Clinical Services Plan

Engagement Feedback and Responses November 2018

Summary of changes required:-

Accepted changes to be incorporated into the final CSP:

Feedback received that has been included in the updated version included the following

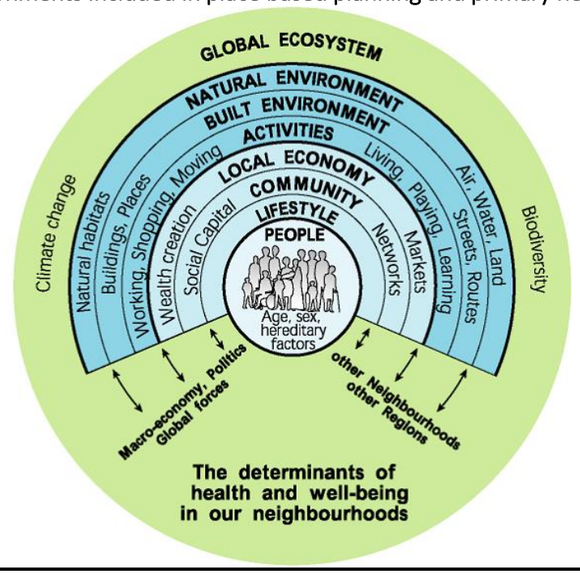
- Language changes
    - Incorrect/ lack of use of the Te Reo Māori. An example includes the description of using Māori health model, Te Whare Tapa Whā but thereafter only using English to describe the four dimensions and not Te Reo. This has now been incorporated into the plan.
    - Terminology or spelling corrections
    - Definitions: including extra definitions such as “Equity and inequity”
    - Clarification
    - Enhanced elements/options

- Additional paragraphs/section to the CSP
    - Environmental sustainability – Not originally covered, but have now included reference this as part of determinants of health and impact on inequity and long term conditions.
    - Dying well – Not originally covered, but have now included under person and whānau centered care and wraparound services.
    - Preventative care/population health/public health – covered within the “plan in a nutshell” but was not sufficiently covered within the plan. This has now been carried through and developed within the plan, examples include the three pillars of health (diet, exercise and sleep).
    - Behavioral economics – Linked to the above as part of understanding the consumer and their needs.
    - Early intervention to dementia – has been added.
    - Tamariki (Children) and Rangatahi (youth) - as a key focus of the plan, this was deemed too implicit and required further development within the plan.
    - Support services – previously community pharmacy, radiology, laboratory and dietitians were not sufficiently covered. It is recognized that these services may need to change to support the new models of care and therefore have now been included through relevant sections of the CSP.
    - Place based planning – Whilst important to recognise community needs by geography, it was also highlighted that the plan did not include “communities of interest” being cohorts of consumers with similar health needs and not necessarily within a geographic area. Applying the same approach and principles used within place based planning would fulfil this requirement.

Ref	Received Feedback by Community	Response to Feedback
1	No plan for people in outer areas or rural people	Feedback Acknowledged. This is addressed through the theme of Place based Planning on pg17 -19 of the Draft Clinical Services Plan through collaborative place –based approaches working with community to identify their needs.
	Increasing hospital bed numbers for the increasing population in emergency acute areas	Feedback Acknowledged. This is addressed on pg 41 through the theme of the Hospital Takes a Narrower Focus whereby reducing the demand on the hospital through good alternative in the community that are easy to access. Only people requiring resuscitation or specialist medical assessment and care that only an emergency department can provide.
3	Confirmed captured main issues and nothing else to consider	Feedback Acknowledged
4	What about transport to/from hospital for disabled and elderly. Will services be provided locally?	Feedback Acknowledged The plan does not specifically mention transport but should further discussions within the theme of Working with Whānau to Design the Services They Need identify transport as a priority – this could be reviewed during the more detailed planning processes.
5	Yes i think you have done a great job. Issues to consider for CHB • The use of technology for Recruitment and attraction of GP's and nurses. • Better hours for doctor visits needed - 5pm finish is no longer the norm • We need competition to create change in GP service I think we can do more with our health centre and it could really become a health hub - build on and up Contracting for health services in CHB needs to be more transparent and connected - always seems like it's a bit competitive and the only people who suffer are the community they serve This is my second bit of feedback – sorry I totally forgot to mention it the first time! After some further thought, one thing I think was missing from the plan was the intention to ensure there is sustainability in regards to maternity services especially in rural communities like Central Hawke's Bay. We have been working locally in Hastings (who is amazing) to see what we can do from a community perspective to ensure that mid wives want to continue working in CHB so that our mums don't have to travel. We believe that there is so much more we can do locally to ensure that we provide a hub of care for mums, dad, and babies and further than that – right through to preschool education. We would love the support to really do this work well and believe that concentration in this area can provide valuable learnings and set a good example/model for further health services moving forward. Imagine a maternity hub based at the health centre, with the well child providers (both of them working together) with wrap around community support services like parents centre, play centres etc and day care for further education and support past maternity care. Thanks for the opportunity to feedback	Feedback Acknowledged Issues raised will be addressed through Place based Planning on Pg 17 to 19 (see above), Evolving primary care on pg 20-23, Working with Whānau to Design the Services They Need on pg 25 -27. The plan also mentioned the key enablers required such as growing our workforce and better information and Communication Technology to support the strategic direction of the plan on pg49-50.
6	I have read the brochure and am not impressed with the plan. Numerous people manage their own health now as I do so nothing changes here.	Feedback Acknowledged. Noted.

	Older people - self management, you are joking…. I have had to do this already so what is going to be new??	
7	Thanks for the opportunity to comment on the draft CSP. I like that the feedback from both patients and clinicians has clearly informed the recommendations, which should put to rest any thoughts that the outcome was pre-determined. The nine themes reflect this, are generally appropriate and the timings have been given thought. I'm particularly pleased to see actions here that will improve patient safety and quality care, for example physician rounding on surgical patients and well supported transitions of care from secondary to community care. Investment in IT including mobile devices and secure messaging will help. I appreciate that the CSP cannot discuss the "how" we will achieve the goals of the CSP, but there are some obvious risks I thought I should raise at this point, for future reference. We can learn from others' experience of implementing many of the recommendations in the CSP. Among these the recent Nuffield Trust report is required reading: https://www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf. The report is an in-depth review of 27 initiatives designed to move care out of hospital. Many of the initiatives improved, or were likely to improve, patient care and experience and are worth pursuing for that reason alone, even if they did not reduce costs overall. Successful initiatives in general: • Targeted particular patient populations, such as those in nursing homes or the end of life. Within the CSP this could include increasing medical and NP support in ARC and advance care planning (NB the correct term is advance care (as in care in advance), not advanced care). • improved access to specialist expertise in the community, or at the front door. Within CSP this could include making the on call physician or surgeon available for GP phone calls (highly desired by GPs), increased nurse practitioners, working at top of scope, extending SMO hours on acute call in ED and medicine in particular. • provided active support to patients including continuity of care. E.g., Clinical Nurse Specialists in heart failure, COPD and diabetes • appropriately supported and trained staff. Many examples, e.g., engaging effectively with Maori and via clinical pathways. Ngātahi offers a useful approach. • addressed a gap in services rather than duplicating existing work. Chronic pain is an obvious example for us currently. The Nuffield Trust report notes the frequent UK experience, and strongly cautions against, over-optimistic assessments of • barriers to change, costs of change, how long change takes, facilities, workforce development, analytical capacity and community-based services revealing unmet need (commonly under-estimated) • likely savings in admissions or costs (commonly over-estimated, eg using prices rather than costs, over-estimating overhead savings). Nuffield caution against over-estimating the savings from "The hospital tak(ing) a narrower focus in future". Consultant clinics in the community increased costs and many of the initiatives suggested in the CSP had mixed evidence at best in particular in terms of saving costs. • failing to genuinely identify patients at greatest risk of hospitalisation, a risk with under-trained staff and failure to properly apply evidence with fidelity The elephant in the room is how to address the real issues of over-work and limited capacity in both primary and secondary care. Nuffield Trust noted that adding work to already overwhelmed clinicians and managers does not produce good outcomes. While it is true (CSP p35 para 3) that "…specialists will have to stop some of what they are already doing", our clinicians and managers are already over-stretched. The Big Listen indicated 45% of all staff felt their health had been affected by workload, 55% of SMOs. The Acuity tool suggests some departments are well behind on follow ups, and we have seen poor patient outcomes already as a result. Engaging clinicians in improvement and clinical governance activities is getting harder.	Feedback Acknowledged. Noted and will be considered as part of the next phase under the strategic planning process.

	Supporting clinicians to stop doing some things will require an analysis of each department's ability to do this. For example, some surgical specialties may be able to create head room by declining new OP referrals where the elective surgical score is very likely to be well below the current threshold for surgery. Other disciplines (eg paediatrics) already have joint triage of new referrals by several SMOs, many common conditions managed in a standardised way, by Virtual FSA with written instructions or in nurse-led clinics, subspecialisation and earlier discharge to GPs. It is hard to see how these disciplines can free up SMO time any further.	
8	Thank you for the opportunity to provide feedback on the CSP. Environmental sustainability and climate change have become increasingly hot topics. Beginning earlier this year the Ministry of Health has communicated to DHB's that there is an expectation to "implement a strong response to climate change". This is also the first time DHBs have been required to report on climate change and waste disposal as part of the annual plan. Our most recent communication from the Ministry has stated they would like all DHBs to: • Understand the risks of climate change to their core functions • Understand how climate change in their areas of operation may change the numbers of patients they deal with, types of illnesses, frequency of interactions with the health system, etc • Have a plan to adapt to the changing climate • Understand their own greenhouse gas emission footprints • Have a plan to reduce emissions in line with the Government's ambition for a net zero emissions country by 2050 • Understand the co-benefits of emissions reduction, climate resilience, and public health Prior to this communication, HBDHB was already taking steps to do our part. Earlier this year we adopted a HBDHB Sustainability Policy and Facilities has created a Sustainability Plan and Action Plan focused on energy and carbon management, waste, water, buildings and site design and transportation and travel management. More recently EMT and the Board supported the formation of a Sustainability Committee to ensure HBDHB implements a strong response to climate change, in an equitable manner, in line with expectations from the Ministry of Health. This includes the development and prioritisation of the HBDHB Environmental Sustainability and Climate Change Strategy to mitigate and adapt to the changing climate across our operations. By the end of the year HBDHB will have its carbon emissions certified and will then be setting carbon emission reduction targets. Due to the expectations from the Ministry and the work that is already happening within Hawke's Bay DHB, I feel sustainability should be integrated into the CSP. This is an integral step in the planning process prior to the drafting of the Facilities Master Plan where we plan to even further address these issues. Thank you again for the opportunity to provide feedback and please feel free to contact me if you have any questions	Feedback Acknowledged As discussed my suggestions for how to address sustainability in the CSP are • To accept the CSP for its scope on clinical services, but acknowledge in the CSP (in Introduction?) that environmental sustainability needs to be integral to everything we do. Climate and environment are key determinants of health, just like social and economic determinants. Without a healthy planet, we can't have healthy people. • Then we can work to develop a more substantive piece in both a 'Population Health Strategy' (yet to be conceived) and/ or the DHB 5 year Strategic Plan. (Which obviously needs a longer time frame if we are considering new hospital build and a CSP vision for 10 years and a Pop health Strategy that will need at least 10-20 year time frame). Other key inputs being the Sustainability policy, CEMARS stocktake and targets, etc Including cross-reference to what the Pop health Management team have already feedback around sustainability: Environments • We would like to see more of a focus on environments that shape behaviours – social, cultural, economic, natural and physical. Less obvious examples (aside from poverty and the hallmarks thereof) include the built infrastructure (e.g. cycle ways, safer roads, pedestrian walkways, age friendly transport systems, and healthy affordable housing for all), community assets (libraries, Marae, churches, swimming pools, etc) and infrastructure for safe drinking water (a fundamental pre-requisite for health and a high priority for Hawke's Bay). • This plan needs to recognise that climate is a huge driver of current and future impacts on health and there is an urgent need for mitigation, as well as adaptation to climate change. There are likely to be significant changes in the economy, with disruption to livelihoods through loss of employment, and risks to the financial system collapsing. Climate change is likely to lead to increased climate refugees and sea level rises and the need for a managed transition of communities away from coastal areas. All of these will cause significant disruption to the health of our communities as well as to our service infrastructure if we don't take this into account now. We recommend: An explicit focus on ensuring a sustainable health care system that assures equity. The health system itself has a big opportunity to show leadership by modelling sustainability in its operations and considering the co-benefits to health and the environment through its activities. The DHB has already shown leadership through its collaboration with the Regional Council in the Go Well transport initiative. Our DHB could take a lead in future scenario planning with Councils and other agencies and future-proofing our services and communities, including from climate change threats (and opportunities) to health. Last but not least I'd like to introduce Hugh Barton's work Hayley (Lisa will be familiar) which is based on Dahlgren and Whitehead's model of health, and I like particularly his model on page 2 of the attached, in case this is useful to you to conceptualise a Population Health focus which gravitates to the outside layers of the onion and depicts a socio-ecological view of health rather than a bio-medical reductionist view. http://swa1.hbdhb.govt.nz/cgi-bin/patience.cgi?id=5bcdee08-9d75-4f81-a2f7-34487b24efc9

		Add section to CSP as part of ensuring our clinical services are environmentally sustainable and contributing to achieving equity. UPDATED – Sustainability section added to Enablers section. Environments included in place based planning and primary health care sections. 
9	Sounds like exactly what is needed! Can't wait to read the plan ☺	Feedback Acknowledged
10	It needs to start with getting people compliant, taking responsibility for themselves. Their health is not someone else's doing!	Feedback Acknowledged Person and Whānau Centred Care approach includes an element of consumers taking responsibility for their own healthcare and becoming active partners.
11	Yes captured main issue. Like your talk of holistic approach. Prevention is key. More preventative medicine approach Using allied practitioners to help keep population well More recognition e.g. naturopaths, osteopaths, acupuncturists, Rongoa Also lack of GP's/NPs in CBH area. Some haven't got a GP/NP.	Feedback Acknowledged Pg v of the Clinical Services Plan talks about investing more into preventative care and primary health services to improve consumer experience and outcomes and avoid the need for more costly hospital treatment wherever necessary. Additionally Person and Whānau Centred Care must also address mental, emotional and spiritual wellbeing and working with Whānau to design services they need which include a full range of services.
12	Yes captured main issues. This is the best service we have had in my lifetime. Porongahau is well looked after	Feedback Acknowledged
13	I want to write a general point of positive feedback for the CSP in its current form. The document has been well-shaped and re-designed from its early stages with effective consultation through the workshop process. The document is also suitably at a high-level, not 'drilling down' excessively into individual service details and this is appropriate for a document requiring this level of overview. It will, however, be highly important that this is well-communicated throughout the process, and I offer feedback that this may need to be communicated a little more strongly than it currently is. For example, there was a stage where many services felt they needed to be included in the plan, but it has now been redesigned at a higher level and not focussing specifically on any individual service. To this extent, it may be	Feedback Acknowledged. Noted.

	important to highlight that the point of the plan is not to focus on any individual service, and to educate Health Professionals in Hawke's Bay that the focus on individual services will come through other planning documents, eg. Portfololio Plans and Service Plans, etc etc.	
14	For a plan based on the population over the next 10-15 years there is no mention of child/youth/family health. As this must surely impact plans going forward, I would urge you to consider further investment into inequities around maternal health, maternal/mental youth breastfeeding young children's health programmes	Feedback Acknowledged Prioritisation for these specific services will come under the theme Working with Whānau to Design the Services They Need. Achieving equitable health outcomes is threaded through every theme of the Clinical services Plan. More detailed planning is to follow which will address specific service plans.
15	Yes- captured main issue. Access to services in rural community for whanau with no transport and bigger whanau	The plan does not specifically mention transport but should further discussions within the theme of Working with Whānau to Design the Services They Need identify transport as a priority – this could be reviewed during the more detailed planning processes.
16	• While the CSP is very well written and provides a very good pathway for HBDHB it is important that we do not ignore the pressing issues that have arisen and will remain in regard to present space and functional flow within our hospital services. Our future space and flow need to meet additional demand which I believe will still occur even if the general CSP direction is achieved. • While there is a large emphasis on new models of care particularly in primary health to help reduce demand on the hospital, there is little mention of how a hospital's secondary services will cope with increases of around two-thirds the elderly population which is stated on page 7 to be in the next 15 years. As mentioned above, demand within the hospital is still likely to increase even if we implement changes to the model of care. • The CSP does not take into account the age of existing hospital infrastructure and the need to include upgrades and replacements of the hospital building stock as we move forward. While this is not generally a part of CSP it is important to include this fact in terms of planning going forward. • The CSP does not take into account the way the hospital has been built over past years. The existing mismatch of buildings and add-ons has meant the existing patient flow is far from ideal. It would be good if the CSP mentioned that work on the overall hospital to improve its services and buildings will need to form part of future planning. • It is true, as per page 8, that if we don't "change" the hospital will consume more resources as provider of "last resort" and it is also true, as per page 8, that to shift activity from hospital to closer to home is quite a challenge, more than most people realise. With this in mind it would be prudent to put some emphasis on what changes may be required within the hospital services to cope with the model of care change and also increased demand on some services. • Over the last 3 months and going forward there have been continued requests for reports on where the hospital is heading in regard to short, medium and long term infrastructure planning. It is critical that this is not rushed separately from the CSP. It would be best to align all strategic infrastructure planning with the CSP where planning is made collectively over all services and streams and where outcomes are driven down based on model of care requirements. • There is no mention of the CSP aligning with the hospitals strategic planning and it would be of value to include this connection. • There is 'little' mention in the CSP on infrastructure changes to the existing hospital site but what is included does, to some extent, align with parts of the present Capital Plan. These include o page 42 of the CSP which recommends changes to ICU, expansion to a discharge lounge and the establishment of women's health acute assessment unit.	Feedback Acknowledged Current capacity is addressed in pg51 of the Clinical services plan under Assets and infrastructure, but agree it does not go into any detail. This level of detail is to follow in the next phase of the strategic planning process once the core concepts have been endorsed. Noted. Pg 54 sets out the next steps in terms working through the strategic planning process to form the next 5 year strategy. It is during this process that other strategies, sub strategies and plans will be integrated and aligned and developed. The CSP is only one strategy that feeds into this process.

	○ page 43 of the CSP which recommends increasing space for older persons in ED and increased space for a surgical assessment unit, ○ page 46 of the CSP which identifies growth infrastructure within surgical services.	
17	Need to focus on tackling racism as a health determinant, especially health provider services. • Breastfeeding support • Focussing on tamriki/rangatahi	Feedback Acknowledged The Clinical services plan talks of wraparound services for whānau, especially tamariki during the first 1000 days of life and rangatahi during adolescent years on pg 26. The theme of Working with Whānau to Design the Services They Need and place based planning will look at needs assessment and identifying communities with the greatest need as part of addressing. However it has been acknowledged that we could expand on this area. Referenced on pg49 the Clinical Services Plan talks about the support structures and this includes the People Plan: Growing our People by Living Our Values, which was developed through the Big Listen, Listening sessions last year. This Plan is focussed on cultural competence, living our values and Person and Whānau Centred Care. Expand on youth and children. UPDATED – section added into whānau services section.
18	Be great to have more information on the How? Will be about working smarter not necessarily increasing staff but effectively utilising staff. Too many management layers and communication down falls. Need to flat-line the hierarchy & be creative with project mgt, team leader and management roles. Ask consumers	More detail will follow after the next phase of strategic planning. Workforce planning is part of the People Plan and is referenced on pg49.
19	Congratulations on taking the brave step forward to change and update HBDHB and involving the community. I am wondering if you realise that there are many wellness practitioners in the Hawkes Bay community who are already seeing many people and keeping them out of hospital. Whenever we have wanted to work with GPs or within the hospital, we often meet barriers. These barriers need to be softened and trust established. The very first step in wellness is to encourage people to be responsible for their own health and to even get off first base is to move out of the victim triangle and into the empowerment triangle where the victim becomes the creator of their own health plan along with their GP/Specialist etc.	Feedback Acknowledged. Implementation of the Person and Whānau Centred approach and elements of the NUKA system of care along with other models of care changes identified within the Clinical Services Plan should see more of a move towards a focus on wellness and the breaking down of these barriers.
20	Thank you for the opportunity to comment on the draft Clinical Services Plan. Overall, we agree with the direction of the plan. We believe the focus on equity will improve outcomes for the most vulnerable in our communities. The enablers of workforce development and IT will be important to mobilise our workforce to respond in new ways to the increasing complexity of health and social issues in our communities. Team work across community teams will need to be coordinated with place based planning. To deliver on the agenda will require better access to information on what is working and analytical and evaluation resources to measure changes in practice and whether this is leading to improvement for individuals and whanau. There are some interesting ideas about how to develop new roles to release specialist staff to provide care in different ways. There will be new roles such as behaviouralist, rehabilitation assistants and others. Health and social services will need to attract younger people leaving school to move into health and social service roles. There is also potential to work differently with older people who are staying in the workforce for longer. Part-time roles can be attractive as they balance working and supporting mokopuna and whanau.	Feedback Acknowledged Agree the phasing will need to addresses as part of the next phase – strategic planning process. The headline goals are indicative and will feed into the overarching strategy where the wording will be tightened in terms of strategic objectives. Update: • Correct spelling errors UPDATED - corrected

