Te Wai Pounamu South Island Health Service Plan

2015-2018

South Island Health Services Plan

Produced in 2015

By the South Island Alliance Programme Office

On behalf of the five South Island District Health Boards

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FOREWORD

The South Island Alliance Board and Alliance Leadership Team continue to support and recognise the efforts of the South Island Alliance teams and District Health Boards (DHBs) in addressing the challenges we face within the region. We continue to make significant progress in developing relationships and aligning systems and processes across the region leading to a better experience of care and outcomes for our people. Examples of these include:

- consistent models of care for stroke, acute coronary syndrome and a dementia framework,
- HealthPathways (primary to secondary and secondary to tertiary)
- aligning of information systems
- single service – multiple sites e.g. bariatric surgery, fertility services
- meeting of health targets including wait times and faster cancer treatment
- working to align radiotherapy fractionations to defer the need for an additional linear accelerator
- workforce training including: 'dementia support - walking in another's shoes', gerontology acceleration programme, advance care planning, allied health assistant.

The approaches are designed to support the DHBs to manage within current resources and to deliver services in the community where possible. While we have not made major service changes we have aligned the way we work and have supported the care of our people in the community. This supports DHBs to manage services without the need for additional facility beds and equipment.

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

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

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

Signed by:

Chris Fleming CEO, Nelson Marlborough DHB

Jenny Black Chair, Nelson Marlborough DHB

David Meates CEO, West Coast & Canterbury DHB

Peter Ballantyne Chair, West Coast DHB

Nigel Trainor CEO, South Canterbury DHB

Murray Cleverley Chair, Canterbury & South Canterbury DHB

Carole Heatly CEO, Southern DHB

Joe Butterfield Chair, Southern DHB

MINISTER OF HEALTH LETTER OF APPROVAL

Office of Hon Dr Jonathan Coleman

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

21 AUG 2015

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

Dear Mr Fleming

South Island Region 2015/16 Regional Service Plan

This letter is to advise you I approve the 2015/16 South Island Regional Service Plan (RSP). I appreciate the significant work that is involved in preparing the RSP and thank you for your effort.

Good progress has been made with regional planning this year, particularly in relation to the alignment between the DHB Annual Plans and RSPs. However, we must continue to strengthen this alignment in the future if we are to achieve the best use of resources.

As greater integration between regional DHBs supports more effective use of clinical and financial resources, I expect DHBs to make significant progress in implementing their RSPs during 2015/16 and to continue to work together to ensure service sustainability within the Region.

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

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

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

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

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

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

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CONTENTS

1 EXECUTIVE SUMMARY

"Steering the course for a sustainable future"

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

1.1 The South Island Context

With a total South Island population of 1,004,370 people (23.7% percent of the total New Zealand population), implementing diverse, but similar, individual responses duplicates effort and investment and leads to service and access inequality. Regional collaboration is an essential part of our future direction.

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

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

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

We continue to work closely and challenge ourselves to look at and find solutions to the big issues. Our Service Level Alliances (SLA) and regional activities continue to grow and build on the work undertaken to-date to achieve the vision for South Island health services. The alliance approach means our District Health Boards (DHBs) are closely involved in all regional activity and are willing to share initiatives and support each other in managing operational challenges and developing new ways of working.

1.2 South Island Alliance Activity

The Alliance framework continues to support regional activity across a wide range of clinical and enabling services. Throughout this plan there are examples of achievements we have made and continue to make (see Gains through Regional Collaboration boxes), to improve the health, and experience of care for our population, while we consider how we ensure sustainability of our services. We recognise that the work to date is only a small start in the challenges we face to achieve our vision of "*a sustainable South Island health system focused on keeping people well and providing equitable, and timely, access to safe, effective, high-quality services as close to people's homes as possible".*

To support the 'Best for People, Best for System' strategic framework, we have developed and agreed to a set of eight high level outcomes.

- Improved environment to support health and wellbeing
- People have increased access to planned care
- People wait less
- People have prevented/delayed burden of long term conditions

- People have fewer and shorter episodes in care facilities
- No wasted resource
- People are protected from harm or needless death
- People die with dignity

These will assist us with measuring the changes we are making and identifying the activities and actions that will support us to achieve our identified strategic goals. This will support all our teams in understanding the impact that they are having or whether they need to refocus their approach.

2 INTRODUCTION

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

GAINS THROUGH REGIONAL COLLABORATION
Audio-visual / videoconference solutions to connect geographically distant clinical MDM teams have been installed in all South Island DHBs.

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

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

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

2.1 Our 2015-18 plan

This updated plan, the *South Island Health Services Plan (2015-2018),* provides a framework for future planning and outlines the regions priorities for 2015-2018. It has been developed by the five South Island District Health Boards (Nelson Marlborough, West Coast, Canterbury, South Canterbury and Southern), and the primary care and community members of the Service Level Alliances and Workstreams. The Plan builds on the achievements and progress of the last four years as it develops a longer term direction for a sustainable South Island health and disability system that is *best for people, best for system*.

The South Island District Health Boards continue to work together at a regional level to make the best use of available resources, strengthen clinical and financial sustainability and increase access to services. The plan, developed and supported by our clinical leaders, reiterates our health services planning processes and agreed framework for regional decision making. The work plans for the coming three years are based around the services we have prioritised for regional and sub-regional focus. The Service Level Alliances/Workstreams continue to focus their efforts on reducing service vulnerability and variability, costs and improving the quality of care provided to the people of the South Island. Appendix 3 outlines the work plans for each of the 2015- 18 Service Performance Priorities.

GAINS THROUGH REGIONAL COLLABORATION

Peter (a SI resident) has chronic renal failure and had a 'living will' prior to being introduced to ACP. Peter reports that with ACP he was able to go into as much detail as he liked, then talk it through with his GP to make sure that everything was OK and correctly recorded. He sees this process as much better as he does not need a legal process to make changes as he did with a 'living will'.

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

2.2 Demographics

WHAT THE 2013 CENSUS TELLS US

The census was held on the 5th of March 2013, two years after it was cancelled as a result of the 2011 Christchurch earthquake and seven years after the previous census. Results indicate how the profile of our population has changed. These changes are crucial to the planning of future health services in the South Island.

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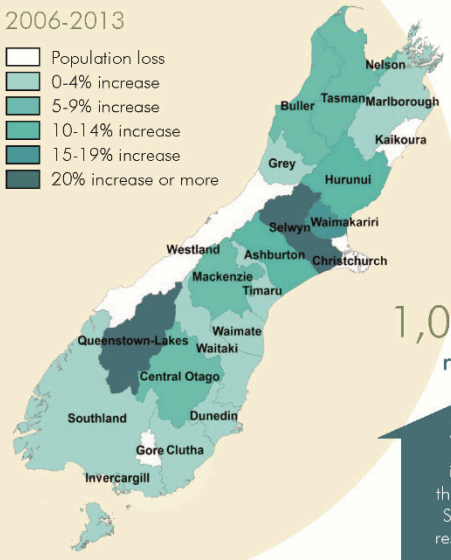
Population change 2006-2013

- Population loss
- 0-4% increase
- 5-9% increase
- 10-14% increase
- 15-19% increase
- 20% increase or more



Resident population of each South Island DHB in 2013:

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

1,004,370 residents

3.8% increase in the number of South Island residents since 2006

4 of NZ's 5 fastest growing districts

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

Fastest growing DHB

5.3% Increase in the usually resident population of the Nelson Marlborough DHB

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

Four of the five fastest growing districts in the country are in the South Island. Queenstown-Lakes, Selwyn and Waimakariri were also the three fastest growing districts last census.

There has been population loss in three rural districts: Kaikoura, Westland and Gore. These are relatively small numbers, with a decrease of less than 100 usual residents in each.

The high growth in areas such as Queenstown-Lakes and Ashburton shows there is not necessarily a population movement away from rural districts and towards the cities.

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

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

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

Canterbury DHB previously had the highest rate of growth of the South Island DHBs. This was disrupted by the earthquakes in the region. Christchurch City has seen a 2% decrease in usual residents since 2006, contributing to accelerated growth in the neighbouring districts of Selwyn and Waimakariri. Much of the growth in these districts has occurred in Christchurch's satellite towns, including Rolleston, Rangiora and Lincoln. Whilst residents may have left Christchurch City after the earthquakes, many are still living in the surrounding area.

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

What Does This Mean?

Population growth around the South Island

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

Our aging population

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

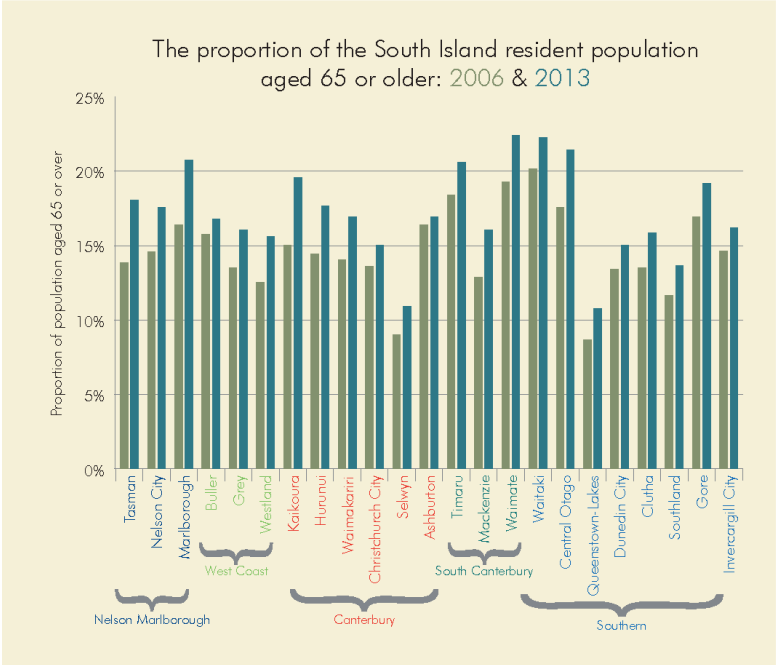
Age

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

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

The number of South Island residents in the 25-44 age group has declined since 2006. The 25-44 year age group represented 27.2% of the South Island resident population in 2006, which has decreased to 24.6% in 2013.

Canterbury DHB has the highest proportion of residents aged 25-44 years in the South Island. Because of the Canterbury DHB's relative size, this increases the South Island proportion.



Ethnicity

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

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

Families

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

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

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

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

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

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

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

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

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

15%
of South Island residents aged 15 years or older are regular smokers, down from 19.9% in 2006

Figure 1: What the 2013 Census tells us

2.2.1 The South Island Māori Population

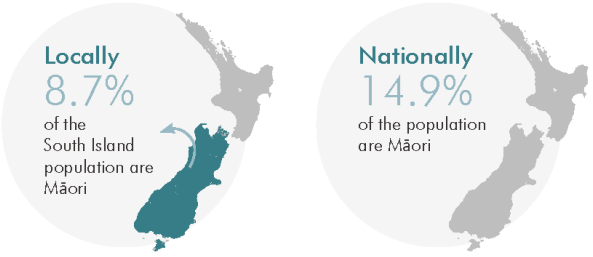
The South Island MĀORI POPULATION

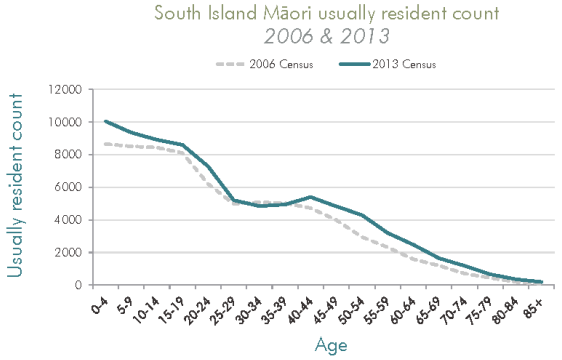
The graphs and figures on these pages present key data from the 2013 Census.

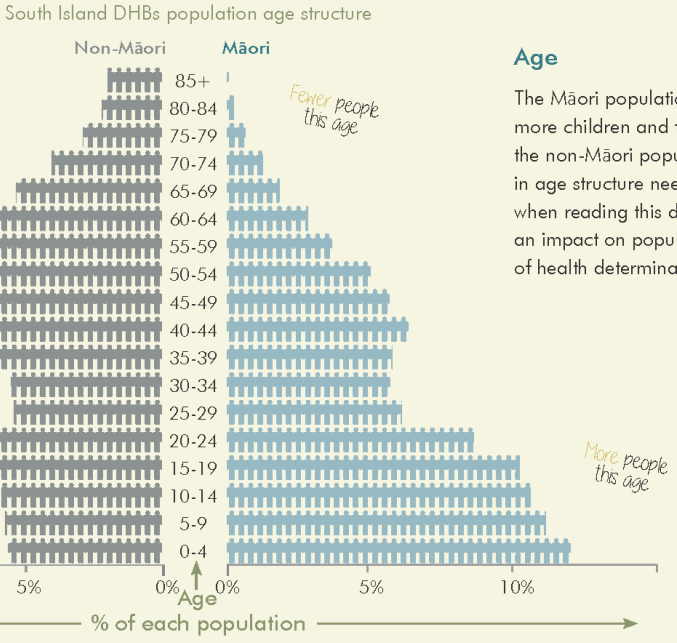
Socioeconomic deprivation, employment, income, qualifications, home ownership, household crowding, and cigarette smoking all affect people's health and are often referred to as 'broader determinants of health'. Collectively, these determinants have a greater impact on the health of a population than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

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

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







Age

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

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The South Island MĀORI POPULATION

Smoking

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

30.6% of Māori smoke regularly[1]

Māori

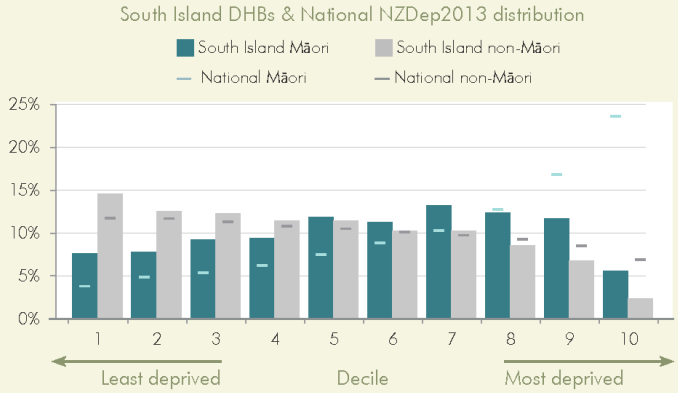
13.8% of non-Māori smoke regularly[1]

non-Māori

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

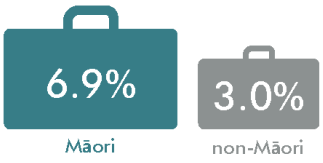
Deprivation

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



Unemployment

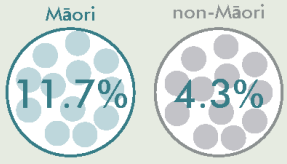
The Māori unemployment rate is more than two times that of non-Māori.[1]



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

Household crowding

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

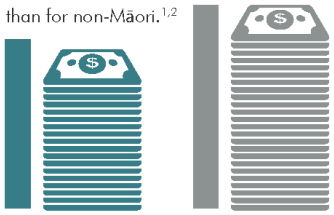


Māori are nearly three times as likely to live in crowded households.

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

Income

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



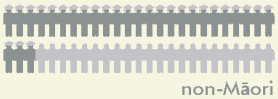
Nationally, median income for Māori is $22,500 and for non-Māori is $29,400 [1,2]

School qualifications

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

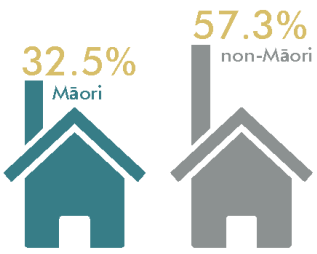
Māori

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



non-Māori

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



Home ownership

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

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

[1] *Aged 15 years and over.*

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

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

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

[5] *Aged 20 years and over.*

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

Figure 2: The South Island Māori Population

2.3 Managing our Risk

GAINS THROUGH REGIONAL COLLABORATION

A 67 year old man with a diagnosis of Alzheimer's dementia and presenting with very resistive behaviour and his loved ones becoming scared of being around him, became calmer and happier and required less medication. This change followed the training in Walking in Another's Shoes programme, and staff subsequently developing a person centred plan and utilisation of skills learned to better meet his needs.

This is now a common story across the South Island.

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

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

To support the management of our risks, we are taking a greater regional approach to address workforce issues and sharing of information. We continue to build on the alignment of support services like human resources and procurement.

2.3.1 The Christchurch Earthquakes

Like the rest of the health sector, the Canterbury DHB faces the challenges of an ageing population, increasing demand for services, rising treatment costs and workforce shortages. However, unlike health providers in other regions, Canterbury is also contending with the consequences of the Canterbury earthquakes.

While the full long-term impacts are hard to determine, international research points to ongoing impacts for portions of the population for upwards of a decade following the disaster. There have been significant increases in demand for health services in Canterbury and worrying signs in terms of the mental health and wellbeing of the Canterbury population.

The need for Canterbury to maintain current service delivery levels remains critical to the whole of the South Island. While more than 90% of Canterbury's DHB activity is for its own population, over 7,000 people from other DHBs were discharged from Canterbury hospitals in 2014 and over 11,000 people had outpatient visits. In all, Canterbury DHB provides over $100m worth of services to the populations of other DHBs, this includes delivering just over half of all surgical services provided in the South Island.

As the 'rebuild' phase gathers momentum, the Canterbury health system will continue to be significantly influenced by the following constraints:

- A sharp increase in demand for mental health services - over the last three years (to March 2015) there has been a 65% increase in rural presentations and a 69% increase in child and youth presentations to community mental health services.
- There is considerable uncertainty about the influx of rebuild workers into Christchurch. Statistics NZ projections do not fully account for this population, however spikes in demand are evident. Between 2011/12 and 2014/15 the census population aged 25-29 increased by 9% but Emergency Department presentations for this age group increased by 37%. Over the same period, there has been a 370% increase in the number of people from overseas presenting to the Christchurch Hospital Emergency Department.
- The challenge of making the best use of $384m of insurance proceeds and capital to manage $518m of earthquake damage - the DHB is engaged in a significant remediation and repair programme that will continue for over a decade.

- While the rebuild and repair is underway, capacity is substantially reduced. Staff continue to work out of wards, laboratories and clinical spaces converted from offices, temporary buildings and port-a-coms. There will be several years of major disruption as the DHB shifts and relocates wards and services to make repairs. Over 86% of the beds (and patients) in Christchurch Hospital have already been moved at least once.

As the DHB deals with these new challenges and the focus moves to the rebuild, Canterbury is conscious of ensuring that the daily delivery of service is not compromised. Completed facilities remain several years off. The Canterbury DHB will require the ongoing support of the South Island DHBs to ensure their future viability and the ongoing delivery of care, not just to their own population, but to the population of the whole of the South Island.

GAINS THROUGH REGIONAL COLLABORATION

eReferrals, which is replacing paper-based referrals, is now being used by all South Island DHBs, after Southern DHB launched stage one of the programme in almost 30 general practices across the district. This also makes the programme one of the first key South Island Alliance Information Services solutions to become fully regional.

To date more than half a million referrals in the South Island have been made using the system. eReferrals is a combination of the Electronic Request Management System (ERMS) and Orion Health's Referral Management System (RMS).

3 SETTING OUR STRATEGIC DIRECTION

3.1 Strategic context

Although DHBs may differ in size, structure and approach, they all have a common goal: to improve the health and wellbeing of their populations. Increasing demand for services, workforce shortages, rising costs and tighter financial constraints make this increasingly challenging.

International direction emphasises that a 'whole of system' approach is required to improve health outcomes and ensure the sustainability of high quality health services. This approach entails four major service shifts:

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

GAINS THROUGH REGIONAL COLLABORATION

Since she was born Isabelle has required IV antibiotic treatment. The first time she was admitted to the paediatric ward, for her parents, on top of the worry for their daughter, the admission meant juggling a family and work schedules around a daily marathon of commuting from a rural town to the city. The second time Isabelle needed IV antibiotic treatment she was discharged early and followed up by the community-based infusion service. Under specialist community nursing guidance, Isabelle's parents and grandmother were all trained to manage her infusion at home.

"They are great at the hospital, and we felt really safe and supported, but getting there every day is a nightmare. And because of the risk of infection Isabelle was pretty much confirmed to her hospital room – which for her was boring and frustrating".

"Being at home is heaps better for her. I was surprised how easy it was to learn to do. Simple and much less stress. We know that next time we could manage at home easily once the line is in, and with the community nurses back up and support if we need it" reports Zoe, Isabelle's mum.

Hospitals continue to be a key support and a setting for highly specialised care, with the importance of timely access to care being paramount. However, the increased prevalence of long-term conditions and the ageing of our population means we need to move away from the traditional health model in order to support our population to maintain good health for longer.

Rather than wait for people to become acutely unwell or require institutionalised care, the whole of the health system needs to works in partnership to deliver accessible and effective services that support people to stay well and in their own homes for as long as possible.

3.2 National direction

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

The ultimate high-level health system outcomes are that all New Zealanders lead longer, healthier and more independent lives and the health system is cost-effective and supports a productive economy.

DHBs are expected to contribute to meeting these system outcomes and the commitments of Government to provide '*better public services*' and '*better, sooner, more convenient health services*' by: increasing access to services; improving quality and patient safety; supporting the health of children; older people and those with mental illness; making the best use of information technology; and strengthening our health workforce.[1]

GAINS THROUGH REGIONAL COLLABORATION

The SI PICS programme has been endorsed by the National Health IT Board, the Health's Capital Investment Committee, and approved by Minister Ryall and Finance Minister Bill English.

