South Canterbury
District Health Board

2021/22 South Canterbury System Level Measures Quality Improvement Plan

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Introduction

The South Canterbury Primary Care Alliance in conjunction with our health partners within the South Canterbury District Health Board are committed to improving the health outcomes of our population through the delivery of services by teams that are well integrated and work collectively to meet the needs of our community. Collaboration across our health partners will seek to ensure services are integrated across the continuum of health care resulting in a person entered approach that is safe, high quality and effective.

This will be achieved working within the intent of the te Tiriti O Waitangi, New Zealand Health Strategy, Whakamaua (Māori Health Action Plan) and the South Canterbury District Health Board Annual Plan. Actions to achieve equity of outcomes are embedded within the plan.

South Canterbury residents have an older age structure than the rest of New Zealand, and forecasts show the population ageing at a faster rate than the country's average. The resident population has lower than average levels of socioeconomic deprivation, and its demographic composition of Māori and Pasifika is among the lowest. Twice the national mean of rural residents per capita live in South Canterbury.

Summary of Actions within the plan

There are six System Level Measures; by way of a summary they are listed here with their respective actions for the 2021/22 year.

1. Ambulatory Sensitive Hospitalisations 00-04 Year Olds.
    a. Focus on the expansion of the expansion of the supervised toothbrushing programme from Arowhenua Māori School and He Manu Hou childhood centre across educational institutions in South Canterbury.

    b. Increase enrolments for babies at three months with primary care through a centrally-managed, streamlined and targeted general practice and child dental health enrolment and recall pathway. This to include an outreach component for missed ENT, dental or paediatric clinic appointments.

2. Acute Hospital Bed Days
    a. Continue and complete the discharge project that was launched in 2019/20. This includes but is not limited to the development and implementation of alternative options to admission, including the completion of the Remote Patient Monitoring study, enhanced discharge planning and further community options for care and support.
    b. Better manage patients at high risk of falling through screening of all community referrals for risk of falls, frailty, and osteoporosis to ensure that they receive the appropriate early intervention.

3. Patient Experience of Care
    a. Kia Tika te Ara training programme is offered to three groups within primary care: front of house personnel, clinicians and business owners.

b. Survey participants of Kia Tika te Ara to identify how they viewed the training and what the most significant change in practice would be for them as a result.

4. Amenable Mortality
   a. Evaluate the efficacy of the Remote Patient Monitoring pilot with view to utilisation across chronic disease management in order to reduce avoidable hospitalisations..

   b. Promote the importance of influenza vaccinations for our over 65 year olds as a contributor to reduction of ASH admissions.Practices achieve the national targets for influenza vaccination.

   c. Implement Primary Care (Pharmacies and General Practices) delivery of Covid -19 vaccinations so that 60% of all Pharmacies and Practices deliver Covid -19 vaccinations to their enrolled population on an on-going basis.

5. Babies Living in Smokefree Homes
   a. Continue to improve the home environment during pregnancy and increase the number of babies living in smokefree homes by expanding the existing Pregnant Mama incentivised programme to include all family members living in the household.

   b. Improve engagement with wāhine Māori and remove barriers to accessing smoking cessation services and supports by introducing an incentivised based Māori Wahine programme, Wāhine Toa Auahi Kore targeting young Māori woman aged 20-30 years through the local Māori Health Provider.Identify Māori-led and Māori focused innovative approaches to reduce smoking prevalence for Māori. This will be actioned through a Community Hui seeking rūnanga and youth engagement.

      Ensure telehealth options are available for clients of the Smokefree team, who live remotely or who would prefer this form of consultation. Telehealth will provide a continuity of service to clients if face to face consultations cannot be delivered.

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6. Youth Access to Health
   a. Implement South Island PICs and focus on data quality for Emergency Department presentations.

