Canterbury Clinical Network
Transforming Health Care. Whanau Ora ki Waitaha.

Canterbury Clinical Network work programme 2019-20

Version: Nov 2019

Introduction

This document brings together the 2019-20 Canterbury Clinical Network (CCN) alliance groups (Workstreams, Service Level Alliances and Service Development Groups) work plans submitted to the CCN Programme Office May 2019.

Background

The CCN is an alliance of health care providers from across the Canterbury Health system. CCN was established in 2008 to provide leadership to the transformation of the Canterbury health system on behalf of the people of Canterbury. Within the alliance framework a number of alliance groups have been established around populations and/or service areas of identified need. These groups work collectively to bring together information on the needs of a specific population or service, identify where improvements can be made that offer the best value, and lead changes that will contribute to improved health outcomes and/or access to health services.

Annually each CCN group develops a work plan that captures their expected activity for the next 12 months. This work planning is undertaken alongside the Canterbury District Health Board's (DHB's) Accountability Team and the System Level Measures Project Lead, with the content of the CCN work plans contributing to both the DHB's Annual Plan and the System Level Measures Improvement Plan.

The CCN Alliance Leadership Team (ALT) endorses all work plans with the alliance groups then reporting on progress against their work plan priority actions quarterly and any risks that could impact progress in their focus area.

2019-20 Work Planning

In Nov. 2018 groups were provided with a work planning guide that included information on system priorities, a work planning process and work plan template for completion. Following this a number of alliance groups presented their draft work plan to the Māori caucus for discussion, including how actions in the plan address the health needs of Māori. Pacific input was provided directly through the alliance groups.

Key themes from the CCN Strategic Planning workshop (1 February 2019) were shared with alliance groups to consider alongside their work planning. These workshop themes will inform the refresh of the CCN's strategic direction for 2019-2024 and be included in this summary work plan when available.

Each alliance groups work plan includes:

- Priority Actions: Where the group will focus their efforts for the next 12 months.
- Monitoring Actions: Activity across the system the group will monitor.
- Data Dashboard: Key metrics the group will use as indicators of progress on their priority actions and health outcomes their work is contributing to.

Any alliance group work plan activity that is contributing towards improved equity outcomes is identified with the code **EOA** (Equity Outcome Action). Where activity is contributing to progress against Canterbury's System Level Measures framework; this activity is identified with the code **SLM** (System Level Measures).

Contents

CCN Strategic Focus 2019 – 2024

CCN Structure June 2019

Canterbury Clinical Network Structure

June 2019

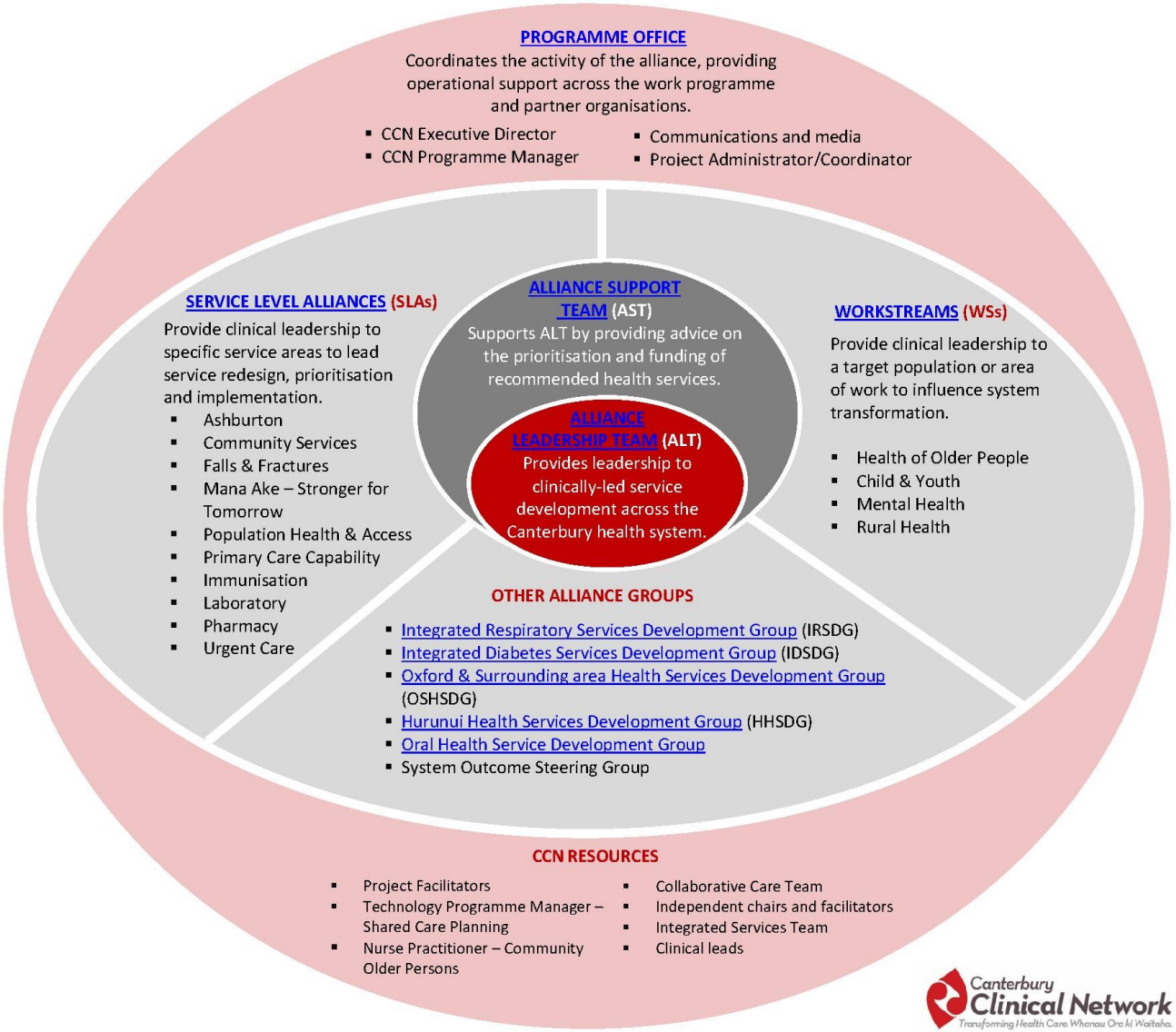
REFERENCE GROUPS
Other advisory groups we consult:

- Te Kahui o Papaki Ka Tai (TKOP)
- Pacific Reference Group
- Culturally & Linguistically Diverse (CALD) Health Advisory Group
- Canterbury District Health Board Consumer Council

ENABLERS
Other system enablers of our transformation:

- The Canterbury Initiative
- Integrated Family Health service
- Electronic Request Management System (ERMS)
- Community HealthPathways
- Hospital HealthPathways
- Allied Healthways
- Enhanced Capitation
- Standing Orders
- Collaborative Care/ Shared Care Plans
- HealthInfo
- HealthOne

FUNDER
Canterbury District Health Board (CDHB)



Ashburton Service Level Alliance Work Plan

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
SECTION ONE: Priority Actions Towards Transformational Change, Improved System Outcomes and/or Enhanced Integration							
1. Safer, efficient transfers of care for the elderly	EOA	1.1 Progress work on integrated journey for people aged 65 and over.	Q1 Q4	▪ Working group formed and prioritised action plan completed. ▪ Agreed elderly pathway developed and implemented.	John	Carol Jenny	▪ Increased planned care/decreased acute care rate ▪ Decreased institutionalisation rates
2. Improving equitable access to primary care for all populations including Māori, Pacific, Migrant and CALD		2.1 Strengthen / maintain relationships between primary, secondary, tertiary and community care.	Q1-Q4	▪ Regular meetings held.	Malcolm	Brenda	▪ Increased planned care/decreased acute care rate ▪ Decreased wait times ▪ Delayed/avoided burden of disease and long term conditions ▪ Primary care access improved ▪ 'At risk' population identified
	EOA	2.2 Confirm access to primary care enrolment and identify opportunities for improvement, with a focus on access for Māori, Pacific, Migrant and CALD populations.	Q1 Q2	▪ Data gathered. ▪ Information reviewed and opportunities for improvement identified.	Sue	Michelle Carol Bill	
	EOA	2.3 Agree additional opportunities to facilitate enrolment in general practice including: ▪ Transfers between practices ▪ Access for vulnerable populations, including ARC residents.	Q3 Q4	▪ Current process clarified and/or pathways developed for enrolment and transfer between practices. ▪ Pathways/protocols implementation by Q4.	Sue	Bill Carol Hiedee	

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
		2.4 Support the uptake of initiatives that assist general practice manage their capacity to enable timely access to care e.g. IFHS, patient portal, shared care plans.	Q4 Q4 Q4	▪ Number of general practices participating in the IFHS programme. ▪ Utilisation of care plans across general practice (number of plans created and updated. ▪ Number of care plans created in Ashburton hospital.	Sue	Bill Carol	
3. Continue with Access to Acute Care co-design recommendations		3.1. Agree and implement a process for non-enrolled (casual) and registered patients presenting at AAU or after-hours GP to access primary care.	Q3	▪ Consistent process agreed and promoted across the district.	Malcolm	John	▪ Increased planned care/decreased acute care rate ▪ Decreased wait times ▪ Delayed/avoided burden of disease and long term conditions ▪ Primary care access improved ▪ 'At risk' population identified
		3.2. Standardise and implement consistent processes for people to access acute care including the use of the 'Call your GP 24/7' message across Ashburton.	Q4	▪ Consistent utilisation of the 'Call your GP 24/7' message.by Ashburton residents.	Brenda	Hiedee	▪ Increased planned care/decreased acute care rate ▪ Decreased wait times ▪ Delayed/avoided burden of disease and long term conditions ▪ Primary care access improved

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
4. Strengthen the integration and coordination of care and in collaboration with patients		4.1. Increase the use of Acute and Advanced Care Plans by primary, secondary and community care providers.	Q4 Q4	▪ Increased number of care plans created in Ashburton hospital. ▪ Increased number of plans created and updated across general practice.	Sue Brenda	Berni	▪ Decreased wait times ▪ Delayed/avoided burden of disease and long term conditions. ▪ Decreased avoidable mortality. ▪ Decreased adverse events. ▪ Decreased institutionalisation rates. ▪ Increased planned care/decreased acute care rate.
5. Placeholder objective around Work Force planning		5.1. Still awaiting further confirmation of this action.			Greg	Mary	
SECTION TWO: Actions Towards Monitoring Progress							
6. Integration of Social Services within Ashburton		6.1. Identify opportunities for better alignment across health and social services, e.g.: ▪ Participation of ASLA member(s) in the Ashburton Community Planning Group. ▪ Expansion of alliance work group membership to include relevant social	Q4	▪ MSD engaged in progressing areas of mutual interest.		Jenny Michelle	▪ Improved environment supports health and wellbeing. ▪ People are supported to stay well.

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
		services partners, e.g. MSD.					
7. Mental health integration and accessibility		7.1. Support the Mental Health Work Stream implement new initiatives in Ashburton.		▪ Meeting quarterly with the Mental Health Work Stream facilitator to receive updates on any new initiatives.		Kathy	Decreased avoidable mortality. Decreased adverse events. Improved environment supports health and wellbeing. People are supported to stay well.
		7.2. Monitor the Canterbury Suicide Postvention work in Ashburton.		▪ Suicide Postvention team present to the ASLA on the work that is being done in the area		Carol	Decreased avoidable mortality. Decreased adverse events. Improved environment supports health and wellbeing.

SECTION THREE: Key metrics the group will use to indicate progress with delivering work plan actions, impact on health outcomes and/or monitor performance targets.

