CANTERBURY HEALTH SYSTEM

# System Level Measures

# Improvement Plan

## 2020-21


# INTRODUCTION

This 2020/21 System Level Measures Improvement Plan was drafted prior to Covid-19 having an impact in New Zealand and was submitted to the Ministry of Health (MoH) while the Canterbury Health System was in the midst of its pandemic response.

The draft Canterbury 2020/21 System Level Measures Improvement Plan was approved by MoH, however Canterbury asked for the opportunity to review the Actions to Improve Performance in the plan to ensure that these were still a priority, relevant and able to be achieved in the changed working environment due to Covid-19. MoH agreed to Canterbury undertaking this review.

The outcome of our review was that all alliance groups felt their Actions to Improve Performance were still relevant in a Covid-19 environment and two new actions were added for 0-4 year old ASH Rate and Acute Hospital Bed Days; these are respectively:

- Refine the process for children who are not engaging with oral health services.
- Support existing Pacific health providers to improve health services for Pacific peoples.

The Canterbury Health System places a high priority on implementing the System Level Measures Framework to support change and system improvement. The connections and trust developed through our alliancing approach not only contributes to delivering on Actions to Improve Performance within the System Level Measures but supports our health system to work effectively together. We are pleased to report we have comprehensively progressed the *Actions to Improve Performance* detailed in Canterbury's 2019/20 Improvement Plan.

Commitment to Te Tiriti o Waitangi and working towards equitable outcomes is integral to the Canterbury Health System and is central to the development of contributory measures within this plan. We recognise that the health and wellbeing of our population is determined by factors both within and beyond the health system (wider determinants of health). Setting measures focused on increasing equity shows our commitment to improving health outcomes for those who do not have fair or equitable access to these factors, in particular health services.

For the factors within the health system, many of our actions address access to health services. We recognise that inequitable access to health services can occur for a myriad of reasons from those that are personal through to those that are institutional, and we are working to reduce these gaps in all areas of this plan.

Then, to reflect our recognition of the factors outside the health system, we have included actions that the Canterbury Health System take to influence the wider determinants of health through its partnerships with governmental, social and other non-health agencies and sectors. The work of Community and Public Health, the public health division of Canterbury DHB, is central to the way the health system connects with other agencies and sectors that can influence policies so that they have a positive impact on whānau health and wellbeing.

It is important to us that the health system is whānau and people centred. To strengthen this, we have started on a journey to re-design the way we co-design services. Our engagement with the community is maturing and deepening to allow the community to better inform the health system what its priorities are. For 2020/21 we have re-developed our approach to Patient Experience of Care and will be seeking input from Māori and Pacific peoples through focus groups to recommend improvements to primary care.

Many of the contributory measures support improvement in more than one System Level Measure. For instance, smoking cessation not only contributes to amenable mortality, but also impacts upon respiratory illnesses contributing to our 0-4 year old ASH Rates, it can contribute to the severity of illness if a person is hospitalised and therefore impacts upon Acute Hospital Bed Days and reducing the number of people who smoke in Canterbury, will improve the rate of babies living in smokefree homes.

To understand how well the Canterbury Health System is improving and reducing the equity gap, data accuracy is vitally important. We have improved the way ethnicity data is collated to ensure priority groups are counted accurately. Using ethnicity prioritisation protocols a master ethnicity is coded through collating information collected from multiple patient management systems. This is a work in progress as we also improve collection of ethnicity data across the system.

Key changes in our 2020/21 Improvement Plan include updating the Actions to Improve Performance and refining some contributory measures in the Patient Experience of Care and Amenable Mortality SLMs.

## MESSAGE FROM SIR JOHN HANSEN

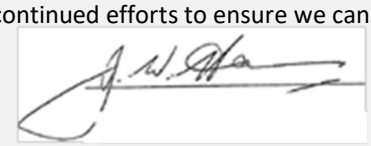
ALLIANCE LEADERSHIP TEAM CHAIR | CANTERBURY CLINICAL NETWORK

Our commitment to a shared vision centred on the needs of our people and their whānau continues to guide our collective approach to reducing inequities and improving the health outcomes of our population. This collective way of working is supporting Canterbury's response to Covid-19 with staff moving seamlessly between organisations and taking on different roles in new teams to deliver what is needed. While this response and transition back to full service delivery is currently taking much of our attention, as capacity allows people from across the system are reviewing and adjusting priorities and timeframes. The impact on our System Level Measures activity will be confirmed over the coming months, but we anticipate the key priorities of this year's plan will remain unchanged.

Key changes to progress in 2020/21 include:

- continuing to focus our efforts in our commitment to Te Tiriti o Waitangi and equity, including the work currently underway in partnership with Māori, Pacific and minority ethnic groups to gain greater insight into their experience of care to improve access to our priority population and reduce inequities;
- developing a measure to monitor the change in physical health outcomes for people with serious mental illness and/or addiction who have completed the Equally Well physical health programmes; and
- strengthening partnerships with Community and Public Health (CPH) around SLM activity, who will lead actions that contribute to improved performance in Ambulatory Sensitive Hospitalisation for 0-4 Year Olds and Amenable Mortality.

The groundwork we've done to build connections and trust over the last decade helps to ensure we are well placed to work effectively together, especially when times get tough. Thank you all for your continued efforts to ensure we can deliver high-quality health services to our community.



David Meates
Chief Executive Officer
Canterbury DHB

Peter Townsend
Chair
Pegasus Health Charitable Ltd

Dr Lorna Martin
Chair
Waitaha Primary Health

Dr Angus Chambers
Chair
Christchurch PHO

## INTEGRATING THE SYSTEM LEVEL MEASURES FRAMEWORK INTO OUR HEALTH SYSTEM

Canterbury's way of working brings together expert groups, including Service Level Alliances, Workstreams, and workgroups within the Canterbury Clinical Network Alliance with the aim of leading change in health services that improve the health outcomes of our population. Typically, these groups include urban and rural clinicians who participate in the services, people that bring consumer, Māori, Pacific and rural perspectives, and management from the relevant organisations.

An alliancing group has been identified to lead each of the System Level Measures contributory and system measures and associated activity. A table illustrating which group(s) are leading each of the contributory measures is included in Appendix One. Also shown in this table are the groups that link with and/or support this activity. A System Outcomes Steering Group involving clinical leaders from across the system, public health experts, quality improvement staff, analysts and planners is in place to guide Canterbury's ongoing development of the System Level Measures framework. Figure 1. Illustrates the roles of this Steering Group and various expert groups.

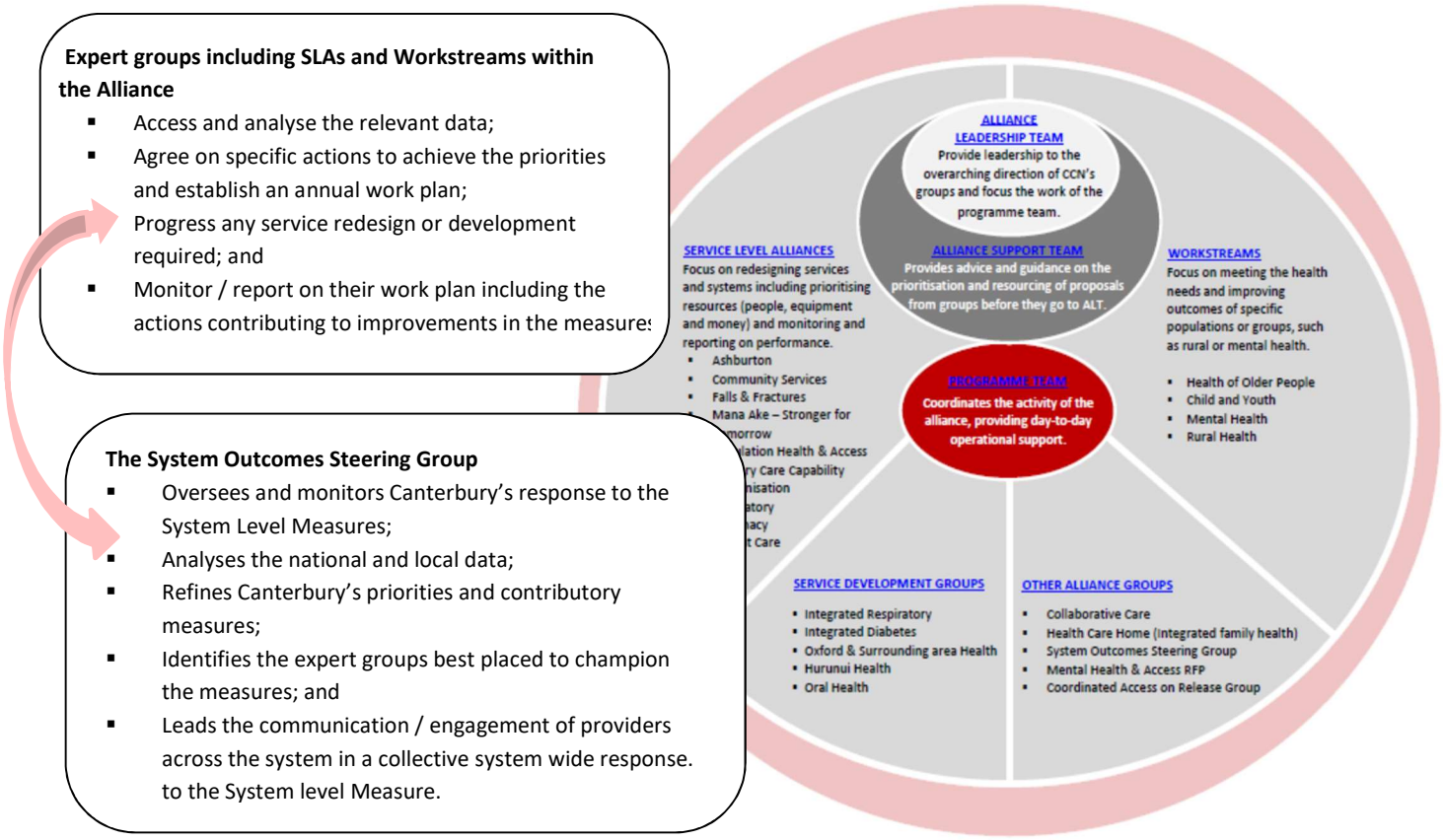



*Figure 1: Summary of the role of the System Outcomes Steering Group and the expert groups leading each contributory measure.*

Four key priorities of the Canterbury Clinical Network Alliance are Productive Partnerships, Meaningful Engagement, Prioritise Equity and Redefine our Alliance. These are woven into the development of the Canterbury System Level Measures Improvement Plan.


**OUR ALLIANCE PARTNERS**

All alliance partners agree to act in accordance to the alliance charter, adhering to the alliance principles and rules of engagement.

Access Homehealth · Healthcare NZ Community Health · Pegasus · Waitaha Primary Health · Nurse Maude · New Zealand College of Midwives Inc · St John Here for Life · Pacific Radiology · SCL · christchurch pho · Canterbury Community Pharmacy Group · Canterbury District Health Board Te Poari Hauora o Waitaha

## KEY ACHIEVEMENTS

Significant progress has been made towards the *Actions to Improve Performance* identified in Canterbury's 2019/20 Improvement Plan. A snapshot of some key achievements are highlighted below.

**ASH Rates for 0-4 Year Olds**

A process was implemented for improving ethnicity data accuracy in the CDHB Data Warehouse. This involves the comparison of the National Enrolment Service (NES) and CDHB Patient Management Systems records to derive a patient master ethnicity value for each patient based on Statistics New Zealand ethnicity prioritisation. This means that if a patient is recorded in either source as Māori, their master ethnicity will be recorded as Māori.

Since this improvement, Canterbury has experienced an increase in the ASH rate for Māori, this is likely partly contributable to having more accurate ethnicity data resulting in better understanding of the 0-4 year old ASH Rate for Māori tamariki.

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**Acute Hospital Bed Days**

Pilot developed for the referral of falls patients taking 10 or more regular medicines (polypharmacy) for a Medication Therapy Assessment (MTA). During 2020/21 we will evaluate the success of this pilot and look to develop this across all Canterbury PHOs.

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**Patient Experience of Care**

We are evolving the way we look at the Patient Experience of Care System Level Measure including looking wider than the Patient Experience Survey to get feedback from consumers. During 2019/20 a review Canterbury's co-design methodology started with the aim of modifying our approach to ensure the voices of Māori, Pacific and minority groups come through more prominently in the design of health services.

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**Amenable Mortality**

Canterbury's Equally Well initiative links people with serious mental illness and/or addiction with physical health programmes to improve physical health for this group. 2020/21 will see the development of a measure to monitor the change in physical health outcomes for people with serious mental illness and/or addiction.

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**Youth Access to Health Services**

Focus groups were held with youth and all dental practices in Canterbury were surveyed to better understand why adolescents do not engage with oral health services. Both these avenues told us that parents are key to children's engagement with services, and that adolescents and often their parents have limited knowledge of oral health services, and the importance of annual reviews.

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**Babies Living in Smokefree Homes**

A programme was established where any pregnant woman who smokes who attends, at a minimum, the first consult with smoking cessation provider Te Hā - Waitaha received a safe sleep device in the third trimester of their pregnancy. Most clients received a pēpi pod, however during 2020/21 we aim to ensure all Māori whānau are offered a wahakura first.

