SOUTH ISLAND

REGIONAL HEALTH SERVICES PLAN

2012-2013

SOUTH ISLAND ALLIANCE
best for patients, best for system

Steering a Course for a Sustainable Future

South Island Regional Health Services Plan

Produced in 2012

By the South Island Alliance Programme Office

On behalf of the five South Island DHBs

Telephone: 03 378 6631

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FOREWORD

From the South Island District Health Chief Executive Officers and Board Chairs

The South Island Alliance Governance and Leadership Team are committed to govern, lead and guide our Alliance as it seeks to improve health outcomes for our populations. We are pleased with the progress to date as we move to our aim of providing increasingly integrated and coordinated health services through clinically-led service development and its implementation within a 'best for patient, best for system' framework. We formed this Alliance to enable the District Health Boards (DHBs) in the South Island region to work effectively together, utilising our combined resources to jointly solve problems, develop innovative solutions to health sector challenges and achieve outcomes for the people of the South Island Region.

The South Island Alliance has proven its effectiveness as a collaboration framework as we have delivered against our plans during 2011-12. This 2012-13 plan continues to identify the opportunities that will make a difference for our population and deliver changes that are best for patient, best for system.

Our Alliance has a clearly defined governance and clinical leadership structure that includes a decision making framework to enhance regional decision making which is in the best interest of the South Island as a whole. This acknowledges that there may be areas within the scope, where a particular DHB either may wish to, fully or partially, be excluded from its activities. Each Board has this option at the time of commencing, however once agreed, the Board is bound to operate within the scope and decision making criteria agreed.

Signed by:

John Peters, CEO
Nelson Marlborough DHB

Jenny Black, Chair
Nelson Marlborough DHB

David Meates, CEO
Canterbury and West Coast DHB

Bruce Matheson, Chair
Canterbury DHB

Peter Ballantyne, Acting Chair
West Coast DHB

Chris Fleming, CEO
South Canterbury DHB

Murray Cleverley, Chair
South Canterbury DHB

Carol Heatly, CEO
Southern DHB

Joe Butterfield, Chair
Southern DHB

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

02 JUL 2012

Mr Chris Fleming
Lead CEO, South Island Region
Chief Executive Officer
South Canterbury District Health Board
Private Bag 911
TIMARU 7940

Dear Mr Fleming

2012/13 South Island Regional Health Services Plan

This letter is to advise you that I have approved the 2012/13 South Island Regional Health Services Plan.

I want to thank the District Health Boards (DHBs) in the South Island Region for making good progress during 2011/12 with the implementation of your Regional Services Plan (RSP). You have now laid a solid foundation from which substantial regional (and sub-regional) integration is expected in the 2012/13 financial year.

As I indicated in my *2012/13 Minister's Letter of Expectations*, regional integration is a key priority to me as we strive for improved health services for all New Zealanders. DHBs working collaboratively within regions is about ensuring services are delivered in a clinically sustainable and financially viable way to meet the needs of the region's populations. It is also about reducing variation in clinical practice, and consolidating some functions to improve the productivity of the health system.

I expect DHBs to make significant progress in implementing their 2012/13 Regional Service Plans. This includes

- implementing actions for identified Government priorities ie. cancer services, cardiac services, elective services, stroke services;
- providing regional workforce initiatives, Regional Training Hubs, the implementation of regional IT systems and capital objectives;
- implementing actions for agreed DHB regional and sub-regional priorities; and
- supporting and advancing the work of Health Benefits Limited, Health Workforce New Zealand, the National Health Committee and the Health Quality and Safety Commission.

I look forward to seeing tangible benefits provided to patients as a result of these important regional initiatives being implemented. The National Health Board will continue to work with the South Island Region DHBs and will closely monitor progress against your identified actions, offer support and act as a resource to assist you to deliver on your RSP.

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

Yours sincerely

Hon Tony Ryall
Minister of Health

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

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1 EXECUTIVE SUMMARY

Steering the course for a sustainable future

The South Island Context

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

By 2025-26, more than one in five people in the South Island will be aged 65 years or over, compared to one in eight in 2010-11. While our older population is living 'well' for longer, older people are more likely to have more complex or multiple long-term conditions, and consequently, are higher users of health services. With the expected increase in the proportion of the population who are aged over 65 and who are Māori or Pacific, the prevalence of long-term conditions is also predicted to increase across the South Island. Both population ageing and increases in long-term conditions across all population groups will drive increases in health expenditure.

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

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

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

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

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

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

South Island Alliance Activity

The South Island DHBs are involved in collaborative activity across a large number of regional and sub-regional service areas. The Alliance Leadership Team and South Island Alliance Board recognise the need for focused effort to gain momentum in achieving collaborative outcomes. The alliance approach will therefore continue to be applied to four priority clinical service areas and two enabling services as the first tranche of a phased approach.

The service level alliances:

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

In addition to these services, the workstreams established for cardiac, elective and stroke services will gain momentum during 2012-13 to deliver the identified national outcomes. Regional planning also continues to deliver regional outcomes for neurosurgery and ophthalmology services. The Regional Training Hub, Asset Planning, Human Resources, Māori Health and Communication activities feed into the Service Level Alliances and the overarching plan to support the vision of a sustainable South Island health system focused on keeping people well and providing equitable, and timely, access to safe, effective, high-quality services as close to people's homes as possible.

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

2 INTRODUCTION

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

Why plan regionally?

Health systems worldwide, including the New Zealand health system, face a number of significant challenges that will continue to intensify in the future. The challenges in the South Island are similar to that of the wider New Zealand health system, these being:

- Changing demographics and growing demand;
- Increasing inequalities;
- Clinical sustainability;
- Fiscal sustainability; and
- Patient expectations.

These pressures make it increasingly difficult to deliver high quality, responsive health services. They are clearly articulated in recent national strategic documents, along with the recognition that a 'whole-of-system' approach is required to sustainably meet the future needs of our population.

The South Island DHBs accept that as individual entities we cannot make a large enough impact on our health system to ensure the future sustainability of services in the South Island. Implementing diverse but similar individual responses to our collective challenges duplicates effort and investment, and leads to further service access inequalities and inconsistencies between DHBs.

With limited health resources, our region continues to be more focused on how we respond to increasing pressures and challenge traditional approaches, and boundaries, to get the best outcome for our health spend and investment.

Since the implementation of our first regional plan in 2010, regional health service planning has supported the South Island DHBs to:

- Improve equity of outcomes to health services delivered across the South Island;
- Enhance the quality and consistency of care provided across the South Island;
- Enhance the sustainability of health services for the South Island population; and
- Engage with key stakeholders to ensure their understanding and acceptability of the way South Island services are organised, and delivered.

VALUES

Equity

Quality

Sustainability

Engagement

Gains made through regional collaboration

The first half of 2011-12 has seen considerable collaborative activity—and benefit from this activity—at a regional level. Examples of key outcomes from the Service Level Alliances and other regional activities include:

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

- Improved access and treatment for cancer patients through:
  - Implementation of a single South Island repository of cancer patient data to enable the collection of key information on treatment outcomes for South Island cancer patients.
  - The establishment of Te Kāhui Kaihautū Māori Leadership Group (an outcome of the inaugural Te Waipounamu Māori Leadership Wānaka for Cancer) to support improved access to information on the prevention of cancer and cancer services for South Island Māori.
  - More patients presenting at multidisciplinary meetings (MDMs) for discussion of treatment options. Sixty-two percent of lung cancer patient cases were presented in 2010, compared with 48% between July and December 2009. This number has increased further in 2011, with a corresponding increase for bowel cancer patients. Evidence has demonstrated that cancer patients presented at MDMs have improved outcomes, as the treatment options are considered by the MDM team.
  - An agreed patient referral pathway for adolescents and young adults with cancer in the South Island, which will be developed by the end of the 2011-12 period.
- Better mental health and addictions support for consumers and their families through:
  - Improved communication between providers and families of children and youth being treated at the Child and Youth Residential Alcohol and Drug centre through Skype, and improved clinician-to-provider engagement through access to videoconference through recently purchased resources.
  - Videoconference education sessions and a 'virtual' meeting room on the videoconference network to smooth the transfer of patients being treated for medical detoxification between secondary and tertiary services.
- Quality, timely and accessible treatment for children through:
  - Agreed referral pathways of care to improve access to and consistency of treatment for children. The South Island Hernia Referral Pathway has been completed; three general surgical and two gastroenterology pathways are in development.
  - Implementation of an agreed South Island paediatric early warning observation chart for children aged 1 to 4 years across South Island paediatric hospital-based services. A care management and communication plan is being piloted as the next step in the development of a paediatric early warning score tool to prevent adverse events for our children in hospital.
- Consistent and restorative care for older people through:
  - Use of the same eligibility criteria for services of care for older people across the South Island to enable fair and consistent access to services across the South Island.
  - The rollout of interRAI assessment modules across the South Island DHB.
- Effective support services and information technology through:
  - Joint purchasing of anaesthetic machines, negative pressure wound care and mobile intensifiers to enable our clinicians to provide safe care for patients anywhere in the South Island using familiar equipment. Having a single South Island market approach and trialing of pressure redistributing mattresses led to less time and effort in clinical trials, and decreased variation across the region.
  - Ongoing steps being taken towards moving our patients' medical information between hospitals, with the aligning of our regional desktop and regional patient information flow. Using MedChart will help prevent medication errors and support the transfer of care between the hospital and the General Practitioner.

These improvements to our health services result primarily from the development and implementation of regional systems and processes.

Our 2012-13 plan

This updated plan, the *South Island Regional Health Services Plan (2012-2013),* builds on our achievements made thus far while addressing new areas for which benefit is expected through applying a regional approach, with an ongoing focus of value for our patients.

From an accountability perspective, this document reiterates our health services planning processes and agreed framework for regional decision making, and provides an action plan for 2012-13 based around the services we have prioritised for regional and sub-regional focus.

We have not recommended radical changes to the current configuration of hospital and specialist services, or attempted to specify where services should be located or what our workforce should look like. Such outcomes will result from ongoing collective discussion and debate, and more integrated planning and decision making between South Island DHBs, our partner organisations and the National Health Board as we continue to move towards delivering a more comprehensive regional health services plan in the coming years.

The South Island Regional Health Services Plan has been approved by the regional Chief Executive Officers (CEOs) and the Boards of all five South Island DHBs. Section 4 outlines the work plans for each of the 2012-13 Service Performance Priorities.

2.1 The Role and Scope of the South Island Region

"Our purpose is to lead and guide our Alliance as it seeks to improve health outcomes for our populations. We aim to provide increasingly integrated and coordinated health services through clinically-led service development, and its implementation, within a 'best for patient, best for system' framework."[2]

Regional governance and leadership

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

The DHBs are adopting this approach to facilitate working together to jointly solve problems by sharing knowledge and resources with a focus on achieving the best outcomes for the region's population.

The alliance framework has been adopted because it is uniquely suited to:

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

"If you want to be incrementally better, be competitive.

If you want to be exponentially better, be collaborative."

The South Island DHB Board Chairs and CEOs have signed the South Island Alliance Governance Board and Leadership Team Charter. The Charter states that the foundation of the Alliance is a commitment to act in good faith to reach consensus decisions on the basis of 'best for patient, best for system'. The Board and Leadership Team have signed the Charter agreeing to conduct themselves and undertake their leadership role in a manner consistent with the following Alliance principles:

- We will support clinical leadership and in particular clinically-led service development;
- We will conduct ourselves with honesty and integrity, and develop a high degree of trust;

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

- 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 patient-centred, whole-of-system approach and make decisions on a 'best for system' basis;
- We will seek to make the best use of finite resources in planning health services to achieve improved health outcomes for our populations;
- We will balance a focus on the highest priority needs in our communities, while ensuring appropriate care across all our rural and urban populations;
- We will adopt and foster an open and transparent approach to sharing information; and
- We will actively monitor and report on our alliance achievements, including public reporting.

Decision making

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 patient, best for system'. However, 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.

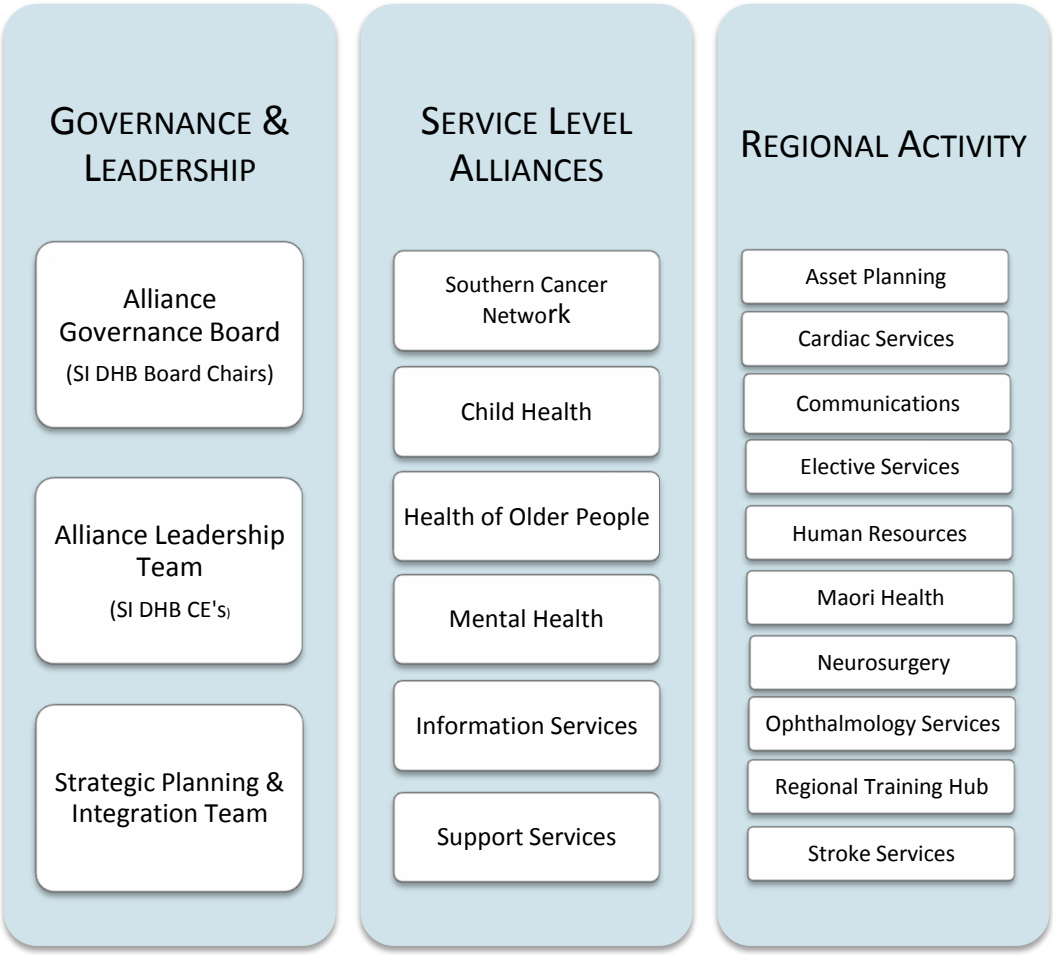
Alliance Framework

A Lead CEO provides direction and support as required for each of the Service Level Alliances. Clinicians from primary care and the DHBs are involved in all of our Service Level Alliances together with managers, non-governmental organisation representatives and consumers. Our Service Level Alliances and regional activities are lead by clinicians, with the exception being the Support Services Service Level Alliance, which has a manager as Chair. The Service Level Alliance and workstream groups include a number of clinicians. Service Level Alliance members come from each of the DHBs, are multi-disciplinary and provide a breadth of expertise and ownership for the development of initiatives.

