Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Ora Toa PHO

Cosine Primary Care Network

Tū Ora COMPASS HEALTH

System Level Measures Improvement Plan 2020/21

Submission 17 July 2020

HCC

Signatories for the 2020/21 CCDHB SLM Plan

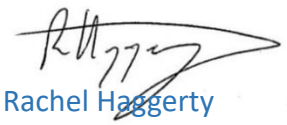
Fionnagh Dougan, Chief Executive
Capital & Coast and Hutt Valley DHBs

Dr Bryan Betty
Chair, Integrated Care Collaborative

Jeff Lowe
Cosine Primary Care Network Trust

Teresa Wall
Chair, Ora Toa PHO

Martin Hefford
CE, Tū Ora Compass Health



Rachel Haggerty
Director, Strategy Innovation & Performance. CCDHB

The Capital and Coast Health System Plan 2030 outlines our strategy to improve the performance of the region's healthcare system. The Plan supports CCDHB aims to improve health outcomes, prevent avoidable demand for healthcare, and improve the use of healthcare services.

CCDHB is responsible for improving, promoting and protecting the health of the people, whānau and communities of our region. This requires CCDHB to collaborate with others to plan and coordinate at local, regional and national levels, to ensure effective and efficient delivery of health services.

The Integrated Care Collaborative (ICC) Alliance is a key mechanism through which the CCDHB HSP will be realised. The ICC Alliance includes primary care, hospital services, planning and funding, ICT, pharmacy, ambulance, consumers and other key partners. The ICC has overseen the implementation of the Health Care Homes, which has enabled initiatives to better integrate community and specialist services. Enablers such as Health Pathways, patient portal, access to patient records across the sector have also been part of the ICC focus. Benefits are monitored through process, quality and impact measures that include some of the national System Level Measures (SLMs).

The COVID-19 response has created opportunity for transformation of models of care. The ICC will champion and progress these over the next year. Some of these opportunities will contribute to achieving the milestones set in the SLM Plan.

The ICC ALT agreed that the milestones for the SLMs should take into consideration the strategic priorities across the sector and focus on equity. All measures within the plan are stratified for Māori, Pacific and non-Māori/Pacific. This is in line with the ICC focus on progressing the pro-equity approach.

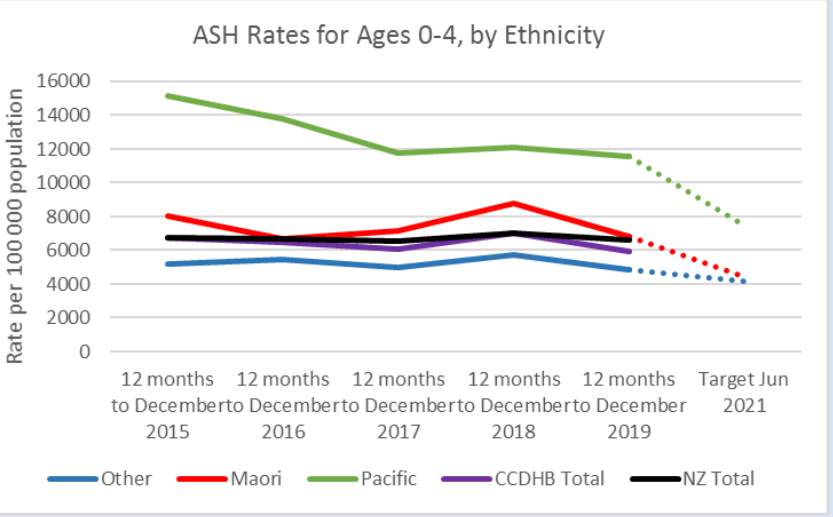
The CCDHB SLM Plan has been developed with the following principles:

- Linked to current strategic priorities
- Build on transformation opportunities created through COVID-19
- Relevant to family & whanau; clinicians; managers
- Focus that improves equity
- Evidence based interventions
- Balancing a mix of outcomes and outputs
- Performance can be influenced through stakeholders and partners
- Return on investment

CCDHB SLM Plan compiled by Dorothy Clendon
Interim Manager – Integrated Care. Strategy Innovation & Performance. CCDHB,
on behalf of the CCDHB Integrated Care Collaborative (ICC) Alliance.

Ambulatory Sensitive Hospitalisations 0-4 Years

One of CCDHB's strategic goals is to improve child health and child health services. Our system will empower all families to maximise their children's health and future potential.

