Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF CAROLYN GULLERY

I, Carolyn Gullery, Executive Director Planning, Funding & Decision Support, Canterbury District Health Board (**DHB**), 32 Oxford Terrace, Christchurch, New Zealand, say as follows:

PROFESSIONAL BACKGROUND

1 I am the General Manager Planning, Funding & Decision Support of Canterbury DHB. In this role I lead teams that plan the current and future health system configuration to enable transformation through the allocation of funding and the integration of system infrastructure to enable best patient outcomes in the system. This is done through the provision of high-quality analysis and accessible data and information.

2 My professional background included in my curriculum vitae which is attached as CG-1 to this statement.

3 I make this statement in my capacity as an employee of Canterbury DHB.

CANTERBURY DISTRICT HEALTH BOARD

Canterbury DHB's organisation and governance

4 The New Zealand health system is made up of 20 DHBs, of which Canterbury is the second largest by population. DHBs are Crown-owned entities that have a governance board that is partially elected and partially appointed. The Ministry of Health monitor DHBs as Crown entities and fund them through a Crown funding agreement. The funding is largely based on a population-based funding model.

5 The Ministry of Health operate DHBs through operating policy frameworks. These are the rules in which DHBs work and how they are required to allocate money towards health services. DHBs own the hospital-based system, so we run the public health system and public hospitals. DHBs also fund primary care to general practice, mental health services, pharmacy, radiology and pathology services and long-term care of the elderly. DHBs also fund some non-government organisations that deliver mental health and social care. We also purchase services from the private hospital sector.

6 Canterbury DHB has an allocated budget of about $1.8 billion. It is the job of my team to allocate our funding to achieve desired health outcomes for our population. Some of our budget flows according to nationally agreed arrangements. For example, the core of the general practice funding is a capitation contract which is a contract that is agreed

nationally. Services such as pharmacy and the cost of dispensing are agreed nationally within a national framework that is negotiated for the 20 DHBs.

Canterbury DHB's commissioning of health and mental health services

7 My team at the Planning, Funding & Decision Support of Canterbury DHB are effectively the commissioners for our DHB together with our executive management team. This includes commissioning specialist mental health services, inpatient mental health services, outpatient activity and forensic services. In respect of forensic services, these are funded at a national level for regional delivery via a top-slice arrangement. We deliver specialist services and fund non-government organisations to deliver a range of community-based responses, including some residential, outpatient and support activity. We also fund primary care organisations to deliver some early intervention measures tied to mental health.

8 In addition, we run a mental health service for primary schools called Mana Ake 'stronger for tomorrow'. The Mana Ake model is an early intervention model that combines health and social care and education to deliver better outcomes for our children. In particular, it built resilience in primary school children and a recent external evaluation by Impact Lab has sized the return on investment in social outcome terms as $13.32 for every dollar spent. I discuss the Mana Ake model further below.

9 All DHBs work in slightly different ways. At Canterbury DHB, as we own the hospital and specialist provider, we fund them on the basis of an expenditure budget rather than an activity based funding formula/tariff. This budget is based on our forecast of the activity that we think they are going to need to deliver and the resources they will require to optimally deliver. We fund the external providers in the rest of the sector through either standard contracts or alliance contract arrangements. Our alliance approach is an adaptation of the commercial alliance in the construction industry. It recognises that the whole system needs to work together to support the population's healthcare. The contract is based on the premise that "everyone wins or everyone loses" encouraging all of the providers and the DHB in its funding role to work together to make it better. Rather than spend time on detailed services specification sand complex funding mechanisms, alliances are built on clear outcome expectations and simple allocative funding models to create certainty and allow for innovation in ow the services are delivered. It is a clear example of the power of collective impact. Canterbury DHB runs many services through alliance-based contracts.

How the DHB facilitates collaboration of multiple health, mental health and social services towards a common goal

10 The way we have multiple health, mental health and social services collaborate is to have everybody come together in the same room and run a co-design process together with consumers, providers and other stakeholders. At Canterbury DHB we have become highly skilled with the co-design process. We may run co-design processes with 60 people in the room where we will define the issues at hand, develop a shared vision and set principles so we can move forward in resolving service delivery around a health issue. We run these co-design processes within an alliance framework that basically indicates a model of collective collaboration - everybody wins or everybody loses. Basically, if you are part of our alliance, then the Canterbury DHB will work with you to make sure that you are sustainable and successful. It is all very open and transparent, and we are very clear about that. Everybody can see everything. We understand the costs structures and how we can help a provider deliver on their services.

11 The Mana Ake model is a very good and recent example of collaboration around a shared common goal for mental health services. This saw us combine health, social care and education services and had them working together to deliver a better outcome around mental health for children in our district. For Mana Ake, we created an almost sub-alliance inside a broader alliance agreement within health, education, social services, teachers, principals and police. We had a service level alliance leadership team made up of representatives of these groups who had oversight of the whole service. We then created a sub-alliance with non-government organisation providers who actually provided the service. All these alliances had the same contractual terms and conditions which was known openly and transparently. Through this alliance approach, we were able to get 13 non-government organisations working together within our schools rather than these organisations competing.

12 We set up clusters of support working with groups of schools, so there is a mixture of teams working within each school. For example, the team might include one person from Presbyterian Support, two people from Family Help Trust and another person from somewhere else, working together as a team. The team could include a psychologist, social worker and a support worker from different organisations, working together as a team. Using these clusters of support, we have been able to leverage all of the different organisations' values, capabilities and skill sets to get a mix, ultimately to get better outcomes for the children. We were also able to balance a generalist approach to classes with a targeted and customised approach for children who needed a more intensive response. All using the same workforce and consistently growing capability.

The organisation and governance of New Zealand's health system

13 As indicated, there are 20 DHBs within New Zealand. The Ministry of Health has the official role as the monitor of these DHBs, creates policy and supports the Minister. The Ministry of Health has a Crown funding agreement with the DHBs and provides funding to them. It is a devolved health system. To confirm, there is no National Health Board in New Zealand any longer. It has been dis-established.

14 The DHBs have a relationship with primary health organisations who contract general practice. Most DHBs, including Canterbury DHB, have formed an alliance with primary health organisations. At Canterbury DHB we also have alliance agreements with non-government organisations and the private sector.

15 Primary Healthcare Organisations known as PHOs are accountable to the DHB for the delivery of services to the population enrolled with the general practices who make up their membership. They get nationally determined funding based on the enrolled population plus additional services a DHB might choose to fund for the population. They coordinate and support the general practices (who are independent businesses) to meet the contractual obligations of the PHO agreement which encompasses core primary care services including doctors and nurse delivered first contact primary care services, after hours care, and immunisation.

Commissioning decisions at a central level and a system-wide level

16 Given the national government provides DHBs with funding, the Ministry of Health has a role in setting priorities for DHBs at a broad, central system level. Generally, the Ministry of Health sets broad priorities for DHBs and then DHBs roll out specific programs to meet these priorities. For example, government may tell DHBs that we are to provide free primary care or partially subsidised primary care, or free dental care and we will roll this out. Government will also advise us the level of elective surgical operations they require by setting the volume they wish to see delivered and determining the allowable waiting times. The DHB has to work out the how it gets done and how to allocate the resources across the acute and planned care as well as investment in early intervention. This allows customisation for a population in the context of the capacity and capability available.

17 However, sometimes, the Ministry of Health or the Department will directly implement health initiatives. For example, bowel screening is being directly implemented from the Ministry of Health and the DHBs will manage the process.

18 There is a space for commissioning at a national level and at a local level to customise health needs for our entire population. In my view, the health system cannot entirely be integrated at a national level to best ensure the health processes work for the people

who require them. Integration of the health system is actually about how these processes work for people. You cannot define that at the national level, you can only make it work at a local level. To address equity, you need the element of local decision-making.

19 For example, in Canterbury DHB, a big issue for our local population is respiratory disease, but not diabetes. However, for the Counties Manukau DHB in the North Island, diabetes is a major issue, but respiratory disease is less so. A national focus may not assist our two DHBs to best treat the health issues we face in our populations. The DHBs enable particular health needs to be prioritised for a more localised population. Additionally, DHBs are able to provide services to rural localities based on the geographical location they cover. Canterbury DHB is the second biggest DHB by geography and the furthest point is four hours away and requires rural services. However, Auckland DHB has no rural services at all given its geography.

