Te Waipounamu South Island Health Services Plan

2017-2020

South Island Health Services Plan 2017-20

Produced in May 2017

By the South Island Alliance Programme Office

On behalf of the five South Island District Health Boards

Telephone: 03 378 6631

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FOREWORD

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

Through our alliance approach – our strong relationships and united vision – we have achieved better outcomes for patients, more integrated health information and a more flexible workforce. Some recent initiatives and ongoing programmes of work include:

- A single, consolidated electronic health record containing relevant health information for all South Island residents, accessible across the South Island health system
- More regionally aligned HealthPathways for consistent diagnosis and treatment.
- A regionally agreed suite of high quality referral options for childhood healthy weight.
- Implementation of a South Island-wide Patient Information Care System (SI PICS).
- 1300 beds with electronic prescribing and administration.
- Regional agreement with St John for regular, scheduled inter-hospital transfers.
- Growing numbers of highly qualified nurse practitioners.
- Over 1700 electronic clinical procedure guidelines accessible anywhere via Lippincott.
- Over 80% of high-risk acute coronary syndrome patients received an angiogram within three days.

This *South Island Health Services Plan (2017-20*) maps the direction of the South Island Alliance and draws from national strategies and priorities, including the draft New Zealand Health Strategy, National Health Targets, the Minister's Expectations, and the Operational Policy Framework. The South Island Health Service Plan actions are interwoven into each of the South Island District Health Board (DHB) Annual Plans with a clear 'line of sight' across plans.

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

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

Signed By:

Nelson Marlborough District Health Board

Peter Bramley
CEO, Nelson Marlborough District Health Board

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

West Coast District Health Board

Mary Gordon
Acting CEO, West Coast District Health Board

Jenny Black
Chair, South Island Alliance Board
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Southern District Health Board

Chris Fleming
Chair, Alliance Leadership Team
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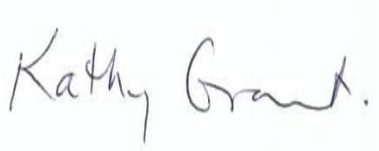

Kathy Grant
Commissioner, Southern District Health Board

Office of Hon Dr David Clark

MP for Dunedin North
Minister of Health
Associate Minister of Finance

Mr Chris Fleming
Lead Chief Executive for South Island region district health boards
Southern District Health Board
Private Bag 1921
Dunedin 9054

21 DEC 2017

Dear Mr Fleming

South Island Region 2017/18 Regional Service Plan

I appreciate the significant work that is involved in preparing the RSP and thank you for your effort. To formalise ongoing accountability and to provide surety, I have approved and signed the 2017/18 South Island Regional Service Plan (RSP).

I understand that your RSP includes a strong focus on the information technology (IT) and health workforce enablers, and that you will be working with the Ministry to progress all your regional IT activities. Your regional workforce activities are aligned to the district health boards (DHB) annual plans, and I expect that alignment between the plans will continue to be strengthened.

I encourage the South Island region DHBs to continue working regionally to support more effective use of clinical and financial resources, while strengthening your focus on my priorities of public provision of health services, improving access to primary care, reducing inequalities and improving mental health services.

Please note that approval of your RSP does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry of Health. Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

Please ensure that a copy of this letter is attached to the copies of your signed RSP held by each DHB Board and to all copies that are made available to the public. Thank you again for your leadership and efforts to deliver high quality and equitable health outcomes for your population.

I look forward to working with you in the future.

Yours sincerely

Dear Chris
I note some of the individual DHB plans have not yet been finalised, but sign this off in the expectation that will occur early in the New Year
Best wishes,
David

Hon Dr David Clark
Minister of Health

cc DHB Chairs and Chief Executives in the South Island region

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1 INTRODUCTION

"Steering the course for a sustainable future"

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

1.1 The South Island context

With a total South Island population of 1,123,930 (23.3 percent of the total New Zealand population)[1], implementing diverse, but similar individual responses duplicates effort and investment and can lead to service and access inequality. Regional collaboration is an essential part of our future direction.

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

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

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

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

1.2 Our 2017-20 plan

Through our alliance approach – our strong relationships and united vision – we have achieved better outcomes for patients, more integrated health information and a more flexible workforce. Some recent initiatives and ongoing programmes of work include:

- More regionally aligned HealthPathways for consistent diagnosis and treatment.
- A regionally agreed suite of high quality referral options for childhood healthy weight.
- Implementation of a South Island-wide Patient Information Care System (SI PICS).
- 1300 beds with electronic prescribing and administration.
- Regional agreement with St John for regular, scheduled inter-hospital transfers.
- A single, consolidated electronic health record containing relevant health information for all South Island residents, accessible across the South Island health system.
- Growing numbers of highly qualified nurse practitioners.
- Over 1700 electronic clinical procedure guidelines accessible anywhere via Lippincott.
- Over 80% of high-risk acute coronary syndrome patients received an angiogram within three days.

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

This updated *South Island Health Services Plan* provides a framework for future planning and outlines the region's priorities for 2017-20. It has been developed by the five South Island DHBs, including the primary care and community members of the South Island Alliance's Service Level Alliances and Workstreams. The plan builds on the achievements and progress of the last five years as it develops a longer term direction for a sustainable South Island health and disability system that is *best for people, best for system*.

South Island health services continue to work together at a regional level to make the best use of available resources, strengthen clinical and financial sustainability and increase access to services. This South Island Health Services Plan outlines many, but not all, of the areas in which the DHBs work together. The alliance way of working is based on relationships and as the number of formal working groups increases, so do the informal approaches to solving issues and working together.

In Quarter 3 of the 2016/17 year the South Island Alliance Board, Leadership Team and Strategic Planning and Integration Team will undertake a survey and workshop to review the achievements, challenges and the opportunities for the South Island Alliance. This will inform the direction for the future.

The plan, developed and championed by our clinical leaders, supports the South Island Outcomes Framework (see Section 4 Improving Health Outcomes), and is governed by our agreed framework for regional decision making (see Section 5 Regional Governance, Leadership and Decision Making).

2 SETTING OUR STRATEGIC DIRECTION

2.1 Strategic context

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

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

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

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

2.2 National direction

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

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

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

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

DHBs are expected to commit to Government priorities and provide 'better, sooner, more convenient health services', and 'better public services'. The Minister of Health's, letter of expectation signals annual expectations and priorities for DHBs and this annual plan outlines how the SI Health Service Plan will meet those expectations.

In 2017/18 the focus is on:

- New Zealand Health Strategy: DHBs need to be focused on the critical areas to drive change that are identified in the Strategy
- Living within our means: DHBs must continue to consider where efficiency gains can be made and look to improvements through national, regional and sub-regional initiatives
- Working across government: cross-agency work to support vulnerable families and improve outcomes for children and young people is a priority, along with health's contribution to Better Public Service Results
- National health targets: while health target performance has improved, this needs to remain a focus for DHBs, particularly the Faster Cancer Treatment target
- Streamlining of planning including developing a longer-term outlook and regional alignment

2.3 Regional direction

The Nelson Marlborough, Canterbury, West Coast, South Canterbury and Southern DHBs form the South Island Alliance – together providing services for over 1 million people, or 23.3 per cent of the New Zealand population.

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

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

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

The *South Island Health Services Plan 2017-20* outlines the agreed regional activity to be implemented through our five priority service areas: cancer, child health, health of older people, mental health and addiction, information services. In addition to this, regional activity will focus on: cardiac services, elective surgery, palliative care, stroke, major trauma services, quality and safety, public health and hepatitis C. Workforce planning, through the South Island Workforce Development Hub will contribute to improved delivery in all service areas.

In developing and implementing a collective regional approach we acknowledge the unique pressures and post-disaster challenges Canterbury face, and the wider impact of this on South Island health services. Prolonged levels of stress, anxiety and poor living arrangements are exacerbating chronic illness, and increased demand is evident right across the Canterbury health system. The increased service demand, coupled with the invasive infrastructure repairs and extensive facilities redevelopment also happening in Canterbury, means service capacity is severely stretched across Canterbury's specialist services. The increased service demand also placing

significant pressure on Canterbury's primary and community service providers, many of whom are operating at or close to full capacity.

Patterns following other international disasters show that psychological recovery after a major disaster can take upwards of a decade, so the increased demand pressures can be expected to continue for some time. It will be several years before Canterbury is back to full capacity. Increased IDF pressures from South Island DHB's are currently placing significant additional strains on the Canterbury Health System. The South Island is working toward addressing these issues and seeking to implement solutions. It is important that care pathways for the South Island are developed with Canterbury's current operating environment in mind.

Earthquakes

The magnitude 7.8 Kaikoura earthquake on 14 November 2016 had a significant impact on Ward and Seddon in the Nelson Marlborough region; Kaikoura; and Hurunui in the Canterbury Region. The earthquake impacts have come on top of three years of drought and have impacted on communities where many earthquake impacted Cantabrian's shifted to following the 2011 earthquakes in Christchurch.

Ongoing review of service delivery to these districts will continue as the Nelson Marlborough and Canterbury DHBs develop ways of flexing to meet the changing psychosocial demands of these communities. It is envisaged, in line with international and local experience (from our understanding following the 2010-11 earthquakes), there will be increased demand for the next five to 10 years. Disaster literature shows a stabilisation of adult mental health need within this timeframe, however need amongst children and adolescents is likely to continue to increase during this period. The impacts of these earthquakes, as with the 2010/11 Canterbury earthquakes will have long term implications for health and social services which the South Island DHBs will need to be cognisant of in its future planning.

All South Island DHBs are involved in the service level alliances and workstreams. Each DHB's commitment in terms of the regional direction is outlined in their Annual Plans. The South Island Alliance is committed to the implementation of the New Zealand Health Strategy regionally and is already delivering actions in line with the Strategy Roadmap and the 2017/18 priorities. This alignment is shown through a South Island version of the Health Strategy Roadmap of Actions diagram in Appendix 2.

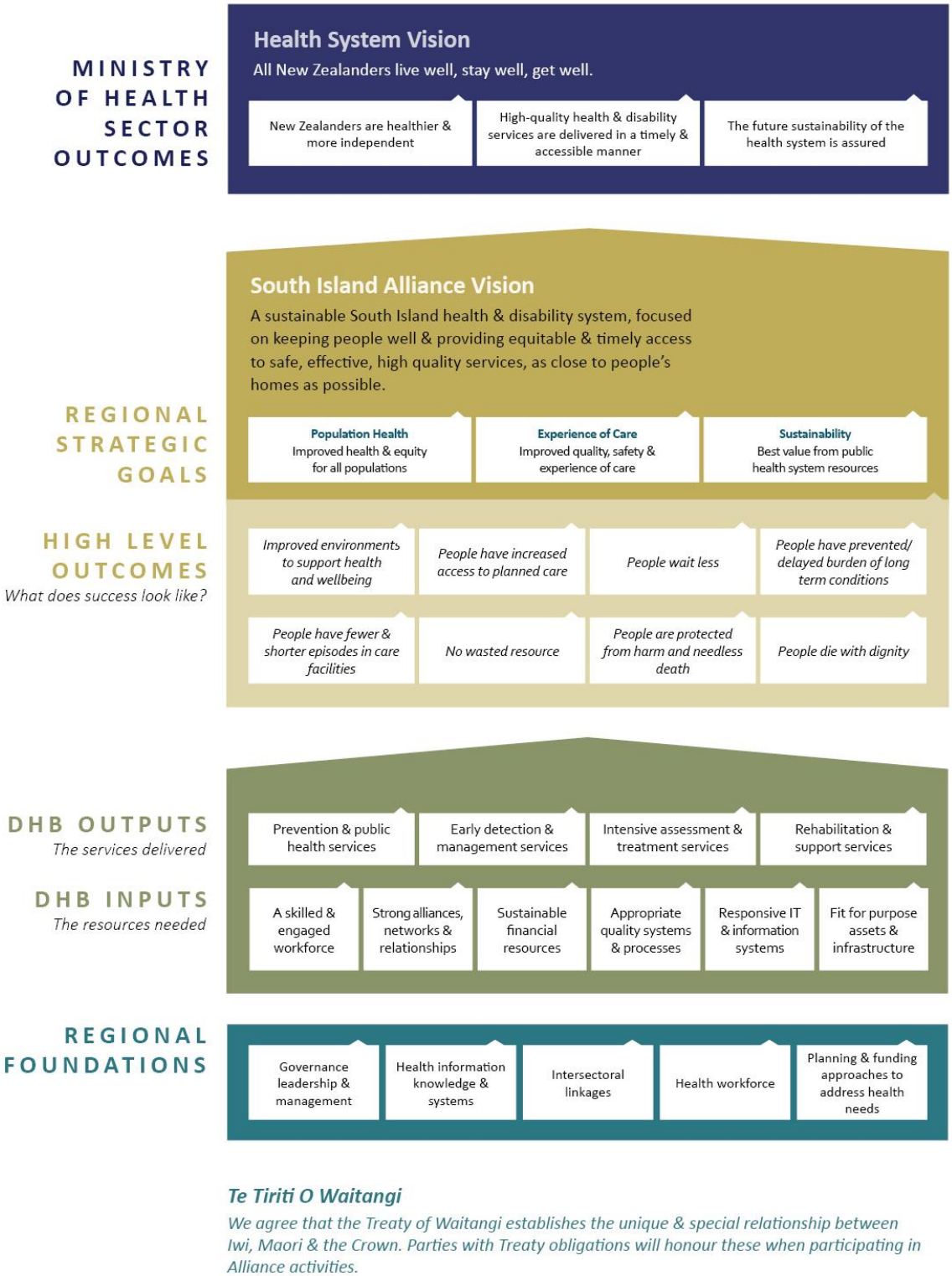
2.4 Local direction

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

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

2.5 South Island intervention logic diagram

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



THE SOUTH ISLAND POPULATION

SOUTH ISLAND ALLIANCE
best for people, best for system

Resident Population of each SI DHB in 2017/18

(PBFF December 2016 Census 2013 Base)

Canterbury	558,830
Southern	324,090
Nelson Marlborough	148,370
South Canterbury	60,040
West Coast	32,600

23.3% of the total New Zealand resident population live in the South Island

1,123,930 residents

3 of NZ's 5 fastest growing districts

Canterbury is the 4th fastest growing DHB

West Coast population is decreasing

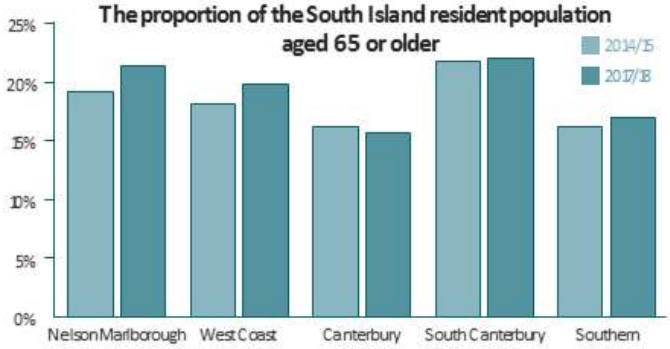
6.1% increase in numbers of South Island residents since 2014/15

Selwyn ↑ 20.3%
Queenstown Lakes ↑ 16.8%
Waimakariri ↑ 10.5%

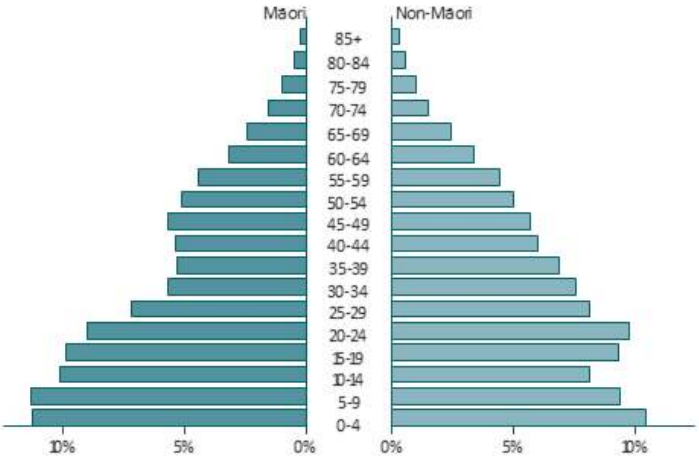
8.6% increase

2.1% decrease

The proportion of the South Island resident population aged 65 or older



South Island DHBs population age structure



17.2% of South Island residents are aged 65+, up from 17% in 2014/15

Fastest growing 65+ population of any SI DHB is Nelson Marlborough, growing 18% since 2014/15

9.7% of South Island residents identified as Māori, an increase of 15,550 people since 2014/15

2.1% of South Island residents identified as a Pacific Island ethnicity, an increase of 3,860 people since 2014/15

7.6% of population of South Island identified as Asian, an increase of 23,800 people since 2014/15

Nationally **15.8%** of population are Māori

Locally **9.7%** of the South Island population are Māori

OUR VISION IS

"Māori are the healthiest people in the world"

3 SOUTH ISLAND MĀORI HEALTH

Objective 1: Māori Health Equity

All South Island DHBs are committed to reducing health inequalities and improving health outcomes for Māori at a local and regional level. As such, working towards the attainment of Māori health equity has been identified as the first key objective within the South Island Health Services Plan 2017-2018. At a national level, Māori have the poorest health of any ethnic group in the country, and across the South Island, significant health inequities exist for Māori relative to the rest of the population. District Health Boards are required to reduce health inequities and to carry out principles-based prioritisation processes in order to meet the objectives of the New Zealand Public Health and Disability Act 2000.

At a regional level Te Herenga Hauora o te Waka-ā-Māui the South Island Director/GM Māori Health leaders will work with the South Island Alliance Programme Office (SIAPO) and various partnerships to progress regional work in the 2017-2018 period. This work will prioritise working towards the attainment of both Māori health equity and "Pae Ora" a healthy future for our whānau. Māori health is a priority for Te Waipounamu and the five South Island DHBs based upon seven key drivers:

1. Te Tiriti o Waitangi (1840) the founding document of our nation
2. He Korowai Oranga the National Māori Health Strategy (2014)
3. Equity of Health Care for Māori Framework (2014) and the Health Equity Tool (2008)
4. The size and composition of the Māori population in Te Waipounamu (over 103,640+)[3]
5. A disproportionately high health need for Māori within Te Waipounamu relative to non-Māori
6. A commitment across all five South Island DHBs to work towards Māori health equity
7. A commitment to build Iwi capacity to respond to their own health needs

Te Herenga Hauora o te Waka-ā-Māui seek to ensure that their regional work programme activity aligns to improving performance against national Māori health indicators which have been established by the Ministry of Health, and are integrated into all South Island DHB Annual Plans (refer appendix 1).

In alignment with this intent, the key area of focus for Māori health for the 2017-2018 period can be grouped into five key areas:

1. Ensuring a Māori health equity approach is adopted by all South Island Alliance workstreams and each South Island DHB's respective Annual Plan
2. Building Māori Health Workforce Capacity within the health sector
3. Building cultural responsiveness amongst the health sector
4. Working to improve the incidence and impact of cancer on Māori, inclusive of building Māori health literacy and ensuring health sector is responsive to the needs of Māori with cancer
5. Working across sectors to address the wider determinants of health for Māori that cause health inequities

[3] New Zealand Census 2013

Based on these five key groupings specific initiatives for the coming period that will be led by Te Herenga Hauora o te Waka-ā-Māui in conjunction with the South Island Alliance workstreams include:

- The integration of the Māori Health Equity Framework into the work of regional alliance workstreams and South Island DHBs Annual Planning
- Trendly regional reporting across the respective South Island DHBs to monitor performance against national Māori Health priority indicator areas
- Implementation of Kia Ora Hauora, the South Island Regional Māori Health Workforce Development programme
- Establishment of Māori health workforce development targets for the South Island DHBs and ensuring these targets are integrated into the South Island Regional Services Plan and the respective South Island DHBs Annual Plans
- Utilisation of online e-learning Ethnicity Data Collection training across all South Island DHBs to improve how we can effectively monitor Māori health inequities
- Sub-regional implementation of Takarangi Cultural Competency programme, that seeks to build a workforce that is not only clinically but culturally responsive to the needs of Māori
- Support the development of Māori Cancer Pathways, implementing the learnings from He Huarahi Mate Puku the South Island's Initiative, which seeks to build health literacy amongst the Māori community about cancer and supports building a health sector that is responsive to the needs of Māori with cancer
- South Island Cervical Screening Initiative for Māori, which seeks to accelerate local and regional performance around the Māori health priority indicator to improve the up-take of cervical screening; and the implementation of key learnings
- Public Health Service Level Alliance which will enable a working across sectors programme that supports addressing the wider determinants of health for Māori
- Intersectoral approach to health care - SLAs/Workstreams to work towards including other sectors within their membership (where possible) to enable collaboration that supports addressing the wider determinants that drive health inequities for Māori

The priorities and actions outlined in the Māori Health section of the South Island Alliance Regional Plan are aligned with He Korowai Oranga and the Ministry priorities. This includes a holistic approach (health and wellbeing), increased collaboration across the health system and placing resources where they are best needed to reduce health inequalities.

