Canterbury Clinical Network Work Programme 2020-22

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

Introduction

This document brings together the 2020-21/22 Canterbury Clinical Network (CCN) alliance groups work plans.

Background

The CCN is an alliance of health care providers from across Canterbury. CCN was established in 2010 to lead the integration and transformation of the Canterbury health system through clinically-led service development and improvement.

A number of our alliance groups have been established around populations, services and/or localities. These groups work collectively to bring together information on the needs of a specific population, service and/or locality, identify where improvements can be made that offer the best value, and lead changes that will enhance equitable health outcomes and/or access to services.

Each CCN group develops a work plan that captures their expected activity for a period of 12-24 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. The alliance groups then report on progress against their work plan priority actions quarterly and any risks that could impact progress in their focus area.

2020-21/22 work planning

In November 2019 groups were provided with a work planning guide that included information on system priorities, a work planning process and template for completion. Alliance groups were given the option of developing a two year plan (July 2020 to June 2022), which some groups have adopted.

Before developing the work plans, most alliance groups met with the Māori Caucus, which brings together Maori perspectives from each group, to discuss future priorities and how these could address the health needs of Māori. The outcome of this process is that the current work plans include more actions that prioritise equity, use data to highlight variations in outcomes for Māori and advance the cultural development of the workforce.

Input was also sought from the Pacific Caucus on five areas the Caucus identified as a priority for Pacific communities.

The impact of Covid-19 significantly changed the delivery of services; accelerating, changing and in some instances delaying service provision. It also impacted alliance groups' ability to progress their 2019/20 priority actions. During May and June all groups reviewed their draft 2020-21/22 work plans and made adjustments to the priority actions and time frames as needed.

Given the dynamic environment and flexibility needed to respond to further changes, alliance groups can seek the ALT's endorsement of an updated plan at any stage if substantial changes in their priorities have occurred. The most current version of each alliance groups work plan will be available on their CCN website page.

Each alliance group's work plan includes:

Priority actions	Where the group will focus their efforts for the next 12-24 months. Actions for year 2021-22 are shaded in grey.
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).

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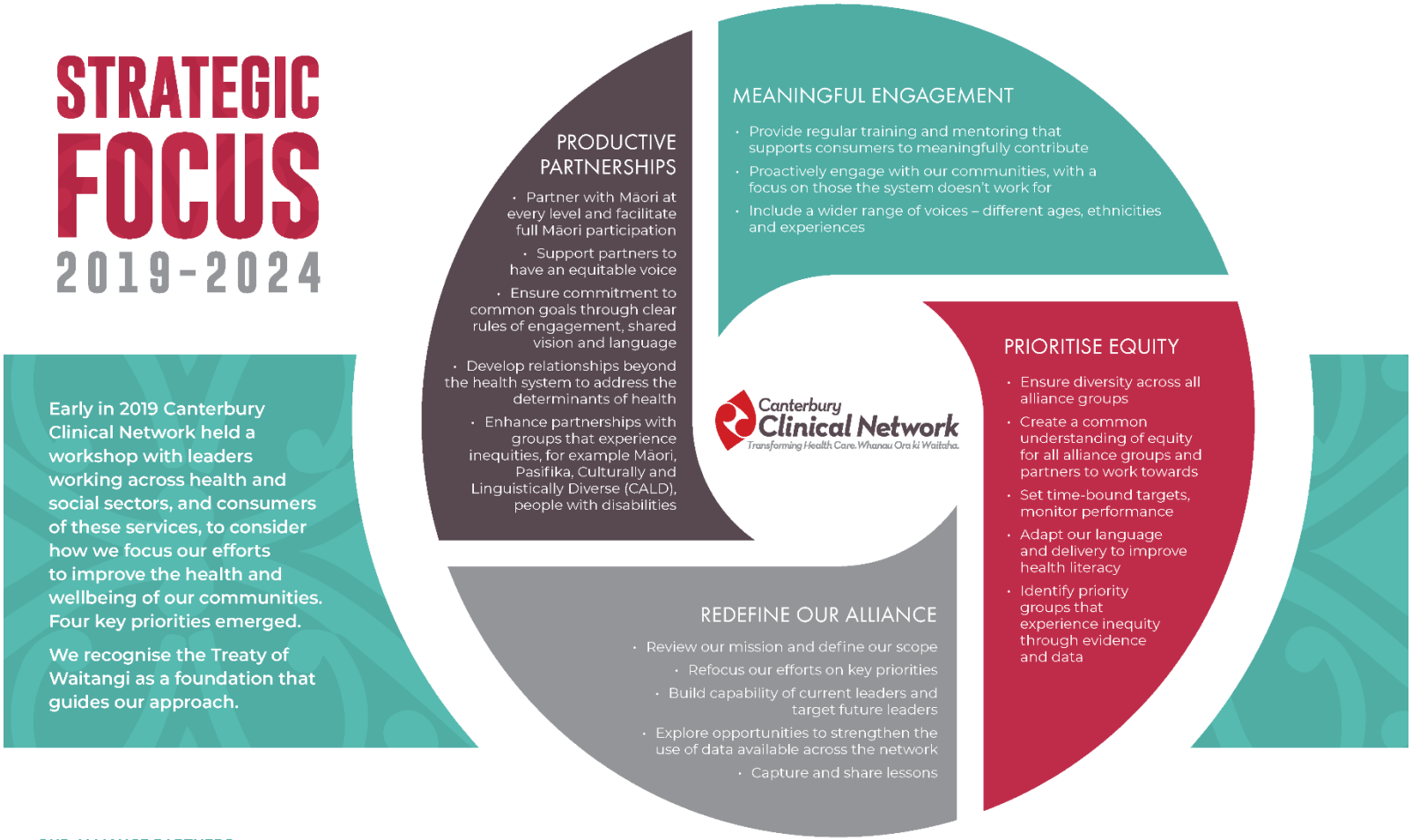
CCN Strategic Focus 2019- 2024



OUR ALLIANCE PARTNERS

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

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

CCN Structure August 2020

ALLIANCE PARTNERS

- Access Homehealth
- Canterbury Community Pharmacy Group
- Canterbury District Health Board
- Christchurch PHO
- Healthcare NZ Community Health
- New Zealand College Of Midwives
- Nurse Maude
- Pacific Radiology
- Pegasus Health
- Canterbury SCL
- St John
- Waitaha Primary Health

SYSTEM REFERENCE GROUPS

Advisory groups we engage with:

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

Ashburton Service Level Alliance Work Plan 2020-21

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Priority actions towards transformational change, improved system outcomes and/or enhanced integration			
1. Safer, efficient transfers of care for the elderly	Progress work on integrated journey for people aged 65 and over (EOA*).	Q4: Working group formed and recommendations made on standardisation of care, ARC enrolment process (as per actions on the Frail Elderly Pathway document) and House GP model.	▪ Increased planned care/decreased acute care rate ▪ Decreased institutionalisation rates
2. Improving equitable access to primary care for all populations including Māori, Pasifika, Migrant and CALD	Strengthen / maintain relationships between primary, secondary, tertiary community care and local rūnanga.	Q1-Q4: Regular meetings held.	▪ 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
	Agree additional opportunities to facilitate enrolment in general practice and transfer of GP (with a focus on Māori, Pasifika, Migrant and CALD) (EOA).	Q1: Consistent enrolment process/ pathway fully embedded in general practice. Q2: Data dashboard developed on non-enrolled patients that present at AAU/hospital team.	
	Explore expansion of scope of practice within general practice and utilisation of other healthcare roles in primary care.	Q2: Stocktake of primary care expertise in Ashburton. Working group formed to explore and make recommendations on: ▪ Use of subsidised procedures and acute demand ▪ Use of St John in a primary care setting ▪ Integration with CNS/Allied Health ▪ Use of Health Improvement Practitioner (HIP), community pharmacists and other healthcare workers	
	Explore the use of mixed model of face to face consultations and telehealth / virtual consultations in primary and secondary care including linking with other alliance groups.	Q3: Working group formed to explore and make recommendations on the best fit model for: ▪ Maori, Pasifika and other minority populations ▪ Elderly and youth ▪ People in remote rural areas ▪ People with disabilities	
	Improve cultural competency of the health care workforce (including admin staff) across Ashburton.	▪ Q4: Develop integrated and consistent training in conjunction with Māori, Pasifika, Migrant and CALD for the Ashburton healthcare workforce. ▪ Develop a regular publication addressing cultural awareness and safety. ▪ Increase awareness cultural events held in Ashburton by promotion and distribution of communications.	
3. Continue with Access to Acute Care co-design recommendations	Continue to support the #CareAroundtheClock advertising campaign, which promotes calling general practice 24/7.	Q4: Develop communication plan. Call volumes to be monitored and reported quarterly.	▪ Increased planned care/decreased acute care rate ▪ Decreased wait times

*EOA – Equity Outcome Action / *SLM – System Level Measures
CCN Work Programme 2020-22

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
	Update and distribute communications and how to access general practices post Covid-19 and what services/new ways of working are available.	Q2: Develop communications and distribute through the Ashburton district.	▪ Delayed/avoided burden of disease and long term conditions ▪ Primary care access improved
4. Sexual Health service provision and accessibility	Monitor overall access of sexual health services in Ashburton, including Youth One Stop Shop (YOSS).	Ongoing: ▪ Undertake a stocktake of sexual health services in Ashburton. ▪ Look for opportunities to improve access and equity.	▪ Decreased avoidable mortality ▪ Decrease adverse events ▪ Improved environment supports health and wellbeing ▪ People are supported to stay well
Actions towards monitoring progress			
5. Integration of Social and Health Services within Ashburton	Identify opportunities for better alignment across health and social services.	Q1-Q4: Provide quarterly updates on: ▪ Collaboration with Safer Ashburton with a focus on refugee service. ▪ Monitor the introduction of the Here Toitū facilitated by MSD. ▪ Engagement with Ashburton District Council. ▪ Local updates on new initiatives shared with Ashburton Hospital, Caring for Communities (Psycho- social and Mental wellbeing Recovery Plan) etc.	▪ Improved environment supports health and wellbeing ▪ People are supported to stay well
6. Improving equitable access to primary care for all populations including Māori, Pasifika, Migrant and CALD	Support the uptake of initiatives that assist general practice to manage their capacity to enable timely access to care e.g. HCH.	Q1 & Q3: Provide 6-monthly reports on: ▪ Number of general practices engaged in the HCH programme. ▪ HCH module uptake for general practices, for example, patient portal, clinical triage, PES.	▪ 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
7. Strengthen the integration and coordination of care and in collaboration with patients	Monitor the use of shared care plans by primary, secondary, and community care providers in Ashburton.	Q1 & Q3: Provide quarterly reports on the number of care plans created and updated across primary, secondary and community care.	
8. Mental health integration and accessibility	Support the Mental Health Work Stream (MHWS) implement new initiatives in Ashburton.	Q1 – Q4: Quarterly meetings with the MHWS facilitator to receive updates on any new initiatives.	▪ Decreased avoidable mortality ▪ Decreased adverse events ▪ Improved environment supports health and wellbeing ▪ People are supported to stay well
	Support the Rural Health Work Stream (RHWS) to implement rural initiatives in Ashburton.	Q1 – Q4: Quarterly meetings with the RHWS facilitator to explore linkages and strengthening of rural initiatives.	
	Monitor mental health services in Ashburton including but not limited to: ▪ Te Tumu Waiora ▪ Mana Ake ▪ Suicide postvention work ▪ Child, Adolescent and Family Services	Ongoing: Updates provided to the Ashburton SLA on mental health services in Ashburton.	

