Lakes District Health Board
System Level Measures

Contents

Background

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 of Health hopes that this planning will be a way for everyone in Lakes District Health Board (Lakes DHB) to work together to make health care better for whānau. 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. This concerns 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.

Babies who live in a smoke-free household at six 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 the Lakes DHB region, your age or gender, 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.

This describes a range of improvement milestones and contributory measures that provide local accountability on quality improvement activities.

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 Māori. 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. Our improvement milestones have a significant focus on improving outcomes for Maori. Appendix 1 provides a summary of the key data points.

Principles supporting development of SLMs for 2019/2020

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 Whānau Ora philosophy so we can see activity in terms of Māori 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 e.g. 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 DHB set of improvement activities
- Build from the health needs assessment to have regular conversations

Development of this plan

In preparation for prioritising and agreeing areas for focus for the SLMs it was decided that fewer improvement activities that are more meaningful was desirable. 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 deliberately chosen tight population sub sets and measures 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 inequity's
- facilitate integration
- are whānau 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

The following pages provide detail of our approach to each of the SLMs. We provide a range of different actions for each SLM, but our focussed actions for 2019/20 are bolded.

Acute hospital bed days per capita

What is our vision?

Through earlier intervention and prevention we will reduce the impact of acute hospital stays and system pressure resulting from this.

We will reduce inequity in acute condition-outcomes.

All (eligible) residents will be enrolled with a general practitioner and proactively participate in long term conditions management programs (where appropriate).

What do we currently know?

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 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.

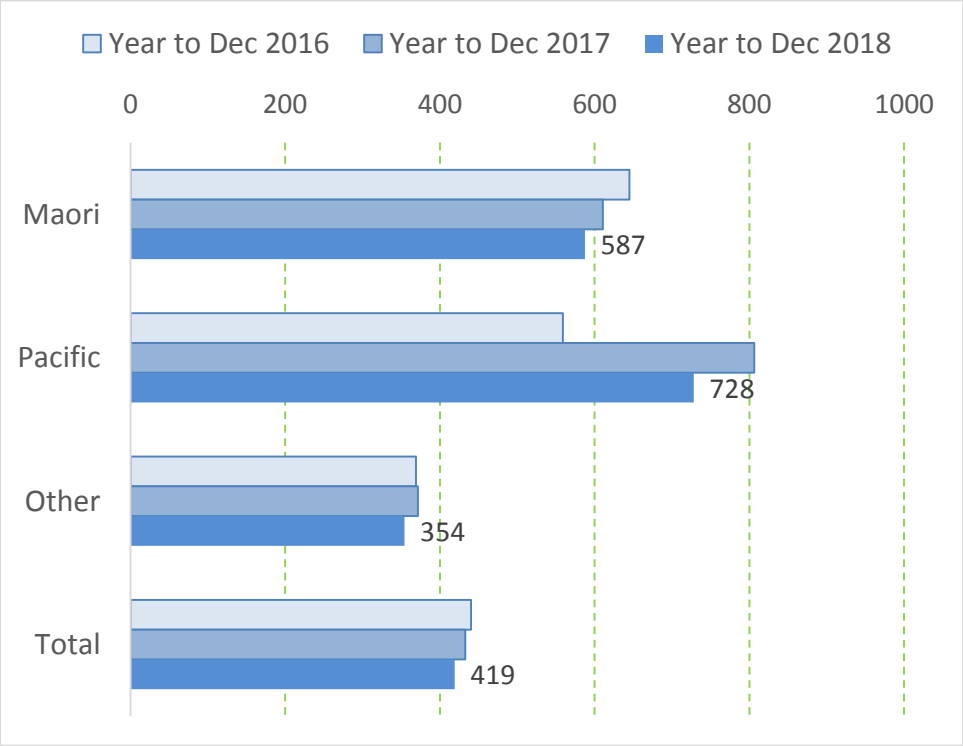
The measure aligns well with the New Zealand Health Strategy's five themes, in particular - value and high performance.

