

# Executive Summary

# Project Scope and Objectives

Links to Section 1

## Project Objectives

Over the last seven months MidCentral Health has developed a comprehensive Clinical Service Plan (CSP) to provide a strategic framework that identifies the clinical services and models of care that will be needed to meet the future demand of the population of the MidCentral District. The CSP focuses on those clinical services that MidCentral Health has responsibility for delivering in hospital, community and home based settings. The CSP is developed for MidCentral Health and is aligned to the broader context and vision for MidCentral District Health Board (DHB). The CSP will be the foundation document for future service development and site development justifications for the next five to ten years. The CSP will assist MidCentral Health to plan for an appropriate clinical capacity to meet the expected demand for clinical services. It will also underpin the medium term funding plan for secondary services.

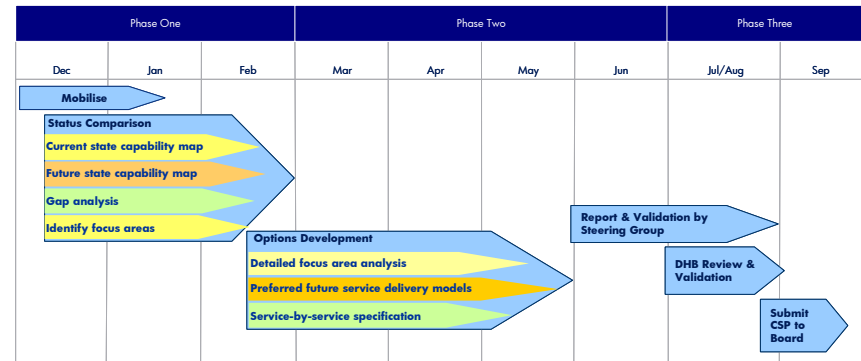
## CSP – An Evolving Plan

In developing the CSP, the project team was cognisant that the health context is constantly changing and that MidCentral Health will need to continually adapt to changes. To manage this change, the project focussed on utilising the best available information to develop a CSP that is sufficiently robust to assist MidCentral Health to plan for the future, with a focus on the next 5 to 10 years. It also identifies areas where further analysis and/or discussions are needed before final decisions can be made.

The CSP should therefore be viewed as a foundation document rather than a final document. It provides a roadmap that will need to be revised and added to over time. The frameworks and principles that were used to shape and test the thinking presented in this CSP have been documented so that they can be used to evaluate other proposals for changes to service delivery.

## Approach

An iterative approach was adopted to development of the CSP. This allowed an initial wide scan of current state and future issues to be undertaken before identifying those areas where more detailed analysis was required.



The project team sought to build a comprehensive understanding of the current position and future demands for clinical services in MidCentral and a high level of commitment to the CSP's proposed future direction through:

- Interviews with over 130 participants conducted with MidCentral DHB, primary health care providers, neighbouring DHBs, and expert advisors
- Workshops and focus groups held with key participants to validate the current state and to inform the development of the future vision and plan
- Research on international and national models of care and trends in clinical practice
- A review of over 100 documents

## CSP Document

The key CSP findings and recommendations are outlined in this document. The initial sections provide background on the current state and strategic context. The CSP planning environment is then discussed prior to presenting an overview of the CSP vision for MidCentral Health and a summary of the key impacts on models of care, workforce, information technology and facilities. The document is supported by appendices that provide additional information on clinical services and facility requirements. These in turn are supported by technical appendices and more detailed clinical service profiles.

# Strategic Context

Links to Section 2

## Strategic Context of MidCentral DHB

MidCentral DHB has undertaken a significant amount of work to shape its vision and strategic direction for the future. MidCentral DHB has defined its vision as:

### 'quality living – healthy lives'

It has identified key priority areas to focus on:

<b>Health Needs</b>	Cardiovascular Disease Mental Health Cancer Diabetes Respiratory Disease Oral Health
<b>People</b>	Maori Health Child Health Elder Health Rural Health
<b>Health &amp; Disability</b>	Promotion & prevention Early detection & intervention Diagnosis & treatment Support & rehabilitation Palliative care Research & surveillance

In line with the DHB's vision, it has embarked on several initiatives to support the capability in the primary health care sector. A key initiative is the chronic disease management for Diabetes, Cardiovascular Disease and Respiratory Disease, which is a collaborative effort between MidCentral DHB, MidCentral Health, Compass Health and the 4 PHOs to train primary care nurses to 'proficient' level.

