Waikato District Health Board

2019/20

SYSTEM LEVEL MEASURES IMPROVEMENT PLAN

Pinnacle Midlands Health Network

HAURAKI PHO HAURAKI PRIMARY HEALTH ORGANISATION NETWORK

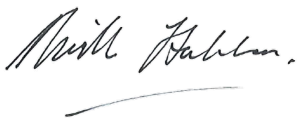
National Hauora Coalition

Contents

Introduction

The System Level Measure (SLM) Framework is a Ministry of Health led tool for integratipon to support District Health Boards to work in collaboration with primary, community and hospital. There is a focus on children, youth and vulnerable populations, and this work is included as aprt of the district's annual planning with the overall improvement targets and plan set locally while sitting within the appendix of the Annual Plan.

The 2018/2019 milestones, contributory measures and activities have been decided and agreed by the below parties.



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Executive summary

Waikato DHB, Pinnacle Midland Health Network, Hauraki PHO and National Hauora Coalition have jointly developed a 2019/20 System Level Measure (SLM) Improvement Plan. Quality improvement is at the heart of this plan with continuous improvement in the quality of care delivered and health outcomes experienced by our population being the main goal. We know we can improve health system performance through focusing on making the health care delivery effective, efficient and sustainable.

The SLM framework and subsequent plan has been developed in response to the Health Quality and Safety Commission (HQSC) and the Ministry of Health call for greater recognition of the value of quality improvement and shifting resources accordingly to deliver on the key government priorities and to meet the goals of the NZ Triple Aim.

With equity of health outcomes being at the forefront of priorities in the Waikato District, this improvement plan has been developed with a Māori and Pacific lens to ensure our priority populations are at the centre of any quality improvement activity undertaken. Equity gaps for Māori and Pacific exist across all SLMs providing a great opportunity to develop targeted milestones and activities to address these gaps.

All SLM partners are committed to developing additional contributory measures and activities over the medium to longer term and acknowledge that the annual SLM plan is a small snapshot of activity occurring across the sector in each of the six areas.

Purpose

The SLM Improvement Plan will be applied across the Waikato district. It summarises how improvement will be measured (contributory measures) and the high-level activities that will drive improvement across each of the six SLM areas towards achievement of the milestones.

Background

The New Zealand Health Strategy 2016 identifies 'value and high performance' as a key theme. This theme places greater emphasis on health outcomes, equity and meaningful results. Under this theme, the Ministry of Health has worked with the sector to develop a framework and suite of SLMs that provide a system-wide view of performance and a platform to deliver on the Government's priority of Improving the well-being of New Zealanders and their families. The six SLMs are the result of a clinically led co-design process over several months. They evolved from an initial list of over 100 measures.

SLM plans are developed each financial year by Waikato DHB and our health system partners (primary care, community care and hospital) in accordance with Ministry of Health expectations. Measures within the plan are outcome focused and provide for continuous quality improvement and system integration. The six SLMs are set nationally and focus on children, youth and vulnerable populations. The contributory measures have been chosen based on local needs, demographics and service configurations and are used to measure local progress against quality improvement activities.

The current nationally set SLMs include:

0-4 Ambulatory Sensitive Hospitalisation

ASH rates in 0-4 year olds seeks to reduce admission rates to hospital for a set of diseases and conditions that are potentially avoidable through prevention or management in primary care. In children, these conditions are mainly respiratory illnesses, gastroenteritis, and skin infections. ASH rates are higher for Māori and Pacific children and addressing this inequity would significantly reduce potentially avoidable hospitalisation rates.

Acute bed days

Acute hospital bed days per capita measures the use of hospital resources, predominantly relating to adults and older people. Effective management of long-term illnesses and disease prevention in primary care prior to hospitalisation and the provision of effective care in the community after discharge have the potential to reduce hospital bed days.

Patient experience of care

The patient experience of care measurement tools in primary and secondary care give insight into how patients experience the health care system, and how integrated their care was. Patient experience is positively associated with adherence to recommended medication and treatments, engagement in preventive care such as screening services and immunisations and ability to use the health resources available effectively. This measure will provide new information about how people experience health care.

