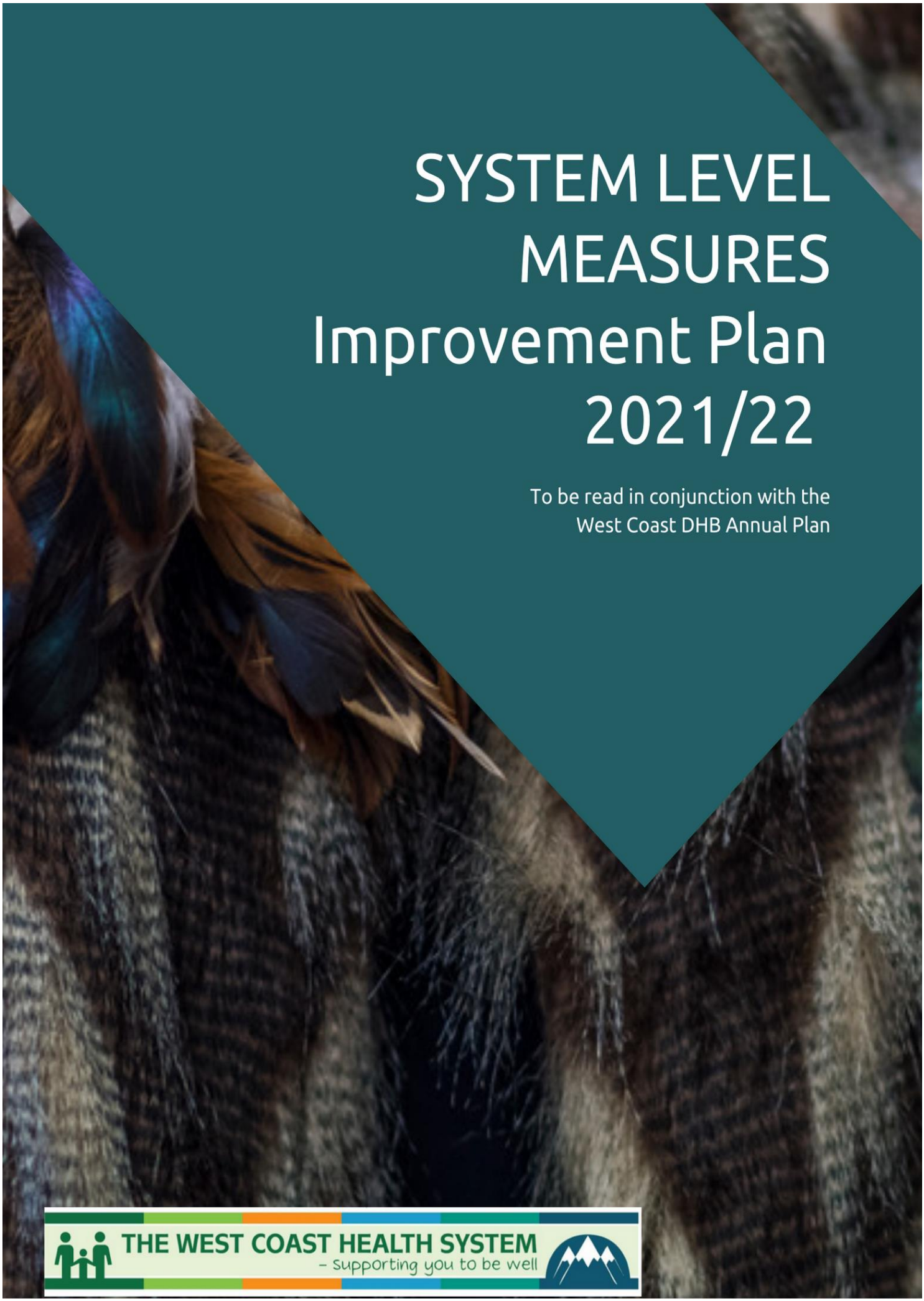
SYSTEM LEVEL MEASURES Improvement Plan 2021/22

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.

The activities described within this plan form the basis of the workplan for the West Coast Alliance. Outcomes are discussed and monitored by the Alliance Support Group and the Alliance Leadership Team considers any resulting recommendations. The West Coast Alliance's workstreams operate on a locality basis (Northern, Central and Southern) with the exception of "Healthy West Coast" which has a population health focus. There is also a transalpine Oral Health Service Development Group whose workplan influences outcomes on the West Coast. This group is overseen jointly by the West Coast Alliance Leadership Team and the Alliance Leadership Team of the Canterbury Clinical Network.

In looking towards the coming year, the West Coast Health System is expecting to realise the benefit of a new health facility in Greymouth where a primary care practice, community pharmacy, outpatient clinic, laboratory service and emergency department are uniquely co-located. Te Nīkau Grey Hospital & Health Centre opened in August 2020.

In setting performance goals for the coming year, the team have been conscious of the unusual events in 2019/20 with the lockdown and shifting of alert levels related to COVID-19. This has created some anomalies in terms of performance for that year impacting across both primary and secondary service areas. Although we have presented the latest available performance data in this Plan, we have chosen to use the 12 months to September 2019 as our baseline for setting most of our performance goals, where it is more reflective of a 'normal' year for our health system.

NEXT STEPS

The West Coast Alliance remains committed to working under the System Level Measures (SLM) Framework to drive improvements across all parts of the West Coast Health System. In particular, the framework provides a good opportunity to place focus on equity of health outcomes and implement actions that specifically reduce those gaps.

The actions laid out here represent the collective thinking of clinicians, health leaders and consumers from across our Health System and detail how we will continue to make progress, with the aim of improving health outcomes for communities and tangata whaiora (people seeking health).

