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

The 2021/22 CCN Work Plan for all alliance groups can be viewed on the CCN website here.