	There are too many actions for the 10-year plan. The implementation plan will need to address the phasing. The underlying business models will also need to support the direction of the plan. The headline goals need tightening. These do not always relate to the list of actions below. In New Zealand Dietitian has two ts not a c. See Dietitians NZ national group. Advance Care Plan does not have a d. Advanced care plan is incorrect. People make a plan in advance.	
Update: • Corrects pelling errors UPDATED - corrected	I am emailing to have my say on the proposed Clinical Services Plan for Hawke's Bay District Health Board. My family and I live in Napier and use the health services provided by the DHB a lot. My main concern regarding the plan is the potential cost to the consumer if there is a shift from secondary care to primary care services. As a family of four dependent on one income, on a low income but only just not low enough to qualify for a Community Services card, I currently can't afford to see a GP as often I require for my chronic medical conditions. Similarly my partner doesn't see a GP when he should, simply because of the cost of a non-urgent visit to with our enrolled GP practice. Does your plan include reducing the charges for locals to see GPs and access other primary care facilities? As I know plenty of other people have the same problem, which is why they choose to delay getting treatment they need in a timely manner or go to the Accident and Emergency department at the hospital, rather than see their GP. I saw no mention in your plan to reduce the cost of primary care for the consumers. I agree that communication between health care providers and services need improving, as referrals are missed. Just this year my partner asked to be referred to the hospital's team to help him quit smoking, but no one bothered to contact him to chase up his request for help. Our daughter was having surgery at the time and he ticked a box on the hospital form to request help, so this was a missed opportunity between hospital departments. In another example, one of my daughters had her hearing tested at the radiology department in the hospital early this year, but the B4 School Check people were not told this. So when my daughter failed two hearing screening tests as part of her B4 School Check at her kindy, she was referred to get tested at the Napier Medical Centre. This turned out to be a waste of our time and your resources, simply because no one informed the B4 School Check people that she had already had her hearing checked at the hospital and passed and no one informed us properly why we had to get her hearing tested again. I also agree that provision for mental health services desperately need improving. Getting any counselling when needed takes far too long, with the patient suffering by the delay. Being lumped together with addiction services is unpleasant, embarrassing, and off-putting for consumers who have a mental health issue, but no addiction problems. Having to use toilets that are set up for drug testing or sitting in the same waiting area as addicts is very upsetting if you're already in a fragile state of mind and this needs to be improved, especially at the Napier Health Centre. Also, if a patient chooses to stop counselling because they feel better, it should be made easier to get access to counselling again if they have a relapse. Waiting months on end is not acceptable if a patient is in crisis. Antidepressants and other medications do help some patients and are necessary, but they are not the only answer to improving ment health. How about making it cheaper to access gyms for people with mental health issues, as they do in Scotland? The current Green Health Prescription provided in Hawke's Bay is ridiculous and woefully inadequate. I've used this in the past and gave up on it, as talking to someone about my exercise how didn't help. But when Iived in Scotland I could go to exercise classes for people with mental health issues for free and get reduced cost membership at city council run gyms - that made a real positive impact on my mental health, not just talking or walking with a group of people. I didn't see any mention of improving access to dentists for adults in the plan. Again seeing a dentist regularly is too expensive for many Kiwis, which means they put it off (like my partner), which causes even more expensive and difficult to treat long term conditions to develop. It cost $165 for me to have a regular check up done this week. This was the first time in 5 years I could afford to see a dentist and that was only because I borrowed money from my parents to do so. Again, when I lived in Scotland I was enrolled with a NHS dentist. I still paid to see the dentist, but at a much cheaper rate than a private dentist, so saw my NHS dentist regularly, preventing any major problems developing. Is the cost of dentists going to be addressed in your plan? Not just for specific ethnicities, but for all hard working people.	Feedback Acknowledged 1. Agree – cost to consumers is a barrier and will be included in the plan. 2. Acknowledged. Improvements to ICT as key enablers of the Clinical Services plan and a person and whānau centred approach as well as improvement to pathways should address these issues. 3. Person and whānau centred care approach and working with whānau as well as relevant holistic responses to supporting mental wellbeing on pg28 should enhance experiences in this area. 4. Adult dentistry other than in exceptional circumstances is not provided for within the Clinical Services Plan as it is not funded through DHB's. 5. Exactly what services will be provided for and where is yet to be determined. This will be developed in accordance with the principles, concepts and commitments provided for in the Clinical Services Plan. 6. Pg 20 talks of a fundamentally different primary care system as being the lynchpin for the Clinical services Plan. The plan also talks of expanding primary care teams which should address this concern. Update the Plan UPDATED – in second para of Evolving Primary Health Care

	Does streaming lining the services provided by the hospital mean that people in Hawke's Bay will have to travel further to access treatment they can currently receive at the hospital? Travelling far for treatment puts more stress on patients. And we all know that once services are reduced and stop being provided they are never re-introduced. They are gone from the community for ever. It's not clear what services will be dropped and this is misleading. I agree that you desperately need to recruit more clinicians. We've had our regular GP changed 4 times in the last 5 year's as they keep quitting our enrolled GP practice. Which doesn't make much difference to us, as we rarely see the same GP twice as it takes too long to get an appointment with our so called regular GP. How are primary care facilities going to be supported to provide better continuity of care to the consumer? Seeing different GPs all the time means consultation time is lost repeating medical history, leaving less time on fixing the current issue. When we get an appointment with a GP we always have to wait at least half an hour to see the GP, as they are always running behind schedule. This is an indication that appointment times are not long enough and there are not enough GPs to service the community. How is this going to be improved if the emphasis is shifted to providing even more care through primary services? The GPs are not coping with their current workload, never mind with additional tasks being lumped on them. New GPs from other countries are shocked by the cost charged to patients in New Zealand and the long waiting times for referrals. The health care system needs drastic improvement now. I don't think your plan will address these problems. Workloads for staff at the hospital are just as bad. Individuals seem to care and try to work hard, but the system lets them and their patients down.	
22	Ae, the status quo cannot remain. Health disparity for Māori is not improving. Congratulations on a plan that recognises inequity and inequality in Ngati Kahungunu. Congratulations on the beautiful whakataukī represented throughout this report. Congratualtion for implmenting the Whanau Ora approach as highlighted in Te Korowai Oranga 2002. ▪ Perfect concept Iwi led ▪ Waiting list for follow up appointments needs improvement, for example, my daughter was referred for Cardiology review in June 2018, finally have an appointment in November 2018 which as advised by the booking staff may not eventuate due to high demand ▪ Māori consultation needs to be by Māori at a venue (Marae) where Māori feel comfortable, presented in a way Māori understand. Time frames don't work for Māori. Timeframes need to be flexible. I attended the Big Listen for staff at Omahu Marae. Marae protocol was not adhered to. This was embarrassing as a tangata whenua and for the kaumātua of that Marae. Respect our customs and do not let this happen again. This shows a total disrespect of Māori and further marginalises the cultural insensitivity for Māori. ▪ Reduce the 'token complicance' for Māori when talking about the Māori workforce. We are all in this together. The 'dial a Māori' approach needs to stop. Māori are invited to participate in groups however our value isn't reciprocated. Institutional racism needs to be addressed. We are the 'check box' that needs to be ticked. Value what each of us bring to the table and give us a voice within the workplace that is not from a kaupapa of tokenism rather from a kaupapa of equality. ▪ Working from a whanau ora kaupapa as in this plan is about collaboration of a cohesive multidisciplinary team. Everyone needs to 'sing from the same song sheet' and 'row the waka in the same direction'. The challenge will be to actually get this to happen. Kia kaha, good luck ▪ Great acknowldgement of Māori healing practices (ie; mahi a atua) that is a polar opposite from the medical model non-Māori world view that is prominant within the health system in Aotearoa. A non-Māori system has caused the disparity, inequity and inequality that is identified throughout the plan and is clearly shown in the evidence available. To the detriment of the non-Māori workforce the	Feedback Acknowledged. Noted. The Kaumātua for that Marae reorganised the set up and Marae protocols were followed before the start of the Big Listen. (Direct feedback only) Implementation of the strategies to achieve our commitment to equity and developing our own local system based our learnings from the indigenous models and working with whānau to design the services they need should all help address the issues raised.

	‘system’ compunds the marginalisation for all Māori (consumers and staff). By acknowledging the Māori worldview gives Māori our Tino Rangatiratanga back. They way it should be. Ka Rawe koutou I think the plan is a great opportunity (and long overdue) to change the direction for Ngati Kahungunu as long as the right people are driving it and the right people are in the right places. Thank you for the opportunity to provide feedback. A reply would be also appreciated.	
23	This feedback acknowledges the work involved with formulating this draft, and the contribution of clinical services support providers during its development within the DHB and external contractors. Clinicians and professional groups within clinical support services[1] can support the direction of travel outlined by this clinical services plan, or will be greatly impacted as changes are implemented. There is limited reference to these core skills and resources within the draft Clinical Services Plan. For these reasons, this submission is being made. Please consider adding clinical support services to the clinical service plan narrative at minimum within Chapter 5 which outlines the support structure to achieve the vision; and more importantly with a wider view that clinical support service clinicians are pivotal to resolving equity, workforce, and patient experience challenges outlined at the beginning of this draft plan. In developing future health services in Hawke’s Bay please view clinical support clinicians wider than a support service; but an intrinsic component of health service delivery. The skills of clinical support service clinicians contribute to health outcomes across the health sector; to get the best value from their skills service planning and development must consider clinical support service clinicians as part of all model of care change, and with a total health system view. Please consider acknowledging the national direction for pharmacist services outlined in Medicines New Zealand 2015 to 2020 and the Pharmacy Action Plan 2016 – 2020 by which pharmacist skills will be harnessed to provide monitoring, screening, brief intervention and triage services along with a focus to increase pharmacist prescribers. The value of pharmacists, a young workforce, working within primary and secondary care, extends beyond increasing the number of clinical pharmacist facilitators. The role of imaging and laboratory tests are key components to an effective functioning health system within primary and secondary care. Radiology services facilitate diagnosis, intervention, treatment and monitoring of patients. Timely access to effective diagnostics, including laboratory testing, in both the hospital and community can reduce specialist appointments, ED attendance, medical and surgical admissions, and length of hospital stay. Diagnostic services: radiology and laboratory, are core tools with high clinician expectations on their use to confirm diagnosis, enable access to pharmaceutical treatment, actively exclude possibilities and track treatment progress. Currently clinical support services provided within the hospital are stretched from both footprint and workforce viewpoint. With ongoing integration and the plan to narrow the future focus of the hospital, engagement of all clinical support service providers will be essential to ensure adequate understanding of each services’ current function and the value-add with service changes as the Hawke’s Bay population changes. We acknowledge that the current focus on services close to home will formulate planned changes in locations of service delivery. Clinical support services are a valuable and important component of improving outcomes and experience from Hawke’s Bay individuals as they travel through our health system. All clinical support services look	Feedback Acknowledged Agree. Further support for update re support services in terms of pharmacy Update the plan to include wider consideration to role community pharmacy plays as support services. See feedback. UPDATED – sentences included in Evolving Primary Health Care, on page 10 and a CSS section under Enablers

[1] Clinical Support Services in this context include pharmacy, radiology, laboratory, allied health, orderlies, security, dietitian and nutrition services.

	forward to being engaged with the changes as the DHB responds to our major challenges including inequities and a changing Hawke's Bay population demographic. Page 16 – notes workforce and IT enables as top priority; I support this and encourage workforce to be expanded to include clinical support staff and IT to be expanded to include technology include diagnostics. Page 20 – totally support inclusion of community pharmacists within the MDT thinking Page 23 – in phasing table mention of clinical pharmacists is supported, however I encourage wider consideration about community pharmacists to ensure we complete our obligations under national strategy e.g. Pharmacy Action Plan and Medicines New Zealand and the new Integrated Community Pharmacy Services Agreement. Page 32 – discussion around supporting ageing population does not mention the role pharmacists (community based and general practice based). Pharmacists have strong mention within the Healthy Ageing Strategy, which could be reflected in our clinical services plan. Page 33 – discussion of use of screening tools is very narrow; NZ national strategy in Medicines NZ and Pharmacy Action Plan are broader aiming to utilise the skills of pharmacists in the community to undertake screening roles, population health roles, triage and minor ailment management. Page 36 – in the table for removing barriers to access the item for building relationships with primary health centres is supported, but I encourage consideration for inclusion of pharmacists to support complex people in addition to GPs and nurses. High support for comment around progress review of pathways to remove barriers to diagnosis and treatment e.g. radiology and laboratory	
24	The (Plan) seems to emphasise desired outcomes without outlining what success looks like. The Whanau engagement model assumes whanau want to engage in changes in lifestyle to improve health outcomes. It would appear from the data that this is not the case ,with smoking rates increasing within the Young Maori Women Cohort. The District Plan draws on Maori tradition with quotes from 1 A comment from Kahungunu on his journey south of Kaitaia. Essentially, you cannot cross a river by looking at the waters and wishing it will happen. You have to jump into the waka, and paddle for your life! Be prepared, be strong of heart, and draw on all the strength of those around you. The future will not wait for those that ponder. A number of the health inequities in the Maori and Pacific Island population eg diabetes , obesity , gout can be accounted for when you consider the traditional diet of many Maori and Pacific Islanders . High in fat and carbohydrate. Abandoning some aspects of cultural diet (as they have done at Ngarawharia Marae may slowly turn the tide of health inequity, The Iron Maori is a great health initiative but probably sets the standard too high. Healthcare starts with Social Care , Housing, Education and.Access to fresh fruit and vegetables As a New Zealand European my Whanau has abandoned traditional "Sunday Roasts" in favour of a Mediterranean diet.To avoid the CVD of our parents. The GP led PHO's have had control of the Primary Health Sector . Which has had 20 years to prove effectiveness.	Feedback Acknowledged. Noted. We have recognised through the engagement activity and other feedback received that the bigger role of pharmacy was not sufficiently reflected within the plan and updates will be made to support the bigger role pharmacy plays in the future under support services. The detail however will fall out of the next phase under the strategic planning process. In terms of the assumption to all whānau wanting to engage in changes in lifestyle to improve their own health and wellbeing. We believe that these challenges/barriers will worked through during the application of the person and whānau centred approach and working with whānau to understand what their needs are. Improving accessibility, knowledge and making health easy to understand should drive improvements in the areas you have highlighted.

	The report suggests its time to look to other healthcare providers.Currently pharmacists are trapped within their businesses with the requirements to be available all opening hours. Home visits are difficult.Rather than trying to minimise pharmacy payments. Funding Pharmacy Triage for common minor topical antibacterial , antifungal infections ,nappy rash, constipation,diarrhoea, minor wound treatment,eye infections , vaccinations ,Oral Contraception , ECP, Trimethoprim , Sildenafil with access to a common healthcare plan for each specific NHI number, this would allow continuity of care. Pharmacies are investing in private consultation rooms suitable for clinical appointments.	
25	Respiratory Sleep Poor sleep quality – depression, anxiety Poor or inadequate sleep affects cognitive performance 20% of car accidents sleep related (Australian data) MVA risk: 2-8x risk of major accident (various studies) Reduced work performance, employment risk, carer impairment Metabolic effects Weight gain, increased risk of heart attack and stroke, Worsens glycaemic control Immune effects Increased inflammatory markers Impaired immune response Increased vulnerability to infection Sleep apnoea is the most common driver of poor sleep quality Even higher risk of problems above, heart attack risk, stroke risk, functional impairment, Severe apnoea untreated reduced sig life expectancy approx. Insidious and difficult to identify (normalized over time) NZ data suggests up to 5% of population have clinically relevant sleep apnoea Risk factors include ethnic minority, obesity, age and social deprivation Hawkes Bay has higher than average proportions of population in obese, ethnic minority, older and socially deprived deciles. 5% an underestimate >8000 people in community with disease, only approx. 700 on treatment Increasing incidence/prevalence due to link with obesity epidemic Sleep services, out of date, operating on a shoestring No dedicated service (bolt on to respiratory) Underappreciates progresses in sleep medicine in last 15 years Operating an outdated, centralized secondary care model Should be warehoused largely in community, close to patients, with focus on socioeconomically deprived patients Rapidly increasing burden of sleep pathology encroaching on previously highly functional respiratory department (?>3x increase in referrals) Current model of care overwhelmed/unfit for purpose Resulting in reducing capacity to focus on most urgent/dangerous need Huge unmet need in community **Despite my strenuous efforts to engage with HYS and CSP and the central role of sleep health in overall health, I was not involved in one meeting or mention of sleep medicine**	Feedback Acknowledged .Agreed. Recognise sleep within the plan by referencing the three pillars of health. Update the plan. Prevention is only reference with the plan in a nutshell and not with the main plan... Include a section within the main plan. Health promotion taking responsibility for reducing demand on healthcare. **UPDATED – Sleep services as emerging area (to be delivered in community) included in long term conditions section.**

	I was initially invited to meetings on hospital and community care until they were delayed and rearranged (not reinvited) I spoke with the lead from Sapere, who also identified sleep medicine as notoriously under appreciated in these processes due to lack of visibility between acute and primary care Internationally sleep is becoming a health priority, Australia moving to centralize sleep in healthcare/health models through recognizing officially as third pillar of health (alongside diet and exercise) Different to almost zero NZ profile The good news NZ data shows that identifying and treating OSA is net cost-beneficial in working age adults, that is saves money when treated. On pure medical cost benefit, a QALY from diagnosing/treating OSA costs of the order of $100's of dollars (compare Dialysis or new cancer drugs) Recent advances in diagnostics validate 'at home' and 'in community' assessment, sleep studies and treatment trials. F&P partnership (and thus competition with other providers) has driven down cost of CPAP treatment to historic lows. NZ exemplar (Christchurch) shows with expert hospital oversight high volumes of patients can be assessed and treated in the community, remote from secondary care centre Potential for CHB and Wairoa clinics running near autonomously GP lead assessment/initial testing with light touch central monitoring/oversight Conclusions Worldwide good sleep increasingly recognized as the third pillar of health OSA is a public health epidemic accounting for a large proportion of sleep pathology Local huge unmet need, with current high clinical risk to organization Sleep burden encroaching on capacity for other services (Lung Ca, Resp in general) Proven models of care to push sleep medicine into the community Local expertise with strong collegial support from tertiary centres Diagnosis and intervention highly cost effective with health, economic and safety benefits to community Fits organizational priority of moving care closer to patients in predominantly primary care setting Focusing improved services particularly on socio-economically deprived and ethnic minority groups.	
	I have now read this CSP several times and would like to commend the team on the change in model of health care that is being proposed in primary care, introducing the Alaskan model with the person / whanau in the centre is definitely the "way to go".....in addition the goal of reduction in long term condition attendance at hospital for OPA is laudable. However with the current model of healthcare in NZ we need to be aware that everything costs in primary care. And although it may not cost the patient directly (eg respiratory programme atm), it needs disinvestment from secondary to primary care to fund this / payment from somewhere else! So although we talk about local services being redesigned this needs to fit with a national direction. This direction does not just encompass the system provision but also the support for HCPs to perform to the top of their scope of practice unhindered by beaurocracy. (more than happy to discuss further if any interest!) I think we also need to have supporting technology....at present I am part of a working party looking at respiratory needs in CHB. Whilst privacy needs to be respected, this needs to not outweigh the safety of the	Feedback Acknowledged. Issues covered within pg 49 under the right support structures will be required to enable the changes within the plan.

	patient: eg this working party consists of public health, school teachers, Breathe HB, councillors, community pharmacy, GP and practice nurse, myself (secondary care), pulmonary rehabilitation (community health), smoke free, hospice, planning and funding: every one of these services are working within different IT systems therefore it is impossible to share knowledge between ourselves! No wonder the client frequently feels unheard because of being asked to repeat their story to each and every one of these professionals! (yet we can all be on Facebook together!) I love the thought about mobile monitoring, having worked previously with different telemedicine systems since the early part of this century; again huge cost outlay to start with, but great payback long term. The healthy homes initiative is great, however we need to think Much Bigger Picture. Eg We need to make sure that all people with a chronic disease have a healthy home to go to (recently having insulated my home for $3,500 this is the equivalent to 7 nights in hospital or less than one day in ICU. The home care / management needs to take into account health needs as well; cleaning walls / to maintain a mould free environment is key for a healthy respiratory environment. The whole age range matters…our tamariki of today are our rangitahi of tomorrow, and our kaumatua of the future.	Several references for health to interact and partner with intersectoral partners to improve overall health outcomes of our community is included within the plan.
26	Thank you for the opportunity to provide feedback on the draft 'Transforming Our Health Services'. This document does present key themes and appropriate planning within a framework familiar to Health Professionals. It is a motivating document identifying many of the activities and approaches currently being utilised or progressed within Paediatric Services, together with opportunities to extend further. However insufficient recognition of required timeframes to embed new models of care is evident. For example Relationship Centred Practice is fundamental to our service delivery, however has been a significant investment (time) to achieve training across a Team, then to embed this within clinical practice. It is important that initiatives are then given an opportunity to be embedded into practice and then evaluated. Some of the phasing depicted in the tables doesn't match our current reality – many of the identified initiatives are reliant on staffing – and many professions have vacancies and challenges in recruiting currently. Some of the existing barriers to service delivery continue to be identified as fundamental yet without acknowledgement that change within these areas is essential, e.g. managing by fact needs robust data (not universally available), implementing existing technology (pg 19) needs support. The need for evidence based practice is paramount, alongside learning from the experience of others where it is applicable. We are fortunate to have a number of unique features in Hawke's Bay, although not all reflect positive health outcomes, but the willingness of & accessibility to our collaborative partners will impact strongly moving forward, this could be depicted more strongly. Likewise acknowledgement that reference to some of the international research is not directly applicable within our setting is valuable but not apparent throughout (e.g. re Nuka System of care pg 22). I am concerned that the 'Childs voice' has not been specifically identified, although there is an appropriate level of consumer input referenced.	Feedback Acknowledged. Agree. The plan does not include within "communities" cohorts of consumers with similar needs. The plan will updated to reflect this. Extending the approach under discussed under place based planning and also specialist management of long term condition on pg35 should address these concerns. Acknowledged. We will strengthen the focus on children and young people. The Clinical services plan set out elements which are a range of options responding to challenges faced. The next stage of the strategic planning process requires us to develop an implementation plan. UPDATED – included a bullet on supporting and working with collectives with similar needs in the Working with whānau to design the services they need. Section on child & youth included in whānau section.

