West Coast Health System

IMPROVEMENT PLAN

System Level Measures Framework 2018-2019

To be read in conjunction with the West Coast DHB Annual Plan

Photo courtesy of Wendy Elwood

THE WEST COAST HEALTH SYSTEM
– supporting you to be well

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Introduction

The System Level Measures Framework was introduced by the Ministry of Health in 2016/17 and encourages a system-wide approach to improving health outcomes. It presents a core set of national outcomes for the health sector to strive towards with the opportunity to identify a set of local contributory measures, aligned with each of the national outcomes.

KEY ACHIEVEMENTS

The West Coast Alliance has monitored the progress of the 2017/18 Improvement Plan throughout the year and is pleased to see the progress being made both in local contributory measures as well as the nationally selected System Level Measures.

Improvements to the enrolment process for Community Oral Health services have seen 99% of our pre-school population receiving their annual oral health check on time in 2017, up from 91% in 2016. Regular checks allow for early intervention where necessary and provide the opportunity for clinicians to reinforce the importance of baby teeth and good oral hygiene practices.

Coordinated promotion and efforts by general practices, pharmacies and the team at Poutini Waiora saw 63% of our Māori population aged 65 or over receiving their free seasonal influenza vaccination in the 2017 flu season, up from 50% in 2016. This key group are at higher risk of influenza and this programme provides good protection against a preventable hospitalisation.

Two of our general practices are now enrolling patients who have a long term mental health condition into the free long term conditions management programme which allows patients to access a free annual health check. Working in this way allows patients to consider their physical and mental health needs as a complete picture.

A data quality improvement project that has seen collaboration between our DHB B4 School Check (B4SC) service, general practices and the Ministry of Health has ensured that 100% of children identified as obese at their B4SC were offered a referral to their GP for ongoing support with growth monitoring and lifestyle interventions, up from 17% in 2016/17.

NEXT STEPS

As the development of this way of working moves into its third iteration, the plan for 2018/19 builds on the coordinated efforts of the West Coast DHB, West Coast PHO, our Māori Health provider Poutini Waiora and Community & Public Health in previous years. This year the System Level Measures Framework has been more visibly woven into the Alliance workstream activity as well as into the DHB Annual Plan and Statement of Intent.

Regular reference to, and reporting against previous System Level Measure plans has highlighted the value of good data and good understanding of trends. As our system becomes more familiar with the framework, our people are better able to understand how selecting the most appropriate contributory measures can have an impact on population level outcomes. During the 2018/19 year further engagement with the wider system, including our NGO partners and our consumers, will be supported by continuing to share knowledge about the measures and inviting their perspectives.

EQUITY LENS

The West Coast Alliance has Poutini Waiora representation on all workstreams and on the operational Alliance Support Group. At the Alliance Leadership Team level, Māori health expertise is appointed by our Mana Whenua Advisory Committee, Tatau Pounamu. The Alliance will provide leadership and is committed to action around achieving health equity. While there are many health issues of interest and concern, it is acknowledged that adopting the health equity lens when planning programmes and services is a priority. The Alliance has continued to focus on areas of inequity by examining local and national data sets to identify where health inequalities exist and prioritise actions to address these. We will continue to report equity outcomes wherever possible.

Stella Ward
CHAIR | WEST COAST ALLIANCE

David Meates
CHIEF EXECUTIVE | WEST COAST DHB

Helen Reriti
EXECUTIVE OFFICER | WEST COAST PRIMARY HEALTH ORGANISATION

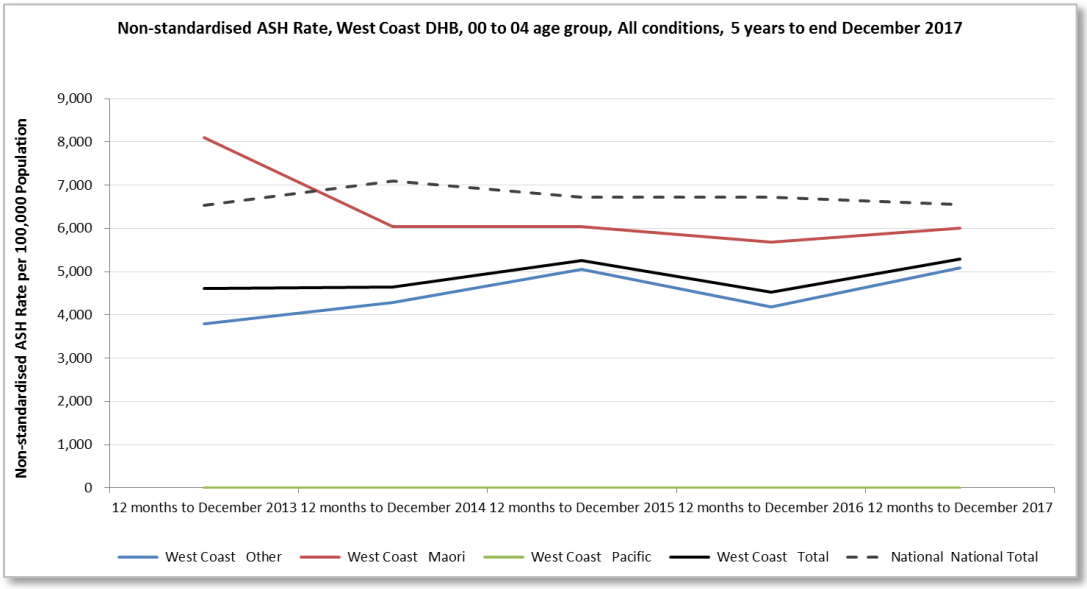
National Outcomes and Local Contributory Measures

1. Ambulatory Sensitive Hospitalisations (0 – 4 year olds)

Outcome: Reduced avoidable hospital admissions among children

Ambulatory Sensitive Hospitalisations (ASH) highlight the burden of disease in childhood with a strong emphasis on health equity. There is high variance among priority populations and also according to social gradient. Reducing ASH rates requires well-integrated and coordinated, preventive, diagnostic and disease management systems and a well-skilled and resourced workforce.

