RBA Performance Measures Table: Health Assessment and Surveillance

**SK =** Skills / Knowledge **AO** = Attitude / Opinion **BC** = Behavioural Change **CC** = Circumstance Change **S** = Subjective **O** = Objective.

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| 1. **Surveillance: review, monitor, analyse and disseminate surveillance data for action** |

| **Activities** | **Key Performance Measures[[1]](#footnote-1)** | | |
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| **How many**  **(Quantity of effort = #)** | **How well**  **(Quality of effort = %)** | **Is anyone better off?**  **(Quantity and quality of effect # / %)** |
| * Ensure local/regional systems for surveillance (that are within the remit of the organisation) are fit for purpose:   + regularly (eg, at least once every two years) assess the information needs of a representative sample of service users[[2]](#footnote-2) of surveillance products/services to undertake effective public health action.   + use the identified needs of service users to guide:     - local/regional surveillance system requirements     - data reporting, analysis and collection activities.   + ensure system is capable of securely collecting, storing and disseminating data in accordance with current legislation[[3]](#footnote-3), guidelines, protocols and with clinical oversight.   + develop, maintain and implement quality improvement mechanisms to monitor and support timeliness, representativeness, acceptability, sensitivity, positive predictive value (of data), flexibility, simplicity and costs ([Institute of Environmental Science and Research Ltd, 2006](#_ENREF_16)).   + use reasonable endeavours to build effective partnerships with appropriate service users (i.e. organisations and communities) to support:     - a mutual understanding of information requirements     - opportunities for local/regional collaboration on analytical work     - effective knowledge exchange.   + collaborate with national surveillance system providers as required to:     - align interoperability of local/regional systems with national systems     - inform any improvements to national systems that receive local/regional data     - refine nationally produced information and intelligence products/services that support local/regional surveillance systems and public health action     - advise on system requirements identified through the assessment of service users’ needs. * Based on the identified information needs of service users of surveillance information products/services to deliver effective public health action, and in accordance with current relevant legislation, Ministry of Health manuals, guidelines and protocols:   + review, analyse, interpret and periodically report existing surveillance data/information to inform:     - knowledge and understanding of significant and emerging disease trends and distribution by population at regional/local levels.     - assessment of regional/local priority health needs and distribution in population     - planning of regional/local services that impact on health outcomes and specific prevention and control responses     - national level health policy and programme planning, implementation and resource mobilisation.   + collect, collate, analyse, interpret and report any new local/regional surveillance data not required under legislation, that is, non-regulatory and not described under the Health Protection or Preventive Intervention specifications (Ref: Health Protection and Preventive Interventions for details), as agreed with the Ministry. * Transform data into usable public health intelligence/information products to meet the needs of relevant service users (eg, disease-specific report for a condition of concern. PHUs may produce periodic bulletins for health professionals describing local/regional notifiable disease epidemiology[[4]](#footnote-4)). Ensure the analysis considers the impact on specific population sub-groups and on health inequities. * Disseminate the public health intelligence/information products to relevant service users. This may include dissemination through existing and dedicated reports (eg, provider website, print newsletters/reports) or networks. * As part of quality improvement processes, periodically seek feedback from a representative sample of service users on the accessibility and usefulness of the disseminated public health intelligence/information products. Include input from service users to inform any improvements. | **Measure/s: examples** | **Measure/s: examples** | **Measure/s: examples** |
| # service users[[5]](#footnote-5)’[[6]](#footnote-6) (total)  # service users by category[[7]](#footnote-7) | % service users report they are satisfied or very satisfied with (insert aspect here)[[8]](#footnote-8) (ie, rating of 4 or 5 for Likert scale of 1 to 5) | *Can choose from below where relevant* |
| # activities[[9]](#footnote-9) | % activities completed in time (as per agreed timeline)[[10]](#footnote-10) | *Can choose from below where relevant* |
| # partners  # partnerships/collaborations  # of routine[[11]](#footnote-11) analyses/reports produced for dissemination  # of ad hoc information provided to inform action by service users  # service user surveys | % compliance with current legislation, guidelines and protocols (including ethnicity data protocols)  % response rate of service user surveys  % information disseminated that considers the impact on specific population sub-groups and on health inequities  % Māori service users engaged with | #/% service users report that the information disseminated improved their knowledge of the (insert topic/s here) (SK, S)  #/% service users report that their understanding and awareness increased about trends in health events, (including emerging health events) by time, place and person (SK, S)  #/% service users report that they used the information disseminated to inform their planning and public health action (BC, S)  #/% of collaborations that resulted in reduced duplication/improved consistency and improved quality of local/regional/national information products (CC, S) |
| **Complementary narrative reporting: examples** | **Complementary narrative reporting: examples** | **Complementary narrative reporting: examples** |
| * Describe the nature and frequency (as appropriate) of the activities implemented (including the provider’s role in these eg, led or contributed data or public health intelligence/advice). | * Describe the level of accuracy, completeness, validity and timeliness of data collected, produced and disseminated (including high-quality ethnicity data). * Describe the extent you have complied with relevant data collection/collation/analysis/output protocols (including ethnicity data protocols). | * Describe the results achieved, including:   + improved engagement with service users   + increased understanding of information requirements   + increased collaboration on analytical work   + increased knowledge exchange across participating organisations   + improvements made to the surveillance system and future information products /services   + increased availability of timely data/information products, including epidemiological analyses and public health intelligence/advice   + improved awareness and understanding of current/emerging health risks/determinants (eg, identifying trends and outbreaks/ clusters   + improved public health planning and action. |

