HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND

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31 July 2019

[redacted]
Email: [redacted]

Dear [redacted],

Official information request for – primary care: quality improvement project Gonville Health, Whanganui

I refer to your request for information, through our website, dated 10 July 2019 which we are treating as an Official Information Act request. This relates to information on one of the projects participating in the Commission's primary care quality improvement programme "Whakakotahi" during the 2018 intake of projects.

You have requested specific information on the Gonville Health project, and all associated material we have in relation to that project, including financial assistance we have provided. You have requested both hard copies and soft copies of information we have on hand.
The information you have requested is enclosed/attached and relates to information and records that we hold. The nature of our role in this partnership is one of support and guidance, and hence much of the information you have requested is not able to be provided, as we do not hold those records at the Commission.

If you want further information you will need to have that engagement directly with Gonville Health, and we suggest you contact [redacted] Gonville Health on [redacted]

It will be helpful to provide further context in terms of the information you have requested, please note the following:

- the Commission has led a primary care quality improvement programme under the name of "Whakakotahi" for the last three years

- this comprises an annual Expression of Interest (EOI) round that respondents need to submit through, with a description of the project they will be working on and which is regarded as important to the population they service

- projects are short-listed and then final selection is made. The selection process is robust, with an evaluation panel selecting final projects.

- each project needs to address three key criteria which are equity, consumer engagement and integration

- a Memorandum of Understanding is signed between the Commission and each project team, which reflects the partnership, with expectations outlined

- each project team receives a one-off funding contribution to the project of $6,000 which is a contribution to staff backfill cost to free up time for staff to work on the project and attend learning events. There is no other direct financial contribution.

- through the duration of their improvement journey (around 12 months in total), the Commission's primary care team supports each project team in a range of ways. This can be through on-site visits, virtual meetings, telephone engagement, and bringing teams together for three knowledge sharing workshops which we refer to as Learning Sessions

- we offer each project team one sponsored position on a formal education and training programme delivered through Ko Awatea in Auckland. Ko Awatea is a learning hub, embedded within Counties Manukau District Health Board, which delivers training and education programmes to build capability in quality improvement science and methodologies. This complements our own on-site and virtual assistance provided through our Whakakotahi programme

- active support is provided for the duration of the programme, and even after completion of their Whakakotahi improvement journey, we offer to provide some assistance and guidance to help with project completion, resulting in a presentation of their project outcomes in a powerpoint storyboard

- in relation to the Gonville project, we have attached a powerpoint storyboard of their project outcomes. It has been a pleasure to support the team in their work, and to see them improve the service they are providing through their 'very low-cost access' service.

In light of the above, we are able to provide:

1. Expression of Interest document
2. Final Project Plan from Gonville Health
3. Memorandum of Understanding
4. Financial support provided
5. Gonville Health Powerpoint storyboard presentation

I hope that this response provides the information you require, and as stated earlier if there is further detail required that will need to be an engagement directly with Gonville Health.

You have the right to seek an investigation and review by the Ombudsman of this decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

If you wish to discuss this decision with us, please feel free to contact [redacted] the Manager for our Primary Care programme. Her email is [redacted]

Yours sincerely

Janice Wilson (Dr)
Chief Executive

Encl List Documents enclosed

1. Expression of Interest document
2. Final Project Plan from Gonville Health
3. Memorandum of Understanding
4. [redacted]
5. Gonville Health Powerpoint storyboard presentation

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND

Whakakotahi
Primary care quality improvement challenge 2018

Expression of interest form

Please complete all sections of this form. Refer to the guidelines when completing this form. Please use the text boxes for each section. You can expand the text boxes as required.

Section 1. Project details	
1. Short title of project	Improvement in early management of high need patients
2. Project location (the region, town or city where the project will be based). If this EOI is related to any other proposals, note them here.	Gonville Health Ltd, Whanganui City

Section 2: Applicant's details	
1. Legal entity or entities applying. For joint ventures between two or more entities note the lead entity and attach an endorsement for their lead role from the other related organisations.	Gonville Health Ltd is a not for profit company that operates as a subsidiary of Whanganui Regional Health Network, which is a Charitable Trust.
2. Primary contact person name	[redacted]
3. Primary contact details	[redacted]
• Phone	[redacted]
• Mobile	[redacted]
• Email	[redacted]
• Postal address	44b Abbot St, Gonville, Whanganui 4501
4. Person who will be delivering the project (if known and not primary contact).	[redacted]
5. Provide a brief description of your	*Gonville Health Ltd (GHL) is a Very Low Cost*

organisation/practice. This can include: • size • enrolled population • population characteristics eg, ethnicity or proportion of high need. • very low cost access practice (VLCA) • integrated family health centre (IFHC) • Other special characteristics	*Access integrated family health centre that was purposely established to meet the health needs of a community that was identified to have high and complex needs. GHL has an enrolled population of 6,379 patients of which 69% are classified as High Needs (Maori, Pacific Island and low income). In addition greater than one fifth of the population are diagnosed with mental health and other co-morbidities.* *GHL is a subsidiary company of Whanganui Regional Health Network (PHO) who developed Gonville Health in a deprivation 9-10 suburb of Whanganui due to there being no primary care options in the suburb as well as a decline in a general practice access options across Whanganui City. GHL has been a strategy of the PHO to act as access point for all people to have equitable enrolment options in general practice. GHL has no enrolment discrimination, close of books or a waiting list for people wishing to enrol.* *GHL was established utilising a community development model and therefore the co-design included other services the community identified important to meet their needs. The purpose built facility includes a Community room (utilised for exercise and community education programmes), a community pharmacy and a community library/ café which is operated by Whanganui District Council. The Gonville Centre was purposely located opposite the local shopping centre and community policing.* *The workforce is salaried. Viability and workforce sustainability is high risk and this along with ensuring the right mix of best practice services and patient centred values has been a priority area of focus.* *More recently we have gained a better understanding of the uniqueness of the Gonville Health enrolled population. The community is consistent with the demographic of low income and complex health needs and associated issues such as high smoking rates, family violence and drug and alcohol issues.*
6. Are there any potential or perceived conflicts of interest you are aware of in this proposal? If so please declare these.	*The practice is a subsidiary company of the Whanganui Regional Health Network*

Section 3: Project information	
Evidence: 1. What is the problem you are trying to address? Why is this a problem?	*One of the features of GHL is that it is the default practice for patients seeking general practice services for the Whanganui population no matter the environment or patient circumstances.* *The GHL population is influenced by the location of Kaitoke prison, reasonably cheap housing in Whanganui and the availability of seasonal work. Because of this and the nature of the population that GHL serves, the practice and its patients experience the flow on effects of high transiency. As an example, over the month period April to October 2017 the practice enrolled approximately 1,000 new patients and 350 patients formally exited the practice with an additional 4% increase in the high need population.*
2. What is the scale and scope of the problem?	***Appendix one (as attached)*** *The scale of churn in and out of the practice is quantified as follows;* • *enrolled population of 6,379* • *1,030 new patients in and 439 patient outs in the past 7 months* *We have found that the patients newly enrolling at GHL typically do not have good clinical notes or clinical work up prior to commencement at GHL.* *A high proportion do not have their population health indicators completed/or recorded. e.g Gonville Health measured the number of cervical screens completed on new patients for the period April and May 2017 (prior to enrolment). Of the total 240 new patients, 76 women of cervical screening age were either not screened or under-screened. A high proportion of these women are Maori, Pacific Island or Asian ethnicity; thereby increasing inequalities for our patients and creating barriers to achieving IPIF/SLM achievement funding and reputational risk for the practice.* *Gonville Health has reviewed the 'new patient process' however, we would like to see the process streamlined and efficiency maximised. The process is costly and time consuming with approximately [redacted] of workforce resource committed to the (new and exit patient) process.*

	The MoH mandated enrolment requirements coupled with the GHL new patient appointment process is off-putting and confusing to patients. *It is common for patients to not agree to complete the enrolment form process and to DNA first patient appointments (this could be contributed to literacy levels / feeling pressured / frustrated with the bureaucracy). Patients are typically not interested in attending or paying for a visit when they are not unwell or not in need of medication, they appear to enrol for short term or acute care and have poor engagement with wellbeing, screening and whole of health issues.*
• What are you proposing to do?	• *Move from a reactive notes system for new patients to a proactive patient care model* • *Create process improvement that works for patients the administrators and the clinical team so the practice copes better with the pressure associated with transient patients.* • *Establish a methodology and process for recording new patient information entering the practice* • *Having a database that reflects accuracy that supports practice and patient planning i.e classifications, medications, screening are absolute (knowing our patients and safety netting)* • *Establishing a new patient process which is customised to meet the individual needs of the patient via record review rather than a standardised plan for all patients* • *Agree a process so that the workforce understands the critical mix between what is important to the patient and what is clinically required to achieve best practice and how to operationally achieve this.* • *First patient appointments focus on health literacy, patient orientation to the practice and their understanding of their own health so that patients are actively engaged, self- motivated from the onset of enrolment, and progress to improved self-management.* • *To create a more customer focused, culturally appropriate service with a population that feels*

	well supported by the practice from the onset. There is evidence that if the patient feels well supported when they first enrol they are more likely to be partners in their care planning and remain patients at the practice longer.

Section 4. Project objectives (please use extra space if required to describe your project)	
Strategic fit: 1. How will this project contribute to the three strategic priority areas for primary care?: a. equity b. consumer engagement c. integration	*Achieving a patient focused and efficient transition in to practice that that meets the needs of patients and staff.* *Equity* *GHL was established with the prime purpose of improving access and reducing equity gaps for a specific high need transient population, Maori, Pacific Island and low income that are disadvantaged in all determinates of health. The GHL population is has a disproportionately higher than average number of patients that have complex health needs, have not had their population health requirements meet and have not been engaging in their own health care. This project is all about addressing access and equity particularly for Maori and Pacific Island people (see appendix one).* *Transient patients typically have not engaged well in health care previous to enrolling in GHL; their records are often incomplete and they are not up to date with screening and care planning. The sheer volume of patients both entering and exiting the practice has impacted on the practices ability to respond to their desire to create comprehensive notes, screening and intervention for every patient that enrols with the practice from onset.(see appendix two)* *Consumer Engagement* *GHL used a community development process for establishing Gonville Health. The centre was purpose built and the health centre designed based on the priorities as determined by the community. This group concluded on completion of the site and its services.* *More recently a consumer group has been established and one meeting held that was constructive, the group is an articulate and challenging and diverse mix of consumers. 75% of*

	the group identify as Maori, one member is a patient of the practice [redacted]. *This team will be the advisory group and consumer sign off for this project and any quality initiatives that GHL undertakes. The group are tasked with being the voice for the community and a key communication link between the practice and the community. The group have the right to co-opt additional members or people with specific skills dependant on the priorities as they are defined.* *While the practice over the past few years has been focused on improving clinical and internal systems there has been little engagement with consumer co-design. This group's establishment marks this change.* *This project is unlikely to involve the wider community in the initial stages; however it is the desire to improve health and social services for a community that is wider than the Gonville Health enrolled population.* *Integration:* *The practice is situated in a Centre that considers health and social needs for a defined community. There is a community room where whanau health meetings take place as does self-management groups. The practice has a strong relationship with the co-located community pharmacy and community library. For dislocated patients, the library acts as a hub for social interaction such as knitting and games groups/events, access to computers and the internet etc.* *Correspondence School has for many years located their programme within the centre to promote education for students that have been dislocated from their local school programmes.* *Well-being does not sit within health alone but also requires a social infrastructure (be that a referral to the GHL Social Worker for case management or a recommendation for attendance at events such as those provided at the library). These are examples of the things that we see being enabled better if we use consumer co-design to support the process improvement.*

