South Canterbury
District Health Board

The South Canterbury District Health Board

Improvement Plan

System Level Measures
2016-2017

Enhancing the health and independence of the people of South Canterbury

www.scdhb.health.nz

Contents

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CHAPTER 1: INTRODUCTION & STRATEGIC INTENTIONS

1.1 Executive Summary

South Canterbury District Health Board (SCDHB) has great pleasure in presenting its 2016/17 Service Level Measure Improvement Plan. This Plan built on the Treaty of Waitangi principles of partnership, participation and protection reflects the themes of the New Zealand Health Strategy, specifically 'value and high performance' and smart system' through a 'one team' approach and has been designed to align with 2016/17 Annual Planning priorities. It will be published alongside the DHBs other accountability documents.

In this inaugural 2016/17 Improvement Plan we seek to further develop our integrated planning that is enabled through our unique Primary Health Care structure – namely having the Primary Health Organisation (PHO) functions integrated within the District Health Board (DHB). Through this Improvement Plan we seek to continue to maintain high levels of access to services across the health continuum, high quality services through standardisation of processes such as provided by Aoraki HealthPathways, good access to services, as well as maintaining fiscal sustainability. We enjoy high confidence from our community and achievement in many of the indicators which primary care has been historically measured against. We are continuing to work actively locally, regionally and nationally to ensure that this performance is maintained and improved and to deliver clinically led integrated health and disability services for our population.

The Primary Health Partnerships directorate provides the Primary Health Organisation (PHO) function for the SCDHB as well as providing the DHB's community services. The Primary Care Alliance of the DHB and 27 Primary Care Providers is now embedded and performing well, providing the forum for the development of integrated health services and will enable further progress in integrating services into the community. Whilst the Plan itself provides a blueprint for improving health outcomes for our community, the true benefits have come from the planning discussions themselves which occurred during a series of Alliance workshops. The Alliance has embraced this opportunity to further embed a culture within the DHB which identifies innovative opportunities to effect improvement in service delivery and health outcomes.

The Primary Care Alliance within our region in the spirit of participation and partnership has worked in collaboration with partners from the community and from within the DHB to develop this Plan, agreeing on contributory performance measures which are meaningful to both practitioners and the public in monitoring our progress, and which will inform future planning for the DHB. This way of working locally within our structure of health services within South Canterbury is based on the recognised and articulated "unique symbiotic relationship" that we enjoy.

1.2 Scope of Improvement Plan

This Plan is based on the high level outcome measures that have been identified centrally as forming part of the System level Measures Framework (SLMF); a quality improvement framework. It is the body of work that has evolved from the Integrated Performance and Incentive Framework (IPIF). There are two types of measures associated with SLMF; system level measures which are high level and provide an overall indicator of the health system and contributory measures. Contributory measures are associated with a system level measure. This framework is made up from the following measures:

- Childhood Ambulatory Sensitive Hospitalisations;
- Acute Hospital Bed Days;
- Patient Experience of Care;
- Amenable Mortality;
- Smokefree Infants; and
- Youth Access to Health.

For the 2016/2017 Improvement Plan, the first four measures need to have an associated plan, with the last two measures being developmental whereby the sector will work with the Ministry of Health to develop these measures over time.

1.3 Treaty of Waitangi

Our responsibilities to Māori

Through our Māori Consultation Framework which is used by our organisation we will ensure Māori participation and partnership in health planning, service design, development and delivery, and in the protection of Māori well-being. Our Māori Health Plan for 2016/17 includes national and local Māori health priorities. We are committed to our statutory obligations to Māori under the NZ Public Health & Disability Act and we are advised by our Māori Health Advisory Committee. The Māori Health Plan for 2016/17 has been endorsed by our Primary Care Alliance as the plan across all services.

1.4 Population Projections 2016/17

SCDHB's population catchment is South Canterbury, bounded by the Rangitata and Waitaki Rivers in the north and south and the Southern Alps in the west. South Canterbury's population of 59,210 is 1.26% of the total New Zealand resident population. An estimated 21.7% of our resident population is aged 65 years or older. This is the one of the highest percentage of over 65 years in any DHB.

It is estimated that 4,960 (8.4%) of our population are Māori, up from 6% in 2006. This is expected to continue to increase during 2016/17. Despite this, South Canterbury still has the lowest proportion of Māori of any DHB. Our Māori population are much younger than our total population. The Ngai Tahu Iwi through their Runaka at Arowhenua and Waihao are the mana whenua of South Canterbury. Approximately 40% of the local Māori population affiliate with Ngai Tahu. South Canterbury has also seen increased proportions of Pacific and Asian ethnicities.

The health status of South Cantabrians appears to be similar to or slightly better than that of New Zealanders generally. The health status of Māori in South Canterbury is better than New Zealand Māori, although their health status remains below that of non-Māori.

Average household income is relatively low in South Canterbury, as are poverty and household overcrowding rates. The New Zealand deprivation index 2013 shows that Māori in South Canterbury have higher levels of socioeconomic deprivation than non-Māori. Overall, the South Canterbury population is relatively less deprived than the total New Zealand population.

1.5 Setting our Strategic Direction

Strategic context

New Zealand's health system is generally performing well against international benchmarks. However, an aging population and a growing burden of long-term conditions is driving increased demand for health services, while financial and workforce constraints limit increasing capacity.

Alongside these health sector drivers, there is growing acknowledgement of the social determinants of health and conversely, the role good health plays in social outcomes. Health outcomes for our communities are interlinked with issues of education, employment, housing and justice, and services will increasingly be asked to take a broader view of wellbeing.

These pressures mean health services cannot continue to be provided in the same way. While hospitals continue to be a setting for highly specialised care, we need to move away from the traditional health model.

There are clear opportunities that are supporting evolution in our health sector through aspects such as shifts towards earlier intervention, investment and preventative care, home and community based care, and new technology and information systems. Further change towards integrating and better connecting services, not only across the health sector, but inter-sectorally is needed to achieve better health outcomes within available resources.

1.6 National direction

Acknowledging these challenges and opportunities, New Zealand's long term vision for health services will be articulated through the New Zealand Health Strategy. The Strategy intends to support New Zealander's to 'live well, stay well, get well' and sets out five themes to give focus for change in health services:

- People powered: understanding people's needs and partnering with them to design services; empowering people to be more involved in their health and wellbeing; building health literacy and supporting people's navigation of the system;
- Closer to home: more integrated health services and better connections with wider public services; investment early in life; care closer to home; focus on wellness and prevention;
- Value and high performance: focus on outcomes, equity, people's experience, best-value use of resources; strong performance measurement; culture of improvement; transparent use of information to share learning; use of investment approaches to address health and social issues[1];
- One team: operating as a team in a high trust system; flexible use of the health and disability workforce; leadership and workforce development; strengthening the role of consumers/communities; linking with researchers; and

[1] *In line with the Productivity Commission's report More Effective Social Services (2015), an investment approach takes into account the long-term impact of an initiative on government spending and quality of life when making funding decisions.*

- Smart system: information reliable, accurate and available at point of care; data and systems that improve evidence-based decision making and clinical audit; standardised technology.

More specifically, health services are guided by a range of population or condition specific strategies, including He Korowai Oranga (Maori Health Strategy), 'Ala Mo'ui (Pathways to Pacific Health and Wellbeing), Health of Older People Strategy (currently being updated), Primary Care Health Strategy, Rising to the Challenge (Mental Health and Addiction Service Development Plan), Palliative Care Strategy, Cancer Strategy and Diabetes Strategy.

1.7 Local direction

Local health services must sustainably cope with the increasing demand for services and design pathways to manage the flow of people. This Improvement Plan seeks to clearly identify the local opportunities for improvement within each system measure, devise actions to address this and the subsequent contributory measures in order to evaluate progress. Our local Alliance, through the partnering with other local stakeholders will work with this Plan to further drive local health service integration. One of the main outcomes for this Alliance is to support health services to deliver care in the most appropriate setting and reduce demand by supporting people to remain independent.

1.8 Annual Planning Local Priorities

This Improvement Plan has natural linkages and alignment with the South Canterbury District Health Board Annual Plan 2016-17. The Plan was developed with input from primary health care through the Primary Care Alliance, made possible through our unique position. Identified in this Annual Plan are the following key priorities:

- Promotion of healthy lifestyle choices in our local population and targeted prevention (including childhood obesity);
- Identification and early interventions for "at risk" populations;
- Management of Long Term Conditions which focuses on self-management strategies;
- Integration of our primary and secondary services to support seamless patient flows;
- Clinically and financially sustainable primary and secondary services;
- Development of child and youth services;
- Coordinated services for older people and bedding in of Health of Older People Project changes;
- Strengthening clinical leadership and accountability;
- Meeting national Health Targets and System Level Performance Measures;
- Maintaining and enhancing the quality and safety of health services;
- Development of a sustainable local workforce;
- Design and development of facilities which meet building compliance standards and supports delivery of services; and
- Implementation of an IT infrastructure which supports clinical practice.