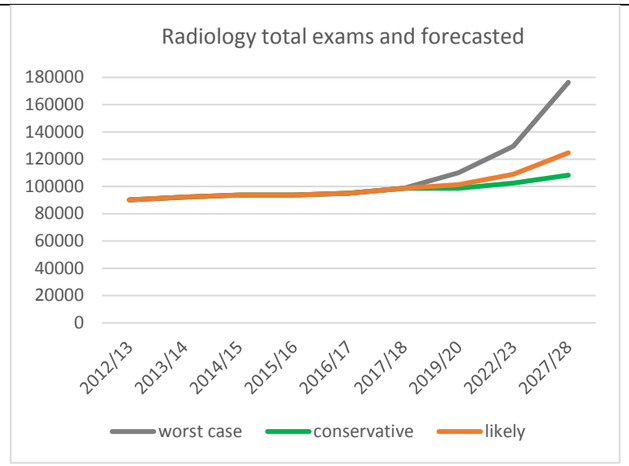
	The voice of communities appears to be more greatly valued than that of cohorts of Consumers with similar needs. This is concerning given the small population within Hawke's Bay. For example within CDS we have a number of children with relatively rare conditions meaning that a GP may only ever have one consumer with this diagnosis in their practice and hence not develop the expertise required to address their needs. This child / whānau will continue to need a Specialist team to work with them. The voice and needs of the Consumers with physical disabilities has also been overlooked and while we appreciate that not every diagnosis can or should be identified within the CSP, these are clients effectively with Long Term Conditions requiring specialist management during their childhood. Many other Long Term Conditions are directly evidenced back to childhood and growing capacity and capability for this work would have long-term benefits. The CDS has for a number of years delivered educational modules focused on fetal alcohol spectrum disorder, aiming to grow understanding across the community – health, education and social workforces, and individuals / whānau attend. The outcomes are apparent, for example in the classroom with Teachers having greater awareness and capability in managing these children. Furthermore this change in 'model of care' is more cost effective, reducing smaller educational presentations to individual schools. Similar initiatives could be more universally achieved and introduced with little resourcing. Little emphasis was shared on robustly strengthening services for children (including antenatal) and young people. If we get it right for this age group then the health care needed later in life will be different from current expectations. There remains a strong medical model apparent within many aspects of this document, despite a growing evidence base that Wellness frameworks are viable, applicable to our population and cost effective. While the aspirations focused on delivering more services within the community are commendable in part, this is an expensive model and some services / components of service delivery cannot feasibly be delivered in a home / most existing Primary care facilities. Some of the aspirations within this plan could /should be implemented in the short term but are directly impeded by either red tape, money or time. For example volunteers could produce a more "whānau friendly" CDS but initial approaches to facilities resulted in strong discouragement. Team / Service Leaders / Clinicians are all stretched in achieving daily outputs, no mandate was clear within this document to allocate time (our biggest resource), to refocus. It is the people on the ground who will achieve / otherwise the aspirations of this document.	
27	Overall I believe the CSP is focusing on the key areas facing healthcare delivery, in the Hawkes Bay. The challenge facing us all now is how to meaningfully implement these identified goals. As someone supporting a nursing workforce that is able to both consolidate existing skills and remain responsive, to new ways of delivering and planning care are paramount. It is the latter which the CSP is wanting to achieve across the health sector. I did not see any explicit mention however, of the important role education needs to play in promoting practical application. From my perspective nurses working on the floor need to be supported to attend regular education sessions, which will grow their capacity to meet the unique care needs of those patients, who require a hospital admission. In practical terms this means we need to find a way to address nurse, patient ratios making them safer and more responsive. Not only will this benefit ongoing knowledge development, but will also have a positive impact on patient safety, effective discharge planning and care of patients presenting with higher acuities. Experience has shown us that providing care at home for longer has a myriad of benefits, however when a hospital admission becomes necessary patients are often so unwell, the acute services they require cannot	Feedback Acknowledged.Whilst not specifically mentioned, each of the key enablers identified under "growing our workforce" on pg49 will require significant amount of education to achieve the levels of change required. Agreed. This objective needs to be addressed when aligning all future planning/budgeting and resource allocation. Agreed.

	cope. Striking a balance and co-designing systems with clinical staff, will underpin the successful implementation of the CSP.	
28	Please take a look at ATMC the Alternative To Meds Centre in Sedona Arizona. They have pioneered a very successful holistic programme to enable people to withdraw from psychiatric drugs … which are addictive and alter the brain in diminishing ways. people get themselves and their life back. I have researched this topic extensively and would love to contribute to raising consciousness about this.	Feedback Acknowledged.Noted.
29	A very BIG thank you for your intention to reach out and Collaborate. After decades of asking for collaboration with psychiatrists in relation to my son, and having a rude "No" your more enlightened approach is welcome and refreshing. Possibly even healing? * I would like you to name and include, Care of the soul & the healing power of arts and crafts. Integration of Trauma The therapeutic system is itself often pathological. Pathology is not limited to patients. It's in all of us, a fundamental element of the soul. Tribal societies knew how to make use of those who were possessed by emotional upheavals. We do not. By trying to fix them, improve them, eliminate them, drug the, and cure them, we show that we have not grasped how they can help us. The best medicine I can offer to a troubled soul is a sense of purpose, the feeling that what he is going through may contribute to the vitality of the community. Psychic illness is an alienation of soul and a possession of the psyche by preoccupations, obsessions, fears, anxieties. Revive the soul and divert the focus on to something positive. Embrace life as subject matter. Engage in the textures, colours, movements of actual things in everyday life. Wherever there is loss of soul, the arts emerge spontaneously as remedies, soul medicine. Daily life is revitalised by imagination. The soul's deepest will is to preserve it's own integrity, against the mind and the whole mass of disintegrating forces. There is no stronger and more reliable eternal function for ART than that of being articulator of the soul's uncensored purpose in works which are personal, risky, intimate - the soul's deepest will. (Colin McCahon) Every true artist is a transmitter of aliveness, vitality, life. Bless those artists who take CARE OF THE SOUL Transforming Hawke's Bay Health services www.ourhealthhb.co.nz *"We want to **invest** in preventative care."* Care of the soul & the healing power of arts and crafts. *"We want to improve the way our health care is delivered to people with disabilities."* Care of the soul & the healing power of arts and crafts. *"Our focus will be on wellness, and helping people have better self management."* Care of the soul & the healing power of arts and crafts. *"Care in mental health and addiction is a **priority f**or our health system."* Care of the soul & the healing power of arts and crafts. *"WE will build from scratch **relevant and holistic** ways to support mental wellbeing."*	Feedback Acknowledged.Noted.

	Care of the soul & the healing power of arts and crafts. *"There will be direct access to **self management, wellness and resilience programmes.** …. for people with emerging mental health and addiction issues."* Care of the soul & the healing power of arts and crafts. *"Better community based support for mental health and addiction issues."* Care of the soul & the healing power of arts and crafts. *"We will grow our work force, expand their expertise and cultural competency."*	
30	1. "Evolving primary health care". There is significant emphasis on evolving primary care to manage both acute care and chronic disease thereby allowing reduced presentations to ED and, along with other process changes, a streamlined hospital without the requirement to increase overnight hospital beds. There are significant primary care workforce and models of care issues that will make this difficult to achieve. Primary care is facing a significant general practitioner workforce crisis over the next 10 years with a very large cohort of GPs approaching retirement without a matched cohort of younger GPs coming on line to replace them. Primary care, particularly urgent care, have demonstrated a planned, considered, and comprehensive withdrawal from provision of after-hours care in Hawke's Bay to the extent that the Emergency Department is the only provider of acute unplanned care after 8pm in Hastings and 9pm in Napier. This represents a little under 50% of the 24hr per day, 7 day working week when there is no access to primary care. It is unlikely that proposed members of the expanded primary care team will be providing services after hours or late into the evening and on weekends where significant demand already exists and is currently managed in ED. There are currently multiple presentations to hospital of patients from aged residential care facilities who are ostensibly being covered by General Practice but whose management in evenings and on weekends involves calling an ambulance and being taken to ED. These volumes are likely to increase in the future with the increasingly aging population. These factors will undermine the proposed extended hours, comprehensive, coordinated acute care philosophy of expanded primary care because for financial reasons, for life-work balance reasons, and as part of a nation-wide trend primary care is moving away from rather than towards extended hours care. 2. "At the Emergency Department" "Currently, our ED receives a large number of people that would be more appropriately managed, and could have a better overall experience, by accessing primary care." This would require primary care being open and available to be accessed extended hours. Many of these patients currently present in the evenings and on weekends. 3. "Multiple entry points and streaming." It is with considerable interest to Emergency Medicine that the recommendation "Triaging away from ED to primary care where appropriate with vouchers to subsidise co-payments targeted to those most in need" has been made. The ED Head of Department has invested considerable time and effort in championing the use of Emergency Q as a safe, effective, proven and cost-effective process of empowering patients to redirect themselves from ED or home to an Urgent Care facility (Hastings Health Centre) through electronic provision of information regarding conditions that are appropriate for Urgent Care and real-time total treatment time data for both ED and HHC Urgent Care. Unfortunately, the Executive Director of Primary Care has declined funding for a trial of Emergency Q and a process that is contained within the Clinical Services Plan is and already up and running in North Shore and Middlemore Hospitals will not be able to be implemented in Hawke's Bay this year as was proposed. In North Shore in the first 12 months of use there was a 4% reduction in ED presentations. This almost unheard of in Australasian EDs where the expectation and experience is consistently to see more patients in ED than in the previous year. 4. "Right start to the hospital journey."	Feedback Acknowledged 1. Acknowledge the issues raised and will be considered as part of the next stages of strategic planning and capacity and workforce planning. 2. Acknowledge the issues raised with after hours and will be considered as part of the more next planning phase. 3. The Goal is to have a solution that provides equitable health outcomes by being affordable and accessible with same day options for consumer's access Primary care. 4. Add to CSP: Include in list of elements under "Right Start to the Hospital" on pg43 5. Acknowledged.

	The use of extended hours assessment units (e.g. MAPU Auckland City Hospital) for medical, surgical, and paediatric patients referred in to hospital from the community currently occurs in most other hospitals in New Zealand. The accepted process for these types of patients is streaming from a single point of entry, generally the ED Triage nurse. Streaming from triage acts as a safety net as a small but significant proportion of such patients will require resuscitation and management in ED, whilst the majority are moved to the appropriate assessment unit from triage. Their use in Hawke's Bay would certainly improve the efficiency of patient processing, reduce the number of patients who require management in the ED, and ensure the right patient in the right setting occurs as frequently as possible. However, even hospitals who have had such extended hours units embedded for many years still experience access block during high winter volumes, and when inpatient bed capacity is exceeded these units become overflow wards which markedly diminishes their function as assessment units and their ability to continue to receive new patients referred from the community. Often in the middle of winter such community-referred patients are then managed in ED because there is no other resourced area available in the hospital to manage them. Careful consideration of acute demand data, inpatient bed occupancy, inpatient LOS data etc. will be essential in predicting the required number of assessment treatment spaces and inpatient beds in the future. It is critical that the reduction in medical inpatient bed number that accompanied the opening of the current Acute Assessment Unit is not repeated. The AAU in its assessment function is able to assess and discharge, and assess and identify short stay medical patients appropriate to have their inpatient stay within the AAU, but it also requires inpatient bed capacity to offload longer stay medical patients and create empty treatment spaces to facilitate flow of new patients from the community or ED. In winter this assessment function and patient flow is undermined by lack of inpatient bed capacity and use of AAU for inpatients that are not short stay, effectively becoming a medical overflow ward. Sufficient inpatient medical bed capacity is essential in order to maintain flow into and out of AAU and any other assessment unit. 5. The following recommendations are supported and welcomed by Emergency Medicine • Streaming of patients who do not require specialist medical assessment or resuscitation to acute assessment units with multiple sources of referral • Presence of Psychiatric liaison nurse in ED to facilitate streaming of acute mental health patients to a safe and more appropriate location (quieter, less environmental stimulation, purpose-designed mental health assessment rooms etc.) for assessment and management. This worked well in Princess Alexandra Hospital ED in Brisbane. • Early senior medical assessment and decision-making with ability to create 0 Day LOS Medical admissions thereby freeing up overnight inpatient beds, and to reduce medical admissions. • Increased presence of Kaitakawaenga and social workers in ED to address social needs/issues contributing to the presentation • Moving towards 7 day a week services e.g. AAU currently runs Mon to Fri 0800 – 1630hrs in its assessment role when it is required 7 days a week. Another current example requiring a 7 day a week approach is weekend discharges by Medicine. At present Medicine admits similar numbers of patents every day, but Saturday and Sunday discharges are only 50% of daily weekday discharges. In the setting of limited bed capacity this results in a pattern of approaching the busiest acute demand day (Monday) with the least medical inpatient bed capacity every week. There is currently no physician tasked to rounding on patients suitable for discharge on the weekends. Patients who have an admission under Medicine that includes a weekend will have increased LOS compared to patients who do not stay over a weekend. • Estimated date of discharge planning from day one, MDT planning and 7 day/week availability and other measures to reduce LOS	
31	Please note the CSP plan referred to the changes in population and healthcare care needs of the population of Hawke's Bay and all associated specialties across primary and secondary care. In the whole document	Feedback Acknowledged. Agree. Add to enabler's clinical diagnostic & support services. Provision will be needed for radiology, lab, pharmacy, sterile services and administration. Need for ongoing development and consequential impacts.

	there was no reference to the associated diagnostic and interventional imaging required to support the delivery of healthcare by these specialties. Radiology services are important to the effective operation of the health system as a whole, as they form a critical component in the effective and timely diagnosis, intervention, and treatment for acute and elective patients. Timely access to effective diagnostics in both the hospital and community can reduce length of stay, and avoid ED attendances, medical and surgical admissions. All of these things affect the patient experience and outcome. This has led to radiology increasingly becoming a core diagnostic tool. There is now an expectation by clinicians in both primary and secondary care that they can rely on radiological investigations to actively exclude possibilities and track treatment progress rather than just confirming diagnosis. As each facet of the health system asks more of radiology, the effect on the service multiplies, even though their client departments' service level may change in a relatively small and measured way. By the time these small increments in demand are added up all the way through from primary to tertiary care, the combined demand growth on the service can be up to 17 percent per year for some imaging modalities. Therefore as radiology services become further ingrained as an intermediate input, the service is coming under increasing pressure to manage growth in demand at a rate faster than planned increases in funding, workforce and assets has been able to keep abreast with. The CSP does not describe how it will achieve its goals but it needs to be noted that however and wherever healthcare is delivered to our population associated diagnostic imaging and interventional services will be required as a core tool and any plan needs to account for the delivery of diagnostic services to support the model applied. The radiology team would like to note that existing radiology services are currently at capacity. Any changes in healthcare services delivery models needs to carefully consider this and look at options for building capacity or reducing demand. In the 2017/18 financial year the service performed approximately 98,650 diagnostic imaging and interventional procedures. This is expected to grow in the next 10 years to just under 125,000 based on the "most likely" demand modelling as shown in graph one below. Five and ten year demand projections have been modelled for the service based on three scenarios. • Conservative**:** current volumes extrapolated by population growth and demographic changes. • Most likely: current volumes extrapolated by the average annual increases and decreases for the different modalities of the past five years • Worst case: current volumes extrapolated by the highest annual increase of the past five years	UPDATED – section added in Enablers

	 Nationally radiology services expect to see a step-rise in demand linked to volume superimposed on the background of upward trends relating to complexity of patients. Current resourced capacity is fully utilised causing wait times to increase. The 5 and 10 year forecasts show that demand is continuing to grow well beyond current resourced capacity based on the most likely scenario modelling.	
32	particularly welcome the emphasis on wellness / wellbeing mentioned throughout the plan. We acknowledge the need to re-structure the health system to refocus efforts to address the pressures (now and in the future) on aspects of Health Services in Hawke's Bay. We endorse the proposal for new investment in preventative activities. We anticipate that this will re-focus the system of care towards a population based model. It fits well with the proposal to have far less focus on the hospital and treatment services. We also applaud efforts to focus on equity and more of "doing with" rather than "doing to and for". We therefore suggest replacing the word "care" which assumes "doing to/for" with the word 'service(s)' to more accurately demonstrate this We applaud the references to intersectoral effort to address health and wellbeing. There are many examples within the Child Health Team where this is already a success. We like the "place based" theme of the plan for service provision and suggest that it has a very definite role in health service provision in the future. We endorse the emphasis on workforce development and the removal of professional silos (p 49-50). suggests: There is a need to change the title from a Clinical Services Plan to a Health Services Plan, and to change the paradigm from a medical model to a wellness model. The use of the word "clinical" limits the scope of the plan to a treatment model. This is a great opportunity to make changes to our services and do things in a different way but having wellbeing as the model that underpins everything we do. That there is confusion here in the hierarchy between a plan and a strategy. It is peculiar that the plan document is intended to lead to a Strategy document in the future. The document is inaccurately named – it's not a "plan" and reads more like a strategy. A plan ought to be a "scheme or method of acting or proceeding" whereas this document is a catalogue of issues that the health sector faces and aspirational concepts of what it might look like if these issues were addressed. To be useful the "plan" should at least explore steps which will need to be taken to get from A to B and should be informed by a well-constructed strategy. For example: pg 27 " Ensure the primary care model is designed to meet physical, mental, whanau, spiritual needs within the Te Whare Tapa Wha model". The document needs to give details of how it is intended this will be achieved. The document appears trapped in the medical model of a "clinical service" that responds when there is ill-health. A more positive and pro-active approach would be to use a model founded on maintaining	Acknowledge all feedback. A change in title has had serious consideration, however the Clinical Services Plan (document) will soon be superseded by our new strategy. As part of the next phase of strategic planning, further documentation and definitions will be produced that should clear up any confusion, but in hindsight agree with the comment on the name of this plan. It is this next stage that will address the "How". Further expansion will provided for within the plan to children and young people. UPDATED – section added on children and young people as well as specific elements in table.

	wellbeing. The sections on the re-structuring of primary care are still rooted in a medical model that assumes people will be ill before they access health services. There is a need to change the paradigm to view people as essentially well and look at ways to maintain that wellbeing. Although determinants of health are referred to, no plan for dealing with these are discussed. Unless serious attempts are made to address these underlying determinants there will not be meaningful systemic change in wellbeing across populations. This will require innovation and ambition, working closely alongside other sectors, particularly including education, MSD, housing, and with Central Government. We need true Intersectoral leadership, governance, and planning at a national level. While we recognise that funding and contractual agreements often dictate how we work collaboratively, the Hawkes Bay health sector has an opportunity to demonstrate that working with other sectors at implementation level can realise health status/outcome improvements. Further to the focus on "doing with" individuals and whanau rather than "doing to and for" them, we suggest that the word "care" implies the latter rather than the former and would therefore urge the use of the word "services" to replace "care". The "Plan in a Nutshell" identifies whanau with children and young people and older people as the two priority groups to which the Plan needs to respond to. However, we are very disappointed to note that the Plan then fails to give adequate attention to how the needs of children and young people will be met. A plan for refreshing health services in Hawkes Bay provides a perfect opportunity to design preventative services when they are most likely to have an impact. In particular, children under 5 are also almost invisible in this plan, and our observations are that they are currently inadequately serviced by the health sector. As the majority of very young children now attend early childhood centres, many of these very young children and their families are not receiving the support that they once got through Well Child/Tamariki Ora services which are largely preventative in nature. Place-based care does not need to be provided via a "health" facility – it may be more appropriate in a school, Marae, church etc., functioning as hubs for the delivery of service in the community. The buildings are of less importance than the relationships. Whanau value continuity of relationships. The Child Health Team already recognises the value of "place-based" services. The Child Health Teams' work in primary and secondary schools and the work of the Healthy Homes Team are effective existing models of this approach. These involve active collaboration alongside agencies such as Iwi-based health and social services and multiple other sectors. The plan seems to suggest that the role of community venues such as schools, and churches, Marae etc. for health service delivery would be a new innovation when, in fact, the Child Health Team has actively provided services in schools and other locations most appropriate to our populations for decades. Primary-level services are not only delivered through general practices but also through nurses in schools, homes and other places. Creative thinking is required to address improving access to primary health services, such as flexible clinic times, costing models (social insurance?), addressing waiting times when appointments have already been made, continuity of care, continuity of relationships, etc.) Within general practice, much more efficient use could be made of nurses utilising standing orders, nurse prescribing, home visiting and other outreach, coaching, etc. This is particularly true given the critical shortage of general medical practitioners in Hawkes Bay (we see a number of families and individuals who cannot enrol with an affordable practice because of this shortage). With reference to the upskilling of the workforce (page 49) we are looking for a real change in behaviour around cultural competency and institutional racism. The considerable challenges of changing the practice culture of health professionals should not be underestimated. This is especially true of cultural responsiveness and behaviours of welcome, inclusion and non-judgement. We look forward to greater emphasis and recognition of the work of nurses and other non-medical professionals so that all employees work at the top of their scope. This will enable significant efficiencies and well as increasing accessibility to services. Growing and developing the skills of the entire workforce will	

	be critical to the new model of care. The model must be truly MDT based rather than having a medical professional in the central position. We definitely see a role for home care workers, health coaches, kaiawhina and similarly qualified/skilled personnel but insist that they must be adequately trained and reimbursed for the roles they have. We are concerned by the apparent reliance on volunteers which seems to us inappropriate and unrealistic in this regard. We note that the plan refers to multiple assessments, particularly of community situation/needs. Experience has shown us that assessments can be very expensive and time consuming and delay the implementation of services and the budget with which to implement these, without necessarily providing the information that will enhance the work to be done. Most often data is available and the situation well known. We urge reducing "assessments" to the barest minimum.	
33	**Feedback on the Clinical Services Plan from representatives from the Hawke's Bay DHB Psychologists Group.** Thank you for the opportunity to submit thoughts on the draft Clinical Services Plan. We acknowledge the hard work that has been carried out to establish the plan: we are particularly excited with the initiatives to connect physical health with mental and emotional wellbeing. We are also pleased that the plan recognises the importance in identifying and highlighting inequities in supporting the health and wellbeing of our whole community. There are some questions and reflections that we would like to offer before the plan is finalised. They are outlined below: **1. The overall framework and overarching models of care.** We understand that a key focus of the plan is addressing the inequity in our Hawke's Bay community. Māori are overrepresented in the inequity statistics and therefore health care services, including mental health services, need to be delivered in a way that is successful for Māori. 1.1. From our review, we thought the plan would benefit further from acknowledging the reasons *why* Māori are experiencing these inequities, and then, how these drivers are going to be addressed. 1.2. The plan is to "develop our own local model that embeds kaupapa Māori practice and build on the strength of our iwi-led services" (Pg 21). We would like to see kaupapa Māori frameworks and models of health as a starting point of the plan to role model how seriously the DHB consider the importance of cultural competence rather than be an added component. Our health services have historically utilised western/medical models of health care. We would like to see that new health initiatives, such as those contained within the plan, be embedded within a Māori framework and owned by Ngāti Kahungunu. 1.3. Te Whare Tapa Whā is referenced in the document: this is *one* example of a widely known Māori model of health. When Te Whare Tapa Whā is referenced in the plan, the English words are used, which we believe loses part of the meaning of the model. In Te Whare Tapa Whā one of the pillars of health and well-being is wairua (identity, belonging): we note that wairua is not mentioned in the plan. Te Whare Tapa Whā has been expanded on in work by Professor Suzanne Pitama. Professor Pitama's expanded version model also identifies possible factors which may contribute to the inequity experienced by our Māori community, although we acknowledge this is not specific to Hawkes Bay or Ngāti Kahungunu. 1.4. The Nuka model referenced in the plan has been developed where Indigenous people of Alaska own and have developed their own healthcare system. We are excited by the wide-spread interest in this relationship focused model of care. Our New Zealand/Aotearoa District Health Board environment is providing a public health service within a bi-cultural country to an increasingly multi-cultural population. We acknowledge Māori as tangata whenua and the over-representation of Māori in health inequities. It is our perspective there should be careful consideration of using models and therapeutic frameworks that are developed	Overall feedback acknowledge. 1. Addressing the inequities that exist within our health system are threaded through the whole plan under all themes. 2. We will update the plan with Te Reo Māori terms for Te Whare Tapa Whā. 3. The talks of learning from NUKA, however we will be looking at developing own local model of care, by working with Whānau to meet the needs of whānau. This will ensure that it works for our Māori communities and addresses the inequities that currently exist. 4. The Clinical services plan is concept level only and detailed planning is to come in terms of deciding specific approached/models that will be implemented. 5. Noted. This will be taken on board under the PWCC work. 6. Acknowledged. Levels of distress data was reported from the Health Equity Reporting and these factors will all need to be considered in wider strategic planning and fall within capacity/workforce planning activities. Add Te Reo Māori terms to the Te Whare Tapa Whā • Taha tinana (physical health) • Taha wairua (spiritual health) • Taha whānau (family health) • Taha hinengaro (mental health) Acknowledge barriers to be broken down include intersectoral/agency and it will be a continued effort that will be worked through over time? **UPDATED – Te Reo terms were already included but have changed order so Māori word is first and English bracketed.**