	Gonville Health has a model of care different from standard general practice in that has a team of health professionals that partners with the patient and the whanau. The team includes; general practitioners and nurses, prescribing, clinical and dispensing pharmacists, mental health liaison, social work and counselling services as examples. District Nursing, Nurse specialists (e.g Renal), Dietitian are all services that are offered in the clinic and act as not only an opportunity to provide patient care but also to support and develop the primary clinicians that work within Gonville Health. Referral in and out of services, coordination of care, development of relationships are all key integration factors. [redacted] *Gonville Health has a draft memorandum of understanding with Te Oranganui Iwi Health Authority general practice that has not been finalised. The intent of the MoU is that both practices have similar populations. It is synergistic for both to work together to achieve better outcomes, to share successes and resources.*
Achieving your goals: 1. How will you know if you have made a difference? 2. How will you monitor your project delivery and success? 3. What is the timeframe for achieving improvement? 4. How well would your project transfer to other health providers?	1.To measure the success of the project; we would use a family of measures as defined in **(appendix 3)** 2..What *is the Time Frame for achieving the improvement ?* • *By November 2018 would have agreed protocols for new patients* 3.How well would your project transfer to other health providers? *The issue of transience is not unique to GHL. The project will be co-lead by the* [redacted] *the learnings and experience will be shared across the PHO and available to the health sector and nationally.* *GHL has a good working relationship with* [redacted] *and has been working on establishing a list of priorities that the practices could support each other with. Both*

	practices have similar populations. This would be a good project for GHL to support [redacted] with and help to cement the operational relationship
Resourcing: Briefly describe how your organisation will resource and support your improvement project.	*The Leadership team are committed to making sustainable changes at Gonville Health. Resourcing will be more related to consumer and staff involvement and change processes rather than financial resourcing.*
PHO support: If the improvement project will involve a general practice, briefly describe how your PHO has endorsed your proposal.	*Whanganui Regional Health Network is committed to the success of changes at Gonville Health. [redacted] the project. Along with the availability of the business analyst and other relevant staff at the PHO. Gonville has been the topic for the PHO –QIF course undertaken by the [redacted] during 2017. This piece of work has been more about getting some understanding in the new team rather than fundamentally changing how Gonville Health delivers care.* *CEO of WRHN is [redacted] and is committed to the success of Gonville Health and this project*

Section 5: Certification

I, _____ certify that this EOI form application to Whakakotahi – primary care quality improvement challenge 2018 is authorised by the legal entity specified above.

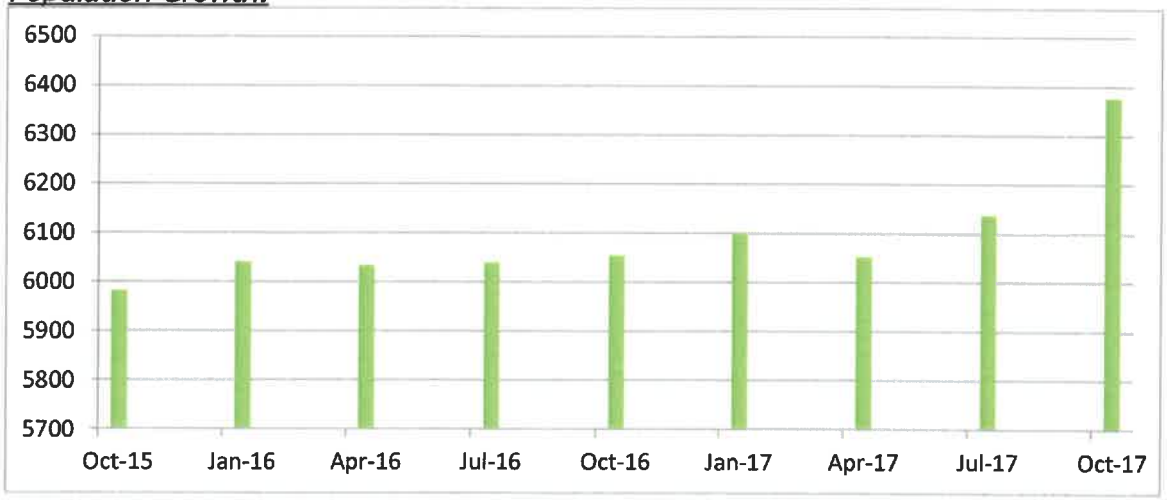
Appendix one- Population, Access, Equity and Services

Population:

GHL currently has an enrolled and funded population of 6,378 patients. 69% of the GHL population is classified as high needs (Maori, Pasifika and decile 5). There has been continued patient growth in the practice since July 2015.

GHL was purpose built in 2009 and the building was planned to manage up to 6,000 patients. Currently we are 378 patients higher than intended. The facility space is coping, but we are stretched and we are no longer able to operate the 'hub' walk in model as we had initially intended.

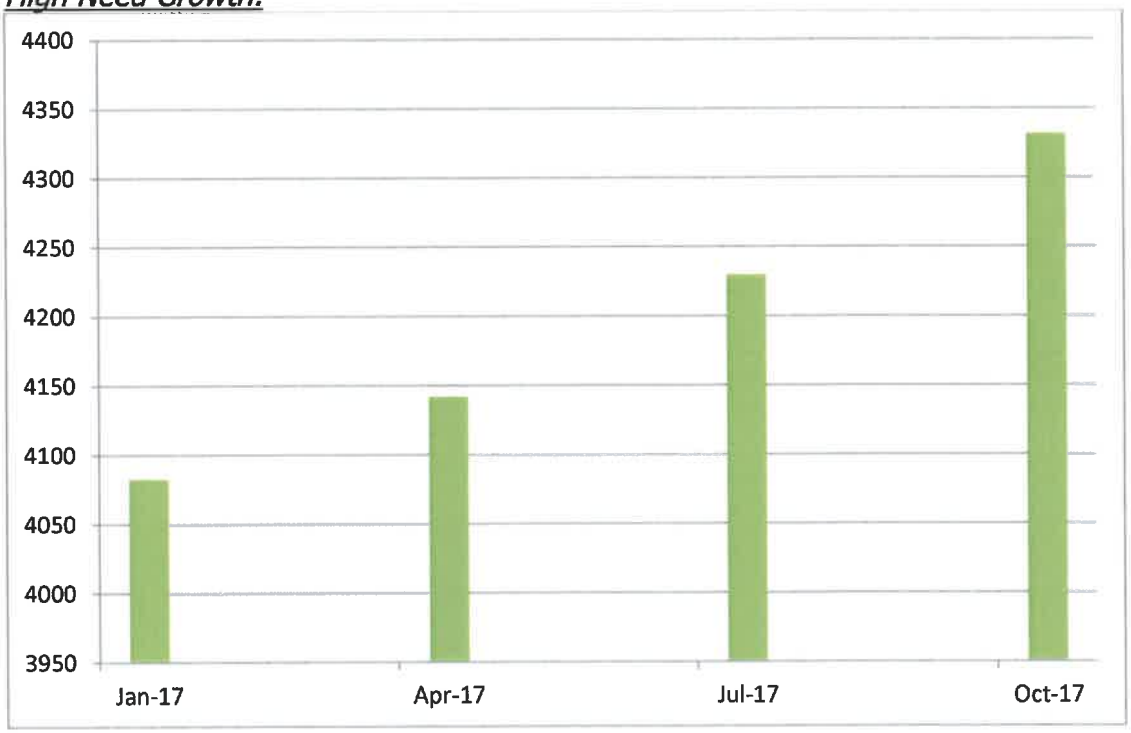
Population Growth:



The high need patient population of GHL over the past two quarters has increased from 65% to 69%; this equates to 4,432 high need patients.

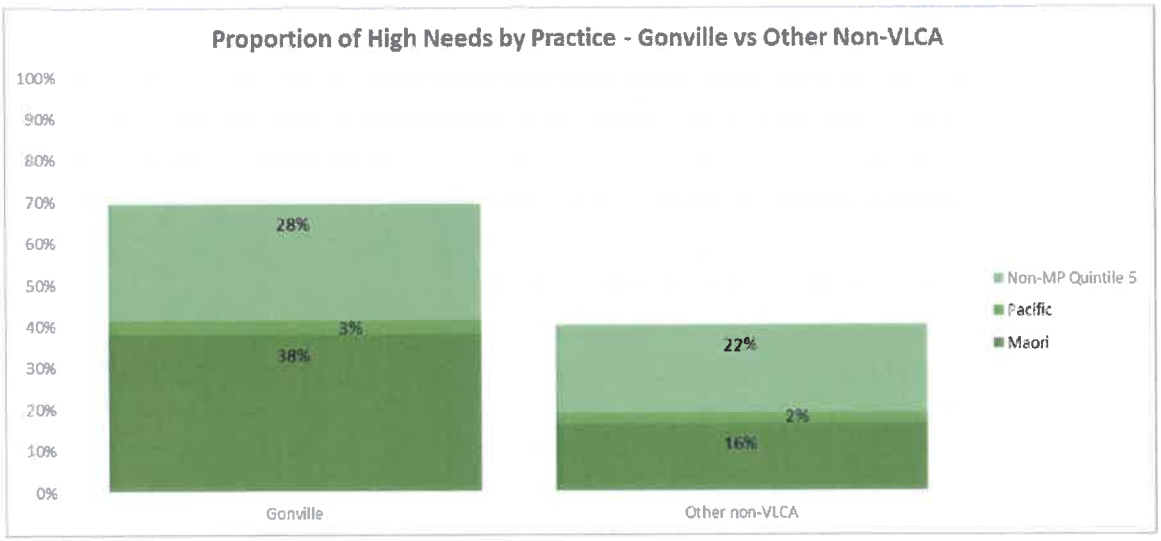
Reviewing new patient information over the past two quarters we have seen a growth in our high need population, specifically Maori who over the past two months have enrolled at the same rate or near same rate as NZ Pakeha.

High Need Growth:

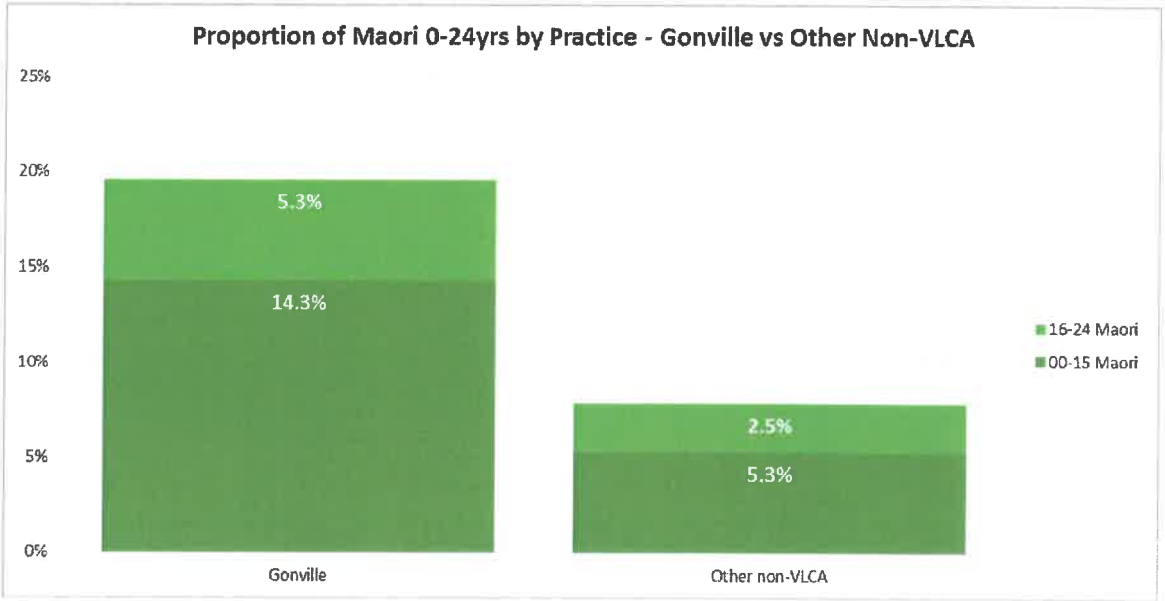


High Need Population:

The below graph demonstrates the variance between the percentage of high need patients that are enrolled at Gonville Health, versus the average percentage of high needs patients that are enrolled at other local non VLCA practices.