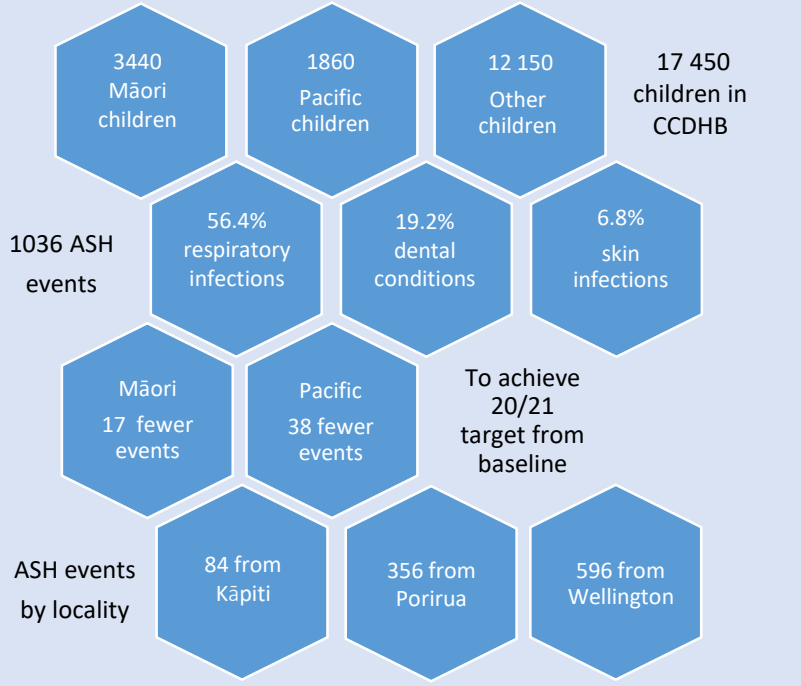


Ambulatory Sensitive Hospitalisation (ASH) 0-4yo 2020/21 milestone: 6% reduction in ASH events for Māori and Pacific, 2% reduction in ASH events for non-Māori/Pacific.

CCDHB's ASH rate for 0-4yo is 10% lower than the national average; however, nationally there has been an increase in the childhood ASH rate. Of the eight DHBs monitored for Pacific ASH rates, CCDHB has the 3rd lowest rate nationally. For Māori children, CCDHB has the 7th lowest ASH rate nationally.

To reduce the equity gap and reduce ASH events, across all populations, will require health & cross sector services to work together. The DHB, PHOs, WCTO providers, dental services, public health, immunization services and hospital teams are partners in the ICC Child & Maternal Network and will oversee SLM plan initiatives.

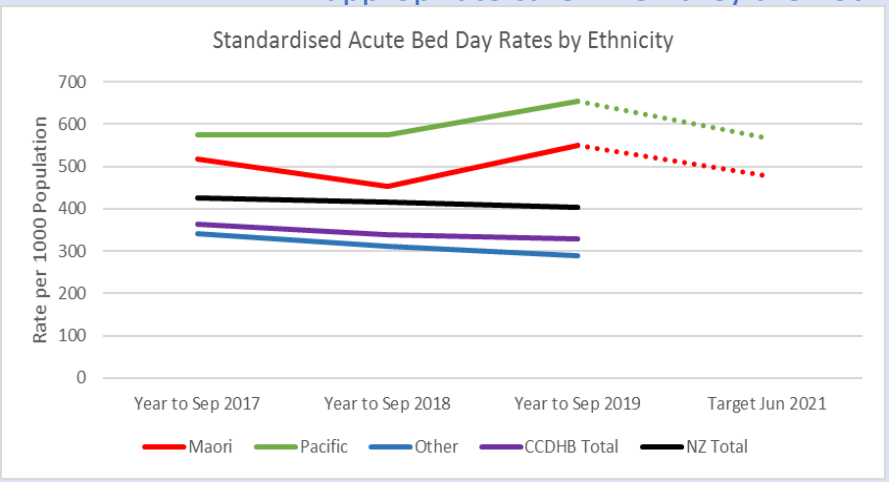
The longer term aim is to ensure that ASH rates for these populations reduce to at least the rates of the non-Maori & non-Pacific population group.