Key metrics to indicate progress delivering work plan actions, impact on health outcomes and/or monitor performance	
Description of metric	Data Source
1. Shared Care Plan data: The number of care plans created and updated across primary, secondary and community care (Objective 6.1).	Shared Care Planning
2. AAU Attendance data including by age, ethnicity and enrolment status (Objective 2.2).	CDHB
3. Call volume data.	Homecare Medical

Child and Youth Health Workstream Work Plan 2020-21

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Priority actions towards transformational change, improved system outcomes and/or enhanced integration			
1. Best start to life / First 1,000 days	Develop and implement a Maternity Work plan in consultation with Māori and the wider community to identify priority areas. (EOA*).	Q2: Work plan developed and implementation under way. 80% of women (all ethnicities) are registered with and Lead Maternity Carer (LMC) by 12 weeks of pregnancy.	▪ Improved Environment supports health and wellbeing. ▪ Building population health capacity & partnerships ▪ Protective factors enhanced
	Implement an evidence informed breastfeeding action plan focused on improving equity for Maori, Pacific, CALD, Rural and high deprivation populations (EOA).	Q1-Q4: Action Plan implemented. Increase in the babies fully/exclusively breastfed at 3 months of age. MOH target = 70%	
	Evaluate the current model of pregnancy and parenting programmes to ensure it better meets the needs of all Māmā and Papa with a specific focus on Māori and Pacific. (EOA).	Q4: Evaluation complete. Response to findings initiated.	
2. Childhood health and wellbeing	Continue to explore the expansion of LinKIDS to achieve better connection and coordination between different components of early childhood child health service delivery (EOA).	Q1-Q4: Improved coordination of LMC, Well Child Tamariki Ora (WCTO) and child primary health services through linkage and use of shared data.	▪ Access to care improved ▪ Multidisciplinary approach ▪ Building population health capacity & partnerships
	Continue development of an integrated approach between child mental health, paediatric services including child development, child disability support services alongside education / Ministry of Education.	Q1-Q4: Implementation of agreed direction for an integrated approach.	
	Review youth access to sexual health services with a focus on high risk populations. This will include service utilisation at general practice, pharmacy, School-based health services and Family Planning to identity any gaps or opportunities to improve access.	Q4: Gaps in Youth Sexual Health service provision and changes in service model to improve access / address any service gaps identified.	
3. Vulnerable children and families	Collaborate with Oranga Tamariki to ensure the joint focus on vulnerable children and young people is maintained during the transition of Children's Team into new model(s) of early intervention over the year (EOA).	Q1-Q4: Support for vulnerable children and families is maintained pending the establishment of early intervention systems.	▪ Improved Environment supports health and wellbeing.
4. Health and wellbeing in adolescence / early adulthood	Promote the transition of young people to adult health services that meet the needs of 16 to 25-year olds with complex care needs (medical, disabilities) by implementing the transition guidelines (EOA).	Q2: Recommendations of the paediatric collaborative transition group and Ministry of Health mental health service transition guidelines progressed.	▪ Access to care improved ▪ Multidisciplinary approach
	Develop suitable health pathways in conjunction with VOYCE (voice of young people with care experience)	Q2: All young people with care experience enrolled in health care relevant to their specific needs.	

*EOA – Equity Outcome Action / *SLM – System Level Measures
CCN Work Programme 2020-22

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
	to improve access to dental health, mental health and sexual and reproductive health.		
Actions towards monitoring progress			
5. Understand our Child and Youth and variance in access to services or health outcomes in particular for Maori, Pacific and other high-risk populations	Develop a Child and Youth Health data dashboard, so we can better monitor and measure utilisation of current services, by our Maori, Pacific and high deprivation populations and monitor progress on agreed priority work plan actions (EOA).	Q1-Q4: Dashboard developed and shared quarterly.	▪ Understanding our population ▪ Resources matched to need
Key metrics to indicate progress delivering work plan actions, impact on health outcomes and/or monitor performance			

Description of metric	Data Source
1. B4SC reports.	MoH reporting (Bridget)
2. Utilisation data from Youth Sexual Health Services across Canterbury general practices to ensure equity of access.	Primary Health Team (Rachel)
3. Violence Intervention Programme (VIP) quarterly reports.	ISR governance reports Sandy McClean
4. Integrated Safety Response data on Family Violence Pilot, to support a rapid response from government and social agencies to the needs of people and families affected by family violence (EOA).	VIP/ISR reports (Pene Kingsford)
5. University of Otago Child and Youth Epidemiology annual reports.	NZCYES
6. SLM Quarterly Reporting.	TBD
7. Safe Sleep Device Quarterly Reporting.	TBD
8. Outcomes of Mana Ake review and evaluation.	Mana Ake (Clare Shepherd)
9. Regular updates from the DSG (Disability Steering Group) on issues relating to child and youth health and disability support services.	Kathy O'Neill

Community Services Service Level Alliance Work Plan 2020-22

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Priority actions towards transformational change, improved system outcomes and/or enhanced integration			
1. Increased implementation of Restorative Support across Community Services	Continue to develop a Restorative Support education strategy for the sector and wider public including: ▪ Socialising a Restorative model of care. ▪ Revising relevant HealthPathways. ▪ Work with Communications team to socialise Restorative Support more widely.	Q3: HealthPathways revised. Q4: Communications strategy developed.	▪ Fewer people need hospital care ▪ People are supported to stay well ▪ Access to care improved
	Navigation Strategies: ▪ Revise HealthInfo to clarify Restorative focus of Home and Community Support Services. ▪ Promote use of Personalised Care Plan.	Q1: Baseline of PCPs established. Q2: HealthInfo revised. Q4: Increased number of active care plans.	▪ Collaborative plans of care ▪ Fewer people need hospital care ▪ People are supported to stay well
	Continued socialisation of Restorative model.	Year 2021/22	
2. More cohesive discharge planning to rural areas	Work with Christchurch Hospital and Burwood Hospital wards and providers to ensure District Nursing referrals to rural areas are planned with attention to available resources: ▪ Work with Rural Workstream to develop a resource describing services available on discharge in rural areas. ▪ Continue to streamline the supply of consumables to rural providers of District Nursing.	Q2: Stocktake of services completed. Q2: Ordering available through CDHB supply department for Rural DN. Q4: Resource compiled.	▪ Equity ▪ People are supported to stay well ▪ Community resilience/capacity enhanced
	Resource distributed to discharging wards.	Year 2021/22	
	Consumables ordering monitored.		
3. Equitable Access for Services for Kaumātua	Continue to develop support services for kaumātua in rural areas by (EOA): ▪ Completing first year of Kahukura Kaumātua programme and gathering feedback from participants (Q2). ▪ Preparing a report on first year of Kahukura Kaumātua project (Birdlings Flat) (Q2). ▪ Handover planning for Kahukura Kaumātua project in Birdlings Flat initiated (Q3).	Q2: Eight sessions completed. Q3: Report circulated to stakeholders.	▪ Equity ▪ People are supported to stay well ▪ Community resilience/ capacity enhanced
	Kahukura Kaumātua project rolled out in the Hurunui (EOA): ▪ Initial hui held in Hurunui. ▪ Hurunui programme developed. ▪ Business plan written for	▪ Q2: Hui held in Hurunui. ▪ Q3: Programme developed alongside local community. ▪ Q4: Business Plan completed.	

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
	Hurunui programme.		
	Kahukura Kaumātua Birdlings Flat project handover to local community (EOA).	Year 2021/22 Q3: First sessions of 2022 run by local kaiawhina.	▪ Equity ▪ People are supported to stay well ▪ Community resilience/capacity enhanced
	Hurunui programme delivered (EOA).	Year 2021/22 Q4: Introductory programme established according to findings from 20/21.	
	Training resource developed to enable other groups to undertake similar processes of engagement with cultural Communities (EOA).	Year 2021/22 Q3- Q4: Resource drafted and Circulated.	▪ Equity
4. Equitable access for support services for the Pasifika and CALD communities	Continue to develop support services for Pasifika Community with a focus on Falls Prevention (EOA): ▪ Work with Sport Canterbury on Pasifika engagement strategy. ▪ Engage with Pasifika providers and community to promote Strength and Balance options.	Q1: Fono held Q2-4: Strategies developed. Q4: Increased attendance at classes for Pasifika.	▪ Equity ▪ Community resilience capacity enhanced
	Continue to develop support services for CALD, refugee and migrant community, with a focus on Falls Prevention (EOA): ▪ Confirm CALD engagement strategy. ▪ Engage with CALD providers and community. ▪ Engage with CALD providers and community to promote Strength and Balance options.	Q1: Meetings held. Q1-4: Strategies developed. Q4: Increased attendance at classes for Pasifika.	
	Continue to prioritise delivery of equity outcomes for these groups, with a focus on Falls Prevention (EOA).	Year 2021/22	▪ Equity
5. Services for under 65 year olds	Work to identify women under 65 at risk of osteoporosis and develop strategies towards early intervention: ▪ Bring together workgroup to define parameters (Q2). ▪ Develop strategies to engage this group (Q2). ▪ Develop pathway for this group (Q4).	Q1-4: Workgroup assembled and strategies Developed.	▪ People are supported to stay well
	Develop communications strategy to target this group.	Year 2021/22 Q1-4: Ongoing work to promote bone health for this group.	▪ People are supported to stay well
Actions towards monitoring progress			
6. CREST transition monitored	Monitor and facilitate where necessary changes in CREST services to ensure changes in delivery model are supported.	Q1-4: Providers report to meetings on outcomes and barriers.	
7. Ethical decision making	Continue to monitor use of Ethical Framework in decision-making (EOA).	Q1-4: Reports received from Clinical groups.	▪ Equity

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
8. Uptake of Funded Family Care options monitored	Monitor uptake of Funded Family Care and Individualised funding.	Q1-4: Reports received from providers (quarterly).	▪ People are supported to stay well ▪ Fewer people ▪ need hospital care
9. Equitable delivery of rural Community Services	Receive reports from Rural Health Workstream on rural models of care.	Q1-4: Reports received.	
10. Social Isolation/ Elder Abuse	Monitor scores of interRAI assessments.	Q1-4: Reports received and considered.	▪ Community resilience/capacity enhanced ▪ People are supported to stay well
11. Monitor ACC/ CREST NAR case mix data	Table data from ACC/ CREST Non-Acute Rehabilitation program.	Q1-4: Data analysed and considered.	▪ People are supported to stay well ▪ Fewer people need hospital care
12. Monitor Falls prevention data	Table data from Falls & Fractures Operations group quarterly.	Q1-4: Reports received and considered.	
13. Engage with Hospital Falls Prevention Steering Group (HFPSG)	Share information (and minutes as appropriate with HFPSG on restorative project.	Q2-Q4: Minutes shared, and appropriate actions taken where agreed.	

Key metrics to indicate progress delivering work plan actions, impact on health outcomes and/or monitor performance

Description of metric	Data Source
1. InterRAI assessments per 1000 population 65+ (Māori 55+).	TAS
2. Percentage of HCSS clients 65+ with an interRAI.	
3. Percentage of people receiving HCSS that have an Advance Care Plan.	CDHB ACP group
4. Percentage of people receiving HCSS that have a cognitive impairment.	TAS
5. Percentage of HCSS clients with a Home Care assessment that are MAPLE 5 (receive 24hr supervision).	TAS
6. Number of Strength and Balance places (Pasifika focus).	Sport Canterbury
7. Number of Strength and Balance places (CALD focus).	Sport Canterbury
8. Number of referrals to in-home FPP.	