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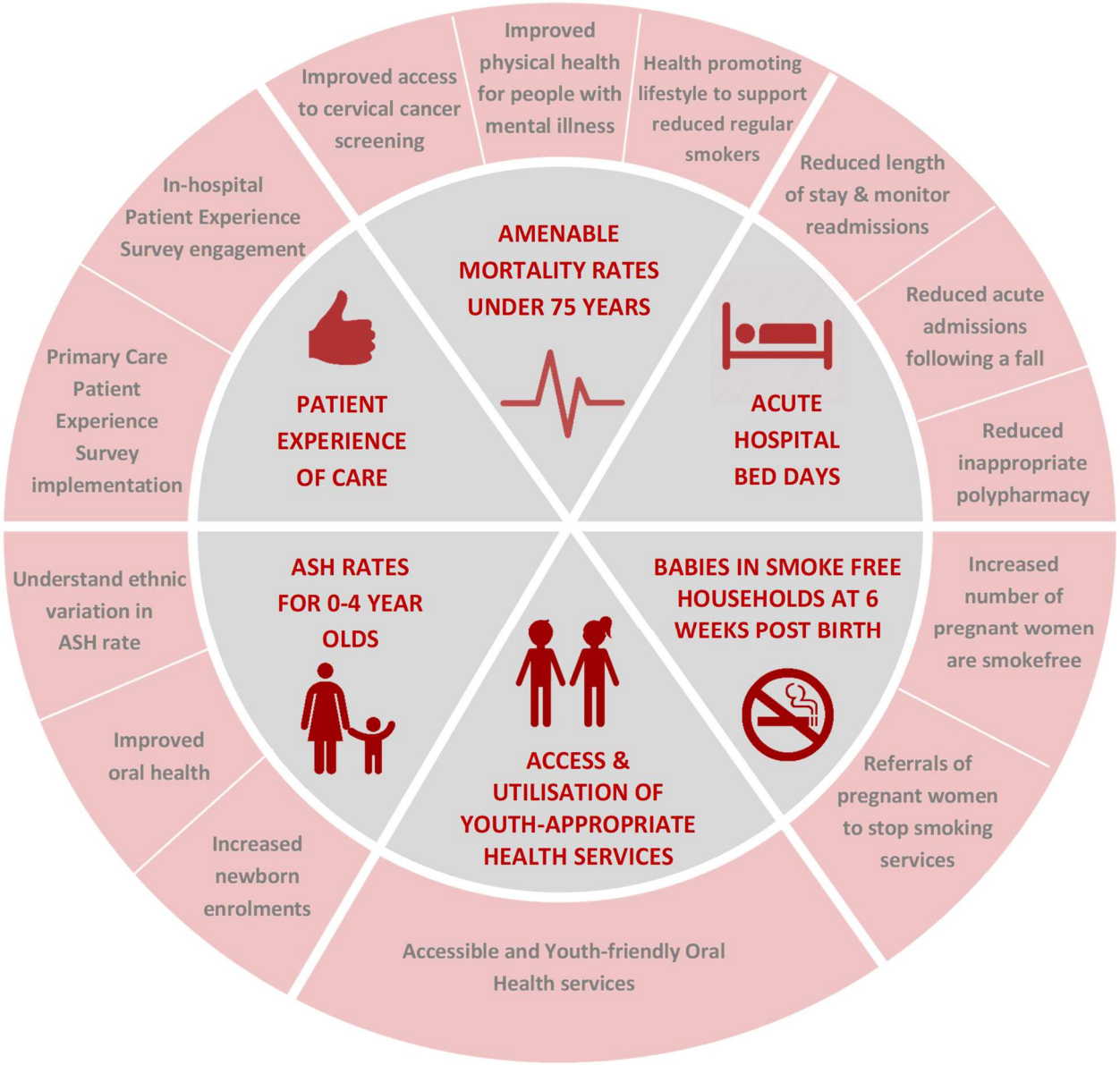
# CANTERBURY'S SYSTEM LEVEL MEASURES FRAMEWORK

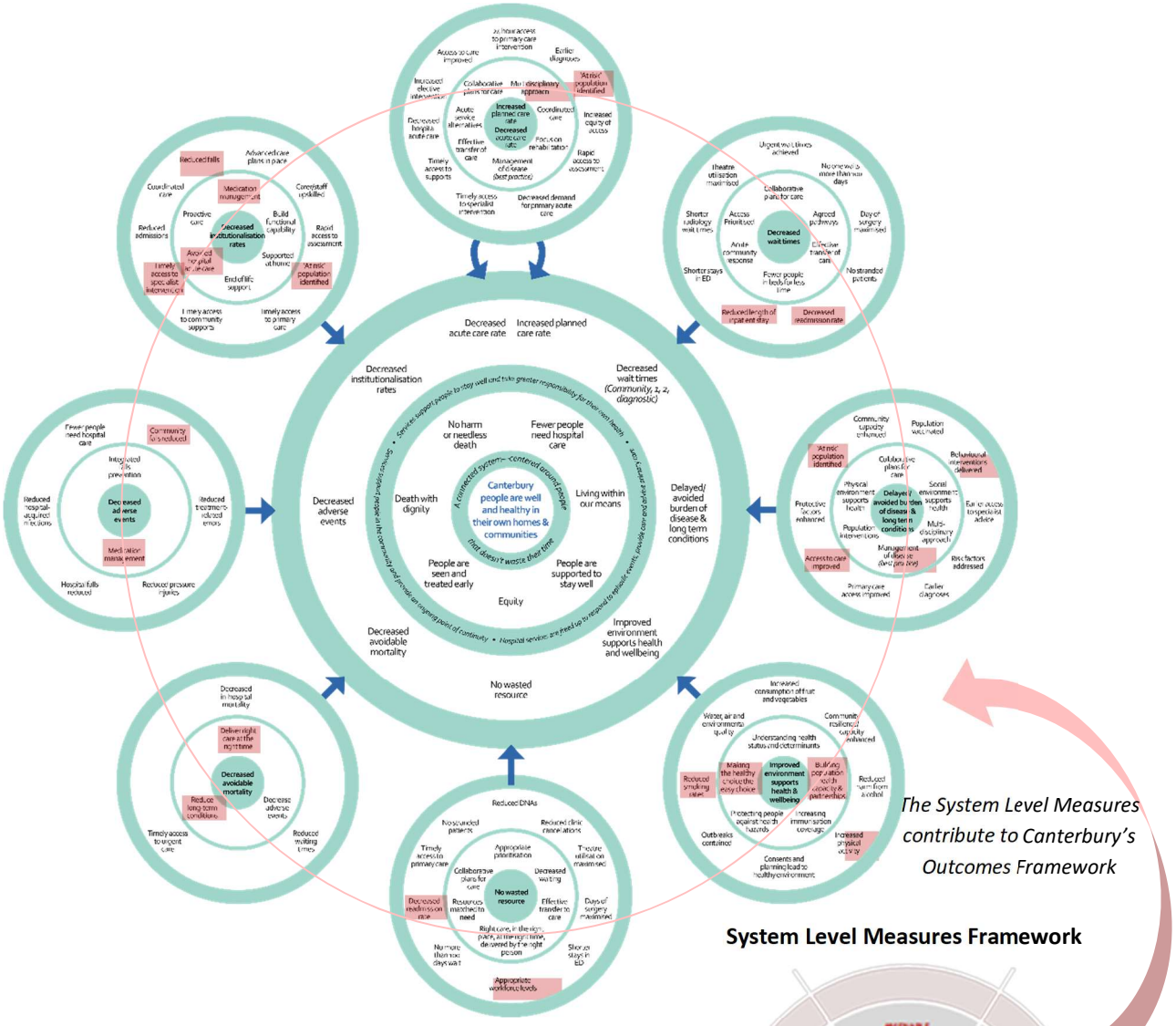
The diagram below demonstrates Canterbury's System Level Measures Framework. In the centre are the System Level Measures and circling those are the locally-selected contributory measures. Further detail on each contributory measure is provided below.



# HOW IT ALL FITS TOGETHER

The Canterbury Health System has tracked performance of our increasingly integrated and person-centred approach through the Canterbury Health System Outcomes Framework since 2013. The System Level Measures and contributory measures detailed in this Improvement Plan are integrated into our existing Outcomes Framework to demonstrate their alignment with Canterbury's approach. The measures identified in this document have been highlighted below within Canterbury's Outcomes Framework to illustrate this alignment.

**Canterbury Health System Outcomes Framework**




*The System Level Measures contribute to Canterbury's Outcomes Framework*

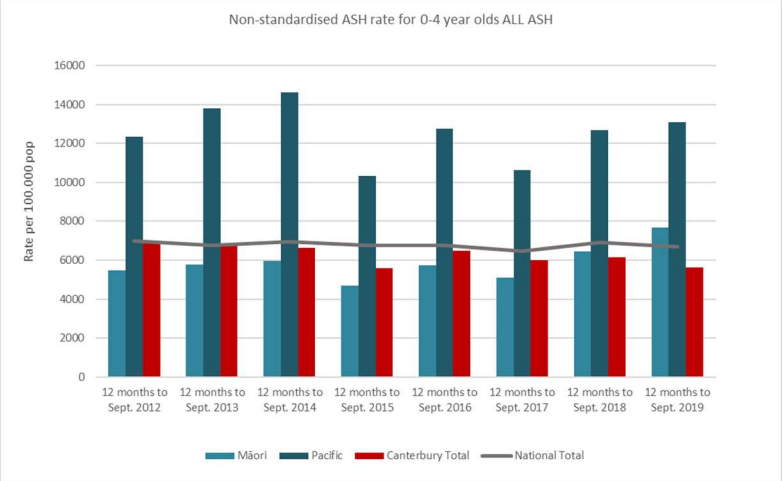
**System Level Measures Framework**

**System level measure:**

# AMBULATORY SENSITIVE HOSPITALISATION RATE FOR 0-4 YEAR OLDS

## CANTERBURY'S EXPERIENCE

Our priority is to reduce the ethnic variation in the ambulatory sensitive hospitalisation (ASH) rate between the Pacific and Total populations.




At September 2019 Canterbury's ASH rate for 0-4 year olds of 5,645 per 100,000 population is below the national average for the Total population[1]. When viewed over the previous four years, it has decreased slightly over the previous year.

Canterbury's 0-4 year old ASH rate for the both Pacific and Māori populations are higher than the Total population rate, at 13,095 per 100,000 and 5,369 per 100,000 respectively. Viewing Canterbury's data by medical conditions illustrates:

- The Upper Respiratory and Ear Nose and Throat (ENT) Infections category is the largest contributor to Canterbury's ASH rate, at 1,667 per 100,000 Population, however has reduced on the year prior.
- Canterbury's 0-4 year old ASH rates for Upper Respiratory and ENT Infections and Lower Respiratory Infections are higher than the national average.

In 2019/20 a process was implemented for improving ethnicity data accuracy in the CDHB Data Warehouse. This involves the comparison of the National Enrolment Service (NES) and CDHB Patient Management Systems records to derive a patient master ethnicity value for each patient based on Statistics New Zealand ethnicity prioritisation. This means that if a patient is recorded in either source as Māori, their master ethnicity will be recorded as Māori.

In addition to this a research project has commenced to gain better understanding of the accuracy of ethnicity data in the health system. The research project will use data from the Statistics NZ Integrated Data Infrastructure (IDI) to provide knowledge about the accuracy of the ethnicity information contained in health datasets for the Canterbury population. Ethnicity data in health datasets will be compared to ethnicity data given in the Census and other datasets.

Since commencing the process of developing a master ethnicity, Canterbury has experienced an increase in 0-4 year old ASH Rate for Māori. It is likely this is partly contributable to the improved accuracy in recording Māori ethnicity. Prior to this Māori had a lower 0-4 year old ASH Rate than the Total Population. Improvements in ethnicity accuracy allow us to better understand how Canterbury whānau are affected by ASH and develop services to meet these needs.

*[1] The National Minimum Data Set of ASH Rate for 0-4 year olds to September 2019 using the New Zealand Standard Population informed Canterbury's analysis and establishment of the 2020/21 milestones.*

Outside the health system, we recognise that the quality housing has a major impact on ASH rates. As in the rest of New Zealand, Canterbury's housing stock, in particular, rental accommodation is not of a standard and is frequently damp and cold. This is a particular issue for Māori, Pacific and low income whānau.

## MILESTONE

Canterbury's internal target is to reduce the Pacific inequity in ASH rates, however the relatively small number of admissions and resulting inherent variation limits the viability of setting a numerical milestone. In addition, analysis of the leading conditions contributing to the ASH rate confirms that influenza, gastro-enteritis outbreaks and dental elective volumes have a significant influence on the yearly variation in ASH rate for 0-4 year olds across all populations. Acknowledging these challenges, the average ratio between the Total and Pacific populations (Total rate: Pacific) has been selected as the soundest approach to setting a milestone.[2]

The small actual numbers involved with the Pacific ASH rate mean there is potential for large fluctuations from quarter to quarter, for example, the addition of just 10 admissions for the 12 months ending September 2019 over the previous year increased the rate by 12% and increased the ratio by 0.25, the ratio was further compounded by a relatively low number of admissions for Canterbury Total for the same period. To reduce the effect of fluctuations due to the small Pacific population in Canterbury the milestone has been calculated based on a four-year average.

The four year average for previous years has been 1:2.02 and 2.11. For the third 12 month period in a row to September, the Pacific rate has increased. As we are not in a reducing trajectory for the group we are targeting, our milestone over 2020/21 is to at least maintain the average ratio (Total rate: Pacific) over four years, to achieve no further increases in the ratio of 1:2.11, by June 2021.

As further data is gathered to better understand the increase in the ASH rate for our Māori population we will develop a milestone and actions to reduce these inequities.

## CONTRIBUTORY MEASURES

### ASH RATE – VARIATION BETWEEN POPULATIONS

*Outcome sought:* Understand the variation that exists between the Canterbury Total and Canterbury Pacific populations, with a focus on the ASH admissions for 0-4 year olds coded with Upper and ENT Respiratory Infections.

