Transforming Our Health Services

Clinical Services Plan: the next ten years

Draft August 2018

Karakia

Rurukutia rurukutia

Rurukutia te poutiriao o mahara

Paiheretia i a Ranginui atea ki a Papa-tua-nuku

Pihi ake te whakaaro pai

Hauhake tonu iho

Kia Ukaipo

Haumie Hui e Taiiki E

Prepared by

Sapere Research Group Limited

For Hawke's Bay District Health Board

July 2018

Mihi

‘He mangawai koia e kore e whitikia’

‘A river never to be crossed ‘[1].

Rerehua a wairua i te kāpehu o Urutengangana,[2]

Ka rangona e te whare o Rongo.

‘Beautiful is the soul that soars through the compass of Urutengangana,

And it embraced in the home of Peace’.

Kei aku nui, kei aku rahi, tēnā koutou katoa kua emi mai ki tēnei rautaki whakaaro, kua eke mai ki tenei waka hauora. He oranga wairua, he oranga tinana, he oranga tangata.

Ka hoki te pae o mahara ki ō tātou tini mano kua karapinepine atu ki Te Kāpunipunitanga O Wairua[3]. E māringiringi māturuturu tonu ana ngā roimata, he maimai aroha ki a rātou. Okioki mai.

Nei rā ngā whetū e tiaho mai nei i te māramatanga hei atawhai, hei arataki i te iwi e anga whakamua ai tātou, e mahea noatia ai ngā taimahatanga.

Heoi anō, ka wani kē te waihangatanga o te hōtaka nei, hao ai i ngā tukanga poipoi whānau o mōhoa nei.

Mātuarautia te whānau, te iwi - kia pihi ake a kounga, hauhake tonu iho.

Mā reira a kāpehu mātāpono[4] - a Āwhina, a Atawhai, a Manaaki, a Mirimiri.

Mātika maranga e tū, huakina e Tāne.

[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.
[2] Urutenganana the eldest child of Rangi and Papa was given the task of looking after the stars the planets. They know not of jealousy but live together in celestial harmony. It is a korowai woven from the universe joining the physical and spiritual elements of life.
[3] The place where the spirits gather
[4] Principle guiding points

Foreword

If you live in Hawke's Bay, you will want to know that the right health care services are there for you and your whānau when you need them.

Over the past 12 months, Hawke's Bay health professionals, who live and breathe the way we deliver services and care throughout the region, governance groups, as well as a wide range of people who use our health care services, have been brainstorming and providing their thoughts and feedback to draft a future-thinking health care services concept plan, called the Clinical Services Plan.

We think we have come up with the right themes and range of options that will best meet future health service needs in Hawke's Bay—what services will be delivered, how they will be delivered and where they should be delivered—looking out for the next 10 years.

Now we are asking the wider Hawke's Bay population—have we got this right?

Once we collect all your feedback, we will finalise this concept plan and begin working on prioritising, designing and implementing those services, as well as identifying what future workforce and infrastructure we are going to need to meet the future health needs of our community.

This is an once-in-a-lifetime opportunity to be part of helping to shape Hawke's Bay's future health services.

We want to hear from you, and welcome your feedback to the draft Clinical Services Plan.

KEVIN SNEE
Chief Executive Officer

Hawke's Bay District Health Board

KEVIN ATKINSON
Chair

Hawke's Bay District Health Board

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The plan in a nutshell

Our purpose

We have developed this clinical services plan to formulate our major responses to the challenges we face. It describes our vision for a very different health system that improves outcomes and experience for individuals and whānau living in Hawke's Bay. This plan is the natural evolution of our previous five year strategy, 'Transform and Sustain', and together with a number of related projects will inform our next strategic plan.

We cannot continue with the status quo

Māori and Pasifika, people with disabilities or experience of mental illness; and those living in socioeconomic deprivation, continue to experience unacceptable inequities in health outcomes. Our system is increasingly seeing the effects of poverty, inadequate or delayed access to services, and significant unmet need.

Demographic changes will increase pressure on our already stretched health services. Māori and Pasifika are more likely to live in deprived areas and their higher growth rate is reflective of the increasing social complexity associated with future health service activity.

If current models continue over the next 15 years, the number of primary care consultations will increase at a rate that is higher than the overall population growth. This is driven by the rapid increase for older people, which almost doubles, bringing with it an increase in complexity and time required to manage multiple co-morbidities and frailty. Similarly, under current models demand for hospital admissions will increase by around one-quarter. Increasing complexity and length of stay driven by an older consumer profile means demand for beds will be even greater. Demand for Māori will increase more rapidly than for other groups.

It is clear we need a new approach if we are to achieve equity amongst our population and meet future demand. We cannot sustain services into the future if we continue to provide them in the same way we do now.

What impact do we want to make?

This plan establishes a firm commitment to prioritising and designing services to meet the needs of populations with the poorest health and social outcomes. We have a bold goal to achieve equity and will monitor this through our system level measures and related performance indicators.

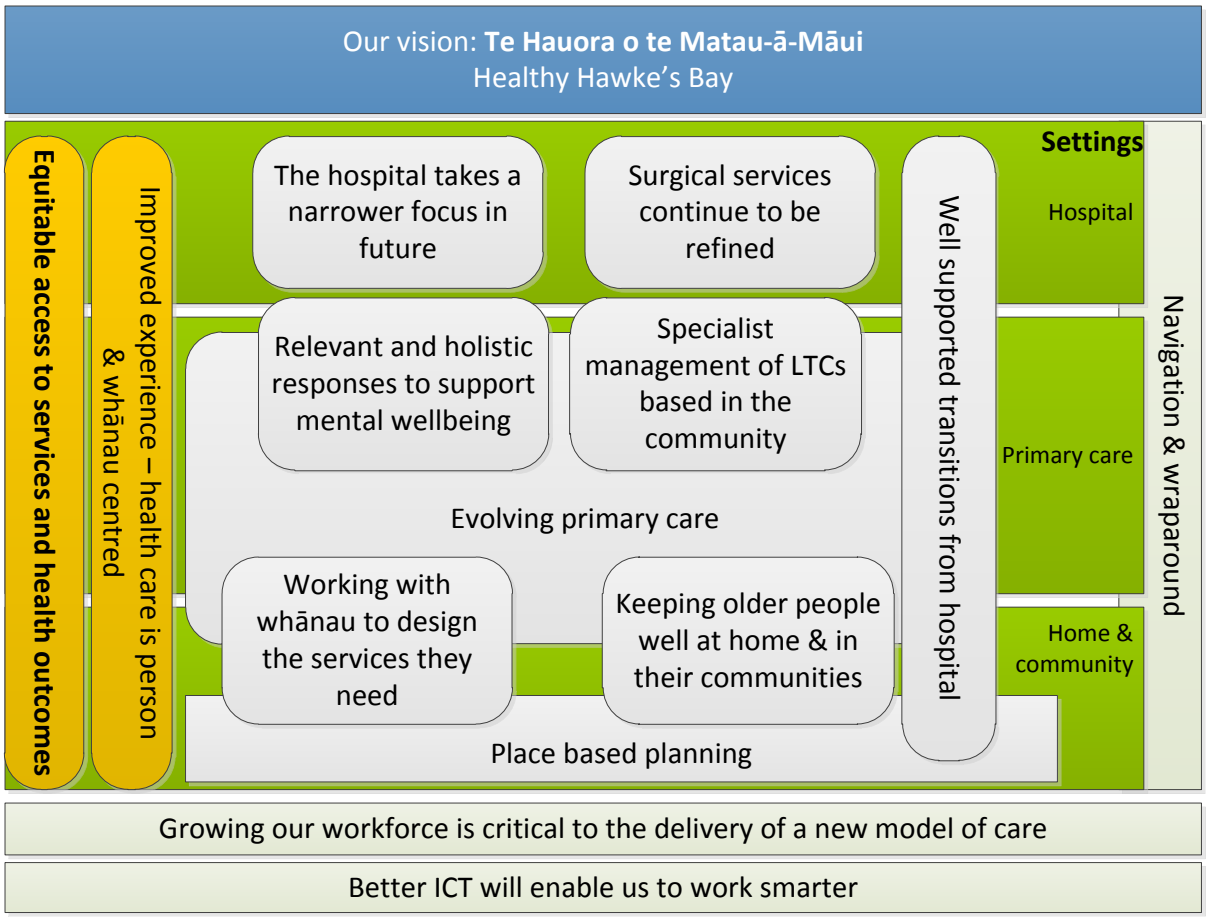
Person and whānau centred care will become the 'way we do things around here'. This means that we will work *with* consumers and whānau rather than doing *to*, or *for*, them. Research shows that person and whānau centred care improves health outcomes and consumer experience, and the use of health resources.

We aim to fundamentally shift our system and invest more in preventative care and primary health services, to improve consumer experience and outcomes, and avoid the need for more costly hospital treatment wherever possible.

We will change the way we commission services. This means that needs assessment will be data driven but will also take a broad approach to community resources. People and whānau will be equal partners in the planning and co-design of services. We will refocus resources in the areas that will make a real difference to eliminating unmet need and inequities, and align incentives so providers are encouraged to innovate.

Our future health system

We have formulated a range of options for responding to the challenges we face, organised around key themes developed with stakeholders in the Hawke's Bay health system. The diagram sets out the key areas for change (in grey), highlights the overarching outcomes we want across all parts of the system (yellow), and sets out the critical enablers to a new system of care.



Place-based planning will provide us with a strong platform to work collaboratively with communities to build on natural assets and co-design services, including primary care.

Evolving primary care is the lynchpin of our plan, with expanded teams offering a wider range of culturally relevant services. In Hawke's Bay, we will develop our own local model that embeds kaupapa Māori practice and builds on the strength of our iwi-led services. Consumers and whānau will be able to interact with their care teams in different ways than they do currently, including virtual and web-based options and same day access.

There are two priority population groups we need to respond to: whānau with children and young people, and older people. Meaningful collaboration with **whānau to design the services they need** is

crucial if we are to eliminate inequities and ensure children have the best start in life. There is good evidence around the impact that adverse childhood experiences have on future outcomes. This means we need to support the whole whānau, to achieve its goals and aspirations.

At the same time, we recognise our population is ageing and we will step up our response to **keep older people well at home and in their communities**. We will identify frailty, developing person and whānau led plans that enable proactive and preventative interventions, and ensuring we provide the best and most appropriate care when health events occur.

We expect the prevalence of long term conditions to increase as the population ages, and we will base the **management of long term conditions firmly in primary care**. The emphasis will be on prevention and proactive self-management, and the majority of specialist clinicians will operate as 'wraparound' specialists integrated with primary care instead of 'destination' specialists requiring consumers to attend hospital.

Care for mental health and addictions is a priority for our health system. We will develop ground up, **relevant and holistic responses to support mental wellbeing**. Primary and community care will facilitate direct access to self-management, wellness and resilience programmes for people with emerging mental health and addiction issues. Good support in primary and community services will include early recognition and referral for specialist services so that those with the most severe and complex needs receive rapid attention by the right level of expertise.

There will always be a need for inpatient hospital care. When it happens, we will engage consumers, their whānau and other support people, and community providers in planning for **well supported transitions from hospital**, from day one. Intensive rehabilitation will be available in the home so people don't spend longer than necessary in hospital.

Many of these themes are inter-related, and all of them are building blocks to achieve our goal that **the hospital takes a narrower focus in future**. If we can achieve our ambition in other areas, in future the hospital will be a place providing specialist assessment and decision making for patients with critical illnesses or injuries, followed by intensive therapies for the first 24-48 hours of inpatient care before discharge or transfer to community settings; or delivering services that require specialist teams or equipment that isn't feasible or cost effective to replicate in multiple settings. Better community based support for mental health and addictions issues will ensure that specialist mental health services at the hospital are focused on those with the highest complexity and need.

We will focus on prevention and non-operative management, but the requirement for surgery will inevitably increase as the population ages and **surgical services will continue to be refined**. In future we will deliver some procedures in different settings, develop a more comprehensive ambulatory surgery model, and organise ourselves in networks with other DHBs for more complex specialties.

All of this relies on us **growing our workforce**, creating new roles and expanding scopes of practice, embedding cultural competency and person and whānau centred care; and the implementation of modern **ICT** to enable sharing of information and new ways of delivering services.

So what happens next?

A number of things in this plan we need to just 'get on and do'. Other elements will be incorporated into upcoming annual planning cycles as they require investment or more detailed development. But to achieve the more profound change we are seeking, some core parts of this plan are strategic decisions that will be taken through to our five year strategy.

INTRODUCTION

1. This plan sets our direction for the next ten years

The clinical services plan is the evolution of our strategic planning

We have developed this clinical services plan (CSP) to formulate our major responses to the challenges we face in the coming years. It describes our vision for a very different health system that improves outcomes and experience for individuals and whānau living in Hawke's Bay.

The CSP informs the priorities for future investment in the Hawke's Bay health system. It sets out the potential demand for services in the future and a range of service and model of care options for how the District Health Board (DHB) and its health and social system partners will respond to that demand. The plan takes a view of the health system as a whole, encompassing primary, community, and hospital level care; and acknowledging the important influence of socioeconomic determinants. The planning horizon is long term and considers options for the Hawke's Bay health system over a ten year time frame.

Over the past five years, we have shifted our perspective from DHB services to whole system management and engagement with iwi and post-settlement governance entities, with our strategy 'Transform and Sustain'. We set up our Consumer Council to work alongside our Clinical Council and Māori Relationship Board, and have generally performed well over a number of years. Now, we need to step up our focus on achievement of equity, the development of primary care, changing our culture, working with local public and business partners, reviewing services across the whole system and considering our infrastructure requirements. Transform and Sustain set us up well for this challenge, and this CSP is the natural evolution of our planning.

The CSP will inform our next five year strategic plan. It is just one input to the strategic plan—we have undertaken and are in the process of other important, and related, pieces of planning work. These related projects will be considered together with the CSP, to determine the investment priorities for our future health system.

Our vision and values guide our approach

OUR PEOPLE

He tāngata.
He tāngata.
He tāngata.

OUR VALUES

HE KAUANUANU RESPECT

*Showing **respect** for each other, our staff, patients and consumers*

ĀKINA IMPROVEMENT

*Continuous **improvement** in everything we do*

RARANGA TE TIRA PARTNERSHIP

*Working together in **partnership** across the community*

TAUWHIRO CARE

*Delivering high quality **care** to patients and consumers*

OUR VISION

Tā mātu whakarehu
Te hauora o te matau-ā-m āui
Healthy Hawke's Bay

Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community

The plan relates to national and regional priorities

This CSP sits within the context of the New Zealand Health Strategy, and other plans or strategies in the Central Region and at the national level. A number of other national strategies set the scene for this CSP, including the NZ Disability Strategy, He Korowai Oranga and Ala Mo'ui.

The Government has established a review into the health and disability sector to identify change that could improve the performance, structure and fairness of the sector. The Review seeks to address the 'pervasive inequities that exist across our health system' and achieve a sustainable public health service in the face of demographic and inflationary pressures. Mental health and addictions and primary care have been identified as areas to be strengthened.

We are also part of the Central Region and rely on our regional DHB partners for provision of some tertiary level clinical care. Regional service arrangements will remain part of the landscape over the life of this CSP and we are committed to the Central Region Services Plan. The current plan focuses on three priority areas, which align to our own local priorities: a health system that is digitally enabled, clinically and financially sustainable, with an enabled and capable workforce. The Plan also provides for the development of specialised care networks across the Central Region, for example cardiac and cancer services.

It has been developed after engagement across the system

Creating the CSP for the Hawke's Bay Health System involved four main stages:

1. **Understanding the current state of service provision and challenges for the future**
   Stage one brought together clinicians and managers in individual service groupings to identify the main issues and challenges of current provision, as well as highlight the good things already happening, and consider the implications of future service demand projections.
2. **Mapping healthcare journeys through patient journey workshops**
   Patient journey workshops provided an opportunity for health professionals, consumers and other stakeholders to identify areas for improvement in the care chain, from a consumer perspective, rather than an organisational perspective. Eleven journeys were mapped over eight workshops.
3. **Exploring options for service and model of care development in broad areas**
   We held workshops around four broad topics: primary care, unmet health and social needs, caring for frailty, the hospital. Participants included consumer representatives, health professionals and managers.
4. **Expanding those possibilities and bringing it all together**
   To build on stage three, we held a final workshop to expand and integrate the CSP options, and identify a sense of priority. Participants included all those involved stage three, along with senior leadership and a number of key individuals supporting the next phase of strategic planning in Hawke's Bay.

2. We face a major challenge

Inequities persist for some groups in our population

Looking across the Hawke's Bay health system, inequities and unmet needs persist. Māori and Pasifika, people with disabilities or experience of mental illness; and those living in socioeconomic deprivation, continue to experience unacceptable inequities in health outcomes. Growth in inequities is also fuelling health need. The system is increasingly seeing the effects of poverty, inadequate or delayed access to services, and significant unmet need.

Alongside this, disability now accounts for over half of the total health loss experienced by the New Zealand population (Ministry of Health, 2016). While increasing resources are required to support older people with both volume and complexity of services increasing, we are not meeting the needs of many in our communities, particularly young Māori and Pasifika families.

Our DHB health equity updates give us a chance to see how we are progressing in some of the key measurable areas of health inequity.

Key findings from our updated health equity monitoring include:

- Immunisation rates are high with no difference between Māori and Pasifika, and children of other ethnicity.
- Cervical screening rates for Māori and Pasifika women are only slightly lower than for women of 'other' ethnicity, however the rate for Asian women is low in comparison.
- There has been a trend towards a decrease in the prevalence of amphetamine use in Hawke's Bay, meaning equity compared to the rest of New Zealand is improving.
- Avoidable hospital admissions for children under five are low compared to national, however the reductions for Māori and particularly for Pasifika children have not been sustained.

There remain many areas of inequity amongst our population:

- Progress in reducing the gap in avoidable deaths between Māori and non-Māori has stalled since 2012.
- The prevalence of psychological distress among adults is higher in Hawke's Bay than any other DHB in the country and there has been no sign of improvement over time.
- Admissions to mental health inpatient services have increased significantly and Māori continue to be admitted at over twice the rate of non-Māori.
- Hazardous drinking is significantly higher amongst Māori compared to non-Māori.
- There has been no improvement in bronchiolitis admissions for 0-4 year olds since 2011, and no reduction of the gap between Māori and Pasifika, and other children since 2013.
- Despite a small improvement since 2015 in the proportion of Māori 5 year olds with no dental decay, a large inequity persists, and there has been no improvement for Pasifika children.
- Māori and Pasifika in Hawke's Bay are less likely to have adequate diabetes control than European or Asian.

- Breastfeeding rates are lower than the national average and lower for Māori and Pasifika.
- Prevalence of obesity has increased across all ethnic groups in Hawke's Bay and our rate is higher than national. Pasifika and Māori, and those living in deprived areas, have higher prevalence.
- Tobacco smoking has decreased but is higher amongst Māori compared to non-Māori. Māori women are still nearly three times more likely to smoke than non-Māori women, and the proportion of Māori mothers smoking during pregnancy increased in the latest year.