Opportunity	Actions	Contributory Measures
Respiratory conditions contribute the majority of ASH conditions in CCDHB, particularly repeat ASH events. Prevention, effective treatment plans and support during acute episodes will support these children in the community.	• Increase the uptake of influenza vaccination of 6 month - 4 year olds across the DHB. PHOs to continue to generate lists of eligible patients for practices to proactively contact. • Increase the uptake of influenza vaccination of 6 month - 4 year olds across the DHB. The DHB will explore opportunistic influenza vaccination in out-patients at WRH and Kenepuru. • Explore implementing an automated referral process for eligible children to be referred to Porirua Asthma Service or Asthma NZ. • Review the relevant respiratory Health Pathways to reflect best practice. Support prescribers and practice nurses to implement these changes through focussed education sessions and reviewing prescribing practice.	Childhood influenza rate Immunisation rates (8 months, 2 years) Frequency of repeat ASH events for asthma and wheeze for Porirua 0-4 year olds
Create more opportunities for children to access health care in Porirua through ECEs, Kohangas and extending the Porirua Children Ear Service.	• Pilot an extension to the RPH Porirua Children's Ear Service to include skin infections. This service provides free checks for children from 0 to 18 years old and is provided by a registered nurse who has special training in ear health and skin care.	ASH rate 0-4 year olds for skin infections in Porirua
Improved access to primary care, particularly for Māori and Pacific children and families, is central to achieving equity in childhood ASH.	• PHOs to implement National Hauora Coalition programme 'Equity generation 2040' (early pregnancy assessments) and measure the number of early pregnancy assessments completed(by Māori/Pacific/other) • Trial the provision of an after hours GP video service as a way of providing services outside the hospital.	Immunisation rates (8 months, 2 years) Newborn enrolment rate

Acute Bed Days

Better health and independence for people, families and communities is the CCDHB vision. We want our population to be well in the community and supported to receive appropriate care when they are not well.

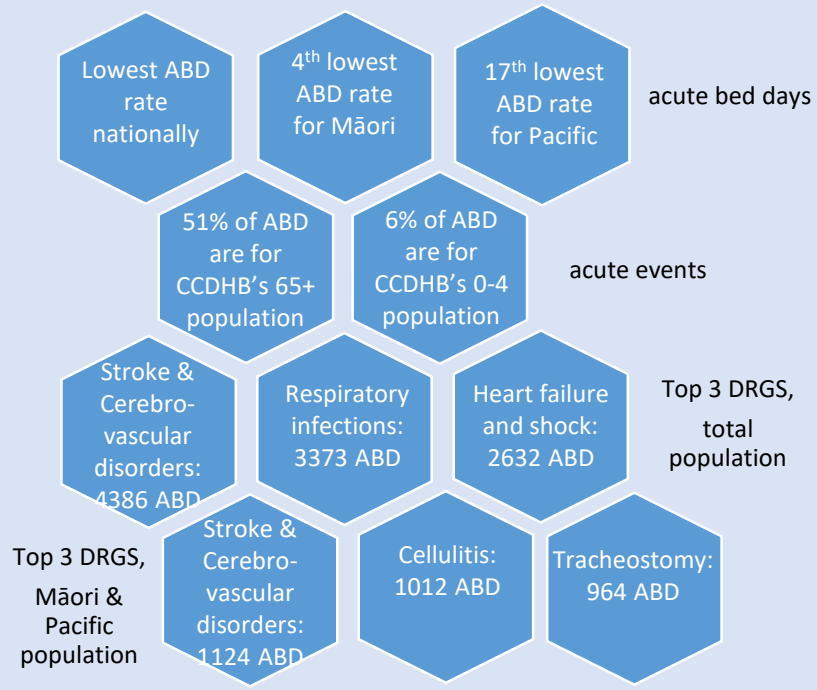


Acute Bed Day (ABD) 2020/21 milestone: 2% reduction in actual acute bed day rate for Māori and Pacific. This equates to a reduction of 466 acute bed days.

The number of acute bed days is complex and attributable to many factors.

The ICC Alliance is providing oversight of a range of initiatives to improve bed occupancy across the system. A newly established Health of Older People (HOP) Steering Group's initial focus is on initiatives to reduce length of stay for older people – namely Allied Health led early supported discharge and a new acute frailty assessment unit.

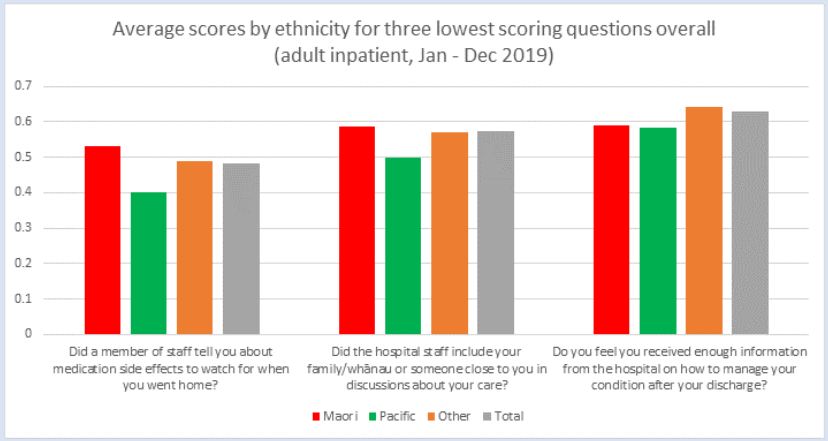
The long-term aim is to ensure that ABD rates for Māori and Pacific populations reduce to at least the same rates of the non-Maori & Pacific population groups.



