Te Waipounamu South Island Health Services Plan

2018-2021

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By the South Island Alliance Programme Office
On behalf of the five South Island District Health Boards

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Kotahi te hoe, ka ū te waka ki uta

When we paddle in unison, we will reach the shore together

The 2017/18 year has seen a new phase in the evolution of the South Island Alliance with the development of a South Island Alliance Strategy to accelerate health service improvement and regional collaboration as we work towards our shared regional vision:

A connected and equitable South Island health and social system

that supports all people to be well and healthy.

The South Island Alliance was established in 2011 to focus on the challenges the region faced collectively and the efficiencies that could be gained by working together. The five South Island DHBs decided the South Island would take a collaborative, clinically-led and patient-focused approach through an alliance structure.

This approach has enabled us to transcend the traditional barriers found in health and brought us to a place where we can commit to a shared direction for the South Island health system. The development of the South Island Alliance Strategy has articulated a step-change in how we engage.

The Strategy identifies six priority areas for the coming 1-2 years. These areas were selected as they have the potential to significantly accelerate our progress towards improving outcomes for South Island communities, in particular towards improving equity. The priority focus areas are:

- Turning data into information that supports decision making
- Understanding and influencing the social determinants of health
- First 1,000 days and vulnerable children – supporting the best possible start in life
- Developing mental health aspects of integrated systems of care across the health, education and social spectrum
- Acute Demand Management Platform - enabling primary care-led acute admission avoidance
- Embedding and utilisation of Advance Care Plans across the whole system.

To deliver on these priority focus areas, we acknowledge the need to strengthen engagement with primary care. We also need to push beyond traditional boundaries by working with the wider social sector to address the social determinants of health more actively and support our common goals for better social outcomes.

Our approach is not without its difficulties, and we are heavily reliant on relationship development, shared understanding and mutual accountability. As the Alliance has matured, we have fostered an environment where robust conversations are possible and have led to better cohesion and consistency at clinical, executive and governance levels.

Growing trust and confidence allow us to be more open in confronting our challenges, but also to respond to those challenges in innovative ways. Inequity in our system is one area we are discussing more explicitly as we work to understand the barriers and identify what we need to do better.

This plan describes how we intend to operationalise the South Island Alliance Strategy, drawing on guidance from the Minister's expectations and New Zealand Health Strategy. Building on the successes of the past six years, we look forward implementing the plan and continuing to work together towards achieving our vision.

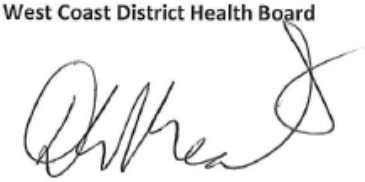
Signed By:

Nelson Marlborough District Health Board

Peter Bramley
CEO, Nelson Marlborough District Health Board

Jenny Black
Chair, South Island Alliance Board
Chair, Nelson Marlborough District Health Board

West Coast District Health Board



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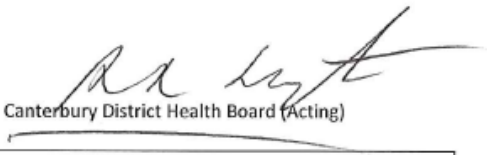

Ron Luxton
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CEO, Southern District Health Board

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1 INTRODUCTION

With a total population of 1,141,160 (23.2 percent of the total New Zealand population)[1], the South Island has dispersed communities, with geographical barriers, pockets of very high population growth and areas with significant older populations, all challenging the way we provide services.

The South Island Alliance brings together the region's five district health boards (DHBs), along with primary care, aged residential care, non-governmental organisations (NGOs) and consumers, to work collaboratively towards a sustainable South Island health and disability system that is *best for people, best for system.*

Through the Alliance, strong relationships have been forged across the region, enabling stakeholders to overcome past barriers. Our practical application of alliance methodology supports transformational change in a complex environment and, as a result, South Island health services have developed a strong collaborative platform for implementing regional and sub-regional priorities.

We have achieved better and more equitable outcomes for patients, more integrated health information and a more flexible workforce. Some recent initiatives and ongoing programmes of work include:

- Implementation of South Island Patient Information Care System (SI PICS) in Nelson Marlborough DHB and Canterbury DHB, with planning underway in the remaining three DHBs.
- Shared South Island electronic patient records: with HealthOne and Health Connect South now available in all five DHBs, primary and secondary care can view key information about a patient's health, such as test results, allergies, or medications. HealthOne is now accessed 4000 times each day.
- The Routes to Treatment project has provided valuable analysis to understand disparities in accessing cancer diagnosis and treatment. The findings will inform initiatives to address these disparities and improve equity of access.
- The reach of the Calderdale Framework (skill sharing & skill delegation framework, led by allied health) continues to grow across the South Island, supporting the use of allied health assistants/kaiawhina to provide increased access to timely care.
- A South Island electronic Advance Care Plan (ACP) has been developed and will be available in mid-June 2018. The region is establishing an ACP Quality Check process through a virtual team to support improving quality and embedding ACP use.

This updated South Island Health Services Plan provides a framework for future planning and outlines our strategic direction, priorities, clinical leadership and work programme for 2018/19, and our direction for the following two years. The plan builds on the achievements and progress of the last six years and is driven by:

- South Island Outcomes Framework
- South Island Strategy
- New Zealand Health Strategy
- Expectations and priorities of the new Government, as laid out in the Minister of Health's Letter of Expectation (Appendix 1) and 2018/19 Regional Planning Guidelines (a summary of the Guidelines and reference to regional activity supporting each requirement is in Appendix 2).

The plan will be governed by the Alliance Board (DHB chairs) and implemented through the Alliance Leadership Team (DHB chief executives), Strategic Planning and Integration Team, and South Island Alliance Programme Office. Further information on this is outlined in Section 4: Delivering our vision, and Appendix 3).

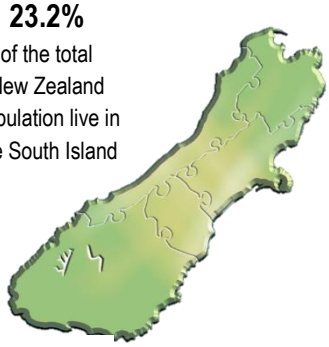
[1] MOH population projection 2018/19

THE SOUTH ISLAND POPULATION

South Island DHBs projected population for 2018/19, and change from 2017/18 (Census 2013 Base)

Nelson Marlborough	150,770	1.62% ⬆
Canterbury	567,870	1.62% ⬆
South Canterbury	60,220	0.30% ⬆
Southern	329,890	1.79% ⬆
West Coast	32,410	0.58% ⬇
South Island	**1,141,160**	**1.53% ⬆**

23.2%
of the total New Zealand population live in the South Island



9.7%
of the South Island population identify as Māori

17.6%
of the North Island population identify as Māori

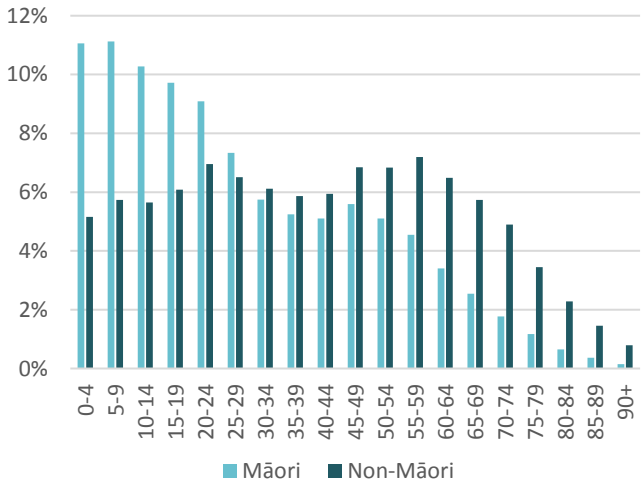
2.1%
of the South Island population identify as a Pacific Island ethnicity

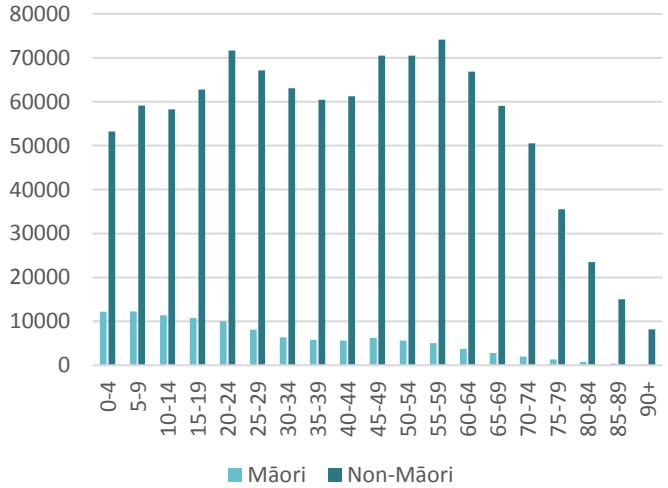
17.4%
of the South Island population are aged over 65 years, up from 17.2 % in 2017/18

14.9%
of the North Island population are aged over 65 years

8.2 %
of the South Island population identify as Asian, up from 7.56 % in 2017/18

Age distribution of the South Island population

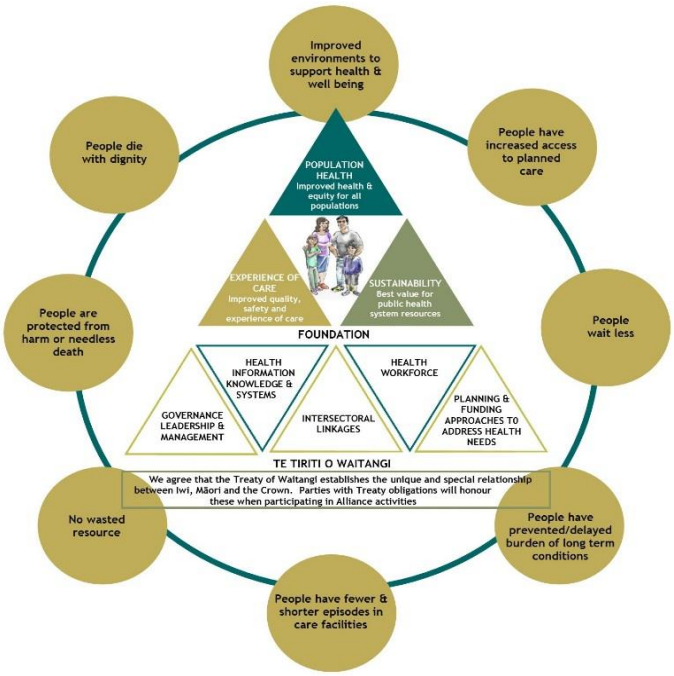




2 IMPROVING HEALTH OUTCOMES FOR OUR POPULATION

This section outlines progress made on some of our ongoing programmes of work, where the work will go next, and how the activities support the eight outcomes of the South Island Outcomes Framework.

South Island Outcomes Measures track our progress and identify service gaps or challenges. It is a wide-ranging set of measures, which is collated annually for consideration by SPaIT and the service level alliances and workstreams to understand trends, identify service challenges and direct future work. This will be refined for the 2018/19 year in light of the new Strategy and six priority areas, and will be supported by the work underway through the Turning Data to Information priority focus area.



Outcome 1: Improved environments to support health and wellbeing – Wai Ora	
Public Health	**Public Health**
Established the Hauora Alliance cross-sector collective impact initiative following a series of co-design workshops. Hauora Alliance includes leaders from Te Pūtahitanga o Te Waipounamu, the Social Equity Network, Oranga Tamariki and the Ministry of Education.	The Healthy Eating and Active Lifestyles (HEAL) working group, has been established. The working group has identified three regional priorities for action and is actively sharing resources and learning.
Workforce Development	**Information Services**
Acknowledging that our workforce should reflect our population, a South Island Māori Workforce Workshop was held with attendees agreeing to work together on a number of actions towards increasing the number of Māori working in health. Māori workforce data is being collated and trend analysis now possible with data set.	The IS SLA and South Island PHOs held an engagement workshop in September 2017. The meeting was a first step to foster an integrated IS environment across primary and secondary care, and develop a shared vision and principles to reduce system complexity. The IS SLA has subsequently strengthen the PHO representation and now has two General Practitioners and one of the PHO CIOs as members of the IS SLA.

Information Services
This is has been a significant year in the progress of the South Island Patient Information Care System programme with two major milestones achieved: Completion of implementation across the Burwood facility (CDHB) the first full DHB implementation was completed at Nelson Marlborough DHB. SI PICs is connecting DHB staff with coordinated, consistent access to a single region-wide solution, resulting in improved quality and safety systems, and a more streamlined patient journey from the community to the hospital and beyond.

Outcome 2: People have increased access to planned care

Cancer Services	Workforce Development
Adoption of the South Island cancer Multidisciplinary system (SIMMS), originally developed by clinicians in Southern DHB, was initiated and there are now six MDMs using this new electronic tool which is accessed via Health Connect South. Early feedback has been extremely positive from clinicians. Bringing the remaining cancer MDMs onto the new system continues in 18/19 with a focus on aligning tumour specific proformas and associated workflows across DHBs, as well as provision of local and regional reporting back to the clinical teams.	A South Island policy and framework for Registered Nurse prescribing was approved by Executive Directors of Nursing. This included participation from acute and primary care, NZNO & University of Otago. The South Island has 29 RN Prescribers working in rural, primary care, family planning, oncology, cancer care, chronic conditions and diabetes.
Workforce Development	**Telehealth**
The reach of the Calderdale Framework (skill sharing & skill delegation framework, led by allied health) continues to grow across the South Island with 26 trained facilitators, and two practitioners which allows us to train our own facilitators. Training has also been provided by the South Island to the Central Region along with ongoing support for their peer support meeting. Use of the allied health assistant/Kaiāwhina workforce to deliver increased patient-centred care has resulted in outcomes such as increased access to receive key pieces of equipment and increased rehabilitation provision.	A South Island Telehealth Strategy has been drafted which outlines the vision for a connected, ubiquitous, well-used, virtual health platform for the region. The Strategy considers governance, change management, and embedding telehealth in clinical practice, technology and infrastructure, monitoring and evaluating use, along with resource requirements. The Strategy is in the process of being reviewed, and it is expected that once approved, work towards implementation of the Strategy will begin.
Mental Health and Addictions	
The youth forensic pathway has been agreed and is being implemented across all South Island DHBs. Smaller DHBs with limited forensic staffing can access the support of a bigger team which the hub offers.	

Outcome 3: People wait less

Cardiac Services	Cancer Services
The Accelerated Chest Pain Pathway has been adopted including an accepted rural approach as the best interim solution until POC hsTn assays become available. The National STEMI Pathway is being implemented in the South Island Region in conjunction with St John.	Five service improvement projects to achieve Faster Cancer Treatment across the South Island were successfully completed: Improving the cancer pathway for Maori High Suspicion of Cancer Gynaecology Referral Pathway Valuing the Patients Time in Complex Cancer – Head and Neck and across DHB borders Diagnostics Fast Track Clinics for Southern DHB Routes to Diagnosis for all South Island Cancer Patients
Mental Health and Addictions	
A gap analysis of forensic transitions has been completed this year. The forensics transitions workgroup will make recommendations to the sector next year.	

Outcome 4: People have prevented and/or delayed burden of long term conditions

Cardiac Services	Cancer Services
Planning for South Island Sustainable Cardiac Services report was completed and approved. The South Island Cardiac Model of Care is being developed based on the recommendations of the report.	The South Island Radiation Partnership Group was formed and undertook work to address unnecessary variation in Radiation Oncology. A proposed standard of care for patients with early stage breast cancer, which describes treatment planning, dose and delivery requirements for patients across the region was developed and is going through the process of being approved. The intention is to replicate this process for other cancer types going forward.
Health of Older People	**Health of Older People**
A stocktake of delirium care was carried out and resulted in the development of a delirium resource and tool that was distributed and promoted across the South Island for World Delirium Day in March 2018. The stocktake will also inform a plan of action to increase awareness and understanding of delirium ('Think Delirium') and increase uptake of the delirium tool.	'Dementia is Everybody's Business – Working together to achieve a shared South Island model of care' was completed and distributed in October 2017. The document outlines a vision and provides a template for collaboration amongst all the South Island's dementia health services to progress the NZ Dementia Framework – including provision of culturally appropriate services and addressing equity. HOPSLA is working with Dementia teams and DHBs to discuss progress and agree next steps for implementing the model of care over the coming three years – this engagement has been very positive and useful for planning. Health Navigator is being progressed across the South Island – for embedding in health pathways and recording the individuals Dementia Health Navigator on the electronic patient record.

Stroke Services	Mental Health and Addictions
Work is underway on a South Island Acute Stroke Plan that will aim to deliver sustainable, consistent stroke services for the region, including the eventual implementation of a clot retrieval service. All DHBs have reviewed their Stroke Health Pathway, with some still completing further action as a result of the review.	The regional advisory group of key stakeholders has worked closely with MoH and Matua Raki on the requirements of the new legislation and has established and operationalised the new national treatment centre in Christchurch

Outcome 5: People have fewer and shorter episodes in care facilities

Health of Older People	Health of Older People
The use of data interRAI (comprehensive clinical assessment) to inform planning became much more accessible through the development of a quarterly regional infographic showing agreed key measures In August, data from 4 quarters will be available and analysis of trends and service gaps will be undertaken. Analysis of interRAI data relating to social isolation was presented in a South Island-wide videoconference and the in-depth analysis was very useful for understanding patient needs (carried out through University of Canterbury summer student programme).	The implementation of electronic Advance Care Plans across the region will support end of life care, including people dying in the place of their choice. Already CDHB data indicates of those with e-ACPs only 18 percent died in hospital, compared to national average of 34 percent.

Outcome 6: No wasted resource

Child Health	Major Trauma
The uptake of the regional e-growth charts in secondary care continues to increase with over 72,000 recorded entries. E-growth charts provide clinicians an accessible record of a child or baby's growth, irrespective of where in the South Island they are receiving secondary care, as well as providing comparison with the population.	From the New Zealand Major Trauma Registry & National Clinical Network Annual Report 2016-2017: *The South Island Region has made significant progress since the previous report and all DHBs are now entering data on the National Registry.*
Public Health	**Information Services**
The South Island Public Health Partnership have developed South Island Quality Framework and a single planning template for Public Health Units, providing a shared and consistent way of understanding their progress and planning. A review was initiated of the out of hours, on call arrangements for both Health Protection Officers and Medical Officers of Health across the South Island. It will identify the opportunities and feasibility of making out of hours, on call cover more sustainable and aligned across the South Island.	The arrangement between Orion Health and the South Island Alliance has been formalised through the South Island Alliance Strategic Partnership (SIASP). This gives South Island DHBs access to dedicated Orion Health resources and products to for the ongoing development, enhancement and support of the Health Connect South platform.

Workforce Development	Information Services
Elearning is now available across the South Island. A national workshop was organized with all 20 DHBs participating to discuss the future of eLearning. Currently there are 111 learning packages available with 51 in development. Support to develop content nationally has now been given from the National GMs HR.	Planning is underway for the South Island Regional Service Provider Index (RSPI) – as a single source of truth for identity management of the South Island health workforce, this is a key foundation block for the region. To deliver the RSPI, the region has entered into a collaborative partnership between the MoH and the SIA to upgrade and extend the national Health Provider Index (HPI). This work is currently progressing through business case approvals prior to commencing the upgrade and extension to the HPI in early 2018/19.

Outcome 7: People are protected from harm or needless death

SUDI	Child Health
Regional programme to support reducing SUDI was initiated. A series of workshops in November and December were held to explore what activities are underway in the South Island and what improvements can be made.	The South Island Youth Alcohol Emergency Department Presentations' Scoping Project report was released (carried out in conjunction with Public Health Partnership and Health Promotion Agency). Work is now underway to implement recommendations from the report.
Cancer Services	**Health of Older People**
SCN has worked to enable increased clinical leadership and wider sector involvement across SCN work. This includes the development of a SI Radiation Oncology Partnership Group and regular engagement with Clinical, Operational and FCT Leads, South Island Cancer Nurses Network, Māori and consumer advisory groups. A focus on this area will continue in 2018/19.	The SI stocktake of Restorative Services was undertaken in August 2017 and the report finalised May 2018. Released alongside the stocktake report, HOPSLA developed a diagram to describe restorative care in the South Island. The next step will be using the information to inform a plan of action to increase awareness and uptake of the Restorative (Person Centred) Model of Care across the region.
Stroke Services	**Quality and Safety**
The annual South Island Stroke Education Day was held again in November 2017, with 150 participants attending and another 100 via VC. Participants were approximately evenly represented from across primary, acute, rehabilitation, residential, and community. The day covered a range of topics including clot retrieval, continence after a stroke, visuospatial issues, Maori perspectives of stroke, and medical imaging in relation to stroke. Feedback on the day was very positive with 49 percent saying they had gained 1-3 new ideas for their practice, and 51 percent saying they had gained more than 3 new ideas.	A successful pilot of South Island DHB training on reportable events was held in April. DHBs will roll this training out. The region is facilitating sharing innovation on quality and safety programmes including Serious and Adverse events and Deteriorating Patients.