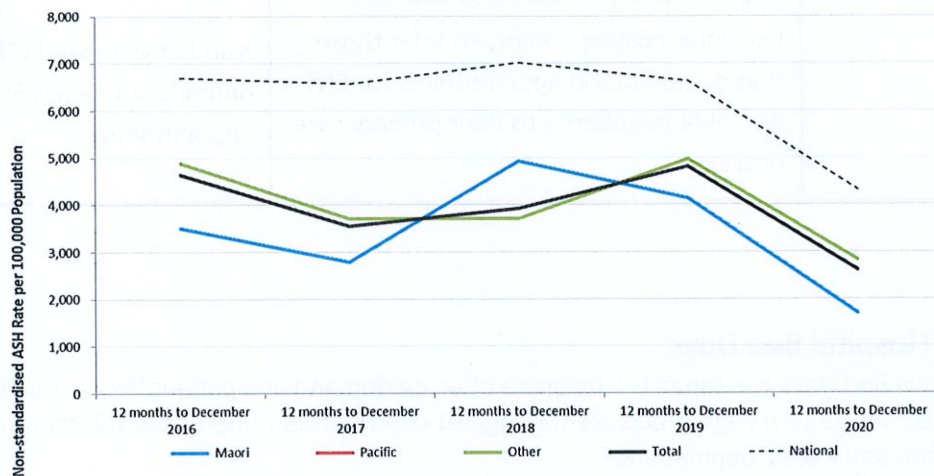
   b. Embed new integrated Primary Mental Health and Addiction roles in Primary Care and establish linkages into Secondary Mental Health and Addiction services through collaborative design implementation.
   c. Embed Access and Choice initiatives for youth within NGO provider.

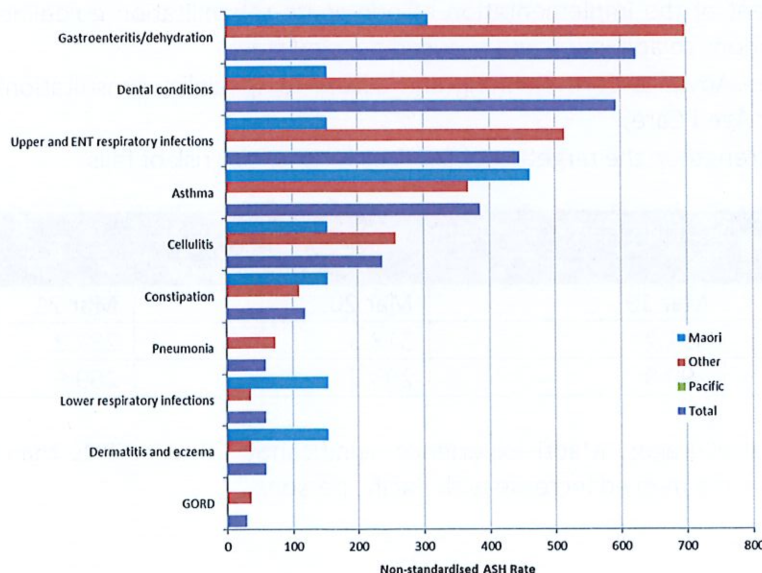
1. Ambulatory Sensitive Hospitalisations 00-04 Year Olds

During 2020/21, work has been completed in the following areas relating to this measure:

- Focused the Child Wellness Alliance on the first 1,000 days of life and work to improve breast feeding rates through working with Arowhenua Whānau Services (AWS, our Māori Health Provider), Fale Pasifika o Aoraki (our Pacific Health Provider) and Aoraki Migrant Centre to enable them to provide holistic support and correct information to families;
- Piloted, then rolled out SCDHB will pilot a 'Oral Health Programme', with our Māori Health Provider, within Arowhenua Māori School and He Manu Hou bilingual early childhood centre, ensuring collaboration with Kaupapa Māori Health Service, Community Public Health and Dental Service in delivery of the programme.

The main conditions driving SCDHB's ASH rates are gastroenteritis, dental and URTI / ENT infections and asthma. Please note the impact of Covid -19 on the 2020 results.





2021/22 Improvement Plan Ambulatory Sensitive Hospital Admissions 00-04-Year-Old		
Milestone	**Actions**	**Contributory Measures**
Maintain ASH rates at 2,611 or below for the 00-04 age group for the year ending June 2022.	Focus on expansion of the supervised toothbrushing programme from Arowhenua Māori School and He Manu Hou childhood centre across educational institutions in South Canterbury.	Percentage of caries-free children at five years of age reported by ethnicity.
	Increase enrolments for babies at three months with primary care through a centrally-managed, streamlined and targeted general practice and child dental health enrolment and recall pathway.	General practice enrolments (new-borns at 3 months)
	Continue existing process to refer those that do not attend appointments for ENT, dental or paediatrics to their primary care provider.	Number of missed ENT, dental and Paediatric appointments.

