Hawke's Bay Health
Consumer Council Meeting

Date: **Thursday, 11 February 2016**

Meeting: **4.00pm to 6.00pm**

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

Council Members:

Graeme Norton (Chair)
Rosemary Marriott
Heather Robertson
Terry Kingston
Tessa Robin
Leona Karauria
Jim Morunga
Nicki Lishman
Jenny Peters
Olive Tanielu
Jim Henry
Malcolm Dixon
Rachel Ritchie
Sarah de la Haye

Apology:

In attendance:

Dr Kevin Snee, Chief Executive Officer
Kate Coley, Director Quality Improvement & Patient Safety (DQIPS)
Tracy Fricker, Council Administrator and PA to DQIPS
Jeanette Rendle, Consumer Engagement Manager
Ken Foote, Company Secretary
Nicola Ehau, Head of Health Services for Health Hawke's Bay Ltd
Debs Higgins, Clinical Council Representative

HB Health Consumer Council
Agenda

Item	Section 1 – Routine	Time (pm)
1.	Karakia Timatanga (Opening) / Reflection	**4.00**
2.	Apologies	
3.	Interests Register	
4.	Minutes of Previous Meeting	
5.	Matters Arising - Review Actions	
6.	Workplan	
7.	Chair's Update	
	Section 2 – For Discussion	
8.	Health Literacy Strategic Review - Quigley & Watts	**4.10**
9.	Alcohol Strategy Update (verbal) - Rachel Eyre	**4.40**
10.	Health and Social Care Networks - Liz Stockley	**5.00**
11.	Consumers Stories: Consumer Council Future Requirements - Kate Coley	**5.15**
12.	Consumer Engagement – Key Principles - Kate and Jeanette	**5.25**
	Section 3 – For Information	
13.	Health One Video - Graeme Norton	**5.40**
14.	Older Persons Panel - Graeme Norton	**5.50**
15.	Te Ara Whakawaiora / Access - No Presenter	
	Section 4 – General Business	
16.	Topics of Interest - Member Issues / Updates -incl Jeanette re Health Literacy	
17.	Karakia Whakamutunga (Closing)	**6.00**

NEXT MEETING Thursday 10 March 2016, commencing at 4.00pm
Te Waiora (Boardroom), HBDHB Corporate Administration Building

Tauwhiro Rāranga te tira He kauanuanu Ākina

Interest Register

Hawke's Bay Health Consumer Council

Dec-15

Name Consumer Council Member	Interest eg Organisation / Close Family Member	Nature of Interest eg Role / Relationship	Core Business Key Activity of Interest	Conflict of Interest Yes / No	If Yes, Nature of Conflict: - Real, potential, perceived - Pecuniary / Personal - Describe relationship of Interest to
Graeme Norton	3R Group Limited	Director/Shareholder	Product Stewardship	No	
	NZ Sustainable Business Council	Deputy Chair	Sustainable Development	No	
	HB Diabetes Leadership Team	Chair	Leadership group working to improve outcomes for people in HB with diabetes	No	Group is sponsored by HBDHB
	NZ Life Cycle Management Centre	Chair, Advisory Group	Advancing life cycle management thinking across NZ	No	
Rosemary Marriott	YMCA of Hawke's Bay	President	Youth Including health issues	No	
Heather Robertson	Restraints Committee of DHB	Committee Member	Representing Consumers on this Committee	No	
Terry Kingston	Central Hawke's Bay District Council	Elected Member	Local body	No	Will declare any perceived interests as they arise.
	Interest in all health matters, in particular - Mental Health, Youth, Rural and Transport.				
Tessa Robin	Te Kupenga Hauora - Ahuriri	Finance and Quality Manager	Responsible for overseeing QMS for organisation and financial accountability	No	Potential - Employer holds contracts with HBDHB
Leonna Karauria	NZ Maori Internet Society	Chairperson	Advocacy on Maori Communities	No	
	Computers in Homes HB Steering Committee	Member and Regional Co-ordinator	ICT Project Management through schools and communities	No	
	Computers in Homes, Wairoa Steering Committee	Member and Regional Co-ordinator	ICT Project Management through homes and communities	No	
	Maori Party Wairoa Branch	Chairperson	Supporting Policies at a local level	No	
	Simplistic Advanced Solutions Ltd	Director/Owner	Information Communications Technology services.	Yes	If contracted for service, there could be a perceived conflict of interest.
	Hastings District Council Digital Enablement Focus Group	Member	Advisory for digital literacy and internet access initiatives for communities	No	
	Wairoa Wireless Communications Ltd	Director/Owner	Wireless Internet Service Provider	Yes	Approached in early 2014 by HBDHB and contracted for service to provide wireless internet service to Wairoa Rural Health Learning Centre and Hallwright House. Could be a perceived conflict of interest.
Nicki Lishman	Employee of Ministry of Social Development	Regional Health Advisor	Liaising with health community and supporting Work and Income Staff.	Yes	Could be perceived/potential eg., situation where gaps identified regarding funding.
	Registered Social Worker, member of ANZASW	Professional body	Social work	No	
Jenny Peters	Nil				
Olive Tanielu	HB District Health Board	Employee	Work with Pacific Island children and families in hospital and in the community	Yes	Perceived/potential conflict between employee HBDHB and roles of Consumer
Jim Morunga	Nil				
Malcolm Dixon	Hastings District Councillor	Elected Councillor		No	
	Sport Hawke's Bay	Board of Trustees	Non paid role	No	
James Henry	Health Hawke's Bay Ltd	Facilitator	Part-time role. Improving lifestyles for people with chronic illness.	No	
Rachel Ritchie	Put the Patient First	Involved when group was active	Advocating for Diabetes Patients	Unsure	Real / potential / Perceived
Sarah de la Haye	TBC				

MINUTES OF THE HAWKE'S BAY HEALTH CONSUMER COUNCIL MEETING HELD IN THE TE WAIORA MEETING ROOM, HBDHB CORPORATE OFFICE ON 10 DECEMBER 2015 AT 4.00PM

PUBLIC

Present: Graeme Norton (Chair)
Heather Robertson
James Henry
Donna Pollard (last meeting)
Nicki Lishman
Rosemary Marriott
Malcolm Dixon
Tessa Robin
Olive Tanielu
Jenny Peters
Sarah de la Haye
Jim Morunga
Rachel Ritchie
Terry Kingston
Leona Karauria

In Attendance: Ken Foote, Company Secretary
Kevin Snee, Chief Executive Officer
Nicola Ehau, Head of Health Services for Health Hawke's Bay Ltd
Jeanette Rendle, Consumer Engagement Manager
Kate Coley, Director Quality Improvement Patient Safety - late

Tessa Robin opened the meeting with a Karakia

WELCOME, APOLOGIES

Graeme Norton extended a warm welcome to members and those in attendance and advised of slight change of agenda.

INTERESTS REGISTER
Reminder of the purpose of the interest register discussed – to make transparent conflicts of interest.

Action
- **Sarah de la Haye to provide detail in due course to Brenda Crene**
- **Nicki Lishman to email her interest register change through also.**

PREVIOUS MINUTES
The minutes of the HB Health Consumer Council meeting held 12 November 2015, were confirmed as a correct record of the meetings.

MATTERS ARISING, ACTIONS AND WORKPLAN
Item 1: Remove. Take up with Leona
Items 2 – 6 had been actioned or were included on the meeting agenda.

CHAIR'S UPDATE

- The Chair advised he attended HealthOne presentation – a shared health record IT platform developed in conjunction with Canterbury Health Sector post Canterbury earthquakes. There is opportunity for other DHB's to come on board from 2017 onwards.

  Action: Hard copy information on Health One was requested. Graeme Norton to edit slide show and distribute

- The Chair advised he met with Caroline McElnay and Shari Tidswell regarding the Population Health team working more closely and more effectively with consumers. The Chair agreed to the actions out of the obesity strategy starting approximately February 2016. They will use alcohol related issues as the first big piece of work /platform for real consumer engagement/co-design.

- The Chair advised of the engAGE launch; a service developed to enable elderly to live longer in the community and one that feels patient and whanau centred. In 2016, the engAGE team will engage with consumer council.

  Malcolm Dixon raised for awareness the issue with elderly taking on boarders to make ends meet and the resultant problems because of this. He advised the Hastings District Council were working on this.

- The Chair advised Jeanette Rendle will look at recruitment of two new consumer council members in the New Year – one to represent youth and another as a replacement for Donna Pollard.

Rosemary Marriott acknowledged The Chairs leadership award at the HB Health Sector Awards held in November.

FOR DISCUSSION/DECISION

Go Well Travel Plan

Council members had previously received presentation and discussed purpose of the Go Well Travel Plan. The Chair and Andrea Beattie introduced the findings and recommendations of the Go Well Travel Plan, advising it had been passed by Clinical Council 9 December 2015 with endorsement to introduce a $1.00 parking charge from 1 February 2017.

Key messages from Consumer members follow:

- Majority felt $1.00 charge fair enough, one voiced concern that it would be a barrier for low income families
- Similar situation to EIT. Their complaints have reduced since paid parking introduced
- Requested one cost for all, no dispensation for staff on minimum wage
- Work happening in primary care may reduce the numbers coming into Villa 6 and therefore the pressure on parking
- Concern for those that travel from rural areas

Andrea Beattie advised in response to some concerns:

- Purpose to change the mode of travel for staff primarily
- Not just a parking plan, but a travel plan; other initiatives ie: bus routes, free transport services will also be introduced
- Cost of parking is to self-fund the whole plan
- Dispensations will be made for those that travel great distances

RECOMMENDATION

The Chair recommended the Go Well Travel Plan is endorsed and Council members agreed to do so.

Specifically to recommend that the Board approve:

- The business case to implement the "Go Well" Travel Plan (Option 3) from 1 July 2016.
- Implementation of parking charges from 1 February 2017 to sustainably fund the Travel Plan.
- 2016/17 capital and operational budgets as set out in the business case.

Adopted

Bilingual Signage

Council members previously received Bilingual signage for information only with an opportunity to provide first impressions and feedback via email. Sharon Mason and Andrea Beattie introduced the presentation, provided a summary of feedback received, presented a new proposal and sought agreement and endorsement of principals.

Kevin Snee reiterated rationale is not just about direction. It is about culture change, preservation of the Maori language, self-esteem and impact on equalities.

RECOMMENDATION

The Consumer Council members endorsed the principals of bilingual signage as presented and asked to have "partnership" included in the rationale.

Adopted

Urgent Care Year End Report

The Chair introduced Job Amos and advised Year End Report approved by Clinical Council 9 December and were seeking feedback from council members.

Key messages from Consumer members follow:

- Concern around the semantics of the "Choose Well" branding was raised; placing the onus on the consumer to make a good decision. How might this be perceived?
- Easy to read report with good points
- Questions about what else is being done besides the website

Consumer Story

Kate Coley told the story of a family's experience in the Emergency Department as a reminder to communicate with families in partnership with patient and how introductions and taking the time to talk makes a real difference to the patient experience and therefore health outcomes of patients.

Quality Accounts

Kate Coley introduced the Quality Accounts seeking feedback.

Key messages from Consumer members below:

- The Quality Accounts are positive but perhaps too long. Too many words.
- Icons and quick statistical information is easy to read
- Feedback from one that they may be too positive; and to tell things "like they are" means reporting on the negative.
- There were questions around suitability and meaningfulness of title
- Please remove section about 17 people on the waiting list. This is a sensitive topic and could be inflammatory to those members of our community who have been declined going on the waiting list.
- The Quality Accounts is communicated to the community as "services". In the future consider separating into items of interest to different ages and stages in the community.