Alongside these longer-term goals and commitments, the Minister of Health's annual 'Letter of Expectations' signals annual priorities for the health sector. The 2015/16 focus is on: clinical leadership; integration between primary and

[1] For further detail refer to the Ministry of Health's Statement of Intent 2014-2018 available on their website – www.health.govt.nz.

secondary care; tackling the key drivers of morbidity; delivery of national health targets; fiscal discipline and performance management.

The South Island Alliance is committed to playing its part in the delivery of longer-term health system outcomes and progress against national goals. Activity planned and prioritised in the coming year is in line with the priorities expressed by the Minister of Health.

3.3 Regional direction

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

The Nelson Marlborough, Canterbury, West Coast, South Canterbury and Southern DHBs form the South Island Alliance - together providing services for 1,004,370 people or 23.7% of the total NZ population.[2]

While each DHB is individually responsible for the provision of services to its own population, we recognise that working regionally enables us to better address our shared challenges. Together we are committed to a sustainable South Island health system focused on keeping people well and providing equitable and timely access to safe, effective, high-quality services, as close to people's homes as possible.

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

Closely aligned to the national direction, and operating under a '*Best for People, Best for System'* framework, the shared outcomes goals of the South Island Alliance are:

GAINS THROUGH REGIONAL COLLABORATION
The South Island Bariatric Surgery Service is now well underway with clinicians and patients on board with the regional service. The regional service is resulting in a fairer and more transparent process for patients as they move through their weight-loss journey.
A testament to the way weight-loss surgery can change patient's outlook on life was received recently from a patient who described how her quality of life and health had improved as she worked through the bariatric surgery pathway. The patient wished to pass on her thanks to the team involved in her care, and said she would always 'use her new stomach appropriately and gratefully' – it's great to hear about the end of result of some of our regional work.

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

A set of high level outcomes to sit alongside the 'Best for People, Best for System' framework and enable evaluation of regional activity has been agreed. These are:

- Improved environment to support health and wellbeing
- People have increased access to planned care
- People wait less
- People have delayed/avoided burden of long term conditions
- People have few and shorter episodes in care facilities
- No wasted resource
- People are protected from harm or needless death
- People die with dignity

[2] 2015/16 Population Based Funding Projection provided to the Ministry of Health by Stats NZ, based off the 2013 Census.

The framework has been undated to show the outcomes as per Figure 3.

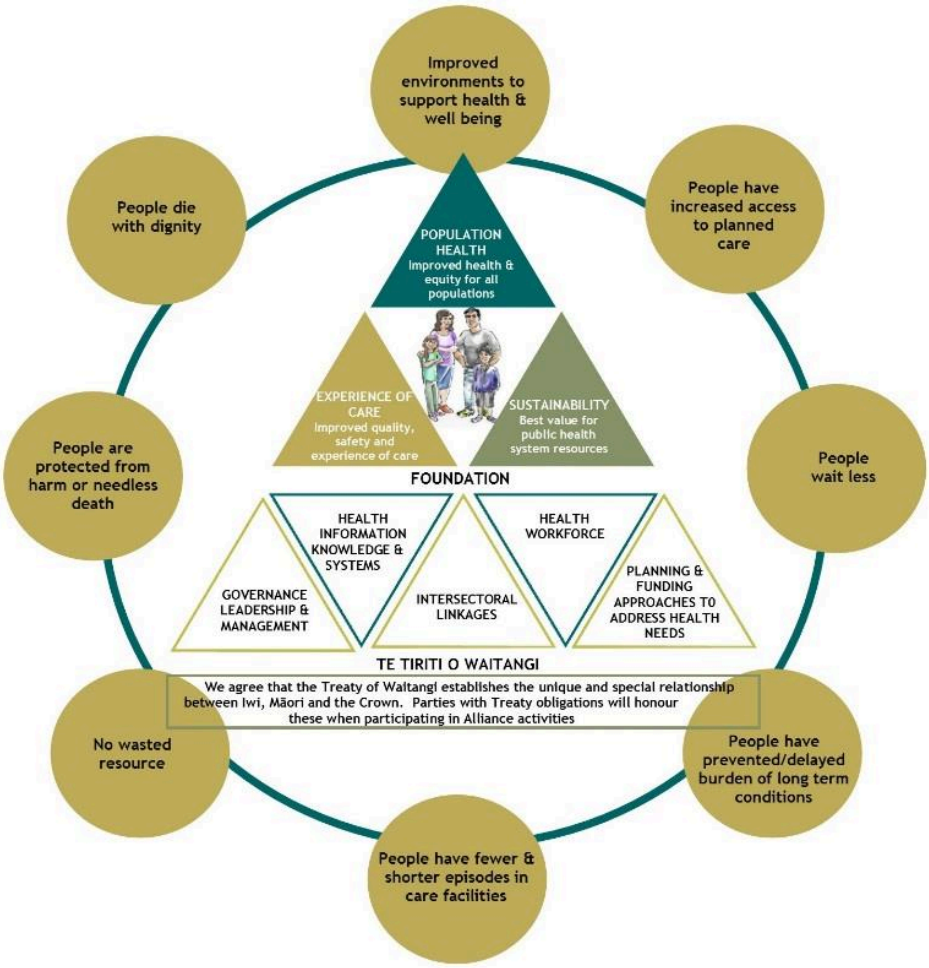


Figure 3: 'Best for People, Best for System' Outcomes Framework

The South Island Health Services Plan highlights the agreed regional activity to be implemented through our seven priority service areas: Cancer, Child Health, Health of Older People, Mental Health and Addiction, Information Services, Support Services and Quality and Safety Service Level Alliances, and our key regional activities.

Regional activity in the coming year will focus on: cardiac services, elective surgery, palliative care, public health, stroke and major trauma services. Workforce planning, through the South Island Workforce Development Hub and regional asset planning, will contribute to improved delivery in all service areas.

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

3.4 Local direction

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

DHBs will work with their stakeholders to effectively coordinate care for the population and to influence demand. Ultimately, this will assist the DHBs to

GAINS THROUGH REGIONAL COLLABORATION

"By working as an alliance we are putting our heads together, sharing our experiences, gathering insight and learning from each other's efforts in ways that can make a big difference in terms of supporting the long term goals of South Island DHBs to improve patient safety."

achieve their desired outcomes that people will receive the care and support they need, when they need it, in the most appropriate place and manner.

4 IMPROVING HEALTH OUTCOMES FOR OUR POPULATION

4.1 What are we trying to achieve?

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

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

In developing its regional strategic framework, the South Island Alliance has identified three strategic goals and eight collective outcomes and an associated set of indicators by which individual DHB performance will contribute to regional success and demonstrate whether they are making a positive change in the health of their populations. As these are long-term outcome indicators (5-10 years in the life of the health system) the aim is for a measurable change in health status over time, rather than a fixed target. An associated set of medium-term (3-5 years) indicators of performance has also been identified. Because change will be evident over a shorter period of time, these impact measures have been identified as the 'headline' or 'main' measures of performance over the next 3–5 years. These medium term impact measures are a collection of regional measures and locally set targets. The locally set targets are outlined in the each DHB Annual Plan.

GAINS THROUGH REGIONAL COLLABORATION

eReferrals continues to receive positive feedback, especially with respect to the noticeable reduction in administration time once practices start using ERMS as illustrated by the feedback received below: "Traditionally at least six of our twelve GP's have dictated letters and had our administrator type them. Since moving to ERMS, a large percentage of this work is now being done by the GP's themselves. Even though we had templates set up for letters before, there is a real shift to using ERMS and doing their own typing. I believe that they can see the benefit of seeing the referral submitted and having an acknowledgement of receipt straight away. This is the case for even our most technophobe doctors!!! So all in all we are very happy with ERMS as it has cut down on a lot of duplication of work with the GP's often cutting and pasting directly from their consult notes instead of dictating."

Judy Gilmour, Practice Manager, Stoke Medical Centre

4.2 South Island Intervention Logic Diagram

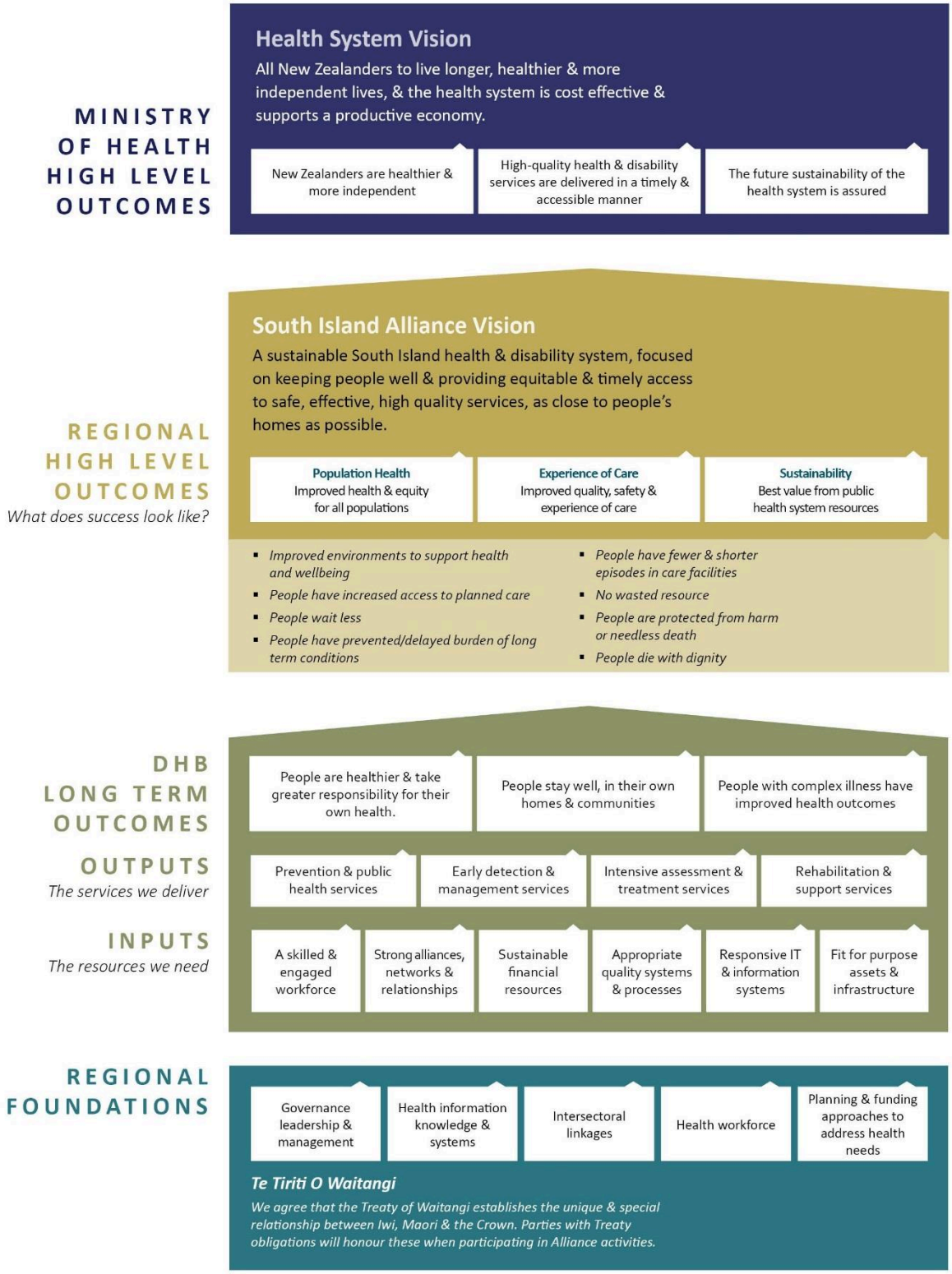


Figure 4: South Island Intervention Logic Diagram

4.3 Outcome 1: Improved environments to support health & well being

Why is this outcome a priority?

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

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

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

GAINS THROUGH REGIONAL COLLABORATION

A community based infusion service has meant that unwell children requiring intravenous medications are able to be managed in their home or at a community based clinic, thereby, avoiding an admission to the paediatric service.

This example of delivery an infusion services in the child's home or as close to the child's home as possible has resulted in a decrease in unavoidable hospital admissions and most importantly greatly improved patient and family satisfaction and engagement in ongoing treatment and care. The model is being explored across SI DHBs for the management of particular chronic conditions such as cystic fibrosis and bronchiectasis.

4.4 Outcome 2: People have increased access to planned care

Why is this outcome a priority?

GAINS THROUGH REGIONAL COLLABORATION

Supported by the Information Services, Service Level Alliance e-Prosafe has now been rolled out in four of the five DHBs in South Island. The database supports improved protection for the children of the South Island by providing risk assessments and interventions to prevent child abuse and family violence cases. It also allows for the sharing of relevant clinical information across the South Island DHBs in a timely and safe manner.

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

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

4.5 Outcome 3: People wait less

Why is this outcome a priority?

We have a commitment to ensure that patients receive timely access to the most appropriate care in the most appropriate place. It's about getting the greatest value for our people from the system, allowing evidence to inform how our scarce health care dollars are best invested and ensuring people receive the care they need as close to home as possible.

Delayed access to medical care may subject patients to increased pain, suffering, and mental anguish. Waiting for health care can also have broader economic consequences such as increased absenteeism, reduced productivity, and reduced ability to work for the individual waiting as well as for family members and friends who are concerned for them or may be called to assist them with activities of daily living. Waiting may also lead to poorer outcomes from care, if not a requirement for more complex treatments, as a result of deterioration in the patients' condition while they wait for treatment. Such deterioration may also result in permanent disability.

We also must value people's time as they move through the health system. By looking at the how, where, when and who of care provision and looking at it from the patient's perspective we remove the barriers and make the system more integrated. This focus improves quality and efficiencies supporting our '*best for people, best for system'* approach.

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

GAINS THROUGH REGIONAL COLLABORATION

The second nursing Gerontology Acceleration Programme has commenced with 10 participants, there were six participants in the first programme. This training targets mid-career nurses to grow clinical leadership skills for the Aged Residential Care sector.

Why is this outcome a priority?

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

It is now widely recognised that the care and support needed to live with a long-term condition requires a radical re-design of services, allowing patients to drive the care planning process. There is growing evidence that engaging patients in decisions about their care and providing supported self-management improves the quality of life for those with long term conditions, alongside co-ordinated care, prevention, early diagnosis and intervention and emotional, psychological and practical support.

The prevalence of long term disease is placing an increasing burden on patients and their carers, and on the whole health system and its service providers. For patients improving service coordination and assistance in moving more seamlessly from one care setting to another (including between health services and sectors) can lead to better continuity of care, resulting in potentially avoidable negative health outcomes such as hospitalisation.

By intervening early, and with improved coordination and proactive provision of care, our people, families and whānau with complex conditions have improved health outcomes. This supports our people to stay well and maintain their functional independence

4.7 Outcome 5: People have fewer & shorter episodes in care facilities

Why is this outcome a priority?

Advancements in medical and health technology have enabled the population to live longer, however more people are living with co-morbidities and needing complex care interventions. We know that investing in community services and the community workforce will help to deliver positive health outcomes and free hospitals to provide more acute and specialised care. By reducing the length of stay in health care facilities we release capacity in the system, including beds and staff time, which helps to minimise waiting times, maximise productivity and improve the patient experience.

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

4.8 Outcome 6: No wasted resource

Why is this outcome a priority?

GAINS THROUGH REGIONAL COLLABORATION

$14.62 million of annual savings accumulated. (1 July 2013-30 June 2014)

We have a commitment to ensure that patients receive timely access to the most appropriate care in the most appropriate place. It's about getting the greatest value for our people from the system, allowing evidence to inform how our scarce health care dollars are best invested and ensuring people receive the care they need as close to home as possible.

As our population ages, so does our workforce, so we need to enable health professionals to work at top of their scope of practice with the support of an appropriately trained unregulated workforce, building an innovative and flexible workforce that will meet the needs of the emerging models of health care.

4.9 Outcome 7: People are protected harm or needless death

Why is this outcome a priority?

Our focus on *'best for people, best for system'* places an emphasis on the system of care delivery that; prevents errors; learns from the errors that do occur; and is built on a culture of safety that involves health care professionals, organisations, and patients.

Quality improvement in service delivery, systems and processes improve patient safety, reduce the number of events causing injury or harm and improve health outcomes. Adverse events and delays in treatment, as well as causing harm to patients, drive unnecessary costs and redirect resources away from other services. Appropriate and quality service provision will reduce readmission rates and better support people to recover from complex illness and/or maximise their quality of life.

GAINS THROUGH REGIONAL COLLABORATION

"Safety 1st is a real win-win for staff and patients in terms of making our health settings safer and improving the quality of care we provide every day. We know that in every health setting around the world adverse events and incidents do happen, and it is our job to learn from them and to reduce the chance of them happening again. This system will make it easier for us to do that. Overall it's about supporting an open and transparent process of reporting and information sharing within the health sector, which we can all benefit and learn from.

Mary Gordon Chair (Q&SSLA)

4.10 Outcome 8: People die with dignity

Why is this outcome a priority?

GAINS THROUGH REGIONAL COLLABORATION

We are supporting people to have the conversation and document their Advance Care Plans through training of staff. In 2013-14 60 participants completed Level 2 Advance Care Planning training

At the end of life our people should be treated with respect and be listened to and be taken seriously. This means different things for different people and may mean death without suffering and pain and death coming calmly. It may be a death with limited medical intervention without unnecessary examinations and treatments. Others may believe death should come with a sense of security, not being left alone while dying. Others may want to die in peace and in a harmonic and calm way.

5 REGIONAL GOVERNANCE, LEADERSHIP AND DECISION MAKING

5.1 The Role and Scope of the South Island Region

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

5.1.1 Regional governance and leadership

In order to advance the implementation of regional service planning and delivery, in 2011 the South Island DHBs established an alliance framework. This approach continues to facilitate the DHBs in working together to jointly solve problems by sharing knowledge and resources with a focus on achieving the best outcomes for the region's population. The alliance framework has been successful in supporting the DHBs to achieve in both the enabler and clinical service areas and has been recognised as a successful model at a national level and by the other regions.

South Island Alliance Charter Principles

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

5.2 Our governance structure

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

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

5.3 Service Level Alliances and Workstreams

South Island regional activity involves a wide representation of the key stakeholders including health professionals, managers, funders, health care providers and consumers. The teams are clinically-led with the exception of the Support Services Service Level Alliance. A Chief Executive or Senior Executive from one of the DHBs, sponsors each Service Level Alliances and Workstream to support the team and where necessary help to

manage risks. Sponsors also provide a point of escalation for the resolution of issues if one of the agreed programmes or projects vary from planned time, cost or scope. The SLA/Workstream is responsible for overseeing the agreed programme of work, providing overarching programme and project governance. The work is supported by the staff employed by the South Island Alliance Programme Office

5.4 Decision making

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

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

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

GAINS THROUGH REGIONAL COLLABORATION

The ePrescribing and Administration implementation is progressing well within Southern DHB. This project is part of the South Island Alliance's eMedicines Programme. ePrescribing and Administration enables doctors to electronically chart patients' medications, removing the risk of handwriting being misinterpreted. It also allows nursing staff to administer and record medications electronically, resulting in fewer errors and a reduction in harm to patients.

5.4.1 Escalation Pathway

The Alliance operates under the following escalation pathway:

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

5.5 Regional Funding and Approval Model

All regional activity that required project, or capital funding requires support from the South Island General Managers Planning and Funding or South Island Chief Financial Officers (as appropriate). A recommendation is then made to the South Island Alliance Leadership Team or Regional Capital Committee for approval. A simple prioritisation process has been used to date based on Impact and Feasibility. A more sophisticated model is currently in development and will be consulted on with the relevant regional groups before presentation to the South Island Alliance Leadership Team and Board for endorsement.

6 SERVICE PERFORMANCE PRIORITIES 2015-2018

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

The South Island DHBs are involved in collaborative activity across a large number of regional and sub-regional service areas. The areas identified in this section are those that have been given national and regional priority. In addition to these priority areas, regional planning continues for neurosurgery, primary care emergency planning and coordination. Māori health approaches have been incorporated into the 2015-18 priority area workplans (Appendix 3).

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

GAINS THROUGH REGIONAL COLLABORATION

Replacing each district health board's patient information system with a single streamlined regional system will provide healthcare staff with more accurate information, and allow them to spend less time on administration and more time on caring for patients. The new system will also be more timely and cost-efficient than the patient information systems it replaces. Nelson Marlborough DHB and Canterbury DHB have both completed implementation business cases for the deployment of SI PICS at their respective DHBs – these implementation cases have been approved by their Board.

6.1 Improving Health Systems Outcomes

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

GAINS THROUGH REGIONAL COLLABORATION

Staff working in all health care settings in the South Island are improving the lives of people with Dementia by reinforcing a person centred approach and providing information to support earlier diagnosis. The dementia framework is being progressed in the South Island to deliver increased integration of older people's health and support services, to ensure seamless pathways of care for older people who live in the South Island. The Cognitive Impairment Pathway is the most commonly viewed site on the HealthPathways website with 4293 hits in the twelve months to 2 June 2014.

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

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

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

The Service Level Alliances/Workstreams work and regional work plan addresses the eight high level outcomes for the South Island region:

- Improved environment to support health and wellbeing
- People have increased access to planned care
- People wait less

- People have delayed/avoided burden of long term conditions
- People have few and shorter episodes in care facilities
- No wasted resource
- People are protected from harm or needless death
- People die with dignity

6.2 Overview of how the activity of the South Island Alliance supports the framework

The following are examples of the work planned for 2015/16 and the outcomes the activity will support. This is a work in progress but supports us understanding how our work relates to the outcomes we are working towards.

