Lakes DHB

System Level Measures

2018/19

Lakes District Health Board
System Level Measures Improvement Plan 2018-19

Systems level measures (SLMs) provide a way of looking at how components of the health care system work together to improve health care for all patients. This can include care provided in the community, for example by GPs, midwives, and well child providers, through to outpatient and inpatient services.

The Ministry hopes that this planning will be a way for everyone in Lakes to work together to make health care better for patients. There is a particular focus on children, youth, and people with high health needs and ensuring that all patients get the best care at the right time for them, including care that prevents illnesses from happening.

There are six SLMs that ensure a focus on a wide range of improvement activities.

- **Ambulatory Sensitive Hospitalisation (ASH) rates 100,000 for 0-4 year olds**. Improving preventive and community care for young tamariki so they can avoid the types of illnesses that need treatment in hospital.

- **Acute hospital bed days per capita.** Improving preventive and community care for adults so they can avoid the types of illnesses that need treatment in hospital.

- **Patient experience of care.** Improving people's experience of health care in the community and in hospital by asking them about this and responding to their feedback.

- **Amenable Mortality.** Focusing on preventing and better treating illnesses that can result in people dying too young.

- **Number of babies who live in a smoke-free household at 6 weeks postnatal.** Giving tamariki the best start to life through reducing exposure to tobacco smoke in pregnancy and infancy.

- **Youth access to and utilisation of youth appropriate health services**. Creating services that meet the needs of teenagers and young adults.

There is a strong focus on improving equity. This means looking for where care differs between different population groups and improving this. For example, care may differ depending on your ethnic group, where you live in Lakes, your age, whether you are male or female, or who your health care provider is. These differences can occur for a number of reasons so it is important to understand and act on them.

The plan has improvement milestones, and underneath that, contributory measures, which are the things we think, will help us get to those milestones. Under that we have all the activities, which will be what happens out and about in Lakes.

The Socio-Demographic Environment in Lakes DHB

The Lakes DHB population environment can be best summarised as one characterised by (1) lower growth, (2) higher social deprivation and, (3) higher proportion of Maori. The socio-economic and ageing challenges for our communities can mask overall health indicators and hide what might be happening within subgroups. Our overall desire to improve equity will mean we may chose foci for improvement that is less able to be seen in the consolidated system measures. To help understand this, the key data points are highlighted below:

- 35% of Lakes population is Maori.
- Current annual growth is estimated at 1% per annum bringing the Lakes' projected population to 108,320 for the 2017/18 fiscal year.
- Most of this projected growth (85%) sits in the 55 years and over age group with the majority of this population being non-Maori.
- Migration and housing demand pressures are contributing to higher population estimates.
- At the same time, the population of those less than 15 years of age is predicted to grow only infinitesimally with Maori growing slightly more quickly providing a window of opportunity to refine the approach to child health.
- The Index of Multiple Deprivation (IMD) shows Lakes as having the third most deprived population behind Tairawhiti and Northland DHBs.
- This IMD analysis also shows that Lakes DHB has particular challenges in the areas of education, crime and housing.
- 52% of the enrolled population in primary care can be defined as 'high need' compared with 36% for Bay of Plenty and 27% for Taranaki DHBs respectively.
- Over half (55%) of the population resides in areas designated as quintile 4 and 5 (the two most deprived quintiles) compared with 40% nationally.
- Over 50% of Maori reside in areas designated quintile 5.
- Average life expectancy (LE) in Lakes DHB is about 2.7 years less than the national average with Maori life expectancy at birth still some 7- 8 years less than non-Maori.

Lakes Principles supporting development of SLMs for 2018/2019:

Early agreement with both Team Rotorua and Midland Health Network Alliance partners, and Community Public Health Advisory Committee (CPHAC) outlined the desired approach to developing the SLM measures. They are:

- Maintain an equity focus
- Be mindful of social determinants (beyond health)
- Consider Whanau Ora philosophy so we can see activity in terms of Maori health
- Use the SLMs as a key measure of success in Alliances
- Have SLMs as an opportunity to focus areas as a lever for change
- Make sure they are visible and track progress eg use info graphics/dashboards linking data and priorities
- Allow inclusion of innovation and wider agency activity
- SLMs need to join up bits of the health system and show contribution of all the parts, not just general practice e.g. immunisation as outreach, National Immunisation Register (NIR), general practice, pharmacy etc.
- Choose a small but important to Lakes set of contributory measures
- Build from the health needs assessment to have regular conversations

Background for development:
In preparation for prioritising and agreeing areas for focus for the SLMs it has been decided that less measures that are more meaningful was desired. In doing so we will endeavour to improve the health systems ability to respond to challenges and overall addressing inequity and health outcomes for our population. The SLMs will be used as a focus for collaboration and allow us to see what the contribution of our individual components are to the overall improvement we are seeking. The final contributory measures may appear odd if taken in isolation and are intended to be used as markers to assure us that we are making the desired differences we wish to see. We have chosen tight population sub sets and measures deliberately to allow us to monitor progress and shift direction should improvements not occur or we see unintended consequences of our activity.

A dashboard with balancing metrics will support our joint monitoring of progress against our set of measures. They will also form the core nucleus of indicators that we as a whole system will focus on both as a collective and individually. They will over time allow us to prioritise and minimise the breadth of pulls on the collective resources and allow us to develop working approaches that are agile and responsive to the most pressing needs within our community.