2. Acute Hospital Bed Days

Acute Hospital Bed Days per capita is a measure of acute demand and patient flow across the health system. The over 65 years age group are the biggest contributors of bed days and there are equity gaps for Māori and Pacific populations.

During 2020/21, work has been completed in the following areas relating to this measure:

- Implementation of a discharge project to improve timeliness of discharges;
- Commencement of the implementation of non-acute rehabilitation guidelines to promote alternative options to admission and reduced hospital stay;
- Strengthen the Advance Care planning and access to specialist consultations for those in community or Aged Care;
- Continue to strengthen the targeting of services for those at risk of falls.

Standardised Acute Bed Days per 1,000 Population			
	Mar 19	Mar 20	Mar 21
SCDHB	391.2	318.3	282.3
National	299.9	293.6	269.6

Comparing to National averages, Māori experience significantly lower AHBDs than the National average, although there is a marked increase with Pacific persons.

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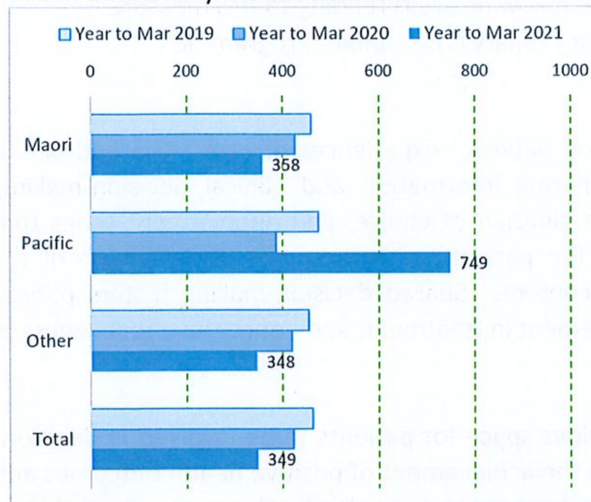
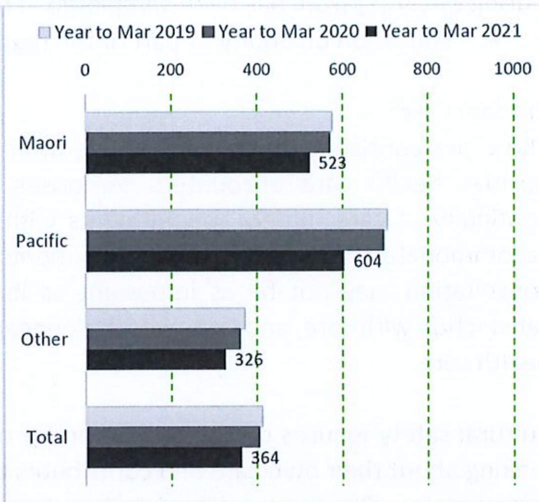


National



2021/22 Improvement Plan: Acute Hospital Bed Days		
Milestone	**Actions**	**Contributory Measure**
SCDHB aims to retain the improvements of the past year to maintain our age standardized AHBD rate at <318* by June 2022.	Continue and complete the discharge project that was launched in 2019/20. This includes but is not limited to the development and implementation of alternative options to admission, including the completion of the Remote Patient Monitoring study, enhanced discharge planning and further community options for care and support.	Inpatient Average Length of Stay (ALOS) for acute admissions – both number and percentage. Percentage of participants completing the pilot against plan.
	Better manage patients at high risk of falling through screening of all community referrals for risk of falls, frailty, and osteoporosis to ensure that they receive the appropriate early intervention.	Number of falls resulting in presentation to ED, comparing those who have previously completed Strength and Balance programme with those that have not.

* Due to the impact of Covid -19 this has not been amended to the 2021 performance.

3. Patient Experience of Care

During 2020/21, work has been completed in the following areas relating to this measure:

- Education on equity as part of the regular Primary Care Update Programme

Primary Care:
There are consistent themes in the literature on patients' experiences of care. The bedrock of positive health care encounters comprises sharing information and clinical decision-making, continuity of care, timely appointments with a clinician of choice, and appointment times that accommodate the social contexts of patients. For patient satisfaction, the actual length of the consultation may not be as important as its content. Shared decision-making fosters patient satisfaction with care, and improves their engagement in treatment, and hence the effectiveness of health care.

