BAY OF PLENTY ALLIANCE LEADERSHIP TEAM

SYSTEM-LEVEL MEASURES FRAMEWORK– IMPROVEMENT PLAN

2017 - 2018

Foreword

This second Improvement Plan is the outcome of ongoing collaboration across the primary/secondary provider networks within the Bay of Plenty (BOP) health system. We held a workshop in March 2017 to review progress of the first plan, identify future opportunities and risks and agree contributory measures and activity for this second plan. The workshop was facilitated by Dr Joe Bourne (Clinical Director of Innovation and Improvement) and Carol Limber (Acute Demand Consultant) from Canterbury DHB. We held group discussions on the four current measures and the two new system level measures to be introduced to facilitate the development of this plan. As part of discussions it was agreed to include the proportion of babies who live in a smoke free household at six weeks post-natal as a contributory measure for 0-4 ASH. Having received the MoH details on the new Youth measure, BOPDHB has decided to choose one contributory measure for 2017-18, being "Sexual and Reproductive Health" (Chlamydia testing). This ties in well with our recent BOP sexual health review.

Workshop presentations demonstrated that as a system we are making good progress on reducing ASH and Acute Bed Days. The latter has been well supported by work being undertaken within the Provider Arm by Francis Health. The workshop identified the need for dedicated resource to deliver the System Level Measures (SLM) Framework Improvement Plan. The absence of this resource in 2016/17 has meant that some activities outlined in our first plan were not completed; therefore, these activities have been carried over into this second plan. The workshop identified initiatives and opportunities which may lead to improved performance against the SLMs, and ultimately will deliver better health outcomes for our community.

Throughout this plan we have applied an equity lens to ensure that none of our communities are left behind, with particular commitment to reducing inequities for Maori as this remains a specific priority in the Strategic Health Services Plan. We are also committed to delivering the Good to Great Maori Health initiative.

Framework to Progress and Implement the Plan

This framework has been informed by experience gained in our previous work with the Integrated Healthcare Strategy and Bay Navigator. Early discussions have identified the need for clear delegation of responsibilities and may include assigning clinical champions and implementation leads for each SLM.

Enablers

The Bay of Plenty Alliance Leadership Team (BOPALT) recognises the importance of using information technology (IT) to facilitate the exchange of patient information to support timely, high quality clinical care. There are many opportunities to better integrate the IT systems

currently used across the healthcare system. In BOP, General Practice clinicians and pharmacists already have access to the DHB's electronic health records via CHIP. This is improving both the safety and efficiency of healthcare delivery.

We have taken a medium to long term view on information system enablers, with our approach to align with local and regional activities. BOPALT has appointed the Bay of Plenty Information Systems Group (BOPIS Group) to progress information system development and initiatives that promote integrated care and support implementation of the System Level Measures Plan.

Current objectives of the BOPIS Group and projects within the Group's work programme include:

- Promoting the adoption of good standards and a governance framework for information sharing initiatives.
- Enabling access for secondary care physicians to view the core health information dataset held by primary care providers.
- Overseeing the development of a risk stratification tool.
- Identifying and trialing the use of a shared care planning tool.
- Scoping a solution to address e-referrals.
- Developing a dashboard to aid GPs in managing their patients' care, with the aim to advance from automated PDF reports to real time data, enabling drill down to event level data for GP patients at key touchpoints within secondary care. Touchpoints may include event level data from ED attendances, acute admissions and DNA.
- Identifying resource requirements to develop these systems and prioritising IT work programmes accordingly.

The BOPIS Group continues to work closely with BOPALT to develop timely, high quality and progressive responses to the changing information needs in our evolving single system integrated environment.

AMBULATORY SENSITIVE HOSPITALISATIONS – 0-4 year olds:
Baseline: Overall ASH Rate: 7698, which equates to 1127 events[1]; Maori: ASH rate: 8623 (551 events); Non-Maori: ASH Rate: 6982 (576 events)
Equity gap: 1641 - Maori 0-4 ASH rate is 24% higher than non-Maori 0-4 ASH rate.
Milestone: a 7.5% (Response to Better Public Service target Released May 2017) reduction in overall ASH rate by 30 June 2018.

Actions:	**Contributory Measure:**
• Embed new Immunisation Accountability Group (IAG) with new GP Chair. • Implement new service support model and baby tracker with new provider. • Implement and embed triple registration form.	• The new triple registration form is adopted in 95% of new-born cases by service providers. • 95% of 8-month olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time. • The equity gap between Maori and Non-Maori for 8-month immunisation coverage is less than 5%.
• Establish a collective oral health service plan for quality improvement, including actions that improve key performance measures. • Improve management and use of available oral health data.	• 95% of new-born Maori babies are enrolled with community dental services. • Oral health dashboard is implemented and circulated to relevant stakeholders (this is provided by Planning & Funding).
• Support general practice and other clinicians to identify children, and their family/whanau, eligible for support for improved housing. • Publish referral pathways. • Reduce SUDI rates.	• A baseline is calculated for the number of GP referrals for housing support. • A baseline is calculated for the number of households/children who are provided with housing support. • 90% of Well Child/Tamariki Ora providers are recording whether they distribute SUDI information at Core Contact 1.