Consumer Engagement Principles

Kate Coley introduced the Draft Consumer Engagement Principles as a first reading seeking input into:

- Draft statement / principles
- Appendix 1 / Framework
- Recommendations for papers coming to council (appendix 2)

Action: **Kate to send out documentation with timeframe for feedback. Consumer Council members invited to feedback prior to February 2016 meeting at which the principles will be signed off and distributed.**

GENERAL BUSINESS

The Chair provided his thanks for the contribution Donna Pollard has made to Consumer Council and Maternity Services in particular and wished Donna and her family all the best as they relocate to the South Island.

Graeme Norton closed the meeting with a Karakia Whakamutunga at 6.00pm.

Confirmed: _____
Chair

Date: _____

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HAWKE'S BAY HEALTH CONSUMER COUNCIL

Matters Arising
Reviews of Actions

Action	Date Issue first Entered	Action to be Taken	By Whom	By When	Status
1	10/12/15	Hard copy information on Health One was requested. Slide show to be distributed.	Chair		
2	10/12/15	Consumer Engagement principles and framework - Consumer Council members invited to feedback prior to February 2016 meeting. Principles will be signed off for further discussion at other governance committees.	K Coley	Dec	Actioned – awaiting feedback

HAWKE'S BAY HEALTH CONSUMER COUNCIL
WORK PLAN 2016

Meeting Dates 2016	Papers and Topics	Lead(s)
11 Feb	Consumer Story future requirements Consumer Engagement Principles Framework Update Health Literacy Alcohol Strategy Update Social Care Networks **For Information – no presenters:** Te Ara Whakawaiora / Access (Local Indicator)	Kate/Graeme Kate Coley Quigley & Watts Rachel Eyre Kevin Snee/Liz Stockley or alternate
10 Mar	Refine Consumer Council Member Portfolios Obesity Strategic Plan (Consultation) Draft Regional Services Plan (for information and comment) Draft Annual Plan Statement of Intent (for information and comment) **For Information – no presenters:** Annual Maori Health Plan Q2 Dashboard Te Ara Whakawaiora / Breastfeeding (National Indicator)	Ken Foote Caroline McElnay
11 Apr	TBC **For Information – no presenters:** Te Ara Whakawaiora / Cardiovascular	

12 May		
9 June		
14 July		
15 Sept		
13 Oct		
10 Nov		
8 Dec		

Health Literacy Strategic Review

Information for the Consumer Council

As you may already be aware, Quigley and Watts Ltd (www.quigleyandwatts.co.nz) have been commissioned by the Hawke's Bay DHB to do a high level review of health literacy within the DHB and across the sector to inform the development of a sector-wide health literacy framework. As part of the high level review, feedback is being gathered from a variety of sources on how health literate the sector is currently as well as opportunities to improve going forward.

Internationally there is no unanimously agreed definition of health literacy. The Ministry of Health defines health literacy as the capacity to find, interpret and use information and health services to make effective decisions for health and wellbeing. As the concept of health literacy has evolved it has shifted from seeing poor health literacy as an individual deficit to acknowledging the health system as key enabler or barrier to health literacy. This review focuses on the health literacy of the system and not of the individual consumer/patient.

Jen Margaret and Kate Marsh, senior researchers from Quigley and Watts, will be gathering your feedback for half an hour during your next meeting. Your feedback will be presented to the DHB who will use it to develop a sector-wide health literacy framework.

As our time with you is limited, it would be much appreciated if you could consider the questions below prior to attending the meeting and come prepared to provide your feedback.

1. **Where do you think the Hawke's Bay health sector is currently at in terms of health literacy?**

2. **How well does the health sector currently engage with consumers?**

- Has anyone looked at how well the DHB communicates with consumers? E.g. written communication (forms, letters, health education resources) and verbal communication (between staff and patients/consumers)
- Are consumers involved in designing, developing and evaluating the DHBs values, vision and structure? If so, how?
- Are consumers involved in shaping service delivery? E.g. patient centred care, quality improvement, all aspects of service delivery. If so, how?
- How are consumers helped to find and engage with these services?

3. **What do you think are the biggest challenges for consumers that need to be addressed in creating and implementing a sector-wide framework for health literacy?**

4. **What are some solutions to the challenges you just mentioned?**

Please direct any queries about these questions to Kate Marsh – jen@quigleyandwatts.co.nz and any queries about this review process to Jeanette Rendle - Jeanette.Rendle@hawkesbaydhb.govt.nz.

HAWKE'S BAY District Health Board Whakawāteatia	**Health and Social Care Networks Programme Brief**
	For the attention of: **HB Clinical Council, HB Health Consumer Council and the Māori Relationship Board**
Document Owner: Document Author(s):	Steering Group – Health and Social Care Networks Kevin Snee
Reviewed by:	Executive Management Team
Month:	February 2016
Consideration:	For Discussion

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RECOMMENDATION

That HB Clinical Council, HB Health Consumer Council and the Māori Relationship Board:

1. Endorse the content of this Programme Brief
2. Provide feedback and input on its content and strategic direction

INTRODUCTION

Under the auspices of Transform & Sustain, we are proposing a new programme of work that will significantly change the structure of the Hawke's Bay health sector. This work is transformational in nature, requiring new ways of operating and strong relationships across all stakeholders.

The programme will take a staged approach, with an initial project that will establish the DHB's processes and standard requirements for network development, plus develop standardised documentation and templates. These resources will be available for use in later projects, by stakeholder groups (including patients and community leaders) that wish to establish geographically-based provider networks ("Health and Social Care Networks") that will work collaboratively to better address the needs of their combined enrolled population. One such group is already considering network development (Wairoa), and two others are in the early stages of considering the potential to work together (Central Hawke's Bay and central-Hastings); these groups will be supported and encouraged within the overall programme.

This paper introduces the programme (the Programme Brief) and provides further information on the development of standard tools and processes (Appendix 1), an intial stakeholder analysis (Appendix 2) and a terms of reference for the Steering Group that will oversee all programme work, ensuring alignment and synthesis across all projects (Appendix 3).

BACKGROUND

The health system in Hawke's Bay, as with the rest of New Zealand, will experience significant challenges in meeting the future needs of our population, particularly in terms of the aging cohort and a rise in conditions requiring long term and complex care. To better prepare our sector for these challenges, an alternative service delivery model that integrates primary, secondary and social services has been proposed; this model seeks to increase effectiveness and efficiency of health care delivery closer to where people live, whilst recognising and addressing the key role of socio-economic factors in determining health outcomes.

Recent discussions have centred upon how this integration could be effected, focussing on the establishment of clusters of health and social service providers working closely together with the patients that they have in common; these clusters have been termed *Health and Social Care Networks.*

Initially networks will focus on delivering current services most appropriately in a manner which is responsive to each community and engages community based resources and facilities effectively. This vision will grow over time to support devolved decision making over service design and investment in resources and facilities to clinicians and community leaders. The time frame to achieve this expanded vision may be different for different communities.

Stakeholder engagement and input will be essential to the success of the Health and Social Care Networks Programme. In Phase One, outlined in Appendix 1, this engagement will focus on DHB and PHO stakeholders. This is because the work focuses on determining these organisations' approach to networks, including a proposal on how networks could be structured, the level of decision-making that could be devolved to communities and developing supporting resources to assist communities on this journey. Where possible, Phase One deliverables will be over-arching, rather than prescriptive, as each Network will result from a co-design process and will be as individual as the community it serves. In later projects, in which communities establish networks that meet their needs and aspiations, co-design will be the key process by which a much wider range of stakeholders will be involved in a partnership to design and implement their network. Such projects will be the subject of separate Terms of Reference.

ATTACHMENTS – Programme Brief, Appendix 1, 2 and 3

Programme Brief

Establishing Health and Social Care Networks

January 2016

Purpose of this document

The purpose of this document is to outline the scope and activities required to enable Health and Social Care Networks to be established in Hawke's Bay.

This document is for:

- The Health and Social Care Networks Steering Group – to describe a way forward for sector redesign, providing a clear statement of intent, leadership and responsibility
- EMT – to gain managerial approval and support for this initiative and approach

Background

The health system in Hawke's Bay, as the rest of New Zealand will experience a significant growth in the population of frail older people and a further growth in the numbers of people living with complex long term conditions. The health system is currently not designed to deliver equitable outcomes or access to services for Māori and Pacific populations and there are groups of people who are unable to afford, access or navigate the health sector. This problem is not unique to health. There is a lack of co-ordination between health and social care services that can be frustrating for individuals and lead to lack of engagement and wasted resources across the board.

Transform and Sustain has established a strategic framework and an environment under which significant change can be achieved, and is already underway in some areas. There is a need for primary care to be better positioned to address acknowledged challenges, to be more connected and collaborative, and to deliver services that are accessible and appropriate for the Hawke's Bay population. Other providers of health and social services in the community need to be more connected and services need to be joined up. The concept of Health and Social Care Networks, as a vehicle for addressing these challenges has been discussed in several forums.

This journey will lead to a health service in which the right clinician is delivering an appropriate service in the most sensible location supported by a network of providers who understand and respond to the needs of the patient and their whānau, who in turn are empowered to manage their own health and social wellness.

The establishment of Health and Social Care Networks requires a significant programme of activity and of change management. We propose to begin this journey by delivering current services differently, to respond to the community more effectively and to encourage and motivate collaboration. This journey will be challenging because of the number and breadth of stakeholders, because it requires changes to the status quo and because the day to day operations of a complex health sector need to continue whilst this vision is realised. It is also an opportunity to revitalise our sector and increase sustainability in terms of service affordability, infrastructure and workforce.

Proposal

We propose to establish a number of networks of collaborative services that are clustered around geographical communities that work closely together to care for patients that they have in common.

Initially networks, with community input, will focus on delivering current services most appropriately in a manner which is responsive to each community and engages community based resources and facilities effectively. This will be the focus of Phase One.

This vision will grow over time to support devolved decision making over service design and investment in resources and facilities to clinicians, professionals and community leaders. The time frame to achieve this expanded vision may be different for different communities - this is a long term vision.

Phase One

We will cluster existing services around geographical communities and use the design of these services as a lever to engage providers, other public services, Iwi, NGO's and voluntary organisations in the concept of community networks. We will begin with health services and invite community partners to also review their services through an aligned approach.

In Napier and Hastings the clustering of services will be based on populations of around 30,000 people, in an aligned geographical area. The 30,000 figure represents a likely lower limit at which a network would be viable; an upper limit, although not specified, would be a figure at which a sense of community is lost. In Wairoa and Central Hawke's Bay remoteness rather than population size determines each to be a sensible geographical network and, therefore, smaller network populations are envisaged for these areas.

In order to reshape services so that they are appropriate for the community the HDBHB and HHB teams will work with local general practice teams and other local clinicians, consumers and community partners to:

- Ensure services are appropriate to prevent ill health, enable people to keep themselves well and independent for as long as possible
- Support the development of quality services that are provided in the community
- Ensure services provided by a wide range of health and social care professionals in the community are better co-ordinated and respond to local need
- Improve communication and information sharing between different health, social care and voluntary sector professionals
- Facilitate closer working between community based and hospital services, ensuring that patients receive a smooth and safe transition from hospital services to community based services and vice versa.

To achieve this first phase the programme of work detailed below proposes:

1. Background work - understanding ourselves (services, processes and models) and the potential benefits to be gained from networks, developing expertise through a central repository of knowledge, tools and resources that will support sector change. Key activities include:
    - ensuring various projects, existing and new initiatives, are aligned
    - reviewing our services and considering the most appropriate delivery models
    - analysing our systems and processes to reflect the collaborative working environment
    - developing a standard pathway, tools and templates to guide establishment of networks throughout Hawke's Bay
    - reviewing examples of good practice from other places to avoid reinventing the wheel
2. Establishing a network in Wairoa
3. Motivating collaboration in Central Hawke's Bay
4. Supporting collaborative general practice initiatives in Hastings (e.g. Totara health and Hastings Health Centre)

5. Supporting the identification of sensible network groupings in Napier and Hastings
6. Initiating the development of the technology platform in primary care.