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

Ehara taku toa, he takitahi, he toa takitini

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

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

Te Herenga Hauora o te Waka-ā-Māui South Island Regional DHB Director/GM Maori Health Leaders strategic workshop 2017

Regional workstream groups whose activities impact on Māori health but fall outside the following action tables will have an opportunity to meet with Te Herenga Hauora o te Waka-ā-Māui periodically on an 'as needed' basis for advice and guidance. Te Herenga Hauora o te Waka-ā-Māui members will actively participate in the following SLA/workstreams.

- South Island Workforce Development Hub

- Southern Cancer Network
- Public Health Service Level Alliance
- Child Health Service Level Alliance
- Mental Health and Addictions Service Level Alliance

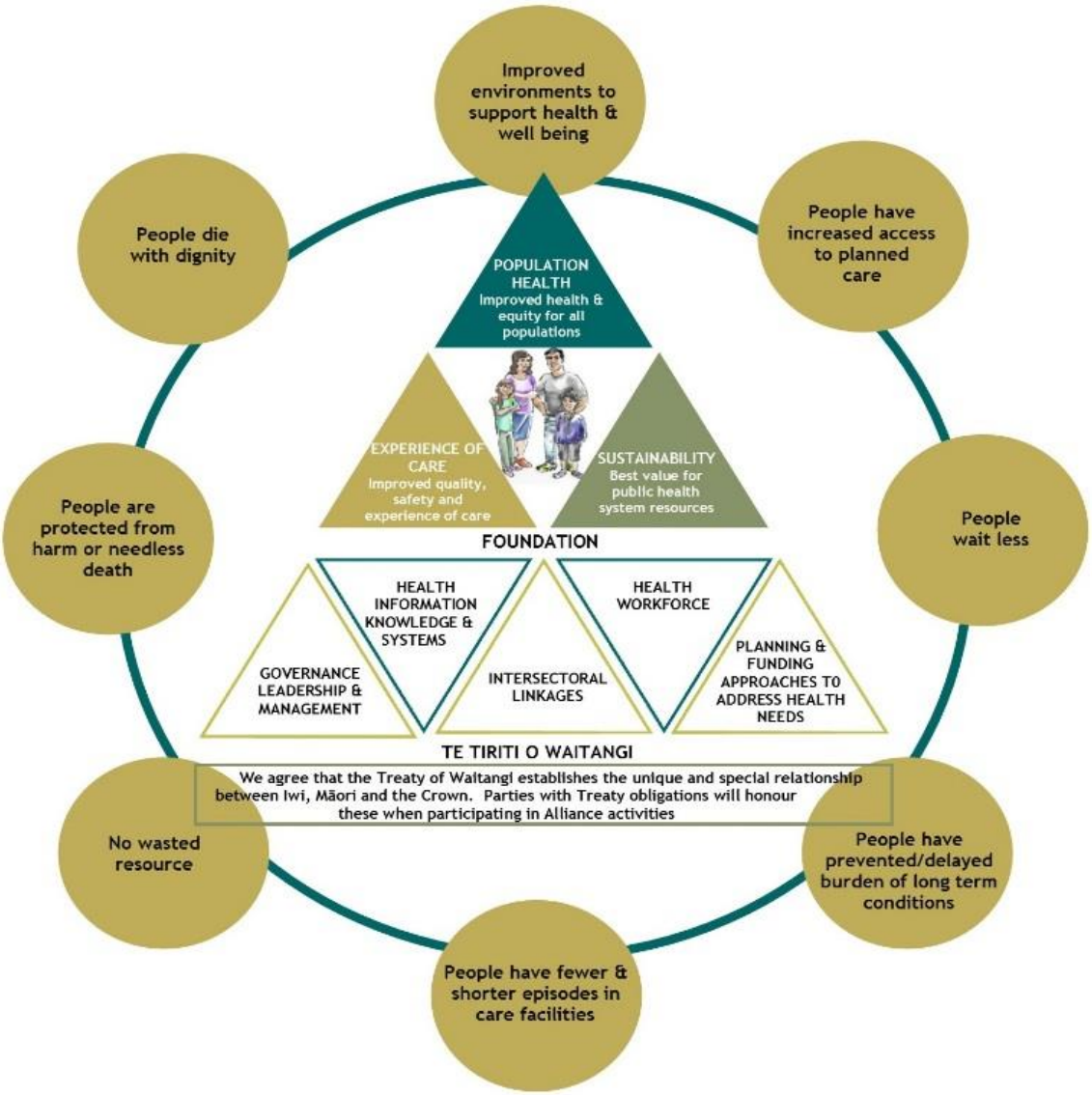
4 IMPROVING HEALTH OUTCOMES FOR OUR POPULATION

4.1 What are we trying to achieve?

Our health system is complex and continues to experience multiple challenges. These 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.. We also aim to support our population to improve their health and lifestyle choices through provision of health literacy and lifestyle education.

The health sector is expected to deliver services that will achieve the vision of the New Zealand Health Strategy: *live well, stay well, get well* and to meet Government commitments to deliver '*better, sooner, more convenient health services*'. Examples of how our work supports the themes of the New Zealand Health Strategy are shown in Section 4.3.

The South Island Alliance acknowledges He Korowai Oranga Māori Health Strategy 2014 with the overarching aim of Pae Ora (healthy futures), and the three elements that are woven together are: Mauri Ora (healthy individuals), Whānau Ora (healthy families) and Wai Ora (health environments).



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

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

There is no single measure that can demonstrate the impact of health services (or separate the impact of various health services), so a mix of population health and service access indicators are used to demonstrate improvements in the health status of the population and the effectiveness of the health system.

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

These measures will be integrated into our planning and reporting in 2017-18.

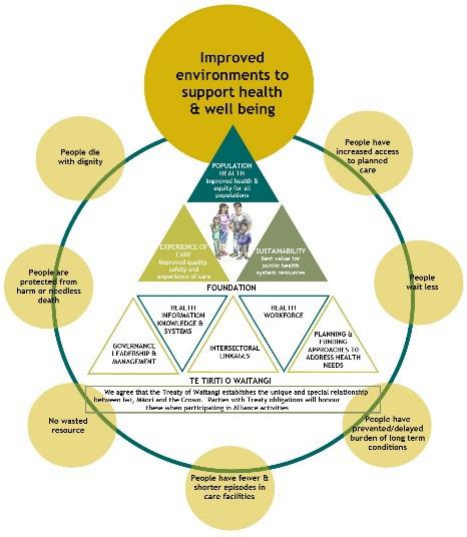
4.2 How the Outcomes Framework aligns with service priorities

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

Outcome 1: Improved environments to support health and wellbeing – Wai Ora

Why is this outcome a priority?

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



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

Supporting innovative Workforce development to ensure health professionals work to their scope of practice in the new and emerging models of patient care with the support of an appropriately trained kaiawhina (unregulated) workforce.

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.

What actions are we taking to address this outcome?

Public Health

Health determinants

- Promote awareness of the position statements once the South Island District health Boards have endorsed them: water fluoridation; air quality and warm homes; sugar sweetened drinks; and environmental sustainability
- Undertake new regional approaches/initiatives to promote healthy eating and active lifestyles as identified in 16/17
- Identify and undertake regional approaches/initiatives re alcohol harm reduction, including contributing a regional population health perspective to the Alcohol Harm Reduction ED Project.

Environmental Sustainability

- Comprehensive current data to inform next steps, including gap analysis and identification of potential and useful and cost-saving measures for DHBs to consider.

Information Services

Regional service Provider Index

- Identify the preferred South Island solution; progress the business case and implementation planning; commence a phased roll-out.

South Island Patient Information Care System (SI PICS)

- Supporting the implementation of SI PICS in other Canterbury sites.
- Preparing for implementation of SI PICS in West Coast and South Canterbury.
- Support project go-live in Nelson Marlborough DHB
- Support the development of SDHB implementation business case for SI PICS
- Identify the preferred South Island Emergency Department Information Solution
- Progress the business case and implementation planning

South Island Workforce Development Hub

To build and align the capacity and capability of the health workforce to deliver new models of care

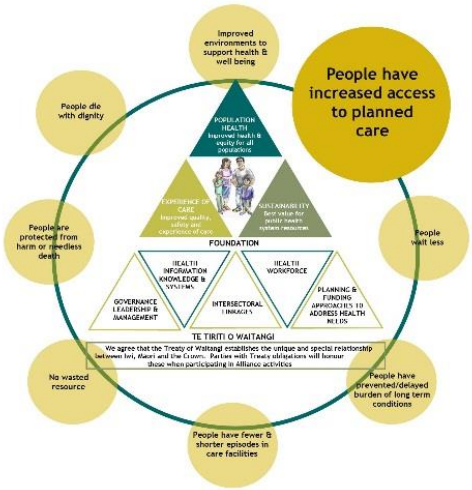
- Health workforce data and intelligence is collected to support planning
- The pipeline for the health workforce is aligned with workforce need
- Kaiāwhina workforce: Allied Health Assistants (AHAs) working across the South Island Health system have access to appropriate NZQA level 3 training

Outcome 2: People have increased access to planned care

Why is this outcome a priority?

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

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



What actions are we taking to address this outcome?

Cardiac Services	Electives Services
Strategies to support access to angiography for Māori, and other high risk population groups • Monitor access rates for high risk population groups; identify and address any issues	*Improve access to elective services* • Improved equity of access to elective services – in particular, bariatric surgery, urology, plastics services, vascular services, eye services, maxillofacial services, orthopaedic services and otolaryngology services. • South Island planning to support Bowel Screening Regional Centre development and implementation and Tranche 2 & 3 rollout schedule.

Cancer Services

People get timely access across the whole cancer pathway

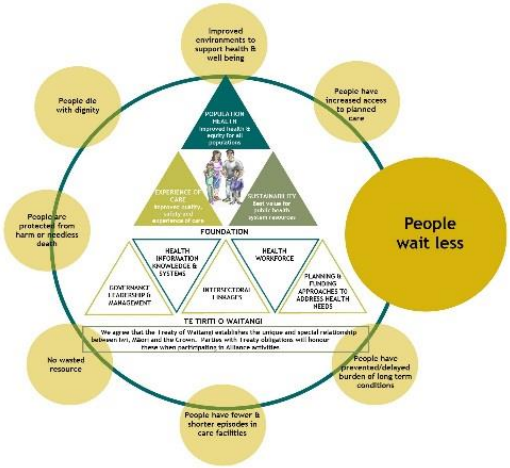
- Undertake a focused review to understand the 'Route to Service Access/Diagnosis' for South Island cancer patients.
- Complete the rollout of the regionally agreed MDT recommendations and service improvement initiatives started in 2015-16.
- Supporting DHBs in preparation for the introduction of a national bowel screening programme – focus on services to support the delivery of additional cancer cases
- Support DHBs with the implementation of the Early Lung Cancer Guidance (to be published shortly)

Outcome 3: People wait less

Why is this outcome a priority?

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

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



What actions are we taking to address this outcome?

Cardiac Services	Cancer Services
Complete project work associated with the South Island Cardiac Model of Care	*People get timely services across the whole cancer pathway* • Support DHBs to deliver the extended FCT target of 'At least 90% of patients receive their first treatment within

<table>
<tr><td>

- South Island Cardiac Model agreed and implemented consistently in the region (within resources available).
- STEMI Pathway in conjunction with St John implemented.
- Common Accelerated Chest Pain pathway implemented in South Island Hospitals.

Patients with suspected Acute Coronary Syndrome (ACS) receive seamless, co-ordinated care across the clinical pathway

- Support South Island DHBs to address any challenges that arise with providing appropriate cardiac care and meeting standardized intervention rates.

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62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks by July 2017

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<tr><td>Information Services</td><td>Stroke Services</td></tr>
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South Island Patient Information Care System (SI PICS)

- Supporting the implementation of SI PICS in other Canterbury sites.
- Preparing for implementation of SI PICS in West Coast and South Canterbury.
- Support project go-live in Nelson Marlborough DHB
- Support the development of SDHB implementation business case for SI PICS
- Identify the preferred South Island Emergency Department Information Solution
- Progress the business case and implementation planning

eReferrals

- Complete eTriage implementation in SCDHB, SDHB, NMDHB

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Regional Intra-arterial clot retrieval service

- A regional intra-arterial clot retrieval service based in CDHB is available in the South Island

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<tr><td>Elective Services</td><td>Workforce Development Hub</td></tr>
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- Supporting DHBs to meet ESPI indicators

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- Ensure sustainability of the workforce redesign model (Calderdale Framework) across the South Island
- An effective delegation model (Calderdale Framework) is in place for services where the Calderdale Framework has been implemented
- Regional clinical/professional leadership frameworks are implemented for smaller Allied Health & Scientific & Technical professions

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<tr><td colspan="2">Major Trauma</td></tr>
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A planned and consistent approach to major trauma services

- South Island region focuses on implementation of local and regional trauma systems.

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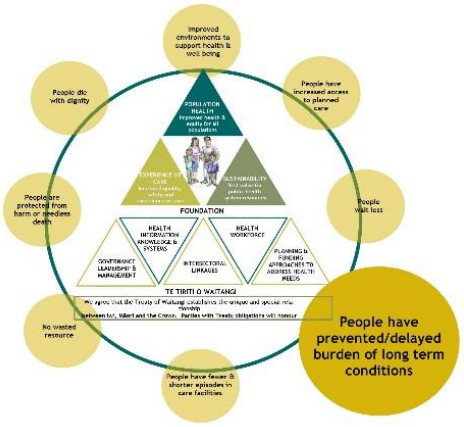
Outcome 4: People have prevented and/or delayed burden of long term conditions

Why is this outcome a priority?

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



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

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

What actions are we taking to address this outcome?

Stroke Services

Thrombolysis

- All people with stroke have access to a quality assured thrombolysis service 24/7 (this will include the development of regional plans to provide remote support via telestroke).

Rehabilitation and Community Stroke Services

- All eligible people with stroke receive early active rehabilitation services and equitable access to community stroke services (as defined by the National Stroke Network), supported by an interdisciplinary stroke team.

Health of Older People

Dementia services

- Ensure people with dementia and their families and whānau are valued partners in an integrated health and social support system that supports wellbeing and have control over their circumstances.
- Support interventions which seek to minimise disparities between Maori and non-Maori in relation to the timely assessment and diagnosis of dementia and subsequent care planning
- Support South Island DHB's with the implementation of the South Island Dementia Model of Care
- Improve the quality and consistency of dementia education and support programmes in operation to support family/whanau carers (e.g. Living Well with Dementia) and people living with dementia.
- Continue to expand Walking in Another's Shoes programme to foster Person Centred Dementia Care across the health continuum including different levels of staff and management

Restorative Care

- Older people will be supported to set and achieve goals by a co-ordinated and responsive health and disability support service that also enables them to maintain their social connections with community life.

Child Health	Cancer Services
Interventions to reduce hospital admissions • Support Interventions to reduce ambulatory sensitive hospitalisations for skin infections; eczema and dermatitis with emphasis on at risk children and families, Māori and Pacific 0 – 5 years • Improve Māori and Pacific engagement with Well Child Tamariki Ora providers to support the reduction in ambulatory sensitive hospitalisation rates for skin infections; eczema and dermatitis *A regional integrated healthy weight (obesity) management programme* • Develop and implement a childhood healthy weight programme to provide a more consistent approach to child weight (obesity) prevention and treatment across the South Island. • Working with Maternity Services reduce the number of dental ambulatory sensitive hospitalisations in 0 – 4 year olds across the South Island so that the burden of dental decay is minimized. • Improve the uptake and use of the South Island regional Electronic Growth chart.	*Initiatives that reduce inequalities and support access to cancer services* • Review and develop a plan to increase the uptake of cervical screening among Maori communities (Te Waipounamu Maori Leadership Group (TWMLG) Priority area)
Hepatitis C	
Integrated Hepatitis C Assessment and treatment services • Improve access to hepatitis C testing in the most appropriate setting and make use of rapid testing as informed by the outcome of the 2017 *Targeted Testing Project* study • Improve access to hepatitis C treatment utilising the hepatitis C clinical pathway to work collaboratively • Provide long term monitoring for hepatocellular carcinoma for people with cirrhosis. Where there is no cirrhosis, monitor patients until cured of hepatitis C.	

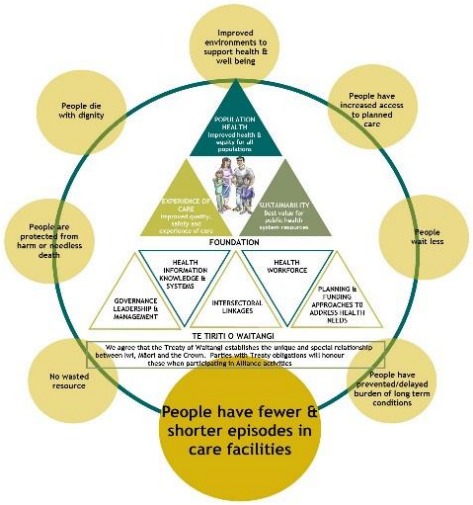
Outcome 5: People have fewer and shorter episodes in care facilities

Why is this outcome a priority?

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

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

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



What actions are we taking to address this outcome?

Cardiac Services

Heart failure

- Implement locally, regionally and nationally agreed protocols, guidance, processes and systems to ensure optimal management of patients with heart failure (within available resources).

Major Trauma

Improve the pathway for patients with major trauma

- Implement Regional Destination Policies in collaboration with DHBs, Ambulance and Air Transport providers.
- South Island data collection and input into national major trauma registry. Achievement of quality improvement markers as defined by the National Major Trauma Clinical Network.

Health of Older People

Comprehensive clinical assessment (interRAI)

- Promote South Island health professionals to use the information from the comprehensive clinical assessment (interRAI) proactively in planning of care and in service planning/ development.
- Monitor interRAI reports to identify trends including any trends or differences that may exist between Māori and non-Māori.
- Analyse specific areas of the data from all South Island DHBs

Child Health

Diabetes

- Support the South Island Diabetes Working Group to implement the areas of work identified in their workplan. This would include understanding of the current delivery of services and resources to Type 1 Diabetic consumers.

Mental Health and Addiction

Access to youth forensic services

- Youth Hub and Spoke model evaluation and reporting to determine effectiveness of plan.

Physical health outcomes of people with low prevalence disorders Injury Prevention work.

- Develop a plan to support the physical health of people with low prevalence disorders.

Forensic services

- A gap analysis of the barriers to the transition between inpatient forensic services to community based services.

Quality and Safety

Regional alignment in the deteriorating patient programme to protect people from harm or needless death

- Support the DHBs in their work on the HQSC Deteriorating Patient programme

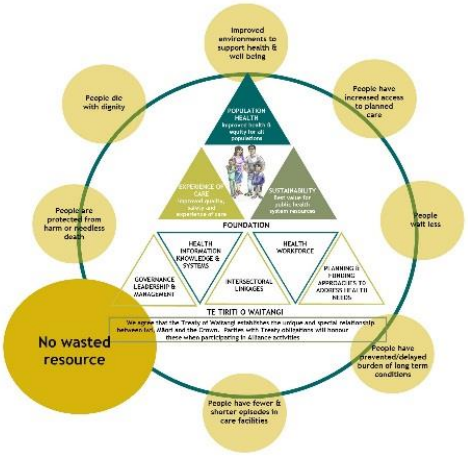
Hepatitis C	
• Establish systems to report on hepatitis C liver elastography in primary and secondary care settings • Improve access to hepatitis C liver elastography using fibroscanning to assist assessment of disease severity	• Improve access to hepatitis C liver elastography for Maori using fibroscanning to assist assessment of disease severity

Outcome 6: No wasted resource

Why is this outcome a priority?

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

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



What actions are we taking to address this outcome?

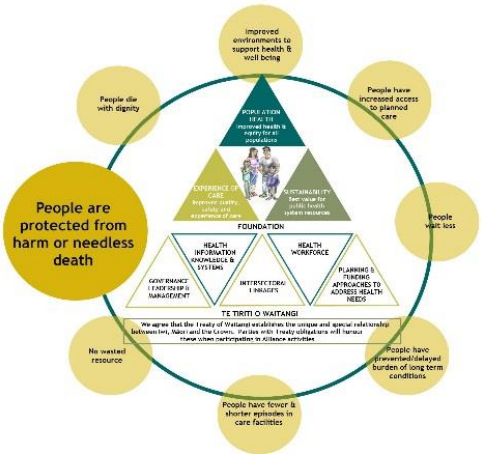
Workforce Development Hub	Workforce Development Hub
Build capacity of the workforce to work flexibly and efficiently • Ensure sustainability of the workforce redesign model (Calderdale Framework) across the South Island • Community based attachments are in place to meet requirements of new Medical Council curriculum • Support the DHBs to integrate the increased number of PGY1 (NZ citizens and permanent residents) into the workforce • Support the employment and orientation of new graduate nurses	*eLearning* • Work with Ko Awatea to establish a single platform for New Zealand • An increased number of eLearning packages are available to the South Island health workforce which can be shared nationally *Interprofessional* • South Island teams participate in the Health care Challenge
Cardiac Services	**Information Services**
Access to tests • All South Island DHBs recording and storing ECGs on common repository.	*Alerts and Warnings* • Identify the preferred South Island solution • Progress the business case / implementation planning
Cancer Services	
Implementation of the South Island Clinical Cancer Information Service • Develop a plan to support and implement the New Zealand Cancer Health Information Strategy across the South Island	*South Island Cancer Strategy* • Develop a regional strategic cancer plan to identify priorities out to 2025.

Outcome 7: People are protected from harm or needless death

Why is this outcome a priority?