It is important that whilst we focus on the metrics the way we deliver on these is kept front of mind. When we develop our dashboards and review our overall progress we will need to see that we have delivered on the agreed principles listed earlier. Additionally it is important that we consider within each project/initiative that they:

- reduce health equality
- facilitate integration
- are whanau centric
- abide by principles of social justice
- avoid further fragmentation (especially if new services added)
- include system mapping (+/- feedback loops)
- are clearly communicated
- that 'Grey space' thinking is enabled
- enhance primary care linkages
- involve co-design and consumers
- develop primary care capacity
- consider workforce planning
- expect information sharing/transparency
- build trust within the system both for health service users and providers
- understand we are all in this together

2018/19 Baseline						
	Year to March 2018	Year to March 2018		Years 2011 - 2015	Year to March 2018	July to December 2017
Summary	Non-standardised 0-4 ASH rates per 100,000	Standardised Acute Bed Days per 1,000 population (WHO 2000 Base)	Patient Experience of Care	Amenable Mortality (AM)	Youth Measures: Self Harm Hospitalisations per 10,000	% Smokefree Households
Māori	9,298	467	NA	248.8	43.6	
Non-Māori	-	-	NA			
Other	8,287	295	-	85.5	37.7	81.7%
Pasifika	-	630	-	-	29.0	
Total Baseline	8,821	342	NA	125.6	40.3	64.4%
National Total	6,748	302	NA	94.8	49.1	
Year 18/19 Milestones						
Māori	8,368	436	100% uptake and utilisation	238.8	40	72%
Non-Māori	-	-		-		
Other	-	-		-	-	72%
Pasifika	-			-	-	
Total	-	-		-	-	
	Achieve equity with other	*Māori bed days will equal the national total Maori baseline*	*Implementation and structure will be embedded to review survey outcomes with focus on acute demand elements*	*4% reduction in Maori (maintaining trend in reducing inequity)*		*Data validation ongoing*

Ambulatory Sensitive Hospitalisation (ASH) rates 100,000 for 0-4 year olds	
Define the problem... 	Ambulatory sensitive hospitalisations (ASH) are mostly acute admissions that are considered potentially reducible through prophylactic or therapeutic interventions deliverable in a primary care setting. ASH rates are also determined by other factors, such as hospital emergency departments and admission policies, health literacy and overall social determinants of health. it is important to note that ASH are seen by many to be a proxy for socio-economic status. It imperative of the DHB, PMHN, RAPHS and Te Arawa Whanau Ora, to reduce disparity between Maori and other ethnicities. These rates are defined as: the number of cases per 100,000 of the population in Lakes DHB of children 0-4 hospitalised because of an ASH defined condition. (Source: Ministry of Health National Minimum Data Set - NMDS) **Key points from the latest data** The 0-4 ASH Lakes DHB data for the year to September 2017 show: • a 5% decline in total rate over the year since September 2016; • a Maori rate that is 11% higher than the total rate, with significant disparity noted in a number of conditions and age groups; • that the top four ASH conditions for children 0-4 are upper respiratory infection, asthma, gastroenteritis and dental conditions. **The imperative to act** • ASH data reflect health inequities present in the Lakes district; • Given these data patterns is there a need to concentrate on and confirm Maori health outcomes (and not just the outcomes of 'high need' populations) as a key focus in the Lakes DHB district? • Many families/whanau experience sub-standard *housing, poor air quality, exposure to smoking, poverty, poor nutrition* related to multiple neighbourhood deprivation. **Our focus for action** Our system level focus for this measure, is to reduce the disparity for 0-4 year old ASH rates, with a emphasis on accelerating Maori health gains and population health improvement overall. **Targeted Action** **Reducing Premature Births (< 37 weeks gestation)** Prematurity is correlated with social deprivation and high 0-4 ASH rates, and Lakes data demonstrates this relationship. Because of the small number of premature babies born to Lakes domiciled mothers and the significant overlap with low birth weight babies, we will include both cohorts. [*Noting that the scope excludes IVF births].* Lakes DHB data indicates greater than 100 preterm births per annum. ASH presentations 0-4 number about 600 per annum

	Our aim is to: • significantly reduce the rate of avoidable low birth weight deliveries • reduce the likelihood of amenable prematurity in subsequent births
Linkages 	Healthy homes (link to Toi Te Ora strategic plan) Shared care plans NZ health strategy – one team Reduce inequity Alliance Unplanned care work programme Newborn enrolment
Key Action	**Action 1** Ensure all eligible Maori babies born in 2018/19 are enrolled in General Practice • By project from Lakes Baby Service with PHOs and whanau ora **Action 2** Ensure all eligible pregnant mums identified as Maori in 2018/19 are offered the pertussis vaccination • By growing provider networks and reinstating MDT for Rotorua for immunisation and provider forums for action • Continuing to expand the Lakes Baby Service

Other Actions
 
	Other actions will be to:
	• Build the evidence to guide actions and interventions by building capacity to integrate information and multi-agency service response, to identify and engage with high needs families/whanau to:
	  ○ target supporting services and develop new models of care
	  ○ ensure we apply this emergent insight to known families/whanau with previous premature birth events
	• Implement the MURIAL child health project when agreed (with a focus for Lakes on LMC connections/Primary Care/Whanau ora included in Multi Disciplinary Team)
	• Host and chair Taupo children's MDT meeting.
	Note: There are other BAU activities in our plans that align with these goals, but are not included in the SLMF Plan and these are referenced below

