NORTHLAND DISTRICT
HEALTH BOARD

Te Poari Hauora Á Rohe O Te Tai Tokerau

System Level Measures

Improvement Plan

12 November 2016

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Signatories

Dr Nick Chamberlain Chief Executive Northland DHB	Donovan Clarke Chief Executive Manaia Health PHO	Rose Lightfoot Chief Executive Te Tai Tokerau PHO

Introduction

Ministry requirements

System Level Measures (SLMs) were announced in April 2016 by the Minister of Health. They have emerged from the development of the NZ Health Strategy (action 14 under the Value and High Performance theme).

Four SLMs are to be reported on from 2016/17 quarter 2:

- ambulatory sensitive hospitalisations (ASH) rates for ages 0-4 (keeping children out of the hospital)
- acute hospital bed days per capita (using health services effectively)
- amenable mortality rates (prevention and early detection)
- patient experience of care (person-centred care).

Two more are still being developed by the Ministry of Health:

- youth access to and utilisation of youth appropriate health services (young people make good choices)
- proportion of babies who live in a smokefree household at 6 weeks post birth (a healthy start).

The Alliance Leadership Team in each DHB's area was charged with developing an Improvement Plan whose core components are:

- milestones for each SLM
- contributory measures
- diagrams and narrative to explain linkages and flows.

This plan is due with the Ministry on 20 October. The Ministry will supply feedback and revised plans will be submitted by 30 November.

Northland response

Northland's Alliance Leadership Team, Te Roopu Kai Hapai Oranga, established a Service Level Alliance Team for SLMs, overseen by the GM Planning, Outcomes, Integration and District Hospitals. The SLAT's membership has comprised:

- the Chief Executives of Northland's two Primary Health Organisations, Te Tai Tokerau PHO and Manaia Health PHO
- Health Promotion Manager, Northland PHOs
- Nursing Director Primary Health Care, Te Tai Tokerau PHO
- Population Health Strategist, Medicine, Health of Older People, Emergency & Clinical Support, NDHB
- Nurse Consultant/Manager, Medicine, Health of Older People, Emergency & Clinical Support, NDHB
- Manager, Patient Safety & Quality Improvement Directorate, NDHB
- Quality Leader, Northland PHO Services
- Portfolio Manager, Northland Health Services Plan, NDHB
- Portfolio Manager, Primary Care, NDHB
- Secondary Care Performance and Development Manager, Finance, Funding & Commercial Services, NDHB
- Health Planner, NDHB

This plan has been circulated for comment to Te Roopu Kai Hapai Oranga, which won't meet formally until November. It has also been discussed by the Executive Leadership Team and SLMs have been discussed at the sector-wide Northland Clinical Governance Forum.

Ongoing consultation

This draft plan is not the end of the process for us. Now that it has been submitted to the Ministry, we will continue to obtain feedback to improve and refine it. The revised plan due on 30 November will incorporate that feedback, in addition to any requirements and suggestions from the Ministry. The draft plan will be circulated (as a minimum) to:

- Te Roopu Kai Hapai Oranga
- Executive Leadership Team of Northland DHB
- Northland Clinical Governance Forum
- Consumer Council
- individual staff in the PHOs and NDHB who deal with issues of concern to the plan (smoking, maternity services etc).

Issues with data

Refinement to milestones over time

In developing this plan, data has been drawn from the SLM website[1]. While the data identifies in a broad sense the highest priorities for attention, in some cases it has been difficult to set SLM milestones with confidence. The milestones in this plan are based on the data available, and will be amended and refined over time. To aid us in this process the Ministry has confirmed they will present data with more finely detailed breakdowns with respect to fields such as conditions, time periods, age, ethnicity and geography. The milestones are our assessment at the moment of the potential combined impact of the contributory measures associated with each SLM over the next year. With the passage of time we will gain a clearer understanding of the degree of impact from each contributory measure and interactions among them.

Age standardisation

SLM milestones are set on the basis of crude (unadjusted) data. However the Ministry has also supplied age-standardised data and we experienced some issues with how thiswas presented. Acute bed days offered three populations for standardisation (WHO, 2013 Census overall and 2013 Census Maori) of which we chose the 2013 Census overall population because it most closely reflects the New Zealand situation. Amenable mortality however offers only the WHO population. It is not clearly stated in the ASH datafile which population is used for age standardising; quarterly reporting requirements indicate that ASH uses the 'Indigenous Standard' population, but it is not apparent how this compares to the two New Zealand population options under acute bed days.

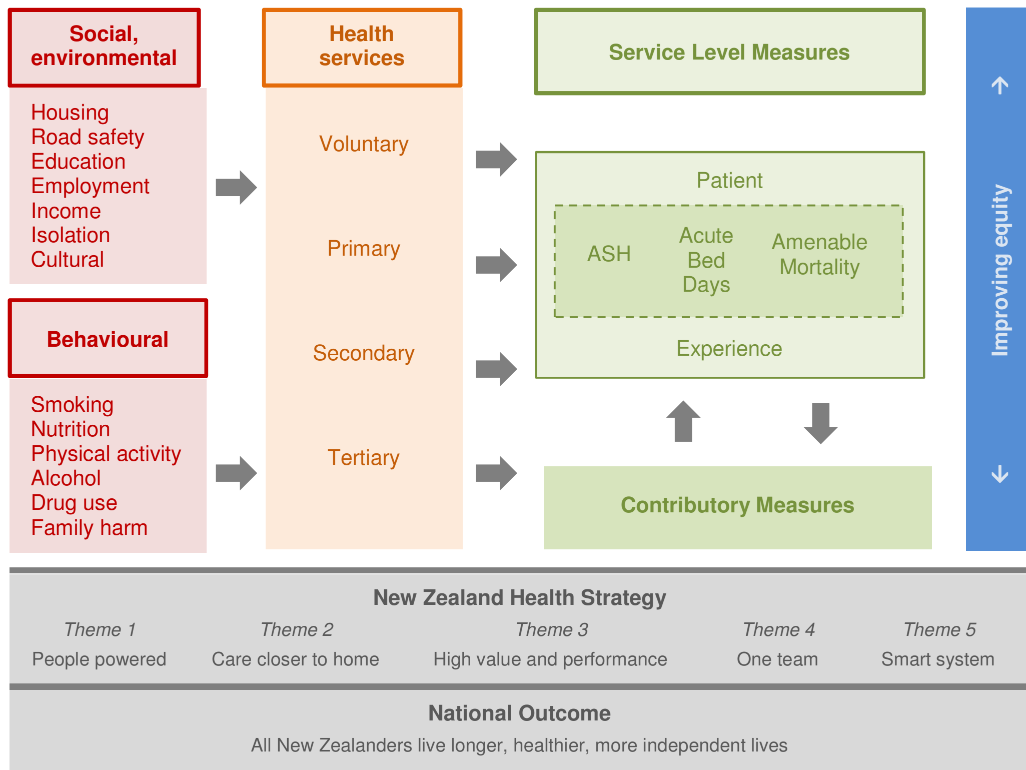
It would have been more useful if all three of these measures used a consistent approach to age standardisation and consistent terminology. An explanation of the pros and cons of the three popluations made available would also have been benefiicial.

Reporting

The workload involved in reporting on the SLMs and their contributory measures will be significant. While two of the SLM leads will likely remain, two of those who have led the planning process will cease their involvement once the plan is approved. These replacements will be considered by Te Roopu Kai Hapai Oranga at their meeting on 11 November.

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

Northland's framework



People's health is affected by many social and environmental factors, though many are outside the influence of the health system. We can however work with non-health sector agencies to improve the quality of housing to reduce the prevalence of ill health (respiratory conditions and infectious disease especially) and to reduce road traffic accidents.

Behavioural factors influence health status too. There are many aspects to this, but the two biggest influences, common across all the SLMs, are smoking and obesity-related nutrition and physical activity.

Organisations across the health sector must work together to improve people's health and reduce the load on services' scarce resources. The more effectively primary care services can identify and treat conditions, and maintain good health and function in children (measured by ambulatory sensitive hospitalisations), the better their health will be and the lower will be the impact on hospital services (measured by acute bed days). Improvements in ASH and acute bed days will lower the prevalence of amenable mortality (premature deaths that are potentially avoidable given effective and timely care). The ratings people give to their experience of health services reflect how well integrated those services are, the timeliness of the care provided, and how accessible, clear and relevant information is.

Improvements in all four System Level Measures will contribute directly to the first four themes of New Zealand's Health Strategy. Smarter systems, the fifth theme, will enable improvements across the board in health services and health status.

1 Ambulatory Sensitive Hospitalisations

Definition

Ambulatory sensitive hospitalisations (ASH) are mostly acute admissions that are considered potentially reducible through prophylactic or therapeutic interventions deliverable in a primary care setting. The measure is the rate per 100,000 for ages 0-4.