BASELINE PERFORMANCE



Population		12 months to December 2013	12 months to December 2014	12 months to December 2015	12 months to December 2016	12 months to December 2017
West Coast	Other	3,788	4,286	5,047	4,194	5,081
West Coast	Māori	8,095	6,047	6,047	5,682	6,000
West Coast	Total	4,605	4,645	5,261	4,523	5,290
National	Total	6,541	7,101	6,729	6,730	6,545

2018/19 MILESTONE

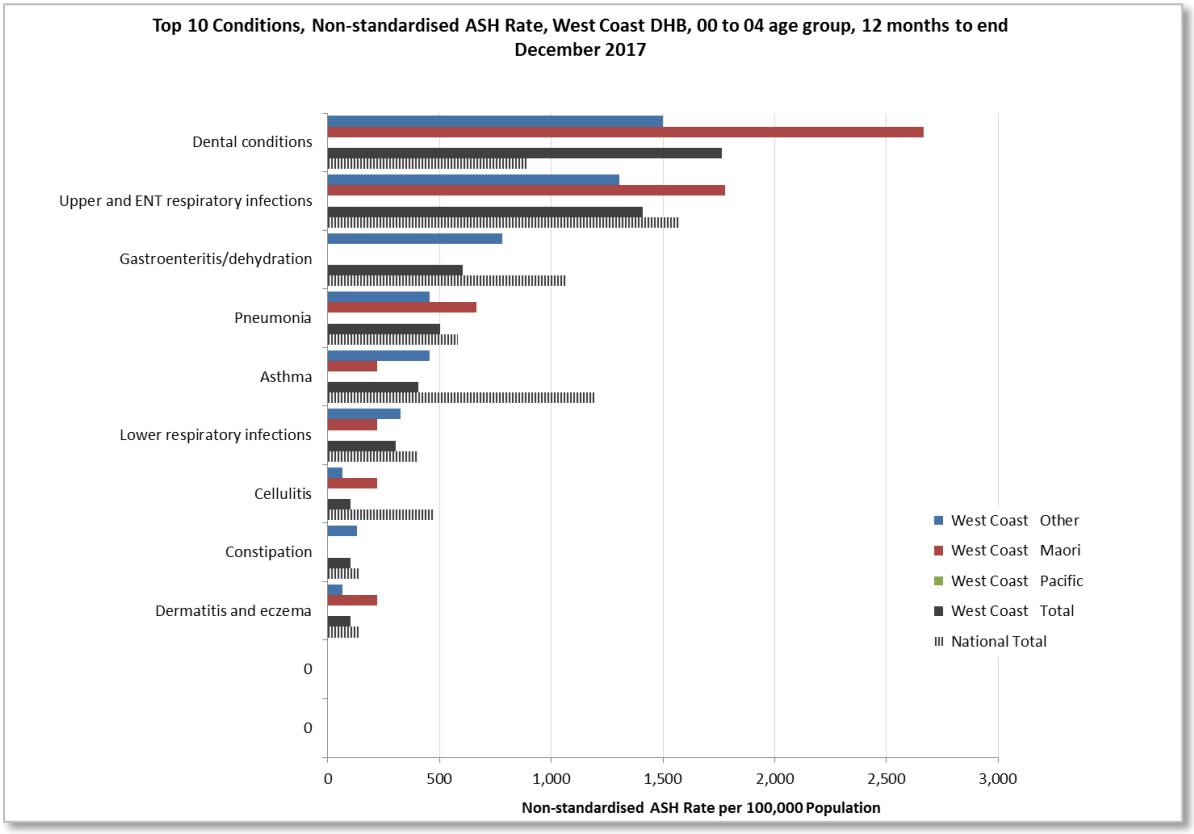
Reduce the equity gap in ASH rates for 0-4 year olds between Māori and non-Māori to less than current rate of 710 (as at the end of December 2017).

In setting the milestone for the 2018/19 year a number of factors have been taken into account:

- West Coast DHB's ASH rate improved significantly in the 12 months to December 2017 and remains much lower than the national average across all population groups. On setting the milestone, the focus has been placed on maintaining these gains, keeping West Coast rates below the national average and reducing the gap between Māori and non-Māori rates.
- Rates are prone to variation given the small size of our population and the statistical effect of converting these small numbers to a rate per 100,000. This is particularly so with Māori, with the 2017 result relating to just 27 people. Whilst the milestone may seem conservative, the result will be impacted by only a few people.

ASH admissions into hospital are for conditions which are seen as preventable through lifestyle change, early intervention and the effective management of long-term conditions. For ASH admissions into hospital on the West Coast, for those aged 0 to 4, the single largest category relates to dental conditions (see graph below). This has been a leading driver for some time and the Alliance has chosen this area as a focus for improving ASH rates for 0 - 4 year olds. The graph also highlights the disparity between Māori and non-Māori. It is important to note however, that the number of actual events (admissions) for dental conditions is just 35 (12 for Māori).

Respiratory and asthma conditions are the next largest drivers of ASH admissions on the West Coast and a number of actions are included elsewhere in this plan that focus on smoking cessation to reduce respiratory admissions including increasing the number of smokefree homes in which our children live (see pages 9 and 15). Again the actual event numbers are small at just 28 admissions (8 for Māori). The Alliance continues to support improved breastfeeding rates as a focus in this space as a means of reducing the risk of obesity and chronic disease later in life, including respiratory disease, but also as a contributor to further improving the oral health of our children.