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

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



What actions are we taking to address this outcome?

Child Health

Regional Sudden and Unexpected Death in Infants (SUDI) rates continue to trend downwards

- Working with Maternity Services continue to reduce Regional Sudden and Unexpected Death in Infants (SUDI) in the South Island with particular attention to Maori and Pacific SUDI rates.

South Island Children's Action Plan

- Working with providers from across the health, education and social sectors understand how best to work together to better manage the safety of vulnerable children and reduce family whanau violence

Programmes to reduce youth risk taking

- In partnership with Health Promotion Agency, South Island Public Health Partnership and the Mental Health and Addictions Service Level Alliance, implement the recommendations of South Island Youth Alcohol Emergency Department Presentations' Scoping Project March 2016

Health of Older People

Dementia Services

- Continue to expand Walking in Another's Shoes programme to foster Person Centred Dementia Care across the health continuum including different levels of staff and management

Information Services

eMedicines

- WCDHB, NMDHB ePrescribing and administration projected completed

Regional service Provider Index

- Identify the preferred South Island solution; progress the business case and implementation planning; commence a phased roll-out.

eOrdering of Radiology tests

- Progress business case and implementation planning;
- Implementation of eOrdering Radiology tests completed for NMDHB, SCDHB, WCDHB
- Confirm integration requirements of SDHB RIS platform into Regional éclair clinical data repositiory

Mental Health

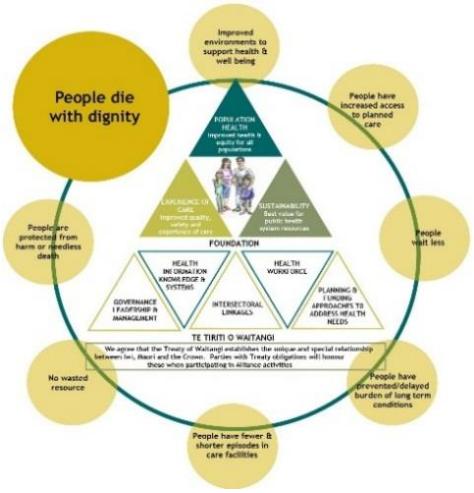
- Identify the preferred South Island mental health solution; progress the business case and implementation planning
- Support SCDHB, WCDHB, NMDHB and SDHB to progress transitioning paper mental health records into an electronic health record

Quality and Safety	Workforce Development Hub
Supporting DHBs to make a positive contribution to patient safety and quality of care • South Island DHBs understand the HQSC National Reportable events policy (reviewed in early 2017); and, its application. • Build regional capability in investigators of serious adverse events *Incident management and quality improvement* • Support ongoing development and review of Safety1st *People are protected from harm or needless death* • Explore regional approaches to share learning of improving quality of care, including good news stories	*Clinical simulation* • A coordinated clinical simulation network for the South Island is established • Lippincott (online evidence based clinical procedures) The South Island and Midland Regions are working in partnership to develop designing a national framework for the management of a Lippincott New Zealand instance *Vulnerable workforces* • South Island vulnerable workforces are identified and plans established to mitigate these • Increase Māori DHB clinical workforce working toward reflecting the South Island population • Establish a framework for Cultural Competence Education which ensures it is embedded into practice for the non-Māori workplace. • Improved employee ethnicity data collected by South Island DHBs
Cancer Services	**Mental Health and Addiction**
Improved functionality and coverage of MDMs across the region • Focused work to support findings from MDT meeting review e.g. meeting etiquette, training - MDT Coordinators, Chairs, referral requirements/timelines for radiology/pathology review, MDM resourcing • Support the rollout of the Māori Cancer Pathways Project across the South Island • Support the ongoing development of the Psychosocial and Supportive Care Initiative across the South Island, and review findings	*Value and Performance* • Workforce Development needs identified and supported

Outcome 8: People die with dignity

Why is this outcome a priority?

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



What actions are we taking to address this outcome?

Palliative Care

Provide the expertise and resources to enable patients to die in their preferred place of care

- Based on the survey findings and best practice, provide the model of care that reflects the integration of specialist, secondary and primary care into a seamless palliative care service in the South Island.
- Explore and understand how Palliative Care is delivered by Māori organisations and other ethnic minority providers

Support consumer participation and decision making about Palliative and End of Life Care at every level in the South Island

- Through benchmarking against the data collected through VOICES, which includes communication with Consumers and Māori on their experience of End of life; determine what and where improvements are called for and use this information to improve performance in the delivery of palliative care in the South Island.

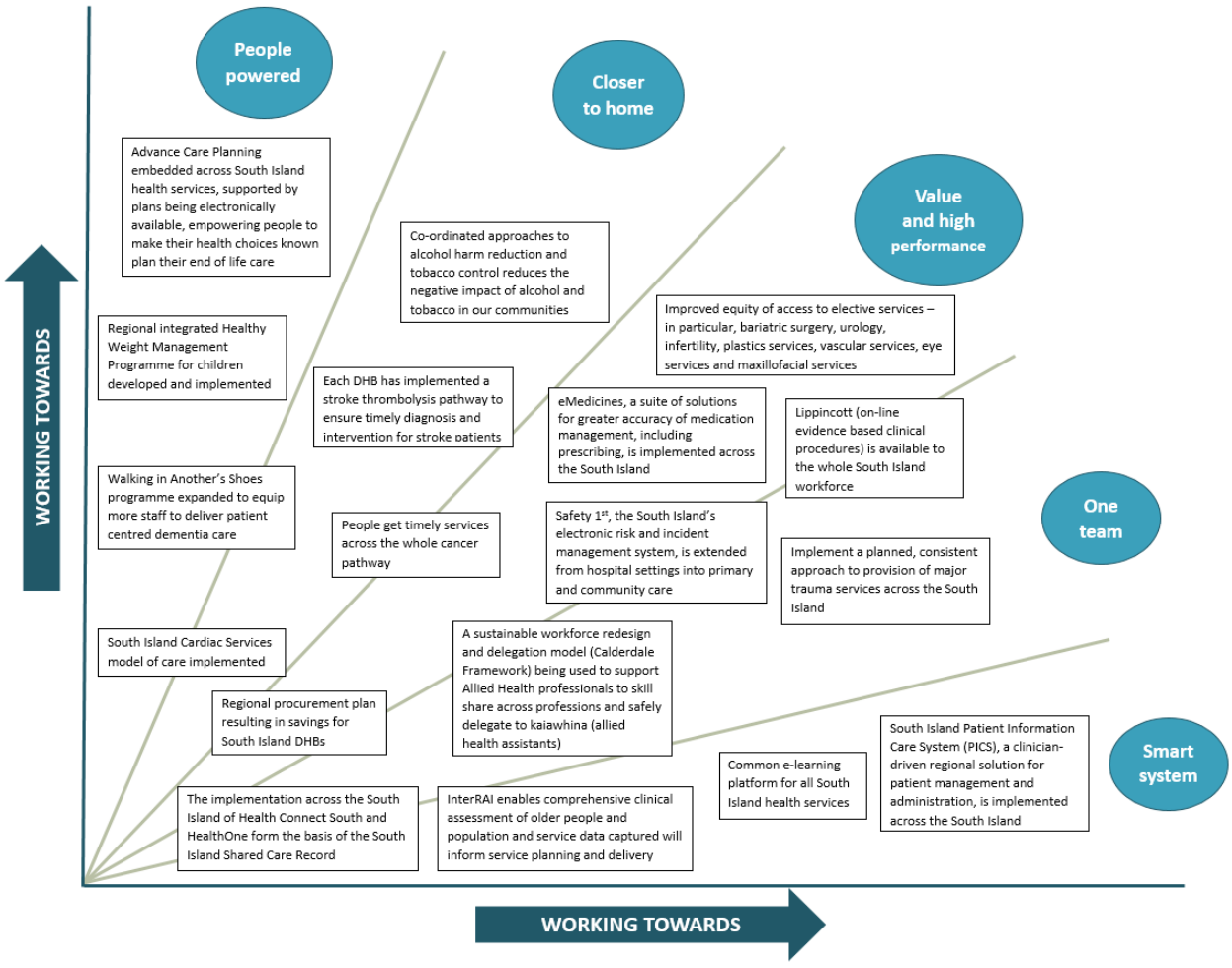
Health of Older People

Advance Care Planning (ACP)

- Support DHBs to develop ACP system implementation with processes to embed ACP as standard practice for those who will benefit
- Support South Island DHBs to participate and support National Conversations that Count Day (CtC). 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

4.3 South Island Alliance activity alignment with New Zealand Health Strategy

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



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.

The alliance provides clinical leadership opportunities and enables active participation for clinical leaders within our service level alliances, workstreams; and expert subgroups. The strategic direction is agreed with our Alliance Leadership, Board and Strategic Planning and Integration Team. A list of the team members is included as Appendix 5.

The South Island's strategic framework identifies three strategic goals and eight collective outcomes; along with a set of measures to track performance and demonstrate whether collectively we are progressing towards our long term strategic goals and making a positive change in the health of the South Island populations. Our measurements include ethnicity data when available to ensure there is continued focus on achieving equitable health outcomes for our population.

South Island Alliance Charter Principles

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

5.2 Our governance structure

The South Island Alliance focuses South Island DHB collaboration through:

- An Alliance Board (the South Island DHB Board Chairs of four DHBs and Commissioner of one DHB) that enables the strategic focus, oversees, governs, and monitors overall performance of the Alliance
- An Alliance Leadership Team (the South Island DHB CEOs) that prioritises activity, allocates resources (including funding and support) and monitors deliverables
- A Regional Capital Committee (SIA Board and Alliance Leadership Team) that reviews capital investment proposals in accordance with the agreed regional service strategy and planning
- A Strategic Planning and Integration Team (SPaIT) (Clinical and Management leaders) that supports an integrated approach, linking the Service Level Alliances (SLA) and Workstreams to the South Island vision, identifying gaps and recognising national, regional and district priorities

- The South Island Planning and Funding Network (SIP&FN) supports regional alliance issues and collaborates on non-alliance issues, including strategic planning, meeting of government priorities, statutory requirements, and provides whole of population funding advice.

5.3 Service Level Alliances (SLA) and Workstreams

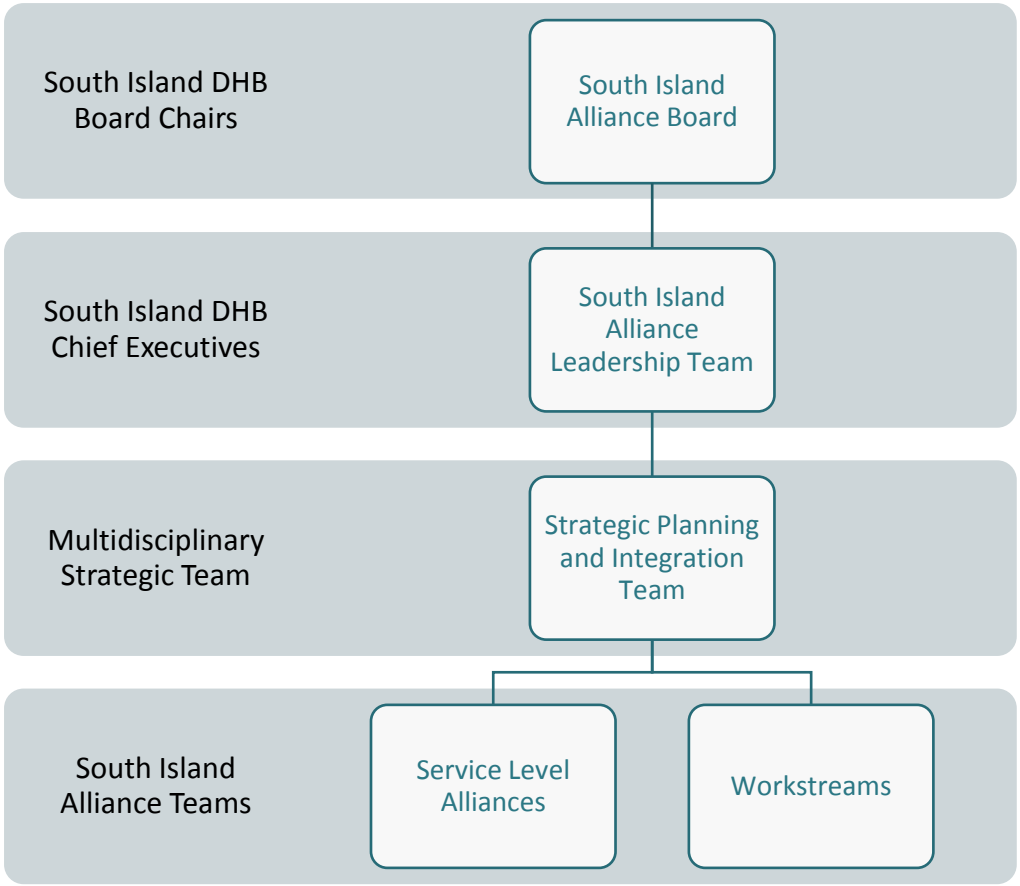
South Island regional activity involves a wide representation of the key stakeholders including health professionals, managers, funders, healthcare providers and consumers. The Service Level Alliances and Workstreams are clinically-led.

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

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

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

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



5.4 Decision making

The South Island Alliance approach to decision making and the process for resolving disputes is detailed in the South Island collective decision making principles (Appendix 1).

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

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

5.4.1 Escalation pathway

The Alliance operates under the following escalation pathway:

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

5.5 Regional funding and approval model

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

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

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

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

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

5.6 Managing our risk

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

5.6.1 Risks and challenges to South Island health services

Earthquake recovery

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

The Kaikoura earthquake on 14 November 2016 has had further impact on Canterbury and also Nelson Marlborough. The earthquake had a significant impact on Ward and Seddon in the Nelson Marlborough region; Kaikoura; and Hurunui in North Canterbury. The communities require ongoing support to manage the aftermath of the earthquake. The psychosocial recovery needs of the communities will change over the coming months and years.

South Island demographics and population shifts

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

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

Vulnerable and small services

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

Financial sustainability

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

Hospital redevelopment

In addition to the significant construction work planned or underway across a number of Canterbury hospital sites and at the Grey Base Hospital in Greymouth, over the next 10 years both Dunedin and Nelson Hospitals will be redeveloped as they are both nearing the end of their economic life and are no longer fit for purpose. Although not driven by natural disaster as in Canterbury, the Dunedin and Nelson Hospital redevelopments will have similar significant financial and capacity consequences for a number of years. Southern DHB, is developing options for the redevelopment of Dunedin Hospital to ensure it is fit-for-purpose and meets the current and future needs of our communities. The Timaru Hospital Front of Hospital business case incorporating change to Emergency, Outpatients, Day Stay services, Hospital reception and café with a spend of $9.88m was approved by the board in 2015 and the project delivery date for the upgraded and new facilities is December 2019.

5.6.2 Regional collaboration mitigating impacts

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

Our Chief Medical Officers, General Managers Planning & Funding and Hospital Services are working together to manage the theatre capacity challenges for Canterbury and Southern DHBs. Options are under consideration for implementation in 2017.

In the last quarter of 2016/17 the South Island Alliance will undertake a survey of key stakeholders. This will inform a workshop being held to review

- SIA governance and strategy approaches
- Is the balance right between DHB and South Island responsibilities?
- Where are we going?

This review will consider the current and future risks facing the region and the opportunities to mitigate the impacts of these.

Appendix 1 – Regional Collective Decision Making Principles

South Island collective decision making principles

Decision Making Principles

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

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

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

Escalation Pathway

The following is the escalation pathway:

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

Appendix 2 – Service Performance Priorities 2017-2020

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.

In measuring our outcomes we will include ethnicity and age data to identify and support actions to address inequity.

Clinical Services: Sustainability and Clinical Integration

All South Island Alliance clinical service groups are chaired by a clinician. The Chair and teams are supported by a Facilitator employed within the South Island Alliance Programme Office. A full list of the membership of the Alliance groups is included as Appendix 5.

Cancer services

Reducing the burden of cancer

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

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

- Provide a framework that supports the linkages between the South Island DHBs, DHB specialist service providers, Non-Government Organisations (NGOs), Public Health Organisations (PHOs), and consumers.
- Coordinate implementation of the New Zealand Cancer Plan across the South Island.
- Provide a formal structure that supports improvement in coordination of population programmes for prevention and screening and the quality of treatment.

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

- Timeliness of services across the whole cancer pathway
- South Island Cancer Service Coordination and Quality Improvement: Ensure people have access to services that maintain good health and independence and receive excellent services wherever they are. Services make the best use of available resources
- South Island Cancer Service reducing inequalities
- South Island Clinical Cancer Intelligence Service

MILESTONES DASHBOARD 2017-20					
ITEM NO	**DELIVERABLE 2017-2018**	**APPROVED SCHEDULE**	**DELIVERABLE 2018-2019**	**DELIVERABLE 2019-2020**	**RESPONSIBILITIES**
CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION					
Southern Cancer Network					
TIMELINESS OF SERVICES ACROSS THE WHOLE CANCER PATHWAY **People get timely services across the whole cancer pathway (screening, detection, diagnosis, treatment and management, palliative care)**					
Faster Cancer Treatment Health Target AND Policy Priority (PP30) Initiatives					
1	Support DHBs to deliver the extended FCT target of 'At least 90% of patients receive their first treatment within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks by July 2017'	Q1,Q2, Q3,Q4	Support DHBs to deliver the extended FCT target of '*At least 90% of patients receive their first treatment within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks by July 2017*	Support DHBs to deliver the extended FCT target of '*At least 90% of patients receive their first treatment within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks by July 2017*	Contributors: SCN coordinate and support the process in collaboration with the DHBs Reported in: SIHSP
2	Support DHBs with undertaking and delivering the FCT Round 2 Funded Projects	Q1,Q2, Q3,Q4	Finding will have been disseminated across all DHBs		Contributors: SCN coordinate and support the process in collaboration with the DHBs Reported in: SIHSP
3	Undertake a focused review to understand the 'Route to Service Access/Diagnosis' for all South Island cancer patients, with a focus on first presentation through ED	Q2	Finding will have been disseminated across all DHBs		SCN supported by DHBs
Improved or maintained performance against the Policy Priority (PP30) Faster Cancer Treatment Indicators					
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 (85% target for PP30 31 day indicator)	Q1,Q2, Q3,Q4	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	DHBs are responsible for the target. SCN support the DHBs
Regional Cancer Pathways					
6	Development of comparable timely, cancer pathways for the SI	Q1,Q2, Q3,Q4	Implementation of pathway guidelines across the SI		SCN Tumour Stream Group, SCN core & DHBs
7	Undertake an annual assessment of the Cancer Clinical Priorities, through the South Island/SCN Cancer Clinical Leads Group	Q1	Undertake an annual assessment of the Cancer Clinical & Service Priorities, through the South Island/SCN Cancer Clinical Leads Group	Undertake an annual assessment of the Cancer Clinical & Service Priorities, through the South Island/SCN Cancer Clinical Leads Group	SCN Tumour Stream Group, SCN core & DHBs
8	Supporting DHBs in preparation for the introduction of a national bowel screening programme - focus on services to support the delivery of additional cancer cases	Q1,Q2, Q3,Q4	Work with CDHB. NMDHB & SCDHB	Work with WCDHB	SCN & SDHB
9	Support DHBs with the implementation of the Early Lung Cancer Guidance (to be published shortly)	Q1,Q2, Q3,Q4	Complete implementation of the guidance		SCN & DHBs
SOUTH ISLAND CANCER SERVICE COORDINATION AND QUALITY IMPROVEMENT **People have access to services that maintain good health and independence and receive excellent services wherever they are. Services make the best use of available resources**					
Improved functionality and coverage of Multi-Disciplinary Meetings (MDMs) across the region					
9	Complete the rollout of the regionally agreed MDT recommendations and service improvement initiatives started in 2015-16	Q1,Q2, Q3,Q4	Further implementation, enhancements and training	Ongoing maintenance	SCN & DHBs
10	Review South Island MDM System against national specification	Q1,Q2, Q3,Q4	Dependent on 2017/18 progress		SCN & DHBs