Amenable mortality

Amenable mortality is a measure of the effectiveness of health care-based prevention programmes, early detection of illnesses, effective management of long-term conditions and equitable access to health care. It is a measure of premature deaths in under 75 year olds that could have been avoided through effective health interventions at an individual or population level.

Babies living in smokefree households

Babies living in smokefree homes aims to reduce the rate of infant exposure to cigarette smoke by focussing attention beyond maternal smoking to the home and family/whānau environment. The measure at six weeks aligns with the first core contact which is when the handover from maternity to Well Child Tamariki Ora providers and general practitioners occurs. Smoking during pregnancy and exposure to smoking in early childhood strongly influence pregnancy and early childhood health outcomes. This measure promotes the roles which collectively, service providers play in the infants' life and the many opportunities for smoking interventions to occur. It also enables the health sector to connect infants and their family/whānau with maternity and childhood health care such as immunisation.

Youth access to health services

Engagement with education, employment and training is critical as is building healthy relationships and making good choices. The youth SLM was co-developed with input from a broad range of people with a particular interest in youth health including: Ministry for Social Development, Ministry of Education, Office of the Children's Commissioner, sector groups such as Ara Taiohi, Youth One Stop Shops, clinicians from across primary and secondary care, academia, and the Ministry of Health. The Ministry also worked with youth agencies to facilitate several youth focus groups and one-on-one interviews to seek feedback from young people on what was meaningful to them and what this SLM should look like.

Development of the plan

To ensure that perspectives from all relevant parts of the health system were captured a workshop with representatives from the Ministry, PHOs, Waikato DHB, Analysts, Strategy and Funding, Community Pharmacy was held in late 2018. At this workshop Ministry expectations were clarified and the approach to be taken was communicated, the group was then guided with this approach to identify and agree activities and contributory measures for each of the six SLMs. Activities have a clear line of sight to the improvement milestone, and the agreed contributory measures will allow progress to be monitored.

In this plan there is a strong commitment to Māori and Pacific health gain and eliminating health inequities. To ensure we make real progress towards this each group has focused on an achievable number of activities that can be done well in the knowledge that new measures and activities can be agreed in future SLM plans. The joint approach to SLMs allows the development of a plan that will enable quality improvement across the sector and ensure we are improving health outcomes for our population as one cohesive team.

Structure

Previously the development and implementation of the SLM plan was completed by six working groups each containing a clinical lead, project manager, technical reference group and an overarching SLM programme manager based within Strategy and Funding. The groups met regularly (monthly or quarterly) to monitor implementation.

Based on growing experience with SLMs this structure has been reviewed and a new approach will be taken in 2019-2020. Areas of focus in each of the six SLM groups often interrelate or overlap. For this reason, the six groups have agreed that they will combine to create one large SLM steering group that meets quarterly for monitoring purposes.

Smaller expert working groups will be formed with a lead for each of the SLMs contributory and system measures and associated activity. The lead will assemble and follow any process they decide is required to implement the activities they are responsible for.

Steering group will be responsible for:

- Oversee and monitor implementation of the SLM plan
- Analyses of the national and local data
- Refine priorities and contributory measures for our district
- Lead communication, engagement with providers across the system in a collective system wide response.

Expert groups will be responsible for:

- Access and analyse the relevant data
- Agree on specific actions to achieve the priorities and establish an annual work plan
- Progress any service redesign or development required
- Monitor/report on their work plan including actions contributing to improvements in the measures. This will be done quarterly and reported to the SLM steering group and Ministry of Health (via PP22 SLM Report).