1.1. Oral health

CONTRIBUTING TO: REDUCING AMBULATORY SENSITIVE HOSPITALISATIONS	
Proposed measures	Percentage of Māori pre-school children enrolled in Community Oral Health Services.
Rationale	Oral health is poor on the West Coast and one of our key objectives is to improve the quality and consistency of oral health service across the West Coast and, over the coming year, to increase access and engagement with the DHB's Community Oral Health Service. As a key contributor to ASH rates for under four year olds, improved access and engagement with oral health services has the potential to make a significant impact on the health of our young children. This is particularly true for our young Māori children who have higher ASH rates related to oral health and poorer oral health outcomes. The DHB has been focused on improving data collection and streamlining enrolment processes and while enrolment rates across the service are high, there is a gap between rates for Māori and non-Māori. More accurate information about the pre-school population will improve targeted approaches to health promotion activity and interventions. It is important to maintain these high rates across all ethnicities for at least five years before effects on the caries free rate will become evident.
Baseline	95.7% of Māori pre-school children were enrolled in DHB-funded oral health services- as at Dec 2017.
30 Jun 2019 target	>95% of Māori pre-school children were enrolled in DHB-funded oral health services
Improvement plan	• Support the establishment of the Oral Health Service Development group ensuring appropriate West Coast and Māori representation to maintain a focus on rural and ethnicity outcome gaps. • Continue promotion of the Newborn Enrolment Form to support early enrolment of children with the Community Oral Health Service. • Support Practice Nurses to complete the "Lift the Lip" check at immunisation events and refer concerns to the Dental Therapists • Support the implementation of "Water Only in Schools" across the Coast as a good oral health promotion tool • Continue to support the Childhood Nutrition Health Promotion role working in Early Childhood Education Centres Coast-wide • Continue to develop opportunities for health promotion and education with families whose children are hospitalised for dental surgery.
Who's involved	West Coast DHB (WCDHB), West Coast PHO (WCPHO), Community & Public Health (C&PH), Poutini Waiora, Healthy West Coast Alliance Workstream, Transalpine Oral Health Service Development Group, paediatric inpatient services, general practice teams.
Who's leading	WCDHB

1.2. Breastfeeding

CONTRIBUTING TO: AMBULATORY SENSITIVE HOSPITALISATIONS	
Proposed measures	Percentage of infants exclusively or fully breastfed at three months of age.
Rationale	While breastfeeding rates are relatively satisfactory for the West Coast, the longevity of breastfeeding is what mitigates the risk of obesity, poor dental health and chronic disease later in life, including respiratory disease. As a key contributor to prevention of a number of the key drivers of ASH rates, our objectives is to enhance knowledge and understanding around breastfeeding for pregnant women and their whānau to increase breastfeeding rates across the West Coast.
Baseline	61% of babies are breastfeeding at three months (57% of Māori)[1]
30 Jun 2019 target	70% of Māori babies are breastfeeding at three months.
Improvement plan	• Continue to train volunteer peer supporters through the Mum4Mum programme to extend the reach of the service to rural communities. Ensure the Mum4Mum volunteers continue to be reflective of the ethnicities of women residing on the Coast. This will include a target of 4 Māori mums completing training. • Investigate strategies to link priority and high needs mothers (e.g. young mothers, isolated rural mothers, and Māori mothers) to a Mum4Mum volunteer during the antenatal period.
Who's involved	WCPHO, Breastfeeding Advocates, Lead Maternity Carers (LMCs), Plunket, Poutini Waiora, Well Child Tamariki Ora (WCTO) service providers, WCDHB, C&PH, general practice teams, Mum4Mum peer support workers.
Who's leading	Healthy West Coast Alliance Workstream.

2. Acute Hospital Bed Days

Outcome: Improved management of the demand for acute care

Acute Hospital Bed Days illustrate acute demand for secondary care services that is amenable to good upstream primary care, discharge planning and transition between services. Actions to address this demand require good communication between primary, community and secondary care and we have come together, through the West Coast Alliance, to develop some of the key foundations needed to make an integrated service approach a reality.

This work includes the development of: HealthPathways; the primary care Long Term Conditions Management (LTCM) programme; the Complex Clinical Care Network (CCCN); and the Pharmacy to GP programme. We have also improved communication between primary and secondary care with the implementation of: HealthOne; the Electronic Referral Management System (ERMS); and the expansion of telehealth services across the West Coast.

The WCDHB has district nursing teams based in Greymouth, Hokitika, Reefton and Westport. These nurses work within multidisciplinary teams consisting of primary care practitioners, home based support services, clinical nurse specialists, and allied health professionals to assist individuals and their family/whānau to meet individual healthcare needs.

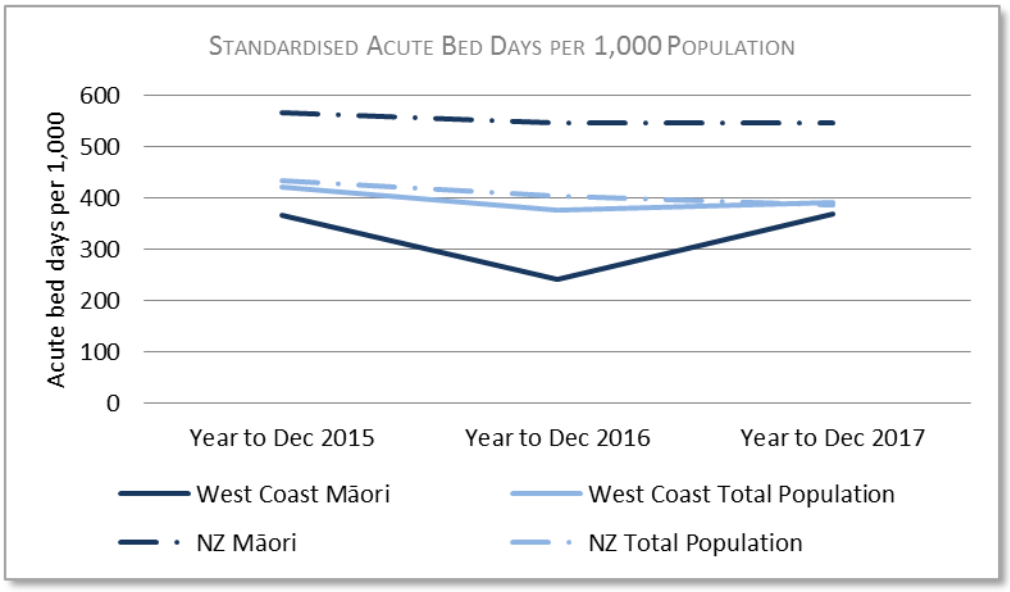
The WCDHB also employs Rural Nurse Specialists who provide 24-hour cover for the nine West Coast rural localities: Haast; Franz Josef; Fox Glacier; Whataroa; Hari Hari; Moana; Reefton; Ngakawau; and Karamea. The breadth of these roles includes delivery of primary and community health services, district nursing, home hospice, public health, health promotion, and Well Child services. Rural Nurse Specialists are also responsible for pre-hospital emergency care and are certified St John PRIME responders.