The CSP has built on this strategic vision and initiatives such as chronic disease management to ensure the future delivery of specialist disability and community services and secondary health services is aligned to the strategic context of the DHB.

## MidCentral Health Overview

MidCentral Health services a wide geographical area. It provides a comprehensive range of specialist health and disability services for the MidCentral District as well as part of the populations of its neighbouring DHBs. Its tertiary Regional Cancer Treatment Services (RCTS) provides for its own population and the populations of 5 other DHBs in the central North Island. While many personal health services are provided in a hospital setting, MidCentral Health also plays a key role in providing specialist health and disability services in outpatient, community and home based settings.

MidCentral Health's' vision is:

### 'Delivering people focussed quality specialist health and disability services'

When compared to the national average, the MidCentral population has a comparatively high proportion of people who live in rural areas (28%) and more older people aged 65+ years. The areas of Otaki and Horowhenua are characterised by higher proportions of Maori and socioeconomic deprivation. Maori comprise approximately 15% of MidCentral's population, which is in line with the national average of 14%.

Analysis of the key health needs in MidCentral indicate that:

- The morbidity and mortality rates in MidCentral are generally the same as, or better than, the rates for New Zealand, except for Ischaemic Heart Disease and Breast Cancer where mortality is higher
- The higher mortality rates for Ischaemic Heart Disease and Breast Cancer contribute to a lower life expectancy in MidCentral when compared to the national average
- Maori living in MidCentral have better health status than their national counterparts, but poorer than MidCentral non-Maori

# Service Delivery Challenges

## MidCentral Health Challenges

Future delivery of health services in MidCentral Health will be challenged by:

- The comparatively high proportion of population aged 65+ years and the high growth projected in this age group
- The burden of chronic diseases which is likely to continue to increase
- Pockets of disparities in health and socioeconomic status across the district
- The increasing pressure arising from needing to strike an appropriate balance between delivering services which are clinically and financially viable whilst providing appropriate access for local populations
- Critical workforce shortages combined with the increased specialisation of the available workforce, and the credentialing and training requirements
- The need to manage a 'hump' in demand arising from the increasing prevalence of chronic and life style related diseases. Initiatives have been put in place to reduce demand in the longer term but these efforts are not expected to reduce demand within the next 5 – 10 years

These challenges will impact how MidCentral delivers services within its own region. Increasingly, it will also challenge the way Whanganui, Wairarapa and MidCentral DHBs work together to provide consistent and sustainable services across the region.

The broader environmental context will also present challenges for MidCentral Health. Consumers are becoming increasingly informed and their expectations regarding service delivery are rising. There is likely to be limited growth in expenditure and MidCentral's share of any additional funding will be relatively less due to slow population growth.

In addition, as regional service delivery models develop further to address clinical viability and recruitment issues, MidCentral Health is likely to play a greater role in regional service delivery.

## Model of Care Issues

Key model of care issues that will challenge MidCentral Health include:

- Limited capacity in some MidCentral Health services to accommodate additional volume growth. For example:
  - Medical inpatient services are at capacity and currently manage outlier patients on a daily basis which impacts capacity in other services, particularly surgical services
  - The RCTS day unit and inpatient ward are at capacity at peak times
  - The current rehabilitation and elder health models of care need to be re-positioned to meet significant future growth in demand
- Processes do not always maximise the use of scarce resource such as facilities and specialist clinicians
- The patient journey:
  - Within MidCentral Health consists of multiple pathways and patient handovers which may lead to extended length of stays
  - Between MidCentral Health and primary health care is often not jointly planned and limited information is shared which may lead to fragmented care
- The silo structure of clinical services does not provide a seamless continuum to meet the needs of some patients
- Secondary services provide limited support to primary health care providers. In the future it will be important for primary health care providers to be better positioned and supported to effectively manage significant population health issues
- Services need to be accessible, and clinically and financially viable. This means:
  - More specialist clinics are needed in outlying areas, where it makes sense to do so
  - The new Horowhenua facility needs to be utilised effectively to ensure clinical and financial viability
  - A strategic regional service delivery approach is needed with Whanganui and Wairarapa DHBs