At a more detailed level, the below graph demonstrates Maori patients aged between 0-24 years who are enrolled at GHL verses other non-high needs practices. This specific group have a high level of risk factors and supports required by the general practice e.g smoking, alcohol and addictions, reports of concern, vulnerable families, SUDI teenage pregnancies, STI's etc



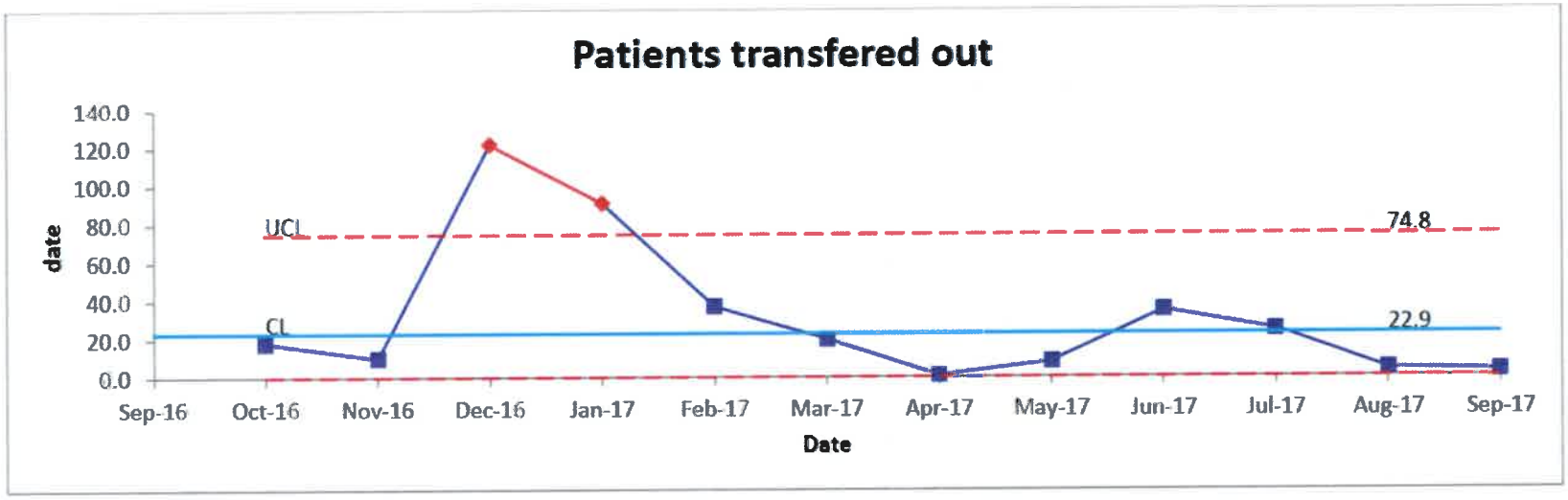
Both of these graphs aim to represent is the level of commitment that GHL is required to provide its patients due to their level of need and equity differences verses the obligations of a non VLCA practice.

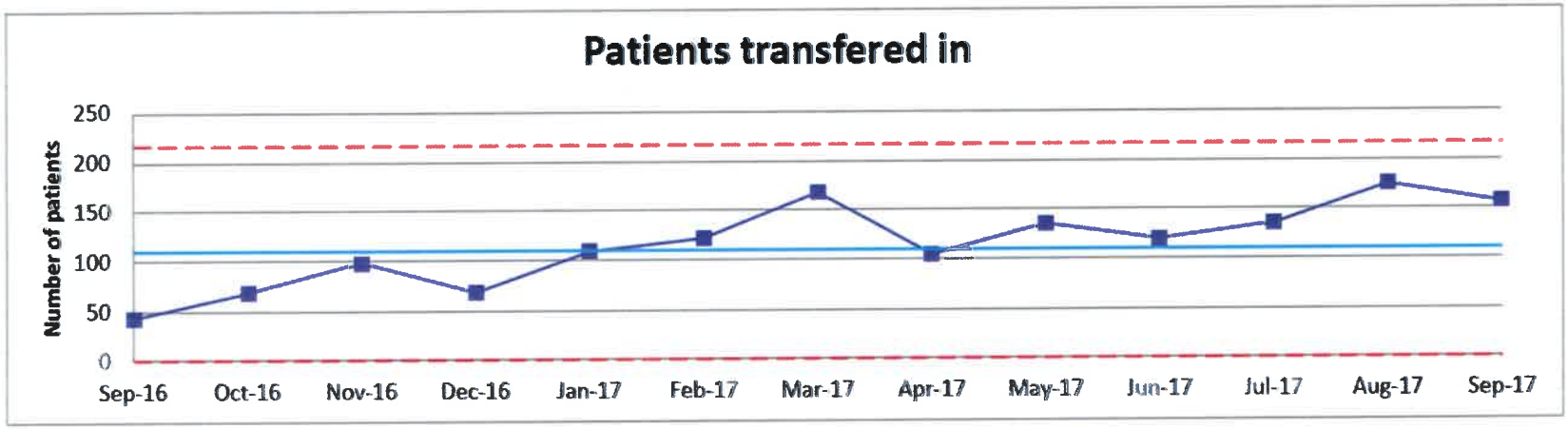
What is the Difference in Clinical Need?

	GHL	Average of other WRHN Practices (incl VLCA)
Vulnerable Children Reports of Concern per 1,000 patients	55.2	27.1
Patients with Diabetes	7.4%	5.8%
Current Smokers	32.6%	19.4%
Mental Health	26.5%	18.8%
COPD	20%	19%
Polypharmacy	6%	5%
Community Mental Health (evidence that CMH patients attend 1.54 times than non CMH patients)	4.7%	2%

Given the population, GHL has been adaptive to change; endeavouring to balance patient need and reduce inequalities within budget capacity.

Appendix two- Transience





Appendix three - Measures

Enrolment and Engagement Process	Description	Measure	Current Performance	Target Performance	Result
Outcome Process	Record number of enrolment enquires to understand how many result in a completed enrolment	# of enrolment enquires that result in a fully completed enrolment form	Not recorded	75% conversion rate within two weeks of first enquiry	Process improvement
Outcome	Record enrolments in and exits out to measure the volume of transience	# of enrolments in # of exits outs	Measured daily and reported monthly	Decrease volumes of exits to local practices	Patient satisfaction
Outcome	Target new enrolees to identify level of satisfaction with the service	Likeart scale for all patients that attend new patient appointment	Not recoded	95% score a 3-5 recording	Patient Satisfaction
Outcome Process	Patients are encouraged to sign up to Manage My Health Patient Portal	% of enrolments in MMH	Not targeted for new enrolments	50% of new enrolments sign with MMH	Health Literacy
Balance	Patients are engaged in general practice rather than other episodic care	# of patients that attend Accident and Medical and ED for triage 3-5	Measured to reported to Governance 2 x monthly	5% reduction in attendance at WAM and ED annually	Coordinated care and health literacy Supports Service Level Measures

New Patient Appointment	Description	Measure	Current Performance	Target Performance	
Process	Efficient and effective use of resources	Consistency in practice for new patient enrolments	Process not adapted to meet demand	Design and map an process and measure level of compliance	Process improvement
Process	Consistency in quality of patient notes	Consistency in health record	Variable	Design and map a process and measure level of compliance	Process Improvement
Process	Increase patient health literacy and self -management pathways	Establish a process that identifies the number of referral and attendance to services that are proven to increase patient health literacy and self-management	Some recording; not comprehensive. Will need to establish baseline for some services	Evidence of recording and / or improvement against current status	Health Literacy
Process	Increase population health outcomes for new patients	Establish a process that identifies population health status on enrolment verses dashboard completion post new patient appointment	Opportunistic	Evidence of improvement against current status for all population health targets	Population Health
Outcome	Improve cervical screening for Māori and Pasifika women	Māori and Pasifika women are screened at the same or higher	Measuring overall screening rate	75% Maori and Pasifika eligible	Population Health targets Equity

		rate than other populations	No measurement for new enrolments	women complete cervical screening	
Outcome	Improve CVD screening for Maori men aged between 30-44	Maori Men aged between 30-44 years are targeted to complete CVD assessment	IPIF measures	90% of Māori men aged between 30 and 44 have CVD risk assessment completed	Population Health targets Equity

MEMORANDUM OF UNDERSTANDING

BETWEEN THE HEALTH QUALITY & SAFETY COMMISSION

AND

GONVILLE HEALTH LIMITED

FOR – 'WHAKAKOTAHI' PRIMARY CARE QUALITY IMPROVEMENT CHALLENGE

Health Quality & Safety Commission

The Health Quality & Safety Commission (the 'Commission') is a Crown Entity established to lead and coordinate improvement of the quality and safety of health and disability support services across the health system, including primary care.

Gonville Health Limited; which is a general practice located in Whanganui that carries VLCA status.

Whakakotahi

In late 2016, the Commission introduced the primary care quality improvement challenge. Entitled Whakakotahi, which translates as "to be as one", the challenge sees the Commission partnering with primary care to support improvement projects submitted by primary care organisations.

1. Purpose

This memorandum of understanding (MoU) is intended to capture the spirit of partnership and collaboration between the Commission and Gonville Health]. It is based on the recognition that the Commission and Gonville Health have a number of shared aspirations and intentions in relation to the Whakakotahi work programme.

The purpose of this MoU is:

a) To recognise the commitment of the Commission and Gonville Health to work together on an improvement initiative identified by Gonville Health to look at quality improvement processes that will improve the patient experience and health journey as part of the enrolment norm.

b) To help build capability and expertise of the health system, all health workers, consumers, and communities to deliver improvements in health and disability services, with a focus on primary care.

c) To agree the different and complementary roles of both parties and the areas of alignment.

2. Agreements

The parties will give effect to this MoU through the agreements below:

a) Both parties

i) Agree to work together, communicate with and consult each other, and share information and skills to establish and ensure the identified improvement initiative is a success.

ii) Agree to work together to share the outputs, findings, experiences and lessons learned from the initiative (and general Whakakotahi work programme) with the wider primary care sector at a local, regional and national level (as appropriate) via relevant professional media and networks, to facilitate the spread of knowledge and uptake of the improvement initiative elsewhere (as appropriate).

iii) Agree to work together to share the outputs, findings, experiences and lessons learned from the initiative to facilitate completion of formal Whakakotahi evaluation reports.

iv) Manage and/or mitigate any risks or conflicts of interest relevant to each party.

v) Will hold confidential any commercial or politically sensitive information disclosed by one party to the other.

vi) Will use reasonable endeavours to protect the intellectual property of the other.

b) Health Quality & Safety Commission

i) The Commission's project team will be available to support Gonville Health Limited, including site visits and regular meetings, quality improvement advice, and facilitation.

ii) The Commission will reimburse staff time up to $NZ6000.00 (excluding GST) per participating organisation to release staff to work on the selected initiative and attend group learning sessions as required. The Commission will also fund reasonable travel costs so three (3) project team members can attend the group learning sessions.

c) Gonville Health Limited

i) Agree to willingly undertake improvement work and complete implementation (testing) of initiative by December 2018, using a recognised quality improvement method, and collaborative sharing and learning approaches.

ii) Agree to participate in site visits and regular meetings (usually teleconferences/webinars, at times to be agreed by both parties), and attend three group learning sessions for quality improvement capability building, sharing ideas, and forming improvement networks.

iii) Agree to provide monthly status update reports as required.

iv) Agree to work with the Commission to support refinement, spread and/or scale-up the initiative (if applicable).

v) Agree to share acquired quality improvement skills and knowledge (ie, tools and methodologies) with others in the primary care sector to support capability building elsewhere.