Commissioning decisions at a regional or local level

20 Decisions at a regional or local level depend on how the DHB chooses to contract. Based on my extensive experience in commissioning roles, I no longer choose to draft complex contracts with carefully constructed financial incentives. What I now focus on is being very clear about what the DHB expects to achieve and being very clear about the resources we are willing to put in. I then leave the rest to the people who have to deliver the service. This is because people on the ground are better at solving how to get a service delivered than anyone else is.

21 An integrated health system can only work when we build connections locally. While DHBs work within a consistent framework and through a consistent set of policies (including the key set of government priorities), we also need to build and adapt local relationships to ensure the entire system is able to operate successfully to deliver services for local populations. Long-standing international evidence would say that if health services are not adapted for local populations it increases inequity. If you try and control healthcare centrally, people miss out.[1]

Improvements in the New Zealand health system since the 2007 Canterbury reforms

22 In 2007, Canterbury DHB made an assessment that if we did not make changes to our health system, that by 2020, we would need 400 more hospital beds, 2000 more aged residential care beds and 8000 more employees in the health workforce. This was because our population demographic was aging. We were not able to see how we could

[1] See for example https://www.nap.edu/resource/24624/RootCausesofHealthInequity/ and *Local Provision of Public Services: The Tiebout Model after 25 Years* (1983) edited by George Z. Zodrow (Oates, Local Provision of Public Services: The Tiebout Model after 25 Years, 1983).

increase these resources, particularly around increasing our workforce by an additional 8000 people. As a result, we commenced a process where we re-designed the health system. This was the beginning of our journey, getting everybody in a room, getting a sense of direction and then empowering a system to change. We literally got everybody in a room and redesigned the health system.

23 Rather than having hospitals in the middle of the system, we instead placed the needs of the person in their own home as being the middle of the system. We reorganised the health system to support people to stay well and healthy and in their own home. Health services were organised around people in this way, and aim not to waste the person's time. A patient's ongoing point of continuity is designed to be their general practice team and general practice is seen as the centre of our system in order to free up hospital-based capacity.

24 This change that started in 2007 allowed us to connect the entire health system through the provision of a shared health record and an electronic referral management system. The alliance approach was established in 2010 but prior to that the integrated way of working based on high trust set up a system of health pathways and assisted people to move through the health system in the best possible way, depending on their clinical condition.

25 The 2007 reforms also saw us seeding a culture in the system that we only have one health system. We changed the system to move away from being a competitive one about who pays for what resources and who accesses the resources. Ultimately there is only one budget, there is only one bottom line and it is all about patients. So the system has moved into a collaborative one that emphasises collective impact and the idea that everybody working together could make a difference.

26 Based on our changes since 2007, Canterbury DHB has been able to bend the curve in terms of the resources. In 2020, we use the same number of hospital beds that we did in 2007, however our population has grown faster than we predicted. We now have 100,000 more people in Canterbury than we had in 2007 but have not had to increase the number of hospital beds. We have less aged care residential beds in 2007 and 15% of our elderly population spend less time in long term care. This means that while we have 30,000 more people aged over 65 in Canterbury, we use 15% less beds in the aged care system. Additionally, we did not need to add 8000 people to or workforce. We have a slightly bigger workforce, but nowhere near the 8000 people we predicted we needed.

27 Therefore, on a number of measures, the Canterbury health system now delivers significantly more within the same physical capacity. We have a 30% lower rate than the national average for our acute medical admission rate. We also have the lowest

emergency department attendance rate probably in New Zealand, Australia and the United Kingdom.

The 2016 Ministry of Health Strategy

28 In 2016, there was a Ministry of Health report strategy for the health system which had five strategies (being people powered, closer to home, value and high-performance, having one team and a smart system)[2]. The 2016 strategy lined up closely to what we had set out to achieve in our 2007 reforms at Canterbury DHB and meant that we were able to readily adapt our local processes to meet the processes set by the Ministry of Health in 2016.

Lessons learnt from past reforms to improve commissioning and governance of mental health services

29 In terms of commissioning mental health services, our changes to the mental health system have progressed more slowly. This is because in Canterbury DHB our immediate concerns were around our aging population, because of the significant number of people who ended up in long-term care. We have now turned our attention to mental health services required for the Canterbury area.

30 However, historically, since the 1990s, mental health services in New Zealand have been somewhat constrained by the 'mental health ring fence.' Basically, a portion of our government funding from the Ministry of Health had a ring fence around it and was required to be spent on mental health and it was expanded in beds and FTE (staff) .The ring fence was in place because in the past mental health funding had been taken to fund acute hospitals. However, the ring fence funding model had passed its use by date because the funding was not flexible enough to deal with the modern mental health needs within our local population. Having a set amount of funding for mental health meant that a very literal interpretation was used in terms of mental health treatment – for example, funding was prescriptively applied so there was a certain amount of funding tied to bed days and staff allocated to mental health funding in order to get the maximum amount of funding allotted. This perpetuated an idea that in order for a service to access more funding, it had to have the maximum number of bed days or hire the full amount of staff allocated within the funding model. This is irrespective of whether those bed days or staff were required.

31 This older funding model also went against the grain of what we wanted to change around Canterbury DHB's contracting model. We wanted to work towards a model of

[2] The report titled 'New Zealand Health Strategy 2016' can be accessed at https://www.health.govt.nz/publication/new-zealand-health-strategy-2016.

supporting people with their mental health concerns in their own homes and in their own communities, rather than our people requiring specialist mental health services.

32 In about 2016, we stopped funding the non-government organisation mental health sector in this way. The idea that a service got funded by the number of staff they employed no longer made sense to Canterbury DHB. It seemed to us that the old model ultimately penalised our providers and provided them with less funding if they came up with a better and more efficient and innovative way of delivering services. As a result, we changed the funding to capacity funding. We told the service what they needed to deliver and what sort of clientele they needed to support. We would ask the service to tell us how they would deliver the service rather than telling them to hire seven staff members, for example. We moved our contracting method away from inputs to focussing on the service's outputs. Ultimately, the government moved towards funding mental health services in a similar way. The government now indicates what percentage of total funding needs to be spent on mental health services to ensure that DHBs do not disinvest from mental health services. However, DHBs now have the flexibility and freedom about how to distribute funding to mental health services as required.

33 Canterbury DHB has again used HealthPathways to support mental health services. We have redesigned our health pathways to support general practice to look after people with mental health issues and have direct access to specialist advice. We have a consult liaison service. We had already built and implemented this service before the Ministry of Health required us to implement one. This means that both non-government organisations and general practice have access to consultant psychiatrists, who they can contact at any time to get support when they are dealing with people with more complex mental health needs. This has enabled Canterbury DHB to get people with more complex mental health presentations looked after in a community-based setting and less in a hospital-based setting. We also removed needs assessment service coordination type models that have previously existed because they take too long and we found that people spent too much time assessing people rather than actually providing treatment.

34 For people who present with complex mental health needs we get community based mental health providers (which includes non-government organisations) in the same room in order to discuss an individual's presentation. In the space of several hours we are able to allocate community-based services to each person that presents with complex mental health needs. This means we have significantly reduced our waiting times which could be as much as 100 days because we have eradicated the assessment service coordination process. This process enables us to understand the skillsets and capacity we have in our region to treat mental health issues.

GOVERNANCE

Merits and limitations of independent Mental Health Commissions

35 In my view, there is merit in having a Mental Health Commission so it can provide scrutiny around our processes, provided that the Commission collects information in the right ways. To me, one of the biggest gaps we are facing in mental health is poor information and data. This is a health system issue and Canterbury Health has invested in building very good data to ensure we have good information sources. We also now have quite a lot of capability in analytics which we use for planning and forecasting in our system which drives change and helps us to get all our stakeholders on the same page. Ultimately, it is very useful to be able to get everyone in the same room and give them some evidence, data and data analysis. This means that everybody can have a conversation from the same base. So, in my view, any Mental Health Commission would have to get information collection right and would have to get better at measuring data around outcomes. If a Mental Health Commission cannot do this, then there is probably no point of the Commission. A Commission needs to know the right information from consumers and to make sure that consumers are included in the process.