# Service Delivery Challenges

Links to Section 3



The key workforce, facility and technology issues that will need to be addressed to ensure these resources are appropriately aligned to the models of care and projected increases in demand are outlined below.

**Workforce Issues:** Current and future workforce issues include:

- Critical workforce shortages due to the ageing workforce
- The ongoing challenge of recruiting and retaining a specialist workforce
- The increasing specialisation of the clinical workforce, and the credentialing requirements of the medical workforce
- Achieving an appropriate balance between specialist and generalist expertise that is effective in meeting the needs of the population
- Developing a workforce that can effectively deliver services to Maori
- Utilising scarce resources effectively across the health sector, and across the district and the region
- Exploring more collaborative and partnership based service delivery models which will need to be supported by different working arrangements
- The continuing investment into the professional development of the workforce
- Ensuring that there is an adequate workforce to meet roster commitments. This is a particular issue for the Horowhenua Health Centre

**Facility Issues:** Current and future facility issues include:

- ED facility is often at full capacity due to lack of alternative mechanisms to better manage patients who are referred by GPs, only require a short stay or are waiting for an inpatient bed
- Medicine has insufficient inpatient beds and significant patient outliers in other wards
- The surgical pre-admission, recovery, DoSA and Short Stay units do not have sufficient capacity and do not support effective patient flows
- The ambulatory care facility is not fit for purpose for some services and does not support an efficient and effective patient flow
- Options to expand the use of RCTS day stay facilities need to be explored as the current utilisation of the inpatient ward is nearing capacity and increasingly cancer patients are outliers on other wards
- High acuity patients are managed across multiple locations in Palmerston North Hospital. The concept of developing a hot floor to better cater for these patients should be explored

**Technology Issues:** Current and future IT issues include:

- The lack of capability to electronically share patient information between MidCentral Health services and between MidCentral Health and primary health care providers contributes to fragmented patient care and duplicated information gathering and recording
- Multiple systems which are not integrated, do not support a single patient view and do not provide timely access to patient information
- A legacy Patient Administration System (PAS) that is likely to require replacement before many of the current IT challenges can be resolved
- An inability to meet clinical audit requirements
- Limited ability to effectively support administrative processes and workflow such as nurse roster planning and bed management
- The IT infrastructure is unlikely to be sufficiently robust to support changing work practices with particular issues likely to include, storage capacity, disaster recovery, networks, desktops, mobility and remote access.

# How Will We Look in 10 Years?

Links to Section 3

Based on this context the CSP maps out a vision for the future that will position MidCentral Health to meet the needs of its population.

## Our Population

- Our population is growing slowly at around 500-600 people a year, but there is disproportionate growth in the older population. In ten years time nearly 20% of our population will be aged over 65 years.
- People will be less likely to smoke, but they will have higher levels of obesity and will suffer more from life style related diseases. Life expectancy will have improved.
- While more people will have chronic health conditions, the most complex patients will have a case manager to help plan and coordinate their care. There will be a strong focus on being supported to self-care, and more people will manage their chronic health conditions at home using telemedicine capability to capture and transmit their vital signs to their case manager
- Most of the population will be e-connected and will use the internet as their first information source for health problems. Direct telephone advice with a clinician will also support self-care and early identification of health problems
- Our population will have:
  - Greater expectations about the services that should be provided, and will be engaged to help shape their way services are provided
  - Strong relationships with their primary health care providers who will play a key role in meeting many of their health needs
  - Confidence that all care will be of a consistently high quality regardless of where it is provided and that access to services will be in line with national rates and timeframes
- Those who use our hospital services will say that when they entered hospital they only had to provide their basic details once, their plan of care and discharge was planned with them soon after admission, and that staff worked closely with them to show them how to manage their own conditions and/or disability