	outside of New Zealand/ Aotearoa, rather the greater learnings may be in *how* these models were developed. We are not certain of the evidence base for internationally developed models of health being successful within our Māori communities. Relevant to our work, cognitive behavioural therapy is an internationally accepted and long established form of psychological therapy; however, there is only a very small, emerging evidence base for the use of modified cognitive behavioural therapy for Māori populations (e.g. Bennett, Flett & Babbage, 20151). Thus we would strongly encourage that any new initiatives are piloted and outcomes measured, before plans are rolled out for the whole Hawke's Bay community to ensure they are genuinely effective, accepted and reducing inequity. 1 Bennett, S., Flett, R. & Babbage, D. (2014) Culturally adapted cognitive behaviour therapy for Māori with major depression. *The Cognitive Behaviour Therapist*, 7, e20 1.5. The Mahi a Atua, Tairāwhiti case study is a great programme, however, we were not clear how it linked into the proposed workplan. One idea would be to look at the successful, efficacious and effective components within this programme and pilot this within Hawke's Bay. 1.6. A wider point of reflection is that greater definition of terms used would provide clarity as to the Clinical Service Plan's focus: for example it would be important to know in more detail how the DHB defines whānau. The definition of this will affect the resources needed to be whānau-centred. We comment on the use of the term 'Behaviourist' next in this document. 2. The role of "Behaviourists" We strongly support the benefit connecting mental health with physical health issues; however, we have some queries regarding the plan to introduce 'Behaviourists' into primary care. 2.1. The 'Behaviourist' role needs to be very clearly defined. The role this workforce are expected to fulfil defines what qualifications they will need and how the outcomes will be evaluated, for example, assessment and triage of any psychological aspects of health/presentation to the GP; rapid access to psychological therapy; or support with health behaviour change. 2.2. If the aim of the 'Behaviourist' role is to work with our population *most* affected by health inequity, then, the complexity of the concerns faced by this group means the workforce will need to be highly skilled in identifying and dealing with multiple issues in a therapeutic manner that engenders behaviour change. Our understanding is that Nuka trained Behaviourists are Masters level registered Psychologists or Social Workers with postgraduate qualifications in mental health. We are concerned by the assumption that 'upskilling' health professionals will enable them to have the tools to deal with complex presentations and postgraduate level qualifications may be required, such as those held by the clinicians working in the Nuka model. We are therefore wondering whether the proposed local roles would be developed in collaboration with training programmes, to provide a workforce to meet this new demand for a psychologically skilled workforce. 2.3. We would like to note that there is a statement in the plan that the prevalence of psychological distress is higher in HBDHB than any other DHB (Pg. 5). Currently the number of psychologists in HBDHB is the *second lowest per capita* for any other DHB in New Zealand. We are concerned that our current primary and secondary mental health provision are known to be struggling to meet demand and that the true 'Behaviourist' role may be engulfed or lost within this. We would hope that a place to start would be strengthening the existing mental health services to work with those in psychological distress. 2.4. A further query is the acceptability of the term 'Behaviourist' within the New Zealand/Aotearoa context. Behaviourism was a movement in the field of psychology last century and has been heavily criticised for not accounting for wider influences on people's actions and states of well-being. The term 'Behaviourist' is not a	

	Protected clinical title and is not widely used in Europe, Australia or New Zealand. We understand from the Nuka conference that one of the considerations in using the term 'Behavioural health' is to capture a wider range of health behaviour and to reduce the stigma associated with mental health; however, care must be taken not to minimise or trivialise psychiatric and psychological disorders. Further, a strict focus on behaviour may be seen to ignore the complex picture that people present with, for example the cognitive, social, physical, spiritual and cultural influences on their mental well-being and health related behaviour. 2.5. As well as the Nuka model, we understand that there are examples of New Zealand/Aotearoa models of care where early and rapid access psychological intervention has been aligned with provision of GP or primary care, including a current pilot in Palmerston North and, within Hawkes Bay, a partnership between a private provider and a Hastings/Flaxmere GP practice. We are excited to hear the outcome of these pilot projects. If effective and well-received, there may be significant benefit in rolling these locally grown initiatives out further. 2.6. We acknowledge the excellent service level outcomes that the Nuka model of health has achieved. We have been unable to ascertain data related to referral rates, input provided and outcomes specific to the 'Behaviourist' role in Nuka so we have been unable to fully understand the potential benefit this could have. Similarly, we have been unable to ascertain data relating to the described 'Learning Circles' in terms of benefit to health behaviour outcomes. The acceptability and mode of delivery of group programmes would need to be evaluated within the local cultural context. 2.7. In summary, we wholly support the recognition of the interplay between mental and physical health and the need to provide a responsive service for the high level of psychological distress in our community as well as providing support for health behaviour change. We are aware that the capacity for the provision of psychological services within the wider Hawke's Bay health system does not meet the demand. However, we would urge careful consideration and reflection on the contributing factors to the psychological distress and health related behaviour patterns in our community, particularly where inequity is observed. We would urge careful consideration of the evidence base of possible modes of delivering of psychological care and its relevance and acceptability to our community and cultural groups. We would urge careful use of resource to bring the most genuine gains in well-being to the widest group. We acknowledge that this may be a complex process and would be willing to contribute in any way that we can. 3. Process and planning 3.1. We acknowledge that the Clinical Services Plan is one contributing document to the health board's investment plans going forward and is not intended to detail financial or operational planning. However, we would find it helpful to have approximate time frames for the 'Phases' (i.e. in months or years) detailed in the plan. 3.2. The Nuka model, which is widely referenced as an exemplar model of primary care, is known to have a higher level of funding per head of population served. We would again highlight that the provision of greater access of psychological care or support for health behaviour change will have significant implications for workforce development. Recruitment of individuals sufficiently skilled and credentialed to deliver evidence based psychological therapies has proved challenging in Hawkes Bay at times. 3.3. We would also highlight that there should be an acknowledgement that collaboration between agencies takes time and resource, for example the Ngātahi project identifies improving links between agencies as a desired outcome and is structured to allow for this. We would like to highlight that there would be benefit for clear expectations for collaboration and realistic time allocation for this to be achieved within roles.	

	3.4. With many national initiatives (e.g. The Government Inquiry into Mental Health and Addiction, Disability Learning Support Action Plan, The Child Well-being Plan) currently unfolding we would welcome detail of how the Hawkes Bay Clinical Services Plan links with these wider programmes. *3.5.* In any service plan, barriers and risks for change need to be acknowledged so that they can be minimised or overcome. For example, one of the common barriers to working holistically is people who do not "fit" service Criteria/ constraints, for example due to lack of diagnosis, severity of diagnosis or age. There would be benefit in identifying the barriers to the Clinical Services Plan at the inception e.g. workforce development, validity of intervention and monitoring of effectiveness to allow for discussion in how we may be best managing these. 4. Summary of Feedback 4.1. We would like to see Hawke's Bay models of care built upon Kaupapa Māori models of health and not see these embedded at a later date; 4.2. We would find benefit in more detailed definitions of key terms e.g. whānau contained in the plan; 4.3. We think there would be benefit in the plan of identifying the specific contributing factors to the patterns of inequity in our local community and how these may be addressed; 4.4. We would welcome acknowledgement of the barriers to/ resources required for working across agencies, so that this can be addressed in the plan; 4.5. Given the plan to improve access to psychologically based assessment and care at a primary care level, the Psychologists group would like to offer representation on any working group that is discussing the development/implementation/delivery of care based on psychological models of behaviour change or mental well-being. Thank you again for the opportunity and we look forward to continuing discussions and plans about how to best serve our community.	
34	Firstly, we would like to applaud the drafting of this ambitious and visionary plan *Transforming our health services Clinical Services Plan: the next ten years (2018)* referred to as the CSP. The inclusion of the case studies and 'element tables' provide a real flavour of what could be achieved here in Hawke's Bay. We have made some observations and pose some questions and suggestions to consider for the next stage of the CSP development. 1. Our Future Health System – the context and scope of the CSP We understand the focus of the CSP is to transform Primary care as a priority but we also note the desire to be more successful at co-design, community engagement and whānau led processes to inform health care. Therefore, is the CSP a response to the challenges we face or a community led plan? ***We suggest the CSP should make clear what operational principles & values will drive the final writing of the plan and support a foundation of trust and positive relationships.*** Page 2 of the CSP acknowledges the socioeconomic determinants (p 2, 26) and page 11 refers to re-framing our approach to focus on wellness and wellness models but throughout the actions continue to focus on service delivery. Wellness starts at home and in the community; environments such as schools and workplaces. The omission of actions related to tackling the wider determinants of health minimises the ability to make wellness gains.	Acknowledge the feedback. *Is the CSP a response to the challenges we face or a community led plan?* *How does the CSP link to wider strategic plans either in development or proposed e.g. HBDHB 5 Year Strategic Plan? Revised Equity Report? Big Listen? DHB People Plan?* The CSP was created in alignment with the themes and information contained in the other strategic/planning documents. A list of strategies, sub strategies and planning documents such as those mentioned but also national regional documents will be inputs into the next 5 years strategy. Further information and a picture will produced in the near future to show how these all come together. The CSP is also an input into that next strategy. The Clinical Services plan does not capture all determinants of health such as a public health plan. It makes reference to it but this will need to captured elsewhere and incorporated into the next 5 year strategy.

	We would like the CSP to indicate how it intends to invest more in broader population health approaches, not simply focusing on preventative care but considering approaches such as environmental change that shape behaviours – social economic, natural and physical e.g. the built community, infrastructure for safe drinking water, sewerage and housing. *In reference we suggest the 'Future health system" diagram on page vi needs a larger focus on home and community and environments, the promotion of wellbeing that sits outside of primary and secondary care.* How does the CSP link to wider strategic plans either in development or proposed e.g. HBDHB 5 Year Strategic Plan? Revised Equity Report? Big Listen? DHB People Plan? *We suggest a planning model / diagram that sets out how they are all linked.* *We also would like to see a more long term vision as transformational change will take time – we suggest 20-30 years or generationally focused.* We agree that children and young people are priority groups and there needs to be increased resourcing for tamariki during the first 1000 days of life p 26. This is not made clear in the CSP. *We encourage the CSP to align with the proposed National Child & Youth Wellbeing Strategy outcomes framework.* 2. Inequities – is the CSP well linked to addressing key equity findings? Reducing inequity across our Hawke's Bay region is acknowledged early in the CSP along with listing some of the persistent inequities across our population. We saw this referenced at the beginning of the plan but then no reference to how we will address some of the key findings listed on page 5. *The CSP needs to articulate how these areas of inequity will be addressed.* *We suggest the CSP includes more discussion on the importance of universal and targeted approaches to achieving equity and examples demonstrating targeted and proportionate universalism*[2] Epidemiologist Geoffrey Rose refers to the 'prevention paradox' and provides an example regarding alcohol harm in a population "greater societal gain will be obtained by achieving a small reduction in alcohol misuse within a far larger group of 'risky drinkers' that by trying to reduce problems among a smaller number of dependent drinkers'. 3. Localities and place based initiatives We agree increased focus on localities and place based approaches is key to the CSP. Place based planning needs to be broader than health services looking at the physical environment, infrastructure, accessibility as well as settings within a community such as schools, workplaces and the home. *We encourage the CSP to acknowledge how we support & build on current locality plans rather than reinventing new. Page 18 needs rewording to acknowledge this - replace 'establish' with 'investigate and support' current community level plans…' for example, Hastings District Council has at least 15 community plans.* 4. Mental health & wellbeing With the national mental health inquiry & proposed HBDHB mental health service re design there is opportunity to ensure broader strategies are incorporated to support maintaining and promoting positive mental health. *We suggest the CSP demonstrates the positive impact that strategies such as the Hawke's Bay Regional Economic Strategy (Matariki) and Social inclusion Strategy impact on mental wellbeing through whanau participation in meaningful employment, education and access to quality housing for example.* 5. Commissioning & building trust The CSP is an opportunity to review how we commission services and providers and minimise competition that ultimately do not serve the community or whānau. South Central Foundation (NUKA) reinforce the importance of trust between agencies and community. The Department of the Prime Ministers and Cabinet	The Health Equity Report was not completed at the time the CSP was drafted. More detailed planning is to follow after the development of the new strategy and this is where the detail will be addressed. Some key points raised will be added to the CSP. Update the plan. Pg11 update second paragraph to include : The Department of Prime Minister and cabinet Child well Being Strategy will form a blueprint for local and regional development and trust based commissioning ensuring authentic community participation in deciding how reserves are used. Update Pg 26 "Ensuring Whānau members receive health promotion to support self-management and screening and preventative interventions" UPDATED –Also references to existing work with communities (schools etc) and focusing preventative strategies in places people congregate etc. Change in 'Nutshell' section.

[2] **Targeted universalism** is a blended approach that recognises that universalism can still result in an unacceptable health gap, and that a targeted approach can have little effect on the slope of the health gradient. Targeted universalism defines goals for all, identifies the obstacles faced by specific groups, and tailors strategies to address the barriers in those situations. (Powell 2012) **Proportionate universalism** recognises that to level up the gradient, programs and policies must include a range of responses for different levels of disadvantage experienced within the population. Marmot states "focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. (Marmot 2010)

	Draft child wellbeing strategy across government departments could be a blueprint for local and regional development and trust based commissioning. Is this a true representation of community engagement? ***We recommend if the community voice is not evident within the feedback mechanism consultation should continue or adapt to ensure authentic community participation.*** 6. Choose language carefully The language we use is important in what is communicated especially when trying to engage with community. ***We suggest a rethink of the name Clinical Services Plan to reflect the move away from a clinical model.*** ***We recommend the following language be considered and changed.*** The term 'consumer' is individualistic, and indicates dependency, if we want whānau empowerment and tino rangatiratanga (self-determination) we need a new term that depicts just that e.g. community member, citizen, customer-owner. The term 'primary health' instead of 'primary health care' broadens the scope of what we are trying to achieve within the plan rather than limiting the focus on a service model. We also see reference to preventative health 'interventions' (p 26) the term denotes being 'done to' as opposed to self-empowerment through health promotion. Thank you for the opportunity to feedback.	
35	Thank you for the opportunity to feedback on the Clinical Services Plan (CSP). We acknowledge all the input and efforts to date and we applaud the intent and desire to change to the way that health services are currently delivered in Hawke's Bay. Overall purpose and scope The title 'Transforming Our Health Services' and the stated intention – "…to respond to the major challenges…that improves outcomes, …achieves and takes a whole of health system approach" is laudable. However, it is also misleading. To achieve these changes would require a major reorientation of our health system as a whole, both nationally and locally. However the plan itself does not and possibly cannot match this level of ambition. If this plan is in essence a major shift in the way that our primary health care model works, then we would agree that this is desperately needed. This would require a major change in how primary care is funded and configured. However, we would also argue that changing the model of primary health care is a necessary step but in-sufficient in itself to significantly change population health outcomes. It is the view of the Population Health team that a population/public health focus is also required, with a genuine effort to address the social determinants of health which lie outside of the health sector's direct control. Yet attention to these issues remains very limited in this plan. Perhaps 'clinical services' implies the scope is limited to clinical services alone (medical model – treatment oriented)? So our question is - do the necessary population health/preventive strategies (and not just preventive care) belong in this plan? Our concern is that if population/public health strategies sit outside of the CSP then the work of our Directorate and the opportunities to exert influence intersectorally and at a national level may get overlooked. There is mention that the CSP will inform a five year strategic plan (page 2). Is it anticipated that the public health outcomes and strategies belong here instead? This does seems odd that a services plan determines the strategic direction of our organisation and not the other way around.	Feedback acknowledged. Population/public health is referenced within the CSP but is not the main focus as the cope is clinical services. However that does not mean that this will be overlooked as it will still need to be incorporated within the overall 5 year strategy. Preventative strategies will need to feature in another document. We have received other feedback rais8ing the issues around definitions of and language being key. As part of the next phase of working the "how" we will need to define these terms. The plan was developed after 12 months of co-design across the sector. Māori and Pacifica representation across clinical/non clinical and consumer participants were part of the core teams that developed the CSP themes and elements which came out of the workshops. The "how" we go about delivering the CSP falls into the next phase. Feedback that is not limited to CSP will be included in the next phase. Pg29 Mental wellbeing - Page 29 • Table at bottom of page - add community programs – that build social connection and social inclusion / celebration of community diversity. Page 19 • We support the provision of mobile services however the example needs to include Maori in addition to Pacific. **UPDATED - New section in Place based planning on Population health and the physical environment.** **Wording change accepted.** **Addition to 'problem with current state table'**

	We recommend: a diagram that shows the various plans and how they inter-relate e.g. DHB Strategic Plan, CSP, Annual Plans, Matariki (REDS), Social Inclusion etc. Many of the comments that follow depend on the response to the question of scope, raised above. Key themes we'd like to comment on follow, then a section that lists specific changes to the plan. 1. Language • We would prefer to see 'prevention strategies' used in favour of 'preventive care' (although depends on the answer to above – is this plan only concerned with services?) For example, a preventive strategy would include facilitating community to advocate for speed bumps in a neighbourhood with a high incidence of pedestrian injuries, versus preventive care might be teaching a new diabetic how to monitor their blood sugars. • Primary health care or primary care? They are used interchangeably but different models are implied. Primary Health Care is a broader term which derives from core principles articulated by the World Health Organisation and which describes an approach to health policy and service provision that includes both services delivered to individuals (Primary Care services) and population-level "public health-type" functions. • 'Consumer' is not value-neutral. This words reflects rational autonomous human beings acting in our individual interests to maximise our self-interest. We would assert the need to challenge this view and appeal to a different set of values; communitarian ethics, participation as citizens not just as consumers of services. Everyone has a stake in health and health care for the population at large and inequities matter for everyone, whether you are sick or well. Māori and Pacific world views are also communitarian and don't fit the consumer discourse. Members of our community, citizens, people... we all want to live in good health and most of us don't achieve this from being a consumer of services. We recommend: A glossary of terms would be helpful and a reconsideration of the terms used. 2. Cultural models/framing of this CSP • It would be great to see this plan adopt a cultural model /lens – Māori or Pacific to communicate the shift in the way that the health system will be reoriented. Whilst Te Whare Tapa Wha is referred to, there is little to suggest that this has framed the thinking. We recommend: A simple executive summary using a cultural model/lens. This could also be shown diagrammatically and incorporate a quality improvement model to create the outcomes we seek for our population. This might help to simplify to all staff and the public what this plan aims to achieve as well as how we'll get there. Otherwise it is hard to envisage what exactly this plan is about. Collaboration and working with existing structures / systems • Collaboration is referred to throughout, with whanau, with communities and with other health and social services. How this is achieved is a lot less clear. • Intersectoral collaboration is going to require collective impact models used across sectors, shared outcomes, and joint funding arrangements. It's also going to take long term relationships and trust. • We would also like to see more focus on strengthening existing services or initiatives that are community or NGO driven where they are achieving results or have the potential to do so, rather than the DHB looking to create these anew. • Collaboration of providers and communities around place based initiatives makes sense. However being aware of whose voices are being heard, and not heard is critical. The bringing of evidence and equity /	A range of other minor edits accepted.

	health impact lenses to this work is a valuable role for the DHB to play and to triangulate community processes to mitigate the risk of perpetuating further inequity or injustices. Population health advisors and others in our team are skilled in these areas. **We recommend:** The DHB commissioning arm facilitates practices and contract agreements that are anti-competitive, and which are funded and incentivised for collaboration. The DHB has the opportunity to facilitate and support through providing a 'capability backbone' (project management support, skills and evidence). Environments • We would like to see more of a focus on environments that shape behaviours – social, cultural, economic, natural and physical. Less obvious examples (aside from poverty and the hallmarks thereof) include the built infrastructure (e.g. cycleways, safer roads, pedestrian walkways, age friendly transport systems, and healthy affordable housing for all), community assets (libraries, Marae, churches, swimming pools, etc) and infrastructure for safe drinking water (a fundamental pre-requisite for health and a high priority for Hawke's Bay). • This plan needs to recognise that climate is a huge driver of current and future impacts on health and there is an urgent need for mitigation, as well as adaptation to climate change. There are likely to be significant changes in the economy, with disruption to livelihoods through loss of employment, and risks to the financial system collapsing. Climate change is likely to lead to increased climate refugees and sea level rises and the need for a managed transition of communities away from coastal areas. All of these will cause significant disruption to the health of our communities as well as to our service infrastructure if we don't take this into account now. **We recommend:** An explicit focus on ensuring a sustainable health care system that assures equity. The health system itself has a big opportunity to show leadership by modelling sustainability in its operations and considering the co-benefits to health and the environment through its activities. The DHB has already shown leadership through its collaboration with the Regional Council in the Go Well transport initiative. Our DHB could take a lead in future scenario planning with Councils and other agencies and future-proofing our services and communities, including from climate change threats (and opportunities) to health. Regional approach More of a regional approach could be reflected in this plan and would bring significant efficiency gains e.g. shared public health intelligence and planning, needs assessment functions (e.g. a shared Health Equity Report for East Coast and Mid-Central North Island), shared workforce development planning, recruitment and training, and other functions. There is much to be gained by sharing expertise and workload. *Has this been fully explored?* Settings • With respect to localities work, there are a number of locality based plans and networks already in place, many led by Councils. The HBDHB needs to work alongside existing community / locality based initiatives already in place. • There is very little mention in this plan of the school-based services and activities already happening in our communities and the strength of working in this way. Public health nurses work with all schools and early childcare/education centres in Hawke's Bay but target those with a higher deprivation rating. They also work in partnership with a significant number of agencies in recognition that it takes a village to raise a child.	