Co-ordinated Access on Release Group Work Plan 2020-22

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Priority actions towards transformational change, improved system outcomes and/or enhanced integration			
1. Improve access to services for people on release	Implement HealthOne into prison health units in Canterbury.	Q2: HealthOne available in all prison health units/clinics.	▪ 'At risk' population identified ▪ Increased equity of access ▪ Multidisciplinary approach
	Explore what work is possible with Probation to link prisoners (paihere) on release with health navigation services, where additional health support is required.	Q2: Opportunities identified to improve the link of prisoners on release with health navigation services. Q4: Scope the opportunities identified for implementation.	
	Implement opportunities identified above.	Year 2021/22	
	Explore the potential for screening/health assessment in prisons with a focus on mental health, alcohol and drug and traumatic brain injury.	Q4: Opportunities identified to improve screening/health assessments in prisons. Process improvements implemented in prisons and shared across the system.	
	Communicate the free and extended consultations initiative to prisons, reintegration services, primary care etc.	Q1: All communications distributed through the agreed communication channels with the parties involved.	
	Explore the health issues and needs of remand clients.	Year 2021/22	
	Update the release process planning map that was developed in 2017.	Q3: Process mapping completed.	
2. Learn from group members about initiatives to improve health outcomes for prisoners on release	Facilitate discussion on improvement of the delivery of health services.	Q4: Information about local initiatives shared to the group twice a year.	
Actions towards monitoring progress			
3. Provide sustainable and integrated programmes	Monitor the effectiveness of the free and extended consultations.	Q1-Q4: Provide quarterly reports on : ▪ Number of patients that access free and extended consultations with General Practices. ▪ Number of consultations over time. ▪ Number of patients enrolled. ▪ Ethnicity, age and gender of patients accessing consultations. ▪ Corrections release data.	

Key metrics to indicate progress delivering work plan actions, impact on health outcomes and/or monitor performance	
Description of metric	Data Source
1.Number of patients that access free and extended consultations with General Practices.	CDHB
2.Number of consultations over time.	CDHB
3.Number of enrolled patients accessing consultations.	CDHB
4.Ethnicity, age and gender of patients accessing consultations.	CDHB
5.Number of prisoners released from Canterbury Prisons.	Corrections

Health of Older People Workstream Work Plan 2020-22

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Priority actions towards transformational change, improved system outcomes and/or enhanced integration			
1. Equitable Access for Services for Kaumātua	Continue to develop support services for kaumātua in rural areas by (EOA): ▪ Completing first year of Kahukura Kaumātua programme and gathering feedback from participants (Q2). ▪ Preparing a report on first year of Kahukura Kaumātua project (Birdlings Flat) (Q2). ▪ Handover planning for Kahukura Kaumātua project in Birdlings Flat initiated (Q3).	Q2: Eight sessions completed. Q3: Report circulated to stakeholders.	▪ Equity ▪ People are supported to stay well ▪ Community resilience /capacity enhanced
	Kahukura Kaumātua project rolled out in the Hurunui (EOA): ▪ Initial hui held in Hurunui. ▪ Hurunui programme developed. ▪ Business plan written for Hurunui programme.	Q2: Hui held in Hurunui. Q3: Programme developed alongside local community. Q4: Business plan completed.	
	Kahukura Kaumātua Birdlings Flat project handover to local community (EOA).	Year 2021/22 Q3: First sessions of 2022 run by local kaiawhina.	▪ Equity ▪ People are supported to stay well ▪ Community resilience /capacity enhanced
	Hurunui programme delivered (EOA).	Year 2021/22 Q4: Introductory programme established according to findings from 20/21.	
	Training resource developed to enable other groups to undertake similar process of engagement with cultural communities (EOA).	Year 2021/22 Q3-Q4: Resource drafted and circulated.	▪ Equity
2. Improved actions to meet anticipated increase in people with Dementia	Produce report with recommendations for service interventions to address delayed dementia diagnoses including: ▪ Dementia Specialist Nurse ▪ Diagnosis funding package	Q2: Report produced.	▪ Earlier Diagnoses ▪ Management of disease (best practice)
	Work with primary care to implement recommendations.	Q4: Business case presented.	
	Continue to work with Community and Public Health to promote dementia specific health messaging.	Q1: Promotional strategy confirmed. Q4: Promotional documents published.	▪ Population interventions
	Continue to work with primary care to implement recommendations.		▪ Earlier Diagnoses ▪ Management of disease (best practice)
	Continue to promote Dementia awareness.		▪ Populations interventions
3. Improved Social integration for Older People	Liaise with #wellconnectednz to compile community resources that promote social integration, with a focus on transport options and solutions to other barriers.	Q2: Meetings held. Q3: Document produced. Q4: Document distributed through HCSS providers.	▪ Behavioural interventions delivered ▪ Social environment supports health

*EOA – Equity Outcome Action / *SLM – System Level Measures

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
	Investigate and report on the potential for a "Social Prescription" model for older people, with attention to people's cultural and linguistic needs.	Q4: Report presented.	
	Work to implement "Social Prescription" model for selected cohort.	Year 2021/22	▪ Behavioural interventions delivered ▪ Community capacity enhanced
4. Enhanced support for cares	Enable streamlined uptake of Carer Support by simplifying systems including (EOA): ▪ Modifying claims process. ▪ Aligning with Funded Family Care policies. ▪ Developing pathways for use of Individualised Funding options.	Q1: Baseline established of Carer Support utilized and service gaps identified. Q4: Growth in Carer Support utilization measured over time. Q4: Health Pathways revised.	▪ Behavioural interventions delivered ▪ Community capacity ▪ enhanced
	Develop up-to-date information package for Carers promoting the benefits of taking time out and detailing strategies to enable people to do so.	Q3: Package produced and approved. Q4: Education package distributed at time of referral.	
	Continue to monitor Carer Support uptake and continue to work to enable accessibility.	Year 2021/22: Increased utilisation of Carer Support.	
5. Quality Improvement in ARC	Work with Health Quality Safety Commission to support work on de-prescribing in Aged Residential Care (ARC).	Q1-Q4	
	Continue work to improve HealthOne access for ARC facilities.	Q1-Q4: Increase ARC facilities have access to HealthOne.	▪ Coordinated care
	▪ Work towards increased ARC engagement in Falls Prevention. ▪ Hold Falls Prevention education session in ARC forum. ▪ Bring together ARC working group to develop strategic direction for falls prevention in Residential Care.	Q2: Falls Prevention session held. Q3: Group meeting. Q4: Strategic plan developed.	▪ Behavioural interventions delivered ▪ Access to care improved
	▪ Cross-provider resource developed to support appropriate de-prescribing of antipsychotics. ▪ Implementation of Falls Prevention plan for ARC.	Year 2021/22	▪ People are supported to stay well ▪ Management of disease (best practice)
6. Provide support for older people identified as Pre-Frail	Identify cohort of pre-frail older people via case-mix group and CAPs.	Q1: Cohort identified.	▪ People are supported to stay well
	Develop system to allow referrals for this cohort to appropriate services including Falls prevention.	Q1: Appropriate services identified. Q3: Referral.	
	Monitor uptake of referred services from this cohort and evaluate success of this approach; adjust appropriately.	Year 2021/22	▪ People are supported to stay well

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Actions towards monitoring progress			
7. Wider access to health plans	Monitor the uptake of: ▪ Advance Care Plans ▪ Medical Care Guidance Plans ▪ Personalised Care Plan	Q1-Q4: Increased use of all plans.	▪ Access to care improved
8. Health literacy	Monitor use of HealthInfo.	Q1-Q4: Traffic on site reported quarterly.	▪ Social environment supports health
9. Pressure injuries project	Review data updates from Sue Wood and team.	Q1-Q4: Reports received.	▪ Management of disease (best practice)
10. Palliative care	Maintain links with South Island Alliance Palliative Care Workstream.	Q1-Q4: Quarterly reports from ARC Palliative Care NZ service received.	▪ Access to care improved ▪ death with dignity
11. CREST	Monitor CREST transition.	Q1-Q4: Report from CSSLA.	▪ Access to care improved
12. Falls and fractures	▪ Monitor transition of Falls & Fractures SLA. ▪ Consider appropriate data monitoring to support strategic developments in falls prevention.	Q1-Q4: Reports received.	▪ People are supported to stay well
Key metrics to indicate progress delivering work plan actions, impact on health outcomes and/or monitor performance			
Description of metric			Data Source
1. Admission to ARC by ethnicity (50+ Māori).			
2. Admissions to Hospital 65+ by ethnicity (50+ Māori).			
3. Length of Stay 65+ by ethnicity (50+ Māori).			
4. ED presentations 65+ by ethnicity (55+ Māori).			
5. Number of #NOF or # humerus referred to in-home FPP (75+) – (55+ Māori).			

Immunisation Service Level Alliance Work Plan 2020-22

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Priority actions towards transformational change, improved system outcomes and/or enhanced integration			
1. Recovery: Improve health of population by responding to impact of Covid-19 and implementing associated learnings	Work with our immunisation system to reach children who have missed an immunisation event due to covid-19 restrictions.	Q1: Immunisation returns to pre-Covid-19 coverage rates.	▪ Population vaccinated. ▪ Protective factors enhanced.
	Support the Ministry of Health with: ▪ The development of the new NIR system. ▪ Improving vaccine supply issues identified in the 2020 Flu programme ▪ Developing a Covid-19 vaccine programme.	Q1-Q4: Canterbury DHB has a voice and influences national planning.	
2. Ensure the current Immunisation Service Model is fit for purpose to improve / maintain Immunisation coverage	Review and refresh (if necessary) the Immunisation Service Model to reflect the current Immunisation environment (EOA).	Q1: Review of service completed.	▪ Contribute to National Health and Performance Targets
	Develop a plan and progress implementation of any necessary service model changes.	Q4: Implementation plan completed. Implementation of any changes in service model progressed.	
3. Protecting mother and baby	Develop a process to identify women who have and have not been vaccinated during pregnancy including by ethnicity, LMC and general practice.	Q1: Pregnancy pertussis coverage available by ethnicity.	▪ Delayed/avoided burden of disease & long term conditions ▪ Protective factors enhanced. ▪ Risk factors addressed ▪ Reduce hospital admissions
	Use the data from this report on pregnancy pertussis coverage programme, to identify and engage with key stakeholders (target Lead Maternity Carers and General Practices) about improving pertussis coverage, with a focus on Māori and Pacific family/whanau.	Q3: Targeted programme around Pregnancy vaccinations developed.	
	Continue to support the Outpatients vaccination programme, and work with them to increase their coverage by 10%.	Q4: Share coverage baseline data with the Outpatients programme.	
4. Ensure timely childhood immunisation	Support the implementation of the 2020 Immunisation Schedule changes.	Schedule changes are implemented.	▪ Population vaccinated. ▪ Protective factors enhanced.
	Continue to monitor immunization coverage at 8 months, 15 month, 5 years, 12 years and HPV for birth cohort year, and ensure there is equity of coverage.	Regular reports on overdue children and practice coverage shared with General Practices.	
	Continue to offer the Immunisation Conversation Programme to general practice teams and deliver this programme to Lead Maternity Carers on an annual basis.	Programmes provided.	