Key points

The standardised data to the year ending December 2018 show (noting that a higher figure equates to higher use of acute hospital services in proportional terms):

- the total Lakes DHB domicile acute bed day rate is 419.1 per 1,000 per annum
- the rate corresponding for non-Māori and non-Pasifika is 354
- the total Māori rate however is 587 giving a rate ratio against non-Māori/non-Pasifika of 1.66 – in other words the rate for Māori is 66% higher than the latter population segment
- the total quintile 5 rate is 698
- the total rate for quintile 5 for Māori though is higher at 760
- acute bed day rates for pacific is high, ranking in 4th place compare with the other DHBs
- in comparison with the other 20 DHBs, the Māori rate is ranking at around 10th
- Lakes DHB quintile 5 other ethnicity rate is 620
- Rank of Lakes DHB is 6th for total population bed days per capita and 3rd for quintile 5 overall (from data to December 2018).

Figure 1: Standardised Acute Bed Days per 1,000 population (Census 2013 Usual Resident Population) for the year to December 2018



The imperative to act

Data around acute hospital bed days exposes differences between Māori and 'other' in terms of the use of acute hospital services. The questions this information raises 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 Māori?
- 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 Māori 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 day measures.

What will we focus on?

Our system level focus for this measure is to reduce acute hospital admissions (in bed days) for the total Lakes DHB population from 419 per 1,000 population to 399 (i.e. by 5%) by 30 June 2020.

This will include:

1. A closing of the inequity gap for the measure "number of 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. Māori residing in the Lakes DHB region 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?"

The GP Unknown Project

The key objectives of this project are:

1. All discharges from ED (initially) will be delivered to the correct general practice, consistent with most up-to-date details from the patient enrolment register validated by the MOH
2. All discharges from ED are securely transferred to the correct General Practice in a format that allows seamless integration with the patient record within the practice PMS
3. Where a patient doesn't have an identified General Practice, RAPHS will link them to one and support their enrolment
4. Rotorua hospital will be provided with an error report with the correct patient and GP details identified for updating within hospital information systems
5. RAPHS will concurrently automate the collection of data from discharge summaries to populate patient registers and joint analytics initiatives

Frequent ED Users

The key objectives of this project are:

1. Monitor frequent ED attendance and make sure these people have primary care plans in place
2. Reduce frequency of ED visits

What will we do?

Our focus for 2019/20

- **Through the 'GP Unknown Project' we will support patients to enrol with a general practice who attend ED without a GP. We will have a focus on enrolment for Māori and our target is 5% GP Unknown by June 2020.**
- **We will identify frequent Emergency Department (ED) attendees and support attendance at Primary Care to develop care plans for this cohort to reduce representation rates.**

Other related activities

- Deliver the Acute demand programme with a focus on unplanned care *(Note Pinnacle MHN delivers unplanned demand actions through its 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 Whānau 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

- Reduce the proportion of people attending ED that do not have a GP to 5% overall
- Track the ED Attendance of frequent ED users over a year, ending 30 June 2020 to obtain baseline data, and to have a care plan in place for at least 25% of all frequent ED users and 50% of all Māori frequent ED users.

Ambulatory Sensitive Hospitalisations (ASH) rates for 0-4 year olds

What is our vision?

Māori children 0-4 years and their whānau in the Lakes DHB region live in a healthy home and are engaged with health and community services that optimise health and wellbeing.

What do we currently know?

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 and practices, capacity for emergency department management, health literacy and overall social determinants of health in the community.

It is imperative of the DHB, Midlands Health Network Charitable Trust (MHN0), Rotorua Area Primary Health Services (RAPHS) and Te Arawa Whānau Ora, to reduce disparity between Māori and other ethnicities.

Key points from the latest data

The 0-4 ASH Lakes DHB data for the year to December 2018 show:

- an increase in total rate over the year since December 2017 for Māori
- a Māori rate that is 21% higher than the total rate for all conditions, with significant disparity noted in a number of conditions (asthma and dental) and;
- that the top four ASH conditions for children 0-4 are asthma, dental conditions, upper and ENT infections and gastroenteritis.

The imperative to act

- ASH data reflect health inequities present in the Lakes DHB region;
- given these data patterns is there a need to concentrate on and confirm Māori health outcomes (and not just the outcomes of 'high need' populations) as a key focus in the Lakes DHB region?
- many families/whānau experience sub-standard *housing, poor air quality, exposure to smoking, poverty, poor nutrition* related to multiple neighbourhood deprivation.

What will we focus on?