6.2.1 Improved environments to support health and wellbeing

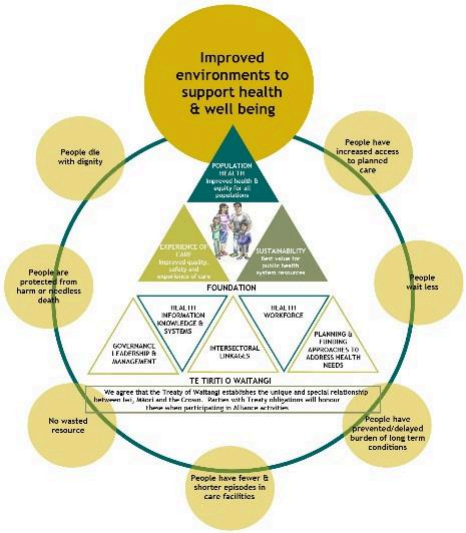
Public Health

South Island DHBs' Alcohol Position Statement and Alcohol Harm Reduction Strategies

- DHB Alcohol Harm Reduction Strategy promotion.
- Coordinated health promotion and health protection activity demonstrated South Island-wide.

Sustainability

- All South Island DHBs become members of the Green and Healthy Hospital Initiative (GGHI).
- Promotion of consistent environmental / sustainability monitoring systems.[3]



Health determinants

- Support DHB efforts to address housing where it impacts health outcomes, including multistakeholder and intersectoral engagement.
- Review opportunities for a coordinated South Island response to obesity and obesogenic environments.

Child Health

South Island Children's' Action Plan

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

Programmes to Reduce Youth Risk Taking

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

Information Services

Health Connect South

- Development enhancements for the regional Health Connect South solution.
- Complete Southern DHB's Health Connect South implementation.

[3] Note, public health can seek to influence here but the outcome is highly dependent on wider DHB commitment and support.

- Complete Nelson Marlborough DHB's Health Connect South implementation.
- Fully implement eDischarge for all South Island DHBs.

South Island Patient Information Care System

- Supporting the first implementations of SI PICS and define the Second Phase of the solution.
- Go-live Phase I and prepare for implementation into the balance of Canterbury DHB sites.
- Project go-live for Nelson Marlborough DHB.
- Prepare for SI PICS Implementation for West Coast DHB.

Workforce Development Hub

eLearning

- Implement a common eLearning platform for all DHB staff.
- Lippincott on-line evidenced based clinical procedure manual is introduced to all South Island DHBs.

Regional Coordination and Development of Interprofessional Learning

- Increased opportunities for interprofessional learning in a clinical environment.

Support all South Island HWNZ Funded Trainees to Make Appropriate Career Choices

- All HWNZ funded trainees have access to career guidance and a career plan aligned to individual aspirations and future workforce needs.

Vulnerable Workforces

- South Island vulnerable workforces are identified and plans established to mitigate these.
- Development of the primary and secondary care health workforce to support a shift in care that is more community based.
- Increase the participation of Māori & Pacific people in the clinical workforce.

Health of Older People

Dementia Services

- Improved services for people with dementia by implementing 'the New Zealand Framework for Dementia Care' in the South Island.
- Develop appropriate dementia education/ training materials for South Island primary health care person centred care.

Stroke

Workforce Planning and Development

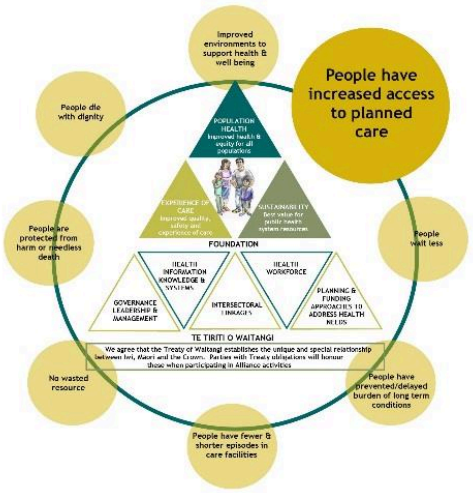
- Named stroke specialist/s within each inter-disciplinary team.
- Named lead stroke clinician and/or nurse in each DHB with specific remit to develop and improve Stroke Services for that DHB.

Cancer

People Get Timely Access across the Whole Cancer Pathway

- Supporting the South Island-wide review of services against national tumour standards, with a focus on supportive care, palliative care and equity.

6.2.2 People have increased access to planned care



Cardiac

Improved Outcomes for People with Suspected Acute Coronary Syndrome

- Standardised intervention rates for ACS patients.
- Support access to angiography for high risk populations groups.

Electives

Improve Access to elective services

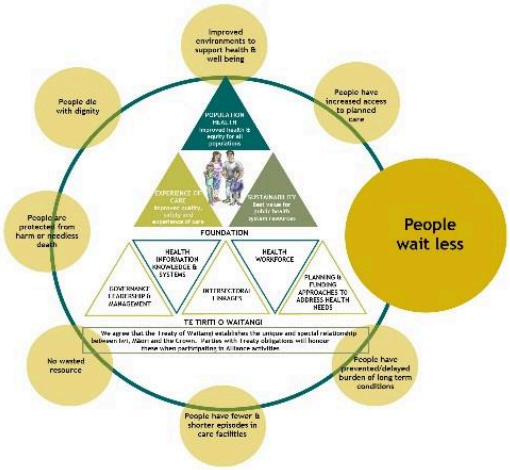
- Improve equity of access to selected elective services.

Stroke

Ensure Rapid Access to Treatment for Potential Thrombolysis Candidates

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

6.2.3 People wait less



Cardiac

Improved Outcomes for People with Suspected Acute Coronary Syndrome

- Standardised intervention rates for ACS patients.

Cancer

People Get Timely Services across the Whole Cancer Pathway

- Achieving the Faster Cancer Treatment Health Target.

Information Services

Emergency Department Whiteboard

- Provide a regional solution to support visibility of ED activity.

6.2.4 People have prevented/delayed burden of long term conditions

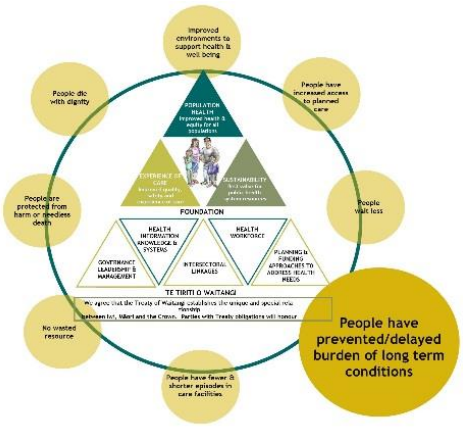
Child Health

Interventions to Reduce Hospital Admissions

- Implement a South Island Health Pathway for Dermatitis and Eczema.
- Increase GP training on Dermatitis and Eczema.

A Regional Integrated Obesity Management Programme

- Develop a regional integrated obesity management programme.
- Enhance collaboration with child dental health services.



Information Services

Patient Portal

- Implement a Patient Portal that helps patients be involved in their care and supports clear communication resulting in a better patient experience and improved patient outcomes.

Health of Older People

Dementia Services

- A Cognitive Impairment Pathway (CIP) will be promoted for adoption across all South Island DHBs.
- WiAS programme continues to be expanded in each South Island DHB reaching a wider range of staff working with people with dementia.

Restorative Model of Care

- A Web Based Toolkit that is evidence based and guides service providers to deliver restorative, person centred care.

Stroke

Rapid Access to treatment for Potential Thrombolysis Candidates

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

Integrated Stroke Rehabilitation Services

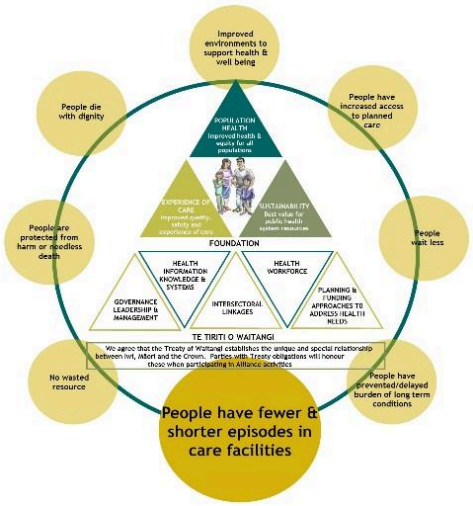
- Community stroke rehabilitation is available to aid adjustment and minimise complications.

6.2.5 People have fewer and shorter episodes in care facilities

Cardiac

Heart Failure

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



Major Trauma

Improve the Pathway for Patients with Major Trauma

- Implement a planned and consistent approach to the provision of Major Trauma services across the South Island.

Health of Older People

Comprehensive Clinical Assessment (interRAI)

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

Child Health

Reduce Hospital Admissions

- A South Island Diabetes Working Group established to improve systems across South Island for young people with Diabetes in particular Type 1.
- Strengthen models of care within primary care right place right time right service.

Mental Health and Addiction

Access to Youth Forensic Services

- Development of community youth forensic services.

Mental Health and Intellectual Disability Dual Diagnosis

- Identify options to support consumers with Mental Health and Intellectual Disability Dual Diagnosis who are inappropriately placed.

Forensic Services

- Improved adult forensic service capacity & responsiveness.

Access to Mental Health Services

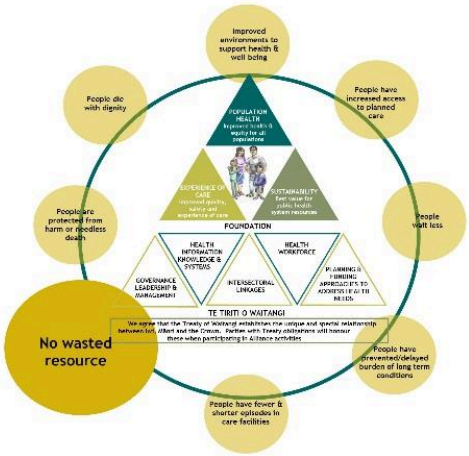
- Monitor and support ongoing improvements in the regional provision of eating disorder services, mothers and babies' services, and alcohol and other drug services.

6.2.6 No wasted resource

Support Services

Procurement and Savings

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



Cardiac

ECG Storage and Sharing

- A common regional method of storing and sharing ECGs.

Workforce Development Hub

eLearning

- Nursing Community of Practice have identified and prioritised a regional suite of eLearning packages.
- Mental Health Core Education Group have identified and prioritised a regional suite of eLearning packages.

Clinical Simulation

- Clinical simulation is accessible to staff working in the smaller centres and rural areas of the South Island. A coordinated clinical simulation network for the South Island.

6.2.7 People are protected from harm or needless death

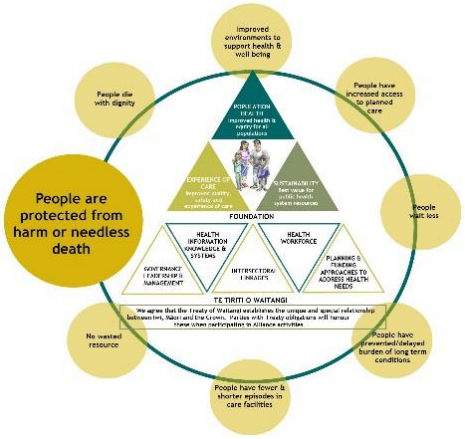
Child Health

Improve Sudden and Unexpected Death in Infants (SUDI) Rates

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

Pathway to improve Health Outcomes for Māori and Pacific Island Youth with Mental Health Conditions

- Evaluation and implementation of an e tool that supports youth, in particular Māori and Pacific Island, to improve health outcomes.



Quality and Safety

Supporting DHBs to Make a Positive Contribution to Patient Safety and Quality of Care

- Monitor and recommend options for reducing perioperative harm.
- Supporting consumer involvement in South Island Alliance activity.

Information Services

eMedicines

- SDHB, CDHB, SCDHB ePrescribing and Administration project complete.
- WCDHB, NMDHB ePrescribing and Administration implementation.

- Complete the implementation of eMedicines Reconciliation within Canterbury DHB and commence implementation planning for remaining South Island DHBs.
- Complete the regional implementation by implementing ePharmacy Management within South Canterbury, West Coast, Southern and Nelson Marlborough DHBs.

Health Connect South

- Complete Southern DHB's Health Connect South implementation.
- Complete Nelson Marlborough DHB's Health Connect South implementation.
- Fully implement of eDischarge for all South Island DHBs.

South Island Patient Information Care System (PICS)

- Supporting the first implementations of South Island PICS and define the Second Phase of the solution.
- Go-live Phase I and prepare for implementation into the balance of Canterbury DHB sites.
- Project go-live for Nelson Marlborough DHB.
- Prepare WCDHB for SI PICS Implementation.

Stroke

Ensure Rapid Access to Treatment for Potential Thrombolysis Candidates

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

Health of Older People

Falls Prevention and Fracture Liaison Service

- Development of an evidence based Fracture Liaison Service.
- Agree a South Island Policy on Community Based Falls Prevention Programmes based on the evidence of the Otago Exercise Programme.

Workforce & Development Hub

Clinical Simulation

- Clinical simulation is accessible to staff working in the smaller centres and rural areas of the South Island. A coordinated clinical simulation network for the South Island.

Mental Health and Addiction

Seclusion and Restraint

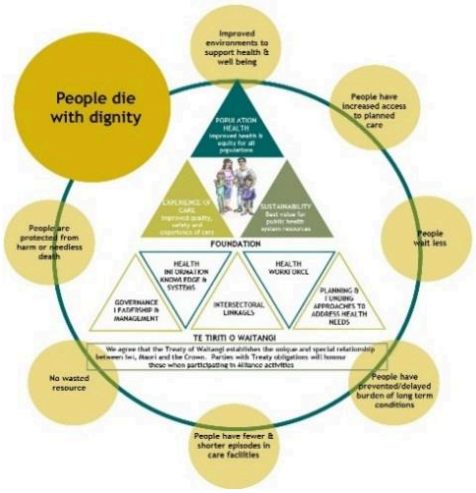
- Collaboration on seclusion and restraint across SI DHBs with a specific focus on Māori.

6.2.8 People die with dignity

Palliative Care

Equitable Access to an Integrated Palliative Care System

- All people who are dying and their family /whānau have access to an equitable and quality palliative care service.
- Primary care provided with expertise and resources to enable patients to die in their preferred place of care.
- Consumer participation and decision making about palliative and end of life care.



Health of Older People

Advance Care Planning (ACP)

- Develop ACP systems and processes to embed ACP as standard practice for those who will benefit.
- ACPs are incorporated into the regional IS system/plan.
- South Island DHB are supported to participate in "Conversations that Count" (CtC) awareness raising day April 2015.

6.3 Clinical Service Developments

6.3.1 Cardiac Intervention Services

The South Island has some challenges in ensuring a sustainable cardiac surgery service, but rather than focusing on one component of the cardiac service we recognise the need for a South Island approach for patients who require cardiac intervention (cardiac surgery or interventional cardiology). This process is critical to ensure that risks to the current wider South Island services are understood. The scope of this work is to agree a clinical pathway for patients who require cardiac intervention. This will include:

- an agreed approach to decision making, management, co-ordination and prioritisation
- be based on best practice
- support patients with a similar level of need to receive comparable access to services, regardless of where they live

Once the Model of Care has been agreed then further work will be required to determine how/where these services are delivered, recognising the need to support sustainable services for the South Island population and the potential impact on the other cardiac services across the country.

6.3.2 Hepatitis C

The South Island DHBs recognise the need to a collaborative and focused approach to identify and treat those at risk of or with Hepatitis C. We will work together to understand the services currently provided across the South Island and to develop a 2015 -16 plan that supports a sustainable service for the South Island population including oversight of the services, support to clinicians. The plan will consider any impact on secondary services, how Fibroscanning is provided and ensure that a clinical pathway is developed and adopted.

6.3.3 Laboratory Services

In 2014, the General Managers Planning and Funding of the Southern, South Canterbury and Nelson Marlborough District Health Boards recognised that their laboratory contracts were due to expire in 2016. It was agreed that a sub-regional laboratory strategy be developed for the purpose of establishing the service needs for community and hospital diagnostic laboratory provision and to inform future contracting options.

The objectives of the laboratory strategy are to:

- Inform DHB Boards about future direction of laboratory services.
- Identify and recommend options to deliver on the triple aim associated with taking a sub-regional approach to the provision of laboratory services.
- Maintain and or where indicated improve the quality medical laboratory diagnostic services.

The scope for the project as agreed by the Southern, Nelson Marlborough and South Canterbury DHB boards includes the preparation and drafting of a strategic paper outlining options for the future delivery of medical diagnostic laboratory services and does not include the management and development of future contractual arrangements.

A steering group has been established to guide the project. In developing the paper the group will consider:

- The current state of service delivery and issues across the South Island and within the three DHB regions,
- Issues across community and hospital services,
- Integration with regional information systems including patient records and pathway of care,
- Current utilisation and future service demand,
- Clinician/ referrer needs and levels of service now and in the future,
- Future technology trends, including digital pathology and point of care testing (POCT),
- Demand management, quality use of tests and cost containment,
- Patient access, including geographic aspects and out of hours,
- Physical infrastructure, including geographic aspects.

Appendix 1 – Minister Letter of Expectation 2015

Office of Hon Dr Jonathan Coleman

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

17 DEC 2014

Chair

Dear Chair

Letter of expectations for DHBs and subsidiary entities 2015/16

Thank you for the continued contribution you and your staff are making to a better public health service. It is important that we drive a team approach across the system.

While recognising these are tight economic times, the Government is committed to improving the health of New Zealanders and will continue to invest in key health services. Investment in our public health services has risen from a budget of $11.8 billion in 2008/09 to $15.6 billion in 2014/15. Health is the only portfolio with this sort of increase, which demonstrates the Government's on-going commitment to protecting and growing our public health services.

Fiscal Discipline/Management of the Health Portfolio

As I have discussed with you previously, DHBs need to budget and operate within allocated funding and must have detailed plans to improve year-on-year financial performance. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of DHBs' operation and service delivery. You and your Board must monitor and hold your Chief Executive accountable against these expectations as keeping to budget allows investment into new and more health initiatives.

Improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs. I recognise that DHBs want to have a greater role in the process of making back office savings to reinvest into frontline services, and want greater control of the implementation phase of the four health shared service business cases. It is essential that these business cases are implemented swiftly and savings achieved. The current transition process in place to shift responsibility for implementation of the business cases takes these considerations on board.

Leadership

Strong clinical leadership and engagement should be embedded in DHBs and utilised in all aspects of DHBs' core business eg budgeting and service design. Clinically driven service changes are encouraged where these make sense for patients and encourage positive

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system changes. DHBs are expected to include clear detail in their annual plans for 2015/16 that shows how they will foster clinical leadership.

DHB governance, senior management and clinical leaders need to work together in order to ensure we are heading in the same direction. As agents of the Crown you and your Board must assure yourselves that you have in place the appropriate clinical and executive leadership to deliver on the Government's objectives. I expect you to spend time talking with clinical leaders and fostering, encouraging and supporting clinically-led decision making.

Integration between Primary and Secondary Care

Integrating primary care with other parts of the health service is vital for better management of long-term conditions, mental health, an aging population and patients in general. The pathways to achieve better co-ordinated health and social services need to be developed and supported by clinical leaders in both community and hospital settings. I expect DHBs to move services closer to home in 2015/16, and DHBs need to have clear evidence of how they plan to do this. The key to better health, as well as financial sustainability, is earlier intervention and population-based initiatives delivered in the community.

National Health Targets

The national health targets are very important for driving overall hospital performance, and have resulted in major improvements in the health outcomes of New Zealanders. Health target performance continues to improve, but DHBs must remain focussed on achieving and improving performance against the targets, particularly the primary care targets, which are still some way from being achieved. I expect DHBs to work directly with primary health organisations and individual practices to drive performance against the primary care targets, and to provide clear and specific plans for achieving all national health targets in their annual plans.

As you are aware, from quarter two of 2014/15, the 62 day Faster Cancer Treatment indicator has become the cancer health target with a target achievement level of 85 percent by July 2016 and then increasing to 90 percent by July 2017. The addition of this indicator ensures continued focus on improving cancer services.

Targets will continue to evolve over time, reflecting a range of dynamic factors. Any changes to current targets for 2015/16 are expected to be known early next year, and may entail adjustments to the electives, more heart and diabetes checks and better help for smokers to quit targets.

I also expect to see elective surgery access further boosted by [$50 million of] new funding to target more orthopaedic and general surgery, and the development of community-based intervention teams to treat musculoskeletal pain non-surgically.

Clinicians should focus on implementation of the agreed clinical prioritisation tools to support appropriate access for patients.

Tackling Key Drivers of Morbidity

As Minister of Sport and Recreation as well as Minister of Health, I am looking to strengthen the link between physical activity and keeping New Zealanders healthy. Obesity is a major risk factor for diabetes and other chronic conditions, which are key drivers of morbidity. We are currently doing a stocktake of 'what works' to reduce obesity, but in the meantime I expect all DHBs to be considering what they can do to help reduce the incidence of obesity in New Zealand.

2

A key Government priority is reducing the number of children living in material hardship. DHBs are already working closely with other social sector organisations to achieve sector goals in relation to the Government's Better Public Services initiatives and other cross-agency initiatives, such as Whānau Ora, Social Sector Trials, Children's Action Plan and Youth Mental Health. I expect district health boards to support cross-agency work that delivers outcomes for children across a range of dimensions – health, education, social and justice.

Refreshed New Zealand Health Strategy

At my request, the Ministry of Health is planning to update and refresh the New Zealand Health Strategy. Once this process is completed, the Strategy will provide DHBs and the wider sector with a clear strategic direction and road map for delivery of health services to New Zealanders into the future. I expect DHBs to take an active part in the consultation for the refresh of the Strategy.

Additionally, a renewed focus on strategic direction should be evident in DHB annual plans for 2015/16. Therefore, all DHBs must refresh their statements of intent in 2015/16 and build these in to their annual plans. I also encourage you to take a strong interest in the Ministry of Health's four-year plan when it is available, as it will provide further clarity on how the sector is expected to manage its resources and prioritise activities over the next four years.

Finally, please keep in mind that the Budget 2015 process will clarify these and other Government priorities, and more information will be provided when available. Please share this letter with your clinical leaders and local primary care networks.

