System Level Measures Improvement Plan

Auckland, Waitemata & Counties Manukau Health Alliances

2017 2018

FINANCIAL YEAR

***Tawhiti rawa tō tātou haerenga te kore haere tonu, maha rawa wā tātou mahi te kore mahi tonu*.**

We have come too far to not go further and we have done too much to not do more.

– Sir James Henare

Photo Credit (cover): John Hettig Westone Productions

CONTENTS

Version	Date	Updates
Final Draft with MOH revisions	**20 October 2017**	**Endorsed by ALTs, Submitted to Ministry of Health.** **Updated Milestone for proportion of babies who live in a smoke-free household at six weeks postnatal.** **Refinement of three contributory measures to two and reorganisation of actions under contributory measures for the above SLM.** **Update of Executive Summary Table as a result of changes.**
Final Draft	**30 June 2017**	**Endorsed by ALTs, Submitted to Ministry of Health**

1. EXECUTIVE SUMMARY

The Counties Manukau Health and Auckland Waitemata Alliance Leadership Teams (the Alliances) have jointly developed a 2017-18 System Level Measures Improvement Plan.

Continuing with the *one team* theme in the New Zealand Health Strategy, the joint approach to development of the single improvement plan will ensure streamlined activity and reporting, and best use of resources within the health system. Building on the work outlined in the 2016-17 System Level Measures Improvement Plan, in 2017-18, improvement milestones and contributory measures for each of the system level measures (SLMs) have been prioritised, in recognition of the significant amount of activity needed to make meaningful change for each measure.

The Alliances are firmly committed to including more contributory measures over the medium to longer term, once the structures, systems and relationships to support improvement activities are more firmly embedded. This plan reflects a strong commitment to the acceleration of Māori health gain and the elimination of inequity for Māori.

The district health boards (DHBs) included in this improvement plan are:

- Auckland DHB;
- Waitemata DHB, and
- Counties Manukau DHB.

The primary health organisations (PHOs) included in this improvement plan are:

- Alliance Health Plus Trust;
- Auckland PHO;
- East Health Trust;
- National Hauora Coalition;
- ProCare Health;
- Total Healthcare PHO, and
- Comprehensive Care.

The diagram below shows an overview of the measures chosen for this improvement plan.

AMBULATORY SENSITIVE HOSPITALISATIONS 0-4 YEARS

Improvement Milestone

5% reduction in rate by June 2018

- Māori children fully immunised by 8 Months of Age
- Skin Infections
- Oral Health
- Respiratory Conditions Potentially Prevented by Special Immunisations

Keeping children out of hospital

ACUTE HOSPITAL BED DAYS

Improvement Milestone

2% reduction – 438.7 standardised acute bed days/1000 by June 2018

3% reduction for Māori populations – 604.6 standardised acute bed days/1000 by June 2018

3% reduction for Pacific populations – 729.6 standardised acute bed days/1000 by June 2018

- Emergency Department Attendance Rate
- Acute Readmission Rates in 28 Days

Using health resources effectively

PATIENT EXPERIENCE OF CARE

Improvement Milestones

PHC Patient Experience Survey: 50% of each PHO practices participating in the Primary care survey by June 2018

Hospital inpatient survey: Aggregate score of 8.5 across all four domains measured

- District Health Board Inpatient Survey
- E-portals
- Participation in PHC Patient Experience Survey

Ensuring patient-centred care

AMENABLE MORTALITY

Improvement Milestone

6% reduction for each DHB (on 2013 baseline) by June 2020

- Cardiovascular Disease Risk Assessment (CVD RA) for Māori
- Cardiovascular Disease Management
- Smoking Cessation

Preventing and detecting disease early

YOUTH ACCESS TO AND UTILISATION OF YOUTH-APPROPRIATE HEALTH SERVICES

Improvement Milestones

Sexual and reproductive health: 80% of pregnant women 15-24 years are screened for chlamydia during pregnancy

Other domains: Establish baselines

- Development of Future Sexual and Reproductive Health Contributory Measures
- All Pregnant Women are Screened for Chlamydia
- Chlamydia Burden of Disease
- Health Care Utilisation by 15–24 year olds
- Participation in Child and Adolescent Mental Health Services Mārama Real-Time Survey
- Development of Baseline Data for Youth Domains

Youth are healthy, safe and supported

PROPORTION OF BABIES WHO LIVE IN A SMOKE-FREE HOUSEHOLD AT SIX WEEKS POST-NATAL

Improvement Milestone

Reduce missing smokefree household data to <10% by June 2018

- Better help for smokers to quit – pregnancy health target
- Maternal Smokefree Services
- Household Smoking Cessation
- Maternal Smoking Prevalence Data

Healthy start

2. PURPOSE

This document outlines how the 2017-18 SLM Improvement Plan will be applied across the Metro Auckland region. It summarises how improvement will be measured for each SLM and the high-level activities that will be fundamental to this improvement. Please note that, as further discussed in section 3.2, implementation planning will be developed to sit under this document to provide a higher level of detail.

3. BACKGROUND

The New Zealand Health Strategy outlines a new high-level direction for New Zealand's health system over the next 10 years to ensure that all New Zealanders live well, stay well and get well. One of the five themes in the strategy is 'value and high performance' 'te whāinga hua me te tika o ngā mahi'. This theme places greater emphasis on health outcomes, equity and meaningful results. Under this theme, the Ministry of Health has been working with the sector to develop a suite of SLMs that provide a system-wide view of performance. The Alliances are required to develop an improvement plan for each financial year in accordance with Ministry of Health expectations. The improvement plan must include the following:

a) Four SLMs, which were implemented from 1 July 2016:
   - ambulatory sensitive hospitalisation rates per 100,000 for 0 – 4 year olds;
   - acute hospital bed days per capita;
   - patient experience of care, and
   - amenable mortality rates.

b) Two developmental SLMs, to be implemented from 1 July 2017:
   - youth access to and utilisation of youth-appropriate health services, and
   - proportion of babies who live in a smoke-free household at six weeks post-natal.

c) For each SLM, an improvement milestone to be achieved in 2017-18. The milestone must be a number that either improves performance from the baseline or reduces variation to achieve equity.

d) For each SLM, a set of contributory measures which show a clear line of sight to the achievement of the improvement milestones, have clear attribution and have been validated locally.

3.1 Process

In 2016, the Counties Manukau Health and Auckland Waitemata Alliances agreed to a joint approach to the development of the System Level Measures Improvement Plan. This included the establishment of a Metro Auckland steering group and working groups for each SLM. Steering group membership includes senior clinicians and leaders from the seven PHOs and three DHBs. The steering group is accountable to the Alliances and provides oversight of the overall process.

Working groups are responsible for drafting contributory measures and identifying the related interventions to be included in the implementation planning. Each working group is chaired by a PHO lead. Working group membership consists of senior primary care and DHB clinicians, personnel and portfolio managers. Groups have public health physician support. This year, there has been further work to involve other areas of the sector in the working groups including pharmacy and maternity.

The steering group and working groups will continue to meet in 2017-18, in order to further develop key actions (particularly at a local level), monitor data, and guide the ongoing development of the SLMs.

