Te Manawa Taki Cardiac Clinical Network Workplan 2021-2026

	Activity	Responsibility *(Note: Network leads to be confirmed at 1st 2021 meeting)*	Linked to achieving health equity=1 linked to achieving equitable access to tertiary services=2	Financial Year		Project deliverable	Success measure
A.	Network to work with local DHB management and cardiology clinicians to report on: - DHB cardiovascular plans - DHB regional community heart health programmes - DHB initiatives to remove access barriers - DHB initiatives to deliver services closer to home	Local DHBs and Network	1	Ongoing		Report provided to Executive group.	Improved integration along the cardiac health Continuum of Care.
B.	Network to work with local DHB management and cardiology clinicians to report on: - Institutional racism and cultural competency. - Formal, ongoing relationships with Māori liaison and partners - Relationships and support available to Māori providers, health coaches and health navigators, integrated with cardiac service delivery	Local DHBs and Network	1	Ongoing		Report provided to Executive group	There will be confidence that DHBs are upholding their obligations as a Treaty of Waitangi partner.
C.	Network to work with local DHB management and cardiology clinicians to confirm there are ongoing working relationships in place to progress cardiac health priorities with local NGOs, Public Health Units, and primary care.	Local DHBs and Network	1	Ongoing		Report provided to Executive group	Improved working relationships between stakeholders.
D.	Develop reporting system to monitor equity of access and utilisation of services across the patient journey between primary care - secondary/tertiary care and subsequent follow-up.	Network	1	2021/2022	To complete	Quarterly report developed and shared with Primary care.	There will be improvements from defined base-line service access markers.

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E.	Develop regional equity-based reporting for acute and elective patients.[1] Monitor on a quarterly basis[2] 1. Standard intervention rates for procedures as reported by the MOH 2. Number of echocardiograms performed at each DHB and average waiting time 3. Average waiting time for Cardiac surgery (and follow up) 4. Average waiting time for Angiograms/CTCA, SHD, EP/Device and PCI procedures 5. Number of patients admitted to cardiac care beds	Network	1	2021/2022	To complete	Equity-based report developed and monitored	There will be improvements from a defined base-line in the key indicators 1-5 listed in the Activity
F.	Develop ToR for executive leadership group Update Cardiac Clinical Network ToR for Steering Group Develop generic ToR for Network working groups	Network chair and PM Network Network		01/2021 02/2021 02/2021	To complete To complete To Complete	Updated/New ToRs	
G.	Complete a stocktake of initiatives trialled by national DHBs to reduce 'missed appointment' rates, and report results to Network and executive group for their information and action	Network PM	1	2020/2021	To complete	Stocktake report developed	Reduce missed appointment rates
H.	Hold consumer/whanau hui in each DHB area during 2021.	Network PM and DHB		2020/2021	To complete	Consumer hui findings report developed	80% satisfaction surveys

[1] Identify any data points requiring agreement of data definitions in order to perform the below regional reporting.

[2] Information about echocardiograms, CTCA, number of patients admitted to cardiac care beds and waiting times for the procedures listed in 2-5 will need to be agreed and supplied by each DHB, in-line with specific parameters.

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	- Findings report and recommendations report to be developed and provided to Network and Leadership/governance group.	Cardiology CNS					completed with positive feedback.
I.	Develop and implement cardiac pathways and agreed patient work-up for inter-district patient transfers.	Network	1	2021/2022	To complete	Cardiac Pathway and patient work-up agreement developed	Patient flow between regions will be improved with inter district acute patients receiving faster access to treatment.
J.	Develop an MOU between all DHBs to define which services should be provided locally and which should be provided by tertiary provider.	Network	1	2021/2022	To complete	MOU developed	More services will be delivered closer to home
K.	Develop an agreement about regional treatment priorities.	Network	1	2021/2022	To complete	Documented agreement	Alignment of DHB services with agreement
L.	Develop a position statement on the "benefits of secondary prevention and the crucial role of nurse practitioners and RN prescribers for improving access, equity and health outcomes".	Network	1	2021/2022	To complete	Position statement developed	DHB alignment with position statement Recruitment and retention rates.
M.	Network to agree a regional position and subsequent strategy, to enhancing the regional echo sonographer and physiologist workforce.	Network		2021/2022	To complete	Position statement and strategy developed	DHB alignment with position statement.

