**Whakakotahi: Where quality improvement drives equity, consumer engagement and integration**

 **Accessible transcript**

**Visual**

**A white PowerPoint slide in the shape of a large speech bubble is framed by green. In the top right corner of the slide, blue and green text reading ‘Health Quality & Safety Commission New Zealand. Kupu Taurangi Hauora o Aotearoa.’ Beside this is the blue and green company logo comprising of three thin square blocks with white circles of differing sizes within them. A heading reads ‘Whakakotahi: Where quality improvement drives equity, consumer engagement and integration.’ Below this in grey, text reads ‘Jane Cullen & Carmela Petagna. Health Quality & Safety Commission.’ To the right of the PowerPoint slide, two small video feeds of two women. The first woman is Carmela, who has black bobbed hair and wears a white top. The second woman is Jane, who has strawberry blonde bobbed hair and wears glasses. Both women wear headsets with microphones.**

Audio

(Carmela): Tēnā koutou, tēnā koutou, tēnā koutou katoa. Ko Carmela Petagna tōku ingoa. I'm a senior manager here at the Health Quality & Safety Commission and oversee a number of our national quality improvement programmes.

(Jane): Tēnā koutou, tēnā koutou, tēnā koutou katoa. Ko Jane Cullen tōku ingoa. I'm the quality improvement advisor on the primary care programme Whakakotahi.

**Visual**

**The slide changes. It’s titled ‘Health Quality & Safety Commission’ and in the middle of the slide is a blue and green illustrated motif which includes the words ‘Adding value together. Mō te iwi.’ The motif is made up of two hands coming together to shake, an electricity spark, a man and a woman with their noses pressed together in a hongi and a heart shape with an electrical impulse inside it. Jane’s video feed disappears, while Carmela’s remains.**

Audio

(Carmela): The Commission is an independent Crown entity and has been established for 10 years. It works across the health and disability sector in Aotearoa New Zealand to improve health services and works towards achieving the Triple Aim. The analogy we often use to describe our work is we do this by 'shining the light' through data intelligence and evaluating our impact, and by lending a helping hand through our improvement work and partnering with others.

**Visual**

**The next slide is titled ‘Tā mātau matakitenga. Our vision. Hauora kounga mō te katoa. Quality health for all.’ Beneath the blue and red heading, a blue and red koru motif. Beneath the motif, more text reads: ‘Tā mātau uaratanga. Our mission. Whakauru. Whakamōhio. Whakaawe. Whakapai Ake. Our mission. Involve. Inform. Influence. Improve.’**

Audio

This is the vision and mission of the Commission, which has recently been refreshed. We hold a unique role in the health sector and deliver our work in partnership with others,

described in four approaches – how we involve, inform, influence and improve.

**Visual**

**The next slide is titled Whakakotahi – ‘to be as one’. Black text beneath that reads ‘partnering with primary care teams to work on small-scale improvement projects chosen by providers.’ A hand-written blue and green illustrated storyboard titled ‘Childhood respiratory warrant of fitness’ with a drawing of a child using an inhaler and spacer labelled ‘Māori and Pacific children’. The storyboard contains groupings of information reading ‘Unichem Russell Street’, ‘our aim’, ‘case study’, ‘what we did’, ‘results’ and ‘key learnings’.**

Audio

Whakakotahi is part of the Commission's primary care quality improvement programme.

The concept was to work as one with the sector to support primary care with improvement projects that they identified as being important to the populations that they serve. The work commenced at small scale, aimed at building on the work that they were already doing and amenable to achieving scale and spread over time. We used a number of methods to capture the work, including visual storyboards, as you can see here.

**Visual**

**The storyboard is replaced by text reading:**

**Focused on:**

* **equity**
* **integration**
* **consumer engagement.**

**To the right of the bullet points, a green box with text reading ‘Progressing consumer engagement in primary care. Te whakakoke i te whai wāhi a te kiritaki ki te tiaki hauora tuatahi.’ Beneath the text is a white-outlined illustration of the woman and man with their noses pressed together in a hongi.**

Audio

Our commitment, as agreed by our expert advisers, focused on three key criteria that all projects had to address. These were equity, integration and consumer engagement.

