South Island Health Service Plan

2014-2017

South Island Regional Health Services Plan

Produced in 2014

By the South Island Alliance Programme Office

On behalf of the five South Island District Health Boards

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FOREWORD

The South Island Alliance Board and Alliance Leadership Team continue to support and recognise the efforts of the South Island Alliance teams and DHBs in addressing the challenges we face within the region. We continue to made significant progress in developing relationships and aligning systems and processes across the region leading to a better experience of care and outcomes for our people. Throughout this plan there are examples of the outcomes and benefits we have achieved to date.

A significant achievement this year has been the approval for the regional incidence of the Patient Information Care System. As this is rolled out across the South Island, this will improve both patient and clinician access to information in order to better support safe and effective care as part of our 'best for people, best for system' approach.

This South Island Health Services Plan (SIHSP) progresses the activities of the South Island Alliance and draws from national strategies and key priorities, including the National Health Targets, the Minister's Expectations, and the Operational Policy Framework. The SIHSP actions are interwoven into each of the South Island DHB Annual Plans with a clear 'Line of Sight' across plans. The plans provide direction and guidance in terms of how the South Island Health System will operate and prioritise its resources and effort. This Plan has been developed taking all of these plans into account, as well as the Minister's Letter of Expectation which is appended to this plan (Appendix 1).

This plan continues to challenge how we work together, however, while acknowledging the efforts and energy of all involved and the progress made, we, as a region and as a country need to address the sustainability of our specialist services. The South Island Alliance recognises that decisions regarding provision of specialist services to our geographically dispersed population cannot be made in isolation from the other regions of New Zealand. The South Island Alliance undertakes to engage with the other regions in regards to reaching decisions around service provision.

While there are some activities underway to support our ageing and rural workforce challenges we will need to continue to focus on these areas to know we can continue to deliver healthcare to our population.

Signed by:

Chris Fleming CEO, Nelson Marlborough DHB

Jenny Black Chair, Nelson Marlborough DHB

David Meates CEO, West Coast & Canterbury DHB

Peter Ballantyne Chair, West Coast DHB

Nigel Trainor CEO, South Canterbury DHB

Murray Cleverley Chair, Canterbury & South Canterbury DHB

Carole Heatly CEO, Southern DHB

Joe Butterfield Chair, Southern DHB

Office of Hon Tony Ryall
Minister of Health
Minister for State Owned Enterprises

2 JUL 2014

Mr Chris Fleming
Chief Executive Officer
Lead Chief Executive Officer for South Island Region District Health Boards
Nelson Marlborough District Health Board
Private Bag 18
NELSON 7042

Dear Chris

2014/15 Regional Services Plan

This letter is to advise you that I approve the 2014/15 South Island Regional Services Plan (RSP). I appreciate the significant work that has been undertaken and I thank you for your effort.

As greater integration between regional DHBs supports more effective use of clinical and financial resources, I expect DHBs to make significant progress in implementing their RSPs during 2014/15. Improving the alignment between DHB Annual Plans and RSPs is an important planning priority and I understand the alignment is better than in 2013/14, however we must continue to strengthen this alignment if we are to achieve the best use of resources.

Improving major trauma services is an important Government initiative as it is the leading cause of disability and death for people under 45 years of age. Regions were asked to focus on this area as a new priority for regional planning in 2014/15. I note there are variations in the approach across the four regions to implement regional major trauma systems and I expect you to continue to work collaboratively with the Clinical Leader for Major Trauma, and with the Ministry to implement and/or improve regional major trauma systems.

Regional Service Plan Agreement
My agreement does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the National Health Board (NHB). All service changes or service reconfigurations must comply with the requirements of the Operational Policy Framework and the NHB will contact you where change proposals need further engagement or are agreed subject to particular conditions. You will need to advise the NHB of any proposals that may require my approval as you review services during the year.

In addition, my agreement of your RSP does not mean approval for any capital projects requiring equity or new lending, or self-funded projects that require the support of the Capital Investment Committee. Approval of such projects is dependent on both completion of a sound business case, and evidence of good asset management and health service planning by your DHBs. Approval for equity or new lending is also managed through the annual capital allocation round.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6804 Facsimile 64 4 817 6504

Finally, please ensure that a copy of this letter is attached to the copy of your signed RSP held by each DHB Board and to all copies of the RSP made available to the public.

Yours sincerely

Hon Tony Ryall
Minister of Health

cc: DHB Chairs and Chief Executive Officers in South Island region

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1 EXECUTIVE SUMMARY

"Steering the course for a sustainable future"

Our vision is a sustainable South Island health system focused on keeping people well and providing equitable, and timely, access to safe, effective, high-quality services as close to people's homes as possible.

1.1 The South Island Context

With a total South Island population of 1,004,370 people (23% percent of the total New Zealand population), implementing diverse, but similar, individual responses duplicates effort and investment and leads to service and access inequality. Regional collaboration is an essential part of our future direction.

This South Island Health Services Plan progresses the direction and key principles that continue to inform regional service development, service configuration and infrastructure requirements.

The regional direction is closely aligned to the national approach and is based on the following concepts:

- More health care will be provided at home and in community and primary care settings;
- Secondary and tertiary services will be provided across District Health Board (DHB) boundaries;
- Flexible models of care and new technologies will support service delivery in non-traditional environments;
- Health professionals will work differently to coordinate a smooth transition for patients between services and providers; and
- Clinical networks and multidisciplinary alliances will support the delivery of quality health services across the health continuum.

Our Service Level Alliances (SLA) and regional activities continue to grow and build on the work undertaken to-date to achieve the vision for South Island health services.

The 2013 census data quantifies the population movements following the Canterbury 2011 earthquakes. Much of this movement has taken place within Canterbury itself. As a region we continue to experience a greater proportion of our population in the older age range while the percentage of our working age group continues to shrink. These factors reinforce the need to continue working together to address the challenges we are face now and will continue to for some time to come.

1.2 South Island Alliance Activity

The Alliance Framework continues to support regional activity across a wide range of clinical and enabling services. Throughout this plan there are examples (see Gains through Regional Collaboration boxes) of achievements we have made and continue to, to improve the health, and experience of care for our population, while we consider how we ensure sustainability of our services. One of the areas that is difficult to measure is the development of relationships. With the supportive nature of the alliance framework there are many occasions where clinicians or managers agree to support another DHB for a period of time through movement of staff or patients. This support has become part of 'business as usual' for the South Island DHBs.

2 INTRODUCTION

The South Island Alliance has brought together the region's five District Health Boards to work collaboratively toward a sustainable South Island health and disability system that is *best for people.*

Our vision to improve the patient journey and the health of the South Island's population emphasises the provision of equitable and timely access to safe, effective, high-quality services, as close to people's homes as possible, consistent with the Government's *Better, Sooner, More Convenient* strategy.

To do this, the South Island Alliance is supporting, existing regional networks to be well-connected and integrated, to align patient pathways, cut waiting times, improve quality and safety, and share information and resources. We are introducing more flexible workforce models and improved patient information systems to better connect the services and clinical teams involved in a patient's care.

By using our combined resources and the strength and experience of our people, our DHBs can collaboratively work towards a shared vision. This collaborative approach will put us in in a better position to respond with a whole of system approach to changes in technology and demographics that will significantly impact the health sector in coming years.

2.1 Our 2014-17 plan

This updated plan, the *South Island Health Services Plan (2014-2017),* provides a framework for future planning and outlines the regions priorities for 2014-2017. It has been developed by the five South Island District Health Boards (Nelson Marlborough, West Coast, Canterbury, South Canterbury and Southern), and the primary care and community members of the Service Level Alliances and Workstreams. The Plan builds on the achievements of the last three years as it develops a longer term direction for a sustainable South Island health and disability system that is *best for people*.

The Chief Executive Officers (CEOs) and the Boards of all five South Island DHBs have approved the South Island Health Services Plan (2014-2017), subject to the submission and approval of business cases by the South Island Alliance Leadership Team. The plan reiterates our health services planning processes and agreed framework for regional decision making, and provides work plans for the coming three years based around the services we have prioritised for regional and sub-regional focus.

GAINS THROUGH REGIONAL COLLABORATION

Over 300,000 electronic referrals submitted using the e-referrals system.

The Ministry of Health has introduced two additional priority areas for the 2014-15 Regional Health Service Plans. These are Health of Older People and Major Trauma. The Health of Older People is an existing service priority area for the South Island. With the inclusion of Major Trauma the service performance priority areas identified in the South Island Health Service Plan 2014-17 remain unchanged.

Appendix 4 outlines the work plans for each of the 2014-17 Service Performance Priorities.

GAINS THROUGH REGIONAL COLLABORATION

Maudsley Family Based therapy success demonstrated in young people continuing to improve when they return home from inpatient Eating Disorders treatment. District services are better prepared to address patient needs locally with only the most complex cases sent to the regional mental health inpatient service.

DHBs are now in a stronger position to continue implementing their regional and sub-regional priorities, as they work together to make the best use of available resources, to strengthen clinical and financial sustainability and increase and improve patient access to services.

The Ministry of Health has introduced the Line of Sight framework for the 2014-15 planning cycle. The framework has been introduced to encourage greater alignment with the DHB Annual Plans and to allow the DHBs to demonstrate how they will individually contribute towards achieving the South Island regional objectives.

The South Island Capital Investment Plan will be submitted as a separate plan in 2014-15, as requested by the Ministry of Health. The plan provides a 10 year view of facility developments, major asset purchases and the information technology plans for the region as identified through local and regional planning.

2.2 Demographics

2.2.1 What the 2013 Census tells us

The census[1] was held in March 2013, the first since the 2010 and 2011 Christchurch earthquakes and seven years after the previous census. Whilst Statistics New Zealand is yet to release all of the data, the early results of the census indicate how the profile of our population has changed. These changes are crucial to the planning of future health services in the South Island.

2.2.2 Where we are living

The South Island usually resident population has increased by 3.8% since 2006. This is a slower than the 6.7% growth seen between 2001 and 2006.

Four of the five fastest growing districts in the country are in the South Island. Queenstown-Lakes, Selwyn and Waimakariri were also the three fastest growing districts between 2001 and 2006. The Ashburton District growth is a more recent occurrence (it was the sixteenth fastest growing districts between 2001 and 2006).

The high growth in areas such as Queenstown-Lakes and Ashburton shows there is not necessarily a population movement away from rural districts and towards the cities. Noting that Dunedin City has increased by 1,560 long term residents since 2006. This is comparable to the increase in the number of usual residents in the Central Otago and Southland districts.

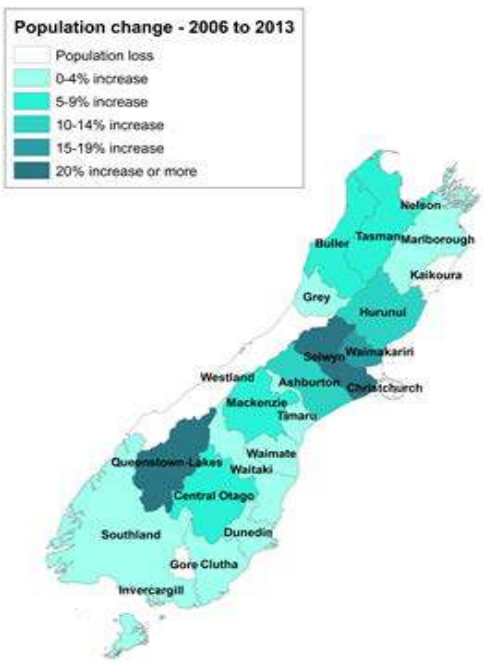


Figure1: South Island Population change 2006-2013

There has been population loss in three rural districts: Kaikoura, Westland and Gore. These are relatively small numbers, with a decrease of less than 100 usual residents in each. The Clutha and Southland districts have seen growth since 2006, having both experienced decreases in the number of usual residents between 2001 and 2006.

The South Island DHB that has seen the highest rate of growth between 2006 and 2013 is Nelson Marlborough. Over half of the growth in Nelson Marlborough DHB has occurred in Nelson City.

Canterbury DHB had the highest rate of growth of the South Island DHBs between 2001 and 2006. The recent rate of growth has been attributed to

The Highlights

1,004,370 South Island usual residents in 2013. This has increased from 967,899 in 2006 (3.8% increase).

23.7% of the total New Zealand resident population live in the South Island, down from 24.0% in 2006.

Four of the five fastest growing districts in the country are in the South Island:

Selwyn - 32.6% increase
Queenstown-Lakes-22.9% increase
Waimakariri - 16.7% increase
Ashburton - 13.4% increase

5.3% increase in the usually resident population of the Nelson Marlborough DHB. This is the fastest growing DHB in the South Island.

Resident population increases in other South Island DHBs:

Southern DHB - 3.9%
Canterbury DHB - 3.4%
South Canterbury DHB - 3.2%
West Coast DHB - 2.6%

Resident population of each South Island DHB in 2013:

Nelson Marlborough DHB – 136,995
West Coast DHB - 32,148
Canterbury DHB - 482,178
South Canterbury DHB - 55,626
Southern DHB - 297,423

16.0% of South Island residents are aged 65 years or older, up from 14.0% in 2006

[1]Data source: Statistics New Zealand, Census of Population and Dwellings, 2013

the earthquakes in the region. Christchurch City has seen a 2% decrease in usual residents since 2006. This has contributed to accelerated growth in the neighbouring districts of Selwyn and Waimakariri. Much of the growth in these districts has occurred in Christchurch's satellite towns. While residents may have left Christchurch City after the earthquakes, many are still living in the surrounding area.

The growth in the Queenstown-Lakes district is contributing to the growth in the Central Otago district. The increases in Central Otago population have occurred in the Cromwell and Dunstan areas, which are close to the Queenstown-Lakes boundary.

2.3 What we do not know

2.3.1 Updated population projections and estimates

The current Statistics New Zealand population projections are still based on the 2006 Census results. Projections based on the 2013 Census results will not be made available until December 2014. Statistics New Zealand population estimates are also still based on the 2006 Census results. Updated population estimates will be made available in August 2014.

2.4 Who we are

2.4.1 Age

The South Island population is continuing to age. 16.0% of our population are now aged 65 years or older, up from 14.0% in 2006. The South Island population continues to have a higher proportion aged 65 years or older than the rest of the country. The proportion of the New Zealand population aged 65 years or older is 14.3%.

South Canterbury has the highest proportion of residents aged 65 years or older of any South Island DHB (20.4%). South Canterbury DHB also had the highest proportion of older residents in 2006. Nelson Marlborough DHB has the fastest

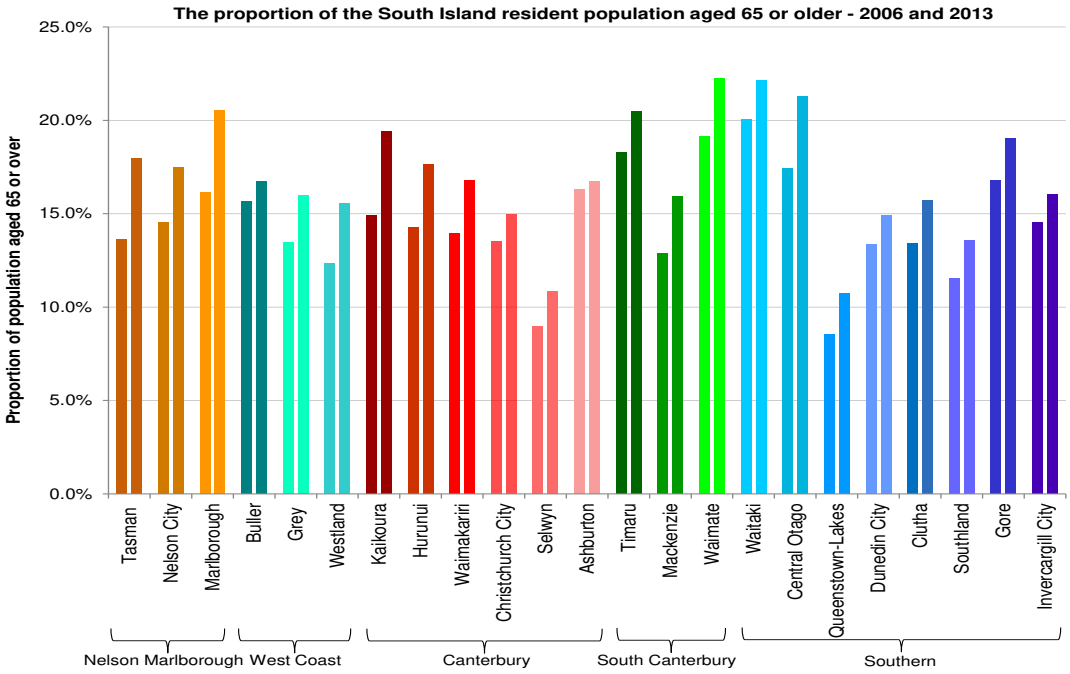


Figure2: The proportion of South Island residents aged 65 or older

Nelson Marlborough has the fastest growing older population (aged 65 years or older) of any South Island DHB

24.6% of South Island residents are aged 25-44 years, down from 27.2% in 2006. This is a loss of 16,400 residents.

8.7% of South Island residents identify as Māori, up from 7.7% in 2006

2.2% of South Island residents identify as a Pacific Island ethnicity, up from 1.9% in 2006

5.5% of South Island residents identify as an Asian ethnicity, up from 4.3% in 2006

No change in the number of families with dependent children in the South Island, despite an increase in the number of households

15% of South Island residents aged 15 years or older are regular smokers, down from 19% in 2006.

Nationally, 15.1% of those aged 15 years or older are regular smokers, down from 20.7% in 2006

growing older population. The proportion of people aged 65 years or older has increased from 14.8% in 2006 to 18.6% in Nelson Marlborough in 2013.

GAINS THROUGH REGIONAL COLLABORATION

Significant savings have been achieved for the 2013 – 14 year. By the end of December (6 months) $7.24 m in savings is reported (using the HBL reporting methodology). This figure only just falls short of the 12 month target of $7.50 m savings to be achieved.

The number of South Island residents in the 25-44 age group has declined since 2006. The 25-44 year age group represented 27.2% of the South Island resident population in 2006. This has decreased to 24.6% in 2013. Canterbury DHB has the highest proportion of residents aged 25-44 years in the South Island. Because of the Canterbury DHB's relative size, this increases the South Island proportion. The other South Island DHBs (excluding Canterbury DHB) have a proportion of residents aged 25-44 years that is lower than the total South Island proportion.

2.4.2 Ethnicity

The South Island population has become increasingly ethnically diverse since 2006. The proportion of the population that identify as Māori has increased from 7.7% to 8.7%. The proportion of the population that identify as a Pacific Island ethnicity has increased from 1.9% to 2.2%. The proportion of the population that identified as an Asian ethnicity has also increased from 4.3% to 5.5%.

In contrast to the national population, the South Island continues to have a much higher proportion of the population that identify as European/New Zealander. 90.3% of South Island residents identify as European/New Zealander, compared with 75.7% nationally.

2.4.3 Families

There has been no overall change in the number of families with dependent children in the South Island between 2006 and 2013. However, three South Island DHBs have seen a decrease in the number of families with dependent children: West Coast (4.7% decrease), Canterbury (1.2% decrease) and South Canterbury (2.1% decrease).

2.5 What does this mean?

2.5.1 Our aging population

The South Island has an increasingly elderly population. While progress has been made to address the needs of older people, new service models will need to continue to be developed. The 25-44 year age group is an important age group for our health workforce. As this age group has declined since 2006 this may have implications our health workforce in the years to come.

2.5.2 Population growth around the South Island

The population continues to increase in many rural areas of the South Island. Therefore, the provision of general practice in these areas is a key requirement, as well as mobile services that operate in people's homes and communities.

2.5.3 Managing our Risk

The South Island DHBs have strengthened their ability to manage risk through their increased regional approach to health service planning and delivery. Enhanced relationships, greater collaboration and having regional systems and processes in place all help to prevent crises, and better manage the issues and challenges the South Island DHBs experience locally, and regionally.

The South Island DHBs are facing a number of fiscal and service delivery risks. The advantage of the South Island Alliance is the ability to share the discussions and develop options to support and collaborate to mitigate those risks.

GAINS THROUGH REGIONAL COLLABORATION

A Nursing sustainability position paper will guide the roll out and retention strategies of nursing staff across the South Island

To mitigate risk, we are taking a greater regional approach to address workforce issues and sharing of information. We are in the early stages of aligning support services like human resources and procurement.

3 SETTING OUR STRATEGIC DIRECTION

3.1 Strategic context

Although DHBs may differ in size, structure and approach, they all have a common goal: to improve the health and wellbeing of their populations by delivering high quality and accessible health care. With increasing demand for services, workforce shortages and rising costs, this is increasingly challenging and the health system faces an unsustainable future.

Populations are ageing, long-term conditions are becoming more prevalent and the needs of vulnerable populations are escalating. As people's conditions become more complex, the care required is more costly in terms of time, resources and dollars.

GAINS THROUGH REGIONAL COLLABORATION
Young people presenting in the Youth justice system with mental health and addiction issues can expect to have timely and appropriate access to mental health and addiction services that greatly support the person's individual wellbeing and thus reduce the risk of re-offending.

To ensure the sustainability of the health system, DHBs need to shift their population's health needs away from the complex and costly end of the continuum of care and support more people to stay healthy and well.

International direction emphasises that an aligned, 'whole of system' approach is required to ensure service sustainability, quality and safety while making the best use of limited resources. This entails four major shifts in service delivery:

1. Early intervention, targeted prevention and self-management and a shift to more home-based care;
2. A more connected system and integrated services, with more services provided in community settings;
3. Regional collaboration clusters and clinical networks, with more regional service provision; and
4. Managed specialisation, with a shift to consolidate the number of tertiary centre/hubs.

Hospitals continue to be a key support and a setting for highly specialised care, with the importance of timely and accessible care being paramount. However, less-complex care (traditionally provided in hospital settings) is increasingly being provided in the community.

The focus is shifting towards supporting people to better manage their own health and to stay well, with the support of connected and integrated clinical networks and multidisciplinary teams.

GAINS THROUGH REGIONAL COLLABORATION
A new electronic record tool (built within Health Connect South Clinical Workstation) for mental health clinical care has gone live. It provides clinicians with a complete view of the client's relevant information. This integrated view frees up clinician time currently designated for administration tasks and allow it to be relocated to the clients.

3.2 National direction

GAINS THROUGH REGIONAL COLLABORATION
South Island DHBs are supporting the use of Health Passports in Emergency Departments and General Practice settings. Health Passports facilitate people in taking responsibility for the sharing of their health information when seeking or engaging with healthcare

These international shifts are consistent with the changes being driven across the New Zealand health system to meet the Government's commitment to providing *'better, sooner, m*ore convenient health services'.[2]

At the highest level DHBs are guided by the requirements of the New Zealand Public Health and Disability Act and by the New Zealand Health Strategy, Disability Strategy, and Māori Health Strategy (He Korowai Oranga) - with the ultimate health sector outcomes being that:

[2] John Key, National Party Health Discussion Paper 2007.

- All New Zealanders lead longer, healthier and more independent lives; and
- The health system is cost effective and supports a productive economy

DHBs are expected to contribute to meeting health sector outcomes and Government commitments by: increasing access to services and reducing waiting times; improving quality, patient safety and performance; and providing better value for money.

GAINS THROUGH REGIONAL COLLABORATION

The Procurement and Supply Chain Workstream submitted an application for the Chartered Institute of Purchasing and Supply (CIPS) Australasia Procurement Professional Awards 2013 and was short listed, along with two others, in the category of Best Cross Functional Teamwork receiving a Highly Commended status

Alongside these longer-term national strategies and commitments; the Minister of Health's 'Letter of Expectations'[3] also signals annual priorities for the health sector – most specifically with regards to the delivery of better public services and the delivery of the six national health targets.

The South Island Alliance is committed to making continued progress against national priorities and health targets and activity planned over the coming year to deliver on national expectations.

3.3 Regional direction

In delivering its commitment to '*better, sooner, more convenient health services*' the Government also has clear expectations of increased regional collaboration and alignment between DHBs.

The South Island Alliance established in 2011 formalised the partnership between the five South Island DHBs While each DHB is individually responsible for the provision of services to its own population, working regionally enables them to better address their shared challenges and support improved patient care and more efficient use of resources.

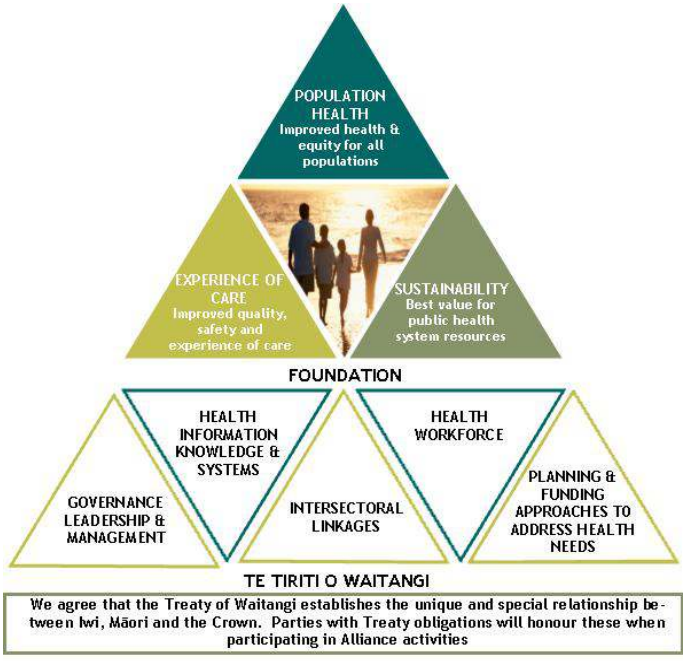


Figure 3: 'Best for People, Best for System' framework

[3] Letter of Expectations for DHBs & Subsidiary Entities 2014/15, 2014, Ministry of Health

In 2013 it was agreed to further develop the approach with a framework that ensures all regional activity aligns to agreed goals. The '*best for patients, best for system*' framework has become '*best for people, best for system*' supporting a focus on the whole population. The shared vision has also been revised to include disability to ensure key population groups are identified within the framework.

Our regional vision is a sustainable South Island health and disability system focused on keeping people well and providing equitable and timely access to safe, effective, high-quality services, as close to people's homes as possible.

Closely aligned to the national direction the shared outcomes goals of the South Island Alliance are:

- Improved health and equity for all populations;
- Improved quality safety and experience of care; and
- Best value for public health system resources.

To help ensure success, regional activity is implemented through service level alliances and workstreams based around priority service areas. The work is clinically led, with multidisciplinary representation from community and primary care, as well as hospital and specialist services, and consumer involvement.

