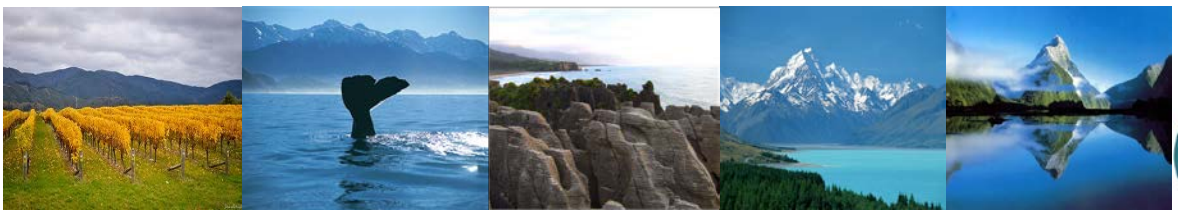
SOUTH ISLAND REGIONAL HEALTH SERVICES PLAN

2013 - 2016



SOUTH ISLAND ALLIANCE
best for patients, best for system

South Island Regional Health Services Plan

Produced in 2013

By the South Island Alliance Programme Office

On behalf of the five South Island DHBs

Telephone: 03 378 6631

PO BOX 639, Christchurch

FOREWORD

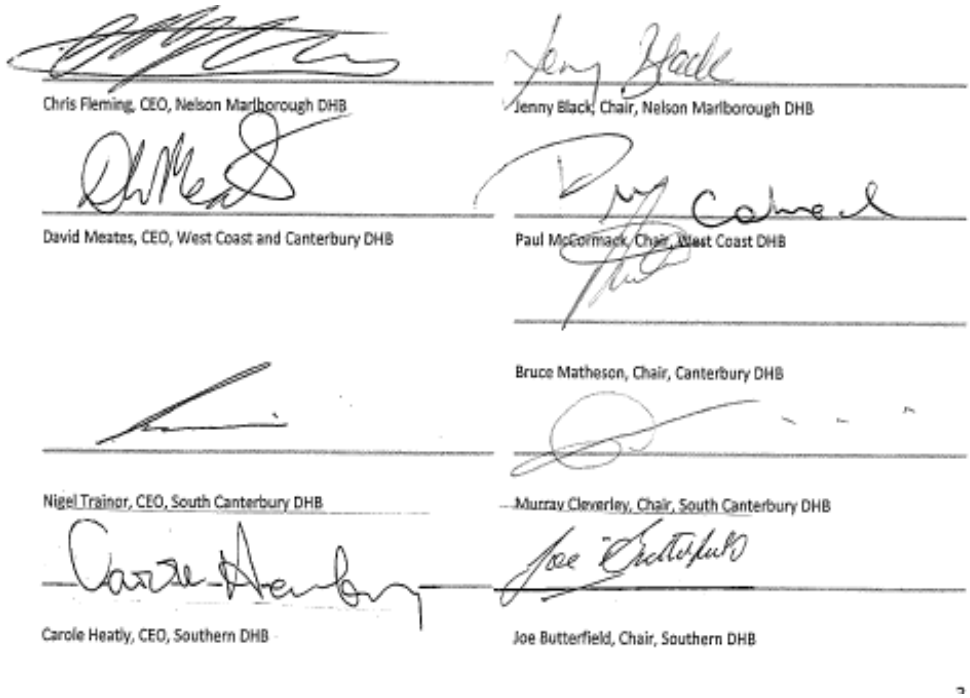
The South Island Alliance Board and Leadership Team have confirmed their commitment to the alliance framework as the means to ensure a sustainable service that continues to reduce disparity in access and outcomes while increasing health gain for the whole South Island population. The alliance approach has begun to show benefits across clinical and enabling service areas and increasingly provides a mechanism to work together in the current fiscally constrained environment.

This South Island Health Services plan (SIHSP) starts to provide a three year approach to our collaborative activities. This will be built on in coming years as we develop a longer term view. The activities take place within a matrix environment with clinical developments, informing workforce, information services and capital planning.

The plan has been submitted to the five South Island DHB Boards and has been endorsed with one proviso. The DHBs are currently finalising their budgets for the coming year. While the majority of the additional resources required for the activities within the workplans (as outlined in Section 6, Service Performance Priorities 2013-2016) have been identified, there are a few initiatives where it will be essential to submit, and have approved, by the South Island Alliance Leadership Team, business cases. In the current fiscally constrained environment we will endeavour to implement initiatives where there is an efficiency gain but this will need to be demonstrated to justify the resource requirements.

The SIHSP draws from national strategies and key priorities, including the National Health Targets, the Minister's Expectations, and the Operational Policy Framework, and is interwoven into each of the South island DHB Annual Plans. These plans provide direction and guidance in terms of how the South Island Health System will operate and prioritise its resources and effort. This Plan has been developed taking all of these plans into account, as well as the Minister's Letter of Expectation which is appended to this plan. This plan continues to challenge how we work together, however successful implementation of the plan will ensure that we move forward in achieving our vision of a clinically and fiscally 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.

Signed by:



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

Received 12 AUG 2013
Copied To
Action
Due

9 AUG 2013

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

Dear Chris

South Island Region, 2013/14 Regional Health Services Plan

This letter is to advise you I have approved the 2013/14 South Island Regional Health Services Plan (RHSP). I appreciate the significant work that goes into preparing such a thorough planning document and I thank you for your effort. I look forward to seeing your progress over the course of the year.

While recognising these are tight economic times, the Government is dedicated to improving the health of New Zealanders and continues to invest in key health services. In Budget 2013, Vote Health received the largest increase in government spending, demonstrating the Government's on-going commitment to safeguarding and growing our public health services.

Greater integration between regional DHBs supports more effective use of clinical and financial resources. I expect DHBs to make significant progress in implementing their Regional Service Plans, including actions for identified Government priorities and your agreed regional clinical priorities. It is evident from your RHSP that the South Island region DHBs are working to realise the benefits of regional collaboration, and that this influences your local service planning. I look forward to seeing delivery on your agreed regional actions.

Mental Health
I am aware that services for patients with high and complex needs and the interface with forensic services is an area that has been identified as needing to be further strengthened in the South Island region. Capacity challenges with forensic services in parts of New Zealand are expected to increase due to increasing demand as prison facilities are commissioned and as the current clinical facilities are expanded and upgraded.

The South Island region needs to be ready to offer support and to be clear about the magnitude of any issues in their own regions.

I am aware that work has already begun in this area. I attach a table outlining actions your region is expected to deliver in 2014/15 so that I can be assured that there is clarity of the issues and that some progress will be made during this year. The regional governance

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

arrangements specific to mental health need to be visible, and to identify the senior executive leader/s that will support the action plans through to implementation. Regular reporting through the quarterly progress reports for Regional Service Plans will also assist the Ministry to support DHBs with making progress.

Quality and Safety
I am also aware that the South Island has recently established a regional Quality and Safety group to support South Island DHBs achieve the New Zealand Triple Aim for quality and safety outcomes. The actions to be completed in 2013/14 need to be provided by the end of quarter one 2013/14 as an addendum to the South Island RHSP. Actions need to be achievable with measurable quarterly milestones provided.

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

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

I would like to thank you, on behalf of the DHB Board Chairs, Boards and DHB Chief Executive Officers in the South Island region, for your valuable contribution and continued commitment to delivering quality health care to your population and wish you every success with the implementation of your 2013/14 Regional Health Services Plan. I will be monitoring your progress throughout the year and look forward to seeing your achievements.

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

Yours sincerely

Hon Tony Ryall
Minister of Health

cc. South Island Region DHB Chairs
South Island Region Chief Executive Officers

Actions to be completed as part of 2013/14 Regional Services Plans

Key area of focus	Actions to deliver	Timeframe
High and complex needs patients	• Complete an analysis of the service needs for people with high and complex needs, including a gap analysis. The linkages and interface with forensic services need to be made transparent. The region needs to agree to actions that will provide tangible benefit to patients in addressing some of the identified issues within the 2013/14 year • Regular progress reports are provided to the NHB / Ministry	Q1 reporting, Oct 2013 Q2, Q3, Q4

Note:

- Q1 is the period ending September 2013
- Q2 is the period ending December 2013
- Q3 is the period ending March 2014
- Q4 is the period ending June 2014.

Contents

1. EXECUTIVE SUMMARY

"Steering the course for a sustainable future"

Our vision is a clinically and fiscally 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.

The South Island Context

With a total South Island population of 1,050,571 people (23% percent of the total New Zealand population), implementing diverse, but similar, individual responses duplicates effort and investment and leads to service and access inequality. Regional collaboration is an essential part of our future direction.

During 2012 the South Island DHBs reiterated their commitment to a 'best for patients, best for system' alliance framework that aligns with national policy. There was overwhelming support for the alliance framework from the reviews undertaken with the Board, Alliance Leadership team (ALT) and Service Level Alliance team members. This South Island Regional Health Services Plan progresses the direction and key principles that continue to inform regional service development, service configuration and infrastructure requirements.

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

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

Our ability to achieve through this approach has been clearly demonstrated by the outcomes achieved to date. Our Service Level Alliances and regional work activities continue to grow and build on the work undertaken to-date to achieve the vision for the South Island.

The challenges faced by Canterbury DHB following the Christchurch earthquakes of 2010 and 2011, have been significant and are acknowledged by the South Island Alliance. The relationships developed through the South Island Alliance have been pivotal in providing support for the continued delivery of patient care through these challenges.

South Island Alliance Activity

The South Island DHBs are involved in collaborative activity across a large number of regional and sub-regional service areas. The South Island Alliance Board and Alliance Leadership Team recognise the need for focused effort to increase momentum in achieving collaborative outcomes. In 2013-16 the alliance approach will continue to be applied to the existing four priority clinical service areas and three. The Quality and Safety Service Level Alliance (SLA), established early 2013, will support the focus on the triple aim approach and determine the options for collaborative activity in line with the national priorities.

The Service Level Alliances:

1. Cancer
2. Health of Older People
3. Child Health
4. Mental Health
5. Support Services
6. Information Services
7. Quality & Safety

During the 2013-14 year the South Island Neurosurgery Governance Board will transfer the oversight of the service to the South Island DHBs. The Neurosurgery service will become our eighth Service Level Alliance.

In addition to these services, the workstreams established for cardiac, elective and stroke services will increase momentum during 2013-16 to deliver the identified national outcomes. The South Island Regional Training Hub, Human Resources, Asset Planning, Māori Health and Communication activities support and align with the Service Level Alliance direction.

Each priority area, whether supported by a 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, along with the regional communication strategy supports the activities across the South Island.

2. INTRODUCTION

The five South Island DHBs face significant and immediate challenges as we refocus efforts to ensure the future sustainability of health services in the South Island and to achieve the priorities of Government. However, as we change the way we work to meet these challenges, we will create exciting opportunities to improve outcomes for our collective populations.[1]

Two reviews of the South Island Alliance framework were facilitated at the end of 2012 with the SLA teams, and the Alliance Board and ALT. The overwhelming response from both the Alliance Board, ALT and SLA teams was the very strong support for the alliance model. The Alliance Board and ALT strongly endorsed that the alliance model is the right way to continue for the South Island.

Gains made through regional collaboration

The South Island Alliance was established in 2011 and undertakes collaborative activity within the alliance framework. The first half of 2012-13 has seen considerable collaborative activity—and benefit from this activity—at a regional level. These improvements to our health services result primarily from the development and implementation of regional systems and processes.

> *"Large system transformations in health care are interventions aimed at coordinated, system-wide change affecting multiple organisations and care providers, with the goal of significant improvements in the efficiency of health care delivery, the quality of patient care, and population level patient outcomes"* (Best A, WHO 2012)

Examples of key outcomes from the Service Level Alliances and other regional activities include:

- Support for the cancer services multidisciplinary meeting process and mitigation of current geographical inequities. The proof of concept for the new audiovisual/videoconference system was completed in Dunedin, Nelson and Invercargill in February 2013 and recommends South Island wide roll-out. The sign-off process to implement this is currently underway.
- The Southern Cancer Network (SCN) South Island Comparative Lung Audit reported a significant improvement in wait times for diagnosis and treatment of lung cancer when comparing data from 2008 with 2010 data. The average wait time for diagnostic procedures reduced by over two weeks, while 88 percent of patients now have a specialist assessment within two weeks of referral.
- The SCN has been working with the South Island DHBs and the National Health IT Board to support the roll out and greater utilization of MOSAIQ across the South Island. South Island cancer patients will benefit from a high quality, connected service wherever they receive treatment and clinicians will be freed up to spend time on clinical responsibilities rather than administrative tasks.
- The Mental Health Mothers and Babies regional clinical leadership team has reviewed standards of care for mothers presenting with serious psychiatric illness in the perinatal period and developed a mental health birth plan process and documentation for all patients. This has been disseminated to the districts during the recent educational visits. This work will support best practice treatment and care.
- The Mental Health Mothers and Babies team and the Canterbury initiative have developed a patient centric relationship between general practitioners and hospital clinicians. This relationship will assist in minimising barriers around access to specialist services.
- The South Island Eating Disorders Service has delivered the Maudsley Family-Based therapy (MFBT) across the South Island. MFBT is recognized as a key aspect in providing best practice treatment and care to improve patient outcomes for young people with anorexia nervosa and their families.
- The Regional Medical Detoxification service explored the options for developing and monitoring clinical standards. This has led to a Standards Checklist being compiled covering each of the five main phases of activity for patients: Referral, Assessment, Treatment, Review and Discharge.

[1] South Island Alliance Charter (refer Appendix 1)

- Shared paediatric clinical review forums between Nelson Marlborough and South Canterbury DHBs are now facilitated through video-conferencing and provide support for sole practitioners improving clinical supervision and clinical decision making for patients.
- Standardised regional referral pathways for children have been successfully implemented and have demonstrated improved access for children requiring tertiary level paediatric surgery.
- Procurement and Supply Chain staff have achieved excellent results with planning and executing procurement strategies to deliver bottom line savings during quarter two. As at 31 March 2013, $10.39m in savings has been achieved using Health Benefits Limited (HBL) methodology freeing up this saving for more direct allocation to the system and patients.
- The Information Services SLA completed a robust process to select Orion Health as the preferred partner to move forward in the regional Patient Administration System development.
- Following a regional stroke thrombolysis training forum held in November one stroke patient has been successfully thrombolysed at Grey Base Hospital (WCDHB) with a good acute recovery phase and reduction of stroke disabilities.

Our 2013-16 plan

This updated plan, the *South Island Regional Health Services Plan (2013-2016),* builds on our achievements to date, while addressing new areas for which benefit is expected through applying a regional approach, with an ongoing focus of value for our patients. The plan provides a framework for future planning and outlines the region's priorities for 2013-2016. It has been developed by the five South Island District Health Boards (Nelson Marlborough, West Coast, Canterbury, South Canterbury and Southern), and the primary care and community members of the Service Level Alliances and workstreams. Emphasis has been placed on building on the achievements of the last two years and developing a longer term direction.

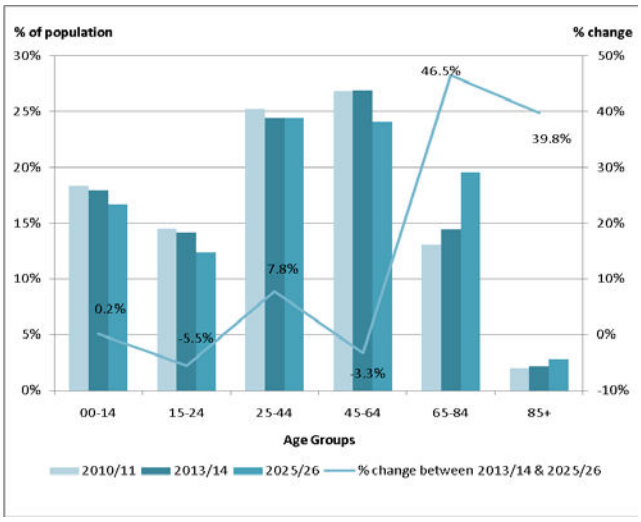
The South Island Regional Health Services Plan (2013-2016) has been approved by the regional Chief Executive Officers (CEOs) and the Boards of all five South Island DHBs, subject to business cases relating to anything not specifically included within the plan being submitted, and approved, by South Island Alliance Leadership Team. It reiterates our health services planning processes and agreed framework for regional decision making, and provides an action plan for 2013-16 based around the services we have prioritised for regional and sub-regional focus.

Section 6 outlines the work plans for each of the 2013-16 Service Performance Priorities.

Demographics

The population data for South Island in 2013/14 remains largely unchanged from that of previous years (see Appendix 2). The South Island Alliance monitors the South Island population data against the predicted trends. In 2010/11 the 25-44 year age group was approximately 26% of the South Island population, by 2025/26 it is predicted to decline to 24%. The 2013/14 South Island population data is trending towards the 25-44 year age group having declined to this level (Figure 1). We believe this is a reflection of one-off changes in Canterbury post earthquake but will monitor this going forward as this is an important age group for our health workforce.

Figure 1: South Island Projected Population Change by Age Group, Period 2013-14 to 2025-26



Managing our Risk

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

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

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

The Christchurch Earthquakes

The February 2011 earthquake dealt the Canterbury DHB (CDHB) infrastructure a huge blow and radically escalated physical capacity constraints. Twenty four months on, the Canterbury health system continues to deliver services but it is a fragile system, beset with uncertainties.

- More than 3,000 homes have been vacated in the residential red zone. Many people are living in temporary accommodation, moving about the city or sharing the homes of friends and relatives, while they wait for repairs, rebuild or look for permanent accommodation.
- Prolonged levels of stress, anxiety and poor living arrangements are exacerbating chronic illness and increasing demand for services.
- There are challenges in maintaining viable health services (general practice and pharmacies) close to the Red Zone where the population has dropped, while demand now exceeds capacity in other areas.
- Many Non Government Organisations (NGOs) are still working from temporary and makeshift facilities and disrupted travel links and amplified health needs are stretching resources.
- Despite converting offices to replace 73 of the hospital beds lost in the earthquakes – the CDHB is still operating with fewer beds than before. Beds are also split between hospital sites, increasing patient transfers and fragmenting clinical teams.
- The earthquakes and ongoing aftershocks have resulted in unplanned costs of over $26m and the final interplay between repair costs, insurance recovery and the financial impact of new Building Codes is yet to be determined.

While there was an initial population drop after the earthquakes, Statistic New Zealand (NZ) is projecting the Canterbury population will be back to pre-quake numbers by June 2013. Concerningly however, international literature on disaster recovery indicates that those who were vulnerable prior to a disaster have an increased risk of poor health afterwards.[2] The earthquakes and ongoing aftershocks will have a significant and ongoing physical and psychological impact on the Canterbury population and increases in demand on health services are expected in the coming years. Primary care providers and the Specialist Mental Health Services in Canterbury are now experiencing a greater demand for services due to the associated trauma and stress resulting from the earthquakes. This demand is placing significant pressure on already compromised services.

There are also a number of predicted population scenarios that suggest around 30,000 may be people coming into the region to help with the rebuild of Christchurch. Planning is underway but currently there is no way of knowing how long these people will stay, whether they will bring family with them or what their health needs will be.

The increased demand, coupled with the fragility of Canterbury's DHB infrastructure post-quake and the strain under which services and staff are operating is particularly significant in terms of the proportion of regional/national capacity that Canterbury DHB represents.

While more than 90% of Canterbury's DHB activity is for its own population, around 4,000 people a year travel to Canterbury from other parts of the South Island to access in-patient services. In all, Canterbury DHB provides over $100m worth of services to the populations of other DHBs around New Zealand and delivers just over half of all the surgical services provided in the South Island (51%). It is critical that Canterbury DHB maintains current hospital and specialist service delivery levels.

The next few years will continue to be challenging. The Canterbury DHB has broken buildings that must be repaired and it must do so without compromising the delivery of services. The repair and rebuild is a slow process and affects the whole of Canterbury's health system. Canterbury DHB needs to be supported during this period to ensure their future viability and the delivery of care, not just to their own population but to the population of the whole of the South Island.

With capacity severely restricted, it is vital that the Canterbury DHB is able to focus investment on restorative models of care and services that support people to stay well to reduce hospital admissions and the demand for Aged Related Residential Care beds. It is also critical that all South Island DHBs have a sharper focus on flexible responses that will get ahead of escalating issues, especially mental health and long-term conditions, so that the need for tertiary care, particularly acute care (in Canterbury facilities), is minimised.

The South Island Alliance can plan the delivery and configuration of services. However, there is no basis on which to predict activity and demand for health services after natural disasters, such as Canterbury has experienced, and no comparable situation to draw upon. In essence, the South Island Alliance have to be prepared to respond quickly and flexibly to changing circumstances and need.

Canterbury DHB has adopted a 'whole-of-system' production planning approach to respond to capacity constraints and will significantly increase outsourcing to the private sector while it repairs and rebuilds its capacity. The Canterbury DHB expects to need private capacity in areas of elective surgical services such as Ophthalmology, Orthopaedics, Cardiac Surgery, General Surgery and Urology.

In their current exceptional circumstances, it is likely that the way in which some Canterbury DHB services are delivered will have to be adjusted to allow for providers' short-term capacity constraints and the short term relocation of services as the DHB undertakes extensive and disruptive facility repairs.

[2] Bidwell, S (2011), 'Long term planning for recovery after disasters: ensuring health in all policies – a literature review', Canterbury DHB Community and Public Health

The development of regional patient pathways and collaborative regional planning will assist to identify any service coverage issues and gaps. Any service changes that Canterbury DHB makes will be carefully considered so as not to destabilise regional work or negatively affect neighbouring DHBs.

Regionally, the South Island Alliance will closely monitor access and utilisation trends across the South Island to identify where in the system support is required to meet patient need and gauge how the system is functioning as a whole. However, the South Island Alliance acknowledges it is dealing with a large element of the unknown and this plan should be read with that in mind.

3. STRATEGIC DIRECTION

3.1 Setting our Strategic Direction

Although the South Island DHBs may differ in size, structure and approach, they each have a common goal: to improve the health of their populations by delivering high quality and accessible health care. With increasing demand for services, workforce shortages and rising costs, this goal is increasingly challenging and the health system without change faces an unsustainable future. In response, significant changes are being made to the design and delivery of health services at all levels of the New Zealand health system.

3.2 Strategic context

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

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

In 2010 the National Health Board released *Trends in Service Design and New Models of Care*. This document provided a summary of international trends and responses to the pressures and challenges facing the health sector, to help guide DHB service planning.[3]

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

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

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

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

3.3 National direction

These shifts are consistent with the changes being driven across the New Zealand health system to meet the Government's commitment to providing *'better, sooner, more convenient health services'.*[4]

At the highest level DHBs are guided by the *New Zealand Health Strategy*, *Disability Strategy,* and *Māori Health Strategy (He Korowai Oranga)* and by the requirements of the *New Zealand Public Health and Disability Act.*

DHBs are also expected to meet Government commitments to: increase access to services and reduce waiting times; improve quality, patient safety and performance; and provide better value for money**.**

[3] Trends in Service Design and New Models of Care: A Review, 2010, Ministry of Health, www.nationalhealthboard.govt.nz.
[4] John Key, National Party Health Discussion Paper 2007.

Alongside these national strategies and commitments, are the Minister of Health's 'Letter of Expectations' and the National Health Board's planning guidelines signal annual priorities for the health sector.

In summary, the Minister's 2013/14 priorities are: [5]

- Better public services – in particular, supporting vulnerable children;
- Care closer to home;
- Health of older people;
- Regional and national collaboration; and
- Living within our means.

"The management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system" WHO working definition of integrated service delivery

DHBs are also expected to deliver against the six national health targets:

- Shorter stays in emergency departments;
- Improved access to elective surgery;
- Shorter waits for cancer treatment;
- Increased immunisation;
- Better help for smokers to quit; and
- More heart and diabetes checks.

The South Island Alliance is committed to making continued progress on national priorities and health targets. Activity planned over the coming year to deliver on the Minister's expectations is outlined in the Service Performance Priorities section (section 6) of this document.

3.4 Regional direction

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

Significant progress is expected in implementing Regional Health Service Plans and delivering on regional workforce, information services and capital objectives in the coming year.

Canterbury, Nelson Marlborough, West Coast, South Canterbury and Southern DHBs form the South Island region. Together providing services for 1,050,571 people, representing 23% percent of the total New Zealand population.

While each DHB is individually responsible for the provision of services to its own population, working regionally enables them to better address their shared challenges and support improved patient care and more efficient use of resources.

Together, the South Island DHBs have established the South Island Alliance: a partnership between the five DHBs that is committed to a '*best for patients, best for system*' framework and strong clinical engagement.

Closely aligned to national direction, the regional vision is a clinically and fiscally sustainable South Island health system focused on keeping people well, where services are provided as close as possible to people's homes.

Regional activity is implemented through service level alliances and workstreams based around priority service areas. The work is clinically led, with multidisciplinary representation from community and primary care as well as hospital and specialist services.

[5] Minister of Health's Letter of Expectations 2013/14, Ministry of Health, www.health.govt.nz.

The South Island Alliance success relies on improving patient flow and the coordination of health services across the South Island by aligning patient pathways, introducing more flexible workforce models and improving patient information systems to better connect the services and clinical teams involved in a patient's care

Seven service areas have been prioritised: Cancer, Child Health, Health of Older People, Mental Health, Information Services, Support Services and Quality and Safety.

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

All South Island DHBs are involved in the majority of SLAs and other collaborative activities and lead at least one area. The longer-term outcomes they are seeking and the impact they are hoping to make on the health of our collective populations are articulated in section 4 of this document. The 2013/16 South Island Regional Health Services Plan is available from the Alliance website: www.sialliance.health.nz.

3.5 Local direction

DHBs are responsible for supplying health and disability services to meet the needs of their populations; however, resources are limited. To sustainably cope with the increasing demand for services, DHBs must design pathways that influence the flow of people—delivering care in the most appropriate setting and reducing demand by supporting people to stay well and maximise their independence.