MILESTONES DASHBOARD 2017-20					
ITEM NO	DELIVERABLE 2017-2018	APPROVED SCHEDULE	DELIVERABLE 2018-2019	DELIVERABLE 2019-2020	RESPONSIBILITIES
11	Focused work to support findings from MDT meeting review e.g. meeting etiquette, training - MDT Coordinators, Chairs, referral requirements/timelines for radiology/pathology review, MDM resourcing	Q1,Q2, Q3,Q4	Dependent on 2017/18 progress		SCN & DHBs
12	Prioritisation of cases for discussion at MDMs	Q1,Q2, Q3,Q4			SCN & DHBs
Survivorship					
13	Rollout (national) Supportive Care Framework across the South Island	Q1,Q2, Q3,Q4	Dependent on progress during 17/18	Dependent on a new NZ Cancer Plan	SCN, TWMLG, DHBs, NGOs
14	Survivorship TBA		Dependent on a new NZ Cancer Plan	Dependent on a new NZ Cancer Plan	SCN, TWMLG, DHBs, NGOs
South Island-wide radiation oncology services					
15	Support implementation of the National Radiation Oncology Plan				
SOUTH ISLAND CANCER SERVICE REDUCING INEQUITIES **People have access to services that maintain good health and independence and receive excellent services wherever they are. Services make the best use of available resources**					
Initiatives that reduce inequalities and support access to cancer services					
16	Improved collection of ethnicity data cross the whole health spectrum	Q1,Q2			SCN, TWMLG, DHBs, NGOs
17	Support the rollout of the Maori Cancer Pathways Project across the South Island	Q1,Q2,			SCN, TWMLG, DHBs, NGOs
18	Review and develop a plan to increase the uptake of cervical screening among Maori communities (Te Waipounamu Maori Leadership Group (TWMLG) Priority area)	Q1,Q2,			SCN & DHBs, including Public Health, possible collaboration with Health Promotion
19	Support the collaborative regional working of both TWMLG & the SI CCG and integrate as co-partners into the regional plan	Q1,Q2, Q3,Q4	Dependent on a new NZ Cancer Plan	Dependent on a new NZ Cancer Plan	SCN, TWMLG, DHBs, NGOs
South Island Psychological and Supportive Care Service					
20	Support the rollout and implementation of the Psychosocial and Supportive Care Initiative across the South Island, and assess early findings	Q1,Q2, Q3,Q4			SCN,DHBs & NGOs
SOUTH ISLAND CANCER INTELLIGENCE SERVICE **Support the implementation of the NZ Cancer Health Information strategy, Ready access to timely, accurate and appropriate cancer data and information across the SI for all Stakeholders,**					
Implementation of the South Island Clinical Cancer Information Service (SICCIS): Robust cancer data and information sources are developed and shared that enable informed service development & planning decision-making					
21	Develop a plan to support and implement the NZ Cancer health Information Strategy across the South Island	Q1,Q2, Q3,Q4	Dependent on a new NZ Cancer Plan	Dependent on a new NZ Cancer Plan	
22	Produce and further develop a Quarterly Cancer Dashboard to understand progress against cancer standards and targets, and to identify areas for service improvement	Q2,Q4	Produce a quarterly South Island Cancer Dashboard to understand progress against cancer standards and targets, and to identify areas for service improvement	Produce a quarterly South Island Cancer Dashboard to understand progress against cancer standards and targets, and to identify areas for service improvement	SCN & DHBs
South Island Cancer Strategy – Cancer in 2025					
23	Develop a regional strategic cancer plan to identify priorities out to 2025.	Q2,Q4	Review Regional Strategic Cancer Plan for areas of change	Review Regional Strategic Cancer Plan for areas of change	SCN & DHBs

Child Health Services

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

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

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

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

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

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

- Growing up Healthy - responding to national strategies for improving children's health outcomes and preventing child abuse.
- Young Persons Health - responding to the Prime Minister's Youth Mental Health project
- Access to Child Health Services - supporting innovation, good practice and equity
- Consumer Consultation

MILESTONES DASHBOARD 2017-20					
ITEM NO	**DELIVERABLE 2017-2018**	**APPROVED SCHEDULE**	**DELIVERABLE 2018-2019**	**DELIVERABLE 2019-2020**	**RESPONSIBILITIES**
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	Working with providers from across the health, education and social sectors understand how best to work together to better manage the safety of vulnerable children and reduce family whanau violence	Q4	Working with providers from across the health, education and social sectors understand how best to work together to better manage the safety of vulnerable children and reduce family whanau violence	Working with providers from across the health, education and social sectors understand how best to work together to better manage the safety of vulnerable children and reduce family whanau violence	SI CHSLA SI PHSLA
2	To support the South Island DHBs to understand and respond to information reported from e-Prosafe.	Q4	Continued achievement to support the child protection teams across the South Island on matters as reported within e-prosafe	Continued achievement to support the child protection teams across the SI on matters as reported within e-prosafe	CHSLA

MILESTONES DASHBOARD 2017-20					
ITEM NO	DELIVERABLE 2017-2018	APPROVED SCHEDULE	DELIVERABLE 2018-2019	DELIVERABLE 2019-2020	RESPONSIBILITIES
Regional Sudden and Unexpected Death in Infants (SUDI) rates continue to trend downwards					
3	Working with maternity services and in alignment with the National SUDI Prevention Programme (July 2017) continue to reduce Regional Sudden and Unexpected Death in Infants (SUDI) in the South Island with particular attention to Maori and Pacific SUDI rates.	Q1,Q2, Q3, Q4	Facilitate the transition back to DHBs		CHSLA
YOUNG PERSONS HEALTH - responding to the Prime Ministers Youth Mental Health project					
Support programmes which reduce youth risk taking resulting in injury/disease from smoking, alcohol, drug and sexual diseases					
4	In partnership with Health Promotion Agency, South Island Public Health SLA and South Island Mental Health and Addictions SLA, implement recommendations of the South Island Youth Alcohol Emergency Department Presentations' Scoping project March 2016	Q3	Implementation of agreed findings Continuous evaluation of mechanisms in place	Facilitate the transition back to DHBs	CHSLA, MH&ASLA, PHSLA, HPA
5	Support DHBs to implement the Ministry of Health's Sexual and Reproductive Health Action Plan as it relates to teen pregnancy.	Q3	Facilitate the transition back to DHBs		CHSLA, MH&ASLA, PH SLA; HPA
ACCESS TO CHILD HEALTH SERVICES supporting innovation, good practice and equity based on the Children's Commissioner Compass report 2013					
Interventions to reduce hospital admission for skin infections and respiratory conditions with emphasis on at risk children and families, Māori and Pacific					
6a	Support interventions to reduce ambulatory sensitive hospitalisations for skin infections; eczema and dermatitis with emphasis on at risk children and families, Māori and Pacific 0 – 5 years	Q2,Q3	Ongoing monitoring of hospital admission rates and ED presentations	Facilitate the transition back to DHBs	CHSLA
6b	Improve Māori and Pacific engagement with Well Child Tamariki Ora providers to support the reduction in ambulatory sensitive hospitalisations rates for skin infections; eczema and dermatitis	Q2	Improve Māori and Pacific engagement with Well Child Tamariki Ora providers to support the reduction in ambulatory sensitive hospitalisations rates for skin infections; eczema and dermatitis	Facilitate the transition back to DHBs	CHSLA, WCTO
7	Support the South Island Diabetes Working Group to implement the areas of work identified in their workplan. This would include understanding of the current delivery of services and resources to Type 1 Diabetic consumers.	Q3	Implement findings of Working Group	Facilitate the transition back to DHBs	CHSLA, Diabetes Working Group
A regional integrated obesity management programme					
8	Develop and implement a childhood healthy weight programme to provide a more consistent approach to child weight (obesity) prevention and treatment across the South Island.	Q4	Develop and implement a childhood healthy weight programme to provide a more consistent approach to child weight (obesity) prevention and treatment across the South Island.	Develop and implement a childhood healthy weight programme to provide a more consistent approach to child weight (obesity) prevention and treatment across the South Island.	CHSLA, PH SLA
9	Work with DHBs to align the Childhood Healthy Weight Program with the MoH health target for Child health	Q4	Work with DHBs to align Childhood Healthy Weight Program with the MoH health target Child Health	Facilitate the transition back to DHBs	CHSLA, PHSLA

MILESTONES DASHBOARD 2017-20					
ITEM NO	DELIVERABLE 2017-2018	APPROVED SCHEDULE	DELIVERABLE 2018-2019	DELIVERABLE 2019-2020	RESPONSIBILITIES
10	Working with Maternity Services reduce the number of dental ambulatory sensitive hospitalisations in 0 – 4 year olds across the South Island, so that the burden of dental decay is minimised.	Q4	Working with Maternity Services reduce the number of dental ambulatory sensitive hospitalisations in 0 – 4 year olds across the SI so that the burden of dental decay is minimised	Facilitate the transition back to DHBs	CHSLA, PHSLA :
11	Support a comprehensive and coordinated approach to preventable chronic disease by sharing the learnings from Healthy Families Canterbury and Invercargill to all South Island DHBs with particular emphasis on improved nutrition and increased physical activity in children and young people.	Q4	Support a comprehensive and coordinated approach to preventable chronic disease by sharing the learnings from Healthy Families Canterbury and Invercargill to all South Island DHBs with particular emphasis on improved nutrition and increased physical activity in children and young people.	Facilitate the transition back to DHBs	CHSLA
12	Improve the uptake and use of the South Island regional Electronic Growth chart.	Q1	Facilitate the transition back to DHBs.		CHSLA, ISSLA
Consumer Consultation **To include children, young people and whanau in the planning , delivery and evaluation of health services**					
13	Identify what consumers really want from the Child Health Services in the South Island and record how the consumer and their whanau experience the service	Q3	Ongoing consultation with consumers and input into workplan	Facilitate the transition back to DHBs	CHSLA, Q&S SLA

Mental Health and Addiction Services

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

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

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

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

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

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

- Alcohol and Other Drug Services
- Youth Forensic
- Workforce Development
- Mental Health and Addiction Service Capacity for People with High and Complex Needs
- People with Low Prevalence Disorders
- Adult Forensic Services
- Suicide Prevention and Actions

MILESTONES DASHBOARD 2017-20					
ITEM NO	**DELIVERABLE 2017-2018**	**APPROVED SCHEDULE**	**DELIVERABLE 2018-2019**	**DELIVERABLE 2019-2020**	**RESPONSIBILITIES**
CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION					
Mental Health and Addiction Service Level Alliance					
Value and Performance - ALCOHOL AND OTHER DRUG SERVICES					
Withdrawal management and the implications of the Substance Addiction Compulsory Assessment and Treatment bill					
1a	Advice provided to the implementation of a South Island withdrawal management plan including the new Substance Addiction Legislation (SAL)	Q1,Q2, Q3, Q4	Services are supported to manage changes to processes and expectations when the new law comes into force in 2018	Services are supported to manage application of the new substance addiction legislation	MH&A SLA and SAL Working group
1b	Support the identification of Māori and Pacific population concerns	Q2, Q4	Māori and Pacific specific deliverables are included in the planning	Māori and Pacific specific deliverables are included in the planning	MH&A SLA and SAL Working group
1c	Workforce Development needs identified and supported	Q2,Q4	Items from Workforce plan included in future plans	Workforce Development needs identified and supported	MH&A SLA and SAL Working group
YOUTH FORENSIC					
Hub and Spoke Model					
2	Youth Hub and Spoke model evaluation and reporting to determine effectiveness of plan.	Q2, Q4	Reporting, review and provide advice on the progress and success of the model	Facilitate transition back to DHBs	Youth Forensic Working group and MH&A SLA

MILESTONES DASHBOARD 2017-20					
ITEM NO	**DELIVERABLE 2017-2018**	**APPROVED SCHEDULE**	**DELIVERABLE 2018-2019**	**DELIVERABLE 2019-2020**	**RESPONSIBILITIES**
WORKFORCE DEVELOPMENT					
Workforce development recommendations					
3a	Continue the engagement started with the South Island Mental Health and Addiction Workforce Development plan in 2016/2017	Q1,Q2 Q2,Q4	Continue the engagement started with the Workforce Development plan in 2016/2017	Continue the engagement started with the Workforce Development plan in 2016/2017	MH&A SLA with SIWDH
3b	Continue to maintain and strengthen the Education and Training group.	Q1, Q2 Q3, Q4	Continue the engagement started with the Workforce Development plan in 2016/2017	Continue the engagement started with the Workforce Development plan in 2016/2017	MH&A SLA with SIWDH
3c	Establish and support the South Island Mental Health and Addiction Workforce Planning Work group	Q1, Q2 Q3, Q4	Continue the engagement started with the Workforce Development plan in 2016/2017	Continue the engagement started with the Workforce Development plan in 2016/2017	MH&A SLA with SIWDH
MENTAL HEALTH AND ADDICTION SERVICE CAPACITY AND CAPABILITY FOR PEOPLE WITH HIGH AND COMPLEX NEEDS					
Intellectual Disability and Mental Health					
4a	Support development of workforce for patients with Intellectual Disability and mental health issues.	Q4	Deliverable based on actions identified in 2017/2018 plan	Deliverable based on actions identified in 2018/2019 plan	MH&A SLA
Forensic Services					
4b	A gap analysis of the barriers to the transition between inpatient forensic services to community based services	Q2, Q4	Recommendations based on the gap analysis	Facilitate transition back to DHBs	MH&ASLA
PEOPLE WITH LOW PREVALENCE DISORDERS					
Physical health outcomes of people with low prevalence disorders					
5	Develop a plan to support the physical health of people with low prevalence disorders.	Q4	Deliverable based on actions identified in 2017/2018 plan	Deliverable based on actions identified in 2018/2019 plan	MH&A SLA
ADULT FORENSIC SERVICES					
Improved adult forensic service capacity and responsiveness					
6	Prison screening data provided (Prison screening occurs within agreed timeframes with 80% of prisoners referred seen within 7 days of receipt of referral)	Reports July 2017, November 2017, February 2018, May 2018	Prison screening data provided	Prison screening data provided	MH&A SLA
SUICIDE PREVENTION PLANNING AND ACTIONS					
Creation of Suicide Prevention Working Group and Activities					
7a	Formation of working group/expert panel to provide advice and strategic planning.	Q1,Q2, Q3,Q4	Provide advice and support to DHB suicide planning	Provide advice and support to DHB suicide planning	MH&A SLA and Expert Panel
7b	Māori and Pacific concerns are addressed as part of the work of the expert panel	Q2,Q4	Provide advice and support to DHB suicide planning	Provide advice and support to DHB suicide planning	MH&A SLA and Expert Panel

Work supported by the Mental Health and Addictions SLA

The Mental Health and Addictions SLA is committed to supporting work led by other SLAs/Workstreams or individual DHBs where appropriate. In particular, the SLA will support South Island DHBs to deliver the preferred South Island Mental Health information solution.

Regional initiatives supported by the Mental Health and Addictions SLA but led by other SLAs/Workstreams or individual DHBs
Mental health information solution (page 73 Item 16) Identify the preferred South Island Mental Health solution and progress Business case and implementation planning for the preferred South Island Mental Health Solution. Support SCDHB, WCDHB, NMDHB and SDHB to progress transitioning paper mental health records into electronic health record *Owner: Information Services SLA* *Reported: SI HSP*

Health of Older People Services

Best healthcare for older people everywhere in the South Island

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

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

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

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

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

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

MILESTONES DASHBOARD 2017-20					
ITEM NO	DELIVERABLE 2017-2018	APPROVED SCHEDULE	DELIVERABLE 2018-2019	DELIVERABLE 2019-2020	RESPONSIBILITIES
CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION					
Health of Older People Service Level Alliance					
STRENGTHENING DEMENTIA PATHWAYS					
1a	Ensure people with dementia and their families and whānau are valued partners in an integrated health and social support system that supports wellbeing and have control over their circumstances.	Q2,Q4	Ensure people with dementia and their families and whānau are valued partners in an integrated health and social support system that supports wellbeing and have control over their circumstances.	Ensure people with dementia and their families and whānau are valued partners in an integrated health and social support system that supports wellbeing and have control over their circumstances.	HOPSLA DHB Health of Older People Managers
1b	Provide DHBs with on-going support and overview so that DHBs identify and strengthen components of dementia care pathways within the parameters of the New Zealand Framework for Dementia Care	Q2,Q4	Provide DHBs with on-going support and overview so that DHBs identify and strengthen components of dementia care pathways within the parameters of the New Zealand Framework for Dementia Care	Provide DHBs with on-going support and overview so that DHBs identify and strengthen components of dementia care pathways within the parameters of the New Zealand Framework for Dementia Care	HOPSLA
1c	Support interventions which seek to minimise disparities between Māori and non-Māori in relation to the timely assessment and diagnosis of dementia and subsequent care planning	Q2,Q4	Support interventions which seek to minimise disparities between Māori and non- Māori in relation to the timely assessment and diagnosis of dementia and subsequent care planning	Support interventions which seek to minimise disparities between Māori and non- Māori in relation to the timely assessment and diagnosis of dementia and subsequent care planning	DHB Health of Older People Managers
1d	Support South Island DHB's with the implementation of the South Island Dementia Model of Care.	Q2,Q4	Support South Island DHBs with the implementation of the South Island dementia model of care in line with identified priorities	Support South Island DHBs with the implementation of the South Island dementia model of care in line with identified priorities	HOPSLA

MILESTONES DASHBOARD 2017-20					
ITEM NO	DELIVERABLE 2017-2018	APPROVED SCHEDULE	DELIVERABLE 2018-2019	DELIVERABLE 2019-2020	RESPONSIBILITIES
2	Improve the quality and consistency of dementia education and support programmes in operation to support family/whanau carers (e.g., Living Well with Dementia) and people living with dementia.	Q2,4	Improve the quality and consistency of dementia education and support programmes in operation to support family/whanau carers (e.g., Living Well with Dementia) and people living with dementia.	Improve the quality and consistency of dementia education and support programmes in operation to support family/whanau carers (e.g., Living Well with Dementia) and people living with dementia.	HOPSLA DHB Dementia teams
3	Continue to expand Walking in Another's Shoes programme to foster Person Centred Dementia Care across the health continuum including different levels of staff and management	Q1,Q4	Continue to embrace Walking in Another's Shoes programme to foster Person Centred Dementia Care	Continue to embrace Walking in Another's Shoes programme to foster Person Centred Dementia Care	HOPSLA
Strengthening Delirium Pathways					
4	Promote the concept of 'Think delirium' across South Island DHBs with regard to delirium prevention. Encourage the development of delirium pathways in all South Island DHBs to assist in the prevention, assessment and management of delirium across the care continuum and create consistencies in care.	Q1,Q2, Q3,Q4	Promote the concept of 'Think delirium' across South Island DHBs with regard to delirium prevention. Record utilisation of delirium pathways in all SI DHBs to assist in the prevention, assessment and management of delirium across the care continuum and create consistencies in care.	Promote the concept of 'Think delirium' across South Island DHBs with regard to delirium prevention. Record the utilisation of delirium pathways in all SI DHBs to assist in the prevention, assessment and management of delirium across the care continuum and create consistencies in care.	HOPSLA DHBs Walking in Another's Shoes Development Team
interRAI					
5a	Promote South Island health professions to use the information from comprehensive clinical assessment (interRAI) proactively in plan of care and in service planning/ development.	Q1, Q2, Q4	Encourage collaboration across DHBs and promote SI health professions to use the information from comprehensive clinical assessment (interRAI) proactively in plan of care and in service planning/ development Monitor interRAI reports to identify trends.	Encourage collaboration across DHBs and promote SI health professions to use the information from comprehensive clinical assessment (interRAI) proactively in plan of care and in service planning/ development. Monitor interRAI reports to identify trends.	HOPSLA Central TAS
5b	Monitor interRAI reports to identify trends including any trends or differences that may exist between Māori and non- Māori Analyse specific areas of the data from all South Islands DHBs	Q1, Q2, Q,3 Q4	Monitor interRAI reports from each DHB and the SI to identify trends including any trends or differences that may exist between Māori and non- Māori. Use these trends to advocate for service delivery according to identified needs.	Monitor interRAI reports from each DHB and the SI to identify trends including any trends or differences that may exist between Māori and non- Māori. Use these trends to advocate for service delivery according to identified needs.	HOPSLA
ADVANCE CARE PLANNING					
People who live in New Zealand experience Advance Care Plan (ACP) enriched lives & deaths, having their values underpin their care and receive care in the place & manner they prefer					
6	Support DHBs to develop ACP system implementation with processes to embed ACP as standard practice for those who will benefit	Q2,Q4	Support DHBs to develop ACP system implementation with processes to embed ACP as standard practice for those who will benefit	Support DHBs to develop ACP system implementation with processes to embed ACP as standard practice for those who will benefit	HOPSLA ISSLA
7	ACP L1A and L 2 Training is available in a planned manner for staff in each DHB district in South Island (subject to resources)	Q1,Q2, Q3,Q4	ACP L 2 Training is available in a planned manner for health professional staff in each DHB district in South Island (subject to resources)	ACP L 2 Training is available in a planned manner for staff in each DHB district in South Island (subject to resources)	
8	Support South Island DHBs to participate and support National Conversations that Count Day (CtC). This will encourage individuals,	Q2,Q3	Support South Island DHBs to participate and support National Conversations that Count Day. This will encourage individuals,	Support South Island DHBs to participate and support National Conversations that Count Day. This will encourage individuals,	HOPSLA

MILESTONES DASHBOARD 2017-20					
ITEM NO	DELIVERABLE 2017-2018	APPROVED SCHEDULE	DELIVERABLE 2018-2019	DELIVERABLE 2019-2020	RESPONSIBILITIES
	communities and health staff to have conversations useful for a person to document their ACP and develop a shared understanding of an individual's choice CtC education (Peer education for the public delivered 'by the public') is available in each South Island DHB (as resources are available)		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	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	
RESTORATIVE MODEL OF CARE					
9	Older people will be supported to set and achieve goals by a co-ordinated and responsive health and disability support service that also enables them to maintain their social connections with community life.	Q2,Q4	Facilitate the transition of ongoing activity regarding the use of restorative principles to DHBs		HOPSLA DHBs
WORKFORCE					
10	Work with HWNZ and DHBSS to develop a sustainable mechanism for collecting a minimum workforce data set on the health workforce working in health of older people outside the DHB provider arm by 30 June 2018.	Q4	The workforce caring for older people will receive training and support in order to provide high quality, person-centred care	The workforce caring for older people will receive training and support in order to provide high quality, person-centred care	HOPSLA DHBs

