Southern District Health Board
Piki Te Ora

Southern Way

Southern Strategic Health Plan Piki te Ora

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Foreword

Our District Health Board is determined to make a difference by improving the health of our population and bring services closer to home for our large and rural district. The challenges we face are well known. Across New Zealand and in the south of the South Island we face increasing demand from our largely ageing population. We also have old buildings which need replacing and the challenge of managing all of this within our existing budget.

Many people across the District, including health professionals, health care providers, academics, local leaders and members of the community have contributed to building the Plan. We are immensely grateful to everyone who has taken an interest and to those who contributed in any way.

The Plan is intentionally high level as it sets the overall direction for publicly-funded health services. We also know we will not be able to do everything everyone would like us to do. Throughout we have been clear that some choices will have to be made. The six priorities that the community has now supported give us the direction, principles and framework to make those choices.

This plan is unique for the Southern district in that it is a whole-of-health-system plan, not one simply for hospitals or health boards. We are committed to playing our part in the Southern health system to implement the plan through the actions outlined under each priority. We know we can improve services if we work together and focus first and foremost, on what is best for individuals, and what will give the most improvement in health for our communities.

Southern district residents generally enjoy a good standard of health compared with the rest of New Zealand, but our recent Health Profile listed a number of health needs, particularly for Māori, Pacific Island and disadvantaged communities. Working on these in particular will reduce inequities and continue to improve health outcomes in the south.

Some people have commented that the success of the plan will be in the detail of implementing it. We do not underestimate the work that needs to begin now at individual locality and specialty level on these detailed plans. However, key to all of this is our continued engagement with our communities and our staff. We know that we can achieve the best for the people we serve if we pull together and understand what needs to be different in implementing the next steps.

This plan has been developed with and through the efforts of local people. We look forward to putting it into action with you.

Joe Butterfield
Chairman

Carole Heatly
Chief Executive Officer

Mihi

I te tīmatanga ko te kupu
Ko te atua ano taua kupu
Ko te atua anō te tīmatanga,
me te whakamutunga o ngā mea katoa
Kia whai korōria ki tōna ingoa.

In the beginning was the word
And God is that word
God is the beginning and the ending of all things.
Glorified to his name

Ko te hunga ko wehe kua mene ki te po, kua hui atu ki te pūtahitanga ki rehua, moe mai. Okioki mai, ko tātou o te ao kikokiko, o te ao hurihuri tēnā tātou.

To our loved ones who have gathered in the night, rest now. To the living in this, the physical world, the ever changing world, greetings.

E te rau i te tini e te tapu, ko te reo karanga ko te reo mihi, nau mai haere mai.

To our distinguished readers, this is the voice of welcome, calling out to you a greeting.

Executive Summary

Kā tangi te tītī
Kā tangi te kākā
Kā tangi hoki ko ahau
Tihei Mauri Ora

The mutton bird cries
The parrot cries
I also cry
Behold there is life!

Te Poari Hauora ki te riu o te tonga, te ariatanga o te manu whakahirahira nei te pouākai, e topa, e tiu ana te mahere, mo te tekau tau. Ki tēnei putanga o te tuhinga hauora nei, ka aro atu ki te hauora o te tangata mai Ōtākou ki Murihiku, ki ngā whakaritenga me ngā wawata a te minita hauora me Te Waipounamu ā rohe hauora, koinei te tirohanga me te tautoko ki te pai, ki te ora.

The Southern Strategic Health Plan provides the strategic direction, objectives and planned activities towards improving the health of the Otago and Southland population for the next ten years. Our priorities for this period are guided by the expectations of the Minister of Health and the South Island Regional Health Services Plan, and are aligned with community, patient and organisational needs.

Tēnei te kaupapa kōrero hei awhi i ngā moemoeā me ngā whāinga mō te pai, mō nāianei hei oranga mō te whānau, hapu, Iwi.

This Strategic Health Plan shares the collective vision of 'Better, Sooner, and More Convenient' health and support systems, in its aim to deliver high quality and accessible health care in supporting more people to stay well.

Nō reira tēnā koutou, tēnā koutou, tēnā tātou katoa.

Greetings, thrice greetings to you all

Treaty of Waitangi relationship

As an agent of the Crown, Southern DHB is committed to fulfilling its role as a Treaty of Waitangi partner. Central to the Treaty relationship and implementation of Treaty principles is a shared understanding that health is a 'taonga' (treasure).

Southern District Health Board (Southern DHB) acknowledges the input and guidance of iwi as critical to the on-going development, scope and delivery of services to Māori. Te Rūnanga o Ngāi Tahu is the Iwi authority and overall representative governing body of Ngāi Tahu Whānui being descendants of the Ngāi Tahu, Ngāti Mamoe and Waitaha tribes. Te Rūnanga o Ngāi Tahu is made up of 18 Rūnanga papatipu, seven of which are in the Southern District:

- Te Rūnanga o Awarua (Bluff)
- Waihōpai Rūnaka (Invercargill)
- Ōraka Aparima Rūnaka (Colac Bay)
- Hokonui Rūnanga (Gore)
- Te Rūnanga o Ōtākou (Dunedin)
- Kāti Huirapa Rūnaka ki Puketeraki (Karitane)
- Te Rūnanga o Moeraki (Moeraki).

Southern DHB recognises and respects the principles of the Treaty of Waitangi: partnership, participation and protection and is committed to working in partnership with Iwi and local Māori to reduce health inequalities and improve health outcomes for Māori.

In May 2011, a Principles of Relationship agreement between Southern DHB and Manawhenua (Te Hauroa o Murihiku me Araiteuru Rūnaka) was signed by each of the seven Rūnanga papatipu. Collectively they are known as Te Hauroa o Murihiku me Araiteuru, and together with the Southern DHB they have formalised a Treaty partnership to work together in good faith to safeguard and improve the health status of Māori living in the Southern district. Through this agreement, Iwi and Southern DHB Board make decisions together to ensure:

- Services are appropriate and effective for Māori
- Relevant priorities for Māori are identified and targeted
- Resources are allocated according to need
- Appropriate Māori representation on all Board committees and groups.

Te Hauroa o Murihiku me Araiteuru make up the Iwi Governance Committee (IGC) including board members that provide input into the Southern DHB strategic direction and operate at a governance level to ensure that Māori health issues are being addressed at all levels of the DHB.

WellSouth Primary Health Network have also formalised a relationship agreement with Ka Rūnaka to allow for better service integration, planning and support for Māori and their whānau. The closer alignment of health care services presents opportunities to deliver services more effectively, improve the continuum of care and improve outcomes for Māori across a range of areas.

Executive summary

Introduction

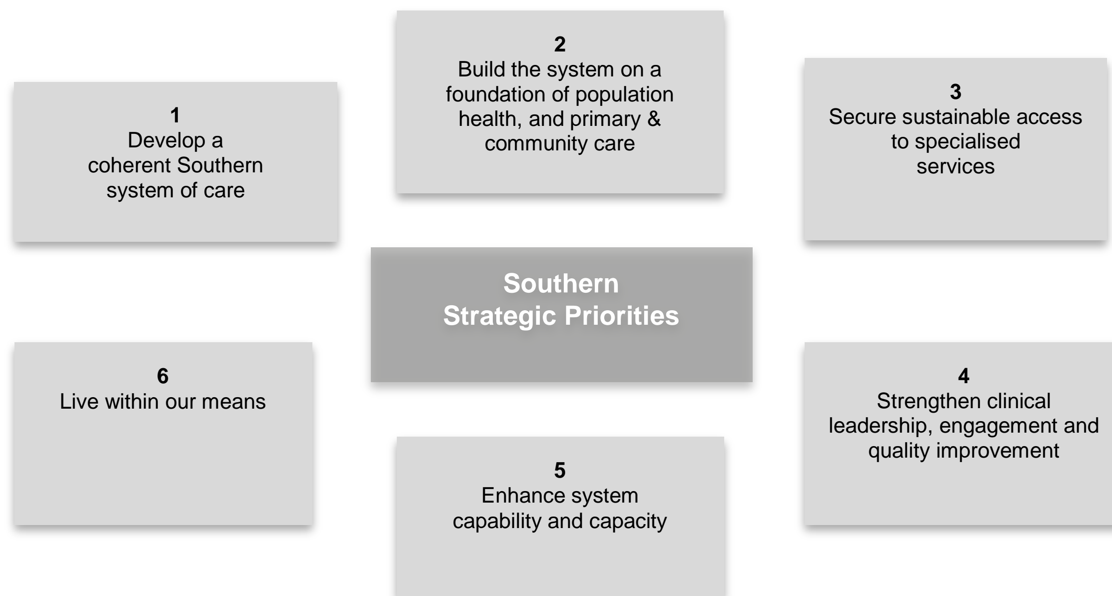
The Southern Strategic Health Plan (SSHP) describes how Southern DHB will develop an effective and efficient system of care over the next decade. The Plan will guide the Southern health system's efforts

to improve patient access and population health outcomes, and achieve clinical and financial sustainability.

Southern strategic priorities

The SSHP presents six priorities for the Southern health system, and includes:

- An Outcomes Framework (Table 9) with a ten-year goal for each priority, along with the headline actions, performance measures and enablers for the first three years; and
- An Implementation Roadmap (Figure 10) depicting the work program for SSHP implementation over the first three years.
- Examples of what the actions in the Plan would mean for patients in different circumstances. All of the examples describe imaginary patients in real situations. Some of the services described exist in the Southern district already, but are isolated examples. The Plan seeks much wider adoption in future.



PRIORITY 1: DEVELOP A COHERENT SOUTHERN SYSTEM OF CARE

Goal

Integrate services to ensure patient journeys are smooth through efficient and effective care pathways, and that the system is easy to use for everyone.

What does this mean for me?

Liz Brown has a big celebration for her 65th birthday, but the next day, she is surprised to see some spots of blood on her underwear. As this continues for several days, Liz contacts her local practice. At her appointment, the General Practitioner reviews the clinical pathway for postmenopausal bleeding, explaining the steps to Liz and answering her questions. The practice nurse takes a smear and arranges an urgent ultrasound scan while the GP fills in the electronic referral form with the required information. The gynaecology clinical leader reviews the referral later that day and judges Liz to be at higher risk so arranges an urgent outpatient appointment. Liz is alerted to expect a pipelle test during the appointment. When the results come through, the gynaecologist is able to phone Liz to reassure her there are no signs of cancer.

Dr Andre Smith, Clinical Leader Gynaecology

Headline actions

1. Define the intended future roles, capabilities, responsibilities and relationships of the core entities within the Southern health system
2. Align Alliance South's work programme with the SSHP's strategic priorities and Roadmap
3. Establish locality networks to improve planning and delivery of well co-ordinated local services
4. Strengthen the planning and delivery of local and district-wide acute and urgent care, and link effectively with South Island services
5. Recognise and develop the rural hospitals' contribution to the Southern health system
6. Within the South Island Alliance, define the regional direction, key principles and care models that will inform specialist service configuration, development and infrastructure.

Discussion

The geography and demography of Southern district requires distributed delivery of the majority of its health services, rather than centralised models of care. In addition, the Southern health system comprises services delivered by a wide array of public, private and non-governmental organization (NGO) entities. Together these factors indicate the need for a network approach that effectively links the various provider organisations, their services, and levels of care in a single unified system.

Role clarity

An important early contribution to increasing the coherence of the Southern heath system will be a clear description of its constituent parts, how they relate to each other, and how they are expected to evolve over the next three to five years. This includes key providers, services and sites/facilities (eg. primary and community services in rural and urban settings; the rural hospitals; and Dunedin and Southland hospitals). Alignment is essential between WellSouth Primary Health Network and the two 'arms' of Southern DHB (Provider and Planning & Funding), and with other South Island DHBs. 'Alliance' partnerships are the preferred mechanism for achieving this alignment.

Strengthening of the structures, tools and processes that will link the components will also be important. These include district and regional clinical networks; shared electronic patient health records; shared care plans; and defined clinical pathways.

Alliances

Use of 'alliance' partnerships has been mandated by government health policy. Alliance South[1] is in place as a partnership between Southern DHB, WellSouth and others, and is delivering its initial work programme. During implementation planning for this SSHP, the Alliance South work programme will be reviewed to ensure it includes the relevant headline actions from the three-year Roadmap.

Southern DHB is also working with the other four South Island DHBs through the South Island Alliance on areas of common interest in service and infrastructure development.

Acute and urgent care

A vital part of any health system is the provision of acute and urgent care, with effective management of trauma and seriously unwell patients at its core. Acute and urgent care encompasses people whose existing medical conditions deteriorate, or who present severely unwell from a new diagnosis. Experience elsewhere in New Zealand has shown the benefits of a structured district and regional approach to acute and urgent care.

The effective management of trauma is one important component of this, and the Emergency Care Coordination Team (ECCT) in each of New Zealand's five regions is tasked with ensuring this. Southern's existing team and its functions could be further supported with significant gains.

An acute care workstream will be developed through the Performance Excellence and Quality Improvement Strategy (see Priority 4) to co-ordinate acute patient flow and management across the district and between providers and services. Options for pursuing this work include expanding the co-ordinating functions of the ECCT beyond pure emergency care to all acute care, or developing a new acute care network.

Three specific acute service areas for focus will be:

- Whether a Medical Assessment & Planning Unit (MAPU) or similar should be developed at Dunedin Hospital to improve access to urgent care
- Whether a third 'hub' (in addition to Dunedin and Invercargill) should be established in the Dunstan/Queenstown area to address the health needs of the growing resident and tourist population, and its significant distances from Southern DHB's major hospitals in Dunedin and Invercargill. If developing a third hub is considered desirable, the impact on these two major hospitals must also be assessed
- Development of a planned approach to road and air transport of patients, particularly from rural areas to Dunedin and Southland hospitals.

Southern DHB has not been meeting the national Emergency Department (ED) wait time target, although its performance is improving. Analysis shows that a significant proportion of ED patients could be seen more appropriately in general practice. Alliance South has now prioritised reducing acute hospital demand, and action is underway to promote earlier intervention in primary care settings.

Locality networks

Networks will be established in each of Southern's eight health localities to plan and co-ordinate local services across the various provider entities, and to engage with community stakeholders. They will build on historic structures and existing clinical relationships. Locality networks will be of particular importance in rural areas, given the demographic and geographic characteristics of Southern.

[1] Alliance South is a partnership within the Southern District where as the South Island Alliance is a regional alliance of DHBs across the whole South island.

Rural health services

Community-based entities of various forms have operated Southern's rural hospitals in Balclutha, Dunstan, Gore, Oamaru and Ranfurly since the 1990s, while Southern DHB continues to operate Lakes Hospital in Queenstown. Southern DHB supports the rural hospitals' evolution to better integrate their services with local primary and community services, including through locality networks; and their desire for not only strengthened support from Southern DHB's Provider Arm (in areas such as telemedicine, visiting specialist clinics, patient pathways and professional leadership), but also more strategic direction and commitment from Planning & Funding.

What does this mean for me?

Andy Smailes worries about his son, Jack, whose diabetes control is all over the place. Andy is a plasterer who moved his family to Wanaka for work six months ago. He is starting to get regular contracts. Andy wants the best treatment for Jack, but taking a whole day off work to drive Jack to a brief appointment in Dunedin is stressful. The family's GP learns about new video-conference consultations for children with diabetes living some distance from Dunedin, and asks for an appointment for Jack. At the virtual clinic visit, the local specialist diabetes nurse sits in on the consultation with Jack and Andy to report on the latest monitoring results and make sure Jack and Andy have all their questions answered by the paediatric diabetes specialist, who is at the other end of the video link in Dunedin. Andy is relieved the whole trip, including the consultation, only takes a couple of hours. Jack isn't as impressed as he has to go back to school the same day!

Dr David Barker, Clinical Leader, Paediatrics

The opportunity exists to strengthen the role of the rural hospitals within the Southern delivery systems, through:

- Reviewing referral and transfer pathways, which will vary by rural hospital to reflect local clinical capability
- Recognition of the core rural hospital role of triage, assessment and stabilisation of acute patients, with either discharge, transfer, or a short treatment stay
- Exploring opportunities for enhanced care capability through collaborative planning and networked delivery across Dunstan and Lakes hospitals
- Locality networks that will foster integration with general practice and community services
- Supporting improved access to 24/7 diagnostics (imaging; point-of-care testing)
- Developing the rural health workforce
- Ensuring access to responsive specialist advice from a major hospital, including use of telemedicine.

PRIORITY 2: BUILD THE SOUTHERN HEALTH SYSTEM ON A FOUNDATION OF POPULATION HEALTH, AND PRIMARY & COMMUNITY CARE

Goal

Strengthen population health approaches, and the core role of general practice as the 'health care home' for patients within the primary & community team.

What does this mean for me?

Although he wouldn't admit it, George King had been frightened by his new diagnosis of type 2 diabetes, although his general practitioner had tried to reassure him, his normal confidence had taken a bit of a knock. So George was relieved when Gini, his Practice Nurse told him about a structured education day that would provide him with information and confidence to manage his type 2 diabetes. George and his wife Aroha attended the education day on his local marae and found it fantastically supportive. Their understanding of diabetes and their confidence really improved. On a recent visit to his general practice, George discussed his goals for weight loss, stopping smoking and increasing his exercise with his GP. George is in control of his own health journey! He left the appointment with support to stop smoking, an appointment for the community dietician at the practice next week and a referral to a community exercise programme specifically for people with diabetes. A few months later, George and Aroha want some extra support to manage his diabetes, so George phones the practice for an appointment with the Long Term Conditions specialist nurse, Anna. Anna and the GP agree some changes to George's medication with George and Aroha, and when Anna discovers George has decreased sensation in his right foot, she refers George to the funded community podiatrist for assessment. Throughout, George and Aroha have been cared for within their general practice where they feel comfortable and the staff know them well. Three months later, George has stopped smoking, lost 2 kgs in weight and has developed a supportive network of other people with diabetes who he met through the exercise programme.

Wendy Findlay, Nursing Director, WellSouth

Headline actions

1. Within the Alliance South framework, develop further service level alliance teams as the key structure for collaborative service planning and development of new models of care
2. Through Alliance South, agree the future primary & community model for urgent care and after-hours care; health of older people services; community mental health services; management of long term conditions; and management of patients with high and complex needs
3. Include prevention and early intervention within the scope of the primary & community teams, and foster their linkage with Southern DHB's health promotion programmes
4. Support intersectoral initiatives that address the determinants of health, such as in housing and the physical environment
5. Implement a risk stratification tool that identifies the patient cohorts at greatest risk, and design care models commensurate with risk
6. Southern DHB to develop a policy based on the Minister's expectations that the DHB will work with community and hospital clinicians to provide a wider range of services in community settings as appropriate and provide these services at no cost to patients
7. Identify and support demonstration sites of agreed models of primary & community care, and spread successful innovation.

Discussion

Through Alliance South, support will be provided for introduction of new models of care within primary & community services, and for an increased emphasis on population health and reduction in health inequalities across the whole system. Emphasis will be given to working with other agencies to address the determinants of health through initiatives in areas such as housing and the physical environment. At the patient and family level, priority for access to services will be determined on the basis of need, ability to benefit and improved opportunity for independence of those with a disability.

Planned and structured care

The Southern health system will continue to treat people with injuries and established disease. However, Southern will move progressively to shift the balance from a predominant focus on episodic care for individuals who present with health problems, to planned and structured care with a focus on the patients and families with high health needs. This approach will emphasise:

- Improved community health literacy to enable people to better manage their own health
- Culturally appropriate care, particularly for Māori and Pacific Island patients and families/whanau
- Prevention, early detection of health risks, and early intervention
- Integrated health and social services (eg, through whānau ora); and
- The core place in the health system of continuity of holistic primary care, centred on general practice.

Health risk profiling at practice level will provide an information base for better understanding the different levels of health need in the local community. This allows identification of cohorts of the population with different levels of risk, and tailoring of models of care and resource intensity to match health needs and workforce capacity. Shared care plans will be personalised to individual patients based on their health status, family support networks, and cultural preferences. For people and families with higher and more complex needs, the care model can be intensified to case management and broadened to include, for example, clinical pharmacy services, community mental health services, and social services.

Model of care change

Alliance South will lead model of care change in accordance with *Better Sooner More Convenient* policy. Particular areas of opportunity include:

- Locality planning and networks
- Multi-disciplinary teams, with core membership from general practice, community nursing and allied health (including clinical pharmacy)
- Nurse-led services
- Referral and discharge management (supported by clinical pathways)
- Improved access to specialist advice, including through the use of telemedicine
- Improving general practitioner (GP) access to investigations (eg, ultrasound, CT, MRI, exercise testing) based on agreed referral guidelines and criteria
- Minimising the need for specialist outpatient follow-up visits
- A planned approach to development of the GP with a Special Interest (GPSI) role
- Intersection of general practice with specialist and NGO services (eg, for mental health services; services for older people; Māori health services; Pacific Island services; St John)
- Drawing on proven primary & community initiatives from elsewhere in New Zealand to tailor local solutions.

Locality networks will be an important vehicle for clinically-led change through supporting development of more effective working relationships. In rural areas this could be fostered through co-location of community services personnel with general practice (based on the local hospital campus where one

exists). In urban areas the trend may be towards the development of ‘neighbourhood hubs’ to accommodate such personnel closer to general practice and to the patients they serve.

Use of demonstration sites, with evaluation and spread of successful solutions will be an important aspect of model of care redesign and health system reconfiguration.

PRIORITY 3: SECURE SUSTAINABLE ACCESS TO SPECIALISED SERVICES

Goal

Ensure that the Southern population has ongoing access to specialised services that have safe and viable staffing levels and activity volumes to treat complex conditions.