It is important to recognise that the Alliance Framework is but one approach. Other regional activity operates within the regional collaboration approach, e.g. neurosurgery, stroke, electives and Māori Health.

The South Island DHB Alliance Framework is illustrated in the figure below.

Figure 1: South Island DHB Alliance Framework



The South Island DHB Alliance Framework supports South Island DHB collaboration through:

- An Alliance Board (the five South Island DHB Chairs) that sets the strategic focus, oversees and governs, and monitors overall performance of the Alliance.
- An Alliance Leadership Team (the South Island DHB CEOs) supported by the South Island General Managers Planning & Funding Network that prioritises activity, allocates resources (including funding and support) and monitors deliverables.
- A Strategic Planning & Integration Team that supports an integrated approach, linking the Service Level Alliances and workstreams to the South Island vision, and identifying gaps and recognising national, regional and district priorities. The Team provides a strategic and integrated view that is broader than the current priority areas, and incorporates the South Island Regional Health Services Plan development.

  The Team is comprised of a Chief Medical Officer, Director of Nursing, General Manager Māori Health, Director of Allied Health, Public Health Physician, primary and community clinicians, General Manager Planning and Funding, and the General Manager of the South Island Alliance Programme Office.
- Service Level Alliances. CEOs and Boards recognise the need for focussed effort to gain momentum in achieving collaborative outcomes. The Alliance approach will be applied to four priority clinical service areas and two enabling workstreams as the first tranche of a phased approach. The South Island Alliance Programme Office supports the Service Level Alliances.
- Collaborative activity also takes place through a number of other workstreams, which include both clinical and non-clinical activity.

3 The South Island Region

3.1 Demographics

In 2011-12, the South Island was home to over 1,038,843 people, 24% of the total New Zealand population. By 2026, our population is projected to increase to 1,120,825 people, a lesser increase of 7.9% compared to a projected population increase of 13.1% for all of New Zealand.

There are five DHBs in the South Island with the population of the largest, Canterbury DHB, at just under half of the total South Island population being fifteen times that of the smallest, West Coast DHB (refer Figure 1). Over the next 20 years (2006 to 2026) there will be differing patterns of demographic change between the DHBs. The Canterbury and Nelson Marlborough DHBs' populations are growing, while Southern, South Canterbury and West Coast DHBs' populations will be relatively static (refer Figure 2).

This follows a similar pattern for the whole of New Zealand, with population growth being concentrated in larger urban centres. Over a third of the South Island population lives in Christchurch City, which is projected to grow at the fastest rate (14%), with the population of Invercargill decreasing 7% between 2006 and 2026. Nelson Marlborough DHB has seen substantial population growth over the past year. Projections indicate the DHB's total population has increased 1%, with 2% to 7% increases in 50+ age groups. Though officially undocumented, it is presumed that a substantial proportion of the Christchurch population reduction of 8,900 relocated within Nelson Marlborough. The Nelson Marlborough DHB rate of increase from last year shows the populations of Nelson and Tasman each increasing by 1.6% for 2011, the same rate as Auckland's growth and the population of Marlborough increasing by 0.7% during 2011.

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

Figure 2: South Island Population by DHB, 2011-12

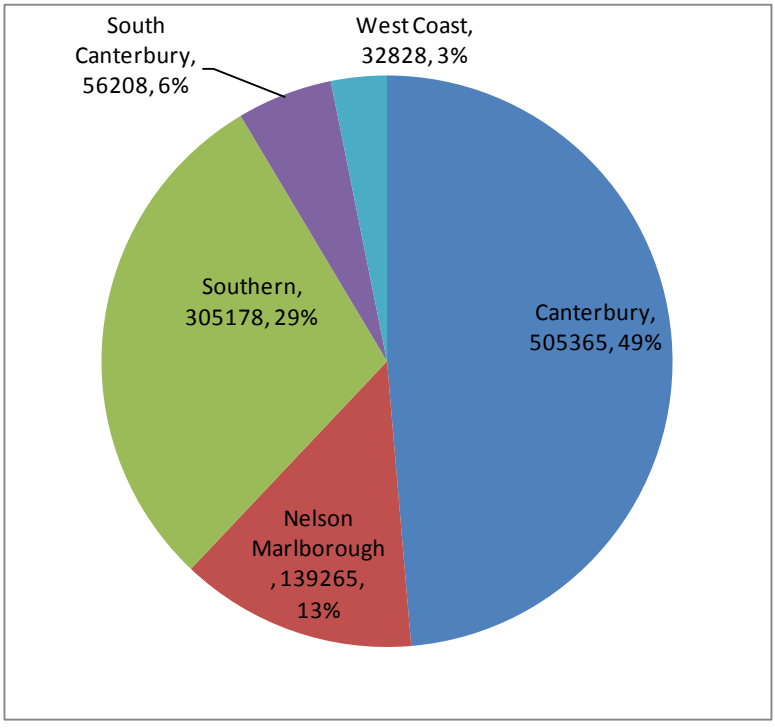
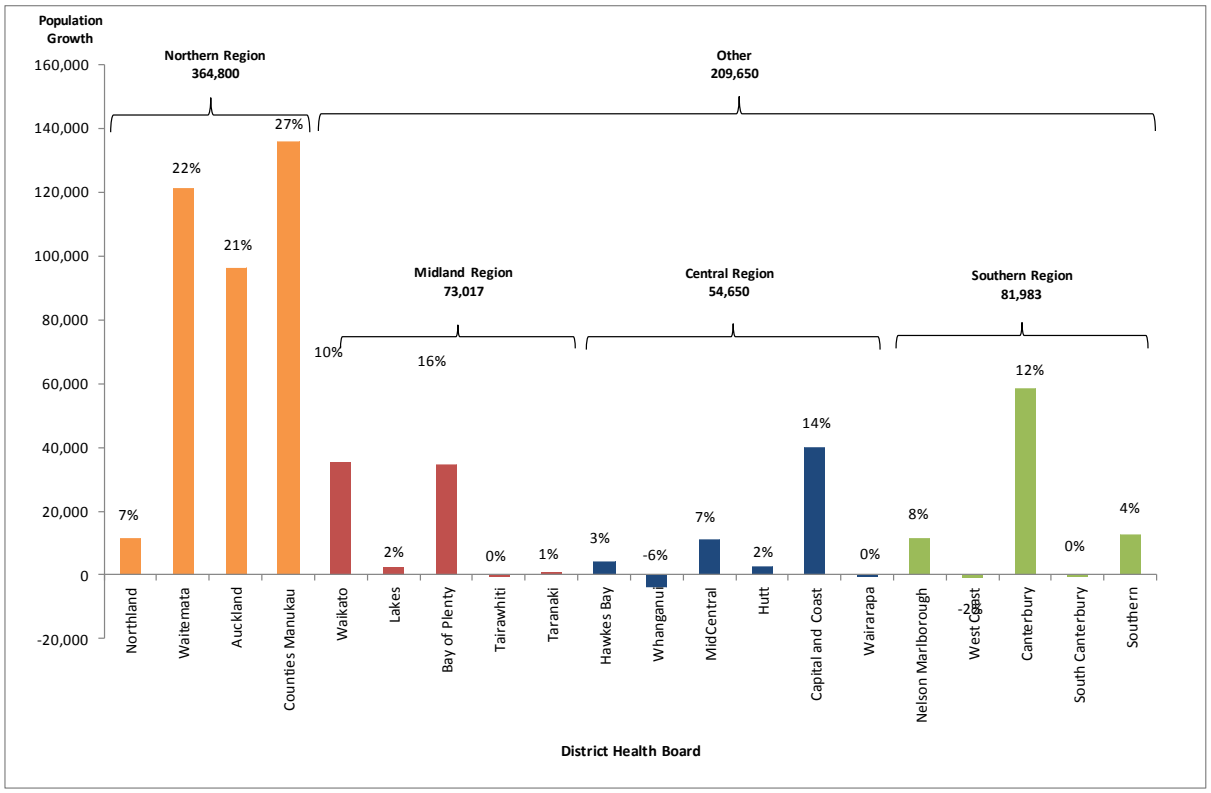


Figure 3: Projected Changes in Population by DHB 2010-11 to 2025-26



Ethnicity

In contrast to the national population, the South Island has a higher proportion of people identifying as European/Other. However, our Māori and Pacific populations are projected to increase by 20.5% and 28.1% respectively from 2010-11 to 2025-26, representing a more rapid growth in the Māori and Pacific populations in the South Island than in New Zealand as a whole, and significant proportional population growth compared to the remainder of the South Island population (at 6%). The Asian population in the South Island is also expected to increase by 58.2%.

The increase in our Māori and Pacific populations provides challenges in that Māori and Pacific people have higher rates of smoking and obesity than Asian or European/Other population groups, are more likely to have complex or multiple long-term conditions, and have higher morbidity and mortality rates. Pacific people have the highest hospitalisation rate in the South Island for diabetes and its complications, followed by Māori, who have significantly higher rates than Asian and European/Others. Rates of mortality and hospitalisation for cardiovascular disease and cancer follow a similar pattern.[3]

Age

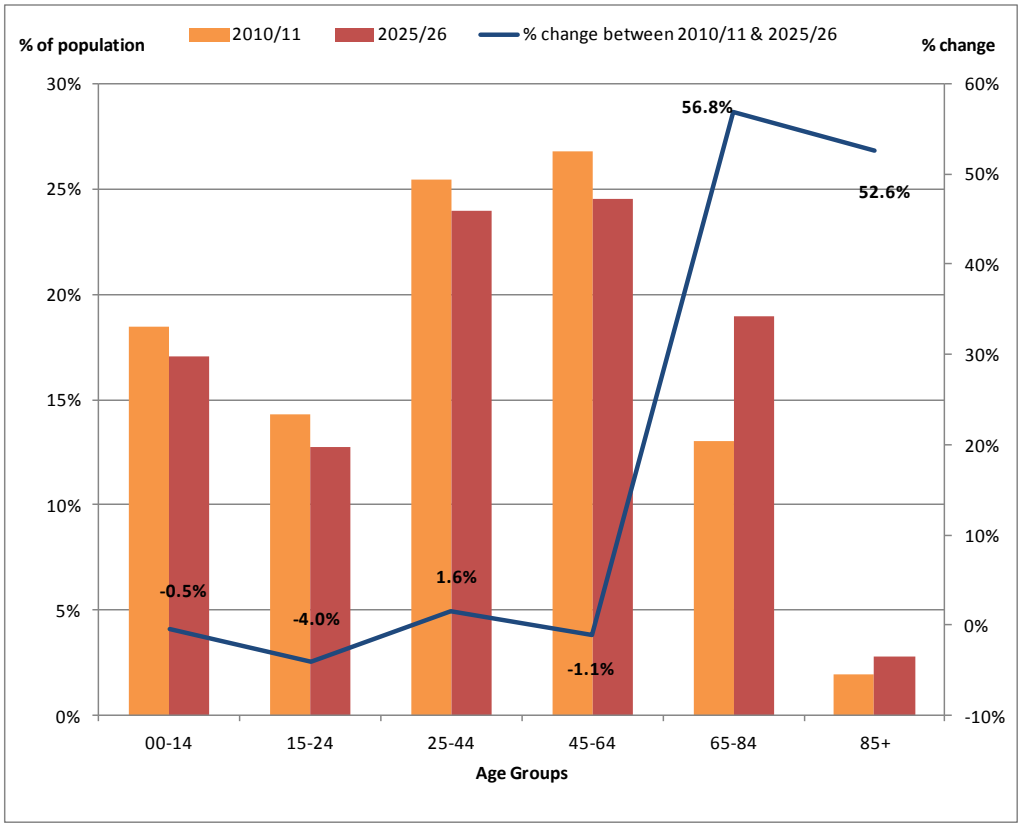
Between 2010-11 and 2025-26, the projected change in the age of the South Island population shows there will be small decreases in the proportion of the population in younger age groups and increases in all age groups over 45 years, with a significant increase in the population aged over 65. By 2025-26, more than one in five people in the South Island will be aged 65 years or over, compared to one in eight in 2010-11 (refer Figure 3).

While our older population is living 'well' for longer and more fit and active, older people are more likely to have more complex or multiple long-term conditions, and consequently, are higher users of health services.

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

Both population ageing and increases in long-term conditions across all population groups will drive increases in health expenditure.

Figure 4: South Island Projected Population Change by Age Group



Population health status and inequalities

Inequalities can be gender-based, ethnic, socio-economic or geographic, and many are driven by social and economic determinants outside the direct influence of the health system. Health must play an active role in influencing these determinants through input into policy and legislative processes. However, the effects of these determinants can be also compensated for by well targeted services or further exacerbated by poor access to services resulting in people presenting late with more complex or multiple conditions.

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

Māori and Pacific people are also more likely to live in lower socio-economic areas (a key determinant of inequalities) and are more likely to have health comprising behaviours such as smoking, lack of physical activity and poor diet leading to obesity. These risk factors are strongly linked to the prevalence of long-term conditions like diabetes and cardiovascular disease. Long-term conditions are the major cause of life expectancy disparities between Māori, Pacific and other New Zealanders.

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

3.2 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 us to prevent crisis, and better manage the issues and challenges we experience locally, and regionally.

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

The South Island Shared Services Agency was restructured to better support the South Island Alliance framework. The organisation's new name is the South Island Alliance Programme Office.

The Christchurch Earthquakes

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

- General practice and pharmacies were lost and community providers were displaced, many are now working from temporarily and makeshift facilities.
- 635 rest home beds were lost and further facilities will still have to close.
- 106 inpatient beds were closed at Christchurch hospital and almost all 200 of the DHB's buildings were damaged, with many being so unstable they had to be closed and demolished.
- More than 3,000 homes have been vacated in the Red Zone with similar numbers still to be vacated and many people have been temporarily relocated either out of Christchurch city or into rental properties, temporary villages or the homes of friends and relatives.
- Over 700 of Canterbury's health workforce are still displaced.
- The earthquakes and ongoing aftershocks have already resulted in unplanned costs of over $26m. The total cost is still an unknown factor. We are unable to predict the final interplay between repair costs, insurance recovery and the financial impact of new Building Codes.
- Over 9,000 rooms need to be repaired across Canterbury hospitals.

Primary Health Care Organisation (PHO) population data shows the number of people enrolled at a general practice in Canterbury has fallen less than two percent—or 9,257 people—since February 2011. However, international literature on disaster recovery indicates that those who were vulnerable prior to a disaster have an increased risk of poor health afterwards.[4] The earthquakes and ongoing aftershocks will have a significant and ongoing physical and psychological impact on the Canterbury population.

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

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

While more than 90% of Canterbury's activity is for its own population, around 4,000 people a year travel to Canterbury from other parts of the South Island to access in-patient services. In all, Canterbury provides over

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

$100m dollars worth of services to the populations of other DHBs around New Zealand and delivers just over half of all the surgical services provided in the South Island (51%). It is critical that Canterbury maintains current hospital and specialist service delivery levels.