36 At Canterbury DHB we have spent the last 13 years trying to integrate mental health into the rest of the health system. I remain surprised that people are still unable to recognise that mental health and physical health needs are all the continuum of the same thing – we have one body. In my view, we do people with mental health issues a disservice by putting them in a separate box away from physical health issues. I feel particularly strongly about this because people with mental health issues often have a shorter length of life, partly because we focus on their mental health and forget their physical health issues. On the other hand, we have people with long term conditions who, by definition, also have mental health issues that we may not treat. As a result, I do think a Mental Health Commission, a body with oversight who can keep on pushing the sector to look to the new evidence to expand its horizons and to consider more broadly about how we support health and wellbeing, is a good idea. I remain concerned however that mental health will be considered by itself without it being considered as a health problem generally because that is what has happened with oversight bodies in the past.

Mechanisms to assist mental health commissions to provide scrutiny around mental health outcomes

37 Data and data analysis are the key mechanism to assist Mental Health Commissions to provide scrutiny around mental health outcomes. In my view, if you have the data, then you can analyse it and 'slice and dice' the information from a population and ethnicity

perspective. It enables us to constantly look for evidence and new or emerging evidence because mental health is an evolving field.

38 One advantage New Zealand has over Australia is that we have a National Health Index (**NHI**) and an enrolled population. This means our population enrols into general practice and have an NHI so we know who they are. We know from the NHI most of the demographics, socioeconomic status, ethnicity and other like details of our population nationally. It enables us to pull that information together and combine it with the knowledge we have as a health system of where a consumer has touched the health system. It then enables us to provide integrated responses. For example, we have an integrated safety response model which is about family violence and includes health and social services as well as the police. Using data from the NHI and from the DHB's data, it means that we can have all the information at hand in relation to family violence – we can put together what the police know about the family, what social services know about the family, what health services know about a family and this gives us a rich landscape to attempt to try and solve the problems. The benefits of being able to look at the data from a number of different areas is that we can sometimes find new and innovative solutions for people's issues that are not obvious or do not follow down a 'normal' path.

The benefits and risks of distributing management functions across multiple organisations (for example, governance and commissioning)

39 I have worked in almost every construct of the health system we have had in New Zealand over the last 30 years. In my view, DHBs are the best model New Zealand has had so far. It is about our ability: we have access to data which assists with commissioning. Commissioning agencies that are separate from the system that they work in frequently do not have broad data – they only have the data they collect through their own commissioning systems. With DHBs, we have got all the operational data and that detailed data can be analysed and looked into in different ways.

40 Since 2007, when the Canterbury DHB brought in the concept of having one health system and one budget, it has enabled us to organise the right services around a person. It has meant that that we do not require separate oversight and has reduced barriers, competition, boundaries and debates around the boundaries about who is paying for what health services. In my experience, health systems end up looking like how the funders organise themselves. If funders of the health system organise themselves in silos, then the health system will also work in competitive silos duplicating service responses.

The benefits and risks of creating new single-focus entities (for example, the New Zealand Suicide Prevention Office)

41 The benefit of creating new entities to focus on a single objective is that you have people solely focused on that objective. Given the size and scale of the system, my team and I are not in a position to have a single focus. However, given we have significant data, we can swing the focus of the data to the problem we have to immediately consider. For example, we had to use our data to consider our response and planning in the system around COVID-19. It also means if you have an entity like the New Zealand Suicide Prevention Office, then you have an organisation who have a single focus who are collecting and analysing data and looking at the evidence around that issue. Additionally, a central entity can guide, encourage and provide guidelines to support the local health entities to deliver services around an issue. Without this, it may be the case that individual local boards set different priorities and policies for an issue or duplicate work that has already been done in other regional areas. Having entitles focus on a single objective is efficient and focussed, however, they need to work well with the people who have to implement their policies.

42 In my view, what is required is for the Ministry of Health and these entities, to establish the policy frameworks and the investment in the single objective. For example, investment in suicide prevention sends a strong signal to the DHBs that we are required to focus on that issue and fund it. These entities can then work with the DHBs and provide us an evidence base about what works.

43 I think there is a role for these entities, it is just preferable not too have too many of them. It is important that new entities draw on existing knowledge and do not get too 'bogged down' in process. For example, it is compelling to write a fantastic plan but that won't make a difference to service delivery. Our compelling vision was on a page and then we got 'stuff done'. A great deal of effort goes into the planning documents, reporting and consultation processes. Where central entities should focus more is on information collection, analysis, providing guidance and facilitating solutions. Emergent strategies are more powerful in a complex system.

PARTNERSHIPS

How Canterbury DHB delivers coordinated and integrated health services

44 Canterbury DHB has a number of major alliances that we work with.

(a) First, there is the Canterbury Clinical Network that is the coordination function for the primary and community system and a key interface with runs the health system.

(b) Second, we have a district alliance. If you have a contract with Canterbury DHB for service delivery, for example if you are Southern Community laboratories and we are purchasing pathology services, we will have a contract for services with you. That contract will also link up to the district alliance contract, which you have also agreed to be part of. So you are one of the district alliance partners, and you have a contract to service in that framework. This means that the district alliance (all of the partners) has some say over how services are delivered, what the outputs are that are being delivered and the outcomes to be measured and monitored. Mental health services are funded through this alliance model.

(c) Third, we have service alliances.

45 The district alliance contract is a proper alliance agreement that is based on some of the commercial licence agreements in the Australian construction industry. There are two ‘twists’ to these contracts.

(a) Firstly, DHBs (by virtue of their statutory role) cannot contract out of their ability to say no. This means if the district alliance collectively says it wants to fund a service the DHB could say ‘no’. But in practice it has never done that because it would undermine the relationship of the alliance. Our way of working with the alliance is to be part of all of these conversations as a funder so we can consider how to fund services or explain to the alliance why the DHB cannot fund certain services based on policy objectives or the like. We can then work with the alliance to develop services so there are no surprises about what our alliance partners wish to fund.

(b) Secondly, we have a large umbrella alliance and then have service alliances underneath. For example, there is a laboratory service level alliance where we have two laboratories working together with numerous clinicians who help us make a decision about what we should invest in and set the priorities for the laboratories, for example, priorities in pathology testing. We want clinicians together at the table so they are included in our decision-making processes. However, we insist that clinicians do not bring their organisations’ interests to the table. We do not have representatives at the table. We are quite clear that each person is there as a participant, with their perspective and expertise. We want a range of perspectives at the table so we can collectively make better decisions.

To make this process work, we get all participants to sign a memorandum that includes a charter. The charter clearly sets out the terms, conditions and principles that underpin the decision-making process, and that each person has come to the table to work with the group to make a decision. There is no voting in the alliances, it is all done by consensus. We have found the charter is quite powerful in terms of getting people on the same page.

46 The alliance based model has also improved the commissioning of our mental health services because of the operational processes discussed above. The deliberation process reflects how we work: in an alliance arrangement, that is open and transparent. Everybody knows how everybody else has been funded. We are all working together with a shared purpose and shared outcomes and we know the basis on which we are making decisions.

Key lessons from Canterbury DHB's establishment and operation of partnership arrangements

47 The key lessons in establishing and operating partnership arrangements is the importance of working together to establish a shared vision and a shared set of principles. Data and it being visible to all members of the partnership is also important as it ensures that everyone is on the same page and can deliver outcomes without the system being prescriptive about how outcomes are delivered.

COMMISSIONING

Commissioning approaches to support new care models

48 To commission new care models, an essential part of the alliance model are co-design processes. We have moved away from request for proposals (**RFPs**) and tenders and those contracting principles. We hardly ever use these anymore. Occasionally for very specific services we may do an RFP. For example, we just did an RFP for fertility services. But generally, what we do is get everybody in the same room, understand the problem collectively and allow innovation through a co-design process.

49 When I first established alliance contracting in Canterbury DHB, I had to work with the Commerce Commission and the Office of the Auditor General because there are rules of purchasing in government. This work was required because in the alliance model, necessarily everybody at the table is conflicted, because they are the people delivering services. The service design is done at the table. However, the commissioning is undertaken by the planning and funding function at the DHB. This ensures that the co-design and the planning/funding functions are kept separate. It means while we may co-design something together, my team will then engage around the purchasing because otherwise there would be commerce sector issues.