The South Island Alliance has prioritised seven service areas: Cancer, Child Health, Health of Older People, Mental Health, Information Services, Support Services and Quality and Safety.

GAINS THROUGH REGIONAL COLLABORATION

South Island patients benefit from regionally adopted patient safety initiatives to reduce harm from falls

Regional activity also focuses on: cardiac, elective surgery, neurosurgery, public health, stroke and major trauma services. Workforce planning, through the South Island Regional Training Hub and regional asset planning, will contribute to improved delivery in all service areas.

All South Island DHBs are involved in the service level alliances and work streams and lead at least one priority area. Each DHB's commitment in terms of the regional direction is outlined in their Annual Plans.

3.4 Local direction

To sustainably cope with the increasing demand for services, DHBs must design pathways that influence the flow of people—delivering care in the most appropriate setting and reducing demand by supporting people to stay well and maximise their independence.

DHBs work with their stakeholders to effectively coordinate care for the population and to influence demand. Ultimately, this will assist the DHBs to achieve their desired outcomes that people will receive the care and support they need, when they need it, in the most appropriate place and manner

4 IMPROVING HEALTH OUTCOMES FOR OUR POPULATION

4.1 What are we trying to achieve?

DHBs are expected to deliver against the national health sector outcomes: "*All New Zealanders lead longer, healthier and more independent lives*" and '*The health system is cost effective and supports a productive economy*' and to meet Government commitments to deliver '*better, sooner, more convenient health services*'.

As part of this accountability DHBs need to demonstrate whether they are succeeding in meeting those commitments and improving the health and wellbeing of their populations. There is no single measure that can demonstrate the impact of the work DHBs do, so a mix of population health and service access indicators are used to demonstrate improvements in the health status of the population and the effectiveness of the health system.

GAINS THROUGH REGIONAL COLLABORATION
A streamlined thrombolysis pathway resulting in patients being rapidly triaged and investigated to ensure those who are eligible for thrombolysis can receive it within required timeframes, thus increasing their chance for an improved outcome

In developing its regional strategic framework, the South Island Alliance has identified three outcome goals. To achieve these goals we have agreed a number of key strategies which will be achieved through the delivery of regional initiatives and the collective activity of all five South Island DHBs (Appendix 2). A comprehensive indicator set is currently under development, to sit alongside the framework and enable evaluation of regional activity.

While the regional framework indicator set is developed, the South Island DHBs have identified four collective outcomes and an associated set of indicators by which individual DHB performance will contribute to regional success and demonstrate whether they are making a positive change in the health of their populations. As these are long-term outcome indicators (5-10 years in the life of the health system) the aim is for a measurable change in health status over time, rather than a fixed target.

- **Outcome 1: People are healthier and take greater responsibility for their own health.**
  - A reduction in smoking rates.
  - A reduction in obesity rates.
- **Outcome 2: People stay well in their own homes and communities.**
  - A reduction in acute medical admission rates.
- **Outcome 3: People with complex illnesses have improved health outcomes.**
  - A reduction in acute readmission rates.
  - A reduction in all-cause mortality rates.
- **Outcome 4: People experience optimal functional independence and quality of life.**
  - An increase in the proportion of the population over 75 living in their own homes.

GAINS THROUGH REGIONAL COLLABORATION
Parents of newborn infants will receive best practice advice for sleeping their babies in a safe environment following the implementation of a regional safe sleep policy.

Each of the South Island DHBs has also identified a set of associated medium-term (3-5 years) indicators of performance. Because change will be evident over a shorter period of time, these impact measures have been identified as the 'headline' or 'main' measures of performance and each DHB has set local targets in their Annual Plans to evaluate their performance over the next three years. These indicators sit alongside the DHB's Statement of Performance Expectations outlined in their DHB Annual Plans.

The following intervention logic diagram demonstrates: how the services that an individual DHB chooses to fund or provide (outputs) will have an impact on the health of their population and result in the achievement of desired longer-term regional outcomes and the expectations and priorities of Government.

4.2 South Island Intervention Logic Diagram

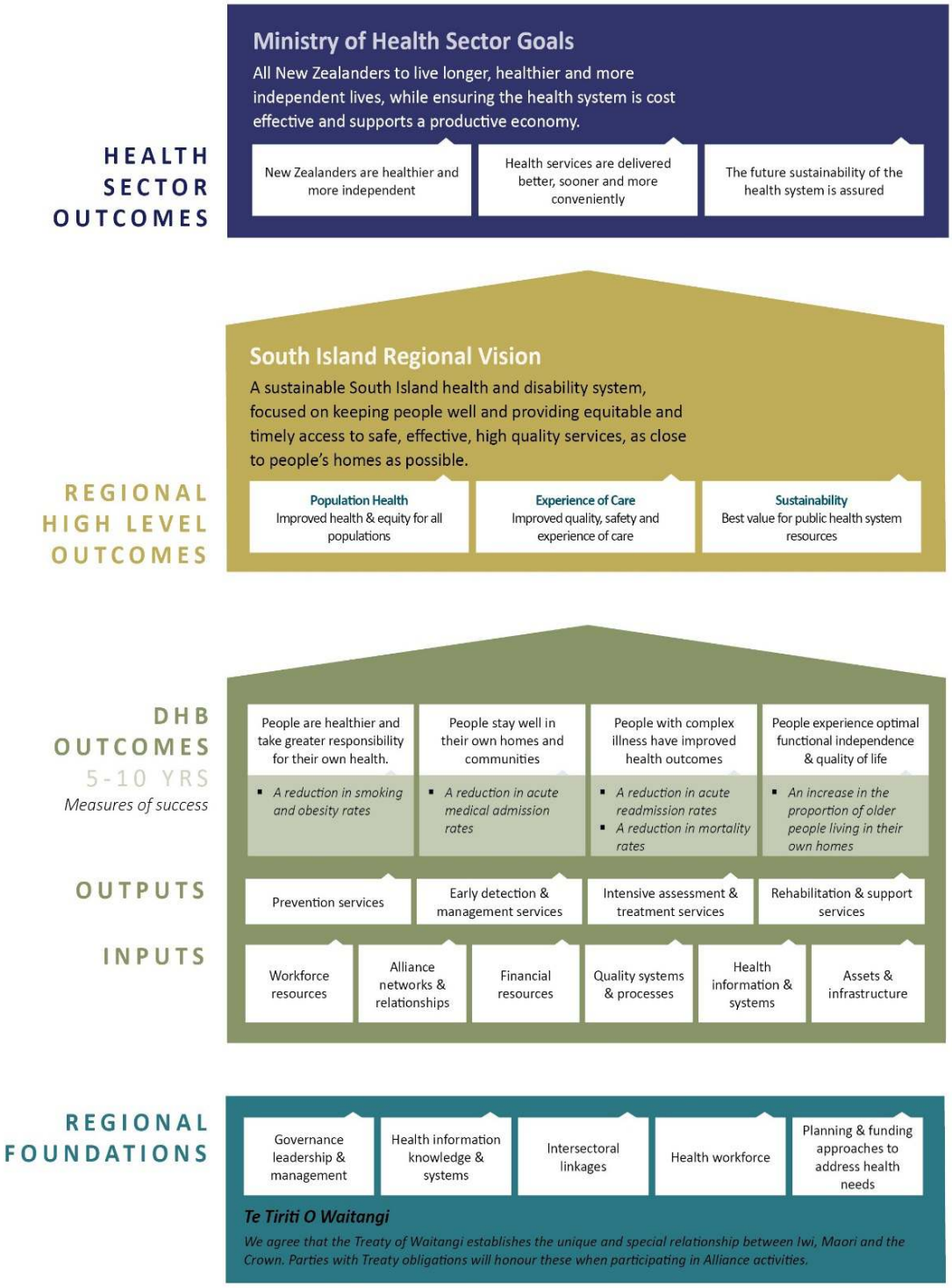


Figure 4: South Island Intervention Logic Diagram

4.3 Strategic Outcome Goal 1

4.3.1 People are healthier and take greater responsibility for their own health

Why is this outcome a priority?

The World Health Organisation (WHO) estimates more than 70% of all health funding is spent on long-term conditions. New Zealand is experiencing a growing prevalence of long-term conditions, such as diabetes and cardiovascular disease, which are major causes of poor health and account for a significant number of presentations in primary care and admissions to hospital and specialist services. As our population ages the incidence and burden of long term conditions increases. Long-term conditions are also more prevalent amongst Māori and Pacific Islanders and are closely associated with significant disparities in health outcomes across population groups.

Tobacco smoking, inactivity, poor nutrition and rising obesity rates are major and common contributors to a number of the most prevalent long-term conditions. These are avoidable risk factors, preventable through a supportive environment, improved awareness and personal responsibility for health and wellbeing. Supporting people to make healthy choices will enable our population to attain a higher quality of life and to avoid, delay or reduce the impact of long-term conditions.

OUTCOME MEASURES LONG TERM (5-10 YEARS)

We will know we are succeeding when there is:

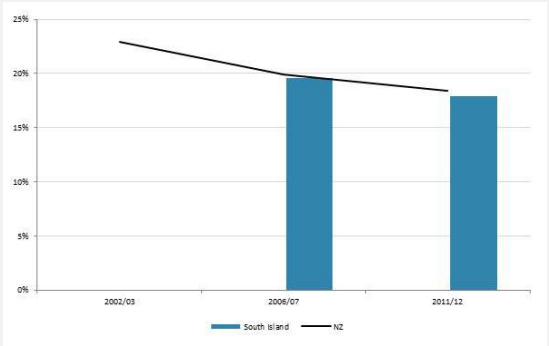
A reduction in smoking rates.

Tobacco smoking kills an estimated 5,000 people in NZ every year, including deaths due to second-hand smoke exposure. Smoking is also a major contributor to preventable illness and long-term conditions, such as cancer, respiratory disease, heart disease and stroke.

In addition, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is spent on tobacco, meaning less money is available for necessities such as nutrition, education and health. Supporting our population to say 'no' to tobacco smoking is our foremost opportunity to reduce inequalities and target improvements in the health of our population.

Data sourced from national NZ Health Survey.[4]

Outcome Measure: The percentage of the population (15+) who smoke.



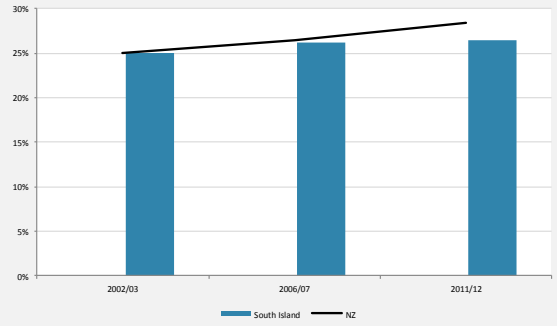
A reduction in obesity rates.

There has been a rise in obesity rates in NZ in recent decades, and the 2011/12 NZ Health Survey found that one in ten children (10%) and three in ten adults (28%) are obese. This has significant implications for rates of cardiovascular disease, diabetes, respiratory disease and some cancers, as well as poor psychosocial outcomes and reduced life expectancy.

Supporting our population to maintain healthier body weights through improved nutrition and increased physical activity levels is fundamental to improving their health and wellbeing and to preventing and better managing long-term conditions and disability at all ages.

Data sourced from national NZ Health Survey.[5]

Outcome Measure: The percentage of the population (15+) who are obese.



[4] The NZ Health Survey was completed by the Ministry of Health in 2003/04, 2006/07 and 2011/12. Results by region and district are subject to MoH availability. 'Obese' is defined as having a Body Mass Index (BMI) of >30.0, or >32.0 for Māori or Pacific people.

[5] The NZ Health Survey was completed by the Ministry of Health in 2003/04, 2006/07 and 2011/12. Results by region and district are subject to MoH availability. 'Obese' is defined as having a Body Mass Index (BMI) of >30.0, or >32.0 for Māori or Pacific people.

4.4 Strategic Outcome Goal 2

4.4.1 People stay well in their own homes and communities

Why is this outcome a priority?

For most people, their general practice team is their first point of contact with health services. General practice can deliver services sooner and closer to home and prevent disease through education, screening, early detection, diagnosis and timely provision of treatment. The general practice team is also vital as a point of continuity and effective coordination across the continuum of care, particularly in terms of improving the management of care for people with long-term conditions and reducing the exacerbations of those conditions and the complications of injury and illness.

Supporting general practice is a range of other health professionals including midwives, community nurses, social workers, personal health providers and pharmacists. These providers have prevention and early intervention perspectives which link people with other health and social services and support them to stay well.

When people are supported to stay well in the community, they need fewer hospital-level or long-stay interventions. This is not only a better health outcome for our population, but it reduces the rate of acute hospital admissions and frees up health resources. Studies show countries with strong primary and community care systems have lower rates of death from heart disease, cancer and stroke, and achieve better health outcomes for lower cost than countries with systems that focus on specialist level care.

OUTCOME MEASURES LONG TERM (5-10 YEARS)

We will know we are succeeding when there is:

A reduction in acute medical admissions.

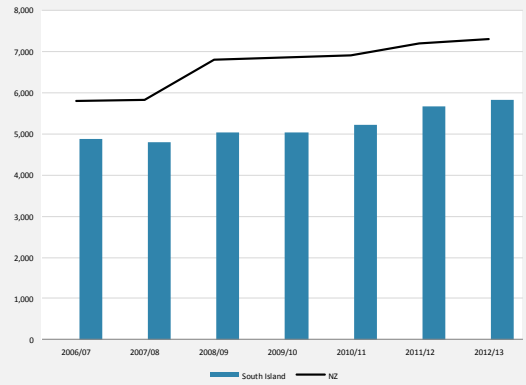
The impact long-term conditions have on quality of life and demand growth is significant. By improving the management of long-term conditions, people can live more stable, healthier lives, and avoid deterioration that leads to acute illness, hospital admission, complications and death.

Reducing acute hospital admissions also has a positive effect on productivity in hospital and specialist services - enabling more efficient use of resources that would otherwise be taken up by a reactive response to demand for urgent care.

Acute medical admissions can be used as a proxy measure of improved conditions management by indicating that fewer people are experiencing an escalation of their condition leading to an urgent (acute) or complex intervention. They can also be used to indicate access to appropriate and effective care and treatment in the community.

Data sourced from National Minimum Data Set.

Outcome Measure: The rate of acute medical admissions to hospital (age-standardised, per 100,000).



4.5 Strategic Outcome Goal 3

4.5.1 People with complex illness have improved health outcomes

This goal reflects the importance of ensuring that hospital and specialist services are sustainable and that the South Island has the capacity to provide for the complex needs of its population now and into the future. It also reflects the importance of the quality of treatment. Adverse events, unnecessary waits or ineffective treatment can cause harm, resulting in longer hospital stays, readmissions and unnecessary complications that negative impact of the health of our population.

Why is this outcome a priority?

For those people who do need a higher level of intervention, timely access to high quality complex care and treatment is crucial in supporting people to recover or in slowing the progression of illness and improving health outcomes by restoring functionality and improving the quality of life.

As providers of hospital and specialist services, DHBs are operating under increasing demand and workforce pressures. At the same time, Government is concerned that patients wait too long for diagnostic tests, cancer treatment and elective surgery. Shorter waiting lists and times are indicative of a well-functioning system that matches capacity to demand by managing the flow of patients through services, and reducing demand by moving the point of intervention to earlier in the path of illness.

OUTCOME MEASURES LONG TERM (5-10 YEARS)

We will know we are succeeding when there is:

A reduction in acute readmissions.

An unplanned acute hospital readmission may often (though not always) occur as a result of the care provided to the patient by the health system.

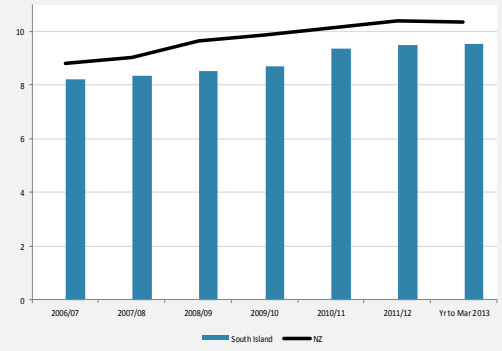
Acute readmissions can be prevented through improved patient safety and quality processes and improved patient flow and service integration - ensuring that people receive more effective treatment, experience fewer adverse events and are better supported on discharge from hospital.

Reducing acute readmissions can therefore be used as a proxy measure of the effectiveness of service provision and the quality of care provided.

They also serve as a counter-measure to balance improvements in productivity and reductions in the length of stay and provide an indication of the integration between services to appropriately support people on discharge.

Data sourced from Ministry of Health.

Outcome Measure: The rate of acute readmissions to hospital within 28 days of discharge.



Note: A national definition is currently being developed and we intend to use this measure to monitor performance once the data and definitions have been confirmed.

A reduction in mortality rates.

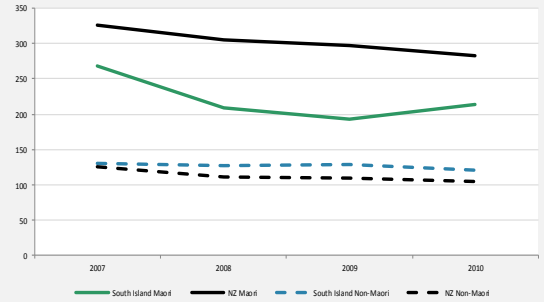
Timely and effective diagnosis and treatment are crucial to improving survival rates for complex illnesses such as cancer and cardiovascular disease. Early detection increases the options for treatment and the chances of survival.

Premature mortality (death before age 65) is largely preventable with lifestyle change, earlier intervention and safe and effective treatment. By detecting people at risk and improving the treatment and management of their condition the more harmful impacts and complications of a number of complex illnesses can be reduced.

A reduction in mortality rates can be used as a proxy measure of responsive specialist care and improved access to treatment for people with complex illness.

Data sourced from MoH mortality collection 2010 update.

Outcome Measure: The rate of all-cause mortality for people aged under 65 (age standardised per 100,000).



Note: A national definition is currently being developed and we intend to use this measure to monitor performance once the data and definitions have been confirmed.

4.6 Strategic Outcome Goal 4

4.6.1 People experience optimal functional independence and quality of life

Why is this outcome a priority?

Health services play an important role in supporting people to regain their functionality after illness and to remain healthy and independent. There are also a number of services or interventions that focus on patient care such as pain management or palliative services to improve the quality of life.

With an ageing population, the South Island will require a strong base of primary care and community support, including home-based support, respite and residential care. These services support people to recover and rehabilitate in the community, giving them a greater chance of returning to a state of good health or slowing the progression of disease. Even where returning to full health is not possible, access to responsive, needs-based services helps people to maximise function with the least restriction and dependence. This is not only a better health outcome for our population, but it reduces the rate of acute hospital admissions and frees up health resources across the system.

OUTCOME MEASURES LONG TERM (5-10 YEARS)

We will know we are succeeding when there is:

An increase in the proportion of the population living in their own home.

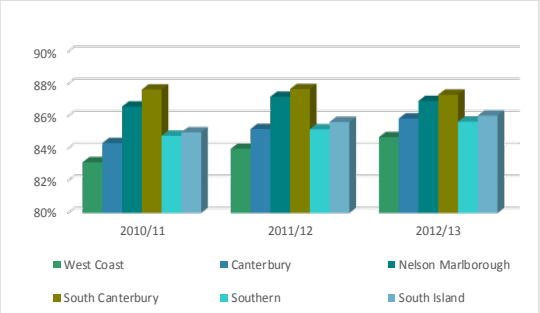
While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, evaluation of older people's services have shown a higher level of satisfaction and better long-term outcomes where people remain in their own homes and positively connected to their communities.

Living in ARC facilities is also a more expensive option, and resources could be better spent providing appropriate levels of Home-Based Support Service (HBSS) to people to stay well in their own homes.

An increase in the proportion of people supported in their own home can be used as a proxy measure of how well the systems is managing age-related long-term conditions and responding to the needs of our older population.

Data sourced from Client Claims Payments provided by SIAPO.

Outcome Measure: The percentage of the population (75+) living in their own homes.



Note: A regional definition is currently being developed and we intend to use this measure to monitor performance once the data and definitions have been confirmed.

5 REGIONAL GOVERNANCE, LEADERSHIP AND DECISION MAKING

5.1 The Role and Scope of the South Island Region

"Our purpose is to lead and guide our Alliance as it seeks to improve health outcomes for our populations. We aim to provide increasingly integrated and coordinated health services through clinically-led service development, and its implementation, within a 'best for people, best for system' framework."

5.1.1 Regional governance and leadership

In order to advance the implementation of regional service planning and delivery, in 2011 the South Island DHBs established an alliance framework. The alliance framework has been successful in supporting the DHBs to achieve in both the enabler and clinical service areas and has been recognised as a successful model at a national level and in the other regions.

South Island Alliance Principles

- *We will support clinical leadership, and in particular clinically-led service development;*
- *We will conduct ourselves with honesty and integrity, and develop a high degree of trust;*
- *We will promote an environment of high quality, performance and accountability, and low bureaucracy;*
- *We will strive to resolve disagreements co-operatively, and wherever possible achieve consensus decisions;*
- *We will adopt a people-centred, whole-of-system approach and make decisions on a Best for System basis;*
- *We will seek to make the best use of finite resources in planning health services to achieve improved health outcomes for our populations;*
- *We will balance a focus on the highest priority needs in our communities, while ensuring appropriate care across all our rural and urban populations;*
- *We will adopt and foster an open and transparent approach to sharing information; and*
- *We will actively monitor and report on our alliance achievements, including public reporting.*

5.2 Our governance structure

The South Island DHB Alliance focuses South Island DHB collaboration through:

- An Alliance Board (the five South Island DHB Board Chairs) that sets the strategic focus, oversees, governs, and monitors overall performance of the Alliance.
- An Alliance Leadership Team (the South Island DHB CEOs) that prioritises activity, allocates resources (including funding and support) and monitors deliverables.
- A Strategic Planning and Integration Team that supports an integrated approach, linking the Service Level Alliances and workstreams to the South Island vision, identifying gaps and recognising national, regional and district priorities.
- The South Island Planning and Funding Network (SIP&FN) supports regional alliance issues and collaborates on non-alliance issues, including strategic planning, meeting of government priorities, statutory requirements, and provides whole of population funding advice.

Membership lists for the Alliance Board, Alliance Leadership Team and the Strategic Planning and Integration Team have been included in Appendix 3

5.3 Regional Capital Committee

The South Island Alliance Board and Alliance Leadership Team members make up the South Island Regional Capital Committee. The committee's purpose is to:

- Work as a region to identify and, if agreed, support significant capital purchase proposals in accordance with the agreed regional service strategy and planning
- Use the regional approach to ensure leverage in negotiations for significant capital purchases and procurement
- Ensure there is clarity in respect of significant proposed capital expenditure and/or significant matters that relate to capital that the DHBs wish to refer to the committee

GAINS THROUGH REGIONAL COLLABORATION
The South Island DHBs have made significant progress towards implementing an integrated stroke service in South Island

- Inform the national process of regional issues

5.4 Information Services

The Information Services programme of work is overseen by the South Island Information Services Service Level Alliance (IS SLA). This group provides overarching South Island IT Programme and Project governance (Appendix 3). They provide a point of escalation for the resolution of issues if the Programme or Projects vary from planned time, cost or scope.

5.5 South Island Regional Training Hub

The South Island Regional Training Hub Steering Group has members from across all five South Island DHB's & represent Nursing, Midwifery, Allied Health Scientific &Technical (AHS&T), Medical and Maori health and South Island Regional Training Hub staff (Appendix 3).

The South Island Regional Training Hub Steering Group functions to create a training and education network within the region that facilitates the coordination and delivery of education and training to all health professionals.

GAINS THROUGH REGIONAL COLLABORATION

A pilot programme is underway for Postgraduate Year 2/3 medical students to complete a rotation at the 24 hour medical centre. Rotations into general practice commenced March 2013

5.6 Service Level Alliances and Workstreams

South Island regional activity involves a wide representation of the key stakeholders including health professionals, managers, funders, health care providers and consumers. The chairs of the majority of the teams are clinicians with the exception being the Support Services Service Level Alliances. The work is supported by the staff employed by the South Island Alliance Leadership Team. A Chief Executive or Senior Executive from one of the DHBs, sponsors each Service Level Alliances and Workstream to support the team and where necessary help to manage any risks identified.

GAINS THROUGH REGIONAL COLLABORATION

Our people with dementia and their families and whānau are valued as individuals as the Walking in Another's Shoes programme supports carers to think outside the box. Autonomy and choice are encouraged as carers focus on the relationship rather than the task

5.7 National Health Committee

The South Island remains committed to working with the NHC and implementing their recommendations in the prioritisation of new and existing technologies and interventions. The National Health Committee (NHC) is establishing Prioritisation Networks to support its work. The South Island will work with the NHC to establish a prioritisation network. The Strategic Planning and Integration Team will take on this role and work with NHC to understand the implications and resource requirements.

6 SERVICE PERFORMANCE PRIORITIES 2014-2017

What do we need to: *Keep people well in the community?* Ensure early detection and early intervention? *Support people to self-manage in a community setting, avoid unnecessary hospital admissions and slow the progression of their condition?* Ensure that when people require complex interventions, they are available at the right time and to a high quality standard? *Provide appropriate and restorative support services so that people can regain their functional independence after injury or illness, and avoid further complications?*

The South Island DHBs are involved in collaborative activity across a large number of regional and sub-regional service areas. The areas identified in this section are those that have been given national and regional priority. In addition to these priority areas, regional planning continues for neurosurgery, primary care emergency planning and coordination. Māori health approaches have been incorporated into each of the 2014-17 priority area workplans (Appendix 4).

Each priority area—whether supported by regional Service Level Alliance, Workstream or group—is clinically led, or, as for the Support Services Service Level Alliance, has clinicians involved in the teams and in all key decision making approaches. Members of the Service Level Alliances and other working groups come from each of the DHBs and provide breadth of expertise and ownership for development initiatives. The South Island Alliance Programme Office and a regional communication strategy support the activities across the South Island.

GAINS THROUGH REGIONAL COLLABORATION

The installation of a high definition audio-visual/videoconference solution to connect geographically distant clinical Multi-disciplinary Meeting (MDM) teams across the South Island and improve the functionality and coverage of MDMs. This will significantly strengthen the MDM framework across the region and lead to improved equity of access for patients to specialist oncology care and treatment outcomes.