What does this mean for me?

Jim Black, who has smoked since his teens, is finally persuaded by his wife, Sarah, to see his GP as he has seen blood on his handkerchief after coughing. Jim's GP listens to his concerns, examines him and follows the relevant Health Pathway to arrange an urgent chest X ray and make an acute referral, including the flag, "high risk of cancer" to the Fast Track cancer service in Dunedin Hospital. Jim is phoned by the service and offered an appointment three days later at the "one stop shop". Jim and Sarah live three hours' drive from Dunedin, and although they are worried, they are glad they will get more information and a plan the same day. In Dunedin, Jim is medically assessed, has blood tests, breathing tests, CT scan and bronchoscopy. At the end of the day, Jim and Sarah meet the specialist to discuss the diagnosis based on the provisional results and next steps. Unfortunately, Jim is likely to need more treatment, so his case is discussed at the multi-disciplinary meeting the following week. There, a decision is made to refer him to Christchurch for more complex tests including endoscopic ultrasound and a PET scan. These are done within the next fortnight and Jim starts his cancer treatment In Dunedin.

Dr Colin Wong, Clinical Leader, Respiratory Medicine

Headline actions

1. Undertake analysis to inform planning of specialised services, including identification of services at risk of clinical and financial unsustainability; analysis of inter-district patient outflows; and updating of the Role Delineation Model assessment of Dunedin and Southland hospitals
2. Based on the analysis, identify whether action within Southern DHB or through South Island collaboration is the most appropriate avenue to pursue planning and development of particular specialised services
3. Continue South Island collaboration to refine governance, management and funding models that support provision of sustainable specialist services across DHB boundaries
4. Conduct a stocktake of visiting specialist outpatient clinics, and develop a planned approach by locality that supports equitable local access for patients to higher volume specialties, and that balances specialist and patient travel.

Discussion

A number of clinical specialty departments at Dunedin and Southland hospitals are struggling to maintain the activity volumes and staffing levels required for clinical viability. This includes both some core secondary services, and more complex and highly specialised services.

Specialist service sustainability is of increasing importance for Southern DHB for a number of reasons, including:

- The very low inflows of patients to Dunedin Hospital services from elsewhere in New Zealand means reliance on the Southern district's own population to support its specialist services

- Increasing sub-specialisation is challenging the critical mass of medical and surgical 'generalist' services, with a key consideration being the number of specialist practitioners needed to maintain a sustainable service
- The specialist workforce is increasingly attracted to work in larger centres, meaning Southern is facing recruitment challenges
- Funding constraints are placing pressure on hospital department budgets.

Overall, Dunedin Hospital's performance may be adversely affected by trying to maintain its own low volume specialties and high levels of clinical support services without sufficient population catchment to warrant adequate specialist staffing.

Assessment of the sustainability of specialist services will include clinical and financial criteria, such as:

- The catchment population required to generate sufficient volumes to warrant staffing levels that meet reasonable roster requirements and practitioner quality standards
- Cost per case compared with benchmarks
- Comparative access/intervention rates to match New Zealand norms.

South Island collaboration

There is increasing collaboration among the South Island DHBs in relation to low volume specialties, driven by recognition that the South Island population is too small for duplication of standalone services, and that regionalisation is likely to assist in ensuring ongoing access. A range of collaborative South Island specialised service models are currently in use, including 'hub & spoke' and distributed models.

Effective South Island collaborative service models must include service funding and governance arrangements that ensure a voice for Southern DHB, viable access for Southern patients, clear clinical pathways, effective interaction with other Southern specialist and clinical support services, and affordable cost structures. Southern DHB already acts as a South Island centre for some low volume specialty services, including radiofrequency ablation and bariatric surgery, and now offers the only specialist paediatric endocrinology service.

Consideration of specialised service configuration will also include engagement with the University of Otago and the Dunedin School of Medicine in acknowledgement of their interests.

PRIORITY 4: STRENGTHEN CLINICAL LEADERSHIP, ENGAGEMENT AND QUALITY IMPROVEMENT

Goal

Further develop a culture of clinically-led innovation, service planning and performance improvement across the Southern health system.

What does this mean for me?

Dr John Palmer, Clinical Director of the Acute Assessment Unit smiled to himself as he watched Violet Robb, aged 72, being ushered into a warm and pleasant assessment room, within four minutes of her arrival, she was greeted by name following instant electronic registration from her patient card. Dr Palmer knew from the information displayed on his screen that yesterday, a GP from Roxburgh had called when she presented to him while visiting her daughter. She had had increasing shortness of breath over several days, and until recently would probably have been sent down to the Emergency Department to be seen eventually by a medical registrar and probably admitted overnight. Instead, a tele-consultation with the duty physician in the unit had led to some initial treatment, transport planned on the regular shuttle this morning and the Rapid Outpatient Assessment process triggered. Following the chest X-ray that had been booked electronically, she was ready for assessment.

He knew that more than likely Violet would be home within the hour with a clear treatment plan, the right community supports already in place, and an automatic review already booked for her with her own doctor within 48 hours. Her GP would have the report of this visit and relevant results transmitted electronically within 20 minutes of Violet leaving the unit.

Since the Acute Assessment Workstream (a team of key medical, nursing, allied health and administrative staff) had completed their quality improvement programme, supported by the Directorate to implement the solutions proposed, this system was working really well for patients. It struck him that the staff at the coal face had taken absolute ownership of the processes and were constantly finding ways to make them better. They seemed to come to work with a real spring in their step and the constant grizzles of a few years ago were a fading memory. Dr Palmer was just as delighted with the most recent Patient Satisfaction scores. The charts on the walls in the staff area showed the team were meeting or exceeding all their performance targets, including meeting their budget and the team had treated more patients this winter than last.

Dr Mike Hunter, Clinical Leader, ICU

Headline actions

1. Clarify the intended nature and role of clinical leadership in the Southern health system, and ensure supportive structures and processes are in place
2. Ensure clinical leaders have the time, skills and tools to deliver on the performance expectations of their roles
3. Revisit the Performance Excellence & Quality Improvement Strategy to ensure its relevance and adoption as a whole-of-system approach, with an appropriate governance structure and implementation plan, and linkage with the work of Alliance South
4. Position the Performance Excellence & Quality Improvement Strategy as a key vehicle for ensuring financial sustainability, by explicitly linking quality improvement with value gain

5. Identify the initial areas in which Southern DHB will lift its performance to world-class levels, and develop action plans for each
6. Develop locality networks as a forum for building the effective clinical relationships that will support local service improvement and integration
7. Through Alliance South, ensure clinical pathway development and implementation is underpinned by robust clinician engagement.

Discussion

Clinical leadership and engagement

The Southern Way introduced increased clinical leadership and engagement inside the Southern DHB Provider Arm through creation of the unified directorate structure. Full implementation of this model is at a relatively early stage, and the leadership roles, structures and processes that will underpin future performance are still maturing. Action is needed to further develop clinical leadership capacity and capability.

Performance improvement

A key vehicle for lifting the performance of the Southern health system will be the Performance Excellence & Quality Improvement Strategy. A review of Strategy implementation will be undertaken to ensure a more strategic and consistent approach to performance improvement across the whole Southern health system. Particular considerations will include:

- Ensure understanding of the Strategy across the Southern health system, and prioritise implementation initiatives
- The implementation plan will include a focus on supporting short and medium term financial recovery planning and action, in recognition that 'good care costs less'
- Consideration will be given to establishment of a single Southern DHB decision support unit to ensure provision of timely data and analytical support for performance improvement
- Continuing emphasis on skills for change training for Southern DHB staff, and broadening of intake to include PHO and NGO personnel
- Effective linkage with national areas of focus led by the Health Quality and Safety Commission.

Increasing day case surgery

A specific performance improvement area already identified by Southern DHB through the Southern Way is the need for a sustained increase in the proportion of surgical procedures that are done on a day case basis. A joint National Health Board (NHB)/Southern DHB review was undertaken in 2013, and opportunities for improvement of the model of care and facility use were identified.

Professional relationships

Communication between the DHB's senior medical staff and general practitioners (GPs) will be strengthened. Opportunities for better structural and personal linkages will be pursued, including strengthening relationships and communication between primary, NGO and hospital-based clinicians, Continued Medical Education (CME) meetings, clinical pathway development, establishment of locality networks, and performance improvement initiatives. Alliance South and Southern DHB's Planning & Funding team will ensure service planning and clinical pathway development engage clinical leaders in taking a broader whole-of-system view across the continuum of primary and community, and hospital and specialist services.

PRIORITY 5: ENHANCE SYSTEM CAPABILITY AND CAPACITY

Goal

Develop a workforce mix and facility configuration that matches future health needs, and recognise Southern's core role in teaching and learning.

Headline actions

1. Mandate the existing Joint Education Committee (or equivalent) as the cross-organisational leadership body to collaboratively plan and develop the Southern health workforce based on intended models of care, workforce roles, and demand and supply forecasts
2. Develop a Southern health system workforce plan, beginning with a stocktake of the district's current health workers, and including clear priorities for workforce development based on the strategic direction presented in this SSHP
3. Expand Southern DHB professional leader roles to include a whole-system scope across primary care, NGOs and rural health services, with a focus on standards, credentialing, continuing professional development, and advice
4. Complete detailed district-wide facility capacity planning to inform business case development for an upgrade of prioritised Dunedin Hospital buildings.

Discussion

Workforce

Increasing service demand and an ageing workforce requires planned replacement and expansion of workforce capacity, including role substitution and new roles within new models of care.

The Southern district is a major health sector teaching and training hub, including three tertiary education providers offering nine health professional streams, together with management and business disciplines. While recognising their different focus and imperatives, the Education and Health sectors will collaborate to build strategic alignment and effective operational relationships to develop the workforce that the future Southern health system will need. Particular issues to be addressed in joint planning include:

- Alignment of University of Otago and Southern DHB strategic planning for the medical workforce, with emphasis on general practice and rural medicine
- Management of joint academic/service employment, with an appropriate balance of clinical performance, teaching and research, and clarity about mutual expectations and accountabilities
- Accommodating clinical placements, including the increasing need for community placements
- Movement toward inter-professional learning from year four of Medical School, which will require complex organisational and professional collaboration
- Development of new workforce roles, building on the current training of enrolled nurses and health care assistants
- Consideration of whether clinical placements should be centrally co-ordinated across disciplines to ensure direct linkage with Southern system priorities and capacity
- Consideration of whether training technologies should be shared across disciplines
- Continuing promotion of an increase in the proportion of medical and nursing graduates entering general practice
- Effective Southern linkage with the South Island Alliance Training Hub, including establishment of a South Island e-learning platform to deliver professional development programmes.

In addition to strategic alignment of education and training for health professionals, other issues to be considered in workforce development include:

- Promotion of multi-disciplinary teams, rural services, and primary & community services
- Assessment of the feasibility of inter-disciplinary training (nursing, allied health, medical) in rural areas
- Building on the existing Incubator Programme to promote health careers in secondary schools, with a particular emphasis on lifting Māori and Pacific participation
- Addressing barriers to training of the rural workforce
- Providing advice to individual health workers to support career progression
- Support for career pathways and skill sets that support new models of care, including primary and community practitioners working at the top of their scopes.

Facilities

Southern DHB has a modern hospital facility in Invercargill that was purpose-built in 2004 (although further development of an education facility is required). In December 2013, a staged redevelopment plan of Dunedin facilities was completed, to bring some critical areas in line with quality standards. There have also been some key infrastructure upgrades at both the Dunedin and Wakari Hospitals.

Recent national agency commitment to further capital investment in Dunedin Hospital has reinforced the need for a deliberate approach that ensures facility planning is strongly aligned with future demand forecasts, and with intended service configuration, and models of care.

Southern DHB has commenced a project that will develop a high-level facility master plan for the Dunedin Hospital campus. Planning for Dunedin Hospital will also look across the Southern district as a whole, and consider the impacts of:

- Forecast population changes, including ageing, and growth and shrinkage in particular localities
- Incidence and prevalence of long term conditions
- Model of care changes, such as hospital avoidance through strengthened primary care-based models; increased day surgical activity; and potential changes in rural hospital roles
- South Island planning of specialist service configuration.

PRIORITY 6: LIVE WITHIN OUR MEANS

Goal

Improve the quality of the care and services we deliver using quality improvement principles and methodologies so that waste is substantially reduced, value for money is improved and the savings contribute to bringing our revenue and expenditure into alignment, complemented where necessary, by tight cost management, improved productivity and different resource allocation patterns.

What does this mean for me?

Lucy Cooper is sitting at breakfast with her young family when she suddenly feels short of breath. She is usually fit, but has noticed her right leg has become uncomfortable over the last few days and seems a bit swollen. She calls her GP, who asks her to attend the practice that morning. After examining Lucy, her GP arranges an urgent referral to Southland Hospital for a specialised CT and ultrasound scans, as she suspects Lucy may have had a clot to the lung from a possible DVT. The scans show this is correct but as Lucy only has a low risk of further clots moving, she is started on tablets to thin the blood and allowed home. She is reviewed in virtual outpatients two weeks later. When she reports no more symptoms, Lucy is referred back to her GP for further follow-up and management.

Dr Colin Wong, Clinical Leader, Respiratory Medicine

Any hospital ward uses a lot of linen. The medical ward is no exception, so Charge Nurse Manager Jayne Anderson decided to use her ward as a "linen laboratory". Her ward team trialled new ways to use hospital linen and they were delighted to find that, starting from one bottom sheet and one pillow slip for every admission, beds could be made up according to each patient's needs, improving comfort for patients, making the job easier for staff and reducing waste.

The team also introduced blue polar fleece blankets to replace air cell blankets and quilts and gradually reduced the number of linen lines ordered from the laundry from approximately 105 to 40 to 50.

Replacing disposable face cloths with reusable colour-coded cloth ones also made a big saving in waste.

Margot Love, Associate Clinical Nurse Manager, Dunedin Hospital

Headline actions

1. Use the Performance Excellence & Quality Improvement Strategy as the framework for lifting performance to world-class levels in prioritised areas and to reduce waste
2. Strengthen analysis and communication of where Southern DHB funds are spent across the Southern health system, the outputs delivered, and the outcomes and value
3. Develop a Southern DHB prioritisation framework to inform resource allocation, including relevant policies, processes and tools (incorporating the Fourfold Aim)
4. Tighten Provider Arm cost management including moderating recent full-time equivalent (FTE) cost growth in key personnel areas
5. Increase use of benchmarking with other DHBs and providers as a basis for budget setting and productivity improvement
6. Develop a Strategic Investment Fund to support shift of resources to prioritised high value services.

Discussion

Southern DHB has a history of its costs exceeding revenue, of positioning the problem as lying with the funding model rather than organisational and system performance, and of not meeting agreed financial targets. There is now widespread acceptance within Southern DHB that this cycle needs to be broken.

In the absence of a strategic framework, Southern DHB resource allocation and activity levels have remained largely based on historic patterns, and lacking in strong rationale. Resourcing needs to be more transparent and reflect the priorities of the Southern health system. In addition, benchmarking with other DHBs and peer organisations has received less focus than it should in informing performance improvement activities.

Based on recent trends, Southern DHB is forecast to continue incurring financial deficits over the next several years. The goals of reducing this deficit, reallocating resources, and preparing for the costs of the Dunedin Hospital upgrade will challenge the whole Southern system to deliver improved performance.

Areas of focus

Strategies to improve medium to long term financial performance will include:

- Rigorously implementing the Performance Excellence & Quality Improvement Strategy's Fourfold Aim in assessing the value and appropriateness of Southern DHB funded services and interventions
- Considering the potential for reducing spending on interventions that are either clinically ineffective or not cost-effective, and redirecting resources to higher value services and interventions
- Improving the quality of DHB Provider Arm services using lean (A3) methodology, with the expectation that this will lead to better value for money (ie, less waste and improved efficiency)
- Focusing on those areas where Southern DHB expenditure is significantly higher than DHB benchmarks
- Improving performance against key efficiency indicators such as ambulatory sensitive hospitalisations, average length of stay, and day case surgery rates
- Scrutinising personnel cost growth in the Southern DHB Provider Arm, both in the numbers of staff and their relative cost, and understanding whether this represents value for money
- Developing clear strategies for capturing savings and redirecting them.

Strategic Investment Fund

When it can afford to do so, Southern DHB will create a Strategic Investment Fund to direct resources to prioritised services and models of care, with an emphasis on supporting cost-effective delivery in community settings in line with the SSHP. The Fund will also provide short-term transitional support where a change is being made to an existing model of care that enables it to be more productive in the future.

Enablers

Achievement of the Southern strategic priorities will be supported by enabling actions and infrastructure development in the following areas:

- Strengthening organisational relationships, both internally and externally
- Better planning of travel and transport
- Making better use of information
- Investing in information & communications technology
- Increasing health literacy in the community
- Improving communications.

Implementing the SSHP

Translation of the SSHP into action will have the following dimensions:

- The Southern DHB Board will oversee the executive's implementation of the SSHP, and support further development of the organisational alliances and other partnerships that will be fundamental to its success
- Collective accountability for SSHP implementation will sit with the Executive Leadership Team (ELT). Individual ELT members will be accountable for leading, planning and implementing each of the actions identified in the SSHP. Alliance South will also lead and be accountable for actions that are relevant to its focus on integration of primary & community care with specialist services
- The Chief Executive Officer will designate a single ELT member to be accountable for overall SSHP implementation and delivery. A programme manager will be appointed to co-ordinate and report on progress with SSHP implementation and achievement
- Detailed implementation plans will be developed for each of the headline actions
- Key performance indicators (KPIs) and targets will be used to monitor the impact of SSHP at a strategic level. The KPIs and targets will be confirmed during detailed implementation planning and inform Southern DHB's Annual Plan and Statement of Intent.

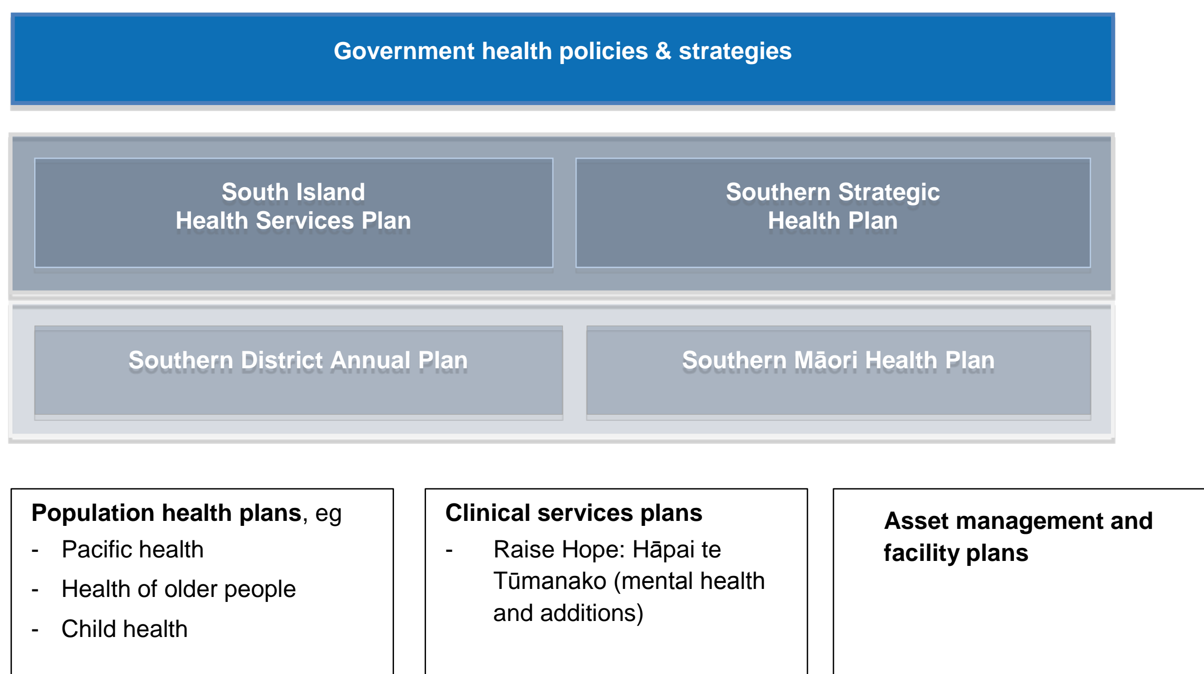
Areas for particular focus during implementation planning will include bolstering of decision support resources to ensure a strong analytical function to underpin further planning and action; support for the clinical leaders who will be actively engaged in driving service improvement through the Performance Excellence and Quality Improvement Strategy, and in developing and leading the initiatives outlined in the Implementation Roadmap; and continued evolution of Southern DHB's Planning & Funding role in supporting alliancing and the move to integrated care.

1. Introducing the SSHP

1.1 Purpose and focus

This Southern Strategic Heath Plan (SSHP) is the first long term plan for Southern DHB since its creation in 2010 through a merger of Otago and Southland DHBs. The SSHP will shape service configuration, models of care, resource allocation and capacity development for the Southern health system over the next decade. (See Figure 1 showing the place of the SSHP in Southern DHB planning.) The SSHP is intended to guide the Southern health system's efforts to improve patient access and population health outcomes; and achieve clinical and financial sustainability.