3. **Independence of the Parties**

a) Nothing in this MoU shall limit the independence of the parties in carrying out their respective responsibilities. However, both parties will carry out their work with due consideration of the tenets and spirit of the MoU.

4. **Memorandum not Binding**

a) The parties acknowledge that this MoU is intended as a statement of mutually agreed intentions. It is not intended to create legally enforceable rights or obligations. However, the parties agree that they are bound in good faith to observe and perform their obligations under this as if they were legally enforceable.

5. **Problem Resolution**

a) All disputes and differences between the parties in relation to the interpretation or performance of this MoU shall be settled in the first instance by the [redacted] Health Quality & Safety Commission, and [redacted] Gonville Health Limited.

6. **Term**

a) This MoU will remain in force until completion of the Whakakotahi quality improvement work (March 2019 at the earliest). The MoU will be reviewed and updated by the parties on an annual basis, as required.

7. **Effective Date**

a) This MoU takes effect from the date that it has been signed by both parties.

8. **Communications and Support**

a) The parties will schedule regular discussions on strategic and operational matters at an interval to be agreed.

b) For the Commission the main contact will be [redacted] project manager.

c) For Gonville Health Limited the main contact will be [redacted]

Signed.

[redacted] – Quality Improvement Programmes

Health Quality & Safety Commission

[redacted] .....

(Signature)

30|1|18

(date)

[redacted]

[redacted]

Gonville Health Limited

[redacted] .....

(Signature)

25|1|2018

(date)

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND
Kupu Taurangi Hauora o Aotearoa

Whakakotahi

Primary care quality improvement challenge 2018

Expressions of interest guidelines and application pack

open FOR BETTER CARE
Hāpai oke te tōtōro

July 2017 v3

"The Commission is increasing its focus on primary care and community services, aged residential care and disability services. The Primary Care programme aims to increase quality improvement capability in these areas".

Contents

Summary

This document describes Whakakotahi – primary care quality improvement challenge. This is a primary care initiative the Health Quality & Safety Commission (the Commission) is working on with primary care providers.

This document establishes a common understanding to inform expressions of interest (EOI) to deliver improvement projects as part of the 'challenge'.

The Commission was established in 2010 and is extending its work in health care quality improvement to the community setting. To help with this work, the Commission created a primary care expert advisory group. This group recommended that the Commission should identify and support selected improvement projects focused on three key areas: equity, consumer engagement and integration.

In 2016, the Commission's primary care programme team launched Whakakotahi to meet this objective. The first year of Whakakotahi drew 16 applications with three teams successfully going through to the improvement phase. These teams accepted the 'challenge' of applying for a place in Whakakotahi, and for stepping up to learn about and apply improvement science to improve the quality of their patients' care.

The project scope (page 6) describes Whakakotahi and the types of initiatives being sought from primary care organisations.

The Commission invites providers to apply and submit proposals that cover the three priority areas. A quality improvement advisor and project manager from the Commission will provide each improvement team with advice, support and guidance through site visits and group learning events.

This document includes:

- details about how to apply (page 8–9)
- eligibility criteria (page 10)
- evaluation guidelines (pages 10–13)
- an expression of interest form (page 14–17).

To apply, providers will submit an initial expression of interest (EOI) form no later than 12 noon on 1 September 2017. A selection panel will select a shortlist from these EOI. The Commission will work with the shortlisted applicants to complete a more detailed application. The final selection will be made from these updated proposals.

For further information visit the Commission's website.

Introduction

The Commission was established in November 2010 to:

- measure and monitor the quality and safety of health and disability services
- work with clinicians, providers and consumers to improve the quality and safety of health and disability services.

We develop systems and processes to ensure the safest and highest quality care, using proven innovation, and learning from mistakes so they do not happen to others.

The 'Triple Aim', developed by the Institute for Healthcare Improvement (IHI) in Boston, has become a well-known goal for quality improvement. The Commission has adapted this for New Zealand:

This New Zealand Triple Aim has been accepted by all health agencies as the overall goal for improvement in health services.

To support the Triple Aim, the Commission is increasing its focus on primary care and community services, aged residential care, and disability services. In 2014, the Commission hosted a workshop with primary care opinion leaders to identify the important quality and safety issues, and how the Commission may best contribute. This led to the establishment of the primary care expert advisory group (PCEAG) in 2015. The PCEAG, chaired by Dr John Wellingham, supports the Commission's engagement with primary care providers, provides a primary care perspective on the Commission's work, and advises on all of the Commission's primary care work and on future initiatives.

In response to the PCEAG's advice, the Commission has agreed to a stronger focus on primary care. In the first instance, this will involve the Commission partnering with primary care teams to work on small-scale improvement projects – this is **Whakakotahi** (te reo Māori for 'to be as one'). Whakakotahi will act as a catalyst for starting valuable discussions with primary care, raising the sector's capability to use improvement science to effect better patient care and outcomes, and to lay important foundations for future improvement work in primary care.

The primary care sector has a strong motivation to undertake quality improvement activities. However, we recognise that there is limited capacity (funding and time) and capability (knowledge and skills) for such activities.

More specifically, the aim of the programme is to increase quality improvement capability in primary care, with the following goals:

- build collaborative partnerships between the Commission and primary care to improve primary care quality and the Commission's understanding of it
- improve one or more health outcomes with associated improvements in equity, integration and consumer engagement
- support sector-led improvement projects to build and spread improvement science expertise and skills in the primary health care sector
- identify improvement projects/initiatives that are suitable for implementing at a local, regional or national level (as appropriate)
- support the implementation of the System Level Measures Framework, by linking improvement projects to the framework and raising improvement science capability in the primary care setting.

Project scope

The Commission is seeking EOI applications for primary care improvement projects. Applicants are welcome to submit proposals about any facet, element or area of patient care that they would like to improve through participating in Whakakotahi, and one that is important to their patients/community and to them as providers of care.

You get to choose the initiative!

Priority areas

Initiatives for this project must support one or more of the Commission's three primary care strategic priority areas:

1. **Equity** – all projects must be underpinned by consideration of equity in the design, implementation and evaluation phases.
2. **Consumer engagement** – consumer co-design will enable projects to move from 'consumer experience' to ideally reflect consumer journeys through health, including their impact on quality of life.
3. **Integration** – integrated patient-centred care will be a key priority to provide seamless transitions of care. The project should target from the consumer perspective either the vertical gap between primary care and secondary care, or the horizontal gaps across primary care and with other social sector services.

Whakakotahi work programme

The Commission will work with the successful applicants on their improvement projects following a structure similar to the IHI breakthrough series (collaborative) methodology, underpinned by the Model for Improvement.

We will be guided by successful applicants about the 'how' part of the improvement phase. We can adapt the style of support, methodology and quality improvement approach depending on what works best for you, your team, patients, and organisation. This includes acknowledgement of tikanga and kawa.

We will bring all of the improvement teams together for three group learning events for quality improvement teaching and workshops, idea sharing, and networking. Between these group learning events, the Commission's quality improvement advisor and project manager

will provide virtual (eg, teleconference calls, Skype) and on-site support and mentoring to the improvement teams, as needed.

Whakakotahi timeline

The Commission is committed to working with primary care providers to build quality improvement capability. After the first, innovative phases of Whakakotahi (the 2017 and 2018 challenges), future work will depend on how suitable the completed projects are to spread and scale. More providers and projects will be involved in later stages. Our plan is to sustain a balance between initiatives being developed (innovation phase), and those being spread and scaled (implementation phase).

Whakakotahi is the start of our journey together. While we collectively and incrementally build improvement science capability and progress the selected Whakakotahi improvement projects, the Commission will continue to work with a broad range of primary care stakeholders and partners to lay the groundwork for future improvement work in the sector.

This phased approach is outlined below, noting that the detail for 2018/19, and beyond, is provisional. The programme's design will inevitably change depending on what we collectively achieve and learn as Whakakotahi progresses and evolves over time. In any case, changes to the Whakakotahi programme will involve valuable input from the PCEAG, other primary care stakeholders and also informed by our independent formative evaluation:

Year	Planned Activities
2016/17 - completed	**Whakakotahi – first phase (three projects selected)** • Support capability building and new improvement projects.
2017/18 - underway	**Whakakotahi – second phase (estimate a minimum of six projects)** • Support capability building and new and ongoing improvement projects • Identify initiatives that are amendable to spread/scale.
2018/19 - proposed	**Whakakotahi – third phase (anticipate 12 projects)** • Support capability building and new and ongoing improvement projects • Identify additional initiatives that are amendable to spread/scale • Support incremental/local spread/scale of successful projects.
2019/20 - proposed	• Sustain improvement network created by Whakakotahi innovative phase (Commission acting as a 'hub') • Support incremental/regional spread/scale of successful projects • Scope possible national approach (formal collaborative for 2020/21) to spread scale initiatives/quality improvement capability.

Will you join Whakakotahi?

Funding

The Commission will contribute towards the costs associated with back-filling positions. This funding is designed to enable organisations to release team members involved in Whakakotahi, so they can undertake their improvement project work and attend learning events (ie, onsite visits and group learning events). In effect, the Commission will reimburse staff time up to $6000 (excluding GST) for each selected improvement project.

In addition, the Commission will also fund reasonable travel costs to support team member attendance at the group learning events (3-4 members, per team, at each event). These events will be held three times during the improvement project and will usually take place in Auckland, Wellington, or other main centre.

In summary, the Commission will provide:

1. $6000 per improvement project (excluding GST) to support back-filling of roles while team members undertake their improvement work/attend learning events.
2. Funding of travel costs to support team member attendance at group learning events (3-4 members, per team, at each event).

Who can submit an EOI application?

All primary care providers are invited to apply including general practice, community pharmacy, Māori health, or other primary care provider. Applications should be submitted with the endorsement and support of the relevant primary health care organisation.

Application process

Applications must be sent by email to the address below and must arrive before the due date. Applications must be on the attached form and contain the information set out in the requirements section on pages 10–12. Applications will be acknowledged by email after the closing date.

The Commission has a five-stage process for receiving and processing applications:

STAGE 1 3 July–1 September 2017	**Short application for EOI** EOI applications will be accepted from 3 July 2017 to midday on 1 September 2017. These should be in the EOI format attached.
STAGE 2 4–29 September 2017	**Shortlisting** The selection panel will review all applications and prepare a shortlist if required.
STAGE 3 2 October–24 November 2017	**Full proposal templates completed** Shortlisted applicants notified who will then complete a full proposal with assistance from the Commission. We will contact applicants at the earliest opportunity to allow this information to be collated. Applicants should be aware of the additional information required when resubmitting their

	improvement project proposal.
STAGE 4 27 November to 15 December 2017	**Selection process** Applicants will be invited to connect with the selection panel via teleconference for a brief Q&A session about their proposal. The selection panel will then make recommendations to the Commission on the preferred proposals. Applicants will be advised about the outcome of the final selection process by 15 December 2017.
STAGE 5 18 December 2017 to 26 January 2018	**MOU negotiations and start-up** The Commission and successful applicants will finalise a memorandum of understanding. Improvement project start-up will commence in February 2018 and finish by June 2019.

Due date for applications

Expressions of interest are invited from 3 July 2017 and close at midday on 1 September 2017. Memorandums of understanding will be completed by 26 January 2018.

Applications should be emailed to primarycare@hqsc.govt.nz or mailed to be received by the due date to:

Whakakotahi
Health Quality & Safety Commission
Private Bag 92 522
Auckland 1141
Attention: John Kristiansen

Further information

The Commission will be hosting a series of webinar/web meetings to provide background about Whakakotahi and allow time for Q&As about the application and selection process for this round of Whakakotahi, or other issues that interested parties may wish to raise.

Details about the webinar/web meetings and additional information can be found on the Commission website.