6.1 Improving Health Systems Outcomes

"Health service integration is bringing together common functions within and between organisations to solve common problems, developing commitment to a shared vision and goals and using common technologies and resources to achieve these goals." World Health Organisation, Technical Brief No.1, May 2008

The South Island region aims to improve the systems within which health services are provided by the individual South Island DHBs.

Each Service Level Alliance and regional activity work plan includes actions, measurable deliverables and outcomes specific to the service area. The Service Level Alliances and other regional activities aim to achieve the following outcomes:

- that the health and disability system and services are trusted and can be used with confidence; and
- that people receive better health and disability services.

The Service Level Alliances work and regional work plan addresses three strategic goals for the South Island region:

GAINS THROUGH REGIONAL COLLABORATION
More people in the South Island are supported to think and talk about their choice at end of life, to be better prepared and have a say about their health care and what medical treatment they receive. These preferences are recorded in an Advance Care Plan and increasingly available to health care professionals across the system.

1. **Population Health:** Improved health and equity for all populations.
2. **Experience of Care:** Improved quality, safety and experience of care
3. **Sustainability:** Best value for public health system resources.

6.2 Māori Health

"As a population group, Māori have on average the poorest health status of any ethnic group in New Zealand".[6]

The Government has made it a key priority to reduce the health inequalities that affect Māori. The 2013 Census data shows a 1% increase in South Island residents that identify as Māori from the 2006 Census. In general, South Island Māori have poorer overall health status than Non- Māori, but in many cases have better health status than Māori nationally. The inequality of the South Island Māori health status is reflected in a range of indicators including cardiovascular disease, cancer, diabetes and respiratory disease.

The South Island Health Services Plan (2014-17) priority areas of Cancer, Child Health, Mental Health, Health of the Older Person, Cardiac, Stroke, Public Health and Workforce include specific measures to reduce the health inequality affecting Māori. The electives priority area will provide ongoing monitoring to maintain the current equitable access to elective services in the South Island between Māori and non-Māori.

The Health of New Zealand Adults 2012/13[7] Health Survey identified that:

- Māori adults continue to have the highest smoking rates, with over a third (36%) of adults smoking daily in 2012/13.
- Māori adults continue to have higher rates of psychological distress than other adults, with about one in ten affected. However, Māori and non-Māori have similar rates of being diagnosed with depressive and anxiety disorders during their lifetime.
- Māori adults and the parents of Māori children are less likely than other people to have confidence and trust in their GP.
- Māori adults have poorer health and more unmet need for health care: Māori adults have higher rates of most health conditions, with differences most notable for asthma, ischaemic heart disease, stroke and diabetes. Māori adults are also less likely than non-Māori adults to rate their health as good, very good or excellent. Part of the reason for differences in health status may be barriers to accessing health care.
- About 30,000 children (3.6%) had a tooth removed in the last year due to decay, abscess or infection, with higher rates of tooth removal in Māori and Pacific children. One in fifteen (7%) adults had a tooth removed in the last year due to decay, abscess, infection or gum disease. Māori (8%) and Pacific (11%) adults were more likely have had a tooth removed than other adults.

6.3 Overview of how South Island Alliance Activity supports the 'Best for People, Best for Systems' Framework

The activity of the South Island Alliance and the connections of this activity back to the 'Best for People, Best for System' Framework are depicted pictorially in the following figures (5-8). The linkages between the activity and the contribution that this makes towards the attainment of three strategic goals from the 'Best for People, Best for System' framework and the South Island Alliance vision is illustrated in Figure 5. Figures 6 – 8 connect the activity within the 2014-2017 workplans (Appendix 4) with the expected outcomes and goals of the strategic framework. The activity from the 2014-2017 workplans may contribute towards one or a combination of the expected outcomes.

[6] Ministry of Health. 2013. http://www.health.govt.nz/our-work/populations/maori-health. Wellington: Ministry of Health

[7] Ministry of Health. 2013. *The Health of New Zealand Adults 2012/13: Key findings of the New Zealand Health Survey*. Wellington: Ministry of Health.

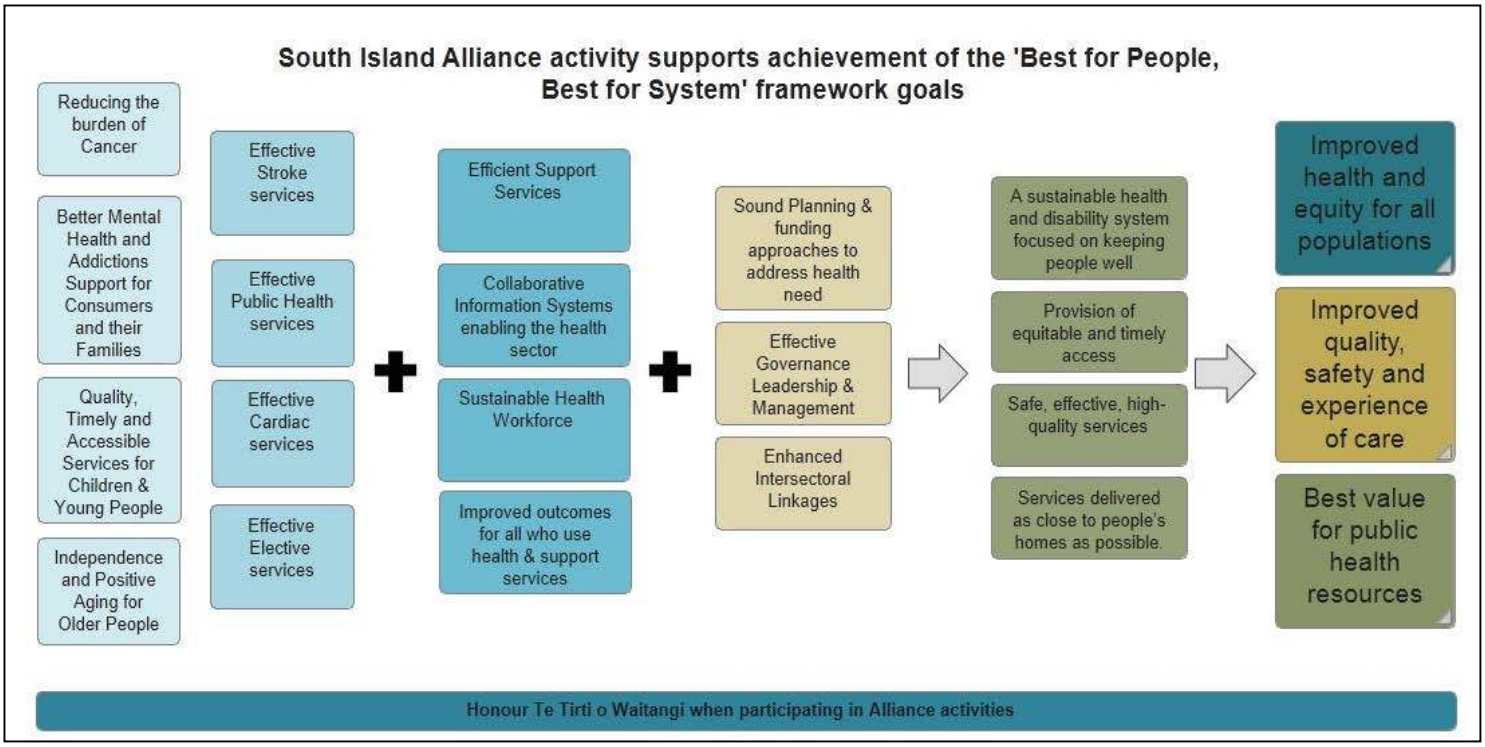


Figure 5: South Island Alliance Activity

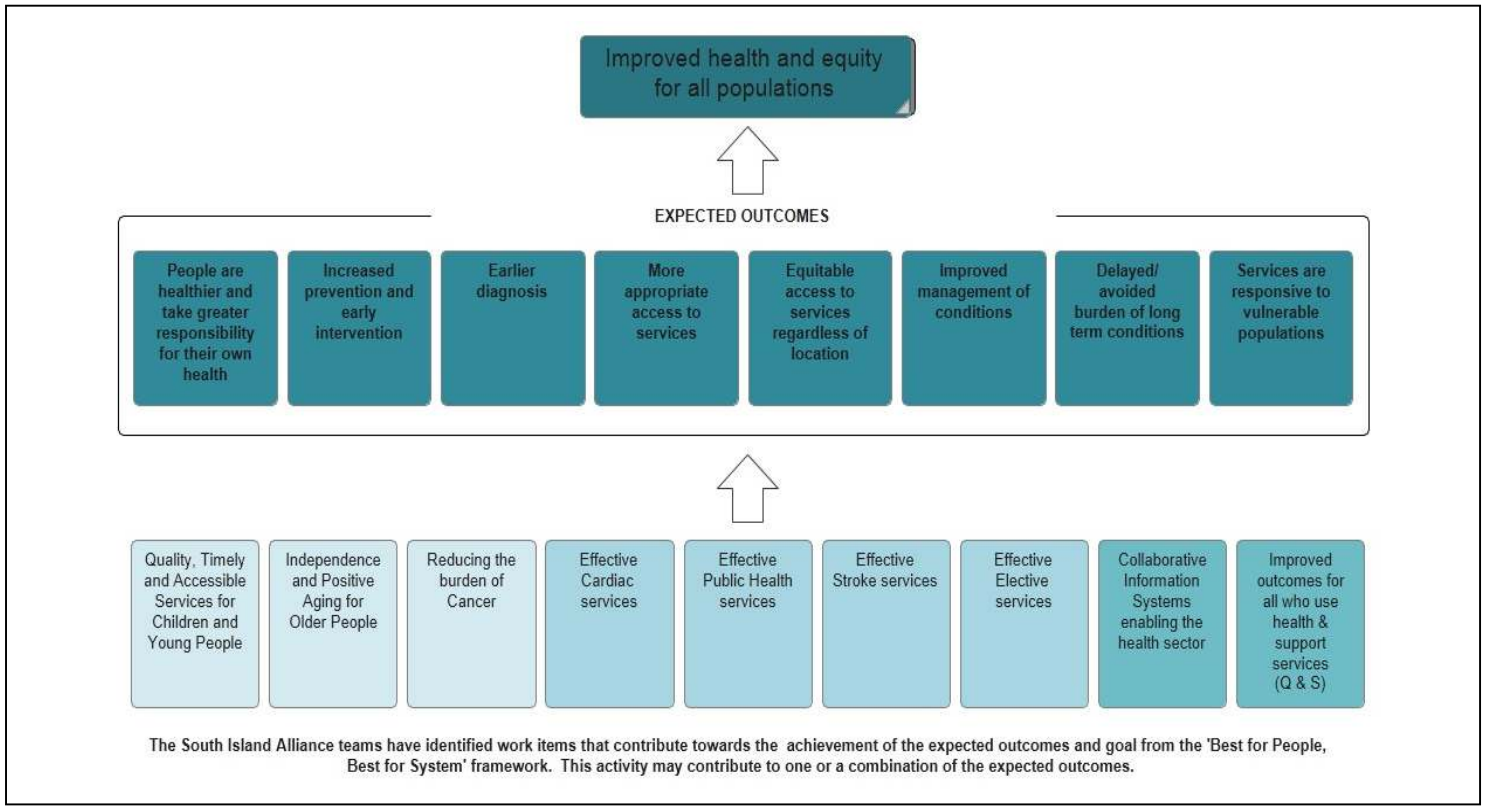


Figure 6: Linking South Island Alliance activity to 'Improved health and equity for all populations'

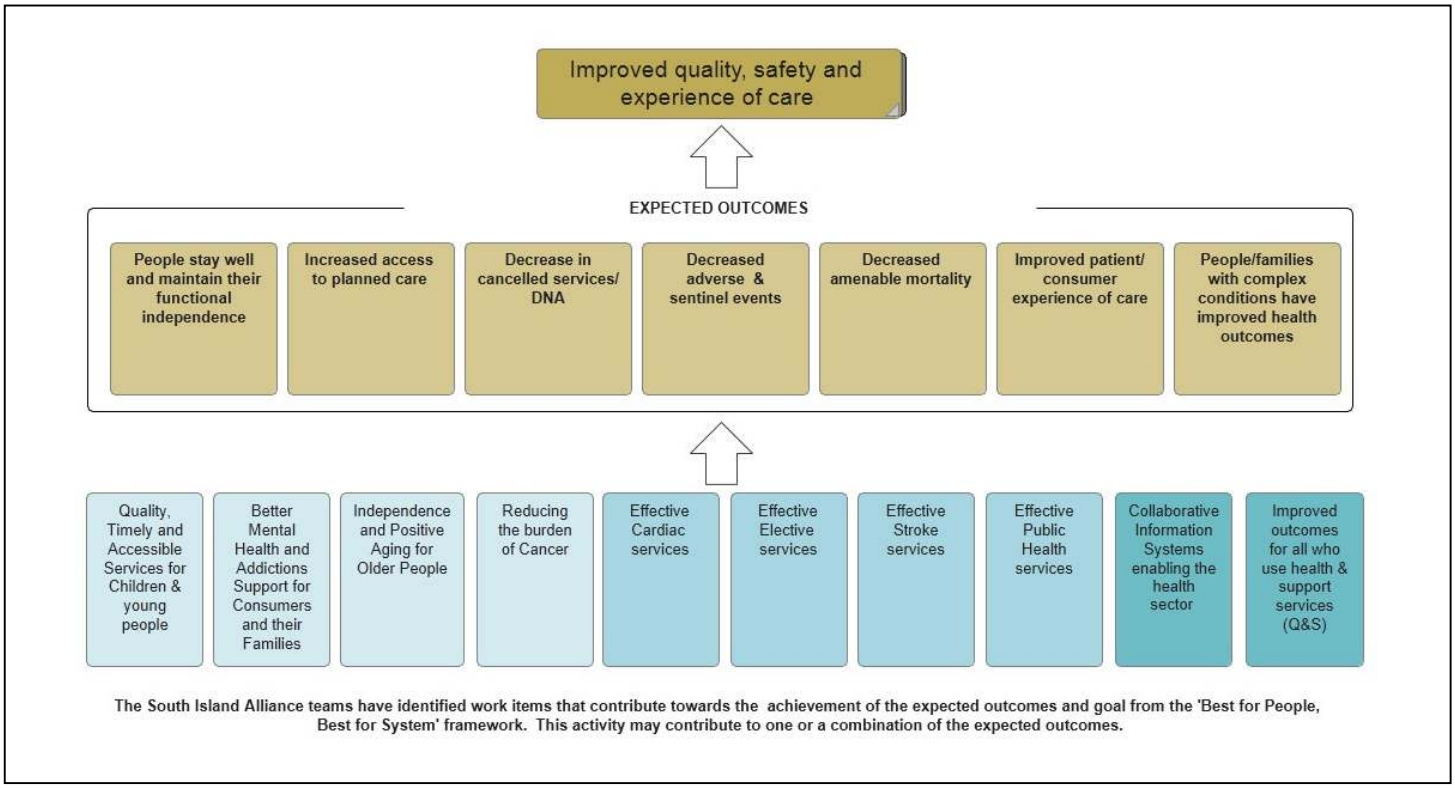


Figure 7: Linking South Island Alliance activity to 'Improved quality, safety and experience of care'

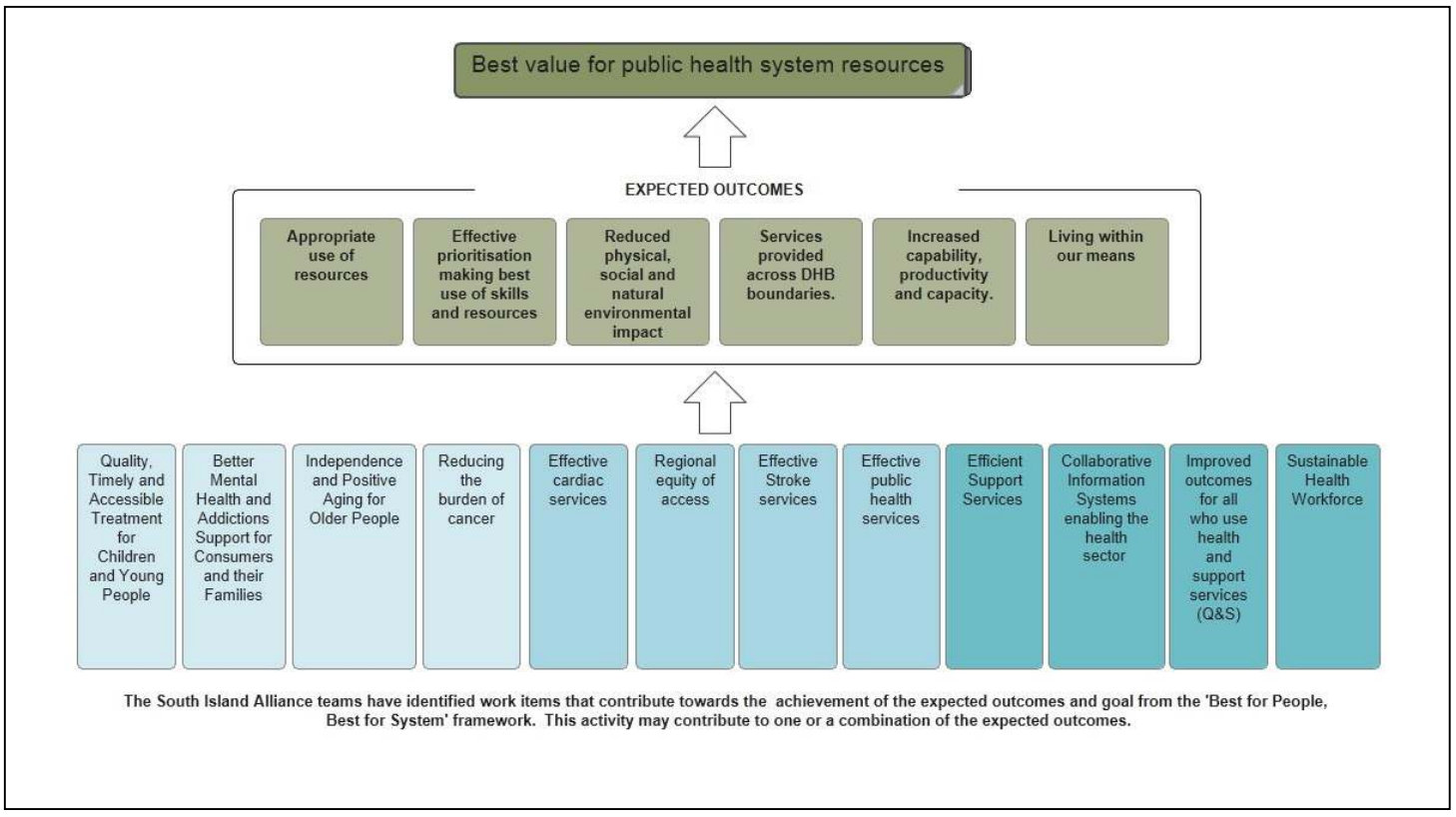


Figure 8: Linking South Island Alliance activity to 'Best value for public health system resources

6.4 Workforce

The South Island Regional Training Hub (SIRTH) seeks to improve workforce development, education and training across the South Island to better meet the health needs of the South Island population. This will be achieved by:

- Supporting innovative workforce development to empower health professionals to work to their full scope of practice in the new and emerging models of patient care with the support of an appropriately trained unregulated workforce
- Strengthening the education and training network across the South Island, and nationally, focusing on encouraging, enhancing and sharing innovative and multi-disciplinary approaches to healthcare delivery through effective education and training processes

6.5 South Island Information Services Service Level Alliance

The Information Services, Service Level Alliance strategy aims to not only address the health technology needs for today, but also to provide a robust foundation that will support future demands, and to develop a sustainable health care model within a fully integrated patient centric environment. By utilising the combined resources across the South Island, DHBs are better positioned to respond to changes in technology. The critical priorities for the Information Services, Service Level Alliance and National Health IT Board are largely a continuation of those identified in the 2013-16 Information Services, Service Level Alliance workplan. This phased implementation approach is reflective of the size and complexity of the initiatives.

The Information Services, Service Level Alliance strategy aligns with the National Health IT Board's framework for eHealth (see figure 9). The framework describes the way an individual's health information is collected during their lifetime over a continuum of care. Each person's 'tree' will be different, because each person has a different life experience. The tree has four levels, which build on each other:

- a person's foundation health information is represented by the roots
- an effective and secure system for sharing information is the trunk
- common clinical information across the continuum of care forms the lower branches
- shared care plans are the upper branches of the tree

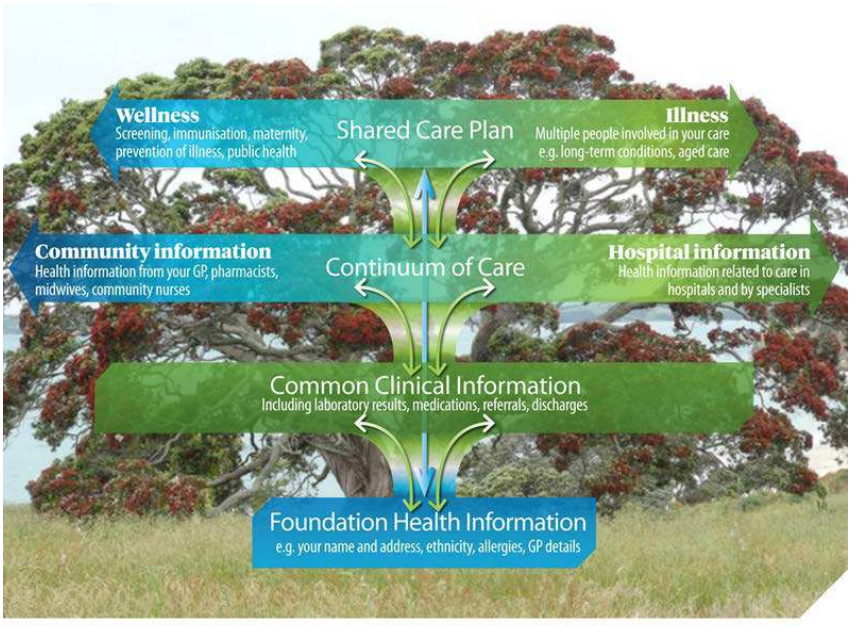


Figure 9: The tree diagram

The Information Service, Service Level Alliance's Portfolio consists of programmes and projects that align with both national and regional priorities.

6.5.1 eMedicines Programme

The eMedicines Programme will reduce the risk of medication errors for our patients by introducing systems that provide greater clarity and accuracy around prescribing and administration of medicines.

The eMedicines Programme consists of the ePrescribing and Administration Project, eMedicines Reconciliation Project and ePharmacy Management Project. These projects will incorporate NZULM and NZ Formulary when sources are made available.

6.5.2 eReferrals Programme

The electronic referral system (eReferrals) Programme will see all paper-based patient referrals between health practitioners replaced with electronic referrals. GPs will be able to use an electronic template that includes the patient's relevant information and can have confidence that the referral is received by the hospital system and can be monitored.

eReferrals is important for improving patients' transition between health service providers. It will improve the reliability of the referrals process and will provide greater transparency in the way DHBs prioritise patients.

6.5.3 Health Connect South Programme (Clinical Workstation and Data Repository)

Health Connect South provides a single repository for clinical records. Clinical staff have the ability to access information from any of the underlying systems that are tied to Health Connect South. It also has the ability to capture patient related documentation and store it in a patient centric way, meaning clinicians will have a better overview of a patient's medical history. Use of a single system across the South Island means that as patients move or are transferred to specialists in other districts, their clinical information is still easily accessible, while remaining secure.

6.5.4 South Island Patient Information Care System Programme

Replacing the current Patient Administration Systems with the South Island Patient Information Care System will result in a more streamlined patient journey through health services, from the community to the hospital and beyond. It will enable better coordinated care between different hospitals and care providers throughout the South Island.

The Information Service, Service Level Alliance's vision is not just to replace the Patient Administration Systems with a similar one, but to use this as an opportunity to embed new functionalities that can be built on to provide ongoing transformation.

6.5.5 National Projects

The Information Services, Service Level Alliance will support the following national initiatives; Self-Care Portal, National Patient Flow; National Trauma Registry, Maternity Information System, interRAI and Finance Procurement Supply Chain projects.

6.5.6 Regional Projects

The Information Services, Service Level Alliance support the following regional projects: Advanced Care Planning, Shared Record View, eLearning, Growth Charts, TeleHealth, Risk Management, regional PACS/RIS solution, Provation, eProSafe (Child Protection database) and Surgical Audit Tool. The Information Services, Service Level Alliance will continue to support the Southern Cancer Network with its Information Services projects; MOSAIQ, Multi-disciplinary Meeting Management Tool and South Island Clinical Cancer Information System.

6.6 Other regional initiatives

6.6.1 South Island Neurosurgery Services

The future governance and management arrangements for the South Island Neurosurgical service are in discussion for implementation for the 2014-15 year.

A new Clinical Director is in place to support the ongoing arrangements. There are still risks to this being a sustainable service, both clinically and fiscally, and it is important that these are recognised in the ongoing arrangements.

6.6.2 Sub-regional initiatives

The South Island DHBs have identified collaborative activities that sit outside of this regional plan. These include consideration of regional or sub-regional agreements with providers. Examples include a regional request for proposal for genetic services for the South Island. Options for a sub-regional laboratory agreement are currently being considered by South Island DHBs.

Canterbury and West Coast DHBs continue to work together to deliver safe and quality services on the Coast.

The South Island DHBs have adopted the principle of considering potential areas of collaborative activity from a region wide perspective. Innovations are considered by all South Island DHBs to determine if the adoption of a regional approach will benefit the South Island population.

Appendix 1 – Minister Letter of Expectation 2014

Office of Hon Tony Ryall
Minister of Health
Minister for State Owned Enterprises

30 JANZ014

Dear

Letter of Expectations for DHBs and subsidiary entities 2014/15

Public and patient confidence in the health service continues to grow strongly. Thank you to your team. This achievement is built on the four objectives of the Government's health plan: *helping families stay healthy, better performance, best use of every dollar, and a strong and trusted workforce.* In the next year we expect continued strong focus on successful implementation.

New Zealand has come through the global financial crisis in much better shape than most other countries. That's because of this government's careful and prudent financial management. Our approach has been to protect the most vulnerable in our society, and rebuild the economy's capacity to create jobs, higher incomes and security.

Despite the toughest of times, we are providing better public services within careful funding increases. This government now invests an extra $2.5 billion a year more into the public health service. And this year's budget will again see more investment in Health.

Better Public Services: Results for New Zealanders

Of the Prime Minister's ten whole-of-government key result areas, DHBs are expected to actively engage and invest in increased infant immunisation, reduced incidence of rheumatic fever, and reduced assaults on children.

