Re-imagining relationships to sustain meaning and purpose in health and care systems

Karen Leach
Churchill Fellow 2018

WINSTON CHURCHILL MEMORIAL TRUST

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Acknowledgements

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Biography

Karen Leach is Head of Community Health & Social Care in Guernsey, Channel Islands.

Karen was born in Scotland and moved to Guernsey in 1989 as an agency nurse. Thirty years later she is still there and has been recognised as a Queens Nurse by the Queens Nursing Institute for leadership and excellence in community care. She is proud to work as part of a fantastic team in finding ways to improve the lives of the people of the Bailiwick of Guernsey through learning, collaboration, connection and general mischief-making.

Executive summary

The Bailiwick of Guernsey is a Crown Dependency with its own assembly called the States of Deliberation. Our health and care system has a mixed funding model where people pay for some elements, e.g. to see their GPs. We have the same challenges as most developed countries; to meet the increasing demand for health and care. With a population of around 62,000, it should be possible to design a system that means people in our islands can live happy, healthy and purposeful lives in an engaged and prosperous community.

But where do we start?

A Partnership of Purpose between providers of health and care services is being created which will need courage, commitment, belief and creative thinking to succeed.

I applied for the Fellowship because I wanted to connect with communities who have started to think and work differently around population health and wellbeing.

What I found in the organisations I connected with in Alaska and New Zealand was a commonality of purpose, an understanding of the community they serve and strong leadership.

It's all about relationships

- Work at and in relationships for the benefit of everyone
- If it affects one of us, it affects all of us
- Value people's time – don't let the needs of the System or process drive or stall change

Leadership

- Sustainable, responsive, visible and authentic leadership that acts as the guardian of the vision
- Use language consistently – live your operational principles
- Have clear organisational vision, mission and values – invest in making sure that people understand and live these and that they bring meaning to work
- Recruit to your values, make them work for everyone
- Use your people effectively – right skills, right place - clinicians don't go to school to be managers – focus on the human in human resources
- Unlock creative potential – use creative talent to challenge wicked problems – create a space for collective work across the system
- Don't underestimate the need to pay attention to your self-care - find joy
- Recognise the individual and societal cost when people don't have the agency to make decisions that enable health and wellbeing
- Organisational development needs resources but it will save time, effort and money in the long run – strategic planning increases organisational agility and responsiveness – keep it simple
- Investment in data and technology is essential but it needs to be designed and implemented in partnership with the people who need and use it

Culture and heritage – who we are and why

- Be yourself – at work – in life
- Recognise that being culturally appropriate is a strength
- Listen to your customer – really listen – it's hard to put the person at the centre if you are standing there yourself – develop shared responsibility throughout the system
- Be a learning organisation – invest in your people – support creativity and curiosity – encourage courage to try things out
- Our community has a past, present and future – learn from the past to improve the future – our heritage, culture, sense of identity and belonging influences and informs current and future community health and wellbeing

Musings

My ikigai - reason for being - is the people I've connected with, the new people I have met along the way, the kindness of strangers. It's having hope and being curious. The Fellowship Programme aims to improve people's lives through connecting and learning globally. They also say 'Fellows - this will change your life'. That's a big statement but it's true.
The personal impact of my Fellowship year has been profound.

I went to see whether these systems were the emperor's new clothes - looks great on a website and at a conference but actually what happens on the ground? What does it feel like to be a customer-owner, a user in these systems? Is there a sense of meaning and purpose in people's lives?

In all four case studies I found real organisations working through real challenges faced by everyone working in health care in the 21st century. They have the same issues as everyone else around managing resources, recruiting, performance management and meeting demand. The difference is they are completely transparent about what they are trying to achieve and how they are trying to achieve it. In some places I visited system design and redesign seemed to be more system and professional led, in others they had moved further, responding to the voice of the person or community groups in a paradigm shift.

You hear the term 'agile' in a business sense. All of the places I visited were agile organisations that were distilling complex theory, informed by evidence to create systems that are responding to the needs of their community. Like the extraordinary landscape of mountains, glaciers and icebergs they sit in, what you see on the surface is being honed over many years in constantly evolving models that responds to their environment.

I saw in all the places that I visited the importance placed on relationships and recognising that we need to look after ourselves and the people we work with so that we can keep hold of the purpose of our work and appreciate that it has meaning. This means people working in this organisation 'keep their bucket full' to care for themselves and others.

I have been reading about integrated health and care system for years. What I learned above all else is that transforming a whole system is a combination of continuous service improvement and transformation over many years. There is no size-fits-all but if we all connect and share our work we are stronger together.

Fellowship report

Context and comparisons

The Bailiwick of Guernsey is part of the Channel Islands. As a British Crown Dependency, it has its own Government Assembly called the States of Guernsey. With a population of around 62,000, there is potential to design systems that mean people in our islands live happy, healthy and purposeful lives in an engaged and prosperous community.

Our health and care systems are unique. The Committee for Health & Social Care oversees the provision of integrated health and social care which in many jurisdictions would be delivered separately by different organisations.

With a mixed model funding for health and care, people pay to see their GP, with a small grant. Secondary care is free at the point of delivery and provided through a commissioned service by the Medical Specialist Group, who employ consultant-grade doctors in medicine and surgery for adults and children. Radiology, pathology and psychiatry are provided by States-employed consultants. Tertiary care is provided through contracts with NHS organisations in England.

People travel to the UK for investigations and treatment that cannot be delivered on island due to economies of scale. The Bailiwick of Guernsey has the same challenges outlined by the World Health Organisation[1]. There is increasing demand for health and care as a consequence of an ageing population living with increasing levels of non-communicable disease.

A Partnership of Purpose[2] is being created to reaffirm the States of Guernsey's commitment to the transformation of health and care services. The States of Guernsey's Committee for Health & Social Care has made a commitment to tackle some of the deep-seated challenges within our local health and care system by developing a partnership approach open to all health and care providers – voluntary, independent, and public-sector or States-commissioned – working with the islands' populations. The proposals are far-reaching and, if successful, will change the landscape of health and care – physically, virtually and financially – in order to improve islanders' health and wellbeing at all ages, provide more joined-up services, and help to mitigate rising health and care costs.

In the western world the cost of health and care is increasingly unsustainable. Long term and chronic conditions – from dementia and cancer to arthritis and diabetes – now dominate populations' health and care needs, with nearly two-thirds of people over the age of 60 in the UK having at least one such condition (NCDs). £7 of every £10 spent on health and care is for treatment or care related to long- term conditions. The demand for services continues to grow, with people over retirement age spending twice as much on health and care as younger generations.

[1] WHO, (2018) Noncommunicable diseases country profiles 2018
https://www.who.int/nmh/publications/ncd-profiles-2018/en/

[2] A Partnership of Purpose: Transforming Health and Care (2017)
Committee for Health & Social Care - P.2017/114
https://www.gov.gg/article/162629/A-Partnership-of-Purpose-Transforming-Health-and-Care

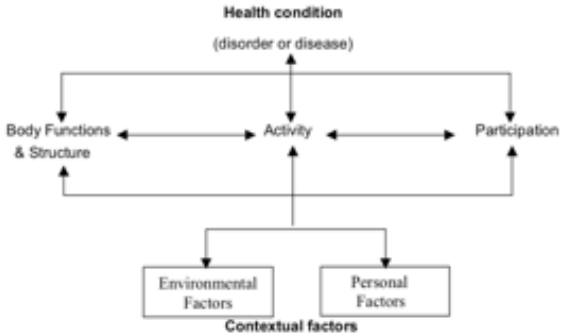
The Committee for Health & Social Care have recognised that system-wide change and improvements in the overall health and wellbeing of the population will be required.

More fundamental change is needed to address:
- Fragmented services
- Focus on provider rather than user
- Inequity of access
- Finding and accessing services
- Need for more prevention and early detection

The ambitions set out in the Partnership of Purpose will need belief, courage and creative thinking to succeed. (Appendix 1) People are living longer with multiple health and care needs. Living longer, happier, healthier, meaningful lives with purpose will require a whole system change. Living with purpose and meaning is becoming more understood as a measure of wellness. As an island community responsible for delivering integrated health and social care, the States of Guernsey can learn from other examples of population health care and continue to develop a model in healthy living and ageing that could be applied elsewhere.

> 'Even where there is clear evidence pointing to the most cost-effective interventions for the prevention and control of Non Communicable Diseases (NCDs) much remains to be done to scale them up, as documented in Chapter 4. In particular, tackling the root causes of NCDs arising from the social determinants of health is a matter of urgency, and countries need to make concerted efforts in order to secure rapid progress. This has significant implications for health systems as the key drivers of the required transformation. NCDs are an example of a "wicked problem", since they are a complex phenomenon affected by multiple factors, including social, environmental, cultural, economic, commercial and political ones, throughout the life course. Tackling them effectively, as described in Chapter 6 on governance, requires cross-sectoral and multilevel working, and an integrated approach to health and social care, both horizontally and vertically.'

