Waikato District Health Board

2017-18 SYSTEM LEVEL MEASURE IMPROVEMENT PLAN

National Hauora Coalition

Waikato District Health Board

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Introduction

The creation of the System Level Measures (SLM's) in 2016/17 and their accompanying contributory measures provided the Waikato Health System as a whole with an opportunity to address key local health priorities for our population. We are committed to improving the health outcomes of all of our population, in particular improving the health outcomes of our Māori population. This second Improvement Plan for 2017/18 has been developed in response to the Ministry of Health's requirements for continuing System Level Measures improvement, along with our desire to address equity.

Our district inter-alliance and individual clinically led SLM working groups have worked collaboratively to set and agree our improvement milestones, contributory measures and activity for 2017/18 in order to contribute to national outcomes and also align with our priority areas. They are based on analysis of local trends, while considering the needs and priorities of our population.

Inter-alliance will oversee and monitor this improvement work.

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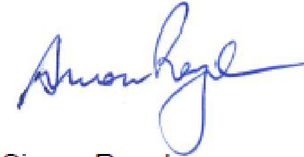

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Background

System Level Measures are high level aspirational goals for the health system that align with the five strategic themes of the Health Strategy and other national strategic priorities such as Better Public Service Targets. They have a focus on children, youth and vulnerable populations.
System Level Measures are part of Waikato DHB's annual planning process and provide an opportunity to work across our primary, secondary and community care providers to improve health outcomes of our local populations. The Ministry of Health's intention in developing this process was to provide a mechanism for improvement science to inform cross sector activities within district health board areas.

This Improvement Plan includes the addition of two developmental System Level Measures - Proportion of babies who live in a smoke-free household at six weeks postnatal and youth access to and utilisation of youth appropriate health services .

The plan includes the following:

- Improvement milestones that are a number showing improvement in performance, for each of the six SLMs.
- A suite of contributory measures for each of the six SLMs
- Description of specific activities to be undertaken by primary, secondary and community providers to achieve the SLMs
- District alliance stakeholder agreement with the Improvement Plan
- Reporting and accountability framework

System Level Measures

The six System Level Measures (SLMs) are:

- Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0-4 year olds
- Acute hospital bed days per capita
- Patient experience of care
- Amenable mortality rates less than 75 years.
- Proportion of babies who live in a smoke-free household at six weeks postnatal (developmental)
- Youth access to and utilisation of youth appropriate health services (developmental)

SLM Plan Development 2017-18

Collaborative development

In 2016/17 we took a regional approach to System Level Measures work with a number of the 2016/17 contributory measures remaining within this plan.

For 2017/18 we have taken a district focused approach with clinically led working groups engaged in reviewing the available data, determining milestone improvement targets, contributory measures, activity that would likely support improvement and advising on the key metric to be used to feedback into improvement cycles.
To decide the most effective approach to the issues identified by the data, the groups looked to ensure:

- Alignment to current inter-alliance work programmes and activities
- Information was available and already collected; and where possible aligned across the Midland region
- Relevance to family and whanau, clinicians and managers
- A focus on reducing inequity
- Relevance to vulnerable populations including but not limited to older people and children
- Impact on a reasonable sized population

The three Primary Health Organisations (PHO's) – Pinnacle Midlands Health Network, Hauraki PHO and National Haora Coalition, Midland Community Pharmacy Group, along with our Maori Health Team (Te Puna Oranga) and appropriate stakeholder groups, provided representation within the SLM working groups and were all involved in the development of the plan.
Having clinical leads for each SLM was also instrumental in the development of an action-focused improvement plan, with endorsement across the district.

Once the draft plan was developed it was taken to inter-alliance for review and approval.
Following approval by the Ministry of Health, appropriate implementation, monitoring and governance for the Improvement Plan for 2017/18 will be carried out.

