West Coast Health System

IMPROVEMENT PLAN

System Level Measures Framework 2019-2020

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

THE WEST COAST HEALTH SYSTEM
– supporting you to be well

Contents

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 quality improvement activities, aligned with each of the national outcomes.

KEY ACHIEVEMENTS

A focus by practices on the consenting process for BreastScreen Aotearoa and support from Poutini Waiora has seen our screening rates for Māori women increase from 61% to 69% and for Pasifika women from 32% to 44%.

Work on data collation across providers during 2018/19 has helped the system to get a better understanding of how the smoking population is being supported to quit. In the period October – December 2018 around 4.5% of the smoking population (approx. 7% for Māori smokers) was engaged with a stop smoking support service against the MoH target of 5%. Quit rates across the services remain high at around 35%.

A quality improvement project that has seen collaboration between our DHB B4 School Check (B4SC) service, and our integrated nutrition services has decreased the proportion of families declining a referral as a result of a high Body Mass Index (BMI) at the check. 73% of children identified as obese at their B4SC are now accepting support and ongoing monitoring of their growth, up from 40% on 2017/18.

NEXT STEPS

The West Coast Alliance remains committed working under the System Level Measures (SLM) Framework to drive improvements across all parts of the Health System. Regular reference to, and reporting against previous SLM plans has continued to highlight the value of good data and good understanding of trends.

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.

Despite having a very small Pacific population on the West Coast, there are certain areas of health where leadership is needed to ensure this population are not left behind, for example in breast screening. The Alliance will continue to consider how best to support leadership in this area.

The SLM framework provides a good opportunity to place focus on equity of health outcomes and developing actions that specifically reduce those gap; the quality improvement methodology adopted allows us to strengthen these actions year to year.

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National Outcomes and Local Activity

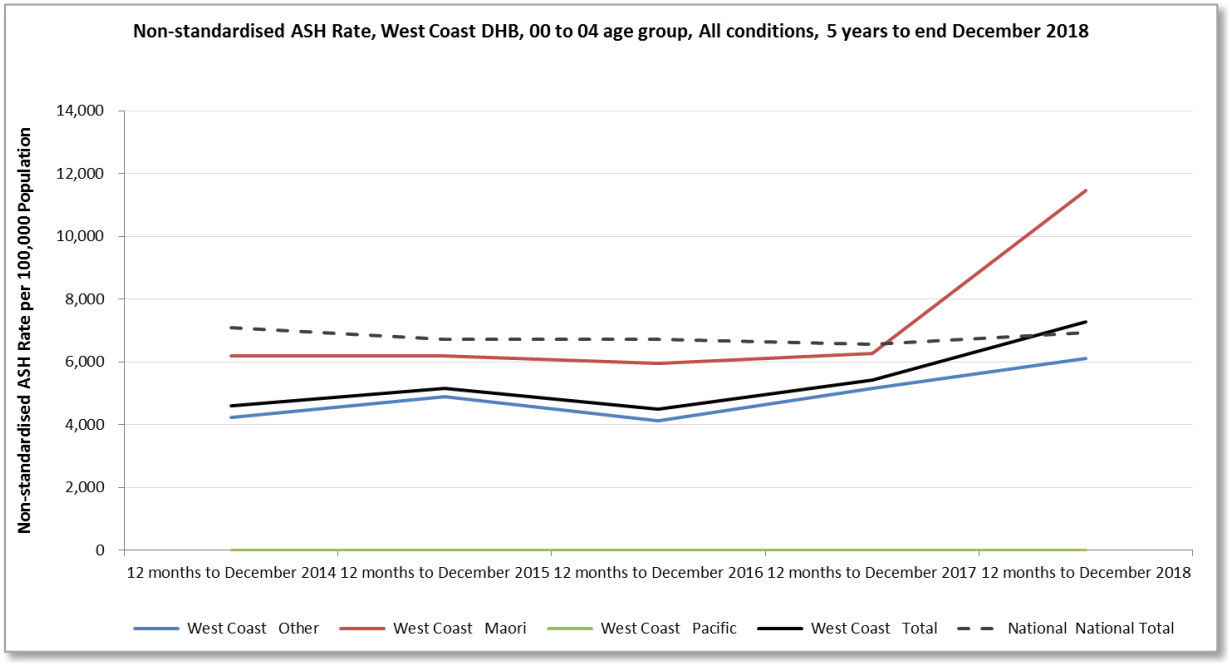
1. Ambulatory Sensitive Hospitalisations (0 – 4 year olds)

Outcome: Reduced avoidable hospital admissions among children

Ambulatory Sensitive Hospitalisations (ASH) are a measure of the burden of disease in childhood with and highlight where children experience health inequalities. The way children experience health and illness varies widely 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.

For example, a family with high health literacy and good access to supports are more likely to manage a child with asthma through providing a warm dry home using healthy heating option and higher compliance with preventative medicines thus avoiding the need for hospitalisation when or if there is an exacerbation of asthma symptoms.