Improvement milestone

Reduce the equity gap between Maori and non-Maori (the numerical gap divided by the non-Maori rate) by 5% from 63% to 58%.

Rationale

In New Zealand children, ASH accounts for approximately 30 percent of all acute and arranged medical and surgical discharges in that age group each year *(*figure for Northland to be obtained from MoH). ASH rates are a measure of whole-of-system activity and many factors impinge on them, so determining the reasons behind high rates and suggesting how they may be reduced is complex.

Admission rates for some conditions serve as proxy measures for primary care access and quality. High admission rates indicate difficulty in accessing care in a timely fashion, poor care coordination or care continuity, or structural constraints such as limited supply of primary care workers.

ASH rates are also affected by other factors, such as emergency department services and hospital admission policies, health literacy and broader influences such as social determinants of health (housing and poverty etc).

Variations exist in ASH rates across different population groups and geographical areas. Determining these will help identify where to target efforts to reduce these disparities.

To improve ASH rates requires a focus on specific conditions, particularly those contributing the most hospital admissions, and the services associated with them. There is however just one overall milestone for ASH because the nature of an SLM is to focus on and monitor performance of the system as a whole.

Where are we now?

From the overall ASH data provided it is difficult to discern trends. We also need to carry out more investigation into some aspects; the rate for dental conditions appears to be rising, for example, but we need to check if that is because services in the community are detecting more need, or the need for secondary treatment is rising.

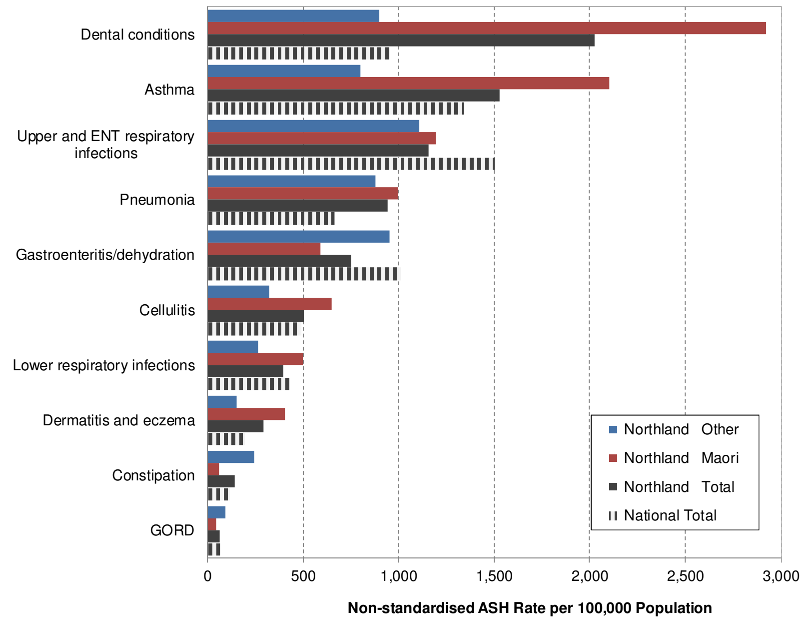
The Maori/non-Maori equity gap is significant, but underestimated from the spreadsheet provided because the standardising function does not work.

The top three diagnosis related groups (DRGs) for ASH are:

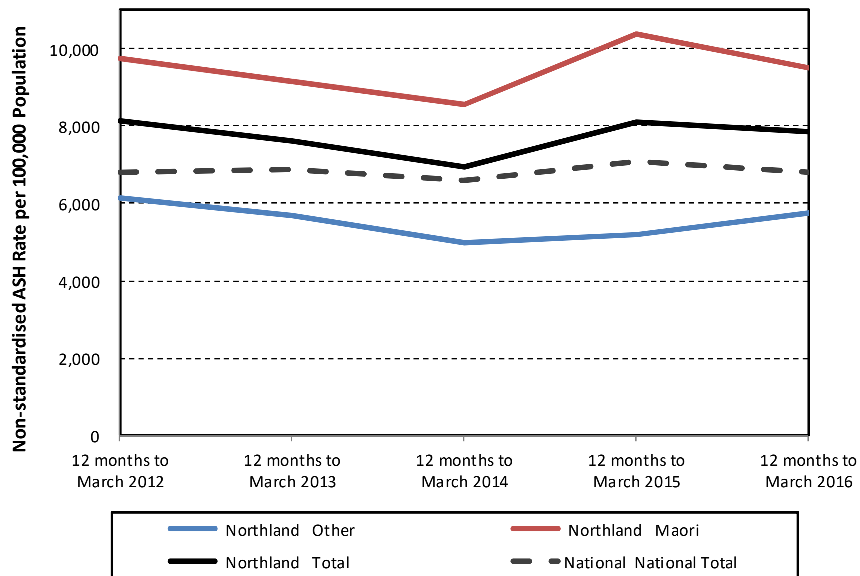
- dental conditions
- asthma
- upper and ENT respiratory infections.

Together these account for 60% of the top ten causes of ASH admissions.

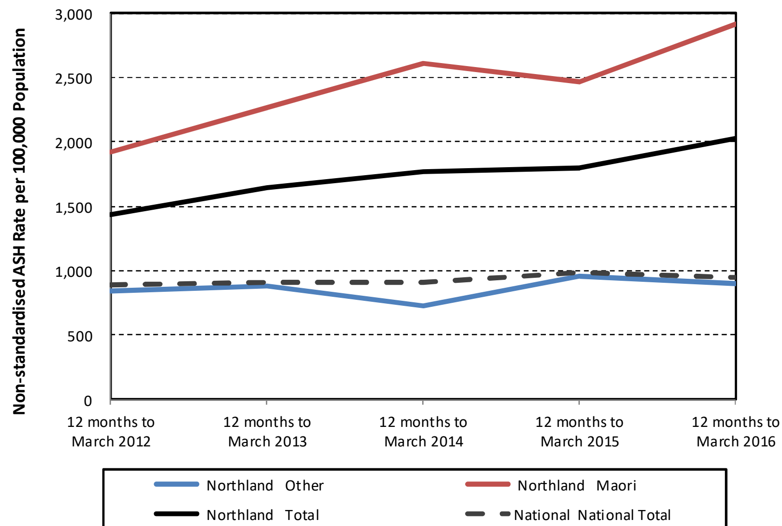
Top 10 conditions, non-standardised ASH rate, Northland DHB, ages 0-4, 12 months to end March 2016



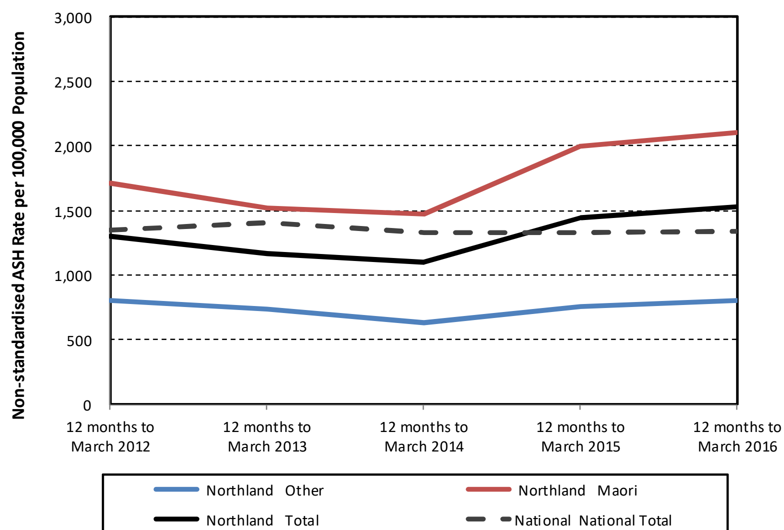
Non-standardised ASH rate, Northland DHB, ages 0-4 all conditions, 5 years to end March 2016



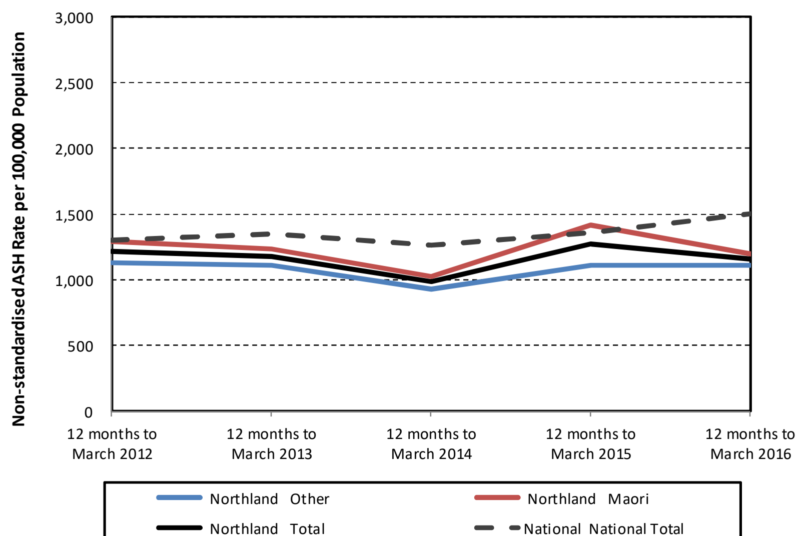
Non-standardised ASH rate, Northland DHB, ages 0-4, dental conditions, 5 years to end March 2016



Non-standardised ASH rate, Northland DHB, ages 0-4, asthma, 5 years to end March 2016



Non-standardised ASH rate, Northland DHB, ages 0-4, upper and ENT respiratory infections, 5 years to end March 2016



How will we get there?