Our system level focus for this measure, is to reduce the disparity for 0-4 year old ASH rates, with a emphasis on accelerating Māori health gains and population health improvement overall. **Our specific aim is to reduce the rate of dental and asthma ASH for Māori 0-4 year olds from December 2018 by 10% by June 2020.**

Respiratory illness in the Lakes DHB population is significantly contributed to by the social determinants of health Māori experience. Prevention interventions where every child has an equal opportunity for good health, quality of life, success and wellbeing, regardless of their ethnicity. ASH asthma serves as a proxy for access to health care for which early interventions are known to reduce or prevent severity and associated complications. Of note is the Māori rate is 33% higher than total rate and 109% higher than Non Māori Rate.

Dental caries is identified by the New Zealand Ministry of Health as the countries most prevalent preventable disease. In small children cariogenic bacteria in the mouth can lead to pain, difficulty eating, speaking, sleeping, concentrating, smiling, mental and physical wellbeing and chronic infection. Inequities in oral health are well documented for children living in areas of high deprivation and Māori known to carry a significantly greater burden of disease. The Māori rate of overdue scheduled examinations is 94% higher than Non Māori rate. Early childhood caries are a predictor of poor long term oral health, systemic disease and subsequent permanent tooth loss.

Figure 2: Non-standardised 0-4 ASH rates per 100,000 population for the year to December 2018

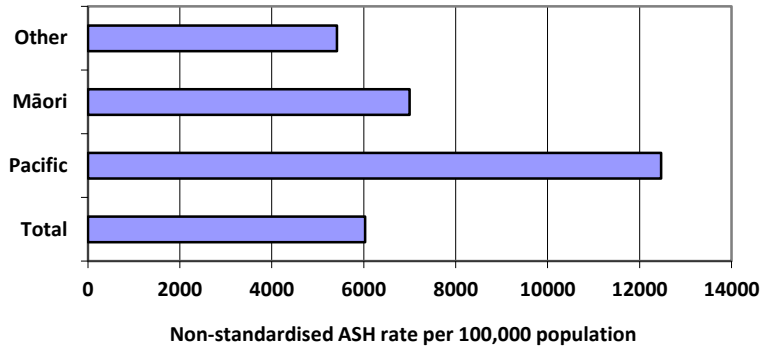
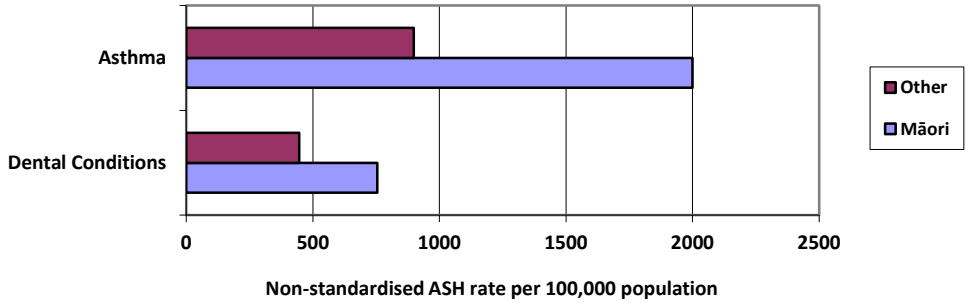


Figure 3: Non-standardised 0-4 ASH rates for Asthma and Dental Conditions per 100,000 population for the year to December 2018



What will we do?

Our focus for 2019/20

- **Increase the number of eligible Māori babies born in 2019-20 that are enrolled in General Practice by implementing system change that makes it easier for parents to register at point of contact with Maternity, WCTO, and an opt-out enrolment**

Other related activities

- Increase the number of number of Māori babies who receive all WCTO core contacts in their first year of life
- Provide ASH 0-4 year olds and their whānau with a whānau care plan and follow up post hospital discharge through primary care
- Establish an ASH working group with a project implementation plan
- Data-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/whānau to target supporting services and develop new models of care and ensure we apply this emergent insight to known families/whānau with asthma and dental admissions
- Discharge planning to include referral to whānau ora and care plans in place and follow-up services
- Workforce development to roll out whole of workforce early intervention and early treatment consistent pathways
- Redirect preventative dental models of care to high needs populations

Our contributory measures

Our contributory measure will be to **increase Māori newborn enrolment rate**. This was 61% in Quarter 3 2018/19. Our goal is to raise these to >90%.

Patient Experience of care

What is our vision?