Each of the associated individual pieces of work will be subject to appropriate project management rigour and business case processes. Some of these initiatives will be concurrent and will inform each other.

Progress to date:

A proposed scope, deliverables and high-level milestones for item 1 above is provided in Appendix 1. Progress to date in this space has included the health services directorates considering services that could be provided in the community and the consideration of some models from elsewhere (e.g. Nuka). Work has also been done to review what the community wants from services – what have we already been told, and to engage consumers in consideration of the general practice model of care.

On the back of the development of the new facility in Wairoa there have been positive discussions between community providers about working together in a smarter way. This will be nurtured and furthered through joined-up activity. Establishing a network in Wairoa is being developed under separate Terms of Reference document.

An initial meeting was held at the end of 2015 in Central Hawke's Bay which was attended by representatives of the key providers. A further meeting will be held in February to identify what the local priorities for service development are.

Whilst the Totara Health and Hastings Health Centre programme has stalled temporarily the opportunity for collaboration between general practices in Hastings remains. The PHO and DHB will continue to motivate collaboration and initiatives such as urgent care will support a collaborative approach.

The EngAGE, District Nursing and Pharmacy Facilitator projects are essentially trialing geographical groupings of services in Napier and Hastings. Lessons will be learned from these.

The DHB and PHO are currently considering what the next steps with the development of primary care infrastructure should be. A single shared care record will be a priority and some research has been undertaken as to solutions in this space.

Interdependencies

A range of other existing projects will also inform and support the network programme:

Project Name	**Interdependency description**
Patient Experience	Will inform this project by providing patient insight to service requirements and information on patient profiling by geographic practice area
EngAGE; DN GP Alignment; Clinical Pharmacy Facilitators roll out	Information on existing models of service delivery and potential geographical networks
Urgent Care	Some of these services, co-designed with primary care stakeholders, may become part of one or more networks. This may motivate collaboration
Customer Focused Booking	Influenced by, and influences, models of care that could be adopted by practices within a network
Health Literacy	Health literacy will be a key component of models of care implemented by general practices within networks
Model of Care support in primary	PHO project to develop a centre of knowledge regarding

Project Name	Interdependency description
Care	general practice models of care. Will inform and assist general practices

What success will look like

Success in the short term will mean we are delivering more health services in the community and we are supporting services to work collaboratively with other organisations (across the health and social care spectrum) in specific geographical communities to deliver better care for individuals and whānau.

For phase one networks will have a standard set of services but these may be delivered against different models of care depending on the needs and resources (such as clinical skill, capacity and facilities) of the community.

During the implementation of phase one, we will analyse information and engage with consumers and providers within communities to better understand the needs and cultural requirements of the community. We will understand what approach will support successful outcomes for each network. This will set up a solid foundation for progressing networks beyond mechanisms for service delivery to meet our longer term vision.

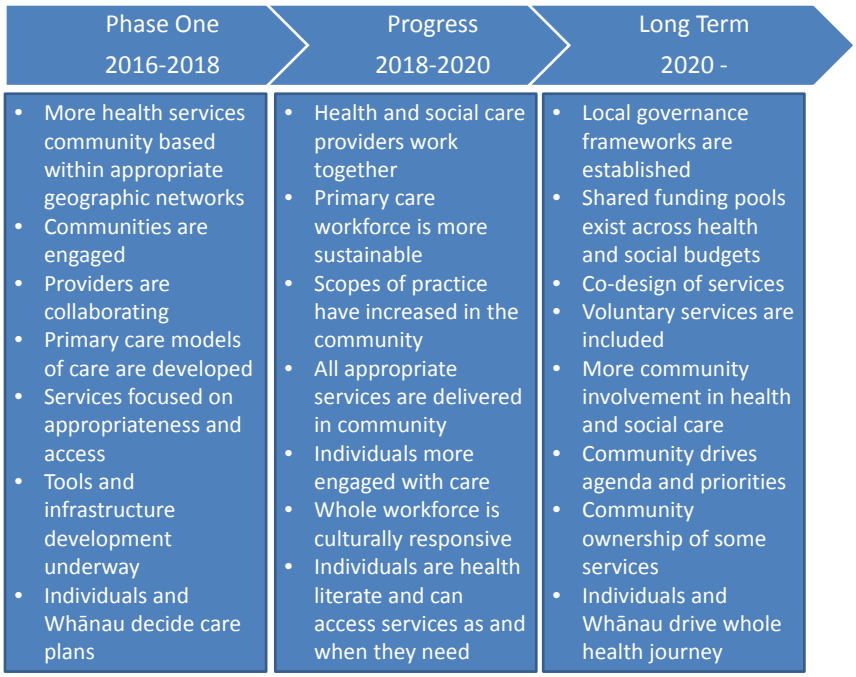
Successful implementation of Phase One means:

- People find it easy to identify and access the help and services they need because they are health-literate, the services have been designed to be easily understood, and there is additional navigation and kaiawhina assistance if required.
- Existing services will be configured in ways that improve the patient experience and respond better to communities.
- Community resources and facilities are increasingly evolving to provide a broad range of services.
- Multi-disciplinary, multi-provider case-management is the established approach for working with people and/or whanau with complex health and social needs.
- There is reduced need for hospital visits because many services are conveniently accessed in a community setting. This has led to reduced waiting times for necessary hospital-based treatment.
- General practice clinicians have the time to work with patients who need it.
- Primary care clinicians have opportunities to increase scopes of practice and develop additional expertise
- General practice business models are motivated to support sector activity
- Patients at risk are proactively identified and supported
- Technology and information is used effectively for joined up service delivery and for to support self-management
- Health outcomes, codified in a set of performance indicators covering central and local expectations, have improved.
- Continuous improvement and innovation is a central tenet of the system,

- Networks are supported by nimble, responsive management, using existing resources where possible. Organisations are working collaboratively to get the best value from all publicly funded resources.

High-level time line

The following diagram highlights the journey networks will take. The dates are indicative only, setting the direction of travel that we intend to take. Some networks may progress more quickly, particularly where geographic locality is clear and there is a group of existing engaged stakeholders. The detail highlights the key anticipated achievements of each phase.



Appendices

The appendices to this document provide additional information on the following:

- Appendix 1 – High level plan for Phase 1 (timelines, financials, deliverables, risks and communication)
- Appendix 2 – Stakeholder Analysis
- Appendix 3 – Terms of Reference for the Steering Group

APPENDIX 1: Phase One – timelines, financials, deliverables, risks

Phase One (Core Network Expertise project) is proposed to run for 7 months (February – August 2016). It will establish minimum/standard requirements of networks and support network establishment in localities.

Deliverables and high-level milestones

Objectives	Deliverables/ high level milestones
1. Set the scene	1. Agreed set of over-arching principles for Network design, operations and benefits realisation • Get approval for progress from EMT • Determine the governance and approvals processes required by HBDHB • Get input/feedback from a wide range of stakeholders (this will get their input and also socialise the ideas) to finalise the principles 2. Review of other current projects (engAGE, Pharmacy and DN) to ensure alignment across these and the Networks programme and identify lessons learned so far 3. Establish an appropriate project management framework, appropriate roles and responsibilities and resources. This will include a communications framework.
2. Geographic groups / communities	1. Localities proposal: proposed geographic regions ('localities') for networks • Analyse HB data (health, economic, other) to characterise the population, identify areas of shared needs or opportunities etc • Propose localities, using principles and interests (populations they serve) to guide boundaries; Wairoa and Central HB are geographically distinct, so work will focus on defining Napier and Hastings groupings • Map current capacity, capability, service provision and facilities in each proposed locality
3. Services and service delivery	2. Standardise a list of services that could be delivered in the community in an integrated way • Map those services for which we have some control over (i.e. DHB and PHO-funded), bring in others as we socialise the networks. • Identify how these services fit with each locality (appropriateness, resources, capability, priorities, local motivations etc.) • With network input identify how individual service lines might work differently to deliver more effective, efficient services in the community that are better of the patient and support a collaborative approach. 3. Service delivery models – options document • Research existing models of integrated services to inform the options (e.g. Nuka, Kaiser Permanente, NHS CCGs, Counties Manukau) • Determine appropriate delivery models (these will be tailored during implementation in each locality) • Create a centre of Knowledge and information around models of integration and primary and community models of care
4. Network development processes and guidelines	1. Document a standard set of requirements and standards that each network will work within. Some of these will be relevant from day one, others will be prepared for when they are needed. These will include: • Governance mechanism • KPIs/targets (minimum standards) and accountability mechanisms • Contracting mechanisms (between funder and provider, between network partners, etc) • Levels of delegated authority and mechanisms to increase autonomy over time • Budget tools and financial accountability requirements

Objectives	Deliverables/ high level milestones
	• Asset mapping tool • Network stakeholder analysis • Communications templates 2. Analyse existing DHB and PHO systems and processes and review/redraft these to reflect the collaborative working environment; develop new systems and processes where required. Examples include funding and contracting arrangements – to enable and support different ways of working. 3. Once we are ready for some decision making to be devolved to networks there will need to be a standard mechanism/pathway for 'applications' from locality groups wishing to establish a network (by submission of an outline business case or similar process). It is prudent to begin drafting what this may look like. 4. Tools and templates as required by locality groups who wish to form a network. Examples could be: • High-level 'how to' plan providing a suggested pathway/series of steps for network establishment (include alternatives/not prescriptive but indicates the minimum requirements) • 'Business Case' application template (for point 3 above) • Terms of Reference template to support establishment project scoping and planning • Terms of Reference for project Steering Groups, Partnership Advisory Groups, etc • Risk identification and management plan • Infrastructure/resource map and plan • budget template • Guide to co-design • Community asset mapping tool (beyond health and social service providers)

Risk Analysis and Management

Preliminary Risk Analysis:

Risk	Likelihood Hi/Med/Lo	Impact Hi/Med/Lo	Planned Response
Lack of primary care engagement	M	H	Early and clear communication to sell benefits, address concerns; gain their involvement in co-design through workshops, feedback opportunities.
Lack of engagement with secondary care	M	H	Senior clinicians to act as champions for the initiative; keep them fully informed of/involved in the project's work programme. Regular communications and opportunities to contribute in the co-design process.
Project doesn't adequately address consumer priorities	L	H	Consumer input based on a co-design approach will be integral to the establishment and operation of networks.
Project, programme and change fatigue	M	M	Communicate the vision and engage stakeholders at an early stage so that they own the solutions. Communicate regularly.

Risk	Likelihood Hi/Med/Lo	Impact Hi/Med/Lo	Planned Response
			Promote and celebrate success
Scale of what we're trying to achieve	M	L	Low impact for this current project stage, but recognised as considerably higher likelihood and impact for network implementation. Stage implementation projects, concentrating on those groups most able to move forward as early adopters, so that we can learn from mistakes. Recognise the need to learn from experience.
Too busy keeping the current state afloat	H	H	Adequately resource the project (staff time, resourcing and financials) to ensure that there is enough 'space' to effect change.
New ways of working/new relationships (as equal partners) that parties are not used to (working in partnership with consumers	M	H	Conduct activities to address gaps in knowledge/skills/experience. Be clear that this is change behaviour and all parties need to take responsibility for engagement and the resulting outputs. Support relationship building opportunities.
Governance of networks; how do we account for them?	M	M	Build robust processes based on best practice.
Duplication of efforts across other T&S projects (e.g. patient experience, urgent care, AIM 24/7, etc)	H	M	Project Manager to get a good understanding of results from other projects, and synthesise the lessons.