50 Secondly, the Office of the Auditor General have a view that all of the government rules around sourcing and processing are ultimately about getting value for money. As a health system we can generally step aside from these constraints because health is difficult. The Office of Auditor General was of the view that the way Canterbury DHB used the alliance process was going to get better value for money. (The Auditor-General's office walked alongside our alliance for about four years and sent a special

auditor to review how the alliance was working to form this view). This was because the alliance was open and transparent and used multiple providers. For example, we have three providers undertaking our community services. It means that my team and I can consider which of these providers are operationally more efficient and can then get this provider to teach others how to run things more efficiently. It has enabled us to constantly improve the efficiency of the system because we are running it in an open and transparent way.

Commissioning preferences to incentivise prevention and early intervention

51 In the past, I was considering commissioning approaches for mental health and working with some of the US models. The US was doing capitation type models. A capitation model is where there is funding allocated per annum for a person. These allocated resources are based on a person's demographic profile and services are provided with a certain amount of money to work with. However, in the US, they discovered capitation type models do not work well for mental health. This is because when you deal with mental health you have people with different health seeking behaviour. If we used a capitation type model for mental health, then we would end up funding a provider who does not necessarily see any patients because the patients do not turn up. In the US, they took mental health out of the capitation model and funded more on a fee for service type basis because they found that patients with mental health issues did not seek out care. The funding models had to change to provide incentives to the service providers to provide the care rather than there being incentives for patients to seek care. When I consider funding models at the Canterbury DHB, I consider the incentives for everyone. The incentives need to be kept simple and be a driver for services to be provided.

52 In terms of incentivising prevention and early intervention approaches, the way we incentivise those is by working between the mental health organisations and primary care. If we do not have mental health organisations and primary care in the same room, we miss the ability for prevention and early intervention approaches. Frequently, if you really want to do prevention and early intervention, the root end is not through a mental health provider.

53 Prevention and early intervention usually occur through general practice and primary care. That is why we are doing the work we are doing with schools through the Mana Ake service. To get that early intervention, we are identifying in a different setting people who need help and then facilitate their access to mental health services, including providing the appropriate workforce. The Mana Ake service is enabling us to get early intervention for school students. This is because it is the schools, parents and general practice that identify if that there is a problem and then the non-government organisations are funded to best respond to that. We have no waiting lists or waiting times. Children get an immediate response from the service providers we fund. The

providers then structure responses that are relevant for that child in the context of their family, as opposed to some pre-specified package or program.

INTEGRATED RESPONSE

Providing an integrated response to minimise acute hospital admissions

54 In New Zealand, we only partially subsidise primary care. This means patients pay to access general practice services. We have organised it in a way that our patients may pay for their initial consults, but if a general practitioner identifies that a patient has an acute problem that needs treating, then the DHB picks up the cost from that point forward. This means we can remove all the barriers to treatment.

55 The way we have organised the system as an overall concept is to provide wrap around care and clinicians to all our patients and have them access a whole range of tools. We do not say this person has depression so we must deliver the following prescriptive services or this person has chronic obstructive pulmonary disease so the following treatment must be offered. What we do instead is work out what treatments are going to work and then have the person decide what will work for them. We then fund this treatment from the system.

Integration around the interface between hospital, primary care and community services

56 Integration around this interface is about putting the patient in the centre and building services around the patient. The health system, irrespective of whether it is primary care and community services, is encouraged to deliver the right health services to a patient which is backed up by hospital specialists who are comfortable with giving primary care and community services control over patients and providing advice when they are needed. We have removed the bureaucracy around moving people into and around they system services and changed the focus to be about integration rather than who organises the service. A key lesson has also been about the importance of good data and building evidence and removing financial incentives and issues of money and funding from the table. From my perspective, the wrong place to start is a focus on contracts and funding. The focus should begin with building the system around patients and how they flow through the system and then resourcing this.

REGIONAL COMMISSIONING

The strengths and limitations of regional approaches to planning and commissioning

57 The strengths of regional approaches can be that where there are big regions, you can build various sizes in respect of capacity and capabilities where the patient is at the centre. You can assess what services are on the ground and what generalist models

exist and then build specialised services. Regional approaches can often by about duplicating the capacity and capability of services for smaller population groups.

58 The weaknesses of a regional approach are that you still have to be able to nuance the service for a person and the context which they live in although this can be mitigated. A limitation with regional planning is patient travel time, which we try to avoid because we know that travelling large distances creates risk. We also need to avoid creating service inequity for patients. For example, patients may not get the same level of service if they are further away from an oncologist unit than those who live close to it.

59 Canterbury DHB has about 578,000 people in it. The evidence from the World Health Organisation suggests that anywhere between half a million to a million people is a natural health economy. Once you get bigger than a million people, the evidence is that you lose connections and that medical providers do not have relationships with each other. Additionally, any smaller than half a million people and you run into capacity problems in having enough people in the sector to offer treatment and connections to treatment in the health system.

60 My team also conducts the commissioning for the West Coast DHB and has done so for the last decade. The West Coast DHB sits on the other side of the South Island and contains 32,000 people. It is a very long and skinny physical area and runs for a distance comparable from Auckland to Wellington. The people that reside in this DHB region are very disparate and spread out. It is the most rural population in New Zealand by a factor of 10.

61 The way that my team and I work in commissioning for the Canterbury DHB and commissioning for the West Coast DHB is to use the capacity and capability of Canterbury DHB to support delivery of services to the West Coast region. However, the West Coast has its own DHB and that is because services need to be designed specifically for services for that local community. However, West Coast DHB is leveraging off Canterbury DHB's ability to test different capabilities, our specialist expertise, our ability to run systems because when you are only dealing with a population of 32,000 you cannot do this on scale. However, what can be done for a population of 32,000 people is custom design of services. The model of working with West Coast DHB has been extremely successful and stabilised the West Coast given the challenges in maintaining health services for a smaller population over a disparate geographical area.

The role of governments in driving system planning, coordination and quality care when commissioning decisions are less central

62 I have discussed the role of government system planning and coordination in paragraphs 16 to19 above.

63 In New Zealand, we also have a Health Quality and Safety Commission. This is a central government agency who supports clinicians, providers and consumers to improve health and disability services around the area of quality and safety improvements. The Commission measures benchmarks in the health system, monitors and reports on quality safety, builds sector capability for quality and safety, provides oversight and so on. The Commission runs series of programs around key issues such as infections, surgical infections, fall prevention and so on, in a community based setting.

The accountability framework of DHBs and the management of performance issues

64 DHBs operate under a single accountability framework. This framework exists in an operating policy framework provided by the Ministry of Health which provides the DHBs with a statement of expectations and a statement of performance expectations each year and is captured in the Crown funding agreement and the *Health and Disability Services (Safety) Act 2001* (NZ). Canterbury DHB, like all the DHBs, draft an annual plan guided by the operating policy framework provided by the government which is provided to the Ministry of Health and signed off by the Minister.

65 In managing performance and accountability issues, there are two parts to what we do at Canterbury DHB. Firstly, we have a regular operational meeting with representatives of the Ministry of Health where the DHB and Ministry are able to raise issues in relation to a performance matrix which is created by the Ministry of Health to measure and compare the performance of New Zealand's DHBs. The Ministry of Health in recent times have been implementing a 'balanced school card approach' (which is a strategic management performance used to measure outcomes and performance for organisations).I think the Ministry of Health may still be hampered by the fact that they do not have the same data reported to them as can be collected at the DHB level. This means the data the Ministry has is not deep or broad enough to enable the Ministry to fully achieve the work they do. I suspect data collection will probably be fixed over time by the Ministry.

66 Secondly, there is a direct relationship between the chair of the DHB and the Minister of Health. The Minister meets with Chairs on a regular basis and advises what direction the DHB is required to go and what the DHB is to achieve in terms of objectives and outcomes. One of the Deputy Director-Generals of the Ministry who is accountable for

DHB performance meets with representatives the chief executives of all DHBs to provide guidance.

