Canterbury
District Health Board
Te Poari Hauora ō Waitaha

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21 July 2021

9(2)(a)
[redacted]

RE Official Information Act request CDHB 10646

I refer to your email dated 29 June 2021 requesting the following information under the Official Information Act from Canterbury DHB regarding DHB's Planned Care three-year plan. Specifically:

1. **A copy of your DHB's Planned Care Three Year plan *(the one that needed to be signed off by Ministry of Health in 2020).***

Please refer to **Appendix 1** (attached).

2. **The latest update on delivery of any existing or new community/general practice-based initiatives under your DHB's Three Year Plan.**

Please refer to **Appendix 2** (attached).

I trust that this satisfies your interest in this matter.

Please note that this response, or an edited version of this response, may be published on the Canterbury DHB website after your receipt of this response.

Yours sincerely

Tracey Maisey
Executive Director
Planning, Funding & Decision Support

APPENDIX 1

Planned Care Services 2020-2023 CDHB Three-Year Plan

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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Contents

Planned Care Principles, Vision, and Values

Our vision and values

The Canterbury DHB approach to Planned Care will be shaped and guided by our vision and values: which are integral to everything we do. Planned Care will enhance the DHB's mission to enable people to maintain their independence by receiving their care, where possible, in their community.

Our Vision – Tā Mātou Matakite

Our vision is of an integrated health system that keeps people healthy and well in their own homes and communities. This requires a connected health system centred around people, that aims not to waste their time.

Te Tiriti o Waitangi (The Treaty of Waitangi)

The Treaty of Waitangi and its implications for health is founded on the principles of partnership, participation and protection.

Partnership involves working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services.

Participation requires Māori to be involved at all levels of the health and disability sector, including in decision-making, planning, development and delivery of health and disability services.

Protection involves the Government working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices.

Our Māori Health Action Plan[1] explicitly states that the CDHB endeavours to work in partnership with our Treaty partners, Manawhenua Ki Waitaha, Māori providers, the wider Māori community, whānau Māori, providers across the Canterbury health system and indeed the whole Canterbury community, to seek pae ora for Māori. We aspire to remove the health inequities that have long persisted in the Māori population as a step towards pae ora for Māori in our community.

The plan articulates the belief best summed up as "Kia whakakotahi te hoe o te waka", that all who work in the Canterbury health system share collective responsibility to reduce health inequities, improve access and outcomes for Māori and strive towards pae ora and whānau ora for all Māori in Waitaha.

How our Three-Year plan was developed

The first stages in developing our Planned Care strategy included compiling a Planned Care Transition document that was widely circulated for comment within the CDHB senior management team. This document was developed to identify a process for working toward the full roll out of Planned Care

[1] https://www.cdhb.health.nz/wp-content/uploads/5a1e36a7-canterbury-Māori-health-action-plan-2015-16.pdf

services. Following feedback, the plan was updated and ready for adoption but formal sign off was delayed by the need to resource a plan for responding to the onset of COVID 19.

In developing our Planned Care strategy the CDHB has already contacted various groups including our Māori Health Team within the CDHB to ask for guidance on who/how we should consult.

While developing our plan we have been in regular contact with the Ministry to seek advice and guidance on what services might be suitable for Planned Care

The transition to Planned Care across more and more services needs to ensure that stakeholders, including patients, primary health care providers and others, are consulted and have a voice in the decision-making process. The following matrix gives an indication of who the changes could affect and how the CDHB intends to engage with them. The list is not exhaustive, and guidance will be sought from bodies like the CDHB Māori Health Team and the Cancer Society on who to include and how best to consult and involve them.

Executive overview and summary

This document along with the CDHB improvement action plan outlines Canterbury DHB's approach to enhancing, supporting, and delivering Planned Care over the next three years and into the future. As we continue to work through the long-term implications of our delayed facilities rebuild programme and the short-term impacts of COVID-19, the mosque shootings, and the flooding of the outpatient building in recent years, we are confident that Canterbury is in a good position to work towards improving services and meeting targets.

We have identified four key areas for planned care services which are:

- Achieving and maintaining compliance against the Elective Services Patient Flow Indicators (ESPIs) and other national targets
- Identifying and where possible moving services into the community
- Addressing equity gaps within planned care services
- Improving patient experience to ensure user expectations are met

Through the development of dashboards and near real-time reporting we will be better able to understand our current performance and identify and prioritise areas for improvement. We will look at our access and Did Not Attend (DNA) rates to maximize the efficiency of our booking processes work to ensure nobody is left behind.

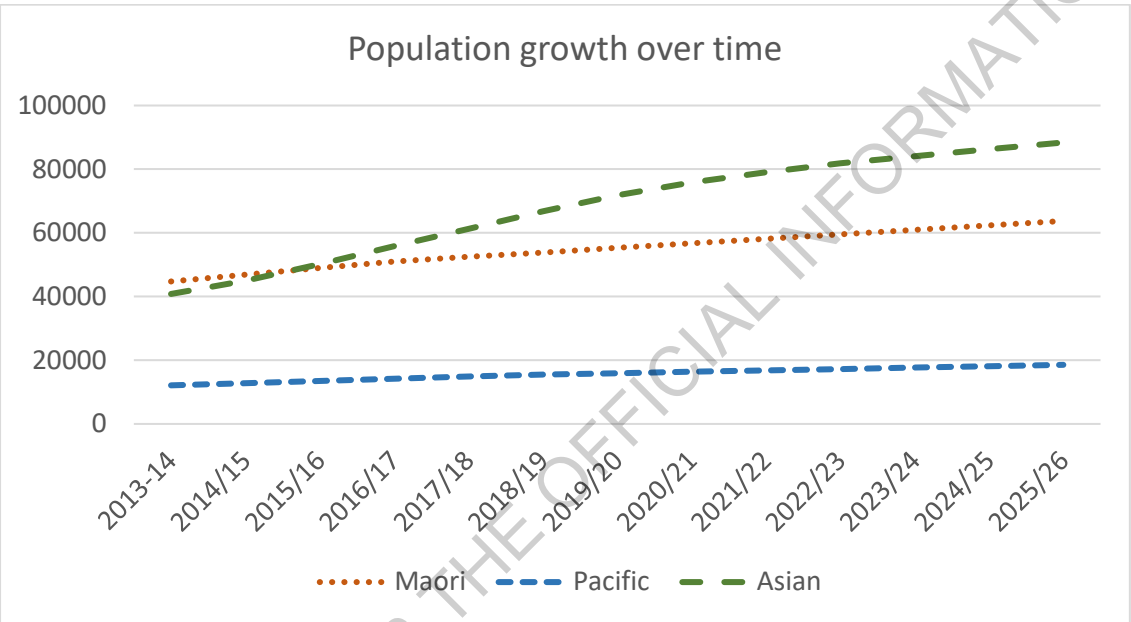
Canterbury DHB has reached its internal physical capacity to provide surgery within its own facilities. The new Hagley Acute Services Building will help to alleviate some pressure which will enable most outsourced and outplaced services to move back in house. This relief will be temporary, however, with modelling showing services will rapidly return to capacity. There are several factors driving this pressure including population growth, an aging population, new technologies, new treatments, and constraints caused by repairs and replacement of existing facilities. To ensure planned care services remain fit for purpose into the future we must evolve, and this plan provides a framework for this change. Moving more services into the community will free up limited capacity and enable better access for our population.

