REPORT: ACHIEVING THE HEALTH AND DISABILITY SYSTEM VISION

Canterbury Clinical Network Learnings.
Shared in support of achieving pae ora/healthy futures for all New Zealanders

September 2021

Canterbury Clinical Network
Transforming Health Care. Whanau Ora ki Waitaha.

CONTENTS

Achieving the Health and Disability System Vision

[1]

SUMMARY

The New Zealand Health and Disability System reforms are seeking a future system that is cohesive, equitable, people centred, and accessible.

For over 25 years Canterbury has worked to achieve a connected system focussed on improving the health and wellbeing of our people and their whānau. Integral to this has been the Canterbury Clinical Network (CCN); a network that has enabled people across the health system to collectively lead the integration and transformation of our system through clinically led service development. Much has been learnt over this time including what factors have enabled and impeded progress[2]. This paper summarises learnings about leading transformational change that has been enabled or enhanced by the CCN to:

- Build trusted relationships.
- Facilitate integration across primary, secondary and community care with people and whānau at the centre.
- Strengthen our partnership with Māori.
- Empower the community to engage in the co-design of health services.
- Gain the greatest value in health outcomes for our people, their whānau and the community.

This information is shared in support of building our capability across New Zealand to collectively transform our Health and Disability System and achieve the Government's vision of a pae ora / healthy futures for all New Zealanders.

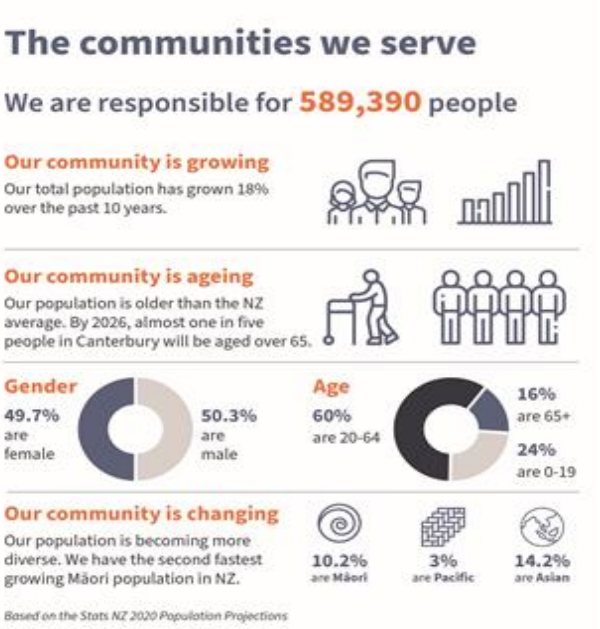
> "
> **KO TE OHONGA AKE O AKU MOEMOEA, KO TE PUAAWAITANGA O NGAA WHAKAARO**
> "
>
> *The awakening of dreams and aspirations come from the blossoming of ideas and thoughts.*

[1] Data source Nationwide Service Framework Library (NSFL). Acute Beds Days data to Dec 2019. WHO (2000) Age standardized. Amenable Mortality DHB Ethnicity and Total Summaries 2018 provisional data.

[2] Information sources include 'CCN Strategic Planning (2019)', MBA dissertation 'Effectiveness of CCN as a Mechanism for Leading Change' (2018),

BACKGROUND

Canterbury is the largest District Health Board (DHB) in New Zealand by region and one of the largest by population estimated at 589,390[3].



While the Canterbury health system has a long history of working towards elements of an integrated and connected health system, delivery on the Better Sooner More Convenient business case (2010) prompted a step change in our journey. The Canterbury Clinical Network District Alliance (CCN) was established to enable collective leadership of the integration and transformation of the health system for the benefit of the people of Canterbury.

CCN is New Zealand's largest district alliance with twelve partner organisations[4] committed to working in a manner consistent with agreed principles that include:

- Taking a person/whānau centred whole of system approach and making decisions on a best for system basis.
- Enabling clinical leadership and clinically led service development.
- Making the best use of finite resources in planning and delivering health services.
- Conducting ourselves with honesty, integrity and in a way that develops a high degree of trust.

These principles have enabled system wide engagement in developing an integrated approach across community, primary, and hospital services. Although not originally conceived as such, this collective approach has also provided a pragmatic way of commissioning healthcare at a 'locality' level.

The work of the CCN is delivered through clinically led alliance groups[5] focused on specific system priorities and areas that require innovative changes in how services are delivered. Each group is tasked with:

- Understanding the needs of the population by exploring data, clinical expertise and what our community tells us.
- Developing innovative changes in health services that reduce inequities and enhance value for our people by making the best use of our collective resources.
- Monitoring the impacts of healthcare changes.

Members of the alliance groups extend beyond CCN partner organisations and include clinicians from primary, secondary and community care, mana whenua, health providers, kaupapa Māori service providers, population health specialists, the broader NGO sector, consumers, planners and funders and other agencies relevant to the group's area of focus. This has included the Ministry of Education, Regional Sports Trusts, Police, the Department of Corrections, and the Accident Compensation Commission (ACC).

The alliance groups within the CCN work programme change over time. Groups are established to progress initiatives, then transition service improvements into business as usual. Updating the groups focus or disestablishing the group allows our collective resources to be prioritised to where they are needed most.

[3] MoH funded population for 2021-22 issued at Dec 2020
[4] Three primary health organisations, Pegasus Health, Waitaha Primary Health and Christchurch PHO; three community services providers (home based support and district nursing), Nurse Maude, Healthcare New Zealand and Access Home Health; Canterbury Community Pharmacy Group; Pacific Radiology, Southern Community Laboratories; St John; NZ College of Midwives (Canterbury & West Coast branch) and Canterbury DHB (CDHB)
[5] Workstreams, Service Level Alliances, Service Development Groups

- The Alliance Leadership Team (ALT) agrees CCN's overarching objectives, areas of focus and the response needed to address these priorities.
- The Alliance Support Team (AST) provides the ALT with advice and guidance on the prioritisation and allocation of resources for changes in health services and delivery models recommended by the alliance groups.
- The Programme Office team is the backbone support, facilitating and coordinating the CCN work programme.