Better together care is achieving 'better' more equitable health outcomes for the Lakes population and for Māori. Survey results will be regularly reviewed and used to develop quality improvement activities.

What do we currently know?

Patient Experience can be defined as '…the quality of care from the perspective of patients/health services users'.

Patient experience measures are routinely collected in hospitals and primary care. Surveying patients/users enables the system to better understand what is important to patients/whānau and all services users in terms of received healthcare service.

The hospital patient experience survey covers four domains (communication, partnership, co-ordination and physical and emotional needs). The most recent data, for patients treated in February 2019, show that Lakes DHB is above the national average, in overall scores, for communication (8.8/10) and about the same on the three remaining domains (scoring 8.7, 8.7, and 8.9, respectively). The lowest scoring questions, averaged over Q1-Q4 2018, in each domain are:

Domain	Question	Percentage answering yes
Communication	Did a member of staff tell you about medication side effects to watch for when you went home?	51 %
Partnership	Did the hospital staff include your family/whanau or someone close to you in discussions about your care?	57 %
Coordination	Do you feel you received enough information from the hospital on how to manage your condition after your discharge?	61%
Need	If you needed help from the staff getting to the toilet or using a bedpan, did you get it in time?	80 %

In primary care, the most recent data show that Lakes DHB is significantly lower than the national average overall score for physical and emotional needs (8.1/10), but not significantly different for coordination (8.4/10), communication (8.4/10) and partnership (7.4/10) domains.

The lowest scoring questions, averaged for 2018, for lakes DHB were:

a) Were you told what to do if you experienced side effects? (58%)

b) Did the specialist doctor ask what is important to you? (54%)

c) After a treatment or care plan was made were you contacted to see how things were going? (38%)

The imperative to act

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 DHB Health System is interested in ensuring there is a culturally responsive system for Māori to meet their care expectations. This means better understanding what our Māori patients expect from their care informed and guided by a better understanding of the impact Māori culture has on their care outcomes.

What will we focus on?

Our system level focus for this measure is to improve our performance in our lowest scoring question, regarding communication about medication side effects in the hospital survey by 10% by 30 June 2020. In addition, we plan to use data currently available, including non-attendance (DNA) rates, HQSC survey data, and complaints received by Lakes DHB to look at where improvements in systems and processes are required. We aim to move towards a client-focussed and whanau-centric organisation that is there to serve the community.

What will we do?

Our focus for 2019/20

- **Publish a regular update (audit and feedback) of survey results on the DHB intranet and PHO communications.**
- **Communicate with hospital and primary care staff via the grand round and primary care CME events.**
- **Work with hospital pharmacy staff to develop and implement systems that help patients understand the use and common side effects of their medications.**
- **Track our performance in the survey domains that are (a) significantly lower than the national average and (b) have a negative gap between Māori and non-Māori.**

Other related activities

- Support all general practices to participate in the national survey by monitoring through alliance groups
- Look for opportunities to Increase the response rate, especially among Māori, of the primary and secondary care surveys.
- Undertake more in-depth analysis of the survey data.
- Monitor non-attendance (DNA) rates for hospital appointments (e.g. outpatient referrals) comparing rates for Māori with non-Māori.
- Investigate the use of technology and social media to enable people to share their experience, ensuring that we are also able to respond to feedback in a timely manner.
- Review the Lakes DHB complaints procedure, to ensure that it is easily accessible and responsive.
- Schedule a joint forum to share findings and consider system response based on these.
- Build a culture within our shared provider workforce membership that responds and supports what Māori expect and deserve in the Lakes DHB region 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

- Improve our performance in the following two survey questions (a) Did a member of staff tell you about medication side effects to watch for when you went home? [hospital] (b) Were you told what to do if you experienced side effects? [primary care].

Amenable mortality rates

What is our vision?

People who reside in Lakes DHB region will have equity of access to interventions that minimise risk of disease progression

What do we currently know?

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 region who have died from a condition for which there is a known successful intervention.[1]

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 Māori 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.

The imperative to act

- In Lakes DHB, there is currently serious disparity between the results of Māori and "other". The "super category" is ischaemic heart disease, with IHD, stroke, lung cancer, suicide and diabetes being other categories with significant disparity for Māori.
- Reasons for the existence of major ethnic differences in amenable mortality rates also involve variables that lie outside the purely clinical.