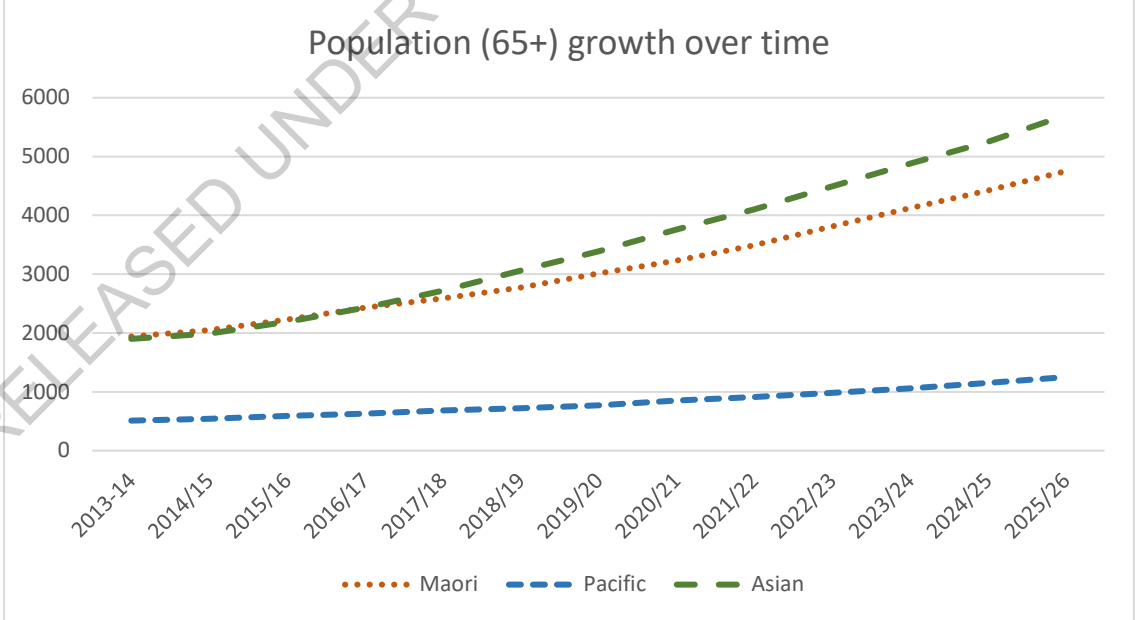
As part of this plan we have outlined our proposed approach to addressing equity gaps within our services and how we will engage with Māori and Pacific groups to ensure services are patient centered and delivered in a way that supports people to live well in their homes for longer. Although this plan was developed to provide a strategic framework for the next three-years, the detailed plan for the 2020-21 financial year is attached to provide further direction over the short term (Appendix 2).

Our population

In 2020/21, Canterbury's projected population will be 578,290, which is 11.5% of the total population of New Zealand. Canterbury has the third largest population of all District Health Boards and the largest number of people aged over 65 in the country. The latest population figures show 16.2% of our population are aged over 65, a total of 93,420 people. By 2026 almost one in every five people in Canterbury will be aged over 65.

Ethnicity, like age and deprivation, is a strong predictor of need for health and disability services. Canterbury has the sixth largest and second fastest growing Māori population in the country. There are 56,710 Māori living in Canterbury, 9.8% of our total population, up 27% since the 2013 Census. By 2026 Māori will represent 10.5% of our population.





Source: Statistics NZ 2019 projected population

Canterbury's growing, ageing and diversifying population creates unique challenges for the DHB and service delivery. Canterbury's changing population demographics influence planned care delivery in various ways including;

- Equity – Canterbury has a greater Māori population than the total population in four other DHBs. The sum of the Māori, Pacific and Asian ethnicities in Canterbury at almost 125,000 is larger than the total individual populations in seven other DHBs. Ensuring services are provided in an equitable way is a significant challenge for us and requires special consideration for our uniquely diverse population.
- Intervention rates: as our population grows we are committed to do more to maintain equity with national intervention rates, however completing more interventions with finite resources remains a key challenge for all DHBs.
- Ageing – more people are living longer requiring more treatment over the course of their lives. Treatment also becomes more complex with longer recovery.
- Co-morbidity – as people age interventional treatment becomes more complicated and takes more time in theatre.
- New treatments – ongoing investment by the sector in new drugs and new therapies continues to drive demand and, in some cases, provide new levels of demand which the health system has not seen before.

Key focus areas for this plan

The main priorities for this plan include

- Identify how planned care services are determined and prioritised,
- Identify services which can be moved out of a hospital setting,
- Engaging with key stakeholders and communities to ensure changes are applied in accordance with the principles of Planned Care,
- How we will work with our Primary Care colleagues to identify enablers for change,
- Communicating the changes to identified stakeholders,
- Improving equity of provision by removing barriers and improving access to community-based services.

The following table lists strategic priorities for Planned Care within the CDHB:

	2019/20	2020/21	2021/22	2022/23	Results
Cancer Care	New PHARMAC Drugs	Bowel Screening Starts, HPV Screening Starts, LINAC replacements, New PHARMAC Drugs	LINAC Replacements	New LINAC @ CDHB, Potential for CDHB run LINAC at NMDHB	Maintain ability to service patients with increases in drug availability and adjunct radiation therapy
Non-Surgical Interventions	MAP programmes of care = 108	MAP programmes of care = 322	Plan for increase of 50 interventions	Plan for increase of 50 interventions	Increasing service delivery in community year on year
Minor Procedures	Minor Procedure volume of 11,385 - new services - pipelle & Punch biopsies, Hysteroscopy to OP and MSK injections	Minor Procedure volume of 11,409, new procedure - TRUS Biopsy	Plan for increase of 500 procedures - plan for blood transfusions, sleep apnea, spirometry	Plan for increase of 500 procedures	Increasing service delivery in community year on year
Inpatient Surgical Care	Inpatient Surgical volume of 19,182 and 26,897 cwds	Inpatient Surgical volume of 19,614 and 26,991 cwds	Plan for 550 case uplift in volume	Plan for 550 case uplift in volume	New facility enables more internal service provision, plans made to service BSP surgical load

Benefits from moving appropriate services into the community

- Patients will be able to access services in locations that are more convenient for them.
- Greater choice of where to access treatment should reduce the number of patients who did not attend (DNA) appointments, often because of the cost of getting to Christchurch and/or problems with parking.
- Accessing services in their community should benefit some parents and caregivers who currently struggle with obtaining cover for dependents when attending appointments.
- It frees up hospital clinic space in the public hospital, which will be at a premium even after the opening of the new Hagley Hospital.
- It reduces the pressure on the Medical Day Unit by moving some infusions and transfusions into the community.
- It builds increased resilience and flexibility, conforming to our patient-centred approach to providing services.