I thank you for the considerable effort you and your team are making, and I look forward to working with you in the future.

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

3

Appendix 2 – 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.

Appendix 3 – Service Performance Priorities 2015-2018

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

Clinical Services: Sustainability and Clinical Integration

Cancer Services

Reducing the burden of cancer

Lead CEO:	**David Meates (Canterbury DHB)**
Chair:	**Dr Steve Gibbons, Consultant Haematologist (Canterbury DHB)**
Clinical Lead:	**Shaun Costello, Clinical Director SCN, Radiation Oncologist (Southern DHB)**

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

- Provide a framework that supports the linkages between the South Island DHBs, DHB specialist service providers, Non-Government Organisations (NGOs), Public Health Organisations (PHOs), and consumers.
- Coordinate implementation of the 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.

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

- South Island Faster Cancer Treatment.
- South Island Cancer Service Coordination and Quality Improvement - People have access to services that maintain good health and independence and receive excellent services wherever they are. Services make the best use of available resources.
- South Island Clinical Cancer Information System - Implementation of the South Island Clinical Cancer Information System (SICCIS): Robust cancer data and information sources are developed and shared that enable informed service development & planning decision-making.
- Southern Cancer Network Support For National Projects - to ensure that the tumour standards continue to promote quality of care and guide uniform standards of service provision across DHBs.

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSBILITIES
CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION					
SOUTHERN CANCER NETWORK					
SOUTH ISLAND FASTER CANCER TREATMENT **People get timely services across the whole cancer pathway (screening, detection, diagnosis, treatment and management, palliative care)**					
Achieving the Faster Cancer Treatment Health Target					
1a	**Support the delivery of the FCTs targets by DHBs** – *At least 85% of patients receive their first treatment within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks by July 2016.*	Q4	Support the DHBs to deliver the extended target of '*At least 90% of patients receive their first treatment within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks by July 2016'.*	Support the DHBs to maintain achievement of the FCT Targets.	Contributors: SI DHBs are responsible for the target. SCN support the DHBs Reported in: SI DHB QR
Improved or maintained performance against the Policy Priority (PP30) Faster Cancer Treatment Indicators					
2a	**Support the maintenance or improvement of the 31 day Indicator** *proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment within 31 days.*	Q2,4	**Continue to support the maintenance or improvement of the 31 day Indicator** *proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment within 31 days.*	**Continue to support the maintenance or improvement of the 31 day Indicator** *proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment within 31 days.*	Contributors: SI DHBs are responsible for the target. SCN support the DHBs Reported in: SI DHB QR
2b	**Support DHBs with sustaining the National radiotherapy and chemotherapy waiting time targets –** *all patients, ready for treatment, wait less than 4 weeks for radiotherapy and chemotherapy.*	Q2,4	**Continue to support DHBs with sustaining the National radiotherapy and chemotherapy waiting time targets –** *all patients, ready for treatment, wait less than 4 weeks for radiotherapy and chemotherapy.*	**Continue to support DHBs with sustaining the National radiotherapy and chemotherapy waiting time targets –** *all patients, ready for treatment, wait less than 4 weeks for radiotherapy and chemotherapy.*	Contributors: SI DHBs are responsible for the target. SCN support the DHBs Reported in: SI DHB QR
The national tumour standards of service provision are implemented					
3a	Disseminate findings of audits (Head & Neck, Thyroid and Bowel) undertaken in 14-15.	Q1	Develop processes to enable audit recommendations to be progressively implemented and extent these processes to all audit areas.		Contributors: SCN coordinate and support the process in collaboration with the DHBs Reported in: SIHSP
3b	Support the South Island-wide review of further services against national tumour standard.	Q2,4	Continue to support the South Island-wide reviews of further services against national tumour standard, should these projects be continued.		Contributors: SCN coordinate and support the process in collaboration with the DHBs Reported in: SIHSP
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					
4a	Establish the (revised) SCN Working Groups Structure.	Q1			Contributors: SCN Reported in: SIHSP
4b	Identify Cancer Clinical Priorities, through the South Island/SCN Cancer Clinical Leads Group.	Q1	Reassess on an annual basis the Cancer Clinical Priorities, through the South Island/SCN Cancer Clinical Leads Group.	Reassess on an annual basis the Cancer Clinical Priorities, through the South Island/SCN Cancer Clinical Leads Group.	Contributors: SCN Reported in: SIHSP
Improved functionality and coverage of MDMs across the region					
5a	Support the South Island DHBs to improve the functionality and coverage of MDTs by implementing regionally agreed MDT priorities.	Q1, Q2, Q4	Implement and rollout the recommendations and service improvement initiatives started in 2015-16.	Yet to be determined.	Contributors: SCN & SI DHBs Reported in: SIHSP

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSBILITIES
Initiatives to understand and harmonise medical and radiation oncology services					
6	Understand radiation oncology requirements and agree implementation plan for future linac capacity, usage and location.	Q1	Implement findings of 15-16 work if not already completed.	Yet to be determined.	Contributors: SCN & Cancer Centres Reported in: SIHSP
6b	Progress towards harmonisation of services through regular activity reporting for medical and radiation oncology.	Q2,4	Continue to review and understand regional services with regard clinical variation and service delivery.	Yet to be determined.	Contributors: SCN & Cancer Centres Reported in: SIHSP
Initiatives that reduce inequalities and support access to cancer services					
7a	Initiatives that support patient, family and whānau access to cancer services and reduce inequalities are identified and implemented across all equality groups.	Q4	Yet to be determined.	Yet to be determined.	Contributors: SCN, Te Waipounamu Maori Leadership Group and other stakeholders Reported in: SIHSP
7b	Run a Maori Awareness Wananga in Invercargill *(TBC, dependent on access to resources).*	Q4	Yet to be determined.	Yet to be determined.	Contributors: SCN, Te Waipounamu Maori Leadership Group and other stakeholders Reported in: SIHSP
7c	Identify needs for Pacifica and Asian communities and modes of engagement.	Q2	Yet to be determined.	Yet to be determined.	Contributors: SCN and other stakeholders Reported in: SIHSP
7d	Support rollout of a regional psychosocial and supportive care service.	Q4	Yet to be determined.	Yet to be determined.	Contributors: SI DHBs & SCN Reported in: SIHSP
SOUTH ISLAND CLINICAL CANCER INFORMATION SYSTEM **Implementation of the South Island Clinical Cancer Information System (SICCIS): Robust cancer data and information sources are developed and shared that enable informed service development & planning decision-making**					
SICCIS, the regional clinical data repository for cancer implementation continues					
8a	Implement the proposed Cancer Informatics Working Groups Structure (in collaboration with the SI Information Services SLA).	Q1	Ongoing support for this structure.	Ongoing support for this structure.	Contributors: SCN Reported in: SIHSP
8b	Support DHBs with further alignment of MOSAIQ across the Cancer Centres.	Q4	Continued implementation of MOSAIQ priority work areas.	Yet to be determined.	Contributors: SCN & SI DHBs Reported in: SIHSP
8c	Support integration and expansion of Metriq (AKA SICCIS).	Q1,4	Continued implementation of Metriq priority work areas.	Not clear at this stage.	Contributors: SCN & SI DHBs Reported in: SIHSP
8d	Produce a Quarterly Cancer Dashboard to understand progress against cancer standards and targets.	Q2,4	Maintenance and further development as required.	Maintenance and further development as required.	Contributors: SCN & SI DHBs Reported in: SIHSP
SOUTHERN CANCER NETWORK SUPPORT FOR NATIONAL PROJECTS **To ensure that the tumour standards continue to promote quality of care and guide uniform standards of service provision across DHBs**					
Supporting the MoH Tumour Standards Working Groups (in collaboration with the Sapere Research Group)					
9	To deliver Stage B & C of the Tumour standards project by supporting the MoH Tumour Stream Working Groups.	***NOTE: this may not now be going ahead***	Work will be completed.	Work will be completed.	Contributors: SCN Reported in: SIHSP
Supporting National Lead for the Psychological and Social Support Workforce Initiative					
10	Host and support the NZ National Lead.	Q4	Continue to host and support the NZ National Lead.	Continue to host and support the NZ National Lead.	Contributors: SCN Reported in: SIHSP

Child Health Services

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

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

Clinical Lead: **David Barker, Paediatrician (Southern DHB)**

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

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

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

- Growing up Healthy - responding to national strategies for improving children's health outcomes and preventing child abuse.
- Young Persons Health - responding to the Prime Ministers youth Mental Health project.
- Access to Child Health Services - supporting innovation, good practice and equity.
- Successful Transition into Healthy Adulthood for Children with Lifelong Health Conditions (for example, implementation of cystic fibrous pathway).
- To adequately address the Challenges of Behavioural Problems in Children and Young People. Child Development and Disability Child and Youth Health Compass Report 2013.
- Consumer Consultation.

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSBILITIES
CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION					
CHILD HEALTH SERVICES					
GROWING UP HEALTHY **responding to national strategies for improving children's health outcomes and preventing child abuse**					
South Island Children's Action Plan (Government strategy) **Healthy Families New Zealand aims to improve people's health where they live, learn, work and play in order to prevent chronic disease**					
1	Identify and monitor the implementation of agreed South Island regional interventions to better manage safety, reduce family violence and childhood poverty.	Q4	Continued evaluation of outcomes.	Continued evaluation of outcomes.	Contributors: CHSLA & PHP Reported in :SIHSP
Regional Sudden and Unexpected Death in Infants (SUDI) rates continue to trend downwards					
2	Implement the findings of the audit of the South Island sudden death in infancy policy.	Q2	Ongoing monitoring and evaluation of audit outcomes.	Ongoing monitoring and evaluation of audit outcomes.	Contributors: CHSLA (Facilitator) Reported in: SIHSP
YOUNG PERSONS HEALTH **responding to the Prime Ministers youth Mental Health project**					
Pathway to improve health outcomes for Māori and Pacific Island youth with mental health conditions					
3	Evaluate and implement an e-tool that would meet the needs of youth, in particular Māori and Pacific Island, health outcomes.	Q4	Implement agreed mechanisms. Continued evaluation of outcomes.	Implement agreed mechanisms. Continued evaluation of outcomes.	Contributors: CHSLA & MHSLA Reported in: SIHSP
Support programmes which reduce youth risk taking resulting in injury/disease from smoking, alcohol, drug and sexual diseases					
4a	In partnership with the Health Promotion Agency, South Island Public Health Partnership and Mental Health Service Level Alliance implement findings of South Island Emergency Department scoping exercise.	Q3	Implement agreed findings.	Implement agreed findings.	Contributors: CHSLA, MHSLA, PHP & HPA Reported in: SIHSP
4b	Explore options and identify solutions to reduce teen pregnancy and referrals to Sexual health.	Q3	Continued evaluation of mechanisms in place.	Continued evaluation of mechanisms in place.	Contributors: CHSLA Reported in: SIHSP
ACCESS TO CHILD HEALTH SERVICES **Supporting innovation, good practice and equity.**					
Interventions to reduce hospital admission with emphasis on at risk children and families, Māori and Pacific					
5a	Review and regionalise the Canterbury DHB Dermatitis and Eczema HealthPathway.	Q3	Ongoing monitoring of hospital admission rates and Emergency Department presentations.	Ongoing monitoring of hospital admission rates and Emergency Department presentations.	Contributors: CHSLA Reported in: SIHSP
5b	Increase GP training on Dermatitis and Eczema.	Q3			Contributors: CHSLA Reported in: SIHSP
5c	Improve systems across South Island for young people with Diabetes in particular Type 1.	Q4	Implement findings of Working Group.	Review further and implement findings of Working Group.	Contributors: CHSLA Diabetes Working Group Reported in: SIHSP
5d	Establish triage criteria and tool for referral to Children's Outpatient Department.	Q4	Continued evaluation of triage process.	Continued evaluation of triage process.	Contributors: CH SLA Reported in: SIHSP
A regional integrated obesity management programme					
6a	Develop a regional integrated obesity management programme.	Q4	Ongoing monitoring and evaluation of programme.	Ongoing monitoring and evaluation of programme.	Contributors: CHSLA, PHP Reported in: SIHSP
6b	Enhance collaboration with child dental health services.	Q4	Ongoing monitoring and evaluation of programme.	Ongoing monitoring and evaluation of programme.	Contributors: CHSLA, PHP Reported in: SIHSP
6c	Share learnings healthy family initiatives in Heathcote Spreydon (Christchurch) and Invercargill.	Q4			Lead: CDHB (dependent on funding) Reported in: SIHSP
A regional electronic growth chart that will become part of a National solution to recording growth from birth.					
7	Implement a South Island e growth chart.	Q1			Contributors: CHSLA, IS SLA Reported in: SIHSP

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSBILITIES
SUCCESSFUL TRANSITION INTO HEALTHY ADULTHOOD FOR CHILDREN WITH LIFELONG HEALTH CONDITIONS (for example, implementation of cystic fibrous pathway)					
To provide youth specific services and transition planning/clinics to young people with a range of diseases					
8	Implement agreed transition pathway for young people with complex disability and with lifelong health conditions.	Q4	Ongoing monitoring and evaluation of HealthPathway.	Ongoing monitoring and evaluation of HealthPathway.	Contributors: CHSLA Reported in: SIHSP
TO ADEQUATELY ADDRESS THE CHALLENGES OF BEHAVIOURAL PROBLEMS IN CHILDREN AND YOUNG PEOPLE. CHILD DEVELOPMENT AND DISABILITY CHILD AND YOUTH HEALTH COMPASS REPORT 2013					
Strengthen models of care within primary care Right place Right time Right Service					
9	Develop a South Island under 5 years old behavioural pathway.	Q4	Yet to be determined.	Yet to be determined.	Contributors: CHSLA Reported in: SIHSP
CONSUMER CONSULTATION					
To include children, young people and whānau in the planning , delivery and evaluation of health services					
10	Develop a parent/care giver survey.	Q3,4	Ongoing consultation with consumers and input into workplan.	Ongoing consultation with consumers and input into workplan.	Contributors: CHSLA Reported in: SIHSP

Mental Health & Addiction Services

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

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

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

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

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

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

- Access to the Range of Eating Disorder Services.
- Adult and Youth Forensic Service Capacity and Responsiveness.
- Perinatal and Maternal Mental Health Service options as part of a Service Continuum.
- Alcohol and Other Drug Services.
- Mental Health and Addiction Service Capacity for People with High and Complex Needs.
- Māori Mental Health.
- Pacifica Mental Health.
- Workforce.
- Information Services.

MILESTONES DASHBOARD 2015-16					
ITEM NO	**DELIVERABLE 2015-2016**	**APPROVED SCHEDULE**	**DELIVERABLE 2016-2017**	**DELIVERABLE 2017-2018**	**RESPONSIBILITIES**
CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION					
MENTAL HEALTH SERVICES					
EATING DISORDERS					
Continued regional provision of eating disorder inpatient services, being cognisant of the needs of Maori and Pacifica in all activity.					
1a	Develop and review reports from the regional service including access, trends, key performance indicators and quality improvement activities.	Q1,2,3,4	Build on data gathered / experience of previous year.	Build on data gathered / experience of previous year.	Lead: CDHB Eating Disorders service Reported in: SIHSP
1b	Identify and support change process as required.	Q1,2,3,4			
ADULT FORENSIC SERVICES					
Improved adult forensic service capacity and responsiveness, being cognisant of the needs of Maori and Pacifica in all activity					
2a	Robust regional contribution to the national network of forensic inpatient services.	Q4	Deliverable to be agreed with the national network.	Deliverable to be agreed with the national network.	Lead: CDHB and SDHB Adult Forensic Service Reported in: SIHSP
2b	Prison screening occur with agreed timeframes with 80% of prisoners referred seen within 7 days of receipt of referral.	Q1,2,3,4	Continue to work with national partners.	Continue to work with national partners.	Lead: CDHB and SDHB Adult Forensic Service Reported in: SIHSP

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSIBILITIES
YOUTH FORENSIC SERVICE CAPACITY AND RESPONSIVENESS					
Development of Community Youth Forensic Services which are cognisant of the needs of Maori and Pacifica.					
3a	Review the community youth forensic hub and spoke model.	Q4	Consider findings of 2015/16 work.	Implement alternatives as appropriate.	Lead: Regional Youth Forensic Service Leads Reported in: SIHSP
PERINATAL AND MATERNAL MENTAL HEALTH SERVICE OPTIONS AS PART OF A SERVICE CONTINUUM					
Continued regional provision of regional mothers and babies services, being cognisant of the needs of Maori and Pacifica in all activity					
4a	Develop and review reports from the regional service including access, trends, key performance indicators and quality improvement activities.	Q1,2,3,4	Build on data gathered / experience of previous year.	Build on data gathered / experience of previous year.	Lead: CDHB Mothers and Babies service Reported in :SIHSP
4b	Identify and support change process as required.	Q1,2,3,4			
Primary and Community					
5	A stocktake and analysis of the range of models and activities in primary and community provision of Maternal Mental Health.	Q4	Consider findings of 2015/16 work.	Implement alternatives as appropriate.	Lead: Primary and community maternal mental health workstream. Reported in: SIHSP
ALCOHOL AND OTHER DRUG SERVICES					
Continued regional provision of alcohol and other drug services, being cognisant of the needs of Maori and Pacifica in all activity					
6a	Develop and review reports from the regional service including access, trends, key performance indicators and quality improvement activities.	Q1,2,3,4	Build on data gathered / experience of previous year.	Build on data gathered / experience of previous year.	Lead: CDHB alcohol and other drug service Reported in: SIHSP
6b	Identify and support change process as required.	Q1,2,3,4			
MENTAL HEALTH AND ADDICTION SERVICE CAPACITY FOR PEOPLE WITH HIGH AND COMPLEX NEEDS.					
Mental Health and Intellectual Disability Dual Diagnosis					
7	Understand the challenges DHBs face in providing individualised care for people with high and complex needs.	Q4	Consider findings of 2015/16 work.	Implement alternatives as appropriate.	Contributors: All South Island DHBs Reported in: SIHSP
Behaviour Support					
8	Report on the impact of the new behaviour support arrangements on the South Island.	Q3	Consider findings of 2015/16 work.	Implement alternatives as appropriate.	Contributors: All South Island DHBs Reported in: SIHSP
MĀORI MENTAL HEALTH **Priority focus on Maori health equity**					
Seclusion					
9	Collaborate on seclusion and restraint across South Island DHBs with a specific focus on Māori.	Q1	Consider findings of 2015/16 work.	Implement alternatives as appropriate.	Lead: Workstream of DHB seclusion reduction strategy Reported in: SIHSP
PACIFICA MENTAL HEALTH					
Consultation on advice regarding responsiveness to Pacifica need					
10	Seek feedback from the sector on the 2015 South Island Pacifica report "Reducing Inequity and Embracing Cultural Competencies".	Q2	Consider findings of 2015/16 work.	Implement alternatives as appropriate.	Contributors: All South Island DHBs Reported in: SIHSP
WORKFORCE					
Workforce development recommendations and integrated plan for primary and NGO sector inclusive of the needs of Maori and Pacifica					
11a	Develop recommendations and integrated plan for South Island DHBs, primary and NGO sector inclusive of the needs of Maori and Pacifica.	Q4	Implementation of Primary and NGO workforce plan.	Evaluate the effectiveness of an integrated Primary and NGO workplan plan in meeting the needs of Māori or Pacifica outcomes.	Lead: Mental Health & Addiction SLA Reported in: SIHSP
11b	Mental Health Core Education Group identify and prioritise a regional suite of eLearning packages.	Q4	An increasing number of eLearning packages available to the South Island health workforce.	Continue to develop regional learning packages, create national content where possible.	Lead: Mental Health & Addiction SLA Supported by SIWDH Reported in: SIHSP

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSIBILITIES
			INFORMATION SERVICES		
12	Agree South Island functionality and delivery of the overall solution for the Health Connect South (HCS) Mental Health module.	Q4	Implementation of regionally agreed solution.	Continued implementation of regionally agreed solution.	Lead: Mental Health & Addiction SLA Supported by IS SLA Reported in: SIHSP

Work supported by the Mental Health and Addiction Service Level Alliance

The Mental Health and Addiction SLA will support the delivery of the following projects:

Regional projects supported by the Mental Health and Addiction Service Level Alliance but led by other SLAs and Workstreams
Pathway to improve health outcomes for Māori and Pacific Island youth with mental health conditions (pg. 46 item 3) **Owner: Child Health SLA** Evaluate and implement an e-tool that would meet the needs of youth, in particular Māori and Pacific Island, health outcomes. **Support programmes which reduce youth risk taking resulting in injury/disease from alcohol (pg. 46 item 4a)** **Owner: Child Health SLA** In partnership with the Health Promotion Agency, Child Health Service Level Alliance and Public Health Partnership implement findings of South Island Emergency Department scoping exercise

