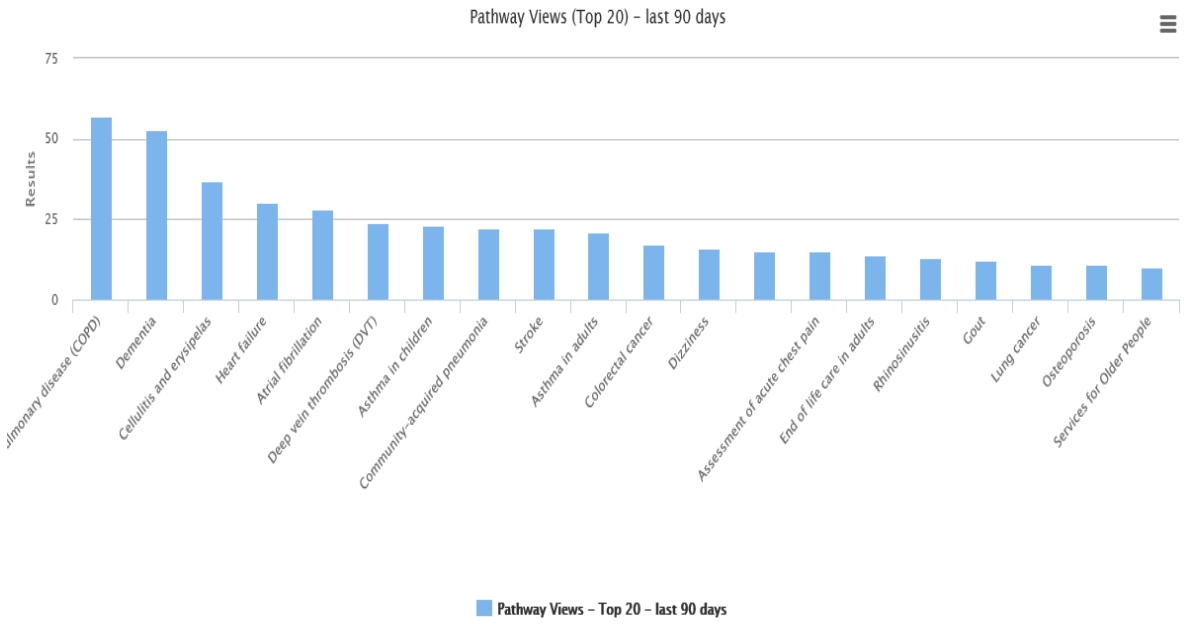
Data



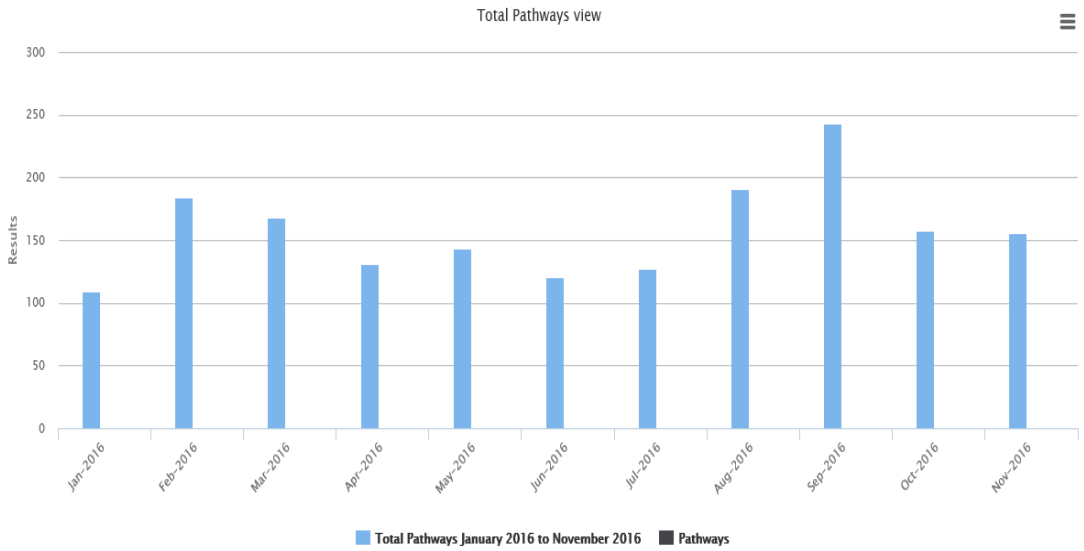
Graph1: General Practice are the higher users of MoM – this is predictable – work to be done marketing in Hospital Services



Graph 2: Please note: External users are also able to access our local Maps - once published are on the international scene!