Information Services	Information Services
Agreement and development of a standardised South Island common tool set for Mental Health documentation commenced. The first completed form was a common risk tool from the South Island specialist mental services. The standardised South Island common risk tool is to be built and accessed through HCS/H1. The next core document to be standardised is the care/treatment plan.	With the launch of HealthOne in Nelson Marlborough all five South Island DHBs now share relevant patient information electronically. General practice teams can view a person's test results and discharge summaries, and hospital physicians can access information about allergies, long-term conditions and current medications. HealthOne provides a portal to patient information such as general practice and hospital records, allergies, prescribed and dispensed medications, and test results, providing a comprehensive picture of an individual's health history. It is accessed by health professionals around the South Island more than 3,000 times each day.

Outcome 8: People die with dignity

Palliative Care Workstream	Health of Older People
Completed surveys of palliative care services across the health sector and released the findings: the surveys of hospital, hospice, planning and funding, PHOs and aged residential care have provided a comprehensive picture of the strengths, gaps and variations in services across the South Island. Comparative analysis across the system like this is unique and there has been significant national interest in the process and findings. The findings will form a basis for planned discussions with local palliative care services to identify next steps towards developing a South Island model of care and increasing consistency and quality of care at end of life.	HOPSLA led work to develop and agree the functionality of the SI Electronic ACP. The Electronic ACP is ready for release across the South Island with the next IT upgrade in mid-June 2018. A Regional ACP Quality Check process for all newly written ACPs across the South Island is being implemented to drive quality and ensure that a documented plan is clinically interpretable and fit for purpose. This supports all users to have confidence in what is written.

3 SETTING OUR STRATEGIC DIRECTION

3.1 National direction

The long-term vision for New Zealand's health service is articulated through the New Zealand Health Strategy, which has the over-arching intent to support all New Zealanders to 'live well, stay well, get well". The strategy identifies five key themes:

- people powered
- closer to home
- value and high performance
- one team
- smart system.

Our direction is further guided by a range of population or condition specific strategies, including: He Korowai Oranga (Māori Health Strategy); 'Ala Mo'ui (Pathways to Pacific Health and Wellbeing); Healthy Ageing Strategy; Rising to the Challenge (Mental Health and Addiction Service Development Plan); Disability Strategy; and the UN Convention on the Rights of People with Disabilities.

DHBs also commit to improving services through the System Level Measures Framework and addressing Government priorities as signalled in the Minister of Health's Letter of Expectation. In 2018/19 the overarching focus is on: 'increased priority for primary care, mental health, public delivery of health services, and a strong focus on improving equity in health outcomes.' Specifically, DHBs have been asked to:

- increase rate of organ donations
- improve health of infants, children and youth, particularly for Maori, Pacific people and people living in areas of high deprivation
- improving equity and reducing the burden caused by long term conditions, in particular diabetes
- respond to climate change in relation to health through medication and adaptation strategies.

Notwithstanding the strategic direction these various channels provide, the future structure, funding arrangements and government policy initiatives for the health sector are uncertain. The Review of New Zealand Health and Disability Sector will consider the way health services are structured, resourced and delivered (final report due Jan 2020); and the Government Inquiry into Mental Health and Addiction aims to identify unmet need and develop recommendations for improvement (report due October 2018).

The Alliance is engaging with both processes. The South Island's history of building strong relationships and working collaboratively (at times in advance of government requirements), means we are well positioned to respond to the reforms and initiatives that may result.

3.2 Regional Direction – South Island Alliance Strategy

Acknowledging the success the Alliance has had over the past six years, in the second half of 2017 the Alliance Leadership Team agreed that a clearer vision and strategic guidance was needed in order to accelerate health service improvement and regional collaboration.

Through a series of workshops and consultation across the Alliance, the South Island Alliance Strategy was developed. It describes how we want to operate collectively and broaden our engagement across the whole system to more actively address the social determinants of health.

This is reflected in the six priority focus areas identified in the Strategy. These will be our focus over the coming 1-2 years and were selected as they have the potential to significantly accelerate our progress towards improving outcomes for South Island communities.

South Island Alliance Strategy

A connected and equitable South Island health and social system that supports all people to be well and healthy

STRATEGIC GOALS:

- We contribute to environments that support people to be healthy and well
- We design services with our people, and those services are primary care and / or community based unless they need to be in a hospital
- Our services empower people to take charge of their own health and wellbeing, and die with dignity
- We release hospital based clinicians' time to both support community based care, and ensure people receive timely and appropriate complex care

PRINCIPLES:

A TRUST BASED SYSTEM:

- We acknowledge our responsibilities under the Treaty of Waitangi and prioritise hauora Māori and working in partnership with iwi
- We work in an environment of trust, strong relationships, interdependence and shared purpose

AN INCLUSIVE, DEVELOPMENT BASED SYSTEM:

- We build capability and value the health skills of all people
- We design services that embrace the whole health and social sector locally. This is supported by sub-regional and regional frameworks or platforms as appropriate

AN ADAPTIVE, LEARNING SYSTEM:

- We actively encourage learning from each other
- We focus on opportunities to continuously improve the quality of our work and services
- Our decision making is informed by high quality data and analysis

A SUSTAINABLE, EFFICIENT, EFFECTIVE SYSTEM:

- We develop services that are clinically, financially and environmentally sustainable
- We value peoples' time
- The whole system feels seamless to those within it and using it
- We ensure effective utilisation of all our resources
- We eliminate system design flaws that result in harm and minimise harm to the patient as they receive services

OUTCOME FOCUSSED:

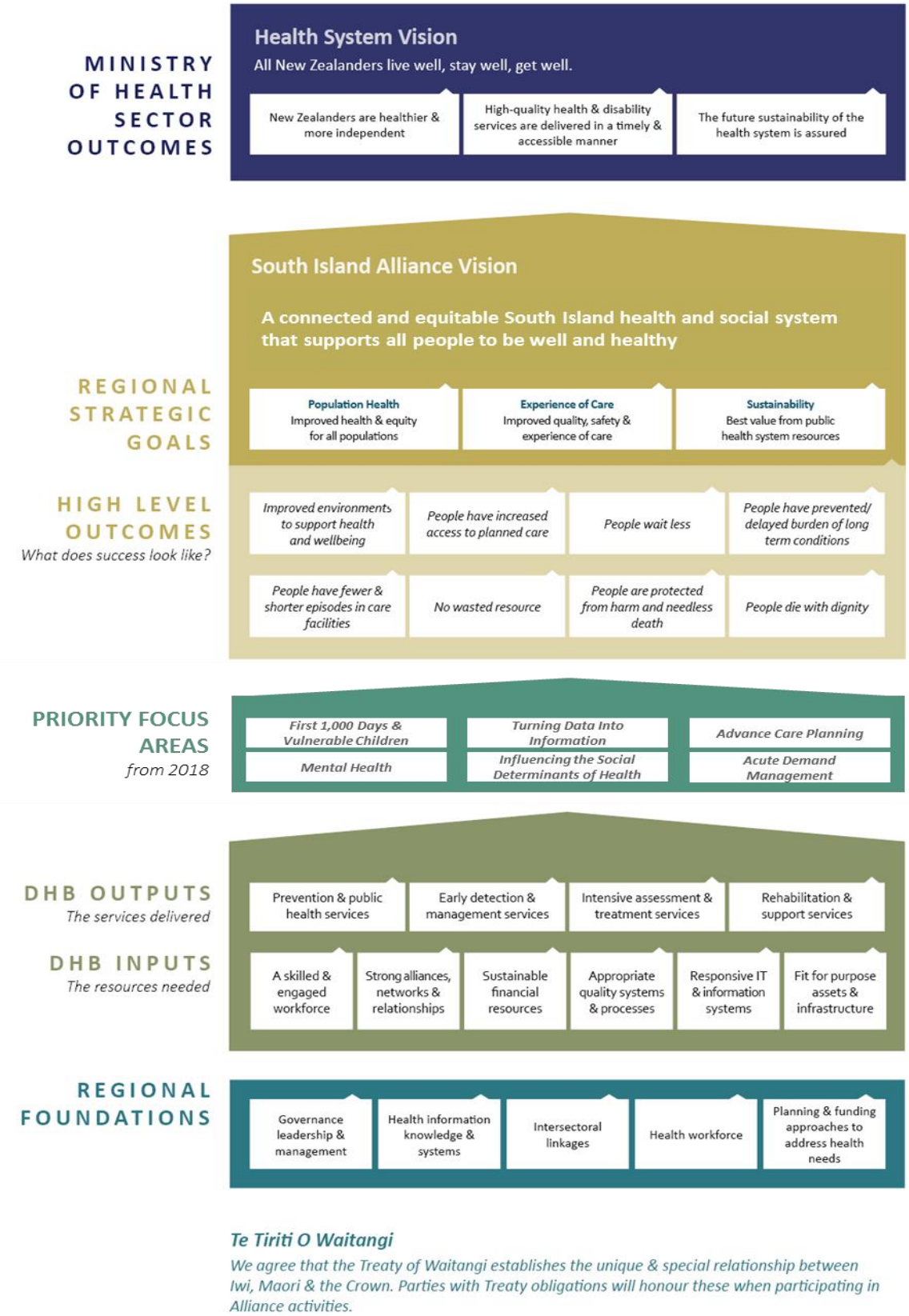
- We target equitable outcomes for all regardless of their culture, background or circumstances
- We commit to common outcomes but support service delivery configured to the needs of the local community
- We remove barriers to integration

PRIORITY FOCUS AREAS (1-2 YEARS):

- Turning data into information that supports decision making
- Understanding and influencing the social determinants of health
- First 1,000 days and vulnerable children – supporting the best possible start in life
- Developing mental health aspects of integrated systems of care across the health, education and social spectrum
- Acute Demand Management Platform - enabling primary care-led acute admission avoidance
- Embedding and utilisation of Advance Care Plans across the whole system

3.3 South Island strategic alignment

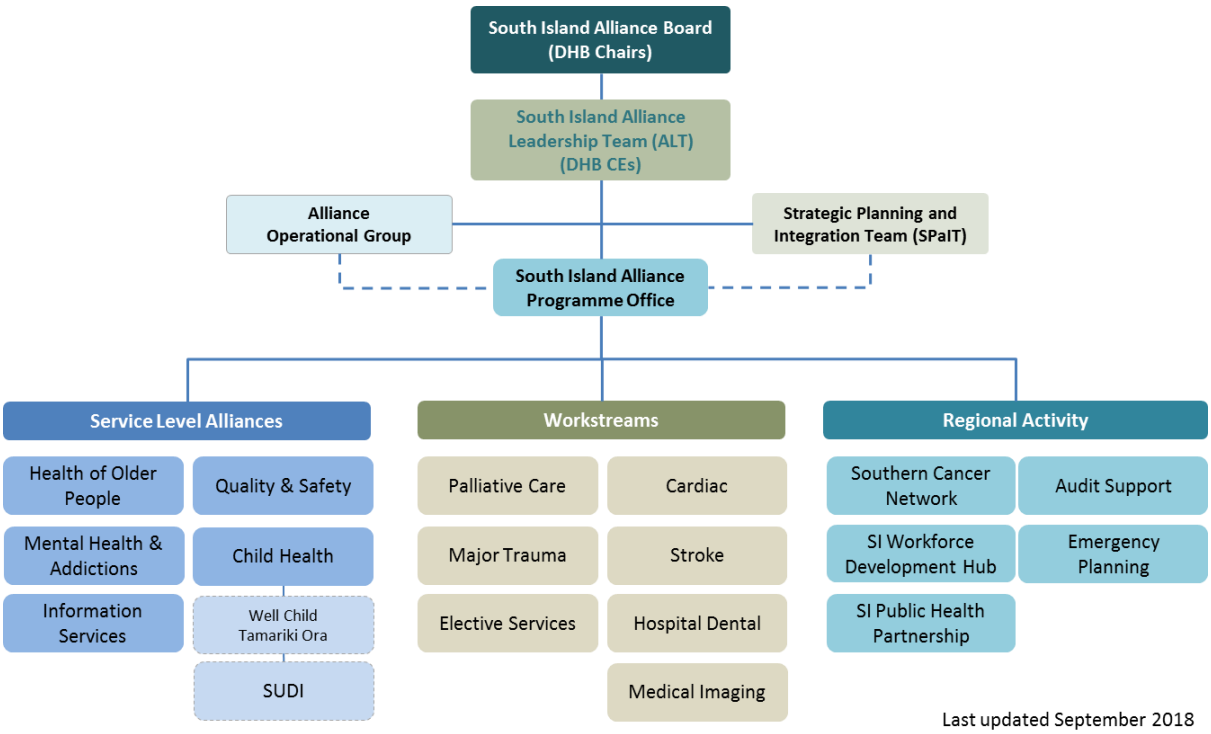
Linking local, regional and national direction outlined in this section, the strategic alignment of the South Island Alliance is described through the following intervention logic.



4 DELIVERING OUR VISION

In light of the South Island Alliance Strategy and the increasing number and complexity of our programmes, we are reviewing our structures and processes to ensure decision making is occurring in the right place, with the right people involved and with a streamlined path to implementation identified.

4.1 South Island Alliance organisational structure



Last updated September 2018

4.2 Our regional governance and leadership structure

The South Island Alliance drives South Island health system collaboration through:

- Alliance Board (South Island DHB board chairs of four DHBs and commissioner of one DHB) that enables the strategic focus, and oversees, governs, and monitors overall performance of the Alliance
- Alliance Leadership Team (the South Island DHB CEOs) that prioritises activity, allocates resources (including funding and support) and monitors deliverables
- Regional Capital Committee (Alliance Board and Alliance Leadership Team) that reviews capital investment proposals in accordance with the agreed regional service strategy and planning
- Strategic Planning and Integration Team (multi-disciplinary group clinical leaders spanning primary care, public health, medical, nursing, allied health, Māori health as well as planning and funding) that supports a whole of system approach, ensuring activities align with regional and national priorities and address the South Island Alliance Strategy
- South Island Alliance Operational Group (SIAOG) provides operational oversight, intelligence, and decision-making (including resource allocation). The recently formalised group is made up of South Island general managers planning and funding, operational hospital managers, and a representative from each of the chief medical officer, director of nursing and director of allied health groups (due to the impracticality of having a meeting with all South Island professional leads present, the representative is expected to provide a strong link and feedback mechanism to the their respective professional leadership group, which also meets regularly).

4.3 Service level alliances and workstreams

Service level alliances and workstreams define and deliver their workplans, and provide overarching programme and project governance. They draw on wide representation from across the region and the health system, including health professionals, managers, funders, health care providers and consumers.

Each service level alliance and workstreams is clinically-led and has a DHB chief executive or senior executive sponsor. Sponsors support the group, where necessary help manage risks and provide a point of escalation for the resolution of issues.

Further information about South Island Alliance decision making processes and principles, escalation pathway and regional funding model are available in Appendix 2.

4.4 South Island Alliance Programme Office

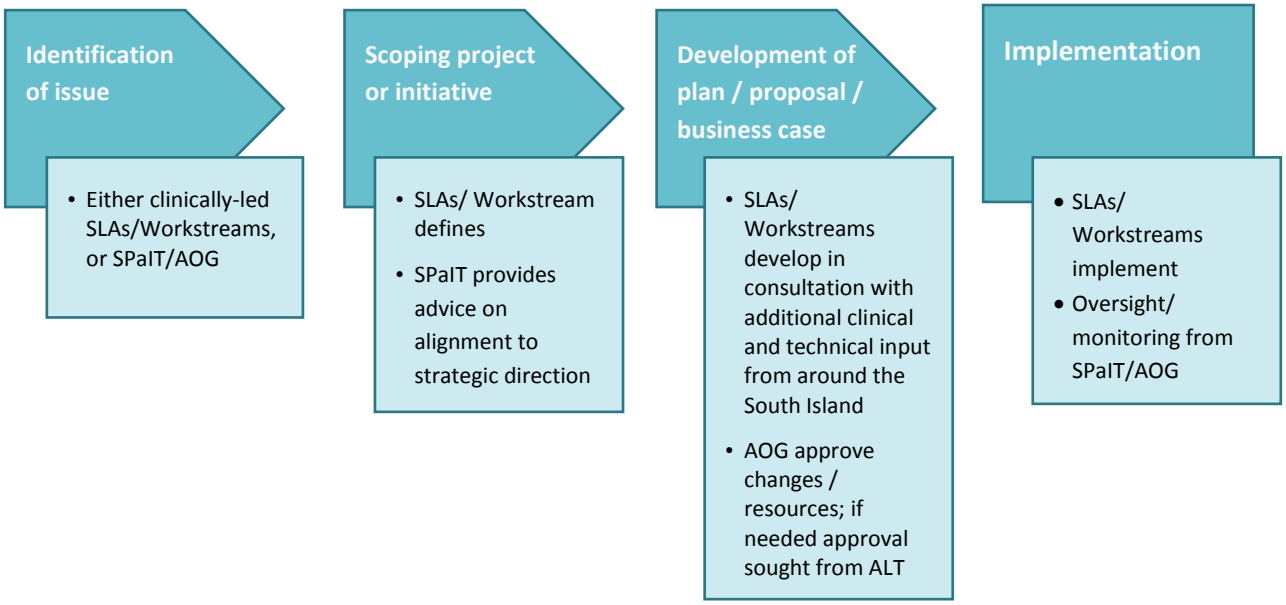
The South Island Alliance Programme office is a hub providing support and facilitating Alliance activities. It spans a broad range of activities, including project managing implementation of discrete initiatives, programme management, and secretariat support to the service level alliances and workstreams. The Programme Office is hosted by Canterbury DHB as a standalone business unit on behalf of the five South Island DHBs.

4.5 Clinical leadership

The participation and leadership of clinical health professionals from across the health system and health disciplines is integral to all Alliance decision making.

Clinical leaders, in conjunction with senior managers, have driven the South Island approach to collaboration, developed the South Island Alliance Strategy, and determined the priority focus areas for the region. As members of Alliance leadership groups, clinical leaders make decisions on all stages of regional initiatives from confirming the scope to final implementation, including decisions around resource allocation. As both chairs and members of our service level alliances and workstreams, clinical leaders define workplans and are accountable for implementing them (see further detail in 4.1, 4.2, 4.3 above).

While noting there is variance in the way in which regional initiatives develop, the typical course of a project would involve or be driven by clinical leaders in the following ways:



The Alliance is conscious of our responsibility to develop clinical leadership, and supports regular rotation of group membership in order to foster emerging leaders and bring new ideas to the group. Each group is required to consider its skill mix, with the clear expectation that a broad range of disciplines is reflected.

The Alliance has identified that our engagement with primary care needs to be stronger and areas where we can improve will be identified over the coming months. One specific action that has already been identified is to link with South Island local alliances with a view to building a network that can pursue information sharing and quality improvement initiatives.

4.6 Managing our risk

The South Island DHBs have strengthened their ability to manage and mitigate risk through their increased regional approach to health service planning and delivery. Increasingly the South Island acknowledges that what affects one, impacts all. Enhanced relationships, greater collaboration and having regional systems and processes in place all help to better manage the issues and challenges the South Island health system experiences locally and regionally.

4.5.1 Risks and challenges to South Island health system

South Island demographics and population shifts

The South Island has an older population than the rest of New Zealand, and consequently an older workforce, which will challenge the way health services are provided in the future. Alongside these macro level demographic changes, shifts in population location will also impact on health service provision in the medium to long term. While total population growth is slightly lower in the South Island than other regions, there is significant internal population movement, resulting in pockets of high population growth such as in Selwyn, Queenstown-Lakes, Waimakariri, Ashburton and Tasman. The districts of Selwyn, Queenstown Lakes and Waimakariri are three of New Zealand's five fastest growing districts.

Addressing how and what services to provide in areas that did not previously have a significant population base, along with the necessary investment in health infrastructure, will be a significant challenge for the South Island in the medium to long term.

Vulnerable and small services

The South Island has a number of health services that are vulnerable due to difficulty to attract and recruit staff, current service provision being unsustainable, or low numbers of patients. Developing sustainable models of care needs to balance demand for services, workforce issues, quality of care, and competing priority for health resources, as well as community views on access to services and the drive to keep services closer to home. The challenge of geographical spread and travel distance for patients to access appropriate health services is also a factor to be considered.

Earthquake recovery

Whilst the repair and redevelopment is gathering momentum, the capacity of the Canterbury health system will continue to be significantly influenced by ongoing factors for a number of years and includes: prolonged levels of stress; anxiety and poor living arrangements exacerbating chronic illness and increasing demand; and, shifts in population. Damage to health infrastructure was extensive and repair strategies are not simple.

The Kaikoura earthquake on 14 November 2016 has had further impact on Canterbury and also Nelson Marlborough. These communities require ongoing support to manage the aftermath of the earthquake. The psychosocial recovery needs of the communities will change over the coming months and years.

Financial sustainability

All South Island DHBs are experiencing significant financial constraint as they respond to increasing demands on health services, and rising workforce and other resource costs, within relatively static funding envelopes.

Hospital redevelopment

In addition to the significant construction work planned or underway across a number of Canterbury hospital sites and the Grey Base Hospital in Greymouth, there are a number of other major infrastructure projects planned, including the rebuild of Dunedin Hospital on a new site, and in the next 10 years it is expected Nelson and Timaru hospitals will also be redeveloped. Although not driven by natural disaster as in Canterbury, these hospital redevelopments will have similar significant financial and capacity consequences for a number of years.

