Federation of Primary Health Aotearoa New Zealand

Kia hauora a Aotearoa

Developing Community Health and Wellbeing Networks

Integrated Care at the Heart of the New Zealand Health System

Discussion paper

Naku te rourou nau te rourou ka ora ai te iwi

With your basket and my basket the people will live

May 2020

This discussion document has been prepared by the members of the Federation of Primary Health Aotearoa New Zealand.

Finalised May 2020

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TĒNĀ KOUTOU KATOA

The Federation of Primary Health Aotearoa proposes Community Health and Wellbeing Networks to deliver *the best possible outcomes for all New Zealanders.*

A healthcare system that delivers high quality outcomes in a way that is equitable, accessible for all people and sustainable will take investment and commitment at both policy and professional levels.

Achieving equity for Māori, their whānau and all New Zealanders through a system that delivers in a joined-up way will take inter-professional trust, and respect. Community Health and Wellbeing Networks, supported by policy, recognition, and incentives, are likely to start small and evolve as trust builds between providers and communities. These will operate in a framework of continuous improvement.

Covid-19 has demonstrated that primary care can work together to deliver when there is a clear, shared goal.

This paper presents a high-level description of the future and what can be achieved when the environment is enabling and connected. Whilst these ideas are not new, the time is right to establish the policy setting and investment that will enable this approach to become a reality across Aotearoa New Zealand. More work is required to develop this model and the next step in this process will be for a working group to determine how this will be achieved.

It has been my pleasure to lead the Federation of Primary Health Aotearoa through this discussion to date. It is great to see our members supporting the development of Community Health and Wellbeing Networks in a collective way.

Ngā mihi nui

Hon. Steve Chadwick

Chair, Federation of Primary Health Aotearoa New Zealand

1 INTRODUCTION

The idea of Community Health and Wellbeing Networks is not new. What is new is the collective commitment of the Federation members to initiate and activate a better networked primary health care system that improves access and health outcomes. The members of the Federation believe that, in the context of Covid-19, the health system has demonstrated that meaningful change can be achieved quickly, and that the time is right to make progress on this broad primary care approach to achieving high quality and equitable outcomes.

A workshop was held in February 2020 to seek input from across the membership of the Federation to this document. A full list of organisations represented at this event is provided in Appendix 1. As a collective, this group has influence and a commonality of vision to give direction to the government and associated agencies with the intention of making a difference. The principles and recommendations of this paper were broadly supported by all those present. There is agreement that:

- Māori health equity is a priority
- Primary health care needs to evolve, change, and improve to ensure we deliver primary health care that is equitable
- Transformational change is required with a goal of healthy communities (whilst noting some districts are already on this journey)
- Networking is the preferred approach where it meets local, regional, and national population needs
- National Service Commissioning should align with national service coverage and funding policies; prioritise the principles of engagement and relationships for a nationally consistent approach to local service commissioning; and support collaborating teams delivering integrated services.

In developing this paper, the Federation members discussed what policies, service models and ways of working locally need to be enacted, supported by the government, to enable providers to work as a team. By bringing together a range of stakeholders from across primary health care this paper presents a jointly agreed approach to actions required to make a difference.

During this work, members recognised the strengths of the current sector, across different professions and acknowledged that the challenges faced are common, including:

- Challenges of bringing together differing philosophies to enhance the strengths of individual providers
- Working within the constraints of infrastructure which is siloed and poorly integrated
- Contracts that do not promote outcomes, collaboration, innovation, and sustainability
- Inequitable access for the vulnerable, and Māori and Pasifika peoples

This paper draws on both international examples of primary and community integration and the lessons from New Zealand-based initiatives that are already underway in this sector to:

1. Present a position which a range of providers from broad primary health care can support
2. Incorporate generic principles to build trust and mutual respect and establish foundations for the future
3. Present a deliberately high-level picture to inform policy makers of a general direction
4. Call for support from the Minister of Health to establish an officials' working group to support implementation of the proposed Community Health and Wellbeing Networks model

2 RATIONALE

The interim report of the Health and Disability System Review Panel identified challenges with fragmented primary and community health care being delivered inconsistently and without meaningful consideration for the needs of individuals, whānau and communities.

