Te Wai Pounamu South Island Health Services Plan

2016-19

South Island Health Services Plan 2016-19

Produced in May 2016

By the South Island Alliance Programme Office

On behalf of the five South Island District Health Boards

Telephone: 03 378 6631

PO BOX 639, Christchurch

FOREWORD

This year the South Island Alliance will continue to dedicate its resources to achieve the South Island Outcomes Framework and drive improvement and efficiencies across the South Island health sector.

The South Island Alliance Board and Alliance Leadership Team support the South Island Alliance teams and health services in addressing the challenges we face within the region. We have made significant progress over the past five years in aligning systems and processes across the region leading to a better experience of care and outcomes for people. Examples of these include:

- *Health Connect South (clinical workstation) will roll out in the two remaining DHBs – it will be the first clinical workstation implemented regionally.*
- *We are implementing single regional services across multiple sites, for example, bariatric surgery.*
- *We continue to work towards meeting challenging targets, including shorter electives wait times and faster cancer treatment.*
- *Our workforce is becoming more skilled, more focused on patient centred care and more flexible through the programmes supported by the Workforce Development Hub*.

This *South Island Health Services Plan (2016-19*) maps the direction of the South Island Alliance and draws from national strategies and priorities, including the draft New Zealand Health Strategy, National Health Targets, the Minister's Expectations, and the Operational Policy Framework. The South Island Health Service Plan actions are interwoven into each of the South Island District Health Board (DHB) Annual Plans with a clear 'line of sight' across plans.

The plan provides direction and guidance in terms of how the South Island health system will operate and prioritise its resources and effort. The plan also continues to challenge how we work together while acknowledging the progress made and the efforts and energy of all involved.

Through the South Island Alliance, South Island health services have developed a strong platform for implementing regional and sub-regional priorities; health services can now work together to make the best use of available resources, strengthen clinical and financial sustainability and increase and improve patient access to services. We look forward to seeing this plan implemented and building on these actions in the coming years.

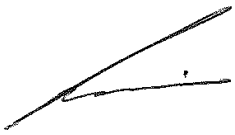
Signed by:

Chris Fleming
Chair, Alliance Leadership Team
CEO, Nelson Marlborough District Health Board

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

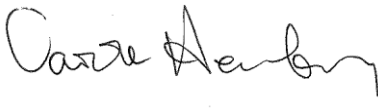
David Meates
CEO, Canterbury and West Coast District Health Boards

Peter Ballantyne
Chair, West Coast District Health Board

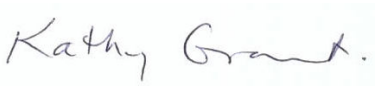


Nigel Trainor
CEO, South Canterbury District Health Board

Murray Cleverly
Chair, Canterbury and South Canterbury District Health Boards



Carole Heatly
CEO, Southern District Health Board



Kathy Grant
Commissioner, Southern District Health Board

MINISTER OF HEALTH LETTER OF APPROVAL

Office of Hon Dr Jonathan Coleman

Minister of Health
Minister for Sport and Recreation
Member of Parliament for Northcote

07 JUL 2016

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

Dear Mr Fleming

South Island Region 2016/17 Regional Service Plan

This letter is to advise you I approve the 2016/17 South Island Regional Service Plan (RSP). I appreciate the significant work that is involved in preparing the RSP and thank you for your effort.

I am planning to strengthen the focus and role of RSPs in the future and you will be engaged in this process.

I acknowledge the good progress that has been made with regional planning this year, particularly in relation to the development of a strong regional vision, goals and outcomes. This is evident in the continued improvement in the alignment between the DHB Annual Plans and RSP, which should continue to be strengthened in the future in order to achieve the best use of resources.

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 2016/17 and to continue to work together to ensure service sustainability within the Region.

Regional Service Plan Agreement
Please note that my approval of your RSP does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry of Health. You will need to advise the Ministry of any proposals that may require Ministerial approval as you review services during the year.

My agreement of your RSP also does not constitute 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.

I would like to thank all the people involved in developing the RSP for their valuable contribution and continued commitment to delivering quality health care to the population. I look forward to seeing your achievements throughout the year.

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 South Island RSP made available to the public.

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

cc DHB Chairs and Chief Executive Officers in the South Island Region

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6818 Facsimile 64 4 817 6518

CONTENTS

1 INTRODUCTION

"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 1,102,630 (23.4 percent of the total New Zealand population)[1], implementing diverse, but similar individual responses duplicates effort and investment and can lead to service and access inequality. Regional collaboration is an essential part of our future direction.

The South Island Alliance has brought together the region's five DHBs, along with primary care, aged residential care, NGOs and consumers, to work collaboratively toward a sustainable South Island health and disability system that is *best for people, best for system.*

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. This vision is consistent with the draft New Zealand Health Strategy and the Government's *Better, Sooner, More Convenient* approach to integrated health care.

To ensure our work remains aligned with this direction and to drive our activities, the South Island's strategic framework identifies three strategic goals and eight collective outcomes that tell us what success looks like as a region.

To achieve these goals and outcomes, the South Island Alliance supports existing regional networks to be well-connected and integrated, 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 health services can work towards this shared vision collaboratively. This collaborative approach will enable the region to respond with a whole of system approach to changes in technology and demographics that will significantly impact the health sector in coming years.

1.2 Our 2016-19 plan

This updated *South Island Health Services Plan (2016-19)* provides a framework for future planning and outlines the region's priorities for 2016-19. It has been developed by the five South Island DHBs, and the primary care and community members of the South Island Alliance's Service Level Alliances and Workstreams. The plan builds on the achievements and progress of the last five years as it develops a longer term direction for a sustainable South Island health and disability system that is *best for people, best for system*.

South Island health services continue to work together at a regional level to make the best use of available resources, strengthen clinical and financial sustainability and increase access to services. The plan, developed and supported by clinical leaders, supports the South Island Outcomes Framework (see Section 4 Improving Health Outcomes), and is governed by our agreed framework for regional decision making (see Section 5 Regional Governance, Leadership and Decision Making).

[1] Based on projections used for the 2016/17 Population Based Funding Formula.

South Island DHBs are involved in collaborative activity across a large number of regional and sub-regional service areas. The areas outlined in the plan are those that have been given national and regional priority. In addition to these priority areas, regional approaches continue for neurosurgery, primary care emergency planning and coordination, and audit services. Māori health approaches have been incorporated into the 2016-19 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.

2 SETTING OUR STRATEGIC DIRECTION

2.1 Strategic context

New Zealand's health system is generally performing well against international benchmarks. However, an aging population and a growing burden of long-term conditions is driving increased demand for health services, while financial and workforce constraints limit increasing capacity.

Alongside these health sector drivers, there is growing acknowledgement of the social determinants of health and, conversely, the role good health plays in social outcomes. Health outcomes for our communities are interlinked with issues of education, employment, housing and justice, and services will increasingly be asked to take a broader view of wellbeing.

These pressures mean health services cannot continue to be provided in the same way. While hospitals continue to be a setting for highly specialised care, we need to move away from the traditional health model.

There are clear opportunities that are supporting evolution in our health sector, for example shifts towards earlier intervention, investment and preventative care, home and community based care, and new technology and information systems. Further change towards integrating and better connecting services, not only across the health sector but inter-sectorally, is needed to achieve better health outcomes with available resources.

2.2 National direction

Acknowledging these challenges and opportunities, New Zealand's long term vision for health services will be articulated through the New Zealand Health Strategy. The Strategy intends to support New Zealanders to 'live well, stay well, get well' and sets out five themes to give focus for change in health services:

- People powered: understanding people's needs and partnering with them to design services; empowering people to be more involved in their health and wellbeing; building health literacy and supporting people's navigation of the system
- Closer to home: more integrated health services and better connections with wider public services; investment early in life; care closer to home; focus on wellness and prevention
- Value and high performance: focus on outcomes, equity, people's experience, best-value use of resources; strong performance measurement; culture of improvement; transparent use of information to share learning; use of investment approaches to address health and social issues[2]
- One team: operating as a team in a high trust system; flexible use of the health and disability workforce; leadership and workforce development; strengthening the role of consumers/communities; linking with researchers
- Smart system: information reliable, accurate and available at point of care; data and systems that improve evidence-based decision making and clinical audit; standardised technology.

More specifically, health services are guided by a range of population or condition specific strategies, including He Korowai Oranga (Māori Health Strategy), 'Ala Mo'ui (Pathways to Pacific Health and Wellbeing), Health of Older People Strategy (currently being updated), Primary Care Health Strategy, Rising to the Challenge (Mental Health and Addiction Service Development Plan – to be updated in 2016), Palliative Care Strategy, Cancer Strategy and Diabetes Strategy.

[2] In line with the Productivity Commission's report *More Effective Social Services (2015)*, an investment approach takes into account the long-term impact of an initiative on government spending and quality of life when making funding decisions.

In supporting people to 'live well, stay well, get well'[3], DHBs are expected to commit to Government priorities to provide better public services; in particular, 'better, sooner, more convenient health services'. However, the health sector also contributes to the achievement of other Government priorities, including a number of Better Public Service results areas, and building a more productive economy.

Alongside these longer-term commitments, the Minister of Health's annual Letter of Expectation signals annual priorities for the health sector. In 2016/17 the focus is on:

- New Zealand Health Strategy: DHBs need to be focused on the critical areas to drive change that are identified in the Strategy
- Living within our means: DHBs must continue to consider where efficiency gains can be made and look to improvements through national, regional and sub-regional initiatives
- Working across government: cross-agency work to support vulnerable families and improve outcomes for children and young people is a priority, along with health's contribution to Better Public Service Results
- National health targets: while health target performance has improved, this needs to remain a focus for DHBs, particularly the Faster Cancer Treatment target
- Tackling obesity: DHBs are expected to deliver on the new health target to address childhood obesity and show leadership in working to reduce the incidence of obesity
- Shifting and integrating services: DHBs need to continue to work with primary care to move services closer to home and achieve better coordinated health and social services
- Health information systems: DHBs need to complete current national and regional IT investments and DHB, PHO and primary care input is sought in the co-design process of the Health IT Programme 2015-2020.

2.3 Regional direction

The Nelson Marlborough, Canterbury, West Coast, South Canterbury and Southern DHBs form the South Island Alliance – together providing services for slightly over 1 million people, or 24 per cent of the New Zealand population.

In delivering its commitment to better public services and better, sooner, more convenient health services, the Government also has clear expectations of increased integration and regional collaboration between health service providers (and other social service agencies).

While each DHB is individually responsible for the provision of services to its own population, the South Island Alliance recognises that working regionally enables us to better address our shared challenges. The Alliance improves the systems within which health services are provided by the individual South Island DHBs. Now entering its fifth year, the Alliance has proven to be a successful model for the South Island, bringing clinicians, managers, CEOs, primary care, aged residential care and consumers together to work towards a shared vision of *best for people, best for system.* The model has become embedded in the culture of the South Island health system with regional and sub-regional activity 'business as usual'.

The Alliance Outcomes Framework defines what success looks like for South Island health services, and outcomes measures will be implemented this year to track if we are heading in the right direction (further detail in Section 4: Improving outcomes for our population).

[3] In the Ministry of Health's Statement of Intent this is articulated as: New Zealanders live longer, healthier, more independent lives and the health system is cost-effective and supports a productive economy (http://www.health.govt.nz/publication/statement-intent-2015-2019)

The *South Island Health Services Plan 2016-19* outlines the agreed regional activity to be implemented through our seven priority service areas: cancer, child health, health of older people, mental health and addiction, information services, support services, and quality and safety service level alliances. In addition to this, regional workstreams will focus on: cardiac services, elective surgery, palliative care, public health, stroke, major trauma services and hepatitis C. Workforce planning, through the South Island Workforce Development Hub will contribute to improved delivery in all service areas.

In developing and implementing a collective regional approach we acknowledge the unique pressures and post-disaster challenges Canterbury face, and the wider impact of this on South Island health services. Five years on from the earthquakes, prolonged levels of stress, anxiety and poor living arrangements are exacerbating chronic illness and increasing demand across the Canterbury health system. Patterns following other international disasters show that psychological recovery after a major disaster can take upwards of a decade, so the increased demand can be expected to continue for some time. Alongside this increased demand, invasive infrastructure repairs combined with extensive facilities redevelopment mean capacity is severely stretched across Canterbury's specialist services. It will be a number of years before Canterbury is back to full capacity and it is important that care pathways for the South Island are developed with this in mind.

All South Island DHBs are involved in the service level alliances and workstreams. Each DHB's commitment in terms of the regional direction is outlined in their Annual Plans. The South Island Alliance is committed to the implementation of the New Zealand Health Strategy regionally and is already delivering actions in line with the Strategy Roadmap and the 2016/17 priorities. This alignment is shown through a South Island version of the Health Strategy Roadmap of Actions diagram in Appendix 2.

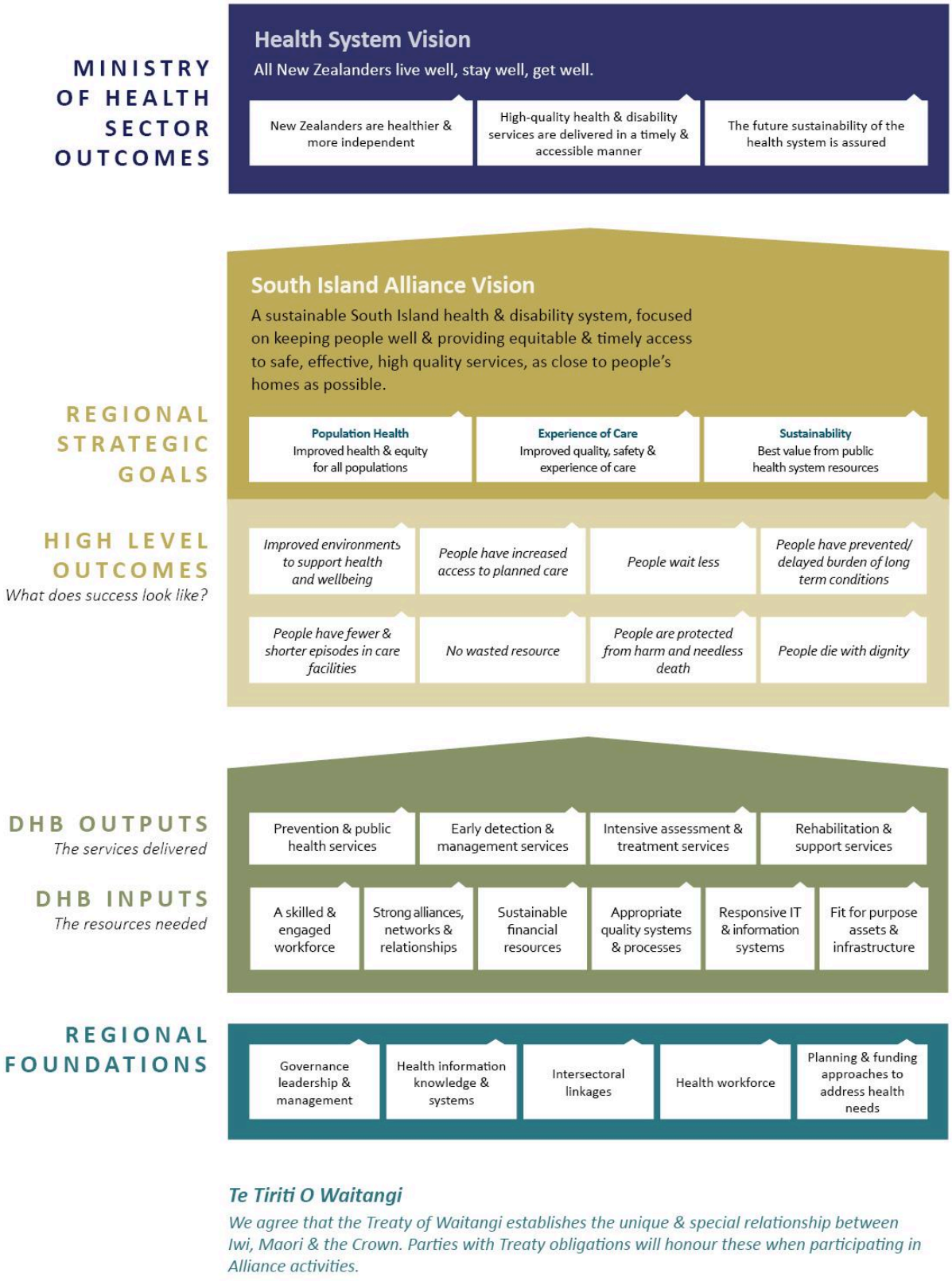
2.4 Local direction

Local health services must cope sustainably with the increasing demand for services and design pathways to manage the flow of people. Each DHB has local alliances through which they partner with primary care and other local stakeholders to drive local health service integration. These local alliances support health services to deliver care in the most appropriate setting and reduce demand by supporting people to remain independent.

While many of the challenges are similar, each DHB must address the particular needs of their community, given the demographics, infrastructure and geographic features that make up its district. We support working towards alignment and collaboration where possible, but recognise the need for flexibility to enable local solutions for local communities.

2.5 South Island intervention logic diagram

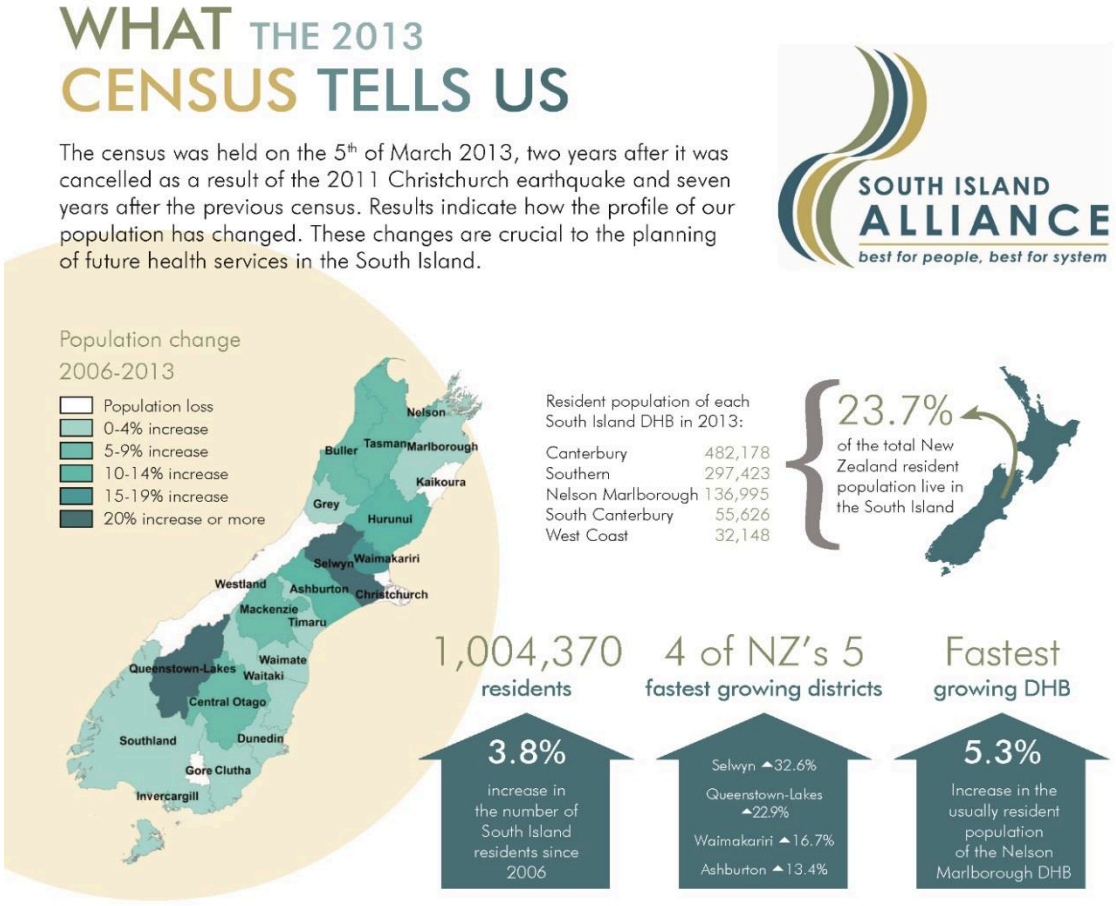
The strategic alignment of the South Island Aliance is described in the following intervention logic diagram.



3 DRIVERS OF HEALTH SERVICE CHANGE IN THE SOUTH ISLAND

3.1 South Island population profile

The Population Based Funding Formula estimates the population of the South Island will be 1,102,630, in 2016/17, an increase of 59,380 people or 5.7 percent from the March 2013 Census. We expect the trends identified in the 2013 Census to continue in the coming year.



The South Island's usually resident population has increased by 3.8% since 2006. This is slower than the 6.7% 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 last census.

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 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.

The Clutha and Southland districts have seen growth between 2006 and 2013, following decreases in the 2001 census.

The growth in the Queenstown-Lakes district appears to be contributing to the growth in the Central Otago district. The increases in population have occurred in the Cromwell and Dunstan areas.

Nelson Marlborough has had the highest rate of growth in the South Island between 2006 and 2013. Over half of this growth has occurred in Nelson City.

Canterbury DHB previously had the highest rate of growth of the South Island DHBs. This was disrupted by the earthquakes in the region. Christchurch City has seen a 2% decrease in usual residents since 2006, contributing 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, including Rolleston, Rangiora and Lincoln. Whilst residents may have left Christchurch City after the earthquakes, many are still living in the surrounding area.

For example, Dunedin City has increased by 1,560 usual residents since 2006, comparable to the increase in the number of usual residents in the Central Otago and Southland districts.

What Does This Mean?

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 community services that operate in people's homes and communities.

Our aging population

The South Island has an increasing 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 it may have implications our health workforce in the years to come.