Health of Older People Services

Best Health Care for Older People Everywhere in the South Island

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

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

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

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

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

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

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSIBLITIES
CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION					
HEALTH OF OLDER PEOPLE SERVICES					
DEMENTIA SERVICES					
Improved services for people with dementia by implementing 'the New Zealand Framework for Dementia Care' in the South Island					
1	Embed a Person Centred Care approach to services that enables people with dementia, their family and whānau to be valued partners in an integrated health and support system.	Q1,2,3	South Island Regional and District plans embed a Person Centred Care approach to services that enables people with dementia, their family and whānau to be valued partners in an integrated health and support system.	South Island Regional and District plans embed a Person Centred Care approach to services that enables people with dementia, their family and whānau to be valued partners in an integrated health and support system.	Contributors: HOPSLA, SI HOP PM, DHB Dementia teams Reported in: SIHSP
TO FURTHER DEVELOP THE PRIMARY CARE WORKFORCE AND IMPROVE THE TIMELINESS FOR A DIAGNOSIS					
A Cognitive Impairment Pathway (CIP) will be promoted for adoption across all South Island DHBs					
2	Agree a South Island Regional Cognitive Impairment Pathway.	Q4	Uptake of the pathway is encouraged/ monitored.	Uptake of the pathway is encouraged/ monitored. Pathway is reviewed and improved where appropriate.	Contributors: HOPSLA, SI HOP PM, DHB Dementia teams Reported in: SIHSP
Develop appropriate education/ training materials for South Island primary health care dementia					
3a	Dementia education supporting the use of CIP is available in a variety of modalities suitable for GPs, Practice Nurses and other community staff across the health care continuum including NGOs.	Q1,2,3,4	A range of dementia education supporting the use of CIP is available in a variety of modalities suitable for GPs, Practice Nurses and other community staff across the health care continuum including NGOs. A facilitator continues to encourage embedding use of dementia education resources in Primary Care in a consistent manner across South Island districts.	Use of dementia education material is embedded as routine in the Primary Care/DHB education calendar.	Contributors: HOPSLA, SI HOP PM, DHB Dementia teams ,SI DHBs PHO Reported in: SIHSP
3b	Encourage uptake of Dementia Education in South Island districts.	Q4		Use of dementia education material is embedded as routine in the Primary Care/DHB education calendar.	Contributors: HOPSLA, SI HOP PM, DHB Dementia teams ,SI DHBs PHO Reported in: SIHSP

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSIBLITIES
Walking in Another's Shoes (WiAS) programme (person centred care) to reach a wider range of staff working with people with dementia					
4	WiAS programme is further developed and enables South Island DHBs to become "Dementia Friendly" where integration occurs across the health, support and community sectors.	Q3	WiAS programme continues to be expanded in each South Island DHB programme reaching a wider range of staff working with people with dementia.	WiAS programme continues to be expanded in each South Island DHB programme reaching a wider range of staff working with people with dementia.	Contributors: HOPSLA, WiAS Development Team, SI HOP PM Reported in: SIHSP
RESTORATIVE MODEL OF CARE **These activities are best achieved at a regional level**					
A Web Based Toolkit that is evidence based and guides service providers to deliver restorative, person centred care					
5	Promote the use of South Island approved principles for restorative care by all services in the South Island.	Q3,4	Older people will be supported to set and achieve goals by a co-ordinated and responsive health and disability support service that also enables them to maintain their social connectedness with their family, whānau and community life.	Older people will be supported to set and achieve goals by a co-ordinated and responsive health and disability support service that also enables them to maintain their social connectedness with their family, whānau and community life.	Lead: HOPSLA Reported in: SIHSP Lead: HOPSLA Reported in: SIHSP
COMPREHENSIVE CLINICAL ASSESSMENT (interRAI)					
Comprehensive Clinical Assessment using a standardised assessment tool (interRAI) facilitating a system wide approach to common assessment					
6a	Advocate to use the information from comprehensive clinical assessment (interRAI) proactively in the South Island DHBs.	Q2,3,4	Embed the necessary elements of comprehensive clinical assessment (interRAI) processes for older people in the South Island DHBs.	Embed the necessary elements of comprehensive clinical assessment (interRAI) processes for older people in the South Island DHBs.	Contributors: HOPSLA, SI HOP PM, SI System Clinicians Reported in: SIHSP
6b	Advocate to encourage use of the information from comprehensive clinical assessment (interRAI) proactively in plan of care.				
Monitor population and service data trend to influence changes in service through advocacy					
7	Monitor interRAI reports to identify equity, population and service trends data to influence changes in service through advocacy.	Q1,2,3,4	Monitor population and service trends data to influence changes in service through advocacy.	Monitor population and service trends data to influence changes in service through advocacy.	Contributors: HOPSLA, SI HOP PM, SI System Clinicians Reported in: SIHSP
FALLS PREVENTION & FRACTURE LIAISON SERVICE					
South Island DHBs are supported to develop evidence based Fracture Liaison Service **A South Island Policy on Community Based Falls Prevention Programmes based on the evidence of the Otago Exercise Programme**					
8a	Facilitate South Island DHBs to share information and ideas to progress falls prevention and embed Fracture Liaison Services.	Q2,4	Implement well tested programmes for fall and fracture prevention in South Island DHBs.	Implement well tested programmes for fall and fracture prevention in South Island DHBs.	Contributors: HOPSLA+Q&S SLA, SI HOP PM, Falls Prevention teams, FLS teams Reported in: SIHSP
8b	Encourage development of Fracture Liaison Services in each South Island DHB	Q3	Opportunities for further developments of Falls prevention/FLS are identified.	Opportunities for further developments of Falls prevention/FLS are identified.	
ADVANCE CARE PLANNING					
South Island DHBs are supported to develop Advance Care Plan (ACP systems and processes to embed ACP as standard practice for those who will benefit					
9a	Support DHBs to develop ACP system implementation with processes to embed ACP as standard practice for those who will benefit.	Q2,4	South Island DHBs are supported to develop ACP systems and processes to embed ACP as standard practice for those who will benefit.	South Island DHBs are supported to develop ACP systems and processes to embed ACP as standard practice for those who will benefit.	Contributors: HOPSLA, SI ACP Steering Group Reported in: SIHSP
9b	ACP L 2 Training is available in a planned manner for staff in each DHB district in South Island.	Q1,3	ACP L2 Training is available in a planned manner for staff in each DHB district in South Island.	ACP L2 Training is available in a planned manner for staff in each DHB district in South Island.	Contributors: HOPSLA, SI ACP Steering Group Reported in: SIHSP
9c	Support South Island DHBs to develop regionally consistent systems, processes and policies to embed ACP as standard practice for.	Q1,2,3,4	Each South Island DHBs develop and implement a system to moderate individuals written ACP before plan published electronically.	An individual's written ACP form is available electronically at the point of acute care including ambulance.	Contributors: HOPSLA, SI ACP Steering Group, SI DHBs Reported in: SIHSP
			Regionally consistent South Island ACP Policies are embedded within each DHB.		

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSIBLITIES
South Island DHB are supported to participate in "Conversations that Count" (CtC) awareness raising day April 2015					
10a	Support South Island DHBs to participate and support National Conversations that Count Day. This will encourage individuals, communities and health staff to have conversations useful for a person to document their ACP and develop a shared understanding of an individual's choice.	Q2,3	Encourage and Support individuals, communities and health staff to have conversations useful for a person to document their ACP and develop a shared understanding of an individual's choice.	Encourage and Support individuals, communities and health staff to have conversations useful for a person to document their ACP and develop a shared understanding of an individual's choice.	Contributors: HOPSLA, SI ACP Steering Group Reported in: SIHSP
10b	CtC education (Peer education for the public delivered 'by the public') is available in each South Island DHB.	Q3	CtC education (Peer education for the public delivered 'by the public') is available in each SI DHB.	CtC education (Peer education for the public delivered 'by the public') is available in each South Island DHB.	
ACPs incorporated into the regional IS system/plan					
11	Develop and implement an electronic ACP accessible to all health care clinicans.	Q1,2,3,4	The South Island patient management system is able to provide an individual's written ACP form electronically at the point of acute care.	An individual's written ACP form is available electronically at the point of acute care.	Contributors: HOPSLA, SI ACP Steering Group Reported in: SIHSP

Palliative Care Services

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

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

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

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

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

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

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

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSBILITIES
CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION					
PALLIATIVE CARE					
INFORMATION TECHNOLOGY AND SERVICES					
By using new electronic systems and tools health professionals are able to securely share and gather relevant patient information that will result in safer, better and timely palliative care to patients					
1a	To inform and influence information systems to support the delivery of more efficient and safer transfer of patient information between Palliative Care Providers (including Hospice services) across the South Island while reducing costs and risk.	Q4	Ongoing implementation of Information Technology developments.	Ongoing implementation of Information Technology developments.	Contributors: SI PCW, IS SLA Reported in: SIHSP
1b	Support the development of a business case and pilot for the implementation of the Palliative Care tool of InterRAI by Canterbury DHB (in partnership with Mid Central and Hawke's Bay DHBs)	Q4	Evaluate the success of the pilot and consider roll out to other South Island DHBs based on outcome of pilot	Roll out as agreed	
HOSPICE AND HOSPITAL PALLIATIVE CARE SERVICES					
To provide all people who are dying and their family /whānau access to an equitable and quality palliative care service wherever that service may be located in the South Island					
2a	Understand the current models of care and how hospital and hospice palliative care services.	Q4	Develop and monitor and work identified as a result of the benchmarking.	Develop and monitor and work identified as a result of the benchmarking.	Contributors: SI PCW Reported: SIHSP
2b	Benchmark against the Resource and Capability Framework for Integrated Adult Palliative Care Services in New Zealand MOH 2013 and the Guidance for Integrated	Q4			

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSBILITIES
	Paediatric Palliative Care Services in New Zealand 2012).				
PRIMARY AND COMMUNITY CARE					
To provide the expertise and resources to enable patients to die in their preferred place of care.					
3a	To explore the provision of Primary Palliative Care and support services to consumers and communities (Including St John, Maori, Allied Health, NGOS, Private).	Q4	Address the gaps in our knowledge about Primary Palliative care providers and what their needs are for the future.	Address the gaps in our knowledge about Primary Palliative care providers and what their needs are for the future.	Contributors: SI PCW Reported in: SIHSP
3b	Understand the current workforce delivering Palliative Care in the community(s) and identify any workforce development opportunities.	Q3	Continue to access and apply current workforce analysis, planning and implementation.	Continue to access and apply current workforce analysis, planning and implementation.	Contributors: SI PCW Reported in: SIHSP
3c	Support HWNZ initiative to create Specialist Nurse and Educator roles to support primary care and ARC.	Q2			
NETWORKING AND ENGAGEMENT					
4	To demonstrate communication with Consumers and Maori on their experience of End of life and PC services in the South Island based on information obtained from the patients and their family/whānau's experience. To include key socio-demographic variables, including ethnicity and age.	Q4	Ongoing implementation of findings through consultation(s) with consumers and their whānau.	Ongoing implementation of findings through consultation(s) with consumers and their whānau.	Contributors: SI PCW Reported in: SIHSP

Cardiovascular services

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

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

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

The Cardiac 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.

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

- Meeting National Indicators.
- Equity of Access.
- Health Pathways.
- Chest Pain Pathway.
- Guidelines for the Arranged Transporting of Cardiac Patients & Transporting/Retrieving of Emergency/Acute Cardiac Patients.
- Minimum Facilities Guidelines.
- Workforce Training.
- ECG Storage and Sharing.
- Heart Failure.
- First specialist assessment.

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSBILITIES
CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION					
CARDIAC SERVICES					
MEETING NATIONAL INDICATORS **Improved outcomes for people with suspected Acute Coronary Syndrome**					
Standardised intervention rates for ACS patients					
1a	>70% of high-risk ACS patients accepted for coronary angiography having it within 3 days of admission. ('Day of Admission' being 'Day 0').	Q1,2,3,4	Continued achievement of national indicators as determined by/modified by National Health Board in conjunction with the National Cardiac network.	Continued achievement of national indicators as determined by/modified by National Health Board in conjunction with the National Cardiac network.	Contributors: Individual Contributors: Individual DHB Service Managers , Planning & Funding staff - support/advice from IS SLA Reported in: SIHSP
1b	>95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS & Cath/Percutaneous Coronary Intervention (PCI) registry data collection, within 30 days.	Q1,2,3,4	Continued achievement of national indicators as determined by/modified by National Health Board in conjunction with the National Cardiac network.	Continued achievement of national indicators as determined by/modified by National Health Board in conjunction with the National Cardiac network.	Contributors: Individual DHB Service Managers , Planning & Funding staff - support/advice from IS SLA Reported in: SIHSP
1c	Achieve Percutaneous revascularisation target rate of	Q1,2,3,4	Continued achievement of national indicators as determined	Continued achievement of national indicators as determined	Contributors: Individual DHB Service Managers ,

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSBILITIES
	at least 12.5 per 10,000 of population.		by/modified by National Health Board in conjunction with the National Cardiac network.	by/modified by National Health Board in conjunction with the National Cardiac network.	Planning & Funding staff - support/advice from IS SLA Reported in: SIHSP
1d	Achieve Coronary angiography target rate of at least 34.7 per 10,000 of population.	Q1,2,3,4	Continued achievement of national indicators as determined by/modified by National Health Board in conjunction with the National Cardiac network.	Continued achievement of national indicators as determined by/modified by National Health Board in conjunction with the National Cardiac network.	Contributors: Individual DHB Service Managers , Planning & Funding staff - support/advice from IS SLA Reported in: SIHSP
Cardiac surgery targets achieved which will improve equity of access as identified and agreed by The National Cardiac Network					
2a	Maintain standardised intervention rates: Cardiac surgery: 6.5 per 10,000 of population.	Q1,2,3,4	Continued achievement of national indicators as determined by/modified by National Health Board in conjunction with the National Cardiac network.	Continued achievement of national indicators as determined by/modified by National Health Board in conjunction with the National Cardiac network.	Contributors: Individual DHB Service Managers , Planning & Funding staff. Reported in: SIHSP
2b	Achieve agreed proportion of patients scored using the national cardiac surgery Clinical Priority Access (CPAC) tool, and of patients treated within assigned urgency timeframe.				
2c	The waiting list for cardiac surgery remains between 5% and 7.5% of planned annual cardiac throughput, and does not exceed 10% of annual throughput.				
2d	Patients wait no longer than four months for a cardiology first specialist assessment, or for cardiac surgery.				
2e	>95% of patients undergoing cardiac surgery will have completion of Cardiac Surgery registry data collection within 30 days of discharge.				
EQUITY OF ACCESS **Ensure access to angiography for high risk populations group such as Māori, Pacific and South Asian people**					
Strategies to support access to angiography for Māori, and other high risk population groups					
3	Monitor access rates for high risk population groups.	Q1,2,3,4	Continue to monitor access rates for high risk population groups.	Continue to monitor access rates for high risk population groups.	Contributors: Delegated Workstream members & Facilitator Reported in: SIHSP
HEALTH PATHWAYS **Health pathway are agreed and utilised**					
Percutaneous Coronary Intervention (PCI) regional health pathways for acute coronary syndrome patients across the South Island					
4a	Agree PCI regional HealthPathway	Q1	Report on regional pathway usage.	Report on regional pathway usage.	Contributors: Regionally by Facilitator Reported in: SIHSP
4b	PCI HealthPathway live and accessible on the Regional HealthPathways site.	Q3	Report on regional pathway usage.	Report on regional pathway usage.	Contributors: Regionally by Facilitator Reported in: SIHSP
CHEST PAIN PATHWAY					
An agreed accelerated chest pain pathway which will reduce unnecessary admissions					
5a	Completed accelerated chest pain pathway workshops across the South Island DHBs	Q1	Report on regional pathway usage.	Report on regional pathway usage.	Contributors: Delegated Workstream members & Facilitator Reported in: SIHSP
5b	Agree processes and protocols for accelerated chest pain pathway	Q2			
5c	Implement accelerated chest pain pathway in 3 South Island DHBs	Q3			

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSBILITIES
5d	Implement accelerated chest pain pathway in remaining South Island DHBs	Q4			
GUIDELINES FOR THE ARRANGED TRANSPORTING OF CARDIAC PATIENTS					
Regionally agreed guidelines for the arranged transportation of cardiac patients					
6	Review agreed 2013 guidelines and update if required (2 year cycle).	Q4		Guidelines agreed in 2015 to be reviewed and updated if required (2 year cycle).	Contributors: Delegated Workstream members & Facilitator Reported in: SIHSP
GUIDELINES FOR THE TRANSPORTING/RETRIEVING OF EMERGENCY/ACUTE CARDIAC PATIENTS					
Regionally agreed guidelines for the transporting/retrieving of emergency/acute cardiac patients					
7	Report developed and endorsed by key stakeholders, based on meeting the less than 90 minute transport/retrieval time.	Q4	Maintain improved transfer times.	Maintain improved transfer times.	Contributors: Delegated Workstream members, particularly St John representative Reported in: SIHSP
MINIMUM FACILITIES GUIDELINES					
Prepare current status document of regional and rural South Island Hospitals' financial and time requirements to meet minimum guidelines for cardiac facilities					
8	Review agreed 2013 guidelines and update if required (2 year cycle).	Q4		Guidelines agreed in 2015 to be reviewed and updated if required (2 year cycle).	Contributors: Delegated Workstream members, particularly representing Planning & Funding, & Facilitator Reported in: SIHSP
WORKFORCE TRAINING					
Workforce training maintained					
A regional approach to cardiology nurse training developed in collaboration with the South Island Regional Training Hub. Initial focus to include: **-increased exposure to cardiology during nursing training** **-training opportunities in New Zealand for Clinical Nurse Specialists in Cardiology.**					
9	Agree and implement a draft plan developed by CDHB staff.	Q1,2,3,4	Continued uptake of education opportunities.	Continued uptake of education opportunities.	Contributors: Cardiac Nurse Educator in each district & Facilitator, with support/advice from SIWDH Reported in: SIHSP
Opportunities for training in echocardiography identified					
10	Develop and implement an action plan.	Q3	Continued uptake of education opportunities.	Continued uptake of education opportunities.	Contributors: Delegated Workstream members, with support/advice from SIWDH Reported in: SIHSP
Investigate the feasibility of establishing a National Registrar training rotation that would be regionally based in line with other specialties					
11	Determine feasibility of establishing a National Registrar training rotation that would be regionally based in line with other specialties.	Q3	Continued uptake of education opportunities.	Continued uptake of education opportunities.	Contributors: Delegated Workstream members, with support/advice from SIWDH Reported in: SIHSP
ECG STORAGE AND SHARING					
A common regional method of storing and sharing Electrocardiogram (ECGs)					
12	Implement a South Island Clinical Electrocardiogram data repository and software.	Q4	Maintain common regional method of storing and sharing ECGs.	Maintain common regional method of storing and sharing ECGs.	Contributors: Delegated Workstream members & Facilitator, with support/advice from IS SLA Reported in: SIHSP
HEART FAILURE					
Implement locally, regionally and nationally agreed protocols, guidance, processes and systems to ensure optimal management of patients with heart failure.					
13a	Determine current clinical situation of the management	Q1	Continued achievement of national indicators as determined	Continued achievement of national indicators as determined	

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSBILITIES
	of patients with heart failure across South Island DHBs.		by/modified by National Health Board in conjunction with the National Cardiac network.	by/modified by National Health Board in conjunction with the National Cardiac network.	Contributors: Delegated Workstream members Reported in: SIHSP
13b	Identify resources required and barriers to the management of patients with heart failure in the South Island.	Q2			
13c	Utilise primary pathways for the management of patients with heart failure in all South Island DHBs.	Q3			
FIRST SPECIALIST ASSESSMENT					
Assist the National Network in developing a nationally agreed standard of patient referrals for the first assessment.					
14	Implement agreed standard of patient referrals for the first assessment.	Q4	Consistent standard of patient referrals for the first assessment applying nationally.	Consistent standard of patient referrals for the first assessment applying nationally.	Lead: National Network & supported by SI workstream Reported in: SIHSP

Elective Services

Sustainable, equitable elective services for South Islanders

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

Chief Operating Officers (South Island DHBs)

The South Island Alliance Elective Services Workstream is now led by GMs Planning & Funding and Hospital General Managers who will:

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

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

- Improve (equity) access to Elective Services.
- Regional/Sub-regional Collaboration (in priority areas), with attention to clinical and business processes.
- Workforce, with attention to recruitment and retention, and collegiality in the South Island.

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSIBLITIES
CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION					
ELECTIVE SERVICES					
IMPROVE EQUITY OF ACCESS TO ELECTIVE SERVICES					
1	Improve equity of access, system quality and practice in selected elective service areas through the establishment of project teams.	Q4	Yet to be determined.	Yet to be determined.	Contributors: SI Electives project groups Reported in: SIHSP
Urology					
2a	Implement South Island urology HealthPathways.	Q1	Yet to be determined.	Yet to be determined.	Contributors: SI Electives project groups Reported in: SIHSP
2b	Agree and implement consistent triage and prioritisation processes for urology referrals.	Q2			
2c	Urology nursing practice & service delivery supports clinical consistency, equity of access and improved patient outcomes via Lippincott Procedures Manual implementation.	Q2			
Bariatric Surgery					
3a	Evaluate the first year of the service, and the local and South Island HealthPathways.	Q1	Yet to be determined.	Yet to be determined.	Contributors: SI Electives project groups Reported in: SIHSP
3b	Provide evaluation to the MOH.	Q2			
Cardiac Interventions					
4	Develop South Island Model of Care and engage with key stakeholders.	Q2	Yet to be determined.	Yet to be determined.	Contributors: SI Electives project groups Reported in: SIHSP

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSIBLITIES
Infertility					
5a	Agree the process for a single South Island waiting list.	Q2	Yet to be determined.	Yet to be determined.	Contributors: SI Electives project groups Reported in: SIHSP
5b	Fully operationalize the service across the South Island.	Q2			
Plastics					
6a	Establish process and criteria for access to plastic surgery to bariatric patients (Body contouring following massive weight loss HealthPathway).	Q4	Yet to be determined.	Yet to be determined.	Contributors: SI Electives project groups Reported in: SIHSP
6b	Support South Island DHBs to meet ESPI targets.	Q1,2,3,4			
6c	Prepare for implementation of 3 Plastics national prioritization tools (currently in testing phase): Appearance related deformity (Breast & Body); Plastics Other; Skin Lesions, sharing learnings.	Q2			
6d	Localise Plastics HealthPathways across 5 South Island DHBs.	Q4			
Vascular					
7	Assess the benefits of developing a sustainable Model of Care for the South Island.	Q3	Yet to be determined.	Yet to be determined.	Contributors: SI Electives project groups Reported in: SIHSP
Ophthalmology					
8a	Assess the benefits of consistent SI preparation for implementation of the national cataracts tool (due 2016) across the South Island.	Q2	Yet to be determined.	Yet to be determined.	Contributors: SI Electives project groups Reported in: SIHSP
8b	Assess the benefits of consistent macular degeneration service protocols and thresholds across the South Island (NB Midland region has done similar work which may be useful).	Q2			
Maxillofacial					
9	Identify requirements for a sustainable Maxillofacial workforce for the South Island.	Q3	Yet to be determined.	Yet to be determined.	Contributors: SI Electives project groups Reported in: SIHSP
Selected Elective Services					
10	Identify baseline for Maori access (current and evidence) in selected priority areas.	Q1,2,3,4	Yet to be determined.	Yet to be determined.	Contributors: SI Electives project groups Reported in: SIHSP
11	Collate and share innovations in the selected service areas via best practice documents and use of HealthPathways.	Q1,2,3,4			
12	Provide Ministry of Health with South Island Electives Programme Stage 6 final evaluation report.	Q3			

Work supported by the Electives Workstream

The Electives Workstream will support the delivery of the following national projects:

NATIONAL INITATIVES
National projects supported by the Electives Workstream: **Project: National Patient Flow** Owner: Nationally led

The Electives Workstream will support the South Island DHBs, individually and collectively, to achieve the Government's Health Targets and targets for EPSIs Two and Five.