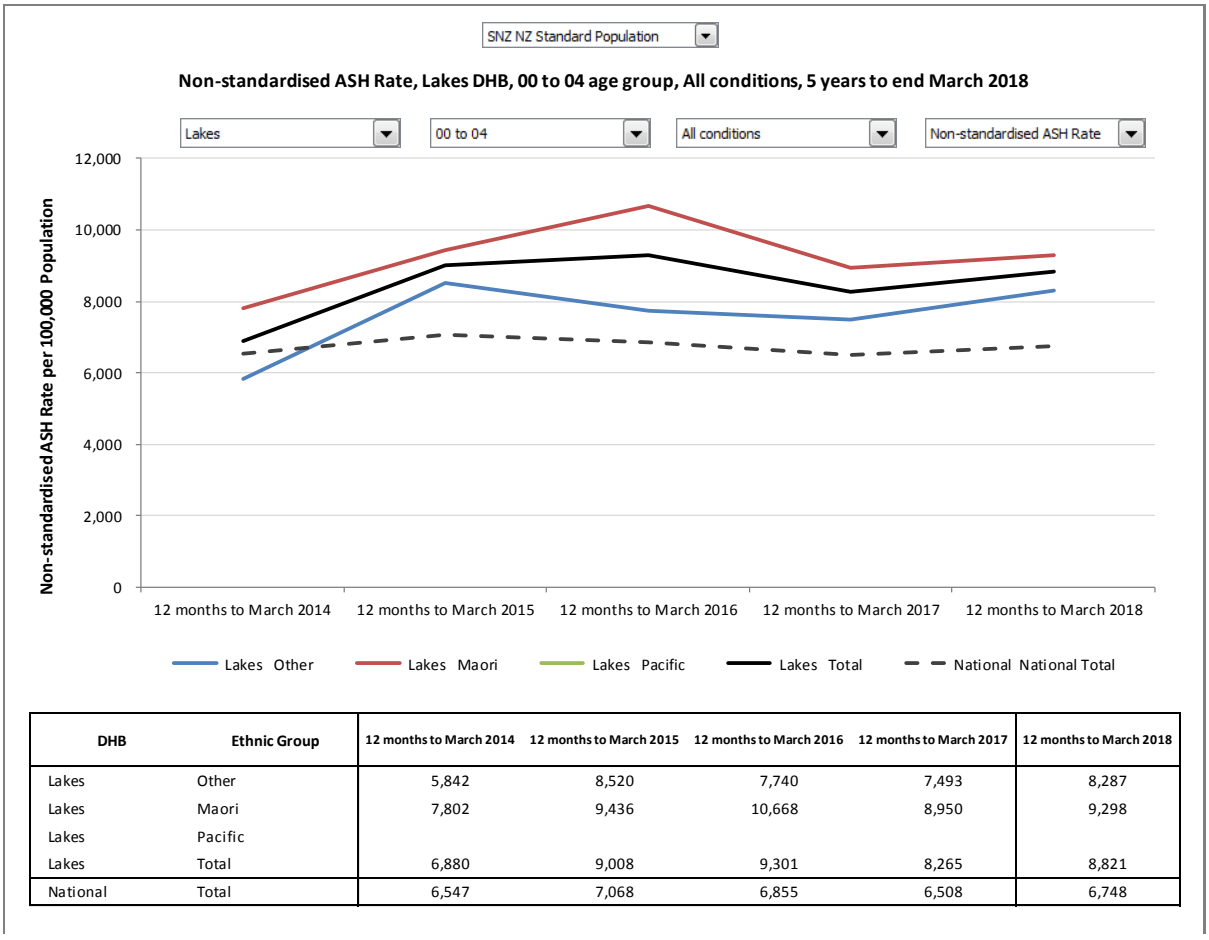
Our Contributory Measures are… 	**Action 1** Baseline: 75% New Born Enrolment rate Goal: New Born Enrolment rate >90% - *Work to determine Maori baseline rates* **Action 2** Baseline: 44% Pertussis immunisation coverage rates Goal: >60% Pertussis immunisation coverage - *Work to determine Maori rates of being offered* pertussis
SLM Vision…  (Goal)	• Babies that are born with low birth weight in the Lakes district live in a healthy home, are engaged with health and community services that optimise health outcomes. • Family/whanau at risk of future prematurity or low birth weight babies are engaged in culturally appropriate pregnancy support services. • Lakes will see an increase in the measure of community/Whanau ora/primary care/LMC service engagement of premature /low birth weight infants and their whanau to prevent prematurity and IUGR the next births.

Aligned BAU activities for noting*

- Target flu vaccines for premature children with respiratory conditions (and other subsidized health conditions) with the appropriate clinical governance
- lowering smoking rates and reducing drugs and alcohol in pregnancy
- Implement Lakes SUDI program (pepi pods and hap wananga)
- Support healthy homes initiatives
- Newborn enrolment processes (to connect children to primary care and other services)

* Business as usual activity, is not part of the system level plan, and is noted to flag potential synergies

Trends in Lakes DHB ASH Rates 0-4 years



DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Lakes	Other	5,842	8,520	7,740	7,493	8,287
Lakes	Maori	7,802	9,436	10,668	8,950	9,298
Lakes	Pacific					
Lakes	Total	6,880	9,008	9,301	8,265	8,821
National	Total	6,547	7,068	6,855	6,508	6,748

- A feature of the Lakes 0-4 years ASH is the recent decline in rates for 'other' from the March year 2014 to 2017 which is matched by Maori between 2016 to 2017
- Rates over the past March year have increased slightly across the board however reflecting a national shift in 0-4 ASH
- There has since 2015 been a decrease in the difference in 0-4 rates between Maori and 'other'

Acute hospital bed days per capita	
Define the problem... 	**Acute Hospital Bed Days** *Number of bed days for acute hospital stays per 1,000 population domiciled within Lakes DHB per year (standardised)* This measure is defined as: the number of Lakes DHB acute patients multiplied by the length of stay per 1,000 in the Lakes population but in our data, age standardised to the World Health Organization (WHO) Standard Population, 2000. (Source: Ministry of Health National Minimum Data Set - NMDS) Acute hospital bed days per capita is a measure of the use of acute services in secondary care that could be improved by effective management in primary care, transition between the community and hospital settings, discharge planning, community support services and good communication between healthcare providers. This includes access to diagnostics services. The measure can be used to manage the demand for acute inpatient services on the health system. The intent of the measure is to reflect integration between community, primary, and secondary care and it supports the strategic goal of maximising the use of health resources for planned care rather than acute care. The measure aligns well with the New Zealand Health Strategy's five themes, in particular - value and high performance. **Key points from the latest data**[1] The standardised data to the year ending December 2017 show (noting that a higher figure equates to higher use of acute hospital services in proportional terms): • the total DHB domicile acute bed day rate is 427.6 per 1,000 per annum; • the rate corresponding for non-Maori and non-Pasifika is 365.5; • the total Maori rate however is 616.6 giving a rate ratio against non-Maori/non-Pasifika of 1.7 – in others words the rate for Maori is 70% higher than the latter population segment; • the total quintile 5 rate is 702.2; • the total rate for quintile 5 for Maori though is higher at 770.5; • except for the non-Maori rate, these acute bed day rates are high in comparison with the other 20 DHBs ranking at around 3rd or 4th • Note, in terms of presentations to ED in Lakes DHB about 1 in 4 is 'admitted to ward'. • Lakes quintile 5 other ethnicity rate is 656.8. • Rank of Lakes DHB is 9th for total population bed days per capita, 5th for Maori, and 4th • for quintile 5 overall (from data to December 2017).