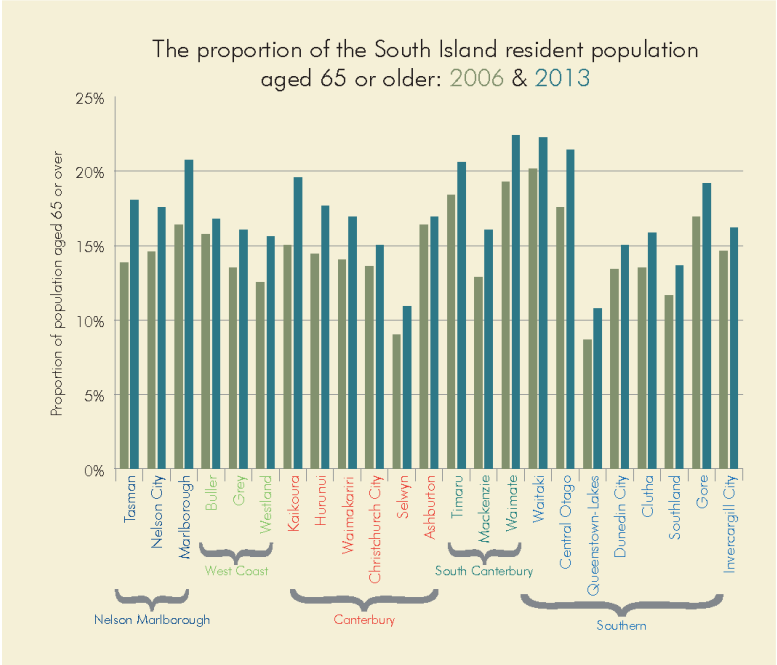
Age

The South Island is continuing to age, and remains older than the rest of the country with16% of our population now aged 65+, up from 14.0% in 2006. The proportion of the New Zealand population aged 65 years or older is 14.3%.

South Canterbury continues to have the highest proportion of residents aged 65 years or older (20.4%). Nelson Marlborough DHB has the fastest *growing* older population, with the proportion increasing from 14.8% in 2006 to 18.6% in 2013.

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, which 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.



Ethnicity

The South Island population has become increasingly ethnically diverse since 2006. The proportion of the population that identify as Maori 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 identify 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.

Families

There has been no 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).

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

16%
of South Island residents are aged 65+, up from 14% in 2006

Fastest growing
65+ population of any South Island DHB is Nelson Marlborough

24.6%
of South Island residents are aged 25-44, down from 27.2% in 2006. This represents 16,400 fewer 25-44 year olds

8.7%
of South Island residents identify as Maori, a 1% increase since 2006

2.2%
of South Island residents identify as a pacific Island ethnicity, a 1.9% increase since 2006

5.5%
of South Island residents identify as an Asian ethnicity, a 4.3% increase since 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 19.9% in 2006

3.2 The South Island Māori Population

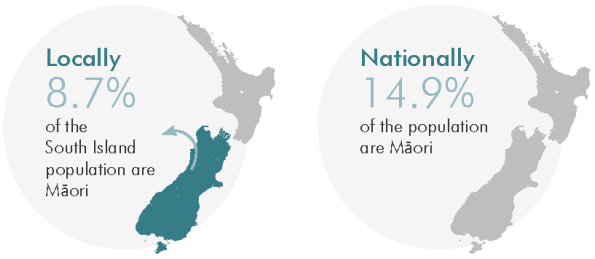
The South Island MĀORI POPULATION

The graphs and figures on these pages present key data from the 2013 Census.

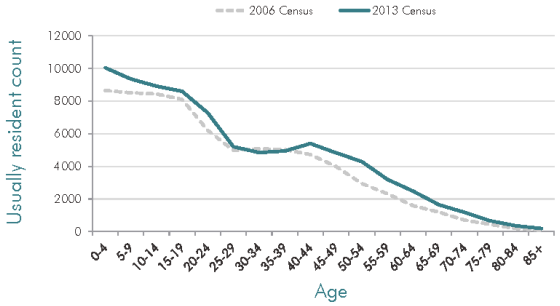
Socioeconomic deprivation, employment, income, qualifications, home ownership, household crowding, and cigarette smoking all affect people's health and are often referred to as 'broader determinants of health'. Collectively, these determinants have a greater impact on the health of a population than the health system itself.

Māori generally have poorer health status than non-Māori. This health inequity can be partly attributed to the differences in access or exposure to the broader determinants of health illustrated in this document. Monitoring these differences is the first step towards addressing them.

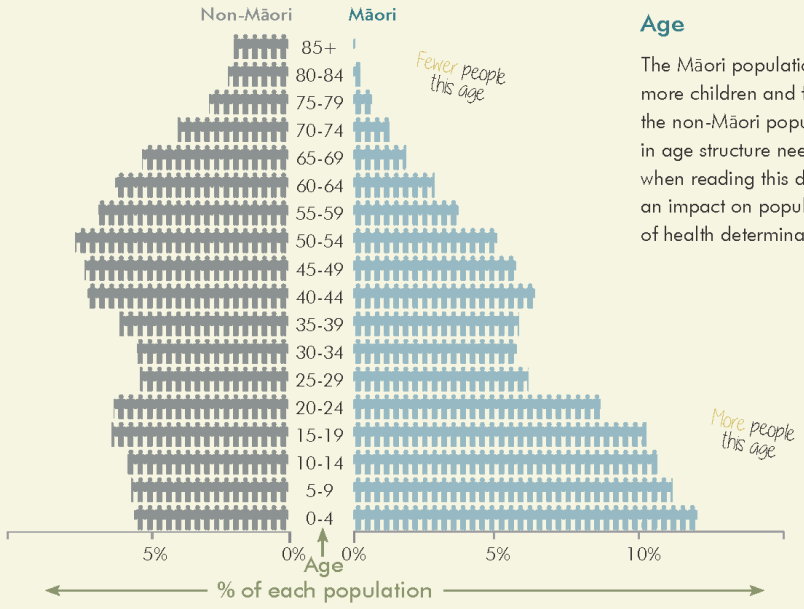
South Island DHBs each have a Māori Health Action Plan and a Public Health Plan, which are companion documents to the Annual Plan. These documents set out key actions and performance measures to improve population health and reduce inequities, including work to influence the broader determinants of health.



South Island Māori usually resident count
2006 & 2013



South Island DHBs population age structure



Age

The Māori population has proportionately more children and fewer older people than the non-Māori population. This difference in age structure needs to be considered when reading this document, as age has an impact on population-based measures of health determinants.

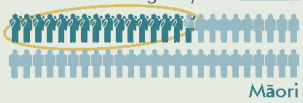
SOUTH ISLAND ALLIANCE
best for people, best for system

The South Island MĀORI POPULATION

Smoking

Smoking is the single biggest preventable cause of illness and death in New Zealand. While rates are slowly decreasing, there is a long way to go before New Zealand achieves the 2025 smoke free goal (less than 5% smokers).

30.6%
of Māori smoke regularly[1]



Māori

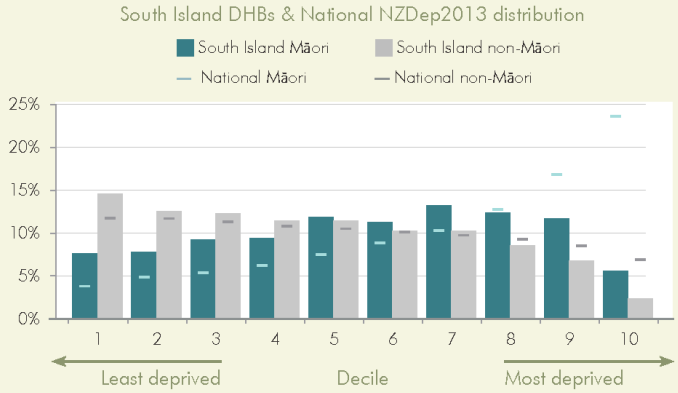
13.8%
of non-Māori smoke regularly[1]

non-Māori

Nationally, 32.7% of Māori and 12.6% of non-Māori smoke regularly [1]

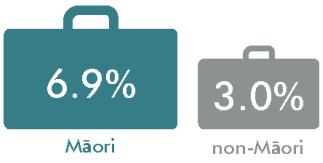
Deprivation

Māori are more likely to live in deprived[3] areas than non-Māori. 54.1% of South Island Māori live in deciles 6-10 compared to 37.9% of South Island non-Māori.



Unemployment

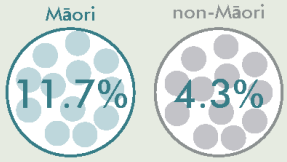
The Māori unemployment rate is more than two times that of non-Māori.[1]



Nationally, the unemployment rate for Māori is 10.4% and for non-Māori is 4.0%[1]

Household crowding

Living in a crowded house is proven to increase the risk of catching and spreading serious infectious diseases.[4]

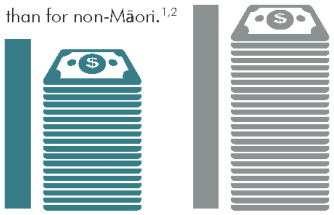


Māori are nearly three times as likely to live in crowded households.

Nationally, 20.0% of Māori and 7.9% of non-Māori live in crowded homes

Income

Median income for Māori is several thousand dollars less than for non-Māori.[1,2]



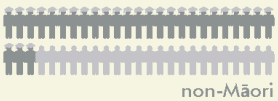
Nationally, median income for Māori is $22,500 and for non-Māori is $29,400 [1,2]

School qualifications

43.4%
of Māori have a Level 3 Certificate at school or above[5]

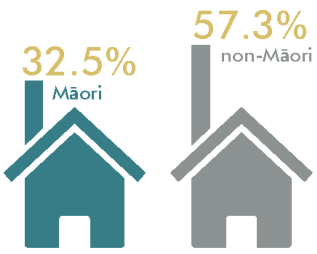
Māori

56.3%
of non-Māori have a Level 3 Certificate at school or above[5]



non-Māori

Nationally, 41.6% of Māori and 61.4% of non-Māori have a Level 3 certificate or above[5]



Home ownership

Rates of home ownership have been falling in NZ since 1991. Māori are less likely to own, or partly own, their homes than non-Māori.[1]

Nationally, 28.2% of Māori and 53.3% of non-Māori own, or partly own, their homes[1]

[1] *Aged 15 years and over.*

[2] *Median income is generally a better measure than average income because income data is heavily skewed; a small number of people have very high incomes compared to the majority. Therefore median income gives a better idea of the majority of people's actual income.*

[3] *The New Zealand Deprivation Index uses census data on personal and household income, employment, qualifications, home ownership, single parent families, household crowding, and access to a car and the internet at home, to attribute a deprivation level to small geographical areas, on a scale from 1 (least deprived), to 10 (most deprived).*

[4] *Taking into account the number of bedrooms, couples, single adults and the age and gender of children.*

[5] *Aged 20 years and over.*

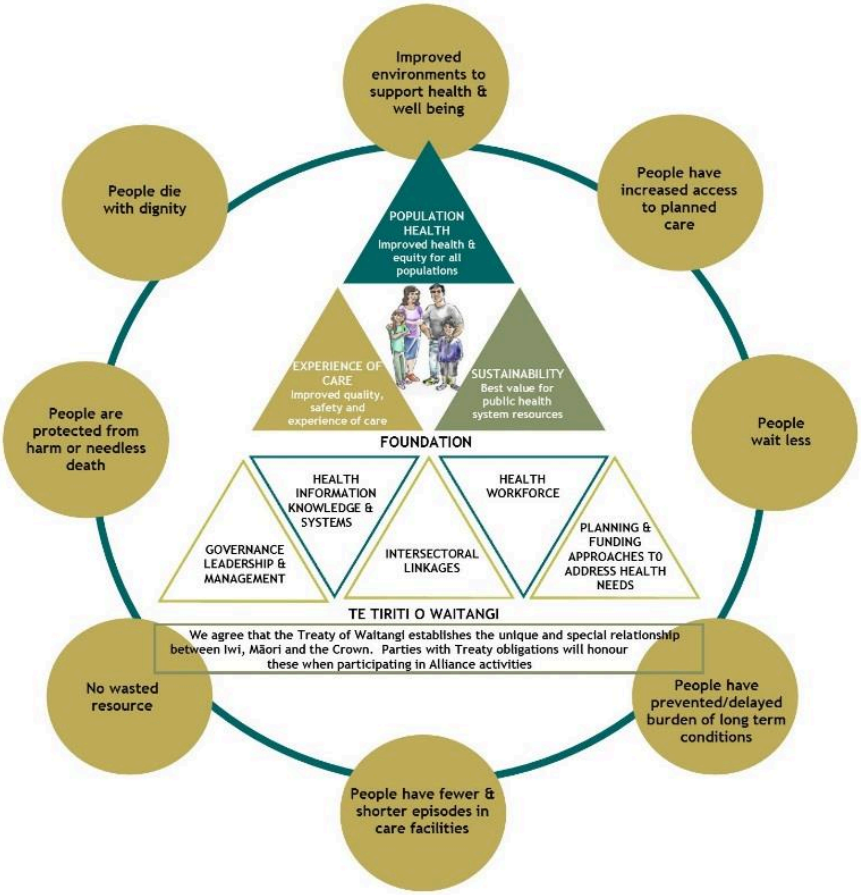
Data source: Statistics New Zealand.
The 'Not Elsewhere Included' ethnicity category (5.4%) was excluded from all calculations.

4 IMPROVING HEALTH OUTCOMES FOR OUR POPULATION

4.1 What are we trying to achieve?

Our health system is complex and continues to experience multiple challenges. Current challenges include: increasing patient complexity, increasing technology, a call for increased efficiency, transparency and accountability from society, changes in social demographics, and workforce shortages. To achieve integrated and coordinated care we need to support an environment that creates connectivity, alignment and collaboration within and between all parts of the health system and other related sectors.

The health sector is expected to deliver services that will achieve the vision of the New Zealand Health Strategy: *live well, stay well, get well* and to meet Government commitments to deliver '*better, sooner, more convenient health services*'.



To ensure we are aligned with this direction and to drive our activities, the South Island's strategic framework identifies three strategic goals and eight collective outcomes that tell us what success looks like as a region.

The Alliance has developed a set of measures to track performance and demonstrate whether collectively, we are progressing towards our long term strategic goals and making a positive change in the health of the South Island populations.

There is no single measure that can demonstrate the impact of health services (or separate the impact of various health services), 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.

Long-term outcome indicators over 5-10 years in the life of the health system will measure change in health status over time, rather than reach a fixed target. A set of medium-term (3-5 years) indicators will be the primary means of gauging performance as change will be more evident in these.

These measures will be integrated into our planning and reporting in 2016-17.

4.2 How the Outcomes Framework aligns with service priorities

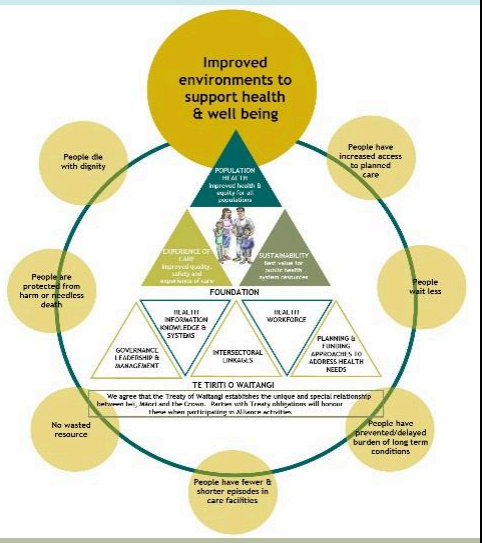
This section outlines why each of the eight collective outcomes is a priority for South Island health services, what activities the Alliance is undertaking to support each outcome, and how we intend to track progress. Further detail of the actions and deliverables can be found in the workplans in Appendix 4. Each of the priority areas that is supported by a Service Level Alliance or a workstream undertakes an annual work plan, with deliverables aligned to the South Island Outcomes Framework and national requirements.

Outcome 1: Improved environments to support health and wellbeing

Why is this outcome a priority?

Health promotion and disease prevention contribute to improved health status and reduction of health inequalities, as well as reducing demand for healthcare services.

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 avoid, delay or reduce the impact of long-term conditions.



What actions are we taking to address this outcome?

Public Health

Health determinants

- Develop consistent South Island approaches to address: water fluoridation; air quality and warm homes; and sweetened drinks
- Contribute to the Alcohol Harm Reduction Emergency Department Project
- Identify coordinated regional opportunities to promote healthy eating and active lifestyles

Environmental Sustainability

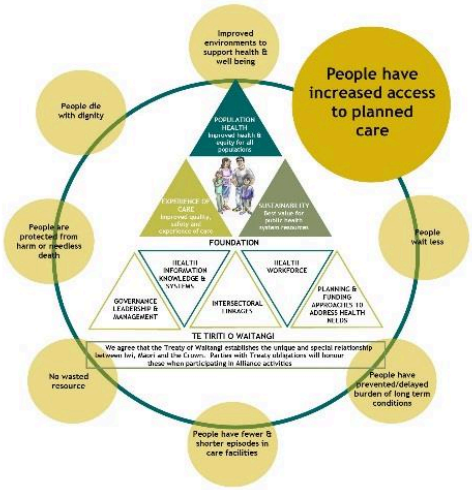
- Promotion of consistent environmental sustainability monitoring systems
- Develop a South Island approach to environmental sustainability

Outcome 2: People have increased access to planned care

Why is this outcome a priority?

Improving access to planned care, rather than emergency care, is important for patients. By providing planned access to services, people suffering from health conditions can get better, timelier care; allowing them to regain their quality of life sooner. This may also allow people to resume or maintain their productive contribution to the community.

In personalised care planning, clinicians and patients work together using a collaborative process of shared decision-making to agree goals, identify support needs, develop and implement action plans, and monitor progress. This is a continuous process, not a one-off event.



What actions are we taking to address this outcome?

Cardiac Services

Improved outcomes for people with suspected acute coronary syndrome

- Support access to angiography for high risk populations groups

Electives Services

Improve access to elective services

- Improved equity of access to elective services – in particular, bariatric surgery, urology, infertility, plastics services, vascular services, eye services and maxillofacial services

Cancer Services

People get timely access across the whole cancer pathway

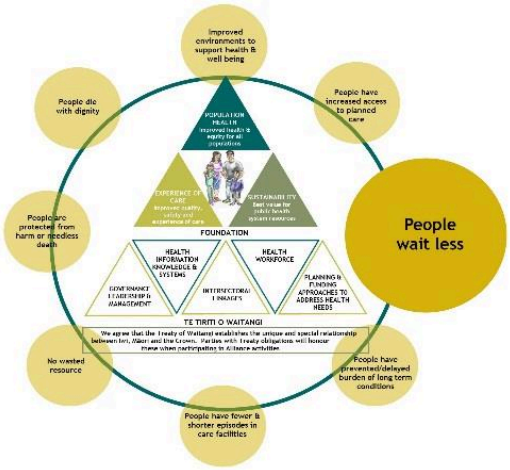
- Supporting the South Island-wide review of services against national tumour standards, with a focus on supportive care, palliative care and equity
- Multi-disciplinary meetings (MDMs) rolled out across the region, supporting quality decision making and a coordinated, planned approach to care
- Routes to Diagnosis project to understand how people are accessing cancer services. The initial focus is on those who first present through ED

Outcome 3: People wait less

Why is this outcome a priority?

Delayed access to medical care may subject patients to increased pain, suffering, and mental anguish. Waiting for healthcare can also have broader economic consequences, such as increased absenteeism, reduced productivity, and reduced ability to work. The individual waiting is affected, as well as family members and friends who are concerned or may be called to assist them with activities of daily living. Waiting may also lead to poorer care outcomes and a requirement for more complex treatments as a result of deterioration in the patients' condition while waiting for treatment.

Health services must value people's time. By looking at the how, where, when and who of care provision and looking at it from the patient's perspective, we can remove barriers and make the system more integrated. This focus improves quality and efficiencies and supports our '*best for people, best for system'* approach.



What actions are we taking to address this outcome?

Cardiac Services

- Implement an agreed cardiac model of care to ensure all patients get consistent, timely care

Cancer Services

People get timely services across the whole cancer pathway

- Working with DHBs to understand barriers to achieving the Faster Cancer Treatment health target and overcoming these

Information Services

South Island Patient Information Care System (SI PICS)

- Supporting the implementation of SI PICS in Canterbury and Nelson Marlborough DHB sites
- Preparing for implementation of SI PICS in other DHBs *Emergency Department Information Solution*
- Provide a regional solution to support visibility of ED activity

eReferrals

- Implement a regional eTriage module in Health Connect South that provides the electronic triage functionality

Stroke Services

Ensure rapid access to treatment for potential thrombolysis candidates

- Each South Island DHB has a system to rapidly confirm a diagnosis of stroke and identify patients who may benefit from thrombolysis therapy
- Support all South Island DHBs to implement stroke thrombolysis pathways

Support Services

- Facilitate and review regional inter-hospital transfer agreement with St John that improves efficiency and service for patients and hospitals

Workforce Development Hub

- Implementation of allied health assistants Level 3 training to up-skill and increase flexibility of the workforce
- Support flexibility and integration in the workforce by introducing a regional clinical allied health leadership role
- Implement a workforce redesign and delegation model (Calderdale Framework) to enable allied health professionals to skill share across professions and safely delegate to kaiawhina (allied health assistants)

Major Trauma

A planned and consistent approach to major trauma services

- Implement agreed regional and local trauma systems

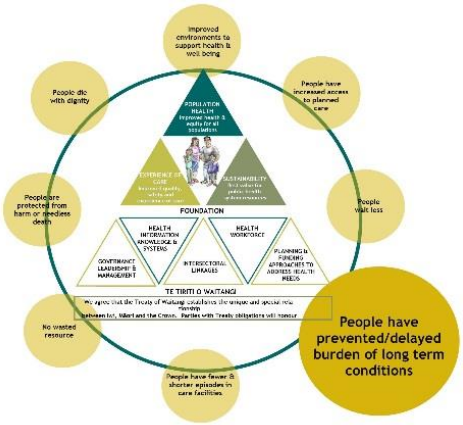
Elective Services

- Supporting DHBs to meet ESPI indicators

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

Why is this outcome a priority?

Chronic diseases are now the most common cause of death and disability. People with chronic diseases tend to be high users of healthcare resources and social care. The prevalence of long-term conditions rises with age and many older people have more than one chronic condition.



The World Health Organisation (WHO) estimates more than 70 per cent of all health funding is spent on long-term conditions. As our population ages, the incidence and burden of long-term conditions increases. Long-term conditions are also more prevalent amongst Māori and Pacific people and are closely associated with significant disparities in health outcomes across population groups.

It is now widely recognised that the care and support needed to live with a long-term condition requires a radical re-design of services, allowing patients to drive the care planning process. By intervening early, and with improved coordination and proactive provision of care, people, families and whānau with complex conditions have improved health outcomes. This supports people to stay well and maintain their functional independence.

What actions are we taking to address this outcome?