In 2016, working groups completed in-depth analytics to inform development of the improvement plan. This was built upon again in the development of the 2017-18 plan. The selection of contributory measures and activities was guided by the impact that measures could have on each SLM, current activity or models of care in an area, and amenability of a contributory measure to change. The process also included a review of national and regional data, analysed by DHB, facility, ethnicity, deprivation and condition. The groups considered both an overarching approach and a condition-specific approach for each SLM. Among the factors considered were the number of hospitalisation events (as well as rates), readmission rates, bed days, general practitioner (GP) visits, DHB inpatient experience survey rates, condition specific amenable mortality rate recent trends, and evidence to support improvement activities and the ability to address equity gaps.

Working groups have engaged with key stakeholders in the process of drafting and selecting contributory measures. In 2017, this included engaging more broadly than primary and secondary care; in particular, the babies in smoke-free households SLM working group included pharmacy and maternity stakeholders. Stakeholder engagement included a sector-wide socialisation workshop, cultural consultation workshops, and a presentation of draft measures, milestones and interventions to the Alliances. Feedback received from the engagement sessions was incorporated into development of the improvement plan.

This plan reflects a strong commitment to the acceleration of Māori health gain and the elimination of inequity for Māori. Each working group has been tasked with considering the role of equity for their particular measures, and providing measures and activities that promote improvement for those most disadvantaged.

The 2017-18 Improvement Plan has been shared with the Māori, Pacific and Asian health teams at Auckland, Counties Manukau and Waitemata DHBs and their feedback has been incorporated. The Māori health gain teams across the region were invited to workshop the final draft of the plan and provided valuable input. The 2017-18 SLM Improvement Plan has been designed to align with the Auckland and Waitemata DHBs Māori Health Plan and the Counties Manukau DHB Maaori Health Plan. Consultation with the relevant cultural groups and equity partners has been an essential part of this process.

Reporting processes, both at a local and regional level, are in development. The data to inform this reporting will comply with the Metro Auckland Data Sharing Framework, agreed by the Alliances in 2015.

3.2 Regional Working

As in 2016-17, a single improvement plan has been developed in 2017-18 for the Alliances and three Metro Auckland DHBs. The rationale for this is that a number of PHOs cross the Metro Auckland DHB boundaries and are members of both Alliances. It was not considered to be practicable or achievable, given limited resources, to have two improvement plans with different contributory measures. Improvement milestones and contributory measures have been carefully selected to take into account the context, population and current performance of each DHB in the wider Auckland region. One regional plan also promotes closer regional collaboration between stakeholders, and ensures that patient outcomes are promoted in a consistent way.

4. SYSTEM LEVEL MEASURES IMPROVEMENT PLAN

The following section outlines the specific improvement plan for each of the six SLMs for 2017-18. For each, a system level milestone is set. Under these milestones, contributory measures provide the structure which direct and measure improvement activity. This ensures activities support the improvement of the system as a whole, and the milestone in particular.

4.1 Ambulatory Sensitive Hospitalisation Rates per 100,000 for 0 – 4 Year Olds

<table>
<tr><td>System level outcome</td><td colspan="4">Keeping children out of hospital</td></tr>
<tr><td>Improvement milestone</td><td colspan="4">5% reduction in total rate by 30 June 2018</td></tr>
<tr><td>Baseline</td><td colspan="4">Ambulatory sensitive hospitalisation rates for 0-4 year olds, by DHB and ethnicity (per 100,000 population) 12 months to September 2016:

<table>
<tr><th>DHB</th><th>Other</th><th>Māori</th><th>Pacific</th><th>Total</th></tr>
<tr><td>Auckland</td><td>6,071</td><td>8,025</td><td>14,379</td><td>7,661</td></tr>
<tr><td>Waitemata</td><td>4,879</td><td>5,940</td><td>10,825</td><td>5,694</td></tr>
<tr><td>Counties Manukau</td><td>4,789</td><td>6,264</td><td>11,977</td><td>7,109</td></tr>
<tr><td>Metro Auckland</td><td>5,213</td><td>6,494</td><td>12,305</td><td>6,758</td></tr>
</table></td></tr>
<tr><td>Rationale and context</td><td colspan="4">Ambulatory sensitive hospitalisations are admissions considered potentially preventable through prophylactic or therapeutic interventions in primary care. The admissions included are made up of a specified set of discharge codes considered to be ambulatory sensitive, and are assigned based on the primary diagnosis assigned. This is a challenging indicator as social determinants of health are a significant contributor. The amount realistically amenable to timely access to quality primary care has not been quantified and there is little evidence about what works outside of immunisation for vaccine preventable diseases. Despite these challenges there are many promising approaches that could be taken.

Exposure to smoking and quality of housing has an impact on this measure; the intention is to recognise the linkages to existing smoke-free activity in the amenable mortality SLM and with the babies in smoke-free households SLM.

Overarching activities
Connect this work with the Better Public Services target Keeping Kids Healthy: ‘By 2021, a 25% reduction in the rate of hospitalisations for avoidable conditions in children aged 0 - 12 years, with an interim target of 15% by 2019’. The avoidable hospitalisations include dental conditions, respiratory conditions (such as bronchiolitis, pneumonia, asthma and wheeze), skin conditions (such as skin infections, dermatitis and eczema), and head injuries.</td></tr>
<tr><td>Linkages</td><td colspan="4">Ambulatory sensitive hospitalisation rates: See the Access to Care section of the Auckland DHB and Waitemata DHB Māori Health Plan and the Hospitalisations section of the Counties Manukau DHB Maaori Heath Plan for more information.
Immunisation: See the Immunisation sections of the Auckland DHB and Waitemata DHB Māori Health Plan, Counties Manukau DHB Maaori Heath Plan and the Increased Immunisation Better Public Service and Health Target in the Auckland DHB, Counties Manukau DHB and Waitemata DHB annual plans for more information.
Oral health: See the Oral Health sections of the Auckland DHB and Waitemata DHB Māori Health Plan and Counties Manukau DHB Maaori Health Plan and the Child Health section of the Auckland DHB, Counties Manukau DHB and Waitemata DHB annual plans for more information.</td></tr>
<tr><td colspan="5">Contributory measures</td></tr>
<tr><td></td><td>Rationale</td><td>Current state</td><td>Target future</td><td>Improvement activities</td></tr>
</table>

<table>
<tr><td></td><td></td><td></td><td>state</td><td></td></tr>
<tr><td>Māori Children Fully Immunised by 8 Months of Age</td><td>Immunisations are required to prevent serious communicable childhood illnesses, which can lead to hospitalisations. Despite great progress there is still an equity gap for Māori babies.

This target may support maintenance or lowering of vaccine preventable disease rates and related hospitalisations, including for rotavirus/gastrointestinal and pneumococcal pneumonia.