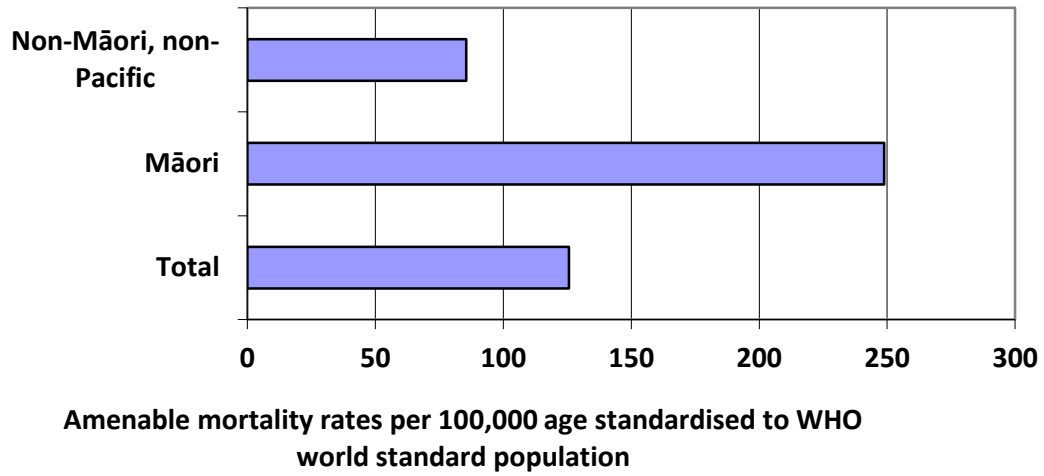
Key points from the latest data

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 130.4 per 100,000 equating to 181 deaths;
- the rate for 'other' (not including Pasifika) is 89.2 equating to 94 deaths;
- the rate for Māori is 250 associated with 83 deaths;
- the rate ratio for Māori against non-Māori/non-Pacific is 2.80
- there has been a reduction in amenable mortality rates for Māori compared to 2012 but an increase compared to 2013 and 2014.

[1] https://nsfl.health.govt.nz/dhb-planning-package/system-level-measures-framework/data-support-system-level-measures/amenable

Figure 4: Amenable mortality rate (number of deaths in those aged 0-74 years per 100,000 age standardized to WHO world standard population) for 2011-2015



What will we focus on?

Our system level focus for this measure is to lower the amenable mortality rate for Māori by 25% over 5 years.

What will we do?

Our focus for 2019/20

- **Increase Māori participation in the bowel screening programme**
- **Increase the proportion of Māori with CVDRA, where indicated**
- **Increase the number of Māori accessing the local stop smoking service**
- **Introduce Health Coaching model into Extended Care Team**
- **Expand Shared Medical Appointment model of care for patients with chronic conditions**

Other related activities

- Create 'grey space' to explore and develop enhanced, culturally appropriate, mechanisms for targeting 'high risk' groups that struggle to engage with screening activities
- Develop data sharing principles to enable information sharing for at risk people/groups across whānau ora/general practice and the hospitals.
- Shared care plans for high care need patients.

Our contributory measures

1. 10% reduction in equity gap for Maori by June 30, 2020 with:
   - Bowel screening participation
   - Diabetes Annual Reviews including accessing podiatry and retinal screening services
2. Equitable measure developed for implementation of CVD assessment guidelines
3. Monitoring whether brief smoking cessation advice is successful using a measure of the number of current smokers as a % of enrolled PHO population by ethnicity, age, deprivation and gender

Babies living in smoke-free homes

What is our vision?