Opportunity	Actions	2019/20 Contributory measure
Increasing the uptake of flu vaccinations for at risk populations will impact acute bed days over winter months. Achieving a high rate of vaccinations for the health workforce across hospital and community will also minimise spread and subsequent admissions.	• Engage with RPH, Tamariki Ora, ARC and PHOs to confirm/implement the 2020/2021 influenza plan • Standardise health system response when demand increases • Publicise role of pharmacies in providing immunisations • Implement the Increasing Māori Flu Vaccinations Programme	Population vaccinated: • vulnerable children 0-4y– 11% Maori and 10% Pacific • 75% of Maori people 55yrs+ • ARC, PHO - 75% people 65yrs+
Growth in ED presentation numbers continue and have exceeded capacity. Enhancing the management of people in primary care via community based acute response services will support people to receive care in the community. Current age-standardised ED presentation rates to sub-regional hospitals are 212 for Māori, 244 for Pacific and 140 for other ethnicities.	• Review POAC programme for Porirua to increase uptake. • Explore options to extend ambulance diversion into Porirua. • Establish Community Health Network/s in Porirua.	Age-standardised ED presentation rates in sub-regional hospitals for Porirua-domiciled population
Frail older people contribute to a significant volume of bed occupancy due to their complex health and social circumstances. Current age-standardised acute events in sub-regional hospitals for CCDHB-domiciled people aged >65 years are 331 Māori, 411 Pacific and 199 for other ethnicities.	• Implement AWHI (Advancing Wellness at Home Initiative) to support earlier discharge for all CCDHB residents • Establish an Acute Frailty Unit in Wellington Regional Hospital, and reconfigure the CAREFul service to provide comprehensive geriatric assessment and interventions earlier in the patient journey • Extend the reach of the Community Health of Older People Initiative (CHOPI – specialist advice and assessment for Primary Care) across the DHB. • Establish a Community Health Network in Kapiti.	Age-standardised acute admission rates in sub-regional hospitals for CCDHB-domiciled people aged >65 years

Patient Experience of Care

It is vital that patients are involved and partnered with in their care.



The CCDHB health system encourages patients to provide feedback about their experience of care through its complaints and compliments process. New national inpatient and primary care surveys provided by IPSOS are about to be rolled out. This impacts on our ability to monitor change from last year to this year, however it should be noted that there is very little variance from year to year in our results, or results nationally. IPSOS promises a more targeted and therefore better response rate from our prioritised populations and this will be of interest to note and to compare with historic data..

The monitoring of results and feedback of the new surveys will be prioritised and used to inform initiatives that will lead to improved patient experience and outcomes. Meanwhile actions are intended to improve people's experience of cleanliness in Hospital, and contact following treatment in Primary Care, and we will aim for an improvement of 2% for the lowest scoring question for the Primary Care Survey.

Combined reviews between Primary Care and Adult Inpatient have been difficult and hard to compare easily due to different questions. In July, when the new surveys become available, a review will be undertaken to consider how a comparison can be achieved more effectively for the 2020-21 year.

9805 people invited to Primary Care Survey

- 19% response rate; 1700 respondents
- 118 Māori respondents (7% of respondents)
- 63 Pacific respondents (4% of respondents)
- 63% of respondents are female
- 6% of respondents are 15-24 years
- 37% of respondents are 65+ years
- 93% of people invited via email to complete the survey
- 7% of people invited via SMS to complete the survey