System level measure overview

System level measure	Baseline data	Improvement milestone 17/18 target	Contributory measures
1. ASH 0 – 4 years	• Maori – 8,224 per 100,000 population. • Pacific – 10,385 per 100,000 population. • "Other" – 6,745 per 100,000 population. • Total – 7473 per 100,000 population. (Baseline set from 12 months, December 2016)	• Reduce ASH admissions for 0-4 year olds by 4% for Maori (7895 per 100,000) • Reduce ASH admissions for 0-4 year olds by 4% for Pacific (9969 per 100,000,) • Reduce ASH admissions for 0-4 year olds by 2% for other (6,611 per 100,000) across the DHB in order to reduce inequity	• Eligible children provided flu vaccination • Implementation of respiratory care pathways • Influenza and boostrix vaccines for pregnant women • 0-4 ASH condition of cellulitis or dermatitis/eczema • Children with a Lift the lip score of 2-6 are referred to an oral health provider with a particular focus on Maori and Pacific • Number of ECE with water and milk only policies • The number of new-borns fully enrolled in a PHO by 6 weeks with a particular focus on Maori and Pacific • Gastro conditions supported in primary care with a particular focus on Maori and Pacific
2. Acute bed days	• Maori - 654 per 1,000 population. • Pacific - 631 per 1,000 population. • "Other" - 421 per 1,000 population. • Total - 462 per 1,000 population.	• Reduce acute bed days by 2% and maintain for Maori (641 per 1,000) by 30 June 2018 • Reduce acute bed days by 2% and maintain for Pacific (618 per 1,000) by 30 June 2018 • Reduce acute bed days by 1% and maintain for 'other' (417 per 1,000) by 30 June 2018	• ED presentation and hospitalisation rates for cellulitis (excluding under 13 years) • ED presentation and hospitalisation rates for COPD • ED presentation and hospitalisation rates for heart failure • ED presentation and hospitalisation rates for asthma • Occupied bed days for patients 75 years and over • Inpatient average length of stay for acute admission

3. Patient experience of care	No data yet	• 80% of General Practices are using the primary care patient survey	• GP practices using the National Enrolment Service • Patients offered the Patient Experience survey in the week of their visit • Patients feel they have received enough information on medication side effects and how to manage their condition on discharge
4. Amenable mortality	• Maori – 251 per 100,000 • Pacific – 190 per 100,000 • "Other" – 86 per 100,000 • Total – 111 per 100,000 (Baseline set by the 2013 results, as per the nationwide service framework library, data to support System Level Measure, Baseline data for setting 17/18 targets)	• Reduce total amenable mortality rate by 4% for Maori • Reduce total amenable mortality rate by 4% for Pacific • Reduce total amenable mortality rate by 2% for 'other' across the DHB in order to reduce inequity	• PHO eligible population who have had a CVD risk recorded within the last five years • PHO population achieving a 5 year cardiovascular risk of less than 15% • PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months • Registered smokers who have been referred to a smoking cessation service (Hospital) • Proportion of patients assessed for risk of deliberate self-harm in primary care • PHO eligible population with a record of a Diabetes Annual Review during the reporting period whose HbA1c test result is 8% or less or 64 mmol/mol or less • Target population who have had a mammography within 2 years • Patients receive 1st cancer treatment within 62 days of being referred with high suspicion of cancer
5. Infants who live in smoke free households (Developmental)		• Smoking status is recorded by WCTO providers for 80% of Core 1 checks in quarter 4 2018**.**	• PHO enrolled Maori patients who smoke are referred to stop smoking services • Pregnant Maori women who smoke are referred to smoking cessation services upon registration with LMC or GP in first trimester • Pregnant Maori women are enrolled in pregnancy and parenting programmes • Pregnant women who smopke are issued nicotine replacement therapy (NRT) • Supporting smokefree households
6. Youth Access to Health services (Developmental)		• 90% of patients 10 – 24 years with a recurrent self-harm admission within 3 years are referred to a health provider	• Youth engagement • Percentage of eligible population receiving HEEADSSS assessments • Improvement of data quality

System Level Measure 1: ASH rates in 0-4 year olds: Reduce hospital admissions rates for conditions avoidable through prevention or management in primary care

Improvement Milestones:

- Reduce by 4% for Maori and Pacific and
- Reduce by 2.0% for 'other' across the DHB in order to reduce inequality

Baseline data analysis:

- ASH rate remain steady throughout the year for all ethnicities measured
- By volume 0-4 year olds are the biggest age group for ASH. Respiratory infection, Dental Conditions, skin infections and Gastroenteritis/ Dehydration being the top issues for the age group.
- 'Other' show a higher rate per 1,000 of population than the other ethnicities measured with the exception of Asthma

	Contributory measures	Rationale	Activity
Respiratory			
1.	Eligible children provided flu vaccination with a particular focus on Maori and Pacific populations	Respiratory in top 10 0-4 ASH condition. Rates of these immunisations remain low. No system in place to identify and vaccinate in primary care Influenza vaccination rates for children hospitalized for respiratory illnesses remain low.	Program to identify and vaccinate all children 0-5 who qualify for the free influenza vaccine. • Systems in place to identify and vaccinate - Defining denominator (who would qualify) - Develop a primary care system recall for eligible population - Develop a disease register to monitor performance • Monitor performance to maintain and improve practice • Raising awareness; update professionals on current activity and resources and offer education and resource support as required with focus on Maori and Pacific children • Align and promote pharmacy options with a focus on Maori and Pacific children
2.	Implementation of respiratory care pathways	Respiratory in top 10 0-4 ASH condition.	Review childhood respiratory care pathway with particular focus on access for Maori and Pacific Island children (note this may include GASP or alternative programmes)
3.	Influenza and boostrix vaccines for pregnant women	Influenza and boostrix vaccines in pregnancy prevent serious communicable illness in newborn children.	Build on work already developed • Data activity to be defined • Review current performance to maintain and improve practice with particular focus on Maori and Pacific • Raising awareness; update professionals on current activity and resources and offer education and resource support as required with particular focus on Maori and Pacific • Align and promote pharmacy program with particular focus on Maori and Pacific
Skin infections			
	Contributory measures	**Rationale**	**Activity**
4.	0-4 ASH condition of cellulitis	Skin infections in top 10 0-4 ASH condition.	Develop a new primary care system of care around childhood skin infections