Stroke Services

Rapid access to treatment for potential thrombolysis candidates

- Each South Island DHB has a system to rapidly confirm a diagnosis of stroke and identify patients who may benefit from thrombolysis therapy and this system is implemented in each South Island DHB
- Implement stroke thrombolysis pathways
- Optimise outcomes for all patients with stroke in rural and urban locations

Integrated Stroke Rehabilitation Services

- Community stroke rehabilitation is available to aid adjustment and minimise complications

Health of Older People

Dementia services

- A Cognitive Impairment Pathway (CIP) will be promoted for adoption across all South Island DHBs
- Improved services for people with dementia by implementing the *New Zealand Framework for Dementia Care* in the South Island
- Develop appropriate dementia education/training materials for South Island primary healthcare person-centred care

Restorative Consensus Statements

- Development of evidence-based statements to help guide service providers and consumers

Child Health

Interventions to reduce hospital admissions

- Implement a South Island Health Pathway for dermatitis and eczema
- Increase GP training on dermatitis and eczema

A regional integrated healthy weight (obesity) management programme

- Develop a regional integrated healthy weight (obesity) management programme
- Enhance collaboration with child dental health services

Cancer Services

- Working with primary care to increase the timely identification of melanoma and reduce unnecessary removal of lesions
- Improve the uptake of cervical screening among Maori women

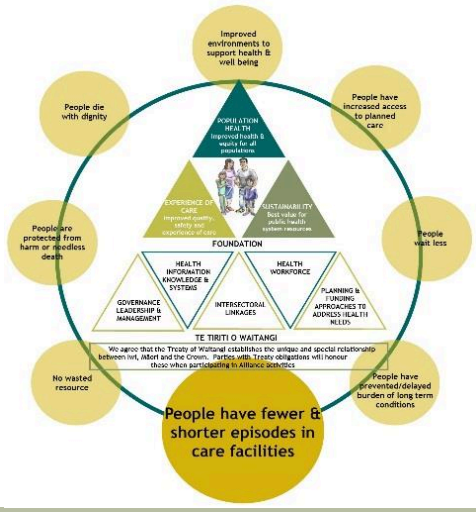
Outcome 5: People have fewer and shorter episodes in care facilities

Why is this outcome a priority?

Reducing the length of stay in healthcare facilities will release capacity in the system, including beds and staff time, which helps to minimise waiting times, maximise productivity and improve the patient experience.

Advancements in medical and health technology have enabled the population to live longer. However, more people are living with co-morbidities and need complex care interventions. We know that investing in community services and the community workforce will help to deliver positive health outcomes and free hospitals to provide more acute and specialised care.

This approach also reduces average hospital length of stay, increases patient choice and satisfaction, improves health outcomes, reduces unscheduled healthcare use, embraces prevention and health promotion models, delivers care closer to people's homes and saves money.



What actions are we taking to address this outcome?

Cardiac Services

Heart failure

- Implement agreed protocols to ensure optimal management of patients with heart failure

Major Trauma

Improve the pathway for patients with major trauma

- Develop and implement regional destination policies in collaboration with DHBs, ambulance, and air transport providers
- Gain understanding of major trauma patient pathways by implementing a national major trauma registry

Health of Older People

Comprehensive clinical assessment (interRAI)

- Comprehensive clinical assessment using a standardised assessment tool (interRAI) facilitating a system-wide approach to common assessment
- Monitor population and service data trend to influence changes in service through advocacy

Child Health

Reduce hospital admissions

- Strengthen models of care within primary care – right place, right time, right service

Diabetes

- Establish a South Island Diabetes Working Group to improve systems across South Island for young people with Diabetes, in particular Type 1

Mental Health and Addiction

Access to youth forensic services

- Development of community youth forensic services.

Mental health and intellectual disability dual diagnosis

- Identify options to support consumers with mental health and intellectual disability dual diagnosis who are inappropriately placed.

Forensic services

- Improved adult forensic service capacity and responsiveness.

Access to mental health services

- Monitor and support ongoing improvements in the regional provision of eating disorder services, mothers and babies' services, and alcohol and other drug services

Quality and Safety

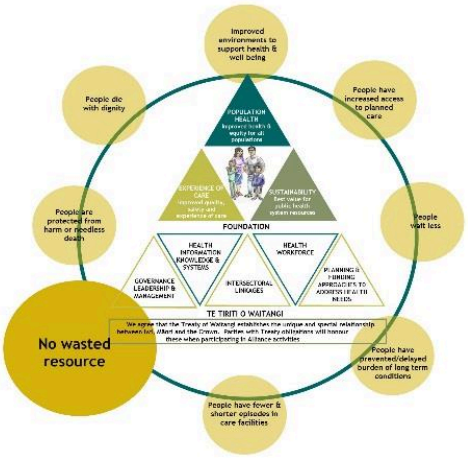
- Reduce complications resulting from being in hospital through ongoing quality and safety initiatives, such as improved hand hygiene and prevention of surgical site infections

Outcome 6: No wasted resource

Why is this outcome a priority?

We have an obligation to provide health services in the most efficient way possible, so patients receive timely access to the most appropriate care, in the most appropriate place. It's about getting the greatest value for our people from the system, enabling evidence to inform how our scarce healthcare dollars are best invested and ensuring people receive the care they need as close to home as possible.

As our population ages, so does our workforce. Alongside the other drivers of change in the health sector, the changing demographics of the workforce will require us to think differently about the way staff are utilised. We need to enable health professionals to work at the top of their scope of practice with the support of an appropriately trained unregulated workforce. We need to build an innovative and flexible workforce that will support the emerging models of healthcare.



What actions are we taking to address this outcome?

Workforce Development Hub

Build capacity of the workforce to work flexibly and efficiently

- Implement a workforce redesign and delegation model (Calderdale Framework) to enable allied health professionals to skill share across professions and safely delegate to Kaiawhina (allied health assistants)
- Facilitate community based attachments for junior doctors (PGY1/2)
- DHBs supported to integrate the increased number of PGY1 (NZ citizens and permanent residents) into the workforce

Workforce Development Hub

eLearning

- Implement a common eLearning platform for the South Island workforce
- Nursing Community of Practice has identified and prioritised a regional suite of eLearning packages

Interprofessional

- Increase opportunities for inter-professional learning in a clinical environment

Cardiac Services

ECG storage and sharing

- A common regional method of storing and sharing ECGs

Information Services

HealthOne

- Complete the roll-out of HealthOne to SDHB
- Complete the roll-out of HealthOne to the Marlborough PHO (NMDHB)

Support Services

Procurement and savings

- Aggregate procurement requirements and improve purchasing power
- Savings achieved enabling redeployment of funds to appropriate services
- Increased rationalisation and standardisation of products and services

Cancer Services

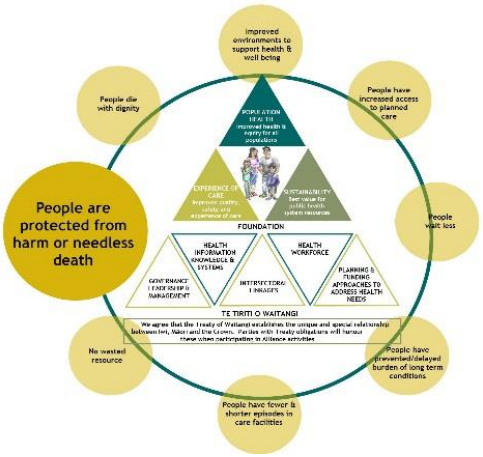
- Using clinical time effectively to support better patient care through Multidisciplinary Meetings
- Working with primary care to promote early diagnosis and care closer to home through the Melanoma project (also reducing unnecessary removal of lesions) and the Route to Diagnosis project

Outcome 7: People are protected from harm or needless death

Why is this outcome a priority?

It is fundamental to health service provision that people receive high quality, safe care and are protected from harm. This is implicit in the high trust relationship between patients and health professionals and is regulated through legislation and professional oversight. As well as the negative impact on patients, adverse events and delays in treatment drive unnecessary costs and redirect resources away from other services.

Quality improvement in systems and processes increase patient safety, reduce the number of events causing injury or harm and improve health outcomes. Our focus on *'best for people, best for system'* places an emphasis on the system of care delivery that prevents errors; learns from the errors that do occur; and is built on a culture of safety that involves healthcare professionals, organisations, and patients.



What actions are we taking to address this outcome?

Child Health

Improve Sudden and Unexpected Death in Infants (SUDI) rates

- Implement the findings of the audit of the SI sudden death in infancy policy

South Island Children's Action Plan

- Agree South Island regional interventions to better manage safety, reduce family violence and childhood poverty

Programmes to reduce youth risk taking

- In partnership with Health Promotion Agency, South Island Public Health Partnership and the Mental Health and Addictions Service Level Alliance, implement the findings of the South Island Emergency Department scoping exercise

Health of Older People

Falls prevention and fracture liaison service

- Development of an evidence based Fracture Liaison Service
- Agree a South Island policy on community based falls prevention programmes based on the evidence of the Otago Exercise Programme

Dementia Services

WiAS programme continues to be expanded in each South Island DHB, reaching a wider range of staff working with people with dementia

Information Services

eMedicines

- SDHB, CDHB, SCDHB ePrescribing and administration project complete
- WCDHB, NMDHB ePrescribing and administration implementation commenced
- Complete the implementation of eMedicines reconciliation within Canterbury DHB and commence implementation planning for remaining South Island DHBs
- Complete the regional implementation by implementing ePharmacy Management within South Canterbury, West Coast, Southern and Nelson Marlborough DHBs

Information Services

Health Connect South

- Complete Southern and Nelson Marlborough DHB's Health Connect South implementation
- Implement a regionally agreed electronic discharge summary
- Develop and pilot a mental health solution

South Island Patient Information Care System (SI PICS)

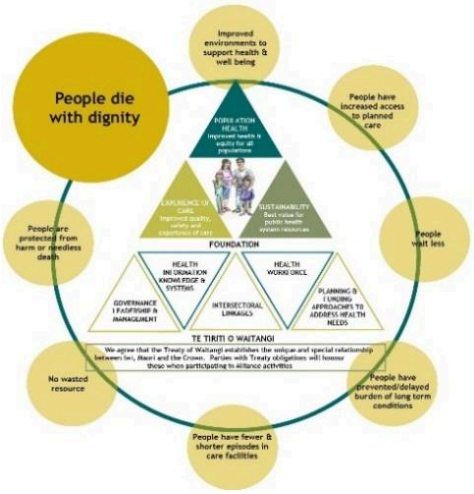
- Supporting the implementation of SI PICS in Canterbury and Nelson Marlborough DHB sites
- Preparing for implementation of SI PICS in other DHBs

Quality and Safety	Workforce Development Hub
Supporting DHBs to make a positive contribution to patient safety and quality of care • Monitor and recommend options for reducing perioperative harm • Supporting consumer involvement in South Island Alliance activity *Incident management and quality improvement* • Roll out Safety 1st, the South Island electronic incident management system, to community care providers	*Clinical simulation* • Clinical simulation is accessible to staff working in the smaller centres and rural areas of the South Island. A coordinated clinical simulation network for the South Island • Lippincott (online evidence based clinical procedures) is introduced to the whole South Island health workforce *Vulnerable workforces* • South Island vulnerable workforces are identified and plans established to mitigate these • Increase the participation of Māori and Pacific people in the clinical workforce
Cancer Services	**Mental Health and Addiction**
• Support the roll out implementation of Psychosocial and Supportive Care Initiative across the South Island • Implementation of electronic Multidisciplinary Meetings solution will reduce existing variation in processes, minimise clinical risk, and improve care co-ordination and timely documentation	*Seclusion and restraint* • Collaboration on seclusion and restraint across South Island DHBs with a specific focus on Māori

Outcome 8: People die with dignity

Why is this outcome a priority?

For many people, end of life is a time of increased interaction with health services and can be a frightening and stressful time for patients and their whānau. While preventing pain and suffering underlies all healthcare and treatment, different people will have different views on what this means in terms of level of medical intervention and what setting they want to be in at the end of their life. It is important that health services support patients to die with dignity by enabling them to understand their options and respecting their needs.



What actions are we taking to address this outcome?

Palliative Care	Health of Older People
Equitable access to an integrated palliative care system • All people who are dying and their family/whānau have access to an equitable and quality palliative care service • Primary care provided with expertise and resources to enable patients to die in their preferred place of care • Consumer participation and decision making about palliative and end of life care	*Advance Care Planning (ACP)* • Develop ACP systems and processes to embed ACP as standard practice for those who will benefit • ACPs are incorporated into the regional information system/plan • South Island DHBs are supported to participate in 'Conversations that Count' (CtC) awareness raising day

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. This approach continues to facilitate the DHBs in working together to jointly solve problems by sharing knowledge and resources with a focus on achieving the best outcomes for the region's population. 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 by the other regions.

South Island Alliance Charter 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 cooperatively, 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.*

5.2 Our governance structure

The South Island 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 Regional Capital Committee (SIA Board and Alliance Leadership Team) that reviews capital investment proposals in accordance with the agreed regional service strategy and planning
- A Strategic Planning and Integration Team (SPaIT) (Clinical and management leaders) that supports an integrated approach, linking the Service Level Alliances (SLA) 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.

5.3 Service Level Alliances (SLA) and workstreams

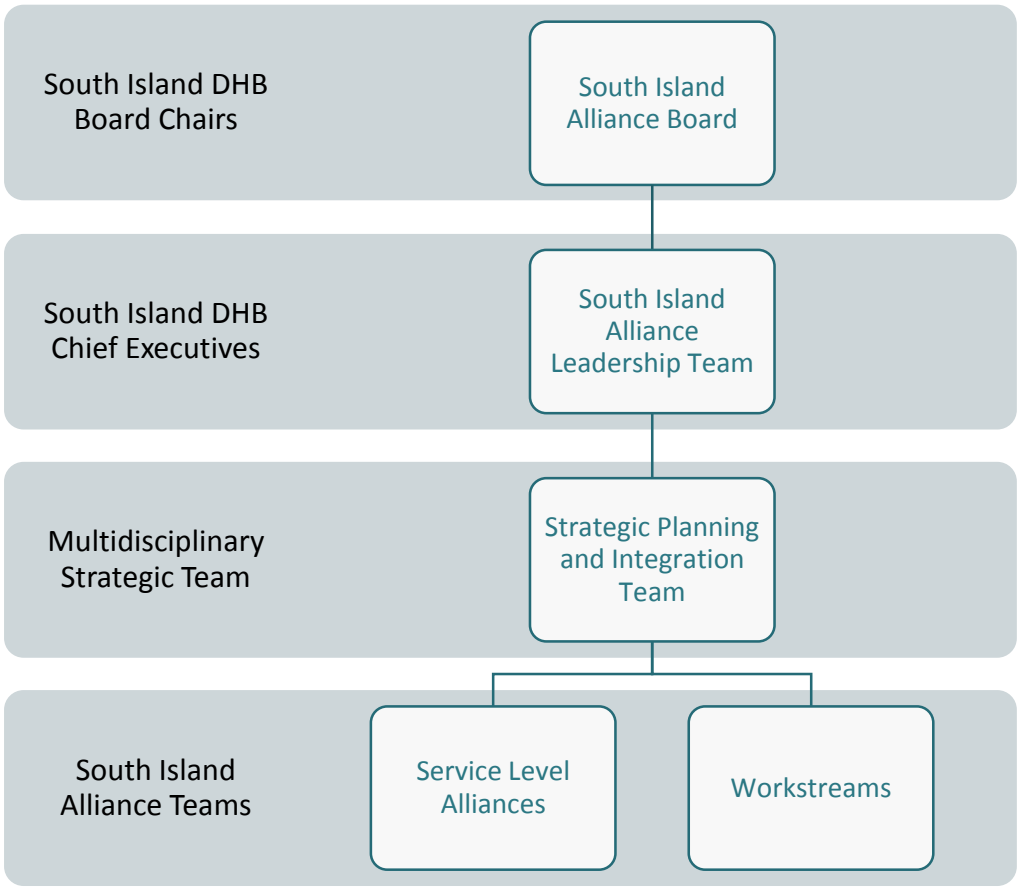
South Island regional activity involves a wide representation of the key stakeholders including health professionals, managers, funders, healthcare providers and consumers. The teams are clinically-led with the exception of the Support Services Service Level Alliance.

A chief executive or senior executive from one of the DHBs sponsors each SLA/workstream to support the team and where necessary help manage risks. Sponsors also provide a point of escalation for the resolution of issues if one of the agreed programmes or projects vary from planned time, cost or scope.

Each Service Level Alliance and Workstream also has a member of the Strategic Planning and Integration Team involved, either as a member or as a link person. This is a new initiative for 2015/16 and the key function for the increased linkage is to provide feedback and guidance on the strategic direction of the group and to understand any proposals / recommendations in order to better support the sign-off process at Strategic Planning and Integration Team and Alliance Leadership Team meetings.

While leadership training and support is provided at a DHB level, the South Island Alliance also supports Chairs and facilitators through the process and specifically at an annual meeting where the direction of the Alliance is discussed and a focussed topic is workshopped.

The SLA/workstream is responsible for overseeing the agreed programme of work, and providing overarching programme and project governance. The work is supported by the staff employed by the South Island Alliance Programme Office.



5.4 Decision making

The South Island Alliance approach to decision making and the process for resolving disputes is detailed in the South Island collective decision making principles (Appendix 2).

The foundation of the South Island Alliance is a commitment to act in good faith to reach consensus decisions on the basis of *'best for people, best for system'*.

It is acknowledged that there may be areas within the scope of the activities of the Alliance where a particular DHB either may wish to, fully or partially, be excluded from the Alliance activities. It is agreed and written into the Charter that each Board will have this option at the time of commencing, however, once agreed, the Board will be bound to operate within the scope and decision making criteria agreed. Any DHB intending to exercise this right will do so in good faith and will consult the other South Island DHBs before exercising this right.

5.4.1 Escalation pathway

The Alliance operates under the following escalation pathway:

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

5.5 Regional funding and approval model

All work undertake by the South Island Alliance must address one or more of the eight outcomes. The region is acutely aware of the fiscal constraints impacting health services and the need to focus on innovation, service integration, improved efficiency and reduced waste to support provision of high quality care. Proposals for regional activity must clearly identify the value proposition for patients and/or the system. The Strategic Planning and Integration Team review all workplans prior to any funding bids.

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

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

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

5.6 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 better manage the issues and challenges the South Island DHBs experience locally, and regionally.

5.6.1 Risks and challenges to South Island health services

Christchurch earthquakes

While the repair and redevelopment is gathering momentum, the capacity of the Canterbury health system will continue to be significantly influenced by the following factors for a number of years:

- Prolonged levels of stress, anxiety and poor living arrangements are exacerbating chronic illness and increasing demand. For example, there has been a sharp increase in demand for mental health services: over the three years to December 2015, there was a 77 percent increase in rural presentations to specialist mental health services and a 60 percent increase in child and youth presentations to community mental health services.
- There continues to be uncertainty about the influx of people into Christchurch. Statistics projections do not appear to fully account for the rebuild population, however spikes in demand are clearly being felt. Between 2011/12 and 2014/15 the census population aged 25-29 increased by 10 percent, but emergency department presentations for this age group increased by 38%. Over the same period there was a 370 percent increase in the number of people from overseas presenting in emergency departments.
- Damage to health infrastructure was extensive, and repair strategies are not simple. Invasive repairs are having to be carried out by relocating and shifting patients and services in and out to repair rooms and buildings. This not only disrupts the continuity of care, but complicates the operating environment and adds additional cost to service delivery. Theatre and bed capacity is reduced and Canterbury DHB is hiring theatres and outsourcing some surgeries to meet demand and delivery expectations.
- Canterbury's situation is further exacerbated by the unanticipated funding interplay between fluctuating population projections and the national population based funding formula. The formula was never designed to deal with the dynamic population shifts and demand being experienced and calculations of deprivation levels are also considered questionable in an environment of rapid migration.

South Island demographics and population shifts

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

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

Vulnerable and small services

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

Financial sustainability

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

Hospital redevelopment

In addition to the significant construction work planned or underway across a number of Canterbury hospital sites and at the Grey Base Hospital in Greymouth, over the next 10 years both Dunedin and Nelson Hospitals will be redeveloped as they are both nearing the end of their economic life and are no longer fit for purpose. Although not driven by natural disaster as in Canterbury, the Dunedin and Nelson Hospital redevelopments will have similar significant financial and capacity consequences for a number of years. Dunedin Hospital, as one of the South Island's larger hospitals and reduced capacity may have an impact on the rest of the region.

5.6.2 Regional collaboration mitigating impacts

Our regional approach will help to support the management of the South Island's risks and challenges. The Service Level Alliance and workstreams we have in place, particularly around workforce issues and information services mitigate some of the risks health services are facing. We continue to build on the alignment of support services, such as human resources and procurement.

To ensure we have a clear understanding of the particular challenges faced by each district, in 2016, the Alliance Leadership Team will hold one of their monthly meetings in each DHB. This will provide the opportunity to discuss what is working well for the host DHB, and get an in-depth understanding of issues that need to be addressed. It is planned that the Strategic Planning and Integration Team and some DHB executive team members also attend. Travelling to each district is a significant commitment and represents the next step in ensuring we collectively understand the risks facing South Island health services and work collaboratively to manage these challenges.

Appendix 1 – Regional Collective Decision Making Principles

South Island collective decision making principles

Decision Making Principles

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

  Key determinants behind whether independent input/mediation/escalation will be used are the relevant group views as to:
  - likelihood of successful resolution of the disagreement in a timely manner; and/or
  - whether time constraints permit delay.

  Where agreement cannot be reached, the parties will document their perspective of the matter to ensure the party or parties to whom the matter has been escalated are fully informed of the difference of views.
- Where independent input or mediation is chosen, the District Health Boards will appoint the independent adviser / mediator by consensus decision. In the event that consensus is not reached the Director General or nominee will be the default mediator.