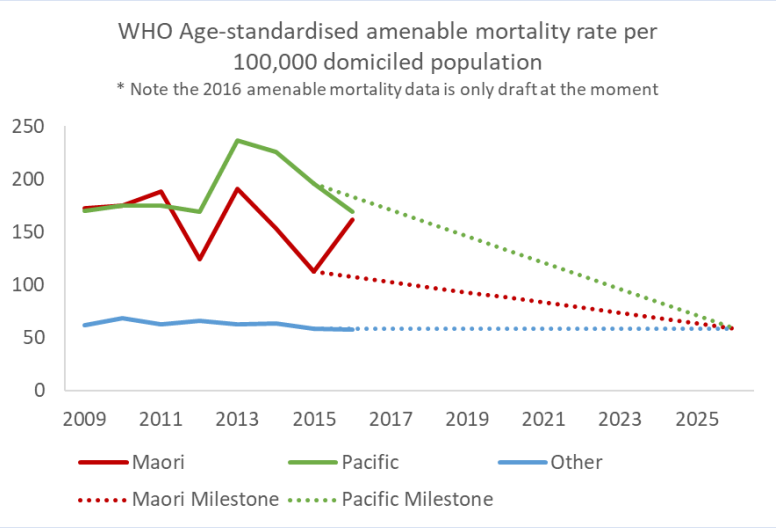
		Communication	Partner-ship	Physical & Emotional Needs	Coordination
Primary Care (Aug 2019)	Māori	8.19 ▬	7.33 ▬	7.73 ▬	8.16 ▼
	Pacific	8.13 ▬	7.40 ▬	7.52 ▼	7.77 ▼
	Other	8.27 ▬	7.51 ▬	8.26 ▬	8.40 ▬
Inpatient (Sep 2019)	Total	8.75 ▲	8.88 ▲	8.83 ▲	8.83 ▲

▲ Above National Average ▼ Below National Average ▬ Same as National Average

Opportunity	Actions	Contributory measure
The new Patient Experience survey is being rolled out in 20/21. This will provide better information about people's experiences with our hospital services. In the 20/21 year there will be a focus on the cleanliness question which directly links to our COVID 19 precaution strategy.	▪ DHB Patient Experience Quality Safety Marker (QSM) oversight group established to oversee the implementation and delivery of consumer engagement and the QSM ▪ Process and template developed for acting on the consumer voice that is already collected and feeding this into the quality improvement cycle ▪ Support implementation of the new patient experience survey by establishing a process to highlight the importance of the survey and to monitor the uptake by populations we know we don't serve so well and try to fill the gap ▪ Work with the provider of the new patient experience survey to ensure we are capturing the voice of all the consumers – especially those in priority groups ▪ Working in conjunction with the cleaning services monitor and improve the response to the 'Were the hospital rooms or wards (including bathrooms) kept clean from median of 72% to 75% for 'Yes Always' responses.	% of patients with a disability who receive and complete the survey Response rates for the ' Were the hospital rooms or wards (including bathrooms) kept clean?
The Primary Care PES will provide improvement opportunities for all practices. In the 20/21 year there will be a focus on 2 questions in the new survey for improvement purposes. The key areas of focus will be on questions related to access and long-term conditions.	▪ Familiarise with the new survey, its format and reporting structure, and develop baseline measures of participation rates. Health improvement practitioners, health coaches and primary care assistants will be involved in the implementation process. Themes and results will be shared and readily visible to all patient-facing staff. ▪ Following the July 2020 rollout of the new 'primary care survey' a focus will be placed on 2 questions (access and long-term conditions) for improvement purposes. ▪ Progress Health Care Home practice development to increase % of year of care plans to improve the response rate by 2% to question "After a treatment or care plan was made were you contacted to see how things were going? "	% of pts with email addresses recorded in the patient management system. commitment to undertake 2 quarterly reviews for 2020. % of YOC plans

Amenable Mortality

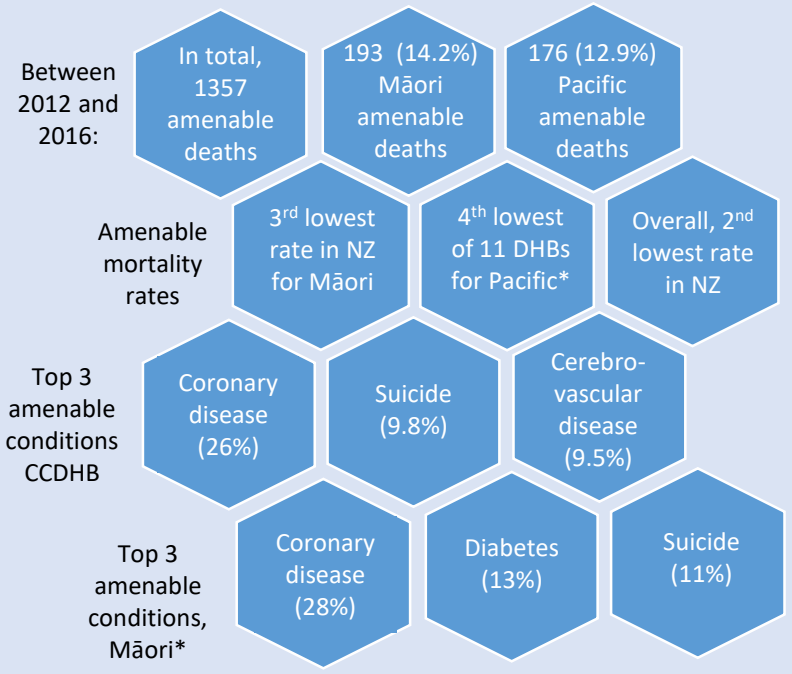
The CCDHB HSP outlines that supporting population interventions to create healthier communities and preventing the onset of long term conditions is a priority in reducing amenable mortality.