All Contributory Measures to be by deprivation, ethnicity, location.

Contributory Measures	Benefit, rationale	Linkages
Promoting caries-free at five years	Oral health promotion services promote positive oral health behaviours. Coverage by and access to oral health promotion services.	Development of a shared oral health strategy across Northland's Oral Health Promoters. Explore an expansion of 'Little Chompers' programme; a non-clinical peer intervention to increase oral health awareness amongst parents of tamariki. Explore implementation of a supervised brushing scheme with preschool tamariki, including identifying appropriate providers and sponsorship.
Percentage of tamariki who have access to fluoridated water	Fluoridated water promotes strong teeth that are resistant to decay. None of Northland's water supplies are fluoridated.	Develop a steering group to explore the requirements to undertake townwide water fluoridation scheme. Socialise and consult with community, professionals and stakeholders on implementation of a townwide water fluoridation scheme. Identify champions to socialise and strengthen the implementation of a townwide water fluoridation scheme. Explore other opportunities to increase tamariki access to fluoridated water for those without access to town supplied water.
Preschool tamariki enrolled in a publicly funded child oral health service	Higher enrolment in and greater attendance at oral health services will promote healthier teeth and gums, and improve self-care.	Monitor and increase the number of tamariki Maori attending at oral health services; both first visits and subsequent visits. Develop strategies to increase the number of first visits and subsequent visits. Strengthen the existing Northland-wide Oral Health Promotion team, with a focus on increasing access to oral health advice and care for tamariki Maori. Monitor and set target to increase the number of tamariki Maori aged 0-2 attending a public oral health service.
Newborns enrolled with a Primary Health Organisation	The High Five Project aims to have all newborns enrolled in five key services: general practice, National Immunisation Register, Well Child/ Tamariki Ora provider, oral health, Newborn Hearing Screening.	Ensure that all newborns are captured and LMCs are promoting enrolment with a PHO. Strengthen existing pathways to increase the number of non-enrolled tamariki through regular touch points such as immunisation.
Hospital admissions for tamariki aged 5 years with a primary diagnosis of asthma	A redesigned B4SC service could pick up more children with asthma and related conditions. Healthier, warmer, less crowded home environments improve respiratory health. Improved post-discharge care and improved management of asthma will reduce readmissions. Lower rates of smoking among pregnant women and mothers of newborns will reduce readmissions.	Redesign the B4 School Check model of care to reach out to more tamariki Maori. Reduce the 28 day readmission rate for tamariki Maori with the same respiratory diagnosis code. Reduce the 1 year readmission rate for tamariki Maori with the same respiratory diagnosis code. Implement the Manawa Ora Healthy Homes Initiative across Northland with a focus on 0-5 tamariki Maori with respiratory conditions. Reduce seasonal admissions to SCBU for Maori tamariki.
Four-year-old	Addressing the effects of	Develop a pathway between Smoking Cessation services

Contributory Measures	Benefit, rationale	Linkages
tamariki living in smokefree homes	smoking on tamariki provides an avenue to address smoking behaviour in the whole whanau / household. Access to the home environment may be achieved through redesigned B4SC services.	and B4 School Check services for parents who are current smokers.
Pregnant women who identify as smokers upon registration with a DHB employed midwife or LMC who are offered brief advice and support to stop smoking.	Lower rates of smoking among hapu mama will benefit pepi and tamariki directly. Lower rates of smoking in households mean lower rates among future adults.	Future SLM for babies living in smokefree households at 6 weeks of age. Increase the number of Maori hapu mama who are smokefree at 4 weeks after ABC advice is given. Increase the number of Maori hapu mama who are smoke free at delivery. Implement a Northland wide incentive project to encourage referral of pregnant women to community based stop smoking services. Continue to support midwives with use of carbon monoxide monitors. Trial use of inhalator (NRT delivery method) with pregnant women.
Newborns enrolled in a Primary Health Organisation	The High Five Project aims to have all newborns enrolled in five key services: general practice, National Immunisation Register, Well Child/ Tamariki Ora provider, oral health, Newborn Hearing Screening.	Develop a measure for the number of newborns enrolled with a Well Child provider. Ensure that all newborns are captured and LMCs are promoting enrolment with a PHO. Strengthen existing pathways to increase the number of non-enrolled tamariki through regular touch points such as immunisation.

2 Acute Bed Days

and

3 Amenable Mortality

Definitions

Amenable Mortality is defined as premature deaths that could potentially be avoided given effective and timely care. That is, deaths from diseases for which effective health interventions exist that might prevent death before an arbitrary age limit (ususally 75)[2].

Improvement Milestones

1. Reduce acute bed days for those in deprivation quintiles 4 and 5 by 3%.
2. Reduce amenable mortality rates for Maori by 20% by 2021; this equates to a reduction in the current year of 4% (which will be reflected in 2014 mortality data).

Rationale

Acute hospital bed days per capita is a measure of acute demand on secondary care that is amenable to good upstream primary care, acute admission prevention, good hospital care and discharge planning, integration of services and transitions between care sectors and good communication between primary and secondary care, all of which can help reduce unnecessary acute demand. Good access to primary and community care and diagnostics services is part of this.

Variation in mortality rates, over time and across populations, reflects variation in the coverage and quality of care (defined as preventive or therapeutic services delivered to individuals and families).

Currently all DRG bed days are treated the same across Northland.

The acute bed day milestone is contingent on further analysis of the MoH data to inform targeted interventions by locality, ethnicity and deprivation/quintile.

Depending on the population against which the data is standardised, there are different results in comparing acute bed days between Maori and non-Maori. Age-standardising to the 2013 Census shows no significant difference in acute bed days Maori and non-Maori patients, but Maori have twice the non-Maori rate when using the WHO population. The most significant difference is evident in deprivation, with quintile five having by far the highest rate of bed days; Maori are over-represented in high deprivation areas.

The diagnostic group for rehabilitation is the highest contributor to acute bed days. This DRG relates to inpatient A&R which is not acute care per se, so we have decided to exclude it as a contributory measure.

The amenable mortality rate for Northland Maori is 3 times higher than the rate for non-Maori. Long term conditions contribute 57% (2013 provisional data) of amenable mortality deaths.

Maori Northlanders are over-represented in the prevalence of chronic conditions and their associated impacts on mortality and health status. Maori also suffer these diseases at much younger ages than non-Maori.

Smoking is the single greatest avoidable cause of mortality and morbidity in New Zealand. Around 19% of Northland adults smoke compared with 15% for New Zealand. The smoking rate is high for Northland Maori (34%) compared to New Zealand Maori (33%).

The latest data from the Northland PHOs population register shows that much greater effort needs to be placed on supporting Maori smokers to quit if we are to reach the 5% smoking prevalence target by 2025.

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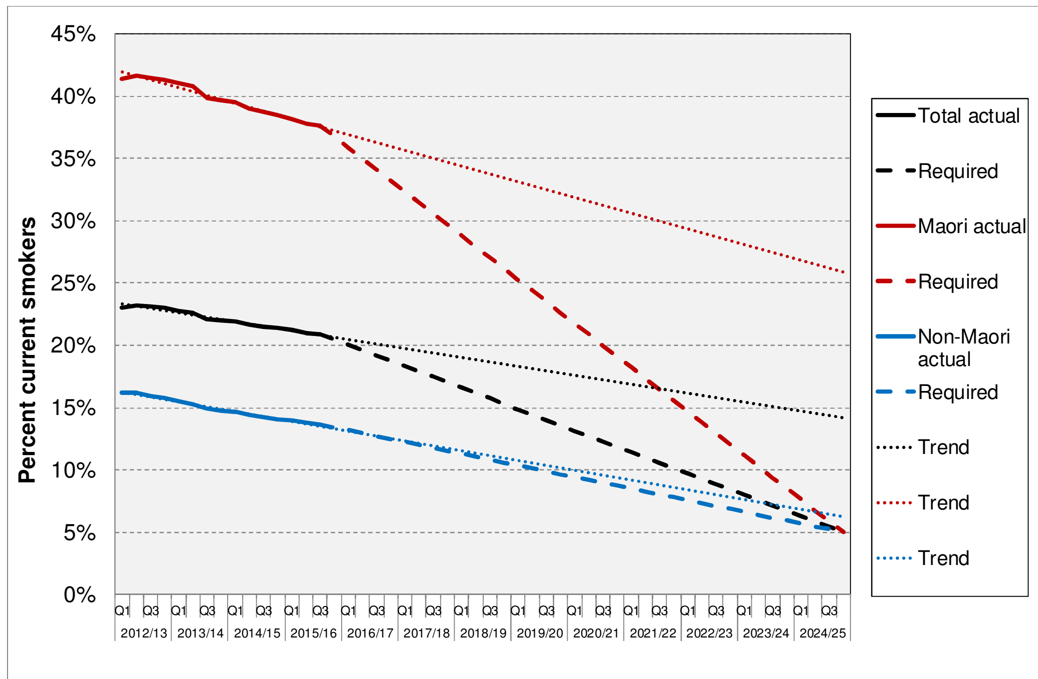
[2] Gay, J G. et al(2011)cited in MoH Amenable Mortality Guidance.

