Canterbury Clinical Network Work Programme 2021-22

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

Introduction

This document brings together the 2021/22 Canterbury Clinical Network (CCN) alliance groups work plans.

Background

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

Our alliance groups have been established around populations, services and/or localities. Members 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 alliance groups then report on progress against their work plan priority actions quarterly and any risks that could impact progress in their focus area.

The CCN Alliance Leadership Team (ALT) endorses all the alliance groups work plans.

2021/22 work planning

In December 2020 alliance groups were provided with a work planning guide summarising requirements for 2021/22, system priorities, the work planning process and a template for completion. Alliance groups that had elected to develop a two-year plan spanning July 2020 to June 2022, were asked to review and update the 2021/22 section of this plan. All groups were asked to consider any learnings from the COVID-19 response and alignment with the Health and Disability System Review direction when updating their priorities.

Before developing the 2020/21 work plans, most alliance groups met with the Māori Caucus to discuss future priorities and how these could address the health needs of Māori. This process resulted in 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.

This engagement with the Maori and Pacific Caucus will be repeated in November 2021 ahead of next year's planning.

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 continue to be available on their CCN website page.

Each alliance group's work plan includes:

Priority actions	Priority actions for 2021/22.
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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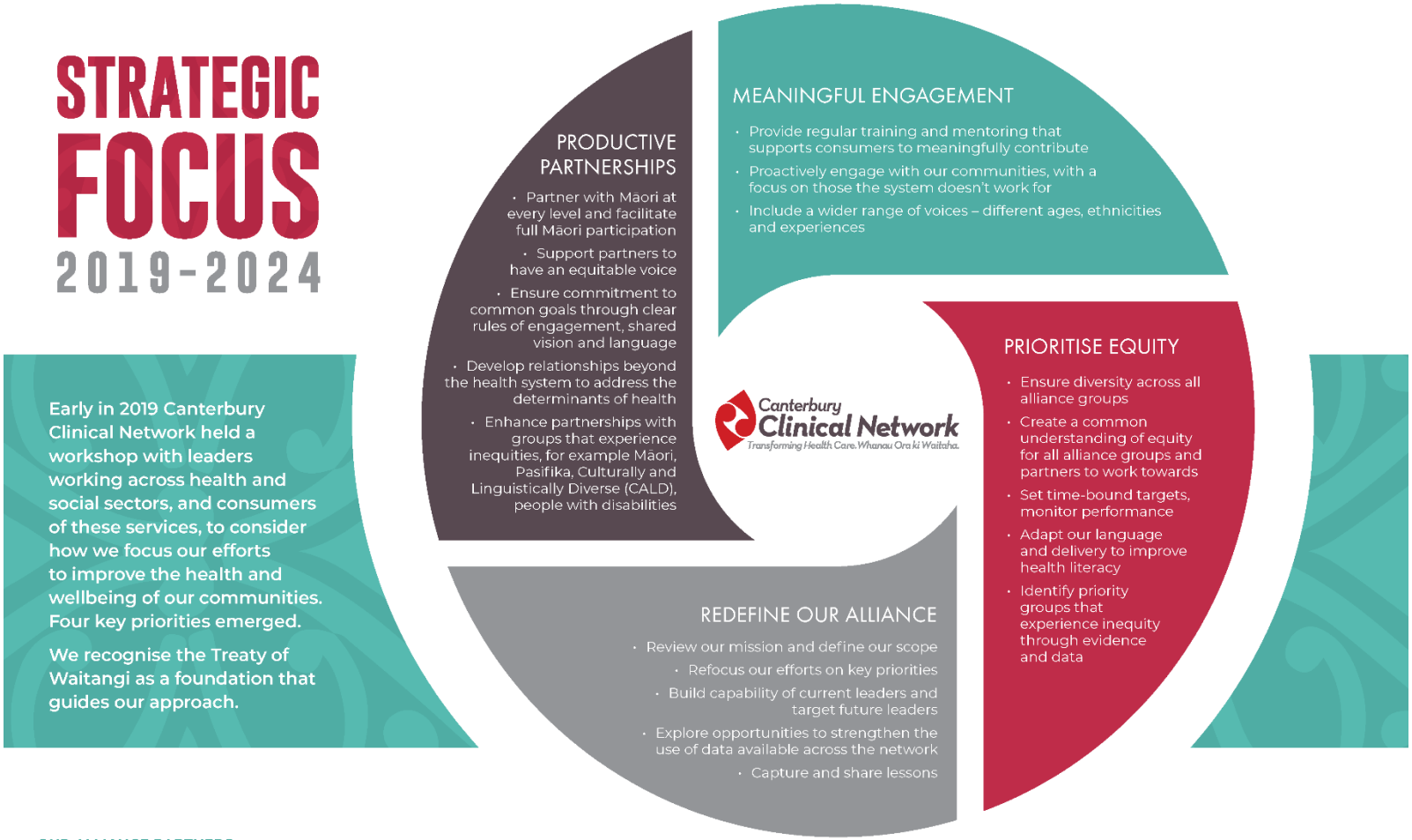

OUR ALLIANCE PARTNERS

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

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 2021-22

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Priority actions towards transformational change, improved system outcomes and/or enhanced integration			
1. Improve access through providing an inclusive and culturally safe experience within healthcare settings that reflects a commitment to Te Tiriti o Waitangi	Facilitate an expansion of knowledge of General Practice and CDHB administrative and support staff cultural competency and customer service.	Q2-Q4 ▪ Each organisation has their own cultural competency training scheduled in the 2022 training plan. ▪ Senior staff support their staff to complete training by leading the way and committing to complete the training themselves.	▪ Multiple links to system outcomes.
	Integrated and consistent training is provided Content is developed in conjunction with local health providers and implemented addressing cultural awareness and safety and customer service.		
	Awareness of cultural events held in Ashburton district is increased by promotion and distribution of communications.		
2. Improve capacity of General Practice through expansion of innovated practices. That all people have equitable access to GP care, with a focus on Māori, Pasifika, Migrant and CALD populations	Form a time limited working group 'Access to General Practice' to identify and implement key actions to progress in Ashburton from research on Access to Primary Health Care Services including enrolment to general practice. (EOA)	Q2: Initiatives are identified and implemented to assist general practice to enable timely access to care.	▪ Primary care access improved. ▪ Equity of access and health outcomes. ▪ Decreased adverse events. ▪ Improved environment supports health and wellbeing. ▪ People are supported to stay well.
	Form a time limited Work group 'Practice Nurses Professional Development (PD)' to facilitate expansion of skills and knowledge of Practice Nurses'(RNs). Continue to investigate Professional Development & recognition programme (PDRP) initiatives. Identify and implement key actions to progress small group practice education groups. Work with RHWSs progress of Canterbury rural workforce sustainability.	Q1: 20% of Practice Nurses are enrolled in learning. Q3: Connections are made and opportunities for PD are shared promoting HealthLearn, supporting them to manage 20 hours annual PD, or pathway to Nurse Prescriber and Nurse Practitioner. Q4: Connections are made with organisations providing new ways of providing PDRP. Ongoing: ▪ Groups are established and RNs are engaged in PD. ▪ Common initiatives are implemented.	
	Identify areas of expansion of community pharmacy scope of practice alongside general practice. Implement key actions.	Q2-Q4: Six-monthly discussion with Pharmacy SLA facilitator held to identify opportunities and initiatives.	
	Identify areas of expansion of telehealth in Ashburton primary care and clinician to clinician. Develop and implement a process to enable expansion.	Q2-Q4: There is an expansion of telehealth use.	