[1] Well Child Tamariki Ora Quality Improvement Framework Indicator results at September 2017

These foundations, or building blocks, are enabling us to take the next steps in integrating primary, community and secondary services across the Coast. They will also help us to reduce avoidable acute demand for secondary services and improve the health of our population.

BASELINE PERFORMANCE

The aged standardised Acute Bed Day Rate, per 1,000 population, for the West Coast DHB for the year ending December 2017 was 391 (total population) and 370 (Māori).[2] West Coast rates are positive in comparison to national rates for both Māori and for our total population.



2018/19 MILESTONE

Continue to track below the national aged standardised Acute Bed Day Rate, per 1,000 population, for both Māori and total population groups, with a target rate of 390 or less for total population.

In setting the milestone for the 2018/19 year a number of factors have been taken in to account:

- It is important to note the rural context in understanding our current baseline. Many of our acutely admitted patients live long distances from the hospital. The clinical risk assessment will take this into account and often means that patients will stay longer, and be further along their road to recovery, before returning home. Longer stays are therefore appropriate for some patients in this context.
- Acute Bed Day Rates are prone to fluctuation, given the small size of our population and the statistical effect of converting these to a rate per 1,000. Whilst the milestone may seem conservative, the result will be impacted by only a few people and the DHB takes a longer-term view of performance against this measure.

[2] MoH supplied data by DHB of Domicile using Census 2013 population

2.1. Influenza vaccinations for 65+

CONTRIBUTING TO: REDUCING ACUTE HOSPITAL BED DAYS	
Proposed measures	Enrolled Māori (65 years and over) have received an influenza vaccine during the most recent influenza campaign.
Rationale	The West Coast is not meeting the population target of 75% of people (aged 65 and over) having a seasonal flu vaccination. Older Māori are a key group at risk of influenza and a subsequent acute hospital presentation. An increased focus on vaccinating this particular population group early could potentially reduce preventable hospitalisation due to flu over the coming winter season.
Baseline	55% of Māori, 65 and older, have received an influenza vaccine - as at 31 Dec 2017.[3]
30 Jun 2019 target	60% of Māori, 65 and older, have received an influenza vaccine - at the end of the funded influenza season (31 Dec 2018).
Improvement plan	• Understand the difference in population coverage reporting between National Immunisation Register (NIR) and the practices' patient management systems. • Develop a process to ensure more timely capture of vaccination event in the NIR that more closely match practice information. • Promote and provide free seasonal flu vaccinations for people 65 years and older at general practices and community pharmacy. • Celebrate the individual practices who have reached the target population and share learning from those practices with others. • Continue to use Poutini Waiora staff and their connections with whānau to support practices who are struggling to reach their target population.
Who's involved	WCPHO, general practice teams, community pharmacies, NIR Coordinator, C&PH, West Coast Immunisation Advisory Group, Poutini Waiora.
Who's leading	WCPHO.

2.2. More heart & diabetes checks

CONTRIBUTING TO: REDUCING ACUTE HOSPITAL BED DAYS	
Proposed measures	The delivery of Cardiovascular Disease Risk Assessments (CVDRA) to eligible Māori men.
Rationale	The West Coast PHO continues to work with general practice to maintain the delivery of Cardiovascular Disease Risk Assessments. While the West Coast continues to meet the target for total population a more targeted focus is required to reach this target for Māori men. It is important to also translate this into satisfactory management of cardiovascular disease and related conditions such as diabetes through engagement in the primary care Long-term Conditions Management Programme.
Baseline	73.7% of Māori men aged 35-44 years have had a CVDRA in the last 5 years – as at March 2018[4]
30 Jun 2019 target	90% of Māori men aged 35-44 years have had a CVDRA in the last 5 years
Improvement plan	• Facilitate collaborative working between Poutini Waiora and general practices to identify and contact Māori eligible for Cardiovascular Disease Risk Assessments.

[3] National Immunisation Register Datamart Report.

[4] Local Karo data

	• Continue to provide practice-specific target performance data in the Primary Bulletin (to practices) supported by advocacy messages targeting clinicians to support the delivery of Cardiovascular Disease Risk Assessments, with a focus on Māori men.
Who's involved	WCPHO, general practice teams, Poutini Waiora.
Who's leading	WCPHO, with oversight from Healthy West Coast Alliance Workstream.