It is important Boards work closely with other social sector organisations and initiatives including Whanau Ora, Children's Action Plan and Youth Mental Health. The government values the contribution of NGOs and DHBs must work with them.

National Health Targets

The national health targets have proven very successful at driving major improvements for patients: more elective surgery, faster access to emergency and cancer care, and better prevention. DHBs will provide clear and specific plans for achieving all national health targets in their Annual Plans.

In particular further work is required to achieve the three preventive targets. You must demonstrate appropriate performance management arrangements for PHOs. Poor performance must be rectified and not ignored. You should again show your local primary care networks are involved in and explicitly endorse your target achievement plans.

Your DHB is expected to help patients by meeting our objectives of shorter waiting times for surgery, diagnostics, cardiac and cancer care.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6804 Facsimile 64 4 817 6504

Care Closer to Home

New Zealanders are living longer, more sedentary lives. This means more of us have chronic conditions like diabetes, asthma, dementia, cancer and mental health disorders. The sooner doctors and nurses can detect, treat or prevent these conditions, the better they can reduce the significant burden these conditions put on both patients and the health system.

A major strategy to do this is *clinical integration* - providing joined-up care across primary and secondary services. With resources and interventions flowing to where they are most effective. So patients get their care sooner and closer to home.

DHBs must focus strongly on service integration across the health system, including integrated family health centres, primary care direct referral for diagnostics, clinical pathways and sharing of patient controlled health records.

Health of Older People

Your DHB is expected to continue working with primary and community care to deliver integrated services for older people to support their continued safe, independent living at home; particularly important are avoiding a hospital admission and care after a hospital discharge. You should continue working with the Ministry to implement our commitments to improving home care, stroke services and dementia care pathways.

Regional and National Collaboration

DHBs are expected to make further progress on implementing Regional Service Plans including workforce, IT and capital objectives. DHBs are expected to strongly support the implementation of the key Health Benefits Ltd savings programmes. Further gains in quality, efficiency and cost control will also come from your work with Pharmac, Health Workforce NZ and the Health Quality and Safety Commission. The new patient satisfaction survey is one example.

Strong clinical leadership and engagement is important and remains essential.

Living Within Our Means

To support New Zealand's recovery your DHB must keep to budget. Your DHB must have detailed and effective plans to improve financial performance year on year. Equity and capital remain constrained. As agents of the Crown you and your Board must assure yourselves that you have in place the appropriate clinical and executive leadership to deliver on the government's objectives. You and your Board must monitor and hold your CEO accountable against these expectations.

Appreciation

Again, thank you for the considerable effort you and your team are making. This makes a real difference to the quality of life of many thousands of New Zealanders. Please share this letter with your clinical leaders and local primary care networks.

Yours sincerely

Tony Ryall
Minister of Health

Attached: PM's Key Result Areas and National Health Targets

Appendix 1: Prime Minister's Key Result Areas and DHB Health Targets for 2014115

Prime Minister's Key Result Areas - Supporting Vulnerable Children

Increase immunisation rates

Increase infant immunisation rates so that 95 percent of eight-month-olds are fully immunised by December 2014 and this is maintained through to 30 June 2017.

Rheumatic Fever

Reduce the incidence of rheumatic fever by two thirds to 1.4 cases per 100,000 people by 2017.

Assist to reduce the number of assaults on children

By 2017, halt the rise in children experiencing physical abuse and reduce current numbers by 5%.

National Health Targets for 2014/15

Shorter stays in Emergency Departments

95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.

Improved access to elective surgery

The volume of elective surgery will be increased by at least 4,000 discharges per year.

Shorter waits for cancer treatment / transitioning to Faster Cancer Treatment

All patients ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy.

Faster cancer treatment.

The 62-day faster cancer treatment indicator that is currently a developmental measure, will transition into a full policy priority accountability measure, and will become the next cancer health target during 2014/15. Further details including the health target definition, DHB performance expectations for 2014/15, and the process for transition will be provided at the end of February 2014.

Increased immunisation

90 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2014 and 95 percent by December 2014.

Better help for smokers to quit

95 percent of hospitalised patients who smoke and are seen by a health practitioner in public hospitals and 90 percent of enrolled patients who smoke and are seen by a health practitioner in General Practice are offered brief advice and support to quit smoking. Within the target a specialised identified group will include:

- progress towards 90 percent of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit.

More heart and diabetes checks

90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years.

Appendix 2 - What are we trying to achieve?

The South Island DHBs are responsible for delivering against the health sector goal: "*All New Zealanders lead longer, healthier and more independent lives*" and for meeting Government commitments to deliver '*better, sooner, more convenient health services*'.

As part of their accountability to their communities the South Island DHBs need to demonstrate whether they are succeeding in meeting those commitments and improving the health and wellbeing of their population. There is no single measure that can demonstrate the impact of the work they do, so they use a mix of population health and service access indicators as proxies to demonstrate improvements in the health status of their population.

In developing the strategic framework, the South Island DHBs have collectively identified three strategic goals. To achieve these goals they have agreed the key strategies along with the expected outcomes, as shown below. A core set of measures and associated indicators, which will demonstrate whether they are making a positive change in the health of their populations, are in development. These will align to the national health targets and to the Integrated Performance Incentive Framework

Goal: POPULATION HEALTH **Improved health and equity for all populations**	
Strategies A. Supporting healthy choices and healthy environments B. More services delivered locally in the community and primary care focusing on people their families and communities, keeping them at the centre of everything we do C. Services are responsive to vulnerable populations D. Health literacy for all E. Increase specific Maori service provision, where appropriate	**Expected Outcomes** ▪ People are healthier and take greater responsibility for their own health ▪ Increased prevention and early intervention rates ▪ More appropriate access to services ▪ Earlier diagnosis ▪ Delayed/avoided burden of long term conditions ▪ Equity of outcomes for all populations
Goal: EXPERIENCE OF CARE **Improved quality, safety and experience of care**	
Strategies A. Provide access to patient centred services that provide choice, promote independence and are effective, efficient, responsive & timely B. Promote intersectoral collaboration C. Agreed clinical pathways across service areas D. Shared decision making across health professionals to coordinate a smooth transition between services and providers E. Clinical networks and multidisciplinary alliances will support the delivery of quality services across the health continuum F. Quality initiatives across all services G. Consumer participation H. Intervene early, with improved coordination and proactive provision of care I. Promote a high standard of cultural competency	**Expected Outcomes** ▪ Improved patient satisfaction ▪ People stay well and maintain their functional independence ▪ People with complex conditions have improved health outcomes ▪ Increased access to planned care ▪ Decreased adverse events ▪ Decreased avoidable mortality ▪ Decrease in cancelled services

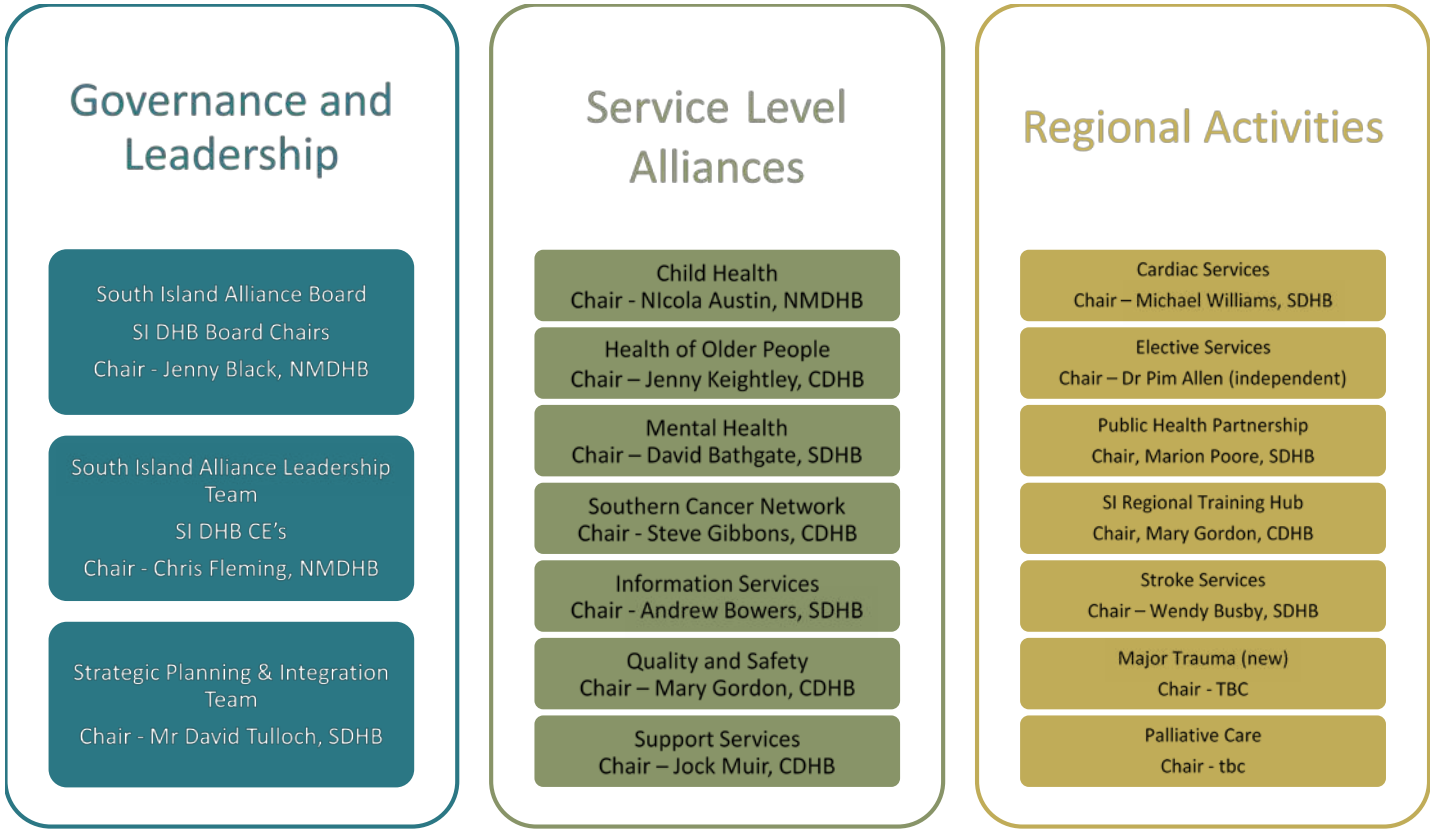
Goal: SUSTAINABILITY

Best value for public health system resources

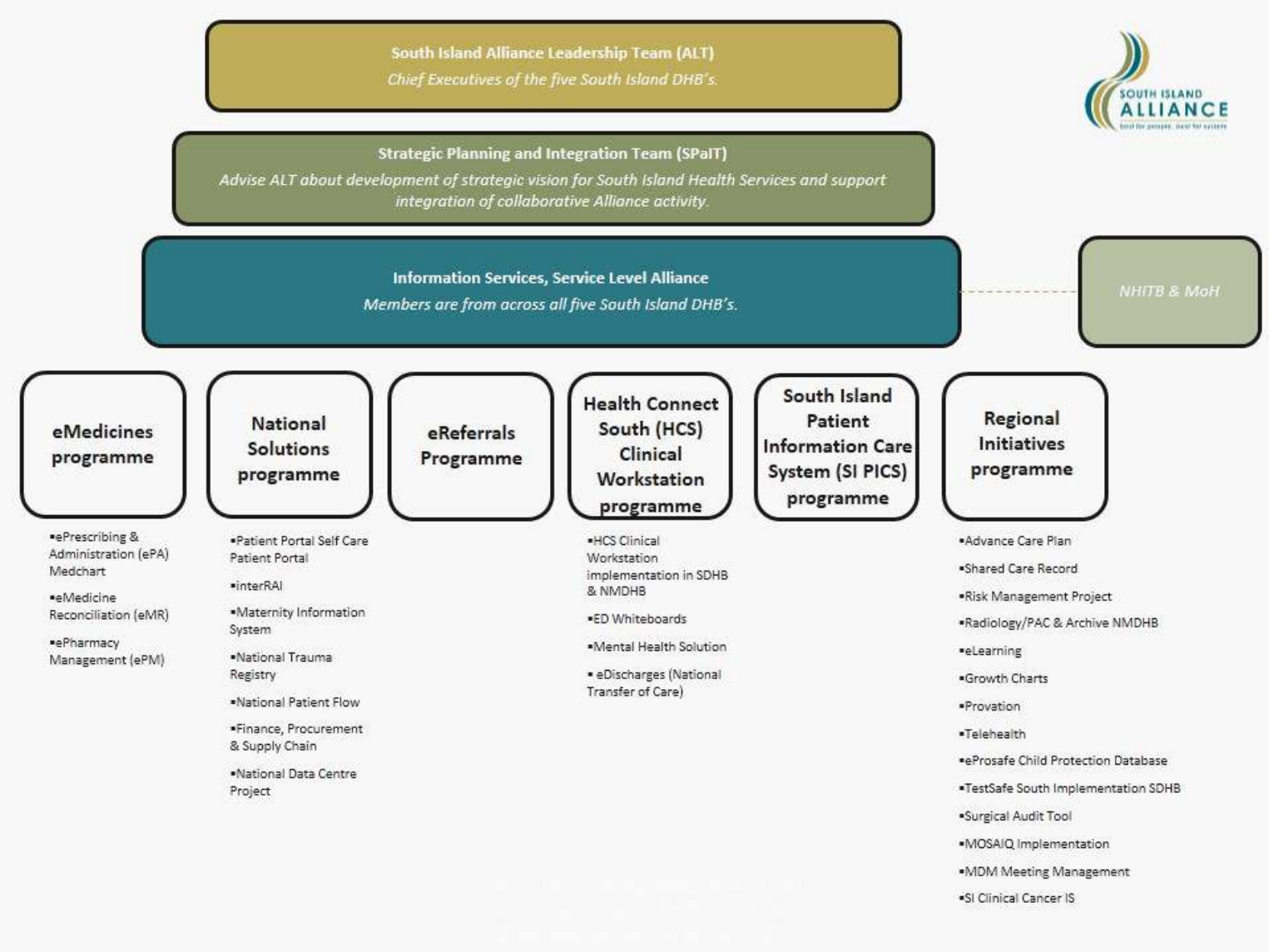
Strategies	Expected Outcomes
A. Adopting a 'whole of system' approach B. Shared planning to support service delivery and mitigate fiscal risk C. Flexible models of care and new technologies to support service delivery in non-traditional environments D. Monitoring and reducing environmental impact E. Workforce development that supports new models of care F. Develop and strengthen the Maori workforce G. Information improvements to optimise resources (time, facilities and equipment) and focus on the delivery of quality health care H. Flexible funding models to achieve best outcomes	▪ Living within our means ▪ Increased capability, productivity and capacity ▪ Appropriate use of resources ▪ Reduced waste of resources ▪ Reduced environmental impact ▪ Services provided across DHB boundaries

Appendix 3 – Governance Structures

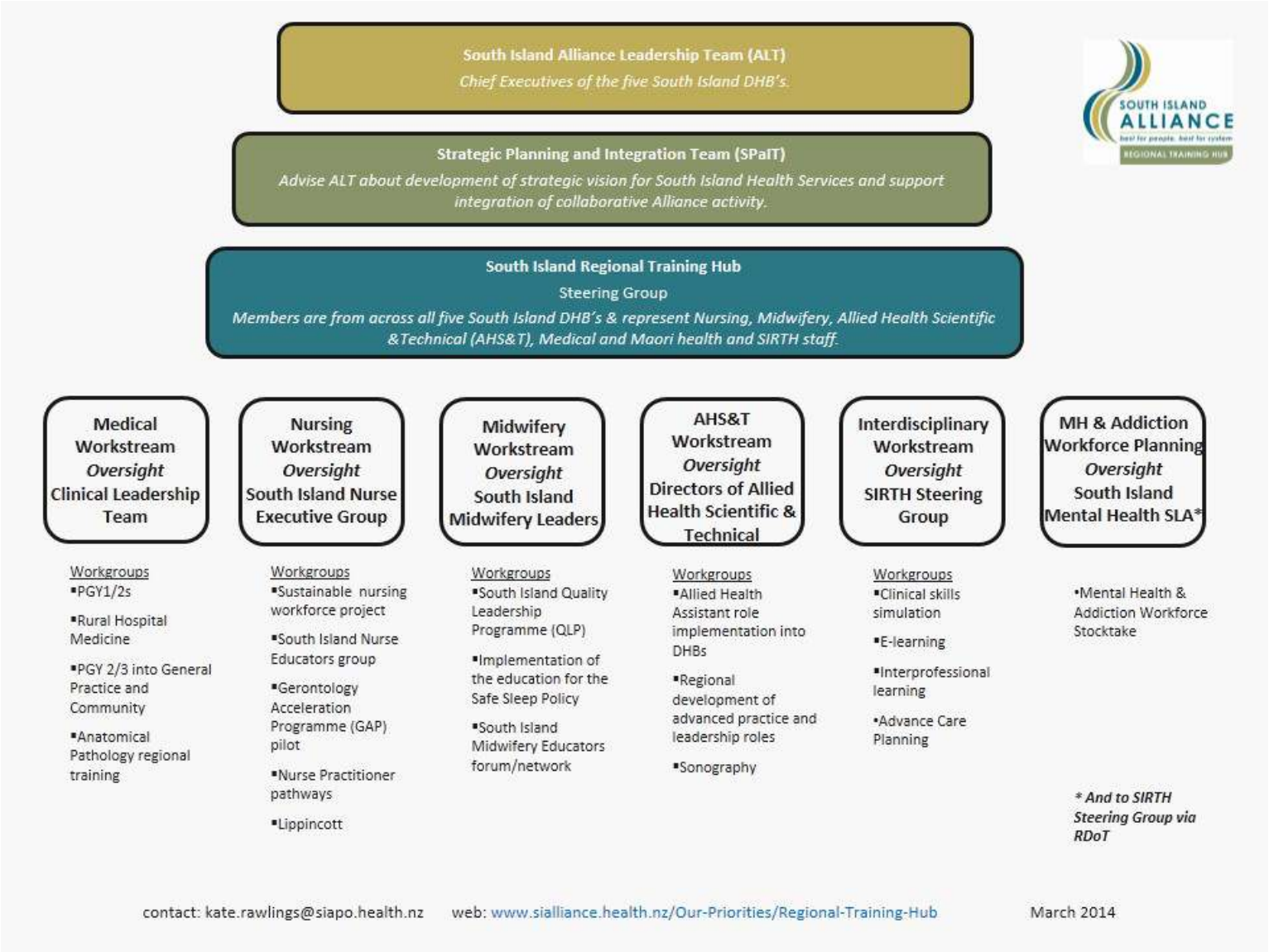
South Island Alliance Structure



Information Services SLA governance structure



SIRTH governance structure



Participation in South Island Workforce Planning and Development across the South Island

South Island Alliance Leadership Team

Name	Role	DHB
David Meates	Lead CE for SIRTH, Chief Executive Officer	CDHB &WCDHB
Chris Fleming	Chief Executive Officer	NMDHB
Nigel Trainor	Chief Executive Officer	SCDHB
Carole Heatly	Chief Executive Officer	SDHB

Strategic Planning and Integration team

Name	Role	DHB
Mr David Tulloch (Chair)	Chief Medical Officer	SDHB
Carolyn Gullery	General Manager Planning and Funding	CDHB
Dr Sharon Kletchko	General Manager Strategy and Planning	NMDHB
Hilary Exton	Service Manager and Director of Allied Health	NMDHB
Fiona Pimm	General Manager Māori Health Services	SCDHB
Robyn Henderson	Executive Director Nursing and Midwifery	NMDHB
Dr Daniel Williams	Public Health Physician	CDHB, WCDHB & SCDHB
Dr Carol Atmore	General Practitioner	WCDHB
Jan Barber	General Manager South Island Alliance Programme Office	SIAPO

South Island Regional Training Hub

Name	Role	DHB/Organisation
Mary Gordon(Chair)	Executive Director of Nursing and Midwifery	NMDHB
Samantha Burke	Director of Midwifery	CDHB
Lynda McCutcheon	Director of Allied Health, Scientific and Technical	SDHB
Dr Carol Atmore	Chief Medical Officer	WCDHB
Harold Wereta	Director of Māori Health and Whānau Ora	NMDHB
Dr Bernhard Kuepper	Consultant Internal Medicine/Cardiology	SCDHB
Margaret Bunker	South Island Alliance Programme Coordinator	SIAPO
Kate Rawlings	Regional Programme Director Training	SIAPO
Kathryn Goodyear	Facilitator	SIAPO

Medical Workstream

	Name	Role	DHB/Organisation
Clinical Leadership Team (oversight)	Dr Carol Atmore (Chair)	Chief Medical Officer/General Practitioner	WCDHB
	Greville Wood	Rural Academic Practice	Greymouth
	David Tulloch	Chief Medical Officer	SDHB
	Marion Poore	Medical Director; Public Health Physician; Medical Officer of Health	SDHB
	Richard Johnson	Chief Medical Officer	SCDHB
	Bernhard Kueppers	Consultant Internal Medicine/Cardiology	SCDHB
	John Fink	Neurologist and Director of Physicians Education	CDHB
	Tim Phillips	RNZCGP General Practitioner Training Programme Educator	Nelson

	Name	Role	DHB/Organisation
	Pragati Gautama	Clinical Leader RHM Training Programme	Central Otago
	John Thwaites	Clinical Director Medical Education and Training Unit	CDHB
	Don Wilson	Dunedin School of Medicine	University of Otago
	Tom Fiddes	Director of Rural Learning Centre	WCDHB
	Nigel Millar	Chief Medical Officer	CDHB
	Nina Stupples	General Practitioner Westport & Reefton	Rural Hospital Medicine
	Suzanne Busch	Intern Supervisor	NMDHB
	Ben Wilson	Branch Education Officer	RANZCR
	Kate Rawlings	Regional Programme Director Training	SIRTH
	Kath Goodyear	Project Facilitator	SIRTH
PGY1/2s	John Thwaites (Chair)	Clinical Director Medical Education and Training Unit	CDHB
	Karen Schaab	Resident Doctor Strategy Advisor, RMO Unit	CDHB
	David Brandts-giesen	Team leader Resident Doctor Support team	CDHB
	Sue Rattray	Education Coordinator	CDHB
	David McGregor	Intern Supervisor,	CDHB
	Miriam Parwaiz	RMO Representative *(Tentative)*	CDHB
	Sean McPherson	Consultant Haematologist	CDHB
	Jessica Taylor	RMO	CDHB
	Dale Sheehan	Education and Training Coordinator, Medical Education Training Unit	CDHB
	Verity Kennedy,	RMO Coordinator	WCDHB
	Carol Atmore	Chief Medical Officer/General Practitioner	WCDHB
	Rhonda Skilling	RMO Coordinator	SDHB
	Adam Falconer	RMO Coordinator	SDHB
	David Tulloch	Chief Medical Officer	SDHB
	Belinda Green	Intern Supervisor	SDHB
	Ari Duthie	Senior RMO advisor	SDHB
	Maree Smith	RMO Coordinator/HR Advisor	SCDHB
	Christine Nolan	General Manager Secondary Services	SCDHB
	Loretta Matheson	RMO Coordinator Nelson Hospital	NMDHB
	Reon van Rensburg	Wairau Hospital	NMDHB
	Tim Wilkinson	Programme Director Medical Student Training (Christchurch)	University of Otago
	David Gerard	Dunedin School of Medicine Undergraduate Medicine Clinical Skills Director and Clinical Education Advisor	University of Otago
	Tim Phillips	Medical Educator/Liaison/Supervisor teaching practices Nelson Marlborough	RNZCGP
	Neil Whittaker	Medical Educator, teaching practices Nelson Marlborough	RNZCGP
	Kate Rawlings	Regional Programme Director Training	SIRTH
	Kath Goodyear	Project Facilitator	SIRTH
Rural Hospital Medicine	Scott Wilson (Chairperson)	Clinical Director for Ashburton and Rural Hospitals	CDHB
	Carol Atmore	Chief Medical Office	WCDHB

	Name	Role	DHB/Organisation
	Nina Stupples	General Practitioner, Westport & Reefton, Rural Hospital Medicine	WCDHB
	Pragati Gautama	RHM South Island Training Coordinator & Medical Officer/General Practitioner Dunstan Hospital	SDHB
	Garry Nixon,	Medical Officer Dunstan Hospital, Academic in Dunedin School of Medicine	University of Otago
	Patrick McHugh	General Practitioner Gisborne, RNZCGP Faculty of Rural Hospital Medicine	RNZCGP
	Kate Rawlings	Regional Programme Director Training	SIRTH
PGY 2/3 into General Practice & Community	Nigel Millar (Chairperson)	Chief Medical Officer	CDHB
	David Tulloch	Chief medical Officer	SDHB
	Loretta Matheson	RMO Unit Coordinator	NMDHB
	Tim Phillips	General Practitioner and Royal NZ College of General Practice	RNZCGP
	Simon Wynn-Thomas	General Practitioner	Christchurch
	Sarah Greegan	General Practitioner	Waimate
	Kate Rawlings	Regional Programme Director Training	SIRTH
Anatomical Pathology regional training	Dr Liz Roberts	SCL Nelson/ RCPA	Southern Community Laboratories
	Dr Peter Gootjes	SCL CEO (Dunedin)	Southern Community Laboratories
	Trevor English	General Manager Canterbury Health Laboratories (CHL)	CDHB
	Dr Peter George	Clinical Director CHL	CDHB
	Dr Gavin Harris	Head of Department CHL	CDHB
	Dr David Roche	SCL Christchurch	Southern Community Laboratories
	Dr Martin Whitehead	Director of Training CHL	CDHB
	Elwyn Eastlake	Consultant	Health Workforce New Zealand

Nursing Workstream

	Name	Role	DHB/Organisation
South Island Nurses Executive	Nursing Executive NZ (NENZ) Members participate from Nurse Maude, Christchurch Hospital, St George's Hospital, Pegasus Health, Canterbury DHB, Burwood Hospital, Nelson Marlborough DHB, South Canterbury DHB, Southern DHB, MetLife Care, Mercy Hospital Dunedin, Ashburton Hospital, West Coast DHB, ASSOCIATE NENZ MEMBERS - Ryman Healthcare, Royal NZ Plunket, Southern Cross (SI), Pegasus Health, Oxford Clinic Hospital, and NZ Blood Service		
Sustainable Nursing Workforce	Jane Brosnahan(Chair)	Director of Nursing, Midwifery and Allied Health	SCDHB
	Jane Collins	Nursing Director-Older Persons Health, Clinical Support and Community Directorate	SDHB
	Becky Hickmott	Nurse Manager, Nursing Workforce Development Team	CDHB
	Kate Gibb	Nursing Director, Older Persons Health	CDHB
	Kelly Robertson	Nursing Development Coordinator	Pegasus Health
	Frederique Gulcher	Communications Advisor	SIAPO
	Anne Tacon	Associate Director of Nursing, Mental Health Services	WCDHB