AMENABLE MORTALITY
Baseline: Standardised amenable mortality rate 107.4 (2013 FINAL)[2]
Maori baseline: Standardised amenable mortality rate 249.1(2009-2013 data) – for comparison amenable mortality rate of 111.3 for total population over the same period[3]
Equity gap: 137.8 – Maori amenable mortality rate is 124% higher than for the total population (2009-2013 data).
MILESTONE: A minimum 2.5% reduction in the standardised amenable mortality rate for both total population and Maori by 30 June 2018.

Actions:	**Contributory Measure:**
• Improve capacity to capture and report on long term quit rates. • Continue supporting brief interventions in general practice and hospitals. • Increase focus on quit attempts amongst people with mental illness and addictions, through training of health professionals, and use of the Hawkes Bay DHB Six Smokefree Best Practice Principles guidance document.	• Continued improvement against the national Health Target of 90% of eligible patients being offered smoking cessation advice in primary care, with the aim to be the number 1 ranked DHB for this metric by 30 June 2018. • Number of patients referred to, and attending, smoking cessation services. • An increase of quit attempts amongst people with mental illness and addictions. • At least 1,520 regular smokers across BOP are enrolled in the Hapainga Regional Stop Smoking service. • Of those enrolled in the Hapainga service, 50% (annually) have validated quit rates at 4 weeks.
• Ensure all eligible women are referred to and access effective cervical and breast screening, with a particular focus on Maori and other priority women as defined by the National Screening Unit.	• Achievement of national breast and cervical screening targets for all populations, but particularly for Maori. • Reduce the equity gap for Maori women by one third for both breast and cervical screening.

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ACUTE BED DAYS:
Baseline: Age standardised rate of acute hospital bed days per 1000 population for the 12 months to September 2016 – 407.0; non-standardised – 492.1[4]; Maori standardised rate – 527.0.
Equity gap: 120 – Maori standardised rate 29% higher than for the total population.
Milestone: A 2.5% reduction in the standardised rate of acute bed days, while reducing the discrepancy between Maori and total population standardised bed day rates to less than 20% by 30 June 2018.

Actions:	**Contributory Measure:**
• Develop an agreed clinical pathway that supports effective management of patients with COPD within community settings. • Embed CME and CNE to support good practice. • Provide tools and resources to support general practice including a COPD exacerbation plan.	• The newly developed COPD strategy is implemented. • A 10% reduction in annualised Maori 45-64 COPD rates.
• Develop a system for transfer of care from the Emergency Department to community providers. • Support patient engagement with general practice for continuing care for cellulitis.	• A 10% reduction in cellulitis admissions for Maori and total populations.
• Identify and extract the data required to report against this contributory measure. • Work with ACC to develop a falls pathway for at risk people over 65 in the community. • Provide a clinical pharmacist for Aged Residential Care (ARC). • Increase the proportion of patients in ARC facilities with completed future care plans.	• Completion and publication of a falls clinical pathway. • 5% reduction in the number of clients being transferred from ARC facilities to public hospital for end of life care. • A 5% reduction in over 65 admissions related to falls • A 5% reduction in acute admissions from ARC facilities. • Ceiling of Intervention pilot implemented.
• Establish a working group to explore opportunities for increased use of ambulatory care, e.g. heart failure. • Develop GP acute demand management plans to ensure timely responsiveness to acute demand and at risk patients. • Validate benefits of a GP lead telephone triage for their enrolled population. • Regular reporting is embedded at individual Practice-level of acute bed day utilisation by ethnicity. • Embed the after-hours telephone triage service. • Align primary care work with the Provider Arm acute bed flow	• Acute Demand Management plans are completed for at-risk patients for all General Practice. • Benefits of implementing a GP telephone triage service are identified and understood. • A 10% increase in over 65 flu immunisation rates for the 2017 flu season for Maori and total populations

Actions:	**Contributory Measure:**
initiative. • Raise awareness of pharmacies that provide free influenza vaccinations for pregnant women and people over 65.	
• Provide St John ambulance crews with an increased range of options to reduce reliance on hospital transfer, through enhanced integration of healthcare services.	• Number of patients referred directly to clinical services by St John. • Numbers of patients referred from St John to the Homecare Medical Clinical Hub for second triage.
ED work stream: • Refer back to general practice to avoid admission e.g. cellulitis. • Ambulatory emergency care. • Acute clinic slots. • Ambulatory assessment. • Early senior assessment. Frail elderly: • Frailty assessment on admission. • Identify patients at risk of deconditioning and long stay. • Early interdisciplinary team involvement. • Additional emergency theatre at weekends	• Referral system established. • Number of referrals sent. • A 10 % reduction in length of stay (LOS) in the Assessment planning unit • Increased number of patients with length of stay less than 1 day. • Reduced numbers of patients 75 years or over with LOS over 7 days. • Increased numbers of patients 75 years or over with LOS less than 36 hours. • Reduced LOS for patients admitted on the weekend with orthopaedic trauma.