During 2016/17 we will continue to build on progress made to date on a number of initiatives to support and facilitate the ongoing development of integrated models of care. These include the continued development of ambulatory care to further facilitate integration between primary and secondary care. The SCDHB will also continue to implement regional Information Technology (IT) projects in accordance with the South Island Alliance IT Plan. These regional IT projects provide linkages into primary care through the use of technology such as HealthOne and Shared Care Plans.

CHAPTER 2: AMBULATORY SENSITIVE HOSPITAL ADMISSIONS 00-04-YEAR-OLD

Ambulatory sensitive hospitalisations (ASH) are mostly acute admissions that are considered potentially reducible through prophylactic or therapeutic interventions delivered in a primary care setting. In New Zealand children, ASH accounts for approximately 30 percent of all acute and arranged medical and surgical discharges in that age group each year. However, determining the reasons for high or low ASH rates is complex, as it is in part a whole-of-system measure.

It has been suggested that admission rates can serve as proxy markers for primary care access and quality, with high admission rates indicating difficulty in accessing care in a timely fashion, poor care coordination or care continuity, or structural constraints such as limited supply of primary care workers.

ASH rates are also determined by other factors, such as hospital emergency departments and admission policies, health literacy and overall social determinants of health. This measure can also highlight variation between different population groups that will assist with DHB planning to reduce disparities.

A composite ASH measure is preferred because it gathers up more conditions and aligns with the intention of using measures that operate at a system level rather than ones that focus on a specific condition or service.

South Canterbury District Health Board Annual Plan - Local focus for 2016/17

Each DHB is required to create a Well Child Tamariki Ora Quality Improvement Implementation Plan that will highlight the quality indicators that their DHB have identified as a priority to address. These plans are reviewed annually to ensure regional priorities are aligned to local strategic direction and to enable key stakeholders to be consulted and feedback incorporated. SCDHB has selected the following indicators:

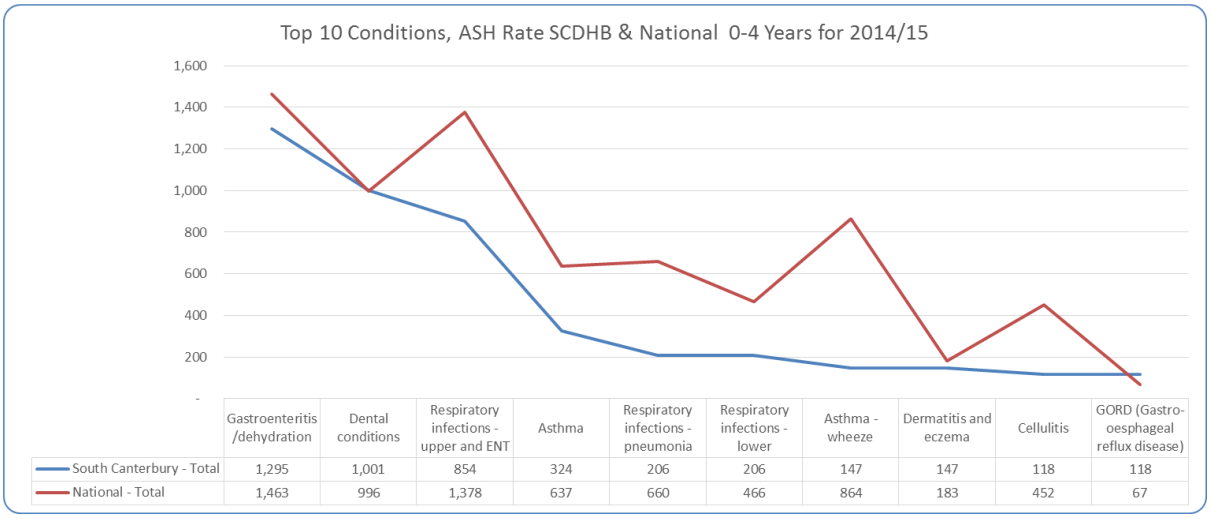
- Children are enrolled with oral health services;
- Mothers are Smokefree at two weeks post-natal;
- Infants receive all WCTO core contacts in their first year; and
- Improve the timeliness of referrals and handover process between the LMC and WCTO.

This Plan also incorporates actions to improve the first two indicators from a primary care perspective.

2.1 ASH in South Canterbury 00-04

In analysing our local ASH admissions from 1 July 2010, consideration has been given to:

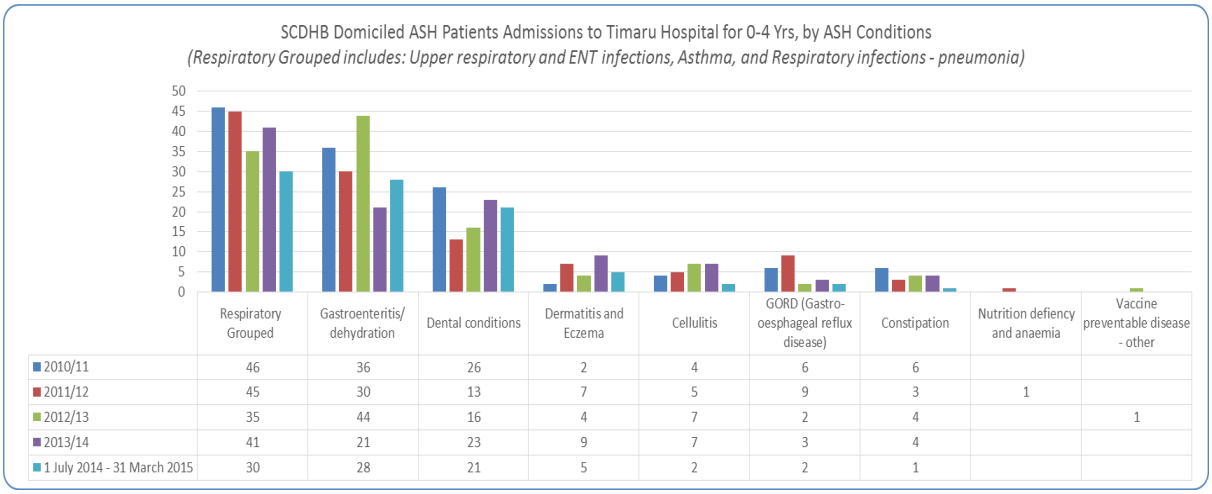
- ASH conditions
- Bed nights (potential indicator of acuity)
- Respiratory – looking at grouped and individually
- Number of admissions as compared to individuals



	Gastroenteritis /dehydration	Dental conditions	Respiratory infections - upper and ENT	Asthma	Respiratory infections - pneumonia	Respiratory infections - lower	Asthma - wheeze	Dermatitis and eczema	Cellulitis	GORD (Gastro-oesphageal reflux disease)
South Canterbury - Total	1,295	1,001	854	324	206	206	147	147	118	118
National - Total	1,463	996	1,378	637	660	466	864	183	452	67

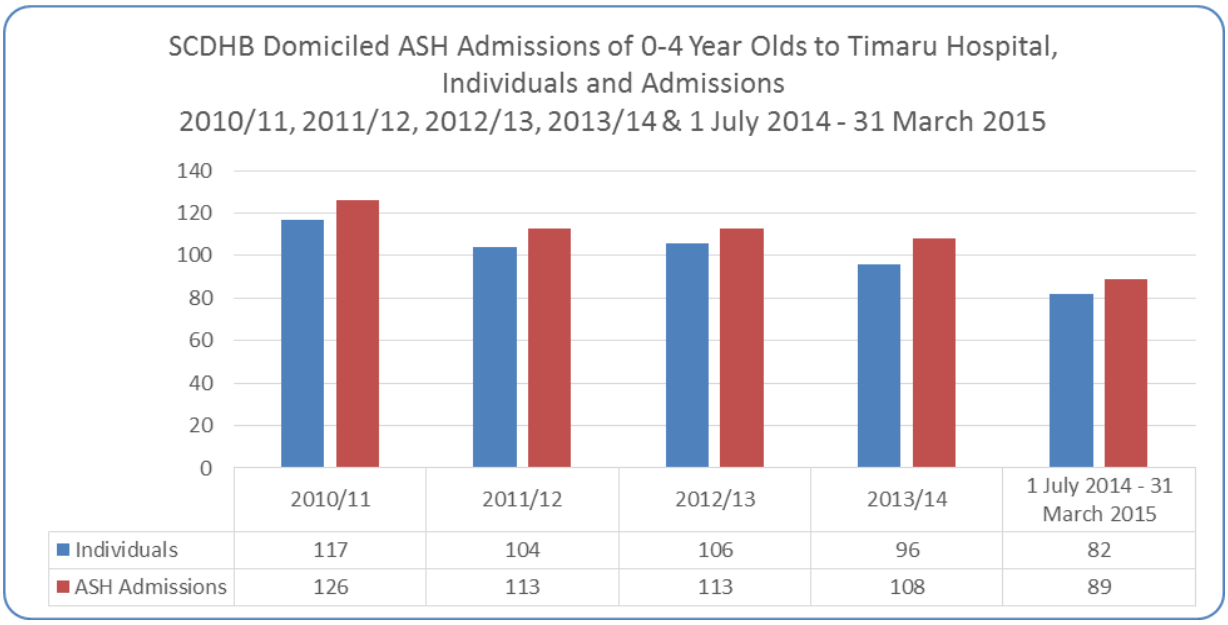
The above graph illustrates the comparison between South Canterbury District Health Board ASH admissions as compared to national ASH rates per 1000 people over the 2014-15 year. This is indicative of the previous years where generally there is a lower ASH rate in South Canterbury as compared to the national rate, except for dental, dermatitis/eczema and GORD. The actual numbers for dermatitis / eczema and GORD are very low.