## MidCentral Health – Our Role

- MidCentral Health will provide strong clinical leadership through a focus on building a culture of learning and excellence in service delivery, and will actively share this culture with our partners across the district and across the region.
- We will play a key role in delivering specialist health and disability services and co-ordinating secondary and tertiary care for our population, providing 90% of services locally. We will not be working in isolation but rather as part of a wide network of health service providers (including tertiary providers, other DHBs, primary health care providers etc)
- Our core role will be to deliver services for complex, chronic and acutely ill patients and for those who meet the thresholds for elective services. Non urgent work will be undertaken where we have sufficient resource to do so or where there is a strong public health imperative to do so
- Only the most complex and acutely ill patients and those undergoing elective surgery will be admitted as inpatients. Our specialists will work across all care settings and follow patients as they move between care settings. Our organisational breadth will allow us to do this effectively
- We will be renowned for the excellent quality of our care and for our innovative approaches to service delivery that use our limited resources effectively

## Our Resources

- Changing models of care will have led us to:
  - A workforce which is multi skilled and flexible
  - Specialists who do the work that only they can do
  - Case management and multidisciplinary teams for complex patients
  - Specialist nurses in specific specialities
  - Different workforce mixes on inpatient wards
  - Collaborative and partnership based working arrangements with other providers including sharing scarce resources between providers
- Our Information Technology will have strong foundation systems, and the clinical services will be supported by bed and other management systems, service specific systems such as PACS/RIS. Our workforce will use the IT systems effectively, and we will increasingly utilise telemedicine to widen the reach of specialist care in our district and in our region
- The first stages of the Palmerston North Hospital site redevelopment will have been completed, and will enable more effective care of patients through new facilities such as an Acute Assessment Unit, a Hot Floor, and a Day Procedure Unit. The ambulatory care environment will be fit for purpose and the wards will be refurbished to provide an environment which supports rehabilitation

# How Will We Look in 10 Years?

Links to Section 3

## MidCentral Health – Our Service Delivery Approach

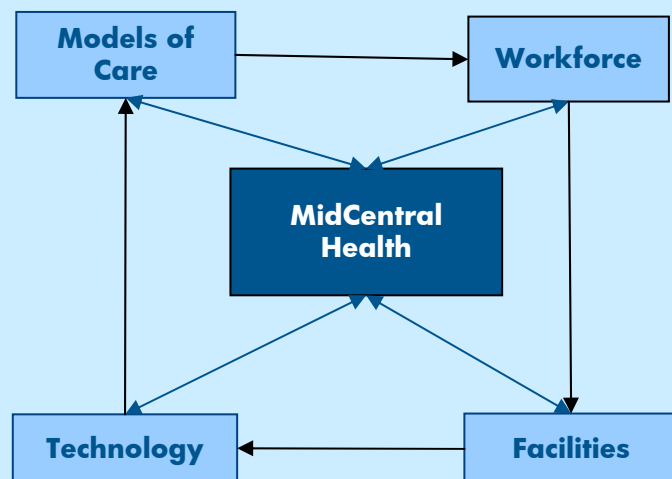
- Our care will be based around the Maori principles of participation in care, and our services will include the patient and people with disabilities, and their family/whanau in the planning of care to support independence and sustainable health gains
- Our models of care will be based around the patient rather than the clinician or facilities. Patients with:
  - Common categories of conditions will be managed along predefined pathways, supported where appropriate by a 'one stop shop' which provides diagnostic, assessment and treatment in 1 to 2 visits
  - Complex conditions will be managed by a 'case manager' who liaises with the multidisciplinary team to plan the patient's care across the continuum of care
- Increasingly we will provide services in outpatient, community and home based settings. Growth in these areas will exceed growth in inpatient services. Having access to this continuum will enable us to manage within a complement of 400 to 420 beds but the acuity of patients in these beds will be significantly higher than it was 10 years ago
- Our care pathways will be tailored to ensure the specific needs of our acute and elective patients within Palmerston North Hospital are appropriately met. Critical to our success will be:
  - Effective front door management for primary care referred patients and self referrals
  - A streamlined patient journey for surgical and day procedure patients
  - In-reach to embed a culture of rehabilitation, elder health, palliative care and management of chronic diseases across inpatient services
  - Out-reach to support closer working relationships between specialist services and primary health care providers.
  - Effective discharge planning, including integration with primary health care providers to assist in the planning of treatment and discharge
  - A culture of continual scrutiny of processes to identify where bottlenecks occur and to correct these bottlenecks to ensure services are well run and effective
- Our clinical support services will have sufficient resource to manage the cumulative growth in the clinical services
- We will be a strong regional provider of services. Areas most likely to be developed first include Women's, Health, Child Health and Surgical Services
- Diagnostic services will be provided on a regional basis with timely and secure access to results