The Alliance Board and Leadership Team are commencing a process to consider the whole of system model of care for the South Island, focusing on the challenges and opportunities that are being delivered by the current and proposed major infrastructure projects in the region.

5 SOUTH ISLAND HEALTH EQUITY AND MĀORI HEALTH

The South Island Alliance is committed to achieving equity of access and outcomes for the whole South Island population, with a particular focus on reducing health disparities for Māori. We also work to understand and address inequities that exist for other groups; due to geography or living in communities with higher deprivation.

While improving equity has always been a priority within our programmes, we are now working to be more explicit in ensuring equity is at the forefront of all our activities. All proposals and business cases need to explicitly assess the impact on equity, based on the consideration of the following questions (which will be used as part of planning processes and at the initiation of any new project):

1. What inequalities exist in relation to this priority area?
2. How did they occur?
3. What are we doing to tackle the issues/barriers?
4. How will the equitable outcome action/activity make a difference?

Through a range of channels, both quantitative and qualitative, there is increasing information available to assist in understanding ethnic and other disparities in access to services and outcomes. We acknowledge significant gaps remain in relation to the robustness of ethnicity data and experience of care. It is expected that ongoing work to improve how ethnicity is recorded and initiatives such as the Health Quality and Safety Commission's Patient Experience project will help to address these gaps.

5.1 Improving Māori health outcomes

We know Māori have lower access to health care and poorer health outcomes than the general population and at a local and regional level we are working to more clearly articulate and own this disparity so address it.

At a regional level, this is being supported through Te Herenga Hauora o te Waka-ā-Maui (South Island director/general manager Māori health leaders), the South Island Alliance Programme Office and various partnerships to ensure an equity focus is being applied to all regional programmes.

Ehara taku toa, he takitahi, he toa takitini

My success is not the success of an individual but the success of many

"By working together we can and will make a positive difference"

Te Herenga Hauora o te Waka-ā-Māui South Island DHB director/general manager Maori health leaders strategic workshop 2017

The attainment of Māori health equity and pae ora (a healthy future for our whānau) in Te Waipounamu is based upon seven key drivers:

1. Te Tiriti o Waitangi (1840) the founding document of our nation
2. He Korowai Oranga the National Māori Health Strategy (2014)
3. Equity of Health Care for Māori Framework (2014) and the Health Equity Tool (2008)
4. the size and composition of the Māori population in Te Waipounamu (110,400 South Islanders identify as Māori in 2018/19 population projections)
5. a disproportionately high health need for Māori within Te Waipounamu relative to non-Māori
6. a commitment across all five South Island DHBs to work towards Māori health equity
7. a commitment to build Iwi capacity to respond to their own health needs.

Te Herenga Hauora o te Waka-ā-Māui seeks to ensure that its regional work programme activity aligns to improving performance against national Māori health indicators, which are integrated into all South Island DHB annual plans.

Te Herenga Hauora o te Waka-ā-Māui provides advisory support to ensure initiatives developed by South Island service level alliances and workstreams are appropriate as well as effective for Māori. At a local level, it is important that such forums create a pathway to enable Māori health teams to be actively involved in all regional activities to ensure access and equitable health outcomes are achieved. As such, the responsibility to work towards Māori health equity is a shared responsibility. By working together, we can and will make a difference.

Key priorities for Te Herenga Hauora o te Waka-ā-Māui in 2018/19 will be workforce development (alongside South Island Workforce Development Hub), cancer services (alongside Southern Cancer Network), and mental health, particularly in light of the national review underway. The South Island Alliance Programme Office and Te Herenga Hauora o te Waka-ā-Māui are actively pursuing closer engagement and alignment to ensure that equity remains at the forefront of regional activities.

6 WHAT WE WILL DELIVER 2018-2021

Each Service Level Alliance and Workstream produces a workplan which outlines their intended deliverables for the coming year, with an indication of the direction of work in future years where possible. Progress in achieving the deliverables outlined in each workplan will be reported quarterly.

This year, two new workplans have been included in the South Island Health Services Plan 2018-21:

- **Hospital Oral Health Services** (page 40): initiated in late 2014 to develop a model of care for clinical and financially sustainable hospital dental services, enabling equity of access to hospital dental services across the South Island. As the group have become more formalised within the Alliance structure, their workplan has now been included in the South Island Health Services Plan 2018-21.
- **Telehealth** (page 53): in 2017 the South Island began work to develop a regional telehealth strategy. Although the Strategy is yet to be finalised, if it is approved, it is expected that a Governance group and a Delivery Interest Group will be established to progress implementation of the Strategy.

A **Medical Imaging** Workstream was also established in 2017. The Workstream will support medical diagnostic imaging services across the South Island to:

- collaborate and cooperate to achieve consistency and reduce unnecessary duplication of resources where possible
- agree regional and local service improvement initiatives aimed at delivering clinically effective and cost efficient services

As an enabler of other services and initiatives, the Workstream will also engage with other SLAs and regional workstreams to align service improvement and achieve shared outcomes.

The group, led by Dr Sharyn MacDonald, Chief of Radiology (Canterbury DHB) is still developing its workplan and topics that are currently being discussed as potential areas of work for the group are:

- Workforce: regional workforce and support for training?
- Pathways (consistent) consistent access for primary care across the SI.
- Guidelines (Consistent)
- Ultrasound solution (POCUS, point of care ultra sound)
- Fair and consistent triage/ consistency and transparency of approach.
- Value adding radiology (HP clinical Suit , decision support)
- Demand management (tumour streams, chest x rays)
- Continuous service improvement
- Develop a strategy for cost sharing for systems
- Health Pathways (hospital): Looking towards regional consistency in protocols.
- Regional sign off of orders (roll out)
- Improving access to southern/ connectivity/ visibility of reports

2018/19 Regional Service Plan Guidelines

Acknowledging the Ministry of Health 2018/19 Regional Service Plan Guidelines and the enabler lens applied to regional planning, Appendix 2 provides a reference to where in our workplans to find each of the enabler requirements.

Priority focus areas

The following table summarises progress in developing the six priority focus areas. Where activities have been confirmed they are included in the appropriate workplan.

PRIORITY FOCUS AREA	Direction of travel	Next steps
Social determinants **Lead Group:** Public Health Partnership	The current workplan largely aligns with this priority focus area: **Collective Impact and Partnerships**: **Hauora Alliance** • Developing project on the 'first 1000 days' to be completed by mid-2019 • Mapping the landscape and establishing shared goals and measures (key steps in enhancing agency buy-in to collective impact) **Facilitating a Health Promoting Health System** • Embedding a *Health in All Policies a*pproach in DHBs **SI PHU Strategic and Operational Alignment** • drinking water, community resilience and psycho-social wellbeing, alcohol harm reduction and healthy eating and active lifestyles	Continue to build momentum around Hauora Alliance Work across the SLAs/Workstreams to understand how their programmes of work can support social determinants of health
First 1000 Days **Lead Group:** Child Health SLA	Infant mental health (in conjunction with MHASLA) (new) Responding to the recommendations and action points identified in a South Island Violence Prevention Co-ordinators workshop held in 2017 (new) Strengthening healthy weight work by engaging with maternity and breastfeed services E-Prosafe data analysis Cross-SLA/Workstream approach required – Mental Health & Addictions SLA/Public Health Partnership will both be closely involved	Further definition of initiatives/resourcing for the new initiatives around infant mental health, and family violence Develop measures to track progress
Acute Demand Management **Lead Group:** TBC	SIAPO to arrange meeting of local alliances with a view to developing a network, initially to support acute demand management (this is expected to broaden) As a shorter term activity, a cooperative regional approach to winter planning is being undertaken	
Integrated mental health **Lead Group:** Mental Health & Addictions SLA	Parts of the current workplan support Awaiting further national direction from Inquiry into Mental Health and Addictions Services MHASLA is supporting activities in First 1000 Days and Social Determinants It is noted this is a large scale, wide scope piece of work which relies heavily on relationship management Local context means a one-size fits all approach will not be appropriate	Further consideration of how the region can support this priority will be given in light of the findings of the Inquiry in October 2018

Advance Care Planning **Lead Group:** Health of Older People SLA	South Island wide electronic ACP will available from June 2018 DHBs have developed and agreed to a South Island ACP Quality Check process via a virtual team to support embedding ACP use and quality improvement Work underway around HealthPathways/ HealthInfo to ensure consistent information is available	Consideration of what support is required to embed electronic ACP is ongoing
Data into information **Lead Group:** IS SLA	There has been a direction of travel agreement to focus on development of a shared regional data warehouse that will provide the South Island DHBs with access to operational, patient flow and forecasting capacity. Following consultation across the Alliance, it was agreed the scope of this will initially be limited to near real time and non-real time information as a starting baseline A proposal to develop a business case for a shared South Island data warehouse is being considered by the Alliance leadership groups It is expected this priority focus area will result in the development of a data governance group	Alliance to confirm in principle support for a shared data warehouse pending development of a robust business case, and how the work will be governed and managed

Cancer services

Reducing the burden of cancer

Lead CEO: **David Meates (Canterbury DHB)**

Chair: **Mr Todd Hore, General and Hepatopancreatobiliary Surgeon, CDHB**

Clinical Lead: **Dr Shaun Costello, Clinical Director SCN, Radiation Oncologist (Southern DHB)**

The Southern Cancer Network (SCN) has been formed to:

- Provide a framework that supports the linkages between the South Island DHBs, DHB specialist service providers, Non-Government Organisations (NGOs), Public Health Organisations (PHOs), and consumers.
- Coordinate implementation of government's priorities for cancer services across the South Island.
- Provide a formal structure that supports coordination of cancer improvement work across the South Island population programmes for prevention and screening and the quality of treatment.

Four key focus areas set the direction of this work plan:

- Timeliness of services across the whole cancer pathway
- South Island Cancer Service Coordination and Quality Improvement
- South Island Cancer Service reducing inequity: reducing inequity is an underlying driver within the SCN workplan. SCN is collaborating with all five South Island DHBs on three equity-focussed improvement areas relating to faster cancer treatment:
  - maintaining focus on timeliness throughout inter-departmental and/or inter-DHB referral processes
  - impact of diagnostics pathways on timeliness of cancer treatment,
  - capacity/process constraint.

  Planned actions on this are outlined throughout our workplan, but already implemented between two DHBs are specific changes that have led to service improvements, where emails are now being sent to MDM coordinators that show how far along the inter-district patients are on the 62-day pathway .
- Clinical Information Systems supporting a single system of cancer care for the South Island

SOUTHEN CANCER NETWORK				
	DELIVERABLES		FUTURE WORK	RESPONSIBILITY
	Faster Cancer Treatment			
	Equity of access to timely diagnosis and treatment services for all patients on the FCT pathway			
1	Support DHBs to deliver the FCT target including systematic approach to monitoring and acting on 62 day pathway breaches. This will include: • Quarterly reporting to DHBs with process mapping to understand where breaches are occurring (by ethnicity, cancer site, treatment modality, IDF) • Alongside this, further work will be undertaken to develop South Island dashboards (refer Item 16) • Initiatives stemming from the Routes to Diagnosis FCT project will contribute to achieving the target (refer Item 14) • A pilot project to minimise breaches of the 62 day target among Māori (supported by Te Waipounamu Māori Leadership Group)	Q1,2,3,4	Support DHBs to deliver the FCT target including systematic approach to monitoring and acting on 62 day pathway breaches.	SCN
2	Support clinical staff to gain visibility of cancer patients on both, 62-day and 31-day FCT pathways. This will include the development of a business case for the implementation of an FCT indicator on patients' records	Q1,2,3,4	Support clinical staff to gain visibility of cancer patients on both, 62-day and 31-day FCT pathways. This will include the implementation of an FCT indicator on patients' records, subject to business case approval	SCN

3	Continue to support performance against the 31 day Indicator: *proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment within 31 days (85% for PP30 31 day indicator)*	Q1,2,3,4	Continue to support performance against the 31 day Indicator: *proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment within 31 days (85% for PP30 31 day indicator)*	SCN
Regional Cancer Pathways				
Comparable, timely cancer pathways for the South Island				
4	Comparable, timely cancer pathways for the South Island to support improved equity of access and outcomes for all patients across the South Island. This will be supported by FCT initiatives, and the further roll out of MOSAIQ and SIMMS to support consistency of cancer patients' journeys, irrespective of location or ethnicity.	Q1,2,3,4	Comparable, timely cancer pathways for the South Island to support improved equity of access and outcomes for all patients across the South Island	SCN
5	Undertake implementation of Oncology patient management and treatment system MOSAIQ in CDHB and fully implement in NMDHB	Q1,2,3,4	Complete implementation of Oncology patient management and treatment system MOSAIQ in CDHB and fully implement in NMDHB	SCN
6	Undertake an annual assessment of the Cancer Clinical & Service Priorities, by the South Island/SCN Cancer Clinical Leads Group, with a focus on understanding and addressing disparities, including for Māori (the group meets six monthly)	Q2	Undertake an annual assessment of the Cancer Clinical & Service Priorities, through the South Island/SCN Cancer Clinical Leads Group, with a focus on understanding and addressing disparities, including for Māori	SCN
7	Supporting DHBs in preparation for and implementation of the national bowel screening programme – focus on services to support the delivery of additional cancer cases.	Q1,2,3,4	Supporting DHBs in preparation for and implementation of the national bowel screening programme – focus on services to support the delivery of additional cancer cases.	SCN
8	Support DHBs with the implementation of the Early Lung Cancer Guidance, once published to support improved equity of access and outcomes for all patients across the South Island.	Q1,2,3,4		SCN
South Island Cancer service coordination and quality improvement				
People have access to services that maintain good health and independence and receive excellent services wherever they are. Services make the best use of available resources				
9	Further implementation, and development for the SI MDM System (SIMMS), including support for South Island alignment of tumour specific work; long term planning for SIMMS resourcing and future requirements; and develop local and regional reporting from SIMMS;	Q1,2,3,4	Further implementation, and development for the SI MDM System (SIMMS), including support for South Island alignment of tumour specific work; long term planning for SIMMS resourcing and future requirements; and develop local and regional reporting from SIMMS;	SCN

Survivorship				
Supporting health adaptation to cancer treatment, recovery and rehabilitation				
10	Explore options for an end of treatment regional service initiative to improve quality of life for people who have recently completed cancer treatment. This will include engagement with stakeholders, drawing on existing evidence, with a view to developing a trial initiative	Q1,2,3,4	Subject to agreement, implement options for an end of treatment regional service initiative to improve quality of life for people who have recently completed cancer treatment. This will include engagement with stakeholders, drawing on existing evidence, with a view to developing a trial initiative	SCN
South Island-wide Radiation Oncology Services				
Improving consistency and reducing variation in care across the South Island				
11	Support implementation of the National Radiation Oncology Plan through reviewing and evaluating heterogeneity of practice within radiation oncology, and implementing strategies to reduce variation and maximise available capacity.	Q1,2,3,4	Support implementation of the National Radiation Oncology Plan through reviewing and evaluating heterogeneity of practice within radiation oncology, and implementing strategies to reduce variation and maximise available capacity.	SCN
South Island cancer service reducing inequities				
People have access to services that maintain good health and independence and receive excellent services wherever they are. Services make the best use of available resources. Initiatives reduce inequities and support access to cancer services				
12	An equity assessment framework is confirmed and applied across the development of new regional initiatives, with a particular focus on Māori and Pacific	Q1,2,3,4	An equity assessment framework is confirmed and applied across the development of new regional initiatives.	SCN
13	Support the collaborative regional working of both Te Waipounamu Māori Leadership Group (TWMLG) and South Island Cancer Consumer Group (SICCG) and integrate as co-partners into the regional plan implementation.	Q1,2,3,4	Support the collaborative regional working of both TWMLGC and SICCG and integrate as co-partners into the regional plan implementation.	
14	Utilise the findings from the 2017/18 Routes to Diagnosis FCT project to target improved access to detection, diagnosis and treatment for high needs and high risk patient groups, particularly Māori. This will generally focus on supporting earlier diagnosis, and will involve engaging with DHBs to understand the findings, identifying opportunities and supporting them to implement actions.	Q1,2,3,4	Utilise the findings from the 2017/18 Routes to Diagnosis FCT project to target improved access to detection, diagnosis and treatment for high needs and high risk patient groups.	
South Island cancer intelligence service				
Ready access to timely, accurate and appropriate cancer data, information & intelligence across the South Island for all Stakeholders				
15	Develop a plan to support and implement the NZ Cancer Health Information Strategy across the South Island (note – content still to be finalised, waiting on MOH guidance).	Q1,2,3,4		SCN
16	Further develop quarterly South Island Cancer Dashboard to understand progress against cancer standards and targets, and report and track service improvement initiatives and progress on reducing inequities.	Q1,2,3,4	Ongoing development of quarterly South Island Cancer Dashboard to understand progress against cancer standards and targets, and report and track service improvement initiatives.	SCN

South Island Cancer Strategy – Cancer in 2025				
17	Support DHBs in their implementation of the prostate cancer decision support tool in the South Island to improve the referral pathway across primary and secondary services	Q1,2,3,4		SCN
18	Undertake stocktake of cancer services regional clinical leadership arrangements across the South Island with recommendations for improvement. The SCN Cancer Clinical Leads group will oversee this process and will implement actions to further enhance clinical leadership roles as appropriate.	Q2,4		SCN
19	Support for the Psychosocial and Supportive Care Initiative across the South Island.	Q2,4		SCN

Cardiac Services

South Island people enjoy quality of life and are prevented from dying prematurely from heart disease.

Lead CEO: **David Meates (Canterbury DHB)**

Clinical Lead: **Dr John Edmond, Cardiologist & Clinical Director of Cardiology (Southern DHB)**

The Cardiac Services Workstream has been formed to provide regional leadership across the South Island Cardiac continuum of care through:

- A supported and planned approach of coordination and collaboration across the delivery of service.
- Reducing inequalities in access to cardiology services across the South Island.
- Enhancing the quality of cardiac health services across the South Island.
- Utilising common referral, prioritisation and condition management tools.
- Ensuring the sustainable management of cardiac services in the South Island.

Equity in Cardiac Services: The Workstream supports the New Zealand Cardiac Network's intention to develop and implement a whole of system approach to cardiovascular care across the health continuum, with a focus on improving equity of cardiovascular care and outcomes for all New Zealanders. The Workstream's South Island Cardiac Model of Care Plan will identify actions within pathways, data collection, workforce development and access to services to monitor and improve equity.

An initial ethnicity summary for South Island ACS patients recorded on ANZACS QI Registry has been prepared and reported and will be added to during 2018/19.

Four key focus areas set the direction of this work plan:

- South Island Model of Care. Articulated in the South Island Sustainable Cardiac Services Plan, the model involves three key components: service quality and improvement; preparing for increasing demand and managing people in the community. At this stage, the Workstreams main focus is on the first two components, with these activities being reflected throughout the workplan below.
- Pathways for cardiac services across the region
- Workforce development
- Support to national initiatives

CARDIAC SERVICES WORKSTRAM				
	DELIVERABLES		FUTURE WORK	RESPONSIBILITY
South Island Cardiac Model of Care Plan				
Implementation of the plan to provide a consistent approach to cardiac services across the region				
1	Implementation strategy for South Island Cardiac Model of Care agreed and actioned (a key outcome of this model is to understand and address any inequities across all communities in the South Island).	Q1		Cardiac Workstream
Model of Care (work already underway or anticipated)				
Providing a consistent approach to cardiac services across the region				
2a	Implement and audit National Guidelines including the Echo Appropriateness Guidelines, 2017 and the Trans Catheter Aortic Valve Implementation (TAVI) Guidelines, May 2017	Q3		Cardiac Workstream
2b	Build on Heart Failure initiatives as identified in the regional stocktake 2017	Q4		Cardiac Workstream
2c	Support DHBs to improve access to cardiac tests	Q4		Cardiac Workstream

2d	Update Minimum Guidelines paper	Q1		Cardiac Workstream
2e	Audit of Cardiac Tests Repository Programme (ECG Project)	Q3		Cardiac Workstream
	Pathways for cardiac services across the region			
	Utilisation of Pathways in cardiac services to improve efficiency through consistent approach of regional and national models			
3a	Agreement and implementation of out of hospital STEMI pathways to ensure a consistent approach across the region, in conjunction with St John	Q2		Cardiac Workstream
3b	Adoption of St John guidelines for transporting patients consistent with out of hospital STEMI pathways	Q2		Cardiac Workstream St John
3c	Clinical HealthPathways on line and accessed across the primary, secondary and tertiary sector	Q3		Cardiac Workstream
	Workforce development, particularly in echocardiography and physiology			
	Increase in personnel resources to meet demand			
4	Work with SI Workforce Development Hub to confirm the current workforce across the SI as it relates to cardiac care and services, identify gaps, and make recommendations for what it would take for the SI to achieve workforce sustainability.	Q1,2,3,4		Cardiac Workstream SIWDH
	Support to national initiatives			
5	Assist national plans including supporting echocardiography and the value of frailty scoring	Q1,2,3,4		Cardiac Workstream
	MONITORING / BUSINESS AS USUAL ACTIVITIES			
6a	The Accelerated Chest Pain pathway will be reviewed/audited, which will include gaining an understanding of how Māori, Pacific and rural people are using the pathway.	Q1,2,3,4		Cardiac Workstream
6b	Provide quarterly reporting at regional and DHB level utilising the ANZACS-QI and Cardiac Surgery registers. Support to DHBs to meet the following intervention rates for cardiac surgery, coronary angiography, and percutaneous revascularisation. Cardiology Services • Acute- 70% of Acute Coronary Syndrome patients will receive an angiogram within 3 days of admission • Acute - 95% of the ANZACSQI data on ACS patients who have an angiogram will be entered within 30 days • Acute – 85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF • Acute – 85% of ACS patients who undergo coronary angiogram are prescribed at discharge appropriate medication • Elective - Patients to wait no longer than 4 months for a Cardiology FSA • Elective + Acute -SIR coronary angiography of at least 34.7 per 10,000 population • Elective + Acute - SIR percutaneous revascularisation of at least 12.5 per 10,000 population Cardiac-Thoracic Services • Elective - 95% of DENDRITE data on patients who have cardiac surgery will be entered within 30 days of discharge • Elective - Patients to wait no longer than 4 months for a Cardio-thoracic FSA • Elective - Report the proportion of patients scored using the national cardiac surgery Clinical Priority Access tool (CPAC) • Elective - Report the proportion of cardio-thoracic patients treated within assigned CPAC urgency timeframes	Q1,2,3,4		Cardiac Workstream

	• Elective - The cardio-thoracic waitlist must remain between 5 and 7.5% of planned annual throughput, and must not exceed 10% of annual throughput • Elective + Acute - SIR of 6.5 per 10,000 population			
6c	Identify service improvements from the visibility of data, including analysis of and acting on matters of equity	Q1,2,3,4		Cardiac Workstream
6d	Continue to work with and support regional cardiac clinical networks, cardiothoracic surgical units, the New Zealand Cardiac Network, and the New Zealand Cardiac Surgery Clinical Network	Q1,2,3,4		Cardiac Workstream

Child Health Services

Working together to improve the health outcomes for children and their families living in the South Island

Lead CEO: **Chris Fleming (Southern DHB)**

Clinical Lead: **Dr Clare Doocey Paediatrician (Canterbury DHB)**

The Child Health SLA (CHSLA) has been formed to improve the health outcomes for children and young people of the South Island through:

- Transforming healthcare services, supporting clinical decision making and the shifting of activities closer to home and communities that children and young people live in.
- Working in partnership and linking with national, regional and local teams/groups to make (and assist the South Island DHBs to make) strategic health care decisions using a 'whole-of-system' approach.
- Supporting collaboration and integration across the South Island DHBs (primary, secondary and tertiary interfaces) and inter-sectorial groups/organisations (education, social welfare) to make the best of health resources.
- Balancing a focus on the highest priority needs areas in our communities, while ensuring appropriate care across all our populations.
- Establishing working groups to advise on and guide the development, delivery and monitoring of new initiatives across South Island children and young people's health services.