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:

- Annual 5% reduction in ASH rate for Māori and 7.5% for Pacific

Baseline data analysis:

- ASH rates have increased throughout the year for all ethnicities except Pacific
- Respiratory Infections and Gastroenteritis/Dehydration being the top issues for this cohort.
- 'Other' shows a lower ASH rate than Māori for most conditions

ASH rate per 100,000 0-4 year olds	12 months June 2018	12 months September 2018
Māori	10,531	11,769
Pacific	10,942	11,232
Other	8,327	8,315
Total	9,290	9,767

- Annual 5% reduction for Māori and 7.5% for Pacific would see the equity gap eliminated in 2023

Respiratory

	Rationale	Activity	Contributory measure
1.	Respiratory conditions have been identified as one of five key areas that can contribute to Iwi and Government Whānau Ora aspirations. New Zealand has high rates of asthma with symptom severity greatest among Māori and Pacific children. Individual level interventions have been shown to be effective in reducing avoidable hospitalisations due to asthma.	Increase uptake of children's influenza vaccination to prevent respiratory admissions by: • Improving vaccination rates in primary care of children aged 0-4 years with previous respiratory admissions through the provision of data, practice-level improvement activities, and following up reporting of vaccination update provided throughout the season. • Prioritising vaccination of eligible Māori and Pacific children. Support a decrease in respiratory admissions with social determinants by: • Developing a partnership between Primary Care and Waikato DHB to develop referral pathways to healthy housing options. • Establishing an accurate baseline for Whare Ora/healthy housing referrals.	Influenza vaccination rates for eligible Māori children. Target 25% Baseline measurement of referrals to healthy housing established by December 2019.

Enrolment			
	Rationale	Activity	Contributory measure
2.	We know from NCHIP data that infants who are enrolled early in general practice are less likely to be admitted to the emergency department, or to be subject to an ambulatory sensitive hospital admission. Early enrolment and engagement with primary care gives opportunity for timely immunisation, support with breastfeeding and smoking cessation services. It enables maternal and child health to be accessible, and supports whānau to access services when needed through precall and recall activities. Early enrolment has more impact on Māori whānau than others, a universal process is needed to capture all Māori infants.	PHOs will implement electronic enrolment of all newborn infants in primary care across all Waikato birth sites.	Newborns enrolled in a primary health organisation by three months. Eligible population – Infants aged up to three months. Number of infants under three months enrolled with a PHO Goal: 98% Māori and Non-Māori. Current rates: Māori 84% Pacific 82% Other 75%

System Level Measure 2:

Acute bed days: Improved management of demand for acute care

Improvement milestones:

- 3% reduction for Māori populations by 30 June 2020
- 3% reduction for Pacific populations by 30 June 2020

Baseline data analysis:

- The overall top issues by bed duration are stroke, respiratory, hip fractures and heart failure.
- Top issues for Māori include chronic obstructive pulmonary disease and smoking.
- Current Acute Bed Day rate:

	Standardised Acute Bed Days per 1000 Population		
Year	**Year to Dec 2016**	**Year to Dec 2017**	**Year to Dec 2018**
Māori	664	677	701
Pacific	628	514	599
Other	437	432	432
Total	477	471	478

Care Management

	Rationale	Activity	Contributory measure
1.	Reducing unplanned acute admissions can therefore be interpreted as an indication of improving quality of care, in the hospital and/or primary care, ensuring that people receive better health and disability services. Māori are overrepresented in ASH conditions.	A new COPD pathway will be established to support patients in the community and avoid hospital admissions. This programme will target Māori and Pacific patients who would otherwise be seen in ED. Māori patients with ASH conditions (e.g. CHF, CVD,COPD, AF/ Stroke and Cellulitis) receive appropriate clinical support: • Māori patients who are eligible for a flu vaccine are targeted. • Management of Māori patients with raised CVD risk as appropriate clinical practice should result in fewer IHD and CVD admissions.	Number of 75+ year olds 'Other' with two or more emergency admissions. Number of 65+ year old Māori and pacific with two or more emergency admissions. Seasonal target of 75% of eligible Māori patients receive the flu vaccine. ASH rate for Māori adults aged 45-64 years old. Target 2% reduction.