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
3. That accessibility and provision of sexual health services are improved	Facilitate a time-limited Working Group 'Access of sexual health service' to: ▪ Confirm status of the youth sexual health service in consultation with Hype board. ▪ Identify further opportunities to improve access and sustainability to the youth service. ▪ Explore current sexual health needs for all ages. (EOA)	Q4: Opportunities to improve access are identified. Q1: Access is improved. A sustainable service managed by community and service providers is in place. Q2: Stocktake of all ages access to sexual health is completed.	▪ Equity of access and health outcomes. ▪ Decreased adverse events. ▪ Improved environment supports health and wellbeing. ▪ People are supported to stay well.
Actions towards monitoring progress			
4. That social and health services are integrated	Identify opportunities for better alignment across health and social services. (SLM)	Ongoing: Provide quarterly updates on: ▪ Collaboration with Safer Ashburton is made with a focus on refugee service. ▪ Effective engagement with Ashburton District Council is maintained. ▪ Local updates on new initiatives are shared with Ashburton communities.	▪ Improved environment supports health and wellbeing. ▪ People are supported to stay well.
5. That the coordination of care is strong, integrated and in collaboration with patients	Monitor the use of shared care plans by primary, secondary, and community care providers. (SLM)	Q2 & Q4: Provide quarterly reports on the number of care plans created and updated across primary, secondary and community care	▪ Multiple links to system outcomes.
6. That mental health services are integrated and accessible	Monitor mental health services. (SLM)	Q2 & Q4: Six-monthly updates are provided to the ASLA on mental health services.	▪ Improved environment supports health and wellbeing. ▪ People are supported to stay well.
	Explore ways to obtain data from other sources, e.g. Te Tumu Waiora.	Ensure evolving trends are identified.	
7. There is safe, efficient transfer of care for the elderly.	Monitor ARC enrolment process (EOA/SLM)	Q2 & Q4: Six monthly reports received from NASC and ARC facilities, are provided to the ASLA and include quantitative / qualitative feedback.	▪ Equity of access and health outcomes. ▪ People are supported to stay well.
8. That people are provided with equitable access to GP care, with a focus on Māori, Pasifika, Migrant and CALD populations.	Monitor referrals of presentations at AAU to GP practice. (EOA/SLM)	Q2 & Q4: AAU Attendance data are provided to the ASLA.	▪ Multiple links to system outcomes.

Key metrics to indicate progress delivering work plan actions, impact on health outcomes and/or monitor performance	
Description of metric	Data Source
1. AAU Attendance data including by age, ethnicity, enrolment status and reason for not wishing to accept an enrolment. (Objective 8.1)	CDHB
2. Shared Care Plan data - number of care plans created and updated across primary, secondary and community care (Objective 5.1)	Shared Care Planning team
3. Patient Experience Survey trends from rural communities	PHOs
4. Health Care Homes (HCH) practice utilisation of elements of the model or uptake of elements of the Hikitia model. (Objective 2.1)	PHOs

Child and Youth Health Workstream Work Plan 2021-22

Objectives	Actions	Measures of Success / Targets / Milestones	Workgroup
Priority actions towards transformational change, improved system outcomes and/or enhanced integration			
5. Equity of outcomes	Develop and implement a Maternity Workplan in consultation with Māori and the wider community to identify priority areas. (EOA*).	Q2: Work plan developed and implementation under way.	First 1000 days
	Implement an evidence informed breastfeeding action plan focused on improving equity for Māori, 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%	
	Support the Implementation of the National WCTO Review.	Q4: ▪ Support is provided for data analysis and IT request from the MoH ▪ Implement new models of care when identified by MoH	First 1000 Days & Tamariki
	Collaborate with Māori & Pacific organisations who work with rangatahi to ensure programmes and services are designed for young people, by young people.	Q4: ▪ Identify providers who deliver services to Rangatahi ▪ Mapping exercise to identify gaps	Rangatahi
	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.	Q4: Support key areas for transition	
	Ambulatory Sensitive Hospitalisations Respiratory & constipation admissions – work with the sector to identify ways to reduce presentations. (SLM*)	Q4: ▪ Support the Healthy Homes implementation across Otautahi ▪ Work determined to identify areas for improvement in ASH admission (including constipation) ▪ Prioritization given to key areas for improvement	Tamariki
6. Cultural development	Support the delivery of regular forums targeted at C&Y workforce to strengthen cultural development. (EOA)	Q4: ▪ Three forums are held each year, each with a specific cultural development focus ▪ Develop a karakia specific to Child & Youth Workstream	All
7. Workforce development and diversity	Support the provision of professional development for those who work with child and youth.	Q3-Q4: Regular workforce support provided at Forums & connection with related groups across rohe.	All
	Support health services to be Youth Friendly.	Q4: ▪ A youth friendly service Framework is developed ▪ Services working with youth (Primary Care, Mental Health, Dental) are encouraged to implement framework	Rangatahi
8. Connectivity and information sharing	Develop a Child and Youth Health data dashboard, so we can better	Q4: Information to share at Forum and Workgroups to help inform future service	All

Objectives	Actions	Measures of Success / Targets / Milestones	Workgroup
	monitor and measure utilization of current services, by our Māori, Pacific and high deprivation populations.	provision	
9. Improved access to wellbeing and mental health support for all rangatahi	Support and input into the national School Based Nursing Review.	Q4: Review recommendations reflects the needs of our community.	Rangatahi
	Youth have access to health services including primary care, sexual health and mental health.	Q4: ▪ Information around access to services is developed and shared with young people ▪ Support the implementation of the Suicide Prevention Governance Group workplan	

Community Services Service Level Alliance Work Plan 2021-22

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Priority actions towards transformational change, improved system outcomes and/or enhanced integration			
10. 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 Comms 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 in line with National Specification.	Q2: HealthInfo revised.	▪ Collaborative plans of care ▪ Fewer people need hospital care ▪ People are supported to stay well
11. 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. Q4: Resource compiled. Q2: Ordering available through CDHB supply department for Rural DN.	▪ Equity ▪ People are supported to stay well ▪ Community resilience/capacity enhanced
12. Equitable Access for Services for Kaumātua	Kahukura Kaumātua project rolled out in the Hurunui (EOA): ▪ Initial hui held in Hurunui. ▪ Hurunui programme developed.	Q2: Hui held in Hurunui. Q3-4: Programme developed alongside local community.	▪ Equity ▪ People are supported to stay well ▪ Community resilience/ capacity enhanced
	▪ Business case developed for sustainable development of this programme.	Q3: Business Plan completed.	
	Training resource developed to enable other groups to undertake similar processes of engagement with cultural communities.	Q4: Resources drafted and circulated.	
13. Services for under 65s	▪ Work to identify women under 65 at risk of osteoporosis and develop strategies towards early intervention (EOA): ▪ Bring together workgroup to define parameters. ▪ Develop strategies to engage this group. ▪ Develop pathway for this group.	Q1-4: Workgroup assembled. Q2: Strategies developed.	▪ People are supported to stay well