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| 1. **Monitor, analyse and report on population health status, health need, risk factors, key determinants and disease distribution** |

| **Activities** | **Key Performance Measures** | | |
| --- | --- | --- | --- |
| **How many**  **(Quantity of effort = #)** | **How well**  **(Quality of effort = %)** | **Is anyone better off?**  **(Quantity and quality of effect # / %)** |
| * Contribute to a regional/local description and understanding of population health status, health needs, health determinants, risk factor and disease distribution and threats to health with a particular focus on health equity and the health of Māori. This may include the following:   + engaging with community and key stakeholders to understand information needs, participate in health needs assessment processes and support dissemination of information   + collecting and collating relevant data (eg, data on health status, risk and protective factors, health determinants, determinants of hauora Māori, health care utilisation data relevant to public health, demographic data), for example, local monitoring of tobacco sales volumes and outlet distribution   + monitoring trends in health events by time, place and person (ethnicity, age, sex, deprivation), including for Māori and for populations experiencing inequitable health outcomes   + transforming data into usable public health intelligence/information products to meet the needs of relevant service users, for example:     - developing or updating health status reports/profiles, disease-specific reports for conditions of concern, reports on key health determinants (eg, national and local analysis of the impact of tobacco-related disease, including impact on specific population sub-groups and on health inequities)     - collaborating with local DHB to contribute to health needs assessment for specific populations[[12]](#footnote-12).   + Disseminating the public health intelligence/information products to relevant service users. This may include dissemination through existing and dedicated reports (eg, provider website, print newsletters/reports) or networks.   + Providing relevant routinely collected public health data /information to support DHB(s) to undertake planning, analysis and reporting function.   + Providing relevant data to the Ministry and other government agencies as appropriate.   + As part of quality improvement processes, periodically seek feedback from a representative sample of service users on the accessibility and usefulness of the disseminated public health intelligence/information products. Include input from service users to inform any improvements.   + Operate effective local /regional information systems for collecting and storing data in accordance with current legislation (including Privacy Act 1993, Health Information Privacy Code 1994, Health Act 1956 and any current amendments), guidelines and protocols[[13]](#footnote-13). System must maintain data security and maintain confidentiality.   **Note**: The use of health assessment information to inform local and regional service planning and prioritisation are described under the Tier 2 Public Health Capacity Development. | **Measure/s: examples** | **Measure/s: examples** | **Measure/s: examples** |
| # service users[[14]](#footnote-14),[[15]](#footnote-15) (total)  # service users by category[[16]](#footnote-16)  # of routine[[17]](#footnote-17) analyses/reports produced for dissemination  # service user surveys | % service users report they are satisfied or very satisfied with (insert aspect here)[[18]](#footnote-18) (ie, rating of 4 or 5 for Likert scale of 1 to 5)  % compliance with relevant data collection/collation/analysis/output protocols (including ethnicity data protocols)[[19]](#footnote-19)  % service user satisfaction with the (insert aspect here ie, quality of content, timeliness of production) of the disseminated information  % response rate of service user surveys  % information disseminated that considers the impact on specific population sub-groups and on health inequities  % Māori service users engaged with | *Can choose from below where relevant:*  #/% service users report that the information disseminated improved their knowledge of health determinants (SK, S)  #/% service users report Improved understanding of Māori health determinants and aspirations for hauora Māori (SK, S)  #/% service users report that their understanding and awareness increased about trends in health evens, by time, place and person (SK, S)  #/% service users report they are sufficiently informed to access and use current public health information and data  #/% service users report that they used the information disseminated to inform their planning, (including identification and prioritisation of priority populations), programme design and delivery of prevention and control services (BC, S) |
| **Complementary narrative reporting: examples** | **Complementary narrative reporting: examples** | **Complementary narrative reporting: examples** |
| * Describe the nature and frequency (as appropriate) of the activities implemented (including the provider’s role in these, for example, led or contributed data or public health intelligence/advice). | * Describe whether ethical issues have been considered and ethical approval sought from an approved ethics committee in New Zealand as appropriate. * Describe whether the data/information collected, produced and disseminated is accurate, complete, and timely and relevant to end users. * Describe the extent you have complied with relevant data collection/collation/analysis/output protocols (including ethnicity data protocols). * Describe whether quality improvement processes have been documented and implemented. Provide any relevant details on:   + actions taken to enhance the accurateness, completeness, validity and timeliness of data collected, produced and disseminated (including high-quality ethnicity data)   + whether end users of information/ intelligence products are being identified and asked to assess the usefulness of the products and their effectiveness in informing public health action at least once every two years | * Describe the results achieved, including:   + Improved engagement with end-users   + Increased understanding of information requirements   + Increased collaboration on analytical work   + Increased knowledge exchange across participating organisations   + Increased availability of timely data/information products including epidemiological analyses and public health intelligence/advice   + Improvements made to the future information products / services (eg, as a result of end-user feedback)   + Increased awareness and understanding of current/ emerging health risks/determinants * Improved public health planning and action including for example:   + Evidence that health needs assessment findings are being used to identify and prioritise public health action to priority populations.   + Evidence that health needs of communities have been understood and prioritised according to the availability of resources to meet those needs. |

