This document is an extract from Northland DHB's Annual Plan 2020/21.

Appendix 2 System Level Measures Improvement Plan 2020/21

This SLM plan covers the requirements of the community part of 2.6.6 Acute demand and 2.7.1 Primary health care integration.

Introduction

In July 2019 a new and sole Primary Health Entity, Mahitahi Hauora, was launched in Northland.

The Mahitahi Hauora Board members are drawn from the NDHB, Iwi Health Providers, General Practice, Primary Care and Community.

This collaborative approach supports the commitment and determination to deliver a transformational strategy for Northland Healthcare. The Board of Mahitahi Hauora is a living embodiment of the Northland Alliance.

Mahitahi Hauora

Mahitahi board members

Geoff Milner (Trustee)
Acting Independent Chairperson

Dr Suzanne Phillips (Trustee)
Deputy Chairperson

Errol Murray (Trustee)

Lynette Stewart (Trustee)

Dr Andrew Miller (Trustee)

Dr Justine Woodcock (Trustee)

Moe Milne (Trustee)

Anthony Thompson (Trustee)

Dr Nick Chamberlain (Non-Trustee member) CEO NDHB

Development of the Mahitahi Hauora Strategy and Action Plan has required a different way of thinking and engaging with consumers, whānau, iwi, tertiary providers, and representatives from across primary, community and secondary care. This approach will be maintained through implementation and extended to include engagement with social and private sectors. There is a strong commitment to meet our Te Tiriti o Waitangi obligations and to achieve Māori health equity in Tai Tokerau/Northland.

Mahitahi Hauora has committed to achieving health equity for Māori across Northland by working in a collaborative and deliberate approach, innovation and transformation in service delivery, effective partnerships across health and social services, and through addressing what matters to whānau to achieve self-determined wellbeing. We are accountable to patients, whānau, and communities, and for improving Māori health outcomes. The SLM plan that has been produced is informed by significant engagement and consultation with providers; whānau; patients and clinicians.

Appreciative Inquiry hui have been held across Tai Tokerau. The process is a strengths-based way of building upon the many good aspects that already exist in human systems. It seeks to engage stakeholders in self-determining change, and identify opportunities for collaboration, establishing trust, and creating a shared sense of purpose and commitment. Localities were determined through mining of data to highlight inequities within the system across the life course of Northlanders.

Our strategic action plan has two key approaches set across the life course of individuals and whānau:

1) A portfolio approach of three key priority areas

- Mama, Pēpi and Tamariki 0-11years: Start Well.
- Taitamariki 12-24 years: Develop Well.
- Healthy Aging: Long term conditions and complex conditions: Age Well.

2) To use localities to incubate ideas, models of care and achieve outcomes. Learning, continuous improvement and collaboration across providers from the locality mahi will be used to inform progress and ensure we are accountable to our aims and objectives.

Benefits framework: A 2026 Northland healthcare system that sustains equitable self-determined well-being

	Whānau Knowledge	Whānau Health	Whānau Relationships	Whānau participation in community	Whānau engagement with Te Ao Māori	Whānau Living Standards	Whānau built natural environments
Whānau Ora Outcomes							
Strategic Focus	**START WELL** **Māmā Pēpi Tamariki** 'Māmā, pēpi and tamariki enabled to reach their aspirations of oranga'	**DEVELOP WELL** **Whakapiki ake Taitamariki** 'Resilient taitamariki'	**AGE WELL** **Healthy Aging** "Adults live healthy happy productive lives and age well in their own homes for longer"	**LIVE WELL** **Wellbeing Health Promotion** 'Building on whānau and community strengths to improve health equity'	**Accessible and Sustainable Primary Care** 'An engaged and responsive Primary Care workforce'		
LEADING THE WAY IN...	1. Achieving equity for Māori pēpi to be enrolled with a GP by 3 months of age 2. Increasing connectivity between health and social service providers	1. Engagement of taitamriki with Youth Workers 2. Enabling taitamariki independence to achieve life milestones that matter to them 3. Increasing taitamariki access to health & social services	1. Planning care that matters to adults 2. Saving the hearts of Māori men	Creating a thriving Northland for whānau to live and grow by: 1. Creating warm, dry, healthy homes 2. Increasing access to healthy kai 3. Supporting agency responsiveness to tamariki and taitamariki 4. Supporting Māori to stop smoking	1. Reflecting the population we serve 2. Implementing health equitable models of care 3. Building whānau capability to achieve wellness 4. Improving access to services		
Population focus	Pēpi and tamariki (0-12 years) in the far North: 0-4 yrs – 1637, 80% Māori 5-14 yrs – 3605, 79% Māori	7000 12-24yr olds, with a special focus on taitamariki Māori and those not enrolled in General Practice or a Health Clinic.	People who are frail (or close in age and interest), have complex needs and are high users of health services; and Māori men who work in or are enrolled in a practice within North Whangarei.	Māori whānau and hapori throughout Tai Tokerau.	Primary care workforce in Northland including GP's, Nursing, Allied Health, Māori Workforce, Non-regulated health, managers and administrators.		
Model of Care	Commencing with newborn enrolment, facilitate the development of a continuum of care model for all tamariki and work together with health and social service providers to deliver consistent support and a collaborative approach. Guide whānau, pēpi and tamariki through case conferencing/MDT using the whānau ora "Kaiarahi programme" navigators and/or health coaches. Promote healthy environments that support healthy kai, physical activity and effective weight management.	Recruit and assign Youth Workers to specific localities. These roles will sit in established Māori Health Providers and NGO's to support collaboration to improve access to health and social services enabling achievement with life passport milestones, drivers licensing and funded activities.	Coordinate multidisciplinary team meetings to coordinate care of highest adult users of health care. A navigation team will work to action outcomes/goals as identified by whānau and providers. Improve equity in heart health outcomes for Māori men through early detection of cardiovascular disease (CVD) and management of risk factors.	Utilise community development approaches and form intersectoral partnerships to deliver health promotion programmes that enhance determinants of health; Healthy Homes Tai Tokerau, Manawa Ora Healthy Homes Initiative, Kai Ora, Oranga Kai, Child and Youth Friendly Tai Tokerau. Work collaboratively with tamariki, taitamariki, whānau and communities to improve health equity, underpinned by Te Tiriti o Waitangi. Strive for Oranga Tamariki/Whānau/Tai Tokerau by celebrating communities strengths to improve wellbeing.	Explore and implement new models of care and build Northland workforce multidisapline pipeline. Launch a health and science academy for tauira Māori and second-chance learners with focus on micro-credentialing NCEA levels 3-5 combined with on the job learning. Partner with key stakeholders to establish rural health immersion hub with focus on growing Māori workforce. Provide workforce enablers; POADMS (primary options acute demand service), Neighbourhood Health Care Homes, Kia ora Vision, GP/ NP hubs / Locum co-ordination.		
Indicators	• Increase newborn enrolments • Increase utilisation of Whānau Tahi multidisciplinary model • Increase whānau access to tamariki nutrition and lifestyle support • Increase the number of tamariki enrolled in an Oral Health Provider • Improvement of health caused by environmental conditions – smoking and poor housing • Increase in connectivity between services and providers	• Youth workers have significant Involvement with taitamariki • Improvement in taitamariki experiences in education, employment and training • Increase in taitamariki in Quintile 4 & 5 passing their Learners Licence on first attempt • Increase in equitable taitamariki access to primary mental health and wellbeing services • Increase taitamariki engagement, leadership and capacity building	• Reduction in ASH rates and inequities attributable to CVD and diabetes • Improvement in CVD and diabetes indicators for Māori • Improvement of care processes for primary prevention of LTCs • Improvement in patient experience • Improved co-ordination of care via shared care plans and coordinators • Improved access to primary mental health and wellbeing services • Improved management of musculoskeletal conditions	• Increase number of Māori homes that are warm and dry • Increased production, availability and consumption of local, healthy, sustainable kai • Increase number of quit attempts for Māori • Improve stop smoking rates for Māori • Increased capacity of Northland Intersectoral Forum member agencies to respond in child and youth-centered ways • Increased capacity of youth workers	• Patients have access to GP services • Reduced burnout of GP workforce • Timely patient-centred urgent care in primary setting • Māori participation, retention and completion in level 3-5 health employment pathways • Equitable secondary education outcomes for tauira Māori • Improved patient experience • Reduced length of stay and ED presentations for specific conditions • Equitable uptake of shared care plans through Kia Ora Vision		
KEY MEASURE/S	**Increase enrolment of pēpi Māori through optimising connectivity between health and social service providers.**	**Taitamariki engaged by Youth Workers to achieve Life Passport Milestones.**	**10% reduction in GP visits and ASH admissions. Reduction in death due to heart attack/stroke in Māori men.**	**60% Māori households insulated and / or heated.**	**Increase Māori workforce** **All individuals, whānau have access to the right care at the right place at the right time.**		
Contributing Measures	• Increase from 81% to 95% tamariki Māori enrolled in General Practice by 3 months of age • Immunization increase at 6 months from 36% to 70% for tamariki Māori • Increase access to oral health services from 82 to 95% for tamariki Māori • Decrease from 4.6% to 3% in in ASH rates for tamariki Māori. (SLM Draft Improvement Plan • Increase from 76% to 90% tamariki Māori enrolled with a Well Child Provider by 3 months of age	• 70 taitamariki providing positive feedback of engagement with Youth Workers (Outcomes Rating Scale) • Taitamariki achieving in education, employment and training opportunities in each locality by 15% • 120 taitamariki enrolled with GP/Youth Health Clinics • 120 taitamariki have STI, ETOH & Drug Screening in achieving their Youth Passport Milestones • 35 taitamariki have Care Plans developed through Community Care Management (MDT) • Taitamariki Māori (20-24yrs) have reduced self-harm hospitalisations & short stay ED presentations	• Reduce ASH admissions from 34.8% to 24.8% • Reduce GP utilisation of 29697 by 10% • Improve pharmacological management of CVD for Māori men from 36.2% to 46.2%	• 80% of whānau Māori reporting home improvements • 95% Māori enrolled in stop smoking service make a quit attempt • 50% of Māori enrolled stop smoking • 75% of Kai Ora projects funded that impact Māori • 10 agencies that complete a child and youth friendly organizational audit • 60 of youth workers trained • 2 youth worker networks throughout Tai Tokerau	• Increase GP sessions over the next 12 months from average of 4-6 sessions to 6-8 sessions per week • Employ 1x locum GPs in 12 month/ Employ 1x locum NP in 12 months • Implement 2x positions health work based Training for Maori • 80% of 30 tauira Māori achieving NCEA L1 and Science • Increase KOV enrolment from 34% for enrolled Maori to 40% in total • Increasing from 70% patients triaged seen same day to 85% patients triaged seen same day Maori being a priority. • In line with KOV enrolment 40% having an active shared care plan • Reduce presentations to ED by 3% • Reduce the number of tamariki Māori aged 0-4 years ASH rates by 3%: • Diabetes HBA1C <64 increase from 40 to 60%. • CVD management from 48% on triple to 55%		

