

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.	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> 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).	<ul style="list-style-type: none"> Year 2020-22 (Year 1 & 2) Increase in referrals to Te Ha Waitaha. Canterbury smoking cessation rates improve. 	<ul style="list-style-type: none"> 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).	<ul style="list-style-type: none"> Q2: Pilot programme/s designed and delivered. Increase in the number of Māori and Pasifika peoples attending community respiratory programmes. 	<ul style="list-style-type: none"> 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).	<ul style="list-style-type: none"> 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).	<ul style="list-style-type: none"> Q1-Q2: Rolling programme designed and piloted. 	
	Improve patient and clinical understanding of community respiratory programmes. Improve communications with patients (EOA).	<ul style="list-style-type: none"> Q4: Increase in number of people attending community respiratory programmes. 	
	Evaluate Māori and Pasifika peoples' community respiratory programmes (EOA).	Year 2021/22 Q3: <ul style="list-style-type: none"> Increase in number of Māori and Pasifika peoples attending community respiratory programmes. Evaluation completed. 	

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	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

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