West Coast Health System

IMPROVEMENT PLAN

System Level Measures Framework 2017-2018

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

Contents

Introduction

The System Level Measures Framework was introduced by the Ministry of Health in 2016/17 to extend the Integrated Performance and Incentive Framework. The System Level Measures Framework encourages a system-wide approach to improving health outcomes and presents a core set of national outcomes for the health sector to strive towards.

As part of the Framework there is an opportunity to identify a set of local contributory measures, aligned with each of the national outcomes.

TURNING OUR CHALLENGES INTO STRENGTHS

On the West Coast we face the unique challenge of providing services to a very small population (32,600 people in 2017/18), spread across a large region that spans 516 kilometres; from Karamea in the north to Haast in the south.

We should not look at this challenge as an immovable barrier to achieving our goals and delivering services that our community can be proud of. Instead, it provides us with an opportunity to think differently and find new approaches to delivering services. Responding to this challenge presents us with an opportunity to become a leader in providing health care in a rural environment.

We have come together through the West Coast Alliance to develop the key foundations needed to bring an integrated health system to life. Our Alliance, between the West Coast DHB (WCDHB) and West Coast PHO (WCPHO) includes a close relationship with our Māori Health provider, Poutini Waiora. Together, we are taking on this challenge - working with our health teams and our communities across the Coast to achieve something that is truly innovative and sustainable.

The West Coast's System Level Improvement Plan for 2017/18, highlights where we intend to make a difference in the health of our population in the coming year, in line with the national System Level Improvement Framework.

APPROPRIATENESS OF FOCUS FOR THE COAST

In the first year of implementing the System Level Improvement Framework, only measures with data already being captured were considered for possible contributing measures. Now, having a good baseline of information available, contributory measures for 2017/18 focus more on those areas where local needs have been identified and where improvements would make the greatest impact in terms of the overall wellbeing of our communities.

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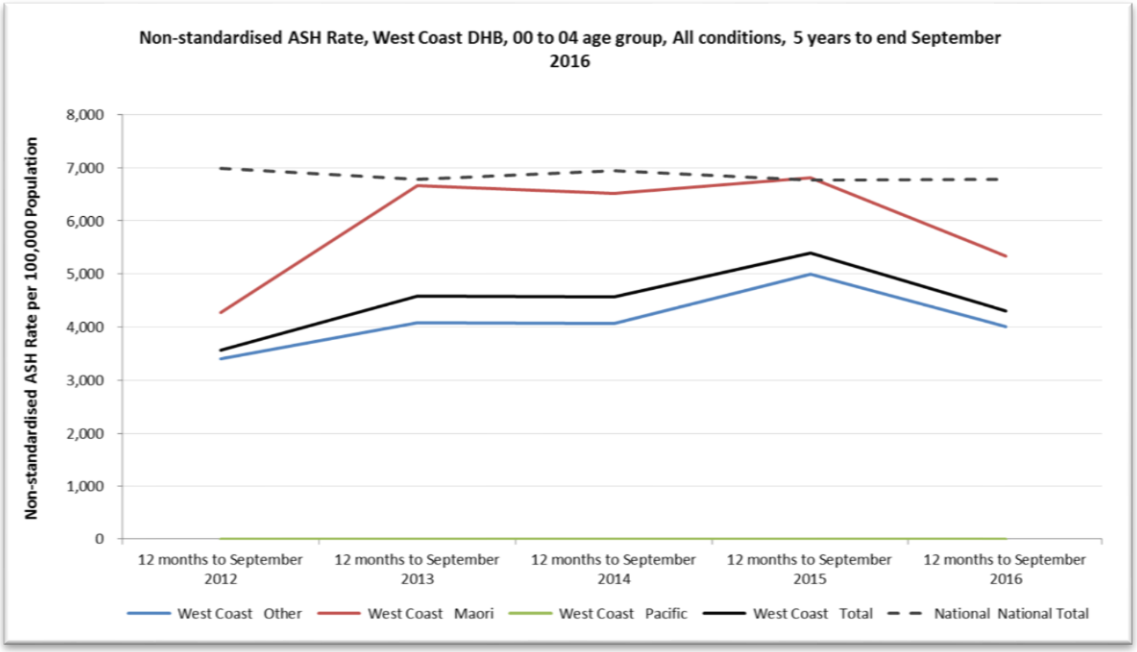
National Outcomes and Local Contributory Measures