*Rationale for selection:* A variation in the ASH rate for 0-4 year olds exists between the two population groups. This is evident in the Diagnosis Related Group (DRG) category Upper and ENT Respiratory Infections which is the single largest contributor to the ASH rate for 0-4 year olds and is above the national average. The September 2015 ratio between the Total and Pacific population of 1:1.96 has increased to 1:2.32 in September 2019, true progress will be achieved through monitoring our progress over an extended period to account for inherent variation.

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*[2] Target setting for ASH rates is difficult due to the uncertainty around projecting future rates, based on the inherent variability of events in a relatively small population. For the 12 months to September 2014, the ASH rate for Pacific 0 to 4 year olds was 14,225 per 100,000 population, with a calculated 95% confidence interval of 12,707 to 15,744; for the Total population the rate was 6,583, and the 95% confidence interval was 6,300 to 6,865. For the purposes of projecting a future target, based on these data, the ratio of Pacific to Total ASH rates may lie between 1.85 (using the lowest extent of the 95% confidence interval for Pacific and the highest for Total population) and 2.50 (using the highest extent of the 95% confidence interval for Pacific and the lowest for the Total population). The ASH rates and the ratios therefore need to be interpreted with caution and looked at over a longer reporting period.*

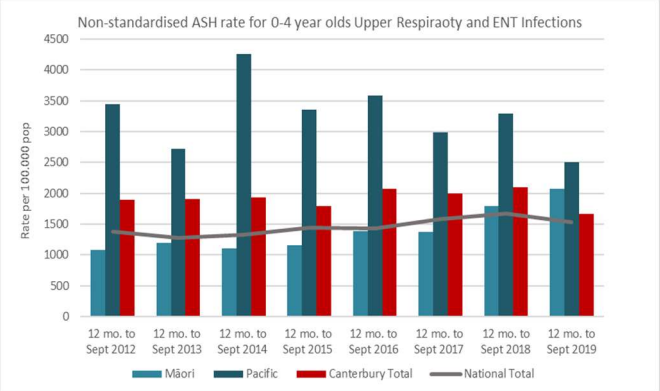
*Measure description:*

The rate of 0-4 year olds admitted with a code of Upper Respiratory and ENT Infections and the gap that exists between the ASH rate for 0-4 year olds in Canterbury's Pacific and Total populations.

*Numerator:* The number of ASH admissions for 0-4 year olds coded with Upper and ENT Respiratory Infections.

*Denominator:* The number of 0-4 year olds.

*Data source:* Ministry of Health data released quarterly.




## ORAL HEALTH

*Outcome sought:* An increase in the number of children who are caries free at five years of age.

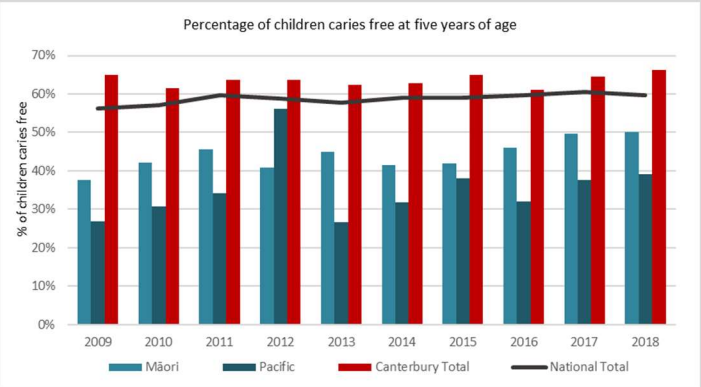
*Rationale for selection:* Dental conditions are the fifth largest contributor to Canterbury's ASH rate for 0-4 year olds with a rate of 540 per 100,000 at September 2019. In addition, there is local variance between population groups in both caries free and enrolment in the Community Dental Service. This measure has been selected from a number of oral health / child health indicators, including the enrolment of children in the wider health services. It should be noted that Canterbury currently does not add fluoride to its water supply, unlike many North Island and some South Island metropolitan areas.

*Measure description:* The percentage of children caries free at five years of age.

*Numerator:* At the first examination after the child has turned five years, but before their sixth birthday, the total number of children who are caries free (decay or filling free).

*Denominator:* The total number of children who have been examined in the five-year-old age group, in the year to which the reporting relates.

*Data Source:* Community Dental Service.




## INCREASED ACCURACY OF ETHNICITY CAPTURE

*Outcome sought:* Increase the accuracy of ethnicity capture of new borns enrolled in general practice.

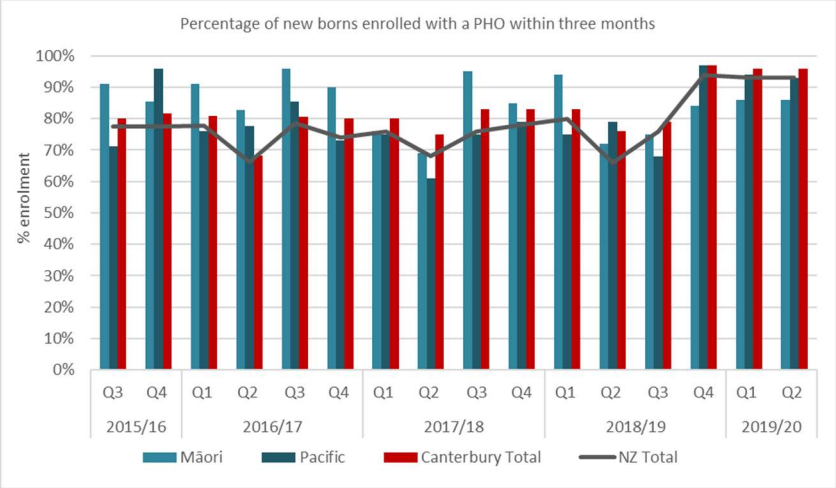
*Rationale for selection:* The collection of robust quality data enables the monitoring of access rates and results by ethnicity; this in turn supports improved health planning and design and delivery of services aimed at reducing health inequities. Any inaccurate capture of ethnicity at birth follows the newborn's registration into other services.

*Measure description:* This measure requires further analysis to identify the contributors of the inaccurate ethnicity capture, the subsequent actions required and the key metric for monitoring change. In the interim, the new borns enrolled in a PHO within three months by ethnicity illustrated below, will be monitored.

## INCREASED NEWBORN ENROLMENT

*Outcome sought:* An increase in the number of new borns enrolled in general practice.

*Rationale for selection:* Early enrolment in general practice and the wider health services (including Well Child Tamariki Ora and the Community Dental Service) is a foundation for patients accessing health care. There is variability in the new born enrolment coverage, most noticeably in the Pacific population.




*Measure description:* The percentage of new borns enrolled with a PHO within three months.

*Numerator:* Number of infants under three months enrolled with a PHO.

*Denominator:* Number of births reported to the National Immunisation Register. Note the register includes all babies born in Canterbury, some of whom are not from our region.

## ACTIONS TO IMPROVE PERFORMANCE: ASH RATE FOR 0-4 YEAR OLDS

| Contributory Measure | Actions to Improve Performance | Responsibility | Other SLMs the actions contribute to |
|---|---|---|---|
| *ASH Rate* | ▪ Finalise provision of data to general practices of their enrolled 0-4 year olds who are admitted to hospital with an ASH event.<br>▪ Develop a HealthPathway that suggests what general practitioners can do to reduce re-admissions for 0-4 year olds from their practice that have been admitted to hospital with an ASH event in the previous quarter.<br>▪ Develop and implement a process to refer children admitted with respiratory conditions for a healthy home check – reducing damp, smokefree etc.<br>▪ Implement a targeted influenza immunisation plan for 0-4 year olds with chronic respiratory conditions, with a focus on Māori and Pacific.<br>▪ Collaborate with housing providers, such as Kainga Ora, to strengthen pathways for primary and secondary healthcare providers to identify and respond to poor quality housing.<br>▪ Advocate for local, regional and national policies that promote healthy housing. | A project group within the Child and Youth Health Workstream and Community and Public Health | ▪ Acute Bed Days<br>▪ Amenable Mortality<br>▪ Babies in Smokefree Homes |

| | | | |
|---|---|---|---|
| *Oral Health* | ▪ Work with community dental services on the targeted recall system based on clinical need.<br>▪ Develop communication that strengthens caregivers of children aged 0-2 years understanding of oral health.<br>▪ Refine the process for children who are not engaging with oral health services.<br>▪ Continue emphasis on oral health initiatives in early childhood education, e.g. promotion of the Menemene Mai toolkit. | Oral Health Service Development Group and Community and Public Health | |
| *New Born Enrolment* | ▪ We will ensure children not enrolled in general practice are supported to be in contact with the health system, with a focus on Māori children. | Immunisation Service Level Alliance and PHOs | |
| *Increased Accuracy of Ethnicity Capture* | ▪ Implement refreshed training on the 2017 Ethnicity Data Protocols to increase accuracy of ethnicity recorded in Maternity Hospital Specialist Services, with a focus on reaching community midwives and ward clerks. | Immunisation Manager and PHOs, Māori and Pacific Reference Groups | |
| *All Measures* | ▪ Continue policy work including maintenance of best evidence relating to housing and other relevant issues to inform position statements and submissions. | Community and Public Health in consultation with wider system | |

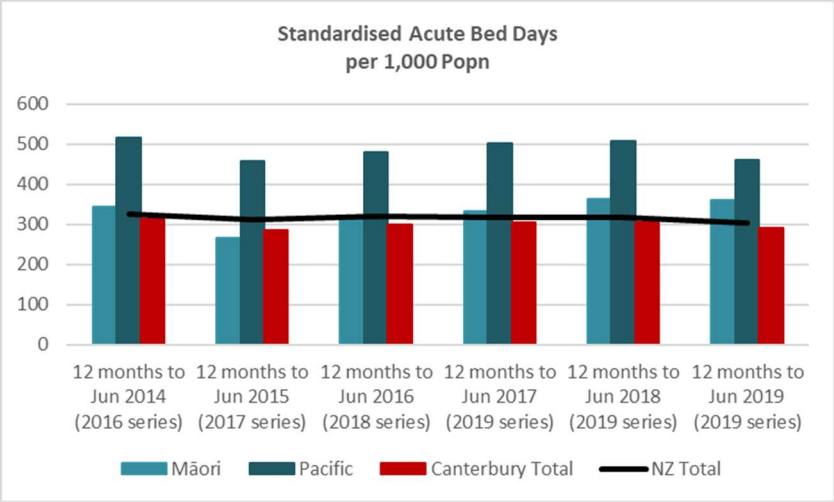
**System level measure:**

# ACUTE HOSPITAL BED DAYS

## CANTERBURY'S EXPERIENCE [3]

Our priority is to further reduce the acute hospital bed day rate for the Total population, while optimising hospitalisation for all ethnic groups.

Averaged over the three years to June 2019, Canterbury DHB's Age Standardised Acute Bed Day rate of 301 per 1,000 population was 4% lower than the New Zealand Total rate of 313 per 1,000. Viewed by ethnicity[4], averaged over the three years Canterbury's Standardised Acute Bed Day rates for the Māori population (352 per 1,000) and Pacific population (490 per 1,000) are higher than Canterbury's Total Acute Bed Day rate; while the Other population rate is lower at 292 per 1,000 population.




Māori and Pacific perspectives are an embedded part of Canterbury's Alliance; membership across expert groups and Reference Groups offer guidance in all aspects of service design and redesign.

Viewing Canterbury's data by medical conditions illustrates that the Stroke and Other Cerebrovascular Disorders category remains the largest contributor to Canterbury's Acute Bed Day rate at 21 per 1,000 population, and is higher than the national average of 18 per 1,000. In 2019/20 data collection has commenced from the StrokeViewer software tool with plans for this to inform development of an early supported discharge model for stroke patients.

Over 2019/20 work continued to implement innovative approaches to the funding and the delivery of health services that align with a Pasifika view of health. To support this work, a Pasifika dental service will be implemented around the end of 2019/20 through access to existing dental chairs and related infrastructure, outside of standard work hours. Pasifika Futures will employ dental staff to work in these clinics.

During 2019/20 the Polypharmacy working group continued to facilitate improvement across the system by piloting a pathway for referring older people that have had a fall and taking 10 or more regular medicines for a Medication Therapy Assessment (MTA). During 2020/21 we will evaluate the success of this pilot and look to develop this across all Canterbury PHOs. Also, during 2019/20 the group championed the sharing of adverse drug reactions data recorded within secondary care across the system. This dashboard is now shared with all PHOs providing visibility of this for general practitioners.

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*[3] The National Minimum Data Set Acute Hospital Bed Days to June 2019 (using Age Standardisation to the WHO 2000 Standard Population) was used to inform Canterbury's analysis and establishment of the 2020/21 Milestones.*

*[4] The National Minimum Data Set Acute Hospital Bed Days to June 2019 (age standardised using WHO 2000 Population Standard) by prioritised ethnic groups*

The group also identified a need to improve general practitioners' visibility to see which of their patients are prescribed multiple medications. Presently only one PHO offers full capability in this space, recommendations have been made to increase this capability across all PHOs and work will continue in this space during 2020/21.

Progress continues with enhancing restorative care services in rural areas across Hurunui, Oxford and surrounding communities.

- During the year practice and district nurses from these communities completed Enable Accreditation to provide low-cost, high-volume Occupational Therapy (OT) equipment, meaning the OT resource from Christchurch can focus on more complex patient needs in rural settings.
- A 'rural' tag linked to rural postcodes was created on Health Connect South to support improved transfer of care considerations for rural patients and their whānau.
- The Oxford and Hurunui Service Development Groups are working with rural general practices and hospital staff (where present) to implement rural observation services in each district.