Five key focus areas set the direction of this work plan:

- First 1000 days and vulnerable Children
- Type 1 Diabetes
- South Island Regional Obesity Management Programme
- Consumer Consultation

CHILD HEALTH SLA				
	DELIVERABLES		**FUTURE WORK**	**RESPONSIBILITY**
First 1,000 days				
Giving all children the best possible start in life				
1a	Working with SI Public Health Partnership and the SI Mental Health and Addictions SLA to improve the mental health outcomes for infants and their mothers.	Q		SI CH SLA SI MH&A SLA PHP
1b	Support the SI DHBs to understand and respond to information reported from e-Prosafe to inform future work to vulnerable families.	Q		SI CH SLA
1c	Working with providers from across the health, education and social sectors understand how best to work together to better manage the safety of vulnerable children and reduce family whanau violence			SI CH SLA
Reduce incidence of SUDI to 0.1 per 1000 babies born by 2025.				
2	Work with the wider maternity and any other relevant services to continue to reduce Sudden and Unexpected Death in Infants in the South Island with particular emphasis on Maori and Pacific populations.	Q		SI CH SLA MoH Regional SUDI prevention programme

Type 1 Diabetes Mellitus				
Improve the service provision in the South Island for paediatric and adolescent Diabetes Mellitus				
3	Support the SI Diabetes Working Group to implement the areas of work identified in their workplan. This would include understanding of the current delivery of services and resources to Type 1 Diabetic consumers.	Q		SI CH SLA tbd
South Island Regional Obesity Management Programme				
Develop and implement a childhood healthy weight programme				
4	Continue to develop and implement the South island Childhood Healthy Weight Programme to provide a more consistent approach to child weight (obesity) prevention and treatment across the South Island. This includes tailoring programmes to Maori and Pacific populations.	Q		SI CH SLA
5	Make wider use of South Island Regional Electronic Growth chart to, for example, Lead Maternity Carers, WCTO, Plunket	Q		SI CH SLA
The Child's Experience as a Consumer				
Acquire learnings about children's experience of hospital in the New Zealand setting				
7	Identify what consumers really want from the Child Health Services in the SI and record how the consumer and their whanau experience the service	Q		SI CH SLA
MONITORING / BUSINESS AS USUAL ACTIVITIES				
8	South Island Child Health HealthPathways	Q1,3		SI CH SLA tbd

Elective Services

Sustainable, equitable elective services for South Islanders

Sponsor: **General Managers Planning and Funding, Chief Medical Officers, Operational General Managers (South Island DHBs)**

The South Island Alliance Elective Services Workstream is overseen by GMs Planning & Funding, Chief Medical Officers and Operational GMs, while each area of focus is supported by a work group that is clinically led. The Elective Services Workstream will:

- Explore elective service delivery across the South Island focussing on:
- Population need and projections
- Options to support clinically and financially sustainable service delivery into the future
- Workforce and other health system enablers (noting that workforce requirements are considered and projected at a regional level, but it remains the responsibility of individual DHBs to manage workforce planning and capacity)
- Take a health system approach, and analyse secondary and tertiary referral elective services (variability of delivery, capacity, capability, sustainability)
- Prioritise services for attention to future configuration and delivery of elective health services across the South Island, using clinical and management tools such as HealthPathways, consistent systems and processes

Equity in Elective Services: Improving equity of access and outcomes for all South Island people is fundamental to all activities of the Elective Services Workstream. Where possible, ethnic, geographic and deprivation disparities are identified as part of understanding and forecasting South Island needs. Models of care and pathways are developed that are patient-centred and work to address any inequities.

The key focus area to set the direction of this work plan:

- Access to services
- Clinical leadership supporting regional consistency
- Colonoscopy services
- Vulnerable services

ELECTIVE SERVICES WORKSTREAM				
	DELIVERABLES		FUTURE WORK	RESPONSIBILITY
	Access to Elective Services			
1	Work with SI DHBs to improve equity of access, health system quality and practice in selected service areas, utilising data and evidence to inform service change. Improving equity is the overarching approach to all Workstream activities.	Q1,2,3,4		SIAPO DHBs
2	Support South Island DHB management of regional electives volumes (if included in Letter of Expectations)	Q1,2,3,4		SIAPO DHBs
	Clinical Leadership supporting Regional Consistency			
3	Implement the nationally agreed Vascular Services model of care in the South Island	Q2,4		SIAPO DHBs
4	We acknowledge that there is work anticipated in 2018/19 relating to improving access, and consistency of access, to plastics and reconstructive services, including breast reconstruction.	Q2, 4		SIAPO DHBs

	We will engage with the national service improvement programme as actions are developed and support regional implementation as required.			
5	Share innovations and lessons to achieve consistent Ophthalmology pathways for Age-Related Macular Degeneration and Glaucoma across South Island DHBs, reducing variations in patterns of care and improving health equity	Q2, 4		SIAPO DHBs
6	Explore the option of South Island DHBs adopting consistent evidence-based early intervention programmes to support patients in the community prior to surgical intervention, for example, Mobility Action Plan	Q3		SIAPO DHBs
Colonoscopy				
7	Support South Island DHBs to meet Colonoscopy Waiting Times Indicators	Q2,4		SIAPO DHBs
Vulnerable Services				
8a,b,c	Orthopaedics: (with SIWDH) • Review current orthopaedic workforce resources, including subspecialty capability, future requirements to meet demand, gap analysis • Develop regional implementation plan (to be confirmed) • Identify progress against implementation plan milestones	Q2 Q2 Q4		SIAPO/SIWDH (regional review) DHBs (implementation)
9	Work with SI DHBs to plan and implement sustainable vulnerable services, including workforce e.g. Maxillofacial, Dermatology, ICU	Q4		

National and regional projects supported by the SLA/Workstream but led by other SLAs/Workstreams or individual DHBs

Deliverable: *Improve access to elective Services – delivery against agreed volume schedule, including elective surgical discharges, to deliver the Electives Health Target*
Owner: Individual South Island DHBs
Reported: Individually by the South Island DHBs quarterly

Deliverable: *Maintain reduced waiting times for elective first specialist assessment and treatment*
Elective Services Patient Flow Indicators expectations are met, and patients wait no longer than four months for first specialist assessment
Owner: Individual South Island DHBs
Reported: Individually by the South Island DHBs quarterly

Deliverable: *National Patient Flow*
Regional collaboration to support improved data quality
Owner: Individual South Island DHBs
Reported: Individually by the South Island DHBs

Health of Older People Services

Best healthcare for older people everywhere in the South Island

Lead CEO: **Chris Fleming (Southern DHB)**

Clinical Lead: **Dr Val Fletcher (Canterbury DHB)**

The Health of Older People SLA (HOPSLA) has been formed to lead the development of health and support services for older people across the South Island through:

- Developing sustainable models of care and systems for the delivery of quality health services for older people.
- Providing expertise and guidance around delivery of service to the South Island population over 65 (to those close in age and need).

Five key focus areas set the direction of this work plan:

- Dementia
- Comprehensive Clinical Assessment (InterRAI)
- Restorative Model of Care
- Advance Care Planning
- Delirium

HEALTH OF OLDER PEOPLE SLA				
	DELIVERABLES		FUTURE WORK	RESPONSIBILITY
	Dementia			
	Embed the Dementia Model of Care, which supports the NZ Dementia Framework, to deliver equity across culture, minority groups and geography			

1	Support progress of NZ Dementia Framework. The regional approach to implementing the Framework is articulated in the South Island Dementia Model of Care
	
	The focus for 2018/19 will be:
	• Embed the South Island Dementia Model of Care, including socialising the model of care with the wider health sector and supporting implementation.
	• Support implementation of navigation approach. In particular this will involve activities including:
	  ○ support to South Island dementia initiatives meetings
	  ○ mapping the role of the navigator, where it fits in the system and what dementia services are available
	  ○ describing this on health pathways
	  ○ amending IT systems so that dementia care plan signals who is navigator.
	• Streamline and enhance the South Island Cognitive Impairment pathways with regard to navigation role.
		Q1,2,3,4	Embedding the South Island Model of Care, incorporating supporting implementation NZ Dementia Framework, is a long-term process. Over subsequent years (or as resources allow) the following projects will be progressed:
			• Support primary care to further embed best practise dementia care in primary care by increasing awareness of the importance of diagnosis and long term management plan.
			• Support South Island DHBs to improve Dementia care partner support in localities, with a focus on rural person with dementia and Māori person with dementia.
			• Improve equity of access and outcomes for people with dementia from vulnerable populations. This will be achieved through support for South Island DHBs to consider action in key areas of dementia services health navigation where there is inequitable access to dementia services, including Māori, Pacific Island people, Asian people, refugees, people with pre-existing intellectual disability, people with other long term neurological illness or long term medical condition, people living rurally, and people with early onset dementia.
			• Support SI DHBs to progress integrated primary, community and specialist health and social care systems understanding the dementia syndrome and having skills in person-centred care planning and work seamlessly to be able to meet the needs of people with dementia and their family / whānau / carers, so they are well supported at the end of their life.
				HOPSLA & DHBs

interRAI				
Proactively use the information from comprehensive clinical assessment (interRAI) in care planning and in service development				
2	Encourage collaboration across DHBs and promote South Island health professions to use the information from comprehensive clinical assessment (interRAI) proactively in the planning of care and in service development.	Q1,2,3	ongoing	HOPSLA, DHBs, PHO
3	Monitor interRAI reports to identify trends including any trends or differences that may exist between Māori and non- Māori	Q1,2,3,4	ongoing	HOPSLA
Restorative Care				
Listen to older people and support them to be independent, care for themselves and participate within their community, family and whānau for as long as possible				
4	Support MOH work to embed provision of restorative care in home based support.	Q1,3	TBC	TBC
5	Raise awareness of Person Centred (Restorative Care) across the SI continuum of care	Q1,3	Repeat the SI Restorative Care Stocktake in Q1 2019-20	HOPSLA, DHBs, PHO
Advance Care Planning				
People who live in South Island (and New Zealand) experience Advance Care Plan (ACP) enriched lives & deaths, having their values underpin their care and receive care in the place & manner they prefer				
6	Support SI DHBs to develop broadly consistent ACP system implementation with processes to embed electronic ACP (across the continuum of providers) as standard practice for those who will benefit. This includes: – Develop the Regional Quality Verification Process with clinicians from each SI DHB participating – Provide support for SI DHBs to develop local change management – Support each SI DHB to finalise their ACP Health Pathway.	Q1,3	It is expected that embedding ACP will take several years, and in subsequent year the region focus will be progressing the following projects/activities: – Support projects that benefit DHBs to develop broadly similar system, policies, protocols – Support DHB's to outline consistent measures and reporting – Electronic ACP – regional systems and processes – Development of electronic ACP progress notes (not yet available) – Development of ACP in Age Residential Care – In conjunction with South Island Māori health teams, embed broadly similar and culturally appropriate advance care plan resources and guidance.	HOPSLA, DHBs, PHO
Delirium				
Embed successful implementation of best practice delirium care by creating a culture of delirium prevention, raising awareness of delirium and involving patients, relatives and carers in the process of delirium prevention and recognition.				
7	Strengthening Delirium Pathways by encouraging the development of delirium pathways in all South Island DHBs, including aged residential care, to assist in the prevention, assessment and management of delirium across the care continuum and create consistencies in care.	Q3	Repeat the SI Delirium stocktake every two years – due again Q1 2019-20	HOPSLA, DHBs, PHO

Hepatitis C Workstream

Clinical Lead: Dr Catherine Stedman, CDHB

The Hepatitis C Workstream was formed in order to design and implement integrated assessment and treatment services for people with Hepatitis C in the South Island. This includes a single clinical pathway.

Initial facilitated through the South Island Alliance Programme Office, once the initial design phase was complete, co-ordination of implementation has been undertaken by CDHB on behalf of the region.

HEPATITIS C WORKSTREAM			
	DELIVERABLES	Planned activity	RESPONSIBILITY
	Integrated Hepatitis C Assessment and Treatment Services		
	Implementing integrated Hepatitis C assessment and treatment services across community, primary and secondary services in the South Island		
1	Work collaboratively with community, primary and secondary care to improve Hepatitis C awareness, knowledge of risk factors, and access to the Hepatitis C treatment pathway	Quarter 1-4 Ensure a whole of system approach to ensure all eligible patients are aware and have access to treatment regardless of circumstance. Quarter 2 Investigate treatment visit subsidy options with PHO's Quarter 2 Development DHB accountability framework to ensure appropriate allocation of funding and measurement of outputs at a DHB level Quarter 2-4 Continue Primary Care education activities, including GP's practice nurses and practice managers.	Hepatitis C Workstream
2	Provide community-based ongoing education and support (including referral to needle exchange services, community alcohol and drug services, general practice primary care services or social service agencies)	Quarter 1-4 Continue to provide education and awareness activities across the region to key stakeholder groups Quarter 2: Integrating local publicity activities with nationally planned activities	Hepatitis C Workstream
3	Provide long-term monitoring (lifelong in people with cirrhosis and until cured in people without cirrhosis)	Quarter 2 Regional audit of long term monitoring protocols to ensure consistency of approach across region and quality of monitoring	Hepatitis C Workstream
4c	Prioritise hepatitis C as a contributory measure within the System Level Measures Framework		TBC
5	Provide care that includes Liver Elastography Scans services (as a means for assessment of disease severity and as a triage tool for referral to secondary care and prioritisation for antiviral therapy)	Quarter 1-4: Continue to expand community based fibroscan clinics based on increased GP referrals Quarter 3-4 Develop integrated liver elastography programme for WCDHB with support from CDHB and NMDHB as geographically appropriate	Hepatitis C Workstream
	Increased Hepatitis C treatment uptake and primary care prescribing		
6	Raise patient and general practice team awareness of long-term consequences of HCV and the benefits of treatment, including lifestyle management and antiviral therapy	Quarter 2-4 Continue Primary Care education activities, including GP's practice nurses and practice managers.	Hepatitis C Workstream

7	Encourage the use of hepatitis C champions in general practices and PHOs	Develop a PHO champions network that will act a s a focal point for GP's and practice nurses providing ready access to Hep C expertise and resources across the region	Hepatitis C Workstream
Increased diagnosis of those undiagnosed and lost to follow up			
8	Provide targeted testing of individuals at risk for Hepatitis C exposure, including in community settings	Quarter 1-4: Focus on activities to increase awareness of increased risk of Hep C in baby boomer populations. (Point of focus for Primary Care Education).	Hepatitis C Workstream
9	Use lab data to identify people who have been diagnosed with possible and active HCV infection who could benefit from new treatments but may have been lost to follow up	Quarter 1 and Quarter 2: Work with Regional PHO's to identify those lost to follow-up or who have never received viral load testing	Hepatitis C Workstream

Monitoring			
9	The South Island will report six monthly on the following measures: • Number of people diagnosed with hepatitis C per annum (by age bands and genotype) • Number of HCV patients who have had a Liver Elastography Scans in the last year (a) new patients (b) follow up (by age and ethnicity) • Number of people receiving PHARMAC funded antiviral treatment per annum (by age and ethnicity)	Q2 and 4	Hepatitis C Workstream

Hospital Oral Health Workstream

Clinical Lead: **Dr Lester Settle, Clinical Director (Canterbury DHB)**

The Workstream was formed to support DHBs to develop a model of care for clinically and financially sustainable hospital dental services, enabling equity of access to hospital dental services across the South Island.

The aims of the Workstream are to ensure:

- Investment in hospital dental services delivers agreed outcomes
- Equitable access to hospital dental services regardless of ethnicity, socio-economic status or where they live in the South Island
- Hospital Dental Services in the South Island work together to improve service equality and safety through better coordination and integration of existing and new services.

The focus of the current workplan includes:

- Patient pathways
- Caries Management for otherwise fit & healthy children –
- Inherited dental anomalies
- Information systems for hospital dental services
- Common coding and reporting
- Identification of workforce gaps and skill development

HOSPITAL DENTAL SERVICES WORKSTREAM				
DELIVERABLES			**FUTURE WORK**	**RESPONSIBILITY**
Improving equity and quality of care				
1	Patient pathways	Q1,2,3,4		Hospital Oral Health Workstream
2	Caries Management for otherwise fit and healthy children: Elective Care Pathway and Paediatric model of care under general anaesthetic	Q1,2,3,4		Hospital Oral Health Workstream
3	Explore demand and treatment options for patients with inherited dental anomalies	Q1,2,3,4		Hospital Oral Health Workstream
Improving support systems				
4	Exploring a single patient management system and data repository across all SI DHBs.	Q1,2,3,4		Hospital Oral Health Workstream
5	Common coding and reporting	Q1,2,3,4		Hospital Oral Health Workstream

MONITORING / BUSINESS AS USUAL ACTIVITIES				
Workforce				
6	Identification of workforce gaps and skill development	Q1,3		Hospital Oral Health Workstream

Major Trauma Services

More patients survive major trauma and recover with a good quality of life

Sponsor: **David Meates, CEO (Canterbury DHB)**

Clinical Lead: **Dr Mike Hunter, Clinical Leader ICU (Southern DHB)**

The South Island Major Trauma Workstream provides regional leadership across the Major Trauma continuum of care through:

- A planned and consistent approach to the provision of major trauma services across New Zealand.

Equity in Major Trauma Services: The Workstream supports improving equity of access and outcomes across the region. The initial focus has been on having all DHBs recording and entering data to the national registry which has now been achieved. Data are now available for analysis (although only the major cases are recorded and there are very limited numbers involved in the smaller hospitals) and this will assist in understanding any disparities.

Geographic variables will be taken into account when confirming pathways and access to services in conjunction with St John.