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

4. IMPROVING HEALTH OUTCOMES FOR OUR POPULATION

4.1 What are we trying to achieve?

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

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

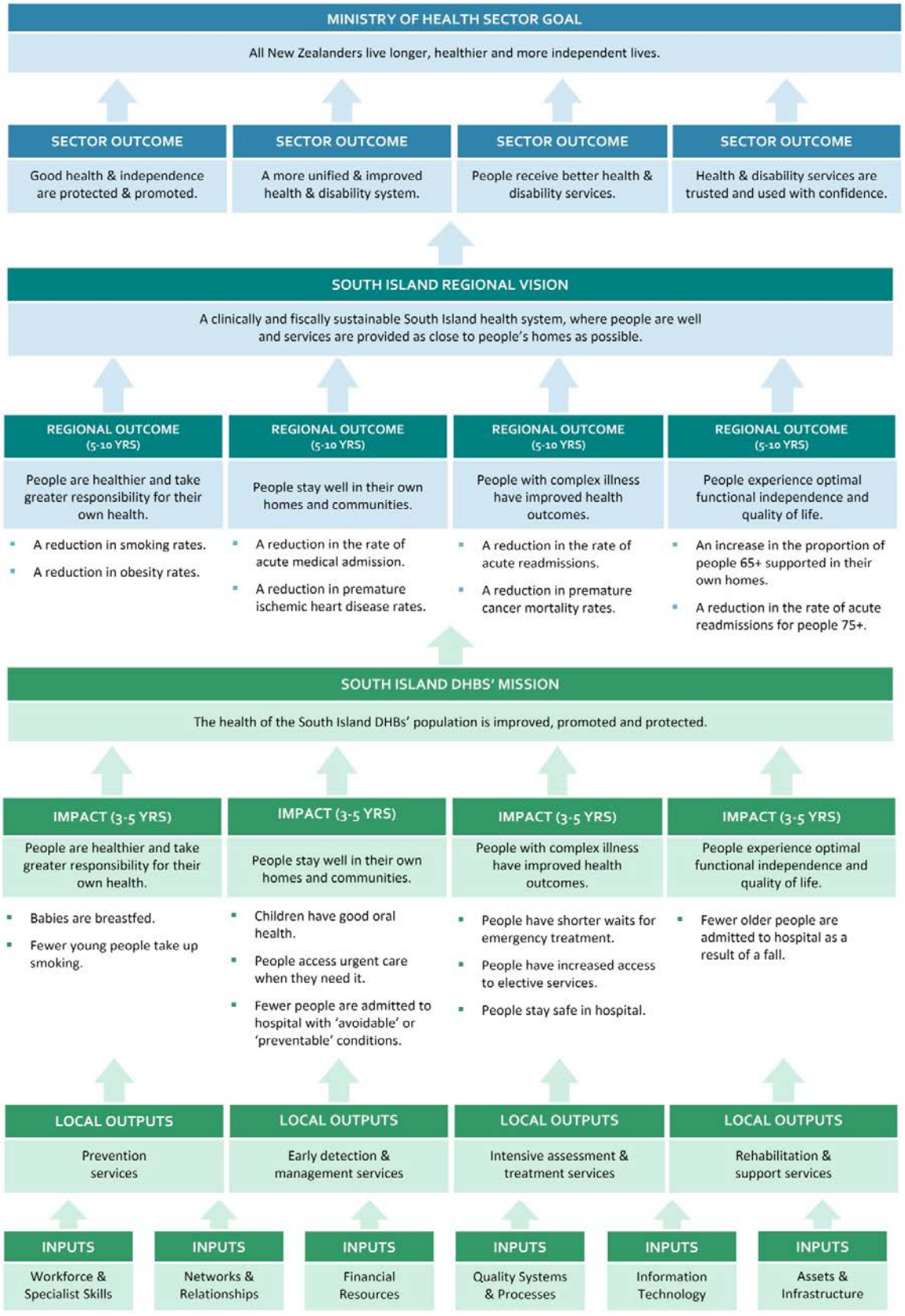
The South Island DHBs have collectively identified four strategic outcomes and a core set of associated indicators, which will demonstrate whether they are making a positive change in the health of their populations. These are long-term outcomes (5-10 years in the life of the health system) and as such, they are aiming for a measurable change in the health status of our populations over time, rather than a fixed target.

- **Outcome 1: People are healthier and take greater responsibility for their own health.**
  - A reduction in smoking rates.
  - A reduction in obesity rates.
- **Outcome 2: People stay well in their own homes and communities.**
  - A reduction in the rate of acute medical admission.
  - A reduction in premature ischemic heart disease rates.
- **Outcome 3: People with complex illness have improved health outcomes.**
  - A reduction in the rate of acute readmissions.
  - A reduction in premature cancer mortality rates.
- **Outcome 4: People experience optimal functional independence and quality of life.**
  - An increase in the proportion of people over 65 supported in their own homes.
  - A reduction in the rate of acute readmissions for people over 75.

For each of these desired outcomes, they have also identified areas where individual DHB performance will have an impact on success and collectively agreed a core set of medium-term (3-5 years) performance measures. Because change will be evident over a shorter period of time, these impact measures have been identified as the 'main measures' of performance and each South Island DHB has set local targets in their Annual Plans to evaluate their performance over the next three years.

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

Figure 2: intervention logic diagram



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 patient, best for system' framework."[6]

Regional governance and leadership

In order to affect the implementation of regional service planning and delivery, the South Island DHBs have established an alliance framework to enable rapid implementation of complex and evolving services without the need to disrupt current organisational structures.

'Innovation is change that creates a new dimension of performance.' Peter Drucker

The DHBs are adopting this approach to facilitate 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 adopted because it is uniquely suited to:

- Collaborative ventures;
- Diverse stakeholder interests;
- Complex and evolving service development; and
- Complex risk situations where traditional 'risk transfer' approaches are precluded because the scope is unclear or the circumstances, and risks, are unpredictable.

South Island Alliance Governance Board and Leadership Team Charter

The Alliance Governance Board and Leadership Teams' charter states that the foundation of the Alliance is a commitment to act in good faith to reach consensus decisions on the basis of 'best for patients, best for system'. The Board and Leadership Team have signed the Charter agreeing to conduct themselves and undertake their leadership role in a manner consistent with the Alliance principles. The charter is signed by each team member. Regional teams including, South Island Strategic Planning and Integration Team (SPaIT), the SLAs and South Island Regional Training Hub (SIRTH) have a charter that reflects the governance charter but is tailored for the specific activity of the team.

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 5).

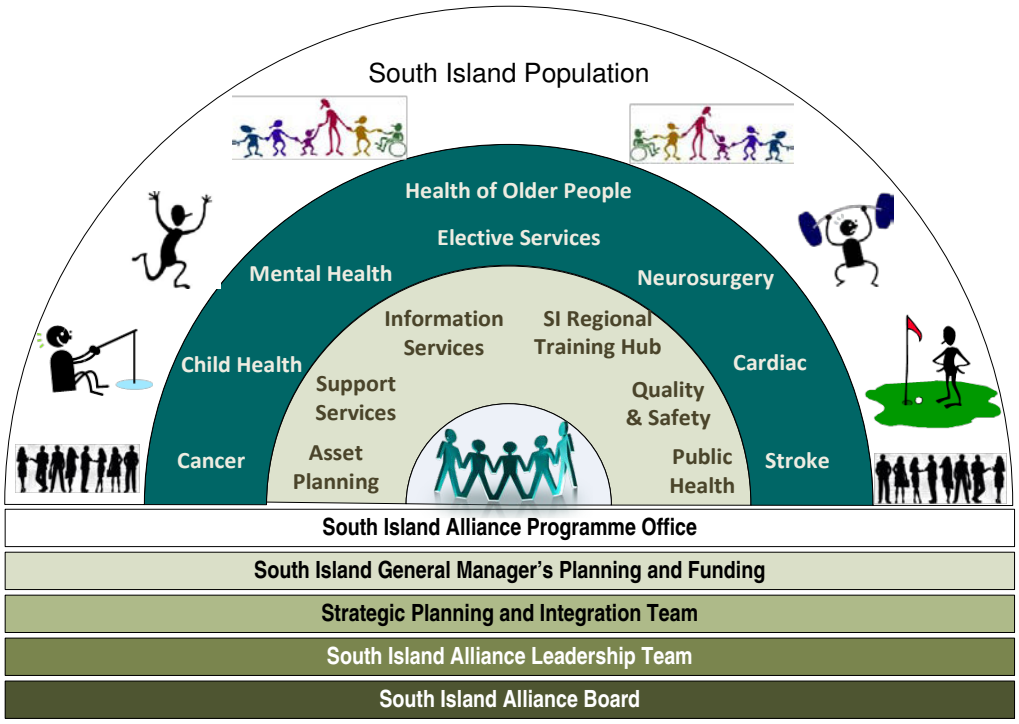
The foundation of the South Island Alliance is a commitment to act in good faith to reach consensus decisions on the basis of 'best for patients, best for system'.

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.

[6] South Island Alliance Charter (refer Appendix 1)

South Island Alliance Structure

Figure 3: South Island Alliance Structure



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

- An Alliance Board (the five South Island DHB Chairs) that sets the strategic focus, oversees, governs, and monitors overall performance of the Alliance.
- An Alliance Leadership Team (the South Island DHB CEOs) that prioritises activity, allocates resources (including funding and support) and monitors deliverables.
- A Strategic Planning & Integration Team that supports an integrated approach, linking the Service Level Alliances and workstreams to the South Island vision, and identifying gaps and recognising national, regional and district priorities. SPaIT provides a strategic and integrated view that is broader than the current priority areas, and incorporates the South Island Regional Health Services Plan development.
- The Team is comprised of a Chief Medical Officer, Director of Nursing, General Manager Māori Health, Director of Allied Health, Public Health Physician, primary and community clinician, General Manager Planning and Funding, and the General Manager of the South Island Alliance Programme Office.
- 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.
- The SIP&FN support SLAs through participation and providing the Planning and Funding function of DHB accountability for the funds allocated and invested to deliver improved health outcomes through a whole of system and population perspective.
- Service Level Alliances. CEOs and Boards recognise the need for focused effort to gain momentum in achieving collaborative outcomes. The South Island Alliance Programme Office supports the Service Level Alliances.
- Collaborative activity also takes place through a number of other workstreams, which include both clinical and non-clinical activity.

5.2 Improving Health Systems Outcomes

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

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

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

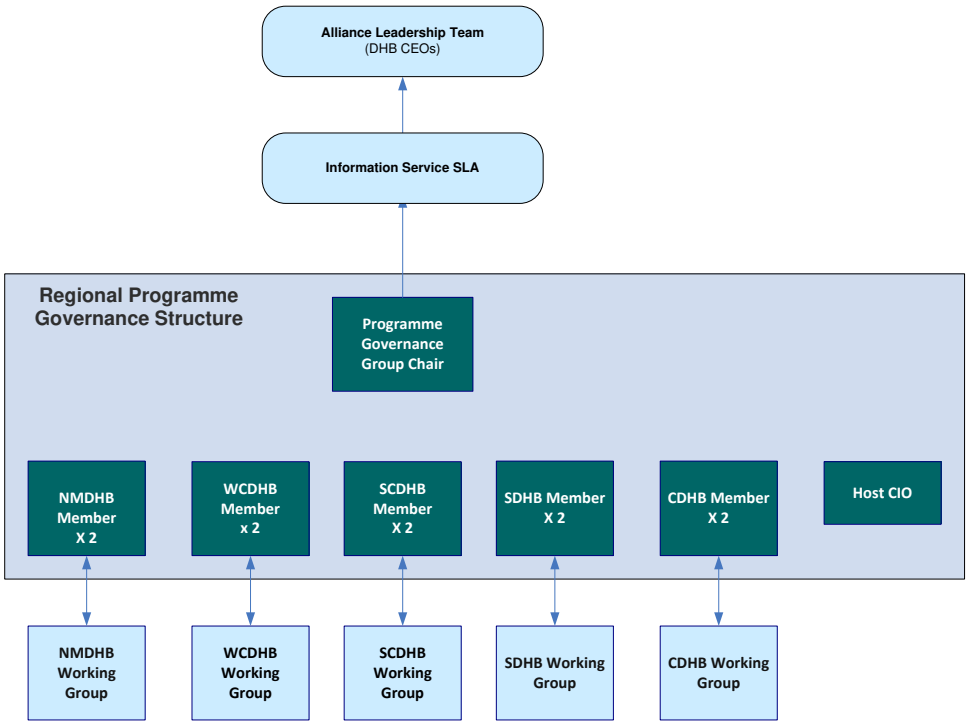
- that the health and disability system and services are trusted and can be used with confidence; and
- that people receive better health and disability services.

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

1. **Reduce the disparity of patient outcomes:** To improve the health system to increase or modify access to address health disparities between population groups, ensuring the outcome for the patient is the same irrespective of their ethnicity, socio-economic status and where they live.
2. **Value for the patient:** To improve the health service that patients receive through improving service quality and safety, taking a 'whole-of-system' approach and better coordination and integration of care.
3. **Productivity of providers:** To address workforce issues, improve service-to-service integration and systems, and increase value for dollar through more efficient and effective support systems.

5.3 Information Services Service Level Alliance

Figure 4: IS SLA Structure



Background

The South Island DHBs work together within the Information Services SLA, utilising combined resources to jointly solve problems, develop innovative solutions to health sector challenges and achieve outcomes for the people of the South Island Region.

The Information Services SLA formed in April 2011. Infrastructure and business processes continue to be developed to manage the large portfolio. The Alliance Leadership Team has approved four Programme Managers to deliver the initiatives identified.

Strategic Direction

The strategic direction has been developed in line with National Health Information Technology Board's (NHITB's) objectives. The Information Services SLA has developed a Communications Plan to engage stakeholders. The Communications Plan outlines how the Information Services SLA can demonstrate to stakeholders its goals and objectives. Media interviews and road show events covering both the purpose of the South Island Alliance and the Information Services SLA activities have been positively received.

Decision Making

The governance structure (figure 3) has been developed as the template for regional project / programme governance. This will be adapted to include other stakeholders when relevant for projects / programmes i.e. NGOs. The Information Services SLA has well developed linkages with the Regional Chief Information Officer (CIO) Group.

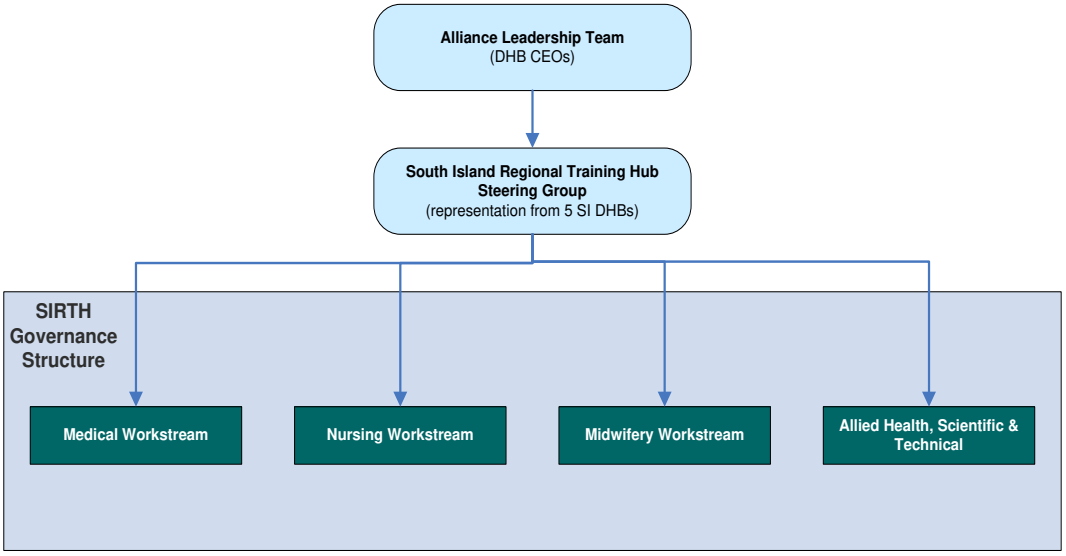
The South Island Information Services SLA will develop formal decision making processes.

Capability and Resource

The ability for Information Services SLA to fulfil its regional capability and resource commitments has been identified as a risk to the Information Services SLA work programme. Regional leads for the programmes have been approved by ALT. A regional workshop is planned for March 2013 to develop a regional plan in conjunction with the Information Services SLA and South Island CIO's.

5.4 South Island Regional Training Hub

Figure 5: SIRTH Structure



The South Island Regional Training Hub's (SIRTH) governance structure sits under the umbrella of the South Island Alliance with its steering group comprising of representatives from the five South Island DHBs.

SIRTH is structured into four work streams (figure 4): Allied Health, Scientific and Technical, Medical, Midwifery and Nursing. A clinical leadership team has been developed for each of the four workstreams. Health professionals and key stakeholder groups in public and private health provision including specialist consultant medical professionals, General Practitioners (GPs), NGOs, education providers, professional colleges, Primary Health Organisations (PHOs) and health unions are being engaged with the relevant workstreams. Opportunities for cross workstream activity will be promoted.

5.5 Regional Capital Committee

Establishment of the South Island Alliance has lead to a review of the approach for asset planning and management at a regional level.

During 2011-12 the South Island Alliance:

- Restructured the Regional Capital Committee (RCC), including:
    - membership, as all members of Alliance Leadership Team and the Alliance Board are now members of RCC to ensure alignment with DHB and South Island strategic approaches
    - review of the RCC Terms of Reference to reflect the South Island Alliance environment
- Established the South Island Asset Management Plan working group
- Established the Strategic Planning & Integration Team to support the links between clinical service and asset planning.

6. SERVICE PERFORMANCE PRIORITIES 2013-2016

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

The South Island DHBs are involved in collaborative activity across a large number of regional and sub-regional service areas. The areas identified in this section are those that have been given national and regional priority. In addition to these priority areas, regional planning continues for neurosurgery, ophthalmology, quality and safety, Primary Health Organisation emergency planning and emergency care coordination. Population Health and Māori approaches have been incorporated into each of the 2013-16 priority area workplans.

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. A regional communication strategy and the South Island Alliance Programme Office support the activities across the South Island.

Māori Health

"As a population group, Māori have on average the poorest health status of any ethnic group in New Zealand".[7]

The Government has made it a key priority to reduce the health inequalities that affect Māori. The South Island Health Services Plan (2013-16) will support activities to enable health outcomes and life expectancy of the South Island Māori Population to be improved. The priority areas of Cancer, Child Health, Mental Health, Health of the Older Person, Cardiac and Stroke include specific measures to reduce the health inequality affecting Māori. The electives priority area will provide ongoing monitoring to maintain the current equitable access to elective services in the South Island between Māori and non-Māori. South Island population data predicates a more rapid growth in the Māori and Pacific populations than in New Zealand as a whole (appendix 2). The increase in South Island Māori and Pacific populations provides challenges in that Māori and Pacific people currently have higher rates of smoking and obesity than other population groups, are more likely to have complex or multiple long-term conditions, and have higher morbidity and mortality rates.[8]

The Health of New Zealand Adults 2011/12 Health Survey

The Health of New Zealand Adults 2011/12[9] Health Survey identified that Māori adults:

- have poorer health and a higher level of unmet need for health care
- are generally disadvantaged across all indicators of health status, including access to health services
- had higher rates of medicated high blood pressure, ischaemic heart disease and stroke than other adults.
- had much higher rates of psychological distress than other people. However, people in these ethnic groups had similar or lower rates of diagnosed common mental disorder than other people.

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

[8] Health and Disability Intelligence Unit (2008); SISSAL *Health Needs Assessment*, Christchurch; Health and Disability Intelligence Unit, Health and Disability Systems Strategy Directorate, Ministry of Health, Wellington

[9] Ministry of Health. 2012. *The Health of New Zealand Adults 2011/12: Key findings of the New Zealand Health Survey*. Wellington: Ministry of Health.

Cancer

Tatau Kahukura: Māori Health Chart Book (2010, 2nd Edition)[10] indicators show large disparities across cancer registration and mortality rates for Māori adults. Breast, lung, colorectal, uterine and stomach cancers were the most common cancers registered for Māori females. The leading causes of cancer death for Māori females were lung, breast, colorectal, stomach and cervical. Lung, prostate, colorectal, stomach and liver were the most common cancer registration sites and causes of cancer death for adult Māori adult males.

Child Health

The children's social health monitor for health and wellbeing indicators shows there are large disparities in child health status with Māori and Pacific children and those living in deprived areas experiencing a disproportionate burden of morbidity and mortality [11]

Hospital admissions in the South Island during 2006 – 2010 for medical conditions such as asthma, gastroenteritis and upper respiratory tract infections with a social gradient were significantly lower than the New Zealand rate in Nelson Marlborough and Otago. Rates in South Canterbury, the West Coast, Canterbury and Southland were similar to the New Zealand rate. In Canterbury during 2000 – 2010 hospital admissions for ambulatory sensitive admissions (avoidable) medical conditions were higher for Pacific and Māori children. In Nelson Marlborough, South Canterbury, Otago and Southland admissions were higher for Māori children.

In Canterbury during 2006 – 2010 hospital admissions for injuries arising from assault, neglect or maltreatment of children were significantly higher than the New Zealand rate. All South Island DHBs were consistently higher hospital admission rates for Māori and Pacific children[12].

Health of Older People

Tatau Kura Tangata: Health of Older Māori Chart Book (2011)[13] indicates that Māori (≥50 years) have higher prevalence rates across many health conditions and chronic diseases than that of non-Māori, including rates of cancer, diabetes and cardiovascular disease. On the whole older Māori are more likely to experience poorer health outcomes, a higher burden of chronic illness and have increased exposure to risk determinants for poor health than non-Māori.

6.1 Clinical Services: Sustainability and Clinical Integration

6.1.1 Southern Cancer Network Services: South Island Cancer Services

Better Sooner More Convenient Health Services for New Zealanders in relation to cancer means all New Zealanders can easily access the best services, in a timely way to improve overall cancer outcomes.

A health system that functions well for cancer is one that ensures all:

- People get timely services across the whole cancer pathway (screening, detection, diagnosis, treatment, management and palliative care)
- People have access to services that maintain good health and independence
- People receive excellent services wherever they are

  Services make the best use of available resources

The Southern Cancer Network has been formed to:

[10] Ministry of Health. 2010. *Tatau Kahukura: Māori Health Chart Book 2010, 2nd Edition.* Wellington: Ministry of Health.
[11] Craig, L., Jackson, C. and Han, D. 2007. *Monitoring the health of New Zealand Children and Young People: indicator handbook.* Paediatric Society of New Zealand and New Zealand Child and Youht Epidemiology Service. Auckland
[12] NZ Child and Youth Epidemiology Service. 2011. *The health status of children and young people in the South Island.* University of Dunedin. Dunedin.
[13] Ministry of Health. 2011. *Tatau Kura Tangata: Health of Older Māori Chart Book 2011.* Wellington: Ministry of Health.

- provide a framework that supports the linkages between the South Island DHB's, DHB specialist service providers, NGOs, PHOs, and consumers
- coordinate implementation of the cancer control action plan across the South Island
- provide a formal structure that supports improvement in coordination of population programmes for prevention and screening and the quality of treatment
- provide support to families and patients on the pathway of cancer care.

Regional system and service efficiencies and quality improvement opportunities will be identified and implemented, with the aim of meeting the national health targets, achieving economies of scale, increased consistency of practice and increased equity of access.

The Southern Cancer Network working alongside South Island DHBs will support the implementation of the regional initiatives identified in the National Cancer Programme Work Plan including:

- Sustain performance against the radiotherapy and chemotherapy wait time targets by more efficient use of existing resources; and investing in workforce and capacity as required.
- Identify and implement actions to improve faster cancer treatment data collection systems to support service improvements along cancer patient pathway
- Improve the functionality and coverage of multidisciplinary meetings (MDMs) across the region.
- Implement the priority areas identified in National Medical Oncology Models of Care Implementation Plan 2012/13
- Begin implementing the national tumour standards of service provision
- Enable and support cancer nurse coordinators attendance at national and regional training and mentoring forums
- Implement priorities identified in the Prostate Cancer Quality Improvement Plan
- Continue implementing regional clinical data repositories for cancer.
- Improve waiting times for diagnostic services: Colonoscopy by supporting the implementation of the Endoscopy Quality Improvement (EQI) Programme. The aim of the EQI programme is to provide safe, patient-focused endoscopy services that are efficient, accountable and sustainable.

A key focus for this year is the implementation of the Faster Cancer Treatment Regional Implementation Plan and the development of South Island protocols, processes and procedures for identifying and referring people with high suspicion of cancer within the primary health care setting.

Progressive standardisation in Medical Oncology processes, procedures and workforce across the region will include the increasingly consistent utilisation of MOSAIQ which includes the South Island core chemotherapy protocols, MDM templates and patient assessments templates.

An audit of Colorectal, Lung, Gynaecological and Head and Neck Cancer Tumour Standards of service provision will be completed.

Through the ongoing implementation of the South Island Clinical Cancer Information System (the first regional clinical cancer data repository in New Zealand) robust cancer data and information sources have been developed and shared to enable informed service development & planning decision-making.

SCN work groups' plans will be implemented to identify and progress South Island cancer continuum efficiencies, equity of access and quality improvement opportunities.

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

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

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
South Island Faster Cancer Treatment	**People get timely services across the whole cancer pathway (screening, detection, diagnosis, treatment and management, palliative care).** **Cancer Health Target** All patients, ready for treatment, wait less than 4 weeks for radiotherapy or chemotherapy. **Faster Cancer Treatment** **DV1: Faster cancer treatment (establishment of baseline). Including the following[14]:** • 62 day indicator - proportion of patients referred urgently with a high suspicion of cancer who receive their first cancer treatment (or other management) within 62 days. • 14 day indicator - proportion of patients referred urgently with a high suspicion of cancer who have their first specialist assessment within 14 days. • 31 day indicator - proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment (or other management) within 31 days of decision-to-treat. **DV2: Improving waiting times for diagnostic services: Colonoscopy as per the diagnostic waiting time indicator (colonoscopy) template i.e.** **Diagnostic Colonoscopy** • Establishment of baseline data • 50% of people accepted for an urgent diagnostic colonoscopy receive their procedure within two weeks (14 days). • 50% of people accepted for a diagnostic colonoscopy received their procedure within six week (42 days). **Surveillance colonoscopy** 50% of people accepted for a surveillance colonoscopy receive their procedure within twelve weeks (84 days) of the planned date.			
	• Sustain performance against the radiotherapy and chemotherapy wait time targets by more efficient use of existing resources and investing in workforce and capacity as required.	National radiotherapy and chemotherapy wait time targets are met. **(Q1,2,3,4)**	National radiotherapy and chemotherapy wait time targets are met.	National radiotherapy and chemotherapy wait time targets are met.
		Implement recommendations from the 2012 & 2013 South Island Radiation Oncology Reports.**(Q1,2,3,4)**	Implement recommendations from the 2012 & 2013 South Island Radiation Oncology Reports.	Implement recommendations from the 2012 & 2013 South Island Radiation Oncology Reports.
	• Identify and implement actions to improve faster cancer treatment data collection systems to support service improvements along cancer patient pathway.	Faster Cancer Treatment data is collected comprehensively (by DHB and ethnicity). **(Q1,2,3,4)**	Faster Cancer Treatment data is collected comprehensively (by DHB & ethnicity).	Faster Cancer Treatment data is collected comprehensively (by DHB & ethnicity).
		Faster Cancer Treatment data collection and service improvements are identified and implemented. **(Q1,2,3,4)**	Data collection and service improvements are identified and implemented.	Data collection and service improvements are identified and implemented.
		Initiatives that support primary care interface with Faster Cancer Treatment indicators are identified and implemented. **(Q3)**	Initiatives that support primary care interface with Faster Cancer Treatment indicators are identified and	Initiatives that support primary care interface with Faster Cancer Treatment indicators are identified and

[14] See Appendix 6 for the South Island Detailed Action Plan: Faster Cancer Treatment

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
			implemented.	implemented.
	• Improve the functionality and coverage of MDMs across the region.	The South Island MDM framework is implemented. **(Q1,2,3,4)**	MDM monitoring data shows improvement from baseline data and meets the national tumour stream standards requirements.	MDM monitoring data shows improvement from baseline and previous year's data and meets the national tumour stream standards requirements
		Monitor MDM functionality and coverage to develop baseline and MDM monitoring data. **(Q1,2,3,4)**		
	• Begin implementing the national tumour standards of service provision.	Colorectal, Lung, Gynaecological and Head and Neck Cancer tumour stream audits including a focus on supportive care, palliative care and equity standards are completed. **(Q3,4)**	The remaining five national tumour stream standard audits are completed.	
			Audit recommendations are progressively implemented.	Audit recommendations are progressively implemented.
	• Begin implementing the national tumour standards of service provision	Implement the South Island Colorectal Treatment Fast Track. **(Q1,2,3,4)**	Pre and post South Island Colorectal Treatment Fast Track data is collected showing improvements in the patient pathway timelines from referral through to first treatment (and adjuvant treatment as appropriate).	Successful components of the South Island Colorectal Fast Track are implemented within other tumour streams.
	• Implementation of the Cancer Care Nurse Coordinator (CCN) roles is supported and evaluated.	Monitor and contribute to the evaluation of the implementation of the Cancer Care Nurse Coordinator roles. **(Q2,4)**	Monitor and contribute to the evaluation of the implementation of the Cancer Care Nurse Coordinator roles.	Monitor and contribute to the evaluation of the implementation of the Cancer Care Nurse Coordinator roles.
		The South Island Cancer Care Nurse Coordination Group to produce a report on the learning's from the first year of implementation of the roles across the South Island. **(Q4)**	Implement recommendations from the first year report on South Island Implementation of the roles.	Implement quality improvement recommendations on South Island Implementation of the roles.
		Cancer Care Nurse coordinators are supported by the South Island DHBs to attend national and regional training and mentoring forums. **(Q1,2,3,4)**	Cancer Care Nurse coordinators are supported by the South Island DHBs to attend national and regional training and mentoring forums.	Cancer Care Nurse coordinators are supported by the South Island DHBs to attend national and regional training and mentoring forums.
	Improve waiting times for diagnostic services: Colonoscopy			
	• Support the implementation of the EQI Programme. The aim of the EQI programme is to provide safe, patient-focused endoscopy services that are efficient,	EQI Programme implementation is monitored.**(Q1,2,3,4)**	Colonoscopy waiting times indicators are met and exceeded.	Colonoscopy waiting times indicators are met and exceeded.
		Baseline colonoscopy wait time data recording is established and monitored. **(Q1,2,3,4)**		

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
	accountable and sustainable.	Service improvements are identified and implemented to support the meeting of national wait times for colonoscopy.**(Q3,4)**		
South Island Cancer Service Coordination and Quality Improvement	**People have access to services that maintain good health and independence and receive excellent services wherever they are. Services make the best use of available resources.**			
	• All SCN network groups are provided with ongoing support to progress actions in their respective work plans.	Monitoring and ongoing implementation of the SCN Work Groups' plans. **(Q2, 4)**	Monitoring and ongoing implementation of the SCN Work Groups' plans.	
	• Implement the priority areas identified in National Medical Oncology Models of Care Implementation Plan 2012/13.	Increased standardisation in Medical Oncology processes, procedures and workforce is supported across the region including the consistent utilisation of the South Island core chemotherapy protocols, MDM templates and patient assessments templates through MOSAIQ.**(Q1,2,3,4)**	Increased standardisation in Medical Oncology processes, procedures and workforce is supported across the region.	
	• Initiatives that reduce inequalities and support access to cancer services are identified and implemented.	Initiatives that support patient, family and whânau access to cancer services and reduce inequalities are identified and implemented. **(Q1,2,3,4)**	Initiatives that support patient, family and whânau access to cancer services and reduce inequalities are identified and implemented.	Initiatives that support patient, family and whânau access to cancer services and reduce inequalities are identified and implemented.
	• Improve rates of Māori woman accessing cervical screening	Review data and identify gaps. **(Q4)**	Develop cervical screening initiative	Implement cervical screening initiative
	• Implement the agreed recommendations from the SCN South Island Radiation Oncology Report to be completed March 2013.	Agree a plan for Linear Accelerator location and investment for the South Island. (**Q1**). Monitor progress against implementation of recommendations from the SCN South Island Radiation Oncology Report. **(Q1,2,3,4)** Begin implementation of radiation oncology workforce, workflow and investment recommendations from the SCN Radiation Oncology report 2013. **(Q2,,4)**	Ongoing implementation of radiation oncology workforce, workflow and investment recommendations from the SCN Radiation Oncology report 2013.	Ongoing Implementation of radiation oncology workforce, workflow and investment recommendations from the SCN Radiation Oncology report 2013.