This is a National Health Target.</td><td>Immunisation rate for babies 8 months of age, Q1 2016/2017, by PHO (enrolled patients):

<table><tr><th>PHO</th><th>Total</th><th>Māori</th></tr><tr><td>Alliance Health Plus</td><td>93%</td><td>89%</td></tr><tr><td>Auckland PHO</td><td>92%</td><td>88%</td></tr><tr><td>East Health Trust</td><td>96%</td><td>96%</td></tr><tr><td>National Hauora Coalition</td><td>95%</td><td>92%</td></tr><tr><td>ProCare Networks</td><td>93%</td><td>88%</td></tr><tr><td>Total Healthcare Charitable Trust</td><td>94%</td><td>86%</td></tr><tr><td>Comprehensive Care</td><td>93%</td><td>91%</td></tr></table></td><td>95% of Māori babies fully immunised by 8 months of age.</td><td>Current immunisation programme (primary care coordinators, general practice systems, outreach immunisation service, Māori and Pacific providers, secondary care).
Continue to develop specific activity to improve Māori coverage (including ways to improve timeliness of immunisation), with leadership from Māori health gain teams and Māori leaders within primary care.
Develop links between immunisation outreach services and Māori Tamariki Ora providers to improve immunisation coverage for their enrolled children.
Investigate the possibility of Well Child Tamariki Ora nurses providing immunisation.
Utilise Whānau Ora services for immunisation of hard to reach children.
Promote immunisation in antenatal classes.
Investigate whether significant numbers of Māori babies are not engaged with general practice, with a view to include improvement activities to connect Māori whānau into the current newborn enrolment work.</td></tr>
<tr><td>Skin Infections</td><td>There are high and growing rates of serious skin infections in Metro Auckland, particularly for Māori and Pacific and those living in areas of high deprivation. Skin infections have not received sufficient attention in primary care and community settings.

The proportion of ASH admissions due to skin infections is higher (nearly double at 14%)</td><td>Skin infection subset of ambulatory sensitive hospitalisation data (per 100,000 population), 12 months to September 2016*:

<table><tr><th>DHB</th><th>Other</th><th>Māori</th><th>Pacific</th><th>Total</th></tr><tr><td>Auckland</td><td>371</td><td>1,432</td><td>2,323</td><td>812</td></tr><tr><td>Counties Manukau</td><td>334</td><td>1,288</td><td>2,195</td><td>1,073</td></tr><tr><td>Waitemata</td><td>467</td><td>1,248</td><td>2,306</td><td>800</td></tr><tr><td>Metro Auckland</td><td>399</td><td>1,303</td><td>2,226</td><td>907</td></tr></table>*Cellulitis and dermatitis/eczema dataset via Ministry</td><td>Reduction in hospitalisation rate by 5% by 30 June 2018 (compared to baseline).</td><td>These activities build on those already developed by the skin infection working group of the regional Child Health Network.
Delivery of an educational package for skin infections to primary care, urgent care, Well Child Tamariki Ora services, and early childhood education centres. Use forums such as the Pacific Community Child Health Network (managed by TAHA, the Well Pacific Mother and Infant Service) to reach community groups.
Use DHB nurse educators and other health</td></tr>
</table>

<table>
<tr>
<td></td>
<td>in Metro Auckland than elsewhere in New Zealand.

Although resources are available, there is not consistent access to or use of resources across the system. In addition there is a lack of consistent messaging and interventions. There is potential to improve opportunities for prevention, early detection and treatment in primary care..

The Northern Regional Child Health Skin Infection Project has undertaken significant developmental work in this area. The resources and enablers could be more systematically applied and delivered in primary and community settings.</td>
<td>of Health SI1 Quarterly data</td>
<td></td>
<td>promotion resources in a coordinated way, so that health promotion messages reach early childhood education centres and other organisations that connect with families of young children. Currently Counties Manukau DHB and Auckland DHB have nurse educators; Waitemata DHB does not.
• Link in to early childhood education centre health promotion activities delivered Auckland Regional Public Health Service.
• Consider further development of primary care skin clinics.
• Consider new approaches for providing access to care, e.g. community outreach, pharmacies, parish nurses.
• Consider the opportunities for community pharmacy to provide more education on the best use of topical and oral products.
• Consider targeted outcomes for Pacific and Māori children.</td>
</tr>
<tr>
<td>Oral Health</td>
<td>Poor oral health is a significant and increasing health issue for Pacific (Tongan in particular) and Māori children.

Poor oral health outcomes lead to dental decay, extractions and general anaesthetics. Dental decay is linked to range of other health conditions.

There are opportunities in primary care to provide health promotion messages and address barriers to care for Pacific children, and link with messaging in the child healthy weight space.

Although enrolment is not an ideal measure, further measures</td>
<td>Percentage of pre-school children enrolled in DHB-funded oral health services, 2016 calendar year:

<table>
<tr><th>DHB</th><th>Other</th><th>Māori</th><th>Pacific</th><th>Total</th></tr>
<tr><td>Auckland</td><td>86.6%</td><td>64.8%</td><td>84.4%</td><td>83.3%</td></tr>
<tr><td>Counties Manukau</td><td>90.0%</td><td>73.2%</td><td>85.9%</td><td>84.7%</td></tr>
<tr><td>Waitemata</td><td>100%</td><td>71.9%</td><td>80.3%</td><td>93.0%</td></tr>
<tr><td>Metro Auckland</td><td>93.7%</td><td>71.2%</td><td>84.4%</td><td>87.3%</td></tr>
</table>
</td>
<td>95% enrolment with oral health services amongst preschool children.</td>
<td>From the Draft 2017 Pre-school Oral Health Strategy:
• Oral health promotion at national, community and individual level. Focus on Pacific churches and parenting groups.
• Messaging to align with Raising Healthy Kids National Health Target.
• Increase awareness of free dental services.
• Upskill primary care, Well Child Tamariki Ora and secondary care providers in lift-the-lip assessments, knowledge of dental services and referral processes.
• Engage with the newborn enrolment project, which is: implementing systems to refer newborns for enrolment with the National Immunisation Register, general practice, oral health providers, Well Child Tamariki Ora providers and newborn hearing screening services.</td>
</tr>
</table>

	will be developed over the coming year.			• Increased number of extended hours and Saturday dental clinics in appropriate locations. • Consider a targeted intervention for Pacific and Māori children to address inequity.

Respiratory Conditions Potentially Preventable by Special Immunisations	This measure provides an opportunity to have a more coordinated and focused approach to doing special immunisations for children, thereby reducing hospitalisations for relevant respiratory illness and preventing readmissions.
	
	Vaccination of pregnant women is a Ministry of Health priority, especially for pertussis for newborns who are too young to be vaccinated. Current uptake is low (around 20%) and many women are unaware.
		Baseline setting year.	Increase flu vaccination coverage by (absolute) 10% for children aged 0-4 who are hospitalised for respiratory illness.
			
			Establish baseline data to measure pertussis and flu vaccines coverage rates for pregnant women.
				• Develop the current activity to identify and vaccinate all children aged 0–5 who qualify for the free influenza vaccine.
				• Build on current activity to support both influenza and pertussis vaccine offer to all pregnant women, e.g. vaccinator at antenatal clinics, promotion campaigns, lead maternity carers education opportunities.
				• Undertake activities in primary and secondary care:
				  • Secondary care
				  ○ Develop a documented, consistent system for providing lists of hospitalised children to PHOs and monitoring through the Influenza season (when the vaccine is available);
				  ○ Make it mandatory to fill in the sections on discharge letters on eligibility for special immunisations, and
				  ○ Promote vaccinations to patients and their families and proactively refer patients back to GPs for vaccinations.
				  • Primary care
				  ○ Immunisation coordinators in PHOs provide education to general practice staff on special immunisations while visiting practices, and
				  ○ The Immunisation Advisory Centre will provide education and support to general practice, to improve understanding of who is

				eligible for special immunisations and to enhance processes for identification and recall, through continuing medical and nursing education sessions. • Develop systems for measuring the impact of these activities, e.g. on readmissions for respiratory illness. • Consider the feasibility of offering Influenza vaccination to all children aged 0-4 years. • Pregnancy related immunisations: develop data definitions and agreed consistent process steps and monitoring points.