Description of Metric	Data Source	Comments on access to data / metrics
1. Enrolment and non-enrolment data by ethnicity	CDHB/PHOs	
2. Shared Care Plan data on plans created and amended.	Collaborative Care	
3. AAU Attendance data including by age, ethnicity and enrolment status	CDHB	

Child and Youth Workstream Work Plan

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
SECTION ONE: Priority Actions Towards Transformational Change, Improved System Outcomes and/or Enhanced Integration							
Child Health & Wellbeing							
1. Support the development of Regional and District Child Wellbeing Strategies, particularly First 1000 days of a child's life		1.1. Strengthen LMC's understanding of key themes and referral pathways around: parenting skills; improving responsive relationships; treating mental health depression; and access to early childhood education; during their home visits.		▪ Improved uptake of nutritional advice, immunisation in pregnancy, SUDI education, family violence prevention, treating depression & anxiety, targeting zero alcohol consumption, and family planning,	Norma	Nicky	Improved Environment supports health and wellbeing. Delayed / avoided burden of disease and long term conditions.
2. Increase children's readiness for School		2.1 Develop improved Early Childhood Health Education (ECE) support systems.	Q1 - Q4	▪ ECE relevant pathways in 'Leading Lights' developed.	Donna E	Wayne T	Improved Environment supports health and wellbeing. Delayed / avoided burden of disease and long term conditions.
		2.2 Support the redevelopment of the Paediatric Community Continence service.	Q2 & Q4	▪ Continence in 5 year olds is improved		Bridget L	
		2.3 Continue supporting alignment between Public Health Nurses and Kahui Ako.	Q1 – Q4	▪ Public Health Nurse's activity supporting all Kahui Ako (Medium Term Measure)	Melissa K Vicky B	Bridget L	
3. Improve access to child development and family mental health services for children with		3.1 Continue the development of an integrated approach between child mental health, paediatric services including child development, child disability support services alongside education / Ministry	Q1 – Q4	▪ Improved integration between services.	Clare D / Judith B.	Anna H & Matt R	Improved Environment supports health and wellbeing. Delayed / avoided burden of disease and long term conditions.

neuro-developmental issues and or disabilities.		of Education (Service Development Group)					
Child and Family Safety							
4. Caring for vulnerable children	EOA	4.1 Collaborate with Oranga Tamariki to ensure the joint focus on vulnerable children and young people is maintained as the transition of Children's Team into new models of intensive care and early intervention over the next two to three years.	Q1 – Q4	▪ Local Governance Group Workshop held to determine future direction for Canterbury Children's Team.	Clare D	Wayne T	Improved Environment supports health and wellbeing.
		4.2 Development of a joined up approach between health, education, and Oranga Tamariki on understanding and providing trauma informed care.	Q1 – Q4	▪ Development of care pathways for trauma informed care (check with Mana Ake) (Service Development Group) ▪ Cross sector training programmes delivered on Trauma Informed care	Clare D	Donna E	Improved Environment supports health and wellbeing. Decreased wait times.
	EOA	4.3 Improve the provision of child health interventions, including appropriate referrals and access to Family Start/ Early Start, Teen Parent Units and Oranga Tamariki.	Q2	▪ Increased uptake of Family Start/ Early Start, Teen Parent Units and Oranga Tamariki interventions	Clare D	Wayne T / Donna E	
		4.4 Develop systems for the coordination of data and information sharing between Health, ISR, Oranga Tamariki, Education, and Police.		▪ Information sharing in place		Wayne T	
Adolescent and Early Adulthood Health and Wellbeing							

5. Supporting Health in Schools		5.1 Promote the CDHB alcohol harm reduction strategy in schools.	Q1 – Q4	▪ Promotion in schools occurs		Kerry M	Improved Environment supports health and wellbeing.
6. Transition from child to adult health services		6.1 Promote the transition of young people to adult health services that meet the needs of 16-25 year olds with complex care needs (medical, disabilities).	Q4	▪ Recommendations of the paediatric collaborative transition group and Ministry of Health mental health service transition guidelines progressed.	Nicola Scott / Judith B	Melissa K / Monique G	
Family wellbeing							
7. Increase family's livening in warm homes	SLM	7.1 Instigate action to reinstate a warm housing programme	Q2 – Q4	▪ A warm housing programme is established in partnership with EECA.		Bridget Lester	Improved Environment supports health and wellbeing.

SECTION TWO: Child and Youth Health Workstream monitoring of other ongoing work related to child and health wellbeing through receiving of regular reporting			
1. Maternity Strategy		Quarterly reporting	Nicky S.
2. Maternity Quality &Safety Programme		Annual reporting	Sam Burke
3. Improve delivery of pregnancy/parenting courses		Quarterly reporting	Rachel Thomas
4. Raising Healthy Kids		Quarterly reporting	Donna Ellen
5. Immunisation		Quarterly reporting	Bridget Lester
6. Oral Health		Six monthly reporting	Bridget Lester
7. SUDI		Quarterly reporting	Nicky Smithies
8. B4SC outcomes		Six monthly reporting	Bridget Lester
9. Unintended teenage pregnancy		Six monthly reporting	Bridget Lester
10. SLM to reduce ASH rates for children		Quarterly reporting	Nicky Smithies
11. Child & Family Safety / VIP		Six monthly reporting	Pene Kingsford
12. Suicide Prevention			

13. ISR		Six monthly reporting	Pene Kingsford
14. Mana Ake		Six monthly reporting	Clare Shepard
15. Alcohol Harm Reduction		Six monthly reporting	Kerry Marshall

Community Services Service Level Alliance Work Plan

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
SECTION ONE: Priority Actions Towards Transformational Change, Improved System Outcomes and/or Enhanced Integration							
1. Increased implementation of Restorative Support across Community Services	EOA	1.1 Develop a Restorative Support education strategy for the sector and wider public including: ▪ Socialising a Restorative model of care ▪ Revising the relevant HealthPathways ▪ Developing and implementing a communications plan	Q1 Q2 Q2-3 Q4	▪ Plan for socialising Restorative Model of Care finalised. ▪ HealthPathways revised. ▪ Communications plan developed ▪ Communications plan implemented.	Glenda Rich	Andrea Davidson Greta Bond	Fewer people need hospital care. People are supported to stay well. Access to care improved.
		1.2 Implement a new referral form for Restorative Support by: ▪ Piloting a new referral form ▪ Gathering feedback to inform revision of the form ▪ Implementing the final referral form	Q1 Q2 Q3	▪ Pilot completed and feedback received. ▪ Final referral form developed. ▪ Referral form implemented.	Glenda Rich	Karen Dennison	Collaborative plans of care. Effective transfer to care. Resources matched to need.
2. Ethical Framework for service delivery	EOA	2.1 Implement an ethical framework to guide service delivery	Q1 Q2	▪ Final draft framework approved by SLA ▪ Plan agreed and implemented.	Kate Lopez	Andrea Davidson	Equity; Living within our means; No wasted resource

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
3. Equitable access to services for Māori	EOA	3.1 With the HOPWS continue to develop support services for kaumātua in rural areas by: ▪ Submitting a business case for the kahukura project in Birdlings Flat. ▪ Establishing the Birdlings Flat programme. ▪ Analysing the programme and assessing the kahukura project. ▪ Completing a business case for the wider roll-out of the project.	Q1 Q1 Q3 Q4	▪ Business Plan submitted ▪ Programme established in Bridlings' Flat ▪ Programme analysed and project assessed ▪ Business case for wider roll-out completed.	Irihapeti Bullmore	Greta Bond	Equity; Resources matched to need; Increased equity of access
4. Equitable access for support services for the Pasifika and CALD communities	EOA	4.1 Continue to develop support services for the Pasifika Community. ▪ Establish a planning group. ▪ Meet with stakeholder groups in the Pasifika community. ▪ Develop a Pasifika strategy and implementation plan.	Q1 Q1-Q3 Q4	▪ Planning group established ▪ Meetings completed ▪ Pasifika strategy and implementation plan developed	Anne Roche	Karen Dennison	Equity; Resources matched to need; Increased equity of access; Access to care improved
	EOA	4.2 Continue to develop support services for the CALD, refugee, and migrant community including:	Q1 Q1-Q3 Q4	▪ Planning group established ▪ Meetings completed ▪ CALD strategy and implementation plan developed	Anne Roche	Karen Dennison	Equity; Resources matched to need; Increased equity of access; Access to care improved

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
		▪ Establish a planning group. ▪ Meet with stakeholder groups in the CALD community. ▪ Develop a CALD strategy and implementation plan.					
SECTION TWO: Actions Towards Monitoring Progress							
5. Elder Abuse/ Social Isolation		5.1. Monitor scores of interRAI assessments.	Q1-Q3	▪ Reports received and considered		Greta Bond	People are supported to stay well
6. Equitable delivery of Rural Community Services	EOA	6.1. Receive reports from the Rural Health WS on rural models of care	Q1-Q4	▪ Reports received		Greta Bond	Equity; Increased equity of access; Access to care improved
7. Monitor delivery of interRAI assessments		7.1. Receive reports on: ▪ Method of Assessing Priority Levels (MAPLe) scores ▪ Institutional risk Clinical Assessment Protocols (CAP) ▪ Social relationship CAP ▪ Appropriate medications CAP.	Q1-Q4	▪ Reports received and considered	Kate Lopez	Andrea Davidson	Access prioritised; Earlier diagnoses; timely access to supports
8. Monitor progress of Bariatric workgroup		8.1. Receive reports on progress of this group.	Q1-4	▪ Reports received	Jane Evans	Andrea Davidson	

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
9. Monitor the uptake of Personalised Care Plan		9.1 Establish a baseline measure of the number of Personalised Care Plans and monitor any change in baseline metrics.	Q1 Q2	▪ Baseline measures for care plans established. ▪ Improvements measured against metric.	TBA	Karen Dennison	Collaborative plans of care;

SECTION THREE: Key metrics the group will use to indicate progress with delivering work plan actions, impact on health outcomes and/or monitor performance targets		
Description of Metric	**Data Source**	**Comments on access to data / metrics**
1. interRAI assessments per 1000 population 65+ (55+ Māori)		
2. % of HBSS clients 65+ with an interRAI		
3. % of people receiving HBSS that have an Advance Care Plan		
4. % of people receiving HBSS that have a cognitive impairment		
5. % of HBSS clients with a Home Care assessment that are MAPLE 5 (receive 24hr supervision)		

Coordinated Access on Release Service Development Group Work Plan

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
SECTION ONE: Priority Actions Towards Transformational Change, Improved System Outcomes and/or Enhanced Integration							
1. Improve access to services for people on release		1.1 Any identified initiatives are bought to the service development group to determine next steps following project methodology e.g. scope, capacity and suitability.	TBC	▪ New initiatives are identified and are successfully established as pilot where appropriate.	Nathan Toni	Melissa Pablo	
		1.2 Develop a HealthPathways page which provides guidance to general practitioners on how to access navigation services for people on release.	TBC	▪ HealthPathways page is developed	Jeremy Health-pathways member	Kathy	
		1.3 Communicate pilot/s including successes and areas for improvement.	TBC	▪ All communications distributed through the agreed communication channels with the parties involved	Carolyn Elly Nathan	Hiedee	
		1.4 Embed pilot/s into existing services across the system where appropriate.	TBC	▪ Services embedded and are seen to be business as usual.	Toni	Melissa Pablo	
2. Identify an appropriate governance group for the		2.1. Work towards a long term solution for governance for the service development	TBC	▪ The work group's work is overseen by an appropriate SLA within CCN.	Jeremy Paul	Jane	

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
Coordinated Access on Release work group		group, perhaps Pop Health and Access SLA					
SECTION TWO: Actions Towards Monitoring Progress							
3. Provide sustainable and integrated programmes		3.1. Monitor the effectiveness of programmes including; ▪ Guided release ▪ Justice precinct ▪ Free & extended consultations	TBC	Reporting occurs on: ▪ Numbers of participants referred by ethnicity. ▪ Number of participants enrolled by ethnicity. ▪ Number of free &extended consultations with general practice. ▪ An evaluation of pilots when available.	Nathan Toni Melissa	Kathy	

SECTION THREE: Key metrics the group will use to indicate; progress with delivering work plan actions, impact of actions on health outcomes, monitor performance targets etc. *(Consider whether the data is available in a way that identifies any inequity of health outcomes or access to services)*

Description of Metric	Data Source	Comments on access to data / metrics
1. Number of participants enrolled and number of participated in general practice at 3/6 months	CDHB/Pegasus	Melissa & Kathy to provide

Falls & Fractures Service Level Alliance Work Plan

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
SECTION ONE: Priority Actions Towards Transformational Change, Improved System Outcomes and/or Enhanced Integration							
1. Fewer fall injuries	EOA	1.1 Increase 65 years+ population's access to accredited Community Strength & Balance classes through: ▪ Target increase in the class places available. ▪ Developing and launching culturally-appropriate classes for Māori, Pasifika and other CALD populations.	Ongoing	▪ Community Strength & Balance class TARGET: 3,005 Places per quarter (annual: 12,020). With an aspirational goal of 3,005 attendees per quarter. ▪ 3 classes created for Māori ▪ 3 classes created for Pasifika ▪ 3 classes created for other CALD groups	Ken Stewart	Rebecca Logan	Decreased adverse event Community falls reduced
2. Fewer serious harm falls and fractures	SLM	2.1 Reduce serious harm fall events in Canterbury compared to baseline. Indicators of progress to include ED presentations as a result of a fall and the % rate of those that are admitted.	Ongoing	▪ Trend analysis through signals from noise reviewed quarterly, including by ethnicity.	Ken Stewart	Rentia Hurter	Acute Hospital Bed Days Reduced acute hospital bed days following a fall
		2.2 Maintain targeted referrals to the Falls Prevention program for those 75+ (65+ for Māori) through: ▪ Launch of 'green dot' referral pathway	Q1 Q2 Q3	▪ 'Green dot' referral pathway launched at 24 Hour Surgery. ▪ Value of 'green dot' referral pathway assessed. ▪ Referral trends from urgent care providers reported on.	Ken Stewart	Koral Fitzgerald	Decreased adverse event Community falls reduced