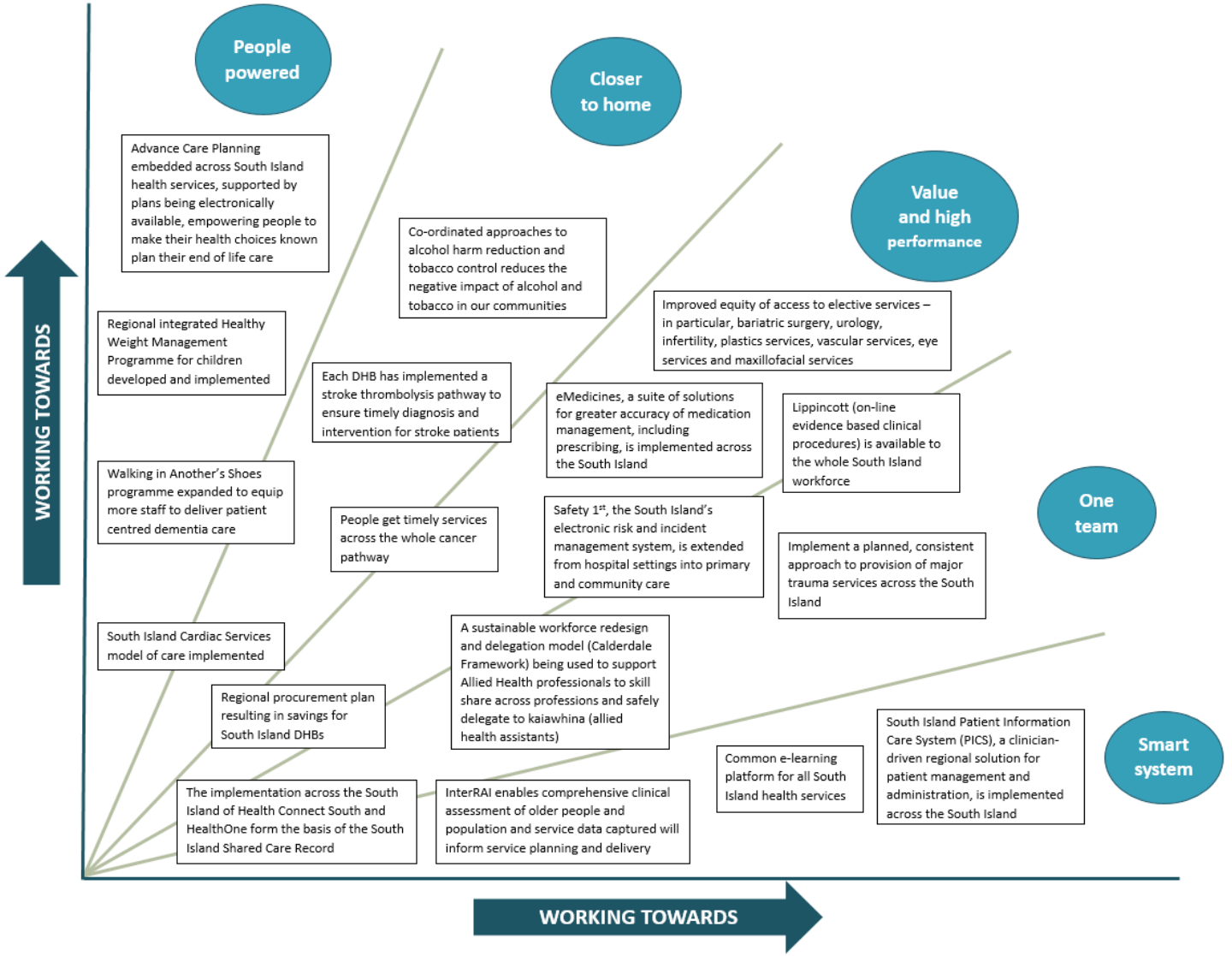
Escalation Pathway

The following is the escalation pathway:

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

Appendix 2 – South Island alignment with draft New Zealand Health Strategy

Similar to the Health Strategy's Roadmap of Actions, this diagram indicates how a small selection of the Alliance's activities support the themes identified in the Health Strategy



Appendix 3 – Minister Letter of Expectation 2016

Office of Hon Dr Jonathan Coleman
Minister of Health
Minister for Sport and Recreation
Member of Parliament for Northcote

22 DEC 2015

Dear

Letter of Expectations for DHBs and Subsidiary Entities 2016/17

The Government is committed to improving the health of New Zealanders and continues to invest in key health services. In Budget 2015 Vote Health received an additional $400 million, the largest share of new funding, demonstrating the Government's on-going commitment to protecting and growing our public health services.

Refreshed New Zealand Health Strategy

It is important that the health sector has a clear and unified direction. The refreshed New Zealand Health Strategy will provide DHBs and the wider sector with this direction, and sets a clear view of the future we want for our health system to ensure that all New Zealanders live well, stay well and get well.

While the Strategy is not yet finalised, DHBs need to be focussed on the critical areas to drive change that come out of the refreshed strategy. The draft covers five themes – people-powered, closer to home, value and high performance, one team, and smart system. The Strategy is supported by a Roadmap of Actions, which sets the direction for the next five years. I am aware that DHBs are already progressing work under some of the themes. I expect that this work will continue and, where possible, be accelerated over the coming year. If you are thinking about new initiatives, these should have a clear link to one or more of the five themes and the outcomes should be able to be clearly linked to the intent of the draft Strategy.

I thank you for your involvement to date in this work and finalised planning expectations will be provided to DHBs in the new year.

Living Within our Means

While the global economic environment continues to be challenging, DHB funding has been increased by around $3 billion over the last seven years. While the health system could always use more resources, DHBs need to budget and operate within allocated funding and must have detailed plans to improve year-on-year financial performance. Your DHB's financial performance is currently tracking to plan for 2015/16. I trust that you will continue to consider where your DHB can make efficiency gains. You and your Board must monitor and hold your Chief Executive accountable against these expectations as keeping to budget allows investment into new and more health initiatives.

Improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs. With the establishment of NZ Health Partnerships Ltd, consistent with the shareholders' agreement, I expect all DHBs to work together to ensure successful implementation of the current programmes and to identify, develop and implement future opportunities.

Working Across Government

Right now, a key focus of Government is vulnerable families. DHBs are already working closely with other social sector organisations to achieve sector goals in relation to the Government's Better Public Services initiatives, and other initiatives, such as Whānau Ora, Social Sector Trials, Prime Minister's Youth Mental Health Project and Healthy Housing. I expect DHBs to continue supporting cross-agency work that delivers outcomes for children and young people. I also expect that DHBs will keep me and the Ministry of Health informed of work they are undertaking with other sector agencies.

In line with this, the cross-government work programme on the Better Public Service Result One: Reducing long-term welfare dependence, is being expanded to include a focus on reducing unintended teenage pregnancies. I expect DHBs to commit to help deliver on this sub-focus in their 2016/17 annual plans.

National Health Targets

All of the national health targets are very important for driving overall hospital performance, and have resulted in major improvements in the health outcomes of New Zealanders. Health target performance continues to improve, but DHBs must remain focussed on achieving and improving performance against the targets, particularly the Faster Cancer Treatment target.

I remain concerned about the overall pace of progress nationally on the Faster Cancer Treatment health target. Locally, has shown good improvement since the target was introduced and this progress needs to continue to ensure that the DHB meets both the current year's goal of 85 percent and the increased goal of 90 percent by June 2017. Faster cancer treatment is a significant priority for the Government with almost $63 million invested over the last seven years to deliver better, faster cancer care. Please ensure delivery of this health target is a priority for your DHB.

Tackling Obesity

A key focus area for 2016/17 will be actions to reduce the incidence of obesity. The Childhood Obesity package of initiatives aims to prevent and manage obesity in children and young people up to 18 years of age, and includes a number of cross-agency activities. The core of the plan is the new childhood obesity health target, which is: by December 2017, 95 percent of obese children identified in the B4 School Check programme will be referred to a health professional for clinical assessment and other interventions.

I expect all DHBs to continue to show leadership in this area and to deliver on the new health target, and to identify other appropriate activities they can undertake to help reduce the incidence of obesity.

Shifting and Integrating Services

Integrating primary care with other parts of the health service is vital for better management of long-term conditions, mental health, an aging population and patients in general. The pathways to achieve better co-ordinated health and social services need to be developed and supported by clinical leaders in both community and hospital settings. I expect DHBs to continue to move services closer to home in 2016/17, and DHBs need to have clear evidence of how they plan to do this.

Health IT Programme 2015-2020

Health information systems have a crucial role to play to make the health system more sustainable, and to improve productivity, efficiency, and health outcomes. The Health IT

Programme 2015–2020 begins with a design phase over the next nine months and I expect DHB, PHO and primary care representatives to be part of the co-design process. Meanwhile, DHBs will need to complete current regional and national IT investments, such as the foundation programmes currently under way.

Please note that all DHBs must refresh their statements of intent (SOIs) for tabling in 2016/17 to reflect the key priority areas outlined above, and a health equity focus, and build these SOIs into their annual plans.

Keep in mind that the Budget 2016 process will clarify the priorities outlined in this letter and other Government priorities, and more information will be provided when available. Please share this letter with your clinical leaders and local primary care networks.

Finally, please note that the provisions of the Enduring Letter of Expectations continue to apply. The Letter can be accessed on the State Services Commission's website.

I would like to thank you, your staff, and your Board for your continued commitment to delivering quality health care to your population. I look forward to seeing your achievements throughout 2016/17.

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

Appendix 4 – Service Performance Priorities 2016-2019

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.

Note – all workplans are tentative pending budgeting and resourcing decisions.

Clinical Services: Sustainability and Clinical Integration

Cancer services

Reducing the burden of cancer

Lead CEO:	**David Meates (Canterbury DHB)**
Chair:	**Dr Steve Gibbons, Consultant Haematologist (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 New Zealand Cancer 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.

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

- South Island Faster Cancer Treatment
- South Island Cancer Service Coordination and Quality Improvement: Ensure 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 Cancer Service reducing inequalities
- 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
- Southern Cancer Network Support For National Projects: Ensure the tumour standards continue to promote quality of care and guide uniform standards of service provision across DHBs.

MILESTONES DASHBOARD 2016-19					
ITEM NO	DELIVERABLE 2016-2017	APPROVED SCHEDULE	DELIVERABLE 2017-2018	DELIVERABLE 2018-2019	RESPONSIBILITIES
CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION					
Southern Cancer Network					
SOUTH ISLAND FASTER CANCER TREATMENT **People get timely services across the whole cancer pathway (screening, detection, diagnosis, treatment and management, palliative care)**					
Achieving the Faster Cancer Treatment Health Target & improved or maintained performance against the Policy Priority (PP30) Faster Cancer Treatment Indicators					
1	Support DHBs to deliver the extended FCT target of 'At least 90% of patients receive their first treatment within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks by July 2016'	Q1, Q2, Q3, Q4	ongoing	ongoing	Contributors: SCN coordinate and support the process in collaboration with the DHBs Reported in: SIHSP
2	Continue to support the maintenance or improvement of the 31 day indicator: proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment within 31 days (85% target for PP30 31 day indicator)	Q1, Q2, Q3, Q4	ongoing	ongoing	Contributors: SCN coordinate and support the process in collaboration with the DHBs Reported in: SIHSP
3	Support DHBs with undertaking and delivering the FCT Round 2 Funded Projects	Q1, Q2, Q3, Q4	ongoing	ongoing	Contributors: SCN coordinate and support the process in collaboration with the DHBs Reported in: SIHSP
4	Undertake a focused review to understand the 'Route to Service Access/Diagnosis' for all SI cancer patients, with a focus on first presentation through ED	Q2, Q4	ongoing		SCN supported by DHBs
Maintaining the National radiotherapy and chemotherapy waiting time targets					
5	Maintain oversight of delivery of the National radiotherapy and chemotherapy waiting time targets: all patients, ready for treatment, wait less than 4 weeks for radiotherapy and chemotherapy	Q1, Q2, Q3, Q4	ongoing	ongoing	SCN supported by DHBs
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**					
The national tumour standards of service provision are implemented					
6	Support the South Island-wide reviews of services against national tumour standard for 2 further tumour areas	Q2, Q4	ongoing	ongoing	Contributors: SCN coordinate and support the process in collaboration with the DHBs Reported in: SIHSP
7	Disseminate findings of audits undertaken in 2015-16	Q2, Q4	2 further tumour site audits will be undertaken	2 further tumour site audits will be undertaken	Contributors: SCN coordinate and support the process in collaboration with the DHBs Reported in: SIHSP

MILESTONES DASHBOARD 2016-19					
ITEM NO	DELIVERABLE 2016-2017	APPROVED SCHEDULE	DELIVERABLE 2017-2018	DELIVERABLE 2018-2019	RESPONSIBILITIES
8	Supporting DHBs and Alliance teams work collaboratively in preparation for the introduction of a national bowel screening programme (tbc)	Q4	ongoing	ongoing	Contributors: SCN coordinate and support the process in collaboration with the DHBs Reported in: SIHSP
9	Support DHBs to implement national prostate referral guidelines through the sharing of available information and data and working regional to address issues as they arise	Q4			Contributors: SCN as required Reported in: SIHSP as required
Improved functionality and coverage of MDMs across the region					
10	Implement and rollout the regionally agreed MDT recommendations and service improvement initiatives started in 2015-16 (subject to funding)	Q1, Q2, Q3, Q4	ongoing	ongoing	Contributors: SCN & SI DHBs Reported in: SIHSP
11	Promote and implement the integration of FCT within the functionality and remit of MDTs	Q1, Q2, Q3, Q4	ongoing	ongoing	Contributors: SCN & SI DHBs Reported in: SIHSP
Initiatives to understand and harmonise medical and radiation oncology services					
12	Review and evaluate the heterogeneity of practice within radiation oncology, and optimal use of radiotherapy across the South Island (subject to available resources)	Q4	For 2017-18 focus may be medical oncology	Too early to indicate at this time	Contributors: SCN & SI DHBs Reported in: SIHSP
Progress and enhance the SCN organisational infrastructure within the South Island Alliance					
13	Undertake an annual assessment of the Cancer Clinical Priorities, through the South Island/SCN Cancer Clinical Leads Group	Q2, Q4	Too early to indicate at this time	Too early to indicate at this time	Contributors: SCN & SI DHBs Reported in: SIHSP
SOUTH ISLAND CANCER SERVICE REDUCING INEQUITIES People have access to services that maintain good health and independence and receive excellent services wherever they are. Services make the best use of available resources					
Initiatives that reduce inequalities and support access to cancer services					
14	Improved understanding and collection of ethnicity data cross the whole health spectrum	Q2, Q4	ongoing	ongoing	Contributors: SCN & SI DHBs Reported in: SIHSP
15	Support the rollout of the Maori Cancer Pathways Project across the South Island	Q1, Q2, Q3, Q4	ongoing	ongoing	Contributors: SCN & SI DHBs Reported in: SIHSP
16	Review and develop a plan to increase the uptake of cervical screening among young Maori (Te Waipounamu Maori Leadership Group (TWMLG) Priority area)	Q1, Q2, Q3, Q4	ongoing	ongoing	Contributors: SCN & SI DHBs Reported in: SIHSP, Maori Health Plans
17	Support a Maori Awareness Hui in the SI with the TWMLG (to be confirmed)	Q4	Will depend on priorities for Maori Cancer Health	Will depend on priorities for Maori Cancer Health	SCN
18	Support the rollout and implementation of the Psychosocial and Supportive Care Initiative across the South Island, and assess early findings	Q1, Q2, Q3, Q4	ongoing	ongoing	Contributors: SCN & SI DHBs Reported in: SIHSP

MILESTONES DASHBOARD 2016-19					
ITEM NO	DELIVERABLE 2016-2017	APPROVED SCHEDULE	DELIVERABLE 2017-2018	DELIVERABLE 2018-2019	RESPONSIBILITIES
SOUTH ISLAND CLINICAL CANCER INFORMATION SYSTEM **Support the implementation of the NZ Cancer Health Information strategy, Ready access to timely, accurate and appropriate cancer data and information across the SI for all Stakeholders,**					
Implementation of the South Island Clinical Cancer Information Service (SICCIS): Robust cancer data and information sources are developed and shared that enable informed service development & planning decision-making					
19	Develop a plan to support and implement the NZ Cancer health Information Strategy across the SI	Q1, Q2, Q3, Q4	ongoing	ongoing	Contributors: SCN & SI DHBs Reported in: SIHSP
20	Produce and further develop a Quarterly Cancer Dashboard to understand progress against cancer standards and targets, and to identify areas for service improvement	Q1, Q2, Q3, Q4	ongoing	ongoing	Contributors: SCN & SI DHBs Reported in: SIHSP

Child Health services

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

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

Clinical Lead: **David Barker, Paediatrician (Southern 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.

Six 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 Ministers youth Mental Health project
- Access to Child Health Services - supporting innovation, good practice and equity
- Successful Transition into Healthy Adulthood for Children with Lifelong Health Conditions
- To adequately address the Challenges of Behavioural Problems in Children and Young People
- Consumer Consultation

MILESTONES DASHBOARD 2016-19					
ITEM NO	**DELIVERABLE 2016-2017**	**APPROVED SCHEDULE**	**DELIVERABLE 2017-2018**	**DELIVERABLE 2018-2019**	**RESPONSIBILITIES**
CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION					
CHILD HEALTH SERVICES					
ACCESS TO CHILD HEALTH SERVICES					
A regional integrated obesity management programme					
1a	Develop regional integrated Healthy Weight management programme	Q4	Ongoing monitoring and evaluation of programme	Ongoing monitoring and evaluation of programme	Contributors: SI Child Health SLA, SI PHP Reported in: SIHSP (CDHB lead - dependent on funding)
1b	Work with DHBs to align Childhood Healthy Weight Program with the Ministry of Health child obesity health target				
1c	Enhance collaboration with child dental health services				
1d	Maintain awareness of the healthy family initiatives in Heathcote Spreydon and Invercargill				

MILESTONES DASHBOARD 2016-19					
ITEM NO	**DELIVERABLE 2016-2017**	**APPROVED SCHEDULE**	**DELIVERABLE 2017-2018**	**DELIVERABLE 2018-2019**	**RESPONSIBILITIES**
2	Agree approach and implement Electronic Growth chart to record growth from birth	Q4			Contributors: SI Child Health SLA, SI IS SLA Reported in: SIHSP
YOUNG PERSONS HEALTH - responding to the Prime Ministers Youth Mental Health project					
Support programmes which reduce youth risk taking resulting in injury/disease from smoking, alcohol, drug and sexual diseases					
3a	In partnership with Health Promotion Agency, SI Public Health Partnership and SI Mental Health and Addictions SLA, implement recommendations of SI ED scoping exercise (subject to funding)	Q3	Implementation of agreed findings Continuous evaluation of mechanisms in place	Implementation of agreed findings Continuous evaluation of mechanisms in place	Contributors: SI Child Health SLA, MHSLA, SI PHP, HPA Reported in: SIHSP
3b	Support DHBs to implement the Ministry of Health's Sexual and Reproductive Health Action Plan 2016 - 2016 (once finalised) as it relates to teen pregnancy.	Q4	Implementation of agreed outcomes	Implementation of agreed outcomes	Contributors: SI Child Health SLA Reported in: SIHSP
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)					
4a	Support the SI DHBs to understand and respond to information reported from e-Prosafe	Q4			SI Child Health SLA
4b	Identify and monitor the implementation of agreed South Island regional interventions to better manage safety, reduce family violence and reduce childhood poverty.	Q4	Continuous evaluation of outcomes	Continuous evaluation of outcomes	Contributor: SI Child Health SLA, SI PHP Reported in: SIHSP
Regional Sudden and Unexpected Death in Infants (SUDI) rates continue to trend downwards					
5	Implement the findings of the audit of the SI sudden death in infancy policy	Q4	Ongoing monitoring and evaluation of audit outcomes	Ongoing monitoring and evaluation of audit outcomes	Contributors: SI Child Health SLA 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					
6	Support the SI Diabetes Working Group to implement the areas of work identified in their workplan, including understanding of the current delivery of services and resources to Type 1 Diabetic consumers	Q4	Implement findings of Working Group	Review further and implement findings of Working Group	Contributors: SI Child Health SLA, Child Health SLA Diabetes Working Group Reported in: SIHSP
7	Interventions to embed a downward trend in avoidable hospital admissions for children with Dermatitis and Eczema	Q3	Ongoing monitoring of hospital admission rates and ED presentations	Ongoing monitoring of hospital admission rates and ED presentations	Contributors: SI Child Health SLA Reported in: SIHSP
8	Understand the triage process of paediatric non-acute referrals from primary to secondary care in each SI DHB to provide better integrated care so that children can receive the most appropriate services, in the right setting in a timely way to improve overall health outcomes	Q4	Continuous evaluation of triage process	Continuous evaluation of triage process	Contributors: SI Child Health SLA Reported in: SIHSP
ADDRESS THE CHALLENGES OF BEHAVIOURAL PROBLEMS IN CHILDREN AND YOUNG PEOPLE					
Strengthen models of care within primary care Right place Right time Right Service					
9	Develop a South Island under 5 behavioural pathway (to be confirmed)	Q4	To be decided	To be decided	Contributors: SI Child Health SLA Reported in: SIHSP

MILESTONES DASHBOARD 2016-19					
ITEM NO	DELIVERABLE 2016-2017	APPROVED SCHEDULE	DELIVERABLE 2017-2018	DELIVERABLE 2018-2019	RESPONSIBILITIES
CONSUMER CONSULTATION					
To include children, young people and whanau in the planning , delivery and evaluation of health services					
10	Develop a child/youth/parent/caregiver survey that can be used across the South Island	Q4	Ongoing consultation with consumers and input into workplan	Ongoing consultation with consumers and input into workplan	Contributors: SI Child Health SLA Reported in: SIHSP
SUCCESSFUL TRANSITION INTO HEALTHY ADULTHOOD FOR CHILDREN WITH LIFELONG HEALTH CONDITIONS					
To provide youth specific services and transition planning/clinics to young people with a range of diseases					
11	Agreed transition pathway implemented for young people with complex disability and with lifelong health conditions	Q4	Ongoing monitoring and evaluation of Healthpathway	Ongoing monitoring and evaluation of Healthpathway	Contributors: SI Child Health SLA Reported in: SIHSP

Mental Health and Addiction Services

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

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

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

The Mental Health and Addiction 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 an integrated service across the continuum of primary, community, secondary and tertiary services.