Smoking			
	Rationale	Activity	Contributory measure
2.	Respiratory illness and its complications are a key issue for acute bed day use that we expect to be impacted by activities in smoking cessation and adult vaccination in particular for influenza in eligible populations.	Public Health Unit to work with Primary Care to partner around health literacy and messaging to improve flu vaccine uptake. PHOs and Community Pharmacy will refresh their focus on smoking cessation with new resources to support practices. Patient outcomes related to harm from smoking will be improved by: • Regular reporting rates and referrals to cessation support and rates of medication therapy in primary care. • Use of a surveillance report to monitor smoking prevalence by ethnicity and age. The importance of smoking cessation as an intervention will be promoted by: • Continued working with cessation providers, including pharmacy, to strengthen relationships and enable access and integrated approaches to care alongside primary and community services • Further development of smoking indicators for quality, to inform primary care approaches and interventions from PMS.	Flu vaccination rates in eligible population. Baseline influenza vaccine coverage for patients with an eligible ASH condition and establish an improvement target. 15 to 74 year old PHO enrolled population who have had a smoking status of current smoker within the last 15 months. ASH rate for Māori adults aged 45-64 years old. Target 2% reduction. PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months.
Acute demand management programme			
	Rationale	Activity	Contributory measure
3.	Acute Demand is driven by a range of conditions. A strategic approach to acute demand management requires continual demand/capacity oversight and continuous quality improvement across our system of delivery.	As a result of the review of POAC, a cross sectoral Quality Improvement Group has been established to drive improvements across the POAC programme in real time to improve admission avoidance. This group will: Systematically review ED presentations and ASH data to improve patient care pathways through the POAC quality improvement group. • Establish baseline data. • Seek quality improvement across services. • Add or delete activity aligned with acute demand.	Decrease in ASH by 5% for Māori and Pacific.

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:

- Improve same day response in primary care to 8.5 for all patients
- Improve understanding of medication use by patients (by ethnicity) by 10% for national patient survey

Baseline data analysis:

- PHO patient portal access – Total patients **registered** / Total patients enrolled 10.2%
- Patient survey results show
  - 7.6 same day response for Māori and 8 for non-Māori
  - 9 for purpose of medications explained 9 for Māori and non-Māori (PHO)

Primary Care

	Rationale	Activity	Contributory measures
1.	Patient experience is a vital but complex area. Growing evidence tells us that patient experience is a good indicator of the quality of health services. Better experience, stronger partnerships with consumers, and patient and family-centered care have been linked to improved health, clinical, financial, service and satisfaction outcomes. Patient e-portals are secure online sites provided by GPs where people can access their health information and interact with their general practice. Using a patient e-portal, people can better manage their own health care.	Obtain baseline data for current numbers and usage. Baseline data has not been used to date when looking at PES data across the PHOs. Evidence shows that to have an effective portal 40% utility is required. Review the process for signing up to the relevant primary care portal, to make it easy for consumers noting that My Health requires consumers. Improvements will be made where required (easy access, less cost). Develop an integrated communication plan (with PHO, GP practices, community pharmacy, NGOs, Māori providers, inpatient and outpatient services (Waikato and rural hospitals) – a separate plan will be required for consumers and staff.	Increased patient portal. Number of patients registered to use general practice portals. Total patients registered/Total patients enrolled.

Primary Care (continued)			
	Rationale	Activity	Contributory measures
1.		Messaging, as part of the communications plan, will show benefits of using the system for consumers / make them excited to use. Likely to include: • Answer phone message • Social media campaigns • Newspaper adverts • ED campaigns (on discharge ask 'have you signed up') • Community providers • Hauora ihub Publicise the portal at planned wellness expo. Target Waikato DHB and PHO staff to join the portal.	
Medicines knowledge			
	Rationale	Activity	Contributory measures
2.	One of the consistently low scoring questions in the patient experience survey is that patients are not being told of the side effects of prescribed medications. This is an opportunity to improve.	Using a PDSA cycle with measures incorporated will allow us to test a number of interventions that might improve the patients understanding of medication. Establish a multidisciplinary working group (Primary care, pharmacy, secondary care, consumers, Māori providers) to: • Develop terms of reference and scope of an improvement project. • Review data – ethnicity/age etc. • Review international innovation best practice. • Define roles for medication safety – who does what from prescribing through to taking. Develop improvement plan by 30 November 2019. Pilot improvement project in chosen community setting e.g. Thames or Tokoroa. Utilise HQSC leaflets and posters (5 questions to ask about your medications).	Pilot results.