Further information about CCN can be viewed here.

PRINCIPLES

CCN has identified these principles as critical to achieving integration and transformational change.

Commitment to a 'one system' shared vision:
A collective vision of an integrated system centred around the needs of the person / whānau and a commitment to three Strategic Objectives[6]. This has given system partners a reason to collaborate beyond their organisational, professional, and/or individual interests.

Collaboration and partnership based on relational trust:
High trust relationships have provided partners with the confidence to relinquish control, share resources and work collaboratively to progress rapid and/or complex change.

Distributed permissive leadership and ceding of control to gain influence:
Having permissive leaders willing to share decision making and control with clinically led alliance groups has gained clinical and community leaders' ownership of health service improvements. The stability of clinical and managerial leaders across the system has enabled relationships and trust to develop.

Every $1 invested in Mana Ake: returned $13.32 to NZ
through improved mental health, educational achievement, and physical health of our tamariki. Inter-sectorial parties collectively designed Mana Ake within the framework of CCN to achieve a shared vision of positive mental health for our tamariki. See Case Study here and the Impact Lab evaluation here.

Clinical leadership and a way of bringing people together:
Bringing clinical leaders from across the system together with consumers has generated a diversity of ideas and contributed to innovative changes being identified that are practical, acceptable and improve the community's access to healthcare. The breadth of group members also reduces the influence of dominant people or organisations, and balances community and hospital interests.

Person/whānau centred and involvement in decision making:
Involving consumers at all levels of CCN activity has facilitated service changes being agreed that provide greater value to the person and their whānau, rather than providers. Seeking 'best for person' and 'best for system' service improvements has balanced addressing person and whānau needs with sustaining a viable health system.

Data driven decision making and monitoring:
Sharing and linking data and the capability to analyse it has improved decision making through better analysis of the current and future needs of populations, identifying improvement opportunities and the impact of any changes made.

Outcome orientation and continuous learning:
Focusing on improving equitable outcomes, rather than outputs, directs resources to where the greatest value can be gained. Agreeing high priority outcomes with system partners has enabled alignment of our collective resources, gained efficiencies and strengthened collaboration. Monitoring progress in achievement of outcomes has further built confidence and trust.

Clear processes alongside innovation and flexibility:
Documented processes (i.e., work planning, membership recruitment) build trust through transparency. It provides accountability of decisions and momentum for getting things done. These 'rules' are balanced with being flexible and responsive to emerging system needs (e.g., rapidly standing up an alliance group).

[6] 1: The development of services that support people to stay well and enable them to take greater responsibility for their own health and wellbeing. 2: The development of primary and community-based services that support people in the community and provide a point of ongoing continuity, which for most will be general practice. 3: The freeing-up of hospital-based specialist resources to be responsive to episodic events, provide timely access to more complex care and specialist advice to primary care.

ENABLING PROGRESS

CCN's progress in leading integration and system transformation has been achieved through enablers applied in a congruent and combined manner. These enablers are described below.

Culture - A Way of Working

- **Purposeful development of trusted relationships**. System leaders' demonstration of trust and valuing of relationships is underpinned by an agreed way of working documented in the CCN Charter and Alliance Agreement.
- **Commitment to collaborate and achieve consensus:** Alliance group members commit time and effort beyond their normal work to progress service improvements. CCN provides a neutral space for members to have open discussions and resolve disagreements, while committing to 'staying at the table' to achieve consensus decisions.

System Design

- **A multiparty alliance:** Involving twelve partners in the CCN has gained the system reach needed to achieve widespread integration. The alliance framework has enabled collaboration between diverse partners[7]. The Alliance is not a legal entity and is reliant on the contribution and commitment of partner organisations.
- **Retaining the DHB statutory obligation and role as system planners and funders:** Including the DHB planning and funding function across all alliance groups ensures service improvements are developed within reasonable parameters and aligned to the system's strategic direction. Being involved through the process enables planning and funding to then apply a contracting model that supports the outcomes sought from the service change. Membership on all alliance groups and the ALT enables the DHB to retain its right to say no, but the threshold for this is high.
- **Separating CCN from functions of purchasing or delivering services:** CCN's role developing service improvements is intentionally separated from the procurement of services. This avoids conflicts of interest arising for alliance group members when changes proposed may impact business interests.
- **Alliance Leadership Team (ALT):** Membership of the ALT intentionally includes clinical leaders who bring perspectives from across the system rather than alliance partner CEOs who represent their organisation. Alongside an independent Chair, mana whenua and consumers, this focusses decisions on improving outcomes for people and their whānau, rather than protecting partner organisations' interests.
- **Alliance Support Team (AST):** Involving system funders in reviewing and providing guidance on the priority and resourcing of service changes recommended by alliance groups enables better management of funding and resource allocation.

Reduced acute admissions and managing acutely unwell people in the community.

Since 2000 our community based acute demand programme has been enabled by a culture of collaboration and trust. General practice and hospital clinicians were involved in the design that includes funded practice visits and access to rapid diagnostics, complemented by directing people to community-based urgent care services, (St John diversion, telephone triage), and clinical guidelines. This integrated community approach to managing previously hospital level care in the community was rigorously evaluated, (Corwin et al 2005, Richards et al 2005) and described by McGeoch et al (2019). This model has been extended throughout the country as Primary Options for Acute Care. To relieve pressure on secondary care it should be retained. The Urgent Care SLA continues to lead improvements in access to urgent care services. A case study on the SLA can be found here.

[7] Partner organisations that vary in function, business model, national or local reach etc.