REGIONAL INITATIVES
Improve access to elective services
Delivery against agreed volume schedule, including elective surgical discharges, to deliver the Electives Health Target.
Owner: Individual South Island DHBs
Reported: Individually by the South Island DHBs quarterly
Maintain reduced waiting times for elective first specialist assessment and treatment
Elective Services Patient Flow Indicators expectations are met, and patients wait no longer than four months for first specialist assessment and treatment, and all patients are prioritised using the most recent national tool available.
Owner: Individual South Island DHBs
Reported: Individually by the South Island DHBs quarterly
Lippincott Procedures Manual (pg.82 item 2b)
Agree South Island localisation of Lippincott nursing procedures for Urology Services
Owner: South Island Workforce Development Hub

Major Trauma Services

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

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

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

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

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

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

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

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSIBLITIES
CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION					
MAJOR TRAUMA SERVICES					
SOUTH ISLAND MAJOR TRAUMA SERVICES					
Systems and processes agreed to support people surviving major trauma and recovering with a good quality of life					
1a	Agree and progress the requirements for systems and process to support the people of the South Island surviving and recovering from major trauma.	Q4	Baseline reporting against the defined performance indicators.	Baseline reporting against the defined performance indicators.	Contributors: Workstream members & facilitator Reported in: SIHSP
1b	Agree and develop regional clinical guidelines for the management of trauma	Q4	Annual Report for the region for the period ending June 2016 is prepared and presented.		
NZ MAJOR TRAUMA MINIMUM DATASET					
System established for South Island region major trauma data collection					
2a	Agree data collection systems/processes for the NZ Major Trauma Minimum Dataset	Q1	Continue to capture and record data for the NZ Major Trauma Minimum Dataset.	Continue to capture and record data for the NZ Major Trauma Minimum Dataset.	Contributors: Workstream members & facilitator Reported in: SIHSP
2b	Confirm required data fields for the NZ Major Trauma Minimum Dataset	Q2			
2c	Commence capturing and recording data for the NZ Major Trauma Minimum Dataset	Q2			
Establish regional oversight role to ensure any actions required to contribute to NZMYMD collection are implemented					
3	Establish regional oversight role to ensure any actions required to contribute to NZMYMD collection are implemented.	Q2	Regional oversight role maintained.	Regional oversight role maintained.	Contributors: Workstream members & facilitator with input from IS specialists Reported in: SIHSP

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSIBLITIES
CLINICAL LEADERSHIP					
South Island DHBs major trauma clinical leaders; co-ordinators; and administrators appointed					
4a	Identify options for clinical lead and coordinator roles across South Island DHBs within current resources.	Q1	Continued clinical lead and coordinator roles in each DHB.	Continued clinical lead and coordinator roles in each DHB.	Contributors: Workstream members, & planning & funding representatives in particular Reported in: SIHSP
4b	Confirm staffing configuration of the 2 South Island Clinical Hubs (Dunedin, Christchurch)	Q1			
4c	Confirm staffing configuration for the remaining South Island DHBs	Q1			
WORKFORCE					
Regions and DHBs are encouraged to explore opportunities for additional experience to be provided to trauma care providers at centres with more exposure to major trauma management.					
5	Develop a training plan to ensure relevant clinical staff are appropriately trained in trauma care.	**Q2**	Implementation of Training plan.	Implementation of Training plan.	Contributors: Workstream members & facilitator Reported in: SIHSP
DESTINATION POLICIES					
Implementation of Regional Destination Policies in collaboration with DHBs, Ambulance and Air Transport providers					
6	Implement Regional Destination Policies in collaboration with DHBs, Ambulance and Air Transport providers	Q2	Regional Destination Policies maintained.	Potential in conjunction with transfer policies for on-line regional health pathway to be developed.	Contributors: Workstream members, & St John & ACC representatives in particular Reported in: SIHSP
INTER HOSPITAL TRANSFER PROTOCOLS					
Development and implementation of inter-hospital transfer protocols.					
7	Develop and implement Inter-hospital transfer protocols.	Q2	Inter-hospital transfer protocols maintained.	Potential for on-line regional health pathway to be developed.	Contributors: Workstream members, & St John in particular Reported in: SIHSP
SPINAL CORD IMPAIRMENT ACTION PLAN					
Acknowledge South Island DHBs' intentions regarding MoH requirements as outlined in the New Zealand Spinal Cord Impairment Action Plan 2014-2019.					
8	Recognise the development of acute supra regional spinal services and early rehabilitation pathways, (Canterbury DHB) and support as required.	Q4			Lead: CDHB Reported in: CDHB quarterly report

Public Health Services

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

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

Clinical Lead: **Ed Kiddle, Clinical Director and Medical Officer of Health (Nelson Marlborough DHB)**

The South Island Public Health Partnership has been formed to:

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

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

- Alcohol.
- Tobacco.
- Sustainability.
- Rheumatic fever.
- Māori.
- Other health determinants – Housing, Healthy Families and Communities (Obesity Prevention) and DHB Position Statements.

MILESTONE DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSBILITIES
CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION					
PUBLIC HEALTH					
ALCOHOL					
South Island DHBs' Alcohol Position Statement and DHB Alcohol Harm Reduction Strategies (AHRS)					
1a	Monitor alcohol harm reduction efforts (e.g. Strategy development and implementation) across South Island DHBs and identifying outcome trends for DHBs and South Island communities.	Q2,4	Monitor alcohol harm reduction efforts) across South Island DHBs and identifying outcome trends for DHBs and South Island communities.	Monitor alcohol harm reduction efforts) across South Island DHBs and identifying outcome trends for DHBs and South Island communities.	Contributors: SI Alcohol workgroup, SI PHP Management group, SI PHP Child Health liaison person & SI DHB Senior executive/ management teams. Reported in: SIHSP
1b	Agree plan for production of annual indicator reports.	Q2,4	Production of annual reports and submission to relevant DHB departments.	Production of annual reports and submission to relevant DHB departments.	
1c	Identify plan for data development projects.	Q2,4	New data informs initiative development.	Ongoing development.	
1d	DHB Alcohol Harm Reduction Strategy (AHRS) promotion (South Island PHP responsible). Strategies in place and implemented by all South Island DHBs (South Island DHBs responsible).	Q2,4	Strategies and projects developed for consideration based on information produced in a, b, c and d.	Ongoing development.	
1e	Coordinated health promotion and health protection activity demonstrated South Island-wide where joint South Island activity adds value e.g. development of school policies and legal responses as needed.	Q2	Identification of joined up activity/projects where added in value in South Island approach.	Identification of joined up activity/projects where added in value in South Island approach.	Contributors: SI Alcohol Workgroup Reported in: SIHSP

MILESTONE DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSBILITIES
TOBACCO					
South Island DHBs' Tobacco Position Statement and joint South Island –wide smokefree initiatives implemented and evaluated according to National Smokefree Coalition Action Plan.					
2a	Ongoing focus on collation and review of needs analyses data to help inform process to achieve Smokefree 2025.	Q2,4	Ongoing focus on collation and review of needs analyses data to help inform process to achieve Smokefree 2025.	Ongoing focus on collation and review of needs analyses data to help inform process to achieve Smokefree 2025.	Contributors: SI Tobacco Workgroup Reported in: SIHSP
2b	Focus will be on creating joined-up process for the development of DHBs' Smokefree Control Plans and seeking collaborative communication opportunities.	Q2,4	Review extent of shared South Island activity and consider appropriateness and PHU readiness for a South Island combined initiative.	Yet to be determined.	Contributors: SI Tobacco Workgroup, SI Partnership Management group, DHB Communications personnel. Reported in: SIHSP
SUSTAINABILITY					
Increased awareness around environmental sustainability and the co-benefits of action in this area for population health. Project plans implemented & monitored. Short-term: Number and quality of new initiatives Long-term: Measures of environmental sustainability with public health co-benefits.					
3a	Prepare sustainability Policy / Position Statement.	Q4	X no. of DHBs have Sustainability policies / Position Statements	Yet to be determined.	Contributors: SI Public Health Analysts Network / SI Sustainability Workgroup SI DHBs Reported in: SIHSP
3b	All South Island DHBs are members of the Green and Healthy Hospital Initiative (GGHI).	Q3	X no of GGHHI projects carried out by DHBs.	Yet to be determined.	
3c	Promotion of consistent environmental / sustainability monitoring systems.[4]	Q4	Energy use and carbon monitoring data is reported to the Board	Information is utilised to develop projects (as in 3b and 3d)	Contributors: SI Sustainability Workgroup in liaison with SI Support Services SLA Reported in: SIHSP
3d	Identify projects where specific synergies occur with public health and environmental benefit (co-benefits approach) e.g. relevant to other regional priority areas.	Q2,4	X no. of projects which flow on from the Workshop.	Yet to be determined.	Contributors: Sustainability Workgroup in liaison with SI Support Services SLA, SI PHP Management group. SI DHBs. Reported in: SIHSP
RHEUMATIC FEVER					
South Island Rheumatic fever cases monitored The Partnership supports DHBs to have mechanisms in place to ensure the Rheumatic Fever Prevention and Management Plan is implemented as intended					
4	Ongoing monitoring and collective South Island public health response to results.	Q2,4	Surveillance reports continue to show Rheumatic Fever case numbers and disease rates across the South Island.	Surveillance reports continue to show Rheumatic Fever case numbers and disease rates across the South Island.	Contributors: SI Medical Officers of Health via SI PHP Management group. Reported in: SIHSP
MĀORI					
Public health services in the priority areas and through workforce development are responsive to Māori health issues and improve equity					
5	Work in partnership with Te Herenga Hauora to develop key messages on South Island priority public health issues as they pertain to Māori.	Q2,4	X no. of key messages or communiqués where liaison between public health and the Māori GMs.	Yet to be determined.	Contributors: SI PHP Management group, Māori GMs (Te Herenga Hauora) Reported in: SIHSP
OTHER HEALTH DETERMINANTS					
Housing					
6	Support for DHB efforts to address housing where it impacts health outcomes, including multistakeholder and intersectoral engagement.	Q2,4	X no. of DHBs with Housing Position Statements.	Yet to be determined.	Contributors: SI PHP Management group. SI PH Analysts, Comms personnel, PHP Facilitator, SI DHBs Reported in: SIHSP

[4] Note, public health can seek to influence here but the outcome is highly dependent on wider DHB commitment and support.

MILESTONE DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSBILITIES
Obesity and obesogenic environments					
7a	Explore the impact and learnings from the two Healthy Families NZ Communities to contribute to wider South Island PHU/DHB efforts	Q2,4	To be determined in response to findings in 15-16	Yet to be determined.	Contributors: PHS/SDHB,CPH/CDHB & SI PHP Management group Reported in: SIHSP
7b	Review opportunities for a co-ordinated South Island response to obesity and obesogenic environments	Q2,4	To be determined in response to findings in 15-16	Yet to be determined.	Contributors: SI PH Analysts network Reported in: SIHSP
DHB position statements					
8	Stocktake of South Island DHB Position statements and identification of opportunities for development of similar position statements on key public health issues e.g. Housing and Fluoridation. Fluoridation Position Statement to be rolled out in South Canterbury and Nelson Marlborough DHB first.	Q2,4	X no of shared Position Statements in place across South Island DHBs.	Yet to be determined.	Contributors: SI PHP Management group, SI PHP Facilitator, SI Child Health SLA, SI PH Analysts & SI PHP Management group, SI DHBs, SI Hospital Dentists Reported in: SIHSP

Regional projects supported by the Public Health Partnership but led by other SLAs and Workstreams
South Island Children's Action plan (pg.46 item 1)
Owner: Child Health SLA
Identify and monitor the implementation of agreed South Island regional interventions to better manage safety, reduce family violence and childhood poverty
Support programmes which reduce youth risk taking resulting in injury/disease from alcohol (pg. 46 item 4a)
Owner: Child Health SLA
In partnership with the Health Promotion Agency, Child Health and Mental Health Service Level Alliances implement findings of South Island Emergency Department scoping exercise
Child Health Obesity Prevention programmes (pg47 item 6a)
Owner: Child Health SLA
The Public Health Partnership will keep abreast of Child Health-led programmes and seek opportunities to link with a public health approach.
Child Health Obesity Prevention programmes (pg47 item 6b)
Owner: Child Health SLA
Enhance collaboration with child health dental services.

Stroke Services

Delivering Organised Stroke Services - Best stroke care, everywhere

Clinical Lead: **Dr John Fink**

The South Island Stroke Workstream has been formed to:

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

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

- Equitable access to Acute Stroke Services for the South Island Population.
- Integrated Stroke Rehabilitation Services for the South Island Population.
- Workforce Planning and Development.

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSBILITIES
CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION					
STROKE SERVICES					
EQUITABLE ACCESS TO ACUTE STROKE SERVICES FOR THE SOUTH ISLAND POPULATION					
Ensure rapid access to treatment for potential thrombolysis candidates					
1	Agree and implement a system to rapidly confirm a diagnosis of stroke and identify patients who may benefit from thrombolysis therapy. Each SI DHB has a system to rapidly confirm a diagnosis of stroke and identify patients who may benefit from thrombolysis therapy and this system is implemented in each South Island DHB.	Q2,4	Each South Island DHB has a system to rapidly confirm a diagnosis of stroke and identify patients who may benefit from thrombolysis therapy implemented in each South Island DHB.	Each South Island DHB has a system to rapidly confirm a diagnosis of stroke and identify patients who may benefit from thrombolysis therapy implemented in each South Island DHB.	Contributor: SI Stroke Workstream, Facilitator & SI DHB Stroke Teams Reported in: SIHSP
Support all South Island DHBs to have stroke thrombolysis pathways					
2a	Achieve 6% compliance for thrombolysis of eligible stroke clients.	Q2,4	Achieve 6% compliance for thrombolysis of eligible stroke clients.	Achieve 8% compliance for thrombolysis of eligible stroke clients.	Contributor: SI Stroke Workstream, Facilitator & SI DHB Stroke Teams Reported in: SIHSP
2b	Thrombolysis register is used in a consistent manner in South Island DHBs and reported regionally.	Q2,4			
Organised stroke services /units					
3	Achieve 80% compliance for stroke patients to be cared for in organised stroke unit (for smaller DHBs with demonstrated stroke pathway as defined by lead Stroke Clinician).	Q2,4	Achieve 80% compliance for stroke patients to be cared for in organised stroke unit (for smaller DHBs with demonstrated stroke pathway as defined by lead Stroke Clinician).	Achieve 80% compliance for stroke patients to be cared for in organised stroke unit (for smaller DHBs with demonstrated stroke pathway as defined by lead Stroke Clinician).	Contributor: SI Stroke Workstream, Facilitator & SI DHB Stroke Teams Reported in: SIHSP
Organised stroke services are accessible and appropriate for Māori and Pacific people					
4	Monitor stroke access data by ethnicity and report regionally.	Q2,4	Achieve 80% compliance for stroke patients to be cared for in organised stroke unit (for smaller DHBs with demonstrated stroke pathway as defined by lead Stroke Clinician).	Achieve 80% compliance for stroke patients to be cared for in organised stroke unit (for smaller DHBs with demonstrated stroke pathway as defined by lead Stroke Clinician).	SI Contributor: SI Stroke Workstream, Facilitator & SI DHB Stroke Teams Reported in: SIHSP

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSBILITIES
Support Participation in Stroke Audit					
5	South Island DHBs use standardised audit tools which are specific to delivery of Organised Stroke Services to regularly undertake quality assurance activities to inform continued improvement.	Q1,2,3,4,	South Island DHBs deliver integrated stroke services which reflect best practice and are regionally consistent. South Island DHB should undertake an audit of their clinical practice at least every second year.	South Island DHBs deliver integrated stroke services which reflect best practice and are regionally consistent. South Island DHB should undertake an audit of their clinical practice at least every second year.	Contributor: SI Stroke Workstream, Facilitator & SI DHB Stroke Teams Reported in: SIHSP
Risks and mitigation strategies for geographic isolation					
6	South Island DHB are supported to develop policies and protocols - utilising technology /distance expertise /transport to support isolated communities to deliver best practice stroke care.	Q3	Each South Island DHB has their own individual, or shared, plan/protocols in place to enable rural communities to access best practice stroke care.	Each South Island DHB has their own individual, or shared, plan/protocols in place to enable rural communities to access best practice stroke care.	Contributor: SI Stroke Workstream, Facilitator & SI DHB Stroke Teams Reported in: SIHSP
INTEGRATED STROKE REHABILITATION SERVICES FOR THE SOUTH ISLAND POPULATION					
System used to measure agreed stroke rehabilitation targets / indicators.					
7	South Island DHBs deliver inpatient and community stroke rehabilitation services which reflect best practice and are regionally consistent.	Q2,4	South Island DHBs deliver inpatient and community stroke rehabilitation services which reflect best practice and are regionally consistent.	South Island DHBs deliver inpatient and community stroke rehabilitation services which reflect best practice and are regionally consistent.	Contributor: SI Stroke Workstream, Facilitator & SI DHB Stroke Teams Reported in: SIHSP
WORKFORCE PLANNING AND DEVELOPMENT					
Named stroke specialist/s within the inter-disciplinary team					
8	Each South Island DHB has a named lead rehabilitation clinician for stroke rehabilitation.	Q4	Each South Island DHB has a named lead rehabilitation clinician for stroke rehabilitation with specific remit to develop and improve Stroke Rehabilitation Services for that DHB.	Each South Island DHB has a named lead rehabilitation clinician for stroke rehabilitation with specific remit to develop and improve Stroke Rehabilitation Services for that DHB.	Contributor: SI Stroke Workstream, Facilitator & SI DHB Stroke Teams Reported in: SIHSP
Named lead stroke physician & nurse in each DHB with specific remit to develop and improve Stroke Services for that DHB					
9	Each South Island DHB has a named lead stroke physician with specific remit to develop and improve Stroke Services for that DHB	Q4	Each South Island DHB has a named lead stroke clinician with specific remit to develop and improve Stroke Services for that DHB	Each South Island DHB has a named lead stroke clinician with specific remit to develop and improve Stroke Services for that DHB	Contributor: SI Stroke Workstream, Facilitator & SI DHB Stroke Teams Reported in: SIHSP
Name lead stroke nurse in each DHB with specific remit to develop and improve Stroke Services for that DHB					
10	Each South Island DHB has a designated Lead Stroke Nurse *who has assigned non clinical hours to achieve the Stroke Nurse role. Including developing and improving the Stroke Service. (In small centres it may not be a fulltime position).*	Q4	Each South Island DHB has a designated Lead Stroke Nurse who has assigned non clinical hours to achieve the role. (In small centres it may not be a fulltime position).	Each South Island DHB has a designated Lead Stroke Nurse who has assigned non clinical hours to achieve the role. (In small centres it may not be a fulltime position).	Contributor: SI Stroke Workstream, Facilitator & SI DHB Stroke Teams Reported in: SIHSP
Health professionals have access to continuing education for acute, rehabilitation and long-term/chronic stroke management					
11	South Island Stroke teams have access to a range of educational opportunities to support continued development of knowledge and skill in delivering best practice stroke services.	Q1,4	South Island Stroke teams have access to a range of educational opportunities to support continued development of knowledge and skill in delivering best practice stroke services.	South Island Stroke teams have access to a range of educational opportunities to support continued development of knowledge and skill in delivering best practice stroke services.	Contributor: SI Stroke Workstream, Facilitator & SI DHB Stroke Teams Reported in: SIHSP

Key Enablers

Quality and Safety Services

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

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

The Quality and Safety SLA has been formed to:

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

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

- Open for Better Care.
- Promoting Safety 1st Framework.
- Partners in Care.
- Clinical Governance.

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSBILITIES
KEY ENABLERS					
QUALITY & SAFETY					
OPEN FOR BETTER CARE					
Reducing Perioperative Harm					
1a	Support South Island DHBs to participate in the HQSC roll-out of the team work and communication interventions.	Q4			Contributors: SI DHBs supported by Q&S SLA Reported in: SIHSP
1b	Support South Island DHBs to prepare for the implementation of the new national Quality & Safety marker.	Q4	South Island DHBs implement new Q&S marker (DHB accountability).		
PROMOTING SAFETY FRAMEWORK					
Safety 1st					
2a	Provide governance to the implementation of Safety 1st including: identifying quality & system improvements; future planning & extension to primary and community care.	Q4	Provide ongoing governance to the implementation of safety first	Provide ongoing governance to the implementation of safety first	Contributors: Q&S SLA Reported in: SIHSP
2b	Capture learnings from implementation and utilise to inform ongoing quality and service improvement.	Q4			Contributors: Q&S SLA Reported in: SIHSP
2c	Inform and develop system capability and improvement by robust review & analysis.	Q4	Continue to Inform and develop system capability and improvement by robust review & analysis.	Continue to Inform and develop system capability and improvement by robust review & analysis.	Contributors: Q&S SLA Reported in: SIHSP
PARTNERS IN CARE					
Consumer involvement					
3	Consumer involvement in South Island Alliance.	Q4	Ongoing education, implementation and review of consumer engagement.	Ongoing education, implementation and review of consumer engagement.	Contributors: Q&S SLA Reported in: SIHSP

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSBILITIES
CLINICAL GOVERNANCE					
4a	South Island DHBs, working together, support the HQSC Clinical Governance Framework development.	Q4			Contributors: SI DHBs supported by Q&S SLA Reported in: SIHSP
4b	Agree South Island approach to implementation, with tailored localisation as appropriate.	Q4	Identify how clinical governance systems can be improved following the HQSC work on clinical governance framework.	Yet to be determined.	Contributors: Q&S SLA Reported in: SIHSP

Work supported by the Quality and Safety Service Level Alliance

Health Quality and Safety Commission priorities including falls, hand hygiene, SSI and Medication Safety are individually reported on by the South Island DHBs. The South Island Patient Safety Campaign work group is responsible for driving a regional approach to the national programme, they report to the Quality and Safety SLA.

