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

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	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

The 2020-21/22 CCN Work Plan for all alliance groups can be viewed on the CCN website here.