## Capital & Coast District Health Board

### Health System Committee

### Public Agenda

**26 September 2018**

Conference Room, Kenepuru Education Centre, Kenepuru Community Hospital, Raiha Street, Porirua

9.30am to midday

<table>
<thead>
<tr>
<th>ITEM</th>
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<td><strong>1 PROCEDURAL BUSINESS</strong></td>
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<td>Apologies</td>
<td>Record</td>
<td>F Wilde</td>
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<td>1.3</td>
<td>Continuous Disclosure – Interest Register</td>
<td>Accept</td>
<td>F Wilde</td>
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<td>1.4</td>
<td>Confirmation of Draft Minutes 29 August 2018</td>
<td>Approve</td>
<td>F Wilde</td>
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<td>1.5</td>
<td>Matters Arising</td>
<td>Note</td>
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<td>1.6</td>
<td>Action List</td>
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<td>1.7</td>
<td>HSC Work Programme</td>
<td>Note</td>
<td>F Wilde</td>
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<td><strong>2 PRESENTATION</strong></td>
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<td>2.1</td>
<td>Key drivers for investment for 2019/20 and beyond.</td>
<td>Presentation</td>
<td>R Haggerty, TP Meihana, A Balram, S Williams</td>
<td>10.00am</td>
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<td>2.2</td>
<td>Allied Health Models of Care – reaching in to our community</td>
<td>Presentation</td>
<td>D Clendon, C Epps</td>
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<td><strong>3 DECISION</strong></td>
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<td>3.1</td>
<td>Long-Term Investment Planning</td>
<td>Paper</td>
<td>R Haggerty / P Guthrie</td>
<td>10.45am</td>
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<td>3.2</td>
<td>3D Health Pathways Update</td>
<td>Paper</td>
<td>A Balram</td>
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<td>3.2.1</td>
<td>3D Health Pathways Report</td>
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<td><strong>4 DISCUSSION</strong></td>
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<td>4.1</td>
<td>HHS Bi-Monthly Report</td>
<td>Paper</td>
<td>C Virtue / D Hunter</td>
<td>11.15</td>
<td>57</td>
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<td>4.2</td>
<td>Health Care Home – Update</td>
<td>Paper</td>
<td>A Balram</td>
<td>11.30</td>
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<td>4.3</td>
<td>SIP Update</td>
<td>Verbal</td>
<td>R Haggerty</td>
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<td>DATE OF NEXT MEETING 24 OCTOBER – KAPITI DISTRICT COUNCIL CHAMBERS, 175 RIMU ROAD, PARAPARAUMU</td>
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Capital & Coast District Health Board
# HEATH SYSTEM COMMITTEE

## Interest Register

**UPDATED AS AT SEPTEMBER 2018**

<table>
<thead>
<tr>
<th>Name</th>
<th>Interest</th>
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| Dame Fran Wilde    | - Ambassador Cancer Society Hope Fellowship  
|                    | - Chief Crown Negotiator Ngati Mutunga and Moriori Treaty of Waitangi Claims  
|                    | - Chair, Remuneration Authority  
|                    | - Chair, Wellington Lifelines Group  
|                    | - Chair, National Military Heritage Trust  
|                    | - Deputy Chair, Capital & Coast District Health Board  
|                    | - Deputy Chair NZ Transport Agency  
|                    | - Director Museum of NZ Te Papa Tongarewa  
|                    | - Director Frequency Projects Ltd  
|                    | - Member Whitireia-Weltec Council  
| Mr Andrew Blair    | - Chair, Capital & Coast District Health Board  
|                    | - Chair, Hutt Valley District Health Board (from 5 December 2016)  
|                    | - Advisor to the Board, Forte Health Limited, Christchurch  
|                    | - Owner and Director of Andrew Blair Consulting Limited, a Company which from time to time provides governance and advisory services to various businesses and organisations, include those in the health sector  
|                    | - Former Member of the Hawkes Bay District Health Board (2013-2016)  
|                    | - Former Chair, Cancer Control (2014-2015)  
|                    | - Former CEO Acurity Health Group Limited  
|                    | - Advisor to Southern Cross Hospitals Limited and Central Lakes Trust to establish an independent short stay surgical hospital in the Queenstown Lakes region  
| Ms Sue Kedgley     | - Member, Capital & Coast District Health Board  
|                    | - Member, CCDHB CPHAC/DSAC committee  
|                    | - Member, Greater Wellington Regional Council  
|                    | - Member, Consumer New Zealand Board  
|                    | - Deputy Chair, Consumer New Zealand  
|                    | - Environment spokesperson and Chair of Environment committee, Wellington Regional Council  
|                    | - Step son works in middle management of Fletcher Steel  
| Dr Roger Blakeley  | - Member of Capital and Coast District Health Board  
|                    | - Deputy Chair, Wellington Regional Strategy Committee  
|                    | - Councillor, Greater Wellington Regional Council  
|                    | - Director, Port Investments Ltd  
|                    | - Director, Greater Wellington Rail Ltd  
|                    | - Economic Development and Infrastructure Portfolio Lead, Greater Wellington Regional Council  
|                    | - Member, Harkness Fellowships Trust Board  

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| Ms ‘Ana Coffey Member    | - Independent Consultant  
- Brother-in-law is a medical doctor (anaesthetist), and niece is a medical doctor, both working in the health sector in Auckland  
- Son is Deputy Chief Executive (insights and Investment) of Ministry of Social Development, Wellington  
- Invited to join the Board of the Wesley Community Action Group  
- Member of the Regional Steering Group, Warm Healthy Homes                                                                                   |
| Ms Eileen Brown Member   | - Member of Capital & Coast District Health Board  
- Councillor, Porirua City Council  
- Director, Dunstan Lake District Limited  
- Trustee, Whitireia Foundation  
- Brother is Team Coach for Pathways and Real Youth Counties Manukau District Health Board  
- Father is Acting Director in the Office for Disability Issues, Ministry of Social Development                                                                 |
| Ms Sue Driver Member     | - Community representative, Australian and NZ College of Anaesthetists  
- Board Member of Kaibosh  
- Daughter, Policy Advisor, College of Physicians  
- Former Chair, Robinson Seismic (Base isolators, Wgtn Hospital)  
- Advisor to various NGOs                                                                                                                                 |
| Mr Fa’amatuainu Tino Pereira Member | - Managing Director Niu Vision Group Ltd (NVG)  
- Chair 3DHB Sub-Regional Pacific Strategic Health Group (SPSHG)  
- Chair Pacific Business Trust  
- Chair Pacific Advisory Group (PAG) MSD  
- Chair Central Pacific Group (CPC)  
- Chair, Pasifika Healthy Home Trust  
- Establishment Chair Council of Pacific Collectives  
- Chair, Pacific Panel for Vulnerable Children  
- Member, 3DHB CPHAC/DSAC                                                                                                                     |
| Dr Tristram Ingham Member | - Senior Research Fellow, University of Otago Wellington  
- Member, Capital & Coast DHB Māori Partnership Board  
- Member, Scientific Advisory Board – Asthma Foundation of NZ  
- Chair, Te Ao Mārama Māori Disability Advisory Group  
- Councillor at Large – National Council of the Muscular Dystrophy Association  
- Member, Executive Committee Wellington Branch MDA NZ, Inc.  
- Trustee, Neuromuscular Research Foundation Trust  
- Member, Wellington City Council Accessibility Advisory Group                                                                                     |
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<tr>
<td></td>
<td>• Member, 3DHB Sub-Regional Disability Advisory Group</td>
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<td>• Professional Member – Royal Society of New Zealand</td>
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<td>• Member, Institute of Directors</td>
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<td>• Member, Health Research Council College of Experts</td>
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<td>• Member, European Respiratory Society</td>
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<td>• Member, Te Ohu Rata o Aotearoa (Māori Medical Practitioners Association)</td>
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<td>• Director, Miramar Enterprises Limited (Property Investment Company)</td>
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<td>• Wife, Research Fellow, University of Otago Wellington</td>
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CAPITAL AND COAST DISTRICT HEALTH BOARD  
DRAFT Minutes of the Health System Committee (HSC)  
Held on Wednesday 27 June 2018 at 9.30am  
Board Room, Level 11, Grace Neill Block, Wellington Regional Hospital

PUBLIC SECTION

PRESENT:
BOARD  
Dame Fran Wilde (Chair)  
Ms Sue Kedgley  
Dr Roger Blakeley  
Ms ‘Ana Coffey arrived 10.15  
Ms Eileen Brown  
Ms Sue Driver left 12pm  
Mr Tino Fa’amatuainu Pereira left 11.40am  
Dr Tristram Ingham arrived 9.45am

STAFF:  
Ms Julie Patterson, Interim Chief Executive  
Ms Rachel Haggerty, Director, Strategy Innovation and Performance

PRESENTER:  
Nevil Pierse, Department of Public Health, University of Otago, item 2.1  
Tara D’Sousa, Team Leader, Analytical & Policy, HVDHB, item 2.2  
Gabrielle Baker, BakerJones, item 2.3  
Sandra Williams, General Manager, Primary and Complex Care, items 3.1 & 3.2  
Lisa Smith, Senior System Development Manager, items 3.1 & 3.2  
Stephen Palmer, CHOD Public Health, item 4.1  
Nigel Fairley, General Manager, Mental Health & Addictions, item 4.2

GENERAL PUBLIC:  
Three members of the public were present

1 PROCEDURAL BUSINESS
1.1 PROCEDURAL
Fran acknowledged the accident on The Terrace this morning which resulted in one death.  
The Karakia was led by Tino Fa’amatuainu Pereira. Committee Chair, Dame Fran Wilde, welcomed  
the public, members and the DHB staff.

Rachel introduce new team members, Rawinia Mariner (General Manager for Mental Health and  
Addictions) and Te Paré Meihana (General Manager for Child, Youth and Families). Rachel also  
welcome Delwyn Hunter and Carey Virtue to their first HSC meeting.

1.2 APOLOGIES
Apologies were received from Andrew Blair.

1.3 INTERESTS
1.3.1 REGISTER OF INTERESTS
No changes were registered.

1.4 CONFIRMATION OF PREVIOUS MINUTES
The minutes of the CCDHB Health System Committee held on 27 June 2018, taken with public  
present, were confirmed as a true and correct record.
Moved: Roger Blakely  Seconded: Sue Driver  Carried:

1.5 MATTERS ARISING

1.6 ACTION LIST
The reporting timeframes on the other open action items were noted.

1.7 HSC WORK PROGRAMME
The Committee noted the plan.

2 PRESENTATION

2.1 Housing and Health
The Committee noted the presentation.

Discussion:
- Nevil seeks the Board’s support on Well Homes.
- The Committee to consider Well Homes for the 2019 budget.
- The current housing standard is 10 to 15 years behind the international standards which is not good enough from the health perspective.
- People who need healthy home are missed out due to tight criteria guidelines.
- Current engagement with DHB and DHB groups, governance groups for Well Homes & Rheumatic Fever, community outreach and GPs.

2.2 Regional Public Housing Approach
The paper was taken as read and the Committee noted the presentation.

a) Supports Regional Public Health’s (RPH) approach to housing as a key determinant of health.

b) Endorses RPH co-leading a regional healthy housing response group as a collective approach for greater impact in the sub-region.

c) Recommends the Board maintain a close watch on the role of healthy housing in supporting health and wellbeing and in particular its impact on hospital admissions.

Discussion:
- The Committee supports the Regional Public Health approach
- The Committee requests for more analytical data on intervention, scope and the results of intervention on an annual basis.
- It was agreed that the Committee will write to the Wellington Regional Council asking it to consider using its powers to regulate for acceptable heating standards and methods including but not limited to the issue of un-flued gas heaters.
- The Committee agreed to make submissions on the current RTA consultation and upcoming consultations on regulations underneath the Health Homes Guarantee Act.

HSC recommends to the Board:

a) To maintain a close watch on the role of healthy housing in supporting health and wellbeing and in particular its impact on hospital admissions.

b) To support RPH's approach to housing and its leadership within the regional healthy housing response group

c) To consider healthy housing investment opportunities as part of the 2019/20 budget setting process.

d) To take the issue of a collective DHB response to healthy housing as a key health determinant to the national Chairs and CEs meeting.
Actions:
1. Nevil to provide the report showing that intervention to the current 300,000 people made a difference to healthy housing.
2. Staff to provide regular data and reporting of impact from health housing action
3. HSC to write to the Greater Wellington Regional Council to ask it to consider regulating heating methods within the region.
4. CCDHB to submit to the consultation on changes to the RTA and any upcoming consultations on new regulation to be introduced under the Healthy Homes Guarantees Act.

1 member of public left the meeting at 10.40am

2.3 Pro-Equity Approach
The Committee noted the presentation and endorses the approach.

Discussion:
• Aiming for transformational change to the whole organisation.
• Patient experience. Optimal ward is currently focussed on looking at the discharge basis specifically for Maori and Pacific families. We have engaged Maori and Pacific consumer groups. We believe the current discharge rates are not successful for Maori and Pacific families.
• CCDHB’s equity approach is focused on five priorities: ethnicity – in particular Maori and Pacific, disability, mental health, economic vulnerability and geographic/locality based inequities.

HSC recommends to the Board:
  a) That the HSC recommend to the Board that they note the importance of a pro-equity approach.

3 FOR DECISION

Items 3.1 and 3.2 were discussed together.

3.1 Developing an Investment Plan for Long-Term Conditions
The paper was taken as read.

The Committee:
  a) Noted the inequitable burden of long-term conditions by our Māori, Pasifika and/or lower socioeconomic status communities as demonstrated.
  b) Noted that the Investment Plan will consider prevention and early-intervention, models of care for long-term conditions and self-management.
  c) Noted working with Regional Public Health to build wellbeing into our locality approach and strengthen our role in creating healthy environments.
  d) Endorses the development of this investment planning approach as a framework for our future investments to support people with long-term conditions to live well, ensuring there is a coordinated approach to care for people with long term conditions.
  e) Noted that the draft Long-Term Conditions Investment Plan will be presented to the Committee in December 2018.
  f) Endorses the investment planning approach as a mechanism to improve equity for our Māori, Pasifika and lower socio economic status populations by developing a people and whānau-led model that supports our communities.
g) **Recommends** to the Board the development of an investment plan for long-term conditions that will improve equity amongst our population and focus on prevention and early-intervention.