Four key focus areas set the direction of this work plan:

- Understanding the magnitude of South Island trauma (NZ Major Trauma Minimum Dataset and NZ Major Trauma Registry)
- Investigate the feasibility of establishing a South Island Trauma Service (involving connected and co-ordinated care for the patient as they journey through the hospital)
- Supporting the workforce
- Improved service through collaboration, including destination policies

MAJOR TRAUMA WORKSTREAM				
	DELIVERABLES		**FUTURE WORK**	**RESPONSIBILITY**
Understanding of the magnitude of South Island trauma				
Collecting, submitting and monitoring data through the national registry				
1a	All South Island hospitals providing complete and accurate major trauma data to the national registry	Q1,2,3,4		Major Trauma Workstream
1b	All South Island DHBs using a common regional dataset and recording non major admitted trauma cases in a consistent manner	Q1,2,3,4		Major Trauma Workstream
1c	National annual reports include complete South Island major trauma data	Q1,2,3,4		Major Trauma Workstream
1d	Renewed agreement with Midland or other for submitting data to the national registry	Q1		Major Trauma Workstream
Investigate the feasibility of establishing a South Island trauma service				
Increased trauma service provision				
2	Prepare a case investigating the feasibility of establishing a South Island trauma service. The case would seek to recognise the value of a trauma service and justify provision of further resourcing to improve trauma services	Q4		Major Trauma Workstream

Supporting the workforce				
The availability of adequate resources to ensure data commitments are met and that trauma services are improving in each DHB				
3a	Trauma Nurse Coordinators (TNCs) and training and development needs are supported	Q1,2,3,4		Major Trauma Workstream
3b	Work with DHBs to encourage administration hours being provided or increased in all DHBs to assist the TNCs achieve their tasks			Major Trauma Workstream DHBs
3c	TNCs importance to improving trauma services is acknowledged and they are more able to provide input through representation on the Workstream	Q1,2,3,4		Major Trauma Workstream
3d	Further TNC education provided (using the ACC incentive fund)	Q1,2,3,4		Major Trauma Workstream
3e	Prepare a case for a regional trauma conference to be organised and held in the South Island	Q2		Major Trauma Workstream
Strengthen relationships with others eg National Network, St John and ACC				
Improved service and performance through collaboration				
4a	Regional destination policies agreed with all SI hospitals and St John implemented	Q2		Major Trauma Workstream St John
4b	Administer the ACC incentive funding provided according to the proportion of data submitted to the national registry	Q1,2,3,4		Major Trauma Workstream
4c	Strengthen the Workstream by further developing relationships and increasing engagement with the National Network, St John, ACC and others as appropriate.	Q1,2,3,4		Major Trauma Workstream

MONITORING / BUSINESS AS USUAL ACTIVITIES				
Performance improving in all DHBs with regular support from				
5a	Support each DHB to have a well governed trauma system, and to track progress (facilitated by a trauma committee meeting on a regular basis)	Q1,2,3,4		Major Trauma Workstream
5b	Education sessions and initiatives planned and delivered in DHBs will be communicated to others offering participation	Q1,2,3,4		Major Trauma Workstream

Mental Health and Addiction Services

Where people in Te Waipounamu/South Island need assessment, treatment and support to improve their mental health and well-being, they will be able to access the interventions they need from a range of effective and well integrated services. The Mental Health and Addictions Service Level Alliance will provide advice, guidance and direction to the mental health sector to strengthen integration, while improving value for money and delivering improved outcomes for people using services.

Lead CEO: **Nigel Trainor (South Canterbury DHB)**

Clinical Lead: **Heather Casey, Nursing Director (Southern DHB)**

The Mental Health and Addiction SLA (MH&A SLA) has been formed to provide advice, guidance and direction to the South Island mental health sector through:

- Best integration of funding and population requirements for the South Island.
- Providing an integrated service across the continuum of primary, community, secondary and tertiary services.

The SLA have structured their workplan in alignment with the following national and regional priorities:

- First 1000 Days
- Equitable access and outcomes
- Clinical Leadership
- Quality
- One Team
- Pathways

MENTAL HEALTH & ADDICTIONS SLA				
	DELIVERABLES		FUTURE WORK	RESPONSIBILITY
First 1000 Days (South Island priority focus area)				
1	Support the DHBs to develop district pathways to address the needs of people identified under Supporting Parents Healthy Children	Q4	Facilitate back to DHBs	Child Health SLA and MHASLA
Equitable Access and Outcomes				
Government Inquiry into Mental Health and Addiction				
2	Support the direction of the Government Inquiry into Mental Health and Addiction where regional collaboration can assist DHBs (it is expected the Inquiry will identify actions and priorities to address inequities in mental health and addiction services)	Q4	Facilitate transition back to DHBs	MHASLA and SI DHBs
Clinical Leadership				
South Island AOD Model of Care				
3	Consolidate the South Island AOD Model of Care Note: The SACAT Area Director is a member of the SLA and provides an ongoing link for the SLA to engage with the SACAT working group and support embedding the model of care.	Q4	Support refresher and maintenance training for Substance Addiction Compulsory Assessment and Treatment Act to support clinicians to be confident in managing patients in line with the Act (noting that courses are already underway and will continue for AOs).	SI SACAT Group
Quality				
National mental health and addiction quality improvement initiative (MHAQI)				
4	MHASLA will collaborate with Health Quality and Safety Commission and South Island Quality and Safety Service Level Alliance regarding the national work pursued by HQSC MHAQI team	Q4	Continue to support the work on the next phases of MHAQI	HQSC MHAQI

One Team				
Mental Health and Addictions Workforce Action Plan 2016-2020				
5	In line with the SI MHA Workforce Development Plan, develop new "whole of systems" regional strategies and activities to build capacity and capability in 1. Leadership 2. Cultural competence and responsiveness to diversity 3. Integration and collaboration 4. Recruitment, Retention and Scope of Practice 5. Education & Training 6. Child and Family Safety and Wellbeing The plan reflects the strategies that will need to be developed in line with the new national Mental Health and Addictions Workforce Action Plan 2016-2020. The plan will be progressed by HWNZ funded resource.	Q4	SI MHA Workforce Development Plan includes development of strategies into 2021. The work will need to consider the future workforce needs, including the anticipated demands of an aging population of mental health service users.	SIWDH MHASLA
Pathways				
Forensic Mental Health				
6	Working group of experts to make pathway recommendations based on a gap analysis of transitions between adult forensic community services and general adult community mental health services.	Q4	Facilitate transition back to DHBs	MHASLA Forensic Transition Group
Maternal Mental Health (supporting First 1000 Days)				
7	Explore pathways for infant mental health integration with child and adolescent mental health services and links to regional maternal mental health services	Q4	Facilitate back to DHBs	MHASLA

MONITORING / BUSINESS AS USUAL ACTIVITIES				
Forensic Mental Health Services				
8	Report prison screening data in line with the schedule of the NZ Forensic Psychiatry Advisory Group.	Q1,2, 3,4	Continue providing prison screening data	MHASLA

National and regional projects supported by the SLA/Workstream but led by other SLAs/Workstreams or individual DHBs

Deliverable: NATIONAL MENTAL HEALTH AND ADDICTION QUALITY IMPROVEMENT INITIATIVE (MHAQI)

Owner: HEALTH QUALITY AND SAFETY COMMISSION

MHASLA will collaborate with Health Quality and Safety Commission and South Island Quality and Safety Service Level Alliance regarding the national work pursued by HQSC MHAQI team

Palliative Care Services

High quality, person centred, palliative and end of life care available to the population of the South Island, according to need and irrespective of location.

Clinical Lead: **Dr Kate Grundy, Consultant Physician in Palliative Medicine (Canterbury DHB)**

The Palliative Care Workstream has been formed to promote the development of and equitable access to a high quality palliative care integrated system for all people across the South Island through:

- The development of an integrated palliative care system, and multidisciplinary workforce across the South Island.
- An integrated system approach to local and South Island Palliative care linkages across the spectrum of services and providers to benefit the patient journey.

  Palliative Care is a workstream within the Health of Older People Service Level Alliance.

Four key focus areas set the direction of this work plan:

- South Island Model of Palliative Care
- Views of Informal Carers' Evaluation of Services (VOICES)
- Allied Health Workforce
- Paediatric Palliative Care

PALLIATIVE CARE WORKSTREAM				
	DELIVERABLES		FUTURE WORK	RESPONSIBILITY
	SOUTH ISLAND MODEL OF PALLITIVE CARE			
	Drawing on palliative care surveys, develop and implement consistent, equitable model of care			
1	Use information from the hospital and hospice Surveys and the evaluation of palliative care in primary care (PHOs ARC and P&F) to promote regional consistency and access to resources for all communities. Inform and influence South Island DHBs so services are aligned to the Resource and Capability Framework for Adult Palliative Care and the work of the National Adult Palliative Care Review. Based on the survey findings and best practice, provide the model of care that reflects the integration of specialist, secondary and primary care and skills and resources required for a seamless palliative care service in the South Island.	Q1,2,3,4		SI PCW
2	Inform and influence the development of **information systems** within the South Island that will deliver a more efficient and safer transfer of patient information between Palliative Care Providers (including Hospice services) across the South Island while reducing costs and risk	Q1,2,3,4		SI PCW SI IS SLA
	VOICES (Views of Informal Carers' Evaluation of Services)			
	Understanding the experience of informal carers to improve palliative care services			
3	Views of Informal Carers' Evaluation of Services (VOICEs) completed (University of Canterbury contracted to undertake the survey to assess the perceived quality of the final three months of life and assess variations in care). VOICEs will provide insight into any inequities in palliative care for Māori and other ethnic groups.	Q2		SI PCW

4	Drawing on the data collected through VOICES, determine what and where improvements are called for. Use this information, in conjunction with the Hospital Hospice and Primary Care survey recommendations, to improve performance and equity in the delivery of palliative care in the South Island.	Q3,4		SI PCW
	ALLIED HEALTH WORKFORCE			
	Recommendations will be made on the learning needs of Allied Health professionals (limited) to support the delivery of Palliative Care in non-specialist settings			
5	Establish an Allied Health working group to design a framework where the Allied Health workforce is prepared, educated and supported to deliver Palliative Care.	Q1,2,3,4		SI PCW SI DAHs SI Workforce Development Hub
	PAEDIATRIC PALLIATIVE CARE			
6	Provide high level guidance within the South Island to those providing Paediatric palliative care, including cultural care, to all communities (working within the National Paediatric Palliative care Guidelines)	Q1,2,3,4		SI PCW
	MONITORING / BUSINESS AS USUAL ACTIVITIES			
7	E prescribing – monitor the roll out across South Island	Q1,2,3,4		SI PCW IS SLA
8	Palliative Care InterRai - following the completion and evaluation of the current pilot, support the development and the roll out of PC interRAI across the South Island	Q1,2,3,4		SI PCW InterRAI NZ
9	HealthPathways - Te Ara Whakapiri support the development of PC HPW in SI DHBs and advise on any updates	Q1,2,3,4		SI PCW
10	Lippincott Palliative Care Clinical Expert Group - Provide an annual review and update of palliative care procedures for the South Island.	Q1,2,3,4		SI PCW SI Workforce Development Hub
11	St John - continue the partnership to understand how palliative and end of life care is provided through St John in order to understand and advise how the experience for the patient, whanau and St John personnel can be improved	Q1,2,3,4		SI PCW St John

Planned engagement with other SLAs/Workstreams, but scope of work still to be confirmed:

Advanced Care Planning

Delirium - Delirium Self-Assessment tool for use in facility based services and other work.

Dementia

Owner: Health Older Persons SLA

Mental Health and Addictions

Owner: Mental Health and Addictions SLA

Public Health Services

A healthier South Island population through effective regional and local delivery of core public health functions

Sponsor: **Cathy O'Malley, General Manager Strategy and Planning (Nelson Marlborough DHB)**

Clinical Lead: **Dr Keith Reid, Medical Officer of Health and Clinical Leader (Public Health) Southern DHB**

The South Island Public Health Service Level Alliance has been formed to:

- Sustain effective and efficient regional and local delivery of Ministry-funded Public Health Unit (PHU) services.
- Improve the interface and support between PHUs and other parts of the health system.
- Support population health approaches and planning.

Four key focus areas set the direction of this work plan:

- Collective impact and partnerships
- Partnership with Te Herenga Hauora
- Facilitating a health promoting health system
- Regional alignment

PUBLIC HEALTH PARTNERSHIP				
	DELIVERABLES		**FUTURE WORK**	**RESPONSIBILITY**
Collective Impact and Partnerships (supporting priority area First 1000 Days, and Social Determinants)				
Cross-sector capacity development and initiatives to contribute to equitable outcomes in the first 1,000 days				
1	Actively contribute public health expertise, leadership, programme facilitation and project management (backbone support/hosting) to the development of the Hauora Alliance.	Q1,2,3,4	Proactively adapt the contribution of the PHP to meet the evolving needs of the Hauora Alliance as resources allow.	SI PHP
2	Actively contribute to the collaborative development of a cross-sector initiative/s to address adaptive public health challenges during the first 1,000 days of life.		As above	SI PHP
Partnership with Te Herenga Hauora to contribute towards equitable outcomes for Māori				
3	Support Te Herenga Hauora to integrate public health indicators into their plans.	Q1,2,3,4	As is developed in partnership with Te Herenga Hauora.	SI PHP and Te Herenga Hauora
4	Partner with Te Herenga Hauora in promoting position statements.	Q1,2,3,4	As agreed with Te Herenga Hauora.	SI PHP and Te Herenga Hauora
Facilitating a Heath Promoting Health System that contributes towards equitable outcomes (supporting priority area Social Determinants)				
A Health in All Policies approach towards the social determinants influencing oral health, safe and warm homes and environmental sustainability				
5	Develop and promote position statements for healthy housing, environmental sustainability and sweetened beverages.	Q1,2, 3,4	Develop and promote further position statements re social determinants.	SI PHP, SI Public Health Analysts Network, Environmental Sustainability Working Group, Child Health SLA, SI Hospital Dentists.

Regional Alignment				
Consistent and coordinated regional strategic and operational approaches to key public health concerns				
6	Develop and implement a consistent and coordinated regional approach to drinking water issues, including/ and community fluoridation	Q3,4	Monitoring and evaluation as BAU	SI PHP, SI Public Health Analysts Network , Environmental Sustainability Working Group and SI Hospital Dentists
7	Develop a coordinated approach to community resilience and psycho-social well being	Q3,4	As above	SI PHP, Mental Health SLA and Child Health SLA
8	Identify and implement a sustainable on call /after-hours system for South Island health protection services	Q1,2	As above	SI PHP
9	Identify and implement regional approaches to alcohol harm reduction	Q1,2,3,4	As above	SI PHP, SI Alcohol Harm Reduction Working Group
10	Develop and implement regional approaches to promote healthy eating and active lifestyles	Q1,2	As above	SI PHP, &Child Health SLA

MONITORING / BUSINESS AS USUAL ACTIVITIES				
11	Evaluation			
12	Communications			
13	Regional working groups and networks			
14	Rheumatic fever monitoring and surveillance			

National and regional projects supported by the SLA/Workstream but led by other SLAs/Workstreams or individual DHBs
Owner: Child Health SLA – First 1,000 Days Initiatives (TBC)

Stroke Services

Delivering Organised Stroke Services - Best stroke care, everywhere

Clinical Lead: **Dr John Fink, Clinical Director Neurology (Canterbury DHB)**

The South Island Stroke Workstream has been formed to:

- Support the implementation of organised stroke services locally and regionally across the South Island and thereby encourage consistency and sustainability in the provision and delivery of acute and rehabilitation stroke services (organised stroke services have been shown to improve the health outcomes of those who have a transient ischaemic attack (TIA) or stroke).

Equity in Stroke Services: Telestroke, data collection, education and audits are all specific initiatives that will contribute to understanding and addressing inequity in service access and outcomes.

The Stroke Workstream considers each quarter the stroke activity data reviewing trends and seeking improvement opportunities, this includes a breakdown of Māori and Pacific Island population data.

The current collection method of the data across South Island DHBs (as well as nationally) is problematic and opportunities to improve the process are underway in the South Island. Work is underway to have a data collection process that is not onerous for South Island DHBs, automated using existing datasets, and minimises error, whilst also allowing better graphical manipulation of the data collected (expected to be complete by Dec 18). This will help to demonstrate trends and highlight inequity.

Of note, in the SI the numbers are very small which makes it hard to detect any trend, particularly in a quarter. Many of the Māori and Pacific Island people who have stroke are under age 65 years and as the further work is undertaken looking at rehabilitation needs (Item 9b), the implications of this will need to be considered to inform appropriate services delivery for these groups.

For those experiencing acute stroke we are working to ensure the pathway and treatment is evidence based and consistent with National Stroke Network direction, irrespective of geographic location. Based on the limited data we have, there are no ethnic disparities in access to treatment, but we acknowledge we do not have information on the cultural appropriateness of care.

Service improvement and innovation: Embedding telestroke across the South Island is a significant change in the way we work. This will further progress equitable, accessible acute stroke service across the South Island DHBs. Christchurch Hospital is the Hub with the satellite hospitals being Grey Base, Timaru, Dunedin, Invercargill, Oamaru and Dunstan. The Nelson Marlborough district is part of the Central Region telestroke and has experience of participating in New Zealand's first telestroke pilot. An inter-disciplinary team from all main centres including Nelson has been formed to help guide this project. Education/training/relationship building between the Hub hospital and the satellite hospitals is acknowledged as a key to the success of the project.

The team involved with the telestroke is also collecting information with regard to a regional stroke clot retrieval service. The South Island region has contributed to the Ministry of Health's efforts to prepare a National Implementation Plan for Endovascular Clot Retrieval (ECR) for acute ischaemic stroke patients. Work in the SI is proceeding in line with the national strategy.

Stroke Workstream will continue to work with DHBs, South Island Workforce Development Hub and Ministry of Health to identify and address any workforce challenges or vulnerabilities, as well as support their work to grow an ethnically proportionate, culturally competent workforce.

Six key focus areas set the direction of this work plan:

- Organised of Stroke Services
- Thrombolysis
- Acute Stroke Services
- Rehabilitation
- Quality and consistency
- Stroke specific education

STROKE WORKSTREAM

	DELIVERABLES		FUTURE WORK	RESPONSIBILITY
	Organised Stroke Services			
	Support implementation of Australasian Stroke Guidelines in each SI DHB in a broadly consistent manner by promoting collaboration and networking. Deliver equity across culture, minority groups and geography.			
1a	Support DHBs to ensure stroke patients are admitted to an organised stroke service (defined by National Stroke Network)	Q1,2,3,4		Stroke Workstream DHBs
1b	Support and advocate for each South Island DHB to establish the clinical leadership through having Lead Stroke Physician and Lead Stroke Nurse in place (with protected non-clinical hours); and fostering an inter-disciplinary approach, in particular considering the role of allied health	Q4		Stroke Workstream DHBs
2	Support DHBs to ensure each South Island designated stroke hospital: • is confirmed on the St John destination policy • has imaging access (in and out of hours); • has thrombolysis expertise.	Q1		Stroke Workstream
3	Support DHBs and St John to ensure all stroke patients are be managed as a time critical emergency.	Q1,4		Stroke Workstream DHBs
	Thrombolysis			
	"Code Stroke" is a key component of effective thrombolysis and denotes a rapid treatment pathway to minimise onset to needle time.			
4	Support DHBs to ensure Thrombolysis is available at designated stroke hospitals	Q1,2,3,4		Stroke Workstream DHBs, PHOs
5	Thrombolysis education is available across the South Island.	Q1,3,4		Stroke Workstream DHBs
	South Island Acute Stroke Services			
	The South Island Acute Stroke Services Plan is a subset of the SI Stroke Workstream plan; it identifies the service improvement planning and funding investment required by each DHB to achieve sustainable, equitable, accessible and organised SI Acute Stroke Services i.e. organised stroke service, access to thrombolysis, acute stroke telehealth and clot retrieval.			
6a	SI DHBs participate in Acute Stroke Telehealth pilot for out of hours acute stroke service project for out of hours acute stroke service. This SI project will: I. Finalise an implementation plan (Christchurch as hub, Grey Base, Timaru, Dunedin, Invercargill, Oamaru and Dunstan as spoke. II. Organise Telestroke resources incl carts, i-pads, installation, III. Ensure training across the SI An evaluation post project will inform further work and the addition of other telestoke spoke centres in the SI.	Q1,4	Review post pilot evaluation. If successful, will transition to business as usual by Q4 2019 or Q1 2020	Stroke Workstream DHBs, PHO

6b	Explore opportunities for other telehealth support to stroke patients, such as rehabilitation (potential to provide services in a new way that addresses disparities in access that occur across the region).			
7a	Develop and agree a plan for a South Island clot retrieval service for suitable patients that: • is sustainable and builds capacity and expertise • identifies the current and forecast South Island need for acute stroke services across the patient journey, include clot retrieval. • considers workforce and resource requirements Note: NMDHB flows to be finalised Clot Retrieval is available at CDHB for the Canterbury population; it is not available in the SI due to capacity constraints. Action is in place to build capacity and capability within CDHB from current 65% of days available to 100% of days available service.	Q2,4	Agree the timeframe for a SI clot retrieval service to be available to all SI residents who may benefit.	Stroke Workstream DHBs
7b	Health Pathways reviewed and updated to reflect progress in implementing telehealth and acute stroke services, to ensure community, primary and secondary services have clear guidance on patient pathways and to improve consistency and equity of care	Q1,4		Stroke Workstream
8	Acute stroke destination policies: • Embed transport protocol for acute stroke patients from the community directly to the most appropriate stroke hospital • Agree the transport protocol for eligible patients from stroke hospitals to clot retrieval centre (CDHB). Document in HealthPathways	Q1,2,3,4	Implement the documented transport protocol for eligible patients from stroke hospitals to clot retrieval centre (CDHB).	Stroke Workstream DHBs, St John
Rehabilitation				
Rehabilitation is delivered in line with the National Stroke Network NZ Organised Stroke Rehabilitation Service Specifications. There is a full range of team members (medical, nursing, allied health and support staff) with an appropriate skill base and training to provide comprehensive, contemporary programmes of care to address the impairments, activity limitations and participation restrictions present in the patients admitted to the stroke rehabilitation service.				
9a	Support DHBs to ensure all eligible people with stroke receive early active rehabilitation services and equitable access to community stroke services (as defined by the National Stroke Network), supported by an interdisciplinary stroke team. This includes all DHBs having rehab services that meet the National Stroke Network service specifications. The following measures will indicate progress towards this: • 80 percent of patients admitted with acute stroke are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission • 60 percentage of stroke cases who are referred to community rehabilitation receive a face-to-face session within 7 days after in-patient discharge.	Q1,3	80 percent of patients admitted with acute stroke are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission 60 percentage of stroke cases who are referred to community rehabilitation receive a face session within 7 working days after in-patient discharge. This will increase from 60% up to 80% in the future.	Stroke Workstream DHBs

9b	Utilise Australasian Rehabilitation Outcome Centre (AROC) monitoring to understand regional rehabilitation needs and identify action to address inequities or service gaps. Encourage each DHB to extend AROC monitoring to community-based rehabilitation services.	Q2,4		Stroke Workstream
	Quality And Consistency			
10	Support each DHB to undertake some form of stroke audit each year and utilise the findings to inform service improvement across the South Island. Promote uptake in South Island DHBs of the electronic audit tool for stroke rehabilitation (the electronic audit tool is a South Island developed innovation that provides real-time assessment of rehabilitation services. There is significant interest in the tool from other areas and the South Island is supporting its uptake elsewhere). The findings of these audits will identify service challenges and inequities, and inform regional and local action to address improvements.	Q2		Stroke Workstream
11	Provide advice on the findings of the nation-wide REGIONS Care audit project, which will measure some aspects of care provision and patient outcome.	Q2,4		Stroke Workstream DHBs
12	Support national service improvement initiatives, including: - Participation in National Stroke Network - Any national work to identify and understand workforce requirements for stroke services Embedding national initiatives across the SI region.	Q1,2,3, 4		Stroke Workstream
	Stroke Specific Education			
	Inter-disciplinary stroke specific education is available			
13	All members of the interdisciplinary stroke team participate in ongoing education, training (a minimum of 8 hours stroke specific education per year (minimum standard) and service improvement programmes. The focus of the education sessions is determined by clinicians and sessions are led by respected clinical leaders. Education is culturally considerate.	Q1,2,3,4		Stroke Workstream
14	Regional telestroke / thrombolysis training session provided to support DHB staff to be confident selecting and managing patients who need to be thrombolysed (undertaken annually via VC across 9 sites).	Q tbc		Stroke Workstream

Telehealth Workstream

TO BE CONFIRMED

Clinical Lead: Dr John Garrett (to be confirmed)

The South Island is developing a Telehealth Strategy that outlines the vision for a connected, ubiquitous, well-used, virtual health platform for the region.