PURCHASING AND PAYMENT MODELS

Budget allocations to DHBs

67 Budget is allocated to DHBs largely based on population funding. There is a formula type model that takes account of demographics and other indicators such as age and necessity of health services.

The purchasing of services by Canterbury DHB

68 As indicated above, I have ceased using funding and incentive structures when contracting and purchasing services at Canterbury DHB. In fact, one of my first initiatives when I joined Canterbury DHB was to stop using any of these funding mechanisms such as price volume schedules, fee for service , financial incentives or penalties.

69 Canterbury DHB is required to report to the Ministry of Health on the basis of spending mechanisms, however, we are not funded based on spending mechanisms. We are required to provide the Ministry of Health with a production plan and report to them on a Price Volume Schedule, which is like activity based funding. A Price Volume Schedule is how DHBs are required to provide information to the Ministry of Health about expenditure, activity plans to meet local demands for health services and government priorities. We provide the Ministry with reporting around healthcare and the aggregate volume of services to be purchased or provided and their cost.

70 Based on the Price Volume Schedule model, when I arrived at Canterbury DHB, there was a model of thinking so deeply embedded that our main acute hospital would not do anything unless you said how much extra money they were going to get. For example, where they had delivered 356 services, if you want the 357th you have to pay for it. In my view, that was not workable because DHBs are population base funded. This means the DHB does not get additional funding from government if the hospital seeks additional funding to deliver the 357th service using my example above.

71 As a result, in 2008, I sought approval from the Canterbury DHB Board to stop internally using a Price Volume Schedule. However, we continue to have a volume schedule which is built up based on the predictive analytics of what we will need to meet in terms of patient demand. This enables the internal provider to plan and acts as the platform for innovation as there is always a mismatch between demand and capacity thus, we have to come up with new ways of meeting the patients' needs.

Funding and incentive structures

72 At Canterbury DHB, we allocate an expenditure budget to our own provider arm that runs the hospitals and specialist services. This budget has been built up from Canterbury DHB's understanding about what our population may require in respect of health services and what resources health services need to provide services. Following the allocation of the expense budget, the health service has flexibility about how they deliver the services they are required to deliver. If the service can provide services in a more efficient way based on this level of flexibility, that is encouraged.

73 As such, Canterbury DHB does not use funding and incentive structures. The basic problem around those funding and incentive structures is that services saw that the only way they could get more resources into the system was by doing more. However, we do not want a hospital-based system to do more. At Canterbury DHB, we want the hospitals to work within an integrated system so that we build better community-based care to ultimately have less hospital admissions. In fact, it was not possible to seek integration while the hospital-based system insisted on performing various assessments and follow ups. The thinking was that they needed to maintain the volume of work, otherwise they would not get a new registrar.

74 We had to break that link in order to begin engaging and working with primary care to build health pathways. The idea being that hospitals may not need to see patients if general practitioners are given the right information or supports to deliver the treatment in the community.

Payment arrangements that can encourage or discourage providers from meeting the needs of complex, disadvantaged and hard-to-reach consumers

75 The objectives around payment mechanisms are about setting incentives and measuring outcomes. Payment arrangements can be problematic in ensuring that health services are offered to all people throughout a population. For example, a health service may have a payment arrangement to ensure a certain people aged over 65 have a certain vaccine. However, based on the payment arrangement, a health service may take a position where they vaccinate white middle class people over the age of 65 to access the goal in their payment incentive, but may avoid working as hard to get people over 65 vaccinated who are from a more disadvantaged part of the community and may be more difficult to engage. This is why we have to be very careful about the way we fund health services and organisations to make sure that not just the easy goals are met. This is because ultimately, as a collective, we want to ensure that services and possible outcomes are delivered to the most vulnerable people in our community first.

76 We measure the complexity of what we deliver. As such, in our model, providers are seen as delivering better outcomes if they have delivered services to the people in our community who may be disadvantaged and be more difficult to engage. As soon as you make these things visible, you can get people to do things that need to be done.

Payment arrangements that encourage or discourage evidence based practice

77 In terms of funding, Canterbury DHB tend to get all relevant stakeholders in a room to decide what health services require funding. We then organise the funding to support these health goals. We design health pathways on the basis of what is best for a patient (taking into account the evidence) and then organising the system and the resources to support the delivery of this pathway. If the work is organised in this way, then we inherently have an evidence-based practice.

78 Additionally, evidence-based practice underpins the way we fund our health system in Canterbury DHB because we have openness and transparency about our funding. The push is always asking how we can do better and what the evidence is saying. This is based on the culture we have created of integration and health pathways. For example, we have a clinically-targeted program in New Zealand called ‘Choosing Wisely’. The idea behind this program is to encourage clinicians to make best use of the evidence so resources are not ultimately wasted. The concept is targeted: – we encourage clinicians to, for example, not perform a CT scan if the evidence does not support a CT scan being used in that clinical circumstance. However, if a clinician does not perform that CT scan, then the other medical tests (or whatever is clinically required based on the evidence) should be performed and should be more available under this model. The general idea being, if we can do less of one thing, we may be able to do more of another thing if it is supported on the evidence.

Payment arrangements that encourage or discourage the development and use of new and emerging technology

79 The risk that all health systems face is complexity. It is tempting to try and create payment mechanism that incentivise certain responses, drive certain behaviours or manage the funder’s risk. However, in a complex system they may all fail and ultimately become perverse. Simple allocative mechanisms that create certainty for the provider particularly if they are a small business or an NGO create the best platform to enable innovation and the use of new technology.

PERFORMANCE MONITORING

Canterbury DHB's current performance monitoring arrangements

80 Canterbury DHB uses a statement of intent in respect of its performance monitoring arrangements which has worked very well because the statement of intent is oriented towards outcomes. This means our system, when it has been conceptualised and drafted, has been structured in terms of meeting these outcomes. We have also found using statements of performance and expectation have been very good in setting these goals and outcomes clearly.

81 The other performance management arrangement that I consider has been a highly effective way of monitoring the system is setting system level measures. I consider these to have been a major breakthrough and we would recommend their use by other health bodies. What system level measures achieve is to identify needs that the system has to deliver on. The Ministry of Health may set a health goal, but each local health system then figures out how they are going to achieve the outcome as set by central government. Canterbury DHB has designed contributory measures to be able to measure the health needs in the system at a lower level all the way up to a broad system level.