Planned Care principles

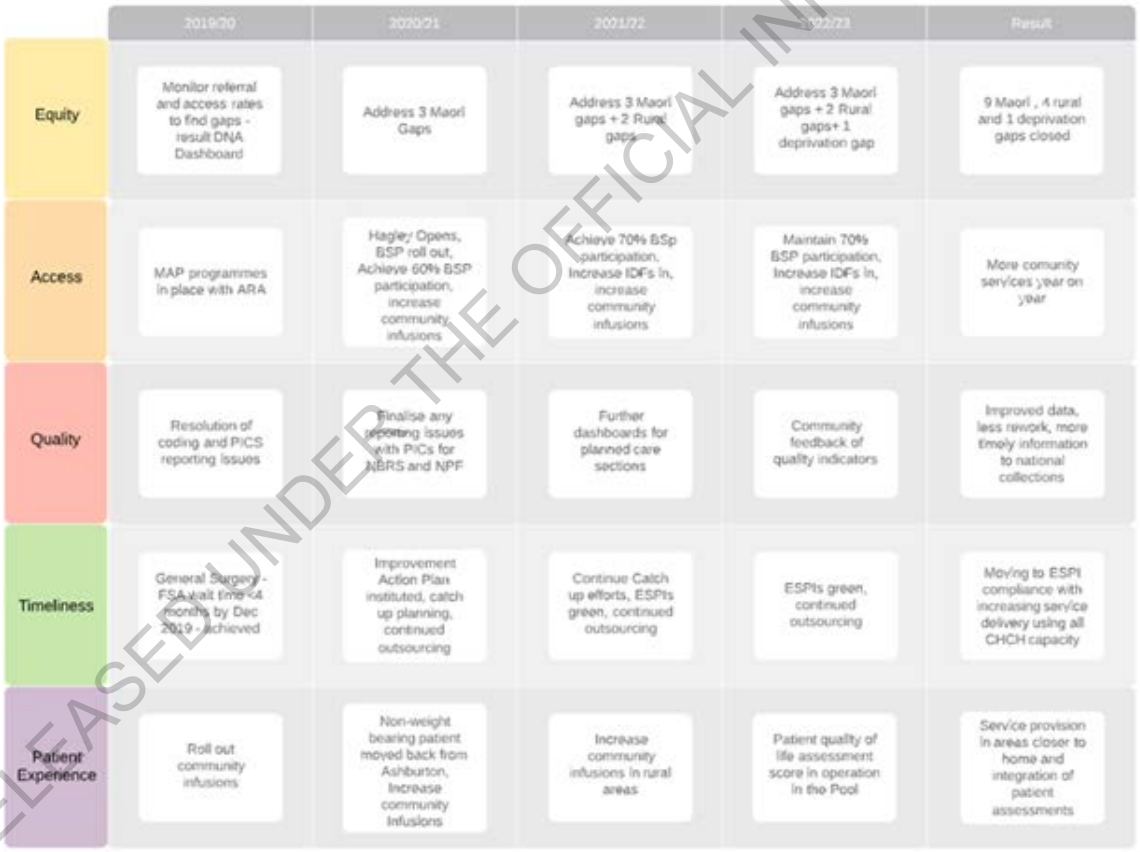
Canterbury's planned care services will be guided by the below principles as well as our commitment to an equitable delivery which drives the DHBs vision.

Access – does the transition increase the potential for patients to access the care they need in the right place, with the right health provider?

Quality - can we guarantee that the services, when delivered in a new setting, are still appropriate, safe, effective, efficient, respectful, and support improved health?

Timeliness – will the move help to ensure that patients will receive care at the most appropriate time to support improved health and minimise ill-health, discomfort and distress.

Experience – no move will be sanctioned until we are confident that patients and their family or whanau will be able to work in partnership with healthcare providers to make informed choices and get care that responds to their needs, rights and preferences.



	2019/20	2020/21	2021/22	22/23	Result
Equity	Monitor referral and access rates to find gaps - result DNA Dashboard	Address 3 Maori Gaps	Address 3 Maori gaps + 2 Rural gaps	Address 3 Maori gaps + 2 Rural gaps+ 1 deprivation gap	9 Maori , 4 rural and 1 deprivation gaps closed
Access	MAP programmes in place with ARA	Hagley Opens, BSP roll out, Achieve 60% BSP participation, increase community infusions	Achieve 70% BSp participation, Increase IDFs in, increase community infusions	Maintain 70% BSP participation, Increase IDFs in, increase community infusions	More comunity services year on year
Quality	Resolution of coding and PICS reporting issues	Finalise any reporting issues with PICs for NBRS and NPF	Further dashboards for planned care sections	Community feedback of quality indicators	Improved data, less rework, more timely information to national collections
Timeliness	General Surgery - FSA wait time <4 months by Dec 2019 - achieved	Improvement Action Plan instituted, catch up planning, continued outsourcing	Continue Catch up efforts, ESPIs green, continued outsourcing	ESPIs green, continued outsourcing	Moving to ESPI compliance with increasing service delivery using all CHCH capacity
Patient Experience	Roll out community infusions	Non-weight bearing patient moved back from Ashburton, Increase community Infusions	Increase community infusions in rural areas	Patient quality of life assessment score in operation in the Pool	Service provision in areas closer to home and integration of patient assessments

Our strategic approach for delivering Planned Care

We intend to fill in more of the boxes in the table as we engage and consult with our key stakeholders, including Canterbury Initiative who are responsible for keeping HealthPathways up to date.

	2019/20	2020/21	2021/22	2022/23	Results
Fit for Future	Monitor referral and access rates to find gaps - result DNA Dashboard	Work with NMDHB to look at regional LINAC	Additional endoscopy space in operation	Prepare for bed shortages	Align CDHB services with regional service provision and continue to use all resources available
Understanding Health Need	Development of DNA Dashboard	Analysis of DNAs and programme to minimise for ethnicities, Patient Pool	Continued Analysis to support Gap reduction, Identify unmet referred demand from Pool info	Continued Analysis to support Gap reduction	Continuous improvement effort to adjust service provision to health need
Balancing National Consistency and Local Context	Resolution of coding and PiCS reporting issues	Monitor SIR rates for future investment decisions and plan	Further dashboards for planned care sections	TBD	Aligning local services within national guidance
Simplifying Pathways for Service Users	Continued review of HealthPathways and Health Info - on-line info	Return outplaced surgery to CHCH campus, Increased use of telehealth			
Optimising Sector Capacity and Capability	Restart Planned Care Post-COVID response	Hagley opening and transition, maintenance of private hospital capacity as needed	Increased capability to handle IDFs in	Increased capability to handle IDFs in	

We propose, that in Years 2 and 3 the DHB will plan to move more services, including:

- Insertion and Removal of Long-acting Reversible Contraceptives (LARCs),
- IV Iron Infusion,
- Other infusions identified as being appropriate for delivery in a community setting,
- Some blood transfusions,
- Mirena Insertion,
- Musculoskeletal Steroid Injection and Joint Aspiration,
- Pipelle Biopsy,
- Skin Cancer Excisions including biopsies and wide local excisions,
- Sleep Assessment,
- Spirometry,
- Coeliac disease follow-up appointments with a community dietician rather than a gastroenterologist,
- Chalazon removal undertaken by trained GPs.