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

- Alcohol and Other Drug Services
- Workforce
- People with low prevalence disorders
- Mental Health and Addiction Service Capacity for People with High and Complex Needs
- Youth Forensic Service Capacity and Responsiveness
- NGO provision
- Māori Mental Health
- Access to the range of Eating Disorder Services
- Adult Forensic Services
- Perinatal and Maternal Mental Health Service options as part of a Service Continuum

MILESTONES DASHBOARD 2016-19					
ITEM NO	**DELIVERABLE 2016-2017**	**APPROVED SCHEDULE**	**DELIVERABLE 2017-2018**	**DELIVERABLE 2018-2019**	**RESPONSIBILITIES**
CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION					
Mental Health and Addiction Service Level Alliance					
ALCOHOL AND OTHER DRUG SERVICES					
Withdrawal management and the implications of the new AOD legislation					
1	Advice provided to the implementation of a South Island withdrawal management plan pending the implications of the new legislation	Q4	Consider findings of 2016/17 work		MHASLA Reported in: SIHSP
WORKFORCE					
Workforce development recommendations and integrated plan for primary and NGO sector					
2	Developing a workforce that supports the South Island withdrawal management plan pending the implications of the new legislation	Q4	Consider findings of 2016/17 work		Lead: MHSLA Reported in: SIHSP
3	Develop the capacity and capability of the practice nurse workforce	Q4	Consider findings of 2016/17 work		Lead: MHSLA Reported in: SIHSP

MILESTONES DASHBOARD 2016-19					
ITEM NO	**DELIVERABLE 2016-2017**	**APPROVED SCHEDULE**	**DELIVERABLE 2017-2018**	**DELIVERABLE 2018-2019**	**RESPONSIBILITIES**
4	Develop a regional approach to increasing NESP capability in the NGO/Community setting	Q4	Consider findings of 2016/17 work		Lead: MHSLA Reported in: SIHSP
PEOPLE WITH LOW PREVALENCE DISORDERS.					
Physical health outcomes of people with low prevalence disorders.					
5	Develop a plan to support the physical health of people with low prevalence disorders. The initial focus to be on regional services. MHASLA to agree an approach and seek agreement from the sector	Q4	Broaden the focus of the work		MHSLA Reported in: SIHSP
MENTAL HEALTH AND ADDICTION SERVICE CAPACITY AND CAPABILITY FOR PEOPLE WITH HIGH AND COMPLEX NEEDS					
Forensic Services					
6	A gap analysis of the barriers to transition between inpatient forensic services to community based services	Q4	Consider findings of 2016/17 work		MHASLA Reported in: SIHSP
YOUTH FORENSIC SERVICE					
Youth forensic service capacity and responsiveness					
7	Report on trends in the new youth forensic services	Q1,2,3,4	Consider findings of 2016/17 work	Implement alternatives as appropriate.	Lead: CDHB and SDHB Youth Forensic leads Reported in: SIHSP
8	Agreed regional pathway for youth forensic services	Q2	Consider findings of 2016/17 work	Implement alternatives as appropriate.	Lead: Regional Youth Forensic Service Leads Reported in: SIHSP
NGO PROVISION					
Regional Residential AOD Services					
9	Develop and review reports from the NGOs that provide regional services including access, trends, key performance indicators and quality improvement activities	Q1,2,3,4	Build on data gathered / experience of previous year	Build on data gathered / experience of previous year	NGOs that provide regional services Reported in: SIHSP
MAORI MENTAL HEALTH					
Priority focus on Maori mental health					
10	Partner with services to inform the physical redevelopment of regional services	Q4	Consider findings of 2016/17 work		Lead: Regional Service Te Herenga Hauora Reported in: SIHSP
EATING DISORDERS					
Continued regional provision of eating disorder inpatient services					
11	Develop and review reports from the regional service including access, trends, key performance indicators and quality improvement activities.	Q1,2,3,4	Build on data gathered / experience of previous year	Build on data gathered / experience of previous year	Lead: CDHB Eating Disorders service Reported in: SIHSP
ADULT FORENSIC SERVICES					
Improved adult forensic service capacity and responsiveness					
12	Prison screening data provided (Prison screening occurs within agreed timeframes with 80% of prisoners referred seen within 7 days of receipt of referral)	Reports November 2016, February 2017, May 2017	Deliverable to be agreed with the national network		Lead: CDHB and SDHB Adult Forensic Service Reported in: SIHSP
13	Report on waiting lists and times for people in prisons requiring assessment in forensic services	Q4	Continue to work with national partners		Lead: CDHB and SDHB Adult Forensic Service Reported in: SIHSP

MILESTONES DASHBOARD 2016-19					
ITEM NO	**DELIVERABLE 2016-2017**	**APPROVED SCHEDULE**	**DELIVERABLE 2017-2018**	**DELIVERABLE 2018-2019**	**RESPONSIBILITIES**
PERINATAL AND MATERNAL MENTAL HEALTH SERVICE OPTIONS AS PART OF A SERVICE CONTINUUM					
Continued regional provision of regional mothers and babies services					
14	Develop and review reports from the regional service including access, trends, key performance indicators and quality improvement activities	Q1,2,3,4	Build on data gathered / experience of previous year	Build on data gathered / experience of previous year	Lead: CDHB Mothers and Babies service Reported in: SIHSP
ALCOHOL AND OTHER DRUG SERVICES					
Continued regional provision of alcohol and other drug services					
15	Develop and review reports from the regional service including access, trends, key performance indicators and quality improvement activities	Q1,2,3,4	Build on data gathered / experience of previous year	Build on data gathered / experience of previous year	Lead: Regional alcohol and other drug service Reported in: SIHSP

Health of Older People services

Best healthcare for older people everywhere in the South Island

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

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

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

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

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

- Dementia Services
- Restorative Model of Care
- Comprehensive Clinical Assessment (InterRAI)
- Falls Prevention & Fracture Liaison Service
- Advance Care Planning

MILESTONES DASHBOARD 2016-19					
ITEM NO	DELIVERABLE 2016-2017	APPROVED SCHEDULE	DELIVERABLE 2017-2018	DELIVERABLE 2018-2019	RESPONSIBILITIES
CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION					
Health of Older People Service Level Alliance					
			ADVANCE CARE PLANNING		
1	Support DHBs to develop ACP system implementation with processes to embed ACP as standard practice for those who will benefit	Q2,4	South Island DHBs are supported to develop ACP systems and processes to embed ACP as standard practice for those who will benefit	South Island DHBs are supported to develop ACP systems and processes to embed ACP as standard practice for those who will benefit	HOPSLA SI ACP Steering Group
2	ACP L 2 Training is available in a planned manner for staff in each DHB district in South Island (subject to resources)	Q1,3	ACP L 2 Training is available in a planned manner for staff in each DHB district in South Island	ACP L 2 Training is available in a planned manner for staff in each DHB district in South Island	
3	Support South Island DHBs to adopt the national consistent ACP documents across the health continuum	Q4	Each SI DHBs develop and implement a system to moderate an individual's written ACP before plan published electronically. Regionally consistent SI ACP Policies are embedded within each DHB	An individual's written ACP form is available electronically at the point of acute care including ambulance	HOPSLA SI ACP Steering Group SI DHBs

MILESTONES DASHBOARD 2016-19					
ITEM NO	DELIVERABLE 2016-2017	APPROVED SCHEDULE	DELIVERABLE 2017-2018	DELIVERABLE 2018-2019	RESPONSIBILITIES
4	Support SI DHBs to participate and support National Conversations that Count Day. This will encourage individuals, communities and health staff to have conversations useful for a person to document their ACP and develop a shared understanding of an individual's choice	Q2,3	Encourage and Support individuals, communities and health staff to have conversations useful for a person to document their ACP and develop a shared understanding of an individual's choice CtC education (Peer education for the public delivered 'by the public') is available in each SI DHB	Encourage and Support individuals, communities and health staff to have conversations useful for a person to document their ACP and develop a shared understanding of an individual's choice CtC education (Peer education for the public delivered 'by the public') is available in each SI DHB	HOPSLA SI ACP Steering Group
DEMENTIA SERVICES					
5	Embed the adoption of the dementia care pathways in the South Island to support people with dementia, their family and whānau to maximise their independence and well-being by reducing stigma and providing information, education and an integrated, holistic approach to dementia care. A high level measure of progress in achieving items 6 & 7 will be the number of views of the Cognitive Impairment Pathway.	Q1, Q4	South Island Regional and District plans embed a Person Centred Care approach to services that enables people with dementia, their family and whānau to be valued partners in an integrated health and support system. Regional participation occurs regularly.	South Island Regional and District plan's embed a Person Centred Care approach to services that enables people with dementia, their family and whānau to be valued partners in an integrated health and support system. Regional participation occurs regularly.	HOPSLA DHB Dementia teams
6	Embed a culture of 'Living Well' with Dementia in South Island communities through use of educational programmes and support groups to support informal careers in the South Island. This will involve collecting information about the range and spread of education programmes for informal carers; reporting on gaps and opportunities; reporting on primary care dementia education uptake; and reporting on 'Walking in another's shoes' uptake.	Q2,4	Embed delivery of dementia awareness and responsiveness education programmes in a consistent manner in the SI. This will improve awareness and responsiveness and provide on-going support and overview to strengthen components of dementia care pathways for people with dementia and their families/whanau	Embed delivery of dementia awareness and responsiveness education programmes in a consistent manner in the SI. This will improve awareness and responsiveness and provide on-going support and overview to strengthen components of dementia care pathways for people with dementia and their families/whanau	HOPSLA
7	Continue to develop Walking in Another's Shoes programme material for other staff groups (subject to funding) Commence the development of material for use with a 2 day workshop for Aged Residential Care Managers	Q1,3,4	Walking in Another's Shoes programme continues to be expanded in each South Island DHB programme reaching a wider range of staff working with people with dementia	Walking in Another's Shoes programme continues to be expanded in each South Island DHB programme reaching a wider range of staff working with people with dementia	HOPSLA Walking in Another's Shoes Development Team
RESTORATIVE MODEL OF CARE					
8	Promote the uptake and use of South Island approved principles for restorative care by all services in the South Island	Q3,4	Older people will be supported to set and achieve goals by a co-ordinated and responsive health and disability support service that also enables them to maintain their social connections with community life. Review the webpage	Older people will be supported to set and achieve goals by a co-ordinated and responsive health and disability support service that also enables them to maintain their social connections with community life. Review the webpage	HOPSLA

MILESTONES DASHBOARD 2016-19					
ITEM NO	DELIVERABLE 2016-2017	APPROVED SCHEDULE	DELIVERABLE 2017-2018	DELIVERABLE 2018-2019	RESPONSIBILITIES
COMPREHENSIVE CLINICAL ASSESSMENT (interRAI)					
9	Promote SI health professions to use the information from comprehensive clinical assessment (interRAI) proactively in plan of care and in service planning/ development. Analyse specific areas of the data from all SI DHBs	Q2,3,4	Embed the necessary elements of comprehensive clinical assessment (interRAI) processes for older people in the South Island DHBs	Embed the necessary elements of comprehensive clinical assessment (interRAI) processes for older people in the South Island DHBs	HOPSLA SI System Clinicians
10	Monitor interRAI reports to identify trends.	Q1,2,3,4	Monitor population and service trends data to influence changes in service through advocacy	Monitor population and service trends data to influence changes in service through advocacy	HOPSLA SI System Clinicians
FALLS PREVENTION AND FRACTURE LIAISION SERVICE					
11	Facilitate SI DHBs to share information and ideas to progress falls prevention programmes in a consistent manner Encourage development of Fracture Liaison Services in each SI DHB	Q2,4	Implement well tested programmes for fall and fracture prevention in SI DHBs. Opportunities for further development of Falls prevention/FLS are identified	Implement well tested programmes for fall and fracture prevention in SI DHBs. Opportunities for further development of Falls prevention/FLS are identified	HOPSLA+Q&S SLA Falls Prevention teams FLS teams

Palliative Care Services

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

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

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

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

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

- Information Technology and Services
- Hospice and Hospital Palliative Care Services
- Primary and Community Care
- Networking and Engagement

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

MILESTONES DASHBOARD 2016-19					
ITEM NO	**DELIVERABLE 2016-2017**	**APPROVED SCHEDULE**	**DELIVERABLE 2017-2018**	**DELIVERABLE 2018-2019**	**RESPONSIBILITIES**
CLINICAL SERVICES: SUSTAINABILITY AND INTEGRATION					
Palliative Care					
INFORMATION TECHNOLOGY AND SERVICES					
By using new electronic systems and tools health professionals are able to securely share and gather relevant patient information that will result in safer, better and timely palliative care to patients					
1a	To inform and influence the development of information systems within the South Island that will deliver a more efficient and safer transfer of patient information between Palliative Care Providers (including Hospice services) across the SI while reducing costs and risk	Q4	Ongoing implementation of Information Technology developments	Ongoing implementation of Information Technology developments	Contributors: SI PC WS SI IS SLA Reported in: SIHSP
1b	Following the completion and evaluation of the current pilot, support the development and the roll out of Palliative Care interRAI across the South Island	Q4	Roll out as agreed	Roll out as agreed	Contributors: SI PC WS SI IS SLA Reported in: SIHSP

MILESTONES DASHBOARD 2016-19					
ITEM NO	DELIVERABLE 2016-2017	APPROVED SCHEDULE	DELIVERABLE 2017-2018	DELIVERABLE 2018-2019	RESPONSIBILITIES
HOSPICE AND HOSPITAL PALLIATIVE CARE SERVICES					
To provide all people who are dying and their family /whanau access to an equitable and quality palliative care service wherever that service may be located in the South Island					
2a	Use the information from Hospital and Hospice Surveys and the evaluation of palliative care in primary care (PHOs ARC and P&F) to promote regional consistency and access to resources. Inform and influence SI DHBs so services are aligned to the Resource and Capability Framework for Adult Palliative Care and the work of the National Adult Palliative Care Review	Q4	Develop and monitor initiatives identified as a result of Palliative Care bench marking	Develop and monitor initiatives identified as a result of Palliative Care bench marking	Contributors: SI PCW Reported: SIHSP
2b	Working within the National Paediatric Palliative care Guidelines: provide high level guidance within the SI to those providing Paediatric palliative care	Q4	Monitor and progress any initiatives or issues as appropriate to Paediatric Palliative Care	Monitor and progress any initiatives or issues as appropriate to Paediatric Palliative Care	Contributors: SI PCW Reported: SIHSP
PRIMARY AND COMMUNITY CARE					
To provide the expertise and resources to enable patients to die in their preferred place of care.					
3a	Conduct the survey and analyse the findings of the Primary Palliative Care Project using information provided by SI ARC, Planning and Funding and Primary Care (subject to funding availability)	Q4	Work with stakeholders to deliver on key priorities to influence change	Work with stakeholders to deliver on key priorities to influence change	Contributors: SI PCW Reported in: SIHSP
3b	Explore and understand how Palliative Care is provided by St John	Q4	Continue to access and apply current workforce analysis, planning and implementation	Continue to access and apply current workforce analysis, planning and implementation	Contributors: SI PCW Reported in: SIHSP
3c	Explore and understand how PC is delivered by Allied Health providers and by Maori organisations and other ethnic minority providers		Continue to access and apply current workforce analysis, planning and implementation	Continue to access and apply current workforce analysis, planning and implementation	Contributors: SI PCW Reported in: SIHSP
NETWORKING AND ENGAGEMENT					
To support consumer participation and decision making about Palliative and End of Life Care at every level in the SI.					
4	To get a better understanding from consumers and Maori on their experience of End of life and Palliative Care services in the South Island based on information obtained from the patients and their family/whanau's experience, including key socio-demographic variables	Q4	Continue to demonstrate communication with Consumers and Maori on their experience of End of life and Palliative Care services in the South Island	Continue to demonstrate communication with Consumers and Maori on their experience of End of life and Palliative Care services in the South Island	Contributors: SI PCW Reported in: SIHSP

Cardiac Services

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

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

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

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

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

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

- South Island Model of Care
- Equity of Access
- Meeting National Indicators
- Heart Failure
- Workforce Training
- Minimum Facilities Guidelines
- Transporting of Cardiac Patients

MILESTONES DASHBOARD 2016-19					
ITEM NO	**DELIVERABLE 2016-2017**	**APPROVED SCHEDULE**	**DELIVERABLE 2017-2018**	**DELIVERABLE 2018-2019**	**RESPONSIBILITIES**
CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION					
Cardiac Services Workstream					
SOUTH ISLAND MODEL OF CARE					
Complete project work associated with the South Island Cardiac Model of Care					
1	South Island Cardiac Model agreed and implemented consistently in the region (subject to resource constraints).		South Island Cardiac Model of Care is acknowledged as providing improved and more efficient services	South Island Cardiac Model of Care is acknowledged as providing improved and more efficient services	Workstream members and co-opted expertise on various projects required to complete the model
Access to tests					
2a	Determine current access and utilisation of cardiac tests in primary, secondary and tertiary services	Q2			Cardiac Workstream
2b	Prepare guidelines to ensure equity of cardiac tests	Q2			Cardiac Workstream
2c	All South Island DHBs recording and storing ECGs (subject to finance and business case approval)	Q2	Maintain common regional method of storing and sharing ECGs	Maintain common regional method of storing and sharing ECGs	Cardiac Services workstream, with support/advice from IS SLA
Optimal HealthPathways					
3a	Determine current access to and utilisation of HealthPathways in primary, secondary and tertiary services	Q2			
3b	Implement and utilise appropriate HealthPathways which ensure equity of access throughout the region	Q2			Cardiac Workstream

MILESTONES DASHBOARD 2016-19					
ITEM NO	**DELIVERABLE 2016-2017**	**APPROVED SCHEDULE**	**DELIVERABLE 2017-2018**	**DELIVERABLE 2018-2019**	**RESPONSIBILITIES**
3c	Percutaneous Coronary Intervention regional health pathway implemented	Q2	Report on regional pathway usage	Report on regional pathway usage	Cardiac Workstream
3d	Common Accelerated Chest Pain pathway implemented in South Island hospitals	Q2	Report on regional pathway usage	Report on regional pathway usage	Cardiac Workstream
	Planning for sustainability				
4	Report on and provide recommendations regarding the optimal mix of cardiac services for the South Island	Q2			Cardiac Workstream
	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				
5	Monitor access rates for high risk population groups				Cardiac Workstream
	MEETING NATIONAL INDICATORS **Improved outcomes for people with suspected Acute Coronary Syndrome**				
	Standardised intervention rates for ACS patients				
6	Support South Island DHBs to address any challenges that arise with providing appropriate cardiac care and meeting standardised intervention rates. In addition, report on: • >70% of high-risk ACS patients accepted for coronary angiography having it within 3 days of admission. ('Day of Admission' being 'Day 0') • >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 • Percutaneous revascularisation (12.5 per 100,000 population) • Coronary angiography (34.7 per 10,000 population) (all South Island hospitals record and report data monthly through ANZACS QI register)	Q1, Q2, Q3, Q4	Continued achievement of national indicators as determined by/modified by National Health Board in conjunction with the National Cardiac network.	Continued achievement of national indicators as determined by/modified by National Health Board in conjunction with the National Cardiac network.	DHBs and Cardiac Workstream
	Cardiac surgery targets achieved which will improve equity of access as identified and agreed by The National Cardiac Network				
7	Support South Island DHBs in the continued achievement of national indicators around equity of access. In addition, report on: • Standardised cardiac surgery rates (6.5 per 10,000 population) • Proportion of patients scored using the national cardiac surgery Clinical Priority Access (CPAC) tool, and proportion of patients treated within assigned urgency timeframe • The waiting list for cardiac surgery remains between 5% and 7.5% of planned annual cardiac throughput, and does not exceed 10% of annual throughput • Patients wait no longer than four months for a cardiology first specialist assessment, or for cardiac surgery		Continued achievement of national indicators as determined by National Health Board in conjunction with the National Cardiac network.	Continued achievement of national indicators as determined by/ National Health Board in conjunction with the National Cardiac network.	DHBs and Cardiac Workstream

MILESTONES DASHBOARD 2016-19					
ITEM NO	**DELIVERABLE 2016-2017**	**APPROVED SCHEDULE**	**DELIVERABLE 2017-2018**	**DELIVERABLE 2018-2019**	**RESPONSIBILITIES**
	• Over 95% of patients undergoing cardiac surgery will have completion of Cardiac Surgery registry data collection within 30 days of discharge				
	HEART FAILURE				
	Implement locally, regionally and nationally agreed protocols, guidance, processes and systems to ensure optimal management of patients with heart failure.				
8	Implement locally, regionally and nationally agreed protocols, guidance, processes and systems to ensure optimal management of patients with heart failure (within available resources). The Model of Care projects will identify best practise processes and enable sharing these across the South Island.		Continued achievement of national indicators as determined by/modified by National Health Board in conjunction with the National Cardiac network	Continued achievement of national indicators as determined by/modified by National Health Board in conjunction with the National Cardiac network	Cardiac Services workstream
	WORKFORCE TRAINING **Workforce training maintained**				
	Opportunities for training in echocardiography identified				
9	Implement recommendations formed in 2015/16 in conjunction with National Network (subject to resource constraints)		Continued uptake of education opportunities	Continued uptake of education opportunities	Cardiac Services workstream, with support/advice from SIWDH
	Regional coordination and development of Inter - professional learning				
	Ensure the workstream is well connected with National Network and MoH				
10	Continued achievement of national indicators around inter-professional learning as determined by National Health Board in conjunction with the National Cardiac network		Continued achievement of national indicators as determined by National Health Board in conjunction with the National Cardiac network	Continued achievement of national indicators as determined by National Health Board in conjunction with the National Cardiac network	Cardiac Services workstream
	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.**				
11	Regional subgroup of cardiac nurse educators continues to meet quarterly Agree and implement a draft plan developed by CDHB staff		Continued uptake of education opportunities	Continued uptake of education opportunities	Cardiac Nurse Educator in each district and Facilitator, with support/advice from SIWDH
	MINIMUM FACILITIES GUIDELINES				
	Review and update minimum facilities guidelines				
12	Guidelines agreed in 2013 to be reviewed and updated if required (2 year cycle)			Guidelines agreed in 2015 to be reviewed and updated if required (2 year cycle)	Cardiac Services workstream
	TRANSPORTING OF CARDIAC PATIENTS				
	Regionally agreed guidelines for the arranged transportation of cardiac patients				
13	Guidelines for transporting cardiac patients agreed in 2013 and updated 2015/16 are consistent for the South Island			Guidelines agreed in 2015 to be reviewed and updated if required (2 year cycle).	Cardiac Services workstream
	Develop regionally agreed guidelines for transporting/retrieving of emergency/acute patients				
14	Report developed and endorsed by key stakeholders, based on meeting the less than 90 minute transport/retrieval time		Maintain improved transfer times	Maintain improved transfer times	Cardiac Services workstream with particular involvement of St John

Elective Services

Sustainable, equitable elective services for South Islanders

Sponsor: **General Managers Planning and Funding (South Island DHBs)**

Chief Operating Officers (South Island DHBs)