Financial Profile

This budget covers the Phase One 'Core Network Expertise' project, and is expected to be conducted during February-August 2016 inclusive (7 months). The project manager role is in addition to this budget. Further budgets will need to be supported by business cases to support implementation of health and social care networks.

As the timing of this project spans two financial years, the indicative spend in each year is as follows:

- 2015/16: $71,400
- 2016/17: $28,600

Item	Itemised Description	Cost$	Budget Source and Status (approved / approval in process etc.)
Project resources and operating expenses	o DHB staff (existing resources) o Incidental travel o Catering at meetings o Printing o Room hire o Patient engagement costs	Time $50,000 (combined items) $20,000 (combined items)	Existing staff budget New New

	o Research costs		
External advice	o Specialist advice (e.g. legal and governance); DHB expertise o Graphic design o Qualitative Engagement software and support (Cognise)	Time $30,000 (combined items)	Existing staff budget New
	Total cash investment:	**$100,000**	**New**

APPENDIX 2: Stakeholder Analysis

Stakeholder group	What they may like	What they may not like	Risks
Consumers	Opportunity to fix the problems they experience re choice, access, etc Potential to be involved in the changes/have a voice More responsive to consumer needs and wants	Shared patient records – perceived confidentiality breaches Change Additional expectations for self management	Perception that this is yet another sector restructure (waste of time/money) Rumours / media stories (negative perception or incorrect info)
General practices	General practices are key partners in this initiative – seen as progressive More influence over what services are commissioned Meritocratic increase in authority as networks prove themselves Opportunity to expand general practice scope/ potential for job enrichment May offer opportunities for succession planning Opportunities for efficiencies Opportunities to be seen to do more for patients Opportunities to improve sustainability of business and workforce	Likely to disrupt current business models Uncertainty of funding in the short-term Collaborating with competitors, particularly if there is ill will Shareholders may have other priorities for their business Business needs may be at odds with required network outcomes Out of their depth (planning etc)	Lack of practice leadership may mean that staff don't engage/ get the wrong story Staff uncertainty re jobs, scope of their role Competitive behaviour leads to perverse outcomes May not share data/info Shared geography may not mean aligned aims/objectives/philosophy Poor use of data for strategic planning – can't see the SWOT
General practitioners	Potential to decrease time pressures Ability to specialise in an area of interest Better able to refer patients with non-medical issues to other network providers Sustainability	May be expected to network with practices or people they don't like or respect May feel forced by the DHB Feel out of control	Stall progress by continually bringing up issues and/or avoiding engagement Curmudgeons promulgate negative stories/perceptions Keeping the current state going uses up all their time/energy
Community-based nurses	Work at top of scope in a new model of care; less admin/low level tasks Introduces new roles and development opportunities	Potential for loading a lot more responsibility on them	Nursing workforce in primary care may not want to change
Health Hawke's Bay	Decrease complexity and variability across practice offerings	Changes potentially conflict with nationally-determined priorities	Inability to get cross-practice information sharing and shared IT

Stakeholder group	What they may like	What they may not like	Risks
	More responsive primary care sector Joined up system, improve access, address inequity Doing better for patients More engagement across the sector Efficiency More services in the community Sustainable workforce	Out of our depth? Resource requirements and effort to achieve this change	platform Lose support of practices Communities/providers not wanting to engage
DHB	Keep the hospital the same size despite increased demand for services Local responsibility for infrastructure and resourcing (??) Address equity gap	Devolving control to communities due to lack of certainty/ track record of delivery Has invested in the current state Resource requirement to make this happen If things don't move at the right pace	Could lead to more complexity of 6-8 'different' systems (networks) to interact with Too prescriptive, meaning that communities don't feel that they own the network
Hospital services	Sustainable workloads Efficient service collaboration with primary care	Keeping the current going doesn't allow time for change Scared about jobs/instability? Might have to travel to work remotely? Worry about community capability Effort in addition to day job	Risk adverse, so will 'dig in their heels'? Perverse behaviour re network vs private patients? Services fail / community-based services don't work
MSD (funder)	Collective impact is greater than working in silos Keep people well; keep people in work Fit with national agenda	Potential lack of clarity re budgets (split between H&SC) Conflict between network outcomes and MSD policy directions? Never been done before Control issues?	Change seen as too difficult, too soon, or only benefitting the health sector Targets / national picture gets in the way of local decision making
MSD-funded services	Better access to the health resources available in the health sector, ability to cross-refer patients/clients Clarity of service provision	Likely to disrupt current business models / have other priorities Uncertainty of funding in the short-term Skills to engage in doing things differently	Service failure Don't meet targets
Maori providers	Better access to the health resources available in the health sector; ability to cross-refer patients/clients Focus on Maori – close gaps, decrease inequities More holistic approach fits with Maori	Likely to disrupt current business models / have other priorities Uncertainty of funding in the short-term How does this fit with current initiatives? Mistrust of HBDHB gets in the way of progress	Fear of losing autonomy

Stakeholder group	What they may like	What they may not like	Risks
	way of approaching things (e.g. whanau ora) Opportunities for collaboration Opportunities to think strategically	A lot going on with post settlement groups – this is 'another thing'	
NGOs	Better access to the health resources available in the health sector; ability to cross-refer patients/clients Potential to re-direct their services/service delivery to become an integral part of the network Better integration / collaboration with voluntary organisations	Likely to disrupt current business models / have other priorities Uncertainty of funding in the short-term Potential for more referrals; will need to see $$ coming their way	Overloading them No resources to engage Don't have sustainable funding streams

APPENDIX 3

HAWKE'S BAY District Health Board

TERMS OF REFERENCE

Health and Social Care Networks Programme Steering Group

HEALTH HAWKE'S BAY Te Oranga Hawke's Bay

Purpose	The purpose of the Steering Group is to ensure sound decision making in the Health and social care network programme, to ensure the programme brief is adhered to and to communicate messages as appropriate.
Functions	At a programme level, the steering group is responsible for achieving the high level strategic vision of the Networks programme. This includes the following responsibilities: • Oversees all deliverables in Phase One - Health and Social Care Networks Programme to ensure strategic fit. • Actively champions the Networks Programme and provides leadership for change • Understands the desired outcomes, and tracks progress towards these, taking corrective action where necessary. • Monitors the management of major programme issues and risks and provides advice on the best approach to resolving these. • Owns the process and the deliverables of the programme. • Maintains a high-level view of project work being conducted across the health sector so that potential synergies with, or impacts on, the Networks Programme can be identified and addressed appropriately. • Reports to HBDHB Executive Management group on a monthly basis. • Holds and allocates the programme budget. • Ensures programme benefits KPIs are tracking positively. • Ensures sound decision making processes are followed • Establishes the brief or terms of reference for subsequent phases • Support and endorse Terms of Reference documents for network establishment projects in each geographic locality.
Decision Making	A consensus is required for any decision. Where meeting attendance is not possible a member will endorse/reject a deicision electronically either before a meeting or upon receipt of the minutes.l
Membership	The Core Membership of the steering group is: GM Primary Care/CEO HHB COO HBDHB GM PIF HBDHB DAH GM Māori Health HBDHB Head of Innovation and development HHB

	CMO (Primary) Chief Nursing Officer Medical Advisor Sector Development HHB (GP to be appointed) Manager, Wairoa Health Centre Service Director, Rural, Oral and Community Health Services Medical Director HBDHB Consumer representative Ministry of Social Development representative Other individuals will be invited to provide expertise as and when appropriate. These will include: HHB leadership team members Health Service Directors Specific service or facility managers
Chairperson	The Chair will be the GM Primary Care
Administration	The Project Manager - Network Development will: • administer the steering group • maintain an accurate and up to date record of decisions and activities • Set up meetings of the group • Draft Reports on behalf of the group • Monitor progress against programme plans
Meetings	Meetings will be held on at least a monthly basis, although additional meetings may be set up as required. Meeting attendance will be restricted to the Group members only (and appropriate support staff) with other persons attending only by specific invitation. Matters may be dealt with between meetings through email exchange with a record being maintained by the project manager.
Reporting	The steering group will report to the CEO HBDHB and to the executive management team on a monthly basis.
Minutes	Notes and action points will be circulated to all members of the Group and a summary of discussion from each meeting will be provided to EMT and the HHB Leadership team for information by email.

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HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora: Access (ASH Rates 0-4 & 45-64 years)**
	For the attention of: **HB Clinical Council, HB Health Consumer Council, Māori Relationship Board and HBDHB Board**
Document Owner: Document Author(s):	Dr Mark Peterson Mary Wills
Reviewed by:	Executive Management Team
Month:	February 2015
Consideration:	Performance Monitoring

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RECOMMENDATION

That Clinical and Consumer Council, Māori Relationship Board and HBDHB Board

Note the contents of this report.

OVERVIEW

The national GMs Māori (Tumu Whakarae) raised concerns about the slow pace of progress on some of the Māori health indicators in 2013. As a result, individual EMT members agreed to providing a championship role for the Māori Health Plan areas of key concern. Part of that role is to provide the Board with a report each month from one of the champions. This report is from Dr Mark Peterson, Champion for the Access Indicators.

UPCOMING REPORTS

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

Priority	Indicator	Measure	Champion	Responsible Manager	Reporting Month
Access *Local Indicator*	Reducing acute admissions of Ambulatory Sensitive Hospitalisations (ASH): 0-4 year olds - dental decay, skin conditions, respiratory and ear, nose and throat infections. 45-64 year olds - heart disease, skin infections, respiratory infections and diabetes	TBC TBC TBC	Mark Peterson	Mary Wills	Feb 2016
Breastfeeding *National Indicator*	Improve breastfeeding rate for children at: 6 weeks, 3 months; 6 months of age	 >75% >60% >65%	Caroline McElnay	Nicky Skerman	Mar 2016

Cardiovascular *National Indicator*	Total number (%) of all ACS patients where door to cath time is between -2 to 3 days of admission. Total number (%) with complete data on ACS forms	70% of high risk >95% of ACS patients	John Gommans	Paula Jones	Apr 2016
Oral Health *National Indicator*	The total number (%) of children are caries free at first examination after the child has turned five years, but before their sixth birthday	>66%	Sharon Mason	Patrick LeGeyt	Jun 2016

OVERVIEW

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

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

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

The Ministry of Health ASH definition and methodology has been revised for ASH reporting from quarter one of the 15/16 year. A group of Ministry and health sector subject matter experts made several consensus recommendations for changes to the ASH definition. Implementation of these recommended changes to the Ministry ASH definition have taken effect for all Ministry ASH reporting from Quarter 2 of the current (15/16) year. There was no expectation of ASH target-setting for the current (15/16) year in light of the review process that was underway at the time of DHB Annual Planning.

However there is an expectation that baseline ASH data (with the revised methodology) be reviewed by DHBs in order to better understand present performance, and in particular variation in DHB performance for different population groups. This will inform the 16/17 planning and appropriately targeted activities for each district. This paper highlights findings from this review.

At the end of June 2014 the results for Hawke's Bay children aged 0-4 were 38% above the national rate of 100%. Analysis of data in 2014/15 concluded that we should focus on the two most preventable ASH conditions (skin infections and dental) which show the highest inequities. The healthy population team has therefore re-established DHB services to Kohanga reo and e introduced new-born oral health enrolment with the aim to reduce hospitalisations for these conditions. We can see from the results outlined in this paper that Maori rates in these conditions have improved.

The highest ASH rates for 45-64 year olds are cardiac conditions and respiratory (including COPD) and cellulitis. Our focus is on development of Clinical Care Pathways.