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
	• Implement priorities identified in the Prostate Cancer Quality Improvement Plan.	Priorities identified in the Prostate Cancer Quality Plan are progressively implemented. **(Q1,2,3,4)**	Priorities identified in the Prostate Cancer Quality Plan are progressively implemented.	Priorities identified in the Prostate Cancer Quality Plan are progressively implemented.
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.**			
	• Ongoing implementation of SICCIS, the regional clinical data repository for cancer.	Ongoing implementation of the South Island Clinical Cancer System and report South Island clinical cancer data. **(Q1,2,3,4)**	Ongoing implementation of the South Island Clinical Cancer System and reports quarterly on South Island clinical cancer data.	The South Island Clinical Cancer System reports quarterly on South Island clinical cancer data.

6.1.2 Child Health

This work plan recognises the changing health needs of children and young people in the South Island, and the importance of planning services over the next three years. The 2013-16 workplan builds on the previous 2011-12 and 2012-13 regional child health workplans.

The Triple Aim Quality Improvement Framework and the Health Status of Children and Young People in the South Island (epidemiology) report underpins the agreed actions to improve quality, safety and experience of care, achieve health and equity for all populations and ensure best value for public health system resources.

This work plan outlines a systematic approach to meeting the clinical and patient's expectations for children and young people's health services to ensure the sustainability, quality and safety of services across the South Island DHBs while making the best use of limited resources.

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

- Growing up healthy: supporting vulnerable children and families
- Young Persons (youth) health
- Improving access to paediatric services

Through the implementation of planned initiatives the following achievements are expected:

- Decreased family violence
- Decreased sudden unexpected death in infant (SUDI) and increased awareness and improved practices in safe sleeping environments for Māori and Pacific infants
- Increased immunisation rates for the at risk and high need population groups
- Increased newborn engagement with primary healthcare services
- Continuation in rare occurrence of rheumatic fever
- Improved primary health care access for Youth Health
- Decreased child and young person's health service variation
- Decreased decayed, missing and filled (DMF) teeth by 5 years of age

These measures will be enabled and realised through strengthening clinical leadership, service integration, quality improvement, collaboration and partnerships, multi-sectoral engagement, technology and information systems and workforce development and planning.

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

- transforming healthcare services and 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 SI DHBs to make) strategic health care decisions using a "whole-of-system" approach;
- supporting collaboration and integration across the SI 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 SI children and young people's health services

In order to progress the actions of the 2013-16 workplan the Child Health Service Level Alliance will need to partner with other South Island service level alliances such as the Mental Health Service Level Alliance, Public Health Partnership and engage with other agencies such as Social Development, Education, Housing and Justice. It should be noted that the national priority areas of rheumatic fever and diabetes have been included in the Child Health work plans

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

Clinical Lead: **Dr Nick Baker, Community Paediatrician (Nelson Marlborough DHB)**

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
Growing up Healthy	**Working together to support vulnerable children and families before the greatest harm occurs**			
	• Access to services and interventions to support infants of women who experience multiple adversity in pregnancy.	Agree services and interventions to support vulnerable infants. **(Q2)** Develop referral pathways[15] for vulnerable infants. **(Q4)**	Implement referral pathways for vulnerable infants.	Determine regional indicator for reduction in reported child abuse and neglect cases and monitor progress towards achievement.
	• Implementation of regional SUDI policy.	Report progress towards Implementing the regional safe sleep policy. **(Q1)** Develop safe sleep evaluation measures with focus on Māori and vulnerable populations. **(Q2)** Implemented safe sleep policy across SI DHBs. **(Q4)**	Monitor the adoption of safe sleep policy and trends by ethnicity in SUDI.	SIDI and SUDI rates continue to trend down across the SI.
	• Develop programmes to	Maternal depression pathway implemented.	Maternal depression pathway evaluated.	Maternal depression pathway completed and

[15] NB: Where pathways are referred to, this refers to the regional development of Health pathways that will be implemented by the local DHB

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
	support and promote healthy beginnings for infants and their families/whānau.	**(Q1)**		continues as operational process within DHBs.
		One policy/pathway for healthy beginnings developed. **(Q2)**	One policy/pathway for healthy beginnings implemented.	Effectiveness of one healthy beginnings policy/pathway evaluated.
		Pathway for children of parents with mental health illness implemented. **(Q4)**	Pathway for children of parents with mental health illness evaluated.	Pathway continues as operational process within DHBs.
	• New born engagement with health services by four weeks of age.	Agreed target by ethnicity for new born children engaged with health and social services by four weeks of age. **(Q4)**	Monitor progress towards achieving new born health targets.	Child health status at aged five years evaluated.
	• Rheumatic fever is monitored in partnership with SI Public Health Partnership team	Monitor rheumatic fever trends include case by case reviews. **(Q1,2,3,4)**	Identify appropriate rheumatic fever prevention plan should trends indicate an upward trend.	
	• Preparing for Children's Teams[16]	Support development of a programme for Children's Teams implementation. **(Q2)**	Agree to outcome measures/impact measures for children's team	
Improving access to child health services	**Better, sooner, more convenient health services for mothers, babies, children and their families/whānau through a 'whole of systems' approach in order to access the right service at the right time by the right health team and as close as possible to the child's home.**			
	• Develop and support the implementation of strategies to reduce hospitalisation for skin infections.	Monitor skin infection trends for Māori and other ethnic groups for reduction in hospitalisation. (Q4)	Ongoing decrease in skin infections monitored through SI child and young person's epidemiology reports.	
	• Inter-hospital/DHB paediatric transfer and transport pathways.	Effectiveness of paediatric transfer and transport pathways evaluated. **(Q4)**	Report on cost-savings in air transport across SI DHBs.	Transfer and transport pathway continues as part of DHB operational process.
	• Develop and implement strategies to reduce avoidable respiratory hospitalisation for children.	Determine targets for reduction of avoidable respiratory hospitalisation. **(Q4)**	Monitoring against agreed targets in avoidable respiratory hospitalisation monitored through SI child and young persons epidemiology reports.	
	• Develop and implement tonsillectomy, adenoid and grommet referral for surgery pathways to reduce variance across SI DHBs.	All DHBs have referral pathway for tonsillectomy, adenoidectomy and grommet surgeries implemented. **(Q2)**	SI DHBS demonstrate reduction in variances for performing tonsillectomies, adenoidectomies and grommets.	
		Agreed treatment threshold for tonsillectomy, adenoidectomy and grommet procedures		

[16] Children's Teams made up of key community professionals from across sectors to ensure
- Vulnerable children's needs are assessed
- Vulnerable children have a single plan covering all of their needs
- Services are delivered, the plan monitored and reviewed and outcomes actioned

Ministry of Social Development, 2012. The White Paper for Vulnerable Children. Wellington, pp.12

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
		across SI DHBs. **(Q3)**		
	• Develop regional diabetes management plan.	Scoping for regional diabetes (Type 1) management plan completed. **(Q4).**	Develop a regional diabetes management plan.	Regional diabetes management plan implemented.
	• Transition of care pathway from child and young persons to adult health services.	Identify transition of care pathways for development. **(Q1)** Transition of care pathway developed. **(Q4)**	Transition of care pathway implemented across South Island DHBs.	Effectiveness of transition of care pathway evaluated.
Young Persons Health	**Better health and well-being for young people including sub-groups of the population at comparatively higher risk of mental health issues**			
	• Identify service gaps and needs for young persons by ethnicity in the SI[17]	Identify and agree service gaps for Māori and other ethnic groups and agree opportunities.(**Q1)** Dashboard of young person's health services in the SI completed. **(Q2)**	Implement initiatives to address identified service gap	Review the health status of young person's in the SI
	• Develop pathways for improving primary care responsiveness to youth with mild to moderate mental health issues	Referral pathway developed between school based health services to primary health services developed.**(Q4)**	One referral pathway implemented for management of young people with mild to moderate mental health condition	Effectiveness of referral pathway for young people with mild to moderate mental heath condition evaluated
	• Improved uptake of HEADSS[18]programme.	Effectiveness of HEADSS programme evaluated. **(Q2)**	Quality improvements integrated into DHB systems.	
	• Develop transition of care pathways from paediatric to young persons and to adult healthcare services	Transition of care pathway developed. **(Q4)**	Transition of care pathway implemented across the SI DHBs.	Evaluate effectiveness of transition of care pathway across SI DHBs.
	• Address workforce development issues to build capacity and capability of trained health professionals.	Stocktake of SI young person's workforce completed in collaboration with SIRTH. **(Q4)**	Workforce plan developed in partnership with SIRTH	Two agreed workforce initiatives implemented.
	• Development of programmes to reduce youth risk taking resulting in injuries.	One programme to reduce youth risk taking implemented. **(Q4)**	Determine rate of reduction in reported youth mortality from self-harm in South Island and monitor.	Monitor youth mortality resulting from self-harm injuries.
	• Develop pathways for self-management of chronic conditions.	One chronic condition pathway implemented. **(Q4)**	Determine rate of reduction by ethnicity in repeat hospital admissions for management of identified chronic conditions and monitor	Ongoing downward trend by ethnicity in repeat hospital admissions for identified chronic conditions
	• Improved access to primary care services to aged 22 years.	Identify barriers and agree opportunities and benefits for improving young	Determine access to primary care indicator rate and by ethnicity and	Review young person's health status by ethnicity.

[17] The Health Status of Children and Young People in the South Island annual report presents an overview of issues affecting the health of young people in the SI DHBs by ethnicity, age, gender and health condition.

[18] HEADSS assessment tool used to assess home, social activities and health factors of young people

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
		person's access to primary care services. **(Q2)**	monitor.	

6.1.3 Mental Health Services

Rising to the Challenge: The Mental Health and Addiction Service Development Plan aims to ensure that across the spectrum of primary, specialist treatment and support services access and responsiveness will be enhanced. Integration will be strengthened while improving value for money and delivering improved outcomes for people using services. Although the majority of services will be delivered locally within a single DHB there are some services that are better suited to regional or national delivery.

The aim of this three year work plan is to improve the health outcomes for people using mental health services in the South Island. The Ministry of Health expectations include:

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

The Mental Health SLA has been formed to provide advice, guidance and direction to the South Island mental health sector through:

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

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

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

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
Eating Disorders	**Continued regional provision of eating disorder inpatient services through quality improvement**			
	• Develop options for patients for whom default treatments are less successful.	Completion data from Maudsley Family Based Therapy (MFBT) reviewed. **(Q1)**	Findings and evidence evaluated and recommendations identified.	Approved recommendations for alternative treatment options implemented.
		Obstacles to completion of MFBT and alternatives utilised have been identified. **(Q2)**		
		MFBT related admissions to the regional provider have been reviewed to identify successful treatments. **(Q3)**		

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
	• Increase family and whānau involvement in inpatient care.	The options for communication with families are expanded. **(Q4)**	Monitor utilisation.	Review effectiveness.
Maternal Mental Health	**Working together to support vulnerable children and families**			
	• Develop programmes to support and promote healthy beginnings for infants and their families/whānau within the mental health system.	Maternal depression pathway implemented as per Child Health SLA workplan. **(Q4)**	Maternal depression pathway evaluated as per Child Health SLA workplan.	Completed and continues as operational process within DHBs as per Child Health SLA workplan.
		Review of processes followed for children of parents with mental illness and addiction (COPMIA) who present to mental health services completed. **(Q4)**	Pathway for COPMIA developed.	Pathway for COPMIA implemented.
	• Strengthen workforce development and liaison mechanisms between regional and district Mothers and Babies services.	An annual Mothers and Babies Liaison day established for the regional service and District Liaison Clinicians. **(Q4)**	Role of the District Liaison Clinicians reviewed.	The effectiveness of liaison mechanisms evaluated.
		Formalised on-site visits from the regional provider to district staff established. **(Q4)**	Effectiveness of on-site visits on district provision of service evaluated.	Completed and continues as operational process within DHBs.
Forensic	**Improved forensic service capacity and responsiveness**			
	• Support the establishment and development of youth forensic services in the South Island	Agreement on the youth forensic hub and spoke model for the South Island. **(Q4)**	Establishment of the hub and spoke service delivery model for South Island DHBs.	A plan for a South Island youth forensic system that can support future growth is developed.
	• Understand the requirements for the National Forensic Network.	Support the development of a national forensic network as agreed nationally. **(Q4)**		
High and Complex Needs	**Improved mental health and addiction service capacity for people with high and complex needs**			
	• Improve service provision for people with intellectual disability and mental health problems.	Pathways developed with Ministry of Health Disability Support Services and DHBs. **(Q4)**	Review and monitoring of the effectiveness of the pathways.	Inappropriate length of stay in inpatient services is decreased.
	• Support more equitable access to detoxification services across the South Island.	Detoxification services reviewed. **(Q4)**	Integrated South Island model for detoxification services developed.	Implementation begins.
Māori Mental Health	**Alignment of South Island DHB Māori Mental Health Service Planning**			
	• Develop shared goals and outcomes across Māori mental health.	South Island Mental Health Service Level Alliance (MHSLA) establishes biannually liaison meetings	Mental health sections of DHB Māori health service plans reviewed.	Te Herenga Hauora and the South Island Mental Health Alliance provide a shared planning approach for

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
		with Te Herenga Hauora (South Island DHB Māori General Managers) to coordinate a shared goals and outcomes approach. **(Q1)**		Māori mental health on the South Island.
	• Align regional plans for Māori to Whānau Ora outcomes and Ministry of Health publications i.e. Te Puawai Whero.	Areas of focus are agreed by Te Herenga Hauora and working party consisting of MHSLA and Māori NGO representatives. **(Q2)**	Planning is aligned to foci and Whānau Ora outcomes by working party and Te Herenga Hauora.	Planning includes Māori population needs and aligns to Te Puawai Whero and Whānau ora specifications and outcomes.
Pacific Mental Health	**Improve the quality of Mental Health and Addiction services delivered to Pasifika**			
	• Implement the next phase of the SI Alliance Pasifika Mental Health work – informed by the outcome of the 2012/13 work.	A South Island Pasifika Mental Health Plan is developed by Pasifika for Pasifika. **(Q4)**	The South Island Pasifika Mental Health Plan is implemented by Pasifika for Pasifika.	The South Island Pasifika Mental Health Plan is reviewed by Pasifika for Pasifika.
Population Health	**Suicide Prevention**			
	• Align South Island DHB approaches to Suicide prevention co-ordination.	Goals developed consistent with the National Suicide Prevention Action Plan– when available. **(Q4)**	South Island DHB Suicide prevention co-ordination approaches reviewed in light of national strategy.	
Workforce	**Work together with the South Island Regional Training Hub**			
	• Work with the SIRTH and national workforce centres to align planning and make best use of training and development resources.	Existing training needs analyses identified and reviewed. **(Q4)**	Gaps and needs identified and recommendations developed in collaboration with SIRTH, Health Workforce New Zealand and national workforce centres.	Workforce plan developed in partnership with the SIRTH, Health Workforce New Zealand and national workforce centres.
Information Services	**Work together with the South Island Information Services Service Level Alliance**			
	• Standardise core clinical documentation requirements for Health Connect South.	Working group established with Information Services SLA. **(Q4)** A suite of types of forms developed for secondary mental health services. **(Q4)**		

6.1.4 Health of Older People Services

Better, Sooner, More Convenient Health Services for New Zealanders, in relation to the health of older people, means all New Zealanders are able to access timely required quality services, in the most appropriate location, in order to improve overall health outcomes.

The Health of Older People SLA (HOPSLA) vision is for all older people to participate to their fullest ability in decisions about their health care and wellbeing. Older people will be supported in such goals by a co-ordinated and responsive health and disability support service that also supports integration into their family, whānau and community life.

A health system that functions well for the health of older people is one where:

- Older people receive timely services
- All older people are able to easily access safe, quality and appropriate services wherever they are and whatever their cultural and language differences are
- Services provide enough support to maintain good health and independence for as long as possible
- Older people are provided with clear information
- Vulnerable older people are protected
- Health of older people services make the best use of available resources
- Ageing is celebrated and individual autonomy and choice is respected
- Resources, developments and innovations are shared and promoted
- Treaty of Waitangi responsibilities towards older Māori people in the region are built into service monitoring and evaluation and inform improvements in services e.g. by monitoring ethnicity data

The Health of Older People SLA has been formed to lead the development of disability 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 (close in age and need)

The work plan was developed with clinical and consumer input to ensure alignment with both national policy and integrated into local DHB plans. The isolated and rural nature of much of the South Island challenges the ability to deliver equivalent services for older people residing in these areas, whilst ensuring financial and workforce sustainability.

Many of the priority areas have strong alignment with the 'Ageing in Place' philosophy and thereby focus on restorative models of care and the increased use of technology. Other priority areas will support the continuum of care and promote the importance of delivering accessible and equitable person-centred care, through a coordinated care planning approach.

In addition to the five priority areas, identified in the 2013-16 workplan, HOPSLA acknowledge the need to integrate developments and regional activity in the areas of information services, stroke, cancer and workforce, as all of these components are fundamental to the overall vision to improve the health outcomes of older people.

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

Clinical Lead: **Jenny Keightley, General Practitioner (Canterbury DHB)**

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
InterRAI	**To enable all older people requiring services to have a timely and effective InterRAI comprehensive assessment of their needs which is clinically effective, shared across multi-disciplinary teams, guides the creation of packages of care and aids in the seamless transition between services Whilst ensuring that older people throughout the SI have equitable access to Home and Community support services that are culturally appropriate and tailored to their assessed needs**			
	• Enhance the utilisation of InterRAI as an timely and effective clinical tool by supporting the roll-out of the same versions of InterRAI modules across each of the SI DHBs, including; – Contact Assessment (CA) – Home Care Assessment (HC) – Community Health Assessment (CHA) – Long Term Care Facility Assessment (LTCF).	Establish reporting measures, baseline and targets. **(Q1)**	Report against agreed suite of measures and targets.	Continue to report against agreed suite of measures and targets.
	• Support SI DHBs to complete timely NASC InterRAI assessments.	Review reporting measures, baselines and targets of timeframes from NASC referral to assessments. Agree new measures and timeframes. **(Q4)**	Report against agreed suite of measures and targets.	Continue to report against agreed suite of measures and targets.
	• Support the extension of read-only access of InterRAI assessments to relevant health practitioners.	Establish reporting measures, baseline and targets. **(Q1)**	Report against agreed suite of measures and targets.	Continue to report against agreed suite of measures and targets.
	• Support national roll out of InterRAI into Aged Related Residential Care(ARRC).	Establish reporting measures, baseline and targets. **(Q4)**	Report against agreed suite of measures and targets.	Continue to report against agreed suite of measures and targets.
	• Achieve excellence and consistency of reporting on aggregate InterRAI data and share and benchmark data across the South Island DHBs.	Subject to InterRAI data access confirmation, aggregate InterRAI data and benchmark across the South Island DHBs to inform further planning. **(Q4)**	Continue to aggregate InterRAI data and benchmark across the South Island DHBs to inform further planning.	Continue to aggregate InterRAI data and benchmark across the South Island DHBs to inform further planning.
	• Continue to ensure the eligibility criteria and processes for access to Home and Community support services are standardised and equitable across the SI.	Establish reporting measures and baseline (including Māori). **(Q4)**	Audit InterRAI data as evidence to monitor the utilisation of services by need.	Continue to audit InterRAI data as evidence to monitor the utilisation of services by need.

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
Advance Care Planning	**To enable all people living with terminal, severe or multiple long term conditions to be informed about Advance Care Planning (ACP) and to be empowered to have the opportunity to develop and express their own cultural values and choices during conversations with a health professional. The outcome of this process is to be captured and documented on an ACP Form which is available to all clinicians at the point of care. Individuals will therefore have access to comprehensive, structured and effective ACP and will have a better understanding of their current and likely future health and the treatment and care options available**			
	• Undertake a stock take of ACP utilisation in the South Island.	Complete stocktake of ACP utilisation (including Māori) in the South Island and establish a baseline. **(Q1)**		
	• Support each South Island DHB to establish ACP Champion Groups to co-ordinate the rollout of culturally appropriate ACP documentation and pathways.	South Island DHB ACP Champion groups to be formed. **(Q1)**		
	• Promote the utilisation of culturally appropriate ACP with both health professionals, patients and the wider community by supporting the development and implementation of ACP documentation and pathways.	Following the stock take of ACP utilisation (including Māori), baseline establishment and formation of South Island DHB groups, plan rollout of implementation of culturally appropriate ACP documentation and pathways across SI DHB provider arm hospitals, primary care and age related residential care. **(Q2)**	Rollout of implementation of culturally appropriate ACP documentation and pathways across South Island DHB provider arm hospitals, primary care and age related residential care. Set goal completion figures e.g. 50% of people presenting with a life threatening exacerbation of chronic disease have an ACP lodged.	Continue with rollout of implementation of culturally appropriate ACP documentation and pathways across South Island DHB provider arm hospitals, primary care and age related residential care. Set DHB targets based on performance 2014/15.
	• Support the utilisation of a regionally agreed IT solution to hold and flag individual ACPs as part of their accessible clinical record at the point of care.	All ACPs to be incorporated into the regional IT solution with an alert flag at the point of care. **(Q4)**	All ACPs to be incorporated into the regional IT solution with an alert flag at the point of care.	All ACPs to be incorporated into the regional IT solution with an alert flag at the point of care.
	• Explore opportunities to integrate ACP training into medical and nursing colleges training credit systems.	Report findings and recommendations to be completed. **(Q2)**	Use report findings to plan the ACP training rollout.	
	• Support the use of Level 1 ACP electronic training for all health professionals and ensure Māori Health professionals and providers are able to access training.	Establish measures and baseline and plan rollout of use of Level 1 ACP electronic training for all health professionals working in South Island DHB provider arm hospitals, primary care and age related residential care. **(Q4)**	Rollout of implementation of level 1 ACP electronic training for all health professionals working in South Island DHB provider arm hospitals, primary care and age related residential care.	Continue with rollout of implementation of level 1 ACP electronic training for all health professionals working in South Island DHB provider arm hospitals, primary care and age related residential care.