When considering admissions to Timaru Hospital, with respiratory conditions grouped, it is illustrated that the three leading causes for ASH for 00-04 year olds in South Canterbury are consistently respiratory, gastroenteritis / dehydration and dental.

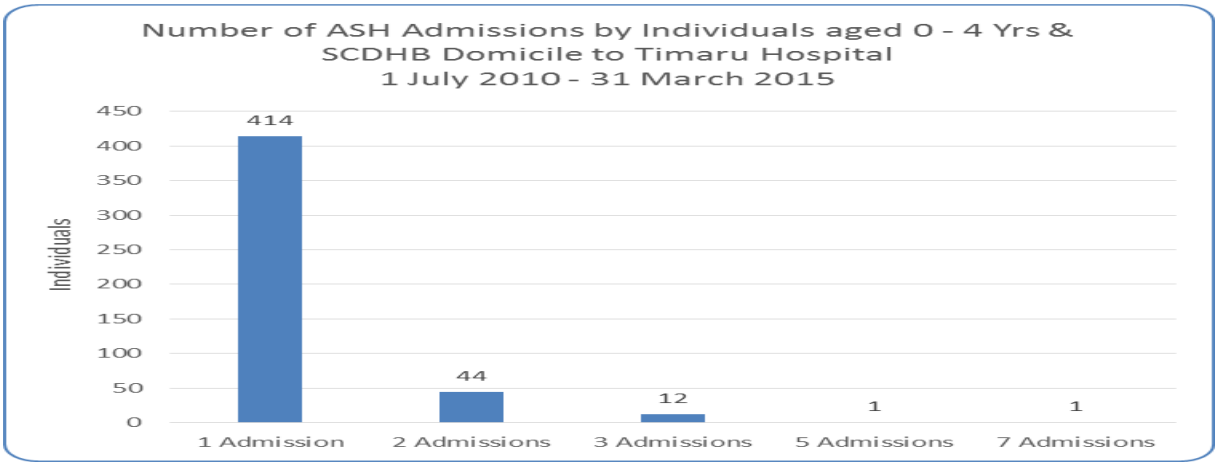


	Respiratory Grouped	Gastroenteritis/ dehydration	Dental conditions	Dermatitis and Eczema	Cellulitis	GORD (Gastro-oesphageal reflux disease)	Constipation	Nutrition defiency and anaemia	Vaccine preventable disease - other
2010/11	46	36	26	2	4	6	6		
2011/12	45	30	13	7	5	9	3	1	
2012/13	35	44	16	4	7	2	4		1
2013/14	41	21	23	9	7	3	4		
1 July 2014 - 31 March 2015	30	28	21	5	2	2	1		

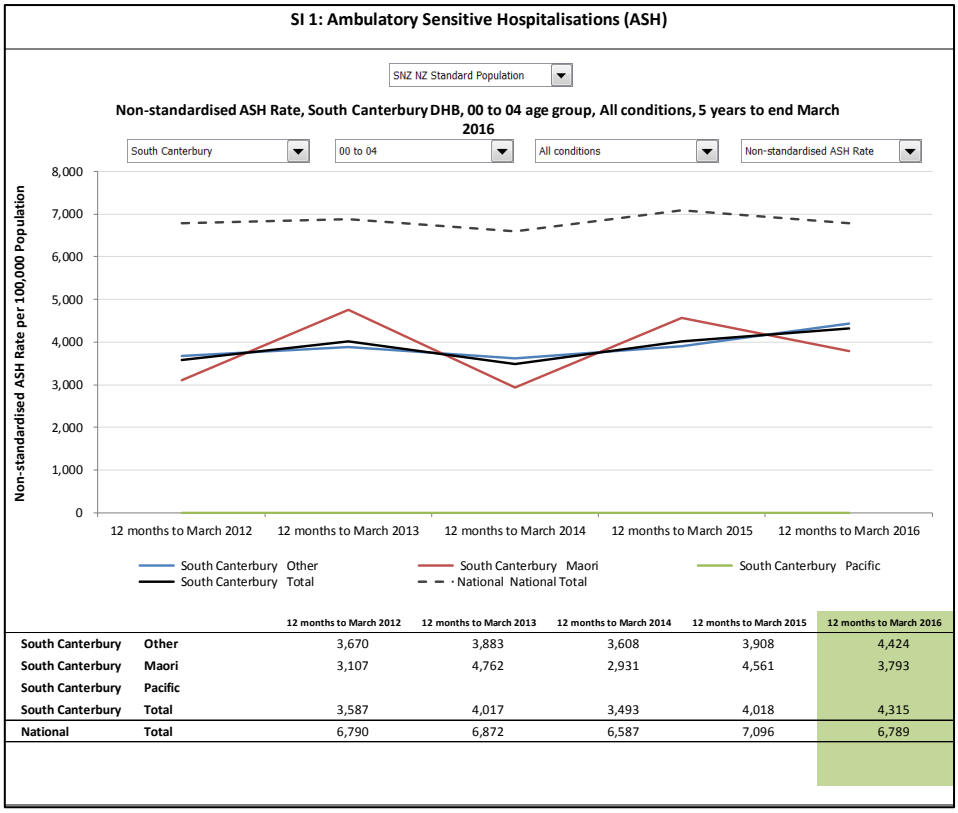
The effects of a small population was then considered in terms of whether we had a small number of children with repeat admissions, or whether we were looking at a wider range of individuals. Analysis of this showed that of the 472 admissions between 1 July 2010 and 31 March 2016, the majority of these children had only one admission.



	2010/11	2011/12	2012/13	2013/14	1 July 2014 - 31 March 2015
Individuals	117	104	106	96	82
ASH Admissions	126	113	113	108	89



In comparing the South Canterbury 0-4 years ASH rates with the national data, as shown in the graph below, the goal is to maintain performance as a minimum as our current ASH rates sit well below the national average.



		12 months to March 2012	12 months to March 2013	12 months to March 2014	12 months to March 2015	12 months to March 2016
South Canterbury	Other	3,670	3,883	3,608	3,908	4,424
South Canterbury	Maori	3,107	4,762	2,931	4,561	3,793
South Canterbury	Pacific					
South Canterbury	Total	3,587	4,017	3,493	4,018	4,315
National	Total	6,790	6,872	6,587	7,096	6,789

2.2 Improvement Milestones – ASH 00-04 years

South Canterbury ASH rates for 00-04 years sits below the national average. As such the goal for this system level measure is to maintain performance.

Goal	Measure
To maintain ASH rates for 00-04 year olds in South Canterbury	ASH rates ≤ 4,315 for the year ending March 2017.

2.3 South Canterbury Priorities

Based on the data provided, it was identified that in order to address ASH rates for this cohort in our population, the focus should be on three areas; respiratory, gastroenterology and dental. The highlighted measure is the measure that has been agreed to be incentivised.

The following tables include the actions and measures that relate to each area:

Dental		
Objective	**Action**	**Contributory Measure**
Improve child oral health enrolment rates.	Establish a local process to link families with all relevant child health services e.g. migrant families, new families to district through embedding the local multi-enrolment process for those families moving into South Canterbury.	Pre-school children enrolled in publicly funded child oral health service.
Advocate for a national enrolment database for Community Oral Health Services or a process for transfer notification for flows in and out of district.	Share on a quarterly basis from the primary care register, an up to date list of the eligible children for the Community Oral Health Service to see in the next quarter.	
Reduce childhood dental caries.	Target oral health promotion at: • DHB venues • Health functions	Hospital admissions for children aged under five years with dental caries as a primary diagnosis.