Ambulatory Sensitive Hospitalisations for 0-4year olds SLM plan 2020/2021

Reduced avoidable hospital admissions among children

See also 2.3.2 Maternity and early years action 2.

Current National Enrolment Service (NES) data illustrates the inequity for the rates of enrolment for Pēpi Māori compared to non-Māori. Stats as at September 2019 (first quarter) and December 2019 (second quarter):

Stats as at September 2019 (first quarter):

	Total popn. % enrolled	% Māori
At 6 weeks of age	77.1%	65.0%
At 3 months of age	94.3%	78.1%

Stats as at December 2019 (second quarter):

	Total popn. % enrolled	% Māori
At 6 weeks of age	74.0%	68.9%
At 3 months of age	85.7%	80.6%

Feedback from both whānau and providers stated a top-ranking issue was the disconnection between services and this has reiterated throughout the Appreciative Inquiry (AI) process. This disconnect has a direct detrimental impact on the continuum of care for individuals and their whānau due to the increased risk of gaps and duplication resulting in delays in accessing relevant services.

Findings from engagement and data analysis identified:

1 Lack of access and complexity of enrolment process. (Reviewing newborn enrolment data and other child health reports tells us that Tamariki Māori are less likely to have access to services compared to those of non-Māori.)
2 Whānau / Tamariki who are not enrolled in general practice are also more likely to have high rates of presentation to secondary care.
3 Whānau / Tamariki who are not enrolled in general practice are more likely to have missed opportunities for preventive care and early assessment and treatment of clinical issues.
4 Whānau who decline vaccinations are often those same Whānau / Tamariki who are not enrolled at general practice.

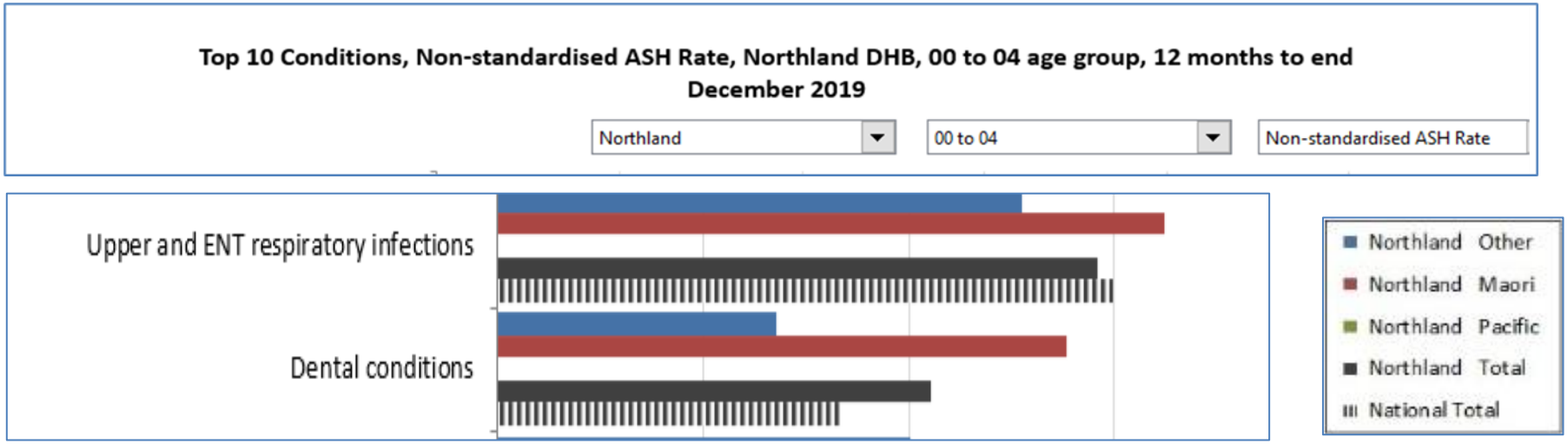
Mahitahi Hauora have identified a high priority group of Pēpi, within the geographical locality of Kaikohe, Kawakawa, Whangaroa (Kaeo), Morewa and Paihia *(Locality One).

Improving enrolment processes to mitigate current barriers and challenges for whānau enrolling newborns will enable Increased access to general practice and other primary health care services for Tamariki Māori.

Increased access to primary care will lead to:

- improved rates of Tamariki Māori fully immunised by 6 months, therefore reducing the risk of preventable diseases
- established relation between provider and whānau increasing access to acute care for Tamariki
- reduced gaps and duplication through increased connectivity between services and providers through MDT and other forums
- Improved Dental care access and reduction in ASH related dental admissions

Our hypothesis is that the introduction of these identified activities will reduce ambulatory sensitive hospitalisation (ASH) rates for 0-4 year olds as access to primary care services and timely interventions increase. The focus in this improvement plan is reducing the rate for respiratory and dental ASH, which will lead to an overall reduction in ASH rates for this age group.