**Visual**

**The next slide is titled ‘An integrated approach.’ A diagram of five connected circles ranging in colour from purple to blue around a green circle named ‘Consumers and whānau’. The five circles are labelled ‘primary care experts’, ‘primary care networks’, ‘evaluation’, ‘improvement science education (model for improvement)’ and ‘adapted learning collaboratives’.**

Audio

A co-creation approach was adopted from the outset of the programme. It was guided by primary care experts and consumers, with feedback from improvement teams to enable rapid learning and adaptation. Consumers were part of the expert advisory group and on the project selection panel for all projects across all three years. The programme theory of change rests on the drivers for achieving integration through partnering with Māori, sector leadership, driving improvement capability, consumer co-design, and doing all this to achieve reduced harm and variation. The collaborative methodology was adapted to meet the specific needs of the people and context.

**Visual**

**The next slide is titled ‘Evaluation – formative and summative.’**

**Drawing on:**

* **project team interviews**
* **surveys**
* **Whakakotahi team collected quality improvement data**
* **key stakeholder interviews.**

**Beneath the bullet points are five different coloured boxes making up a flow chart. The boxes are labelled left to right as ‘Tranche 1 progress report Dec 2017’, ‘Preliminary feedback report Oct 2018’, ‘Tranche 2 progress report Dec 2018’, ‘Tranche 3 progress report Dec 2019’ and ‘final report June 2020’.**

Audio

Evaluation was a key part of the process, and we had an independent provider partner with us from the outset of the programme. We did this in a formative way which meant that we could distil learning each year through progress reports and adapt and refine the programme and processes as required to ensure that what we were doing was fit for purpose and the sector we were working with. This was a three-year journey. Some of the refinements adopted were around simplifying our EOI process, increasing our criteria weighting for equity and improving our own cultural competence as a team.

**Visual**

**Jane’s video feed reappears. The next slide is titled ‘Whakakotahi – primary care improvement.’ A blue-toned table is laid out as follows:**

|  |  |  |
| --- | --- | --- |
| **2017** | **2018** | **2019** |
| **Three projects** | **Six projects** | **Nine projects** |
| **All in general practice, one integrated with the DHB.****Two very low cost access practices with high-needs populations.****Two projects centred on Māori, Pacific peoples and areas of high deprivation.**  | **Four general practices, one pharmacy (Hastings), one NGO kaupapa Māori health organisation (Turanga Health, Gisborne).****All projects centred on Māori, Pacific peoples (Tuvaluan) and areas of high deprivation.** | **Equity weighted in selection criteria.****Seven embedded in general practice, three pharmacies, four Māori/iwi health providers and the Tongan Health Society.****All projects centred on Māori, Pacific peoples and areas of high deprivation.**  |

Audio

(Jane): After the first year, all of the projects came from health providers servicing areas of high deprivation and/or Māori and Pacific populations. In the first year, we started with a focus on general practice services, but broadened our criteria to include pharmacies and other primary care providers in the subsequent years. We encouraged teams to develop projects involving other providers and had several joint general practice/pharmacy and primary/secondary care projects. In 2019, the increased weighting given to equity saw four Māori health organisations and the Tongan Health Society among the nine projects selected.

**Visual**

**The table updates as follows:**

|  |  |  |
| --- | --- | --- |
| **2017** | **2018** | **2019** |
| **Three projects** | **Six projects** | **Nine projects** |
| **Diabetes****Gout****Post-stent management** | **Diabetes (2)****New patient enrolment – access to services****Access to services for Māori****Asthma****Skin and soft tissue infections – Tuvaluan youth.** | **Diabetes (3)****Eczema (2)****Asthma****Gout****Access to health screening for methadone treatment patients****Access to medicines (rural).** |

Audio

As you can see here, most of the projects focused on chronic conditions, and diabetes was a key area of focus across all three years. I'm just going to share some successful project outcomes.