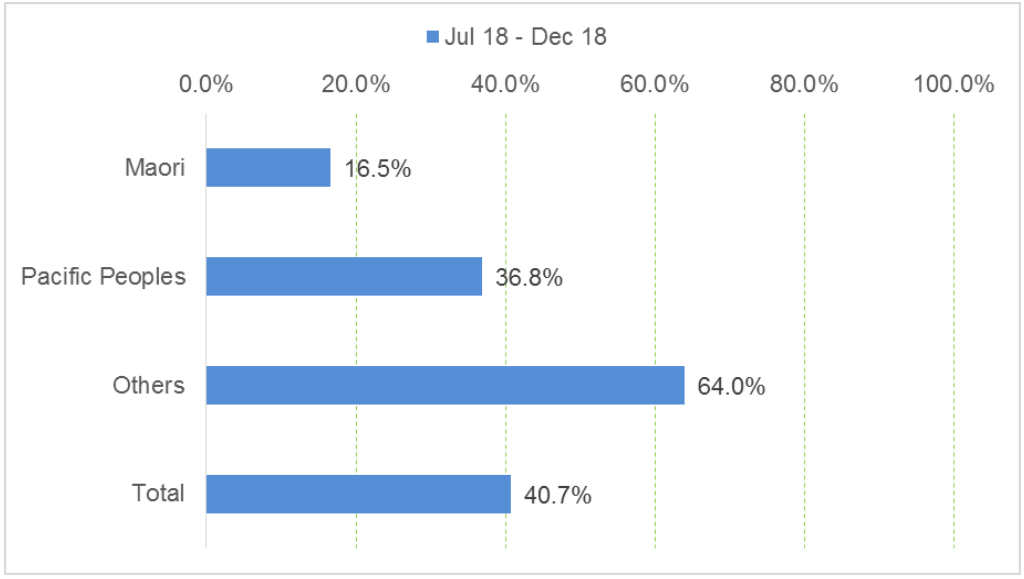
- Social determinants of health for Māori are improved
- Health outcome for Māori and other vulnerable groups matches the best that can be achieved
- Reduction in preterm birth, low birth weight, SUDI, ASH admissions for respiratory conditions
- Reduction in smoking related illness in adults
- Smokefree Aotearoa

What do we currently know?

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 six weeks domiciled in the Lakes DHB region who live in smoke free households.

Figure 5: Percentage of children (up to 56 days of age), domiciled in Lakes DHB, who are living in smokefree households for the six months June-December 2018



What will we focus on?

We aim to increase the proportion of Māori children living in smokefree homes, at 6-weeks post-natal, from 16.5% to 40% by 30 June 2020. To do this will involve the following:

- Maximise opportunities for pregnant women, mothers and whānau to receive support to stop smoking.
- Reduce smoking amongst young Māori women to decrease inequities in Māori health outcomes, increase whānau well-being and relieve the high burden and costs of smoking for multi-stressed families and communities and the health system.
- Improve the coordination and integration of infant and child and youth health services so that the services delivered to mother and baby (both during and post-pregnancy) are consistent and seamless.

What will we do?

Our focus for 2019/20

- **Increase the availability of hapū wānanga across the district, with an increase in the number of pregnant Māori women enrolling in these wānanga. We are taking this approach because hapū wānanga provide a whānau centric model of care.**
- **Establish an opt-out referral process in maternity care to ensure that all pregnant women who are (1) current smokers (and whānau who smoke) are supported to quit; and (2) recent ex-smokers are supported to remain abstinent. This process will connect WCTO, primary care, LMCs, whānau ora and appropriate NGOs using provider networks, MDT, and social media.**

Other related activities

- Work with local stop smoking service to focus their support on helping young wāhine Māori, and their whānau, quit smoking before they become pregnant. This work can build upon the findings from the Ministry of Health project.
- Work with the local stop smoking service to prioritise support for pregnant Māori women, and their whānau, including support being integrated into hapū wānanga.
- Increase the proportion of babies enrolled in a PHO.
- Increase in the number and rate of babies enrolled and receiving services from WCTO providers, with equity of access and uptake.

Our contributory measures

- To increase the proportion of pregnant Māori women and their whānau participating in hapū wānanga by 10%.
- To develop an opt-out referral system for all pregnant women who smoke, and for this system to achieve a 95% referral rate for Māori, and non-Māori women over the first year of operation.
- To increase the number of young (under the age of 40) Māori women being supported by the stop smoking service, with a short-term quit rate of at least that of non-Māori by 10%.
- To increase the number of pregnant Māori women and their whānau being supported by the stop smoking service, with a short-term quit rate of at least that of non-Māori by 10%.

Youth access to and utilisation of youth appropriate health services

What is our vision?

Youth in the Lakes DHB region will have access to the right health services that are easily accessible and youth friendly.

There will be a reduction in youth suicide and self harm in the Lakes DHB region.

What do we currently know?

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.

In the light of the latest data, 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 Māori, 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 Māori is only 24 years compared with 40 years for non-Māori; 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.