2.3. COPD screening

CONTRIBUTING TO: REDUCING ACUTE HOSPITAL BED DAYS	
Proposed measures	Screening of Māori Smokers and ex-smokers for Chronic Obstructive Pulmonary Disease (COPD)
Rationale	Smoking is a major risk factor for a number of the leading long-term conditions and acute hospital presentations including respiratory and cardiovascular disease. Supporting more people to access support to quit smoking and to manage long-term conditions will contribute to two national outcomes (reducing ASH rates for 0-4 year olds and acute admission rates for adults) and improve the health of our population.
Baseline	96% of Māori smokers or ex-smokers registered at the Buller Health practice, aged 45 years or older, received spirometry screening and lifestyle coaching.[5]
30 Jun 2019 target	90% of Māori smokers or ex-smokers registered at the Buller Health practice, aged 35 years or older, receive spirometry screening and lifestyle coaching.
Improvement plan	• Work with the Buller Health Practice to identify all smokers and ex-smokers registered at the practice who have not been appropriately screened for COPD • Work with Poutini Waiora to engage those patients in Spirometry clinics where screening can be performed, smoking cessation advice and/or referral given as well as other appropriate opportunistic interventions offered. • Extend the invitation to whānau members as necessary • Explore roll out to other practices
Who's involved	WCPHO, Poutini Waiora, WCDHB Respiratory Nurse Specialists, WCPHO
Who's leading	Poutini Waiora

[5] Local practice management data

3. Patient Experience of Care

Outcome: Improved clinical outcomes for patients in primary and secondary care through improved patient safety and experience

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. Integration has not happened until people experience it and the West Coast health system encourages patient involvement and feedback to support improvement initiatives that will lead to improved patient experience of care.

2018/19 MILESTONE

40% of patients have provided an email address to practices to enable participation in the primary care patient experience survey.

3.1. Hospital services using the adult inpatient survey

CONTRIBUTING TO: IMPROVED PATIENT EXPERIENCE OF CARE	
Proposed measures	% patients who responded positively to the question "Did hospital staff include your family/whanau or someone close to you in discussion about your care?"
Rationale	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. Data on our patients' experience of hospital care can be used for monitoring service quality and identifying areas for improving quality improvement and patient safety.
Baseline	59% of patients responded positively to the question "Did hospital staff include your family/whanau or someone close to you in discussion about your care?"[6]
30 Jun 2019 target	65% of patients responded positively to the question "Did hospital staff include your family/whanau or someone close to you in discussion about your care?"
Improvement plan	• Work with the consumer council to co-design the 'nominated' patient contact role including defining whether the term 'nominated' or 'preferred' is used. • Develop promotional material for consumers describing the role • Develop an organisational change process for DHB staff that emphasises the importance of data capture
Who's involved	WCDHB Quality Team, WCDHB Consumer Council, Clinical Nurse Managers.
Who's leading	WCDHB Quality Team.

3.2. Hospital mental health services using the Marama Real-Time survey

CONTRIBUTING TO: IMPROVED PATIENT EXPERIENCE OF CARE	
Proposed measures	% Patients completing the Marama Real-Time Survey
Rationale	While the DHB has been using the Marama Real-Time survey within mental health services, a more systematic approach to requesting that this is completed, by all patients discharged after and inpatient event, is needed in order to gather enough responses for data to be analysed.

[6] HQSC Result for patients treated in February 2018

Baseline	7.6%[7] of consumers discharged from the mental health inpatient service have completed a patient experience survey.
30 Jun 2019 target	50% of consumers discharged from the mental health inpatient service have completed a patient experience survey.
Improvement plan	• Work with the Community Mental Health Teams to develop process for offering the Marama Real-Time Survey to consumers who have been discharged after an inpatient stay. • Work with the WCDHB Quality Team to develop regular quarterly reporting to the service regarding consumer feedback. • Work with the DHB Consumer Council and their networks to promote completion of the survey.
Who's involved	WCDHB Quality Team, WCDHB Mental Health Team, WCDHB Consumer Council.
Who's leading	WCDHB Quality Team.

3.3. Uptake of the primary care patient experience survey

CONTRIBUTING TO: IMPROVED PATIENT EXPERIENCE OF CARE	
Proposed measures	Patients have provided an email address to practices to enable participation in the primary care patient experience survey.
Rationale	As above, evidence tells us that patient experience is a good indicator of the quality of health services. Work has been underway to introduce measures for primary care using on-line patient surveys. 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 general practices on the West Coast, with the guidance of the West Coast PHO, have recently enabled the system to offer surveys to patients using their services.
Baseline	22.6% of patients have provided an email address to practices to enable participation in the primary care patient experience survey.
30 Jun 2019 target	40% of patients have provided an email address to practices to enable participation in the primary care patient experience survey.
Improvement plan	• Develop a communications plan to promote and encourage consumers of primary care to complete the survey upon receiving an invitation • Ensure general practices are supported to collect email contacts for patients through training and education provided by the PHO. • Work with the DHB Consumer Council and their networks to promote completion of the survey.
Who's involved	WCPHO, Practice Managers & Administrators, WCDHB Consumer Council
Who's leading	WCPHO.

[7] Numerator = responses from the "Greybase" device; denominator = discharges from Mental Health Inpatient Unit