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
	• Support the use of Level 2 ACP training programme and ensure Māori Health professionals and providers are able to access training.	Subject to confirmation of South Island ACP training budget, aim for 60 health professionals from across the South Island to receive L2 training. **(Q4)**	Subject to confirmation of South Island ACP training budget, aim for 30 health professionals from across the South Island to receive L2 training.	Subject to confirmation of South Island ACP training budget, aim for 30 health professionals from across the South Island to receive L2 training.
	• Support the use of Level 3 ACP training programme and ensure Māori Health professionals and providers are able to access training.	Subject to confirmation of South Island ACP training budget, aim for three clinicians to be L3 trained in the South Island.**(Q4)**	Subject to confirmation of South Island ACP training budget, aim for three more clinicians to be L3 trained across the South Island.	Subject to confirmation of South Island ACP budget, aim for three more clinicians to be L3 trained across the South Island.
	• Utilise the 'Conversations that Count' programme.	Subject to confirmation of SI ACP training budget, pilot 'Conversations that Count' programme in local senior citizens groups and Rununga in groups across the SI. **(Q4)**	Review outcomes and implement 'Conversations that Count' programme in other areas as appropriate.	
Restorative	**To enable older people to remain independent at home and in their community with services tailored to their needs and increase their wellbeing**			
	• Promote the use of technologies to maintain independence at home and in the community.	Report on the utilisation and availability of technologies to maintain independence at home and in the community. **(Q2)**	Encourage the identification of a pilot with an appropriate business associate.	
	• Support each SI DHB to establish a whole of system falls prevention working group within their DHB to co-ordinate evidence-based best practice falls prevention programmes in accordance with HQSC requirements.	Report on current falls prevention programmes and the number of participants by ethnicity (e.g. community-based home care falls prevention programmes and ARRC) falls prevention policies). **(Q2,4)**		
		Establish targets and report on (including ethnicity) the reduced harm from falls by reporting on: -the serious and sentinel event fall rates. **(Q2)** -the proportion of the population (75+) presenting to the Emergency Department (ED) as a result of a fall quarterly. **(Q1,2,3,4)** -the proportion of the population (75+) admitted to hospital as a result of a fall quarterly. **(Q1,2,3,4)**	Continue to report on (including ethnicity) the targets related to reduced harm from falls by reporting on: -the serious and sentinel event fall rates. -the proportion of the population (75+) presenting to ED as a result of a fall quarterly. -the proportion of the population (75+) admitted to hospital as a result of a fall quarterly.	Continue to report on (including ethnicity) the targets related to reduced harm from falls by reporting on: -the serious and sentinel event fall rates. -the proportion of the population (75+) presenting to ED as a result of a fall quarterly. -the proportion of the population (75+) admitted to hospital as a result of a fall quarterly.
	• Support the ACC promotion of the use of Vitamin D.	Report on the percentage of ARRC residents (including ethnicity)	Continue to report on the percentage of ARRC residents (including	Continue to report on the percentage of ARRC residents (including

Key area of focus	Actions to deliver		Measures 2013/14	Measures 2014/15	Measures 2015/16
			prescribed Vitamin D. **(Q2,4)** 75% proportion	ethnicity) prescribed Vitamin D.	ethnicity) prescribed Vitamin D.
	• Promote the use of generalist and dementia restorative care options for short term respite, long-term permanent ARRC residents, secondary care patients and patients living in the community.		Report on the use of generalist and dementia restorative care options for; intermediate care (e.g. CREST), short term respite, long-term permanent ARRC residents, secondary care patients and patients living in the community. **(Q4)**	Continue to report on the use of generalist and dementia restorative care options for; intermediate care (e.g. CREST), short term respite, long-term permanent ARRC residents, secondary care patients and patients living in the community.	Continue to report on the use of generalist and dementia restorative care options for; intermediate care (e.g. CREST), short term respite, long-term permanent ARRC residents, secondary care patients and patients living in the community.
	• Share Innovations in Restorative Care e.g. CREST, Medication Management Service.		Report on the proportion of people aged 80+ in aged related residential care. **(Q2,4)**	Continue to report on the proportion of people aged 80+ in aged related residential care.	Continue to report on the proportion of people aged 80+ in aged related residential care.
Workforce	**To implement and promote strategies that address regional workforce challenges so health professionals can work in the new and emerging models of patient care. Strengthen education and training uptake within ARRC, enhancing innovative approaches in healthcare delivery and support greater integration and coordination of training and education across all health professional groups**				
	• Promote the sharing of resources and educational tools (e.g. e-learning).		Report on the number and types of resources created and rates of utilisation. **(Q4)**	Continue to report on the number of resources created and rates of utilisation.	Continue to report on the number of resources created and rates of utilisation.
	• Promote training in restorative, person-centred care and advance care planning. and develop methods to ensure Māori are encouraged to train so that by Māori for Māori care can be provided as required		Identify programmes and produce reporting measures and baseline. **(Q4)**	Continue to report against agreed suite of measures.	Continue to report against agreed suite of measures.
	• Share workforce innovations across the SI (e.g. Gerontology Nurse Specialist supporting ARRC model).		Report on workforce innovations. **(Q4)**	Continue to communicate innovations and progress.	Continue to communicate innovations and progress.
Dementia	**To enable people with dementia to receive a more person-centred model of care by cultivating a person-centred approach to care amongst the aged-care workforce through education and support initiatives**				
	• Support the Walking in Another's Shoes (WIAS Leadership Team to continue to implement the WIAS programme across all SI DHB's).	**CDHB**	1. Continue to implement Carer (Dementia ARRC) WIAS programme. **(Q1,2,3,4)**	1. Continue to implement Carer (Dementia ARRC) WIAS programme.	1. Continue to implement Carer (Dementia ARRC) WIAS programme.
			2. Complete first Carer (Home Based Support Services (HBSS)) WIAS programme. **(Q2)**	2. Continue to implement Carer (HBSS) WIAS programme.	2. Continue to implement Carer (HBSS) WIAS programme.
			3. Pilot Registered Nurse (RN) (Dementia ARRC and HBSS) WIAS programme. **(Q4)**	3. Continue to implement RN (Dementia ARRC and HBSS) WIAS programme.	3. Continue to implement RN (Dementia ARRC and HBSS) WIAS programme.

Key area of focus	Actions to deliver		Measures 2013/14	Measures 2014/15	Measures 2015/16
			4. Engage with Provider Arm Hospital services regarding WIAS programme. **(Q4)**	4. Rollout of Provider Arm Hospital services WIAS programme.	4. Continue to implement Provider Arm Hospital services WIAS programme.
				5. Pilot Senior Leadership Team (Dementia ARRC) WIAS programme.	5. Continue to implement Senior Leadership Team (Dementia ARRC) WIAS programme.
					6. Rollout of Carer (Generalist ARRC) WIAS programme.
		NMDHB	1. Complete first Carer (Dementia/Generalist ARRC and HBSS) WIAS programme. **(Q4)**	1. Continue to implement Carer (Dementia/Generalist ARRC and HBSS) WIAS programme.	1. Continue to implement Carer (Dementia/Generalist ARRC and HBSS) WIAS programme.
				2. Rollout of RN (Dementia/Generalist ARRC and HBSS) WIAS programme.	2. Continue to implement RN (Dementia/Generalist ARRC and HBSS) WIAS programme.
					3. Rollout of Senior Leadership Team (Dementia/Generalist ARRC) WIAS programme.
		SCDHB	1. Continue to implement Carer (Dementia/Generalist ARRC and HBSS) WIAS programme. **(Q1,2,3,4)**	1. Continue to implement Carer (Dementia/Generalist ARRC and HBSS) WIAS programme.	1. Continue to implement Carer (Dementia/Generalist ARRC and HBSS) WIAS programme.
				2. Rollout of RN (Dementia/Generalist ARRC and HBSS) WIAS programme.	2. Continue to implement RN (Dementia/Generalist ARRC and HBSS) WIAS programme.
					3. Rollout of Senior Leadership Team (Dementia/Generalist ARRC) WIAS programme.
		SDHB	1. Complete first Carer (Dementia ARRC and HBSS) WIAS programme. **(Q4)**	1. Continue to implement Carer (Dementia ARRC and HBSS) WIAS programme.	1. Continue to implement Carer (Dementia ARRC and HBSS) WIAS programme.
				2. Rollout of RN (Dementia ARRC and HBSS) WIAS programme.	2. Continue to implement RN (Dementia ARRC and HBSS) WIAS programme.
					3. Rollout of Senior Leadership Team (Dementia ARRC) WIAS programme.
		WCDHB	1. Continue to implement Carer (Generalist ARRC and HBSS and Provider Arm Hospital) WIAS programme. **(Q1,2,3,4)**	1. Continue to implement Carer (Generalist ARRC and HBSS and Provider Arm Hospital) WIAS programme.	1. Continue to implement Carer (Generalist ARRC and HBSS and Provider Arm Hospital) WIAS programme.
				2. Rollout of RN (Generalist ARRC and HBSS) WIAS programme.	2. Continue to implement RN (Generalist ARRC and HBSS) WIAS programme.
					3. Rollout of Senior

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
				Leadership Team (Generalist ARRC) WIAS programme.
	• Support the WIAS Leadership Team to continue to co-ordinate the regional planning and implementation of the WIAS programme.	1. Continue to train and support WIAS Facilitators in the SI. **(Q1,2,3,4)**	1. Continue to train and support WIAS Facilitators in the SI.	1. Continue to train and support WIAS Facilitators in the SI.
		2. Continue to support WIAS Leaders in the North Island. **(Q1,2,3,4)**	2. Continue to support WIAS Leaders in the North Island.	2. Continue to support WIAS Leaders in the North Island.
		3. WIAS Leaders to engage with Careerforce and New Zealand Qualifications Authority regarding integration of the WIAS Carer programme into a national training framework. **(Q1)**		
		4. WIAS Leaders to engage with New Zealand Nurses Organisation regarding the integration of the WIAS RN programme into a national training framework. **(Q1)**		
		5. Continue quality review of WIAS programme and ongoing evaluation. **(Q1,2,3,4)**	5. Continue quality review of WIAS programme and ongoing evaluation.	5. Continue quality review of WIAS programme and ongoing evaluation.
		6. Develop an ongoing WIAS graduate support programme (e.g. Master Class).**(Q4)**	6. Implement WIAS graduate support programme	6. Continue to implement WIAS graduate support programme
		7. Develop a regional benchmarking framework. **(Q4)**	7. Implement a regional benchmarking framework.	7. Continue to implement the regional benchmarking framework.
		8. Complete a cultural evaluation of Carer WIAS programme (initially in Dementia ARRC). **(Q4)**	8. Implement cultural evaluation of WIAS programme more widely.	8. Continue to implement cultural evaluation of WIAS programme.
	• Promote and support the development of Dementia Care Pathways in all DHBs and continue to provide regional representation on the National Dementia Cooperative.	Report on the creation of Dementia Pathways in Primary Care and Specialist Services. **(Q4)**	Continue to report on the creation of Dementia Pathways in Primary Care and Specialist Services.	Continue to report on the creation of Dementia Pathways in Primary Care and Specialist Services.

6.1.5 Cardiovascular services - Acute Coronary Syndrome (ACS)

Improving access to cardiac services will help New Zealanders to live longer, healthier and more independent lives.

- Better Sooner More Convenient Health Services for New Zealanders in relation to Cardiac Services means improved and more timely access to cardiac services.
- More patients survive acute coronary events, cardiac damage from these events is minimised, and the likelihood of subsequent cardiac events is reduced.

- Patients with suspected ACS receive seamless co-ordinated care across the clinical pathway.
- Patients with a similar level of need receive comparable access to services, regardless of where they live.
- The health and disability system and services are trusted and can be used with confidence.

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

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

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

Clinical Lead: **Michael Williams, Clinical Leader Cardiology, Cardiologist (Southern DHB)**

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
Meeting National Indicators	**Achievement of requirements for National Indicators**[19]			
	• Continue to work with regional cardiac clinical networks and, when appropriate, the New Zealand Cardiac Network to implement actions to improve outcomes for people with suspected Acute Coronary Syndrome (ACS).	Chairperson of National Cardiac Network attends/participates in at least two workstream meetings. **(Q4)** At least one in person meeting held between workstream facilitator and counterpart in Northern regions. **(Q2)**	Regular liaison and sharing of projects enhanced.	Regular liaison and sharing of projects enhanced.
	• Implement regionally agreed protocols, processes and systems to ensure prompt local risk stratification of suspected ACS patients, and transfer of high risk patients to tertiary centres for the interventions they need.	Implementation of agreed clinical protocols, processes and systems for referral of ACS patients from secondary to tertiary centres. **(Q2)** Implementation of agreed clinical protocols, processes and systems for defining "high risk" patients. **(Q2)**	Continuing review and maintenance of appropriate clinical protocols, processes and systems.	Continuing review and maintenance of appropriate clinical protocols, processes and systems.
	• Implement regionally the clinical pathway from primary to tertiary care for management of patients with suspected ACS.	Implementation of pathways which were agreed regionally in 2012/13, are in action. **(Q2)**	Continuing review and maintenance of appropriate pathways.	Continuing review and maintenance of appropriate pathways.
	• Continue reporting on established measures	**>70%** of high-risk ACS patients accepted for	Continued achievement of national indicators as	Continued achievement of national indicators as

[19] See Appendix 7 for the South Island Detailed Action Plan – Cardiac Services with a focus on Acute Coronary Syndrome

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
	of ACS risk stratification and time to appropriate intervention in 2013/14 • Work towards a nationally consistent reporting framework.	coronary angiography having it within 3 days of admission. ('Day of Admission' being 'Day 0'). **(Q3,4)**	determined by/modified by National Health Board in conjunction with the National Cardiac Network.	determined by/modified by National Health Board in conjunction with the National Cardiac Network.
		>95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS & Cath/PCI registry data collection. **(Q3,4)**		
		Population access to the following conditions will not be significantly below the agreed rate: • Cardiac surgery: 6.5 per 10,000 of population • Percutaneous revascularization: 12 per 10,000 of population • Coronary angiography: 33.9 per 10,000 of population. **(Q1,2,3,4)**		
	• Work to cardiac surgery targets which will improve equity of access as identified and agreed by The National Cardiac Network	The waiting list for cardiac surgery will remain between 5 and 7.5% of annual cardiac throughput, and not exceed 10% of annual throughput. **(Q1,2,3,4)**	Cardiac surgery indicators are achieved	Cardiac surgery indicators are achieved
		85% of people will receive elective coronary angiograms within 90 days and no patient will wait longer than five months. **(Q1,2,3,4)**		
		Regional solutions introduced for any access problems, identified through data analysis, within the cardiology and cardiac services. **(Q4)**		
	• Ensure local staff, in referring hospitals, are trained in risk assessment of patients with suspected ACS according to national guidelines.	Identify training needs for staff in referring hospitals. **(Q2)**	Support staff in receiving training according to national guidelines.	Support staff in receiving training according to national guidelines.
		Develop and implement training plan for staff in referring hospitals. **(Q4)**		
	• Analyse angiography access rates for high risk populations group such as Māori, Pacific and South Asian people. To provide a baseline for monitoring	Analyse angiography access rates for Māori, and other high risk population groups. **(Q1)**	High risk population groups data reporting enhanced.	High risk population groups data reporting enhanced.
		Review data and identify initiatives to address issues in data. **(Q4)**	Develop initiatives to address identified service gaps.	Implement initiatives to address identified service gaps.

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
	against changes when ANZACS QI has been implemented.			
	• Participate in the implementation and roll-out of the national cardiac register. ANZACS QI • Establish links with SI Alliance IS Service Level Alliance.	DHBs aware of requirements for implementation of ANZACS QI. **(Q1)** DHBs have staff assigned to above subject to funding. **(Q2)** DHBs reporting requirements of national cardiac register as expected. **(Q4)**	Maintenance of ANZACS QI.	Maintenance of ANZACS QI.
	• Participate in the implementation and roll out of the national Cardiac surgery register to allow for consistent and common monitoring and comparison across the regions and internationally.	Implement new Cardiac Surgery register supported by the South Island Alliance's Information Services SLA. **(Q4)**	Maintenance of Cardiac Surgery Register.	Maintenance of Cardiac Surgery Register.
Regional Service Plan	**Regional Service Plan agreed and operational**			
	• Implement and monitor the regional service plan for cardiac services to support appropriate access to cardiac services, including surgery and percutaneous revascularization.	Regional services plan for cardiac services developed and in action. **(Q2)**	Regional services plan for cardiac services developed and in action	Regional services plan for cardiac services developed and in action
Health Pathways	**Health pathways agreed and utilised**			
	• Implement health pathways for cardiac services across the South Island based on the Canterbury DHB model.	South Island Alliance assists with resources to provide and implement agreed health pathways. **(Q2)**	Pathways reviewed and maintained	Pathways reviewed and maintained
	• Improved processes and continuity through working closely with St John.	St John clinical representative is regular member of the workstream. **(Q1)**	St John clinical representative is regular member of the workstream	St John clinical representative is regular member of the workstream
	• Assist with the preparation and monitoring of the St John agreement for Patient Transfer Services (PTS).	Seek representation from a St John clinical staff member to the workstream to liaise with the South Island Support Services SLA who are responsible for the PTS. **(Q1)** Contribute to the six month review of the above agreement. **(Q2)**	Contribute to the annual review of the St John PTS agreement.	Contribute to the annual review of the St John PTS agreement.

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
Minimum facilities	**Essential minimum facilities in hospitals**			
	• Determine the options and Models of Care to achieve the "Essential Minimum Cardiac Facilities (for South Island hospitals)"	Options and models of care identified for "Essential Minimum" facilities. **(Q1)**	"Essential Minimum cardiac facilities" implemented	"Essential Minimum cardiac facilities" reviewed
Training	**Workforce training maintained**			
	Encourage increased cardiology nurse training in regards to: • increased exposure to cardiology during nursing training • training opportunities in New Zealand for Clinical Nurse Specialists in Cardiology.	Current position reviewed and reported to the workstream. **(Q1)**	Training opportunities are maintained	Training opportunities are maintained
		Links maintained with the South Island Alliance Regional Training Hub. **(Q1,2,3,4)**		
		Opportunities identified. **(Q1,2,3,4)**		
		Professional training encouraged through South Island Alliance Regional Training Hub and through National Cardiac Network. **(Q1,2,3,4)**		
		Training undertaken and reported. **(Q3)**		
		Opportunities are shared/communicated through the workstreams. **(Q1,2,3,4)**		
		Training attended by all workstream members is reported to SLA. **(Q1,2,3,4)**		

6.1.6 Elective Services

Better Sooner More Convenient Health Services for New Zealanders in relation to electives means improved and more timely access to elective services.

- More people receive access to services which support New Zealanders to live longer, healthier and more independent lives.
- People have shorter waiting times for elective services meaning they receive better health services, and can regain good health and independence sooner
- People with a similar level of need receive comparable access to services, regardless of where they live.

A health system that functions well for Electives is one that is:

- Increasing elective surgery discharges
- Increasing first specialist assessments
- Reducing waiting times for people requiring elective services

- Improving prioritisation and selection of patients
- Supporting innovation and service delivery
- Optimise regional and clinical integration
- Maintains and provide ongoing monitoring to the current equitable access to elective services in the South Island between Māori and non-Māori

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

- Explore elective service delivery across the South Island focussing on:
  - Population need and projections
  - Options to support clinically and financially sustainable service delivery into the future
- Support the South Island DHBs to achieve the Government elective services waiting time targets
- Gain a better understanding of the resources (facility and workforce) and the use of production planning across the South Island
- Undertake analysis of secondary and tertiary referral elective services and identify the capacity and capability of these services across the South Island. The outcome of the analysis will inform and support future configuration and delivery of elective health services across the South Island
- Understand the variability of delivery of elective services across the five DHBs of the South Island

Informed recommendations will be made as to which clinical specialties will benefit from being managed as regional elective services with regional Health Pathways, consistent systems and processes.

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

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

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
Models of Service and Care	**Regional partners discuss options to support improved access to elective services, and continued reductions in waiting times[20].**			
	• A regional representative group discussion will be held at least quarterly (expected).	Regional representative group for electives established. **(Q1)**	Representation of regional electives group will be reviewed.	Representation of regional electives group will be reviewed.
		Nominations for the South Island Elective Services Workstream will be selected from clinicians from relevant professional groups across the healthcare continuum. **(Q1)**		
		Meeting schedule set; minimum quarterly meetings. **(Q1)**	Meeting schedule set.	Meeting schedule set.
	• Improvement to quality patient care will be a focal point of activity	The South Island Elective Services Health Target is met. **(Q4)**	The South Island Elective Services Health Target is met.	The South Island Elective Services Health Target is met.

[20] See Appendix 8 for the South Island Detailed Action Plan: Elective Services

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
	for elective services.	South Island DHBs will maintain the MoH reduced waiting times of no patient waiting longer than 5 months. **(Q4)**	South Island DHBs will meet the MoH reduced waiting times of no patient waiting longer than 4 months by 31 December 2014.	South Island DHBs will maintain the MoH reduced waiting times.
	• Regional electives options are developed for services with known access issues.	Services will be identified in South Island Electives project and options agreed by South Island Electives group. **(Q4)**		
		Elective Services identified as likely specialties for a South Island regional approach are: Plastics; Vascular: sub-specialty of General Surgery; Urology. One service to be confirmed initially by South Island Elective Services Workstream. **(Q1)**		
	• South Island Electives project will identify secondary services requiring regional plans.	Regional or sub-regional plans will be developed and implemented of in progress for clinical services identified in Part One of the South Island Electives project. **(Q4)**		
	• Redesign of regional pathways to support management of sub-speciality service delivery.	All South Island DHBs use the agreed Regional Health Pathways. **(Q4)**	Use of the agreed Regional Health Pathways evaluated.	Use of the agreed Regional Health Pathways evaluated.
	• Solutions will be developed for secondary services where appropriate, that consider use of regional capacity and resources.	All South Island DHBs use the agreed elective services planning methods. **(Q4)**		
		Inter-district flow agreements and principles, which will facilitate patients accessing first specialist assessment or treatment at a neighbouring DHB will be agreed by the South Island Planning & Funding General Managers by the commencement of the first quarter. **(Q1)**		
		Systems will be in place for South Island DHBs to identify and utilise another DHBs facilities and staff resources to deliver care to another DHB's residents, where possible and appropriate**. (Q4)**		

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
		Access for Māori to regional referral Health Pathways is measured. **(Q4)**	Access for Māori to regional referral Health Pathways is measured.	Access for Māori to regional referral Health Pathways is measured.
	• Common barriers to regionalisation (e.g. transport costs, ownership of care) are discussed and solutions are developed.	Development of South Island referral Health pathways will address access to service barriers. **(Q4)**	Effectiveness of referral Health pathways is evaluated and action plan identified if required.	Effectiveness of referral Health pathways is evaluated and action plan identified if required.
	Regional Plans are developed and implemented to ensure equity in access to, and delivery of, bariatric surgery.			
	• The region will deliver at least 42 (CDHB 14; NMDHB 4; SCDHB 4; SDHB 19; WCDHB 1) bariatric surgery procedures during 2013/14 with minimum expectations met for each DHB population.	Agreed regional volume for bariatric services is met. **(Q4)**	DHB funding to support delivery of regional bariatric surgery procedures is maintained.	DHB funding to support delivery of regional bariatric surgery procedures is maintained.
	• A whole of South Island service for bariatric surgery will be implemented.	Equity of access according to assessed need across the South Island. **(Q2)**	All South Island DHBs use the agreed elective services planning methods.	All South Island DHBs use the agreed elective services planning methods.
	• A Bariatric Health Pathway agreed for South Island.	The South Island region develops and agrees the use of one Bariatric Health Pathway. **(Q2)**		
	• All South Island residents assessed for bariatric surgery are assessed using a consistent approach.	The MoH Bariatric CPAC score tool is implemented across all DHBs. **(Q4)**		
	• Establish one referral process and selection meeting process for Bariatric Surgery for the South Island region.	One referral process and one selection meeting process for bariatric surgery will be established for the South Island. **(Q2)**		
Clinical Leadership	**Clinical groups will be strengthened across the region to support development and leadership of regional plans.**			
	• Regional Electives groups will have members who are representative of relevant clinical groups.	Electives workstream membership review. **(Q1)** Clinicians with appropriate clinical expertise will be recruited for specialty workstreams. **(Q1)** Clinical leader will be appointed as Chair. **(Q1)**	Electives workstream membership review to ensure appropriate clinical membership.	Electives workstream membership review to ensure appropriate clinical membership.

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
Workforce	**The South Island will strengthen collaboration with regional training hubs to identify actions to establish and develop innovative programmes which utilise either the existing workforce differently; technology in an innovative way; or changing models of care.**			
	• Establish relations with the SIRTH.	Seek opportunities for Elective Services workstream to be informed of role and direction of SIRTH. **(Q2)**	One innovative program identified which will benefit workforce.	Relevant workforce issues are identified through utilisation of SIRTH workforce data.
Resourcing, operating and capital expenditure	**Funding to support regional approaches for elective delivery should be clearly linked to plans for regional solutions.**			
	• Regional funding for electives delivery will have allocated funding identified.	Expenditure for funded solutions will be monitored against budget and reported each quarter. **(Q1,2,3,4)**	Expenditure for funded solutions will be monitored against budget and reported each quarter.	Expenditure for funded solutions will be monitored against budget and reported each quarter.

6.1.7 Stroke Services

The key purpose of the workstream is to facilitate the implementation of the New Zealand Clinical Guidelines for Stroke Management 2010: Implementation Plan (2011). The workstream aims to ensure that risks are reduced and improvements are made in the provision of acute and rehabilitation stroke services delivered across the South Island[21]. The South Island Stroke Workstream works closely with the national stroke groups to implement actions.

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.

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

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

[21] The South Island Stroke Dashboard will be used as a monitoring tool

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
Equitable access to acute stroke services for the South Island population	**Improved health outcomes for people who experience a TIA or stroke**			
	• Support the rapid response from community to hospital.	Ambulance to ED rapid response pathway implemented. **(Q3)**	Ambulance to ED pathway evaluated for effectiveness.	Stroke monitoring and outcome measurement programme developed.
	• Support all South Island DHBs to have Stroke thrombolysis pathways.	Thrombolysis pathway implemented. **(Q2)** 6 % of potentially eligible[22] stroke patients are thrombolysed within the agreed pathway criteria. **(Q4)**	Regional thrombolysis outcome measurement target achieved.	Thrombolysis pathway is evaluated for effectiveness.
	• Support all South Island DHBs to have an acute stroke pathway.	Acute stroke pathway implemented. **(Q2)**	Acute stroke pathway is evaluated for effectiveness.	Acute stroke pathway quality improvement identified.
	• Support all South Island DHBs to have organised stroke services /units.	Monitor percentage of eligible stroke patients admitted to an organised stroke service[23] (working towards national target of 80%). **(Q4)**	National target for eligible stroke patients admitted to an organised stroke service/ unit is achieved.	
	• Ensure all providers assessing patients with TIA have access to documented TIA pathway.	All South Island DHBs have implemented a TIA health referral pathway. **(Q4)**	TIA pathway is evaluated for effectiveness.	TIA referral pathway quality improvement identified.
	• Ensure organised stroke services are accessible and appropriate for Māori,Pacific and other ethnic groups.	Access to acute stroke services for Māori, Pacific and other ethnic group is monitored and reported across South Island DHBs. **(Q1,2,3,4)**	Agree regional access to stroke services target for Māori, Pacific and other ethnic groups experiencing stroke.	Outcome measures for Māori, Pacific and other ethnic groups experiencing TIA and stroke.
Integrated stroke rehabilitation services for the South Island population	**Patients who have a stroke receive timely access to integrated stroke rehabilitation services**			
	• Develop a referral pathway for rehabilitation and re-integration into community.	Rehabilitation health referral pathways developed. **(Q4)**	Rehabilitation health referral pathway implemented.	Outcome measurements agreed and implemented (linked to stroke AROC).
	• Enable all patients identified as requiring inpatient rehabilitation to have timely access an organised stroke rehabilitation service[24]	Monitor percentage of patients receiving inpatient stroke rehabilitation and average time in acute care prior to transfer to inpatient rehabilitation. **(Q4)**	National indicators will be developed for eligible stroke patients admitted to an organised stroke rehabilitation service.	
	• Establish a system to measure agreed stroke rehabilitation indicators.	Measured progress towards achieving national stroke rehabilitation	Stroke rehabilitation outcome measurements agreed and implemented.	Outcomes evaluated.

[22] All ischemic stroke patients who meet criteria for thrombolysis treatment as defined by the acute stroke thrombolysis pathway

[23] Organised stroke service is defined by the provision of inpatient hospital service provided at specific hospital. Patients admitted to smaller rural hospitals will followed an agreed health pathway with input and oversight from DHB stroke specialist services.

[24] An organised stroke rehabilitation service is defined in the New Zealand Clinical Guidelines for Stroke Management 2010.

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
		specific indicator targets. **(Q3)**		
Workforce planning and development	**Health professional workforce is trained in acute and rehabilitation stroke management**			
	• Identified named stroke specialist/s within the inter-disciplinary team (IDT).	Stock take of named stroke specialist/s within the IDT completed. **(Q2)**	SI stroke services have access to expert stroke (specialist) health professionals within the IDT.	
	• Support health professionals to have access to continuing education for acute, rehabilitation and long-term/chronic stroke management.	Work with national and regional agencies (SIRTH) towards the development of a training plan for health professionals. **(Q4)**	Regional stroke education plan programme implemented.	Evaluate regional stroke education programme.
Health promotion	**Working collaboratively to support effective stroke health promotion and prevention programmes in the South Island**			
	• Secondary stroke prevention programmes will be part of an organised stroke service.	All South Island DHBs will include secondary prevention within their stroke services. **(Q4)**	Explore opportunities to work with the South Island Public Health Partnership Group for enhanced primary prevention of stroke and related diseases.	Explore opportunities to work with the South Island Public Health Partnership Group for enhanced primary prevention of stroke and related diseases.