The development of truly integrated health and social care is in its infancy. Funding models have historically created barriers and disincentives to individual, professional and public creativity and innovation. In the Bailiwick of Guernsey our hospital, community, mental and public health and social care services for both children and adults sit under one executive team and a single budget. This puts us in a stronger position than many jurisdictions to operate differently. Documents on health medical outcomes is not enough. The World Health Organisation[3] in 2018 recognised a need to accelerate improvements.
The WHO International Classification of Functioning, Disability and Health[4] (ICF) is based on a biopsychosocial model which is an integration of medical and social. ICF combines the different perspectives of health: biological, individual and social. (WHO, 2002)



Despite the publication of this classification in 2002, the predominant approach in health care remains the biomedical model. Given the recognition by WHO that there needs to be a paradigm shift towards tackling the root causes of non-communicable disease, what I want to understand is how a whole system change can respond to a need for multidimensional wellbeing.

[3] WHO (2018) Health systems respond to noncommunicable diseases: time for ambition, (2018) http://www.euro.who.int/__data/assets/pdf_file/0009/380997/hss-ncd-book-eng.pdf

[4] WHO International Classification of Functioning, Disability and Health, (2002) https://www.who.int/classifications/icf/icfbeginnersguide.pdf?ua=1

Aims & Objectives

Purpose
I applied for the Fellowship because I wanted to connect with communities around the world who have started to think and work differently around individual and population health and wellbeing. In particular, I wanted to understand how or if this relates to the social determinants of wellbeing and where individual meaning and purpose fits in.

I hope to inform understanding of different models of care in relation to integrated care. I hope to add to the discussion about what gives a person meaning and purpose and be able to change the conversation around what systems can do to keep the person at the centre of design.

Where did I go and why?
My first trip was to Anchorage in June 2018 to learn about the Nuka System of Care. I had been interested in Southcentral Foundation[5] since reading about their improvement journey through the Kings Fund[6]. I attended a masterclass in 2016 where Steve and Michelle Tierney explained the history behind the system redesign and the fundamental shift made to put the customer in charge of the health system. With a shift to personal responsibility for health and wellbeing that reached across the community, I wanted to learn about how prioritisation happens and what this means for individual and population health.

Project aims

To identify ways to increase population health and wellness

To understand how cultural shift is achieved in relation to personal responsibility and building meaning and purpose

To learn how community outcomes are agreed and measured

I participated in Core Concepts, the 2018 Nuka System of Care Conference, and undertook a week-long masterclass in coaching with members of the Southcentral Foundation team.

My second trip was to New Zealand. In the North Island, I was invited to visit the team at Turuki HealthCare[7] in Auckland whose Chief Executive, Te Peau Winiata, I had met in Alaska. The aim of this organisation is to provide whānau-based health, wellness and social services to people in South Auckland. I spent time with key members of the team and delivered a presentation on my Fellowship experience.

Through social media connections during the first part of my travels, I was invited to spend a week in Hamilton, North Island, with the Ventures team at Pinnacle Incorporated[8]. This primary care network is the provider interface for health care in the community and its members play a crucial role in achieving better health care outcomes in the Midland region. With a strong focus on technology, I was interested to understand more about the visionary work in designing primary care services for the future and particularly the role that data is playing in population health management for primary care.

My final destination was to Christchurch in South Island to spend some time with the team at Canterbury District Health Board[9]. This area of New Zealand had already begun on a journey of transformation when a devastating earthquake caused a crisis in the health and care system which accelerated the rate of change. The Canterbury model is described as a single unifying 'one vision, one budget' approach. I wanted to learn about the whole system change required to achieve their aim to keep people well and healthy in their own homes.

For complete itinerary for Canterbury District Health Board please see Appendix 1.

[5] https://www.southcentralfoundation.com

[6] https://www.kingsfund.org.uk/publications/population-health-systems/nuka-system-care-alaska

[7] https://turukihealthcare.org.nz

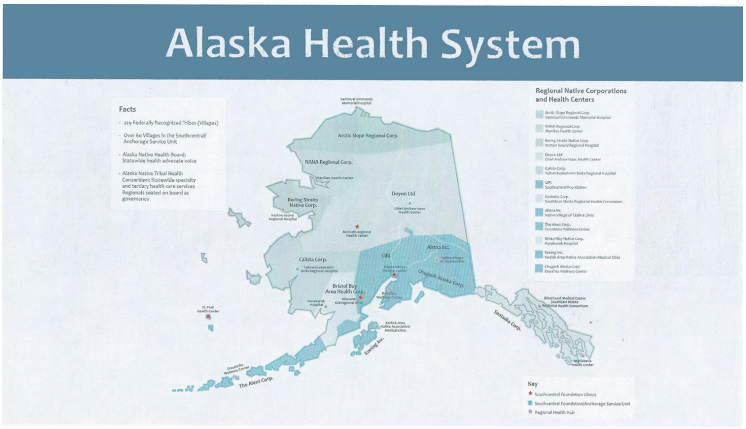
[8] https://www.pinnacle.co.nz/about

[9] https://www.cdhb.health.nz

Findings

Alaska

Case Study 1 - Southcentral Foundation, Anchorage



Southcentral Foundation is an Alaska Native-owned, non-profit healthcare organization serving nearly 65,000 Alaska Native and American Indian people living in Anchorage, Matanuska-Susitna Valley and 55 rural villages.

The story of SCF and the creation of the Nuka System of Care is one of intention and attention to change and improvement over the last 30 years. Nuka is an Alaska Native word used for strong, giant structures and living things. Southcentral Foundation's Nuka System of Care is a name given to the whole health care system created, managed and owned by Alaska Native people to achieve physical, mental, emotional and spiritual wellness.

The Alaska Native Tribal Elders recognised that the model of care provided through the Federal System was not relevant to or meeting the needs of Alaska Native people. Health outcomes were poor. In what was a transactional model, people's lives were increasingly medicalised, with a pill for every problem. The system was plagued with long waits, fragmented services and no attention was given to culturally appropriate care. It was described as 'sick care from a system of tradesmen'. There was no incentive for innovation and creativity and any revenue generated went back to the US Treasury.

The Nuka System of Care[10] is an innovative, relationship-based and customer owned approach to transforming heath care, improving outcomes and reducing cost. Lobbying for a change in legislation allowed Alaska Native people to take greater control over their health services, transforming the community's role from 'recipients of services' to 'owners' of their health system, and giving them a role in designing and implementing services. Nuka is therefore built on partnership between Southcentral Foundation and the Alaska Native community, with the mission of 'working together to achieve wellness through health and related services.

'Southcentral Foundation's vision is a Native Community that enjoys physical, mental, emotional and spiritual wellness; its mission is to work together with the Native Community to achieve wellness through health and related services. The organisation has developed and implemented comprehensive health-related services to meet the changing needs of the Native Community, enhance culture and empower individuals and families to take charge of their lives.' [11]

Feedback from Alaska Native community

Care was ineffective. Did not address overall wellness of individuals. Not culturally appropriate. System plagued by long waits. Low satisfaction from patients and employees. No continuity. Lack of care coordination

[10] https://www.southcentralfoundation.com/nuka-system-of-care/nuka-system-of-care/

[11] https://www.southcentralfoundation.com/about-us/history-2/

So how is it different?

Southcentral Foundation paid attention to the heritage, culture and traditions of the community in how they have created their operational principles and values. There is a shared sense of identity, belonging and respect for the relationship. It is recognised that like any relationship it needs constant attention. They have created a way to think differently about how customer owners connect and influence.

In this relationship-based system, there is shared responsibility to achieve multidimensional wellness. Alaska Native people value the reconnection with their history, however painful, and keeping their traditions alive to build and sustain the strength of their people. Their reason for being is to continue to connect and share their stories. Population health and wellbeing is improving because they are working together as an Alaska Native Community.

One of the themes identified through my research is the need to own and share our stories. To know and make peace with ourselves in order to be open to connection with others in the community we live and work in. To be person-centred. As an organisation Southcentral Foundation understands its ikigai – its reason for being – because it understands and respects its community and the people it serves.

Example 1

One of the most striking differences is the way that Southcentral Foundation prioritises spend based on what customer-owners have determined is important for the wellness of the community.

Community Priorities reducing individual and societal impact of:
Domestic violence
Child abuse
Child neglect
Behavioural health
Addictions

Village wants to improve children's dental health

SCF review request through strategic planning

Village told more dental clinics can be provided but will need to decide whether they can accept service reduction in another area

Village decides to increase dental clinics and reduce physio clinics

SCF monitors and advise village elders of impact of decision

This is truly a community which values multidimensional wellness and recognises that paying attention to the social determinants of health is essential to build a strong community with opportunity for growth and wellbeing for all. This approach is so different with regard to the power of the customer-owners to truly influence strategic priorities through priority setting and shaping the emerging model. I can understand how difficult it is for others to understand how such a paradigm shift works.

