National Health Targets

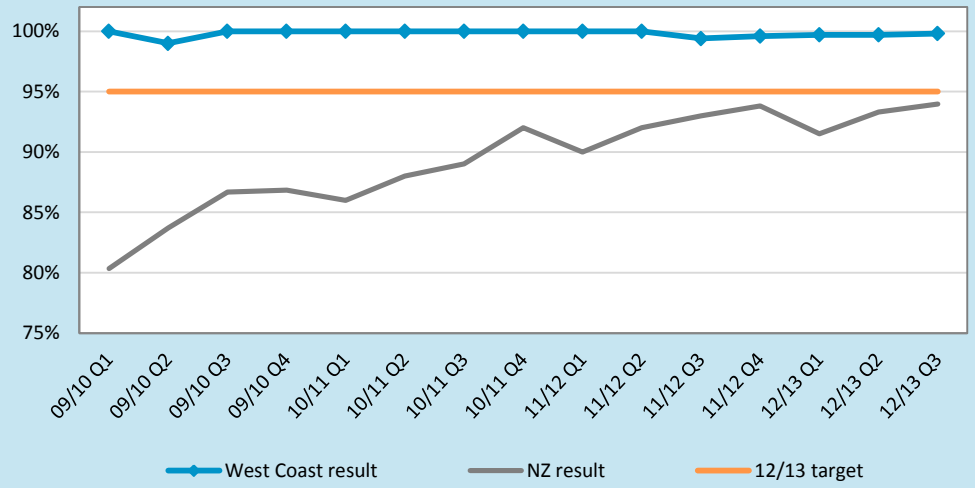
Quarter 3 2012/13 Performance Summary

Target	Q4 11/12	Q1 12/13	Q2 12/13	Q3 12/13	Target	Status	Pg
Shorter Stays in ED: Patients admitted, discharged or transferred from an ED within 6 hours	99.6%	99.7%	99.7%	99.8%	95%	✓	2
Improved Access to Elective Surgery: West Coast's volume of elective surgery	1,751	447 YTD	846 YTD	1,173 YTD	1,592	✗	2
Shorter Waits for Cancer Treatment: People needing cancer radiation therapy or chemotherapy having it within four weeks	*new*	100%	100%	100%	100%	✓	3
Increased Immunisation: Eight-month-olds fully immunised	*new*	79%	84%	78%	85%	✗	3
Better Help for Smokers to Quit: Hospitalised smokers receiving help and advice to quit	90%	91%	89%	91%	95%	✗	4
Better Help for Smokers to Quit: Smokers attending general practice receiving help and advice to quit	39%	40%	44%	53%	90%	✗	5
More Heart and Diabetes Checks: Eligible enrolled adult population having had a CV risk assessment in the last 5 years	57%	60%	58%	58%	75%	✗	6

Shorter Stays in Emergency Departments

Target: *95% of patients are to be admitted, discharged or transferred from an ED within 6 hours* ✓

Figure 1: Percentage of patients who were admitted, discharged or transferred from ED within six hours

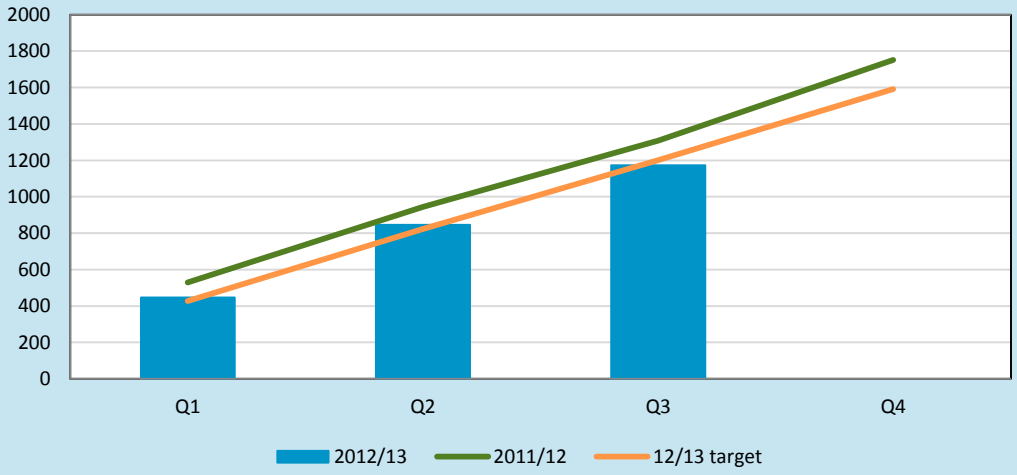


The West Coast continues to achieve impressive results against the ED health target, with **99.8%** of patient events admitted, discharged or transferred from ED within 6 hours.