Government theme: Improving the well-being of New Zealanders and their families	
System outcome: We have health equity for Māori and other groups	**Government priority outcome:** Make New Zealand the best place in the world to be a child

Milestones	Activities	Contributory measures
Reduce ASH rate for tamariki Māori by 3%.	Continue the ongoing implementation of NCHIP and Te Māhuri Care connection process as per identified activity in 2019/2020 SLM Formulate a priority matrix for contacting Whānau with unenrolled Tamariki newborn to 3 months of age within Q1 and implement for our priority Populations* by Q4. Implement a pilot project initially in Mahitahi Hauora Locality One * that prioritises those Tamariki Māori with notified recurrent admission with identified ASH conditions to refer for proactive case management, through existing MDT processes. Initiate the resourcing and planning for the implementation of two projects within the Locality for Mama,Pepi, Tamariki as identified priorities * by Mahitahi Board, our Northland Alliance : • Start Well (Immunisation) and • Start Well (Oral Health) Projects	Increase Percentage of Māori infants in Northland enrolled in the Primary Health Entity by 3 months (from 80.6%) Number of Manawa Ora Healthy Home Initiative (HHI) referrals received and actioned for priority tamariki Number of tamariki Māori within our pilot locality One * admitted to hospital with identified recurrent ASH admissions who are subsequently referred for MDT proactive case management Rate of Tamariki Māori receiving immunisations by 6 months of age. Rate of Tamariki Māori receiving appropriate dental care before starting school.

Acute Bed Days SLM Plan for 2020/2021

Improved management of demand for acute care

There is an increasing burden of long-term conditions as well as a growing population of older frail people in Whangarei. Care coordination for people with complex needs is fragmented and is confusing and exhausting for the individual or whānau to navigate. Mahitahi Hauora employed a collaborative approach using the Appreciative Inquiry (AI) methodology for management of long-term conditions within the North Whangarei locality. As a result of these workshops, it was determined that supporting people with complex health needs to live well in their own homes for longer was a top priority.

This project will work on the following problems being experienced by individuals who are high users of the health system:

- high readmission rate
- duplication/absence of service delivery
- delay in appropriate service delivery/treatment
- fragmented care
- high cost of people going into residential care facilities
- inequitable service provision for priority populations.

These challenges contribute to early death, increased system level demand through service usage, increased strain on physical and financial resources and poorer health outcomes and quality of life for these people. In addition, Appreciative Inquiry workshop findings have pointed to clinical stress and job dissatisfaction due to inability to fully meet the needs of complex patients.

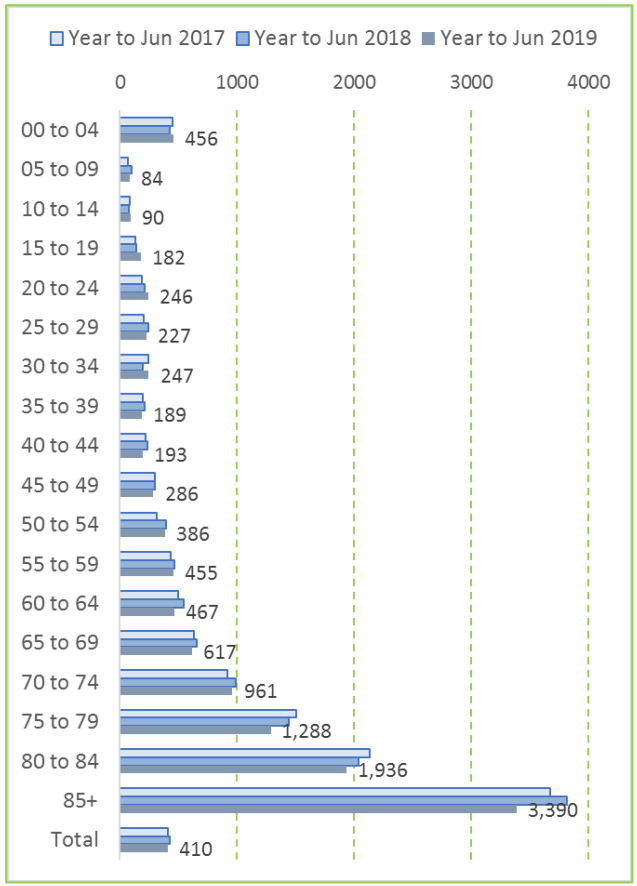
Northland is experiencing a significant increase in population. Coupled with our aging workforce and ever-increasing demand on access of health services, it is putting the system under significant strain:

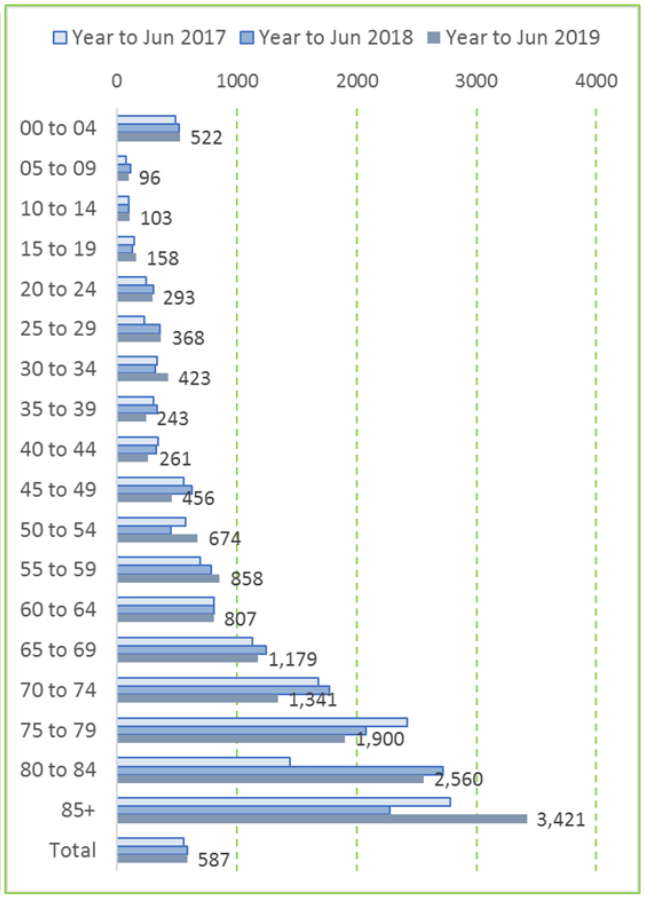
	Census Year	Age																				
		Total	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90-94	95-99	100-
Total population	2018	179,076	11,682	13,359	12,579	10,494	8,520	9,822	9,513	8,751	9,600	11,649	12,345	13,239	12,495	11,724	9,456	6,507	3,831	2,271	993	216	2
	2013	151,689	10,659	11,019	11,070	9,627	7,056	6,657	6,591	7,899	9,834	10,629	11,502	10,914	10,464	9,333	7,269	4,836	3,399	2,004	753	147	2
5 year growth		18.05%	9.60%	21.24%	13.63%	9.01%	20.75%	47.54%	44.33%	10.79%	-2.38%	9.60%	7.33%	21.30%	19.41%	25.62%	30.09%	34.55%	12.71%	13.32%	31.87%	46.94%	#####
Māori population	2018	64,458	6,582	7,446	6,645	5,469	4,206	4,320	3,708	3,219	3,366	3,825	3,795	3,720	2,784	2,169	1,422	960	507	240	69	9	
	2013	44,931	5,145	5,022	4,974	4,032	2,853	2,388	2,178	2,460	2,697	2,850	2,913	2,247	1,725	1,287	1,005	648	339	132	33	6	
5 year growth		43.46%	27.93%	48.27%	33.59%	35.64%	47.42%	80.90%	70.25%	30.85%	24.81%	34.21%	30.28%	65.55%	61.39%	68.53%	41.49%	48.15%	49.56%	81.82%	109.09%	50.00%	#####
Non-Māori population	2018	114,618	5,100	5,913	5,934	5,025	4,314	5,502	5,805	5,532	6,234	7,824	8,550	9,519	9,711	9,555	8,034	5,547	3,324	2,031	924	207	2
	2013	106,758	5,514	5,997	6,096	5,595	4,203	4,269	4,413	5,439	7,137	7,779	8,589	8,667	8,739	8,046	6,264	4,188	3,060	1,872	720	141	2
5 year growth		7.36%	-7.51%	-1.40%	-2.66%	-10.19%	2.64%	28.88%	31.54%	1.71%	-12.65%	0.58%	-0.45%	9.83%	11.12%	18.75%	28.26%	32.45%	8.63%	8.49%	28.33%	46.81%	0.00

This data clearly demonstrates the impact of the growing population trends across Northland. Northland is also experiencing severe GP shortages which is resulting in more and more pressure on walk in services such as urgent care centres and ED centres. Managing the impact of Long-Term conditions, as well as identifying opportunities to improve patient flow throughout the system continues to a be a significant priority.