Amenable Mortality (AM) 2020/21 milestone: Based on the most recent (2012-2016) data, we aim to reduce Māori AM rate by 3% to 143 per 100, 000; in particular, to reduce the rate of death from CVD by 3% to 81 per 100, 000 by 2022-2026. The long term milestone is that Māori and Pacific AM rates will be equal to Other. In 2014 and 2015, AM rates improved for Māori and Pacific. However, rates have fluctuated due to the relatively small population size and data for 2016 is currently in draft. 2016 draft data suggests more action is required to achieve set milestones.

The time to influence the change in the AM rate and current delay in the reported data are barriers to establishing time relevant milestones for this SLM. In 2014 and 2015, AM rates improved for Māori and Pacific. However, rates have fluctuated due to the relatively small population size.

To achieve Equity in AM rates, requires focus on prevention and pro active care approach to the long term conditions are managed well and people receive the care the need to self manage at home, particularly focusing interventions for Māori and Pacific populations. The CCDHB has taken a long term Equity approach to reduce AM rates to the rate of other, which means the actions taken today will be realised in the future.

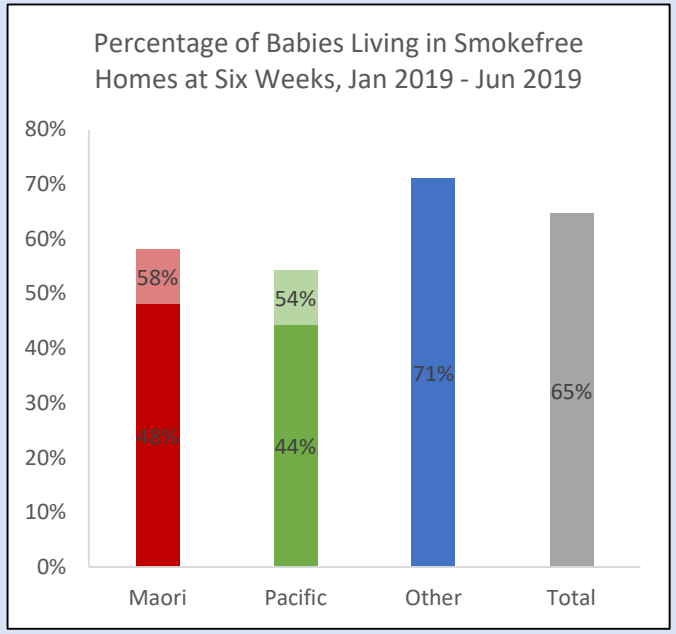


*Rates suppressed due to low numbers; Conditions for Pacific population not published by MOH

Opportunity	Actions	Contributory measure
Effective long term condition management requires a wide range of approaches and increasingly requires an approach that supports a range of co-existing long term conditions. The creation of Community Health Networks which build on the Health Care Home model will enable expand the menu of services delivered closer to home and support better management of long term conditions.	• Enable and extend telehealth options for long-term conditions management in primary care • Establish at least two Community Health Networks in CCDHB • Implement the DHB long term conditions investment plan to develop new models of care to address Māori cardiovascular disease and those at risk of developing LTCs (prevention) • Collaborate to deliver targeted speciality clinical nursing and system navigation for Māori patients and whānau with cardiac and/or long-term conditions • Develop methods to capture ethnicity of primary and community workforce.	Ratio of virtual to face to face consultations in primary care. % enrolled with Manage My Health portal % of Māori hospitalised for diagnosed long-term conditions. DHB Māori workforce proportional to the population. % of Primary and Community workforce who are Māori
Improving CCDHB smoking quit rates will significantly reduce the risk related to a number of long term conditions, the related morbidity and future mortality. Supporting smokers and their families to quit continues to be a focus across the CCDHB system. Smoking quit rates are 8% for Māori, 8% for Pacific and 14% for other ethnicities.	• Use of vaping approaches to support Māori to quit smoking • Support the Whanau Care Services smoking cessation project – working with Māori patients, whanau and staff and addressing system barriers to improve access and uptake	Smoking quit rate Māori quit rate
Cardiovascular disorders and diabetes continue to be the largest causes of amenable mortality for the total population and Māori. Implementing the new screening guidelines that recommend expanded target age bands will activate earlier care for people at higher risk of these conditions.	• PHOs will work with practices with large volumes of people who require screening with a range of activities such as establishing targeted clinics, funding Māori and Pacific men's breakfast event and facilitating men's health groups • Cardiovascular screening practice level data to be included in the Diabetes Clinical Network. The Network will drive cyclical improvement activities to improve screening, including the identification of three key healthy heart messages that can be promoted across the DHB.	Percentage of PHO enrolled population identified as high risk of CVD and not on statin