MĀORI PLAN INDICATOR

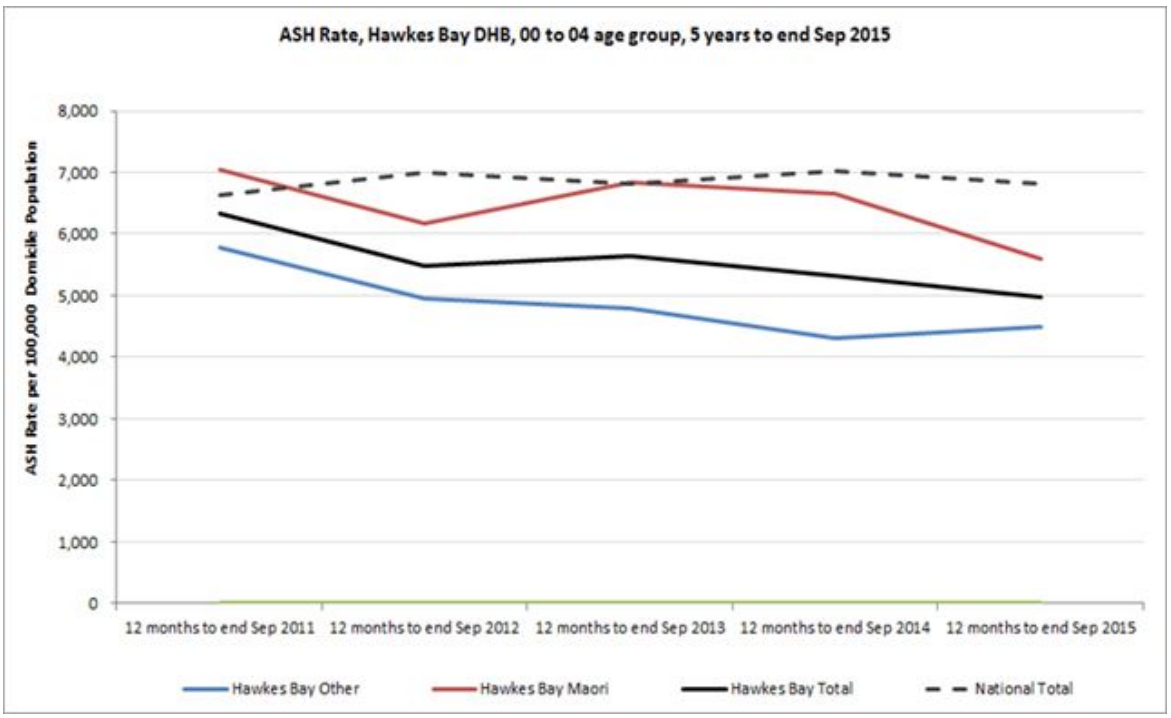
Target 0-4 year age group

There is no expectation of ASH target-setting for the current (15/16) year in light of the review process that was underway at the time of DHB Annual Planning. DHBs have received 2015/16 baseline ASH performance results using the new ASH definitions and the expectation is that DHBs review the present performance of ASH and in particular variation in performance between Maori and Non Maori results. These results gives us an opportunity to examine performance over a 5 year period.

At the end of June 2014 the ASH results for Hawke's Bay children aged 0-4 were 38% above the national rate of 100%. Analysis of data in 2014/15 concluded that we should focus on the two most preventable ASH conditions (skin infections and dental) which show the highest inequities. The healthy population team has therefore re-established DHB services to Kohanga Reo and the introduced of new-born oral health enrolment with the aim to reduce hospitalisations for these conditions.

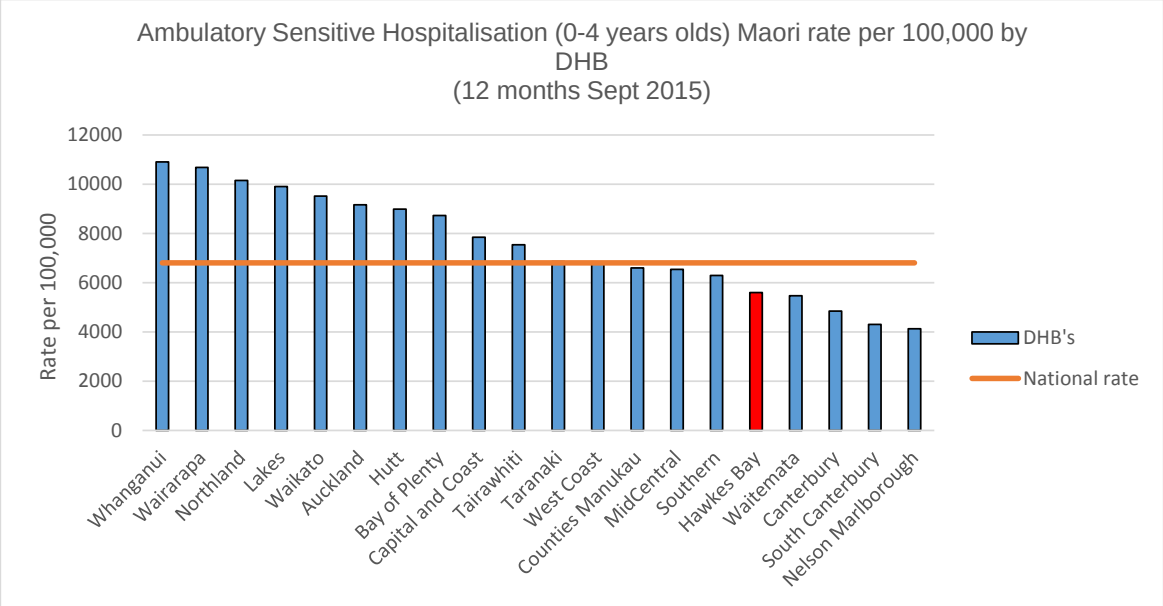
Hawke's Bay Distribution and Trends

Hawke's Bay Māori ASH rates 0-4 year age group– 12 months to end Sept 2011-2015



Hawkes Bay tamariki have lower rates of ASH compare to national rates for both Maori and Non Maori. There has been a reduction in the gap between the Maori ASH rate and the National rates particularly in the 12 months to Sept 2015. By 2015 the Top 5 ASH conditions for Maori in the 0-4 year age group are Asthma, Dental conditions, Respiratory Infections- Upper and ENT,Respiratory Infections – Lower, Gastroenteritis/Dehydration and Cellulitis (5th equal).

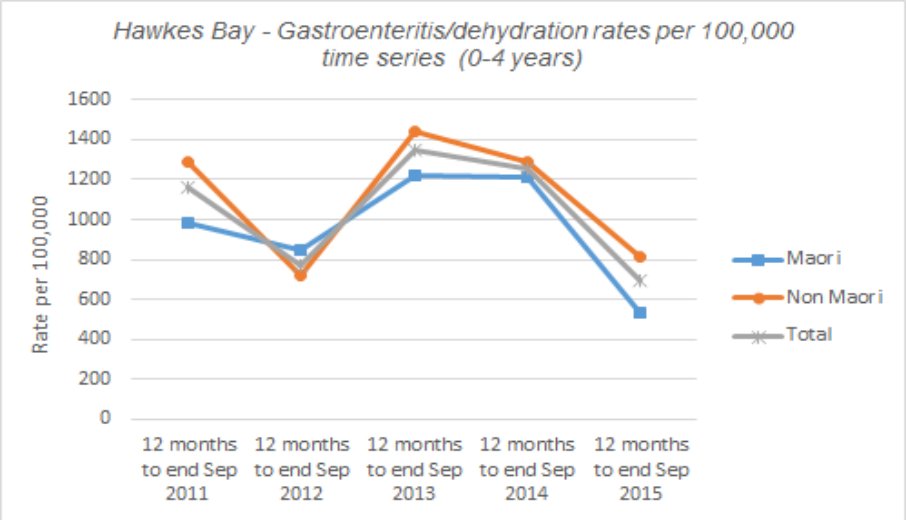
Māori ASH rates 0-4 year age group by DHB's – 12 months to end Sept 2015



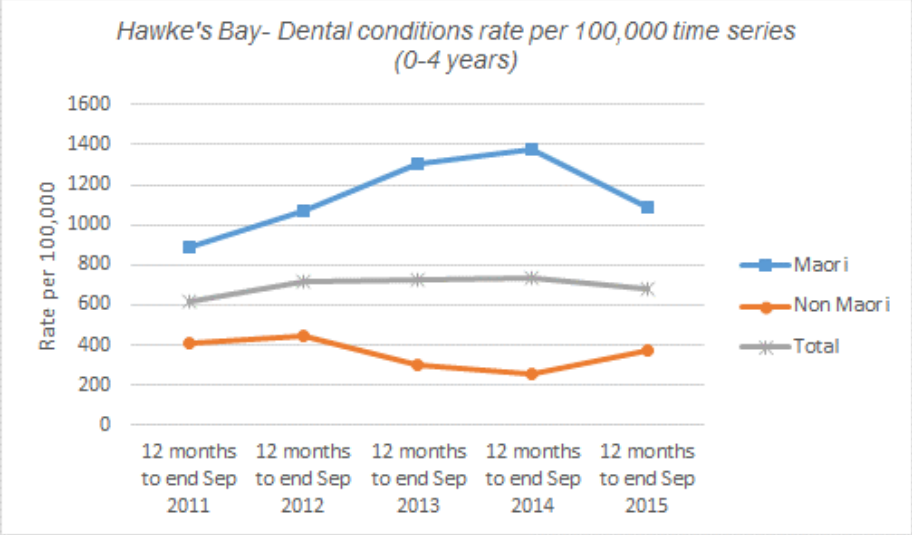
In the 12 months to Sept 2015 the Hawkes Bay Maori rate was 82 % of the national rate and Hawkes Bay DHB was the 5 th best performer of all DHB's with Maori rates substantially lower than national rates in this age group.

In 2015 the largest differences between Hawkes Bay Maori rates and national rates in the 0-4 year age group are in the conditions Asthma and Respiratory infections- lower.

ASH conditions where Maori rates are improving



Gastroenteritis/dehydration rates in the 0-4 years have declined in the last 2 years. The Hawke's Bay Maori 0-4 year rate is half the national rate.



Dental is the 2nd ranked Maori ASH condition in the 0-4 year olds. Rates have dropped in the last 12 months to Sept 2015 and the gap has narrowed between Maori and non Maori. In the 12 months to Sept 2015 Hawke's Bay Maori rates are 2.9 times the Hawke's Bay Non Maori rate and 1.1 times the national rate.