Figure 1: The place of the Southern Strategic Health Plan in Southern DHB planning



Population health plans, eg - Pacific health - Health of older people - Child health	**Clinical services plans** - Raise Hope: Hāpai te Tūmanako (mental health and additions)	**Asset management and facility plans**

In developing the SSHP, the primary objectives have been to ensure that the identified longer term direction for Southern health services:

- Is practical and achievable
- Reflects Government policies and contemporary best practice
- Has been developed with active engagement of Southern's clinicians and communities
- Considers community health needs and priorities in the context of current service configuration, and the cost and effectiveness of interventions
- Uses information in a systematic way to inform prioritisation of competing demands for resources.

Development of the SSHP is essential at this time because:

- Clinical and managerial leaders of the Southern health system are acutely aware of the absence of a strategic framework to guide their work
- Development of a long term plan is a key marker of organisational capability development
- Southern DHB now has an 'alliance' partnership (Alliance South) in place with Southern Primary Health Organisation (now called WellSouth Primary Health Network), rural hospitals, residential aged care providers, St John and others, that can plan and action 'whole of health system' initiatives

- The SSHP will provide a strategic context for detailed service and capacity planning (including workforce, facilities and technology), and short and longer term financial planning.

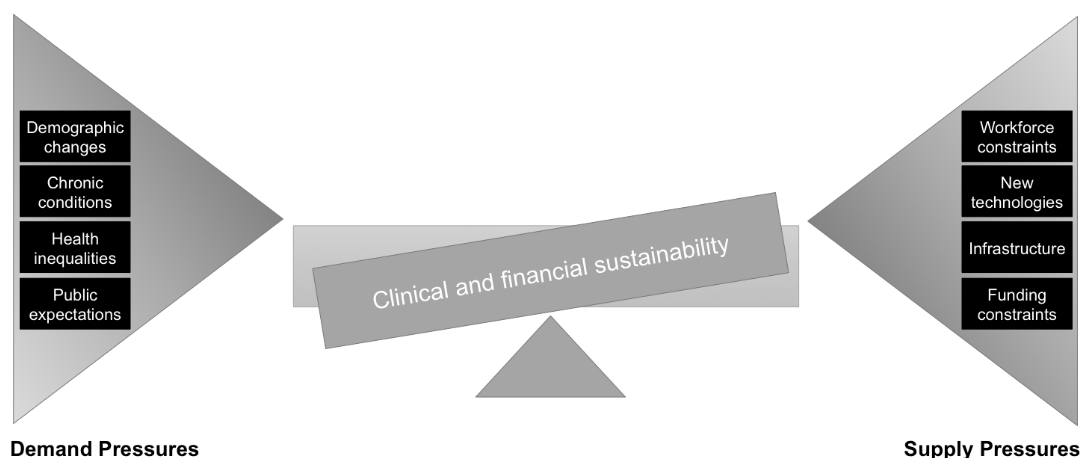
While the SSHP presents priorities and goals within a ten-year planning horizon, its focus is on the actions over the next three years (2014/15 to 2016/17) that will ensure the Southern health system takes the critical early steps that will lead it in the desired direction. The SSHP includes:

- An Outcomes Framework (Table 9) with a ten-year goal for each priority, along with the headline actions, performance measures and enablers for the first three years; and
- An Implementation Roadmap (Figure 10) depicting the work program for SSHP implementation over the first three years.

1.2 Sustainability

A goal of the SSHP is to ensure a sustainable health system – one that can provide ongoing access for Southern district's resident population (and visitors to our district) to safe, effective and efficient services. Sustainability also requires the capability to anticipate and respond to a changing operating environment, and to contribute to the wider wellbeing of our communities. As is the case in all developed nations, the Southern health system is operating in a testing environment, with intensifying demand and constrained supply. Together these pressures - illustrated in Figure 2 – are challenging the clinical and financial sustainability of health systems.

Figure 2: Demand and supply pressures on health systems



In addition to these general demand and supply pressures, the Southern health system also faces two particular challenges.

Geographic and demographic challenges

The Southern health system delivers services to a large geographic area (the largest of any DHB) that is sparsely populated. Rural and remote health services face particular sustainability challenges arising from:

- Small communities with ageing and often reducing populations
- The distances that people and health professionals must travel
- Limited transport and health service infrastructure
- Relatively high delivery costs, particularly for community services; and
- Difficulty in attracting and retaining a skilled workforce.

However, Southern's rural communities have advantages over many other such areas in New Zealand in that they generally do not have high levels of deprivation (although in some cases, disadvantaged communities are obscured in analysis by their better-off surrounding population); Central Otago and Lakes in fact have growing populations; a number have health services operated by highly motivated local communities; and the Southern district has a well-developed tertiary education sector with a strong focus on the health professions and rural health.

Financial challenges

Southern DHB has delivered financial deficits each year since its establishment in 2010, following a pattern established by its predecessor organisations (Otago and Southland DHBs). Southern DHB is the predominant funder of the Southern health system, so any deficit impacts on all publicly funded health services. While the annual deficit is relatively small as a percentage of the DHB's total revenue, it has proved persistent. Elimination of this deficit will be achieved through actions in the short-medium term that are congruent with the Southern health system's longer term direction presented in this SSHP.

Furthermore, Southern DHB will need to invest to:

- Meet the additional operating costs arising from the essential upgrade of some of Dunedin Hospital's facilities that will take place over the next five to ten years. A clear understanding of the intended future service configuration and associated capacity requirements, together with strong financial management disciplines, will ensure mitigation of the financial risks of capital investment for the organisation as well as avoiding the opportunity costs associated with less than optimum models of care
- Meet the costs of implementing the change initiatives outlined in this SSHP. This will be supported through establishment of a Strategic Investment Fund.

1.3 Recent changes impacting upon the Southern health system

Several major health system changes at local, regional and national levels have affected Southern DHB since 2010. These include:

- Creation of a number of new national entities to strengthen health system leadership and support for DHB performance improvement and innovation. These include the National Health Board (NHB), Health Workforce New Zealand (HWNZ), National Health IT Board (NHITB), the Capital Investment Committee (CIC), the Health Quality and Safety Commission (HQSC), and the National Health Committee (NHC)
- Stronger direction from government to deliver on policies, priorities and expectations, most notably in respect of the national Health Targets
- Expectation that each DHB will lead and champion service integration through whole of system planning involving primary and community services as well as regional and sub-regional services, rather than focusing predominantly on its own Provider Arm
- Requirement for strengthening of clinical engagement and leadership to improve service delivery
- Emphasis on regional and national DHB collaboration to gain efficiencies through shared 'backroom' services
- Requirement for collaborative DHB regional service planning, and an updated regional plan to be produced annually
- National planning and funding completed by the NHB for a small number of highly specialised, low volume services, such as paediatric sub-specialty services
- NHB-led intervention to determine the configuration of South Island neurosurgical services, and make recommendations about Wakatipu health services
- A joint NHB/Southern DHB assessment of systems at Dunedin Hospital

- National mandating of an alliance model for partnering between DHBs and Primary Health Organisation's (PHO)
- Planning for the rebuilding of Christchurch Hospital post-earthquake, with consequences for all other South Island DHBs
- A commitment from government to capital investment in Dunedin Hospital facilities.

1.4 SSHP development

Development of this SSHP has been overseen by a Steering Group comprising of leaders from Southern DHB, WellSouth, urban and rural general practice, Māori, rural hospitals and public health services. The process has engaged a range of Southern DHB, primary care, Māori, Pacific Island and NGO stakeholders, together with local government leaders, and the tertiary education sector. This input was extended to the wider community during consultation on the draft SSHP in late 2014. The planning process and Steering Group membership are described further in the Appendix.

2. Operating environment

2.1 Legislative context

Southern DHB is one of New Zealand's 20 DHBs. Each DHB is a Crown Entity, owned by the Crown for the purposes of Section Seven of the Crown Entities Act 2004, and is accountable to the Minister of Health. The New Zealand Public Health & Disability Act 2000 defines the role of the DHBs, and the organisation of publicly funded health and disability services. It establishes DHBs with specified geographically-defined populations, and sets out the duties and roles of key participants, including the Minister of Health, Ministerial committees, and health sector provider organisations.

The New Zealand Public Health and Disability Amendment Act 2010 outlines the planning framework and requirements for DHBs. Southern DHB has a statutory responsibility to prepare an Annual Plan with a Statement of Intent (SOI), and a regional service plan in collaboration with the four other South Island DHBs. In these plans Southern DHB must:

- Address local, regional, and national priorities/needs for health services
- Show how health services will be properly co-ordinated to meet those priorities/needs
- Demonstrate the optimum arrangement for the most effective and efficient delivery of health services.

Through the New Zealand Public Health and Disability Act, Southern DHB is responsible for:

- Planning the most effective and efficient health and disability services that will improve outcomes, in accord with national and regional priorities
- Taking a whole-of-system view across the service continuum
- Reducing health inequalities
- Working in partnership with stakeholders to determine the models of care and types of services that will lift performance and outcomes
- Investing in priority services, and disinvesting in lower priorities
- Funding services to be delivered by the DHB's Provider Arm, by NGOs, and by primary care providers through the PHO
- Achieving agreed performance levels as measured by national Health Targets and other indicators
- Managing within a finite budget
- Managing the Crown assets that it owns.

DHBs are guided by the New Zealand Health Strategy, Disability Strategy, and Māori Health Strategy (He Korowai Oranga). DHBs, including Southern, have planning and funding responsibilities for health of older people, which covers both personal health and disability support services for people aged over 65 years. The Ministry of Health has national planning and funding responsibility for disability support services for people under the age of 65 years, and hence these are beyond the scope of this SSHP. Southern DHB will, however, continue to support intra and cross sector collaboration in improving the overall health and wellbeing of people with disabilities.

The outcomes the national health sector seeks are for all New Zealanders to lead longer, healthier and more independent lives and for the health system to be cost effective and support a productive economy. DHBs are expected to contribute to meeting these health sector outcomes and government commitments by improving access to services and reducing waiting times; improving quality, patient safety and performance; and providing better value for money.

2.2 Government health policy

Better, Sooner, More Convenient[2] is the Government's over-arching policy for health services. It seeks services that put the patient first, provide seamless integrated care closer to the person's home, and are good value for money. The Minister of Health's *Letter of Expectations* to DHBs signals specific annual priorities for the health sector that link with *Better Sooner More Convenient*, and that are to be responded to in the DHB's Annual Plan and Statement of Intent (SOI). In setting expectations for 2014/15, the Minister emphasised that the public health system must continue to deliver better, sooner and more convenient health care and lift health outcomes for patients within constrained funding increases.

Specific priorities for 2014/15 presented in the Minister's *Letter of Expectations* are:

- Better public services – in particular, increased infant immunisation, reduced incidence of rheumatic fever, and reduced assaults on children
- Care closer to home
- Health of older people
- Regional and national collaboration
- Living within our means.

Continuing emphasis is also given to delivering on the six national Health Targets:

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

Government health policy is reflected in the Ministry of Health's Statement of Intent. The SOI for 2014-18 presents the strategic direction for the Ministry, work that will be undertaken to deliver key priorities, and how success will be measured. It identifies two outcomes for the health system and the Ministry: that New Zealanders live longer, healthier and more independent lives; and that the health system is cost-effective and supports a productive economy.

The improved wellbeing and health of New Zealanders will be achieved by the delivery of services that are accessible, safe, individual and family-centred, clinically effective and cost-effective. Among the Ministry's priorities is implementation of the Minister's objectives for the sector, which are to:

- Maintain wellness for longer by improving prevention
- Improve the quality and safety of health services
- Make services more accessible, including more care closer to home
- Implement Rising to the Challenge (the national Mental Health and Addiction Service Development Plan 2012–2017)
- Support the health of older people
- Make the best use of information technology (IT) and ensure the security of patients' records
- Strengthen the health and disability workforce
- Support regional and national collaboration.

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[2] *Better Sooner More Convenient: Health Discussion Paper* (New Zealand National Party (2007). A companion document *Better Sooner More Convenient Health Care in the Community* was published by the Ministry of Health in 2011 http://www.health.govt.nz/system/files/documents/publications/better-sooner-more-convenient-health-care_0.pdf

2.3 Regional planning and action - the South Island direction

Government policy is for increased regional and sub-regional collaboration and alignment between DHBs in the interests of improved integration and quality of care, and reduced service vulnerability and cost. While each DHB is individually responsible for its own population, working regionally enables them to better address their shared challenges and support improved patient care and more efficient use of resources. Effective regional governance, accountability and decision-making will set the direction for integrated models of care, which in turn will inform effective planning of information and communications technology (ICT), workforce, and capital investments to enable a sustainable health system.

The South Island Alliance was established in 2011 by Canterbury, Nelson Marlborough, South Canterbury, Southern and West Coast DHBs, which together fund and provide services for just over 1 million people (almost 24% of the total New Zealand population). The South Island Alliance formalises the partnership between the five DHBs, and was developed further in 2013 with a framework that ensures all regional activity aligns to agreed goals. The DHBs are committed through the South Island Alliance to make the best use of all available resources, strengthen clinical and financial sustainability, and increase access to services for the South Island population.

The shared vision of '*Best for People, Best for System*' envisages a sustainable South Island health and disability system focused on keeping people well and providing equitable and timely access to safe, effective, high quality services, delivered as close to people's homes as possible. Closely aligned to the national direction, the shared outcome goals of the South Island Alliance are:

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

The success of the South Island Alliance relies on improving patient flows and the co-ordination of health services across the South Island by aligning patient pathways, introducing more flexible workforce models, and improving patient information systems to better connect the services and clinical teams involved in a patient's care. Regional activity is implemented through service level alliances and workstreams based around priority service areas. The work is clinically led, with multi-disciplinary representation from community and primary care, hospital and specialist services, and consumers.

Service areas that have been prioritised for South Island focus[3] include:

- Cancer	- Child health
- Health of older people	- Mental health
- Cardiac surgery	- Elective surgery
- Neurosurgery	- Public health
- Major trauma	- Stroke.

In addition, a regional approach is being taken to planning and development of ICT, support services, quality and safety, facility planning and workforce planning, which will contribute to improved delivery across all service areas.

In developing their Alliance framework, the South Island DHBs have identified four collective outcomes (see Table 1) where individual DHB performance will contribute to regional success, together with a core set of associated long-term outcome indicators which will demonstrate whether the DHBs are making a positive change in the health of their populations. To achieve these outcomes, the DHBs have agreed a

[3] The South Island Health Services Plan is available from the South Island Alliance website: www.sialliance.health.nz.

number of strategies that will be delivered through regional initiatives and the collective activity of all five South Island DHBs. Each DHB sets three-year local targets for each indicator in their annual plans.

Table 1: South Island DHB outcome areas and indicators

OUTCOME 1: PEOPLE ARE HEALTHIER AND TAKE GREATER RESPONSIBILITY FOR THEIR OWN HEALTH
A reduction in smoking rates
A reduction in obesity rates
OUTCOME 2: PEOPLE STAY WELL IN THEIR OWN HOMES AND COMMUNITIES
A reduction in acute medical admission rates
OUTCOME 3: PEOPLE WITH COMPLEX ILLNESSES HAVE IMPROVED HEALTH OUTCOMES
A reduction in acute readmission rates
A reduction in all cause mortality rates
OUTCOME 4: PEOPLE EXPERIENCE OPTIMAL FUNCTIONAL INDEPENDENCE AND QUALITY OF LIFE
An increase in the proportion of the population over 75 living in their own homes

2.4 Reducing inequalities

As shown in the *Southern Health Profile*, Māori and Pacific people living in Southern experience significant health inequalities. Southern DHB is committed to reducing inequalities – including those experienced by Māori and Pacific peoples - through improving access to services, and directing resources to the populations and patients with the greatest health and support needs. Actions that will make a difference to Māori and Pacific health outcomes and reduction in inequalities will include:

- Use of the Health Equity Assessment Tool (HEAT), a planning tool that improves the ability of mainstream health policies, programmes and services to promote health equity. HEAT will be used during detailed planning for SSHP implementation
- Setting specific targets for improving health system performance for Māori and Pacific people in the SSHP's key performance indicators
- Defining the intended role of Māori health service providers within the Southern health system, and their relationship with mainstream providers
- Supporting Māori health providers to play an active role within locality networks, and build partnerships with mainstream providers
- Building the Southern health system's cultural competence, recognising that the majority of Māori and Pacific people receive most of their care from mainstream services
- Including measures that assess the effectiveness of services for Māori and Pacific people in review and implementation of the Performance Excellence and Quality Improvement Strategy
- Lifting the participation of Māori and Pacific people within the health workforce
- Continuing to ensure Māori leadership and engagement is reflected within all levels of decision-making
- Ensuring that whānau ora and promotion of healthy lifestyles is incorporated as a core component of the population health approach
- Collaboration of Southern DHB and WellSouth in developing annual plans for Māori Health and for Pacific Health, linked with the priorities presented in this SSHP.

3. The Southern people

The Southern district has a resident population of 306,430 (2013 Census estimated resident population) that is mainly European and slightly older than the national average. The average deprivation level is low compared with New Zealand as a whole, although there are pockets of relatively high deprivation.

Population growth for the Southern district from 2006 to 2013 at 4% was lower than the national average growth of 6.2%. Growth in Southern is expected to slow markedly out to 2031, with growth for the next 18 years forecast to be the same as that of the past seven years. The populations of Central and Queenstown localities[4] are expected to grow by 6400 and 6170 people respectively over the next 18 years. Although these numbers are small compared with the total Southern population, they represent local growth rates of 23% and 30%, reflecting potentially greater demand for health care services in the future. In contrast, the populations of Gore, Waitaki, Southland and Invercargill localities are projected to fall, suggesting reducing demand for health care in years to come.

Older people make up a growing proportion of the Southern population. Currently 14.7% of the population are aged 65 and over, and this is expected to rise to 23.8% by 2031. This ageing of the population is expected to bring increased demand for health services, and the need for new resource allocation patterns and models of care.

Life expectancy at birth for people living in Southern district was 81 years for 2010 to 2012, which is slightly lower than the New Zealand average of 81.2 years. Given the relatively low deprivation levels of the Southern population, a better result might be expected.

Population health priorities

An analysis of population risk factors, the chronic disease burden, and use of primary care and hospital services (published in early 2014 as the *Southern Health Profile*[5]) concluded that the most important areas for the health of Southern residents that Southern DHB and service providers should address include:

- Tobacco smoking
- Obesity and nutrition
- Hazardous alcohol consumption
- Chronic disease management – particularly diabetes and cardiovascular disease
- Access to and use of primary care – in-hours and after-hours
- Māori health - particularly child health and chronic disease
- Pacific health - particularly child health and chronic disease
- Access to mental health services – particularly through strengthening of community services.

[4] Eight localities are described in this Plan, and will be used as a core component of future health service planning and delivery. See discussion in Priority 1.

[5] *The Southern Health Profile* is available on the Southern DHB website: www.southerndhb.govt.nz. It presents a detailed analysis of the demography of the Southern district.

4. Current Southern DHB services and performance

Southern DHB has three main roles in the health system - those of planner and funder; service provider; and owner of Crown assets. This Section of the SSHP describes those roles and functions, and then briefly considers Southern DHB's current performance.

4.1 Southern DHB services

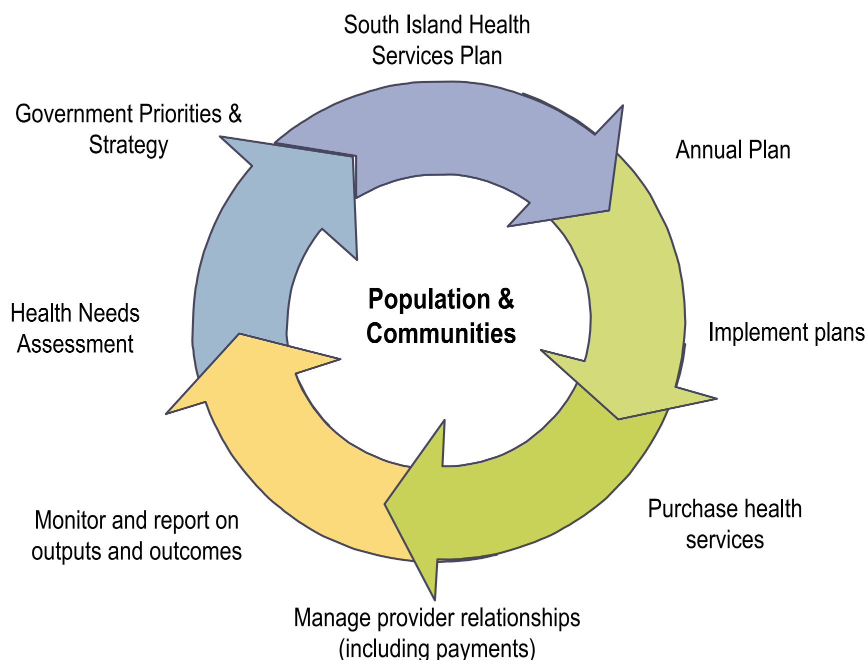
Planning and Funding

Southern DHB has a statutory responsibility to base its planning and resource allocation on the health needs of the local population, and to seek the most effective and efficient delivery of health services that improve health outcomes. In doing so, the DHB also needs to align with government and regional priorities.

Southern DHB planning and funding takes a whole of system view, encompassing the service continuum from primary prevention and early intervention, through to specialist diagnostic and treatment services, rehabilitation, and end of life care. This broad view is becoming more important in light of growing demand and constrained supply (as discussed in Section 1), and the quest for better integrated and more cost-effective services.

Southern DHB's planning and funding role includes setting of resource allocation priorities, that in turn determines funding for services and capital investment (ie, in facilities, equipment and information systems). Part of that role is also to identify services that no longer align with priorities in that they don't contribute strongly to desired outcomes, fit with preferred models of care, or provide good value for money. In such circumstances, the DHB would seek to disinvest in these services in order to reallocate resources to higher priority areas. Figure 3 illustrates the Southern DHB planning and funding cycle.