- If preventive strategies/ initiatives focus on the places that people congregate as groups within community they are more efficient as they can reach wider than whanau / families and households and help to reduce stigma. It also raises the awareness of those whose decisions impact on the health of others, rather than risk victim-blaming e.g. via workplaces and policies around healthy eating, smokefree, mental health etc. Also these initiatives are more likely to be bottom-up and can be supported by the DHB with minimal effort. There is a precedent for this kind of work all over NZ in many different guises, including many community development initiatives as well as intersectoral/interagency networks led/facilitated by Councils.

We recommend: that the DHB is clear who is primarily responsible for connecting with the various locality groups and how working in this way is helping to deliver population health outcomes, being cognisant of community development principles, equity and evidence.

Child and youth

- Given the importance of the early years on life for health trajectories later in life, we'd like to see more of a focus on this age group. There is much work to be done in harnessing the efforts of many to improve the experience of growing up for our children and youth in Hawke's Bay. The schools settings based approach is already a key way of working for public health nurses and health promoting schools staff.

We recommend: A strengthening of the existing supports to children and youth by improving both the environments and the services available to child and youth via schools and other youth friendly services delivered in a culturally appropriate way, and to those most in need.

Suggested Specific Changes to the Plan (with page references)

The Plan in a nutshell - Page v

- Add in section on 'Scope' and include diagram of other Strategies and Plans and how they inter-relate.
- Include reference to the need to keep people well in their own homes and communities Consider change from preventive care to preventive strategies to include a population health focus.

Our future health system - Page vi

- Diagram:
    - Needs inclusion of Key Outcomes/Indicators of progress
    - Change wording of box "Keeping **older people** well at home & in their communities" to "Keeping **everyone** well at home & in their communities".
    - Left side – add Population health / wellbeing focussed initiatives/ Pro-equity and environmentally sustainable
    - This diagram gives the greatest emphasis to Primary Care over Home & Community and Hospital settings. While primary care should absolutely be at the heart of healthcare provision, it is important to reflect that the majority of people are well and emphasis should be given to 'Home & community' as the level to focus on if we want to take a truly preventive approach and keep people well, rather than to treat disease.

Place based planning

- This section needs to recognise and respect existing providers and community structures and work in partnership with communities, whilst adopting community development principles and bringing evidence to the table.

Page vii

- Not just services, but needs to reference environments that support well-being.
- Reference the need to add life to years for older people.
- Mention rurality in relation to transitions home and intensive rehabilitation – how might that work in rural CHB or in Mahia?

Introduction page 2

- Mixed messaging as to what this plan is about. Is it a whole of systems approach or just a clinical services plan?

Page 5

- Reference needed here to Housing being a well-recognised major driver of ill health and inequity in Hawke's Bay. If you don't have security of tenure, or live in crowded damp, cold and unaffordable housing, then stress, ill health and family living is seriously impacted.

Page 6

- Add to second paragraph that the liveability of our communities, and the environments that shape our behaviour are also important influences on the development of long term conditions e.g. the increasing sedentary nature of our lives, concentration of alcohol and junk food outlets in poorer neighbourhoods, etc.

Page 9

- The table which outlines the "problem with the current state" and "what a person and whanau centred system looks like in the future" on page 9/10 could also focus more on environmental determinants. An example of a population focused problem and solution is included below:

Problem with the current state	What a person and whanau centred system looks like in the future
A shortage of safe, warm, dry homes mean children experience an unnecessary burden of childhood illness	Issues of housing supply and affordability are addressed so that all children, including those in rental and social housing grow up in a safe, warm, and dry home.

Chapter 3 - Page 11

- This is a good section. Like the focus on wellness, equity, rights –based approach and the Treaty. Need to also recognise Pacific models of health, values and solutions too. The health needs and cultural considerations for Asians in Hawke's Bay increasingly need to be understood.

Page 13

- Needs to reference that people also want to have control over the determinants of health and that health has a role to influence these and to support community to advocate on its own behalf (e.g. community input to alcohol licensing decisions).

Place-based planning - Page 17

- We know which of our communities with the greatest needs are already. Let's work together to provide solutions. For many this is around addressing poverty and the barriers this imposes to health, as well as health literacy.

- Needs to reference the working with Councils and the many existing community/locality plans/ networks in place

Elements of service and model of care development – Page 18

	• The suicide prevention plan is only one aspect to empower and enable communities to promote wellbeing, build resilience and stay connected. It requires a more holistic, multi-pronged, intersectoral approach than simply suicide prevention. Page 19 • We support the provision of mobile services however the example needs to include Maori in addition to Pacific. Mental wellbeing - Page 29 • Table at bottom of page - add community programs – that build social connection and social inclusion / celebration of community diversity. Page 31 • Reference the Positive Ageing Strategy and the myriad of examples of community initiatives that help to address the needs of older persons – Timebanks, University of the Third Age, Falls Prevention Programs, activity programs Page 52 • Suggest examples of what functions could be shared regionally are added – e.g. Health and Business Intelligence and Workforce Capacity and Capability - recruitment and development, would seem like a good place to start. Thank you again for the opportunity to comment. We hope the above is useful, if not for this plan then that it can feed forward to the Strategic plan. Thank you again for the opportunity to comment. We hope the above is useful, if not for this plan then that it can feed forward to the Strategic plan.	
36	Submission to the HB DHB from HDC on the Draft Clinical Services Plan – October 2018 On behalf of the Hastings District Council, thank you for presenting to our Council meeting on Thursday 25 October on your proposed Clinical Services Plan. It was very insightful for our Council to hear about the current challenges facing our local District Health Board and staff. This plan provides a significant opportunity for our community to have a say on what our health care services should look like over the next ten years and beyond. The Hastings District Council supports the plan as it is and doesn't seek any changes. The current challenges faced by the DHB with stretched hospital services, an increasing population of older people and cultural barriers affecting people's access to receiving timely and adequate health care are concerns for us all. We support the Hawke's Bay District Health Board's direction in the plan, in particular with the strong focus on mental health, care for the elderly and embedding kaupapa Māori practice into the plan. These are critical service areas of our community which have growing demands for a variety of resources and need preventative care and highly-focused primary health services. Changing how our community can access health care in Hawke's Bay is vital. The work our Council delivers throughout the Hastings district goes hand-in-hand with the work the DHB also carries out with our people. We too see the effects of poverty, poor housing and unequal opportunities. We agree that parts of the current health care system are broken, and major changes will be needed in the next ten years to ensure our people can reach appropriate and affordable care. We fully support a plan which opens up access for the whole community to good quality health care and support. Following your presentation, Council is	Acknowledge your feedback.

	supportive of the DHB focusing on eliminating (or at least reducing) the extent of current barriers to the whole community having access to appropriate health care services. Hastings is a wonderfully ethnically diverse district and we would like to see a plan which encompasses all of these various communities. We welcome the opportunity to support the Hawke's Bay District Health Board on this important journey. The Council's Community Development Team look forward to any opportunity in this change process that engages them in a helpful role that leads to improved outcomes to the wider community.	
37	I do think that my feedback substantially changes the commitments and goals and is consistent with He Ngakau Aotea and with current evidence on achieving equity I've summarised feedback below : There needs to be a definition of what we mean by equity in the report. I suggest the following : ***Equity is the absence of avoidable or remediable differences among groups of people. Health inequities involve more than inequality with respect to health determinants, access to the resources needed to improve and maintain health or health outcomes. They also entail a failure to avoid or overcome inequalities that infringe on fairness and human rights norms. Social determinants of health, including environmental, housing, income, education explain most of our inequities in outcomes with healthcare estimated to account for approximately 10% of inequities. The inter-generational traumatic impact of colonialism has had long term impacts on Māori culture.*** There needs to be a description of access barriers. I suggest we include : ***We know that many in our community face barriers to access and high quality care including low health literacy, limited cultural competence of providers and lack of transport, Out-of-pocket costs are significant barriers to access to care and co-payments to general practitioners are unaffordable to some*** There should be a description of the impact of inequity. I suggest : ***Examples of inequity are the avoidable differences in outcomes for people with cancer and heart disease patterns of hospital presentation for bowel cancer. Of people with colon cancer, 43% of people in the lowest NZ Deprivation (NZDep) quintile had their initial disease presentation at an emergency department, as opposed to within primary care, compared to 29% in the highest quintile. Forty-four percent of Māori and 51% of Pacific people diagnosed with colon cancer present as an acute emergency, compared with 33% of non-Māori-non-Pacific people. Among people with cardiovascular disease, preventable deaths have occurred from lack of access to life-saving cardiac interventions and surgery. These preventable deaths contribute to 25% of Maori males dying before the age of 50 and 50% dying before the age of 60.*** There should be a description of our commitment to equity. I suggest : ***Our commitment to achieving equity will include implementing a data-driven quality improvement process with root cause analysis that addresses the specific needs of people and whanau in context, and forming partnerships with whanau, hapu and iwi ; Team-based approaches incorporating community health workers ; tackling issues at multiple levels of person and whanau, clinician, organisation, community, and policy, and address medical and social determinants of health.*** There should be acknowledgement of the influence of the NUKA model of care in the CSP. I suggest : ***In doing this we will learn from the Nuka System of Care which is a holistic, population-based healthcare system owned, created, and implemented by Alaska Native people to maximize physical, mental, emotional, and spiritual well-being. The learning that we apply from Nuka will include shared responsibility, commitment to quality and continuous improvement, and whanau wellness. We will focus on building trusting relationships and through this improving access to care and quality of care; reducing emergency department visits, specialty visits, and hospital days; reducing staff turnover; and delivering high patient satisfaction. Applying Nuka to our context will include promoting self-determination, community participation, Maori knowledge and leadership in collaborative partnerships with communities. A key principle of our quality improvement will be a***	Feedback acknowledged 1. Add definition of "Equity" and inequity. 2. Add to access Barriers cost to consumer. 3. The detail around data driven quality improvement process to be included as part of the strategic planning process. 4. Nuka is acknowledged on pg. 11 and 21, where it the plan talks about learning from the NUKA model of care. 5. Add to pg. 13 "easy to navigate". 6. Include feedback around suicide in the mental health section. 7. Include headline goals Update Plan 1. Add definition of Equity and inequity (pg9) 2. Add to access Barriers cost to consumer. Consider if adds value to add any further barriers 3. Add to pg. 13 "easy to navigate". 4. Add suicide to mental wellbeing section. 5. Include the headline goals. Could repeat element on pg18 "working with community …suicide..." UPDATED – Definition of 'inequity' was already included (but in simpler language) but have added wording around social determinants. Definition of 'equity' added. Barriers added. Added point to our commitment to equity (which was already included). Added 'navigate'. Suicide added to mental health section

	focus on person and whanau. We recognise that partnering with people and whanau in meaningful, participatory ways where power is shared, is critical for understanding root causes of inequities and successfully designing and implementing solutions. The Nuka System of Care has shown us that health inequities are not inevitable when self-determination is enabled. This will mean giving Māori providers more self-determination and autonomy, challenging rigid non-Māori world views of health care systems, funding, and power. We fully anticipate that these views will challenge our current distribution of resources and require us to focus more on key community concerns such as family violence, mental health and addictions, health of young Maori women during pregnancy There should be a significant statement in the CSP relating to our commitment to address inequity. I suggest *: Our commitment to health equity will bridge the chasm between aspirational goals and persistent health inequities in quality of care and outcomes by becoming increasingly intolerant of inequitable health outcomes. Our intent is to* *1) Increasingly invest additional resource in prevention and screening programmes that reduce the burden of disease and ill health on our community* *2) Explicitly commission quality of care with funding mechanisms to achieve equity, holding ourselves accountable through public monitoring and evaluation, and supporting with adequate resources;* *3) Working inter-sectorally to address all determinants of health for individuals and communities with coordinated approaches, integrated funding streams, and shared accountability across agencies;* *4) Using person and whanau centred care to share power authentically and self-determination;* *5) Have free, frank, and fearless discussions about impacts of re-distributing resources towards those currently under-served in our community* We need to further describe our commitment to commissioning for equity. I suggest : *Our commissioning approach will be underpinned by achieving health equity and will consist of 1) assessing population need, 2) codesigning the best 'services' to meet that need, 3) purchasing the services and 4) holding service providers to account* *We need to reference making our services easy to navigate as well as being easy to understand* We need to describe further how we will work with whānau to design the services they need. I suggest : *The vision of 'everyone in Hawke's Bay to be healthy' is necessarily an equity vision and requires a particular focus on those with 'unmet needs'. This means* • *Services being designed specifically to meet those populations who currently experience the poorest health and social* • *Up-skilling of clinicians/health professionals, with particular regard to cultural competence, mental health and addictions, wellness focus, and family violence.* • *"Commissioning for equitable outcomes"* • *Multidisciplinary approaches which more holistically consider and address health and social needs and aspirations for families.* • *Whānau wellness model to be considered in addition to an expectation that core services will equitably meet the needs of those with unmet need.* • *A rights-based approach to health meeting our responsibilities under Te Tiriti o Waitangi* • *Incorporating the guiding principles of the 'Nuka' system of care whilst giving primacy to Māori indigenous thinking, values and solutions.* *Our response to working with whanau to design the services they need will include:* *1. Better understanding of the health needs and aspirations of young, low income families in Hawkes Bay, and in particular Māori and Pacific families. To do this we will undertake more regular health needs assessments with an explicit health equity focus. Services will be designed to prioritise addressing the needs of those with the poorest outcomes.*	

	2. Embedding cultural competence, and multidisciplinary approaches as necessary enablers for services that work for everyone. There will be an expectation of equitable outcomes for all services, supported by appropriate monitoring and consequences. *3. Commissioning for equitable outcomes by developing and adopting a commissioning framework that commissions for equity, holding providers of services to account to ensure equitable outcomes are met.* *4. Taking life-course approach - recognising the need to shift resources to services focussed on the best possible start to life, and including addressing Adverse Childhood Experiences.* *5. A rights-based approach to health that addresses all determinants of health.* *6. Meaningfully including the voices of 'individuals and whānau with unmet need' at every step.* We need to describe our commitment to codesign. I suggest : ***We recognise the value of equal partnership with 'real people and whanau' in designing services. In our workshops a young Māori woman re-centred the conversations when she related her own circumstances and reminded everyone of the contexts and conditions in which many young families (especially Māori and Pacific) live. We will prioritise the health of those who have the greatest health and social needs with meaningful input from people with lived experience of unmet health and social needs.*** *I*n terms of mental well being I think we need to fully describe our commitment to reducing suicide and addiction. I suggest ***: In particular there is a growing burden of mental ill health in our rangatahi with high levels of suicide and methamphetamine addiction. We will invest more in services for Rangatahi with methamphetamine addiction*** In terms of mental health there is a need to acknowledge that we need to integrate physical and mental healthcare. ***I suggest : We also need to integrate services for those 50% of people who have chronic physical health conditions and common mental health conditions such as anxiety and depression. We will use peer support for people with mental health conditions.*** In terms of headline goals for mental health I suggest adding ▯ ***Support is provided for all Rangatahi with mental health and addiction issues*** ▯ ***There are no suicides of young people in our community***	
38	I would like to commend the team who have worked on the clinical services plan for recognising the immense challenges faced by our health system, as well as the vision to realise that the status quo cannot continue and a fundamental shift needs to occur in the way community wellbeing is nurtured and health care services are delivered. From my perspective, there are many parts of the clinical services plan that are exemplary and forward thinking, including: (1) A recognition that the current model of primary care urgently needs to change. This includes a vision that primary care should be proactive rather than solely reactive, better integrated with secondary care, and accessible to those who need it most. (2) A plan to integrate specialist clinicians within primary and community care teams, meaning people with complex needs can be successfully managed in the community. (3) A key focus on mental health and wellbeing, including better access to self-management, wellness and resilience programmes that address emerging mental health and addiction issues. (4) A recognition of the importance of developing the cultural competency of our workforce, the need for every health professional to be working at the top of their scope, and a requirement for multidisciplinary teams to meet the needs of healthcare users. (5) An appreciation that partnership with community is key to designing successful health services, and mechanisms for meaningful community consultation and feedback should be integrated into every level of the system.	Feedback acknowledged. Agree, population health will need to fit under an overarching Strategy that includes the wider determinants of health such as public health. Noted your point around confusion. We will endeavor to clarify this within the plan. As part of the strategic planning activity – visuals will be created to show how these integrate, but this is not a key focus of the CSP document as the CSP is only one input. Add the point re equity and balance of targeted health strategies. Add issues to table on pg9 and 10 The plan takes a view of the health system as a whole, encompassing primary, community, and hospital level care; acknowledging the important influence of socioeconomic determinants' The word "whole" is confusing people. Maybe we tweak this sentence. Add the point re equity and balance of targeted health strategies.

	However, if the clinical services plan is going to achieve its goal of health equity for the Hawkes Bay region a greater focus on actions to improve the drivers of population health and wellbeing is needed to ensure individuals, whanau, and community can thrive. I have made a number of general points of feedback for your consideration below, followed by more specific comments about some individual sections of the plan. Scope & Purpose: 'Transforming Our Health Service' Clinical Services Plan: the next ten years, sets the intention of the plan firmly in the realm of clinical service delivery – that is, heath care services which are delivered to those with ill health/disease. This appears at odds with the sentiment that "The plan takes a view of the health system as a whole, encompassing primary, community, and hospital level care; acknowledging the important influence of socioeconomic determinants' (pg. 2). **If the provision of health care services to individuals and whanau is the focus of this plan, it is imperative that it fits under an overarching DHB strategy, of which population health should be a key focus. If, however, this plan is truly a whole of DHB plan, a focus on population health and wellbeing needs to be weaved throughout and accompanied by specific and measurable outcomes. If this is the case, the title of the plan should also be changed to reflect its broad scope.** Integration with other DHB strategies and plans: The focus and actions of the clinical services plan must integrate with other strategic documents including the HBDHB Annual Plan, the HBDHB health equity report, the Central Region Regional Services Plan, and the Regional Economic Development Strategy and Action Plan. The current plan does not clearly, or in one place, illustrate how it is informed by, or feeds into, other DHB and regional strategic planning documents. **I would recommend, with the help of a flow-chart, or other simple illustration a clear description of how the clinical services plan integrates into other regional strategic planning documents.** A balance of targeted and population health strategies is needed to achieve health equity: Health Equity must remain at the heart of all we do and those communities who carry an unfair burden of disease deserve the greatest investment from health services. However, it is important to appreciate that without shifting the drivers of health and disease at a population level many of these inequities will be perpetuated despite additional targeting of clinical or social services. A balance of these two approaches is vital to achieve health equity. A key example of this is in alcohol harm reduction. Results of the 2015/16 New Zealand Health survey indicate that Maori and Pacific are 1.5 times more likely to be hazardous drinkers than non-Maori or non-pacific.[1] Likewise, those living in the most deprived areas are 1.4 times more likely to be hazardous drinkers compared to those living in the least deprived areas.[3] A targeted approach (for example) would see greater resource put into screening for alcohol harm in these communities and referring hazardous drinkers to appropriate community-based services. Population strategies, such as reducing the availability of alcohol (through regulation of the hours of sale, and density of licenced premises) act to reduce the harm from alcohol across the entire population. However, because there is greater availability of alcohol in low socioeconomic areas, such strategies have the potential to disproportionately benefit those of low socioeconomic status and therefore improve equity while also benefiting the community as whole.[4] Identifying key areas where both targeted and population approaches can work together to benefit health equity is critical. **I would recommend keeping health equity as a key and overarching focus of the plan, while also recognising that health equity is not only achieved through a targeted focus on high risk communities but in some circumstances requires driving change at a population level.**	Add issues to table on pg9 and 10 Consider feedback on place based planning section as part of extending the definition as listed above. **COMPLETED – balance of targeted services + population strategies added to section 'We need a new approach' pg 9.** **Additional item added to table on problem with current state (as per previous feedback).**

[3] Ministry of Health, *Annual Update of Key Results 2015/16: New Zealand Health Survey.* Wellington: *Ministry of Health*; 2016. Retrieved from http://www.health.govt.nz/system/files/documents/publications/annual-update-key-results-2015-16-nzhs-dec16-v2.pdf
[4] Roche, A., Kostandinov, A., Fisher, J., Nicholas, R., O'Rourke, K., Piddi, K., et al. 2015. Health Promotion International, 2015, Vol. 30, No. S2 ii20–ii35. doi: 10.1093/heapro/dav030

Healthy environments drive healthy communities:
A responsive and top performing healthcare system is only one of the components needed to achieve health equity. In addition to healthcare services, collaborative action needs to be taken to create social, physical, and economic conditions which allow communities to thrive. The DHB should be positioning itself to influence decisions on the built environment (including safer street design, the density of alcohol and fast food outlets, infrastructure which encourages active methods of transport etc.), as well as the social environment (initiatives to improve social cohesion, meaningful educational and employment activities etc.). Acknowledging the important part the DHB plays in the provision of safe drinking water is also vital.
I would recommend incorporating key actions and initiatives focused on the upstream determinants of health into the 'Elements of service and model of care development' tables to ensure these key activities are not side-lined.

The clinical services plan is a vital opportunity to build in sustainability measures:
Climate change has been described as "the biggest global health threat of the 21st Century" but also as "the greatest global health opportunity".[5] Any long-term health plan or strategy must consider the implications of climate change. The clinical services plan is a key opportunity to build in measurable sustainability goals to both mitigate the DHBs contribution to greenhouse gas emissions and adapt to the changes in disease patterns, environmental, and social challenges that climate change will bring.
I would recommend building in actions focused on reducing DHB greenhouse gas emissions as well as actions focused on adapting to environmental challenges brought on by climate change.

Specific Recommendations:

(1) The diagram under "Our future Health System" on page VI, gives the greatest emphasis to Primary care, over Home & Community and Hospital settings. While primary care should absolutely be at the heart of healthcare provision, it is important to reflect that 'Home & community' is the level to focus on if we want to take a truly preventative approach and keep people well, rather than to treat disease.

(2) The table which outlines the "problem with the current state" and "what a person and whanau centred system looks like in the future" on page 9/10 could also focus more on environmental determinants. An example of a population focused problem and solution is included below:

Problem with the current state	What a person and whanau centred system looks like in the future
A shortage of safe, warm, dry homes mean children experience an unnecessary burden of childhood illness	Issues of housing supply and affordability are addressed so that all children, including those in rental and social housing grow up in a safe, warm, and dry home.

(3) The place based planning section needs greater recognition of cross-sector partnerships. Its headline goal to establish community level plans that promote and build healthy, safe and resilient whanau can only be achieved in collaboration with partners such as councils, police, iwi-lead organisations, and industry representatives. A clear action plan for priority areas for cross sector collaboration should be developed, with a concrete and measurable indicators of success.

(4) The place based planning section should also aim to build on the current good work that is currently being carried out in the community including public health nurses who are based in schools and early childhood centres, as well as promoting health and wellbeing initiatives through workplaces, churches, sports clubs etc.