[1] 2013 NZ Census Data

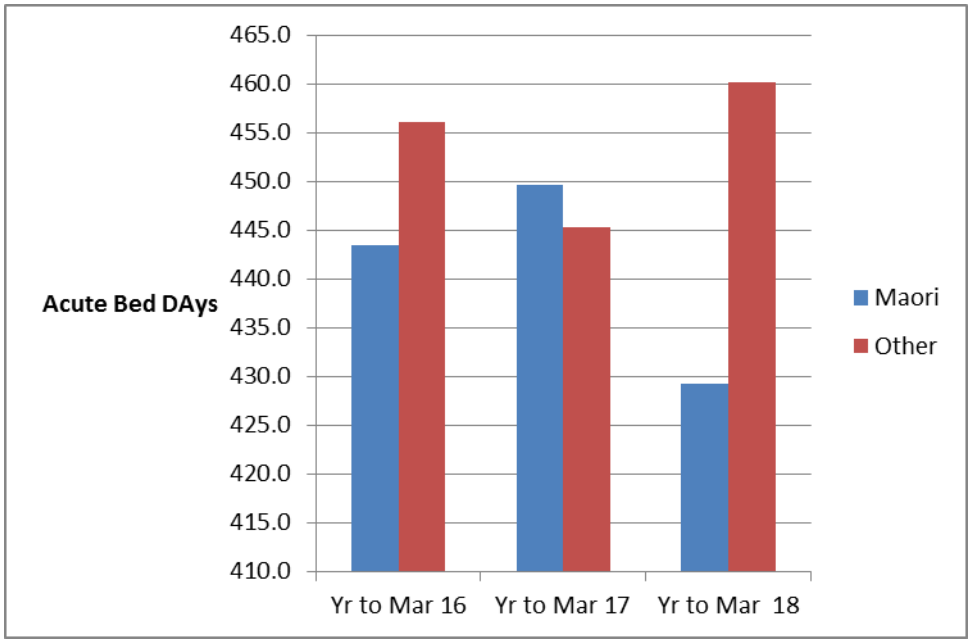
	The imperative to act **Implications and Comments for Health Strategy and Planning** Data around acute hospital bed days exposes differences between Maori and 'other' in terms of the use of acute hospital services. The questions these data raise include: • What factors, in terms of primary care arrangements and secondary care arrangements (and arrangements elsewhere) can be identified that have associated mechanisms which can be triggered to reduce acute admissions for Maori? • Do structures and processes in the community sector optimally support the capacity to influence such a reduction? • What is the common vision around health care configuration and delivery in the Lakes DHB region that supports a focus on reducing health disparity? • What is the likelihood that efforts to reduce acute bed days could exacerbate health inequalities between Maori and others? • Why does Lakes DHB have high rates of acute bed days when compared against the majority of other DHBs? • Hospital admission policies and processes which influence acute hospital bed days measures. **Our focus for action** Our system level focus for this measure, is to reduce acute hospital admissions (in bed days) for illness related diagnoses (ie the scope excludes injury related presentations/admissions). This will include: 1. A closing of the equity gap for the measure "Number of illness related bed days for acute hospital stays per 1,000 population domiciled within Lakes DHB per year (standardised)" using shared data to gain an understanding of the reasons for this gap and data informed decision making to address issues. 2. Maori residing in the Lakes district will access care earlier reducing the complexity and severity of health conditions. 3. All (eligible) residents will be enrolled with a general practitioner and proactively participate in long term conditions management programmes (where appropriate) 4. Reduce the proportion of patients presenting to ED with a status of "unknown/no GP" 5. Data sharing project: develop pathways to improved data sharing to gain understanding and answer the question "why does Lakes DHB have high rates of acute bed days?" 6. Pinnacle will share data based on the determinants set out by its Board.
Linkages 	Lakes DHB Annual Plan Maori Health New Zealand Health Strategy's five themes, in particular - value and high performance.

Key Action	**Action 1** Ensure eligible patients who turn up to ED (Taupo and Rotorua) have an identified GP or are enrolled subsequently • By GP unknown project **Action 2** Patients who identify as Maori presenting at ED (Taupo and Rotorua) >5 times in prior 12 month period with amenable cause have shared management plans in place • By ED frequent fliers project and phase two transition nurse/Manawa ora/Extended Care Support team project **Action 3** Maori with LTC are identified and enrolled in LTC programme • By phase two transition nurse and whanau ora LTC projects
Other Actions 	Other actions will be to: • **Deliver the Acute demand programme with a focus on unplanned care** ○ **Note** Pinnacle MHN deliver unplanned demand actions through Health Care Home model • **Transfer stable mental health patients to Primary care** • **Refine the Safe Transition of Care project**. Transition nurse care project developed including Manawa Ora/MDT type of approaches (primary care and Whanau Ora) and peer support roles explored • **Develop the Data sharing project.** Improving data sharing capacity to gain understanding and answer the question "why does Lakes DHB have high rates of acute bed days? Pinnacle will share data based on the determinants set out by its Board • **Development of new clinical pathways**. Continue to focus on shared clinical pathways (support transition from Map of Medicine to Health Pathways) • **Manage DNAs and Upcoming Appointments.** Introduce a platform and access for General Practice to view GP triage and hospital ED and ASH data
Our Contributory Measures are… 	**Action 1** Baseline: 10% identify as GP unknown Goal: <5% identify as GP unknown **Action 2** Baseline: 20 (Taupo) and 50 (Rotorua) identified high presenters identified Goal: 100% of those identified in baseline have documented management plans in general practice **Action 3** Baseline: 50% of referrals to extended care or LINC programme are Maori Goal: >60% of Maori with LTC and eligible are enrolled in LTC programme