- **Service or population focused alliance groups** designed for clinical leadership, diversity of perspectives and innovation:
  - Establishing alliance groups around a specific focus area (e.g., condition, population, or service) enables relevant leaders from across the system to be recruited onto groups and work in teams. This includes people outside CCN partner organisations and from agencies outside health. For example; Corrections, Education, Regional Sports Trusts, NGOs, ACC, etc.
  - Groups harness the expertise of clinicians that deliver services to design service and system responses.
  - People are recruited to bring their perspective, rather than providing representation, further reducing any organisational bias.
- **Remuneration of alliance group members:** Payment of attendees acknowledges their commitment to healthcare improvement. Many organisations support staff to participate as part of their contribution to the CCN.
- **Responsiveness to emerging issues:** The Alliance Agreement is based on a way of working rather that defining the specific areas of work CCN will progress. This allows the ALT to rapidly establish or cease groups in response to emerging system priorities.
- **A programme team to coordinate and support the activity of the CCN:**
  - The inclusion of a programme office team in the design of CCN provides the coordination and day-to-day operational support required to drive the work of the alliance.
  - The team is intentionally located in the community, rather than the DHB, to emphasise the neutrality of the alliance as independent from any alliance partner.
- **Processes designed to retain flexibility and provide clarity.**

Improved care through sharing of important health information

A collaborative innovative culture in a permissive environment enabled the development of HealthOne (eSCRV), an electronic platform that displays essential information and diagnostic test results to clinicians across the system. A HealthOne Case Study is here and website is here.

Technology connecting healthcare and empowered people to manage their health

Canterbury has led the development of a suite of electronic shared care plans that are now used across the South Island. A case study is here.

Integrated Digital Tools

Investment in digital tools for system integration has enabled information exchange, the coordination of care, improved decision making, and the efficient use of resources. Of note are tools that:

- **Share information between providers** to strengthen integration and coordinated care.
- **Provide access to clinical guidelines** for primary care management and referral pathways.

Change in COPD management improved access and reduced hospital admissions.

Use of data alongside collaborative leadership enabled the redesign of Chronic Obstructive Pulmonary Disease management across our system, (Epton et al, 2018).
View the case study here

Using Data as an Improvement Tool

Sharing population data has enhanced service improvement and decision making through better population analysis, service redesign, monitoring of utilisation and the impact of service changes. For example:

- **Supporting decision making** through the capability to link and analyse data and identify variation in access or outcomes across populations.
- **Identifying changes in demand** through real time and predictive modelling tools enabling the system to respond to emerging issues.

Funding and Incentives

Examples of how funding has been used to enable integration and change include:

- **Encouraging innovation and demonstrating trust to 'do the right thing'**: A permissive funding model that ultimately puts decision making as close to the patient as possible (clinician: patient interface) encourages timely and individualised responses to patients' needs. This high-trust approach is accompanied by greater clinical accountability through combining clear outcomes and service parameters, with auditing or reporting.
- **Supporting service changes:** Applying a 'one system one budget' approach removes funding as a barrier to changing where services are provided and enables clinicians to provide better care for patients. For example, funded subsidised procedures in primary care, such as the management of skin cancers, has reduced wait times for procedures, allowed general practice teams to work at top of scope and provided benefits for the system; this is described here.
- **Encouraging integration and collaboration:** Applying a funding model that requires providers to collaborate and reduce duplication of services, where competition is impeding progress and using resources inefficiently.

Change in funding model provided flexibility to better care for people with complex health and social needs.

General practitioners, public health specialists, consumers, PHO, analysts and planners and funders designed an alternative approach to distributing Care Plus funds that encouraged general practice to adopt innovative ways of enhancing quality and coordination of care and responding to their patients' needs; it also reduced the administration burden.
Read more here.

Reduced wait time and increased access to elective surgery

Facilitated by Canterbury Initiative local clinicians developed guidance on clinical assessment and management of conditions. HealthPathways disseminate this information required for integration. Bringing primary and secondary clinicians to develop the pathways strengthened trust, McGeoch et al, (2015).

WHAT HAVE WE LEARNED ABOUT WHAT IS NEEDED

Our learnings continue to influence our principles and understanding about progressing integration and service improvements that benefit our people and their whānau.

- **A clear decision process for deciding which work CCN will lead and a clear scope** for this work is needed**.**
- **Success of alliance groups is enabled by**:
  - Involving innovative clinical leaders who are respected by their peers.
  - Recruiting the 'right' people onto alliance groups. Enthusiastic change agents, with a broad network, who take a system view.
  - Members being responsible for delivering on agreed actions and being collectively accountable for the outcomes.
  - The capability and capacity of the Chair and Facilitator.
  - Using an independent Chair where organisation / individual tensions are likely to impact progress.
  - Accessing timely population data and analyst support.
  - Using time-limited project groups to rapidly progress distinct pieces of work.
- **Some factors undermining progress are:**
  - The converse of points above.
  - When the purpose and scope of a group is unclear.
  - Discussing funding/purchasing of services, shifting the focus to self/organisational interests.
  - Making decisions based on information asymmetry, insufficient data, or lack of agreed interpretation of the data.
- **Strengthening our partnership with Māori and better reflecting our commitment to Te Tiriti o Waitangi** will increase our impact on achieving equity for Māori. This has received increased effort over recent years.
- **Involving agencies outside health achieves greater impact** on the wider determinants of health and avoids duplication.
- **Evolving our codesign approach and additional ways to hear consumer voices** to drive system improvements that better meet the needs of our community.
- **Alliance groups are easier to start than stop:** On completion of substantive change work, groups may identify ongoing beneficial, but less substantive, improvement opportunities and express value in networking to the extent members resist disestablishing the group. This impacts the system's ability to redirect resources to other (higher value) areas for improvement. Planning for transitioning to business as usual should occur when starting a new group.
- **Where multiple partners provide similar functions to the system a competition: cooperation tension can impede progress.** While processes are in place to strengthen collaboration (i.e., Charter, Alliance Agreement Principles, Chair) further ways to address this tension are required.
- **There is a need to manage inherent conflicts of interest** where it is difficult to divorce transformational changes from business or other interests.
- **Processes for implementing agreed services improvements need to be clear and supported by organisations' operational management**. Instances of CCN alliance groups stepping from advising on service improvements to implementing agreed changes reduces the accountability of providers to operationalise changes. It is poor use of our investment in system transformation and is less effective because CCN does not have organisational control.
- **More formative, process and impact evaluations of initiatives is required** to increase our learning from service improvements and support longer term outcome evaluations.
- **Continued facilitation of primary and secondary care integration is required**. For example, significant collaborative work between primary and secondary care occurred when HealthPathways were initially developed. However, this level of working together has diminished as less substantive updates of existing HealthPathways are required.