The next few years will be challenging. The Canterbury DHB has broken buildings that must be repaired and it must do so without compromising the delivery of services. Capacity that was already stretched is now on a knife edge. Canterbury needs to be supported or their future viability and the delivery of care, not just to their own population but to the population of the whole of the South Island, will be compromised.

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

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

Canterbury will implement their Transitional Recovery Plan to tackle urgent demand issues and restore and maintain capacity. They have also adopted a 'whole-of-system' production planning approach to respond to capacity constraints and will significantly increase outsourcing to the private sector over the next two years. The DHB expects to need private capacity in areas of elective surgical services such as Ophthalmology, Orthopaedics, Cardiac Surgery, General Surgery and Urology.

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

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

Regionally, we will closely monitor access and utilisation trends across the South Island to identify where in the system support is required to meet patient need and gauge how the system is functioning as a whole.

Ultimately, however, we are dealing with a large element of the unknown and this plan should be read with that in mind.

4 STRATEGIC DIRECTION

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

What will a sustainable health system look like?

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

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

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

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

Alongside these overarching strategies, the National Health Board has released *Trends in Service Design and New Models of Care*.[5] This document provides a high-level summary of emerging worldwide trends and international responses to the pressures, and challenges facing the health sector.

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

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

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

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

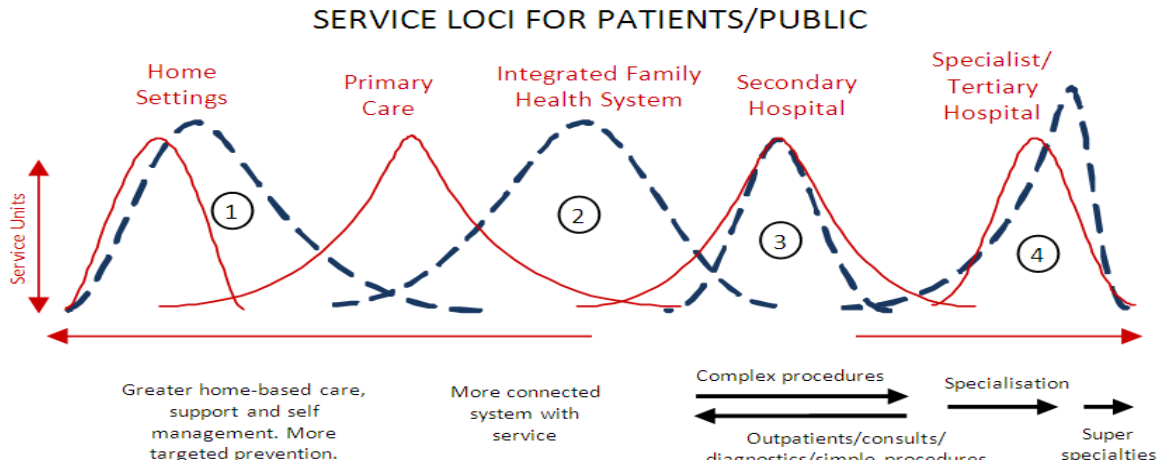
[5] *Trends in Service Design and New Models of Care: A Review (2010)*, Ministry of Health, www.nationalhealthboard.govt.nz

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

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

Figure 5: Pictorial Representation of Shifts in Service Trends

MORE SERVICES WILL BE PROVIDED CLOSER TO WHERE PEOPLE LIVE



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

Increased Regional collaboration

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

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

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

4.2 Regional Direction—best for patient, best for system

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

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

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

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

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

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

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

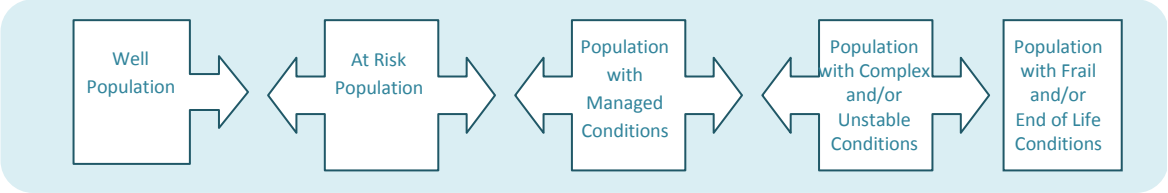
These concepts emphasise the significant step change in the way we design and deliver services. Through regional service planning, traditional DHB boundaries and patient flows are being challenged to ensure that services are supported in a sustainable manner.

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

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

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

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



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

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

An alliance approach

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

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

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

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

4.3 Local Direction—Bringing it all together

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

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

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

At a regional level, the South Island DHBs are working collectively to deliver "*A clinically and fiscally sustainable South Island health system"*. The regional focus on "*providing equitable and timely access to safe, effective, high quality services"* will not only contribute to ensuring health services are sustainable but by keeping people well, it will also alleviate the increasing demand for services and improve health outcomes.

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

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

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

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

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

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

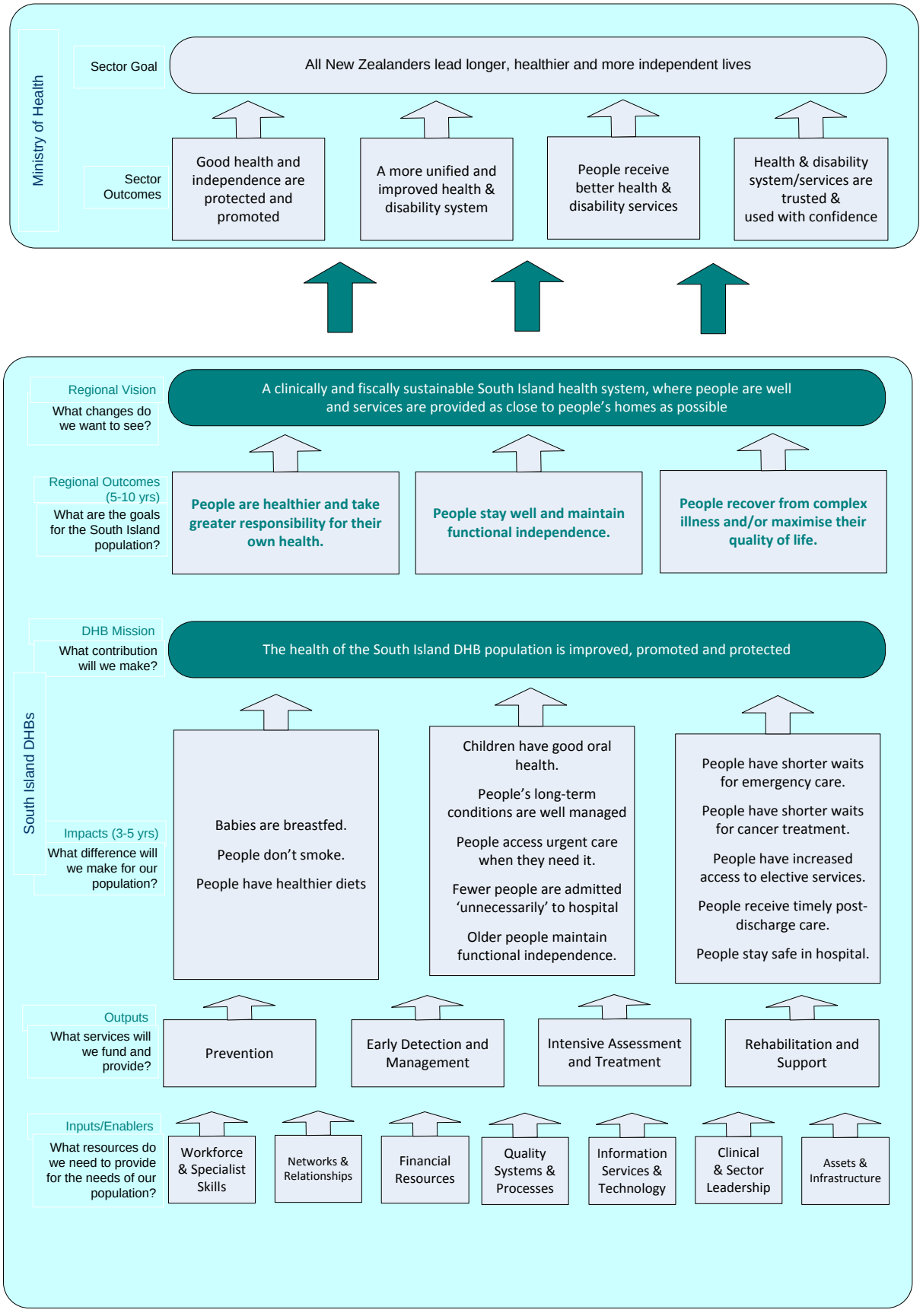
Outcome 3: People receive timely and appropriate complex care.

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

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

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

Figure 7: Intervention Logic Diagram



5 SERVICE PERFORMANCE PRIORITIES 2012-2013

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

The South Island DHBs are involved in collaborative activity across a large number of regional and sub-regional service areas. The areas identified in this section are those that have been given national and regional priority. In addition to these priority areas, regional planning continues for neurosurgery, ophthalmology, stroke, emergency planning and emergency care coordination. Each priority area—whether supported by regional Service Level Alliance, workstream or group—is clinically-led, or, as for the Support Services Service Level Alliance, has clinicians involved in the teams and in all key decision making approaches. Members of the Service Level Alliances and other working groups come from each of the DHBs and provide breadth of expertise and ownership for development initiatives. A regional communication strategy and the South Island Alliance Programme Office support the activities across the South Island.

5.1 Clinical Services: Sustainability and Clinical Integration

5.1.1 Cancer Services

Better Sooner More Convenient Health Services for New Zealanders in relation to cancer services means all New Zealanders can easily access the best services in a timely way to improve overall cancer outcomes. A health system that functions well for cancer is one that ensures all:

- people get timely services
- people have access to services that maintain good health and independence
- people receive excellent services wherever they are
- services make the best use of available resources.

The Southern region has a commitment to implementing the National Faster Cancer Treatment goals and achieving the shorter cancer wait time targets.

Lead CEO: David Meates, CEO, Canterbury DHB
Clinical Director: Shaun Costello, Clinical Director Medicine and Emergency Service, Dunedin Hospital, Southern DHB

Key planning approaches	Actions to deliver	Measured by	Outcomes
Implementation of the SI Blood and Cancer Service Plan (SIBCSP) which includes: • faster wait times • medical oncology • radiation oncology • MDMs • bowel and lung • Advanced Symptom Management System (ASYMS). Southern Cancer Network (SCN) working groups are	Implementation of the regional initiatives identified in the National Cancer Programme Work plan with regional cancer networks which includes: • implementation of the agreed priorities in the regional implementation plans for the faster cancer treatment indicators • the priority areas identified in the report *New Models of Care for Medical Oncology* • implementing agreed recommendations from the Radiation Oncology project	Phase one priorities implemented (Q4) Monitoring progress against SIBCSP action plan goals and measures (Q2 & 4) Monitoring progress against SICCIS action plan goals and measures (Q2 & 4) Monitoring progress of network groups against their work plans (Q2 & 4) The development and implementation of the SI Fast	More people have improved access to services that maintain good health and independence. More people have shorter waiting times for cancer treatment meaning people receive better health services. More people have improved access to prompt and early diagnosis meaning better outcomes and improved quality of health services. More people have timely

Key planning approaches	Actions to deliver	Measured by	Outcomes
provided with ongoing support to progress their respective work plans. Reducing Inequalities projects are supported across the SI region. Implementation of the SI Clinical Cancer Information System (SICCIS), the SI regional clinical data repository for cancer.	• sustained performance against the radiotherapy and chemotherapy wait time targets by more efficient use of existing resources, and investing in workforce and capacity as required • improving the functionality and coverage of multidisciplinary meetings (MDMs) • implementing agreed recommendations from the SI Lung and Bowel projects • identifying innovations (e.g. ASYMS) and adapting them to the SI setting • identifying actions to support service improvements along the cancer patient pathway • identify actions to establish data collection systems to support service improvements along cancer patient pathway • implementing SICCIS	Track Colorectal Pathway (Q2 &4) Monitoring progress (Q2 &4) against the national and regional cancer health targets including: Improving cancer treatment (establishment of baseline and progress) the following: • all New Zealanders needing radiation or chemotherapy treatment will have this within four weeks of the decision to treat62 day indicator - proportion of patients referred urgently with a high suspicion of cancer who receive their first cancer treatment (or other management) within 62 days • 14 day indicator - proportion of patients referred urgently with a high suspicion of cancer who have their first specialist assessment within 14 days • 31 day indicator - proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment (or other management) within 31 days of decision-to-treat	access to cancer treatment resulting in better cancer outcomes. More people have shorter waiting times for colonoscopy services meaning improved outcomes for people who are, or go on to be, diagnosed with bowel cancer. Innovation and infrastructure planning and development are supported to reduce inequities and build regional capacity and capability. Regional system and service efficiencies, and quality improvement opportunities, identified and implemented resulting in the meeting of national health targets, economies of scale, increased consistency of practice and increased equity of access. Robust cancer data and information sources are developed, and shared, to enable informed service development, planning and decision making.

5.1.2 Cardiac Services

Better Sooner More Convenient Health Services for New Zealanders in relation to cardiac services means improved and timelier access to cardiac services.

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

- increasing cardiac surgery discharges
- improving access to cardiac diagnostics and specialist assessment
- reducing waiting times for people requiring cardiac services
- improving prioritisation and selection of patients selected for cardiac surgery.

CEO Sponsor: David Meates, CEO, Canterbury DHB
Clinical Lead: David Smyth, Clinical Director Cardiology, Canterbury DHB

Key planning approaches	Actions to deliver	Measured by	Outcomes
Within its available resources, the SI Cardiac Workstream Group will work with clinical networks (including the National Cardiac Network) to implement actions to improve	Establish regionally agreed protocols, processes and systems to ensure prompt local risk stratification of suspected ACS patients and transfer of high risk patients to tertiary	85% of people will receive elective coronary angiograms within 90 days and no patient will wait longer than six months (Q3) At least 70% of ACS patients	Patients with suspected ACS receive seamless coordinated care across the clinical pathway. More patients survive acute coronary events, cardiac

Key planning approaches	Actions to deliver	Measured by	Outcomes
outcomes for people with suspected Acute Coronary Syndrome (ACS). Specifically, the Group will work together to: • support a planned approach to coordinated and collaborative regional service delivery and support local service delivery • reduce inequalities in access to cardiology services across the SI • enhance the quality of health services across the SI • use common referral, prioritisation and condition management tools • engage with all associated disciplines to ensure sustainable management of cardiac services in the SI and implement national cardiac strategies • ensure continuous improvement to reduce access times for acute and elective work through improved efficiencies.	centres for necessary interventions Agree regionally the clinical pathway from primary to tertiary care for management of patients with suspected ACS Ensure local staff are trained in risk assessment of patients with suspected ACS according to national guidelines Ensure systems and processes for patients with suspected ACS are effective by being tailored to the needs of high risk population groups such as Māori, Pacific and South Asian people The National Cardiac Network will identify and agree cardiac surgery targets which will improve equity of access Improve access to cardiac diagnostics to facilitate appropriate treatment referral A regional service plan for cardiac services will be developed and implemented to support appropriate access to cardiac services, including surgery and percutaneous revascularisation Formulate a plan to implement health pathways for cardiac services across the SI based on the Canterbury DHB model SI Alliance determines costs and protocols for cardiac pathways	accepted for diagnostic coronary angiogram will receive this within three days of admission Population access to the following conditions will not be significantly below the agreed rate: • Cardiac surgery: 6.5 per 10,000 of population • Percutaneous revascularization: 12 per 10,000 of population • Coronary angiography: 32.3 per 10,000 of population (Q4) Regional solutions will be introduced for access problems within the cardiology and cardiac services (Q4) No one will wait longer than five months for first specialist assessment or treatment The waiting list for cardiac surgery will remain between 5 and 7.5% of annual cardiac throughput, and not exceed 10% of annual throughput Regional services plan for cardiac services developed (Q3) SI Alliance approach to health pathways agreed (Q3) Two cardiac health pathways agreed (Q4)	damage from these events is minimised, and the likelihood of subsequent cardiac events is reduced. More people receive access to cardiac services which supports New Zealanders to live longer, healthier and more independent lives. Patients have appropriate and timely access to cardiac services.
	Develop consensus for improving transfer times and travel	Protocols developed and agreed (Q1)	
	Develop a consensus as to what would be regarded as the absolute minimum essential cardiac facilities for a small to medium hospital	Current position reported to the workstream (Q1) Minimum criteria decided on and reported to the workstream (Q1) National network supportive of this initiative (Q2) All SI DHBs working to at least minimum level (Q3)	

Key planning approaches	Actions to deliver	Measured by	Outcomes
	Ensure increased cardiology nurse training in regards to: • increased exposure to cardiology during nursing training • training opportunities in New Zealand for Clinical Nurse Specialists in Cardiology	Current position reported to the workstream (Q1) Opportunities identified (Q1) Links made and maintained with the SI RTH (Q1) Training undertaken and reported (Q3)	

5.1.3 Child Health Services

Better Sooner More Convenient Health Services for New Zealanders in relation to children and young people means all children can easily access the best services in a timely way to improve their overall health and social service outcomes.