PATIENT EXPERIENCE OF CARE/EMPOWERMENT

Baseline: A baseline does not currently exist against this system level measure.

Milestone: 90% of the eligible enrolled population have been offered the chance to participate in the national Patient Experience of Care Survey. (NB: this Milestone remains dependent on effective PMS alignment to the NES and the national survey system being fully implemented.) We have chosen to broaden this measure to encompass both patient experience and patient empowerment. Outpatient doctor appointment DNA rates for Maori are 15% on average and 6% on average for non-Maori.

Actions:	**Contributory Measure:**
• Increase rollout of Patient Portals across General Practice to improve the interface between patients and their Primary Care Health Team.	• 50% of eligible patients within General Practices currently offering this facility will have access to a Patient Portal. • 50% of General Practices will offer Patient Portals.
• Ensure PHO's support their practices with provision of necessary infrastructure to enable survey participation. • Improve collection of enrolled patient email addresses to enable survey participation.	• 70% of enrolled patients with an email address have this email address on file with their general practice and available to be utilised for PES activities.
• Develop a range of effective methodologies to enable General Practice to better support patients engaging with secondary care services, with a particular focus on reducing DNAs for specialist service appointments for Maori. e.g. Automated texting for appointments.	• Reduce the Maori DNA rate for ENT and Maternity FSA and follow-up by10% from 2016-17 baselines. • Implement the Māori DNA model for improvement within Opotiki over 2017/18 as the next locality for focus.
• Identify areas with high rates of decline referrals and develop strategies to reduce these rates for implementation in the 2018-19 SLM plan.	• Decline rates for elective surgical specialties within secondary and tertiary care are monitored and two areas where there is the greatest potential for patient improvement are identified.
• Implement the agreed approach to increase Future Care Planning in BOP; a patient-centred process to planning end-of-life care	• Numbers of healthcare staff who have completed training in advance care planning (Levels 1A and 2) across the BOP. • 25% of targeted populations have submitted future care plans to the BOPDHB.

YOUTH SYSTEM MEASURE

Domain chosen: Sexual and Reproductive Health with an emphasis on reducing chlamydia. BOPDHB undertook a Sexual and Reproductive Health Services Review in 2016 in line with the Ministry's draft Sexual and Reproductive Health Action Plan. This had strong input from providers and youth through consultation including interactive social media. Key issues noted included the need to improve services in rural areas and for Maori and Pacific to reduce inequalities of access and therefore outcomes. Chlamydia is the most commonly confirmed STI in the BOP, but with asymptomatic rates of 25% in male cases and 70% of female cases, there is a need to increase rates of chlamydia testing, particularly amongst youth, to increase treatment and reduce spread.

The national indicator is chlamydia testing coverage for 15-24 year olds. BOPDHB will aim to increase test coverage in this age group by 20% in 2017/18 with a longer term aim to reduce chlamydia infection.

Baseline: Baseline data for chlamydia rates will be collected from the BOPDHB sexual and reproductive health service review and from providers.

Milestone: A 5% increase in chlamydia testing coverage for youth, based on baseline data collected in 2017/18 and out years, as services are contracted and bedded in. Note that some measures may initially show an increase as access to services is improved, before the new service starts to have a positive impact on measures, e.g. strategies.

Actions:	**Contributory Measure:**
• Establish a sexual and reproductive health working group. • Young people in rural communities who have sexually transmitted infections, particularly chlamydia, are treated in a timely and user friendly manner. • Improve access to age appropriate sexual and reproductive information for young people through a wide range of youth-friendly sources. A focus is placed on transgender youth. • Develop improved relationships with providers and work with them to improve our collective understanding of available data, while identifying opportunities to enhance data quality.	• A 5% reduction in chlamydia rates for 15 to 24 year olds in BOP. • Additional options for accessing sexual health services are implemented in the East. • Funding strategies to support general practice led sexual health clinics are implemented.

PROPORTION OF BABIES WHO LIVE IN A SMOKE-FREE HOUSEHOLD AT SIX WEEKS POST-NATAL
Baseline: Baseline data has been provided, but not accessed at the time of compiling this plan.
Milestone: A 5% increase in the proportion of babies who live in smoke-free households at six weeks post-natal.

Actions:	**Contributory Measure:**
• Extend Hapu Mama Programmes, similar to those currently running in Western Bay of Plenty, into the Eastern BOP. • Develop improved relationships with providers (particularly LMCs and WC/TO) and work with them to improve our collective understanding of available data, while identifying opportunities to enhance data quality.	• Reduce the prevalence of Maori women smoking in pregnancy by 5%. • 30% of pregnant women are registered with a Lead Maternity Carer by third trimester of pregnancy.