[5] Wang H, Horton R. Tackling climate change: the greatest opportunity for global health. The Lancet 2015; 386 (10006):1798 – 1799.

	Thank you for the opportunity to feedback my perspective on what is a critical document to guide DHB direction over the next 10 years.	
39	Firstly, I would like to acknowledge the opportunity to submit on your proposal. Unfortunately I've had to send this brief submission via your 'communications' email address as your website does not list any alternative electronic address in respect to this process. *Clinical Services Plan and Engagement with Hawkes Bay Citizens:* Having only briefly reviewed the Plan, it appears to me that it is driven by your clinical staff, (top down) rather than from the wider Hawkes Bay community (bottom up); my reasons for offering such a critical comment is that the actual opportunity for our community and citizens such as myself to provide any sort of meaningful input was limited to a window of two months? This begs the question of the genuine desire by the Hawkes Bay District Health Board to seek its electors considered views on such a significant document put together by its professional health bureaucracy. Whilst their views in regard to their professional field of expertise is to be acknowledged, it concerns me that how they see the health needs of our community being served in the future as the basis for this document seems a curious driver; though I'm sure some will say that by the community having a window of two months to provide input somehow suffices? Having worked in the health sector for a number of years and served in the sphere of local governance, I have found the District Health Board's promotion of this plan and engagement with its community wanting. For my part, living in Central Hawkes Bay; the first I was aware of the Plan and our ability to provide input was seeing the Mauri Ora brochures appear at our local Pharmacy two weeks ago! They certainly weren't on public display beforehand. Furthermore, having recently called into the Central Hawkes Bay Health Centre (X-ray Department); your brochures were not on display and the somewhat disinterested staff certainly made no referral to such a significant engagement opportunity. My own General Practitioner's reception area and staff neither had information displayed and/or material encouraging engagement; so what does this tell me? I makes a very clear and definitive statement that the District Health Boards community engagement appears to be little more than an 'administrative' exercise and an over reliance on electronic medium (website) is extremely passive. For my part I would have welcomed an opportunity to attend a local public presentation and forum; to have the ability to engage with the architects of what is proposed, to have meaningful dialogue if you will. Again, the lack of such an opportunity for my community says a lot about the District Health Board and its leadership. As such, I only hope that the pathway you are proposing is to the benefit of the community you serve; as you see it.	• Acknowledge that CSP out for public engagement for only two months and apologise for limited exposure in Central Hawkes Bay. Reasonable endeavours were made to make it available from appropriate facilities, but accept that we did not meet expectations on this occasion • There was however significant community and consumer input into the development of the CSP over the previous 15 month • This was a genuine attempt to check with the general community about 'have we got this right'. • Community/consumer engagement will be an ongoing feature of health and social care planning and delivery, as noted in the CSP with concepts such as: - 'People and whānau will be equal partners in the planning and co-design of services' - 'Meaningful collaboration with whānau to design the services they need - 'Place based planning' is a key theme within the plan - 'Person and whānau centred care' is based on the development of relationships with individual consumers/whānau and support people, and with general communities.

40	Thank you for the opportunity to provide feedback on the Draft *Clinical Services Plan – Transforming Hawke's Bay Health Services.* The following feedback is from the Hawkes Bay Nursing and Midwifery Leadership Council (HBNMLC and/or we) Firstly, we, collectively, support the overall direction and plan to achieve equal health opportunities for everyone as close to where people live as possible. We agree to achieve this and eliminate inequities health services will need to be community and primary care focussed underpinned by kaupapa Māori practice. The challenges that we will face with the Older Persons and Mental Health populations require significant attention and we welcome the CSP spotlight on these areas. We support the emphasis on primary, preventative and alternative treatment. Co-designing our future health services with our community, the people who use health services and the Iwi is paramount to achieving the CSP goals, however, and equally, if not more important, is involving the community, the people who use health services and the Iwi in deciding on what services to potentially stop if we are to invest in other, higher priority, areas. *A sustainable critical mass of nurses and midwives working to the fullest extent of their scope of practice, is essential. Investment, resources and commitment to the nursing and midwifery workforce is a positive in meeting the vision and aims of the clinical services plan.* We would like to offer the following feedback: Evolving Primary Care: This is a great opportunity to refocus and expand primary care including the developing of outreach services. However, across sector several points have been raised. One general practice is concerned that general practitioners will be asked to do more without the additional resources or funding put in place. Stress was put on recruitment in rural areas particularly the inability to attract GPs. They also find it difficult to recruit registered nurses for general practice, iwi providers, and aged care who are understanding of the unique needs of rural communities. There was also concern that information technology will not be in place to communicate changes in patient care. There is concern around not being involved in any changes to how they operate. As health providers it is imperative that we recognise that a significant proportion of our patients have Long Term Conditions and will move between primary, secondary and tertiary health care sectors frequently. This document still emphasises the leadership role of the hospital acute setting. Community transitions into acute care or their role in transitions back out into community are not mentioned or seemed to be planned for in this document. Responsibility to transition should be across the sector, utilising the specific, appropriate skills and actively planning the transition from both directions. This way of thinking of te Hauora o te Matau ā Māui supports the hospital being a narrower/more specialised focus. Unless the GP/Business owner changes their model of business/care, or the overall funding model changes, there will continue to be barriers with expanding into new roles e.g. lack of funding for advanced nurse practice roles, and inability to develop equitable and a community nursing models Remuneration is not in parity across the sector, primary care is less than secondary care, NGO providers wages are even less, RN's reported to be leaving ARC as a result of the recent MECA settlement – difficulty recruiting highly skilled clinicians into these areas Nursing Development and support in clinical services plan Given nursing is the largest workforce within the DHB important to highlight and provide examples of clinical services plan relevant to this group and the key role they will play in bringing the clinical services plan to life. e.g. Funding models that will ensure staffing is prioritised and nurses enabled to work to their full scope to better improve access for consumer's e.g. Support prescribing, support nurse practitioners in hard to reach areas, upskill Māori nursing and growth. Changes and increasing health promotion and education (health literacy roles required of health professionals to improve client knowledge of health needs). Nursing models that support improved approaches to rural health and access for Maori to trained health professionals.	Feedback Acknowledged 1. Workforce issue acknowledged under 'Growing our Workforce': • 'Through delivery of the People Plan, we will ensure that our workforce is well supported, capable, appropriately resourced, engaged and motivated to provide the best possible service to our community' • Need for appropriate ICT to support changes acknowledged under 'Better Information and Communication technology' 2. Current situation relating to movements between primary, secondary and tertiary is acknowledged, as is the need to do better. References in the plan to possible improvements include: • Specialist management of long term conditions based in the community • Pathways • Case management • Specialist integrated with primary and community care teams – 'wrap around' specialists • Transitions from hospital to be organised better • Whānau/friends/support people and community providers to be engaged in planning for transitions from hospital 3. To be considered as part of 'Evolving primary health care' Unless the GP/Business owner changes their model of business/care, or the overall funding model changes, there will continue to be barriers with expanding into new roles e.g. lack of funding for advanced nurse practice roles, and inability to develop equitable and a community nursing models 4. Remuneration parity issues will need to be addressed as part of growing our workforce. The CSP does not go to that level of detail. 5. Nursing development and support requirements noted under' Growing our Workforce': • 'All workforces will come under increasing pressure to managing increasing levels of need and complexity. All roles involved in healthcare will be working to the top of their scope of practice and will perform tasks that have traditionally been done by more senior roles. Senior nurses and allied health professionals will play an increasingly important role in the planning and delivery of health care, and in turn we will use care assistants and therapies assistants more effectively' • Details of how all this will be achieved, and aligned with service planning, will be undertaken as part of a workforce plan which has yet to be developed • All detailed recommendations will be forwarded to the team involved in facilitating this process 6. Strategic intent around Māori responsiveness and engagement, highlighted in several areas, such as: • 'Our commitment to achieving equity underpins this Plan' • 'Meeting the health and social needs, and aspirations of whānau' • 'Incorporating the guiding principles of the NUKA system of care whilst giving primacy to Māori indigenous thinking values and solutions' • 'We will develop our own local model that embeds kaupapa Māori practice and build on the strengths of our iwi-led services' • 'Working with whānau to design the services they need' • 'Rongoā Māori, Mirimiri and traditional healing practices are valued and integrated with care plans' • 'Cultural competency and person and whānau centred care'

	It is noted that there will be well supported transitions from hospital to discharge and home. This will require a skilled clinical nursing workforce that is able to monitor and support requirements of care. Given there will be a more narrow focus on hospital /acute important the nursing workforce is supported in engaging within homes and managing higher acuity of clients within home environment. We are keen to collectively work together in developing and implementing new models of care that will support this direction. Recommendations • Imperative to get into high schools earlier than the Incubator programme currently does, need to be thinking year 9 onwards to influence towards careers in health, year 12 & 13 too late as the subject choices in year 9 onwards is critical • Primary care especially need to accept they need to grow their own, currently not taking graduate nurses, will only take nurses who are already vocationally trained as a primary care nurse – this is a chicken & egg situation and lacks long term strategic thinking • The support of the workforce requires a change in approach. To enable nursing roles to expand it is imperative that investment of clinical support, supervision and mentorship is put into planning. In rural areas especially, clinical advancement roles and pathways need to be clear, using annual plans to seek out potential leaders within the community to further support health care and reducing acute care need • Working at top of scope – again unless other health professionals e.g., medical colleagues, change from their traditional 'doctor owned' patient care model, the development of advanced roles / working at top of scope is limited and generally only works with those 'who are willing' • Nurses have already demonstrated the impact when they work at top of scope, need others to come on board with changing models of care, an open mind, and funding to support changes / improvements • Using care assistants to do more will only work, when there is a model of care that permits those above to be working at top of scope & an infrastructure around it to help make this work • Nursing Models in line with equity and improvement in health outcomes for all. Give examples to nurses of what this change in practice may look like e.g. Nurse Navigators within primary health care. • Nursing models that support improved approaches to rural health and access for Maori to trained health professionals (more cost effective that GP lead and holistic focus – moving away from medical model). • Nursing leadership that encourages diversity and approaches to care (language utilized, health education information offered, and increasing mix of staff of other cultures). An agreed programme of clinical leadership development should be available to clinical nurse and midwife managers. • To support management within homes and transition it is important to highlight the changing management of care and requirements for nurses. Will there be investment in models that support this transitional care e.g. increased support health literacy / IT and resourcing to work within home based environments. • Hawkes Bay needs a critical mass of nurses who have expertise to assess and prescribe in the area of long-term conditions, a model of care that supports long-term condition management in diverse settings, and access to health care for those at most risk. Improving quality of life for long term health conditions and reducing potential for readmission would be a key focus in supporting and meeting the clinical services plan and reducing inequity for Maori. (Better investment than up skilling primary health care physicians who are medically focussed). • Investing in post-graduate training for nurses in long-term conditions and prescribing is a positive investment for the region. Māori Responsiveness and Engagement • Responsive to Māori – There is no Te Reo pamphlet, important this is provided if intending to be responsive to Māori within a Māori world-view. • Māori workforce strategy - Mentioned and highlighted as a collective and unified focus over the next 5 years. (Cannot be marginalized in the clinical services plan). • Health – flourishing communities. Need to encompass socio – cultural and economic determinants of health.	Details and implications arising from this intent, have yet to be developed 7. Given that whānau with children and young people are one of the two priority population groups identified that we need to specifically respond to, and despite many references to this throughout, this focus has been strengthened within the final document 8. A holistic approach to health and social care is a theme that runs through the Plan and is identified as essential. Your additional comments on this are noted 9. Comments on mental health and maternal, children and youth are noted and will be passed to those involved in facilitating the next stage of developing a Strategic Plan 10. Recommendation around change will be addressed at the next stage where this CSP will form the foundation of a 5 year Strategic Plan and include the People Plan which is focussed on an appropriate culture and workforce necessary to achieve the desired changes in services. 11. All other recommendations appear to add a layer of detail to concepts and themes referred to in the CSP, so will similarly be passed on for future reference. Update the plan Point 3, 7 UPDATED – changes to business / funding models added in Evolving primary health care

	• Responsive to Māori as tangata whenua if presenting on Marae to iwi and to Māori relationship boards and iwi will need a more responsive and indigenised presentation approach geared to Māori audience and presented by Māori. (Investment in presentation will give best opportunity to get this right) • The CSP needs to be clear that there will be ongoing engagement with Maori (or regular feedback to ensure create and encourage responsiveness and change early) e.g. evaluations / focus groups/ feedback Recommendations • Develop Te Reo pamphlet to support Maori providers and ensure supports inclusion of te reo speakers • Highlight workforce diversity within the clinical plan and that improving the current gap that exists for Maori in Health disparity is a key driver within clinical services plan so that it is clearly visible and stated within clinical services plan. Need to ensure that mainstream staff and leaders aware of this change and understand their role in creating a diverse workforce and a more inclusive environment. • Strengthen comments re: models that address cultural and socio-economic determinants of health - this supports and applies diversity within the clinical services plan. • Prepare presentations with tangata whenua in mind and connect to aspirations of Kahungunu – important that this sets the scene for the change in approach to all our marketing and information in future plan. (Also demonstrates application) Creating improvement in Māori Health • Changes in staffing and priorities in recruitment - Maori workforce Strategy needs to be included in the clinical setting - staff need to state we are looking at - increasing the diversity of staff to meet population mix and demographic. • No mention of Maori Health models Recommendations • Provide statements identifying that new models including indigenous health models will be applied within clinical services (still seems to be lack of understanding what this means in application) - use the gaps between Maori and Non-Maori to support importance of indigenous health models. Mental Health The data indicates that maintaining the "status quo" is not a viable option. Recent years have shown us that our hospital and supporting community services cannot uphold the volume of unwell people seeking health care. Maori and non-Maori populations have different health profiles with respect to determinants of health – education, employment, housing, income, income support, literacy, engagements with criminal justice system and deprivation.[6] The inequalities experienced by Maori are higher than those of non-Maori, therefore urgent priority is needed for improving health outcomes for Maori. These outcomes can be measured through improved access to and engagement with primary health care, reduced relapses in mental health and addiction through regular screening and follow up, and overall improvement in people's quality of life through living healthier, being engaged in meaningful activities including employment and living in improved housing conditions. As outlined in "He Korowai Oranga" (Maori Health Strategy, 2014), the aim is "whanau ora – supporting families to achieve their maximum health and wellbeing".[7] The CSP rightly identifies that we have an aging population and the rate of mental health issues are on the rise. There is a deficit of resource to support our older peoples who experience mental illness and also develop dementia related illnesses. The aging population, also includes an aging workforce and there is lack of resources to support people remaining longer in their homes. A focus of growing the EngAGE model is paramount to meeting the needs of our elderly to remain as independent as possible.	

[6] Reid, P. & Robson, B. 2006. The State of Maori Health. Auckland.

[7] Ministry of Health. 2014. The Guide to He Korowai Oranga: Maori Health Strategy.

There is a need to increase the focus on our young people (tamariki) – babies and youth who are the future of our community. In terms of mental health services, the Child, Adolescent and Family Service (CAFS) have received double the referrals to specialist services in that past 1-2 years; showing a high number of our youth struggling with distress and emotional dysregulation, increase in self-harm and suicidal ideations, families struggling to manage their children safely as they progress through social and relationship issues, including domestic violence, trauma. Children using and becoming addicted to alcohol and drugs as a means to manage their psychological issues; not to mention succumbing to today's never relenting peer pressure.

The future of care in Hawkes Bay has to be focused on prevention and working with our youth and their families to support them to build resilience, to empower them to work towards recovery, empower the family to be a functioning unit moving forward. This requires a complete overhaul; a change in the primary health model of care and community services to provide appropriate supports for families. It is not viable for secondary/hospital services to continue to manage symptoms of ill-health and the social issues that face our families today, for example poverty. Improvement in healthcare in Hawkes Bay cannot succeed without the involvement of consumers and their family/whanau but also requires a multi-sector approach including Ministry of Education and Ministry of Social Development. In order to succeed with a holistic viewpoint, health cannot work in isolation.

Mental Health Services embarked on developing a new model of care which officially launched when the new inpatient unit opened in January 2016. It was identified through the 5 year long project that services were not able to adequately sustain what the community required by way of meaningful mental health care. An important aspect was to have a co-design approach and listening to the consumer voice (and their whanau) regarding the development of this model. The new model of care also identified that people recover and get well quicker when they are cared for at home, with the support of their loved ones. It was also identified that services needed to be culturally responsive. These akin to the themes identified in the CSP.

Despite a new model of care, MHS have been under considerable pressure to provide service to the Hawkes Bay (HB) community. This is secondary to high volumes of referrals received and lack of resources to manage this.

There has been a significant increase in volumes of referrals, placing a lot of clinical risk on clinicians on a day to day basis. Since 2016, the number of face to face contact with patients has almost doubled. The patient population is complex, often complicated by increasing social determinants, such as homelessness.

It has been identified within primary and secondary sectors that each portion needs to work more in partnership and collaboration with one another. This occurs as best as possible and with all good intention, but the differences in models of care, allocation of resources and differences in technology places strain on an already stressed health system. For nursing, it is the difference in pay scales from one sector to the other that causes workforce issues.

The current state of play for mental health services is not isolated to HBDHB but across the country. There is high prevalence of staff burn out and turnover, especially for intensive services e.g. crisis team. Locally and nationally, it has been challenging to recruit appropriately qualified applicants, as nursing and allied health clinicians are not abundant or available.

Improving primary mental health care

Like DHB services, primary care services have also been under pressure. In 2016 Health Hawke's Bay commissioned a review of their Primary Mental Health contracts through Chiplin Associates and one of the recommendations from that report was for Health Hawkes Bay to consider Mental Health credentialing as a means of increasing the capacity and capability of the primary sector in responding to mild to moderate mental health issues. It is based on the recognition of specific competencies and provides one way to 'bridge the gap'. A training programme which follows the guidelines as set by the New Zealand College of Mental Health Nurses (Te Ao Maramatanga) is imperative to support primary health care nurses to meet the

credentialing criteria. The primary care workforce in relation to mental health and addiction issues and in particular workforce development effort will focus on building:[8]

- a multidisciplinary primary care workforce that includes mental health expertise
- workforce ability to identify and address mental health and addiction needs and to deliver brief, effective interventions.
- assisting people in making healthy choices the easy choices (for example: knowledge, availability and cost, supportive environment)
- by empowering people to make decisions that will positively influence their health and wellbeing.

A further review of the DHB mental health services is required and the National Mental Health Inquiry will assist in the future direction of services. The population needs in 2018 differs in parts from those identified during the HBDHB MHS project. Service and supports need to focus more toward primary care but that could mean that DHB teams working within general practice to assist and build on what is already occurring with the Primary care credentialing. This is already occurring in other regions and would be of benefit to the Hawkes Bay community.

Investment is required to increase the numbers of nursing and allied health staff in the sector as there are current deficits in mental health. Whilst the New Entry to Specialist Practice (NESP) is well imbedded in DHBs today, in recent interviews there was a lack of interest by new graduates to embark on a nursing career in MH. Like other areas of health, there is a growing risk to staff working in MHS; the complexity and acuity of patients affected by psychotic phenomena, compounded more often than not by the use of mind altering substances, is leading to higher incidents of assault on staff or patient on patient. Whilst staff are trained to manage such challenging behaviours, the psychological trauma of repeated assaults takes a toll on staff.

Midwifery & Child Health

Whilst we acknowledge that the plan does not explicitly address every area of the health system, the visibility and clarity of Maternal, Children and Youth is not evident.

The national government and MOH strategic priority of child and youth wellbeing strategy needs to be strongly reflected in our local health care strategic planning and delivery; focus on prevention and support for ownership of health from the start of life has strong international evidence of generational change in health outcomes. A key principle should be to support children and young people to have the best possible outcomes; for the purposes of our CSP in terms of health outcomes preventative, wellness focussed models of care that empower and support child health - this is inclusive of maternal wellbeing from conception onwards.

The first 1000 days (ready for school) evidences the long term effects on the wellbeing of the new-born baby and the child not only in terms of health, but academically, socially and mentally - our future vision should demonstrate support of better maternal physical and mental health e.g. Smokefree pregnancies, healthy weight, breastfeeding, health promotion, maternal mental health (the leading cause of maternal death in NZ for the last 6 years is suicide - focus resource in primary care for maternal wellness in a preventative model is vital to change these statistics

Further emphasis on wellness models of care provision; in particular ongoing investment in maternal and child services will support a long term health outcome change in wellbeing e.g. right woman, right place for birth, right outcome - lowering intervention, decreasing trauma, improving bonding and attachment, breastfeeding, empowering confident parenting - the driving change in the maternity service provision space at a national level is gaining momentum and needs our attention to participate in the change both nationally and at a local level to ensure our consumers and key stakeholders have a voice and continue to co-design and shape our services.

A balance is important in ensuring the emergency responsiveness services such as ED, NICU, ICU, Labour and Birthing suites, Theatres have facilities, capacity, workforce and capability to meet the demand, support

	wellness, best practice and modern health care at its best - in so doing empowers the consumer to strive for wellness, shortens lengths of stays, reduces reliability on the 'hospital' acute system and enables an increase in community driven health provision. Workforce is identified as a key support to our plan - this section appears relatively short and needs to be clear about the current workforce crises in a number of key specialties - in particular dental, radiologists (particularly obstetrics), physiotherapists and midwifery. The emphasis on recognition of the key workforces to provide specialist services both in primary and secondary/tertiary care is paramount with a clear plan on the response to the now crisis, the soon and the medium/long term. The ability to grow the workforce of this proposed model will take time and will need resource to ensure the right direction for what our community wants - e.g. integrated health care teams providing a one stop shop in the community with swift and easy access to specialists by a number of mediums. General recommendations • *Change wording the hospital will take a narrower focus in future* - with the aim of Strength based approach: *Improving access to primary health will mean less need for hospital based care our aim is keeping people well and out of hospital with stronger resourcing in primary health care. E.g. more strength based statements to support rationale.* • Need to look at whanau ora workforce and training within non-regulated workforce if working with Maori. • Would be good to ensure a change management plan is in place and support in changing our approaches is supported by leaders. Change will be difficult for some groups the DHB and hospital is the cornerstone of health care for many and will potentially be some push back from more traditional health professionals and community groups. • The use of the word holistic in the document is welcome however, it is disappointing that this word occurs almost exclusively in relation to mental well-being. We feel that relevant and holistic responses should be a part of all health care, particularly in the field of long-term conditions. • A large barrier to a move to a system focussed on mental well-being is the ongoing reliance of a model dominated by the need for a psychiatric diagnosis, and a resulting dependency on pharmacological treatment. This may be addressed by the MH inquiry. • There is a great need for improving MH delivery in primary care, but the differing service and funding models may well be a barrier to this. Likewise, the involvement of different services such as NGOs in mental health runs the risk of various silos working from differing philosophies and models creating gaps for consumers to be pushed into (this already happens now). • Support set up of surgical assessment unit to divert pts from ED/provide rapid assessment and turn around (either admit or transfer out to home or another facility). This must be resourced with experienced staff (medical and nursing) and be placed close to ED • To compliment this unit the concept of the Bone Shop could be introduced- rapid assessment and treatment of fractures (direct admits from GPs/Home) to ensure right treatment/ at right time in right place/ and decrease number of follow ups required. This also needs placement close to ED • Daily MDTs- should also occur in weekends- increase Allied Health out of hours support • Support the ICU with no walls approach- but for HDU pts. Units for high care in wards and training of staff- needs to happen ASAP • Transit lounge- needs to be front of house too- with facilities that allow more nursing interventions- wound care/IV infusions etc • Delirium/dementia pathways a must- again there is urgency with this- training needed for all staff (medical and nursing and allied health)to recognised differences and correct treatment • Short stay units- 23 hour stay. We would like to see this possibly set up in the new perioperative structure- say 4 beds to trial to start- will help support shorter LOS for electives	

[8] Ministry of Health. 2012. Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017.