1 member of public left the meeting at 11.20am

### 3.2 Investment in Prevention and Treatment of Long-Term Conditions

The paper was taken as **read**.

The Committee:

a) **Noted** in 2018/19 we will invest $250 million in services for people with long-term conditions.

b) **Noted** inequalities for Māori and Pacific populations in prevalence of long-term conditions and outcomes.

c) **Endorses** the draft long-term conditions performance dashboard.

d) **Recommends** to the Board that it notes the current levels of investment in long-term conditions and the significant inequities experienced in our Māori and Pasifika communities.

**Discussion:**

- This plan is for the intermediate steps. It is about what we as a health system can be doing to support people more effectively and recognising how communities operate. It is important not take a self-blame approach.

- Long-term conditions has been an important part of the Pacific strategy for the last 3 years. However the team has yet to see any milestone investment. It was explained that the level of investment hasn’t shifted the results at present time. What changes are the things we need to do, the targeted resources and support required. Current spending is mainly on hospital, and medications with and some money is spent on working in the community. However, this is not targeted at community that needs our help the most but it presents a significant opportunity. We have increased spending in the Child and Youth. But we need to focus on long-term conditions.

- The Committee was pleased to note that the BMI measurement has been replaced by nutrition measurement.

- Update on the Porirua integration project will be presented to the table at the next meeting and SIP to introduce the team leader on this project.

- It was noted that the targets set out in the Performance Dashboard was set by Ministry Health.

**HSC recommends to the Board:**

- That it be aware of the inequitable burden from long-term conditions experienced in our Māori and Pasifika communities beyond socio-economic status.

- That it be aware we invest around $250 million each year on prevention and treatment services for long-term conditions, of which 83% are on hospital speciality services.

- Support the development of an investment plan for long-term conditions that will improve equity and focus on prevention and early intervention.

**Actions:**

1. Provide an update on the Porirua integration project at the next HSC meeting. SIP to introduce the team leader on this project.

**Moved:** Eileen Brown   **Seconded:** Roger Blakely   **Carried:**
4.1 Bi-Monthly Regional Public Health Performance Report

The paper was taken as read.

The Committee:

a) **Noted** the update from Regional Public Health.

b) **Noted** that the Strategy, Innovation and Performance Directorate is working closely with Regional Public Health to integrate our approach to improving wellbeing in our communities.

c) **Recommends** to the Board that they note the contents of this update.

**Discussion:**

- CCDHB funds around one-third of Regional Public Health initiatives. Processes needs to be put in place to create more strategic focus rather than reactive responses. Require a clearer population health approach in partnership between CCDHB and RPH.
- The Committee sees an opportunity in partnership with the DHBs to develop public health, including a strategic plan around long-term conditions. CCDHB is working with RPH to line these initiatives up more effectively. CCDHB is currently doing a public health strategy and a locality strategy with population health approaches within communities.
- The Committee endorses the focus on synthetic cannabis and commended on the collaborative work with Porirua City Council.

**HSC recommends to the Board:**

a) Notes the update provided by RPH.

b) Notes the partnership of CCDHB and RPH to better integrate our approach to public health action.

**Actions:**

1. SIP to work with RPH to identify specific topics and bring these back as a series that allows a deeper dive into these individual issues instead of general compendium updates.

4.2 Bi-Monthly MHAIDS Performance Report

The paper was taken as read.

The Committee:

a) **Noted** Corrections is increasing in beds at Rimutaka and Arohata Prisons, which will impact MHAIDS Forensic Service and Hutt Valley DHB hospital services.

b) **Noted** a new Youth respite, 6 bed facility for Hutt Valley & Capital & Coast DHB is to open in Lower Hutt on the 17th September 2018.

c) **Noted** that MHAIDS 3DHB are well on their way to meeting the Zero Seclusion target. The Key performance indicators have been met, with some inpatient units having a zero seclusion for months at a time.

d) **Recommends** to the Board that they note this update.

**Discussion:**

- One of the staff challenges is specialist services such as forensic.
- Occupancy rate. There is a demand across the system. We are investing time and resources on inpatient. There is possibly demand for further inpatient acute bed capacity and we are looking at that. We need to change the way we look at these problems.

**HSC recommendations to the Board:**

a) To note this update.
Suicide and Self Harm

This paper was not on the agenda.

The Committee noted the presentation.

Discussion:

- Zero tolerance for suicide approach. Zero tolerance for suicide and suicide behaviour reduces the rate of suicide. The approach is our health system response to preventing suicide and opportunities for intervention to help reduce suicide and suicidal behaviour. We intend to get specialised assistance to develop our strategy.

HSC recommendations to the Board:

a) Endorse the change of focus and zero tolerance approach for suicide.

4.3 Bi-Monthly SIP Update

The paper was taken as read.

The Committee:

a) Noted the update from SIP on current activity.

b) Noted the update on the Citizens Health Council establishment.

c) Recommends to the Board that they note this update.

Discussion:

- Citizens Health Council establishment was discussed at the Board meeting in June. The establishment group to determine the Terms of Reference, the process and timeline. The appointments will be determined by Diana Crossan and Rachel Haggerty.

- Health Care Homes roll out. At the HSC meeting in February, Tristram had expressed concern that we should wait until the equity approach is working effectively. He would like to see an update on how the model is being progressed with regard to equity. This work is currently being undertaken by ICC.

HSC recommendations to the Board:

a) To note this update.

Action:

1. SIP to provide an update to HSC at its next meeting on how we are addressing equity concerns within the HCH roll out.

The meeting closed at 12.42 pm.

5 DATE OF NEXT MEETING

26 September 2018, 9.30am, Kenepuru Education Centre, Kenepuru Community Hospital, Raiha Street, Porirua.
1. PURPOSE

This report summarises the key discussions at Health System Committee on 29 August 2018 and makes recommendations to the Board. The minutes of the meeting are attached as appendix one. The full papers from this meeting are available on Boardbooks.

2. HOUSING AND HEALTH

Associate Professor Nevil Pierse from the Department of Public Health at the University of Otago presented on the Housing and Health Research initiatives of He Kainga Oranga including the Housing, Insulation & Health Study and the Housing Heating & Health Study. Regional Public Health (RPH) spoke to its paper outlining its approach to housing through the Well Homes Partnership (funded by CCDHB, HVDHB and MoH) and the Regional Healthy Housing Response Group. Both presentations stimulated broad discussion on the critical role that healthy housing plays in good health and wellbeing at both an individual and a community or population level. The negative impacts of poor quality housing manifest as increased pressure on our health system through high rates of potentially avoidable hospitalisations.

There was discussion on the opportunities to improve housing quality through proposed legislative and regulatory change. Associate Professor Pierse encouraged CCDHB to submit on consultations on the Residential Tenancies Act and Healthy Homes Guarantees Act regulations, which the committee agreed with. The committee also decided to write to the Greater Wellington Regional Council to ask it to use its powers to regulate safe heating methods within the region.

Committee members wanted to know to what extent the healthy housing interventions are actually making a difference to the health and wellbeing of communities. They asked to receive regular trend data and reporting to understand the impact.

Recommendation:

a) The Board should maintain a close watch on the role of healthy housing in supporting health and wellbeing and in particular its impact on hospital admissions.

b) The Board to support RPHs approach to housing and its leadership within the regional healthy housing response group.

c) The Board to consider healthy housing investment opportunities as part of the 2019/20 budget setting process.

d) The Board to take the issue of a collective DHB response to healthy housing as a key health determinant to the national Chairs and CEs meeting.
3. PRO-EQUITY APPROACH
A presentation was given outlining CCDHB’s intention to undertake an equity health check as part of our commitment to being a pro-equity organisation. CCDHB has five priorities for equity; ethnicity – in particular Māori and Pacific, disability, mental health, economic vulnerability and geographic/locality based inequities. We have a renewed focus on achieving both equity of access and outcome for our population and the health check will be foundational for supporting us in this transformational aim. It involves review of all documentation, policies and procedures to assess how well we address factors influencing equity and will include consideration of issues such as unconscious bias and institutional racism. The Committee endorsed the approach being undertaken.

Recommendation:

a) The Board should note the pro-equity approach being undertaken across CCDHB.

4. INVESTMENT IN LONG TERM CONDITIONS
Two papers outlined our current investment (and associated performance) in long term conditions management and our intended approach to developing an investment plan for people with long-term conditions. Attention was drawn to the inequitable differences in health outcomes for Māori and Pasifika as well as the proportion of direct investment in long term conditions that is delivered in hospital settings. Committee members noted that despite initiatives such as the regional Pacific strategy we are yet to see any real difference in access to services or in health outcomes for this priority population. Investment to date has been low and not well targeted. There was broad agreement that a much more focused investment approach that prioritises prevention and early intervention is necessary if we are to see a shift in outcomes and start to address inequities.

Recommendation:

a) That the Board is aware of the inequitable burden from long-term conditions experienced in our Māori and Pasifika communities beyond socio-economic status.
b) That the Board be aware we invest around $250 million each year on prevention and treatment services for long-term conditions, of which 83% are on hospital speciality services.
c) That the Board support the development of an investment plan for long-term conditions that will improve equity and focus on prevention and early intervention.

5. REGIONAL PUBLIC HEALTH PERFORMANCE REPORT
RPH updated the Committee on the range of activity it delivers. CCDHB funds around one-third of RPH activity. There was wide discussion about the need to establish a more strategic approach to public health issues rather than reactive responses to challenges as they arise. Committee members felt we need a much clearer population health partnership approach between CCDHB and RPH. The Committee sees an opportunity for RPH in partnership with the DHBs to strengthen our public health efforts, including a strategic plan around long-term conditions. CCDHB is working with RPH to line these initiatives up more effectively. CCDHB is currently doing a public health strategy and a locality strategy with population health approaches within communities.

The Committee noted it was a challenge to consider issues and activities in any depth when presented as part of a summary or compendium paper such as this. It requested that RPH work with SIP to develop a series of papers that would allow the Committee to take a deeper look at areas of significant public health interest.

Recommendation:

a) The Board should note the importance of our public health interest and a close working relationship with Regional Public Health, who are funded by CCDHB, HVDHB and the Ministry of Health.

6. MHAIDS PERFORMANCE REPORT
The 3DHB MHAID service provided its bi-monthly update to the committee. A key challenge remains staffing specialist services such as forensic. Occupancy also continues to be high with substantial demand across the
system and sizeable investment in time and resources on inpatient services. We anticipate there is possibly further demand on acute inpatient bed capacity and staff are looking at this further.

**Recommendation:**

a) That the Board **notes** this update.

7. **SUICIDE AND SELF HARM PRESENTATION**

This item was not on the agenda but with the release of the latest national suicide statistics it was timely to update the committee on our local experience and our refreshed, more focused approach to reducing suicide and suicidal behaviour. Comprehensive analysis of our data highlights the degree to which people interact with the health system before dying, presenting opportunities for the health system to provide more focused responses and support to people in distress. This includes a zero tolerance for suicide at a system level, which has been shown to reduce rates of suicide.

The presentation prompted wide discussion from members and broad support for the new more focused local approach CCDHB is developing.

**Recommendation:**

a) That the Board **endorse** the change of focus and zero tolerance approach to suicide.

8. **SIP BI-MONTHLY UPDATE**

SIP updated the Committee on progress with its current work programme, highlighting in particular, progress with establishing the Citizens Health Council and the Health Care Homes roll out. The Committee requested an update on how the HCH model is addressing equity concerns that were raised by Committee members in February. SIP will provide a full HCH update at the next HSC meeting.

**Recommendation:**

a) That the Board **notes** this update.
# SCHEDULE OF ACTION POINTS – HEALTH SYSTEM COMMITTEE (HSC)

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<tr>
<th>AP No:</th>
<th>Topic:</th>
<th>Action:</th>
<th>Responsible:</th>
<th>How Dealt With:</th>
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<tr>
<td><strong>HSC Public Meeting 29 August 2018</strong></td>
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</table>
| 2.1 & 2.2 | Housing and Health & Regional Public Housing Approach | 1. Nevil to provide the report showing that intervention to the current 300,000 people made a difference to healthy housing.  
2. Staff to provide regular data and reporting of impact from health housing action.  
3. HSC to write to the Greater Wellington Regional Council to ask it to consider regulating heating methods within the region.  
4. CCDHB to submit to the consultation on changes to the RTA and any upcoming consultations on new regulation to be introduced under the Healthy Homes Guarantees Act. | Nevil Pierse  
Tara D’Sousa | Information requested  
Information requested  
Submission being drafted by Regional Public Health on CCDHBs behalf  
Submission being drafted by Regional Public Health on CCDHBs behalf | Oct 2018  
Oct 2018  
Oct 2018  
Oct 2018 |
<p>| 3.2 | Investment in &amp; Treatment of Long-Term Conditions | 1. Provide an update on the Porirua integration project at the next HSC meeting. SIP to introduce the team leader on this project. | Director, SIP | Transferred to October meeting. | October |
| 4.3 | Bi-Monthly SIP Update | 1. SIP to provide an update to HSC at its next meeting on how we are addressing equity concerns within the HCH roll out. | Director, SIP | To be discussed at the September HSC meeting | September |
| 4.1 | Bi-Monthly Regional Public Health Performance Report | 1. SIP to work with RPH to identify specific topics and bring these back as a series that allows a deeper dive into these individual issues instead of general compendium updates. | SIP &amp; RPH | Schedule being developed commencing Oct 2018. | Oct 2018 |
| <strong>HSC Public Meeting 27 June 2018</strong> | | | | | |
| 2.1 | Investment Planning Approach | 1. SIP to present the results of the approach, specifically the partnership table at a future HSC | Director, SIP | Remains open | Open |</p>
<table>
<thead>
<tr>
<th>3.1</th>
<th>2018/19 CCDHB Draft Annual Plan Excluding Financials</th>
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<tbody>
<tr>
<td>1.</td>
<td>SIP to clarify the healthy ageing workforce approach and to report at a future HSC meeting.</td>
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<td>2.</td>
<td>SIP to provide a graphic of all of the HSP design processes in a compact way.</td>
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<td>Director, SIP</td>
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<td></td>
<td>The ageing workforce</td>
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<td>To be presented at September meeting.</td>
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<tr>
<th>5.1</th>
<th>Investment Planning to Support Living Well, Dying Well</th>
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<tbody>
<tr>
<td>1.</td>
<td>SIP to provide more information on the investment to increase practitioner’s resources to Maori and Pacific areas when we get to the budget</td>
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<tr>
<td>2.</td>
<td>HSC to be kept informed about the budget in this area</td>
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<td>Director, SIP</td>
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<td></td>
<td>Verbal update at September meeting.</td>
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HSC Public Meeting 30 May 2018

