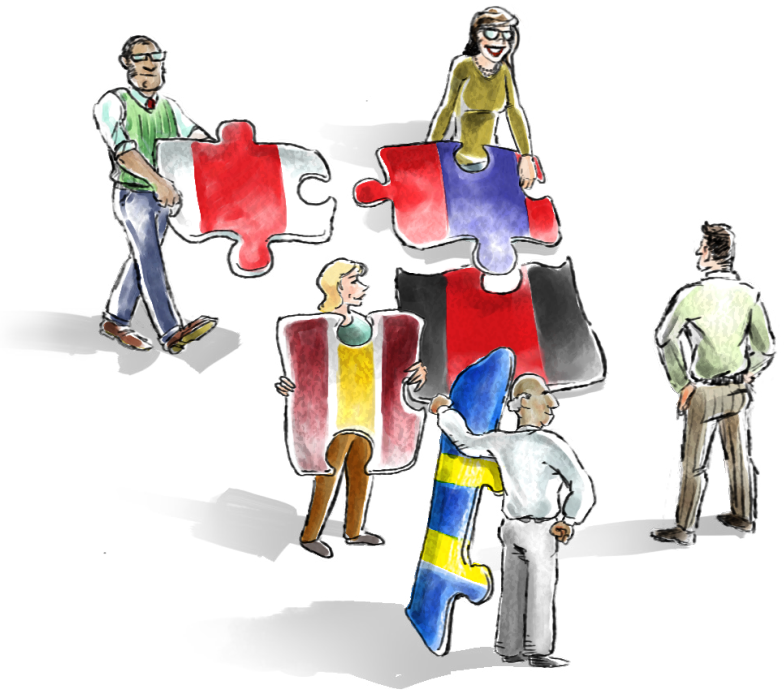
SOUTH ISLAND
ALLIANCE

best for people, best for system

ANNUAL PROGRESS REPORT 2015-2016



When the South Island Alliance was established in 2011, the five South Island district health boards (DHBs) recognised the challenges they faced individually and collectively required a whole of system approach.

With finite health resources, our region continues to focus on how we respond to increasing pressures and challenge traditional approaches to get the best outcomes for our health spend and investment, to achieve sustainability and meet the future needs of the South Island population.

Highlights of a successful year

Over the past 12 months, the South Island workstreams and service level alliances have brought a range of activities and initiatives to fruition, which are outlined in this report. This progress would not have been possible without the strong relationships and clear vision developed over the past five years for how South Island health services should work together.

More integrated health information

- One million electronic referrals
- South Island Patient Information Care System (SI PICS) went live on 30 May – the first step in regional implementation
- 60,000 views on HealthOne each month by 1500 GPs and 450 pharmacy users across three DHBs
- Over 1300 beds with electronic prescribing and administration

A more flexible workforce

- More nurse practitioners - from 11 in 2010 to 36 in 2016, with 12 more on identified pathways
- Calderdale Framework projects support delegation and skill sharing within allied health staff
- 457 primary care staff attended dementia education sessions about the importance of early diagnosis and ongoing support
- Palliative care services surveyed in 14 hospitals and eight hospices to inform better models of care
- Over 1700 electronic clinical procedure guidelines, accessible anywhere via Lippincott