Federation members agree that collaboration between providers is necessary to meet the needs of all people seeking health services but especially people with complex health and social needs. We acknowledge that collaboration is hard work. Primary and community health providers want to be supported to work together to provide services to individuals and whānau based on their needs, regardless of employment and funding lines, to improve equity of outcomes.

The Federation recognises the obligations under Te Tiriti o Waitangi to protect and promote Māori wellbeing and rangatiratanga. Local arrangements are essential to enable the positive contribution that can be made by local hapū and iwi, and to provide a mechanism to collaborate to make a positive impact on Māori health outcomes.

There are pockets of excellence already in Aotearoa and this is acknowledged by the Federation. However, as identified by the interim report of the Health and Disability System Review Panel, we lack national consistency. For this vision to be achieved at scalable levels, there needs to be change in the framework within which primary and community health care providers are operating. In rare spots in Aotearoa, a comprehensive primary and community care response may be delivered by a single provider employing or contracting all team members delivering services to a population. Much more often, team members are employed or contracted by a variety of employers/funders. Each provider brings their own strengths to local service delivery. Each would resist being subsumed into one lead contractor or service provider. Hence networking is proposed as a means of bringing together many primary and community service providers into one team for the benefit of individuals and their whānau.

We understand Network Agreements to be an accord among members to work together in an organised way locally to improve the health and wellbeing of the people and populations they serve.

Network agreements are proposed as a way of supporting local providers to work together to ensure a co-ordinated approach to providing services to those with complex health and social needs. This approach will be less important for those whose health needs are more straight forward.

We have used the term “Community Health and Wellbeing Networks” to describe the local collaborations in order to emphasise that the focus is not just delivery of integrated health services, but also includes working with NGO and community providers to improve the wellbeing of the people living in the area.

This piece of work is timely. Initiatives are already happening, and Covid-19 has shown us that radical change is possible to achieve when there is a clear shared goal. Providers are already acting on the need to work together better in spite of the current model and so the time is right to identify how a common approach and framework can build on these initiatives with some pace to deliver consistent good results nationwide.

3 CREATING COMMUNITY HEALTH AND WELLBEING NETWORKS

The point of a structured local Community Health and Wellbeing Network is to provide a very practical, highly level mechanism to:

1. Support collaboration between clinical providers for the benefit of consumers /people who use health services.
2. Support collaboration between providers and local iwi, hapū and community organisations that increases accessibility and suitability for the benefit of shared populations in an area.
3. Improve service quality from the person and clinician perspective.
4. Use the strengths of each provider to improve health outcomes and spread the workload for providers.

We expect flexibility in what exactly constitutes a local Community Health and Wellbeing Network, driven by the needs of the community, the providers, and the local system capabilities. Community Health and Wellbeing Networks may start with a specific focus (such as palliative care, first 1,000 days or long-term conditions) and build up to deliver on multiple areas of focus. While Networks will look and feel different as they reflect their local community, but they will align around improving equity of access and outcomes for people and communities.

For many people, most of the time, access to straightforward single services is adequate and appropriate. However, health inequalities persist at unacceptably high rates and access is not universal. For people with complex health and social needs who require regular access to multiple providers; and for Māori, Pacific, underserved, rural, marginalised, elderly, and people with long-term conditions the Community Network approach will deliver most value.

The next section articulates the key features of Community Health and Wellbeing Networks. These would be codified and formally signed up to by those entering the local accord to form a Community Health and Wellbeing Network.

3.1 Characteristics

A nationally consistent set of criteria should underpin each network. This will support credibility, consistency of outcomes and provide an appropriate platform upon which further services can be developed and implemented.

Community Health and Wellbeing Networks will:

Be in partnership with local community and consumers who are represented in the governance which emphasises community engagement, direction, collaboration and shared- decision making.

Include multiple service providers, usually including general practice teams, community pharmacies, allied health providers, midwifery services, NGOs, nursing services and iwi providers, among others.

Be geographically defined to include the entire population in natural communities. Developed locally, responding to the needs of the local community within a nationally consistent framework.

Natural geographic communities of interest will be determined locally and may, for example, be aligned through the local Iwi, hapū, Local Territorial Authority (TLA) boundary, town boundaries or suburban centre. Function should come before form, thus a Network aligned around an isolated rural community with a population of 8,000 may be wholly appropriate for smaller communities but is less likely to be appropriate for larger urban centres.