Cancer care

Recent PHARMAC announcements on the provision of new drugs, including those used in the treatment of cancers, requires the CDHB to plan for the delivery of these drugs, especially where they are administered by infusion, over and above what we currently provide.

Radiation therapy capacity

With a growing and ageing population, and loss of capacity due to the programme of upgrading two of the four public linear accelerators (linacs) in Christchurch, there is an urgent requirement to investigate where extra capacity should and could be provided. The principles of Planned Care (equity, access, quality of provision, timeliness and patient experience) will be instrumental in shaping decisions. For example, from an equity of provision, patient experience and accessibility point of view, should new provision be based in Nelson/Marlborough or perhaps the West Coast? Many patients faced with the prospect of having to stay in Christchurch for the duration of their treatment (which could be as long as nearly 8 weeks) may be unable to do so simply because of work/home commitments. But can provision away from the main centre (Christchurch) still guarantee the same quality of service?

A new radiation therapy centre could serve as a hub for other services including follow-up appointments, Speech and Language Therapy (SLT) services, dietician support, nursing care and psycho-social support. Chemotherapy could also be delivered which would increase the number of suitable patients by including those requiring concomitant chemo-radiation treatment.

Musculoskeletal (MSK) early intervention programme

The CDHB already provides MSK interventions: the advantages of doing so are that they can reduce pain, improve patients' quality of life, and delay or prevent the need for invasive surgery. Interventions include the provision of physiotherapy as well as anti-inflammatory injections.

Exercise is beneficial in helping people with osteoarthritis and other arthritic conditions to remain active, so we intend to increase the number of locations, and therefore attendees, where Mobility Action Plan (MAP) exercise programmes are delivered. Developed in conjunction with the Orthopaedic Department, they are free for patients in Canterbury (funded by Canterbury DHB) Support and are run with encouragement from a health professional to improve engagement.

The benefits of MAP programmes is that they can reduce the number of people who go on to have major joint-replacement surgery by strengthening joints and addressing pain triggers. As a form of 'Pre hab' they can also help prepare people for surgery and reduce recovery times.

Identifying opportunities to deliver chronic pain and back pain groups in a similar way to MAP is also being considered.

Gender-affirming care

Psychological packages of care for gender-affirming care are in the last phases of development for roll out this year. Based on demand, these could be delivered in locations other than Christchurch.

Bowel screening

The introduction of the bowel screening programme (BSP) will necessitate increases in colonoscopy provision as this is the next step for following up people who return a positive sample requiring investigation. In turn at the start of the programme there will be an increase in surgical procedures to

remove tumours identified through the screening programme until (probably two to three years) the demand for surgeries levels off. Although this was planned to start in 2019/2020 it is now scheduled for 2020/2021.

Canterbury has developed a schedule that increases its own provision to cope with expected additional bowel cancer surgery emanating from the BSP programme roll out: we included this for 20/21 and also have capacity for other DHBs in the South Island when they gear up.

Equity

Understanding, identifying, and reducing inequities is one of the main pillars of the DHBs planned care improvement, and recovery goal. The flexibility and patient-centered approach that moving the identified services into the community brings will contribute to meeting this objective.

To improve equity of access and outcomes for Māori and Pacific peoples in Canterbury, greater emphasis is being placed on ensuring these key stakeholders are appropriately engaged and consulted on when planning services. We need to continue to work to improve outcomes for Māori.

Barriers to accessing health services as well as co-morbidities can create an environment where diagnosis and treatment occurs much later than in other population groups. The Health Quality & Safety Commission report, *A window on the quality of Aotearoa New Zealand's health care 2019 – a view on Māori health equity*, highlighted the national health system is failing to provide accessible, available and acceptable appointments with 16% of Māori not attending a specialist appointment compared to only 6% of non-Māori. Once in the system, Māori are spending more time waiting to access specialist appointments than non-Māori and have twice the rate of hospital bed-days following an acute admission. The report suggested a key reason could be access to primary care and differences in discharge planning or community support services for Māori.

In the future, the health system needs to give more thought as to why people may not access care. These may include practical constraints such as the affordability of care, access to transport and health literacy. Other reasons could include cultural considerations such as language barriers or belief systems different to the traditional medical model. The Canterbury DHB fully supports the view that 'all New Zealanders should have equitable access to Planned Care, regardless of who they are, where they are, who they are seen by, or where they are seen'[2].

In terms of Planned Care, the DHB's Māori Health Team were consulted and their feedback sought on ways to improve equity of provision. Their comments, for example, highlighted the benefits of involving a patient's kaitiaki when discussing the best place for administering treatment. They also pointed out that there is a need for a place where patients' whanau can wait while their whanaunga is having treatment; therefore we should ensure that, wherever possible, the facilities meet the needs not just of the patient but also their whanau.

To ensure Māori perspectives are understood and considered, the DHB has developed a set of actions to encourage a closer working relationship with key Māori stakeholders. As planned care services evolve it is important that changes are transparent and informed.

- 2019-20: Consultation with DHB Māori clinical group;

[2] *Electives and National Services Team, Planned Care Strategic Approach 2019 – 2024-MoH, 2019*

- 2020-21: Meet with the Canterbury Clinical Network Māori caucus to discuss planned care, improvement plan, barriers to access, and future needs;
- 2020-21: Develop a planned care communication strategy to ensure changes to services and improved access are shared within Māori and Pacific communities;
- 2020-21 meet with Manawhenua ki waitaha (Ngai Tahu representative board in Canterbury health system) discuss planned care, improvement plan, barriers to access, and future needs;
- 2020-21: provide input into the DHB's Māori Health Action Plan,
- 2020-21: formalise a model to ensure that there is appropriate Māori input into planned care in Canterbury,
- 2022-23: embed learnings and consultation outcomes into production planning process.