*EOA – Equity Outcome Action / *SLM – System Level Measures

Key metrics to indicate progress delivering work plan actions, impact on health outcomes and/or monitor performance	
Description of metric	Data Source
1. 95% of 8month olds, 2 year olds and 5 year olds are fully vaccinated, each quarter.	MoH
2. 70% of those born in 2007 are fully vaccinated for HPV. Annually Due in July.	MoH
3. 85% of 12 year olds are fully vaccinated for Tdap. Annually due in July.	MoH / NIR
4. 65% of pregnant women have received the Tdap vaccination during pregnancy annually due in March.	DHB NIR analysis,
5. 65% of those 65 years and older are vaccinated for Influenza. Annually to the end of September.	MoH

Integrated Diabetes Service Development Group Work Plan 2020-22

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Priority actions towards transformational change, improved system outcomes and/or enhanced integration			
1. Improve health outcomes for high risk populations with diabetes by increased engagement in health services by: ▪ Māori, ▪ Pasifika Peoples, ▪ Indian ▪ Adolescents/Young Adults, ▪ People with mental illness	Gather information and apply this to advance service delivery to high risk populations (EOA): ▪ Access and analyse PHO and practice level data for population health outcomes to enable prioritisation of community service delivery. ▪ Analyse Canterbury wide data to identify population groups, including where they reside and attend general practice by: ▪ Identify national diabetes programmes that have demonstrated positive outcomes for priority groups and disseminate successful models of care and innovation. ▪ Support and enable Marae based diabetes outreach services to Māori & whānau, including diabetes education, testing, and retinal screening. ▪ Plan a community outreach for Pacific people with diabetes.	▪ Q2-Q4: ▪ Increased access to services for priority populations. ▪ Improved Hba1c results in all population (HBA1c. Baseline 78.3% (2017, Atlas of Healthcare Variation) for Māori). ▪ Reduced ethnic variation. ▪ Narrow gap between European and priority population. (HBA1c. Baseline 78.3% (2017, Atlas of Healthcare Variation) for Māori).	▪ Delayed/avoided burden of disease & long-term conditions ▪ 'At risk' population identified
2. Increased service delivery for people with diabetes in the community and alignment of the dietetic and nutritionist workforce to the location of service delivery	Align dietetic and nutritionist workforce: ▪ Complete a stock take of the current access to and location of dietetic and nutritional services to establish baseline and unmet need. ▪ Develop recommendations for changes in workforce and location.	Q1 Dietetic/nutritionist services stocktake completed and baseline and unmet need established. Workforce proposal developed.	▪ Delayed/avoided burden of disease & long- term conditions ▪ Access to care improved
3. Increased system level Integration and access to clinical notes E.g. Documentation , I.T, and clinical oversight	Improve integration and access to clinical information by: ▪ Complete a stock take of the current access of key providers and identify any gaps. ▪ Develop recommendations for changes.	Year 2021/22 Q4: Key stakeholders have access to the same level of information to provide best outcomes and a system level approach to care and treatment.	▪ Delayed/avoided burden of disease & long-term conditions ▪ Access to care improved
4. Reduce people with diabetes hospital admissions and length of stay in secondary care in-patient service	Develop an inpatient in-reach service to actively identify and engage with people with diabetes while in hospital.	▪ Year 2021/22 Q4 ▪ Reduced length of stay of people in hospital. ▪ Continuity of care provided for people to remain well and out of hospital.	
Actions towards monitoring progress			
5. Monitor engagement with high risk groups such as: ▪ Māori ▪ Pasifika Peoples	Monitor integrated diabetes (specialist and community) services, general practice, retinal screening, and high-risk diabetic foot) activity for priority populations.	▪ Q2/Q4 ▪ Number of Māori and Pasifika people with diabetes. ▪ Six-monthly reporting to IDSDG on activity, including ethnicity.	▪ Delayed/avoided burden of disease & long-term conditions

*EOA – Equity Outcome Action / *SLM – System Level Measures
CCN Work Programme 2020-22

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
▪ Indian ▪ Adolescents/ Young adults ▪ People with ▪ mental illness			
6. Enhance self-management and health literacy for people with diabetes including for priority populations	Monitor progress with implementation of redesigned patient education in a range of community settings to support improved access for priority populations.	Q1-Q4: Education is accessible and increased attendance is evident.	
7. Enable people with diabetes to better manage their condition	Monitor integration of diabetes nursing workforce to allow: ▪ Increased community service delivery. ▪ Consistent clinical oversight ▪ Equity of access for patients regardless of complexity of diabetes.	Q1: Work plan for integrated nursing services project completed.	▪ Reduced clinic cancellations ▪ No wasted resource ▪ Right care, in the right place, at the right time, delivered by the right person
8. MoH reporting	Monitor delivery against the Ministry of Health Quality Standards for Diabetes Care.	Annual review completed. Service delivery reflects the National Quality Standards for Diabetes Care.	

Key metrics to indicate progress delivering work plan actions, impact on health outcomes and/or monitor performance

Description of metric	Data Source
1. Number of people with diabetes and their HbA1C results by age and ethnicity at PHO and Practice level.	PHOs/DHB
2. Volume and wait times for retinal screening by ethnicity.	Decision Support
3. Volume of participants receiving diabetes foot care – community.	PHOs/DHB
4. Volume of participants receiving diabetes foot care – MDT podiatry/vascular/ID clinics.	Decision Support

Integrated Respiratory Service Development Group Work Plan 2020-22

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Priority actions towards transformational change, improved system outcomes and/or enhanced integration			
1. People at risk of presenting/re-admitting to hospital acutely are supported	Pilot community-based FEV6 lung function testing (EOA).	Q2: Increase in number of Māori and Pasifika people receiving community lung function tests.	▪ Increased planned care rate Decreased acute care rate ▪ At Risk population
	Identify and contact people who are frequently attending hospital by a Respiratory CNS. Put in place a package of care to support them at home.	Q1: Increased number of referrals to IRNS, especially for Māori and Pasifika.	
	Work with hospital nurses and specialists to support people being discharged.	Year 2021/22 Q2: Reduction in patients readmitting to hospital within 28 days.	▪ Increased planned care rate Decreased acute care rate ▪ Delayed/ avoided burden of disease & long term conditions
	Support people with mild exacerbations of COPD to remain safely in their homes. Work with general practice, St John Ambulance, 24 Hour Surgery and others.	Year 2021/22 Q1: Reduction in patients presenting to ED with mild COPD.	
	Work with general practices to identify people undiagnosed by providing CNS support for Query Builds, etc. (EOA)	▪ Year 2021/22 Q1 ▪ Increase in number of patients receiving community spirometry tests. ▪ Increase in number of referrals to IRNS.	
2. People at risk of a respiratory disease are supported to make lifestyle changes	Preventative measures such as smoking cessation are encouraged and monitored (EOA).	▪ Year 2020-22 (Year 1 & 2) ▪ Increase in referrals to Te Ha Waitaha. ▪ Canterbury smoking cessation rates improve.	▪ Improved environment supports health & wellbeing
3. Access to interventions for people with respiratory conditions is improved	Co-create community respiratory programmes with Māori and Pasifika peoples (EOA).	▪ Q2: ▪ Pilot programme/s designed and delivered. ▪ Increase in the number of Māori and Pasifika peoples attending community respiratory programmes.	▪ Building population health capacity & partnerships ▪ Delayed/ avoided burden of disease & long term conditions ▪ Access to care improved
	Work with rural communities to design and deliver alternative rehabilitation and/or community exercise programmes (EOA).	Q2: ▪ Pilot programme/s designed and delivered. ▪ Increase in number of referrals to and people attending respiratory programmes in rural communities.	
	Pilot a rolling Better Breathing Pulmonary Rehabilitation Programme to reduce wait times between referral to and attendance (EOA).	▪ Q1-Q2: Rolling programme designed and piloted.	
	Improve patient and clinical understanding of community respiratory programmes. Improve communications with patients (EOA).	▪ Q4: Increase in number of people attending community respiratory programmes.	
	Evaluate Māori and Pasifika peoples' community respiratory programmes (EOA).	Year 2021/22 Q3: ▪ Increase in number of Māori and Pasifika peoples attending community respiratory programmes. ▪ Evaluation completed.	

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
	Evaluate community respiratory programmes for rural communities for people with respiratory conditions (EOA).	Year 2021/22 Q3: Evaluation completed.	
	Evaluate rolling pulmonary rehabilitation programme.	Year 2021/22 Q3: Evaluation completed. Patient satisfaction scores.	
Actions towards monitoring progress			
4. People receive respiratory supports closer to their own homes	Community Sleep and Spirometry programmes are monitored for quality (EOA).	Q1-Q4: Quality measures are met.	
Key metrics to indicate progress delivering work plan actions, impact on health outcomes and/or monitor performance			

Description of metric	Data Source
1. ED presentations for people with COPD.	Data Warehouse
2. Better Breathing programme referrals.	Local database
3. Attendance at community respiratory programmes by ethnicity.	Local database
4. Practice data on people with respiratory conditions.	Practice/PHO data
5. Volume of spirometry tests by ethnicity.	Claims

Laboratory Service Level Alliance Work Plan 2020-21.

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Priority actions towards transformational change, improved system outcomes and/or enhanced integration			
1. Objective One Ensure equitable access to lab services	Provide advice and recommendations about e-lab referrals.	Q2: Agreed system has the confidence of key stakeholders.	▪ Increased equity of access
	Undertake detailed analysis of home visit data supplied by Southern Community Labs (SCL) and Canterbury Health Labs (CHL) to identify: ▪ Criteria for requesting and delivering home visits to patients. ▪ Ethnic breakdown. ▪ Geographic breakdown. ▪ Opportunities to better meet the needs of Māori and vulnerable populations.	Q2: Agreed equitable criteria for requesting and delivering home visits to patients are implemented.	
	Measure the variability of laboratory testing by ethnicity gender domicile and age.	Q2: Data is available to enable measurement of variability	
	Develop a laboratory equity and access panel of laboratory test markers that reflect variability of testing in Canterbury and enable optimal use of laboratory testing through identifying and overcoming inequities.	Q2: Equity and access panel of laboratory test markers is agreed, data is available, and surveillance undertaken.	
2. Identify targeted "Choosing Wisely" initiatives	Develop and recommend a common list of self-request tests that can be offered in the Canterbury health system that includes consideration of the following: ▪ Who holds the information ▪ Where it would be visible ▪ Who has clinical responsibility ▪ Any other relevant considerations.	Q2: The common list of self-request tests is agreed, implemented and data monitored.	
3. Objective Three Quality Improvement	Consider thematic feedback received by CSCL and CHL from their consumer surveys and recommendations about access and equity quality improvement opportunities.	Q2: Agreement and implementation of quality activities.	
	For all Objectives actions for Year 2 pending findings of year 1	Year 2021/22	
Key metrics to indicate progress delivering work plan actions, impact on health outcomes and/or monitor performance			

Description of metric	Data Source
1. To be developed over 2020-21 and include identification of measures of variability of laboratory testing.	To be determined