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<thead>
<tr>
<th>2.1</th>
<th>Annual Plan Update</th>
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<tr>
<td>1.</td>
<td>SIP to present to the Committee at a future HSC meeting the development of suicide prevention approach and the DHB role as a health system.</td>
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<td>2.</td>
<td>SIP to share the School Based Health System strategy with the Committee at a future HSC meeting.</td>
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<td>Director, SIP</td>
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<td></td>
<td>Presented to September DSAC To be presented at October DSAC</td>
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<tr>
<th>3.1</th>
<th>Investment in and Performance of CCDHB NGO Providers for Child Services</th>
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<tr>
<td>1.</td>
<td>SIP to report on the integration progress of the different programmes at a future HSC meeting.</td>
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<tr>
<td>2.</td>
<td>SIP to present the investment planning approach at the next meeting in June.</td>
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<tr>
<td>3.</td>
<td>Housing issues to be discussed at a future HSC meeting and SIP will bring back information to the Board regarding what actions they will be taking.</td>
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<td>4.</td>
<td>An action from Sue requesting that at some point, for the Board to look at the whole public healthcare funding.</td>
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<td>Director, SIP</td>
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<td></td>
<td>Presentation at September meeting</td>
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<td></td>
<td>Presented to June meetings</td>
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<td></td>
<td>Presented to August DSAC</td>
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<td></td>
<td>Scheduled for November HSC</td>
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<tr>
<th>4.2</th>
<th>Regional Public Health Bi-Monthly Report</th>
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<tr>
<td>1.</td>
<td>Peter Gush to join the meeting when the next Regional Public Health Bi-Monthly Report is presented.</td>
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<td></td>
<td>Peter Gush</td>
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<td></td>
<td>Presented to August DSAC</td>
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<td></td>
<td>Peter Guthrie representative in attendance.</td>
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<td>Closed</td>
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</table>
2. It is important for RPH integration to occur across the DHB services and strategies.

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<thead>
<tr>
<th>HSC Public Meeting 2 May 2018</th>
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<tr>
<td><strong>3.1</strong> Investment in &amp; performance of CCDHB Primary Health Organisations (PHOs)</td>
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</tbody>
</table>

| **3.2** Investment & Performance – Aged Residential Care, Community Dental Agreement, Community Pharmacy Service Agreement | 1. Equity expectation on combined dental agreement is an issue to be added to the work plan to identify how long it takes to work out. | Director, SIP | SIP advised this cannot be completed until 2019. The information is provided by MoH. | Open |

Closed since last meeting – 29 August 2018

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<th>AP No:</th>
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<td><strong>HSC Public Meeting 27 June 2018</strong></td>
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<tr>
<td><strong>4.2</strong> Hospital &amp; Health Care Services (HHS) Bi-Monthly Performance report</td>
<td>1. Work Programme to be amended to reflect the HHS new structure.</td>
<td>Committee Secretary</td>
<td>Updated Work programme</td>
<td>Closed</td>
<td></td>
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</tbody>
</table>

<p>| <strong>HSC Public Meeting 30 May 2018</strong> |
| 2.1 Annual Plan Update | 1. SIP to bring an organisational approach on equity to the Committee. | Director, SIP | Pro-equity presentation to August 2018 meeting. | Closed |</p>
<table>
<thead>
<tr>
<th>3.1</th>
<th><strong>Investment in &amp; performance of CCDHB Primary Health Organisations (PHOs)</strong></th>
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<tr>
<td></td>
<td>SIP to amend the recommendation (g) to include Tristram’s advice of adding additional data points across all populations and remove the word “particularly”. SIP to add an additional recommendation (i) “SIP to advise the Board to explore further mechanism for accountability.”</td>
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<td>Director, SIP</td>
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<td>Amended</td>
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<td>Included in Actions</td>
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<td>Closed</td>
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<tr>
<td>Date</td>
<td>Topic</td>
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<tr>
<td>2 May 2018</td>
<td>HSC Work Programme</td>
</tr>
<tr>
<td>30 May 2018</td>
<td>Evaluation of 3D HealthPathways</td>
</tr>
<tr>
<td>27 June 2018</td>
<td>Primary Birthing Unit</td>
</tr>
<tr>
<td>25 July 2018</td>
<td>CANCELLED.</td>
</tr>
<tr>
<td>29 August 2018</td>
<td>Present results from the Investment Planning Approach – specifically the partnership table</td>
</tr>
<tr>
<td>26 September 2018</td>
<td>Prioritisation and Investment Update for implementing the Health System Plan</td>
</tr>
<tr>
<td>24 October 2018</td>
<td>Prioritisation and Investment Update for implementing the Health System Plan</td>
</tr>
<tr>
<td>28 November 2018</td>
<td>Presentation by Kapiti Health Advisory Group:</td>
</tr>
<tr>
<td>19 December 2018</td>
<td>Potential attendance/presentation by Mary Potter Hospice</td>
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<tr>
<td></td>
<td>System Performance Reporting</td>
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<td>Provider Performance</td>
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<td></td>
<td>Community Providers Performance report - (ARC, PHO, Dental, Pharmacy)</td>
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<td></td>
<td>Community Providers Performance report - (NGOs, Integrated Care)</td>
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<tr>
<td></td>
<td>System and Service Planning</td>
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<td></td>
<td>Prioritisation and Investment Update for implementing the Health System Plan</td>
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<td></td>
<td>Investment Planning Approach</td>
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<td></td>
<td>Long Term Conditions Investment Plan</td>
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<td></td>
<td>Whole of System Investment Update</td>
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</table>

**Holding topics for HSC**
1. Evaluation of 3D HealthPathways
2. Primary Birthing Unit
3. Healthy Ageing Workforce approach
4. Present results from the Investment Planning Approach – specifically the partnership table
It is recommended that the Health System Committee:

a) Notes that CCDHB provided Treasury with its first Long-Term Investment Plan (LTIP) in 2017. CCDHB is required to review and provide Treasury with an updated LTIP by July 2019;

b) Notes that understanding our current and future whole of system service demand and service configurations is essential to identifying the assets we require to deliver these services;

c) Notes that Hutt Valley and Capital & Coast DHBs have entered into a joint sub-regional planning process.

d) Notes that the investment planning process includes future service configurations and master site planning.

APPENDICES

1. LTIP GOVERNANCE STRUCTURE
2. LTIP MILESTONES

1. INTRODUCTION

1.1 Purpose

This paper updates the Health System Committee (HSC) on our investment planning. This planning is informed by our health system planning and the choices we make to invest in services in homes, community health networks and in our hospitals and mental health units to implement the HSP and the associated strategies for the populations we serve.

These service choices are then converted into operating cost and asset investment requirements. The asset requirements include the clinical equipment; information, communication and technology, (ICT) and facilities we require (and must replace), in our hospital and health services (HHS), mental health, addiction and intellectual disability (MHAIDS), as well as our community over the next ten years.

1.2 Long Term Investment Plan (Treasury)

CCDHB will use the information from this planning process to complete a Long-Term Investment Plan (LTIP). CCDHB provided Treasury with its first LTIP in 2017 and we are required to review and provide Treasury with an updated LTIP by July 2019. LTIPs are part of the Treasury Investment Management and Asset Performance (IMAP) system for monitoring investments across government.

The LTIP is required to identify, over at least 10 years, the organisation’s critical investment choices and their impact on organisational performance including outputs and outcomes for defined population groups.
2. THE PLANNING PROCESS

This planning process brings together information including clinical services planning, health system planning, investment plans and provider requirements to develop a cohesive view of our service intentions over the next ten years. Our planning process considers models of care, the use of technology and service delivery models across our whole system of care. It considers the demand for care from our Capital & Coast community, our Hutt Valley community and our tertiary and complex care demands from the central region and, for a very small number of services, the nation. It combines this with the current state of our assets and master site planning to inform our asset investments. This process is a joint-planning processes with Hutt Valley DHB.

It is ELT led and clinically supported. There is a strong use of system-dynamic modelling, capacity modelling and financial modelling to inform options and choices. Technology is a significant influencer on these choices.

The process is being led by Strategy, Innovation and Performance (SIP) supported by Finance and Corporate. EBHC, SIP, Finance and Corporate have created the capacity for this planning process. It will be supported by architects when we reach the Master Site Planning process. The structure for the planning process is attached as Appendix One.

2.1 Shared Planning across two DHBs

CCDHB and Hutt Valley DHB have entered into a joint sub-regional clinical planning process to realise the opportunities for joint provision of key services and to strengthen the network of hospitals in the greater Wellington region. This hospital network serves the Wellington, Kāpiti, Porirua and Hutt Valley communities.

The two DHBs serve populations that are geographically co-located and there are currently a few services that are already jointly provided. These services include: mental health, addictions and intellectual disability (MHAIDS), advanced care planning, and the disability strategy.

A joint planning process enables the DHBs to identify services that would benefit clinically, and financially, from joint provision across the network could significantly improve the ability of both DHBs to improve health outcomes with our available resources. The joint planning approach across the hospital network will be a crucial aspect of the LTIP redevelopment.

The initial HVDHB and CCDHB joint planning process, under this new approach, is the breast service. This project is underway and will allow the DHBs to test the concepts outlined above. A small joint governance group has been created to provide guidance to the project managers. Work has begun on identifying a common clinical pathway for women who access the service. Once this is understood we will be able to understand the resources required to support a sustainable service and the most effective way of configuring those services and the support functions they need to be efficient. The group is also identifying a joint decision making process to ensure the planning process recommendations are able to be implemented consistently across the two DHBs.

3. OUR FUTURE SERVICE CONFIGURATION

3.1 The Strategic Context – Health System Plan 2030

The Health System Plan 2030 (HSP) sets the long-term strategic direction for CCDHB. It describes our ambition for improved health and wellbeing for our communities through services designed to meet people’s needs earlier, deliver care when and where it will make best use of health system resources, reduce the onset of complex health needs, and ensure financial and clinical sustainability in the context of limited resources and known demand pressures.

3.2 Future service configurations

Understanding our current and future service demand and service configurations is essential to identifying the substantive investments we require to deliver these services. There are a number of key contributions to understanding future service configurations including:
Populations we serve and the major service user groups,
Whole-of-system planning,
System dynamic modelling,
Clinical services planning, and
Demand and capacity planning.

One of the significant drivers of future health service configuration is the profile of the populations we serve. For this work our planning constructs consider the five major service user groups below and the care they need in their homes, community health networks and hospital/specialist settings.

- Acute demand
- Planned demand
- Complex care
- Mental health
- Older people especially those with frailty
- Maternity, children young people and their families/whānau

The whole-of-system planning processes are developing investment plans for our populations. The Health System Committee has received papers on some of the key areas that inform this process including:

- Long term Conditions
- Dying Well and Palliative Care
- Addiction Services
- Suicide Prevention and Postvention
- Healthcare Homes

System Dynamic Modelling will support the LTIP work programme. System Dynamic Modelling is about understanding the short term and long term impacts of decisions made across the entire health system and community. The whole of system analysis includes these types of considerations:

- Hospital Network Planning – Wellington Regional, Hutt Valley and Kenepuru hospitals
  - Options for shared service development for example Breast Services across the hospital network.
- Regional tertiary/complex care service provision
  - Regional specialty services such as cardiology and regional/national forensic services.
- Patient flow within our services
  - Acute demand from our communities and community services
  - Early intervention support to prevent avoidable demand for older people
  - Discharge planning for those returning to the community

Clinical services planning is being undertaken in key areas. The immediate service modelling is focused on key areas of pressure that may require investment. This includes:

- Cancer unit requirements with the planned corridor from the children’s hospital impacting on the current space,
- Planning for renal dialysis and colonoscopy capacity as demand profiles exceed available capacity,
- Radiology services and how to meet demand for urgent MRI and CT scans,
- Acute mental health capacity including specialist inpatient and community care

The demand modelling work currently underway in the Hospital and Health Services (HHS) Provider Arm, is looking at understanding the forces that drive patients towards the hospital and project inflows of patients into the hospital. The demand modelling will look at the range of drivers of demand, including: institutional drivers, technological drivers, epidemiological drivers and economic drivers.

The capacity modelling projects will identify how to best manage expected inflow of patients within the short term and long term supply constraints. Some of these constraints are: space constraints, workforce constraints, budget constraints and technological constraints.
3.3 Asset Planning

Knowing the state and condition of our assets ensures we can make informed decisions about how these assets are used and what is required to maintain and/or replace them. Assets include: buildings & facilities, clinical equipment, non-clinical equipment, workforce and information & communication technology (ICT). The significant work completed at CCDHB on the current state of facilities, clinical equipment and ICT are a critical input into the planning process.

CCDHB has been commended by Treasury for its developing asset management plan. The condition of our facilities and assets inform our options and choices.

Master site planning is a significant part of the facility planning process. CCDHB has a draft master site plan for the Wellington Regional Hospital site. This plan informed the location of the Children’s Hospital. In February 2019 architects will be engaged to develop site master plans for our three main sites, including Wellington regional Hospital, Kenepuru Hospital and Kāpiti Clinic.

3.4 Financial Modelling

The finance team will develop a model that considers the impacts of choices on our operating and capital expenditure focusing on the forecast implications and what this means for our financial sustainability including both our profit and loss and balance sheet implications. The CCDHB costing system will provide valuable input into this forecasting process.

4. MILESTONES

Attached as Appendix Two are the milestones for the development of the Long term Investment Plan and the completion of the planning process. This process has commenced. The Health System Committee and the Finance, Risk and Audit Committee on progress with this planning process. In early 2019 these committees will be considering options and their implications for the sustainability of CCDHB.