Babies Living in Smokefree Homes

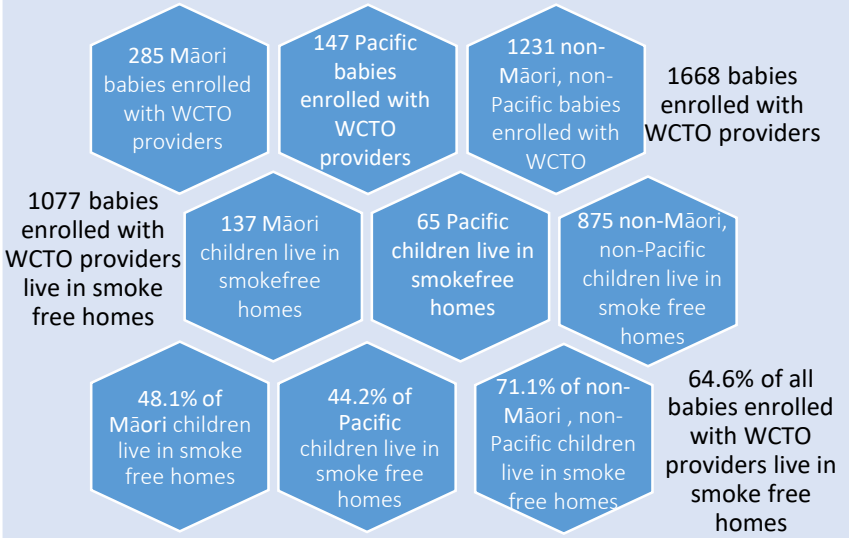
Supporting our whanau and their children, giving them the best start in life, is a CCDHB priority and linked to the national SUDI prevention programme.



Babies Living in a Smokefree Home 2020/21 milestone: 10% improvement in percentage of Māori and Pacific babies live in smokefree homes. This will result in an additional 14 Māori babies and 7 Pacific babies living in smokefree homes.

As the HSP 2030 is implemented, it is expected that all services that support women and children to live well will be connected within a defined locality and linked with their primary health care team. A focus on the first 1000 days for our mātua, pepi and tamariki aligns with the focus early in the population life course approach.

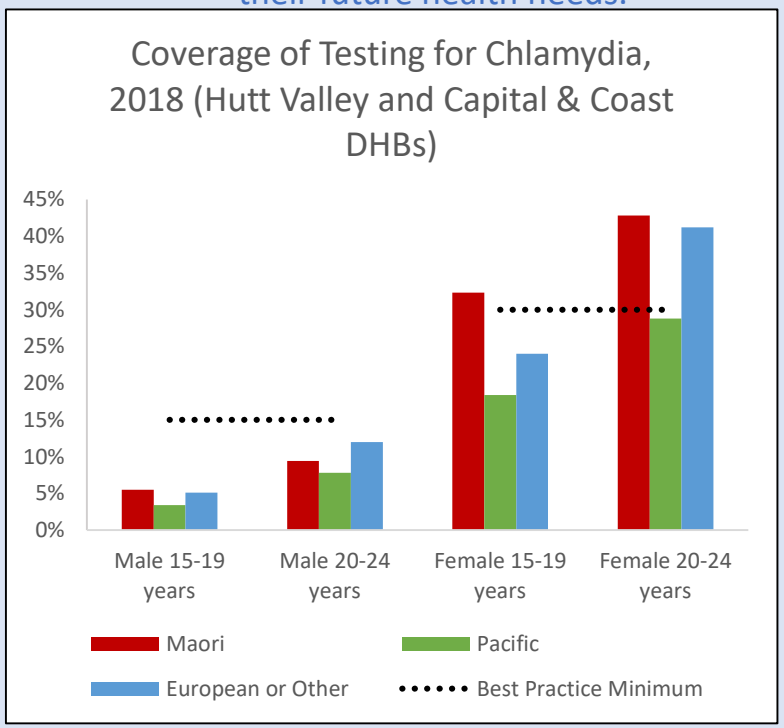
Reducing babies' exposure to tobacco smoke through collaboration between the services focussed on child health and smoking cessation is a key aspect of wellness. The DHB, PHOs, WCTO providers, dental services, public health, immunization services and hospital teams will work in partnership to oversee these SLM plan initiatives.