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
		▪ Report on assessing the value and referral trends. ▪ Engage with other Urgent Care providers across Canterbury, with a view to launch the assessed pathway.	Q3	▪ Number of 65+ with a fragility fracture presenting at after-hours and referred to the Falls Prevention Programme; shared with 24HS clinicians. Engagement with other Urgent Care providers across Canterbury confirmed.			
3. Improved recovery (both hospital and home)	SLM	**In Home** See point 1: Fewer fall injuries **In Hospital** 3.1 Increase referrals from Fracture Liaison Service to Falls Prevention Programme , compared to baseline	Ongoing Q1 – Q4	TARGET: 100% #NOF reported to ANZHFR ▪ Monitor trends of targeted referrals from the Fracture Liaison Service	Ken Stewart	Lynda Te Momo	Decreased adverse event Serious Harm falls reduced
		3.2 All Canterbury patients with #NOF reported to the Australian & New Zealand Hip Fracture Registry (ANZHFR)	Q1 – Q4	▪ ANZHFR dashboard updated quarterly.	John Geddes	Lynda Te Momo	
		3.3 Consider application of ANZHFR quality measures within secondary care	Q1 Q2 Q4	▪ Report on ANZHFR measures and relevant signals from noise data for Canterbury received ▪ Staged modifications in processes identified ▪ Comparative report on 12 month length of stay for #NOF received	John Geddes	Lynda Te Momo	
		3.4 Launch pilot for automatic referrals to the Falls Prevention Program for patients 75+ who are	Q1 Q2	▪ Automatic referral pathway pilot and communications launched ▪ Review pilot and outcomes	John Geddes	Rentia Hurter	

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
		admitted to hospital with a fractured Humerus or a #NOF	Q3	▪ Implement Automatic Referral Pathway			
4. Integrated falls and fracture care across the system	EOA	4.1 Falls Prevention Programme education delivered to health professionals (Aug/Sept 2019) including consideration of large group education (September 2019) for additional primary care and/or allied health and older person's health professionals.	Q1	▪ Align Falls Prevention education to wider health professional groups alongside ACC CME Falls Education for GP's scheduled August 2019	Ken Stewart	Heather Bushaway Koral Fitzgerald	Decreased adverse event Integrated falls prevention
		4.2 Align with the Hospital Falls Prevention Steering Group (HFPSG) through sharing information and representative's attending meetings.	Ongoing	▪ Regular attendance of HFPSG meetings and associated working groups (April Falls).	Ken Stewart	Koral Fitzgerald	Decreased adverse event Hospital falls reduced
	SLM	4.3 Work with OPH&R to implement the non-acute rehabilitation (NAR) case mix across our inpatient and community teams to reduce length of stay and ensure targeted community service provision to those with fractures.	Q1-Q4	TARGET: 1,200 CREST bundles of care	Ken Stewart	Mardi Postill	No wasted resource Resources matched to need; right care, right place, right time, right person
		4.4 Improve rates of Bisphosphonate prescribing	Q1	▪ Baseline bisphosphonates prescribing identified.	Lynda Te Momo	Koral Fitzgerald	Decreased Institutionalisation rates Reduced harm from falls

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
		post-fragility fracture, through: ▪ Identifying a baseline of prescribing habits (inpatient and community), ▪ Identify factors impacting delivery and compliance	Q2	▪ Report on biphosphonate prescribing trends and delivery received Q2.	John Geddes	Lynda Te Momo	
SECTION TWO: Actions Towards Monitoring Progress							
5. Fewer fall injuries	SLM	5.1 Maintain people aged 75+ access to In-Home falls prevention programs.	Ongoing	TARGET: 300 people (75+) per quarter (annual total target: 1,200).	Ken Stewart	Heather Bushaway	Acute Hospital Bed Days Reduced acute admissions following a fall
		5.2 Monitor hospital-acquired conditions (HAC) and mortality rate (30 days & 180 days post-surgery) for patients with #NOF.	Q1 & Q3	▪ ANZHFR dashboard update received 6-monthly.	John Geddes	Rentia Hurter	Decreased avoidable mortality Decreased in-hospital mortality

SECTION THREE: Key metrics the group will use to indicate progress with delivering work plan actions, impact on health outcomes and/or monitor performance targets		
Description of Metric – Core / clinical metrics	**Data Source**	**Comments on access to data / metrics**
1. Number of classes, places, reach, super-reach and average utilization of Community Group Strength & Balance Classes, including cultural appropriate class measure	Sport Canterbury	
2. Number of acute admissions following a fall for 65+ year olds (55+ for Māori and Pasifika)	CDHB / sfn	
3. Number of acute hospital admissions for #NOF for 75+ year olds (65+ for Māori and Pasifika)	CDHB / sfn	

4. Number of non-acute bundles of care delivered to patients by CREST	CDHB	
5. Number of people on bisphosphonates in Canterbury compared Nationally	HQSC Dashboard	
6. Number of Canterbury patients 75+ years old (65+ for Māori and Pasifika) utilising In-Home FPP	CDHB /	
7. Number of 65+ year olds (55yrs+ for Māori and Pasifika) presenting with a fragility fracture at after-hours, referred to the Falls Prevention Programme (FPP) and /or on bisphosphonates	Pegasus Health & FLS	
8. Number of fractured NOF and humerus referred to FPP as a result of the automatic referral pilot (Q2 & Q4)	CDHB	

Health of Older People Workstream Work Plan

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
SECTION ONE: Priority Actions Towards Transformational Change, Improved System Outcomes and/or Enhanced Integration							
1. Equitable access to services for kaumātua	EOA	1.1 Develop support services for kaumātua in rural areas by: ▪ Submitting a business case and establishing the Birdlings Flat kahukura programme. ▪ Collecting data (including feedback from Kaumātua) ▪ Completing a review of the programme including its feasibility. ▪ Completing a business case for roll-out to a second rural marae. ▪ Planning plan for a hui at the second rural marae.	Q1 Q1 Q3 Q4 Q4	▪ Business Plan submitted ▪ Programme established in Birdlings Flat ▪ Programme analysed & project assessed ▪ Business case for wider roll-out completed. ▪ Initial plan for hui at other rural marae completed	Annette Finlay/ Irihapeti Bullmore	Greta Bond	Equity; People are supported to stay well; Community resilience/capacity enhanced
2. Improved actions to meet anticipated increase in people with Dementia		2.1. Develop information on dementia prevention by agreeing a set of messages and work with Community & Public Health to socialise these.	Q1 Q2-Q4	▪ Messages agreed. ▪ Messages socialised.	Matthew Croucher	Greta Bond	People are supported to stay well; Protecting people against health hazards; protective factors enhanced; Population interventions; Risk factors addressed
		2.2. Work with PHOs to promote benefits of early diagnosis for people with dementia and their family/ whānau by	Q1 Q2 Q2-4	▪ Stocktake of referrals completed and frequent referrers identified ▪ Messages distributed	Matthew Croucher	Greta Bond	Timely access to supports; Earlier access to specialist advice;

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
		▪ Identifying frequent referrers to Dementia Canterbury ▪ Developing and distributing messages to general practice ▪ Monitoring change in referral patterns		▪ Referrals from new referrers received.			
	EOA	2.3 In accordance with South Island Dementia Framework explore options for implementing dementia specialist nurses/champions by: ▪ Undertaking a stocktake ▪ Consulting with stakeholders. ▪ Developing strategies and ▪ Submitting a business case.	Q1-Q2 Q3 Q4	▪ Stocktake of services and consultation completed ▪ Strategies developed ▪ Business case submitted	Matthew Croucher	Greta Bond	Management of disease (best practice); Collaborative Plans for Care
3. Pre-frail cohort identified and services developed to improve wellness		3.1. Identify pre-frail cohort and develop services to improve their wellness, and develop a HealthPathway	Q1 Q2-Q3 Q4	▪ Pre-frail criteria identified. ▪ Strategies developed for addressing strength and balance, nutrition and social connection ▪ HealthPathway developed	Val Fletcher	Karen Dennison	People are supported to stay well; Delayed/avoided burden of disease and long-term conditions
4. Enhanced supports for Carers	EOA	4.1 Implement a more flexible delivery of Carer Support including: ▪ Research and recommend changes in carer support. ▪ Implement recommendations. ▪ Increase utilisation of carer support by ethnicity.	Q1 Q2 Q1 Q4	▪ Recommendations completed ▪ Changes to carer support utilisation implemented ▪ Uptake of Carer Support by ethnicity benchmarked. ▪ Utilisation of Carer Support by ethnicity increased	Anne Roche	Greta Bond	People are supported to stay well; Management of disease (best practice); Community resilience/capacity enhanced

OBJECTIVE	EOA / SLM	ACTIONS	TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY CLINICAL LEAD	ACCOUNTABILITY PROJECT LEAD	SYSTEM OUTCOMES
5. Quality Improvements in Aged Residential Care (ARC)		5.1 Increase visibility of the roll-out of Health Connect South/ Health One in Aged Residential Care.	Q2	▪ General Practice and RNs in facilities have a timeline for Health Connect South/ Health One roll-out.	Richard Scrase	Alison Young	People are supported to stay well; delayed/avoided burden of disease and long-term conditions
	EOA	5.2 Increase cultural competency of staff in Aged Residential Care facilities, especially those trained overseas by: ▪ Undertaking a stocktake of programmes to address cultural competency of ARC staff ▪ Identify any gaps and develop resources.	Q1 Q2 Q3	▪ Stocktake completed ▪ Gaps identified ▪ Resources developed	Richard Scrase	Greta Bond	Equity
SECTION TWO: Actions Towards Monitoring Progress							
6. Wider Access to Health Plans		6.1. Monitor the uptake of: ▪ Advance Care Plans ▪ Medical Care Guidance Plans ▪ Personalised Care Plans	Q1-4	▪ Increased use of all plans	Janice Lavelle	Karen Dennison	Access to care improved; Coordinated care
7. Links with other workstreams and alliances		7.1. Review CCN Quarterly reports to identify shared areas of work across other SLAs and Work Streams	Q1-4	▪ Quarterly meetings completed with relevant facilitators	Janice Lavelle	Greta Bond	
8. Palliative Care	SLM	8.1. Maintain links with South Island Alliance Palliative Care Workstream	Q1-4	▪ Quarterly reports from ARC Palliative Care CNZ service show increasing coverage of ARCs	Richard Scrase	TBA	Access to care improved; Death with Dignity
9. Health Literacy		9.1. Monitor Use of HealthInfo	Q1-4	▪ Traffic on site reported quarterly	Richard Scrase	Greta Bond	Social environment supports health;

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
				▪ Positive consumer feedback post review of selected HealthInfo content			
10. Monitor Corporate Quality and Patient Safety team work on Pressure Injuries funded by ACC		10.1. Review interRAI data updates from Sue Wood and team	Q1-4	▪ Updates received quarterly	Diana Gunn	Andrea Davidson	Management of disease (best practice);
11. Dental Health education for ARC workers		11.1. Monitor GNS roll-out of education sessions for support workers on dental hygiene and health	Q1-4	▪ Reports received	Richard Scrase	Greta Bond	Behavioural interventions delivered;

SECTION THREE: Key metrics the group will use to indicate progress with delivering work plan actions, impact on health outcomes and/or monitor performance targets		
Description of Metric	**Data Source**	**Comments on access to data / metrics**
8. Admissions to ARC by ethnicity (55+ Māori)		
9. Admissions to Hospital 65+ by ethnicity (55+ Māori)		
10. Length of stay 65+ by ethnicity (55+ Māori)		
11. % of people 65+ living in their own homes by ethnicity (55+ Māori)		
12. ED presentations 65+ by ethnicity (55+ Māori)		

Immunisation Service Level Alliance Work Plan

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
SECTION ONE: Priority Actions Towards Transformational Change, Improved System Outcomes and/or Enhanced Integration							
1. Improve Pregnancy Vaccinations coverage.		1.1 Survey new parents around pregnancy vaccinations.	Q2	Understand why parents are not vaccinations and the messages they are given during pregnancy will be developed.	Helen Fraser	Bridget Lester	Delayed/avoided burden of disease & long term conditions Population vaccinated. Protective factors enhanced. Risk factors addressed
		1.2 Develop Education Programmes for General Practitioners and LMCs, including updating the LMC Toolkit.	Q2	General practice, LMCs and Pharmacies have the tools to talk to women around pregnancy vaccinations	Helen Fraser	Bridget Lester	
		1.3 Further investigate the opportunity to provide Pregnancy Vaccinations through community pharmacy	Q3	Increase vaccination coverage rate. Target =60%	Helen Fraser	Bridget Lester	
2 Ensure timely childhood immunisation	EOA	2.1 Continue reducing declines for childhood vaccinations, by supporting general practice teams, with a focus on decreasing the Māori decline rate.	Q1	▪ Declines are reduced each quarter to an level of 3.5%	Sarah Marr Alison Wooding	Bridget Lester	Contribute to National Health and Performance Targets Delayed/avoided burden of disease & long term conditions Population vaccinated
	EOA	2.2 Work with National Immunisation Register and Outreach Immunisation Services to improve coverage at 5 years olds for all population groups.		▪ Declines are reduced each quarter to an level of 3.5%	Sarah Marr Alison Wooding	Bridget Lester	
3. Improve equity coverage of	EOA	3.1. Consult with Māori and Pasifika groups to better understand	Q2		Ramon Pink	Bridget Lester	