Figure 3: Southern DHB planning and funding cycle



Operating within the finite funding available is a fundamental accountability area for Southern DHB. Southern DHB's Planning & Funding team is responsible for the allocation and management of $831m in funding for 2014/15. Approximately half of this funding is spent on health and disability services delivered by the DHB's own Provider Arm (see below), with the other 50% being spent on services delivered by NGOs, primary care providers and other DHBs for the Southern population.

In its funder role, Southern DHB purchases a wide range of health and disability services, delivered in institutional, community and home-based settings. Primary and community (including domiciliary) services funded by Southern DHB include:

- General practice services, through WellSouth
- Allied health services (eg, occupational therapy, physiotherapy, dietetics, speech language therapy, child development services, social work, orthotics, pharmacy, vision & hearing)
- Nurse specialist services (eg, cardiac, diabetes, respiratory, breast care)
- District nursing services
- Public health services (including health protection, health promotion, and preventative health services)
- Oral health services for children and adolescents
- Well child services
- Māori health services
- Pacific health services
- Community mental health services
- Home-based support services
- Other community support services for older people.

Institutional based services funded by Southern DHB include age-related residential care (delivered by private and NGO providers), and rural hospital services in Balclutha, Dunstan, Gore, Oamaru and Ranfurly (NGO providers).

Provider

Through its Provider Arm, Southern DHB is a major provider of health and disability services, and is one of the largest employers in the Southern district with over 4,500 staff. Services delivered by the Provider Arm include some of the community and home-based services listed above, and hospital-based specialist services. The latter include:

- Acute services for conditions that have an abrupt onset. They are usually of short duration, progress rapidly, and require urgent care – often needing an inpatient admission
- Emergency services delivered through hospital emergency departments (EDs). The district's main EDs are at Dunedin Hospital and Southland Hospital (Invercargill), which have the specialised services available to provide definitive care for most patients who require admission. Lakes District Hospital also provides an ED service.
- Elective (planned) services are for patients who do not require immediate hospital treatment, but rather diagnostic or treatment procedures that can be scheduled in advance. Some are performed on a day case basis; others require one or more nights in hospital
- Non-admitted services (generally referred to as outpatient services) are generally non-urgent and do not require an overnight hospital stay. They include access to a wide range of specialties for provision of both treatment services, and patient assessment and advice to the referring GP.

Owner of Crown assets

Southern DHB is the owner of Crown assets and is accountable for managing them in a fiscally responsible manner. This includes planning and funding facility maintenance and future replacement. Southern DHB owns the following major facilities:

- **Dunedin Hospital**: A secondary/tertiary hospital facility with 371 resourced inpatient beds, located in central Dunedin and operated by Southern DHB's Provider Arm
- **Southland Hospital**: A secondary hospital with 157 resourced inpatient beds, located in Invercargill and operated by Southern DHB's Provider Arm
- **Lakes District Hospital**: A rural hospital located in Queenstown with 14 resourced inpatient beds and operated by Southern DHB's Provider Arm. (An aged care facility is also located on the Lakes campus, and operated by Bupa New Zealand.)
- **Wakari Hospital**: A satellite facility with 91 resourced beds including specialist inpatient mental health services and rehabilitation services. Wakari is located in the Dunedin hill suburbs and operated by Southern DHB's Provider Arm. Southern DHB's corporate offices are also located at Wakari.
- **Dunstan Hospital**: A rural hospital located in Clyde and operated by Central Otago Health Services Ltd.

4.2 Current performance of Southern DHB

In 2014 a review was undertaken of Southern DHB's performance against a number of service and financial measures, with the information from the review informing this SSHP's development.

Southern DHB (and its predecessor organisations) have recorded persistent operating deficits for a number of years. A number of areas were identified during the review in which Southern DHB's expenditure patterns appeared significantly different to those of other DHBs (discussed briefly in Priority 6 of this SSHP). The DHB is now taking action to ensure reduction of its deficit.

5. Shaping the Southern response

5.1 Facing the challenge

The previous sections of the SSHP have described the need for Southern DHB and the wider Southern health system to pursue new directions over the next ten years in order to achieve improved results for the patients and communities they serve.

Southern DHB is at a pivotal point in its development, with the opportunity to define a longer term direction for the Southern health system that ensures:

- Service configuration and capacity are appropriate to meet the forecast increase in demand arising from population ageing and the increasing incidence, prevalence and complexity of long term conditions, and the locally changing demands due to population shifts within the district
- Southern's dispersed rural communities have ongoing access to services that reflect their changing demographics
- Specialist services are clinically and financially sustainable
- Improved performance in key national health policy areas and related KPIs and targets
- Financial management disciplines that eliminate the DHB's persistent deficit, and allow investment in priority service and outcome areas, and in the enabling infrastructure that will underpin improved system performance
- Deferred capital investment is addressed, and in particular upgrading of prioritised Dunedin Hospital facilities.

The Southern health system's focus has been on short term cost reduction. Adoption of this SSHP allows a concurrent focus on longer term service performance improvement, and alignment of capacity and configuration with contemporary care models and forecast demand. In this environment, the challenge for Southern DHB and its partner organisations will become one of planning and implementing actions of sufficient scale, scope and ambition to deliver the required performance improvement, while balancing short, medium and long term imperatives.

5.2 Trends in service design

Whilst the challenges facing Southern DHB and the Southern health system have some unique dimensions reflecting the district's special characteristics and circumstances, in general they are similar to the pressures on health systems throughout New Zealand and other developed nations (as discussed in Section 1).

As health systems rethink their strategic direction to ensure sustainability, the trend is towards models of care that shift activity and resources away from hospitals to earlier intervention in lower cost community and home-based settings, and that take advantage of new communications, monitoring and treatment technologies.

The broad service design responses by developed countries' health systems are similar[6], and include:

- Investment in improving the population's health literacy and strengthening patient self-management, prevention, early intervention, and home-based services
- Consolidation of primary and community services into larger health centres and networks, with multi-disciplinary teams, and services integrated with local hospitals in rural areas

[6] The challenges facing health systems and their responses are summarised in *Trends in Service Design and New Models of Care: A Review*, Ministry of Health (2010). This document provides a summary of international responses to the pressures and challenges facing the New Zealand health sector, to help guide DHB service planning. It is available at http://www.nationalhealthboard.govt.nz/sites/all/files/trends-service-design-new-models-care-jul2010.pdf

- Clustering of hospitals to share resources and expertise, and networking of practitioners across sites
- Consolidation of sub-specialist services across networked sites to create critical mass, with outreach to ensure access for local populations.

Health systems internationally are also seeking to better integrate services – both ‘horizontally’ across primary and community services, and ‘vertically’ across primary and secondary (specialist) care. Integration is seen as improving the Triple Aim dimensions - patient access, experience and outcomes; population outcomes; and resource use. For Southern this is highly relevant, as the Southern Way includes the dimensions of the Triple Aim (with the addition of a fourth aim - promotion of high quality teaching and learning, research and scholarship)[7].

Rural health services

Sustainable and effective rural health services are a particular focus for the Southern health system, given its large geographic area and dispersed population. Organisations delivering health services to rural communities face greater challenges in their quest for sustainability arising from:

- Geographic distance
- Low population density and in many cases, population shrinkage, particularly in working age populations
- Limited infrastructure, including transport, telecommunications and facilities
- Difficulty in attracting and retaining a skilled clinical workforce.

In addition, rural health services tend to have higher community service delivery costs than those in urban areas because of such factors as lack of economies of scale and scope, direct travel costs and loss of productive time for staff, and the need for effective telecommunications and mobile services.

The policy response to the health needs of rural communities seeks to both strengthen locally available services, and support patient access to services in centralised locations.

The scope of services available locally in a rural community is determined largely by the volume of demand, and the available workforce, funding and infrastructure (facilities and technology in particular). Clinical safety is a key consideration. Experience internationally and in New Zealand shows that rural communities recognise the trade-offs that are necessary in determining service configuration. In general, they give priority to local availability of the comprehensive primary care services that they use most often, and are willing to travel to more specialised services that need a critical mass of demand and staffing, are capital intensive, and are used only very infrequently by local residents.

The trend – supported in New Zealand by government policy and increasingly evident in Southern district (for example in Balclutha) – is for integration of health services in rural communities to ensure a critical mass of health professionals, and ease of access for patients to safe and effective services. General practice is increasingly linked with provision of local hospital services, including emergency response and urgent care. Services are ‘bulking up’ into local micro-systems through co-location, shared care, and common governance, management and information. Collaborative support is being provided from a larger centre, and from peer organisations.

[7] The Triple Aim forms the basis for Southern’s Fourfold Aim – see Section 5.4.

5.3 The Southern Way

The Southern Way framework was developed by Southern DHB in 2012 to address immediate developmental priorities associated with:

- Fully implementing the Otago-Southland DHB merger through building effective clinical-managerial partnerships through Southern DHB's Provider Arm directorate structure
- Establishing the Southern DHB/Southern PHO alliance ('Alliance South').

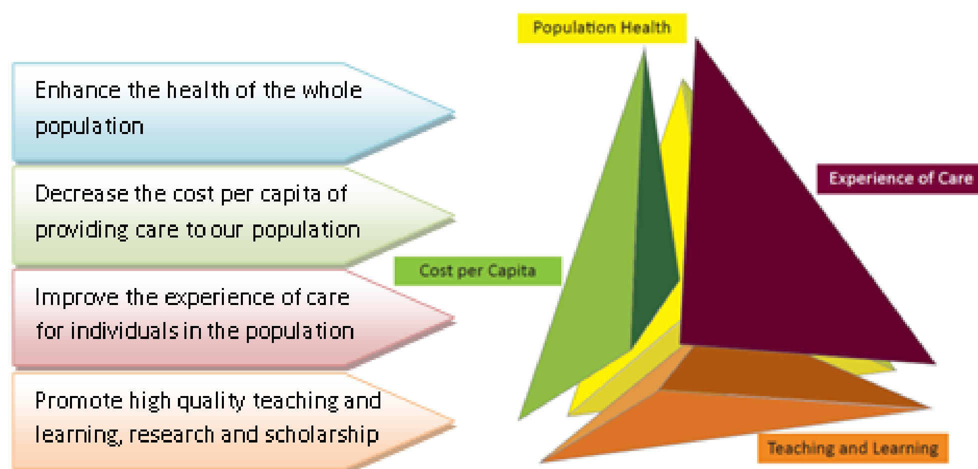
The Southern Way Framework

VISION
Better health, better lives, Whānau Ora
MISSION
We work in partnership with people and communities to achieve their optimum health and wellbeing. We seek excellence through a culture of learning, inquiry, service and caring
SOUTHERN WAY
The community and patients are at the centre of everything we do We are a single unified DHB which values and supports its staff We are a high performing organisation with a focus on quality We provide clinically and financially sustainable services to the community we serve We work closely with all primary care to provide the right care in the right place at the right time and to improve the health of the community

5.4 Performance Excellence and Quality Improvement Strategy

In the context of the Southern Way, in 2012 Southern DHB adopted a Performance Excellence and Quality Improvement Strategy[8] as a framework for lifting organisational performance to world class levels. The Strategy is driven by a Fourfold Aim[9] that guides service planning and delivery (Figure 4).

Figure 4: Southern DHB Fourfold Aim



[8] Available at http://www.southerndhb.govt.nz/files/20130320105142-1363729902-0.pdf

[9] Southern DHB's Fourfold Aim has four goals, based on the Triple Aim of the Institute for Healthcare Improvement (IHI), together with an additional goal recognising the key role of teaching and learning in Dunedin Hospital and across Southern district generally.

The Fourfold Aim defines the performance improvement outcomes Southern DHB is working towards. These four aims are underpinned by:

- Quality improvement activities, which are to be guided by the six dimensions of quality[10]: safety, effectiveness, patient centredness, timeliness, efficiency, and equity
- A performance excellence system, based on the Baldridge criteria for excellence: leadership, strategic planning, customer focus, measurement, analysis and knowledge management, workforce focus, operations focus and results; and
- Methodologies for quality improvement, such as 'lean', project and programme management, performance measurement, and the production of a Quality Account[11].

Southern DHB also participates in a number of sector benchmarking exercises (such as the New Zealand chapter of the Health Roundtable) to understand performance in the context of other DHBs and the wider health sector, and to inform performance improvement initiatives.

5.5 Improving Māori health

Māori make up 9.1% of the Southern population (approximately 27,000 Māori people). The Māori population is youthful, with 75% being below 45 years, and only 5% being over 65 years of age. As shown in the *Southern Health Profile*, Māori experience significantly worse health outcomes than non-Māori.

In addition to recognition of the Treaty of Waitangi through the Iwi Governance Committee, Southern DHB also enacts a Treaty-based relationship at an operational level by establishment of a Management Advisory Group – Māori Health to provide appropriate advice to the Chief Executive Officer and Iwi Governance Committee on Māori health matters. This is inclusive of maatawaka and contributes to the development and implementation of action plans to improve Māori health.

Southern DHB produces an annual Māori Health Plan that underpins the DHB's efforts to improve Māori health and reduce the disparities between Māori and non-Māori. In 2014, the first joint Southern Māori Health Plan was developed in partnership between Southern DHB and Southern PHO[12] with both Iwi and local Māori input, to address health issues in order to achieve indicator targets set nationally, regionally and locally.

Success in improving Māori health outcomes relies on improving health pathways and the coordination of health services across primary and secondary care. Māori health providers within the Southern district contribute to local and regional success, and together the DHB and primary health care services will continue to agree on key strategies and initiatives that will contribute to improved health care for Māori. In addition, specific projects and initiatives have been pursued to reduce inequalities, including:

- Developing Māori provider capacity and capability
- Developing Te Kākano nurse-led clinics on marae, targeting lower socio-economic areas across the Southern district
- Establishing a voucher system for those unable to afford general practice and pharmacy costs
- Establishing a very low cost access (VLCA) general practice in Invercargill
- Establishing a high need adult dental programme
- Action to reduce the impact of respiratory disease (asthma in particular), and to improve early detection of diabetes

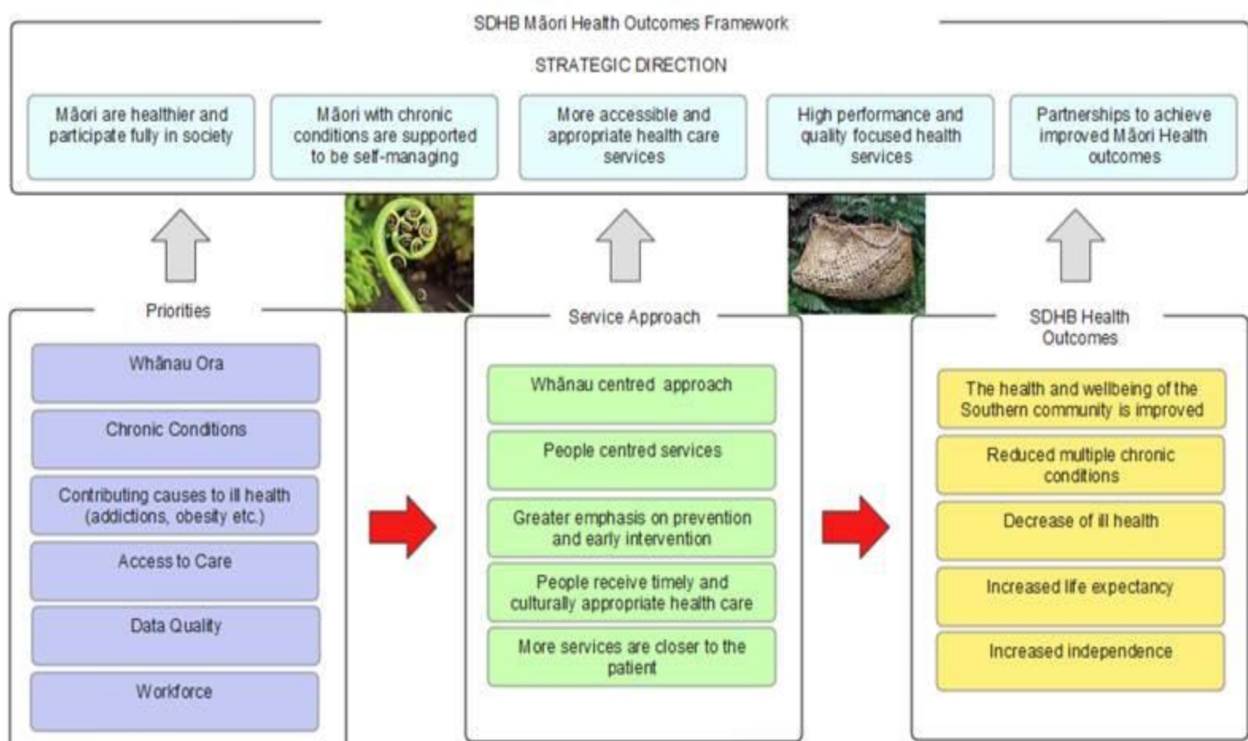
[10] The Six Dimensions of Quality have been adapted from the Institute of Medicine report *Crossing the Quality Chasm* (2001).
[11] Quality accounts require health care providers to give an account for the quality of their services in a similar way to financial accounts. DHBs have been required to prepare an annual quality account since 2012/13. Southern DHB's accounts for 2013/14 are available at http://www.southerndhb.govt.nz/files/15103_2014121083204-1418153524.pdf.
[12] Southern Primary Health Care Organisation (Southern PHO) underwent a name change in 2014 to WellSouth Primary Health Network.

- Improving the accuracy of ethnicity data collection within both secondary and primary care databases.

The profile of Māori health within the Southern health system has increased to a position where it is now represented at all levels of Southern DHB and across the Well South network, including a strong focus through Alliance South. Leaders in health care are better informed on Māori health issues through the establishment of Southern DHB's Māori Health Directorate, Māori advisory groups and Māori representation in many health areas and services.

The Southern DHB Māori Health Outcomes Framework (Figure 5) underpins the strategic direction for Māori health within the Southern district. In order to achieve the desired outcomes, the focus is now shifting to ensure every primary and secondary health service plays its part in improving health outcomes for Māori.

Figure 5: The Southern DHB Māori Health Outcomes Framework



6. The Southern strategic direction

The future direction of the Southern health system builds on its underpinning strengths (Table 2). It has two key dimensions:

- Longer term planning to define a clear, system-wide direction, and a framework for action to pursue the strategic priorities, supported by a well-managed implementation work programme
- A focus on performance improvement, with the aim of lifting the Southern health system to world class levels.

Drawing together these two strands will ensure a sustained focus on:

- Quality improvement
- Reprioritising low value spending
- Horizontal (primary and community) and vertical (primary, community and specialist) integration of services
- Delivery of the right care, at the right time, in the right setting
- 'Upstream' prevention and early intervention
- Service co-ordination for high needs patients and their families
- Facility and service networking, to provide better support for rural hospitals, and smoother patient journeys to and from the major hospitals
- Modernising of models of care to cater for the prioritised future health needs of the catchment populations
- 'Right-sizing' of workforce and facility capacity and capability, within a high performance environment.

Some changes in service configuration and capacity will occur over the ten-year horizon of this SSHP. These will emerge largely as by-products of improved system performance, complemented by deliberate model of care redesign. Two specific aspects of focused service and facility planning will be:

- The upgrading of key buildings on the Dunedin Hospital campus
- Consideration of the future configuration of hospital services across the Central and Queenstown localities.

Table 2: Underpinning strengths of the Southern health system

• Partnerships are in place with Iwi Māori, WellSouth, and the South Island DHBs • The Performance Excellence and Quality Improvement Strategy provides a platform for stronger clinical and financial performance • The Southern Way has introduced a clinical directorate structure across the Southern DHB Provider Arm • Southern communities are very aware of their health services, and supportive of local health care institutions • The presence in Southern district of a strong tertiary education sector supports access to a highly skilled clinical, technical and managerial workforce, and research capacity • Southland Hospital is a modern and effective facility • The rural hospital network is stable, and is increasingly linking with local primary and community services • Southern district's overall population is growing at a modest rate, meaning a small but positive future health service funding path

This SSHP presents six strategic priorities for the Southern health system. These are:

1. Develop a coherent Southern system of care
2. Build the system on a foundation of population health, and primary & community care
3. Secure sustainable access to specialised services
4. Strengthen clinical leadership, engagement and quality improvement
5. Enhance system capability and capacity
6. Live within our means.

These strategic priorities are described below. For each, a ten-year outcome goal is presented, along with 'headline'[13] actions over the next three years (2014/15 to 2016/17) that will build momentum in the Southern health system towards that goal. Together the priorities, goals, headline actions, performance measures and enablers comprise the Southern Health Outcomes Framework (Table 9). An Implementation Roadmap for the SSHP is presented in Figure 10.

The SSHP focuses on the actions Southern DHB and its partner organisations will work together to deliver over the next three years. While the SSHP provides examples of particular services and localities, it does not prescribe solutions for specific issues in particular services, facilities or communities. Those will be the focus of more detailed district-wide and locality operational and capacity planning that will flow from this SSHP. Similarly the goals, headline actions and indicators are intended to focus efforts, rather than capture all achievements and associated activity undertaken in each priority area.

Figure 6: The six Southern strategic priorities

[13] The term 'headline' is used to indicate that these are key strategic actions, that will be amplified as a project plan is developed for each.

Priority 1: Develop a coherent Southern system of care

Goal

Integrate services to ensure patient journeys are smooth through efficient and effective care pathways, and that the system is easy to use for everyone.