There is significant evidence to suggest that providing shared care platforms through Multidisciplinary Teams (MDT) provides patients with the confidence to manage their condition at home, reducing the need for unplanned admission and presenting to urgent care facilities.

Age Group Comparison data for Acute Bed Days per Capita Rates in Northland, SLM Data are as follows:


Year to Jun 2017
Year to Jun 2018
Year to Jun 2019
0
1000
2000
3000
4000
00 to 04
456
05 to 09
84
10 to 14
90
15 to 19
182
20 to 24
246
25 to 29
227
30 to 34
247
35 to 39
189
40 to 44
193
45 to 49
286
50 to 54
386
55 to 59
455
60 to 64
467
65 to 69
617
70 to 74
961
75 to 79
1,288
80 to 84
1,936
85+
3,390
Total
410


Year to Jun 2017
Year to Jun 2018
Year to Jun 2019
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2000
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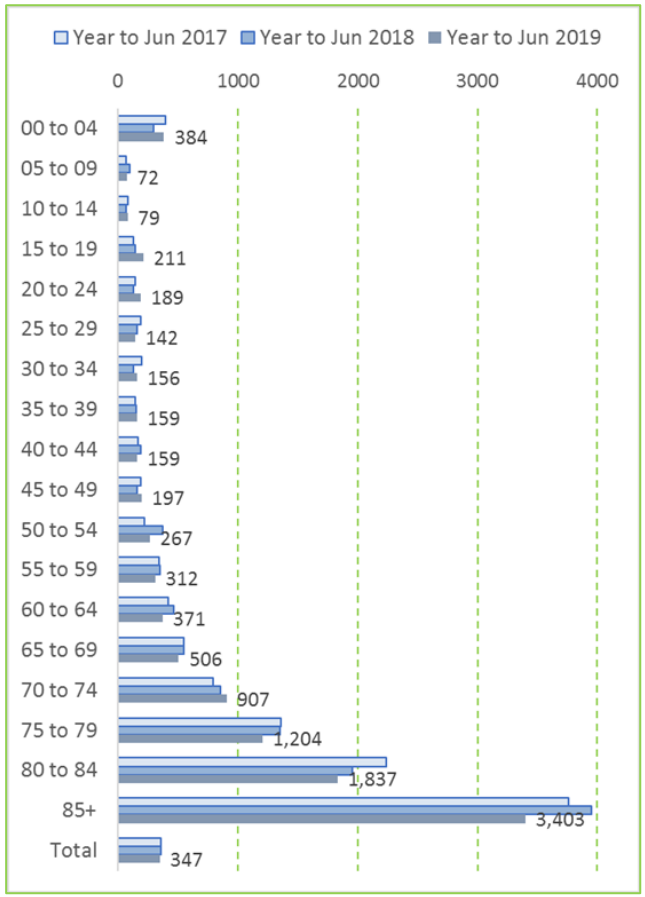
4000
00 to 04
522
05 to 09
96
10 to 14
103
15 to 19
158
20 to 24
293
25 to 29
368
30 to 34
423
35 to 39
243
40 to 44
261
45 to 49
456
50 to 54
674
55 to 59
858
60 to 64
807
65 to 69
1,179
70 to 74
1,341
75 to 79
1,900
80 to 84
2,560
85+
3,421
Total
587


Year to Jun 2017
Year to Jun 2018
Year to Jun 2019
0
1000
2000
3000
4000
00 to 04
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05 to 09
72
10 to 14
79
15 to 19
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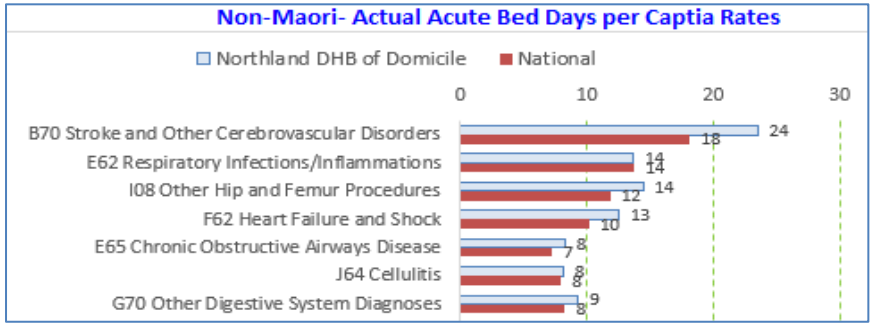
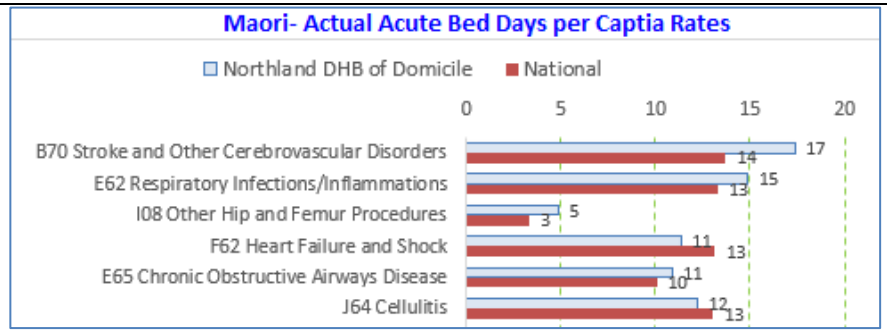
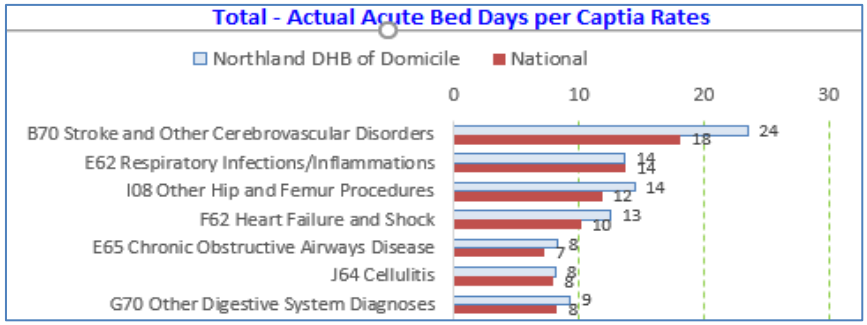
20 to 24
189
25 to 29
142
30 to 34
156
35 to 39
159
40 to 44
159
45 to 49
197
50 to 54
267
55 to 59
312
60 to 64
371
65 to 69
506
70 to 74
907
75 to 79
1,204
80 to 84
1,837
85+
3,403
Total
347

Review of the actual acute bed day data on condition by condition basis shows the following:







The DRG codes suggest that primary care can make impact in the ABD rates for Māori respiratory conditions, cellulitis and COPD.

The reality of the situation is clear: Northland must innovate models of care than enable people to live well in their own communities, to have access to high quality primary care, and to support the development and resilience of primary and community providers to meet the rising demand. This is particularly evident for Māori who are the single largest growing population and are disproportionately overrepresented in acute bed day stays in all categories across the life span.

Mahitahi Hauora has a significant investment strategy to look at upstream workforce programmes which look to increase access to clinical teams and grow capacity in the primary care system. Our immediate focus in this plan is to provide models which can help us to manage the current levels of demand and ABD rates.