	or dermatisi/eczema	There is high and growing rate of hospitalizations for serious skin infections. There is a lack of consistent messaging and educational resources for families on how to manage skin infections.	• Data analysis to identify self-referral vs primary care referral for ASH admission and enrolled vs not enrolled to provide targeted support and consistent pathways with particular focus on Maori and Pacific • Build on midland work already developed including updating the child pathway of care with particular focus on Maori and Pacific and distribution of education and resource as required. • Work with CHAG to review tools and resource available with particular focus on Maori and Pacific and carry out analysis on local admissions against resource support available • Expansion of paediatric business rules for primary options with particular focus on Maori and Pacific • Consider pharmacy standing order for mild conditions produces for example fatty creams.
Oral health			
	Contributory measures	**Rationale**	**Activity**
5.	Children with a Lift the lip score of 2-6 are referred to an oral health provider with a particular focus on Maori and Pacific children	Oral Health in top 10 0-4 ASH condition. Hospitalizations due to dental conditions in the 0-4 age group are significant and increasing 2016/17 contributory measure with focus for 2017/18 on assessment being carried out earlier than B4SC check up	• Upskill primary care, well child and secondary providers in lift the lip assessments, knowledge of dental services and how to refer • Improvement of referral process for providers to be able to access NCHIP data and call Community Oral Health at time of assessment to review oral health status (enrolled, DNA, decay being managed already) and set up appointment at the same time
6.	Number of Early Childhood Education (ECE) Centres with water and milk only policies with a particular focus on Maori and Pacific children	Primary prevention oral health focus Opportunity to align and drive primary prevention work across the sector	Improve understanding of the sector through developing partnerships between population health, early childhood centres and sport Waikato. • Capture baseline data of current number of ECE with water and milk only policies in Waikato • Develop and implement a Program across the 3 partners to promote and support the adoption of water and milk only policies in ECEs
Newborn enrolment			
	Contributory measures	**Rationale**	**Activity**
7.	The number of new borns fully enrolled in a PHO by 6 weeks with a particular focus on Maori and Pacific children	2016/17 contributory measure Inter-alliance primary prevention priority aligning with 8 month immunisation activity Access to healthcare is key equity focus	• Develop and implement an early electronic enrolment service via NCHIP throughout the Waikato region • Monitor and reduce proportion of children not enrolled by 6 weeks with a particular focus on Maori and Pacific children.

Gastroenteritis			
8.	**Milestones**	**Rationale**	**Activity**
	Gastro conditions supported in primary care with a particular focus on Maori and Pacific children	Gastroenteritis in top 10 0-4 ASH condition.	• Expand capacity in GP to provide assessment and treatment • Expansion of paediatric business rules for primary options • Review pharmacy options for assessment and treatment of infants with gastroenteritis

System Level Measure 2: **Acute Bed Days:** Improved management of demand for acute care

Improvement Milestone:

- Reduce acute bed days by 2% and maintain for Maori and Pacific by 30 June 2018
- Reduce acute bed days by 1% and maintain for 'other' by 30 June 2018

Baseline data analysis:

- The overall 3 top issues by bed duration are Congestive heart failure, Pneumonia and Acute subendocardial myocardial infarction.
- Each ethnicity show a different duration per visit with Maori being the shortest durations per visit, in some conditions up to 10 day shorter
- Top issues for each ethnicity vary from the total and includes Cellulitis of lower limbs for Maori and Chronic obstructive pulmonary disease with acute lower respiratory infection for Pacific population

Cellulitis (excluding under 13 year olds)			
	Contributory measure	**Rationale**	**Activity**
1.	ED presentation and hospitalisation rates for cellulitis	Cellulitis is a top reason for ED presentations and admissions for Maori.	• Updated Map of Medicine clinical pathway • Project to look at patients with cellulitis admitted one day or less • Evaluate primary options cellulitis framework • Secondary outpatients HOT clinics implemented for Cellulitis and the mechanism for primary care HOT clinics/urgent slots to be developed
COPD			
	Contributory measure	**Rationale**	**Activity**
2.	ED presentation and hospitalisation rates for COPD	COPD is a top reason for ED presentations and admissions for Pacific, along with pneumonia being in the top 3 overall.	• Work with operation and support team and Te Puna Oranga to review the Maori/Pacific patient journey in emergency department • Launch of COPD Homebased Support Team (CHEST) new care model initiative in the community
Heart Failure			
	Contributory measure	**Rationale**	**Activity**
3.	ED presentations and hospitalisation rates for people with heart failure		• Development of new integrated approach for management of heart failure in the community
Asthma			
	Contributory measure	**Rationale**	**Activity**