System Level Measure 4:

Amenable mortality: Reduction in the number of avoidable deaths and reduced variation for population groups

Improvement milestones (age standardised):

- For Māori and Pacific reduce amenable mortality rates by a total of 4% and sustain by 30 June 2023 (*this is when 2019/20 data will be available)
- For other reduce total amenable mortality rates by 2% and sustain by 30 June 2023

Baseline data analysis:

- Milestone baseline data from 2014/15
- Increase the proportion of patients assessed for risk of suicide in primary care
- Risk management in those with a CVD RA score of ≥ 15%

Coronary/CVD

	Rationale	Activity	Contributory measures
1.	Amenable mortality in the latest figures available (2015) shows Māori inequity at its starkest. In Waikato Māori amenable mortality numbers show a preponderance towards cardiovascular diseases. Well supported practices that are connected to their communities and have the right systems in place have the best opportunity to identify and engage with eligible patients, particularly Māori in their communities. With Māori men being at high risk for CVD this work will specifically target this population group. Modification of risk factors through self-management, lifestyle and pharmaceutical interventions has been shown to significantly reduce mortality and morbidity in people with diagnosed and undiagnosed CVD and diabetes.	Clinical Health pathways are implemented and accessed. PHOs will provide information to their practices that will enable GPs to see their population more clearly. PHOs will incentivise GP practices to provide CVRA. PHOs will educate general practice teams in Equally Well approaches to improve access for Māori men with serious mental health issues to CVRA. Implement a process to ensure all PHOs have an electronic decision support tool that will have the ability to calculate and update CVD risk consistent with the National Consensus Statement for Assessment and Management of CVD in Primary Care.	Clinical Health pathways rates of access. CVRA rates Māori males 30-44+ and rate of those with a > 15% risk with a management plan. CVRA rates for Māori. Target 90% Percentage of Māori with a previous CVD event who are prescribed triple therapy. Target 60%

Diabetes			
	Rationale	Activity	Contributory measures
2.	Diabetes affects 6% of the enrolled population with Māori and Pacific disproportionately represented at 6% and 11% respectively. Only 42% of diabetics have their HbA1c levels managed adequately and Māori and Pacific are once again overrepresented in these figures. (Figures as at Q3 2018/19) Focusing on diabetes management through the following activities will reduce these inequities as well as overall morbidity and mortality.	Incentivising the improvement activity at practice level around diabetes management through a quality plan. These plans will incorporate the following initial activity: • Upskilling of practice nurses to help manage more complex diabetic patients. • Provision of prioritised lists to practice of patients who need to be targeted for better control of diabetes with Māori and Pacific prioritised. • Referral of Māori to culturally appropriate providers for self-management and support.	Reducing the equity gap between Māori and non-Māori in respect to HbA1c result less than 64mmol/mol. Target: Total population should be >60%. Equity gap between Māori and non-Māori and wider population no greater than 10%.

System Level Measure 5:

Babies living in smoke free homes: Reduction in the number of maternal smoking as well as the home and whānau/family environment

Improvement milestones:

- A reduction in the equity gap between Māori and non-Māori living in a smoke free household at 6 weeks from 34% to 17%.
- Increase referrals to maternal incentives smoking cessation programmes by 10% for pregnant women and whānau.

Baseline data analysis:

- While the overall percentage of babies living in a smoke-free household hovers around 72%-74% for the Waikato, huge inequity exists in this measure. As little as 50% of Māori babies in the Waikato live in a smoke-free household as opposed to 84% of non-Māori, non-Pacific babies.
- This SLM is important because it focuses attention on maternal smoking as well as the home and whānau/family environment. For these to be a success, stop smoking support and services need to be available across the lifespan and therefore our contributory measures are focused across the different stages of the pregnancy pathway.