4.2 Acute Hospital Bed Days per Capita

<table>
<tr><td>System level outcome</td><td colspan="5">Using health resources effectively</td></tr>
<tr><td>Improvement milestone</td><td colspan="5">2% reduction for total population – 428.9 standardised acute bed days/1000 by June 2018
3% reduction for Māori populations – 604.6 standardised acute bed days/1000 by June 2018
3% reduction for Pacific populations – 729.6 standardised acute bed days/1000 by June 2018</td></tr>
<tr><td>Baseline</td><td colspan="5">Acute hospital bed days per capita, (age standardised) year to September 2016, by ethnicity:

<table>
<tr><th>DHB</th><th>Other</th><th>Māori</th><th>Pacific</th><th>Total</th></tr>
<tr><td>Auckland</td><td>375.7</td><td>595.8</td><td>851.1</td><td>433.6</td></tr>
<tr><td>Counties Manukau</td><td>370.2</td><td>690.8</td><td>710.1</td><td>460.1</td></tr>
<tr><td>Waitemata</td><td>390.3</td><td>554.8</td><td>730.6</td><td>422.3</td></tr>
<tr><td>Metro Auckland</td><td>380.4</td><td>623.3</td><td>752.2</td><td>437.7</td></tr>
</table></td></tr>
<tr><td>Rationale and context</td><td colspan="5">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. 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. We will achieve a greater reduction in bed days for higher risk populations via targeted initiatives to improve the health status of Māori and Pacific peoples in particular. Specific milestones for these populations are higher due to the inequity when compared to the total population.

We plan to target populations most likely to be admitted or readmitted to hospital, and focus on conditions that contribute most to acute hospital bed days. Conditions identified as highest priority are Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD) and the frail elderly. Risk stratification to identify patients at highest risk of readmission will be undertaken by Counties Manukau Health stakeholders and explored by those in Auckland and Waitemata DHBs.</td></tr>
<tr><td>Linkages</td><td colspan="5">Emergency department attendance rate: See the Shorter Stays in Emergency Departments Health Target and the Primary Care Integration section in the Auckland DHB and Waitemata DHB annual plans for more information. Acute hospital readmission: See the Primary Care Integration section in the Counties Manukau DHB Annual Plan for more information.</td></tr>
<tr><td colspan="6">Contributory measures</td></tr>
<tr><td></td><td>Rationale</td><td colspan="2">Current state</td><td>Target future state</td><td>Improvement activities</td></tr>
<tr><td>Emergency Department (ED) Attendance Rate</td><td>Overall reduction in ED presentations will result in fewer admissions and lower bed day use.

Improving the appropriate use of Primary Options in Acute Care (POAC) should reduce ED attendance. Currently there is wide variation in POAC use at</td><td colspan="2">ED attendance per 1000 population by ethnicity (standardised), 12 months to 30 September 2016:

<table>
<tr><th>DHB</th><th>Other</th><th>Asian</th><th>Māori</th><th>Pacific</th><th>Total</th></tr>
<tr><td>Auckland</td><td>196.9</td><td>170.1</td><td>260.0</td><td>351.1</td><td>206.0</td></tr>
<tr><td>Counties Manukau</td><td>187.0</td><td>135.9</td><td>283.3</td><td>337.6</td><td>215.4</td></tr>
<tr><td>Waitemata</td><td>224.1</td><td>150.6</td><td>275.3</td><td>382.9</td><td>222.3</td></tr>
<tr><td>Metro Auckland</td><td>206.1</td><td>150.2</td><td>274.0</td><td>349.3</td><td>214.3</td></tr>
</table></td><td>Reduce the ED attendance rate by 2% by June 2018 by promoting and supporting more effective use of POAC.</td><td>Primary Options in Acute Care (POAC) activities:
• Determine baseline utilisation of POAC across the region, including an ethnicity-level and a practice-level analysis.
• Identify gaps and areas for potential improvement.
• Convene expert group to determine and agree</td></tr>
</table>

	a practice level.			consistent interventions. • Monitor POAC utilisation, intervention rate and impact. • Develop and implement an education programme to promote appropriate use of POAC. • Explore current barriers to general practices using POAC. • Develop practice-level reports showing POAC usage relative to peers. Pilot new and innovative ways to encourage patients to use primary care services appropriately, e.g. social media campaigns, vouchers for after-hours care.
Acute Readmission Rates in 28 Days	Current clinical processes associated with discharge planning focus on quality of care in hospitals. The risk of readmission is partly determined by this care, but the literature also suggests that factors such as presence of a social network after discharge and the patient's capacity for managing their own care also influence the likelihood of being readmitted. The focus is on understanding the discharge planning processes that are currently undertaken in hospitals and augmenting them with interventions that support effective transitions of care. The proposed intervention involves identifying patients	Methodology for this rate currently in progress and data will be supplied once confirmed.	Target TBC, considering an equity reduction target once data is available.	• Determine baseline readmission rates by ethnicity, by PHO and across the region. • Explore the potential of risk stratification to identify patients at highest risk of readmission. • Review discharge planning processes across the hospital systems. • At the point of discharge and in primary care, target patients discharged with CHF, COPD and the frail elderly. • Encourage active follow up of patients discharged from hospital with a relatively high risk of readmission, in particular for those with CHF, COPD and the frail and elderly • Ensure that patients discharged from hospital with

	discharged from hospital who have a relatively high risk of readmission and developing a care plan with them to prevent avoidable admissions in the future. While it is expected that it will reduce the rate of readmissions, it will also provide the necessary infrastructure for risk stratification and care planning.			a relatively high risk of readmission have a patient centred care plan and, ensure Advance Care Plans (ACP) are in place, with a focus on initiating the ACP in primary care settings.

4.3 Patient Experience of Care

<table>
<tr><td>System level outcome</td><td colspan="4">Ensuring patient-centred care</td></tr>
<tr><td>Improvement milestones</td><td colspan="4">• Hospital inpatient survey: aggregate score of 8.5 across all four domains measured.
• Primary care survey: 50% of each PHO's practices (approximately 166 practices) are participating in the Primary Health Care Patient Experience Survey (PHC PES) by June 2018.</td></tr>
<tr><td>Improvement outcome</td><td colspan="4">Improved clinical outcomes for patients in primary and secondary care, through improved patient safety and experience of care</td></tr>
<tr><td>Context and rationale</td><td colspan="4">Patient experience is a good indicator of the quality of health services. Evidence suggests that if patients experience good care, they are more engaged with the health system and therefore likely to have better health outcomes. The Health Quality and Safety Commission (HQSC) patient experience survey (PES) scores domains covering key aspects of a patient's experience when interacting with health care services: communication, partnership, coordination, and physical and emotional needs.