4.	ED presentations and hospitalisation rates for people with asthma		• Roll out GASP Programme (Hauraki PHO)
75+ years			
	Contributory measure	**Rationale**	**Activity**
5.	Occupied bed days for patients 75 years and over		• Advance Care Plan implemented • Last 1000 days of life project • Roll out START phase two expansion • Roll out Waikato Falls and Fragility Fracture Prevention Programme
Inpatient LOS			
6.	**Contributory measure**	**Rationale**	**Activity**
	Inpatient average length of stay for acute admissions	The efficient flow of patients through and out of hospital supports the focus of keeping people in the community.	• Progressing the 'Patient Flow Programme' • Rollout the iMPACT patient flow manager IT Project

System Level Measure 3: Patient Experience of Care: Improved clinical outcomes for patients in primary and secondary care through improved patient safety and experience of care

Improvement Milestones:

- 80% of General Practices are using the primary care patient survey

Baseline data analysis:
Waikato inpatient patient experience survey scores are similar to the national weighted average scores for the last quarter – Q4, 2016. We have worked hard to improve our response rate for the survey and are now one of the highest response rates in New Zealand, typically above 40%.
The key themes from feedback are not being told about medication side effects to look out for at home, and not receiving enough information about how to manage conditions after discharge
Primary care survey to be rolled out.

National Enrolment Service			
	Contributory measures	**Rationale**	**Activity**
1.	GP practices using the National Enrolment Service	In order to roll out primary care surveys the practices need to have transitioned to the National Enrolment Service	• Ensure PMS are compatible with National Enrolment Service (NES) • Support and training to transition to NES
GP Surveys			
	Contributory measures	**Rationale**	**Activity**
2	Patients are offered the Patient Experience Survey in the week of their visit	Provides the ability for practices to understand their customer in order to improve customer experience	• Roll out the primary care patient survey • Training and support for general practice in use of primary care patient survey • Monitoring of uptake • Communication and training plan with general practices, hospital, patients and community
Medication Safety			
	Contributory measures	**Rationale**	**Activity**
3	Patients feel they have received enough information about medication side effects and how to manage their condition on discharge	A key theme from inpatient survey	• Improve discharge planning to include safe medication transfer (?safer bundle of care) • Collaborative development of patient safety week around medication safety • Raising awareness of health literacy

System Level Measure 4: Amenable mortality: Reduction in the number of avoidable deaths and reduced variation for population groups.

Milestone improvement:

- Reduce amenable mortality rate by 4% for Maori and Pacific
- Reduce amenable mortality rate by 2% for 'other' while reducing the equity gap across the district

Baseline data analysis

- There are significant inequities between Maori and 'other' which is also seen nationally. We have a higher rate of both Maori and other group compared to New Zealand. The area with the most significant equity gap is diabetes.
- The most common causes of premature death are coronary and cerebrovascular disease, COPD, suicide, diabetes and cancers. Injuries (unintentional and self-harm are also important causes
- Overall the highest number of preventable deaths is from Coronary disease

Coronary/CVD			
	Contributory measures	**Rationale**	**Activity**
1. **2.**	PHO eligible population who have had a CVD risk recorded within the last five year PHO population achieving a 5 year cardiovascular risk of less than 15%	Cardiovascular disease represents a continuing major cause of premature mortality and in order to impact this it is important to modify risk factors early	• CVD risk assessment screening for Maori men 35 – 44 years - Identify and agree measures and work programme to improve access to screening and modify risk • Modification following risk assessment - Agree a work programme to modify risk following a risk assessment score of ≥ 20% • Identify what post CVD event management activities are required
COPD – Smoking cessation			
	Contributory measures	**Rationale**	**Activity**
3. **4.**	PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months Registered smokers who have been referred to a smoking cessation service (hospital)	Smoking remains a significant causal factor for amenable mortality including COPD, cancer and cardiovascular disease Smoking is the most important cause of avoidable death for Maori	• Roll out 'onceandforall' smoking cessation referral program with a specific focus on Maori, Pacific • Develop an intervention to improve referral to smoking cessation provider and issue of NRT on the cardiac and respiratory wards • Improve smoking data collection and sharing (links to Babies living in smokefree homes SLM)
Self Harm/Suicide			
	Contributory measures	**Rationale**	**Activity**