Multiple agencies improving access for a vulnerable population.

Te Ara Whakapuāawai, a multi-agency project involving health, Social Services and Corrections, is improving access for people released from prison by re-engaging them with their general practice. Read more here.

WHAT ARE CCN's ONGOING PRIORITIES

The CCN Strategic Focus 2019-2024 viewed here captures our collective priorities for improving the health and wellbeing of our community. These are summarised as Meaningful Engagement, Prioritising Equity, Productive Partnerships and Redefining our Alliance. Current work includes:

- Strengthening our partnership with Māori and our way of working to reflect a bi-cultural approach and our commitment to Te Tiriti o Waitangi.
- Building data use to identify inequities in both access and health outcomes of priority groups.
- Addressing variances in health outcomes and access through enhancing partnerships and engaging people and whānau within communities that experience inequities in all levels of CCN activity.
- Continuing to build leadership and an understanding of working collectively across the system.
- Enhancing productive relationships within and beyond the health system.
- Increasing knowledge and the application of integration and transformation frameworks.

Underpinning these strategic actions is an openness for continuous improvement and evolving our approach to achieve greater value for our community and alignment with the health and disability system reforms.

SPECIFIC RELEVANCE TO THE HEALTH AND DISABILITY SYSTEM REVIEW

This section explores our collective activity of specific relevance to the health and disability system reforms. Our priority on achieving equitable health outcomes is embedded throughout our work rather than discussed in isolation.

Localities

Through the health reforms primary and community services will be organised to serve communities in New Zealand through 'localities'; recently described as a community of interest set in a geographic area used for the purposes of localising primary and community-based care[8].

Via the alliance groups CCN has created a mechanism for designing, planning, implementing, monitoring, improving and redesigning services. Where required, funding (with the funder at the table through the entire process) has been used to enable service delivery of these initiatives. Although not described as such, this process has developed a pragmatic model to enable effective commissioning at a 'locality' level.

Since the inception of CCN, alliance groups formed to advise on developing greater health system integration and improved health outcomes. Each has a different focus and was established in response to an identified priority area of need, effectively with a specific community of interest, be that geographical, population or condition based (e.g., respiratory, diabetes).

The CCN work programme currently includes groups developing ways to improve health outcomes for a population (e.g., Health of Older People Workstream), people with a chronic condition (e.g., Integrated Respiratory Service Development Group), accessing a specific service (e.g., Community Services Service Level Alliance) and a community within a geographical area (e.g., Rural Models of Care).

Applying this concept of a locality and considering that a locality may be a community of interest, all CCN groups are leading greater integration and health service improvements within each 'locality'. A discussion on CCN activity in geographical localities is provided below.

Geographical Locality: Rural Models of Care

Background

In 2013, concerns about the sustainability of rural health services prompted work to create fit for purpose models of care in each rural Canterbury community. This was led by the Rural Health Workstream within the CCN work programme. The guiding principles highlighted the importance of engaging local communities and stakeholders (including local government), in developing each model of care and the need to strengthen rural sustainability through better service integration.

Workshops in each location brought together clinicians, leaders from local health and social provider organisations, mana whenua, and members of the community, to consider information on population trends and access to health services alongside local knowledge of service needs. Local service development groups[9] were established to lead work that culminated in a Model of Care recommending priorities for improving the communities' health and access to sustainable equitable health services. Endorsement from the DHB and the CCN ALT was provided ahead of implementing the Model of Care recommendations.

[8] Localities Information Gathering Exercise July 2021.
[9] involving local clinicians, consumers, mana whenua, council, and social service providers, PHOs, and DHB planners and funders.

Some recommendations were consistent across all rural localities (e.g., telehealth access, workforce), and led by the Rural Health Workstream on behalf of all the localities.
Other recommended improvements were best achieved by:

- Local adaption of an agreed rural approach;
- Local service providers changing how they delivered services; or
- Engaging central providers (based elsewhere and delivering services in the locality) on ways to deliver services locally to improve access.

Following implementation of each locality's Model of Care the service development group was disestablished. Long term voluntary consumer, and health and social provider groups were formed to provide leadership to ongoing improvements in health and wellbeing. Support for the groups was provided by the PHOs and a process agreed for the groups to have ongoing communication with the Rural Health Workstream.

Increased access to services for rural communities

The Hurunui Model of Care initiative increased access to:

- After-hours services by local general practices working closely with St John and Fire & Emergency New Zealand.
- Intensive rehabilitation support.
- Outpatient appointment times between 10 am and 2 pm.
- Locally provided maternity services.

View the Hurunui Case Study here.