The process will be ongoing and the models will be informing all future Board decisions.
APPENDIX ONE: LTIP DEVELOPMENT GOVERNANCE STRUCTURE
## APPENDIX TWO: KEY MILESTONES

### Major Milestones 2018 - 2019

<table>
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<tr>
<th>Financial Structures</th>
<th>Aug</th>
<th>Sept</th>
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<td>Facility Asset Schedules</td>
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<td>Urgent Occupancy Issues</td>
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### Future Service Configurations

| Demand Modelling Across the Whole of Hospitals           |     |      |     |     |     |     |     |     |     |     |     |     |
| Capacity Modelling (Theatres/Beds etc.)                 |     |      |     |     |     |     |     |     |     |     |     |     |
| HHS Service Considerations                              |     |      |     |     |     |     |     |     |     |     |     |     |
| MHAIDS Service Considerations                           |     |      |     |     |     |     |     |     |     |     |     |     |
| Hutt Valley Network                                     |     |      |     |     |     |     |     |     |     |     |     |     |

### Scenario Development

| Options Development                                      |     |      |     |     |     |     |     |     |     |     |     |     |

### LTIP Drafting

| Draft Plan Written                                      |     |      |     |     |     |     |     |     |     |     |     |     |
| Draft to Board                                          |     |      |     |     |     |     |     |     |     |     |     |     |
| Final Draft to MoH/Treasury                             |     |      |     |     |     |     |     |     |     |     |     |     |

---

Health System Committee PUBLIC - 3.1 Long-Term Investment Planning
# Recommendations:

It is recommended that the Health System Committee:

- **Notes** the 3DHB Health Pathways programme was introduced in 2014 as a key enabler for progressing integration and is part of the Integrated Care Collaborative (ICC).  
- **Notes** the 3D HealthPathways Evaluation Report has been completed and recommendations have been reviewed by the 3DHB Governance Group.  
- **Notes** in June 2018 there were 390 live Pathways on the 3D HealthPathways site and on the 3rd January 2018, the milestone of one million-page views had been reached.  
- **Endorses** the development of 3DHealthPathways investment proposal for 2019/20 and future years to meet the increasing demand required for technical writing and manage the increased workload in managing revisions.  
- **Provides feedback** on the option of developing a proposal for Hospital HealthPathways.

## Appendix 1. 3DHealthPathways Evaluation

**1. PURPOSE**

The evaluation report was discussed at the 3D Health Pathways Governance Group that is part of the Integrated Care Collaborative (ICC). This paper requests the Executive Leadership Team (ELT) provide direction on recommendations identified in the evaluation to progress the 3D HealthPathways programme.

**2. BACKGROUND**

In 2014 (Capital & Coast DHB (CCDHB), Hutt Valley DHB (HVDHB) and Wairarapa DHB (WrDHB)) introduced 3D HealthPathways. Health Pathways was identified as a key enabler for progressing integration. It aims to support primary and secondary health providers to develop sustainable, clear and concise pathways that reduce variation, increase provider performance and improve outcomes for people.

**3. EVALUATION - KEY FINDINGS**

The evaluation undertaken has provided insight into the use and value of HealthPathways across the 3D region and presented some considerations to support its ongoing delivery. The process adopted a mixed method design, drawing on key stakeholder and user interviews, Google analytics, project documentation and relevant DHB data.

There has continued to be 100 pathways either localised or reviewed per year. In June 2018 there were 390 live Pathways on the 3D HealthPathways site.

Capital & Coast District Health Board
The number of users for 3D HealthPathways has consistently increased over time. Since March 2017, there has been over 2000 users each month and March 2018 there were 2,172 users who looked at an average of 4.89 pages per session. Since May 2014 there have been 46,625 users access 3D HealthPathways.

Clinicians value HealthPathways especially for their guidance in assessment, management and referral to secondary services and feel confident and supported in their clinical and treatment pathway decisions. Users regard HealthPathways as a highly credible source of information. The clarity provided by local protocols supports and improves communication between primary and secondary services. HealthPathways provides benefits to patients, clinicians and contributes to health system outcomes.

4. FUTURE DIRECTION

The evaluation has highlighted the role of HealthPathways in facilitating care closer to home for patients, enabling clinicians to confidently provide best practice care, promoting an integrated approach across sectors and supporting system change. The evaluations key recommendations and considerations by the Governance Group are as follows:

**Review work programme and KPIs**

The Governance Group noted that recommendation and is currently considering options to support the further development of KPIs for the programme. It is likely that it will include measures including process (e.g. live pathways), quality (e.g. improving referrals) and impact (e.g. Admission rates).

**Resourcing for maximum efficiency**

The Governance Group notes the evaluation’s recommendation and is considering options for what may be required to adequately resource the Health Pathways programme. Additional resource may be required to accelerate the localisation of pathways as well as manage the required pathways revisions that are accumulating.

**Monitoring and reporting**

The Governance Group has endorsed the development of a monitoring dashboard, which was a recommendation of the evaluation and that would include the measures noted above.

**Hospital HealthPathways**

Canterbury has established Hospital HealthPathways and the evaluation highlighted this as a future opportunity. As the existing programme has matured and the benefits of community HealthPathways realised this option of expanding this to the hospital may be considered. This may be progressed across Capital & Coast District Health Board.
the 3DHB similar to the existing programme. Direction from ELT and the HHS clinical leadership is required about whether this should be scoped for an investment bid for 2019/20.
EVALUATION OF 3D HEALTHPATHWAYS

A process and outcome evaluation for the 3D HealthPathways Steering Group

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25th June 2018

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Acknowledgements

Synergia would like to acknowledge the support of the stakeholders that took part in this evaluation. We would particularly like to thank the HealthPathways Steering Group, chaired by Chris Masters and Ken Greer, for their participation, and Sam McLean for providing DHB data sets. We also want to thank the clinicians across the three DHBs who made the time to talk to us about HealthPathways.
EXECUTIVE SUMMARY

HealthPathways: Evaluation overview
HealthPathways provide web based guidance for primary care clinicians and promote consistency in the local assessment, management and referrals of patients to secondary health care. Patients receive the right care, at the right time, from the right place.

Evaluation approach
AIM: To understand if Health Pathways have been implemented as intended and achieved the expected outcomes.

METHODS
- Interviews (n=29)
- Google Analytics data for pathway use
- Documentary analysis

HealthPathways availability and use

1,078,209 PAGE VIEWS

362 LOCALISED PATHWAYS

MAY 2014 – MARCH 2018

Clinician Engagement
The use of HealthPathways is increasing each year, and is supported by the perceived quality and integrity of information in the localised pathways. Use by GPs varies from a few times a month to most days.

Key ways in which clinicians use the pathways included:
- Primary care assessment and management
- Supporting the interface with secondary care, including enhanced quality and appropriateness of referrals
- Learning and development, both for new and existing GPs

Clinicians less likely to use HealthPathways to identify community resources. Use is related to the health condition, with clinicians most likely to use it for the dementia pathway for example.

HealthPathways Case Studies
Cognitive Impairment and Dementia
- Most viewed pathway: 15,378 page views
- Highly socialised
- Referrals to secondary care increased, but referrals are more appropriate
- More management and investigations are now in the community

Colorectal symptoms and Direct Access to Colonoscopy
- Highly viewed pathways, 5,357 page views combined
- Perceived need for pathway use varies between clinicians
- Wait time for first specialist appointment is reducing

Childhood asthma (acute and non acute)
- Relatively highly viewed
- Once confident with management, GPs less likely to access pathway
- Hospital outcomes unchanged, trend of shorter length of stay

Heavy Irregular menses
- Highly viewed pathway – 6,095 page views
- Use linked to funding for community radiology
- Patients being diagnosed earlier and referred to secondary services.
- Shorter wait times for specialists.
- Percentage of rejected referrals has decreased

Cellulitis
- Highly viewed pathway: 5,820 page views
- Pathway use strongly linked to POAC funded interventions
- Reduced burden on secondary services

Deep Vein Thrombosis
- Highly viewed pathway: 8,832 page views
- Most searched for pathway
- Well established complementary use by primary and secondary care.
- Use enabled by funding for ultrasound and anti-coagulants
- People getting faster treatment in the community and there is reducing ED demand

Benefits of HealthPathways

Patients
- Get the right treatment, at the right time, closer to home
- Supports optimal health outcomes

Clinician
- Supports delivery of consistent, quality care
- Increases clinician confidence and knowledge
- Effective communication between clinicians

System
- Reduces demand on secondary services
- Enabler of wider integration programme
- Supports whole system efficiency

Summary and key considerations
By March 2018 there were 362 localised pathways and 2,712 users. The landmark of one million-page views was achieved in January 2018. HealthPathways are well established across the 3D region, are working largely as intended and producing, or contributing to, the benefits expected for people, clinicians and the wider health system.

- Review work program and KPIs to support balance between the localisation of new pathways and the review of existing. More localisations encourage more use and up to date information maintains the integrity of HealthPathways.
- Develop a dashboard of simple high-level indicators that are reported in quarterly periods in a consistent manner to track ongoing performance.
- Consider allocating additional resource to enable the programme team to expedite the localisation of pathways while addressing the review programme in this transitional phase.
- Explore opportunities for ongoing enhancement

This summary was completed as part of the HealthPathways evaluation conducted by Sarah Andrews and Dr Sarah Appleton-Dyer from Synergia Ltd with the HealthPathways 3DHB project team in June 2018.
1. INTRODUCTION

Wairarapa, Hutt Valley and Capital and Coast District Health Boards (DHBs) have implemented a 3D HealthPathways approach since 2014. This approach has aimed at supporting primary and secondary health providers to develop sustainable, clear, concise and localised pathways that reduce variation, increase provider performance and improve outcomes for people.

The Steering Group leading this work on behalf of the 3D region wanted to understand if these benefits were being realised and identify any opportunities for enhancement and improvement. Synergia submitted a quote for a process and outcome evaluation in December 2017. The work was completed between February and June 2018.

The evaluation adopted a mixed methods design, drawing on key stakeholder and user interviews, Google Analytics data, project documentation and relevant DHB trend data.

The evaluation has provided insight into the use and value of HealthPathways across the 3D region and presented some considerations to support its ongoing delivery. This report presents the findings of the evaluation.

1.1 Report structure

This introduction is followed by an overview of the background and context of HealthPathways and a summary of the evaluation approach and methods. The report then describes the process of localising HealthPathways, followed by a review of implementation that includes evidence from Google Analytics and clinician feedback relating to use.

The benefits of HealthPathways are presented, generally, and then as they relate to the six pathways selected as mini case studies. The report then reflects on opportunities for continued programme development.

The report concludes with a brief summary of the findings and presents considerations for ongoing development.

A data supplement containing the DHB outcome data used in this report in a less aggregated format, is available separately.
1.2 Background and context

HealthPathways was created by Canterbury District Health Board (CDHB) in 2008 to help clinicians make better decisions regarding assessment, management and referrals to secondary care. In 2014, 99% of surveyed CDHB GPs used it weekly and there are now 40 local versions of Health Pathways across Australia and New Zealand with up to 800 pathways available to be localised.

In 2013, the 3D DHBs recognised the need for clinical pathways to integrate information across services and decided to adopt HealthPathways. 3D HealthPathways went live in May 2014, with 26 localised pathways and over 600 clinical, resource, and request pathways from CDHB with Canterbury information. The intention was to localise the CDHB pathways at the rate of 100 per year to ensure the content was accepted best practice across the region and that the information regarding referral to secondary services aligned with agreed local process.

1.3 HealthPathways

HealthPathways provides web based guidance for primary care clinicians and promotes consistency in the local assessment, management and referrals of patients to secondary health care. It supports the vision of providing patients with the right care, at the right time, from the right place.

Figure 1 represents the process of delivering HealthPathways and how the intended changes support benefits for patients, clinicians and the health system.

Figure 1: HealthPathways development and implementation process, intended benefits and outcomes at 3D

1 McGeoch, G; McGeoch, P; Shand, B (2015) Is HealthPathways effective? An online survey of hospital clinicians, general practitioners and practice nurses NZMA Vol 128 No 1408 p36-46
2. EVALUATION AIMS AND OBJECTIVES

The aim of the evaluation was to understand if HealthPathways have been implemented as intended and achieved the expected outcomes. Objectives developed with the Steering Group were to:

- Describe the development and implementation of HealthPathways across 3D
- Describe the ways clinicians engage with HealthPathways and barriers and enablers to engagement
- Understand the benefits of HealthPathways and the impact on patients, clinicians and the local health system from the clinician’s perspective
- Identify ideas and considerations to support the ongoing development of HealthPathways.

2.1 Evaluation approach and methods

Synergia has conducted a process and outcomes evaluation, working collaboratively with the 3D HealthPathways Steering Group to deliver a mixed methods evaluation that has synthesised insights from newly collected and collated data, and existing DHB data. Six pathways were selected by the team as mini case studies to explore themes of use and value. Initial results and insights were shared with the team in a sense making session on 31 May 2018.

The Aotearoa New Zealand Evaluation Association Standards have guided the work.

2.1.1 Evaluation methods and sources

- Interviews with a range of stakeholders (Table 1)
- Google Analytics regarding pathway use up to 31 March 2018
- CCDHB, HVDHB and Wairarapa DHB data relating to health system outcomes associated with the six sample pathways (for example: procedures delivered in primary care, referrals and presentations to secondary services)
- Documentary analysis of project documentation to identify structures, process and delivery of the work programme.

Table 1: Interviewees by DHB and role type

<table>
<thead>
<tr>
<th>DHB</th>
<th>Primary</th>
<th>Secondary</th>
<th>Community</th>
<th>Project</th>
<th>Total by DHB</th>
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<td>HVDHB</td>
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<td>5</td>
<td>12</td>
</tr>
<tr>
<td>WRDHB</td>
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<td></td>
<td></td>
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<td>2</td>
</tr>
<tr>
<td>Total by type</td>
<td>19</td>
<td>4</td>
<td>5</td>
<td>11</td>
<td>29</td>
</tr>
</tbody>
</table>

Note: some interviewees were represented in more than one category

2.1.2 Limitations

The following are noted as limitations to this evaluation.

- Consumer engagement was beyond the scope of the evaluation.
- Under representation of clinicians from Wairarapa in interview.
- Only a small number of secondary clinicians participated in an interview.
3. HEALTH PATHWAYS DEVELOPMENT

This section describes the people and processes involved in delivering HealthPathways and their reflections on the process of prioritizing, developing, socialising and reviewing HealthPathways. The section concludes with a summary of the barriers and enablers to this process.