## Our Partners

- A vibrant primary health care community will be playing a pivotal role in providing a robust range of primary, and increasingly, some specialist services. Where appropriate, our staff will work alongside their primary health care colleagues in community settings. A core group of GPs and other primary care practitioners will have developed competencies in areas of interest such as mental health
- Stronger partnerships will be developed with primary health care providers in key areas such as mental health, rest homes, hospice and rehabilitation services etc, to provide residential and home based care which is supported by strong clinical governance
- A strong network of private specialists will be working in the region and open dialogue between MidCentral Health and the private specialists and providers will support:
  - Meeting the credentialing requirements for the specialist workforce
  - Recruitment initiatives
  - Planned provision of some publicly funded services in private facilities where it is appropriate to do so
- We will have a Regional CSP in place. Together with our neighbouring DHBs we will deliver some services on a regional basis to support clinical and financial viability. We will have robust clinical governance in place and our respective workforces will be aligned to deliver services which are provided locally where it is viable to do so, and regionally where it is clinically beneficial for the region's population.
- Our RCTS partners will have dedicated physicians and other health professions to provide treatment for cancer patients in their local area, where it is possible to do so. We will all use common treatment pathways for the main types of cancer, and our partners will receive timely support as needed
- The Regional Cancer Network will ensure that cancer services are effectively delivered across the cancer continuum and that major asset decisions take into account region wide requirements
- We will have strong working relationships with our tertiary providers to support the training and credentialing for specialist staff, and to ensure the sustainable delivery of tertiary services within the region

# Key Directions

To achieve this vision MidCentral Health will need to find innovative ways to deliver services differently, being cognisant of the resource constraints and the broader context within which it operates. It will need to introduce changes to the four core components described below.



## Models of Care

MidCentral Health will progressively adopt more patient centred models of care that will make a long term difference in the health status and independence of its population. It will not do this in isolation but rather as part of an integrated network of providers that are working seamlessly across care settings and geographical boundaries. Proposed changes include:

- Adopting a district wide service delivery model for health and disability services with specialist support increasingly being provided in settings outside the hospital
- Encouraging patients, their care givers and their whanau to actively participate in the planning of their care and where appropriate support them to self manage their care and maximise their independence