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

- Explore elective service delivery across the South Island focussing on:
  - Population need and projections
  - Options to support clinically and financially sustainable service delivery into the future.
- Take a health system approach, and analyse secondary and tertiary referral elective services (variability of delivery, capacity, capability, sustainability)
- Prioritise services for attention to future configuration and delivery of elective health services across the South Island, using clinical and management tools such as HealthPathways, consistent systems and processes

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

- Regional/Sub-regional collaboration in:
  - Inter-district flows
  - Urology
  - Bariatric surgery
  - Cardiac model of care
  - Infertility
  - Plastics services
  - Vascular services
  - Eye health services
  - Maxillofacial services
- Reducing disparities

MILESTONES DASHBOARD 2016-19					
ITEM NO	**DELIVERABLE 2016-2017**	**APPROVED SCHEDULE**	**DELIVERABLE 2017-2018**	**DELIVERABLE 2018-2019**	**RESPONSIBILITIES**
CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION					
Elective Services					
INTER-DISTRICT FLOWs					
South Island Inter-district flows modelling and capacity planning to sustainably manage acute and elective, secondary and tertiary delivery					
1a	Complete demand analysis, including consideration of demographics, forecasting volumes, infrastructure and workforce.	Q2			Electives Steering Group
1b	Complete supply analysis, including forecasting of South Island capacity	Q2			Electives Steering Group
	Agree and implement the regional delivery of electives discharges towards meeting the electives health target (Budget 2016)	Q2, Q4			Electives Steering Group
1c	Develop models of care and appropriate pathways, incorporating clinical, business and information processes	Q4			Electives Steering Group and CMOs
UROLOGY					
2	Implement consistent clinical protocols for urology conditions in interested DHBs	Q2			Urology Project Group

MILESTONES DASHBOARD 2016-19					
ITEM NO	DELIVERABLE 2016-2017	APPROVED SCHEDULE	DELIVERABLE 2017-2018	DELIVERABLE 2018-2019	RESPONSIBILITIES
3	Implement urology online Lippincott Procedures	Q2			Urology Nursing Group
			INFERTILITY SERVICES		
4	Fully operationalize the service across the South Island, including implementing the single South Island waiting list	Q2			Electives Steering Group
			PLASTICS SERVICES		
5a	Quantify demand for plastics services (all services, 2015/16 demand; projected demand to 2019/20)	Q2, Q4			Plastics Services Project Group and Electives Steering Group
5b	Describe evidence-based plastics services and workforce models across the spectrum of care (international, NZ, SI)				
5c	Identify and quantify variations between Plastics Services HealthPathways across the South Island				
5d	Establish an agreed South Island plan to implement the national Plastics prioritization tools in 2016				
5e	Recommend Plastics Services service and workforce model(s) for the South Island that support equity of access and sustainable service delivery across the region				
5f	Recommend a transition pathway, including resource implications, to achieve the desired model(s)				
			VASCULAR SERVICES		
6	Implement the nationally agreed Vascular Services model of care in the South Island (subject to resource constraints)	Q2, Q4			Vascular Services Project Group, Electives Steering Group
			EYE HEALTH SERVICES		
7a	Quantify demand for eye health services (all services, 2015/16 demand; projected demand to 2019/20)	Q2, Q4			Eye Health Services Project Group, Electives Steering Group
7b	Describe evidence-based eye health service and workforce models across the spectrum of care (international, NZ, South Island)				
7c	Identify and quantify variations between eye health HealthPathways across the South Island				
7d	Establish and agree SI plan to implement the Cataract prioritisation tool in 2016				
7e	Recommend eye health service and workforce model(s) for the South Island that support equity of access and sustainable service delivery across the region				
7f	Recommend a transition pathway, including resource implications, to achieve the desired model(s)				
			MAXILLOFACIAL SERVICES		
8	Agree a sustainable South Island plan for Maxillofacial Services	Q1, Q3			Electives Steering Group

MILESTONES DASHBOARD 2016-19					
ITEM NO	DELIVERABLE 2016-2017	APPROVED SCHEDULE	DELIVERABLE 2017-2018	DELIVERABLE 2018-2019	RESPONSIBILITIES
	REDUCING DISPARITIES				
9	Identify baseline for Maori access (current and evidence) in selected priority areas.	Q2, Q4			Electives Steering Group
10	Collate and share innovations in the selected service areas via best practice documents and use of HealthPathways	Q2, Q4			Each project group

Work supported by the Elective Services Workstream

The Elective Services Workstream is committed to supporting work led by other SLAs/Workstreams or individual DHBs where appropriate. In particular, the Workstream will support South Island DHBs to deliver timely care to their patients and meet the Elective Services Health Target through collaboration and sharing of best practice to address and overcome issues as they arise. The work on inter-district flows is an example of this.

National and regional initiatives supported by the Elective Services Workstream, but led by other SLAs/Workstreams or individual DHBs
South Island Cardiac Model of Care (page 53, items 14a &14b) *Owner: Cardiac Services Workstream* **Improve access to elective services** Delivery against agreed volume schedule, including elective surgical discharges, to deliver the Electives Health Target *Owner: Individual South Island DHBs* *Reported: Individually by the South Island DHBs quarterly* **Maintain reduced waiting times for elective first specialist assessment and treatment** Elective Services Patient Flow Indicators expectations are met, and patients wait no longer than four months for first specialist assessment and treatment, and all patients are prioritised using the most recent national tool available. *Owner: Individual South Island DHBs* *Reported: Individually by South Island DHBs quarterly*

Major Trauma services

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

Sponsor: **David Meates, CEO (Canterbury DHB)**
Lexie O'Shea, Executive Director of Patient Services (Southern DHB)

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

The South Island Major Trauma Workstream has been formed to provide Regional Leadership across the Major Trauma continuum of care through:

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

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

- South Island Major Trauma Services systems and processes agreed to support people surviving major trauma and recovering with a good quality of life
- Establishing systems to collect NZ Major Trauma Minimum Dataset and NZ Major Trauma Registry
- Clinical Leadership
- Workforce
- Networks
- Destination policies
- Inter hospital transfer protocols
- Spinal cord impairment action plan

MILESTONES DASHBOARD 2016-19					
ITEM NO	DELIVERABLE 2016-2017	APPROVED SCHEDULE	DELIVERABLE 2017-2018	DELIVERABLE 2018-2019	RESPONSIBILITIES
CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION					
Major Trauma Workstream					
SOUTH ISLAND REGION MAJOR TRAUMA PLAN					
South Island Major trauma regional action plan reviewed and updated					
1 a	South Island region focuses on implementation of local and regional trauma systems	Q1, Q2, Q3, Q4	Baseline reporting against the defined performance indicators. Report quarterly against the regional workplan. Annual Report for the region for the period ending June 2017 is prepared and presented	Baseline reporting against the defined performance indicators. Report quarterly against the regional workplan	Major Trauma Workstream
1 b	South Island region reports major trauma using the agreed national minimum dataset	Q1, Q2, Q3, Q4	Consideration to extending data collection to moderate and minor data as well	Consider research and academic opportunities with available data	Major Trauma Workstream
NZ MAJOR TRAUMA MINIMUM DATASET					
System established for South Island region major trauma data collection					
2	South Island data collection and input into national major trauma registry commenced 1 July 2016	Q1, Q2, Q3, Q4			Major Trauma Workstream
South Island region trauma definitions aligned to those used in the NZ Major Trauma Minimum Dataset (NZMTMD)					
3	Local trauma definitions aligned with those used in the NZMTMD.	Q1, Q2, Q3, Q4			Major Trauma Workstream

MILESTONES DASHBOARD 2016-19					
ITEM NO	DELIVERABLE 2016-2017	APPROVED SCHEDULE	DELIVERABLE 2017-2018	DELIVERABLE 2018-2019	RESPONSIBILITIES
NZ MAJOR TRAUMA REGISTRY					
South Island DHBs participate in the implementation and roll-out of the national major trauma registry					
4	National major trauma registry available and implemented across the South Island using Midland's Registry and Collector™ software.	Q1, Q2, Q3, Q4			Major Trauma Workstream, with assistance from SI IS SLA
CLINICAL LEADERSHIP					
South Island DHBs major trauma clinical leaders; co-ordinators; and administrators appointed					
5	Responsibilities identified and assigned for Clinical lead and coordinator roles in each DHB	Q1	Continued clinical lead and coordinator roles in each DHB	Continued clinical lead and coordinator roles in each DHB	Major Trauma Workstream,
WORKFORCE					
Regions and DHBs are encouraged to explore opportunities for additional experience to be provided to trauma care providers at centres with more exposure to major trauma management.					
6	Training plans developed by each DHB to ensure relevant clinical staff are appropriately trained in trauma care	Q2	Implementation of Training plan	Implementation of Training plan	Major Trauma
DESTINATION POLICIES					
Agree Regional Destination Policies in collaboration with DHBs, Ambulance and Air Transport providers					
7	Develop, assess and understand implications of Regional Destination Policies, with a view to implementing these, in collaboration with DHBs, Ambulance and Air Transport providers	Q2	Regional Destination Policies maintained	Potential in conjunction with transfer policies for on-line regional health pathway to be developed	Major Trauma Workstream
INTER-HOSPITAL TRANSFER PROTOCOLS					
Development and implementation of inter-hospital transfer protocols.					
8	Develop, assess and understand implications of Inter-hospital transfer protocols, with a view to implementing these subject to resources constraints	Q2	Inter-hospital transfer protocols maintained	Potential for on-line regional health pathway to be developed	Major Trauma Workstream
SPINAL CORD IMPAIRMENT ACTION PLAN					
Acknowledge SI DHBs' intentions regarding MoH requirements as outlined in the New Zealand Spinal Cord Impairment Action Plan 2014-2019.					
9	Maintain awareness of: - work to establish acute supra regional spinal services and early rehabilitation pathways (led by Canterbury DHB) - other SI DHBs implementation of agreed nationally directed destination and referral processes for acute spinal cord injuries and work with supra regional spinal services	Ongoing	Note progress	Note progress	CDHB

Public Health Services

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

Sponsor: **Andrew Lesperance, GM Strategy, Planning and Alliance Support (Nelson Marlborough DHB)**

Clinical Lead: **Dr Ed Kiddle, Medical Officer of Health (Nelson Marlborough 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.

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

- Māori
- Quality
- Environmental sustainability
- Health in all policies – environmental determinants of health
- Rheumatic fever

MILESTONES DASHBOARD 2016-19					
ITEM NO	DELIVERABLE 2016-2017	APPROVED SCHEDULE	DELIVERABLE 2017-2018	DELIVERABLE 2018-2019	RESPONSIBILITIES
CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION					
PUBLIC HEALTH					
MĀORI					
Support and develop a Māori voice within the South Island Alliance					
1	Work in partnership with Te Herenga Hauora to develop key messages on South Island priority public health issues as they pertain to Māori	Q2, Q4	Continue to strengthen this approach	Yet to be determined	Contributors: SI PHP Management group, Māori GMs (Te Herenga Hauora) Reported in: SIHSP
Increase awareness of the key Māori public health issues in the South Island					
2	Review of the key public health issues for Māori in the South Island	Q1,2	Selection of a priority public health issue for Māori for a collaborative approach	Yet to be determined	Contributors: SI PHP Management group, Māori GMs (Te Herenga Hauora) Reported in: SIHSP
QUALITY					
System development					
3	Development of a results based accountability approach for public health planning in the South Island	Q4	Implementation, evaluation and further development	On-going evaluation and development	Contributors: SI PHP Management group, SI Quality and Safety SLA, Health Quality and Safety Commission
4	Development of a quality framework for public health services	Q4	Implementation, evaluation and further development	On-going evaluation and development	Contributors: SI PHP Management group, SI Quality and Safety SLA, Ministry of Health, Health Quality and Safety Commission
ENVIRONMENTAL SUSTAINABILITY					
Increased awareness around environmental sustainability and the co-benefits of action in this area for population health					
5	Completion of a stocktake of environmental sustainability initiatives across South Island DHBs	Q2	Develop and implement and promote a plan to address the gaps	Yet to be determined	Contributors: Support Services SLA, SIPHP Management group

MILESTONES DASHBOARD 2016-19					
ITEM NO	**DELIVERABLE 2016-2017**	**APPROVED SCHEDULE**	**DELIVERABLE 2017-2018**	**DELIVERABLE 2018-2019**	**RESPONSIBILITIES**
6	Prepare environmental sustainability policy/position statement	Q4	Promote awareness of the policy/position statement once Boards endorse	On-going promotion	Contributors: SI Public Health Analysts Network, Support Services SLA, Reported in: SIHSP
7	Promotion of consistent environmental sustainability monitoring systems	Q4	Information is utilised to develop projects	Yet to be determined	Contributors: SI PHP Management Group, Support Services SLA
HEALTH IN ALL POLICIES (HiAP)					
Actively promote a HiAP approach towards the environmental determinants influencing healthy weight, oral health, clean air, warm homes and alcohol harm reduction					
8	Development of South Island position statements within the following areas: • Water fluoridation • Air quality and warm homes • Sweetened drinks • Sustainability	Q1, Q2, Q3, Q4	Promote aware of the position statements once Boards endorse	On-going promotion	Contributors: SIPHP Management group, SI PHP Facilitator, SI Child Health SLA, SI PH Analysts , SI DHBs, SI Hospital Dentists Reported in: SIHSP
9	Identification of further regional approaches / combined initiatives to promote healthy eating and active lifestyles	Q2,4	Undertake initiatives identified in 16/17	Yet to be determined	Contributors: SI PH Analysts network, Child Health SLA Reported in: SIHSP
10	Explore the impact and learnings from the two Healthy Families NZ projects in the SI to contribute to wider South Island PHU/DHB efforts	Q1,3	To be determined in response to the findings in 2016-17	Yet to be determined. Current projects due to end in June 2018.	Contributors: PHS/SDHB, CPH/CDHB , Child Health SLA & SI PHP Management group Reported in: SIHSP
11	Contribution of a regional population health perspective to the Alcohol Harm Reduction ED Project	Q1,Q3	Yet to be determined.	Yet to be determined	Contributors: Si PHP management Group, Child Health SLA, Health Promotion Agency
RHEUMATIC FEVER					
South Island Rheumatic fever cases monitored **The Partnership supports DHBs to have mechanisms in place to ensure the Rheumatic Fever Prevention and Management Plan is implemented as intended**					
12	Ongoing monitoring and collective South Island public health response to results	Q2, Q4	Surveillance reports continue to show Rheumatic Fever case numbers and disease rates across the South Island	Surveillance reports continue to show Rheumatic Fever case numbers and disease rates across the South Island	Contributors: SI Medical Officers of Health via SI PHP Management group. Reported in: SIHSP

Stroke Services

Delivering Organised Stroke Services - Best stroke care, everywhere

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

The South Island Stroke Workstream has been formed to:

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

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

- Primary and secondary stroke prevention and reduced stroke related disability and mortality
- Access to high quality stroke services
- Rehabilitation and community stroke services
- Workforce education and training

MILESTONES DASHBOARD 2016-19					
ITEM NO	**DELIVERABLE 2016 -2017**	**APPROVED SCHEDULE**	**DELIVERABLE 2017-2018**	**DELIVERABLE 2018-2019**	**RESPONSIBILITIES**
CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION					
Stroke Services					
Primary and secondary stroke prevention and reduced stroke related disability and mortality					
1	Each SI DHB has a system to rapidly confirm a diagnosis of stroke and identify patients who may benefit from thrombolysis and improve door to needle time to 60 minutes Note: Average door-needle time for SI is 82 minutes, similar to other regions in NZ but greater than current NZ target of 60 minutes	Q2 Q4	Each SI DHB has a system to rapidly confirm a diagnosis of stroke and identify patients who may benefit from thrombolysis therapy implemented in each SI DHB	Each SI DHB has a system to rapidly confirm a diagnosis of stroke and identify patients who may benefit from thrombolysis therapy implemented in each SI DHB	SI Stroke Workstream, DHBs, St John
2	Every hospital providing organised stroke care in the South Island has a Lead Stroke Nurse with assigned non clinical hours who works in the Stroke Service.	Q4	Each SI DHB has a designated Lead Stroke Nurse who has assigned non clinical hours to achieve the Stroke Nurse role. Including developing and improving the Stroke Service. (In small centres it may not be a fulltime position)	Each SI DHB has a designated Lead Stroke Nurse who has assigned non clinical hours to achieve the Stroke Nurse role. Including developing and improving the Stroke Service. (In small centres it may not be a fulltime position)	SI Stroke Workstream, DHBs
Access to high quality stroke services					
3	Achieve 6% compliance for thrombolysis of eligible stroke clients. Thrombolysis register is used in a consistent manner in SI DHBs and reported nationally	Q2 Q4	Achieve 8% compliance for *thrombolysis of eligible stroke clients*	Achieve 8% compliance for *thrombolysis of eligible stroke clients*	SI Stroke Workstream, DHBs
4	Facilitate the delivery of Organised Stroke Care (defined by National Stroke Network) in each South Island DHB. Achieve 80% compliance for stroke patients to be cared for in organised stroke unit.	Q2 Q4	Achieve 80% compliance for stroke patients to be cared for in organised stroke unit.	Achieve 80% compliance for stroke patients to be cared for in organised stroke unit.	SI Stroke Workstream, DHBs
5	Monitor stroke ethnicity data and geographic domicile and report regionally	Q2 Q4	Monitor stroke ethnicity data and geographic domicile and report regionally. Identify trends	Monitor stroke ethnicity data and geographic domicile and report regionally. Identify trends	SI Stroke Workstream, DHBs

MILESTONES DASHBOARD 2016-19					
ITEM NO	**DELIVERABLE 2016 -2017**	**APPROVED SCHEDULE**	**DELIVERABLE 2017-2018**	**DELIVERABLE 2018-2019**	**RESPONSIBILITIES**
Rehabilitation and community stroke services					
6	South Island DHBs deliver inpatient and community stroke rehabilitation services which reflect best practice and are regionally consistent. Supporting this deliverable will be work on the following measures: 80% of patients admitted with acute stroke who are transferred to in-patient rehabilitation services are transferred within 7 days of acute admission. Explore a consistent mechanism to measure the proportion of patients admitted with stroke who receive a face to face community rehabilitation session within 7 days after in-patient discharge (with a view to being ready to measure in 2017-18).	Q2,Q4 Q1,2,3,4 Q4	Community rehabilitation is available to aid adjustment and minimise complications.	Community rehabilitation is available to aid adjustment and minimise complications.	SI Stroke Workstream, DHBs
Ongoing education and training for interdisciplinary stroke team					
7	South Island Stroke teams have a minimum of 8 hours stroke specific education per year (minimum standard) Stroke teams have access to a range of educational opportunities (regional and local) to support continued development of knowledge and skill in delivering best practice stroke services	Q2,Q4	South Island Stroke teams have a minimum of 8 hours stroke specific education per year (minimum standard) Appropriate educational opportunities are promoted to primary care, community teams, Age Residential Care, Acute and Rehabilitation teams	South Island Stroke teams have a minimum of 8 hours stroke specific education per year (minimum standard) Appropriate educational opportunities are promoted to primary care, community teams, Age Residential Care, Acute and Rehabilitation teams	SI Stroke Workstream, DHBs

Hepatitis C Workstream

Clinical Lead: Dr Alan Pithie **(Canterbury DHB)**

The Hepatitis C Workstream is newly formed in order to design and implement integrated assessment and treatment services for Hepatitis C in the South Island.

The membership of the South Island Hepatitis C Workstream is confirmed, and an assessment of the clinical and diagnostic capacity and capability requirements in the South Island has been carried out.

The focus of this workplan will be to:

- Develop a clinical pathway for Hepatitis C patients (based on national developments on the availability of treatments and guidance from the Ministry of Health)
- Agree a business case for the ongoing provision of Hepatitis C services
- Supporting national awareness programmes and education for health professionals

Milestones Dashboard 2016-9					
ITEM NO	**DELIVERABLE 2016-2017**	**APPROVED SCHEDULE**	**DELIVERABLE 2017-2018**	**DELIVERABLE 2018-2019**	**RESPONSIBILITIES**
CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION					
Hepatitis C					
Integrated Hepatitis C Assessment and Treatment Services					
1	Develop an agreed clinical pathway through engagement with primary and secondary sectors across the region based on guidance provided by the Hepatitis C Implementation Advisory Group.	Q1			Hepatitis C Workstream
2	With MoH, develop an agreed business case to identify the costs of ongoing delivery of Hepatitis C services	Q1			Hepatitis C Workstream
3	Complete implementation planning	Q1			Hepatitis C Workstream
4	Appoint a Co-ordinator to drive the hepatitis C programme (subject to resourcing) in the South Island	Q2			Hepatitis C Workstream
5	Promote and implement the hepatitis C clinical pathway	Q2			Hepatitis C Workstream
6	Direct testing toward people at increased risk	Q2			Hepatitis C Workstream
7	Support the national campaign to raise community awareness of hepatitis C and risk factors for infection	Q3			Hepatitis C Workstream
8	Support the national GP awareness and education programme	Q3			Hepatitis C Workstream
9	Monitor and report on hepatitis C measures	Q2 and Q4			Hepatitis C Workstream

Quality and Safety Services

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

Clinical Lead: **Mary Gordon, Executive Director of Nursing 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.