Be supported by an independent organising function, to support the analysis and prioritisation of services, design of services and change management.

Provide support for health professionals to work across their scope in the most appropriate way to meet the needs of individuals, whānau and the community.

Have a clinical governance function which operates within an agreed decision-making framework and is clinically led with no single professional group in the majority.

Be a collaboration between members of those providing services locally.

Provide services which are co-designed and culturally appropriate (e.g. kaupapa Māori services are developed, designed by Māori for Māori) with information sharing arrangements ensuring that continuity of high-quality integrated care is supported and enabled.

Be easy to navigate.

Be integrated across the relevant providers and have access to appropriate and relevant information to support individuals with complex health and social needs.

The Network is not expected to be the employer or funder of all local services.

Framework Principles

The values of the framework within which each Community Health and Wellbeing Network operates will be established locally. They will reflect:

The Principles of Te Tiriti o Waitangi – as recommended by the findings of Stage one of the Health Services and Outcomes Kaupapa Inquiry (see pop out box below).

Inclusivity - inclusive of the full range of local primary and community health providers - an inclusive list of whom should be determined locally and will depend on local capability.

Cultural Responsiveness - which spans the continuum of the care journey and ensures professional cultural awareness and competency as well as culturally appropriate options for access to, and delivery of services for individuals and whānau.

Individual and Whānau Centredness - led and developed in such a way as to prioritise individual, whānau and community interests over the business interests of its participating professionals and thus incentivising integrated practice.

Encourage investment and reinvestment into direct care, service developments and better integration of teams whilst recognising the need for fair reward and incentivisation for its constituent professionals and businesses, including fair return on business investment.

Quote from the report on stage one of the Health Services and Outcomes Kaupapa Inquiry – Wai 2575 - Finding on the Treaty Principles

'We recommend that the following are adopted as the Treaty principles for the primary health care system:

(a) The guarantee of tino rangatiratanga, which provides for Māori self-determination and mana motuhake in the design, delivery, and monitoring of primary health care.

(b) The principle of equity, which requires the Crown to commit to achieving equitable health outcomes for Māori.

(c) The principle of active protection, which requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori. This includes ensuring that it, its agents, and its Treaty partner are well informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.

(d) The principle of options, which requires the Crown to provide for and properly resource kaupapa Māori primary health services. Furthermore, the Crown is obliged to ensure that all primary health care services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.

(e) The principle of partnership, which requires the Crown and Māori to work in partnership in the governance, design, delivery, and monitoring of primary health services. Māori must be co-designers, with the Crown, of the primary health system for Māori.'

From: https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_152801817/Hauora%20W.pdf (pp. 163-4)

3.2 Benefits of the Approach

Community Health and Wellbeing Networks as intended by the Federation will be established around natural communities of interest for the benefit of individuals and their whānau; the local community; and, the health system. The intended benefits are summarised below:

Individuals and their Whānau	· Improved access, continuity, quality, and experience of care · Every point of access leads to the right care, in the right setting with the right provider · Coordinated care for those with complex health and social needs · Increased options for care closer to home · Sustainable and robust primary and community health services
The Local Community	· Active participation and protection for Māori and equitable outcomes · Relationship/Partnership approach which underpins the development of Māori led services and service providers · Mainstream services that are responsive to the needs and tikanga of Māori · No avoidable duplication of service · Strengthened population health and self-management · Reduced risk of individuals and whānau being left behind · Scarce or high-cost workforce skills available consistently, including to smaller, vulnerable, or remote rural communities
The Health System	· Improved connections and strengthened cross-agency and multi-disciplinary clinical governance (including key agencies covering the wider social determinants of health, such as Councils/TLA, social services and NGOs) · Integrated multi-disciplinary teams · Optimised workforce with appropriate capabilities · Local service innovation capability · Whole-of-system efficiency with more services provided outside of hospitals and closer to home · Better IT connectivity

3.3 Structure and Governance

Community Health and Wellbeing Networks will be developed and established in a way which works for the local community they serve and the stakeholders they encompass. Structural form will only be important insofar as it enables all stakeholders to work together, to build trust and mutual respect and to focus on delivering improved outcomes for their communities. Where entities are developed, they will be not-for-profit.