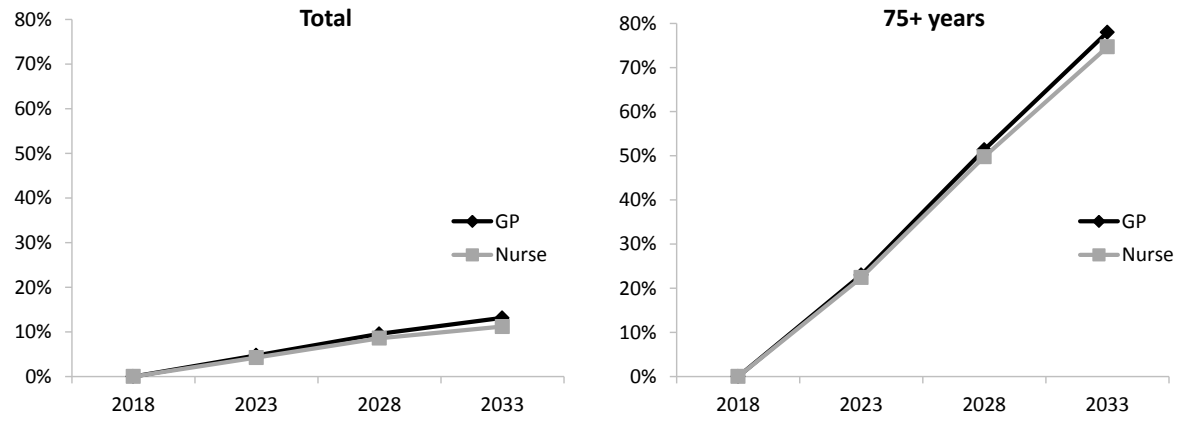
We cannot continue with the status quo

The Hawke's Bay population is not projected to grow significantly over the next 10–15 years, but the profile of our population will change. Like the rest of New Zealand, we will experience substantial ageing with a much greater proportion of older people in the community. Our Māori, Pasifika, and Asian populations will grow, representing a greater proportion of our total population in future. These demographic changes will increase pressure on our already stretched health services. Māori and Pasifika are more likely to live in deprived areas and their higher growth rate is reflective of the increasing social complexity associated with future health service activity. This complexity is likely to change the nature of many interactions between consumers and health professionals, and interactions may take longer.

The increasing prevalence of long term conditions such as diabetes, heart disease and arthritis will place additional strain on our health services and we need to find better ways of working with people and communities to prevent and manage their impact.

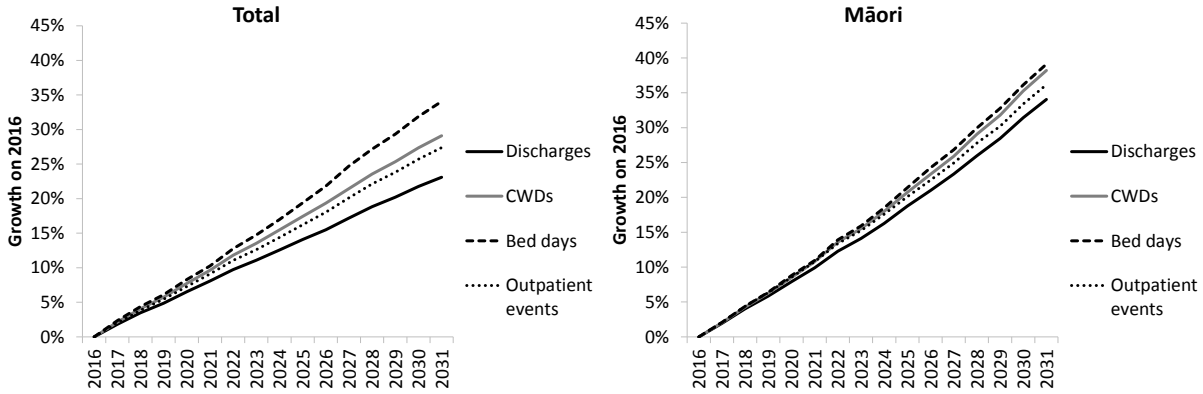
If current models of general practice continue over the next 15 years, the number of consultations will increase at a rate that is higher than the overall population growth (Figure 1). This is driven by the rapid increase for older people, which almost doubles, bringing with it an increase in complexity and time required to manage multiple co-morbidities and frailty.

Figure 1 Percentage growth in primary care consultation volumes on 2018 base



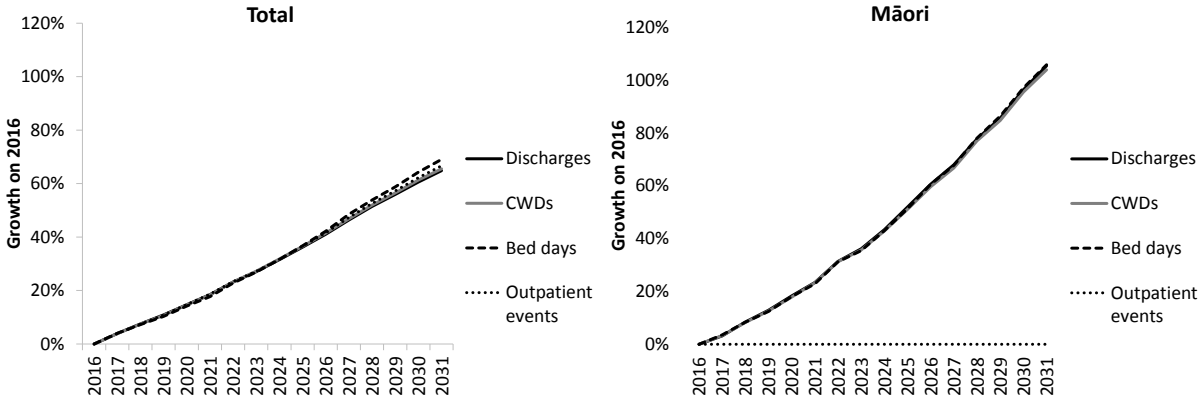
Similarly, under current models demand for hospital admissions will increase by around one-quarter. Increasing complexity and length of stay driven by an older consumer profile means demand for beds will be even greater (Figure 2). Demand for Māori will increase more rapidly than for other groups. Although our population appears to be reasonably well serviced for elective surgery compared to the national average, we have significantly lower rates of orthopaedic and plastic surgery.

Figure 2 Percentage growth in hospital volumes on 2016 base



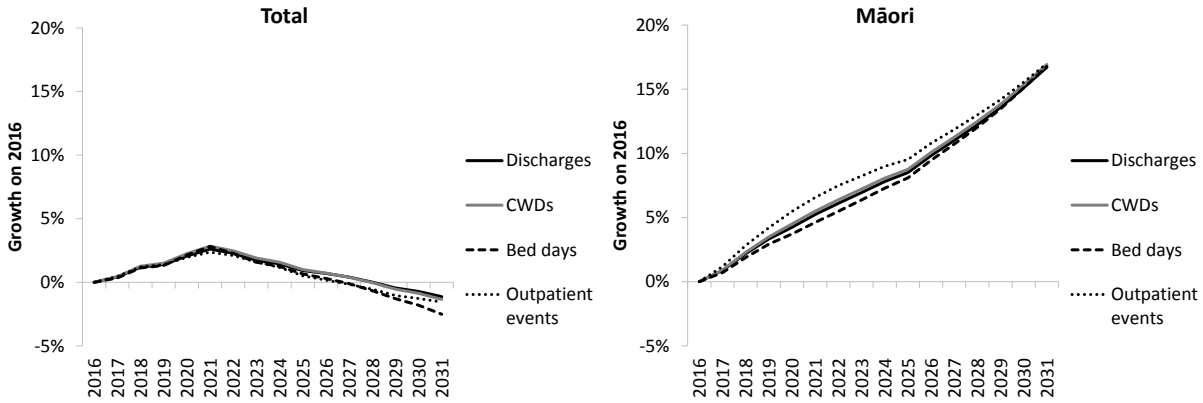
Within this overall growth picture, hospital demand for older people will increase substantially, by around two-thirds (Figure 3). We will need to respond appropriately to the increasing care requirements of kaumātua—hospital demand will double for older Māori. Under the status quo, we would see increases in admissions in the order of 40–60 percent for key areas of older persons' activity such as general medicine, ophthalmology, rehabilitation and community nursing.

Figure 3 Percentage growth in volumes on 2016 base, 65+ years



We don't expect significant change in the overall number of hospital events for children, but within that there will be a steady growth for Māori children, driven by the higher birth rate (Figure 4). This change in the child population being seen by our health services is one that is likely to bring with it an increase in need and social complexity.

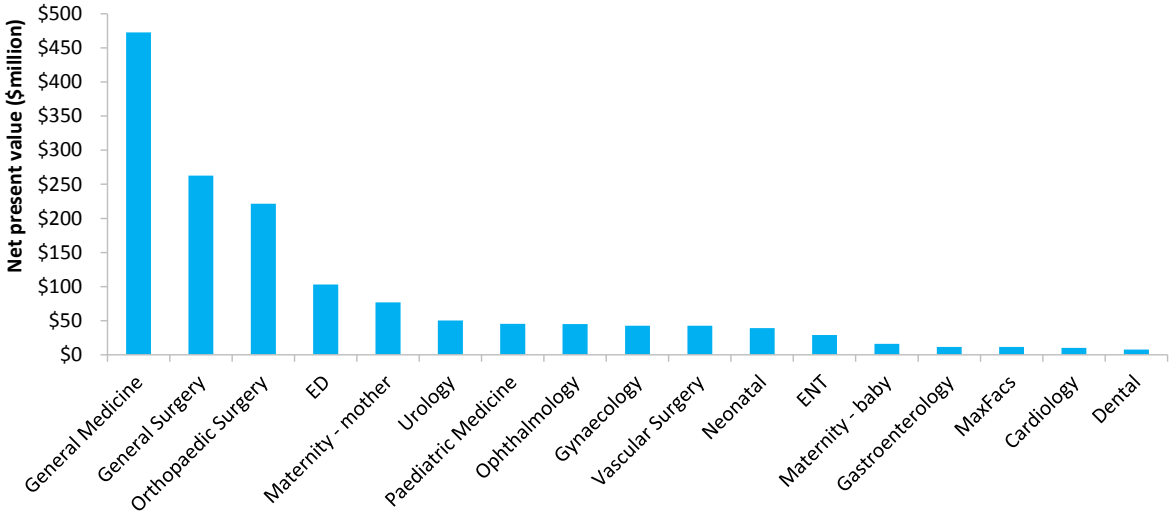
Figure 4 Percentage growth in volumes on 2016 base, 0-14 years



If we don't change the hospital will consume more and more resources as a 'provider of last resort'

A central aim of modern health systems is to shift activity from the hospital and closer to the consumer and their home. This is quite a challenge—more than most people realise. To demonstrate the extent of this challenge, the following chart shows the potential cost of hospital inpatient services within a 15 year horizon, if nothing changes. It is a 'net present value', that is, the value in today's dollars of inpatient medical and surgical care over all the years from now until 2031. The total present value of these services is $1,488 million.

Figure 5 Net present value of medical and surgical inpatient services, 2018 to 2031



These demand pressures are coupled with evidence that we don't use our health systems as effectively as we could. Research from the United Kingdom suggests that when services do not respond appropriately, needs remain unmet or increase, creating artificial demand and spiralling cost (Locality and Seddon, 2014).

We need a new approach to achieve equity and meet future demand

It is clear we need a new approach if we are to achieve equity amongst our population and meet future demand. We cannot sustain services into the future if we continue to provide them in the same way we do now.

Holding people at the centre of planning has been challenging as technology, funding, government accountability and business systems have been focused on organisations and how they perform, rather than what works for people. The Government focus on investing for social wellbeing and significant changes in medical and information technology open up new opportunities. They have the potential to change health care investment decisions, and the way care is organised and delivered.

Listed below are some key problems identified with the current state, through service engagement and patient journey workshops. Alongside this we re-define the future we want for our health system.

Problem with the current state	What a person and whānau centred system looks like in future
Services are not accessible or appropriate to the needs and wants of all groups.	Services are designed with communities, whānau and consumers to reflect their needs and wants, and are delivered as close to home as possible. Nobody misses out on the care they deserve because of affordability, transport, or other social issues.
Lack of clear communication tailored to people and their whānau.	Health workers are friendly and welcoming and take time to develop relationships with people. Communication is clear and health information is easy for all people to understand.
Cultural competency is variable across services and workforce.	People and whānau have their cultural needs met no matter which health service they engage with.
Care is organised around the service rather than the people it serves and it tends to be focussed on a single issue and not holistic.	People have a broad range of services in the community, designed with them, to help them achieve their objectives and keep them well. Longer consultations are available when necessary and specialist services support primary care to manage people closer to home.
Care is not coordinated well, with too many referrals, delays, and discontinuity. There are multiple points where people can be lost in the system.	Everyone has a care plan that is developed with them and based in primary care. The consumer and whānau, and all health workers involved in their care can view and update the plan. Referrals are minimised by having a wider range of services available in primary care. Navigators support people and whānau with complex needs through the system.
Physical spaces are not well designed, lack privacy and can be inappropriate for children, older people, and whānau.	Assessments and interventions are delivered in appropriate spaces, both in primary care and the hospital. Health facilities are whānau friendly—consumers have whānau and support people on site, with specific areas for group conversations and meetings.
Workforce and services are stretched too thinly across both primary and secondary care. Hospital and theatres are full.	The hospital has a narrower scope in the future. People and whānau are empowered to self-care at home and can access services virtually when appropriate. Primary care consultations are targeted to those who need them most, and services are delivered by a range of different professionals working to the top of scope. Proactive care reduces the occurrence of acute events.

Problem with the current state	What a person and whānau centred system looks like in future
Discharge from hospital is not well planned and some people have poor experiences.	If people are admitted to hospital, their transfer back home is well supported and planned from day one, and involves the consumer, their whānau or support people, and other professionals involved in their care. People are able to return home as soon as they are medically fit, with appropriate care and support in place at home.
Expenditure is focussed at the hospital end of care.	The system is designed to deliver care when and where it will make best use of health system resources, meeting people's needs at the earliest and lowest cost opportunity and reducing the onset of complex health need.
Lack of IT development hinders service productivity.	Consumers, whānau and health professionals have access to modern IT infrastructure (hardware and applications) that supports self-care, access to services, and appropriate sharing of information. Tele-health supports equal access to specialist services for people living in remote or rural locations.

We have pockets of service excellence already and will build on these in our new system

We are not starting from scratch—there are clear examples of service excellence within our system already. Just a few examples are: strong and innovative service provision amongst kaupapa Māori providers and some primary health centres, emerging workforce models such as nurse practitioners, close connections with inter-sectoral agencies by child development services, and the engAGE model of multi-disciplinary care for older people. Diabetes and respiratory nurses are working with primary care. Some of our services are held up nationally as best practice.

Now we need to redesign our health system for the future; retaining and growing the good things we're doing and taking bold and courageous decisions to ensure we deliver the best and fairest outcomes for all people in Hawke's Bay.

3. Our commitment to achieving equity underpins this plan

Health inequities are differences in health outcomes that are avoidable or preventable—and therefore unfair. The health system can make a difference with a determined and focused effort that works to address underlying causes and provides better, closer to home health services. It also means working across the whole community to make sure living conditions that support health are distributed fairly. Our vision of a healthy Hawke's Bay is necessarily an equity vision and requires a particular focus on those with unmet needs.

The CSP establishes a firm commitment to **prioritising and designing services to meet the needs of populations with the poorest health and social outcomes.** This means:

- Up-skilling of health professionals, with particular regard to cultural competence, mental health and addictions, wellness focus, family violence and poverty. The workforce reflects the population it serves
- Commissioning for equitable outcomes
- Multi-disciplinary and team-based approaches which more holistically consider and address health and social needs and aspirations for whānau
- Re-framing our approach to focus on wellness, preserving mana and building on existing strengths of whānau, communities, and population groups
- Whānau wellness models in addition to an expectation that core services will meet the needs of those with poorer outcomes
- A rights-based approach to health meeting our responsibilities under Te Tiriti o Waitangi
- Incorporating the guiding principles of the Nuka System of Care[5] whilst giving primacy to Māori indigenous thinking, values and solutions.

A new approach to commissioning is required to ensure equitable access and outcomes

Commissioning is defined as

> The process of continuously developing services and committing resources to achieve the best health outcomes for individuals and the population, and ensure equity and enhance experience within the resources available.

We want to shift our system so that it targets and works with people and whānau experiencing the poorest outcomes, and supports them to thrive and enjoy good health and wellbeing.

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

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 whānau in context, and forming partnerships with whānau, hapu and iwi.

The national commissioning framework for mental health and addiction (Ministry of Health, 2016) provides a useful guide when commissioning services to improve equity; acknowledging the social determinants of health by taking a much broader approach to health and wellbeing.

Figure 6 The commissioning framework for mental health and addiction

Note: KPIs = key performance indicators

Source: Ministry of Health, 2016

Commissioning for equity means that:

- Needs assessment will take a broad approach to community resources, considering disconnects or gaps between health, social, community, government and non-government funded services. It will capture the voices of communities, consumers and whānau, as well as clinical leaders and health social services
- Resources (including but not limited to money) will be refocused in the areas that will make a real difference to eliminating unmet need and inequities. This might mean disinvesting in some things in order to prioritise others
- Whānau are equal partners in planning and co-design of services. We will ask people what services they need and how they want to access them, and act on this so whānau continue to engage and have a sense of ownership of their own health and health system
- Aligning incentives and supporting providers to innovate, with robust monitoring and evaluation to ensure equity of access and assess their contribution to achievement of equity. Where possible we will scale up and spread services that are achieving good outcomes, and stop or change those that are not achieving outcomes.

Person and whānau centred care is a core principle of commissioning

A person and whānau centred approach has its primary focus on people, their whānau, friends and carers; understanding their needs and aspirations and what matters to them (not, 'what is the matter with them'). Research[6] shows that person and whānau centred care improves health outcomes and consumer experience, and the use of health resources. Creating a culture that is person and whānau centred requires a fundamental shift in behaviours, systems, processes and services for all people working across the Hawke's Bay Health system. Person and whānau centred care is a core plank of our DHB People Plan.

Co-design is the process of working collaboratively with other key stakeholders to develop a response to an identified need or opportunity. If we are to 'transform our model of care towards an integrated primary and community based response that leverages our hard won but limited capacity in specialist care' (Health Workforce New Zealand, 2011), then services need to be designed in quite a different way. Fundamentally, we need to work with people and whānau whose needs are not met, to 'design out' the inequities that are built into our current system.

We will support people to make good choices by making health easy to understand

Making health easy to understand is critical to ensure people stay well at home and in their communities, and know when and how to access services. Often this concept is described as 'health literacy'. We need to improve the way we organise health information and services and the competencies and behaviours of the health workforce. When we make health easy to understand people are able to make better informed and more appropriate health decisions, and better manage their own health. Unfortunately, the health system does not make its information easy for everyone to access and we often don't spend enough time ensuring consumers and their whānau are able to process it. In addition, many of the choices made by the most disadvantaged groups in our communities are influenced by factors outside their control. We need to dig deeper into what those influences are so we can help people make the best decisions they can, in their circumstances at different points in time.