Headline actions

1. Define the intended future roles, capabilities, responsibilities and relationships of the core entities within the Southern health system
2. Align Alliance South's work programme with the SSHP's strategic priorities and Roadmap
3. Establish locality networks to improve planning and delivery of well-co-ordinated local services
4. Strengthen the planning and delivery of local and district-wide acute and urgent care, and link effectively with South Island services
5. Recognise and develop the rural hospitals' contribution to the Southern health system
6. Within the South Island Alliance, define the regional direction, key principles and care models that will inform specialist service configuration, development and infrastructure.

Discussion

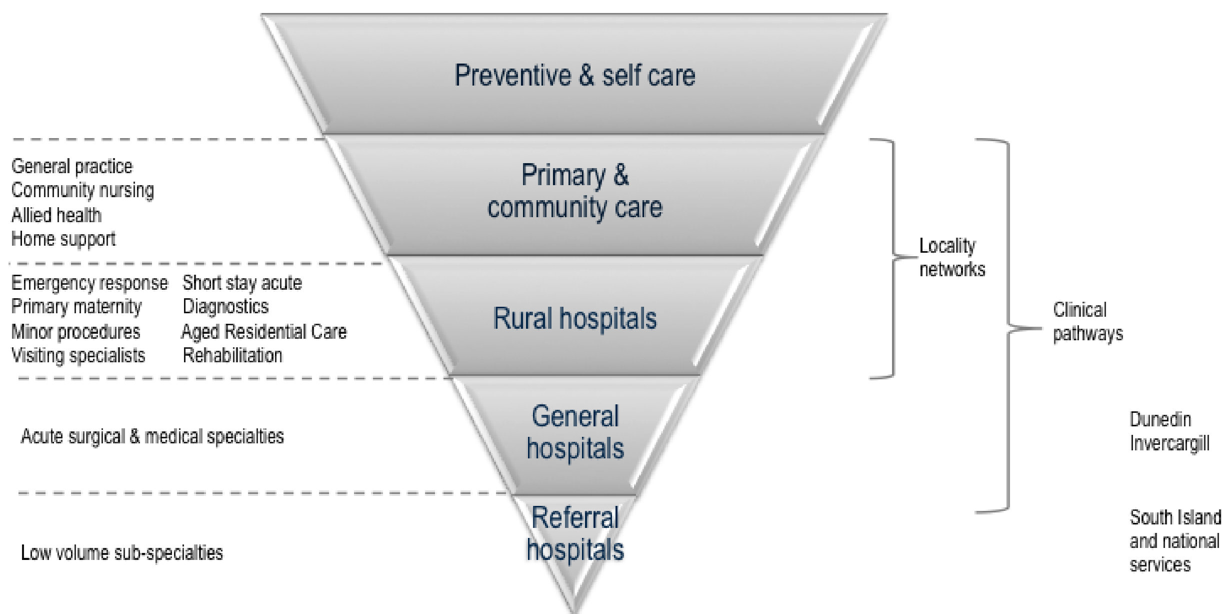
The geography and demography of Southern district requires distributed delivery of the majority of its health services, rather than centralised models of care. In addition, the Southern health system comprises services delivered by a wide array of public, private and NGO entities. Together these factors indicate the need for a network approach that effectively links the various provider organisations, their services, and levels of care in a single unified system.

The infrastructure that will align the components of the Southern system is at a relatively early stage of its development. Examples include:

- The directorate structure to support a unified Southern DHB Provider Arm across multiple sites is still 'bedding in', particularly in Dunedin Hospital
- The Alliance South structure to support service integration has recently been reconstituted and is undertaking its first projects
- The first clinical pathways for referral from general practice to specialist care have been defined and made available in a low key manner, but many clinicians are yet to be engaged in a way that will ensure pathways become a strong feature of the Southern health system
- Southern DHB is actively collaborating with other South Island DHBs in a shared regional work programme
- There are no formal structures or resources to support collaboration or integration at the locality level, although a loose general practice framework remains from the former multi-PHO entities
- Southern DHB's Planning & Funding team is moving beyond its historic transactional and 'arms-length' approach to fostering closer strategic engagement with providers.

Figure 7 illustrates the various components of the Southern system of care. The Southern health system includes key provider sites and services (eg, Dunedin and Southland hospitals; the rural hospitals; and primary and community services in rural and urban settings); the two 'arms' of Southern DHB (Provider and Planning & Funding); Southern PHO; and Alliance South. Strengthening of the structures, tools and processes that will link the components will also be important. These include shared electronic patient health record summaries; shared care plans; defined clinical pathways; and clinical networks.

Figure 7: The Southern health system



Role clarity

An important early contribution to increasing the coherence of the Southern heath system will be a clear description of its constituent parts, how they relate to each other, and how they are expected to evolve over the next three to five years. This includes key providers, services and sites/facilities (eg, primary and community services in rural and urban settings; the rural hospitals; and Dunedin and Southland hospitals). Alignment is essential between WellSouth Primary Health Network and the two 'arms' of Southern DHB (Provider and Planning & Funding), and with other South Island DHBs. 'Alliance' partnerships are the preferred mechanism for achieving this alignment.

Strengthening of the structures, tools and processes that will link the components will also be important. These include district and regional clinical networks; shared electronic patient health records; shared care plans; and defined clinical pathways.

Alliances

Health systems are seeking to strengthen integration of their various components, in order to contribute to improved patient access, population outcomes, and resource use. An important step in this across New Zealand has been mandating of 'alliance' relationships between the DHB and PHOs operating in its area.

Alliance South is in place, and delivering against its initial work programme (Table 5). During implementation planning for this SSHP, the Alliance South work programme will be reviewed to ensure it includes the relevant headline actions from the Implementation Roadmap (Figure 10).

Extension of the collaborative planning and decision-making relationships established and fostered through alliancing will be an important feature of the future Southern health system. Early actions will include:

- Application of the alliancing model through locality networks that will foster collaborative planning and delivery for local communities

- Establishment of service level alliances to plan and develop services in prioritised areas, including community mental health, and health of older people services.

Effective alliances and networks are also critical in Southern's relationships with other DHBs, and especially with the other South Island DHBs. The role and focus of the South Island Alliance is discussed in Section 2.3.

Table 3: Role and membership of Alliance South

The Alliance Agreement between Southern DHB and WellSouth provides the foundation for an integrated system approach to the design and delivery of health services in the Southern district. Alliance South is the leadership and decision-making structure that provides oversight and coordination of the joint work programme. Its focus is on transformational change to develop a better integrated, more connected Southern health system with models of primary, community and secondary care that support better health for people and communities.

The work is generally undertaken by specially convened service level alliance teams. Following decisions made by Alliance South, implementation is progressed through Southern DHB's contracts with providers.

Membership
Southern DHB participates as a member of the Alliance and is represented on Alliance South by both Planning & Funding and Provider Arm personnel. The DHB retains some reserved powers in order to reflect its statutory roles and accountabilities. WellSouth also participates as an Alliance member. Other members include representatives of aged residential care, Māori clinicians, rural health trusts, public health, St John and a community leader.

Alliance South members are predominantly clinical, have an identified community of influence, and are drawn from a wide range of disciplines and localities across the Southern district. Members are chosen because of their skills, competencies and abilities to contribute to the broader aims of the Alliance. They are also expected to act as conduits of information and bring recommendations from their organisations and its networks.

Approach
Alliance South's work is guided by Southern DHB's Fourfold Aim for quality and service excellence (Section 5.4). Alliance South's guiding principles include:

- Best care and outcome for the patient: right care, right place, right provider
- A whanau/family-centred approach when making decisions to improve the health outcomes of our population
- Health professionals to drive system development
- Clinical leadership and involvement in the system design and development
- Clinical and financial sustainability
- Resource, workforce and money follows the patient
- A 'whole of system' integrated approach
- Reducing barriers of access
- Development within existing funding streams
- Best practice from New Zealand and internationally
- Te Tiriti o Waitangi and Whanau Ora will guide responses to Māori health issues
- An environment of safety, quality, performance and accountability, and low bureaucracy.

Work programme
Areas of focus for Alliance South during 2014/15 are shown in Table 5.

Acute and urgent care

A vital part of any health system is the provision of acute and urgent care, with effective management of trauma and seriously unwell patients at its core. Acute and urgent care encompasses people whose existing medical conditions deteriorate, or who present severely unwell from a new diagnosis.

Experience elsewhere in New Zealand has shown the benefits of a structured district and regional approach to acute and urgent care. The effective management of trauma is one important component of this, and the Emergency Care Coordination Team (ECCT) in each of five regions is tasked with ensuring this. Southern's existing team and its functions could be further supported in its work.

An acute care workstream will be developed through the Performance Excellence and Quality Improvement Strategy (see Priority 4) to co-ordinate acute patient flow and management across the district and between providers and services. Options for pursuing this work include expanding the co-ordinating functions of the ECCT beyond pure emergency care to all acute care, or developing a new acute care network.

Three specific acute service areas for focus will be:

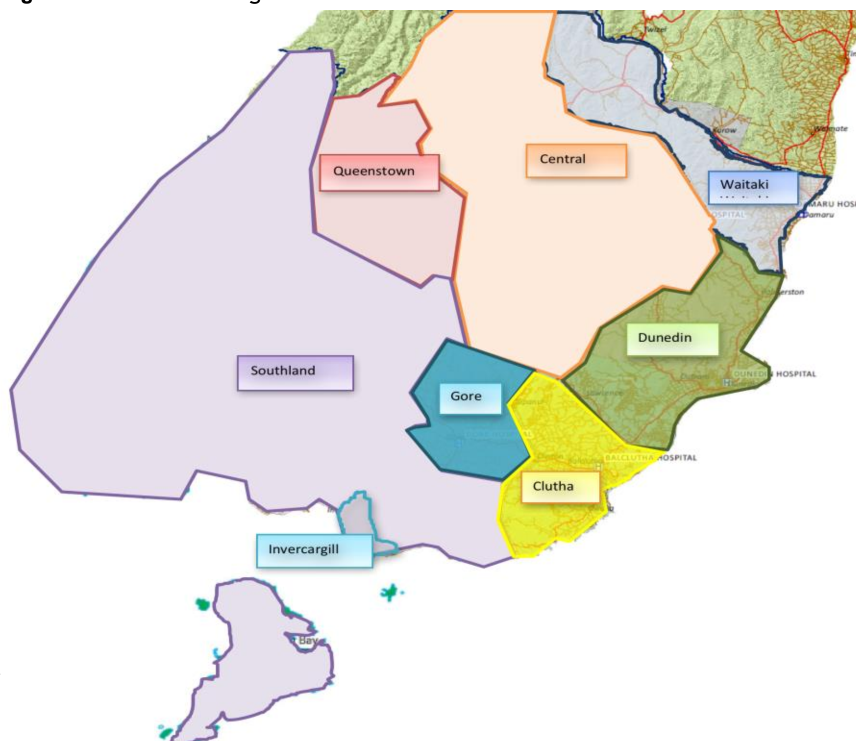
- Whether a Medical Assessment & Planning Unit (MAPU) or similar should be developed at Dunedin Hospital to improve access to urgent care
- Whether a third 'hub' (in addition to Dunedin and Invercargill) should be established in the Dunstan/Queenstown area to address the health needs of the growing resident and tourist population, and its significant distances from Southern DHB's major hospitals in Dunedin and Invercargill. If developing a third hub is considered desirable, the impact on these two major hospitals must also be assessed
- Development of a planned approach to road and air transport of patients, particularly from rural areas to Dunedin and Southland hospitals.

Southern DHB has not been meeting the national ED wait time target, although its performance is improving. Analysis shows that a significant proportion of ED patients could be seen more appropriately in general practice. Alliance South has now prioritised reducing acute hospital demand, and action is underway to promote earlier intervention in primary care settings.

Localities and rural health services

Locality networks will provide a useful vehicle for planning and development of local health services in Southern's eight health localities (Figure 8). Localities will become a focus for planning and co-ordination of local services across the various provider entities, and for engaging with community stakeholders. They will build on historic structures and existing relationships.

Figure 8: Southern's eight health localities



Locality networks will be of particular importance in rural areas, given the demographic and geographic characteristics of Southern. Local community-based entities of various forms have operated Southern's rural hospitals in Balclutha, Dunstan, Gore, Oamaru and Ranfurly since the 1990s, while Southern DHB continues to operate Lakes District Hospital in Queenstown. Southern DHB supports the rural hospitals' actions to better integrate their services with local primary and community

services, and their desire for not only strengthened support from Southern DHB's Provider Arm (in areas such as telemedicine, visiting specialist clinics, and clinical pathways), but also more strategic direction and commitment from Planning & Funding.

Rural health services are evolving, including in the role that the rural hospital plays (Table 4). While the range of services that are available in the rural hospital will vary from community to community, the opportunity exists to generally strengthen the role of the rural hospitals within the Southern delivery systems, through:

- Reviewing referral and transfer pathways, which will vary to reflect local clinical capability
- Developing the Southern acute care network and framework, including recognition of the core rural hospital role of triage, assessment and stabilisation of acute patients, with either discharge, transfer, or a short treatment stay
- Exploring opportunities for enhanced care capability through collaborative planning and networked delivery across Dunstan and Lakes Hospitals
- Locality networks that will foster integration with general practice and community services
- Ensuring access to 24/7 diagnostics (imaging; point-of-care testing)
- Developing the rural health workforce (see Priority 5 – Enhance system capability and capacity)
- Ensuring access to responsive specialised advice from a major hospital, including through use of telemedicine.

Table 4: The changing role of the rural hospital

In contemporary service delivery models, the core role of a rural hospital is in emergency care, offering initial assessment, stabilisation and short-stay observation of acute presentations, with advice from and transfer to a major referral hospital when required, and with short inpatient stays when local care is appropriate. Acute care is increasingly the role of the major hospital, which has better access to diagnostic equipment and specialised expertise. This, together with improvements in transport systems over the recent decades, has resulted in a reduced requirement for acute inpatient capacity in rural hospitals.

The range of other services that are available in the rural hospital will vary from community to community, and depend on local factors such as population size, composition and future trends; distance from other hospitals; and local availability of other primary, community and institutional services. The rural hospital campus is increasingly the base for integrated service delivery, the scope of which may include (in addition to acute care):

- General practice
- Southern DHB community services (including nursing, allied health and mental health)
- NGO community services
- Primary maternity
- Subacute care (see below)
- Visiting clinics by Southern DHB major hospital staff
- Aged residential care.

Transfers from a major hospital to a rural hospital for sub-acute care can be appropriate for palliative care, or where a further recovery/rehabilitation period is warranted, and the patient does not need the resource intensity and complexity of the larger hospital. However, such discharges, transfers and admissions carry costs for both the health system and patients, and active rehabilitation is required through a care plan agreed as part of the discharge planning process. The aim is not to fill available bed capacity at the rural hospital; rather it is to achieve good patient outcomes and efficient resource use.

Key to making cost-effective use of rural hospital capacity will be strengthening of discharge planning resources and processes. The aims are to minimise length of hospital stay and prevent readmissions across the system through:

- Timely discharge and transfer from the major hospital, and admission to the rural hospital
- Supported early discharge from the rural hospital
- Close liaison with local primary & community health services to ensure post-discharge follow-up.

Clinical pathways

An important component of service integration within the Southern health system will be the development and application of clinical pathways. The clinical pathway is a quality improvement tool to support standardisation of care and improve outcomes. Clinical pathways can contribute to service redesign and standardisation across primary and specialist care, across sites, and within specialist services. Clinical pathways (also referred to as care pathways) are usually focused on improving the management of common conditions in primary care, and ensuring high quality referrals are made for hospital level advice. This avoids duplication of diagnostics, supports a high conversion of assessment to treatment, and an improved patient experience.

Southern intends to take a broader approach to clinical pathways. As part of alignment within a single system of care across the district, the Southern pathways won't stop at the hospital door, but move inside the hospital and consider in particular how patients with complex needs (eg, co-morbidities) are best managed and discharged back to primary and community care (or to another provider). This will ensure evidence-based practice, reduced clinical variation, and therefore reduced waste across the whole system.

Southern's clinical pathways – adapted from the Canterbury Health Pathway's model - will be developed through close collaboration between clinicians working in primary and hospital services, building better relationships between clinicians and ensuring the content applies locally. An overall project plan will be developed through Alliance South, including how the pathways will be implemented.

Priority 2: Build the Southern health system on a foundation of population health, and primary & community care

Goal

Strengthen population health approaches, and the core role of general practice as the 'health care home' for patients within the primary & community team.

Headline actions

1. Within the Alliance South framework, develop further service level alliance teams as the key structure for collaborative service planning and development of new models of care
2. Through Alliance South, agree the future primary & community model for urgent care and after-hours care; health of older people services; community mental health services; management of long term conditions; and management of patients with high and complex needs
3. Include prevention and early intervention within the scope of the primary & community teams, and foster their linkage with Southern DHB's health promotion programmes
4. Support inter-sectoral initiatives that address the determinants of health, such as in housing and the physical environment
5. Implement a risk stratification tool that identifies the patient cohorts at greatest risk, and design care models commensurate with risk
6. Southern DHB to develop a policy based on the Minister's expectations that the DHB will work with community and hospital clinicians to provide a wider range of services in community settings as appropriate and provide these services at no cost to patients
7. Identify and support demonstration sites of agreed models of primary & community care, and spread successful innovation.

Discussion

Southern district's primary & community health sector has not developed over the past decade at the pace and scale seen in many other areas of New Zealand. Pockets of innovation are present, but primary care has been relatively slow to take the lead in promoting and adopting new models of care that will better meet future health needs and contribute to system sustainability. Reasons for this include a history of predominant Southern DHB focus on hospital and specialist services; loss of momentum associated with restructuring of the nine PHOs into the single WellSouth; and the Southern health system lacking a widespread understanding of the need for change, and a unifying strategic direction.

However, there is evidence of a new commitment and energy emerging:

- Key primary care and NGO entities support development of a more strategic approach and alliance partnerships with Southern DHB
- The Alliance South structure is in place, providing a basis for fostering clinically-led change, more trusting organisational relationships, and delivery of short, medium and long term work programmes (Table 5)
- WellSouth is now in place, covering all 89 general practices, and focused on lifting practice performance against national primary care key performance indicators (KPIs)
- New models of corporate ownership of general practice are emerging that offer the potential for practice consolidation to create the critical mass needed for general practitioners to be able to develop special interests, extended hours, training placements, and demonstration sites for clinical and operational innovation

- NGOs are recognised as key partners in health of older people and mental health service development
- Rural health service entities are broadening their focus beyond hospitals, and developing integrated service models.

Table 5: Alliance South's 2014/15 work programme

- Acute demand, including acute respiratory conditions, the frail elderly, and development of Primary Options to Acute Care (POAC)
- Minimum technology standards for providers
- Rural health funding
- Primary radiology referral guidelines
- Community & hospital pharmaceutical prescribing
- Child health
- Youth health
- Health pathways

Focus on high health needs

The Southern health system will continue to treat people with injuries and established disease. However, the balance will shift from a predominant focus on the usually infrequent and episodic care for individuals, to planned and structured care with a focus on the patients and families with high health needs. This collaborative approach emphasises the importance of:

- Improved community health literacy
- Integration of health and social services
- Prevention, early detection of health risks, and early intervention; and
- The core place in the health system of continuity of holistic primary health care, and general practice in particular.

This approach is particularly important given the ageing Southern population; the increasing prevalence, incidence and complexity of long term conditions; and the pressing need to reduce persistent health inequalities. It is highly relevant for most of the priorities identified in the *Southern Health Profile*, including linking of population and personal health action to address:

- Tobacco smoking
- Obesity and nutrition
- Hazardous alcohol consumption
- Chronic disease management – particularly diabetes and cardio-vascular disease (CVD)
- Access and use of primary care – in-hours, and after-hours
- Māori health - particularly child health and chronic disease
- Pacific health - particularly child health and chronic disease
- Access to mental health service access – particularly through strengthening of community services.

Through Alliance South, support will be provided for introduction of new models of care within primary & community services, and for an increased emphasis on population health and reduction in health inequalities across the whole system. Emphasis will be given to working with other agencies to address the determinants of health through initiatives in areas such as housing and the physical environment. At the patient and family level, priority for access to services will be determined on the basis of need, ability to benefit and improved opportunity for independence of those with a disability.