In health and care systems where hierarchy and paternalism rule, the power dynamic generally require users take a passive role. If they challenge the available offer, they risk being viewed as troublesome or demanding. The approach in Southcentral is very different. There is a requirement that customer-owners use the various communication methods to voice what the System needs to provide for the community. At the same time, the community is required to participate in the decision-making about what strategic prioritisation and therefore what services will be available.

The number of requests for family GP appointments have reduced in volume as people are taking control of decisions around their health. Southcentral Foundation have invested in coaching approach for clinical staff which is used to realise the potential of the person by leveraging their own strength. This recognises that staff need support to develop the right skills for a new model of care.

SCF does not portray itself as perfect. Some customer-owners will complain but the performance target for complaints management is 5 days as what they place value on is relationship, connection and listening.

Example 2

System Change – a new primary care model

Family Physicians (provider) are conductors of the orchestra rather than solo violinists. Power relationships have changed as the provider is a partner not a hero. Rather than 'Thank you – you are going to heal me' or 'treat me', customer-owners now understand there is a shared responsibility for tribal or community wellness that they are required to participate in.

Customer-owners are empanelled, mainly as family units, to a core care team where the focus is on valuing the person's time. The core team consists of a family physician, nurse and administrator. Customer-owners can connect with their team through telephone, SMS, email and video calls. They can book their own appointments directly into the system, recognising that their time is important too. As we enter an age where increasingly connection will be virtual, Southcentral Foundation have developed processes that allows customer-owners a choice but built on a solid foundation of relationship first.

Investment in front-end primary care services, in high-quality data systems and highly skilled administrators means that clinical time is focused appropriately to the people with most complex care needs. The wider team are co-located and includes behavioural health (mental health) consultants, dieticians, physiotherapists and pharmacists. This investment in an integrated system has reduced the referrals into secondary mental health services significantly. Around 80% of people will be supported through their initial visit with the primary care team.

This investment in front-line primary care services has resulted in a reduction in prescribing, radiology and pathology testing, emergency admissions to hospital services and referrals to hospital specialists. This means greater efficiency through the system as people are seen in the right place at the right time by the right person.

Investment in people

In health and care systems, our biggest and most important asset is our people. In Southcentral Foundation they recognised the need to create a different type of workforce.

For clinicians working in this system of partnership with customer-owners, achieving better outcomes for people and services including choice, quality, effectiveness and efficiency gives better job satisfaction. This is evidenced by excellent staff survey results and employee retention rates. It is recognised that this way of working will not suit everyone. Recruitment using a values-based method is crucial to maintaining the core concepts of the organisation. There are still performance management and capability issues but what they aim to do is start by recruiting people who 'get us' and then continue to invest in employees through a comprehensive education and training programme.

Again, this attention to a whole system approach is evident. Develop your organisational principals and use them. All the time. Not just when you are being inspected.

Leadership

Dr Katherine Gottleib is the President/CEO of Southcentral Foundation CEO and is the beating heart at the centre of this trail-blazing system of care. An innovative and visionary leader, Dr. Gottlieb has partnered with SCF's Alaska Native board of directors, fellow customer-owners and other leadership, to transform health care for the Alaska Native Community.

Today, as SCF's chief executive, she oversees 2,300 people and administers an annual budget of in excess of $225 million to manage more than 80 health care programs, services and departments. Under her direction and guidance, SCF's Nuka System of Care has earned the Malcolm Baldrige National Quality Award and other national and international recognitions for performance excellence and innovation.

'Relationships are truly the core of our entire system of care'

'Being present'

'Being in relationship'

Building relationships with Sharing story

This way of connecting with yourself and your purpose is introduced to people joining the organisation during a three-day introduction to the 'secret sauce' of this integrated system. In Core Concepts the executive leadership team explain the past, present and future of Southcentral and how it connects with the past, present and future of the Alaska Native people they serve as customer-owners. 'Being present' and 'being in relationship' are how they do business as usual in Southcentral.

Programmes such as RAISE, where senior school children work in the system to understand their place in the community, develop purpose and connections as well as credits for their future, is true investment in the community.

Focus on people

New hire orientation over four days
One-day customer and culture
½ day innovation and improvement

Core Concepts
RAISE - Grow Your Own
Executive Leadership
Experience Programme
Managers' annual reorientation

My trip to Alaska gave me much to think about around the role of community in health and the culture of its people. There were a lot of questions for me to develop my thinking for the next leg of my journey.

New Zealand

Case Study 2 - Turuki HealthCare, South Auckland

I first took notice of health and care services in New Zealand after reading a couple of Kings Fund publications on whole system redesign and accountable care. As someone working in an organisation that was delivering integrated health and social care, these publications gave me a lot to think about. I'm eternally curious, so went to a Kings Fund Integrated Care Summit. Commissioners and providers across public, private and the third sector from around the UK plus international delegates discussed ways to meet the growing challenge of population health and wellbeing - the holy grail of effective and efficient person-centred services. Whole system redesign. Some amazing projects were described but it was the discussions about housing and homelessness that still stick in my mind.

At the time I wasn't really paying much attention to the social determinants of health and wellbeing. An organisational restructure later and I find myself responsible for care and support services in three extra care housing schemes. It's all pretty straight forward I was told, won't add much to your workload. It's no cliff-hanger that that wasn't really the case. We have a great team and great properties, but it takes sustained effort to create and maintain a community. People with a level of need that meet the criteria for extra care living can easily shift from independence to dependence. The question I couldn't stop asking was '...but what gives their life meaning?' This is not a care home. How do we help people connect or reconnect with their purpose?

My Fellowship has provided me with the opportunity to learn from others about their communities and identity, their traditions and rituals and the impact on health and care service delivery. It's been a window into cultures I didn't expect to look through.

I met Te Puea Winiata[12] in Anchorage, where she and some of her executive team and board were learning about the Nuka model created by Southcentral Foundation. Te Puea and her team want to create a relationship-based care model that meets the specific needs of people in their community.

Te Puea was appointed to CEO of Turuki Health Care in 2010, which is an NGO providing integrated health and social services to people and their families in South Auckland. Turuki has its own pharmacy and opened a new GP clinic in Panmure which delivers satellite services at Ruapotaka Marae.

I learned how the team are making better use of existing resources by refocusing on building health literacy and self-determination in their community. At the core of their approach is a recognition that 'It takes a community to raise a child'. There is an acknowledgement that the best environment to nurture our whānau 'to get well, live well and stay well', is through active involvement with different agencies and professions.

Whānau ora, through a coalition of providers working in a Collective Impact Alliance model of care, is creating more meaningful outcomes for whānau whilst bearing in mind the social and economic return on investment essential for non-profit organisations.

[12] https://100maorileaders.com/te-puea-winiata

This organisation is standing in the gap for a community with complex health and social care needs where the social determinants of wellbeing are at play. Their work around preventive health through the FitKids programme to reduce childhood obesity and Housing Support Programme shows a breadth of thinking and response that is truly systemic, and person centred. A person-centred approach surely starts with our people. Our uniqueness and individual potential have to be the building blocks for happy and healthy communities that help people thrive and stay connected in meaningful ways.

Example 1[13]

South Auckland has the highest levels of preventable asthma rates in the country among 0-14-year olds.

The Asthma and Respiratory Foundation and **Turuki Health Care** have partnered to proactively reach out to affected tamariki and their whānau via Turuki's school-based services, in order to reduce the disproportionately high rates of Māori and Pasifika children who are unable to lead healthy, well lives due to asthma and other respiratory conditions.

The project aims to reduce sick days from school, acute doctors' visits and admissions to hospital for asthma and other respiratory conditions. The pilot aims for every child with asthma in four of South Auckland's schools to have a management plan, and for their whānau and schools to know how to better

Example 2[14]

Te Tumu Waiora 'to head towards wellness and health'.

Testing a new model of care approach for mental health and wellbeing

The pilot has been designed as a holistic model, supporting and addressing the physical, emotional, and social needs of the person, rather than the traditional focus on mental health or addiction needs.

The aim of the pilot is to deliver a small amount of targeted, brief intervention to a large number of people, as opposed to a large amount of therapy, to a small group of people, as well as to connect social and specialist support across one continuum of care.