BASELINE PERFORMANCE



Population		12 months to December 2014	12 months to December 2015	12 months to December 2016	12 months to December 2017	**12 months to December 2018**
West Coast	Other	4,223	4,908	4,127	5,166	6,122
West Coast	Māori	6,190	6,190	5,952	6,279	11,463
West Coast	Total	4,612	5,171	4,511	5,412	7,287
National	Total	7,096	6,729	6,712	6,562	6,948

2019/20 MILESTONE

Reduce the average ratio between ASH rates for Māori children aged 0-4 year olds and total children to below the current ratio of 1:1.35 (as at the end of December 2018).

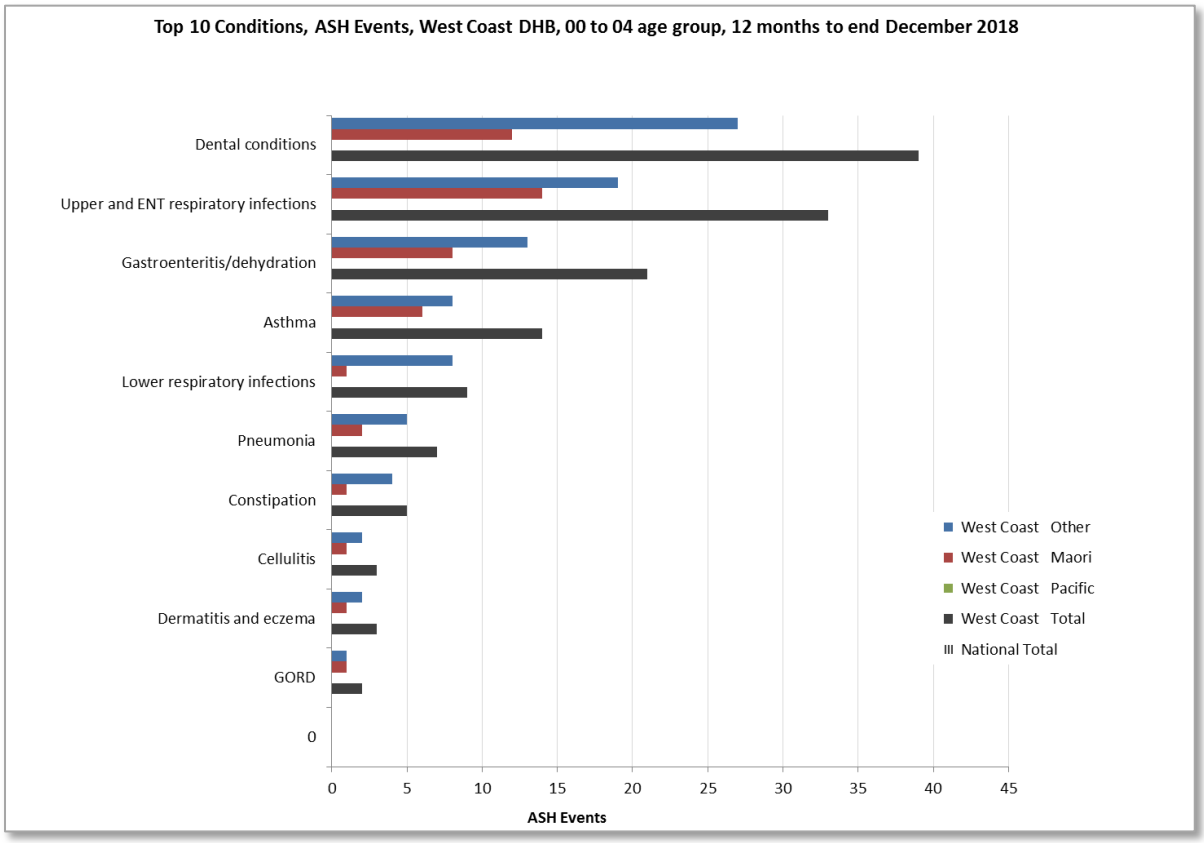
In setting the milestone for the 2019/20 year a number of factors have been taken into account:

- West Coast DHB's ASH rate for Māori children spiked in the 12 months to December 2018 raising the DHB's overall rate above the National figure for the first time in a number of years. In setting the milestone, the focus has been placed on reversing this spike 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 2018 result relating to just 47 events; this compares to 27 in the same period last year.
- To reduce the effect of fluctuations due to the small population, the milestone has been calculated based on a 3 year average.

ASH admissions into hospital are for conditions which are regarded as preventable through lifestyle changes such as smokefree households, vaccination, engagement with primary care and Well Child Tamariki Ora and the effective community 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 39 (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 7,11, 17 and 18). Again the actual event numbers are small at just 33 admissions (14 for Māori) for upper and ENT respiratory infections and 14 admissions (6 for Māori) for asthma.