The 2012-13 work plan continues on from the previous plan with the aim to provide the best possible treatment and health outcomes for every child and young person, and their families/whanau, requiring specialist and community-based care by ensuring that:

- the child is at the centre of the service
- children and young people receive timely services
- children and young people have access to services that promote and maintain good health and independence
- children and young people receive treatment and care by appropriately skilled health professional/teams
- children and young people receive quality services wherever they are
- services make the best use of available resources to deliver safe, clinically effective and sustainable health services
- taking a whole-of-system approach to enable health and social services integration across the South Island unconstrained by DHB boundaries
- clinical leadership and engagement across all relevant health, and social service agencies, to plan, implement and evaluate current and new ways of doing things to create better health outcomes for children and young people.

The work plan recognises the changing health needs of children and young people in the South Island, and the importance of planning services over the next 3 to 5 years accordingly through applying epidemiology data to determine demographic need, DHB-by-DHB inequalities and workforce vulnerabilities.

The priority areas of focus and approaches to planning regional South Island child and young person's health services recognise that achieving 'best for patient, best for system' requires a coordinated and integrated approach at local, regional and national levels.

CEO Sponsor: John Peters, CEO, Nelson Marlborough DHB
Clinical Lead: Dr. Nick Baker, Community Paediatrician and Executive Clinical Director, Community-based Service Directorate, Nelson Marlborough DHB

Strategic Planning for South Island Children and Young People

Key planning approaches	Actions to deliver	Measured by	Outcomes
Annual child and youth health service planning and identify areas for service improvement with a focus on: • taking a whole-of-system approach across DHBs • at-risk, high health needs and vulnerable children, families and communities • SI child and youth epidemiology report findings • clinical leadership and engagement with the wider health and social service • Māori • stakeholder engagement.	Establish effective engagement /partnerships with the wider range of stakeholders to get input into 'new ways of doing things' Identify agreed SI Alliance initiatives for Māori and other ethnic groups Identify opportunities to deliver/connect service providers more effectively to improve delivery of services for vulnerable children and their families/whanau Identify areas of variability in children and young people's health and social service planning across the SI	Completion of stakeholder engagement survey (Q1) Annual service plan developed and agreed (Q2)	SI DHBs have organised child and youth health services across the continuum of care through sharing of innovations. Health and inter-sectoral services are delivered in more accessible, acceptable and are culturally appropriate to vulnerable children, young people and their families/whanau.

Improving access to South Island Children and Young People health and social services

Key planning approaches	Actions to deliver	Measured by	Outcomes
Working together to improve access across the continuum of healthcare and social welfare to: • take a whole-of-system approach • support children, young people and their families/whanau • develop a framework of care.	Develop and implement a programme of integrated care across DHBs, and associated services Utilise SI child and youth epidemiology data to monitor, and trend, progress across SI DHBs to reduce variation in the provision and delivery of services	Agreed regional programme of care for children and young people implemented (Q4) Regional health pathways developed and implemented (Q4), these being: • four condition specific general surgery • two gastroenterology • two community-focused Two regional general surgery pathways evaluated (Q4) Effectiveness of SI paediatric travel pathway reported (Q4)	Children and young people receive more timely access to the right health and social services, at the right time. Children and young people with a similar level of need receive comparable access to services, regardless of where they live in the SI.

Collaboration and Integration

Key planning approaches	Actions to deliver	Measured by	Outcomes
Strengthen collaboration and integration of child and youth health care and social services within the continuum of care across SI DHBs, and relevant community providers.	Identify and map (through a regional stock take) community-based child development programmes Implement processes to improve linkage and share clinical information across GP, and well-child providers, to secondary and tertiary health services Develop regional transition pathways from youth health	SI child development programmes mapped and report prepared (Q1) Implementation of two child development services quality improvement initiatives by (Q4) Reduction in inappropriate referrals from primary care to secondary care health services reported (Q4) Narrative progress report on	Children and young people receive seamless, coordinated care across the continuum of care.

Key planning approaches	Actions to deliver	Measured by	Outcomes
	services to adult health services	implementation of the national digital child growth charts submitted (Q4)	

Workforce Development

Key planning approaches	Actions to deliver	Measured by	Outcomes
Shared regional workforce development and planning innovations.	Develop shared education sessions/forums across the SI using: • shared innovative education approaches, such as e-learning and video-conferencing • develop and implement peer support/mentoring programme for practitioners working in isolation Work in partnership with regional and national workforce training programmes to identify future workforce requirements, and initiatives: • understand and influence workforce development in collaboration with the SI RTH • grow and repatriate our workforce	Regional child and youth workforce plan developed (Q2) Two workforce initiatives implemented (Q4): • implementation of regional multidisciplinary child education forum • implementation of a regional peer support/mentoring programme for practitioners working in isolation	Future workforce is planned to support sustainable and organised health services for children, and young people, in the SI.

Health Promotion and Prevention

Key planning approaches	Actions to deliver	Measured by	Outcomes
Work with regional community and public health teams to implement effective health promotion, and prevention, programmes in SI child and youth health services. Participate in national social marketing programmes.	Support SI DHBs to implement national strategies for protection of vulnerable children Implement pathways to support children with chronic conditions	High-needs infant care pathway developed and narrative report on progress towards implementation submitted (Q4) 80% of pregnant mothers are enrolled with well-child services and have ante-natal well-child service contact (Q4) Maternal depression pathway developed and implemented (Q4) Two regional referral pathways for the management of children and young people with chronic condition developed and submission of a progress report on implementation (Q4) Evaluation of SI epidemiology data related to health promotion/prevention initiatives and identification of	Better health outcomes for children and youth in adulthood years leading to a healthier population.

Key planning approaches	Actions to deliver	Measured by	Outcomes
		areas for improvement submitted in narrative report (Q2 and Q4)	

Quality and Safety

Key planning approaches	Actions to deliver	Measured by	Outcomes
Share learning's through quality improvement initiatives.	Develop child and youth health quality indicators to measure improvements in health outcomes in SI Use of morbidity and mortality review findings, Quality & Safety Commission adverse event data and child and youth mortality review learning's to inform change SI child health pathways have nominated quality and safety indicators	Submission of Quarterly narrative reports providing the following progress towards a schedule of regional child and youth quality indicators An evaluation of reportable events and identification of system improvements	Whole-of-system approach to improve quality, access and sustainability of health services.

5.1.4 Mental Health Services

Better Sooner More Convenient Health Services for New Zealanders in relation to mental health means that all New Zealanders can easily access the best mental health services in a timely way to improve overall mental health outcomes. A health system that functions well for mental health is one that ensures all:

- people get timely services
- people have access to services that maintain good health and independence
- people receive excellent services wherever they are
- services make the best use of available resources.

CEO Sponsor: John Peters, CEO, Nelson Marlborough DHB
Clinical Lead: Sue Nightingale, Chief of Psychiatry, Canterbury DHB

Key planning approaches	Actions to deliver	Measured by	Outcomes
A regional approach to the Intellectual Disability and Mental Health Interface drawing on the national project on disability and mental health.	Creation of a Health and Disability Sector Working Group to: • identify services currently available in each district and regionally • explore ways of enhancing access, capability and capacity • work effectively across health and disability agencies • create regional consult liaison capacity	Working group report on current services (Q4) Relevant pathway established for clients (Q4) Clear liaison mechanism established with Disability Support Services (Q4)	Consumers are enabled to access to services which are responsive to their needs and improve their well-being. Districts are able to access expertise in the area of Intellectual Disability (IDPH) when required.
Service plans to identify mental health needs in smaller Pacific	Working group to explore ways of improving quality of services	Report from Working Group	Increase accountability to smaller communities.

Key planning approaches	Actions to deliver	Measured by	Outcomes
People communities in each District.	delivered to Pacific assessing SMHS		Improve access rates of Pacific people or health outcomes. Consistent plan for ethnic specific population.

Mothers and Babies

Key planning approaches	Actions to deliver	Measured by	Outcomes
The regional Mothers and Babies service supports local, regional and national developments to ensure consistency and quality of care across the SI.	The regional provider reviews existing local and national protocols to identify areas requiring further development The regional provider continues to provide additional education opportunities for the District Liaison staff The regional provider selects and endorses a suite of screening tools for use across the SI (enhancing core skills and competencies for clinicians) A SI-wide working group develops a responsive care pathway to be followed when cases are identified on screening tools The regional provider undertakes a review of the baby boarder status	Standards of care protocols reviewed and areas needing development identified (Q4) Educational opportunities provided on an ongoing basis; reviewed (Q2) Suite of screening tools endorsed and care pathway agreed (Q4) Review presented to the Mental Health Service Level Alliance (Q4)	Promotion of the most appropriate tools for the Mothers and Babies service. A responsive care pathway for the Mothers and Babies service.

Eating Disorders

Key planning approaches	Actions to deliver	Measured by	Outcomes
A wide range of services based on the guidelines outlined in *"Future Directions for Eating Disorders Services in New Zealand" (MoH 2008).*	The Eating Disorders Working Group explore the options for developing and monitoring clinical standards in eating disorders services The Eating Disorders Working Group clarify liaison arrangements with general mental health services The Eating Disorders Working Group advises DHB Planning and Funding on workforce issues	Introduction of standardised outcome measures for eating disorders across the SI: • all districts collecting the same data (Q3) • complete a review of the process (Q4) Review and agree standardised liaison arrangements (Q3) Roll out Werry Centre e-learning aimed at developing eating disorders capability in the broader workforce. Agreement with the districts and Werry Centre will be required to confirm targeted clinicians will have the time to complete the workforce development: • some clinicians will have	An integrated service journey for people with an eating disorder.

Key planning approaches	Actions to deliver	Measured by	Outcomes
		completed training (Q3) • review the process (Q4) Introduction of multi-family therapy as part of the national roll out of Maudsley Family Based Therapy for Anorexia Nervosa for those under 18: • plan discussed with districts and suitable cases located. Ensure funding in place for all to travel (Q1) • run Intensive treatment (Q2) • review value of treatment (Q3)	

Medical Detox

Key planning approaches	Actions to deliver	Measured by	Outcomes
An integrated medical detox system that involves partners from across the region.	The regional provider visits the Districts regularly in order to provide education and support for medical detoxification The regional provider explicitly articulates admission criteria in the Service Provision Framework The tertiary level service is accessed through secondary services	Each district is visited twice annually (Q4) Patients received appropriate and timely treatment (Q4) Admission criteria agreed and specified in Service Provision Framework (Q1)	Districts across the SI are kept up-to-date on medical detox treatment options.

Child and Youth Alcohol and Other Drug Residential Services

Key planning approaches	Actions to deliver	Measured by	Outcomes
More appropriate treatment options for youth with internalising behaviours (e.g. anxiety and depression). Consultation with the sector.	Understand the demand for residential services for youth with internalising behaviour Districts and region work together to develop a family-inclusive model	A SI position on the best way to meet the need for residential services for youth with internalising behaviour is agreed (Q4) Districts demonstrate the way they work with families while the youth is in the Odyssey programme (Q4)	Families are kept involved in the care of child and youth alcohol and other drug residential service users, addressing issues in a whole-of-system manner.

Inpatient Child and Youth Services

Key planning approaches	Actions to deliver	Measured by	Outcomes
Improve the monitoring of clinical standards, to maintain a continuous quality improvement cycle. Promote best practice for CAMHS across the SI.	Establish a regional working group to address issues such as model of care, bed planning, eligibility criteria, discharge and consideration of a hub, and spoke, model Consider access pathways for specialist inpatient services for children aged 4 to 10 years	Regional working group established (Q4) The Specialist Mental Health Service Inpatient Services Proposal will address pathways for access (Q4)	An integrated journey for children and youth through the mental health system.

Forensic Services

Key planning approaches	Actions to deliver	Measured by	Outcomes
A watching brief on government priorities on youth forensic.	Complete a review of progress against the Forensic Strategic Plan Use videoconferencing to deliver training	Completion of the review (Q4) Monthly sessions rotating around the SI (Q4)	Align forensic services with the expectations of the new National Service Plan and revised Blueprint.

5.1.5 Health of Older People Services

Better Sooner More Convenient Health Services for New Zealanders in relations to the health of older people means all New Zealanders can easily access the best services in a timely way to improve overall older people's health outcomes.

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

- older people receive timely services
- older people have access to services that maintain good health and independence
- older people receive excellent services wherever they are
- health of older people services make the best use of available resources.

The work plan was developed with clinical and consumer input to ensure its alignment with national policy. The uniquely isolated and rural nature of large parts of the South Island challenge the ability to deliver equivalent services for older people residing in these areas whilst ensuring financial and workforce sustainability.

The key focus of providing an optimal and effective Restorative Model of Care throughout the region will contribute to the overall regional, and national, goals of reducing acute admissions and readmissions, and improved discharge management.

The associated areas of the plan dealing with InterRai, standardised eligibility, advance care planning and dementia will all contribute to continuous quality improvement in areas of person-centred care and coordinated care-planning. The working group is aware of the need to coordinate with other regional activity especially in the areas of information technology, stroke, cancer and workforce training, as all of these will impact upon progression to improved health care of older people.