Signatories

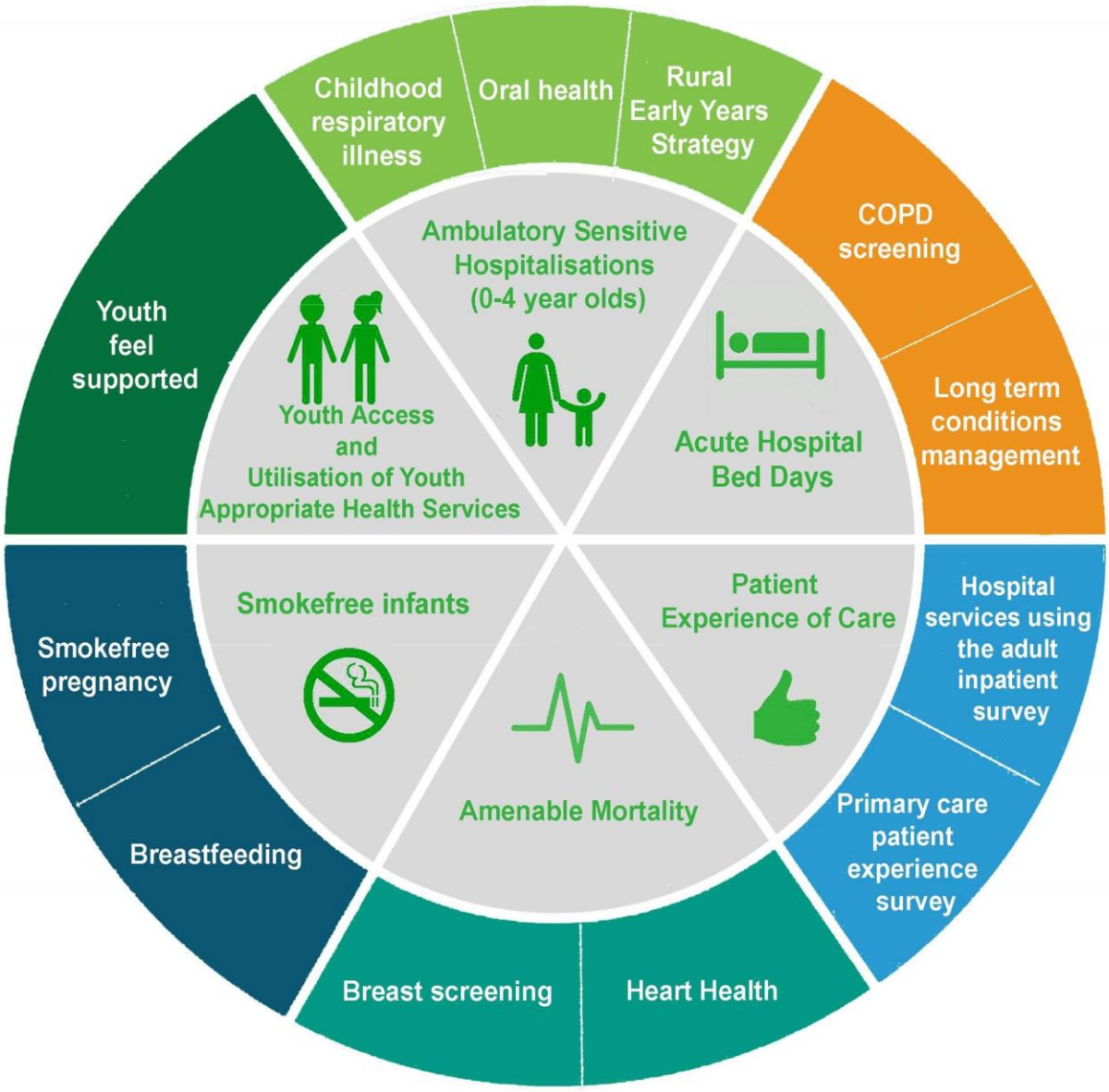
Kevin Hague, Chair
West Coast Alliance Leadership Team

Peter Bramley, Chief Executive
West Coast District Health Board

Helen Reriti, Chief Executive Officer
West Coast Primary Health Organisation

System Level Measures Framework Snap Shot

The focus areas of the West Coast's System Level Measures Framework is depicted in following diagram. The centre of the wheel contains the West Coast selected System Level Measures and the outer circle shows the associated contributory measures. The detail of each measure and contributory measure is detailed in the correlating section of this implementation plan.



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 and highlight where children experience health inequalities. The way children experience health and illness varies widely among priority populations and according to social gradient. Reducing ASH rates requires well-integrated and coordinated, environmental, preventive, diagnostic and disease management systems and a well-skilled and resourced workforce.

For example, a child with asthma living in a family with high health literacy, good access to support a warm dry home using healthy heating options and higher compliance with preventative medicines is less likely to need hospitalisation when or if there is an exacerbation of asthma symptoms.

BASELINE PERFORMANCE

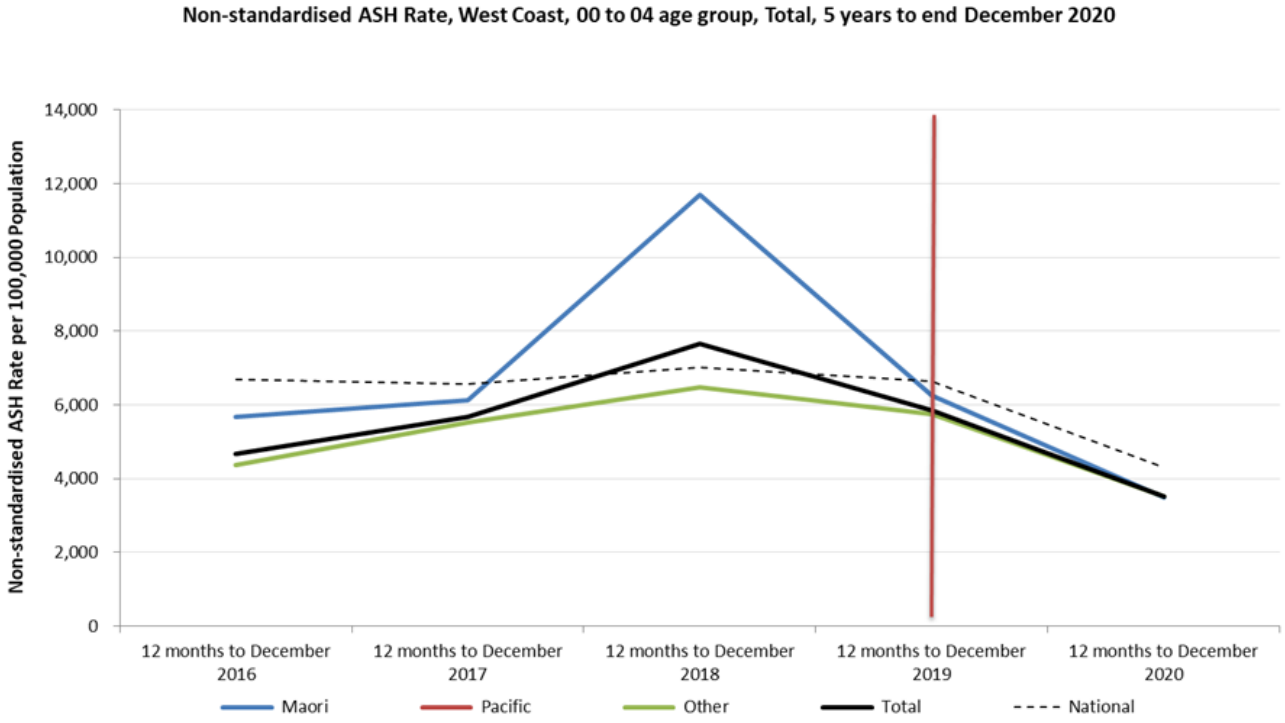


Table 1. Non-Standardised 0-4 ASH Rate (per 100,000 population) 5 years to end December 2020

DHB	Ethnic Group	12 months to December 2016	12 months to December 2017	12 months to December 2018	12 months to December 2019	12 months to December 2020
West Coast	Maori	5,682	6,136	11,707	6,250	3,500
West Coast	Pacific	-	-	-	-	-
West Coast	Other	4,377	5,532	6,475	5,745	3,521
West Coast	Total	4,675	5,676	7,667	5,856	3,516
National	Total	6,697	6,564	7,010	6,628	4,315
				1.08	1.53	1.07
	3-Year Average					1.23

Table 2. Actual 0-4 ASH Events 5 years to end December 2020

DHB	Ethnic Group	12 months to December 2016	12 months to December 2017	12 months to December 2018	12 months to December 2019	12 months to December 2020
West Coast	Maori	25	27	48	25	14
West Coast	Pacific	-	-	-	-	-
West Coast	Other	65	78	90	81	50
West Coast	Total	90	105	138	106	64
National	Total	20,451	20,043	21,373	20,278	13,224

2021/22 MILESTONE

Maintain or further reduce the average ratio between ASH rates for Māori children aged 0-4 years old and total children 0-4 years old to below the current 3-year ratio of 1:1.23 (as at the end of December 2019).