Hospital Inpatient PES: This has been in place since 2014. A stretch milestone has been selected to improve on gains made in the 2016-17 year.

Primary Health Care PES: The PHC PES was developed more recently and has not yet been implemented widely, in part due to the slower than expected roll out of the National Enrolment Service. Before reporting on PES scores, the focus must be on ensuring participation in the PES at a PHO and practice level. This is the focus for the 2017-18 year. A milestone of 50% participation has been selected as achievable based on the PHC PES pilot evaluation and the experience of the two Auckland PHOs (ProCare and National Hauora Coalition) that participated in the PHC PES pilot. Practice participation in the PHC PES will require a great deal of developmental work by PHOs (for example, infrastructure, practice engagement, capacity building, and patient communication).</td></tr>
<tr><td>Linkages</td><td colspan="4">DHB inpatient survey: See the Improving Quality section in the Auckland DHB, Counties Manukau DHB and Waitemata DHB annual plans for more information.</td></tr>
<tr><td colspan="5">Contributory measures</td></tr>
<tr><td></td><td>Rationale</td><td>Current state</td><td>Target future state</td><td>Improvement activities (equity and communication lens)</td></tr>
<tr><td>DHB Inpatient Survey Communication Score</td><td>Communication is an essential component of patient experience of care and as such is one of the four domains that make up the PEC score.

Our focus across the three DHBs will be on communications and equity aspects in recognition of the fact the survey cannot adequately address all domains in a concentrated or focussed way. These will</td><td>DHB Inpatient Survey Results for Q1 2016-17 by domain:

<table><tr><th>Domain</th><th>Auckland</th><th>Counties Manukau</th><th>Waitemata</th></tr><tr><td>Communication</td><td>8.7</td><td>8.7</td><td>8.2</td></tr><tr><td>Partnership</td><td>8.6</td><td>8.5</td><td>8.2</td></tr><tr><td>Coordination</td><td>8.6</td><td>8.9</td><td>8.5</td></tr><tr><td>Physical and emotional needs</td><td>8.5</td><td>8.7</td><td>8.7</td></tr><tr><td>Aggregate across domains</td><td>8.6</td><td>8.7</td><td>8.4</td></tr></table></td><td>Aggregate 8.5/10 for four domains.</td><td>• Individual DHB focus areas via annual planning will be worked on at a local level. For 2017-18 there will be a particular focus on enhancing connections through improved communication and addressing equity gaps, via specific programmes and initiatives, which will be locally delivered.
• A regional DHB group for patient experience of care meets monthly via teleconference and quarterly face-to-face. The SLM Improvement Plan will become core business for this group.
• Develop long-term strategies in response to specific equity challenges (Pacific and Māori specialist team engagement), and broaden communication and conversations for patients</td></tr>
</table>

<table>
<tr>
<td></td>
<td>mirror activities already recognised as part of the district annual plans and will include aspects such as the discharge planning programme, Friends and Family Test, patient experience week improvement activities, and engagement with consumer literacy groups.</td>
<td></td>
<td></td>
<td>to improve their experience and journey of care.
• Share individual DHB learning and harness opportunities to replicate successes across Metro Auckland.</td>
</tr>
<tr>
<td>E-portals</td>
<td>E-portals can enhance patient experience by giving patients more control over ordering prescriptions, booking appointments and viewing lab results. Research shows that the use of patient portals is associated with higher patient retention rates, lower appointment no-shows, improved communication, increased trust and confidence in their healthcare providers and an increase in patients feeling that they are able to take a more active role in their health care and decision-making. This measure is linked to the Youth SLM and the potential to positively affect the youth experience of healthcare via a mode of engagement that is relevant, safe and supported.</td>
<td>E-portal implementation by PHO, February 2017 data:

<table>
<tr><th>PHO</th><th>Percentage of practices registered with a portal</th><th>Percentage of enrolled patients (18+) with login access to a portal</th></tr>
<tr><td>Auckland</td><td>40%</td><td>10%</td></tr>
<tr><td>Alliance Health Plus</td><td>66%</td><td>5%</td></tr>
<tr><td>Waitemata</td><td>42%</td><td>12%</td></tr>
<tr><td>East Health</td><td>27%</td><td>24%</td></tr>
<tr><td>ProCare</td><td>64%</td><td>15%</td></tr>
<tr><td>Total Healthcare</td><td>100%</td><td>5%</td></tr>
<tr><td>National Hauora Coalition</td><td>0%</td><td>0%</td></tr>
<tr><td>Metro Auckland</td><td>52%</td><td>13%</td></tr>
</table>

Note: later data sets will not restrict data to 18+ enrolled.</td>
<td>Increase to 55% of each PHO’s practices registered with a portal.

Increase to 15% of each PHO’s enrolled population who have login access to a portal.</td>
<td>• E-portal ambassadors and provider options will continue to be socialised amongst clinicians and consumers via PHOs and practices.
• PHO teams will provide support to practices to implement e-Portal enrolment systems.
• Portal options are explored by practices and adopted in a staged approach relative to level of clinician confidence and consumer request. These will include:
○ access to clinical data – diagnoses, notes, allergies, immunisations, lab results;
○ access to communications – messaging to doctor or nurse, repeat prescription, requesting appointments, self-scheduling;
○ access to education – condition specific information, websites with merit, self-management activities, and
○ PHOs will access resource materials and actively use these to support e-Portal implementation in practices and e-Portal uptake by patients.</td>
</tr>
<tr>
<td>Practice Participation in the PHC PES</td>
<td>Patient experience is a good indicator of the quality of primary health services. The PES is the mechanism by which this can be measured and improved. Further</td>
<td>Two Auckland PHOs participated in the PHC PES pilot (ProCare and the National Hauora Coalition). All of the National Hauora Coalition’s (12) and 25% of ProCare’s practices (53) participated.</td>
<td>50% of each PHO’s practices participate in the PHC PES</td>
<td>• Ensure socialisation of resources and support for practice-related activities, such as, PHOs follow HQSC/Ministry of Health ‘Getting Started’ resource pack and advice.
• PHOs advise Cemplicity of PHO name and contact for survey, and IT key contact to enable</td>
</tr>
</table>

	activity and input into its ongoing evaluation and modification through the Ministry of Health and the HQSC is expected in order for it to more ably serve the needs of our diverse Metro Auckland population, particularly for service users with English as a second language.			log on via email address. • Practices are supplied with and follow getting started guide and resources. • Practices provide PHO with details to appear on survey invitation email, text message and online survey. • Marketing of the survey week (one week every quarter), process and survey intent across practices is enabled. • Practices check email addresses of all patients 15 years and over and save preferences. • Follow up by PHO and practices to view real-time patient experiences and appropriately respond to request for contact or any indicated follow up required. • Once survey is closed, practices and PHOs will review the final results of the survey.