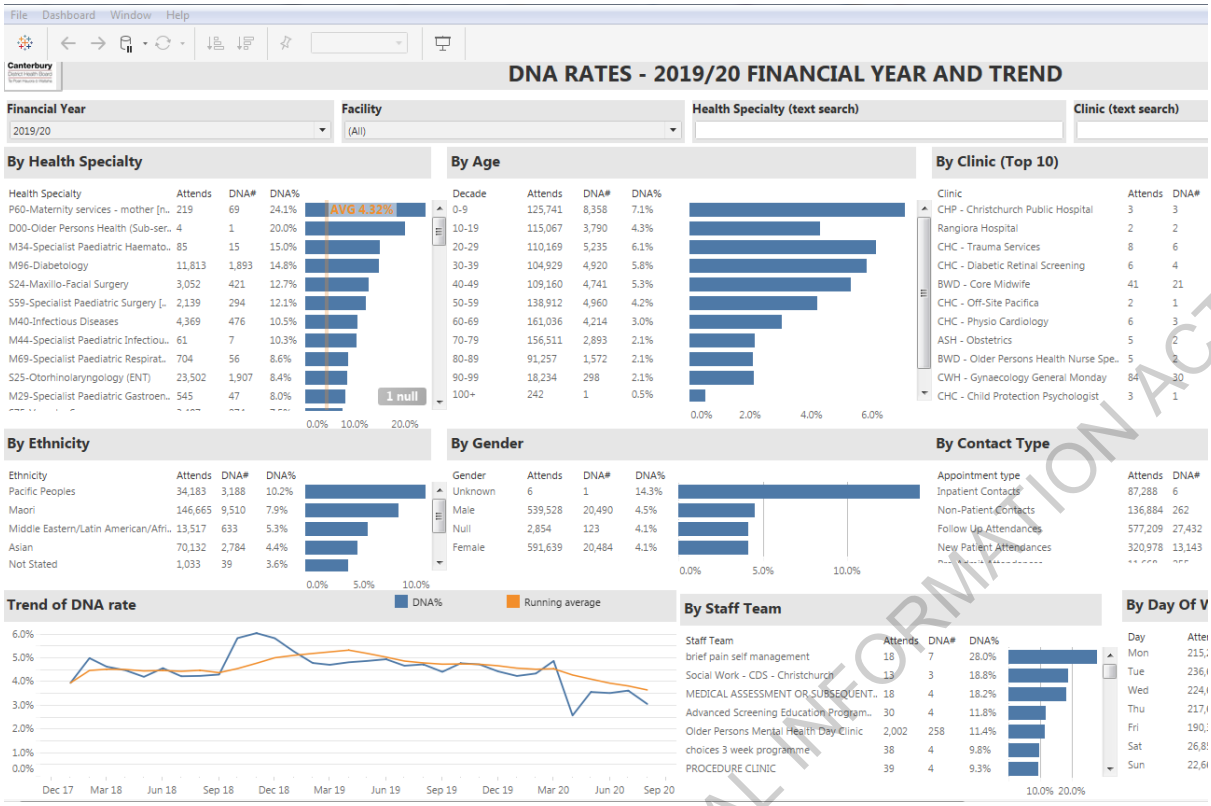
To measure our progress in improving equity we need access to comprehensive, accurate data. This will require

- Having robust policies to check and record patients' ethnicity,
- Not make assumptions about someone's ethnicity,
- Working with Quality Coordinators to improve data cleansing and collection.

How will we monitor progress?

- Percentage of people with no ethnicity recorded reduces,
- Decrease in incomplete ethnicity fields,
- Need for accurate data embedded in equity policies,
- Need for accurate data collection is included in the induction syllabus.

Canterbury is committed to understanding where and why gaps exist and facilitate improvement data-collection processes. Identifying and fixing shortfalls in our data, however, is only worthwhile if it leads to evidence-based strategies to improve equity. One example of how the DHB has developed tools to help manage equity-related data is the DNA dashboard which allows individual services to analyse their DNA rates based on a multitude of selectable parameters. The screenshot below shows some of the fields available in the Dashboard.



Access

Greater choice of where to access treatment should reduce the number of patients who did not attend (DNA) appointments. Evidence suggests that DNAs are often because of the cost of getting to Christchurch and/or problems with parking.

Improved access to community-based services frees up hospital clinic space in the public hospital, which will be at a premium even after the opening of the new Hagley Hospital. Already at capacity, clinic space will become even scarcer as more pharmaceuticals will be delivered by infusion. The growth in the number of drugs that are delivered by infusion is driven by the availability of new drugs and also an increase in the conditions that some established drugs are licensed to treat. Moving some infusions and transfusions into the community will reduce the pressure on the Medical Day Unit, including blood transfusions.

Quality

Underpinning our approach to service delivery is a commitment to continuous improvement.

Key focus areas are:

- Ensuring that our decisions are based on evidence, not assumptions,
- Identifying which services are suitable for inclusion as falling under the Planned Care umbrella,
- Deciding if the identified services can be moved out of a hospital setting,
- Testing the move against the principles of Planned Care,
- Working with our Primary Care colleagues to identify potential providers,

- Communicating the changes to identified stakeholders.

Planned Care data

The DHB is committed to ensuring that our data is accurate and that the National Booking Reporting System (NBRS) and other national data collections reflect the true state of our Planned Care services in a timely manner. This is being addressed at a corporate level by our Decision Support team and at a service provision level by individual service areas. Service Managers are provided with regular updates on likely data errors and admin teams are given guidance on how to minimise reoccurrences.

Dashboards already exist that show DNA rates and there are a range of reports that show Elective Services Performance Indicators (ESPI) performance. Other dashboards can and will be developed to show how the CDHB is performing in key areas.

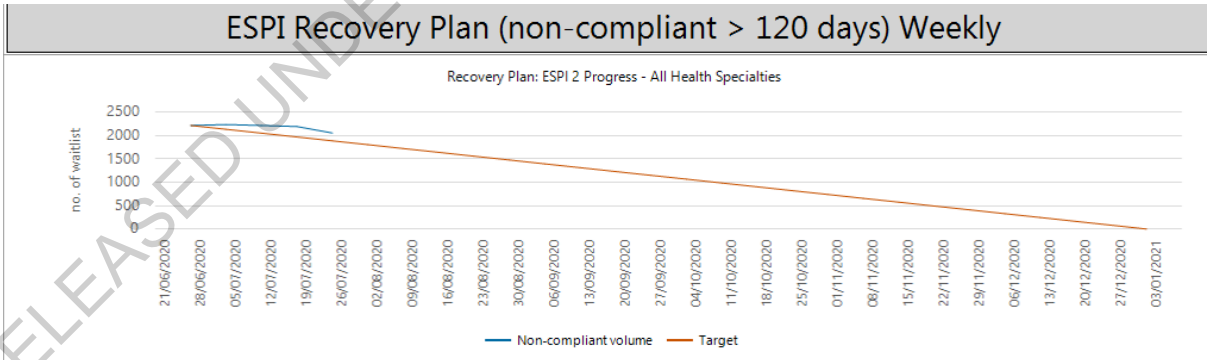
National Patient Flow (NPF)

The CDHB acknowledges that we have issues with data mismatch in various data collection systems, i.e. NBRS, NMDS and NNPAC. We have now identified the degree of unmatched records compared to successfully matched data (and also volumes) and have a much better understanding of why errors occurred. This means that we have been able to agree a plan to fix errors and agree a date for completion. For the majority of records the 'fix-by' date is the end of October 2020.

Timeliness

Many services provided through Planned Care are measured against ESPI performance. Canterbury DHB has developed an Improvement Plan (Appendix 1) which specifies when and how services not currently ESPI-compliant will return to compliance.