5.	Proportion of patients assessed for risk of deliberate self-harm, in primary care	A leading cause of amenable mortality	• Develop data sources, capacity to track and analyse self harm data from primary mental health (Hauraki)
Diabetes			
	Contributory measures	**Rationale**	**Activity**
6.	PHO eligible population with record of Diabetes Annual Review during the reporting period whose HbA1c test result is 8% or less or 64 mmol/mol or less	Diabetes represents a continuing major cause of premature mortality and in order to impact this it is important to modify risk factors early.	• Upskill practice managers in complex care • Utilise virtual health for primary and secondary care collaboration • Investigate a Kiawhina role to work with communities to promote healthy eating/exercise and engagement with healthcare to optimally manage diabetes • Investigate how TPO and Population Health may be able to influence healthy lifestyles at a population health level • Co-design a programme to prevent progression from prediabetes to diabetes for Maori • Undertake study to validate new diabetes prevention App Betame. Designed to equip people with prediabetes with tools, support, education and confidence to prevent diabetes
Cancers			
	Milestones	**Rationale**	**Activity (draft)**
8. **9.**	Target population who have had a mammography within 2 years Patients receive their first cancer treatment within 62 days of being referred with a high suspicion of cancer	Cancers represent a continuing major cause of premature mortality and in order to impact this it is important to identify and treat early	• Roll out Waikato Hospital Inpatient and Outpatient Breast Screen Aotearoa Recruitment Project with a focus on unenrolled, unscreened and overdue screening for Maori women • Clinical Nurse Specialist – Equity and Access for high risk patients with potential of DNAing to follow the patient through the cancer pathway, ensuring they get seen on time. - Priority Maori and Pacific • PHO's to roll out their support to screening programmes focusing on providing extra support for Maori and Pacific women who experience barriers accessing breast screening, assessment and treatment services

System Level Measure 5: Proportion of infants who live in a smoke free household at 6 weeks postnatal (This measure is in development for 2017/18)

Improvement Milestone:

- Smoking status is recorded by WCTO providers for 80% of Core 1 checks in Quarter 4 2018

Baseline data analysis

- Locally we have limited across sector access to regular robust smoking data
- The data analysis available identified that only 24% of Core 1 WCTO visits had the smoking status recorded. In 70% of Core 1 visits, the smoking status field was left blank, which would likely indicate that the smoking status was not known or recorded as not asked.

Pre pregnancy and household contacts			
	Contributory measures	**Rationale**	**Activity**
1.	Māori patients who smoke are referred to stop smoking services. (denominator PHO enrolled)	*Whanau engagement* Population measure to capture the wider household population *Equity* Significant equity gap between Maori and NZ European. This measure targets Maori results to enhance equity focus for monitoring and activity. *Utilisation and access* Low numbers referred to stop smoking services *Data quality improvement* Data reports only the number of smoking given brief advice and does not report the number referred and does not provide ethnicity breakdown	• System in place to establish baseline and report on referral data by ethnicity and equity gap • Explore opportunities to develop a local dashboard[1] • Communication plan agreed

[1] A separate smoking dashboard does not have agreed resource so may not be progressed in 2017/18 and the first step will be to review smoking data reporting on the SLM dashboard. It was noted by the Child and Youth Health Network Chair that in the interim smoking data available from Waikato's lead smoking cessation service could be reported to the Network alongside the smoking data that will be captured in the SLM dashboard.

Early pregnancy			
	Contributory measures	**Rationale**	**Activity**
2.	Pregnant Maori women who smoke are referred to stop smoking services at first contact (upon registration with a LMC or when seen by a GP in first trimester)	*Provider relationships* Early pathway intervention measure focused on provision of high quality care by LMCs and general practice *Data quality improvement* Data comes from two sources, MMPO and from DHB employed midwives. Due to issues with data collection, available data is not complete *Equity* Significant equity gap between Maori and NZ European. This measure targets Maori results to enhance equity focus for monitoring and activity. *Utilisation and access* Low numbers accepting referrals to smoking services	• System in place to establish baseline and report on referral data by ethnicity and equity gap • Explore opportunities to develop a local dashboard • Communicate incentive scheme for pregnant women to the midwifery community and general practice. • Clinical pathway for GP first trimester visit promoted
Pregnant			
	Contributory measures	**Rationale**	**Activity**
3.	Māori women enrolled in pregnancy and parenting programmes	*Whanau engagement* Opportunity to focus on total wellbeing. Local pregnancy and parenting workshops include wider whanau *Data quality improvement* No baseline data *Equity*	• Pregnancy and Parenting Programmes data collected including ethnicity and smoking status • Stop smoking services promoted in pregnancy and parenting programmes