If you have any questions, please contac[redacted]

Phone: [redacted]

Email [redacted]

Eligibility criteria

The Commission invites EOIs from primary care providers who meet the following criteria:

- the proposed improvement project is focused on quality improvement in the New Zealand primary care sector
- proposals must be for activities commencing in 2018, through to 2019.

The Commission will not consider EOIs for:

- capital expenditure
- IT software or hardware projects
- projects with commercial application
- pharmaceuticals research and development or research undertaken as part of an undergraduate or postgraduate programme
- attendance at conferences or seminars
- international travel.

Evaluation guidelines

The key criteria required for EOI applications to fulfil each of the Commission's strategic priority areas which are explained below. We have obtained expert advice from the primary care sector to identify these criteria. Each EOI response will be assessed against these criteria by a selection panel.

Equity

- Use an existing evidence base of qualitative and quantitative data to explain the problem in a local context, including inequities between population groups
- Include a clear description of the equity outcomes that the improvement project will achieve (in practice, this will mean that data are able to be monitored and grouped according to the identified population inequities)
- Demonstrate understanding of how these inequities have arisen, and how the proposed approach differs from the current state (why this needs to happen)
- Demonstrate understanding of and commitment to equity-enhancing actions. This should include equitable representation from the local population, focusing on collaborative community participation, as well as partnering with other experts to address inequities.

Consumer engagement

- Describe the improvement the provider wants to achieve, and how this is a quality improvement activity centred on consumer engagement
- Show commitment to consumer co-design and involving the consumer in every stage of the improvement project. Consumer engagement should feature throughout the improvement project, from scoping, through project governance, to evaluating outcomes
- (Ideally) Be consumer initiated – brought to the provider's attention by the community, with accountability back to the community through the evaluation process
- Demonstrate how consumers are valued, supported and trained appropriately so they can participate fully in the improvement project from the outset. There will be evidence of value of a collaborative and consensus-building approach

- Focus on patient experience and the patient journey, concentrating on issue(s) that are important to the consumer. Any barriers will be stated and understood from a local consumer perspective
- Demonstrate the team's willingness to change as a result of the improvement project and respond to feedback from consumers during the evaluation process, even if that means further unforeseen change is required.

Integration

- Articulate a shared understanding of the integration problem (current state) and that all parties have a shared vision and understanding of the changes required to reduce waste and fragmentation
- Embody the concept of 'teams without walls'. It will identify the relevant parties and their accountabilities across roles, responsibilities and funding. Joint governance, decision-making and co-design processes will support the initiative
- Focus on consumer needs and their journey to create integrated pathways that deliver improved care, as well as understanding the wider relationships that are important to the consumer, so that their supporting infrastructure is woven throughout the programme. The EOI will consider health literacy needs, and what actions may be required to address them.

Evaluation criteria

Applications will also be assessed against the criteria below. The Commission will also provide brief feedback to applicants whose proposals are not successful. The selection panel's decisions will be final and not subject to review.

Criteria	Measures
Strategic fit	Does the proposal align with the Commission's strategic priority areas of focus?: - Stronger partnerships with consumers - Improving health equity - Reducing harm and preventable mortality - Reducing unwarranted variation in patterns of care - Improving capability and leadership. Does the proposal align with other agencies' and the health sector's priorities?

Evidence	Does the proposal relate to a known and clearly defined problem? How well stated is the problem definition? What is the size and impact of the problem identified? What are the possible/probable causes for this problem? Is the problem to be addressed amenable to change taking into account, for example time/resource constraints? How strong is the evidence for the proposed changes in practice or interventions proposed? How are the proposed changes linked to the identified causes of the problem? Is there support for this improvement area/topic in the sector? Are there any potential unintended consequences that may need to be addressed?
Achieving proposed goals	What are the benefits of the proposed solution? How easy will it be to measure benefit from the project? Is there potential for significant health gain and/or reduced risk/harm/inequity? What is the timeframe for achieving improvement? Can the proposed ideas for change/improvement be easily and sustainably incorporated into practices? How will the changes be sustained over time? What short- and long-term costs will be incurred? What support for this proposal will be provided by others in the sector? What are the perceived risks in this proposal for the organisation, the consumer, and the Commission?
Equity	Does the problem affect some population groups more than others? Who are these groups? What are the origins of existing inequities? Does the proposed project contribute to equitable health outcomes? How will the proposal promote health equity? How will this initiative decrease existing inequity?

	How will inequity be measured? What are the potential impacts on Māori health?

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND

Whakakotahi
Primary care quality improvement challenge 2018

Expression of interest form

Please complete all sections of this form. Refer to the guidelines when completing this form. Please use the text boxes for each section. You can expand the text boxes as required.

Section 1. Project details	
1. Short title of project	
2. Project location (the region, town or city where the project will be based). If this EOI is related to any other proposals, note them here.	

Section 2: Applicant's details	
1. Legal entity or entities applying. For joint ventures between two or more entities note the lead entity and attach an endorsement for their lead role from the other related organisations.	
2. Primary contact person name	
3. Primary contact details	
• Phone	
• Mobile	
• Email	
• Postal address	
4. Person who will be delivering the project (if known and not primary contact).	
5. Provide a brief description of your	*This description helps the Commission to*

organisation/practice. This can include: • size • enrolled population • population characteristics eg, ethnicity or proportion of high need. • very low cost access practice (VLCA) • integrated family health centre (IFHC) • Other special characteristics	*assess equity.*
6. Are there any potential or perceived conflicts of interest you are aware of in this proposal? If so please declare these.	*For example: Is there anyone involved in this EOI working for the Commission in any capacity, or with a commercial interest in the outcome of the project?*

Section 3: Project information	
Evidence: 1. What is the problem you are trying to address? Why is this a problem?	*Describe the problem and how you know that this is a problem.*
2. What is the scale and scope of the problem?	*Provide quantitative and/or qualitative data about the problem here, including data about existing inequities*
3. What are you proposing to do?	*Describe your ideas for change.*

Section 4. Project objectives (please use extra space if required to describe your project)	
Strategic fit: 1. How will this project contribute to the three strategic priority areas for primary care?: a. equity b. consumer engagement c. integration	*Does the problem affect some population groups more than others?* *How will the proposal seek to address health equity?* *Review the evaluation guidelines on pages 10–12 and provide a description of how your proposal will meet these criteria.*

Achieving your goals: 1. How will you know if you have made a difference? 2. How will you monitor your project delivery and success? 3. What is the timeframe for achieving improvement? 4. How well would your project transfer to other health providers?	*What data/measures will you collect and how will you collect them? How much data do you already have?* *Please explain how the focus areas would be measured:* • *Equity* • *Integration* • *Consumer engagement.* *Describe the possible barriers and obstacles that might hinder your improvement efforts.* *How long will you need to show sustainable change?* *What are the opportunities for your initiative to be spread across the sector and how can sustainability be assured?*
Resourcing: Briefly describe how your organisation will resource and support your improvement project.	
PHO support: If the improvement project will involve a general practice, briefly describe how your PHO has endorsed your proposal.	

Section 5: Certification

I, _____ certify that this EOI form application to Whakakotahi – primary care quality improvement challenge 2018 is authorised by the legal entity specified above.

If you have any questions, or need any help to complete this EOI form please contact Jane Cullen:

Phone [redacted]

Email [redacted]

Requirements – Process	Please ✓
1. All applications must be received at the Commission by midday on 1 September 2017.	
2. All applications must be completed correctly and contain the information requested.	
3. Nominate a contact for administrative purposes, including name, contact number, email and address.	
4. Each proposal must be submitted separately. If there are links between proposals these should be noted.	
5. Joint ventures between organisations should identify a lead organisation and include an indication of endorsement for their involvement in this project from the other organisations.	
6. Indication of endorsement from PHO (if a general practice is submitting).	
7. Proposals should be emailed to: primarycare@hqsc.govt.nz by the due date.	

Improvement Team:

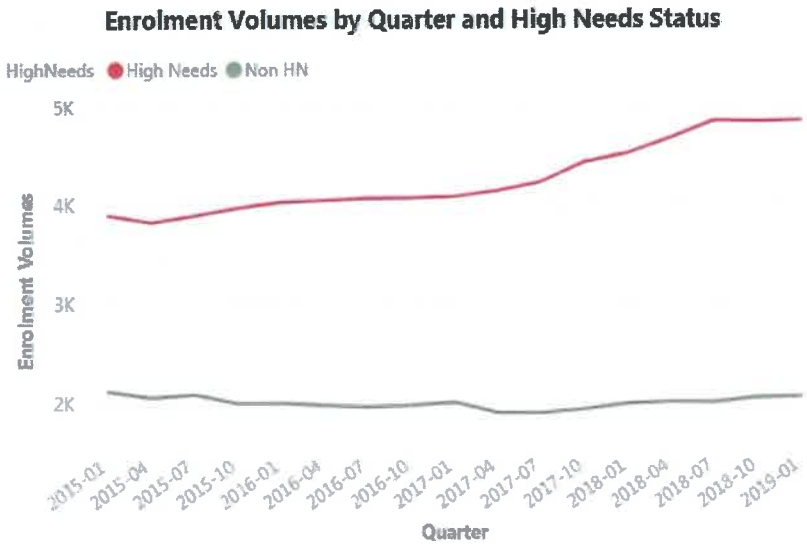
Gonville Health

Health Quality & Safety Commission New Zealand

Ko Awatea
Health System Innovation and Improvement

Background

- Gonville Health is a purpose built general practice located in a high deprivation area of Whanganui
- VLCA practice with approximately 7,000 enrolled patients - 70% are high Needs
- 19% of our patients are registered with Community Mental Health service
- 5.5 per 1,000 have a report of concern (high number of vulnerable children)
- We have a transient and increasing enrolled population



HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND

KO AWATEA
HEALTH SYSTEM INNOVATION AND IMPROVEMENT

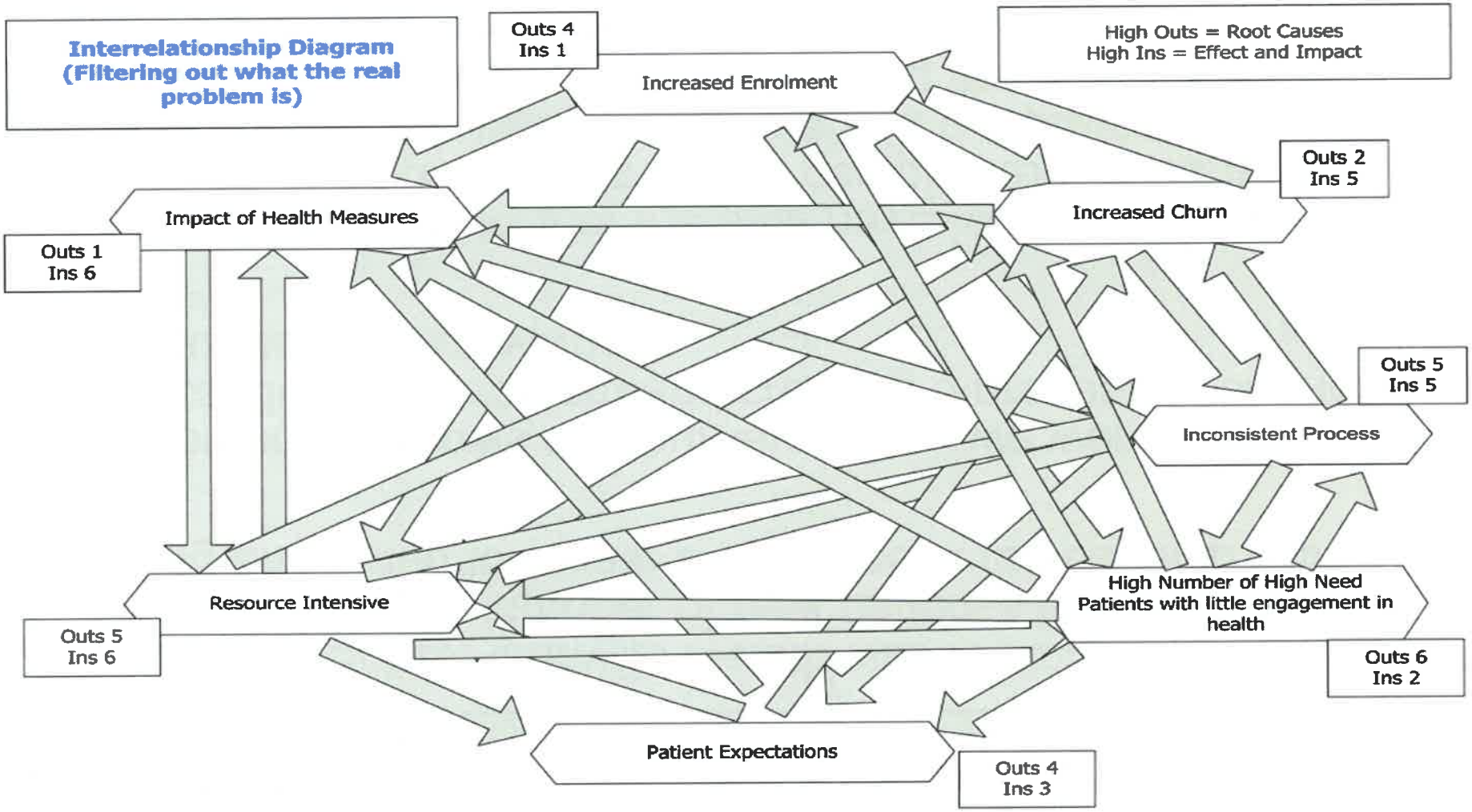
Executive Summary

As a VLCA practice, Gonville Health was feeling overwhelmed by the number of new patient's that we were enrolling and trying to create a therapeutic relationship with.