We will **make health easier to understand** and navigate by:

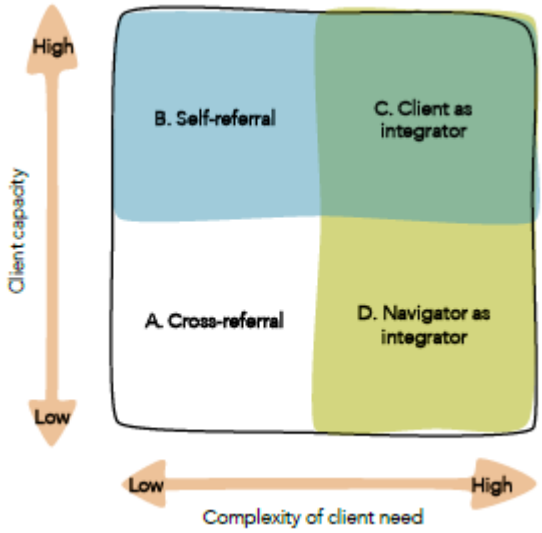
- Ensuring whānau have information about the role of different services, including when, how and where to access services for urgent needs
- Developing the health literacy and cultural competencies of the workforce and embedding person and whānau centred practice as the way we do things
- Investing in the workforce that supports people in their healthcare journeys, for example kaitakawaenga, navigators, social workers, and informal supports
- Making it easier for consumers and whānau to participate in their health and wellbeing by making their health information available to them electronically
- Developing health coaching, peer support and behavioural services in community settings.

[6] Del Canale et al, 2012; Dahlin et al, 2010; Pereira et al, 2016; Bertakis and Azari, 2011; Stewart et al, 2000

We will provide appropriate services responses for different groups

The New Zealand Productivity Commission has found it useful to segment four different social service consumer types, shown in the diagram below.

Figure 7 Characteristics of clients of the social services system



Source: New Zealand Productivity Commission, 2015

To maximise effectiveness, services should be arranged differently to match the needs of people in different quadrants. The Commission notes that there is the most potential for improvement in services and outcomes for people in quadrant D, with high and complex needs but lower capacity to navigate the system. 'Capacity' does not refer to a deficit of the person or whānau. It means that for a variety of reasons, which are often complex and outside people's direct control, they are less able to get what they need from health and social systems.

Many people are low users of the health system, and only need episodic clinical interventions to meet specific, short-term health needs. Often these people are able to access the service they need on their own, or cross-referral between providers or health professionals works well for them. We want to simplify care for those with high capacity, with standardisation of pathways and a range of virtual and electronic options to access services. This will unlock resources and allow us to provide more intensive services to those people with more complex or unmet needs.

We need specific responses for those people and whānau with unmet health and social needs. For whānau with lower capacity, we will wrap a range of services around them and use navigators to support them through the system. Whānau with limited capacity, unmet need and risk factors for mental illness and addictions are particularly vulnerable, and wraparound support that recognises these critical factors will be delivered. Whānau empowerment is our aim—we will partner with whānau to identify the mix of services that will support them to achieve their goals and aspirations.

Along with targeted initiatives, we also need *all* services and those working within them, to be culturally responsive, and demonstrate values and behaviours that are characterised as welcoming, inclusive, caring and non-judgemental.

THE PLAN

4. We have a range of options for responding to the challenge

The plan that follows sets out a range of options for service and model of care development, organised around key themes developed with stakeholders in the Hawke's Bay health system. It does not explicitly address every area of the health system. In the future, we will keep doing many of the things we do currently, and continue to develop new models of care we have already started. As well as that we will change our system in the areas described here. There is significant overlap between many of the themes and some are dependent on others to achieve the model we want for the future. The themes in this plan are:

1. Place-based planning
2. Evolving primary health care
3. Working with whānau to design the services they need
4. Relevant and holistic responses to support mental wellbeing
5. Keeping older people well at home and in their communities
6. Specialist management of long term conditions based in the community
7. Well supported transitions from hospital
8. The hospital takes a narrower focus in future
9. Surgical services continue to be refined

Each theme includes a high-level description of what the model of care could look like in the future and our headline goal or goals. A range of more specific elements of service and model of care development follows in table format, with the possible phasing of each.

Prioritisation will take a variety of information into account

We need to determine the priority of each theme, its place in our new five year strategic plan and the elements that will be adopted and developed collaboratively with stakeholders. Prioritisation will take into account the outcomes of other key pieces of planning work occurring in the DHB.

A sense of priority was identified through the CSP workshops. Participants valued models that specifically target a reduction in unmet needs and achievement of equity the most highly. This includes services to meet the needs of under-served whānau, practising person and whānau centred care in all parts of the system, and a de-medicalised model of care for mental wellbeing that is based in the community. Workforce and IT enablers were ranked a top priority to facilitate different ways of working and consumer ownership of their health.

Once we have considered all the options and determined our course of action, we will need an implementation plan to make it happen.

We will monitor our progress over time

The headline goals describe what success looks like. We have seen the demand growth path we are on if we don't change what we're currently doing; in the appendices to this CSP we show what it will take to contain that demand. We will monitor our progress in key areas by using a suite of performance indicators—we have many useful measures already and will develop new ones to ensure we have a comprehensive picture of how we're tracking.

Place-based planning

Community partnerships and development

The population health and equity focus of the CSP and the multi-factorial nature of many health needs in Hawke's Bay requires inter-sectoral collaborative action to address. Pooling expertise and resources across inter-sectoral partners and aligning planning and action should provide greater leverage to address longstanding social determinants of health in Hawke's Bay.

Effectively involving communities in the design and development of health services can support improvements in population health outcomes and consumer experience. Communities have local knowledge that can help us to provide cost-effective and sustainable services. It can also empower communities to take ownership for addressing previously intractable issues, producing more sustainable outcomes.

In this CSP we define the concept of place-based planning as

> Stakeholders engaging collaboratively in a process to address issues they are experiencing within a geographical space, be it, a neighbourhood or region.

Collaborative place-based approaches rather than person-based approaches are most effective when the problems are complex and the solutions either uncertain or require multiple forms of intervention. Not all places or communities will need the same type of place-based approach. This approach might only be needed or justified in communities with entrenched social problems while other communities may benefit from other forms of place-based or integrated services.

Place-based initiatives focus resources and efforts in selected communities over a period of time. They share a commitment to community level systematic change through inter-connected approaches, including: community decision making, collaborative partnerships, integrated programmes and data and results-driven programmes. Depending on the needs identified the emphasis of the initiatives can vary (e.g. health, education, other factors).

Place-based planning will provide us a strong platform to work closely and collaboratively with communities to prioritise and co-design place-based initiatives that will meet the needs of our communities and populations with the poorest health and social outcomes and thereby working towards a goal of achieving equity.

Important components in the place-based planning process will be:

- needs assessments to identify communities with greatest need
- integration of health and social services around the needs of the communities they serve (e.g. health connects with social services, justice and education)
- effective co-ordination of local assets
- integration of population health information with local service provision
- consideration of social commissioning
- monitoring outcomes (e.g. have all young mothers been identified and linked with an appropriate maternity service?)

Headline goals

- Establish community level plans that promote and build healthy, safe and resilient whānau
- Establish place-based initiatives in self-identified and high need communities, bringing local leaders together to address health and social issues and improve outcomes for individuals and whānau
- Communities are activated with the tools and support to take ownership of their local service network

Elements of service and model of care development

Element		Phasing		
Focus	Broad determinants of health including social services (e.g. housing), wellbeing, prevention, early intervention.			
	Work with the community (at a population level rather than individual level) to build safe, resilient whānau through the elimination of family harm (i.e. by a collective group including police, health, etc.).			
	Work closely with communities to implement the suicide prevention plan, designed to empower and enable communities to promote wellbeing, build resilience and stay connected.			
Needs assessment	Consult and work with the community/stakeholders to map out their needs.			
	Complete community level needs analysis to identify needs and gaps.			
	Provide stakeholders with robust data to give them information so they can see what the issues are and decide what they need (dialogue).			
	Use the Integrated Data Infrastructure to bring together data from multiple sectors and identify 'hot spots' of need in the community.			
Planning and co-ordination	Support local communities' involvement throughout the planning process from information sharing, need assessment to planning services.			
	Develop a central registry of community-based health and social service providers by geographical location and a plan to raise community awareness.			
	In Wairoa provide enabling resources that will improve the co-ordination of current services.			
	Facilitate rural service integration and identify what is required in and around the rural facilities (e.g. rural nurse capacity).			
	Fully implement existing technology, such as tele-health and videoconferencing, and explore new technology, to support delivery of rural health services.			
	Work with councils, Ministry of Social Development (MDS) and local business to grow socially responsible employment and enterprise.			
	Support the development of frameworks and pathways to prepare and support people into employment.			
Commissioning and funding	Investigate options for co-funding and contracting.			
	Explore a commitment to social commissioning with combined funding from inter-sectoral agencies.			
	Investigate separating roles and responsibilities at a governance level while maintaining responsibility for own areas.			

Element		Phasing		
Partnerships, co-location and links to other services	Review and improve services: • how they link or should link • where are they or should they be located to provide (e.g. consider co-location with other social services) • enhance and/or expand and invest in services that work well (e.g. taiwhenua provider) • build on prior experience when developing new options (e.g. the community partnership group) • identify any services that are not working well.			
Community hubs as settings for wellness	Take the services to the people and be more responsive locally with the co-design of services.			
	Build on services already available in primary care (e.g. dieticians, dental, district nurses, public health nurses in schools and early childhood education, child development service).			
	Set up and resource location-based hubs, community-based clusters (not based in the DHB but in community).			
	Use existing structures/systems that are in place and build around them to enhance current hub-like facilities, consider the use of: • schools (education/health in partnership) • community cultural centres • MSD community hubs • council facilities.			
	Implement mobile services (e.g. a mobile wellbeing centre to get around to Pasifika communities or to remote towns).			

Evolving primary health care

A fundamentally different primary care system is the lynchpin of this CSP. There are large expectations for a primary care response to burgeoning health need, and the model of general practice will continue to evolve to respond to this demand. There is a groundswell of readiness for a new approach and we already have examples of practices doing things differently. Some are implementing telephone triage to better manage appointments, holding daily team 'huddles', and there is good uptake in places of the patient portal. Strong relationships between primary care and the DHB need to be developed and nurtured to amplify the scale of this change.

Our health system needs to work with communities and people who need services to improve access, remove barriers and deliver proactive and preventative care. This is particularly important for under-served populations with long term physical and mental health conditions, with an expectation of an integrated service. Primary health centres will operate within community networks that are planned and developed as part of place-based planning.

Primary care teams will be expanded with new roles and capabilities

Traditional primary care is based on a medical model, focused on the role of general practitioner and practice nurse. This workforce is ageing, under significant workload pressure, and is unable to address all the health and related social needs of consumers. In future, the primary care team will be expanded with new roles including (for example): specialist long term conditions therapists or nurses, midwives, district nurses, care navigators or key workers, social workers, behaviourists, mental health workers, clinical pharmacy facilitators as well as community pharmacists, allied health and home support carers. These practitioners will not necessarily be employed by practices but will be a core part of a multi-disciplinary team around them, enabled by shared IT and providing holistic and culturally appropriate stepped care.

The Health Care Home model has many of the features we want in our primary care services

The Health Care Home (HCH) model of care, as it develops, is being implemented throughout New Zealand and represents an opportunity for a fundamental and sustainable change in the primary care model to improve the quality of care delivered in, and around, general practices. It works to improve the management of people in community settings and increase equity of access to primary care, and enables greater integration with health and social services across the system as a whole.

The HCH model has six core attributes:

- **Person & whānau centred**: supports people to manage and organise their own care based on their preferences, and ensures that consumers, whānau, and caregivers are fully included in the development of their care plans and ultimately the design of primary care services.
- **Comprehensive**: a team of professionals providing care for a person's physical and mental health needs, including prevention and wellness, acute care, and chronic care.
- **Coordinated**: ensures that care is organised across all elements of the health care system, including specialty care, hospitals, and community services and supports.
- **Accessible**: delivers accessible services with shorter waiting times, enhanced in person hours by prioritising consumer–clinician contacts for those who need it most, extended hours, electronic or telephone access, and alternative methods of communication through IT innovations.

- **Continuous**: recognises the value of continuity of care, and enables this by creating capacity within practices.
- **Accountable and committed to quality**: demonstrates commitment to quality improvement through the use of data and other tools to guide people and whānau to make informed decisions about their health and to monitor progress at a practice population level.

We will develop our own local system based on our learning from indigenous models

In Hawke's Bay, we will develop our own local model that embeds kaupapa Māori practice and builds on the strength of our iwi-led services. Our model will be based on a real understanding within the primary care team of who consumers and whānau are, and how to respond to their wellbeing needs. This includes easy access to advice around any social problems (e.g. social welfare, housing) and specific access equity components such as co-payment reduction or removal for priority groups.

We have learnt a lot from the Nuka System of Care at the Southcentral Foundation in Alaska. We will take the lessons from Nuka but create a local system that is co-designed by our own communities and whānau, and is completely in tune with our Hawke's Bay culture.

The Nuka System of Care incorporates key elements of the Health Care Home model, with multi-disciplinary teams providing integrated health and care services in primary care centres and the community, co-ordinating with a range of other services. This is combined with a broader approach to improving family and community wellbeing that extends well beyond the co-ordination of care services—for example, through initiatives like Nuka's Family Wellness Warriors programme, which aims to tackle domestic violence, abuse and neglect across the population through education, training and community engagement. Traditional healing is offered alongside other services, and all services build on indigenous culture (The King's Fund, n.d.).

Primary care will be at the heart of rural health service provision in Hawke's bay, with the development of outreach models to reach those in remote locations (for example, nurse-led care and mobile clinics).

Scale and consistency of operating model and care philosophy is critical to allow more specialisms to be provided in and around the healthcare home. There may be cross-referral to other practices with special interests, where sufficient size allows this to develop.

Active involvement of consumers in the on-going development of primary care

One of the key successes of Nuka, that we will adopt in Hawke's Bay, is actively involving consumers in its management in a number of ways. These include community participation in place-based planning groups, the active involvement of consumers in management and governance structures, and the use of surveys, focus groups and telephone hotlines to ensure that people can give feedback that is heard and acted on.

Stakeholder and community engagement will be undertaken in a far more responsive way than in the past. We will keep listening to what the community is saying, go away to find ways of meeting their needs, then report back on our progress. We will not be able to achieve everything that people want and we need to be transparent and realistic about the limitations we work within. But the Nuka experience suggests that by listening, feeding back and being honest with our community, people can understand they are partners in the transformation and delivery of care, and walk with us through challenging decisions.

IT is critical to support this approach

The model requires IT enablement to work. This means a single electronic record and shared care plan, that is accessible to all those involved in a person's care and to the consumer (through a patient portal). Ideally, consumers will be able to add their own information to their record. As well as email and telephone contacts, consumers will be able to use patient portals and video-chat to interact with members of their primary care team. Clinicians will be able to refer electronically for specialist appointments and diagnostics.

Headline goal

- Consumers and whānau have choice to meet their needs and wants, with services easily accessed when they want them

Components of service and model of care development

Element		Phasing		
Business processes	Change management support for practices and support for process improvement methodologies.			
	Structured co-design process for progressing the primary care model and wraparound services.			
	Primary care clinician triage and call management to ensure face-to-face consultations are targeted to those that need them most—clinicians triage calls each morning to see whether people can be managed by phone, on another day, etc.			
Accessible and acceptable services	Same day acute appointments—practices block out time slots to accommodate acute appointments from clinician triage or walk ins.			
	A greater number of practices with extended opening hours e.g. until 7pm or Saturdays.			
	Electronic booking of appointments via the patient portal.			
	Appropriate appointment lengths are booked based on people's needs, longer appointments are available for those with more complex health and social needs.			
	Practices proactively identify people and whānau with affordability issues and put in place a planned approach to facilitate access. Consider reduction or removal of co-payments for target groups.			
	Web based or virtual consultation options – alternatives to face-to-face consultations via the secure patient portal.			
	Practices have a commitment and plan to provide care appropriate to cultural needs.			
Proactive care and alternatives for acute care	Proactive assessment, care planning, and care coordination processes are put in place to support people and whānau with complex needs, facilitating integrated health and social care.			
	Population stratification is used to identify levels of clinical risk and those with complex health or social needs.			
	Implementation of an electronic shared care plan tool & development of shared care plans for those with the most complex care needs initially and extending to all.			
	People identified as having high and complex needs have a named care coordinator.			
	Practices proactively work to involve whānau support practitioners/advocates/navigators in care planning and coordination for the most under-served people.			
	Members of the primary care team have greater decision rights to arrange care support to keep people well at home.			
	Implementation of a full range of primary options for acute care, including rapid response at home (above), and using ambulance services where appropriate (e.g. Chronic			

Element		Phasing		
	Obstructive Pulmonary Disease (COPD) management).			
Expanding the primary care team	Extension of the clinical pharmacy facilitator programme to cover all practices.			
	Extension of the general practice team to include mental health professionals, health coaches, behaviourists, etc. as well as development of the unregulated and lay workforce.			
	Practices participate and lead multi-disciplinary team (MDT) meetings in the community and support integration with specialist and community services.			
	Close collaboration with other health and social providers, and government agencies in localities.			
	Expansion of engAGE as necessary so community nurses and allied health form community based teams or clusters, and are full members of MDTs.			
	Key specialist services (geriatrics, general medicine, midwifery and paediatrics, mental health, and other specialist services in the area of diabetes, respiratory and cardiac etc.) provide support for primary care through expert advice, case collaboration and supporting the management of more complex people in the community.			
	Referrals to secondary care are prioritised based on severity of condition, not capacity, and urgent referrals can be seen on the same day if necessary.			

Case study: Health Care Home model of care, New Zealand

The overarching aim of the Health Care Home (HCH) model is the creation of an improved and sustainable primary care service for New Zealand. It puts patients at the centre, enhancing and simplifying their experience, and it gives practitioners the tools they need for better management of their time and resources. The first HCH practices were established in New Zealand around 2011 and there are now 128 practices using some, or all, of the Health Care Home model of care. A new requirements guide sets out the service elements and characteristics of a HCH practice over and above the traditional model.

The most recent roll-out has been in Capital & Coast and Hutt Valley DHBs. Early indications in Capital & Coast were positive, suggesting a reduction in ED attendances and acute hospital admissions for HCH practices (Compass Health, 2017). High need practices are less stressed and more proactive. The practice may phone a person and ask them to attend whereas, in the past, the person may not have been contacted, and may not have prioritised their own health. HCH teams have time for proactive management with consumers, and in cooperation with other providers.

An evaluation of the HCH model in Pinnacle practices (EY, 2018) compared service utilisation rates by patients at HCH practices with patients at comparable practices with a traditional general practice model, over a six month period April to September 2017. A multiple logistic regression analysis found the HCH model was associated with significantly lower rates of ambulatory sensitive hospitalisations (odds ratio of 0.80 favouring HCH). Additionally, patients attending HCH practices had a significantly lower rate of ED presentations (odds ratio of 0.86). Two important contributions to this effect were a large difference in Māori ED presentation rates and a large difference in ED presentations for older people aged 65+ years.

Shared Medical Appointments are proving popular with both HCH clinicians and consumers. A group of people, perhaps six to 10, with similar conditions or needs, receives both individual attention and the benefits of sharing and learning at a group session organised by their practice. These might last for around 90 minutes and attendees might include the chief clinician as well as members of the extended care team.

In Taupo, a peer support worker in the extended HCH team, runs an 'Off Highways' group consultation for truckers, which meets every fortnight. GPs, dieticians, nurse practitioners and

clinical pharmacists are invited into group meetings as required for 'light touch' health education and individual assessment.

A GP gives another example of a COPD shared medical appointment in Taupo, where a kuia involved herself in a discussion with a young woman about her smoking, 'I saw a dramatic change in the younger woman from hearing the message from an older woman that she respected, who could describe her own journey'.