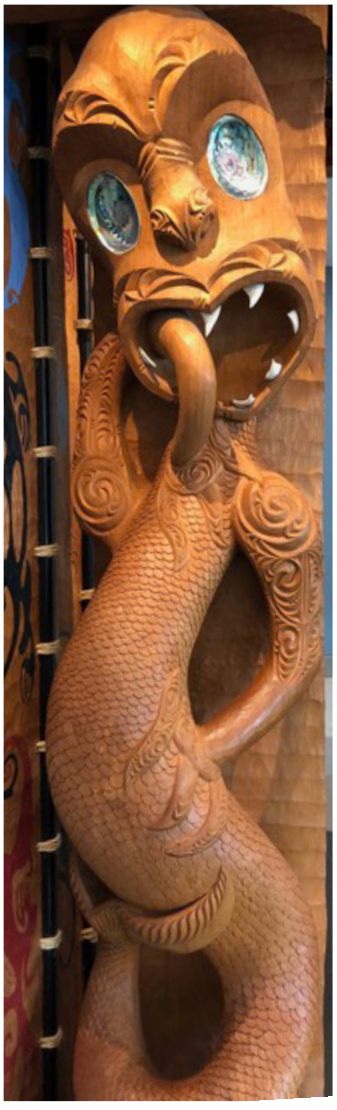
[13]https://www.asthmafoundation.org.nz/news-events/2017 foundation-turuki-health-care-selected-for-pro-bono-project-from-allen-clarke

[14]https://www.nzdoctor.co.nz/sites/default/files/2018-10/ProCare_Briefing%20to%20 Ministry%20of%20Health_Te%20Tumu%20Waiora_FA.pdf

It was great to discuss my observations of how elements of the Nuka model could be adapted and adopted in other systems and to see how this organisation are thinking and working in a similar way. We talked about the challenges of funding, how a whole system approach requires excellent data systems but that's not very easy to achieve and how we need to pay attention to appreciating ourselves and each other.

We talked about the role of sharing story in relationship-based care systems and how powerful it can be. I described a personal experience of sharing too deeply with people who were unprepared to appreciate my story, how that made me feel and the potential impact on them. We need to tread carefully in developing these approaches in our own systems ensuring there is the right support, training and assurances. We had an interesting discussion on language and how we need to find ways to communicate with people that makes sense in our cultures but also explains the changing model and expectations on both sides. Not easy stuff. The risk with systems is that they can reduce people by turning them into units. 'Service user' sounds like a job title. The term patient masks the reality that we are people. It probably makes it easier for us to deal with because they are then things that we can fix or flow or whatever this week's target is.

The Kete of Knowledge



Think Local Act Personal[15]

I had the privilege to hear Clenton Farquharson, MBE, (pictured) from Think Local Act Personal, speak at the Guernsey Academy. This initiative brought together people from public, private and third-sector organisations to find new ways to think and work differently for the benefit of people in Guernsey.
Clenton shared his story of a traumatic event, resulting in significant physical injury. He shared his loss of identity and the frustration of being seen as 'something that needed fixed'. Clenton was being seen in parts rather than as a whole because that is how the system works. Fixing one thing rarely works and can have unintended consequences.
What Clenton wanted was 'an ordinary life'.
It was when someone actually listened to what mattered to him and heard what would give his life meaning that he started to live what, in my view, is an extraordinary life.
Clenton's challenge to us was around language and silo working. About seeing people as assets that add value rather than problems to be solved in isolation.
From my research I know there are over 100 definitions of 'person-centred' but getting it working in practice is tricky. System says no.

In Te Puea, this health care organisation has a strong Māori leader who understands her community, her heritage and her culture. I found Te Puea's story inspirational when I met her in Alaska. She helped me understand that in order to truly transform the future, we must listen to the past to understand the needs of our communities in the present wherever we live. If people in our communities are to have lives with meaning and purpose, there needs to be a societal shift in attitude towards health and wellbeing. Health outcomes cannot be achieved in health services alone. A 'Health in all policies' approach is required.

Our capacity as humans to make decisions depends on many factors such as social class, education, religion, gender, ethnicity, subculture, etc that can limit or influence the opportunities that individuals have and the decisions that they can make. It is too simplistic to say that people should take greater responsibility for their own health and wellbeing. Life matters but not everyone has a happy life with meaning, purpose, direction and joy.

Collective action will be required by our communities with individual responsibility sitting alongside social responsibility and the right social actions and social policies to support individual healthcare that helps people own their stories and find the life that matters to them.

Thank you Te Puea and the Turuki team for a thought-provoking afternoon, your great hospitality and my lovely gift (the Kete of Knowledge).

[15]https://www.thinklocalactpersonal.org.uk/

Case Study 3 - Pinnacle Group, Midlands Health Network, Hamilton

New Zealand Primary Health Organisations (PHO) were formed in 2002 to increase access to wider, integrated primary care based on population need. These not-for-profit trusts are diverse throughout the country in size, governance and functions with some operating through GP-owned networks. Core primary care services are funded through government capitation with agreed funding for other services. There is a patient co-payment for GP and Nurse consultations for over 13s.

'It's difficult to put the patient at the centre if you are standing there yourself'

Helen Parker, 2019

The Pinnacle Group serves a population of around 500k through 90 practices. Visionary leadership recognised a need to invest in new models of care to ensure a primary care for the future. I was invited to spend a week with Helen Parker, Director of Strategic Development. Helen has a wealth of clinical, managerial and general practice development experience. Prior to joining Pinnacle in 2014, she was supporting the development of new models of general practice in the UK and a Senior Fellow with the health policy think tank, The Nuffield Trust. Helen is now CEO of the HCH Programme focusing on further development of the model.

Invest in the business of 'Transformation' was evident as I joined the Pinnacle Ventures[16] team for their Monday team huddle. Feedback and updates on progress and challenges are exchanged which allows Helen and John Macaskill-Smith, Ventures CEO, to check in with the programme teams. They can identify links and opportunities for cross project or programme working as everyone knows what everyone else is doing. Time is made to appreciate what has gone well and recognise the need for additional support or direction. This all sounds quite straightforward but the impact of this relationship-based collaborative way of working cannot be underestimated as the approach is promulgated in how they work with others and drives the success of the programmes these teams lead.

The Pinnacle Group have three Critical Success Factors and three Design Principals for supporting practices to move to the Health Care Home model of care which the Ventures team deliver. (www.healthcarehome.co.nz)

Critical Success Factors

1 Engage all the people on the ground in the same vision

2 Shared information system, developed with patients and practitioners

3 Value a patient's time

Design Principals

Transformation

Care Model

Care Delivery

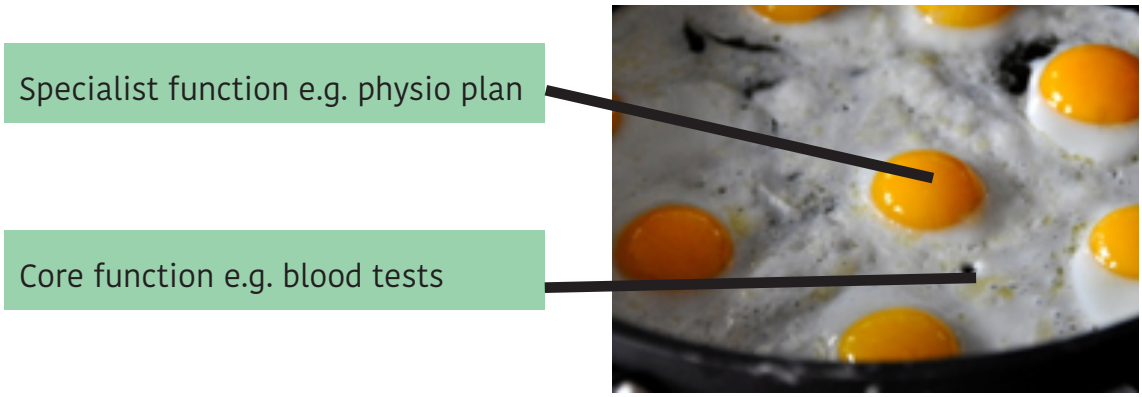
Care Connection

[16]https://www.ventures.health.nz

An underlying principle of the model is not wasting people's time. Like Southcentral Foundation, Pinnacle recognise the importance of getting the best clinical value from all members of the MDT.

Understanding that change management is around changing how people work, the Ventures team facilitate workshops that begin the process of unlocking silo professional working. This can be uncomfortable for people, threatening professional identity, roles, hierarchy and power relationships within teams. Individuals are asked to agree what it is about their role that offers a unique contribution to patient care. They then agree core and specialist functions which will be different for each team depending on the MDT set-up.

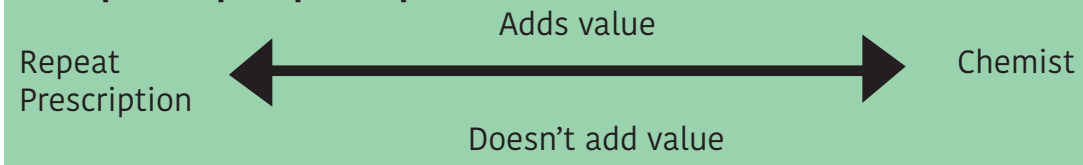
An analogy of frying eggs is used to help people recognise how to get the best clinical value for the patient and each other.