1.1. Oral health

CONTRIBUTING TO: REDUCING AMBULATORY SENSITIVE HOSPITALISATIONS	
Proposed measures	Proportion of children admitted for treatment of dental conditions who have engaged in wrap around oral health support.
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 target whānau that are most at risk of hospital admission for treatment. Improved engagement with oral health services and improved health literacy relating to oral health and hygiene 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. In previous years, the work has been focused on improving data collection and streamlining enrolment processes however focus will now move to targeting the whānau that are known to be at risk of further admission.
Baseline	No families currently receiving this targeted support package for oral health
30 Jun 2020 target	75% of Māori whānau with a child admitted for treatment of a dental condition are engaged in a targeted wrap around support package
Activity	• Provide families with a package of support that addresses both good oral hygiene practices (supervised brushing twice a day with a fluoride toothpaste) and health literacy related to good oral health (promote breastfeeding, limit sugary drinks and eat a balanced diet that includes fresh fruit and vegetables). • Ensure Practice Nurses complete the "Lift the Lip" check at immunisation events, record this screening event and refer concerns to the Dental Therapists • Continue to provide Childhood Nutrition Health Promotion in Early Childhood Education Centres Coast-wide
Who's involved	Healthy West Coast Alliance workstream, Oral Health Service Development Group, paediatric inpatient services, general practice teams.
Who's leading	WCDHB Māori Health

1.2. Childhood respiratory illness

CONTRIBUTING TO: AMBULATORY SENSITIVE HOSPITALISATIONS	
Proposed measures	Number of children aged 0-4 admitted with ambulatory sensitive respiratory illness
Rationale	Childhood respiratory infections cause a large burden of illness especially in Māori and Pacific groups, and low-income groups are affected the most. For some children, severe or repeated respiratory infections lead to permanent lung damage resulting in a life time of ill health.
Baseline	63 events (23 for Māori) for ASH categories; Upper and ENT respiratory infections, Asthma, Lower respiratory infections and Pneumonia.
30 Jun 2020 target	50 events for ASH categories; Upper and ENT respiratory infections, Asthma, Lower respiratory infections and Pneumonia.
Activity	• Use social media, local newspapers, DHB & PHO websites to promote messages about keeping well during winter with a particular emphasis on respiratory illnesses and influenza vaccination. • Identify whānau who need Asthma Action Plans for their children and use General Practice, Respiratory Clinical Nurse Specialist and Poutini Waiora staff to develop or refresh these. • Offer referral to stop smoking services for parents who smoke that have children with respiratory illness.

	• Refer whānau to the local Curtain Bank in the Buller region to support healthy home environments.
Who's involved	West Coast DHB, West Coast PHO, Poutini Waiora
Who's leading	West Coast PHO

1.3. 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 (52% of Māori)[1]
30 Jun 2020 target	70% of Māori babies are breastfeeding at three months.
Activity	• Identify Breastfeeding Champions in each of the primary care practices on the Coast • Work with these Champions to promote one breastfeeding message or bust one breastfeeding myth each month • Provide education and myth-busting sessions in each practice across the Coast with the support of the Champions • Increase the face to face breastfeeding support for new mothers in Greymouth by providing a drop-in session in partnership with Poutini Waiora • Increase the number of Māori parents and whānau attending Pregnancy & Parenting education by providing a Kaupapa Māori programme for this • Promote the importance of breastfeeding as a protective factor against Sudden-Unexpected Death in Infancy as part of all Pregnancy & Parenting programmes.
Who's involved	WCPHO, Breastfeeding Advocates, Lead Maternity Carers (LMCs), 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.

[1] Well Child Tamariki Ora Quality Improvement Framework Indicator results at November 2018