Hora Te Pai Health Service in Paraparaumu has also formed a COPD group. As one attendee says, 'Being Maori, it's easier to share your conditions with a group of other people. If you're hurting, sometimes the tendency is to shut up, "she'll be right", you know? But when you're all in there with the same problem, it's easier to share.' The longer appointment also led to an increase in consumers' general understanding of their condition—especially what to do when they had an acute exacerbation of their COPD. 'By the end of the 90 minutes, everyone walked out with a back-pocket script and a new inhaler script, if necessary.'

Working with whānau to design the services they need

The New Zealand Health Survey (Ministry of Health, 2018) shows that Māori and Pasifika in Hawke's Bay experience persistent unmet need for health care. Through consumer experience surveys and consumer engagement forums, whānau have spoken of services that are not designed to meet their needs. They articulated feelings of not being listened to, lack of cultural competence, unclear communication and explanation from health professionals, and not being treated with respect. Rangatahi have told us they want integrated health and social services that are close to where they live, with virtual as well as drop-in options for accessing care, and a diverse workforce that includes young people as well as different ethnicities and cultures.

As well as ensuring our workforce is culturally competent, we need two key things to be happening: better design of all services and resourcing that is geared towards meeting the needs of underserved people, plus targeted services that are wrapped around whānau with complex needs, supporting them to achieve their goals and aspirations and independently manage their own health and wellbeing.

Equal partnerships with whānau in service design

In section 3 of this plan, we stated our commitment to achieving equity and set out our principles for prioritising service design for those with unmet needs. Addressing the social determinants of health goes hand-in-hand with health service provision. Our response to working with whānau to design the services they need will also include:

- Better understanding of the health needs and aspirations of young, low income whānau in Hawke's Bay, and in particular Māori and Pasifika families. To do this we will undertake more regular health needs assessment with an explicit health equity focus. Services will be designed to prioritise addressing the needs of those with the poorest outcomes.
- Analysis and identification of complex health and social need will become more sophisticated in future. We will use tools such as the Integrated Data Infrastructure and Index of Multiple Deprivation to quantify this complex population group and plan the size and location of our responses.
- Taking a life course approach, recognising the need to shift resources to services focussed on the best possible start to life and achieving better outcomes for future generations, and addressing adverse childhood experiences
- Meaningfully including the voices of individuals and whānau with unmet need at every step.

We will trial and adopt new ways of doing this to ensure the voices of under-served whānau are heard—not just through surveys but using alternative tools such as smart devices. Young people have told us they want to interact with supports in an environment that is tailored to their age-group and that includes their own peers in delivering that support. Rangatahi with lived experience will be encouraged and supported to assist in co-design and to form peer support groups. Co-design and feedback will extend beyond primary and community services, to ensure these whānau are able to access specialist and hospital based services (including those provided outside of Hawke's Bay) when they need them. We will address barriers such as cost, transport and child care.

New services will be defined with consumers and whānau, but examples might include an increase in free drop-in and one-stop-shop clinics, which may be mobile or located near to where people live in marae, schools or early childhood education, churches; or home visiting services. Fundamentally, the

primary care model will be designed within cultural frameworks, such as Te Whare Tapa Wha and Fono Fale, to support all aspects of wellbeing: physical (taha tinana), mental (taha hinengaro), family (taha whānau) and spiritual (taha wairua).

Whānau wraparound

With our inter-sectoral partners we will increasingly identify the whānau most in need of support and work in equal partnerships to manage their health care alongside other aspects of their lives. Our focus will be to work with Oranga Tamariki to invest in and provide intensive wraparound services for whānau, especially tamariki during the first 1000 days of life and rangatahi during the adolescent years. We already have some services that are meeting broader needs by taking a whānau ora approach but we need to expand and coordinate them. This will mean resourcing existing providers to do more and commissioning additional providers. Key workers, or kaimahi whānau (family workers), will be assigned to individual whānau and work with them to develop a whānau plan centred on their goals. Wraparound services will include, but are not limited to:

- Ensuring whānau members receive screening and preventative health interventions
- Education and coaching around healthy behaviours and self-management of physical and mental health conditions and addictions
- Provision of accessible, positive pregnancy and parenting programmes, home visiting services, mental wellbeing services, addiction services, and other intensive services the whānau needs
- Advocacy and support for interactions with health and other social services, for example housing, work and income support and budgeting, education, justice, etc. Key workers will act as navigators and walk with consumers across community and hospital services.

Coordination, referral, budgets

Expanding provision of wraparound services may require a coordination service, or whānau service centre, as a single point of entry. Referrals will come from multiple places including general practices or other community providers, hospital, schools or early childhood education, social service providers, police and corrections, or self-referrals. Risk assessment tools will be used that incorporate known social determinants and the relationship of health and wellbeing with adverse childhood experiences. Some referrals may be straightforward and can be directed to an appropriate service. Others requiring wraparound and navigation will be assessed and assigned to a key worker. Budgets for wraparound services will follow people. The key worker will partner with the whānau so they have greater choice and control over the services they access.

Headline goals

- People and whānau are equal partners in design of health services and decisions about their care
- Within 10 years there is no difference between population groups in self-reported health status
- Rangatahi feel that services for them are appropriate and accessible
- All population groups have equal access to health services and equitable outcomes

Elements of service and model of care development

Element		Phasing		
Needs analysis and service design	Work with expert providers (kaupapa Māori, Pacific navigators, etc.), Māori Relationship Board, Consumer Council and Youth Council to establish mechanisms for engaging the voices of under-served people and particularly young Māori and Pasifika in service design.			
	Develop DHB commissioning framework that explicitly delivers equity and resources services designed to meet the needs of under-served consumers and whānau.			
	Investment in prevention of type 2 diabetes and heart disease in Māori and Pasifika.			
	New primary care model is developed through a co-design process that uses mechanisms identified to engage with the most under-served whānau.			
	Ensure the primary care model is designed to meet physical, mental, whānau, spiritual needs within the Te Whare Tapa Wha model.			
	Rongoā Māori, mirimiri and traditional healing practices are valued and integrated with care plans.			
	Work with consumers and whānau to establish real time service feedback tools.			
	Investigate and where appropriate establish with consumer input, mobile, drop-in, one-stop shop, home visiting services.			
	Implement specific service access equity projects that address cost, cultural competency, transport, and other barriers.			
	On-going design of hospital services involves consumers and whānau so that they are accessible and culturally appropriate.			
	Utilise the Integrated Data Infrastructure for complex needs analysis, including bespoke analysis for Hawke's Bay DHB and tools such as the Index of Multiple Deprivation.			
Expand wraparound/whānau ora	Introduce risk assessment and stratification tools for referrers and promote them to the health and social service workforces.			
	Resource additional capacity within existing kaupapa Māori and whānau ora providers and/or expand services to other appropriate providers.			
	Develop expanded wraparound services as required to track screening and health interventions, provide education and support for self-management, provide access to a range of intensive health and social services, provide advocacy support and navigation.			
Establish coordination and budget model	Establish a care coordination/whānau service centre as a single point of entry for whānau health and social support services.			
	Develop a referral pathway for care coordination and needs assessment.			
	Determine a devolved funding model for whānau wraparound services, with budgets that follow people.			
	Establish reporting requirements and budget management processes for care coordination/whānau service centre, and wraparound services.			

Relevant and holistic responses to support mental wellbeing

Social deprivation is closely linked to poorer mental health and addiction outcomes and, with the socio-economic profile across Hawke's Bay, it is not surprising that there is excess demand for intensive mental health services that are in fact directly related to social issues.

We have some good examples of mental health services in Hawke's Bay, that deliver peer support, day centres and recovery programmes, advocacy and housing services and return to work programmes; and nurse-led primary mental health clinics. We need more and we need to intervene earlier, so we focus on wellness and prevention, as well as recovery. Strengthening mental wellbeing and resilience is critically important if we are to achieve equity for those people with the poorest health and social outcomes.

Access to a wider range of services and workforces in the community

Our primary mental health packages of care are limited in scope and not able to be offered to everyone that would benefit. Referrals to our specialist mental health services have increased dramatically in the last decade, especially for young people, and we are not able to see everyone in a timely fashion.

In future, primary and community care will facilitate direct access to self-management, wellness and resilience programmes for people with emerging mental health and addiction issues. We will need to work much more closely with other agencies to develop more holistic community responses and we will develop ground up approaches to this including, for example, peer led services and culturally specific services. Access to assistance for mild and moderate mental health and addiction issues will be expanded in three key ways. Firstly, new roles will be recognised to ensure responsiveness to a wider range of people who need varying support in different settings. The services of the future will have to rely on a broader range of skills than those currently only offered by registered health professionals. Secondly, mental health and addiction workers will become an integral part of the primary care team. We will develop better support for new families, maternal wellbeing and inclusive support for youth. And thirdly, close liaison with, and access to, specialist mental health services will enable members of the primary care team to manage better care in the community. Good support in primary and community services will include early recognition and referral for mental health and addiction services so that those with the most severe and complex needs will receive rapid attention by the right level of expertise.

We will use alternative therapies

We will explore and implement alternative therapies, which could include e-therapies, narrative based approaches, learning circles or group work. Group work provides opportunities for people to connect and build relationships through a variety of wellness activities. They bring small groups of people with similar needs together to talk, share stories and learn from each other. Group-based therapies could focus on topics such as healthy relationships, pregnancy and parenting, nutrition and fitness, addictions and recovery, and general life skills.

Emergence of the primary care behaviourist

There is growing advocacy for integration of 'behaviourists' within primary care. By extending or up-skilling primary care teams to include behaviourists we can provide a better first line mental wellbeing service, providing early intervention as part of holistic primary care services and, ultimately, reducing referrals to specialist services. It is an opportunity to increase equity, providing direct support for the most vulnerable people.

Behavioural services deal with psychological, emotional, relationship and cultural issues, offering alternative therapies that are culturally relevant to consumers. They help people to cope with their health and social issues as well as with life in general, and have a positive impact on health literacy.

Behaviourists will collaborate with consumers and whānau, and members of the wider general practice team to develop shared care plans, monitor progress and flexibly provide care to meet people's changing needs. It may become the norm for people to see a GP and behaviourist together.

There are alternative workforce models for behavioural services—all will require significant training. Behaviourists may be psychologists, primary care clinicians with advanced training and certification in the diagnosis and treatment of mental and behavioural problems, or behavioural health consultants such as those embedded within the Nuka System of Care. Behaviourists are trained in processes they can perform in the practice, such as motivational interviewing and brief interventions

Behavioural services may include assessment, case management, individual and group therapies, and medication management; as well as unplanned interactions and crisis intervention. If additional care is needed, the behaviourist can coordinate care and facilitate engagement with specialist mental health and addiction services. Behavioural services will also support those caring for people with mental illness or substance dependency.

Headline goals

- Access to mental health and addictions support is expanded to cover mild and moderate issues
- Primary and community services ordinarily provide a range of support and treatment options for mental health and addictions
- The primary and community workforce will expand to recognise a wider array of skills that support mental wellbeing
- A stepped-care approach to service access is integrated across the district
- Behavioural services are more widely available to primary and community services

Elements of service and model of care development

Element		Phasing		
Expanded mental wellbeing services in community	Investigate expansion of existing mental health services in the community, such as those provided by Whatever it Takes Trust and taiwhenua health services.			
	Develop primary mental wellbeing services in primary care for people with emerging mental health and addiction issues, including peer led and culturally specific services.			
	Provide support services for new families and whānau, with training for primary care team members in the recognition of post-natal depression.			
	Mental health workers are embedded as part of the primary care team.			
	Alternative therapies are available in the community such as e-therapies, narrative based approaches, learning circles/group work.			
Primary care behaviourists	Investigate alternative workforce models for primary care behaviourists and provide the required education and training.			
	Behavioural services are embedded within all primary health centres.			
	Primary care behaviourists offer a range of services, including case management, assessment, individual and group therapies and coaching, help with medication and life skills.			
	Behaviourists and other mental health workers in primary care are available for			

Element		Phasing		
	unplanned, same day consultations and crisis management.			
	Shared care plans are developed between consumers and whānau, behaviourists and members of the wider primary care team, with input from specialist services if required. Shared care plans are viewable by all parties.			
Specialist integration with primary care	Specialist mental health services are closely integrated with primary care, providing case collaboration and consultation.			
	Increase capacity and access to maternal and child mental health services.			
	Behaviourists and other members of the primary care team coordinate and facilitate engagement with service coordination and specialist mental health services.			
	Specialist mental health and addiction service consumers have a behaviourist assigned to them to support them in the community and act as an integrator of holistic care.			

Case study: Mahi a Atua, Tairāwhiti

Te Kūwatawata, a primary mental health service in Tairāwhiti, is using a Māori approach to primary mental health care called *Mahi a Atua* (tracing the ancestral footsteps of the Gods). Anecdotal evidence suggests that the programme has reduced referrals and use of secondary mental health services however a study into the programme's outcomes is being undertaken.

Mahi a Atua is an engagement, an assessment and an intervention based on pūrākau (Māori creation and custom narratives). Stories are recited and shared by the consumer, their whānau and the therapeutic team. The story telling is guided by Mataora who may be mental health, social, education workers, or artists, and who are trained as 'change makers'.

The whānau are introduced to a particular Atua (God) within the pūrākau, for example Uru-te-ngārara, the oldest brother who became reclusive (and depressed) after he couldn't cope with the bullying challenges of his younger brother. Consumers and whānau are able to contextualise the pūrākau and its characteristics to their own situation and are able to reflect on feelings (in this case of depression) in a manner that can create a shift in awareness.

Advocates point to the rapid development of therapeutic relationships, identification of the 'problem' within a Māori lens, the injection of meaning into the pathway ahead, and the sharing of a common set of understood values, beliefs and practices. The process appears to facilitate consumers to be 'on board' rather than in opposition, therapies that are agreed on rather than enforced, a likely increase in 'talk therapy' and decrease in medication, involvement of whānau members, and an appreciation of the complex nexus of relationships that make up real life for the person. It frameworks the 'road to wellness from a difficult place', rather than a 'road to recovery from illness'.

Mahi a Atua is now part of the front door to mental health services—Te Kūwatawata is a single point of entry for those who are struggling with mental distress and who don't meet the criteria for specialist services.

(Rangihuna et al, 2018)

Keeping older people well at home and in their communities

Community connections to keep people well

We need to renew our focus on keeping people well at home, and preventing loneliness and depression, by connecting older people with opportunities to contribute to, and participate in their community. Wellness clinics in the community can provide an opportunity for socialisation, exercise classes, screening and health promotion, connection to health and social services, as well as philanthropic services. Many older people still have much to offer their community, and a wellness clinic or 'hub' is a place to find volunteering opportunities or work that will keep them active. Clinics may be run by a variety of people and in a variety of places, dependent on the neighbourhood they serve. They will be well connected to primary health centres in their locality and to transport services.

There are many volunteers in the older person's sector, but often little coordination. We need to centralise coordination of such services, and this could be organised through the council, as it is in some overseas examples. There is also benefit in bringing young people together with older people to share knowledge and skills, and reduce social isolation. An example is the young person teaching and helping the older person to use technology.

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 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-to-day lives. The community is made up of dementia friendly individuals, businesses, organisations, services and faith communities that support the needs of people with dementia.

We will build on the aspects of older person's care we do well

Our engAGE service was designed as a 'whole-of-health system' approach with the older person in the centre, linking care across the primary, community, and secondary services continuum, providing earlier and more responsive input, and making more effective use of all available health professional expertise. It includes community multi-disciplinary teams (MDTs), intermediate care beds, and the ORBIT rapid response team in ED. engAGE works closely with other DHB services for older people as well as with general practice, home based support providers and aged residential care. We will embed and expand this approach as the primary care model evolves, and extend its reach to the rural areas of Hawke's Bay.

Proactive care that gives people choice

We will provide increasing support for carers in future, including greater access to respite care as well as education and training for whānau carers. Respite care might be in an aged residential care facility, or it might be an in-home option during the day or overnight. We know that Māori and Pasifika populations are ageing rapidly and are likely to want to care for their older people at home. We will work with whānau to ensure they can to do this according to their cultural customs, and with access to appropriate support and services.

Intensive, restorative home based support services will be targeted to those who will benefit the most. We will provide a coordinated approach to training and support so our home support workforce are up-skilled to do more. Home support workers may be the person in most regular contact with an older person. With training and supervision, there is much more they could be doing,

such as ensuring safe home environments (to prevent falls etc.), providing support with diet and nutrition.

Aged residential care providers have identified they need more support. This means greater access to GPs, specialist or advanced nurses and geriatricians in future (and particularly out-of-hours). Practice teams will also be better supported to manage their growing register of older and frail consumers, with specialist nursing and geriatrician support for the primary health centre.

'Health care home' models wrap allied health, community nursing and others around the person, working towards the goals of a shared care plan that has been developed with the person and their whānau and carers. Although it can be very complex, we will introduce standardisation of frailty pathways, with agreed definitions and screening tools. Screening and assessment will happen in the home as much as possible, and we will be using a wider range of validated tools (such as additional interRAI modules). We will consider alternative options for community support and residential care for younger people with disability or early onset dementia.

IT is critical to support this way of working, particularly shared tools, clinical records and care plans, and easy communication between health professionals. It will facilitate access to specialist medical and allied health support from a distance (telehealth). On-going training of the workforce is also required to manage challenging behaviours and dementia, the impacts of trauma and poverty, and respectful conversations around advanced care plans (ACPs). We also need to attract and retain younger staff to a new model of home support provision.

Appropriate responses to acute need

When there is an acute need, the primary care team will be able to organise rapid response, short term care in the home, or hospital in the home services, to avoid the need for hospitalisation. This could be multiple daily visits from a home support worker or nurse.

Advanced care plans will become commonplace. When someone with an ACP presents to hospital, it is immediately alerted to and can be viewed by those involved in their hospital care. Discharge planning starts on day one, and rehabilitation services pull older people through the hospital system to avoid deconditioning and accidental harm.

People at the end of life that will benefit from palliative care services (which are not just required by older people), will have a personalised plan. Their primary care team will be educated and supported to be the integrator of care.