Improved Access to Elective Surgery

Target: *West Coast's volume of elective surgery is to be 1,590 in 2012/13* ✗

Figure 2: Elective surgical discharges delivered by the West Coast DHB[1]



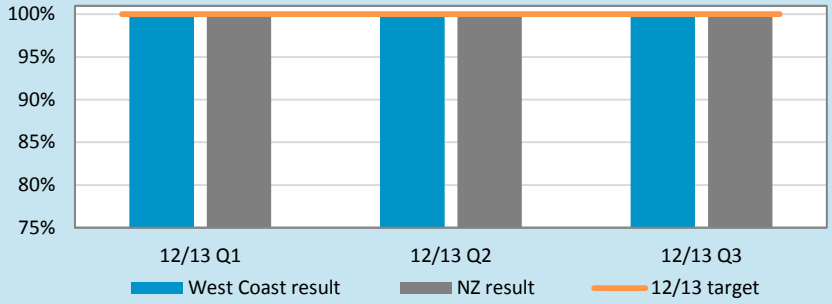
For the nine months year-to-date March, **1,173** elective surgical discharges have been delivered, representing **98%** of our target delivery (28 discharges below target). A recovery plan is in place, and we anticipate meeting the full-year target by the end of the year.

[1] *Excludes cardiology and dental procedures. Progress is graphed cumulatively.*

Shorter Waits for Cancer Treatment

Target: *100% of people needing radiation or chemotherapy are to have it within four weeks* ✓

Figure 3: Percentage of West Coasters needing radiation or chemotherapy treatment who received it within four weeks[2]

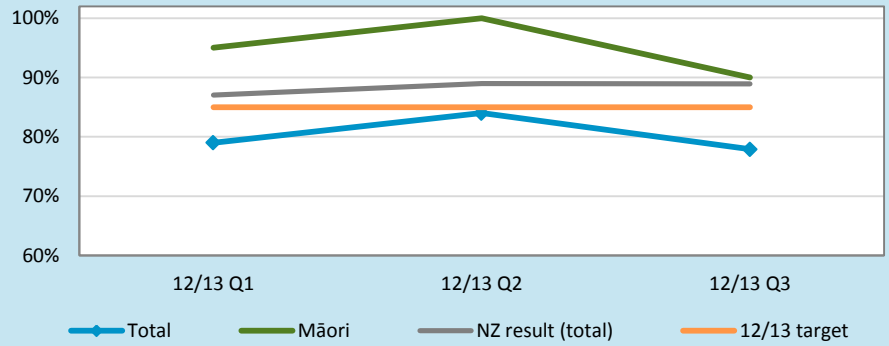


In Quarter 3, **100%** of patients met the 4 week target for both radiation therapy and chemotherapy.

Increased Immunisation

Target: *85% of eight-month-olds are to be fully immunised* ✗

Figure 4: Percentage of West Coast eight-month-olds who were fully immunised



While West Coast achieved strong results for Māori (90%) eight-month-olds, overall eight-month-old immunisation coverage declined in Quarter 3, with **78%** of all eight-month-olds fully immunised in Quarter 3 2012/13 – a decrease of 6% from the previous quarter.

The decrease in overall immunisation coverage in Quarter 3 was the result of the high rate of parents choosing to decline immunisation (4.7%) or opt their child off the NIR (11.6%), leading to a combined opt-off and decline rate of 16.3% of eligible children.

This left just five eight-month-old children overdue for their vaccinations who had not opted off or declined.

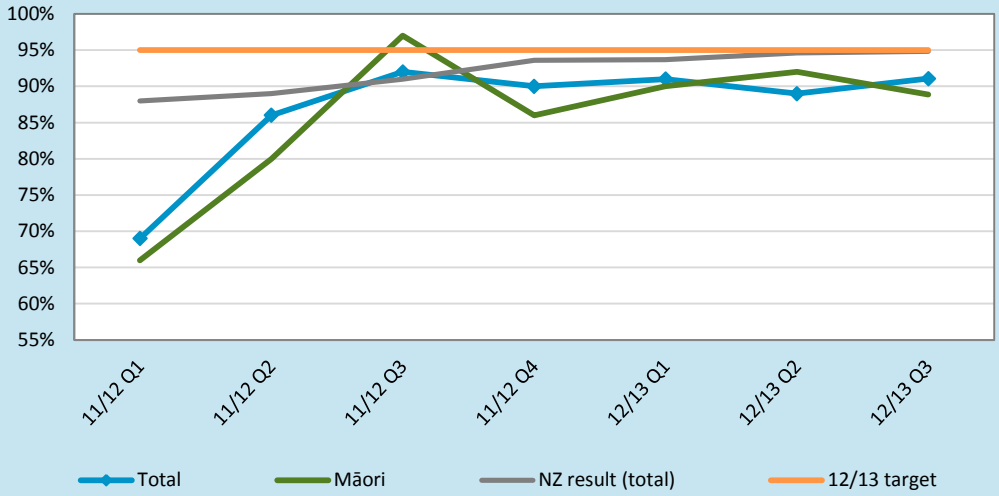
The West Coast and Canterbury DHBs are now working together more closely on immunisation. This has proven positive for data management, and our next steps are to improve efforts to reach missed children and children who decline immunisation events as we strive to fully immunise all reachable children.