An ingenuous way to encourage people to think differently about working at the top of your license.

Patient journeys described during the workshops focus on keeping the person at the centre and identifying what adds value for the person and what doesn't. A person's time is valuable and should not be wasted with unnecessary actions that don't add value for them. Activities are plotted above or below a line. This simple approach would be easy to adopt locally in health pathway development.

Example - Repeat prescriptions



In the planning and design workshops, putting the person at the centre is critical. For teams shifting to a new way of working, investing in time to get together, talk and plan change has been essential. Within the workshops and ongoing development and improvement work, myth-busting the stories we tell ourselves is continually attended to. This reduces drift back to usual ways of working as well as refocusing around the person. Sustainability and continued improvement are achieved through peer-to-peer support, real time data that demonstrates outcomes and progress and a live action plan.

Example 1

System change - Patient Access Centre

Serves the Health Care Home Practices. Designed to improve call management in primary care ensuring all patients get calls answered first time, quickly, and by someone who can help. It is staffed by trained call takers who take all practice calls. The Centre manages 70% of the calls with 30% going back to the practice as an 'electronic task' for a clinician to respond to. Previously most practices had a call abandonment rate of 25-30% at peak times, now reduced to 3.4%

Calls requesting a same day GP appointment are diverted back to the GP practice. Patients know a GP will call them back within 30 minutes. The doctor's IT system holds a log of telephone calls to be made and with time built in to their schedule to respond, usually it's the person's own GP that calls back.

GPs on average call in 50% of those people for face-to face appointments. The remaining 50% are managed through telephone consultation which includes onward referral or prescribing medication. This approach means that the people with the highest care need are prioritised rather than whoever called in first. Evidence has shown that outcomes for people are better when triage is undertaken by a GP rather than a nurse. Nurses are more likely to bring a patient in for consultation as they have a lower risk avoidance threshold.

In a recent Pinnacle Health Care Home evaluation by Ernst & Young, 62% of people asking for a same day appointment did not need it. Patients now have increased choice in how they interact with the system. They can have telephone, face to face, group consultations or shared medical appointment with family or significant person. This recognises their role in managing their health and values their time.

Health Care Home

Health Care Home1[17] (HCH) is now a national initiative that was pioneered by the Pinnacle Group who distilled elements of the US Primary Care Medical Home model with other global evidence of 'what works' to create a model for the New Zealand health care system.

[17]http://www.healthcarehome.co.nz

Health Care Home improves care over four core domains of health care:

- Managing urgent and unplanned care effectively
- Shifting from reactive to much more proactive care for those with more complex health or social needs
- Ensuring routine and preventative care are delivered conveniently, systematically and aimed at keeping people as well as they can be
- Ensuring that this is all done with greater business efficiency for long-term sustainability

Extended Care Team review workshop

Dietician
Child Health
Community Health Worker (Maori – walking alongside)
Community Peer Support worker
Social Worker
Pharmacist
Nurse Practitioner
Clinical Lead
Exercise Specialist
Administrator

Health Care Homes (HCH) serve a population of 30-50k or a natural community if smaller, recognising geographical context. This provides the greatest efficiencies for services around the person. The NZ Health Care Home Collaborative was established in 2016 to ensure model consistency, support for new adopters and to provide a forum for shared learning and evaluation.

Most Primary Health Organisations (PHO) are currently rolling out HCH. The aim is a wraparound service that meets the needs of the person in the community with a focus on wellness and wellbeing to enable people to have healthier lives. HCH has single point of access with coordination through a single care record and care plan[18].

'One Team' approach and weekly IDT meeting to review people with high care needs was working well. Better collaboration and communication meant an increase in appropriate referrals. Inefficient documentation and connections were still an issue but that will be resolved when all the team move to a single record.

Health literacy is a significant issue in the Maori population – the community health workers spend increasing time translating what has been said by professionals. They play a significant role in advocacy although it is recognised they need more people in these roles.

Time is taken to 'establish a relationship' through sharing story and nuanced conversation. This is similar to Nuka but in this system is only being attended to by the Maori community health workers where in Nuka model, it is seen as core in all connections.

The CHW and Peer worker see this as a responsibility to their community and whānau which is very similar to Family Wellness Warrior Programme in Southcentral Foundation.

The Pinnacle experience is that already good integrated working has been enhanced through the single care record. There needs to be a single vision and relationships. A single Electronic Patient Record is not sufficient to make people work differently. Constant attention to sustainability and continuous improvement is required.

[18]https://www.healthcarehome.org.nz/integrated-health-care-management-nz

Data and technology

indici™[19] is a cloud-based patient information system developed in partnership between Pinnacle and Valentia Technologies. indici™ links families together within the data in a similar way to families being empanelled together in the Southcentral system.

MyIndici patient portal, designed using 3 critical principals

1. I want everyone who is involved in my care to see what's happening
2. I want to see what's happening
3. I want my carers to see what's happening

Cancer screening and other Public Health targets are built into the data dashboards so there is local accountability that supports a preventative health model.

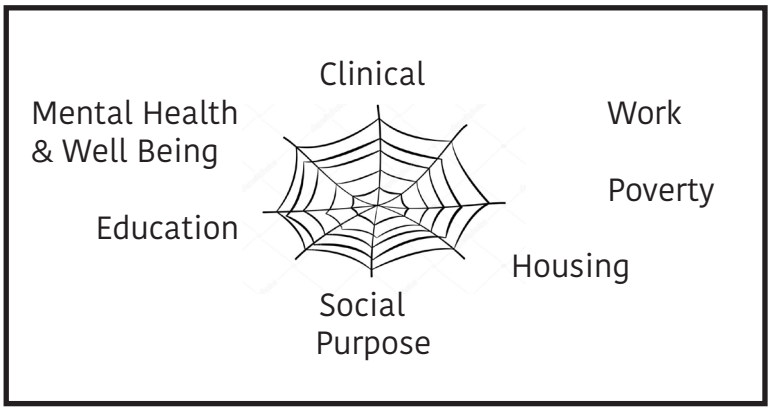
Melon Health[20] is integrated into indici™. to provide 16 weeks of health coaching online and continuing peer support. The model is one of self-management, enabling people to take control of their health by giving them tools, information, motivation and confidence to manage their health.

Given the concern over increasing volumes, complexity, population numbers and long-term conditions, linking Melon Health with MyIndici fits with the model of care, makes it simple to have health coaching as part of the offer and encourages people to take responsibility for their health and wellbeing.

How is this different?

The Pinnacle Group have taken a person-centred rather than provider centric approach to data as this enables a different type of care model. Data from INDICI supports a move from a biomedical model towards a biopsychosocial model. The cloud-based data systems are very impressive because they have been built in partnership with clinicians and with the needs of patients at the forefront of design.

Power BI drives data from the system into dashboards so decisions – clinical or organisational – are data driven. This supports the multidisciplinary team to work in a person-centred way that pays attention to the person in their life rather than focusing on disease or illness. By identifying variations in usual patterns of behaviour, there can be a shift from reactive to proactive care, support and self-determination.



The creation of the 'spiders' web' informatic using the wider determinants of wellbeing will be a significant paradigm shift in primary care practice.

[19]https://www.indici.co.nz

[20]https://www.melonhealth.com

Case Study 4 - Canterbury Health System

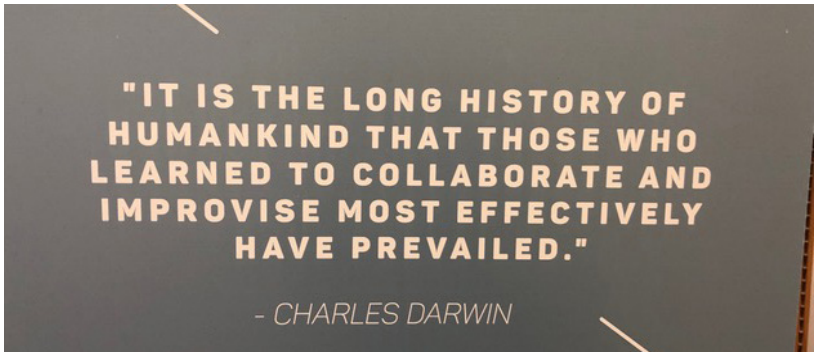
Canterbury District Health Board is a funder and provider of hospital and community services for a population of around 590k of predominantly white middle class. There is underlying deprivation, similar to the local context in Guernsey, with a 'squeezed middle'. 90% of the Canterbury population are enrolled into Pegasus practices who receive the associated capitation budget from the Ministry of Health to deliver services.

Canterbury District Health Board
Te Poari Hauora ō Waitaha

Canterbury Clinical Network (CCN) was set up 25 years ago as a voluntary cooperative for the delivery of general medical services. The CCN became a registered charity which allowed reinvestment in the system with the provision of free mammography screening, sexual health services before national programmes were established. There has been a proactive approach to evidence and its applicability in design and transformation evidenced in the early recognised that it would be necessary to purchase partner data to develop integrated patient management systems.