Actions towards monitoring progress			
14. CREST transition monitored	Monitor and facilitate where necessary changes in CREST services to ensure changes in delivery model are supported.	Q1-4: Reports received from providers (quarterly).	▪ People are supported to stay well
15. Ethical decision making	Continue to monitor use of Ethical Framework in decision-making (EOA).	Q1-4: Reports received.	▪ People are supported to stay well ▪ Fewer people need hospital care
16. Uptake of Funded Family Care options monitored	Monitor uptake of Funded Family Care and Individualised funding.	Q1-4: Reports received and considered.	▪ Community resilience/capacity enhanced
17. Equitable delivery of rural Community Services	Receive reports from Rural Health Workstream on rural models of care.	Q1-4: Data analysed and considered.	▪ People are supported to stay well ▪ Fewer people need hospital care
18. Social Isolation/ Elder Abuse	Monitor scores of interRAI assessments.	Q1-4: Reports received and considered.	
19. Monitor ACC/ CREST NAR case mix data	Table data from ACC/ CREST Non-Acute Rehabilitation program.	Q2-4: Minutes shared, and appropriate actions taken when agreed.	
20. Monitor falls prevention data	Table data from Falls & Fractures Operations group quarterly.	Q2-4: Minutes shared, and appropriate actions taken when agreed.	
21. 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.	▪ 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. InterRAI assessments per 1000 population 65+ (Māori 55+).	TAS
2. Percentage of Home Care Support Services (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).	
6. Number of Strength and Balance places (Pasifika focus).	Sport Canterbury
7. Number of Strength and Balance places (CALD focus).	

Co-ordinated Access on Release Group Work Plan 2021-22

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	Continue to share health information to improve the care provided to prisoners through further implementation of HealthOne into prison health units in Canterbury.	Q1: Corrections staff are utilising and contributing to HealthOne.	▪ 'At risk' population identified ▪ Increased equity of access ▪ Multidisciplinary approach
	Work with Probation to link prisoners (Paihere) on release with health navigation services, where additional health support is required.	Q1: Utilisation of Partnership Community Workers service from prisoners on release.	
	Explore the potential for screening/health assessments 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. Including: ▪ Community Services Cards ▪ Sexual Health ▪ Traumatic Brain Injury Report ▪ Use of HealthPathways ▪ Process improvements implemented in prisons and shared across the system.	
	Communicate the free and extended consultations initiative including to prisons, reintegration services and primary care.	Q3: Communications distributed through the agreed channels with the parties involved. Q4: Education sessions provided by Canterbury Initiative.	
	Explore the health issues and needs of remand clients. ▪ Obtaining numbers of clients on remand for 6-12months and more than 12months. ▪ Scoping health needs of those clients on remand for more than 6 months.	Q2: Data and health need analysed.	
	Use this information to determine whether this cohort can be included in the voucher scheme.	Q4: Decision made on inclusion in the voucher scheme.	
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.	

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Actions towards monitoring progress			
3. Provide sustainable and integrated programmes	Continue to 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
6. Number of clients on remand for 6-12 months.	Corrections
7. Number of clients on remand for more than 12 months.	Corrections
8. Utilisation of PCW service by prisoners on release.	Pegasus

Health of Older People Workstream Work Plan 2021-22

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	Kahukura Kaumātua project rolled out in the Hurunui (EOA): ▪ Initial hui held in Hurunui. ▪ Hurunui programme developed.	Q2: Hui held in Hurunui. Q3: Programme developed alongside local community.	▪ Equity ▪ People are supported to stay well ▪ Community resilience /capacity enhanced
	Business case developed for the sustainable development of this programme (EOA).	Q3: Business Plan completed.	
	Training resource developed to enable other groups to undertake similar processes of engagement with cultural communities (EOA).	Q3-4: 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 (EOA).	Q2: Report produced.	▪ Earlier diagnoses ▪ Management of disease (best practice)
	Continue to work with Community and Public Health to promote dementia specific health messaging.	Q2: Meetings held. Q3: Strategy developed.	
3. Improved social integration for older people	Investigate and report on the potential for a "Social Prescription" model for older people, with attention to people's cultural and linguistic needs (EOA).	Q4: Report presented.	▪ Behavioral interventions delivered ▪ Equity ▪ Social environment supports health
	Work to implement "Social Prescription" model for selected cohort.	Q1: Meetings held to agree strategy. Q2: Cohort identified. Q3: Pilot begun.	▪ Behavioural interventions delivered ▪ Community capacity enhanced
4. Improved social integration for older people	Enable streamlined uptake of Carer Support by simplifying systems including: ▪ Modifying claims process ▪ Aligning with Funded Family Care policies ▪ Developing pathways for use of Individualised Funding options	Q1: Baseline established of Carer Support utilised and service gaps identified. Q4: Growth in Carer Support utilisation measured over time. Q4: Health Pathways revised.	▪ Behavioral interventions delivered ▪ Community capacity enhanced
5. Enhanced support for carers	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.	▪ Behavioral interventions delivered ▪ Community capacity enhanced
	Enable streamlined uptake of carer Support by simplifying systems including: ▪ Modifying claims process. ▪ Aligning with Funded Family Care policies.	Q1: Baseline uptake established. Q4: Qualitative survey of users. Q4: Increased uptake identified	▪ People are supported to stay well ▪ Community capacity enhanced

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

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
	▪ Developing pathways for use of Individualised Funding options.		
6. Quality Improvement in ARC	▪ Work towards increased ARC engagement in Falls Prevention. ▪ Bring together ARC working group to develop strategic direction for falls prevention in Residential Care.	Q2: Falls prevention sessions held. Q3: Group meeting. Q4: Strategic plan developed.	▪ Behavioral interventions delivered ▪ Access to care improved
	Cross-provider resource developed to support appropriate de-prescribing of antipsychotics.	Q2: Strategy developed. Q3: Pilot implementation developed. Q4: Pilot begun.	▪ People are supported to stay well ▪ Management of disease (best practice)
Actions towards monitoring progress			
7. Wider Access to Health Plans	Monitor the uptake of: ▪ Advance Care Plans ▪ Medical Care Guidance Plans ▪ Personalised Care Plan	Q1-4: Increased use of all plans.	▪ Access to care improved
8. Health literacy	Monitor use of HealthInfo.	Q1-4: Traffic on site reported quarterly.	▪ Social environment supports health
9. Palliative care	Maintain links with South Island Alliance Palliative Care Workstream (SLM).	Q1-4: Quarterly reports from ARC Palliative Care NZ service received.	▪ Access to care improved ▪ Death with Dignity
10. CREST	Continue to monitor CREST transition.	Q1-4: Report from CSSLA.	▪ Access to care improved
11. Falls and fractures	Monitor CSSLA Falls Prevention actions and receive reports of developments and progress in this area.	Q1-4: 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			
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 2021-22