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

- Infection Prevention and Control
- Partners in Care
- Clinical Governance
- Promoting safety frameworks – Safety 1st
- Emerging priorities

MILESTONES DASHBOARD 2016-19					
ITEM NO	DELIVERABLE 2016-2017	APPROVED SCHEDULE	DELIVERABLE 2017-2018	DELIVERABLE 2018-2019	RESPONSIBILITIES
KEY ENABLERS					
Quality and Safety					
Infection Prevention and Control					
Safe Surgery New Zealand					
1	SI DHBs implement the new Quality and Safety Marker as part of the Safe Surgery New Zealand HQSC programme	Q4			Contributors: SI DHBs supported by Quality and Safety SLA Reported in: SIHSP Individual DHBs will be responsible for reporting their own QSM audit results
ICNet (Infection Control)					
2	SI DHBs understand the capabilities of ICnet and determine the direction for the use of ICnet in the SI DHBs	Q4			Contributors: Quality and Safety SLA Reported in: SIHSP
Regional Infection Prevention and Control work shops					
3	Regional SI DHB Infection Prevention and Control workshops are held	Q4			Contributors: SI DHBs supported by Quality and Safety SLA Reported in: SIHSP
PARTNERS IN CARE					
Consumer Engagement					
4	Effective Consumer engagement in the SIA and South Island DHBs	Q4	Undertake further stocktake of consumer engagement to understand progress since the 2015/16 stocktake		Contributors: Quality and Safety SLA and SI DHBs Reported in: SIHSP

MILESTONES DASHBOARD 2016-19					
ITEM NO	DELIVERABLE 2016-2017	APPROVED SCHEDULE	DELIVERABLE 2017-2018	DELIVERABLE 2018-2019	RESPONSIBILITIES
			CLINICAL GOVERNANCE		
5	Place holder: Clinical governance framework (specific details of this are subject to the outcome of the HQSC work 2015/2016)	Q4			Contributors: Quality and Safety SLA Reported in: SIHSP
			PROMOTING SAFETY FRAMEWORKS		
			Safety1st		
6a	Provision of ongoing governance to Safety1st	Q4	Provision of ongoing governance to safety1st	Provision of ongoing governance to safety1st	Contributors: Quality and Safety SLA Reported in: SIHSP
6b	Safety1st Control Group (made up of representatives from each DHB) meet monthly to discuss Satety1st	Q4			
6b	Ongoing regional support for Safety1st is established	Q4			
6c	Enhancement and rollout of additional Safety1st modules: Risk Module Hazard Module RCA Module	Q4	Patient Feedback (subject to successful resource request)		Contributors: Quality and Safety SLA Reported in: SIHSP
6d	Consistent regional SI DHB Safety1st taxonomy System admin position/role descriptions or similar document Regional policies and change request forms	Q4			
6e	Provide regional SI DHB Safety1st reports	Q4	Regional SI DHB Safety1st reports	Regional SI DHB Safety1st reports	Contributors: SI DHBs supported by Quality and Safety SLA Reported in: SIHSP
6f	1. Business case and framework for the roll out of Safety1st into primary care and community providers (Subject to approval of the resource request for a project manager) 2. Safety1st rolled out into primary care and community providers (Subject to the recommendations of the business case)	Q3 Q4			Contributors: Quality and Safety SLA Reported in: SIHSP Contributors: Quality and Safety SLA Reported in: SIHSP
6g	Scoping of a national RL Solutions user group	Q4			
			EMERGING PRIORITIES		
			The Deteriorating Patient		
			Support SI DHBs with the work on the Deteriorating patient (HQSC initiative)		
			Pressure Injury Prevention		
			Support SI DHBs with the work on Pressure Areas (HQSC initiative)		

Work supported by the Quality and Safety Service Level Alliance

National projects supported by Quality and Safety
Health Quality and Safety Commission priorities including falls, hand hygiene, SSI and Medication Safety are individually reported on by the South Island DHBs. The South Island Patient Safety Campaign work group is responsible for driving a regional approach to the national programme, they report to the Quality and Safety SLA. The Health Quality and Safety Commission is actively engaged with the Quality and Safety SLA.
Regional projects enabled by Quality and Safety, but led by other SLAs and Workstreams
Inter-professional Learning (Item 1a & 1b, page 72) *Owner: South Island Work force Development Hub* **Falls Prevention (Item 8, page 48)** *Owner: Health of Older Persons SLA*

South Island Information Services

Lead CEO:	**Nigel Trainor (South Canterbury DHB)**
Clinical Lead:	**Andrew Bowers, Medical Director, Information Technology & Physician (Southern DHB)**
Programme Director:	**Paul Goddard (South Island Alliance Programme Office)**

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

The Information Services, Service Level Alliance has been formed to:

- Oversee the Information Services portfolio of work
- Provide overarching governance to the South Island Information Technology programme and projects
- Provide a point of escalation for the resolution of issues if the Programme or Projects vary from planned time, cost or scope

The Information Services, Service Level Alliance is implementing an information supported clinically led approach to patient care. With guidance from the National Health IT Board, the Information Services, Service Level Alliance has developed a portfolio of projects and programmes. Initial emphasize has been on establishing the regional platform by the systematic replacement of our legacy systems with the standardised regional solutions of Health Connect South, HealthOne, South Island Patient Information Care System, eReferrals Management and eMedicines Management. As these projects begin to transition from implementation into the business as usual phase the Information Services, Service Level Alliance can begin to implement additional building blocks to provide a foundation platform to support the delivery of care across the whole system.

The continued implementation of the portfolio is outlined within this Health Service Plan. This has been developed into a long term plan to address the priorities that the Alliance has identified. The 2016-17 Information Services Service Level Alliance workplan has been developed in line with the Ministry of Health's five year (2015-2020) Health IT Programme focus areas.

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

- **eHealth Records**
- **Digital hospitals**
- **Health Data**
- **Preventive Care**

The South Island is progressing the implementation of electronic solutions across the whole of the South Island health system that will provide better, safer, more efficient healthcare.

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

The IS SLA recognise that for information sharing and integrated services to work well it takes a team approach across the whole of the health system. As a core component of the alliance model we are clinically driven and supported by strong leadership and working in partnership with patients and vendors.

The IS SLA outcomes for implementing health informatics solutions is that they must ensure that people wait less, no wasted resource and that people are protected from harm or needless death.

As part of the SI commitment to delivering on the Minister of Health's[4] electronic health record vision the IS SLA programme of work will enable and support:

- Quality and productivity benefits to be realised through rationalising and eliminating duplication and replication of patient information across multiple systems and services through the consolidation and delivery of a single SI unified electronic health record;
- Creation of the SI unified electronic health record, that physically consolidates health information in one place, will improve decision support and care coordination especially for complex patients with multiple long-term conditions;
- A whole of system approach Primary Care will be incorporated into the SI unified electronic health record;
- The implementation of the eMedicines programme the SIA will enable the highest benefits in terms of patient safety and quality;
- The integration of consumer Portal access into the SI health system to deliver care closer to home. This leverages the ability to serve up information from a physical repository in real-time.

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

MILESTONES DASHBOARD 2016-19					
ITEM NO	DELIVERABLE 2016-2017	APPROVED SCHEDULE	DELIVERABLE 2017-2018	DELIVERABLE 2018-2019	RESPONSIBILITIES
KEY ENABLERS					
INFORMATION SERVICES					
eHEALTH RECORDS					
HEALTH CONNECT SOUTH PROGRAMME					
Regional Programme					
Southern HCS Implementation					
1	Complete Southern DHB's Health Connect South implementation.[5]	**Q1**			Lead: Regional Programme Manager SIAPO Reported in : SIHSP
2	Project closure for SDHB Health Connect South implementation	**Q2**			Lead: Regional Programme Manager SIAPO Reported in : SIHSP
Nelson Marlborough HCS Implementation					
3	Project closure for NMDHB Health Connect South implementation	**Q1**			Lead: Regional Programme Manager SIAPO Reported in : SIHSP
Mental Health					
4	Mental Health solution requirements agreed for SI DHBs	**Q1**	Phased implementation of SI Mental Health solution commences		Lead: Regional Programme Manager SIAPO Reported in : SIHSP
5	Pilot the Mental Health solution in one SI DHB	**Q3**			
HEALTHONE					
HealthOne enables pharmacists and other authorised clinicians to view patient information that is shared between multiple healthcare providers, including test results, allergies, prescribed and dispensed medications together with hospital information					
6	Complete the roll-out of HealthOne to SDHB	**Q2**	Project closure		Lead: Regional Programme Manager SIAPO Reported in : SIHSP
7	Complete the implementation of HealthOne for Marlborough PHO (NMDHB)	**Q2**			

[4] Jonathan Coleman Health Informatics New Zealand Conference, Christchurch , 20 October 2015
[5] Dependency on SMT solution

MILESTONES DASHBOARD 2016-19					
ITEM NO	**DELIVERABLE 2016-2017**	**APPROVED SCHEDULE**	**DELIVERABLE 2017-2018**	**DELIVERABLE 2018-2019**	**RESPONSIBILITIES**
SOUTH ISLAND PATIENT INFORMATION CARE SYSTEM (PICS)					
Alerts and Warnings					
8	Have an agreed solution and process for managing Alerts and Warnings across the South Island	**Q4**	Business case approved and implementation commenced	Project closure	Lead: Regional Programme Manager SIAPO Reported in: SIHSP
eMEDICINES PROGRAMME					
ePrescribing and Administration (ePA)					
Implementing ePA into inpatient wards across the South Island DHBs (incorporating NZULM & NZ Formulary when sources are available) with the aim of improving medication safety for patients whilst an inpatient					
9	Canterbury DHB ePrescribing and Administration project completed	**Q2**			Lead: Regional Programme Manager SIAPO Reported in: SIHSP
10	West Coast DHB ePrescribing and Administration project planning and implementation commenced	**Q4**	West Coast DHB ePrescribing and Administration project completed		
11	Nelson Marlborough DHB ePrescribing and Administration project planning and implementation commenced	**Q4**	Nelson Marlborough DHB ePrescribing and Administration project completed		
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)					
12	Deployment of eMR to CDHB completed	**Q2**	Implementation continues across remaining DHBs	Project closure	Lead: Regional Programme Manager SIAPO Reported in: SIHSP
13	Phased implementation commenced (starting with WCDHB) across the SI DHBs	**Q4**			
TELEHEALTH					
To scope and define a TeleHealth regional direction for the South Island					
14	Agree and define a South Island definition of Telehealth	**Q4**	Provide the SI DHBs with an agreed telehealth framework that identifies minimum SI standards when implementing a telehealth strategy.		Lead: IS SLA Reported in: SIHSP
15	Agree concepts of telehealth to be addressed and prioritise order for completion				
NATIONAL ELECTRONIC HEALTH RECORD					
Integration with the National EHR					
16	*Emerging/placeholder further detail maybe provided* Engage with the national programme to establish sector requirements and develop the roadmap for an EHR environment	**Q4**	Support the integration of SI systems with the national EHR implementation	Continue to support the national EHR implementation	Lead: IS SLA Reported in: SIHSP
CLINICAL OBSERVATIONS PLATFORM (Contingent on the approval of funding request)					
To implement an e-observations platform for the capture of vital signs and clinical data					
17	Scope and agree SI requirements for a clinical measurements platform	**Q4**	Regional Business case approved. Phased implementation of an e-measurements platform across the SI DHBs commenced.	Implementation completed	Lead: IS SLA Reported in: SIHSP
DIGITAL HOSPITALS					
eREFERRALS PROGRAMME					
Stage 1					
Regional implementation of Stage 1. eReferrals received by ERMS via fax					
18	Project closure and implementation reviewed completed	**Q3**			Lead: Regional Programme Manager SIAPO Reported in: SIHSP
Stage 2					
eReferrals received through the RMS module in Health Connect South					
19	Complete regional Stage Two implementation of eReferrals for NMDHB	**Q3**			

MILESTONES DASHBOARD 2016-19					
ITEM NO	**DELIVERABLE 2016-2017**	**APPROVED SCHEDULE**	**DELIVERABLE 2017-2018**	**DELIVERABLE 2018-2019**	**RESPONSIBILITIES**
20	Complete regional Stage Two implementation of eReferrals for SDHB	**Q4**			Lead: Regional Programme Manager SIAPO Reported in: SIHSP
21	Project closure and implementation reviewed completed	**Q4**			
Stage 3					
Implementation eTriage - eReferrals received through the RMS module in Health Connect South with triage functionality					
22	Regional eTriage Business case approved	**Q1**	Project closure and implementation reviewed completed		Lead: Regional Programme Manager SIAPO Reported in: SIHSP
23	Phased implementation commenced across all SI DHBs	**Q4**			
SOUTH ISLAND PATIENT INFORMATION CARE SYSTEM (PICS)					
Canterbury DHB Implementation					
24	Prepare for implementation into the balance of Canterbury DHB sites	**Q4**	Implement SI PICS into other Canterbury DHB sites		Lead: Regional Programme Manager SIAPO Reported in: SIHSP
Nelson Marlborough DHB Implementations					
25	Project go-live for Nelson Marlborough DHB	**Q4**	Project closure		Lead: Regional Programme Manager SIAPO Reported in: SIHSP
South Canterbury DHB Implementation					
26	Prepare for SI PICS Implementation	**Q4**	Implement SI PICS		Lead: Regional Programme Manager SIAPO Reported in: SIHSP
West Coast Implementation					
27	Prepare for SI PICS Implementation	**Q4**	Implement SI PICS		Lead: Regional Programme Manager SIAPO Reported in: SIHSP
Southern DHB Implementation					
28	Support the development of SDHB implementation business case for SI PICS	**Q4**	Prepare for SI PICS Implementation	Implement SI PICS	Lead: Regional Programme Manager SIAPO Reported in: SIHSP
ED Information Solution					
Provide a regional solution to support visibility of ED activity					
29	Progress with defining requirements and scope for a regional ED solution		Phased implementation of the ED information solution across the SI DHBs (commencing with NMDHB and CDHB)	Continue progression of implementation for the remaining DHBs	Lead: Regional Programme Manager SIAPO Reported in: SIHSP
eMEDICINES PROGRAMME					
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					
30	CDHB upgrade and WCDHB implementation complete	**Q1**			Lead: Regional Programme Manager SIAPO Reported in: SIHSP
31	Business case for regional instance of ePharmacy approved[6]	**Q2**			Lead: Regional Programme Manager SIAPO Reported in: SIHSP
32	Implementation of ePharmacy completed across remaining DHBs	**Q4**			
REGIONAL PROVIDER INDEX (contingent on the approval of funding request)					
To implement a SI Regional Provider index					
33	Define and agree SI requirements for a single instance of RPI	**Q1**	Phased implementation across remaining SI DHBs commenced	Project closure	Lead: IS SLA Reported in: SIHSP
34	Implement a single instance of the Regional provider index across CDHB	**Q4**			

[6] Contingent on having a completed review and agreed South Island Model for hospital pharmacy

MILESTONES DASHBOARD 2016-19					
ITEM NO	**DELIVERABLE 2016-2017**	**APPROVED SCHEDULE**	**DELIVERABLE 2017-2018**	**DELIVERABLE 2018-2019**	**RESPONSIBILITIES**
35	Agree phased deployment across the remaining DHBs	**Q4**			
eORDERING OF LABORATORY TESTS					
To implement a fully electronic laboratory ordering process					
36	Commence project scoping and agreement of regional direction.	**Q4**	Implementation commences	Continue progression of implementation	Lead: IS SLA Reported in: SIHSP
eORDERING OF RADIOLOGY TESTS					
To implement a fully electronic radiology ordering process					
37	Scope and commence implementation planning for SCDHB, WCDHB & NMDHB	**Q4**	Continue progression of implementation	Continue progression of implementation	Lead: IS SLA Reported in: SIHSP
SOUTH ISLAND MOBILITY STRATEGY FRAMEWORK					
To define the South Island mobility framework					
38	Define and agree components of a South Island mobility framework	**Q4**	Provide the SI DHBs with an agreed mobility framework that identifies minimum SI standards for when implementing a mobility strategy		Lead: IS SLA Reported in: SIHSP
HEALTH DATA					
DATA ARCHITECTURE FRAMEWORK (Contingent on approval of funding request)					
To define a regional data architecture framework[7]					
39	Agree and define a South Island data architecture framework	**Q4**			Lead: IS SLA Reported in: SIHSP
40	Agree and define regional network security policies and processes	**Q4**			
HEALTH CONNECT SOUTH					
PROXIMITY AUDITING (Contingent on approval of funding request)					
To implement privacy auditing to safeguard the sharing patient data across secondary and primary care in Health Connect South					
41	Agree and approve the SI direction for proximity auditing within HCS	**Q4**	Implement a proximity auditing in SI DHBs across secondary and primary care in Health Connect South		Lead: Regional Programme Manager SIAPO Reported in: SIHSP
SECURE MESSAGING FRAMEWORK					
To define the SI clinical secure messaging strategy					
42	Provide the SI DHBs with an agreed secure messaging framework that identifies minimum SI standards for attaching a digital message to a patients records	**Q4**			Lead: IS SLA Reported in: SIHSP
PREVENTIVE CARE					
The Information Services, Service Level Alliance portfolio provides solutions that support the delivery of preventive care (i.e. the means to provide data for national collections such as screening initiatives). In the 2016/17 workplan there is not a specific programme solely focused on contributing towards preventive care.					

[7] The Regional Data Architecture Framework will adhere to all relevant National Standards including HiSO standards

Work supported by the Information Services Service Level Alliance

The Information Services, Service Level Alliance with the role of an enabler, will be support and/or monitoring the delivery of the following projects; South Island National Trauma Project National Patient Flow, eLearning, Safety First, Advance Care Planning, Growth Charts, Mental Health Module, MOSAIQ, MDM Meeting Management, South Island Clinical Cancer Information System. These projects with either be led by the Ministry or another regional Workstream or Alliance.

National projects enabled by the IS SLA but led nationally or by DHBs or by other South Island Workstreams
Project: National Trauma Minimum Dataset (page 57, item 4) Owner: South Island National Trauma Workstream
Project: National Infrastructure Programme Owner: Nationally led
Project: National Patient Flow Owner: Nationally led
Project: National Maternity Solution Owner: Nationally led and implemented by individual DHBs
Regional projects enabled by IS SLA but led by other SLAs and Workstreams
Project: Improved functionality and coverage of MDMs across the region (page 38, items 9&10) **Project: South Island Clinical Cancer Information System (page 38, item 18)** Owner: Southern Cancer Network
Project: Growth Charts (page 41, item 8b) Owner: Child Health SLA
Project: New electronic systems and tools will enable health professionals to securely share and gather relevant patient information that will result in safer, better and timely palliative care to patients (page 50, item 2a) Owner: Palliative Care Workstream
Project: South Island Electrocardiogram Clinical Data Repository (page 53, item 12) Owner: Cardiac Workstream
Project: Advance Care Plan (page 48, item 13) Owner: Health of Older Peoples SLA
Project: Safety First (Risk Management Project (RL6) (page 64, items 6c&f) Owner: Quality and Safety SLA.
Project: eLearning (page 75, item 5a) Owner: South Island Workforce Development Hub

South Island Workforce Development Hub

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

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

The South Island Workforce Development Hub (SIWDH) works with the South Island health whole of sector to improve workforce development, education and training across the South Island to better meet the health needs of the South Island population. This is achieved by:

- Supporting innovative workforce development to ensure health professionals work to their full scope of practice in the new and emerging models of patient care with the support of an appropriately trained kaiawhina[1] (unregulated) workforce
- Strengthening the education and training networks across the South Island, focusing on enhancing and sharing innovative and multi-disciplinary approaches to healthcare delivery through effective education and training processes
- Collaborating with the other Regional Workforce Development Hubs and Health Workforce New Zealand to share workforce development ideas and initiatives and by participating in national and regional fora.

The work plan for 2016-17 builds on the work of the SIWDH workgroups, which involve over 120 clinicians from across health in the South Island. Further work to identify measures is ongoing and where appropriate these will be noted in the quarterly reports.

The areas of focus for 2016-17 are:

- Build and align the capability of the workforce to deliver new models of care
- Improve the sustainability of priority (vulnerable) workforces
- Grow the capacity and capability of Māori in the health workforce
- Grow the capacity and capability of Pacific People in the health workforce
- Optimise enablers to support workforce development
- Optimise the capacity and capability of the health workforce
- Strengthen health leadership through regional collaboration

MILESTONES DASHBOARD 2016-19					
ITEM NO	DELIVERABLE 2016-2017	APPROVED SCHEDULE	DELIVERABLE 2017-2018	DELIVERABLE 2018-2019	RESPONSBILITIES
KEY ENABLERS					
WORKFORCE & THE SOUTH ISLAND WORKFORCE DEVELOPMENT HUB					
BUILD AND ALIGN THE CAPACITY OF THE WORKFORCE TO DELIVER NEW MODELS OF CARE					
1a	Interprofessional The opportunities for interprofessional learning in a clinical environment are increased	Q4	Implementation is continued.	Progress is re-evaluated and action plan revised.	Lead: SIWDH Steering Group Reported in: SIHSP
1b	Interprofessional A coordinated clinical simulation network for the South Island is established	Q4	An evaluation system is in place.	Implementation is reviewed using evaluation information.	Contributors: SIWDH Steering Group Reported in: SIHSP
1c	Nurse Practitioner (NP): NP roles have increased across the South Island in identified areas of need	Q4	Ongoing.	Ongoing.	Lead: South Island EDONs Reported in: SIHSP

MILESTONES DASHBOARD 2016-19					
ITEM NO	**DELIVERABLE 2016-2017**	**APPROVED SCHEDULE**	**DELIVERABLE 2017-2018**	**DELIVERABLE 2018-2019**	**RESPONSBILITIES**
1d	Clinical Nurse Specialists Develop and support expert clinical nurse specialists groups to review and develop Lippincott clinical procedures	Q4	ongoing	ongoing	Lead: South Island EDONs Reported in: SIHSP
1e	Kaiawhina workforce Allied Health Assistants (AHAs): AHAs working across the South Island health system have access to appropriate NZQA level 3 training	Q4	Implementation of the New Level 3 NZQA qualification for Dental Assistants.	Ongoing	Lead: South Island Directors of Allied Health Reported in: SIHSP
	The Careerforce NZQA Level 4 Health and Wellbeing qualification is included in the AHA development framework	Q4	The initial cohort of trainees have completed their training using the Careerforce NZQA Level 4 Health and Wellbeing An evaluation of the initial cohort has been completed.	The Level 4 AHA training and development framework is 100% implemented across the SI DHB's. Outcomes are embedded into the South Island development framework.	Lead: South Island Directors of Allied Health Reported in: SIHSP
1f	Kaiawhina workforce Allied Health Assistants (AHAs): An effective delegation model is in place for services where Calderdale Framework has been implemented	Q4	Recommendations from evaluation have been reviewed and implemented. Priority areas are identified for delegation activity in new CF projects. This may include working with other health professional groups.	An effective SI toolkit exists for delegation to AHAs within the CF model	Lead: South Island Directors of Allied Health Reported in: SIHSP
1g	Workforce redesign A workforce redesign model (Calderdale Framework) is used in Allied Health settings to allow Allied Health Professionals (AHPs) to work to the top of their scope	Q4	Training of the 2nd cohort is completed. Standard outcome measures are included in all new CF projects. Recommendations from evaluation have been reviewed and implemented.	A sustainable framework for the CF implementation is developed.	Lead: South Island Directors of Allied Health Reported in: SIHSP
	Ensure sustainability of workforce redesign model across South Island	Q4	Ongoing	Ongoing	Lead: South Island Directors of Allied Health Reported in: SIHSP
IMPROVE THE SUSTAINABILITY OF PRIORITY (VULNERABLE) WORKFORCES					
2a	Nursing Strategy and planning to support older nurses to remain in the workforce and to maximise their contribution	Q4	Ongoing.	Ongoing.	Lead: SIWDH Nursing Sustainability Working Group and SI EDONs Reported in: SIHSP
2b	Sonography Support for the training of Sonographers to meet the identified South Island need	Q4	Ongoing	Ongoing	Lead: South Island DAHs Contributors: The South Island Sonography training group Reported in: SIHSP
GROW THE CAPACITY AND CAPABILITY OF MAORI IN THE HEALTH WORKFORCE					
3a	Maori Work alongside South Island GMs Maori to increase the number of Māori working in health	Q4	Ongoing.	Ongoing.	Lead: SIWDH Steering Group and SI GMs Maori Reported in: SIHSP
3b	Monitor DHB ethnicity workforce data (Maori and Pacific) to understand the current situation and trends	Q4	Ongoing.	Ongoing.	Lead: SIWDH Reported in: SIHSP and SIWDH Workforce Report