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
Adolescent Immunisations		barriers to adolescent vaccinations.					Contribute to National Health and Performance Targets Delayed/avoided burden of disease & long term conditions Population vaccinated
		3.2 Continue to support general practice, to enable them to promote the co-delivery of HPV and Tdap at age 11, including development of resources.	Q2	▪ General Practice continue to be supported to offer the programme. ▪ Coverage rates of Tdap and HPV given in general practice are similar.	Ramon Pink	Bridget Lester	
		3.3 Develop a trial for an online consenting process for the school based programme.	Q2	▪ Online consenting is offered for the 2020 School based programme	Ramon Pink	Bridget Lester	
4. Rheumatic Fever patients receive their medication in a timely manner		4.1. Oversee delivery of the new service model implemented March 2019 including timeliness of engagement	Ongoing	▪ Regular reports on the timeliness of engagement received. ▪ 70% of Rheumatic Fever patients receive their regular treatment on time.	Tony Walls	Bridget Lester	Contribute to National Health and Performance Targets Delayed/avoided burden of disease & long term conditions
SECTION TWO: Actions Towards Monitoring Progress							
5. Monitoring of Funded vaccines to ensure equity of coverage of these vaccines		5.1. Receive regular reports on coverage, review and monitor these, and develop a plan to improve if coverage is decreasing	Ongoing	Reports received and reviewed			Contribute to National Health and Performance Targets Delayed/avoided burden of disease & long term conditions. Population vaccinated

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
6. Improve Older Person Vaccinations		6.1 Work with PHO and Pharmacy Leads to identify local strategy's to support an integrated approach to improving older person's vaccination (Influenza and Shingles) rates with a focus on Māori. This will include: ▪ Reviewing current performance data; ▪ Identifying any areas of improvement; and ▪ Develop a plan for improvement as needed	Q1 Q2 Q3	Improvement in Influenza coverage by 2% on previous year rates.			Contribute to National Health and Performance Targets Delayed/avoided burden of disease & long term conditions Population vaccinated

SECTION THREE: Key metrics the group will use to indicate progress with delivering work plan actions, impact on health outcomes and/or monitor performance targets		
Description of Metric	**Data Source**	**Comments on access to data / metrics**
1. Vaccination coverage including by ethnicity		
2. Vaccination declines by ethnicity		
3. HPV coverage by ethnicity		

Integrated Diabetes Service Development Group Work Plan

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
SECTION ONE: Priority Actions Towards Transformational Change, Improved System Outcomes and/or Enhanced Integration							
1. Enhance self-management and health literacy for people with diabetes	EOA	1.1 Deliver patient education in a range of community settings to support improved access for priority population groups	Q3	▪ Recommendations for the redesign of patient education completed.	Juliet Berkeley	Denise Brankin, Rachel Thomas	Delayed/avoided burden of disease & long term conditions
2. Enable people with diabetes to better manage their condition	EOA	2.1 Further integrate the diabetes nursing workforce to encourage: ▪ Increased community service delivery ▪ Consistent clinical oversight ▪ Equity of access for patients regardless of complexity of diabetes.	Q3 Q4	▪ A vision and road map to achieving an integrated diabetes nursing team agreed. ▪ Implementation Plan for integrating the diabetes nursing team completed	Juliet Berkeley	Denise Brankin, Sandy Marshall, Rachel Thomas	Reduced clinic cancellations No wasted resource Right care, in the right place, at the right time, delivered by the right person
	EOA	2.2 Explore increasing service delivery in the community and aligning the dietetic and nutritionist workforce to the location of service delivery.	Q4	▪ Stock take of the current access to and location of dietetic/nutrition completed to establish baseline and unmet need ▪ Recommendations for changes in workforce and location are completed. ▪	Juliet Berkeley	Denise Brankin, Sandy Marshall, Rachel Thomas	Delayed/avoided burden of disease & long term conditions Access to care improved

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
SECTION TWO: Actions Towards Monitoring Progress							
3 Promote engagement with high risk groups such as: ▪ **Māori** ▪ **Pasifika Peoples** ▪ **Indian** ▪ **Adolescents/ Young adults** ▪ **People with mental illness**	EOA	3.1. Monitor integrated diabetes (specialist and community services, general practice, retinal screening, and high risk diabetic foot) activity for priority populations through data sharing and analysis.	Q1-4	▪ Number of Māori and Pasifika people with diabetes ▪ Number of Māori and Pasifika with HbA1c <65mmol/mol ▪ Six-monthly reporting to IDSDG on activity, including ethnicity	Juliet Berkeley	Simon Berry, Paul Bridgford, Rachel Thomas	Delayed/avoided burden of disease & long term conditions 'At risk' population identified
4 MoH Reporting		4.1 Monitor delivery against the Ministry of Health requirements for the 20 Quality Standards of Diabetes Care	Q1-4	▪ Service delivery reflects the national quality standards ▪ Review of delivery against the 20QS completed regularly (at least annually)	Juliet Berkeley	Rachel Thomas	

SECTION THREE: Key metrics the group will use to indicate progress with delivering work plan actions, impact on health outcomes and/or monitor performance targets

Description of Metric	Data Source	Comments on access to data / metrics
1. Number of people with diabetes and their HbA1C results by ethnicity	PHOs/DHB	Shared data from PHOs; collected six-monthly; managed by Simon Berry at Planning & Funding
2. Volume and wait times for retinal screening by ethnicity	Decision Support	

3. Volume of participants receiving diabetes foot care – community	PHOs/DHB	PHO managers and Simon Berry
4. Volume of participants receiving diabetes foot care – MDT podiatry/vascular/ID clinics	Decision Support	
5. Volume of participants receiving diabetes foot care – podiatry/orthopaedic clinics	Decision Support	

Integrated Respiratory Services Development Group Work Plan

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
SECTION ONE: Priority Actions Towards Transformational Change, Improved System Outcomes and/or Enhanced Integration							
1. Timely diagnosis and access to care for people with respiratory disease	EOA	1.1. Work with Māori and Pasifika providers to increase the engagement of people with respiratory conditions.	Q1-4	▪ Increase in the number of Māori and Pasifika people seen by the Integrated Respiratory Nursing Service (baseline = Māori 2 (5%); Pasifika >0 (0%) (Dec 18)).	Mike Epton, Maureen Trewin, Teresa Chalecki	Maureen Trewin, Teresa Chalecki, Deborah Callahan	Delayed/avoided burden of disease & long term conditions. Earlier Access to Specialist advice. Increased planned care. Decreased unplanned care.
	EOA	1.2. Deliver workshop to Rehua Kaumatua group on inhaler and medication use.	Q1	▪ Workshop held.	Louise Weatherall	Deborah Callahan	Increased equity of access
	EOA	1.3. Explore opportunities to screen people for respiratory disease at community locations including community pharmacies.	Q2-4	▪ Meet with community pharmacy representatives. ▪ Opportunities identified.	Greg Frazer, Mike Epton, Lauren Wallace		'At risk' population identified. Increased equity of access.
2. People diagnosed with a chronic respiratory condition access pulmonary	EOA	2.1. Increase referrals to pulmonary rehabilitation with a focus on priority populations through: ▪ Increasing the number of Māori /Pasifika who have been diagnosed	Q1-4	▪ Increase in the number of Māori and Pasifika people who have had spirometry tests (baseline = Māori 152 (8%); Pasifika 33 (2%)). ▪ Increase in number of Māori and Pasifika people referred to Better	Michael Maze, Karen Willsman, David Chen	Deborah Callahan, Karen Willsman	Delayed/avoided burden of disease & long term conditions. Increased planned care. Decreased unplanned care.

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
rehabilitation or other appropriate interventions		through lung function tests. ▪ Promoting referrals from allied health / community pharmacy. ▪ Working with health and community leaders to identify alternate methods of reaching Māori and Pasifika. ▪ Presenting at marae and Māori and Pasifika health days.		Breathing pulmonary rehabilitation and/or other related programmes/ interventions (baseline = Māori 36 (8%); Pasifika 5 (2%)).			
	EOA	2.2. Review demographics of people currently accessing pulmonary rehabilitation and trial alternative models to increase access particularly for Māori and Pasifika, e.g. after hours, or modified programmes.	Q4	▪ Current access reviewed. ▪ Alternative model piloted.	Karen Willsman, David Chen, Louise Weatherall	Deborah Callahan, Karen Willsman	Increased equity of access Timely access to supports Earlier access to specialist advice
3. People with sleep disorders are supported to understand their condition and treatment options		3.1. Work with general practice and people that disengage from the CPAP pathway to develop an improved model of care.	Q4	▪ Meet with General practice and patient group. ▪ Improved model of care developed and implemented.	Michael Hlavac, Paul Kelly, Sally Powell	Paul Kelly	Delayed/avoided burden of disease & long term conditions
	EOA	3.2. Partner with employers and health professionals (e.g. occupational health nurses)	Q1-4	▪ Presentation at Rehua marae Kaumatua programme completed.	Michael Hlavac, Paul Kelly,	Paul Kelly	'At risk' population identified

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
		to deliver sleep health messages with a focus on priority populations. 3.2.1. Presenting to Rehua marae. 3.2.2. Presenting at a workplace with a large number of Māori and Pasifika employees.		▪ Presentation at a workplace with large number of Māori and Pasifika employees completed.	Sally Powell		
SECTION TWO: Actions Towards Monitoring Progress							
4. Delayed/ Avoided burden of long-term disease		4.1. Monitor hospital presentations, admissions, LOS for patients with COPD.	Q1-4	▪ Hospital admissions (baseline = 1,123 in 2018). ▪ Occupied bed days (baseline = 4,762 in 2018).	Mike Epton	Deborah Callahan	Reduced Institutionalisation rate
		4.2. Identifying COPD frequent attenders and supporting them to reduce readmission.	Q2	▪ Frequent attenders project identifies high risk patients and delivers individualised respiratory nursing and physiotherapy support.	Mike Epton, Maureen Trewin, Teresa Chalecki	Deborah Callahan	Reduced Institutionalisation rate
5. People are supported to maintain and build fitness before and/or after attending pulmonary rehabilitation		5.1. Maintain community exercise groups for people with respiratory conditions; support leaders to deliver appropriate exercises.	Q1-4	▪ Increase number of community support and exercise groups and average number of participants (baseline = 10 groups; 180+/- participants per week) ▪ Physio to visit groups 2xp.a. ▪ Exercise leaders' workshop 1x p.a.	David Chen	Deborah Callahan	Delayed/avoided burden of disease & long term conditions. Decreased unplanned care. Protective factors are enhanced.
	EOA	5.2. Work with community leaders to support culturally appropriate	Q2-4	▪ New Māori and/or Pasifika community group developed or links made to existing groups.	David Chen	Deborah Callahan	Delayed/avoided burden of disease & long term conditions.

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
		community exercise groups.					

SECTION THREE: Key metrics the group will use to indicate; progress with delivering work plan actions, impact of actions on health outcomes, monitor performance targets etc.
(Consider whether the data is available in a way that identifies any inequity of health outcomes or access to services)

Description of Metric	Data Source	Comments on access to data / metrics
4. ED presentations for COPD by ethnicity	Decision Support	
5. Hospital admissions for COPD by ethnicity	Decision Support	
6. Respiratory ward length-of-stay for COPD	Decision Support	
7. Spirometry tests claimed, by ethnicity	ePortal/Helicon	
8. Pulmonary rehabilitation referrals, attendances by ethnicity	Local Medtech & Excel spreadsheet	
9. Number of groups and participants in community exercise	Excel spreadsheet	

Laboratory Service Level Alliance Work Plan

Following a workshop on the achievements of the Laboratory SLA and possible future priorities, work is required to confirm:

- The change required in this service area that would support our system objectives
- The priority for this work to progress; and
- The role of the SLA as a mechanism for progressing this change.

Once the future role and scope of the SLA is confirmed a work plan for 2019-20 will be submitted, as necessary.