	• Our emphasise needs to be on a wellness model- obesity is a huge issue causing increased demand for multiple health services. • Support moving out specialities that can be completed in primary care • Support ambulatory theatre- do we have this off site? • Support more input from geriatricians/physicians in complex/frail surgical patients- pre and post operatively • Increasing cancers are not addressed really in the plan but this will be a huge strain on both elective and acute surgical admissions • Support looking at Hub and Spoke model- currently have this in vascular and works really well. Will need more specialist advanced nurses (NPS/CNS's) to supports such a model. One of the most significant work streams over all for the above is the **choosing wisely- goals of treatment/care.** Currently we cannot sustain what we are doing- complex/high risk /invasive surgery on frail/elderly/compromised patients whose outcomes are poor and quality of life significantly decreased The strain on the health system of our aging population cannot be underestimated.	
41	Nga mihi nui ki a koutou katoa I would like to give my feedback on the Hawkes Bay District Health Board's Clinical Services Plan. Positive Feedback: - User friendly document to read with little jargon and hard words. - Comprehensive document that scoped all health elements relating to past, present and future. - Detailed and listed specific areas of health challenges and improvement for health vision. - Identified challenges by layering cultural health disparities - I liked how the plan detailed the journey of the DHB over the past five years and how the platform for inclusion from the Consumer, Clinical and MRB was established and how the future direction for better health change will now be driven by the consumer and community voices. - I like how the DHB have identified where they can attempt to make improvements and continue to make improvements. - The CSP shows synergy in our health ecosystem. Negative Feedback: - I felt that culture and poverty superceeded health and wellbeing in the document. My daughter's health was neglected by a health professional, we don't always come under culture and poor living backgrounds. I wanted to read something that resonated with our familie's health journey. - I wanted to read about healthy people and their aspirations on keeping healthy instead of all the health disparities overriding the document. - I wanted to read more about the challenges of the clinicians instead of the challenges of health consumers accessing services. Overall the document was good. There was a bit of repetitiveness that I found, but overall, the document showed me that our health system and drivers are looking forward to help and improve the lives of all our Hawkes Bay whanau.	Feedback acknowledged. The CSP has to consider the health issues that affect the wider community as a whole and the document highlights the main issues that the health system currently faces. The Clinical Services Plan is focussed around the future services the that the health system will deliver to the community and part of changing our culture to being Person and Whānau Centred is that this is built around the consumer and therefore it is essential that the consumer feature as a main focus of the document.
42	Thank you for the opportunity to provide feedback.	Acknowledge feedback. Include dietitian working with behaviourist with the consumer in primary care and thread through other sections of the plan.

	We agree with the focus of increasing health care in the community which will reduce the hospital admissions. 1. Recommend that the emphasis is on working with General Practice providers to improve the health of our customers 2. The Nuka model of care utilises the dietitian to work with the behaviourist with the customer in primary care. This is successful because diet and nutrition is often central to LTC, mental health, whanau engagement and customers that are at risk of malnutrition (deconditioning/ frailty), and children. The Headline goals mentioned on page 18 would be met through the establishment of a dietitian working with a behaviourist in the general practice. The way of working is able to be flexible and responsive to the needs of whanau. The model makes health easier to understand. 3. As seen with the three year work of a dietitian in Totara Health Flaxmere and Nelson street the dietitian contributes to :- a) keeping older people well at home in their communities b) assisting with the management of long term conditions in primary care c) assisting with supporting mental wellbeing d) supporting customer's transitioning from hospital to home e) focusing on wellness f) increased work force development g) supporting children and their whanau with nutrition related conditions 4. Evolving primary health care - Primary Care teams on page 20 gives examples of the team members. It seems that there has been an over sight omitting dietitians. It is essential that dietitians are included in the list given the central role they play in working with customers. The Nuka model has the dietitian and pharmacist working with the customer. Dietitians are frequently overlooked in HBDHB as seen in the engAGE model of care. The case study on page 23 has a dietitian included in the care of the 'Off Highways' group in Taupo. 5. Customers would benefit with a model of care that sees a behaviourist work with other health practitioners such as pharmacist and dietitian. This would allow the work to be centred on the needs of the customer and whanau. It is essential that the CSP reflect the theme that improving health of our community needs to come from the customer and whanau. To enable this a behaviourist working with a health practitioner can work with (not to and not at) the customer. 6. We are interested in understanding how the Hoki te Whare service would work– would it be a primary care based service or secondary care service? We recommend that a dietitian be included in this team (until dietitians are established in general practice as recommended earlier). 7. We look forward to increased data capture and IT capability (MOW and patient meal service). 8. Support is given to modifying the GP practices so that they are large enough to accommodate the increase in staff working from the practice in addition to making them culturally appropriate and appealing. I think it is better to see the GP practice as the heart of care, where customers go for all sorts of health care rather than the DHB look to increasing the number locations for different services in the community.	The "How" of the plan it yet to be worked through and will be developed within the next phase as part of the strategic planning process. Add to plan 1. Dietitian and behaviourist and other relevant sections such as older persons and pg 20 etc. UPDATED – dietitians included in Evolving primary health care and e.g. given of behaviourist working with dietitian and pharmacist
43	It's important that we focus on the importance of health for all age groups. There is a very strong focus on children and youth, which is important, but we must continue to ensure we have the same focus for	Feedback acknowledged

	women, it, takes a village to raise our children and women are the core group and if they are not around what is the impact on our youth. It's important that we encourage our women to demonstrate taking care of their health and be encouraged to do so by the many health professionals that a woman may see in her life time particularly breast, cervical and bowel screening. Over the last 12 months three young women outside of HB have lost their lives to cervical cancer – a preventable disease, sadly they left young babies and children without their mother. One of these woman had her first smear when she was pregnant with her 7th child, by then it was too late and she chose the life of her baby over her own, a choice that no mother should have to face (Stuff Aug. 11, 2017). When I reflect on this, my question is; how many health professionals did this woman see, and how many asked if she was up to date with her cervical screening, and or discussed HPV immunisation. This woman's children may have been up to date with their imms, which is fabulous, but her cervical screening status should have had the same importance as her babies imms status.	Screening is referenced within the plan under the Whānau wraparound services, by ensuring whānau members receive screening and preventative interventions. This includes women and cervical screening on pg 26.
44	d like to provide feedback primarily from an Allied Health Team Leaders perspective, who manage multidisciplinary teams rather than discipline specific allied health services, namely Engage Community Allied Health Services and Child Development Service (CDS). There are many opportunities for Allied Health professionals to strongly contribute to the transformation and this has in part been acknowledged. The following aspects need to be considered within the 'implementation phase' as have potential to significantly impact. We recognise the variability across the AHP', particularly noting several multidisciplinary teams with satisfactory outcomes and progressive service delivery. These teams do have some clear characteristics which are not universally shared, including strong values driven Leadership, transparent client focused services and valued workforce. We see the CSP and transformational vision as an opportunity for a reconfiguration of many of the Allied Health Services. Allied Health professionals are/ need to be a significant and important part of the workforce needed to achieve this plan. For example as highlighted in the CSP, frailty and long term conditions are a major challenge and these consumers are intensive users of our resources. A service structure that promotes more of a multidisciplinary/Interprofessional wrap around practice approach enables a more responsive service to the consumers. The engAGE Program and recent merge of the community allied health services is an example of service delivery with an improved consumer focus. Many Allied Health Professionals (AHP) teams and individuals remain working in silos, creating barriers and not optimising the potential impact their service contribution can make. It is to be acknowledged that there will always be the need for specialist AH services and skill/expertise, however changes in model of care using Interprofessional practice could significantly improve consumer centred service delivery. While interprofessional practice has been introduced this requires more support / education / leadership to realise its potential. In general we do have concerns regarding resourcing, specifically to ensure the planning is achieved with true co-design with Consumers and Service Providers. There is also a paucity of AHP Leadership at a Directorate level, professional leadership is also a concern and to enable the CSP to reach its potential this needs to be addressed. We would also like to highlight the importance of workforce. As identified in the CSP, supporting the growth of the Allied Health workforce and having leadership that promotes learning and innovation in the way services are run is also an essential investment. There are currently challenges in the recruitment of allied health workforce into the HBDHB, with competing demands for AH in other sectors/ private companies. Retention and recognition of roles is extremely important as is having the right skills and expertise. Allied Health professionals are well positioned in their skills / expertise in recognising and responding to the holistic needs of Consumers, this is vital as we move away from the medical model to a collaborative multidisciplinary model with a strong Consumer focus. This model is evident in both the Engage and CDS.	• Noted that feedback intended to be considered within the 'implementation phase' as it has the potential to significantly impact. • Feedback will be passed on to those facilitating this next phase.

45	**What we like about the Plan** • Support the broader themes and direction of travel of the plan. • It is inspirational, aspirational and investing in prevention and community is the right thing to do. • The direction of travel is similar to that which has been our focus for some time. We strongly support the submission from the Child Health team and have endeavoured not to duplicate this **Comments** <u>Maternal, Children & Youth</u> • Although we appreciate the consumer focus throughout this plan, the voice / needs of children, youth and Mums is not strongly apparent and these consumer groups need recognition. • There needs to be clearer evidence of the national strategic foci on the maternal, child and youth priorities threaded throughout the CSP to ensure generational change in health outcomes. • CW&C would like to see a stronger emphasis on improving management of long term health conditions beginning in childhood, including children with disabilities. Evidence would support early intervention to deliver long term gains – investment in Older Persons needs to be strongly balanced with investment in children / families • Opportunities exist to improve shared care with Primary care, however some children with long term conditions will continue to need Specialist input at a secondary care level e.g. cystic fibrosis. <u>Evolving Primary Care</u> • We support the shift to invest more in primary health care services that are closer to home, accessible and culturally relevant. • Allied Health, Primary Care Nursing, Community Nursing, and Advanced Nursing roles (CNS, NPs) will be key to the success of this plan – however unless the GP/Business owner changes their model of business/care, or the overall funding model changes, there will continue to be barriers to the introduction of new roles and models of care (eg Nuka) <u>In General</u> • Workforce is fundamental to achieving this plan, we note no elements of 'service phasing' within section 5 (pg 54), this would be valuable. • We support the ongoing use of evidence based practice and quality improvement methodology throughout the implementation of this CSP • We support recognition within the CSP of the wellness & social models, with less emphasis on the traditional medical model. • Some of the terminology would benefit from inclusion in a glossary of terms , for example 'Behaviourist' • The phasing of this CSP (& progress of change) is dependent on funding models changes, workforce capability and capacity. Realistic timeframes need to be recognised, including time to embed and evaluate/monitor changes in outcomes. • We appreciate the case studies and reference to the existing evidence base, and acknowledge the need to contribute to a New Zealand (& International) evidence base throughout this change process. <u>Specific recommendations</u> • Page v, the diagram is valuable, we would like to see the addition of Children and Youth, to increase their specific visibility. We note they are identified clearly in the text but this should be reflected in the diagram. • Page 12, 'family harm' is recommended wording to replace the current 'family violence' terminology	• The focus on whānau with young children has been strengthened • Many of the specific recommendations relating to clarification and/or additional wording have been actioned **Agree to update the following:** • Page 12, 'family harm' is recommended wording to replace the current 'family violence' terminology • Page 19, within the headline goals table we recommend changing the 'establish' to 'Build on' recognising the considerable work already achieved in this area • Page 19 within the Planning and Coordination section Central Hawke's Bay needs to be added alongside Wairoa • Page 22 (& elsewhere) please could a review of language be taken – 'But the Nuka experience' doesn't require the 'but' and thus be more positive • In the section 'working with whānau to design the services they need' (page 26), we recommend adding strength from a population focus – including encouraging and supporting community action, citizen' movement. We need to empower active community participation. Update plan accordingly From feedback we are happy for the following pages to be updated • Page 12, 'family harm' is recommended wording to replace the current 'family violence' terminology • Page 19, within the headline goals table we recommend changing the 'establish' to 'Build on' recognising the considerable work already achieved in this area • Page 19 within the Planning and Coordination section Central Hawke's Bay needs to be added alongside Wairoa • Page 22 (& elsewhere) please could a review of language be taken – 'But the Nuka experience' doesn't require the 'but' and thus be more positive • In the section 'working with whānau to design the services they need' (page 26), we recommend adding strength from a population focus – including encouraging and supporting community action, citizen' movement. We need to empower active community participation. **UPDATED – a number of suggested edits made. Particularly liked the interdisciplinary LTC CNS/allied health professional, thanks!**

	• Page 14, bullet point three please add 'kaiawhina', as our experience has shown these roles to be very supportive of whānau • In all the documentation listing the 9 themes (e.g.page 17), we would recommend specifying 'children and youth' or 'tamariki and rangatahi', as in #3 " Working with children, youth and whānau to design the services they need". We would like to see greater visibility of these priority groups. • Please consider the above bullet point throughout the section from page 26 • Page 19, within the headline goals table we recommend changing the 'establish' to 'Build on' recognising the considerable work already achieved in this area • Page 19 within the Planning and Coordination section Central Hawke's Bay needs to be added alongside Wairoa • Page 20 the phasing of Community Hubs has already commenced, so the shading needs to depict that • Page 22 (& elsewhere) please could a review of language be taken – 'But the Nuka experience' doesn't require the 'but' and thus be more positive • In the section 'working with whānau to design the services they need' (page 26), we recommend adding strength from a population focus – including encouraging and supporting community action, citizen' movement. We need to empower active community participation. • Page 34 phasing of the 'expand engAge... rural localities' needs to be prioritised – to the first column • Page 37, opportunitiy to consider adding into the 'change the workforce' section 'interdisciplinary Clinical Nurse Specialists/ Allied Health Professionals for Long term conditions for example a holistic approach not just addressing cardiac / diabetes needs • Page 40 change the passive approach 'are aware of risks' (within the table) to 'aware of and upskilled to prevent' • In this section (page 40) 'well supported transitions' is the model clear – many consumers need a single point of contact for the health service (case manager type role), this is different from a navigator role. This could be for a fixed period e.g. 6 weeks post discharge, would also be really valuable for consumers with long term conditions • Page 40 'establish navigator roles that pull consumers out of hospital' could also recognise the role a navigator has in keeping people well at home / preventing admissions	
46	Thank you for the opportunity to comment on the HBDHB CSP 2018. Summary Many of us, contributed to the multiple workshops which fed into the CSP and we feel that our voices have largely been reflected in the document. The general direction of the plan is supported as it is a continuation of the direction of the last few years. It is positive to see the level of description and the degree of integration of Allied Health within themes of the CSP. As an Allied Health group we strongly feel that we are in a unique position to support the DHB and community to achieve the direction set out in the CSP. Support for primary care The proposal to wrap general practitioners with more support, including Allied Health staff, is supported. Better management of particularly long term condition patients in primary is recognised as reducing secondary care volumes. A structure/ model to support rural populations should be generated so harder to reach people are specifically planned for, rather than just an adjunct to the urban system. Models of care such as the Engage/Community team and Hoki te Whare require appropriate resourcing, integration and support to cope with the aging population. A careful plan is required with our rural communities to understand their unique needs, rather than assuming that the Engage model can just be replicated to the rural areas. Much care can be effectively and efficiently led by allied health or nursing, meaning reduction of cost and GP workload through demedicalisation. Allied Health supports models of care mentioned in the CSP such as: working at top of scope, advanced practitioner, long term condition therapist, life-course approach, health	• Although population health does not form part of the CSP, health promotion and preventative care has been identified as an area for investment to improve outcomes, so an additional section has been added to expand on this. • All other issues are noted and will be passed to those facilitating the development of the next stage, being the 5 year Strategic Plan

	care home, in-home programmes such as the proven effective Falls programme and Engage service, Hoki te Whare, early supported discharge, outreach, mobile clinics and the Nuka system of care model. There is concern however that general practices are privately owned businesses designed to make profit through providing health care. The cost to the user can therefore be higher than their financial circumstances can readily allow. Financial support through direct government subsidies is acknowledged however cost of visiting GPs is still a disincentive to many in New Zealand to manage their own health maximally. That is compared with other health systems where GP visits are free. Advocacy to government to change the model is recommended. It is also important that with any shift of allied health staff to GP's that adequate resources is also considered and allocated to optimise the impact of allied health. The recent experience of social workers being established with local GP's has been welcomed but significant resourcing issues has impacted on delivery. This includes lack of phones, cars, office space, consistency of position profiles, consistency in the understanding of what registered social workers can provide by existing GP staff and lack of consideration to support professional practice (e.g. releasing time for clinical supervision and training). A commitment from GPs to be flexible with space and resourcing (so the benefits of co-location of the allied health workforce is realised) is required. A system which allows a single electronic patient record is supported by Allied Health. It is seen as THE major improver to communication across providers of the health system. This is currently a significant barrier to the integration of services and a cohesive and substantial investment is required to rectify this issue. Multiple information systems across services carries substantial risk. The impact of technology on managing chronic disease and some rehabilitation is looked on with positivity. The current computer based Manage My Health is a boon to users who are technology literate. However, flexibility in the system is required to ensure that those households who do not have access or have the required level of skills do not miss out. We support the idea of health navigators to guide people through the complex health care system. Elective surgery Under the 'Hospital will Grow' heading it is stated orthopaedic surgery will grow. This is highly desirable, as are the statements to "identify people at risk through screening tools and risk stratification" and "intervene earlier" and "provide alternatives interventions before surgery". Allied Health professionals support the wellness model. An effective service currently in place is the non-surgical treatment option provided by physiotherapy service which delays the need for joint replacement, facilitates self-management and improves recovery from eventual surgery. A commitment to growing the Allied Health workforce alongside the expansion of surgical services is essential to maximise health outcomes. This includes but is not limited to including Allied Health in service development, pre-screening, education and exercise programs prior to surgery, providing intensive inpatient rehabilitation post-surgery, facilitating transfer into the community with the correct level of support and providing rehabilitation and support in community settings. Surgery for chronic conditions such as osteoarthritis is likely to remain less than the population would seek. It is recommended selective targeting of working age people should be actioned for hip/ knee replacement surgery. Earlier replacement of the first joint is known to reduce the impact of bony misalignment on other joints which would attempt to compensate. This then reduces the probability for that patient of requiring multiple joint replacement in later years. Early investment to reduce later expense is a positive investment. Prevention of deconditioning/ rehabilitation	

	Rehabilitation occurs and must continue to occur on acute wards as soon as the patient is able to participate. This reduces deconditioning and accidental harm. Building capacity in community to pull medically well patients back to their own homes is supported. Functionally based rehabilitation (at times delivered by an unregulated workforce) is supported but requires the backup of specialist allied health disciplines with access to specialised assessment and treatment facilities e.g. gymnasium, hydrotherapy pool, flexible endoscopic evaluation of swallowing, community hand therapy clinics etc. Therapy Assistants could become a major staff group in keeping people at home, reconditioning after a health event and building their ability to remain at home. Inter professional practice (IPP) The IPP model has been successfully demonstrated in Orbit within ED and AAU and this concept is currently being used through some acute wards. As part of the ATR review, the new Model of Care has proposed an IPP approach for both nursing and allied health. Use of the Calderdale Framework will assist in formalising the skill-sharing process between disciplines, as well as delegation of skills to an unregulated workforce. The use of an IPP model and the assistant workforce will be crucial to the implementation of proposed Hoki te Whare and early supported discharge models. Further evolution of IPP needs to be mindful that the model promotes clinicians working to their top of scope rather than becoming generalist practitioners. Junior regulated staff need time to both consolidate their own disciplinary skills alongside support and training in an IPP model. Cultural competence A growing understanding of kaupapa Maori within our existing workforce and recruitment that reflects not only technical skills but the ability to demonstrate the values of our organisation and influence change in our community is key. Training of staff in cultural competence is a continuation of previous direction and if stepped up, should pay dividends to users and services. Relationship centred practice, literacy training, and patient centred/led goals are in place or being strengthened. These are the building blocks to improving patient satisfaction and engagement. Chronic disease management requires behaviour change and allied health are well skilled to influence behavioural change. It is believed all health providers would benefit greatly from further training in cognitive behavioural therapy and the availability of more psychology based services is supported. The financial commitment already shown by HBDHB, Ngati Kahungunu Iwi and PHO to Nuka training for senior managers and clinicians bodes well for the establishment of Nuka model approach in achieving our vision for health in Hawke's Bay. Equity Allied Health believe that co-designing the health care system is essential to addressing inequity in Hawke's Bay. Our presence in the community and the established relationships that our work allows, places us in a unique position to help facilitate these conversations. It is positive to see the emphasis on moving services into the community as this is a first step to improving access which will assist with addressing unmet need. The impact of more home based rehabilitation assistants would bolster the economic situation in Hawkes Bay and bring more people into permanent versus seasonal employment; the benefits of employment are widely recognised and impact positively on health indicators. We are seeing a growing relationship between Ngati Kahungunu Iwi and health services and Allied Health services see themselves as being involved in nurturing this relationship to improve Maori involvement in a Healthy Hawke's Bay.	