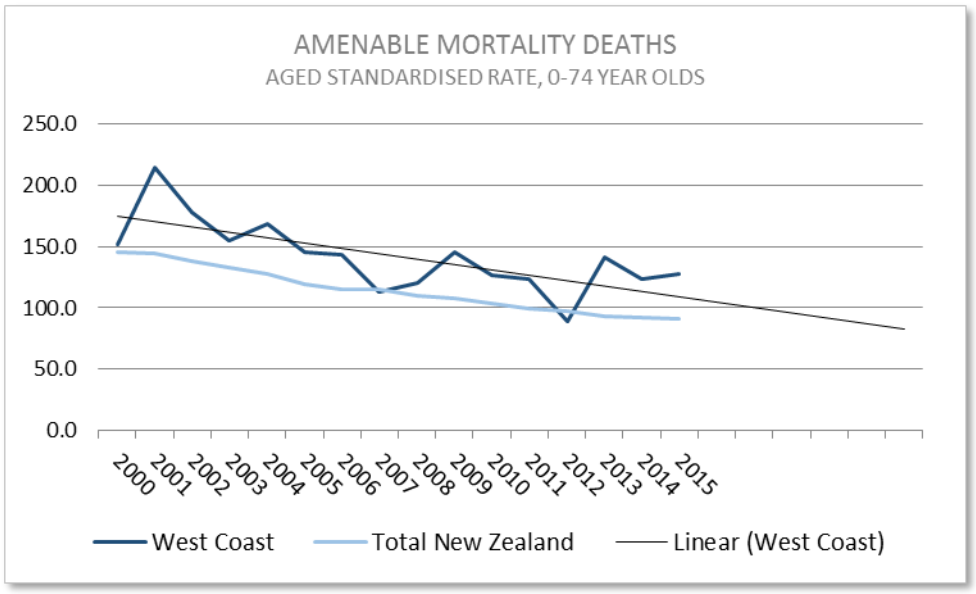
4. Amenable Mortality

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

A review of the longitudinal amenable mortality data by cause of death identifies a number of medical conditions contributing to West Coast's Amenable Mortality Rate. Many of these will be addressed by the contributory measures discussed not only in this section but throughout this document, including a reduction in risk factors such as smoking and obesity rates that impact on mortality and increased engagement in screening and risk assessment programmes which lead to improvements in the management of people's long-term conditions.

BASELINE PERFORMANCE

Data by ethnicity has not been reviewed as the number of amenable deaths for West Coast Māori was too small to produce a meaningful rate.



2018/19 MILESTONE

Maintain the current downward trend for Amenable Mortality. Extending the trend line, using currently available data, the DHB would anticipate achieving a rate at or close to 80 amenable deaths per 100,000 people by June 2021.

In setting this milestone a number of factors have been taken into account:

- The timeframe involved in influencing change for this outcome measures is long and the delay in reporting on results against the measure are barriers to a more targeted milestone.
- Rates are prone to variation given the small size of our population and the statistical effect of converting these small numbers to a rate per 100,000. This is particularly so with Māori, where the numbers are too small to establish a meaningful rate. Whilst the milestone may seem conservative, the result will be impacted by only a few people and the long-term trend is seen as the important factor with regards to this outcome.

4.1. Breast screening

CONTRIBUTING TO: REDUCING AMENABLE MORTALITY	
Proposed measures	Eligible women (targeting Māori and Pacific women aged 50-69) have had a mammogram (breast screen) in the past two years.
Rationale	Early detection and treatment of breast cancer lowers the rate of death from breast cancer. Breast screening provides an opportunity to make a difference to the lives of women and their families. BreastScreen Aotearoa's target is to screen 70 percent of eligible women aged 50–69 every two years. On the West Coast there continue to be opportunities for improvement particularly for high priority populations, where uptake of screening is lower than for other ethnicities.
Baseline	As at 31 March 2018[8]: 61.4% of eligible Māori women have had a breast screen in the past 2 years 32% of eligible Pacific women have had a breast screen in the past 2 years
30 Jun 2019 target	70% of eligible women (in all population groups) have had a breast screen in the past 2 years.
Improvement plan	• Identify a champion in each practice to lead and support improvements in screening rates. • Work with the practices to improve the rates of women consented for breast screening by ensuring they have access to, and regularly monitor, data that identifies eligible women who have no documented consent in the Patient Management System. • Support practices with processes for checking results received from BreastScreen Aotearoa so that screening terms and results are filed and captured accurately in the practice patient management system. • Utilise Poutini Waiora Whānau Ora nurses (who are integrated in general practice teams) to support Māori and Pasifika women who are not engaging with breast screening. • Increase health promotion to practices, rural communities, community pharmacies and via social media to increase awareness and promote the importance of breast screening for priority populations (Māori and Pacific).
Who's involved	WCPHO, BreastScreen Aotearoa, General Practice Champions, Poutini Waiora.
Who's leading	WCPHO.

4.2. Long term conditions management

CONTRIBUTING TO: REDUCING AMENABLE MORTALITY	
Proposed measures	Model of care for patients with long term mental health conditions is developed.
Rationale	There are known inequities in health outcomes for people who live with long term mental health conditions and this includes amenable mortality. Providing an integrated service that supports these patients to look after both their physical and mental health as part of a whole person approach will be beneficial to their overall health outcomes.
Baseline	One general practice is offering patients with long term mental health conditions enrolment in the Long Term Conditions Management programme.
30 Jun 2019 target	A model to improve capacity of primary care to manage those with long term mental health issues is agreed.
Improvement plan	• Support the Mental Health Project Team to explore options for model of care

[8] NSU data from BreastScreen Aotearoa

	• Consult with mental health service consumers about their experience • Agree the model for future integration of mental health management into primary care
Who's involved	WCDHB Mental Health services, WCPHO, Poutini Waiora, consumers.
Who's leading	WCDHB

4.3. Childhood obesity

CONTRIBUTING TO: REDUCING AMENABLE MORTALITY	
Proposed measures	Children with Body Mass Index (BMI) greater than 98th percentile are referred to a health professional for clinical assessment and family based nutrition, activity and lifestyle intervention.
Rationale	Despite a much improved performance in identifying these children, the West Coast DHB continues to record a high number of families declining the offer of a referral for support with obesity in childhood. Due to the small number of children involved there is significant variation in results, however there is room for improvement.
Baseline	60% of children identified as obese in the Before School Check (B4SC) programme had declined a referral - as at March 2018.
30 Jun 2019 target	Less than 30% of children identified as obese in the B4SC programme declined a referral.
Improvement plan	• Deliver Health Promotion activities in Early Childhood Education and primary school settings that raise awareness of the importance of healthy weight in childhood e.g. "Water Only in School" policy development. • Provide Dietitian nutrition advice and support to all families/whānau regarding healthy weight in childhood at the time of their B4SC, working alongside the Public Health Nurse in this clinic setting. • Provide primary care teams with training/education regarding healthy weight in childhood and support appropriate onward referrals for family/whānau support.
Who's involved	B4 School Check team, general practices, PHO Health Promoter, C&PH, Healthy West Coast Alliance Workstream.
Who's leading	B4 School Check Coordinator.