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 place 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 September 2012	12 months to September 2013	12 months to September 2014	12 months to September 2015	12 months to September 2016
West Coast	Other	3,397	4,080	4,061	5,000	4,012
West Coast	Māori	4,270	6,667	6,512	6,818	5,333
West Coast	Total	3,568	4,583	4,567	5,388	4,300
National	Total	6,991	6,783	6,950	6,774	6,776

2017/18 MILESTONE

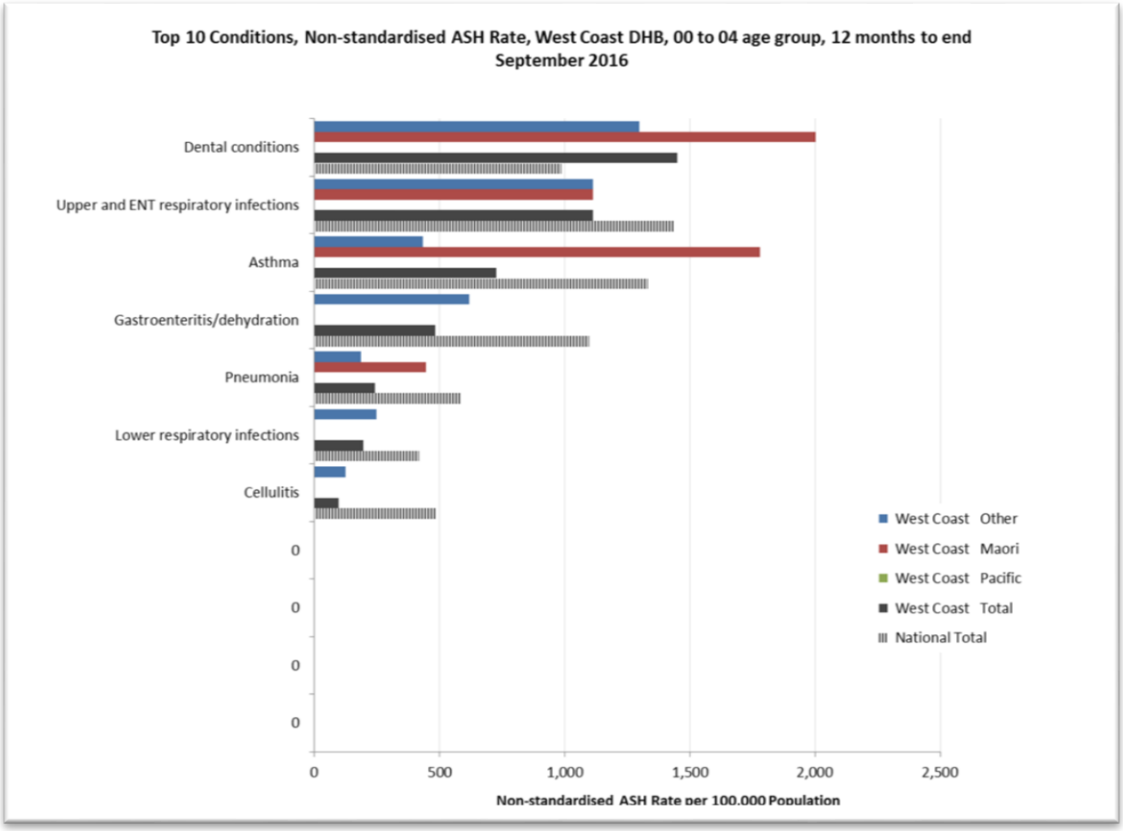
Reduce the equity gap in ASH rates for 0-4 year olds between Māori and non-Māori to less than current rate of 1,033 (as at the end of September 2016).

In setting the milestone for the 2017/18 year a number of factors have been taken into account:

- West Coast DHB's ASH rate improved significantly in the 12 months to September 2016 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 2016 result relating to just 24 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.