Dental		
Objective	**Action**	**Contributory Measure**
	• Education settings • Churches • Marae • Oral health services Deliver a Communication Plan containing age appropriate messaging consistently across health sector.	
	Review the role and access to the oral health promoter, including but not limited to: • Inform referral sources through the development of an Aoraki HealthPathway.	Referrals to oral health promoter by volume, ethnicity, deprivation and source
	Review access to treatment under sedation.	Developmental measure relating to increasing understanding of demand and capacity.

Respiratory		
Objective	**Action**	**Contributory Measure**
Understand social determinants impacting on childhood respiratory health.	Analyse the living conditions for all ASH admission 0-4yrs for the past 12 months through consideration of deprivation, ethnicity and geographical location.	Developmental measure relating to increasing understanding of demand and capacity.
Ensure children live in Smokefree households.	Establish a consistent local code in primary care for passive smoking status for children, against the child's health record. Initiate family referrals for smoking cessation.	Four year old children living in smoke-free homes.
Ensure children live in warm dry homes.	Establish a consistent local code in primary care for damp home status for children, against the child's health record. Initiate family referrals to Energy Smart.	Developmental measure relating to increasing understanding of demand and capacity.

Gastroenterology		
Objective	**Action**	**Contributory Measure**
Understand social determinants impacting on childhood gastrointestinal health and improve childhood health through ensuring our children with gastroenterology conditions are well managed.	Analyse the living conditions for all ASH admission 0-4yrs for the past 12 months through consideration of deprivation, ethnicity and geographical location.	Developmental measure relating to increasing understanding of demand and capacity.
Reduce the prevalence of gastroenteritis in children under four years.	Assess the effectiveness of the Rotavirus vaccine; started in last 18 months through monitoring the admissions for gastroenteritis and the receipt of the vaccine. This to include comparison of the ASH rate for 00-02 (age cohort who have received this vaccine) with the 03-04 age group (pre-vaccine).	Developmental measure.

General		
Objective	**Action**	**Contributory Measure**
Promote an integrated approach to child health.	Share all B4 School check summaries with primary care electronically.	Local measure: 100% of B4 School Check summaries are sent electronically to practices within two weeks of completing the check.

2.4 Performance Funding

For ASH admission rates for those children under the age of four, the activity undertaken by primary care that is likely to have the greatest impact is the reduction of children living in households where persons smoke. As such it has been chosen to have this as the incentivised measure for 2016-17. The first three quarters being used to develop the measure, and commence the activity with the last quarter being incentivised for the achievement of the measure.

The funding for this area will be divided equally between the following:

a) 8 month immunisation
b) Coding of passive smoking status in children four years old and under. For this measure a local code will be set up in all practices to indicate whether a child is living in a smokefree household or not. Payment will be based on:

$$\frac{\text{Number of children under four with passive smoking status coded}}{\text{Enrolled population under four in South Canterbury as at 1st April 2017}}$$

It is assumed that practices will refer onto appropriate services when there are smokers in the household and they consent to the referral.

25% of performance funding will be attributed to ASH for 00-04.

CHAPTER 3: PATIENT EXPERIENCE OF CARE

This measure captures patient experience of care in the primary care setting and aligns with hospital inpatient surveys which have been undertaken quarterly since 2014. Patient experience surveys provide scores for four domains which cover key aspects of a patient's experience when interacting with health care services. These are:

- Communication;
- Partnership;
- Coordination; and
- Physical and emotional needs.

The purpose of these measures is to evaluate whether patients in New Zealand are receiving quality, effective and integrated health services. Evidence suggests that if patients experience good care, they are more engaged with the health system and therefore likely to have better health outcomes.

This system level measure is dependent upon the roll-out of the National Enrolment Service within South Canterbury. This is commencing in August 2016 and is due to be fully implemented by the end of June 2017.

3.1 Improvement Milestones – Patient Experience Survey

South Canterbury has currently not got all practices on the National Enrolment Service. As such the goal for this system level measure is to achieve participation in the patient experience survey.

Goal	Milestones
To implement Patient Experience Survey all practices in South Canterbury the patient experience survey	27 (100%) practices live on NES by end Q3
	27 practices have 10% of patients seen during survey week completing the survey by the end of Q4.

3.2 South Canterbury Priorities

It is expected that all South Canterbury practices are on the National Enrolment Service by the end of 2016, or soon thereafter. As such the focus for our region is to ensure that practices collect the relevant information within the PMS in order for patients to be contacted.

Patient Experience of Care		
Objective	**Action**	**Contributory Measure**
Improve clinical outcomes for patients in primary care through improved patient safety and experience of care.	Ensure all practices are active on the national enrolment service by the end of June 2017.	GP practices are using the National Enrolment Service.
	Promote the Patient Experience Survey to patients, and all practices ensure that their enrolled population's mobile or email addresses are up-to-date in Medtech.	GP Practices using the primary care patient experience survey.
	Increase accessibility to primary care through the introduction of patient portals.	GP Practices offering an e-portal access. Patients are registered to use general practice e-portals.

3.3 Performance Funding

For Patient Experience, funding for the Q4 2016-17 period will be calculated for each practice using the primary care patient experience survey, they will get a proportion of the funding allocated to this measure based on their enrolled population. This will be calculated by:

Eligible practices for funding: Practices with ≥ 10% patients seen in survey week respond to survey

Payment: Numerator = number of patients that respond
Denominator = total number of patients in South Canterbury that respond

In future years it is anticipated to shift the focus for this measure from participation to uptake of the survey by patients, then onto the outcomes in terms of quality.

25% of performance funding is attributed to this measure.

CHAPTER 4: ACUTE HOSPITAL BED DAYS

Acute hospital bed days per capita is a measure of acute demand on secondary care that is amenable to: good upstream primary care, acute admission prevention, good hospital care and discharge planning, integration of services and transitions between care sectors and good communication between primary and secondary care. These can all help reduce unnecessary acute demand. Good access to primary and community care and diagnostics services supports this reduction in demand. . The value and the desired outcome of this measure are referenced through international practices with the following aims:

- to understand demands on the health system;
- to measure burden of care incurred by inpatients in the course of their hospital stay;
- to improve system-wide health services delivery;
- to ensure care appropriateness and efficiency;
- to support care in the home and community; and
- to enhance partnership between hospital, primary and community care sectors.

This measure aligns well with the New Zealand Health Strategy's five themes, which are people-powered, closer to home, one team, smart system, and in particular value and high performance. These themes place an emphasis on measuring the performance of the whole system in order to determine the value the country receives from the system. This measure will be used to manage the demand for acute inpatient services on the health system. The intent of the measure is to reflect integration between community, primary, and secondary care and supports the strategic goal of maximising the use of health resources for planned care rather than acute care. Different cohort groups of population such as Māori would have a high capacity to benefit from improved primary care that will reduce the need for acute care.

This measure is supported by a suite of locally selected contributory measures to strengthen the ability to detect and understand factors that drive acute demand. This combination of measures avoids the risk of a single high level measure which gives no indication of where improvements could be made. It also creates opportunities for inter-provider communication, and promotes data transparency and knowledge sharing.