Government theme: Improving the well-being of New Zealanders and their families	
System outcome: We live longer in good health	**Government priority outcome:** Support healthier, safer and more connected communities

Milestones	Activities	Contributory measures
Reduce the equity gap by 10% between Māori and non-Māori in the number of actual acute ASH rates[1] by June 2021:	Target top 100 patients with complex needs that are high users of secondary care and are amenable to primary care intervention: Coordination of individual packages of care by POADMS, including active pull from wards for amenable early discharge. COPD winter rescue packs. Implement Multidisciplinary Team meetings to address complex management across cross sectoral health providers focused on improving management in primary care settings.	Acute bed days saved in respiratory conditions, Stroke and COPD. Reduction in average LOS Māori Reduction in ASH rates Māori Reduction in ASH events Māori

Amenable Mortality SLM Plan for 2020/2021

Prevention and early detection

Draft Amenable Mortality DHB summary 2016 (NSFL), DHB of domicile Northland:

	2009		2010		2011		2012		2013		2014		2015		2016	
	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate
Māori	146	323.1	121	253.8	132	280.7	140	284.6	135	253.1	116	210.9	115	211.8	126	220.3
Pacific	4	…	7	…	3	…	1	…	5	…	5	…	3	…	6	…
Non Māori, Non-Pacific	158	102.7	170	98.4	166	97.7	181	96.1	148	75.6	153	84.3	159	74.6	191	97.1

Rates per 100,000 age standardised to WHO world standard population. Rates are suppressed where there are less than 30 deaths

[1] For Whangarei Hospital

In Northland, the 2 leading causes of Amenable Mortality in Northland are Diabetes and CVD related conditions.

Amenable mortality deaths, 0-74 year olds, 2010-2016:

	2010	2011	2012	2013	2014	2015	2016 (provisional)
Diabetes	26	25	25	21	20	17	30
Valvular heart disease	7	10	7	5	10	9	9
Hypertensive diseases	3	5	4	3	2	7	3
Coronary disease	84	88	87	86	73	71	69
Heart failure	2	3	1	2	2	0	1
Cerebrovascular diseases	22	22	17	22	25	27	28
Pulmonary embolism	1	1	1	0	1	0	2
Atrial fibrillation and flutter	2	1	2	4	5	4	5
COPD	32	24	31	19	25	38	35

Approach to CVD

In 2018 the Ministry of Health consensus statement recommended that all Māori should have a CVD risk assessment at a younger age; 30 years for Māori men and 40 years for Māori women.

A number of collaborative workshops were conducted within the North Whangarei locality using the Appreciative Inquiry methodology. As a result of these workshops it was determined that reducing premature death of Māori men was an immediate priority.

Overall, Māori are more than twice as likely as non-Māori to be hospitalised, and two and-a-half times as likely to die from cardiovascular disease CVD (Ministry of Health). Māori are also less likely to access health care and do not receive the same level of referrals and specialist care as non-Māori. Māori are more than twice as likely to have gone without health care in the past year due to significant barriers such as cost.

In Northland there are 40,984 men eligible for CVRA; of these eligible men 10,620 are Māori. To date there have been 8,418 Māori men screened. The screening uptake is high but management of heart health risk greater than 15% needs significant improvement:

- current rates for dual therapy are 21.1% for those with a risk of 15-20% and 35.9% for those with risk >20%
- current rates for prior CVD on triple therapy are 48.0%.

In 2018/19 the Northland Alliance conducted a Point of Care testing pilot at AFFCO Moerewa, as part of SLM long term conditions CVRA screening, focused on HbA1c testing.

The predominant ethnic group was Māori 64.9%. 56 (98.3%) of the participants completed questionnaires which were designed to assess their impressions and gain feedback about the study. The results showed 98.3% participants would recommend this programme to their family, whānau and work mates and 98.3% would participate if it was repeated in 2020.

A paper has been published on the research from this project. It is with this learning in mind, alongside The Heart Foundation Māori men co-designed heart health work, that Mahitahi Hauora will implement Heart Health Hauora Ecosystem Popup Clinics.

Approach to diabetes

Select DHB of Domicile:	Northland		Period	Q2 2019-20 to 31-Dec 2019

SS13 Improved management for long term conditions (Diabetes)

Numbers of people with diabetes

PHO register total (all PHOs) as at 31-Dec 2019			VDR estimate of diabetes prevalence as at 31 Dec 2018			Estimated completeness of diabetes ascertainment by PHOs		
	Denominator							
	Ages 15-74 only	All ages		Ages 15-74 only	All ages		Ages 15-74 only	All ages
Maori	3,641	4,150	Maori	4123	4,719	Maori	88.3%	87.9%
Pacific			Pacific	201	223	Pacific	0.0%	0.0%
Other	3,750	5,394	Other	4368	6,377	Other	85.9%	84.6%
Total	7,391	9,544	**Total**	8,692	11,319	**Total**	85.0%	84.3%

HbA1c measurement data- for people aged 15-74 years inclusive

	Numerator					
	Number with HbA1c ≤ 64mmol	Number with HbA1c > 64 mmol and ≤ 80mmol	Number with HbA1c > 80mmol and ≤ 100mmol	Number with HbA1c > 100mmol	Total number with any available HbA1c result	Total number with no available HbA1c result
Māori	1,346	501	363	182	2,392	**1,249**
Pacific					0	**0**
Other	2,263	605	263	70	3,201	**549**
Total	**3,609**	**1,106**	**626**	**252**	5,593	**1,798**

Percentage rate based on total PHO/practice count rate						
	% HbA1c ≤ 64mmol	% HbA1c ≥ 65mmol and ≤ 80mmol	% HbA1c > 80mmol and ≤ 100mmol	% HbA1c > 100mmol	Percentage with any available HbA1c result	Percentage with no available HbA1c result
Māori	**37.0%**	**13.8%**	**10.0%**	**5.0%**	**65.7%**	**34.3%**
Pacific	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
Other	**60.3%**	**16.1%**	**7.0%**	**1.9%**	**85.4%**	**14.6%**
Total	**48.8%**	**15.0%**	**8.5%**	**3.4%**	**75.7%**	**24.3%**

There are approximately 1,7752 people living with diabetes who are unknown to the Northland health system.

Northland's Māori are significantly disproportionately affected by diabetes.3

Only 75.7% of Northlanders living with diabetes have an HbA1c recorded, 34.3% of Māori with diabetes have not got an HbA1c recorded, compared to 14.6% non-Māori.

There is a significant equity gap between Māori and non-Māori for patients with good control of 23%.4

Of the diabetic-related amputations in 2017/18, 44%5 were undertaken on Māori.

Effective primary and community care is widely accepted as being a critical enabler to support individuals living with diabetes to self-manage and improve their overall health and wellbeing outcomes. Mahitahi Hauora has made a commitment to prioritise funding to achieve health equity for Māori by:

- ensuring that the Cardiovascular Disease Risk Assessment for Primary Care guidelines are met and implemented
- that patients who have elevated risk for CVD are effectively prescribed triple and dual therapies on an equitable basis for Māori

that patients who live with diabetes have appropriate support to live well with diabetes and manage their condition well in the community.

Government theme: Improving the well-being of New Zealanders and their families	
System outcome: We have health equity for Māori and other groups	**Government priority outcome:** Support healthier, safer and more connected communities

Milestones	Activities	Contributory measures
Reduce amenable mortality for Māori Men by 10% by June 2023.	Provide Hauora ecosystem CVD clinics across multiple employers and community sites for the North Whangarei locality population. Develop, trial, refine and implement a pathway within the North Whangarei Locality to increase engagement for Māori men to optimise dual and triple therapy for CVR management by end of Q3. Development of a whole sector Northland Diabetes plan, utilising a co-design methodology by end of Q2. Socialise the Northland Diabetes plan across Northland by end of Q4.	Number of people seen in Hauora ecosystem heart health clinics Uptake of pharmaceutical dispensing of diabetes medication for Māori men with diabetes and prior CVD Uptake of pharmaceutical dispensing Dual/triple therapy for Māori men with prior CVD Number (and Percentage) of Māori with HbA1c<64mmol/mol

[2] MoH Virtual Diabetes Register predicts 11,319 people in Northland with diabetes: 9,544 in Northland have been diagnosed.
[3] 43.4% of the diagnosed population are Māori, against an overall Māori population of 34.2%.
[4] 1,346 Māori patients aged 15-74 (37%) had HbA1c result of under 64mmol/mol compared to 2,263 (60.3%) non-Māori. 1,046 Māori had HbA1c of 64mmol/mol or more compared to 938 non-Māori.
[5] National Minimum Data Set

		Number (and percentage) of Māori with known diabetes completing an annual Hba1c Number of mobile providers across Northland trained to use new pathway.