Respiratory and asthma conditions are the next largest drivers of ASH admissions on the West Coast, 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 8 and 15). The Alliance has chosen breastfeeding 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	Pre-school children (aged 0-4) are receiving their annual oral health check.
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.
Baseline	91% of pre-school children have had their annual oral health check - as at Dec 2016.
30 Jun 2018 target	95% of pre-school children will have their annual oral health check – as at Dec 2017.
Improvement plan	• Implement the Oral Health Promotion Plan, in conjunction with the Transalpine Oral Health Steering Group and Healthy West Coast Workstream, to increase capacity of the

	Community Oral Health service to reach pre-schoolers. • Continue promotion of the Newborn Enrolment Form to support early enrolment of children with the Community Oral Health Service. • Provide training and support to the Well Child Tamariki Ora workforce, regarding the use of the risk assessment tool and referral pathway for children at risk of developing dental caries. • Provide education for practice nurses to encourage uptake of the 'Lift the Lip Check' at children's 15 month immunisation visit. • Develop opportunities for health promotion and education with families whose children are hospitalised for dental surgery. • Develop a referral pathway from the Community Oral Health Service to the public health nursing team, for at risk families to support improved health outcomes in other areas.
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 Steering 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	57% of babies are breastfeeding at three months (63% of Māori).
30 Jun 2018 target	60% of all babies are breastfeeding at three months.
Improvement plan	• Develop and implement a new Breastfeeding Plan, building on the actions completed in the previous plan. • Continue to ensure currency of knowledge among primary care clinicians regarding the benefits of breastfeeding vs formula or mixed feeding to ensure consistent messaging to mothers. • Continue to support Mum4Mum peer support training, which targets recruitment of peers in low decile areas who are young and Māori.
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.

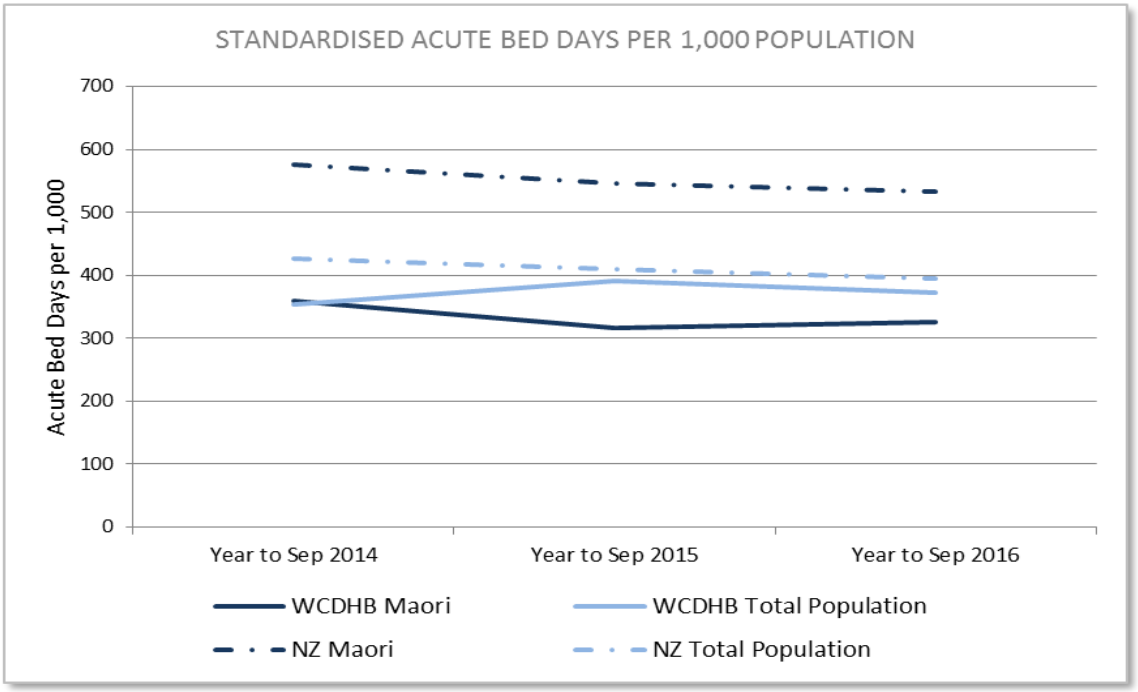
The WCDHB has district nursing teams based in Greymouth, Hokitika, Reefton and Westport. These nurses work within multidisciplinary teams consisting of primary care practitioners, home based support services, clinical nurse specialists, and allied health professionals to assist individuals and their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

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 September 2016 was 372 (total population) and 326 (Māori).[1] West Coast rates positive in comparison to national rates for both Māori and for our total population.