This storyboard shows our journey of how we went about understanding our problem and creating a process of change and evidencing improvement.

The results have been that the staff have felt more in control, patients have said enrolling is less complicated, patients are more informed and we know more about our patients in a way that helps us partner them towards being more engaged in the practice, their health and self management.

Understanding the Problem



HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND

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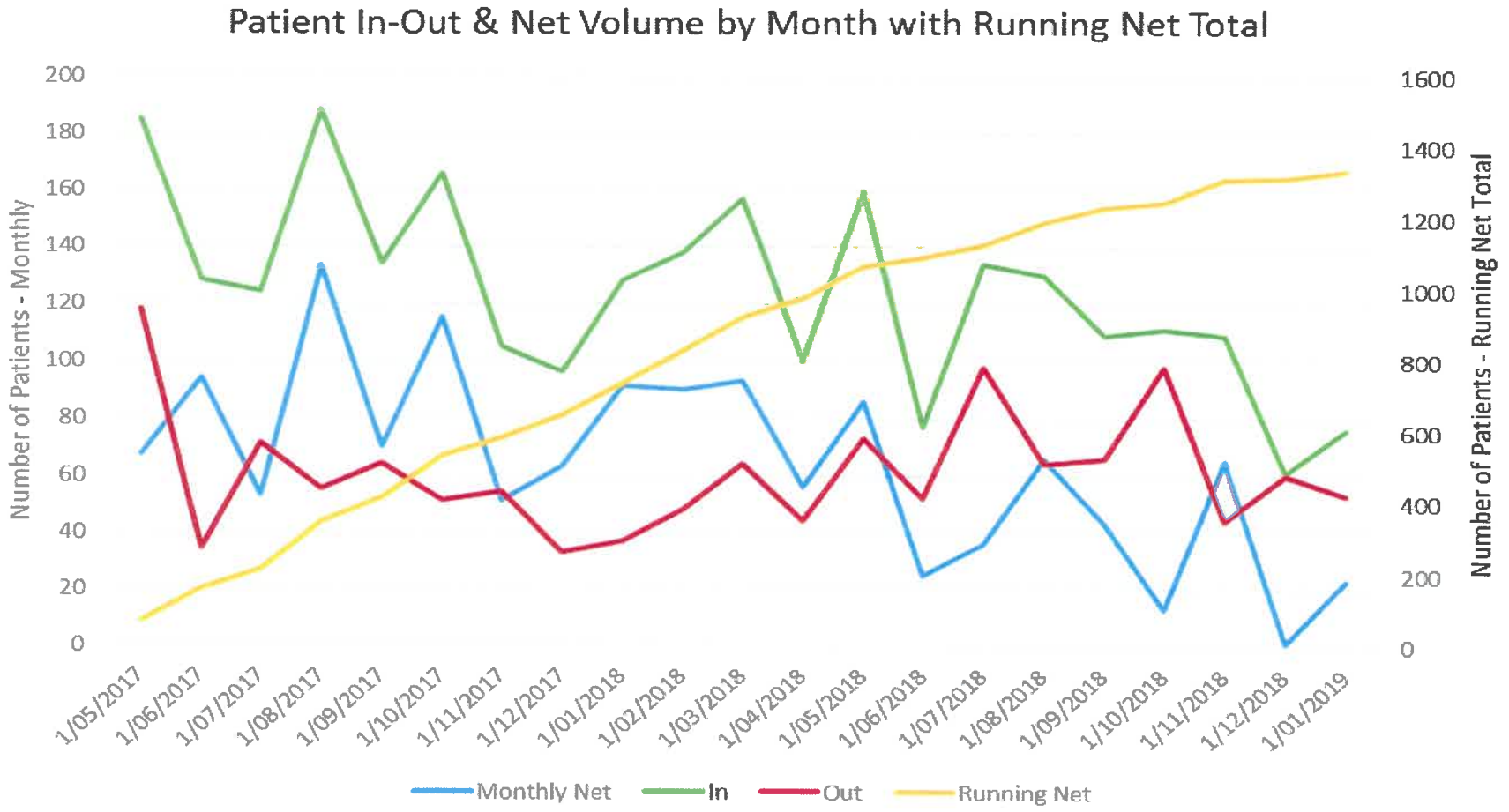
HEALTH SYSTEM INNOVATION AND IMPROVEMENT

Understanding the Problem



New Enrolments	**May 2017 – January 2019**	**2,637**
Patient Exits	**May 2017 – January 2019**	**1,301**

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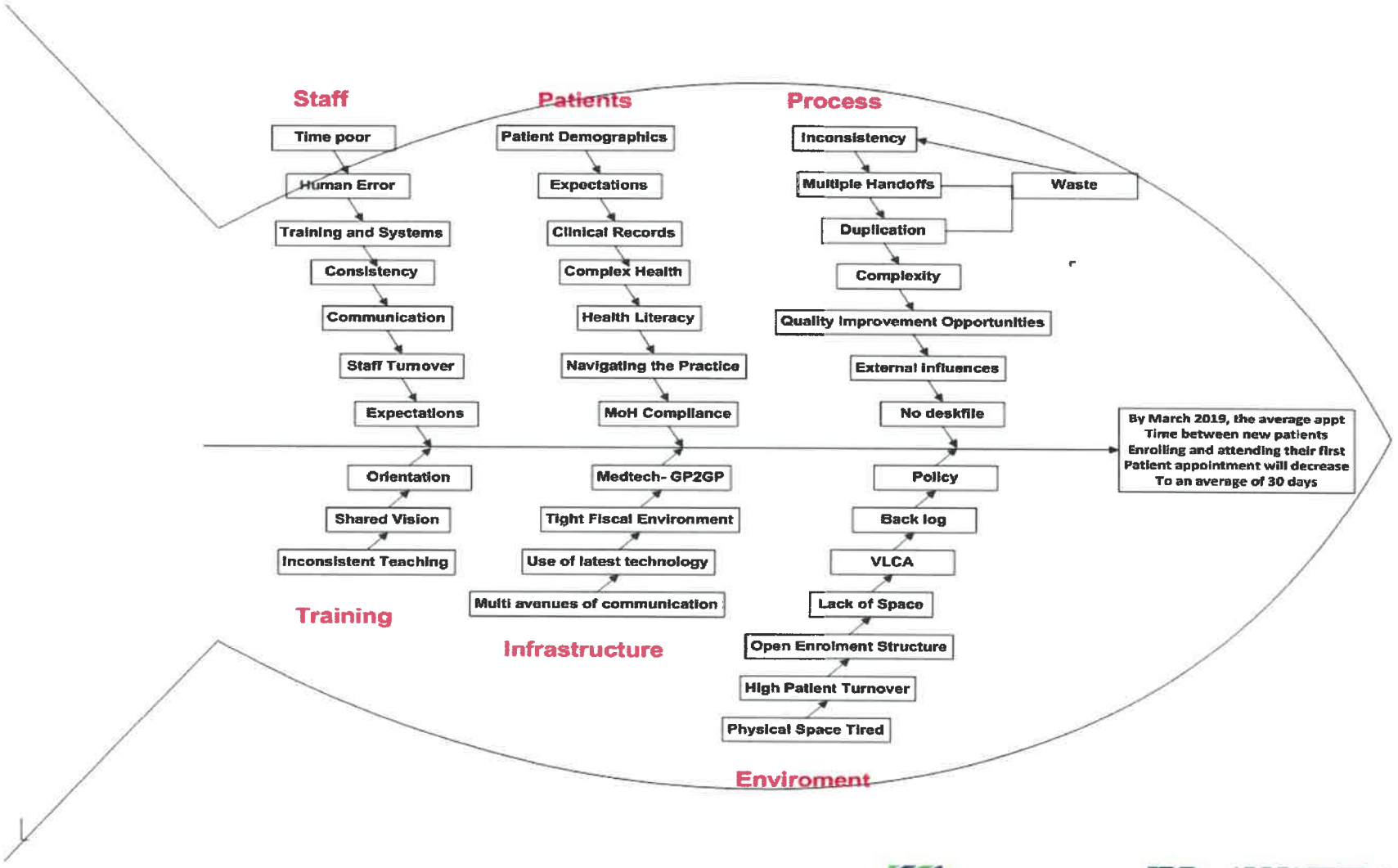
Problem Statement

High enrolment of high need patients with little engagement in health combined with inconsistent and resource intensive processes are overwhelming the practice

Aim Statement

By March 2019, the average appointment time between new patients enrolling and attending their first patient appointment will decrease to an average of under 30 days

Diagnosis: Fishbone Diagram



Diagnosis: Driver Diagram

Version:
Contact Person:
Date Updated:

Driver Diagram: Gonville Whakakotahi 2018

AIM Measures	Primary Drivers	Secondary Drivers	Change Concepts	Change Ideas
What are we trying to achieve?	In order to achieve this change we will need to have/influence/ consider:	A critical component of this is		• We have to do this ..... • One way how to do this is .....
The average appointment time between new patients enrolling and attending their first patient appointment will decrease to under 30 days by March 2019	Enrolment and orientation to GHL is simple for patients and the process supports structured engagement and improved health outcomes	Professional and consistent enrolment process for patients	Professional enrolment form	• Simplify and tidy up the enrolment form
			Staff ensure that patients understand the enrolment and engagement process	• Welcome to Gonville orientation process
		Patients feel welcome, informed and engaged in their health	Patients are supported and have the tools to self manage their own health	• Develop a range of medium to support consistent and clear communication for patients
			Patients are well orientated to the practice so that they can self navigate their health journey	• Encourage activation of a patient information portal to support patient self management
		New patients will be provided with supports to encourage smoking cessation	New appointment is a conduit for screening and intervention opportunities	• Process for identifying who needs a new patient appointment and that notes are comprehensive
				New patient appointment records age appropriate screening and intervention
	The enrolment and first patient appointment process is standardised, structured, consistent and all staff understand their roles and responsibilities	Patient notes are processed accurately, consistently and managed within 10 days	Simple and efficient enrolment and new patient appointment process	• Review and update enrolment and new patient appointment process and create flowchart
				• Process for ensuring receipt of notes and new patient appointment is timely
		Consistent and timely process for first patient appointments	Staff identify early potential interruptions in the enrolment *journey*	• Staff training for updated enrolment process
			Staff present a consistent communication message	• Process and prompts for consistent communication