6.2 Key Enablers

6.2.1 South Island Regional Training Hub (SIRTH)

The South Island Regional Training Hub is one of four national training hubs established through a Health Workforce NZ (HWNZ) initiative. Its governance structure sits under the umbrella of the South Island Alliance with its steering group comprising representatives from all the South Island DHBs (Nelson Marlborough, Canterbury, West Coast, South Canterbury and Southern).

SIRTH seeks to:

- Strengthen the education and training network, across the South Island and also nationally. Its focus is on encouraging and enhancing innovative and multi-disciplinary approaches to healthcare delivery through effective education and training processes
- Facilitate greater integration and co-ordination of training and education for all health professional groups
- Support innovative workforce development so health professionals can work at the top of their scope of practice in the new and emerging models of patient care
- Analyse workforce capacity and trends across the South Island to ensure a robust future health workforce
- Ensure future workforce initiatives are responsive to health disparities and Māori health through effective education and training

This work plan reflects early development of the Training Hub and builds on the initial work of developing links with relevant health professionals and key stakeholder groups in public and private health provision including specialist consultant medical professionals, general practitioners (GPs), non-government organisations (NGOs), education providers, professional colleges, primary health organisations (PHOs) and health unions.

The aim of this work plan is to improve education, training and workforce development across the South Island to better meet the health needs of the South Island population.

The areas of focus identified are:

- developing strategies to mitigate the identified vulnerable health professional staffing (ageing nursing and general practitioner workforce, rural health, aged care),
- promoting the roll out of advanced practice roles in the South Island
- developing capability and capacity in the non regulated workforce particularly for allied health assistants
- engaging with the General Managers Maori in supporting the education and workforce aspects of the Maori Health Plan (currently in development).

This plan also reflects the workforce development needs identified in the service level alliances (national priorities and the clinical work streams (regional priorities) and the developing partnership with Health Workforce New Zealand and the three other Regional Training Hubs. The Hubs have agreed to work together, nationally in regards to engagement with professional bodies in the health sector and the education sector.

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

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

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
Workforce supply CAPACITY	**Consolidation of training resources to ensure economies of scale and sharing of good practice by:**			
	• Standardising at least four PGY[25] 1/2 programmes annually regionally:	A plan for identifying programmes to be regionalised is developed. **(Q2)** Two education packages developed. **(Q4)**	50% of plan implemented.	100% of plan implemented.
	• Orientation.	Standard orientation for South Island PGY1/2s (recognised need for site specific orientation as well) is agreed. **(Q1)** Standard Orientation Package Plan developed.	Standard orientation is implemented across all South Island DHBs.	The standard orientation programme is evaluated and action plan identified if required.

[25] Medical Post Graduate Year

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
		(Q2)		
		Standard Orientation Package Plan implemented.(**Q4**)		
	• Core e-learning education is enhanced e.g. infection control.	Core education that can be delivered by e-learning is identified and prioritised. **(Q2)**	The uptake across the South Island DHBs is evaluated and action plan identified if required.	
		Educational packages for the four are developed and implemented across primary, secondary and tertiary care. **(Q4)**		
	• PGY2/3 alternative rotation (e.g. patient safety, audit and quality).	One South Island pilot site for a patient safety rotation is identified, negotiated and implemented. **(Q2)**	Effectiveness of placement is evaluated and action plan identified if required.	Identification of placements for other health professionals into these rotations.
	• Developing electronic Multidisciplinary Clinical Presentations and put onto SIRTH website.	Multidisciplinary Clinical presentations that can be delivered by e-learning are identified and prioritised across the South Island. **(Q1)**	The uptake across the South Island DHBs is evaluated and action plan identified if required.	
		Ten electronic Clinical Presentations are available on SIRTH website. **(Q4)**	Relevant clinical presentations are rolled out nationally in collaboration with the other Regional Training Hubs and Health Workforce New Zealand.	
	Recruitment and retention of the workforce in the sector by:			
	• Support all South Island HWNZ funded trainees to develop and implement career plans (100%) with regional reporting.	A regional process is developed and implemented with 100% compliance. **(Q1)**	100% compliance.	100% compliance.
		A suite of initiatives to enhance career planning is identified and implemented (e.g. medical vocational trainee evenings, post graduate education fairs. **(Q4)**		
		Evaluate the need for further advisor/mentor education and support across the health professional groups. **(Q4)**		
	• Strategy and planning is developed to support older nurses in the workforce to maximise their contribution to the sector.	Literature search and recommendations for strategic action is completed regarding how the sector should manage the ageing nursing workforce. **(Q1)**	Continued implementation of action plan.	Evaluation undertaken and further action identified.

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
		Action plan is developed, approved by Directors of Nursing in primary secondary and tertiary care in the South Island. **(Q3)**		
		Implementation commences. **(Q4)**		
	• South Island vulnerable workforces are identified and plans established to mitigate these.	Completion and refinement of the data set for South Island Health workforce. **(Q1)**		
		Chief Medical Officers, Directors of Nursing and Directors of Allied Health, Scientific and Technical identify vulnerable workforces and work with SIRTH to develop an action plan. **(Q2)**	Action plan finalised and implemented.	Review outcomes of the action plan and reassess vulnerable health workforces.
		Draft plan used for broader South Island health professional consultation. **(Q4)**	Regional Co-ordination evaluated.	
		South Island Anatomical Pathology Training is co-ordinated regionally across private and public providers. **(Q2**)	Process evaluated by all stakeholders.	
		Medical Physicist training is co-ordinated regionally with SIRTH as the lead training hub in conjunction with the service providers and the University of Canterbury. **(Q4)**	Review workforce and education needs and identify strategies to meet the need.	
		Demonstrated liaison with the service level alliances and work streams to identify changing workforce needs to meet the emerging models of care e.g. need to develop and recruit anaesthetic technicians to meet the elective services volumes. **(Q3)**		
	• Development of primary and secondary care health workforce to support shift in care to be more community based.	Identify education and workforce needs of health professionals in primary and secondary care. **(Q3)**	Action plan implemented.	Review outcomes of the action plan and reassess needs.
		Develop action plan and commence implementation. **(Q4)**		
	• In conjunction with the Child Health SLA address child and youth workforce development issues to build capacity	Transition of care pathway developed. **(Q4)**	Transition of care pathway implemented across SI DHBs.	Two agreed workforce initiatives implemented.

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
	and capability of health professionals to meet the identified needs in the Children's Action Plan.			
	• Work with the Mental Health Service Level Alliance (MHSLA) and national workforce centres to align planning and make best use of training and development resources.	Existing training needs analysed identified and reviewed. **(Q2)** Gaps and needs identified and recommendations developed in collaboration with, MHSLA, Te Pou, Health Workforce New Zealand and national workforce centres. (Q4)	Workforce plan developed in partnership with the SIRTH, Health Workforce New Zealand and national workforce centres.	
	• Work with the Elective Services Workstream to identify workforce issues.	Workforce needs identified based on elective Services plan. **(Q4)**	One innovative program identified which will benefit workforce.	Evaluation of innovative programme.
	• In conjunction with the Stroke Workstream identify a named stroke specialist/s to work with the multi-disciplinary team (MDT).	Workforce analysis survey developed. **(Q2)** Workforce analysis survey completed. **(Q4)**	South Island workforce development plan.	South Island stroke services have access to expert stroke (specialist) health professionals within the MDT.
	• In association with the Stroke workstream ensure health professionals have access to continuing education for acute and rehabilitation stroke management.	Education plan for health professionals is developed in collaboration with with the Stroke workstream. **(Q3)**	Regional stroke education plan programme implemented.	Education programme evaluated
Sector Transformation and innovation CAPABILITY	**Participation and roll out of HWNZ innovation projects**			
	• Diabetes nurse specialist prescribing.	Further demonstration site is Central Otago. **(Q1)** 1 RN authorised already (Dec 2012). Identify at least 3 further sites for diabetes nurse specialist prescribing in conjunction with the Executive directors of Nursing. **(Q2)** Support their implementation. **(Q4)**	Continued development of RN Diabetes Prescribers.	Continued development of RN Diabetes Prescribers.
	Train and develop the unregulated workforce in the disability support, aged care, mental health and addiction service sector			
	• Allied Health Assistant role training programme into the DHBs.	Systems and processes for the teaching and assessment of Careerforce NZQA learning packages for the Allied Health Assistant role are developed. **(Q3)**	Teaching and assessment are implemented and evaluated across two pilot sites within the South Island.	100% implemented across the South Island DHBs.

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
		Opportunities for the new roles are identified in primary, secondary and community care. **(Q4)**		
	• SIRTH will work with the South Island General Managers Maori to support development of the Maori health workforce.	Educational and workforce priorities and pathways identified on completion of the South Island Maori Health Plan and an action plan developed. **(Q4)**	Action plan implemented.	Action plan evaluated.
	Promote best use of all possible training settings for entry to practice in particular for the most vulnerable workforces. **E.g. strengthening partnerships in aged care facilities, increasing number of new graduates in priority service areas.**			
	• Nursing; 4 NetP positions in the aged care setting are implemented across the South Island.	Four NETP positions are recruited into Health of Older People facilities across the South Island. **(Q1)** Evaluation of the programme completed. **(Q4)**	Sustainability of positions assured.	
	Promote the development of a workforce with more generic skills that is flexible and integrated between hospital and community settings.			
	• PGY2/3s are introduced to general practitioner training.	Two South Island pilot sites for PGY 2 to have a General Practice rotation are identified and negotiated. **(Q2)** Resources required identified and put in place prior to implementation. **(Q4)**	Two PGY 2 General Practice rotations are implemented.	Effectiveness of placements including ability to retain participants in the workforce is evaluated and action plan identified if required.
	• Registrars in vocational training programmes are exposed to Rural Hospital Medicine.	Two South Island pilot sites for non tertiary registrar rotation are identified and negotiated. **(Q2)**	Two South Island pilot sites for non tertiary registrar rotation are implemented.	Effectiveness of placements including ability to retain participants in the workforce is evaluated and action plan identified if required.
	• Nursing Aged Care rotation – into General Medicine; Assessment, Treatment and Rehabilitation (ATR); and Aged Related Residential Care (ARRC).	Pilot site established in Canterbury DHB. **(Q2)**	Evaluation undertaken with expected roll out across the South Island.	
Cultural / Change leadership	**Regional collaboration to further strengthen clinical leadership and build upon successes in line with the "In Good Hands 2011" report.** **Example: leadership development through sector collaboration, making best use of existing resources (e.g. coordinate leadership training, support and research across all disciplines)**			
	• Support current structures and establish	Three South Island wide nurse education projects	Outcomes are identified. Further collaborations	Education initiatives are evaluated.

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
	new South Island networks to identify opportunities for collaboration.	are identified and implemented by the Nurse Educator Group that was established in 2012. **(Q4)**	identified.	
		Three South Island wide PGY1&2 projects are identified and implemented by the PGY1& 2 Group established in 2012. **(Q4)**	Three cross disciplinary education initiatives are identified and implemented.	Action plan is place to support continued education collaboration including all health providers in the South Island.
		Two Standardised tools for generic clinical skills are developed by Midwifery Educators. **(Q3)**	Two tools are implemented.	Implementation is evaluated.
	• Support the workforce development of the South Island clinical work-streams.	Plan developed and implementation commenced to increase the capability of cardiac nurses. **(Q4)**	Plan fully implemented and evaluated by Cardiac SLA.	
		Advanced Care Planning (ACP) education is delivered across the South Island. **(Q4)**	ACP compliance is evaluated. Development of the next level education plan.	Full South Island evaluation is completed and action planned developed if required.
Human Resources Work Plan	**South Island DHB General Managers (GMs) Human Resources (HR) Work Plan** **Working collaboratively with South Island GMs HR, SIRTH is also integrating the following strategies into the workplan. These strategies significantly enable workforce development within and across the health sector ensuring appropriate HR and leadership skills not only across the clinician groups but more broadly across the sector.**			
	Develop and implement regionally coordinated HR processes: • Regional and sub regional appointments process and joint appointment memorandum of understanding.	A South Island Alliance joint appointment policy and protocol is agreed and implemented to ensure consistency in personnel agreements across the South Island. **(Q3)**	A monitoring process is established including information collection.	
	• South Island recruitment and retention strategy.	Plan developed to regionalise components of DHB recruitment and retention technology. **(Q3)**	South Island recruitment and retention technology is rolled out into three DHBs.	South Island recruitment and retention technology is rolled out into the other two DHBs.
			Areas of innovation are identified.	
			Best practice standards are agreed.	
	• Establish baseline HR metrics of the current health workforce in the South Island including Māori and Pacific.	A sustainable regional data collection and review protocol is established. **(Q4)**	Continued implementation of action plan.	Evaluate the action plan.
		South Island data is benchmarked against national data set. **(Q4)**	Expansion of additional regional HR metrics in consultation with key stakeholders.	
		Priority health workforce areas are identified and an action plan developed.	Data is used to inform workforce planning.	

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
		(Q4)		
	• Implementation of a South Island leadership and management framework in collaboration with DHBs and tertiary education providers.	Develop, implement and undertake initial evaluation in CDHB and WCDHB. (**Q4**)	Rolled out to SDHB.	Rolled out to NMDHB & SCDHB. Full evaluation is undertaken.
	• To identify a common learning and development system.	National agreement with learning and e- portfolio tools. **(Q4)**	South Island has one e-learning and e-portfolio tool implemented in all five DHBs.	

6.2.2 South Island Information Services Service Level Alliance

The South Island DHBs work together within the Information Services SLA, utilising combined resources to jointly solve problems, develop innovative solutions to health sector challenges and achieve outcomes for the people of the South Island Region.

The South Island Alliance Information Services Service Level Alliance has been formed to delivery patient focused Information Technology systems that will support health care delivery across the South Island.

(An abridged version of the 2013/14 South Island Information Services Service Level Alliance Regional Service Plan – NHITB Priority Programme workplan is included below. The full version of this workplan is available in Appendix 6)

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

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

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

Priority Area	Initiative	Description	Target
eMedicines Programme	ePrescribing and Administration (ePA) MedChart	This project is implementing ePA in inpatient wards to facilitate and enhance: - the communication of a prescription (or medicine order) - aiding the choice, administration and supply of a medicine incl. decision support - providing a robust audit trail - improved quality and safety of the patient experience - the efficiency of clinical workflow.	All South Island DHB's to have ePA implemented in at least 3 wards using NZULM. The target is all Regional DHBs by December 2014 working with the national eMedications programme team. Approved regional / local plans for ePA for extended hospital deployment with budget allocated for future years. SDHB - 95% of Inpatient wards deployed by end Jun-14
	eMedicine Reconciliation (eMR)	The project is trialling paperless eMedicine Reconciliation (eMR) at admission, transfer and discharge in selected wards at SDHB, SCDHB, WCDHB, CDHB, NMDHB. eMR is the utilisation of electronic systems to facilitate the process of medicine reconciliation.	eMR implemented regionally and linked into the national SMT discharge summary. Compliant with national eMR HISO standard. This project is part of the eMeds Go for Gold Programme.

Priority Area	Initiative	Description	Target
	e-Pharmacy Management (ePM)	Upgrade current ePharmacy application at CDHB. Create a Regional instance of ePharmacy required for integration of MedChart to ePharmacy.	Upgrade CDHB to latest version of ePharmacy
	Universal List of Medicines (NZULM) Rollout	The NZ Universal List of Medicines (NZULM) is New Zealand's national dictionary of medicines list for universal use across the sector. It is updated regularly, and is readily accessible via a website and participating prescribing and dispensing software systems and medicines information sources (including the NZ Medicines Formulary).	This will be incorporated into the eMedication Programme - ePharmacy, ePrescribing
	NZ Formulary (NZF) Rollout	The NZ Formulary NZF is intended to be a core medicines information resource across the NZ health system, and to be used as the first reference source in both primary and secondary care. It is updated regularly, and is readily accessible via a website and participating prescribing and dispensing software systems.	This will be incorporated into the eMedication Programme - ePharmacy, ePrescribing
Regional Information Platform (DHBs)	eReferrals	Referal Management System - ERMS and HCS Referral Module. All GPs referring to all secondary services using one regional solution.	This project is made up of 4 Stages: 1 - Primary Care Engagement & Integration 2 - Secondary Care Integration 3 - Referral Management capability 4 - Secondary Care Generated Referrals Targets for 2013/14: 1. Engagement and project planning with all SI DHB's for the delivery of Stage 1 2. Stage 2, Project Initiation commenced in SCDHB & WCDHB. 3. Engagement with CRISP Programme Director for NMDHB patients referred to Wellington Hospital
	eDischarges	Implementation of Orion SMT as a regional service with national standards.	All hospitals using the national SMT discharge template and meeting the Connected Care HISO standard. An average of 80% of all hospitals discharges for all specialities, including ED; have an electronic discharge summary sent to the GP within 2 days of the patient's discharge from hospital.
	Clinical Data Repository (CDR) TestSafe South	The CDR (TestSafe South) stores laboratory, radiology results and a Varity of other investigations	Migration of SDHB from Healthlinks to TestSafe South. Business Case signed off Project initiation commenced
	Clinical Data Repository (CDR – Clinical Workstation CWS) Health Connect South (HCS) -	Regional CDR that stores and makes accessible structured and unstructured clinical information via the CWS or other portals includes clinic letters, discharges,	A regional CDR system that stores and makes accessible structured and unstructured clinical information via the CWS or other portals. The CDR stores DHB

Priority Area	Initiative	Description	Target
	South Island Solution *(NHITB – Critical Deliverable for 13/14 – Base target must be achieved)*	referrals, medications and other patient documentation. - eCDR.	laboratory and radiology results and discharge summaries. Activity planned for NMDHB and SDHB: Business Case sign off for HCS Pre implementation planning - Technical & Functional Project Initiation Project Planning Project Execution Activity planned for WCDHB: Project Closure
	Clinical Workstation (CWS) *(NHITB – Critical Deliverable for 13/14 – Base target must be achieved)*	Regional instance of Health Connect South (Concerto) implemented at 5 SI DHB's to assist patient search, accessing laboratory results, radiology results, discharge summaries, referrals, clinic letters and other patient documentation and investigations.	Refer to Clinical Data Repository, Health Connect South - South Island Solution
	ED		ED White Board under development between CDHB and Orion Health as a National Initiative under the strategic partnership. The Base Target is for complete design and development with regional clinical input.
	Radiology / PACS	An integrated Radiology Information System (RIS) and PACS (digital radiology) supporting all modalities delivering reporting/viewing and the ability to view images online outside the Radiology department.	A regional archive or repository containing patient's images are made available, on demand, for viewing through CWS or regional RIS. The local PACS repository only stores images for up to 12 months, but can reload images from the Regional Archive at any time. Implementing the ability to view radiology images from the Regional CWS and other portals through the interoperability reference architecture standard (XDS).
	PACS Archive	A regional archive or repository containing patient's images are made available, on demand, for viewing through CWS or regional RIS. The local PACS repository only stores images for up to 12 months, but can reload images from the Regional Archive at any time.	A regional archive or repository containing patient's images are made available, on demand, for viewing through CWS or regional RIS. The local PACS repository only stores images for up to 12 months, but can reload images from the Regional Archive at any time. Implementing the ability to view radiology images from the Regional CWS and other portals through the interoperability reference architecture standard (XDS).
	Picture / EHG's Archives	Secure patient digital image storage and retrival solution with audit functionality and security access levels	

Priority Area	Initiative	Description	Target
	Laboratory Information System	A laboratory system supporting laboratory services which is compliant with NZPOCS (NZ Pathology Observation Code Sets) and which feeds results through to the CDR.	A laboratory system supporting laboratory services which is compliant with NZPOCS (NZ Pathology Observation Code Sets) and which feeds results through to the CDR. Migration of SDHB onto Regional TestSafe South
	Pharmacy	A Pharmacy system supporting stock control, manufacturing and dispensing of medications, and which uses the NZ Universal Lists of Medicines (ULM).	Refer to ePharmacy Management Project, as this is item is part of this project.
	Patient Administration System (PAS)	The PAS is used to manage Admission/ Discharge/Transfer (ADT), procedure and diagnosis coding, medical records tracking, outpatient appointments and interfaces with ED and theatre management.	This is a very large and complex Programme. 1. PAS Replacement Partner Selection completed 2. Partnership contractual completed. 3. Project Initiation commenced for NMDHB, CDHB and WCDHB
	Cardiac Health	The Cardiac Health project will create and implement consistent clinical criteria for two surgeries (Coronary Artery Bypass Graft and Valve Replacement) to ensure fair and equitable access for patients.	Engagement with the project and support as required.
	Comprehensive Clinical Assessment for Aged Care	InterRAI is an evidence-based clinical assessment and planning tool that will be rolled out for all Aged Care providers.	Engagement with the project and support as required.
	Health Identity	Replaces the existing technology platform (Geo Stan) supporting the National Health Index (NHI), Health Practitioner Index (HPI) and associated address services using a approach that enables systems to 'talk' to each other.	Engagement with the project and support as required.
	Finance Procurement and Supply Chain	Nationally lead project	Engagement with the project and support as required.
Clinical Integration Initiatives	Patient Portal	Portals providing patient access to their health information from primary healthcare, regional CDRs and Ministry of Health. Examples of current patient portals include Manage my Health, Care Insight, HSA Global etc.	There is no decision on a national solution but there will be guidance and it will be regionally implemented (Who TBC). This will involve the PHOs and will be community based.
	Maternity / Well Child	Delivery of a system for shared care records for maternity services. Includes core health information, care plans, links to clinical data (lab results), clinical and patient portals.	The IS SLA will support the national maternity implementation for the South Island DHB's
	Summary View of Primary Health Information	See details under Patient Portal	Clinical Data Repository CDR - CWS) Health Connect South - South Island Solution
Other SLA Engagement	Regional - Advanced Care Plan		Engagement with the project and support as required.
	Regional - RL6 Incident Management System	Patient incident Management Systems - in line with HQSC	Reviewing and prioritising RL6 as regional solution for Patient Incident Management.

Priority Area	Initiative	Description	Target
			If approved, first implementation will be in SDHB.
	Regional - Child Growth Weight Charts	Implementation of the Child Growth Weight Charts	Growth Weight Chart installed at 1 pilot DHB and evaluated. If pilot successful, finalise implementation planning for regional implementation.
	Southern Cancer Network Project Support	Provision of Project support to Southern Cancer Network as required (this includes but not limited to Health Connect South, Patient Administration System, eMedications Management and eReferrals Programmes).	Provision of Project support to Southern Cancer Network as required (this includes but not limited to Health Connect South, Patient Administration System, eMedications Management and eReferrals Programmes).
	MOSAIQ Oncology implementation.	Oncology patient treatment and prescibing solution.	CDHB MOSAIQ Oncology implementation. Interfaced to the Nationla ePrescribing solution for CDHB (MedChart) to be implemented.
	Regional - Multi Disciplinary Meeting - Video Conference Solution	Muti media video conferencing solution for multi disciplinary meetings across the South Island	Implement MDM solutions for SCDHB, WCDHB, NMDHB and CDHB.
	Regional - HCS Mental Health Module	Mental Health case management module for HCS	Project closure for WCDHB. Plan implementation for the remaining South Island DHBs.
	Regional Provation	Electronic Bronchoscope and Endoscopic Reporting	Implementation of Provation in SCDHB and SDHB.
	National Titanium - Dental Solution	National Data Patient Management Solution	Once national Business Case and resourcing is signed off, IS SLA to agree on solution for the South Island.
	Regional - eSCRV	Regional view of the patients health record from Primary Care, Secondary Care, Community Care and Community Pharmacy dispensing	Provide a view of patient clinical data from Primary & Ssecondary Care, Dispensed medication from community pharmacy and data from community care Stage 1 Completion on 25% of GP's within CDHB & Nurse Maude submitting data to eSCRV data repository. Plan Stage 2 - Regional Configuration Plan implementation strategy for WCDHB, SCDHB
	ECG	To make ECG data available to Primary care, secondary care and St John both on and off site. To have the ability to upload patient data in real time and have clinical access both on and off site	Support nationally lead project.
	Microsoft G2012	Upgrade of the MS licensing model and Windows OS and Office.	Monitoring the progress of the upgrades which will be done locally at each DHB.
	Cardiac Health ANZAC-QI	Participate in the national implementation of the national cardiac register.	All South Island DHBs live by June 2014.

6.2.3 Support Services

Better Sooner More Convenient Health Services for New Zealanders in relation to support services means improved more timely and efficient support for all services.

A health system that functions well for support services is one that:

- Is committed to delivering the best services at optimal financial efficiency
- Involves clinicians in rationalisation and standardisation of products and services across the DHBs to reduce clinical risk and increase purchasing power.

The Support Services 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

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

Clinical Lead: **George Downward, Medical Director, Patient Safety (Canterbury DHB)**

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

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
Procurement and Savings	**Achieve and report savings in line with Health Benefits Limited (HBL) methodology**			
	• Aggregate procurement requirements and improve purchasing power.	Preparation and implementation of South Island Procurement Plan. **(Q1)**	Preparation and implementation of South Island Procurement Plan	Preparation and implementation of South Island Procurement Plan
		Preparation and implementation of South Island Capital Expenditure Plan. **(Q1)**	Preparation and implementation of South Island Capital Expenditure Plan	Preparation and implementation of South Island Capital Expenditure Plan
		Improved financial performance in the form of savings and/or investments. Accumulated savings reported. **(Q1,2,3,4)**	Improved financial performance in the form of savings and/or investments. Accumulated savings reported at the end of each quarter	Improved financial performance in the form of savings and/or investments. Accumulated savings reported at the end of each quarter
		Increased number of collaborative projects, with at least one new project underway each quarter. **(Q1,2,3,4)**	Increased number of collaborative projects, with at least one new project underway each quarter.	Increased number of collaborative projects, with at least one new project underway each quarter.
	• Reduce procurement costs.	South Island Procurement and Supply Chain workstream reports savings of $7.5 million (using agreed national methodology) during the 2013-14 year. **(Q1,2,3,4)**	South Island Procurement and Supply Chain workstream reports savings of $6 million (using agreed national methodology).	South Island Procurement and Supply Chain workstream reports savings of $6 million (using agreed national methodology).
		Accumulated savings reported. **(Q1,2,3,4)**	Accumulated savings reported at the end of each quarter.	Accumulated savings reported at the end of each quarter.
Collaboration and professional input	**Collaboration and cooperation of parties to enable efficiency and savings**			
	• South Island Procurement and Supply Chain workstream will work	South Island DHBs deliver savings and optimise financial and service performance in a timely manner. **(Q1,2,3,4)**	South Island DHBs deliver savings and optimise financial and service performance in a timely manner	South Island DHBs deliver savings and optimise financial and service performance in a timely manner

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
	collaboratively to identify and act on opportunities to secure savings.	Regular reporting against South Island Procurement Plan and South Island Capex Plan. **(Q1,2,3,4)**	Regular reporting against South Island Procurement Plan and South Island Capex Plan	Regular reporting against South Island Procurement Plan and South Island Capex Plan
		Ongoing engagement maintained with those who work in key related services, and management from relevant local, regional and national health services organisations, including clinician's relevant professional groups, provider organisations, DHB Planning and Funding and HBL. **(Q1,2,3,4)**	Ongoing engagement maintained with those who work in key related services, and management from relevant local, regional and national health services organisations, including clinician's relevant professional groups, provider organisations, DHB Planning and Funding and Health Benefits Limited (HBL).	Ongoing engagement maintained with those who work in key related services, and management from relevant local, regional and national health services organisations, including clinician's relevant professional groups, provider organisations, DHB Planning and Funding and Health Benefits Limited (HBL).
		Establish and maintain ongoing engagement with Pharmac, who have signalled intentions to enter the sector and procure medical devises nationally and regionally. **(Q1,2,3,4)**	Maintain ongoing engagement with Pharmac, who have signalled intentions to enter the sector and procure medical devises nationally and regionally.	Maintain ongoing engagement with Pharmac, who have signalled intentions to enter the sector and procure medical devises nationally and regionally.
	• Maintain clinician involvement on SLA and workstreams.	Clinicians regularly contributing to workstreams. **(Q1,2,3,4)**	Clinicians regularly contributing to workstreams.	Clinicians regularly contributing to workstreams.
		Less clinical variation to achieve safer and easier clinical exchanges. **(Q1,2,3,4)**	Less clinical variation to achieve safer and easier clinical exchanges	Less clinical variation to achieve safer and easier clinical exchanges
	• Build on the work of national initiatives and ensure these are applied locally.	HBL in agreement with work plans. **(Q2)**	HBL in agreement with work plans.	HBL in agreement with work plans.
		HBL has representation on SLA and all workstreams. **(Q1,2,3,4)**	HBL has representation on SLA and all workstreams.	HBL has representation on SLA and all workstreams.
		Contact established and maintained with Pharmac, both directly and through HBL. **(Q1,2,3,4)**	Contact maintained with Pharmac, both directly and through HBL.	Contact maintained with Pharmac, both directly and through HBL.
	• Align with national or other regional activity to deliver the best outcomes for cost and service.	HBL in agreement with work plans. **(Q2)**	HBL in agreement with work plans.	HBL in agreement with work plans.
		HBL has representation on SLA and all workstreams. **(Q1,2,3,4)**	HBL has representation on SLA and all workstreams.	HBL has representation on SLA and all workstreams.
	• Align with the target of collective procurement driven by HBL and Ministry of Economic Development (MED) to take advantage of bulk purchasing savings.	Increased rationalisation and standardisation of products and services (where appropriate) across the DHBs to reduce clinical risk and increase purchasing power. **(Q1,2,3,4)**	Increased rationalisation and standardisation of products and services (where appropriate) across the DHBs to reduce clinical risk and increase purchasing power.	Increased rationalisation and standardisation of products and services (where appropriate) across the DHBs to reduce clinical risk and increase purchasing power.
		Increased number of collaborative projects, with at least one new project underway each quarter. **(Q1,2,3,4)**	Increased number of collaborative projects, with at least one new project underway each quarter.	Increased number of collaborative projects, with at least one new project underway each quarter.
		HBL are in agreement with work plans. **(Q2)**	HBL are in agreement with work plans.	HBL are in agreement with work plans.
		HBL has representation on SLA and all workstreams. **(Q1,2,3,4)**	HBL has representation on SLA and all workstreams.	HBL has representation on SLA and all workstreams.