2. Acute Hospital Bed Days

Outcome: Improved management of the demand for acute care

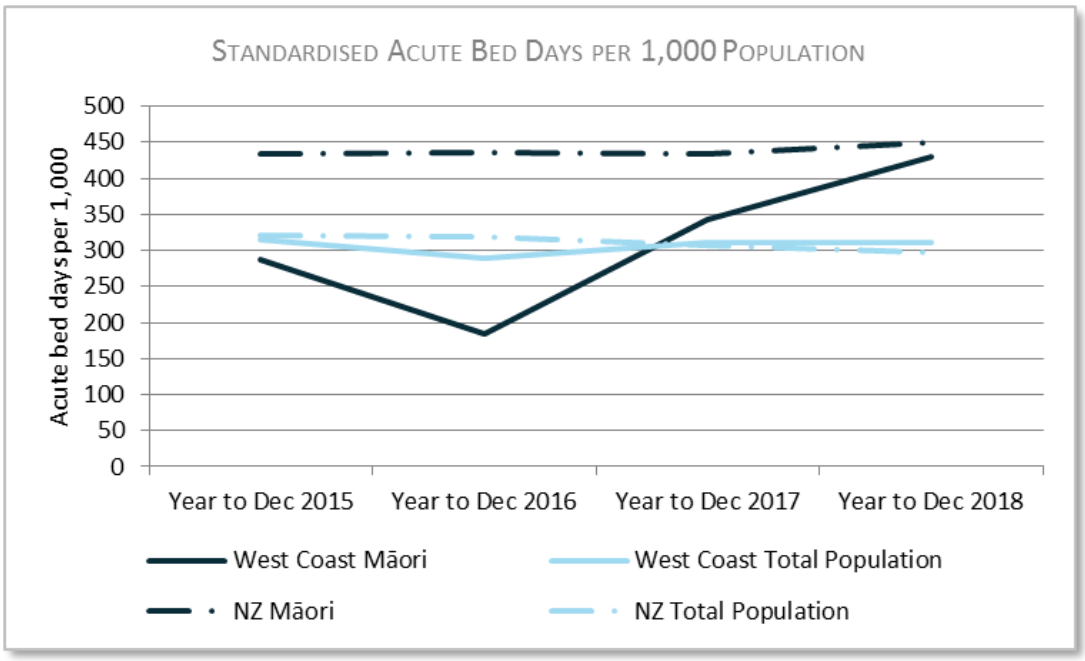
Acute Hospital Bed Days illustrate the demand for secondary care (hospital) services that can be prevented through good care provided close to home (through general practices), discharge planning and transition between services. Actions to address this demand require good communication between the people providing planned and unplanned care. Through the West Coast Alliance, the West Coast Health System is developing processes that make an integrated service approach a reality.

Work already completed includes the development of: HealthPathways; implementation of 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 planned and unplanned care with the implementation of: HealthOne; the Electronic Referral Management System (ERMS); and the expansion of telehealth services across the West Coast.

Delivery of integrated and high quality care in the rural context relies heavily on the skill and coordination of the workforce. Working in this way does not suit everyone and recruitment to the West Coast in the context of national supply shortages in specific areas will continue to be a challenge; however workforce development continues to expand and enhance the roles of staff across all professions and all providers towards a Specialist Generalist model. This model sees professionals working to the full extent of their scope of practice, safely and with appropriate support.

BASELINE PERFORMANCE

The aged standardised Acute Bed Day Rate, per 1,000 population, for the West Coast DHB for the year ending December 2018 was 312 (total population) and 429 (Māori).[2] Three year averages are 303 (total population) and 319 (Māori).



Work has been undertaken to look at the sharp increase in acute bed days for the Māori population of the West Coast over the last 12 months. As is often the case with West Coast data, fluctuations such as this come down to a very small number of individual cases; in 2018 there were less than 10 Māori across 4 diagnosis groups that have contributed to the increase. The Alliance will continue to analyse the data available to ensure the trend reverses as anticipated.

[2] MoH supplied data by DHB of Domicile using WHO (2000) Population

2019/20 MILESTONE

Reduce the Acute Bed Day Rate for Māori to below the current 3 year average rate of 319 per 1,000 of population, as at the end of December 2018.

In setting the milestone for the 2019/20 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 patients who are acutely admitted 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. To reduce the effect of these fluctuations, the milestone has been calculated based on a 3 year average.
- There has been a spike in Acute Bed Day rates for Māori in the last 12 months that can be attributed to a small number of patients. Work will continue in the coming year to analyse the data and ensure these cases were anomalies as opposed to indicators of a reversing trend.

2.1. 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	72.8% of Māori men aged 35-44 years have had a CVDRA in the last 5 years – as at February 2018[3]
30 Jun 2020 target	90% of Māori men aged 35-44 years have had a CVDRA in the last 5 years
Activity	• Use the collaborative relationship between Poutini Waiora and general practices to identify and contact Māori men aged 35 -44 who are eligible for Cardiovascular Disease Risk Assessments. • 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. • Approach employers to establish opportunities to provide CVD risk assessments in workplaces or and/or during work hours.
Who's involved	West Coast PHO, general practice teams, Poutini Waiora.
Who's leading	West Coast PHO

[3] Local Karo data

2.2. Falls risk screening

CONTRIBUTING TO: REDUCING ACUTE HOSPITAL BED DAYS	
Proposed measures	Proportion of people in the Long Term Conditions Management (LTCM) programme who have been screened for falls risk at their annual review
Rationale	Early identification of patients who would benefit from prevention strategies such as improved Strength & Balance or prescription of bisphosphonates will contribute to fewer people falling and fewer people needing hospitalisation for a fracture.
Baseline	Falls risk screening is not currently recorded as part of LTCM reviews
30 Jun 2020 target	Establish baseline for the number of people who have had an LTCM review and who have been screened for falls risk.
Activity	• Add a falls risk screening question to the checklist for LTCM annual reviews. • Work with HealthPathways Coordinator to ensure practitioners are able to refer eligible patients to the Fall Champion for ongoing support. • Promote referral to Community Strength & Balance classes for people at risk of a fall by practitioners across the health system.
Who's involved	West Coast PHO, General Practices, Falls Champion
Who's leading	West Coast PHO