Federation members feel strongly that the governance structure must reflect the Wai2575 - Stage One of the Health Services and Outcomes Kaupapa Inquiry findings on the Treaty Principles and that clinical governance needs to be apparent in local governance. The following principles will support the structure and governance of Community Health and Wellbeing Networks consistently:

Structure	Governance
Relationship based with appropriate information sharing tools to support Communication between and across Network members shall be regular, open and transparent Continuity of care through existing service providers Designed around the needs and capabilities of the community Organising function to provide: · Change management · Workforce support · Service Design Support · Informatics support and analysis ·	Reflective of Te Tiriti o Waitangi and Wai2575 'Light touch' empowering people to get on with the job rather than impeding them Includes strong clinical governance through culturally appropriate clinical governance forum Transparent and appropriate decision making in line with Te Tiriti o Waitangi Articles Includes the consumer Leadership will be fair, equitable, representative, and transparent without one professional group or part of the community being in the majority Leadership by a Chair with strong links and engagement with the community, who may be iwi, community or independent

The focus is on enabling collaboration among those working with a common population: this focus on **clinical governance and continuous improvement** includes mechanisms to agree common pathways for conditions, information sharing, and role definition.

4 AN ENABLING NATIONAL POLICY, FUNDING AND SUPPORT FRAMEWORK

Much of what is anticipated here and in the 2016 update of the New Zealand Health Strategy is little changed from the vision of the 2001 Primary Health Strategy. Many might then ask what will be different with Community Health and Wellbeing Networks? The answer will be in the enabling policy and support framework which will be developed alongside Networks as part of a structured change management programme – an enabling framework which has historically been missing from the implementation of many laudable visions and strategies (see diagram).

The policy and support framework must address the issues that have plagued primary and community providers over the past decades, including:

- Variable and inequitable service needs decision making and funding by 20 DHBs.
- The significant growth in DHB-hospital deficits which is adversely impacting sustainability of all primary and community service providers.

For networks to succeed, their constituent primary and community care providers need committed and sustainable funding, which supports their development and delivery of services through Networks. We recommend a move to longer-term three-year funding agreements which better support continuity of care and rely less on fee for service frameworks.

It is necessary that planning and funding processes for primary and community care services are not in competition with hospital service budgets, and that collaboration within networks is rewarded.

Experience shows that price increases and allowances for demographic growth in the primary and community sector are too often treated as discretionary investments that are made only if hospital budgets allow. Future

funding arrangements for primary and community health services need to be independent of local conflicts of interest such as DHBs' responsibility to manage their own provider arm with increasing numbers of associated financial deficits.

Community Health and Wellbeing Networks are a local collaboration and delivery mechanism. Whilst they will require a local organising function, they will not be responsible for meso-level or inter Network services – it will not be cost-effective for them to undertake such strategic level services and to do so will likely conflict with their required skill set and focus on the provision of local services.

The regional support required may cover services such as population health planning; epidemiology; data analysis and health intelligence; information technology and systems; service redesign/models of care; contracting support; and, continuing professional development.

Further discussion is required and will be co-ordinated nationally to ensure the provision of such services is structured in the most cost-effective way and prevents duplication, perverse incentives, or conflict of interest.

5 ROLE RESPONSIBILITY AND ACCOUNTABILITY

Accountability means being answerable to someone for decisions and actions. As with the delivery of any publicly funded services Community Health and Wellbeing Networks require a clear accountability framework. The framework will need to reflect accountability to the community as well as to respective funding agencies.

The framework will include the following aspects of accountability:

- **Professional -** Individual service providers will be accountable to their service users as well as to their organizations to provide high-quality care and complying with the professional and organisational standards and guidelines set up by the respective bodies.
- **Financial and Legal** – at a contracting level service provider need to deliver the outcomes they plan for within the budget agreed upon.
- **Performance -** Service providers carry the main accountability for delivering safe, effective, and efficient services across the continuum of care. To achieve this, service organisations will utilise guidelines and best practices that are culturally responsive, organise providers and develop structures and processes that support performance monitoring and improvement.
- **Community and Tangata Whenua**– Networks will be accountable to the community and Tangata Whenua for outcomes achieved. The Network may include outcomes in areas such as workforce development and service design and innovation as well as individual health-based outcomes.