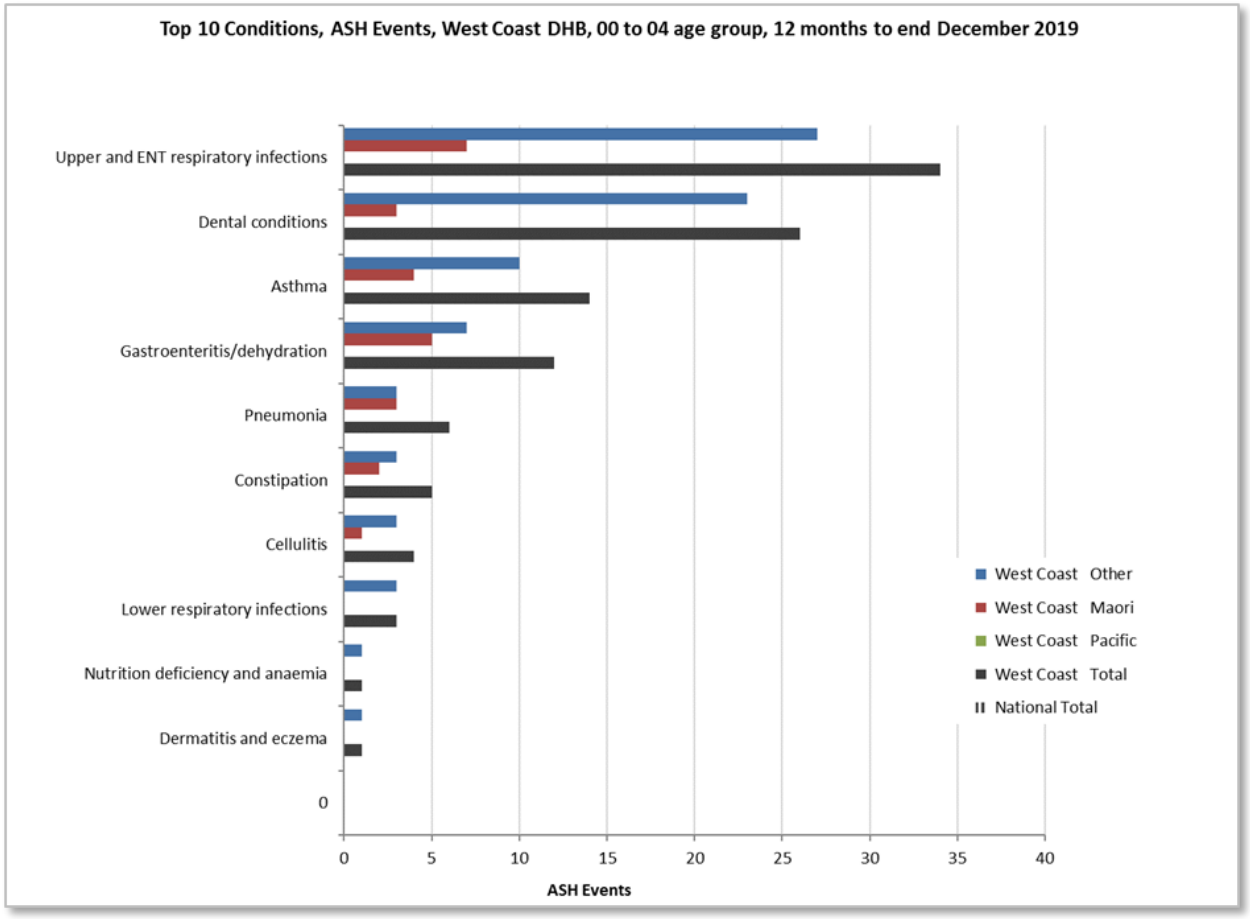
In setting the milestone for the 2021/22 year, the following key factors have been considered:

- 2019/20 data has been skewed by COVID events in 2020 and has not been included.
- 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. When focusing on actions to decrease admissions we note the very small number of children admitted with individual conditions.
- To reduce the effect of fluctuations due to the small population, the milestone has been calculated based on a 3-year average and is expressed as a ratio where we are looking to narrow the gap between Māori and non- Māori rates.

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 services and the effective management of long-term conditions.

Respiratory and asthma conditions are two of the three leading drivers of ASH admissions on the West Coast for children aged 0-4 years, and key actions which focus on respiratory admission are highlighted in the following section. A number of related actions are included elsewhere in this plan that focus on smoking cessation to further support a reduction in respiratory admissions including increasing the number of smokefree homes in which our children live (see 0). While this is the leading driver for ASH admissions for young children, the actual event numbers are small with 34 admissions (7 for Māori) for upper and ENT respiratory infections and 14 admissions (4 for Māori) for asthma in the 12 months to December 2019.