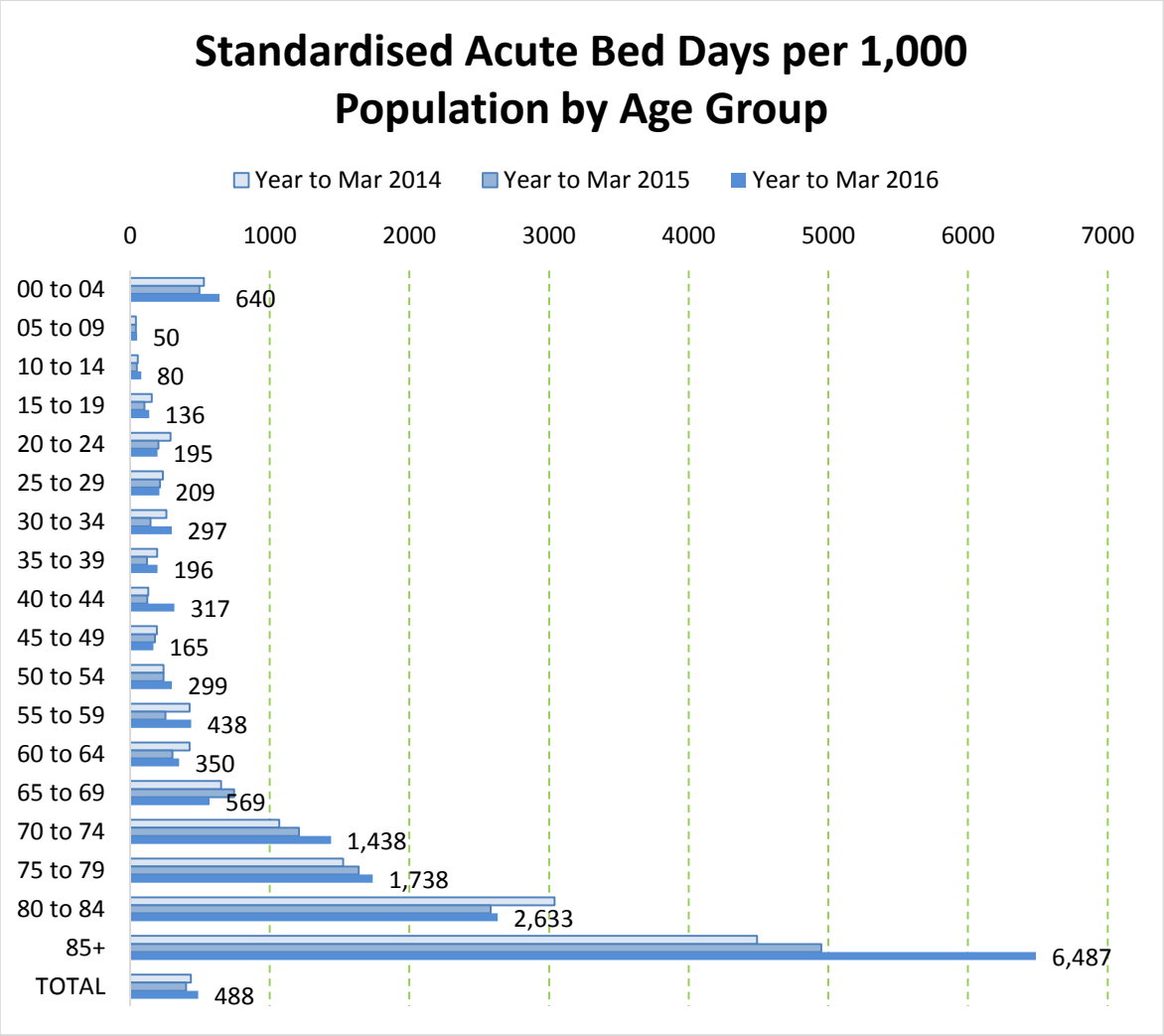
4.1 Acute Hospital Bed Days in South Canterbury

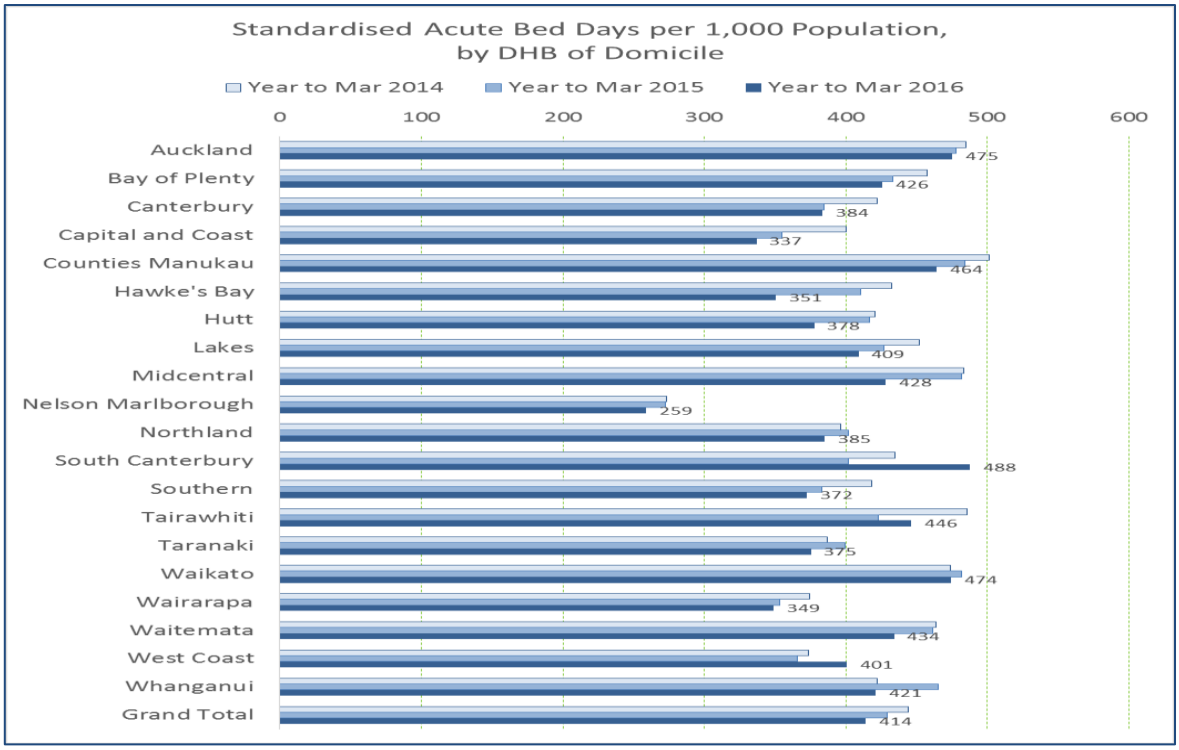
Within the context of having an estimated 21.7% of our resident population aged 65 years or older, one of the highest percentage of over 65 years in any DHB in New Zealand, the South Canterbury Primary Care Alliance selected the focus for 2016-17 relating to Acute Hospital Bed Days as reducing polypharmacy. The following data illustrates that in using age standardisation to population, based on the 2013 usual census, we have the highest number of bed days across the DHB in the year to March 2016.

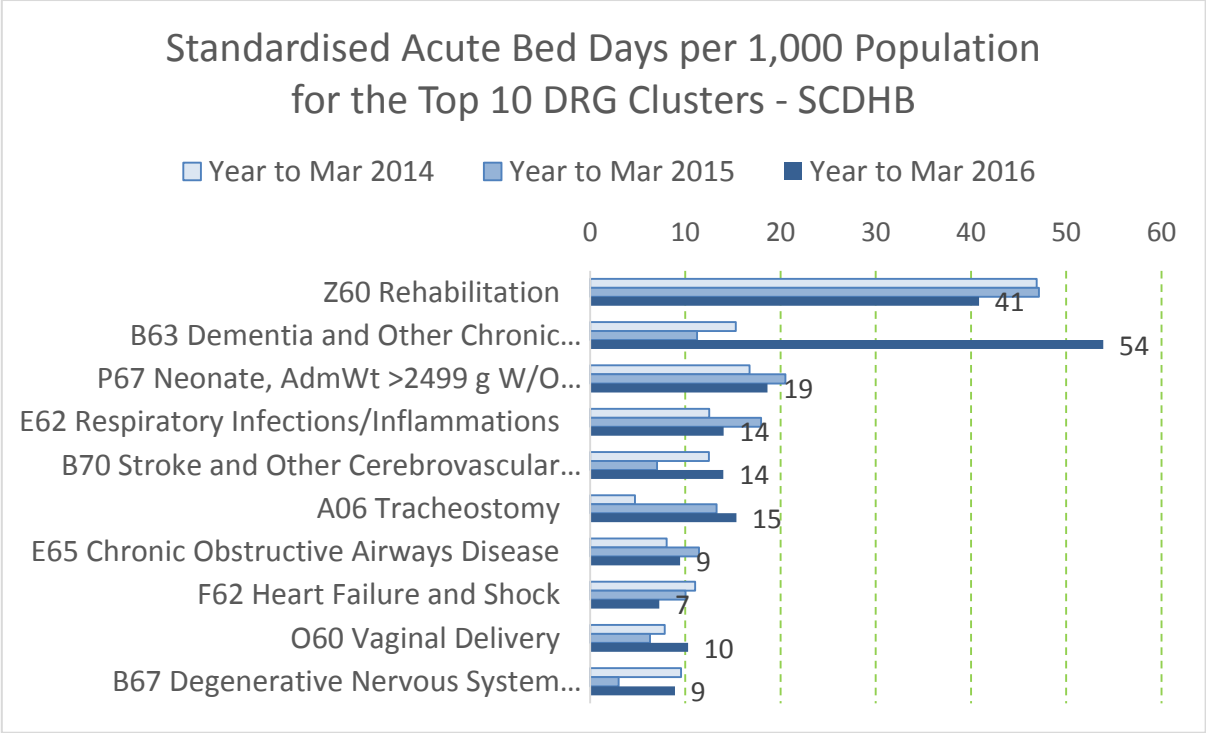
The following four graphs contain data from the National Service Framework Library and illustrate that the age range where there is the highest acute hospital bed days is in the 85+ year old age group, with the main diagnostic related groups including rehabilitation and dementia. The apparent increase in dementia-related admissions in the year to March 2016 relates to our low population and has been influenced by a few individuals. This also explains the apparent high rate of acute bed days for Pacific people, where there was a small number of individuals with prolonged stays.