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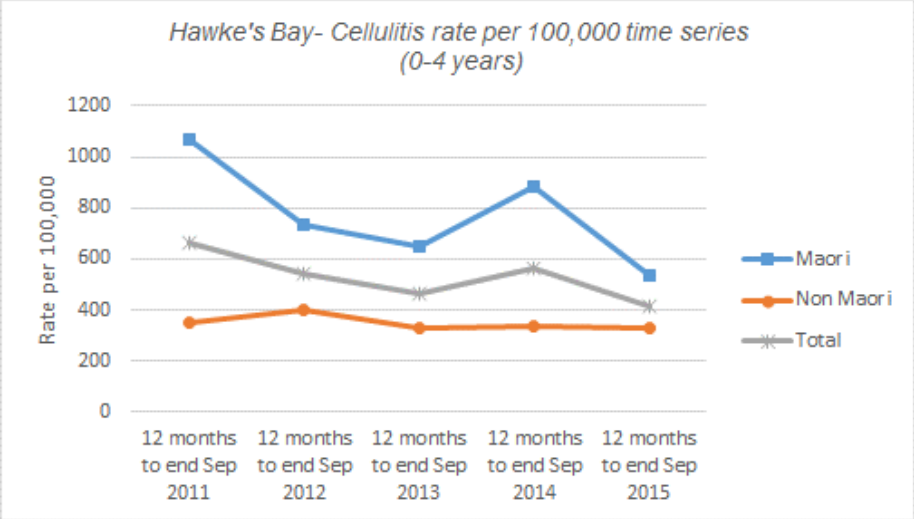
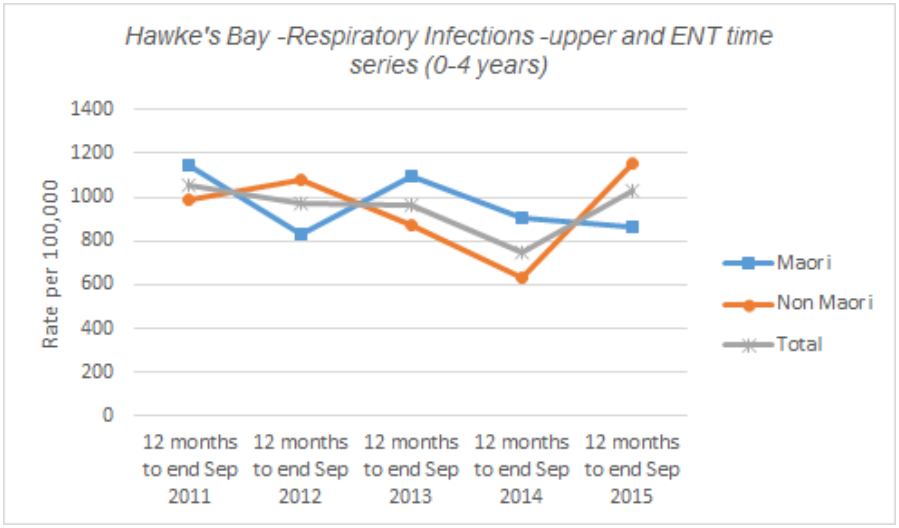
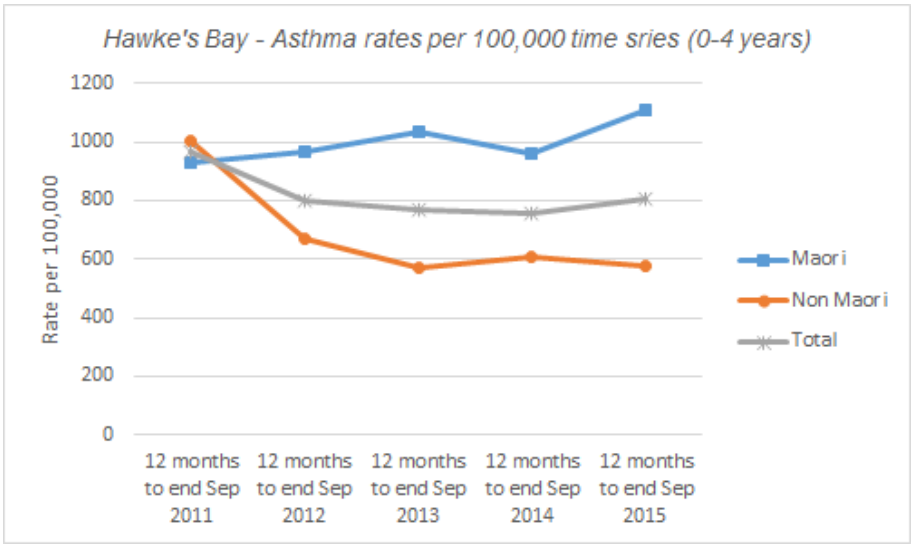


Cellulitis rates for both Maori and Non Maori have improved Maori rates are 1.6 times the Non Maori rates in the 12 months Sept 2015 and 1.2 times the national rate .

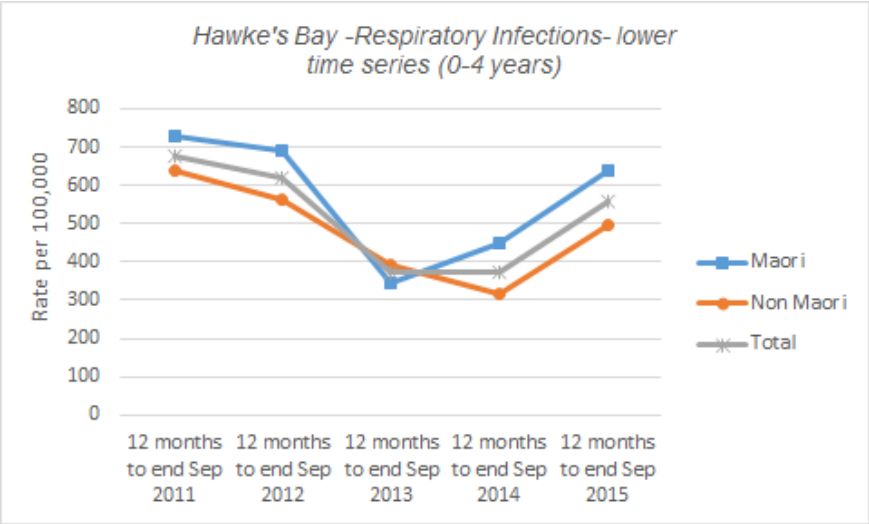


Respiratory Infections – upper and ENT are the 3rd highest ASH conditon for Maori 0-4 year old children. Maori rates have dropped particularly in the last 2 periods. Maori rates are lower than Non Maori rates and national rates in the 12 months to end of Sept.

ASH conditions where rates are not improving



Asthma is the top ASH condition for Maori 0-4 years and rates have been increasing over time and the gap between Maori and Non Maori have widened. By 12 month to end of September 2015 Maori rates were 90 % higher than Non Maori rates.



Respiratory infections – lower are the 4th ranked ASH condition in Maori children and rates have increased in the last 2 years.

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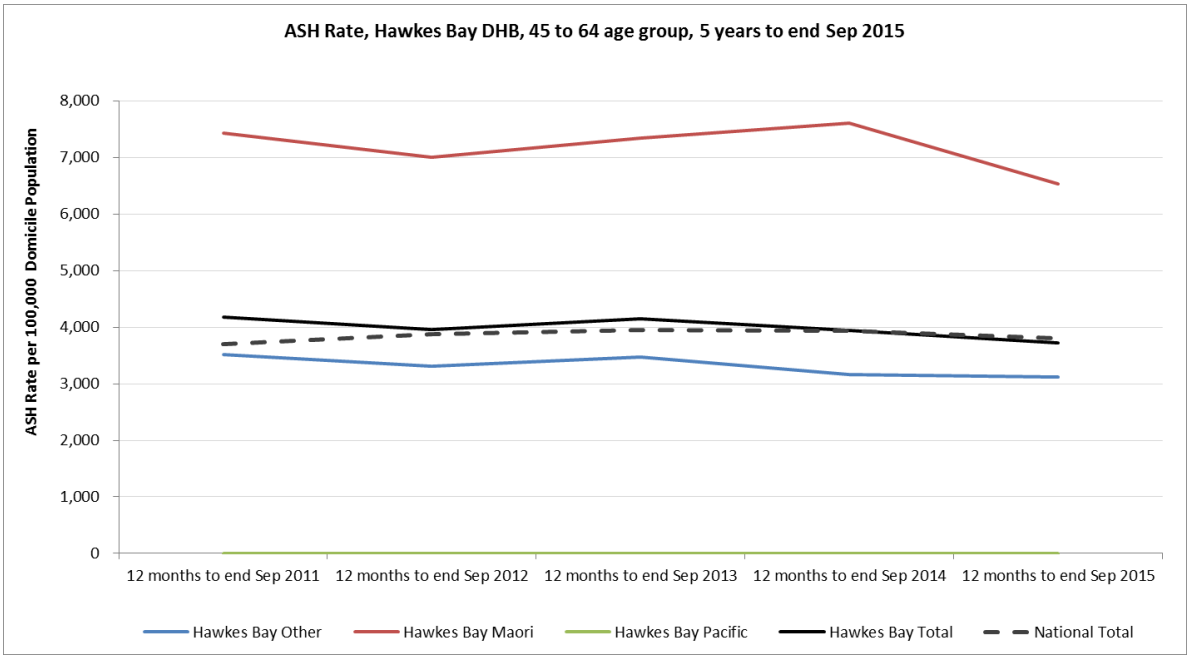
Target 45-64 age group

There is no expectation of ASH target-setting for the current (15/16) year in light of the review process that was underway at the time of DHB Annual Planning. DHB's have received 2015/16 baseline ASH performance results using the new ASH definitions and the expectation is that DHBs review the present performance of ASH and in particular variation in performance between Maori and Non Maori results. This has also given us an opportunity to examine performance over a 5 year period.

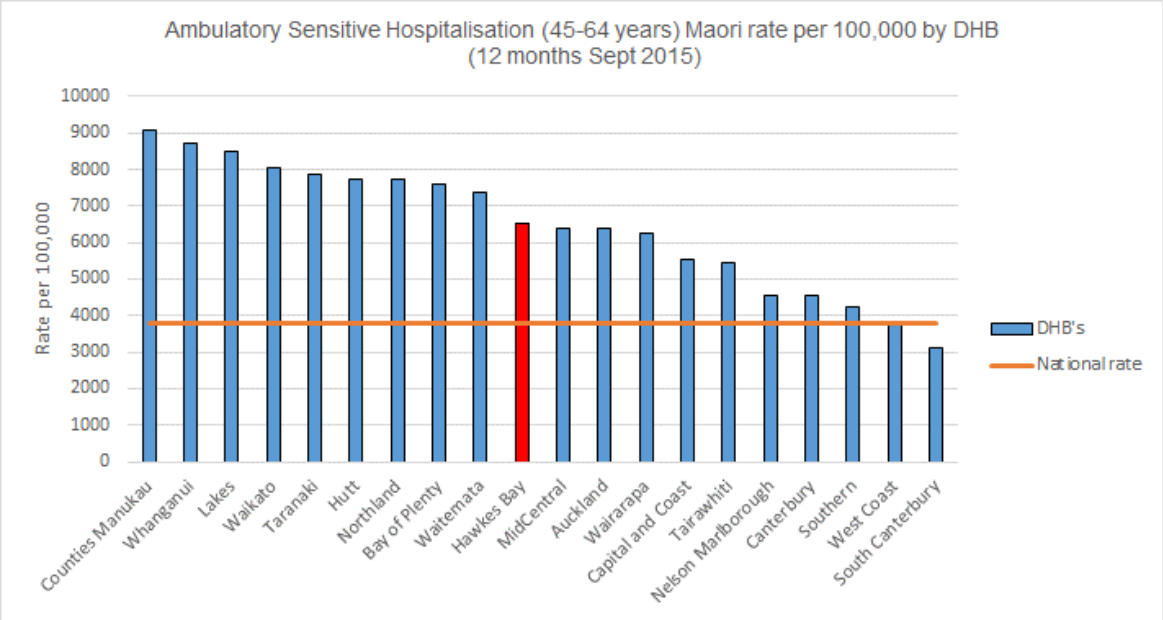
Hawke's Bay Distribution and Trends

Hawke's Bay Māori ASH rates 45-64 age group 2010/11 – 12 months Sept 2015



There has been improvement in Hawke's Bay ASH rates in the 45-64 year age group in both Maori and Non Maori. The gap between the Hawke's Bay Maori rate and the Hawke's Bay Non Maori rate has narrowed between 2011 and 2015 as has the gap between the Hawke's Bay Maori rate and the national rate. In the 12 months to Sept 2015 the Hawkes Bay Maori rate was 2.1 times the Hawke's Bay Non Maori rate and 1.7 times the national rate. The top 5 ASH conditions for Maori in this age group are Angina and Chest pain, Congestive Heart Failure, Respiratory Infections- COPD, Cellulitis and Myocardial Infarction.