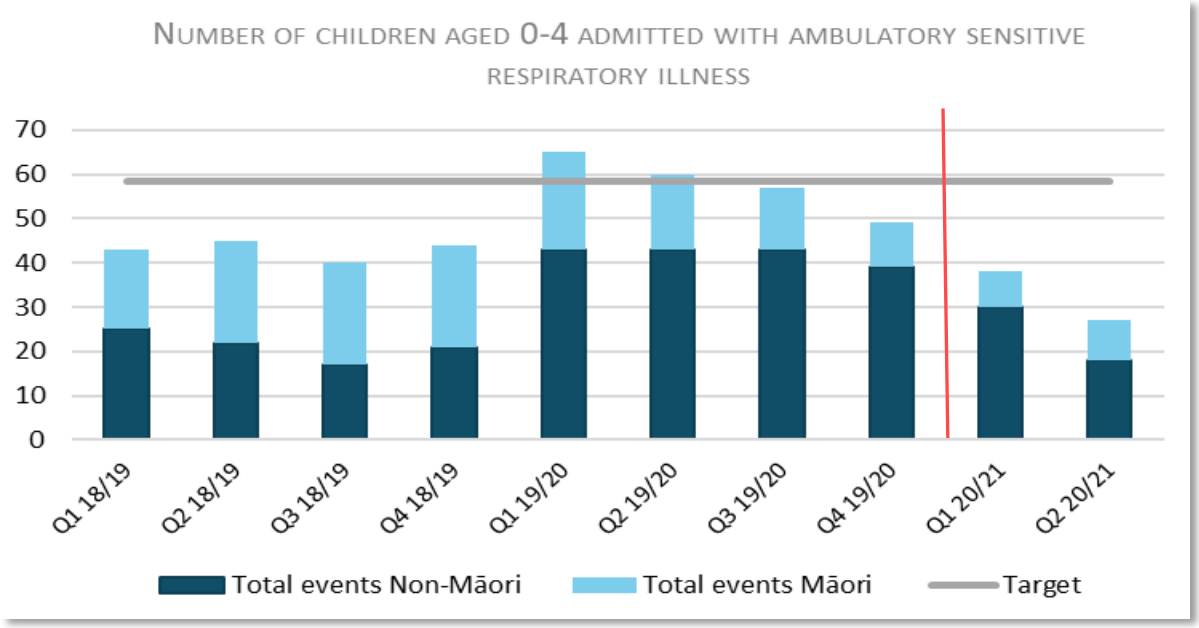
Dental conditions also continue to contribute as a key driver for ASH admissions for this age group (see graph below). This has been a leading driver for some time and the Alliance has chosen to continue their focus in this area as a factor in improving ASH rates for 0 - 4-year olds. The number of actual events (ASH admissions) for dental conditions was 26 in the 12 months to December 2019. We acknowledge that this is a very small number but there are a reasonable number of repeat or related admissions (27%) within this cohort. There are also persistent inequities in terms of dental health outcomes for children on the West Coast, with significant gaps in the proportion of children carries-free (no holes or fillings) at age five. The actions highlighted here will help to influence both ASH rates and longer-term dental health outcomes for children.



1.1. 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 (to December2019)	57 events (14 for Māori) for ASH categories; Upper and ENT respiratory infections, Asthma, and Lower respiratory infections and Pneumonia.
2021/22 target	Maintain the downward trend for ASH rates 0-4 year olds: Upper and ENT respiratory infections, Asthma, Lower respiratory infections and Pneumonia.
Activity	• Retrospectively review cases of children presenting to ED with respiratory conditions who are not admitted, to identify the current state of referral to the DHB's Clinical Nurse Specialist (CNS) service for ongoing support and management. • Review and map the optimal referral pathway for respiratory presentations, with Paediatrics, General Practice and the CNS Service, using data from the review.

	• Implement a multidisciplinary team approach to frequent presenters.
Who's involved	West Coast DHB, West Coast PHO, Poutini Waiora
Who's leading	West Coast PHO



1.2. 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 services across the West Coast and 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 tamariki Māori who have poorer oral health outcomes. In previous years, the work has been focused on improving data collection and streamlining enrolment processes. Focus has now moved to targeting whānau who are known to have had a dental-related ASH admission or can be identified as at risk of admission.
Baseline 2020/21	No families currently receiving this targeted support package for oral health.
2021/22 target	75% of Māori whānau with a child admitted to hospital for treatment of a dental condition are engaged in a targeted wrap around support package.

Activity	• Develop and implement the West Coast Oral Health Education and Promotion Plan with the oversight of the Oral Health Service Development Group. • Adopt a presence alongside whānau visiting our services during an admission for oral health, building relationships and demonstrating a Whānau Ora approach to wellbeing. • Offer 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). • Support the appointment of a Clinical Lead for Oral Health to drive improvements across the service and integration with other service providers to identify other children at risk. • Continue to use connections within primary and community health to identify non-attenders and other children being lost to recall and re-engage them and their whānau with school and community oral health services.
Who's involved	Healthy West Coast Alliance workstream, Oral Health Service Development Group, paediatric inpatient services, general practice teams.
Who's leading	WCDHB Hauora Māori Team, Community and Public Health (for oral health promotion).

1.3. Rural Early Years Strategy

CONTRIBUTING TO: AMBULATORY SENSITIVE HOSPITALISATIONS	
Proposed measures	Model of care for families with young children is developed.
Rationale	The way parents and whānau access and make use of the various support services available in early childhood varies from whānau to whānau and from locale to locale across our West Coast region. Local stakeholder and community engagement as part of the development of our Maternity Strategy has indicated that work is required to understand how we provide services in the early childhood life-stage. A co-ordinated understanding of how services are distributed and accessed will drive improved wellbeing for our youngest patients and in turn reduce hospitalisations for preventable or manageable illnesses.
Baseline 2020/21	Services are administered individually as separate teams across the DHB and other health providers.
2021/22 target	"Growing Up Well on the West Coast" consultation is completed and leads to an informed model of care for families with young children.
Activity	• Complete the formal engagement process with our stakeholders and community to better understand the priorities and issues for children and their whānau across our three localities. • Develop a Rural Early Years Strategy to improve engagement with services and outcomes for our most vulnerable populations.

	• Continue connecting children to health services (encompassing the Newborn Multi-Enrolment Form, capturing movement of families into and out of the district and identifying children in the region who are new to New Zealand), supporting families who are not engaging with health services (identifying the service barrier and getting them back to their service provider) and referrals out to relevant service providers (e.g. Outreach Immunisation, WCTO, Public Health Nursing Service).
Who's involved	West Coast DHB, West Coast PHO, Poutini Waiora, Consumer Council
Who's leading	West Coast DHB

2. Acute Hospital Bed Days

Outcome: Improved management of the demand for acute care

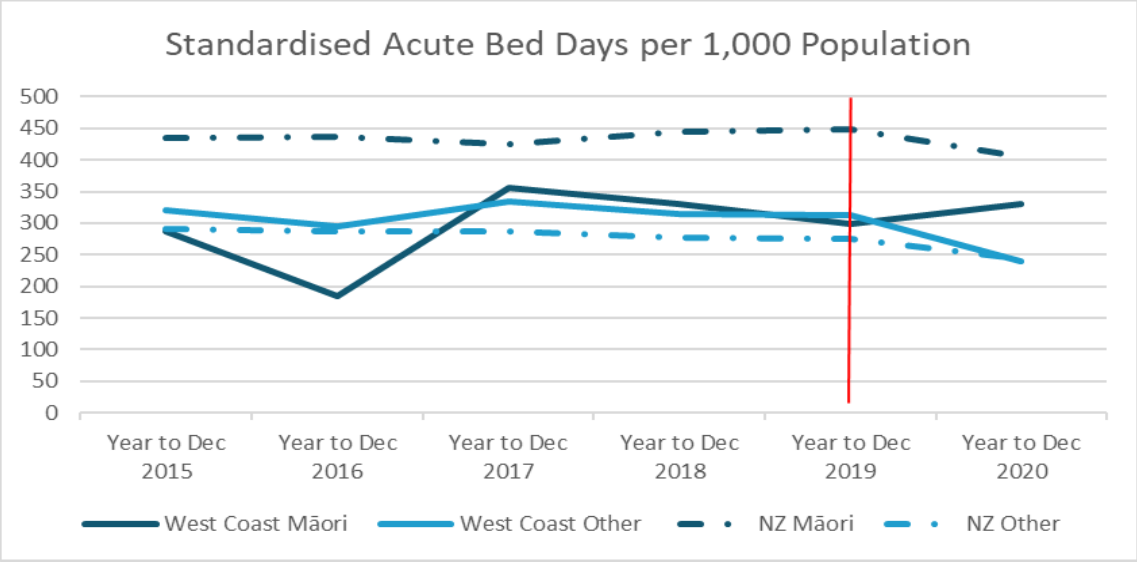
Utilisation of Acute Hospital Bed Days illustrates the demand for, and length of stay in, secondary care (hospital) services some of which can be prevented through good care provided close to home (through general practice and community services), good discharge planning and supported transition between 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: integrated primary/secondary HealthPathways; implementation of the primary care Long Term Conditions Management (LTCM) programme; the development of the Complex Clinical Care Network (CCCN); and the Pharmacy to GP programme. We have also improved communication between teams to support 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.