A new dashboard has been developed that shows how services are progressing, both individually and collectively, against a timetable to be compliant. An example is below:



	26/06/2020	03/07/2020	10/07/2020	17/07/2020	24/07/2020	31/07/2020	07/08/2020	14/08/2020	21/08/2020	28/08/2020	04/09/2020	11/09/2020	18/09/2020	25/09/2020	02/10/2020	09/10/2020	16/10/2020	23/10/2020	30/10/2020	06/11/2020	13/11/2020	20/11/2020	27/11/2020	04/12/2020	11/12/2020	18/12/2020	25/12/2020	01/01/2021
Actual	2,217	2,238	2,216	2,194	2,056																							
Drop	82	82	82	82	82	82	82	82	82	82	82	82	82	82	82	82	82	82	82	82	82	82	82	82	82	82	82	82
Target	2,217	2,135	2,053	1,971	1,889	1,806	1,724	1,642	1,560	1,478	1,396	1,314	1,232	1,150	1,067	985	903	821	739	657	575	493	411	328	246	164	82	0
Balance	0	-103	-163	-223	-167																							

Patient experience

Canterbury DHB puts the patient at the heart of everything we do: a Planned Care approach offers patients more choice and better access to many services through a delivery model that encompasses flexibility. Planned Care will be the cornerstone of our strategic aims to deliver

- Equity of access to surgery within our resources by investing in surgical services where we deliver below national intervention rate and by identifying ways to increase access where Māori are particularly impacted,
- Robust and timely data and management information and monitoring of performance,
- Timely access to surgery,
- Improvements to our level of ESPI achievement,
- Completing the review of Choosing Wisely principles that determines which surgeries are completed.

Planned care drivers, actions and risks

Planned Care drivers	Actions being developed/implemented	Potential roadblocks
Flexible working patterns	• Multi-disciplinary approaches to patient care • Increase nurse specialist and midwife lead clinics • Expand roles of allied health professionals • Identification of smarter ways of working	• Access to overseas recruitment during COVID • National shortage of staff in some professions • Overall FTE constraints • Recruitment timing to align with Hagley opening
Review and Monitor progress Improved data access and visualisation to identify issues sooner and take targeted actions	• Enhance Predictive reporting • Flag priority patients in waitlist to ensure focused action • Continuous improvement of HealthPathways to ensure correct referral criteria	• Changeover to new patient systems creates delays and new process learning • Poor or non-existent access to data and systems away from the main campus
Prioritise deliverable capacity Free up space and time in our existing capacity and systems to provide planned care for those outside of the ESPI targets.	• Increase clinics including out of normal hours and away from main campus • Clinical pathways for same day discharge • Increase threshold of co-morbidity that can be managed in private hospitals allowing more patients to be outsourced if required • Increase theatre sessions and filling of First Specialist Appointment (FSA) Did Not Attend (DNA) slots by encouraging greater use of 'available at short notice' lists • Post-op clinics changed to release SMO/RMO time: e.g. more use of telehealth clinics • Increase use of other disciplines including allied health in follow up provision	• Hagley Acute services building not open with inevitable constraints on theatre capacity at CHCH campus • Lack of ICU availability in private limits which patients can be outplaced/outsourced • New outpatient clinics spaces not available in Hagley • New infrastructure and equipment not yet released in Hagley • Labs capacity with COVID • Scope of practice issues
Improved efficiency of referrals Optimise the quality of referrals into our system so the right patient gets the right services.	• Continue with scheduled reviews of ERMS and HealthPathways, especially in key areas • Increase use of tele-health to allow faster access to consultations • Run more combined Primary Care clinics, including face-to face (F2F) and	• Primary Care constraints post COVID-19 • IT limitations for information sharing between primary care and main campus • Scheduling processes for hybrid clinics (F2F and Virtual)

As a health system manage from the community and back to the community	virtual to manage patients in the community • Expand and refine the Patient Pool approach • Review triaging processes to confirm prioritisation is occurring • Ensure CDHB policies on DNAs are being adhered to • Whanau inclusion to enhance clinic engagement	
Operational efficiency Optimise the resources available to us and continually look for opportunities to improve how we deliver services using evidence-based methods	• Consolidate clinics for efficiency and review clinic locations • Action focused production planning tools • review management of surgical lists to seek improvement • Increase clinical audits capacity • Better engagement with administration teams	• Resourcing issues for clinical audits • COVID-19 readiness: plan for possible 'second wave' • Physical space limitations • Analytical capability and capacity • Managing surgical lists across multiple sites
Embedding an equity-centric focus Continually review our equity performance and act on evidence, working in partnership with Manawhenua Ki Waitaha.	• Increase access to translators • Tele-health options of engagement where traditional engagement is not working • Increase knowledge of equity dashboards and use them to facilitate change • Whanau inclusion to enhance clinic engagement	• Existing digital inequity and fluency in vulnerable populations • Availability of diagnostics in rural setting requires travel. • Outpatient clinic space for large whanau consultations

Patient Pool

What is 'The Patient Pool'?

The Patient Pool is a concept that has been trialled in some Canterbury DHB services since COVID-19 Alert Level 4 in April 2020. When a DHB service receives more referrals than it has capacity to see, the usual response over many years has been to decline the referrals, even if they meet a reasonable clinical threshold. This is very difficult for patients, inconvenient for general practice, which has to re-refer patients until care can be provided, and frustrating for services who want to provide this care. When COVID-19 Alert Level 4 exacerbated this problem, Planning and Funding wanted to try to find a better way to handle these referrals.

Referring clinicians continue to refer patients in line with the criteria documented in HealthPathways. With The Pool, when general practice teams and other referrers send routine requests, the requests do not go straight to hospital services. Instead, they go to a web-based 'pool' which sits at the interface

between primary and secondary care. Requests are reviewed promptly by clinical reviewers (the usual department reviewers) according to HealthPathways criteria. When services have capacity, routine requests are then passed through to them from the Pool in priority order.

Acute, high suspicion of cancer and urgent requests continue to go straight to services without delay.

Patients remain under the care of their general practice team or other referrer while they are in the Pool and are advised to contact their general practice team directly if their condition changes. This approach means that patients can be proactively monitored while they are waiting for their next appointment in secondary care.

The Patient Pool approach allows us to have a much better understanding of unmet need, improve our ability to manage resources and will reduce inequities by eliminating the peaks and troughs of varying capacity and demand. It also allows us to see and treat patients in a timely manner when they are moved from the Pool to the service.

What Services Are Using the Pool

General Surgery is using the pool for their routine requests, excluding breast, endocrine and bariatic requests i.e. mostly gall bladders, hernias and perianal conditions.

Since its inception, over 2,000 routine General Surgery requests have been accepted into the Pool, and at present on average 55 new requests are accepted each week.

Each week, 60 requests are flowed out of the Pool to the service and replaced by new referrals. If service capacity remains stable, the general surgery pool will be empty by January or February next year.

The pool process with Urology for incontinence and prolapse has finished.

Ophthalmology management of 'declined during COVID' cataract requests have all been flowed to the service and Ophthalmology use of the pool is complete.

How we engage with our stakeholders

The following tables indicate the different avenues that we have identified for engaging with stakeholders. The first table summarises our engagement methods in forming this plan with the second table showing how we will engage stakeholders once the plan is approved. These methods and the list of stakeholders are not set in stone: we will continue to identify ways in which engagement can be improved and learn from what others are doing.