Headline goals

- People remain well at home with whānau support, for as long as that remains their choice

Elements of service and model of care development

Element		Phasing		
Community connections to keep people well	Wellbeing clinics based in the community that may be run by a variety of people such as advanced practice nurses, rehabilitation or care assistants, social workers, health promoters, volunteer organisations, etc. Wellness clinics will be able to connect older people to medical services, or social and volunteering services (to either receive or provide).			
	Social work support in the primary health centre particularly for those on the lowest			

Element		Phasing		
	incomes. Social workers can connect people to budget advice and a range of other services and supports.		■	
	Establish steering group(s) and process to develop one or more elder/dementia-friendly communities. Resources include the WHO Global Age-friendly Cities guide and local examples include work in Rotorua, drawing on research outcomes from the Netherlands and Scotland.		■	■
	Central (one-stop-shop) volunteer coordination function that may be organised out of councils or other agencies.	■		
	Initiatives that bring young people to support older people to stay well (e.g. through exercises or activities), navigate electronic tools, etc.			■
	Connect people to free transport to attend wellbeing clinics, general practice with chronic care nurses overseeing plans of care, pharmacy support and regular medicines reconciliation, and hospital appointments if necessary.		■	
	Increase access to funded respite care, including in-home options during the day and overnight if possible. Maintain strong connections with specialists and primary care.	■		
	Education and training available for whānau carers, possibly run by home-based support providers. Culturally specific approaches to this education and training, including training existing whānau carers to provide peer support and education to other whānau.	■		
Proactive and accessible care in the community	Expand engAGE and embed within primary health centres to cover the rural localities.		■	
	Sufficient gerontology nurses and geriatricians linked with aged residential care facilities and general practices to provide specialist advice and training for practitioners (e.g. dementia diagnosis) and case collaboration, either physically or virtually.	■		
	Aged residential care facilities have evening and weekend access to specialist nurse or GP, and pharmacist advice and support.		■	
	Support aged residential care with workforce development for regulated and non-regulated workers.		■	■
	Up-skill the home-based support workforce to deliver other services, e.g. simple exercises to increase strength and balance, nutrition support, etc.		■	■
	Screen for frailty in general practice using an agreed tool. Develop frailty pathways.	■		
	Multi-disciplinary team wrapped around primary health centre uses a shared care planning tool. Everyone can see interRAI assessments and update care plans.		■	
	Specialist services (medical or nursing) are provided in the primary health centre either physically or virtually. GPs can consult with geriatricians and other specialists virtually while the person is in front of them.		■	
	Complex people have a named case manager in their 'health care home'. HCHs have close relationships with aged-residential care and home-based support providers.		■	
Appropriate responses when things go wrong	Navigators, case managers or liaison workers are available to support people and facilitate other services when they attend hospital.	■		
	Advanced care plans are put in place that may be developed by a range of professionals, are viewable by all health providers, and are alerted to when people attend hospital.	■		
	Rapid response or 'hospital in the home' to avoid hospital admission or facilitate discharge. This may include intensive visiting from home-based support providers, or nursing support in the home (e.g. IV antibiotics).		■	
	Implement a return to home/transfer of care service – Hoki te Whare.	■		
	interRAI assessments are completed in the home, not in the hospital.	■		
End of life	People requiring palliative care have an individualised plan, supported by specialist services but based in community and primary care. Primary care providers receive education and training in core palliative care competencies.	■		
	People at the end of life have access to 24/7 services.			■

Case study: engAGE community teams, Hawke's Bay

EngAGE is part of Hawke's Bay DHB's Older Persons Health Service. engAGE community teams are locality-based multidisciplinary teams who meet weekly, at general practices, and bring together professionals from primary care, hospital older person's services, and a range of community agencies. Team members work inter-professionally—the clinician visiting the person carries out a person-centred, holistic assessment, and shares this information with the rest of the team, avoiding the need for multiple visits.

Working together, teams develop a better picture of the older person's needs and develop creative solutions to maximise independence. Home care staff and district nurses working in people's homes identify problems early and bring crucial information about the home situation which the GP may not have been aware of. Home care staff follow-up and feed back to the team about how the person is going, so changes can be made and crises averted. Faxed paper referrals to distant departments have been replaced by phone calls and emails between colleagues who support each other to provide the best care possible.

While the numbers of older people in Hawke's Bay grew between 2015 and 2016, ED presentations for people aged over 85 years decreased and there was a reduction in acute hospital bed days utilised by this group.

ED presentations	**2015**	**2016**	**Change**	**Population change**
65+ years	10,495	10,625	+1.2%	+3.7%
85+ years	2345	2283	-2.6%	+3.3%
Acute bed days	**2015**	**2016**	**Change**	**Population change**
65+ years	32,082	31,463	-1.9%	+3.7%
85+ years	8941	8766	-2.0%	+3.3%

For those who have presented to the emergency department a thorough assessment and discharge support plan, from the engAGE ORBIT team, and follow-up by engAGE community teams, has increased the likelihood of an early and successful return to home rather than an inpatient admission.

engAGE also provides an Intermediate Care Beds (ICB) service, that involves MDT input in partnership with primary care for up to six weeks in an aged residential care facility for people not well enough to be home but not requiring hospital care.

(Shanahan S et al, 2017)

Specialist management of long term conditions based in the community

A new model for accessing specialist support

Specialist clinicians will be deeply integrated with primary and community care teams, providing advice, episodic care for people with more complex needs virtually or in clinic-based settings, and contributing to the development and implementation of health pathways. The majority of specialist clinicians will operate as 'wraparound' specialists integrated with primary care instead of 'destination' specialists requiring consumers to attend hospital.

The current system of referral and appointments will evolve, to provide a much more responsive service, with minimal waiting time, that ultimately supports self-management of long term conditions. The primary care team will have rapid access to specialist advice and, if required, will be able to refer people for same day consultation with a secondary care specialist.

Specialist services will be delivered in a much wider range of settings, in different ways and in unstructured formats as well as organised meetings. Unstructured conversations will be as much the norm as 15 or 30 minute appointments. To do this, specialists will have to stop some of what they are currently doing. First specialist assessments (FSAs) and follow-ups will be reduced or organised differently and nurses will take over much more specialist work.

Working in this way will be supported by availability of secure messaging and email options as well as videoconferencing and video-chat.

Identifying people early will ensure proactive and preventative care

There are a number of specialist services working in the community already such as diabetes and respiratory services, and engAGE community teams. These are good examples of meeting needs by working inter-professionally and in an increasingly flexible way. However, even in these good examples we see people, particularly Māori and Pasifika, accessing services at a later stage of illness.

Prevention and wellness will be a core focus of our future health system, and we will also proactively identify at risk people through screening tools and risk stratification. Care plans will be developed with consumers and their whānau, with shared care between a range of health professionals to support self-management and ensure all needs are met. Specialists will participate in the development of shared care plans and multi-disciplinary team meetings in primary health centres.

Up-skilling primary care clinicians to deliver more complex care in the community

Primary care may need to be up-skilled in some areas of work such as gynaecology. Specialists will be attached to large practices within a clustered network of need. General practice will, over time, continue to develop specialism to manage the particular needs of their community by supporting development of GPs with special interests. Scale of operation will need to change to enable this to occur. Fragmented small businesses are unable to maintain specialist services and practices will need to network together to allow the transfer of some services from secondary to primary care settings. Practices may cross-refer to each other for some things, as well as to specialists.

Clinical pathways will be one lever to make change happen

Clinical pathways need to be simplified and re-ordered both to allow clinicians to address issues as they turn up (for example, resolving an issue with a brief phone call rather than a referral) or by by-passing the GP (for example, if there is a breast lump). GPs will be able to seek that advice and support in an unstructured way.

Headline goals

- Reduce booked appointments for secondary care management of long term conditions by at least 30%
- Establish unstructured consultation and liaison with primary care as standard practice

Elements of service and model of care development

Element		Phasing		
Remove barriers to access	Reduce FSA and follow-up workload and release time to unstructured consultations.			
	Build relationships with primary health centres to support GPs and nurses to manage complex people.			
	Allow brief phone calls so GPs can get brief advice rather than generate a referral.			
	Provide specialist access at a time GPs are able to call (typically after hours).			
	Establish a platform for secure virtual consultations.			
	Establish case management (extensivist) for people needing multiple specialisms.			
	Allow direct referral to specialists without a referral from General Practice (e.g. assessment of breast lumps).			
	Progressively review pathways to remove barriers and reduce workload and enhance speed of diagnosis and treatment.			
Change care settings	Develop primary care–specialist relationships through shared training (in evenings so primary care can train).			
	Undertake most specialist work in a primary or community care setting.			
	Identify specialist character of large primary health centres and build additional specialist services into them.			
	Actively follow-up Do Not Attends as per the Wairoa model; register them as a quality of service failure.			
	Actively track quality service failures to identify and address common patterns in geography or demographics.			
	Provide diagnostics (e.g. spirometry) in primary care.			
	Provide drop in clinics with diagnosis and treatment where possible.			
	Establish a common clinical portal.			
Change the workforce and facilities	Train primary care practice nurses in clinical nurse specialties focussed on metabolic disease.			
	Undertake increasing specialist work with Clinical Nurse Specialists.			
	Remove administration load from specialists by active time management and administrative streamlining.			
	Redesign ambulatory care so it is person focussed not the current specialty focussed villas.			
	Provide specialist consultation to primary care and case management services so whānau are empowered to manage long term conditions.			
	Provide online booking integrated across primary and secondary care and different settings.			
	Provide business intelligence to identify who is not being seen but should be.			

Case study: Reducing specialist referrals, Southcentral Foundation in Anchorage, Alaska

Southcentral Foundation is a not-for-profit health system, owned and run by Alaska Native people for Alaska Native people, located in Anchorage, Alaska. It delivers a broad spectrum of services and also co-owns and co-manages a 150-bed hospital, the Alaska Native Medical Center, providing inpatient, specialist and tertiary services. It delivers services to a population of 65,000 Alaska Native people in Anchorage, Alaska and across the Southcentral region, covering a landmass twice the size of England.

Alongside improvements to access and quality of primary care, Southcentral Foundation has built effective working relationships between primary care teams and hospital specialists, as a strategy for retaining people in primary care where possible and reducing pressure on hospital services. For example, the primary care teams have built strong relationships with the cardiologists and respiratory physicians in the hospital. The hospital doctors also tend to know most of the people with fragile cardiology and fragile respiratory cases on the primary care teams' books. When they see service users with complex conditions, the primary care doctors and nurses are able to phone the specialists for rapid consultations. The specialists spend a greater proportion of their time supporting and educating the primary care teams instead of treating people themselves. The primary care doctors are, in turn, able to spend more time with people with complex needs, and to take on more demanding roles, because they are themselves pushing more routine work down to the nurses and other staff in their teams.

For their part, the specialists understand that it is in their interests to respond quickly to the primary care teams when they ask for support. If they can respond in five minutes, they can help the general practitioners to manage the person's condition in primary care. If they can't, they will receive a referral for which, there is often no financial reimbursement.

These strategies have contributed to huge reductions in referrals to hospital specialists, with referrals per person falling by more than 60 per cent between 2000 and 2009. The specialists in many of the hospital's clinics have in turn been able to reduce the waiting times for outpatient appointments, in some cases moving from long waits to same-day appointments. The changes have also helped to reduce the costs of the hospital system. The numbers of hospital specialists in some disciplines and the number of hospital beds have been held roughly constant over the past 17 years, despite an approximate tripling of Southcentral's regional Alaskan Native population.

(Collins B. The King's Fund, 2015)

Well supported transitions from hospital

We recognise that many patients could avoid admission or be discharged earlier if better home support services or options for convalescent care were provided, and that for older people a prolonged stay can lead to deconditioning and harm. When people do require hospital care, the transition needs be organised better than it is currently. Within that transfer, whānau, friends and support people are as important as the health professional but are not always included in planning. People do better at home and we currently both disempower and decondition them in hospitals.

We know we could do better. Our own review of what we do suggests poor discharge planning leads to extended length of stay. We currently have limited whānau or cultural engagement resulting in poor ownership by consumers of their journey. Delirium and dementia are not well-recognised and we need to better manage people with these conditions. Some people are accepted for rehabilitation with little potential for improvement, which is not a good use of limited resources.

We will develop better transitions for people with complex mental health needs who may require intensive wraparound services or tailored treatment and care packages. Growing complexity of mental health issues may result in some of our current community services being unable to cope. In order to prevent an automatic return to intensive hospital services, we will need to ensure the supply of community services continues to be developed and supported to match the need that we are seeing.

We need to anticipate admissions

Development of proactive person-centred planning with primary care teams is an opportunity to anticipate and plan for hospital admissions. A well-developed stepped care model of mental health and addictions services will also contribute to more appropriate use of intensive services.

A new way of doing things for older people

The development of our new model of care for discharge of older people is built around the following principles:

- Consumer and whānau ownership of their health journey
- Streamlined processes, focused throughout to achieve the discharge date set on admission
- All activity with the consumer is rehabilitation focused and delivered by one cohesive team (inter-professional practice)
- Early supported discharge and other alternatives to inpatient care to improve hospital flow and consumer satisfaction, improving outcomes and six month readmission rates
- On-going consumer involvement with robust quality assurance/improvement processes.

We will establish Hoki te Whare, a home-based rehabilitation service. The service will be staffed mostly by rehabilitation assistants and overseen by a registered health practitioner. After returning home from hospital, rehabilitation will continue at home with up to four visits a day, for up to six weeks.

We expect these changes will have material, positive impacts on people. We expect increased consumer and whānau engagement in their own care, and improved satisfaction as a result. We expect reduced complications associated with hospitalisation (deconditioning). As a result, functional well-being of our consumers will improve.

Inter-professional practice ensures the whole team is activated

We need to consistently apply functional rehabilitation principles to preserve independence. Implementing inter-professional practice will ensure the whole team is involved in active functional rehabilitation of each person, with their whānau.

Core mental health and addiction skills will be evident in community and primary care while specialised treatment skills will need to be retained in the intensive/acute hospital teams to support greater accessibility to the right level of care. People with mild to moderate mental health and addiction needs will be much better served outside of the hospital, with strong support to those services, while people with moderate to severe conditions and greater risk will also have quick access to the right level of support via a range of options.

Appropriate responses to social issues

For whānau with unmet social needs, we need to bring community partners in from the start of the hospital stay. We sometimes keep children in hospital while sorting through social issues and the hospital is not the place to do that, but at the moment may be the only alternative. We need to find a different place for children until safe arrangements are in place that is not characterised by a medical model of practice. Increasing interagency work, such as social housing, will also add strong support to transitions for people with mental health and addictions issues that are further complicated by social complexity. We will ensure people can leave hospital appropriately and safely, using navigators to draw all the services together if required.

Reducing co-ordination issues

Co-ordination is the key as we currently work in silos and do not pass on the baton. IT is a key enabler of this co-ordination and will ensure full inclusion of the health workforce in the community, primary and hospital care. That enablement will ensure the team working with people and whānau on transitions have the right information, at the right place, and at the right time. We need to step our Needs Assessment and Care Co-ordination processes up to this new challenge.

Headline goals

- People return home after an acute medical stay in hospital as soon as they are medically stable and have regained an adequate level of function
- Average length of stay for older people is reduced substantially
- Re-admission rates are reduced substantially
- Stepped care model for mental health and addictions is in place

Elements of service and model of care development

Element		Phasing		
Re-define attitudes to hospital	Ensure there are appropriate destinations after discharge for vulnerable children.			
	Ensure consumers and whānau are aware of risks of hospitalisation including pressure injuries and deconditioning.			
	Use mental health and general practice approaches to identify generic situations and build information packs around triggers and responses other than hospital.			
	Establish navigator roles in primary care that pull consumers out of hospital.			
	Honest conversations with consumers and whānau about goals of care and recovery paths.			

Element		Phasing		
	Provide support/education to whānau likely to be supporting consumers through surgery and recovery.			
	Build local MDT teams that link closely with geography and practices and localised resources.			
	Focus NASC as a client relationship management team.			
	Provide supporting IT and shared care records to the wider health team.			
Build the Consumer's health care team and supporting enablers	Electronically share discharge plans.			
	Build discharge plans prior to hospitalisation.			
	Better enable volunteering.			
	Better utilise home care support workers to provide early warning and support on discharge.			
	Work with local social agencies including Housing NZ to provide alternative accommodation solutions.			

Case study: Community Rehabilitation Enablement and Support Team (CREST), Canterbury

Community Rehabilitation Enablement and Support Team (CREST) began as a community-based supported discharge team facilitating earlier discharge from hospital to appropriate home-based rehabilitation services. It has since been extended to accept referrals directly from general practice, providing older people referred this way with care and support to be rehabilitated in their own homes to avoid hospital admission altogether.

CREST provides goal oriented, interdisciplinary support for up to six weeks which may involve: nursing services; occupational therapy and physiotherapy; daily support until the person can manage on their own or with assistance from their usual service provider; home-based rehabilitation; continuing clinical assessment to recognise any deterioration; development of agreed individualised care plans for long-term use in the person's home; improved education and information for consumers, their carers and families; and liaison with general practice.

The University of Otago is evaluating the CREST service, using a retrospective cohort (looking backwards), a prospective cohort (looking forwards) and qualitative interviews.

Between 2010 and 2014:

- Overall hospital admissions reduced—the admission rate for people aged 75+ decreased from 197 per 1000 to 187 per 1000, a 5 percent decrease
- Length of stay reduced from 9.2 to 7.8 days ($p<0.001$)
- Inpatient older person's health use reduced.

For those receiving CREST in 2014 (605 people)

- Reduction in aged-residential care use after older person's health admission—5.6 percent compared to 8.1 percent for those that didn't receive CREST support
- Increased time to ARC—65 days compared to 48.9 days for those entering ARC having not received CREST prior.

(Heppenstall C, 2017)

The hospital takes a narrower focus in future

The hospital will have a narrower focus in future. Achieving this would free up resources that will be redirected for investment in preventative and primary health care services and addressing the needs of people with the poorest outcomes. In future, the hospital will be a place providing specialist assessment and decision making for patients with critical illnesses or injuries, followed by intensive therapies for the first 24-48 hours of inpatient care before discharge or transfer to community settings; or delivering services that require specialist teams or equipment that isn't feasible or cost effective to replicate in multiple settings. Better community based support for mental health and addictions issues will ensure that specialist mental health services at the hospital are focused on those with the highest complexity and need.

We will always need hospital services and they are the right place for some specialist assessment and care. We have a number of challenges within our current hospital—our facilities and workforce are stretched and wards are often full. All of the previous sections in this CSP are the building blocks for the hospital we want in the future, and we need to achieve our ambition across all of them if we are to use hospitals in a different way. We need providers across the whole system to step up to the challenge, and we need to support and resource them to do that.

At the Emergency Department

Only people requiring resuscitation or specialist medical assessment and care that an only ED can provide, should be managed in an ED. 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.

We need good alternatives in the community that are easy for people to access, especially those for who access is inequitable at present. A primary driver of our acute model of care will be to improve access to urgent primary care for those with unmet needs in order to improve longer term outcomes. For mental health crises, a 24 hour response is essential but the ED is not the right place for this either. Future pathways will result in fast access to emergency mental health services including ease of access after-hours along with greater input from social and cultural resources. In addition, primary care clinicians will require rapid access to specialist advice via telephone or other means, and access to the necessary diagnostics.

People who do not require specialist medical assessment or resuscitation, but do require hospital admission for further care, should not be admitted via the ED. This means community providers have the ability to refer directly into various acute assessment units. In addition, streaming will move people rapidly from ED to the right service in the hospital, or support people to attend primary care where more appropriate.

A range of disciplines and professionals will be present in the ED to ensure journeys start off right, that all people's health, social and wellbeing needs are attended to, and transition back to home is facilitated.

Improving flow through the inpatient journey

Early senior assessment will support better decision making and planning, and the future hospital will enable this over extended hours, seven days per week. Discharge planning will begin on day one of a person's hospital stay, and daily MDT reviews on the wards will ensure continued progress and that any issues are addressed quickly. In future, a large majority of hospital inpatients will be older people

with increasing prevalence of comorbidities and frailty, and their care will be led by physicians and geriatricians, with allied health input and appropriate specialist nursing care. For others with enduring and complex needs we will need to keep innovating in terms of step down facilities, wraparound services, navigation support and tailored treatment and care packages in the community.

An 'Intensive Care Unit (ICU) without walls' approach will enhance the care of many seriously ill or potentially unstable patients on general medical and surgical wards, reducing demand on the ICU.

Maximising touch points and looking after all needs

Avoiding unnecessary admissions to hospital is the priority, but when it does happen we will maximise each touch point. Bringing navigators, kaitakawaenga and social workers to the front door is a good start. We also need to ensure our hospital is whānau friendly, allowing whānau members and support people to accompany consumers at a vulnerable time. Providing whānau and meeting rooms enables shared care with all players and provides space for respectful conversations in hospital, as well as ones around wellness at home.