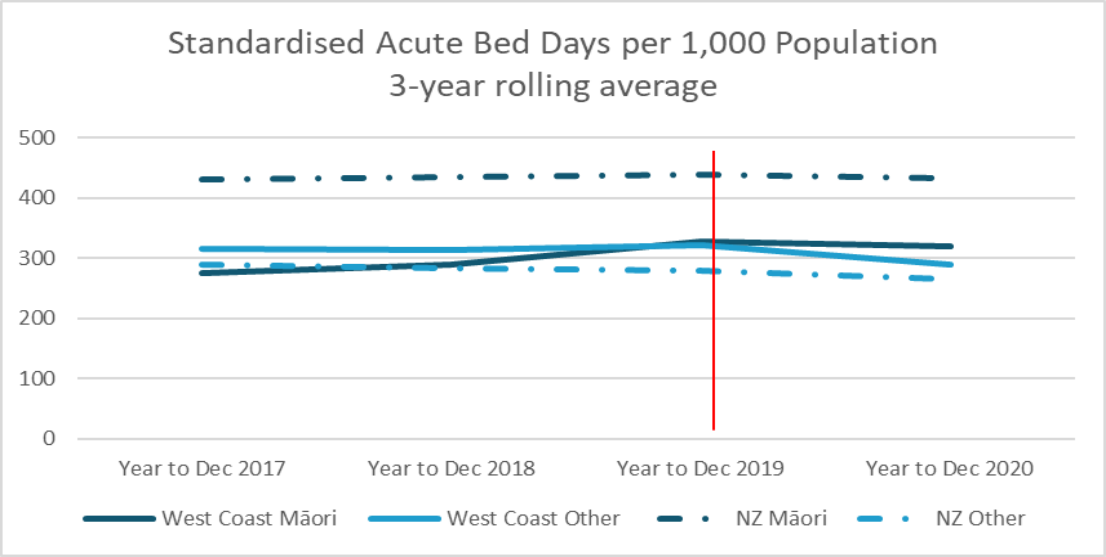
The delivery of integrated and high-quality care in the rural context relies heavily on the skill and coordination of the workforce. Working in this way does not suit everyone and recruitment to the West Coast in the context of national supply shortages in specific areas will continue to be a challenge. Our Health System's move towards a Rural Generalist workforce model continues to expand and enhance the roles of staff across all professions and providers. This workforce model supports and enables professionals to work to the full extent of their scope of practice, safely and with appropriate support and will enable further integration across our health system, better supporting our population to access the services they need when they need them.

BASELINE PERFORMANCE

The age standardised Acute Bed Day Rate, per 1,000 population, for the West Coast DHB for the year ending December 2019 was 306 (total population) and 299 (Māori).[1] Three-year averages are 321 (total population) and 328 (Māori).



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



2021/22 MILESTONE

Reduce the Acute Bed Day Rate for Māori to below the 3-year average rate of 328 per 1,000 of population, as at the end of December 2019, and continue to maintain the equity gap between Māori and total population to either negligible or favourable to Māori.

In setting the milestone for the 2021/22 year several key factors have been taken into account:

- December 2019 baseline has been used to discount data skewed by COVID events in 2020.
- 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.

2.1. 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 2020/21[2]	69% of the total population (63% for Maori) who have had a LTCM review for COPD have an exacerbation plan in place.
2021/22 target	85% of people in all populations who have had a LTCM review for COPD have an exacerbation plan in place.
Activity	• Provide education for practice staff on having planning conversations with patients and developing individualised plans. • Continue to work with the Clinical Nurse Specialists –Respiratory to ensure exacerbation plans are communicated with other health services such as St. John. • Utilise system-wide tools, including shared care plans, to ensure the acute care response is informed by patients' individual needs.
Who's involved	West Coast PHO, General Practices, West Coast DHB
Who's leading	West Coast PHO

2.2. Long term conditions management

CONTRIBUTING TO: REDUCING ACUTE HOSPITAL BED DAYS	
Proposed measures	Model of care for patients with long term mental health conditions is expanded.
Rationale	There are known inequities in health outcomes for people who live with long term mental health conditions and this includes acute hospital bed days. 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 and help to avoid unplanned hospital care.
Baseline 2020/21	Three general practices are offering patients with long term mental health conditions enrolment in the Long-Term Conditions Management programme.
2021/22 target	Five general practices are offering patients with long term mental health conditions enrolment in the Long-Term Conditions Management programme.
Activity	• Focus on expanding the model already established in Westport and Hokitika practices to support patients enrolled in the two Greymouth practices (and one other) to access the Long-Term Conditions Management programme. • Utilise Poutini Waiora Whānau Ora nurses and Community Mental health teams to support the enrolment of Māori with long term mental health conditions in the LTCM. • Promote healthy lifestyle changes to patients with mental health concerns who are enrolled in the primary care Long Term Conditions programme.
Who's involved	WCDHB Mental Health services, West Coast PHO, Poutini Waiora, General practices.

[2] Data set is annual to May 2021

Who's leading	West Coast DHB

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. The 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.

During 2020/21, Te Nīkau Grey Hospital & Health Centre opened. The co-location of a primary care practice, community pharmacy, Emergency Department, outpatient clinics and hospital wards has changed patients' experience of care and there is a focus on maintaining both the inpatient and primary care survey results.

2021/22 MILESTONES

Adult Inpatient Survey: Improve the positive responses to the question "Were you told the possible side effects of the medicine (or prescription for medicine) you left hospital with, in a way you could understand?" from 69% to 75%.

Primary Care Patient Experience Survey: Improve the positive responses to the questions "Did the [healthcare professional] involve you as much as you wanted to be in making decisions about your treatment and care?" and "In the last 12 months, was there ever a time when you wanted health care from a GP or nurse, but you couldn't get it?".