CEO Sponsor: Chris Fleming, CEO, South Canterbury DHB
Clinical Lead: Jenny Keightley, General Practitioner, Canterbury DHB

Restorative Model of Care

Key planning approaches	Actions to deliver	Measured by	Outcomes
Develop a common approach to restorative delivery of community services. Align outcome reporting on the Restorative Model of Care with national direction.	Implement the regional restorative homecare specification Assess the effectiveness of restorative services and staff training	All home support services will be delivered using the restorative specification and funding method (Q4). 75% of Canterbury DHB services will do so (Q4), with a view to reach parity with the rest of the SI 12 months later Agreement on regional outcome measures (Q1) to	More older people remain independent in their own homes with services tailored flexibly to their needs. Improved consistency and effectiveness of restorative services across the SI. Older people receive consistent and effective

Key planning approaches	Actions to deliver	Measured by	Outcomes
		measure effectiveness of restorative services and staff training, and attitudinal change across the health of older people sector (this may require a qualitative study method and relevant funding)	restorative care irrespective of where they live in the SI.

InterRAI

Key planning approaches	Actions to deliver	Measured by	Outcomes
Roll-out InterRAI across each of the SI DHBs, including: • Contact Assessment • Home Care Assessment • Long Term Care Facility Assessment • enhance the use of the InterRAI as an effective clinical tool.	Continue extending read-only access to InterRAI to relevant health practitioners Secure agreement from the ITSLA that InterRAI server will be reliable Training and Competencies maintained to the national standards Consolidate use of the InterRAI suite to improve quality and clinical applicability Achieve excellence and consistency of reporting on aggregate InterRAI data and match it to service utilization	Half of SI primary care practitioners, ARC facilities and homecare agencies will have read-only training and access to InterRAI (Q4). 20% of Canterbury DHB services (Q4), with a view to reach parity with the rest of the SI 12 months later Subject to technical capability and resourcing, Of this half (20% for Canterbury DHB), 90% will be using it (Q4) DHB audit of compliance with national standards is provided to HOPSLA (Q4) All DHBs use the same InterRAI modules and all homecare, and new ARC recipients, will have been assessed prior to entry using InterRAI (Q4) Regular and consistent data extraction available to HOP service managers and DHB Planning and Funding portfolio managers	All older people needing services receive a standardised comprehensive assessment of their needs which is clinically effective and guides packages of care.

Standardised Eligibility Criteria

Key planning approaches	Actions to deliver	Measured by	Outcomes
Standardize the eligibility criteria and processes for entry to services across the SI.	Work with SI DHB NASC managers and HOP Portfolio Managers to achieve consistent guidelines	All SI NASCs work to standardised criteria for access to service (Q4)	Older people throughout the SI have similar access to support services appropriate to their needs.

Dementia

Key planning approaches	Actions to deliver	Measured by	Outcomes
Implement the SI Dementia Initiative (SIDI). HOPSLA will take over the advisory role for SIDI. SIDI to continue to manage the MoH Dementia Behaviour Advisory Service tagged funds	SIDI to present a budget to HOPSLA which will make recommendations to ALT on the future use of regional annual funding to assist with "Walking" and local Training Facilitator appointment Ensure that the 'Walking'	Local Training Facilitators appointed by DHBs (Q2) Initial training by SIDI completed (Q2) First iterations of the 'Walking' programme in each DHB, with the first HBSS group in	The dementia care workforce moves toward a more person-centred model of care as recognised by people with dementia and their families. The quality improvement feedback generated by the 'Walking' programme will be

Key planning approaches	Actions to deliver	Measured by	Outcomes
for the SI. *Walking in Others Shoes* ('Walking') is as a key training programme.	programme is assessed for quality outcomes Complete a SI dementia services stocktake	Canterbury DHB (Q2) Quality improvement outcomes for 'Walking' established (Q4). The first regional dementia services stocktake content finalised by HOPSLA/SIDI (Q1) and the results passed on to DHBs (Q1)	reviewed by SIDI and result in annual improvements to local programme delivery.

Advance Care Planning

Key planning approaches	Actions to deliver	Measured by	Outcomes
Advance Care Planning (ACP) to be championed by HOPSLA as a key planning approach for older people. Primary Care as the key location. Older people and people with Long Term Conditions involved in DHB ACP planning from the outset.	Place ACP on the Annual Plan for each SI DHB for all age groups Establish ACP cooperative training in the SI Provide ACP material in different languages and standardise terminology as much as possible Use electronic records in order that physicians are aware an advance directive is in place	Each DHB annual plan includes ACP DHBs complete ACP cooperative training or equivalent Standard terminology is used across the SI in the languages relevant to populations served InterRAI assessment roll-out includes a question on advance directives	People are informed and enabled to consider and complete their own ACP.

5.1.6 Elective Services

Better Sooner More Convenient Health Services for New Zealanders in relation to elective procedures means improved and timelier access to elective services for all. A health system that functions well for elective services is one that is:

- improving prioritisation and selection of patients for specialist assessment and elective surgery
- increasing elective surgery discharges
- increasing surgical first specialist assessments
- improving access to diagnostics and specialist assessment
- reducing waiting times for people requiring elective services
- supporting innovation and service delivery.

Sponsor: Lexie O'Shea, Chief Operating Officer, Southern DHB
Workstream Chair: Christine Nolan, General Manager Clinical Services, South Canterbury DHB

Key planning approaches	Actions to deliver	Measured by	Outcomes
A standardized, regional approach to the production of electives volumes delivered by the SI DHBs' Provider Arm services.	Regional plans or solutions developed, and implemented, to support improved access to elective services: • minimisation of the risk of	All SI DHBs use the agreed elective services planning methods (Q4) All vulnerable services are identified and risk	Hospital systems are more productive. More people able to access elective services and receive

Key planning approaches	Actions to deliver	Measured by	Outcomes
Along with improving timely and equitable access to elective services for those in the SI, outcomes of the plan include: • identification of capacity issues • plans to maximise theatre capacity • contingency options • assistance in meeting additional elective volumes (discharges or case weights) • options for secondary elective service volumes (discharges and case weights to be provided at another DHB) • improvement to quality patient care will be a focal point of activity for elective services.	under delivery due to limitations of vulnerable services • consistency in elective services planning methods at each of the individual SI DHBs • a consistent approach to elective services planning across the whole of the SI. The ability to forecast electives 'hot spots' within a year term and address them within that year • the ability to plan for elective services at a regional, as well as individual, DHB level • the SI region collectively meeting its elective services health target • regional (or sub-regional) solutions will be developed for secondary services where appropriate, considering: – use neighbouring SI DHB capacity – sharing of resources – clinical leadership to be sourced per current workstream for each selected elective service	management strategies agreed, and implemented, for these services (Q4)[6] A forecasting tool to identify elective 'hot spots' in 2012-13 is developed (Q2) An approach to address identified 'hot spots' is agreed and in place (Q2) There is a clinical leader assigned to each service area workstream (Q1) Access to Ophthalmology and Otorhinolaryngology (ENT) services is improved to meet national intervention rates in each DHB where indicated (Q4) Agreed regional volume for bariatric services is met (Q4) The SI Elective Services Health Target is met (Q4) SI DHBs will meet the reduced waiting times to a maximum of five months by June 2013 (Q4) SI DHBs will work together to meet equal SIRs for one elective specialty (Q4)	better health services to regain good health and independence sooner. Patient-centred approach and improved outcome a regional focus [e.g. timely access to service; equalized standardised intervention rates (SIRs) across the SI].

5.1.7 Stroke Services

The South Island Regional Stroke Workstream will work with national, regional and local DHB groups, service managers and clinical teams to implement its annual work plan, utilising appropriate clinical expertise from DHBs and primary health services to participate/contribute in specific workstream groups.

The key purpose of the workstream is to facilitate the implementation of the *New Zealand Clinical Guidelines for Stroke Management 2010* and the *Stroke Implementation Plan (2011)* to ensure that risks are reduced and improvements are made in the provision of acute and rehabilitation stroke services delivered across the South Island.

Our key drivers for change include:

- Reducing risk to people who have experienced a transient ischaemic attack (TIA) or stroke
- Improving health outcomes for people who experience a TIA or stroke
- Supporting the implementation of organised stroke services locally and across the South Island and encourage consistency and sustainability in the provision and delivery of acute and rehabilitation stroke services.

CEO Sponsor: John Peters (interim)
Workstream Co-Chairs: Dr Wendy Busby, Vivian Blake, General Manager Hospital Services, Southern DHB

[6]The South Island COOs have identified Bariatric Surgery, Ophthalmology and ENT as the priority areas for 2012-13.

Strategic Planning for South Island Organised Stroke Services

Key planning approaches	Actions to deliver	Measured by	Outcomes
Annual stroke health service planning and identify areas for service improvement with a focus on: • taking a whole-of-system approach across DHBs • clinical leadership and engagement with the wider health service providers • Māori • stakeholder engagement.	Establish a SI Stroke Workstream Group with defined and agreed terms of reference that fit within an alliance framework Develop and implement a communication plan Establish effective engagement /partnerships with the wider range of stakeholders to get improve access to acute and rehabilitation stroke services and re-integration with health services Implement a stakeholder engagement survey Undertake a stocktake of current SI Stroke services	Establish regional clinical stroke groups (Q1) Annual service work plan developed and agreed (Q1) Implementation of communication plan (Q1) Completion of stakeholder engagement survey (Q2) Stocktake of current SI stroke services completed (Q1) Establishment of a regional dashboard of acute and rehabilitation stroke services (Q1 and Q4)	SI DHBs have organised stroke services across the continuum of care through sharing of innovations. Stakeholder engaged and participating in changes at local DHB level and when appropriate at regional SI DHB level.

Improving access to South Island stroke services

Key planning approaches	Actions to deliver	Measured by	Outcomes
Working together to achieve organized stroke services across SI DHBs: • take a whole-of-system approach to improve access to coordinated acute and rehabilitation stroke services and re-integration • all SI DHBs provide thrombolysis services using best practice documented protocols • small DHBs provide thrombolysis services or a timely, effective pathway to access a thrombolysis service.	Agree benchmarks for SI stroke service Develop regional TIA referral pathway for high and low risk patients Determine regional thrombolysis targets Prioritise three actions points from the national stroke audit 2010 report for service improvement Promote increased awareness of stroke treatment across health disciplinary team	Benchmarks for SI stroke services in place and reported (Q1, Q2, Q3,Q4) A regional TIA referral pathway for high risk patients is implemented (Q3) A regional TIA referral pathway for low risk patients is implemented (Q3)	More patients survive stroke events, and the likelihood of subsequent stroke events is reduced. More people receive timely access to organised stroke services. Reduced variability in the provision and delivery of stroke services in the SI.

Workforce Development

Key planning approaches	Actions to deliver	Measured by	Outcomes
Support and facilitate shared regional workforce development and planning innovations to ensure sustainability of SI stroke services.	Share national training/ education programmes Support SI DHBs to participate in regional training/education sessions/forums Undertake a stocktake of SI training needs in collaboration with SI RTH Identify and share national training/education that is	Training and education information is available on a shared SI website (Q3) SI stroke services have accessed at least one web-based training programmes (Q3) Two shared regional education sessions made available to SI DHBs (Q4)	Future workforce is planned to support sustainable and organised stroke services in the SI.

Key planning approaches	Actions to deliver	Measured by	Outcomes
	available through web-based training tools Improved access to thrombolysis services		

Health Promotion and Prevention

Key planning approaches	Actions to deliver	Measured by	Outcomes
Work with Stroke Foundation and regional community and public health teams to support effective stroke health promotion, and prevention, programmes in SI. Participate in national social marketing programmes.	Support and promote participation of SI DHBs and community providers in national public awareness campaigns, such as FAST (fast, arm, speech, time) Promote SI DHBs to use common patient and caregiver information	SI DHBs participate in one national public awareness campaigns (Q4) Implementation of HealthInfo portal on SI Health Pathways for patient and care giver information (Q2)	Better health outcomes for people at risk of a stroke related event.

Quality and Safety

Key planning approaches	Actions to deliver	Measured by	Outcomes
Share learnings through quality improvement and benchmarking initiatives to improve organised stroke services quality and sustainability.	Develop regional stroke services dashboard of quality indicators to measure achievement towards organised stroke services	Implementation of regional stroke services quality indicator dashboard (Q2) Evaluate SI dashboard trends (Q4) Make recommendations for service improvements from evaluation findings (Q4)	Whole-of-system approach to improve quality, access and sustainability of health services thereby increasing sharing and reducing duplication and fragmentation of services.

5.2 Non-clinical Services: Key Enablers and Priorities

5.2.1 Support Services

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

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

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

Health Benefits Limited (HBL) endorsement of this regional work is evidenced by their active representation and participation in the Support Services Workstream. The South Island region is represented on HBL's national working group.

CEO Sponsor: David Meates, CEO, Canterbury DHB
Clinical Lead: George Downward, Medical Director Patient Safety, Canterbury DHB

Key planning approaches	Actions to deliver	Measured by	Outcomes
Support a planned approach to coordinated and collaborative regional support services delivery and support local service delivery Use common data bases and management tools. Engage with all associated disciplines to ensure consistency of services across the SI. Ensure clinical engagement to maintain appropriateness of support services. Provide regional leadership. Align with HBL processes and plans to achieve mutual benefits and savings. Maintain and strengthen the relationship with HBL to assist them to achieve their signaled intention of an operating model in partnership with DHBs where regional shared service organisations will be their primary interface.	Aggregate procurement requirements Reduce procurement costs Improve purchasing power Remove road blocks to delivering the workstream objectives	SI DHBs deliver savings and optimise financial and service performance in a timely manner Improved financial performance in the form of savings and/or investments. Accumulated savings reported at the end of each quarter Increased rationalisation and standardisation of products and services (where appropriate) across the DHBs to reduce clinical risk and increase purchasing power Timely access to products and services Less clinical variation to achieve safer and easier clinical exchanges Increased number of collaborative projects, with at least one new project underway each quarter Standard reporting on all activity	SI clinicians are delivering best services at optimal financial efficiency.
	Continue to acquire and maintain clinician involvement on SLAs and workstreams	Clinicians regularly contributing to workstreams	New initiatives are clinically-led.
	SI Procurement and Supply Chain workstream and working	SI Procurement and Supply Chain workstream reports	

Key planning approaches	Actions to deliver	Measured by	Outcomes
	group will work collaboratively to identify and act on opportunities to secure savings	savings of $15 million (using agreed national methodology) during the 2012-13 year Accumulated savings reported at the end of each quarter	
	Build on the work of national initiatives and ensure these are applied locally Align with national or other regional activity to deliver the best outcomes for cost and service Align with the target of collective procurement driven by HBL and MED to take advantage of bulk purchasing savings	HBL are in agreement with work plans (Q2) HBL has representation on SLA and all workstreams Ongoing engagement maintained with those who work in key related services, and management from relevant local, regional and national health services organisations, including clinicians relevant professional groups, provider organisations, DHB Planning and Funding and HBL	
	Food Services workstream which was put on hold in 2011 will be re-engaged	Food services business case updated to show how savings will be achieved in this sector across the SI (Q2)	
	Laundry Services workstream which was put on hold in 2011 will be re-engaged	Laundry services business case updated to show how savings will be achieved in this sector across the SI (Q2)	
	Maintenance and Engineering Services workstreams which were put on hold in 2011 will be re-engaged	Maintenance and Engineering services business case updated to show how savings will be achieved in these sectors across the SI (Q2)	
	Implementation of Oracle in CDHB and WCDHB to mitigate risk of collapse of current system instability	FMIS under Oracle demonstrates a stable platform (Q3)	

5.2.2 Workforce and the Regional Training Hub

Workforce is a key component of all South Island Alliance activity. The region's focus has been on establishing the clinical/service-based Service Level Alliances and will progress in 2012-13 to ensuring enablers are developed and agreed to achieve integrated workforce development and planning. In order to achieve this, the following work programme is planned:

- Agreement to a set of common workforce planning tools for Alliance Programme and DHB use
- Establishment of a common DHB Individual Employment Agreement contract
- Agreement to common DHB Human Resource guidelines for joint appointments

- Establishment of and reporting on a common set of DHB Human Resource metrics across the South Island
- Agreement to five core DHB Human Resource policies.