- Streamlining the patient journey by building on current practice to ensure we have in place:
  - Preferred pathways for common categories of patients, with different pathways for acute and elective patients
  - Pathways for acute patients that will be supported by new mechanisms at the front door. The Acute Assessment Unit concept is proposed to support streamlined transfer of care for patients who are referred from primary health care providers, to avoid unnecessary admission and to provide for planned episodic care for case managed patients.
  - Pathways for elective patients that will be supported by discharge planning at the earliest contact with elective services, and will be characterised by pathways which are widely understood and followed to manage the common categories of patients. The Day Procedure Concept is proposed to support same-day admission and discharge for patients from a range of specialities including surgical, medical and other sub-specialities.
  - One-stop shop services will also be considered to limit the number of times and locations that a patient needs to visit for outpatients or elective procedures.
- Planning treatment and discharge early, and embedding a culture of rehabilitation and elder health across inpatient services
- Case management of patients with chronic conditions across the continuum of care in collaboration with primary health care providers
- Strengthening the Multidisciplinary Team (MDT) approach in key areas such as Cancer and Surgical Services to support care of the patient and to coordinate care between providers.
- Developing further the concept of regional service delivery with Whanganui and Wairarapa DHBs to ensure the clinical and financial viability of services
- Strengthening the Specialist Community Services to ensure there is sufficient capacity and flexibility to meet changing demands
- Continually scrutinising processes to identify and address bottlenecks to better support streamlined processes and patient flows

# Key Findings

Links to Section 4

## Workforce

MidCentral Health will need to redraft the Workforce Strategy and review the way the workforce is utilised to effectively manage the predicted shortages in key areas and to ensure there is an appropriately trained and credentialed workforce. Key proposed changes include:

- Aligning the workforce to new models of care and changing demand
- Building strong competencies to effectively deliver services for Maori
- Exploring different ways to develop a flexible workforce, by up-skilling in key areas and to share scarce resources between primary and secondary health care providers and across DHB boundaries
- Including the full spectrum of clinical support, therapy and administrative staff in any proposals for service development

## Information Technology

Information technology will be a key enabler of change for MidCentral Health. It will be important moving forward to review its Information System Strategic Plan (ISSP) to ensure that proposed technology initiatives are aligned with and progressively support the changing models of care.

It is important the future information environment provides value for money for MidCentral Health and supports the following capabilities across all care settings from self care in the community through to tertiary level care to provide:

- Collection of clinically appropriate information at the point of care
- Collation of clinically relevant outcome information at the point of need
- Patients, their care givers and their whanau with access to their records to assist with promoting participation in the planning and delivery of their care
- Clinicians with access to the right information, at the right time, securely to support decision making and effective patient management
- Clinical audit capability to support evidenced based learning and decision making

## Information Technology Cont'd

To achieve this vision there are three key application components (The Digital Hospital, Integrated Patient Continuum, and Workflow and Operational Management) that MidCentral Health will need to consider to develop a robust, connected information environment.

The proposed IT work programme is highly ambitious but is critically important to the successful implementation of the CSP. Significant investment will be required in infrastructure, applications and implementation support. There will also need to be a high level of engagement from MidCentral Health staff to ensure that the IT environment aligns with and support work practices and that staff have the confidence to use the systems effectively once they are implemented.

## Facilities

MidCentral Health will also need to invest in its facilities to ensure there is sufficient capacity to meet the demand projected from demographic changes and diseases trends and to ensure that the facilities support the implementation of new models of care. A site master plan and prioritised capital investment plan need to be developed to incorporate the findings of the CSP. Key proposals for Palmerston North Hospital include:

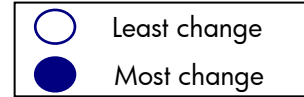
- Continuing plans to replace the Linear Accelerator and Bunker
- Configuring an Acute Assessment Unit co-located with the ED, and increasing the footprint of the ED
- Establishing a 'hot floor' concept co-locating theatres with an ICU and HDU
- Configuring a Day Procedure Unit for radiology, medical, surgical and other patients
- Ensuring that the ambulatory care/outpatient environment will support the increasing patient volumes expected across all specialties
- Aligning the cancer day unit to meet increasing ambulatory volumes