Table 6: The future shape of Southern mental health services

Five strategic directions are identified in Raise HOPE, Southern DHB's mental health and addictions plan 2012-15:

- Prevent mental illness/addiction and intervene early
- Intervene in targeted, effective ways across the life course
- Locate support closer to consumers and in communities
- Work as one sector with a whole of systems approach
- Constantly improve sector quality, capability, productivity and capability

Target groups are identified as priority:

- Māori and people who, as a group, experience mental health and addiction inequalities
- Those with health inequalities
- Those where the system can intervene early (child and youth)
- Specific groups including:
  - Families and whānau with risk factors
  - Children with cognitive, developmental and behavioural disorders
  - Youth with risk factors
  - People with low prevalence, high severity psychiatric problems
  - People with alcohol and other drug problems
  - People involved in the forensic/justice system
  - People with organic degenerative conditions (eg, dementia)

Raise HOPE recognises the need to address mental health determinants, including working with other agencies at policy and operational levels, including education, housing, justice and social welfare

Raise HOPE's implementation framework encompasses activities in four major areas - systems, service, workforce and infrastructure:

- The **systems** model identifies the need for collaborative effort, and prescribes prevention, early targeted intervention, with a whole of sector approach. Services will be delivered in community settings where possible, with a culture of continuous improvement. To lead and embed the system and service model throughout Southern, a Network Leadership Group will be established, using the alliance framework
- The **service** model recognises the need to deliver more services in the primary and community setting, with new workforce models and roles. A stepped care approach will be used, intervening in the least intensive way through support for self-care, and increased resources and activity through early intervention by primary & community services. Specialist service capacity will be focused on those with more complex needs. Even fewer consumers will require access to highly specialised inpatient and crisis resolution services from time to time. Clear care pathways across primary, secondary and tertiary services will ensure effective access and ease of movement between the different levels of service provision
- A **workforce development** plan will ensure that the workforce has the capacity and capability to deliver new and existing services in different ways

The ability to work as a whole of sector with a systems approach relies on fit for purpose **infrastructure**, including:

- Timely, accurate and consistent information for planning, measuring performance, and as a basis for decision-making
- A continuous quality improvement focus to support system-wide and service improvements, whilst maintaining confidence that legislative guidelines are being met
- Use of telemedicine and other fixed and mobile communication options to enhance service effectiveness

Planned and structured primary & community care

Working through Alliance South, Southern will move progressively to adoption of structured primary & community based care. Early actions will include:

- Identify an appropriate methodology for risk stratification, and ensure baseline data is of appropriate quality. This can include a mix of hospital and general practice based risk criteria, but the tool is best applied to the enrolled general practice population in line with the 'health care home' concept (see further discussion of risk stratification below)
- Design future models of care taking account of what already works well in rural and urban areas of the Southern district
- Identify evidence-based models of care for different risk profiles and population groups (eg, frail older people; adults with diabetes or chronic obstructive pulmonary disease)
- Define the scope and mix of health professionals required for each level of risk stratification and associated models of care
- Identify varying methods of patient contact, including nurse-led models, home visits, mobile clinics, and 'virtual consults' (eg, telephone, email), and the suitability for patient groups
- Undertake a task and activity analysis to identify appropriate clinical and support staff input to models of care, and identify where possible staff substitution opportunities to improve efficiency and free-up time of more specialised professionals
- Size resource and utilisation intensity for different models of care to inform resource and funding allocation
- Align with urgent, after-hours and acute care, services for older people and nursing/allied health integration initiatives.

Risk stratification

A foundation for shifting to planned and preventive care is to develop understanding of the different levels of health need in the local community through use of health risk profiling. This allows identification of cohorts of the population with different levels of risk, and tailoring of models of care and resource intensity to match the varying levels of health need.

The objective is to help people achieve the best health and quality of life possible by preventing risk factors developing into long term conditions, and stabilising current chronic conditions to prevent disease progression. Importantly, adoption of risk stratification supports patient partnerships in designing the way care will be delivered and resourced, supports better integrated services, and minimises hospital attendances and admissions.

Figure 9 provides a stylised depiction of population risk stratification and the types of intervention that may effectively address the needs of groups with different risk profiles. As this is completed for each local population, care models for the different population segments can be developed to match their level and type of need, with more resources being required as the level of risk increases. Table 6 describes this approach for people with mental health needs, and Table 7 for older people.

Care plans are personalised to individual patients based on their health status, family support networks, and cultural preferences. The care team will include Māori and Pacific providers where appropriate. For people and families with higher and more complex needs, the care model can be intensified to case management, and include, for example, clinical pharmacy services, community mental health services, and social services.

Model of care change

WellSouth will lead model of care change in partnership with Southern DHB through Alliance South, and in accord with *Better Sooner More Convenient* policy. Particular areas of opportunity include:

- Locality planning and networks
- Multi-disciplinary teams, with core membership from general practice, community nursing and allied health (including clinical pharmacy)
- Nurse-led services
- Referral and discharge management (supported by clinical pathways)
- Improved access to specialist advice, including through use of telemedicine
- Improving general practitioner access to investigations (eg, ultrasound, CT, MRI, exercise testing)
- Minimising the need for specialist outpatient follow-up visits
- A planned approach to development of the General Practitioner with a Special Interest (GPSI) role
- Managed intersection of general practice with specialist and NGO services (eg, mental health services; service for older people; Māori health services; services for Pacific people; St John)
- Accelerated development using proven primary & community initiatives from elsewhere in the South Island.

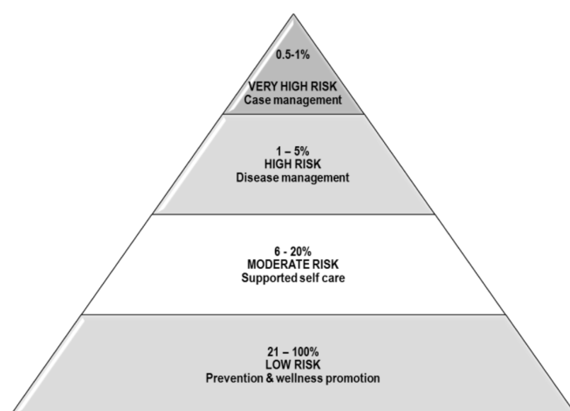
An area of particular challenge in designing future models of care will be how to simultaneously:

- Reinforce the role of general practice as the patient's 'health care home' and continuity of care; and
- Reorient DHB community services from a hospital discharge focus to a community focus as part of a primary health care multi-disciplinary team.

Locality networks will be important in this regard, supporting development of closer and more effective local working relationships. In rural areas this could be fostered through co-location of community services personnel with general practice on the local hospital campus (where one exists). In urban areas the trend is likely to be towards development of 'neighbourhood hubs' to accommodate such personnel closer to general practice and to the patients they serve.

The use of demonstration sites, with the opportunity to evaluate and encourage the spread of successful solutions, will be an important aspect of model of care redesign and health system reconfiguration.

Figure 9: Stylised risk stratification profile and associated intervention model



Note that the percentages of the population in each group are not necessarily representative of the Southern population, and are for illustrative purposes only.

Table 7: The future model of primary & community care for older people

A plan for future provision of community health services for older people was developed for Southern DHB[14] to address the future health needs of its older population. The aim was to identify a structure that will, within currently available funding, enable services to refocus around the needs of older people. The recommended structure builds on the strengths of existing primary and community services to enable improved integration between services, reduced duplication, and reduced risk of disconnection between multiple services involved in the older person's care.

Under the model, the older people with complex needs will have an identified care manager who works with the general practice and other providers to ensure that all the care is connected. The care manager will work with the general practices in a locality to support development of better working relationships and effective support from a locally based team of Southern DHB community nurses and allied health practitioners, community pharmacists, and NGO staff. The locality teams would be supported from a central 'hub' of professional leadership, and with specialised input from nurses and doctors.

This model is in accord with the strategic direction presented in this SSHP, and builds forward on infrastructure that is already in place in Southern – such as the increasing integration of services in rural communities; the trend in general practice to risk stratification and structured care; the increasing focus of some specialist services, such as geriatrics, to strengthen their outreach role in supporting community-based solutions; and the desire to better link clinical, community and home-based support services for older people.

Particular features of the model will be:

- Improved transfer of care to avoid hospitalisation of older people with acute needs, and reduce the risk of readmission
- Targeted medicines review by pharmacists, working within a multi-disciplinary team
- Improved primary health care support for aged residential care facilities to address acute needs of residents, and to prevent avoidable ED attendance and urgent admissions to an acute hospital
- Introduction of acute response services (eg, Primary Options for Acute Care, or POAC) to provide GP-initiated alternatives to ED referral and hospital admission.

[14] *Southern District Health Board: a model of care that integrates health and support services in the community for the older person.* S Jacobs et al. Auckland Uniservices (2011)

Priority 3: Secure sustainable access to specialised services

Goal

Ensure that the Southern population has ongoing access to specialised services that have safe and viable staffing levels and activity volumes to treat complex conditions.

Headline actions

1. Undertake analysis to inform planning of specialised services, including identification of services at risk of clinical and financial unsustainability; analysis of inter-district patient outflows; and updating of the Role Delineation Model assessment of Dunedin and Southland hospitals
2. Based on the analysis, identify whether action within Southern DHB or through South Island collaboration is the most appropriate avenue to pursue planning and development of particular specialised services
3. Continue South Island collaboration to refine governance, management and funding models that support provision of sustainable hospital level services across DHB boundaries
4. Conduct a stocktake of visiting specialised outpatient clinics, and develop a planned approach by locality that supports equitable local access for patients to higher volume specialties, and that balances clinician and patient travel.

Discussion

A number of clinical specialty services at Dunedin and Southland hospitals are struggling to maintain the activity volumes and staffing levels required for clinical viability. This includes both some core secondary services, and more complex sub-specialty services. These issues were given a high profile during consideration of the future configuration of South Island neurosurgical services during 2008/09, and more recently in relation to breast screening.

Hospital level service sustainability is of increasing importance for Southern DHB for a number of reasons, including:

- The very low inflows of patients to Dunedin Hospital services from elsewhere in New Zealand means reliance on the Southern district's own population to support its hospital services. Whilst Southern is the sixth largest DHB by population and funding, because of the low numbers of inflows from other DHBs its clinicians serve a relatively small population catchment
- Increasing sub-specialisation is challenging the critical mass of medical and surgical 'generalist' services, with a key consideration being the number of specialist practitioners needed to maintain a sustainable service
- The specialist workforce is increasingly attracted to work in larger centres meaning Southern is facing recruitment challenges
- Funding constraints are placing pressure on hospital department budgets.

Overall, Dunedin Hospital's performance may be adversely affected by trying to maintain its own low volume specialties and high levels of clinical support services without sufficient population catchment to warrant adequate specialised staffing. An updating of the 2009 Role Delineation Model assessment will help identify any such imbalances.

Assessment of the sustainability of hospital services will include clinical and financial criteria, such as:

- The catchment population required to generate sufficient volumes to warrant staffing levels that meet reasonable roster requirements and allow practitioners to maintain their skills
- Cost per case compared with benchmarks

- Comparative access/intervention rates to match New Zealand standards.

In response to these (and other) imperatives, Southern DHB has implemented a Provider Arm-wide directorate structure to unify operational planning and delivery of specialty services across Dunedin and Southland hospitals, and achieve a larger scale.

South Island collaboration

There is also increasing South Island DHB collaboration in low volume specialties, driven by recognition that the South Island population is too small for duplication of standalone services, and that regionalisation is likely to help ensure ongoing access. A range of collaborative South Island specialist service models is currently in use, including:

- ‘Hub & spoke’, with centralisation plus outreach
- A single service across multiple sites, with shared governance
- Outsourcing to a third party with delivery in multiple sites.

Hub & spoke models operated by Canterbury DHB for the South Island are proving effective for a number of services, including paediatric surgery; gynae-oncology; maternal foetal medicine; and renal transplants. Bariatric surgery has also recently been established as a South Island shared service, with the surgery being performed in Christchurch and Invercargill.

For neurosurgery, the NHB-commissioned panel concluded that Southern patient volumes were too small for a standalone service, and the solution was a merged South Island service, delivered in two sites (Dunedin and Christchurch) with a Dunedin-based professorial appointment at the University of Otago. Dunedin provides the neurosurgical stereotactic service for New Zealand.

Effective South Island collaborative service models must include service funding and governance arrangements that ensure a voice for Southern DHB, access for Southern patients, effective interaction with other Southern specialised and clinical support services, and affordable cost structures. In addition, any business case for a merged service needs to consider:

- Impact on teaching, training and research
- Impact on specialised nursing staff
- Impact on clinical support services
- Cost impact of delivery of inpatient services on more than one site
- Arrangements for rapid response to the needs of acute patients with life-threatening conditions
- Use of telemedicine, clinical pathways and access to electronic patient records
- The balance of clinician and patient travel
- Development of local practitioner capability.

Priority 4: Strengthen clinical leadership, engagement and quality improvement

Goal

Further develop a culture of clinically-led innovation and improvement across the Southern health system.

Headline actions

1. Clarify the intended nature and role of clinical leadership in the Southern health system, and ensure supportive structures and processes are in place
2. Ensure clinical leaders have the time, skills and tools to deliver on the performance expectations of their roles
3. Revisit the Performance Excellence & Quality Improvement Strategy to ensure its relevance and adoption as a whole-of-system approach, with an appropriate governance structure and implementation plan, and linkage with the work of Alliance South
4. Position the Performance Excellence & Quality Improvement Strategy as a key vehicle for ensuring resource sustainability, by matching expenditures within services to the revenue level, improving productivity, and preferentially investing in high priority services that demonstrate significant value gain
5. Identify the initial areas in which Southern DHB will lift its performance to world-class levels, and develop action plans for each
6. Develop locality networks as a forum for building the effective clinical relationships that will support local service improvement and integration
7. Through Alliance South, ensure clinical pathway development and implementation is underpinned by clinician leadership.

Discussion

Clinical leadership and engagement

One of the areas of focus of the Southern Way has been increased clinical leadership and engagement inside the Provider Arm through creation of the unified directorate structure. Full implementation of this model is at a relatively early stage, and the leadership roles, structures and processes that will underpin future performance are still maturing. Particular dimensions of the next stage of development will include action to:

- More explicitly define ‘clinical leadership’, and the organisation’s expectations of clinical leaders, including at departmental level
- Provide support for developing the skills and knowledge of clinical leaders
- Develop the recently established Clinical Council and establish processes for considering organisation-wide issues of concern to clinical leaders
- Increase engagement between clinical leaders and Southern DHB’s Planning & Funding Arm
- Close the gap between the formal leadership structure (ELT/directorates/departments) and front-line staff
- Build stronger mechanisms to link Dunedin and Southland hospitals, while recognising their distinct cultures and issues.

Performance improvement

As described in Section 5.4, a key vehicle for lifting the performance of the Southern health system will be the Performance Excellence & Quality Improvement Strategy. The Strategy is intentionally high level and aspirational, and was to be followed by an implementation structure and plan. An action plan has been developed, but implementation has not achieved the scope and scale originally envisaged.

A review will be undertaken to ensure a more strategic approach to performance improvement. Particular considerations will include:

- Building understanding of what the Strategy and its Fourfold Aims mean in practice across the Southern health system, and prioritising implementation initiatives in a systematic approach to evaluate and spread successful innovation
- The implementation plan will include a focus on supporting short and medium term financial recovery planning and action, in recognition that 'good care costs less'
- Encouraging uptake of the Strategy across organisations and professional groups. It should be a vital part of the Alliance South framework, enabling a joint approach across the Southern health system
- Transformational change through a quality improvement approach requires investment, data, skills and methodologies. Quality improvement initiatives in Southern DHB are hampered by difficulty in obtaining timely data and analytical support. Data is gathered, but is difficult to access and share. Consideration will be given to establishment of a single Southern DHB decision support unit (that would potentially encompass primary care as a partnership with WellSouth)
- Continuing emphasis on skills for change training for Southern DHB staff, and broadening of intake to include WellSouth Primary Health Network and NGO personnel
- National areas of focus through the Health Quality and Safety Commission will also be part of Strategy implementation and include:
    - Prevent falls and reduce harm from falls
    - Improve hand hygiene practices in order to reduce healthcare associated infections
    - Use the World Health Organisation Surgical Safety Checklist to enhance the surgical team's communication
    - Utilise effective antibiotic prophylaxis in lower limb joint replacements.
    - Utilise appropriate skin preparation in lower limb joint replacements.
    - Prevent harm caused by surgery by improving communication and feedback within teams
    - Preventing harm due to medication errors
    - Capturing people's health care experiences to identify how to use that information to develop new ideas, measure change and report back to consumers.

Alliance South provides a vehicle to broaden the scope of the Performance Excellence & Quality Improvement Strategy to encompass the whole Southern health system. Visible and active leadership by senior clinicians in both the Provider Arm and primary & community services will be critical to clinically led service integration, and to the unified approach to performance improvement that together will be key contributors to a sustainable Southern health system.

Increasing the day case surgery rate

A specific performance improvement area already identified by Southern DHB through the Southern Way is a sustained increase in the proportion of surgical procedures that are done on a day case basis, in order to improve the patient experience and efficiency of services. A joint NHB/Southern DHB day surgery review was undertaken in 2013, and key issues for improvement of the model of care and facility use were identified. These included the need:

- For a 'day case mindset', with day surgery being seen as the default and overnight stay the exception
- To factor expansion of day case procedures into facility design at Dunedin Hospital (more theatres, fewer beds) and professional roles
- For improved connection with primary and community services to optimise pre- and post-surgical care.

Professional relationships

Communication between hospital and primary care clinicians will be strengthened. Opportunities for better structural and personal linkages will be pursued, including CME meetings, clinical pathway development, establishment of locality networks, and performance improvement initiatives. Alliance South and Southern DHB's Planning & Funding team will ensure service planning and clinical pathway development engage clinical leaders in taking a broader whole-of-system view across the continuum of primary & community, and hospital & sub-specialist services.

Priority 5: Optimise system capability and capacity

Goal

Develop a workforce mix and facility configuration that matches future health needs, and recognises Southern's core role in teaching and learning.

Headline actions

1. Mandate the existing Joint Education Committee (or equivalent) as the cross-organisational leadership body to collaboratively plan and develop the Southern health workforce based on intended models of care, workforce roles, and demand and supply forecasts. Committee membership should include Southern DHB, primary care, and the three tertiary education providers
2. Develop a Southern health system workforce plan, beginning with a stocktake of the district's estimated 9000 current health workers, and including clear priorities for workforce development based on the strategic direction presented in this SSHP
3. Expand Southern DHB professional leader roles to include a whole-system scope across primary care, NGOs and rural health services, with a focus on standards, credentialing, continuing professional development, and advice
4. Complete detailed district-wide facility capacity planning to inform business case development for an upgrade of prioritised Dunedin Hospital buildings.

Discussion

Workforce

Increasing service demand and ageing of the existing workforce bring the need for planned replacement and expansion of workforce capacity, including role substitution and new roles within new models of care.

The Southern district is a major health sector teaching and training hub, including three tertiary education providers[15] (University of Otago, Otago Polytechnic and Southern Institute of Technology), and offering nine health professional streams (including medicine, nursing, midwifery, pharmacy, dentistry and physiotherapy), together with management and business disciplines. In addition to its large contribution to the national health workforce, this concentration of tertiary education gives the Southern district a significant strategic advantage, in having local access to a highly educated workforce, and the ability to shape teaching, training and learning curricula and approaches to align with future health needs and models of care. However, the trends in specialisation and the mix of skills that most of our clinical workforce come with are more influenced by the training pathways and requirements of the professional Colleges who provide most of the postgraduate training, particularly for doctors. Engaging and influencing these organisations particularly when many of them are Australasian, is not easily done by a single DHB.

Southern DHB and the University of Otago in particular have a long history of co-operation and collaboration. Many Southern DHB-employed health professionals are engaged in research and teaching, while a number also hold joint appointments across both institutions. As is often the case when two different but supportive organisations work closely together, many opportunities exist for mutual support and benefit, but it is important both parties are clear about their respective and different accountabilities.

[15] Health Workforce New Zealand also funds postgraduate education for Southern DHB staff through tertiary institutions elsewhere in New Zealand.

The focus now is on achieving appropriate strategic alignment and effective operational relationships across the health and education sectors, to develop the workforce that the future health system will need. Particular issues to address in joint planning include:

- Alignment of University of Otago and Southern DHB strategic planning for medical specialties to ensure consistent and explicit assumptions regarding clinical services, teaching and research, whilst recognising that the two organisations have different but complementary priorities
- Management of joint academic/service employment, with an appropriate balance of clinical performance, teaching and research, and clarity about separate accountabilities
- Engaging with the specialist Colleges either directly or through larger common-interest organisations such as the South Island Alliance to improve matching of training with the future roles and service delivery models we expect to develop. This also requires engagement with Health Workforce NZ and the Medical and Nursing Councils.
- Accommodating clinical placements, including the increasing need for community placements
- Movement toward inter-professional learning from year four of Medical School, which will require complex organisational and professional collaboration
- Development of new workforce roles, building on the current training of enrolled nurses for acute hospital roles, and health care assistant training for aged care and acute hospital services
- Consideration of whether clinical placements should be centrally co-ordinated across disciplines to ensure direct linkage with Southern system priorities and capacity
- Consideration of whether training technologies should be shared across disciplines (eg, simulation)
- Continuing promotion of an increase in the proportion of medical and nursing graduates entering primary care
- Effective Southern linkage with the South Island Alliance Training Hub, including establishment of a South Island e-learning platform to deliver professional development programmes.

In addition to strategic alignment of education and training for health professionals, other issues to be considered in workforce development include:

- Promotion of multi-disciplinary teams, rural services, and primary & community services
- Assessment of the feasibility of inter-disciplinary training (nursing, allied health, medical) in rural areas
- Building on the existing Incubator Programme to grow the local health workforce (clinical, managerial and technical) through promotion of health careers in secondary schools, with a particular emphasis on lifting Māori and Pacific participation
- Addressing barriers to training of the rural workforce
- Providing advice to individual health workers to support career progression
- Support for career pathways and skill sets that support new models of care, including primary and community practitioners working at the top of their scopes.

Ensuring the sustainability of rural health services will be a particular priority for Southern DHB, WellSouth, and the rural health service provider organisations. Rural workforce issues to be addressed include:

- Support for the rural hospital medicine specialist role through increased registrar positions, and particularly support for joint rural hospital medicine/general practice training
- Further development of a rural nursing specialist role, building on existing practice (eg, on Stewart Island) and aligning with nurse practitioner and physician assistant roles, and with primary response in medical emergency (PRIME) nurse training
- Increased support for self-employed Lead Maternity Carer (LMC) midwives in rural areas, who are struggling with on-call demands

- Deliberate and early succession planning locally, and at a strategic level through professional leaders and locality networks
- Overcoming barriers to rural training (eg, broadband, facilities, supervision). Access to videoconferencing and the internet are important to support 'virtual' training. The Mobile Surgical Bus is part of the solution, however training needs to be directly relevant to the population's and practitioner's needs, and with a focus on the generalist.