2.3. COPD screening

CONTRIBUTING TO: REDUCING ACUTE HOSPITAL BED DAYS	
Proposed measures	Proportion of patients with Chronic Obstructive Pulmonary Disease (COPD) who have an exacerbation action plan in place.
Rationale	As a Health System the West Coast aims to keep people well in their own homes and this includes people living with a long term conditions. This group of the population are at higher risk of being admitted to hospital with an exacerbation of their condition and so a focus on improving patients' knowledge of their condition and how to manage an exacerbation at home will ensure they keep well at home.
Baseline	Currency of a COPD exacerbation action plan is not currently recorded as part of LTCM annual reviews
30 Jun 2020 target	Establish baseline for the number of people who have had a LTCM review for COPD who have an exacerbation plan in place.
Activity	• Add COPD Action Plan to the checklist for LTCM annual reviews. • Provide direct smokefree advice and an offer of support to all people with COPD who continue to smoke as part of their annual LTCM review. • Work with Poutini Waiora to contact Māori with COPD; enrol those not already enrolled, ensure annual reviews are up to date and offer referral to a stop smoking service.
Who's involved	West Coast PHO, Poutini Waiora, Smokefree Services Coordinator, Stop Smoking services, Respiratory Nurse Specialists, General practices
Who's leading	West Coast PHO

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. West Coast health system encourages patient involvement and feedback to support improvement initiatives that will lead to improved patient experience of care.

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.

Construction of the new Te Nikau Grey Hospital and Health Centre is nearing completion with migration to take place throughout the year for hospital services as well as community pharmacy and primary practice. These changes are likely to impact on patients' experience of care and there will be a focus on maintaining both the inpatient and primary care survey results.

2019/20 MILESTONE

Improve the positive responses to the question "Did hospital staff include your family/whānau or someone close to you in discussion about your care?" from 53%[4] to 65%.

3.1. Hospital services using the adult inpatient survey

CONTRIBUTING TO: IMPROVED PATIENT EXPERIENCE OF CARE	
Proposed measures	Number of inpatient staff members who have completed training regarding patients' nominated contact person.
Rationale	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. The inclusion of a family/whānau member or other significant contact person for patients is an important indicator that demonstrates health working in partnership with patients to ensure good outcomes. Currently the DHB is has limited ability to capture and record a contact other than next of kin details. Work is planned for 2019/20 that will expand the ability to reflect other people who are important to each patient and ensure staff recognise the importance of other nominated contacts.
Baseline	Nil
30 Jun 2020 target	30 DHB staff members have completed training regarding patients' nominated contact person.
Activity	• Update information packages to include education material (co-designed with patients and families) to reinforce the role of a nominated person with patients in the early stages of admission. • Procedure for patient contact details collection updated to include a nominated contact person. • Complete training with inpatient staff to reinforce the importance of a patient nominated contact person. • Continue to promote completion of the Adult Inpatient Experience Survey through the WCDHB Consumer Council
Who's involved	WCDHB Consumer Council, Clinical Leaders, WCDHB Quality Team

[4] HQSC Result for patients treated in May 2018

Who's leading	WCDHB Quality Team

3.2. 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 and completion of the primary care patient experience survey.
Rationale	Work has been completed during the 2018/19 year to introduce the primary care patient experience survey through all general practices on the West Coast. This has now been completed and the focus will now move to ensuring a high proportion of the enrolled population have provided an email address through which they can be invited to participate and provide feedback on their care. This in turn will drive an increase in numbers invited to complete the survey, it is therefore important that patients are encouraged to use the opportunity to feedback.
Baseline	19% of patients completed the survey following invitation[5].
30 Jun 2020 target	22% of patients complete the survey following invitation.
Activity	• Ensure general practices have a documented process in place to collect email contacts for patients. • Ensure general practices are supplied with patient flyers to promote the survey during s during survey week and ensure there is a process in place to distribute these to all patients. • Promote the survey in practices during survey clip via the TV clip showing in waiting rooms or with posters. • Use the DHB Consumer Council and their networks to promote the importance of completing of the survey upon receipt of an invitation. Provide practices with regular feedback on response rates.
Who's involved	WCPHO, Practice Managers & Administrators, WCDHB Consumer Council
Who's leading	WCPHO.