**Visual**

**The next slide is titled ‘Project outcomes – Skin & soft tissue infections.’ A line graph plotting the Tuvaluan SSTI occurrence per 1000 patients over a two-year period. The x axis is marked in monthly increments from the first month of 2017 to the second month of 2019. The y axis is marked in increments from 0 to 45 to show the number of Tuvaluan SSTI patients per 1000.**

Audio

Here you can see a project from a Pacific general practice and community provider whose project aims to reduce skin and soft tissue infections in the Tuvaluan community.

**Visual**

**The next slide is titled ‘Project outcomes – SSTI equity.’ A line graph plots and compares the rates of SSTI per 1000 patients for Tuvaluans, main PI groups and non-PI. By February 2019, the occurrence rates of the three groups have dropped and are in a similar range.**

Audio

They were able to narrow the equity gap between the Tuvaluan population and other Pacific Island groups and the rest of the community, as you can see on this graph.

**Visual**

**The next slide is titled ‘Project outcomes – Gout.’ A line graph from May 2017 to March 2018 shows the percentage of patients on allopurinol increasing from 40 percent to around 87 percent.**

Audio

This is a Māori general practice example – improving the management of gout for Māori patients diagnosed with gout who were not receiving the standard treatment.

**Visual**

**The next slide is titled ‘Project outcomes – Asthma’. A line graph from July 2018 to December 2018 shows the percentage of patients reaching target ACT score incrementally increasing from 0 percent to around 82 percent.**

Audio

This next one is a pharmacy project with Māori and Pacific youth who set and subsequently achieved their own asthma control target scores.

**Visual**

**The next slide is titled ‘Capability building outcomes’. A line graph titled ‘Whakakotahi capability building.’ Three lines on the graph plot the overall increase of Tranche 1, Tranche 2 and Tranche 3 from March start to October mid and the following March end.**

Audio

Capability building was one of our key aims, and over the three years, 53 primary care workers were educated in improvement science. We sponsored one or two people from each team into a formal course, in addition to the three learning sessions and on-site support provided as part of Whakakotahi. Teams' feedback tells us that the gains in quality improvement capability do not simply drop off after the programme ends. The tools and mindset that comes with gaining confidence and experience and applying quality improvement methodology continues to be evident in their work afterwards.

**Visual**

**The next slide is titled ‘Equity outcomes.’ A bar graph titled ‘Proportion of Whakakotahi projects focused on Māori, Pacific Peoples &/or low socio-economic populations.’ The bar graph shows an increase of both total final projects and Māori, Pacific Peoples &/or Quintile 5 projects from 2017 to 2019. In 2017, there are more total final projects but in 2018 and 2019, the number of two types of projects are the same.**

Audio

Across the three years, 17 out of the 18 projects were equity focused.

**Visual**

**The bar graph changes and is now titled ‘Proportion of equity focused projects achieving their aim.’ From 2017 to 2019, the number of equity projects and the number of successful projects increases.**

Audio

And while not all of the projects achieved their stated aims, even those who did not achieve their aims would still rate the project as a success because of the progress they made towards achieving their often aspirational aims. Understanding improvements in health equity is a long-term journey that is best achieved through a systems approach

and subsequently understood in the same way, which is difficult to achieve within the constraints of the programme timeframes.

**Visual**

**The next slide is titled ‘Consumer engagement outcomes.’ Text reads: Ali Sinclair talks about her experience. To hear from other consumers and project leads about the value of involving consumers in quality improvement.’ A hyperlink reads** [**www.hqsc.govt.nz/our-programmes/primary-case/publications-and-resources/publication/4105**](http://www.hqsc.govt.nz/our-programmes/primary-case/publications-and-resources/publication/4105)**.**

Audio

Here we have a video of one of the consumers sharing her experience... on being involved in Whakakotahi.