# Where the key changes are needed for services

Links to Section 4

Key



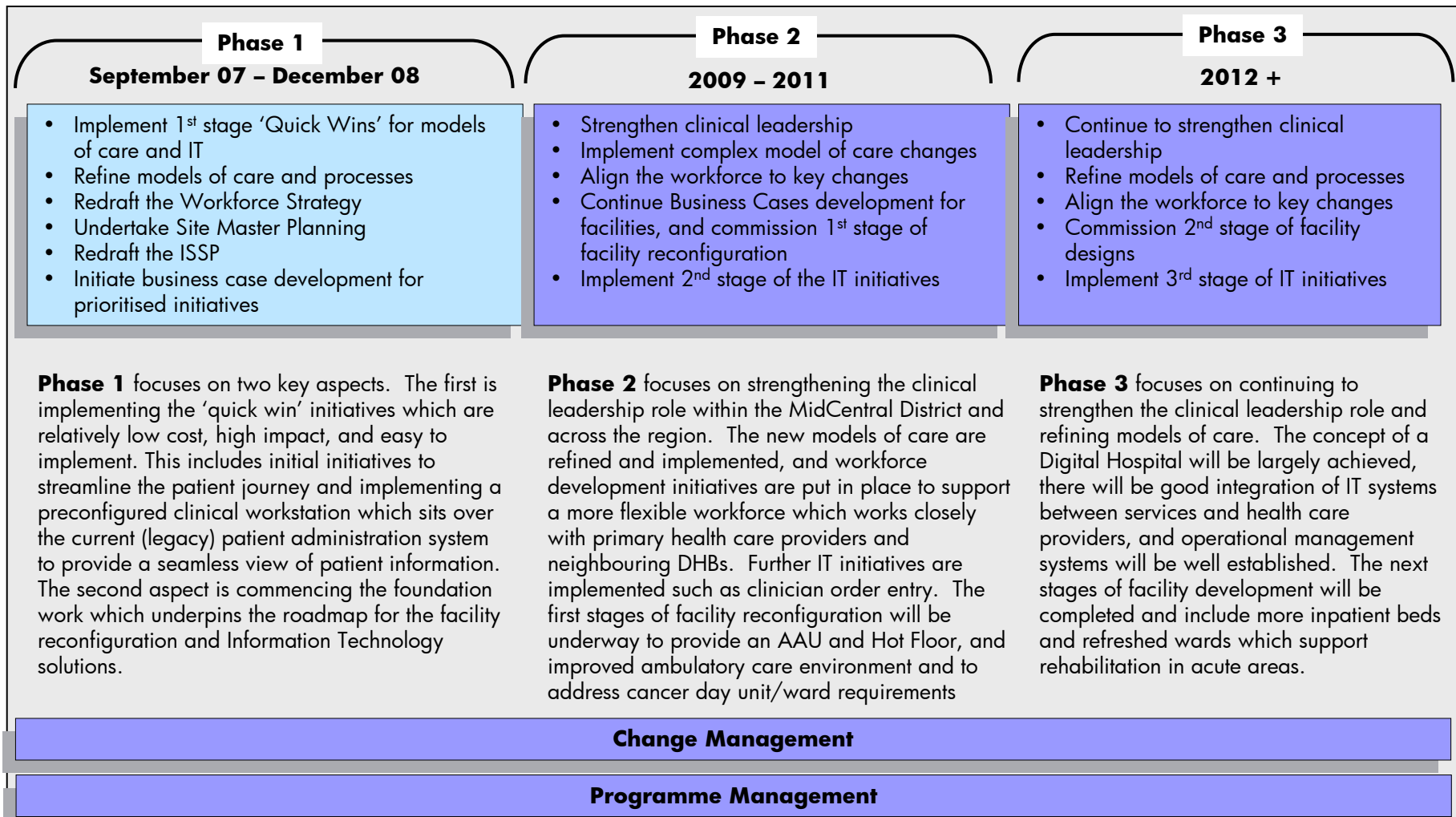
The CSP maps out an overall direction for MidCentral Health for the next 5-10 years and beyond. Considerable work has been undertaken at a clinical service level to ensure that service specific issues have been taken into account in shaping the CSP and that the impact of adopting the CSP for specific services is well understood. A high level snapshot has been prepared which summarises where the greatest and least change is likely to be required across a number of dimensions for one clinical service relative to other clinical services.