3.1 Team roles and functions

HealthPathways is Governed by a group consisting of representatives from the Alliance Leadership Teams, Hospital services and Primary Health Organisations in the 3D region. A member of the Strategy Innovation & Performance team at CCDHB oversees the work plan and budget as part of their service development management role. The Steering Group is responsible for the delivery of HealthPathways. Alongside the manager, it includes the following roles and functions:

- Coordinator: co-ordinates pathway development, reviews and socialisation, and monitors and reports on their use. This is a full time dedicated role.
- Clinical Leads (0.2FTE): Provide clinical leadership and advice to the team, and engages with health organisations and clinicians.
- Clinical Editors (0.9 FTE for 2017/2018 financial year): work with workgroups of local clinicians to write and edit pathways, focusing on clinical content. These are specialty rather than geographically focused, and include practising GPs and an allied health practitioner.

The HealthPathways community is supported by Streamliners, who provide technical, publishing and administration support. The Coordinator is the team’s day to day link with Streamliners.

3.2 Prioritizing pathways for development

Canterbury DHB now has around 800 HealthPathways that could potentially be localised. The Steering Group set itself a target of 100 localisations per year but must determine which ones to localise first. To date, preference has been given to pathways that support DHB strategic priorities. A revised prioritization process, with a greater focus on HealthPathways required by primary care user needs, was recently developed. This new process was approved by the Governance Group in March 2018.

“We now want to give more weight to the actual demand in primary care, even if it’s not on the District Annual Plan” - Steering Group member

Steering and Working Group members reflected pragmatically on prioritisation and the need to consider the strength of support for pathway work, as well as general demand. This refers to the existence of a motivated group with capacity to work on a pathway and taking opportunities from initiatives or change programmes (such as the Faster Cancer Treatment Health Target).

The effort required to localise pathways can differ considerably. The simplest pathways involve few stakeholders and can be completed in a few weeks, while the more
complex involve many stakeholders, include a network of pathways within the broader pathway and can take over a year. Experience gained, processes streamlined and the vast network of relationships built over the past few years have helped make localisation easier and more efficient than in the early days. Scoping the annual work programme against resources is still challenging.

Prioritisation has evolved with a maturing programme and can make use of available data (such as search information) balanced with practical considerations (such as willing champions) to determine the best use of programme resources.

3.3 Developing a HealthPathway

Feedback from the Clinical Leads and Editors describes this process as working largely as intended. A “fluid and flexible” approach is required however, to respond to the diversity of clinical conditions, stakeholders and geography.

“It’s OK when it’s about evidenced based practice but it’s a lot of work to localise them... blood, sweat and tears.” - Steering Group member

Localisation involves clinical decision making and operational consensus. Small working groups have been found to be more efficient, but this must be balanced with the need to involve essential stakeholders in the process. Bigger workgroups involve multiple hospital departments and/or agencies; a process that delivers real, but less tangible benefits for the integration programme as demonstrated by the Cognitive Impairment and Dementia pathway. This large workgroup addressed a suite of older persons pathways and in the process developed a strong cross sector network of relationships and promoted awareness of the conditions as well as guiding response. This demonstrates the value of the approach in supporting engagement and uptake of a pathway.

The shift towards more varied working groups was reflected on positively, this refers to the inclusion of allied health and a range of community organisation representatives. Such an approach reflects a multi-disciplinary and whole of system approach to care, that will position the programme well for the next phase of localisations. Likewise, the work underway to incorporate Māori and Pacifica approaches to health and relevant resources, has potential to add to the value of HealthPathways that guide support in the community.

Localisation work programmes often get delayed, most commonly because the work required has been underestimated or due to the lack of available clinicians (especially secondary clinicians). Limitations in the coordination capacity (as evidenced through interviews and progress reports) are also reasons for delay.

The smaller size and relative remoteness of Wairarapa DHB has limited the involvement of this DHB in the localisation process. Keeping a GP Clinical Editor from Wairarapa in the HealthPathways team has been a particular challenge. Technology (email or teleconference) replaces some face to face communication. Sometimes a compromise about Wairarapa’s involvement is made, such as the decision to launch a pathway with less detailed information about Wairarapa referral processes than the other two DHBs.
At 31 March 2018, 362 pathways have been localised. Once localisation is completed going live is authorised by the Clinical Editor and subject matter expert.

3.4 Socialising HealthPathways

Most newly localised HealthPathways are socialised in a very “low key” manner though emails to HealthPathways subscribers and PHO communications. HealthPathways appear to be a regular part of PHO Continuing Professional Development, though efforts to “squeeze them in” were sometimes required. The people involved in HealthPathways – from Governance to Working Group members – are often leaders in their field or organisation, and use their influence to support socialisation through their organisations, networks and individual relationships.

“I can’t imagine there is a GP out there who isn’t aware of HealthPathways.” - PHO lead

Roadshows, in particular the one that promoted the Cognitive Impairment and Dementia pathway, appear to have been well received by clinicians. This may be an effective form of socialisation, but is resource intensive. Short videos about cancer pathways (related to Faster Cancer Treatment) have been developed recently. This may be an effective and sustainable approach to socialisation going forward. Information about the reach and impact of this new approach would inform this decision.

The sheer volume of communication and information received by clinicians was cited as a challenge to communicating HealthPathways. Despite this, HealthPathways is well known, well established and clinicians spoken to were using HealthPathways regularly.

Those in secondary care noted there was no systematic socialisation of HealthPathways. HealthPathways are seen as a tool for primary care clinicians but they often have a clinical and operational role to play in the interface between primary and secondary care. Systematic socialisation in secondary services (particularly at triage and discharge points) and alignment with hospital processes would support the aim of consistency of response.

3.5 Review of Health Pathways

The Steering Group postponed the systematic review of localised HealthPathways from two to three years since launch, in line with other DHBs. The challenge continues to be the increased number of reviews that need to be completed.

“If [currency of information] were allowed to lapse we should still reduce variation but not in a good way. They need to be continually updated” - Governance Group member

Existing resources are insufficient to support ongoing localisation at a rate of 100 pathways per year while keeping up with the review of existing HealthPathways as they become due. The pragmatic approach to concentrate on high use or high-risk pathways would potentially leave other pathways with out of date information. Users of HealthPathways valued them for their local and up to date information. Users indicated that out of date information would reduce the credibility of the HealthPathways programme and make them less likely to trust the programme.
Prioritising and scoping up the work required to review pathways is something the Steering Group now face. Frequency of use and degree of risk were suggested as prioritisation guides. Opportunities to mitigate the risks to pathway credibility from information that may no longer be current should be explored. This may include a notification that review is overdue/underway (and encourage feedback) as well as increasing capacity in the team to complete reviews.

3.6 Delivering Health Pathways: Barriers and enablers

The process of developing localised HealthPathways works largely as intended. There is huge passion and significant capability driving this work and the enablers of the work have propelled the programme forward. The barriers are mostly systemic and reflect the complex context of the work. Figure 2 summarises the key barriers and enablers to the development of Health Pathways.

Figure 2: An overview of the barriers and enablers to HealthPathway development
4. HEALTHPATHWAYS IMPLEMENTATION

This section explores the implementation and use of HealthPathways. First, Google Analytics data identifies patterns of use, and this is followed by clinicians’ descriptions of their use and the factors that influence use.

4.1 Localised HealthPathways and page views

By March 2018, 362 pathways had been localised. Since the first 3D HealthPathways were released, use (in terms of page views) has kept pace with the increasing number of localised HealthPathways available. On the 3rd January 2018, the milestone of one million-page views had been reached. In May 2014, there were 6,000 page views of 3D HealthPathways. In March 2018, this had increased to 45,000 views.

The annual cost per page view has fallen by 78% from $5.84 in the 2014/2015 financial year, to $1.27 per page view for 2017/2018 (up to March 31). This is calculated on programme actual costs, minus Health Navigator costs.
4.2 Patterns of use through Google Analytics

The number of users for 3D HealthPathways has consistently increased over time. Since March 2017, there have been over 2000 monthly users each month and in March 2018, there were 2,712 users who looked at an average of 4.89 pages per session. Since May 2014, there have been 46,625 users access 3D HealthPathways.

The search function has been used more over time. In March 2015, there were 1.32 searches per user, and in March 2018 there were 3.46 searches per user. This is a 160% increase in the number of searches per user.

Search is the main way that users navigate the site, with 237,434-search driven page views since 3D HealthPathways went live, which is equivalent to 90% of the 265,196-page views for the Home page. In comparison, the 3D Localised Pathways page, another possible key way to navigate the site, only had 23,504-page views.

Hypertension is the 9th most searched for pathway, the only one of the top ten searched pathways that isn’t localised.
Data on the number of users cannot be contextualised as access is available quite freely and the number of primary care clinicians with access or the source of access is not available through Google Analytics.

4.3 Interface experience

HealthPathways are easily accessible to clinicians - a click away on their patient management system, and simple to navigate. The one-page standard structure for information is appreciated and clinicians understand how to navigate the broad and shallow information on each page, using the drop-down menus to hone in on more detailed information.

Interface experiences were positive, but there were several people who said it can be hard to find things from the menu as it’s not clear what section to start with. That may partially explain why the majority of uses begins with a search query.

The ability to make e-referrals directly from HealthPathways was a required improvement identified by many. This functionality is in development and is likely to encourage the use of HealthPathways, provide a greater insight into HealthPathway use across the sector and contribute to system efficiency.

“We really want e-referrals. Not only would they reinforce minimum standards and integration but would save time for GPs and hospital services” – PHO lead
5. **CLINICIANS’ USE OF HEALTHPATHWAYS**

During interviews, clinicians were asked how they use HealthPathways. They were often used as a tool to support assessment and management in primary care, as well as guiding appropriate and successful referral to secondary care. The use of HealthPathways as a tool to support ongoing learning and development was also a common theme. Though discussed separately, these uses are interlinked.

The primary care clinicians we spoke with used the pathways from a few times a month to “most days”. Support for HealthPathways was overwhelmingly positive.

“**HealthPathways is the most significant aid to GPs in the last 30 years**” (PHO representative and GP)

HealthPathways are designed to provide self-management information to patients and information on relevant community resources. This aspect was referred to by only a few of those interviewed, with the exception of those talking about the Cognitive Impairment and Dementia pathway, who identified community resources, such as Dementia Wellington and information for patients and their families. Monitoring of Health Navigator views from HealthPathways would provide broader insight into this aspect, but such data was not available for the evaluation.

Some GPs noted the existence of some of the sample pathways that form our mini case studies and said they didn’t need to use them, but would if necessary. Whether this indicates competence, a knowledge of the content or ignorance of the content is not clear.

5.1 **Assessment and management**

The GPs we spoke to were motivated to provide quality care that aligned with best practice, in terms of clinical evidence and locally accepted practice. This was a key driver for use. HealthPathways supported the GPs to work at the top of their scope, guided by credible, current protocols for assessment and management of patients, including conditions that had historically been referred to secondary services.

“**Health Pathways is almost always my first place to go**” (GP)

Low prevalence or high complexity of a condition (or the response required to manage it) were factors that GPs described as key reasons to use HealthPathways. They simply could not retain all the information required to safely support a patient without guidance.

“**Microscopic haematuria – I often refer to it as it’s hard to remember what to do for the different age groups**” - GP

Recently changed protocols were also another reason GPs would use HealthPathways for assessment and management. This may be due to a change in recent clinical evidence affecting treatment protocols, or a change in local protocols for treatment, particularly those linked to funded interventions, such as community radiology or Primary Options for Acute Care (POAC).
HealthPathways were mostly used during consultations. Clinicians would refer to HealthPathways outside consultations, when they needed to concentrate, or read more extensively than they could with a patient present.

Use has also enabled nurses, GPs and others in primary care to work effectively as a team, sharing patient care.

“[HealthPathways] gives us a common language…. you have more credibility in discussions with doctors” - Community Nurse

Clinicians also referred to other resources they would use to support assessment and management of patients. This included advice from colleagues as well as online resources (such as the Best Practice Advisory Service or the Mayo Clinic). The demise of the New Zealand Guidelines Group was noted as another reason GPs would use HealthPathways, as even non-localised pathways had current assessment and management information relevant to New Zealand available.

5.2 Referral to secondary care

Primary care clinicians used HealthPathways to ensure they had followed due process and were referring to secondary services appropriately, with sufficient information to meet the criteria required and ensure referrals would be received.

Some GPs also explained the pathway/referral to secondary care to their patients to justify the management of their condition in primary care, or explain why they weren’t eligible for secondary services.

Many of the GPs said they referred to the use of HealthPathways on their referral to specialist services, confident this would expedite the triage process. The secondary service clinicians we spoke to referred to using HealthPathways in their triage process. Consultants said they still used their discretion when accepting referrals; their discretion broadened rather than narrowed the criteria for acceptance.

Consultants use HealthPathways to triage referrals and to teach their registrars to triage referrals and, in some cases, develop discharge plans to align with the treatment protocols for community management. Consultants would refer GPs back to the appropriate HealthPathway, leaving them confident in their triage decision so that the patient would get the right care. We heard from one GP who had received laboratory tests back that referred him to HealthPathways.

5.3 Learning and development

HealthPathways were used for learning and development separately from being used for a specific patient. Newer GPs, and those still in training, valued the site. Examples were shared of HealthPathways used by individuals as well as training cohorts, for example, supporting long term conditions management. More experienced GPs said they used HealthPathways to keep their knowledge current. Only a few GPs said they used it to broaden their knowledge about what resources were available in the community.
“Yesterday new pathways were added. It’s a good reminder to think about things. I’ll go do a refresher on what’s required at a first antenatal visit” - GP

GPs use of pathways for learning or refreshing was frequently prompted by communications about newly localised or updated pathways.

5.4 Improvements identified by users

When asked about any required improvements to HealthPathways the responses were predominantly about having more localised pathways and keeping them up to date.

Interface experience will be improved for users when there is e-referral functionality directly from HealthPathways. Pathway design was generally well regarded (with exceptions relating to pathways with too many levels to drill down or navigation to other sites that required a sign in process). Users also identified some inconsistencies between pathway information and other procedures, such as community radiology access, and felt these should be aligned.

Many users were aware of the feedback function on the site and had used this, with some getting an acknowledgement and others not, suggesting a potential opportunity for improvement here.

5.5 Barriers and enablers

The number of users of Health Pathways has increased each year, and the use of HealthPathways has also increased. The critical mass of HealthPathways combined with its credibility has seen the resource become established as an essential primary care tool.