Mana Ake Work Plan

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
SECTION ONE: Priority Actions Towards Transformational Change, Improved System Outcomes and/or Enhanced Integration							
1. Mana Ake implemented across all school clusters in Canterbury	EOA	1.1. Support school clusters to implement Mana Ake.	Ongoing	▪ All primary schools, have access to Mana Ake. ▪ A range of group programmes offered by Mana Ake is available across clusters.	Clare	Murray	Improved access; decreased wait times; equitable access across Maori and other priority populations; reduce accessing of specialist mental health support. Local community needs are met. Mana Ake Outcomes framework.
		1.2. Further develop processes to support service delivery and ongoing improvement.	Ongoing	▪ Satisfaction surveys.		Desiree	
2. School clusters are supported to develop collaborative practices to prioritise use of resources		2.1 Maintain facilitated meetings to develop consistent processes around Mana Ake across clusters.	Ongoing	▪ Facilitation cluster wide meetings occur at least each school term.	Clare	Murray	Equitable use of resource – early intervention; no wasted resource.
		2.2 Work with clusters to establish well-being orientated strategic goals.	Dec 2019	▪ All clusters have a wellbeing strategic goal.		Murray	
		2.3 Support clusters to access Mana Ake / pastoral support data to inform their decisions on best use of resources.	Ongoing	▪ Clusters provided with data and supported with its use.		Caralyn	
		2.4 Support the establishment of cluster-wide meetings to collectively develop the effective use of pastoral resources.	Dec 2019			Murray	

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
3. Communities are better connected to support wellbeing outcomes		3.1 Explore possibility of mapping community networks alongside schools and community organisations.	July 2019	▪ Feasibility established.	Ken	Caralyn	Well and healthy in their own homes/communities.
		3.2 Make Leading Lights pathways visible across a wide range of organisations 3.3 Explore mechanisms for providing culturally appropriate online information to whanau; consistent with resources available through Leading Lights.		▪ Leading Lights used by system partners to guide consistent approaches.	Clare	Murray Anna	
		3.3 Seek opportunities to connect with, and across, a variety of organisations to maximise wellbeing outcomes.		▪ Schools, organisations and whanau report more accessible support networks for children, whanau and communities.	Clare	Murray	
		3.4 Explore approaches to enhance the interface and connection between schools and the Canterbury health system, with a specific focus on general practice.	May 2019	▪ Exploration of approaches completed.	Clare	Clare	
		3.5 Apply learnings from this investigation to implement an agreed approach to strengthen the interface between schools and general practice/primary care across Canterbury.	Sept 2019	▪ An effective interface between schools and general practice/primary care is implemented.	Clare	Clare	

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
4. Mana Ake providers work collectively to build sustainable approaches to support wellbeing		4.1. Work with providers to consistently support kaimahi including: ▪ Share data including narrative information across providers. ▪ Maintain monthly provider forums including team leaders and supervisors to enhance capacity and consistency.	Ongoing	▪ Data and narrative shared. ▪ Increase in cross agency referrals.	Clare	Desiree	No wasted resource
5. The network of support (system of care) for Maia and her whanau is easy to access and understand		5.1 Clarify the network of available support available by: ▪ Providing early intervention through Mana Ake in a way that enhances what is already in place. ▪ Maintaining Leading Lights provision of clear pathways of support ▪ Continue providing advice, guidance and support for whanau and educators.	Ongoing	▪ Agencies report more targeted referrals. ▪ Educators report more clarity and confidence of when to access support and where to go. ▪ Whanau report satisfaction with and easier access to support.	Clare	Bruce	Equitable access to resources
6. Have ways to demonstrate the impact of Mana Ake		6.1 Further develop and implement a comprehensive evaluation approach.	Ongoing	▪ Evaluation approach endorsed by the SLA.	Ken	Caralyn	
SECTION TWO: Actions Towards Monitoring Progress:							

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
7. Mana Ake implemented across all school clusters in Canterbury	EOA	7.1 With the provider network appoint kaimahi with the appropriate skills, knowledge and cultural diversity.		▪ 80 FTE kaimahi with diverse skills, experience and cultures are appointed.	Karaitiana Tickell	Clare Shepherd	Improved access; decreased wait times; equitable access; reduce accessing of specialist mental health support.
8. Implement Mana Ake evaluation approach		8.1. Monitor impact of the implementation approach in selected clusters. 8.2. Capture feedback from tamariki, whānau and teachers. 8.3. Capture Tu Tauira data for individual case work. 8.4. Capture feedback from kaimahi, providers and partners with regard to impact of Mana Ake. 8.5. Liaise with sector partners to capture key data points and assess relevance for Mana Ake	Ongoing to June 2021 June 2019 & ongoing Ongoing to June 2021 Ongoing to June 2021 Ongoing to June 2021	▪ Schools report benefits such as increased knowledge, improved systems, and fewer service gaps. ▪ Improved outcomes for Maia; whanau and teachers better supported. ▪ Students show improvement across the domains, as appropriate. ▪ System partners report positive impacts for children and for their services of working more closely together. ▪ Reduced wait times for services; increased school attendance; reduced demand for specialist services.	Ken	Caralyn/ Murray	

SECTION THREE: Key metrics the group will use to indicate; progress with delivering work plan actions, impact on health outcomes and/or monitor performance targets		
Description of Metric	**Data Source**	**Comments on access to data / metrics**
1. Number and demographics of those accessing support including but not restricted to: 1.1 Status of Requests for Support to Mana Ake – Active, Exited, Pending, Unallocated, Did Not Engage. 1.2 Requests for Support to Mana Ake – Individual, Therapeutic Groups and Groups for: whole cohort, geographic cluster and Kahui Ako, Individual school. 1.3 Gender Data – Individual Services, Theraputic Groups, Groups, for: whole cohort, geographic cluster and Kahui Ako, Individual school. 1.4 Requests for Support from Mana Ake by Age Range and Gender for: whole cohort, geographic cluster and Kahui Ako, Individual school. 1.5 Ethnicity Data: whole cohort, geographic cluster and Kahui Ako, Individual school.	Mana Ake Case Management System: Paua	▪ Data in Paua collected in a manner that enables Mana Ake to report on these particular fields. ▪ Data integrity is maintained through monthly Exception Reports and monthly 15% Random Sample Reports of Active cases to ensure compliance with data entry requirements.
2. Length of intervention : 2.1 Length of individual service support by: whole cohort, geographic cluster and Kahui Ako, Individual school. 2.2 Number of Groups by: whole cohort, geographic cluster and Kahui Ako, Individual school. 2.3 Number of Theraputic Group by: whole cohort, geographic cluster and Kahui Ako, Individual school.	Mana Ake Case Management System: Paua	▪ Data in Paua collected in a manner that enables Mana Ake to report on these particular fields. ▪ Data integrity is maintained through monthly Exception Reports and monthly 15% Random Sample Reports of Active cases to ensure compliance with data entry requirements.
3. Service outcomes (Tu Tauira tool) Outcome Measurement Tool (OMT) that measuring: Presence, Learning and Wellbeing, Achievement. 3.1 OMT Results by: Whole cohort, geographic clusters and Kahui Ako.	Mana Ake Case Management System: Paua	▪ Data in Paua collected to enable report on fields. ▪ Data integrity maintained through monthly Exception Reports and monthly 15% Random Sample Reports of Active cases to ensure compliance with data entry requirements.
4. School/whanau/child satisfaction surveys 4.1 Evaluation data being collected through: 4.1.1 Client satisfaction Surveys – child, whanau, schools 4.1.2 Feedback from cluster Forums 4.1.3 Professional Development Forums	Mana Ake Case Management System: Paua	
5. Evaluation Data being collected through various narrative forms as part of the overall Evaluation of Mana Ake	Ongoing Interviews across a range of providers, schools and recipient's of the Mana Ake Service	

Mental Health Workstream Work Plan

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
SECTION ONE: Priority Actions Towards Transformational Change, Improved System Outcomes and/or Enhanced Integration							
1. An Integrated System that delivers care at the level required when it is needed.		1.1. Review workstream membership and functioning to ensure an effective co-design process occurs for new and improvement initiatives aligned with recommendations from He Ara Oranga: Mental Health and Addictions Inquiry Report.	Q3	▪ Workstream TOR updated ▪ Mechanisms to elicit meaningful input from consumers and whanau established.	Mary	Monique Gale	Workstream supports effective initiatives that reflect co-design
		1.2. Provision of coordinated and enduring wellbeing and mental health recovery programme in response to the March 15 attack.	Q1	▪ Implementation of the recovery and wellbeing plan for those impacted by the March 15 attack	Peri Renison Shelley McCabe	Sandy Mclean	
2. Strengthen Suicide Prevention and Postvention focus.	SLM	2.1. Canterbury Suicide Prevention Cross agency Governance Committee develops action plan with input from stakeholders, including service users and family members.	Q2	▪ Action plan completed ▪ Canterbury Suicide Prevention Website operational	Peri Renison	Monique Gale	Reduce avoidable mortality

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
3. Improve access across the system and reduce wait times	EOA	3.1 Monitor impact of the new Integrated Rural Mental Health model in Hurunui/Kaikoura	Q1	▪ Monitoring mechanism agreed by oversight group and routine review.	Paul Wynands	Sandy McLean	Access to care improved. Improved environment supports health and wellbeing
		3.2 Trial new ways of providing services in primary care settings.	Q2	▪ Trial launched in three general practices	Shelley McCabe	Sandy McLean	
		3.3 Develop more child and adolescent services in primary/community, including individual and group interventions	Q4	▪ Potential gaps and current projects identified.	Rebecca Nichols	Sandy McLean	
		3.4 Trial and evaluate a new model for Opioid Substitution Treatment with three pharmacies in collaboration with the Pharmacy SLA.	Q3	▪ New model trialled and evaluated.	Simon Church	Sandy McLean	
		3.5 Enhance role of peer support for people with addictions	Q2	▪ Peer support available to people with Opioid Addictions.	Nigel Loughton	Sandy McLean	
4. Equity Outcomes	EOA	4.1 Support implementation of integrated care for Pacific by Pacific that includes mental health and addictions within a primary/community environment.	Q1	▪ Mental health model integrated with Whanau Ora services for Pasifika.	Mary Gordon	Sandy McLean	Reduce avoidable mortality Access to care improved

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
	EOA	4.2 Adopt recommendations agreed by CCN for achieving equitable health outcomes for Māori in Canterbury. *	Q4	▪ Work progressed to implement initiatives to support equitable health outcomes for Māori in Canterbury*	Karaitiana Tickell	Monique Gale	
		4.3 Equally Well initiatives identified and implemented by PHO/SMHS	Q3	▪ Equally Well initiatives monitored/supported by CCN	Paul Wynands	Toni Gutschlag	
SECTION TWO: Actions Towards Monitoring Progress: Nil monitoring actions							

**wording to be confirmed by the Mental Health Workstream*

SECTION THREE: Key metrics the group will use to indicate progress with delivering work plan actions, impact on health outcomes and/or monitor performance targets

Data Metric Definition	Data Source	Comments
1. Rates of Māori, Pacific and CALD consumers accessing SMHS and PHO and NGO Mental Health services are monitored bi-annually.	CDHB Pegasus	
2. Number of free GP consults accessed due to March 15 attack monitored quarterly.	PHO	
3. Number of calls to 1737 related to March 15 attack presented biannually.	Homecare Medical	
4. Canterbury Suicide Prevention Governance Committee to establish cross agency data monitoring mechanism.	CDHB et al	
5. Wait times for access to services presented bi-annually for adults and children.	PRIMHD	
6. Numbers of people accessing OST peer support monitored biannually.	Christchurch Central Alcohol and Drug Coordination Service	
7. Equally well initiatives have data metric built into design.	SMHS/PHO	

Oral Health Service Development Group Work Plan

Vision "Aiming for equity of access and outcomes, and the best possible oral health, for all Canterbury and West Coast residents"

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
SECTION ONE: Priority Actions Towards Transformational Change, Improved System Outcomes and/or Enhanced Integration							
1. Oral Health Education and Health Promotion	EOA	5.3. Progress implementation of the Oral Health Education and Promotion Plan by: ▪ OHSDG approving implementation of the Plan. ▪ Developing three key priority areas to be delivered on by Q2 with a focus on Māori and Pacific peoples	Q1 Q2	▪ Implementation of Plan approved by OHSDG ▪ Three priority areas identified and delivered on	Juliet Gray	Bridget Lester	Improved environment supports health and well being Delayed / avoided burden of disease and long term conditions
2. Develop a Model of Care of Oral Health Services on the West Coast	EOA WC DHB	2.1 Develop West Coast Model of Care (MoC) by: ▪ Presenting first draft of the Model of Care to the OHSDG ▪ Presenting final draft of the Model of Care to the WCDHB ALT and Board ▪ Seeking approval for the Implementation Plan (with a focus on access for Māori and Pasifika) for the Model of Care	Q1 Q2 Q3	▪ MoC Draft presented to the OHSDG, West Coast ALT and West Coast Board ▪ MoC finalised by the end of 2019 ▪ Implementation Plan for Model of care approved by OHSDG	Juliet Gray	Bridget Lester	Improved environment supports health and well being Equity of Access

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
3. Knowing our population	EOA WC DHB	3.1 Ensure we have a comprehensive database of children accessing Community Dental Services by Implementing the West Coast Oral Health database	Q2	▪ The Oral health database is updated to reflect patient flows	Martin Le	Maureen Frankpitt	Delayed / avoided burden of disease and long term conditions Equity of Access SLM - ASH Equity of Access Delayed / avoided burden of disease and long term conditions
	EOA CDHB	3.2 Support improved ethnicity coding for new-borns in the CDHB including working with Community Dental Services on improved quality of ethnicity data	Q3	▪ Evaluation of current systems completed, to determine if ethnicity collection has improved	Martin Lee	Bridget Lester	
	EOA Both DHB	3.3 Continue to refine the process developed to ensure Community Dental Services have all the correct information for children lost to recall, with a focus on Māori and Pacific Tamariki.	Q3	▪ Evaluation of the programme changes completed.	Martin Lee	Sally Wright	
	EOA Both DHB	3.4 (*Carry over items from 2018/19 plan)* Undertake an analysis of the available data to determine the oral health care being accessed by hospital inpatients in CPH, Burwood and Hillmorton.	Q2	▪ Data report to be presented to the OHSSDG, and some key decision made.	Victoria McKelvey	Melissa Kerdemelidis	
4 Providing an accessible and linked up service	EOA	4.1 Continue to monitor the service hours of community clinics to ensure a Community Dental Services	On going	▪ OHSDG is updated regularly on the Community Dental Services service hours	Julie Denton	Julie Denton	Delayed / avoided burden of disease and long term conditions.