2017/18 MILESTONE

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

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 371 or less for total population.

In setting the milestone for the 2017/18 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.

2.1. 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	50% of Māori, 65 and older, have received an influenza vaccine - as at 31 Dec 2016.[2]
30 Jun 2018 target	60% of Māori, 65 and older, have received an influenza vaccine - at the end of the funded influenza season (31 Dec 2017).
Improvement plan	• Promote and provide free seasonal flu vaccinations for people 65 years and older at general practices and community pharmacy. • Look at opportunities that enable primary care teams to provide greater coverage of vaccinations for those 65 and over, specifically focusing on Māori. • Look at opportunities to utilise local iwi Kaumatua as an extra resource for promoting flu vaccination. • Facilitate collaborative working between Poutini Waiora and general practices to identify and contact Māori eligible for vaccination.
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. Better help for smokers to quit

CONTRIBUTING TO: REDUCING ACUTE HOSPITAL BED DAYS	
Proposed measures	An offer to support quitting has been made to current smokers by a health care practitioner in the last 15 months.
Rationale	The West Coast achieved the national primary care smoking target at the end of the 2014/15 and again in the first quarters of 2016/17. However, one of the objectives in the annual plan is to support sustainable delivery against the 'better help for smokers to quit' health target. Smoking is a major risk factor for a number of the leading long-term conditions and acute

[2] Source: National Immunisation Register Datamart Report.

	hospital presentations including respiratory and cardiovascular disease. Supporting more people to stop smoking 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	91% of the enrolled population and 89% of enrolled Māori, who identify as smokers, were offered advice and support to quit smoking within the last 15 months – as at Dec 2016.[3]
30 Jun 2018 target	90% of enrolled Māori patients who identify as a smoker are offered advice and support to quit smoking within the last 15 months.
Improvement plan	• Work with the local stop smoking service, Oranga Hā - Tai Poutini, to promote cessation services to smokers identified through general practices patient management systems. • Continue to support the use of advanced IT tools in general practice to capture and promote smoking cessation (ABC) activity. • Continue to identify and promote Smokefree Champions to support health target activity. • Maintain monthly reporting of current smokers, without brief advice given, to Champions. • Utilise practice admin teams to support clinicians with identifying coding of brief advice.
Who's involved	WCPHO, general practice teams, Oranga Hā - Tai Poutini, C&PH, WC Tobacco Free Coalition.
Who's leading	WC Smokefree Coordinator, with oversight from Healthy West Coast Alliance Workstream.

2.3. More heart & diabetes checks

CONTRIBUTING TO: REDUCING ACUTE HOSPITAL BED DAYS	
Proposed measures	The delivery of Cardiovascular Disease Risk Assessments (CVDRA) to eligible people.
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. 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	87% of the eligible Māori population have had a CVDRA in the last 5 years - as at Dec 2016.[4]
30 Jun 2018 target	90% of the eligible Māori population 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. • 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. • Look at opportunities to utilise local iwi Kaumatua as an extra resource for promoting uptake of Cardiovascular Disease Risk Assessments.
Who's involved	WCPHO, general practice teams, Poutini Waiora .
Who's leading	WCPHO, with oversight from Healthy West Coast Alliance Workstream.

[3] Source: Local Karo data

[4] Source: Local Karo 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.

2017/18 MILESTONE

85% of practices complete the primary care patient experience survey by June 2018.