Palliative Care Services

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

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

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

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

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

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CLINICAL SERVICES: SUSTAINABILITY AND INTEGRATION					
Palliative Care					
INFORMATION TECHNOLOGY AND SERVICES					
By using new electronic systems and tools health professionals are able to securely share and gather relevant patient information that will result in safer, better and timely palliative care to patients					
1a	To inform and influence the development of information systems within the South Island that will deliver a more efficient and safer transfer of patient information between Palliative Care Providers (including Hospice services) across the SI while reducing costs and risk	Q4	Ongoing implementation of Information Technology developments	Ongoing implementation of Information Technology developments	Contributors: SI PC WS SI IS SLA Reported in: SIHSP
1b	Following the completion and evaluation of the current pilot, support the development and the roll out of Palliative Care interRAI across the South Island	Q3	Ongoing implementation of Information Technology developments	Facilitate the transition back to DHBs	Contributors: SI PC WS SI IS SLA Reported in: SIHSP

MILESTONES DASHBOARD 2017-20					
ITEM NO	**DELIVERABLE 2017-2018**	**APPROVED SCHEDULE**	**DELIVERABLE 2018-2019**	**DELIVERABLE 2019-2020**	**RESPONSIBILITIES**
HOSPICE AND HOSPITAL PALLIATIVE CARE SERVICES					
To provide all people who are dying and their family /whanau access to an equitable and quality palliative care service wherever that service may be located in the South Island					
2a	Use the information from Hospital and Hospice Surveys and the evaluation of palliative care in primary care (PHOs ARC and P&F) to promote regional consistency and access to resources. Inform and influence South Island DHBs so services are aligned to the Resource and Capability Framework for Adult Palliative Care and the work of the National Adult Palliative Care Review	Q4	Develop and monitor initiatives identified as a result of Palliative Care bench marking	Develop and monitor initiatives identified as a result of Palliative Care bench marking	Contributors: SI PCW Reported: SIHSP
2b	Working within the National Paediatric Palliative care Guidelines: provide high level guidance within the South Island to those providing Paediatric palliative care	Q4	Monitor and progress any initiatives or issues as appropriate to Paediatric Palliative Care	Facilitate the transition back to DHBs	Contributors: SI PCW Reported: SIHSP
PRIMARY AND COMMUNITY CARE					
To provide the expertise and resources to enable patients to die in their preferred place of care.					
3a	Based on the survey findings and best practice, develop and support the model of care that reflects the integration of specialist, secondary and primary care into a seamless palliative care service in the South Island.	Q4	Work with stakeholders to deliver on key priorities to influence change	Work with stakeholders to deliver on key priorities to influence change	Contributors: SI PCW Reported in: SIHSP
3b	Partner with St John to understand how palliative and end of life care is provided and how it can be improved	Q4	Continue to access and apply current workforce analysis, planning and implementation	Facilitate the transition back to DHBs	Contributors: SI PCW Reported in: SIHSP
3c	Explore and understand how Palliative Care is delivered by Maori organisations and other ethnic minority providers	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
3d	Explore opportunities to provide guidance on the substantive competencies for allied health professionals undertaking education in palliative care in South Island.	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, SIWDH Reported in: SIHSP
NETWORKING AND ENGAGEMENT					
To support consumer participation and decision making about Palliative and End of Life Care at every level in the SI.					
4	Through benchmarking against the data collected through VOICES, which includes communication with Consumers and Maori on their experience of End of life; determine what and where improvements are called for and use this information to improve performance in the delivery of palliative care in the SI.	Q4	Continue to demonstrate communication with Consumers and Maori on their experience of End of life and Palliative Care services in the South Island	Continue to demonstrate communication with Consumers and Maori on their experience of End of Life and Palliative Care services in the South Island	Contributors: SI PCW Reported in: SIHSP

Cardiac Services

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

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

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

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

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

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

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

MILESTONES DASHBOARD 2017-20					
ITEM NO	**DELIVERABLE 2017-2018**	**APPROVED SCHEDULE**	**DELIVERABLE 2018-2019**	**DELIVERABLE 2019-2020**	**RESPONSIBILITIES**
CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION					
Cardiac Services Workstream					
SOUTH ISLAND MODEL OF CARE					
Complete project work associated with the South Island Cardiac Model of Care					
1a	South Island Cardiac Model agreed and implemented consistently in the region (within resources available).	Q2,Q4	South Island Cardiac Model of Care is acknowledged as providing improved and more efficient services	South Island Cardiac Model of Care is acknowledged as providing improved and more efficient services	Workstream members and co-opted expertise on various projects required to complete the model
1b	SI Alliance Leadership Team approves the recommendations of the model of care project group.	Q2			
1c	Recommendations adopted by the cardiac workstream and specific project groups established	Q2			
1d	Implementation of change evidenced by audit	Q4			
Access to tests					
2	All South Island DHBs recording and storing ECGs on common repository	Q2,Q4	Maintain common regional method of storing and sharing ECGs	Maintain common regional method of storing and sharing ECGs	Cardiac Services workstream, with support/advice from IS SLA
Optimal HealthPathways					
3a	STEMI Pathway in conjunction with St John implemented	Q2	Report on regional pathway usage	Report on regional pathway usage	Cardiac Workstream and project group B

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3b	Common Accelerated Chest Pain pathway implemented in South Island hospitals.	Q2	Facilitate transition back to DHBs		SI DHBs
3c	Review and audit Acute Chest Pain Pathways in Emergency Departments	Q4			
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					
4	Monitor access rates for high risk population groups. Prepare reports at Q2 and Q4 from ANZACS QI data to show intervention rates for Maori, Pacific and Asian people to help identify and address any issues.	Q1,Q2, Q3,Q4	Improved access for high risk population groups	Improved access for high risk population groups	Cardiac Workstream
MEETING NATIONAL INDICATORS **Improved outcomes for people with suspected Acute Coronary Syndrome**					
Patients with suspected Acute Coronary Syndrome (ACS) receive seamless, co-ordinated care across the clinical pathway					
5	Support South Island DHBs to address any challenges that arise with providing appropriate cardiac care and meeting standardised intervention rates.	Q1, Q2, Q3, Q4	Continued achievement of national indicators as determined by/modified as determined nationally in conjunction with the National Cardiac network.	Continued achievement of national indicators as determined by/modified as determined nationally in conjunction with the National Cardiac network.	DHBs and Cardiac Workstream
Cardiac surgery targets achieved which will improve equity of access					
6	Support South Island DHBs in the continued achievement of national indicators around equity of access.	Q1,Q2 Q3,Q4	Continued achievement of national indicators as determined nationally in conjunction with the National Cardiac network.	Continued achievement of national indicators as determined nationally in conjunction with the National Cardiac network.	DHBs and Cardiac Workstream
HEART FAILURE					
Implement locally, regionally and nationally agreed protocols, guidance, processes and systems to ensure optimal management of patients with heart failure.					
7	Implement locally, regionally and nationally agreed protocols, guidance, processes and systems to ensure optimal management of patients with heart failure (within available resources).	Q4	South Island DHBs continue achievement of national indicators as determined by/modified by Ministry of Health in conjunction with the National Cardiac network	South Island DHBs continue achievement of national indicators as determined by/modified by Ministry of Health in conjunction with the National Cardiac network	Cardiac Services Workstream
WORKFORCE TRAINING **Workforce training maintained**					
Opportunities for training in echocardiography identified					
8	Implement recommendations formed in conjunction with National Network (subject to resource constraints)	Q4	Continued uptake of education opportunities	Continued uptake of education opportunities	Cardiac Services Workstream, with support/advice from SIWDH
Transporting of Cardiac Patients					
Regionally agreed guidelines for the arranged transportation of cardiac patients					
9	Guidelines for transporting cardiac patients agreed in 2013 and updated 2015/16 are consistent for the South Island	Q4	Facilitate transition back to DHBs		SI DHBs responsibility

Cardiac Services

Intervention rates for cardiac surgery, coronary angiography, and percutaneous revascularisation

The South Island DHBs will strive to meet the following intervention rates for cardiac surgery, coronary angiography, and percutaneous revascularisation.

Item 5: **Cardiology Services**

- Acute- 70% of Acute Coronary Syndrome patients will receive an angiogram within 3 days of admission
- Acute - 95% of the ANZACSQI data on ACS patients who have an angiogram will be entered within 30 days
- Elective - Patients to wait no longer than 4 months for a Cardiology FSA
- Elective + Acute -SIR coronary angiography of at least 34.7 per 10,000 population
- Elective + Acute - SIR percutaneous revascularisation of at least 12.5 per 10,000 population

Item 6: Cardiac-Thoracic Services

- Elective - 95% of DENDRITE data on patients who have cardiac surgery will be entered within 30 days of discharge
- Elective - Patients to wait no longer than 4 months for a Cardio-thoracic FSA
- Elective - Report the proportion of patients scored using the national cardiac surgery Clinical Priority Access tool (CPAC)
- Elective - Report the proportion of cardio-thoracic patients treated within assigned CPAC urgency timeframes
- Elective - The cardio-thoracic waitlist must remain between 5 and 7.5% of planned annual throughput, and must not exceed 10% of annual throughput
- Elective + Acute - SIR of 6.5 per 10,000 population

Elective Services

Sustainable, equitable elective services for South Islanders

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

Chief Operating Officers (South Island DHBs)

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

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

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

- Improve Equity of Access to Elective Services
- Bariatric Surgery
- Plastics Services
- Vascular Services
- Eye Health Services
- Maxillofacial services
- Otolaryngology
- Orthopaedic Services
- Colonoscopy / Bowel Screening
- Urology

MILESTONES DASHBOARD 2017-20					
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CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION					
Elective Services					
IMPROVE EQUITY OF ACCESS TO ELECTIVE SERVICES					
1a	Improve equity of access, system quality and practice in selected elective service areas through the establishment of project, team and methodology	Q1,Q2 Q3,Q4	Review priority areas and add or remove	Review priority areas and add or remove	Elective Services Steering Group
1b	Identify baseline for Māori access (current and evidence) in selected priority areas Including access to primary care, and referrals into services. When collecting health data, this will be recorded separately by Māori & non Māori.	Q1,Q2 Q3,Q4			Elective Services Steering Group
1c	Collate and share innovations in the selected service areas via best practice documents and use of HealthPathways	Q1,Q2 Q3,Q4			Elective Services Steering Group

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2	Support South Island DHB management of regional electives volumes including the longer term approach to electives across the South Island that maximises resources.	Q1,Q2 Q3,Q4	Annually agree management of regional electives volumes if applied by MOH	Annually agree management of regional electives volumes if applied by MOH	Elective Services Steering Group
BARIATRIC SURGERY					
3	Support management of South Island Bariatric Surgery Service by CDHB	Q4	Oversight by GMs Planning & Funding and Hospital GMs	Oversight by GMs Planning & Funding and Hospital GMs	Elective Services Steering Group
PLASTICS SERVICES					
4	Implement agreed process to access Plastic surgery for post bariatric patients.	Q2, Q4	South Island Model of Care agreed	South Island Model of Care implemented by DHBs	Plastics Services Project Group/ Elective Services Steering Group
VASCULAR SERVICES					
5	Implement the nationally agreed Vascular Services model of care in the South Island	Q2, Q4	South Island implementation of national Vascular Services model of care		Vascular Services Project Group, Elective Services Steering Group
EYE HEALTH SERVICES					
6a	Develop sustainable Model(s) of Eye Health Care for the South Island.	Q2, Q4	South Island implementation of Eye Health model(s) of care		Eye Health Services Project Group, Elective Services Steering Group
6b	Complete model(s) of care and agree implementation process				
6c	Recommend a transition pathway, including resource implications, to achieve the desired model(s).				
MAXILLOFACIAL SERVICES					
7	Agree a sustainable South Island plan for Maxillofacial Services	Q1, Q3	South Island implementation of Maxillofacial model(s) of care		Elective Services Steering Group
OTOLARYNGOLOGY					
9	Agree a sustainable South Island plan for ENT Services	Q1, Q3	South Island implementation of ENT model(s) of care		Elective Services Steering Group
ORTHOPAEDIC SERVICES					
10	Agree a sustainable South Island plan for Orthopaedic Services	Q1, Q3	South Island implementation of Orthopaedic model(s) of care		Elective Services Steering Group
COLONOSCOPY/BOWEL SCREENING					
11	Support South Island DHBs to meet Colonoscopy Waiting Times Indicators	Q2, Q4	South Island monitoring and support to meet Colonoscopy waiting times indicators	South Island monitoring and support to meet Colonoscopy waiting times indicators	Elective Services Steering Group
12	South Island planning to support Bowel Screening Regional Centre development and implementation and Tranche 2 & 3 rollout schedule	Q1, Q2, Q3, Q4	South Island implementation of SI Bowel Screening Regional Centre SI support for DHBs as they rollout the Bowel Screening Programme:	South Island implementation of SI Bowel Screening Regional Centre South Island support for DHBs as they rollout the Bowel Screening Programme:	Elective Services Steering Group
UROLOGY					
13	Consistent Urology follow-up and surveillance processes	Q4	Implement consistent follow up and surveillance processes in South Island DHBs		Elective Services Steering Group

Work supported by the Elective Services Workstream

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

National and regional initiatives supported by the Elective Services Workstream, but led by other SLAs/Workstreams or individual DHBs
South Island Cardiac Model of Care (page 56, item 1) *Owner: Cardiac Services Workstream* **Improve access to elective services** Delivery against agreed volume schedule, including elective surgical discharges, to deliver the Electives Health Target *Owner: Individual South Island DHBs* *Reported: Individually by the South Island DHBs quarterly* **Maintain reduced waiting times for elective first specialist assessment and treatment** Elective Services Patient Flow Indicators expectations are met, and patients wait no longer than four months for first specialist assessment and treatment, and all patients are prioritised using the most recent national tool available. *Owner: Individual South Island DHBs* *Reported: Individually by South Island DHBs quarterly*

Major Trauma Services

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

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

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

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

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

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

- South Island Major Trauma Plan
- NZ Major Trauma Minimum Dataset and NZ Major Trauma Registry
- Clinical Leadership
- Destination policies

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CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION					
Major Trauma Workstream					
SOUTH ISLAND REGION MAJOR TRAUMA PLAN					
South Island Major trauma regional action plan reviewed and updated					
1	South Island region focuses on implementation of local and regional trauma systems	Q2,Q4	Baseline reporting against the defined performance indicators.	Baseline reporting against the defined performance indicators.	Major Trauma Workstream
NZ MAJOR TRAUMA MINIMUM DATASET					
Report the elements of the National Major Trauma Minimum Dataset					
2a	South Island data collection and input into national major trauma registry no more than 30 days after patient discharge. Achievement of quality improvement markers as defined by the National Major Trauma Clinical Network	Q1, Q2, Q3, Q4	Facilitate the transition back to DHB		Major Trauma Workstream IS SLA
2b	South Island ethnicity and rurality data by site is known including patient outcomes	Q1, Q2, Q3, Q4	Facilitate the transition back to DHB		Workstream members and facilitator, with assistance from IS SLA
CLINICAL LEADERSHIP					
South Island DHBs major trauma clinical leaders; co-ordinators; and administrators appointed					
3	Responsibilities identified and assigned for Clinical lead and coordinator roles in each DHB	Q1	Facilitate the transition back to DHB		Workstream members, Planning and Funding member, COOs, Nurse Managers
Trauma Committees established and active in each DHB					
4	Trauma committees established in each DHB	Q2	Facilitate the transition back to DHBs		Trauma Clinical Lead (TCL), Trauma Nurse Coordinator (TNC); Workstream member and DHBs from 2018

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Agreed regional clinical guidelines and inter-hospital transfer processes to manage major trauma patients within the region					
5	Clinical leaders agree to and follow guidelines and inter hospital transfer processes	Q1, Q2 Q3, Q4	Facilitate the transition back to DHBs		TCL, TNC, trauma committees and Workstream member
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	Major Trauma Workstream; St John and ACC representatives, and ECCT committees in particular

Public Health Services

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

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

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

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

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

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

- Collective Impact
- Maori
- Environmental sustainability
- Health in all policies
- Rheumatic fever

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CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION					
PUBLIC HEALTH					
COLLECTIVE IMPACT					
SLA Governance and Infrastructure					
1	Established and engaged cross-sector Public Health SLA.	Q4	Progress as agreed by SLA towards 2019-2010 deliverables. Developing engagement with Iwi	Clear strategic leadership or population health activities. Engagement with Iwi Clear connection with DHB and other sector's priorities, plans and measures	SI PHSLA Members Reported in: SIHSP
2	South Island Public Health strategic framework	Q4	Progress as agreed by SLA towards 2019-2010 deliverables	Agreed SLA framework shaping effective intersectoral action to measurable improve health, address Māori health priorities and reduce inequalities	SI PHSLA and Sub-groups Reported in: SIHSP
Population Health Reporting					
3	Initial South Island population health report	Q4	Progress as agreed by SLA towards 2019-2020 deliverables.	Information on health status, determinants and intervention effectiveness widely visible and used.	SI PHSLA; and Sub Groups and PHU staff
PHU Infrastructure and Collective Action					
4	Enhanced leadership alignment of the SI PHP /three PHUs	Q1,Q2, Q3,Q4	Progress towards 2019-2020 deliverables.	Joined-up PHU leadership across three PHUs (multi-levels). Consistent voice and systematic approach around key public health issues.	SI PHP Workstream Reported in: SI HSP

MILESTONES DASHBOARD 2017-20					
ITEM NO	**DELIVERABLE 2017-2018**	**APPROVED SCHEDULE**	**DELIVERABLE 2018-2019**	**DELIVERABLE 2019-2020**	**RESPONSIBILITIES**
5	Strengthened operational alignment of the SI PHP /three PHUs	Q1,Q2, Q3,Q4	Progress towards 2019-2020 deliverables	Three PHUs planning and delivering work to an agreed South Island framework. Shared delivery of regional functions. Best practice approaches agreed and implemented. Workforce aligned with strategic and operational priorities	SI PHP Workstream Reported in: SI HSP
Evaluation					
6	Evaluation of the SI PHP's evolution and the SLA's development is underway.	Q3	Progress towards initial evaluation report.	Initial evaluation report.	SI PHSLA and Sub Groups Reported in: SIHSP
Communications					
7	Positive profile and support of the PH SLAs work	Q1,Q2, Q3,Q4	Continuing positive profile and support of the PH SLA's work.	Population health issues and activities widely visible and understood. High positive profile for public health work in the South Island and the success of the PH SLA.	SI PHSLA and Sub Groups Reported in: SIHSP
MĀORI					
Support and develop a Māori voice within the South Island Alliance					
8	Promotion of key messages on South Island priority public health issues as they pertain to Māori by Te Herenga Hauora	Q1,Q2 Q3,Q4	Supporting Te Herenga Hauora to promote key messages on South Island priority public health issues for Māori	Supporting Te Herenga Hauora to promote key messages on South Island priority public health issues for Māori	SI PHSLA, Subgroups and Te Herenga Hauora Reported in: SIHSP
Increase awareness of the key Māori public health issues in the South Island					
9	Selection of a priority public health issue for Māori for a collaborative approach	Q1	Working with Te Herenga Hauora to review and identify the priority public health issues for Māori.	Working with Te Herenga Hauora to review and identify the priority public health issues for Māori.	Te Herenga Hauora and SI PH SLA members Reported in: SIHSP
ENVIRONMENTAL SUSTAINABILITY					
Increased awareness around environmental sustainability and the co-benefits of action in this area for population health					
10	Comprehensive current data to inform next steps, including gap analysis and identification of potential useful and cost-saving measures for DHBs to consider.	Q3	Develop and implement a plan to address the identified gaps	Further implementation of the plan	Sustainability Subgroup, SI PHSLA Reported in: SIHSP
11	Promote awareness of the policy/position statement once South Island DHB Boards endorse. Utilise DHB Boards endorsement of sustainability to promote awareness and action in DHBs.	Q3,Q4	Continued promotion of the policy/position statement and related activity.	Continued promotion of the policy/position statement and related activity.	Sustainability Subgroup, SI PHSLA Reported in: SIHSP
HEALTH IN ALL POLICIES (HiAP)					
Actively promote a HiAP approach towards the environmental determinants influencing healthy weight, oral health, clean air, warm homes and alcohol harm reduction					
12	Promote awareness of the position statements once the South Island District Health Boards have endorsed them: • Water fluoridation • Air Quality • Warm Homes • Sugar sweetened beverages • Environmental Sustainability	Q2,Q3 Q4	Continued promotion of the position statements and related activity.	Continued promotion of the position statements and related activity.	SI PHP Workstream, SI PHSLA, SI Public Health Analysts Network, Child Health SLA , SI Hospital Dentists Reported in: SIHSP