3.1. Hospital services using the adult inpatient survey

CONTRIBUTING TO: IMPROVED PATIENT EXPERIENCE OF CARE	
Proposed measures	Increase the proportion of patients surveyed who respond positively to the question "Were you told the possible side effects of the medicine (or prescription for medicine) you left hospital with, in a way you could understand?".
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. Patients who respond to the survey nationally consistently feedback that information about side effects from medications was not either provided or provided in a way that was not easily understood. Improvements in this aspect of care delivery can lead to improved patient outcomes, reduced readmission rates, and reduced health care costs associated with these readmissions.

Baseline 2020/2021[3]	69% of patients surveyed responded positively to the question "Before giving you any new medicine, did hospital staff describe possible side effects in a way you could understand?".
30 Jun 2022 target	75% of patients surveyed responded positively to the question "Were you told the possible side effects of the medicine (or prescription for medicine) you left hospital with, in a way you could understand?".
Activity	• Evaluate the process for providing patients with information about new medications prescribed during a hospital stay. • Implement a process for ensuring that each patient is provided with medication related information before discharge and survey compliance. • Continue to promote completion of the Adult Inpatient Experience Survey through the WCDHB Consumer Council.
Who's involved	WCDHB Pharmacy, WCDHB Consumer Council, Clinical Leaders, WCDHB Quality Team
Who's leading	WCDHB Quality Team

3.2. Primary care patient experience survey

CONTRIBUTING TO: IMPROVED PATIENT EXPERIENCE OF CARE	
Proposed measures	Number of general practices engaging meaningfully with the results of any patient experience survey resulting in positive responses to two survey questions (highlighted below).
Rationale	The perspectives a patient shares about their experiences in primary care are valuable for informing service improvement. Where business continues 'as usual' without a process for taking into account feedback from consumers, opportunities for driving consumer engagement with preventative health measures and improving self-management of long-term conditions are lost. Practices engaging with the results of patient experience surveys contribute positively to the outcomes measures in this framework, particularly Acute Bed days, Reduced Ambulatory Sensitive Admissions and Amenable Mortality.
Baseline 2020/2021[4]	0% of the general practices on the West Coast can demonstrate a quality improvement programme informed by the results of patient experience surveys. 80% of responses were Yes to the question "Did the [healthcare professional] involve you as much as you wanted to be in making decisions about your treatment and care?". 72.5% of responses were Yes to the question "In the last 12 months, was there ever a time when you wanted health care from a GP or nurse, but you couldn't get it?".

[3] Data from Cemplicity™ July 2020-February 2021. This measure is a proportion of all West Coast inpatients and is not seen to be significantly skewed by COVID-19 impacts.

[4] Data is from Ipsos August 2020-February 2021 and is an average of the quarterly results. This measure is a proportion of all West Coast patients and is not seen to be significantly skewed by COVID-19 impacts.

30 Jun 2022 target	Seven out of seven (100%) of the general practices on the West Coast can demonstrate a quality improvement programme informed by the results of patient experience surveys. Maintain or improve the proportion of positive responses to the questions above.
Activity	• The West Coast PHO will deliver an action learning programme in which Quality teams are identified within each general practice to undergo a series of Quality Improvement Projects. One of the data sources for this process is Patient Experience of Care. • Quality improvement projects will include actions targeted to obtain positive responses to the questions: **?** Did the [healthcare professional] involve you as much as you wanted to be in making decisions about your treatment and care?; and **?** In the last 12 months, was there ever a time when you wanted health care from a GP or nurse, but you couldn't get it?. • Continue to promote completion of the Primary Care Patient Experience Survey through the WCDHB Consumer Council.
Who's involved	West Coast PHO, West Coast DHB Consumer Council
Who's leading	West Coast PHO

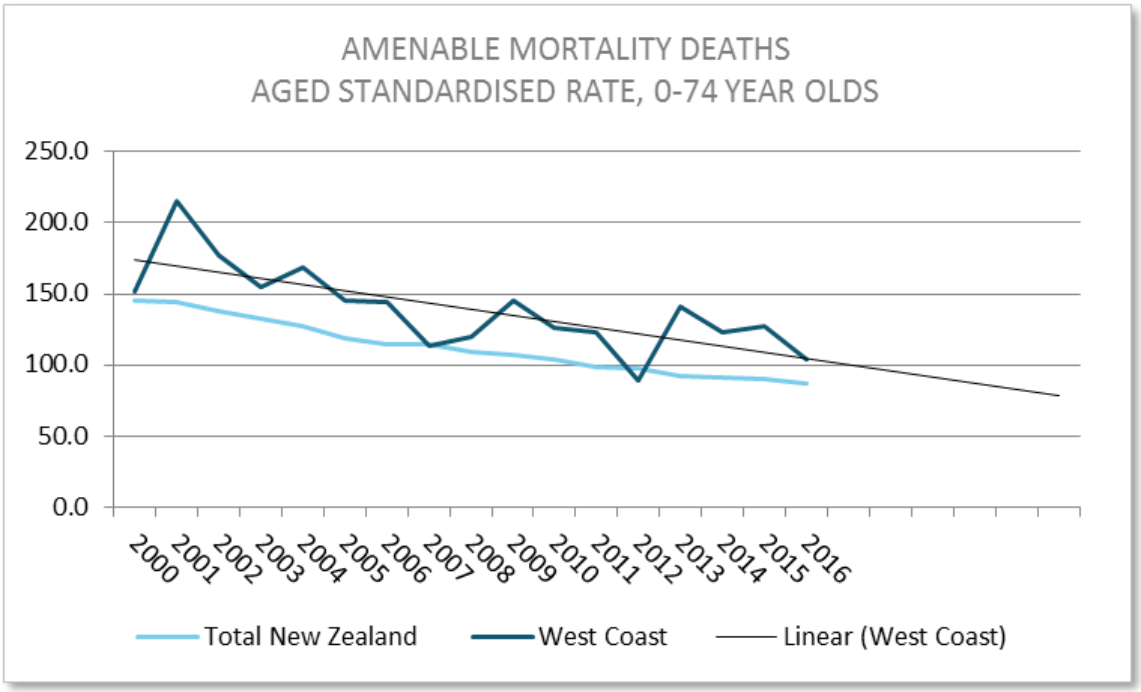
4. Amenable Mortality

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 is too small to produce a meaningful rate.



2021/22 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 70 amenable deaths per 100,000 people by 2023.