The community falls prevention programme for those aged 75+ continues to contribute to a reduction in acute bed days. In the seven years of the programme running there have been approximately 2,500 fewer falls related ED attendances and over 800 fewer fractured neck of femur (NOF).

## MILESTONE

Despite Canterbury's Acute Bed Day rate being significantly below the national average, further reducing this rate is a high priority for Canterbury to manage its population within a constrained bed supply that will continue, even after the new Acute Services Building opens in 2020/21. Higher than projected population growth is anticipated to place pressure on Canterbury's inpatient capacity with system-wide efforts underway to manage the demand on hospital services and across the system.

In this context, work to reduce the ethnic variation in the Acute Bed Day rates is being progressed alongside a focus (and setting of a milestone) on Canterbury's Total Acute Bed Days rate. Canterbury considered setting a milestone based on the ethnic variation between the Māori, Pacific and total population, however it is unclear what ethnic variation is appropriate. Striving for equivalent acute bed day rates across all ethnicities may lead to Māori and Pacific populations who have a higher burden of disease not receiving optimal access to acute hospital care. In seeking equitable health outcomes Canterbury will work towards appropriate hospitalisation for all ethnicities.

Finally, in the process of establishing an achievable milestone for 2019/20, further analysis of Canterbury generated data on Acute Bed Days was undertaken including consideration of the admitting medical conditions and how amenable they were to change. Grouping the Acute Bed Days into those amenable to change (Medical, Surgical and Rehabilitation admissions) and non-amenable (Mental Health and Maternity admissions) highlighted that a realistic milestone would be based on 85% of the total Acute Bed Days. While this approach could not be replicated using the National Service Framework Library data set, these local calculations continue to inform the setting of Canterbury's milestone.

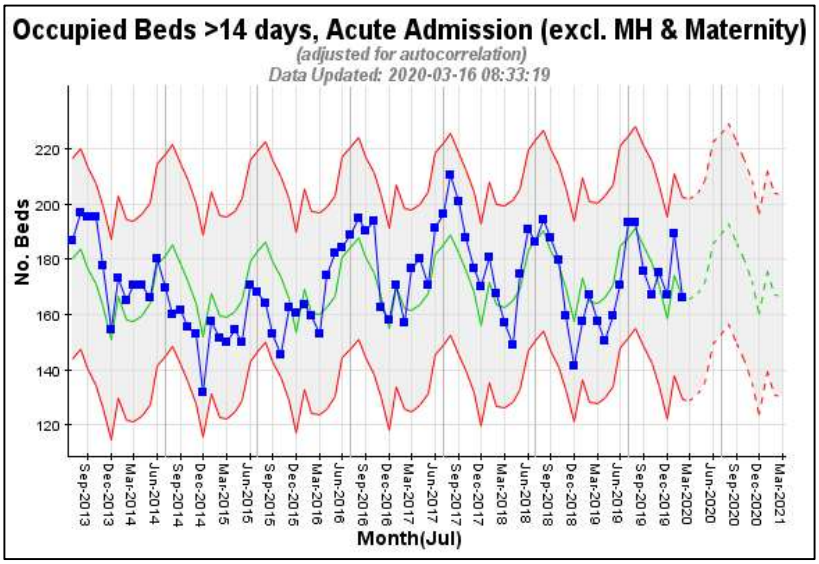
The Canterbury Health System's agreed milestone for June 2021 is to reduce the Acute Bed Days rate to 300 per 1,000 population or less.[5] This has been generated using Canterbury's Acute Bed Days average over the three

[5] *Milestone set using the National Minimum Data Set Acute Hospital Bed Days to June 2019 (age standardised using WHO 2000 Population Standard) by prioritised ethnic groups. The previous three years (June 2017-19) Total rate was averaged to develop the milestone for June 2021.*

years to June 2019. It is noted that within this longer-term trend, the Acute Bed Days rate will be influenced by external factors such as the severity of the influenza season and impact of COVID-19 in Canterbury.

## CONTRIBUTORY MEASURES

### REDUCED LENGTH OF STAY FOR ACUTE ADMISSIONS




*Outcome sought:* To reduce the number of occupied bed days following an acute admission while ensuring patients receive clinically appropriate care during their hospital stay and after discharge, to avoid a readmission.

*Rationale for selection:* Canterbury's investment in primary care and work on condition specific pathways has supported an overall reduction in the acute phase of hospital stays. At March 2019 Canterbury's standardised average length of stay of 2.44 bed days is below the New Zealand average stay of 2.49 bed days.[6] This is a slight increase in Canterbury's average length of stay, factors contributing to this are unforeseeable events that have had a high impact on the system. Victims from the Christchurch Mosque attacks who were treated within the Canterbury Health System are captured within this data, and a 'bad batch' of synthetic cannabis resulted in long periods of hospitalisation for a high number of people.

*Measure description:* The number of beds occupied for greater than 14 days following an acute admission. Note patients coded as Mental Health and Maternity are excluded. While several measures will be monitored locally as indicators of the length of stay for acute admissions, this measure is considered a key metric for monitoring change.

*Data source:* Local data generated through Signals from Noise (SFN).

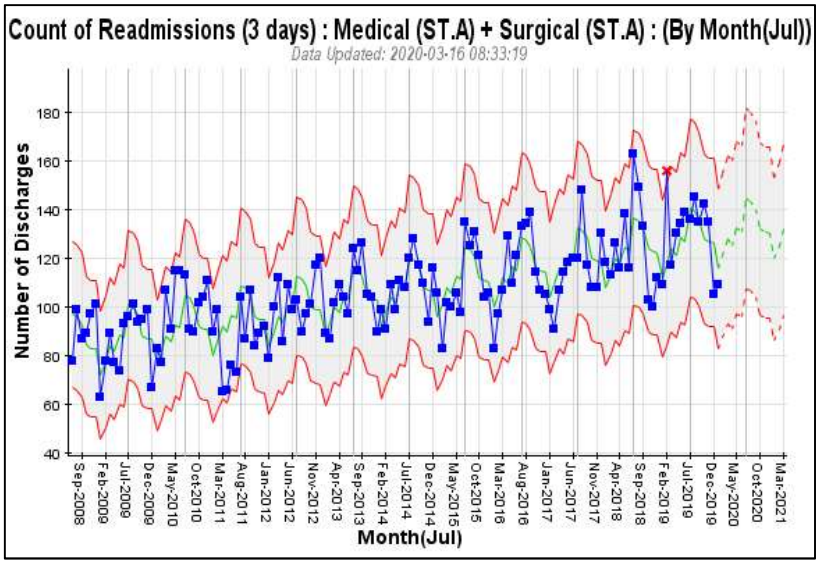
[6] *National Minimum Data Set Inpatient Average Length of Stay (OS3) at March 2019 (standardised on age, sex, ethnicity, rurality, deprivation, acuity, primary diagnosis, secondary diagnoses, comorbidity/complexity, operations, external cause codes)*

## MONITOR ACUTE READMISSIONS

*Outcome sought:* That people receive effective (and safe) treatment in our hospitals, as well as appropriate support and care on discharge.

*Rationale for selection:* Measures of readmission rates are important balancing metrics for the reduced length of stay for acute admissions. Monitoring the rates at different times post-discharge provides a more comprehensive picture of factors contributing to readmissions, and better informs the response required.

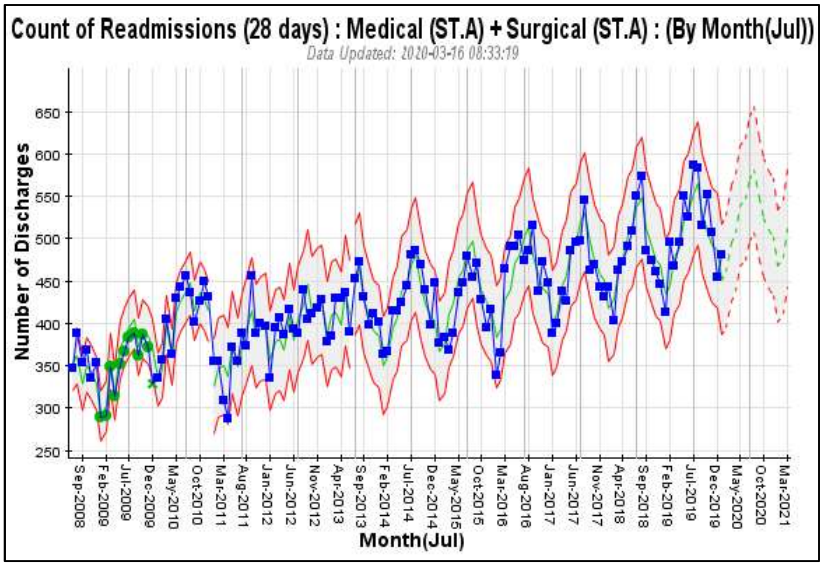
The selection of both the 3 day and 28 day readmission rates as contributory measures provide appropriate balancing metrics. The contributors to the readmission rates are multifaceted. Based on current knowledge, it is proposed that an acute readmission to hospital within 3 days may be an indicator of a 'failed discharge'. Any increase in this rate would suggest further exploration into discharge timing, planning and its implementation, and patient readiness was required. While an increase in the 28 day readmission rate could be driven by an additional number of factors; with further investigation into contributors such as patients' access to services, the disease process, the integration and coordination of primary care and community services required.




*Measure description:* Monitor Canterbury's acute readmission to hospital within 3 days.

*Numerator:* Canterbury's average number of acute readmission stays in hospital within 3 days for a medical or surgical admission.

*Data source:* Local data generated through SFN.




*Measure description:* Monitor Canterbury's acute readmission to hospital within 28 days.

*Numerator:* Canterbury's average number of acute readmission stays in hospital within 28 days for a medical or surgical admission.

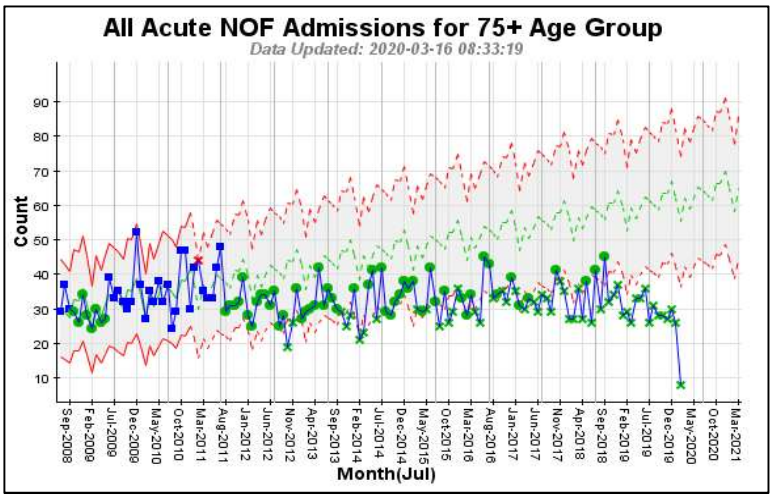
*Data source:* Local data generated through SFN.

## REDUCTION IN FALLS

*Considerations for this measure:* In October 2018 Christchurch Hospital Campus and Ashburton Hospital successfully went live with the South Island Patient Information System (SI PICS), and Maternity transferred to this system in early 2019. SI PICS works in conjunction with the existing South Island-wide clinical portal Health Connect South and is a step closer to the vision of a fully integrated electronic patient record. With more than one million patient records transferred into the new patient management system we have experienced some unexpected challenges with data quality. One of the key issues being faced is that during the migration to SI PICS several irregularities were exposed from the previous legacy systems, including historic workarounds to meet Ministry data requirements.

As part of the move from PMS Homer to SI PICs, a new Emergency Department patient management system was introduced called ED at a Glance (EDaaG). The EDaaG system changed the way falls are being recorded at ED which has impacted on the reporting of results for the falls presentations.

Due to this we have had to find an alternative way to measure the effect of the community falls prevention programme on acute hospital bed days, so are now measuring acute admissions for fractured neck of femur in people aged 75 years and over. The drop in the last point on the graph is due to a delay in coding.




*Outcome sought:* A reduction in the number of acute admissions to hospital following a fall for those aged 75 years and over.

*Rationale for selection:* Hip and Femur Procedures, Hip Replacements, and Humerus, Tibia, Fibula and Ankle Procedures, are in the top fifteen DRG clusters[7] contributing to Canterbury's Acute Bed Days rate. A high proportion of patients entering rehabilitation (which is generally a longer component of a patient's overall stay) have a primary code of femur, humerus and other fractures. Given Canterbury's ageing population, reducing the harm from falls will reduce the fracture related demand on acute services and help people to stay well and independent in their own homes, whilst maintaining quality of life.

*Measure description:* A decrease in the number of acute admissions against a forecasted pre-intervention trend of the number of acute admissions to hospital following a fractured neck of femur for those aged 75 years and over.

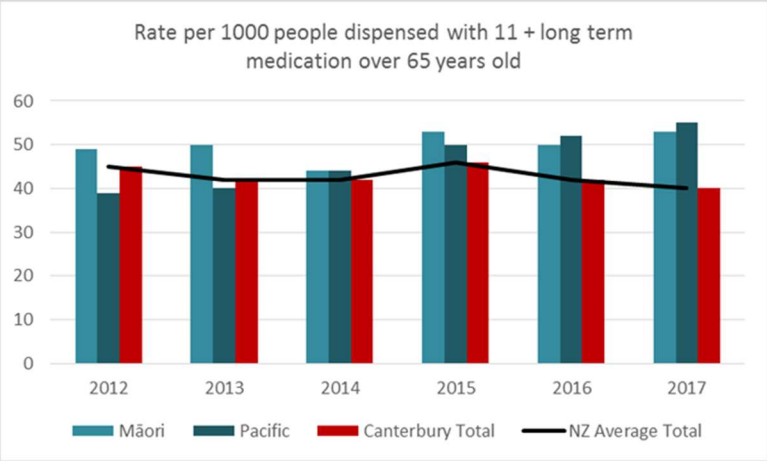
*Data source:* Local data generated through SFN.