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
	• Manage change in conjunction with HBL who are expected to appoint new providers of food, laundry and supply chain services nationally and regionally.	Opportunities for joint ventures with providers of food, laundry and supply chain services explored. **(Q1)**		
		Initial negotiations conducted with potential joint venture partners. **(Q2)**		
		South Island Alliance Communications Coordinator reports regularly to SLA and assists with conveying messages. **(Q1,2,3,4)**		
	• Assist in research, analysis and implementation as required to maximise benefits and minimise risks with South Island DHBs for staff and patients.	Specific projects of workstreams reflect maximum benefits and minimal risks for staff and patients. **(Q1,2,3,4)**	Specific projects of workstreams reflect maximum benefits and minimal risks for staff and patients.	Specific projects of workstreams reflect maximum benefits and minimal risks for staff and patients.
Workstreams	**Sector specific workstreams sanctioned and reporting to SLA[26]**			
	• Merge the current Procurement and Supply Chain Work Group and Workstream into one unit for greater efficiency.	Work Group and Workstreams merged and operating effectively as one Workstream. **(Q1)**		
	• Maintain a strong, functioning clinically led Procurement and Supply Chain workstream. • Examples of projects include: - Preparation & carrying out a regional procurement & Capex Plan - Preparing monthly saving reports utilising HBL methodology	The Workstream's Work Plan contains at least three quantifiable, measureable Key Performance Indicators (KPIs), at least one of which is financial, which are reported to and monitored monthly by the SLA. **(Q2)**	The Workstream's Work Plan contains at least three quantifiable, measureable KPIs, at least one of which is financial, which are reported to and monitored monthly by the SLA.	The Workstream's Work Plan contains at least three quantifiable, measureable KPIs, at least one of which is financial, which are reported to and monitored monthly by the SLA.
		Clinical engagement maintained. **(Q1,2,3,4)**	Clinical engagement maintained.	Clinical engagement maintained.
		Rationalisation demonstrated without compromising quality and clinical safety. **(Q1,2,3,4)**	Rationalisation demonstrated without compromising quality and clinical safety.	Rationalisation demonstrated without compromising quality and clinical safety.
	• Maintain a strong, functioning clinically led Food Services workstream.[27]	The Workstream's Work Plan contains at least three quantifiable, measureable KPIs, at least one of which is financial, which are reported to and monitored monthly by the SLA. **(Q2)**	The Workstream's Work Plan contains at least three quantifiable, measureable KPIs, at least one of which is financial, which are reported to and monitored monthly by the SLA.	The Workstream's Work Plan contains at least three quantifiable, measureable KPIs, at least one of which is financial, which are reported to and monitored monthly by the SLA.
		Clinical engagement maintained. **(Q,3,4)**	Clinical engagement maintained.	Clinical engagement maintained.
		Rationalisation demonstrated without compromising quality and clinical safety. **(Q3,4)**	Rationalisation demonstrated without compromising quality and clinical safety.	Rationalisation demonstrated without compromising quality and clinical safety.
	• Maintain a strong,	The Workstream's Work Plan contains at least three	The Workstream's Work Plan contains at least three	The Workstream's Work Plan contains at least three

[26] The workstreams KPI's have been accepted by the Support Services Service Level Alliance, subject to the final feedback being incorporated. The final KPIs will be appended to the SIHSP when they have been finalised.

[27] NB: Due to the extraordinary factors associated with Health Benefits Limited, Support Services SLA accepted a recommendation to place the Food Services workstream on hold. This decision will be reassessed in August 2013

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
	functioning clinically led Laundry Services workstream. • Examples of projects include: - New inpatient bed making project - Decreasing towel usage in inpatient word - Rationalisation of linen item	quantifiable, measureable KPIs, at least one of which is financial, which are reported to and monitored monthly by the SLA. **(Q2)**	quantifiable, measureable KPIs, at least one of which is financial, which are reported to and monitored monthly by the SLA.	quantifiable, measureable KPIs, at least one of which is financial, which are reported to and monitored monthly by the SLA.
		Clinical engagement maintained. **(Q1,2,3,4)**	Clinical engagement maintained.	Clinical engagement maintained.
		Rationalisation demonstrated without compromising quality and clinical safety. **(Q1,2,3,4)**	Rationalisation demonstrated without compromising quality and clinical safety.	Rationalisation demonstrated without compromising quality and clinical safety.
	• Maintain a strong, functioning clinically led Facilities and Engineering workstream. • Examples of projects include: - Regional energy collaboration projects	The Workstream's Work Plan contains at least three quantifiable, measureable KPIs, at least one of which is financial, which are reported to and monitored monthly by the SLA. **(Q2)**	The Workstream's Work Plan contains at least three quantifiable, measureable KPIs, at least one of which is financial, which are reported to and monitored monthly by the SLA.	The Workstream's Work Plan contains at least three quantifiable, measureable KPIs, at least one of which is financial, which are reported to and monitored monthly by the SLA.
		Clinical engagement maintained. **(Q1,2,3,4)**	Clinical engagement maintained.	Clinical engagement maintained.
		Rationalisation demonstrated without compromising quality and clinical safety. **(Q1,2,3,4)**	Rationalisation demonstrated without compromising quality and clinical safety.	Rationalisation demonstrated without compromising quality and clinical safety.
	• Maintain a strong, functioning clinically led Clinical Engineering workstream.	The Workstream's Work Plan contains at least three quantifiable, measureable KPIs, at least one of which is financial, which are reported to and monitored monthly by the SLA .**(Q2)**	The Workstream's Work Plan contains at least three quantifiable, measureable KPIs, at least one of which is financial, which are reported to and monitored monthly by the SLA .	The Workstream's Work Plan contains at least three quantifiable, measureable KPIs, at least one of which is financial, which are reported to and monitored monthly by the SLA .
		Clinical engagement maintained.**(Q1,2,3,4)**	Clinical engagement maintained.	Clinical engagement maintained.
		Rationalisation demonstrated without compromising quality and clinical safety. **(Q1,2,3,4)**	Rationalisation demonstrated without compromising quality and clinical safety.	Rationalisation demonstrated without compromising quality and clinical safety.
Information Systems	**Efficient and effective information systems in place**			
	• Liaise with South Island Information Systems SLA.	Efficiencies demonstrated through availability of appropriate information systems. **(Q3)**		
	• Maintain common programme for Support Services information and data.	Procurement and Supply Chain data and savings maintained consistently on Daptiv programme. **(Q1)**	Procurement and Supply Chain data and savings maintained consistently on Daptiv programme.	Procurement and Supply Chain data and savings maintained consistently on Daptiv programme.
		Daptiv training needs met as required. **(Q1,2,3,4)**		
		At least one other workstream maintaining project information and data on Daptiv. **(Q2)**		
Workforce	**Professional knowledge maintained**			
	• Encourage professional training through workstreams.	Opportunities are shared/communicated through the workstreams. **(Q1,2,3,4)**	Opportunities are shared/communicated through the workstreams.	Opportunities are shared/communicated through the workstreams.
		Training attended by all workstream members is reported to SLA. **(Q1,2,3,4)**		

Key area of focus	Actions to deliver	Measures 2013/14	Measures 2014/15	Measures 2015/16
St John Regional Agreement for Patient Tranfser Service (PTS)	**Assistance given to develop and implement a new Regional PTS agreement between South Island DHBs and St John**			
	• Assist with the preparation and monitoring of the St John agreement for PTS.	The agreement, which is being facilitated by the Support Services St John Work Group during 2012/13, is signed by DHBs. **(Q1)** Six month review of the above agreement is conducted. **(Q2)**	Facilitate the annual review of the St John PTS agreement.	Facilitate the annual review of the St John PTS agreement.

6.2.4 Quality and Safety Service Level Alliance

The South Island Quality and Safety Service Level Alliance was established in Quarter 3 2012/13. The work of this SLA will support South Island health services work towards the New Zealand Triple Aim for quality and safety outcomes which will:

- improve quality, safety and experience of care
- improve health and equity for all populations
- provide better value for public health system resources

The Quality and Safety SLA will:

- lead, advice 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

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

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

The initial workplan for the Quality and Safety SLA will focus on a regional approach in supporting:

- Health Quality and Safety Commission campaigns:
  - Reducing harm from falls,
  - Infection prevention and control,
  - Medication safety,
  - Reducing peri-operative harm
- Other Health Quality and Safety Commission priorities:
  - Health, quality and safety indicators,
  - Quality and safety markers,
  - Consumer engagement
- Other SLA quality initiatives e.g.:
  - HOPSLA falls prevention programme,
  - Child Health SLA Quality Indicators,

- IS SLA medication safety
- Consumer experience

6.2.5 Capital Investment – Regional Asset Management Plan

Regional Capital Committee

Chair: **Jenny Black, Chair, Nelson Marlborough DHB**

Members: **South Island DHB Chairs, South Island DHB Chief Executives**

Strategic Planning and Integration Team

Chair: **David Tulloch, Southern DHB**

Members: **See Appendix 3**

Establishment of the South Island Alliance has led to a review of the approach for asset planning and management at a regional level. The South Island comes off a historically low capital investment basis i.e. 10% of total national capital spend. During the last ten years there has been little major facility development or investment across the South Island. Most facilities investment has been aimed at keeping pre-existing and often old facilities in service. This low historical investment means that much of the infrastructure is poor to very poor.

This is going to pose significant challenges for the South Island over coming years with major clinical and safety issues will come to the forefront. Consequently, a number of major capital investments have been identified in order to bring facilities up to a reasonable condition, meet seismic requirements and ensure facilities are equipped to service the South Island population in the future and meet modern standards of care. The Canterbury earthquakes have increased the focus and importance of seismic standards and led to increased focus on identifying risks across facilities in all South Island DHBs.

As health services planning progresses and service delivery models and service configurations across the South Island are clarified, the subsequent impact on clinical, technology and facilities requirements is being identified. However, the condition of the majority of South Island DHB facilities, their lack of physical space and their inflexibility, the inability to co-locate related services and the appropriateness of facilities for the delivery of modern models of care are all current and apparent issues which will need to be planned for in the immediate future. While recognising the importance of this, South Island Regional Capital Committee (RCC) has identified a need to understand the future requirements for the South Island through a capital plan based on regional service planning.

To support this approach the South Island has:

- Restructured the RCC, including:
  - membership, as all members of Alliance Leadership Team and the Alliance Board are now members of RCC to ensure alignment with DHB and South Island strategic approaches
  - review of the RCC Terms of Reference to reflect the South Island Alliance environment
- Established the South Island Asset Management Plan working group
  - completed asset stocktake
  - established linkages with South Island Information Services and Support Services Service Level Alliances
  - commenced demographic and capacity planning
- Established the Strategic Planning & Integration Team SPaIT) to support the links between clinical service and asset planning. Prioritisation is provided by SPaIT as required, who then provide a recommendation to the South Island Alliance Leadership Team, who in turn discuss with Regional Capital Committee

In addition, each South Island DHB has:

- Completed a seismic review
- Established more robust building information, such as:
  - replacement cost
  - geotechnical analysis
- Improved their individual Asset Management Plan
- Increased emphasis on equipment age and condition.

These and the ongoing programme of work will provide greater rigour to the RCC processes and in line with the National Capital Investment Committee requirements, improve planning for assets at the South Island level.

Examples of South Island Alliance activity is designed to improve productivity of providers and impact on asset management include:

- Development and implementation of the Regional Elective Services Production Plan Template to providing a standardised production plan of South Island DHB Provider Arm elective volumes
- Regional online health pathway development
- Joint purchasing of clinical equipment to support clinicians delivery services across the South Island
- Increase multidisciplinary team meetings to improve patient care
- Coordinated approach to information systems
- Coordinated approach to patient assessment
- Better Sooner More Convenient healthcare approaches across the continuum of care.

The South Island submitted its capital investment plan to the Ministry of Health in April 2012; this plan includes a high level stocktake, values, conditions, demand projections and the capital investment intentions.

The South Island has been advised by the Ministry that planning should be completed in the context of approximately $1.0b of new debt or equity being available to the South Island over the next 10 years. Given the lower level of investment (as compared to the remainder of the Country) over the last 20 years, this has been viewed as a challenge, but one which the South Island is taking seriously.

In the April version of the capital investment plan the capital plans that require Capital Investment Committee approval totalled $1,260m of which new debt or equity of $852m was signalled as being required. The April plan did not include the full requirements for investment in regional systems and work was continuing in a number of DHB in analysing the need. This has resulted in some changes to the requirements with further demand going on the $1,0b envelope; it needs to be acknowledged that work is on-going in a number of areas including models of care, seismic and affordability.

South Island Alliance activity that will feed into regional capital planning:

Elective Services Workstream

The Elective Services Workstream will undertake analysis of secondary and tertiary referral elective services of South Island DHB facilities and identify the capacity and capability of these services across the South Island. The outcome of the analysis will inform and support future configuration and delivery of elective health services across the South Island. In turn this will inform capital investment required.

Radiation Oncology

The Southern Cancer Network has undertaken modelling of Linear Accelerator Requirements for the South Island from 2012 to 2026. This work has informed the ten year capital plan in Figure 6 and will be reviewed as required with emergence of new treatments and technologies. The location of any additional Linacs will be subject to further investigation of the options.

Rural services

A review of current services and models of care in the rural facilities across the South Island will inform planning for workforce, technology and facility requirements going forward. The outcomes of this review will determine the workplan going forward.

Figure 6: Project Schedule by year, DHB and $'000s

Project Name	*DHB*	*Year of Strategic case review*	*Year(s) of Spending*	*Total Estimate*[28]	*Total New Debt Required*
Stage 1 ChCh & stage 1&2 Burwood	CDHB	2011/12	201319	$661,000	$490,000
Subtotal, 2011/12				$661,000	$490,000
Buller	WCDHB	2012/13	2013-15	$ 16,300	
Kaikoura Health facility	CDHB	2012/13	2013-15	$13,700	
Regional Information Systems	Various	2012/13	2012-16	$54,352	$36,397
Nelson Learning Centre	NMDHB	2012/13	2016	$10,000	
Nelson Hospital Tower block(s)	NMDHB	2012/13	2016-18	$64,000	$64,000
Greymouth	WCDHB	2012/13	2014-16	$42,000	$ 41580
Subtotal 2012/13				$200,352	$141,977
Timaru Hospital	SCDHB	2013/14	2014-16	$20,000	
Lakes District Hospital Redevelopment	SDHB	2013/14	2014-15	$2,400	
Subtotal 2013/14				$22,400	
SI Regional Forensic Plan	CDHB	2014/15	2015-18	$15,000	$15,000
Linacs (1 replacement & 5th Bunker & Linac)	CDHB	2014/15	2016-18	$8,200	$3,000
Subtotal 2014/15				$23,200	$18,000
Dunedin Campus Redevelopment	SDHB	2015/16	2016-22	$300,000	$300,000
Specialist Mental Health	CDHB	2014/15	2016-19	$69,000	$69,000
Subtotal 2015/16				$369,000	$69,000
Rural Integrated Health Centres	CDHB	2018/19	2020-22	$15,000	
Subtotal 2018/19				$15,000	
Laboratories/St Asaph St redevelopment	CDHB	2020/21	2021-22	$20,000	
Stage 2 ChCh (Cancer centre)	CDHB	2020/21	2021-22	$60,000	$40,000
Linacs (3 replacement)	CDHB	2020/21	2021-22	$10,000	
Subtotal 2020/21				$90,000	$40,000
10 –year Totals (all rounds)				**$1,380,952**	**$1,058,977**

[28] Out-year capital expenditure is indicative and subject to detailed planning and analysis

6.2.6 Public Health

"Health starts where we live, learn, work and play."

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

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

The main providers of public health services in the South Island are the three District Health Board Public Health Units (PHUs):

- Public Health South (Southern DHB);
- Community and Public Health (Canterbury, West Coast and South Canterbury DHBs);
- Nelson-Marlborough Public Health Service (Nelson Marlborough DHB).

These services are currently funded directly by the Ministry of Health, and have joint accountability to both the Ministry of Health and to their respective DHBs. Whilst there are a number of other providers of public health services, DHB Public Health Units (PHUs) play a particularly important role in supporting a public (or population) health approach in other organisations both within and outside the health sector and in supporting intersectoral strategies such as Whānau Ora.

Since 2010 the three South Island District Health Board Public Health Units have been working together as the 'South Island Public Health Partnership'; a work stream under the South Island Alliance framework. An evaluation completed in March 2012 showed that the project was progressing well and had been successful in forming a collaborative approach to leadership, sharing planning, resources and strategic work across the South Island.

In August 2012 a South Island Public Health Partnership plan (2012-2015) was signed off by the Alliance Leadership Team (see Appendix 7). This three year plan sets out how the Partnership, through its four workgroups, will continue to improve the effective and efficient regional and local delivery of PHU services. In addition, the Partnership aims to go beyond its focus on public health services, to improve the interface and support between PHUs and other parts of the health system e.g. through collaboration with other divisions of the DHB, primary health organisations, local government and non-government organisations and regional Service Level Alliances.

The Partnership is committed to an outcomes-focussed Public Health Plan for each DHB which will accompany each DHBs annual plan and describe how the PHU and other health services will deliver the five core public health functions[29] in each district. This will help to ensure integrated delivery of public health services at both a district as well as regional level.

In addition, at the regional level, an example of future collaborative work has been signalled through the Partnership's development of a DHB Position Statement on Alcohol, which has now been signed off by all five South Island DHBs. This creates the opportunity for consistent DHB Alcohol Harm Reduction Strategies South Island wide. The Partnership is also working to support a public (or population) health approach by the other SLAs. For example, as indicated in the Child Health Service Level Alliances' workplan, public health services will have input to a regional 'acute rheumatic fever prevention plan'.

[29] The five core functions are included in the Partnership Plan (Appendix 4) and consist of: health assessment and surveillance; public health capacity development; health promotion; health protection, and; preventative interventions, which are population programmes delivered to individuals.

6.3 South Island Neurosurgery Services

Over the past year the South Island Neurosurgical Governance Board has continued its work implementing the recommendations from the Panel convened by the Director General of Health.

The projects launched at both the Christchurch and Dunedin nodes to maximize the available resources needed to deliver neurosurgical services are near completion. Good progress has been made towards recruitment of neurosurgeons at Dunedin, and more latterly at Christchurch. In tandem with recruitment the South Island DHBs made excellent progress in addressing appropriate supervision requirements of neurosurgeons at the two nodes by preparing their application to Medical Council to be recognised as an Approved Practice Setting (APS) for neurosurgical services.

With resources in place the Service is positioned to roll out those recommendations important for generating organisational change to patients and clinicians. This pertains to Outreach services, transport and accommodation, workforce development and shared care.

The four areas of work in order of priority for the upcoming year are:

- Implementing referral protocols and pathways to ensure access to acute (time sensitive) care in place relative to subspecialisation
- Implementing an Outreach Service plan
- Good post-discharge links and appropriate referrals for rehabilitation
- Implementing plans for training /upskilling of all staff working in Neurosciences and appropriate linkages with other services and inter-professional groups, especially nursing and management at both “host” DHBs and other South Island DHBs.

In addition the South Island Neurosurgery Service Board will work with the South Island Alliance Board and Leadership Team to consider governance arrangements for South Island Neurosurgery Services from 2014 onwards. This will include a framework for clinical governance built on the success of the current Board, and any on-going funding matters.

6.4 National Health Committee

The National Health Committee (NHC) is an independent statutory body charged with prioritising new and existing health technologies and making recommendations to the Minister of Health. All new diagnostic and treatment (non-pharmaceutical) services, and significant expansions of existing services, are referred to the NHC. The Committee also provides advice on what technologies are obsolete or no longer providing value for money for New Zealanders.

The South Island Alliance supports the work of the NHC by taking the opportunity to provide feedback from a regional perspective to consultation documents and supporting clinical staff involvement. The region is also keen to recognise and determine the options for the South Island in relation to the NHC disinvestment in existing technologies work to support our *value for money* goal. Within the South Island Alliance the Strategic Planning and Integration Team has the responsibility of establishing and maintaining a key relationship with the NHC. The Strategic Planning and Integration Team have the central role in coordinating the regional prioritisation process; all prioritised requests and recommendation are forward to the Alliance Leadership Team for sign off.

7. APPENDICES

7.1 Appendix 1—South Island Alliance Charter (14/09/2011)

SOUTH ISLAND DISTRICT HEALTH BOARD ALLIANCE GOVERNANCE BOARD & LEADERSHIP TEAM CHARTER

This Charter document outlines our commitments and the key principles and "rules of engagement" we will follow as members of the South Island District Health Board Alliance Governance Board and Leadership Team, for the South Island District Health Board Alliance.

We are appointed to the Alliance on the basis of our position within our respective District Health Boards, and are tasked with successfully governing and leading the South Island District Health Board Alliance to achieve its objectives.

While we serve at different levels within the Alliance framework, we share common objectives and commitments, which are outlined in this Charter, and are committed to ensuring the South Island District Health Board Alliance is successful.

PURPOSES

Our purpose is to govern, lead and guide our Alliance as it seeks to improve health outcomes for our populations. We aim to provide increasingly integrated and co-ordinated health services through clinically-led service development and its implementation within a 'best for patient, best for system' framework. We have formed this Alliance to enable the District Health Boards in the South Island region to work effectively together, utilising our combined resources to jointly solve problems, develop innovative solutions to health sector challenges and achieve outcomes for the people of the South Island Region.

In the first instance, our priority is to implement the agreed regional priorities as outlined in the South Island Health Service Plan.

PRINCIPLES

The foundation of our Agreement is a commitment to act in good faith to reach consensus decisions on the basis of 'best for patients, best for system'. As a leadership team we will conduct ourselves and undertake our governance and leadership roles in a manner consistent with the following Alliance principles.

- We will support clinical leadership, and in particular clinically-led service development;
- We will conduct ourselves with honesty and integrity, and develop a high degree of trust;
- We will promote an environment of high quality, performance and accountability, and low bureaucracy;
- We will strive to resolve disagreements co-operatively, and wherever possible achieve consensus decisions;
- We will adopt a patient-centred, whole-of-system approach and make decisions on a Best for System basis;
- We will seek to make the best use of finite resources in planning health services to achieve improved health outcomes for our populations;

- We will balance a focus on the highest priority needs in our communities, while ensuring appropriate care across all our rural and urban populations;
- We will adopt and foster an open and transparent approach to sharing information; and
- We will actively monitor and report on our alliance achievements, including public reporting.

We acknowledge that there may be areas within the scope of the activities of this Alliance where a particular DHB may wish to either fully or partially be excluded from the Alliance activities. 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. We understand the DHB intending to exercise this right will do so in good faith and will consult each other before exercising this right.

COMMITMENTS

We will work closely and collaboratively with our team members, in an innovative and open manner, to produce outstanding results. To achieve this we make the following commitments:

- **Shared responsibility:** We will actively address all tasks and duties of our role as members of our leadership team, and will comply with the operational provisions and guidance for our team.
- **Shared decision making:** We agree that our decisions will be supported by the best available evidence. We will use our best endeavours to facilitate unanimous decisions, and will not prevent a consensus being reached for trivial or frivolous reasons.
- **Shared accountability:** We agree that we will have a robust airing of views, but that once our team has reached a decision we will all abide by that decision and support it publicly. (This includes keeping confidential the views of particular individuals expressed during the discussion, but does not prevent us sharing the issues that were balanced in reaching that decision.)
- **Good faith:** We agree to openly discuss all matters that affect our ability to make firm decisions, including any conflicts of interest and any limits on our mandate (where we carry these from participant organisations), so that all members of our team are fully aware of any restrictions, caveats or further authority that may be required.
- **Treaty of Waitangi:** We agree that the Treaty of Waitangi establishes the unique and special relationship between Iwi, Māori and the Crown. Parties with Treaty obligations will honour these when participating in Alliance activities.
- **Confidentiality:** To encourage the open and transparent sharing of information we agree to keep confidential matters shared on a confidential basis, to enable improved decision making.
- **Active engagement:** We agree our members' continuous involvement in and attendance at our team meetings is critical, and will make every effort to attend and participate fully.

If a member of our team does not act in accordance with our principles and commitments, we will collectively discuss the situation with the member involved and seek an appropriate resolution in a timely manner. We recognise that if no resolution can be found, then depending on the magnitude of the issue, this may jeopardise the existence of the Alliance moving forward. If this arises the South Island District Health Board Alliance Governance Board will address the issue and determine the pathway forward.

MANDATE AND FUNCTIONS

South Island DHB Alliance Governance Board

For members of the South Island DHB Alliance Governance Board, our role is set out in the Agreement. Broadly, our functions are to:

- Determine the strategic focus for the South Island District Health Board Alliance
- Approve the annual work plan through the South Island Health Service Plan
- Approve any change of scope of priorities
- Monitors overall performance of the Alliance
- Resolve any conflicts that arise from the Alliance Leadership Team in a timely manner

South Island DHB Alliance Leadership Team

For members of the South Island DHB Alliance Leadership Team, our role is set out in the Agreement. Broadly, our functions are to:

- Agree our Alliance Objectives and Key Results Areas within the scope of our Alliance Activities , including the systems and KPIs for assessing achievement of these;
- Agree the work, activity and services that need to be provided to meet our Alliance Objectives;
- Make recommendations on the method and form of contracting to give effect to agreed priorities and service delivery mechanisms, on a best practice basis;
- Monitor the outcomes of Alliance Activities, and use that information to inform our stakeholders (particularly our populations) and to guide further decisions on prioritisation and service change;
- Develop a process for how our alliance will annually review its scope and objectives, to keep refreshing our strategy and approach to meet our Alliance Objectives;
- Discuss with any DHB any potential exercise of its right to make an independent decision.