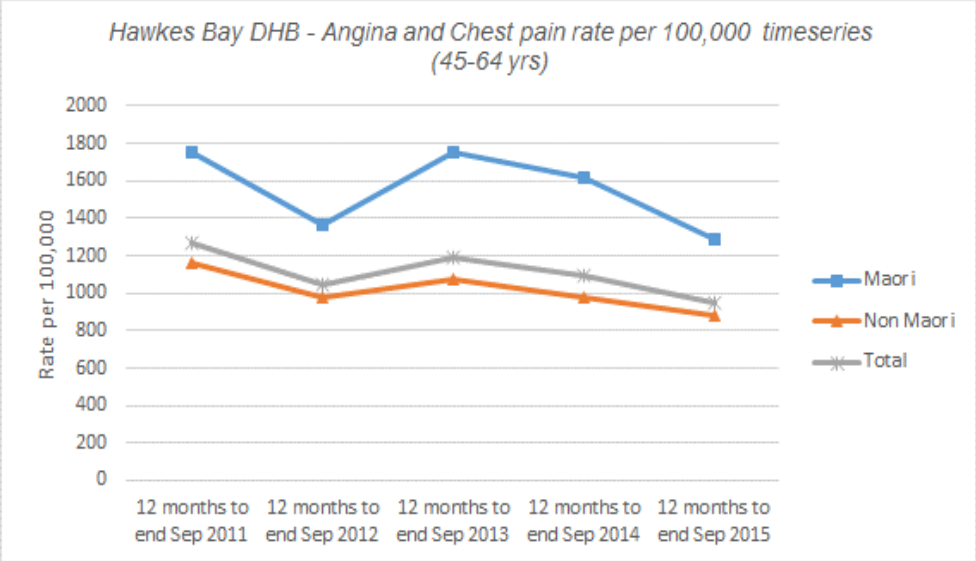
Māori ASH rates 45-64 year age group by DHB's – 12 months to end Sept 2015



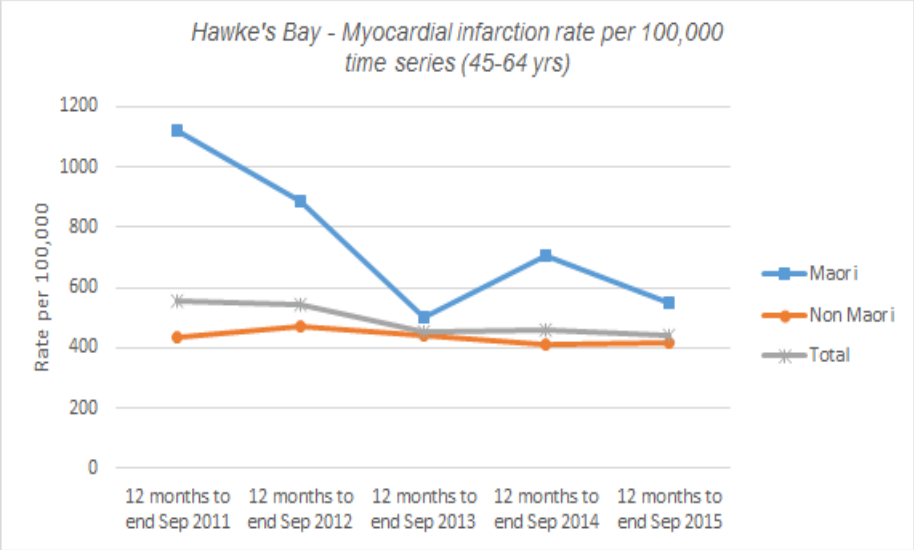
In the 12 months to Sept 2015 the Hawke's Bay Maori rate was 72 % higher than the national rate and Hawkes Bay DHB is ranked 11 th out of 20 DHBs. Maori rates are substantially higher than national rates in this age group across the majority of DHB's.

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

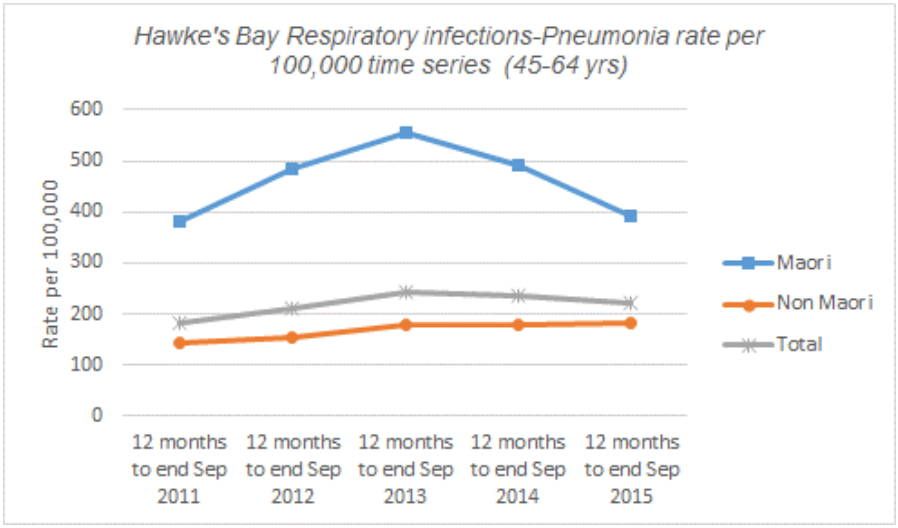
ASH conditions where Maori rates are improving



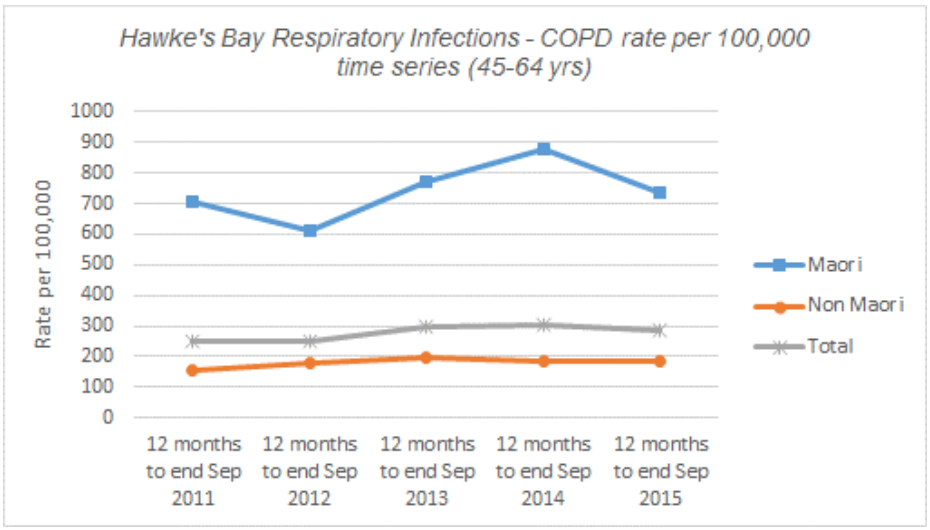
Angina and Chest Pain is the top ASH condiiton for Maori in the age group contributing 20 % of all Ambulatory Sensitive Hospitalisations in Maori in the 45-64 year age group. We have seen Maori rates decline and the gap between Maori and Non Maori narrow. In the 12 months to Sept 2015 Maori rates were 50 % higher than Non Maori rates.



Maori rates in the ASH condition Myocardial Infarction have also improved and by 12 months to end Sept 2015 Maori rates were 30% higher than Non Maori rates.

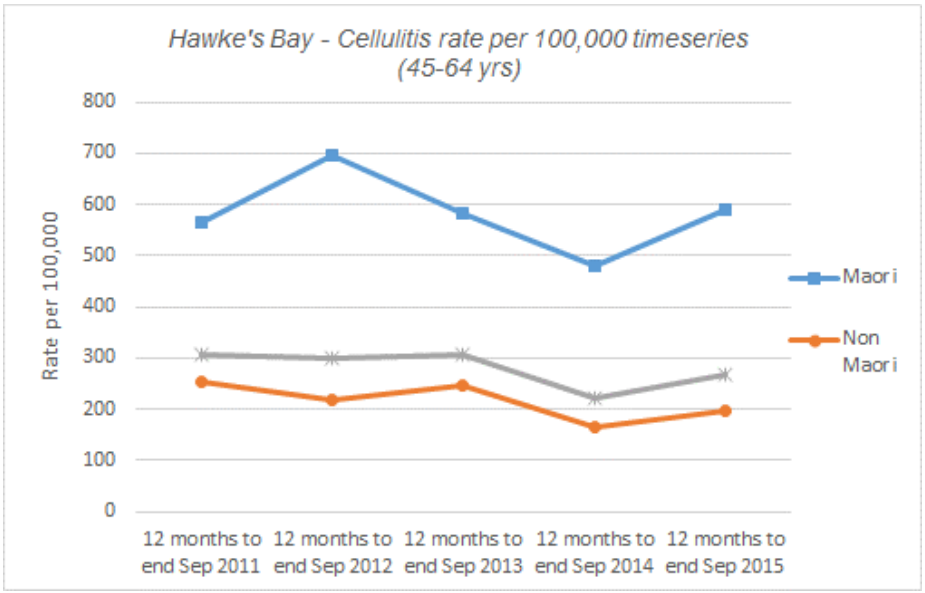


Maori rates in the ASH condition Respiratory Infections – Pneumonia have also improved in the last 2 years.

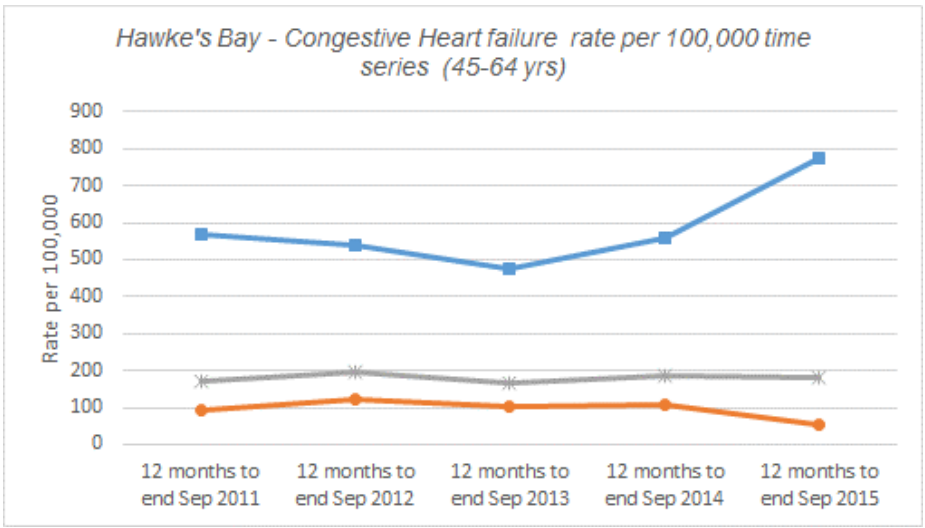


Respiratory Infections – COPD is the 3rd ranked ASH condition in terms of volume of hospitalisations for Hawke's Bay Maori in the 45-64 years age group. There has been some improvement in rates in the last reported period. In the 2015 period Maori rates are 3.9 times the Non Maori rates and 2.9 times the national rates for this condition and age group.