[7] *Top 15 Grouped by the Highest Case Weighted Hospital Event within each Acute Stay at March 2018 (WHO 2000 Population Standard).*

## POLYPHARMACY

*Outcome sought:* Prevention of, or a reduction in, the risks associated with polypharmacy.

*Rationale for selection:* The appropriate prescribing and dispensing of medications for people aged 65 years and over will support improved health outcomes for older people, which is important for the Canterbury Health System given its ageing population. This measure is also an indicator of integration across general practice, community pharmacy, and hospital care.




Note: It is acknowledged that while any medication therapy assessment will determine the appropriateness of medications; it may not impact the number of medications being taken. The number of polypharmacy audits completed and referrals for medication therapy assessments will be monitored locally alongside the rate of people aged 65 years and over on 11+ medications.

*Measure description:* The rate of people dispensed with 11 or more long term medications.

*Numerator:* The count of patients aged 65 years and over who have been dispensed 11 or more distinct chemicals in two consecutive quarters.

*Denominator:* The count of the DHB population that is aged 65 years and over.

*Data source:* The Health Quality and Safety Commission (HQSC) Atlas of Variation.

### ACTIONS TO IMPROVE PERFORMANCE: ACUTE BED DAYS RATE

| Contributory Measure | Actions to Improve Performance | Responsibility | Other SLMs the actions contribute to |
|---|---|---|---|
| *Reduced Length of Stay* | ▪ Use data collected from StrokeViewer to develop an early supported discharge model for stroke patients.<br>▪ Participate in national benchmarking for community stroke rehabilitation services using Ambulatory AROC data. | Adult Rehabilitation Steering Group. | ▪ Patient Experience of Care<br>▪ Amenable Mortality<br>▪ ASH Rate |
| *Monitor Acute Readmissions* | ▪ Continue to monitor the number of readmissions as a balancing metric alongside the implementation of changes in patient pathways and length of stays. | Urgent Care Service Level Alliance | |
| *Minimise Harm from Falls* | ▪ Continue to provide evidence based In-Home falls prevention services to 5% of the 75 years and over population in Canterbury.<br>▪ Maintain access to 12,000 places at community strength & balance 'accredited' classes per year in Canterbury. | Falls and Fracture SLA (until October 2020), Community Services SLA | |

| | | | |
|---|---|---|---|
| *Polypharmacy* | ▪ Monitor and evaluate polypharmacy patterns in Canterbury including by age band and ethnicity.<br>o Further develop general practices' capability to view their enrolled patients on multiple medications, including by ethnicity.<br>o Promote audit and review capability of patients on multiple medications to general practices.<br>▪ Identify opportunities to improve the use of medicines<br>▪ In collaboration with other work groups including secondary care, develop and promote multi-modal interventions to improve the use of medicines.<br>▪ Evaluate the effectiveness of interventions<br>o Evaluate the Falls Prevention Programme and medication review initiative and if yielding positive results implement across all Canterbury PHOs.<br>o Promote polypharmacy visibility in community pharmacy and develop this as another point of prompting medication review.<br>o Provide information to the public on Choosing Wisely for medicines with their doctor and pharmacist through increasing general practice and community pharmacy knowledge of Choosing Wisely.<br>o Support the public to learn about their medicines and ask questions of their health professionals – including by promoting use of HealthInfo medicines information. | An expert project group convened by the Clinical Quality Education Team and the Pharmacy Service Level Alliance. | |
| *System Level Measure* | ▪ Support existing Pacific health providers to improve health services for Pacific peoples.<br>▪ Build partnerships to support Etu Pasifika to implement primary healthcare services that improve Canterbury Pasifika health.<br>▪ Implement innovative approaches to the funding and delivery of health services for Pacific peoples through work with our strategic partner Pasifika Futures Limited. | Canterbury DHB, PHOs and Pacific Reference Group | |
| *System Level Measure* | ▪ Embed and monitor agreed principles of restorative home-based care in Hurunui and Oxford for rural people to support discharge | Rural Health Workstream | |

| | | | |
|---|---|---|---|
| | and/or restored function following a period of illness. | | |

**System level measure:**

# PATIENT EXPERIENCE OF CARE

## CANTERBURY'S EXPERIENCE

Canterbury places a high priority on engaging consumers in the ongoing development and design of services. All CCN alliance groups include members that bring a consumer, Māori and (for many groups) a Pacific perspective. These members partner with clinicians, system leaders and planning and funders in the design or development of services that improve the health outcomes of our population. The contribution of these members is supported by Māori, Pacific and consumer caucuses, where participants share experiences and ways to strengthen their leadership and contribution to alliance activities.

Over the last ten years the co-design methodology has frequently been applied in Canterbury to capture diverse views and progress changes that matter to our population. We are currently developing a kaupapa Māori co-design approach to enhance how we gather information to guide health system improvements that further reduce inequities.

Alongside this system wide work to engage with our community in a meaningful way, we continue to receive feedback on patients' experience through the in-hospital and primary care patient experience surveys, consumer councils, Māori and Pacific forums, individual general practice surveys and other means to inform ongoing improvements in service delivery.

*In-Hospital Patient Experience Survey*

The in-hospital patient experience survey is well established in Canterbury with the survey sent to over 25,000 people in 2018/19, over 5,000 (21%) of these people completed the survey.

Canterbury's results from the four domains overall remain static.

| **Domain – Overall Question** | **Canterbury weighted average score out of 10 for Q1 2017 – Q4 2018** | **Canterbury weighted average score out of 10 for Q1 2018 – Q4 2019** |
|---|---|---|
| Communication | 8.4 | 8.6 |
| Coordination | 8.5 | 8.5 |
| Partnership | 8.6 | 8.6 |
| Physical & Emotional Well-being | 8.7 | 8.7 |

*Canterbury DHB Adult In-Hospital Survey Results, Health and Quality Safety Commission*

During 2019/20 work to enable the inpatient survey to be sent to all inpatients who qualify was completed, this resulted in an increase from the previous 1,000 per fortnight who were given the opportunity to provide feedback in relation to their experience.

*Outpatient Patient Experience Survey*

As well as the inpatient survey, Canterbury also has an outpatient survey that was developed over the past year and is available for all Christchurch Hospital outpatients.

*Paediatric In-Hospital Patient Experience Survey*

Canterbury has also been exploring ways to get feedback from children regarding their inpatient hospital experience in the Paediatric wards. For 14 months the South Island Alliance and Canterbury DHB trialled an interactive application (app) featuring an animated frog (Fabio) to encourage children and young people from six to 16 years to provide feedback regarding their inpatient hospital experience in the Paediatric wards. Children and parents were invited to provide feedback during their stay with a kiosk available 24 hours a day. The app also featured an email facility where a survey link was sent to parents after their child was discharged. The app yielded on average more monthly feedback than the traditional suggestions, compliments and complaints boxes. The trial found that Fabio provided an option to capture paediatric patient experience, however more cost effective ways to do this will be explored.

*Primary Care Patient Experience Survey*

At the time of writing the primary care patient experience survey is going through a changeover of provider, prior to the changeover PHOs downloaded their historical raw data. During 2019/20 results from the Patient Experience Survey were included in education programmes delivered to primary care clinicians (including pharmacists) to remind them of the importance of considering a patient's experience of care as well as to demonstrate data availability and how it can be used to improve their practice and experience for their patients. Work to promote the primary care patient experience survey across the sector will continue in 2020/21.

During the 2019 calendar year there was an increase of nine general practices (from 85 to 94) obtaining feedback from their patients via the primary care Patient Experience Survey. Canterbury's response rates to the survey aligns with national levels of response

*Improving Patient Feedback Methods*

In previous years Canterbury has focused on improving low scores in areas shown as needing improvement from the patient experience survey. It has been found that creating even a small change in a survey score is difficult to influence with system change. Through assessing what we can influence, and where we can drive change towards equity we will include multiple methods of understanding patient experience feedback to inform quality improvement, and specifically seek response from Māori, Pacific and minority ethnic groups on their experience.

Part of this process will be to modify the co-design process used in Canterbury to develop and implement health services. Feedback has been received that the current approach needs to be enhanced to ensure the voices of Māori, Pacific and minority groups are at the fore and not lost amongst the majority of voices in the room. Initial changes being tried to our co-design approach have received feedback that it is starting to work better with consumers feeling their contributions are being heard.

## MILESTONE

### *In-Hospital Patient Experience*

Construction of new facilities is nearing completion with migration of some services to new buildings underway, and to continue throughout the year. These changes are likely to impact on patients' experience of care, maintaining the inpatient survey results will locally be considered a significant achievement.

*Primary Care Patient Experience*

In 2019/20 the number of general practices using the Patient Experience Survey to access feedback from the enrolled population continued to increase (74% in December 2018 to 83% in December 2019). In 2020/21 Canterbury will continue to embed the use of the data collected to inform and drive quality improvement.

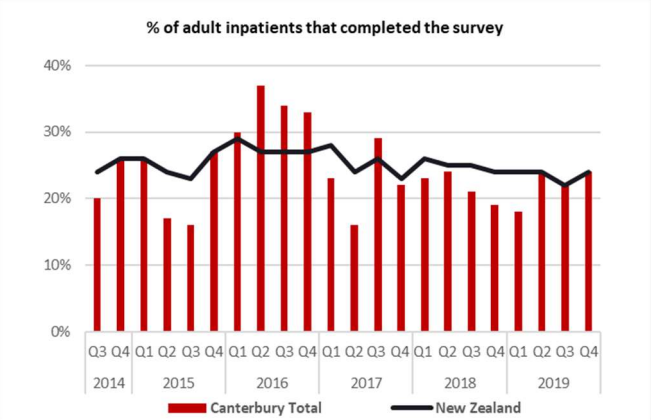
In addition to this, Canterbury will work with general practices and Service Level Alliances to present three case studies of improvement in healthcare services or outcomes that have been achieved from changes made because of patient experience survey results or other patient feedback data.

## CONTRIBUTORY MEASURES

### IN-HOSPITAL SURVEY RESPONSE RATE

*Outcome sought:* An increase in the proportion of adults completing the in-hospital survey.
*Rationale for selection:* Canterbury's Survey response rate was historically lower than the national rate. Improvements over 2016 reflect the increased focus on capturing patients' email addresses, allowing communication of the survey to them. During 2017 Canterbury merged fortnightly survey data collected locally with the quarterly national collection to increase the number of respondents contributing to the results. While this initially improved the In-Hospital Survey response rate, during 2018 a process to systematically capture patients' email addresses as business as usual was implemented. It is anticipated that this will improve response rates over the long term, however a new patient management system is yet to have patient email address information migrated into it. While this is unlikely to affect response rate, it may initially impact the survey sample size.

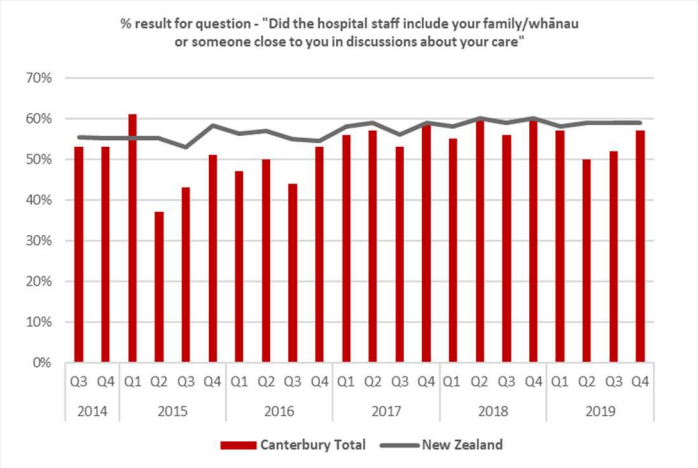
*Measure description:* The proportion of adult inpatients who complete the survey.
*Numerator:* The number of hospitalised patients aged 15 years and over who provided feedback via the adult in-patient survey.
*Denominator:* The number of hospitalised patients aged 15 years and over who are surveyed.
*Data source:* The Health, Quality and Safety Commission.




### IN-HOSPITAL ENGAGEMENT OF FAMILY / WHĀNAU IN PATIENT CARE

*Outcome sought:* Patients experience increased engagement between hospital staff and their family/whānau in discussions about their care.
*Rationale for selection:* Canterbury's In-Hospital Survey result in this supporting question has historically been lower than the national rate. The Always Events project is providing a framework for Canterbury to explore various stakeholder perspectives of patient care, and through this understand and address the contributors to this result. We are now in the second phase of the Always Events improvement project and this work will continue over 2019/20.

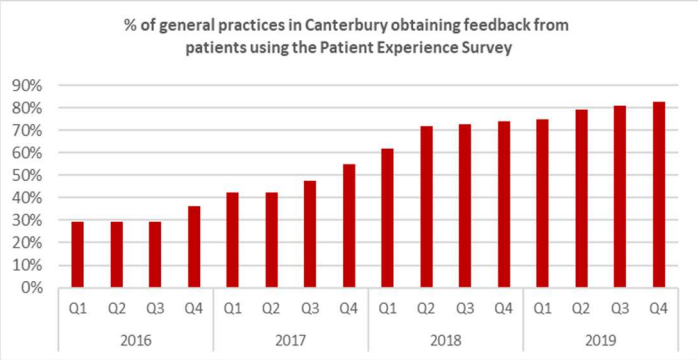
*Measure description:* To better understand what influences the score on the In Hospital Survey result for the supporting question "Did the hospital staff include your family/whānau or someone close to you in discussions about your care?"
*Numerator:* The sum of the weighted average scores out of ten for this question response.
*Denominator:* The number of responders that answered this question.
*Data source:* The Health, Quality and Safety Commission.