In setting this milestone several key 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 45-69) 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 (Dec 2019) [5]	70% of eligible Māori women have had a breast screen in the past 2 years 42% of eligible Pacific women have had a breast screen in the past 2 years
2021/22	70% of eligible women (in all population groups) have had a breast screen in the past 2 years.
Activity	• Enable clinicians to refer all eligible high-risk women who present at Outpatient appointments for screening. • Actively target Māori and Pacifica wahine by utilising group sessions (such as a 'Top and Tail' programme, including whānaungatanga, kai and education) to facilitate attendance. • Quarterly meetings coordinated with West Coast PHO, Poutini Waiora and BreastScreen Aotearoa to analyse system data, identify gaps and minimise barriers to access. • Deliver education to practices to support an understanding of barriers that affect participation in screening particularly for Māori and Pacifica wāhine. • Identify overdue priority women and those not enrolled in the national breast screening programme at a practice level and provide practices with targeted follow-up to lift rates. • Collaborate to offer local support to Māori whānau to engage in screening, seek early advice and understand cancer diagnosis to reduce inequity of outcomes for Māori.
Who's involved	WCPHO, BreastScreen Aotearoa, General Practice Champions, Poutini Waiora.
Who's leading	BreastScreen Aotearoa

[5] NSU data from BreastScreen Aotearoa. The December 2019 baseline has been used as the 2020 year has been impacted by COVID-19 lockdowns and alert levels restricting access to screening.

4.2. Heart Health

CONTRIBUTING TO: REDUCING AMENABLE MORTALITY	
Proposed measures	Māori men aged 35-44 years have had a Cardiovascular Disease Risk Assessments (CVDRA).
Rationale	The West Coast PHO continues to work with general practice to maintain the delivery of CVDRA's. While the West Coast continues to meet the target for total population a more targeted focus is required to reach the target for eligible younger Māori men who are traditionally difficult to engage. 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 (Dec 2019) [6]	66% of Māori men aged 35-44 years have had a CVDRA in the last 5 years
2021/22 target	90% of Māori men aged 35-44 years have had a CVDRA in the last 5 years
Activity	• Continue to actively invite men in this cohort to appointments outside of normal business hours. • Trial virtual consultations and follow-ups for men in this cohort who have never accessed screening. • Continue to use an outreach service using Poutini Waiora nurses to complete screening in workplaces or at home. • Address barriers to completing CVDRA such as seamless phlebotomy access alongside clinical consults after hours.
Who's involved	West Coast PHO, General Practices, Poutini Waiora
Who's leading	West Coast PHO

[6] Local Karo data from the West Coast PHO. The December 2019 baseline has been used as the 2020 year has been impacted by COVID-19 lockdowns and alert levels restricting access to screening.

5. Smokefree Infants

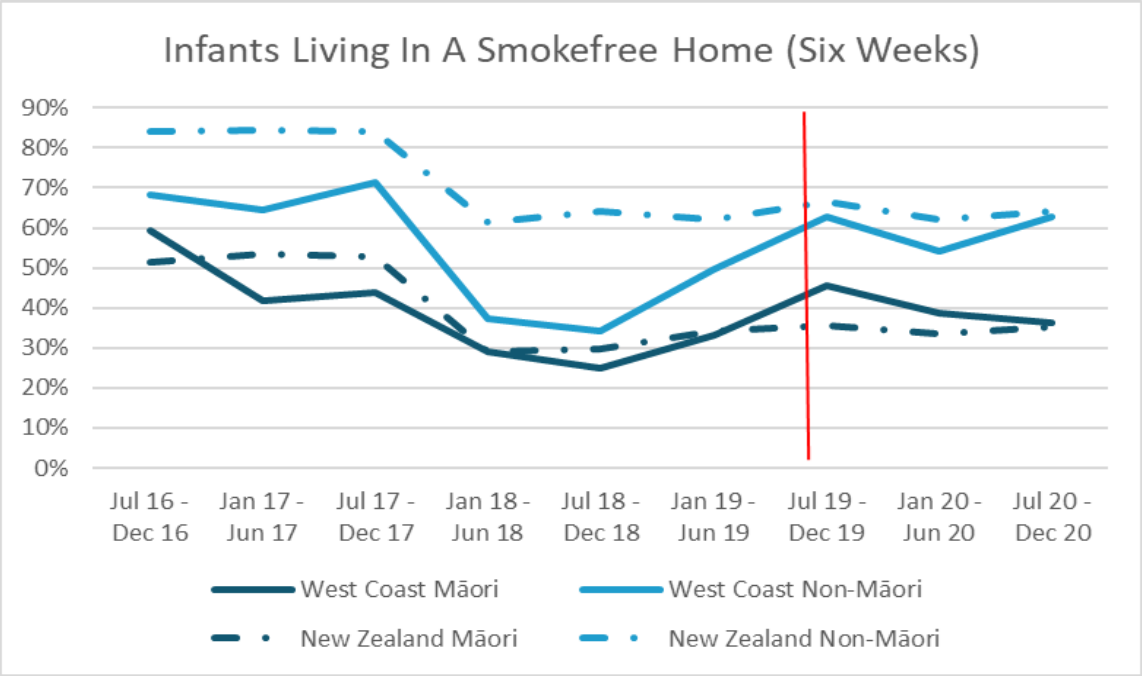
Outcome: A healthy start in life

In 2019 there were 55 women who identified as a smoker at registration with their chosen Lead Maternity Carer (LMC); this represents 16% of all birthing women (33.8% for Māori, 13.2% for Other). The 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 four-six weeks, usually in the baby's home. Data collection systems were updated during 2019 and this is expected to have improved the quality of the data for this measure.

BASELINE PERFORMANCE

59.3% of all West Coast households with a newborn were known to be Smokefree as recorded at the first Well Child Tamariki Ora Core check (45.7% for Māori).



2021/22 MILESTONE

Reduce the equity gap between Māori and Non-Māori babies living in a smokefree home to less than the rolling three-year average of 12%.

5.1. Smokefree pregnancy

CONTRIBUTING TO: SMOKEFREE INFANTS	
Proposed measures	Proportion of women who are Smokefree 2 weeks following delivery.
Rationale	The West Coast has a good range of services available to smokers for cessation support during pregnancy. 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 2019[7]	85.7% of women (71.2% for Māori) were Smokefree at 2 weeks following delivery.
2021/22 target	90% of women, including 90% for Māori were Smokefree at 2 weeks following delivery.
Activity	• Invest in local Hapū Wānanga (Kaupapa Māori antenatal education programme) that promotes SUDI prevention and supports access to smoking cessation, safe sleep devices and breastfeeding support. • Offer woven safe sleep devices (wahakura) where possible and appropriate. • Report results of this measure to Maternity Services to assist promoting referral to the cessation services. • Continue to offer incentives to women to quit smoking through pregnancy and up to 16 weeks after their baby is born. • Follow up with 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] Data from Well Child Tamariki Ora Quality Improvement Framework - results July – Dec 2019. Data from 2019 has been used as the baseline due to the unquantified impact of COVID-19 on people's lives in the 2020 year.