	Name	Role	DHB/Organisation
	Sandy Matheson	Nurse Consultant Education	NMDHB
	Samantha Burke	Director of Midwifery	CDHB
	Kate Rawlings	Regional Programme Director Training	SIRTH
	Kath Goodyear	Project Facilitator	SIRTH
South Island Nurse Educators	Janette Dallas (Chair)	Nurse Manager Professional Practice Development	CDHB
	Linda Collier	Lead Clinical Educator	Pegasus Health
	Di McGowan	Clinical Facilitator	Pegasus Health
	Jo Butterfield	Nurse Educator	Pegasus Health
	Chris Black	Nurse Educator	WCDHB
	Brittany Jenkins	Nurse Educator	WCDHB
	Megan Stark	Nurse Educator	SCDHB
	Jodie Black	Nurse Educator	Southern PHO
	Sandy Matheson	Nurse Educator	NMDHB
	Carolyn Bennison	Nurse Educator	NMDHB
	Steve Smith	Nurse Educator	Mobile Health
	Tony Farrow	Nurse Educator	CDHB
	Karen Betony	Nurse Educator	Nurse Maude
	Juliet Manning	Nurse Educator	SDHB
	Debs Ashworth	Nurse Educator	SDHB
	Isabel Radka	Nurse Educator	SDHB
	Nicola Bransden	Nurse Educator	SDHB
	Vicki McGhie	Nurse Educator	WCDHB
	Cheryl Hutchison	Nurse Educator	WCDHB
	Kate Rawlings	Regional Programme Director Training	SIRTH
	Kath Goodyear	Project Facilitator,	SIRTH
Gerontology Acceleration Programme (GAP)	Kate Gibb (Convenor)	Nursing Director	CDHB
	Jenny Gardner	Robyn Hulme	BUPA
	Diana Gunn,	Director of Nursing Older Person's Health & Rehabilitation	CDHB
	Kate Rawlings	Regional Programme Director Training	SIRTH
	Deb Gillon	Professional Practice Fellow Centre Postgraduate Nursing Studies	University of Otago
	Mark Crawford	Medical Nursing Director	CDHB
	Janette Dallas	Nurse Manager Professional Practice Development	CDHB
	Rhonda Sherriff	Southern Regional Manager	Ultimate Care Group
	Becky Hickmott	Nurse Manager Nursing Workforce Development	CDHB
	Rebecca Winsor	Clinical Nurse Specialist Older Person's Health	CDHB
	Daphne Manderson	Department of Nursing	CPIT
	Janice Lavelle	Service Manager	CDHB
	Janetta Skiba	Director of Nursing	Rural PHO
Nurse Practitioner pathways	Leanne Samuel (Chair)	Executive Director of Nursing	SDHB
	Maree Steel	Manager Staff Development	SCDHB
	Karyn Bousfield	Director of Nursing	WCDHB

	Name	Role	DHB/Organisation
	Heather Gray	Director of Nursing, Medical/surgical	CDHB
	Robyn Henderson	Director of Nursing and Midwifery	NMDHB
	Louisa Sullivan	Clinical Director	Pegasus Health
	Kate Rawlings	Regional Programme Director Training	SIRTH
	Kath Goodyear	Project Facilitator	SIRTH
Lipponcott *(to be confirmed)*			

Midwifery Workstream

	Name	Title	DHB/Organisation
South Island Midwifery Leaders (oversight)	Samantha Burke (Chair)	Director of Midwifery	CDHB
	Chris Davey	Clinical Midwifery Manager	WCDHB
	Julie Dockrill	Clinical Midwifery Manager	SCDHB
	Jane Brosnahan	Director of Nursing and Midwifery	SCDHB
	Jenny Humphries	Director of Midwifery	SDHB
	Debbie Fisher	Midwifery Advisor	NMDHB
	Anna Van Uden	Charge Midwife	St George's
South Island Midwifery Educators	Ann Shaw	Midwifery Educator	SCDHB
	Chris Davey	Midwifery Educator	WCDHB
	Christine Graham	Midwifery Educator	SDHB
	Julie Dockrill	Midwifery Educator	SCDHB
	Liz Nash	Midwifery Educator	NMDHB
	Rhonda Ayles	Midwifery Educator	CDHB
	Tina Hewitt	Midwifery Educator	CDHB
	Wendy Munro	Midwifery Educator	SDHB

Allied Health Scientific & Technical Workstream

	Name	Title	DHB/Organisation
South Island Directors of Allied Health (oversight)	Lynda McCutcheon	Director of Allied Health Scientific & Technical	SDHB
	Hilary Exton	Director of Allied Health/Service Manger Allied Health	NMDHB
	Stella Ward	Executive Director of Allied Health	CDHB & WCDHB
	Jane Brosnahan	Director of Nursing Midwifery and Allied Health	SCDHB
Allied Health Assistant role	Stella Ward (Project Sponsor)	Executive Director of Allied Health	CDHB & WCDHB
	Lynda McCutcheon	Director of Allied Health Scientific & Technical	SDHB
	Hilary Exton	Director of Allied Health/Service Manger Allied Health	NMDHB
	Jane Brosnahan	Director of Nursing Midwifery and Allied Health	SCDHB
	Amber Salanoa Haar	Allied Health Advisor	WCDHB
	Rene Templeton	Associate Director of Allied Health	SCDHB
	Garth Munro	Director of Allied Health	CDHB
	Wendy Fulton	Director of Allied Health	CDHB
	Rose Henderson	Director of Allied Health	CDHB
	Sandy Clemet	Allied Health Change Architect	CDHB
	Andrew Metcalfe	Allied Health Director	SDHB

	Name	Title	DHB/Organisation
	Dale Radford	Allied Health Director	SDHB
	Noelle Bennet	Allied Health Director	SDHB
	Tracey Hoggarty	Allied Health Director	SDHB
	Catherine Coups	Allied Health Project Lead,	SIRTH
Development of Advanced Practice roles *Full membership and Project Sponsor TBC*	Stella Ward	Executive Director of Allied Health	CDHB & WCDHB
	Lynda McCutcheon	Director of Allied Health Scientific & Technical	SDHB
	Hilary Exton	Director of Allied Health/Service Manger Allied Health	NMDHB
	Jane Brosnahan	Director of Nursing Midwifery and Allied Health	SCDHB
	Amber Salanoa Haar	Allied Health Advisor	WCDHB
	Rene Templeton	Associate Director of Allied Health	SCDHB
	Catherine Coups	Allied Health Project Lead	SIRTH
Sonography *Membership and Project Sponsor TBC*	Lynda McCutcheon	Director of Allied Health Scientific & Technical	SDHB

Interdisciplinary Workstream

	Name	Title	DHB/Organisation
SIRTH Steering Group	Bernhard Kueppers (Workstream lead)	Consultant Internal Medicine/Cardiology,	SCDHB
	Mary Gordon	Executive Director of Nursing	CDHB
	Samantha Burke	Director of Midwifery	CDHB
	Harold Wereta	Director Maori Health & Whanau Ora	NMDHB
	Carol Atmore	Chief Medical Officer / General Practitioner	WCDHB
	Lynda McCutcheon	Director Allied Health Scientific & Technical	SDHB
	Margaret Bunker	SIA Programme Coordinator	SIAPO
	Kate Rawlings	Regional Director of Training	SIRTH
Clinical Skills Simulation	Chris Beasley (Chair)	Coordinator, Clinical Skills Unit	CDHB
	Paul Winder	Resuscitation Service Coordinator, Nurse Educator Critical Care	SDHB
	Steve Smith	Rural Health Development Manager	Mobile Health
	Brittany Jenkins	Resuscitation Service Leader	WCDHB
	Sue Dawkins	Nurse Practitioner, Murchison Hospital and Health Centre	NMDHB
	Bernhard Kuepper	Consultant Internal Medicine/Cardiology	SCDHB
	still to be confirmed	Allied Health Scientific & Technical representative	
	still to be confirmed	St John representative	
	Kath Goodyear	Project Facilitator	SIRTH
Inter-professional learning	Dr Tom Fiddes	Academic Director, Rural Learning Centre	WCDHB
	Joanna Saunders	Nurse Educator Professional Development Unit and Clinical Emergency Coordinator Christchurch Women's Hospital	CDHB
	Sandra Matheson	Nurse Consultant Education	NMDHB

	Name	Title	DHB/Organisation
	Tony Egan	Senior Teaching Fellow Medical Education	University of Otago
	Carol Gaskell	Coordinator Rural Learning Centre	West Coast DHB

Mental Health & Addiction Workforce Planning Workstream

	Name	Title	DHB/Organisation
Mental Health SLA (oversight)	Dr David Bathgate (Chair)	Consultant Psychiatrist	SDHB
	Dr Alfred Dell'Ario	Consultant Psychiatrist	CDHB
	Heather Casey	Director of Nursing	SDHB
	Rose Henderson	Allied Health	CDHB
	Sal Faid,	Consumer	
	Key Frost	Pacifica	PIACT
	Paul Wynands	Primary Care	RCPHO
	Karaitiana Tickell	Maori Advisor	Purapura Whetu Trust
	Diane Issac	Family Advisor	Supporting Families
	Robyn Byers	Service Director	NMDHB
	Judy Walker	Planning & Funding	SDHB
	Martin Kane	Facilitator	SIAPO
Mental Health & Addiction Workforce Stocktake	Valerie Williams	Mental Health & Addictions Workforce Planning Lead	SIRTH
	Klare Bray	Project Leader	Matua Raki
	Terry Huriwai	Senior Advisor	Matua Raki
	Jane Vanderpyl	Research & Evaluation Manager	Te Pou
	Joanne Richdale	Workforce Analyst	Te Pou
Mental Health & Addictions Workforce Planning	Valerie Williams	Mental Health & Addictions Workforce Planning Lead	SIRTH
	Nathalie Esaiah-Tiatia	Mental Health & Addictions Workforce Planning Lead	Midlands Region
	Deb Christensen	Mental Health & Addictions Workforce Planning Lead	Northern Regional Alliance
	Karen Moses	Mental Health & Addictions Workforce Planning Lead	Central TAS
	Emma Wood	Relationship Management Lead	Te Pou
South Island Mental Health Educators (*Membership and Project Sponsor TBC)*			

Appendix 4 - Service Performance Priorities 2014-2017

The South Island Alliance 'Best for People, Best for System' Framework underpins the agreed actions to achieve: improved health and equity for all populations, improved quality, safety and experience of care and best value for public health system resources.

Clinical Services: Sustainability and Clinical Integration

Southern Cancer Network Services: South Island Cancer Services

Reducing the burden of cancer

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

Clinical Lead: **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 the cancer control action plan across the South Island.
- Provide a formal structure that supports improvement in coordination of population programmes for prevention and screening and the quality of treatment.

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

- South Island Faster Cancer Treatment - People get timely services across the whole cancer pathway (screening, detection, diagnosis, treatment and management and palliative care) in line with the Faster Cancer Health Target.
- 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.
- South Island Clinical Cancer Information System - Implementation of the South Island Clinical Cancer Information System (SICCIS): Robust cancer data and information sources are developed and shared that enable informed service development & planning decision-making.

Actions to deliver	Deliverable 2014-15	Deliverable 2015-17	Responsibilities
SOUTH ISLAND FASTER CANCER TREATMENT **People get timely services across the whole cancer pathway (screening, detection, diagnosis, treatment and management, palliative care)**			
Performance sustained against the radiotherapy and chemotherapy wait time targets by more efficient use of existing resources and investing in workforce and capacity as required.	National radiotherapy and chemotherapy waiting time targets are met. **(Q1, Q2, Q3, Q4)**	National radiotherapy and chemotherapy waiting time targets are met.	Contributors: All South Island DHBs Reported in: SIHSP
	Implement recommendations from the 2012 & 2013 South Island Radiation Oncology Reports. **(Q1, Q2, Q3, Q4)**	Implement recommendations from the 2012 & 2013 South Island Radiation Oncology Reports.	Contributors: All South Island DHBs Reported in: SIHSP

Actions to deliver	Deliverable 2014-15	Deliverable 2015-17	Responsibilities
Improved faster cancer treatment data collection systems to support service improvements along cancer patient pathway.	Faster Cancer Treatment data is collected comprehensively (by DHB & ethnicity). **(Q1, Q2, Q3, Q4)**	Faster Cancer Treatment data is collected comprehensively (by DHB & ethnicity).	Contributors: All South Island DHBs Reported in: SIHSP
	Review FCT data and identify service improvements and implement. **(Q1, Q2, Q3, Q4)**	Data collection and service improvements are identified and implemented.	Contributors: All South Island DHBs & SCN Reported in: SIHSP
	Review primary care interface with FCT indicators and identify improvement opportunities for discussion with key stakeholders. **(Q3)**	Initiatives that support primary care interface with Faster Cancer Treatment indicators are identified and implemented.	Contributors: All South Island DHBs & SCN Reported in: SIHSP
	85% patients with a cancer diagnosis receive their first treatment within 62 days of referral with a high suspicion of cancer, in line with the cancer treatment health target by 1 July 2016. **(Q1, Q2, Q3, Q4)**	Patients with a cancer diagnosis receive their first treatment within 62 days of referral with a high suspicion of cancer, in line with the cancer treatment health targets.	
DHBs are supported to implement projects to meet the 62 day Faster Cancer Treatment target.	Review individual DHB FCT Health Target reports. **(Q1, Q2, Q3, Q4)**	Individual DHB FCT Health Target Reports reviewed with actions identified to support DHBs to meet the FCT 62 Health Target.	Contributors: All South Island DHBs & SCN Reported in: SIHSP
	Identify and support the implementation of appropriate actions to meet the FCT 62 day health target. **(Q1, Q2, Q3, Q4)**		
Improved functionality and coverage of MDMs across the region.	Proof of Concept for ORION solution for MDM meeting management tool is completed and evaluated. **(Q1)**	MDM monitoring data shows improvement from baseline and previous year's data and meets the national tumour stream standards requirements.	Contributors: All South Island DHBs & SCN Reported in: SIHSP
	Together with SI IS SLA support development of business case(s) for MDM Meeting Management Tool. **(Q1, Q2, Q3, Q4)**	MDM monitoring data shows improvement from baseline data and meets the national tumour stream standards requirements.	
The national tumour standards of service provision are implemented.	Audits against standards for remaining tumour stream(s) are complete and include a focus on supportive care, palliative care and equity **(Q3, Q4)**	The remaining agreed national tumour stream standard audits are completed.	Contributors: All South Island DHBs & SCN tumour stream working groups Reported in: SIHSP
		Audit recommendations are progressively implemented.	
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**			
All SCN network groups are provided with ongoing support to progress actions in their respective work plans.	South Island Clinical Cancer Information Service Data Request and Review Group is established and functional. **(Q1, Q2, Q3, Q4)**	Network groups are reviewed and, if appropriate, secretariat support incorporated to become self-sufficient.	Contributors: All South Island DHBs & SCN
National Medical Oncology Models of Care Implementation Plan 2012-13 implemented.	Increased standardisation in Medical Oncology patient assessments, processes, procedures and workforce is supported across the region. **(Q1, Q2, Q3, Q4)**	Increased standardisation in Medical Oncology patient assessments, processes, procedures, and workforce is supported across the region.	Contributors: CDHB, SDHB & SCN Reported in: SIHSP
Initiatives that reduce inequalities and support access to cancer services.	Initiatives that support patient, family and whānau access to cancer services and reduce inequalities are identified and implemented. **(Q1, Q2, Q3, Q4)**	Initiatives that support patient, family and whānau access to cancer services and reduce inequalities are identified and implemented.	Contributors: All South Island DHBs & SCN Reported in: SIHSP

Actions to deliver	Deliverable 2014-15	Deliverable 2015-17	Responsibilities
Implementation of SCN South Island Radiation Oncology Report recommendations.	Ongoing implementation of radiation oncology workforce, workflow and investment recommendations from the SCN Radiation Oncology report 2013. **(Q1, Q2, Q3, Q4)**	Ongoing Implementation of radiation oncology workforce, workflow and investment recommendations from the SCN Radiation Oncology report 2013.	Contributors: All South Island DHBs & St George's Cancer Centre & SCN Reported in: SIHSP
SOUTH ISLAND CLINICAL CANCER INFORMATION SYSTEM **Implementation of the South Island Clinical Cancer Information System (SICCIS): Robust cancer data and information sources are developed and shared that enable informed service development & planning decision-making**			
SICCIS, the regional clinical data repository for cancer implementation continues	Collection of surgical information in the SICCIS, automatic transfer of treatment information via MOSAIQ CONNECT. **(Q1, Q2, Q3, Q4)** Data validation of the SICCIS and reports quarterly on South Island clinical cancer data. **(Q1, Q2, Q3, Q4)**	Ongoing expansion and data validation of the SICCIS. The SICCIS reports quarterly on South Island clinical cancer data. The SICCIS Data Request and Review Group is implemented.	Contributors: All South Island DHBs & SCN Reported in: SIHSP

Child Health

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

Lead CEO: **Carole Heatly (Southern DHB)**

Clinical Lead: **Dr Nicola Austin, Neonatal 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.

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

- Growing up healthy: responding to national strategies for improving children's health outcomes and preventing child abuse.
- Young Persons health - responding to the Prime Minister's Youth Mental Health project.
- Access to Child Health Services: supporting innovation, good practice and equity based on the Children's Commissioner Compass report 2013.[8]

Actions to deliver	Deliverable 2014-15	Deliverable 2015-2017	Responsibilities
GROWING UP HEALTHY responding to national strategies for improving children's health outcomes and preventing child abuse			
South Island Children's Action Plan (Government strategy).	Identify and prepare for implementation of agreed South Island regional interventions to better manage safety, reduce family violence and childhood poverty. **(Q4)**	Scope methodology to evaluate achievements of Children's Action Plan and specific programmes.	Contributors: CHSLA Reported in: SIHSP
Regional Sudden and Unexpected Death in Infants (SUDI) rates continue to trend downwards.	Evaluate effectiveness of sudden death in infancy policy. **(Q4)**	Monitor SUDI rates and recommend areas for improvement as required.	Contributors: CHSLA (facilitator) Reported in: SIHSP
YOUNG PERSONS HEALTH responding to the Prime Ministers youth Mental Health project			
Pathway to improve health outcomes for Māori and Pacific Island youth with mental health conditions.	One primary care disease prevention approach agreed and implemented. **(Q3)**	Evaluation of Māori and Pacific Island youth health outcomes.	Contributors: CHLSA & MHSLA (facilitators) Reported in: SIHSP

[8] The Child and Youth Health Compass Report, November 2013: Undertaken in Partnership with The Office of the Children's Commissioner, The Paediatric Society of New Zealand, and Ko Awatea.

Actions to deliver	Deliverable 2014-15	Deliverable 2015-2017	Responsibilities
Support programmes which reduce youth risk taking resulting in injury/disease from smoking, alcohol, drug and sexual diseases.	Downward trend in youth smoking rates and alcohol & drug related presentations to hospital and improved access to sexual health services reported across the South Island. **(Q1, Q3)**	Evaluate programmes designed to reduce youth risk taking behaviours.	Contributors: CHSLA facilitator & nominated PHP workstream representative Reported in: SIHSP
ACCESS TO CHILD HEALTH SERVICES **supporting innovation, good practice and equity based on the Children's Commissioner Compass report 2013**			
Interventions to reduce hospital admission for skin infections and respiratory conditions with emphasis on at risk children and families, Māori and Pacific.	Downward trend in avoidable hospital admissions for children across the South Island **(Q2, Q4)**	Monitoring and evaluation to ensure a continuing downward trend of avoidable hospital admissions.	Contributors: CHSLA facilitator Reported in: SIHSP
A regional integrated obesity management programme.	A regional integrated obesity management programme developed. **(Q4)**	Monitoring and evaluation of regional obesity management plan.	Contributors: CHSLA facilitator Reported in: SIHSP
Successful transition into healthy adulthood for children with lifelong health conditions (for example, implementation of cystic fibrous pathway).	Agreed transition pathway implemented. **(Q4)**	Evaluation of cystic fibrous pathway.	Contributors: CHSLA facilitator Reported in: SIHSP

Mental Health 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 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: **Carole Heatly (Southern DHB)**

Clinical Lead: **Dr David Bathgate, Consultant Psychiatrist (Southern DHB)**

The Mental Health SLA (MHSLA) 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 san integrated service across the continuum of primary, community, secondary and tertiary services.

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

- Improved access to the range of eating disorder services.
- Improved adult forensic service capacity and responsiveness through the national forensic network.
- Improved youth forensic service capacity and responsiveness.
- Improved perinatal and maternal mental health service residential options as part of the service continuum.
- Improved mental health and addiction service capacity for people with high and complex needs.

Actions to deliver	Deliverable 2014-15	Deliverable 2015-2017	Responsibilities
ACCESS TO THE RANGE OF EATING DISORDER SERVICES			
Evaluate options for those patients for whom best practice treatments are less successful.	Research findings and evidence evaluated and recommendations made to MHSLA. **(Q2)**	Implement alternative approaches where appropriate.	Contributors: Clinical Director South Island Eating Disorders Service CDHB Reported in: SIHSP
Increase family and whānau involvement in inpatient care.	Expand utilisation of available technologies across both the Eating Disorders Service and the Mothers and Babies Unit. **(Q1)**	Implement alternative approaches where appropriate.	Who: CDHB Reported in SIHSP
ADULT FORENSIC NATIONAL FORENSIC NETWORK SERVICE CAPACITY AND RESPONSIVENESS THROUGH THE NATIONAL FORENSIC NETWORK			
Understand the requirements for the National Forensic Network.	Support the development of a national forensic network as agreed nationally. **(Q4)**		Reported in: SIHSP
Prison screenings occur within agreed timeframes.	80% of prisoners referred for prison screening are seen within 7 days of receipt of referral. **(Q1, Q2, Q3, Q4)**		Who: CDHB & SDHB Reported in: SIHSP
Development of Forensic KPI measures.	Engage in the national forensic KPI project to identify and agree to Forensic KPI measures. **(Q4)**		Who: CDHB & SDHB Reported in: SIHSP

Actions to deliver	Deliverable 2014-15	Deliverable 2015-2017	Responsibilities
YOUTH FORENSIC SERVICE CAPACITY AND RESPONSIVENESS			
Establish the hub and spoke service delivery model for South Island DHBs.	Embed hub in CDHB. **(Q2)** Establish second hub in SDHB. **(Q4)** Recruit 1.6 additional FTE's for SDHB, WCDHB and NMDHB. **(Q4)**	Implement alternative approaches where appropriate.	Contributors: Both CDHB and SDHB have leads on youth forensic Reported in: SIHSP
PERINATAL AND MATERNAL MENTAL HEALTH SERVICE OPTIONS AS PART OF A SERVICE CONTINUUM			
Pathway for Children of Parents with Mental illness and Addiction.	Pathway agreed and implemented. **(Q4)**	Implement alternative approaches where appropriate.	Contributors: All South Island DHBs Reported in: SIHSP
Review the district/consult liaison mechanism.	Review completed and recommendations provided to MHSLA. (**Q4)**	Implement alternative approaches where appropriate.	Contributors: All South Island DHBs Reported in: SIHSP
MENTAL HEALTH AND ADDICTION SERVICE CAPACITY FOR PEOPLE WITH HIGH AND COMPLEX NEEDS.			
South Island DHBs to pursue a regionally collaborative mechanism to coordinate access to services for people with high and/or complex needs.	The development of a collaborative mechanism to coordinate access to services for people with high and/or complex needs and agreed implementation approach. **(Q4)**	Implementation of agreed mechanism.	Contributors: All South Island DHBs Reported in: SIHSP
MĀORI MENTAL HEALTH			
MHSLA will be looking to DHBs for progress on: • Actively involve Māori in service planning • Work together to identify and address disparities for Māori • Evaluate service effectiveness for Māori and use this information to inform future funding and service development decisions • Reduce and eliminate the use of seclusion and restraint for Māori • Kaupapa Māori services - Evaluate whether these services are more effective than mainstream services in addressing disparities in outcomes. Where the number of Māori who need a service is sufficiently high and Māori are not achieving equitable outcomes relative to other populations from mainstream service use, DHBs will offer kaupapa Māori services.	Review completed and recommendations provided to MHSLA. **(Q4)**	Review appropriateness of adjustments.	Contributors: All South Island DHBs Reported in: SIHSP
PASIFIKA MENTAL HEALTH			
A South Island Pasifika Mental Health Plan, utilising the Pasifika lens work which is aligned to "Rising to the Challenge" and other Pasifika Health planning.	Plan completed and recommendations provided to MHSLA. **(Q4)**	Report findings implemented.	Reported in: SIHSP

Actions to deliver	Deliverable 2014-15	Deliverable 2015-2017	Responsibilities
WORKFORCE			
Gaps and needs identified and recommendations developed in collaboration with DHBs, SIRTH, Health Workforce New Zealand and national workforce centres.	Recommendations provided to MHSLA. **(Q4)**	Review implementation of recommendations to address gaps and needs.	Contributors: Planning Lead South Island Mental Health and Addiction Workforce Reported in: SIHSP
INFORMATION TECHNOLOGY			
Standardise core clinical documentation requirements for Health Connect South.	Mental Health module rolled out across all South Island DHBs within timelines agreed with Health Connect South. **(Q4)**	Align with Health Connect South developments.	Contributors: ISSLA Reported in: SIHSP

Health of Older People Services

Best Health Care for Older People Everywhere in the South Island

Lead CEO: **Chris Fleming (Nelson Marlborough DHB)**

Clinical Lead: **Jenny Keightley, General Practitioner (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 Services - improving services for people in the South Island with dementia by implementing the New Zealand framework for dementia care. Develop the primary care workforce and improve the timeliness for a diagnosis - develop and commence delivery of dementia awareness and responsiveness education programmes.
- Restorative Model of Care - encourage 'best health care for older people everywhere' by preventing avoidable decline and focussing on person centred care.
- Comprehensive Clinical Assessment (interRAI) - Use of a standardised assessment tool designed for older people to facilitate a system wide approach to common assessment across the continuum. Evidence demonstrates that when comprehensive clinical assessment informs the plan of care outcomes are improved for the older person.
- Falls Prevention & Fracture Liaison Service - facilitate the development of effective South Island policy and procedures to best manage falls and fracture prevention in order to implement evidenced based, best practice and systematic approaches.
- Advance Care Planning (ACP) - those who are in their last 12 months of life (or where consumer chooses) are supported to record their choices/preferences in a consumer friendly ACP format. Their choices/preferences are easily available to give direction to their family and the healthcare team across the continuum of services/settings of care.