Patient Experience of Care 2020/2021

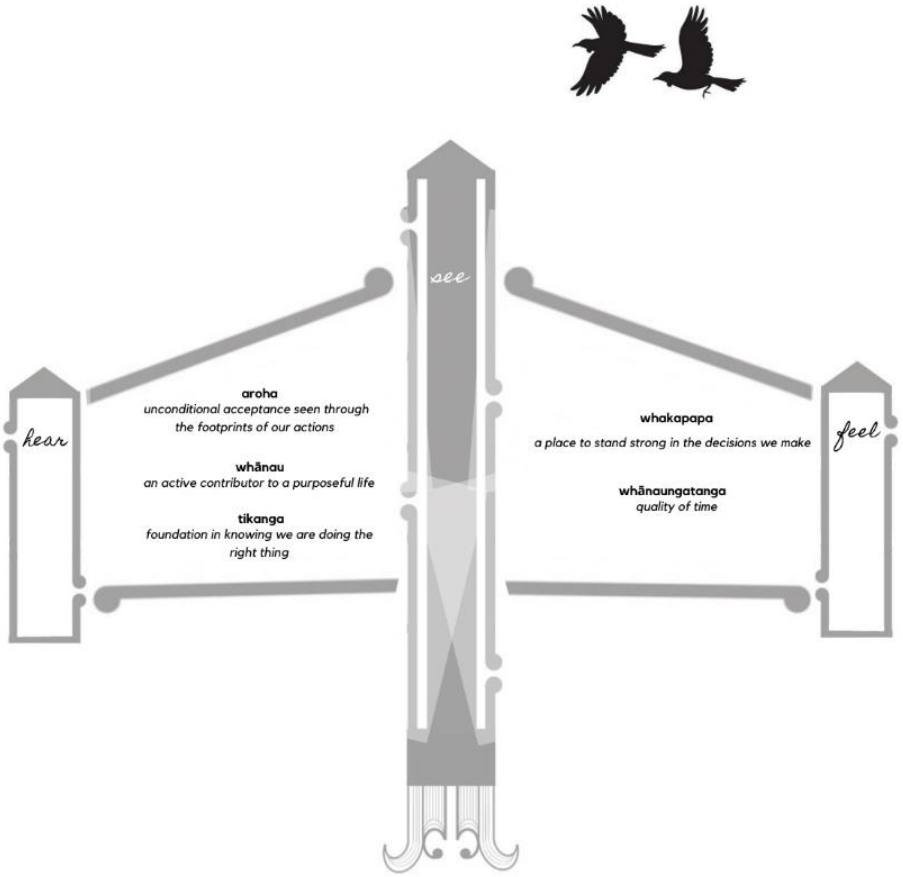
Improved clinical outcomes for patients in primary and secondary care through improved patient safety and experience of care

This SLM is described as “patient experience of care using the [Health Quality and Safety] Commission’s national adult hospital and primary care patient experience surveys”. Improvement milestone and activities for this SLM should focus on:

- questions that highlight inequities for Māori, Pacific and other high priority populations
- groups of questions in the domains that highlight an issue such as access to services, health literacy, medication reconciliation and adherence, flow of information between PHO/ practice to specialists or hospitals
- low scoring questions from the adult inpatient survey.

It must be acknowledged that the Commission’s national patient experience surveys are both under review and there has been a change of host provider. The reporting portal that has been used since inception of the national patient experience surveys closed on 30 January 2020, and a new portal is under development. The questionnaire itself is being refreshed, meaning that the old and new data sets will not be comparable.

At its essence, a patient experience survey informs planning and clinicians in the way they can deliver health care services in a more meaningful to patients. In a westernised world perspective, the models of engagement for surveys work relatively well However listening to the Māori community, we know that these methods are less effective at understanding their experience of care. Coupled with this, the infrastructure and delivery models for the surveys is predominantly via electronic collection.



what matters to whānau measurement papa tikanga

While western measures focus on physical outputs and outcomes, the What Matters to Whānau papa tikanga is measured by how whānau experience the tahā principles within an environment or context. Within a provider environment for example, we create experiences that enable whānau to hear, see and feel the things that matter to them. These are portrayed as a dual-axis measurement papa tikanga with an initial set of experience measures which will continue to evolve as this work progresses.

what matters to whānau tahā

	aroha *unconditional acceptance seen through the footprints of our actions*	*whānau* *an active contributor to a purposeful life*	*tikanga* *foundation in knowing we are doing the right thing*	*whakapapa* *a place to be strong in the decisions we make*	*whānaungatanga* *quality of time*
hear *how do whānau hear the tahā*	Whānau hear Te Reo Māori in the right context and natural form; correct pronounciation of their name and place names Whānau hear mana enhancing language when interacting with providers e.g. what matters to you vs. what's the matter with you	Whānau are connected and safe when service providers confidently use both te reo Māori and English Whānau voice is heard authentically developing trust and unity	Whānau values are acknowledged Whānau have a positive relationship with Te Ao Māori Whānau world view and context is acknowledged and sought for holistic understanding	Whānau can access and express their lineage, ancestry, descent, parentage culture and identity in ways that are meaningful to them Whānau whakapapa and talents are acknowledged and understood with authentic interest	Whānau are engaged in a process of relationship building (whānaungatanga) Whānau and providers work together to increase wellness for the whānau Whānau are listened to actively, without judgement
feel *how do whānau feel the tahā*	Whānau are acknowledged with a smile, hongi, warm gestures, body language or cues and a warm hand shake which makes them feel not alone in the process Whānau wellbeing is promoted through processes of powhiri (welcoming), karakia (prayer), kai (food) & hospitality Whānau are offered food, water or something else when a need needs to be met	Whānau feel empowered and valued when their voice and work is heard, noted and utilised developing a plan with whānau Whānau are working together and everyone has a place and identity and feel welcomed Whānau share common goals and everyone that is important to the individual is included	Whānau feel respected and are talked 'to', not 'at'. Whānau are engaged through a culturally safe process and correct protocol is followed Whānau opportunities are created for inter-generational transfer of knowledge & experience	Whānau identity with places of importance is acknowledged e.g. ko au te whenua, te whenua ko au (I am the land and the land is me) Whānau skills are acknowledged, strengthened and maintained when delivering service Whānau are supplied with resources to support and sustain their interests	Whānau wellness is enhanced through collaborative efforts directed by whānau Whānau are known personally by providers Whānau and community champions are identified and utilised to increase authentic and positive narrative about Māori in public messaging
see *how do whānau see the tahā*	Whānau see providers working alongside them which nurtures their wairua (spirit) by allowing whānau to create their own pathways	Whānau perspective of wellness is acknowledged, even if different from your own Whānau are not viewed or defined by their illness	Whānau see providers acknowledge tuakana, teina role - a reciprocal teaching and learning relationship between two people Whānau are given space to exercise leadership in Te Ao Māori	'Registering' whānau is not confined to service providers but can also include marae, iwi, community groups, local businesses, rugby, hunting & fishing	Whānau rangatiratanga (self-determination) flourishes when whānau are in control and leading the way for their whānau, hapu, iwi Whānau are offered both te ao Māori and Western options as choices of wellness

Northland is a highly rural and deprived population, with Māori overrepresented in the rural and remote communities, it can be argued they are offered less access to contribute to the surveys. This is reflected in the lower response and completion rates for Māori.

Mahitahi Hauora has developed an engagement framework that will support engaging with Māori whānau from a Te Ao Māori perspective. The Whānau Wellness Papa Tikanga approach (see pictorial above) describes our commitment to engagement and is a leading edge kaupapa to give voices to whānau and Māori communities across Tai Tokerau.

While the current health system is determined by western approaches that treat individuals, symptoms and disease using conventional medicine and mainstream methods, it is important to acknowledge the unique contribution Māori Provider communities contribute to transforming care delivery through operating in an inherent paradigm of Taonga tuku iho (traditional healing systems handed down over generations).\

Inpatient Survey

System level outcome: delivering patient centred care.

Rationale:

How people experience health care is a key element of system performance that can be influenced by all parts of the system and the people who provide the care. Improved patient experience of care will reflect better integration of heath care at the service level, better access to information and more timely access to care.

Northland DHB has actively participated in the design of the revised national inpatient survey due for release in August 2020.Historically there has been a poor uptake of the national survey in Northland. For this reason, we have augmented uptake using an in-house survey based on a subset of the national inpatient survey questions.