Collaborative approaches to workforce approached occur both regionally and sub-regionally. Canterbury and West Coast DHBs have a number of cooperative approaches to appointments and to continuing education. Shared education sessions have been developed through regional activity and include joint meetings and continuing education for cancer, ophthalmology and maternity. The 2012-13 child and mental health services work plans both include workforce support activities.

Health Workforce New Zealand (HWNZ) tasked DHBs with creating Regional Training Hubs to support post graduate training and education and enhancement of the health workforce within their regions.

The South Island Regional Training Hub seeks to strengthen the training network within Te Waipounamu and facilitate the coordination and delivery of post graduate training and education to all health professional groups. Although in its establishment phase, a key feature to the Regional Training Hub will be to analyse workforce capacity trends across the South Island and provide appropriate actions, and responses.

Workforce education and training is key to building a knowledge base within New Zealand and responding to two key government policies—Better Sooner More Convenient and Whanau Ora.

The South Island Regional Training Hub will work with HWNZ and the other three Regional Training Hubs to support a cohesive national approach to health professional education and training across the New Zealand health sector.

Lead CEO: David Meates, CEO, Canterbury DHB
Chair: Robyn Henderson, Director of Nursing and Midwifery, Nelson Marlborough DHB

Development of Regional Training Hub

Key planning approaches	Actions to deliver	Measured by	Outcomes
Through the Regional Director, provide coordinated shared workforce planning and innovation regionally through effective planning and administration of the SI Regional Training Hub (RTH).	Standardise training/ education programmes regionally Coordinate clinical placements to specialist training programmes regionally Administer and implement national workforce initiatives e.g. voluntary bonding, leadership development Align workforce training to match national service delivery needs and regional clinical service plans	Annual plan by workstream developed and agreed (Q2) This plan will include: • a minimum of three standardised programmes • an approach and number of clinical placements to specialist training programmes Completion of data analysis for the SI health workforce by workstream (Q1) Completion of a stakeholder survey regarding innovation and cross-discipline opportunities (Q3)	Workforce relationships across the health system are strengthened (HWNZ Annual Plan 2011-12). SI health workforce have improved access to post graduate education and training. There is improved alignment of workforce training against national service delivery needs and regional clinical service plans.

Strategic Planning

Key planning approaches	Actions to deliver	Measured by	Outcomes
Annual workforce planning for medicine, nursing, midwifery and allied health workstreams in association with identification of areas for	Establish baseline data on the SI health workforce to identify opportunities for delivery within and across the region Identify agreed SI Alliance	Annual plan by workstream developed and agreed (Q2) Completion of data analysis for the SI health workforce by	SI health workforce have improved access to innovative regional and rural post-graduate education and training.

Key planning approaches	Actions to deliver	Measured by	Outcomes
project focus for individual and collective hub workstreams: • taking a whole of systems view to workforce planning across DHB's in the SI • review current workforce data to inform education and training opportunities across the region • consider opportunities for Māori, pacific, and those from other ethnic communities • Key Stakeholder engagement • contribute to the integration and alignment of work programmes as part of the SI RSP.	initiatives to support Māori and other ethnic groups Identify opportunities to deliver or connect education to professional group workstreams as part of the SI Alliance Align and integrate current activities to the work programme set out in the SI RSP	workstream (Q1) Completion of a stakeholder survey re innovation and cross discipline opportunities (Q3) Review current work programme initiatives in the SI RSP and align current activities (Q4)	Health workforce training is able to support primary and community-based care service delivery (HWNZ Annual Plan 2011-12).

Improving Access to Education and Training

Key planning approaches	Actions to deliver	Measured by	Outcomes
Working with the health sector to improve access to tertiary institutions to support education and training opportunities at a post-graduate level. This will be achieved through: • Taking a whole of systems approach to education and training. • Working closely with tertiary institutions in the SI to establish areas of opportunity and innovation. • Developing a framework to support future educational pathways.	Coordinate and work with tertiary education providers to strengthen or formalize working relationships Develop and implement a programme of education and training across the SI to encourage post graduate studies by the health workforce Utilise workforce data to review trends and to establish opportunities for future programmes	Quarterly meetings held with tertiary institutions to strengthen current relationships (Q1 – 4) Agree to a regional programme of education to promote post-graduate studies (Q3)	Develop closer liaison with TEC is developed to achieve common understanding of priorities and projections of trainees required to meet workforce needs (HWNZ Annual Plan 2011-12). Workforce relationships across the health system are strengthened (HWNZ Annual Plan 2011-12).
Working with SI DHBs, improve and standardise the career pathways and trainings opportunities for PGY1 & PGY2 students.	Develop career plan pathways for PGY1 &PGY2 students in line with HWNZ guidelines Complete stock-take and analyse current training delivered to PGY1 & PGY2 students across the SI DHBs Standardise the training offered to PGY1 & PGY 2 students to ensure consistency in education across the SI	Review current career planning (Q1) and submit a report with actions for alignment of actions (Q2) A review is completed on all training delivered to PGY1 & PGY2 students (Q3) and a final report is submitted for approval (Q4) Implement reported stocktake and associated training (Q4) Standardise a minimum of three PGY1 & PGY2 programmes regionally (Q4) Communicate and coordinate implementation with DHB Training Coordinators (Q4)	Career planning tools are available for all health career professionals (HWNZ Annual Plan 2011-12). Services are supported to be clinically and financially sustainable through the development of better and regionally aligned approaches to professional training and career planning (HWNZ Annual Plan 2011-12).

Key planning approaches	Actions to deliver	Measured by	Outcomes
Coordinate and improve career planning for all DHB staff who are funded by HWNZ to achieve their career aspirations into the future.	Work with DHBs to review current funding and career planning pathways for all who receive HWNZ funded education Establish career pathway plans that maps future aspirations through the use of a planning tool used across all DHBs Review and establish mentoring and support services across all DHBs	Establish and implement standardised career plans for all HWNZ-funded DHB and NGO provider staff (Q1) Coordinate with TEC, Kia ora Hauora, and DHBs the establishment of mentors to align with professional development (Q2) Implement a minimum of three innovative new clinical placements/new roles of practice (Q4)	Services are supported to be clinically and financially sustainable through the development of better and regionally aligned approaches to professional training and career planning (HWNZ Annual Plan 2011-12).
Develop and up-skill the SI Allied Health workforce.	Undertake a survey to identify all tertiary training organisations providing allied scientific and technical profession training Provide Careerforce training to the SI Allied Health Assistant workforce. Workforces targeted are Dietetics, Speech Language Therapy (dual) and Rehabilitation Identify a resource to create a procedure manual for in-house workplace training and supervision of staff	Complete the tertiary training organisation survey (Q1) (Resource dependent) A procedure manual for in-house workplace training and supervision of staff is created (Q4)	Career planning tools are available for all health career professionals (HWNZ Annual Plan 2011-12).

Strengthening Workforce Development

Key planning approaches	Actions to deliver	Measured by	Outcomes
Coordinate shared workforce planning and innovation regionally with key stakeholders.	Work with the SI RTH workstreams to: • promote cross regional education sessions/forums • promote post graduate training opportunities both regional and rural • coordinate peer support/ mentoring for post-graduate studies • maintain a presence at national and inter-regional forums to build existing knowledge basis to: – understand and influence workforce development opportunities in the SI – grow and repatriate our workforce.	Develop a SI workforce plan (Q4) Develop a peer supporting/ mentoring programme for post-graduate students (Q2)	Workforce relationships are strengthened across the health system (HWNZ Annual Plan 2011-12). SI health workforce have improved access to post graduate education and training.

Strengthening Relationships with Education and Training Providers and the NGO Sector

Key planning approaches	Actions to deliver	Measured by	Outcomes
Effective relationships are established with education providers, training providers and the NGO sector.	Work with SI RTH workstreams to: • Ensure representation on each work stream of appropriate education and training providers • Ensure NGO representation is included in work stream leadership • Provide ongoing communications to all education providers, training providers and NGO related to developments and activities of SI RTH workstreams	Allied Health tertiary training network and relationship building forum held (Q2) Mix and contribution of education and training providers on each work stream (Q4) Mix and contribution of NGO providers on each work stream (Q4) Feedback from education, training and NGO providers that they are fully informed regarding activities of SI RTH work streams (Q4)	Improved relationships and common understanding of the work force demands for the health sector into the future. Clarity of the requirements for health workforce integration between Ministry of Education, TEC and SI RTH across the SI.

Key Initiatives Regionally

Key planning approaches	Actions to deliver	Measured by	Outcomes
Outline of key initiatives in the areas of culture, change leadership, capability and capacity.	Work with SI RTH work streams and SI General Managers of Human Resources to: • Identify key strategies for change leadership and culture development across each work stream Work with SI RTH work streams to: • Identify capacity deficits and develop plans to remedy same aligned to DHB and Regional plans	A minimum of two key strategies are identified and plans established for change leadership and culture development across the SI RTH region (Q4) A minimum of two capacity deficits are identified and remedial plans established to Identify opportunities to deliver or connect education to professional capacity and capability requirements as part of the SI Alliance (Q4)	Alignment of SI RTH with Regional requirements for culture development, change leadership and capacity and capability is in place. Capacity and capability needs are becoming aligned between education and workforce development.

5.2.3 South Island Information Services Service Level Alliance

The South Island has established the South Island Information Services Service Level Alliance to implement the National Health Information Technology Plan. This plan aims to:

- improve quality
- increase efficiency, through shared information
- achieve better value for money.

The South Island has appointed an Information Systems Programme Director. The Information Systems Medical Director (0.5 full-time equivalent) will be in place 1 July 2012. These appointments support the development of a long-term capital investment plan that includes local, regional and national programmes of work for all DHBs to ensure delivery of Information Technology systems in the next three years.

CEO Sponsor: John Peters, CEO, Nelson Marlborough DHB
Clinical Lead: Dr Andrew Bowers, Medical Director of Information Technology, Southern DHB

Concerto Rollout

Implementation in every SI DHB, a unified approach to concerto. This will utilise a single regional instance hosted in Christchurch and will ensure regional governance of future direction. This will collectively support.

Single logins for all clinical systems in each DHB for clinicians, for example ease for clinicians when moving between DHB and hospitals.

A unified interface supporting regional repository of labs, radiology and medicine data, e-referrals, electronic ordering of tests and acknowledgement, e-sign off and patient document, such as discharges and clinic.

Key milestones/ timeline	New regional version by July 2012. CDHB Continues to implement modules as the modules become available NMDHB Currently own instance, June 2012 discussion on alignment WCDHB June 2012 regional implementation of base concerto and éclair SCDHB June 2012 - June 2013 finalising base implementation complete, as modules are implemented as they become available SDHB June 2012 SDHB will WCDHB, July – Dec 2012 Regional instance
Risks/issues/ constraints/ dependencies	Uncertainty of buy in from all DHBs in the SI region; this may result in a reallocation of the development costs for this programme for DHBs. Lack of alignment with SI processes therefore inability to transfer patient information between SI hospital and an incomplete SI repository.
Budget allocation by DHB	Committed CAPEX budget +5 years OPEX with a breakdown of contribution from each DHB in the region. If the programme is multi-year, provide the total budget broken down by financial year.
Benefits and enablers from implementation and measures	Financial: benefit includes shared development costs and single instance and reduction in duplication of hardware, and support. Workforce: direct improvement to workforce includes ease of movement of clinicians between other DHBs and hospitals; regional helpdesk requires consideration for future development. The benefit from this collaborative process is that DHBs learn from other DHBs implementation process. Clinical: improvements in business processes within a clinical context include; ease of access of patient information between DHBs/hospitals. Patient: direct benefits to patients include ease of access to all relevant patient information and reduction in duplication of tests, improved efficiency of decision making and ease of movement of patients within hospitals and DHBs.
Health priorities supported by implementation	Regional integration – Focused on accelerated collaboration between neighbouring DHBs to maximise clinical and financial resources and evidence of real gains from these endeavours. DHBs are expected to make significant progress in implementing regional service plans and delivering on regional workforce, IT and capital objectives. Efficiency and containing costs – Significant productivity gains are expected to be made across services and organisations.

e-Referrals

An electronic system requesting consultative service between clinical services.

Circumstances will include: GP to Hospital, inpatient to inpatient service (for non-urgent/non-acute conditions unrelated to the current admission), hospital-to-hospital within the same DHB and DHB hospital to another DHB hospital within the SI region. The first Information Services (IS) SLA focus in the GP to hospital setting for e-referrals. There are two stages within the e-referral process: (1) hospital processing the referral and (2) the management of referrals internally. While GP referrals include clinical pathways.

Key milestones/ timeline	A collective decision will be made in Feb 2012 once the e-Referrals workshop provides feedback to the SI IS SLA. Integration with concerto Nov 2011 due for completion within CDHB in Apr 2012 (eRMS). CDHB May 2012 NMDHB Nov/Dec 2012 move to a regional instance of concerto SCDHB June 2012 (fax capacity) and Dec 2012 concerto integration SDHB June 2012 (fax capacity) and Oct/Nov 2012. This is dependent on the concerto roll out at SDHB

e-Referrals	
Risks/issues/ constraints/ dependencies	Inability to achieve IS capacity and resources to support the expected milestones. Lack of DHB support for specific regional resource allocation. Uncertainty with outcomes in the current selection process which may adversely impact of the defined timeline. Uncertainty of future direction from NMDHB.
Budget allocation by DHB	Committed CAPEX budget +5 years OPEX with a breakdown of contribution from each DHB in the region. If the programme is multi-year, provide the total budget broken down by financial year.
Benefits and enablers from implementation and measures	Financial: savings in terms of efficiency with a reduction in duplication of referrals and therefore cost. Cost of the financial savings by leveraging from other DHB development of the programmes in the SI region, increased efficiency with development process such as utilising the incumbent solution. Workforce: direct improvement to workforce. Greater transparency of processing outpatient appointments, standardisation of processes and enhanced benchmarking of referrals times. Clinical: improvements in business processes within a clinical context, these include greater reliability of referral process, better feedback and acceptance of referrals, greater transparency of the approval process for referrals. Patient: direct benefits to patients include, reduction in lost or misplaced referrals, e-referrals provide GPs with better feedback and overall have greater efficiency in feedback such as appointment status.
Health priorities supported by implementation	Regional integration – Focused on accelerated collaboration between neighbouring DHBs to maximise clinical and financial resources and evidence of real gains from these endeavours. DHBs are expected to make significant progress in implementing regional service plans and delivering on regional workforce, IT and capital objectives. Efficiency and containing costs – Significant productivity gains are expected to be made across services and organisations.

e-Prescribing and e-Medicines Management	
A complete electronic record of a patient's medications, integration with allergies and intolerances. This will include e-prescribing, dispensing and administration for inpatients and outpatients in hospital setting as well as data for prescribing and dispensing in primary care. This workstream will support regional repositories for medication; this will be integrated into concerto interface with a single logon. It will support regional implementations of e-pharmacy and discharge summaries and the community prescribing process.	
Key milestones/ timeline	Facilitate SI regional funding discussion 7 March 2012 Establish a regional medicines management group Align MedChart regionally in terms of version and supported processes Integrate MedChart with New Zealand Universal List of Medicines (version 5.3) Develop regional protocols (e.g. common use antibiotics and common conditions) Develop a Statement of Intent on regional alignment by March 2012 Note: The Information Services SLA intends to support the national process regarding this priority when applicable Timeline: September 2012 Regional e-pharmacy to be available
Risks/issues/ constraints/ dependencies	Reliant on the outcome of the e-pharmacy Midland Development Programme. Expected date of completion is approximately Aug 2012. Assessment of suitability of MedChart as a single regional implementation option. Stakeholder engagement: CMO, GP and community pharmacies. Supporting the national direction and process for the completion of an e-prescription service. Reliant on a national prescribing and dispensing information repository.
Budget allocation by DHB	Committed CAPEX budget +5 years OPEX with a breakdown of contribution from each DHB in the region. If the programme is multi-year, provide the total budget broken down by financial year.

e-Prescribing and e-Medicines Management	
Benefits and enablers from implementation and measures	Financial: refer to the National Medicines Management Programme. Clinical: improvements in business processes within a clinical context such as safer medicines management programme, improvement of quality and safety of scripts, development of medicines safety group and more efficient use of clinician time. Patient: direct benefits to patients such as improved patient safety and reduction of harm.
Health priorities supported by implementation	Regional integration – Focused on accelerated collaboration between neighbouring DHBs to maximise clinical and financial resources and evidence of real gains from these endeavours. DHBs are expected to make significant progress in implementing regional service plans and delivering on regional workforce, IT and capital objectives. Efficiency and containing costs – Significant productivity gains are expected to be made across services and organisations.