Actions to deliver	Deliverable 2014-15	Deliverable 2015-2017	Responsibilities
DEMENTIA SERVICES			
Improved services for people with dementia by implementing 'the New Zealand Framework for Dementia Care' in the South Island.	Two South Island Dementia Workshops are held with participation from all South Island DHBs. **(Q2, Q4)**	HOPSLA facilitate two regional workshops per annum	Clinical Lead: Dr Matthew Croucher Contribution: Each DHB to progress pathway. Reported in: SIHSP
Region representation provided at national dementia meetings organised by the Ministry of Health.	South Island is represented at all national meetings. **(Q4)**	South Island is represented at national meetings.	Contribution: HOPSLA Reported in: SIHSP
TO FURTHER DEVELOP THE PRIMARY CARE WORKFORCE AND IMPROVE THE TIMELINESS FOR A DIAGNOSIS			
A Cognitive Impairment Pathway (CIP) will be promoted for adoption across all South Island DHBs.	Facilitate a workshop to discuss and agree the role of health disciplines in an integrated approach to diagnosis of dementia. **(Q3)**	Uptake of the pathway is encouraged/ monitored.	Clinical Lead: Dr Jenny Keightley Who: HOPSLA : facilitate workshop CIP Lead: Health pathways

Actions to deliver	Deliverable 2014-15	Deliverable 2015-2017	Responsibilities
	Agree a generic clinical and support pathway (utilising University of Otago). **(Q3)** A South Island regionally consistent CIP is on the Health Pathways website in each DHB. **(Q4)**		Contributors: Each DHB to progress pathway & utilisation Reported in: SIHSP
Develop appropriate education/ training materials for South Island primary health care dementia.	Three education resources with training manuals are available (DVD or online) for implementation in DHB/PHO. **(Q2)**	Develop joint training opportunities for GPs, Practice Nurses and other community staff across the health care continuum including NGOs.	Who: Development of resources for workshops HOPSLA with Univ Otago/ Dr Matthew Croucher. Implementing: South Island DHBs Reported in: SIHSP
Walking in Another's Shoes (WiAS) programme (person centred care) to reach a wider range of staff working with people with dementia.	A report of progress against the calendar is received by HOPSLA. **(Q1, Q2, Q3, Q4)** Develop plan for format & content of graduate support programme. **(Q1)** Model of master class implemented in CDHB. **(Q2)** One master class held in another South Island DHB as WiAS coordinator resource permits. **(Q4)** WiAS program report to HOPSLA in respect of future of manager's programme in South Island. **(Q3)**	WiAS programme continues to be expanded in each South Island DHB programme reaching a wider range of staff working with people with dementia. A South Island implementation plan is developed. WiAS coordinator resource is optimised in each South Island DHB to deliver the expanded programme.	Contributors: All South Island DHBs: Reported in: SIHSP
RESTORATIVE MODEL OF CARE **These activities are best achieved at a regional level**			
A Web Based Toolkit that is evidence based and guides service providers to deliver restorative, person centred care.	Publish web based toolkits endorsed by HOPSLA are available on the South Island Alliance website. (**Q3)**	Four new tools are added to the website.	Contributors: HOPSLA Reported in: SIHSP
COMPREHENSIVE CLINICAL ASSESSMENT (interRAI)			
Comprehensive Clinical Assessment using a standardised assessment tool (interRAI) facilitating a system wide approach to common assessment.	Share messages/good news stories about the practical use of Comprehensive Clinical Assessment (InterRAI) to advocate for increased use of the information when agreeing a plan of care. **(Q1, Q3)**	Share messages/good news stories about the practical use of Comprehensive Clinical Assessment (InterRAI) to advocate for increased use of the information when agreeing a plan of care.	Contributors: HOPSLA & SIAPO Communication team Reported in: SIHSP
Monitor population and service data trend to influence changes in service through advocacy.	InterRAI schedule of reports agreed and delivered. **(Q2, Q4)**	Monitor population and service trends data to influence changes in service through advocacy.	Contributors: HOPSLA & I&A Team Reported in: SIHSP
FALLS PREVENTION & FRACTURE LIAISON SERVICE			
South Island DHBs are supported to develop evidence based Fracture Liaison Service A South Island Policy on Community Based Falls Prevention Programmes based on the evidence of the Otago Exercise Programme.	Two South Island Workshops re Implementing National Fracture Liaison Service are held with participation from all South Island DHBs. **(Q1, Q3)** Facilitate a workshop to develop a health pathway. **(Q3)** Agree work plan with Quality & Safety SLA (Q&S SLA). **(Q2)**	Facilitate bi annual FLS South Island DHB meeting. Progress the development of a South Island Community Based Falls Prevention Programme.	Contributors: HOPSLA & Q&SSLA Contributors: Implementing FLS: Each DHB Reported in: SIHSP

Actions to deliver	Deliverable 2014-15	Deliverable 2015-2017	Responsibilities
	Commence implementation of prioritised work. **(Q4)**		Community Based Falls prevention Programme : All DHBs Reported in: SIHSP
MĀORI HEALTH			
Promote improved health outcomes for kaumatua and kuia with their whānau through quality services that are integrated (across social sectors and within health), responsive and person/whānau centred.	**InterRAI** Reports include ethnicity data are reviewed twice yearly to inform improvement action. **(Q2, Q4)**	Continue to develop quality services that improve health outcomes for kaumatua and kuia with their whānau.	Contributor: HOPSLA & Each DHB Reported in: SIHSP
	Advance Care Planning ACP L1 training is promote used by Whanau and Māori Health providers. **(Q4)**		
	Dementia Dementia rates for Māori are accessed for SI and shared with each DHB. **(Q1)**		
	Restorative Culturally appropriate material is included in the website. (**Q4)**		
ADVANCE CARE PLANNING			
South Island DHBs are supported to develop Advance Care Plan (ACP systems and processes to embed ACP as standard practice for those who will benefit.	Number of South Island ACP L2 & L3 trained staff is increased in agreement with SIRTH. **(Q4)**	South Island DHBs are supported to develop ACP systems and processes to embed ACP as standard practice for those who will benefit.	Contributors: Each DHB, SIRTH Reported in: SIHSP
South Island DHB are supported to participate in "Conversations that Count" awareness raising day April 2015.	Develop a communication plan for "Conversations that Count" for South Island DHBs. **(Q2)**	Continued support is provided for the national awareness day "Conversations that Count".	
ACPs incorporated into the regional IS system/plan.	Agree on a regional ACP template and decide on technical infrastructure. **(Q4)**	Written ACP forms are available at the point of acute care including ambulance.	Contributors: HOPSLA & ISSLA Reported in: SIHSP
Written ACP Forms are available at the point of acute care, including ambulance.	Progress with regional implementation. This includes an alert flag at a point of care. **(Q4)**		Contributors: HOPSLA & ISSLA Reported in: SIHSP
WORKFORCE			
Promote training to increase capacity in gerontology services.	Identify and agree training programmes available for South Island uptake. **(Q1)**	To be confirmed.	Contributors: HOPSLA & SIRTH Reported in: SIHSP

Cardiovascular services - Acute Coronary Syndrome (ACS)

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 David Smyth, Cardiologist & Clinical Director of Cardiology (Canterbury DHB)**

The Cardiac 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.

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

- Meeting national indicators - improved outcomes for people with suspected acute coronary syndrome.
- Equity of access - ensure access to angiography for high risk populations group such as Māori, Pacific and South Asian people.
- Health Pathways - health pathways are agreed and utilised.
- Accelerated chest pain pathway.
- Guidelines for the arranged transportation of cardiac patients.
- Guidelines for the transporting/retrieving of emergency/acute cardiac patients.
- Minimum facilities guidelines.

Actions to deliver	Deliverable 2014-15	Deliverable 2015-17	Responsibilities
MEETING NATIONAL INDICATORS **Improved outcomes for people with suspected Acute Coronary Syndrome**			
Establish measures of ACS risk stratification and time to appropriate intervention	Agree factors for ACS risk stratification and time to appropriate intervention. **(Q4)**	Continued achievement of national indicators as determined by/modified by National Health Board in conjunction with the National Cardiac network.	Contributors: South Island DHBs Reported in: SIHSP
Standardised intervention rates for ACS patients	>70% of high-risk ACS patients accepted for coronary angiography having it within 3 days of admission. ('Day of Admission' being 'Day 0'). **(Q1, Q2, Q3, Q4)**		Contributors: South Island DHBs Reported in: SIHSP
	>95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS & Cath/Percutaneous Coronary Intervention (PCI) registry data collection, within 30 days. **(Q1, Q2, Q3, Q4)**		
Cardiac surgery targets achieved which will improve equity of access as identified and agreed by The National Cardiac Network.	The waiting list for cardiac surgery will remain between 5 and 7.5% of annual cardiac throughput, and not exceed 10% of annual throughput. **(Q1, Q2, Q3, Q4)**		Contributors: CDHB, SDHB, NMDHB Reported in: Individual DHB view Regional view in: SIHSP

Actions to deliver	Deliverable 2014-15	Deliverable 2015-17	Responsibilities
Cardiac surgery prioritisation tool implemented	Clinical Prioritisation tool implemented. **(Q2)**		
EQUITY OF ACCESS. **Ensure access to angiography for high risk populations group such as Māori, Pacific and South Asian people**			
Strategies to support access to angiography for Māori, and other high risk population groups.	Determine baseline for monitoring against changes when ANZACS QI has been implemented. **(Q1)**	Ongoing monitoring.	Contributors: ACS workstream facilitator Reported in: SIHSP
HEALTH PATHWAYS **Health pathway are agreed and utilised**			
Percutaneous Coronary Intervention (PCI) regional health pathways for acute coronary syndrome patients across the South Island.	Regional flow of patients to PCI capable hospitals is agreed. **(Q2)** Regional flow of patients to PCI capable hospitals is developed. **(Q2)**	Pathway implemented.	Contributors: ACS Workstream Reported in: SIHSP
CHEST PAIN PATHWAY			
An agreed accelerated chest pain pathway which will reduce unnecessary admissions.	All South Island DHBs implement pathway. **(Q4)**	Pathway implemented.	Contributors: ACS workstream Reported in: SIHSP
GUIDELINES FOR THE ARRANGED TRANSPORTING OF CARDIAC PATIENTS			
Regionally agreed guidelines for the arranged transportation of cardiac patients.	Transport guidelines available on South Island Alliance website and disseminated throughout the sector. **(Q1)**	Guidelines reviewed and updated within two years of acceptance.	Contributors: ACS workstream Reported in: SIHSP
GUIDELINES FOR THE TRANSPORTING/RETRIEVING OF EMERGENCY/ACUTE CARDIAC PATIENTS			
Regionally agreed guidelines for the transporting/retrieving of emergency/acute cardiac patients.	Report developed and endorsed by key stakeholders, based on meeting the less than 90 minute transport/retrieval time. **(Q1)**	Report findings implemented.	Contributors: ACS workstream and Facilitator Reported in: SIHSP
MINIMUM FACILITIES GUIDELINES			
Prepare current status document of regional and rural South Island Hospitals' financial and time requirements to meet minimum guidelines for cardiac facilities.	Document developed in conjunction with South Island DHB General Manager's (GM's) planning and funding. (**Q4**) Recommendations and implementation plan agreed. (**Q4**)	Facilities meet minimum requirements by agreed date. Minimum facilities guidelines reviewed and updated two years from adoption date.	Contributors: ACS Workstream, GM's Planning & Funding Reported in: SIHSP
WORKFORCE TRAINING **Workforce training maintained**			
A regional approach to cardiology nurse training developed in collaboration with the South Island Regional Training Hub. Initial focus to include: -increased exposure to cardiology during nursing training -training opportunities in New Zealand for Clinical Nurse Specialists in Cardiology.	Regional subgroup of nurse educators is formed and meets at least quarterly. **(Q1, Q2, Q3, Q4)**	Regional subgroup continues to meet quarterly	Contributors: Cardiac Nurse Educator in each district and Facilitator Reported in: SIHSP

Actions to deliver	Deliverable 2014-15	Deliverable 2015-17	Responsibilities
Opportunities for training in echocardiography identified.	Identify training needs. **(Q2)**	Action plan developed and implemented.	Contributors: ACS workstream Reported in: SIHSP
Investigate the feasibility of establishing a National Registrar training rotation that would be regionally based in line with other specialties.	Workstream delegation to consult with NZ Cardiac Society to explore feasibility. **(Q1)** Strategies formed in conjunction with SIRTH, subject to feasibility. **(Q2)**	Strategies implemented.	Contributors: ACS workstream Reported in: SIHSP
ECG STORAGE AND SHARING			
A common regional method of storing and sharing Electrocardiogram (ECGs).	All South Island DHBs recording and storing ECGs. **(Q2)** All South Island DHBs store and access ECG records through Concerto. **(Q4)**		Contributors: ACS workstream Reported in: SIHSP
Integrate with St John IT storage system.	Integration with St John systems achieved. **(Q4)**		Contributors: ACS workstream Reported in: SIHSP

Elective Services

Sustainable, equitable elective services for South Islanders

Lead CEOs: **South Island Alliance Leadership Team**

Clinical Lead: **Dr Pim Allen, Independent Chair**

The South Island Alliance Elective Services Workstream has been formed to:

- 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.
- Support the South Island DHBs to achieve the Government elective services waiting time targets.
- Gain a better understanding of the resources (facility and workforce) and the use of production planning across the South Island.
- Undertake analysis of secondary and tertiary referral elective services and identify the capacity and capability of these services across the South Island. The outcome of the analysis will inform and support future configuration and delivery of elective health services across the South Island.
- Understand the variability of delivery of elective services across the five DHBs of the South Island.

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

- Regional equity of access.
- Regional/sub-regional (clinical and business process) collaboration.
- Integrated whole of system care with patient at centre.
- Best sustainable use of South Island Health System Resources.

Actions to deliver	Deliverable 2014-15	Deliverable 2015-17	Responsibilities
REGIONAL EQUITY OF ACCESS			
South Island DHBs meet Electives Health Target & ESPI 2 + 5 compliance.	South Island DHBs meet Health Target & ESPIs. **(Q2)**	Ministry contract ends 30 June 2015. Any continuation past this date will require South Island Alliance Leadership Team approval and endorsement. Programme evaluation due 30 September 2015.	Contributors: South Island DHBs: individual responsibility for, and reporting of, performance against Electives Health Target & ESPIs 2 + 5 Reported in: Each SI DHB responsible for reporting their performance against Electives Health Target & ESPIs 2 + 5. Elective Services Programme: WG1 & Electives Workstream responsible for oversight of whole of South Island DHB performance, and ensuring DHBs support each other e.g. through service delivery, to ensure Health Target & ESPIs met at SI level [as per Programme Plan].
REGIONAL/SUB-REGIONAL (CLINICAL & BUSINESS PROCESS) COLLABORATION			
South Island population profile and assessment of current/future need/demand for Electives.	Description of South Island population profiles, health needs, expected demand and electives capacity, patient flows, requirements in 2018, 2026 and DHB plans. **(Q4)**	Ongoing monitoring.	Lead: WG1 and Electives Workstream Contributors: South Island DHBs (who may include more specific information in Health Needs

Actions to deliver	Deliverable 2014-15	Deliverable 2015-17	Responsibilities
	Māori needs and access to elective services quantified and monitored. **(Q4)**		Assessments and planning documents). Reported in: SIHSP
INTEGRATED WHOLE OF SYSTEM CARE WITH PATIENT AT CENTRE			
Regional/sub-regional improvements to business and clinical processes and patient journey in selected service areas.	South Island business and clinical pathways agreed and consistently implemented to improve processes and patient experience. South Island Urology System HealthPathway and South Island Urology condition pathways (as template models to be developed, implemented and reviewed), the pathway to reflect the patient journey across the continuum[9]. **(Q2)**	Ongoing monitoring.	Lead: WGs 2 + 3, Elective Services Workstream Contributors: DHB staff and decision makers Reported in: SIHSP
	Determine the feasibility of South Island health pathways and processes for selected service areas: Hernia and Abdominal Aortic Aneurysm. **(Q4)**		
	Investigate opportunities to leverage local South Island DHB activity in Eye Health and Orthopaedics for a broader South Island approach. **(Q4)**		
	Patient letters reviewed across South Island against guidelines (to ensure consistency with ESPI requirements and MOH guidelines, 2014). **(Q2)**		
BEST SUSTAINABLE USE OF SOUTH ISLAND HEALTH SYSTEM RESOURCES			
Increased regional/sub-regional Electives collaboration e.g. capacity, workforce, information systems.	Achieve positive Electives collaboration across South Island DHBs in selected service areas: workforce, business + clinical processes; information **(Q4)**		Lead: WGs 2 + 3, Elective Services Workstream Contributors: DHB staff and decision makers Reported in: SIHSP
	Collate and share innovations in the selected service areas, evaluate, share learnings and disseminate innovations **(Q2, Q4)**		
Bariatric Surgery regional health pathway agreed & implemented.	Bariatric Surgery pathway implemented. **(Q1)**	Pathway reviewed.	Reported in: SIHSP

[9] The Patient journey includes the end to end journey from primary care referral into secondary care, assessment and treatment and discharge back to primary care referrals, triage, prioritisation.

Major trauma

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

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

- South Island Region Major Trauma Plan.
- NZ Major Trauma Minimum Dataset.
- NZ Major Trauma Registry.
- Clinical Leadership.

Actions to deliver	Deliverable 2014-15	Deliverable 2015-2017	Responsibilities
SOUTH ISLAND REGION MAJOR TRAUMA PLAN			
South Island Major trauma regional action plan developed; endorsed; and, implemented.	Major trauma Workstream approved and established (First meeting set for 13 August). **(Q1)**	South Island region focuses on implementation of local and regional trauma systems.	Reported in: SIHSP
	Workstream meets quarterly. **(Q1, Q2, Q3, Q4)**		
	A three year South Island major trauma regional action plan is developed. **(Q1)**		Reported in: SIHSP
	Year one of the South Island major trauma plan implemented. **(Q4)**		
	South Island region action plan supports the collection and reporting of a nationally consistent major trauma data set. **(Q4)**	South Island region reports major trauma using the agreed national minimum dataset.	Reported in: SIHSP
NZ MAJOR TRAUMA MINIMUM DATASET			
System established for South Island region major trauma data collection.	Establish a process to collect the data required to implement a national major trauma register by 1 July 2015. **(Q4)**	South Island data collection and input into national major trauma registry (2016).	Contributors: IS SLA Reported in: SIHSP
South Island region trauma definitions aligned to those used in the NZ Major Trauma Minimum Dataset (NZMTMD).	Local trauma definitions to be aligned with those used in the NZMTMD. **(Q4)**		Reported in: SIHSP
NZ MAJOR TRAUMA REGISTRY			
South Island DHBs participate in the implementation and roll-out of the national major trauma registry.	National major trauma registry available and implemented across the South Island. **(Q4)**	Audit/risk management process in place to ensure major trauma registry input updated.	Reported in: SIHSP
	Major trauma information system programme implemented. **(Q4)**		Reported in: SIHSP
CLINICAL LEADERSHIP			
South Island DHBs major trauma clinical leaders; co-ordinators; and administrators appointed.	Each South Island DHB will identify a designated major trauma clinical lead; co-ordinator; administrator. **(Q2, Q4)**		Reported in: SIHSP

Public Health

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

Sponsor: **Fiona Pimm, General Manager Primary and Community, Māori Health Services (South Canterbury DHB)**

Chair: **Marion Poore, Medical Director and Medical Officer of Health (Southern DHB)**

The South Island Public Health Partnership 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.

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

- Alcohol - the overall goal is to reduce alcohol harm to communities.
- Tobacco - support the achievement of Ministry targets for 'Better Help for Smokers to Quit' and enable the vision for a 'Smokefree Aotearoa 2025', e.g. through promoting smokefree environments.
- Environmental Sustainability - the focus is on increasing South Island PHUs' ability to emphasise and address environmental sustainability as a key priority for a) public health service delivery and b) for the wider health sector.

In addition the Partnership will continue to take a regional approach to operational and emerging issues.

Actions to deliver	Deliverable 2014-15	Deliverable 2015-2017	Responsibilities
ALCOHOL			
South Island DHBs' Alcohol Position Statement and DHB Alcohol Harm Reduction Strategies (AHRS).	Develop: 1. An outcomes framework 2. An indicator set 3. Guidance and other resources to support AHRS development by all South Island DHBs. **(Q2)**	Ongoing shared learning, comparing and contrasting and evaluating alcohol harm reduction efforts across South Island DHBs and identifying outcome trends for DHBs and South Island communities.	Lead: South Island Alcohol Workgroup Sponsor –(NM PHU Clinical Lead) DHB contribution: All DHB / PHUs through the South Island Alcohol Workgroup All South Island PHUs will be responsible for the SI alcohol health promotion plan/delivery/evaluation. Reported in: SIHSP
	Develop: South Island health promotion activities to reduce alcohol related harm in identified settings. **(Q3)**	Evaluate (process evaluation): the delivery of the South Island shared alcohol health promotion activities.	
TOBACCO			
South Island DHBs' Tobacco Position Statement and joint South Island –wide smokefree initiatives implemented and evaluated according to National Smokefree Coalition Action Plan.	Agree: South Island project objectives and joint projects across South Island DHBs/PHUs. **(Q2)**	Evaluate (process evaluation): The delivery of the South Island tobacco health promotion projects.	Lead: CDHB Smokefree Manager. DHB contribution: All South Island DHBs and PHOs. Reported in: SIHSP (NB Targets to be reported via individual DHBs).
SUSTAINABILITY			
Increased awareness around environmental sustainability and the co-benefits of action in this area for population health. Project plans implemented & monitored.	Implement one project internal to DHBs aimed at system change (e.g. position statement, local working groups/workstreams, DHB workshops). **(Q4)**	Evaluation of initiatives and measures / baselines.	Lead: The South Island Sustainability Workgroup Lead PHU yet to be determined. Contribution: SI PHP will engage with SS SLA Reported in: SIHSP

Actions to deliver	Deliverable 2014-15	Deliverable 2015-2017	Responsibilities
Short-term: • Number and quality of new initiatives Long-term: • Measures of environmental sustainability with public health co-benefits.	Implement one project with public health and/or community) focus. **(Q4)** Establish intervention logic and potential baseline measures to measure both health and sustainability improvement. **(Q2)**		
RHEUMATIC FEVER			
South Island Rheumatic fever cases monitored.	The Partnership continues to provide a surveillance function for Rheumatic Fever. **(Q2, Q4)**	Ongoing monitoring.	Lead: The South Island Public Health Partnership Communicable Diseases Protocol group. CDHB Representative on this group is nominated lead. DHB contribution: All South Island DHBs and PHUs. This will need a level of district and regional coordination. Reported in: The South Island PHUs will notify case numbers through individual DHBs The Plan implementation via SIHSP.
The Partnership supports each DHB to have mechanisms in place to ensure the Rheumatic Fever Prevention and Management Plan is implemented as intended.	Clinical Leads identified for each DHB. **(Q2)** Multi-stakeholder engagement meetings held in each DHB. **(Q4)**		
MĀORI			
Public health services in the priority areas and through workforce development are responsive to Māori health issues and improve equity.	Report on how Māori health issues are being identified, understood and addressed with respect to • Tobacco • Alcohol • Sustainability, • Workforce. **(Q4)**	Ongoing monitoring.	Lead: The South Island Public Health Partnership Management. DHB contribution: All South Island DHB PHUs. Reported in: The South Island PHUs will report at each individual PHU level and the South Island PHP will report with a regional view via the SIHSP.

Stroke Services

Lead CEO: **Carole Heatly (Southern DHB)**

Clinical Lead: **Dr Wendy Busby, Consultant Physician & Geriatrician (Southern 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).

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

- Equitable access to acute stroke services for the south island population.
- Integrated stroke rehabilitation services for the south island population.
- Workforce planning and development.

Actions to deliver	Deliverable 2014-15	Deliverable 2015-17	Responsibilities
EQUITABLE ACCESS TO ACUTE STROKE SERVICES FOR THE SOUTH ISLAND POPULATION			
An agreed ambulance to Emergency Department (ED) rapid transit protocol for potential thrombolysis candidates.	Ambulance to ED pathway evaluated. **(Q3)** Thrombolysis audit is undertaken in each DHB. Audit criteria determined. **(Q2)** Audit implemented. **(Q3)** Outcome actions identified. **(Q4)**	Undertake yearly thrombolysis audit. Monitor and improve services.	Contributor: South Island DHBs Reported in: SIHSP
Support all South Island DHBs to have stroke thrombolysis pathways.	Regional thrombolysis outcome measurement target achieved and monitored for ongoing compliance. (6% of potentially eligible stroke patient's thrombolysed). **(Q1, Q2, Q3, Q4)**	Improve coding in line with national work and monitor for ongoing compliance.	Contributor: South Island DHBs Reported in: SIHSP
A Stroke non-thrombolysis pathway.	Non-thrombolysis pathway for acute CVA admission. Pathway in line with national template is in place in each SI DHB. **(Q2)**	Pathway in line with national template is in place in each South Island DHB and is evaluated.	Contributor: South Island DHBs Reported in: SIHSP
Organised stroke services /units.	National target for eligible stroke patients admitted to an organised stroke service/ unit is achieved. (80% of stroke patients admitted to a stroke unit, stroke patients admitted to an organised stroke service with a demonstrated stroke pathway in smaller South Island DHBs). **(Q1, Q2, Q3, Q4)**	Monitor for ongoing compliance.	Contributor: South Island DHBs Reported in: SIHSP
Organised stroke services are accessible and appropriate for Māori and Pacific people.	Monitor access data by ethnicity and Identify opportunities for improvement. **(Q2, Q4)**	Monitor access data by ethnicity.	Contributor: South Island Workstream Reported in: SIHSP
Support Participation in Australasian Stroke Audit.	Each DHB provides the data requested. **(Q4)**	An audit of stroke services using a valid audit tool such as NSF audit tool is undertaken in at least one South Island DHB.	Contributor: South Island DHBs Reported in: SIHSP

Actions to deliver	Deliverable 2014-15	Deliverable 2015-17	Responsibilities
Risks and mitigation strategies for geographic isolation.	Identify patient risks and mitigation strategies for people geographically isolated developed within available resources for South Island DHBs. **(Q4)**	Policies and protocols are developed utilising technology /distance expertise /transport to support isolated communities to deliver best practice stroke care.	
INTEGRATED STROKE REHABILITATION SERVICES FOR THE SOUTH ISLAND POPULATION			
System used to measure agreed stroke rehabilitation targets / indicators.	Proportion of people with acute stroke (ICD10 codes I61, I63, I64) who are discharged\transferred from an acute admission to either an internal or separate facility for inpatient rehabilitation. **(Q2)**	AROC data is collected and reviewed for each stroke rehabilitation 'unit'. Therapy time is measured for each client and action identified to improve consistency across South Island DHBs.	Contributor: South Island DHBs Reported in: SIHSP
	Proportion of above (i.e. those transferred to rehab) who are transferred within 10 days of acute stroke admission. **(Q3)**		
	Mechanisms for measuring Therapy time is measured for each client is identified in each DHB. **(Q3)**		
WORKFORCE PLANNING AND DEVELOPMENT			
Named stroke specialist/s within the inter-disciplinary team.	Major/larger - hospitals to have lead stroke physician identified. **(Q1)**	A network of Lead Stroke Nurses is developed in the South Island. Stroke Nurses facilitate and coordinate care planning across the team, education and peer support to the team, review and evaluation of stroke service (quality improvement).	Contributor: South Island DHBs Reported in: SIHSP
Named lead stroke clinician in each DHB with specific remit to develop and improve Stroke Services for that DHB.	Each hospital SI DHB- (provider (e.g. rural)-at NGO/DHB/PHO where) has a designated doctor identified. **(Q1)**		
Name lead stroke nurse in each DHB with specific remit to develop and improve Stroke Services for that DHB.	Each South Island DHB provider has a designated nurse identified. **(Q1)**		
Health professionals have access to continuing education for acute, rehabilitation and long-term/chronic stroke management.	South Island initiatives are shared each quarter. **(Q1, Q2, Q3, Q4)**	An electronic calendar of events is available for Health professionals to have ongoing access to continuing education for acute, rehabilitation and long-term/chronic stroke management.	Contributor: South Island DHBs Reported in: SIHSP

Key Enablers

Quality and Safety Service Level Alliance

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

Lead CEOs: **South Island Alliance Leadership Team**

Chair: **Mary Gordon, Executive Director of Nursing and Midwifery (Canterbury DHB)**

The Quality and Safety SLA has been formed 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.