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Priority actions towards transformational change, improved system outcomes and/or enhanced integration			
1. Ensure the current Immunisation Service Model is fit for purpose to improve / maintain Immunisation coverage	Continue the refresh to the Immunisation Service Model to reflect the current Immunisation environment (EOA).	Q4: A new service model is implemented.	▪ Population Vaccinated. ▪ Delayed/ avoided burden of disease & long-term conditions.
2. Immunisation communication and engagement plan	Develop an engagement and communications plan in partnership with Māori, Pasifika and other consumers to more effectively promote / increase knowledge of the importance of immunisation, particularly amongst high need and hard to reach populations (EOA).	Q1: Hui on key messages completed. Q2: Engagement and Communication Plan developed.	▪ Community capacity enhanced. ▪ Population Vaccinated.
	Identify and implement two priority actions from the Immunisation Engagement and Communications Plan (EOA).	Q2: Priorities identified. Q4: Two priorities implemented.	
3. Protecting mother and baby	Continue to identify ways to improve immunisation coverage of pregnant women.	Q3: Maintain pregnancy pertussis coverage over 60% for the 2021 year.	▪ Population Vaccinated. ▪ Reduce hospital admissions. ▪ Delayed/ avoided burden of disease and long-term conditions.
	Review the effectiveness of the Outpatients vaccination programme.	Q4: Share coverage baseline data with the Outpatients programme team.	
4. Ensure timely childhood immunisation	Continue to monitor immunisation coverage at 8 months, 15 month, 5 years, 12 years and HPV for birth cohort year, and ensure there is equity of coverage (EOA).	Q4: Regular reports on overdue children and practice coverage shared with General Practices.	▪ Population Vaccinated. ▪ Delayed/ avoided burden of disease and long-term conditions.
	Restart the Immunisation Conversation Programme that was placed on hold in 2020-21 due to Covid-19 vaccination programme (EOA).	Q3: Programme restarted 2022.	
	Provide an updated process chart to general practice to raise awareness about the timeframes for the new 12-month immunisation event.	Q2: Updated process chart distributed to general practice.	
	Develop a pathway to identify children who are overdue for their 12- and 15-month immunisations and link them back to their general practice, to enable the practice to prioritise and reach the families of children overdue for vaccinations.	Q1: Pathway agreed and implemented.	

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
5. Ensure equity of access to Immunisation	Review the current processes undertaken by the National Immunisation Register team to identify children overdue for immunisations. In doing so ensure: ▪ NIR and NES ethnicity for children match and if not, the child's ethnicity is confirmed. ▪ Māori and Pacific children are referred to the Missed Events Service within the agreed timeframes. ▪ Māori and Pacific families, who agree to be referred to Outreach Immunisation Services are given a priority referral. (SLM)	Q1: Review complete. Q2: Processes confirmed and updated with the NIR team.	▪ Population vaccinated. ▪ Delayed/ avoided burden of disease and long-term conditions. ▪ Reduce inequitable outcomes.
	Implement key learnings from the 2020 Kaumātua Flu programme: ▪ Partner with the Māui Collective and public health team to deliver community-led education and awareness sessions on the importance of immunisation for Māori. ▪ Develop a process to support general practice to improve Māori ethnicity data collection for Kaumātua, so this group can be prioritised for Influenza vaccinations (EOA).	Q1: Process agreed. Q3: Annual sessions planned and delivered. Q3: Māori influenza vaccination coverage increases.	▪ Community capacity enhanced. ▪ Population vaccinated.

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 2021-22

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Priority actions towards transformational change, improved system outcomes and/or enhanced integration			
1. Increased engagement of high-risk populations in health services including: ▪ Māori, ▪ Pasifika Peoples ▪ Indian ▪ Adolescents/ young Adults ▪ People with mental illness	▪ 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. ▪ 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, retinal screening. ▪ Plan a community outreach for Pacific people with diabetes. ▪ Explore access for people with Mental Health conditions. (EOA)	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 Narrower gap between European and priority population.	▪ Delayed/avoided burden of disease & long-term conditions ▪ 'At risk' population identified
2. Increased service delivery in the community and alignment of the dietetic and nutritionist workforce to the location of service delivery	Build on the stocktake of the current access to and location of dietetic and nutritional services to: ▪ Establish baseline and unmet need. ▪ Consider the Pae Ora ki Waitaha Principles for designing Health Lifestyles - being led by the Population Health and Access SLA ▪ Develop recommendations for changes in workforce and location. (EOA)	Q4: ▪ 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. System wide access to clinical notes e.g. Documentation, I.T, and clinical oversight	▪ Complete a stock take of the current access of key providers and identify any gaps. ▪ Develop recommendations for changes.	Q4: Key stakeholders have access to the same level of information to provide best outcomes and a system level approach to care & treatment.	
4. Reduce hospital admissions and length of stay in secondary care in-patient services	▪ Develop an inpatient in-reach service to actively identify and engage with people while in hospital. ▪ Identify gaps in service delivery ▪ Identify pathways / processes on discharge back to general practice	Q4: ▪ Reduced length of stay of people in hospital ▪ Continuity of care provided for people to remain well and out of hospital.	

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Actions towards monitoring progress			
5. Monitor engagement with high-risk groups such as: ▪ Māori ▪ Pasifika Peoples ▪ Indian ▪ Adolescents/ young adults ▪ People with mental illness	Monitor integrated diabetes (specialist and community) services, general practice, retinal screening, and high-risk diabetic foot) activity for priority populations.	Q1-Q4: ▪ Number of Māori and Pasifika people with diabetes. ▪ Six-monthly reporting to IDSDG on activity, including ethnicity.	▪ Delayed/avoided burden of disease and long-term conditions
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-Q4: Work plan 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.	Q2: 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 2021-22

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Priority actions towards transformational change, improved system outcomes and/or enhanced integration			
1. All presentations admitting to hospital acutely are supported	Establish a pathway that people admitted to hospital with COPD are assessed. Provide the necessary support on discharge that addresses individual biopsychosocial needs in the community for people with COPD. (COPD Day 2 project) (EOA)	Q4: Reduction in hospital admissions for people with COPD. (Baseline: 800 patients pa 1200 overall admissions pa. Target reduce overall admissions by 20%).	▪ SLM Acute Hospital Bed Days
	Co-create a pathway with Māori and Pasifika people in relation to the COPD Day 2 project. (EOA)	Q4: Striving for equivalent acute bed day rates across all ethnicities may lead to Māori and Pacific populations who have a higher burden of disease not receiving optimal access to acute hospital care. In seeking equitable health outcomes Canterbury will work towards appropriate hospitalisation for all ethnicities.	
Actions towards monitoring progress			
2. Enable people to receive supports, monitoring and diagnosis which is sooner, better, and more convenient	▪ Community Sleep and Spirometry programmes are monitored for quality, accessibility, and equitable access. ▪ Community respiratory services are monitored for quality, accessibility, and equitable access. Focus on priority populations of Māori and Pasifika. (EOA)	Q1-4: ▪ Quality measures are met. ▪ Monitor approved providers capacity and timeliness of service provision.	▪ Equity
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 services by ethnicity.	Local database
4. Practice data on people with respiratory conditions.	Practice/PHO data
5. Volume of spirometry/sleep tests by ethnicity.	Claims