Key points from the latest data

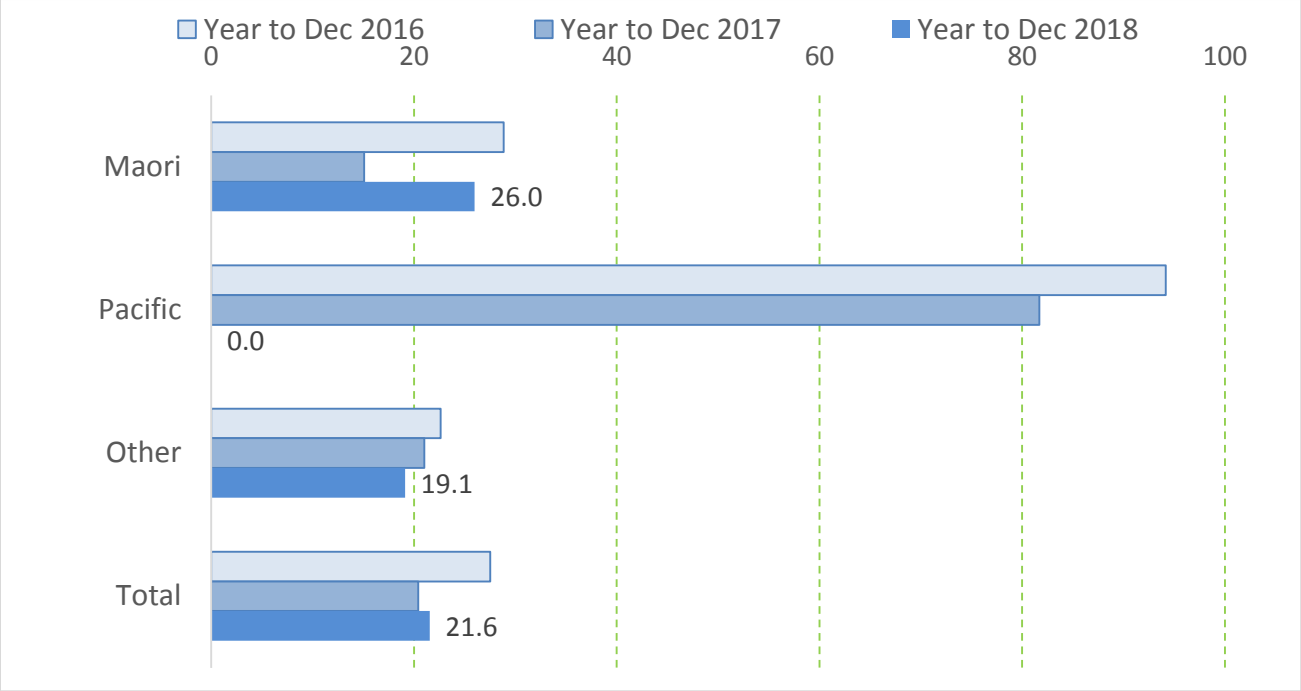
Youth suicide rates (25 years and under) also pose a concern in this space noting that:

- 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 Māori than non-Māori;
- 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.

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.

Figure 6: Age standardized self harm hospitalisations (for ages 10-24) per 10,000 for the years 2016-2018



What will we focus on?

We aim to achieve a 10% reduction in the rate of hospital admissions for self harm for Māori by 30 June 2020. We are taking a new approach to delivering better health and wellbeing services for young people by working collaboratively with two communities of learning (Kāhui Ako) to develop and implement a new model of care for school-based health services. The two Kāhui Ako that will participate in this project, have identified challenges regarding child and youth wellbeing and the relationship with learning - children need to be well to learn. It is intended that this project will provide support to schools through knowledge to manage health presentations and behavioural issues, by up-skilling the workforce and creating efficient and effective pathways for referrals and feedback through a collaborative approach and where practically possible by making use of the Kāhui Ako mechanisms.

We are also trying to accomplish seamless system of health care access for young people residing within Lakes DHB. Improved communication between schools, mental health, YOSS and general practice services and a reduced youth suicide rate for the Lakes DHB region. 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 will we do?