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

- "Open for Better Care".
- Incident Management.
- Quality Systems and Indicator Framework.
- Consumer Participation.

Actions to deliver	Deliverable 2014-15	Deliverable 2015-2017	Responsibilities
OPEN FOR BETTER CARE			
Support the South Island DHBs to implement the Open for Better Care campaign.	Falls prevention programme monitored across SI DHBs hospital and community setting identifying and implementing strategies for improvement. **(Q1, Q2, Q3, Q4)**	Ongoing monitoring and evaluation of falls prevention programmes.	Contributors: All South Island DHBs (Portfolio Managers) and Q&S SLA -facilitator Reported in: SIHSP
	Regional falls metrics agreed. **(Q1)**		
	Review Falls makers of success dataset. **(Q2, Q4)**		
	Surgical Site Infections project monitored across SI DHBs identifying and implementing strategies for improvement. **(Q1, Q2, Q3, Q4)**	Ongoing surveillance of surgical site infection programmes.	Contributors: All South Island DHBs (Portfolio Managers) and Q&S SLA -facilitator Reported in: SIHSP
	Review SSI markers of success dataset. **(Q2, Q4)**		
	Peri-operative harm project implemented across SI DHBs. **(Q1)**	Ongoing monitoring and evaluation of peri-operative harm programmes.	Contributors: All South Island DHBs (Portfolio Managers) and Q&S SLA -facilitator Reported in: SIHSP
	Peri-operative harm project monitored across SI DHBs identifying and implementing strategies for improvement. **(Q1, Q2, Q3, Q4)**		
	Review peri-operative harm markers of success dataset. **(Q2, Q4)**		
	Medication errors programme implemented across South Island DHBs. **(Q3)**	Ongoing monitoring and evaluation of reported medication events.	Contributors: All South Island DHBs (Portfolio Managers) and Q&S SLA -facilitator

Actions to deliver	Deliverable 2014-15	Deliverable 2015-2017	Responsibilities
	Quarterly monitoring programme implemented including identifying improvement opportunities. **(Q4)**		Reported in: SIHSP
INCIDENT MANAGEMENT			
Governance of the RL6 implementation.	Agreed regional taxonomies for incident management and feedback modules. **(Q1)**	Monitoring and evaluation of reported incidents. Providing support and advice to DHB.	Contributors:: Q&S SLA - facilitator Reported in: SIHSP
	Support South Island DHBs to prepare implementation project plan. **(Q1, Q2, Q3, Q4)**		
	Implement quality improvement processes to monitor, evaluate regional markers of success and make improvements. **(Q4)**		
QUALITY SYSTEMS AND INDICATOR FRAMEWORK			
Support the implementation of the Integrated Performance Incentive Framework (IPIF) across the South Island DHBs.	Support and advice to DHBs for implementation of the national IPIF, ensuring regional consistency when agreed. **(Q3)**	Monitoring and evaluation of regional IPIF outcomes.	Contributors: All South Island DHBs (Portfolio Managers) and Q&S SLA facilitator Reported in: SIHSP
Support the implementation of the national quality indicator framework.	Regional health quality indicators (makers of success) evaluated and initiatives for improvement actioned. **(Q2, Q4)**	Monitoring and evaluation of regional quality indicator outcomes.	Contributors: All South Island DHBs (Portfolio Managers) and Q&S SLA facilitator Reported in: SIHSP
Primary care quality improvement framework.	Primary care quality improvement framework piloted in one South Island General Practice group. **(Q2)**	Ongoing roll out of primary care framework.	Contributors: Q&S SLA – Population Health Specialist Reported in: SIHSP
CONSUMER PARTICIPATION			
Support the South Island DHBs to deliver the Consumer experience project.	Initiate implementation of national (HQSC) consumer experience project across SI DHBs. **(Q2)**	Monitoring regional consistency and providing advice to DHBs on findings/recommendations from consumer experience process.	Contributors: Q&S SLA - facilitator Reported in: SIHSP
	Evaluate experience of care datasets for quality improvement initiatives. **(Q4)**		
	Submit progress report. **(Q4)**		
Support the South Island DHBS to deliver the Quality Accounts.	Development of Clinical Governance training resources for SI DHBs. **(Q1)**	Supporting DHBs to evaluate effectiveness of quality programmes.	Who: Q&S SLA -facilitator Reported in: South Island DHBs Quarterly Reports
	Support and advice to South Island DHBs implementing their Quality Accounts, encouraging consistency of clinical practice. **(Q2)**		
	South Island DHB Clinical Governance self-assessment completed. **(Q2)**		
	Regional DHB Clinical Governance action plan developed for implementation. **(Q3)**		
	DHB Clinical Governance Action Plan implemented and progress report submitted. **(Q4)**		

South Island Information Services Service Level Alliance

Lead CEO: **Carole Heatly (Southern DHB)**

Clinical Lead: **Andrew Bowers, Medical Director, Information Technology & Physician (Southern DHB)**

Programme Director: **Paul Goddard (South Island Alliance Programme Office)**

An abridged version of the 2014-17 South Island Information Services, Service Level Alliance Regional Service Plan – National Health IT Board Priority Programme workplan is included below. The full version is available here:

IS SLA Health Service Plan 0104201

(For PDF copies of the South Island Regional Health Services Plan 2014 – 2017 please refer to the attachments for the full version of the workplan).

Actions to deliver	Deliverable 2014-15	Deliverable 2015-2017	Responsibilities
eMEDICINES PROGRAMME			
ePrescribing and Administration (ePA) MedChart.	Implementing ePA into inpatient wards across the SI DHBs (incorporating NZULM & NZ Formulary when sources are available) with the aim of improving medication safety for patients whilst an inpatient	1336 beds implemented over Canterbury & Southern DHBs.	Lead: Regional Programme Manager, SIAPO Reported in: SIHSP
eMedicine Reconciliation (eMR).	Implementing electronic Medication Reconciliation across South Island DHBs. eMR helps health professionals create the most accurate and up-to-date list available of a patient's medicines on presentation to hospital (incorporating NZULM & NZ Formulary when sources are available).	The process of implementation within South Island DHBs will commence once the eMR system is available and individual DHBs are ready to proceed.	Lead: Regional Programme Manager, SIAPO Reported in: SIHSP
ePharmacy Management (ePM).	Implement ePharmacy into South Island DHBs using a single Regional instance (incorporating NZULM & NZ Formulary when sources are available) to enable the management of medications from a shared South Island perspective.	ePharmacy implemented in all South Island DHBs.	Lead: Regional Programme Manager, SIAPO Reported in: SIHSP
NATIONAL SOLUTIONS			
Patient Portal Self Care Patient Portal.	To implement a Self Care Patient Portal that helps patients be involved in their care. Ensuring clear communication resulting in a better patient experience and improved patient outcomes.	The IS SLA will provide support and awareness of this project.	Lead: IS SLA Reported in: SIHSP

Actions to deliver	Deliverable 2014-15	Deliverable 2015-2017	Responsibilities
interRAI.	Support the National interRAI solution to enable widespread access to interRAI assessment and Careplan to health professionals at the point of care.	interRAI reports developed.	Lead: HOPSLA Reported in: SIHSP
	Integrate Momentum with Health Connect South.		
	Design and develop reports so that the data from InterRAI can be used to support the care of Older People.		
Maternity Information System.	Support the nationally led programme of implementing CleverMed. This includes a patient portal view and secondary care maternity management.	Progress with South Island implementation.	
National Trauma Registry.	To establish data systems capable of capturing the NZMTDS to be able to report that data to national major trauma registry.	To be defined.	
National Patient Flow.	To implement the National Patient Flow project which will track and report on the patient journey.	Phase 1 National Data Collection (Referrals to First Specialist Assessment) live 1 July 2014. Project scoping, requirements gathering for Phase 2 commenced.	Contributors: Each DHB responsible for their own project Reported in: SIHSP
Finance, Procurement and Supply Chain.	To support the Procurement and Supply Chain (FPSC) programme which aims to improve the way DHBs purchase goods and services.	Deliverables still to be defined by this nationally lead project.	
National Data Centre Project.	To migrate South Island DHB hardware to the agreed HBL data centre to meet the requirements of the national Infrastructure Programme.	Deliverables still to be defined by this nationally lead project.	
eREFERRALS			
eReferrals.	Regional implementation of eReferrals (electronic referrals), including the use and maintenance of Electronic Request Management System (ERMS) and Orion Health's Referral Management System (RMS) in Health Connect South (HCS).	Regional implementation of Stage 2 complete. eReferrals received through the RMS module in Health Connect South	Lead: Regional Programme Manager, SIAPO Reported in: SIHSP
HEALTH CONNECT SOUTH CLINICAL WORKSTATION			
Health Connect South Clinical Workstation Health Connect South Implementation.	To implement Health Connect South for Southern DHB.	Health Connect South implemented for Southern DHB.	Lead: Regional Programme Manager, SIAPO Reported in: SIHSP
	To implement Health Connect South for Nelson Marlborough DHB.	Health Connect South implemented for Nelson Marlborough DHB.	
Health Connect South Clinical Workstation: • ED Whiteboards	Provide a regional solution to support visibility of ED activity.	Scope regional direction for ED Whiteboard and progress with regional implementation.	Lead: Regional Programme Manager, SIAPO Reported in: SIHSP

Actions to deliver	Deliverable 2014-15	Deliverable 2015-2017	Responsibilities
• Mental Health Solution • eDischarges (National Transfer of Care).	To implement the Mental Health solution built within Health Connect South throughout the South Island DHBs.	Progress with Health Connect South Mental Health module implementation.	
	To implement the National Transfer of Care template to create standardisation.	National Transfer of Care template available for all specialties.	
SOUTH ISLAND PATIENT INFORMATION CARE SYSTEM (SI PICS)			
South Island Patient Information Care System (SI PICS) Patient Administration System (PAS) Implementation: Nelson Marlborough Burwood Hospital CDHB.	Replace end of life PAS Systems and provide a future enabler to provide improved support for community services, to support better access by GP's to DHB clinical and patient information and to provide greater integration and visibility across the continuum of care for both care teams and users of the health service.	CORE PAS developed and delivered to Model Community by Orion: Project Initiation Data Configuration Data Migration.	Lead: Regional Programme Manager, SIAPO Reported in: SIHSP
South Island Patient Information Care System (SI PICS) Patient Administration System (PAS) Implementation: Canterbury DHB West Coast DHB South Canterbury DHB Southern DHB.	To provide a future enabler to provide improved support for community services, to support better access by GP's to DHB clinical and patient information and to provide greater integration and visibility across the continuum of care for both care teams and users of the health service.	Foundation PICS developed and delivered to Model Community by Orion.	Lead: Regional Programme Manager, SIAPO Reported in: SIHSP
REGIONAL INITIATIVE			
Advance Care Plan.	Develop and implement a regional Advance Care Plan (ACP) template accessible to all health care clinicians to support a person to make an informed choice about their end of life plan – for when this plan is needed. The plan to be accessible to Primary, Community Nursing, First Response (Ambulance) and Secondary Clinicians.	Agree and decide on a regional ACP template and technical infrastructure. Progress with regional implementation. This includes an alert flag at a point of care.	Lead: Regional Programme Manager, SIAPO Reported in: SIHSP
Shared Care Record.	To implement a South Island Solution that provide access to the patient record.	Agreement on a South Island solution and progress with regional implementation.	Lead: IS SLA Reported in: SIHSP
Risk Management Project.	To implement a regional Risk Management solution. This will include report incidents, risks and enables shared clinical learnings from outcome reviews.	Progress with the regional Risk Management implementation.	Lead: Regional Programme Manager, SIAPO Reported in: SIHSP
Radiology / PACS & Archive Nelson Marlborough DHB.	Nelson Marlborough DHB to join Regional RIS PACS solution.	Nelson Marlborough DHB joining the regional RIS PACS solution.	Lead: NMDHB Project Manager Reported in: SIHSP
	Geographically distributed architecture for redundancy.	Nelson Marlborough DHB site of one archive.	
eLearning.	Support the regional eLearning implementation lead by South Island Regional Training Hub.	Support the regional eLearning implementation lead by South Island Regional Training Hub.	Lead: SIRTH Reported in: SIHSP
Growth Charts.	To implement a growth chart solution to replace paper based forms.	Project closure.	Lead: SIAPO Reported in: SIHSP

Actions to deliver	Deliverable 2014-15	Deliverable 2015-2017	Responsibilities
Provation.	Electronic Bronchoscope and Endoscopic Reporting Tool fully implemented throughout the South Island.	SCDHB and SDHB to be fully implemented.	Contributor: each DHB responsible for their upgrade Reported in: SIHSP
Telehealth.	To scope and define a TeleHealth regional direction for the South Island.	To be defined	Lead: IS SLA Reported in: SIHSP
eProSafe Child Protection Database.	Implementation of eProsafe within all South Island DHB's. eProsafe is an electronic application that enhances risk assessments and interventions for child abuse and family violence cases. It allows for the sharing of relevant clinical information across DHB's in a timely and safe manner.	Implementation of eProsafe within Nelson Marlborough and Southern DHBs.	Lead: Child and Family Safety Advice Service Co-ordinator, Canterbury DHB Reported in: SIHSP
TestSafe South implementation - Southern DHB.	Laboratory & Radiology results for Southern DHB available in TestSafe South.	Laboratory and Radiology results for Southern DHB to be available in TestSafe South.	Lead: SDHB Reported in: SDHB
Surgical Audit Tool.	Investigate and project scope the potential to implement a regional surgical audit tool.	Project scoping and regional decision whether to implement a Surgical Audit tool.	
MOSAIQ Implementation.	MOSAIQ Medical Oncology system utilised for oncology services, including chemotherapy prescribing, in secondary and tertiary centres across the South Island.	Support implementation at WCDHB, SCDHB, and NMDHB.	Lead: Project Manager, CDHB Reported in: SIHSP
MDM Meeting Management Tool.	MDM Meeting Management tool. To scope and define a "fit for purpose" electronic application to support MDM at a local, regional and potentially national level.	Project scoping and decision on implementation milestones.	Lead: SCN Reported in: SIHSP
South Island Clinical Cancer Information System (SICCIS).	SICCIS functioning as comprehensive oncology registry.	Support data feeds of surgical cancer information into METRIQ. Support SICCIS as comprehensive FCT data recording and reporting database.	Lead: SCN Reported in: SIHSP

Information Services SLA Programme Financials for 2014-15

The 2014-15 Information Services SLA Programme Financials is available in the attached spreadsheet. NB: That the investment requirements for Regional Information Service Programme was provided by the South Island Information Services Alliance Programme Manager. This process occurred after the Districts' annual planning cycle. In some cases the values provided in this report may differ from the values shown in the District Health Board Annual Plans. The values shown in this report are estimates at a point in time and will change as Business Cases are finalised and submitted for approval.

South Island IS Programme Financia

(For PDF copies of the South Island Regional Health Services Plan 2014 – 2017 please refer to the attachments for the South Island IS Programme Financials).

Workforce

Lead CEO: **David Meates, Canterbury DHB**

Clinical Lead: **Mary Gordon, Executive Director of Nursing and Midwifery, Canterbury DHB**

South Island Regional Training Hub

Actions to deliver	Deliverable 2014-15	Deliverable 2015-2017	Responsibilities
An IT framework to support, e-learning and e-portfolios across the South Island.	Business case developed & approved. Plan staged roll out for all DHB regions, CDHB & WCDHB initially. **(Q1)** Staged implementation across all DHBs agreed. (**Q2**)	All South Island health staff have access to e-learning.	Lead: South Island GMs HR/SIRTH Reporting: South Island (SI) RSP
e-learning packages and teaching resources across the South Island.	PGY 1/2 group to identify further learning packages. **(Q1)** Relevant clinical resources are rolled out nationally in collaboration with the other Regional Training Hubs and Health Workforce New Zealand. **(Q4)**	Suite of education packages available on-line for all health staff. In the South Island and shared nationally.	Contributors: South Island PGY1/2 Working Group Reported in: SIHSP
	Lippincott on-line evidenced based nursing procedure manual introduced to all South Island DHBs. **(Q3)**	The South Island Nursing workforce will have access to the Lippincott online procedure manual.	Contributors: South Island Executive Directors of Nursing Reported in: SIHSP
Regional coordination of Clinical Simulation Training and use of resources.	Action Plan identified by regional clinical simulation working group. (**Q2**) Implementation commenced. **(Q4)**	Evaluation of training plan Ongoing	Contributors: South Island Clinical Simulation Training Group Reported in: SIHSP
Regional coordination and development of Interprofessional learning.	Implementation of identified actions, including increasing the opportunities for interprofessional learning in a clinical environment. **(Q3)**	Ongoing	Contributors: South Island Interprofessional learning working group Reported in: SIHSP
Support all South Island HWNZ funded trainees to make appropriate career choices.	**Career Plans** Support all South Island HWNZ funded trainees to develop and implement career plans (100%) with regional reporting. **(Q4)**	100% compliance.	Contributors: SIRTH Steering Group Reported in: SIHSP
	Career Events Identification of events and initiatives across the South Island to support career choices ((e.g. medical vocational trainee evenings, post graduate education fairs). **(Q1)** All South Island health professional trainees have access to these events and initiatives**. (Q3)** Online resources to support career choices. **(Q3).**	Regular Calendar of events in place	
	Midwifery South Island Quality Leadership Programme (QLP) implemented. **(Q4).**		

Actions to deliver	Deliverable 2014-15	Deliverable 2015-2017	Responsibilities
	Work with DHB RMO Units to reduce non-vocational RMOs. **(Q4)**	Ensure all PGY 3+ have access to formal vocational programmes.	
South Island vulnerable workforces are identified and plans established to mitigate these. • Aging workforce (Nursing & General Practice)	**Nursing sustainability** Strategy and planning is developed to support older nurses in the workforce to maximise their contribution to the sector. **(Q1)**	Ongoing review and development.	Contributors: SIRTH Nursing Sustainability Group Reported in: SIHSP
	Continued implementation of the identified action plan. **(Q4)**		
• Aged Residential Care	**Aged Residential Care Gerontology Acceleration Nursing Programme (GAP)** Pilot in CDHB is evaluated and rolled out in 2 other places in the South Island. **(Q1)**	GAP programme has been implemented across the South Island.	Contributors: South Island Executive Directors of Nursing. Reported in: SIHSP
• Mental Health	**Mental Health & Addiction** Phase 1: workforce Stocktake, organisational survey completed & analysed. **(Q2)**	Mental Health & Addictions workforce meets the identified health needs and is fiscally responsible.	Contributors: South Island MHSLA Reported in: SIHSP
	Gaps & needs identified with recommendations developed in partnership with Mental Health SLA, Te Pou, workforce Centres & HWNZ. This will include the unregulated workforce**. (Q4)**		
• Unregulated workforce (Allied Health & Mental Health)	**Unregulated Workforce: Allied Health Assistants:** Complete implementation of the Allied Health Assistant training and development framework into the South Island DHBs. **(Q1)**	Implemented across all South Island DHBs An ongoing regional process for review of training & development and outcomes of action plan.	Contributors: South Island Directors of Allied Health Reported in: SIHSP
• Sonography • General Practice (refer section below).	**Sonography** Coordination of training across the South Island and development of a plan to meet regional service needs in conjunction with South Island Directors of Allied Health and the national Radiology group. **(Q4)**	Ongoing.	Lead: South Island Directors of Allied Health Reported in: SIHSP
Development of primary and secondary care health workforce to support shift in care to be more community based.	**PGY 2/3 rotation into general practice & community** pilots in place & evaluation commenced. **(Q4)**	All PGY2s have a general practice or community rotation.	Contributors: PGY2/3 Working Group Reported in: SIHSP
	GPEP Supporting roll out of GPEP 2 in South Island re-experience in second scope of practice. **(Q4)**	Evaluation to ensure all GPs have the skills required to meet the needs of their patients.	Contributors: SIRTH Medical Leadership Team/Chief Medical Officers Reported in: SIHSP
	Diabetes Nurse Prescribers; Continued development of Registered Nurse (RN) Diabetes Prescribers. (Currently there are 15 nurses on the pathway in Canterbury (11 CDHB, 3 District Nursing, and 1 independent); West Coast 1; Southern 7.). **(Q4)**	Evaluation of role completed.	Contributors: South Island Executive Directors of Nursing. Reported in: SIHSP

Actions to deliver	Deliverable 2014-15	Deliverable 2015-2017	Responsibilities
	Nurse Practitioner (NP): NP roles are increased across the South Island. (currently there are 14) Develop an action plan. **(Q2)**	Nurse Practitioners roles are integrated across the health system in greater numbers.	Contributors: South Island Executive Directors of Nursing. Reported in: SIHSP
	Commence implementation. **(Q4)**		
Increase participation of Māori in the clinical workforce.	Collate available workforce data and initiatives in place. **(Q2)**	Increase number of Māori studying/ working in health. South Island suite of initiatives supporting participation in health as a career.	Contributors: SIRTH Steering Group/GMs Māori/GMs HR in conjunction with the national " Grow your own" project Reported in: SIHSP
	Develop a regional action plan. **(Q4)**		
Increase participation of Pacific People in the clinical workforce.	Collate available workforce data and initiatives in place. **(Q2)**	Increase number of Pacific studying/ working in health. South Island suite of initiatives supporting participation in health as a career.	Contributors: SIRTH Steering Group/GMs HR in conjunction with the national " Grow your own" project Reported in: SIHSP
	Develop a regional action plan. **(Q4)**		
Support workforce initiatives in the Clinical SLAs and Work Streams.	**Health of Older People: Advance Care Planning** 80 health professionals have completed L2 ACP training. **(Q2)**	Quantified increase in the use of advance care plans.	Contributors: HOPSLA/SIRTH/ National Co-ordination group Reported in: SIHSP
	Dementia Dementia education packages are available online. **(Q4)**	Access to education and learning packages is available to all South Island health professional online.	Contributors: HOPSLA Reported in: SIHSP
	Stroke: Online stroke education calendar available to the South Island workforce. **(Q1)**		Contributors: Stroke Work Stream Reported in: SIHSP
	Elective Services: Work with the Elective Services Work stream to support urology and eye health workforce development, once the model of care has been determined. **(Q4)**	The urology and eye health workforce meets the identified model of care staffing requirements.	Contributors: Elective Services SLA Reported in: SIHSP
	Child Health Implementation of the education for the South Island Safe Sleep Policy. **(Q3)**		Contributors: South Island Midwifery Leaders Reported in: SIHSP
Regional collaboration to further strengthen clinical leadership.	**AHS&T regional professional leadership, education and advanced practice roles** Development and implementation of agreed action plan. **(Q4)**	Ongoing review and development.	Contributors: South Island Directors of Allied Health Scientific & Technical Reported in: SIHSP
Increase the number of New Zealand trained Senior Medical Officers employed in New Zealand.	Work with DHBs to support the recruitment of New Zealand trained SMO's. **(Q4)**	New Zealand trained Senior Medical Officers remain in New Zealand.	Contributors: South Island CMO's Reported in: SIHSP
The medical workforce is fit for purpose and sustainability.	Supporting the DHBs to comply with 70/20/10 funding criteria in 2015. **(Q4)**		Contributors: South Island CMO's Reported in: SIHSP

Actions to deliver	Deliverable 2014-15	Deliverable 2015-2017	Responsibilities
Provision of 1 year internship for nursing graduates.	**Registered Nurses** Work with the South Island Nursing Leaders to ensure that all new graduates participate in a NetP (New entry to practice) programme **Enrolled Nurses** Work with the South Island Nursing Leaders to ensure an extended orientation programme for new entry to practice enrolled nurses. **(Q4)**		Contributors: South Island Executive Directors of Nursing Reported in: SIHSP

Human Resources

Actions to deliver	Deliverable 2014-15	Deliverable 2015-2017	Responsibilities
Regional Human Resources (HR) platform Consistent application of common terms and conditions of employment for regional health services.	Agree a common HR platform with stakeholders and South Island DHB Chief Executive Officers. **(Q2)**	Common HR platform has been implemented across the South Island. Ongoing policy shifts are developed and agreed by CEOs. South Island Shared Services approval for HR reviewed and determined. Regional data framework established. Virtual regional ER team established/operating.	Contributors: CDHB GMHR Reported in: SIHSP
	Common and consistent HR policies to support South Island regionalisation of health services. **(Q2)**		
	Common employment contracts, MECA arrangements where appropriate, consistent practices for example relocation, travel arrangements, remuneration etc. **(Q2)**		
Three year South Island Recruitment and Retention Strategy.	Strategy in place. Customisation of technology to achieve one single platform. Manage technology changes for Nelson/Marlborough/South Canterbury and Southern DHBs. Review budget and personnel consolidation. Communication and education plans for Managers. **(Q2)**	Budget consolidation, confirm organisational arrangements. Advertising recruitment managed from a single point, South Island campaign management underway.	Contributors: CDHB GMHR Reported in: SIHSP
An integrated workforce plan for the South Island Health Workforce.	Participate in Health Workforce NZ initiatives. Common tools and methodology in place at a DHB level for all critical workforce groups. Identify gaps and supply issues. Priority health workforce areas are identified and an action plan developed. **(Q2)**	Campaign management and targeted marketing in place for critical workforce groups.	Contributors: CDHB GMHR Reported in: SIHSP
Business driven HR metrics.	Key measures developed, agreed and in place. Measures reported quarterly and discussed with South Island CEOs. **(Q3)**	Monitoring and reporting against HR Lifecycle in place.	Contributors: CDHB GMHR Reported in: SIHSP

Actions to deliver	Deliverable 2014-15	Deliverable 2015-2017	Responsibilities
A common approach to South Island learning and development.	Agree common framework. Standards agreed common understandings, common language and common policy statements and aligned products. Common technology and e-learning platforms established. All South Island DHBs part of tertiary alliance. (**Q4)**	Systems and technology integration. Delineation of specialist and core activities to leverage a virtual workforce in South Island Learning and Development.	Contributors: CDHB GMHR/SIRTH Reported in: SIHSP

Support Services

Regionally consistent support functions enable the best clinical care at the best value for money.