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND

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Model of Improvement
Example: PDSA Summary

Review enrolment new patient appointment process

Process Mapping- By working with staff involved; we reviewed the current state to see whether there was consistency and duplication around the process. We used a range of mapping processes being; post its and walk through

Review and Trial- After review and discussion we started trials and this included; scenarios, process timing and cast studies

Observations- There was variance in process and time taken, duplication, lack of common vision and communication, there was also a range of errors and some competition between staff members. ' this is how we have always done it'

Current state- Reduced the change for human error (TIMWOOD), had a range of meetings and training to align vision and approach, developed an evolving flow chart to support consistency. Efficiencies have been identified, pressure has reduced, the team are more aligned and 'proactive with improvements and ideas'

Where to: Continue PDSA cycle

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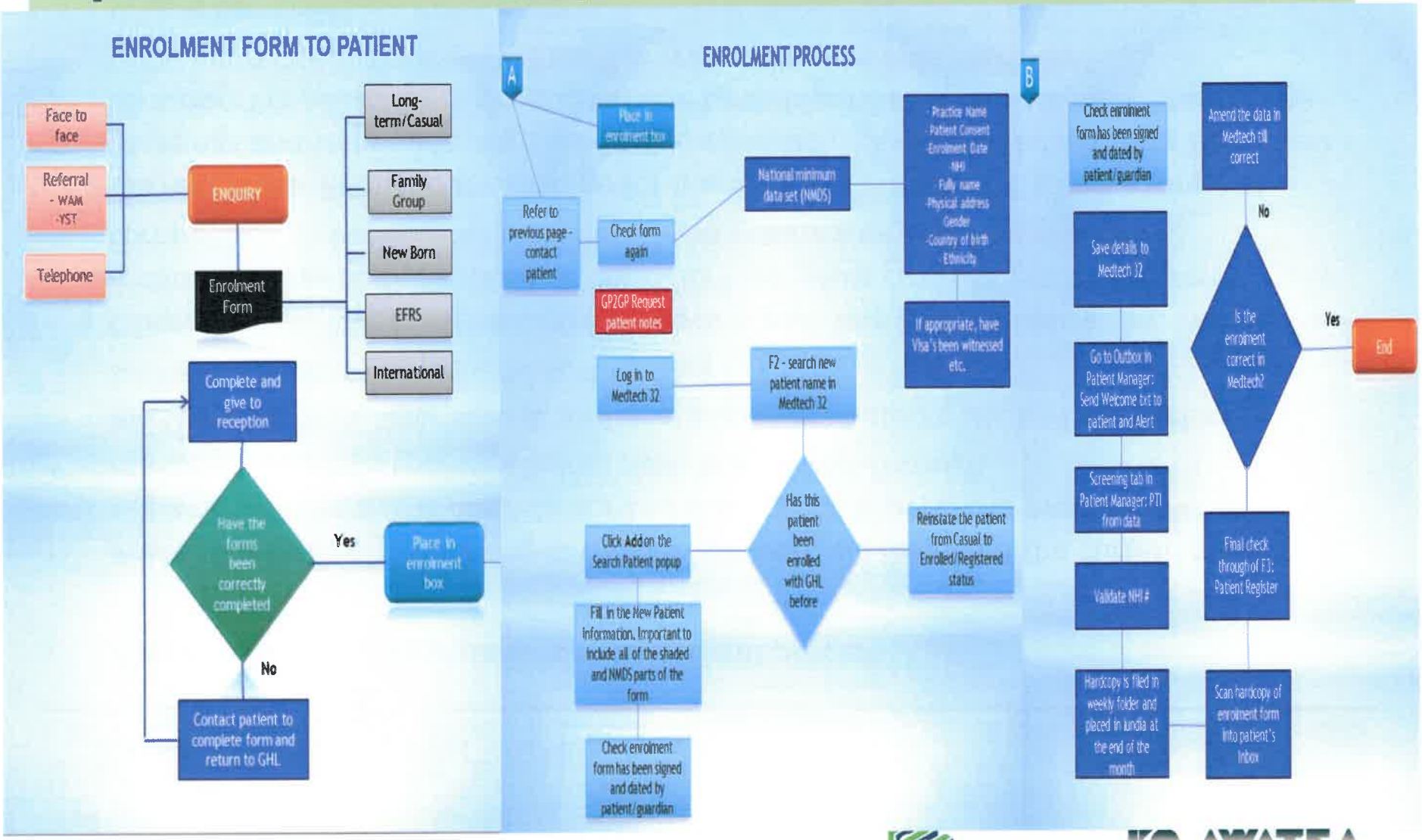
Updated State Map



HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND

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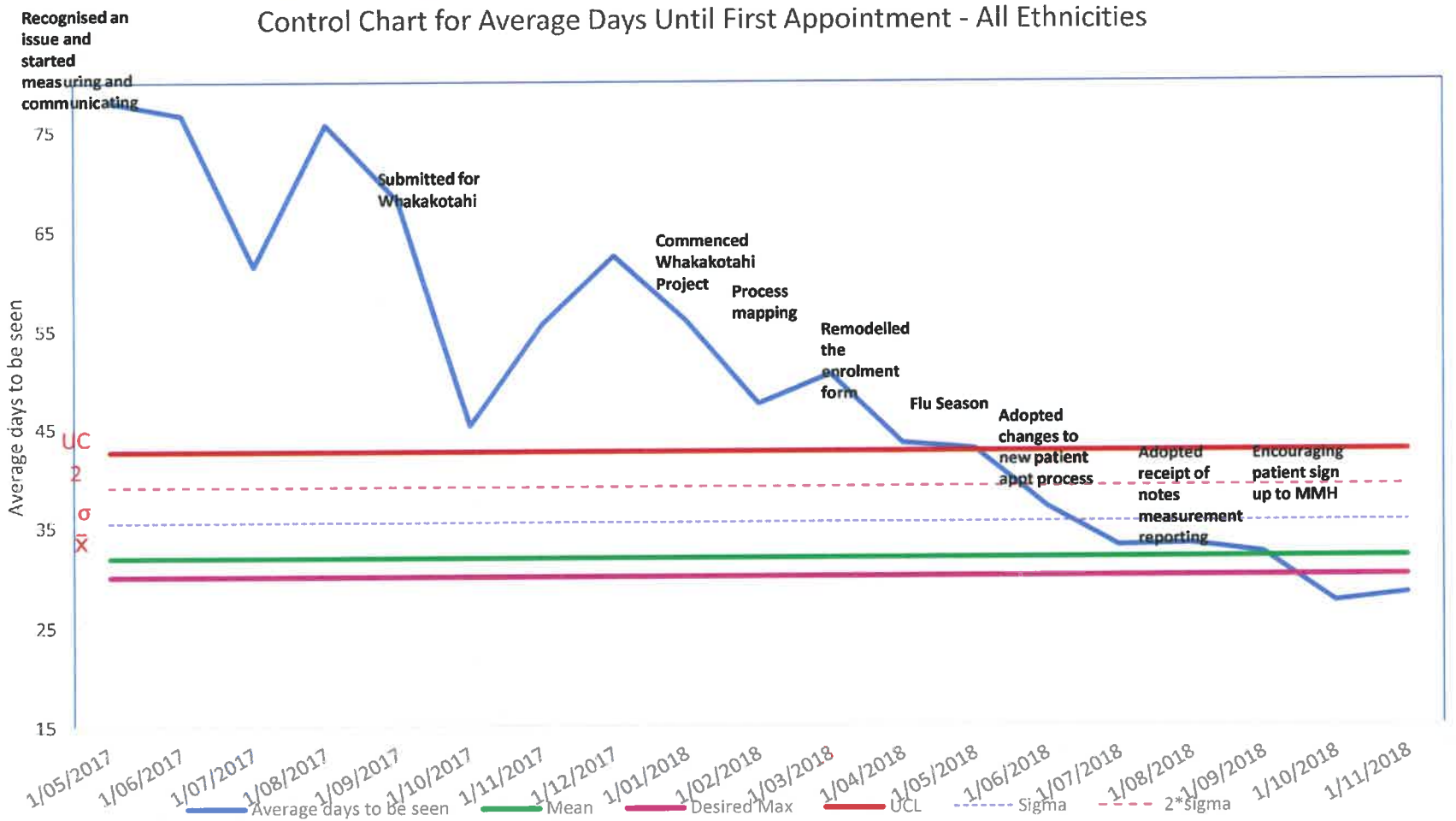
Family of Measures

	Description	Measure	Performance at Project Planning Stage	Target performance
Outcome measure	Reduce the time between the patient enrolling in the practice and attending their first appointment to assist with the patient being engaged in the practice and their healthcare journey as soon as possible after enrolment	By March 2019, the average appointment time between new patients enrolling and attending their first patient appointment will decrease to an average of under 30 days	As at July 2018 average time is 30 days. This is decrease to the 75 days average May 2017	Reach 30 average days between the patient enrolling and attending their first patient appointment by March 2019
Process measure	Measure and reduce the time taken between enrolling the patient and receiving their notes	By December 2019, the average time taken between enrolment and patient notes being received will be less than 10 working days	No measurement, no follow up of notes not received	By week 8 100% had been achieved and consistently thereafter
	Patient portal will be adopted by new patients as a support mechanism of self management	By March 2019, 80% of new enrolees will adopt Patient Portal	No Between 4.4 – 4.6% Oct/Nov 2018 and less than 1% prior to rollout of the change	80% of new enrolees by March will also enrol in Patient portal at the same time as enrolling at the practice
Balance measure	Ensure that the change process does not affect staff satisfaction or empowerment	That the indicators of staff feeling in control of the process stay the same or improve over time	In January 2018 indicated that they were a 2 on a scale of 1-5 of feeling in control of the enrolment process	In November 2018 70% of staff stated they were a 4 and 30% a 5 on the scale of control