## PRIMARY CARE PATIENT EXPERIENCE SURVEY IMPLEMENTATION

*Outcome sought:* An increase in the proportion of general practices obtaining feedback from patients via the Primary Care Patient Experience Survey.
*Rationale for selection:* PHOs continue to have an important role in working with general practices to increase the number obtaining feedback from their enrolled populations. In 2020/21 Canterbury will continue to focus on general practice's engagement with the survey.

*Measure description:* The proportion of Canterbury general practices participating in obtaining feedback from patients via the Primary Care Patient Experience Survey.
*Numerator:* The number of general practices in Canterbury participating in obtaining feedback from patients via the Primary Care Patient Experience Survey.
*Denominator:* The number of general practices in Canterbury.
*Data Source:* Reported quarterly by the PHOs.



## ACTIONS TO IMPROVE PERFORMANCE: PATIENT EXPERIENCE OF CARE

| Contributory Measure | Actions to Improve Performance | Responsibility |
|---|---|---|
| *Patient survey responsiveness* | ▪ (In and outpatient) Patient experience survey feedback is used as part of every improvement project.<br>▪ Improvement actions following feedback are visible to the organisation and made available to the public. | DHB Quality & Safety staff |
| *In-Hospital engagement of family /whānau in care.* | ▪ Following the development of the nominated contact process roll out will occur in inpatient areas as per implementation plan<br>▪ The nominated contact is the person nominated who is available to support the patient during their care episode. Each patient has two nominated contacts. | DHB Quality & Safety staff |
| *Primary Care Patient Experience Survey Implementation* | ▪ Work with general practice to increase the proportion obtaining feedback from the Patient Experience Survey.<br>▪ Assist general practice teams to interpret and use Patient Experience Survey results and other patient experience data as part of their ongoing quality improvement. | Primary Care & Capability SLA and PHO Quality & Safety staff |
| *Response Rate* | ▪ Monitor the Primary Care Patient Experience Survey response rate by different population cohorts.<br>▪ Monitor data in relation to Primary Care survey respondents by age bands and ethnicity to identify population cohorts that are underrepresented.<br>▪ Engage with Māori and Pacific Caucus to determine areas of focus on consumer and whānau experience.<br>▪ Use information from Māori and Pacific engagement to recommend improvements to primary care. | Primary Care & Capability SLA and PHO Quality & Safety staff |
| *Improvement in Patient Experience through increased utilisation of patient feedback.* | ▪ Maintain and strengthen communication to PHO, Integrated Family Health Services/Healthcare Home initiative and general practice about patient feedback use and potential to make improvements.<br>▪ Share patient experience survey results with Service Level Alliances, Workstreams and expert groups where relevant. | Primary Care & Capability SLA and PHO Quality & Safety staff |

**System level measure:**

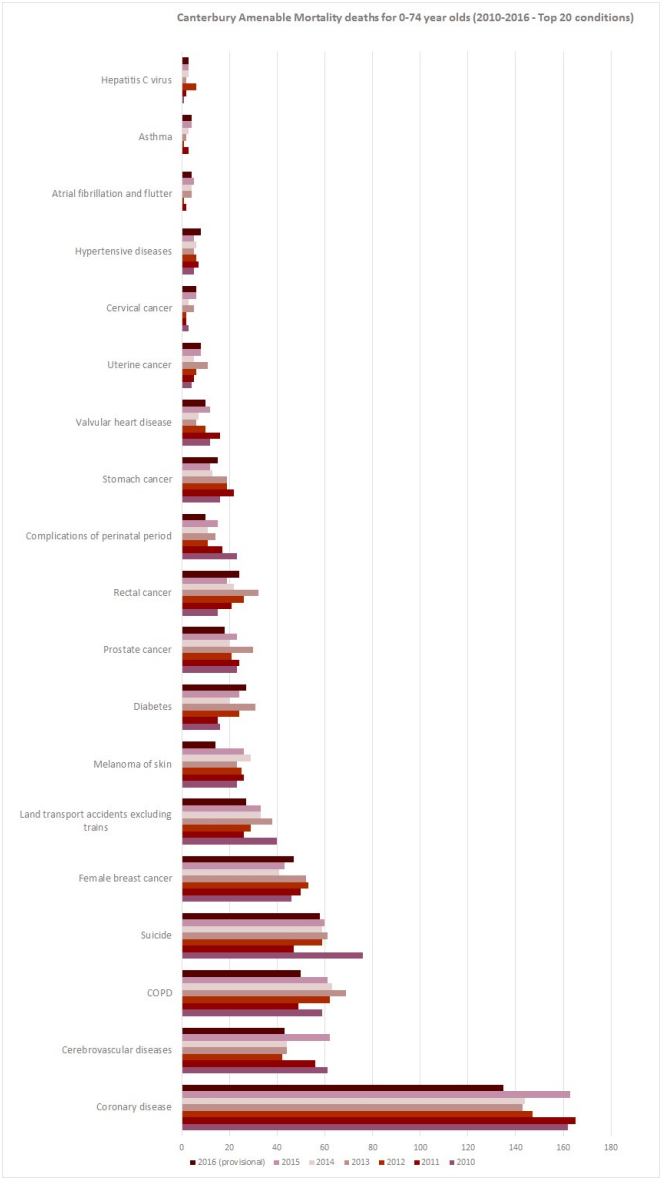
# AMENABLE MORTALITY

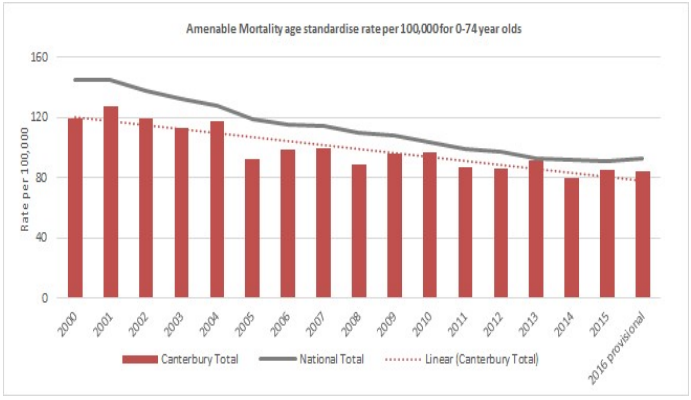
## CANTERBURY'S EXPERIENCE

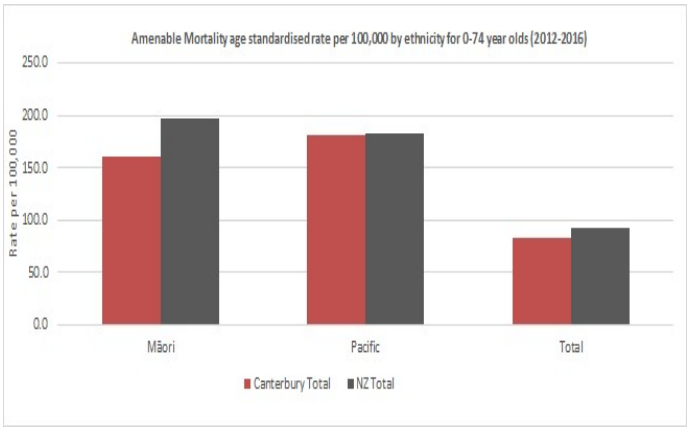
Our priority is to continue to decrease the amenable mortality rate.

Canterbury's Amenable Mortality age standardised rate for under 75-year-olds is trending down and remains lower than the total New Zealand rate.[8] The national data provided by ethnicity indicates that both Māori and non-Māori non-Pacific populations in Canterbury have rates lower than the New Zealand rates in 2016.[9] When data are aggregated for 2012 to 2016 the Māori (160 vs. 197) and Pacific (181 vs 182) amenable mortality rates are lower than the national rates, but the rate non-Māori non-Pacific (77 vs 75) population is higher. In the same data Canterbury has the fifth lowest Māori amenable mortality rate among 19 DHBs where a Māori rate is recorded and the sixth lowest Pacific rate among 11 DHBs.

A review of the longitudinal Amenable Mortality data by cause of death identifies that a number of medical conditions contributing to Canterbury's Amenable Mortality Rate could be responsive to actions both at the health system level and the wider determinants of health level, for example interventions that increase physical activity, improve nutrition and reduce smoking.




*[8] National Minimum Data Set Amenable Mortality – Draft 2016 Data*

*[9] A standardised rate per 100,000 for Canterbury Pacific people is unable to be determined due to the small number of Canterbury Pacific people recorded in this cohort.*

## MILESTONE

The Canterbury Health System's agreed milestone is to maintain the current downward trend over time in the overall Amenable Mortality Rate. Applying this approach results in a milestone for the Amenable Mortality rate at 30 June 2021 of 80 per 100,000 population. Additionally, we aim to reduce the ratio between Māori and non-Māori non-Pacific to be lower than the 2016 ratio of 2.79.

## CONTRIBUTORY MEASURES

The contributory measures selected include a focus on achieving equitable outcomes across ethnic groups. These measures and the underlying actions are fundamental to reducing the impact of high and inequitable rates of cancer morbidity and mortality among Māori. In addition, two measures of smoking prevalence are added as indicators of Canterbury's progress towards being Smokefree in 2025.

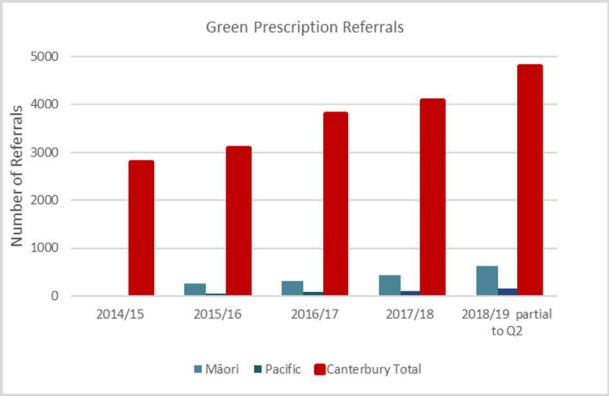
### INDICATORS OF HEALTH PROMOTING LIFESTYLE

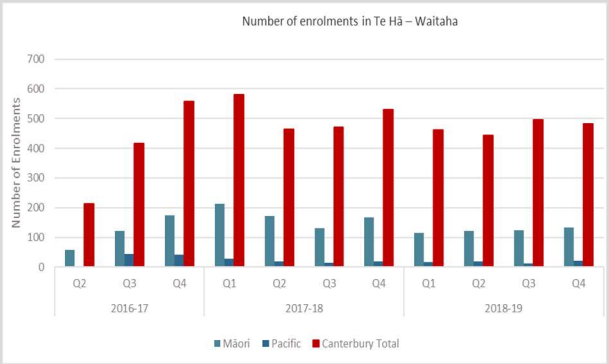
*Outcome sought:* An increase in factors that protect health and reduce risk factors in our population.

*Rationale for selection:* A range of services are available to support our population in taking up healthier behaviours. Increasing referrals to these services is an indicator of our health system assisting people to navigate and access this support.

*Measure description:* Two measures; Green Prescription referrals and enrolments in Te Hā – Waitaha / Stop Smoking Canterbury service, have been selected as indicators of people accessing a wider range of lifestyle support services.

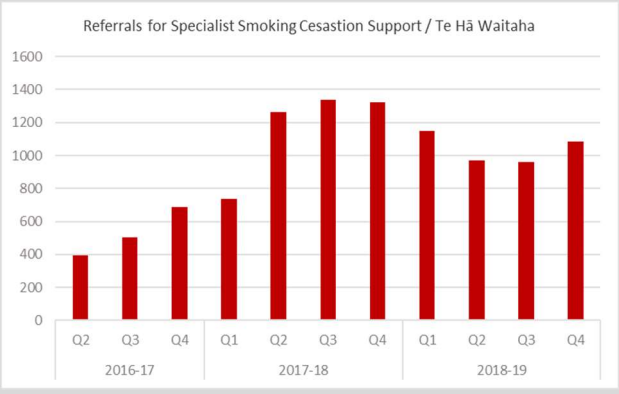
*Data source:* Provider data collected locally.




*Measure description:* Te Hā – Waitaha Stop Smoking Services provides most smoking cessation services in Canterbury. In 2020/21 one of Canterbury's PHOs will continue to provide their enrolled population with access to their own comprehensive smoking cessation support. To monitor all smoking cessation activity across Canterbury, enrolments in the PHO smoking cessation services are combined with the Te Hā – Waitaha activity.

*Data source:* Provider data collected locally.



## MEASURE OF REGULAR SMOKERS IN CANTERBURY

*Rationale for selection:* Smoking is a major contributor to amenable mortality as a risk factor for many illnesses including cancers, cardiovascular disease, strokes, chronic obstructive pulmonary disease, complications of the perinatal period and sudden unexpected death in infancy. Reducing smoking through a range of interventions in the health system can therefore contribute to a reduction in amenable mortality. Two indicators of the proportion of Canterbury's population that are smokers are included below.

*Outcome sought:* A decrease in regular smokers to 5% prevalence in 2025.

*Measure description:*

The proportion of the Canterbury population who are regular smokers.