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

Clinical Lead: (vacant)

Chair: **Jock Muir, Director, Strategic Projects (Canterbury DHB)**

The Support Services SLA (SS SLA) has been formed to:

- Secure better savings by aggregating procurement requirements, improving purchasing power and reducing procurement costs.
- Align with national or other regional activity to deliver the best outcomes for cost and services.
- Procure high value consumable product group, Assets (CAPEX) and non-clinical Services.

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

- Procurement and Savings - Achieve and report savings in line with Health Benefits Limited (HBL) methodology.
- Maintain relationships with staff from relevant local, regional and national health services organisations, to ensure national initiatives deliver best outcomes for people & system.
- Maintain strong functioning clinically led workstreams.
- Manage change in conjunction with HBL, as they appoint new providers of food, laundry and supply chain services nationally and regionally.

  St John Regional Agreement for Patient Transfer Service (PTS) - Provide assistance to develop and implement a new Regional PTS agreement between South Island DHBs and St John.

Actions to deliver	Deliverable 2014-15	Deliverable 2015-17	Responsibilities
PROCUREMENT AND SAVINGS **Achieve and report savings in line with Health Benefits Limited (HBL) methodology**			
Aggregate procurement requirements and improve purchasing power (using HBL national methodology).	Preparation and implementation of South Island Capital Expenditure Plan. **(Q1)**	Preparation and implementation of South Island Capital Expenditure Plan.	Contributors: SS SLA Reported in: SIHSP
	Increased number of collaborative projects, with at least one new project underway each quarter. **(Q1, Q2, Q3, Q4)**		
Savings of $7.5 million (using HBL national methodology) reported during the 2014-15 year by the South Island Procurement and Supply Chain workstream.	Accumulated savings reported. **(Q1, Q2, Q3, Q4)**	Accumulated savings reported.	Contributors: SS SLA Reported in: SIHSP
MAINTAIN RELATIONSHIPS WITH STAFF IN KEY RELATED SERVICES, FROM RELEVANT LOCAL, REGIONAL AND NATIONAL HEALTH SERVICES ORGANISATIONS, TO ENSURE NATIONAL INITIATIVES DELIVER BEST OUTCOMES FOR PEOPLE & SYSTEM			
Representation on SS SLA & workstreams includes: clinical representation and HBL.	Clinical endorsement of initiatives. (**Q1, Q2, Q3, Q4**)	Clinical endorsement of initiatives.	Contributors: SS SLA Reported in: SIHSP
	HBL endorsement of all workplans. **(Q1, Q2, Q3, Q4)**	HBL endorsement of all workplans.	Contributors: SS SLA Reported in: SIHSP

Actions to deliver	Deliverable 2014-15	Deliverable 2015-17	Responsibilities
PROJECT AND SAVINGS COLLABORATION WITH OTHER WORKSTREAMS OF THE SLA			
Align with the target of collective procurement driven by HBL and Ministry of Business, Innovation and Employment to take advantage of bulk purchasing savings.	Increased rationalisation and standardisation of products and services (where appropriate) across the DHBs to reduce clinical risk and increase purchasing power, in alignment with HBL initiatives. **(Q1, Q2, Q3, Q4)**	Increased rationalisation and standardisation of products and services.	Contributors: SS SLA Reported in: SIHSP
SS SLA MAINTAIN STRONG FUNCTIONING CLINICALLY LED WORKSTREAMS			
Workstream's Work Plans contain at least three quantifiable, measureable Key Performance Indicators (KPIs), at least one of which is financial.	KPIs reported and monitored. **(Q1, Q2, Q3 Q4)**	KPIs reported and monitored.	Contributors: SS SLA Reported in: SIHSP
MANAGE CHANGE IN CONJUNCTION WITH HBL AS THEY APPOINT NEW PROVIDERS OF FOOD, LAUNDRY AND SUPPLY CHAIN SERVICES NATIONALLY AND REGIONALLY.			
Opportunities for joint ventures with providers of food, laundry and supply chain services explored.	Opportunities agreed and implemented where appropriate, in alignment with HBL initiatives. **(Q1, Q2, Q3, Q4)**	Opportunities agreed and implemented where appropriate.	Contributors: SS SLA Reported in: SIHSP
SPECIFIC TO FOOD SERVICES WORKSTREAM			
Redefine KPIs in line with HBL's work in appointing regional providers of food services.	Redefined KPIs reported and monitored. **(Q1)**		Contributors: SS SLA Reported in: SIHSP
SPECIFIC TO LAUNDRY SERVICES WORKSTREAM			
Redefine KPIs in line with HBL's work in appointing regional providers of laundry services.	Redefined KPIs reported and monitored. **(Q1)**		Contributors: SS SLA Reported in: SIHSP
ST JOHN REGIONAL AGREEMENT FOR PATIENT TRANFSER SERVICE (PTS) **Assistance given to develop and implement a new Regional PTS agreement between South Island DHBs and St John**			
Facilitate the annual review of the regional PTS agreement negotiated between the South Island DHBs and St John.	Annual review of the regional PTS agreement completed. **(Q3)**	Annual review of the regional PTS agreement completed.	Contributors: SS SLA Reported in: SIHSP

Appendix 5 – Membership

Strategic Planning and Integration team

Name	Title	DHB
Mr David Tulloch (Chair)	Chief Medical Officer	SDHB
Carolyn Gullery	General Manager, Planning and Funding	CDHB
Dr Sharon Kletchko	General Manager, Strategy and Planning	NMDHB
Hilary Exton	Service Manager and Director of Allied Health	NMDHB
Fiona Pimm	General Manager, Māori Health Services	SCDHB
(vacant)	Executive Director Nursing and Midwifery	SDHB
Dr Daniel Williams	Public Health Physician	CDHB, WCDHB & SCDHB
Dr Carol Atmore	General Practitioner	WCDHB
Jan Barber	General Manager South Island Alliance Programme Office	SIAPO

Service Level Alliances and Workstreams

SLA	Name	Title	DHB
Southern Cancer Network	Dr Steve Gibbons (Steering Group Chair)	Haematologist, Clinical Services	CDHB
	Dr Shaun Costello	Clinical Director, Southern Cancer Network/Clinical Director Medicine & Radiation Oncologist	SDHB
	Dr Dean Millar-Coote	General Practitioner	SDHB
	Glenis McAlpine	Clinical Nurse Manager	Marlborough PHO
	Theona Ireton	Kaitiaki	CDHB
	Marj Allan	Consumer	
	Danielle Smith	Cancer Support Coordinator	West Coast PHO
	Dr Frances Beswick	Anaesthetist, Clinical Secondary Services	SCDHB
	Trish Clark	Oncology Nurse Manager	SDHB
	Christine Nolan	GM Secondary Services	SCDHB
	Michelle Driffill	Regional Manger Northern South Island for CanTeen	Canterbury
	Ginny Green	CE Hospice Otago	Otago
	Jan Barber	Interim General Manger Planning and Funding Representative	SIAPO
	Dr Ursula Jewell	Southern Cancer Network Manager (Acting)	SCN
Child Health Services	Dr Nicola Austin (Chair)	Neonatal Paediatrician	CDHB
	Jane Kinsey	PHO Manager, Community Physiotherapist	Nelson PHO
	Dr Nick Baker	Community Paediatrician	NMDHB
	Dr Clare Doocey	Paediatrician	CDHB
	Anne Morgan	Service Manager, Child Health	CDHB
	Donna McCann	Service Manager, Child Health	SCDHB
	Dr Mick Goodwin	Paediatrician	SCDHB
	Dr David Barker	Clinical Director, Women's & Children's Health	SDHB
	Prof Barry Taylor	Professor of Paediatrics	University of Otago
	Dr Ian Shaw	Paediatrician	SDHB
	Jane Wilson	Nursing Director	SDHB

SLA	Name	Title	DHB
	Jenny Humphries	Director of Midwifery	SDHB
	Dr Viv Patton	General Practitioner Paediatric Liaison	CDHB
	Wayne Turp	Project Specialist, Planning and Funding	CDHB
	Jaana Kahu	Māori Child and Youth Health	Te Tai o Marokura
	Rose Laloli	Facilitator	SIAPO
Health of Older People Services	Dr Jenny Keightley (Chair)	General Practitioner	CDHB
	Michael Parker	CEO, Presbyterian Support Service South Canterbury	SCDHB
	Carole Kerr (Deputy Chair)	Walking in Another's Shoes Dementia Educator	NMDHB
	Margaret Hill	General Manager, Strategy, Planning and Accountability	SCDHB
	Ruby Aberhart	Older Person's Advocate	NMDHB
	Dr Val Fletcher	Consultant Physician and Clinical Director of Community Services Older Persons Health	CDHB & WCDHB
	Dr Stanley Smith	Geriatrician	SCDHB
	Kate Gibbs	Nursing Director, Older People – Population Health,	CDHB+WCDHB
	Dr Petra Hoggarth PhD	Clinical Psychologist	CDHB
	Amber Salanoa Haar	Allied Health Advisor/Occupational Therapist	WCDHB
	Andrew Metcalfe	Allied Health Director, Older People, Clinical Support, Community Directorate	SDHB
	Karen Kennedy	Community Pharmacist, Primary and Community Services	SCDHB
	Caroline Teichert	Older Person's Advocate (alternative)	WCDHB
	Jane Large	Facilitator	SIAPO
Mental Health	Dr David Bathgate (Chair)	Consultant Psychiatrist	SDHB
	Dr Alfred Dell'Ario	Consultant Psychiatrist	CDHB
	Heather Casey	Director of Nursing	SDHB
	Rose Henderson	Allied Health	CDHB
	Sal Faid	Consumer	
	Key Frost	Pacifica	Pacific Island Advisory & Cultural Trust
	Paul Wynands	Primary Care	Rural Canterbury PHO
	(vacant)	NGO	
	Robyn Byers	Service Director	NMDHB
	Diane Issac	Family Advisor, Supporting Families	CDHB
	Karaitiana Tickell	CEO, Purapura Whetu Trust	CDHB
	Margaret Hill	GM Strategy and Accountability	SCDHB
	Martin Kane	Facilitator	SIAPO
Support Services	Jock Muir (Chair)	Director, Strategic Projects	CDHB
	(vacant)	Clinical Director	
	Eric Sinclair	General Manager Finance & Performance	NMDHB
	Mark Newsome	General Manager Grey/Westland Health Services	WCDHB

SLA	Name	Title	DHB
	(vacant)		SCDHB
	Dr Peter Bramley	Service Director, Medical Surgical Services	WCDHB
	Sharon Jones	Director of Nursing	SDHB
	Nigel Wilkinson	CEO	HBL
	Elaine Chisnall	General Manager, Women's, Children's, Public Health and Support Services	SDHB
	Alan Lloyd	Facilitator	SIAPO
Information Services	Dr Andrew Bowers (Chair)	Medical Director, Information Technology and Physician	SDHB
	Dr Bev Nicolls	Community Based Services Directorate / General Practitioner	NMDHB & Stoke Medical Centre
	Chris Dever	CIO	CDHB
	Jane Brosnahan	Nursing, Midwifery and Allied Health	SCDHB
	John Beveridge	Nurse Consultant	CDHB
	Dr Nigel Millar	Chief Medical Officer	CDHB
	Russell Rarity	Clinical Director, Anaesthetics	SCDHB
	Stella Ward	Executive Director, Allied Health	WCDHB/CDHB
	Patrick Ng	General Manager IT & Infrastructure	NMDHB
	Carolyn Gullery	GM, Planning and Funding	CDHB
	Peter Beirne	Executive Director Finance	SDHB
	Dr Peter Gent	General Practitioner Rep	Mornington Health Centre
	Sheree East	Nursing Director	Nurse Maude
	Paul Goddard	Programme Director, Information Services	SIAPO
	Beth Dillon	Facilitator	SIAPO
Quality and Safety	Mary Gordon (Chair)	Executive Director of Nursing	CDHB
	Dr Richard Johnson	Chief Medical Officer	SDHB
	Ken Stewart	Community Physiotherapist, CDHB Falls Clinical Lead, HQSC expert panel	Selwyn Village Physiotherapy
	Lexie O'Shea	Executive Director of Patient Services	SDHB
	Karen Vaughan	GM Clinical Governance Support	NMDHB
	Tina Gilbertson	General Manager Organisational Development	SDHB
	Chris Eccleston	General Manager Clinical Governance	SCDHB
	Dr Elizabeth Wood	General Practitioner, Executive Clinical Director NMDHB	Mapua Health Centre, NMDHB
	Dr Lynley Cook	Population Health Specialist	Pegasus
	Robyn Moore	Consumer Representative	WCDHB
	Rose Laloli	Facilitator	SIAPO
Cardiac Services	Dr David Smyth (Chair)	Cardiologist & Clinical Director of Cardiology	CDHB
	Lisa Smith	Cardiac Clinical Nurse Specialist	WCDHB
	Gary Barbara	Service Manager	CDHB
	Dr Bernard Kuepper	Consultant Internal Medicine/Cardiology	SCDHB
	Dr Rachael Byars	Physician and Clinical Leader	SDHB

SLA	Name	Title	DHB
	Kara Ogilvy	Associate Nurse Manager for the Medical Ward, Southland Hospital	SDHB
	Christine Nolan	General Manager Secondary Services	SCDHB
	Dr Garry Nixon	Medical Officer	Dunstan Hospital
	Dr Nick Fisher	Consultant Cardiologist	NMDHB
	Dr Gerard Devlin	Interventional Cardiologist (National Cardiac Network rep)	WDHB
	Dr Belinda Green	Cardiologist	SDHB
	Janine Cochrane	Service Manager	SDHB
	Carol Horgan	Team Leader Primary and Secondary Care Planning and Funding	CDHB
	Daniel Ohs	Clinical Planning Manager St John	Independent
	Alan Lloyd	Facilitator	SIAPO
Elective Services	Dr Pim Allen	Independent Chair	Independent
	Diana Gunn	Director of Nursing Older Persons Health; Rehabilitation and Orthopaedics	CDHB
	Suzanne Beuker	SMO & HoD Urology	NMDHB
	Dr Peter Bramley	Service Director Medical & Surgical Directorate	NMDHB
	Mr Greg Robertson	Chief of Surgery	CDHB
	Mr Murray Fosbender	Medical Director, Surgical Services Director	SDHB
	Dr David Hunt	Anaesthetist	SDHB
	Dr Graham McGeoch	General Practitioner, Canterbury Initiative	CDHB
	Carole Stuart	Service Manager - Anaesthesia	CDHB
	Maree Jackson	Elective Services Manager	SDHB
	Margaret Hill	General Manager Planning and Funding	SCDHB
	Ralph La Salle	Electives Service Manager, Portfolio Manager (CDHB) & Acting Operations Manager (WCDHB)	CDHB & WCDHB
	Dr Richard Johnson	Chief Medical Officer, Anaesthetist	SCDHB
	Christine Nolan	General Manager Secondary Services	SCDHB
	Pauline Clark	General Manager, Medical & Surgical Division, Women's & Child Health Division Christchurch Hospital	CDHB
	Pamela Kiesanowski	Assistant Director of Nursing	NMDHB
	Janice Donaldson	SI Electives Programme Manager	SIAPO
Stroke Services	Dr Wendy Busby (Chair)	Consultant Physician & Geriatrician	SDHB
	Clare Jamison	Occupational Therapist	CDHB
	Julian Waller	Stroke Clinical Nurse Specialist	SCDHB
	Dr John Fink	Clinical Director, Neurology	CDHB
	Dr Suzanne Busch	Geriatrician, General Physician	NMDHB
	Dr Carl Hanger	Stroke Rehabilitation Consultant & Geriatrician	CDHB
	Dr Barbara Weckler	General Physician	WCDHB
	Jane Large	Facilitator	SIAPO
South Island Public Health Partnership	Dr Marion Poore (Chair)	Medical Director & Medical Officer of Health	SDHB
	Fiona Pimm (Project Sponsor)	General Manager Primary and Community, General Manager Māori Health	SCDHB

SLA	Name	Title	DHB
	Dr Ed Kiddle	Medical Officer of Health	NMDHB
	Evon Currie	General Manager, Community & Public Health	CDHB, WCDHB, SCDHB
	Dr Daniel Williams	Clinical Director, Community & Public Health, Medical Officer of Health SCDHB	CDHB, WCDHB, SCDHB
	Peter Burton	Public Health Service Manager	NMDHB
	Grant Pollard	Group Manager, Public Health Group	NHB
	Dr Ramon Pink	Medical Officer of Health, and Māori Public Health Portfolio	CDHB
	(vacant)	Service Manager, Public Health Services	SDHB
	Margaret Bunker	South Island Alliance Programme Co-ordinator	SIAPO
	Dr Rachel Eyre	Facilitator	SIAPO

South Island Regional Training Hub

Name	Title	DHB
Mary Gordon(Chair)	Executive Director of Nursing	CDHB
Samantha Burke	Director of Midwifery	CDHB
Lynda McCutcheon	Director of Allied Health, Scientific and Technical	SDHB
Dr Carol Atmore	Chief Medical Officer	WCDHB
Harold Wereta	Director of Māori Health and Whānau Ora	NMDHB
Dr Bernhard Kuepper	Consultant Internal Medicine/Cardiology	SCDHB
Margaret Bunker	South Island Alliance Programme Coordinator	SIAPO
Kate Rawlings	Regional Programme Director Training	SIAPO
Kathryn Goodyear	Facilitator	SIAPO

Appendix 6 - Glossary of terms

The following table provides definitions on terms used in this document:

Term		Definition
	Acute Care	The provision of appropriate, timely, acceptable and effective management of conditions with sudden onset and rapid progression that require attention.
ACP	Advance Care Planning	ACP is focused on the end-of-life care for an individual and involves both the person and the health care professionals responsible for their care. It may also involve the person's family/whānau and/or carers. The planning process assists the individual to identify their personal beliefs and values and incorporate them into plans for their future health care.
ANZAC Q1		One of the national Registers for Cardiac that is to be implemented. Covers acute coronary syndrome, elective and acute percutaneous coronary interventions.
CAPEX	Capital Expenditure	Spending on land, buildings and larger items of equipment.
CEO	Chief Executive Officer	A CEO is the highest-ranking corporate officer/executive in charge of total management of an organization.
	Continuum of Care	Exists when a person can access responsive services matched to their level of need at any time throughout their illness or recovery.
DHB	District Health Board	District Health Boards are responsible for providing or funding the provision of health services in their district.
ECG	Electrocardiogram	An ECG is used to measure the rate and regularity of heartbeats, as well as the size and position of the chambers, the presence of any damage to the heart, and the effects of drugs or devices used to regulate the heart, such as a pacemaker.
eHealth		Healthcare practice using the Internet. It can also include health applications and links on mobile phones.
eLearning		E-learning (or eLearning) is the use of electronic media and information and communication technologies (ICT) in education. E-learning is broadly inclusive of all forms of educational technology in learning and teaching.
e-portfolios	Electronic-portfolio	An electronic portfolio is a collection of electronic evidence assembled and managed by a user, usually on the Web.
HBL	Health Benefits Limited	HBL facilitates and leads initiatives that result in savings and efficiencies for District Health Boards on non-clinical initiatives.
HBSS	Home Based Support Services	HBSS support services are funded by DHBs for older people who require support services to enable them to continue to live in the community and in their own environment.
HCS	Health Connect South	HCS is the South Island Clinical Workstation and provides one place to view clinical information about the South Island patients. It will present information that is currently stored in many different systems and aggregate the information in a patient centric view. That means that clinical staff can access information from any of the underlying systems that are tied to the Clinical Information System. It also has the ability to capture patient related documentation and store it in a patient centric way (see Clinical Workstation).
	Health Pathways	Health Pathways provides a range of information for health professionals responsible for referring to specialty services.
	Health Outcomes	A change in the health status of an individual, group or population which is attributable to a planned programme or series of programmes, regardless of whether such a programme was intended to change health status.

Term		Definition
HQSC	Health Quality and Safety Commission	The Health Quality & Safety Commission was established under the New Zealand Public Health & Disability Amendment Act 2010 to ensure all New Zealanders receive the best health and disability care within our available resources. The Commission is also working towards the New Zealand Triple Aim for quality and safety outcomes.
HWNZ	Health Workforce New Zealand	HWNZ was formed to lead and co-ordinate the planning and development of the health and disability workforce. It ensures that we have a high quality, fit-for-purpose workforce and that workforce issues are aligned with planning of services.
	Integration	Combine into a whole or complete by addition of parts.
InterRAI	International Resident Assessment Instrument	Comprehensive assessment tool.
	Kaumatua	Māori Elder.
	Kaupapa Maori Services	Clinical support services.
	Kuia	Elderly woman.
	Maudsley Family Based Therapy	MFBT is a family therapy for the treatment of anorexia nervosa devised by Christopher Dare and colleagues at the Maudsley Hospital in London in 1985.
MoH	Ministry of Health	The Ministry of Health aims to ensure that the health and disability support system works for all New Zealanders. The Minister of Health has overall responsibility for the health and disability system.
	Māori Health Strategy (He Korowai Oranga)	He Korowai Oranga: Māori Health Strategy sets the direction for Māori health development in the health and disability sector. The strategy provides a framework for the public sector to take responsibility for the part it plays in supporting the health status of whānau.
	Mortality	Death.
MOSAIQ		MOSAIQ is a complete patient information management system that centralizes radiation oncology, particle therapy and medical oncology patient data into a single user interface, accessible by multi-disciplinary teams across multiple locations.
MDMs	Multidisciplinary meetings	MDMs are regular meetings at which health professionals from a range of different specialities consider relevant treatment options and together develop a recommended individual treatment plan for each patient.
NHB	National Health Board	The NHB was established in November 2009 and is made up of a Ministerial appointed Board and a branded business unit within the Ministry of Health.
NHITB	National Health IT Board	The IT Health Board leads the implementation and use of information systems across the health and disability sector. They ensure health sector policy is supported by appropriate health information and IT solutions.
	New Zealand Health Strategy	The New Zealand Health Strategy sets the platform for the Government's action on health. It identifies the Government's priority areas and aims to ensure that health services are directed at those areas that will ensure the highest benefits for our population, focusing in particular on tackling inequalities in health.
NGO	Non-Government Organisations	In the context of the relationship between the Health and Disability NGOs and the DHBs, NGOs include independent community and iwi/Māori organisations operating on a not-for-profit basis, which bring a value to society that is distinct from both Government and the market. In reality this will mean that any profits are put back into the organisation, rather than distributed to shareholders.
NZULM	NZ Universal List of Medicines	NZULM is New Zealand's national dictionary of medicines list for universal use across the sector. It is updated regularly, and is readily accessible via a website and participating prescribing and dispensing software systems and medicines information sources (including the NZ Medicines Formulary).

Term		Definition
	Primary Care	Primary Care means essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods. It is universally accessible to people in their communities, involves community participation, is integral to, and a central function of, the country's health system, and is the first level of contact with the health system.
PHO	Primary Health Organisation	PHOs encompass the range of primary care and practitioners and are funded by DHBs to provide of a set of essential primary health care services to those people who are enrolled in that PHO.
	Population Heath	Population health refers to the health outcomes of a group of individuals, including the distribution of such outcomes within the group. It is an approach to health that aims to improve the health of an entire population. One major step in achieving this aim is to reduce health inequities among population groups. An important theme in population health is importance of social determinants of health and the relatively minor impact that medicine and healthcare have on improving health overall.
	Public Health	The science and art of preventing disease, prolonging life and promoting health and efficiency through organised community effort. A collective effort to identify and address the unacceptable realities that result in preventable and avoidable health outcomes and it is the composite of efforts and activities that are carried out by people committed to these ends.
RL6		Incident Management software solution.
	Secondary Care	Specialist care that is typically provided in a hospital setting.
SIRTH	South Island Regional Training Hub	SIRTH is designed to support more effective and integrated health professional training, covering a population of approximately one million people. SIRTH works collaboratively across each region to oversee the planning and delivery of clinical training, ensuring it meets the needs of trainees and local communities and is aligned with regional service planning.
	South Island Alliance	The South Island Health Alliance, a partnership between the five South Island District Health Boards, is working to support a clinically and financially sustainable South Island health system where services are as close to people homes as possible.
	South Island Alliance Programme Office	The South Island Alliance Programme Office supports the regional activities of the South Island Alliance.
SIHSP	South Island Health Services Plan	Regional Health Services Plan provided by the South Island Alliance.
SLA	Service Level Alliance	Agreed priority area for the South Island Alliance.
	TePou	Te Pou's purpose is to enhance people's health and wellbeing by developing a sustainable workforce delivering quality services. To achieve this, they provide health organisations with tools, products and resources to help them build a strong and enduring workforce and improve their services.
WIAS	Walking in Another's Shoe	WIAS is a dementia workforce education programme being rolled out around the South Island.
	Whanāu	Family.
WHO	World Health Organisation	WHO is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends.
	Workstream	Other areas of regional activity of the South Island Alliance.