5.2. Breastfeeding

CONTRIBUTING TO: SMOKEFREE INFANTS	
Proposed measures	Proportion of infants exclusively or fully breastfed at 3 months of age.
Rationale	Mothers who breastfeed may be more motivated to remain Smokefree and breastfeeding adds another protective factor against Sudden Unexplained Death in Infancy (SUDI). While breastfeeding rates at discharge from hospital and at six weeks of age are often high 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.
Baseline 2019[6]	66% of all babies (56% for Māori) were breastfed at 3 months of age.
2021/22 target	70% of all babies, including 70% for Māori, are breastfed at 3 months of age.
Activity	• Invest in local Hapū Wānanga (Kaupapa Māori antenatal education programme) that promotes SUDI prevention and supports access to smoking cessation, safe sleep devices and breastfeeding support. • Implement a system improvement for connecting children to health services (encompassing the Newborn Multi-Enrolment Form, capturing movement of families into and out of the district and identifying children in the region who are new to New Zealand), supporting families who are not engaging with health services (identifying the service barrier and getting them back to their service provider) and referrals out to relevant service providers (e.g. Outreach Immunisation, WCTO, Public Health Nursing Service). • Report results of this measure to Maternity Services to assist promoting referral to the breastfeeding support service.
Who's involved	Lead Maternity Carers, Poutini Waiora, West Coast PHO, Well Child Tamariki Ora providers, West Coast DHB
Who's leading	West Coast DHB

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

Outcome: Young people feel safe and supported by health services

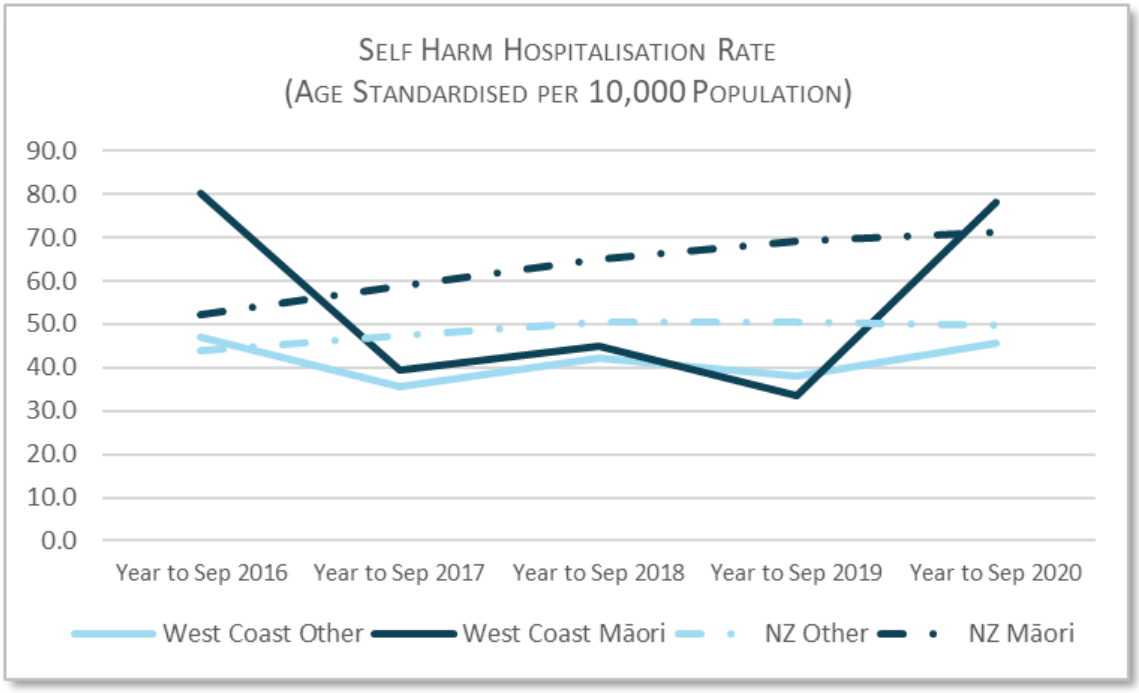
Intentional self-harm is an indicator of young people who are in distress and coping with that distress in an unhealthy way. It is often associated with low mood, depression, anxiety, wider family/peer group issues and events, stress, bullying, bereavement, relationship issues, trauma, intense or difficult feelings, or being in a group that self-harms.

Not all young people who self-harm and then present to an emergency service are admitted to hospital but admission rates do provide an indicator of the need. Some young people will present multiple times each year and have previously accessed support from community-based services. Around 49% of young patients who present to hospital for self-harm are treated only in the emergency department and are discharged home on the same day they are admitted.

BASELINE PERFORMANCE

The standardised self-harm hospitalisation rate for West Coast DHB youth aged 10-24 per 10,000 population was 39.9 (total population), 37.9 (Other) and 33.5 (Māori) for the year ending September 2019. West Coast rates have been positive in comparison to national rates for our total population and for Māori. However, we note the increased rates to September 2020 to 51.4 (total population), 45.7 (Other) and 78.1 (Māori).

While this comparison to the national picture is encouraging, engagement with stakeholders locally indicates there continues to be a need to provide better support for young people experiencing mental distress. Noting this feedback and the increased rates over the last year, the Alliance have identified the need to ensure that young people are appropriately supported during an acute presentation to Te Nīkau Grey Hospital & Health Centre, the actions that follow are intended to drive an improved experience and access to mental health supports in an integrated system.



2021/22 MILESTONE

Return to a downward trend for self-harm hospitalisations toward the lower rate of 32 per 10,000 population in 2019 and continue to ensure the equity gap between Māori and total population is either negligible or favourable to Māori.

We note that because of the West Coast's small population numbers, the increase in self harm hospitalisation rates for Māori in the year to September 2020 represents a difference of only four individuals. Whilst this may seem small, the action set out below will support a group wider than those presenting to Te Nikau by capturing those at risk of admission and needing support in our community.

6.1. Youth feel supported

CONTRIBUTING TO: YOUTH ACCESS TO AND UTILISATION OF YOUTH APPROPRIATE HEALTH SERVICES	
Proposed measures	A youth friendly pathway is in place for young people who make an unplanned presentation to the new Te Nīkau Grey Health Centre with mental distress.
Rationale	During 2021/22 health services in Greymouth will continue to become more integrated and co-located in the new Te Nīkau Grey Hospital & Health Centre. It is important to be proactive and consider how patients experiencing mental distress will be received and directed to the most appropriate clinician for assessment and support. This is particularly true for young consumers who have consistently provided feedback both locally and nationally about the importance of services feeling welcoming and like they are "for young people".
Baseline	Current pathway directs most patients through emergency department triaging.
2021/22	A youth friendly pathway is in place for young people who make an unplanned presentation to Te Nīkau Grey Hospital & Health Centre with mental distress that ensures they receive support from the most appropriate clinician and in the most appropriate setting.
Activity	• Utilise new mental health educator resource in acute care to support clinicians to confidently and appropriately manage youth presenting with mental health issues. • Continue to embed and refine patient flow pathways for all patients presenting acutely to Te Nīkau Grey Health Centre. • Review young consumers' feedback from the Primary Care Patient Experience Survey about walk-in appointments for opportunities to improve. • Continue to focus on increasing the responsiveness of suicide prevention activity for Māori and promote a 'by rangitahi for rangitahi' approach that is tikanga Māori and whānau centred.
Who's involved	WCDHB Mental Health services, West Coast PHO, General practice
Who's leading	West Coast DHB