3.1. Hospital services using the adult inpatient survey

CONTRIBUTING TO: IMPROVED PATIENT EXPERIENCE OF CARE	
Proposed measures	Consistency of DHB performance against the survey questions in the Communication Domain of the Adult Inpatient Survey.
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. While the DHB does well in some areas of communication, results for survey questions vary across quarters.
Baseline	Variation in positive response ranges from 30%-10% quarter on quarter.
30 Jun 2018 target	Reduced variation to 20%-5% quarter on quarter.
Improvement plan	• Work with the DHB Consumer Council to promote the importance of survey responses, particularly qualitative comments, in monitoring service quality. • Develop a consistent format for sharing survey results with staff and our community. • Continue to promote the IDEAL model for involving consumers in their own care.
Who's involved	WCDHB Quality Team, WCDHB Consumer Council, Clinical Nurse Managers.
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	Percentage of general practices that offer the primary care patient experience survey.
Rationale	Data on our patients' experience of primary care and how their care is managed can be used for monitoring service quality and identifying areas for improving quality and patient safety.
Baseline	50% of practices have taken up the primary care patient experience survey.
30 Jun 2018 target	All Medtech practices take up the primary care patient experience survey.
Improvement plan	• Ensure general practices are supported to offer the patient experience survey through training and education provided by the PHO. • Work with the Health Quality & Safety Commission to support the roll out of the patient experience survey to practices not using MedTech, as this becomes available.
Who's involved	WCPHO; Practice Managers & Administrators.
Who's leading	WCPHO.

3.3. General practices offering E-portal access

CONTRIBUTING TO: IMPROVED PATIENT EXPERIENCE OF CARE	
Proposed measures	The number of general practices offering an e-portal.
Rationale	The Patient Portal will assist with wider patient access to general practice. Work on delivering a Patient Portal tool is already underway and this fits with local priorities to use Information Technology as an enabler to improve patient experience, service quality and outcomes.
Baseline	Three practices.
30 Jun 18 target	Seven practices.
Improvement plan	• Roll out the Patient Portal to the remaining four general practices. • Develop a community communications plan to ensure consumers are informed of their rights and choices.
Who's involved	WCPHO; general practice teams; DHB IT Project Support; Patient Portal Provider.
Who's leading	WCPHO.

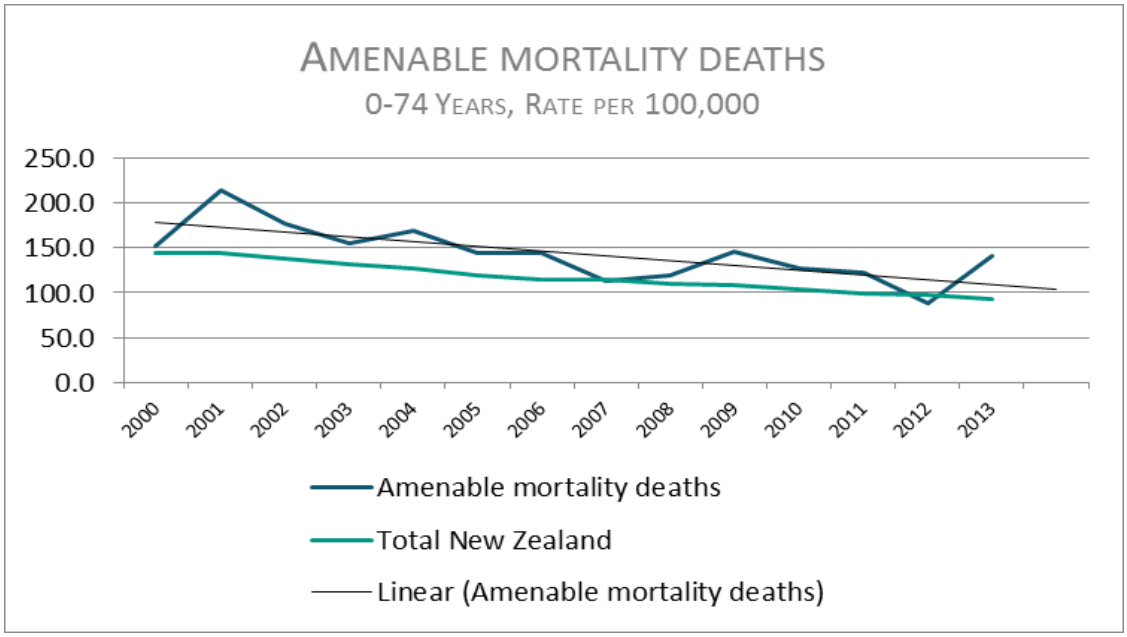
4. Amenable Mortality

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 were too small to produce a meaningful rate.