The accountability framework will be proportionate and permissive. The expected benefits and outcomes will be clearly articulated and agreed. How those benefits and outcomes are then to be achieved will be for the Network and their local community to determine.

Existing accountability frameworks will be challenged and replaced where appropriate to ensure a framework that binds all the member organisations and practitioners within the Network to serve the people within the community/locality. regulatory accountability of respective health practitioners or providers will not be interfered with or replicated.

A performance dashboard for Community Health and Wellbeing Networks may be developed at a national level to ensure consistency with specific objectives assigned locally. The development of such a dashboard must be cognisant of the potential benefit to individuals and whānau, community accountability, internal leadership, as well as to inform funding agencies of the growth of the Network and its readiness to provide extended primary and community services.

In order to strengthen accountability Community Health and Wellbeing Networks must operate in an environment where:

- **Contracts are permissive,** allow and encourage cross-organisational and inter-professional collaboration.
- **Compensation models** support collaboration between care providers within and across settings.
- **Policy and legislation** support a move away from single provider performance liability to shared/joint accountability as a Network.
- **Infrastructure and Tools support** successful achievement of performance objectives.
- **Shared-decision making is embedded,** and providers are actively supported to develop trusting relationships with other providers. Consumers have access to feedback mechanisms that drive services improvement.

6 LESSONS FROM THE COVID-19 PANDEMIC RESPONSE

The Covid-19 pandemic experience has highlighted the ability of the primary health sector to rapidly adapt and work with others in the interest of both the person/whānau and the community. It has also highlighted how the sector can work differently when motivated by an identified beneficial purpose. Disrupter Covid-19 enabled rapid change and responsiveness with some previous barriers between secondary and primary dissolved.

It has connected more people to each other in a way that demonstrated new ways of working e.g. how to adapt to become more inclusive and efficient teams and to better utilise technology for health services. Technology enabled access and support through an enhanced virtual model using telehealth, video conferencing, phone calls and Apps to provide care.

It has moved all health practitioners to think out of the square and impressed upon many the importance of well-functioning relationships and networks. “We are in this together…this is us!” It has provided an ideal opportunity to review service delivery and funding models. However, isolation was traumatic for many and reinforces that virtual consultations are not a panacea for all and the ongoing need for in person interactions for many in the community remains essential.

The pandemic response also exposed fragmentation, inequality, and variability in services across localities and regions. It exposed gaps in service providers’ systems knowledge and often highlighted the lack of integrated service delivery and funding contracts between different services. Many contracts did not allow for the significant increases in workload or provide for sustainability of services.

There were some areas of disconnect between Civil Defence and Emergency Management, Public Health Units, DHBs and provider organisations at a national level. A well supported and better networked primary and community health service would support better identification and understanding of service gaps and their consequences. Better understanding across local services may have supported improved continuity of care provision for those who needed it most.

Health professional and peoples/patient’s ability to utilise technology effectively was highly variable and any permanent change will require a national socialising programme to improve access and usability for people.

The distribution and provision of influenza vaccines highlighted issues due to a lack of a single organising framework with the authority and mandate locally to coordinate service delivery to target the most vulnerable.

We believe that primary and community providers want to work together, and that with the environmental elements outlined above aligned and nationally consistent. they could do so more effectively.

Appendix 1 – Workshop Details

A workshop was held at the Brentwood Hotel in Wellington on 24 February 2020 where the content of this document was broadly supported by individuals and attendees from the organisations listed below:

Individuals:

Chair - Martin Hefford, Tū Ora Compass Health
Facilitator – Philip Grant
Consumer Representatives

Organisations:

New Zealand College of Midwives
Primary Health Alliance
Procare
Pegasus
Pharmacy Guild of New Zealand
Te Awakairangi Health Network
THINK Hauora
Ora Toa PHO
Waitaha Primary Health
College of Nurses
Kimi Hauora Wairau (Marlborough PHO)
Western Bay of Plenty PHO
Eastern Bay of Plenty PHO
School of Nursing, University of Auckland
Health Care NZ
Christchurch PHO
College of Midwives
WellSouth Primary Health Network
Comprehensive Care
General Practice NZ
Royal New Zealand Plunket Trust
Family Planning New Zealand
Cosine
Health Hawke's Bay
Pharmaceutical Society of New Zealand
Arthritis NZ
New Zealand Association of Optometrists