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
		is provided to all children in a timely manner.					Equity of Access. Delayed / avoided burden of disease and long term conditions. Delayed / avoided burden of disease and long term conditions.
	EOA	4.2 Redesign the Community Dental Services waiting spaces and mobile clinics to become more child and culturally appropriate spaces.		▪ Community Dental clinics and mobile spaces redesign are completed.	Julie Denton	Julie Denton	
	EOA	4.3 (Carry over item from 18/19) Develop a recall plan for Community Dental Services, with an appropriate risk assessment tool, which will have a focus on Māori and Pacific children.	Q1 Q4	▪ Draft project scope presented to the OHSDG ▪ Project Scope Completed ▪ Review completed and presented to OHSDG.	Tula Misa	Team Leader, Community Dental Service	
	EOA	4.4 Consideration of the model for youth oral health services to identify ways to improve service coverage	Q1 Q3	▪ Project Scope Completed ▪ Proposed model for improved access to oral health services for Adolescents presented to the OHSDG	Lester Settle	Bridget Lester	
		4.5 (carry over item from 19/20) Determine what connection Oral Health providers have with other health information systems, such as HealthOne.	Q4	▪ Scoping of what service needs are by Oct 2019	Lester Settle	Melissa Kerdemelidis	
5 Access to Specialist Dental Services		5.1 Referrals pathways between Community and		▪ Children referred to the hospital dental services are seen in a timely	Martin Lee	Bridget Lester	Equity of Access.

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
from Community Dental Services are improved		Hospital Dental are better coordinated by ensuring : ▪ Appropriate referrals are being made to Community Sedation Providers ▪ Appropriate referrals are being made to Hospital Dental Services ▪ Developing and agreeing a clinical referral pathway waiting times for access to Hospital Dental Services are delivered in line with ESPI guidelines ▪ Dental Therapists are supported to work at the top of their scope of practice		manner for their FSA and treatment.	Lester Settle	Belinda Smith Jackie Powers Belinda Smith	
6 Support for Low Income Adults		6.1 Review the current literature on the level of unmet need in adult dental care	QTr4	The level of unmet need for CDHB and WCDHB is identified. This information will be used to identity actions for OHSDG in 2020.2021	? Juliet	?who	

SECTION THREE: Key metrics the group will use to indicate progress with delivering work plan actions, impact on health outcomes and/or monitor performance targets										
Data Dashboard			**CDHB 2017/18 COVERAGE**				**WC 2017/18 COVERAGE**			
Data Metric Definition	**Data Source**	**Measure**	**Māori**	**Pacific**	**Total**	**Target**	**Māori**	**Pacific**	**Total**	**Target**
1. Pre-schoolers Enrolled in Community Dental Services	Annual CDS data	SLM CFA reporting	52.60%	70.50%	76.10 %	95%	95.7%	126.7%	108%	95%
2. Number of enrolled pre-schoolers and primary school children overdue for their scheduled examinations	Annual CDS data	CFA reporting	14%	15%	12%	>10%			5%	>10%
3. Caries Free at 5 years old	Annual CDS data	CFA Reporting	50%	39%	65%	65%	42%	67%	57%	65%
4. DMFT Score at Year 8	Annual CDS data	CFA Reporting	1.02	1.06	0.84	0.86	1.87	0.67	1.12	0.86
5. Adolescent Utilisation	Annual MoH data	SLM/CFA Reporting	33%	40%	65%	85%	55%	53%	83%	76%
5 CDHB - Access and Utilisation of Youth-Appropriate Health Services ▪ Increase enrolments in the Community Dental Service ▪ Community Dentists recall process	Annual	SLM								
6 CDHB ASH Rates for 0-4 year old ▪ Improved Oral Health ▪ Increased new-born enrolments	Annual	SLM								

Pharmacy Service Level Alliance Work Plan

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
SECTION ONE: Priority Actions Towards Transformational Change, Improved System Outcomes and/or Enhanced Integration							
1. Create a platform and pathway for improved services for patients		1.1 Implement and evaluate service models for integrated and pro-active pharmacist care for people with chronic physical and/or mental health conditions who enrol with their preferred provider	Q1-4	▪ Pilot service for people receiving opioid substitution treatment established by Q2, in collaboration with the Mental Health workstream. ▪ Evaluation of the pilot completed by Q4.	Simon Church	Gareth Frew	Timely access to primary care. Increased planned care rate. Delayed/avoided burden of disease & long term conditions.
2. Safer, efficient transfers of care for people being admitted and discharged from hospital		Develop an agreed communication protocol/pathway to support a safe pathway for patients admitted to, and discharged from, hospital. 2.1 Work group to develop: ▪ A quick medication reconciliation guide for pharmacists which includes; a flowchart to illustrate the suggested process. ▪ A pharmacist medication reconciliation summary for GP's, outlining the intervention and the value proposition.	Q1-4	The following will be developed; ▪ Quick medication reconciliation guide for pharmacists. ▪ A summary of medication reconciliation pharmacy process for GPs.	Gareth Frew	Mike James/ Rebecca Muir	Decreased institutionalisation rates. Decreased wait times. Delayed / avoided burden of disease & long term conditions. No wasted resource. Decreased adverse events.
		2.2 Contribute to the development of a model of care that supports integration between primary and secondary pharmacy services.	Q4	▪ Members of SLA will contribute to tasks that have been identified in the workshop on the future of	Helen Little	Mike James	▪

				hospital pharmacy report produced in Feb 2019.			
3. Reduced patient risk from inappropriate polypharmacy and optimise their care	SLM	3.1 Increase the assessment of people who are most at risk from polypharmacy (including those referred for falls prevention support).	Q1-2	▪ Increase GP referrals to Medicines Therapy Assessments ▪ Up to 240 MTA completed in 2019-20	Gareth Frew	Aarti Patel	Decreased adverse events Decreased institutionalisation rates
	SLM	3.2 Enhance collective impact to identify opportunities to improve and integrate MMS and other services to reduce inappropriate polypharmacy.	Q1-2	▪ New opportunities identified, scoped and discussed with PSLA members.	Gareth Frew	Rebecca Muir	
4. Advance model of Care for community pharmacy to improve services of patients with long term conditions.		4.1 Work group will develop a set of principles and framework that could be used to inform local redevelopment of the pharmacy Long Term Conditions (LTC) service.	Q1-4	▪ A set of principles are defined and an agreed framework is developed.	Gareth Frew	Rebecca Muir	Delayed / avoided burden of disease & long term conditions. No wasted resource
5. Contribute to local antibiotic stewardship initiatives.		5.1 Promote antibiotic stewardship by contributing to the development or refinement of antibiotic stewardship resources to ensure these are fit for purpose for pharmacy.	Q1-4	▪ Updated resources distributed to community pharmacies.	Gareth Frew	Ian Town	No wasted resource
6. Future Service development of pharmacist led clinical services		6.1 Develop a guide for the development of pharmacist led clinical services in the new Zealand pharmacy context.	Q1-4	▪ A student will research and develop a resource that canbe used to inform future service development	Gareth Frew	Steve Duffull/ Kezia Buttle	
▪ **SECTION TWO: Actions Towards Monitoring Progress**							

7. Improve patient health literacy to support their self-managing of their medicines.		7.1 Monitor pharmacist support for people with chronic conditions to self-manage their medicines well.	Q1-4	▪ 14,000 people receive the Pharmacy LTC Service ▪ 1,500 people receive a Medicines Use Review	Gareth Frew	Rebecca Muir	
		7.2 Review messaging and available resources about self-management of medicines across the system to ensure that messaging is consistent across community and hospital pharmacies.	Q1-4	▪ Messaging and resources provided by both community and hospital pharmacies are consistent across the system.			
8. Equitable health outcomes for; • **Maori** • **Pasifika** • **Other migrant populations.**	EOA	Promote existing and new partnerships to enhance the roles of pharmacists and support access to pharmacy services at events for Māori, Pasifika and migrant communities. 8.1 CCPG to support Pharmacist champions to provide mobile clinics with a Kaupapa Māori lens. This includes performing the medication management service in ethnically appropriate locations such as on the Marae, and using an adapted Māori health framework to help improve the service outcomes for Māori.	Q1-4	▪ Patient feedback will be received regarding appropriate delivery of medication management services on Marae's.	Gareth Frew	Rebecca Muir	▪ Delayed/ avoided burden of disease & long term conditions. ▪ Decreased adverse events. ▪ Decreased institutionalisation rates. Decreased acute care rate; Increased planned care rate.
		8.2 Leverage existing health days, church projects and consider Community Outreach	Q1-4	▪ Community pharmacists will be supported to participate in health hui's on a quarterly basis.			

		opportunities for Maori, Pasifika and other migrant populations.					

SECTION THREE: Key metrics the group will use to indicate progress with delivering work plan actions, impact on health outcomes and/or monitor performance targets		
Description of Metric	**Data Source**	**Comments on access to data / metrics**
1. MMS Provision – trends and variations by age, ethnicity and urban / rural location	CCPG	
2. Pharmacy LTC Service patient enrolments	CDHB	
3. MTA quality measure – prescribing trends 12 months post-MTA	CCPG/CDHB SFN	
4. The rate of people dispenses with 11 or more long term medications	Nicky Smithies	

Population Health Service Level Alliance Work Plan

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
SECTION ONE: Priority Actions Towards Transformational Change, Improved System Outcomes and/or Enhanced Integration							
1. Progress towards smokefree 2025	EOA / SLM	1.1. Complete the Tobacco Control Plan 2019/20.	Q1	▪ The 2019/20 Tobacco Control Plan endorsed by ALT. ▪ A contract for Stop Smoking Services with MoH is renewed by July 2019.	Vivien Daley / Matthew Reid	Jane Cartwright / Jonathan Amos	Smokefree 2025 Reducing our population smoking rates across Canterbury
	EOA / SLM	1.2. Refine the Te Hā - Waitaha service model to achieve greater outcomes for our high needs populations including CALD and Asian populations	Q2	▪ Te Hā - Waitaha delivery model refined. ▪ Increased proportion of Asian/MELAA smokers enrolled in Te Hā - Waitaha.			
	EOA / SLM	1.3. Work with Smokefree Canterbury to further Integrate local Smoking Cessation Services including PHO delivered smoking cessation and Te Hā – Waitaha.	Ongoing	▪ Pegasus PEGS programme aligned with Te Hā – Waitaha. ▪ Additional support and Stop Smoking Practitioners are in place within Pegasus Health ▪ Continued with Smokefree Canterbury			
2. Reduced Alcohol Harm in our population	EOA	2.1 A cross sector working group will progress implementation of the Alcohol Strategy by: ▪ Developing recommendations to guide implementation of the Strategy and propose their adoption by CCN partner organisations.	Ongoing	▪ An Alcohol Policy and support processes developed for DHB staff as a mirror of our wider population alongside People and Capability. ▪ This 'pilot' implementation of the Alcohol Strategy recommendations is adopted by CCN partners.	Anna Stevenson	Bronwyn Larsen / Jon Amos	Reducing rates of alcohol related harm in our population