2017/18 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 100 amenable deaths per 100,000 people by June 2019.

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. Cervical screening

CONTRIBUTING TO: REDUCING AMENABLE MORTALITY	
Proposed measures	Eligible women (targeting Māori, Pacific and Asian women aged 25-69) have had a cervical sample taken (a cervical screen) in the past three years.
Rationale	Cervical screening provides an opportunity to make a difference to the lives of women and their families. There continue to be opportunities for improvement particularly for high priority populations, where uptake of screening is lower.
Baseline	As at 31 December 2016: 65% of eligible Māori women have had a cervical screen in the past 3 years 60% of eligible Pacific women have had a cervical screen in the past 3 years 50% of eligible Asian women have had a cervical screen in the past 3 years.
30 Jun 2018 target	70% of eligible women (in all population groups) have had a cervical screen in the past 3 years.
Improvement plan	• Continue the integration of Poutini Waiora and the DHB's Sexual Health Service with general practice teams – to support a more integrated approach to health promotion and engagement with cervical screening services. • Consult with our consumers regarding strategies to increase the uptake of screening. • Develop and implement a plan (including health promotion and targeted approaches) to increase screening rates for priority populations (Māori, Pacific and Asian).
Who's involved	WCPHO, DHB Sexual Health Service, General Practice Champions, Poutini Waiora.
Who's leading	WCPHO.

4.2. Long term conditions management

CONTRIBUTING TO: REDUCING AMENABLE MORTALITY	
Proposed measures	Enrolment of people with long term mental health conditions into the primary care Long Term Conditions Management (LTCM) programme.
Rationale	West Coast has a well-functioning LTCM programme supporting people with established diabetes, cardiovascular disease, and Chronic Obstructive Pulmonary Disease (COPD). Amenable mortality rates for people with long term mental health conditions is much higher, at younger ages, than the general population so including these people in the LTCM programme is an opportunity to improve the wellbeing of this population.
Baseline	One general practice is offering patients with long term mental health conditions enrolment in the LTCM programme.
30 Jun 2018 target	Two general practices will be enrolling and supporting people with long term mental health conditions in the LTCM programme.
Improvement plan	• Hold regular clinics to enrol patients in the LTCM programme. • Promote the LTCM programme to the community in Westport. • Align community mental health staff with the general practice to support this cohort. • Incentivised visits for these patients – free as part of the LTCM programme. • Facilitate collaborative working between Poutini Waiora and general practice teams to identify and contact Māori eligible for enrolment in LTCM programme.
Who's involved	WCPHO; Buller Medical Centre; DHB CMH – Buller, Coast Medical Ltd.
Who's leading	Clinical Manager WCPHO.

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	Referrals for support for those identified with obesity in childhood are lower than expected and are below the national average. Due to the small number of children involved there is significant variation in results, however there is room for improvement.
Baseline	17% of children identified as obese in the Before School Check (B4SC) programme had been offered a referral - as at March 2017.
30 Jun 2018 target	95% of children identified as obese in the B4SC programme will be offered a referral.
Improvement plan	• Work with the Ministry of Health to ensure consistent tools are in place to accurately calculate BMI percentile at the point of referral. • Work with the wider early childhood sector to raise awareness of childhood obesity and its inclusion in the B4 School Check. • Continue to support B4 School Check clinicians to have positive conversations with families regarding healthy weight in childhood, in order to encourage consent to referrals for intervention. • Provide primary care teams with training 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 routinely 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.