Cultural safety focuses on the patient and provides space for patients to be involved in decision-making about their own care and contributes to the achievement of positive health outcomes and experiences. The patient experience surveys act as a way to understand, among other things, patients' experience of receiving culturally safe care.
The two national adult patient experience surveys: the adult inpatient experience survey and the primary care patient experience survey both aim to improve the quality of health services in Aotearoa New Zealand by enabling patients to give feedback that can be used to monitor and improve the quality and safety of health services. These surveys provide consistent tools that can be used for national measures as well as local assessment and improvement.

The cultural factors shape the experience of care. South Canterbury District Health Board is clear with its intent to address inequities, in particular for Māori. As such concerted effort is being paid to ensuring that our Primary Care workforce is supported to work towards cultural safety as a priority.

Kia Tika te Ara training programme has been recognised by SCDHB as a programme to be implemented across the health system in South Canterbury to address contributors to inequity.

2021/22 Improvement Plan: Patient Experience of Care – Primary Care		
Milestone	Actions	Contributory Measure
Improve equity in patient experience of care for Māori receiving primary care services through establishing cultural safety and cultural competence as a core component of professionalism in health care teams.	Kia Tika te Ara training programme is offered to three groups within primary care: front of house personnel, clinicians and business owners. Survey participants to identify how they viewed the training and what the most significant change in practice would be for them as a result.	Proportion of each practice completing the endorsed training. % of persons who reported that the clinical staff pronounced names properly, or asked how to say the name if uncertain, across hospital and primary care survey. % of persons

		reporting that the clinical teams included the person in making decisions about their treatment, across hospital and primary care survey. % of persons who felt that their cultural, spiritiual and individual needs were met, across hospital and primary care survey?

4. Amenable Mortality

Amenable mortality is defined as premature deaths (deaths under age 75) that could potentially be avoided, given effective and timely healthcare. That is, early deaths from causes (diseases or injuries) for which effective health care interventions exist and are potentially accessible to New Zealanders in need of them. There is no nationally available updated data since the 2020/21 plan.

During 2020/21, work has been completed in the following areas relating to this measure:

- Expansion of options for cardiovascular risk assessment through working in conjunction with our Māori Health Provider;
- Establishing outreach service from Primary Care to the Māori Health Provider.

In order to maximise the utility of performance metrics through catalysing a tranche of positive changes improvements within coding within Primary Care is required. Historically, an average of only 20 – 30% of general practitioner consultations in New Zealand have a Read Code recorded. It is believed that implementation of performance metrics will facilitate more complete use of medical classifications for long term conditions in electronic records. These measures also provide a concrete framework for us to benchmark clinics, and for clinics to measure themselves against – currently there is very limited ability to achieve both tasks.

2021/22 Improvement Plan Amenable Mortality		
Milestone	Actions	Contributory Measures
Maintain Amenable Mortality rate below 78.2 per 100,000 year over the next three years.	Evaluate the efficacy of the Remote Patient Monitoring pilot with view to utilisation across chronic disease management in order to reduce avoidable hospitalisations. Promote the importance of influenza vaccinations for our over 65 year olds as a contributor to reduction of ASH admissions. Implement Primary Care (Pharmacies and General Practices) delivery of Covid -19 vaccinations so that 60% of all Pharmacies and Practices deliver Covid -19 vaccinations to their enrolled population on an on-going basis.	Remote Patient Monitoring pilot is evaluated and a direct link to hospital avoidance is identified. ASH rates for 65+ rates (numbers and %)Achievement of national influenza target for those over 65 years.

5. Babies Living in Smokefree Homes

This measure is important as it aims to reduce the rate of infant exposure to cigarette smoke by focusing attention beyond maternal smoking in the home to the family and whānau environment. There is a need to focus on the collective environment that the infant could possibly be exposed to, from pregnancy; birth; to where they will be nurtured and raised.