Our focus for 2019/20

- **Work with two local Communities of Learning (Kāhui Ako) to test a model of care to ensure there is early engagement and prevention across the life course and robust pathways for children/tamariki who have been identified with challenges that threaten their wellbeing.**
- **Develop a Health Pathway for youth suicide prevention* that will provide guidance to health practitioners to help at-risk youth by March 2020.**
- **Develop a Suicide Pre/Postvention* Governance Group and postvention framework to monitor suicide risk and reduce likelihood of suicide contagion by October 2019.**

Other related activities

- Establish communication pathways between schools, YOSS, primary care, and mental health services. These communication pathways are likely to include better referral pathways, but could also utilise consulting expertise in primary care and mental health services.
- Review what is required in SBHS and YOSS to address wellbeing, which includes physical, mental, spiritual, and whānau wellbeing, and develop systems for early recognition of problems and management.
- Review School Based Health Services and investigate how other models, such as Mana Ake,[2] might be integrated within Lakes DHB.
- Youth suicide prevention added to Te Ara Tauwhirotanga model of care

*Although this work is focused on suicide prevention, we expect it to contribute to a reduction self harm.

Our contributory measures

- Reduce total Maori Self Harm Hospitalisation rate by 10% by 30 June 2020
- New model of care implemented in one high school by 30 June 2020
- We will not have robust quantitate data available in the early phase of the Health Pathways and Suicide Governance Group projects, but we will provide a narrative on baseline qualitative data and process measures.

[2] http://ccn.health.nz/FocusAreas/ManaAke-StrongerforTomorrow.aspx

Appendix 1: Lakes District Health Board key socio-demographic data points

- 34.7% of Lakes population is Māori.
- Current annual growth is estimated at 1% per annum bringing the Lakes projected population to 110,410 for the 2018/19 fiscal year (projection).
- Most of this projected growth sits in the 55 years and over age group with the majority of this population being non-Māori.
- The Index of Multiple Deprivation (IMD) shows Lakes as having the third most deprived population behind Tairawhiti and Northland DHBs.[3]
- The median IMD rank in the Lakes DHB was 21.4% worse than the NZ median. Most of the Q5 data zones were concentrated in the northern part of the DHB in the areas surrounding Lake Rotorua.
- This IMD analysis also shows that Lakes DHB has particular challenges in the areas of education, crime and housing. For example:
    - The median employment deprivation rank in Lakes DHB was 9.7% worse than the NZ median.
    - The median income deprivation rank in Lakes DHB was 18.7% worse than the NZ median.
    - The median crime deprivation ranks in Lakes DHB was 21.5% worse than the NZ median.
    - The median housing deprivation rank in Lakes DHB was 11.6% worse than the NZ median.
    - The median health deprivation rank in the Lakes DHB was 19.8% worse than the NZ median.
    - The median education deprivation rank in Lakes DHB was 24.4% worse than the NZ median.
- Access is the distance from the population weighted centre of each neighbourhood to the nearest three GPs, supermarkets, service stations, schools and early childhood education centres. The median access deprivation rank in the Lakes DHB was 10.5% worse than the NZ median. High (Q5) level of access deprivation occurred in rural parts of Lakes DHB.
- At the same time, the population of those less than 15 years of age is predicted to grow only infinitesimally with Māori growing slightly more quickly providing a window of opportunity to refine the approach to child health.
- 34% of the population can be defined as 'high need' (Quintile 5) compared with 25% for Bay of Plenty and 15% for Taranaki DHBs respectively.
- Over half (55%) of the population resides in areas designated as quintile 4 and 5 (the two most deprived quintiles).
- Over 50% of Māori reside in areas designated quintile 5.
- Average life expectancy (LE) in Lakes DHB is about 2.7 years less than the national average with Māori life expectancy at birth still some 7- 8 years less than non-Māori.

[3] https://www.fmhs.auckland.ac.nz/assets/fmhs/soph/epi/hgd/docs/dhbprofiles/Lakes.pdf

Signatures of Lakes DHB participating Alliance representatives:

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Date: June 2019	Name:	Signature:
Team Rotorua Alliance Leadership Team	Kirsten Stone Chief Executive Officer Rotorua Area Primary Health Service	
Midland Health Network Alliance	Helen Parker Chief Executive Officer Pinnacle Midland Health Network	
Team Rotorua Alliance Leadership Team	Mala Grant General Manager Te Arawa Whānau Ora Collective	
Lakes DHB	Karen Evison Director, Strategy Planning and Funding