Patient feedback is used widely throughout the organisation by way of consumer council participation in advisory groups, patient compliments and complaints and national and various in-house surveys that incorporate the patient experience when measuring service redesign. The in-house survey based on the national survey translates into publicly displayed ward posters that incorporate both qualitative and quantitative feedback and benchmarking. These posters are shared across all levels of the organisation from board to ward. Feedback to all levels of the organisation will in 2020-21 include equity reporting and the inclusion of the bias experience feedback from patients.

Government theme: Improving the well-being of New Zealanders and their families	
System outcome: We have health equity for Māori and other groups	**Government priority outcome:** Support healthier, safer and more connected communities

Milestones	Activities	Contributory measures
Primary Care survey Reduce inequities in self-determined wellbeing by increasing the number of Māori who are involved in decisions regarding their own care by June 2021. • Achieve at least 5% increase in positive responses from Māori patients to the survey question "Did the healthcare professional involve you as much as you wanted to be in making decisions about your treatment and care?"	Work with practice staff to improve access to programmes that can empower self-determined wellbeing for Māori. • Improvement Partners (formerly practice facilitators`) to encourage practices to meet their Kia Ora Vision enrolment and Whānau Tahi Patient Centred Care Plan targets for Māori patients with long term conditions through identifying enrolled Māori without current or up-to-date care plans using risk stratification tools. Then meeting with practices to create an action plan to improve, including working with the wider workforce (eg HIPs) and other providers (eg iwi and Māori providers). • Educate staff on the importance of the PE Survey and promote positive communications about it to patients through highlighting the survey at monthly practice managers' meetings and seeking ideas on how they will work with their staff, or what support they require, to highlight importance. Improvement Partners will also discuss with practice staff prior to quarterly surveys.	• Enrolments rates in Kia Ora Vision for Māori • Rates of Māori with LTCs have been involved in creating their Whānau Tahi Shared Care Plan • Number of Māori patients who accessed their Care Plan Achieve at least 5% increase in positive responses from Māori patients to the following survey questions;" ○ *Do you have a shared treatment or care plan agreed with a healthcare professional to manage your condition(s)?*" ○ *Did the healthcare professional involve you as much as you wanted to be in making decisions about your care and treatment?"*
Inpatient survey A 3 % improvement on the question 'Were you told the possible side effects of the medicine (or prescription for medicine) you left hospital with, in a way you could understand?' by 30 June 2021.	Add national survery medication questions to the local inpatient survey. Use patient experience results for medication questions to inform the patient experience dimension currently absent in medication administration audits. Add patient experience quarterly survey results to quarterly consumer council agenda. Consumer council input on all patient facing documentation to ensure health literacy lens applied. Pilot of the Falls Assessment Form to include polypharmacy prompt for pharmacy review and whānau discussion on side effects to watch out for with identified at risk patients.	Number of advisory groups the consumer council participate in. 5% reduction in number of medication related falls during inpatient stay.

Youth Health SLM Plan for 2020/2021

Youth are healthy, safe and supported

Through the appreciative inquiry process undertaken in the Whakapiki ake Taitamariki locality, taitamariki, services and communities expressed the need for more youth workers to provide facilitation and connection to health and social services as well as regular activities such as sports, arts as designed by taitamariki. Taitamariki describe the need for 'youth appropriate access' enabling successful navigation and participation in the community to achieve life's transitions.

3 key priorities were identified by youth across Bream Bay, Onerahi, Raumanga and Dargaville:

- variable access to health, education, employment and recreational opportunities
- barriers of distance or rurality, creating disincentives for acquiring life passports and participating in recreational activities
- ability to exercise autonomy is restrained by the availability and access to support service options.

The extent of these problems is further supported by the following statistics identified in the Health Needs analysis for Te Tai Tokerau:

- for those 2-14yrs 4.4% were diagnosed with emotional or behavioural problems (5.5% for Māori & 3.2% for Non-Māori) and higher for males
- 20% of the Northland population >15years had a mood or anxiety disorder diagnosed which is one of the highest rates in New Zealand
- 8% of Northland adults scored highly on the Kessler 10 score, indicating psychological distress and a high probability of anxiety/depressive disorder. The 15-24-year age group were the most likely to score highly (10% of Tane).

There is a significant opportunity to collaborate with the community supported by the findings of the Mental Health review, which indicates a willingness to correct issues impacting on emotional well-being. Significant benefits for taitamariki in the areas of improving access to recreational services, reducing depression and increased emotional wellbeing can be achieved. Our goal is that taitamariki have access to their choice of experiences required for health and wellbeing as they transition into adulthood.

We have selected the Mental Health and Wellbeing domain to measure the impact of our plan. Young people experience less mental distress and disorder and are supported in times of need as measured by Self-harm hospitalisations and short stay ED presentations for <24 year olds. Our data set will be the PHO level data for the specific age group of10 -24 year olds and 20 to 24 year olds, which as at end of March 2020 is as follows:

Ethnic Group Analysis:

Self Harm Hospitalisations - Total <= Select Self Harm Hospitalisation Classification

20 to 24 <= Select Age Group

Total <= Select Gender

Report for Patient PHOs, March 2020

Ethnic Group Data - Youth Self Harm Hospitalisation Rates (per 10,000 population)

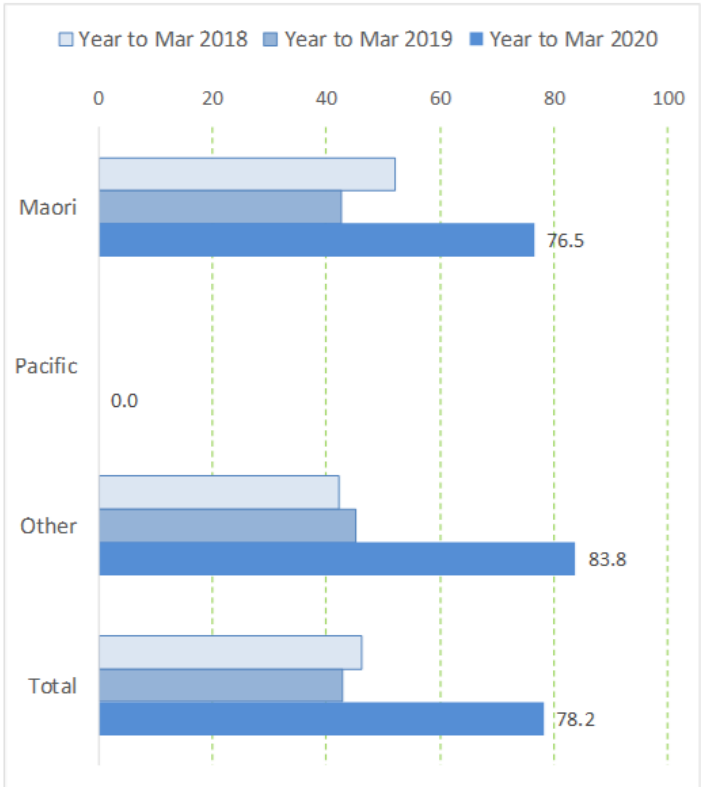
Using Standard Population: Census 2013 Usual Resident Population

Te Kaupapa Mahitahi Hauora

	Population	Number of Self Harm Hospitalisations - Total	Actual Self Harm Hospitalisation Rate (per 10,000 popn)	Age Standardised Self Harm Hospitalisation Rate (per 10,000 population)		
Ethnicity	Year to Mar 2020	Year to Mar 2020	Year to Mar 2020	Year to Mar 2018	Year to Mar 2019	Year to Mar 2020
Maori	4,315	33	76.5	52.1	42.6	76.5
Pacific	183	0	0.0	0.0	0.0	0.0
Other	3,940	33	83.8	42.3	45.2	83.8
Total	8,437	66	78.2	46.2	42.9	78.2

Age Standardised Youth Self Harm Hospitalisation Rates

Te Kaupapa Mahitahi Hauora



Government theme: Improving the well-being of New Zealanders and their families	
System outcome: We have improved quality of life	**Government priority outcome:** Ensure everyone who is able to, is earning, learning, caring or volunteering

Milestones	Activities	Contributory measures
5% reduction in Age Standardised youth self -harm hospitalisation rates by 30 June 2020.	Workforce training –MH Credential for all those working with youth, evidence-based and equity focused. Workforce training – MH:101 Employ and follow up with Induction training 5 youth workers. All Youth and PMH workers report monthly on incidence of Self Harm. Trial 10 x Community Care Management (CCM)/Multidisciplinary Team Meetings (MDT) Taitamariki engaged with youth and PMH workers have pre and post-depression and anxiety screening scores Taitamariki engaged with youth and PMH workers have Care plans	Number of workers trained MH Credential Number of workers trained MH:101 / Health literacy Induction training completed for all new Youth workers Monthly reporting demonstrates trends of Self Harm and promotion/ prevention activities Report monthly on CCM/MDT meetings Number of referrals of vulnerable youth to primary mental health services 80% Taitamariki engaging primary mental health support show an improvement in post screening scores (e.g Kessler 10) 80% Taitamariki complete Care Plans developed through Community Care.