Three key approaches were central to delivering the transformation in Canterbury:
- the development of a clear, unifying vision of 'one system, one budget'
- sustained investment in giving staff skills to support them to innovate and giving them permission to do so
- developing new models of integrated working and new forms of contracting to support this.

The 2011 earthquake accelerated changes that had been under way since 2007 in the health system. Canterbury is a health system that has rapidly transformed the way it delivers care[21].



[21] https://www.kingsfund.org.uk/publications/developing-accountable-care-systems

Leadership

It is unquestionable that Canterbury and its people have gone through a lot over the past eight years including six earthquakes, several floods, fires and most recently a terrorist attack on two mosques. The Canterbury Health system has had to respond in extraordinary ways. The golden threads through my Fellowship travels have been authentic, visionary and consistent leadership where relationships are valued. CDHB is no different.

David Meates, MNZM, Chief Executive, Canterbury DHB
Leadership matters

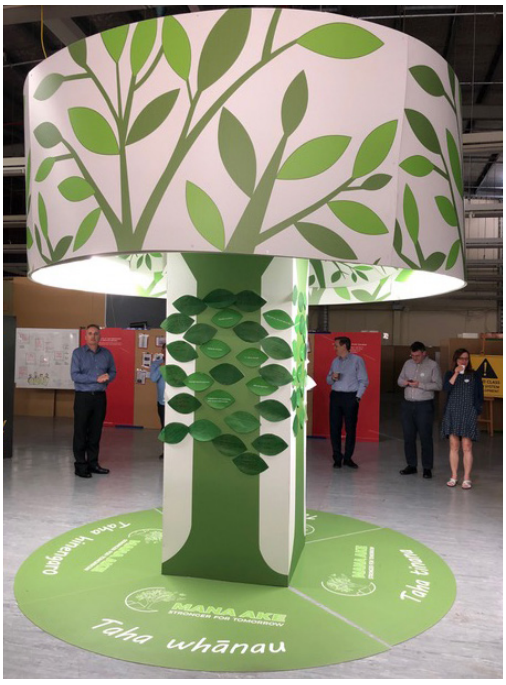
The focus & orientation of the Canterbury Health System is on 'how to make it happen' as opposed to 'why it can't happen'

The Canterbury Health System has a consistent narrative.
- Link to experience
- Connection shape thinking
- Discretionary effort
- Connect into individual value and purpose
- Value people's time

At its centre this is a trust model with core values and shared learning. There is an understanding that they have their role in changing and improving the system. Similar to Southcentral Foundation, while the new starters induction is online, orientation is about connecting people to the CDHB story – the why. This connects people with their values and their workers meaning and purpose.

Why Whole System Transformation?

Services were fragmented and not serving the needs of the people in the community. They were missing targets; targets were not working or recognised the need to work in a 'systematised' way resulting in negative media. The focus was on hospital and acute services due to issues with capacity and demand. The prediction was that, without change, by 2020 there would need to be an additional 400 acute beds. By 2020 there would need to be an additional 400 aged care beds. There was a loss of articulation of purpose and a need to return to the why.



Creating Agnes

The method for creating Agnes[22] was devised following consultation with New Zealand companies including New Zealand Air. The Agnes persona is the Canterbury health system's prototypical patient. She represents the most important part of a health system – the people accessing the services. As Canterbury continues to transform its health system, consumers are an incredibly important perspective. A person-centred health system means that any decisions made about how health services are delivered are in the best interests of the consumers accessing those services.

System Design Principle

'keeping people well and healthy at home (and out of our institutions)'

'If Agnes isn't waiting, we aren't waiting either'

Valuing patients time is a core value within CDHB. The vision for the integrated health and care system is to look after Agnes at home in a connected system. This echoes the thinking in both Southcentral Foundation and the Pinnacle Group with a focus on collaboration and connection through partnership.

With regards to National Targets for public health and outcomes, the Ministry of Health sets six national targets. The DHB then decides on 12 local targets based on local factors. What I struggled to find was when, how or if users of the system were able to influence these policy decisions at national level.

Invest in Innovation

The Design Lab[23] is the engine room of design and transformation in Canterbury. It's a warehouse space and it should not make me as excited as it does. It is a warehouse.

What it offers is a place for people to think and breath that is used to facilitate design and innovation across the whole system.

[22]http://ccn.health.nz/NewsStories/tabid/1273/ArticleID/728/The-newest-voice-of-Agnes.aspx

[23]https://www.healthpathwayscommunity.org/News/LatestCommunityNews/tabid/772/ArticleID/1354/Design-Lab-tour-reveals-heart-of-one-system-approach.aspx

Showcase

'you need to create the space for people's individual values'	Who are we? What's important to us?

Showcase was the initial event at the Design Lab. 80 people from across Canterbury District Health Board were invited for 3 days, including consumers of the system. They became the primary influencers in developing the Canterbury Health System. Each of the original 80 then invited 10 people to the Design Lab for a 2-hour conversation about the why of the system. Up to now 2,000 people across the system have participated in growing and reaffirming the narrative.

The Design Lab has been used to design and test ward layouts for the new hospital, bed spaces and is in constant use redesigning pathways that keep Agnes at the centre of all they do.

Example 1 Xceler8[24]

Xceler8 & Collabor8
The Xceler8 & Collabor8 courses were designed to help people reconnect with the 'Why?'. Xceler8 is for leaders to solve system wide problems, looking at improvement and design solutions.

Participants for Xceler8 are identified by Directors who have identified their potential. Invitation comes with kindle with reading list. They are also given a DVD with leaders of the Health System which explains about the programme and aspiration for the system and developing leaders.

Eight-day programme over four weeks. On the first evening of the programme, participants are served mocktails and canapes by the Leadership Team.

16 participants split into four groups according to DISC assessment and asked to agree a problem and work together to find a solution. Presented to the CEO in Dragons Den style – 'David's Den' to secure leadership support.

Participants sign a pledge in front of the CEO. They are given an Xceler8 card for future use which allows them to unblock future change. This gives a sense of permission from the CEO and legitimacy.

Collabor8
Collabor8 is for front line workers to solve problems identified by them within business unit. A two-day programme using LEAN principles.

[24] https://www.healthlearn.ac.nz/pluginfile.php/8498/course/summary/Xcelr8%20 2017.pdf

This programme and the shortened version Collabor8, shows an investment in individuals by the Leadership team. It allows for consistency of message. The Xceler8 card is a physical manifestation of trust. These programmes are non-technical. They are relationship based and give people the space and permission to investigate and find new ways of working – alliancing. The aim is to connect and empower people working and experiencing all aspects of the system using a common approach and methodology.

Example 2 CCN Education Programme[25]

Canterbury Clinical Network Education Programme
This impressive initiative has been a core component of the CCN. Initially for GPs who are paid to attend sessions in evenings or weekends. It costs the CCN 300-440k per annum to run the back office function and a payment to participants to attend which has not changed in 17 years.

The aim of the education programme was initially to make sure that all practices in the CCN were working to standardised evidence-based practice. This created efficiencies and effectiveness and is a key tool in demand management. It allowed GPs to recognise trends and work together to find solutions. It is now interdisciplinary in the creation of Health Pathways across the System through Network Alliance Groups. It can also be used for 'wicked problems' such as ensuring equality of provision, for example, for people who are transgender.

Attendance has stayed at around 60% of GPs attending. A pre-briefing pack is produced which those attending are expected to read before the session.

[25]https://www.healthpathwayscommunity.org/About.aspx

Conclusion

Me and my community

I didn't expect to spend time learning about myself, sharing story and making connections with people of such depth that took my breath away and brought me to tears on a number of occasions. And I'm not easily moved to tears. The Nuka model is relational. If we don't understand ourselves how can we be present and honest in our connections with others? This is so far removed from how we practice in a boundaried and restrictive way. It takes some getting used to and I can appreciate the need to recruit the right people who have the capacity to think and work differently.

I didn't expect to learn and reflect on heritage and cultural identity and the impact that this has on health and well-being in communities. I knew that Southcentral provided services for native Alaskans. I knew that there were Maori in New Zealand. I have to be honest and say I never really thought about what that meant. In Core Concepts, people from indigenous communities across America and throughout the world shared their stories about how the loss of tribe, land and language impacting on heritage and cultural identity continues to influence population health and wellbeing. Policy decisions meant that families were separated, children sent to boarding schools, elders banned from using traditional healing and prohibited from speaking their own languages. And I began to understand.

Initially though I was thinking 'this is really interesting but how is it relevant to my community? I just want to know about your model'. Once I started to reflect at a deeper level, I realised that this was entirely relevant to my community, and any community which has suffered conflict or trauma. Which - let's be honest - could be any community.