The discharge lounge will be expanded to facilitate better transitions back to the community, including the ability to enrol and book people directly with primary care. It is important to consider the particular challenges for each consumer and their whānau, for example transport for people to attend general practice.

Rehabilitation focus across the whole hospital

An increasing proportion of inpatients will be frail, older people requiring a whole of hospital rehabilitation focus. Geriatricians and allied health input will be required at the front door of the hospital and throughout the hospital stay, with additional social support.

The rehabilitation model for older people will change and pull people through the system to reduce deconditioning and harms from hospitalisation. It will take a broad view, with close person and whānau engagement to address all aspects of rehabilitation.

Headline goals

- A substantial reduction in wasted consumer time while in hospital i.e. time waiting to see the right person, waiting for diagnostics or treatment is minimised
- The hospital is focussed on specialist assessment and intensive therapies for the first 48 hours of acute medical care

Elements of service and model of care development

Element		Phasing		
Multiple entry points and streaming	Direct referral from general practice, aged residential care facilities, ambulance service to acute assessment units within the hospital, following triage by GPs, senior nurses, paramedics, etc.			
	Triaging from ED to primary care where appropriate with vouchers to subsidise co-payments targeted to those most in need.			
	Extend hours of the Paediatric Acute Assessment Unit.			
	Establish women's health acute assessment unit, staffed by senior midwives, gynaecology nurses and senior doctors, with direct access for pregnant women.			

Element		Phasing		
	Develop and implement a public communication plan on the role of the hospital and good community alternatives for urgent care as they develop.			
	Establish surgical assessment unit that can deal with minor acute presentations, e.g. abscesses.			
	Create separate area within the ED that is more appropriate for older people, e.g. to manage delirium more appropriately.			
	Attendances at ED trigger a follow-up with primary care.			
Right start to the hospital journey	Re-design the workforce model so people in ED receive early senior medical assessment and decision making.			
	Psychiatric liaison nurse in ED to ensure mental health consumers are directed to the safest and most appropriate place as soon as possible.			
	Kaitakawaenga and social workers in ED to address unmet health and social needs from the start of the inpatient journey, as well as community navigators being able to follow the person from community to hospital and out again.			
	Consider a range of other disciplines in ED such as specialist nurses, physiotherapists, etc.			
	Create a whānau friendly hospital with facilities such as meeting rooms to support whānau centred practice and consumer support and advocacy during a vulnerable period.			
	Establish shared care early on with whānau and all practitioners involved in a person's care.			
	Expand ORBIT model to include additional disciplines as required.			
Better, more streamlined inpatient stays	Estimated date of discharge planning starts on day one in conjunction with the person and whānau, and connecting with community providers involved in care.			
	Daily multi-disciplinary huddles and regular assessment on the wards to ensure continued progress and attend to issues efficiently.			
	Essential services will run 7 days a week (e.g. allied health and radiology). Higher dependency and ICU outreach services provided for general medical and surgical wards.			
	Surgical cases will be managed by physicians and geriatricians on the wards as much as possible with shared care arrangements where necessary.			
	Expand the discharge lounge to transition a greater number of people with the ability to enrol people in general practice and book appointments.			
Rehabilitation focus	Fast track admission from ED or acute assessment unit for frail older people requiring non-surgical management after a fall.			
	Fast track people to rehabilitation 48 hours post-fractured neck of femur surgery.			
	Implement proposed rehabilitation model of care with the longer term aim of predominantly community-based rehabilitation.			
	Implement inter-professional practice to reduce duplication and overlap, using the Calderdale framework to extend inter-professional scope of practice.			
	Care assistants are used as key workers for designated people.			
	Functional rehabilitation focus and early mobilisation to limit deconditioning in hospital.			
	Develop delirium/dementia pathways to manage length of stay and improve outcomes.			

Summary of evidence: care closer to home and reducing hospital length of stay

Bed audits across a large number of acute hospitals in the United Kingdom found that up to half of bed days could theoretically take place in other settings, but pointed out that there are some constraints on this in practice (Monitor, 2015a).

Monitor (2015b) developed an approach to modelling the impact of telehealth, enhanced step-up, rapid response and early supported discharge, and reablement services. The schemes reviewed show it is possible to treat people with quite severe clinical needs in community-based settings. A literature review of the clinical impacts (Monitor, 2015a) indicates that although there are risks, well-designed schemes are likely to have clinical outcomes that are equal to hospital care and sometimes better (particularly the case for older people). Financial analysis (Monitor, 2015c) suggests that in the long run, well-designed schemes could be used to create capacity for managing expected increases in demand, reducing the rate of expenditure growth by substituting for, or at least delaying, the need for investment in new acute hospital facilities.

A review by Imison et al (2017) found the most positive evidence of impact for the following initiatives: improved GP access to specialist expertise, ambulance/paramedic triage to the community, condition specific rehabilitation, remote monitoring of people with certain long-term conditions and support for self-care, additional clinical support to aged residential care and improved end-of-life care.

Reducing length of stay in hospital

We have been working hard to improve flow within our hospital but we know we can do better. The Health Roundtable (2018) shows we have improved our length of stay (LOS) and we do well at discharging people from hospital before noon; but we still have a relative stay index near the upper quartile of our peer group and high readmission rates.

Figure 8 Acute relative stay index

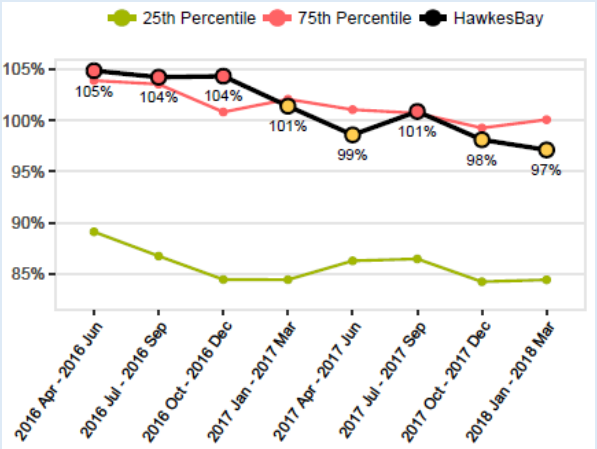
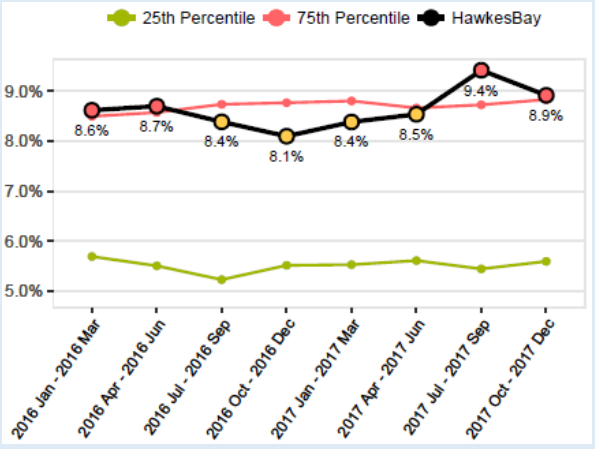


Figure 9 28 day emergency readmission rate



Nuffield Trust (2015) undertook a high-level review of the literature relating to hospital flow and length of stay. They collected case study material (including from interviews) from hospitals that had made significant improvements in length of stay over the last five years. The following approaches were highlighted as having a positive impact on improving flow and LOS:

- **Early senior input** – A UK study of senior review in the ED reported that senior review of 556 patients reduced inpatient admissions by 11.9 percent and reduced admissions to the acute medical unit by 21.2 percent (White et al, 2010).
- **Designated short-stay units** – Short stay observation and assessment units can reduce LOS and prevent a full admission. Some units are successful in discharging upwards of 65 percent of patients before the third night in hospital (Emergency Care Intensive Support Team, 2010).
- **Frailty units and services** – A study in the United States found that a service for the elderly located in the ED

reduced admissions by 3 percent (Keys et al, 2014). Specialist frailty units are associated with shorter LOS (Barnes et al, 2012), less functional decline and lower readmission rates (Traissac et al, 2011). Specialist frailty services that provide in-reach services to outliers can also reduce LOS (Foundation Trust Network, 2012).

- **Tracking patient progress through the hospital** – There have been few large-scale studies on systems that track patient progress through hospitals however individual hospital case studies and interviewees highlighted the value of constant visibility of patient progress when supported by proactive MDT patient management.
- **Proactive multi-disciplinary management through rounds** – The number of unnecessary days in hospital can be reduced through twice-daily MDT rounds and decision-making (Singh et al, 2012; Emergency Care Intensive Support Team Urgent, 2010). Some successful hospitals have an early morning round that provides an action list for the ward coordinator and a mid-afternoon round to review new admissions and check on the progress of patients.
- **Seven-day rounds and supporting services** – In Hawke's Bay, the LOS for a general medical patient admitted over the weekend is on average more than a day longer than someone admitted on a Wednesday (Health Roundtable, 2018). Increasing senior review and seven day working does usually require investment in numbers of staff however a case study hospital managed to stretch occupational therapy services to seven day working with only minimal additional investment (Nuffield Trust, 2014). Therapy services available seven days a week can reduce LOS and support increased weekend discharges. An Australian study found that increasing physiotherapy input over the weekend led to a 3.2 day reduction in LOS (Brusco et al, 2007).
- **Discharge planning** – Effective discharge planning and timely transfers of care can reduce the length of hospital stays and reduce readmissions (Shepperd et al, 2003; Kahnna et al, 2012). Case study hospitals have found that early identification and active case management of people at risk of complex discharge on admission can reduce LOS. These people are given a comprehensive geriatric assessment and tracked through the hospital, while district nursing and other community services are lined up in parallel for transfer home. Case study hospitals that implemented nurse-led discharge found that equipping senior nursing staff to facilitate discharge, once defined medical criteria have been reached, can enable more timely transfers.
- **Standardised enhanced recovery programmes and clinical pathways** – Standardisation of enhanced recovery programmes (ERPs) and clinical pathways has been found to reduce LOS and costs across a range of conditions. For example, in a heart failure ERP, managed patients had a significantly lower length of stay (3.9±2.2 days) compared to unmanaged patients (6.1±2.8 days) (Discher et al, 2003). In Hawke's Bay heart failure accounts for the largest number of general medical bed days (ranked by diagnosis) and our relative stay index is in the upper quartile of our peer group (Health Roundtable, 2018).
- **Therapy interventions to improve flow and support transfer to alternative settings** – Therapy interventions can enable recovery at home, reducing overall LOS in hospital. Systematic reviews have consistently found that physiotherapy can reduce LOS by one day (Peiris et al, 2011; de Morton et al, 2007). Evidence suggests there is a reduction in LOS when home-based multidisciplinary early supported discharge is used instead of usual care. A review of evidence found that early mobilisation and therapy interventions post joint replacement surgery can result in a reduced LOS of about 1.8 days (Guerra et al, 2014; College of Occupational Therapists, 2012).
- **Working with partners to transfer complex people out of hospital** – The literature and case studies highlighted the need for effective communication and close working between health and social partners, consumers and carers at the point of transfer out of the hospital. Case study sites that were successful in improving discharge planning moved away from 'discharge' to 'care transfer'—where community, social care and acute teams share core links and decision making points.

Surgical services continue to be refined

Surgical services will continue to be provided in Hawke's Bay in a manner that both meets the needs of our geographically isolated population and is sustainable for a hospital of our size. This means we will continue to provide general surgery, orthopaedic surgery and other key elements of surgery relevant to our consumers including appropriate diagnostic and support services; and will have good relationships with tertiary providers for those services than cannot be provided locally.

All of these services will come under increasing pressure as our population ages; operations related to cancer will increase particularly in the short term following introduction of bowel screening. We know we have lower than average rates of orthopaedic and plastic surgery currently. We have made improvements in our surgical productivity over time and we will continue to refine our surgical services into the future, making sure we offer timely surgical intervention to those who will benefit.

Prevention first and foremost

Currently we talk about surgical outcomes and need to emphasise wellness outcomes. Surgery is a response to a symptom that has an underlying cause rather than an intervention that will fix all health issues. People may have expectations that surgery will give them the full level of functionality they once had and that is not always the case. We need to focus more on understanding and preventing, and finding alternatives to surgery rather than continuing to build capacity in the way we have. This means looking closely at pathways for a number of conditions to understand how we can intervene earlier and provide alternative interventions before surgery is needed. Allied health professionals will support a wellness model with earlier intervention using non-operative management. For example, physiotherapy interventions can delay the need for joint replacement, and improve recovery from eventual surgery. We will need to re-set expectations of consumers in primary care, using health pathways as a tool to help us do that.

New settings for surgical interventions

Some minor procedures will be shifted to less resource intensive settings. Examples are removal of skin lesions and some eye procedures that could be done in primary care if clinicians were up-skilled. Some of the work we do in operating theatres could be moved to procedure rooms. By shifting procedures to different settings we can create capacity in our operating theatres for more rapid access to urgent theatre, and to meet increasing demand for some surgeries.

We will develop our day surgery model further, establishing the need for an ambulatory theatre facility and considering where that would be most appropriately located.

Continuing to improve surgical productivity

We are planning for additional theatre capacity and need to ensure we use our theatre capacity as efficiently as we can. This may mean extended theatre lists in future so that, for example, an additional operation is performed in each elective theatre each day, or additional cases are done on a weekend day. This will reduce the need to outsource surgery to private providers.

We have already changed our model to protect acute operating time and will continue to refine our acute surgical efficiency. Part of this is having more senior assessment of people at the front door of the hospital so people are not admitted unnecessarily. We will also improve access to acute theatre, balancing the need for additional acute operating theatres (including obstetric) with increasing efficiency of those theatres.

In future, a large majority of surgical inpatients will be older people with increasing prevalence of medical comorbidities and frailty. Therefore, over time, we are likely to distinguish less between medical and surgical patients and wards with physicians having a substantial role in the care of those needing surgery, to address issues of medication, perioperative disease management and rehabilitation before and after surgery. Increasingly enhanced recovery after surgery programmes will mean that the needs of those arriving in the surgical ward will be anticipated in care planning, and reactions to their arrival and recovery from surgery will be faster. Perioperative activities will be undertaken by a wider team.

Networks to provide more complex surgery closer to home when possible

We will work in service networks supported by tertiary providers to provide some more complex surgery closer to home where possible. Examples of this will include plastic surgery, minor paediatric surgery, and vascular surgery.

Headline goals

- Referrals for surgery are appropriate and decline rates are low. Non-operative management options are offered where people will benefit
- Elective surgeries are planned after a discussion with the consumer has clarified their wellness goals
- An increase in the proportion of day case surgeries

Elements of service and model of care development

Element		Phasing		
Refine demand for surgery	Undertake discussion of surgical options in a wellness discussion based on alternatives and quality of life.	■		
	Ensure the workforce has the health literacy skills that consumers understand what surgery is going to offer them.	■		
	Ensure there are practical alternatives (such as physiotherapy-led programmes) to invasive surgery in key areas of demand.		■	
	Ensure advanced care plans are in place for all people considering elective surgery and, over time, all people likely to need acute surgery.		■	■
	Re-examine health pathways for conditions that may require surgery.			■
	Revamp pain management services to provide better support pre and post-surgery.		■	
	Increase prevention activities aimed as weight loss and reduction in smoking and alcohol consumption.	■		
	Ensure proactive care planning for Māori and Pasifika to ensure they receive an increased level of surgical intervention where appropriate.	■		
Shorter surgical stays	Provide geriatrician and allied health support on all surgical wards.	■		
	Focus available surgeon time on surgery.	■		
	Support pre and post-surgical.	■		
	Develop an ambulatory surgery model of care within a dedicated space. Determine whether this facility is best place on or off the hospital site.		■	■
	Clinical assessments are performed by a multi-disciplinary team.	■		
	Develop day stay practices aggressively.		■	
	Ensure acute theatre capacity is available in the weekend and use that capacity for catch-up operations.		■	

Element		Phasing		
Build a sustainable surgical model	Ensure all surgical patients in hospital are there for surgery and go for surgery.			
	Embed and/or maintain enhanced recovery after surgery programmes.			
	Only offer surgical specialties where there are two surgeons at a minimum, and sufficient supporting service capacity including beds.			
	Provide weekend and evening lists for elective catch-ups, and possibly extend regular lists (e.g. one more procedure a day).			
	Develop long-term capacity and capability contracts with the private sector.			
	Networked (hub and spoke) models being supportive of local surgeons. Priority services include vascular surgery, plastics, minor paediatric surgery.			

5. We will put the right support structure in place to achieve our vision for the future

Growing our workforce is critical to the delivery of a new model of care

A key enabler for achieving our vision and for delivering this CSP is to create a culture shift—from being system-centric to person and whānau centred. By that we mean working with our community and whānau to build our services around the people it serves and creating a safe environment for staff and consumers. Our first step was to embark on the development of a People Plan: *Grow Our People by Living Our Value*, based on stakeholder feedback, models and theories around improving engagement, and our desire to demonstrate our values in everything we do. The Plan is a people focussed strategy that will also inform the next 5 year strategic plan and along with ICT is critical to delivering this CSP.

The People Plan is a commitment to our staff to make this a great place to work and bring our workforce together as a cohesive health system and one team. Living our values will require immediate changes in behaviour, particularly from leaders at all levels of the health system. Through delivery of the 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. In relation to this CSP it means aligning our workforce capacity and capability with the future models of care described here, as well as the introduction of new roles and up-skilling the workforce both professionally and culturally. There are three key themes:

1. Cultural competency and person and whānau centred care

One of our intentions is that our workforce reflects, understands and supports the health needs of the population it serves. We will work proactively with schools, training institutions, and the Ministry of Social Development to facilitate employment of Māori and Pasifika in particular. As part of the Māori and Pacific Workforce Action Plan, we will provide culturally appropriate vocational pathways so we can 'grow our own' and improve the ethnic diversity of our workforce. Cultural competency will be a core competency for all our staff and organisation. We will set our expectations high and provide regular and active education and training in tikanga Māori, Pacific custom and practice, and disability responsiveness.

Person and whānau centred care is firstly about enabling the workforce to develop partnerships with people, whānau, carers, communities and colleagues. This requires working in a different way and not simply developing new skills and knowledge. Behaviour change is not easy—it requires the combination of workforce capability together with the opportunity and motivation to change.

2. Working to top of scope and new scopes of practice

All workforces will come under increasing pressure to managing increasing levels of need and complexity. All roles involved in health care 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. Volunteer workforces will be called upon more frequently, so we must recognise and value their contribution to

ensure their continued participation in our system. Workforces such as paramedics and home support carers will play an increasingly important role, as they do more in the community and people's homes.