During 2020/21, work has been completed in the following areas relating to this measure:

- Expanded the Pregnant Mama programme;
- Initiated the Māori Wahine programme

The Jul 20 to Dec 20 data shows that the rate of smokefree homes for babies has increased from 64.2% in Jan-Jul 2019 to 69.5% for the period of Jul to Dec 2020. Although this improvement is promising, there is significant inequity as shown by the table below:

	Smokefree Homes	Babies Born	Rate of Smokefree Homes
Year	Jul 20 - Dec 20	Jul 20 - Dec 20	Jul 20 - Dec 20
Māori	19	41	46.3%
Pacific Peoples	9	13	69.2%
Others	177	240	73.8%
Total	205	295	69.5%

There is a strong correlation with deprivation as shown:

	Smokefree Homes	Babies Born	Rate of Smokefree Homes
NZDep Quintile	Jul 20 - Dec 20	Jul 20 - Dec 20	Jul 20 - Dec 20
Quin 1	40	46	87.0%
Quin 2	59	83	71.1%
Quin 3	58	83	69.9%
Quin 4	45	76	59.2%
Quin 5	3	7	42.9%
Mean (average)			69.5%
Total	205	295	

2021/22 Improvement Plan: Babies in Smokefree Households		
Milestone	Actions	Contributory Measure
Reduce the rate of infant exposure to cigarette smoke by increasing the percentage of babies who live in a smokefree household by 6 weeks of age *69.5% (Jul – Dec 2020)* to >70% by June 2022.	Continue to improve the home environment during pregnancy and increase the number of babies living in smokefree homes by expanding the existing Pregnant Mama incentivised programme to include all family members living in the household. Improve engagement with wāhine Māori and remove barriers to accessing smoking cessation services and supports by introducing an incentivised based wāhine Māori programme, Wahine Toa Auahi Kore targeting young Māori woman aged 20-30 years through the local Māori Health Provider. Identify Māori-led and Māori focused innovative approaches to reduce smoking prevalence for Māori. This will be actioned through a Community Hui seeking rūnanga and youth engagement. Ensure telehealth options are available for clients of the Smokefree team, who live remotely or who would prefer this form of consultation. Telehealth will provide a continuity of service to clients if face to face consultations cannot be delivered.	Number of referrals to the Stop Smoking Service for women who are pregnant. Number of and % of those referred to the wāhine Māori programme who are CO validated at 4 weeks. Number and % of participants in the Pregnant Mama programme who are smokefree validated at 4 weeks.

6. Youth Access to Health Services

Youth have their own specific health needs as they transition from childhood to adulthood. Most youth in New Zealand successfully transition to adulthood but some do not, mainly due to a complex interplay of individual, family and community stressors and circumstances, or risk factors. Evidence shows that youth are not in the habit of seeking the services or advice of a registered health practitioner when unwell. Generally, they cope with illness with advice from friends and Whānau as they see fit. Attending a health clinic is often viewed as a last resort instead of a reasonable first choice.

This measure focuses on youth accessing primary and preventive health care services. Research shows that youth whose healthcare needs are unmet can lead to increased risk for poor health as adults and overall poor life outcomes through disengagement and isolation from society and riskier behaviours in terms of addictions and alcohol misuse and criminal activities.

Early interventions which target younger populations may potentially be an effective strategy for improving adult health and reducing future healthcare costs in the long term.

During 2020/21, work has been completed in the following areas relating to this measure:

- Youth experience less alcohol and drug harm and receive support by:
  - Establishing baseline data of engagement in services.
  - Developing a wellness approach to youth alcohol and drug usage. Involve the Hauora Māori team earlier in the process for Māori community;
  - Closer collaboration between Infant, Child, Adolescent Mental Health teams, Youth Alcohol and Drug teams.
  - Working in partnership with NGOs to enable improved access and choice.

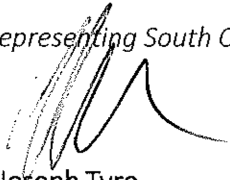
Currently the DHB is working to re-organise their Mental Health and Addiction services to ensure the needs of the community are met and align to the Primary Mental Health and Addiction initiatives. As part of this work, we seek to introduce Mental Health credentialing for clinicians, in particular practice nurses working in primary care.

2021/22 Improvement Plan: Youth Access to Health Services		
Milestone	**Actions**	**Contributory Measure**
Decrease the number of presentations by youth to ED where alcohol was involved by 10% over 2 years.	Implement South Island PICs and focus on data quality for Emergency Department presentations. Embed new integrated Primary Mental Health and Addiction roles in Primary Care and establish linkages into Secondary Mental Health and Addiction services through collaborative	% of youth attending Emergency Department where alcohol as a contributory factor has been completed Yes / No versus Unknown. Number of clinicians within each practice working alongside the Health Improvement Practitioners.

	design implementation. Embed Access and Choice initiatives for youth within NGO provider.	

Signatories

Representing South Canterbury District Health Board:



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