There is particular relevance for the Channel Islands which I hadn't really considered before. During the Second World War, the Channel Islands were occupied by German military forces. During the war, families were separated, with adults going to fight for their country - mainly men but some women, with the evacuation of most children to the UK but also Canada and through the incarceration of some people as prisoners of war by the occupying forces. If we think about the impact of occupation and the plight of refugees in the world today, we know and understand more that it's likely that the impact of this trauma being observed in people today would have been present for our islanders during the Second World War. We understand the physical and emotional impact; we see it in the media, and we expect these people will struggle with wellbeing.

I had never given this a moment's thought. Yet here in our islands there will be families still experiencing the after-effects of the Second World War. This may relate to physical or emotional trauma or separation of families with an intergenerational impact and legacy. The impact of adverse childhood events (ACEs) on population health is being paid more attention by researchers, professionals and public health experts.

Childhood trauma isn't something you just get over as you grow up. Paediatrician Nadine Burke Harris[26] explains that the repeated stress of abuse, neglect and parents struggling with mental health or substance abuse issues has real, tangible effects on the development of the brain. This unfolds across a lifetime, to the point where those who have experienced high levels of trauma are at triple the risk for heart disease and lung cancer. Nadine makes an impassioned plea for paediatric medicine to confront the prevention and treatment of trauma, head-on. For these reasons, we need to educate our people and our teams on the impact of ACEs for the individual and population health of our communities.

[26]https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime?language=en

I thought a lot about the cultural identity of Guernsey while I was away and how that would have been influenced by the occupation in a similar way to what happened with indigenous people in the United States, Australia and New Zealand. Families were separated, sons and daughters went off to fight and didn't come home, children lost their ability to speak the local language, Guernesiais[27]. I don't know enough about this time or local culture, but I do want to understand our local heritage and culture better. I want to live in a community with multidimensional wellness – physical emotional & spiritual - where a connection with personal meaning and purpose is explicit in all government policies.

My travels gave me a lot to think about in relation to myself and my community on a much deeper level than I expected. I am still trying to process but have started to understand myself and my place in my community better. I have a better understanding of how cultural identity, traditions and heritage influence wellbeing from a population health perspective.

The same themes were consistent in these high-performing systems with three system enablers that connect to an individual's meaning and purpose.

Culture & heritage

By appreciating the heritage and history of our community and working in partnership with people to create the vision for the future, systems can produce different results as long as there is whole system redesign.

Shifting to focus on outcomes rather than cost or income, and thinking about the person not the disease, the population not the process and service over practice creates a different culture for the people working in the system in the relationships they have with themselves, each other and the people they provide services for.

Leadership

Strong leadership and investment in the workforce to develop leadership at all levels was evident in the places that I visited. In some organisations, the voice of the user of services was clear and evident in decision making at all levels. In others, the clinical voice seemed more dominant. For a truly integrated system to work, the voices of all need to be valued equally. This is not easy and will take time and major cultural shifts in action and power dynamics.

The stand-out area for me was in organisational design and transformation, like the Innovation division in Southcentral and the Ventures team in Hamilton, CDHB have invested in the Design Lab team. The investment in making whole system change live within the system with innovative leadership and development programmes was inspirational and definitely something I want to see develop locally.

Relationships

'Its all about relationships' was the golden thread of my Fellowship. Sharing stories and being in relationship is how Southcentral Foundation does business. In Turuki, the relationship with the community was as old as time and built on the principles of whānau. It was clear within Canterbury DHB in their Alliancing approach to developing health pathways. The team at Pinnacle were an exemplar in their approach to recognising the particular strengths of the communities they were working with, using an impressive base of evidence and information to make best use of people's time.

[27]https://en.m.wikipedia.org/wiki/Guernésiais

Recommendations

I am in the fortunate position of working as part of our Health & Care Transformation team in Guernsey. My recommendations have already found their way into our Community Transformation Programme Blueprint which will be available online in due course.

Relationships are the golden thread that will shift the system from doing to people to doing with people and support a move from transactional to relational where true partnerships can flourish. Working at and in relationship for the benefit of everyone will allow us to recognise that if something affects one of us, it affects all of us.

Value people's time – don't let the needs of the system or process drive or stall change.

Don't underestimate the need to pay attention to **self-care**. Being in relationship with yourself means recognising when your bucket is empty.

Leadership

Sustainable, responsive, visible and authentic leadership that acts as the guardian of the vision requires clear **organisational vision, mission and values**. We need to use language consistently so that we all live our operational principles.

This requires investment in making sure that people understand and live these as that will bring meaning to their work. A **leadership programme** at team and system level will be key for successful and sustainable change.

Recruit to your values, make them work for everyone. Sounds simple but again it will require an investment and change in how we recruit. Use your people effectively – **right skills, right place, right time** - clinicians don't go to school to be managers – focus on the human in human resources.

Unlock **creative potential** – use creative talent to challenge wicked problems – create in a space for collective work across the system.

Organisational development needs resources but it will save time, effort and money in the long run – strategic planning increases organisational agility and responsiveness – keep it simple.

Investment in **data & technology** is essential but it needs to be designed and implemented in partnership with the people that need and use it.

Culture and heritage – who we are and why

Be yourself – at work – in life.

Recognise that being **culturally appropriate** is a strength.

Recognise the individual and societal cost when people don't have the **agency** to make decisions that enable health and wellbeing. For me this means investing in Trauma Informed Care training for my teams.

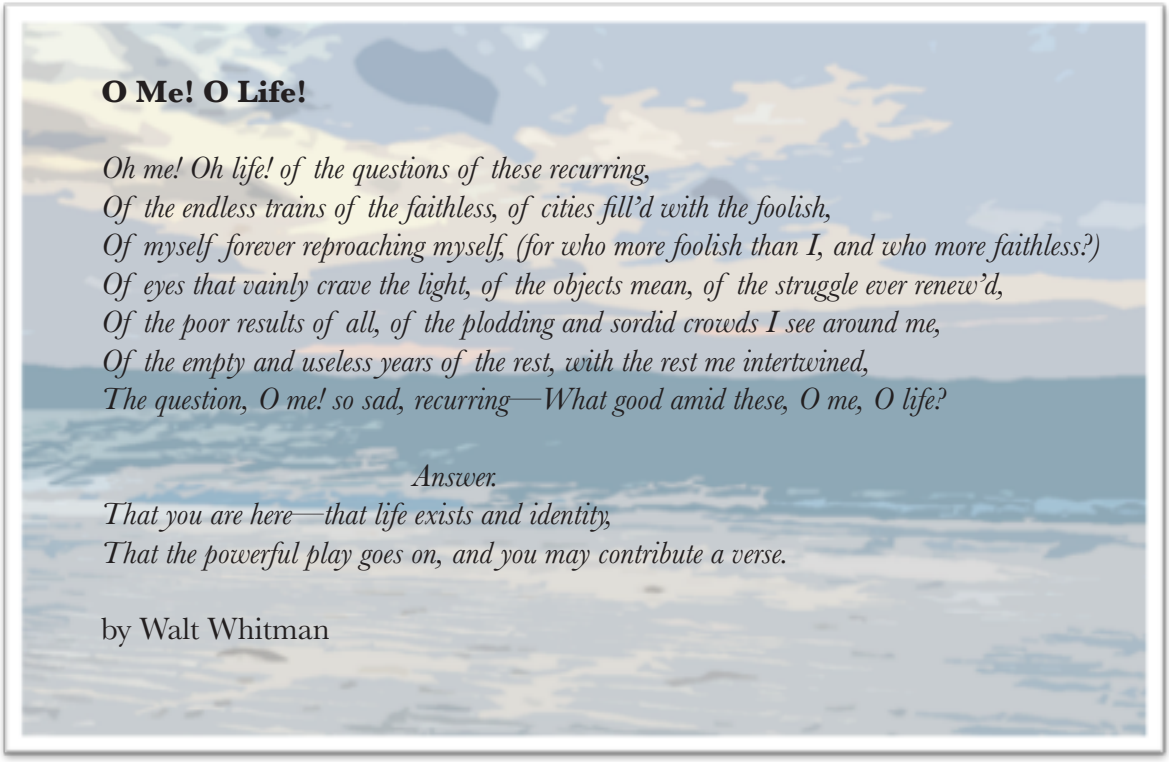
Listen to your customer – really listen – **it's hard to put the person at the centre if you are standing there yourself** – develop shared responsibility throughout the system

Be a learning organisation – invest in your people – support creativity – **encourage courage** to try things out

Our community has a past, present and future – **learn from the past to improve the future** – our heritage, culture, sense of identity and belonging influences and informs current & future community health and wellbeing

Create a single vision for the whole system with shared values developed in partnership with the community.

Recognise that all this takes time.