OUTCOME MEASURE

Average Number of Day between Enrolment and First Patient Appointment over Time



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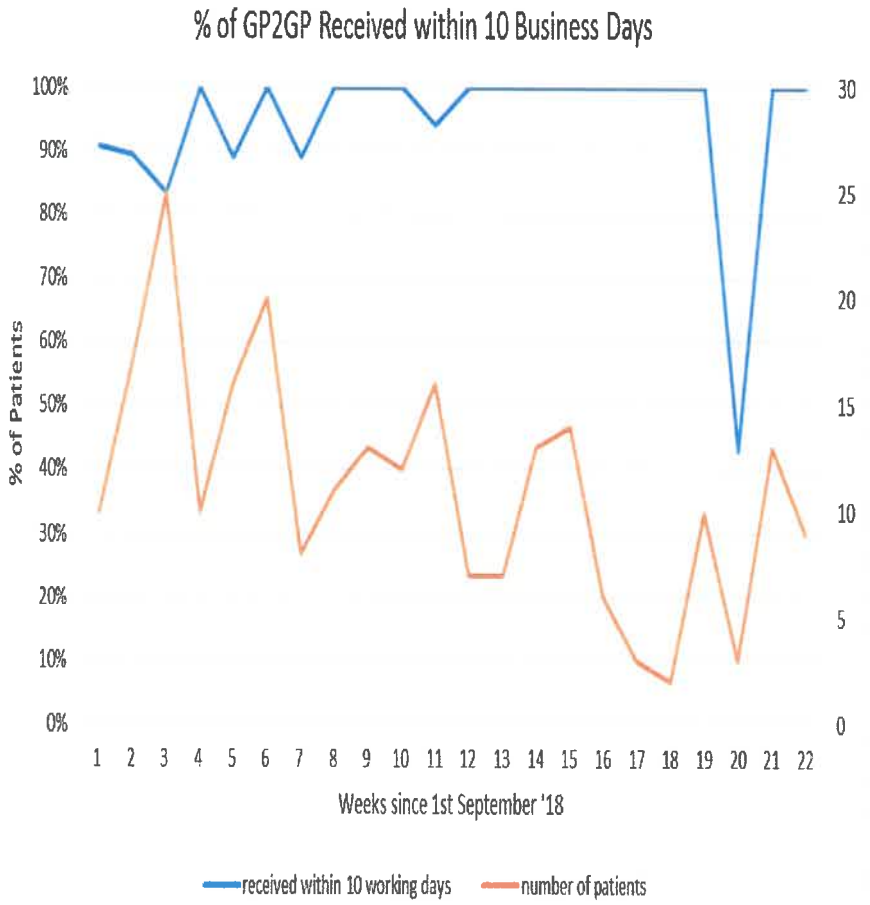
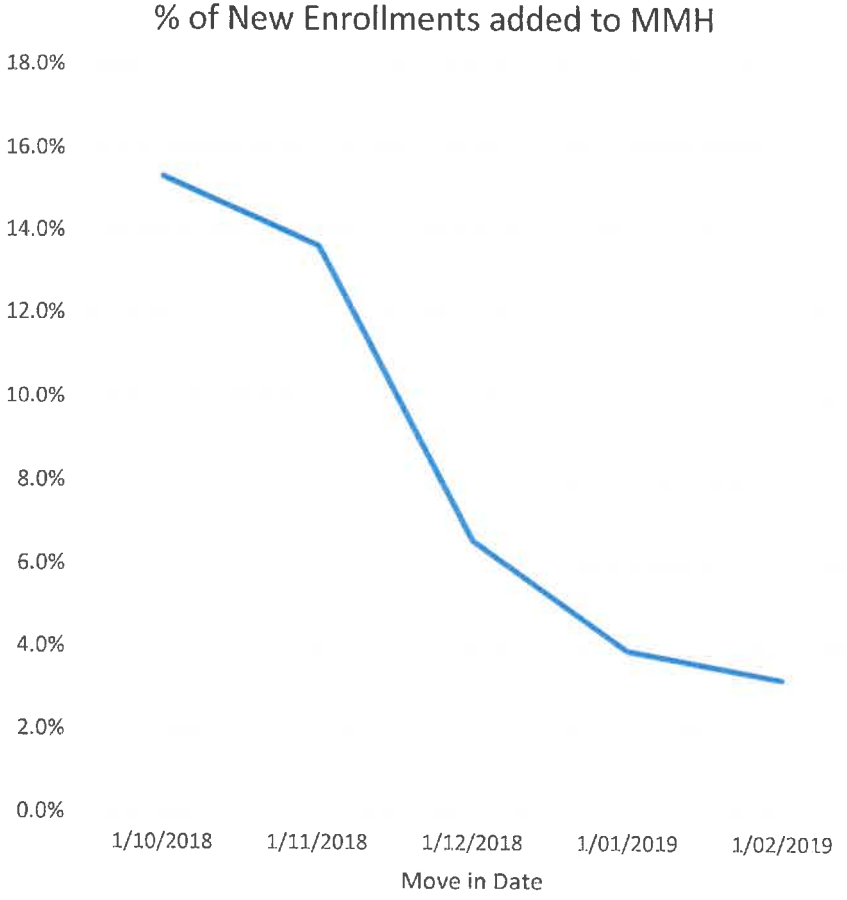
PROCESS MEASURES





Health Quality & Safety Commission New Zealand

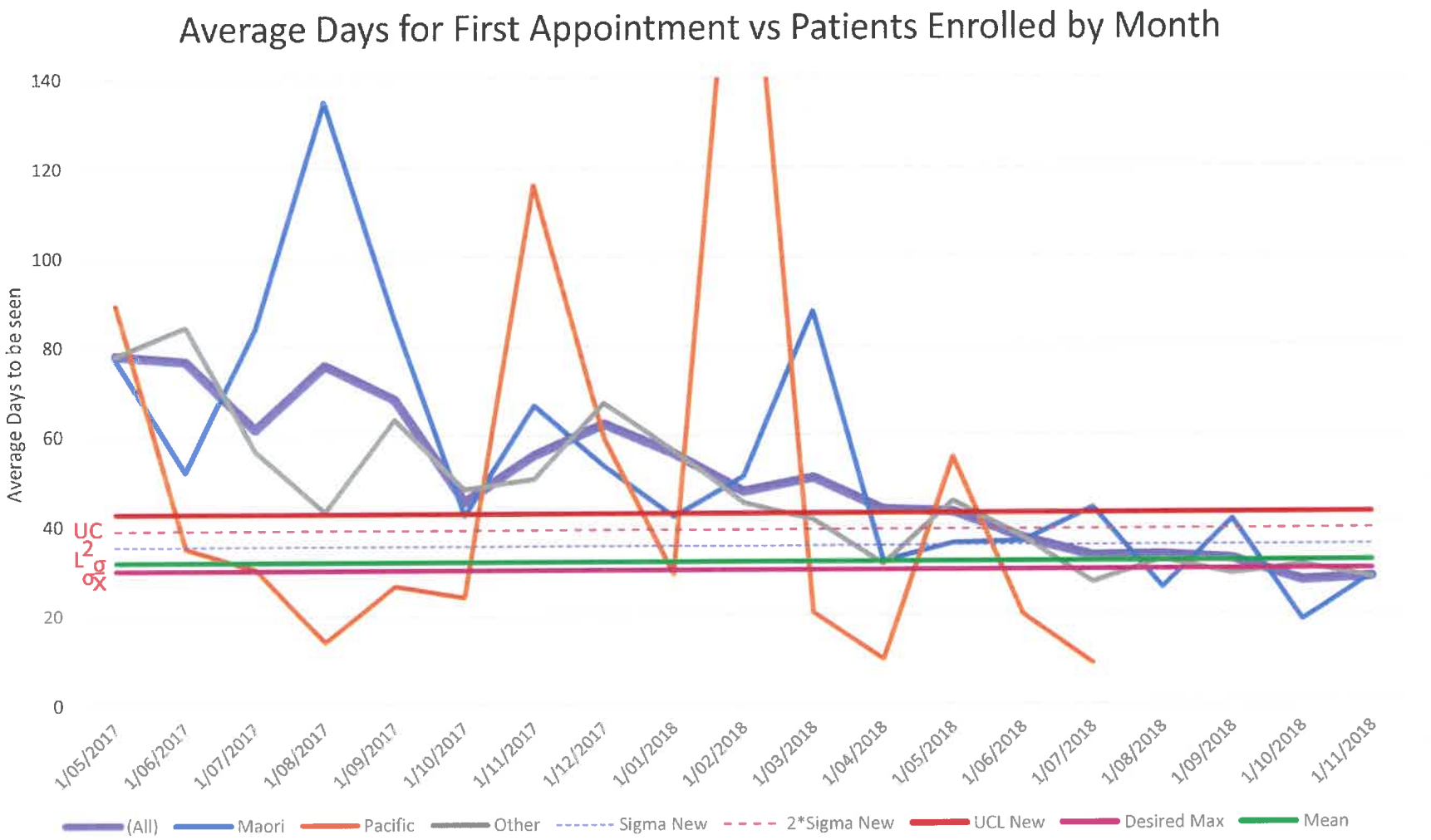
Te Kaupapa Hauora o Aotearoa

Ko Awatea

Health System Innovation and Improvement

BALANCING MEASURE

Ensuring that the Changes Don't Create Inequities



HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND

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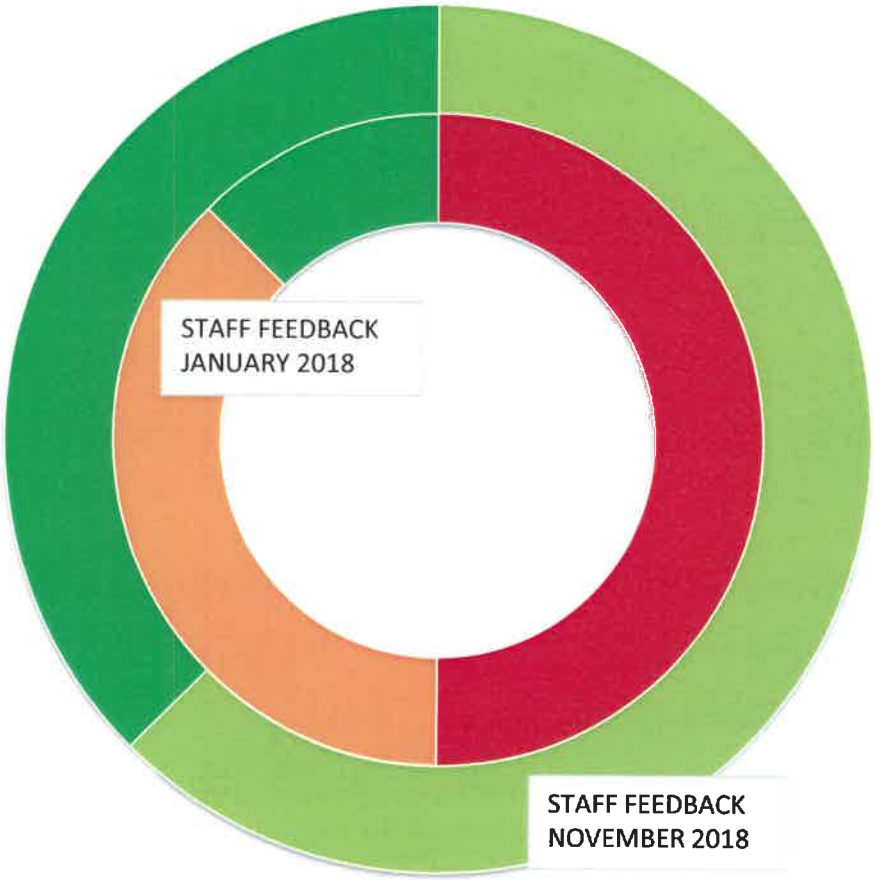
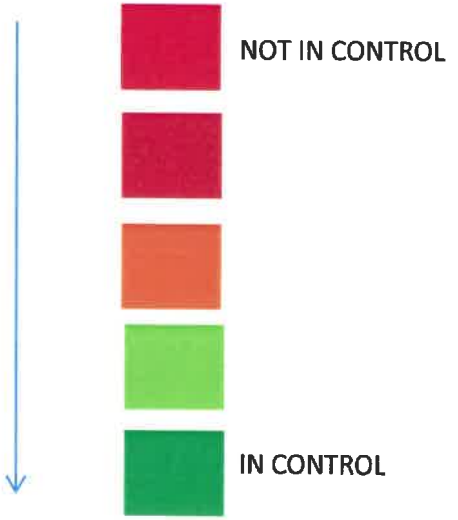
HEALTH SYSTEM INNOVATION AND IMPROVEMENT

BALANCING MEASURE
Staff Satisfaction





Staff Satisfaction Survey

'How in control do you feel of the enrolment process'?

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Health System Innovation and Improvement

Lessons Learned

- That sustainable change will only come from using quality improvement methods and good measurements provide evidence. As identified in the Outcome Measure Graph we started creating change before we started our quality journey
- What we can see by the graph is that we see improvements from May 2017-Jan 2018 but they are more erratic and there is no evidence that the changes put in place at that time would have continued to improve or even remain
- From Jan 2018 to current we are seeing sustainable and more regular improvement as we put the model of change in place.

Highlights – Lowlights

Highlights

- Increased patient engagement and staff satisfaction
- Knowledge and skills to achieve sustainable improvement
- Working as a team
- Level of calm and satisfaction that has emerged post quality improvement changes
- Data as evidence to validate or determine focus areas
- Side streams of work done due to knowledge gained e.g cancer register
- Using the information and skills gained
- Knowing it will only get better from here

Lowlights

- Finding time and competing priorities
- The urge to reach a solution/conclude without going through a quality process
- Easy to move off track