RELEASE OF LIABILITY

As members of the governance board and leadership team for the South Island DHB Alliance, we are committed to govern, direct and lead the Alliance in accordance with this Charter. It is not our intention that our actions as members of our governance board or leadership team will give rise to an action in law from alliance participants or other members of our leadership team.

7.2 Appendix 2 – The South Island Region

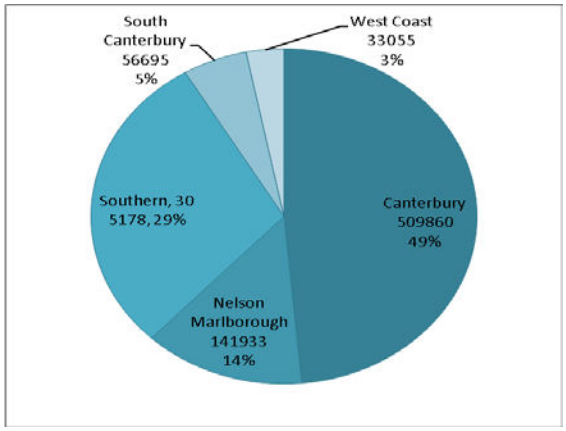
Demographics

> *"We need to reinvent the way we think about ageing itself. We want to be stretching life in the middle, not just at the end. This means keeping people healthy for as long as possible, and giving them the opportunity to do the things they want and that society needs."* (The health-care challenges posed by population ageing, 2012)

In 2013-14, population estimates show the South Island will be home to over 1,050,571 people, 23% of the total New Zealand population. By 2026, our population is projected to increase to 1,132,900 people, a lesser increase of 7.8% compared to a projected population increase of 11.2% for all of New Zealand.

Nelson Marlborough, Canterbury and Southern DHBs' populations are growing, while South Canterbury and West Coast DHBs' populations will be relatively static. Population estimates for the period 2013-14 to 2025-26 shows the largest increase in population will occur in Canterbury DHB with an increase of 56,020 (11%) compared to the lowest being West Coast DHB with 308 (1%).

Figure 1: South Island Population by DHB, 2013-14



This follows a similar pattern for the whole of New Zealand, with population being concentrated in larger urban centres. Over a third of the South Island population lives in Christchurch City, which is projected to increase by 14% between 2006 and 2026. Of the urban city Territorial Authorities, Nelson City has the largest projected percentage increase at 15.6% compared to Invercargill City the lowest at 3.5%.

Likewise, while the South Island rural population is predicted to be relatively stable overall, there are areas of growth and decline. Significant growth is anticipated in the surrounding Christchurch Districts and Queenstown-Lakes District. Some rural areas also experience high inflows of tourist populations or seasonal workers in summer and winter seasons, increasing the population several-fold for significant periods of time and putting considerable strain on existing health services.

Population estimates for Territorial Authorities in the South Island show population growth accelerated as people relocated from the earthquake-affected areas. Nationally, the five territorial authority areas with the fastest rate of population growth in the June 2011 year were the districts of Selwyn, Queenstown-Lakes, Ashburton, Waimakariri, and Hurunui. All of these districts are located in the South Island, with most close to Christchurch city.

Ethnicity

In contrast to the national population, the South Island has a higher proportion of people identifying as European/Other (2013-14, SI 84% compared to NZ 66%). In the South Island Māori and Pacific populations are projected to increase by 17.2% and 21.1% respectively from 2013-14 to 2025-26, representing a more rapid growth in the Māori and Pacific populations than in New Zealand as a whole. The proportion of Māori and Pacific people is estimated to increase from 8.7% and 1.9% respectively in 2013-14 to 9.8% and 2.2% respectively in 2025-26. The largest increase in the South Island will occur in the Asian population (increasing by 30.8%) to become 7.5% of the total population in the South Island in 2025-26 (5.6% in 2013/14).

The increase in our Māori and Pacific populations provides challenges in that Māori and Pacific people currently have higher rates of smoking and obesity than other population groups, are more likely to have complex or multiple long-term conditions, and have higher morbidity and mortality rates. Pacific people have the highest hospitalisation rate in the South Island for diabetes and its complications, followed by Māori, who have significantly higher rates than Asian and European/Others. Rates of hospitalisation and mortality for cardiovascular disease and cancer follow a similar pattern.[30]

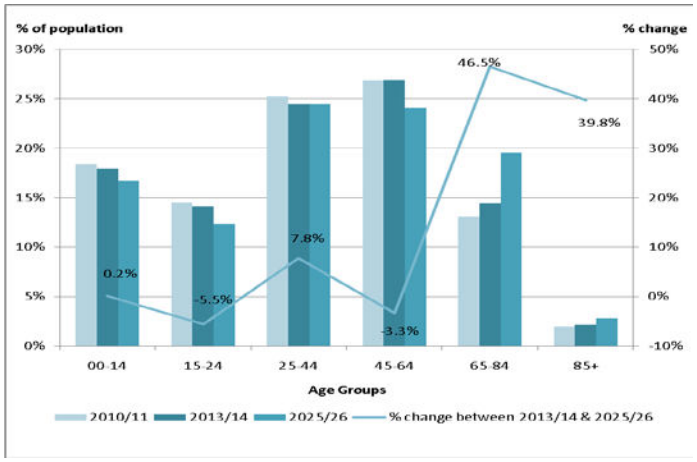
Age

Between 2010-11 and 2025-26, the projected change in the age of the South Island population shows there will be small decreases in the proportion of the population in younger age groups and increases in all age groups over 60 years, with a significant increase in the population aged between 70 and 80 years. By 2025-26, it is trending towards one in four people in the South Island will be aged 65 years or over, compared to one in six in 2013-14 (refer Figure 2).

While our older population is living 'well' for longer and fitter and more active, older people are more likely to have more complex or multiple long-term conditions, and consequently, are higher users of health services. Both population ageing and increases in long-term conditions across all population groups will drive increases in health expenditure.

In 2010/11 the 25-44 year age group was approximately 26% of the South Island population. At that time the proportion was predicted to decrease to 24% by 2025/26, however we are already seeing this decrease. We believe this is a reflection of one-off changes in Canterbury post earthquake but will monitor this going forward as this is an important age group for our health workforce.

Figure 2: South Island Projected Population Change by Age Group, Period 2010-11 to 2025



[30] Health and Disability Intelligence Unit (2008); SISSAL *Health Needs Assessment*, Christchurch; Health and Disability Intelligence Unit, Health and Disability Systems Strategy Directorate, Ministry of Health, Wellington

Population health status and inequalities

Inequalities can be based on gender, ethnicity geography or socioeconomic status, and many are driven by social and economic determinants outside the direct influence of the health system. Reducing the impact of these social and economic determinants is a current focus for New Zealand. New Zealand understands its own particular set of social and economic determinants and has made some progress in converting this knowledge into action, however in some areas New Zealand continues to perform poorly when compared with other OCED countries. Health services must play an active role in influencing these determinants through input into policy and legislative processes.

Health outcomes (life expectancy and overall mortality rates) and rates of avoidable hospitalisation, and avoidable mortality (that could potentially have been avoided through population-based intervention or through preventive and curative interventions at an individual level), of the South Island population exceed those of the wider New Zealand population. However, there are differences between DHBs and between population groups.

With the expected increase in the proportion of the population who are aged over 65 and who are Māori, or Pacific, the prevalence of long-term conditions is also predicted to increase across the South Island. This is significant for health service planning, as an ever increasing proportion of our health budget will be spent on managing these conditions.

Addressing the social determinants of health will not only achieve better health equity, but is crucial in controlling the spiralling costs of healthcare, leading to a financially sustainable health system. Reducing the influence of social and economic determinants will require Inter-sectoral (social development, transport, finance, education and justice) initiatives. A whole of government (central and local) and whole of society approach is required if New Zealand is to eliminate inequities in health.

7.3 Appendix 3 – Minister Letter of Expectation 2013

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

28 JAN 2013

Letter of expectations for DHBs and subsidiary entities for 2013/14 year

Thank you for the contribution you and your staff are making to a better public health service. Public and patient confidence in health services continues to improve.

The government will be investing more money in Health this budget. This contrasts with the ongoing cuts in health spending in many parts of the world.

In this context the government continues to expect **better, sooner, more convenient** healthcare for patients and communities within constrained funding increases.

Better Public Services: Results for New Zealanders

The Prime Minister has set ten whole-of-government key result areas. The health service is responsible for leading increased infant immunisation and reduced incidence of rheumatic fever. We are also involved in the key result of reducing the number of assaults on children and supporting the implementation of the white paper on vulnerable children.

DHBs are expected to actively engage and invest in these key result areas. Your DHB has been given step targets to contribute to the Prime Ministerial challenges. Achieving these is not negotiable.

It is important Boards work closely with other social sector organisations and initiatives, including Whanau Ora.

National Health Targets

Good progress is being made on the three patient access targets. More effort is needed on the three preventive targets. DHBs are expected to include clear and specific plans for achieving all the national health targets in their Annual Plans, including the use of general practice-specific incentives where appropriate. You must demonstrate appropriate performance management arrangements for PHOs. You should show your local primary care networks are involved in, and explicitly endorse, your targets plan and your preventive targets plan in particular.

Patients' time is a valuable non-renewable resource. Timely access improves outcomes, is preferred by patients and saves cost. The government has made clear its ambitious objectives to further shorten waiting times for surgery, diagnostics, cardiac and cancer care. Your DHB is expected to meet these objectives.

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

Care Closer to Home

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. This is achieved through better coordinated health and social services and the development of care pathways designed and supported by community and hospital clinicians. The outcome is patients treated closer to home with fewer acute and unplanned hospital admissions.

DHBs are expected to focus much more strongly on service integration across the health system particularly showing how this will be done with primary care. This includes integrated family health centres, primary care direct referral to diagnostics, clinical pathway development, and sharing of patient controlled health records.

Health of Older People

Your DHB is expected to work with primary and community care to provide integrated services for older people that support their continued safe, independent living at home particularly to avoid a hospital admission and after a hospital discharge. DHBs should continue working with the Ministry on implementing government commitments to improving home care, stroke and dementia care.

Regional and National Collaboration

There are significant financial and clinical gains to be derived from regional DHBs working together. I expect DHBs to progress much faster implementing Regional Service Plans. This includes delivering on regional workforce, IT and capital objectives that are set and monitored in the NHB dashboard.

Further improvements in quality, efficiency and cost control will come from accelerating DHBs national work with Health Benefits Limited, Health Workforce NZ and the Health Quality and Safety Commission. More information on this will be forthcoming.

Strong clinical leadership and engagement has been pivotal to the gains made so far and remains essential.

Living within our means

The government is determined to return to surplus in 2014/15. Like the public health service as a whole, your DHB must contribute by lifting productivity and keeping to budget. DHBs are obliged to operate within their agreed financial plans. Your DHB must have detailed and defensible plans to improve financial performance year on year. The supply of equity and debt is constrained so Boards should prioritise capital investment more rigorously and fund from internal sources.

As agents of the Crown, you and your Board must assure yourselves that you have in place the appropriate clinical and executive leadership needed to deliver on the government's objectives. The performance of chief executives must be monitored against these expectations.

I appreciate the effort you and your teams are making. Thank you. Please share this letter with your clinical leaders and local primary care networks.

Yours sincerely

Hon Tony Ryall
Minister of Health

Appendix 1: Prime Minister's Key Result Areas and National Health Targets

Prime Minister's Key Result Areas – Supporting Vulnerable Children

Infant immunisation rates

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

Rheumatic fever

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

Assist to reduce the number of assaults on children

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

National Health Targets

Shorter stays in emergency departments

95 percent of patients will be admitted, discharged, or transferred from an emergency department within six hours.

Improved access to elective surgery

The volume of elective surgery will be increased by at least 4000 discharges per year.

Shorter waits for cancer treatment

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

Increased immunisation

85 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2013, 90 percent by July 2014 and 95 percent by December 2014.

Better help for smokers to quit

95 percent of patients who smoke and are seen by a health practitioner in public hospitals and 90 percent of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking.

More heart and diabetes checks

90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years. DHBs are required to achieve at least 75 percent by 1 July 2013, and DHBs exceeding 75 percent are expected to be actively moving toward the 90 percent goal.

7.4 Appendix 4—Strategic Direction 2012-13

"Meanwhile, the nature of health problems is changing dramatically. Urbanisation, globalisation and other factors speed the worldwide spread of communicable diseases, and increase the burden of chronic disorders." World Health Organisation, *Annual Report (2008)*

What will a sustainable health system look like?

Although they may differ in size, structure and approach, health providers have a common goal: to improve the health of their populations by delivering high-quality and accessible health care. With increasing demand for services, workforce shortages and rising costs, this goal is increasingly challenging and our health system faces an unsustainable future. In response, significant changes are being made to the design and delivery of health services at all levels of the New Zealand health system.

National Direction—'better, sooner, more convenient' health care

The changes being driven across the New Zealand health system are in line with the wider strategic context outlined in the *New Zealand Health Strategy (2000)*, the *New Zealand Disability Strategy (2001)* and *He Korowai Oranga*: *Māori Health Strategy (2002)*.

These national strategies, combined with the Minister of Health's annual letter of expectations and the *New Zealand Public Health and Disability Amendment Act (2010),* provide guidance for policy and planning at regional and local levels. The *New Zealand Health Strategy,* in particular, outlines objectives for the health of the New Zealand population and the role of DHBs in delivering the national vision: "*All New Zealanders lead longer, healthier and more independent lives*".

Alongside these overarching strategies, the National Health Board has released *Trends in Service Design and New Models of Care*.[31] This document provides a high-level summary of emerging worldwide trends and international responses to the pressures, and challenges facing the health sector.

The national direction emphasises four major shifts in service delivery based on the view that an aligned system-wide approach is required to improve health outcomes and meet the ever-increasing demand for health services:

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

The following diagram (refer Figure 5) is adapted from the national document and describes this 'whole-of-system' shift in the way health services are delivered. The solid line represents current service configuration and the dotted line future service configuration.

> *"National wants our public health system to deliver better, sooner, more convenient care for all New Zealanders. We want reduced waiting times, better individual experiences for patients and their families, improved quality and performance and a more trusted and motivated health workforce."*
>
> *John Key*
> *National Party Health Discussion*

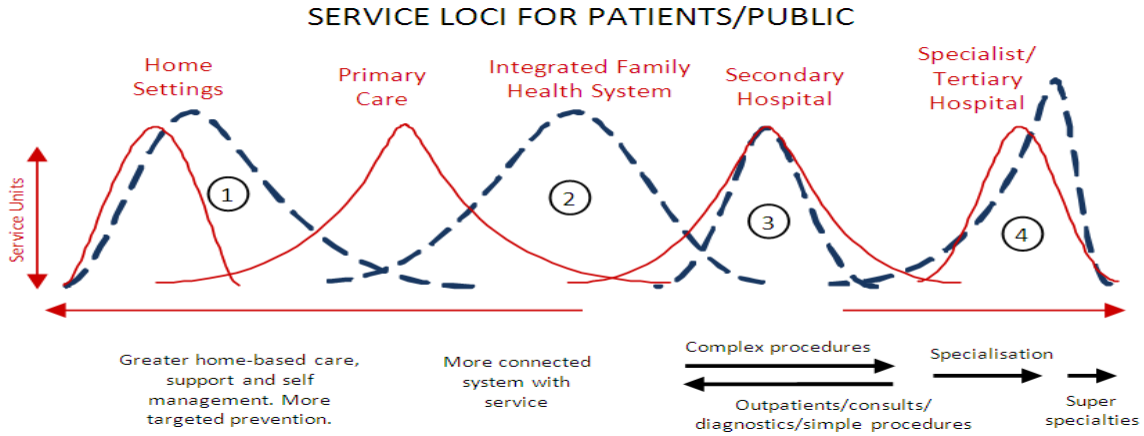
[31] *Trends in Service Design and New Models of Care: A Review (2010)*, Ministry of Health, www.nationalhealthboard.govt.nz

Hospitals will continue to be a key support and a setting for highly specialised care, with the importance of timely and accessible complex care being paramount. However, less-complex care (traditionally provided in hospital settings) will be provided in the community. Supported by clinical networks and multidisciplinary teams, the focus is shifting towards supporting people to better manage their own health and to stay well—reducing the current unsustainable growth in demand for health services.

The development of Integrated Family Health Centres (IFHCs), community hubs and collaborative partnerships between health professionals will further enhance primary and community services and free-up hospital and specialist services to provide more intensive treatment and complex care.

Figure 5: Pictorial Representation of Shifts in Service Trends

MORE SERVICES WILL BE PROVIDED CLOSER TO WHERE PEOPLE LIVE



This reorientation is consistent with Government's commitment to *'better, sooner, more convenient'* healthcare and clear expectations to bring more health services closer to where patients' live, and accelerate, the integration of primary and secondary services.

Increased Regional collaboration

Government also has clear expectations that alongside the blurring of traditional primary and secondary roles, the role of hospitals and the provision of specialised (tertiary) services will be critically reviewed and consolidated nationally and across DHB regions. Greater collaboration between DHBs is seen as a means to reduce duplication and waste, maximise clinical and financial resources and ensure the ongoing sustainability of health services.

The National Health Board has identified five 'vulnerable' services that will become national services: Clinical Genetics, Paediatric Pathology, Paediatric Metabolic Services, Paediatric Cardiology and Paediatric Cardiac Surgery. These services will be planned and funded centrally instead of by individual DHBs. They were chosen because issues around their small size, specialist retention or critical mass make them vulnerable if they are not managed in a coordinated way across the country.

A second set of services have been identified for national service improvement: Cardiac Surgery, Paediatric Oncology, Paediatric Gastroenterology, Neurosurgery and Major Trauma. National service improvement programmes and clinical networks will be established in each of these areas, but services will still be funded and provided by individual DHBs.

Regional Direction—best for patients, best for system

The South Island region includes Nelson Marlborough, West Coast, Canterbury, South Canterbury and Southern DHBs. Each South Island DHB individually ensures the provision of health and disability services for its population and faces similar challenges in delivering high quality services, ensuring the future sustainability of those services and achieving Government priorities.

All South Island DHBs are changing the way they work within their local districts to meet these challenges and alleviate the pressures they face. However, as individual DHBs, we cannot make a large enough impact to ensure the future sustainability of South Island services, particularly more highly specialised and complex services.

With a relatively small total South Island population (1,038,843 people, 24% percent of the total New Zealand population), implementing diverse but similar individual responses duplicates effort and investment, and leads to service and access inequalities. Regional collaboration is an essential part of our future direction.

In agreeing a collaborative regional direction, the South Island DHBS have committed to a 'best for patients, best for system' alliance framework that aligns with national policy. The South Island Regional Health Services Plan articulates the regional direction and key principles that will inform regional service development, service configuration and infrastructure requirements over the next several years.

Our vision is a clinically and fiscally 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.

Closely aligned to the national approach, the regional direction is based on the following concepts:

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

These concepts emphasise the significant step change in the way we design and deliver services. Through regional service planning, traditional DHB boundaries and patient flows are being challenged to ensure that services are supported in a sustainable manner.

While regional planning initially focused on the sustainability of vulnerable hospital and specialist services, the emerging 'whole-of-system' approach recognises primary and community services as essential to future sustainability.

In support of the whole-of-system approach, the South Island has adopted a generic model of care to ensure a consistent understanding of the range of health needs a person may have over their lifetime. The model (refer Figure 6) focuses health planning on the patient's needs and the provision of the right service, at the right time and in the right place—across all stages of the continuum from wellness to end of life.

Figure 6: Generic (patient-centred) Model of Care

OUR SOUTH ISLAND MODEL OF CARE ENSURES A CONSISTENT APPROACH TO THE FULL RANGE OF HEALTH NEEDS OVER A PERSON'S LIFETIME

This prompts the development of patient pathways that flow across the system and supports service redesign by questioning gaps and barriers. In this sense, the model supports quality clinical outcomes by identifying with the needs of the patient. It also encompasses a Whānau Ora approach by taking a holistic view of the person (or population) and the determinants of health that influence wellbeing.

Our success relies on improving patient flow across the South Island by aligning these patient pathways, introducing more flexible workforce models and improving patient information systems to connect services across service levels, providers and DHB regions.

An alliance approach

Regional service planning in the South Island is implemented through service level alliances and workstreams based around priority service areas. These areas have been identified nationally, regionally or locally as clinically 'vulnerable', under pressure from high demand, or as key enablers to support change.

Each service level alliance and workstream is clinically-led and has active clinical input, with multidisciplinary representation from community and primary care, as well as from hospital and specialist services.

Six service level alliances have been prioritised to respond to immediate challenges in the coming year: Cancer, Child Health, Health of Older People, Mental Health, Information Services and Support Services.

Alongside these service level alliances, collaborative activity is expanding through workstreams and the South Island Regional Training Hub across a number of other priority areas: cardiac, elective, neurosurgery, ophthalmology, stroke, Māori Health and human resource services.

Local Direction—Bringing it all together

DHBs are responsible for supplying health and disability services to meet the needs of their populations; however, resources are limited. To sustainably cope with the increasing demand for services, we must design pathways that influence the flow of people—shifting care to the most appropriate setting and reducing demand by supporting people to stay well and maximise their independence.

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

In line with the functions and responsibilities of a DHB, we will deliver on the priorities and expectations of Government. In achieving the local missions, DHBs will also deliver the Government's vision: "*All New Zealanders lead longer, healthier and more independent lives*".

At a regional level, the South Island DHBs are working collectively to deliver "*A clinically and fiscally sustainable South Island health system*". The regional focus on "*providing equitable and timely access to safe,*

effective, high quality services" will not only contribute to ensuring health services are sustainable but by keeping people well, it will also alleviate the increasing demand for services and improve health outcomes.

This section presents an overview of how DHBs will demonstrate whether they are succeeding in improving the health and wellbeing of our population and that of the wider South Island. There is no single measure for desired outcomes or for the impact of the work we do. Rather, we use population health indicators as proxies to demonstrate the outcome or impact being sought.

The South Island DHBs have identified three outcomes and a core set of associated regional performance measures, at a population level, which will demonstrate whether we are making a positive change in the health of our collective population. These are long-term outcome measures (5 to 10 years in the life of the health system) and as such, we are aiming for a measureable change in the health status of the South Island population over time, rather than a fixed target.

Outcome 1: People are healthier and take greater responsibility for their own health.

The development of services that better protect people from harm and support people to reduce risk factors, make healthier choices and maintain their own health and wellbeing.

Outcome 2: People stay well and maintain their functional independence.

The development of primary and community-based services that provide early diagnosis and treatment, and support people to better manage enduring health conditions, reduce the complications of disease and injury and maintain functional independence in their own homes and communities.

Outcome 3: People receive timely and appropriate complex care.

The freeing-up of secondary and specialist services to provide timely, and appropriate, responses to episodic events in order to better support people's functional capacity and reduce the progression of illness.

Against each of these desired regional outcomes we have identified areas where individual DHB performance will have an impact on achievement and collectively agreed a core set of related medium-term (3 to 5 years) performance measures. Because change will be evident over a shorter period of time, these impact measures have been identified as the 'main measures', and each South Island DHB has set local targets to evaluate their performance over the next three years.

The Intervention Logic Diagram (refer Figure 7) visually demonstrates the value chain: how the services that an individual DHB chooses to fund or provide (outputs) have an impact on the health of their population and result in the achievement of desired regional outcomes, and the delivery of the expectations, and priorities of Government.

7.5 Appendix 5 – 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 5 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 Ministers.

7.6 Appendix 6 – Detailed Action Plan: Cancer Services, with a focus on faster cancer treatment

Appendix 6 -
Detailed action plan -(

7.7 Appendix 7 – Detailed Action Plan: Cardiac Services, with a focus on Acute Coronary Syndrome (ACS)

Appendix 7 - Detailed action plan -

7.8 Appendix 8 – Detailed Action Plan: Electives Services

Appendix 8 - Detailed action plan -

7.9 Appendix 9 – 2013/14 South Island Information Services Service Level Alliance Regional Service Plan – NHITB Priority Programme

Appendix 9 IS SLA RSP 2013-14.pdf

7.10 Appendix 10 – South Island Public Health Partnership Plan 2012-15

Vision

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

Background

The main providers of public health services in the South Island are the three District Health Board Public Health Units (PHUs): Public Health South (Southern DHB); Community and Public Health (Canterbury DHB, also covering West Coast and South Canterbury); and Nelson-Marlborough Public Health Service.

There is a long history of co-operation between South Island Public Health staff. In 2010 the three PHUs developed the South Island Public Health Project, which became a work stream under the South Island Health Services Planning process with four work streams:

- Knowledge Management
- Workforce Development
- Whānau Ora
- Issues-Specific workgroups (e.g. Communicable Disease Protocols, Alcohol)

In spite of the disruption caused by the Canterbury earthquakes, work continued through 2011, with considerable progress towards shared planning, improved communication and sharing of resources, and enhanced collaboration. At the same time, the national Public Health Clinical Network was developing its 2011 *Core Public Health Functions for New Zealand* report, describing the principles and core functions underlying public health service delivery. The report has provided a framework for thinking more broadly about the role of the South Island Public Health Project. It includes a number of examples of public health services better delivered regionally:

- Advanced surveillance and analysis, including GIS.
- Public health policy analysis.
- Programme design and evaluation.
- Environmental health technical expertise.
- Support for outbreak investigation and control, including surge capacity support.
- Health impact assessment.
- Development of consistent operational protocols to suit local needs.
- Public health workforce training.

As a result, the three PHUs agreed in 2012 to continue with a South Island Public Health Partnership under the South Island Alliance Programme, and to broaden the Partnership's focus from alignment of current PHU work to a more outcomes-focused and DHBand community-focused programme, with a major emphasis on a Health in All Policies (Social Determinants of Health) approach.
The Partnership's vision is consistent with the South Island Regional Health Service Plan's vision of
a clinically and fiscally 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.
The Partnership's Goals, Work streams and Tasks will be derived from the Core Public Health Functions (see below). The focus of the Partnership will be on supporting population health approaches and planning and coordinating public health services for one million people across the South Island.

Scope

- Effective and efficient regional and local delivery of Ministry-funded Public Health Unit (PHU) services.

- Improving the interface and support between PHUs and other parts of the health system.

Principles

The key public health principles outlined in the Public Health Clinical Network's Core Functions Report are:

a. focusing on the health of communities rather than individuals
b. influencing health determinants
c. prioritising improvements in Māori health
d. reducing health disparities
e. basing practice on the best available evidence
f. building effective partnerships across the health sector and other sectors
g. remaining responsive to new and emerging health threats.

Goals and key tasks for South Island Public Health Partnership

Goal	Key regional tasks
1. Improved information across the South Island on health status, health determinants and effective population health interventions	• supporting regional and local reporting on health status and health determinants (including communicable disease surveillance) • supporting development of population health indicators ("quality accounts" for population health) • developing evidence papers for population health interventions
2. Improved capacity across the health sector and other sectors in the South Island to address population health issues.	• workforce development • HiAP and Whānau ora training • knowledge management • supporting health impact assessment and public health policy analysis • developing DHB position statements on key health determinants • supporting partnerships and advocacy between the SI health system and other sectors which influence health in the community.
3. Co-ordinated and efficient regional and local delivery of health promotion, health protection and preventive care services	• developing shared protocols • sharing specialised expertise • strengthening staff connexions • supporting primary care (e.g. immunisation co-ordination and support).