Furthermore the graph on page 15 illustrates that the rate of people in South Canterbury on the Community Pharmacy Long Term Condition (Long Term Conditions) service is the third highest in the country. This Long Term Conditions service relates to people – usually older, whom have assessed difficulties with medication management and adherence. This is aligned to the ageing population in South Canterbury.

With a high number of individuals impacting on our acute bed days, the main diagnostic group being cognitive disorders, coupled with the Health Round Table data showing that syncope or collapse is a major contributor to acute bed days, a focus on polypharmacy is appropriate. In addition, a new pathway on delirium has just been launched in secondary services using the Dems Cams tool (Delirium Early Monitoring system). This tool will trigger where appropriate, an inpatient polypharmacy review.


Standardised Acute Bed Days per 1,000 Population by Age Group
Year to Mar 2014
Year to Mar 2015
Year to Mar 2016
0
1000
2000
3000
4000
5000
6000
7000
00 to 04
640
05 to 09
50
10 to 14
80
15 to 19
136
20 to 24
195
25 to 29
209
30 to 34
297
35 to 39
196
40 to 44
317
45 to 49
165
50 to 54
299
55 to 59
438
60 to 64
350
65 to 69
569
70 to 74
1,438
75 to 79
1,738
80 to 84
2,633
85+
6,487
TOTAL
488


Standardised Acute Bed Days per 1,000 Population, by DHB of Domicile
Year to Mar 2014
Year to Mar 2015
Year to Mar 2016
0
100
200
300
400
500
600
Auckland
475
Bay of Plenty
426
Canterbury
384
Capital and Coast
337
Counties Manukau
464
Hawke's Bay
351
Hutt
378
Lakes
409
Midcentral
428
Nelson Marlborough
259
Northland
385
South Canterbury
488
Southern
372
Tairawhiti
446
Taranaki
375
Waikato
474
Wairarapa
349
Waitemata
434
West Coast
401
Whanganui
421
Grand Total
414



South Canterbury Comparison against National average last three years – Acute Bed Days

Year	South Canterbury District Health Board	National Average
To March 2014	434	429
To March 2015	401	413
To March 2016	488	414

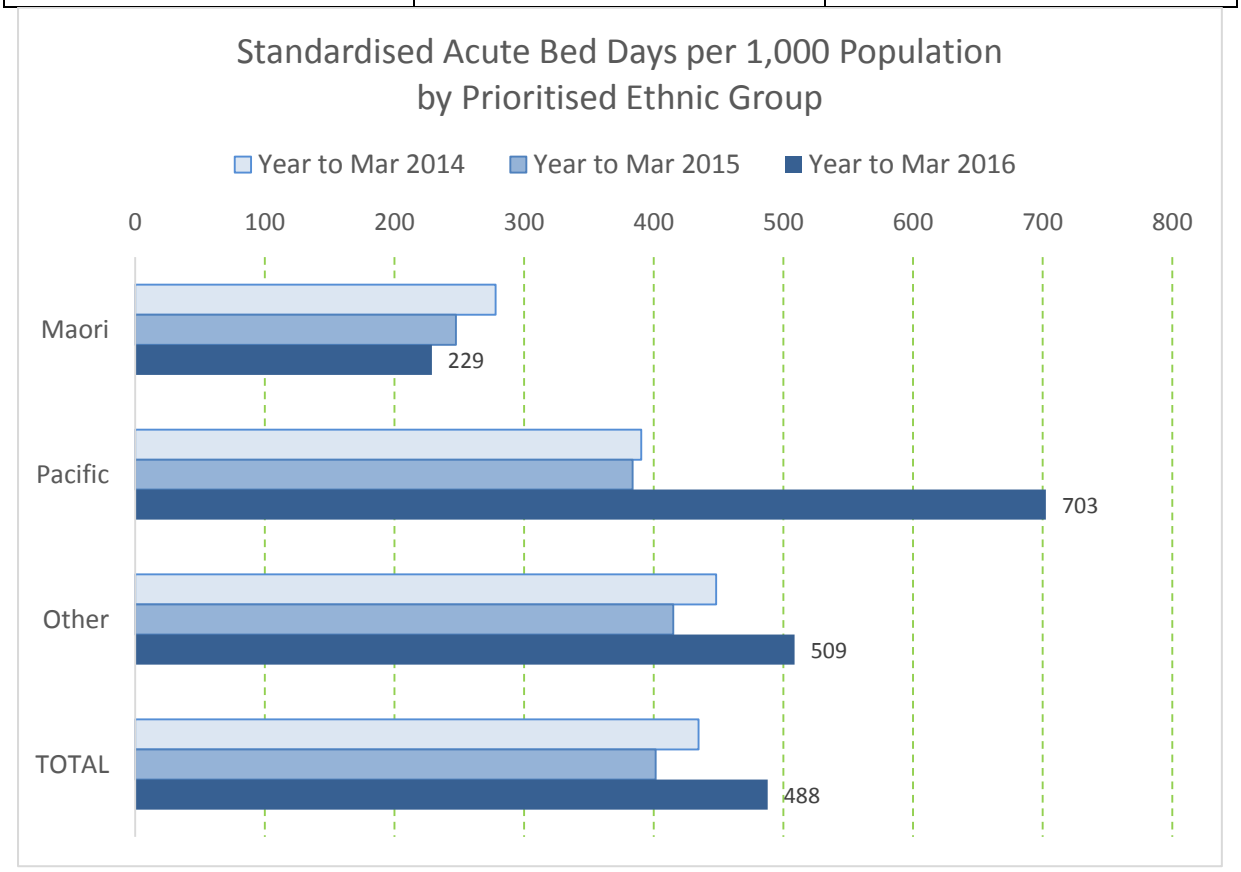
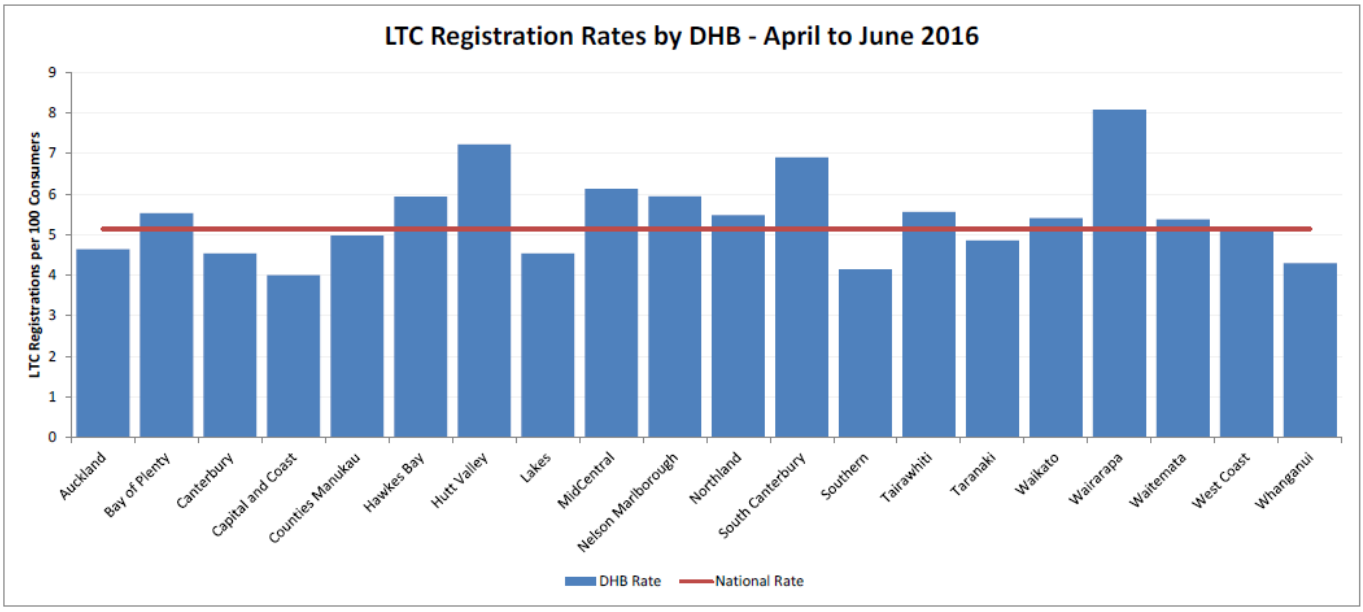


Figure 2: LTC Registration Rates by DHB of Service



The following table illustrates the main contributors to potential bed day savings within South Canterbury DHB. This table is part of the Health Round Table benchmarking and relates to the period June 2015-July 2016.