The primary objective of the Strategy is to increase the availability and use of telehealth to the point where it is offered to all patients who would benefit from it.

Achieving this goal will deliver equity by upholding the right of patients to timely access to health care as close to home as possible and ensure health care is delivered with a focus on the needs of the whanau. It will reduce professional isolation, provide education opportunities for staff and ensure telehealth approaches align with current best practice. This strategy will ensure a telehealth funding system is in place that is transparent, cost neutral and sustainable. It will improve the quality and effectiveness of telehealth services through review, audit and analysis.

The Strategy considers governance, change management, and embedding telehealth in clinical practice, technology and infrastructure, monitoring and evaluating use, along with resource requirements. Although the Strategy is yet to be finalised, if it is approved, it is expected that a Governance group and a Delivery Interest Group will be established to progress implementation of the strategy.

DRAFT WORKPLAN – YET TO BE APPROVED BY STRATEGY GROUP

TELEHEALTH WORKSTREAM				
DELIVERABLES			**FUTURE WORK**	**RESPONSIBILITY**
An agreed South Island Telehealth Strategy				
1	A South Island Telehealth Strategy is confirmed	Q1		Alliance Leadership Team (ALT).
2	South Island Telehealth Governance Group is established to oversee implementation of the Telehealth Strategy	Q1		SIAPO
Programme of work developed				
6	Stocktake of current Regional Telehealth resources	Q2		Telehealth Governance Group
3	Programme of work and resourcing for implementation of the Telehealth Strategy is agreed and approved, including implementation plan of initiatives that are based on approved Health Information Standards Organisation (HISO) standards	Q1,3		Telehealth Governance Group
4		Q1,2, 3,4	Implement Regionally the National Video Conference Directory.	Telehealth Governance Group
		Q2,4	Implement Regionally the use of the mode of delivery field (NNPAC) to record the use of VC to deliver health services on existing Patient Management Systems.	Telehealth Governance Group

KEY ENABLERS

Quality and Safety Services

Supporting South Island DHBs to make a positive contribution to patient safety and the quality of care

Clinical Lead: **Mary Gordon, Executive Director of Nursing (Canterbury DHB)**

The Quality and Safety SLA provides regional, multi-disciplinary governance to:

- Lead, advise and make recommendations to support and coordinate improvements in safety and quality in health care for the South Island DHBs.
- Identify and monitor initiatives that support improvements in national health and safety indicators.
- Report on safety and quality, including performance against national indicators.
- Share knowledge about and advocate for, safety and quality.

Six key focus areas set the direction of this work plan:

- Serious Adverse Events
- Deteriorating patient programme
- Pressure injury prevention
- Safety 1st
- Regional sharing of Learnings and Quality Improvement

The SLA is considering how best to engage consumers/whanau in regional governance of quality work, with a view to potentially expanding the membership to include a consumer.

QUALITY AND SAFETY SLA				
	DELIVERABLES		FUTURE WORK	RESPONSIBILITY
Serious Adverse events				
Regional alignment in SI DHB's Serious Adverse Event Reviews to protect people from harm or needless death				
1	Continue to support application of the new national reportable events policy	Q4	Support DHBs to embed the new national reportable events policy	QSSLA
2	Support capability in DHB approaches to investigations of serious adverse events	Q2,4	Facilitate the transition back to DHBs	QSSLA
Deteriorating Patient Programme				
Regional alignment in the deteriorating patient programme				
3	Continue to support DHB approaches to the deteriorating patient programme	Q1,3	Support the SI DHBs to embed the deteriorating patient programme	QSSLA
Pressure injury prevention				
Regional alignment in pressure injury prevention				
4	Support the South Island DHBs in their work on the HQSC Pressure Injury Prevention work by sharing experiences and learnings across all SI DHBs	Q1,3	Support the SI DHBs in their work on the HQSC Pressure Injury Prevention work	QSSLA
Safey1st				
Ongoing development and review of Safety1st				
5	Support ongoing development and review of Safety1st	Q1,3	Support ongoing development and review of Safety1st	QSSLA

Regional sharing of Learnings and Quality Improvement				
Shared learnings of improving quality of care				
6	SI DHBs share learnings and quality improvement initiatives.	Q1,3	SI DHBs share learnings and quality improvement initiatives.	QSSLA

National and regional projects supported by the SLA/Workstream but led by other SLAs/Workstreams or individual DHBs

National Mental health and Addiction Quality Improvement Initiative
Owner: Health Quality and Safety Commission
Mental Health and Addiction SLA will liaise with HQSC and Quality and Safety SLA

South Island Information Services

Lead CEO:	**Nigel Trainor (South Canterbury DHB)**
Chair:	**Graham Crombie (Independent Chair)**
Portfolio Director:	**Paul Goddard (South Island Alliance Programme Office)**

Information Technology provides the platform to support improved information sharing that enables new models of care and better decision making. Well-designed Information Technology systems will help the South Island to work smarter to reduce costs, support care pathways and give patients better, safer treatment. Greater reliance on technology requires effective management of Information Technology investments, implementations and ongoing operations. Sustained investment in Information Technology is one of the ways to manage increasing demand with limited resources.

The Information Services, Service Level Alliance programme of work is supporting the vision of enabling clinicians and health providers to have access to health information where and when they need it supporting clinical decision making at the point of care. Across the South Island we are working to actively implement well-designed, easy to use solutions, we are developing these in consultation with our clinical leaders to support clinical workflow requirements, linked to smarter, safer health care delivery.

The IS SLA recognise that for information sharing and integrated services to work well it takes a team approach across the whole of the health system. As a core component of the alliance model we are clinically driven and supported by strong leadership and work in partnership with patients and vendors. The IS SLA also recognise their role in enabling other activities and outcomes, such as improved data collection and analysis through consistent platforms like SI PICS and HSC. These regional platforms support DHBs to undertake better decision support processes, and enable improved data collection and contribution to national initiatives such as National Patient Flow.

The MoH have identified that the delivery of ICT enabled change and innovation is critical in supporting the delivery of the New Zealand Health Strategy and the Government ICT Strategy. Underpinned by technology supporting transformational change in the way patients and care teams access health services.

As part of the commitment to delivering on Digital Health Strategy the South Island will continue to implement the key regional foundation priorities. For 2018/19 these are:

1. eMedications programme
    a. Medchart implementation (NMDHB & WCDHB)
    b. Regional instance of ePharmacy
2. SI PICS
3. eReferrals
    a. clinical triaging
    b. Create Electronic Request in the Hospital
4. Regional Service Provider Index
5. eOrdering
    a. Radiology
6. Mental health Information Solution

Equity in IS SLA: The IS SLA is committed to supporting the South Island Alliance to deliver equitable access and outcomes for the people of the South Island. The IS SLA is an enabler and acknowledges that information systems/technology is a tool for the wider model of care/service delivery change that is required to address equity of access and outcomes. In 2018/19 information systems and technology enable, contribute and support a number of initiatives that have a focus of delivering equitable access and outcomes for the people of the South Island including:

1. Shared clinical information available “at the right time, right place to the right person” via our regional platforms of Health Connect South and HealthOne
    a. Including the availability of common standardised SI Risk and Care planning information for Mental Health

2. Through the implementation of key regional systems (such as HCS/HealthOne/SIPICs) the SI will access to better quality, standardised, consistent and comparable datasets that will enable disparities to be more easily identified and responded to where need is indicated.
3. Implementation of the South Island Virtual health Strategy
4. Supporting the National Bowel Screening project, in particular the delivery of the information system/technology ensuring equitable and timely access to services
5. Supporting the delivery of the Cancer information Strategy to ensure equitable and timely access to services
6. Supporting the DHBs to provide safe and sustainable thrombolysis services through the provision of telestroke services ensuring equitable and timely access to services

Note – the workplan is tentative pending budgeting and resourcing decisions.

INFORMATION SERVICES SLA				
	DELIVERABLES		FUTURE WORK	RESPONSIBILITY
ePharmacy Management (ePM)				
Implement ePharmacy into South Island DHBs using a single Regional instance (incorporating NZULM & NZ Formulary) to enable the management of medications from a shared South Island perspective				
1	Implementation of one instance of ePharmacy completed across SDHB and SCDHB	Q4		Lead: SDHB DHB: SDHB & SCDHB Reported in: SIHSP
2	Implementation of CDHB instance of ePharmacy completed across NMH and WCDHB	Q4		Lead: CDHB DHB: NMH & WCDHB Reported in: SIHSP
eREFERRALS PROGRAMME				
Stage 3 – Electronic Triage of Referrals				
Implementation eTriage - eReferrals received through the RMS module in Health Connect South with triage functionality				
3	Complete SCDHB eTriage implementation	Q4		Lead: ERMS Regional Programme Manager SIAPO DHB: SCDHB Reported in: SIHSP
4	Complete SDHB eTriage implementation	Q,4		Lead: ERMS Regional Programme Manager SIAPO DHB: SDHB Reported in: SIHSP
5	Complete NMDHB eTriage implementation	Q,4		Lead: ERMS Regional Programme Manager SIAPO DHB: NMDHB Reported in: SIHSP
Create eRequests within the hospital				
Provide the ability to deliver electronic requests inter and intra hospital including out to community, private and ACC providers.				
6	Direction for create eRequests regionally agreed.	Q2		

7	Business Case approvals progressed	Q4	Phased implementation commenced across the DHBs as per agreed implementation order	Lead: ERMS Regional Programme Manager SIAPO DHB: NMDHB Reported in: SIHSP
SOUTH ISLAND PATIENT INFORMATION CARE SYSTEM (SI PICS)				
Canterbury DHB Implementation				
8	Complete the implementation of SI PICS into the remaining CDHB sites	Q2		Lead: Regional Programme Manager SIAPO DHB: CDHB Reported in: SIHSP
West Coast Implementation				
9	Commence and complete the implementation of SI PICS Project go-live for West Coast DHB	Q4		Lead: Regional Programme Manager SIAPO DHB: WCDHB Reported in: SIHSP
South Canterbury DHB Implementation				
10	Commence and complete the implementation of SI PICS Project go-live for South Canterbury DHB	Q4		Lead: Regional Programme Manager SIAPO DHB: SCDHB Reported in: SIHSP
Southern DHB Implementation				
11	Complete the development of SDHB implementation business case for SI PICS	Q4	Commence the development of SDHB implementation business case for SI PICS Prepare for SI PICS Implementation including the completion of the implementation business case and initiation of project planning Project go-live for Southern DHB	Lead: Regional Programme Manager SIAPO DHB: SDHB Reported in: SIHSP
REGIONAL SERVICE PROVIDER INDEX				
To implement a SI Regional Service Provider index through alignment with HPI development				
12	Support MoH to progress upgrade and extensions to the national HPI	Q3	Phased implementation of the Regional Service Provider Index continues as per agreed implementation order	Lead: RSPI Project Manager SIAPO Reported in: SIHSP
13	Commence roll-out of extended HPI functionality to the agreed applications	Q4		Lead: IS SLA Reported in: SIHSP
eORDERING OF RADIOLOGY TESTS				
To implement a fully electronic radiology ordering process				
14	Implementation of eOrdering Radiology tests completed for hospital radiology services	Q4		Lead: IS SLA SIAPO DHB: NMDHB, SCDHB, WCDHB, SDHB Reported in: SIHSP

MENTAL HEALTH				
Provide an electornic regional solution to support Mental Health activity				
15	Progress agreed direction for the SI Mental Health Solution	Q4	Implementation of SI Mental Health solution completed following agreed regional roll-out	Lead: IS SLA SIAPO Reported in: SIHSP
16	Implement agreed single SI Mental Health Risk form	Q1		
17	Implement agreed SI Regional Mental Health Care plan	Q4		
18	Continue to support SCDHB, WCDHB, NMDHB and SDHB to progress a paper-lite strategy for transitioning paper mental health records into the electronic health record	Q4		
CLINICAL WORKFLOW				
Enable SI DHBs to develop and implement flexible clinical workflow that supports and enables the delivery of care at the right place and right time				
19	Scope, agree and commence the implementation of the processes and structures to enable the SI DHBs to create, configure and manage automated clinical workflow	Q4	Continue the implementation of the processes and structures to enable the SI DHBs to create, configure and manage automated clinical workflow	Lead: IS SLA SIAPO Reported in: SIHSP
ALERTS AND WARNINGS				
Provide an agreed electronic regional solution for Alert and Warnings				
20	Identify the preferred South Island solution	Q4	Progress implementation of an agreed SI Alerts and Warning solution	Lead: IS SLA SIAPO Reported in: SIHSP
21	Progress business case/implementation planning			

National and regional projects supported by the SLA/Workstream but led by other SLAs/Workstreams or individual DHBs

Project: Single Electronic Health Record
Deliverable 2018/19: Development of Detailed Business Case
Responsibilities: All DHB engaged in detailed business case development process
Owner: Nationally Led

Project: Digital Health Strategy
Deliverable: 2018/19: Publishing of the Digital Health Strategy
Responsibilities: All DHBs engaged and aligning with the Digital Health Strategy
Owner: Nationally Led

Digital Hospital
Deliverable 2018/19: Target gaps in hospital digital maturity with regionally aligned solution based on EMRAM assessment. DHBs to recognise the need for enabling infrastructure to support delivery of digital hospital capability.
Responsibilities: All DHBs engaged in accelerate maturity through regional and sub-regional activities where possible.
Owner: DHBs

Project: Shared Clinical Information
Deliverable: 2018/19: Continued integration of standards based systems for sharing clinical information with consumers and providers regardless of location with a focus on the person
Responsibilities: All DHBs accountable for the continued delivery of secure, digitally accessible clinical information
Owner: DHBs

Project: IT Security maturity enhancement
Deliverable: 2018/19: Collaborate with the MoH and across the wider sector to drive increased IT security maturity
Responsibilities: All DHB CIOs responsible for the introduction and implementation of a suite of sector wide IT security maturity initiatives
Owner: Nationally Led

Project: National Screening Solution
Bowel screening rollout (page 35, item 7; and page 28, item 7)
Deliverable 2018/19: SI planning to support Bowel Screening Regional Centre development and implementation and Tranche 2 & 3 rollout schedule
Owner: Electives Workstream and Southern Cancer Network

Cervical Screening project
Deliverable 2018/19: Engage in cervical screening project planning to support HPV testing
Owner: Nationally Led

Project: Integration Services
Deliverable: 2018/19: National Screening Solution to be the first tranche on the Integration Service
Responsibilities: All DHBs engaged in integration services planning and integration
Owner: Nationally Led

Project: Virtual Health (Telehealth) (page 51)
Deliverable: 2018/19: Development of programme of work to implement South Island Telehealth Strategy (once confirmed)
Responsibilities: Regions to resource telehealth initiatives, DHBs to implement National Video Conference Directory and use mode of delivery field (NNPAC) to record the use of VC.
Owner: Telehealth Workstream and DHBs

Project National Maternity Solution
Deliverable 2018/19: Continued work with DHBs to implement the National Maternity Record
Responsibilities: All DHBs to have in place a plan to implement the National Maternity Record by 2020
Owner: Nationally Led and implemented by individual DHBs

Project: IT Newborn Hearing Screening (NHIMS)
Deliverable: 2018/19: Collaborate with the MoH to progress a regional approach to implementing NHIMS
Responsibilities: All DHBs to have in place a plan to implement the NHIMS by 2020
Owner: Nationally Led and implemented by individual DHBs

Project: Nationally consistent Electronic Oral Health Record (EOHR)
Deliverable 2018/19: Working to address issues and risks by making improvements where possible that incrementally move towards a nationally consistent and integrated EOHR
Responsibilities: All DHBs engaged with the programme to continue with the development and implementation of the Future Operating Model
Owner: Nationally led with DHB governance and co-design.

Project: National Digital Services
Deliverable: 2018/19: Enhancement, adoption and operation of national digital service
Responsibilities: All DHB engaged with NHI extension work, contributing data to national collections
Owner: Nationally Led

Project: Medicines Management Digital Services
Deliverable: 2018/19: Support the MoH to develop an action plan for the adoption of NZePS across general practices
Responsibilities: All DHB
Owner: Nationally Led

Project: National Patient Flow
Deliverable: 2018/19: Support DHBs to be able to provide quality reporting
Responsibilities: All DHB will provide quality reporting as per National Patient flow service specification
Owner: DHBs

Project: Cancer Information Strategy: (page 27-29, item 5, 9, 11, 15, 16)
Deliverable 2018/19: Develop a plan to support and implement the NZ Cancer Health Information Strategy across the South Island (note – content still to be finalised, waiting on MOH guidance).
Responsibilities:
Owner: SCN

Project: Stroke Services (page 49, item 5-6)
Deliverable: 2018/19: Support the delivery of regionally (where practical) consistent systems
Responsibilities: All DHB will provide a safe and sustainable thrombolysis service in designated stroke hospitals
Owner: Stroke Workstream

Project: National Trauma Minimum Dataset (page 40, item 1)
Deliverable: All DHBs report the elements of the National Major Trauma Minimum Dataset to NZ Major Trauma Registry
Responsibilities: All DHBs will provide quarterly reporting to the National Major Trauma Minimum Dataset
Owner: South Island Major Trauma Workstream

South Island Workforce Development Hub

Lead CEO:	**David Meates, Canterbury DHB**
Clinical Lead:	**Mary Gordon, Executive Director of Nursing (Canterbury DHB)**
Programme Director:	**Kate Rawlings, Programme Director, (South Island Alliance Programme Office)**

The South Island Workforce Development Hub (SIWDH) works across the South Island Health sector to lead and support workforce development, education and training to better meet the health needs of the South Island population.

The work plan for 2018/9 builds on the achievements of earlier years. There are over 170 clinicians and health managers across the South Island participating in the work of the Hub.

The areas of focus for 2018/9 are:

- Workforce Planning including priority (vulnerable) workforces and clinical leadership
- Workforce Diversity
- Workforce Enablers
- Workforce Data and Intelligence

We will do this by:

- Building and aligning the capability of the workforce to deliver models of care and priorities outlined in the New Zealand Health Strategy.
- Supporting increased opportunities to learn in interprofessional settings.
- Improving the sustainability of the workforces particularly those deemed vulnerable.
- Supporting the growth and retention of the Māori workforce to better support a health workforce that reflects the South Island population.
- Ensuring a culturally competent workforce.
- Providing leadership opportunities for the clinical workforce.
- Optimising enablers to support the health workforce.
- Improving workforce data and intelligence in collaboration with HWNZ & DHBSS.
- Collaborating with the other Regional Development Hubs, Health workforce New Zealand (HWNZ) and District Health Boards Shared Services (DHBSS) to share workforce development initiatives at national and regional levels.