[5] February 2019 result

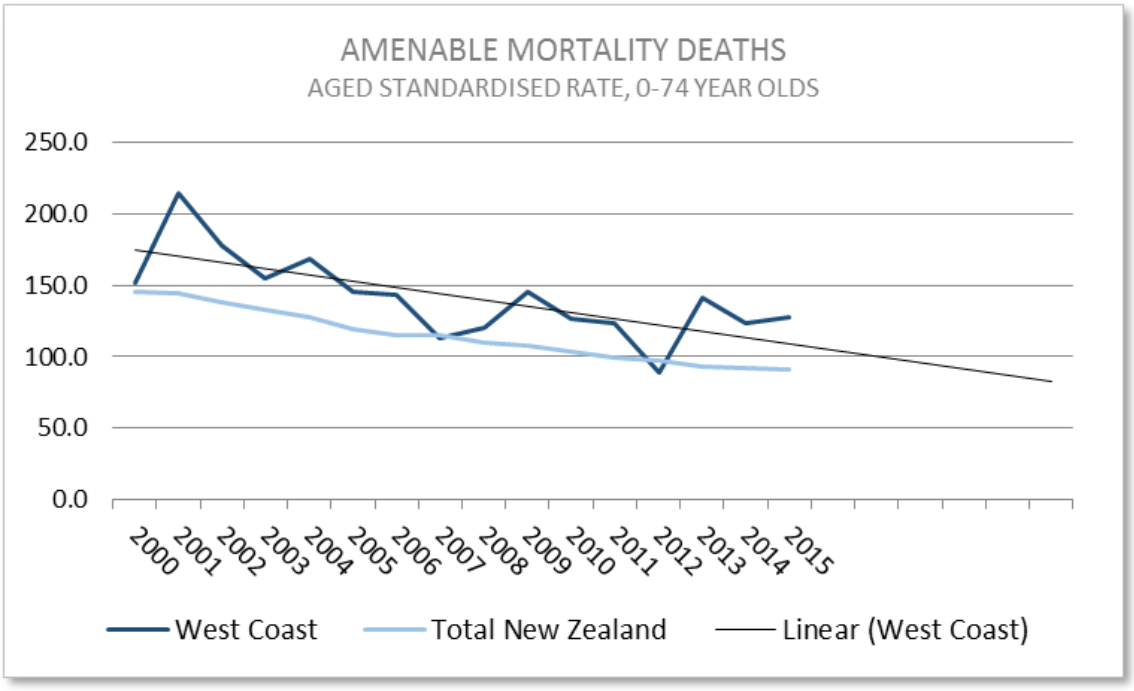
4. Amenable Mortality

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.



2019/20 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 December 2018[6]: 69% of eligible Māori women have had a breast screen in the past 2 years 44% of eligible Pacific women have had a breast screen in the past 2 years
30 Jun 2020 target	70% of eligible women (in all population groups) have had a breast screen in the past 2 years.
Activity	• Ensure there is a process in place 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 actively contact and recall Māori and Pasifika women who are not engaging with breast screening. • Provide health promotion materials 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	Two general practices are offering patients with long term mental health conditions enrolment in the Long Term Conditions Management programme.
30 Jun 2020 target	Three general practices are offering patients with long term mental health conditions enrolment in the Long Term Conditions Management programme.
Activity	• Expand the model already established in Westport practices to support patients enrolled in the Hokitika practice to access the Long Term Conditions Management programme. • Utilise Poutini Waiora Whānau Ora nurses and Community Mental health teams to enrol Māori with long term mental health conditions in the LTCM.
Who's involved	WCDHB Mental Health services, West Coast PHO, Poutini Waiora, General practices

[6] NSU data from BreastScreen Aotearoa

Who's leading	West Coast DHB

5. Smokefree Infants

Outcome: A healthy start in life

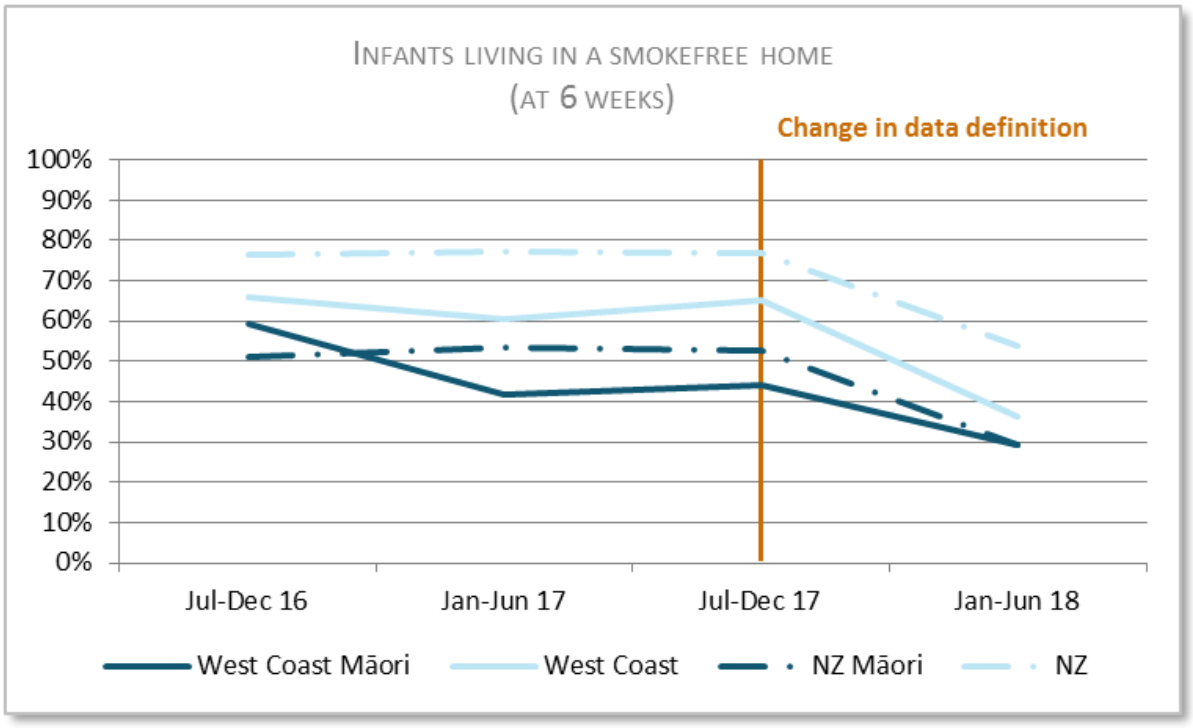
The West Coast has an estimated 80-100 women annually who are smoking during pregnancy - prevalence rates are between 25% and 30%. The tragic effects on the unborn baby are well documented as well as the negative impact on mother's health and birth outcomes. However, due to its addictive nature, smoking can be difficult for many women to stop at a time when they should, but might not necessarily feel able. Beyond this, many babies are also living with wider family members who continue to smoke. This measure aims to quantify the extent to which newborns are exposed to second-hand smoke.