Implementation and reporting

Implementation

The South Island Public Health Partnership will operate as a series of work groups reflecting Partnership goals:

1. Population health information (including knowledge management, DHB support, and support for other organisations including PHOs and local authorities)

2. Population health capacity-building (including workforce development, Whānau Ora, Health in All Policies)
3. Issues-specific work groups, focused on aligning and streamlining promotion, protection and preventive care services
4. SIPHP Management Group: planning, oversight, evaluation, communications

Annual Plans and Reports

Annual plans and reports will be brief and outcomes-focused.

Each PHU will develop an annual plan and report in conjunction with its own District Health Board(s), to accompany or form part of the DHB District Annual Plan and Report, based on a South Island template incorporating the core public health functions.

The South Island Public Health Partnership Management Group will develop a SIPHP annual plan and report reflecting regional work on the Partnership work streams and including ongoing evaluation of the Partnership.

Strategic Plan administration

This Strategic Plan will be reviewed annually by the SIPHP.

This plan was approved by the South Island Leadership Team on 27 August 2012.

Core Functions Report table and diagram

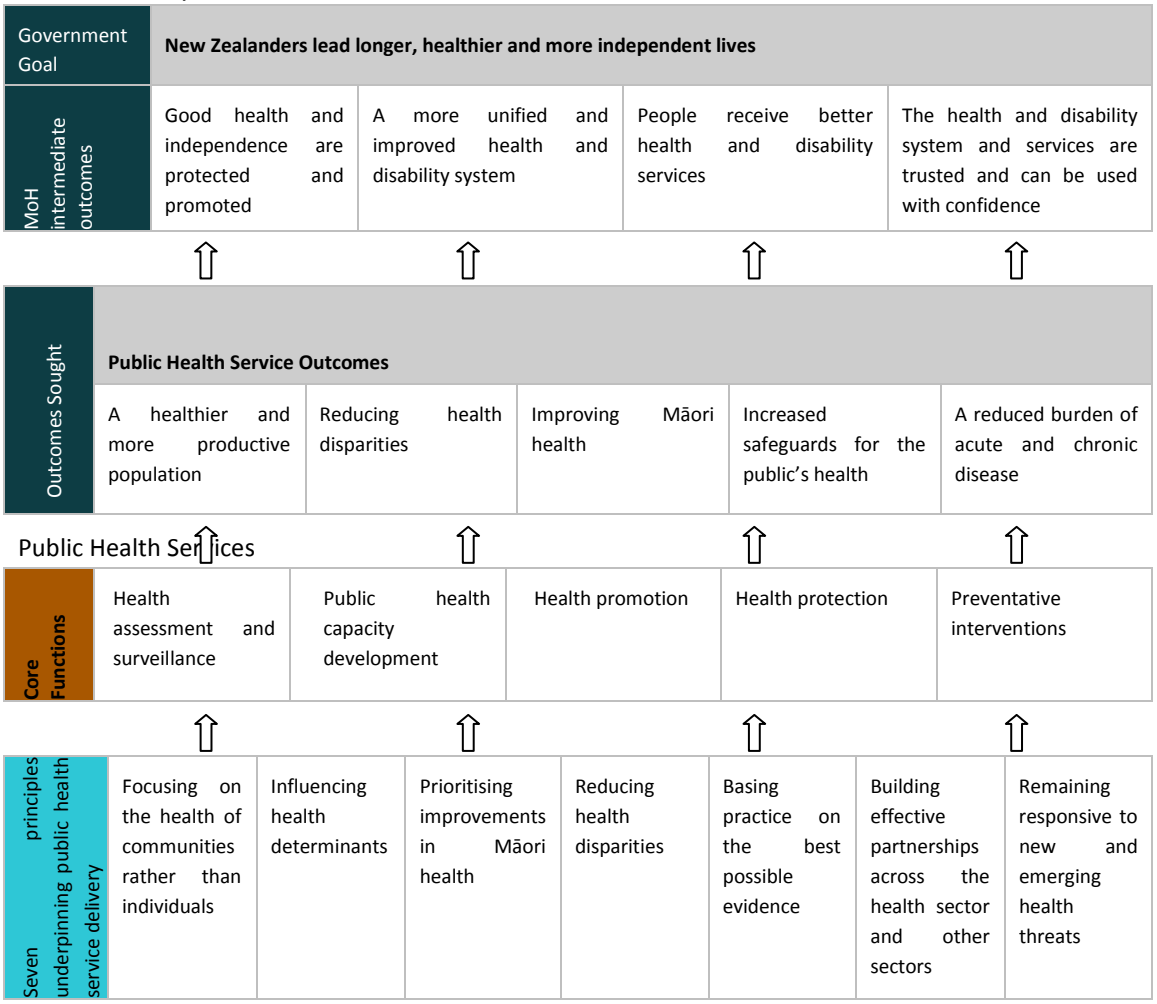
Core functions, descriptions and strategies

Core function	Strategies
1. Health assessment and surveillance: understanding health status, health determinants and disease distribution	• **Monitoring,** analysing **and reporting** on population health status, health determinants, disease distribution, and threats to health, with a particular focus on health disparities and the health of Māori. • Detecting and investigating **disease clusters and outbreaks** (both communicable and non-communicable).
2. Public health capacity development: ensuring services are effective and efficient	• Developing and maintaining public health **information systems**. • Developing **partnerships** with iwi, hapü, whānau and Māori to improve Māori health. • Developing partnerships with Pacific leaders and communities to improve Pacific health • Developing **human resources** to ensure public health staff with the necessary competencies are available to carry out core public health functions. • Conducting **research, evaluation and economic analysis** to support public health innovation and to evaluate the effectiveness of public health policies and programmes. • **Planning, managing, and providing expert advice** on public health programmes across the full range of providers, including PHOs, Planning and Funding, Councils and NGOs. • **Quality management** for public health, including monitoring and performance assessment.
3. Health promotion: enabling people to increase control over and improve their health	• Developing public and private sector **policies** beyond the health sector that will improve health improve Māori health and reduce disparities. • Creating physical, social and cultural **environments** supportive of health. • Strengthening **communities' capacities** to address health issues of

Core function	Strategies
	importance to them, and to mutually support their members in improving their health. • Supporting **people to develop skills** that enable them to make healthy life choices and manage minor and chronic conditions for themselves and their families. • Working in **partnership with other parts of the health sector** to support health promotion, prevention of disease, disability, injury, and rational use of health resources.
4. Health protection: protecting communities against public health hazards	• Developing and reviewing **public health laws and regulations**[32]. • Supporting, monitoring and enforcing **compliance** with legislation. • Identifying, assessing, and reducing **communicable disease risks**, including management of people with communicable diseases and their contacts. • Identifying, assessing and reducing **environmental health risks**, including biosecurity, air, food and water quality, sewage and waste disposal, and hazardous substances. • Preparing for and responding to **public health emergencies**, including natural disasters, hazardous substances emergencies, bioterrorism, disease outbreaks and pandemics.
5. Preventive interventions: population programmes delivered to individuals	• Developing, implementing and managing **primary prevention programmes** (targeting whole populations or groups of well people at risk of disease: e.g. immunisation programmes). • Developing, implementing and managing population-based **secondary prevention programmes** (screening and early detection of disease: e.g. cancer screening).

[32] Public health legislation covers a wide variety of issues, including communicable disease control, border health protection, food quality and safety, occupational health, air and drinking water quality, sewerage, drainage, waste disposal, hazardous substances control, control of alcohol, tobacco and other drugs, injury prevention, health information, screening programmes, and control of medicines, vaccines and health practitioners.

Core Functions, Services and Outcomes



7.11 Appendix 11 – Membership

7.11.1 Service Level Alliances and Workstreams

SLA	Name	Title	DHB
Cancer Services	Dr Steve Gibbons (Steering Group Chair)	Haematologist, Clinical Services	CDHB
	Dr Shaun Costello	Clinical Director, Southern Cancer Network/Radiation Oncologist	SDHB
	Dr Dean Millar-Coote	GP	SDHB
	Glenis McAlpine	Clinical Nurse Manager	Marlborough PHO
	Theona Ireton	Kaitiaki	CDHB
	Marj Allan	Consumer	
	Sue Teague	Service Manager, Secondary Services	CDHB
	Danielle Smith	Cancer Support Coordinator	West Coast PHO
	Dr Frances Beswick	Anaesthetist, Clinical Secondary Services	SCDHB
	Konrad Richter	Surgical Services	SDHB
	Trish Clark	Oncology Nurse Manager	SDHB
	Dr Rob Corbett	Paediatric Oncologist	CDHB
	Christine Nolan	GM Secondary Services	SCDHB
	Catherine Dwan,	Community Liaison North Canterbury, Cancer Society	North Canterbury
	Ginny Green	CE Hospice Otago	Otago
	Annie Bermingham	Southern Cancer Network Manager	SCN
Child Health Services	Dr Nick Baker (Chair)	Community Paediatrician	NMDHB
	Jane Kinsey	PHO Manager, Community Physiotherapist	Nelson PHO
	Dr Nicola Austin	Neonatal Paediatrician	CDHB
	Dr Clare Doocey	Paediatrician	CDHB
	Anne Morgan	Service Manager	CDHB
	Donna McCann	Service Manager	SCDHB
	Dr Mick Goodwin	Paediatrician	SCDHB
	Michele Coghlan	Service Manager	WCDHB
	Dr David Barker	Clinical Director, Women & Children's Health	SDHB
	Prof Barry Taylor	Professor of Paediatrics	U of Otago
	Dr Ian Shaw	Paediatrician	SDHB
	Jane Wilson	Nursing Director	SDHB
	Dr Viv Patton	GP Paediatric Liaison	CDHB
	Wayne Turp	Project Specialist, Planning and Funding	CDHB
	Rose Laloli	Facilitator and Project Manager	SIAPO
Health of Older People Services	Dr Jenny Keightley (Chair)	General Practitioner	CDHB
	Michael Parker	CEO, Presbyterian Support Service South Canterbury	SCDHB
	Carole Kerr	Walking in Another's Shoes Dementia Educator	NMDHB
	Margaret Hill	General Manager, Strategy, Planning and Accountability	SCDHB

SLA	Name	Title	DHB
	Jane Collins	Nursing Director, Older Persons' Health, Clinical Support and Community Directorate	SDHB
	Ruby Aberhart	Older Person's Advocate	NMDHB
	Professor John Campbell	Geriatrician	SDHB
	Dr Jeff Kirwan	Chief of Service, Older Person's Health and Rehabilitation	CDHB
	Dr Jackie Broadbent	Geriatrician	CDHB
	Amber Salanoa Haar	Allied Health Advisor/Occupational Therapist	WCDHB
	Andrew Metcalfe	Allied Health Director, Older People, Clinical Support, Community Directorate	SDHB
	Karen Kennedy	Community Pharmacist, Primary and Community Services	SCDHB
	Caroline Teichert	Older Person's Advocate (alternative)	WCDHB
	Gillian Pearce	Facilitator and Project Manager	SIAPO
	Dr David Bathgate (Acting Chair)	Consultant Psychiatrist	SDHB
	Dr Alfred Dell'Ario	Consultant Psychiatrist	CDHB
	Heather Casey	Director of Nursing	SDHB
	Rose Henderson	Allied Health	CDHB
	Sal Faid	Consumer	
	Key Frost	Pacifica	Pacific Island Advisory & Cultural Trust
	Paul Wynands	Primary Care	Rural Canterbury PHO
	Glenn Dodson	NGO	Stepping Stone
	Robyn Byers	Service Director	NMDHB
	Bryan Jamieson	Commuications	WCDHB
	Dianne Gooch	Family Advisor, Supporting Families	CDHB
	Karaitiana Tickell	Māori Advisor, Purapura Whetu Trust	CDHB
	Martin Kane	Facilitator and Project Manager	SIAPO
Support Services	Jock Muir (Chair)	Director, Strategic Projects	CDHB
	Dr Peter Bramley	Service Director, Medical Surgical Services	WCDHB
	George Downward	Medical Director, Patient Safety	CDHB
	Nick Lanigan	GM, Corporate Services	NMDHB
	Sharon Jones	Director of Nursing	SDHB
	Karalyn van Deursen	Manager, Strategic Communications	CDHB
	Nigel Wilkinson	CEO	HBL
	Elaine Chisnall	General Manager, Women's, Children's, Public Health and Support Services	SDHB
	Alan Lloyd	Facilitator and Project Manager	SIAPO
Information Services	Dr Andrew Bowers (Chair)	Medical Director, Information Technology and Physician	SDHB
	Carol Heatly	CEO Sponsor	SDHB
	Chris Dever	CIO	CDHB
	John Beveridge	Nurse Consultant	CDHB

SLA	Name	Title	DHB
	Lexie O'Shea	Executive Director of Patient Services	SDHB
	Nigel Millar	Chief Medical Officer	CDHB
	Russell Rarity	Clinical Director, Anaesthetics	SCDHB
	Stella Ward	Executive Director, Allied Health	CDHB
	Nick Langian	GM Corporate Services	NMDHB
	Carolyn Gullery	GM, Planning and Funding	CDHB
	Peter Gent	GP Rep	CDHB
	Paul Goddard	Programme Director, Information Services	SIAPO
	Beth Dillon	Facilitator and Project Manager	SIAPO
Quality and Safety	Mary Gordon (Chair)	Executive Director of Nursing	CDHB
	Dr Richard Johnson	Chief Medical Officer	SDHB
	Ken Stewart	Community Physiotherapist, CDHB Falls Clinical Lead, HQSC expert panel	Selwyn Village Physiotherapy
	Lexie O'Shea	Executive Director of Patient Services	SDHB
	Denise Hutchins	GM 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
	Lynley Cook	Population Health Specialist	Pegasus
	Robyn Moore	Consumer Representative	WCDHB
	SIAPO representative to be confirmed	Facilitator and Project Manager	SIAPO
Cardiac Services	Dr Michael Williams (Chair)	Cardiologist & Clinical Leader, Cardiology, Dunedin Hospital	SDHB
	Dr David Smyth	Cardiologist & Clinical Director of Cardiology	CDHB
	Dr Andrew Hamer	Consultant Cardiologist and National Cardiac Network Representative	NMDHB
	Lisa Smith	Cardiac Clinical Nurse Specialist	WCDHB
	Gary Barbara	Service Manager	CDHB
	Dr Bernard Kuepper	Consultant Cardiologist and Head of Department of Medicine	SCDHB
	Dr Rachael Byars	Physican	
	Kara Ogilvy	Associate Nurse Manager for the Medical Ward, Southland Hospital	SDHB
	Dr Gary Nixon	Medical Officer	Dunstan Hospital
	Carol Horgan	Team Leader Primary and Secondary Care Planning and Funding	CDHB
	Daniel Ohs	Clinical Planning Manager St John	Independent
	Alan Lloyd	Facilitator and Project Manager	SIAPO
Elective Services	Dr Pim Allen	Independent Chair	Independent
	Diana Gunn	Director of Nursing Older Persons Health; Rehabilitation and Orthopaedics	CDHB
	Suzanne Baker	SMO & HoD Urology	NMDHB
	Greg Robertson	Chief of Surgery	CDHB

SLA	Name	Title	DHB
	Murray Fosbender	Medical Director, Surgical Director	SDHB
	David Hunt	Anaesthetist	SDHB
	Graham McGeoch	Primary Health Clinician	CDHB
	Carole Stuart	Service Manager - Anaesthetics	CDHB
	Maree Jackson	Elective Services Manager	SDHB
	Margaret Hill	General Manager Planning and Funding	SCDHB
	Ralph La Salle	Electives Manager, Portfolio Lead	CDHB & WCDHB
	Christine Nolan	General Manager Secondary Services	SCDHB
	Pauline Clark	General Manager, Medical and Surgical Division and Women's and Child Health Division Christchurch Hospital	CDHB
	Margaret Bunker	Programme Coordinator	SIAPO
Stroke Services	Dr Wendy Busby (Chair)	Consultant Physician & Geriatrician	SDHB
	Clare Jamison	Occupational Therapist	CDHB
	Simone Newsham	Community Speech & Language Therapist, Nelson Bays PHO	NMDHB
	Julian Waller	Stroke Clinical Nurse Specialist	SCDHB
	Dr John Fink	Clinical Director, Neurology	CDHB
	Jane Large	Portfolio Manager, Planning and Funding	NMDHB
	Dr Suzanne Busch	Geriatrician, General Physician	NMDHB
	Dr Carl Hanger	Stroke Rehabilitation Consultant & Geriatrician	CDHB
	Diane Brockbank	Clinical Nurse Manager	WCDHB
	Dr Barbara Weckler	General Physician	WCDHB
	Peter Bramley	Service Director	NMDHB
	Rose Laloli	Facilitator and Project Manager	SIAPO
South Island Public Health Partnership management group	Marion Poore (Chair)	Medical Director & Medical Officer of Health	SDHB
	Fiona Pimm (Project Sponsor)	General Manager Primary and Community, General Manager Maori Health	SCDHB
	Stephanie Read	Public Health Service Manager	NMDHB
	Ed Kiddle	Medical Officer of Health NMDHB	NMDHB
	Evon Currie	General Manager, Community & Public Health	CDHB, WCDHB, SCDHB
	Daniel Williams	Clinical Director, Community & Public Health, Medical Officer of Health SCDHB	CDHB, WCDHB, SCDHB
	Stephen Jenkins	Service Manager, Public Health Services	SDHB
	Kathrine Clark	Senior Portfolio Manager, Public Health	National Health Board
	Darren Hunt	Deputy Director of Public Health	Ministry of Health
	Margaret Bunker	South Island Alliance Programme Co-ordinator	SIAPO
	Rachel Eyre	Facilitator	SIAPO

7.11.2 Regional Training Hub

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

7.11.3 Strategic Planning and Integration Team

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

7.12 Appendix 12 - Glossary of terms

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

Term		Definition
ACC	Accident Compensation Corporation	Crown Entity set up to provide comprehensive, 24hour, no-fault personal accident cover for all New Zealanders.
	Acute Care	The provision of appropriate, timely, acceptable and effective management of conditions with sudden onset and rapid progression that require attention.
ACP	Advanced Care Planning	ACP is focused on the end-of-life care for an individual and involves both the person and the health care professionals responsible for their care. It may also involve the person's family/whānau and/or carers. The planning process assists the individual to identify their personal beliefs and values and incorporate them into plans for their future health care.
ANZAC Q1		One of the national Registers for Cardiac that is to be implemented. Covers acute coronary syndrome, elective and acute percutaneous coronary interventions.
CAPEX	Capital Expenditure	Spending on land, buildings and larger items of equipment.
CEO	Chief Executive Officer	A CEO is the highest-ranking corporate officer/executive in charge of total management of an organization.
CREST	Community Rehabilitation Enablement and Support Team	CREST is a service for people over 65 years of age that would benefit from a short period of rehabilitation in their own home, up to 6 weeks.
	Continuum of Care	Exists when a person can access responsive services matched to their level of need at any time throughout their illness or recovery.
CWS	Clinical Workstation	The CWS is a web based portal which draws information from multiple sources and presents it in the context of the patient's record. All regions have agreed to implement Concerto as their clinical workstation, and this will be further standardised nationally by configuring a common patient banner, and document display categories. For the South Island DHBs this is known as Health Connect South
Daptiv		Project and Portfolio Management Software.
	Determinants of Health	The range of personal, social, economic and environmental factors that determine the health status of individuals or populations.
DHB	District Health Board	District Health Boards are responsible for providing or funding the provision of health services in their district.
ECG	Electrocardiography	An ECG is used to measure the rate and regularity of heartbeats, as well as the size and position of the chambers, the presence of any damage to the heart, and the effects of drugs or devices used to regulate the heart, such as a pacemaker.
eCDR	Electronic Clinical Data Repository	The CDR will contain a nationally agreed core set of clinical information, and additional clinical data to be determined by each region.
eMeds	Electronic medicines programme	A range of electronic programmes around medication including ePrescribing (ePA), eMedicine Reconciliation (eMR) and e-Pharmacy Management (ePM).
eReferral	Electronic referral	IT solution for making and receiving electronic referrals.
eSCRV	Electronic Shared Care Record View	eSCRV will make information available to the key providers of an individual's healthcare. The information includes: a summary of medical conditions and date of last GP visit; medical diagnoses; details of medications recently dispensed at a community pharmacy and information about home care visits including care coordination information, who the provider is and the allocation of care.
HBL	Health Benefits Limited	HBL facilitates and leads initiatives that result in savings and efficiencies for District Health Boards on non-clinical initiatives.

Term		Definition
HBSS	Home Based Support Services	HBSS support services are funded by DHBs for older people who require support services to enable them to continue to live in the community and in their own environment.
HCS	Health Connect South	HCS is the SI CWS and provides one place to view clinical information about the SI patients. It will present information that is currently stored in many different systems and aggregate the information in a patient centric view. That means that clinical staff can access information from any of the underlying systems that are tied to the Clinical Information System. It also has the ability to capture patient related documentation and store it in a patient centric way (see Clinical Workstation).
	Health Pathways	Health Pathways provides a range of information for health professionals responsible for referring to specialty services.
	Health Outcomes	A change in the health status of an individual, group or population which is attributable to a planned programme or series of programmes, regardless of whether such a programme was intended to change health status.
HISO	Health Information Standards Organisation	HISO is an advisory group to the National Health IT Board, which sits under the National Health Board (NHB). The HISO committee is supported by an office located within the Ministry of Health's National Health Board Business Unit.
HQSC	Health Quality and Safety Commission	The Health Quality & Safety Commission was established under the New Zealand Public Health & Disability Amendment Act 2010 to ensure all New Zealanders receive the best health and disability care within our available resources. The Commission is also working towards the New Zealand Triple Aim for quality and safety outcomes.
HWNZ	Health Workforce New Zealand	HWNZ was formed to lead and co-ordinate the planning and development of the health and disability workforce. It ensures that we have a high quality, fit-for-purpose workforce and that workforce issues are aligned with planning of services.
	Integration	Combine into a whole or complete by addition of parts.
InterRAI	International Resident Assessment Instrument	Comprehensive assessment tool.
MedChart		Software used for medication reconciliation.
MFBT	Maudsley Family Based Therapy	MFBT is a family therapy for the treatment of anorexia nervosa devised by Christopher Dare and colleagues at the Maudsley Hospital in London in 1985.
MoH	Ministry of Health	The Ministry of Health aims to ensure that the health and disability support system works for all New Zealanders. The Minister of Health has overall responsibility for the health and disability system.
	Morbidity	Illness, sickness.
	Mortality	Death.
	National Health Board	The NHB was established in November 2009 and is made up of a Ministerial appointed Board and a branded business unit within the Ministry of Health.
MOSAIQ		MOSAIQ is a complete patient information management system that centralizes radiation oncology, particle therapy and medical oncology patient data into a single user interface, accessible by multi-disciplinary teams across multiple locations.
MDMs	Multidisciplinary meetings	MDMs are regular meetings at which health professionals from a range of different specialities consider relevant treatment options and together develop a recommended individual treatment plan for each patient.
	New Zealand Health Strategy	The New Zealand Health Strategy sets the platform for the Government's action on health. It identifies the Government's priority areas and aims to ensure that health services are directed at those areas that will ensure the highest benefits for our

Term		Definition
		population, focusing in particular on tackling inequalities in health.
	New Zealand Public Health and Disability Act	The New Zealand Public Health and Disability Act 2000 introduced a major change to the public funding and provision of personal health services, public health services, and disability support services. It also established new publicly owned health and disability organisations, such as District Health Boards and the Pharmaceutical Management Agency (Pharmac).
NGO	Non-Government Organisations	There are many ways of defining NGOs. In the context of the relationship between the Health and Disability NGOs and the DHBs, NGOs include independent community and iwi/Māori organisations operating on a not-for-profit basis, which bring a value to society that is distinct from both Government and the market. In reality this will mean that any profits are put back into the organisation, rather than distributed to shareholders.
NZULM	NZ Universal List of Medicines	NZULM is New Zealand's national dictionary of medicines list for universal use across the sector. It is updated regularly, and is readily accessible via a website and participating prescribing and dispensing software systems and medicines information sources (including the NZ Medicines Formulary).
OPF	Operational Performance Framework	The OPF is one of a set of documents known as the Policy Component of the DHB Planning Package which sets out the accountabilities of DHBs. The OPF is endorsed by the Minister of Health and comprises the operational level accountabilities that all DHBs must comply with, given effect through the Crown Funding Agreements between the Minister and the DHB.
PACS	Picture Archiving Communication Systems	PACS is part of a common systems platform for each of the four DHB regions which will deliver on Phase 1 of the National Health IT Plan.
PMS	Patient Management System	PMS (secondary-care), or Practice Management System (primary-care) used to keep track of patients. In secondary care the focus is usually on tracking the admissions, discharges or transfers of patients, in primary care, the focus is on maintenance of the register.
PHARMAC	Pharmaceutical Management Agency	Government Agency which secures the best health outcomes that are reasonably achievable from pharmaceutical treatment and from within the amount of funding provided.
	Primary Care	Primary Care means essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods. It is universally accessible to people in their communities, involves community participation, is integral to, and a central function of, the country's health system, and is the first level of contact with the health system.
PHO	Primary Health Organisation	A new development in service delivery PHOs encompass the range of primary care and practitioners and are funded by DHBs to provide of a set of essential primary health care services to those people who are enrolled in that PHO.
	Population Heath	Population health refers to the health outcomes of a group of individuals, including the distribution of such outcomes within the group. It is an approach to health that aims to improve the health of an entire population. One major step in achieving this aim is to reduce health inequities among population groups. An important theme in population health is importance of social determinants of health and the relatively minor impact that medicine and healthcare have on improving health overall.
	Public Health	The science and art of preventing disease, prolonging life and promoting health and efficiency through organised community effort. A collective effort to identify and address the unacceptable realities that result in preventable and avoidable health outcomes and it is the composite of efforts and activities that are carried out by people committed to these ends.
	Red Zone	The area of Christchurch City centre inaccessible to the public.

Term		Definition
	Residential Red Zone	The residential red zone is areas in Christchurch where there is significant and extensive area wide land damage; most buildings are uneconomic to repair; there is a high risk of further damage to land and buildings from low levels of shaking; and the success of engineering solutions would be uncertain and uneconomic; and any repair would be disruptive and take a considerable period of time.
RL6		Incident Management software solution.
RIS	Radiology Information Systems	RIS is part of a common information systems platform for each of the four DHB regions.
	Secondary Care	Specialist care that is typically provided in a hospital setting.
SLA	Service Level Alliance	Agreed priority area for the South Island Alliance.
SIRTH	South Island Regional Training Hub	SIRTH is designed to support more effective and integrated health professional training, covering a population of approximately one million people. SIRTH works collaboratively across each region to oversee the planning and delivery of clinical training, ensuring it meets the needs of trainees and local communities and is aligned with regional service planning.
	South Island Alliance	The South Island Health Alliance, a partnership between the five South Island District Health Boards, is working to support a clinically and financially sustainable South Island health system where services are as close to peoples homes as possible.
	South Island Alliance Programme Office	The South Island Alliance Programme Office supports the regional activities of the South Island Alliance.
	South Island Neurosurgery Governance Board	The South Island Neurosurgery Governance Board is an independent group that has been responsible for establishing one South Island neurosurgery service.
SMT	Soprano Medical Template	SMT is a discharge template within Health Connect South.
	Tertiary Care	Very specialised care often only provided in a smaller number of locations.
	Triple Aim	The Health Quality & Safety Commission works towards the New Zealand Triple Aim for quality improvement: Improved quality, safety and experience of care; improved health and equity for all populations; best value for public health system resources.
YTD	Year to Date	The period up to a given date within a defined 12 month period.
WIAS	Walking in Another's Shoe	WIAS is a dementia workforce education programme being rolled out around the South Island.
	Workstream	Other areas of regional activity of the South Island Alliance.