Northland smoking rates by ethnicity: historical and required to reach 2025 5% target



An integrated planning approach is being adopted due to the synergy between acute bed days and amenable mortality rates for Northland.

NDHB will target:

Five DRGs:

- ischaemic heart disease
- cerebrovascular disease
- respiratory infections /inflammation (pneumonia ICD)
- COPD
- cellulitis (based on relevant ICDs)

Six medium term outcomes:

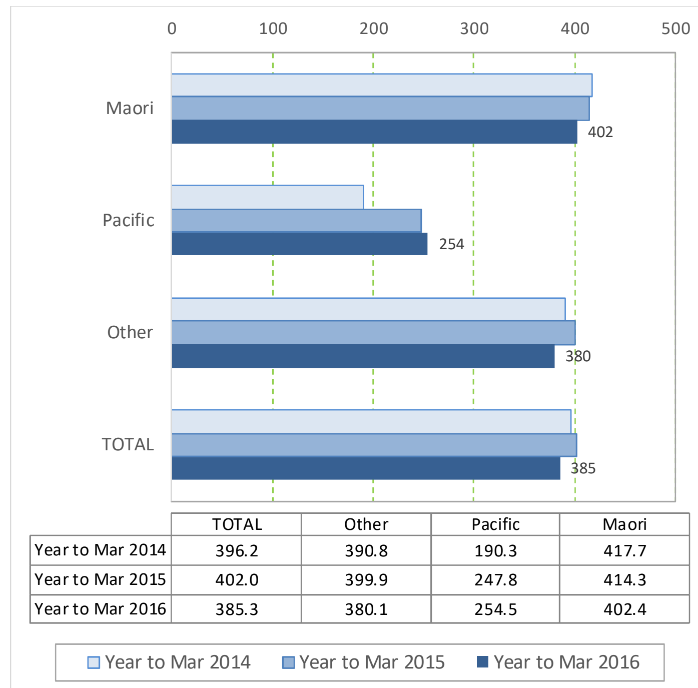
- improved outcomes and reduced disparities for patients in the six targeted areas above
- prevention activity is focused on those most at risk
- patient experience of health service is positive, timely and responsive
- people are supported to manage their long term conditions
- more people experience independence and quality of life
- people are supported to live and stay well in their own communities.

Where are we now?

The following MoH data supports the planning approach and rationale.

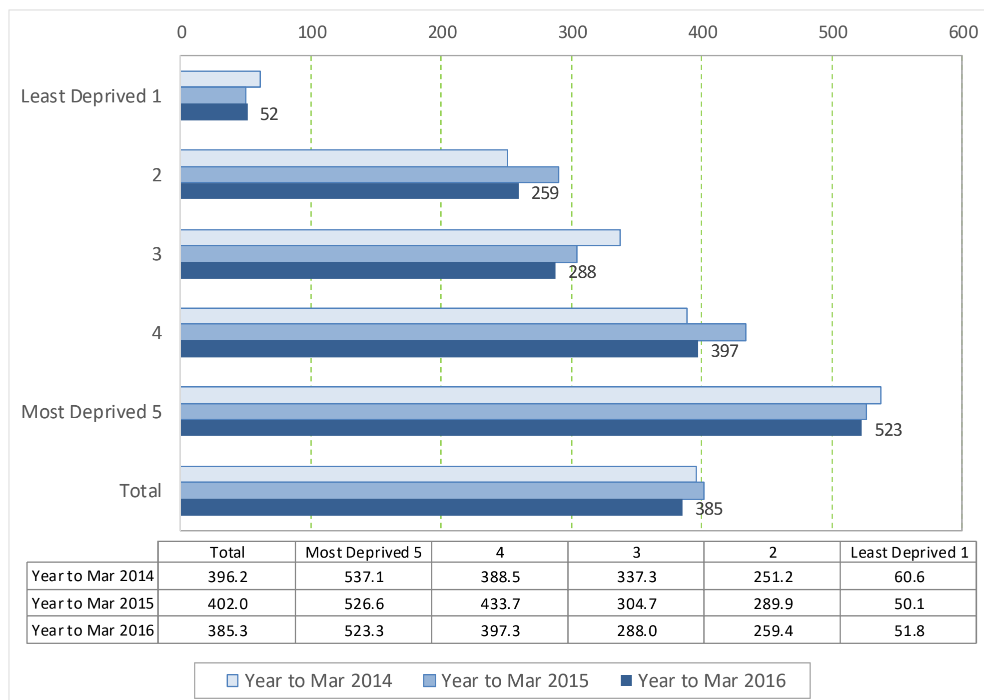
Acute bed days

Acute bed days per 1,000 population by prioritised ethnic group (standardised to NZ 2013 Census total population)



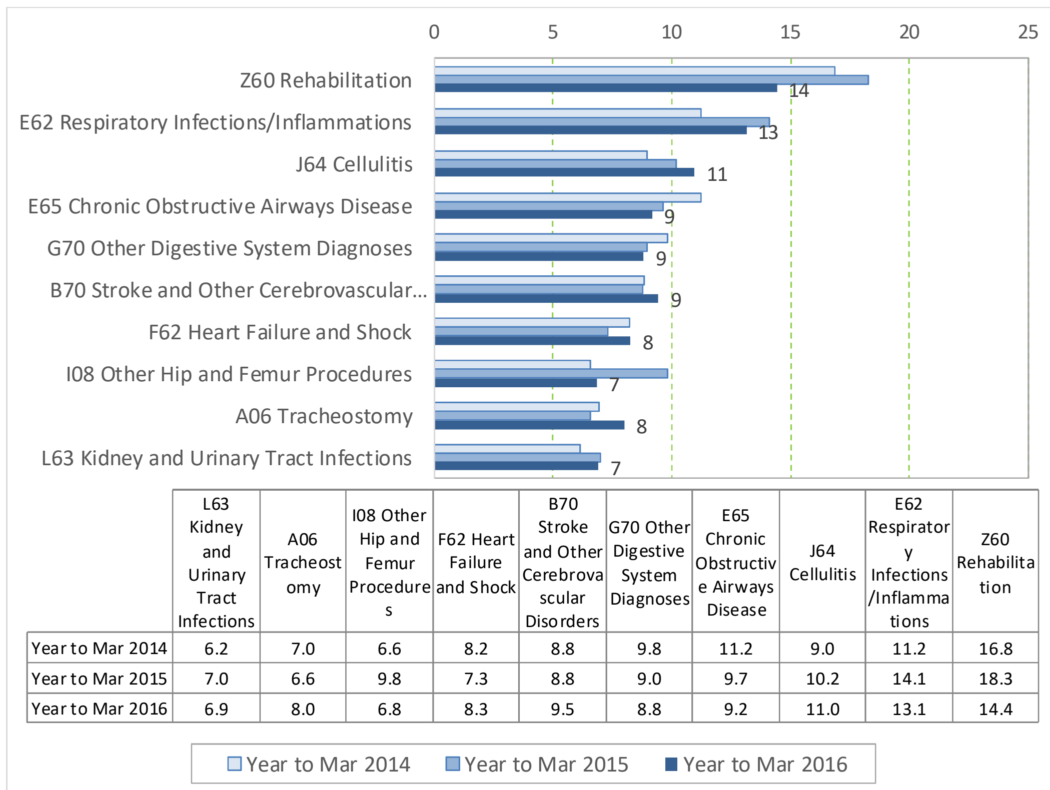
	TOTAL	Other	Pacific	Maori
Year to Mar 2014	396.2	390.8	190.3	417.7
Year to Mar 2015	402.0	399.9	247.8	414.3
Year to Mar 2016	385.3	380.1	254.5	402.4

Acute bed days per 1,000 population by deprivation quintile (standardised to NZ 2013 Census total population)



	Total	Most Deprived 5	4	3	2	Least Deprived 1
Year to Mar 2014	396.2	537.1	388.5	337.3	251.2	60.6
Year to Mar 2015	402.0	526.6	433.7	304.7	289.9	50.1
Year to Mar 2016	385.3	523.3	397.3	288.0	259.4	51.8