Patient Administration System	
The SI IS SLA is developing a project plan to have a single instance of PAS in the SI. The rationale for the inclusion of this project in the 2012-13 SI IS SLA, is that some PAS in the SI region are at end of life. There is currently a lack of alignment of process in data entry and inability to share information between DHBs. The SI IS SLA is evaluating and making direct comparisons between iPM instances (SDHB and WCDHB), and Orion HIS with the intention of the eventual alignment to a single regional PAS.	
Key milestones/ timeline	CDHB September 2012 supporting regional IPS/ hardware planning February - June 2013 IPS October 2013 start implementation NMDHB September 2012 decision point on regional suitability October 2012 commence implementation of the planning study (IPS) April 2013 commencing local implementation WCDHB June 2012 regional evaluation subsequently alignment with Southern DHB SCDHB June 2012 regional evaluation September 2012 commence implementation plan SDHB currently alignment of district iPM version June 2012 regional evaluation then implementation in conjunction with West Coast DHB Timeline: at least six years
Risks/issues/ constraints/ dependencies	Uncertainty regarding NHB direction in terms of PAS development. Unavailability of staff to participate in workshops. Financial cost of alignment of district solutions as opposed to single implementation across to region, mitigated through the comprehensive decision making process.
Budget allocation by DHB	Committed CAPEX budget +5 years OPEX with a breakdown of contribution from each DHB in the region. If the programme is multi-year, provide the total budget broken down by financial year.
Benefits and enablers from implementation and measures	Financial: dollar savings through alignment of IS systems and processes. Clinical: improvements in ability to transfer patients from hospital services within a DHB (inpatient and outpatient).
Health priorities supported by implementation	Regional integration – Focused on accelerated collaboration between neighbouring DHBs to maximise clinical and financial resources and evidence of real gains from these endeavours. DHBs are expected to make significant progress in implementing regional service plans and delivering on regional workforce, IT and capital objectives. Efficiency and containing costs – Significant productivity gains are expected to be made across services and organisations.

Other South Island Alliance Activity	
Provation	SI implementation of endoscopy software underway; this is a collective process that is working well. This is a single implementation of a regional solution. Next step is to align CDHB and SDHB. Process to be completed for the two DHBs by June 2012. Other DHBs to join programme sequentially, proof of concept pilot is required by an alternative DHB (yet to be planned).
Titanium	The SI IS SLA is supporting the national project however this has separate instance and aligned processes.
Development of Regional Results Data Repositories	Results repositories.
Picture/EHGs archives	Privacy policy applied to in and webalogic™ (regional process option). This is unlikely to be in 2012-13. However, with the development of concerto the image will be available to clinicians.
Radiology Software	Alignment of SDHB and NMDHB; alignment of single instance of teleRAD. As of Nov 2010, three of five DHBs on single system (WCDHB, CDHB and SDHB).
Supportive requirements for other alliances	Southern Cancer Network: Mosaic/METRIQ/MDM Mental Health Older Persons Health (interRAI) Child Health

5.2.4 Capital Investment—Regional Asset Management Plan

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

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

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

To support this approach during 2011-12 the South Island has:

- Restructured the RCC, including:
    - membership, as all members of Alliance Leadership Team and the Alliance Board are now members of RCC to ensure alignment with DHB and South Island strategic approaches

    - review of the RCC Terms of Reference to reflect the South Island Alliance environment
- Established the South Island Asset Management Plan working group
    - completed asset stocktake for 2011-12
    - established linkages with South Island Information Services and Support Services Service Level Alliances
    - commenced demographic and capacity planning
- Established the Strategic Planning & Integration Team to support the links between clinical service and asset planning.

In addition, each South Island DHB has:

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

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

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

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

5.2.5 National Health Committee

Initial contact has been made with the National Health Committee (NHC) and agreement made to have further discussions on developing a working relationship. The South Island Alliance is committed to working with the NHC to ensure that any decisions on prioritising investment are aligned to national processes.

6 IMPROVING HEALTH SYSTEMS OUTCOMES

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

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

Each Service Level Alliance and regional activity work plan includes actions, measurable deliverables and outcomes unique to the service area. There are also outcomes that all of the Service Level Alliances and other regional activities aim to achieve, these being that:

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

Our work addresses three strategic goals for the South Island region to achieve through its regional work plan:

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

Each of the outcomes in the work plans has been mapped to one or more of these strategic goals (refer Appendix 2).

We continue to focus on our clinical priority areas identified in 2009, with work beginning in additional areas (e.g. stroke and ophthalmology). Alongside these, our focus has been on supporting our enabling services of work force, asset planning and support services.

6.1 Māori Health

The South Island Alliance recognises the need to address the disparities in the health of our Māori population. *Whakatataka-Māori Health Action Plan 2006-2011*, set out to achieve change within the DHBs. DHB activities are directed at improving Māori health rather than efforts being concentrated on ad hoc programmes and initiatives. It seeks to build on the strengths and assets within whanau and Māori communities.

There are four pathways for action:

- Te Ara Whakahaere: Pathway Ahead – Implementing Whakatataka
- Te Ara Tuatahi: Pathway 1 – Developing whanau, hapu, iwi and Māori communities
- Te Ara Tuarua: Pathway 2 – Increasing Māori participation throughout the health and disability sector
- Te Ara Tuatoru: Pathway 3 – Creating effective health and disability services
- Te Ara Tuawha: Pathway 4 – Working across sectors.

The pathways for action in Whakatataka 2006-2011 continue and are integral to the South Island DHBs. National priority measures include Health Targets and DHB Performance Measures shown in DHB Annual Plans that have either Māori measures or are of significance to Māori health. Regional priority measures include

indicators of importance at a regional level and have been determined by Te Herenga Hauora – South Island DHB Māori Health Managers.

Te Herenga Hauora is represented on our South Island Alliance Strategic Planning and Integration Team and the South Island Regional Training Hub. Our clinical Service Level Alliances include representatives who bring a Māori Health perspective to the teams.

6.2 South Island Neurosurgery Services

The South Island Neurosurgical Service has been established in line with the South Island Neurosurgery Expert Panel's Recommendations to the Director-General of Health, dated 5 November 2010, to provide one integrated neurosurgical service for the whole of the South Island, delivered from two sites—Christchurch Hospital and Dunedin Hospital.

The Expert Panel recommendations can be summarised into the following five broad workstreams with a sixth added after the February 2011 earthquake in Christchurch:

- Sound Governance arrangements for the service
- Sustainable services at the Dunedin node—renewal and rebuilding of the service
- Processes for managing the available South Island-wide capacity
- Robust succession planning and professional development of workforce
- Options for different funding models developed
- Sustainable services at the Christchurch node—impact of earthquake.

Responsibility for implementation rests with a clinician-led independent governance board, their goal being *"High quality neurosurgery services for the South Island".*

Areas of focus for 2012-13 are:

- Sound governance arrangements in place for the service
- Sustainable services at the Dunedin node—renewal and rebuilding of the service
- Sustainable services at the Christchurch node—impact of earthquake
- Processes for managing the available South Island-wide capacity
- Robust succession planning and professional development of workforce
- Options for different funding models developed.

The South Island DHBs support the implementation of the South Island Neurosurgical Service.

6.3 Health, Quality and Safety Commission

The South Island Alliance Leadership Team determined that the 2012-13 South Island Health Services Plan should have an increased emphasis on quality and safety from a regional perspective. Focus would be coordinated alongside the focus of the Health Quality & Safety Commission (HQSC).

The Strategic Planning and Integration Team is developing a longer term strategy for the South Island Alliance and this will take into consideration the relationship with HQSC, and the approach for linking of local and regional initiatives with the national HQSC work plans.

Clinical leadership is demonstrated in all South Island Alliance activities. Increasingly, our Service Level Alliances include consumers in the teams and working groups as they develop. Our regional workforce competencies and capabilities are supported through the South Island Regional Training Hub and our joint Human Resources approaches.

One of our key strategic goals is value for the patient and this must include the quality and safety of the services provided. These are reflected in the work plans and the quality activities can be seen in the Outcomes Matrix (refer Appendix 2).

The key initiative agreed for 2012-13 is the E-medicines Management. See the Information Services Service Level Alliance work plan for further detail.

6.4 Strategic Planning and Integration Team

Our Strategic Planning and Integration Team (SPaIT) facilitates an integrated approach linking the Service Level Alliances and workstreams to the South Island vision; identifies gaps; and recognises national, regional and district priorities. The Team will enable a strategic and integrated view that is broader than the current priority areas, and incorporates the South Island Health Services Plan development for optimal healthcare provision.

7 GOVERNMENT EXPECTATIONS

When planning investment and activity across the health system, DHBs must consider the role they play in the achievement of the vision and goals of Government - reflected in the annual expectations of the Minister of Health.

In setting expectations for 2012-13, Government has been clear that the public health system must deliver '*better, sooner, more convenient*' health care and lift health outcomes for patients with constrained funding increases. The Government has made commitments to New Zealanders to deliver even fast access to elective surgery, diagnostic tests, chemotherapy and youth drug and alcohol services, and expects DHBs to meet these commitments.

The Minister of Health continues to advocate for strengthened clinical leadership and engagement, and expects to see improvements in productivity, patient safety and the quality of services.

The Minister also expects DHBs to focus strongly on service integration, particularly with primary care, including the development of integrated family health centres, direct-referral access to diagnostics and clinical pathways involving community and hospital clinicians.

The Minister's priorities for DHBs in 2012-13 are:

- **Integrated care** – and the development of integrated services to drive delivery and improve performance in three priority areas: unplanned and urgent care, long-term conditions and wrap-around services for older people.

  DHBs are also to work across their local networks to implement the Government's commitments related to zero fee after hours GP visits for children under 6, shorter waits for child and youth drug and alcohol treatment and further integration of child and maternity services.

- **Shorter waiting times** – and improved access to services including: faster access to elective surgery, diagnostics tests, cancer treatments and child and youth drug and alcohol treatment.

- **Improving health services for older people** – focused on developing integrated services for older people that support their continued safe, independent living at home, particularly after hospital discharge. DHBs will also work to implement the Government commitments related to dedicated stroke units and dementia.

- **Regional integration** – focused on accelerated collaboration between neighbouring DHBs to maximise clinical and financial resources and evidence of real gains from these endeavours. DHBs are expected to make significant progress in implementing regional service plans and delivering on regional workforce, Information Technology and capital objectives.

- **Efficiency and containing costs** – including support for the work of HBL, Health Workforce New Zealand and the Health Quality and Safety Commission. Significant productivity gains are expected to be made across services and organisations.

- **Achievement of health targets** – including joint planning with primary and community networks to deliver smoking, cardiovascular disease and immunisation targets.

The national health targets measure progress against key national priorities with the anticipation that a unified collaborative focus will drive performance improvement across the sector. Progress against the health targets is monitored quarterly by the National Health Board.

While the health targets capture only a small part of what is necessary and important to our community's health, they do provide a focus for action and improved performance across the continuum, from prevention and early intervention services through to improved access to intensive assessment, treatment and support.

There is also clear alignment between regional and local priorities and the national health targets. In this sense, achievement of the national health targets is a reflection of how well the whole health system is working together to improve the health and wellbeing of our population.[7]

[7] Information regarding the Health Targets can be found on the Ministry's website www.health.govt.nz

8 APPENDICES

8.1 Appendix 1—South Island Alliance Charter

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

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

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

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

PURPOSES

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

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

PRINCIPLES

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

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

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

We acknowledge that there may be areas within the scope of the activities of this Alliance where a particular DHB may wish to either fully or partially be excluded from the Alliance activities. Each Board will have this option at the time of commencing however once agreed, the Board will be bound to operate within the scope and decision making criteria agreed. We understand the DHB intending to exercise this right will do so in good faith and will consult each other before exercising this right.

COMMITMENTS

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

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

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

MANDATE AND FUNCTIONS

South Island DHB Alliance Governance Board

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

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

South Island DHB Alliance Leadership Team

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

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

RELEASE OF LIABILITY

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

COMMITMENT TO SERVE

On the basis of the above, I agree to serve as a member of a leadership team for the South Island DHB Alliance.

Alliance Governance Board	Alliance Leadership Team
Signed: Jenny Black **Date** 14/9/11 **Jenny Black** Chair Nelson Marlborough District Health Board	**Signed:** **Date:** 14/09/11 **John Peters** Chief Executive Nelson Marlborough District Health Board
Signed: **Date:** 14/9/11 **Bruce Matheson** Chair Canterbury District Health Board	**Signed:** **Date:** 14/9/11 **David Meates** Chief Executive Canterbury & West Coast District Health Boards
Signed: **Date:** 14/9/11 **Paul McCormack** Chair West Coast District Health Board	
Signed: **Date:** 22/9/11 **Murray Cleverley** Chair South Canterbury District Health Board	**Signed:** **Date:** 14/9/11 **Chris Fleming** Chief Executive South Canterbury District Health Board
Signed: **Date:** 14/09/11 **Joe Butterfield** Chair Southern District Health Board	**Signed:** **Date:** 14/09/11 **Brian Rousseau** Chief Executive Southern District Health Board

8.2 Appendix 2—Outcomes Matrix

Strategic Goal 1—Equity of Patient Outcomes
To improve the health system to increase or modify access to address health disparities between population groups, ensuring the outcome for the patient is the same irrespective of their ethnicity, socio-economic status and where they live.

Strategic Goal 2—Value for the Patient
To improve the health service that patients receive through improving service quality and safety, taking a 'whole-of-systems' approach and better coordination and integration of care.