Laboratory Service Level Alliance Work Plan 2021-22

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Priority actions towards transformational change, improved system outcomes and/or enhanced integration			
1. 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. Identify if any inequities regarding location of collection centres	Mapping of the location of collection centres to meet access and equity considerations.	Q1: Data is available for analyses and recommendations about collection centre spread are made.	
4.Quality Improvement	Consider thematic feedback received by SCL and CHL from their consumer surveys and recommendations about access and equity quality improvement opportunities.	Q2: Agreement and implementation of quality activities.	
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 2021-22 and include identification of measures of variability of laboratory testing.	To be determined

Mana Ake Service Level Alliance Work Plan 2021-22

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Priority actions towards transformational change, improved system outcomes and/or enhanced integration			
2. Realign Mana Ake resources to ensure accessible, timely and equitable response for tamariki and their whānau when wellbeing or mental health concerns are identified	Realign support for school clusters in response to feedback from schools, and informed by cluster data, to accommodate the current, and possible future, reduction in Mana Ake FTE.	Q1: Realignment agreed and confirmed.	Improved access Equitable access across Maōri and other priority populations
	Refine the supports available from Mana Ake kaimahi to schools, whānau and tamariki based on learnings and feedback to date regarding what works best for whom, to accommodate the current, and possible future, reduction in Mana Ake FTE.	Ongoing: Matrix agreed and implemented across clusters. Clusters and Mana Ake teams agree local responses, including how schools and other services can help to address areas of concern. Use of Leading Lights further embedded in school processes. School Cluster Forums continue to share good practice for enhancing student wellbeing. School satisfaction surveys indicate predominantly positive experiences Individual cluster hui and outcomes are conveyed to be positive in discussions with kaiarahi.	Equitable use of resource No wasted resource Local community needs are met
	Work with the Canterbury Primary Principals Association and key stakeholders to agree a prioritisation matrix, based on learnings to date (Q1).		
	Transition backbone support for Mana Ake to a longer term, sustainable option	Q1: Suitable transition plan agreed and underway.	
Enhancing cultural capacity and capability	Work with the Provider Network to prioritise cultural diversity of the workforce.	Ongoing: Percentage of kaimahi who identify as Māori, from Pacific Island nations and Asian cultures is maintained or increases as FTE decreases.	Equitable access across Māori and other priority populations
	Support the development and implementation of Uia Ka Pou, a locally created cultural development approach for all agencies, endorsed by Ngai Tahu and supported by the Rātā Foundation, Oranga Tamariki and Canterbury DHB on behalf of Mana Ake Providers.	Ongoing: Mana Ake providers engage in implementation of Uia Ka Pou, once finalised Kaimahi report increased knowledge and confidence in working with tamariki and whanau from different cultures. Improved confidence and knowledge of bicultural practice are evident through narrative reports between providers, kaiarahi, kaimahi, and Project Team.	Equitable outcomes for Māori
	Support schools to enhance cultural support for tamariki by aligning cultural group programme delivery with the goals of Ka Hikitia, specifically Te Tuakiritanga, and the objectives of Whakamaua. A more intentional approach to the provision	Ongoing: Partnership agreement developed and implemented with schools where cultural groups are run, to build sustainable practice to support Māori and Pasifika tamariki. Feedback from schools about the long-	Equitable outcomes for Māori and other priority populations

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
	of groups supporting tamariki cultural identity to ensure sustainability of impact.	term impact for tamariki, whanau, and school.	
Transformational system change through better connected health, education and social sector supports	Contribute to enhanced collaboration between and across school clusters through local and regional cluster forums.	Ongoing: Schools share practice that enhances student wellbeing at cluster forums.	Equitable use of resource, no wasted resource. Local community needs are met. People are well and healthy in their own communities.
	Contribute to cross sectoral alignment through promotion of the use of Leading Lights across agencies and services as well as in schools.	Ongoing: Utilisation of, and engagement with, Leading Lights (new users and returning users).	
	Contribute to cross sectoral integration by facilitating an Expo of service providers for schools.	Q1: Expo held # participants Feedback from attendees	
	Facilitate Provider Network to identify and address opportunities to enhance practice across the workforce, including quarterly shared professional development opportunities.		

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

Description of metric	Data Source
To Be Confirmed	

Transalpine Oral Health Service Development Group Work Plan 2021-22

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Priority actions towards transformational change, improved system outcomes and/or enhanced integration			
1. Improved whole of life Oral Health awareness, with a focus on Māori and Pacific and caregivers on low incomes	Implement the Canterbury Oral Health Education and Promotion Plan, ensuring these are evidence based and focus on improving equity for identified groups. These include: ▪ Implementing the Well Child Tamariki Ora project to improve Oral Health literacy for parents of 0-2-year-olds. ▪ Supporting Pegasus to develop an oral health webinar for use in primary care. (EOA, SLM CDHB)	Q1-Q4: ▪ Improved equity of access to toothbrushes and education. ▪ Pre and post training evaluation of WCTO staff to measure improved understanding. ▪ Māori and pacific whānau/caregivers of 0-4-year-olds and rangatahi have an improved understanding of oral health. ▪ Māori and pacific whānau/caregivers and their tamaraki and rangatahi are more engaged with services (measured by uptake in accessing DHB funded dental services).	▪ Improved environment supports health and wellbeing. ▪ Decrease in OH contribution to ASH rate for Māori and Pacific 0-4 years. ▪ Improved Oral Health status of Māori and Pacific tamaraki and adolescents.
	▪ Develop and implement a West Coast Oral Health Education and Promotion plan. ▪ Offer a package of support that addresses both good oral hygiene practices (supervised brushing twice a day with a fluoride toothpaste) and health literacy related to good oral health (promote breastfeeding, limit sugary drinks and eat a balanced diet that includes fresh fruit and vegetables). ▪ Support the appointment of a Clinical lead for Oral health. (EOA, SLM WCDHB)	Q1: Plan completed. Q2-4 ▪ Prioritised actions commenced. ▪ Prioritised actions completed. Q1: 75% of Māori whānau with a child admitted for treatment of a dental condition are engaged in a wraparound support package. Q2: Appointment of Clinical Lead Dental at WCDHB.	▪ Reduce the 3-year average ratio between ASH rates for Māori children to below 1:1.23 (2021/22 SLM plan).
	▪ Collaborate with Community and Public Health to advocate for, and support, policies that will improve oral health for our most vulnerable populations, including water fluoridation and reduced sugar/sugar free policies /position statements. ▪ Connect with other advocacy initiatives. (EOA WCDHB and CDHB)	Q4 ▪ Fluoridation actions undertaken following approval of CDHB position statement when/as directed by MoH. ▪ Reduced sugar/sugar free oral health messaging included in new Healthy food and drink policy. ▪ Quarterly progress updates/collaboration with other initiatives completed.	
2. Improve the oral health of children through streamlining the patient flows process	Improve the Canterbury Oral Health Service Model: ▪ Undertake a patient flow project to investigate how Māori with acute dental needs flow through the system and identify opportunities to improve links into earlier dental care. ▪ Implement recommendations of the patient flow process / pathway. ▪ Support Dental Therapists to work at the top of their scope, within	Q4: ▪ Patient flow opportunities are identified, and recommendations implemented. ▪ 10% less children are referred out of Community Dental Service. ▪ 10% less children are referred for Sedation and then on referred to Hospital Dental. ▪ Performance reporting programme completed. ▪ Regular reports to CCN and Māori	▪ Access to care. ▪ Improved Coordinated care. ▪ Timely access to specialist intervention.