Acute bed days per 1,000 population, for the top 10 most prevalent DRG clusters (standardised to NZ 2013 Census total population)



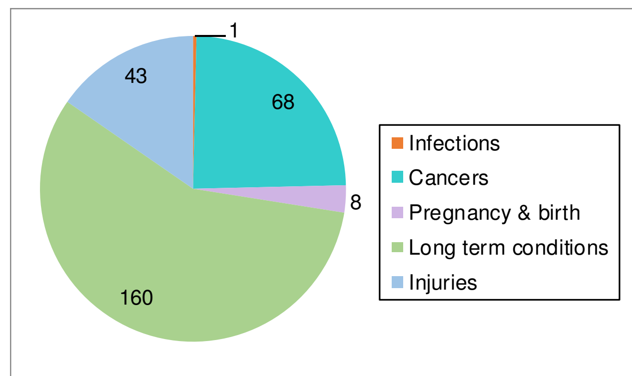
	L63 Kidney and Urinary Tract Infections	A06 Tracheostomy	I08 Other Hip and Femur Procedures	F62 Heart Failure and Shock	B70 Stroke and Other Cerebrovascular Disorders	G70 Other Digestive System Diagnoses	E65 Chronic Obstructive Airways Disease	J64 Cellulitis	E62 Respiratory Infections /Inflammations	Z60 Rehabilitation
Year to Mar 2014	6.2	7.0	6.6	8.2	8.8	9.8	11.2	9.0	11.2	16.8
Year to Mar 2015	7.0	6.6	9.8	7.3	8.8	9.0	9.7	10.2	14.1	18.3
Year to Mar 2016	6.9	8.0	6.8	8.3	9.5	8.8	9.2	11.0	13.1	14.4

Amenable Mortality

Total 2013 (provisional) Amenable Mortality Rates for Northland is 342 per 100,000.

Long term conditions contribute 57% of total deaths.

Northland amenable mortality 2013, numbers by major disease categories

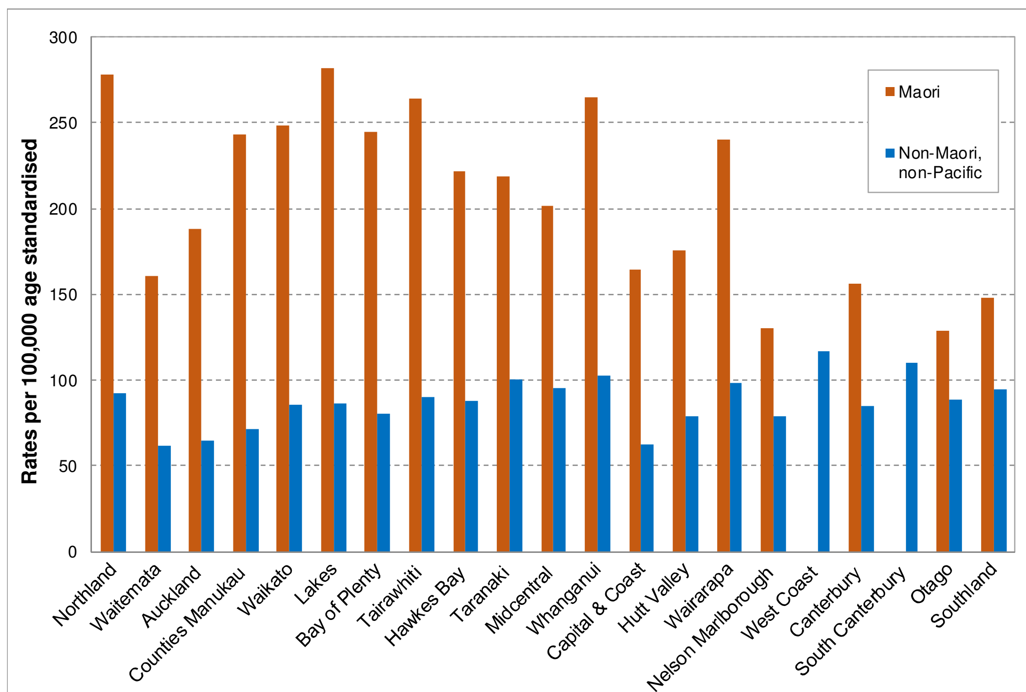


Amenable mortality deaths, age standardised rates, ages 0-74, 2001-2013

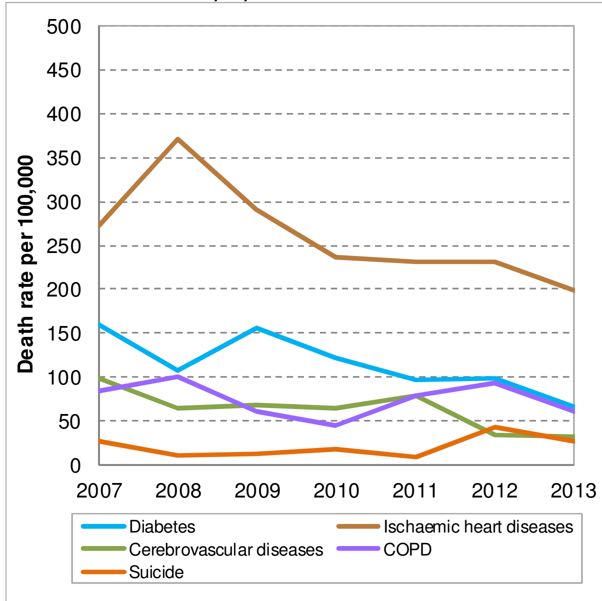
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013 provisional
Total New Zealand	144.9	144.6	137.7	132.6	127.6	119.2	115.0	114.8	109.8	107.8	102.1	97.6	95.5	90.8
Northland	187.8	168.4	199.4	180.3	157.6	158.4	150.5	143.1	148.6	148.7	133.2	130.3	138.9	117.0
Waitemata	111.5	110.4	105.7	101.2	93.2	92.8	89.2	81.6	82.7	76.7	67.8	76.2	72.6	63.5
Auckland	138.7	121.6	118.5	117.4	118.3	97.0	92.0	101.7	96.1	98.4	81.6	79.3	81.1	70.8
Counties Manukau	147.9	144.8	158.5	139.7	126.6	130.3	123.3	123.9	114.3	115.7	114.2	108.4	106.1	102.0
Waikato	163.6	150.4	144.4	129.6	139.5	130.0	131.6	135.8	127.6	113.2	116.9	115.3	106.1	97.3
Lakes	176.0	203.8	191.0	162.4	171.9	137.1	157.3	141.3	146.7	160.3	129.7	131.2	126.0	119.1
Bay of Plenty	161.1	164.2	143.3	146.1	146.3	126.6	122.4	134.8	119.8	118.0	112.9	106.2	112.0	105.6
Tairawhiti	193.4	197.5	220.8	243.8	207.0	183.2	202.3	189.0	151.7	185.2	158.5	128.7	133.2	152.3
Hawkes Bay	179.1	179.3	154.3	177.6	144.9	166.8	142.4	141.5	134.9	114.5	123.8	114.5	105.5	102.3
Taranaki	149.3	134.4	128.9	132.1	137.3	153.8	115.7	142.0	103.0	135.3	121.9	101.4	103.8	93.9
Midcentral	154.1	165.7	136.6	149.4	139.3	137.9	129.8	125.1	120.5	136.2	113.3	103.5	89.9	106.9
Whanganui	193.9	200.1	178.3	162.0	149.0	163.4	161.5	140.4	143.7	148.4	142.3	146.6	109.7	107.2
Capital & Coast	127.7	122.4	124.7	115.8	106.1	105.1	99.5	88.4	95.0	76.7	79.2	74.4	75.2	78.4
Hutt Valley	146.0	138.7	124.7	151.1	118.9	107.6	104.7	120.1	122.1	94.0	90.6	91.9	90.7	96.7
Wairarapa	155.9	172.8	123.3	163.5	156.9	101.8	104.2	113.3	151.9	118.8	115.2	131.3	97.7	119.0
Nelson Marlborough	140.9	135.1	123.7	104.9	102.2	106.3	104.1	113.6	88.4	97.1	91.1	75.7	76.5	75.6
West Coast	152.0	214.8	177.4	154.7	168.8	144.9	143.8	113.3	120.0	145.4	126.8	121.4	87.3	131.4
Canterbury	119.6	127.3	119.3	113.0	118.0	92.6	98.9	100.1	89.2	96.0	96.0	86.1	84.8	89.1
South Canterbury	117.7	157.1	142.3	111.7	117.1	136.9	110.4	98.1	119.4	113.2	120.0	116.7	124.1	94.1
Otago	130.4	132.0	123.2	121.0	118.9	109.7	99.1	99.2	105.8	98.8	97.3	91.0	97.5	73.3
Southland	154.5	172.7	148.3	143.2	139.7	119.0	122.5	136.8	117.9	111.1	100.3	96.5	97.0	90.8

While there has been a decline in rates since 2000, the rate for Maori remains high.