Stakeholder engagement in developing the plan

	CEO Newsletter	Face to face meetings	Workshops	CDHB Intranet	CDHB Internet	Emails	Printed material	Health pathways	Health Info
CDHB staff including internal clinical, equity and disability champions		☑		☑		☑			
Primary care organisations		☑				☑			
Primary care staff		☑				☑			
Rural support groups and organisations									
Welfare organisations									
Health issue related organisations									
Community facilities		☑				☑			
Age-related organisations									
Private hospitals		☑				☑			

Stakeholder engagement once the plan is approved

	CEO Newsletter	Face to face meetings	Workshops	CDHB Intranet	CDHB Internet	Emails	Printed material	Health pathways	Health Info
CDHB staff	☑	☑		☑		☑			☑
Primary care organisations		☑	☑		☑	☑	☑	☑	☑
Primary care staff		☑	☑		☑	☑	☑	☑	☑
Ethnic groups and organisations e.g. Manawhenua Ki Waitaha, Pasifika Futures		☑	☑		☑	☑	☑		☑
Rural support groups and organisations		☑	☑		☑	☑	☑		☑
Welfare organisations		☑	☑		☑	☑	☑		☑
Health issue related organisations		☑	☑		☑	☑	☑	☑	☑
Community facilities		☑			☑	☑	☑		☑
Age-related organisations		☑	☑		☑	☑	☑		☑

Assessment of priorities for improvements in Planned Care

The table below sets out what the strategic priorities are that we need to address.

Strategic Priority area	Year 1 (2020/2021) Actions establishing the foundations	Year 2 (2021/2022) Actions building successful programmes	Year 3 (2022/2023) Actions embedding changes
Strategic Priority 1 Improve understanding of local health needs, with a specific focus on addressing unmet need, consumer's health preferences, and inequities that can be changed.	Review of ethnicity-collection processes to ensure data is accurate and complete. Identify existing inequities through comparison of data in our Data Warehouse and national data collections. Work with our Māori Health Team and others to identify priorities.	Using the data from our systems to compare performance, including levels of unmet need, between new and previous Planned Care delivery models.	Ensure all processes relating to delivery of Planned Care have a focus and well-defined expectations on how equity status is to be monitored and improved. Services to be responsive to unmet need and work with stakeholders to develop and implement alternative treatment options where appropriate.
Strategic Priority 2 Balance national consistency and the local context	Passed the 19/20 Planned Care provision target.	Continue with our focus on delivering and surpassing our Planned Care targets bearing in mind probable disruption caused by move to Hagley Hospital.	Review to identify Best Practice within departments.
Strategic Priority *3* Support consumers to navigate their health journeys	Review current available information and identify gaps in provision.	Use stakeholder forums to check that the information we provide is appropriate, accessible and complete.	Keep seeking different delivery methods to provide the best possible information to the widest audience through diverse channels.
Strategic Priority 4 Optimise sector capacity and capability	Identify where service is currently delivered and monitor progress against delivering 30,000+ Planned Care interventions	Validate that any changes made have resulted in desired performance outcomes.	Look for further opportunities to take service delivery out into the wider community.

Strategic Priority 5 Ensure the Planned Care Systems and supports are sustainable and designed to be fit for the future.	Ensure that we have a clear, agreed plan for rolling out Planned Care services over the 3-year period.	Monitor the agreed changes to service provision are being actioned in accordance with our 3-year schedule.	Review the plan and prepare the next 3-year plan incorporating lessons learned.

Strategic Priority #1 Understanding health need*:* both in terms of access to services and health preferences, with a focus on understanding inequities that we can change

Priorities	Actions	Risks and mitigations	Definition of success in Year One	Definition of success in Year Two	Definition of success in Year Three
Complete and accurate ethnicity data (1)	Decision Support Team review data to determine scale of non-collection.	Scarce resource but schedule it as a formal task.	Better understanding of our data including areas where data is lacking.	Fewer gaps in data and improved confidence in accuracy.	Regular data review to identify areas for improvement.
Complete and accurate ethnicity data (2)	Work with Quality Team to improve data collection: remind teams not to guess ethnicity but to ask, and check demographics in systems when meeting new patients.	Priorities of Quality Team: try and agree a set programme.	Decrease in incomplete ethnicity fields.	Fewer gaps in data and improved confidence in accuracy.	Importance of correct ethnicity data embedded in culture.
Monitor unmet need so we can respond to changes in resources.	The Patient Pool approach has the ability to capture patients who did not meet the acceptance criteria for secondary care and also patients who would benefit from surgery (i.e. meet the clinical threshold) but are declined because of capacity constraints. This information will be useful in determining where resources should be targeted to address unmet need.	There will be no increase in resources to allow services to address current unmet need.	We have a new system capable of managing unmet need in Primary Care until capacity allows us to accept them into Secondary Care.	Reduction in patients declined through capacity issues.	Fewer patients declined and of those who are, more managed through other treatment options with written healthcare advice for Primary Care teams.

Strategic Priority #2: Balancing national consistency and local context: Ensuring consistently excellent care, regardless of where you are or where you are treated

Priorities	Actions	Risks and mitigations	Definition of success in Year One	Definition of success in Year Two	Definition of success in Year Three
Identify key areas where we compare unfavourably against national provision.	Review services to understand why we are not meeting the national provision levels.	There may be circumstances beyond our control, e.g. IDF provision but should at least acknowledge it. Unfortunately the latest data on the MoH website is for Q2 2019/20 but when we receive an update we will review our performance on each performance indicator.	We are either planning to improve performance to meet national provision rates or are confident that our performance is at an optimal level for our DHB.	Where we deem it appropriate, we have improved performance to equal or better than national provision.	Continued satisfactory performance against our agreed standards.

Strategic Priority #3: Simplifying pathways for service users: Providing a seamless health journey, with a focus on providing person-centred care in the most appropriate setting

Priorities	**Actions**	**Risks and mitigations**	**Definition of success in Year One**	**Definition of success in Year Two**	**Definition of success in Year Three**
Appropriate information available in an array of formats for different ethnicities and conditions.	Consult widely including Māori Health Team and In-house publishing team to develop relevant content.	Scope may be much bigger than currently anticipated.	Some material is not only available in different languages and formats but also culturally appropriate.	Wider range of appropriate information available in both paper and digital formats	As Planned care develops so does the available information to meet the new requirements. Existing content is reviewed at agreed intervals.
Plan for producing online Healthinfo in te reo Māori.	Discuss with HealthInfo team and Māori health team.	Attention to cultural considerations as well as simple translation.	Plan agreed to provide online HealthInfo in te reo Māori.	Start review and translation	Online HealthInfo available in te reo Māori

Strategic priority 4: Optimising sector capacity and capability: Optimising capacity, reducing demand on hospital services and intervening at the most appropriate time