[2] *The wait time is defined as the time between the first specialist assessment and the start of treatment. The measure does not include instances in which a patient chooses to wait for treatment or there are clinical reasons for delay. The measure reflects groups A, B and C. Group D patients have planned treatment (either as part of a trial or because of given protocols) and are therefore not included.*

Better Help for Smokers to Quit: Hospital

Target: *95% of hospitalised smokers are to receive help and advice to quit*

Figure 5: Percentage of smokers in West Coast DHB hospitals who were offered advice and help to quit smoking



In Quarter 3, West Coast DHB staff provided **91%** of hospitalised smokers with smoking cessation advice and support – up from 89% in the previous quarter.

During the quarter, work continued with Clinical Nurse Managers to identify 'missed' patients and pinpoint any gaps at ward level. This continues to be a key area of focus, due to the effect of small numbers contributing to month-to-month fluctuations in performance. With fewer than 100 current smokers discharged in a month, a single 'missed' ABC contributes to more than 1% off the target. It is therefore crucial to identify any gaps in delivery so that these can be resolved to improve the next month's results.

Most clinical areas in the DHB achieve close to 100% coverage; however, the Critical Care Unit (CCU) has been identified as an area of concern. During Quarter 3, the Smokefree Services Coordinator worked with the CCU Clinical Nurse Manager, smokefree champion and staff. Improved results followed in February and March, and the Smokefree Services Coordinator will continue to work with CCU to cement and build on these gains. Another focus area of support in Quarter 4 will be Buller ED.

A new handout has been developed for the orientation pack regarding ABC, in order to bridge the gap between clinical staff starting their role and attending mandatory ABC training. This was particularly relevant for Quarter 3, as there was a high intake of clinical staff in February.

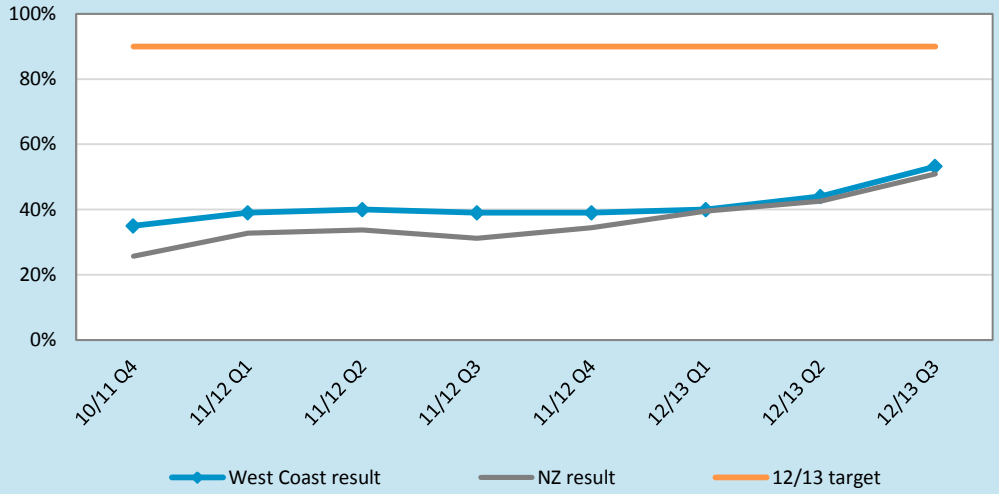
Dr Hayden McRobbie visited the West Coast DHB in March to meet with management, senior clinical staff and Smokefree staff and discuss progress, challenges and the activities put in place to improve performance against the health target. It was a positive visit, and Dr McRobbie's recommendations will be incorporated into DHB's health target 'action plan' over the coming quarter, including maintaining a clinical focus around the health target, keeping the health target relevant by using some of the key messages and tools produced by the Ministry of Health and considering the current training approach to ensure it provides clear and simple rationale.