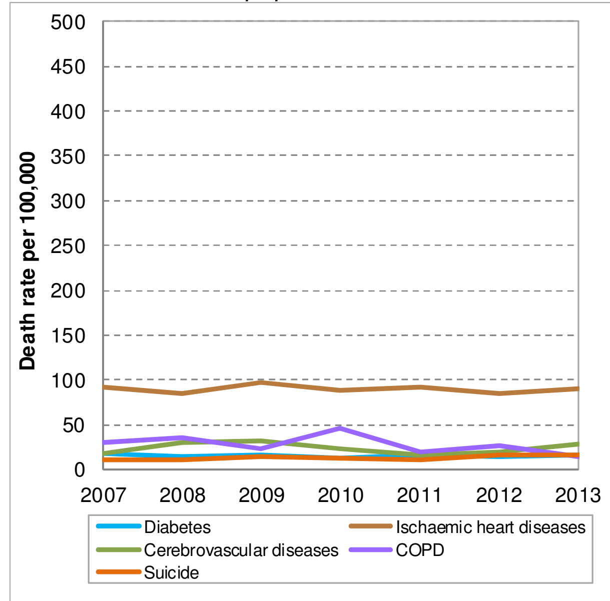
Death rates 2013 by DHB by ethnicity age standardised to WHO population



Deaths /100,000 from selected causes, Northland Maori population 2007-2013



Deaths /100,000 from selected causes, Northland non-Maori population 2007-2013



How will we get there?

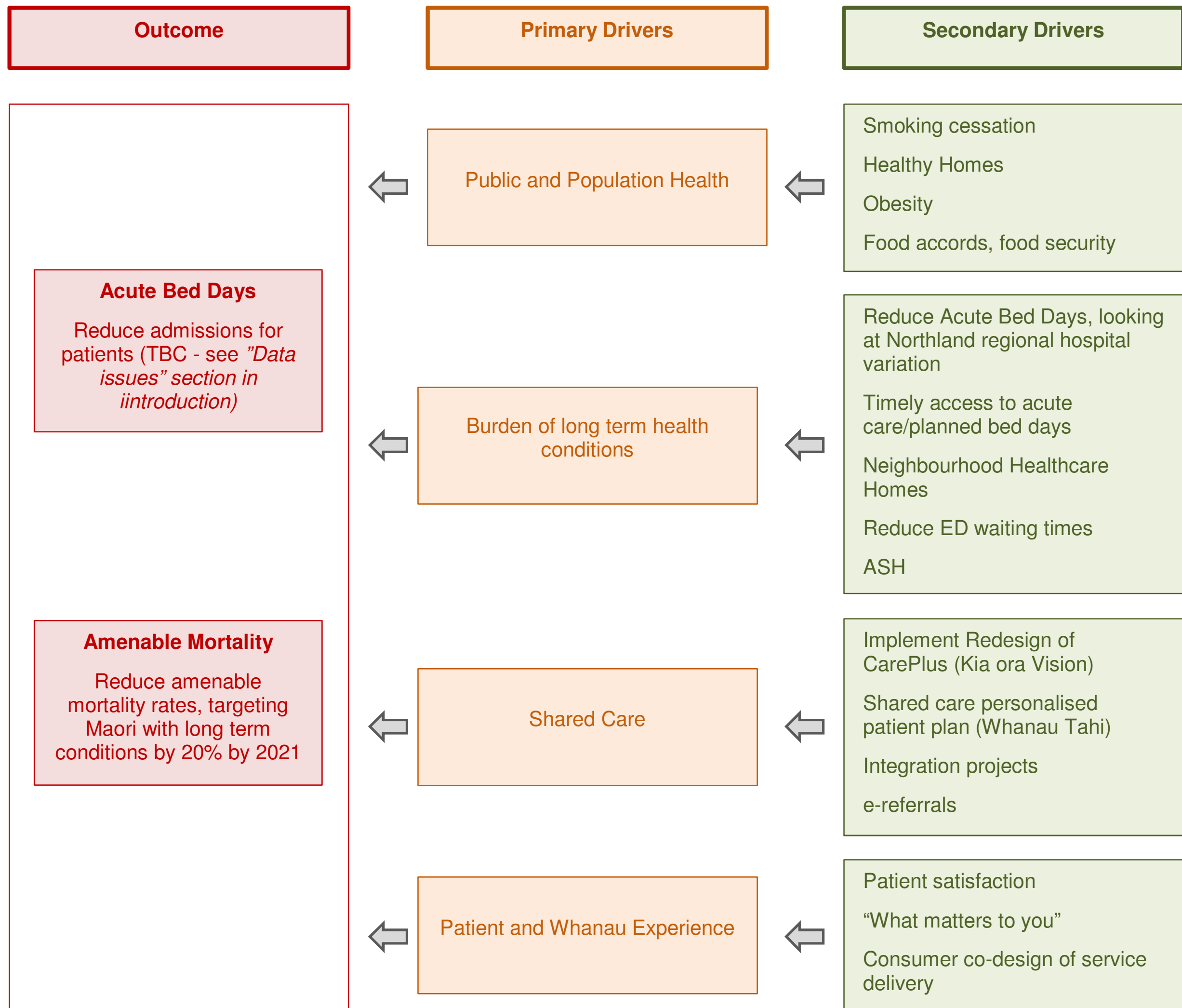
Contributory Measures	Benefit/ Rationale	Linkages
Smoking Hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking. Primary Health Organisation (PHO) enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months. Pregnant women who identify as smokers upon registration with a DHB employed Midwife or Lead Maternity Carer who are offered brief advice and support to stop smoking.	Reduction in ASH for respiratory conditions and for amenable mortality More life years	Community Respiratory Service. Primary Care Specialist Respiratory Pathway. Increased emphasis on reducing tobacco uptake and increasing cessation, with a particular focus on Maori and primary health care delivery. Community based stop smoking services supporting a target of 1350 quits per annum across Northland. Northland PHOs supporting 2,000 quit attempts per annum. Supporting promotion of smokefree messages and cessation through World Smokefree Day, Stoptober. Tobacco control strategies: smokefree parks, playgrounds, town centres across Northland, controlled purchase operations. Advocacy for national legislation on implementation of plain packaging, e-cigarettes, increasing tax. Work being done by Auahi Kore Hapunga Alliance.

All these Contributory Measures need more detail by deprivation, ethnicity and quintile (refer to “Data issues” in the introduction).

Other Contributory Measures	Benefit/ Rationale	Linkages
Acute admissions Acute/arranged hospital admissions of	Reduce acute bed days, looking at Northland regional	Primary Options ED target

Other Contributory Measures	Benefit/ Rationale	Linkages
PHO enrolled population aged 15-75. Inpatient Average Length Of Stay (ALOS) for acute admissions Patients admitted, discharged, or transferred from an emergency department within six hours	hospital variation. Care closer to home Timely access to acute care	Screening and prevention programs Amenable mortality Risk stratification Neighbourhood Healthcare Homes
ASH Ambulatory Sensitive Hospitalisation (ASH) rate per 100,000 population, for 45 - 64 year olds Influenza vaccinations for 65 year olds and over PHO enrolled people within the eligible population who have had a CVD risk recorded within the last five years	Reduction in amenable mortality for Maori Reduction in acute bed days	CVD risk assessment in primary health care Flu Vacs Smoking rates and ABC intervention Tobacco control Kia Ora Vision (Care Plus) Whakamana Hauora (Stanford model) Urgent Care Access Programme Manaaki Manawa Heart Care Healthy Homes, housing generally Amenable mortality Shared care planning (Whanau Tahi) Health Strategy – “Living Well” Diabetes Strategy
LOS Inpatient average length of stay for acute readmissions for people aged 20 to 64 years old Occupied bed days for patients 75 years and over who had two or more emergency admissions within a calendar year	Safety in transition of care and handover of care Early engagement of community based rehabilitation, specialist gerontology services and home based support, close to home Reduction in polypharmacy	Primary Options Community based rehabilitation Stroke Hospital to Home Pathway Cardiac/ respiratory rehabilitation Dementia Pathway Discharge planning Community Pharmacy Contract

Driver diagram



4 Patient Experience of Care – a system level measure for Northland DHB and Northland PHOs

Definition

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-centred care have been linked to improved health, clinical, financial, service and satisfaction outcomes.

This measure captures patient experience in two settings: ospital Inpatient Surveys (currently undertaken quarterly since 2014) and Primary Care Survey (introduced in a phased approach quarterly from Feb 2016).

Patient experience surveys provide scores for four domains which cover key aspects of a patient's experience when interacting with health care services:

- communication
- partnership
- coordination
- physical and emotional needs.

The purpose of these measures is to ensure patients in New Zealand are receiving quality, effective and integrated 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.