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 have been updated during the 18/19 year which will improve the consistency and therefore quality, of the data for this measure.

It should also been noted that there has been a change to the definition of this measure during the last year changing the way the result is calculated and therefore portraying a more accurate but lower result both locally and nationally. Despite this, the West Coast made progress during the year on increasing the proportion of families where Smokefree status is recorded at the 4-6 week Well Child Tamariki Ora check.

BASELINE PERFORMANCE

36.3% of West Coast households with a newborn were known to be Smokefree as recorded at the first Well Child Tamariki Ora Core check (29.2% for Māori).



2019/20 MILESTONE

95% 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. Well Child Tamariki Ora Checks completed

CONTRIBUTING TO: SMOKEFREE INFANTS	
Proposed measures	Proportion of West Coast newborns that have had their first Well Child Tamariki Ora (WCTO) Core check on time.
Rationale	The handover period from maternity to early infancy and child health services is known to be an important time for families as they grow. Whether this is a first baby or a new sibling; the early weeks and months pose a period of big adjustment. This adjustment is best managed when the family is well supported by a trusted network. Early contact by a WCTO nurse with minimal gap in support following discharge from a maternity care provides the best opportunity for the family to build a high trust relationship in this crucial period.
Baseline	80% of West Coast babies (85% for Māori) had their first WCTO core check on time.
30 Jun 2020 target	90% of West Coast babies had their first WCTO core check on time.
Activity	• Complete analysis of the data for Core 1 checks to find gaps where families are receiving this contact later than expected. • Ensure WCTO providers have a process in place to access NHI numbers at the time of referral for families in their care. • Develop a plan with LMCS and all WCTO providers to address the gaps identified.
Who's involved	Child & Youth workstream, West Coast Maternity services, WCDHB Public Health Nurses, Plunket, Poutini Waiora, Rural Nurse Specialists.
Who's leading	Child & Youth workstream

5.2. 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 collection systems have been updated during the 2018/19 year which will improve the consistency and therefore quality, of the data for this measure. There is further education needed for providers regarding 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	54.2% of West Coast households (45.8% for Māori) with a newborn had their Smokefree status recorded at the first WCTO core check.
30 Jun 2020 target	95% of West Coast households with a newborn had their Smokefree status recorded at the first WCTO core check across all ethnicities.
Activity	• Provide education to the WCTO and Lead Maternity Carer workforce regarding the measure and its new definition. • Monitor monthly smokefree data completion rates for DHB-funded providers and provide reports to clinicians where this has not been completed. • Provide information to women and whānau who are engaged with the Smokefree Pregnancy and Newborn Incentive programme about the new measure definition, i.e. that smokefree includes all members of the household and that this provides good protection against SUDI.
Who's involved	WC Smokefree Services Coordinator, WCDHB Public Health Nurses, Plunket, Poutini Waiora.
Who's leading	WC Smokefree Services Coordinator.

5.3. Smokefree pregnancy

CONTRIBUTING TO: SMOKEFREE INFANTS	
Proposed measures	Proportion of women who are referred to the Smokefree Pregnancy and Newborns Incentives Programme who stay engaged until 4 months after baby is born.
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 17% for total population but as high as 28% for Māori.[7] 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	35% of women who were referred to the Smokefree Pregnancy and Newborns Incentives Programme achieved 80% weeks of achievable abstinence during pregnancy in 2018
30 Jun 2020 target	50% of women who are referred to the Smokefree Pregnancy and Newborns Incentives Programme achieve 80% weeks of achievable abstinence during pregnancy in 2019
Activity	• Continue to offer incentives to women to quit smoking through pregnancy and up to 16 weeks after their baby is born. • 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 who have successfully quit through media stories.
Who's involved	WC Smokefree Services Coordinator, DHB Cessation Service, Oranga Hā – Tai Poutini, Lead Maternity Carers
Who's leading	WC Smokefree Services Coordinator.