Mana Ake Service Level Alliance Work Plan 2021

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Priority actions towards transformational change, improved system outcomes and/or enhanced integration			
1. School clusters supported to build or enhance collaborative use of skills, knowledge and resources to more equitably meet the needs of their communities	Clusters provided with data and supported with its use. (EOA)	Timeframe - termly Paua data reflects similar level of need across cohort.	▪ Improved access ▪ decreased wait times ▪ equitable access across Māori and other priority populations ▪ better targeted use of primary services and specialist mental health support ▪ Local community needs are met
	▪ Support consideration of cluster wide strategic wellbeing plans. ▪ Support schools and clusters to promote wellbeing messages with their communities. ▪ Termly Cluster Forums to share innovation and learning.	Timeframe - termly ▪ Kaiarahi report clusters increasing focus on wellbeing. ▪ Schools share innovations at Cluster Forums (made visible on Leading Lights. ▪ Attendance at Cluster Forums.	
2. Build on developing system relationships to further align system partners who form the children's workforce	Work with providers and others to identify and develop opportunities for shared learning.	Ongoing Q1-Q4: ▪ Schools, organisations and whanau report more accessible support networks for children, whanau and communities. ▪ Providers report increasing opportunities for staff to learn together.	▪ Equitable use of resource – early intervention ▪ no wasted resource
	Further leverage Mana Ake relationships and learning with system partners to facilitate stronger collaboration, e.g. Tuturu, Children's Team transition.	Ongoing Q1-Q4: Services report ongoing and increasing alignment/working relationships between health, education and social service providers.	
	Review and enhance Leading Lights pathways with system partners.	Q2: More timely and earlier support for tamariki and whānau.	
3. Communities are better connected to support wellbeing outcomes	Embed of ERMS Online.	Q4: Use of ERMS Online by GPs and schools.	
	▪ Identify opportunities to work with schools to connect more closely with their communities and vice versa and show case these. ▪ Provide community focused information for schools through Leading Lights. ▪ Ongoing development of Mana Ake website.	Ongoing Q1-Q4: ▪ Opportunities shared at Cluster Forums. ▪ Usage and qualitative feedback. ▪ # Users and page views.	
4. Mana Ake providers work collectively to build sustainable approaches to support wellbeing	Work with providers to embed systems and processes that contribute to sustainability including: ▪ Sharing qualitative and quantitative data. ▪ Maintaining monthly provider forums including team leaders and supervisors to maintain and enhance existing relationships. ▪ Developing opportunities for providers to share skills and knowledge across their workforce.	Ongoing Q1-Q4: Provider quarterly reporting identifies: ▪ Increase in within and cross agency referrals. ▪ Increase in skills and knowledge across organisations. ▪ Tamariki and whānau better supported.	▪ No wasted resource ▪ Improved access ▪ Equitable access

*EOA – Equity Outcome Action / *SLM – System Level Measures
CCN Work Programme 2020-22

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
5. The network of support for Maia and her whānau is easy to access and understand	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 Q1-Q4: ▪ 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. ▪ Use of Leading Lights.	▪ Equitable access to resources
6. Planning for transition	Range of implementation plans to be developed to respond to the range of potential long term options for Mana Ake.	Ongoing Q1-Q4: ▪ Schools, providers, kaimahi and system partners feel as supported as possible to move to the next phase of collaborative working to support wellbeing of tamariki and whānau in Canterbury as possible.	▪ Building population health capacity & partnerships
Actions towards monitoring progress			
7. Identify benefits of Mana Ake and learnings	Work with external evaluation teams to identify benefits of Mana Ake and learnings.	Timeframe to be confirmed by the MoH.	▪ Early intervention
8. Evaluate Mana Ake initiative	Complete internal evaluation reports	Q4: Evaluation report completed	
9. Use health and education data to inform wider learnings about the Mana Ake cohort	Undertake data matching across CDHB, Pegasus, MoE and Mana Ake data sets.	Q4: Data matching completed.	
Key metrics to indicate progress delivering work plan actions, impact on health outcomes and/or monitor performance			

Description of metric	Data Source
1. Number and demographics of those accessing support including but not restricted to: ▪ Status of Requests for Support to Mana Ake – Active, Exited, Pending, Unallocated, Did Not Engage. ▪ Requests for Support to Mana Ake – Individual, Groups for: whole cohort, geographic cluster and Kahui Ako, Individual school. ▪ Gender Data – Individual Services and Groups, for: whole cohort, geographic cluster and Kahui Ako, Individual school. ▪ Requests for Support from Mana Ake by Age Range and Gender for: whole cohort, geographic cluster and Kahui Ako, Individual school. ▪ Ethnicity Data: whole cohort, geographic cluster and Kahui Ako, Individual school.	Mana Ake Case Management System: Paua
2. Service outcomes: ▪ Tu Tauira tool measuring: Presence, Learning and Wellbeing, Achievement. ▪ Child Outcome Rating Scale. ▪ Teacher Group Feedback. ▪ Satisfactions Surveys.	Mana Ake Case Management System: Paua
3. 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 recipients of the Mana Ake Service.

Mental Health Workstream Work Plan 2020-22

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Priority actions towards transformational change, improved system outcomes and/or enhanced integration			
1. An Integrated system delivers care at the level required when it is needed	Support implementation of the new integrated primary care mental health service Te Tumu Waiora. (SLM).	Q4: Access to Te Tumu Waiora service available to 150,000 enrolled population.	▪ Workstream supports effective initiatives that reflect co-design
	Kaupapa Māori organisation supported to develop local Muslim capacity to respond to people impacted by the Mosque attacks. (EOA)	Q2: Muslim Mental Health and Addictions (MH&A) Model of Care fully operational and reporting in place.	▪ Access to care improved
	Whānau and lived experience contribution to MH&A services in Canterbury improved.	Q2: Stocktake undertaken of lived experience and whanau roles across Canterbury to identify opportunities to strengthen input.	▪ Workstream supports effective initiatives that reflect co-design
	Recovery College Curriculum developed by Providers and available to consumers.	Q2: Canterbury Recovery Curriculum confirmed and offered to consumers.	
	Maternal Mental Health boosted by completion of Canterbury Plan for "First 1000 days".	Q2: First 1000 days plan identifies actions to support Maternal Mental Health.	
	Support expansion of the new integrated primary care mental health service, Te Tumu Waiora. (EOA)	Year 2021/22 Q4: Access to Te Tumu Waiora available to over 150,000 enrolled population.	▪ Workstream supports effective initiatives that reflect co-design
	Kaupapa Māori organisation continues to assist local Muslim capacity to respond to people impacted by the Mosque attacks. (EOA)	Year 2021/22 Q3: Muslim MH&A Model of Care fully operational and evaluation report completed.	▪ Access to care improved
	Improve whanau and lived experience contribution to MH&A services in Canterbury.	Year 2021/22 Q2: Number of lived experience and whānau roles expanded across Canterbury.	▪ Workstream supports effective initiatives that reflect co-design
	Recovery College Curriculum developed by Providers and available to consumers.	Year 2021/22 Q2: Canterbury Recovery Curriculum and participation reviewed.	
	Maternal Mental Health boosted by completion of Canterbury Plan for "First 1000 days".	Year 2021/22 Q3: Maternal Mental Health actions achieved to provide increase in access for mothers and families.	
2. Improve access across the system and reduce wait times	Support implementation of new and expanded youth mental health and addiction services. (EOA)	Q4: New and/or expanded services implemented.	▪ Workstream supports effective initiatives that reflect co-design
	Model for Opioid Substitution Treatment in pharmacies evaluated and expanded.	Q4: Evaluation of Opioid Substitution Treatment Model in pharmacies evaluated.	▪ Access to care improved
	Alcohol and Other Drug (AOD) Services expanded to provide greater range of care options.	Q4: Mental Health Respite beds available for those with addictions.	

*EOA – Equity Outcome Action / *SLM – System Level Measures

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
	Implementation of new and expanded youth mental health and addiction services.	Year 2021/22 Q4: Additional and/or new youth mental health and addiction services reporting in place and evaluation undertaken.	▪ Access to care improved
	Model for Opioid Substitution Treatment in pharmacies evaluated and expanded.	Year 2021/22 Q3: Opioid Substitution Treatment Model in pharmacies expanded further.	
	AOD Services expanded to provide greater range of care options.	Year 2021/22 Q1: Increased detoxification options available in the community.	
3. Strengthen Suicide Prevention and Postvention	Cross-agency Canterbury Suicide Prevention Action plan implemented.	Q2: Cross -agency dashboard developed.	▪ Workstream supports effective initiatives that reflect co-design
	Agencies given opportunities to collaborate on prevention and postvention. (EOA)	Bi-annual forums provide agencies with education and opportunities to collaborate.	
	Postvention counselling available to those who need it, when they need it.	Q2: Work with Clinical Advisory Services Aotearoa to implement new bereavement counselling service across Canterbury.	▪ Access to care improved
	New Māori Tiriti and Equity group formed to inform the sector in Canterbury on Māori mental health and addictions equity and cultural safety[1].	Q2: Māori Tiriti and Equity group formed and equity actions identified.	
	Cross-agency Canterbury Suicide Prevention Action plan implemented.	Year 2021/22 Q4: Annual Report of the agreed actions available online.	Access to care improved
	Opportunities for support of people after they present in crisis with suicidal behaviour expanded in line with the national direction.	Year 2021/22 Q4: Options for support of people who present to crisis and emergency services with suicidal behaviour increased.	
4. Provision of supporting services to assist in recovery	Housing options increased for the most vulnerable consumers in Canterbury.	Q1: Additional housing options houses available for consumers.	▪ Improved environment supports health and wellbeing
	Community Forensic Capacity is expanded to reflect demand.	Q2: Additional community forensic resources available.	
	Peer Support is enhanced by expanding opportunities for MH&A training and education.	Q4: Three training programmes available annually.	
Actions towards monitoring progress			
5. An Integrated System that delivers care at the level required when it is needed.	Provision of coordinated and enduring wellbeing and mental health recovery programme in response to the March 15 attack. (EOA)	Implementation of the recovery and wellbeing plan for those impacted by the March 15 attack.	▪ Reduce avoidable mortality
	Equally Well initiatives identified and new Canterbury Action Plan implemented by PHO/SMHS. (EOA/SLM)	Equally Well initiatives monitored/supported by CCN.	
	Support integrated care for Pasifika by Pasifika that includes mental health and addictions within a primary/community environment. (EOA)	Mental health model integrated/expanded with Whanau Ora services for Pasifika.	