5. Smokefree Infants

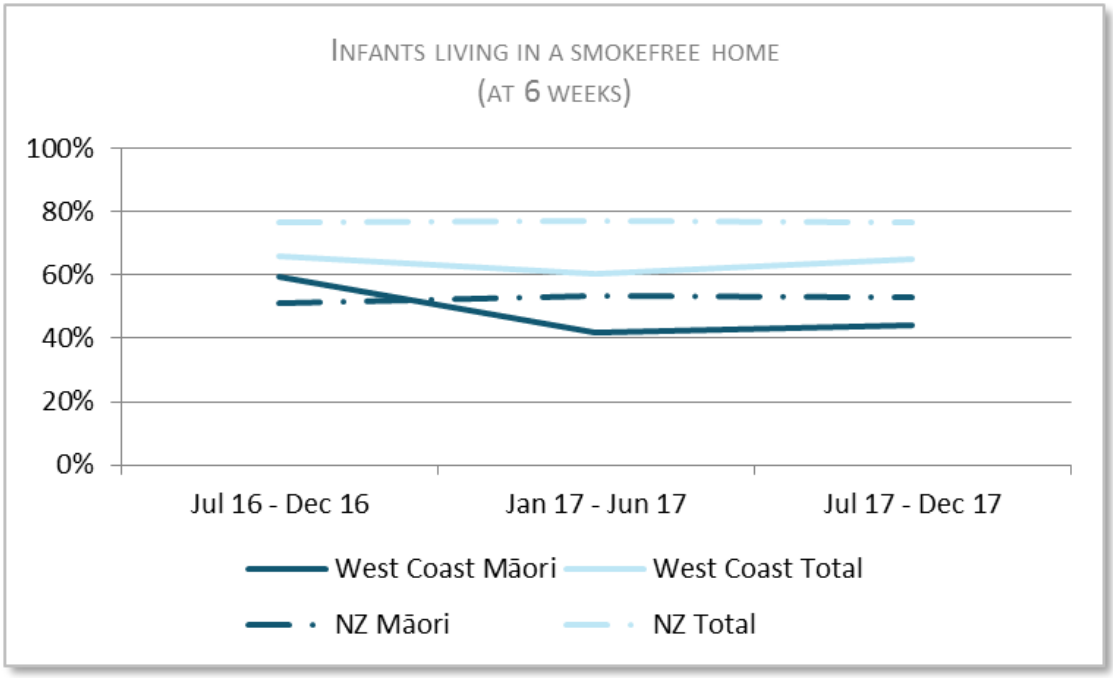
Outcome: A healthy start in life

The West Coast has an estimated 80-100 women annually who are smoking during pregnancy - prevalence rates are between 25% and 30%. The tragic effects on the unborn baby are well documented as well as the negative impact on mother's health and birth outcomes. However, due to its addictive nature, smoking can be difficult for many women to stop at a time when they should, but might not necessarily feel able.

Data for this measure is collected as part of the Well Child Tamariki Ora core check schedule with the first core contact taking place at six weeks, usually in the baby's home. Data collection systems in place currently have led to variability in the data; the current recording systems do not use a consistent question about Smokefree status nor are they consistently recording the answer. These systems are being updated during the 18/19 year and there will be a focus on improving the consistency, and therefore quality, of the data for this measure.

BASELINE PERFORMANCE

65.2% of West Coast households with a newborn were Smokefree as recorded at the first Well Child Tamariki Ora Core check (44.0% for Māori).



2018/19 MILESTONE

90% of West Coast households with a newborn had their Smokefree status recorded at the first Well Child Tamariki Ora Core check across all ethnicities.

5.1. Smokefree homes

CONTRIBUTING TO: SMOKEFREE INFANTS	
Proposed measures	Proportion of West Coast households with a newborn that have had their Smokefree status recorded at the first Well Child Tamariki Ora Core (WCTO) check.
Rationale	Data quality for this measure has been identified as problematic since recording across providers is variable and inconsistent. There is also variable understanding of the definition of a "Smokefree" home. Improving the accuracy of local data will help identify targeted actions to improve the overall proportion of babies living in a smokefree home.
Baseline	82% of West Coast households with a newborn had their Smokefree status recorded at the first WCTO core check (69% for Māori).
30 Jun 2019 target	90% of West Coast households with a newborn had their Smokefree status recorded at the first WCTO core check across all ethnicities.
Improvement plan	• Implement improvements to the data capture systems for DHB funded WCTO providers that support mandatory collection of the Smokefree status. • Provide education to the WCTO and Lead Maternity Carer workforce regarding the new measure and its definition. • Monitor monthly smokefree data completion rates for DHB funded providers and provide support and guidance to clinicians where this has not been completed. • For women and whānau being supported by the Smokefree Pregnancy and Newborn Incentive programme, provide advice that WCTO providers will capture this data at the first core check around 4-6 weeks after their baby is born.
Who's involved	WC Smokefree Services Coordinator, WCDHB Public Health Nurses, Plunket, Poutini Waiora.
Who's leading	WC Smokefree Services Coordinator.

5.2. Smokefree pregnancy

CONTRIBUTING TO: SMOKEFREE INFANTS	
Proposed measures	Proportion of women who are referred to the Smokefree Pregnancy Incentives Programme who go on to set a quit date.
Rationale	The West Coast has a good range of services available to smokers for cessation support during pregnancy and smoking rates at 2 weeks post birth are around 18% for total population but as high as 32% for Māori. Local workshops and consultation have celebrated the success of the current Smokefree Pregnancies Incentive Programme but acknowledge the high smoking rates among Māori and the high number of mothers returning to smoking following the birth of their baby.
Baseline	20% of women (12 of 60) went on to set a quit date following referral to the Smokefree Pregnancy Incentives Programme.
30 Jun 2019 target	75% of women (both Māori and non-Māori) set a quit date following referral to the Smokefree Pregnancy Incentives Programme.
Improvement plan	• Extend the schedule for incentives to support continued engagement with the cessation service beyond birth for mothers from the current 2 weeks post-birth up to 16 weeks in order to promote a smokefree environment for babies during the most vulnerable early

	months. • Incorporate messaging about the increased risk of Sudden Unexplained Death in Infancy (SUDI) into promotion of the programme. • Continue to offer support to women who choose not to set a quit date immediately, throughout their pregnancy and beyond. • Celebrate the success of women how have successfully quit through media stories.
Who's involved	WC Smokefree Services Coordinator, DHB Cessation Service, Oranga Hā – Tai Poutini, LMCs.
Who's leading	WC Smokefree Services Coordinator.