Lessons for the future

- **Local leadership is critical:** Appoint a local well-respected and influential leader in the community as Chair of the service development group to provide neutral leadership and relationships with agencies inside and outside of health. Involve local clinicians (primary, community and secondary) in leading service improvements to ensure local resources and workforce are applied in an integrated and sustainable way. Actively build trust and allow time for the community to progress changes. Without this, efforts to drive changes are more likely to be met with resistance.
- **Set realistic timelines and manage community expectations**: Include a limited number of recommendations for service improvements that have been prioritsed by the community. Be realistic about the time frames and scale of change that can be achieved. For example, be explicit to the community that improvements may be through multiple incremental changes, rather than a comprehensive new service. Regularly communicate progress to the community and set expectations at the start of a transition back to business as usual or long-term groups in the community.
- **Undertake intensive improvement work for a limited time (12-24 months):** Extended time spent on projects risks a loss of community engagement and changes in community's needs and/or operating environment that then shifts the project priorities.
- **Recognise the unique resources of each community:** Provide permission for local determination of how services are delivered that acknowledges differences in each locality's population, resources, geography etc.
- **Strengthen the transfer from healthcare development to implementation:**
  - Strengthen local providers commitment to implementing changes agreed through the Model of Care for the benefit of their community. Establish the value proposition for providers.
  - Be clear that the function of CCN is leading service improvements while the accountability and responsibility for delivering services remains with the providers.
- **Funding models need to align with progressing integration:** For example, in one area funding individual general practices undermined work to support practices adopt a collective, more sustainable delivery model.
- **Integration with central service providers is essential:** Connecting centrally based and local service provision is critical to central providers knowing and responding to local priorities, improving integration, and providing the person / whānau with seamless care. For example, maternity care in the Hurunui was enhanced through the DHB and PHO hearing and responding to the needs of local women, see article here.
- **Be clear on the service development group's role and scope** so members understand what improvements can be influenced locally and/or where advocacy to central (district wide) leadership is needed to progress healthcare improvement across all rural areas.
- **Ongoing local community / provider groups need support:** Long term groups established in rural areas to lead healthcare improvements need a dedicated resource to coordinate and facilitate their work and provide a connection back to regional / district wide work being undertaken.

Partnership with Māori

Background

Manawhenua ki Waitaha Community Trust (MKWCT)[10] is the iwi representative board with a formal relationship to the Canterbury DHB. It brings together the views of the seven Rūnunga that sit within the boundaries of the Canterbury DHB to act and speak as a single entity. When the CCN was established, engaging with MKWCT was a way to strengthen Māori participation and ensure mana whenua contributed to strategies for improving Māori health. From the onset, MKWCT has supported CCN through recruiting and supporting people to bring a Māori perspective to the ALT and alliance groups. All alliance groups have at least one member to provide a Māori perspective on service improvements. The relationship between CCN and MKWCT has continued to develop, with a greater focus recently on working in partnership to achieve equity for Māori.

Māori Caucus

In 2015, a Māori Caucus was established to strengthen the voice of Māori leaders involved in the CCN work programme. It enables members to support each other in promoting a coordinated focus on equitable health outcomes for Māori in all CCN work. The Māori Caucus provides guidance to alliance groups on their work plan priorities for improving Māori health. A change in the CCN work planning process (2019) increased the involvement of the Māori Caucus in shaping the alliance group's future priorities, described here. The Caucus also provides the MKWCT person on ALT (who co-Chairs the Māori Caucus) with an overview of CCN activity and supports this person to speak, when appropriate, on behalf of all Māori leaders involved in CCN. The Māori Caucus Terms of Reference can be viewed here.

What we have learnt

While CCN has always recognised the importance of equitable health outcomes for Māori, several local experiences accelerated our focus on prioritising this work and our relationship with MKWCT. Three experiences are summarised below.

- A Te Tiriti and Equity Discussion Document, tabled with the ALT December 2018, recommended ways the Canterbury health system could achieve equity for Māori. ALT has a role in implementing these recommendations directly and/or through influencing system partners.
- A Maternity Strategy co-design (2018), where Māori leaders expressed concern that a dated and formulaic methodology inadequately captured the voices of Māori participants in the co-design workshop summary. An alternative design approach was applied that produced a Strategy that better reflected the needs of Māori, viewed here.
- Designing and developing Te Hā Waitaha, (Canterbury's Stop Smoking Service). This service, designed in partnership with Māori, has improved access and outcomes for Māori.

Innovative service design that improves equity for Māori

Te Hā Waitaha enrolls Māori (29%) and Pacific (5%) in stopping smoking; 49% of people enrolled have quit at 4 weeks.
Involving Māori and Pasifika providers at the start of designing of Te Hā Waitaha informed the development of a hub and spoke delivery model that reaches people and whānau in priority communities. View a Case Study on Te Hā Waitaha here.

[10] The Manawhenua Ki Waitaha board was established to ensure mana whenua have oversight and influence on the decision making of the Canterbury District Health Board. Manawhenua Ki Waitaha has the mandate of Papatipu Rūnanga and is supported by Te Rūnanga o Ngāi Tahu (TRoNT) as the Ngāi Tahu representative body in Canterbury for health issues.

Key learning from these experiences and through our engagement with MKWCT include:

- **The importance of engaging and partnering with Māori and forming genuine relationships:** An increased focus on relationships with local hapu and iwi is enabling improvements in the way we offer services and how hauora is perceived by our diverse communities.
- **A values-based approach provides a platform for working collaboratively:** Values, such as Manaakitanga, Kaitiakitanga, Kotahitanga and Whanaungatanga can be collectively understood and committed to. Where we have identified and agreed values for pieces of work, and embedded these into our approach, we have experienced greater 'buy in' from our communities.
- **The importance of partnering with Māori at the start of service improvement mahi** to reflect our commitment to partnership, rather than 'consulting' through the process.

What we are working on

Our learnings are reflected in our Strategic Focus (viewed here) that is centred around: Productive Partnerships including to partner with Māori at every level and facilitate Māori participation: Meaningful Engagement; and Prioritising Equity. Recent actions consistent with our strategy include:

- Establishing a Te Tiriti and Equity Group and through this redesigning our approach to co-design in partnership with MKWCT.
- Actively recruiting for diversity on alliance groups.
- Strengthening the voice of Māori across CCN and building on our improved work planning approach.
- Seeking co-Chairs for alliance groups, with selection reflecting our commitment to partner with Māori.
- Increased focus on accessing data to identify inequitable access and outcomes for Māori.
- Broadening our understanding of tikanga and weaving this into our way of working.
- Further strengthening our relationship with MKWCT to guide, advise and influence how we partner in advancing equitable health outcomes for Māori.

Partnering with our Community

Background

People from our local communities are valued partners within CCN. Consumers on our alliance groups provide insights, experience and knowledge of specific health services that is vital to ensuring our work is centred on and responds to the needs of people and their whānau.