[1] Action to be agreed by MHWS

*EOA – Equity Outcome Action / *SLM – System Level Measures
CCN Work Programme 2020-22

Key metrics to indicate progress delivering work plan actions, impact on health outcomes and/or monitor performance	
Description of metric	Data Source
1. Rates of Maori and Pacific consumers accessing SMHS and PHO and NGO Mental Health services are monitored bi-annually.	CDHB, Pegasus , PHO
2. Number of consults accessed from Purapura Whetu and Christchurch Resettlement Service due to March 15 attack monitored quarterly.	CRS, PPW
3. Canterbury Suicide Prevention Governance Committee cross agency data monitoring.	CDHB et al
4. Wait times for access to services presented bi-annually for adults and children.	PRIMHD
5. Equally well initiatives have data metric built into design.	SMHS, PHO

Oral Health Service Development Group Work Plan 2020-22

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Priority actions towards transformational change, improved system outcomes and/or enhanced integration			
1. Recovery of Dental Services	Work with community dental, hospital dental and combined dental agreement holders to ensure all oral health services have a clear Covid-19 recovery plan.	Q1: Each service has a documented recovery plan. A report is completed which outlines the learning from the Covid-19 response and how learnings will be captured going forward.	▪ Protecting people against health hazards ▪ Community resilience/ capacity enhanced
2. Improved whole of life Oral Health awareness, with a focus on Māori and Pacific	Implement the Oral Health Education and Promotion Plan. (EOA) ▪ Develop additional resources and programmes to fill gaps identified in the 2019/20 stock take. ▪ Develop a Māori and Pacific Health Promotion Programme based on gaps identified in the 2019/20 resources stocktake. ▪ Continue the Health Providers education sessions.	Q1-Q4: ▪ Improved oral health status of Māori and Pacific children (0-5years of age). ▪ Improved uptake of the Combined Dental Agreement by Māori and Pacific adolescents. ▪ Focus on supporting Well Child Tamariki Ora providers.	▪ Improved environment supports health and wellbeing
	Advocacy for improved Oral Health, including water fluoridation and reduced sugar/ sugar free policies.	Q3: ▪ Refreshed DHB Fluoridation policy presented to the Board. ▪ Refreshed Sugar Free Policy presented to the Board.	
	Continue implementation of the Oral Health Education and Promotion Plan.	Year 2021/22	
3. Improve the oral health of children through streamlining the patient flows process	Improve the Oral Health Service Model ▪ Develop a patient flow process / pathway for the Canterbury DHB region. ▪ Implement the recommendations of this work. ▪ Support Dental Therapists to work at the top of their scope, within the patient pathway. (EOA CDHB)	Q4: ▪ 10% less children are referred out of CDS ▪ 10% less children are referred for Sedation and then on referred to Hospital Dental.	▪ Access to care improved ▪ Coordinated care ▪ Timely access to specialist intervention
	Develop Patient Pathways to facilitate access to Hospital or Specialist Dental Services on the West Coast for people with special dental or health conditions with consideration given to older persons, low income adults and those who experience mental health issues. (EOA WCDHB)	Q2: ▪ Pathways are developed. ▪ People living on the West Coast have improved access to hospital dental services.	
	Support appointment of a Clinical Lead Oral Health according to the new WCDHB Organisational Structure. (EOA WCDHB)	Q4: New proposed structure is implemented.	
	Scope Private Dentists access to HealthOne and apply findings to implement recommended changes (CDHB WCDHB).	Q2: Review options /costs/ benefits. Q4: Implement recommendations as agreed.	▪ Multidisciplinary approach
	Evaluate the CDHB Community Dental	Q4:	▪ Increased equity

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
	Services Recall Plan.(EOA CDHB)	▪ Evaluation completed on change to Recall Plan ▪ Service targets for Māori and Pacific established.	of access
	Implement recommendations from the National Adolescent Dental Landscape Review (CDHB WCDHB).	Q4: Review the report and implement actions.	
	Actions planned for Year 2 The continuation for the items outlined above.	Year 2021/22	
4. A Culturally Competent Oral Health Service	Improve private dentists provision of a culturally competent service by (EOA CDHB WCDHB): ▪ Working with local branch of the Dental Association to identify support required. ▪ Implementing an appropriate response.	Q1: Address local branch Dental association to level of support required by private dentists identified. Q4: Programme to support their cultural development implemented.	▪ Increased equity of access ▪ Access to care improved
	Support improved relationships and engagement with Māori and Pacific people working in Oral Health.	Q1 & Q3: Regular hui held.	
	Actions planned for Year 2 ▪ Continue education for Private practitioners. ▪ Implement programme to support providers of Aged Residential Care.	Year 2021/22	

Key metrics to indicate progress delivering work plan actions, impact on health outcomes and/or monitor performance	
Description of metric	Data Source
1. Children caries fee at 5 years of age – target 67.4%.	Community Dental
2. Mean DMFT score at school year 8 - target 0.70.	Community Dental
3. 3. Preschool Enrolment with Community Dental Services – target 95%.	Community Dental
4. Number of enrolled preschoolers and primary school aged children overdue for their schedule's assessment.	Community Dental
5. Adolescents receiving services under the Combined Dental Agreement – target 85%.	MoH – claims data

Pharmacy Service Level Alliance Work Plan 2020-22

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Priority actions towards transformational change, improved system outcomes and/or enhanced integration			
1. Create a platform and pathway for improved services for patients	▪ Oversee the evaluation of phase 1 of the pilot service for people receiving Opioid Substitution Therapy (OST). ▪ Review evaluation findings and apply any learnings to further roll out. ▪ Monitor wider roll out.	Q1: Evaluation completed learnings applied and wider roll out progressed. Better system resilience and enhanced model of patient care.	▪ Timely access to primary care ▪ Increased planned care rate ▪ Delayed/avoided burden of disease & long term conditions
	Evaluation of wider roll out.	Year 2021/22	
2. Advance models of Care that enable community pharmacy to improve care of services for patients with long term conditions	▪ Develop Long Term Conditions (LTC) project scope (including any implications and data). ▪ Refine the agreed principles and LTC framework that could be used to inform local redevelopment of the service. ▪ Develop timeframe for roll out of new service.(EOA)	Q1: Project scope developed. Q1: Principles and framework are refined. Q2: Proposed principles and framework used to inform local redevelopment of the LTC service.	▪ Delayed / avoided burden of disease & long term conditions ▪ No wasted resource
	SWOT analysis/literature review undertaken to determine what has led to effective implementation of services. Learnings from the review used to inform local service design.	Year 2021/22 Learnings are used to guide other local service redevelopment.	
3. Improve medication management for patients through improving transfer of care process	▪ Develop a process map to identify gaps in the current patient transfer process, focusing on management of medications during admission from and discharge back to the community. ▪ Examine relevant data to identify risks and areas of opportunity to improve medication management.	Q2-Q3: Improved transfer of care for patients being admitted and discharged from hospital.	▪ Effective transfer of care
4. Understand our population's use of pharmacy services including by ethnicity	Complete a stocktake of what relevant data is available on population use of pharmacy services.	Q1-Q2: Relevant data that could be used to better understand our population identified.	▪ Understanding health status ▪ 'At risk' population identified ▪ Increased equity of access
	Deep dive into the available data to identify any areas for improvement, including any inequitable access to pharmacy services. (EOA)	Q1-Q2: Data is used to provide a better understanding of our population's access to pharmacy services, and inform our future priorities.	
	Create a dashboard and regularly monitor relevant pharmacy data. (EOA)	Q3-Q4: Dashboard developed to monitor trends.	
	Continue to monitor dashboard and use it to inform our work direction.	Year 2021/22 Data used to inform our work direction.	
5. Equitable health outcomes for: ▪ Maori ▪ Pasifika ▪ Culturally & Linguistically Diverse (CALD)	Identify opportunities where the Meihana approach can be embedded into practice across pharmacy services.	Q1-Q2: A pathway/process for cultural competency training (including Meihana model) developed for pharmacy.	▪ Increased equity of access

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
populations			
Actions towards monitoring progress			
6. Reduced patient risk from inappropriate polypharmacy and optimise their care	Monitor the number of assessments of people who are most at risk from polypharmacy including: ▪ Monitor initiative to link people referred to falls prevention with a review of their medication. ▪ Progress all general practices having polypharmacy audit capability. ▪ Identify opportunities to improve and integrate MMS and other services.	▪ Increase GP referrals to Medicines Therapy Assessments. ▪ Up to 240 MTA completed in 2019-20. ▪ New opportunities identified, scoped and discussed with PSLA members.	
7. Improve patient health literacy to support their self-managing of their medicines	Monitor pharmacist support for people with chronic conditions to self-manage their medicines well.	14,000 people receive the Pharmacy LTC Service. 1,500 people receive a Medicines Use Review.	
	Undertake a stocktake of pharmacy related information being provided by the hospital and community pharmacies.	Q3-Q4: Consistent messaging is being provided by hospital and community pharmacy to patients.	
8. Equitable health outcomes for: ▪ Maori ▪ Pasifika ▪ Culturally & Linguistically Diverse (CALD) populations	Monitor existing and new partnerships to enhance the roles of pharmacists and support access to pharmacy services at events for Māori, Pasifika, Culturally and Linguistically Diverse (CALD) communities. CCPG to support Pharmacist champions to provide mobile clinics with a Kaupapa Māori lens including: ▪ Performing the medication management service in ethnically appropriate locations and using an adapted Māori health framework. ▪ Leveraging existing health days, church projects and consider CommunityOutreach opportunities for Maori, Pasifika and CALD populations.	Patient feedback will be received regarding appropriate delivery of medication management services on Marae's.	▪ Delayed/ avoided burden of disease & long term conditions ▪ Decreased adverse events ▪ Decreased institutionalisation rates ▪ Decreased acute care rate Increased planned care rate
9. Improve uptake of electronic Prescribing (NZePS)	Monitor uptake of Electronic Prescribing across Canterbury.	Increase in uptake of NZePS.	

Key metrics to indicate progress delivering work plan actions, impact on health outcomes and/or monitor performance	
Description of metric	Data Source
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.	CDHB
4. The rate of people dispenses with 11 or more long term medications.	CCPG / CDHB SFN
5. Adverse drug reaction data.	TBC
6. Patient Experience data relating to medicines.	CDHB
7. Monitor uptake of Electronic Prescribing (NZePS).	Mike James

Population Health Service Level Alliance Work Plan 2020-22

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Priority actions towards transformational change, improved system outcomes and/or enhanced integration			
1. A system approach to promoting and supporting healthy lifestyles is developed through co-design and is implemented across the Canterbury Health System	Oversee a co-design process on the Canterbury Health Systems approach to promoting and supporting healthy lifestyles. Note: by "promoting and supporting healthy lifestyles" we mean all the ways that the health system can/could enable people to flourish. This includes not only the services that we would usually think of (smoking cessation and so on), but all direct interactions with people, including communications where there are opportunities to support people.	Q2: Co-design completed and report finalised that identifies principles for a new approach to health lifestyles for the Canterbury Health System (CHS). Q3: Opportunities identified in the CHS to improve approach to health lifestyles. Q3-Q4: Recommendations taken to ALT regarding the development of healthy lifestyles in the CHS.	▪ Decreased amenable mortality
	Following the co-design, work with other groups within the CCN (alliance groups, partners and reference groups) and stakeholders in the wider community to facilitate the development of a shared approach to healthy lifestyles. Identify how the Canterbury Health System can influence healthy public policy by reviewing our current approach and identify areas to further strengthening this approach.	Year 21/22 Q4: ▪ A Canterbury Health System healthy lifestyles plan is developed and presented to ALT for approval that includes measures that will track outcomes of plan. ▪ Recommendations to strengthen our influence on healthy public policy is presented to the ALT.	▪ Decreased amenable mortality ▪ Inequity is more closely monitored and reduction of inequity begins to be monitored
2. Improve the equitability of access to Canterbury Health Services	Progress knowledge of enrolment in general practice in Canterbury: ▪ Complete the research project on people who are tenuously enrolled or unenrolled with general practice in Canterbury. ▪ Review the findings of the above research and other research collated to date to identify any gaps in our understanding. ▪ Identify research on the impact on equity of access from telephone and virtual consultations. ▪ Commission further research to address gaps in understanding.	Q1: ▪ Research report received ▪ Gaps in our understanding are identified Q3: ▪ Further research is undertaken	▪ Across all outcomes
	Establish a set of metrics to monitor health outcomes and access across the CHS using a pae ora framework that can be used by PHASLA and wider.	Q4: ▪ Metrics identified and report distributed across the CHS.	
	Work with other CCN groups (alliance groups, partners and reference groups) and outside the CCN to facilitate the development of a shared system approach to access to health care services across Canterbury.	Year 2021/22 Q1: A CHS plan is developed around access to primary health care services and presented to ALT for approval.	▪ Across all outcomes