4.4 Amenable Mortality Rates

<table>
<tr><td>System level outcome</td><td>Preventing and detecting disease early</td></tr>
<tr><td>Improvement milestone</td><td>6% reduction for each DHB (on 2013 baseline) by June 2020</td></tr>
<tr><td>Baseline</td><td>Amenable mortality rate per 100,000 population (age standardised), 0–74 year olds, using New Zealand estimated resident population as at June 30:

<table>
<tr><th>DHB</th><th>2013</th><th>2009–2013</th></tr>
<tr><td>Auckland</td><td>72.9</td><td>87.5</td></tr>
<tr><td>Counties Manukau</td><td>104.4</td><td>113.0</td></tr>
<tr><td>Waitemata</td><td>65.6</td><td>74.6</td></tr>
<tr><td>Metro Auckland</td><td>80.2</td><td>89.4</td></tr>
</table>
</td></tr>
<tr><td>Context and Rationale</td><td>There were four contributory measures for the Amenable Mortality SLM for 2016-17: cardiovascular disease risk assessment (CVD RA) and management; smoking cessation; hepatitis C (identification and support to treatment); and breast screening (data matching to improve Māori coverage). Of these, only the first two contributory measures will be retained for the 2017-18 Improvement Plan. The reasons for discontinuing hepatitis C and breast screening are:
• Insufficient capacity for primary care to deliver against a large number of indicators;
• Hepatitis C is currently already in the Northern Regional Alliance workplan, and
• Breast screen data matching is still pending Ministry of Health progress against resolving confidentiality and privacy issues.

Therefore the decision was made to continue with the two contributory measures that have the greatest evidence-based impact on amenable mortality – cardiovascular disease (CVD) management and smoking cessation.

CVD is a major cause of premature death in New Zealand and contributes substantially to the escalating costs of healthcare. Modification of risk factors, through lifestyle and pharmaceutical interventions, has been shown to significantly reduce mortality and morbidity in people with diagnosed and undiagnosed CVD. Patients with established CVD (and those assessed to be at high CVD risk) are at very high risk of coronary, cerebral and peripheral vascular events and death, and should be the top priority for prevention efforts in clinical practice.

The burden of CVD falls disproportionately on Māori and Pacific populations, and there are well-documented inequities in CVD mortality, case fatality and incidence. Reducing these inequities is a high priority and can be achieved through increased use of evidence-based medical management of high-risk patients.

Tobacco smoking is a major public health problem in New Zealand. In addition to causing around 5,000 deaths each year, it is the leading cause of disparity, contributing to significant socioeconomic and ethnic inequalities in health. In 2011, the Government set a goal of reducing smoking prevalence and tobacco availability to minimal levels, essentially making New Zealand a smoke-free nation by 2025. In 2013, 15% of New Zealanders smoked tobacco every day. That rate was even higher among Māori (33%) and Pacific people (23%). Differences continue to be evident in the prevalence of smoking between the three ethnicity groupings of European/Other, Māori and Pacific.

For the first financial year we plan to achieve 2% reduction for each DHB (on single year baseline) by June 2018.</td></tr>
<tr><td>Linkages</td><td>See the Long Term Conditions and the Ambulatory Sensitive Hospitalisation 45-65 years of age sections of the Auckland DHB and Waitemata DHB Māori Health Plan, the Cardiovascular Disease section of the Counties Manukau DHB Maaori Health Plan and the Living Well with Diabetes and Better Help for Smokers to Quit Health Target section of the Auckland DHB, Counties</td></tr>
</table>

<table>
<tr><td></td><td colspan="4">Manukau DHB and Waitemata DHB annual plans for more information.</td></tr>
<tr><td colspan="5">Contributory measures</td></tr>
<tr><td></td><td>Rationale</td><td>Current state</td><td>Target future state</td><td>Improvement activities</td></tr>
<tr><td>Cardiovascular Disease Risk Assessment (CVD RA) for Māori</td><td>CVD RA for Māori is lower than the 90% national target.

Successful implementation of dual therapy replies on identification of people with CVD RA ≥20%.</td><td>CVD RA eligible patients who received a CVD RA, Quarter 1 2016-17:

<table><tr><th>DHB</th><th>Other</th><th>Māori</th><th>Pacific</th><th>Total</th></tr><tr><td>Auckland DHB</td><td>92.7%</td><td>88.7%</td><td>91.5%</td><td>92.2%</td></tr><tr><td>Counties Manukau DHB</td><td>93.1%</td><td>88.6%</td><td>91.4%</td><td>92.0%</td></tr><tr><td>Waitemata DHB</td><td>91.7%</td><td>86.7%</td><td>90.2%</td><td>91.1%</td></tr><tr><td>Metro Auckland</td><td>92.4%</td><td>88.1%</td><td>91.3%</td><td>91.8%</td></tr></table></td><td>90% CVD RA for Māori.</td><td>• Follow up phone calls (evenings) for practice generated CVD RA recall letters to Māori.
• Pilot of phlebotomy services in the practices or point-of-care testing when Māori males visit opportunistically.</td></tr>
<tr><td>Cardiovascular Disease (CVD) Management</td><td>Modification of risk factors, through lifestyle and pharmaceutical interventions, has been shown to significantly reduce mortality and morbidity in people with diagnosed and undiagnosed CVD.

Increasing dual or triple therapy for those with a CVD RA ≥20% or a prior CVD event should lead to morbidity and mortality gains.</td><td>1. Cardiovascular disease management contributory measures (Percentage of enrolled patients with a CVD risk assessment score ≥20% dispensed dual therapy pharmaceuticals, and
2. Percentage of enrolled patients with a prior CVD event dispensed triple therapy pharmaceuticals.</td><td>5% increase (relative) in dual therapy for those with CVD RA greater than 20%.

5% increase (relative) in triple therapy for those with a prior CVD event.</td><td>• Identification of patients at a NHI level who have had a CVD event and are not dispensed triple therapy. Feedback and comparison of these results to GPs via PHOs.
• Total population and specific interventions for Māori, Pacific and Asian peoples to improve uptake and adherence to dual and triple therapy.
• Post-event medication counselling and other rehabilitation services in hospital.
• Ongoing medication counselling by community pharmacists.
• Consider an activity focussed on ensuring access to prescription subsidy cards and reducing prescription co-payments.
• Establish a single process to report CVD indicators from PHO practice management systems. This dataset includes collection of ethnicity data to level 2 supporting equity interventions.</td></tr>
<tr><td colspan="5"></td></tr>
</table>

Percentage of enrolled patients who are on dual or triple therapy (dispensing records), by ethnicity, 12 months ended 30 September 2016:

Ethnicity	% CVD RA ≥20% on dual therapy			
	Auckland	Counties Manukau	Waitemata	Metro Auckland
Māori	37.8%	48.3%	43.3%	45.1%
Pacific	54.2%	49.2%	50.0%	50.5%
Asian	45.7%	43.4%	38.2%	42.2%
Indian	44.4%	51.3%	45.7%	48.1%
Other	36.4%	44.2%	39.4%	40.2%
Total	41.6%	49.1%	41.4%	44.4%

Ethnicity	% CVD on triple therapy			
	Auckland	Counties Manukau	Waitemata	Metro Auckland
Māori	51.9%	55.1%	55.0%	54.4%
Pacific	57.4%	61.7%	60.5%	60.4%
Asian	46.9%	50.5%	46.0%	47.5%
Indian	61.7%	69.1%	65.6%	65.7%
Other	51.3%	56.5%	53.2%	53.7%
Total	52.7%	58.1%	53.8%	55.0%