The Health Quality and Safety Commission is actively engaged with the Quality and Safety SLA. In partnership with the Health Quality and Safety Commission the South Island will implement and support the Open for Better Care national patient safety campaign effectively by:

- Involvement of consumers.
- Maintaining and participating in regional campaign governance through reports and updates to the SLA
- Work with the commission to design the topic-specific approaches to the campaign
- Work with the commission to implement the campaign regionally and locally
- Develop and maintain regional leadership and networks to support the campaign capability for improvement such as ongoing involvement, reports on activities, reviews post implementation

REGIONAL INITATIVES
Open for Better Care campaign Implement and support the Open for Better Care national patient safety including: falls, hand hygiene, SSI and Medication Safety **Owner: Individual South Island DHBs** Reported: Individually by the South Island DHBs quarterly

South Island Information Services

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

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

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

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

With guidance from the National Health IT Board, the Information Services, Service Level Alliance has developed a portfolio of projects and programmes. The portfolio is outlined within this Health Service Plan. This has been developed into a long term plan to address the priorities that the Alliance has identified. The four key programmes for the Information Service, Service Level Alliance are the South Island Patient Information Care System, eReferrals, eMedicines and Health Connect South Programmes;

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

- South Island Patient Information Care System
  The South Island Patient Information Care System (SI PICS) is becoming the South Island solution for patient management and administration across the South Island District Health Boards. It will connect health workers with coordinated, consistent access to a single region-wide solution, resulting in improved quality and safety systems. SI PICS is based on a core principle of providing a safe and efficient health care foundation, flexible enough to meet the ever changing demand of health care services provided across the South Island.
  How it works
  This clinician-driven programme is being developed in close consultation with key people from each of the five South Island DHBs working together as part of the Functional Design Group. SI PICS will not just replace the existing patient administration systems, but embed new and sustainable functionality to provide greater integration and quality of health care.

- eReferrals
  eReferrals is replacing paper-based patient referrals with an electronic version, enabling more efficient and reliable referrals between health care providers. This is not only improving the transition between health care providers, but is providing better access to, and supporting improving quality of care.

  How it works
  eReferrals will go directly from GPs to other healthcare providers including secondary care, providing greater transparency in the way DHBs prioritise patients. By reducing administrative burden and improving clinical process, the solution is supporting improved quality of care. The goal is to enable a referral cycle that allows for communication between the referring provider and the provider of which the patient is referred too.

- Health Connect South Clinical Workstation

  Health Connect South will provide South Island-based clinical staff with a single repository for patient clinical records, streamlining and simplifying access to patient information. This will significantly support improved safety and quality in the region's health care provision. A single system across the South Island ensures that patients and their clinical information are more easily transferred and accessed throughout the district.

  How is it works

  Health Connect South captures patient documentation and stores it in a patient-centric way, giving clinicians a single overview of medical history within a secure environment. The clinically-led solution also aggregates information from other underlying systems into one clinical workstation. This will eventually become accessible across the region.

  This regional, single clinical workstation will provide a single point to access patient information delivering greater efficiencies and supporting improved quality health care.

- eMedicines Programme

  eMedicines is a suite of IT solutions that is improving and providing greater accuracy of medication management across the South Island health sector.

  How it works

  The suite, which includes MedChart, an Electronic Prescribing and Administration solution, enables clinicians and nursing staff to electronically chart patients' medications, removing the risk of handwriting being misinterpreted and allows nursing staff to administer and record medications electronically, resulting in a reduction in errors. This is improving patient safety and the quality of health delivery across the South Island. eMedicines is standardising the prescribing and administration of medicines throughout South Island hospitals. These initiatives are not only integrating with each other, but they also connect to wider regional programmes including eReferrals and Health Connect South.

- Other Regional Projects

  The Alliance is also delivering other projects which include HealthOne, TeleHealth, ED Whiteboard, Patient Portal, eOrdering of Laboratory Tests, eOrdering of Radiology Tests, ECG Project, Mobility Strategy and the South Island Data Warehouse.

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSBILITIES
KEY ENABLERS					
INFORMATION SERVICES					
IS SLA Portfolio Management **Further establish the IS SLA's Portfolio Management framework to enable the successful delivery of the Health Service Plan.**					
1	Agree and implement the IS SLA portfolio management framework	Q4			Lead: IS SLA Reported in: SIHSP
REGIONAL PROJECTS					
HealthOne **HealthOne enables pharmacists and other authorised clinicians to view patient information that is shared between multiple healthcare providers, including test results, allergies, prescribed and dispensed medications together with hospital information.**					
2	Progress HealthOne Business Case and Financial Model for South Island.	Q1,3	Progress roll-out of HealthOne across the South Island.	Continue roll-out of HealthOne across the South Island.	Lead: IS SLA Reported in: SIHSP
TeleHealth **To scope and define a TeleHealth regional direction for the South Island**					
3	Establish a South Island TeleHealth Strategy	Q1,3,4	Implementation commenced.	Continue progression of implementation	Lead: IS SLA Reported in: SIHSP

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSBILITIES
ED Whiteboard **Provide a regional solution to support visibility of ED activity.**					
4	Progress with defining requirements and scope for a regional ED solution.	Q2,3,4	Implementation commenced.	Continue progression of implementation	Lead: IS SLA Reported in: SIHSP
Patient Portal **To implement a Patient Portal that helps patients be involved in their care. It also ensures clear communication resulting in a better patient experience and improved patient outcomes.**					
5	The IS SLA to agree a regional patient portal solution for the South Island.	Q2,3,4	Implementation commenced.	Continue progression of implementation	Lead: IS SLA Reported in: SIHSP
eOrdering of Laboratory Tests **To implement a fully electronic laboratory ordering process.**					
6	Project scoping and agreement of regional direction.	Q4	Implementation commenced.	Continue progression of implementation	Lead: IS SLA Reported in: SIHSP
eOrdering of Radiology Tests **To implement a fully electronic radiology ordering process.**					
7	Project scoping and agreement of regional direction.	Q4	Implementation commenced.	Continue progression of implementation	Lead: IS SLA Reported in: SIHSP
Mobility Strategy **To define the South Island regional mobility strategy**					
8	Scope regional mobility strategy.	Q3	Implementation commenced.	Continue progression of implementation	Lead: IS SLA Reported in: SIHSP
Initial Data Store to address SI PICS Requirements **An initial warehousing solution for CDHB and NMDHB for future SI PICS requirements, which has potential to form the foundation for a future regional warehouse approach**					
9	To consolidate basic warehouse requirements for CDHB and NMDHB into a single solution that can be used to meet the warehousing requirements for the South Island PICS solution.	Q1,2,4	Implementation commenced.	Continue progression of implementation.	Lead: Regional Programme Manager, SIAPO Reported in: SIHSP
eMEDICINES PROGRAMME					
ePrescribing and Administration (ePA) **Implementing ePA into inpatient wards across the South Island DHBs (incorporating NZULM & NZ Formulary when sources are available) with the aim of improving medication safety for patients whilst an inpatient**					
10a	Southern DHB ePrescribing and Administration project complete.	Q2			Lead: Regional Programme Manager, SIAPO Reported in: SIHSP
10b	Canterbury DHB ePrescribing and Administration project progressed.[5]	Q4	Implementation commenced.		Lead: Regional Programme Manager, SIAPO Reported in: SIHSP
10c	South Canterbury ePrescribing and Administration DHB project complete.	Q4			
10d	West Coast DHB ePrescribing and Administration progressed.[6]	Q4	Business case approved.	Implementation commenced.	
10e	Nelson Marlborough DHB ePrescribing and Administration project progressed.[7]	Q4	Business case approved.	Implementation commenced.	
eMedicine Reconciliation (eMR) **Implementing electronic Medication Reconciliation across South Island DHBs. eMR helps health professionals create the most accurate and up-to-date list available of a patient's medicines on presentation to hospital (incorporating NZULM & NZ Formulary when sources are available)**					
11	Complete the implementation of eMedicines Reconciliation within Canterbury DHB and commence implementation planning for remaining South Island DHBs	Q4	Business case approved.	Implementation commenced.	Lead: Regional Programme Manager, SIAPO Reported in: SIHSP

[5] Dependency on release on NZULM from vendor
[6] Dependency on release on NZULM from vendor
[7] Dependency on release on NZULM from vendor

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSBILITIES
ePharmacy Management (ePM) **Implement ePharmacy into South Island DHBs using a single Regional instance (incorporating NZULM & NZ Formulary when sources are available) to enable the management of medications from a shared South Island perspective**					
12	Define requirements, scope and progress Regional Business Case for an ePharmacy Management Solution for the South Island.	Q4	Roll-out ePharmacy Management Solution for the South Island.	Roll-out ePharmacy Management Solution for the South Island.	Lead: Regional Programme Manager, SIAPO Reported in: SIHSP
eREFFERALS PROGRAMME					
Stage 1 **Regional implementation of Stage 1. eReferrals received by ERMS via fax.**					
13	Complete regional Stage One implementation of eReferrals for SDHB and NMDHB.	Q1,2,3			Lead: Regional Programme Manager, SIAPO Reported in: SIHSP
Stage 2 **eReferrals received through the RMS module in Health Connect South.**					
14	Complete regional Stage Two implementation of eReferrals for SDHB and NMDHB	Q3,4			Lead: Regional Programme Manager, SIAPO Reported in: SIHSP
Stage 3 **Implementation eTriage - eReferrals received through the RMS module in Health Connect South with triage functionality.**					
15	Pilot implementation of Stage 3 with Canterbury DHB. Once pilot is complete progress with regional implement.ation	Q2	Business case approved and implementation commenced.		Lead: Regional Programme Manager, SIAPO Reported in: SIHSP
HEALTH CONNECT SOUTH PROGRAMME					
Regional Programme					
16	Functional development and enhancements for the regional Health Connect South instance.	Q4	Functional development and enhancements for the regional Health Connect South instance.	Functional development and enhancements for the regional Health Connect South instance.	Lead: Regional Programme Manager, SIAPO Reported in: SIHSP
Southern HCS Implementation					
17	Complete Southern DHB's Health Connect South implementation.[8].	Q3,4			Lead: Regional Programme Manager, SIAPO Reported in: SIHSP
Nelson Marlborough HCS Implementation					
18	Complete Nelson Marlborough DHB's Health Connect South implementation.	Q2,3			Lead: Regional Programme Manager, SIAPO Reported in: SIHSP
eDischarges **(National Transfer of Care)** **To implement the National Transfer of Care template to create standardisation.**					
19	To fully implement feDischarge for all South Island DHBs.	Q4			Lead: Regional Programme Manager, SIAPO Reported in: SIHSP
SOUTH ISLAND PATIENT INFORMATION CARE SYSTEM (PICS)					
Regional Programme					
20	Supporting the first implementation of SI PICS and define the Second Phase of the solution.	Q1,2,3,4			Lead: Regional Programme Manager, SIAPO Reported in: SIHSP
Canterbury DHB Implementation					
21	Go-live Phase I and prepare for implementation into the balance of Canterbury DHB sites.	Q4	Implement SI PICS into other Canterbury DHB sites.		Lead: Regional Programme Manager, SIAPO Reported in: SIHSP

[8] Dependency on SMT solution

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSBILITIES
Nelson Marlborough DHB Implementations					
22			Project go-live for Nelson Marlborough DHB.		Lead: Regional Programme Manager, SIAPO Reported in: SIHSP
South Canterbury DHB Implementation					
23			Prepare for SI PICS Implementation.	Implement SI PICS.	Lead: Regional Programme Manager, SIAPO Reported in: SIHSP
West Coast Implementation					
24			Prepare for SI PICS Implementation.	Implement SI PICS.	Lead: Regional Programme Manager, SIAPO Reported in: SIHSP
Southern DHB Implementation					
25				Prepare for SI PICS Implementation.	Lead: Regional Programme Manager, SIAPO Reported in: SIHSP

Work supported by the Information Services, Service Level Alliance

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

NATIONAL INITATIVES
National projects enabled by the IS SLA but led nationally or by DHBs or by other South Island Workstreams
Project: National Trauma Minimum Dataset(pg.64 item 3)
Owner: South Island National Trauma Workstream
Project: National Infrastructure Programme
Owner: Nationally led
Project: National Patient Flow
Owner: Nationally led
Project: National Maternity Solution
Owner: Nationally led and implemented by individual DHBs

REGIONAL INITATIVES
Regional projects enabled by the IS SLA but led by other SLAs and Workstreams
Project: eLearning (pg.80 item 1)
Owner/Lead: South Island Workforce Development Hub
Support the regional eLearning implementation led by South Island Workforce Development Hub.
Project: Safety First (Risk Management Project (RL6) (pg.72 item 2a)
Owner: Quality and Safety SLA
To implement a regional Risk Management solution. This will include reporting of incidents, risks and enables shared clinical learnings from outcome reviews.
Project: Advance Care Plan (pg.53 item 11)
Owner: Health of Older Peoples SLA
Implement an electronic Advance Care Plan accessible to all health care clinicians.
Project: Growth Charts (pg.47 item 7)
Owner: Child Health SLA
To implement a growth chart solution to replace paper-based forms.
Project: South Island Clinical Cancer Information System (pg.43 item 8a)
Owner: Southern Cancer Network
Implement proposed cancer informatics working group structure.
Project: Mental Health Module (HCS) (pg.50 item 12)
Owner: Mental Health and Addiction SLA
To standardise Mental Health workflow to create a trusted source of patient care information. (HCS)
Project: South Island Electrocardiogram Clinical Data Repository (pg.59 item 12)
Owner: Cardiac Workstream
To implement a South Island Clinical Electrocardiogram data repository and software to allow all five South Island DHBs to upload clinical data regardless of the end devices

Information Services SLA Programme Financials for 2015-16

The 2015-16 Information Services SLA Programme Financials is available in the attached spreadsheet. NB: That the investment requirements for Regional Information Service Programme was provided by the South Island Information Services Alliance Programme Manager. This process occurred after the Districts' annual planning cycle. In some cases the values provided in this report may differ from the values shown in the District Health Board Annual Plans. The values shown in this report are estimates at a point in time and will change as Business Cases are finalised and submitted for approval.

Copy of IS SLA 2015_16 RHSP Budg

(PDF copies of the South Island Health Services Plan 2015 – 2018 South Island IS Programme Financials are available on request).

South Island Workforce Development

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

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

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

The work plan for 2015-16 builds on the work of the SIWDH workgroups, which involve over 120 clinicians from across health in the South Island. Further work to identify measures is ongoing and where appropriate these will be noted in the quarterly reports.

Five priorities for 2015-16 include:

- Establishment of an eLearning platform for the South Island.
- Increasing the PGY2 placements in the community.
- Implementation of pilot projects utilising the Calderdale framework (workforce design tool for skill sharing across professions and delegation to the unregulated workforce).
- Continued development of clinical learning packages across the South Island by the Nursing Community of Practice.
- Roll out of Lippincott into primary care and community services.

MILESTONES DASHBOARD 2015-16					
ITEM NO	**DELIVERABLE 2015-2016**	**APPROVED SCHEDULE**	**DELIVERABLE 2016-2017**	**DELIVERABLE 2017-2018**	**RESPONSBILITIES**
KEY ENABLERS					
THE WORKFORCE DEVELOPMENT HUB					
An eLearning platform and ePortfolio is accessible to the health workforce across the South Island.					
1	A common eLearning platform is available to all DHB staff.	Q4	A common eLearning platform is rolled out to all South Island health workforce staff.	Continue to develop regional content.	Contributors: SIWDH Steering Group and ISSLA Reported in: SIHSP
			Establish an ongoing evaluation process.	Support progression towards a national platform.	Contributors: SIWDH Steering Group Reported in: SIHSP
e-learning packages and teaching resources across the South Island					
2a	**Nursing** Nursing Community of Practice has identified and prioritised a regional suite of 2 eLearning packages.	Q4	An increased number of eLearning packages available to the South Island health workforce.	Continue to develop regional learning packages, create national content where possible.	Contributors: South Island Executive Directors of Nursing (EDONs) Reported in: SIHSP
2b	**Nursing** Lippincott on-line evidenced based clinical procedures has been introduced to all South Island DHBs.	Q4	In partnership with Midlands Region continue to review content and develop new content for Lippincott New Zealand Instance.	Ongoing review and development.	Contributors: SI Executive Directors of Nursing in partnership with the Midlands Region Executive Directors of Nursing Reported in: SIHSP
			Monitor usage through the Lippincott reporting mechanism.		

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSBILITIES
Clinical simulation is accessible to staff working in the smaller centres and rural areas of the South Island.					
3	**Interprofessional** A coordinated clinical simulation network for the South Island is established.	Q4	An evaluation system is in place.	Implementation is reviewed using evaluation information.	Contributors: SIWDH Steering Group Reported in: SIHSP
Regional coordination and development of Interprofessional learning					
4	**Interprofessional** The opportunities for interprofessional learning in a clinical environment are increased.	Q4	Implementation is continued.	Progress is re-evaluated and action plan revised.	Contributors: SIWDH Steering Group Reported in: SIHSP
Support all South Island HWNZ funded trainees to make appropriate career choices					
5a	**Career Events** All HWNZ funded trainees have access to career guidance and a career plan aligned to individual aspirations and future workforce needs.	Q1,2,3,4	Opportunities to work collaboratively across the South Island are identified.	Opportunities to work collaboratively across the South Island are identified.	Contributors: South Island Chief Medical Officers & South Island RMO Units Reported in: SIHSP
5b	**Medicine** Support the DHBs to integrate the increased number of PGY1s (NZ citizens and permanent residents) into the workforce.	Q2	The South Island has employed their share of the increasing number of PGY1s with NZ citizenship or permanent residence.	The South Island has employed their share of the increasing number of PGY1s with NZ citizenship or permanent residence.	
South Island vulnerable workforces are identified and plans established to mitigate these					
6a	**Nursing** Specialist Nurses are available to perform colonoscopies as required.	Q4	Specialist Nurses are available to perform colonoscopies as required.	Specialist Nurses are available to perform colonoscopies as required.	Contributors: South Island Executive Directors of Nursing Reported in: SIHSP
6b	**Nursing** The role of the Clinical Nurse Specialist is expanded as identified by the Nursing leaders in the South Island.	Q4	The role of the Clinical Nurse Specialist is expanded as identified by the Nursing leaders in the South Island.	The role of the Clinical Nurse Specialist is expanded as identified by the Nursing leaders in the South Island.	Contributors: South Island Executive Directors of Nursing Reported in: SIHSP
6c	**Nursing** Nursing sustainability Strategy and planning supports older nurses in the workforce to maximise their contribution.	Q4	Nursing sustainability Strategy and planning supports older nurses in the workforce to maximise their contribution.	Nursing sustainability Strategy and planning supports older nurses in the workforce to maximise their contribution.	Contributors: SIWDH Nursing Sustainability Working Group and SI EDONs Reported in: SIHSP
6d	**Nursing** The Aged Residential Care Gerontology Acceleration Nursing Programme (GAP) has been implemented in a further South Island site (currently operating in Canterbury).	Q4	Further DHBs are implementing the GAP programme.	Further DHBs are implementing the GAP programme.	Contributors: South Island Executive Directors of Nursing Reported in: SIHSP
6e	***Kaiawhina workforce*** ***Allied Health Assistants (AHAs):*** *Implement a delegation model for AHAs (Calderdale framework).*[9]	Q4	An effective evaluation tool is developed and applied.	Recommendations from evaluation have been reviewed and implemented.	Contributors: South Island Directors of Allied Health Reported in: SIHSP
6f	***Kaiawhina workforce*** ***Allied Health Assistants (AHAs):*** AHAs have access to appropriate NZQA level 3 training.	Q4	AHAs have access to appropriate NZQA level 3 training.	AHAs have access to appropriate NZQA level 3 training.	Contributors: South Island Directors of Allied Health Reported in: SIHSP
6g	**Sonography** The number of Sonography trainees has increased to meet the identified South Island need from 2 to 4.	Q4	The number of Sonography trainees has increased to meet the identified South Island need.	The number of Sonography trainees has increased to meet the identified South Island need.	Contributors: South Island DAHs in conjunction with the South Island Sonography training group Reported in: SIHSP

[9] Subject to funding approval

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSBILITIES
6h	**Midwifery** Midwives are recruited into hard to staff areas in the South Island.	Q4	Midwives are recruited into hard to staff areas in the South Island.	Midwives are recruited into hard to staff areas in the South Island.	Contributors: South Island Midwifery Leaders Reported in: SIHSP
6i	**Rural Health** The opportunity of a regional rural health medicine training programme is explored.	Q4	The identified pathway is implemented.	The identified pathway is evaluated.	Contributors: South Island Chief Medical Officers Reported in: SIHSP
6j	**Medical Physicists** The South Island has sufficient Medical physicists to meet its clinical need and this will continue to be monitored.	Q4	The South Island has sufficient Medical physicists to meet its clinical need and this will continue to be monitored.	The South Island has sufficient Medical physicists to meet its clinical need and this will continue to be monitored.	Contributors: South Island Directors of Allied Health Reported in: SIHSP
6k	**Cardiac Physiologists** Training, recruitment and retention of cardiac physiologists is supported.	Q4	Training, recruitment and retention of cardiac physiologists is supported.	Training, recruitment and retention of cardiac physiologists is supported.	Contributors: South Island Directors of Allied Health Reported in: SIHSP
Development of primary and secondary care health workforce to support shift in care to be more community based					
7a	**PGY 2 rotation into general practice & community** to meet the new pre vocational curriculum criteria has commenced.	Q4	Increasing numbers of PGY2s have a community experience.	Increasing numbers of PGY2s have a community experience.	Lead: South Island Chief Medical Officers & RMO Units Reported in: SIHSP
7b	**Nurse Practitioner (NP):** NP roles have increased across the South Island in identified areas of need.	Q1,2,3,4	NP roles have increased across the South Island in identified areas of need.	NP roles have increased across the South Island in identified areas of need.	Lead: South Island EDONs Reported in: SIHSP
Increase participation of Māori in the clinical workforce					
8	**Māori** Increased number of Māori working in health.	Q4	Increased number of Māori working in health.	Increased number of Māori working in health.	Lead: SIWDH Steering Group Reported in: SIHSP
Increase participation of Pacific People in the clinical workforce					
9	**Pacific** Increased number of Pacific working in health.	Q4	Increased number of Pacific working in health.	Increased number of Pacific working in health.	Lead: SIWDH Steering Group Reported in: SIHSP
Regional collaboration to further strengthen clinical leadership					
10a	**Midwifery** A pathway has been developed for future clinical Midwifery Leaders.	Q4	A pathway has been developed for future clinical Midwifery Leaders.	A pathway has been developed for future clinical Midwifery Leaders.	Lead: South Island Midwifery Leaders Reported in: SIHSP
10b	***Allied Health Scientific & Technical*** A model of professional skill sharing and delegation across AH professions has been implemented.	Q2	A model of professional skill sharing and delegation across AH professions has been implemented.	A model of professional skill sharing and delegation across AH professions has been implemented.	Lead: South Island Directors of Allied Health Reported in: SIHSP
10c	***Allied Health Scientific & Technical*** A regional clinical/professional leadership role is identified and implemented for an Allied Health profession.	Q4	Further roles are identified and implemented.	Further roles are identified and implemented.	
Provision of 1 year internship for nursing graduates					
11	**Registered Nurses** South Island new graduate nurses have participated in a NetP (New entry to practice) programme.	Q4	South Island new graduate nurses have participated in a NetP (New entry to practice) programme.	South Island new graduate nurses have participated in a NetP (New entry to practice) programme.	Lead: SI EDONs Reported in: SIHSP

Work supported by the South Island Workforce Development Hub

SIWDH with the role of an enabler, will be supporting and/or monitoring the delivery of the following projects; Mental Health e-Learning package and resources, Mental Health & Addiction vulnerable workforces, Clinical Networks established for identified priority areas within the Electives Workstream, South Island Urology nursing

practice and service delivery, Understanding the Palliative Care workforce requirements, A regional approach to cardiology nurse training developed, Opportunities for training in echocardiography identified, Investigate the feasibility of establishing a National Registrar training rotation that would be regionally based in line with other specialties. These projects with either be led by a regional Service Level Alliance or Workstream.