**Visual**

**The PowerPoint slide changes to a video clip. On a blue background, white text is bordered in green. The text reads ‘Ali Sinclair, a health consumer in Nelson, talks about her involvement with the Victory Square Pharmacy Whakakotahi quality improvement project.’ Ali, a woman with long chestnut-coloured hair, sits on a wooden park bench on a sunny day. She wears a black jacket and blue trousers.**

Audio

(MELLOW MUSIC)

(Ali): My name's Ali Sinclair, and I've been on the methadone programme for quite a while now – about 20 years, and, um, I have quite a few health issues. I think it's important for us- for a consumer to be part of the project is cause we're the ones that are taking the medication, we're the ones that have the experience, and we're the ones that can let the health professionals know what we're going through. It's been really good going to the seminars with the ladies, being asked everything about – they wanted my input; it made me feel very proud to be part of it. The benefits and the outcomes of the project would be that we will not be losing 20 years off our lifespan, we'll be getting looked after just like everybody else, and it'll be equal – equal health to everybody, whether you're – when you're on the methadone programme. I feel very proud to be asked to be part of it. It's, uh... and to have it – it's enlightened me to be asked to be part of the project. I feel very privileged. I felt like I've been listened to, being there, and as a consumer. Definitely. Definitely.

**Visual**

**The PowerPoint resumes, with Carmela’s and Jane’s video feeds to the right of the slide. The slide is titled ‘Integration’ and a quote reads ‘They [the medical centre] were receptive to working with us, despite not previously working together and I can see a good relationship developing that could help improve integration for our population going forward.’**

Audio

(Jane): Integration was a key principle for the projects. Evaluation survey data identified that across all three years, everyone considered their project to have a positive or very positive impact on integration, with some case examples demonstrating this far more explicitly than others.

**Visual**

**The next slide is titled ‘Barriers.’**

* **Resource-intensive application process – simplified and modified throughout**
* **Access to data and data infrastructure**
* **Knowledge, time and resources for quality improvement**
* **Variation in experience and knowledge of co-design.**

Audio

There were some barriers encountered by the participating teams, and some of these are of particular concern in the primary care setting, such as the limitation of primary care data and data infrastructure. However, participating in Whakakotahi provided the opportunity to build these skills and capabilities.

**Visual**

**The next slide is titled ‘Enablers.’**

* **Support from the Commission for the project teams**
* **A flexible approach to engagement**
* **Collaboration and partnerships**
* **Cultural advice and support.**

Audio

All of the teams valued the support from the Commission and the flexible approach that we developed after the initial year. Before the third year, we partnered with a Māori organisation to provide cultural advice and support for the team. This helped build the cultural capacity of our team, accelerate the focus on equity and ultimately improve health equity for Māori. The partnership was important in supporting Māori providers to use their Māori models within the improvement programme.

**Visual**

**The next slide is titled ‘Next steps.’**

* **Co-design in primary care 2020**
* **Capability building in quality improvement and a specific focus on the use of data for improvement**
* **Building a national measures library**
* **Kaupapa Māori model for improvement.**

Audio

(Carmela): Building on the findings of our evaluation during 2021, we are looking at how we strengthen the system enablers to grow scale and spread of quality improvement in primary care. We have a number of projects underway that will help us support a consumer co-designed programme in primary care, develop a capability-building programme that reflects the unique context of primary care in Aotearoa, build a national measures library to influence equity-driven improvement decisions and improvement activities, and develop a kaupapa Māori quality improvement framework. These are works in progress that we hope will support improved quality improvement at scale in primary care.

**Visual**

**The next slide has black bold text reading ‘Ehara taku toa, i te toa takitahi engari, he toa takitini.’ Beneath that, italicised text reads ‘My success should not be bestowed onto me alone, as it was not individual success but success of a collective.’**

Audio

(Carmela and Jane): Ehara taku toa, i te toa takitahi engari, he toa takitini.

(Carmela): Kia ora, thank you very much.

(Jane): Kia ora.