3. Team based practice

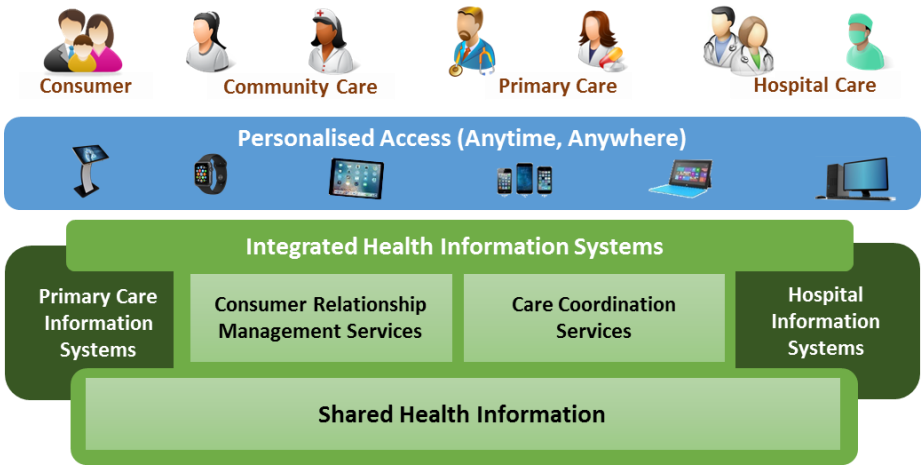
We are increasingly working alongside each other in an inter-professional manner rather than working within our professional silos. We need to keep on doing this, to be able to work with and include whānau and consumers as carers as well as the range of skills in the health care team. This inter-professional practice requires a multi-disciplinary team focussed on collaborating and sharing skills to meet consumers' needs.

The Calderdale Framework (Smith and Duffy, 2010) provides a clear and systematic method of reviewing skill mix and roles within a service to ensure quality and safety for consumers. It is transferable to any health or social care setting, and enables consumer focused development of new roles and new ways of working, leading to improved efficiency in utilisation of roles (Nancarrow et al, 2014).

Better information and communication technology will enable us to work smarter

Our Information and Communication Technology (ICT) environment has not kept pace with developments in healthcare and other parts of society. The health system we have described for the future relies on closer alignment between ICT and health objectives—without it we cannot achieve our plan. We have put in place best practice ICT foundations with business led governance and operating frameworks within our organisation. In addition we are actively working on continuously improving our ICT capabilities by investing in our people and strategic partnerships. This positions us strongly to enable the transformation of our health eco-system through digital services.

Figure 10 Accessible and integrated health information systems



Our new models of care require the availability of trusted health information for consumers and providers, at the right place and time. This relies on us working in partnership providing innovative and agile solutions. Our new models of care require the integration of our information systems to provide a single and accessible view of the patient's health record, care plan, and interactions.

The team-centric approach in our new primary care model emphasises the need for care coordination and communication. We will enable and facilitate this through modern unified communications and collaboration services as well as a range of coordination services supporting collaborative pathways, workflow, referral, and case management. Additionally, consumer relationship management services will enable consumer and whānau information, contact details and preferences, relationships, interactions, and tasks to be recorded and shared.

Modern technology solutions enable new methods for consumers and providers to access information and health services, personalised to support different preferences and work situations. For example, the use of smart devices, such as smart phones and tablets, will enable a mobile workforce and gain measurable productivity improvements. Consumer technologies provide opportunities to enhance access to health information and our services; enabling consumers to view and add their own information, make appointments, receive reminders, interact with their health care providers through a self-care facility such as kiosks, web portals or mobile applications. Emerging technologies that support self-management, such as home based monitoring systems, wearable digital devices, and near patient testing, will be adopted with real time data feeds into systems that people can access easily. Remote medical care through telehealth technologies, for example, will improve access to specialist services, particularly for those living at distance to health facilities.

Underpinning these enablers will be a portfolio of secure and resilient infrastructure and systems management services to ensure ‘always on’ access to our information.

We will deliver these health enablers by working collegially and adopting an agile implementation strategy underpinned by a skilled ICT team that delivers real business value. We will design and develop our services following a ‘business value first, technology second’ principle to ensure we focus on delivering measurable benefits to people and the health eco-system.

Assets and infrastructure

The capacity of some of our facilities is stretched. Our ED was not designed to receive the number of patients that attend currently, and triage and waiting areas are not well laid out. The Intensive Care Unit has outgrown its footprint and there is considerable pressure on our operating theatres. In many cases primary health centres lack the physical space to be able to deliver new services in the community. This constrains our ability to deliver contemporary models of care, of the highest quality and in the most efficient manner.

Our view of assets needs to extend across community and primary care and not just be focussed on the hospital. We need fit for purpose primary care facilities and we need fit for purpose hospital facilities. We will make best use of all existing spaces and look for opportunities in new models of care that make use of non-specific assets.

This CSP recognises that we cannot, and do not wish to, build bigger and bigger hospitals; however we need to address our immediate term pressures while we focus on improving service delivery outside and around the hospital. We are already preparing for an additional operating theatre, and we will extend this planning to include all our facilities through a master site planning exercise over the next 18 months.

Governance and leadership

We are fortunate in having built a committed and functional consumer and clinical council which, over the years, has assisted the Board and the health system more generally with sound advice and comment. We will continue with this effort to integrate consumer views in particular and seek to extend our governance strategies further.

We see that a key role of the DHB is to align people with the skills and insights to lead change is a complex sector, around a common vision, and with a greater degree of inter-dependence. We need to trust those system leaders with the tools and problem solving capabilities, to work with communities and people who need services, to transform care and increase health equity.

Many parts of New Zealand's health sector operate in alliances but rarely do those alliances extend beyond health services. Bringing together local community, primary care and DHB resourcing, together with social services agencies (Education, Justice, Police, Social Development, Oranga Tamariki and our councils) will be needed for us to achieve our health goals. We will ally ourselves with social agencies at the health system level.

Regional cooperation and collaboration

We are part of the Central Region of six lower North Island DHBs. We collaborate with our regional partners to develop and implement the Central Regional Services Plan (RSP), and we rely on other DHBs to provide some tertiary services for our population. In addition to the clinical care arrangements articulated in current and future RSPs, there are opportunities with our close neighbours; with shared challenges around rural service provision and the Ngāti Kahungunu rohe stretching beyond our district boundary. We will work with partners that have shared characteristics, where there is benefit for our populations, services and staff.

Health and business intelligence

Health and business intelligence plays a vital role in supporting evidence-based planning, funding and care delivery. This includes supporting the rapid evaluation of initiatives and provision of feedback for performance improvement. Health and business intelligence will be strengthened at strategic and operational levels, through an expanded health and business intelligence function working closely across primary and secondary care. Integration of data across primary and secondary care providers enables a deeper understanding of health journeys and health outcomes.

A system that learns needs timely person-centred data and analytics to be available to decision makers at all points in the system. Cost-effectively collecting, sharing and analysing data across the health (and social) system will greatly increase our capacity to design and commission effective services, and to target resources to where they have the strongest effect on improving outcomes (New Zealand Productivity Commission, 2015).

Creating a learning and innovation culture

Increasing the effectiveness of our services will require a system that learns over time about what works, then spreads the successful approaches and changes or winds down those that don't achieve results. An effective learning system results in innovation. Innovation runs in starts and stops in our

health system and we need to commit to an innovation pipeline that pilots, assess and then implements fully.

The Productivity Commission (2015) describes learning systems as having clear goals, incentives and flexibility to try new ways of doing things, on-going feedback about what is working, a willingness to tolerate trials that fail (while dealing with failure quickly), the ability to structure trials in a way that can be scaled up if successful, and the flexibility to take up and spread successful innovations.

More devolved approaches to commissioning tend to result in more bottom up experimentation however information on what works must be shared and success rewarded so innovation spreads.

6. We aim to make a significant impact on the system

We have a bold goal to achieve equity

We know that life expectancy is significantly less for Māori compared to non-Māori and it is taking too long to close the gap. Difference in life expectancy is related to broader factors than just health alone; however we have a key role to play as an influencer and ensuring we eliminate the inequity in preventable deaths. We also need to eliminate inequities in a number of other areas listed below. The Ministry of Health System Level Measures[7], along with a number of other indicators, help us to quantify our performance in these areas, and our goal is to achieve equity between population groups across all measures.

Domain	System level measure
Healthy and safe home environments	Babies living in smoke-free homes
Access to high quality and timely health services	Youth access and utilisation of youth appropriate health services Ambulatory sensitive hospitalisations
Experience of care	Patient experience of care (primary and hospital care surveys)
Health outcomes	Acute hospital bed days per capita Amenable (avoidable) mortality rates

A significant impact means the hospital footprint will not be increased

In the introduction to this CSP, we highlighted the demand pressures on hospital services if we don't change the way we do things. We aim to fundamentally shift our system and invest more in preventative care and primary health services, to improve consumer experience and avoid the need for more costly hospital treatment wherever possible. To do this we must contain the costs of hospital care.

To demonstrate the size of the impact we would need to target, we present a scenario analysis in Appendix 1 that show how changes in hospital admission rates and length of stay would change the potential requirement for hospital beds. This sort of analysis helps us to think about the level of our ambition and where we want to aim.

So what happens next?

At the start of this plan, we described the journey that has led to the development of the CSP, from understanding our current state of service provision and what challenges we face in the future, through a series of patient journeys and workshops to design our future options, pulling it all together to form the plan you have just read.

This process is the first part of the overall journey to develop the next five year strategy, which will build on and replace Transform and Sustain. The CSP is a key input to the new strategy along with other strategic initiatives such the People Plan and Health Equity Report 2018.

[7] https://www.health.govt.nz/new-zealand-health-system/system-level-measures-framework

A number of things in this plan we need to just ‘get on and do’. Other elements will be incorporated into upcoming annual planning cycles as they require investment or more detailed development. But to achieve the more profound change we are seeking, some core parts of this plan are strategic decisions that will be taken through to our five year strategy.

Our new strategic plan will set the direction and pace of implementation for the next five years. Out of this will fall a series of implementation plans or road maps, including long term investment, facilities and workforce plans.

7. List of acronyms and te reo Māori terms

Acronyms

ACP	Advanced Care Plan
CSP	Clinical Services Plan
COPD	Chronic Obstructive Pulmonary Disease
DHB	District Health Board
ED	Emergency Department
FSA	First Specialist Assessment
GP	General Practitioner
HCH	Health Care Home
ICT	Information and Communication Technology
InterRAI	International Resident Assessment Instrument, a suite of comprehensive clinical assessment tools for older people
MDT	Multi-Disciplinary Team
NASC	Needs Assessment & Service Coordination
WHO	World Health Organisation

Te reo Māori terms

Atua	God
Iwi	Tribe—often refers to a large group of people descended from a common ancestor and associated with a distinct territory
Kaimahi whānau	Family support worker
Kaitakawaenga	Liaison worker
Kaumātua	Elder
Kaupapa	Topic, purpose
Kuia	Elderly woman, grandmother, female elder
Mana	Authority, influence, status, spiritual power
Mirimiri	Massage
Pūrākau	Myth, ancient legend, story
Rangatahi	Youth
Rohe	Boundary, district, region, territory, area, border (of land)
Rongoā Māori	Traditional Māori healing
Tamariki	Children
Whānau	Extended family, family group, a familiar term of address to a number of people. Sometimes used to include friends who may not have kinship ties to other members.

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Appendix 1: Hospital bed projections scenario analysis

The scenario analysis presented here shows how changes in hospital admission rates and length of stay would change the potential requirement for hospital beds. This sort of sensitivity analysis helps us to think about the level of our ambition and where we want to aim.

The lines represent the projected number of beds, assuming they are occupied at a planning benchmark percentage (to ensure there is still reasonable flow of people through the hospital during busy periods):

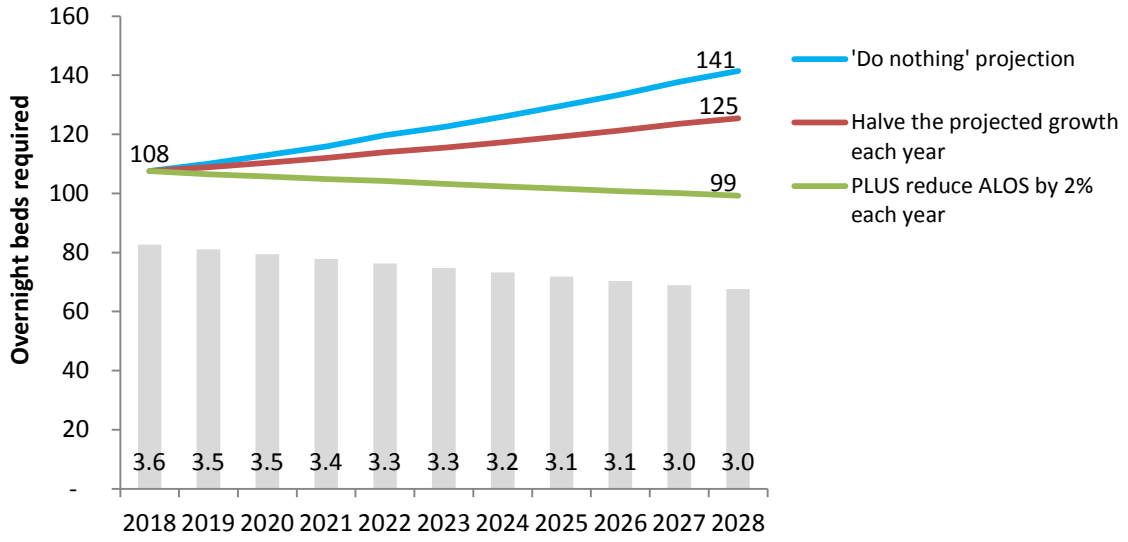
- The blue line is the beds required under a basic demographic projection, that is, the 'do nothing' projection.
- The red line is the beds required if the projected yearly growth in admissions can be constrained (but average length of stay may still increase with the ageing population).
- The green line is the beds required if admission growth is constrained AND the average length of stay is reduced year on year.

This analysis does not determine or recommend the future number of beds we will need in Hawke's Bay Hospital. It shows us a range of possibilities, including an ambitious bed scenario, and what it might take to land within it.

General medicine

Here is the picture for general medicine, comparing against beds required under the 'do nothing' projection, firstly if we halve the expected growth each year, and if we also reduce the average length of stay by 2 percent year on year. The bed number assumes benchmark occupancy of 85 percent.

Figure 11 Change in general medicine beds under the base projection and modified scenarios

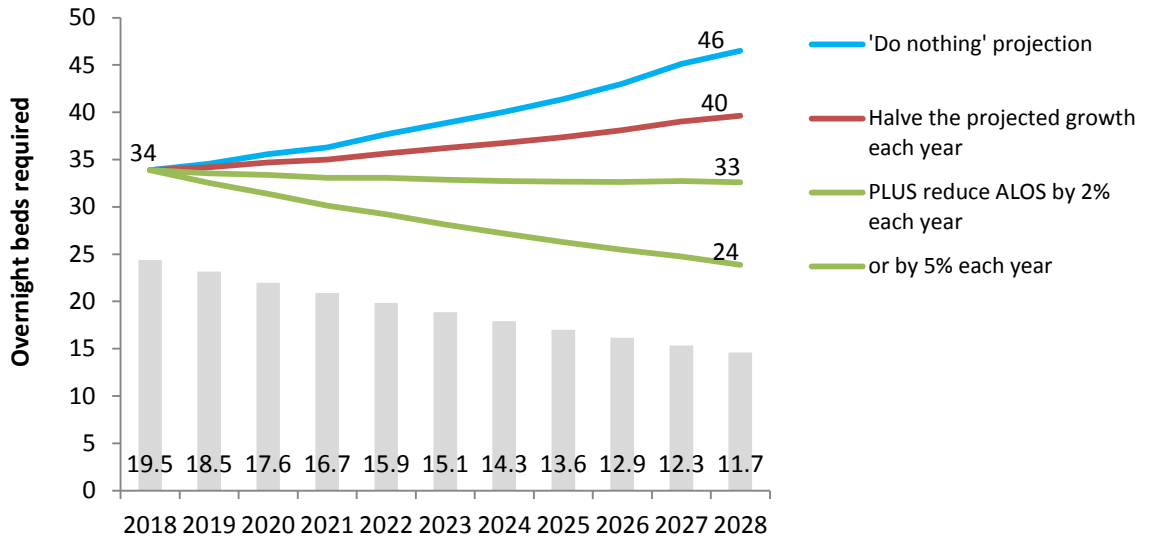


The grey bars represent the average length of stay in days if it were to be reduced in this way. It does not look unreasonable and we have a goal to focus hospital care on the first 48 hours, followed by out of hospital options. It does get harder to reduce length of stay as people in hospital are older and more complex, and as we prevent admissions that were likely to be short stay cases, but if we can achieve this, we could hold or even reduce the number of general medical hospital beds we need.

Rehabilitation

Here is the same picture for rehabilitation, comparing against beds required under the 'do nothing' projection, firstly if we halve the expected growth each year, and if we also reduce the average length of stay by 2–5 percent year on year.

Figure 12 Change in rehabilitation beds under the base projection and modified scenarios



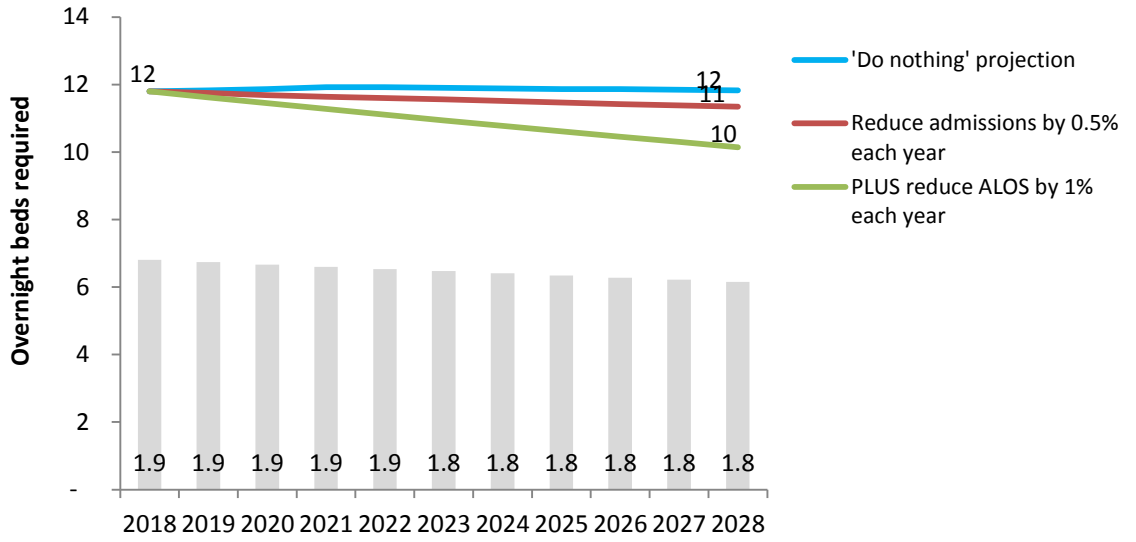
The grey bars represent the average length of stay if it were to be reduced by 5 percent each year. The reduction in length of stay is challenging, however we know from Australasian benchmarking[8] we have a high rehabilitation length of stay compared to other hospitals, and this CSP aims to provide rehabilitation in the community and at home as much as possible.

Paediatric medicine

In paediatric medicine, we are not expecting growth in bed demand over the next decade. Here is the picture under the 'do nothing' projection, then if we reduce admissions by 0.5 percent each year, and if we also reduce the average length of stay by 1 percent each year.