SLM Vision…  (Goal)	Through earlier intervention and prevention we will reduce the impact of acute illness and system pressure resulting from this. We will reduce inequity in acute illness-related condition-outcomes. All (eligible) residents will be enrolled with a general practitioner and proactively participate in long term conditions management programs (where appropriate).

Trends in Lakes DHB Acute Bed Days

Lakes DHB Actual Acute Bed Days by Ethnicity



- Out of the last three March years Maori have taken up fewer actual bed days than 'other' on two of these years
- The number of actual bed days for Maori declined over the past year

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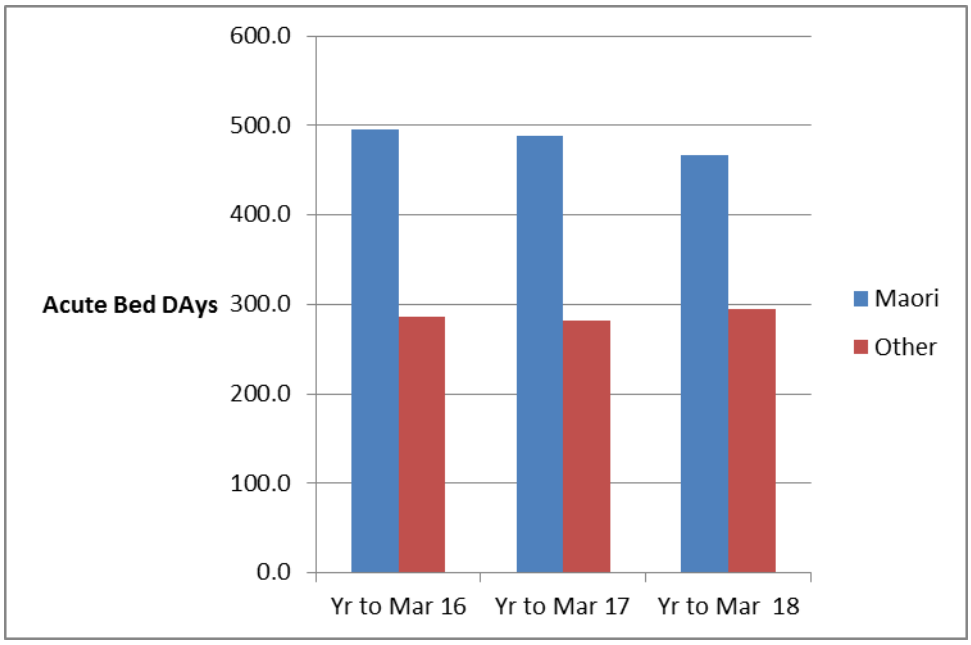
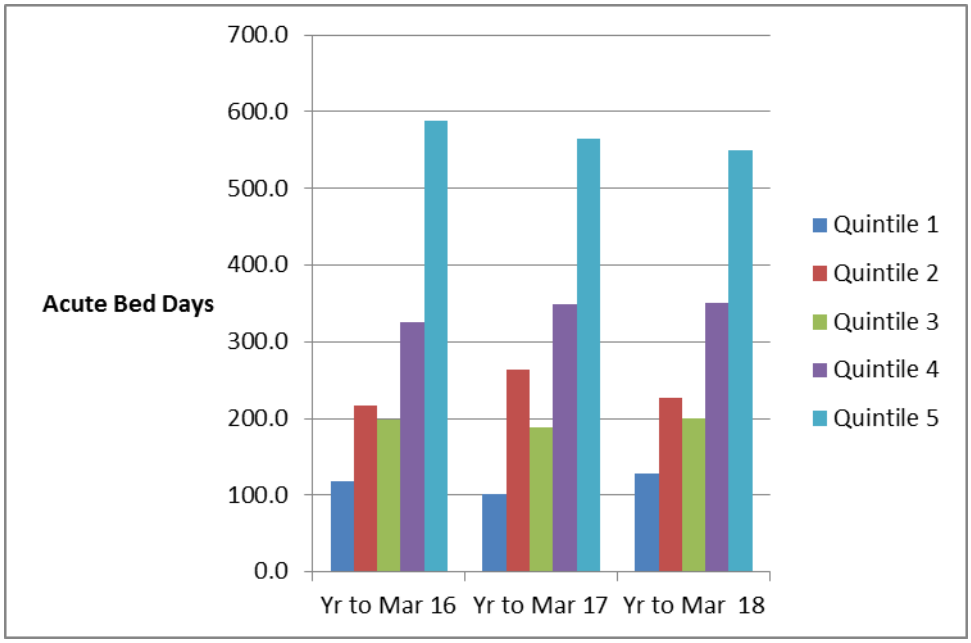
akes DHB Acute Bed Days per Capita Standardised by WHO 2000 Population



- The Lakes graphed data shows the relative challenges facing Maori in the Lakes population where the per capita rate for Maori was 58% higher than 'other' in the latest March year
- There is some suggestion that Maori acute bed days per capita is declining slightly

Lakes DHB Bed Days Per Capita by Social Deprivation Standardised by WHO 2000 Population



- This data clearly illustrates the pressures faced by Lakes DHB in dealing with its highly deprived population