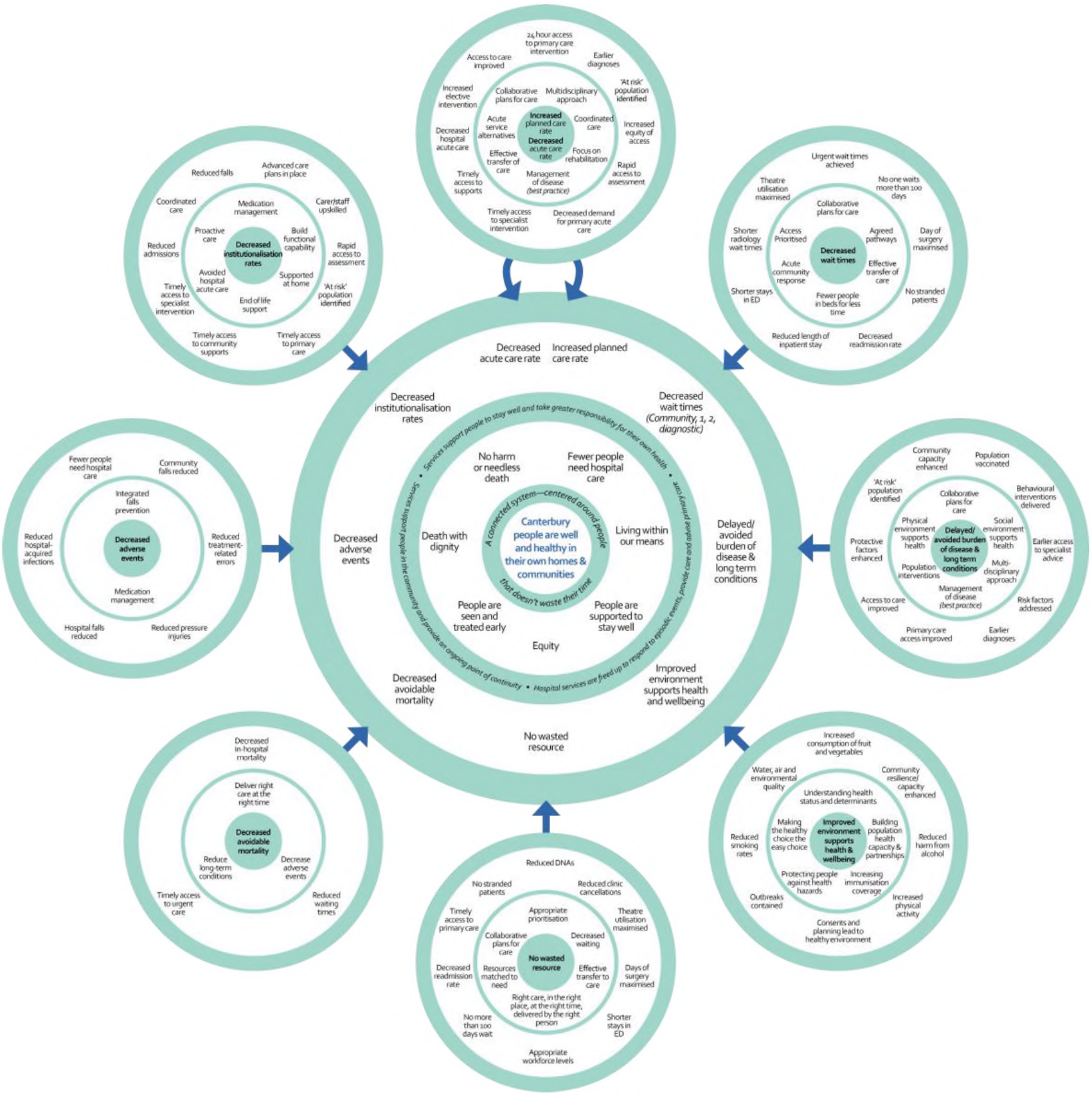
82 For example, if at the system level outcome, we are hoping to achieve a reduction in acute hospital admissions, we can then consider the data to analyse what is driving acute admissions. We then can identify why there may be a cluster of acute hospital admissions. For example, through data analysis, we were able to recently see a rise in hospital admissions for children because of dental issues (which happens to be an issue the Canterbury DHB is attempting to provide services around at the moment). We can then consider from a system level, what we may need to be implement at an early stage for children to address dental issues and to reduce the need for children to be coming to hospital in respect of their teeth. System level measures are a brilliant way of monitoring the system, and getting everybody focused in the right direction.

Capturing outcomes and experiences that are meaningful to consumers, families and carers

83 The implementation of system level measures as discussed above, has partly been a way to drive meaningful experiences for our consumers and their families/carers. However, that is more nationally driven.

84 On a more local level, in 2014, Canterbury DHB has developed an outcomes framework. This has some similarities to how data is used for the system level measures but pre-dates the implementation of that system. The outcomes framework recognises that Canterbury DHB operates in an integrated system. This means there is

no attribution because as an integrated system, everything has contributed to a health event. Essentially, this outcomes framework includes a series of system level outcomes which are broken down into a series of lower level outcomes and strategies to achieve them. The framework can be demonstrated by the diagram below:



Levers and structures to ensure approaches to performance monitoring evolve

85 In my view, the most important factor for ensuring the continuous evolvement of approaches to performance monitoring is to move away from the concept of targets. This is why the system level measures have worked so well, because it is not a target-approached model and instead, focusses on outcomes. In my experience, what happens with targets is that the 'target' may be hit but may have completely missed the reason why the target was set.

86 For example, one of the targets we had in New Zealand was a 'six-hour target' where the target was to get people out of an emergency department within six hours. I

understand Australia may have a similar target but based on a four-hour period. Ultimately, in New Zealand, this meant that our providers were coming up with fairly interesting models about how to get people out of the emergency department to ensure that they achieved the six-hour target. But these models were not necessarily delivering better care to a patient. In actual fact, what we saw occur was an increase of admissions of patients into hospital for surgical procedures that were ultimately never performed. This was because this was an easy pathway to get a patient through the emergency department and to ensure the six-hour target was met.

87 This type of example is the reason why New Zealand stopped using targets – because they became an end in themselves. Instead, we consider the better way to consider the health system is to have a balanced metric approach. For example, you cannot look at the length of a person's hospital stay without looking at readmission and mortality rates. A balance is required.

QUALITY, SAFETY AND REGULATORY APPROACHES

The regulatory environment and how it has assisted or hindered Canterbury DHB in providing services

88 While I am not best placed to respond to issues around the regulatory environment, in my view, the biggest issue in terms of regulation for Canterbury DHB in providing services is in navigating around the relevant privacy legislation. This is manageable if the problem is understood, but in my experience, privacy legislation is not well understood and can be an ongoing barrier to us being able to roll out some of the work we want to do. For example, people have used privacy issues as a barrier to sharing information that ought to be shared and can legally be shared.

89 Another regulatory issue sits around issues relating to pharmaceuticals and constraints on the use of various pharmaceuticals. For example, in New Zealand you still have to have a piece of paper with a signature on it for a prescription. However, in a modern society, we have to reconceptualise how to prescribe medication without it needing to be paper-based with a signature.

90 Finally, regulatory issues around clinical accountability and moving away from traditional hierarchy are important in my view. We need to move away from doctors thinking they are more accountable than other health providers, such as nurses. All health clinicians that have been involved in some part of a person's healthcare should be accountable for their actions and decisions.

LIVED EXPERIENCE IN GOVERNANCE

Engaging people with lived experience in decision making

91 In respect of mental health, at Canterbury DHB, we have people with lived experience on our service level alliances. This means that people with lived experience are part of the design process for health services and in the resource allocation process. We ensure there are always at least two consumers within our service level alliances and we never have just have a lone consumer. This is because we appreciate that these alliance meetings can often have multiple health sector people talk jargon and can unintentionally leave people out of the conversation.

92 People with lived experience also sit in our Community and Public Health Advisory Committee (which is a statutory sub-committee of the DHB).

93 We also have a consumer council. This enables us to get a consumer perspective without necessarily putting consumers into clinical design processes without giving them good supports. The consumer council is like an umbrella organisation that enables and supports people working in the service level alliances. We always make sure there are at least two consumers.

94 We also employ people with lived experience in our mental health service and ensure that there are people with lived experience at all levels of our mental health service, be it as part of the executive leadership team, our clinical processes or down to the more ground level service delivery. People with lived experience are part of the decision making in terms of how mental health works.

95 The strength of this approach is that it keeps people grounded. In my experience, it can be very easy for health systems to become paternalistic and think that they may 'know better'. I found that our mental health system at Canterbury DHB was ahead of the rest of New Zealand's health system in respect of bringing in people with lived experience. I consider it has also brought real value to our mental health system because it has challenged people's assumptions about how consumers wish to receive mental health services.

96 The weakness of this approach is that the people with lived experience are a person of one. They have their views. They do not necessarily represent everyone's view. How we keep this balanced can be challenging at times.

RESEARCH, EVALUATION AND INNOVATION

Embedding innovation cultures and 'cycles of learning' into collaborative governance structures

97 Health systems by nature are often hierarchical because organising systems in a hierarchical way is often very efficient. However, one thing we have done at Canterbury DHB is to build networks across these systems. This means we have networks of clinicians, who do not have a role in the hierarchy, who work together as part of the innovation and co-design of our health systems. This has been an effective way to allow for innovation to happen on a hierarchical structure where these networks of coalitions are backed either by myself or the chief executive to get things done and make change..

98 For example, we may want to redesign health pathways relating to gynaecological issues for women. We then hold a number of meetings, say five meetings, where we bring gynaecologists, general practitioners, allied health practitioners and any other relevant staff together in the same room and redesign health pathways to address the issues. Once we hold the five meetings to re-design the health pathways around this issue, we move onto the next health issues to ensure we keep momentum moving, particularly knowing we can come back later and fix or tinker with the health design pathways once we know how they are tracking. We can evolve that system rather than getting bogged down debating changes or trying to perfect the changes to a health pathway from the beginning.