Graph 3: This data reflects practice delivery – COPD access is encouraged by CNS working in this field to all workforces and the good work of the Dr E. Plesner who will refer back referrals that are in complete and denotes in the letter back to refer to dementia pathway



Graph 4: Pleasing to see the increase in usage over August/ September months as this is when the CP team commenced socialisation (visits to GP practices) to market the product.

Dashboard: **Collaborative Clinical Pathways progress –** **Updated November 2016**

Pathway e.g. 1:4 – 4 pathways under one heading e.g. c/date: commencement date e.g. p/date: published date	**Shaded denotes progress to date:** 1: In developmental phases 2: Published and advertised 3: Socialised (circulated and advertised and/or educated) 4. Review	**Clinical Leads**	**Measure of success**	**Estimated costs (non inclusive of Publishing) (-) number of sessions *Shared Publish costs **Stand-alone Publish costs**
OVERALL SUMMARY				
1 + 2 + 3 = 4	In developmental phases	4 Pathways curently under development		
1 + 2 + 3 = 4	Published and advertised	**30** Pathways have been developed, published and advertised		
1 + 2 + 3 = 4	Published/advertised and CME and or specific group sessions held	Out of the **30** Pathways published and advertised **19** Pathways have been presented at a CME/CNE session or dedicated education session		
1 + 2 + 3 = 4	Review since published	Out of the 30 Pathways published and advertised **7** have had a review		
Cortisone C/date:11/2016	1 + 2 + 3 = 4	A. West M. Peterson D. Rogers	Redesign Processess	
Eczema in Children C/date:11/2016	1 + 2 + 3 = 4	A. Craig D. Wales	Support change of practice	?
Breast C/date:11/2016	1 + 2 + 3 = 4		Align to Faster Cancer Streams	*Central Region
Hepatitis C/date:1o/2016	1 + 2 + 3 = 4	A. Burns D. Rogers M. Peterson	Algin with national changes	*Central Region
Rehydration C/date:1o/2016	1 + 2 + 3 = 4	B. Wright	Algin with CPO	$600 (2)
Last Days of Life 1:1 C/date:06/2016	1 + 2 + 3 = 4	L. Twigley M. Peterson	Support new practice	* ?
Colorectal 1:4 C/date:05/2016	1 + 2 + 3 = 4	T. Boswell D. Rogers	Align to Faster Cancer Streams	*Central Region $900 (3) to date
Lung Cancer 1:1 C/date:03/2016 P/date: 05/2016	1 + 2 + 3 = 4	L. King	Align to Faster Cancer Streams	*Central Region $360 (3) to date
Community Acquired Pneumonia C/date:03/2016	1 + 2 + 3 = 4	J. Curtis D. Smith	Reduce ASH CPO Focus Standardised prescibing	* $1656 (3) to date
Cellulitis (CPO) C/date:03/2016	1 + 2 + 3 = 4	A Burns A Wright	Reduce ASH CPO Focus Change of prescibing	* $900 to date
Primary Care Management of Acute TIA 1:1 C/date:06/2016 P/date: 06/2016	1 + 2 + 3 = 4	C. Providence D. Rogers	Standardised referral Access to Diagnostics Standardised practice Alert for Thyrombolis	* $1800 (5) to date