		Anecdote evidence suggests low enrolment of Maori women in pregnancy and parenting programmes.	
4.	Pregnant women who smoke are issued NRT	NRT has been shown to be effective in supporting pregnant women to stop smoking. It is best used in conjunction with other measures including biofeedback/CO monitoring, counselling and incentives.	• NRT baseline established for primary and secondary care • NRT information is updated
Lifespan			
	Contributory measures	**Rationale**	**Activity**
5.	Supporting smokefree households	Focusing attention on maternal smoking as well as home and family/whanau environment. Promoting opportunistic screening and follow up by existing providers/services working with families and pregnant women	• Work with WCTO providers to improve data quality • Establish system to roll out Tupeka Kore Framework • Smokefree household information promoted

System Level Measure 6: **Youth Access to Health:** Improved access to and utilization of youth appropriate health services (This measure is in development for 2017/18)

Improvement Milestone:

- 90% of patients with a recurrent self-harm admission within three years are referred to a health provider

Baseline data analysis:

- The national indicator chosen for this SLM is is 'Intentional self-harm hospitalisations including short-stay hospital admissions through Emergency Department for 10-24 year olds'.
  - The overall rate for Waikato for the 10-24 year old age group is 406.4 per 100,000 population.
  - This equates to 1,021 episodes for the three year period (772 unique NHIs).
  - The rate has steadily increased in the last 3 years (255, 408, 454)
  - Based on data for 2013 published by MOH, Waikato DHB is not significantly different to national rates
  - Nearly all admissions are through ED with approximately 86% being stays of less than one day.
  - The majority of cases are female (73%)
  - The ethnic breakdown demonstrates a slight over-representation of Māori (24% compared to 19% of the Waikato youth population, 2013)
  - Rates per 100,000 are significantly higher in the 15-19 age-group (645) and in females (613)
  - Approximately 18% of individuals had more than one admission in the last 3 years (136 individuals)

In this development year we have proposed a referral improvement milestone to ensure we have across sector systems in place for recurrent self harm referrals from hospital to community health providers.

Youth Engagement			
	Contributory measures	**Rationale**	**Activity**
1.	Youth engagement	Poor youth health literacy reported and poor youth voice represented in health Evidence shows that young people who do not have positive interactions with health care services/providers do not return and have poorer outcomes. Rheumatic fever research	• Youth representatives established on advisory groups • Youth health literacy training delivered to professionals

		(University of Auckland) and qualitative data from local rheumatic fever project, reports health professionals are not youth health literate	
	Youth not in Education, Employment or Training (NEET	Youth not in employment, education or training are a high needs priority group in order to achieve health equity No baseline data on current population so no ability to target this particular group with coordinated service delivery	• Youth NEET population identified • Consider additional access points for NEET population • Improve understanding of services available to NEET population
	Quality of care: utilisation and access	Poor understanding of current youth services quality and availability To achieve health equity for youth, primary to tertiary services need to be accessible, appropriate and effective	• Stocktake of youth services carried out • Communication plan to stakeholders agreed • System in place for monitoring of referrals from hospital to community health providers
	HEEADSSS	Currently decile one to three secondary schools, teen parent units and alternative education facilities in Waikato have access to SBHS HEEADSSS assessments for Year 9 students. HEEADSSS is our current best practice screening tool to improve youth opportunistic	• Increased percentage of eligible population receiving HEEADSSS assessments • Achieve equity for eligible population receiving HEEADSSS assessments • Work with providers to improve access

		care.	
Data quality			
	Contributory measures	**Rationale**	**Activity**
2.	Improvement of data quality	Key 2017/18 focus is on data improvement with poor data quality and inconsistent self harm reporting across primary care, ED and school based health services. Clear and consistent measure of outcome data is required to achieve equity (including Maori, non-Maori analyses) Alcohol related ED presentations for 10-24 year olds is a mandatory reporting field from July 2017.	• Systems in place for self-harm reporting • Outcome data captured and reported on • System in place for mandatory reporting for alcohol related ED presentations for 10–24 year olds