*Numerator:*

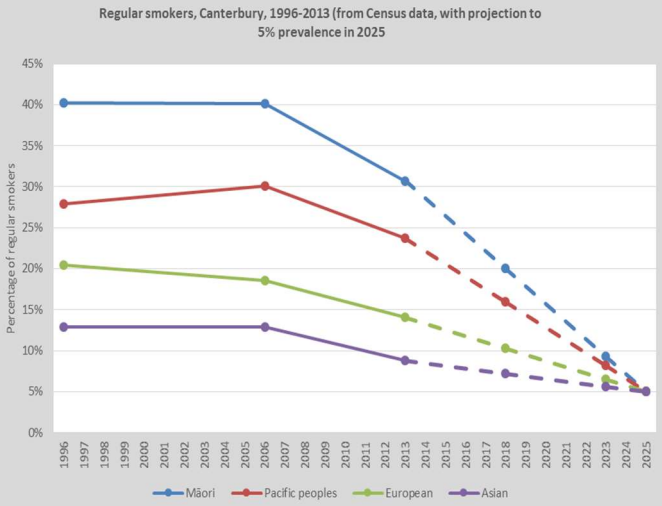
For each ethnic group, regular smokers are people who actively smoke one or more manufactured or hand–rolled tobacco cigarettes per day.

*Denominator:*

Census usually resident population, by ethnicity.

*Data source:*

Statistics New Zealand Census 1996, 2006, 2013 data, with projections of the reduction in regular smokers needed for the proportion of regular smokers to be 5% for all ethnic groups by 2025.

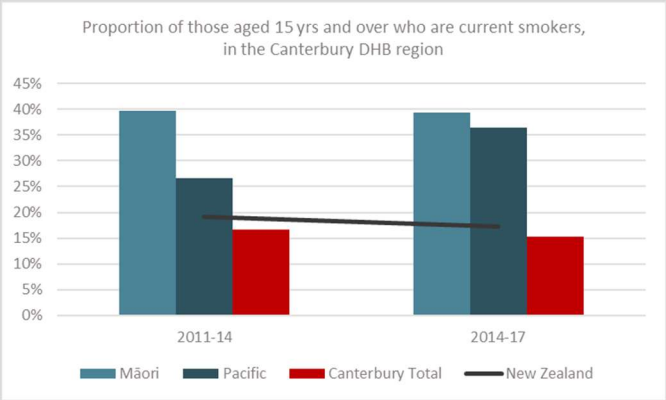



*Measure description:* The proportion of people aged 15 years and over who are current smokers, in the Canterbury DHB region, by ethnicity.

*Numerator:* The number of respondents to the adult New Zealand Health Survey who indicated that they smoke cigarettes or tobacco at least once a day.

*Denominator:* The number of respondents to the "how often do you now smoke?" question in the 2011/12 to 2017/18 New Zealand Health Surveys.

*Data source:* Canterbury Wellbeing Index which uses the New Zealand Health Survey conducted by the Ministry of Health.




## IMPROVED PHYSICAL HEALTH FOR PEOPLE WITH MENTAL ILLNESS AND/OR ADDICTION

*Rationale for selection:* People with lived experience of mental health and addiction issues, on average have worse physical health outcomes and reduced life expectancy than their peers without mental health and addiction issues. The health disparities go across the spectrum of mental health and addiction diagnoses but are often greatest for people who are in contact with Specialist Mental Health and Addiction services. Equally Well[10] is a

[10] https://www.tepou.co.nz/initiatives/equally-well-and-covid-19/260

nationwide movement of collaborative action to achieve physical health equity for people with lived experience of mental health and addiction issues.

The delivery of Equally Well consults enables people with lived experience to access physical health and wellbeing support through their general practice. In Canterbury, the Equally Well Committee collated a list of physical health programmes offered for people experiencing mental health and/or addiction issues[11]. The resource is intended for use by the sector to assist at-risk people access the appropriate supports they need to help improve physical health and wellbeing.

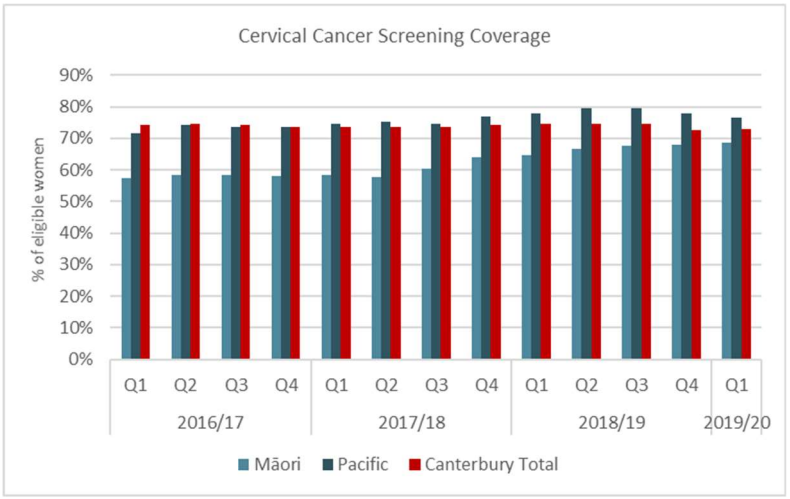
Equally Well is an indicator of the health equity approaches being implemented in Canterbury to provide people with timely access to the right physical health care and support.

*Outcome sought:* Improved physical health for people with mental health and addiction issues.

*Measure description:* This measure is currently under development. There is potential to include measures of a number of indicators such as: HbA1c levels in people who have diabetes and mental health issues. Other possibilities are to monitor blood pressure, lipids, cholesterol (metabolic monitoring), smoking rates, diabetes pathways of care, and cervical cancer screening and mammograms in this cohort. To do this, the cohort needs to be defined. A key action for 2020/21 is to develop a clear definition of the Serious Mental Illness and Addiction (SMIA) patient cohort for primary and secondary care so that a measure can be applied to this group.

## IMPROVED ACCESS TO CERVICAL CANCER SCREENING

*Rationale for selection:* Cancer morbidity and mortality for Māori is high when compared with other population groups. Access to health services, including screening programmes, have the potential to reduce cancer mortality. Improving access to cervical cancer screening, with a focus on Māori, Pacific and Asian women will assist with the earlier detection of cancer and improve outcomes.




*Outcome sought:* Increase in the proportion of eligible Māori, Pacific and Asian women who have had a cervical cancer screening test in the previous three years.

*Measure description:* The quarterly number of eligible women screened in the previous three years divided by the population of eligible women, by ethnicity.

*Data Source:* Data reported to the National Screening Unit quarterly.

[11] http://www.comcare.org.nz/wp-content/uploads/2017/01/Equally-Well-Physical-Health-Programmes.pdf

## ACTIONS TO IMPROVE PERFORMANCE: AMENABLE MORTALITY

| Contributory Measure | Actions to Improve Performance | Responsibility | Other SLMs the actions contribute to |
|---|---|---|---|
| *Indicators of Healthy Lifestyle* | ▪ Refine Te Hā – Waitaha's focus on priority populations including:<br>○ Monitor enrolments and outcomes for Māori, Pacific, and pregnant women.<br>○ Develop an approach that targets culturally and linguistically diverse (CALD) communities. | Population Health and Access Service Level Alliance | ▪ Acute Hospital Bed Days<br>▪ Babies Living in Smokefree Homes |
| *Regular smokers in Canterbury* | ▪ Refine the Te Hā - Waitaha service model to be more responsive for young women, Māori and Pacific populations to become smokefree. | Population Health and Access Service Level Alliance | |
| *Improved Physical Health for People With Mental Illness and/or Addiction* | ▪ Develop a clear definition of the Serious Mental Illness and Addiction (SMIA) patient cohort for primary and secondary care.<br>▪ Develop a measure using the SMIA patient cohort definition to monitor change in physical health of this cohort.<br>▪ Deliver comprehensive annual health checks, preferably nurse-led with general practitioner follow up as appropriate for enrolled patients with SMIA. (A minimum of one comprehensive physical health check per year).<br>▪ Strengthen community partnerships to deliver low-cost active transport initiatives and make sure they reach people with lived experience of mental health and addiction issues, e.g. the BuyCycles initiative.<br>▪ Advocate at a local, regional and national level for healthy environments that make the healthy choice the easy choice. | Mental Health Workstream, Equally Well Regional Group and Community and Public Health | |
| *Improved access to cervical cancer screening* | ▪ Establish where there is a shortage of smear takers and explore how to increase coverage to improve access for priority group women (PGW).<br>▪ Explore potential for employer funded cervical smear tests for PGW and other ways to increase access to free screening tests.<br>▪ Collaborate with other services seeing PGW to promote cervical cancer screening. | Population Health and Access Service Level Alliance | |

| | | | |
|---|---|---|---|
| *All Measures* | ▪ Work with health and non-health agencies to ensure determinants of health and wellbeing, and sustainability and equity issues are explicitly addressed in policy, planning and decision-making processes, and outputs.<br>▪ Support communities to improve their health and wellbeing within identified settings, e.g. marae and workplaces, and by addressing specific health determinants, e.g. housing and transport.<br>▪ Advocate for a healthier environment through work with providers and developers to increase opportunity for both indoor and outdoor physical activity and access to healthy food. | Community and Public Health and Population Health and Access Service Level Alliance | |

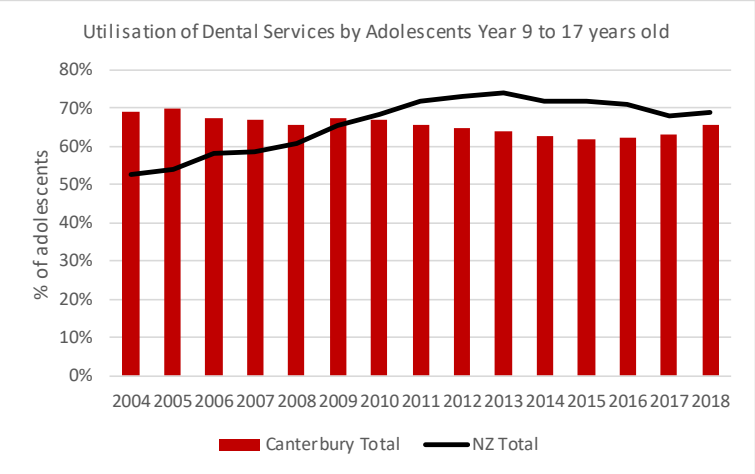
**System level measure:**

# YOUTH ACCESS TO HEALTH SERVICES

## CANTERBURY'S EXPERIENCE

Our clinically-led priority focus on the 'Access to Preventive Services' domain for 2020/21 is to improve adolescent access to dental services.

In 2018 19,542 (66%) of the estimated 29,750 adolescents (School Year 9 to 17 years of age) in Canterbury accessed DHB funded dental services[12]. This utilisation rate was an improvement on the previous year with over 500 more adolescents accessing dental services.




In 2019/20 Canterbury worked to better understand why adolescents do not engage with oral health services. This was done via focus groups with youth and a survey of all dental practices in Canterbury. Both these avenues told us that parents are key to children's engagement with services, that adolescents and often their parents have limited knowledge of oral health services, and the importance of annual reviews.

During 2020/21 we will work to understand how we can better engage with Māori and Pacific families around oral health and improve processes around the transfer of adolescents from the community dental service to general dental practices.

While Canterbury's Dental Service measure of youth access and utilisation focused on a specific part of preventive health services, it will be used to generate lessons that could be applied more generally to young people's perception of and willingness to use services.

## MILESTONE

The Canterbury Health System's agreed milestone is to have 66% of the adolescents from Year 9 to 17 years of age utilising the Canterbury DHB funded Dental Service at June 2021.

[12] *Policy Priority 12 data*

## DELIVER AN ACCESSIBLE YOUTH FRIENDLY ORAL HEALTH SERVICE

### CONTRIBUTORY MEASURES

*Outcome sought:* Increase adolescent utilisation of oral health services by developing a service for youth that is accessible and feels welcoming.

*Rationale for selection:* Work completed during 2018/19 has led to the next tranche of work which is to review youth oral health services by developing a service that is youth friendly. Utilisation data shows that while adolescents are transferred to dental practices in Year 9, they are not using the services. Understanding what youth want in an adolescent oral health service will inform how to change the design of this service to encourage equitable access.

*Measure description:* Adolescents utilisation of the Adolescent Oral Health Service by ethnicity.

*Data Source:* The Proclaim Payments System data linked to the Combined Dental Agreements.

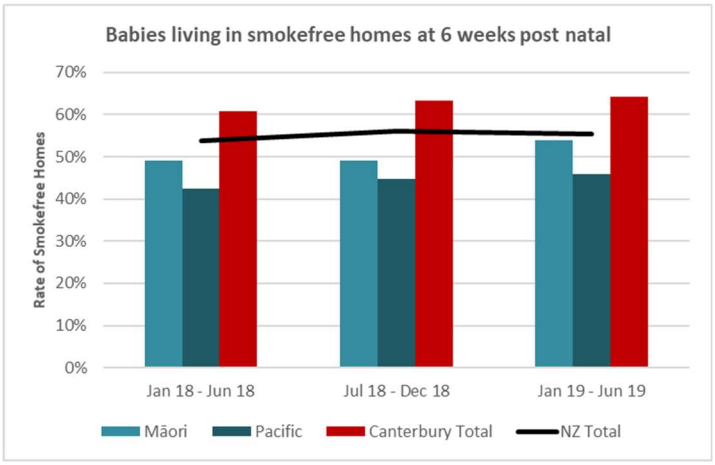
### ACTIONS TO IMPROVE PERFORMANCE: YOUTH ACCESS TO HEALTH SERVICES

| Contributory Measure | Actions to Improve Performance | Responsibility | Other SLMs the actions contribute to |
|---|---|---|---|
| *Deliver an accessible youth friendly Oral Health Service.* | ▪ Identify ways to improve engagement with Māori and Pacific families around oral health.<br>▪ Work with the Adolescent Oral Health Coordinator to develop an electronic transfer of care process from Community Dental Services to General Dental Practices.<br>▪ Examine the current Adolescent Dental Service Model including looking at other DHB models, and identify ways to improve youth engagement with services. | Oral Health Service Development Group | ▪ Patient Experience of Care<br>▪ Amenable Mortality |

**System level measure:**

# BABIES LIVING IN SMOKEFREE HOMES

## CANTERBURY'S EXPERIENCE




Our priority is to increase the number of babies living in smokefree homes and to address the ethnic variation between Māori, Pacific and Total populations.