The following diagram summarises the factors that enable or act as barriers to use. There are many mediating/moderating factors that affect how it is used, but there are few actionable barriers to the use of HealthPathways.
### SUMMARY OF BENEFITS

The process of developing and using HealthPathways across 3D is working largely as intended. This section presents a summary of interview and DHB trend data to explore the intended and other, benefits experienced locally. These are further explored for the six mini-case study pathways that follow.

| PATIENT BENEFITS                                                                 | Supporting patients to get the right treatment at the right time  
|---------------------------------------------------------------------------------|------------------------------------------------------------------- |
|                                                                                  | Clinicians confirm use supports care closer to home and more efficient referral to specialist services when required.  
|                                                                                  | Supporting optimal health outcomes  
|                                                                                  | Clinicians agree this is a logical consequence of following best practice and local protocols.  
| CLINICIAN BENEFITS                                                             | Supporting delivery of consistent, quality care  
|                                                                                  | Adherence to best practice and locally agreed protocols was a key motivating factor for their use in primary care and its interface with secondary care. Use can support consistent, quality care from individuals and across primary care teams.  
|                                                                                  | Increasing clinician confidence and integration  
|                                                                                  | Primary clinicians with a range of experience feel more confident in their practice. This is especially true with low prevalence, high complexity conditions, and conditions where there has been a change in treatment protocols. Secondary care clinicians have confidence that patients can be well managed in primary care, where appropriate, and there is a better understanding of each other’s responsibilities.  
| SYSTEM BENEFITS                                                               | Reducing the demand on secondary services  
|                                                                                  | Primary care clinicians cited this as a key benefit of HealthPathways. The DHB data also provides some evidence to support this notion, but not consistently. Indicators of demand on secondary services are whole of system indicators, influenced by a multitude of factors from health determinants and shifts in funding (such as POAC) right down to capacity in individual hospital departments. The evidence presented here however, provides positive indicators of the contribution of HealthPathways to the wider system. The implementation of e-referrals functionality from HealthPathways will provide an opportunity to further develop this evidence base. In the meantime, proximal indicators (such as fewer rejected referrals) can continue to be monitored to determine impact.  
|                                                                                  | Supporting whole system efficiency  
|                                                                                  | Interviewees suggested that HealthPathways improved management in primary care, improved quality and timeliness of referrals and reduced inappropriate demand on secondary services. HealthPathways are a key enabler of the wider integration programme.  |
7. SUMMARY: ASTHMA IN CHILDREN (ACUTE AND NON-ACUTE)

**Antecedents**
- Ambulatory Sensitive Hospitalisation.
- High rates of ED presentation and admission.
- Māori and Pacific Islanders over represented.

**Clinic feedback**
- "I don't use it, don't need it but I'd probably use the Starship guidelines; I use them for a lot of paediatric information" - GP
- "My gut feeling is that referrals for asthma in children have improved...the general management of asthma has improved" - Consultant Paediatrician
- "Acute admissions are often appropriate - they have been managed in primary and have been given steroids" - Consultant Paediatrician

**Use: Monthly page views**

- Acute Asthma in Children: Pathway located
- Acute Asthma in Children: Pathway reviewed

- Pathway located: 150
- Pathway reviewed: 20

**Whole of system indicators**
- Pathway located: 1,200
- Pathway reviewed: 200

**Benefits associated with use**

**Patients**
- Clinicians say the condition well managed and high pathway use likely to support this.

**Clinicians**
- Supports clinician confidence where this is required and builds knowledge. Doesn't need to be used repeatedly as asthma at high prevalence.

**Systems**
- Contribution through supporting clinics who need it with managing the condition in the community.

**Summary**
Asthma is a frequently searched for topic, and these two pathways are in a group of asthma pathways with relatively high use. Once confident with management, GPs are less likely to use this pathway. Hospital outcomes have no observable trend since localisation, though length of stay has decreased.
8. SUMMARY: CELLULITIS

**Antecedents**
- Large number of ED admissions
- Ambulatory sensitive hospitalisations
- Over representation of some ethnic groups in ED
- No funding for GPs to administer IV antibiotics in primary care
- Specialists concerned about over administration of IV antibiotics if it were funded in primary care
- HVCHS and WRHS had pre-existing pathways

**Clinician feedback**
- "Before we used to send them to hospital for IV antibiotics and of course, that’s what they got, so it was a bit of a self-fulfilling prophecy" - GP
- "I’ve used it several times because of POAC and antibiotics – I get the nurse to print all the forms off" - GP
- "I got pretty frustrated as I haven’t done an IV for 30 years, then the chemical was out of stock, so we had to send them to the after hours clinic" - GP

**Whole of system indicators**

**Benefits associated with use**

**PATIENTS**
- Best quality of care
- More timely access to services
- Delivered by GP or after hours clinic instead of going to ED

**CLINICIANS**
- Primary care confident in best practice process to manage condition they previously referred to secondary services
- More efficient interface with secondary care

**SYSTEMS**
- Efficient delivery of secondary services with reducing ED and inpatient admissions
- Supports capability in primary care as part of wider integration programme

**Summary**

This pathway is highly viewed and also searched for frequently. Pathway use is strongly linked to POAC funded interventions. There has been a reduced burden on ED and inpatient services since localisation.
SUMMARY: COGNITIVE IMPAIRMENT AND DEMENTIA

Antecedents
- GPs were referring simple and complex dementia patients to secondary services, and weren’t referring complex cases early enough.
- GPs not referring patients to Alzheimer’s services.
- GPs couldn’t request head CTs for dementia.

Clinician feedback
"It’s changed what I do – I used to refer to local gerontology. I might eventually do that but I’m much more likely to make the diagnosis and support them myself" - GP
"It’s long but actually really helpful" - Student GP
"I find referrals more appropriate and the right tests and investigations have been done. I wouldn’t send referrals back if (the pathway) hadn’t been followed because these patients are complex" - Geriatrician
"Referrals have increased (to Dementia Wellington) since the pathway" - Community worker

Benefits associated with use
- PATIENTS
  - Getting tests and early diagnosis by their GP. Earlier diagnosis, family preparation and connection with community resources supports care planning
- CLINICIANS
  - Better awareness of conditions and more confident about diagnoses and management
  - Clear when to refer to secondary services and how range of services can be drawn on for support.
- SYSTEMS
  - Appropriate quality referrals received by secondary services supports efficiency
  - Supports capability in primary care
  - Supports integration/ exchange programme and quality improvement

Summary
This pathway is the most viewed pathway. Its development involved a large working group with sector representation, and was socialised through a road show. Referrals to secondary services have increased, but clinician feedback indicates that there are more appropriate referrals and the pathway has heightened awareness of the conditions.
10. SUMMARY: BOWEL CANCER AND DIRECT ACCESS TO COLONOSCOPY

Antecedents
- Symptomatic patients needed ESA in order to be referred for Colonoscopy.
- ESA waiting time up to 4 months.
- Extra waiting for colonoscopy.
- Late diagnosis and treatment of bowel cancer resulting in poor outcomes.

Clinic feedback
- "Really useful for risk stratification and help to check referral criteria". - Student GP
- "I'm aware of it. I looked at it when released and would definitely use it required - it's getting harder to get into gastro". - GP
- "We use it for triage I make the new referrals aware of it". - Gastroenterologist.
- "It's not reduced the number of referrals and procedures here - I'm quite liberal with what I allow". - Gastroenterologist.

Benefits associated with use

PATIENTS
- Receive best quality of care including direct referral for colonoscopy by GP if indicated.
- Shorter wait times if they do need to see a specialist.

CLINICIANS
- Confidence from following best practice and use colonoscopy diagnostics to determine need for referral.

SYSTEMS
- Improved efficiency in secondary services (time to ESA).
- Supports capability in primary care to identify bowel cancer indicators and refer to specialist services effectively.

Whole of System Indicators

The 12-month rolling total number of referrals for colonoscopy began increasing until early 2017, and has been decreasing since then.
- The average wait time from referral to colonoscopy has increased since localisation.
- The 12 month rolling average wait time from referral to ESA has varied significantly since 2014, but has been decreasing overall.

Summary

These two pathways combined are highly viewed. The perceived need and usefulness of the pathway varies amongst clinicians due to prevalence of conditions. Referral numbers have increased over time. There are many initiatives linked to the pathways, including Faster Cancer Treatment Health Target, Bowel Cancer Screening, and funding for community radiology.
11. SUMMARY: DEEP VEIN THROMBOSIS

Antecedents
- Inequitable access to ultrasounds for DVT via community radiology (HVDHB).
- Increased ED admissions.
- No funding for GPs for Clexane administration and education.

Clinician Feedback
"The secondary clinicians have bought in – they refer people back for Clexane" - GP
"I'd definitely use it presented with it as I'm aware things have changed and I would use it for clinical guidance" - GP
"I will refer GPs to the pathway, it helps reduce referral numbers, but also reduces the number of calls I get asking for advice, that gives me more time for those that do need specialist input" - Consultant Haematologist

Benefits associated with use
- PATIENTS
  - Receive timely diagnosis of DVT and effective treatment in the community, rather than ED.

- CLINICIANS
  - Confident in diagnosis using ultrasound and treatment with anticoagulant. Integration with POAC funding.

- SYSTEMS
  - More DVT managed in the community, and capacity of primary care increased.
  - Reduced demand on ED and specialist services.

Whole of system indicators

2nd
8,832
page views
1st
2,624
searches

MOST CLICKED ON
1 DVT = 2,504
2 DVT Diagnosis = 639
3 DVT Pathway = 562
4 Thrombophilia test = 180
5 Deep Vein Thrombosis = 83

Summary
DVT is the most frequently searched for pathway and the second most viewed pathway. Its use by primary care is well established and reinforced by secondary care. Funding for ultrasounds and anticoagulants through POAC also supports use. Patients are now getting faster treatment in the community and there is reducing demand on ED.
12. SUMMARY: HEAVY OR IRREGULAR MENSES

Antecedents

- Inequitable access to pelvic ultrasounds to exclude/diagnose serious causes via community radiology
- Patient required PSA for ultrasounds and there was a wait up to 4 months
- CDUH had pre-existing pathway

Clinician Feedback

- "It’s an exemplary HealthPathways example – good practical steps not overloaded with information and linked to funding" - student GP
- "I haven’t used it but would consider it. I have other algorithms from other gynaecos but HealthPathways are always useful" - GP
- "I haven’t used it. I wouldn’t need to" - GP

Whole of system indicators

Benefits associated with use

PATIENTS

- Receive best practice care, including ultrasound for earlier diagnosis in the community. Those needing a specialist appointment are seen sooner.

CLINICIANS

- Gynae pathways are well respected and used. GPs are confident that they are providing the best care, including ultrasound where indicated, and only referring to secondary services when necessary.

SYSTEMS

- Supports appropriate and timely referrals to secondary care.

Summary

This is a highly used pathway, with use increasing over time. Use is linked to the funding for community radiology. Patients are being diagnosed earlier, referred to gynaecology as needed and have shorter wait times to see the specialist. The percentage of rejected referrals has halved since review but these numbers are small.
13. **ONGOING PROGRAMME DEVELOPMENT**

The process of localising pathways has been working well but is challenged by the next phase of work and the need to balance the tension between continuing to localise new pathways and the need to review those that are already due, or overdue, for review. Feedback from users conveys the real risk that out of date information will severely impact on the credibility the programme has built over the past four years.

The programme is also entering a new phase in terms of its focus on primary care’s needs, and has an amended prioritisation process to support this. Balancing reviews with the continued benefits that can be anticipated through further localisations is the programme’s key challenge over the next couple of years and requires the team to develop and communicate a strategy to support this phase of work, illustrated in the diagram below.

![Diagram showing Health Pathway Localisation and Reviews over time]

**Work plan priorities and resourcing**

An increase in resource, in the short term, would support the team to maintain and maximise the value and benefits of HealthPathways across the 3D region by continuing localisations and managing the review schedule. The programme has a history of managing within its resources and any increase in funding could be reviewed once this transition is completed, and the work programme ahead will be predominantly ongoing reviews.

Some of the additional resource is likely to include administration support but a work programme review would identify where capacity was most beneficial. Additional resource for administration could release the coordinator of routine administration tasks, support continuity for the programme and could contribute to longer-term succession planning.

**Reviews**

During this next phase, it is likely the process of planning and conducting reviews will be improved, as the team has experienced with pathway development. This will see the
team test, reflect and adapt the process of assigning reviews to administrative, low or high input workstreams that could begin as a desk top exercise. Unscheduled reviews are required when clinical or service changes affecting the pathway are made and there should be capacity in the work programme to respond to these requests. This will be an intense period for learning about managing reviews effectively and brings the opportunity to develop a triage and work process that stands the programme in good stead for its longer-term future.

Keeping on track

More regular and consistent quarterly monitoring of the work programme outputs, HealthPathways use and specific KPIs would help the team, and its Governance Group understand and account for ongoing progress. The most direct indicator of success is an increasing number of users and the increasing use of those users. A dashboard of simple high-level indicators that are reported in quarterly periods in a consistent manner will help track performance over this new phase. These should include:

- Work programme indicators relating to the quarter as well as year to date
- Health Pathways utilisation indicators, such as user and page view growth.
- Efficiency indicators, such as cost per page view.

In addition to whole programme monitoring there can be pathway specific metrics to consider. Where pathways are developed to support specific changes (such as decrease in referrals to a specialist service) an audit framework that determines the feasibility and baseline measures of these indicators of success can be incorporated into annual monitoring and/or part of the review process. This will help demonstrate value from the use of HealthPathways and highlight areas for exploration where change has not occurred.
14. **SUMMARY AND CONSIDERATIONS**

By March 2018 there were 362 localised pathways and 2,712 users. The landmark of one million-page views was achieved in January 2018. HealthPathways are well established across the 3D region, working largely as intended and producing, or contributing to, the benefits expected for people, clinicians and the wider health system.

“It started off as something that was desirable. Now it’s essential.” (GP)

**Development and implementation is working largely as intended.**

HealthPathways development can be complex as it needs to reflect local protocols of three DHBs and the integration of a range of primary, secondary and community services. Learning from experience has enabled the process to become more efficient over time. The critical mass of localised pathways has created momentum that has led to more users and more use (160% increase in searches per user in the last three years and monthly page views increasing from 6,000 a month in May 2014 to 45,000 in March 2018), which has positioned HealthPathways as an important, if not essential, resource for primary care across 3D.