Performance monitoring and reporting

System level measure	Data source	Freq.	Governance responsibility	Monitoring and reporting responsibility
SLM 1: Ambulatory sensitive hospitalisations, 0-4 years				
Milestone improvement 17/18 target: • Reduce ASH admissions for 0-4 year olds by 4% for Maori and Pacific 2% for other • Reduce ASH admissions for 0-4 year olds by 2% for other across the DHB in order to reduce inequity	Ministry of Health	Quarterly	Interalliance and Board	Strategy and Funding
SLM 2: Acute bed days				
Milestone improvement 17/18 target: • Reduce acute bed days by 2% and maintain for Maori and Pacific by 30 June 2018 • Reduce acute bed days by 1% and maintain for 'other' by 30 June 2018	Ministry of Health	Quarterly	Interalliance and Board	Strategy and Funding
SLM 3: Patient experience of care				
Milestone improvement 17/18 target: • Increased numbers of patients being offered the Patient Experience Survey in the week of their visit	Ministry of Health	Quarterly	Interalliance and Board	Strategy and Funding
SLM 4: Amenable mortality				
Milestone improvement 17/18 target: • Reduce total amenable mortality rate by 4% for Maori and Pacific • Reduce total amenable mortality rate by 2.5% for 'other' across the DHB in order to reduce inequity	Ministry of Health	Quarterly	Interalliance and Board	Strategy and Funding
SLM 5: Smoke free infant				
Milestone improvement 17/18 target: • Smoking status is recorded by WCTO providers for 80% of Core 1 Checks in Quarter 4 2018	Ministry of Health	Quarterly	Interalliance and Board	Strategy and Funding
SLM 6: Youth access				

Milestone improvement 17/18 target: • 90% of patients with a recurrent self-harm admission within three years are referred to a health provider three years are referred to a health provider	Ministry of Health	Quarterly	Interalliance and Board	Strategy and Funding

2017/18 SYSTEM LEVEL MEASURES (SLM) WORKING GROUP
TERMS OF REFERENCE AND MEMBERSHIP

Purpose

The purpose of the SLM working group is to bring together local experts across the sector to collaborate and recommend the following for their 2017/18 measure by June 15 2017

- An improvement milestone[2,3];
- contributory measures and milestones;
- quality improvement activities to achieve contributory measures and therefore SLM.

Specific Responsibilities

***Plan*:**

- Review analysis of local data supplied by the TRG to identify main contributors
  (Where we are now)
- Identifying improvement milestone
  (Where we want to be)
- Selecting the most relevant contributory measures
- Identifying wider supporting measures which assist the delivery of the system level measure but are not the nominated contributory measures

Do

- Identifying activity and provider that will impact the contributory milestones and supporting measures. This could be current, planned i.e. listed in annual plan or new activities ideas
  (How will we get there)

Study

- Oversee activity agreed that will impact the milestones
  Reflect on activity progress and outcome data with the identified governance group (this will be alongside the technical reference group who will report on performance

Act

- Adapt, adopt or abandon activity

Outside of Scope

- Waikato's System Level Measure Plan sign off

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[2] The youth SLM working group will also be asked to put forward their recommendation for the domain area
[3] To recommend quarterly improvement milestones if data frequency enables

- Funding related decisions

Linkages
The improvement milestones chosen should take into consideration the strategic priorities across the region, particularly reducing inequity and should aim to:

- Align to current strategic priorities
- Align to current alliance work programmes and activities
- Information that is already collected and readily available; and where possible aligned across the region
- Relevant to family and whanau, clinicians and managers
- Relevant to vulnerable population including but not limited to older people and children
- Impacting on a reasonable sized population
- Desirable with regard to a return on input investment

Formation Details
The working group are established in May 2017

Terms of Membership
The length of term for each member (designated role) will be 13 months until end of June 2018. Each PHO~~s~~ operating in the Waikato District have been asked to provide a representative. DHB representatives and wider providers are included as appropriate. Appendix one has a list of members as of 3 May 2017 for each working group. Membership may change dependent on each organisations desired attendees. A delegate may represent members on the proviso that the delegate has the ability to report to their own services/organisations and can make informed contribution to discussions.

Meetings
Meetings to be held fortnightly until the 17/18 Improvement Plan has been agreed and at a minimum quarterly thereafter. Working groups to report to their governance groups at a minimum quarterly.

Accountability
The working group are an expert advisory group and will make recommendations to either the Waikato Child Health Network, Demand Management Advisory Group or Inter-Alliance as determined below.

Waikato Child Health Network and DMAG make final recommendations to Inter-Alliance

Governance
Waikato DHB’s executive leads for SLM are

- Damian Tomic - Clinical Director Primary and Integrated Care and
- Julie Wilson, Executive Director Strategy and Funding.

The Waikato Inter-alliance will have oversight for Waikato system level measures.

The working group will all report to one of the two following groups or straight to Inter-Alliance

1. Waikato Child and Youth Health Network
   - Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0-4 year olds;
   - Proportion of babies who live in a smoke-free household at six weeks post-natal (new 17/18)
   - Youth access to and utilisation of youth-appropriate health services (new 17/18)

2. Demand Management Advisory
   - Acute hospital bed days per capita;

Midlands Regional Linkages will be in the form of information sharing.
There may also be linkage with the Ministry team around data sources and SLM reporting

Decision Making
The working group are chaired by the DHB clinical lead for each SLM (see appendix one). If the Chair resigns from the working group during this period another member of working group will be appointed by the DHB SLM executives.