DATA COMMONS AND DATA SHARING

The role of data sharing in facilitating more integrated care between services

99 In the South Island of New Zealand, we have a shared electronic health record called HealthONE . This is an electronic and centralised record that pulls health information out of everybody's health records. This means if you are sitting in general practice, HealthONE can poll that general practice and pull out information relating to various issues or themes. HealthONE also has immediate access to hospital-based information and community pharmacy dispensing. For example, every time a prescription is dispensed in a hospital or a community pharmacy that information immediately is placed on HealthONE.

100 HealthONE works like this: I may be a doctor sitting in my general practice looking at my patient management system (which in New Zealand is likely to be a program called MedTech). On that patient management system I can push a certain button that will pull up an individual patient's entire health information so I can have access to all sorts of health data relating to that patient (for example, radiology results that are publicly and privately funded, any lab results, any medications that have been prescribed and so on).

If a person is on a shared care plan, advanced care plan or an acute care plan, this is also included on the patient management system.

101 HealthONE was initially difficult to establish because it contains the holy grail of people – all of their information – and there were privacy concerns. People had concerns, for example, that they did not want their pharmacist to know about their liver function test so the pharmacist could not sell them a herbal remedy. These issues essentially were based around trust. To counter these issues, we built up a privacy matrix around information available in that record. So if you were a general practitioner you could see all of a person's information, however, if you were a physiotherapist for example, you could only see parts of the health information that related to a person's physiotherapy needs. This almost 'need to know' basis for clinicians got the health system over the hurdle around people's concerns about their health information being shared on HealthONE.

102 HealthONE requires consumers to 'opt out' rather than 'opt in'. This means that everyone on the South Island of New Zealand is included in HealthONE unless they have explicitly chosen not to have one. If a person seeks to 'opt out' they are provided a free consultation with a general practitioner who explains the benefit of having HealthONE. This discussion appears to have helped consumers understand the benefit of having their health information available electronically. For example, if a person has an accident or becomes unwell and ends up in an emergency department, their health information can be readily accessed to ensure they are provided with the best individualised care possible. If a person still chooses not to have the record, we then drop them off the electronic record. A person can also 'opt out' in part. They may, for example, indicate that they do not want any mental health information to be visible. However, the 'opt out' rate is low. Across the almost 1.1 million people that live in the South Island (HealthONE only exists in the South Island) only about 800 people have elected to opt out of HealthONE. However, it seems to me that increasingly our entire population has given us the social license to store their health information in this way.

103 In terms of mental health information on HealthONE, it sits behind a thing called "break glass" because there was so much concern around people admitting they had mental health issues feeling the need for it to be hidden. The "break glass" worked like this - if a general practitioner opened up a client's records on the patient management system, it would tell a doctor that the person had a mental health record. However, the doctor was required to check another box to confirm that they were allowed to look at the mental health information and this was recorded on the patient management system. This ensures there is clinical accountability around a clinician having the requisite permission to look at a patient's mental health information to provide treatment. The reality is that we have now been asked by clinicians and consumers to take away this additional

accountability level. Clinicians and consumers are concerned that because of the extra 'break glass' clinicians are scared to look and the practical result is that people's mental health issues (which are relevant to their care) are being missed.

104 Another concern around this "break glass" for mental health records on HealthONE is that it also tended to promote this idea that mental health is different to other forms of healthcare. In my view, that just should not be the case. It was sensitivity around mental health information that led to us imposing the "break glass" on HealthONE. However, the requests from both consumers and clinicians to remove the "break glass" demonstrates that the culture around mental health has evolved and shifted and that we are increasingly seeing mental health as being part of a whole picture around a person's health and wellbeing.

105 We run a live auditing process over HealthONE and to date in eight years we have had no great problems about any inappropriate release of health information. The system has also been built to try and emphasise clinician accountability as discussed above. So if a clinician looks at a patient's health record and they should not have done so, the clinician will get a notification from the system indicating that the clinician is not delivering any care to that patient because the patient is not enrolled with that clinician and asking why they have accessed the record. It means that a clinician has to really consider whether they should be looking at the health information.

106 The second part of our data system is the data we have at the DHB level, which we use to run the health system, as discussed above. We use this data to support what we call a 'purpose-use matrix'. Basically, it means that for a certain purpose we can see initial identified data from the NHI which is deidentified. For another purpose, we may only be able to see aggregated data. We have a framework about this data and its collection, and we have consulted our community about the collection of this data and the rules by which we can look at the data.

Essential requirements of contemporary data/IT infrastructure in enabling integrated care

107 I have discussed contemporary data infrastructure above. However, in respect of IT infrastructure, the world has moved on since we started our journey of integrated care in 2007. What we could have only imagined then in terms of technology is able to be easily done now and we can easily integrate data systems.

108 In terms of managing data analytics, which is something that my team and I consider to be essential, there are also a number of key issues that we have had to face. The problem has been that in health systems there is substantial information that is siloed in terms of existing IT infrastructure. For example, there is data completed for radiology, and data completed for oncology and what we have had to do is get in to the backend of

that data, the raw data, and collate it into a data 'warehouse'. In this data 'warehouse' we have had to join the raw data back up again to be meaningful for our analytics process. We have had a lot of vendors in the IT/data analytics space who have not wanted to pull raw data together in this way because it prevents them from selling us reports. However, I do not want 'canned' reports where data is analysed in certain ways. What I am looking for is more data, and the ability to pull that data into my ecosystem and then look at it and analyse it in different ways. I can then also apply any kind of analytical tool over the top of the data. I think where people have gone wrong is that they have bought into analytic systems, and they put everything into an analytic system, and then they are dependent on that system. What we have done is pulled everything into a data warehouse, which gives us control over how we manage the business rules, how we connect data, and then we can choose whatever analytic tool we like. As a result, the data can tell us different things.

WORKFORCE

Challenges in achieving integrated, cross-disciplinary professional practice

109 We have different workforces employed in different settings. One of the biggest things we have had to overcome is respect. For example, often those in hospital-based settings may incorrectly believe that general practitioners do not really know what they are doing because they refer cases to hospitals. This means we have had to spend time rebuilding relationships across the health sector. One way of rebuilding these relationships is through the co-design process where we have collaboratively built health pathways. General practitioners were deliberately very involved in that health pathway process. When we commenced the health pathway process, over the first two or three years, we had 180 different general practitioners working with different groups (for example, we might have had seven general practitioners working with gynaecology and another six working with cardiology and so on). We also had some general practice leaders, so champions who were highly respected, working on the health pathway process in a room with others to solve a problem jointly. As a result of this process, people began to improve their level of respect.

110 In my view, one of the biggest change mechanisms is conversation. If we can get our workforce into conversations, we can easily change the health system. We used to be accused as a health system of overly having a meeting culture. The reality is those conversations are what actually made the health system work.

111 Because we invested quite a bit in the early stages in having these conversations, now we can redesign pathways rapidly. We do not need to have big workgroup programs unless we are doing something very innovative. We have also built trust around how we

design health pathways – that is having built trust our processes and having built trust across our workforce.

112 In my view, in terms of building collaboration in our workforce is moving past official boundaries. In terms of how we built up integration, we first began with just hospital based medical staff, then doctors, then community-based structures. We then brought in nurses and then allied health staff. It is now assumed within our health system that they will have every different type of staff in the room to recreate parts of the health system.

The 'optimal scope of practice' for professions to individually and collectively work together

113 What can help professionals to work optimally on both an individual and collective level is building the health pathways, the electronic request management system and shared health records. This has given our workforce the best tools they need to do the best work they can. It has also enabled our workforce to seek advice and collaboration from others in the system. For example, we have put respiratory clinicians into general practice who see patients alongside the general practitioners. This means that the general practitioners can look after patients who may have more complex respiratory circumstances because they have learnt alongside a specialist. We put a lot of different professional groups and get them to work together in this way to ensure they are learning from one another. The key to everything is communication and consultation.

114 For mental health, we have a consultation liaison model. Virtually or in real time we can offer mental health specialists to work with other parts of the health workforce so they can deal with mental health issues alongside other health issues. We also have a specialist mental health workforce working in general practices and seeing patients in general practice so that they can provide earlier intervention. At the same time, the mental health professionals working in general practice are upskilling the whole team because they are part of the health conversations.