MILESTONES DASHBOARD 2017-20					
ITEM NO	**DELIVERABLE 2017-2018**	**APPROVED SCHEDULE**	**DELIVERABLE 2018-2019**	**DELIVERABLE 2019-2020**	**RESPONSIBILITIES**
13	Undertake new regional approaches/ initiatives to promote healthy eating and active lifestyles as identified in 20116/17.	Q1,Q2, Q3,Q4	Continuous evaluation of the mechanisms in place with developments as indicated	Continuous evaluation of the mechanisms in place with developments as indicated	SI PHSLA, CHSLA , SI Public Health Analysts Network Reported in: SIHSP
14	Identify and undertake regional approaches/initiatives re alcohol harm reduction, including contributing a regional population health perspective to the Alcohol Harm Reduction ED Project.	Q1,Q2 Q3,Q4	Ongoing monitoring and evaluation of the regional approach/initiatives	Ongoing monitoring and evaluation of the regional approach/initiatives	SI PHP Workstream Reported in: SIHSP
RHEUMATIC FEVER					
15	Ongoing monitoring and collective South Island public health response to results.	Q1,Q2, Q3,Q4	Ongoing monitoring and collective South Island public health response to results.	Further ongoing monitoring and collective South Island public health response to results.	SI Medical Officers of Health via SIPHP Workstream Reported in: SIHSP

Stroke Services

Delivering Organised Stroke Services - Best stroke care, everywhere

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

The South Island Stroke Workstream has been formed to:

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

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

- Organisation of Stroke Services
- Thrombolysis
- Regional intra-arterial Clot retrieval service
- Rehabilitation and Community Stroke Services
- Workforce, ongoing specific inter-district stroke education/ training and quality assurance
- Information Technology

MILESTONES DASHBOARD 2017-20					
ITEM NO	**DELIVERABLE 2017 -2018**	**APPROVED SCHEDULE**	**DELIVERABLE 2018-2019**	**DELIVERABLE 2019-2020**	**RESPONSIBILITIES**
CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION					
Stroke Services					
ORGANISATION OF STROKE SERVICES					
1a	People with stroke admitted to hospital are treated in a stroke unit and/or in the setting of an organised stroke service (see PP20 for definitions of a stroke unit and organised stroke services). Support interventions which seek to minimise disparities between Maori and non-Maori	Q1,Q2, Q3, Q4.	Achieve 80% compliance for stroke patients to be cared for in organised stroke unit.	Achieve 80% compliance for stroke patients to be cared for in organised stroke unit.	SI Stroke Workstream, DHBs
1b	Ensure that existing acute stroke pathway information that is available to primary care is consistent across the South Island.	Q4			
THROMBOLYSIS					
2a	All people with stroke have access to a quality assured thrombolysis service 24/7).	Q1, Q,2 Q3, Q4.	Achieve 8% compliance for thrombolysis of eligible stroke clients	Achieve 8% compliance for thrombolysis of eligible stroke clients	SI Stroke Workstream, DHBs SI Telehealth
2b	South Island regional centres collaborate with local ambulance services to ensure pre-notification to hospital services	Q2,Q4			
2c	A telestroke service for SI DHBs will be scoped for embedding in the South Island within available resources	Q2,Q4			
REGIONAL INTRA-ARTERIAL CLOT RETRIEVAL SERVICE					
3	A regional Intra-arterial clot retrieval service based in CDHB to be scoped for the South Island.	Q2, Q4	A regional Intra-arterial clot retrieval service based in CDHB is available in the South Island.	A regional Intra-arterial clot retrieval service based in CDHB is available in the South Island.	SI Stroke Workstream, SI DHB, ALT, MOH Cardiology Workstream

MILESTONES DASHBOARD 2017-20					
ITEM NO	**DELIVERABLE 2017 -2018**	**APPROVED SCHEDULE**	**DELIVERABLE 2018-2019**	**DELIVERABLE 2019-2020**	**RESPONSIBILITIES**
REHABILITATION AND COMMUNITY STROKE SERVICES					
4	All eligible people with stroke receive early active rehabilitation services and equitable access to community stroke services (as defined by the National Stroke Network), supported by an interdisciplinary stroke team. All stroke measures will be collected and split by ethnicity (specifically Māori, Pacific Island & European) and evaluated quarterly to determine trends. Work collaboratively with Stroke Foundation and Ministry of Health in order to Integrate Primary care at every opportunity including: – education – identifying prevention review workstream membership and include primary care professional(s)	Q1,Q2, Q3,Q4	80 percent of patients admitted with acute stroke are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission	80 percent of patients admitted with acute stroke are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission	SI Stroke Workstream, DHBs
WORKFORCE, ONGOING SPECIFIC INTER-DISTRICT STROKE EDUCATION/ TRAINING AND QUALITY ASSURANCE					
5	A regional workforce plan that supports the delivery and achievement of sustained, consistent, culturally appropriate and safe thrombolysis, comprehensive evidence-based interdisciplinary acute and rehabilitation stroke care provision. CDHB will provide standardised thrombolysis education across the South Island regional centres via videoconference using a hub and spoke model All members of the interdisciplinary stroke team participate in ongoing education, training (a minimum of 8 hours stroke specific education per year (minimum standard) and service improvement programmes. This will include education which is culturally considerate.	Q2,Q4	All members of the interdisciplinary stroke team participate in ongoing education, training and service improvement programmes	All members of the interdisciplinary stroke team participate in ongoing education, training and service improvement programmes	SI Stroke Workstream, DHBs SI Workforce Development Hub
INFORMATION TECHNOLOGY					
6	Identified actions that the region will take to support improved information management, e.g., establishing a regional oversight role. Identify trends in delivery of acute stroke services, thrombolysis, and rehabilitation services to detect disparity between Maori and non-Maori to inform improved service delivery	Q1,Q2, Q3,Q4	Support interventions which seek to minimise disparities between Māori and non- Māori	Support interventions which seek to minimise disparities between Māori and non- Māori	SI Stroke Workstream, DHBs, MOH

Hepatitis C Workstream

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

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

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

- Integrated Hepatitis C Assessment and Treatment Services
- Liver Elastography
- Education and awareness

MILESTONES DASHBOARD 2017-20					
ITEM NO	DELIVERABLE 2017-2018	APPROVED SCHEDULE	DELIVERABLE 2018-2019	DELIVERABLE 2019-2020	RESPONSIBILITIES
CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION					
Hepatitis C					
Integrated Hepatitis C Assessment and Treatment Services					
Implementing integrated hepatitis C assessment and treatment services across community, primary and secondary care services on the South Island					
1a	Improve access to hepatitis C testing in the most appropriate setting and make use of rapid testing as informed by the outcome of the 2017 *Targeted Testing Project* study	Q2	Transitioned back to DHBs		Hepatitis C Workstream
1b	Improve access to hepatitis C treatment utilising the hepatitis C clinical pathway to work collaboratively	Q2	Transitioned back to DHBs		Hepatitis C Workstream
1c	Provide long term monitoring for hepatocellular carcinoma for people with cirrhosis Where there is no cirrhosis, monitor patients until cured of hepatitis C.	Q4	Transitioned back to DHBs		Hepatitis C Workstream
Liver Elastography					
Enhance use of fibroscanning services					
2a	Establish systems to report on hepatitis C liver elastography in primary and secondary care settings	Q1	Transitioned back to DHBs		Hepatitis C Workstream
2b	Improve access to hepatitis C liver elastography using fibroscanning to assist assessment of disease severity	Q4	Transitioned back to DHBs		Hepatitis C Workstream
2c	Improve access to hepatitis C liver elastography for Maori using fibroscanning to assist assessment of disease severity	Q4	Transitioned back to DHBs		Hepatitis C Workstream
Education and Awareness					
Raise community and GP awareness and education of the hepatitis C virus and the risk factors for infection					
3a	Raise patient and GP awareness	Q2	Transitioned back to DHBs		Hepatitis C Workstream
3b	Participation in the national approach to education and awareness in line with the Draft South Island Hepatitis C Workstream Education and Awareness Plan	Q4	Transitioned back to DHBs		Hepatitis C Workstream
Data Collection Measures					
4a	Number of people diagnosed with hepatitis C per annum by genotype.	Q2,Q4			
4b	Number of HCV patients who have had a Liver Elastography Scan in the last year (a) new patients: (b) follow up.	Q2,Q4			

MILESTONES DASHBOARD 2017-20					
ITEM NO	DELIVERABLE 2017-2018	APPROVED SCHEDULE	DELIVERABLE 2018-2019	DELIVERABLE 2019-2020	RESPONSIBILITIES
4c	Number of people receiving PHARMAC funded antiviral treatment per annum (by age and ethnicity).	Q2,Q4			

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.

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

- Serious Adverse Events
- Health Quality & Safety Commission projects
- Regional Policies
- Safety 1st
- Tikanga
- Regional sharing of Learnings and Quality Improvement

MILESTONES DASHBOARD 2017-20					
ITEM NO	**DELIVERABLE 2017-2018**	**APPROVED SCHEDULE**	**DELIVERABLE 2018-2019**	**DELIVERABLE 2019-2020**	**RESPONSIBILITIES**
KEY ENABLERS					
Quality and Safety					
Serious Adverse events					
Regional alignment in SI DHB's Serious Adverse Event Reviews to protect people from harm or needless death					
1	South Island DHBs understand the HQSC National Reportable events policy (reviewed in early 2017)	Q3	Facilitate the transition back to DHBs		Q&S SLA
2	Regional agreement on the application of the new reportable events policy	Q4	Facilitate the transition back to DHBs		Q&S SLA
3	Build regional capability in investigators of serious adverse events	Q4	Build regional capability in investigators of serious adverse events	Facilitate the transition back to DHBs	Q&S SLA
Health Quality and Safety Commission Projects					
Regional alignment in the deteriorating patient programme to protect people from harm or needless death					
4	A regional approach to the HQ&SC deteriorating patient programme is agreed, in anticipation of implementation across all SI DHBs.	Q4	Support the SI DHBs in their work on the HQSC deteriorating patient programme	Support the SI DHBs in their work on the HQSC deteriorating patient programme	Q&S SLA
Regional alignment in pressure injury prevention to protect people from harm or needless death					
5	Support the South Island DHBs in their work on the HQSC Pressure Injury Prevention work by sharing experiences and learnings across all SI DHBs.	Q4	Support the South Island DHBs in their work on the HQSC Pressure Injury Prevention work	Support the SI DHBs in their work on the HQSC Pressure Injury Prevention work	Q&S SLA

MILESTONES DASHBOARD 2017-20					
ITEM NO	DELIVERABLE 2017-2018	APPROVED SCHEDULE	DELIVERABLE 2018-2019	DELIVERABLE 2019-2020	RESPONSIBILITIES
Regional Policies					
Identify policies that could be regional policies to enable there to be no wasted resources					
6	Work with the South Island DHBs to determine what policies could be regional policies	Q4	Development of regional policies	Development of regional policies	Q&S SLA
Safety1st					
Improved environment to support health & wellbeing and people are protected from harm or needless death					
7a	Regional South Island DHB Safety1st reports	Q4	Regional South Island DHB Safety1st reports	Regional South Island DHB Safety1st reports (until there is a regional role SIAPO will need to continue with the support)	Q&S SLA
7b	Support ongoing development and review of Safety1st	Q4	Support ongoing development and review of Safety1st	Support ongoing development and review of Safety1st (until there is a regional role SIAPO will need to continue with the support)	Q&S SLA
7c	Support the Safety1st Control group	Q4	Support the Safety1st Control group	Support the Safety1st Control group (until there is a regional role SIAPO will need to continue with the support)	Q&S SLA
Tikanga					
Improved Environment to Support Health and Wellbeing					
8	A stocktake of Tikanga in the South Island DHBs	Q4	Deliverable will be informed by the Stocktake undertaken in 2017-18		Q&S SLA
Regional sharing of Learnings and Quality Improvement					
People are protected from harm or needless death					
9	Explore regional approaches to share learnings of improving quality of care, including good news stories	Q4	South Island DHBs share learnings and quality improvement initiatives.	South Island DHBs share learnings and quality improvement initiatives.	Q&S SLA

Work supported by the Quality and Safety Service Level Alliance

National projects supported by Quality and Safety
Health, Quality and Safety Commission priorities including falls, hand hygiene, surgical site infections and medication safety are individually reported on by the South Island DHBs. The South Island Patient Safety Group is responsible for driving a regional approach to the national programme; they report to the Quality and Safety SLA.
Regional projects enabled by the Quality and Safety and working with other SLAs & Workstreams
Owner: South Island Workforce Development Hub Inter- disciplinary Learning (Item 8) pg. 78 *Owner: Child Health SLA* Consumer Consultation (Item13) pg. 46

South Island Information Services

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

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

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

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

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

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

The Ministry of Health have established Digital Health 2020 to progress the core digital technologies presented in the New Zealand Health Strategy. It guides the strategic digital investments that are expected to occur across the health and disability sector in the next five years, 2016–2020.It will also align sector investment with value delivery and encourage health organisations to invest with greater clarity and confidence. The Digital Health 2020 programme consists of five core components (Single Electronic Health Record, Health and Wellness Dataset, Preventive Health IT Capability, Digital Hospital, Regional IT Foundations) and three enabling functions (Architecture and Standards, Information Governance, ICT enablers)

The IS SLA is committed to the Ministry of Health Digital Health 2020 strategy the IS SLA programme of work will enable and support:

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

As part of the commitment to delivering on Digital Health 2020 the South Island will continue to implement the key regional foundation priorities. For 2017/18 these are:

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

The IS SLA will continue to put effort and energy into supporting HCS and HealthOne as the programmes transition from project/programme to BAU state. It is not envisaged that the IS SLA will include any deliverables in the 2017-18 SIHSP in relation to either of these projects/programmes. Any key work to come out of HCS or HealthOne will be reflected in the IS SLA Operational Portfolio.

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

MILESTONES DASHBOARD 2017-20					
ITEM NO	DELIVERABLE 2017-2018	APPROVED SCHEDULE	DELIVERABLE 2018-2019	DELIVERABLE 2019-2020	RESPONSIBILITIES
KEY ENABLERS					
Information Services					
OUTH ISLAND INFORMATION SERVICES STRATEGIC PLAN					
1	Complete a review and refresh of the SI Information Services strategic plan, including the identification and prioritisation of future areas of focus	**Q2**	Progressively implement the revised SI Information services strategic plan	Progressively implement the revised SI Information services strategic plan	Lead: IS SLA 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					
2	West Coast DHB ePrescribing and Administration project completed	**Q2**			Lead: Regional Programme Manager SIAPO DHB: WCDHB Reported in : SIHSP
3	Nelson Marlborough DHB ePrescribing and Administration project completed	**Q4**	Nelson Marlborough DHB ePrescribing and Administration project completed for Nelson campus		Lead: Regional Programme Manager SIAPO DHB: NMDHB Reported in : SIHSP
ePharmacy Management (ePM)					
Implement ePharmacy into South Island DHBs using a single Regional instance (incorporating NZULM & NZ Formulary when sources are available) to enable the management of medications from a shared South Island perspective					
4	Implementation of ePharmacy completed across DHBs	**Q4**			Lead: Regional Programme Manager SIAPO Reported in : SIHSP

MILESTONES DASHBOARD 2017-20					
ITEM NO	DELIVERABLE 2017-2018	APPROVED SCHEDULE	DELIVERABLE 2018-2019	DELIVERABLE 2019-2020	RESPONSIBILITIES
eREFERRALS PROGRAMME					
Stage 3					
Implementation eTriage - eReferrals received through the RMS module in Health Connect South with triage functionality					
5	Complete SCDHB eTriage implementation	**Q3**			Lead: Regional Programme Manager SIAPO DHB: SCDHB Reported in: SIHSP
6	Complete SDHB eTriage implementation	**Q3**			Lead: Regional Programme Manager SIAPO DHB: SDHBReported in: SIHSP
7	Complete NMDHB eTriage implementation	**Q3**			Lead: Regional Programme Manager SIAPO DHB: NMDHB Reported in: SIHSP
SOUTH ISLAND PATIENT INFORMATION CARE SYSTEM (PICS)					
Canterbury DHB Implementation					
8	Commence the progressive implementation of SI PICS into other Canterbury DHB sites	**Q4**	Complete the implementation of SI PICS into the remaining CDHB sites		Lead: Regional Programme Manager SIAPO DHB: CDHB Reported in: SIHSP
Nelson Marlborough DHB Implementations					
9	Project go-live for Nelson Marlborough DHB	**Q3**			Lead: Regional Programme Manager SIAPO DHB: NMDHB Reported in: SIHSP
South Canterbury DHB Implementation					
10	Prepare for SI PICS Implementation, including the development of the implementation business case and initiation of project training.	**Q4**	Project go-live for South Canterbury DHB		Lead: Regional Programme Manager SIAPO DHB: SCDHB Reported in: SIHSP
West Coast Implementation					
11	Prepare for SI PICS Implementation, including the development of the implementation business case and initiation of project training.	**Q4**	Project go-live for West Coast DHB		Lead: Regional Programme Manager SIAPO DHB: WCDHB Reported in: SIHSP
Southern DHB Implementation					
12	Commence the development of SDHB implementation business case for SI PICS	**Q4**	Prepare for SI PICS Implementation including the completion of the implementation business case and initiation of project planning.	Project go-live for Southern DHB	Lead: Regional Programme Manager SIAPO DHB: WCDHB Reported in: SIHSP
ED Information Solution					
Provide a regional solution to support visibility of ED activity					
13a	Identify the preferred South Island solution	**Q2**	Business Case approval		Lead: IS SLA SIAPO

MILESTONES DASHBOARD 2017-20					
ITEM NO	**DELIVERABLE 2017-2018**	**APPROVED SCHEDULE**	**DELIVERABLE 2018-2019**	**DELIVERABLE 2019-2020**	**RESPONSIBILITIES**
13b	Progress Business Case/implementation planning	**Q4**	Prepare for ED information Solution implementation ED information solution implementation commenced.	ED information solution implementation completed	Reported in: SIHSP
REGIONAL SERVICE PROVIDER INDEX					
To implement a SI Regional Service Provider index					
14a	Identify the preferred South Island solution	**Q1**	Phased implementation of the Regional Service Provider Index continues	Implementation of Regional Service Provider Index completed	Lead: Regional Programme Manager SIAPO Reported in: SIHSP
14b	Progress Business Case/implementation planning	**Q2**			
14c	Commence a phase roll-out	**Q4**			
eORDERING OF RADIOLOGY TESTS					
To implement a fully electronic radiology ordering process					
15a	Progress Business Case/implementation planning	**Q2**	Implementation of eOrdering Radiology tests completed for SDHB		Lead: IS SLA SIAPO DHB: NMDHB, SCDHB, WCDHB, SDHB Reported in: SIHSP
15b	Implementation of eOrdering Radiology tests completed for NMDHB,SCDHB,WCDHB	**Q4**			
15c	Confirm integration requirements of SDHB RIS platform into Regional éclair Clinical data repository	**Q4**			
eORDERING OF LABORATORY TESTS					
To implement a fully electronic laboratory ordering process					
16a	No formal work programme planned for 2017-18		Progress Business Case/implementation planning	Implementation of eOrdering Laboratory tests completed	Lead: IS SLA SIAPO Reported in: SIHSP
16b			Implementation of eOrdering Laboratory tests commenced		
MENTAL HEALTH					
17a	Identify and confirm the preferred SI approach for delivering the required Mental Health functionality.	**Q2**	Implementation of SI Mental Health solution commenced	Implementation of SI Mental Health solution completed	Lead: IS SLA SIAPO Reported in: SIHSP
17b	Progress Business Case/implementation planning	**Q4**			
17c	Support SCDHB, WCDHB, NMDHB and SDHB to progress a paper-lite strategy for transitioning paper mental health records into the electronic health record	**Q4**			
ALERTS AND WARNINGS					
18a	Identify the preferred South Island solution	**Q2**	Implementation of SI Alerts and Warning completed		Lead: IS SLA SIAPO Reported in: SIHSP
18b	Progress Business Case/implementation planning	**Q4**			
CLINICAL WORKFLOW					
To enable SI DHBs to develop and implement flexible clinical workflow that supports and enables the delivery of care at the right place and right time					
19	Scope, agree and commence the implementation of the processes and structures to enable the SI DHBs to create, configure and manage automated clinical workflow	**Q4**	Complete the implementation of the agreed processes and structures		Lead: IS SLA SIAPO Reported in: SIHSP
CLINICAL MEASUREMENTS PLATFORM					
To implement an e-measurements platform for the capture of observations, vital signs and clinical data					
20	Agree the clinical requirements for a clinical measurements platform	**Q4**	Pilot of e-measurement platform undertaken		

MILESTONES DASHBOARD 2017-20					
ITEM NO	DELIVERABLE 2017-2018	APPROVED SCHEDULE	DELIVERABLE 2018-2019	DELIVERABLE 2019-2020	RESPONSIBILITIES
	Complete the scoping for a clinical measurements platform Commence regional business case approval		Complete evaluation of pilot	Progressive implementation of an e-measurement platform continues.	Lead: CDHB CIO & IS SLA 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; National Maternity Solution, Nationally consistent Electronic Oral Health Record, Cancer Information Strategy, National Immunisation Register replacement, South Island Major Trauma Project, eLearning, Safety First, Advance Care Planning, Palliative Care, Stroke services, MOSAIQ, MDM Meeting Management,. These projects will either be led by the Ministry or another regional Workstream or Alliance.