Regional projects enabled by SIWDH but led by other SLAs and Workstreams
South Island vulnerable workforces (Mental Health & Addiction)are identified and plans established to mitigate these (pg.50 item 11a)
Owner: Mental Health and Addiction SLA
Mental Health & Addictions workforce meets the identified health needs and is fiscally responsible.
Mental Health e-Learning packages and resources across the South Island (pg.50 item 11b)
Owner: Mental Health and Addictions SLA
Mental Health Core Education Group have identified and prioritised a regional suite of eLearning packages.
Understanding the Palliative Care workforce requirements (pg.55 item 3c)
Owner: Palliative Care Workstream
Understand the current PC workforce delivering PC in the community(s)and identify any workforce development opportunities
A regional approach to cardiology nurse training developed (pg.59 item 10)
Owner: Cardiac Workstream
Agree and implement a draft plan developed by CDHB staff
Opportunities for training in echocardiography identified (pg.59 item 11)
Owner: Cardiac Workstream
Action plan developed and implemented.
Investigate the feasibility of establishing a National Registrar training rotation that would be regionally based in line with other specialties (pg.59 item 12)
Owner: Cardiac Workstream
Determine feasibility of establishing a National Registrar training rotation that would be regionally based in line with other specialties

Support Services

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

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

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

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

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

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

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

- Procurement and savings.
- Project and savings collaboration with other Workstreams of the SLA.
- Manage change in conjunction with national agencies for local and regional benefits.
- Incorporate sustainability practices.
- St John Regional agreement for Patient Transfer service.

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSBILITIES
KEY ENABLERS					
SUPPORT SERVICES					
PROCUREMENT AND SAVINGS Achieve and report savings in line with nationally agreed methodology					
Aggregate procurement requirements and improve purchasing power (using nationally agreed methodology)					
1a	Develop and adhere to the regional procurement plan and policy (for non-health Alliance – out of scope).	Q1,2,3,4	Maintenance of efficient procurement activity resulting in regional savings and risk mitigation for South Island DHBs. Regional procurement policy implemented to end user satisfaction.	Maintenance of efficient procurement activity resulting in regional savings and risk mitigation for South Island DHBs.	Contributors: Preparation overseen by Procurement and Supply Chain Workstream Chair P and SC managers in each district implement Reported in: SIHSP
1b	Savings of $3 million (using nationally agreed methodology) reported during the 2015-16 year through the South Island Procurement and Supply Chain workstream.	Q1,2,3,4	Savings of $3 million (using nationally agreed methodology) reported during the 2016-17 year through the South Island Procurement and Supply Chain workstream.	Savings of $3 million (using nationally agreed methodology) reported during the 2017-18 year through the South Island Procurement and Supply Chain workstream.	Contributors: P and SC managers oversee preparation of district reports monthly Facilitator prepares regional summaries monthly and quarterly Reported in: SIHSP
Opportunities for joint ventures with providers of services					
2	Agree and implement opportunities where appropriate.	Q3			Contributors: All, but SLA Chair, Workstream Chairs &Facilitator in particular Reported in: SIHSP
PROJECT AND SAVINGS COLLABORATION WITH OTHER WORKSTREAMS OF THE SLA					
Align with the target of collective procurement driven by national agencies					
3	Increase rationalisation and standardisation of products and services.	Q1,2,3,4	Maintain increased rationalisation and standardisation of products and services by working in conjunction with other key agencies.	Maintain increased rationalisation and standardisation of products and services by working in conjunction with other key agencies.	Contributors: All, but particularly Workstream Chairs Reported in: SIHSP

MILESTONES DASHBOARD 2015-16					
ITEM NO	DELIVERABLE 2015-2016	APPROVED SCHEDULE	DELIVERABLE 2016-2017	DELIVERABLE 2017-2018	RESPONSBILITIES
MANAGE CHANGE IN CONJUNCTION WITH NATIONAL AGENCIES FOR LOCAL AND REGIONAL BENEFITS					
4	Projects active and achieved through collaboration with other agencies for example DHBs, health Alliance, Pharmac, MOBIE.	Q3	Maintenance of efficient procurement activity resulting in regional savings.	Maintenance of efficient procurement activity resulting in regional savings.	Contributors: All, Reported in: SIHSP
INCORPORATE SUSTAINABILTY PRACTICES					
Workstreams incorporate sustainability practices					
5	Sustainability practices acknowledged in workstreams.	Q1	Sustainable practices enhanced with increased knowledge.	Sustainable practices enhanced with increased knowledge.	Contributors: Workstream Chairs &facilitator with public health support Reported in: SIHSP
ST JOHN REGIONAL AGREEMENT FOR PATIENT TRANFSER SERVICE (PTS) **Assistance given to develop and implement a new Regional PTS agreement between South Island DHBs and St John**					
Facilitate the annual review of the regional PTS agreement negotiated between the South Island DHBs and St John.					
6	Complete annual review of the regionally co-ordinated PTS agreement.	Q2			Contributors: SLA Chair & facilitator Reported in: SIHSP

Appendix 4 – Membership Lists

Strategic Planning and Integration team

Name	Title	DHB
Dr Carol Atmore (Chair)	General Practitioner	Primary Care, Otago
Carolyn Gullery	General Manager, Planning and Funding	CDHB
Hilary Exton	Service Manager and Director of Allied Health	NMDHB
Dr Daniel Williams	Clinical Director, Community and Public Health	CDHB
Lynda McCutcheon	Director of Allied Health, Scientific and Technical	SDHB
Harold Wereta	Director of Māori Health and Whānau Ora	NMDHB
Karyn Bousfield	Director of Nursing and Midwifery	WCDHB
Steve Earnshaw	Orthopaedic Surgeon	SCDHB
Jan Barber	General Manager South Island Alliance Programme Office	SIAPO

Service Level Alliances and Workstreams

SLA	Name	Title	DHB
Southern Cancer Network	Dr Steve Gibbons (Chair)	Haematologist, Clinical Services	CDHB
	Dr Shaun Costello	Clinical Director, Southern Cancer Network/Clinical Director Medicine & Radiation Oncologist	SDHB
	Elizabeth Cunningham	Māori representative	Te Waipounamu Māori Leadership Group
	Glenis McAlpine	Associate Director of Nursing (Primary Care)	Marlborough PHO
	Theona Ireton	Kaitiaki	CDHB
	Marj Allan	Consumer & South Island Alliance Palliative Care	Canteen
	Danielle Smith	Cancer Support Coordinator	West Coast PHO
	Dr Tristan Pettit	Paediatric Oncology	CDHB
	Pania Coote	Acting Executive Director of Māori Health	SDHB
	Christine Nolan	General Manager Secondary Services	SCDHB
	Michelle Driffill	Regional Manger Northern South Island for CanTeen	Canterbury
	Kimberley Reimers	Service Manager	CDHB
	Sandra Boardman	Executive Director Planning & Funding	SDHB
	Di Riley	Southern Cancer Network Manager	SCN
Child Health Services	Dr David Barker (Chair)	Clinical Director, Women's and Children's Health	SDHB
	Jane Kinsey	PHO Manager, Community Physiotherapist	Nelson PHO
	Dr Nick Baker	Community Paediatrician	NMDHB
	Dr Clare Doocey	Paediatrician	CDHB
	Anne Morgan	Service Manager, Child Health	CDHB
	Donna Addidle	Service Manager, Child Health	SCDHB
	Dr Nicola Austin	Paediatrician	CDHB
	Dr Mike Goodwin	Paediatrician	SCDHB
	Prof Barry Taylor	Professor of Paediatrics	University of Otago
	Jane Wilson	Nursing Director	SDHB
	Jenny Humphries	Director of Midwifery	SDHB
	Dr Viv Patton	General Practitioner Paediatric Liaison	CDHB
	Wayne Turp	Project Specialist, Planning and Funding	CDHB
	Jaana Kahu	Māori Child and Youth Health	Te Tai o Marokura
	Traci Stanbury	Consumer	Canterbury
	Jane Haughey	Facilitator	SIAPO

SLA	Name	Title	DHB
Health of Older People Services	Dr Jenny Keightley (Chair)	General Practitioner	Canterbury
	Michael Parker	CEO, Presbyterian Support Service South Canterbury	South Canterbury
	Carole Kerr	Walking in Another's Shoes Dementia Educator	NMDHB
	Margaret Hill	General Manager, Strategy, Planning and Accountability	SCDHB
	Ruby Aberhart	Older Person's Advocate	Nelson/Tasman
	Dr Val Fletcher	Consultant Physician and Clinical Director of Community Services Older Persons Health	CDHB
	Dr Stanley Smith	Geriatrician	SCDHB
	Kate Gibb	Nursing Director, Older People – Population Health,	CDHB
	Amber Salanoa Haar	Allied Health Advisor/Occupational Therapist	WCDHB
	Karen Kennedy	Community Pharmacist, Primary and Community Services	SCDHB
	Jane Large	Facilitator	SIAPO
Palliative Care	Dr Kate Grundy (Chair)	Consultant Physician in Palliative Medicine	CDHB
	Dr Stanley Smith	Geriatrician	SCDHB
	Dr Amanda Lyver	Clinical Director of Paediatric Oncology	CDHB
	Marj Allan	Consumer	West Coast
	Kate Gibb	Nursing Director Older People and Population Health	CDHB
	Carla Arkless	Palliative Care Nurse Practitioner	Presbyterian Support Southland
	Rachel Teulon	Clinical Nurse Specialist, Paediatric Palliative Care	Nurse Maude
	Dr Brigid Forest	General Practitioner	Hospice Marlborough
	Jane Rollings	Service Manager	Nurse Maude
	Sharon Stewart	Nurse Leader	Otago Community Hospice
	Sharon Adler	Portfolio Manager Planning and Funding	SDHB.
	Rachel Nicolson-Hitt	Clinical Development Manager	St John South Island
	Theona Ireton	Māori representative	CDHB
	Jane Haughey	Facilitator	SIAPO
Mental Health & Addiction Services	Dr David Bathgate (Chair)	Consultant Psychiatrist	SDHB
	Dr Alfred Dell'Ario	Consultant Psychiatrist	CDHB/WCDHB
	Heather Casey	Director of Nursing	SDHB
	Rose Henderson	Allied Health	CDHB
	Sal Faid	Consumer	Canterbury
	Paul Wynands	Primary Care	Rural Canterbury PHO
	Robyn Byers	General Manager	NMDHB
	Diane Issac	Family Advisor, Supporting Families	Canterbury
	Karaitiana Tickell	CEO, Purapura Whetu Trust	Canterbury
	Judy Walker	Portfolio Manager	SDHB
	Martin Kane	Facilitator	SIAPO
Support Services	Jock Muir (Chair)	Director, Strategic Projects	CDHB
	Dr Geoff Shaw (Clinical Lead)	Intensive Care Specialist	CDHB
	Jane Wilson	Nursing Director Women's, Children's, Public Health & Support Services Directorate	SDHB
	Eric Sinclair	General Manager Finance & Performance	NMDHB
	Mark Newsome	General Manager Grey/Westland Health Services	WCDHB
	Dr Peter Bramley	Service Director, Medical Surgical Services	WCDHB
	Elaine Chisnall	General Manager, Women's, Children's, Public Health and Support Services	SDHB

SLA	Name	Title	DHB
	Alan Lloyd	Facilitator	SIAPO
Information Services	Dr Andrew Bowers (Chair)	Medical Director, Information Technology and Physician	SDHB
	Dr Bev Nicolls	Community Based Services Directorate / General Practitioner	NMDHB & Stoke Medical Centre
	Chris Dever	Chief Information Officer	CDHB
	Jane Brosnahan	Nursing, Midwifery and Allied Health	SCDHB
	John Beveridge	Nurse Consultant	CDHB
	Dr Nigel Millar	Chief Medical Officer	CDHB
	Dr Russell Rarity	Clinical Director, Anaesthetics	SCDHB
	Stella Ward	Executive Director, Allied Health	CDHB/WCDHB
	Patrick Ng	General Manager IT & Infrastructure	NMDHB
	Carolyn Gullery	General Manager, Planning and Funding	CDHB
	Peter Beirne	Executive Director Finance	SDHB
	Dr Peter Gent	General Practitioner	Mornington Health Centre
	Sheree East	Nursing Director	Nurse Maude
	Paul Goddard	Programme Director, Information Services	SIAPO
	vacant	Facilitator	SIAPO
Quality and Safety	Mary Gordon (Chair)	Executive Director of Nursing	CDHB
	Ken Stewart	Community Physiotherapist	Selwyn Village Physiotherapy
	Lexie O'Shea	Executive Director of Patient Services	SDHB
	Karen Vaughan	General Manager Organisational Development	NMDHB
	Tina Gilbertson	General Manager Organisational Development	SDHB
	Chris Eccleston	General Manager Clinical Governance	SCDHB
	Dr Elizabeth Wood	General Practitioner, Executive Clinical Director NMDHB	Mapua Health Centre, NMDHB
	Dr Lynley Cook	Population Health Specialist	Pegasus Health
	Carolyn Gullery	General Manager Planning and Funding	CDHB/WCDHB
	Dr Richard Johnston	Chief Medical Advisor	SCDHB
	Anna Carey	Facilitator	SIAPO
Cardiac Services	Dr David Smyth (Chair)	Cardiologist & Clinical Director of Cardiology	CDHB
	Lisa Smith	Cardiac Clinical Nurse Specialist	WCDHB
	Gary Barbara	Service Manager	CDHB
	Dr Bernard Kuepper	Consultant Internal Medicine/Cardiology	SCDHB
	Dr Rachael Byars	Physician and Clinical Leader	SDHB
	Christine Nolan	General Manager Secondary Services	SCDHB
	Dr Garry Nixon	Medical Officer	Dunstan Hospital
	Dr Nick Fisher	Consultant Cardiologist	NMDHB
	Dr Belinda Green	Cardiologist	SDHB
	Janine Cochrane	Service Manager	SDHB
	Vacant	Planning and Funding	
	Curt Ward	Clinical Practice Manager, South Island, St John	Independent
	Alan Lloyd	Facilitator	SIAPO
Elective Services	Andrew Lesperance	General Manager Strategy, Planning and Alliance Support	NMDHB
	Carolyn Gullery	General Manager, Planning and Funding	CDHB/WCDHB
	Margaret Hill	General Manager Strategy Planning and Accountability	SCDHB
	Sandra Boardman	Executive Director of Planning and Funding	SDHB

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

South Island Workforce Development Hub

Name	Title	DHB
Mary Gordon(Chair)	Executive Director of Nursing	CDHB
Samantha Burke	Director of Midwifery	CDHB
Lynda McCutcheon	Director of Allied Health, Scientific and Technical	SDHB
Nigel Millar	Chief Medical Officer	CDHB
Pania Coote	Acting Executive Director of Māori Health	SDHB
Pam Kiesanowski	Director of Nursing and Midwifery	NMDHB
Margaret Bunker	South Island Alliance Programme Coordinator	SIAPO
Kate Rawlings	Regional Programme Director Training	SIAPO
Kathryn Goodyear	Facilitator	SIAPO

Appendix 5 – Glossary of terms

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

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

Term		Definition
	Integration	Combine into a whole or complete by addition of parts.
InterRAI	International Resident Assessment Instrument	Comprehensive assessment tool.
	Kaumatua	Māori Elder.
	Kuia	Elderly woman.
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.
MOSAIQ		MOSAIQ is a complete patient information management system that centralizes radiation oncology, particle therapy and medical oncology patient data into a single user interface, accessible by multi-disciplinary teams across multiple locations.
MDMs	Multidisciplinary meetings	MDMs are regular meetings at which health professionals from a range of different specialities consider relevant treatment options and together develop a recommended individual treatment plan for each patient.
NHB	National Health Board	The NHB was established in November 2009 and is made up of a Ministerial appointed Board and a branded business unit within the Ministry of Health.
	National Health IT Board	The IT Health Board leads the implementation and use of information systems across the health and disability sector. They ensure health sector policy is supported by appropriate health information and IT solutions.
NGO	Non-Government Organisations	In the context of the relationship between the Health and Disability NGOs and the DHBs, NGOs include independent community and iwi/Māori organisations operating on a not-for-profit basis, which bring a value to society that is distinct from both Government and the market. In reality this will mean that any profits are put back into the organisation, rather than distributed to shareholders.
NZULM	NZ Universal List of Medicines	NZULM is New Zealand's national dictionary of medicines list for universal use across the sector. It is updated regularly, and is readily accessible via a website and participating prescribing and dispensing software systems and medicines information sources (including the NZ Medicines Formulary).
	Primary Care	Primary Care means essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods. It is universally accessible to people in their communities, involves community participation, is integral to, and a central function of, the country's health system, and is the first level of contact with the health system.
PHO	Primary Health Organisation	PHOs encompass the range of primary care and practitioners and are funded by DHBs to provide of a set of essential primary health care services to those people who are enrolled in that PHO.
	Population Heath	Population health refers to the health outcomes of a group of individuals, including the distribution of such outcomes within the group. It is an approach to health that aims to improve the health of an entire population. One major step in achieving this aim is to reduce health inequities among population groups. An important theme in population health is importance of social determinants of health and the relatively minor impact that medicine and healthcare have on improving health overall.
	Public Health	The science and art of preventing disease, prolonging life and promoting health and efficiency through organised community effort. A collective effort to identify and address the unacceptable realities that result in preventable and avoidable health outcomes and it is the composite of efforts and activities that are carried out by people committed to these ends.
RL6		Incident Management software solution.

Term		Definition
	Secondary Care	Specialist care that is typically provided in a hospital setting.
SIWDH	South Island Workforce Development Hub	SIWDH is designed to support more effective and integrated health professional training, covering a population of approximately one million people. SIWDH works collaboratively across each region to oversee the planning and delivery of clinical training, ensuring it meets the needs of trainees and local communities and is aligned with regional service planning.
	South Island Alliance	The South Island Health Alliance, a partnership between the five South Island District Health Boards, is working to support a clinically and financially sustainable South Island health system where services are as close to people homes as possible.
	South Island Alliance Programme Office	The South Island Alliance Programme Office supports the regional activities of the South Island Alliance.
SIHSP	South Island Health Services Plan	Regional Health Services Plan provided by the South Island Alliance.
SLA	Service Level Alliance	Agreed priority area for the South Island Alliance.
	TePou	Te Pou's purpose is to enhance people's health and wellbeing by developing a sustainable workforce delivering quality services. To achieve this, they provide health organisations with tools, products and resources to help them build a strong and enduring workforce and improve their services.
WIAS	Walking in Another's Shoe	WIAS is a dementia workforce education programme being rolled out around the South Island.
	Whanāu	Family.
WHO	World Health Organisation	WHO is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends.
	Workstream	Other areas of regional activity of the South Island Alliance.