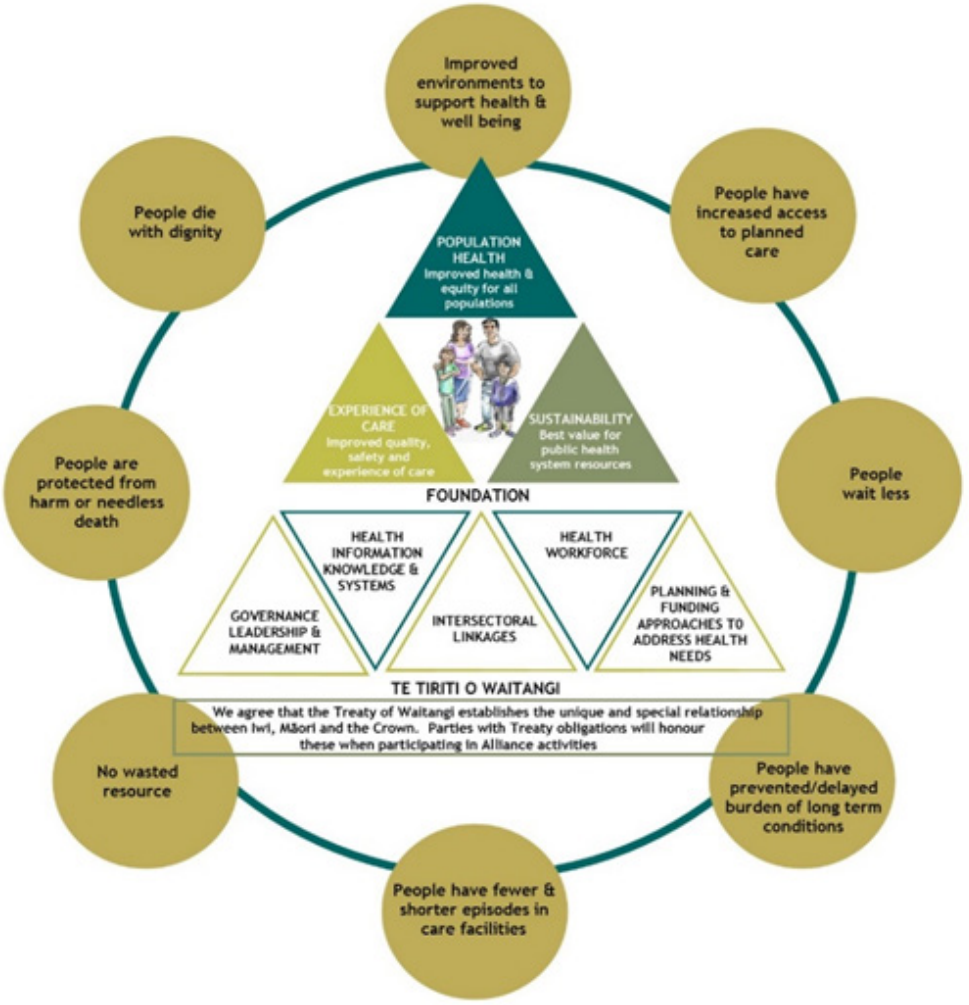
Better outcomes for patients

- Over 80% of high-risk acute coronary syndrome patients received an angiogram with three days of admission
- A consistent suite of high quality resources agreed regionally to address childhood healthy weight
- Equitable access to one South Island waiting list for bariatric surgery
- Regional agreement with St John for regular, scheduled inter-hospital transfers
- 81% of cancer patients received their first treatment within 31 days
- More regionally aligned HealthPathways for consistent diagnosis and treatment

SOUTH ISLAND ALLIANCE

Achieving better health outcomes for the South Island

This report outlines some of the activities, initiatives and developments the South Island Alliance has led during 2015-2016 that support our "best for people, best for system" vision and the South Island Outcomes Framework.



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

Outcome 1: Improved environments to support health and wellbeing

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

PUBLIC HEALTH

Reducing alcohol related harm in young people.

- The Public Health Partnership continues to support DHBs to implement alcohol harm reduction strategies.

- It has collaborated with the South Island Child Health Service Level Alliance on the Emergency Department Youth Alcohol Scoping Project. The aim of which is to better understand youth alcohol-related presentations to emergency departments and interventions to prevent future alcohol harm.

- The Alcohol in Schools document has been finalised and is now available to school principals throughout the South Island.

Collaboration with other agencies to achieve better health and social outcomes.

- The Public Health Partnership has developed a collaborative, whole-of-system, regional approach to public health issues. This approach will drive action to positively influence the environments in which we learn, live, work and play.

- The Public Health Partnership has also partnered with Te Herenga Hauora on shared actions to encourage smokefree lifestyles, and is supporting Southern Cancer Network's focus on increasing Māori cervical screening rates.

SUPPORT SERVICES

- A range of sustainable health care initiatives are shared across the South Island to support more efficient and cost-effective health care delivery, including energy initiatives, lighting, waste reduction, and a decrease in carbon emissions.

QUALITY AND SAFETY

Ensuring everyone has a voice in determining how our health services are provided will result in better health outcomes.

- A South Island consumer engagement stocktake has been completed involving the Alliance, DHBs, and various government and non-government organisations. The findings will inform further work on ensuring greater levels of consumer engagement and participation in health service planning and delivery.

Outcome 2: People have increased access to planned care

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.

INFORMATION SERVICES

eReferrals provides unprecedented connectedness and transparency for health services.