Pathway e.g. 1:4 – 4 pathways under one heading e.g. c/date: commencement date e.g. p/date: published date	**Shaded denotes progress to date:** 1: In developmental phases 2: Published and advertised 3: Socialised (circulated and advertised and/or educated) 4. Review	**Clinical Leads**	**Measure of success**	**Estimated costs (non inclusive of Publishing) (-) number of sessions *Shared Publish costs **Stand-alone Publish costs**
Diabetes with focus on ARC – **ON HOLD**	1 + 2 + 3 = 4	T. Speeding D. Vicary	Align with ARC Guidleines currently for review	* Nil
Vertigo 1: 1 C/date:11/2015 P/date: 05/2016	1 + 2 + 3 = 4	P. Mason A. Wright	Reduced FSA Use of Physio	** $2750 (5)
Congestive Heart Failure 1:4 C/date:11/2015 P/date: 06/2016	1 + 2 + 3 = 4	K. Dyson GP The DDs	Standardised prescibing	*$1760 (4 sesions
Diabetic Foot Ulcer 1:1 C/date:11/2015 P/date: 05/2016	1 + 2 + 3 = 4	Healthy Feet Podiatrist	Align with new Podiatry Contract	*
Obstructive Sleep Assessment 1:1 C/date:11/2015 P/date: 01/2016	1 + 2 + 3 = 4	DHB Sleep Scientist	Support Respiratory Service Criteria Access	** $560 (4)
Thyroid C/date:11/2015 P/date: TBC	1 + 2 + 3 = 4	R. Leikis N. Smuts	Reduced FSA Reduce F/Up OPD	** $2680 (4)
PVD Lower Limb 1:1 C/date:11/2015	1 + 2 + 3 = 4	NP: Fiona	Timeliness of referals to right place	** $1760 (4)
Urinary Incontinence 1:4 C/date:02/2016 P/date: TBC	1 + 2 + 3 = 4	L. Fergus N. Smuts	Standardised referral criteria to Incontinenance Service	* $2680 (4)
DVT 1:1 C/date:09/2015 P/date: 01/2016	1 + 2 + 3 = 4	A. Wright S. Payne	Reduced ED assessments Reduced Diagnositic access Medication Prescribing	* $1200 (4)
Services for Older Person C/date:09/2015 P/date: 12/2015	1 + 2 + 3 = 4	L. White M. Peterson	Cental access (Multi-Disciplianry) to support Engage Process – outcome of UCA Proesses	** Nil
Asthma **Adults:** 1:2 C/date:08/2015 P/date: 01/2016 **Children**: 1:3 C/date:08/2015 P/date: 01/2016	1 + 2 + 3 = 4	Paeds: N. Dunphy Adult: S. Ward	Child and Adults Reduced admissions Length of Stay Medication Prescribing	* $3170 (4) To date
Osteoporosis 1:1 C/date:08/2015 P/date: 01/2016	1 + 2 + 3 = 4	D. Gardner	Presented at Grand Round DEXA Medication Management	* $2760 (4)

13

Pathway e.g. 1:4 – 4 pathways under one heading e.g. c/date: commencement date e.g. p/date: published date	**Shaded denotes progress to date:** 1: In developmental phases 2: Published and advertised 3: Socialised (circulated and advertised and/or educated) 4. Review	**Clinical Leads**	**Measure of success**	**Estimated costs (non inclusive of Publishing) (-) number of sessions *Shared Publish costs **Stand-alone Publish costs**
Atrial Fibrillation 1:1 C/date:08/2015 P/date: 12/2015	1 + 2 + 3 = 4	K. Dyson	Reduced admissions Length of Stay	* $1870 (4)
Assessment of Chest Pain 1:1 C/date:08/2015 P/date: 11/2015	1 + 2 + 3 = 4	K. Dyson	Reduced admissions Length of Stay	* $1870 (4)
COPD 1:3 C/date:07/2015 P/date: 01/2016	1 + 2 + 3 = 4	S. Ward Breathe HB	Reduced admissions Reduce Length of Stay Reduced Spirometry Supporting Pracice – interface with GASP	* ?
Gout 1:1 C/date:07/2015 P/date: 12/2015	1 + 2 + 3 = 4		High number of Māori CME sessioin booked	** ?
Smoking cessation 1:1 C/date:07/2015 P/date: 10/2015	1 + 2 + 3 = 4	K. Moriatry	Links with multiple pathways	*?
Rhinosinusitis 1:1 C/date:07/2015 P/date: ?/2015	1 + 2 + 3 = 4		TAS Link Standardised Practice	**?
Dementia 1:2 C/date:07/2015 P/date: 07/2015	1 + 2 + 3 = 4	E. Plesner Dr Cullen	Advanced Form CME session planned (05/16) – Capacity Assessment	*?
Diabetes 1:8 C/date:? P/date: 11/2014	1 + 2 + 3 = 4		Organised for Review (April)	*?
Osteoarthritic Hip/Knee 1:2 C/date:? P/date: 09/2014	1 + 2 + 3 = 4		On hold – changes with Orthopaedic Service – Redesign	*?
Skin Lesions 1:1 C/date:? P/date: 01/2015	1 + 2 + 3 = 4		On hold – Impact on Elective Services	*?
Melanoma 1: 1 C/date:? P/date: 09/2014	1 + 2 + 3 = 4		On hold – Impact on Elective Services	*?