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
3. Improve access to best practice interpreting services across the Canterbury Health System for people with limited English proficiency (LEP) and those who are deaf	Improve access to best practice interpreting services. ▪ Promote and support the adoption of best practice guidelines across the CHS. ▪ Review the use and uptake of 'ezispeak' in Canterbury. ▪ When national guidelines on interpreters services are released, update Canterbury guidelines. ▪ Develop and present to the PHSLA/ALT a draft action plan to enable the implementation of the Best Practice guidelines. ▪ Agree on minimum standards for qualifications to work as professional interpreters in the CHS. ▪ Agree on a common set of criteria to guide the definition of a professional interpreter.	Q2: ▪ Alliance partner organisation uptake of best practice guidelines. ▪ An increase in the utilisation of interpreter services by alliance partner organisations. Q3: ▪ Draft action plan presented to the PHASLA.	▪ Increased equity of access ▪ Greater access for our population to interpreting services for their health needs ▪ A common approach to the standards of interpreting services for our population
	N/A as work group has 12 months term and work will transition to ongoing improvement as part of normal operations.	Year 2021/22	
4. Improve access to gender affirming health care	Progress access to gender affirming services. ▪ Embed the new HealthPathways established through the co-design project including responding to any emerging issues and changes needed to the pathways. ▪ Communicate the new pathways for accessing care to the Trans community and health professionals. ▪ Support the upskilling and education on Trans care for general practice teams. ▪ Further strengthen relationships with clinicians across primary and secondary care to increase knowledge within and between the services.	Q4: ▪ Utilisation of relevant HealthPathways. ▪ Summary report received. ▪ A high level of acceptability of new processes from the perspective of consumers and health professionals.	Increased equity of access
	N/A as work group has 12 months term and work will transition to ongoing improvement as part of normal operations.	Year 2021/22	
Actions towards monitoring progress			
5. Progress is made towards being smokefree by 2025	Oversite of the Tobacco Control Plan 2020/21 (EOA/SLM).	▪ Timeline TBC by MoH. ▪ The 2020/21 Tobacco Control Plan endorsed by ALT. ▪ A contract for Stop Smoking Services with MoH is renewed by July 2020.	▪ Smokefree 2025 ▪ Reducing our population smoking rates across Canterbury
	Oversite of the refining of the Te Hā - Waitaha service model to achieve greater outcomes for our Wahine population to become smokefree. (EOA/SLM)	Ongoing: Measures of cessation from service users by ethnicity.	

*EOA – Equity Outcome Action / *SLM – System Level Measures

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
6. Reduced Alcohol Harm in our population	Oversite of work with Smokefree Canterbury towards our goal of Smokefree 2025. (EOA/SLM)	Ongoing Population level smoking rates by ethnicity.	
	Monitor the refinement of the Te Hā - Waitaha service model to achieve greater outcomes for our Wahine population to become smokefree. (EOA/SLM)	Year 2021/22 Ongoing Te Hā - Waitaha delivery model refined.	▪ Smokefree 2025 ▪ Reducing our population smoking rates across Canterbury
	Monitor work with Smokefree Canterbury towards our goal of Smokefree 2025. (EOA/SLM)	Year 2021/22 Ongoing Continued coordination with Smokefree Canterbury.	
	Monitor the development and implementation of a communications plan to increase awareness of the health risks associated with alcohol (EOA).	Q4: Communications plan approved by cross sector working group that includes communications both for within the health system and for the wider population /media.	▪ Reducing the rates of alcohol related harm in our population
	Oversee the improvement and understanding of individual and population level alcohol data across the health system.	Q4: ▪ Updated BERL (Business and Economic) research on the cost of alcohol harm to Canterbury health sector completed and disseminated. ▪ Research project initiated on alcohol data collection and availability from other local agencies.	
	Monitor the implementation of policy which reduces alcohol-related harm.	Year 2021/22 Ongoing ▪ Adoption of a CDHB staff Alcohol & Drug Policy. ▪ Review completed of workplace alcohol policies in place by other organisations across the health sector.	Reducing the rates of alcohol related harm in our population
	Oversee the support of staff to identify and address risk and harm related to alcohol.	Year 2021/22 Ongoing Brief intervention training for hospital staff made available and promoted.	
7. Increased motivational interviewing skills of primary health care professionals	Oversee the progress of influencing norms and behaviour change. (EOA)	Q4: Develop and implement a Communications Plan.	▪ Enable Health Sector workforce to support our population to stay well and take greater responsibility for their own health and wellbeing
	Oversee the coordination of prevention, identification, treatment and support.		
8. Amenable mortality	▪ Monitor referrals to Green Prescription. Develop a system wide approach to increase cervical screening coverage (SLM).	▪ Target of 4,000 referrals/annum. ▪ A proposed approach to increasing cervical screening coverage developed.	Goal 1 - People take greater responsibility for their own health

Key metrics to indicate progress delivering work plan actions, impact on health outcomes and/or monitor performance	
Description of metric	Data Source
1. Better Help For Smokers to Quit – Primary, Secondary, Maternity.	MoH
2. Quarterly performance reporting of Te Hā – Waitaha data to MoH.	CDHB
3. Quarterly performance reporting of Green Prescription Referral data to CDHB.	Sport Canterbury / CDHB
4. Quarterly performance reporting of Motivational Conversation Service provision.	Pegasus / CDHB
5. Quarterly performance reporting of cervical screening coverage.	MoH NSU
6. National Cervical Screening Programme Coverage Data.	National Cervical Screening Programme
7. To be established - a set of metrics identified to monitor health outcomes and access across the Canterbury Health System using a pae ora framework that can be used by PHASLA and wider.	Various

Rural Health Workstream Work Plan 2020-22

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Priority actions towards transformational change, improved system outcomes and/or enhanced integration			
1. Support progress of Canterbury rural workforce sustainability and different ways of working	Undertake an analysis of the Canterbury rural workforce to confirm status, identify gaps and determine opportunities that exist to improve workforce sustainability. This will include reviewing current information and activity being undertaken regionally and nationally. (EOA)	Q1: Report on the analysis completed.	▪ No wasted resource ▪ Resources matched to need ▪ Access to care improved ▪ Improved environment supports health and wellbeing ▪ Carer/staff upskilled
	Establish a time-limited Working Group to: ▪ Capture Canterbury's rural workforce perceptions of gaps and opportunities. ▪ Summarise opportunities and recommend prioritised actions the RHWS can take to improve workforce sustainability in support of what is occurring regionally and nationally. ▪ Progress the implementation of these including monitoring of regional and national activity and advocacy.	Q2-Q3: ▪ Agree and prioritise ways the RHWS can influence improvements in workforce sustainability in Q2. ▪ Progress Implementation of agreed actions by Q3. ▪ Share findings of workforce analysis and activity being progressed by the RHWS across the alliance by Q3.	
	Actions planned for Year 2: ▪ Progress recommended actions for improving Canterbury rural workforce sustainability. ▪ Access information gathered from the Patient Experience of Care (rural practice themes) and identify opportunities to improve. ▪ Further support Health Care Home opportunities.	Year 2021/22	
2. Improve after-hours and urgent care responses	▪ Engage with General Practice and St John to understand access to after-hours urgent care[2] and emergency responses in rural Canterbury communities, including PRIME[3]. ▪ Identify response required following consideration of the status report findings. (EOA)	Q2: ▪ Status report completed end of Q2. ▪ St John actions/targets to provide a local response, subject to St John responsibilities, progressed within known constraints in National funding.	▪ 24 hour access to primary care intervention ▪ Timely access to community supports
	TBC	Year 2021/22	
3. Improve the model & distribution of rural subsidies	Review the criteria and model for distributing Rural Subsidies to eligible general practices. (EOA)	Q2-Q3: ▪ Funding allocation confirmed. ▪ Implement appropriate payment for Canterbury.	▪ Primary care access improved ▪ 'At risk' population identified

[2] Links to review of rural subsidy provided through PHOSA.
[3] The Primary Response in Medical Emergencies (PRIME) service aims to ensure high quality, timely access to pre-hospital emergency treatment in areas where access to appropriate clinical skills (i.e., to Paramedic level) is not available, or where ambulance service rural response times may be longer than usual. https://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/national-ambulance-sector-office-naso/emergency-ambulance-services-eas/prime-service

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
	Consider indicators identified by Garry Nixon's work to define rural in a Canterbury context.	Year 2021/22.	
4. Identify and address inequities for rural communities, including distance to service and ethnicity (Māori, Pasifika, CALD)	Explore data, including by ethnicity, on our rural population to increase knowledge of any inequities that exist in access to services, service utilisation and health outcomes including comparisons with urban Canterbury and NZ. This will include: ▪ Establishing a dashboard of rural measures to monitor. ▪ Identifying future RHWS priority actions to address inequities. (EOA)	Ongoing Q1-Q4: ▪ Report on identified inequities in rural Canterbury. ▪ Dashboard established and updated quarterly. ▪ Identify priority areas by Q2.	▪ 'At risk' population identified ▪ Delayed/avoided burden of disease and long term conditions ▪ Primary care access improved
	Strengthen the cultural development of Canterbury's rural health workforce by: ▪ Exploring cultural development opportunities available to the rural workforce, including the Meihana Model to improved clinical cultural practice. ▪ Distributing information on training opportunities.	Q2: ▪ List of cultural competency opportunities collated and distributed to rural workforce by Q2. ▪ Identify groups to work with using Meihana Model by Q2.	▪ Carer/staff upskilled ▪ Access to care Improved ▪ Social environment supports health
	Enrich our relationship with Manawhenua ki Waitaha, Te Kāhui o Papaki Kā Tai, Māori Caucus, Maui Collective, and local Rūnunga.	Ongoing Q1-Q4: ▪ Māori-led engagement to focus next steps. ▪ Discuss opportunities and embed in practice.	Equity of access and health outcomes
	Monitoring progress on recommendations in the NZ Health & Disability Sector Review that will improve health outcomes for rural Canterbury population.	Ongoing Q1-Q4: Quarterly updates included in CDHB and PHO updates.	▪ Access to care improved
	▪ Advocate for progress on recommendations in the NZ Health and Disability Sector Review to improve health outcomes for rural Canterbury population. ▪ Address inequities identified in Year One and progress opportunities for improvement.	Year 2021/22	
Actions towards monitoring progress			
5. Respond to emerging healthcare issues in rural communities and as needed, advocate for areas needing increased efficiencies and/or improved service levels	Monitor Model of Care implementation for: ▪ Hurunui Health Services Development Group (HHSDG). ▪ Oxford and Surrounding areas Health Services Development Group ▪ Ashburton SLA.	Ongoing Q1-Q4: Quarterly updates received.	▪ Provide rural health considerations to regular updates received from OG
	Monitor service integration and improvements from Kaikōura and Akaroa.	Ongoing Q1-Q4: Quarterly updates received.	
	Monitor progress of the CDHB Telehealth Operational Group and advocate for an increase in rural	Q1-Q3: Provide rural health considerations to regular updates received from OG.	▪ Delayed/avoided burden of disease and long