ASH conditions where rates are not improving



Cellulitis contribute 10 % of total Maori ASH hospitalisations in the 45 -64 year age group and is the 4th ranked ASH conditon for Hawke's Bay Maori in the age group. Maori rates have deteriorated in the last 12 month reporting period. Maori rates are 3 times the Non Maori rates and 2.9 times the national rates.



Congestive heart failure is the 2nd ranked ASH condition for Hawke's Bay Maori in the age group 45-64 years. Maori rates have deteriorated in the last 2 years and the gap between Maori and Non Maori rates has widened.

ACTIVITY TO SUPPORT THIS INDICATOR
0-4 YEAR OLDS

New Born Enrolment Programme

All children are linked to general practice as part of the new born enrolled programme with nearly 98% of children linked by 8 weeks. Quadruple enrolment with General Practitioner; Well Child/Tamariki ora; National Immunisation Register and Oral Health is now standard practice.

Kohanga Reo

Public Health Nurse Visits and Vision/Hearing screening for Kohanga continues. Public health nurse's offer education and advice to whānau, tamariki and Kohanga staff around key ASH conditions including gastroenteritis/dehydration and skin conditions.

The recent re-establishment of DHB service provision within HB Kohanga reo enable's the provision of education and advice to whānau, tamariki and Kohanga around the management and treatment of skin conditions. 2015/2016 will see the development of

A skin resource has been translated to be used in local Kohanga. This supports parents and Kaiako around best practice in recognition and management of skin issues. This aims to lead to earlier recognition and treatment of skin infections, avoiding the need for admission.

Co-Ordination of Child Health Data Systems

Excellent communication is maintained between different child health programmes databases in Hawke's Bay due to the goodwill of the NIR/immunisation team, however this is relationship based rather than a reflection of good systems. It is clear that what is required is a national child health database developed at the Ministry of Health level.

Hawkes Bay Child Interagency Network Group

This group is co-ordinated by the HBDHB child health team and meets bi-monthly with a wide range of key stakeholders include representatives from early childhood centres, kindergartens and home-based care for pre-school children. Each meeting a different topic is covered to ensure information provided around the prevention of conditions and promotion of initiatives and services is consistent.

Healthy Homes Programme

HBDHB and HHB continue to fund a programme providing insulation and a range of safety measures for households living in low socioeconomic areas who have significant health need. The greatest percentage of referrals into the Healthy Homes programme are for Maori and Pacific whānau.

ACTIVITY TO SUPPORT THIS INDICATOR
45-64 YEAR OLDS

Collaborative Clinical Pathways

Health Hawke's Bay and Hawke's Bay DHB are developing clinical care pathways across a range of services to increase consistency of practice in Hawke's Bay. In 2015/16 there will be another 24 pathways. Our focus is on promoting the use of the pathways in primary care, ensuring easy access for GPs and developing more pathways for high priority conditions.

Atrial fibrillation and chest pain pathways have been developed and were published in December. Asthma Pathways through Map of Medicine have been completed for children and adults and are currently being published. The next phase is to socialise the pathways into general practice. Key outcomes are evidence based practice, standardisation across Hawke's Bay, care planning continuity of care and reduced hospitalisations. Currently co-ordinating a multi-disciplinary group to work on community acquired pneumonia.

Nurse-Led Respiratory Pilot

Nurse led respiratory (including asthma and Chronic Obstructive Pulmonary Disease-COPD) clinics located in General Practices from 1 September 2014 to 30 June 2015. The project has been jointly implemented by Health Hawke's Bay, Hawke's Bay District Health Board and Asthma Hawke's Bay. Key goals of the project are to reduce unnecessary hospital admissions, emphasis on co-ordination and streamlining of client healthcare, with a strong Primary Health Care ethos focusing on early detection and timely management of chronic conditions at the primary care level. Evaluation of this Project has been undertaken by EIT and results are to be presented to EMT January 2016. In summary:

- nurse-led clinics are effective in co-ordination and self-management.
- the majority of clients enrolled in the pilot were identified as being in Quintiles 4 and 5 (45% Maori accessing from quintile 5, and 65% Pacific) reflecting improved access to healthcare for high-needs clients
- higher representation of women compared with men;
- nurses working in the pilot felt empowered and autonomous in their respiratory practice highlighting a high level of professional development in the management of chronic respiratory conditions.

The pilot has proven that costs and spirometry charges have been a barrier to access. It is clear that for the pilot to continue with success is to have security of ongoing funding (business case will be presented at next bid rounds).

Sharing Primary Care Practice Information

Business Intelligence has produced reports for several general practices on their admission rates to hospital and emergency department attendances. This is now available as a regular report. We are working with Health Hawke's Bay to extend this to all practices, with appropriate oversight.

RECOMMENDATIONS FROM TARGET CHAMPION

The data provided shows quite a bit of variability in the change in rates of ASH in both age groups in the different diagnostic criteria. With the 0-5 age group there is a pleasing drop in the overall Maori ASH rates and a significant narrowing of the disparity gap. It is also notable that HB rates are among the lowest in the country.

Most notable is the change in gastroenteritis admissions in the last two years, and that HB rates are about half the national average. This will need to be correlated with the uptake of the Rotavirus immunisation. HB's high immunisation rate, especially among Maori children may be part of the answer to this (pleasing) improvement.

The ASH rates for the 45-65 age group show higher levels of disparity between Maori and the total population than for the 0-5 group. While rates have come down the disparity gap remains very similar.

Most concerning is the very large difference and climbing rates of admission for congestive heart failure. While the myocardial infarction rate has improved this is not reflected in CHF, which is often a longer term complication of IHD.

A clinical pathway for CHF should be developed and introduced as soon as possible.

CONCLUSION

Kohanga Reo targeted initiatives focussing on specific conditions have seen a decline in cellulitis ASH rates for 0-4 year olds. In addition whanau will have increased awareness of the need for early intervention with skin issues for all family members which includes the 0-4 year age group. The focus of public health nurses on early intervention with skin issues in low decile schools and Kohanga Reo is likely to have contributed to improvements in rates.

GLOSSARY OF COMMONLY USED ACRONYMS

A&D	Alcohol and Drug
AAU	Acute Assessment Unit
AIM	Acute Inpatient Management
ACC	Accident Compensation Corporation
ACP	Advanced Care Planning
ALOS	Average Length of Stay
ALT	Alliance Leadership Team
ACP	Advanced Care Planning
AP	Annual Plan
ASH	Ambulatory Sensitive Hospitalisation
AT & R	Assessment, Treatment & Rehabilitation
B4SC	Before School Check
BSI	Blood Stream Infection
CBF	Capitation Based Funding
CCDHB	Capital & Coast District Health Board
CCN	Clinical Charge Nurse
CCP	Contribution to cost pressure
CCU	Coronary Care Unit
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CHB	Central Hawke's Bay
CHS	Community Health Services
CMA	Chief Medical Advisor
CME / CNE	Continuing Medical / Nursing Education
CMO	Chief Medical Officer
CMS	Contract Management System
CNO	Chief Nursing Officer
COO	Chief Operating Officer
CPHAC	Community & Public Health Advisory Committee
CPI	Consumer Price Index
CPO	Co-ordinated Primary Options
CQAC	Clinical and Quality Audit Committee (PHO)
CRISP	Central Region Information System Plan
CSSD	Central Sterile Supply Department
CTA	Clinical Training Agency
CWDs	Case Weighted Discharges
CVD	Cardiovascular Disease
DHB	District Health Board
DHBSS	District Health Boards Shared Services
DNA	Did Not Attend
DRG	Diagnostic Related Group
DSAC	Disability Support Advisory Committee
DSS	Disability Support Services
DSU	Day Surgery Unit
ED	Emergency Department
ECA	Electronic Clinical Application

ECG	Electrocardiograph
EDS	Electronic Discharge Summary
EMT	Executive Management Team
EoIs	Expressions of Interest
ER	Employment Relations
ESU	Enrolled Service User
ESPIs	Elective Service Patient Flow Indicator
FACEM	Fellow of Australasian College of Emergency Medicine
FAR	Finance, Audit and Risk Committee (PHO)
FRAC	Finance, Risk and Audit Committee (HBDHB)
FMIS	Financial Management Information System
FSA	First Specialist Assessment
FTE	Full Time Equivalent
GIS	Geographical Information System
GL	General Ledger
GM	General Manager
GMS	General Medicine Subsidy
GP	General Practitioner
GP	General Practice Leadership Forum (PHO)
GPSI	General Practitioners with Special Interests
GPSS	General Practice Support Services
HAC	Hospital Advisory Committee
H&DC	Health and Disability Commissioner
HBDHB	Hawke's Bay District Health Board
HBL	Health Benefits Limited
HHB	Health Hawke's Bay
HQSC	Health Quality & Safety Commission
HOPSI	Health Older Persons Service Improvement
HP	Health Promotion
HR	Human Resources
HS	Health Services
HWNZ	Health Workforce New Zealand
IANZ	International Accreditation New Zealand
ICS	Integrated Care Services
IDFs	Inter District Flows
IR	Industrial Relations
IS	Information Systems
IT	Information Technology
IUC	Integrated Urgent Care
K10	Kessler 10 questionnaire (MHI assessment tool)
KHW	Kahungunu Hikoi Whenua
KPI	Key Performance Indicator
LMC	Lead Maternity Carer
LTC	Long Term Conditions
MDO	Maori Development Organisation
MECA	Multi Employment Collective Agreement
MHI	Mental Health Initiative (PHO)
MHS	Maori Health Service
MOPS	Maintenance of Professional Standards
MOH	Ministry of Health
MOSS	Medical Officer Special Scale
MOU	Memorandum of Understanding

MRI	Magnetic Resonance Imaging
MRB	Māori Relationship Board
MSD	Ministry of Social Development
NASC	Needs Assessment Service Coordination
NCSP	National Cervical Screening Programme
NGO	Non Government Organisation
NHB	National Health Board
NHC	Napier Health Centre
NHI	National Health Index
NKII	Ngati Kahungunu Iwi Inc
NMDS	National Minimum Dataset
NRT	Nicotine Replacement Therapy
NZHIS	NZ Health Information Services
NZNO	NZ Nurses Organisation
NZPHD	NZ Public Health and Disability Act 2000
OPF	Operational Policy Framework
OPTIONS	Options Hawke's Bay
ORBS	Operating Results By Service
ORL	Otorhinolaryngology (Ear, Nose and Throat)
OSH	Occupational Safety and Health
PAS	Performance Appraisal System
PBFF	Population Based Funding Formula
PCI	Palliative Care Initiative (PCI)
PDR	Performance Development Review
PHLG	Pacific Health Leadership Group
PHO	Primary Health Organisation
PIB	Proposal for Inclusion in Budget
P&P	Planning and Performance
PMS	Patient Management System
POAC	Primary Options to Acute Care
POC	Package of Care
PPC	Priority Population Committee (PHO)
PPP	PHO Performance Programme
PSA	Public Service Association
PSAAP	PHO Service Agreement Amendment Protocol Group
QHNZ	Quality Health NZ
QRT	Quality Review Team
Q&R	Quality and Risk
RFP	Request for Proposal
RIS/PACS	Radiology Information System Picture Archiving and Communication System
RMO	Resident Medical Officer
RSP	Regional Service Plan
RTS	Regional Tertiary Services
SCBU	Special Care Baby Unit
SLAT	Service Level Alliance Team
SFIP	Service and Financial Improvement Programme
SIA	Services to Improve Access
SMO	Senior Medical Officer
SNA	Special Needs Assessment
SSP	Statement of Service Performance
SOI	Statement of Intent

SUR	Service Utilisation Report
TAS	Technical Advisory Service
TOR	Terms of Reference
UCA	Urgent Care Alliance
WBS	Work Breakdown Structure
YTD	Year to Date