Consumers are involved in all levels of the CCN work programme through:

- Membership on the ALT and across all alliance groups.
- Involvement in workshops where consumers participate alongside clinicians from across the system, people that being a Māori perspective, and planners and funders to advise on healthcare improvements.
- The rural Model of Care initiatives where community input (through local events and surveys) captured what was important to the community and opportunities to improve access to health services.
- The Consumer Forum, established in 2015 for consumers to connect and support each other with their contribution on alliance groups; the Consumer Forum Terms of Reference can be viewed here.

In 2019, the importance of broadening and strengthening our engagement with a diversity of consumers and communities was acknowledged as a Strategic Focus for CCN. This alongside feedback from our consumers, prompted a rethink of how we further embed the voices of people, whānau and community in our health system.

What we have learnt

- Consumer members provide valuable insight into the broader systemic issues, such as social and economic determinants of health, rather than acting as advocates for a single issue.
- Consumers influence service improvements that seek a 'right for person/whānau' outcome.
- A culture of valuing consumer input and clear processes to support this (e.g., chair actively seeking consumer input, use of plain language) are needed to manage any imbalance in power.
- Consumers need a clear understanding of their role, expectations, responsibilities, and an ongoing awareness of the impact and value their contribution provides.

What we are working on

We are actively expanding our approach to better partner with consumers. Our goal to improve ā tātou (our own) health system has to date involved:

- **Developing a new approach to co design** that seeks genuine partnership and a diversity of voices to design healthcare improvements.
- **Setting up time-limited work groups** that bring a specific cohort of consumers together with experience of a particular service or pathway. For example, rangatahi from high priority populations are exploring ways to improve access to youth oral health services.
- **Connecting to existing community groups** to seek input on specific initiatives rather than establishing a health specific group. For example, the Pae ora ki Waitaha project involved health system leaders with reach into communities that experience inequities, to gather feedback from existing groups. An article about this initiative that explored how our health system could better support people and their whānau to stay well is here.

Partnership in Design: Co-designing to meet the needs of those that experience inequities.

Several events highlighted the need to change our approach to co-design. In partnership with Mana whenua ki Waitaha and applying design methodology a new approach to codesign has been developed and is currently being piloted.

Draft Principles

Consumers involved in CCN have drafted principles to underpin our future collective work to put the voice of people, whānau and communities at the heart of what we do, and through the health reforms; see Appendix One.

Population Health

Exploring the health needs of populations is an integral part of CCN work. Alliance groups explore data to identify inequities or variations in health outcomes and access across populations, and identify priorities based on this information alongside clinical and consumer / whānau expertise. Further strengthening this population focus is the involvement of Public Health / Population Health specialists in CCN including:

- **As Chairs of several alliance groups including:**
  - The Population Health and Access SLA monitors population level health and advises on innovative ways of enabling a health promoting health system. The SLA's work includes exploring how the system could better support people and their whānau to stay well, improving access to and enrolment in general practice, embedding the use of best practice Interpreter Services guidelines, and overseeing the implementation of Te Hā Waitaha Stop Smoking Programme.
  - The Immunisation SLA that is focused on improving pertussis coverage for Māori and Pacific whānau.
  - The System Outcomes Steering Group leading Canterbury's response to the System Level Measures
- **As members on several groups** including Child and Youth Health Workstream and the Oral Health Service Development Group.
- **Supporting evaluations of CCN service improvements:** Examples include comprehensive evaluations of Motivating Conversations, Te Hā Waitaha Maternity Incentive Project, Literature review of Healthy Lifestyles programmes.

Other Populations that Experience Inequities:

Improving access and health outcomes for populations that experience inequities underpins the work of CCN. This is reflected in:

- Alliance groups established to address areas of identified need (e.g., Rural Models of Care work to improve access for rural communities); and
- Priority actions identified by each alliance group within their area of focus, (e.g., Oral Health Service Development Group prioritising Māori and Pasifika access to dental services).

For specific population groups this work is further supported by the following:

Pasifika Population:

Pasifika peoples across our health system have lower overall health status than other population groups. Specific actions seeking improvements in equity for Pasifika are a focus of several alliance groups including Integrated Diabetes, Respiratory and Oral Health Service Development Groups and the Immunisation Service Level Alliance.

Enabling this is a Pacific Caucus formed in 2017. This group supports Pasifika leaders involved in CCN to use their collective skills and voice to support each other in expressing their focus on equitable health outcomes for Pasifika. Information about the Pacific Caucus and Terms of Reference can be viewed here. In 2019 this group collectively reviewed five alliance group work plans that the Pacific Caucus identified as a priority. Additional Pasifika members on key groups has also strengthened their contribution into service improvement.

Advisory Groups & Disability Steering Group

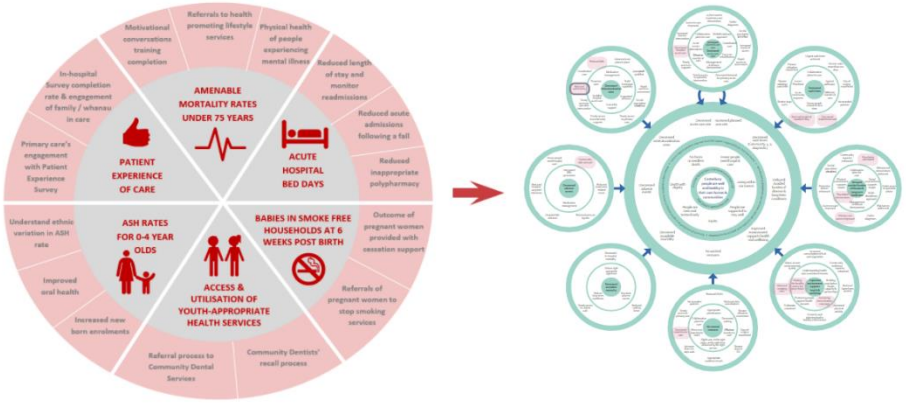
These system wide groups provide leadership, advice and ensure the needs of their communities are consistently considered in service development across the Canterbury health system, including to CCN.