SOUTH ISLAND WORKFORCE DEVELOPMENT HUB

	DELIVERABLES		FUTURE WORK	RESPONSIBILITY
	Workforce Planning (value & high performance; one team; closer to home)			
	To build and align the capability of the workforce to deliver models of care and priorities outlined in the refreshed New Zealand Health Strategy. • To support increased opportunities to learn in interprofessional settings. • To Improve the sustainability of the workforces particularly those deemed vulnerable			
1a	**Skill Sharing & Skill Delegation (using the Calderdale Framework).** The Calderdale Framework (CF) for skill sharing and skill delegation continues to be rolled out in Allied Health across the South Island. Projects include skill delegation to Allied Health Assistants (AHAs) and skill sharing with other health professionals. This includes the training of more CF practitioners (2) and facilitators (10—12). Collaboration with Central & Northern Regions continues. Evaluation of the projects is presented	Q1,2,3,4	CF is embedded into acute and community health allied health service delivery, thereby maximising the use of health resources	Lead: SI Directors of Allied Health Reported in: SIHSP
1b	**Allied Health: ENABLE equipment accreditation:** Regional approach to development of resources to support ENABLE accreditation for equipment issue - mobility aids & Activities of Daily Living equipment	Q1,2,3,4	South Island DHBs have agreed clinical & training resources to support Allied Health ENABLE equipment issue	Lead: SI Directors of Allied Health Reported in: SIHSP
1c	**Medicine: new graduates (PGY1s)** Support the South Island DHBs to integrate the increased number of PGY1s (NZ citizens and permanent residents) into the workforce for 2018 graduates	Q1,2,3,4	The South Island DHBs continue to employ their share of medical graduates	Lead: South Island Chief Medical Officers Contributors: South Island RMO Units Reported in: SIHSP
1d	**Medicine: General medicine vocational training** Coordination of general medical vocational training regionally is explored in conjunction with the Royal Australasian College of Physicians.	Q1,2,3,4	Implementation of general medical vocational training regionally is commenced with the support of the Royal Australasian College of Physicians.	Lead: South Island Chief Medical Officers Contributors: South Island RMO Units Reported in: SIHSP
1e	**Nursing** Registered Nurse (RN) Prescribing implementation is coordinated across the South Island. This includes a SI policy, framework and communication plan.	Q1,2,3,4	RN Prescribing role is developed and supported consistently across the South Island health sector to support improved patient outcomes.	Lead: SI Executive Directors of Nursing. Reported in: SIHSP
1f	**Interprofessional Learning/Working is supported** A coordinated clinical simulation network for the South Island is supported with particular focus on rural & Primary care 2-3 South Island teams participate in the Health Care Challenge	Q1,2,3,4	Clinical simulation is supported across the South Island Develop further regional strategies to support interdisciplinary learning	Lead: SIWDH Steering Group Reported in: SIHSP

1g	**Health Literacy** The Workforce Development Hub will support DHBs with any activities that DHBs have identified from their Health Literacy Review as being beneficial across the South Island.			
1h	**Rural Health Medicine** The opportunity of a South Island rural health medicine clinical placement programme is explored to support vocational training	Q4	The identified pathway for clinical rotations is evaluated Rural hospitals have a pool of trainees to recruit from	Lead: South Island Chief Medical Officers Contributors: Rural Hospital Medicine working group. Reported in: SIHSP
Clinical Leadership				
To provide leadership opportunities for the clinical workforce (value & high performance, one team)				
2a	**Regional clinical/professional leadership** Regional networks enable effective professional support for smaller Allied Health & Scientific & Technical professions. This results in clinically led service delivery improvements and increased staff retention Networks that are currently supported are: – Speech language therapy – Audiology – Cardiac physiologists Further networks will be established in 2018/19	Q1,2,3,4	Further professions identified for regional clinical leadership framework	Lead: SI Directors of Allied Health Reported in: SIHSP
2b	South Island AHS&T Career Framework Support the regional development & implementation of the SI AHS&T Career Framework	Q1,2,3,4	Framework agreed to and implementation commences	Lead: SI Directors of Allied Health Reported in: SIHSP
Workforce Diversity				
To support the growth and retention of the Māori workforce to better reflect the South Island population.(equity; value & high performance; one team)				
3a	**Cultural Competence Education** In conjunction with the GMs Māori & GMs HR support a framework for Cultural Competence education which ensures it is embedded into practice for the workforce.	Q1,2,3,4	Establish an evaluation process to ensure there is appropriate change in the clinical environment	Lead: SIWDH Steering Group and SI GMs Māori
3b	**Experience of Māori in the South Island DHBs** Evaluation of the experiences of Māori who have recently entered the South Island DHB health workforce in conjunction with Ass Prof Joanne Baxter, University of Otago	Q4	To identify how DHBs can best support emerging Māori health practitioners (individually, collectively and organisationally) as they transition from the education sector, into the workforce.	Lead: SIWDH Steering Group and SI GMs Māori
3c	**Ethnicity Data** Present ethnicity data (including trend analysis) annually to the South Island DHB clinical leaders	Q3	Annual update with revised data	Lead: SIWDH Steering Group and SI GMs Māori & GMs HR/P&C

				Reported in: SIHSP
3d	**Māori Workforce** Increased Māori DHB clinical workforce, working towards reflecting the South Island population.	Q3	Monitor that SI DHB Māori workforce is increasing to better reflect the population	Lead: SIWDH Steering Group and SI GMs Māori
Workforce Enablers				
Optimise enablers to support the health workforce (value & high performance; smart system)				
4a	**NZ Instance of Lippincott (Clinical Procedures)** The South Island and 8 North Island DHBs are working in partnership to implement a framework for the management of New Zealand instance All changed procedures are reviewed Oncology & renal clinical expert groups have reviewed relevant procedures	Q1,3	Ongoing monitoring to ensure increased usage in the South Island.	Lead: SI Executive Directors of Nursing in partnership with the Midland Region Executive Directors of Nursing Contributors: Lippincott Implementation Group. Reported in: SIHSP
4b	**Elearning platform**: Work with the sector, which is using similar technology, to collaborate on alignment of design, content sharing & learning community activities.	Q1,2,3,4	Continue to explore opportunities to develop and share content across the NZ health sector	Lead: SIWDH Steering Group Reported in: SIHSP
Workforce Data and Intelligence				
To improve workforce data and intelligence in collaboration with HWNZ & DHBSS.				
5a	**Workforce Data and intelligence** Health Workforce data and intelligence is collected to support planning	Q,3	Workforce modelling for service planning with available data South Island whole of sector data is available for workforce planning as per HWNZ/MOH/DHBSS plan	Lead: SIWDH Steering Group Reported in: SIHSP
5b	**Workforce pipeline** Priority workforces are identified and plans developed to ensure adequate supply in conjunction with the education providers and HWNZ.	Q1,2,3,4	Ongoing monitoring of workforce need/supply based on the model of care.	Lead: SIWDH Steering Group Reported in: SIHSP
Monitoring/ business as usual activities.				
Workforce planning				
6a	**Kaiāwhina** workforce Allied Health Assistants (AHAs) working across the South Island health system have access to appropriate NZQA level 3 training	Q4,	Through regional provision of training & an established framework for delegation, AHAs are fully utilised in the delivery of care in acute & community settings Continue to work with Careerforce to ensure qualifications remains relevant to the health sector	Lead: South Island Directors of Allied Health Reported in: SIHSP

6b	**Medicine**: new graduates Community based attachments (CBAs)are in place to meet requirements of new Medical Council curriculum	Q4	Increasing numbers to achieve 100% compliance in 2020.	Lead: South Island Chief Medical Officers Contributors: RMO Units Reported in: SIHSP
Priority (Vulnerable) Workforces				
6c	**Sonography** Support for the training of Sonographers to meet the identified South Island need	Q4		Lead: South Island DAHs Contributors: South Island Sonography training group Reported in: SIHSP
6d	**Imaging Workforce** is fit for purpose. Contribute to the national work being undertaken by DHBSS.	Q4		Lead: South Island Directors of Allied Health Reported in: SIHSP
Workforce Enablers				
6f	**Elearning** An increased number of eLearning packages are co-designed which can be shared nationally	Q4	Ongoing review and development of online learning modules	Lead: SIWDH Steering Group. Reported in: SIHSP

National and regional projects supported by the SLA/Workstream but led by other SLAs/Workstreams or individual DHBs

Deliverable: (Item 5, page 44)
Owner: Palliative Care Workstream

Deliverable: (Item 4, page 30)
Owner: Cardiac Services Workstream

Deliverable: Vulnerable Services: Orthopaedics (Item 8a,b,c, page 35)
Owner: Elective Services Workstream

Deliverable: (Item 5, page 43)
Owner: Mental Health & Addictions SLA

Deliverable: (Item 6, page 39)
Owner: Hospital Oral Health Workstream

Deliverable: (Item 3a-e, page 41)
Owner: Major Trauma Workstream

Deliverable: Has identified workforce as a potential focus (page 24)
Owner: Medical Imaging

Appendix 1: Minister of Health's Letter of Expectation

Hon Dr David Clark

MP for Dunedin North
Minister of Health
Associate Minister of Finance

Mrs Kathy Grant
Chair
Southern District Health Board
Private Bag 1921
DUNEDIN 9054

Dear Mrs Grant

Letter of expectations for District Health Boards and Subsidiary Entities for 2018/19

This letter sets out the Government's expectations for District Health Boards (DHBs) and their subsidiary entities for 2018/19.

The Government wishes to signal an increased priority for primary care, mental health, public delivery of health services, and a strong focus on improving equity in health outcomes.

This Government listened to New Zealanders, and campaigned on these concerns. We will deliver on our democratic mandate to ensure New Zealand has a strong and effective public health service that we can all be proud of. To achieve this we want the public health service to be accessible and affordable for all New Zealanders, and to ensure that appropriate services are provided in the right locations at the right times.

Our Approach

Our Government wants to improve population health. Population health approaches and services are essential components of strategies to address determinants of health and achieve better health equity and wellbeing. I expect DHBs to work closely with and support their local public health units and health promotion providers. New Zealanders have made it clear that they are concerned about the increasing unaffordability of primary health services, regional inequity of access to secondary health services, and inadequate mental health service provision nationwide.

Our Government takes a longer term view. To this end, we will review the primary care funding formula and DHB targets, as well as wider sector settings. The Ministerial Advisory Group will also advise me on further opportunities to improve equitable health outcomes for all New Zealanders including how the system needs to change to enable those improvements. It is expected that you will be fully supportive of this work, and where appropriate will provide direct contribution.

We intend to better resource primary care in order to deliver better health outcomes, and to reduce the growing pressure on emergency services. In Budget 2018, we will lay out our plan to reduce the cost of access to primary care for New Zealanders.

In our first 100 days we have introduced legislation to increase access to medicinal cannabis, and launched the Government Inquiry into Mental Health and Addiction. We expect your staff and members of your community to participate in the Inquiry and I expect you will encourage your people to do this.

Funding

There is no doubt that there has been a low priority on funding health in recent years. In contrast to other countries, core Crown health expenditure in New Zealand dropped as a proportion of the overall economy between 2008 and 2017. It is a credit to those who serve across the health sector that health outcomes have held up as well as they have despite nine years of under investment. Please pass on my sincere thanks to your staff for their commitment and service to the public, particularly during difficult times.

The Government is committed to delivering a well-funded public health service. That is why we will invest $8 billion to meet cost pressures and deliver new initiatives over the next four years. While this is more generous than before, much of the new funding will be absorbed in the service improvements already signalled by the Government. The public will rightly want to see the health system delivering more for them in return for the increased investment.

Capital Planning

I expect that your DHB will continue to focus on long term capital planning. This work should include service planning and understanding the state of your assets. I anticipate the need to prioritise the available capital funding, and your work in this area will assist in this process. I also require you to continue to work regionally when developing business cases for investment.

Accountability for Improved Performance

We will hold DHB Chairs directly accountable for their DHB's performance. We expect Boards to be highly engaged and to hold Chief Executives and management tightly accountable for improved performance within each DHB, particularly in relation to equity of access to health services and equity of health outcomes.

Under the previous government, relationships across the health sector became strained. My expectation is that the Ministry Advisory Group will work with the Ministry of Health to strengthen these relationships.

I trust that you will work with your regional DHBs to support regional delivery of services where appropriate. There should be strong shared responsibility and accountability across regions to ensure that regional services are delivered well and support equity of access for the population.

I expect that you will incorporate and share best practice innovation with the wider sector. Clinical leaders play a key role in this work. Strong and proactive relationships with the Ministry, other DHBs, primary health organisations (PHO), non-governmental organisations, and other stakeholders across the sector will be required. I am looking for increased collaboration across all parts of our health

service to deliver more affordable primary care, improved elective surgery volumes, improvements in equity of access to services, and a higher quality of care.

I will be meeting and speaking with you frequently during the year to discuss performance, and I will be looking particularly closely at your ability to work together to deliver in the Government's priority areas, and to keep within budget.

Workforce

To deliver affordable, accessible and quality care, workforce changes will be needed. This includes greater utilisation of different workforces in primary care settings. With a growing and aging population, there will be more work for all, and an increased emphasis on the use of generalist workforces for less specialised tasks will be required. Health care professionals from allied health, nursing, medicine and related fields will need to operate at the top of their scope of practice. I expect DHBs to be bold in their vision for change while also remaining responsive to the concerns raised by the workforce.

I understand DHB Chief Executives have collectively signed up to having Care Capacity Demand Management fully in place in all DHBs by July 2021 with oversight of progress and feedback on milestones monitored by the Safe Staffing and Health Workplaces Governance Group. I encourage you to proceed with timely implementation and expect that acute mental health inpatient services are a first priority. I also encourage you to address wider workforce development to better respond to mental health issues, in line with the *Mental Health and Addiction Workforce Action Plan.*

Additionally, to ensure greater community-based care and assist in workforce development, I expect all DHBs to adhere to the Medical Council's requirement for Community Based Attachments for interns.

We are also interested in expanding the role of health-based professionals in school settings. This includes considering the role of health-based professionals in primary and early education in the future, and extending School Based Health Services so all secondary schools have a comprehensive youth health service.

Expansion of PHARMAC model to manage hospital medicines

PHARMAC's role in managing hospital medicines has steadily increased. Most recently, since 2013 PHARMAC has made decisions on the adoption of new technology in hospital medicines. In my letter of 27 April 2018, I confirmed that from 2018/19 the full budget management responsibility for all remaining hospital medicines will move from DHBs to PHARMAC, in order to support our wider health priorities.

National Patient Flow

As you will be aware, National Patient Flow is a new developmental national collection that the Ministry and DHBs have been implementing over the past three years. The collection will provide information at key points of the patient journey through secondary and tertiary care, helping DHBs to quantify unmet referred demand for services, and to better understand and improve their patient management processes.

I anticipate that this will become a core national collection in the future, and I expect DHBs to continue working in partnership with the Ministry with a focus on improving data submission and data quality for the National Patient Flow collection during 2018/19.

Planning for 2018/19 and the future

We are focused on ensuring better health outcomes for the public, and have clear expectations for all DHBs. This includes the following.

- Increasing the rate of organ donations. DHBs are expected to manage the associated costs within their baselines.
- Improving the health and wellbeing of infants, children and youth. I expect that your 2018/19 annual plan shows how you will achieve this, particularly for Māori, Pacific people, and people living in high areas of deprivation.
- Improving equity and reducing the burden caused by long term conditions, in particular diabetes. I expect DHBs in their contracts with PHOs to explicitly require improvements in performance and reporting. I expect DHBs to incentivise PHOs to demonstrate improvement in primary care settings and increase PHO accountability for effectively managing long term conditions with particular regard to diabetes.
- The Government also wants to support our health system to implement a strong response to climate change, this will include working with other DHBs, other agencies and across Government. Plans to address climate change and health, need to incorporate both mitigation and adaptation strategies, underpinned by cost benefit analysis of co-benefits and financial savings.

Your DHB's annual plan for 2018/19 will need to reflect my expectations. In addition, I am not requiring your DHB to refresh your Statement of Intent in 2018/19. However, I will expect all DHBs to demonstrate a renewed focus on their strategic direction by refreshing their Statements of Intent in 2019/20.

Finally, I would like to thank you and your DHB again for your ongoing work to improve the health of New Zealanders. The public deserves the highest standards of leadership and performance, and by working together we can ensure that improvements are made for our population.

Yours sincerely

Hon Dr David Clark
Minister of Health

Appendix 2: 2018/19 Regional Service Plan Guidelines

Acknowledging the Ministry of Health 2018/19 Regional Service Plan Guidelines and the enabler lens applied to regional planning, the following table directs where in our workplans to find each of the enabler requirements.

Priority	Guidance	Refer to
Enabler: Workforce		
Workforce Diversity	Workforce data and intelligence Training placements for new health professional graduates Increase Maori participation and retention, build cultural competence	Workforce Development Hub, page 63-67
Health Literacy	Build health literacy skills among the health workforce	Workforce Development Hub, page 65
Palliative Care	Resource requirements for palliative care services Address current and future needs for palliative care	Palliative Care Workstream, page 46-47
Cardiac Services	Cardiac physiology services Resource requirements for cardiac services	Cardiac Services Workstream, page 30-32
Elective Services	Workforce plan to maximize resources Review of Orthopaedics resources and plan	Elective Services Workstream, item 8-9; page 36
Mental Health	Implementation of Mental Health and Addiction Workforce Action Plan 2016-2020	Mental Health & Addictions SLA, item 5; page 45
Addiction Treatment Services	Build capability to support implementation of SACAT	Mental Health & Addictions SLA, item 3; page 44
Stroke Services	Understand acute and rehabilitation service needs Innovation in service delivery	Stroke Services Workstream, item 7-10, page 52
Enabler: Technology and Digital Services		
Single Electronic Health Record	Develop business case	Information Services SLA, page 60
Digital Health Strategy	Publishing of the Digital Health Strategy	Information Services SLA, page 60
Digital Hospital	Target gaps in hospital digital maturity with regionally aligned solution based on EMRAM assessment. DHBs to recognise the need for enabling infrastructure to support delivery of digital hospital capability.	Information Services SLA, page 60
Share Clinical Information	Continued integration of standards based systems for sharing clinical information with consumers and providers regardless of location with a focus on the person	Information Services SLA, page 60
IT security maturity enhancement	Collaborate with MOH and across the wider sector to drive increased IT security maturity	Information Services SLA, page 61
National Screening Solution	SI planning to support Bowel Screening Regional Centre development and implementation and Tranche 2 & 3 rollout schedule Engage in cervical screening project planning to support HPV testing	Southern Cancer Network, item 7, page 27 Electives Workstream, item 7, page 36
Integration Services	National Screening Solution to be the first tranche on the Integration Service	Information Services SLA, page 61
Telehealth	Regional telehealth programme	Telehealth Workstream, page 54

Maternity	Continued work with DHBs to implement the national maternity record	Information Services SLA, page 61
Newborn hearing screening	Collaborate with the MoH to progress a regional approach to implementing NHIMS	Information Services SLA, page 61
Nationally consistent Electronic Oral Health Record	Working to address issues and risks by making improvements where possible that incrementally move towards a nationally consistent and integrated EOHR	Information Services SLA, page 61
National Digital Services	Enhancement, adoption and operation of national digital services	Information Services SLA, page 61
Medicines Management Digital Services	Support the MoH to develop an action plan for the adoption of NZePS across general practices	Information Services SLA, page 61
National Patient Flow	Support DHBs to be able to provide quality reporting	Information Services SLA, page 61 Elective Services Workstream, page 36
Cancer Information Strategy	Regional coordination for DHBs alignment to collect and report consistent cancer data	Southern Cancer Services, item 5,9,11,15,16; page 26-29
Mental Health	Implement integrated systems for sharing clinical and mental health information, including creating Mental Health Patient Care Plans and record mental health activity	Information Services SLA, item 15-18; page 60
Stroke Services	Support access to thrombolysis through telestroke services	Stroke Services, item 5-6; page 51-52
National Major Trauma data collection	Report the elements of the National Major Trauma Minimum Dataset to the NZ Major Trauma Registry	Major Trauma, item 1; page 42
Enabler: Quality		
Regional Quality and Safety	Multi-disciplinary regional governance structures that focus on patient safety and quality improvement	Quality and Safety SLA, page 55-56
Healthy Ageing	Support Healthy Ageing Strategy, in particular interRAI quality indicators	Health of Older People SLA, 37-28
Elective Services	Quality improvement, particularly equity, through regional models of care for vascular, breast reconstruction, regional collaboration on ophthalmology	Elective Services Workstream, item 3-5, page 35
Cancer Services	Regional co-ordination and quality improvement initiatives that align with national strategies to achieve health gain for Māori Support DHBs to achieve service improvements around FCT, prostate cancer decision tool, quality of life for people who have completed treatment	Southern Cancer Services, page1-3, 5, 9, 10, 17, 19; page 26-29
Mental Health	Regional quality improvement activities in conjunction with HQSC	Mental Health & Addictions SLA, item 4; page 44
Stroke Services	Support DHBs to ensure patients are admitted to a stroke unit or organised stroke service	Stroke Services Workstream, item 1; page 50
Major Trauma	Quarterly reporting of the NZ Major Trauma Minimum Dataset to the National Major Trauma Registry	Major Trauma Workstream, item 1; page 42