National projects enabled by the IS SLA but led nationally or by DHBs or by other South Island Workstreams

Project: Single Electronic Health Record
Deliverable 2017/18: Development of Detailed Business Case
Responsibilities: All DHB engaged in business case development process
Owner: Nationally Led

Digital Hospital
Deliverable 2017/18: Target gaps in hospital digital maturity with regionally aligned solution based on EMRAM assessment. DHBs to recognise the need for enabling infrastructure to support delivery of digital hospital capability.
Responsibilities: All DHBs engaged in accelerate maturity through regional and sub-regional activities where possible.
Owner: DHBs

Project: Health and Wellness Dataset
Deliverable 2017/18: Establish information governance based on the draft health information governance framework. Complete analysis of current state of Ministry held datasets to identify improvements. Consider analytics use of health data in all ICT investments.
Involvement: All DHB engaged in the development of an information governance framework.
Owner: Nationally Led

Project: Preventive Health IT Capability
Deliverable 2017/18: DHB and sector engagement to inform development of business, data and technology architecture framework to guide and target investment in health screening solutions to drive consistency and maximise reuse. Cervical screening project to support HPV testing.
Responsibilities: DHB engagement in framework development
Owner: Nationally Led and implemented by local DHBs

Project: Bowel screening rollout (page 59, item 12)
Deliverable 2017/18: SI planning to support Bowel Screening Regional Centre development and implementation and Tranche 2 & 3 rollout schedule
Owner: Electives Workstream

Project National Maternity Solution
Deliverable 2017/18: The national solution for Maternity Care will be ready for adoption by the second adopter DHBs who wish to implement
Responsibilities: All DHBs who wish to implement or plan.
Owner: Nationally Led and implemented by individual DHBs

Project: Nationally consistent Electronic Oral Health Record (EOHR)
Deliverable 2017/18: Investment approval and implementation planning for preferred software solution.
Responsibilities: All DHBs community and hospital based oral health services engaged in investment case development and implementation planning.
Owner: Nationally led with DHB governance and co-design.

Project: Cancer Information Strategy:
Deliverable 2017/18: *MDM System Specification gap analysis review*: all regions will be asked to assess themselves against the system specification for local/regional MDM solutions.
Responsibilities: SCN's to undertake an assessment in May/June 2018 following the implementation across the SI of the Southern MDM System[4].

[4] The rationale for this is that the rollout had been agreed before this gap analysis was proposed, and realistically we will not be changing our approach to supporting MDMs for the next 12-18 months. Also, there are no additional resources identified for any development other than those allocated for the rollout.

National projects enabled by the IS SLA but led nationally or by DHBs or by other South Island Workstreams
Owner: SCN
Deliverable 2017/18: *Radiation Oncology National Plan and Associate Dataset:* to be sent monthly to the CHIS/MoH as a pseudo 'national collection' from June 2017. **Responsibilities:** SI DHBs who provide radiation oncology services. **Owner:** SCN
Deliverable 2017/18: *National Patient Flow:* NPF with regard the transfer of cancer information, with a view to it being a vehicle for the transfer of FCT information. Initially the proposal is to pilot with a NI DHB. **Responsibilities:** The MoH Cancer Team & CHIS **Owner:** MoH Cancer Team
Project: National Immunisation Register (NIR) replacement **Deliverable 2017/18:** Investment approval and implementation planning for preferred software solution. **Responsibilities:** All DHBs engaged in investment case development and implementation planning **Owner:** Nationally led
Project: National Trauma Minimum Dataset (page 61, item 2a, 2b) **Owner:** South Island Major Trauma Workstream

South Island Workforce Development Hub

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

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

Programme Director: **Kate Rawlings, Programme Director, (South Island Alliance Programme Office)**

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

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

The work plan for 2017-18 builds on the work of the SIWDH workgroups, which involve over 120 clinicians from across health in the South Island. Further work to identify measures is ongoing and where appropriate these will be noted in the quarterly reports.

The areas of focus for 2017-18 are:

- Build and align the capability of the workforce to deliver new models of care and priorities outlined in the New Zealand Health Strategy
- Improve the sustainability of priority (vulnerable) workforces
- Grow the capacity and capability of Māori in the health workforce
- Grow the capacity and capability of Pacific People in the health workforce
- Optimise enablers to support workforce development
- Strengthen health leadership through regional collaboration
- Improving workforce data and intelligence in collaboration with HWNZ and DHBSS.

MILESTONES DASHBOARD 2017-20					
ITEM NO	**DELIVERABLE 2017-2018**	**APPROVED SCHEDULE**	**DELIVERABLE 2018-2019**	**DELIVERABLE 2019-2020**	**RESPONSBILITIES**
KEY ENABLERS					
SOUTH ISLAND WORKFORCE DEVELOPMENT HUB (SIWDH)					
Workforce Planning					
To build and align the capacity and capability of the health workforce to deliver new models of care (value & high performance; one team; closer to home)					
1	Health Workforce data and intelligence is collected to support planning	Q1, Q2, Q3, Q4	Workforce modelling for service planning with available data South Island whole of sector data is available for workforce planning as per HWNZ/MOH/DHBSS plan	Ongoing analysis and communication with the South Island health sector Ongoing analysis and communication with the South Island health sector	Lead: SIWDH Steering Group Reported in: SIHSP

MILESTONES DASHBOARD 2017-20					
ITEM NO	DELIVERABLE 2017-2018	APPROVED SCHEDULE	DELIVERABLE 2018-2019	DELIVERABLE 2019-2020	RESPONSBILITIES
2	The pipeline for the health workforce is aligned with health workforce need	Q1, Q2, Q3, Q4	Priority workforces are identified and plans developed to ensure adequate supply in conjunction with the education providers	Ongoing monitoring of workforce need/ supply based on the model of care	Lead: SIWDH Steering Group Reported in: SIHSP
3	Kaiāwhina workforce Allied Health Assistants (AHAs) working across the South Island health system have access to appropriate NZQA level 3 training	Q1, Q2, Q3, Q4	AHAs are fully utilised in the delivery of care Ongoing feedback to Careerforce to ensure the qualification remains relevant to the health sector	Ongoing assessment of scope of practice	Lead: South Island Directors of Allied Health Reported in: SIHSP
4	Kaiāwhina workforce The Careerforce NZQA Level 4 Health and Wellbeing qualification is included in the AHA development framework	Q4	The Level 4 AHA training and development framework is 100% implemented across the SI DHB's. Outcomes are embedded into the South Island AHA development framework.	Monitor outcomes	Lead: South Island Directors of Allied Health Reported in: SIHSP
5	Kaiāwhina workforce Allied Health Assistants (AHAs): An effective delegation model is in place for services where Calderdale Framework (CF) has been implemented	Q4	Evaluation of the clinical task delegation model is undertaken		Lead: South Island Directors of Allied Health Reported in: SIHSP
6	An effective skill sharing model is in place for services where Calderdale Framework has been implemented	Q4	Ongoing monitoring & evaluation	Ongoing monitoring & evaluation	Lead: South Island Directors of Allied Health Reported in: SIHSP
7	Ensure sustainability of workforce redesign model (CF)across South Island	Q4	Support Central Region in NZ in their implementation of the Calderdale Framework.	Develop a collaborative NZ model for CF education	Lead: SI Directors of Allied Health Reported in: SIHSP
8	Inter-disciplinary A coordinated clinical simulation network for the South Island is established	Q4	Roll out to further sites	Clinical simulation is supported across the South Island	Lead: SIWDH Steering Group Reported in: SIHSP
9	Inter-disciplinary South Island teams participate in the Health Care Challenge	Q2	Develop further regional strategies to support interdisciplinary learning	Ongoing review and evaluation	Lead: SIWDH Steering Group Reported in: SIHSP
10	Allied Health Scientific & Technical Regional clinical/professional leadership frameworks are implemented for smaller Allied Health & Scientific & Technical professions	Q4	Further professions identified for regional clinical leadership framework	Further professions identified for regional clinical leadership framework	Lead: South Island Directors of Allied Health Reported in: SIHSP
11	Medicine: new graduates Community based attachments (CBAs)are in place to meet requirements of new Medical Council curriculum	Q3	Increasing numbers to achieve 75% compliance in 2019.	Increasing numbers to achieve 100% compliance in 2020	Lead: South Island Chief Medical Officers Contributors: RMO Units Reported in: SIHSP
12	Medicine: new graduates 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 national total.	The South Island has employed their share of the national total.	Lead: South Island Chief Medical Officers Contributors: South Island RMO Units Reported in: SIHSP

MILESTONES DASHBOARD 2017-20					
ITEM NO	**DELIVERABLE 2017-2018**	**APPROVED SCHEDULE**	**DELIVERABLE 2018-2019**	**DELIVERABLE 2019-2020**	**RESPONSBILITIES**
13	Nursing: new graduates Support the employment & orientation of new graduate nurses	Q4	Monitor	Monitor	Lead: SI Executive Directors of Nursing. Reported in: SIHSP
14	Midwifery Clinical leadership is further developed	Q4	Ongoing	Ongoing	Lead: SI DHB Midwifery Leaders Reported in: SIHSP
Priority (Vulnerable) Workforces					
Improve the Sustainability of Priority (Vulnerable) Workforces (Value and high Performance; one team)					
15	Sonography Support for the training of Sonographers to meet the identified South Island need	Q4	Ongoing monitoring	Ongoing monitoring	Lead: South Island DAHs Contributors: The South Island Sonography training group Reported in: SIHSP
16	Rural Health Medicine The opportunity of a South Island rural health medicine clinical placement programme is explored to support vocational training	Q4	The identified pathway for clinical rotations is evaluated	Rural hospitals have a pool of trainees to recruit from	Lead: South Island Chief Medical Officers Contributors: Rural Hospital Medicine working group. Reported in: SIHSP
17	Imaging Workforce is fit for purpose	Q1,Q2, Q3,Q4	Ongoing monitoring and assessment of model of care	ongoing	Lead: South Island Directors of Allied Health Reported in: SIHSP
Workforce Diversity					
To grow the capacity and capability of Māori in the health workforce (value & high performance; one team)					
18	Improved employee ethnicity data collected by South Island DHBs	Q4	Annual update with revised data Evaluation of module is undertaken and updated as appropriate	Annual update with revised data Monitor uptake of module	Lead: SIWDH Steering Group and SI GMs Māori & GMs HR/P&C Reported in: SIHSP
19	Increased Māori DHB clinical workforce, working towards reflecting the South Island population.	Q4	Monitor that SI DHB Māori workforce is increasing to better reflect the population	SI DHB Māori workforce is increasing to better reflect the population	Lead: SIWDH Steering Group and SI GMs Māori
20	Establish a framework for Cultural Competence Education which ensures it is embedded into practice for the non-Māori workforce.	Q4	Establish an evaluation process to ensure there is appropriate change in the clinical environment	Monitor the evaluation outcomes	Lead: SIWDH Steering Group and SI GMs Māori
Workforce Enablers					
Optimise enablers to support the health workforce (value & high performance; smart system)					
21	Lippincott Clinical Procedures The South Island and Midland Regions are working in partnership to develop designing a national framework for the management of Lippincott New Zealand instance	Q4	Ongoing monitoring to ensure increased usage in the South Island	Ongoing monitoring	Lead: SI Executive Directors of Nursing in partnership with the Midland Region Executive Directors of Nursing Contributors: Lippincott Project Board and Lippincott Implementation Group. Reported in: SIHSP

MILESTONES DASHBOARD 2017-20					
ITEM NO	DELIVERABLE 2017-2018	APPROVED SCHEDULE	DELIVERABLE 2018-2019	DELIVERABLE 2019-2020	RESPONSBILITIES
22	Elearning platform: Work with Ko Awatea to establish a single platform for NZ	Q2,Q3, Q4	The opportunity for a single national platform is explored with Ko Awatea		Lead: SIWDH Steering Group. Reported in: SIHSP
23	Elearning packages An increased number of eLearning packages are available to the South Island health workforce which can be shared nationally	Q1,Q2	Ongoing review and development of online learning modules	Ongoing review and development of online learning modules	Lead: SIWDH Steering Group. Reported in: SIHSP

Work supported by the South Island Workforce Development Hub

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

Healthy Ageing :

Owner: Health of Older People SLA

Item 2; Pg. 52

Improve the quality and consistency of dementia education and support programmes in operation to support family/whanau carers (e.g., Living Well with Dementia) and people living with dementia.

Item 7; Pg. 52

ACP L1A and L 2 Training is available in a planned manner for staff in each DHB district in South Island (subject to resources)

Item 10; Pg. 53

Develop a sustainable mechanism for collecting a minimum workforce data set on the health workforce working in health of older people outside the DHB provider arm by 30 June 2018.

Palliative Care:

Owner: Palliative Care Workstream

Item 3c; Pg. 55

Explore and understand how Palliative Care is delivered by Allied Health providers and by Maori organisations and other ethnic minority providers

Item 3d; Pg. 55

Explore opportunities to provide guidance on the substantive competencies for allied health professionals undertaking education in palliative care in SI.

Mental Health & Addiction:

Owner: Mental Health & Addiction SLA

Item 3; Pg. 49

Continue with the engagement started with the Workforce plan in 2016/2017. (This is a South Island Mental Health & Addiction workforce plan that has been aligned with the National MHA Workforce strategy which has recently been released. Signoff is expected by the MHASLA in July, an action plan will then be developed and implementation commence)

Item 5; Pg. 49

Explore strategies for greater integration of primary, community and specialist workforces including a sharing of resources between specialist, primary and community services with the goal of developing a 'one team' approach

Item 6c: Pg 49

Workforce development implications and needs identified and included in the document

Item 9 Pg 50

Workforce development needs around training and support for suicide prevention activities identified for DHB and PHO and NGO

Stroke:

Owner : Stroke Workstream

Item 5; Pg. 66

A regional workforce plan that supports the delivery and achievement of sustained, consistent, culturally appropriate and safe thrombolysis, comprehensive evidence-based interdisciplinary acute and rehabilitation stroke care provision.

All members of the interdisciplinary stroke team participate in ongoing education, training and service improvement programmes according to the Stroke Guidelines, and as recommended by the national and regional stroke networks.

Support Services

The Support Services Service Level Alliance has completed its current programme of work. Potential regional projects related to support services may be identified by the South Island Alliance and project groups will be formed on approval.

Sudden Unexpected Death in Infancy Prevention Programme

The South Island Alliance will develop and provide a Regional Sudden Unexpected Death in Infancy (SUDI) Prevention Plan to the Ministry by the end of quarter one 2017-18. This will occur once the Regional SUDI Prevention Coordinators are in place; and, in alignment with the new National Sudden Unexpected Death in Infancy (SUDI) Programme (NSPP) to be implemented from 1 July 2017.

Appendix 3 - Action Plan Māori Health Section of Regional Services Plan

The following action tables illustrate the activities that Te Herenga Hauora o te Waka-ā-Māui will progress with our South Island SLA/workstream partnerships to work towards Māori health equity and making a practical difference for our whānau. For us it is all "about whānau" and building a better future for our people especially our tamariki whom are the wairua of our whānau. The following activities are not an end in themselves but the start of a journey that has a Te Waipounamu (South Island) wide focus on working towards Māori health equity and "Pae Ora" a healthy future for our whānau. In the end "Pae Ora" is about our people's future, "It's about whānau".

***Objective 1-2:** **Work Towards Māori Health Equity and building Cultural Responsiveness** within Regional Alliance Networks and within South Island DHBs*

MĀORI HEALTH EQUITY AND REGIONAL MĀORI HEALTH TOOLS

Priority Area	Outcome Reported	Timeframe	Responsibility	Milestones reported against
Māori Health Equity	***Maori Health Equity*** • All South Island SLA/Workstreams will agree that reducing inequities for Māori will be one of their key priorities • All South Island SLA/Workstreams will undertake training on what drives Māori health inequities and the application of the Māori Health Equity Tool • All South Island SLA/Workstreams will apply the Māori Health Equity Tool to their work programme • Where appropriate South Island SLA/Workstreams will align the work of their Workstream to national Māori Health priority indicators	Q2- Q4 2017/18	Te Herenga Hauora, SIAPO, all South Island SLA/ Workstreams	• Evidence that all South Island SLA/Workstreams agree that Māori Health Equity is a key priority for their workstream (100%) • At a minimum all South Island SLA/Workstreams chairs (100%) have completed training on Māori health equity and the application of the Māori Health Equity Tool • Evidence that all South Island SLA/Workstreams have applied the Māori Health Equity Tool to their respective work programmes (100%) • Evidence that as appropriate South Island SLA/ Workstreams have aligned the work of their Workstream to the 13 Māori Health indicators (100%) • Evidence of the application of the Māori Health Equity Tool across South Island DHBs' Annual Planning (100%)
Regional Tools	***Establish Regional Tools to Support Māori Health Equity / Cultural Responsiveness*** • Trendly Report against South Island DHBs' performance against Māori Health priority indicators completed every 6 months (Te Waipounamu Māori Health Indicator Report) • Māori Health Equity Tool integrated into Annual; Planning and South Island SLA/Workstreams • Online e-learning training around Ethnicity Data Collection distributed across South Island DHBs (regional or sub-regional initiative) • Agreement reached that Ethnicity Data training is compulsory training requirement for all clerical/admin staff across South Island DHBs • Cultural Competency programme established sub -regionally (Takarangi Cultural Competency training)	Q2-Q4 2017/18	Te Herenga Hauora, SIAPO, all South Island SLA/ Workstreams	• Trendly reporting against South Island DHBs' Māori Health priority indicators completed (quarter 2 and quarter 4 report) • Māori Health Equity Tool integrated into DHB Annual Planning process to ensure that each plan aligns to working towards Māori health equity • All 13 Māori Health Plan indicators are integrated into South Island DHBs' Annual Plans for 2017-2018 period (Māori Health section Annual Plan, 100%) • Online Ethnicity Data Collection training distributed regionally / sub-regionally to ensure accurate ethnicity data to better monitor progress towards Māori health equity • Evidence across South Island DHBs that Ethnicity Data Collection is compulsory for DHB clerical /admin staff • Narrative report on sub-regional Cultural Competency programme being implemented to build both clinically and culturally responsive health workforce

***Objective 3:** Building both the numbers and capability of the Māori Health Workforce across the South Island DHBs to ensure our workforce is responsive to and reflective of the Māori population it serves*

MĀORI HEALTH WORKFORCE DEVELOPMENT

Priority Area	Outcome Reported	Timeframe	Responsibility	Milestones reported against

Māori Health Workforce Capacity Development (linked to Workforce Development Hub section of RSP)
 	
Kia Ora Hauora
Supporting Māori into Health
	Build Māori Health Workforce Capacity Development
	• Report against Kia Ora Hauora South Island Māori health workforce development initiative completed. Key achievements for the 2017-2018 period will include:
	  ○ 10 Roadshows across South Island
	  ○ 6 Hauora Māori workshops across the South Island
	  ○ 10 Career Expos across the South Island
	  ○ 12 Café Korero across the South Island
	  ○ 2 Conference Exposure sessions held across the South Island
	  ○ 6 Work Prep Workshops held across the South Island
	  ○ 2 Iwi events held across the South Island
	  ○ 9 Strategic events held across the South Island
	  ○ Recruit and support new Māori onto a health career pathway (100 individuals across South Island)
	  ○ Māori graduates transitioned into Health sector workforce (25 individuals across the South Island)
	  ○ Support new Māori into 1st year tertiary study including foundation programmes (25 individuals across the South Island)
	• Establishment of Māori health workforce development targets within the South Island Workforce Development Hub (SIWDH) across South Island DHBs which are integrated into Regional and Annual Planning: Targets for Māori Health Workforce increase will target Nursing and Midwifery and Allied Health Professions in the first instance
	
	• Each DHB within South Island provides a workforce profile report that identifies the number and percentage of Māori employed by professional group within each of their DHBs. This workforce profile is utilised to track building Māori health workforce capacity development. By 2018 final reporting period a regional workforce profile will be established across South Island DHBs
		Q2-Q4 2017/18	Te Herenga Hauora, SIAPO, South Island Workforce Development Hub (SIWDH), respective South Island DHB's Allied Health and Nursing and Midwifery Directorates	• Narrative report detailing milestones for Kia Ora Hauora completed and targets attained (quarter 2 and quarter 4 report)
				• South Island Workforce Development Hub work with Te Herenga Hauora to establish Māori health workforce development targets in Regional and Annual Planning across all South Island DHBs (100% of DHBs have targets in place)
				• Evidence of activities / actions being undertaken within each South Island DHBs (100%) respective Annual Plan on how they are working to build Māori health workforce capacity in Nursing and Midwifery and Allied Health
				• Evidence that each DHB is progressing toward the attainment of respective Māori health workforce targets (% increase in Māori health workforce evidenced quarter 4 report)
				• Each DHB within South Island provides a workforce profile report that identifies the number and percentage of Māori employed by professional group within each of their DHBs. This workforce profile is utilised to track building Māori health workforce capacity development (quarter four report)
				• By 2018 final reporting period a regional workforce profile will be established across South Island DHBs

***Objective 4:** Reducing the Impact and Incidence of Cancer on Māori within the South Island as a way to accelerate our pathway towards Māori health equity*