Strategic Goal 3—Productivity of Providers
To address workforce issues, improve service-to-service integration and systems, and increase value for dollar through more efficient and effective support systems.

		Strategic Goal		
Service Area	**Outcome**	**Equity of Patient Outcomes**	**Value for the Patient**	**Productivity of Provider**
Cancer	More people have improved access to services that maintain good health and independence.	■	■	
	More people have shorter waiting times for cancer treatment meaning people receive better health services.		■	■
	More people have improved access to prompt and early diagnosis meaning better outcomes and improved quality of health services.	■	■	■
	More people have timely access to cancer treatment resulting in better cancer outcomes.	■	■	
	More people have shorter waiting times for colonoscopy services meaning improved outcomes for people who are, or go on to be, diagnosed with bowel cancer.	■	■	
	Innovation and infrastructure planning and development are supported to reduce inequities, and, build regional capacity and capability.	■		■
	Regional system and service efficiencies, and quality improvement opportunities, identified and implemented resulting in meeting national health targets, economies of scale, increased consistency of practice and increased equity of access.	■	■	■
	Robust cancer data and information sources are developed, and shared, to enable informed service development, planning and decision making.			■
Cardiac	Patients with suspected ACS receive seamless coordinated care across the clinical pathway.		■	■
	More patients survive acute coronary events, cardiac damage from		■	

Service Area	Outcome	Strategic Goal: Equity of Patient Outcomes	Strategic Goal: Value for the Patient	Strategic Goal: Productivity of Provider
	these events is minimised, and the likelihood of subsequent cardiac events is reduced.		■	
	More people receive access to cardiac services which supports them to live longer, healthier and more independent lives.	■	■	
	Patients have appropriate and timely access to cardiac services.		■	■
Child Health	South Island DHBs have organised child and youth health services across the continuum of care through sharing of innovations.		■	■
	Health and inter-sectoral services are delivered in more accessible, acceptable and are culturally appropriate to vulnerable children, young people and their families/whanau.	■		■
	Children and young people receive more timely access to the right health and/or social services, at the right time.		■	
	Children and young people with a similar level of need receive comparable access to services, regardless of where they live in the South Island.	■	■	
	Children and young people receive seamless, coordinated care across the continuum of care.		■	■
	Future workforce is planned to support sustainable and organised health services for children and young people in the South Island.		■	■
	Better health outcomes for children and youth in adulthood years leading to a healthier population.	■	■	
	Whole-of-system approach to improve quality, access and sustainability of health services.		■	■
Mental Health	Consumers are enabled to access to services which are responsive to their needs and improve their well-being.	■	■	
	Districts are able to access expertise in the area of Intellectual Disability when required.			■
	Increase accountability to smaller communities.	■	■	
	Improve access rates of Pacific people or improve health outcomes.	■	■	
	Consistent plan for ethnic specific population.	■	■	
	Promotion of the most appropriate tools for the Mothers and Babies service.		■	■
	A responsive care pathway for the Mothers and Babies service.		■	■
	An integrated service journey for people with an eating disorder.		■	■
	Districts across the South Island are kept up-to-date on medical detox treatment options.			■

Service Area	Outcome	Strategic Goal: Equity of Patient Outcomes	Strategic Goal: Value for the Patient	Strategic Goal: Productivity of Provider
	Families are kept involved in the care of child and youth alcohol and other drug residential service users, addressing issues in a whole-of-system manner.		■	
	An integrated journey for children and youth through the mental health system.		■	■
	Align forensic services with the expectations of the new National Service Plan and revised Blueprint.		■	
Older Persons	More older people remain independent in their own homes with services tailored flexibly to their needs.	■	■	
	Improved consistency and effectiveness of restorative services across the South Island.		■	■
	Older people receive consistent and effective restorative care irrespective of where they live in the South Island.	■	■	
	All older people needing services receive a standardised comprehensive assessment of their needs which is clinically effective and guides packages of care.		■	
	Older people throughout the South Island have similar access to support services appropriate to their needs.	■		
	The dementia care workforce moves toward a more person-centred model of care as recognised by people with dementia and their families.		■	■
	The quality improvement feedback generated by the 'Walking' programme will be reviewed by South Island Dementia Initiative and result in annual improvements to local programme delivery.		■	■
	People are informed and enabled to consider and complete their own Advance Care Planning.		■	
Electives	Hospital systems are more productive.			■
	More people able to access elective services and receive better health services to regain good health and independence sooner.	■	■	
	Patient-centred approach and improved outcome a regional focus (e.g. timely access to service; equalized standardised intervention rates (SIRs) across the South Island).	■	■	■
Stroke	South Island DHBs have organised stroke services across the continuum of care through sharing of innovations.	■	■	■
	Stakeholders are engaged and participating in changes at local DHB level and when appropriate at regional South Island DHB level.		■	■
	More patients survive stroke events and the likelihood of subsequent events is reduced.	■	■	

Service Area	Outcome	Strategic Goal: Equity of Patient Outcomes	Strategic Goal: Value for the Patient	Strategic Goal: Productivity of Provider
	More people receive timely access to organised stoke services.	■	■	
	Reduced variability in the provision and delivery of stroke services in the South Island.	■	■	
	Future workforce is planned to support sustainable and organised stroke services in the South Island.	■	■	■
	Better health outcomes for people at risk of a stroke related event.		■	
	Whole-of-system approach to improve quality, access and sustainability of health services thereby increasing sharing and reducing duplication and fragmentation of services.		■	
Support Services	South Island clinicians are delivering best services at optimal financial efficiency.	■	■	■
	New initiatives are clinically-led.	■	■	■
Workforce and Regional Training Hub	Workforce relationships across the health system are strengthened (HWNZ Annual Plan 2011-12).			■
	South Island health workforce have improved access to post graduate education and training. There is improved alignment of workforce training against national service delivery needs and regional clinical service plans.			■
	South Island health workforce have improved access to innovative regional and rural post-graduate education and training.			■
	Health workforce training is able to support primary and community-based care service delivery (HWNZ Annual Plan 2011-12).			■
	Develop closer liaison with TEC is developed to achieve common understanding of priorities and projections of trainees required to meet workforce needs (HWNZ Annual Plan 2011-12).			■
	Career planning tools are available for all health career professionals (HWNZ Annual Plan 2011-12).		■	■
	Services are supported to be clinically and financially sustainable through the development of better and regionally aligned approaches to professional training and career planning (HWNZ Annual Plan 2011-12).	■	■	■
	Improved relationships and common understanding of the workforce demands for the health sector into the future.		■	■
	Clarity of the requirements for health workforce integration between the Ministry of Education, TEC and South Island Regional Training Hub across the South Island		■	■

		Strategic Goal		
Service Area	**Outcome**	**Equity of Patient Outcomes**	**Value for the Patient**	**Productivity of Provider**
	Alignment of the South Island Regional Training Hub with regional requirements for culture development, change leadership and capacity and capability is in place.			
	Capacity and capability needs are becoming aligned between education and workforce development.			

8.3 Appendix 3—Membership

8.3.1 Service Level Alliances and Workstreams

SLA	Name	Title	DHB
Cancer Services	Dr Steve Gibbons (Chair)	Hematologist, Clinical Services	CDHB
	Dr Shaun Costello	Clinical Co-director, Southern Cancer Network/Radiation Oncologist	SDHB
	Dr Dean Millar-Coote	GP	SDHB
	Glenis McAlpine	Clinical Nurse Manager	Marlborough PHO
	Theona Ireton	Kaitiaki	CDHB
	Marj Allan	Consumer	
	Sue Teague	Service Manager, Secondary Services	CDHB
	Nicki Kitson	CEO	Hospice Southland
	Danielle Smith	Cancer Support Coordinator	West Coast PHO
	Dr Frances Beswick	Anaesthetist, Clinical Secondary Services	SCDHB
	Konrad Richter	Surgical Services	SDHB
	Robert Mackway-Jones	GM, Funding and Finance	SDHB
	Liz Horn	Support Services Manager, Canterbury & West Coast	Cancer Society
	Trish Clark	Oncology Nurse Manager	SDHB
	Dr Rob Corbett	Paediatric Oncologist	CDHB
	Annie Bermingham	Facilitator and Network Manager	SCN
Child Health Services	Dr Nick Baker (Chair)	Community Paediatrician	NMDHB
	Sue Smart	Paedatric Charge Nurse, Nelson	NMDHB
	Jane Kinsey	PHO Manager, Community Physiotherapist	Nelson PHO
	Dr Nicola Austin	Neonatal Paediatrician	CDHB
	Dr Clare Doocey	Paediatrician	CDHB
	Anne Morgan	Service Manager	CDHB
	Donna McCann	Service Manager	SCDHB
	Dr Mick Goodwin	Paediatrician	SCDHB
	Michele Coghlan	Service Manager	WCDHB
	Pip Stewart	Group Manager, Women & Children's Health	SDHB
	Dr David Barker	Clinical Director, Women & Children's Health	SDHB
	Dr Barry Taylor	Professor of Paediatrics	U of Otago

SLA	Name	Title	DHB
	Dr Ian Shaw	Paediatrician	SDHB
	Jane Wilson	Nursing Director	SDHB
	Viv Patton	GP Paediatric Liaison	CDHB
	Wayne Turp	GM, Planning and Funding	WCDHB
	Rose Laloli	Facilitator and Project Manager	SIAPO
Health of Older People Services	Dr Jenny Keightley (Chair)	General Practitioner	CDHB
	Dr Matthew Croucher	Psychiatrist of Old Age	CDHB
	Michael Parker	Provider sector representative	SCDHB
	Carole Kerr	NASC Manager	NMDHB
	Margaret Hill	GM, Planning and Funding	SCDHB
	Stella Ward	Allied Health Services Lead	CDHB
	Jane Wilson	Nursing Lead	SDHB
	Ruby Aberhart	Older Person's Advocate	NMDHB
	Professor John Campbell	Geriatrician	SDHB
	Dr Jeff Kirwan	Clinical Director, Older Person's Home Support Services	CDHB
	Dr Jackie Broadbent	Geriatrician	CDHB
	Dr Rachel Eyre	Facilitator and Project Manager	SIAPO
Mental Health Services	Dr Sue Nightingale (Chair)	Chief of Psychiatry	CDHB
	Dr David Bathgate	Consultant Psychiatrist	SDHB
	Dr Alfred Dell'Ario	Consultant Psychiatrist	CDHB
	Jane Collins	Director of Nursing	SDHB
	Sally Feely	Nursing (Primary)	SCDHB
	Rose Henderson	Allied Health	CDHB
	Toni Gutschlag	Planning and Funding	CDHB
	Sal Faid	Consumer	
	Key Frost	Pacifica	Pacific Island Advisory & Cultural Trust
	Paul Wynands	Primary Care	Rural Canterbury PHO
	Glenn Dodson	NGO	Stepping Stone
	Robyn Byers	Service Director	NMDHB

SLA	Name	Title	DHB
	Martin Kane	Facilitator and Project Manager	SIAPO
Support Services	Jock Muir (Chair)	Director, Strategic Projects	CDHB
	Vivian Blake	Chief Operating Officer	SDHB
	George Downward	Medical Director, Patient Safety	CDHB
	Nick Lanigan	GM, Corporate Services	NMDHB
	Sam Powell	Director of Nursing	SCDHB
	Nigel Trainor	GM, Finance and Information Technology & Commercial	SCDHB
	Hecta Williams	GM, Community and Mental Health Services	WCDHB
	Nigel Wilkinson	CEO	HBL
	Alan Lloyd	Facilitator and Project Manager	SIAPO
Information Services	Dr Andrew Bowers (Chair)	Medical Director, Information Technology and Physician, Acute Internal Medicine	SDHB
	John Peters	CEO Sponsor	NMDHB
	Chris Dever	CIO	CDHB
	John Beveridge	Nurse Consultant	CDHB
	Lexie O'Shea	Deputy CEO and COO	SDHB
	Nigel Millar	Chief Medical Officer	CDHB
	Nigel Trainor	GM, Finance, Information Technology & Commercial	SDHB
	Russell Rarity	Clinical Director, Anaesthetics	SCDHB
	Stella Ward	Executive Director, Allied Health	CDHB
	Tom Morton	Clinical Director, Emergency Departments	NMDHB
	Sam Powell	Director of Nursing and Midwifery	SCDHB
	Carolyn Gullery	GM, Planning and Funding	CDHB
	Carey Virtue	Services Director	NMDHB
	Hayley McManus	Facilitator and Project Manager	SIAPO
Cardiac Services	Dr David Smyth (Chair)	Clinical Director	CDHB
	Dr Andrew Hamer	Consultant Cardiologist and National Cardiac Network Representative	NMDHB
	Lisa Smith	Cardiac Nurse Specialist	WCDHB
	Gary Barbara	Service Manager	CDHB
	Dr Bernard Kuepper	Consultant Cardiologist and Head of Department of Medicine	SCDHB

SLA	Name	Title	DHB
	Michael Williams	Cardiologist & Clinical Leader, Cardiology, Dunedin Hospital	SDHB
	Kara Ogilvy	Associate Nurse Manager for the Medical Ward, Southland Hospital	SDHB
	Dr Gary Nixon	General Practitioner	Dunstan Hospital
	Carolyn Gullery	GM, Planning and Funding	CDHB
	Alan Lloyd	Facilitator and Project Manager	SIAPO
Elective Services	Christine Nolan (Chair)	GM, Secondary Services	SCDHB
	Peter Bramley	Service Director, Medical Surgical Services	NMDHB
	Vivien Blake	COO	SDHB
	Carolyn Cooper	GM, Older Persons Orthopaedics and Rehabilitation	CDHB
	Margaret Bunker	Programme Coordinator	SIAPO
Stroke Services	Dr Wendy Busby (Co-Chair)	Geriatrician	SDHB
	Vivian Blake (Co-Chair)	COO	SDHB
	Mr David Tulloch	Chief Medical Officer	SDHB
	Julian Waller	Stroke Clinical Nurse Specialist	SCDHB
	Dr John Fink	Clinical Director, Neurology	CDHB
	Dr Stephen Withington	Physician	CDHB
	Jane Large	Portfolio Manager, Planning and Funding	NMDHB
	Dr Suzanne Busch	Geriatrician, General Physician	NMDHB
	Dr Carl Hanger	Stroke Rehabilitation Consultant & Geriatrician	CDHB
	Diane Brockbank	Clinical Nurse Manager	WCDHB
	Consumer (To be appointed)	Consumer	
	Allied Health To be appointed	Allied Health representative	
	Rose Laloli	Facilitator and Project Manager	SIAPO

8.3.2 Regional Training Hub

Name	Title	DHB
Robyn Henderson (Chair)	Director of Nursing	NMDHB
Samantha Burke	Director of Midwifery	CDHB
Lynda McCutcheon	Director of Allied Health, Scientific and Technical	SDHB
Carol Atmore	Chief Medical Officer	WCDHB
Cecilia Smith Hamel	Clinical Director of Mental Health	SCDHB
Harold Wereta	Director of Māori Health and Whanau Ora	NMDHB
Jan Barber	General Manager South Island Alliance Programme Office	SIAPO
To be appointed	Regional Programme Director Training	
Kathryn Goodyear	Facilitator	SIRTH

8.3.3 Strategic Planning and Integration Team

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