- Te Kāhui o Papaki Ka Tai.
- Pacific Reference Group.
- Culturally and Linguistically Diverse Health Advisory Group.
- The Disability Steering Group, established by the Canterbury and West Coast DHB ensures people with disabilities have the health services they need, and are included in decisions about their health.

OUTCOMES AND ACHIEVEMENTS

CCN is one component of the system's efforts to improve the health of our people and their whānau. As such, outcomes and achievements in Canterbury are attributable to the system in its entirety; individual contributions are not easily extracted and attributed.

Canterbury's Outcomes Framework (November 2014) viewed here recognises that the contribution of multiple improvements are required to achieve progress against our system outcomes. This approach reflects the Ministry of Health System Level Measures framework where improvement in nationally agreed measures is achieved through the collective efforts of multiple providers within each district. Our System Level Measures performance is summarised below as a measure of our achievements[11].



Total Acute Bed Day rate 283 per 1,000 population.
Consistently lower rate than national across all populations
by 5% Total, 14% Māori and 18% Pacific

Amenable mortality rate trending downwards**.**
Consistently lower than the national rate by
9% Total and 18% Māori populations *(Figure 1)*

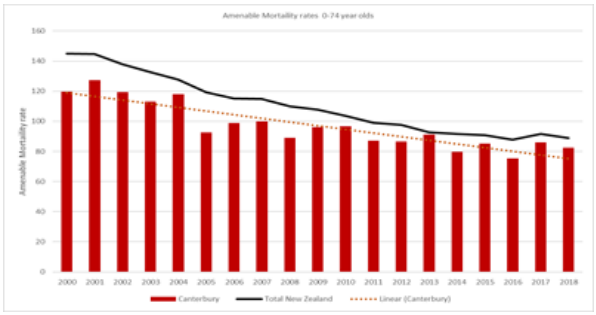


Figure 1

Ambulatory Sensitive Hospital admissions 0 to 4-year-olds
Total population rate 5,270 events per 100,000
Consistently lower than the national rate by
8% Total and 15% Māori populations

66% of babies in Canterbury are living in smokefree homes
Higher than national for all populations by
21% Total, 61% Māori and 30% Pacific *(Figure 2)*

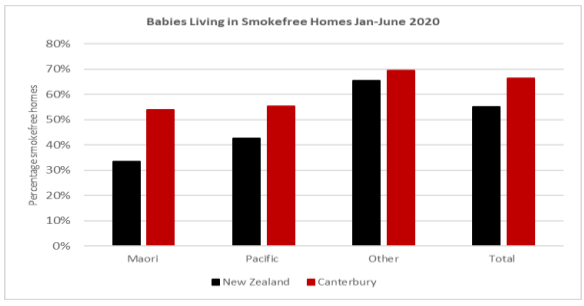
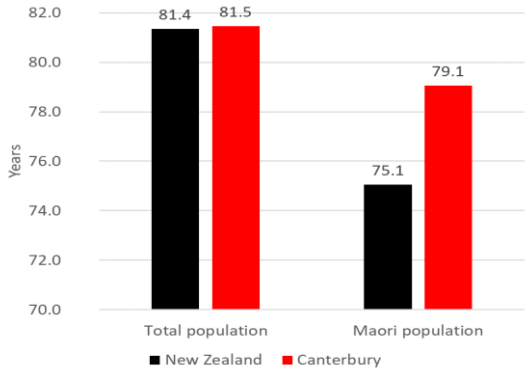


Figure 2

Patient experience survey results consistently at or above national rates
87% of general practices accessing survey feedback

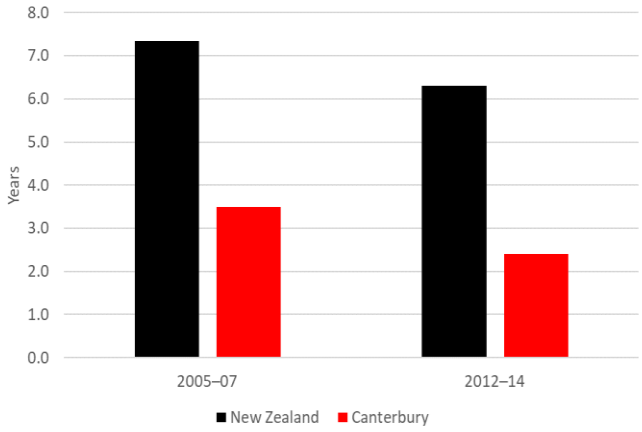
[11] Data sourced Sept 2021. https://nsfl.health.govt.nz/dhb-planning-package/system-level-measures-framework/data-support-system-level-measures: ASH 0–4-year-old data, average rates March 2017 to March 2021, Non-Standardised NZ Census. Acute Beds Days data: average rates Dec 2017 to Dec 2019, WHO (2000) Age standardized. Amenable Mortality DHB Ethnicity Rates Summary 2014-2018 using 2016 population data. DHB Report Sept. 2020, Babies Living in Smokefree Homes at 6 weeks post-natal, Jan 20 to June 20.

Life Expectancy



Life expectancy for Māori living in Canterbury is **4 years or 5% higher** than for Māori in all New Zealand.

Life expectancy at birth by region: Differential: Māori vs non-Māori



Between 2005-07 and 2012-14 the Canterbury **differential between Māori and non-Māori closed by 46%** (from 3.5 to 2.4 years) compared with 17% nationally (from 7.4 to 6.3 years)

Although it is unlikely to be linear, at the current rate of change Canterbury would achieve equity within 15 years, while across New Zealand this feat would require 42 years

Achieving Integration

Advancing integration across the health system and between health and social services is widely acknowledged as improving patient care and experience through greater coordination and efficiency of service provision.

Several publications have pointed to the Canterbury health system demonstrating characteristics of successful integration; (McGeoch et al 2019; Timmins & Ham 2013) while the State Services Commission (2013) recognised Canterbury DHB as an “innovative organisation”.