Hawke's Bay Collaborative Pathways Update November2016

Published November

- **Gout** – review
  - Thanks to Dr Gardner and Dr Rogers for review of this pathway – no changes
- **Rehydration**
  - Thanks to Dr A. Wright

Education - Colorectal pathways

Thanks to Tom Boswell for taking the time out to connect with Hastings Health Centre GPs and for Dr Louise Haywood for organising.

We had feedback

Map of Medicine is too "clunky" so don't use

We like E-referrals but let's get them right to meet our local requirements and align to the Maps

Answers

Conversations are what count – having both parties in the room so open dialogue can occur is a great bonus.

We are reviewing the E-referrals – with our IT Department

Published Pathways (update June 2016)

- Atrial Fibrillation
- Assessment of Acute Chest Pain
- Asthma in Adults (Acute/Chronic)
- Asthma in Children (Wheeze in Preschool, Acute (1-15 yrs.), Chronic 5-15 yrs.)
- Cellulitis (Primary Care)
- Community Acquired Pneumonia
- Colorectal (Suspected, Iron Deficiency Anaemia, Altered bowel Habits, Rectal Bleeding & Surveillance)
- COPD (Suspected, Stable, Management of Acute)
- Dementia (Assessment ,Uncomplicated)
- Diabetes – (Type 1,2, Foot Ulcer)
- DVT (Lower Limb)
- Gout
- Heart Failure (Suspected, Management in Primary Care)

Quick questions – I have been told

It can take up to 6 years for changes to be truly embedded – Is this right???

I am hoping not??

Nearing readiness for Publication: December/January

- **Hep C** (this has been a national development to localise and we have delayed this pathway due to a number of reasons – getting it right for us in HB!)
- **Eczema in Children –** a dynamic group led by Dr A. Craig (Paediatrician) and GP Dr D. Wales – collaboratively having the discussions on the skin care that is required!
- **Breast –** this is being led by our external facilitator based in Mid-central
- **Cortisone** (demand is exceeding provision of service – yes there will be some changes – we have Dr Peterson and Dr Rogers working with our Andrew West to pave a new direction – watch the space!)

Circulating pathways for consultation to wider networks is the way to go

We recently circulated the Hepatitis C Pathway and now have put a stop until we include our public Health Unit referral processes – this shows to our small team that circulating pathways for consultation to wider networks is a must – whole sector approach is what we want – Thanks to the Public health Unit

Published Pathways (update June 2016)

- Lung Cancer (Suspected)
- Obstructive Sleep Disorder (Suspected)
- Osteoporosis
- Last Days of Life
- Lung cancer (Suspected)
- Melanoma (Suspected)
- Osteroarthritic Hip
- Osteroartic Knee
- Osteoporosis and Fracture Prevention
- PVD
- Rhinosinusitis
- Services for Older people
- Skin Lesions
- Smoking Cessation ABCD
- Stroke and Transient Ischaemic Attack (Primary Care)
- Abnormal Thyroid
- Vertigo Assessment and Management

Contact the Team

mapofmedicine@hawkesbaydhb.govt.nz

OURHEALTH
HAWKE'S BAY
Whakawateatia

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

That the public now be excluded from the following parts of the meeting, namely:

14

15. Minutes of Previous Meeting (Public Excluded)

16. Matters Arising – Review of Actions (Public Excluded)

17. Member Topics of Interest

The general subject of the matter to be considered while the public is excluded, the reason for passing this resolution in relation to the matter and the specific grounds under Clause 32(a) of the New Zealand Public Health and Disability Act 2000 for the passing of this resolution are as follows:

- Official Information Act 1982 9(2)(ba) to protect information which is subject to an obligation of confidence.
- Official Information Act 1982 9(g)(i) to maintain the effective conduct of public affairs through the free and frank expression of opinions between the organisation, board and officers of the Minister of the Crown.
- NZPHD Act 2000, schedule 3, clause 32(a), that the public conduct of the whole or relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i) of the Official Information Act 1982).