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

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
	the patient pathway. ▪ Develop an oral health performance reporting programme with a focus on equity including regular reports through to CCN and Māori advisory groups. (EOA CDHB)	advisory groups, recommendations / feedback from these groups implemented.	
	Community Dental Service targeted recall system: ▪ Continue to develop/improve the targeted recall system based on clinical need. ▪ Refine the processes which identify Māori and Pasifika children lost to recall/not engaging and re-engage them and their whānau in school and community Oral Health services. (EOA, SLM CDHB)	Q4 ▪ Quarterly updates provided. ▪ Regular reports identify children lost to recall. ▪ Service targets for Māori and Pasifika established. ▪ Re-engagement with services meets targets for Māori and Pasifika.	▪ Increased equity of access.
	Continue to use connections within primary, paediatric inpatient and community health services to identify non-attenders and other children being lost to recall and re-engage them and their whānau with school and community oral health services. (SLM WCDHB)	Q4: Evaluation completed on impact.	
	Work with Hospital Dental services to develop a Transalpine Service.	Q1: Transition completed.	
3. (a) Improve the oral health of Adolescents (b) An accessible youth friendly Oral Health service	Working group that has a strong Māori, Pasifika and Rangatahi voice develops and implements a transalpine Oral Health adolescent utilisation improvement workplan. (EOA, SLM CDHB)	Q1-Q4 ▪ Quarterly reporting on progress. ▪ Reduced equity gap in adolescent utilisation of Oral Health services under the Combined Dental Agreement, e.g. a) referred but not utilising service b) not referred ▪ 67% of adolescents utilise DHB funded dental service at June 2022.	▪ Oral Health services are accessible and feel welcoming ▪ Patient experience ▪ Increased equity of access
4. A Culturally Competent Oral Health Service	Improve the cultural competency of Oral Health service (DHB and dental practices) by: ▪ Investigating options to improve this at a national and local level (e.g. service specifications, association/ council expectations, education, when new staff are employed). ▪ Implementing appropriate responses in collaboration with the local branch of the NZ Dental Association, Hospital and Community Dental Services. (EOA WCDHB and CDHB)	Q1-Q4 ▪ SDG/GM advocates for cultural competency expectation in appropriate service specs (eg CDA). ▪ Appropriate programmes to improve cultural competency completed by Oral Health staff (including front of house). ▪ Increase in Māori/Pacific accessing Oral Health services (CDS, Private).	▪ Oral Health services are accessible and feel welcoming. ▪ Patient experience. ▪ Increased equity of access.
	Support improved relationships and engagement with Māori and Pacific people working in Oral Health. (EOA WCDHB and CDHB)	Q1-Q3: Regular hui for Māori and Pasifika OH workforce held.	

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

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
5. Improved Oral Health for other populations	Develop patient pathways that facilitate access to Hospital or Specialist Dental Services on West Coast for people with special dental or health conditions. (EOA WCDHB and CDHB)	Q2: Pathways developed which consider older persons, low income adults and those who experience mental health issues.	
	Support private dentists in Canterbury and West Coast to utilise local community Health Pathways and HealthInfo. (EOA WCDHB and CDHB)	Q1 ▪ Increased awareness via branch meetings/physical visits to introduce/ refresh awareness. ▪ Increased utilization.	
	Ensure regular access to Oral Health education opportunities for Older Persons Health and Mental Health workforce. (EOA WCDHB and CDHB)	▪ Training opportunities such as MoH/NZDA Healthy Mouth Healthy Aging seminars for Older Persons Health are endorsed and regularly circulated.	
	Work with the Alcohol and Other Drugs team (AOD) and Community Pharmacies to offer Oral Health hygiene consumables, brief advice and printed resources to consumers of Opiate Substitution Therapy to support and enable them to maximize their oral health. (EOA WCDHB and CDHB)	Q4 ▪ Develop service with AOD, Pharmacies engaged and supported. ▪ Initial learnings quantified and applied according to quality improvement principles. ▪ Evaluation – number of packs distributed, continued engagement.	

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 free at 5 years of age – target 67.4%.	Community Dental
2. Mean DMFT score at school year 8 - target 0.70.	Community Dental
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 2021-22

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	▪ Monitor and evaluate the rollout of electronic prescribing for Opioid Substitution Therapy (OST) across Canterbury and the West Coast. ▪ Plan for and rollout electronic prescribing for OST consumers in the GP Care program.	Q1: Electronic prescribing of OST implemented for consumers in the Canterbury Opioid Recovery Service. Q2: Evaluation of the rollout of the electronic prescribing for consumers in the Canterbury Opioid Recovery Service completed. Q4: Electronic prescribing of OST implemented for consumers in the general practice Care service.	▪ Timely access to primary care ▪ Increased planned care rate ▪ Delayed/avoided burden of disease and long term conditions
2. Develop and implement models of care that enable community pharmacists to improve care for patients with long-term conditions	▪ Develop a condition-specific model of care, e.g.gout, or an event-specific package of care (such as, discharge from hospital), that could augment the current pharmacy long-term conditions (LTC) service. ▪ Prioritise and implement a new model/package of care. (EOA)	Q1-Q2 ▪ Project brief developed for a condition-specific module of care. ▪ Project brief developed for an event-specific package of care. Q3: Implementation of a new model/package of care is underway.	▪ Delayed/avoided burden of disease and long-term conditions ▪ No wasted resource
3. Improve medication management for patients through improving the transfer of care process	▪ Map the journey for consumers transitioning between hospital and community care from a medication management perspective. ▪ Examine relevant data to identify and prioritise opportunities for improvement.	Q1-Q2 ▪ The current medication management process for consumers transferring between community care and secondary care and vice versa is mapped. ▪ Opportunities for quality improvement in the current process are identified and prioritised. ▪ A business case/improvement project plan to address the opportunity with the highest priority is developed.	▪ Effective transfer of care
4. Understand our population's use of pharmacy services including by ethnicity	Identify the data available for the Canterbury population's use of pharmacy services, prescribing and use of medicines, medicines related adverse events, and areas of inequitable access or outcomes. (EOA, SLM)	Q1-Q2: Relevant data to better understand our population are identified and used to inform the activity of PSLA workgroups and measure the outcomes.	▪ Understanding health status ▪ 'At risk' population identified ▪ Increased equity of access
	Analyse the available data to identify potential areas for quality improvement or service development. (EOA)	Q1-Q4: Data used to identify areas of service improvement.	
5. Equitable health outcomes for: ▪ Māori ▪ Pasifika ▪ Culturally & Linguistically Diverse (CALD)	Identify opportunities to incorporate cultural safety training and or the Meihana model into practice across pharmacy services. (EOA)	Q1-Q4: New pharmacy services developed locally incorporate training in cultural safety and or the Meihana model.	▪ Increased equity of outcomes