Defining and measuring integration is difficult and a focus of health systems across the world. Canterbury is exploring current tools to measure integration and the readiness for system transformation so we can leverage these to assess our status, guide future work and monitor progress. This includes exploration of the self-assessment tool to support health system transformation in the New Zealand health system (Sharma K. 2020). This tool identifies ten elements needed to increase success in implementing large scale transformation.

RECOMMENDATIONS FOR ACHIEVING THE HEALTH AND DISABILITY SYSTEM VISION

Canterbury is committed to achieving the vision for New Zealand's Health and Disability System. Reflecting on what we have learnt in the context of the reforms, achieving a cohesive, equitable, people centred, and accessible system will require:

- **Strengthening trusted relationships** across the New Zealand Health and Disability System.
- **Central leadership that balances a commitment to national consistency with flexibility** for regions / localities to innovate in response to local population needs and use the natural strengthen of each locality.
- **Harnessing the kaupapa Māori, community and clinician innovations** that contribute to improved health outcomes that are not consistently available across New Zealand.
- **Creating strong localities by building on local collaborative networks** that are independent of existing providers to evolve in line with the reforms. Resource their capacity and capability to:
    - Coordinate and facilitate clinical and community leaders and agencies outside of health to work collectively within localities to agree shared priorities and advise on innovative service improvements.
    - Involve people their whānau and communities in a meaningful and genuine way.
    - Strengthen / maintain partnerships with mana whenua through Iwi-Māori Partnership Boards.
    - Facilitate the use of best practice co-design methodology to inform healthcare improvements.
    - Drive and coordinate integration and transformational change efforts within regions including across multiple localities and between secondary care and localities, to achieve efficient use of resources and a seamless consumer experience of healthcare.
    - Maintain / strengthen primary and secondary care integration to counter any risk of the structural changes through the reforms disrupting these relationships and continuity of care.
- **Encouraging innovative healthcare improvements** and share these nationally.
- **Establishing an accountability framework that measures improvement** in system outcome and progress on priority actions determined by localities to achieve these outcomes. Consider inclusion of a tool that measures improved integration and capability for transformational change.

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REFERENCES

1. Paul Corwin[1], Les Toop, Graham McGeoch, Martin Than, Simon Wynn-Thomas, J Elisabeth Wells, Robin Dawson, Paul Abernethy,Alan Pithie,Stephen Chambers, Lynn Fletcher, Dee Richards. Randomised controlled trial of intravenous antibiotic treatment for cellulitis at home compared with hospital. *BMJ* 2005; 330 doi: https://doi.org/10.1136/bmj.38309.447975.EB (Published 13 January 2005)

2. Dee A Richards, Les J Toop, Michael J Epton, G Ian Town, Robin D Dawson, Michael C Hlavac, Graham R B McGeoch, Simon M H Wynn-Thomas, Paul D Abernethy and Anja M Werno. Home management of mild to moderately severe community-acquired pneumonia: a randomised controlled trial. *Med J Aust* 2005; 183 (5): 235-238. || doi: https://pubmed.ncbi.nlm.nih.gov/16138795/

3. McGeoch, G., Shand, B., Gullery, C., Hamilton, G., & Reid, M. (2019). Hospital avoidance: an integrated community system to reduce acute hospital demand. *Primary Health Care Research & Development.*

4. McGeoch G, Anderson I, Gibson J, Gullery C, Kerr D, Shand B. Consensus pathways: Evidence into practice. New Zealand Medical Journal 2015; Jan 30:128 (1408):86-96.

5. Epton M, Limber C, Gullery C*, et al.* Reducing hospital admissions for COPD: perspectives following the Christchurch Earthquake. *BMJ Open Respiratory Research* 2018;5**:** e000286. doi: https://bmjopenrespres.bmj.com/content/5/1/e000286

6. Timmins, N., Ham, C. (2013) *The quest for integrated health and social care: A Case study in Canterbury New Zealand*. The Kings Fund. https://www.kingsfund.org.uk/publications/quest-integrated-health-and-social-care

7. State Services Commission (2013) Designing and growing innovation capability: A Case Study. New Zealand Government. (pp 12-20). https://www.publicservice.govt.nz/assets/Legacy/case-study-growing-innovation-capability.pdf

8. Sharma, K. (2020) *Implementation of large-system transformation initiatives in the New Zealand health system.* Doctoral Thesis , University of Victoria, Wellington New Zealand.

9. Varsamis, D. (2020). *Incentives and levers for digitising and integrating primary care in New Zealand, Australia and the USA – lessons for the UK NHS* (p. 232). Winston Churchill Memorial Trust. https://www.wcmt.org.uk/sites/default/files/report-documents/Varsamis%20D%202019%20Final.pdf

APPENDICES

Appendix One: Draft Principles Community Engagement

COMMUNITY LED

The health system trusts that the community knows what they need to achieve better health and wellbeing.
People / whānau voices at all levels of engagement and decision making are valued and given equal importance.

EMBEDDED IN THE COMMUNITY

The health system is part of the community it serves. It does not 'reach in' to hear the voices of the people. It meets people where they are.

HEARING DIVERSE VOICES

The voices we hear are diverse. We ensure that the loudest voices come from those with the greatest need.

HOLISTIC APPROACH

The wider determinants of health are acknowledged. Cultural, spiritual, social influences are considered in all engagement and decision making.

GENUINE PARTNERSHIP

Responsive communication between health and the community. The health system has a genuine dedication to listen to and meet the health needs of people and their whānau.

VALUING EXISTING NETWORKS

The predominant approach of establishing consumer groups within the health system is complimented by engaging with established and connected existing community groups and networks.

CLOSING THE LOOP

The process of engagement and innovation is completed by feeding back on progress and outcomes to the community in a timely manner.

COMMITMENT TO ACT

The system provides the resources to act on what they hear.
Community engagement and consultation work means nothing if nothing is done as a result.