5.1. Mothers are smokefree at six weeks post-natal

CONTRIBUTING TO: SMOKEFREE INFANTS	
Proposed measures	Babies who live in a smokefree household (as reported at their first Well Child check).
Rationale	This measure is important because it aims to reduce the rate of infant exposure to cigarette smoke by focussing attention beyond maternal smoking to the wider home and family/whānau environment. The outcomes measure emphasises the need to focus on the collective environment that an infant will be exposed to; from pregnancy, to birth, to the home environment within which they will initially be raised and encouraging an integrated approach between maternity, community and primary care. Māori smoking rates are higher on the West Coast and Māori babies at therefore more likely to be exposed to second-hand smoke – reducing Māori smoking rates is a key focus.
Baseline	As at December 2016: [5] 40% of West Coast babies are living in a smokefree home 13% of West Coast Māori babies are living in a smokefree home
30 Jun 2018 target	75% of West Coast Māori babies are living in a smokefree home
Improvement plan	• Review national well child data to confirm baseline and establish target for improvement. • Work with Well Child Tamariki Ora (WCTO) providers to improve the level of data capture regarding smokefree households. • Monitor results for babies living in a smokefree home and the associated Well Child Quality Improvement Framework Indicators (which relate to reduced rates of infant exposure to cigarette smoke) to identify gaps and opportunities to improve results. • Facilitate integration between primary care, Lead Maternity Carers (LMCs), WCTO providers and smokefree services to improve data collection and quality. • Continue to invest in the Smokefree Pregnancy Incentives Programme for pregnant women and their nominated support person, to increase the proportion of babies born into smokefree homes.
Who's involved	WC Smokefree Services Coordinator, DHB Cessation Service, Oranga Hā – Tai Poutini, LMCs, WCTO services.
Who's leading	WC Smokefree Services Coordinator.

[5] This result is based on data sourced locally by the DHB funded WCTO providers only, and excludes Plunket data, therefore is not representative of the whole population. The result reflects the answer to the question "Is there anyone in your household who is a tobacco smoker" - where the smoking status of the household was checked as part of the assessment.

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 high rates of women smoking during pregnancy and smoking at two weeks post-delivery. In response the West Coast has established the Smokefree Pregnancy Incentives Programme, an integrated programme that has generated an increase in the number of referrals for cessation support by LMCs. However there are still a number of women who decline the service or choose not to set a quit date so significant opportunity to further improve uptake of the service and contribute to the national outcomes measure – more babies in smokefree homes.
Baseline	45.5% of women (25 of 55) went on to set a quit date following referral to the Smokefree Pregnancy Incentives Programme.
30 Jun 2018 target	75% of women (both Māori and non-Māori) set a quit date following referral to the Smokefree Pregnancy Incentives Programme.
Improvement plan	• Review the schedule for incentives to support engagement with the cessation service following referral. • 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

Reviewing the five domains that make up the Youth system level measure provided the opportunity for the local Youth Health Action Group, part of the West Coast Alliance structure, to select a domain most relevant to the needs of young people on the West Coast.

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.

6.1. Youth feel supported

CONTRIBUTING TO: YOUTH ACCESS TO AND UTILISATION OF YOUTH APPROPRIATE HEALTH SERVICES	
Proposed measures	Proportion of young people accessing iCAMHS in Greymouth, who complete a real-time survey about their experience.
Rationale	Evidence shows that young people who do not have positive interactions with health care services are less likely to return, which can lead to an increased risk of poorer health outcomes both in the short term and as adults. Implementation of the Marama Real-Time Survey provides the opportunity to respond to feedback, both positive and negative, and allows the service to gain the confidence of our younger community.
Baseline	Nil.
30 Jun 2018 target	50% of young people attending an appointment at iCAMHS in Greymouth have completed the Marama Real-Time survey.
Improvement plan	• Work with iCAMHS staff to highlight the benefits of consumer feedback. • Develop a process for including the use of the survey as a routine part of all iCAMHS Greymouth contacts. • Promote the Marama Real-Time Survey through advertising at the iCAMHS Greymouth location. • Develop regular reporting of survey results back to iCAMHS staff, the wider Mental Health Steering Group and to the Youth Health Action Group.
Who's involved	DHB's Infant Community Adolescent Mental Health Service (iCAMHS), Mental Health Steering Group, Youth Health Action Group.
Who's leading	iCAMHS.