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			
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 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
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. Q4: Resource compiled. Q2: Ordering available through CDHB supply department for Rural DN.	▪ Equity ▪ People are supported to stay well ▪ Community resilience/capacity enhanced
3. 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.	
4. 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	Q1-4: Workgroup assembled. Q2: Strategies developed.	▪ People are supported to stay well

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	define parameters. ▪ Develop strategies to engage this group. ▪ Develop pathway for this group.		
Actions towards monitoring progress			
5. 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
6. 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
7. 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
8. 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
9. Social Isolation/ Elder Abuse	Monitor scores of interRAI assessments.	Q1-4: Reports received and considered.	
10. 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.	
11. Monitor falls prevention data	Table data from Falls & Fractures Operations group quarterly.	Q2-4: Minutes shared, and appropriate actions taken when agreed.	
12. 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).			

The current CCN Work Plan for all alliance groups can be viewed on the CCN website here.