DRG		Veritas		
	Name	RSI	Eps	Savings
E62	RESPIRATORY INFECTN/INFLAMM	114%	226	356
O60	VAGINAL DELIVERY	112%	424	230
F62	HEART FAILURE & SHOCK	123%	132	209
F73	SYNCOPE & COLLAPSE	156%	132	160
K60	DIABETES	134%	80	152
O01	CAESAREAN DELIVERY	118%	141	137
E65	CHRNIC OBSTRCT AIRWAY DIS	108%	143	135
G02	MJR SMALL & LARGE BOWEL PR	110%	65	128
J64	CELLULITIS	125%	94	124
G67	OESOPHAGITIS & GASTROENTERITIS	112%	190	117

The selected focus for the South Canterbury Primary Care Alliance is polypharmacy and this is supported by the following information from bpac[2].

Number, proportion and age of registered patients who have had 10 or more medicines compared to nationally April 2015-March 2016		
	Primary & Community Services	National
Age Band (years)	10+ medicines	10+ medicines
0-29	0% (n=16)	0%
30-39	0% (n=20)	0%
40-49	1% (n=82)	1%
50-59	2% (n=180)	2%
60-69	5% (n=397)	5%
70-79	13% (n=678)	12%
80+	24% (n=733)	23%

This selected focus was also based on the following key messages:

- *For many people, appropriate polypharmacy will extend life expectancy and improve quality of life;*
- *Older patients are more likely than younger patients to be affected by problematic prescribing due to comorbidities and reduced renal and hepatic function;*
- *Polypharmacy may result in patient confusion as well as contributing to reduced adherence and an increased burden of treatment;*
- *Polypharmacy increases the risk that unused to waste.*[3]

[2] *bpac New Zealand Ltd. 2016 Polypharmacy Update – Primary & Community Services, South Canterbury*

[3] *bpac New Zealand Ltd 2016 Polypharmacy Update – Primary & Community Services, South Canterbury*

4.2 Improvement Milestones – Acute Bed Days

South Canterbury has a higher than national average relating to acute bed days. As such, South Canterbury has an improvement goal to move performance closer to the national average. This measure requires an integrated approach across the service continuum.

Goal	Milestones
To improve performance to reduce acute bed days by 10% to closer align with national average per 1,000 population – reduce from 488 to 439 per 1,000 population	Acute bed days are at or below 439 for the 2015-16 year

4.3 South Canterbury Priorities

The priority of reducing unnecessary polypharmacy is developmental, and as agreed by the Primary Care Interim Alliance, this work forms part of our base expectation for primary care. As a region we will continue to focus to ensure that our population has good access to influenza vaccinations and pneumovax.

Acute Hospital Bed Days		
Objective	**Action**	**Contributory Measure**
Improve clinical outcomes and quality of life through appropriate use of pharmaceuticals.	Develop audit tools to assist practitioners to identify potential polypharmacy patients. The parameters being: • Patients – registered with 6/7 or more highlighted / long term medications • Patients – registered with 8/9 or more highlighted / long term medications • Patients – registered with 10/11 or more highlighted / long term medications • Patients – registered with 12 + highlighted / long term medications. Practices to undertake pharmaceutical reviews through a variety of mechanisms: • Virtual independent review by prescriber • Face to face review at next consultation by prescriber • Virtual review by prescriber and geriatrician • Face to face review by prescriber and geriatrician • Multi-disciplinary team review including clinical pharmacist. Develop advanced form for practices to record polypharmacy review activity.	People aged 65 years and over dispensed 11 or more unique long term medications.

4.4 Performance Funding

Performance funding for the measure of acute hospital bed days will be linked to two areas of activity. These payments are made to practices who achieve national targets in each of the areas below:

a) Brief advice for smokers to quit and
b) Influenza vaccinations to eligible patients 65 years and over

25% of performance funding to practices will be attributed to this measure.

CHAPTER 5: AMENABLE MORTALITY

About half the deaths under 75 years of age in New Zealand are classified as amenable according to the current code list. That is, they are 'untimely, unnecessary' deaths from causes amenable to health care. There is currently a list of 35 causes of deaths in this category in New Zealand.

South Canterbury District Health Board Annual Plan - Local focus for 2016/17

SCDHB continues to facilitate an integrated approach to the management of people in South Canterbury with Long Term Conditions. This includes a focus on these conditions being primarily managed in the primary care setting except where specialist input is required. Tools are available to assist primary care including the use of the Dr Info Audit tool and Patient Dashboard. A number programmes for those people with long term conditions such as the diabetes encounter programme, foot care programme for diabetics, conversation maps and pre-long-term condition lifestyle group education, are all scheduled to continue during 2016/17. Specialist support continues to be provided to general practices by clinical nurse specialists.

The Aoraki HealthPathway for Sleep Apnoea, introduced during 2013/14, was evaluated for effectiveness during 2015/16 and has resulted in reviewed referral practices between secondary and tertiary services. Also reviewed in 2015, the Primary Physiotherapy Intervention Programme for osteoarthritis was deemed to be effective in the early intervention of joint problems and will continue to be funded.

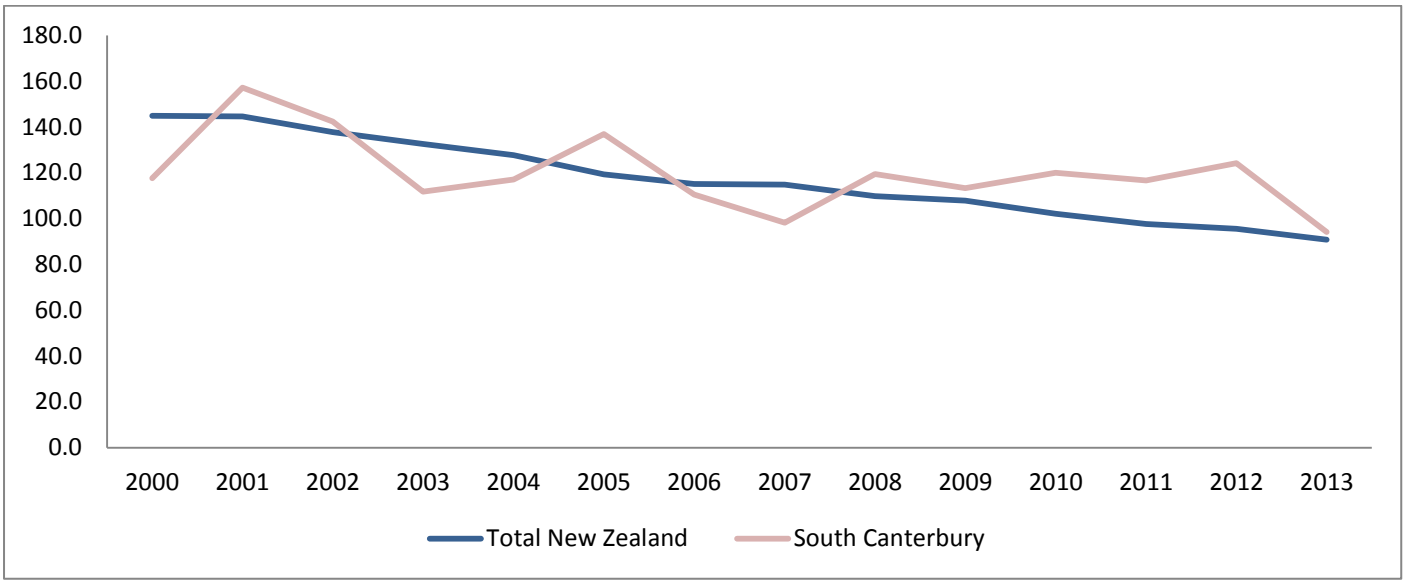
During 2016/17 we will focus on embedding its partnership approach to managing and monitoring service delivery for persons with long-term health conditions and on the further development of its Model of Care guidance documents, namely heart failure along with improving timeliness for patients requiring services. Included within this focus is the increasing engagement rate of Māori and Pacific people in CVDRA screening through a partnership approach with our local Māori Health provider and Fale Pasifika.

5.1 Amenable Mortality in South Canterbury

The table below shows the amenable mortality deaths, age standardised rates, 0-74 year olds, 2000-2013 across New Zealand. This has been calculated using estimated resident population, as at June 30th. Note that 2013 results are provisional only.