1. A reporting period will be agreed for all performance measures. Data may be requested by ethnicity, age, sex or socio-economic status. [↑](#footnote-ref-1)
2. Service users (or clients) of surveillance data include, for example, health and social sector providers, such as local/regional government, health protection services, other personal and public health service planners and providers (e.g. DHBs, PHUs, NGOs, Māori and Pacific NGOs), researchers, and also members of communities, iwi/hapū/whānau, individuals, media, national surveillance system providers. Service users may also include internal staff, colleagues, teams or units of the DHB. It is recognised that communities (including members/stakeholders) are effectively our client pool and the actual clients are service users that are actually engaged with. [↑](#footnote-ref-2)
3. Including Privacy Act 1993, Health Information Privacy Code 1994, Health Act 1956 and any current amendments, Ethnicity Data Protocols for the Health and Disability Sector 2004 and 2009. [↑](#footnote-ref-3)
4. Examples include: CPH Public Health Information Quarterly <http://www.cph.co.nz/Files/PHIQ2013-1.pdf> , ARPHS Public Health Quarterly <http://www.arphs.govt.nz/health-information/health-professionals>, Toi te Ora Medical Officer Health Reports <http://www.ttophs.govt.nz/vdb/document/1013> [↑](#footnote-ref-4)
5. Service users are ‘clients’ and they will be discussed and agreed between funder and provider. They may include public health staff who receive capacity development support/services from the provider. [↑](#footnote-ref-5)
6. Reported by ethnicity in accordance with Ethnicity Data Protocols for the Health and Disability Sector 2004 and 2009. [↑](#footnote-ref-6)
7. Category to be defined between funder and provider. [↑](#footnote-ref-7)
8. For example, you may want to know about how easy the content of distributed material is to read (from the service user perspective) or the timeliness of engagement hui. You can either ask for overall satisfaction related to a particular aspect of the activities delivered. We suggest that Public Health Group (PHG) National Services Purchasing adopt a similar Likert scale for satisfaction measures of this nature across the board, if this measure is chosen (Likert scale: 1 very dissatisfied; 2 dissatisfied; 3 neutral; 4 satisfied; 5 very satisfied). [↑](#footnote-ref-8)
9. The type of activities you want to count should be agreed between the funder and provider or you can ask the provider to self-define linked to the type of activities they will deliver. [↑](#footnote-ref-9)
10. You will need to either agree the dimension of time or agree for providers to report against the timelines they set independently. [↑](#footnote-ref-10)
11. Routine is defined as: annual/quarterly/monthly/weekly. [↑](#footnote-ref-11)
12. Health Needs Assessment (HNA):

    Under the New Zealand Public Health and Disability Act 2000, DHBs are required: “*to regularly investigate, assess, and monitor the health status of its resident population, any factors that the DHB believes may adversely affect the health status of the population and the needs of that population for services* (Clause 18(g))”. Thus in many districts the development of a HNA is led by the DHB Funding and Planning team, with variable levels of input from PHUs and other public health providers. In some districts, where there is capacity, the PHUs may prepare Health Profiles for the district/region.

    There are a number of useful guides and examples of HNA, for example: <http://www.nice.org.uk/aboutnice/whoweare/aboutthehda/hdapublications/health_needs_assessment_a_practical_guide.jsp> DHB websites [↑](#footnote-ref-12)
13. Including Privacy Act 1993, Health Information Privacy Code 1994, Health Act 1956 and any current amendments [↑](#footnote-ref-13)
14. Service users are ‘clients’ and they will be discussed and agreed between funder and provider. They may include public health staff who receive capacity development support/services from the provider. [↑](#footnote-ref-14)
15. Reported by ethnicity. Ethnicity definitions to be agreed. [↑](#footnote-ref-15)
16. Category to be defined between the funder and provider. [↑](#footnote-ref-16)
17. Routine is defined as: annual/quarterly/monthly/weekly. [↑](#footnote-ref-17)
18. For example, you may want to know about how easy the content of distributed material is to read (from the service user perspective) or the timeliness of engagement hui. You can either ask for overall satisfaction or satisfaction related to a particular aspect of the activities delivered. We suggest that PHG should adopt a similar Likert scale for satisfaction measures of this nature across the board, if this measure is chosen (Likert scale: 1 very dissatisfied; 2 dissatisfied; 3 neutral; 4 satisfied; 5 very satisfied). [↑](#footnote-ref-18)
19. Includes consideration of ethics. [↑](#footnote-ref-19)