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
		▪ Develop a communications plan ▪ Develop an implementation plan ▪ Evaluate and monitor the implementation of the recommendations					
3. Equitable access to Interpreter Services across the Canterbury Health System	EOA	3.1 The Interpreter Services Working Group will: ▪ Develop best practice guidelines for interpreter use and disseminate them to CCN Partner organisations ▪ Confirm current service model and any existing gaps ▪ Explore alternative models that offer an across system consistent approach to the use of Interpreter Series ▪ Reported back to the SLA on best practice guidelines and delivery models for local services.	Q3	▪ Actions of the Interpreter Services Working Group completed and reported back to the SLA.	Jane Cartwright	Ester Vallero / Jon Amos	Greater access for our population to interpreting services for their health needs A common approach to the standards of interpreting services for our population
4. The Canterbury Health System reduces health care related inequities	EOA	4.1. Identify how the Canterbury Health System can influence healthy public policy by reviewing our current approach and identify areas to further strengthening this approach.	Q2	▪ A paper recommending ways to strengthen our influence on healthy public policy is presented to the ALT.	Lynley Cook	Mathew Reid / Wendy Dallas - Katoa	Inequity is more closely monitored and reduction of inequity begins to be monitored

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
		4.2. Better understand people with poor access to Canterbury health services by completing a stocktake of current data and reporting on people with very poor access, identifying any additional data sources, and recommending mechanisms for ongoing monitoring.	Q3	▪ Report of very poor access completed, presented to the ALT and then disseminated through the Canterbury health system	Lynley Cook	Mathew Reid / Wendy Dallas - Katoa	
		4.3. Conduct a Health Literacy Review into an area of health need	Q4	▪ A Health Literacy Review report completed and recommendations formulated for dissemination through the Canterbury health system	Lynley Cook	Mathew Reid / Wendy Dallas - Katoa	
5. The Canterbury Health System supports and enables people/whānau to stay well and take greater responsibility for their own health and wellbeing.	-	5.1. Deliver Motivating Conversations training to an additional 150 people	Q4	▪ 150 additional people trained in Motivating Conversations.	Lynley Cook	Sue Aitken	Enable Health Sector workforce to support our population to stay well and take greater responsibility for their own health and wellbeing.
		5.2 Extend the Motivating Conversations education to incorporate a focus on alcohol		▪ The Motivating Conversations curriculum includes alcohol harm.	Lynley Cook	Sue Aitken	
		5.3 Review the current model of behaviour change interventions delivered by the Motivating Conversations service.		▪ Review of behaviour change interventions completed.	Lynley Cook	Sue Aitken	
SECTION TWO: Actions Towards Monitoring Progress							

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
6. Progress towards smokefree 2025	SLM	Refine Te Hā – Waitaha's focus on priority populations including: 5.1 Monitor enrolments and outcomes for Māori, Pacific and pregnant women.	Ongoing	▪ Enrolments monitored	Matthew Reid	Jonathan Amos	Smokefree 2025 Reducing the smoking prevalence rates across our Canterbury population
		5.2 Develop an approach that targets culturally and linguistically diverse (CALD) communities	Q2	▪ Ensure we meet the needs of the CALD smoking population	Matthew Reid	Jonathan Amos	
		5.3 Strengthen referral pathways from Lead Maternity Carers to Te Hā – Waitaha by: ○ Developing conversation scripts to guide discussions on smoking cessation with pregnant women; ○ Raising awareness of the Te Hā – Waitaha and Pregnancy Incentive programmes; Reviewing the referral pathway from Lead Maternity Providers with a view to identifying ways to streamline this process.	Ongoing	▪ Conversation Scripts for Lead Maternity Providers developed. ▪ Referral pathway from Lead Maternity Providers streamlined	Matthew Reid	Jonathan Amos	
7. The Canterbury Health System reduces health care		8.1 In partnership with the ALT on the recommendations within the Te Tiriti and Equity paper to identify actions required by the	Ongoing	▪ To be developed with feedback from Alliance Leadership Team	Lynley Cook	Matthew Reid / Wendy Dallas-Katoa	Inequity is more closely monitored and reduction of inequity begins to be monitored

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
elated inequities		ALT, Population Health & Access SLA, Māori Caucus, and TKOP.					
8. Amenable mortality	SLM	9.1 Monitor the referrals to Green Prescription	Ongoing	▪ Target of 4,000 referrals/annum	Lynley Cook	Jonathan Amos Matthew Reid	Goal 1 - People take greater responsibility for their own health:
		9.2 Develop a system wide approach to increase cervical screening coverage		▪ A proposed approach to increasing cervical screening coverage developed	Lynley Cook	Jonathan Matthew	

SECTION THREE: Key metrics the group will use to indicate; progress with delivering work plan actions, impact of actions on health outcomes and/or monitor performance targets

Description of Metric	Data Source	Comments on access to data / metrics
1. Better Help For Smokers to Quit – Primary, Secondary, Maternity	MoH	
2. Amenable mortality: Maintain the downward trend over time: 30 June 2019 of 83 per 100,000.	MoH NSFL	
3. Quarterly performance reporting of Te Hā – Waitaha data to MoH	CDHB	
4. Quarterly performance reporting of GRx Referral data to CDHB	Sports Canterbury / CDHB	
5. Quarterly performance reporting of Motivational Conversation Service provision	Pegasus / CDHB	
6. Quarterly performance reporting of cervical screening coverage	MoH NSU	
7. National Cervical Screening Programme Coverage Data	National Cervical Screening Programme	

Primary Care Capability Service Level Alliance Work Plan

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
SECTION ONE: Priority Actions Towards Transformational Change, Improved System Outcomes and/or Enhanced Integration							
PCC SLA ROLE ONE: Providing strategic leadership to the enablers listed in the ToR.							
1. **Improve the person and their whanau's experience of primary care**	EOA	1.1. Advance models of primary care that improves a person and their whanau's experience of care and /or increases the sustainability of primary care through ▪ Agreeing measures of progress and impact of the; IFHS / HCH initiative. ▪ Monitoring implementation of the IFHS / HCH initiative and performance against these measures.	Q2	▪ Metrics agreed by IFHS operational group including measures of, a person / whanau experience, practice and system (including ethnicity measures).	David Pilbrow	Sue Wood	Increased planned care rate Decreased acute care rate
		1.2. Explore information available about people and their whanau's experience of primary care and identify opportunities to strengthen how this can be used to improve the provision of primary care including: ▪ Understanding the strengths, limitations, and ability to localise the National Patient Experience Survey. ▪ Identify other sources of patient information.	Q4	▪ Identify opportunities for integrating information about patient experience across primary care (with a focus on SLMs).		Jackie, Lovey, Malu and Fran	

2. Improve the coordination of care of people with complex needs	EOA	2.1. Review the general practice report on the use of Enhanced Capitation funding and apply learnings from the report to advance models of primary care.	Q3	▪ General practice report completed. (Narrative from the report to support Planned: Unplanned Care measures.)	Lorna Martin	Jon Amos Linda Wensley	Increased planned care rate Decreased acute care rate Delayed/avoided burden of disease and long term conditions
		2.2. Monitor the distribution of Enhanced Capitation funds and the refresh of the algorithm for the distribution of funds.	Q4	▪ Refresh of algorithm completed.	Lorna Martin	Jon Amos	
		2.3. Agree measures of progress and impact of the shared care planning.	Q4	▪ Measures agreed and collection of the data established.	Rose Laing	Rebecca Muir	
		2.4. Monitor implementation of the Collaborative Care initiative.		▪ Acute Plan and Personalised Care Plan use monitored.		SLA	Delayed/avoided burden of disease and long term conditions
PCC SLA ROLE TWO: Optimising our system enablers							
3. Ensure alignment of system enablers		3.1. Shared alignment and adoption of the three enablers within the PCC SLA	Q3	▪ Measures of alignment agreed by project / clinical leads of the three enablers	Rosie Laing, Lorna Martin & David Pilbrow	Rebecca Muir, Sue Wood and Jon Amos	No wasted resource
4. Improve wellbeing of Primary Care workforce.		4.1. Alignment of health and wellbeing of the Canterbury health system workforce with the Te Tatau Ora and PHO priorities.	Q4	▪ Align opportunities to improve the wellbeing of the primary care workforce.	Ken Stewart	Greta Bond	Improved environment supports health and wellbeing

PCC SLA ROLE THREE: Monitor and contribute to the strategic direction of Primary Care							
5. Learn from other health systems about innovative ways to improve outcomes in Primary Care	EOA	4.1 Facilitate discussion on improvement of the delivery of Primary Care health care in a New Zealand and international context.	Q4	▪ Information about local innovation collated and shared across the system.	SLA	SLA	No wasted resource
SECTION TWO: Actions to Monitor Progress							
6. Monitor impact of Community Services Card holder Policy change		4.1 Assess information on the impact of CSC Policy change including any impact on capacity of general practice and people and their whanau's access to care, across the health system	Q2 & Q4		SLA	Erin / Hiedee	Increased planned care rate Decreased acute care rate

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SECTION THREE: Key metrics the group will use to indicate progress with delivering work plan actions impact on health outcomes and monitor performance.	
Data Metric Definition	**Data Source**
ROLE ONE:	
1. General practice engagement in IFHS / HCH including analysis of the practices by percentage of high needs patients. Further outcome measures under development.	PHOs
2. Acute, Personalised Care Plan: Measures under development.	
ROLE TWO:	
3. Measures of Primary Care Workforce Wellbeing – yet to be determined	
4. Measures of Patient Experience of Primary Care including by ethnicity – yet to be determined	

Rural Health Workstream Work Plan

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGETS/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOMES
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
SECTION ONE: Priority Actions Towards Transformational Change, Improved System Outcomes and/or Enhanced Integration							
1. Advocate for sustainable rural workforce nationally		1.1 Actively advocate to strengthen the rural workforce by providing a Canterbury response to national organisations activity / focus, including NRHAG & RHAANZ[1].	Q1- Q4	▪ Submissions provided to NRHAG, RHAANZ and MoH as necessary.	Lorna Martin Justine Schroder	Bill Eschenbach	No wasted resource. Resources matched to need; appropriate workforce levels; no stranded patients.
2. Improved Emergency Response in rural Canterbury		2.1 Complete a stocktake and summarise the emergency response across rural Canterbury, including: ▪ Availability of services, workforce and resources. ▪ Service demand. ▪ Response and transportation times. ▪ Christchurch Hospital ED and Urgent Care Centres attendances.	Q2–Q4	▪ Stocktake and report completed by Q4.	St John TBC	Bill Eschenbach Koral Fitzgerald	Decreased institutionalisation rates. Rapid access to assessment. coordinated care; build functional capability. Decreased wait times Acute community response. 24 hour access to primary care intervention.

[1] *National Rural Health Advisory Group (NRHAG) and Rural Health Alliance Aotearoa New Zealand (RHAANZ)*

		▪ Identification of any gaps and opportunities for improvement.					
3. Enrich our relationship with Manawhenua ki Waitaha	EOA	3.1 Attend the Manawhenua ki Waitaha Board hui biannually to korero on RHWS activity and seek feedback.	Q2 & Q4	• Attendance at Manawhenua ki Waitaha Board hui completed biannually.	Jaana Kahu Jane Cartwright	Koral Fitzgerald	Improved environment supports health & wellbeing Building population health capacity & partnerships; understanding health status and determinants**.**
	EOA	3.2 Identify any opportunities to align / contribute to the Older People Workstream (HOPWS) Kaumatua visits.	Q1-Q4	• Opportunities identified to align / contribute to HOPWS visits.	Jaana Kahu	Koral Fitzgerald, Greta Bond	
4. Develop a Rural Restorative Model of Care		4.1 Work with Community Services Service Level Alliance (CSSLA) to implement rural restorative models of care recommendations in the Hurunui and Oxford Models of Care.	Q1 - Q3	▪ Hurunui and Oxford restorative models of Care established by Q3.	TBC	Koral Fitzgerald Michael James	No wasted resource Resources matched to need; appropriate workforce levels; right care, right place, right time, right person
		4.2 Agree a local approach to delivering rural restorative care in Canterbury by: ▪ Capturing learnings from the Hurunui and Oxford areas; ▪ Reviewing restorative care models in urban	Q3-Q4	▪ Learnings from Hurunui and Oxford summarised by Q4; ▪ Locally agreed approach to rural restorative care completed by Q4.	N/A	Koral Fitzgerald RHWS	

		and rural settings across NZ; ▪ Drawing on South Island Alliance Programme Office (SIAPO) Restorative Care resources.					
		4.3 Work with CSSLA to identify any updates to HealthPathways, HealthInfo, and Allied Healthways required.	Q4	▪ Updates to HealthPathways HealthInfo, and Allied Healthways completed, as necessary.	N/A	Koral Fitzgerald	
5. Increased use of technology in rural settings to improve communities access to quality care		5.1 Map the current IT hardware / software across rural areas including the capability it provides, and monitor any ongoing developments.	Ongoing	▪ Mapping exercise completed by Q1 and further changes monitored.	N/A	Koral Fitzgerald Win McDonald	**No** wasted resource Timely access to primary care; no stranded patients. Decreased institutionalisation rates Coordinated care; build functional capability
		5.2 Monitoring progress towards the consistent provision of specialist follow up appointments for people based rurally.	Ongoing	▪ Regular updates on progress with provision of specialist follow up appointments using telehealth received.	N/A	Win McDonald	Increased planned care rate; decreased acute care rate Increased equity of access; access to care improved.
		5.3 Review the rural workforce's access to education using IT tools and progress any changes identified to improve access.	Q1-Q3	▪ Review of workforce access to education completed by Q1.Changes identified to improve access implemented by Q3.	N/A	Koral Fitzgerald	Decreased institutionalisation rates Carer/staff upskilled