Patient experience of care	
Define the problem... 	*Consumer health care experience and level of integration of care covering the domains of communication, partnership, co-ordination and physical and emotional needs.* Patient Experience can be defined as '…the quality of care from the perspective of patients/health services users'. Surveying patients/users enables the system to better understand what is important to patients/whanau and all services users in terms of received healthcare service. Looking at this from the patient's perspective indicates that the patient's experience of the care they receive is vital. How a patient experiences their care has been shown to have a significant impact on the outcomes of the care they receive. The Lakes Health System is interested in ensuring there is a culturally responsive system for Maori to meet their care expectations. This means better understanding what our Maori patients expect from their care informed and guided by a better understanding of the impact Maori culture has on their care outcomes. **The imperative to act** The Lakes system has no current mechanism to know, understand and build into care systems elements that assure cultural responsiveness for Maori. The imperative to act is recognition that what we are doing now is not working, resulting in disparity of health outcomes for Maori. **Our focus for action** Our system level focus for this measure is to learn and develop an agreed approach that addresses health and community services that meet the expectations of Maori patients and their whanau. Maori DNA rates for hospital appointments (eg outpatient referrals) will be monitored as a proxy measure for the responsiveness of the system as a first step.
Linkages 	Learn from Whanau Ora and apply that to our programme of work Reducing inequity in health outcomes for our population Ensuring Maori health gain within the Lakes DHB population Addressing 'listening and learning from the patient/user' as outlined in the NZ Health Strategy – increasing consumer voice Ensuring community and Maori provider involvement

Key Actions	**Action 1** General practices participate in the patient experience survey • By PHO encouragement and feeding back findings **Action 2** The top 25 patients identified as Maori who DNA/DNB are visited in the home to develop a health care plan • By phase two transition nurse and whanau ora LTC projects
Other Actions 	Other actions will be to: • Build a culture within our shared provider workforce membership that responds and supports what Maori expect and deserve in the Lakes district by exploring the Tairawhiti 'Te Kuwhatawhata' cultural training model. • Develop the use of national survey results to help inform future quality improvement activity.
Our Contributory Measures are… 	**Action 1** Baseline: 0.1% participating Goal: 100% participating **Action 2** Baseline: New activity Goal: 100% visited and management plans developed and all are enrolled in GP
SLM Vision…  (Goal)	Better together care is achieving 'better' more equitable health outcomes for the Lakes population and for Maori.

Amenable Mortality	
Define the problem... 	Lakes DHB Amenable Mortality Rate is the number of deaths of those aged 0-74 years per 100,000 in this age cohort domiciled in Lakes DHB district who have died from a condition for which there is a known successful intervention. (Source: Ministry of Health National Minimum Data Set - NMDS) *https://nsfl.health.govt.nz/dhb-planning-package/system-level-measures-framework/data-support-system-level-measures/amenable* Long-term conditions comprise the major health burden for New Zealand now and into the foreseeable future. This group of conditions is the leading cause of morbidity in New Zealand, and disproportionately affects Maori and Pacific peoples and people who experience mental illness and addiction. As the population ages and lifestyles change these conditions are likely to increase significantly. Diabetes is important as a major and increasing cause of disability and premature death and is a good indicator of the responsiveness of the health system to the people in most need. **Key points from the latest data will be updated** Noting that a higher amenable mortality figure indicates a (proportionally) higher number of deaths per 100,000 from conditions for which there is a known successful intervention, the amenable mortality data from 2011-2015 data covering the age range 0-74 years show: • the total rate for Lakes DHB to be 125.6 per 100,000 equating to 181 deaths; • the rate for 'other' (not including Pasifika) is 85.5 equating to 94 deaths; • the rate for Maori is 248.8 associated with 83 deaths; • the rate ratio for Maori against non-Maori/non-Pacific is 2.91; • there has been a reduction in amenable mortality rates for Maori over the past four years. **The imperative to act** • In Lakes DHB, there is currently serious disparity between the results of Maori and "other". The "super category" is ischaemic heart disease, with IHD, stroke, lung cancer, suicide and diabetes being other categories with significant disparity for Maori. • Reasons for the existence of major ethnic differences in amenable mortality rates involve variables that lie outside the purely clinical. **Our focus for action** Our system level focus for this measure, is to lower the amenable mortality rate for Maori to be equal to that of non-Maori.
Linkages 	NZ Health Strategy – One team Reducing inequities

Key Action	**Action 1** The bowel screening programme is implemented equitably • By bowel screening project **Action 2** There is a continued focus on reducing smoking rates and CVD and Diabetes • By PHO LTC programmes, establishment of health pathways and joint clinical governance actions
Other Actions  	Other actions will be to: • Develop data sharing principles to enable information sharing for at risk people/groups across whanau ora/general practice and the hospitals (Pinnacle will share data based on the determinants set out by its Board). • Create 'grey space' to explore and develop enhanced, culturally appropriate, mechanisms for targeting 'high risk' groups that struggle to engage with screening activities (aim any door is the right door and one contact connections to all opportunities). In particular focus on Maori rates for: 1. Bowel Cancer 2. Smoking 3. CVDRA and management 4. *Culturally different approach – e.g. competition, using Maori role models, enhanced Maori leadership 5. Introduce Health Coaching model into Extended Care Team 6. Expand Shared Medical Appointment model of care for patients with chronic conditions 7. Shared care plans for high care need patients.
Our Contributory Measures are… 	**Action 1** Baseline: New activity Goal: At a minimum equal participation rates for Maori and other from start of programme **Action 2** Baseline: 80% rates of DAR for Maori Goal: > 90% rates of DAR for Maori Baseline: 85% Quit health target Goal: Proportion of those identified as smokers in general practice who identify as non smokers over a 12 month period reduce Baseline: 70% CVDRA rates for Maori 35 - 44 Goal: 40% of patients with known CVD on triple therapy - Work undertaken to establish a baseline figure of patients with known CVD on triple therapy
SLM Vision…  (Goal)	People who reside in Lakes district will have equity of access to interventions that minimise risk of disease progression.