Smokefree staff and the DHB as a whole continue to work towards achieving the health target of 95%.

Better Help for Smokers to Quit: Primary Care

Target: *90% of smokers attending primary care are to receive help and advice to quit*

Figure 6: Percentage of smokers expected to attend primary care who were offered advice and help to quit smoking[3]



West Coast general practices have reported giving 2,306 smokers brief advice and help to quit in the year to 31 March 2013. This figure is an increase of 430 patients compared to the last quarter. The quit activity during this quarter represents **53%** of current smokers expected to be seen in general practice during this period receiving advice and help to quit – an increase of 9% from the previous quarter.

During Quarter 3, a new PHO Clinical Manager started in the role. The new manager has a strong West Coast primary care background and has brought similar strengths and leadership to the role as her predecessor, who has remained in the organisation, helping to ensure a strong handover of leadership of the health target.

Key activities during Quarter 3 included:

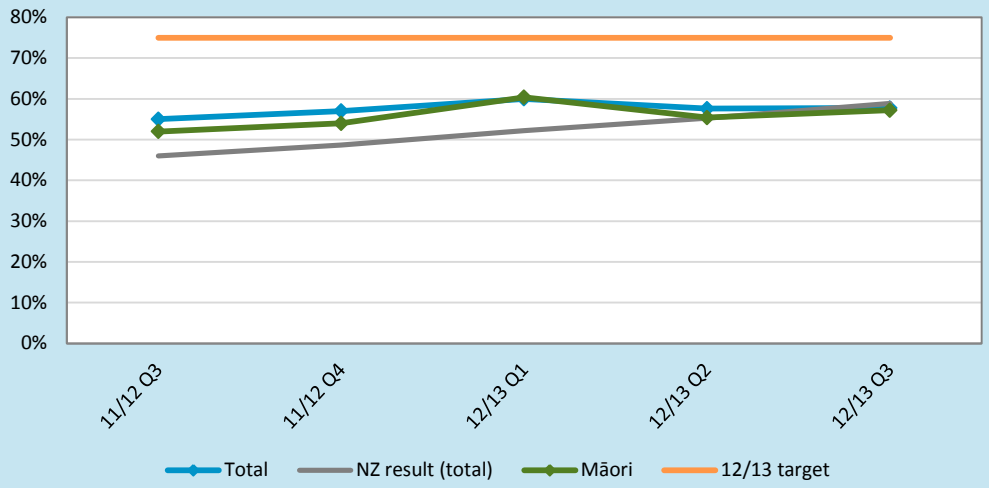
- Continued support to practices in the use of the new HealthStat tool (installed in Quarter 2), which can provide more frequent, practice-specific feedback about the target. The Clinical Audit Tool component of HealthStat is expected to be installed in Quarter 4 and will further support improved data capture, as it enables clinicians to more easily identify patients who do not have a smoking status coded.
- Installation of automatic READ coding on two more advanced forms (in addition to the 'smoking cessation' enrolment form): the diabetes 'get checked' and cardiovascular risk assessment.
- A new monthly 'Primary Health Target Bulletin' circulated to all staff within general practice. As well as reporting both PHO-wide and practice-specific ABC performance, the bulletin is also an opportunity to communicate clinical guidelines around the health target to practice staff or transfer MoH information/guidance, including the clinical rationale.
- Commencement of coding and data entry training at the WCPHO (provided by the Smokefree Services Coordinator) as part of the orientation for all new practice staff. This training will continue as part of orientation for all new practice staff and updates for identified current staff. Planning also took place for Quit Card training via the Heart Foundation for June 2013, and for a new Quit Card Update revision session, for initial delivery in May.
- Working with four targeted practice teams to improve the Brief Advice coding and to link patients to cessation via their own practice's Coast Quit provider (or other available cessation services). It is hoped that this will close the gap between A's and B's while other activities take time to implement.

[3] *Data for this measure is supplied by the Ministry on a quarterly basis from the PHO Performance Programme (PPP).*

More Heart and Diabetes Checks

Target: *75% of the eligible enrolled population are to have had a CV risk assessment in the last 5 years*