[8] https://ahsri.uow.edu.au/aroc/index.html

Figure 13 Change in paediatric medicine beds under the base projection and modified scenarios

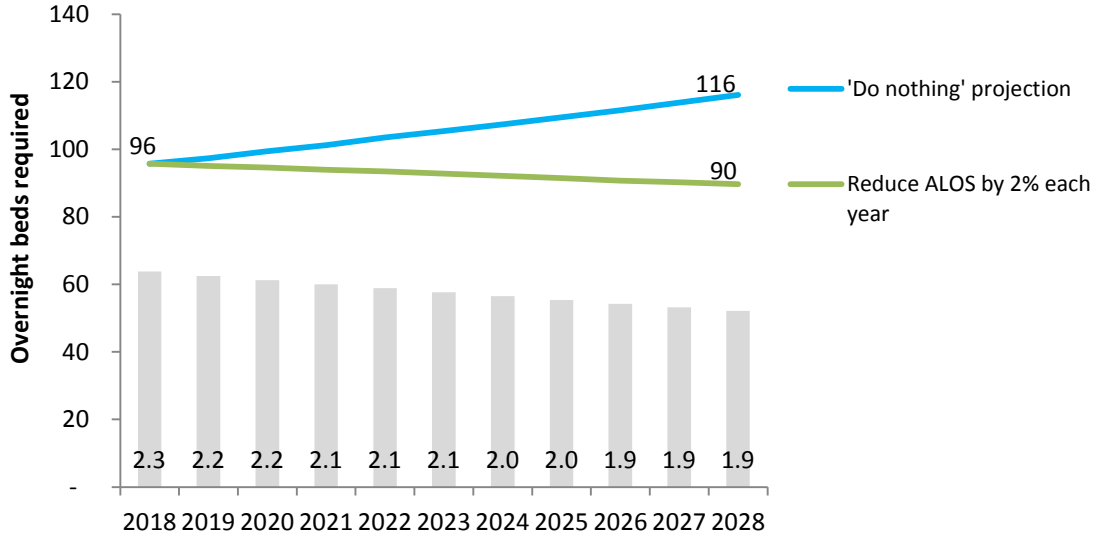


The grey bars show the average length of stay is already low. The changes in future bed requirements are probably marginal even when we reduce admissions. Note that this chart only shows paediatric medical cases. There are also children that require a bed for an overnight, or multiple night stay after having surgery.

Surgery

Here is the picture for surgery, showing the beds required under the 'do nothing' projection, and if we reduce the average length of stay by 2 percent year on year. Surgical admissions are less amenable to change than medical admissions—we want fewer acute operations but more elective operations for those who will benefit. Future Government policy directions will play a part. Advances in surgical techniques will be balanced by conversations around anticipated benefit and quality of life impact.

Figure 14 Change in surgical beds under the base projection and modified scenarios



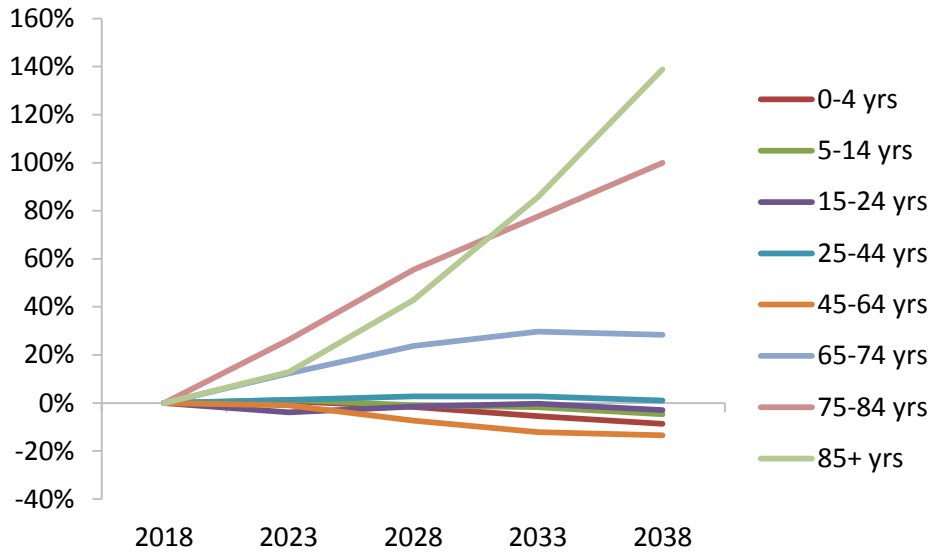
Appendix 2: Hawke's Bay population profile

Demographic changes

The Statistics New Zealand medium population projection is used as the basis for demographic service demand projection. It is important to understand the population projections in order to understand their impact on future demand for clinical services. The Hawke's Bay projection has the following features over a 15-year horizon:

- A small increase in total population from 163,580 to 173,800.
- A significant increase in the older population (51 per cent increase in the overall population aged 65 years plus, and within that an 80 per cent increase in the population aged 75 years plus).

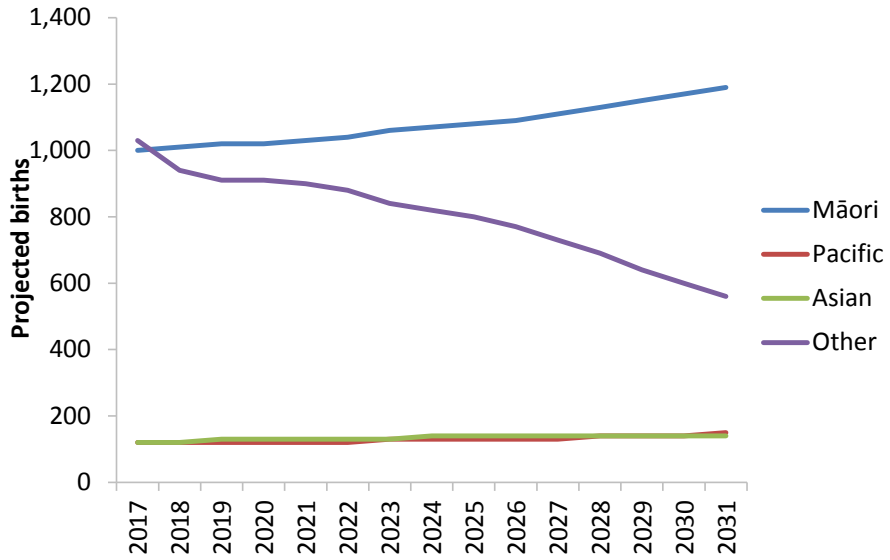
Figure 15 Hawke's Bay population growth on 2018



Source: Statistics New Zealand

- A slight decrease in the number of children and young people, and working aged adults (around 5000 decline).
- A significant decline in the number of births in the 'other' ethnic group (from about 1000 to fewer than 600 per year), and increasing births for Māori (from about 1000 to nearly 1200).

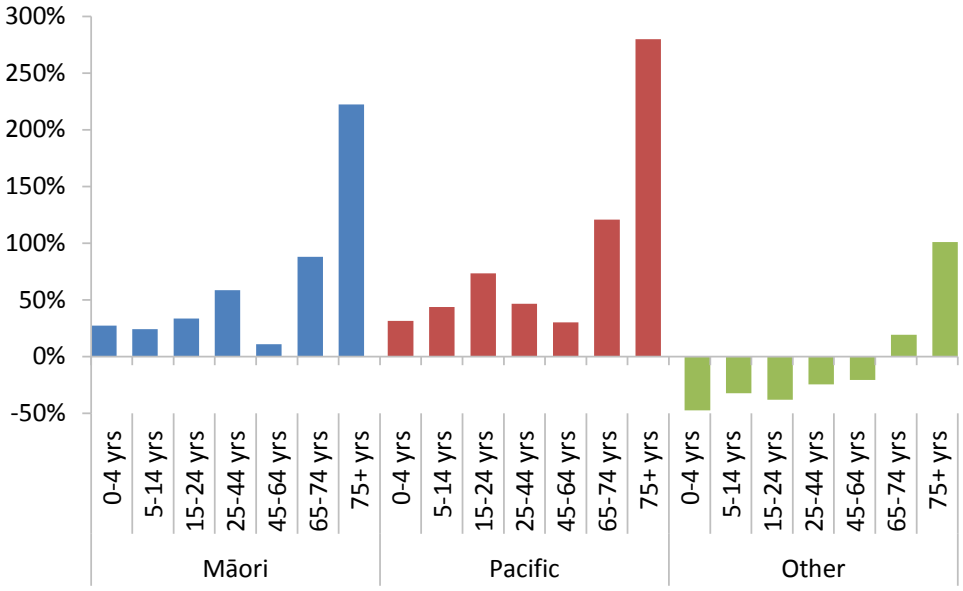
Figure 16 Hawke's Bay births projections



Source: Statistics New Zealand

- An increase in the proportion of population identifying as Māori (from around one-quarter to nearly one-third of the population) or Pasifika (from around four to five per cent). Māori and Pasifika populations increase in all age groups.

Figure 17 Growth by ethnicity & age, 2018 to 2038



Source: Statistics New Zealand

- A decline in the population living in the Wairoa District.

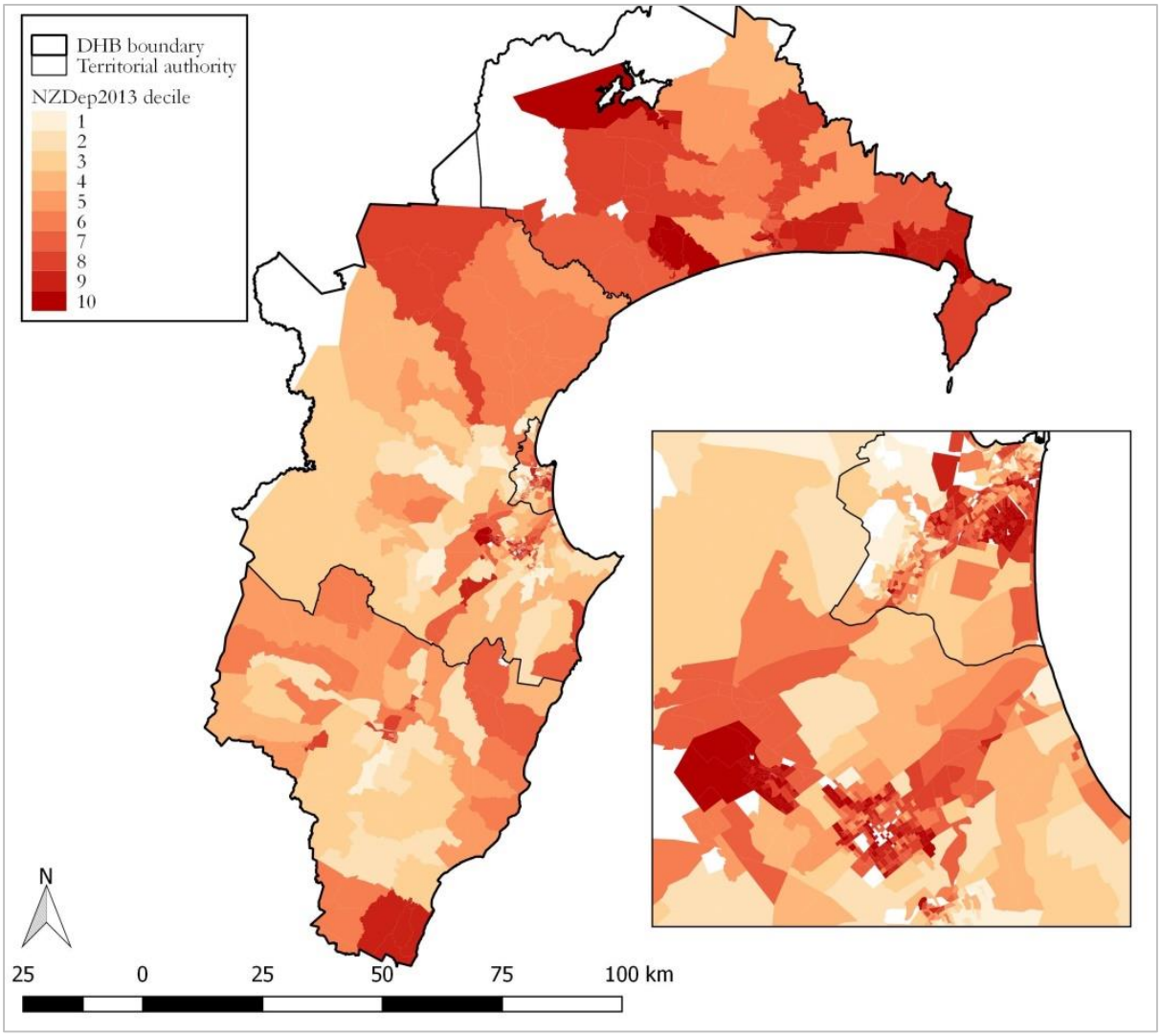
The major trends are the significant increase in the older population and the increasing proportion of Māori within the total population. There is a higher prevalence of disease seen within each of these groups. Māori have a tendency to exhibit the disease of age at a younger stage, showing earlier onset of symptoms of chronic conditions associated with ageing.

In absolute terms, the increase in the population for Māori aged 65 years plus is about 2,700 people and smaller than the absolute increase for the 'other' population, which is approximately 12,370. However, in proportionate terms, the increase in the older Māori population is much greater. The impact of changes associated with ageing is therefore likely to have a disproportionate impact upon services for Māori.

Determinants of health

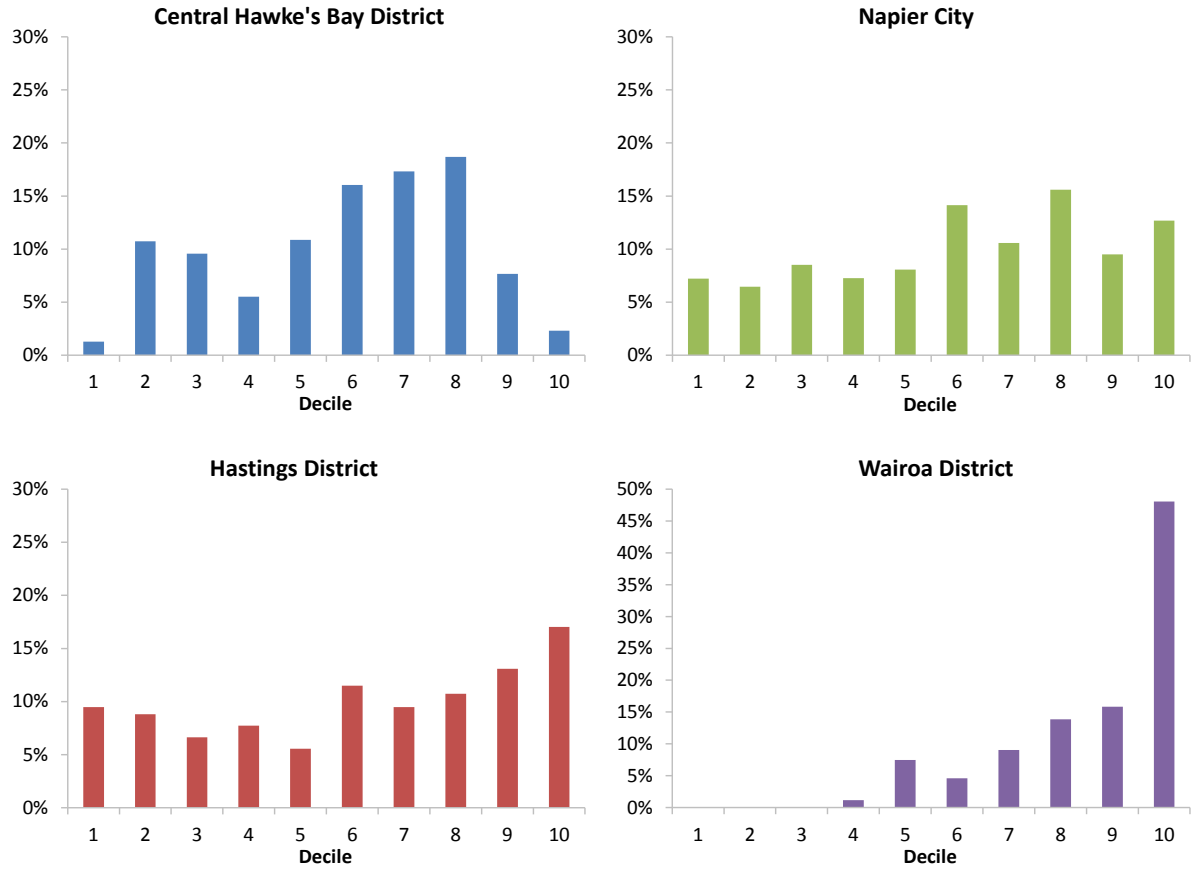
The New Zealand Index of Deprivation or NZDep2013 (Atkinson et al, 2014) combines census data relating to income, home ownership, employment, qualifications, family structure, housing, access to transport and communications. It provides a deprivation decile for each small area in New Zealand, where 1 represents the areas with the least deprived scores and 10 the areas with the most deprived scores.

Figure 18 Map of Hawke's Bay meshblocks by NZDep2013 decile



Source: University of Otago, Sapere map

Figure 19 Population distribution by deprivation decile



Source: University of Otago, Sapere chart

- Twenty-seven per cent of the DHB's total population live in decile 9 or 10 areas; however, the profile differs between the four local authorities:
- Nearly half of the Wairoa population lives in a decile 10 area (48 per cent) with a further 16 per cent in decile 9. There are no decile 1-3 areas in the Wairoa District.
- The Napier and Hastings populations are slightly overrepresented in decile 6-10 areas. Thirty per cent of the Hastings population lives in the most deprived areas (decile 9-10).
- The Central Hawke's Bay population has a very small proportion of population at either extreme (decile 1 or decile 10) and has a higher than average proportion of population living in deciles 6-8.

Appendix 3: CSP engagement process

Creating the CSP for the Hawke's Bay Health System involved four main stages with the following analysis and engagement:

Understanding the current state of service provision and challenges for the future	
Desktop review of relevant documents	Review of national strategies and documents, as well as: Transform & Sustain, Annual Plans/Statement of Intent, Annual Report and Quality Account, Regional Services Plan, Matariki, Hastings District Council locality plans, various strategies, DHB Equity Update, locality planning documents, Regional Services Plan. A number of additional documents were provided by DHB services.
Technology horizon scanning	A brief scan of emerging models and health technologies.
Data analysis and projections	Review of New Zealand and Australasian benchmarking reports; summary of population projections, primary care utilisation, hospital utilisation and intervention rates. Primary care and hospital demographic demand projections.
Meetings with primary care	During May – July 2017
Meetings with hospital services	July to September 2017
Mapping healthcare journeys through patient journey workshops	
Patient journey workshops	Stroke & congestive heart failure – 11 September 2017 Youth alcohol & drug – 12 September 2017 Youth pregnancy, fractured neck of femur & inflammatory arthritis – 13 September 2017 Tertiary oncology, paediatric asthma (Pacific) – 20 September 2017 Diabetes/kidney disease & ear disease (Wairoa) – 21 September 2017 Mild dementia (Central Hawke's Bay) – 22 September 2017
Themed workshops	
Four thematic workshops	Looking After Frailty – 9 April 2018 What is the Character of our Hospital in Ten Years' Time – 10 April 2018 Designing Services for Whānau with Unmet Health & Social Needs – 2 May 2018 Reorganising Primary Care for the Challenge – 3 May 2018
Integrated workshop	
Integrated workshop	31 May 2018 with participants from across all the thematic workshops and other key stakeholders.
Approval process	
Consumer and Clinical Councils, Māori Relationship Board	11-12 July 2018 and 10-11 October 2018
District Health Board	25 July 2018
Sharing and feedback on draft	August to October 2018
Board approval	November 2018