	Integration of the Our Health Hawke's Bay values into all areas of our operational and strategic direction will only strengthen our workforce and the outcomes for consumers. It is recommended the duality of the NZ health system generated by the ACC structure and funding be addressed with government. The discrepancy of the level of support available for medically impaired people compared to accident impaired people is gravely unfair. **Workforce** It is exciting to see a focus on growing our workforce, and we believe that continuing to embed a values based approach to our work will help us to retain staff. There are significant challenges currently in recruiting experienced and advanced practitioners across allied health and it's important to see a focus on this in our CSP. Staff are the tools by which health advice and care are provided. Staff need to have safe and reasonable workloads which do not put the patient and the staff member at risk through error from the need of speed. Adequacy of clerical support at all relevant levels is required to ensure all staff can work to the top of their scope of practice. Significant funding of a robust service structure to train and oversee an unregulated workforce by a smaller number of regulated staff is essential. Well trained and supervised Therapy Assistants can contribute significantly to rehabilitation in homes, outpatient services and acute wards. This workforce needs to be supported by a robust career structure to ensure staff remain in the field and build their knowledge and skills. Therapy assistants currently work across a range of disciplines and area, however expansion of their skill set could increase (Calderdale could assist with identifying delegation of tasks) as could the number of disciplines they work alongside. **General** Concern is expressed on the relative gap in the document regarding Population Health. This needs to be a significant and strong underlying thread to support primary health and long term disease management. A focus on introducing 'behaviourists' to primary care, suggests a step towards integration of physical and mental health at this touch point with the health care system. A clearer description of the integration between physical health and mental health care would strengthen the CSP and would also demonstrate an alignment with Maori models of health care (e.g. Te Whare Tapa Wha). The 'behaviourist' concept should not only be considered within primary care, as the skills described in the CSP that these people would hold would be valuable across a number of interactions with the health system (e.g. Emergency Department). Again, utilisation of Allied Health professions that can transition between both physical and mental health would aid in our community accessing the appropriate care. Consideration of the aging population with both physical and mental health issues also needs to be considered in a unified way rather than in silos. **Summary** The Allied Health Inpatient Therapy Team Leaders and team, look forward to further mahi regarding the "how". With the right resourcing, we have the skills of whakawhanaguatanga and influence to enable change in the health of the Hawke's Bay. Although this document has been generated from the inpatient allied health team leaders, we recognised and support other documents created by services within the directorate, including a separate submission from the Engage Team.	
47	**CSP for Dementia** CSP states "In future we will work with our partners to develop elder friendly and dementia friendly communities. A dementia friendly community is a place where people living with dementia and their care partners feel understood, respected and supported, and confident that they can contribute to community	• Your point about 'the cart before the horse' is noted • Some additional comments about the need to implement early intervention and ongoing support to live well and to family carers has been added to the paragraph focussed on dementia.(Pg 32)

	life. In a dementia friendly community people are aware of and understand dementia, and people with dementia feel included and involved, and have choice and control over their day-today lives. The community is made up of dementia friendly individuals, businesses, organisations, services and faith communities that support the needs of people with dementia." This is putting the cart before the horse and can only be achieved when some of the following is achieved first 1. Intervene early to improve detection, diagnosis and support Only about 50% of people with dementia get a diagnosis and even then immediate post-diagnosis services are inadequate. Improvements can be made by: • including cognitive assessment and hearing checks in the free annual health check for people 65 and over; and • providing for 12 months' post-diagnosis support to equip people with dementia, their families and care partners with tools, connections, resources and plans to allow them to live as well as possible with dementia . 2. Support people to live well Provide services that support people to live at home, healthier, for longer, by: • establishing navigation services and • providing high quality information brochures to support people with dementia and their care partners to better understand dementia, what to expect, and the care and support available. 3. Support family carers to continue to provide care Enable carers to have a break when **they need it** – by providing flexible, high quality respite (home, community and residential) services consistently across the area. People diagnosed with dementia need to have an input into the type of services provided. "Nothing about us without us" CST be provided to all people given a diagnosis with dementia and in a timely manner Upskilling GP's (health professionals) to make a diagnosis of dementia and preferably in early stages of the disease. Referral to specialists can be reduced and diagnosis provided earlier. GP's/Health professionals providing referral to dementia service providers following a dementia diagnosis. There should be no differentiation of services provided because of age at time of diagnosis (currently those under 65yrs do not receive the same level of services as those over 65). A further recommendation is to have a HBDHB "Champion" to start the implementation of a plan based on the "Framework for Dementia Care" that was provided in 2013. The South Island Alliance has enabled the regions five DHBs to work collaboratively to develop more innovative and efficient health services that could be achieved independently. The Health of Older People Service Level Alliance (HOPSLA) enables South Island DHBs to take a coordinated approach to implementing a model of care that focuses on keeping people well and improving support and processes so that when people do need it, they can receive streamlined, high quality care. They ensure that people with dementia receive a more person-centred model of care as a key focus of the HOPSLA workplan. This is achieved by cultivating a person-centred approach amongst their dementia workforce through implementing and supporting the education programme "Walking in Another's Shoes" across all South Island DHBs. Their workplan could be a adopted and modified to meet HBDHB dementia services. Supporting people diagnosed with dementia, with a human rights based approach to live their acquired cognitive disabilities caused by dementia. We all have a moral and ethical duty to change what happens at the time of diagnosis, and just after, by providing positive support to live well, that includes rehabilitation and support to remain active in our communities, including employed or volunteering.	Update the plan **UPDATED – changed 'elder and dementia friendly communities' and associated text to 'age-friendly communities', think this is better.** **Added brief section on dementia.**

48	<u>TRANSFORMING OUR HEALTH SERVICES:</u> CLINICAL SERVICES PLAN: The next ten years. A document from the Hawke's Bay District Health Board. "If you live in Hawke's Bay you will want to know that the right health care services are there for you and your family when you need them." (Quote first lines from the foreword page ii) *Too right we do. And not cut to the miserable cloth of not enough money to provide these services.* "Over the past 12 months Hawke's Bay professionals, plus a wide range of people who use our health and care services have provided their thoughts and feedback to draft a future-thinking health care services "concept plan" called the Clinical Services Plan." (Quote from foreword page ii)*What is wrong with what we had? What do you need future-thinking? Is this a new word for penny pinching? Nowhere in your forward do you say why.* <u>The Plan in a Nutshell (Pages v –vii)</u> "The Challenges we face are for a very different health system. We cannot continue with what we are doing." *Grey Power asks why? What has changed?* "Maori and Pasifika, people with disabilities or mental illness, the poor all continue to experience unacceptable inequities in health outcomes. These people will increase pressure on our already stretched health services". *But that is not the cause. That is the problem.* "If we continue as we are the for the next 15 years, the number of primary care consultations will increase at a rate that is higher than the overall populations growth: this is driven by the rapid increase for (*for? what do you mean*) older people which almost doubles, bringing with it an increase in complexity and time required to manage multiple co-morbidities and frailty." *We used to die at 60. This longevity is due to the direct interference of our health system till it is now be over 80 years. The frailty has been pushed out also to the older age group and the 60s are now almost as fit and useful as any other age group.* *Some possible solutions* *Why can't we have a small Ministry of Health run health insurance for the over 70s. That way, much as we resent it, having already paid huge taxes in our time, we do help with the primary problem of lack of money. Another way is to pay for half of our hospital fees. Both of these solutions are more inventive than 67 pages of long sentences.* *What are you going to do?* "Prioritise and design services to meet the needs of the populations with the poorest health and poorest social outcomes. We have a bold goal to achieve equality". *We say not if the whole aged sector falls flat on its face.* "We will work with consumers rather than to or for them.*" Our Grey Power is not keen on the word consumer which is a business word. We think health is a social service not a business. You might note that where it is a business in the private health service many of the services you are re-considering are still standard. People who need health care are not consumers. The more they need money to achieve their health goals the less likely they are to get them in the public health sector.* *The HBDHB wants to keep the older person safely at home but it chose, cheapest out of town system it could find. This is not a system that keeps a person safely at home.* *Then you talk of preventative care. Many people have lead a healthy life, walking, exercising, eating greens and raw food, contributing to our community. In our late 70s one part of us disintegrates. No we can't have it fixed. Serves us right. We didn't do enough preventative work. No we can't have an operation – the return for the money isn't good enough. Our members hear it again and again.* On page vi – we aren't out of the foreword yet – you tell us that: Evolving primary care *is the lynchpin of your plan.*	Acknowledge feedback. Noted. As the Clinical Services Plan documents, our demographic is changing and we cannot continue as we are. It is vital that we change and build a sustainable health system based on equitable health outcomes.

	Wait, on page v you told us that for the elderly the number of primary care consultations will increase at a rate higher than the population growth. Are we talking all your patients and service users? Or did you forget the elderly. This is the main point you make for the elderly and you undermined it in the "Plan in a Nutshell." Grey Power would love the elderly to get the help they need to stay safely and securely in their own homes. A few minutes housework a week doesn't do it. *It does seem an awful shame that the next ten years of health in our district is to be set on such narrow parameters, with such a miserable income to achieve your goals.* *We have no objection to adequate home help, diverse pharmaceutical services that use another set of professionals effectively, the Enliven programme, support for people to exercise, be mobile, access practical help when caring for the mentally and physically disabled and an holistic approach. Go ahead.* *By all means save money, deliver the services where they are needed, keep people in their communities, provide home care and facilities. These all make sense.* *Our commitment to achieving equity. Is this another way to say that we will all be brought down to the lowest common denominator? That is also equity.* *The hospital taking a narrow focus in the future is a very sensible option. Much healing and keeping healthy can take place out in the community and there are many options. Just don't delay a short, effective hospital intervention that has a satisfactory outcome for a long term, miserable, extensive, complex set of community based therapies which, in the end leave the patient no better and in a much worse position to come quickly through a straight forward surgical intervention.* • Headline goals on page 26 are admirable but probably unachievable. • People remain well at home with family support for as long as that remains their choice. *What if medical opinion thinks that is not a good choice? Patient has untreated diabetes? This seems a woolly goal.* *There is definitely a place for nurses in the community. Many of our GPs see elderly patients every 3-6 months. A nurse could easily keep an eye on these people and do repeat prescription.* *In terms of the elderly in hospital for prolonged stays, in the past 3 months three patients have had iatrogenic misadventures which have resulted in long stays in hospital.* *While digital is a boon, for many current elderly people it is not the answer.* *Perhaps the main message we see in the Consultation is "don't let our hospital cost any more."*	
49	They provided the following feedback: Positives: • it was good Māori and consumers had participated in the plan's development. • Good to 'look out of the square' and at other successful indigenous models i.e. Nuka, identified within the plan Opportunities for Improvement: • Change the name from 'Clinical Services Plan' o It is really about services that meet consumer and whānau health needs and not purely 'clinical services' • If there is an increased focus on whānau and whānau driven approaches this needs to be more prominent at beginning of document • Need more positive 'wellness approaches' o Traditional wellbeing approaches need to be designed and invested in o Ask whānau what matters to them o Base indicators and outcome measures on what matters to whānau • We need a joined up approach o 'The voice of Māori' not being listened to or 'heard'	• Feedback acknowledged. Add section around behavioural economics with health literacy section to improve wellbeing. Working with our providers is critical to delivering the plan. Add to plan **UPDATED – sentence on understanding what motivates Māori whānau and communities to get behaviour change**

	○ Māori need to be prominent in leading transformational change ▪ What is the role of iwi? ○ Need to ensure Māori/iwi are fully on board ○ Plan needs to be integrated with other population priorities • DHB need to support the development of Māori providers ○ Māori providers are heavily under resourced ○ Need more resources in community approaches ○ Tap into Māori providers innovative approaches • Behavioural economics and health literacy approaches are not prevalent ○ Need to understand what is important, inspirational and motivational for Māori ○ Do we understand what will motivate change in Māori communities and whānau? ○ Need to explore incentivisation for both provider and consumer ○ Need to explore cost effectiveness of services • Information Technology ○ Need to explore the innovative and future role of IT in health care delivery ○ It will ultimately support to drive down health delivery costs The plan is high level and needs an adjoining action plan	
50	Yes captured main issues. How the various community service providers (private, incl not for profit) can work with the DHB in delivering better engagement with population of all ages. These providers need to receive appropriate funding from the DHB – they cannot continue to rely on donations	Acknowledge feedback The plan covers changes to commissioning for services. The detail will follow in the next round of strategic planning.
51	Yes captured main issues. Pleased to see an integrated approach with close to home care	Feedback acknowledged
52	Plan for Hawke's Bay ('the Plan'). We applaud the District Health Board's (DHB's) intention to commit to prioritising and designing services to meet the needs of populations with the poorest health and social outcomes to achieve equity. We have some further comments on the Plan, for the DHB's consideration: • The Plan has a clear focus on being responsive to community needs. We welcome discussing with the DHB how Napier residents' needs will be met through the future design of health services for our city, in particular for our high need communities. We regularly receive feedback from our residents about health services available in Napier. Recently we have heard from young people, parents and caregivers with their feedback on the draft Napier Youth Strategy. We have also received comments from many older residents during the development of our draft Positive Ageing Strategy. This is what they tell us: o reduce travel distance to health services (including hospital and specialist services) – provide services closer to home o make all services more affordable, particularly for 18-24 year olds, and seniors to enable easier access to primary care (registration with a GP) o provide more support for young people to access mental health, addiction and counselling services o provide a well-resourced, affordable after-hours service o improve hospital 'discharge' practices and times (particularly for seniors).	Feedback acknowledged This was useful feedback passed on from other engagement/consultation processes. We believe that all these point are captured at a high level and some will fall out of the more detailed planning yet to be worked through in the next stage. Agreed, we have already captured that there needs to be more n the plan on preventative health care and also children and youth. The DHB has committed to working with our intersectoral partners to deliver the plan.

	At present, some of our community are disadvantaged with the way services are delivered for Napier residents. • We are pleased to see there will be an increased focus on accessible primary and community care, and that access to mental health and addictions support will be extended to cover mild and moderate issues. Our submission to the recent Mental Health Inquiry asked for more mental health and addiction services at the preventative, early intervention, treatment and management levels. We also requested long term, responsive and expert service provision to those who need it, where they need it, how they need it, and when they need it. Such an approach would go some way towards preventing and addressing issues that councils across New Zealand (including in Napier) are responding to in order to manage the effects of unsupported mental health and addiction issues. • We would like to see more emphasis in the Plan on preventative health care. The Plan has a clear focus on narrowing the focus of future hospital services and to delivering care in community settings. If we are truly to reduce future costs to the health system then increased investment in prevention, in particular population health initiatives, is essential. Similarly, adequate funding transfer to community providers will also be needed should they be more involved in service delivery. • The Plan has a focus on the Bay's ageing population. We would like to see more recognition in the Plan of the relatively youthful profile of the Maori and Pacific populations, who are often high needs and therefore have an impact on the health system. This will be particularly important for maternal and well child services delivery in the future. • We understand that planning for how and what facilities will be needed will follow adoption of the Clinical Services Plan. We request that this planning involves an analysis of the needs of Napier residents - to ensure the aims of the Plan are realised for our residents and they are not disadvantaged by the inequitable delivery of health services across Napier and Hastings. • We have not commented on the elements of service and model of care development outlined in the Plan for each suggested option. In several instances we note that some of these elements refer to possible involvement of councils - Napier City Council would like to be involved in discussions about these before details are finalised. There are opportunities for co-delivery/co-location of services through planned new community facilities in Napier (eg, Maraenui community facility and Napier public library). We are keen to explore these opportunities with you while they are in the planning stage. We also have a number of existing facilities that may be appropriate for service delivery in the community	
53	Feed-back relates to all areas of HB DHB regional coverage. It is great to see such a wide ranging plan addressing the complexities of Health Provision within Hawke's Bay (clinical services). MSD share some of the same challenges • Growing inequity particularly for Maori and Pacifica populations. • An aging population and how this impacts on our service provision in the future. • Supporting isolated rural communities and addressing their unmet needs.	All feedback acknowledged and noted.

	• Our service is seeing growing numbers of whanau with mental health conditions. who have poor health social and economic outcomes. • We need to develop resilient tamariki rangatahi and whanau. • Growing dependence on government services. • Many whanau who access both our services live in poverty this has negative impacts on social and health outcomes. **Mental Health**: MSD also acknowledge that a mental health service provision change is required as the current mental health system is failing our whanau and has far too many gaps. The proposal to develop a model of care that is more holistic, that is well resourced and meets the needs of our whanau is exciting. Services like WIT and Hinengaro Services at TTOH are great examples of services that meet the needs of our population and tailored to meet an individual's unique needs, however these services require more resource to be effective. **Primary Care**: Agree that the current system is not working for whanau our regions poor health stats particularly for Maori and Pacifica reflect the need for change. We support the development of a model which will meet the needs of our diverse HB community. Taking the right components from models such as Nuka and HCH to develop the right primary health service for HB is going to be essential if Primary care is going to be the lead player in the wellbeing of our HB whanau. **ICT:** Currently multiple systems in place across all levels of Health provision which means a disconnect at all levels and impacts on whanau care. Difficulty in gathering important population data. Changes to improve ICT will have huge impacts for our whanau. **Older people:** Responding to the an aging population impacts on many government and community services, the importance of linking up services to support the plan for a healthier socially engaged and financially stable senior population can be achieved if we work together to ensure we are all up to speed on what each service can bring to the table to support common goals. I.e. MSD can support with on-going health costs not covered by DHB or PHO via the Disability Allowance max $63.00 a week, are our seniors who are eligible for this assistance accessing it? **Hospital Care:** Current gaps in Hospital services impact on the whanau receiving income support. If our whanau could access surgical interventions improve wellness and increase capacity for work this might mean improved outcomes. Many are declined access to funded specialist intervention because they are not priority and can mean longer time in receipt of Income Support benefits for many whanau. The proposed plan would address this inequity. **Work Force Development:** All of this relies on **growing our workforce,** **expanding their expertise and embedding** **cultural competency** into all we do. Are the DHB recruiting the right people with the right skills? Perhaps there some scope for HB DHB and MSD to work together to identify and recruit whanau receiving Work and Income assistance in to positions at the DHB. Our health system like other government systems in our communities are big machines and will take some clever coordination to improve systems that do not meet all the needs of our HB community. The plan is ambitious but needs to be if HB DHB is going to improve the wellness and reduce inequity. Great first step towards change.	
54	<u>CLINICAL SERVICES PLAN:</u> We are seeing the effects of poverty in health especially among whanau who cannot afford the basic everyday health needs and because of this more and more whanau are presenting to our Emergency services i.e. ambulance, Emergency Departments and after hours visits to rural medical wards. Maori and Pacifica are a very uncomplaining group who would much rather "tuff it out" then spend what little money they have on doctors and medication. The introduction of the Whanau Wellbeing Program has been very positive with whanau taking advantage of this program to get their health needs back on track. However	Feedback acknowledged and noted.

	the only downfall is that the program is only for 12 months although 60 years and over have the benefit of staying on the program for life. We have 84 clients registered for the 2019 program, who are patients of 2 of our local G.P. in CHB and with the program in Hastings Napier and Wairoa, the number of whanau taking up this opportunity, would be high and hopefully by the end of 2019 we will start seeing some improvement in whanau health. We have a big goal to achieve with health equity and the only way forward to achieving our goals, especially among Maori and Pacifica, is to have skilled navigators support these whanau from day one. Navigators should have local knowledge, and be able to support and advocate for clients to all services available to achieve a positive outcome. A relationship with the following services should be paramount: • G.P. services • Community Health Providers • Maori Health Providers • Work and Income • Police • Housing N.Z. • Emergency/Transitional Housing • Budget Advice • Food Banks • Church groups • Maori Marae committee • Real estate Agents • Residential Care facilities • Homecare Agencies • Red Cross transport • Funeral Services Having a good working relationship with these services, enables you to be able to advocate and negotiate the most appropriate services for the wellbeing of our community. <u>Conclusion:</u> There should be more Navigators employed per area allowing them to spend quality time with clients until they are no longer required and have reached their expected health goals. Reporting on all clients and their outcomes should also be expected therefore allowing management to analyse whether or not our goals are being met.	
55	Page 38. Hoki to Whare, should now read Hoki te Kainga (the Maori team suggested the change) Page 40. Case Study – author Heppenstall – a bit weak as it doesn't appear to have peer reviewed and I can't find it published anywhere. Better to use Matthew Parson's as he has three peer reviewed and published RCT's involving Crest and START (Waikato) programmes. Parsons, M., et al., *Supported Discharge Teams for older people in hospital acute care: a randomised controlled trial.* Age and Ageing, 2017: p. 1-6. Attached is a well-researched ACC paper on early supported discharge largely based off Matthew Parsons studies and experience, that can be used for validation.  Early Supported Discharge Fina...	Acknowledge feedback. Agree to include within the plan Dying well. And agree to update thepg38 term. Dying Well Dying is a normal part of the human experience and affects people regardless of age. The support a person and their whānau receive can significantly change their experience during this period of their life, and can help to avoid complicated bereavement for the whānau. Both chronic disease and cancer for the person who is dying and their whānau can be a protracted experience and it is important to manage and support this period of living proactively from the start of this final stage of life. High quality and well-coordinated planning and care provides a setting for a healthy experience of death, for whānau and connected community.

	Can we also add the following two paragraphs Dying Well Dying is a normal part of the human experience and affects people regardless of age. The support a person and their whānau receive can significantly change their experience during this period of their life, and can help to avoid complicated bereavement for the whānau . Both chronic disease and cancer for the person who is dying and their whānau can be a protracted experience and it is important to manage and support this period of living proactively from the start of this final stage of life. High quality and well-coordinated planning and care provides a setting for a healthy experience of death, for whānau and connected community. The Hawke's Bay population will be living with and dying from, not only malignant conditions such as cancer, but chronic conditions, with multiple co-morbidities, including dementia. Their longevity will be frequently compromised by frailty and disability. Advanced Care Planning and palliative care have an important role in helping to provide support to family members and their carer network (including volunteers). Reliance on informal carers and the volunteer workforce will only increase, and we will need to support them to undertake potentially more complex roles. Head Line Goal Our goal is to proactively support people and their whānau in the last years of life so they die well; with ongoing support for their whānau in bereavement Reference Hawke's Bay DHB (2016) *Live Well, Stay Well, Die Well Palliative Care in Hawke's Bay Our vision and priorities for the future 2016-2026* strategic plan1	The Hawke's Bay population will be living with and dying from, not only malignant conditions such as cancer, but chronic conditions, with multiple co-morbidities, including dementia. Their longevity will be frequently compromised by frailty and disability. Advanced Care Planning and palliative care have an important role in helping to provide support to family members and their carer network (including volunteers). Reliance on informal carers and the volunteer workforce will only increase, and we will need to support them to undertake potentially more complex roles. Head Line Goal Our goal is to proactively support people and their whānau in the last years of life so they die well; with ongoing support for their whānau in bereavement Update plan Dying well to be included. Update term Page 38. Hoki to Whare, should now read Hoki te Kainga (the Māori team suggested the change) UPDATED – included dying well in long term conditions section (and shifted elements from table that was previously in older persons section. Palliative care not just about older people. Case study updated & Hoki te Kainga update