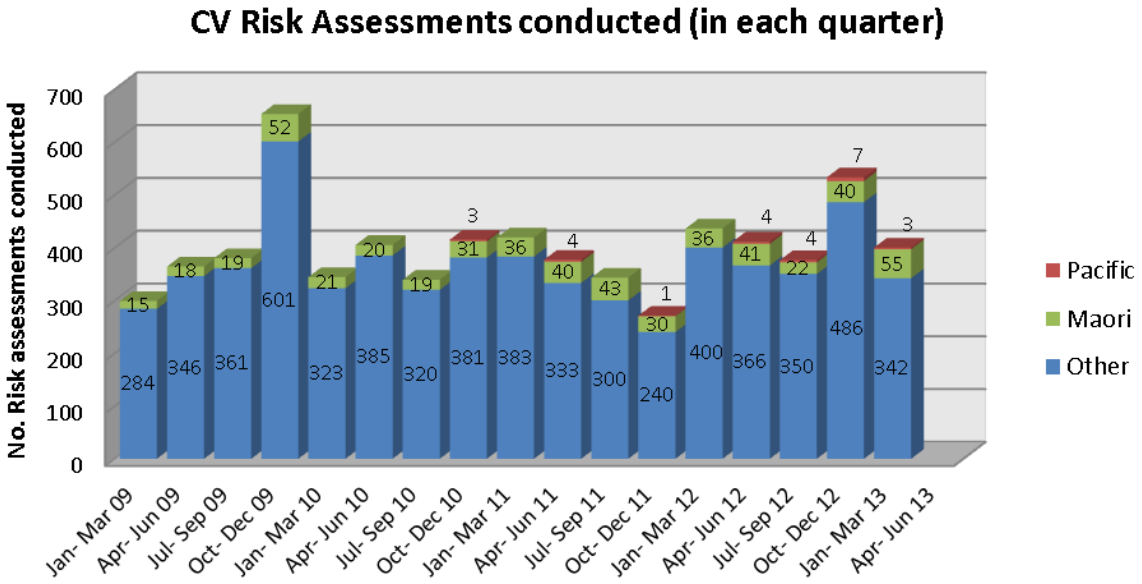
Figure 7: Percentage of the eligible enrolled West Coast population having had a CVD risk assessment in the last 5 years [4]



Data for the period to 31 March 2013 shows that West Coast general practices have maintained the same coverage as the previous quarter, with **58%** of the eligible enrolled West Coast population having had a cardiovascular risk assessment (CVRA).

A total of 400 cardiovascular risk assessments were conducted during Quarter 3 (see Figure 8). This reduction is partly due to GP and nurse staff shortages across this period. It is also a reflection that general practices have now screened the 'easy to reach' people, while the more 'reluctant' people remain to be screened. However, it is positive to note that Māori made up 10% of completed CVRAs this quarter. By comparison, Māori make up 7.8% of the eligible cohort for CVRA on the West Coast

Figure 8: Number of cardiovascular risk assessments conducted each quarter



[4] *Data for this measure is supplied by the Ministry on a quarterly basis from the PHO Performance Programme (PPP).*

Activities to follow up eligible patients for CVRA include:

- Ongoing support from clinical manager to practice nurses/teams to identify eligible patients for screening;
- Practice teams actively inviting people to nurse-led clinics to have their CVRA;
- Collaboration between primary and secondary services during February 2013 Heart Month, which concentrated on encouraging West Coasters to get their CVRA and included, among other activities, the West Coast DHB Cardiac Nurse Specialist completing CVRAs for DHB staff who haven't had reviews;
- Installation of Healthstat: a Quality Improvement (QI) tool that enables monitoring of practice performance for cardiovascular indicators for practice QI teams (the Clinical Audit Tool will be installed in Quarter 4);
- Concentration on the high-need population who haven't been screened (practices receive quarterly reports on high-need patients who aren't screened);
- Targeting of workplaces and out-of-hours screening opportunities to help enable those people in work to access CVRAs more conveniently; and
- Planning with Rata Te Awhina Trust, West Coast PHO and West Coast DHB to implement a series of actions to encourage Māori who are not engaging with their general practices to take up invitations for CVRA screening. Plans include an awareness campaign; working with practices to proactively follow up patients who due and overdue for their CVRA; offering options including outreach services and community clinics; and a tailored package of care from Rata Te Awhina.

The biggest barrier to date has been the need for fasting blood tests. This does not appear to be due to cost; these tests have been free of charge to patients on the West Coast since January 2011, but this has not seen any increase in rates of uptake. It appears the additional time required and the need to fast have been the impediment to completing fasting tests. We will propose to the next meeting of the PHO Clinical Governance a move to non-fasting blood testing for people who have never been screened before for screening purposes, with follow-up of identified high risk people with a fasting test for diagnostic and treatment purposes. This should help remove one of the barriers to access as we can provide CVRA opportunistically, instead of having people leave to fast in the first instance.

Patient focus remains paramount; in endeavouring to meet the target, we must also ensure quality care, follow-up and active support for patients in the various tiers of the long-term conditions management programme in line with best practice to ensure the best outcomes for our patients.