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

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Actions towards monitoring progress			
6. Monitor the sustainability of pharmacy services during pandemics or natural disasters	▪Monitor the potential impact of having a vulnerable workforce who would be unable to work in pharmacies if there was a widespread outbreak of infectious diseases. ▪Advocate regarding the potential impact of this to local or nation bodies if necessary.	Q1-Q4: Pharmacy services are prepared and responsive during pandemics and natural disasters.	
7. Improve patient health literacy to support their self-managing of their medicines	Monitor the provision of the Medication Management Service and Pharmacy Long Term Conditions Service to people with chronic conditions who need support to manage their medicines.	Q1-Q4 ▪14,000 people per annum receive the Pharmacy LTC Service. ▪1,500 people per annum receive a Medicines Use Review.	
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. MTA quality measure – prescribing trends 12 months post-MTA			CCPG / CDHB SFN
3. Pharmacy Long Term Conditions Service patient enrolments			CDHB
4. Polypharmacy in people aged 65 and older			CDHB
5. Adverse drug reactions and Canterbury DHB hospital admissions trends			CDHB
6. Primary and Secondary care Patient Experience Survey data relating to medicines			CDHB
7. New Zealand Electronic Prescription Service (NZePS) uptake by Canterbury GPs			CDHB

Population Health Service Level Alliance Work Plan 2021-22

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	▪ Apply a co-design process to explore how the Canterbury health system promotes and supports healthy lifestyles (Pae Ora ki Waitaha). ▪ Following Stage 1 of Pae Ora ki Waitaha work with CCN partners, alliance groups, reference groups, other groups outside CCN and stakeholders in the wider community, to facilitate the development of a shared approach to healthy lifestyles (Stage 2). ▪ Identify how the Canterbury health system can influence healthy public policy by reviewing our current approach and identify areas to further strengthening this approach. (SLM / EOA) 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.	▪ A Canterbury Health System Pae Ora ki Waitaha Implementation Plan is developed and presented to ALT for approval. This will include measures to track the outcomes of the plan. ▪ Recommendations to strengthen our influence on healthy public policy is presented to the ALT.	▪ 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, through: ▪ Completing the research project on people who are tenuously enrolled or unenrolled with general practice in Canterbury. ▪ Reviewing the findings of the above research and other research collated to date to identify any further gaps in our understanding. ▪ Identifying research on the impact on equity of access from telephone and virtual consultations. ▪ Commissioning further research to address gaps in understanding. (EOA)	Q2: ▪ Research report received ▪ Gaps in our understanding are identified Q3: ▪ Further research is undertaken	▪ Across all outcomes
	With other CCN partners, alliance groups and other groups outside CCN develop a shared system approach to access to health care services across Canterbury. (EOA)	Q1: A Canterbury health system plan around access to primary health care services is presented to ALT for their endorsement.	▪ Across all outcomes

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
3. Improve access to gender affirming health care	Complete progress of Year One actions to improve access to gender affirming services, through: ▪ Embedding the new HealthPathways established through the co-design project including responding to any emerging issues and changes needed to the pathways. ▪ Communicating the new pathways for accessing care to the trans community and health professionals. ▪ Supporting the upskilling and education on trans care for general practice teams. ▪ Further strengthen relationships with clinicians across primary and secondary health care to increase knowledge within and between the services. (EOA)	Q1-Q2: ▪ Utilisation of relevant HealthPathways. ▪ Summary report received. ▪ A high level of acceptability of new processes from the perspective of consumers and health professionals.	▪ Across all outcomes
Actions towards monitoring progress			
4. Improved access to best practice interpreting services across the Canterbury Health System for people with limited English proficiency (LEP) and those who are deaf	▪ Progress the adoption of interpreter services Best Practice Guidelines in the hospital settings and PHOs across the Canterbury health system. ▪ Update Canterbury guidelines, as required when national guidelines on interpreters' services are released. (EOA)	Ongoing: ▪ Maintain connection with provider organisations and PHOs on the uptake of best practice guidelines. ▪ An increase in the utilisation of interpreter services by alliance partner organisations.	▪ Greater access for our population to interpreting services for their health needs ▪ A common approach to the standards of interpreting services for our population
5. Progress is made towards being smoke free by 2025	Monitor the refinement of the Te Hā - Waitaha service model to achieve greater outcomes for our wāhine population to become smoke free. (EOA)	Ongoing: Te Hā - Waitaha delivery model is refined and has a priority focus on wāhine Māori.	▪ Smokefree 2025 ▪ Reducing our population smoking rates across Canterbury
	Support work towards Smokefree 2025.	Ongoing: Continued coordination with Smokefree Canterbury.	
6. Reduced Alcohol Harm in our population	Monitor the implementation of policies that reduce alcohol-related harm. (EOA)	Ongoing: ▪ Adoption of a Canterbury DHB staff Alcohol and Drug Policy. ▪ Review completed 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.	Ongoing: Brief intervention training for hospital staff made available and promoted.	

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 / Interviewing 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. Establish a set of metrics to monitor health outcomes and access across the Canterbury Health System using a Pae Ora framework, that can be used by PHASLA and wider CCN groups (identify additional gaps and/or issues in access).	Various
8. Quarterly monitoring of HealthPathways – Gender-affirming care page visits	HealthPathways

Rural Health Workstream Work Plan 2021-22

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	Implement opportunities identified in Year One for enhancing Canterbury's rural workforce sustainability, including: ▪ Advocating for improved recruitment of Voluntary Bonding Scheme (VBS) nurses and increase in NetP training support in rural locations. ▪ Supporting a PHO-coordinated approach to advocate for secure Health Workforce NZ funding for increasing Nurse Practitioner (NP) resource across rural Canterbury. ▪ Advocate for Ara to proactively support nursing placements in rural settings. ▪ Complete a stocktake of the current access to allied health in rural Canterbury, including the use of Kaiāwhina. ▪ Explore opportunities to support allied health capacity gaps in rural areas. ▪ Continue monitoring local, regional, and national activity and advocacy, including Hauora Taiwhenua. (EOA)	Q3: Progress Implementation of agreed opportunities for Canterbury by Q3, including: ▪ Update from PHOs on VBS status. ▪ Update on increasing NP resource. ▪ Secure response from Ara on increased rural nurse placements. ▪ Stocktake of allied health and Kaiāwhina workforce. ▪ Allied health capacity gaps reported. ▪ Share findings of analysis, activity, and progress across CCN.	▪ No wasted resource. ▪ Access to care improved. ▪ Primary care access improved.
	Increase utilisation of the 'Making it Work' framework to support trainee placements and relocating of health workforce into rural communities.	Q4 ▪ Trainee placements identified. ▪ Toolbox created to adapt to any rural community.	
2. Improve the model and distribution of rural subsidies	Support the development of a new model for distributing Rural Subsidies, including the application of the Geographic Classification for Health Research in Canterbury (EOA).	Q3: Funding provided.	▪ Primary care access sustained. ▪ 'At risk' population identified.
3. Identify and address inequities for rural communities, including distance to service and ethnicity (Māori, Pasifika, CALD)	Advocate for improved health outcomes for the rural Canterbury population through the implementation of the NZ Health & Disability Services Review (EOA).	Q1-Q4 ▪ Report on identified inequities in rural Canterbury. ▪ Dashboard of key metrics established and updated quarterly.	▪ 'At risk' population identified. ▪ Delayed/avoided burden of disease and long-term conditions. ▪ Primary care access improved.
	Continue to enrich our relationship with Manawhenua ki Waitaha, Te Kāhui o Papaki Kā Tai, Māori Caucus, Maui Collective, and local Rūnunga through Tiriti-focussed ways of working (EOA).	Q1-Q4 ▪ Māori-led engagement to focus next steps. ▪ Discuss opportunities and embed in practice.	▪ Equity of access and health outcomes.