Facilities

Southern DHB has a modern hospital facility in Invercargill that was purpose-built in 2004 (although further development of an education facility is required on the campus). In December 2013, a staged redevelopment plan of Dunedin facilities ($24.4m) was completed, to bring some essential areas in line with quality standards. A new mental health acute inpatient ward was built on the Wakari Hospital site, and the Neonatal Intensive Care Unit (NICU) and Paediatrics were relocated to a new ward on the first floor of the main Dunedin Hospital campus building. There have also been some key infrastructure upgrades at both the Dunedin and Wakari Hospitals.

Recent national commitment to future capital investment in Dunedin Hospital has reinforced the need for a deliberate approach to facility planning to ensure it is strongly aligned with the intended service configuration, models of care, and staffing. In association with this SSHP, Southern DHB has commenced a project looking at the medium to longer term facility requirements and configuration in Dunedin and the necessary capital requirements to re-life or replace existing facilities. This will lead to a high-level facility master plan that includes staging and timing, spatial planning for the Dunedin Hospital site, a review of building condition and seismic strength assessment, and a refresh of population demographic demand models. These pieces of work will feed into the development of a new Southern DHB asset management plan.

Planning for Dunedin Hospital will also look across the Southern district as a whole, and consider the impacts of:

- Forecast population changes, including ageing, and growth and shrinkage in particular localities
- Incidence and prevalence of long term conditions
- Model of care changes, such as hospital avoidance through strengthened primary care-based models; increased day surgical activity; and potential changes in rural hospital roles (eg, strengthening of hospital services in the Queenstown/Dunstan area).

A particular issue that will be considered in facility capacity planning will be the potential contribution of the private hospital sector within the overall system. Dunedin and Invercargill have private specialist hospitals that offer surgical and diagnostic capacity. Capacity planning will ensure resources are used efficiently. For example, Dunedin Hospital currently has 11 operating theatres, and Mercy Hospital a further six theatres. Together this is a substantial capacity for the catchment of Dunedin's surgical services.

Previous facilities planning work has identified considerable financial hurdles to be overcome. Southern DHB will need to develop strategies to manage this, including ensuring existing bed capacity across the district is optimised. South Island capacity planning will also be an important feature of facility planning, including consideration of specialist service configuration (see Priority 3 – Secure sustainable access to specialised services).

In addition to the physical building requirements, Southern DHB faces challenges in financing equipment replacements within normal asset life cycles. Many assets are currently utilised well beyond their technical use life with replacements being made when the item breaks or completely loses functionality. As part of medium term financial planning, a prioritised proactive replacement cycle will be adopted.

Priority 6: Live within our means

Goal

Improve the quality of the care and services we deliver using quality improvement principles and methodologies so that waste is substantially reduced, value for money is improved and the savings contribute to bringing our revenue and expenditure into alignment, complemented where necessary, by tight cost management, improved productivity and different resource allocation patterns.

Headline actions

1. Use the Performance Excellence & Quality Improvement Strategy as the framework for lifting performance to world-class levels in prioritised areas to reduce waste
2. Strengthen analysis and communication of where Southern DHB funds are spent across the Southern health system, the outputs delivered, and the outcomes and value
3. Develop a Southern DHB prioritisation framework to inform resource allocation, including relevant policies, processes and tools (incorporating the Fourfold Aim)
4. Tighten Provider Arm cost management including moderating recent FTE cost growth in key personnel areas
5. Increase use of benchmarking with other DHBs and providers as a basis for budget setting and productivity improvement
6. Develop a Strategic Investment Fund to support shift of resources to prioritised high value services.

Discussion

Southern DHB (and its predecessor Otago and Southland DHBs) has a history of its costs exceeding revenue, of positioning the problem as lying with the population-based funding model rather than organisational and system performance, and of not meeting agreed financial targets. This has flowed through into Southern DHB's relationship with national agencies, and with the providers it funds. There is now widespread acceptance within Southern DHB that this cycle needs to be broken.

In the absence of a strategic framework, Southern DHB resource allocation and activity levels have remained largely based on historic patterns, and without strong rationale. Resourcing needs to be more transparent and reflect the priorities of the Southern health system. Additionally, benchmarking with other DHBs has received less focus than it should in informing performance improvement activities.

Based on recent trends, Southern DHB is forecast to continue to incur financial deficits over the next several years. The DHB is pursuing a range of actions to achieve its 2014/15 and end of year financial targets agreed with the NHB. These actions will be supplemented by those arising from this SSHP, and provide the base for a revised medium-long term financial plan and budget.

Benchmarking of Southern DHB's financial performance and patterns of resource use has identified three areas where the DHB expenditure appeared significantly higher than sector norms:

- Age-related residential care
- Community pharmaceuticals
- Southern DHB personnel costs.

These are discussed briefly below. They will remain the focus of particular attention in Southern DHB's short to medium term planning and action to reduce its deficit, concurrent with actions to improve efficiency, shift spending to higher priority services and disinvest where returns or value are limited.

The goals of reducing the DHB's structural deficit, reallocating resources, and preparing for the costs of the Dunedin Hospital upgrade will challenge the whole Southern system to deliver improved performance. The actions outlined in this Plan are anticipated to have a positive material impact on the DHB's financial performance, ultimately enabling the DHB to live within its available funding.

Implementation of Southern DHB's Performance Excellence & Quality Improvement Strategy as described in Priority 4 will contribute significantly to improving medium to long term financial performance. Key actions will include:

- Rigorously implementing the Performance Excellence & Quality Improvement Strategy's Fourfold Aim in assessing the value and appropriateness of SDHB funded services and interventions
- Considering the potential for reducing spending on interventions that are either clinically ineffective or not cost-effective, and redirecting resources to higher value services and interventions
- Improving the quality of DHB Provider Arm services using lean (A3) methodology, with the expectation that this lead to better value for money (ie, less waste and improved efficiency)
- Focusing on those areas where Southern DHB expenditure is significantly higher than DHB benchmarks
- Improving performance against key efficiency indicators such as ambulatory sensitive hospitalisations, average length of stay, and day case surgery rates
- Scrutinising personnel cost growth in the Southern DHB Provider Arm, both in the numbers of staff and their relative cost, and understanding whether this represents value for money
- Developing clear strategies for capturing savings and redirecting them.

Areas of relatively high expenditure

Southern DHB has been spending more than the national average on rest home and hospital level age-related residential care (ARRC), with the fifth highest spend per person aged 65+ of New Zealand's DHBs. Above average spending was estimated to have been an additional $129 per person aged 65+ in 2012/13. Southern DHB is undertaking further analysis to better understand this spending pattern, and is considering how the mix of services for older people could be rebalanced in line with the national policy of 'ageing in place' and the future directions presented in this SSHP (such as those outlined in Table 7).

Southern DHB spends more on community pharmaceuticals than the national DHB average and also more than comparative DHBs. Reducing Southern DHB's community pharmaceutical spend to the population-based funding formula (PBFF) weighted sector average would save approximately $3.7M per year.

Across New Zealand, DHB personnel costs comprise around 39% of total DHB sector costs and around 63% of DHB Provider Arm costs (2012/13). As a consequence, effective management of personnel costs will be a crucial determinant of Southern DHB's ability to operate within available funding.

Southern DHB Provider Arm medical personnel cost growth has been increasing at almost three times the rate of revenue growth (5.9% per year compared with 2%) in period from 2008/09 to May 2014. Medical personnel costs are now 41% greater than they were in the year ended June 2009, with Southern DHB medical personnel full-time equivalents (FTEs) having increased by 88 over the period with a further ten FTEs budgeted for 2014/15. The recent rate of average cost growth now means that Southern DHB spends significantly more per FTE per year than the sector as a whole and than other large DHBs.

Further more detailed investigation is underway to ascertain the reasons for Southern DHB's relatively high rate of medical FTE and cost growth between 2009 and 2014. Southern DHB's nursing personnel FTE and cost growth has been more restrained since 2009, with FTEs increasing by 7% over the period and total nursing personnel costs increasing by 20%. FTE growth has been less than sector and large DHB averages while average cost per FTE has been higher.

Improving efficiency

Improving efficiency of service delivery will also be an important component of Southern DHB's strategy to live within its available funding. This will include improving performance against key indicators of Provider Arm resource use such as average length of stay (ALOS) and day case surgery rate. Other areas of Southern health system performance for focus will be identified through the review of Performance Excellence and Quality Improvement Strategy – see Priority 4.

Southern DHB has been steadily improving its ALOS performance since 2008/09, which has contributed to the DHB's efficiency improvement and cost saving strategy. However, further efficiencies can be made that will contribute to the DHB living within its means.

As discussed in Priority 4, Southern DHB has identified the opportunity to lift the proportion of its surgical procedures that are performed on a day case basis. This is more cost-effective than surgery involving an inpatient stay since the costs of overnight stay are not incurred.

Prioritisation and potential disinvestment

Ensuring Southern DHB's spending is prioritised towards higher value interventions will be a crucial component of its strategy for living within its means. Reducing spending on interventions that are either clinically ineffective or not cost-effective will free up DHB resources that can be redirected to services and interventions that are more likely to improve health outcomes and patient experience. In some instances, it may also enable Southern DHB to contain its overall expenditure growth, thereby contributing to the DHB living within its available funding.

The process for identifying lower value interventions and associated spending will be systematic and evidence-based. It will include using New Zealand and international evidence as well as work undertaken nationally by the Ministry of Health, the National Health Committee and NHB.

Strategic Investment Fund

When its finances allow, Southern DHB will create a Strategic Investment Fund to shift resources to prioritised services and models of care, with an emphasis on supporting cost-effective delivery in community settings in line with the SSHP. The Fund will also provide short-term transitional support where a change is being made to an existing model of care that enables it to be more productive in the future.

7. Enablers

A range of enabling actions will support achievement of the six Southern strategic priorities.

7.1 Organisational relationships

Development of this Plan has been underpinned by engagement with the organisations and sectors that will be critical to its successful implementation. Southern DHB is committed to building stronger and more effective external relationships, including with rural health service providers, other NGOs, local government, and other government agencies. Southern DHB's Treaty relationship with Iwi Māori is described at the start of the SSHP, and actions to address inequalities and Māori health in Sections 2.4 and 5.5.

Alliances

Relationships based on the 'alliance' framework are of increasing importance in the New Zealand health sector. The existing Alliance South relationship between Southern DHB, WellSouth and others is described in Table 3, and between Southern DHB and the other South Island DHBs in Section 2.3. Table 8 provides an overview of the alliance concept.

Table 8: Alliances in the New Zealand health system

Alliance agreements have been used in the New Zealand health system since 2010 to support integrated care development. They are intended to create a 'high trust, low bureaucracy' environment with high quality and accountability, and represent a deliberate move away from the concept of an arms-length purchaser who holds providers independently accountable. Successful alliances are dependent on shared values, agreed outcomes and principles, and transparent processes and information sharing.

Importantly, the alliance is a means of effecting service change to improve performance without disrupting current organisational structures. This is intended to shorten timeframes for action, and avoid potentially disruptive debate between organisations and professional groups, allowing new arrangements to evolve over time. In addition, the alliance is intended to operate without formal legal incorporation, and without the need for additional resources.

The key goal of an alliance in a health sector context is to promote clinical leadership, alignment of clinical and financial accountability, and clinically-led decision-making.

An alliance reflects a group of organisations who have agreed to work together to achieve shared outcomes and use a shared decision-making forum (the Alliance Leadership Team or ALT). The parties to the alliance mandate the ALT to have over-arching decision-making authority within the agreed scope of the alliance. The role of an ALT is to:

- Provide leadership within a health community
- Assess needs of populations
- Plan and design health services in a district (or locality) at high level, including decisions about prioritisation
- Establish, set goals for, and monitor service level alliances
- Identify opportunities for service development
- Identify the need for workstreams and service level alliances
- Problem solve.

ALTs involve clinical leaders who have a community of influence amongst their professional groups, and senior managers from the key organisations. They are committed to participating in the decision-making processes of the alliance in a way that is consistent with the principles of the alliance. Service level alliances (SLAs) are established by the ALT as required to design and implement significant service change, and or specific service redesign. They are forums (either time-limited or ongoing) for organising groups of related health services, including decisions on contractual mechanisms and budgets. They involve the relevant health professionals and key managers who are needed to make robust decisions about service expectations, service development and redesign.

Tertiary education
Southern DHB's relationship with the tertiary education sector providers in Southern is discussed in Priority 5 – Enhance system capability and capacity.

DHB Shared Services
DHB Shared Services (DHBSS) delivers services at a national level, and where appropriate, produces work for all DHBs. The overall purpose of DHBSS is to help the DHBs meet their objectives and accountabilities to the Crown.

DHBSS activity is guided by the Health Sector Work Plan agreed between DHBs, as endorsed by DHBs, the Minister and the Ministry of Health, and acts in the interests of DHBs on agreed national issues.

National agencies
Southern DHB is actively engaged in working with the various national health agencies listed in Section 1, and in particular those that have a strong role in shaping the DHB operating context and performance expectations, including:

- The *National Health Board* which is responsible for the funding, planning, and monitoring of DHBs including annual funding and planning processes
- The *Capital Investment Committee* of the NHB which is responsible for a centrally-led process for the national prioritisation and allocation of health capital investment in the health sector and will, in future years, lead the implementation and use of information systems across the health and disability sector. They ensure health sector policy is supported by appropriate health information and IT solutions
- The *Health Quality & Safety Commission* which is responsible for leading and coordinating quality and safety improvement initiatives across public and private sector health and disability providers
- *Health Workforce New Zealand* which has overall responsibility for planning and development of the health workforce to ensure that staffing issues are aligned with planning of delivery of services and that the health workforce is fit for purpose
- The *National Health IT Board* that leads the implementation and use of information systems across the health and disability sector, and ensures health sector policy is supported by appropriate health information and IT solutions
- *PHARMAC* which is responsible for the management of the community pharmaceuticals budget, and whose role has been expanded to include hospital pharmaceuticals and some medical devices.

7.2 Travel and transport

The Southern district is characterised by small communities and large geographic distances. This necessitates a configuration that locates services as close to the communities as possible, but also means significant travel for patients and families to hospital services that must be centralised. The burden of travel must also be balanced between patients and clinicians, for both of whom travel means significant inconvenience and loss of productive time.

The need for travel will be minimised where feasible through increased use of telehealth (eg, for 'virtual' specialist consultations), better co-ordination of scheduling of hospital appointments and investigations for rural patients, and delegation of some follow-up specialised consultations to GPs.

In addition, a Southern patient road and air transport plan will be developed, including identification of planned alternatives for when an ambulance is not available in a rural area, when conditions prevent air travel, and when patient need is less complex and does not require the sophistication of an ambulance.

7.3 Use of information

Health system planning, decision-making and performance improvement must be underpinned by robust information on health needs, resource allocation and use, clinical practice, service utilisation, patient experience, and patient and population outcomes. This information is needed at clinical, managerial and governance levels, and at practitioner, department, locality and district levels.

Leaders in the Southern health system recognise that current data has its limitations, and that a more deliberate approach to development of a culture of capture, reporting and use of timely and accurate data is required.

Specific areas of focus over the next three years will include:

- Review of progress with the Performance Excellence and Quality Improvement Strategy to include consideration of development of a single decision support unit (or 'health intelligence unit') to serve Southern DHB and potentially WellSouth
- Locality analysis and planning will require information about local services, population, and resource use. Locality networks will improve the accuracy and use of data at the local level, with sharing of analytical skills and information across primary, community and specialist services
- A set of key performance indicators will be used to measure overall SSHP implementation, and each headline action will have specific measures and targets.

7.4 Information & communications technology

Southern DHB's information & communications technology (ICT) development is planned on a regional basis through the South Island Alliance. Over the next three years, Southern DHB is giving priority to implementation of systems for:

- *Electronic reconciliation* of medicines on admission and discharge from hospital
- *A regional clinical workstation (CWS) and clinical data repository (CDR)*. The CWS is a web based system accessed via a single sign-on that connects multiple clinical applications and data sources to provide clinicians with secure access to patient data. A CDR is a database of patient identifiable clinical information such as medications, laboratory results, radiology reports, care plans, patient letters and discharge summaries
- *Patient administration* that manages the administrative details of a patient's encounter with a hospital or other DHB service. It supports the management of the resources used to provide patient care such as clinical staff, rooms, beds and equipment
- *National Patient Flow* will create a new national collection that provides a view of wait times, health events and outcomes in a patient's journey through secondary and tertiary care
- *Self-care portals*. These are on-line IT tools that enable individuals to have access to their own health information. When implemented, portals will also allow hospital-based services - in particular ED - to have access to a summary view of primary care patient information. In later phases, it will enable patients to communicate with their primary health practitioners and add information to their health record. General practice patient management systems are also developing patient portals.

Other areas of focus will be promotion of use of telehealth applications to support care in rural areas. This will be highly dependent on access to ultrafast broadband.

7.5 Health literacy

A key factor in improving population and individual health outcomes in Southern will be increased health literacy to encourage healthy lifestyles and self-care. Helping Southern communities to access, process and understand health information will mean people are better prepared to make informed and appropriate health decisions, and therefore better able to manage their own health.

Use of new technologies will be an important contributor, including patient portals; a shared health record; new technologies for monitoring, assessment and treatment; plus web-based access to health education content.

7.6 Communications

The effective flow of information to and from organisations and practitioners in the health system, and the wider community will be essential for the successful implementation of the SSHP. Southern DHB will build on the connections made during Plan development with the aim of strengthening two-way communications to interact more closely with its communities, support transparent and well-informed decision-making, foster collaboration within the Southern heath system and with other agencies, and build shared understanding of the intended future direction. This will be closely linked with other enablers described above, including organisational relationships, use of information and health literacy.

7.7 Implementing the SSHP

This SSHP outlines an ambitious programme of work that Southern DHB considers essential to achieving sustainable services, and improving access and outcomes for the people of the Southern district. Delivering on this SSHP will require a whole of system commitment to the headline actions, and a sense of urgency. Inertia is the greatest threat to the future sustainability of the district's health system.

Translation of the SSHP into action will have the following key dimensions.

Governance

The Southern DHB Board is the decision-maker and 'owner' of the SSHP. Given the extensive nature of the work programme in the SSHP, the Board has a critical role to play in supporting the Executive Leadership Team (ELT) to ensure management and clinician time is focused on delivering on the actions.

The Board will also support further development of the organisational alliances and other partnerships that will be fundamental to the success of the Plan.

Leadership

The Board has delegated implementation of the SSHP to the Chief Executive Officer who in turn will ensure performance accountability across the ELT. ELT will carry a collective accountability for delivery of the Plan, and individual ELT members will be accountable for leading, planning and implementing each of the actions identified in the Plan. Alliance South will also lead and be accountable for actions that are relevant to its focus.

Programme management

The Chief Executive Officer will designate a single ELT member to be accountable for overall SSHP implementation and delivery. The first step will be development of a detailed work programme for each of the strategic priorities. A programme manager will be appointed to co-ordinate and report on progress with SSHP implementation and achievement. Regular dashboard reports will be generated for the ELT and the Board.

Key performance indicators

Key performance indicators will be developed in agreement with the Clinical Council for the ELT and Board to use to monitor progress of implementation and the strategic impact of the SSHP. The timing and quantified targets will be confirmed during the detailed implementation planning stage. Where relevant, specific targets will be set for the Māori and Pacific populations to ensure focus on reducing population health inequalities.

Organisational and system development

Effective implementation of the SSHP will require Southern DHB and its partners in the Southern system to have the capacity and capability to manage both current business and short term imperatives, and the longer term, strategic agenda arising from the SSHP.

Examples of areas for focus during implementation planning will include:

- Bolstering of Southern DHB's decision support resources to ensure a strong analytical function to underpin further planning and action. This capability and capacity could be developed as a shared resource with WellSouth
- Support for the clinical leaders who will be actively engaged in driving service improvement through the Performance Excellence and Quality Improvement Strategy, and in developing and leading the initiatives outlined in the Implementation Roadmap. Support will include skills development, and access to the analysis that will inform the change programme. As noted in the discussion regarding Priority 4, performance improvement will require a whole of system approach, with stronger clinical relationships and working to be developed both horizontally and vertically to facilitate gains in areas such as chronic conditions, elective procedures, acute care, and teaching and learning
- Continued evolution of Southern DHBs' Planning & Funding role towards support for alliancing and integrated care. In this environment, Planning & Funding is moving beyond the traditional arms-length 'purchasing' to work collaboratively with professional and organisational leaders to plan, design and invest in models of care, processes and systems that support improved performance and outcomes. While Planning & Funding's core transactional processes and capabilities are needed to enable implementation, these are increasingly seen as secondary to developing a commonality of purpose with shared leadership. New approaches, skills and relationships will be required in Planning & Funding to contribute effectively in advancing the Southern health system.

Implementation Roadmap

The Roadmap, figure 10, provides an overview of the staging and sequencing of the 'headline actions' for each of the six strategic priorities. Implementation planning will be undertaken for each of the headline actions identified in the roadmap. The sequencing of actions will be strengthened when more detailed implementation planning is undertaken and the linkages and dependencies (and relationship to the enablers) are identified. This implementation planning will inform Southern DHB's annual plan, which will be the key document for Board governance purposes.