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Total NZ	144.9	144.6	137.7	132.6	127.6	119.2	115.0	114.8	109.8	107.8	102.1	97.6	95.5	90.8
Northland	187.8	168.4	199.4	180.3	157.6	158.4	150.5	143.1	148.6	148.7	133.2	130.3	138.9	117.0
Waitemata	111.5	110.4	105.7	101.2	93.2	92.8	89.2	81.6	82.7	76.7	67.8	76.2	72.6	63.5
Auckland	138.7	121.6	118.5	117.4	118.3	97.0	92.0	101.7	96.1	98.4	81.6	79.3	81.1	70.8
Counties – Manukau	147.9	144.8	158.5	139.7	126.6	130.3	123.3	123.9	114.3	115.7	114.2	108.4	106.1	102.0
Waikato	163.6	150.4	144.4	129.6	139.5	130.0	131.6	135.8	127.6	113.2	116.9	115.3	106.1	97.3
Lakes	176.0	203.8	191.0	162.4	171.9	137.1	157.3	141.3	146.7	160.3	129.7	131.2	126.0	119.1
Bay of Plenty	161.1	164.2	143.3	146.1	146.3	126.6	122.4	134.8	119.8	118.0	112.9	106.2	112.0	105.6
Tairawhiti	193.4	197.5	220.8	243.8	207.0	183.2	202.3	189.0	151.7	185.2	158.5	128.7	133.2	152.3
Hawkes Bay	179.1	179.3	154.3	177.6	144.9	166.8	142.4	141.5	134.9	114.5	123.8	114.5	105.5	102.3
Taranaki	149.3	134.4	128.9	132.1	137.3	153.8	115.7	142.0	103.0	135.3	121.9	101.4	103.8	93.9
Midcentral	154.1	165.7	136.6	149.4	139.3	137.9	129.8	125.1	120.5	136.2	113.3	103.5	89.9	106.9
Whanganui	193.9	200.1	178.3	162.0	149.0	163.4	161.5	140.4	143.7	148.4	142.3	146.6	109.7	107.2
Capital & Coast	127.7	122.4	124.7	115.8	106.1	105.1	99.5	88.4	95.0	76.7	79.2	74.4	75.2	78.4
Hutt Valley	146.0	138.7	124.7	151.1	118.9	107.6	104.7	120.1	122.1	94.0	90.6	91.9	90.7	96.7
Wairarapa	155.9	172.8	123.3	163.5	156.9	101.8	104.2	113.3	151.9	118.8	115.2	131.3	97.7	119.0
Nelson Marlborough	140.9	135.1	123.7	104.9	102.2	106.3	104.1	113.6	88.4	97.1	91.1	75.7	76.5	75.6
West Coast	152.0	214.8	177.4	154.7	168.8	144.9	143.8	113.3	120.0	145.4	126.8	121.4	87.3	131.4
Canterbury	119.6	127.3	119.3	113.0	118.0	92.6	98.9	100.1	89.2	96.0	96.0	86.1	84.8	89.1
Sth Canterbury	117.7	157.1	142.3	111.7	117.1	136.9	110.4	98.1	119.4	113.2	120.0	116.7	124.1	94.1
Otago	130.4	132.0	123.2	121.0	118.9	109.7	99.1	99.2	105.8	98.8	97.3	91.0	97.5	73.3
Southland	154.5	172.7	148.3	143.2	139.7	119.0	122.5	136.8	117.9	111.1	100.3	96.5	97.0	90.8

The graph below shows the comparison over time between changes in the national rate and that of South Canterbury.



Both national and local data shows a downwards trend to this information, with the provisional data for 2014 expected in February, it is expected to maintain this downward trend.

Amenable mortality deaths, age standardised rates, 0-74 year olds, 2013, calculated using estimated resident population as at June 30th. 2013 data is provisional only.

	2013		2009-2013
	Number of deaths	Age standardised rate	Average 4 highest
Northland	280	117.0	137.8
Waitemata	443	63.5	73.3
Auckland	370	70.8	85.1
Counties Manukau	587	102.0	111.1
Waikato	485	97.3	112.9
Lakes	160	119.1	136.8
Bay of Plenty	309	105.6	112.3
Tairawhiti	93	152.3	157.3
Hawkes Bay	224	102.3	114.6
Taranaki	150	93.9	115.6
Midcentral	244	106.9	115.0
Whanganui	95	107.2	136.7
Capital & Coast	282	78.4	77.4
Hutt Valley	173	96.7	93.3
Wairarapa	76	119.0	121.1
Nelson Marlborough	165	75.6	85.1
West Coast	58	131.4	131.2
Canterbury	597	89.1	91.8
South Canterbury	80	94.1	118.5
Otago	209	73.3	96.1
Southland	142	90.8	101.2
Overseas and undefined	52	...	...
Total New Zealand	**5274**	**90.8**	**100.7**

The table above shows that the provisional age standardise rate is reducing for South Canterbury, when

The table below illustrates for 2013 some of the predominant contributors to South Canterbury amenable mortality statistics. This shows that ischaemic heart diseases and COPD are the main contributory factors. This supports the on-going focus in South Canterbury to maintain CVD risk assessments as a priority.

In relation to COPD as a contributor, a project is underway in primary care which was developed as part of the Whakakotahi quality improvement challenge which seeks to provide equitable access to spirometry as a screening tool for detection and management of respiratory disease amongst smokers between ages of 45 and 64 years within South Canterbury. It is an international recommendation that spirometry be used as a screening tool for the early detection of COPD in middle aged smokers. The improved range of approved inhaled medications contingent upon COPD validation using spirometry earlier this year was the driver for this project.

Suicide prevention is covered by the South Canterbury Suicide Prevention Action Plan, which is a district wide plan that includes primary care.

Amenable mortality deaths, 0-74 year olds, provisional 2013

	South Canterbury	NZ
Rectal cancer	**2**	**240**
Melanoma of skin	**3**	**199**
Female breast cancer	**4**	**428**
Prostate cancer	**3**	**201**
Complications of perinatal period	**4**	**148**
Diabetes	**6**	**377**
Ischaemic heart disease	**24**	**1370**
Heart failure	**1**	**13**
Cerebrovascular diseases	**5**	**436**
Pulmonary embolism	**0**	**13**
COPD	**13**	**474**
Land transport accidents excluding trains	**7**	**253**
Accidental falls on same level	**1**	**24**
Suicide	**7**	**480**

5.2 South Canterbury Priorities

Improvement Milestone Amenable Mortality:
Q4: Maintain the recent improvements in amenable mortality to ≤ 94.1 age standardised.

Amenable Mortality		
Objective	**Action**	**Contributory Measure**
Improve health outcomes through appropriate universal vaccination coverage.	Increase vaccination coverage for the following groups, maintaining 95% or higher coverage for both total population and Māori at: • 8 months • 2 years • 5 years	Immunisation coverage for 8 months, 2 years and 5 years.
Facilitate early health intervention through appropriate health screening programmes.	Undertake cardiovascular assessments within eligible population.	Eligible population have had a CVDRA completed in the last five years. Target 90%.
	Offer persons over the age of 65 years with risk factors pneumovax vaccinations.	350 pneumovax vaccinations administered per annum
Improve health outcomes through appropriate vaccination of high risk populations.	Offer persons over the age of 65 and those with chronic health conditions the annual influenza vaccination.	Influenza vaccinations for 65 year olds and over. Target 70% or higher.

5.3 Performance Funding

Performance funding for the measure of amenable mortality will be linked to the maintenance of achievement of CVDRA at or above 90%.

Eligible practices for funding: Practices with ≥ 90% eligible patients whom have a completed CVDRA within national guidelines.

25% of performance funding to practices will be attributed to this measure.

APPENDIX 1: PRACTICE FUNDING

There is an incentive pool for South Canterbury practices of approximately $200,000 (varies on enrolment) that will be used to build capacity and capability in primary care, while also rewarding performance. This will help achieve the System Level Measures Improvement Milestones and the two primary care National Health Targets.

Two capacity and capability payments and performance payment will be paid to practices:

- Payment 1: 25% capacity and capability payment up front in quarter one (15 Oct 2016)
- Payment 2: 50% capacity and capability payment in quarter two once the Ministry approves the South Canterbury Improvement Plan (15 December 2016)
- Payment 3: 25% performance payment based on quarter four 2016/17 performance as per the table below (15 September 2017).

Q4 (Apr-Jun 2017) Performance funding to practices

<table>
<tr><td colspan="2">Ambulatory Sensitive Hospital (ASH) Admissions

00-04 year olds

Performance funding: <u>25%</u></td><td>Patient Experience Survey

Performance funding: <u>25%</u></td></tr>
<tr><td>12.5%

8 month immunisation</td><td>12.5%

Coding of passive smoking status in 00-04 year olds.

Number of children under four with passive smoking status coded / Enrolled population under four in South Canterbury as at 1st April 2017</td><td>Eligible practices for funding: Practices with ≥ 10% patients seen in survey week respond to survey

number of patients that respond / total number of South Canterbury patients that respond</td></tr>
<tr><td colspan="2">Acute Hospital Bed Days Per Capita

Performance funding: <u>25%</u></td><td>Amenable Mortality

Performance funding: <u>25%</u></td></tr>
<tr><td>12.5%

Brief advice for smokers to quit</td><td>12.5%

Influenza vaccinations to eligible patients 65 years and over</td><td>Eligible practices for funding: Practices with ≥ 90% eligible patients whom have a completed CVDRA within national guidelines.</td></tr>
</table>