Priorities	Actions	Risks and mitigations	Definition of success in Year One	Definition of success in Year Two	Definition of success in Year Three
Services delivered in the right setting by the right people or teams.	Identify a) where service is currently delivered and b) appropriate KPIs to measure performance	Unable to identify suitable alternative delivery options for some areas. Keep working with key stakeholders to consider alternative methods/premises.	That the services we identified as being appropriate for delivery under Planned Care in Y1 have been successfully transitioned.	That the services we identified as being appropriate for delivery under Planned Care in Y2 have been successfully transitioned.	That the services we identified as being appropriate for delivery under Planned Care in Y3have been successfully transitioned.
Optimise infusion provision by utilising clinic space in the community.	Review our in-hospital capacity for giving transfusions and infusions and look to optimise capacity by moving suitable trans/infusions into a community setting.	No suitable clinic space is available. 'Widen the net' to explore other options such as used by the blood doning service.	More trans/infusions are offered in a community setting than at present. Particular focus on blood transfusions, possibly based on centres used for blood donations.	The range of acceptable trans/infusions for moving out of secondary care into the community has increased.	As year Two

Strategic Priority #5: Fit for the future: Planning and Implementing system support for long-term funding, performance and improvement

Priorities	Actions	Risks and mitigations	Definition of success in Year One	Definition of success in Year Two	Definition of success in Year Three
Establish a robust framework for consulting stakeholders	Work with identified stakeholders to agree how consultation should occur	No existing consultation structure and difficulties in identifying who needs to be involved. Seek advice from the MoH, Māori Health Team and Senior Mgt team.	Framework has been agreed and 1st meetings have been held.	Meetings are occurring to the agreed schedule and are proving worthwhile with good attendances.	Meetings are producing positive, tangible results that benefit the stakeholders.

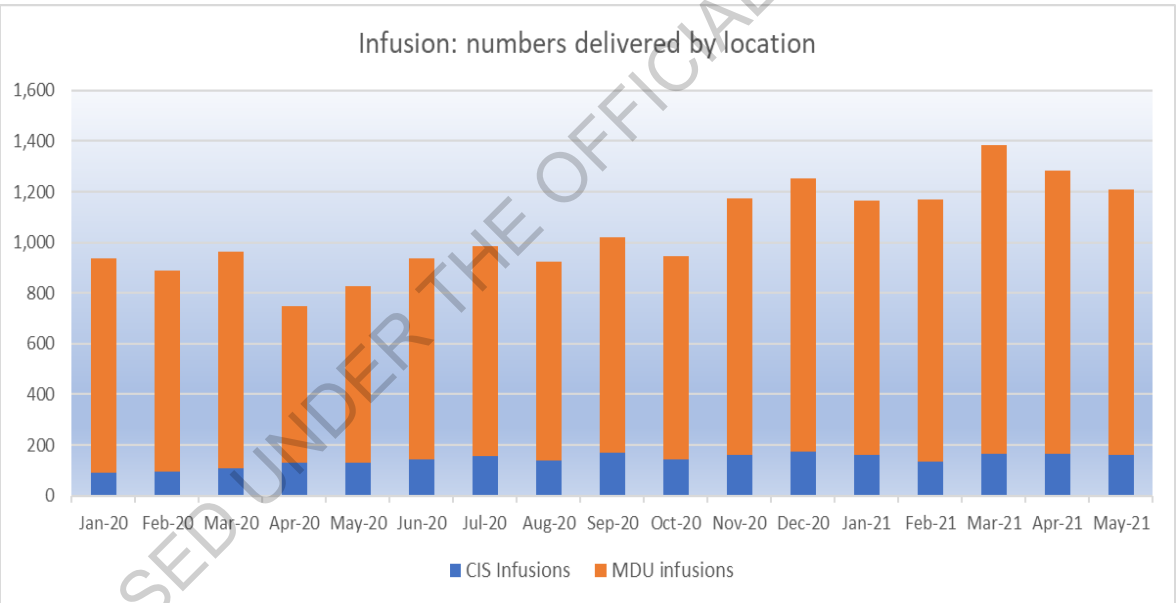
APPENDIX 2

Appendix 2 latest update:

Infusions in the community

Benefits from moving appropriate services into the community

- Patients will be able to access services in locations that are more convenient for them.
- Greater choice of where to access treatment should reduce the number of patients who did not attend (DNA) appointments, often because of the cost of getting to Christchurch and/or problems with parking.
- Accessing services in their community should benefit some parents and caregivers who currently struggle with obtaining cover for dependents when attending appointments.
- It frees up hospital clinic space in the public hospital, which will be at a premium even after the opening of the new Hagley Hospital.
- It builds increased resilience and flexibility, conforming to our patient-centred approach to providing services.
- It reduces the pressure on the Medical Day Unit by moving low complexity/high volume infusions and lengthy (ie up to 6-7 hours) blood transfusions into the community. The graph below shows the number of infusions delivered by the Community Infusions Service (CIS) and those delivered in the medical Day Unit (MDU) in the public hospital.



Planned Care procedures: an update

Since January 2020, the following subsidised procedures have counted as Planned Care. Canterbury DHB funds general practice to perform the procedures in the community on a fee-for-service basis. This has enabled the following volumes of fully DHB-funded procedures to be performed in the community from 1 July 2020 to 31 May 2021 at no cost to patients.

- MSK steroid injection: 3,560
- Pipelle biopsy: 1,079
- Punch biopsy: 2,148
- Skin lesion excision: 2,126

Musculoskeletal (MSK) early intervention programme

- The CDHB already provides MSK interventions: the advantages of doing so are that they can reduce pain, improve patients' quality of life, and delay or prevent the need for invasive surgery. Interventions include the Mobility Action Programme (MAP) and the provision of community MSK physiotherapy.
- Exercise is beneficial in helping people with osteoarthritis and other arthritic conditions to remain active. MAP is an eight-week programme for people with knee or hip osteoarthritis. Each week includes a one-hour physical activity session and a one-hour interactive education session covering topics such as managing pain, medications, complementary and alternative therapies, eating well, well-being and mental fitness. The overall aim of the programme is for participants to fulfil their health potential and increase independence. In turn this can improve quality of life and the need for surgery, including major joint replacement, may be reduced by strengthening joints and addressing pain triggers. As a form of 'Pre hab' they can also help prepare people for surgery and reduce recovery times.
- The CDHB contracts four physiotherapy providers who between them deliver 16 programmes a year. The programmes start regularly throughout the year and are held at various places in Canterbury. Online sessions are also available.
- Developed in conjunction with the Orthopaedic Department, MAP sessions are free for patients in Canterbury (funded by Canterbury DHB) Support and are run with encouragement from a health professional to improve engagement.
- The community MSK physiotherapy scheme is for non-ACC patients who need MSK physiotherapy and who can not otherwise afford treatment and do not have any other funding options.
- Identifying opportunities to deliver chronic pain and back pain groups in a similar way to MAP is also being considered.

Bowel screening

- The introduction of the bowel screening programme (BSP) has necessitated increases in colonoscopy provision as this is the next step for following up people who return a positive sample requiring investigation. This has led to an increase in surgical procedures to remove tumours identified through the screening programme and will continue to do so until (probably two to three years) the demand for surgeries levels off. Although this was planned to start in 2019/2020 it was rescheduled for 2020/2021 and is now being delivered
- Canterbury developed a schedule that increased its own provision to cope with expected additional bowel cancer surgery emanating from the BSP programme roll out and this included capacity for other DHBs in the South Island when they offer the service.