SECTION TWO: Actions Towards Monitoring Progress							
6. Monitor and align local service		6.1 Monitor the implementation of Models of Care in the Hurunui, Oxford and Akaroa.	Ongoing	Reports on the Hurunui, Oxford and Akaroa received quarterly	N/A	Linda Wensley,	Decreased institutionalisation rates

integration and improvement						Carol Horgan, Jane Cartwright	Increased planned care rate; decreased acute care rate
		6.2 Monitor service integration and improvement in Ashburton (ASLA) and Kaikōura	Ongoing	Updates on Ashburton and Kaikōura activity received as necessary	N/A	Hiedee Harris, Justine Schroder	Increased planned care rate; decreased acute care rate Access to care improved; decreased hospital acute care; increased equity of access
		6.3 Update rural service co-design documentation, including integration of learnings from the Model of Care work over the past three years as a CCN / system resource.	Q4	Principles for Integration of Rural Services' document reviewed and updated by Q4.	TBC	Win McDonald Jane Cartwright	Increased planned care rate; decreased acute care rate Access to care improved; decreased hospital acute care; increased equity of access No wasted resource Timely access to primary care; no stranded patients.
7. Monitor activity locally to develop a sustainable rural workforce		7.1 Monitor local activity including the role of nurse and PRIME practitioners, through the: ▪ Outcome of the Health Workforce NZ (HWNZ) application for a Rural Health Internship Pathway; ▪ PHO activity;	Q1 & Q3	Regular updates received on: ▪ HWNZ application (quarterly); ▪ PHO activity (Q1 & Q3) ▪ Nurse Practitioner Peer Group (as necessary) ▪ SIAPO (Q1 & Q3)	Jo Talarico	Bill Eschenbach Carol Glover Mike James	No wasted resource Resources matched to need; appropriate workforce levels; right care, right place, right time, right person

		• South Island Alliance Programme Office (SIAPO) activity.				Koral Fitzgerald	
8. Maintain oversight of Rural Subsidies activity / governance		8.1. Oversee the Rural Subsidies activity and any proposed changes to funding model. (Currently this work led by the Rural Funding SLA is in abeyance).	Ongoing	Any proposed changes provided to RHWS.	-	Koral Fitzgerald	Increased planned care rate; decreased acute care rate Access to care improved; decreased hospital acute care; increased equity of access

SECTION THREE: Key metrics the group will use to indicate; progress with delivering work plan actions, impact on health outcomes and/or monitor performance targets.

Description of Metric	**Data Source**	**Comments on access to data / metrics**
1. ED presentations of rural patients to CHED, by ethnicity	CDHB	
2. Acute bed days of rural patients, by ethnicity	CDHB	
3. Rural patients discharged from hospital (ChCh, Burwood or Ashburton) to rural community, by ethnicity	CDHB	
4. Number of clinics sessions utilising telehealth technology for specialist follow-up patient appointments across Canterbury	CDHB, PHOs, CI	
5. % of education sessions offered for GPs, nurses, community pharmacists & other allied health via telehealth/videoconferencing	CDHB, PHOs, CI	

System Outcomes Steering Group Work Plan

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGET/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOME
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
SECTION ONE: Priority Actions Towards Transformational Change, Improved System Outcomes and/or Enhanced Integration							
1. Understand the data used to generate each System Level Measure.	SLM	1.1 Steering group review data linked to each System Level Measure.	Q4	▪ Each SLM and contributory measure is reviewed and made available to the relevant expert groups.	Les Toop / Greg Hamilton	Simon Berry / Nicky Smithies	Assisting expert groups access data to inform and prioritise activity that will improve health outcomes and System Level Measures.
		1.2 Facilitate service alliances and expert groups in reviewing the relevant data.					
2 Contributory measures developed with equity as a focus.	SLM	2.1 Review contributory measures to ensure they reflect priorities of our system with a focus on reducing inequities.	Q1-4	▪ Review and update as needed through system leaders collectively identifying and agreeing the contributory measures for 2020-21.	Lynley Cook	Nicky Smithies	Prioritisation of effort to improve Canterbury's System Level Measures performance
		2.2 Contribute to the development of system wide equity measures by supporting and reflecting projects across the system					
3 Understand the accuracy of data, particularly in relation to ethnicity.	SLM	3.1 Compare health system registers to determine any discrepancy in recording of ethnicity.	Q2	▪ Any discrepancy in data is identified and a process to improve (if needed) is developed.	Greg Hamilton	Simon Berry / Matthew Reid	Improved data accuracy so that services can be developed and prioritised to improve health outcomes and System Level Measures.
		3.2 As needed, look to improve data accuracy	Q4				

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF SUCCESS / TARGET/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOME
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
		(implementation to occur in the following year).					
SECTION TWO: Actions Towards Monitoring Progress							
4 Monitor performance against the current plan	SLM	4.1 Quarterly review of progress against the System Level Measures and 'Actions to Improve Performance'	Q1-Q4	▪ Steering Group review updated actions each quarter.	Lynley Cook	Nicky Smithies	Enable the Steering Group's oversight of progress.
5 Complete annual Improvement Plan	SLM	5.1 Oversee the Ministry of Health requirements and guide / progress the development of the Improvement Plan.	Q4	▪ Improvement Plan submitted to Ministry in required time frame.	Les Toop / Lynley Cook	Nicky Smithies	Meet Ministry Requirements
6 Contribute to the national development of the SLM	SLM	6.1 Canterbury continues to participate in national forums; i.e. technical advisory group	Q1-Q4	▪ Canterbury continues to participate in the national development.	Les Toop / Greg Hamilton	Nicky Smithies	Actively support national adoption of using outcomes to measure performance.

SECTION THREE: Key metrics the group will use to indicate progress with delivering work plan actions, impact on health outcomes and/or monitor performance targets		
Description of Metric	**Data Source**	**Comments on access to data / metrics**
1. System Level Measures and Contributory Measures	SLM Viewer collating data from a range of sources	SOSG oversee the SLMs. Dashboard/Viewer will be updated as data becomes available.

Urgent Care Service Level Alliance Work Plan

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF UCCESS / TARGET/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOME
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
SECTION ONE: Priority Actions Towards Transformational Change, Improved System Outcomes and/or Enhanced Integration							
1. Improve patient flow through the system	SLM	1.1. Proactively plan for coordinated system responses for periods of exceptional demand (Particularly during winter).	Q1-4	▪ Number of times acute demand reaches capacity – target is zero ▪ Number of times ED reaches capacity based on ED overload indicator scores.	Andrew Meads Martin Than	Rebecca & Greg	Shorter stays in Emergency Department Decreased hospital acute care
	SLM	1.2 Monitor Acute Bed Days data including by ethnicity to identify areas of opportunities to decrease length of stay.	Q1-4	▪ Acute bed day's data will identify opportunities and areas of focus each	Greg Hamilton	Rebecca & Greg	
		1.3 Keep abreast of winter planning groups and plans across the system.	Q1-4	▪ Winter planning strategies are in place for potential challenges expected throughout the winter period.	Greg Hamilton	Rebecca & Greg	
2. Improving access to timely care	SLM	2.1 Explore ways to reach patients earlier and maintain them in a primary and secondary care setting.	Q1-4	▪ Areas of focus to improve access to timely care are identified	Greg Hamilton Paul Abernethy	Rebecca	Increased planned care rates Access to care improved Decreased acute care rates
		2.2 Undertake a deep dive into data (Including ACC available data) to identify focus areas including areas of injury prevention and acute orthopaedic work load.	Q1	▪ Deep Dive completed by Q1 (The findings from the deep dive analysis will determine what projects need to occurs in the 19/20 period)	Greg Hamilton Paul Abernethy	Rebecca	
3. Maximise the use of the		3.1. Reinvigorate the messaging around the acute demand service.	Q1-4	▪ General refreshed messages will be sent to all general practices and other areas of the health system.	Andrew Meads	Rebecca Muir	Access to care improved

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF UCCESS / TARGET/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOME
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
Acute Demand service		3.2 Share data around acute demand usage across general practice		▪ Acute demand data will be made available to general practice.			Decreased hospital acute care Decreased acute care rates
		3.3 Explore current acute demand utilisation and further opportunities optimise use across the system.					
4. Improve patient centred promotion of community based urgent care health services		4.1 Establish a work group to explore current promotion of community based services, including: ▪ Map out what messaging currently exists. ▪ Determine patients understanding of existing community based services.		▪ Current messaging is mapped out.	TBC	Rebecca Muir	Access to care improved Decreased hospital acute care
		4.2 Work group to promote; ▪ What community based services are available 7 days a week ▪ What urgent care facilities can provide. ▪ How services can be accessed.		▪ Improved promotion and consistency of information about community based services	TBC	Rebecca Muir	
SECTION TWO: Actions Towards Monitoring Progress							
5. Improving patient access to care		5.1 Continue to invest in Acute Demand services that provide primary care with	Q1-4	▪ Maintain between 30,000 to 35,000 packages of care in the community by ethnicity	Andrew Meads	Rebecca & Greg	Decreased hospital acute care

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF UCCESS / TARGET/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOME
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
		options to support people to access appropriate urgent care in the community rather than in hospital					Decreased acute care rates Decreased hospital acute care Access to care improved
		5.2 Continue to engage with St John, ED and the Urgent Care clinics to monitor Ambulance Referral Pathways and Acute Demand services to safely manage appropriate patients in the community.		▪ Total number of calls to St John in Canterbury area ▪ Number of patients St John divert away from ED quarterly, by condition reported quarterly (if available) (baseline 400 patients per annum) ▪ Percentage of these calls in relation to total call volumes ▪ ED/Hospital admissions, referrals to GP's/Urgent Care Clinics reported quarterly (Baseline for admissions from ED to hospital wards 10,500)	Wally Mitchell	Rebecca	
6. Continue to develop and refine community based acute demand services		6.1 Continue to support the "#CareAroundtheClock" advertising campaign, which promotes calling general practice 24/7.	Q1-Q4	▪ Call volumes to be monitored and reported quarterly.	Brian O'Connell	Rebecca	Increased planned care rates Decreased acute care rates Decreased hospital acute care Access to care improved
		6.2 Monitor the implications of increased call volumes through Homecare Medical and the consequent impacts on general practice & the Urgent Care Clinics.		▪ Homecare medical call volumes data Monitored and reported quarterly	Brian O'Connell	Rebecca	

OBJECTIVE	ACTIONS		TIME FRAME	MEASURES OF UCCESS / TARGET/ MILESTONES	ACCOUNTABILITY		SYSTEM OUTCOME
	EOA / SLM				CLINICAL LEAD	PROJECT LEAD	
		6.3 Establish a process and monitor the percentage of people who present at ED or an urgent care facility following a tele triage		▪ Once data is available monitor the percentage of people who present at ED or an urgent care facility following a tele triage	Brian O'Connell	Rebecca	
7. Promote appropriate and where possible shorter stays in the Emergency Department		7.1 Work with key areas and specialities within the hospital to ensure flow through the ED to enable the national target to be met e.g. continued development and refinement of the recently implemented Production Bed Planning Model and appropriate use of the ED Observation Unit.	Q1-4	▪ 95% of ED attendances waiting less than 6 hours to be treated, admitted, discharged or transferred.	Dr Martin Than	Rebecca & Greg	Shorter stays in Emergency Department

SECTION THREE: Key metrics the group will use to indicate; progress with delivering work plan actions, impact of actions on health outcomes, monitor performance targets		
Description of Metric	**Data Source**	**Comments on access to data / metrics**
1. Number of times ED reaches capacity	Decision support	
2. Acute bed days data	Decision support	
3. ED wait times (ensure national target is being met)	Decision support	
4. Non-medical admissions	Decision support	
5. Number of time ADMS reaches capacity	AMDS	Pegasus (PaulB)
6. ADMS Packages of Care	ADMS	Pegasus (Paul B)
7. Number of patients diverted away from ED	St John	
8. Total number of calls to St John each quarter	St John	
9. Care around the clock call volumes	Decision support	(Kathleen)
10. Percentage of people who present at ED or urgent care facility following teletriage	HML/Decisionsupport	Brian