Pregnancy

	Rationale	Activity	Contributory measures
1.	Equity: Significant equity gap between Māori and NZ European. This measure targets Māori results to enhance equity focus for monitoring and activity. Utilisation and access: Low numbers accepting referrals to smoking services. Smoking during pregnancy leads to increased carbon monoxide concentration in the blood of both the mother and her baby, resulting in reduced oxygen and nourishment available to the baby. This increases the risk of babies being born with a low birth weight and increases the risk of neonatal mortality, sudden and unexpected death in infancy and long-term respiratory problems for the child.	Develop a robust process for referral of pregnant women to smoking cessation programmes from LMC/GP/WCTO. Develop a toolkit that would enable the use of the Tupeka Kore framework to be rolled out in primary care (LMCs/GPs/Well Child Tamariki Ora). Hapu Mama (our District wide maternity support programme for pregnant Māori women) will have increased capacity for smoking cessation support for pregnant mums. Initial activity will include: • Increased focus on being smoke free during pregnancy and providing stop smoking support and/or referral to Once and for All Stop Smoking Service. • Provide incentives to stop smoking for hapū mama.	Smoking cessation referral rates for Māori and Pacific. Target 10% increase. Enrolment rates into smoking cessation programme. Smoking rates of postnatal women and households at 6 weeks (by Māori, Pacific, Other and Total). Smoking cessation programme completion rates for Māori and Pacific will increase by 25%.

Lifespan			
	Rationale	Activity	Contributory measures
2.	Placing the spot-light on particular data sets has resulted in data quality improvement in the past and it is anticipated this will occur for these datasets as well. Locally we have limited across sector access to regular robust data and the focus for 2019/20 activity is on data quality and monitoring to capture our denominator data accurately.	The DHB will roll out training to Tamariki Ora providers and monitor their smoking cessation referral rates.	Smoking rates of postnatal women and households at 6 weeks (by Māori, Pacific, Other and Total). Referral and programme completion rates to be audited by DHB.

System Level Measure 6:

Youth: Intentional self-harm hospitalisations including short-stay hospital admissions through Emergency Department for 10-24 year olds'.

Improvement milestone:

- 5% reduction in intentional self-harm hospitalisations including short-stay hospital admissions through Emergency Department for 10-24 year old

Baseline data analysis:

- Waikato rates are generally increasing and Waikato's rate is higher than the national rate

Ethnicity	Waikato rate (per 10,000)	National rate (per 10,000)
Māori	72.3	67
Pacific	25.7	35.3
Other	61.2	49.8
Total	63.3	52.2

	Rationale	Activity	Contributory measures
1.	Poor understanding of current youth service availability and quality. To achieve health equity for youth, primary to tertiary services need to be accessible, appropriate and effective. The Waikato DHB region has no up to date needs assessment for youth in our region. Improved access to quality of care is required for youth in the Waikato region. Focus is on increased collaboration, enhanced understanding of youth needs and youth service provision, and increasing opportunities for alignment.	Waikato DHB to provide workforce development for school based nurses and GPs on identification and referral pathways for self-harm.	10% increase in referrals to youth primary mental health services.

Appendix

2019/20 SYSTEM LEVEL MEASURES (SLM) WORKING GROUP
TERMS OF REFERENCE

Purpose

The purpose of the SLM working group is to bring together local experts across the sector to collaborate and recommend the following for the 2019/20 measure

- An improvement milestone
- Quality improvement activities to achieve system level measure improvement
- Contributory measures that allow monitoring of progress

Specific responsibilities

- Identifying improvement milestone (Where we want to be)
- 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?)
- 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
- Oversee activity agreed that will impact the milestones

Outside of scope

- 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 whānau, 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 were established in May 2017

Terms of membership

Each PHO operating in the Waikato District have been asked to provide a representative. Representatives from appropriate providers and the DHB are also included. Membership may change dependent on each organisations desired attendee. 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

The SLM working group will meet quarterly for the purpose of monitoring implementation.
Smaller working groups responsible for implementation will meet at the leads discretion.

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 DMG make final recommendations to Inter-Alliance.

Governance

Waikato DHB's executive leads for SLM are:

- Damian Tomic – Clinical Director, Primary and Integrated Care
- Tanya Maloney – 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
   Youth access to and utilisation of youth-appropriate health services

2. Demand Management Advisory
   Acute hospital bed days per capita
   Amenable mortality

3. Inter-Alliance
   Patient Experience of Care

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.