	Six monthly regional review process of alignment of actual service delivery for major trauma patients with inter-hospital transfer and staging policies	
Enabler: Clinical Leadership		
Regional clinical leadership and capacity	Identify: the role of clinical leaders within the governance structure, level of authority, level of multi-disciplinary involvement clinical leadership have been engaged with early development of priorities and expenditure decisions how clinical leadership capability has been developed how clinical networks support quality and sustainability of services services within the region that may benefit from development of clinical network	Section 4.5 Clinical Leadership, page 18-19
Healthy Ageing	Regional support for DHB delivery of actions in Healthy Ageing Strategy, in particular support for carers following diagnosis of dementia	Health of Older People SLA, page 37-38
Cardiac Services	Support cardiac networks Provide quarterly reporting utilising ANZACS-QI and Cardiac Surgery registers Review and audit the Accelerated Chest Pain Pathways in EDs	Cardiac Services Workstream, item 6; page 31-32
Elective Services	Regional clinical leadership supports effective decision making in regional collaboration, particularly for ophthalmology, vascular and breast reconstruction services	Elective Services Workstream, item 1-5; page 35
Cancer Services	Ensure clinical leadership at a regional level to support service improvements	Southern Cancer Services, item 18 (among others); page 26-29
Mental Health	Outline how clinical leadership will support quality improvement, in particular HQSC mental health improvement initiative	Mental Health & Addictions SLA, item 4; page 44
Addiction Treatment Services	Outline how clinical leadership is supporting SACAT implementation	Mental Health & Addictions SLA item 3; page 44
Stroke Services	Support nursing and medical stroke leadership roles, including identifying the importance of non-clinical hours and allied health stroke service activity. Provide regular stroke education programme	Stoke Services Workstream, item 1, 12; page 50-53
Major Trauma	Provide clinical leadership of the National Major Trauma Registry to support service improvements	Major Trauma Workstream; page 42-43
Enabler: Pathways		
Cardiac Service	Work regionally to improve pathways for patients with acute coronary syndrome, heart failure, atrial fibrillation, ischaemic heart disease	Cardiac Services Workstream, page 30-32
Elective Services	Development and implementation of regional models of care for vascular, breast reconstruction, and ophthalmology Explore the option of adopting early intervention programmes to prevent/delay surgery	Elective Services Workstream, item 3-5, 6; page 35-36

Cancer Services	Regional co-ordination and support of actions to improve cancer systems to ensure health gain for Māori and equitable services	Southern Cancer Services, item 4, 6, 8, 12, 14; page 26-29
Mental Health	Outline how: Primary, secondary and tertiary pathways are being improved Forensic and maternal mental health pathways are being improved The care of complex clients requiring medium secure rehabilitation is being improved	Mental Health & Addictions SLA, item 6-7; page 44-45
Addiction Treatment Services	Outline how the addiction treatment model of care is being implemented, particularly in relation to SACAT Act	Mental Health & Addictions SLA, item 3; page 44
Stroke Services	Work regionally to improve acute and rehabilitation stroke pathways for patients with ischaemic stroke and TIA	Stroke Services Workstream, item 7-11; page 50-53
Major Trauma	Continue to implement regional stroke destination policies, inter-hospital transfer processes and staging guidelines	Major Trauma Workstream, item 4; page 42
Regional priorities		
Hepatitis C	Range of actions to support integrated Hepatitis C assessment and treatment, increase Hepatitis C treatment uptake and diagnosis	Regional Hepatitis C working group, page 39-40

Appendix 3: Regional governance, decision making and funding model

6.1 Decision making

The South Island Alliance approach to decision making is guided by the South Island Alliance Strategy. Decision making is detailed, along with the process for resolving disputes, in the South Island collective decision making principles below.

As a region we acknowledge that each DHB has different drivers and circumstances, but are committed to ensuring equity of outcomes for South Island people. It is acknowledged that there may be areas within the scope of the activities of the Alliance where a particular DHB either may wish to, fully or partially, take a separate path from the Alliance activities. The Charter outlines that each Board can choose not to take up a regional activity at the time of commencing however, once agreed, the Board will be bound to operate within the scope and decision making criteria agreed. Any DHB intending to exercise this right will do so in good faith and will consult the other South Island DHBs before exercising this right.

6.1.1 Escalation pathway

The Alliance operates under the following escalation pathway:

- Operational group (including SLA/Workstreams) to Alliance Leadership Team (South Island DHB CEOs);
- Alliance Leadership (South Island DHB CEOs) to Alliance Board (South Island DHB Chairs); and
- Alliance Board (South Island DHB Chairs) to Shareholding Minister.

6.2 Regional funding and approval model

All work undertaken by the South Island Alliance must align with the goals and principles of the South Alliance Island Strategy and address one or more of the eight South Island Alliance outcomes. The region is acutely aware of the fiscal constraints impacting health services and the need to focus on innovation, service integration, improved efficiency and reduced waste to support provision of high quality care. Proposals for regional activity must clearly identify the value proposition for patients and/or the system, including how it will address equity.

As the workplans are developed and endorsed, resource requirements are identified. Where possible implementation is undertaken by staff within the DHB services or SIAPO. Where this is not an option the people resource is included in the budget bid process as outlined below.

The budget bid process is undertaken with the South Island General Managers Planning and Funding. This allows bids to be prioritised against national, regional and local priorities. Bids are identified that are supported subject to the DHB funding package and, where requested, for significant and /or multi-year investments, a fully costed proposal or business case. A final recommendation to the South Island Alliance Leadership Team is made when the DHB funding package is known and the GMs Planning & Funding have endorsed the recommendations.

Regional activity that needs project or capital funding for Information Services and other capital investments involves discussions with South Island GMs Planning & Funding and South Island Chief Financial Officers. A recommendation is then made to the South Island Alliance Leadership Team or Regional Capital Committee (if greater than $500k) for approval.

The South Island Alliance Programme Office manages the operational budget for the Programme Office activities, including facilitation for the regional planning activities as outlined in the South Island Health Services Plan. The DHBs fund the Programme Office on a PBFF basis.

South Island collective decision making principles

Decision Making Principles

- The parties will be proactive to ensure that decisions required are made in a timely manner. Where delays in decision making are unacceptable to any of the DHBs, they can trigger escalation.
- Decisions will be taken at the lowest level that meets individual DHBs delegated authority policy requirements, and escalation will only be used if agreement cannot be reached after reasonable attempts to resolve disagreement.
- Where decisions are required of the Chief Executive Group and beyond, documentation will include detailed cost benefit analysis and an impact analysis which demonstrates both the collective and individual DHB impacts. Evidence that the South Island CFO's have supported the cost benefit analysis, and that the relevant Senior Leadership (such as GM's Planning and Funding, COO's, HR, CMO's, DON's etc.) have supported the robustness of the impact analysis and recommendations will be included in the papers.
- As much advance notice of decision making requirements will be given as possible. This is particularly pertinent where the decisions are significant or it is reasonably foreseeable that there will be either divergent views or significant stakeholder interest. Advance notice will be considered as a part of the relevant groups planning processes.
- Where a decision is required to be made, this will be noted through the appropriate agenda, together with supporting papers, distributed with no less than five working days' notice, unless shorter notice is supported unanimously by the parties making the decision.
- Decisions will be by consensus.
- In the event that a DHB is unable to attend the meeting, either through the substantive member or an alternate, the relevant DHB will either appoint a proxy or they will subsequently confer with the Chair of the meeting to determine whether they can support the consensus reached by the attending parties
- It is noted that each DHB has slightly different delegations policies, and because of this, time needs to be provided in any planning process to allow significant decisions to be taken back through individual DHB internal processes. This will be accommodated in planning processes.
- Where consensus agreement cannot be reached, the relevant group will agree to either:
- Seek independent input or mediation to attempt to resolve any disagreement, or
- Escalate the matter through the escalation pathway noted below.

Key determinants behind whether independent input/mediation/escalation will be used are the relevant group views as to:

- likelihood of successful resolution of the disagreement in a timely manner; and/or
- whether time constraints permit delay.

Where agreement cannot be reached, the parties will document their perspective of the matter to ensure the party or parties to whom the matter has been escalated are fully informed of the difference of views.

- Where independent input or mediation is chosen, the District Health Boards will appoint the independent adviser / mediator by consensus decision. In the event that consensus is not reached the Director General or nominee will be the default mediator.

Escalation Pathway

The following is the escalation pathway:

- Operational groups to Chief Executive group;
- Chief Executive Group to Chair Group; and
- Chair Group to Shareholding Minister

Appendix 4: Alliance group membership

Strategic Planning and Integration Team

Name	Title	DHB
Dr Carol Atmore (Chair)	General Practitioner	Primary Care, Dunedin
Carolyn Gullery	Executive Director, Planning and Funding and Decision Support	CDHB/WCDHB
Hilary Exton	Director of Allied Health	NMDHB
Daniel Williams	Community and Public Health	CDHB
Pania Coote	Executive Director, Māori Health (Kaiwhakahaere Hauora Māori)	SDHB
Karyn Bousfield	Director of Nursing and Midwifery	WCDHB
Mark Leggett	General Manager, South Island Alliance Programme Office	SIAPO

Alliance Operational Group

	Name	Title	DHB
Oversees Elective Services workplan	Cathy O'Malley	General Manager Strategy, Planning and Alliance Support	NMDHB
	Carolyn Gullery	Executive Director, Planning and Funding and Decision Support	CDHB/WCDHB
	Lisa Blackler	Director Patient, Nursing & Midwifery	SCDHB
	Pauline Clark	General Manager, Christchurch Hospital	CDHB
	Lexie O'Shea	General Manager, Clinical Services	NMDHB
	Philip Wheble	General Manager Grey Westland Health Services (Acting)	WCDHB
	Nigel Millar	Chief Medical Officer	SDHB
	Lisa Gestro	General Manager, Planning and Funding	SDHB
	Jason Power	Director, Corporate Services	SCDHB
	Sue Nightingale	Chief Medical Officer	CDHB
	Nick Baker	Chief Medical Officer	NMDHB
	Mark Leggett	General Manager, South Island Alliance Programme Office	SIAPO
	Janice Donaldson	Programme Manager, South Island Electives	SIAPO

Service Level Alliances and Workstreams

SLA	Name	Title	DHB
Southern Cancer Network	Mr Todd Hore (Chair)	General and Hepatopancreatobiliary Surgeon, CDHB	CDHB
	Nicholas Glubb	Southern Cancer Network Manager	SIAPO
	Shaun Costello	Clinical Director, Southern Cancer Network/Clinical Director Medicine & Radiation Oncologist	SDHB
	Dr Sue Crengle	Chair	Te Waipounamu Māori Leadership Group
	Theona Ireton	Kaitiaki	CDHB
	Marj Allan	Consumer & South Island Alliance Palliative Care	South Island Cancer Consumer Group
	Danielle Dawson	Cancer Support Coordinator	West Coast PHO
	Tristan Pettit	Paediatric Oncologist	CDHB
	Pania Coote	Director of Maori Health and Whanau Ora	SDHB
	Michelle Mathijssen	Regional Manager Northern South Island	CanTeen
	Ralph La Salle	Planning & Funding (Team Leader Secondary Care)	CDHB
	Mike Kernaghan	National Strategic Advisor	Cancer Society of New Zealand
	Lisa Blacker	Director of Patient, Nursing and Midwifery Services	SCDHB
	Lexie O'Shea	GM Clinical Services	NMDHB
	Dr Pragati Gautama	GP	Cromwell Medical Centre

SLA	Name	Title	DHB
Child Health	Dr Clare Doocey (Chair)	Paediatrician, Chief of Child Health	CDHB
	Vacant	Facilitator	SIAPO
	Peter McIlroy	Paediatrician	NMDHB
	Teresa Back	Maternal, Child and Youth Services	SCDHB
	Barry Taylor	Professor of Paediatrics	University of Otago
	Wayne Turp	Project Specialist, Planning and Funding	CDHB
	Jaana Kahu	Māori Child and Youth Health	Te Tai o Marokura
	Traci Stanbury	Consumer	Canterbury
	Rosalie Waghorn	Nurse Manager Clinical Services - Strategic	WCDHB
Health of Older People Services	Dr Val Fletcher	Consultant Physician	CDHB
	Jane Large	Facilitator	SIAPO
	Maria Scott-Multani	Wellness Manager, Ardvida Group Ltd	Canterbury
	Jason Power	Snr Business Analyst, Planning & Funding	SCDHB
	Yoram Barak	Psycho-geriatrician	SCDHB
	Margaret O'Connor	Nurse Practitioner	SDHB
	Karen Kennedy	Community Pharmacist, Primary and Community Services	SCDHB
	Ann Armstrong	Consumer	Nelson
	Andrew Metcalf	Director Allied Health	SDHB
	Janette Balfe	Clinical Manager, Allied Health	CDHB
Palliative Care	Dr Kate Grundy (Chair)	Consultant Physician in Palliative Medicine	CDHB
	Vacant	Facilitator	SIAPO
	Faye Gilles	Clinical Nurse Manager Hospice South Canterbury	South Canterbury
	David Butler	Clinical Lead Otago Hospice	Otago
	Karen Kennedy	Pharmacist	Timaru
	Dr Richard Fuller	GP	Motueka
	Carla Arkless	Palliative Care Nurse Practitioner/ ACP co-ordinator	Nelson Tasman Hospice/NMDHB
	Rachel Teulon	Clinical Nurse Specialist, Paediatric Palliative Care	Nurse Maude
	Jane Rollings	Service Manager	Nurse Maude
	Theona Ireton	Māori representative	CDHB
	Christine Cuff	Consumer	Hokitika
Mental Health & Addiction Services	Heather Casey (Chair)	Director of Nursing	SDHB
	Martin Kane	Facilitator	SIAPO
	Alfred Dell'Ario	Consultant Psychiatrist	CDHB/WCDHB
	Evan Mason	Consultant Psychiatrist	SDHB
	Jane George	Allied Health	WCDHB
	Jane Kinsey	General Manager Mental Health, Addictions & Disability Support	NMDHB
	Karaitiana Tickell	CEO, Purapura Whetu Trust	Canterbury
	Thomas Cardy	Operations Manager	pact
	Dianne Black	Consumer Advisor	SCDHB
	Sandy Dawson	Family Advisor	ABLE-Invercargill
	Steve Bayne	Service Manager	SCDHB
	Kaye Johnston	Service Manager	CDHB

SLA	Name	Title	DHB
Information Services	Graham Crombie (Chair)	Director Innovatio Ltd	Independent
	Paul Goddard	Portfolio Director, Information Services	SIAPO
	Sonya Morice	IS SLA Regional Portfolio Manager	SIAPO
	Bev Nicolls	Community Based Services Directorate / General Practitioner	NMH & Stoke Medical Centre
	Nigel Trainor	Chief Executive	SCDHB
	John Beveridge	Nurse Consultant	CDHB
	Nigel Millar	Chief Medical Officer	SDHB
	Russell Rarity	Clinical Director, Anaesthetics	SCDHB
	Stella Ward	Chief Digital Officer	CDHB/WCDHB
	Patrick Ng	Executive Director, Specialist Services	SDHB
	Carolyn Gullery	General Manager, Planning and Funding	CDHB & WCDHB
	Peter Gent	General Practitioner	Mornington Health Centre
	Gabe Rijpma	Senior Director, Health and Social Service Industry, Microsoft	Independent
	Kyle Ford	Chief Information Officer	WellSouth Primary Health Network
Quality and Safety	Mary Gordon (Chair)	Executive Director of Nursing	CDHB
	Martin Kane	Facilitator	SIAPO
	Ken Stewart	Community Physiotherapist	Selwyn Village Physiotherapy
	Peter Twamley	Clinical Governance Manager	NMDHB
	Tina Gilbertson	General Manager Quality and Risk	SDHB
	Karen Foster	Quality and Risk Nurse Coordinator	SCDHB
	Iwona Stolarek	Medical Advisor	HQSC
	Karen Orsborn	Deputy CEO	HQSC
	Carolyn Gullery	General Manager Planning and Funding	CDHB & WCDHB
	Nick Baker	Chief Medical Officer	NMDHB
Cardiac Services	John Edmond (Chair)	Cardiologist	SDHB
	Alan Lloyd	Facilitator	SIAPO
	Rob Hallinan	Service Manager	CDHB
	Rachael Byars	Physician and Clinical Leader	SDHB
	Garry Nixon	Medical Officer	Dunstan Hospital
	Tammy Pegg	Cardiologist	NMDHB
	Harsh Singh	Cardiac Surgeon	CDHB
	Philip Davis	Cardiac Surgeon	SDHB
	John Lainchbury	Cardiologist	CDHB
	Ralph la Salle	Team Leader Secondary Care, Planning and Funding	CDHB
	Dr Ken Boon	Cardiologist	SCDHB
	Kirsty Mann	Right Care Advisor, South Island	St John
	Nina Stupples	Rural GP/Medical Officer	WCDHB

SLA	Name	Title	DHB
Major Trauma	Dr Mike Hunter (Chair)	Clinical Leader ICU	SDHB
	Alan Lloyd	Facilitator	SIAPO
	Dominic Fleischer	Specialist Emergency Physician	CDHB
	Christopher Wakeman	Surgical Consultant	CDHB
	Dr Andrew Laurenson	Clinical Lead, ED and Rural Medicine	WCDHB
	Peter Doran	SMO Anaesthetist	SCDHB
	Kris Gagliardi	National Patient Pathways Manager	St John
	Ralph la Salle	Team Leader Secondary Care, Planning and Funding	CDHB
	Martin Watts	Emergency Medicine Specialist, Acting Clinical Leader	SDHB
	Alison Drewry	Senior Medical Advisor	ACC
	Angus Jennings	Orthopaedic Surgeon	NMDHB
	Melissa Evans	Trauma Nurse Coordinator	CDHB
	Rebecca Coats	Trauma Nurse Coordinator	SDHB
Stroke Services	Dr John Fink (Chair)	Clinical Director, Neurology	CDHB
	Jane Large	Facilitator	SIAPO
	Dr Wendy Busby	Consultant Physician & Geriatrician	SDHB
	Dr Kylie Butcherine	GP and Lead Stroke Physician	SDHB
	Clare Jamieson	Occupational Therapist	CDHB
	Julian Waller	Stroke Clinical Nurse Specialist	SCDHB
	Dr Suzanne Busch	Geriatrician, General Physician	NMDHB
	Dr Carl Hanger	Stroke Rehabilitation Consultant & Geriatrician	CDHB
	Jason Power	Director, Corporate Services	SCDHB
	Mary Griffith	Clinical Nurse Specialist - Stroke	CDHB
	Margot van Mulligen	Physiotherapist	WCDHB
South Island Public Health Partnership	Keith Reid (Chair)	Clinical Leader, Medical Officer of Health	SDHB
	Ruth Teasdale	Facilitator	SIAPO
	Dr Stephen Bridgman	Clinical Director, Public Health	NMDHB
	Peter Burt	Portfolio Manager	MoH
	Peter Burton	Public Health Service Manager	NMDHB
	Evon Currie	General Manager, Community & Public Health	CDHB, WCDHB, SCDHB
	Lynette Finnie	Service Manager, Public Health Services	SDHB
	Andrew Forsyth	Team Leader , Public Health Group	MoH
	Dr Natasha Murray	Principal Adviser, Public Health	MoH
	Dr Ramon Pink	Clinical Director, Medical Officer of Health, and Māori Public Health Portfolio	CDHB
	Sarah Reader	Manager, Public Health Group	MoH

SLA	Name	Title	DHB
South Island Workforce Development Hub	Mary Gordon (Chair)	Executive Director of Nursing	CDHB
	Kate Rawlings	Programme Director	SIAPO
	Kathryn Goodyear	Facilitator	SIAPO
	Jenny Humphries	Director of Midwifery	SDHB
	Rene Templeton	Associate Director of Allied Health, Scientific and Technical	SCDHB
	Nigel Millar	Chief Medical Officer	SDHB
	Gary Coghlan / Hector Matthews	General Managers of Māori Health	WCDHB / CDHB
	Pam Kiesanowski	Director of Nursing and Midwifery	NMDHB
Hospital Oral Health Workstream	Lester Settle	Clinical Director Hospital Oral Health	CDHB
	Tim Mackay	Oral Health Clinical Leader & Deputy Chief Medical Officer	SDHB
	Jacqui Power	Practice Coordinator Hospital Dental Service & Department of Oral & Maxillofacial Surgery	CDHB
	Donna Kennedy	Head of Department	NMDHB
	Dr Ronald R Schwass	Clinical Director Faculty of Dentistry	Otago School of Dentistry
	Jason Power	Director, Corporate Services	SCDHB
	Irene Wilson	Service Manager	SDHB
	Pamela Gordon	Service Manager	CDHB
	Christine Holloway		SCDHB
	Belinda Dore	Elective Services Manager South Canterbury District Health Board	SCDHB
	Matthew Wood	Workstream Co-ordinator	SIAPO
Medical Imaging Workstream	Nathan Taylor	Radiology Services Manager	SCDHB
	Jess Ettma	Radiology Operations Manager	NMDHB
	Sharyn McDonald	Chief of Radiology	CDHB
	Thomas Bryant	Radiologist	NMDHB
	Benjamin Lang	South Island Regional Radiology Systems Manager	CDHB
	Stephen Jenkins	District Service Manager, Radiology	SDHB
	Philip Thomas	Radiology Team Leader	NMDHB
	Ben Wilson	Clinical Leader. Radiology.	SDHB
	Matthew Wood	Workstream Co-ordinator	SIAPO