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If you fancy meeting for a coffee, let me know

Appendix 1

A Partnership of Purpose: Transforming Health and Care
Committee for Health & Social Care - P.2017/114

Partnership of Purpose Key Aims

• **Prevention**: supporting islanders to live healthier lives;

• **User-centred care**: joined-up services, where people are valued, listened to, informed, respected and involved throughout their health and care journey;

• **Fair access to care**: ensuring that low income is not a barrier to health, through proportionate funding processes based on identified needs;

• **Proportionate governance**: ensuring clear boundaries exist between commissioning, provision and regulation;

• **Direct access to services**: enabling people to self-refer to services where appropriate;

• **Effective community care**: improving out-of-hospital services through the development of Community Hubs for health and wellbeing, supported by a Health and Care Campus at the PEH site delivering integrated secondary care and a Satellite Campus in Alderney;

• **Focus on quality**: measuring and monitoring the impact of interventions on health outcomes, patient safety and patient experience;

• **A universal offering**: giving islanders clarity about the range of services they can expect to receive, and the criteria for accessing them;

• **Partnership approach**: recognising the value of public, private and third sector organisations, and ensuring people can access the right provider; and

• **Empowered providers and integrated teams**: supporting staff to work collaboratively across organisational boundaries, with a focus on outcomes.

Appendix 2

Where	Key contact	For	What
Auckland	Te Peau Winiata, CEO	Turuki Health Care	Primary care Provider – non-profit
Hamilton	Helen Parker	Ventures & Pinnacle overview	Non-profit Change & Innovation organisation within Pinnacle Group
	Raewyn Dean Charge Nurse Manager & Sharon McPherson, Nurse Practitioner	START (Supported Transfer Accelerated Rehabilitation Team)	Waikato District Health Board
	Graham Guy Chronic Care and Community Medical Services Manager	Disability Support Services	Waikato District Health Board
		Health of Older People, Acute Home Based Supports, Waikato Strength and Balance	Waikato District Health Board
		REACH - Realising Employment through Active Coordinated Healthcare	Waikato District Health Board
		Maori Needs Assessment and Service Coordination	Waikato District Health Board
Taupo	Helen Parker	Health Care Home Extended Care Team	Health Care Home practice
Hamilton	Rawiri Blundell, Health Manager	Visit to Rauawaawa Trust	non-profit
Christchurch	Vince Barry COE, Pegasus Health	Overview of primary care model	Canterbury District Health Board
	Ester Vallero - CALD Health Manager (Cultural and Linguistically Diverse)	Cultural diversity	Canterbury District Health Board
	Deb Gillon – Canterbury Clinical Network Nurse Practitioner	Nurse Practitioner role	Canterbury District Health Board
	Aarti Patel – General Manager Gareth Frew – Clinical Lead	Canterbury Community Pharmacy group	Canterbury District Health Board
	Melissa McCreanor – Community Liaison Access Manager	Partnership Community Workers	Canterbury District Health Board
	Richard Hamilton & Brian Dolan	Staff training programmes/Design Lab	Canterbury District Health Board

Canterbury Health System Visit
5th March – 8th March 2019

DRAFT PROGRAMM

Day 1 – Tuesday 5 March

Time	Topic	By Whom
8.00am	Mihi/Welcome & introductions	Eru Waiti
8.20am	The Canterbury Story	Greg Hamilton
9.30am	DesignLab Introduction Tour	Richard Hamilton
9.50am	Morning Tea	
10.00am	Alliancing	Kim Sinclair-Morris/Mark Leggett
11.00am	Mana Ake	Clare Shepherd
12.30pm	Lunch	
1.00pm	The role of Planning & Funding	Greg Hamilton
2.00pm	DHB context Government delegations	David Meates
9.30am	DesignLab Introduction Tour	Richard Hamilton
9.50am	Morning Tea	
10.00am	Alliancing	Kim Sinclair-Morris/Mark Leggett
11.00am	Mana Ake	Clare Shepherd
12.30pm	Lunch	
1.00pm	The role of Planning & Funding	Greg Hamilton
2.00pm	DHB context Government delegations Government framework Leadership approach Lessons learnt	David Meates
3.00pm	Travel to Streamliners - vehicles being provided	
3.30pm	Primary Care HealthPathways	Ian Anderson
	Hospital HealthPathways	Mike Ardagh
	Canterbury Initiative	Graham McGeoch
5.00pm	Debrief and Prep for Day 2	
6.30pm	Group Dinner - Curators House Restaurant *Sponsored by Lightfoot (drinks are at own cost)*	

Day 2 - Wednesday 6 March

<table>
<tr><td colspan="3">8.00 am
Measuring System Outcomes
Saxon Connor – General Surgery
Ken Stewart - Falls
Trevor Read
Ian Shields</td></tr>
<tr><th>Group 1 (Trevor)</th><th>Group 2 (Ken)</th><th>Group 3 (Brian)</th></tr>
<tr><td>9.30am
Travel to Rural Canterbury PHO</td><td colspan="2">9.30am
Tour of the Manawa building and SIMs Centre</td></tr>
<tr><td rowspan="3">10.00am (Level 1 567 Wairakei Road)
Canterbury Primary Health System & Rural Health

Bill Eschenbach and Lorna Martin</td><td>10.30am (Venue TBA)
Clinically Lead Innovation,
Saxon Connor</td><td rowspan="3">10.00am (Corporate Rm 1.25)
Radiology Transformation
Rob Graham & Felicity Woodham</td></tr>
<tr><td>11.15am
Travel to Pegasus Health</td></tr>
<tr><td>11.30am (Pegasus Room 1.01)
Primary Care education programme
Louise Kennedy & Marie Burke</td></tr>
<tr><td>12.00 – Lunch & Travel</td><td>12.30 - Lunch</td><td>11.30pm – Lunch & Travel</td></tr>
<tr><td rowspan="2">1.00pm (Pegasus/24 Hour – Room 1.02)
Acute Demand & 24 Hour Surgery – Andrew Meads</td><td rowspan="2">1.30pm (Pegasus Room 1.03)
Patient care plans
Rebecca/ Gavin/Rose</td><td>12.30pm (310 Manchester St – Waitaha Room)
Health in All Policies
Community & Public Health
Evon Currie & Ramon Pink</td></tr>
<tr><td>1.30pm Ramon Pink</td></tr>
<tr><td colspan="3">2.30pm (Pegasus Health, Room 1.03)
Integrated Community Respiratory Service
Deborah Callahan/ Robin Rutter-Bowman</td></tr>
<tr><td colspan="3">3.30pm – Travel to CDHB Corporate office – transport arranged</td></tr>
<tr><td colspan="3">4.00pm (CDHB Corporate Rm 211)
Clinical Leadership in facility design
Nicky Topp/ Rob Ojala</td></tr>
<tr><td colspan="3">4.45pm (CDHB Corporate Rm 211)
City Council (Local Authority) Engagement
Jane Cartwright</td></tr>
<tr><td colspan="3">5.15pm- 6pm - Debrief and prep for Day 3</td></tr>
</table>

7.30 (or earlier) Mumbaiwala Indian Street Kitchen (03 943 9536) (120 Hereford St opposite Ibis) Lightfoot sponsored, pay own drinks

Day 3 – Thursday 7 March

Group 1 (Trevor)	Group 2 (Ken?)	Group 3 (Brian)
8.00am ED Visit - Sarah Carr	8.00am (Great Escape Annex) General Medicine Handover Dave Nichols	8.00am (Lower Grd Floor) Nursing Operations Centre Nicky Topp
9.00am (CDHB Corporate - Room 211) GP Liaison role Rose Laing		
10.00am – Coffee Break – St Asaph Street Kitchen		
10.30am (CDHB Corporate - Room 211) Home Support & CREST Sam Powell and Mardi Postill, Andrea Davidson, Greta Bond		
11.30am (CDHB Corporate - Room 219) St Johns – The changing role of the Ambulance Service Kirsty Mann	11.30am (CDHB Corporate - Room 211) The Patient Voice Ngaere Dawson	
12.15 – Travel		
12.30pm (Pegasus Rm 1.03) (NB: Working Lunch) HealthOne Martin Wilson (Pegasus Health)		

1.45pm (Pegasus, Room 1.03) HealthCare Homes – Lisa Brennan	1.45pm Travel to Travis Medical Centre	1.45pm (CDHB Corporate Rm 211) Cardiff Planning Session – Richard Hamilton Brian Dolan Roger Dennis Ken Stewart
2.30pm Travel to Burwood Hospital	2.00pm Visit Travis Medical Centre	
3.00pm (Burwood Rm 2.6) Burwood Hospital Overview and Tour - Janice Lavell/Helen Skinner	3.00pm Travel to Red Zone	
	3.15pm Community Engagement – Sam Johnson (City)	
	4.30pm Travel to Design Lab	
4.45pm – Debrief and plan for Day 4 (CDHB Corporate Rm 211)		
5.30pm – Travel to Hotels		