**Used and valued for best practice guidance and local protocol information.**

Clinicians value HealthPathways especially for their guidance in assessment, management and referral to secondary services and feel confident and supported in their clinical and treatment pathway decisions. Users regard HealthPathways as a highly credible source of information. The clarity provided by local protocols supports and improves communication between primary and secondary services.

**Provides benefits to patients, clinicians and contributes to health system outcomes.**

The evaluation has highlighted HealthPathways role in facilitating care closer to home for patients, enabling clinicians to confidently provide best practice care, promoting an integrated approach across sectors and supporting system change.

HealthPathways are contributors to many whole of system indicators, such as ED presentations and wait time for first specialist appointments; the evaluation has demonstrated how these contributions are made. Attributing whole of system indicator change (or not) to the existence of a HealthPathways is misleading, simplistic and can shift the focus away from the value that pathway development and use adds. This reinforces the value of a mixed methods approach to understanding HealthPathways.

**New programme phase will see ongoing development**

The programme is entering a new phase with a focus on primary care needs and an amended prioritisation process to support this. Feedback from users conveys the real risk that out of date information will severely impact on the credibility of the programme that has built over the past four years. Balancing reviews with the continued benefits that can be anticipated through further localisations is the programmes key challenge over the
next couple of years. An increase in resource, in the short term, would enable the team to maintain and maximise the value and benefits of HealthPathways across the 3D region.

14.1 Considerations

The following considerations are presented as opportunities to consolidate and extend the benefits of HealthPathways for 3D.

Review work programme and KPIs

- Revise localisation goals as the requirements of the review programme (overdue, scheduled and unscheduled reviews) are understood.
- Initially prioritise overdue reviews based on use (to maintain credibly) and risk.
- Agree programme priorities and develop a two to three-year work programme.
- Focus KPIs around use and growing use. Use creates change and this should continue to increase in line (or better) with the number of localised pathways.

Resourcing for maximum efficiency

Additional resource for the programme will enable the Steering Group to expedite the localisation of pathways while addressing the review programme in this transitional phase.

Monitoring and reporting

A dashboard of simple high-level indicators that are reported in quarterly periods in a consistent manner will help track performance over this new phase. These should include:

- Work programme indicators relating to the quarter as well as year to date
- Health Pathways utilisation indicators, such as user and page view growth
- Efficiency indicators, such as cost per page view.

Other opportunities for enhancement

- Maximise opportunities for congruence with secondary care by involving service management and/or quality teams as well as clinicians in the process of localising and reviewing HealthPathways.
- Socialisation across the secondary care interface with primary care will help to further embed and align common processes.
- Once developed, review the uptake of culturally specific HealthPathway information, consider additional socialisation requirements and seek opportunities to routinely link other HealthPathway information to this resource.
- Identify mandatory aspects of pathways to differentiate from guidance.
HSC DISCUSSION PAPER
12th Sept 2018

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Subject
Hospital & Healthcare Services (HHS) Bi-Monthly Performance Report

RECOMMENDATIONS
It is recommended that the Committee:

a) Notes that winter demand and influenza have been later to arrive this year but have had an impact on staffing and occupancy over the last month.

b) Notes that the implementation of Schedule 10 rosters for RMO’s continues across the services, however both RMO and Registrar recruitment is being affected nationally by a shortage of suitable candidates

c) Notes that anticipated disruption to services resulting from the NZNO industrial action impacted on elective surgery and outpatients resulting on us being behind target for the elective services health target.

d) Notes that the backlog of Ophthalmology patients awaiting follow up will be cleared by November

e) Notes that we are seeing an immediate impact of the additional ICU beds leading to a reduction in surgery cancellations

f) Notes that wait times for MRI and CT remain high but that a programme of work focusing on workforce development and demand management is in place

g) Notes that activity to develop the case to expand dialysis service by 2020 has started.

h) Notes that work is underway to develop the business case and support the MOH to develop a treasury business case to commence bowel screening in November 2019

1. INTRODUCTION

1.1 Purpose
The purpose of this paper is to inform the Health System Committee of key activities and priorities being progressed through the Hospital and Healthcare Services of CCDHB.

2. KEY STRATEGIC ISSUES / PRIORITIES

2.1 Winter Planning & Influenza
July was a quieter month for hospital activity with New Zealand Nurses Organisation (NZNO) industrial action seeing planned reductions in services and overall bed requirements. Winter ills and flu have also been later to arrive with an increase in winter demand and influenza type illnesses being more evident in August.
The CapPlan forecast tool has enabled us to undertake better up-to-the-minute planning for bed utilisation, discharge timing, opening and closing of beds as clinically required.

### 2.2 Implementation of Schedule 10

Implementation of the new rosters is mostly linked to the run changeover times, being June and December each year, as this facilitates recruiting into the new positions. Of the 13 rosters that required redesign and implementation all except General surgery, Neurosurgery and Cardiothoracic surgery have been implemented. General Surgery is awaiting the appointment of 2 fellows, it is understood that one offer has been made and we are awaiting references on another candidate. Due to the additional resources required to implement the Neurosurgery and Cardiothoracic surgery rosters formal approval for additional resources is being sought.

### 2.3 NZNO industrial action

Two 24-hour nationwide strike notices were issued by New Zealand Nurses Organisation (NZNO) covering 5 and 12 July. The first notice was withdrawn at short notice, but the second strike went ahead.

As result of extensive contingency planning across many departments at CCDHB, the organisation continued to function safety on all our campuses and we were able to provide essential services for all our inpatients. The hospital demand was reduced leading up to the strike allowing us to close beds throughout Wellington and Kenepuru Hospital resulting in around 73% bed occupancy on the day of the strike. Demand in ED was just a little below average for a 24 hour period at 153 presentations.

Both strike periods impacted on our productivity, particularly as it related to elective surgery and less so for outpatients. As a result we are behind target for the elective services health target year to date and are reliant on productivity gains to make good the lost volume.

NZNO and the DHBs have since reached settlement. The new MECA has achieved significant pay increases across all steps in the MECA, along with clearer monitoring and reporting mechanisms for safe staffing. The settlement is supported by a commitment by the Director General of Health to provide additional funding to address workforce capacity issues (2 percent of baseline costs or $38 million) and for Care Capacity Demand Management (CCDM) implementation (an estimated $10 million to support the ongoing local and national implementation and development of CCDM). Ministry of Health (MOH) Guidelines set out the expectations concerning the allocation of the funding and apply to the 2018/19 year only. The allocation for CCDHB is around 34 nurses and there is a process underway to agree with NZNO the allocation of these nurses across the DHB.

### 2.4 Ophthalmology Outpatient Services

As our population ages so does the demand on our medical and surgical ophthalmology services. Across New Zealand demand has exceeded capacity and patients have not been able to be seen within clinically indicated treatment timeframes, particularly those needing regular medical follow up. Due to the risk of patients suffering avoidable deterioration of eyesight, all DHBs are required to report monthly to the MOH on timeliness for access to ophthalmology follow ups.

We have a project team focused on this work for CCDHB. One of the key deliverables for the project is to have zero patients waiting >50% longer than the planned clinical treatment time by 31 October and this is sustained going forward. We are on track to achieve the end of October timeframe. To ensure we continue to treat patients within the clinically indicated timeframes we have seven weekend clinics arranged between now and December. Further clinics will be required in the New Year and ongoing.

Project work is focused on ensuring data quality, changing medical and nursing models of care, workforce planning and changing administrative processes. The project is closely aligned with the national ophthalmology working group established by the MOH.
2.5 Intensive Care Services

The Intensive Care Unit (ICU) ‘South End’ was opened in August with the commissioning of two additional ICU bed spaces, bringing the total of resourced beds from 18 to 20, and the total physical beds from 18 to 24. The project was delivered on budget and on time.

The beds have been well utilised which has been reflected in an increase in ICU patient hours. Elective surgical ICU volume was low in July, which was a direct impact of preparations for the nursing strikes. In August, the highest post-operative ICU care count for the last 12 months was achieved. This included 41 cardiac patients and 15 general elective surgical patients. Unfortunately 6 elective patients were cancelled by ICU in August, with 4 being on the same day, which directly followed receiving 10 acute admissions in one day compared to an average of 4 to 5 acute admissions.

We expect to see continued improvement in ICU access for elective surgery throughout the year.

2.6 Cancer Service Review

In December 2017, the clinical service planning review work started with the three cancer services (Haematology, Medical Oncology and Radiation Oncology). All three services have experienced increasing demand which has led to capacity and resource constraints. The three cancer services are large and complex services. Cancer service delivery is a key priority for the Central Regional DHBs.

As part of the review process, Ernst and Young (EY) provided some independent analytical support and benchmarking analysis which identified opportunities to review the level of access, improve service provision and outcomes across the three cancer services. Initial discussions on the data findings have occurred with the Clinical Leaders of the three services and some additional data analysis was undertaken as a result. A longer-term improvement project has started to address issues arising from the data analysis and discussions to date.

The challenges to be addressed by the project were to understand and develop options to reduce the workload pressures on staff, to reduce pressures on ambulatory areas and ward occupancy and the resultant over flow of patients into other wards, to ensuring future models of care can support the DHB goals of increasing access to care, reducing health disparities, better integrating health care across our health system while living within our means, to understand and respond to the concerns from other regional DHBs on the level of servicing of their population, to be able to clearly justify the levels of servicing of our local population and to improve the use of data within cancer services.

The first stage of this was to commission an external clinical review. This commenced in August and is being led by Professor David Currow the Chief Cancer Officer of New South Wales (NSW) and Chief Executive Officer of the Cancer Institute NSW, the NSW Government’s cancer control agency.

The review team included Nursing, Allied Health and SMOs from Radiation Oncology and Medical Oncology from New Zealand and Australia.

The review team will provide a report this month with recommendations and will come back later in the year to lead discussions with the team on changes to models of care. It is also intended to carry out a detailed patient survey to contribute to the findings of this review.

2.7 NICU Service Review

The service planning review completed in February 2018 identified areas where NICU could improve performance or demonstrate achievement of key clinical performance indicators, such as long line infections. NICU exceeded the long-line infection rate target in last quarter (5.5 per 1000 long-line days against a target of 5.0) however has generally maintained a rate less than 5.0 per 1000 long-line days since 2014 except for 2 quarters, from a starting base of 12.2 in 2013. The missed target was in part due to a community strain MRSA outbreak in NICU earlier this year. NICU are currently working with Infectious Diseases Team to understand which data would provide useful monitoring of cross-infection rates for the clinical team.
Other areas of focus include hand hygiene and pressure area care. NICU has written and piloted a pressure area evaluation tool as part of improving transparency in clinical audits, which will now be used nationally and achieved 100% compliance with this audit.

It was identified that the management of patient flows between NICU and other DHBs could be improved to provide more care closer to home, and reduce the sustained levels of over occupancy that all tertiary units are facing. This will involve working collaboratively with all regional DHBs and in particular Hutt Valley DHB as high level analysis indicates that Hutt Valley DHB patients is probably over represented in NICU when compared to the other DHBs in the region.

The MOH and joint DHBs Chief Executives has commissioned a review of neonatal units in New Zealand led by the New Zealand Child and Youth Clinical Network Programme’s (NZCYCN) Newborn Clinical Network. The review has just commenced and is expected to be complete by January. The review is focused on NICU service provision from a national perspective, particularly given the sustained pressures all NICUs are under.

### 2.8 Neurosurgery Service Review

The Neurosurgery service plan is set up with a number of targets to report against quarterly. A report for Q1 2018/19 will be provided in October 2018.

The Neurosurgery outreach project was implemented to improve delivery of CCDHBs elective Neurosurgical service. It also sought to clarify tertiary service provision, and to focus on patient experience, particularly pre-referral to First Specialist Assessment (FSA) and surveillance following the post-surgery follow-up appointment.

The project aim was to develop tertiary acceptance criteria and implement referral and triage processes so that from 1 July 2018 no referrals would be accepted direct from GPs for non CCDHB patients. The central region DHBs would triage the referrals, and only send the referrals that would benefit from Neurosurgery input. Clinical care pathways would be developed and implemented.

As of 1 July 2018 six of the regional DHBs have implemented the tertiary acceptance referral criteria. We are still working through some outstanding issues with Hutt DHB. Back and neck pain pathways have been completed and were published on 3D Health Pathways website 31 Aug 18. Acute neuro-assessment, non-acute neuro surgery assessment and neurosurgery advice pathways are in the final stage of development.

To assist with this change a Neurosurgery nurse coordinator was appointed to be the point of contact between the DHBs in order to improve the patient journey before and after surgery, optimise the patient for surgery, increase day of surgery admissions, to ensure the referral criteria is maintained and that appropriate referrals with required imaging are received.

### 2.9 Acute Flow Programme

The acute flow improvement programme continues to be an important programme of work for the HHS. Despite reductions in the rate of increase in demand over recent years, the numbers acute admissions continue to increase, leading to high ward occupancy and delays in ED.

The demands on the acute care system are projected to continue to increase which means we need to identify new ways of working to manage greater demands effectively. Work continues across a number of DHB programmes to support this including the Integrated Care Collaborative acute demand work streams and the Ever Better Health Care Programme.

The two key areas of focus for the HHS are to reduce the patient time spent waiting in ED and to reduce beds days in the inpatient areas. General medicine, the largest acute service have continued to make improvements to the way they work and their model of care leading to reductions in length of stay, higher numbers of same day discharges and ongoing reductions to bed days. For August the service experienced the highest number of discharges on record for that month. As a result of changes to the way they work and reducing their average Length of Stay (LOS) the impact on ward occupancy was reduced.
A recent change to the team model has demonstrated a reduction of on average 0.12 day per patient. If this was sustained over a year, this is about 800 patients getting home a day earlier.

The programme is currently being reviewed to focus our efforts over the next year to ensure we achieve the greatest impact.

Current priorities include improving the process for patients leaving ED to reduce time in ED, focusing on response times for specialties to ED, improving ward flow (including expansion of work underway with optimal ward) and providing timely responses for Mental Health acute patients presenting to ED.

2.10 Satellite Dialysis

CCDHB provides renal services for the sub region including community based dialysis services. The Regional Renal Service Models Facilities Feasibility Study July 2010 determined the need for growth in the number of satellite chairs available in the CCDHB renal sub region by 2020.

Over the past 5 years the service has had improved rates of transplantation and maintained around 44% of patients on home dialysis, which is consistent with the national average. Despite this, there is a strong growth in patients requiring centre based haemodialysis treatment. This is largely driven by the aging population with an increasing burden of vascular disease and complications of diabetes.