[7] 2017 MAT data

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

Outcome: Young people feel safe and supported by health services

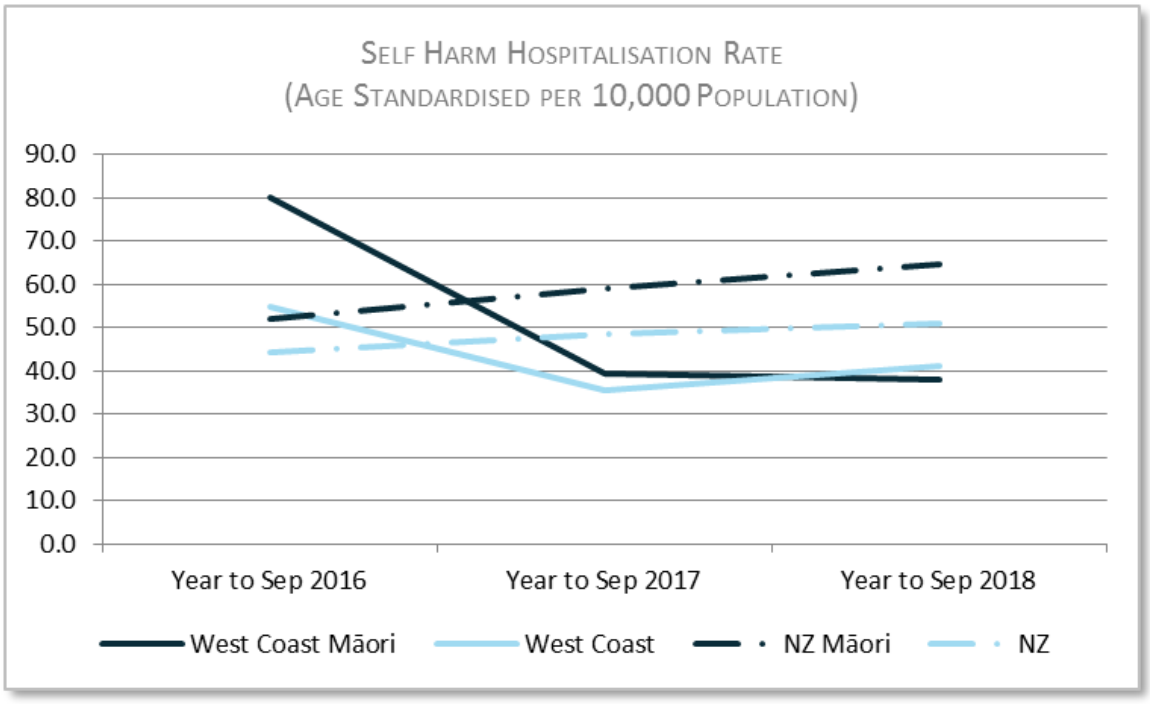
Intentional self-harm is an indicator of young people who are in distress and coping with that distress in an unhealthy way. It is often associated with low mood, depression, anxiety, wider family/peer group issues and events, stress, bullying, bereavement, relationship issues, trauma, intense or difficult 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. Around 35% of patients who present to hospital for self-harm are treated only in the emergency department and are discharged on the same day they are admitted.

BASELINE PERFORMANCE

The aged standardised hospitalisation rate for self-harm, per 10,000 population, for the West Coast DHB for the year ending September 2018 was 41.2 (total population) and 38.1 (Māori). West Coast rates are positive in comparison to national rates for both Māori and for our total population.

While this comparison to the national picture is encouraging, engagement with stakeholders locally indicates there continues to be a need to provide better support to young people who self-harm. Noting this feedback, and the proportion of young people who present to the Emergency Department without being admitted for a hospital stay, the actions that follow are intended to drive a reduction in repeated self-harm behaviours and therefore a continued decrease in in the hospitalisation rate.



2019/20 MILESTONE

Maintain a downward trend for self-harm hospitalisations to a rate of 32 per 10,000 population and continue to ensure the equity gap between Māori and total population is negligible.

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	23% of young people who presented to the emergency department (ED) with self-harm or suicidality and were discharged to the community were referred to the PHO Brief Intervention Counselling service.[8]
30 Jun 2020 target	75% 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.
Activity	• Work with the ED in Greymouth and the unplanned care team in Westport to embed a triage tool consistent with that used by Mental Health Crisis response. • 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	West Coast DHB, West Coast PHO, Suicide Prevention Coordinator
Who's leading	Suicide Prevention Coordinator

[8] Local data for 2018