- The one millionth electronic referral or request for specialist advice in the South Island was received on 16 March 2016. Using ERMS, general practice teams make a referral or request for specialist services via an electronic form, which is securely and automatically delivered to one of over 700 community and hospital services.

"I love how it works; it makes sense. Our process is more streamlined."
Brief Intervention Counselling team member

ELECTIVE SERVICES

Analysis of inter-district patient flows supports service sustainability, improves pathways to care and ensures equitable access.

- The Electives Workstream began work to understand interdistrict flows and the impact on the ability of DHBs to deliver elective services. Three projects will continue in 2016-17: demand analysis; supply analysis; and development of models of care and HealthPathways. Feedback on the process has been very positive.

Providing greater consistency and equity in access to care for people in the South Island.

- Regional bariatric surgery volumes have been met and the bariatric surgery pathway has been reviewed and amended to improve service. There is now one South Island waiting list for bariatric surgery.

- The South Island has agreed and implemented urology pathways, which provide clarity for GPs and ensure greater equity for patients across the South Island.

WORKFORCE DEVELOPMENT

Developing the role and number of nurse practitioners will support more flexible models of care.

- A national survey of nurse practitioners was undertaken by the South Island Workforce Development Hub. The information gathered is now part of a toolkit to assist the development of clinical pathways in areas of need.

- The number of nurse practitioners in the South Island increased from 11 in 2010, to 35 in 2016, with a further 12 on identified pathways.

"The [survey] results provided excellent information for nursing leaders as they work on supporting and sustaining a nurse practitioner workforce in the South Island."
Heather Gray, Chair, South Island Nurse Practitioner Group

The clinically-led Calderdale Framework develops a more flexible and skilled allied health workforce.

- The South Island Workforce Development Hub is supporting Calderdale Framework training and projects in each DHB. Projects include delegation to allied health assistants and skill sharing between allied health practitioners.

CANCER SERVICES

Faster cancer treatment through improved processes and coordination.

- Approximately 81% of South Island patients received their first treatment within 31 days of a confirmed cancer diagnosis.

- Southern Cancer Network hosted two workshops for multidisciplinary meeting (MDM) coordinators to encourage peer support, networking and collaboration. Feedback was positive, with strong support for ongoing regional engagement. Staff turnover has decreased, assisting to embed MDM processes.

Outcome 3: People wait less

By minimising waiting times, patients experience reduced pain and suffering, and better health outcomes.

MAJOR TRAUMA

Consistent, streamlined processes for people with major trauma means they receive the right care more quickly.

- Work has continued on the implementation of major trauma pathways. Good progress has been made towards developing regional destination policies with St John and Emergency Care Co-ordination Teams so trauma patients receive the most appropriate, timely care.

- Three DHBs have identified and assigned trauma roles to staff, while the remaining two are working through this process.

- Data collection is underway to better understand patient flows and plan services.

STROKE SERVICES

Patients who have had a stroke are being diagnosed and treated faster, potentially reducing the long-term effects.

- The Stroke Services Workstream has supported each DHB to implement a system to rapidly confirm a stroke diagnosis and identify patients who may benefit from thrombolysis therapy, along with a thrombolysis pathway.

CARDIAC SERVICES

Improved processes mean acute coronary syndrome patients receive treatment faster.

- The South Island Cardiac Workstream has developed and agreed to the scope of the South Island Cardiac Services Model of Care. The model aims to support equitable and sustainable services for the South Island and consists of three main projects: access to tests; optimal HealthPathways; and planning for sustainability. Workgroups have been established with representation from across the South Island and strong links to national and other regions' work programmes.

- Over 80% of high-risk acute coronary syndrome patients in the South Island received a coronary angiogram within three days (the national target is 70%).

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

Early intervention, improved coordination and proactive provision of care, improves health outcomes for people, families and whānau with complex or long-term conditions.

HEALTH OF OLDER PEOPLE

Assessment, early diagnosis, intervention and ongoing support for people living with dementia and their carers/family/whānau improves health outcomes.

- As part of the Primary Care Dementia Education project, education sessions were held across the South Island, attended by 457 primary care staff.

- All DHBs are now using a regionally aligned Cognitive Impairment HealthPathway.

- Interviews with people diagnosed with dementia, their carers and health professionals were filmed and used for training purposes. These have been described as profound.

"After watching a patient explaining the value of knowing, and a doctor sensitively telling a person they had dementia, we will make changes to our practice."
South Island general practitioner

HEPATITIS C

A South Island Hepatitis C Workstream was has been established to review and assess current services, and clinical and diagnostic capacity and capability. A proposal for an integrated approach, in conjunction with national initiatives, is now being considered.