The Wellington renal service continues to support transplantation as the first renal replacement therapy option where possible, followed by home based therapy if dialysis is undertaken. This is with both home haemodialysis and peritoneal dialysis.

A project has started to undertake demand analysis and stakeholder consultation to support the development of a strategic business case for the expansion of dialysis services for the region. The plan is to complete this work by October 2018 in order to seek approval to proceed with a preferred option for delivery by Feb 2020.

2.11 National Bowel Screening Project

CCDHB have been advised that the start date for the programme will be in the first quarter in 2019. Bowel cancer is the second most commonly registered cancer (after prostate cancer\(^1\)) and the second most common cause of cancer death (after lung cancer\(^2\)) in New Zealand. Bowel cancer screening has been proven internationally to reduce cancer deaths and increase survival by finding cancers at an early stage. Screening also has the potential to reduce bowel cancer incidence, by removing pre-cancerous polyps in the screened population.

There is a project now working on the development of a business case for implementation at CCDHB and with the MOH on preparation of the treasury business case and expect a draft paper to be prepared by October 2018.

2.12 Access to Diagnostics – Radiology

MOH Performance Indicators - CT

Performance against the CT and MRI MOH indicator for non-urgent referrals continues to be a challenge for CCDHB. August saw a slight improvement to 61% against a target of 95% of referrals seen within 6 weeks

The steady increase in the referral numbers continues to place a high demand on the service with an additional 413 referrals received during July/August compared with the same period in 2017 (11.8% growth). Overtime elective lists run on the weekends and outsourcing increased output by 323 patients. Thus, while more scans than ever are being completed, demand continues to outpace capacity.

\(^1\) 2015 Cancer Registration data, MoH

\(^2\) 2013 Mortality data, MoH
Additional budget approved this year will be used to increase staffing which will enable elective lists on weekends. Some additional FTE has already been approved and recruitment of technologists is underway.

**MOH Performance Indicators - MRI**

Performance against the MRI MOH indicator is relatively stable for the last 3 months and is currently at 35% against a target of 90% of referrals seen within 6 weeks.

Overtime elective lists and outsourcing has reduced the waiting list in MRI by approximately 200 patients in the last two months. Referral volumes were relatively stable when compared to the preceding 2 months.

Development of this workforce is challenging and will take a number of years to train staff to meet the standards for MRI. Approval of additional staff and training posts has been agreed this month.

Note that urgent MRI outpatient imaging continues to be completed within three weeks. These are prioritized and scanned within the clinically appropriate timeframe.

**Actions to reduce the number of patients waiting**

A number of strategies are in place to assist with reducing the numbers of patients waiting and to improve access for non-urgent referrals. These include:

- Outsourcing both MRI and CT scans
Radiologist SMO resource will be assigned specifically to validate MRI referrals as they are received. During July, we piloted this improved validation process and saw good results with up to 5% of referrals identified as unnecessary (e.g. duplicate orders, alternative imaging options etc.).

- Additional FTE for increased production as outlined above
- A project is underway working with SIP and HHS to develop a work force plan for Radiology and to coordinate a number of strategies to manage demand including regional care arrangements, choosing wisely, demand management and community referred radiology.

2.13 Access to Diagnostics - Colonoscopy

The CCDHB is measured on access to urgent, non-urgent and surveillance diagnostic colonoscopies. Current capacity (historically based) is approximately 230 slots per month, but demand exceeds existing colonoscopy provision due to a number of MoH funded colonoscopy wait list initiatives in the last two years. We have prioritised urgent and non-urgent colonoscopies and consequently there are 163 surveillance patients who have waited longer than the target timescales.

**Urgent Colonoscopy**

Internal Diagnostic reports for August indicated that 100% of people accepted for an urgent diagnostic colonoscopy received their procedure within two weeks (14 days) against a Target of 90%. **Target Met.**

**Non-Urgent Colonoscopy**

Internal Diagnostic reports for August indicated that 85.1% of people accepted for a non-urgent colonoscopy received their procedure within six weeks (42 days) against a Target of 70%. **Target Met.**

**Surveillance Colonoscopy**

Internal Diagnostic reports for August indicated that 57.5% of people waiting for surveillance waited no longer than twelve weeks (84 days) beyond the planned date against a Target of 70%. **Target Not Met.**

**Surveillance Colonoscopy Performance**

Surveillance colonoscopies are a result of colonoscopies where precancerous polyps have been identified and removed. There is evidence which demonstrates that there are significant benefits to following-up patients through surveillance colonoscopies. The graph below demonstrates the increase in demand for these services in line with the other increases in demand. There is also a requirement for the service to demonstrate to the MOH waiting time compliance as a pre-requisite to introducing Bowel Screening which is anticipated for CCDHB later in 2019. The service is currently reviewing the options for managing this demand.

**Referrals for Surveillance Colonoscopies**
RECOMMENDATION

It is recommended that the Health System Committee:

- **Notes** that the Health Care Home (HCH) roll-out will reach 240,000 people, 78% of CCDHBs population, by the end of 2018/19 including 78% and 73% of the Māori and Pacific populations respectively.

- **Notes** the HCH model has been reviewed by the State Sector Productivity Commission, with Auckland University of Technology, noted a statistically significant drop in ED admissions.

- **Notes** that the Health Service Research Centre report on Primary Health Care Innovation (June 2018) identified the CCDHB approach with PHOs in the delivery of HCH model as an example of the positive impact of PHO and DHB collaboration.

- **Notes** the CCDHB HCH model was selected as a finalist in the 2018 Wellington Gold awards.

- **Recommends** to the Board that HCH investment remains a priority and that the initial evaluations of the HCH model show a positive impact on ED admissions, and independently cited as an excellent model of PHO and DHB collaboration.

1 **PURPOSE**

This paper gives an update to the Health System Committee on the progress in the implementation of the Health Care Home (HCH) model with a focus on the evaluation of the implementation.

2 **INTRODUCTION**

The HCH is a shared programme with our PHOs to improve the impact of primary care on the health, wellbeing of our communities and sustainability of the health care system.

The HCH programme has been led through the CCDHB Integrated Care Collaborative (ICC) Alliance Leadership Team (ALT). It has been implemented in partnership with the PHOs, and with support from across the CCDHB services.

The CCDHB Health Care Home (HCH) model forms the core of the Community Health Network development strategy of CCDHBs within the Health System Plan (HSP). CCDHB is working with the primary care sector to develop the Community Health Network model.
3 HEALTH CARE HOME MODEL

HCH is a model that provides comprehensive and continuous health care with the goal of supporting individuals to obtain maximised health outcomes in primary care. Primary care is the core of the universal health system in New Zealand. Key HCH elements and services provide improved urgent, proactive and preventative care by the practices.

Based on the requirements of people and their place on their health journey, each of these elements work together to provide a comprehensive primary care service that supports them in the community.

HCH aims to keep people well in the community through primary health care teams that have undertaken to transform their services in line with the agreed model of care and providing a platform that specialists services can confidently integrate with. It is quite early in the journey to ascertain the potential benefits of the HCH model, but the programme is on track and benefits that are being demonstrated to date are positive.

4 COVERAGE OF THE POPULATION – TRANCHE 3

The DHB board made its initial investment in the HCH model in 2015. Subsequent analysis by Synergia identified that the ability for the HCH model to impact on population health is determined by coverage of the population.

Through the 2018/19 investment approach, the CCDHB Board has approved the roll-out of the Health Care Home (HCH) model to reach 80% of CCDHB’s population. This will be the third tranche of HCHs across CCDHB.

The selection for Tranche 3 practices has been completed and their development is underway. The practice selection process aims to maximise benefits for targeted populations in keeping them well in the community and to make improvements on the hospital presentation rates. Selection is based on practices volume of Māori, Pacific and high deprivation populations and the volume of presentations to the hospital. Other considerations such as absolute size of the practice, clustering by geography and the practices commitment to the change are also included. Through the selection process thirteen practices including an additional 93,689 people have been included.
There were a few practices that had higher numbers of Māori and Pacific populations that were of high interest for HCH developments. However based on practice readiness for change and their preferences they did not progress to Tranche 3.

The practices included in the three tranches of HCHs are spread across the CCDHB geography and are as follows:

With the roll-out of Tranche 3, by the end of 2018/19 about 240,000 people, close to 78% of CCDHBs will be included in the HCH model. This will include the HCH model reaching 78% and 73% of the Māori and Pacific populations. The HCH model will also reach 83% of the 0-14yo and 83% of the 85+yo populations.

This spread is an important element supporting the HCH as a core element of the development of the Community Health Network model.

5 ARE WE MAKING PROGRESS?

5.1 Population Health – Emergency Department Presentations & Acute Admissions

In addition to developmental milestones, the HCH is being monitored against a number of quality and population outcome indicators. As described earlier, practices were selected into the HCH based on the...
potential to have an impact on their populations acute demand, so as a cohort Tranche 1 practices had higher ED and acute demand rates that other practices. Previous analysis presented to the Health System Committee included Tranche 1 practices performance as at the end of 2016/17. The analysis has been updated to the end of 2017/18. Tranche 2 practices only launched during 2017/18.

A linear projection has been applied to the ED growth prior the HCH tranches launching. Tranche 1 practices launched during 2016/17 and Tranche 2 practices during 2017/18 so reasonably recently.

The projection for Tranche 1 compared to actual ED presentation rates for Māori indicate a positive difference. The actual ED presentation rates for Māori in Tranche 1 HCHs is 9% lower in 2017/18 compared to in 2015/16. A longer timeframe for conclusive impacts on the change in trend of ED presentation is likely to be required.

At this point in time, there appears to be minimal different for Māori in Tranche 2 HCHs between the actual ED presentations and the projected ED presentations.
The projection for Tranche 1 compared to actual ED presentation rates for Pacific indicate a positive difference. The actual ED presentation rates for Pacific in Tranche 1 HCHs is 8% lower in 2017/18 compared to in 2015/16. A longer timeframe for conclusive impacts on the change in trend of ED presentation is likely to be required.

At the end of 2017/18 there appears to be a small increase in ED presentations for Pacific in Tranche 2 HCHs compare to previous.

The projection for Tranche 1 compared to actual ED presentation rates for the other population indicate a positive difference. The actual ED presentation rates for the other population in Tranche 1 HCHs is 1% higher in 2017/18 compared to in 2015/16. A longer timeframe for conclusive impacts on the change in trend of ED presentation is likely to be required.

At the end of 2017/18 there appears to be a small decrease in ED presentations for Pacific in Tranche 2 HCHs compare to previous.

5.2 HCH Case Study

The HCH model was identified as an opportunity for a case study on the impact of Primary Care Developments by the State Sector Productivity Commission. The report is being finalised, and early findings have identified a statistically significant drop in emergency department (ED) admissions (between comparable HCH and Non-HCH practices) in the period after the implementation of HCH. This draft report is available on Board Books for Board members.

This study was on only four practises. The study authors from Auckland University of Technology have identified the need for future evaluation to consider the wider elements of the Health Care Home model and its contribution to the development and implementation of service transformation through new models of care and service delivery models.

In addition the Health Service Research Centre report on Primary Health Care Innovation (June 2018) identified that the collaborative network between the PHOs and partner DHBs in setting standards and
sharing learnings around the implementation of the HCH is a key enabler for primary care innovation. The report identified the CCDHB approach with PHOs in the delivery of HCH model as example of this collaboration.

6 PRIMARY CARE SERVICE ENHANCEMENTS

The HCH practices focus on delivering the required elements of the model and within these are developing innovative solutions that suit their population. Examples of these include the delivery of group consultations and support for people presenting to after-hours services.

6.1 Group Consultations

Consultations with groups of people may have benefits in enabling shared learning, support between people and introducing self-management approaches.

Hora Te Pai is part of the Tranche 1 HCHs and continued to evolve its services. The practice was interested in trialling the concept of a group consultation and invited a group of seven Māori men who had chronic obstructive pulmonary disease (COPD). The group met twice with the practices GP and primary health care nurse as a whole. The groups held discussions about the condition, self-management strategies and personal stories. Each member of the group also received an individual assessments and acute management plans. Initial feedback from the group has been very positive and further group consultations are being planned with other practices and covering other conditions.

Newlands Medical Centre was one of the first HCHs. With a focus on year of care planning for people at risk of admissions the practice embarked on promoting Advance Care Planning. The practice organised a hui at their local community centre where they had about fifteen people attend to hear about Advance Care Planning and consider their first conversations. The Hui was supported by a practice GP, two of the primary care nurses and the practice manager. Feedback received from the participants and was overwhelmingly positive. The practice is looking to repeat this process as well as follow up with the completion of Advance Care Plans with those that attended.

6.2 Support for people presenting to after-hours services

Continuity of care is a key element of improved health outcomes for people. Primary health care and HCHs provide the best place that people may be able to receive this ongoing care.

Porirua Union and Community Health Services (PUCHS) launched as a HCH in October 2017 as part of Tranche 2. PUCHS registered patients have the highest daytime presentations at KAMC from Porirua practices and second highest per population. As a HCH, the practice wanted to support people to have their health care needs met by them as a practice and reduce the need for using the Kenepuru Accident and Medical Centre.

The teams worked together to developed strategies that supported people presenting to the Accident and Medical Centre back to the practice during opening hours. The practice promoted their enhanced services such as extended opening hours and GP triage. The practice clinical leads, including a GP and a primary care nurse, carry a mobile phone that the nurses from Kenepuru Accident and Medical Centre can call to arrange a transfer back to their practice. Between May – July 2018 there have been 23 people who have been transferred back to PUCHS.

7 HEALTH SYSTEM APPLICATION FOR HEALTH CARE HOMES – NETWORKS & LOCALITIES

The establishment of community health networks, as described in the Health System Plan, will also strengthen the HCH model. The community health networks will include a grouping of Health Care Home practices at its core service with robust connections with other health services relevant to the population. The framework for community health networks is being developed in partnership with stakeholders and support of the Integrated Care Collaborative (ICC). The framework will presented at the October Health System Committee meeting for endorsement.
Complementary to the community health networks are the localities as per the Health System Plan the locality approach will focus on empowering and activating the community, to tap into the potential for people to lead their care, self-manage and develop supportive linkages within the community. The locality development work that is being scoped will enhance the HCH developments in Porirua with targeted investment for this area of high need.