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							Recruitment and retention rates will improve.
N.	*Implement a regional information system which includes a real-time view of referrals, waiting lists and clinical outcomes*	*Network*	2	*2021/2022*	*To complete*	*Information system developed*	*System will be utilised and considered helpful by DHBs*
O.	Based on current treatment and referral practices, assess the region's capacity to meet the current and future demand for regional cath lab services.	Network	2	2021/2022	Begin within financial year	Cath lab capacity plan developed	There will be an understanding of the ability to meet the future demand for cath lab services, if practices and capacity stay the same.
P.	Network to establish and agree formal working relationships/MOUs (as appropriate) with Public Health Units and primary care representatives regarding local DHB Rheumatic fever programmes.	Network		2021/2022	Begin within financial year	MOUs developed as appropriate	There will be a collaborative rheumatic fever programme in each DHB region.
Q.	Perform a: 1. Stocktake of the number of cardiac care beds and utilisation across the region	Network	2	2021/2022	Begin within financial year	Deliverables as listed for activity 1-3 will be developed.	There will be a regional view of the issues and effectiveness

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	2. Stocktake and evaluation of inter-hospital patient transfers for acute patients and, 3. Stocktake and evaluation of transport **and** accommodation options for elective patients and their whanau who must travel for treatment. *(Stocktake to include what procedures patients are travelling for, how many patients this affects, what are the transport options and how the system is functioning)*						of the regional: cardiac care bed resources, the inter-hospital patient transfer process, transport and accommodation options for patients and their whanau
Activities to be completed in 2022/23 and/or ongoing:							
R.	Develop patient reported outcome measures for patients who have undergone a cardiac procedure.	Network		2022/2023	To complete	Patient outcome measures developed	Improved patient focussed services??
S.	Identify and prioritise regional cardiac database requirements.	Network		2022/2023	To complete	A plan will be developed specifying the need for a cardiac database.	
T.	Undertake a stock-take of cardiac health literacy resources and processes and report results to Network and executive group	Network		2022/2023	To complete	Health literacy stocktake report completed	People will be empowered to make healthy lifestyle choices?
U.	Develop, report, and monitor regionally agreed clinical quality indicators for cardiology and cardiac surgery.	Network	1	2022/2023	To complete	Clinical quality indicators agreed and documented	

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V.	Agree Māori/Iwi partnerships at all levels, meet with key representatives and agree ongoing workplan & equity outcome priorities	Network	1	Ongoing	Formal Māori representation at Network and executive governance level	There will be a sustained focus on achieving health equity
W.	Develop and agree a regional CTCA program	Network		Ongoing	Each DHB cardiology DHB service will have access to a CTCA scanner	There will be an increase in patients receiving a CTCA
X.	Share with the Network and Leadership/governance group, the outcome of local projects whose purpose is to improve access and remove barriers - including: 1. Waikato Telehealth/GP project 2. Waikato Community Maori nurse specialist role and community echo project 3. Other regional projects & lessons learnt, including innovative service delivery during COVID-19.	Network	1	Ongoing	Project updates will be provided and minuted at Network and Executive leadership group meetings.	There will be an outcome of whether the objectives were met for the Waikato Telehealth/GP project and the Waikato community Māori nurse specialist role/community echo projects.
Y.	Support any national initiatives to enhance the echo sonographer and physiologist workforce	Network		Ongoing	Network will partake in any national initiatives and provide updates at Executive leadership and Network meetings.	

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Z.	Explore alternative models of care that will support meeting the demand for echoes; summarise options in a report to the Network and executive leadership group	Network	1	Ongoing	The Network and Executive leadership group will be updated on any progress regarding finding alternative solutions to meeting the demand for echoes.	Waiting times for echoes are reduced