Smoking Cessation	This contributory measure sits both under this SLM and the Babies in Smoke-free Households SLM. Smokers lose at least one decade of life expectancy compared with those who have never smoked. Cessation before the age of 40 years reduces the risk of death associated with continued smoking by about 90%. Aim: an increase in smokers who successfully quit, and a reduction in smoking prevalence. This supports the Better Help for Smokers to Quit National Health Target.	Better Help for Smokers to Quit (Primary Care) 2016/2017 Indicator 4: Cessation support received by enrolled patients, Q1 2016/2017: **DHB** / **Cessation support rate** **Auckland** 24.7% **Counties Manukau** 24.4% **Waitemata** 32.9% **Metro Auckland** 27.0%	An increase in cessation support by 10% (desegregated by ethnicity).	• Analyse reasons for historical low referrals to smoking cessation providers. • Improve referral pathways to smoking cessation providers. • Improve feedback to referrers from smoking cessation providers. • Access aggregated data for Auckland population. • Establish a single process to report smoking from PHO practice management systems. This dataset includes collection of ethnicity data to level 2 supporting equity interventions. • Benchmark 'access to smoking cessation' READ codes across PHOs: i.e. the number of patients with codes 1, 2 and 3: 1. ZPSC10 – referral to smoking cessation support; 2. ZPSC20 – prescribed smoking cessation medication, and 3. ZPSC30 provided smoking cessation behavioural support.

4.5 Youth Access to and Utilisation of Youth-appropriate Health Services

System level outcome	**Youth are healthy, safe and supported**
Domains	**Youth access to and utilisation of youth-appropriate health services as measured via:** • **Youth experience of the health system: Child and Adolescent Mental Health Services Mārama Real-Time Survey results for 10–24 year olds;** • **Sexual and reproductive health: chlamydia testing coverage for 15–24 year olds – percentage of age group tested in one year;** • **Mental health and wellbeing: intentional self-harm hospitalisations (including short-stay hospital admissions through ED) for 10–24 year olds;** • **Alcohol and other drugs: alcohol-related ED presentations for 10–24 year olds, and** • **Access to preventive services: utilisation of DHB-funded dental services by adolescents from school Year 9 up to and including 17 years of age.**
Improvement milestone	**Sexual and reproductive health: 80% of pregnant women aged 15–24 years are screened for chlamydia during pregnancy**
Context and rationale	Youth have their own specific health needs as they transition from childhood to adulthood. Most youth in New Zealand successfully transition to adulthood but some do not, mainly due to a complex interplay of individual, family and community stressors and circumstances, or risk factors. Research shows that youth whose healthcare needs are unmet can lead to increased risk for poor health as adults and overall poor life outcomes through disengagement and isolation from society and riskier behaviours, in terms of drug and alcohol abuse and criminal activities. **Youth experience of the health system:** Evidence shows that young people who do not have positive interactions with health care services and providers do not return, which can lead to increased risk for poor health as adults. Research suggests that lapses in healthcare can lead to overall poor life outcomes. **Chlamydia testing coverage:** Chlamydia is the most commonly reported sexually transmitted infection in Auckland. It is most commonly diagnosed in females aged 15-19 years and in males aged 20–24 years. There is significant variation in rates and testing between males and females and between Māori, Pacific and non-Māori. Males, Māori, and Pacific young people are under-tested in Auckland laboratory data, reflecting inequities in the services and systems to meet the needs of these populations. Māori and Pacific youth are more frequently hospitalised with sexually transmitted infection complications and pregnancy-related conditions than young people of other ethnicities. International modeling suggests that testing coverage needs to be between 30–40% to begin to reduce prevalence of infection. In the UK, data from the youth screening programme shows that more than 50% of 16–24 years olds with chlamydia have no or non-specific symptoms. **Intentional self-harm:** Intentional self-harm is a mal-adaptive coping mechanism indicating young people who are in distress and coping with that distress in an unhealthy way. It is often associated with low mood, depression, anxiety, wider family or peer group issues and events, stress, bullying, bereavement, relationship issues, trauma, intense or difficult feelings, or being in a group that self-harms. **Alcohol-related ED presentations:** Identifying and monitoring alcohol-related ED presentations enables better understanding of the contribution of excessive alcohol consumption to health outcomes in young people and supports appropriate public health responses. **Utilisation of DHB-funded dental services by adolescents:** There is strong evidence that dental care is associated with improved oral health outcomes. This measure is a marker of inequalities in utilisation and youth engagement into health services by deprivation and ethnicity.

<table>
<tr><td></td><td colspan="4"></td></tr>
<tr><td>Linkages</td><td colspan="4">See the Youth Mental Health section of the Auckland DHB and Waitemata DHB Māori Health Plan, Mental Health (Youth) section of the Counties Manukau DHB Maaori Health Plan and the Prime Minister's Youth Mental Health Project in the Auckland DHB, Counties Manukau DHB and Waitemata DHB annual plans, and the Mental Health section of the Counties Manukau DHB Annual Plan for more information.</td></tr>
<tr><td colspan="5">Contributory measures – Sexual and Reproductive Health</td></tr>
<tr><td></td><td>Rationale</td><td>Current state</td><td>Target future state</td><td>Improvement activities</td></tr>
<tr><td>Development of Future Sexual and Reproductive Health Contributory Measures</td><td>Baseline data is required for planning, identifying appropriate contributory measures and developing improvement activities.</td><td>To be determined.</td><td>Establish baseline.</td><td>• Analysis of SLM data by age, ethnicity, and PHO.
• Identify gaps and potential areas for improvement.
• Review the literature to identify options for improving access to chlamydia testing for Māori and Pacific youth including school-based services, pharmacy, community laboratories, primary care, outpatients, justice systems, and other opportunistic settings.</td></tr>
<tr><td>All Pregnant Women are Screened for Chlamydia</td><td>Screening during pregnancy is recommended in current national guidelines including pre-termination of pregnancy. A 2015 publication of implementation of this guideline for pregnant women could be strengthened, expanding screening to male partners.</td><td>To be determined.

Screening in pregnancy, Middlemore and Auckland Hospitals:<table><tr><th>Hospital</th><th colspan="3">% screened</th></tr><tr><th></th><th><19 yrs</th><th>19-23 yrs</th><th><25 yrs</th></tr><tr><td>Middlemore*</td><td>74%</td><td>65%</td><td></td></tr><tr><td>Auckland**</td><td></td><td></td><td>68%</td></tr></table>*2011 **2013</td><td>80% of pregnant women aged 15–24 years are screened for chlamydia.</td><td>• Workforce development activities for lead maternity carers.
• Data analysis looking for missed opportunities, e.g. primary care visits during pregnancy.
• Data analysis looking for the potential to report back screening rates to lead maternity carers.</td></tr>
<tr><td>Chlamydia Burden of Disease</td><td>The purpose of increasing chlamydia screening is to reduce the disease burden. It is important to monitor this to assess the impact of screening activities on health outcomes.</td><td>To be determined.</td><td>Baseline.</td><td>• Establish regular reporting of chlamydia prevalence by age, ethnicity and locality.</td></tr>
<tr><td colspan="5">Contributory measures – Other Domains</td></tr>
<tr><td></td><td>Rationale</td><td>Current state</td><td>Target future state</td><td>Improvement activities</td></tr>
<tr><td>Health Care Utilisation by 15–24 year olds</td><td>Understanding where and how frequently youth access health care services across</td><td>To be determined.</td><td>Analysis completed.</td><td>• Explore the availability of data across services potentially accessed by youth and the feasibility of data linkage to</td></tr>
</table>