STROKE SERVICES

Sharing knowledge and innovation about caring for patients with stroke enables health professionals to improve services.

- The Stroke Services Workstream arranged a successful South Island Stroke Study Day. More than 190 people attended in person and over 100 joined through video-conference. Participants reported that they found it very beneficial.

CHILD HEALTH

Addressing childhood obesity improves health outcomes and prevents a range of long-term conditions.

- South Island DHBs agreed to a regional approach to address childhood obesity. Started in 2014, this work now supports the government's Childhood Obesity Plan and new health target.

- A suite of referral options will be made available to ensure equal access to high quality resources. These include Triple P Healthy Lifestyle Group (behavioural change, nutrition and physical activity for the whole family) and BeSmarter (a way to start conversations about health and goal-setting).

"We have agreed on a common set of key resources so the same messages are delivered consistently across the region."
Professor Barry Taylor, Chair, South Island Childhood Healthy Weight Clinical Advisory Group

- e-Growth charts went live on 30 June 2016 across the South Island and will enable the collection of electronic growth data from birth to death.

The Well Child Tamariki Ora Quality Improvement project is supporting more joined up early childhood services.

- Consumer engagement to better understand the experience of 'high risk' parents/caregivers is underway.

CANCER SERVICES

Increased support for people with cancer.

- Extra support is provided for patients whose diagnosis has a large psychological and/or social impact. Lead psychologists have been appointed in each cancer service, and psychologists or social workers are being appointed in each DHB. Regional leads are working on service planning together. It is envisioned the group will work as one regional team.

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

Investing in community services improves health outcomes and frees up hospitals to provide more acute and specialised care.

MENTAL HEALTH AND ADDICTIONS

South Island Eating Disorder Service supports therapy at home.

- The South Island continues to be strong in the provision and sustainability of Maudsley Family Based Therapy for young people with eating disorders.

- The South Island Eating Disorder Service found that young people were being admitted with increasingly embedded and complex issues. Further training has been provided to services around the region to address this and provide better support for patients and their families closer to home.

CARDIAC SERVICES

Pathways will help reduce unnecessary admissions for patients.

- Accelerated chest pain pathways have been implemented on schedule in three of the five South Island DHBs.

HEALTH OF OLDER PEOPLE

Using interRAI data to ensure services provide support to older people where and when they need it.

- After wide consultation, a South Island Restorative Consensus Statement was developed. Guides were also produced for health professionals and consumers to support older people to live independently, care for themselves and stay connected to the community.

- The findings of a collaboration between the South Island Alliance and University of Canterbury to understand and improve the health care needs of older people was presented to the health care community. Data analysis reviews looking at predictors of poor outcomes in dementia, predictors of hip fractures, and end-of-life issues were carried out using interRAI data combined with other data sets. Presentations to clinical teams were held at nine sites throughout the South Island. Feedback was positive about how they this information could be used to shape service delivery.

"We achieved some really interesting results, for example, 2,800 people in New Zealand suffer from hip fractures every year, which is a very traumatic and painful experience. The data showed the predictors for those who have a higher chance of suffering from hip fractures, so they can now be targeted through the health sector."

Dr Hamish Jamieson,
Geriatrician and Senior Lecturer

Outcome 6: No wasted resource

We need to get the greatest value from the system and use evidence to inform how our scarce health care dollars are best invested.

SUPPORT SERVICES

A regional inter-hospital transfer contract enables more efficient planning of services and greater confidence for clinicians when making decisions about patient transfers.

- South Island DHBs implemented a regional agreement with St John for inter-hospital transfers, which includes regular, scheduled journeys, and provides greater clarity around administration and costs. As a result, there has been a significant reduction in out-of-schedule transfers. Feedback from clinical staff has been very positive.

- The agreement has been in place for a year and all parties are pleased with the benefits, so it will be rolled over for a further year. An additional agreement for out-of-schedule journeys has also been negotiated with St John.

INFORMATION SERVICES

The South Island Patient Information Care System (SI PICS) is enabling more integrated, efficient care.

- SI PICS went live on 30 May 2016 in Canterbury DHB with some outpatient services. The launch represents the first phase of implementation and coincided with the opening of the new Burwood facility. The transition has been relatively smooth. More than 75,000 patient records were migrated to the new system and the software was put through its paces with several rounds of testing.