Whakataukī - Proverb

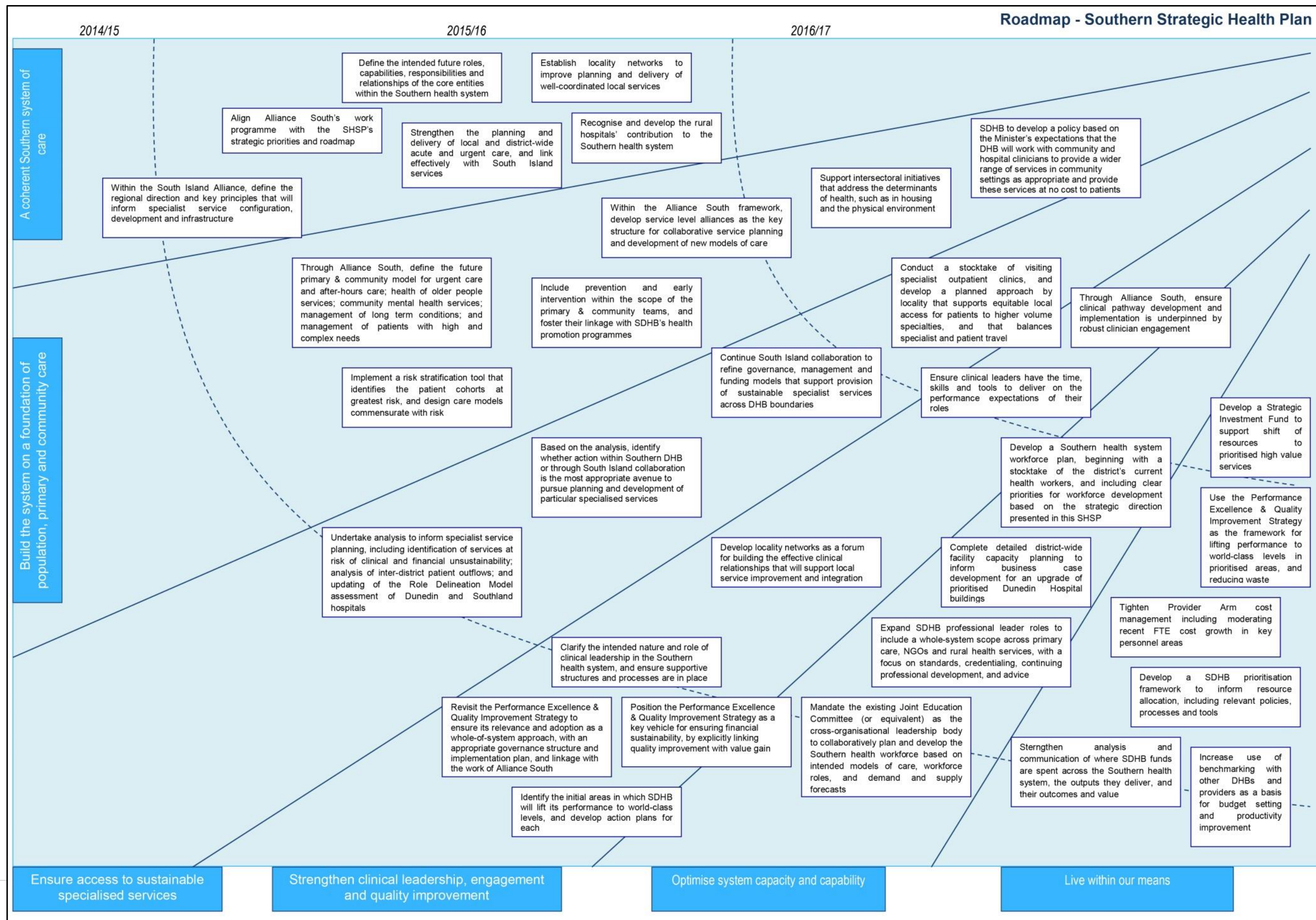
Koutou mā te ihu o te waka hauora e wāwāhi ana ngā ngaru o te moana, kia tau ai te waka ki uta.	The prow of the canoe that cuts through the waves of the sea, so that the canoe may land safely ashore.

Table 9: The Outcomes Framework

Shared vision	*Better health, better lives, Whānau Ora*					
Strategic priorities	Develop a coherent Southern system of care	Build the Southern health system on a foundation of population health, and primary & community care	Secure sustainable access to specialised services	Strengthen clinical leadership, engagement and quality improvement	Enhance system capability and capacity	Live within our means
Goals	Integrate services to ensure patient journeys are smooth through efficient and effective care pathways, and that the system is easy to use for providers	Strengthen population health approaches, and the core role of general practice as the 'health care home' for patients within the primary & community team	Ensure that the Southern population has ongoing access to specialised services that have safe and viable staffing levels and activity volumes to treat complex conditions	Further develop a culture of clinically-led innovation, service planning and performance improvement across the Southern health system	Develop a workforce mix and facility configuration that matches future health needs, and recognise Southern's core role in teaching and learning	Improve the quality of the care and services we deliver using quality improvement principles and methodologies so that waste is substantially reduced, value for money is improved and the savings contribute to bringing our revenue and expenditure into alignment, complemented where necessary, by tight cost management, improved productivity and different resource allocation patterns
Headline actions	1. Define the intended future roles, capabilities, responsibilities and relationships of the core entities within the Southern health system 2. Align Alliance South's work programme with the SSHP's strategic priorities and Roadmap 3. Establish locality networks to improve planning and delivery of well-coordinated local services 4. Strengthen the planning and delivery of local and district-wide acute and urgent care, and link effectively with South Island services 5. Recognise and develop the rural hospitals' contribution to the Southern health system 6. Within the South Island Alliance, define the regional direction, key principles and care models that will inform specialist service configuration, development and infrastructure.	1. Within the Alliance South framework, develop further service level alliance teams as the key structure for collaborative service planning and development of new models of care 2. Through Alliance South, agree the future primary & community model for urgent care and after-hours care; health of older people services; community mental health services; management of long term conditions; and management of patients with high and complex needs 3. Include prevention and early intervention within the scope of the primary & community teams, and foster their linkage with Southern DHB's health promotion programmes 4. Support intersectoral initiatives that address the determinants of health, such as in housing and the physical environment 5. Implement a risk stratification tool that identifies the patient cohorts at greatest risk, and design care models commensurate with risk 6. SDHB to develop a policy based on the Minister's expectations that the DHB will work with community and hospital clinicians to provide a wider range of services in community settings as appropriate and provide these services at no cost to patients 7. Identify and support demonstration sites of agreed models of primary & community care, and spread successful innovation.	1Undertake analysis to inform planning of specialised service, including identification of services at risk of clinical and financial unsustainability; analysis of inter-district patient outflows; and updating of the Role Delineation Model assessment of Dunedin and Southland hospitals 2. Based on the analysis, identify whether action within Southern DHB or through South Island collaboration is the most appropriate avenue to pursue planning and development of particular specialised services 3. Continue South Island collaboration to refine governance, management and funding models that support provision of sustainable specialist services across DHB boundaries 4. Conduct a stocktake of visiting specialist outpatient clinics, and develop a planned approach by locality that supports equitable local access for patients to higher volume specialties, and that balances specialist and patient travel.	1.Clarify the intended nature and role of clinical leadership in the Southern health system, and ensure supportive structures and processes are in place 2. Ensure clinical leaders have the time, skills and tools to deliver on the performance expectations of their roles 3. Revisit the Performance Excellence & Quality Improvement Strategy to ensure its relevance and adoption as a whole-of-system approach, with an appropriate governance structure and implementation plan, and linkage with the work of Alliance South 4. Position the Performance Excellence & Quality Improvement Strategy as a key vehicle for ensuring financial sustainability, by explicitly linking quality improvement with value gain 5. Identify the initial areas in which Southern DHB will lift its performance to world-class levels, and develop action plans for each 6. Develop locality networks as a forum for building the effective clinical relationships that will support local service improvement and integration 7. Through Alliance South, ensure clinical pathway development and implementation is underpinned by robust clinician engagement.	1. Mandate the existing Joint Education Committee (or equivalent) as the cross-organisational leadership body to collaboratively plan and develop the Southern health workforce based on intended models of care, workforce roles, and demand and supply forecasts 2. Develop a Southern health system workforce plan, beginning with a stocktake of the district's current health workers, and including clear priorities for workforce development based on the strategic direction presented in this SSHP 3. Expand Southern DHB professional leader roles to include a whole-system scope across primary care, NGOs and rural health services, with a focus on standards, credentialing, continuing professional development, and advice 4. Complete detailed district-wide facility capacity planning to inform business case development for an upgrade of prioritised Dunedin Hospital buildings.	1. Use the Performance Excellence & Quality Improvement Strategy as the framework for lifting performance to world-class levels in prioritised areas, and reducing waste 2. Strengthen analysis and communication of where Southern DHB funds are spent across the Southern health system, the outputs they deliver, and their outcomes and value 3. Develop a Southern DHB prioritisation framework to inform resource allocation, including relevant policies, processes and tools (incorporating the four-fold aim) 4. Tighten Provider Arm cost management including moderating recent FTE cost growth in key personnel areas 5. Increase use of benchmarking with other DHBs and providers as a basis for budget setting and productivity improvement 6. Develop a Strategic Investment Fund to support shift of resources to prioritised high value services.
Performance measures	A set of comprehensive key performance indicators (KPIs) are being developed in conjunction with the Clinical Council and will be published on the Southern DHB website.					

Enablers	*Strengthening organisational relationships*	- Alliances at South Island and district levels - Iwi Governance Committee to lead action to reduce Māori health inequalities	- Strategic partnership with tertiary education sector - Membership of DHB Shared Services	- Effective working relationships with national agencies
	Better planning of travel and transport	- Balanced impact of travel on specialists and patients - Equitable distribution of visiting specialist clinics	- Increased use of telehealth - Better scheduling of speciali appointments for rural patients	- Delegation of specialist follow-up appointments to GPs - Patient road and air transport plan
	Making better use of information	- Culture of capture, reporting and use of timely and accurate data	- Consideration of a single decision support unit	- Availability and use of information at a locality level
	Investing in ICT	- Southern implementation of South Island systems	- Telehealth applications to support rural care	
	Increasing health literacy	- Use of new technologies to encourage self-care and healthy lifestyles		
	Implementing the SHSP	- Board ownership - Exective leadership	- Programme management - KPIs to track progress	- Organisational and system development - Detailed implementation planning

Figure 10: Implementation Roadmap



Appendix: Plan development

The process for development of the Southern Strategic Health Plan began with preparation of the *Southern Health Profile*, published in March 2014.

Other milestones in SSHP development during 2014 have included:

- Service and financial performance analysis
- Stakeholder interviews (individuals and groups)
- Workshop with Southern DHB's Community & Public Health Advisory Committee (CPHAC) and Board members
- Five workshops on specific topics with clinical and managerial leaders
- Workshop on the overall Plan with a group of Southern district leaders
- Plan drafting
- Public consultation on the draft Plan.

Preparation of the Plan has been overseen by a Steering Group with members comprising:

Who	Organisation
Carole Heatly (Chair)	Chief Executive, Southern DHB
Stephen Graham	Rural/remote GP representative; Board member, WellSouth
David Tulloch	Chief Medical Officer / Southland clinical representative, Southern DHB
Leanne Samuel	Chief Nursing and Midwifery Officer, Southern DHB
Lexie O'Shea	Deputy CE and Executive Director Patient Services, Southern DHB
Sharon Kletchko Sandra Boardman	Executive Director - Planning and Funding, Southern DHB (resigned January 2014) Executive Director - Planning and Funding, Southern DHB (from February 2014)
Marion Poore	Medical Director, Public Health South and Medical Director, Women's Children's and Public Health directorate, Southern DHB
Ray Anton	Chair, Rural Health Services Network
Peter Beirne	Executive Director Finance, Southern DHB
Donovan Clarke Pania Coote	Executive Director, Māori Health, Southern DHB (resigned December 2014) A/Director, Māori Health (from January 2015)
Jim Reid	Primary Care Advisor, Southern DHB
Mike Hunter	Otago clinical representative, (Southern DHB and Otago University)
Steve Addison	Executive Director - Communications, Southern DHB

Plan development was co-ordinated by Dr Pim Allen of Southern DHB, supported by Health Partners Consulting Group.

Glossary

Alliance South	The Alliance Agreement between Southern DHB and WellSouth provides the foundation for an integrated system approach to the design and delivery of health services in the Southern district. Alliance South is the leadership and decision-making structure that provides oversight and coordination of the joint work programme. Its focus is on transformational change to develop a better integrated, more connected Southern health system with models of primary, community and secondary care that support better health for people and communities. A number of other provider groups are now represented within Alliance South and its service level alliance teams. Following decisions made by Alliance South, implementation is progressed through Southern DHB's contracts with providers.
Ambulatory sensitive hospitalisations (ASH)	Ambulatory sensitive hospitalisations (ASH) are mostly acute admissions that are considered potentially avoidable through preventive or therapeutic interventions deliverable in a primary care setting.
Average length of stay (ALOS)	Duration of a single episode of hospitalisation. Inpatient days are calculated by subtracting day of admission from day of discharge.
Capital Investment Committee (CIC)	The CIC is responsible for a centrally-led process for the national prioritisation and allocation of health capital investment in the New Zealand public health sector. The Committee's primary objective is driving better investment decisions in the health system through planning and prioritisation of capital funding, along with advising on investment and infrastructure matters to support the government's service planning direction.
Determinants of health	The multitude of different factors that determine a person's health. This means that people living in the same community, or people of the same age, can have vastly different chances of good health. Factors such as where we live, the state of our environment, genetics, our income and education level, and our relationships with friends and family all have considerable impacts on health, whereas the more commonly considered factors such as access and use of health services often have less of an impact.
Estimated resident population	An estimate of all people who usually live in New Zealand at a given date. This estimate *includes* all residents present in New Zealand and counted by the census (census usually resident population count), residents who are temporarily overseas (who are not included in the census), and an adjustment for residents missed or counted more than once by the census (net census undercount). Visitors from overseas are *excluded*. The estimated resident population at a given date after a census also *includes* an update for births, deaths and net migration (arrivals less departures) of residents during the period between census night and the given date.
Health localities	Geographic groupings in Southern district that are broadly based on local government areas but that have been adjusted to be consistent with current patient flows to health services. Eight localities have been identified for Southern: Waitaki, Dunedin, Clutha, Gore, Invercargill, Southland, Queenstown and Central.

Health Quality and Safety Commission (HQSC)	The Commission is a national agency responsible for: • providing advice to the Minister of Health on how quality and safety in health and disability support services may be improved • leading and coordinating improvements in safety and quality in health care • identifying key health and safety indicators (such as events resulting in injury or death) to inform and monitor improvements in safety and quality • reporting publicly on safety and quality, including performance against national indicators • sharing knowledge about and advocating for safety and quality.
Health Workforce New Zealand (HWNZ)	HWNZ has overall responsibility for planning and development of New Zealand's health workforce, ensuring that staffing issues are aligned with planning on delivery of services and that workforce is fit for purpose. HWNZ is directed by an independent board comprising senior clinicians and health sector leaders, appointed by and reporting to the Minister of Health.
Incidence	A measure of the probability of occurrence of a given medical condition in a population within a specified period of time.
Inter-district flows	Southern DHB is funded to provide care to all its residents. When a Southern DHB resident receives care outside the Southern district, this event is called an Inter-district Flow (or IDF). Southern DHB pays other DHBs for the services they provide to our residents at standard national prices. IDFs includes the complex treatment we don't provide in our hospitals, and health care provided when people are away from home (eg, commuters; holiday-makers going to ED or visiting a GP and collecting prescriptions outside our boundaries. Southern DHB also receives IDF payments for other residents of DHBs treated in Southern.
Locality network	A group of practitioners in a locality who work together to improve health services for the population they serve, through collaborative planning and action.
National Health Board (NHB)	The NHB is appointed by the Minister, and is supported by a dedicated business unit within the Ministry of Health. The NHB is responsible for overseeing the NHB business unit's work programme, which includes: • funding, monitoring and planning of DHBs, including annual planning and funding rounds • the planning and funding of designated national services • oversight of DHB regional service planning and arbitration over regional disputes • stronger alignment of service, capital and capacity planning • strengthening and accelerating the linkages between IT, workforce and facilities capacity investment • supporting the government initiative to reduce bureaucracy.
National Health Committee (NHC)	The NHC provides the Minister with independent advice on a broad spectrum of health and disability issues, and is explicitly responsible for providing advice on the kinds, and relative priorities, of public health services that should be publicly funded. Its current focus is strengthening the prioritisation of new and existing technologies and interventions, to provide the New Zealand people and the health sector with greater value for the money invested in health.
National Health IT Board (NHITB)	The NHITB provides strategic leadership on the implementation and use of information and information technology systems across the sector, and ensures IT strategy is reflected in capital allocation and capacity planning.
Planning and funding	A DHB function that concerns determining population health needs, setting priorities, allocate resources, contracting with service providers to achieve the best possible outcomes, and monitoring provider performance. The DHB's Planning and Funding team also leads service planning, and manages the implementation of national, regional and local health strategies.

Primary health care	Primary health care relates to the professional care provided in the community, usually from a general practitioner (GP), practice nurse, community nurse, pharmacist or other health professional working within a general practice or community setting. Primary health care covers a broad range of health services, including diagnosis and treatment, health education, counselling, disease prevention and screening. A strong primary health care system is seen as central to improving the health of all New Zealanders and reducing health inequalities between different groups.
Primary Options for Acute Care (POAC)	POAC is a service providing health professionals access to additional investigations, care or treatment for their patient, where the patient can be safely managed in the community and as an alternative to referral and/or admission to a hospital. The POAC programme has been active in a number of DHB areas for more than a decade, and has proven effective in avoiding unnecessary hospitalisations.
Prevalence	The proportion of a population found to have a condition (typically a disease such as diabetes, or a risk factor such as smoking). It is arrived at by comparing the number of people found to have the condition with the total number of people studied.
Primary Response in Medical Emergency (PRIME)	The PRIME (Primary Response in Medical Emergency) scheme aims to ensure high quality access to pre-hospital emergency treatment in areas where there is a shortage of Advanced Life Saving (ALS) paramedics. PRIME is provided by specially trained GPs and practice nurses who assist ambulance services. It is a 24-hour a day, seven-day a week service with PRIME providers on an on-call roster.
Provider Arm	The division of a DHB that is responsible for delivery of health and support services. Southern DHB's Provider Arm is responsible for managing hospital, mental health and rehabilitation services based at Southland Hospital in Invercargill, Lakes District Hospital in Queenstown and Wakari and Dunedin Hospitals in Dunedin, and community nursing and allied health services throughout the district.
Region	New Zealand has four health regions – three in the North Island (Northern, Midland and Central), and one in the South (South Island). The regions provide a forum for collaborative DHB service and capacity planning.
Role delineation model (RDM)	The role delination model describes the clinical support services, staff profile, minimum safety standards and other requirements to ensure that hospital clinical services are provided safely and appropriately supported. The RDM describes five levels of care complexity and resource use.
Standardised discharge rate (SDR)	The level of certain hospital procedures provided to people in a DHB area compared to DHBs in other parts of New Zealand. Standardisation takes into account the particular sex, age, ethnicity and social deprivation mix of the DHB's population, and allows a 'like with like' comparison. The SDR measures the intervention rate – this does not necessarily indicate what the right rate might be, but compares individual DHBs with each other, taking DHB population demographics into account.
Secondary care services	Services provided by medical specialists and other health professionals who generally do not have first contact with patients. This includes acute care provided for a short period of time for a brief but serious illness, injury or other health condition. Most but not all DHB-funded secondary care services are provided on a hospital campus, and provided by the DHB's Provider Arm.
Service level alliance team (SLAT)	The work of an alliance (such as Alliance South) is generally undertaken by specially convened service level alliance teams (SLATS), which can have either an ongoing or fixed term role. Membership is from Southern DHB, and relevant provider organisations. They are clinically led expert teams looking at specific services areas, responsible for considering possible service delivery alternatives and innovations for patients and populations.

South Island Alliance	The South Island Alliance enables the region's five DHBs to work collaboratively to develop more innovative and efficient health services than could be achieved independently. By using our combined resources to jointly solve problems, we are better positioned to respond to changes in the technology and demographics that will have a significant impact on the health sector in the coming years.
South Island trauma network	A SLAT within the South Island Alliance that works together to ensure that seriously injured patients from around the region get to the best trauma services that can be provided in the South Island as quickly as possible.
Strategic Investment Fund	When its finances allow, Southern DHB will create a Strategic Investment Fund to shift resources to prioritised services and models of care, with an emphasis on supporting cost-effective delivery in community settings in line with the future direction described in the SSHP. The Fund will also provide short-term transitional support where a change is being made to an existing model of care that enables it to be more productive in the future.
Subregion	A smaller grouping of DHBs than exists at the regional level, who work together to address specific service issues of common interest.
Sustainability	A sustainable health system can provide ongoing access for a district's resident population (and visitors to the district) to safe, effective and efficient services. Sustainability also requires the capability to anticipate and respond to a changing operating environment, and to contribute to the wider wellbeing of communities.
Very low cost access (VCLA) general practice	The Very Low Cost Access (VLCA) scheme supports general practices with an enrolled population of 50% or more high needs patients, where the practice agrees to maintain patient fees at a low level. VLCA payments provide: • extra funding in return for general practices agreeing to maintain fees within the fees thresholds • recognition of the extra effort involved in providing services to high need populations, and keeping fees low for the people who can least afford primary health care and improving health outcomes for those most likely to have the worst health.