Improvement milestone

1 Northland patients will rate their overall inpatient experience at 8.5 or greater.

2 The Primary Care survey will be introduced across Northland general practices in 2017.

Rationale

How people experience health care is a key element of system performance that can be influenced by all parts of the system and the people who provide the care. Improved patient experience of care will reflect better integration of heath care at the service level, better access to information and more timely access to care.

Where are we now?

Primary Care Survey not currently active in Northland.

Patient portal is available in some practices in Northland and uptake, at this stage, is optional for use within general practice. It is however strongly supported and encouraged by the PHOs.

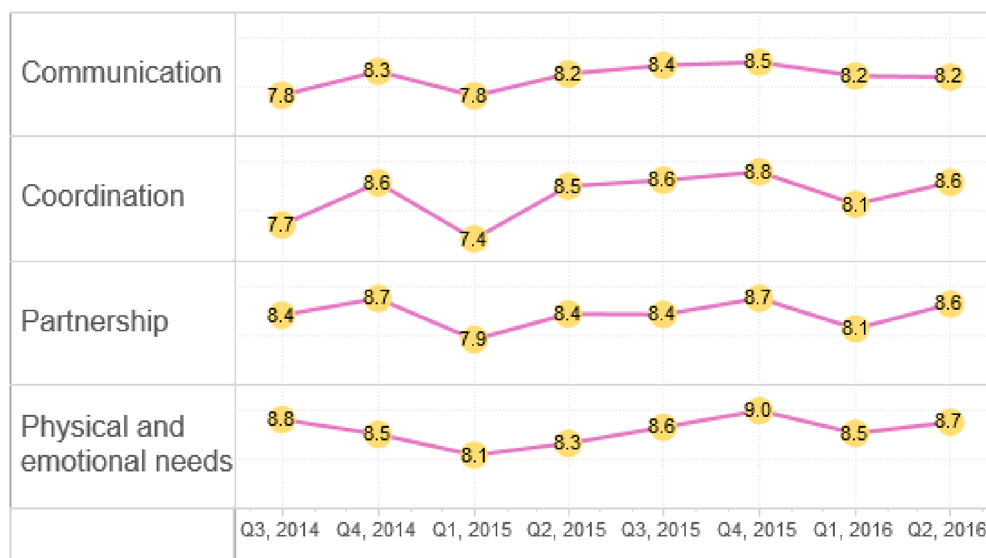
National Enrolment Service is not currently available across Northland primary health care practices.

Inpatient survey within DHB in use as per MoH guidelines.

Current patient survey, connectivity states

Northland DHB Inpatient Survey data – Q2 report

Score out of 10



Patient Portal Information for Te Tai Tokerau PHO Ltd (July 2016)

Lead DHB	PHO Name	Practice Name	Offering a Patient Portal?	Number of Patients Using a Patient Portal	Type of Portal	Offering shared access to other providers?
Northland DHB	Te Tai Takerau PHO Ltd	Bayview Medical Centre	Yes	474	Manage My Health	"No"
Northland DHB	Te Tai Takerau PHO Ltd	Broadway Medical Center	Yes	176	Manage My Health	"Yes"
Northland DHB	Te Tai Takerau PHO Ltd	Commercial Street Surgery	No			"Yes"
Northland DHB	Te Tai Takerau PHO Ltd	Hauora Hokianga	Yes	n/a	My Practice	"Yes"
Northland DHB	Te Tai Takerau PHO Ltd	Hauora Whanui Kawakawa MC	Yes	n/a	Manage My Health	"Yes"
Northland DHB	Te Tai Takerau PHO Ltd	Kerikeri Medical Centre	Yes	1,447	Manage My Health	"Yes"
Northland DHB	Te Tai Takerau PHO Ltd	KeriMed Doctors Partnership	Yes	412	Manage My Health	"Yes"
Northland DHB	Te Tai Takerau PHO Ltd	Moerewa Medical Services	No			"Yes"
Northland DHB	Te Tai Takerau PHO Ltd	Russell Medical Services	No			"Yes"
Northland DHB	Te Tai Takerau PHO Ltd	Te Kohanga Whakaora	No			"Yes"
Northland DHB	Te Tai Takerau PHO Ltd	Te Whare Hauora O Te Hiku	Yes	614	Manage My Health	"Yes"
Northland DHB	Te Tai Takerau PHO Ltd	The Paihia Surgery	Yes	45	Manage My Health	"Yes"
Northland DHB	Te Tai Takerau PHO Ltd	Top Health	No			"Yes"
Northland DHB	Te Tai Takerau PHO Ltd	Whakawhiti Ora Pai	Yes	11	Manage My Health	"Yes"
Northland DHB	Te Tai Takerau PHO Ltd	Whangaroa Health Services Trust	Yes	257	Manage My Health	"Yes"

Patient Portal Information for Manaia Health PHO Ltd (July 2016)

Lead DHB	PHO Name	Practice Name	Offering a Patient Portal?	Number of Patients Using a Patient Portal	Type of Portal	Offering shared access to other providers?
Northland DHB	Manaia Health PHO Limited	Bream Bay Medical Centre Ltd	Yes	301	Manage My Health	"Yes"
Northland DHB	Manaia Health PHO Limited	Bush Road Medical Centre	Yes	870	Manage My Health	"Yes"
Northland DHB	Manaia Health PHO Limited	Central Family Health Centre	Yes	179	Manage My Health	"Yes"
Northland DHB	Manaia Health PHO Limited	Dargaville Medical Centre	Yes	345	Manage My Health	"Yes"
Northland DHB	Manaia Health PHO Limited	Hikurangi Medical Centre	No			"Yes"
Northland DHB	Manaia Health PHO Limited	James Street Doctors Ltd	No			"Yes"
Northland DHB	Manaia Health PHO Limited	Ngunguru Medical Centre	No			"No"
Northland DHB	Manaia Health PHO Limited	Northland Environmental Health	No			"No"
Northland DHB	Manaia Health PHO Limited	Onerahi Medical Centre	Yes	129	Manage My Health	"Yes"
Northland DHB	Manaia Health PHO Limited	Paramount Medical Centre	Yes	469	Manage My Health	"Yes"
Northland DHB	Manaia Health PHO Limited	Peak Health Ltd t/a WSM	Yes	859	Manage My Health	"Yes"
Northland DHB	Manaia Health PHO Limited	Primecare	Yes	55	Manage My Health	"Yes"
Northland DHB	Manaia Health PHO Limited	Rata Family Health - Dr Scott	Yes	27	Manage My Health	"Yes"
Northland DHB	Manaia Health PHO Limited	Rata Family Health - Dr Testa	Yes	16	Manage My Health	"Yes"
Northland DHB	Manaia Health PHO Limited	Raumanga Medical Centre	Yes	254	Manage My Health	"Yes"
Northland DHB	Manaia Health PHO Limited	Rust Ave MC -Dr Whitton	Yes	141	Manage My Health	"Yes"
Northland DHB	Manaia Health PHO Limited	Te Aroha Noa Medical Centre	No			"Yes"
Northland DHB	Manaia Health PHO Limited	Te Hau Awhiowhio Health Centre	No			"Yes"
Northland DHB	Manaia Health PHO Limited	Te Whareora O Tikipunga	Yes	65	Manage My Health	"Yes"
Northland DHB	Manaia Health PHO Limited	Tui Medical Centre	Yes	113	Manage My Health	"Yes"
Northland DHB	Manaia Health PHO Limited	Waiarohia MC - Dr Bowker	No			"No"
Northland DHB	Manaia Health PHO Limited	Waiarohia MC - Dr Ohnmar	No			"No"
Northland DHB	Manaia Health PHO Limited	Waiarohia MC - Dr Pishief	No			"No"
Northland DHB	Manaia Health PHO Limited	Waipu Medical Centre	Yes	12	Manage My Health	"Yes"
Northland DHB	Manaia Health PHO Limited	Westend Medical Centre	Yes	434	Manage My Health	"Yes"

How will we get there?