	the system will support planning for improving access.			explore systems-wide youth health service utilisation and identify gaps. • Baseline primary health care enrolment and utilisation.
Participation in Child and Adolescent Mental Health Services Mārama Real-Time Survey	Baseline data is required for planning, identifying appropriate contributory measures, and developing improvement activities.	To be determined.	Establish baseline.	• Analysis of SLM data. • Engage with Mārama, the regional child and adolescent Mental Health Service group, and service providers to identify gaps and potential areas for improvement.
Development of Baseline Data for Youth Domains: alcohol and other drugs, access to preventative services, mental health and wellbeing	Baseline data is required for planning, identifying appropriate contributory measures and developing improvement activities.	To be determined.	Establish baseline.	• Analysis of SLM data by age, ethnicity, and PHO. • Identify gaps and potential area for improvement.

4.6 Proportion of Babies Who Live in a Smoke-free Household at Six Weeks Post-natal

System level outcome	Healthy start
Improvement milestone	Reduce missing smokefree household data to <10% by June 2018
Context and rationale	The definition of a smoke-free household is one where no person ordinarily resident in the home is a current smoker. This measure is important because it aims to reduce the rate of infant exposure to cigarette smoke by focusing attention beyond maternal smoking to the home and family/whānau environment. It will also encourage an integrated approach between maternity, community and primary care. It emphasizes the need to focus on the collective environment that an infant will be exposed to – from pregnancy, to birth, to the home environment within which they will initially be raised. Of note, smoking during pregnancy and exposure to tobacco smoke in infancy is highest for Māori and Pacific. Baseline data from Well Child Tamariki Ora providers suggests that 98% of babies lived in a smokefree household at 6 weeks post-partum during Q1-2 of 2016/17. Given current smoking prevalence this is unlikely to be accurate. In addition, nearly 1 in 5 babies in Metro Auckland did not have smokefree household data recorded WCTO activities in the 17/18 plan focus on improving data quality. As data quality improves, the proportion of babies living in smokefree households is likely to decline initially. Therefore, measuring the impact of activities on the SLM will be challenging in the short term.
Linkages	*See the Tobacco section of the Auckland DHB and Waitemata DHB Māori Health Plan and the Death in Infants, the Babies Exposed to Smoking section of the Counties Manukau DHB Maaori Health Plan, and the Better Help for Smokers to Quit Health Target in the Auckland DHB, Counties Manukau DHB and Waitemata DHB annual plans for more information.*

Proportion of Babies in SmokeFree homes at 6 weeks post-partum, July-Dec 2016

DHB	Māori	Pacific	Asian	Other	Total
Auckland	96.1%	96.8%	99.6%	99.4%	98.8
Counties Manukau	96.4%	97.9%	99.5%	99.1%	98.5
Waitemata	96.2%	99.5%	99.0%	98.4%	98.3
Metro Auckland	96.3%	98.0%	99.3%	98.9%	98.5

Proportion of babies for whom there is no information about their smokefree home status at 6 weeks post-partum, July-Dec 2016

DHB	% missing
Auckland DHB	14.8%
Counties Manukau	25.6%
Waitemata DHB	16.3%
Metro Auckland	19.5%

Note: Includes babies for whom the response was missing, unknown, or was not asked.

	Contributory measures			
	Rationale	**Current state**	**Target future state**	**Improvement activities**
Maternal Smoke-free Services Pregnant smokers referred to cessation support by lead maternity carers. Referrals of pregnant	Ensuring that pregnant women who smoke are offered referral to cessation support is a crucial step in the pathway to them becoming smoke-free. This measure has two components. One looks at the proportion of pregnant smokers referred to cessation support	Due to the number of referral services and inconsistent systems for recording referrals sent and referrals received, accurate data is not available. Available data is of poor quality but suggests that referral rates are	Baseline data.	• Improve regional data collection so that timely maternal smoking prevalence data is available, brief advice and quit support can be monitored, and referral to SSS for women who are pregnant and are current smokers can be monitored.

smokers to stop smoking services (SSS).	using data collected from DHB employed midwives and from lead maternity carers using the Midwifery and Maternity Providers programme. As this dataset does not currently give a complete picture of the number of pregnant smokers offered intervention, it is supplemented by the second component, the number of referrals received by SSS.	low.		• Analyse reasons for historical low referrals to smoking cessation providers, particularly for Māori women. • Promote regional pathway for first trimester visit (includes smoking cessation referral) with a focus on Māori women. • Facilitate early enrolment of pregnant women with lead maternity carers. • Provide lead maternity carers and GP training on smoking cessation. • Provide feedback to lead maternity carers on their referral rates. • Provide pregnancy SSS incentives programme. • Arrange for SSS providers to attend pregnancy and parenting classes in the community (particularly those for Māori and Pacific). • Explore innovative ways of engaging pregnant smokers to quit, with a focus on Māori women, e.g. through use of a Sudden Unexpected Death in Infancy App.
Household Smoking Cessation	**Whānau:** Smokers who live in the same household as babies and young children may be reached through community, primary care and secondary care. Offering cessation support, stop smoking therapy or referral to SSS is important to assist whānau members to become smoke-free. The use of other settings to identify and support smokers that live with young children will also be explored. A focus on activities that will increase quit rates for Māori and Pacific is particularly important given the higher prevalence of smoking in these ethnic groups. **Other:** This contributory measure sits both under this SLM and the Amenable Mortality SLM. A total population	Whānau smoking cessation support information is not yet available. As per data supplied in amenable mortality SLM.	Obtain robust, timely data. Scoping complete data for smoking exposure and prevalence through Well Child Tamariki Ora, and scope data collection in DHBs. Scope providing whānau smoking cessation through maternity services and Well Child Tamariki Ora for 2018-19 plan.	• WCTO Data Quality Improvement: Review and align data collection processes for SLM measure across WCTO providers and provide SOPs for data collectors. • Provide WCTO providers feedback on missing smokefree data rates. • Scope processes to identify household members of pregnant women and newborns who are current smokers, including data collection processes. • Explore opportunities to offer smoking cessation support to whānau of newborn inpatients and outpatients, and paediatric ED attendances. • Explore additional ways of offering smoking cessation support to whānau

	approach undertaken in the amenable mortality SLM will support an overall increase in quit rates.			of young children, e.g. pharmacy initiatives, Well Child providers. • Support the work undertaken in the Amenable Mortality SLM.

5. GLOSSARY

CHF	Congestive Heart Failure
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardiovascular disease
CVD RA	Cardiovascular disease risk assessment
DHB	District health board
ED	Emergency department
GP	General practitioner
HQSC	Health Quality and Safety Commission
NHI	National Health Index
PES	Patient experience survey
PHC PES	Primary health care patient experience survey
PHO	Primary health organisation
POAC	Primary Options in Acute Care
SLM	System level measures
SSS	Stop smoking services