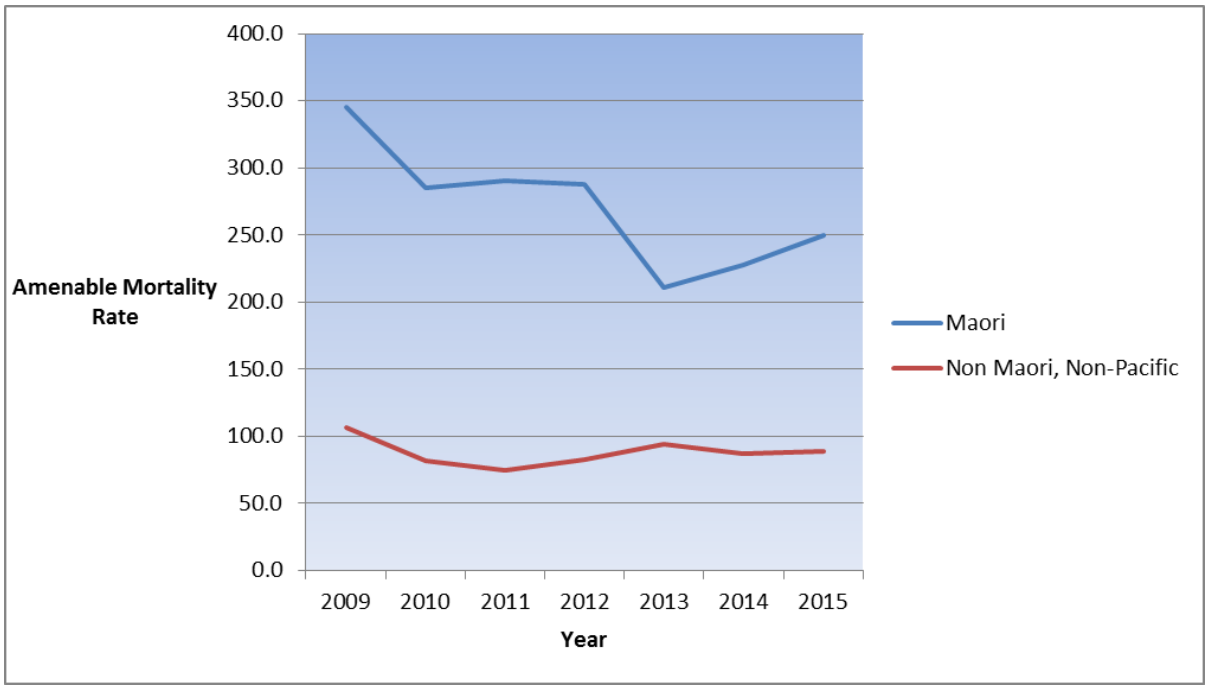
Aligned BAU activities for noting*

Continue our individual organisation obligations to meet screening targets for:

1. Bowel Cancer
2. Smoking (note link to Smokefree homes SLM)
3. CVDRA and management
4. Immunisation schedule
5. B4school check
6. HPV
7. Family harm
8. Youth mental wellbeing (note link to Youth SLM)
9. Enhance long-term condition risk stratification tools to support pro-active care coordination for patients with long term conditions through data connectivity
10. Implement updated national CVD risk assessment and management guidelines
11. Support transfer of mental health patients to primary care
12. Clinical pathways development for long term conditions.

* Business as usual activity, is not part of the system level plan, and is noted to flag potential synergies

Trends in Lakes DHB Amenable Mortality Rates 2009 - 2015



- Amenable mortality rates for Maori declined from 2009 to 2013 but increased from 2013 to 2015
- Non- Maori/non-Pacific rates have remained essentially flat
- The rate-ratio for Maori to non-Maori/non-Pacific in 2015 was 2.8

Youth access to and utilisation of youth appropriate health services	
Define the problem... 	Young people (10-24 years of age) are valuable to our community with important contributions to make now and in the future. As agencies and providers of health care we're entrusted with supporting the wellbeing of our young people. **Key points from the latest data** The Lakes DHB data covering hospitalisation from self-harm rates for 12-24 year olds in the year to December 2017 (where N = number of self-harm admissions in the category) show that: • there has been a decline in self harm rates; • the total actual hospitalisation rate for self-harm in Lakes DHB is 38.1 per 10,000 (N = 82); • the quintile 5 rate is higher at 54.5 (N = 47) showing the greater propensity for those experiencing higher levels of social deprivation to self harm; • the Maori quintile 5 rate is even higher at 57.2 per 10,000 (N = 33) showing that being Maori and experiencing high levels of deprivation are two of the key risk factors in self-harm; • the total rate for 'other' is 35.2 (N = 36) compared with 41.5 for Maori (N = 44) showing a slightly increased predilection for Maori youth to self harm; • the rate for 'other' in quintile 5 is 53.6 (N = 13); • the most common age for self-harm presentation is 15-19 years where the rate is 60.3 (N = 44); • total female and male rates are 58.3 (N = 60) and 19.6 (N = 22) respectively illustrating the general observation about the major differences across gender with young women three times as likely to be hospitalised because of self-harming. Youth suicide rates (25 years and under) also pose a concern in this space noting that: • New Zealand has the second highest rate globally at nearly 16 per 100,000 compared with the UK at 3, the USA at 7.8, Australia at 8.4, Ireland at 9.6 and Canada at 10; • There is a death from youth suicide every 67 hours; • The New Zealand teen rate (15-19 years) is the worst in the world; • The youth suicide rate is 84% higher for Maori than non-Maori; • These data translate into a figure for Lakes DHB of about 15 suicides per annum across all age groups of which about 4 will be youth suicides. **Why do we need to act?** In the light of the above statistics, early and equitable access to appropriate health services for young people has the much needed potential to reduce health disparity by improving opportunities for young people to begin a life path that is more likely to be fulfilling across the board. Moreover, early engagement with the health care system, particularly for Maori, creates a population better informed about the nature of health care provision and thus knowing better how to access appropriate care in later years for themselves when disease conditions become more prevalent. Also given that the median age for Maori is only 24 years compared with 40 years for non-Maori; it is clear