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Actions towards monitoring progress			
4. 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): - Include a report on the transition journey from HHSDG to Provider and Community groups. ▪ Ashburton SLA.	Ongoing: Quarterly updates received.*	▪ Improved environment supports health and wellbeing
	Monitor service integration and improvement strategies from Kaikōura, Oxford & surrounding Area, Akaroa.	Ongoing: Quarterly updates received.*	▪ Improved environment supports health and wellbeing
	Monitor progress of the CDHB Telehealth Operational Governance Group (TOGG) and advocate for identified opportunities to further support rural communities.	Ongoing: ▪ Regular updates received from TOGG. ▪ Rural community considerations advocated to TOGG.	▪ Delayed/avoided burden of disease and long-term conditions
	Monitor progress of: ▪ Rural Restorative Care framework implemented in the Hurunui community (including number of clients supported). - Geographic Classification for Health research to define rural in the NZ health context. - Rural Kaumātua Project (through HOPWS). - Te Tumu Waiora rollout for rural communities. - Te Ha Waitaha in rural communities.	Ongoing: Six-monthly updates on service received.	▪ Effective transfer of care ▪ Improved health and wellbeing
	Monitor emerging issues that are raised: ▪ Data dashboard on our rural population to increase knowledge of inequities that exist in access to services, service utilisation and health outcomes including comparisons with: - urban Canterbury and NZ; - within/between rural Canterbury communities; and - raised through local, regional and national forums.	▪ Six-monthly data and narrative tabled with RHWS. ▪ Emerging issues tabled with RHWS as and when necessary.	▪ Equity of access and health outcomes ▪ 'At risk' population identified
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 rural presentations trends including by age, ethnicity, enrolment status and source of referral. Rural frequent attenders targeted.			CDHB, St John
2. Shared Care Plan data on plans created and amended through the rural General Practices.			Shared Care Planning, PHO
3. Baseline ratio of enrolled population for primary care workforce FTE across rural Canterbury population bases established.			PHOs, General Practice, CDHB
4. Patient Experience Survey trends from rural communities.			PHOs

*Reports to include (but not limited to): key activity for period: integration, changes in health services, technology, relationships, identified risks/mitigation, upcoming activity.

System Outcome Steering Group Work Plan 2021-22

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 in reviewing the relevant data. ▪ Ethnicity level data is reviewed to enable understanding of inequities and drive actions to reduce these. ▪ With PHASLA and DHB Portfolio Manager Māori Health, establish a Canterbury Health System "access and equity of outcomes monitoring report" for use 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 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	▪ 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)	Q3: 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	Improving ethnicity data capture project – progress a project to improve quality and comparability of ethnicity data across Tier 1 and Tier 2 services (EOA).	Quality of ethnicity data across Tier 1/Tier 2 services improved.	▪ Improved understanding of data accuracy to enable improved interpretation of data for improved health outcomes.
4. Develop partnership with all Alliance partners	Include all Alliance partners in contributing to operational parts of the 2022/23 SLM Improvement Plan. (SLM)	Q2-Q4: All alliance partners contribute to improved performance.	▪ Prioritisation of effort to improve Canterbury's System Level Measures performance.
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)	Q1-Q4: 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.

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

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
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 2021-22

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 a coordinated system response to periods of exceptional demand, particularly during winter or infectious disease outbreaks. (SLM*)	Q1-Q4: Number of times acute demand reaches capacity – target is zero.	▪ Shorter stays in Emergency Department ▪ Decreased hospital acute care
	Explore key metrics of patient flow through urgent and emergency care providers to identify and progress opportunities to maintain timely access to care. Urgent Care providers include: ▪ ED ▪ Urgent care clinics (Moorhouse Medical, Riccarton Clinic, 24 Hour Surgery) ▪ St John ▪ Whakarongorau (formerly Homecare Medical) Key metrics will include: ▪ ED presentations ▪ Acute Bed Days ▪ Re-admission And will explore ethnic variation. (SLM)	Q1-Q4: Improvement opportunities identified and progressed to decrease ED attendances and /or acute bed days rate. Note: The Canterbury Health System's System Level Measures agreed milestone for June 2022 is to reduce the Acute Bed Days rate for the Total population to 297 per 1,000 or less.	
	Identify opportunities to decrease the number of frail elderly patients (over 75 years of age) presenting to ED. This includes connecting with the Health of Older Persons Workstream to ensure alignment with their work plan priorities.	Q1-Q4: Decreased number of frail elderly patients presenting to the emergency department and being admitted.	
	Remain connected and support the coordination of system activity to improve patient flow including winter planning and other activity such as making Waipapa flow.	Q1-Q4: Coordinated system wide winter planning response.	
2. Improving patients access to timely care and in the right 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. Identify areas where data matching may be able to occur. ▪ Identify any areas for improvement in access to appropriate and timely care with an initial focus on: - Concussion - Access to diagnostics: High Tech imaging - Orthopedics	Deep Dive completed by Q3.	▪ Increased planned care rates ▪ Access to care improved ▪ Decreased acute care rates
	Review and reset measures around accessing urgent care in collaboration with the CDHB and	Q3-Q4: Improved understanding, promotion, and consistency of information about urgent care/after-hours services.	

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
	CCN communications teams. ▪ Areas of focus will include: - Working with the CDHB and CCN communications teams on any changes required to messaging about urgent care centres. - What urgent care facilities can provide.		
Actions towards monitoring progress			
3. 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 ▪ Increased planned care rates
4. Monitor patient's access and response to telephone triage and impact on system	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 tele triage.	
5. 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.	
6. Improving patients access to timely care and in the right place	Support and align activity with the Integrated Respiratory Service Development Group e.g., reducing the admission and readmission of patients with COPD.	Q1-Q4: Areas of focus to improve access to timely care and response identified and progressed.	
7. 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.	
8. Improving patient access to care	Monitor the work undertaken by the CDHB to understand how ED is operating when Maori present to them, identifying any gaps in data capture and equity actions that will better meet the needs for Māori. The work will include: ▪ Completing a data analysis ▪ Reviewing and communicating key findings within ED, connect with the Maori health worker (based in ED) ▪ Partaking and supporting a collaborative workshop to identify actions which will be priorities for implementation.		

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
9. Improve patient flow through the system	Monitor outcomes data from Home Care Medical to identify and respond to areas of opportunity to align their messaging, pathways, and processes with other parts of the system.	Q1-Q4: Coordinated system response to those calling home care medical and presenting to urgent care centres.	
10. Coordinated pandemic response	Monitor pandemic response across urgent care services and where required ensure they align to the system wide pandemic responses.	Q1-Q2: Coordinated system wide pandemic response.	
11. Improve patient flow through the system	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.	▪ 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).	

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