WORKFORCE DEVELOPMENT

A single shared eLearning platform creates efficiencies in terms of development and maintenance. It also means South Island staff can create a portfolio of learning that is transferable across the region.

- Approval has been given and work is now underway to roll out eLearning across the South Island.

- A regionally representative group has co-designed a South Island suite of intravenous learning packages for use across the sector. A respiratory package has also been developed.

Fostering inter-disciplinary learning will result in efficiencies in training, and encourage greater interdisciplinary engagement.

- A South Island inter-disciplinary learning workshop was held in March. It was attended by over 50 people, with representation from whole-of-health and tertiary education. Very positive feedback has been received.

- South Island principles to encourage greater inter-disciplinary learning have been endorsed and a draft action plan is being developed.

Outcome 7: People are protected from harm or needless death

Quality improvement in systems and processes increase patient safety, reduce the number of events causing injury or harm and improve health outcomes.

INFORMATION SERVICES

HealthOne enables health professionals to access to more information (such as GP records, community pharmacy and care coordination referrals) at the point of care.

- HealthOne was successfully implemented in November 2015 in South Canterbury DHB, the third South Island DHB. It is viewed nearly 60,000 times a month by around 1500 GP users and 450 pharmacy users, and contains data relating to 580,000 people. Preparation has begun to bring St John, private hospitals and home-based care providers into HealthOne, and the business case for implementing HealthOne in Southern DHB was approved (expected to go-live in September 2016).

eMedicines reduces medication and prescribing errors.

- MedChart (electronic prescribing and administration) is available in over 1300 beds in the South Island. Planning is underway in Nelson Marlborough and West Coast DHBs to implement MedChart.

	Beds in use	Total beds	Ratio complete
CDHB	550	1,340	39.0%
SCDHB	120	125	96.0%
SDHB	647	680	95.1%

- Southern DHB has completed implementation of MedChart into targeted adult inpatient beds in core hospitals. Each patient now has an electronic medication record that is current, up-to-date and accessible.

- Canterbury DHB has migrated its instance of MedChart to New Zealand Universal List of Medicines as its source of medication information. This is a first in New Zealand.

QUALITY AND SAFETY

Regularly sharing ideas and innovations in patient safety enables improved quality of care for patients.

- The South Island Alliance facilitates a fortnightly meeting with quality managers from each South Island DHB and the Health Quality and Safety Commission. Progress on implementing the Open for Better Care campaign is discussed, ideas and innovations are shared, and challenges are discussed. Participants have found the regional collaboration useful to support quality improvement initiatives.

WORKFORCE DEVELOPMENT

Lippincott Procedures provides health professionals with access to agreed best practice; supporting higher quality, more consistent care.

- There have been over 76,000 hits on Lippincott Procedures across the South Island. In the community it has been rolled out to 69 organisations so far, including six Māori non-government organisations in Canterbury.

- Eighteen clinical nurse specialist/educator expert groups have been established across the South Island and Midland regions to review and develop clinical procedures collaboratively.

"There have been some extremely positive reports of the value of HealthOne - practices being able to access medication lists for people travelling through the district, as well as community pharmacy being able to check dispensing from other pharmacies. It is also saving hospital pharmacists significant time reconciling medicine."

Ruth Kibble, General Manager
Primary and Community Services, SCDHB

Outcome 8: People die with dignity

Helping people understand their options and respecting their needs at the end of life will support them to die with dignity.

PALLIATIVE CARE

Comprehensive surveys of palliative care services are increasing understanding of services and will inform South Island models of care.

- The South Island Palliative Care Workstream carried out the first comprehensive survey of palliative care services within 14 hospitals and eight hospices across the South Island. The survey provided insight into how services are currently managed and the results have prompted significant discussion about how the South Island can support better palliative care services for patients and their families.

HEALTH OF OLDER PEOPLE

Promoting Conversations that Count means people receive the care they want at end of life.