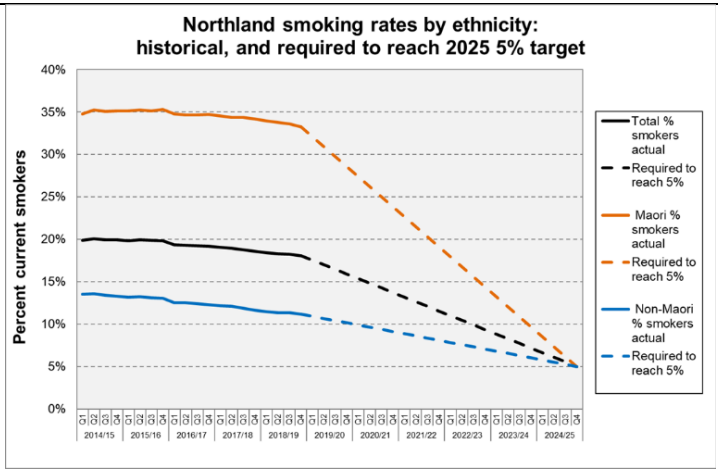
Babies Living in Smoke Free Homes SLM Plan for 2020/2021

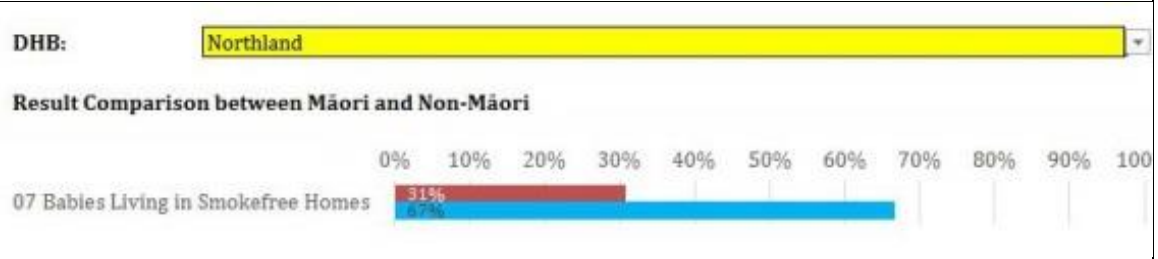
A healthy start

Tamariki across Northland are living in environments which are not compatible with health, including damp, cold housing or whānau who smoke cigarettes, with a significant equity gap for Pēpi Māori versus non-Māori pēpi:

Only 31% of Māori babies are living in smokefree homes compared to 69% for non-Māori – an equity gap of more than 30%. As the newly available data from the Well Child Tamariki Ora question set becomes available, we will link this directly to evaluating our approach to increase the number of Māori pēpi living in smoke free homes.

The graph below shows Northland smoking rates by ethnicity[6] and what will be required to meet the target of 5% across all ethnicities by 2025.





Significant additional effort, over and above current service delivery, is required to prioritise and support Māori to stop smoking, with a significant push to support hapū mama to quit.

From 1 July 2020 Mahitahi Hauora will implement a new model will implement a new model for Support To Stop Smoking within certain General Practices across Tai Tokerau. Within this model three levels of service were proposed. 13 practices have been contracted with to provide Support to Stop Smoking with a priority on hapū mama and wāhine Māori. For further details of the service levels please see attached (**Appendix A**).

[6] Data source is 'current smokers' out of the primary care smokers Quarterly Report to Northland DHB. We will use the newly available data as our baseline when it is available to us.

Government theme: Improving the well-being of New Zealanders and their families	
System outcome: We have health equity for Māori and other groups	**Government priority outcome:** Make New Zealand the best place in the world to be a child

Milestones	**Activities**	**Contributory measures**
Rate of smokefree homes for Māori pēpi has increased from 27.8% to 35% by June 2021	Implement the new model of Support to Stop Smoking within general practice. Incentives (Warehouse vouchers) to stop smoking will be offered to hapū mama and wāhine Māori. Stop smoking attempts will be validated through CO monitors at 4 and 12 weeks post quit date. Engage with whānau and hapū mama to inform new models of care that lead to increased quit rates of hapū mama. Evaluate and refine the model using continuous quality improvement methodology. At level two practices will be incentivised to refer to Toki Rau (community-based stop smoking providers). Work with Toki Rau providers and GPs to embed feedback loops so that outcomes are shared and referrals increased.	Priority groups enrolled in service # and % Total # and % of Māori # and % of hapū mama # and % of parents Priority groups that make quit attempt # and % total # and % of Māori # and % of hapū mama # and % of wāhine Māori Priority groups that stop smoking at follow up CO validated # and % all population # and % of Māori Satisfaction surveys reviewed regularly for quality improvements # and % of surveys completed, total and Māori # and % of people satisfied or very satisfied, by total & Māori # and % of people who would return to service, by total & Māori # and % of people who would recommend service, by total & Māori Number of referrals from General Practice to Toki Rau.
	Improve the quality of data collection on smoking status of households for infants at six weeks of age by: Support LMCs and Well Child / Tamariki Ora providers to improve the quality of their data collection through face to face contact and education by the Smokefree Kaitiaki roles.	2% reduction of unknown's responses 5% increase of enrolment of Māori to Toki Rau Stop Smoking Services

	Utilising the Smokefree Kaitaiki role support to LMCs and Well Child / Tamariki Ora providers to increase the number of referrals for their clients to quit smoking services.	
	Implementation of hapū mama and whānau wellbeing wānanga "Whaia Te Ora" – focus on wellbeing with the overall goal of whānau working towards a quit smoking decision. Based on the Māori creation narrative following the same journey as Hine Kopu. Referrals to Whaia Te Ora will predominately be via Hine Kōpū with other options being explored from secondary care.	Number of referrals for hapū mama and whānau to Toki Rau following attendance at Whaia te Ora

Appendix A.

The previous 'opt out' model applied by Mahitahi Hauora to general practices has been changed to an 'opt in' model. There are three levels of service that general practices can opt in to, as described below:

Level 1:

- Supply of Nicotine Replacement Therapy (NRT) to patient
- There is no contract for service, just informal agreement the general practice will distribute NRT to patients as appropriate.

Level 2:

- Supply of NRT to patient, and referral to Toki Rau.
- The general practice receives an incentive payment of $10 for each eligible service user who is referred to Toki Rau and subsequently enrols. The incentive payment is payable on confirmation of enrolment on Ara Whanui IT System. Practices that refer to Toki Rau will use the Careselect platform. Practices will have discussed the referral process with the patient and have their consent for the referral. Toki Rau will provide feedback to the Practice with regard to the referral outcome and if a quit attempt was made.

Level 3:

Supply of NRT to patient, referral to Toki Rau, and practice based stop smoking support.

General practices will be required to:

a) Provide the stop smoking service completely free of charge to patients
b) Meet MoH Tier One Service Specification for stop smoking services
c) Nominate a Stop Smoking champion as a first point of call within the general practice
d) Agree to use existing database for reporting purposes
e) Ensure staff (nurses, health care assistants, health coaches etc.) have been trained in stop smoking support, and commit to on-going training / professional development
f) Ensure quit attempts are validated through CO-monitor (a device to measure carbon monoxide ppm level, also known as a 'smokelyser'). The CO monitor is to be used as a quitting aid

Provide an incentive to hapū mama and wāhine Māori to complete a CO-monitor validated quit attempt.