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
	communities' access to specialist appointments using telehealth through the CDHB Telehealth Operational Group.		term conditions
	Monitor changes in the rural workforce access to education following the ALT endorsement of principles for Canterbury providers in their delivery of education to the primary health workforce, including report on access to education and mobile services for the health care workforce and community e.g. Mobile Surgical Bus and education, provided by Mobile Health.	Q2 & Q4: Updates received. Q2: Report received.	▪ Carer/staff upskilled
	Monitor progress of: ▪ Rural Restorative Care framework implemented in the Hurunui and Oxford and Surrounding areas communities. ▪ Transfer of Care considerations and tools. ▪ Health Research Council project led by Garry Nixon to define rural in the NZ health context and apply any findings to Canterbury. ▪ Kaumātua Project (through HOPWS). ▪ Te Tumu Waiora rollout.	▪ Ongoing ▪ Quarterly updates received.	▪ Effective transfer of care ▪ Improved health and wellbeing
	Support the proactive care of rural communities through development of Shared Care Plans for vulnerable people in rural communities. ▪ Stocktake of vulnerable people with up-to-date Shared Care Plans completed (baseline) by Q1. ▪ Report on trends and variations shared with rural Canterbury practices by Q3.	Q1: Stocktake completed (baseline). Q3: Report shared.	▪ Increased planned care rate ▪ Decreased acute care rate

Key metrics to indicate progress delivering work plan actions, impact on health outcomes and/or monitor performance

Description of metric	Data Source
1. After-hours urgent care and emergency care presentations (active MoC rural communities compared to urban trends) including by age, ethnicity and enrolment status.	CDHB
2. Shared Care Plan data on plans created and amended through the rural General Practices.	Shared Care Planning
3. Census / Statistics NZ data (Details to be determined).	
4. Patient Experience data summary from community who are rurally domiciled.	PHOs

System Outcome Steering Group Work Plan 2020-22

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Priority actions towards transformational change, improved system outcomes and/or enhanced integration			
1. Improved use of data to strengthen Canterbury's improvement activity	▪ Steering group review data linked to each System Level Measure. ▪ Facilitate service alliances and expert groups with reviewing the relevant data. ▪ Ethnicity level data is reviewed to enable understanding of inequities and drive actions to reduce these. ▪ With Population Health and Access SLA, explore notion and utility of a set of metrics for a Canterbury Health System "access and equity of outcomes monitoring report" that could be used by all Alliance Partners and the Alliance to identify needs. (SLM)	Q4: Each SLM and contributory measure data is reviewed and made available to the relevant expert groups.	▪ Assisting alliance / expert groups' access data to inform and prioritise activity that will improve health outcomes and performance in System Level Measures.
2. Selection of Contributory Measures includes a focus on reducing inequities to ensure priority on high value improvement activity	▪ Steering group review data linked to each System Level Measure. ▪ Facilitate service alliances and expert groups in reviewing the relevant data. ▪ Ethnicity level data is reviewed to enable understanding of inequities and drive actions to reduce these. (SLM)	Year 2021/22 Q4: Each SLM and contributory measure data is reviewed and made available to the relevant expert groups.	▪ Assisting alliance / expert groups access data to inform and prioritise activity that will improve health outcomes and performance in System Level Measures
	▪ Review contributory measures to ensure they reflect priorities of our system with a focus on reducing inequities. ▪ Develop contributory measures that are supported by reliable ethnicity level data. (SLM)	Q1-Q4: Review and update contributory measures as needed through system leaders collectively identifying and agreeing the contributory measures for 2021-22.	▪ Prioritisation of effort to improve Canterbury's System Level Measures performance
	▪ Review contributory measures to ensure they reflect priorities of our system with a focus on reducing inequities. ▪ Contribute to the development of system wide equity measures by advocating for this across the system. (SLM)	Year 2021/22 Review and update contributory measures as needed through system leaders collectively identifying and agreeing the contributory measures for 2022/23.	▪ Prioritisation of effort to improve Canterbury's System Level Measures performance
3. Understand the consistency and accuracy of ethnicity data	Compare primary and secondary care ethnicity data sources to determine level of consistency. (EOA)	Q4: Consistency is understood to determine the accuracy of ethnicity data.	▪ Improved understanding of data accuracy to enable improved interpretation of data for improved health outcomes
4. Develop partnership with	Develop partnership with Alliance partners to increase awareness of the SLM Plan and develop their	Q1-Q4: Increased number of Alliance partners contributing to the SLM Improvement	▪ Prioritisation effort to improve Canterbury's

*EOA – Equity Outcome Action / *SLM – System Level Measures

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
all Alliance partners	consideration of what they could contribute to future plans. (SLM)	Plan.	System Level Measures performance
	Include all Alliance partners in contributing to operational parts of the 2021/22 SLM Improvement Plan.	Year 2021/22 Q2–Q4: Actions to improve performance developed by all Alliance partners.	
Actions towards monitoring progress			
5. Monitor performance against the current SLM plan	Quarterly review of progress against the System Level Measures and 'Actions to Improve Performance' completed. (SLM)	Steering Group review updated actions each quarter.	▪ Enable the Steering Group's oversight of progress
6. Complete annual Improvement Plan	Oversee the Ministry of Health requirements and use these to guide the development of the Improvement Plan. (SLM)	Q4 Improvement Plan submitted to Ministry in required time frame.	▪ Meet ministry requirements
7. Contribute to the national development of the SLM framework	Canterbury continues to be an advocate for the national development of the SLM framework. (SLM)	Q1-Q4: Canterbury advocates and/or participates in the national development.	▪ Actively support national adoption of using outcomes to measure performance

Key metrics to indicate progress delivering work plan actions, impact on health outcomes and/or monitor performance	
Description of metric	Data Source
1. System Level Measures and Contributory Measures.	SLM Viewer collating data from a range of sources.

Urgent Care Service Level Alliance Work Plan 2020-22

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Priority actions towards transformational change, improved system outcomes and/or enhanced integration			
1. Improve patient flow through the system	Proactively plan for coordinated system responses for periods of exceptional demand, particularly during winter or infectious disease outbreaks. (SLM*).	Q1-Q4 ▪Number of times acute demand reaches capacity – target is zero. ▪Number of times ED reaches capacity based on ED surge scores.	▪Shorter stays in Emergency Department ▪Decreased hospital acute care
	Monitor Acute Bed Days data including by ethnicity to identify and respond to areas of opportunities to decrease acute bed days. (SLM)	Q1-Q4: Improvement opportunities identified and progressed to decrease acute bed days.	
	Identify opportunities which could assist in decreasing the number of frail elderly patients (over 75 years of age) presenting to ED. (EOA)	Q1-Q4: Decreased number of frail elderly patients presenting to the emergency department and being admitted.	
	Provide support to the redesign of re-contact pathways to decrease representation and admissions to hospital.	Q1-Q4: Improvement opportunities identified and progressed to decrease representation.	
	To remain connected to winter planning groups and plans across the system, and support their coordination.	Q1-Q4: Coordinated system wide winter planning response.	
	Develop a coordinated plan for a pandemic response across urgent care services that is aligned to the system wide pandemic responses. Review any learnings from the Covid-19 response and identify ways to enhance efficiencies.	Q1-Q2: Coordinated system wide pandemic response.	
	As above - Monitor readmission data including ethnicity as per previous year.	Year 2021/22 TBC	
2. Improving patients access to timely care and in the right place	Strengthen community providers care of patients with chronic health conditions with an initial focus on patients presenting with mild exacerbations of COPD.	Q1-Q4: Areas of focus to improve access to timely care and response progressed.	▪Increased planned care rates. ▪Access to care improved. ▪Decreased acute care rates.
	Explore opportunities for avoidable admissions in key areas by utilising virtual ward concept. Key areas to explore: ▪ Paediatrics ▪ ARC/Older Persons Health ▪ Step down from hospital-COPD/Heart failure focus	Q1-Q2: Reduce potential admissions, readmissions, bed days and ED attendance by having virtual process in place.	
	Undertake a deep dive into data (Including available ACC data) to identify areas for improved care starting with people presenting with injuries requiring acute orthopaedic care.	Year 2021/22 Q3-Q4 Deep Dive completed by Q3. (The findings from the deep dive analysis will determine what projects need to occurs in the 2020/22 period.)	
	Identify any areas for improvement in access to appropriate and timely care. Initial areas of focus to include: ▪ Low back pain	Year 2021/22	

*EOA – Equity Outcome Action / *SLM – System Level Measures

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
	▪ Concussion		
3. Sustainability of Acute Demand Service	Monitor progress with implementing actions from the acute demand project to standardise services including: ▪ Radiology use ▪ Transport- cost savings ▪ Standardisation of claiming rates ▪ Appropriate use of ADMS	Q1 ▪ New guidance released. ▪ Maintain and improve ED/Acute medical admission rates.	Resources matched to need.
4. Improving patient access to care	Continue to engage with St John, ED and the Urgent Care Clinics to safely manage appropriate patients in the community by monitoring: ▪ Ambulance Referral Pathways- including call and diversion volumes. ▪ Acute Demand services.	Q1-Q4 ▪ Total number of calls to St John in Canterbury. ▪ Number of patients St John divert away from ED quarterly, by condition, if available. (Baseline 400 patients per annum). ▪ Percentage of these calls in relation to total call volumes to ED/Hospital admissions, referrals to GP's/Urgent Care Clinics reported quarterly (Baseline for admissions from ED to hospital wards 10,500).	
5. Improve patient centred promotion of community based urgent care health services	Review the current promotion of community based services, including: ▪ What messaging currently exists. ▪ Patient's knowledge of existing community based services.	Q1-Q4: Improved understanding of current messaging and services that exist.	
	Based on the findings of above the work group will promote: ▪ What community based services are available 7 days a week ▪ What urgent care facilities can provide. ▪ How services can be accessed. Information provided to all relevant services (including pharmacies across Christchurch).	Q3-Q4: Improved promotion and consistency of information about community based services.	
Actions towards monitoring progress			
6. Improving patient access to care	Continue to invest in Acute Demand Management Services that provide primary care with options to support people to access appropriate urgent care in the community rather than in hospital.	Q1-Q4: Maintain between 30,000 to 35,000 packages of care in the community by ethnicity.	▪Decreased hospital acute care ▪Decreased acute care rates ▪Access to care improved
7. Monitor patient's access and response to telephone triage and impact on system	Continue to support the "#CareAroundtheClock" advertising campaign, which promotes calling general practice 24/7.	Q1-Q4: Call volumes to be monitored and reported quarterly.	
	Monitor call volumes through Homecare Medical and any impacts on general practice and the Urgent Care Clinics	Q1-Q4: Homecare medical call volumes data Monitored and reported quarterly.	
	Provide visibility and monitor people who present at ED or an Urgent Care Clinic following a tele triage.	Q1-Q4: Once data is available monitor the percentage of people who present at ED or an urgent care facility following a telephone triage.	

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
8. Promote appropriate and where possible shorter stays in the Emergency Department	Work with key areas and specialities within the hospital to ensure flow through the ED to enable the national target to be met ED attendance wait time data provided by ethnicity.	Q1-Q4: 95% of ED attendances waiting less than 6 hours to be treated, admitted, discharged or transferred.	

Key metrics to indicate progress delivering work plan actions, impact on health outcomes and/or monitor performance	
Description of metric	Data Source
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
6. ADMS Packages of Care	ADMS
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
10. Percentage of people who present at ED or urgent care facility following tele-triage	HML/Decision support