		ED	ICU	Clinical Support	Medicine	Surgery	RCTS	Child Health	Women's Health	Mental Health	Rehabilitation	Elder Health	Community	Therapies	Public Health	Dental Health
<b>Pressure points</b>	Demand – Demographic	◐	◐	◐	●	◐	◐	○	◐	◐	◐	●	◐	◐	○	○
	Disease Trends	◐	◐	◐	◐	◐	◐	○	○	◐	○	◐	○	○	○	○
	Service Delivery	◐	◐	◐	◐	◐	◐	◐	◐	◐	◐	◐	◐	◐	◐	◐
	Maori Health	◐	○	○	◐	◐	◐	◐	◐	◐	◐	◐	◐	◐	◐	◐
<b>Where change is needed</b>	Models of Care	◐	◐	◐	●	◐	◐	◐	◐	●	◐	◐	◐	◐	◐	◐
	Workforce	◐	◐	◐	◐	◐	◐	◐	◐	◐	◐	◐	◐	◐	○	◐
	IT	◐	◐	◐	◐	◐	◐	◐	◐	◐	◐	◐	◐	◐	◐	◐
	Facilities	◐	◐	◐	●	◐	◐	◐	○	◐	◐	◐	○	○	◐	◐
<b>Other pressure points</b>	Whanganui / Wairarapa	◐	◐	◐	◐	●	○	●	●	○	○	○	○	◐	○	○
	Other regional delivery change	○	◐	◐	◐	◐	◐	○	◐	○	○	○	○	○	◐	○
	Policy Change	○	○	○	○	◐	○	○	○	◐	○	○	◐	◐	◐	●

# Roadmap

Links to Section 5

An indicative implementation roadmap has been developed for key initiatives in the CSP. In the road map there are three phases of activity, with proposed timeframes for implementation. Across all phases of work are supporting functions such as strong change management and programme management to ensure the implementation of the initiatives is aligned. Each phase of work builds on previous work and takes an iterative approach to align the models of care with the workforce, IT and facilities developments. Given the constrained funding environment that MidCentral Health is operating in, a review of this roadmap will be needed to prioritise initiatives and agree the implementation timeframe.



# Proposed Next Steps

Links to Section 5

## The Way Forward

The Implementation Roadmap outlines a number of specific initiatives that have been identified which are designed to provide a solid foundation to meet the vision for the future and to address the key issues within the current operating environment. In developing the implementation roadmap a number of prioritisation principles have been adopted. These principles ensure the proposed initiatives:

- Effectively improve patient outcomes
- Provide appropriate access to services
- Are clinically and financially sound
- Are aligned to the vision and direction of MidCentral DHB as outlined in its District Annual Plan and District Strategic Plans

The progressive implementation of these proposed initiatives will assist MidCentral Health to meet the current and future needs of the MidCentral population and the population of its catchment area, and will help shape the way health services work together to provide consistent, high quality clinical care.

The recommendations that are presented in this CSP will impact several stakeholder groups. In particular, they will impact MidCentral Health, the other divisions of the DHB, the MidCentral population, other primary health care providers within the District and neighbouring DHBs. A number of steps are proposed to agree the recommendations and their prioritisation prior to implementation. These steps include:

- Presenting the CSP to the Hospital Advisory Committee and MidCentral DHB Board for discussion and debate
- Undertaking further work to progress the prioritised recommendations.
- Undertaking a Site Master Planning exercise and developing a prioritised funding plan to incorporate the findings of the CSP. This process needs to include:
  - Strong clinician input to the facility design
  - Concurrent business case development for developments that require national capital investment
  - An analysis of the issues and risks associated with not implementing proposals
  - Development of alternative strategies for proposals which are not feasible to be implemented
- Undertaking a risk analysis and developing a benefits tracking framework
- Developing a consultation strategy for staff and other key stakeholders to allow their feedback into the process

It is also essential from the outset to establish a Steering Group and program structure that will guide the roll out of the CSP recommendations and subsequent stages of work such as the Site Master Plan and the redraft of the ISSP. There is an imperative to include strong clinical input throughout the process to ensure the recommendations are successfully implemented and aligned to the clinical models of care.