Opportunity	Actions	Contributory measure
Give our pepi the best possible chance of living in a smoke free household with wrap around support for our mātua, pepi and tamariki aligns	• Increase utilisation of the Hapū Ora Smoking Cessation Incentive programme and Regional Stop Smoking Service by promoting these services through our antenatal education, LMC, breastfeeding services and primary care. • Continue to invest and evaluate the impact of non-traditional approaches to antenatal education including wahakura wānanga, which will deliver smokefree messages and support. • PHOs to strengthen relationships with WCTO providers and collaborative initiatives on health and wellness (which includes smoking cessation).	Utilisation of smoking cessation programmes Mothers who are smokefree at two weeks post-natal
Increasing our focus and support for the whanau surrounding our pepi to be smoke free.	• Education session with prescribers and practice nurses on the effectiveness of smoking cessation treatments and encouraging prescribing of these treatments.	Uptake of cessation service by hapū mama and their whanau

Youth access to & utilisation of youth appropriate services

Supporting our youth to build healthy and safe lives is a focus in the CCDHB HSP. Young people are not high users of the health system, but the choices they make now impact on their future health needs.

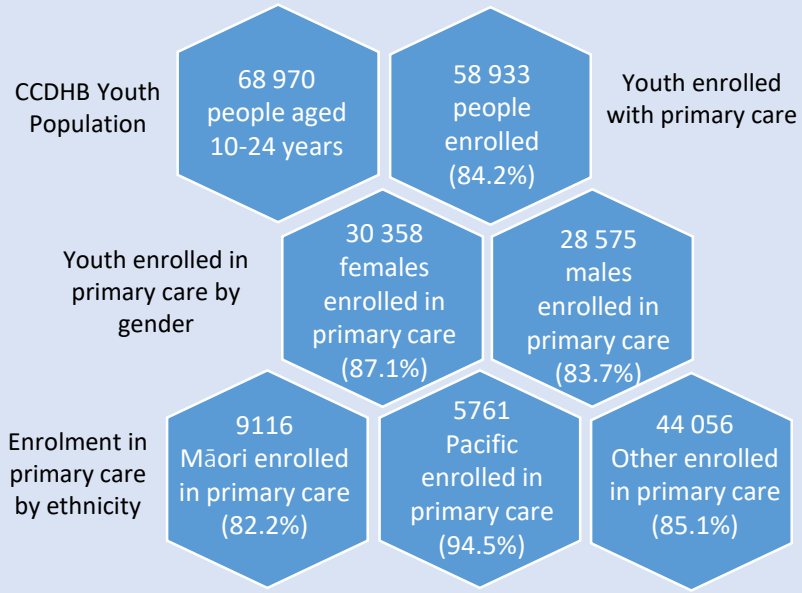


In 2020/21, CCDHB will continue to focus on the sexual health domain of the Youth SLM and aim to support young people to manage their sexual and reproductive health safely by giving them access to youth friendly healthcare.

The 2020/21 milestone is to improve male coverage of testing for Chlamydia by 5%, across all ethnic groups and maintain 32% coverage of testing for females. This will increase tests in males by 2077 and improve testing rates in Māori and Pacific by 11%

Chlamydia is the most commonly reported STI and screening rates vary considerably between gender and ethnicity. Increasing the coverage of chlamydia testing will improve youth engagement with healthcare services. Enrolment in primary care will increase as will utilisation of healthcare services. An improvement in testing coverage will also have positive impacts on unwanted pregnancy rates and mental health conditions.

CCDHB have current projects aimed at improving healthcare services for youth which will positively impact on screening rates.



Opportunity	Actions	Contributory measure
Providing youth with appropriate health services and enrolling youth early in primary care will lead to better health outcomes throughout life.	• Complete data matching exercise between the existing YOSS's and primary care to reflect actual enrolments in primary care. • Work with the SBHS, YOSS's and primary care to ensure youth who are accessing services are enrolled in a practice as well.	Youth enrolment in primary care by ethnicity
Youth often cope with health issues by connecting with friends and whānau and use primary care as a last resort. Engagement in primary care supports health literacy and promotes improved health outcomes.	• Establish a YOSS for Porirua. • Continue to work with primary care to use vaccinations as a method of providing opportunistic testing. • Develop a quick test kit in co-design with youth.	Utilisation of primary care health services
Youth can feel worried or anxious about sharing sensitive information especially if it may impact on how they are perceived. Providing a platform to share important information confidentially will improve outcomes.	• Trial the SXT anonymous contact tracing app in the sexual health service	Utilisation of primary care health services