We also advocate for an increase in the number of smokefree environments in wider community smokefree policies and spaces to reduce the harm from tobacco smoke in all locations where a baby may be.

At June 2019 Canterbury's percentage of Babies Living in Smokefree Homes at 6 weeks post-natal of 64% compares favourably with the national average for the Total population of 55%.[13] Viewed by ethnicity Canterbury's results for the Māori population (54%) and Pacific population (46%) are lower than Canterbury's Total population.

Babies not recorded as living in a smokefree home, also includes those where the question was not asked of their caregiver. Smoking prevalence in Canterbury for those aged 15 or older is 16%[14], therefore it is expected that the rate of babies living in smokefree homes is much higher than that recorded in this data.

The number of pregnant women enrolling with smoking cessation services and remaining smokefree at the four week follow-up is remaining fairly static. Babies who live in homes with smokers, and/or had a mother who smoked during pregnancy are at higher risk of sudden unexpected death in infancy (SUDI), and if bed sharing occurs with an adult, these babies' risk of SUDI becomes even greater. During 2019/20 a programme was established where any pregnant woman who smokes and attended, at a minimum, the first consult with smoking cessation provider Te Hā - Waitaha received a safe sleep device in the third trimester of their pregnancy. Most clients received a pēpi pod, however during 2020/21 we aim to ensure all Māori whānau are offered a wahakura first. Pēpi pods and wahakura provide a safe sleep space for baby that can also be used in an adult bed, while keeping baby safe, for those who want to bed share.

## MILESTONE

The ratio of Total Rate: Māori for babies living in smokefree homes is 1:0.84, and Total Rate: Pacific it is 1:0.71. The Canterbury Health System's agreed milestone for June 2021 is to decrease the equity gap for Māori and Pacific to 0.87 and 0.76 respectively, an increase in approximately 15 homes that are smokefree; and to continue to increase the number of infants living in smokefree homes by 30 June 2021.

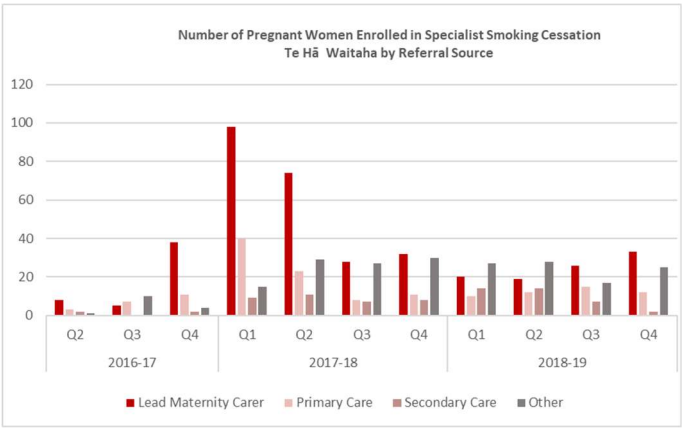
[13] *The National Minimum Data Set for Babies Living in Smokefree Homes at December 2019.*
[14] *Canterbury Wellbeing Index, Smoking – Adults. Proportion of those aged 15 years and over who are current smokers, in the Canterbury DHB region and New Zealand, 2011-2018.*

## PREGNANT WOMEN ACCESSING SPECIALIST SMOKING CESSATION SUPPORT

*Outcome sought:* An increase in the number of pregnant women and their family/whānau who are smokefree.

*Rationale for selection:* Engaging pregnant women and their family/whānau who are smokers in specialist smoking cessation support seeks to reduce infant exposure to harm from smoking through pregnancy, birth and in the home environment. The number of women enrolling in Canterbury's specialist smoking cessation service is an indicator that an effective delivery pathway is in place, including:

- The referring health professional has provided help to quit, has knowledge of the specialist smoking cessation service and how to refer; and
- The provider of the specialist cessation responds in a timely way to the referral.



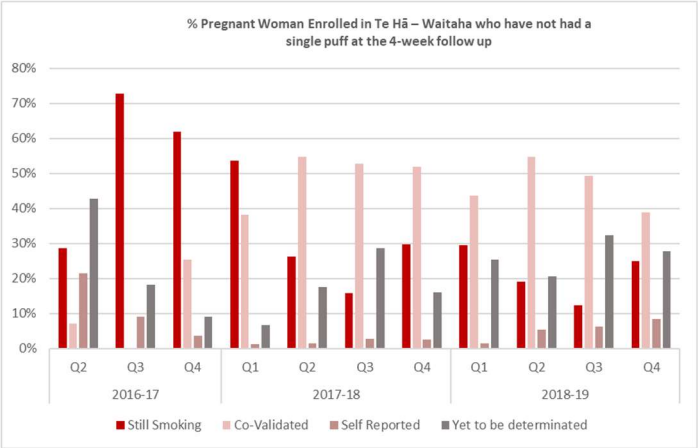

*Measure description:* The number of pregnant women enrolling in Te Hā – Waitaha / Stop Smoking Canterbury, by referrer type.

*Data source:* Reported quarterly from Te Hā – Waitaha.

## OUTCOMES OF PREGNANT WOMEN ENGAGING IN SPECIALIST SMOKING CESSATION SUPPORT

*Outcome sought:* An increase in the number of pregnant women and their family/whānau who are smokefree.

*Rationale for selection:* This builds on the previous measure as an indicator of whether women that engage in Canterbury's specialist smoking cessation service become smokefree.




*Measure description:* The smoking status of the pregnant women enrolled in Te Hā – Waitaha.

*Numerator:* The proportion of pregnant women who, at the 4-week follow–up, have not had a single puff in the previous 2 weeks; this includes smoking status that is self-reported or carbon monoxide (CO) validated.

*Denominator:* The number of pregnant women enrolled in Te Hā – Waitaha.

*Data source:* Reported quarterly from Te Hā – Waitaha.

## ACTIONS TO IMPROVE PERFORMANCE: BABIES IN SMOKEFREE HOMES

| Measure | Actions to Improve Performance | Responsibility | Other SLMs the actions contribute to |
|---|---|---|---|
| *Pregnant Women accessing smoking cessation* | ▪ Strengthen the referral pathways from Lead Maternity Carers to Te Hā – Waitaha by:<br>○ Working with midwives and Lead Maternity Carers to increase the number of clients motivated towards smokefree care routinely;<br>○ Develop a stop smoking clinic for pregnant women who smoke, within a community setting. | Te Hā – Waitaha Steering Group and the Pregnancy sub-group of Te Hā – Waitaha | ▪ ASH Rate<br>▪ Amenable Mortality |
| *System Level Measure* | ▪ Advocate for and support the establishment of smokefree community spaces | Population Health & Access SLA | |

# APPENDIX ONE: OVERVIEW OF CANTERBURY'S SYSTEM LEVEL MEASURES RESPONSE

**OVERVIEW OF SYSTEM LEVEL MEASURES RESPONSE** ✓ = leading delivery on the measure 🔗 = linked / contributing to delivery on the measure *Updated July 2020.*

| | Child & Youth Health Workstream | Health of Older People Workstream | Community Services SLA | Urgent Care SLA | Primary Care Capability SLA | Pharmacy SLA | Population Health & Access SLA | Community & Public Health | Mana Ake – Stronger for Tomorrow | Clinical Quality Education | Oral Health Service Development Group | Immunisation SLA | Realign / DHB Service Areas | Quality & Safety Expert Group | Project group PHOs / DHB | Pacific Reference Group | Te Kāhui o Papaki Kā Tai | Consumer Council | Mental Health Work stream | Falls & Fractures SLA | Midwives | Rural Health Workstream |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **ASH rate 0-4 year olds** | ✓ | | | | | | | | | | | | | | | | | | | | | |
| ASH rate ethnic variation | ✓ Project | | | | 🔗 | | | 🔗 | | | | | | | | 🔗 | 🔗 | | | | | |
| Oral Health 0-4 year olds | 🔗 | | | | | | | 🔗 | | | ✓ | 🔗 | | | | 🔗 | 🔗 | | | | | |
| New Born Enrolment | 🔗 | | | | 🔗 | | | | | | | ✓ | | | 🔗 | 🔗 | 🔗 | | | | | |
| Accuracy of Ethnicity Capture | 🔗 | | | | 🔗 | | | | | | | 🔗 | 🔗 | | ✓ | 🔗 | 🔗 | | | | | |
| **Acute Bed Days** | | 🔗 | 🔗 | ✓ | | | | | | | | | 🔗 | | | | | | | | | |
| Reduced Length of Stay | | 🔗 | 🔗 | 🔗 | | | | | | | | | ✓ | | | | | | | | | 🔗 |
| Readmission Rate | | 🔗 | 🔗 | ✓ | | 🔗 | | | | | | | 🔗 | | | | | | | | | 🔗 |
| Polypharmacy | | 🔗 | | | 🔗 | ✓ Expert group | | | | 🔗 | | | | | | | | | | | | |

| | Child & Youth Health Workstream | Health of Older People Workstream | Community Services SLA | Urgent Care SLA | Primary Care & Capability SLA | Pharmacy SLA | Population Health & Access SLA | Community & Public Health | Mana Ake – Stronger | Clinical Quality Education | Oral Health Service Development Group | Immunisation SLA | Realign / DHB Service Areas | Quality & Safety Expert Group | Project group PHOs / DHB | Pacific Reference Group | Te Kāhui o Papaki Kā Tai | Consumer Council | Mental Health Workstream | Falls & Fractures SLA | Midwives | Rural Health Workstream |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Falls Prevention / Reduction in Falls | | 🔗 | 🔗 | | | 🔗 | | | | | | | 🔗 | | | | | | | ✓ | | |
| Pasifika Futures Engagement | | | | | | | | | | | | | | | 🔗 | 🔗 | | | | | | |
| **Patient Experience of Care** | | | | | | | | | | | | | | | ✓ Expert group | | | 🔗 | | 🔗 | | |
| In-Hospital Response Rate | | | | | | | | | | | | | 🔗 | | ✓ | | | 🔗 | | | | |
| In hospital Engagement of Family & Whanau in Patient Care | | | | | | | | | | | | | | | ✓ | | | 🔗 | | | | |
| Primary Care implementation of PES | | | | | 🔗 | | | | | 🔗 | | | | | ✓ | | | 🔗 | | | | |
| Monitor / analyse local response rate, identify common focus area and utilise feedback | | | | | 🔗 | | | | | 🔗 | | | | | ✓ | | | | | | | |

| | Child & Youth Health Workstream | Health of Older People Workstream | Community Services SLA | Urgent Care SLA | Primary Care & Capability SLA | Pharmacy SLA | Population Health & Access SLA | Community & Public Health | Mana Ake – Stronger for Tomorrow | Clinical Quality Education | Oral Health Service Development | Immunisation SLA | Realign / DHB Service Areas | Quality & Safety Expert Group | Project group PHOs / DHB | Pacific Reference Group | Te Kāhui o Papaki Kā Tai | Consumer Council | Mental Health Workstream | Falls & Fractures SLA | Midwives | Rural Health Workstream |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Amenable Mortality** | | | | | | | ✓ | 🔗 | | | | | | | | | | | 🔗 | | | |
| Green Prescription Referrals | | | | | 🔗 | | ✓ | | | | | | | | | | | | | | | |
| Enrolment in Te Hā - Waitaha | | | | | 🔗 | 🔗 | ✓ Te Hā Waitaha Steering Group | | | | | | | | | 🔗 | 🔗 | | | | | |
| Cervical Cancer Screening | | | | | 🔗 | | 🔗 | | | | | | | | ✓ | 🔗 | 🔗 | | | | | |
| Improved Physical Health for People with Mental Illness and/or Addiction | | | | | 🔗 | | ✓ | 🔗 | | | | | | | ✓ | 🔗 | 🔗 | | ✓ | | | |
| **Youth Access to Health Services** | | | | | | | | | | | ✓ | | | | | | | | ✓ | | | |
| Deliver an accessible youth friendly Oral Health Service. | 🔗 | | | | | | 🔗 | | | | ✓ | | | | | 🔗 | 🔗 | | | | | |

| | Child & Youth Health Workstream | Health of Older People Workstream | Community Services SLA | Urgent Care SLA | Primary Care & Capability SLA | Pharmacy SLA | Population Health & Access SLA | Community & Public Health | Mana Ake – Stronger for Tomorrow | Clinical Quality Education | Oral Health Service Development Group | Immunisation SLA | Realign / DHB Service Areas | Quality & Safety Expert Group | Project group PHOs / DHB | Pacific Reference Group | Te Kāhui o Papaki Kā Tai | Consumer Council | Mental Health Workstream | Falls & Fractures SLA | Midwives | Rural Health Workstream |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Smokefree Infants** | | | | | | | ✓ Te Hā Waitaha Steering Group | | | | | | | | | | | | | | | |
| Pregnant Women accessing smoking cessation | 🔗 | | | | 🔗 | | ✓ | | | | | | 🔗 | | | 🔗 | 🔗 | | | | 🔗 | |
| Outcomes of pregnant Women accessing cessation | 🔗 | | | | 🔗 | | ✓ | | | | | | 🔗 | | | 🔗 | 🔗 | | | | 🔗 | |