A quorum for the group will be at least the chair or delegated chair and 50% of permanent members.
Due to tight timeframes, engagement and agreement may be made via email as appropriate

The working group role is to put forward recommendation to the group they report to as above. The working group Chair will strive to seek consensus from the group on recommendations put forward. Final decisions on recommendations put forward to the Waikato Inter Alliance group will be decided by the Waikato Child health Network or DMAG as appropriate. Please note Patient experience of care and amenable mortality report directly to Waikato Inter-Alliance.

Issues with recommendation to be escalated through each organisations management structure

Membership

Technical Reference Group

Regan Webb
Katpaham Kasipillai/ Peter Hemming
Michelle Bayley
Jo Scott-Jones
Boudine Bijl
Reuben Kendall
NHC tbc

Acute hospital bed days per capita (ie, using health resources effectively)

Reports to Demand Management Advisory Group

Damian Tomic (Waikato DHB) –lead
Doug Stephenson (Waikato DHB)
Boudine Bijl (Hauraki)
Puamaria Maaka (MHN)
Susan (MHN)
Lorraine Hetaraka-Stevens (NHC)
Marc ter Beek (Waikato DHB)
Alex Gordon (Waikato DHB)
Julie Wilson (Waikato DHB)
Cath Knapton (Midland Pharmacy Group)
Kathryn Hugill (project manager)

Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0–4 year olds (ie, keeping children out of hospital)

Reports to Waikato Child and Youth Health Network

Dave Graham - chair (Waikato DHB)
Boudine Bijl (Hauraki)
Katie Ayers (Oral health, Midlands)
Bronwen Warren (MHN)
Karina Elkington (Waikato DHB)
Regan Webb (TRG Chair Waikato DHB)
Bryan Panopio (Waikato DHB analyst)
Kui White (Raukura – Wellchild provider)
Kath Yuill Proctor (project manager Waikato DHB)
Lorraine Heteraka-Stevens (NHC) teleconference/email feedback

Patient experience of care (ie, person-centred care)

Reports to Inter-Alliance

Mo Neville (Waikato DHB) lead
Trish Anderson (Hauraki)
Michelle Bayley (MHN)
Fiona Murdoch (Waikato DHB)
Lorraine Hetaraka-Stevens (NHC)

Amenable mortality rates (ie, prevention and early detection)
Reports to Inter-Alliance

Doug Stephenson (Waikato DHB) lead
Boudine Bijl (Hauraki)
Hayley Arnett (MHN)
Clare Simcock (Waikato DHB)
Fraser Hamilton (GP/Waikato DHB)
Ross Lawrenson (Waikato DHB)
Nina Scott (Waikato DHB)
Lorraine Hetaraka-Stevens (NHC)
Justina Wu (Waikato DHB)
Shona Haggart (Waikato DHB)
Loraine Elliot (Waikato DHB)
Kathryn Hugill (Fromont) (project manager)

Proportion of babies who live in a smoke-free household at six weeks post natal (ie, healthy start)
Reports to Waikato Child and Youth Health Network

Nina Scott – chair (Waikato DHB)
Michelle Rohleder (Hauraki)
Dallas Honey – Strategy and Funding (Waikato DHB)
Dave Graham (Waikato DHB)
Ruth Galvin – Women's Health (Waikato DHB)
Bronwen Warren (MHN)
Kelly Spriggs – TPO (Waikato DHB)
Karina Elkington – Strategy and Funding (Waikato DHB)
Kym Tipene (Wellchild provider)
Cass Gray (plunket)
Kate Dallas (Waikato DHB)
Cath Knapton (MCPG)
Kath Yuill Proctor (project manager)
Regan Webb (Chair TRG)
Shirley Hopping – Community and Clinical Support (Waikato DHB)
Lorraine Heteraka-Stevens (NHC) teleconference/email feedback
Primary Birthing Unit rep (tbc)

Youth System Level Measure (ie, youth are healthy, safe and supported)
Reports to Waikato Child and Youth Health Network

Polly Atatoa Carr (Waikato DHB) – Lead
Debi Whitham (Hauraki)
Karen McKellar (Hauraki)
Family planning – Karen Bennetar (Waikato DHB)
Rachel Haswell – Youth Intact
Child & Adolescent mental health Jolene Profitt
Katie Ayers (oral health)
Bronwyn Campbell MHN School based health service
Lorraine Heteraka-Stevens (NHC) teleconference/email feedback
Cath Knapton (MCPG)
Clare Simcock – suicide prevention (Waikato DHB)
Jane Morgan – sexual health (Waikato DHB)
Larry Clarke – Strategy and Funding (Waikato DHB)
Kath Yuill Proctor (project manager)

[i] Only those measures significantly influenced by PHOs will be considered in relation to funding on contributory measures