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	▪ Q2: Hui held in Hurunui. ▪ Q3: Programme developed alongside	

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	in the Hurunui (EOA): ▪ Initial hui held in Hurunui. ▪ Hurunui programme developed. ▪ Business plan written for Hurunui programme.	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 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

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

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
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
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.	

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