6. Youth Access to and Utilisation of Youth Appropriate Health Services

Outcome: Young people feel safe and supported by health services

This measure does not have a single National target; instead Alliances select a minimum of one 'Domain' from a series of five that cover different aspects of young peoples' wellbeing. There is then a 'National Indicator' associated to that Domain against which an improvement milestone is set with appropriate quality improvement activities. The five domains are: Sexual and Reproductive Health, Access to Preventive Services, Youth Experience of Health System, Mental Health & Wellbeing and Alcohol & Other Drugs.

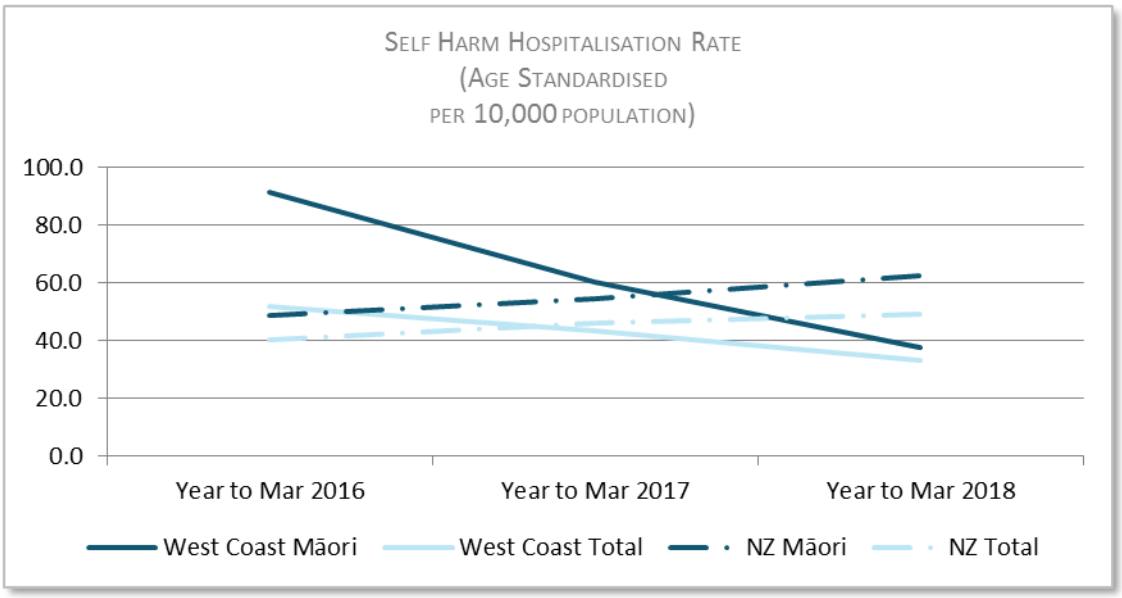
It has been identified that Mental Health and Wellbeing is an area of focus for young people on the Coast and as such the health system is keen to understand the drivers and barriers for young people accessing mental health services.

Intentional self-harm is an indicator of 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/peer group issues and events, stress, bullying, bereavement, relationship issues, trauma, intense or difficult feelings, or being in a group that self-harms.

While not all young people who present to an emergency service are admitted to hospital as a result of self harm, admission rates provide an indicator of the need. Some young people will present multiple times each year and be known to services. Approximately half of the total patients admitted to hospital for intentional self-harm are treated only in the emergency department and are discharged on the same day they are admitted or after an overnight stay.

BASELINE PERFORMANCE

The aged standardised hospitalisation rate for self-harm, per 10,000 population, for the West Coast DHB for the year ending March 2018 was 33.1 (total population) and 37.9 (Māori). West Coast rates are positive in comparison to national rates for both Māori and for our total population.



2018/19 MILESTONE

Maintain the current downward trend for self-harm hospitalisations and continue to reduce the equity gap between Māori and total population to less than the current rate of 4.8.

6.1. Youth feel supported

CONTRIBUTING TO: YOUTH ACCESS TO AND UTILISATION OF YOUTH APPROPRIATE HEALTH SERVICES	
Proposed measures	% young consumers (age 12-25) who present to the emergency department for intentional self-harm who are referred for support through PHO counselling.
Rationale	Some young people who present to the emergency department can be further supported beyond discharge from secondary services by a short series of counselling sessions which can be delivered through the West Coast PHO Mental Health Team. This type of support can reduce repeat presentations.
Baseline	0% of young people who present to the emergency department (ED) with self-harm or suicidality and are discharged to the community were referred to the PHO Brief Intervention Counselling service.[9]
30 Jun 2019 target	50% of young people who present to ED with self-harm or suicidality and are discharged to the community were referred to the PHO Brief Intervention Counselling service.
Improvement plan	• Work with the ED in Greymouth and the unplanned care team in Westport to define referral criteria for young people who would benefit from PHO counselling. • Work with DHB Mental Health service and the ED to develop a process for routine referral to the PHO Mental Health Service following discharge for ongoing counselling and support. • Develop a process for regularly reporting back to ED and PHO regarding progress towards this target.
Who's involved	WCDHB, WCPHO
Who's leading	WCDHB

[9] Local data for 2016/17