	that a strong focus on youth health is critical for this population simply in terms of the comparative demography let alone the clear differences in social deprivation and the health consequences of this. Transition periods for young people create additional stress and risk of increased vulnerability. The Government has indicated a desire for more accessible school health services. Ensuring a health system provides easy access and systems to share appropriate and relevant health information for young people is critical. A life long connection with general practice can be enhanced by easy transitions from high school to adult health services. Mental health services have been the subject of much media coverage including the focus of a Government inquiry. This suggests that there is dissatisfaction across the board with the state of impact of current arrangements. A thorough assessment of local arrangements that cater for youth is needed; in particular looking at the extent to mental health service configuration aligns with best practice. **What are we trying to accomplish?** A seamless system of health care access for young people residing within Lakes DHB. Improved communication between schools, mental health, YOSS and general practice services.
Linkages 	Mauri Ora – mental health model of care NZ Health Strategy – care closer to home 2018/19 Annual Plan requirements re increased linkage and understanding of school health services Team Rotorua Alliance acute care programme
Key Action	**Action** Schools with health services (incl. mental well-being) are increased for lower decile populations • By co-design project with Education
Other Actions 	*Other actions will be to:* • Develop a plan to support a transition focus from school to adult services and knowledge of services available to youth and how to access them. • develop a mechanism to share HEADS assessment with general practice as appropriate. • Improve DHB coding and sharing of self harm data.
Our Contributory Measures are… 	**Action** Baseline: 10 high schools with SBHS - 5 funded by MoE Goal: 11 high schools with SBHS - 5 funded by MoE

SLM Vision…  (Goal)	Youth will be able to access the right health services via any door and that appropriate information pertaining to that care will be shared with relevant health care providers

Roles:

PHOs/General Practice: linking with local high schools post survey to facilitate access to enrollment for those not enrolled

DHB: Baseline survey in all high schools
Work with schools, MoE and MoH regarding sharing of year 9 HEADS Assessment

Whanau Ora: linking with known whanau, cross checks with the known non school attenders and bringing them into enrollment

Both: agree data sharing principles, participate in work to develop a care pathway for early intervention youth mental health under acute demand work programme (involving at least YOSS, high schools, general practice and primary mental health service providers)

Number of babies who live in a smoke-free household at 6 weeks postnatal	
Define the problem... 	A reduction in the prevalence of smoking in women who are intending pregnancy or who are pregnant is a priority. Maternal smoking is associated with a range of poor neonatal and child health outcomes, as is exposure to second-hand cigarette smoke in the environment in which an infant lives. This measure will focus attention beyond just maternal smoking to the home and family/whānau environment and will encourage an integrated approach between maternity, community and primary care. This measure is simply defined as the percentage of babies at 6 weeks domiciled in the Lakes DHB district who live in smoke free households. (Source: Ministry of Health) This is a developmental measure for the 2018-19 year. **Key points from the latest data** The challenges within the Lakes population and persisting high smoking rates indicate that a different approach is required to complement the current smoking cessation, SUDI, and other child health services that work to decrease smoking rates in the Lakes district. For the SLM improvement programme we will complement the conventional approach and particularly focus more broadly on engaging whanau/families in their health and wellbeing, take a whanau centric view to support health prioritisation, ensure our workforces key messages are consistent and trust building for any service provider, increase integration between providers and grow Maori leadership. A majority of this activity will be designed with consumers and providers, taking evidence informed approach and building a test of change approach. We will investigate such concepts as community development, incentives and partnering with iwi in more meaningful ways.
Linkages 	• Strategic directions outlined at recent Board workshops • New Zealand Health Strategy
Key Action	**Action 1** Roll out hapu wananga • By increasing resourcing for the Lakes Baby service **Action 2** A referral process is established that connects WCTO, GP, LMC, whanau ora and appropriate NGOs • By provider network, social media project and MDT

Other Actions  	Other actions will be to: • Will be to focus on relationship building to support future wrap around support services with the LMC and mother/whanau that leads to: ○ LMC ensuring pregnant mums have a primary care provider (enrolment process starting at first antenatal booking) ○ LMC smoke free support/smoking cessation advise/treatment ○ Outreach services are linked and aim to be one visit all services • Maori leadership and whanau ora methods will be explored to enable access and engagement with whanau.
Our Contributory Measures are… 	**Action 1** Baseline: No hapu wananga in Rotorua - 2 per year in Taupo Goal: 150 women participate in hapu wananga (at least 80% quintile 5 and or Maori) **Action 2** Baseline: New initiative Goal: 150 pregnant mums are enrolled in all available under 5 health services - Immunisation rates for this group - Smokefree rates for this group - Pepi pods for this group
SLM Vision…  (Goal)	Healthy home environments for Lakes babies to thrive seen through improving health risk factors having a particular impact within Maori whanau.

Signatures of Lakes DHB participating Alliance representatives:

Date: June 2018	Name:	Signature:
Team Rotorua Alliance Leadership Team	**Kirsten Stone** **Chief Executive Officer** **Rotorua Area Primary Health Service**	
Midland Health Network Alliance	**David Olderdshaw** **Chief Executive Officer** **Pinnacle Midland Health Network**	
Team Rotorua Alliance Leadership Team	**Mala Grant** **General Manager** **Te Arawa Whanau Ora Collective**	
Lakes DHB	**Karen Evison** **Director, Strategy Planning and Funding**