115 The other practice we do at Canterbury DHB that is slightly unusual is that we run an education program in the community. We run education programs for general practice, nurses, and pharmacists. We generally run these at different times for different parts of the workforce but on the same topic. So, if the topic is depression, then these groups of the workforce are learning from the same group of people, but we tweak the teachings for the particular profession. For example, the education for a group of pharmacists on the topic of depression may focus more on pharmaceutical medications. So, the basics in relation to these education topics are the same, but we have lifted the whole system to another level because the workforce has had the opportunity to learn in a structured way.

116 Canterbury DHB has also been through a number of disasters in the last decade such as the Canterbury and Kaikoura earthquakes, the Port Hill fires and the mosque attack. The consequential effect is that the mental health demand is quite high. Given this mental health demand and the reasons behind the demand, we are looking at integrating with other parts of our community such as the police. For example, the number of people who ring the police with the potential of committing suicide in Canterbury is very high. It sits about two or three times more than the rest of the country; however, our suicide numbers are in line with the rest of the country. What we are considering is how our system responds to people when they are distressed and how to mitigate some of the demand on mental health services. We have placed mental health nurses into our police cells in Canterbury on a 24 hour, seven day a week basis. We have also upskilled the police in terms of how they deal with mental health issues. If you get arrested by police in Canterbury, you will be given a mental health assessment. We have also got a fair amount of practice at psychosocial recovery models given the natural disasters in the last decade. We have become adept at recovering our community but also recovering our health workforce.

Composition, roles and capabilities of the mental health workforce to achieve integrated service models

117 In my view, the composition, roles and capabilities of the mental health workforce needs to change to make integrated workforce models work. To achieve this we need to work well with support workers and ensure that support workers are well supported and get access to training. Support workers now have had their qualification levels increased so they are more qualified than ever before.

118 However, one of our main issues that we are still in the process of trying to resolve is to get our specialist workforce to understand what it is like to work in a community-based setting. For example, we need to get specialist mental health nurses to understand the dynamics of general practice where you may not have an hour to work with, assess and offer treatment to a client. General practice is much shorter and is much more about how to help a patient find resources. If you think about how general practice works, a general practitioner does not take responsibility away from their patient, a general practitioner gives their patient the support to look after themselves. It has been awkward at times to try and teach specialist mental health services how to build that mindset of offering short and sharp services.

119 One of the biggest issues we struck is the perception of risk. General practice is very used to dealing with high levels of risk in the work they do. That is because they are running 15-minute consults based on the information in front of them and making treatment decisions. In other parts of the health system, the workforce is very risk averse and this is the reason why we have these overarching assessment processes to

ensure that nothing is missed. However, we need to help the rest of the workforce be less risk averse about making treatment decisions and feeling supported about these decisions. That is the journey we are still on. In my view, dealing with the issue of risk is going to transform our ability to provide services, and that will really drive the early intervention prevention model.

120 We have also designed new roles at Canterbury DHB. These included brief intervention counsellors, roles in health promotion and health coach roles.

Preparing and supporting workforces to take part in significant changes

121 The best way to prepare and support workforces is to have our workforce involved in every part of the journey when we are recreating and co-designing parts of the heath system. We have been on this journey for 12 years which means that we have seen the next generation of the workforce coming through and taking our integrated heath pathways for granted. We make sure that we educate new members of our workforce about these processes to ensure that we continue valuing and appreciating the work we have done and our achievements. This helps our workforce understand the journey Canterbury DHB has come on.

122 In terms of working with general practice, we also need to support our general practice in getting them to work in a strategic way and to get them to understand that they do not need to 'hang onto' their business model as small business owners. It seems to me that what general practitioners actually value is that they have choice over how they deliver services and care to their population and see their business model as the vehicle by which they have autonomy in the way they deliver care. However, in my view this autonomy is not dependent on this GP business model. We work with general practitioners and mental health workers, to understand what is important to them about how they deliver care and support them to ensure that remains part of their practice when we move them to different environments. This enables GPs to understand that they have control over the clinical patient relationships and that this is not contingent on the business models or contracts.

sign here ►

print name Carolyn Gullery

date 1 September 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT CG-1

This is the attachment marked 'CG-1' referred to in the witness statement of Carolyn Gullery dated September 2020

Carolyn Gullery

carolyn.gullery@cdhb.health.nz

Employment History

2007-Current: Executive Director Planning, Funding and Decision Support, Canterbury District Health Board

Accountable in this role for the planning and funding of the Canterbury public health system ($1.8 billion) and since September 2012 the West Coast District Health Board. Also leads the Analytical Function for the Canterbury Health System.

2004 -2007: Chief Executive Partnership Health Canterbury – Te Kei o Te Waka

Founding Chief Executive of the largest Primary Health Organisation in New Zealand with an enrolled population of 360,000

1999 – 2007: Health Sector Contractor | Consultant

Focused on strategic advice, strategic planning, policy advice, project management, new service design and organizational management. Clients included

- Partnership Health Canterbury Te Kei o Te `Waka
- Pegasus Health
- New Zealand Pharmaceutical Society
- North Island based Independent Practitoner Asscoation and PHOs
- Non government organisations
- District Health Boards
- National membership organisations (eg IPAC)
- He Oranga Pounamu
- Phoenix Group

1998-1999: Project Leader, Change Management and Personal Health team within the Health Funding Authority.

1998: National Manager of Primary Care Contract Implementation - Transitional Health Authority

1997-1999: Director of Pharmac (Government Pharmaceutical Buying Agency)

1996–1998: Manager, Primary Care, Policy and Contracting - Southern Regional Health Authority, financially accountable for $270 million

1993–1996: Contract Manager - Southern Regional Health Authority

1987-1993: NZ Pharmaceutical Division Manager – Abbott Laboratories NZ Ltd

1985- 1987: Pharmaceutical Representative – Abbott Laboratories

1982 – 1985: Finance industry

Academic Background

Victoria University, BSc in Psychology (1982).

Further courses in history, criminology, marketing and physiology completed.

A number of other relevant courses and papers in topics ranging from Change Management to Accounting for Non-Accountants including a short course at Harvard University in 1996 on the "Challenges of Managing Evolving Health Systems".

Publications

McGeoch G, Shand B, **Gullery C**, Hamilton G, Reid M. Hospital avoidance: An integrated community system to reduce acute hospital demand. Accepted for publication subject to minor revision by Primary Health Care Research and Development, June 2019

Epton M, Limber C, **Gullery C**, McGeoch G, Shand B, Laing R, Brokenshire S, Meads A, Nicholson-Hitt R. Reducing hospital admissions for COPD – perspectives following the

Christchurch Earthquake. BMJ Open Respiratory Research. 2018;5:e000286. doi: 10.1136/bmjresp-2018-000286

Holland, K; McGeoch, G; **Gullery,C**; A multi-faceted intervention to improve primary care radiology referral quality and value in Canterbury; New Zealand Medical Journal April 2017

McGeoch, G, Holland K, Kerdemelidis M, Elliot N, Fink C, Dixon A, Shand B, **Gullery C**. Unmet need for referred services as measured by general practice. Journal of Primary Health Care. 2017, doi:10.1071/HC17044.

Gullery, C; Hamilton, G; Towards integrated person-centred healthcare- the Canterbury Journey; Future Hospital Journal 2015 Vol 2, No 2: 111-6

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

Invited Speaker (a selection of events)

SNOMED CT Expo James Read Memorial Lecturer: Advanced Healthcare Analytics, Kuala Lumpur 2019

Primary Health Networks National Forum: Achieving the Canterbury Health System model of integrated services, Australia 2019

NSW Integrated Care Conference: New Zealand Alliance for Health Outcomes, Australia 2019

International Forum on Quality and Safety in Healthcare: Smoke Signals – how to use predictive analytics to avoid system failure, Australia 2018

International Peer Review: Healthy System Capacity Planning for the Republic of Ireland, Ireland 2018

Destravis Group: Pathways for Hospital Avoidance, Australia 2017

Integrated Health Forum: Health Integration – moving to the future, Australia, 2017

Inner Nth West Melbourne Health Collaberative: Alliancing Masterclass, Australia 2017

World Health Organisation Centre for Health Development: Global Forum on Healthy Ageing, Kobe Japan, 2013.