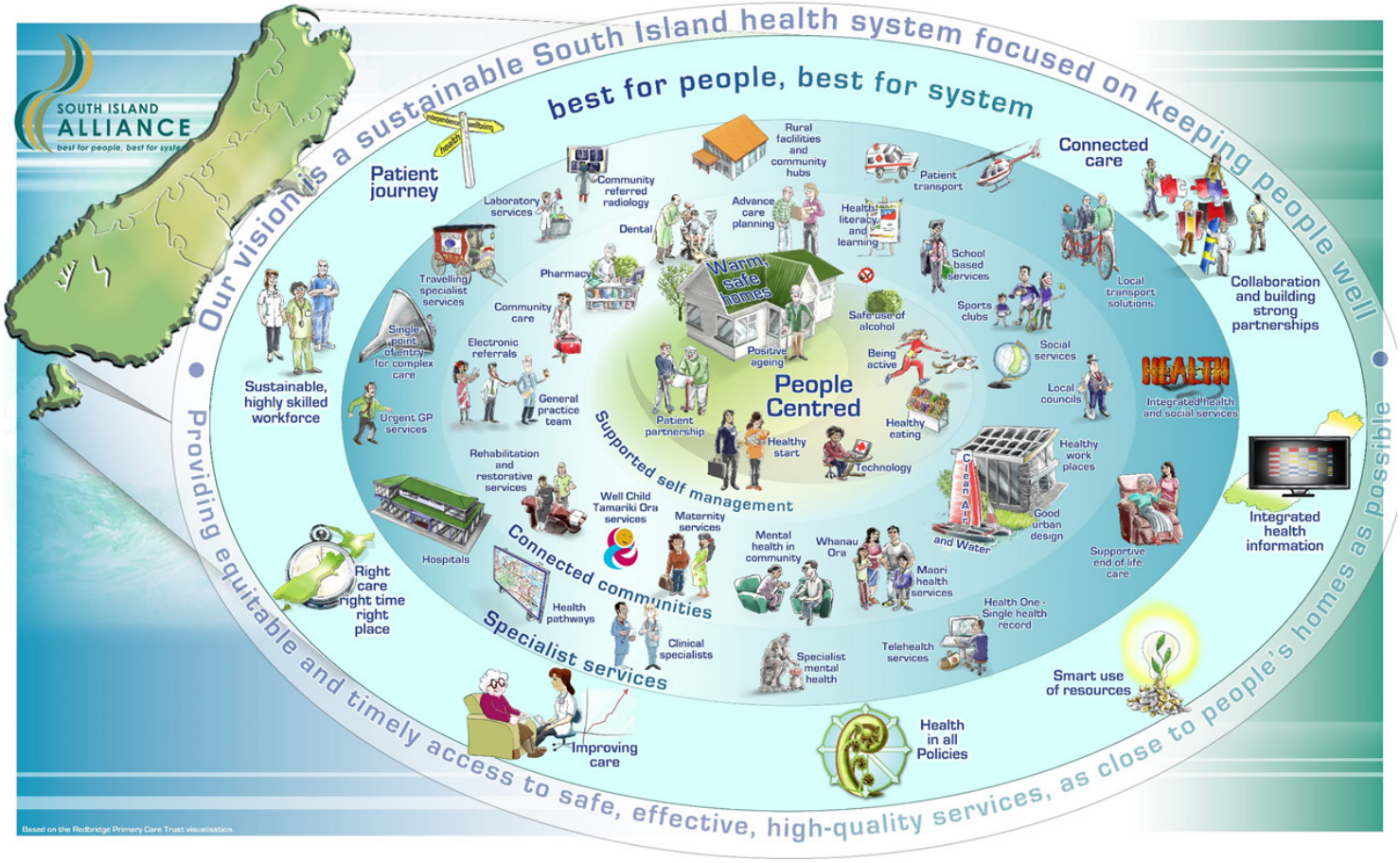
- The South Island Health of Older People Service Level Alliance (HOPSLA) supported the many and varied activities that took place around the South Island for Conversations that Count Day in April. Morning teas were arranged to encourage people to have a 'conversation that counts', and posters, postcards, and media stories were shared.

"Having a 'conversation that counts' gives us the opportunity to talk about who we are, our values and beliefs, and our choices for future treatment. The next step is having an advance care plan written and lodged with health services to guide health staff, family and caregivers, if we are unable to speak for ourselves. I am really happy with how Conversations that Count Day went this year and how many people were interested in starting a 'conversation that counts'."

Val Fletcher, Geriatrician and Chair of HOPSLA

Training in advance care planning is supporting health professionals to be able to discuss choices for end of life care.

- Level 2 Advance Care Planning education continued with eight workshops held around the South Island to equip senior health professionals from all disciplines (acute, rehab, primary care, community, etc.) to enhance their communication skills regarding care choices at end of life.



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