REDUCING THE IMPACT AND INCIDENCE OF CANCER ON MĀORI

Priority Area	Outcome Reported	Timeframe	Responsibility	Milestones reported against
Māori Health Gain- Cancer (Linked to the work of the Southern Cancer Network)	***Reduce Māori Cancer rates, specifically in the area of Breast and Cervical cancer*** • Review and develop a plan to increase the uptake of cervical screening among Māori communities (Te Waipounamu Māori Leadership Group (TWMLG) Priority area. South Island Cervical screening initiative for Māori, which seeks to accelerate regional and local performance around the Māori health priority indicator to have 80% of eligible Māori woman undertake cervical screening • He Huarahi Mate Puku the South Islands Māori Cancer Pathways Initiative, which seeks to build health literacy amongst the Māori community about cancer and supports building a health sector that is responsive to the needs of Māori with cancer. Key areas of focus for the initiative include: ○ Understand and improve the processes for collection and collation of ethnicity data around Cancer ○ Engage with key stakeholders around Cancer ○ Collate and analyse quantitative and qualitative information from various sources ○ Map related patient pathways and services within each South Island DHB ○ Coordinate the identification of Cancer service improvement opportunities ○ Motivate the development of Cancer service improvement initiatives ○ Provide coherent analysis and reports/plans • Implement Māori cancer health literacy campaign across Te Waipounamu (Dr Lance O'Sullivan/Stan Walker etc)	Q2- Q4 2017/18	Te Herenga Hauora, SIAPO, South Island Cancer Network, South Island DHB's	• Narrative report against the South Island Cervical Screening Initiative and local performance around the Māori health priority indicator to have 80% of eligible Māori woman undertake cervical screening • Narrative report against He Huarahi Mate Puku the South Islands Māori Cancer Pathways. Report will include: ○ A critical review paper relating to the collection, recording and collation of Ethnicity Data across the health continuum, including analysis of local data ○ A 'stocktake' document to include services provided and an understanding of local linkages and relationships for each DHB ○ A detailed report to compare and contrast the Māori cancer experience across the 4 South Island DHBs, including specific local issues, priority areas and the key areas for focus for service improvement ○ A DHB-specific implementation plan for service improvement areas including timelines, resource requirements, local approval processes and plans for the roll-out of the Cancer Educator service ○ Regular reporting to key stakeholders, including quarterly and 6-monthly reports to the Ministry of Health • Support the development of Māori Cancer Pathways, implementing the learnings from He Huarahi Mate Puku • Campaign implemented total number of sessions and attendees recorded and evaluation of programme completed • South Island health literacy/cultural competency campaign (utilizing well known Maori Dr Lance O'Sullivan/Stan Walker etc) completed in a minimum of 3 South Island locations

***Objective 5:** Fostering strategic relationships and working across sectors to address the wider determinants of health such as housing, employment, income, and educational attainment that all drive health inequities for Māori living in Te Waipounamu (the South Island) relative to the rest of the population*

WORKING ACROSS SECTORS PUBLIC HEALTH ALLIANCE

Priority Area	Outcome Reported	Timeframe	Responsibility	Milestones reported against
Maori Health gain, fostering strategic relationships and working across sectors (linked to the Public Health Service Level Alliance)	***Fostering Strategic Relationships*** • Te Herenga Hauora the Director/GMs Māori Health Leadership Network Te Waipounamu will build strategic relationships with key stakeholders to progress initiatives that support the attainment of Māori health equity. Key relationships will include but are not limited to: ○ SIA - South Island Alliance (SIA) the alliance of the 5 South Island DHBs, SIALT - South Island Alliance Leadership Team (SIALT) - CEs and Commissioner of the 5 South Island DHBs, SPaIT - Strategic Planning and Integration Team (SPaIT) ○ SIAPO - South Island Alliance Programme Office (SIAPO) support office for the South Island Alliance ○ SIWDH - South Island Workforce Development Hub (SIWDH) for Māori health workforce development. ○ Child Health Service Level Alliance and its associated programme of work ○ Mental and Addictions Service Level Alliance and its associated programme of work ○ Public Health Service Level Alliance (PH SLA) links together the three South Island Public Health Units; also in 2017 will have cross sector agency membership ○ Te Waipounamu Iwi and key personal within Iwi infrastructure that can support our journey to Māori health equity ○ Te Putahitanga South Island Whanau Ora Commissioning Agency ○ Te Herenga Hauora membership on the Public Health Service Level Alliance (PH SLA) and participation in any regional intersectorial programmes that can support working towards Māori health equity	Q2- Q4 2017/18	Te Herenga Hauora, SIAPO, all South Island SLA/ workstreams, South Island DHBs	• Narrative report on strategic relationships and the work programmes which have resulted from these relationships that support working towards Māori Health Equity • Narrative report on at least one intersectorial initiative and how it is working to improve Māori health inequities across Te Waipounamu

SUMMARY OF MĀORI HEALTH INDICATORS

National Priorities	Maori Health Indicator		Why this issue is important
Data Quality	1. Ethnicity data accuracy		Collecting accurate ethnicity data in accordance with the national Ethnicity Data Collection Protocols will improve the quality of ethnicity health data enabling us to effectively measure working towards health equity for Māori.
Access to care	2. Māori enrolled in PHOs meet and / or maintain the national average enrolment rate of 90%		PHO enrolment is the first step in ensuring all population groups have equitable access to primary health care services and is therefore a critical enabler for first point of contact health care. Differential access to and utilisation of healthcare services plays an important role in health inequities, and for this reason it is important to focus on enrolment rates for Māori.
Access to care	3. Ambulatory sensitive hospitalisation (ASH)	0-4 yrs 45-64 yrs	ASH is a proxy measure for avoidable hospitalisations, and unmet healthcare need in a community based setting. There are significant differences in ASH rates for different population groups and a key focus on activities to reduce ASH must address the current inequities.
Child health[5]	4. Exclusive or fully breastfed at LMC discharge 5. Exclusive or fully breastfed at 3 months 6. Receiving breast milk at 6 months	6 weeks 75% 3 months 60% 6 months 65%	Breastfeeding provides infants with nutritional needs and builds infant immunity against a range of infectious diseases within the first 6 months of life.
Diabetes/ Cardiovascular Disease	7. 90% of 'eligible Māori men in the PHO aged 35-44 years who have had a CVD risk recorded within the past five years		The burden of cardiovascular disease (heart and stroke) is greatest among the Māori population, and mortality is more than twice as high compared to non-Māori. CVD risk assessments are an important tool to enable early identification and management of people at risk of heart disease and diabetes. Fast access to treatment for heart related attacks is essential to achieve health equity and improve health outcomes for Māori.
Cancer	8. Breast screening rate 70% of eligible woman		Historically, Māori women have significantly higher incidence and mortality from breast cancer compared to non-Māori. Inequities in access to screening services need to be addressed to ensure Māori women experience the benefits of early detection of breast cancer.
	9. Cervical screening rate 80% of eligible woman		In 2012, Māori women were twice as likely as non-Māori to develop cervical cancer, and 2.3 more likely to die from it. Regular cervical screening detects early cell changes that would, over time, lead to cancer if not treated. Nationally, cervical screening coverage for Māori is 62.2%, compared to coverage in European/Other populations with coverage at 82.2%. Improving screening coverage in Māori women is therefore an important activity to improve this equity gap.
Smoking	10. Improving the percentage of households who are smoke free at six weeks postnatal.		Hapu Māori wahine have very high smoking prevalence (three times higher than the national prevalence). Smoking during pregnancy increases the risk for pregnancy complications and tobacco smoke harms babies before and after they are born.
Immunisation	11. 95% of infants fully immunised by 8 months of age		Immunization is the most effective way to actively protect your child from preventable diseases, ranging from whooping cough to meningitis and measles (Immunisation Advisory Centre, 2013). Although immunization rates are high, there is still a large he**alth** equity gap between Māori and non-Māori. Initiatives need to target Māori pēpi in order to achieve health equity.
	12. 75% of the eligible population (>65 years) are immunised against influenza annually		In 2014, Māori had the second highest rate of influenza confirmed hospitalisation, 49.2 per 100,000. The 65 years and over age group also have the highest rates of influenza admissions to ICU. A 75 percent influenza vaccination rate is required to provide the best protection for this age group and in particular for Māori. If we are able to increase immunisation rates for Māori, we will see a significant reduction in overall influenza cases.
Rheumatic Fever	13. 55% reduction in the number and rate of hospitalisations for acute rheumatic fever rate 0.2 per 100,000 (2017-18 tbc)		Rheumatic fever is a serious but preventable illness that mainly affects Māori and Pacific children and young people aged 4 to 19 years. Reducing rheumatic fever will contribute to achieving equity of health for Māori.
Sudden Unexplained Death in Infancy	14. National SUDI target tba from 1 July 2017		The target for SUDI will be lowered from 0.5 to 0.4 SUDI per 1,000 live births. The target has been lowered to match the reduced rate of SUDI among non-Māori infants (0.38 SUDI per 1,000 live births during 2010-2014). Yet there is still a significant difference in SUDI rates between Māori and non-Māori families living in Te Wai Pounamu.
	15. All caregivers of Māori infants are provided with SUDI prevention information at Well Child Tamariki Ora Core Contact 1 (minimum of 70% of all caregivers)		
Mental Health	16. Mental Health Act: section 29 community treatment order comparing Māori rates with other (per 100,000)		New Zealand has very high rates of compulsion under the Mental Health Act, compared with similar jurisdictions. Māori are nearly three times as likely as non-Māori to be treated under a community treatment order which represents a significant disparity.

[5] Ministry of Health. 2016. Indicators for the Well Child / Tamariki Ora Quality Improvement Framework: September 2015. Wellington: Ministry of Health

National Priorities	Maori Health Indicator	Why this issue is important
Oral Health	17. 95% of Māori preschool tamariki are enrolled in the community oral health service	The inequity between Māori and non-Māori enrolments is significant, therefore the need for more Māori targeted initiatives and programs is crucial.

Appendix 4 - Memberships of Alliance groups

Alliance Groups - clinical leaders of all Alliance groups are identified with their professional title. Members of Alliance groups listed **title** indicates clinical specialty.

Strategic Planning and Integration Team

Name	Title	DHB
Dr Carol Atmore (Chair)	General Practitioner	Primary Care, Otago
Carolyn Gullery	General Manager, Planning and Funding and Decision Support	CDHB & WCDHB
Hilary Exton	Director of Allied Health	NMDHB
Daniel Williams	Clinical Director, Community and Public Health	CDHB
Lynda McCutcheon	Director of Allied Health, Scientific and Technical	SDHB
Pania Coote	Director of Māori Health and Whānau Ora	SDHB
Karyn Bousfield	Director of Nursing	WCDHB
Steve Earnshaw	Chief Medical Officer	SCDHB
Mark Leggatt	General Manager, South Island Alliance Programme Office	SIAPO

Service Level Alliances and Workstreams

SLA	Name	Title	DHB
Southern Cancer Network	Dr Steve Gibbons (Chair)	Haematologist, Clinical Services	CDHB
	Dr Shaun Costello	Clinical Director, Southern Cancer Network/Clinical Director Medicine & Radiation Oncologist	SDHB
	Elizabeth Cunningham	Māori representative	Te Waipounamu Māori Leadership Group
	Theona Ireton	Kaitiaki	CDHB
	Marj Allan	Consumer & South Island Alliance Palliative Care	South Island Cancer Consumer Group
	Danielle Smith	Cancer Support Coordinator	West Coast PHO
	Tristan Pettit	Paediatric Oncologist	CDHB
	Pania Coote	Director of Maori Health and Whanau Ora	SDHB
	tba	General Manager Hospital Services	
	Michelle Driffill	Regional Manger Northern South Island for CanTeen	Canterbury
	Ralph La Salle	Planning & Funding (Team Leader Secondary Care)	CDHB
	Mike Kernaghan	National Strategic Advisor	Cancer Society of New Zealand
	tba	Southern Cancer Network Manager	SIAPO
Child Health	Dr Clare Doocey (Chair)	Paediatrician, Chief of Child Health	CDHB
	Peter McIlroy	Paediatrician	NMDHB
	Teresa Back	Maternal, Child and Youth Services	SCDHB
	Mick Goodwin	Paediatrician	SCDHB
	Barry Taylor	Professor of Paediatrics	University of Otago
	Wayne Turp	Project Specialist, Planning and Funding	CDHB
	Jaana Kahu	Māori Child and Youth Health	Te Tai o Marokura
	Traci Stanbury	Consumer	Canterbury
	Rosalie Waghorn	Nurse Manager Clinical Services - Strategic	WCDHB
	Jane Haughey	Facilitator	SIAPO
Health of Older People Services	Dr Val Fletcher	Community Geriatrician	CDHB
	Carole Kerr	Walking in Another's Shoes Dementia Educator	NMDHB
	Jason Power	Snr Business Analyst, Planning & Funding	SCDHB
	Stanley Smith	Geriatrician	SCDHB

SLA	Name	Title	DHB
	Kate Gibb	Nursing Director, Older People – Population Health,	CDHB
	Karen Kennedy	Community Pharmacist, Primary and Community Services	SCDHB
	Ann Armstrong	Consumer	Nelson
	Andrew Metcalfe	Director Allied Health	SDHB
	Penny Taylor	Regional Manager Presbyterian Support (Greater Christchurch & North Canterbury)	Canterbury
	Jane Large	Facilitator	SIAPO
Palliative Care	Dr Kate Grundy (Chair)	Consultant Physician in Palliative Medicine	CDHB
	Faye Gilles	Clinical Nurse Manager Hospice South Canterbury	South Canterbury
	David Butler	Clinical Lead Otago Hospice	Otago
	Marj Allan	Consumer	South Island Cancer Consumer Group
	Kate Gibb	Nursing Director, Older People - Population Health	CDHB
	Carla Arkless	Palliative Care Nurse Practitioner	Nelson Tasman Hospice
	Rachel Teulon	Clinical Nurse Specialist, Paediatric Palliative Care	Nurse Maude
	Brigid Forest	General Practitioner	Hospice Marlborough
	Jane Rollings	Service Manager	Nurse Maude
	Sharon Stewart	Nurse Leader Otago Community Hospice	Otago
	Sharon Adler	Portfolio Manager Planning and Funding	SDHB.
	Theona Ireton	Māori representative	CDHB
	Lydia Bras	Social Worker	CDHB
	Jane Haughey	Facilitator	SIAPO
Mental Health & Addiction Services	Heather Casey	Director of Nursing (Mental Health, Addictions & Disability)	SDHB
	Alfred Dell'Ario	Consultant Psychiatrist	CDHB/WCDHB
	David Barker	Consultant Psychiatrist	SDHB
	Rose Henderson	Allied Health	CDHB
	Jane Kinsey	General Manager Mental Health, Addictions & Disability Support	NMDHB
	Karaitiana Tickell	CEO, Purapura Whetu Trust	Canterbury
	Thomas Cardy	Operations Manager	pact
	Dianne Black	Consumer Advisor	South Canterbury
	Sandy Dawson	Family Advisor	ABLE-Invercargill
	Martin Kane	Facilitator	SIAPO
Information Services	Graham Crombie	Independent	Otago
	Bev Nicolls	Community Based Services Directorate / General Practitioner	NMDHB & Stoke Medical Centre
	Nigel Trainor	Chief Executive	SCDHB
	Chris Dever	Chief Information Officer	CDHB
	Jane Brosnahan	Director of Nursing	CDHB
	John Beveridge	Nurse Consultant	CDHB
	Nigel Millar	Chief Medical Officer	SDHB
	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 & WCDHB
	Peter Gent	General Practitioner	Mornington Health Centre

SLA	Name	Title	DHB
	Sheree East	Nursing Director	Nurse Maude
	Paul Goddard	Programme Director, Information Services	SIAPO
	Sonya Morice	Facilitator	SIAPO
Quality and Safety	Mary Gordon (Chair)	Executive Director of Nursing	CDHB
	Ken Stewart	Community Physiotherapist	Selwyn Village Physiotherapy
	Peter Twamley	Clinical Governance Manager	NMDHB
	Tina Gilbertson	General Manager Organisational Development	SDHB
	Lynley Cook	Population Health Specialist	Pegasus Health
	Carolyn Gullery	General Manager Planning and Funding	CDHB & WCDHB
	tba	Hospital General Manager	WCDHB
	Martin Kane	Facilitator	SIAPO
Cardiac Services	Dr David Smyth (Chair)	Cardiologist & Clinical Director of Cardiology	CDHB
	Lisa Smith	Cardiac Clinical Nurse Specialist	WCDHB
	Rob Hallinan	Service Manager	CDHB
	Rachael Byars	Physician and Clinical Leader	SDHB
	Garry Nixon	Medical Officer	Dunstan Hospital
	Nick Fisher	Consultant Cardiologist	NMDHB
	John Edmond	Cardiologist	SDHB
	Harsh Singh	Cardiac Surgeon	CDHB
	Philip Davis	Cardiac Surgeon	SDHB
	Liz Disney	Acting Executive Director, Planning & Funding	SDHB
	Curt Ward	Clinical Practice Manager, South Island, St John	Independent
	Alan Lloyd	Facilitator	SIAPO
Elective Services	Cathy O'Malley	General Manager Strategy, Planning and Alliance Support	NMDHB
	Carolyn Gullery	General Manager, Planning and Funding	CDHB/WCDHB
	Lisa Blackler	Director Patient, Nursing & Midwifery	SCDHB
	Liz Disney	Planning and Funding (Acting)	SDHB
	TBC	General Manager Hospital Services	NMDHB
	Pauline Clark	General Manager, Christchurch Hospital	CDHB
	Lexie O'Shea	Executive Director of Patient Services	SDHB
	Philip Wheble	General Manager Grey Westland Health Services (Acting)	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
	Vicky Mann	Radiologist (Trauma/ED)	CDHB
	Dominic Fleischer	Specialist Emergency Physician	CDHB
	Christopher Wakeman	Surgical Consultant	CDHB
	Peter Kyriakoudis	Medical Officer	WCDHB
	Peter Doran	SMO Anaesthetist	SCDHB
	Kris Gagilardi	National Patient Pathways Manager	St John
	Ralph la Salle	Team Leader Secondary Care, Planning and Funding	CDHB
	Martin Watts	Emergency Medicine Specialist, Acting Clinical Leader	SDHB
	David Brands-Geisen	Service Manager	CDHB
	Phyllis Meier	Category Delivery Manager, Rehabilitation Services	ACC
	Alan Lloyd	Facilitator	SIAPO

SLA	Name	Title	DHB
Stroke Services	Dr John Fink (Chair)	Clinical Director, Neurology	CDHB
	Wendy Busby	Consultant Physician & Geriatrician	SDHB
	Clare Jamieson	Occupational Therapist	CDHB
	Julian Waller	Stroke Clinical Nurse Specialist	SCDHB
	Suzanne Busch	Geriatrician, General Physician	NMDHB
	Carl Hanger	Stroke Rehabilitation Consultant & Geriatrician	CDHB
	Jason Power	Senior Business Analyst, Planning & Funding	SCDHB
	Mary Griffith	Clinical Nurse Specialist - Stroke	CDHB
	Margot van Mulligan	Physiotherapist	WCDHB
	Jane Large	Facilitator	SIAPO
Hepatitis C	Dr Alan Pithie, Chair	Chief of Medicine, Infectious Disease & General Physician	CDHB
	Catherine Stedman	Assoc Prof. Medicine, Gastroenterologist & Clinical Pharmacologist	CDHB
	Margaret Fraser	Clinical Nurse Specialist	SDHB
	Cheryl Brunton	Public Health Physician	CDHB
	Sandy McLean	Team Leader Mental Health & Addictions, Planning & Funding; Member Hepatitis C National Advisory Group	CDHB
	Thomas Caspritz	Consultant Gastroenterologist & General Physician	SCDHB
	Paul Hercock	General Practitioner	Christchurch
	Jenny Bourke	Hepatitis C Clinical Nurse Specialist	Christchurch Hep C Clinic
	Barb Smith	Manager – Dunedin Intra Venous Organisation	Dunedin Intra Venous Organisation
	Eileen Varley	Manager – AOD Services	NMDHB
	Gilbert Taurua	Principal Advisor, Tautawhihia Kaua e whiu	NZ Drug Foundation
	Susan Levin	GP Liaison Gastroenterology	Christchurch GP
	Kathryn Leafe	CEO Needle Exchange Services Trust	NEST
	Martin Kane	Facilitator	SIAPO
South Island Public Health Partnership	Dr Keith Reid, Chair	Clinical Leader, Medical Officer of Health	SDHB
	Evon Currie	General Manager, Community & Public Health	CDHB, WCDHB, SCDHB
	Daniel Williams	Clinical Director, Community & Public Health, Medical Officer of Health SCDHB	CDHB, WCDHB, SCDHB
	Peter Burton	Public Health Service Manager	NMDHB
	Grant Pollard	Group Manager, Operational Excellence, Service Commissioning	MoH
	Ramon Pink	Medical Officer of Health, and Māori Public Health Portfolio	CDHB
	Lynette Finnie	Service Manager, Public Health Services	SDHB
	Ruth Teasdale	Facilitator	SIAPO
South Island Workforce Development Hub	Mary Gordon (Chair)	Executive Director of Nursing	CDHB
	tba	Director of Midwifery	
	Rene Templeton	Associate Director of Allied Health, Scientific and Technical	SDHB
	Nigel Millar	Chief Medical Officer	SDHB
	Gary Coghlan / Hector Matthews	General Managers of Māori Health	WCDHB / CDHB
	Pam Kiesanowski	Director of Nursing and Midwifery	NMDHB
	Heather Smith	General Manager Human Resources	NMDHB
	Kate Rawlings	Programme Director	SIAPO
	Kathryn Goodyear	Facilitator	SIAPO