MILESTONES DASHBOARD 2016-19					
ITEM NO	DELIVERABLE 2016-2017	APPROVED SCHEDULE	DELIVERABLE 2017-2018	DELIVERABLE 2018-2019	RESPONSBILITIES
GROW THE CAPACITY AND CAPABILITY OF PACIFIC PEOPLE IN THE HEALTH WORKFORCE					
4a	Pacific Continue work to identify how best to support increasing the number of Pacific working in health	Q4	Ongoing.	Ongoing.	Lead: SIWDH Steering Group Reported in: SIHSP
OPTIMISE ENABLERS TO SUPPORT WORKFORCE DEVELOPMENT					
5a	eLearning platform A common eLearning platform accessible to all South Island health workforce staff	Q4	Ongoing	Ongoing	Lead: SIWDH Steering Group and ISSLA Contributors: eLearning working group. Reported in: SIHSP
5b	eLearning packages An increased number of eLearning packages are available to the South Island health workforce	Q4	Regional learning packages continue to be developed. Content developed is shared nationally.	Ongoing	Lead: SIWDH Steering Group. Reported in:SIHSP
5c	Lippincott Procedures The South Island and Midlands working in partnership designing a national framework for the management of Lippincott New Zealand instance	Q4	Ongoing review and development	Ongoing	Lead: SI Executive Directors of Nursing in partnership with the Midland Region Executive Directors of Nursing Contributors: Lippincott Project Board and Lippincott Implementation Group. Reported in: SIHSP
5d	Regional Health Library Service Exploring the concept of a South Island regional health library service	Q4	To be determined	To be determined	Lead: SIWDH Steering Group Reported in:SIHSP
OPTIMISE THE CAPACITY AND CAPABILITY OF THE HEALTH WORKFORCE					
6a	Medicine Community based attachments to meet requirements of new Medical Council curriculum	Q4	Increasing numbers to achieve 100% compliance in 2020.	Increasing numbers to achieve 100% compliance in 2020.	Lead: South Island Chief Medical Officers Contributors: RMO Units Reported in: SIHSP
6b	Medicine Support the DHBs to integrate the increased number of PGY1s (NZ citizens and permanent residents) into the workforce	Q4	The South Island has employed their share of the national total (114 in November 2017).	The South Island has employed their share of the national total (120 in November 2018).	Lead: South Island Chief Medical Officers Contributors: South Island RMO Units Reported in: SIHSP
6c	Rural Health The opportunity of a regional rural health medicine clinical placement programme is explored	Q4	The identified pathway for clinical rotations is implemented.	The identified pathway for clinical rotations is evaluated.	Lead: South Island Chief Medical Officers Contributors: Rural Hospital Medicine working group. Reported in: SIHSP

MILESTONES DASHBOARD 2016-19					
ITEM NO	DELIVERABLE 2016-2017	APPROVED SCHEDULE	DELIVERABLE 2017-2018	DELIVERABLE 2018-2019	RESPONSBILITIES
STRENGTHEN HEALTH LEADERSHIP THROUGH REGIONAL COLLABORATION					
7a	Midwifery A pathway has been developed for future clinical Midwifery Leaders	Q4	Ongoing.	Ongoing.	Lead: South Island Midwifery Leaders Reported in: SIHSP
7b	Allied Health Scientific & Technical leadership: A regional clinical/professional leadership role is implemented for an Allied Health profession	Q4	Implementation of regional roles in other professions.	Ongoing	Lead: South Island Directors of Allied Health Reported in: SIHSP
	An agreed framework for determining/establishing and implementing regional AHS&T clinical/professional leadership roles exists		Ongoing	Ongoing	Lead: South Island Directors of Allied Health Reported in: SIHSP

Work supported by the South Island Workforce Development Hub

Regional projects enabled by SIWDH but led by other SLAs and Workstreams

A regional approach to cardiology nurse training developed (page 52, item 10)

- Cardiac nurse educators supported to continue meeting quarterly
- Agree and implement a draft plan

Owner: Cardiac Services Workstream

Opportunities for training in echocardiography identified (page 53, item 11)

- Implement recommendations formed in 2015/16 in conjunction with National Network

Owner: Cardiac Services Workstream

Urology nursing (page 54, item 2)

- Practice and service delivery supports clinical consistency, equity of access and improved patient outcomes via Lippincott Procedures Manual implementation

Owner: Elective Services

Workforce Development recommendation& integrated plan for primary & NGO sector (page 44,

- Developing a workforce that supports the South Island withdrawal management plan pending the implications of the new legislation
- Develop the capacity and capability of the practice nurse workforce
- Develop a regional approach to increasing NESP capability in the NGO/Community setting

Owner: Mental Health & Addictions SLA

Advance Care Planning (page 47, item 2)

- ACP L 2 Training is available in a planned manner for staff in each DHB district in South Island (subject to resources)

Owner: Health of Older People SLA

Dementia Services (page 48, item 8)

- Continue to develop Walking in Another's Shoes programme material for other staff groups (subject to funding)
- Commence the development of material for use with a 2 day workshop for Aged Residential Care Managers

Owner: Health of Older People SLA

Workforce (page 60, item 6)

- Training plans developed by each DHB to ensure relevant clinical staff are appropriately trained in trauma care

Owner: Major Trauma Services

Ongoing education and training for interdisciplinary stroke team (page 64, item 7)

- South Island Stroke teams have a minimum of 8 hours stroke specific education per year (minimum standard)
  Stroke teams have access to a range of educational opportunities (regional and local) to support continued development of knowledge and skill in delivering best practice stroke services

Owner: Stroke Services

Projects that continue to be supported or monitored by SIWDH

- The nurse endoscopist who is training in Southern DHB as part of the bowel screening initiative lead by the Elective Services workstream.
- The development of palliative care nurse specialists and education roles in Hospices. This includes the establishment of a South Island & Midland regional Lippincott palliative care expert group which includes Hospice and aged residential care nurses in collaboration with the South Island Palliative Care workstream.
- Medical physicists' recruitment & retention in the South Island.

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: **Dr Geoff Shaw, Intensive Care Specialist (Canterbury DHB)**

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.

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

- Procurement and savings
- Building networks
- Project and savings collaboration with other Workstreams of the SLA
- SS SLA maintains strong functioning, clinically-led workstreams
- Manage change in conjunction with national agencies for local and regional benefits
- Incorporate sustainability practices
- Cultural and consumer input
- St John Regional agreement for Patient Transfer service

MILESTONES DASHBOARD 2016-19					
ITEM NO	DELIVERABLE 2016-2017	APPROVED SCHEDULE	DELIVERABLE 2017-2018	DELIVERABLE 2018-2019	RESPONSIBILITIES
KEY ENABLERS					
Support Services					
PROCUREMENT AND SAVINGS **Achieve and report savings in line with nationally agreed methodology**					
Aggregate procurement requirements and improve purchasing power					
1 a	Regional procurement policy (for non-health Alliance – out of scope) adhered to.		Maintenance of efficient procurement activity resulting in regional savings and risk mitigation for South Island DHBs. Regional procurement policy implemented to end user satisfaction	Maintenance of efficient procurement activity resulting in regional savings and risk mitigation for South Island DHBs	Procurement and Supply Chain Workstream; P and SC managers in each district implemernt
1 b	Regional procurement plan (for non-health Alliance – out of scope) activities adhered to.		Maintenance of efficient procurement activity resulting in regional savings and risk mitigation for South Island DHBs	Maintenance of efficient procurement activity resulting in regional savings and risk mitigation for South Island DHBs	Procurement and Supply Chain Workstream; P and SC managers in each district implement
1 c	Procurement projects active and achieved through collaboration with other agencies for example DHBs, health Alliance, Pharmac, MOBIE		Maintenance of efficient procurement activity resulting in regional savings	Maintenance of efficient procurement activity resulting in regional savings	

MILESTONES DASHBOARD 2016-19					
ITEM NO	**DELIVERABLE 2016-2017**	**APPROVED SCHEDULE**	**DELIVERABLE 2017-2018**	**DELIVERABLE 2018-2019**	**RESPONSIBILITIES**
1 d	Savings of $3 million (using nationally agreed methodology) achieved during the 2016 - 17 year through the South Island Procurement and Supply Chain workstream		Savings of $3 million (using nationally agreed methodology) reported during the 2017-18 year through the South Island Procurement and Supply Chain workstream	Savings of $3 million (using nationally agreed methodology) reported during the 2018-19 year through the South Island Procurement and Supply Chain workstream	SS SLA
MAINTAIN RELATIONSHIPS WITH STAFF IN KEY RELATED SERVICES, FROM RELEVANT LOCAL, REGIONAL AND NATIONAL HEALTH SERVICES ORGANISATIONS					
Representation on SS SLA & workstreams includes: clinical representation and key national bodies					
2 a	Clinical endorsement of initiatives.		Maintenance of strong clinically endorsed activity	Maintenance of strong clinically endorsed activity	SS SLA
2 b	Input by national agencies to workplans.		Maintenance of strong clinically endorsed activity	Maintenance of strong clinically endorsed activity	SS SLA
PROJECT AND SAVINGS IN COLLABORATION WITH OTHER WORKSTREAMS OF THE SLA					
Align with the target of collective procurement driven by national agencies					
3	Increased rationalisation and standardisation of products and services.		Maintain increased rationalisation and standardisation of products and services by working in conjunction with other key agencies	Maintain increased rationalisation and standardisation of products and services by working in conjunction with other key agencies	SS SLA
SS SLA MAINTAIN STRONG FUNCTIONING CLINICALLY LED WORKSTREAMS					
Workstream's workplan contain at least three quantifiable, measureable Key Performance Indicators (KPIs), at least one of which is financial					
4	KPIs reported and monitored.		Strong functional workstreams delivering results	Strong functional workstreams delivering results	SS SLA
MANAGE CHANGE IN CONJUNCTION WITH NATIONAL AGENCIES FOR LOCAL AND REGIONAL BENEFITS					
Opportunities for joint ventures with providers of services					
5	Opportunities agreed and implemented where appropriate.		Additional local and regional benefits gained from collaborative projects	Additional local and regional benefits gained from collaborative projects	SS SLA
ST JOHN REGIONAL AGREEMENT FOR INTER HOSPITAL TRANSFERS (IHT)					
Facilitate the annual review of the regional IHT agreement negotiated between the South Island DHBs and St John.					
6	Annual review of the regional Inter-Hospital Transfers agreement completed.		Review agreement Q2	Review agreement Q2	SS SLA
INCORPORATE SUSTAINABILTY PRACTICES					
Workstreams incorporate sustainability practices					
7	Sustainability practices acknowledged in workstreams		Sustainable practices enhanced with increased knowledge	Sustainable practices enhanced with increased knowledge	SS SLA with support from Public Health Partnership
CULTURAL AND CONSUMER INPUT					
Opportunities for cultural and consumer input investigated					
8	Cultural and consumer input acknowledged in workstreams		Increased range of knowledge and skills enhances Support Services work	Increased range of knowledge and skills enhances Support Services work	SS SLA

Appendix 5: Memberships of Alliance groups

Strategic Planning and Integration team

Name	Title	DHB
Dr Carol Atmore (Chair)	General Practitioner	Primary Care, Otago
Carolyn Gullery	General Manager, Planning and Funding	CDHB
Hilary Exton	Service Manager and Director of Allied Health	NMDHB
Dr Daniel Williams	Clinical Director, Community and Public Health	CDHB
Lynda McCutcheon	Director of Allied Health, Scientific and Technical	SDHB
Pania Coote	Executive Director of Māori Health	SDHB
Karyn Bousfield	Director of Nursing and Midwifery	WCDHB
Steve Earnshaw	Orthopaedic Surgeon	SCDHB
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 (Chair)	Haematologist, Clinical Services	CDHB
	Dr Shaun Costello	Clinical Director, Southern Cancer Network/Clinical Director Medicine & Radiation Oncologist	SDHB
	Elizabeth Cunningham	Māori representative	Te Waipounamu Māori Leadership Group
	Theona Ireton	Kaitiaki	CDHB
	Marj Allan	Consumer & South Island Alliance Palliative Care	Canteen
	Danielle Smith	Cancer Support Coordinator	West Coast PHO
	Dr Tristan Pettit	Paediatric Oncology	CDHB
	Pania Coote	Acting Executive Director of Māori Health	SDHB
	Christine Nolan	General Manager Secondary Services	SCDHB
	Michelle Driffill	Regional Manger Northern South Island for CanTeen	Canterbury
	Andrew Lesperance	General Manager Planning & Funding	NMDHB
	Mike Kernaghan	Chief Executive	Cancer Society, Southern
	Di Riley	Southern Cancer Network Manager	SCN
Child Health Services	Dr David Barker (Chair)	Clinical Director, Women's and Children's Health	SDHB
	Dr Nick Baker	Community Paediatrician	NMDHB
	Dr Clare Doocey	Paediatrician	CDHB
	Anne Morgan	Service Manager, Child Health	CDHB
	Donna Addidle	Service Manager, Child Health	SCDHB
	Dr Nicola Austin	Paediatrician	CDHB
	Dr Mick Goodwin	Paediatrician	SCDHB
	Prof Barry Taylor	Professor of Paediatrics	University of Otago
	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
	Traci Stanbury	Consumer	Canterbury
	Rosalie Waghorn	Nurse Manager Clinical Services - Strategic	WCDHB
	Jane Haughey	Facilitator	SIAPO

Health of Older People Services	Dr Val Fletcher	General Practitioner	CDHB
	Michael Parker	CEO, Presbyterian Support Service South Canterbury	South Canterbury
	Carole Kerr	Walking in Another's Shoes Dementia Educator	NMDHB
	Margaret Hill	General Manager, Strategy, Planning and Accountability	SCDHB
	Dr Stanley Smith	Geriatrician	SCDHB
	Kate Gibb	Nursing Director, Older People – Population Health,	CDHB
	Karen Kennedy	Community Pharmacist, Primary and Community Services	SCDHB
	Jane Large	Facilitator	SIAPO
	Ann Armstrong	Consumer member	Nelson
	Andrew Metcalf	Director Allied Health	SDHB
Palliative Care	Dr Kate Grundy (Chair)	Consultant Physician in Palliative Medicine	CDHB
	Dr Stanley Smith	Geriatrician	SCDHB
	Dr Amanda Lyver	Clinical Director of Paediatric Oncology	CDHB
	Marj Allan	Consumer	West Coast
	Kate Gibb	Nursing Director Older People and Population Health	CDHB
	Carla Arkless	Palliative Care Nurse Practitioner	Presbyterian Support Southland
	Rachel Teulon	Clinical Nurse Specialist, Paediatric Palliative Care	Nurse Maude
	Dr Brigid Forest	General Practitioner	Hospice Marlborough
	Jane Rollings	Service Manager	Nurse Maude
	Sharon Stewart	Nurse Leader	Otago Community Hospice
	Sharon Adler	Portfolio Manager Planning and Funding	SDHB.
	Rachel Nicolson-Hitt	Clinical Development Manager	St John South Island
	Theona Ireton	Māori representative	CDHB
	Lydia Bras	Social Worker	CDHB
	Jane Haughey	Facilitator	SIAPO
Mental Health & Addiction Services	Dr David Bathgate (Chair)	Consultant Psychiatrist	SDHB
	Dr Alfred Dell'Ario	Consultant Psychiatrist	CDHB/WCDHB
	Heather Casey	Director of Nursing	SDHB
	Rose Henderson	Allied Health	CDHB
	Paul Wynands	Primary Care	Rural Canterbury PHO
	Robyn Byers	General Manager	NMDHB
	Sandra Boardman	Executive Director Planning and Funding	SDHB
	Karaitiana Tickell	CEO, Purapura Whetu Trust	Canterbury
	Thomas Cardy	Operations Manager	pact
	Dianne Black	Consumer Advisor	South Canterbury
	Martin Kane	Facilitator	SIAPO
Support Services	Jock Muir (Chair)	Director, Strategic Projects	CDHB
	Dr Geoff Shaw (Clinical Lead)	Intensive Care Specialist	CDHB
	Jane Wilson	Acting Director Nursing Operations	SDHB
	Eric Sinclair	General Manager Finance & Performance	NMDHB
	Mark Newsome	General Manager Grey/Westland Health Services	WCDHB
	Dr Peter Bramley	Service Director, Medical Surgical Services	WCDHB
	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
	Nigel Trainor	Chief Executive	SCDHB
	Chris Dever	Chief Information Officer	CDHB
	Jane Brosnahan	Nursing, Midwifery and Allied Health	SCDHB
	John Beveridge	Nurse Consultant	CDHB
	Dr Nigel Millar	Chief Medical Officer	SDHB
	Dr Russell Rarity	Clinical Director, Anaesthetics	SCDHB
	Stella Ward	Executive Director, Allied Health	CDHB/WCDHB
	Patrick Ng	General Manager IT & Infrastructure	NMDHB
	Carolyn Gullery	General Manager, Planning and Funding	CDHB
	Dr Peter Gent	General Practitioner	Mornington Health Centre
	Sheree East	Nursing Director	Nurse Maude
	Paul Goddard	Programme Director, Information Services	SIAPO
	Sonya Morice	Facilitator	SIAPO
Quality and Safety	Mary Gordon (Chair)	Executive Director of Nursing	CDHB
	Ken Stewart	Community Physiotherapist	Selwyn Village Physiotherapy
	Karen Vaughan	General Manager Organisational Development	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 Health
	Carolyn Gullery	General Manager Planning and Funding	CDHB/WCDHB
	Mark Newsome	General Manager Grey and Westland Health Services	WCDHB
	Anna Carey	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
	Christine Nolan	General Manager Secondary Services	SCDHB
	Dr Garry Nixon	Medical Officer	Dunstan Hospital
	Dr Nick Fisher	Consultant Cardiologist	NMDHB
	Dr Belinda Green	Cardiologist	SDHB
	Curt Ward	Clinical Practice Manager, South Island, St John	Independent
	Alan Lloyd	Facilitator	SIAPO

Elective Services	Andrew Lesperance	General Manager Strategy, Planning and Alliance Support	NMDHB
	Carolyn Gullery	General Manager, Planning and Funding	CDHB/WCDHB
	Margaret Hill	General Manager Strategy Planning and Accountability	SCDHB
	Sandra Boardman	Executive Director of Planning and Funding	SDHB
	Dr Peter Bramley	General Manager Clinical Services	NMDHB
	Pauline Clark	General Manager, Christchurch Hospital	CDHB
	Christine Nolan	General Manager, Secondary Services	SCDHB
	Lexie O'Shea	Executive Director of Patient Service	SDHB
	Mark Newsome	General Manager Grey Westland Health Services	WCDHB
	Janice Donaldson	Programme Manager, South Island Electives	SIAPO
Major Trauma	Dr Mike Hunter (Chair)	Clinical Leader ICU	SDHB
	Maureen Beentjes	Southern Region Emergency Care Coordinator Team Coordinator and Snr Registered Nurse ICU	SDHB
	Dr Vicky Mann	Radiologist (Trauma/ED)	CDHB
	Dr Dominic Fleischer	Specialist Emergency Physician	CDHB
	Dr Christopher Wakeman	Surgical Consultant	CDHB
	Lesley Owens	Service Manager	CDHB
	Dr Peter Kyriakoudis	Medical Officer	WCDHB
	Dr Peter Doran	SMO Anaesthetist	SCDHB
	Rachel Nicholson-Hitt	Clinical Development Manager, South Island	St John
	Ralph la Salle	Team Leader, Secondary Care, Planning and Funding	CDHB
	Dr Alf Deacon	General Surgeon	NMDHB
	Dr Martin Watts	Emergency Medicine Specialist, Acting Clinical Leader	SDHB
	Phyllis Meier	Category Delivery Manager, Rehabilitation Services	ACC
	Alan Lloyd	Facilitator	SIAPO
Stroke Services	Dr John Fink (Chair)	Clinical Director, Neurology	CDHB
	Dr Wendy Busby	Consultant Physician & Geriatrician	SDHB
	Clare Jamieson	Occupational Therapist	CDHB
	Julian Waller	Stroke Clinical Nurse Specialist	SCDHB
	Dr Suzanne Busch	Geriatrician, General Physician	NMDHB
	Dr Carl Hanger	Stroke Rehabilitation Consultant & Geriatrician	CDHB
	Nanette Ainge	Planning & Funding	CDHB
	Allison Gallant	Nurse Coordinator Acute Stroke	CDHB
	Margot van Mulligen	Physiotherapist	WCDHB
	Jane Large	Facilitator	SIAPO
South Island Public Health Partnership	Dr Ed Kiddle (Chair)	Medical Officer of Health	NMDHB
	Dr Keith Reid	Clinical Leader, Medical Officer of Health	SDHB
	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	MoH
	Dr Ramon Pink	Medical Officer of Health, and Māori Public Health Portfolio	CDHB
	Lynette Finnie	Service Manager, Public Health Services	SDHB
	Margaret Bunker	South Island Alliance Programme Co-ordinator	SIAPO
	Ruth Teasdale	Facilitator	SIAPO

South Island Workforce Development Hub

Name	Title	Organisation
Mary Gordon (Chair)	Executive Director of Nursing	CDHB
To be advised	Director of Midwifery	
Lynda McCutcheon	Director of Allied Health, Scientific and Technical	SDHB
Nigel Millar	Chief Medical Officer	SDHB
Pania Coote	Acting Executive Director of Māori Health	SDHB
Pam Kiesanowski	Director of Nursing and Midwifery	NMDHB
Margaret Bunker	South Island Alliance Programme Coordinator	SIAPO
Sarah Creegan	General Practitioner, Waimate Medical Centre	SCDHB/Primary Care
Kate Rawlings	Regional Programme Director Training	SIAPO
Kathryn Goodyear	Facilitator	SIAPO