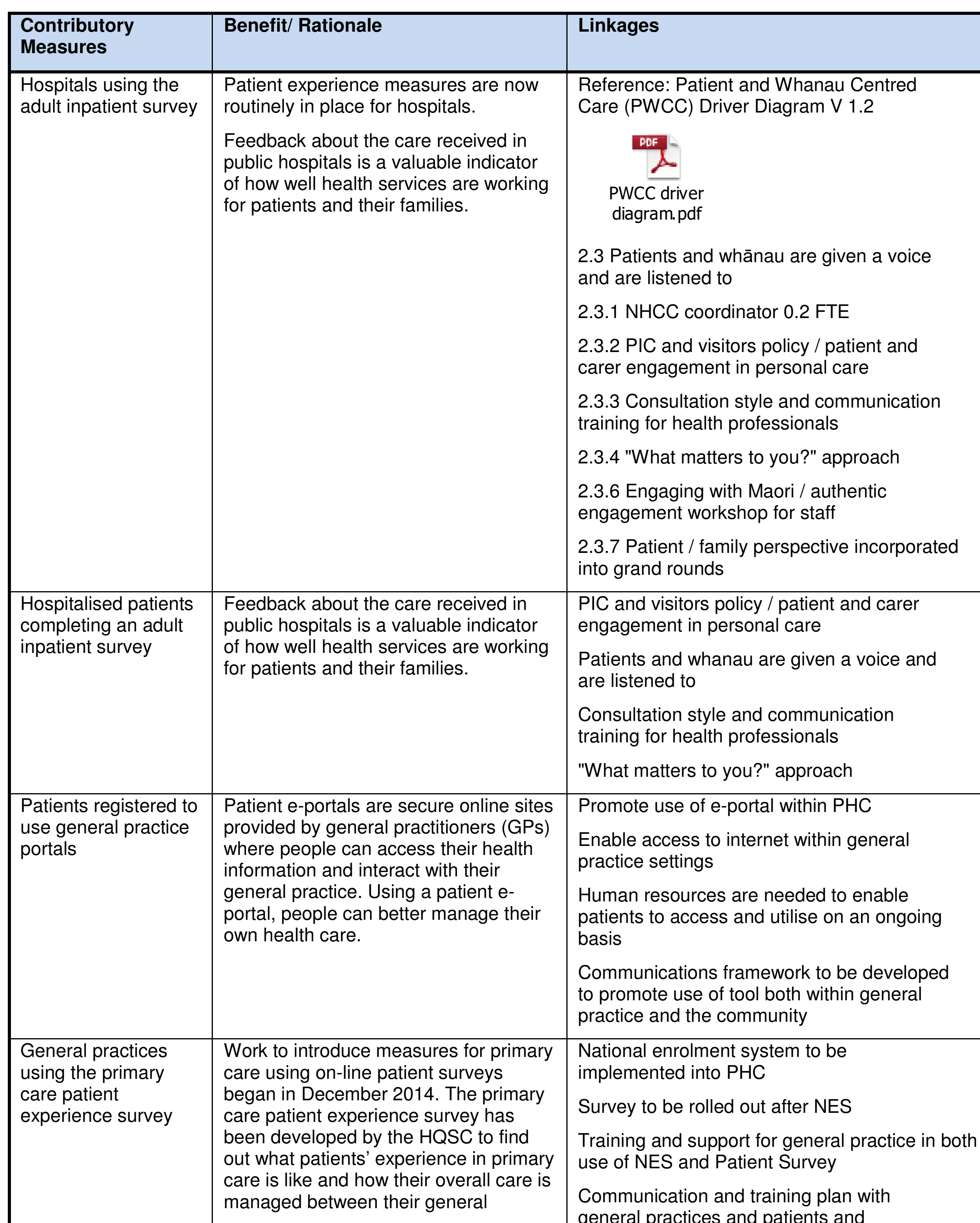
National enrolment system to be implemented during 2017.

Primary Care Survey to be implemented during 2017.

Training, communications and IT Infrastructure and resources will be required.

Use of MoH inpatient data survey is already well embedded in NDHB Quality Systems management.

Efforts will be made to gather data on all contributory measures by deprivation, ethnicity and geographic location if available.



Contributory Measures	Benefit/ Rationale	Linkages
Hospitals using the adult inpatient survey	Patient experience measures are now routinely in place for hospitals. Feedback about the care received in public hospitals is a valuable indicator of how well health services are working for patients and their families.	Reference: Patient and Whanau Centred Care (PWCC) Driver Diagram V 1.2 PWCC driver diagram.pdf 2.3 Patients and whānau are given a voice and are listened to 2.3.1 NHCC coordinator 0.2 FTE 2.3.2 PIC and visitors policy / patient and carer engagement in personal care 2.3.3 Consultation style and communication training for health professionals 2.3.4 "What matters to you?" approach 2.3.6 Engaging with Maori / authentic engagement workshop for staff 2.3.7 Patient / family perspective incorporated into grand rounds
Hospitalised patients completing an adult inpatient survey	Feedback about the care received in public hospitals is a valuable indicator of how well health services are working for patients and their families.	PIC and visitors policy / patient and carer engagement in personal care Patients and whanau are given a voice and are listened to Consultation style and communication training for health professionals "What matters to you?" approach
Patients registered to use general practice portals	Patient e-portals are secure online sites provided by general practitioners (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.	Promote use of e-portal within PHC Enable access to internet within general practice settings Human resources are needed to enable patients to access and utilise on an ongoing basis Communications framework to be developed to promote use of tool both within general practice and the community
General practices using the primary care patient experience survey	Work to introduce measures for primary care using on-line patient surveys began in December 2014. The primary care patient experience survey has been developed by the HQSC to find out what patients' experience in primary care is like and how their overall care is managed between their general	National enrolment system to be implemented into PHC Survey to be rolled out after NES Training and support for general practice in both use of NES and Patient Survey Communication and training plan with general practices and patients and

Contributory Measures	Benefit/ Rationale	Linkages
	practice, diagnostic services, specialists and/or hospital staff. The information will be used to improve the quality of service delivery and patient safety.	community
Patients completing the primary care patient experience survey	Work to introduce measures for primary care using on-line patient surveys began in December 2014. The primary care patient experience survey has been developed by the HQSC to find out what patients' experience in primary care is like and how their overall care is managed between their general practice, diagnostic services, specialists and/or hospital staff. The information will be used to improve the quality of service delivery and patient safety.	Communications and training plan to be developed to encourage use of survey across Northland
General practices using the National Enrolment Service	The NES has been developed to provide a single definitive source for all national enrolment and identity data. The benefits of NES are: • centralised register with real time patient enrolment status enabling more timely payment calculation for enrolled patients • "single source of truth" for enrolment data to ensure accuracy of Capitation Based Funding calculations • validated National Health Index numbers and up to date patient demographics, supporting accurate identification of patients and clinical safety • validated addresses using e-SAM service, supporting accurate geocoding and assignment of deprivation-based funding • nightly register updates to NES • amended enrolment business rules, due to real time enrolment and more timely funding of patients • web services integration with PMS, creating a seamless experience for the user when interacting with the national service • enabler for performance management purposes • no stand down period for patient enrolment, allowing patients to be funded from the day they are physically enrolled and entered into NES by the practice. • population of the new patient preference fields made available as part of the NES rollout, enabling practices to begin using the new Patient Experience Survey, which will be recognised as a source of evidence towards meeting Indicator 9 of the Foundation Standard and Aiming for Excellence: The practice includes patients' input into service	National enrolment system to be implemented into primary health care across Northland Communications and training plan to be developed to encourage use

Contributory Measures	Benefit/ Rationale	Linkages
	planning. • enabler for System Level Measure "Patient Experience of Care"	
GP practices offering an e-portal	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	Promote use of e-portal within PHC Enable access to internet within general practice settings Survey those not using e-portals to identify barriers Provide a change management process with support

5 Youth Appropriate Services

The Ministry is yet to announce the nature of the measure. It is intended to capture how well youths are making good choices about their health and wellbeing. Early detection and proactive management is vital to youth health, though access to youth-appropriate services is variable.

Irrespective of how the measure is worded or the data is to be captured, we can still select contributory measures which we consider to be the most relevant and important. These are:

- % of teenage births/terminations
- % of youth enrolled in and utilising Health Services (primary care, GPs)
- % of youth enrolled in education or training
- % of youth hospitalisations due to alcohol related conditions
- % of youth hospitalisations due to intentional or unintentional injuries
- % of youth that are decay free at 12 years
- % of youth that have been diagnosed with an STI
- % of youth under 18 years that are using contraception
- % of girls aged 12 are fully immunised against HPV infections
- Number of services using screening tools to diagnose mental health
- Number of youth screened for mental health issues
- Waiting times for non-urgent mental health and addiction service for 0 – 19 year olds
- Youth smoking rates
- Sexual health assessment project

6 Smokefree Babies

The Ministry is yet to announce the nature of the measure for this; the draft wording is "babies who live in a smokefree household at 6 weeks postnatal".

Irrespective of how the measure is worded or the data is to be captured, we can still select contributory measures which we consider to be the most relevant and important. Provisionally, these are:

- Mothers who are smokefree at two weeks postnatal
- Pregnant women who identify as smokers upon registration with a District Health Board (DHB) employed midwife or Lead Maternity Carer (LMC) who are offered brief advice and support to stop smoking
- Four-year-old children living in smokefree homes
- Hospital patients who smoke and are seen by a health practitioner in a public hospital who are offered brief advice and support to quit smoking
- Primary Health Organisation (PHO) enrolled patients who smoke who have been offered help to quit smoking by a health care practitioner in the last 15 months
- Babies whose families/whanau have been referred from their LMC to a Well Child Tamariki Ora provider

- Early registration with a midwife.