DRAFT WRHN Annual Plan 2022 – 2023

Pae Ora (Healthy Futures) Bill is expected to come into force on 1 July 2022. The Bill's purpose is to: (a) protect, promote, and improve the health of all New Zealanders; and (b) achieve equity by reducing health disparities among New Zealand's population groups, for Māori; and (c) build towards pae ora (healthy futures) for all New Zealanders.

The New Zealand Health Plan, national health strategies, and a New Zealand Health Charter are all under development and will set the framework nationally, within which local areas will ensure the needs and priorities of their people are being addressed by the type and way services are delivered.

The health system redesign is focused on a more equitable, accessible, cohesive and people centred system to improve the health and wellbeing of all New Zealanders. WRHN is well aligned with this mantra.

Whanganui has been selected as one of the 9 Locality prototypes across Aotearoa New Zealand. WRHN will have a role in contributing to this mahi over the next 12 months. As the shape of this is unfolding, WRHN will require some flexibility in its ability to respond to its part in the vision and fruition of the locality plan as it evolves.

The focus of our 2022/23 annual plan is to focus on areas that need extra care and attention to bring about equitable outcomes, to support mahi for improving population health outcomes (which has borne the brunt of the necessary focus on the Covid 19 pandemic), and to ensure that our workforce sustainability plans are developed, including contemporary skills for a focus on people centred health services. In the past 12 months we have been working to improve our organisational capability around data, digital and technology. There is still much to be attained in this area, which will be important in our capacity to work seamlessly across the health system, and importantly within our rohe.

The population of the Whanganui rohe continues to grow, with access to primary health care through the general practice teams continuing to be challenging.

The planned activities for 2022/23 align with the intent of the Locality plan, along with the overarching focus of the HNZ and MHA.

Our service performance statements (required for the Charities Commission) are focused on equity outcomes and access with KPIs that measure Enrolment, Ethnicity Enrolment and Access. This supports our ability to measure and build on our commitment to equitable outcomes and improved access to primary health care.

Population Health: Child health

Context *(why this is important):*

Since 2019, the Covid-19 pandemic has made a significant impact on whanau engaging with health services in a timely, trustworthy manner. Multi-factorial issues including isolating at home with family, avoiding spaces with unwell people (e.g., clinic waiting rooms), growing mistrust in vaccinations and health professionals via increased media consumption, and limited or cessation of some core health services have impacted on routine health behaviours. In turn, this has widened already existing equity gaps between Māori and non-Māori, particularly tamariki.

Goal *(what we are trying to achieve)*:

To improve health outcomes for tamariki Māori aged 0 to 5 years old by closing the existing equity gap between Māori and Non-Māori tamariki. This will be done ensuring that child health touchpoints within primary care and outreach services are maximised via the provision of: General Practice enrolment, child immunisation, and B4School check services.

Our goal aims to improve the completion rate for each respective service by Māori tamariki by 2% per quarter. This will result in an overall 8% improvement in equity for Māori tamariki for each service by the end of quarter four.

By focussing on this goal, it is also projected that overall immunisation, B4School check rates and General Practice enrolment rates will increase within the Whanganui rohe.

Enablers *(things that will help us reach our goal)*

Quality Improvement Projects:

- Newborn transfer of care project- ensuring timely and effective transfer of care from birth/ LMC care to Wellchild, Tamariki Ora and General practice. This is a collaboration between WRHN, WDHB, LMCS, WCTO, and maternity services.
- 7 -week Project- identifying pepe who have not completed their 6-week immunisations and/or enrolled with a General Practice.
- Newborn enrolment project- initiating follow-up by General Practice and/or outreach for pepe not enrolled with GP within 3-4 weeks of birth.
- Outreach Immunisation Quality Improvement Plan- revising existing systems, processes, people, and equipment to improve efficiency and effectiveness of the WRHN outreach team.

Workforce Development

- Upskilling existing Māori provisional vaccinators situated in Iwi and General Practice organisations to deliver childhood immunisations via a funded bridging
- Supporting Manaaki Te Whanau and wider WRHN kaimahi to utilise connections via their marae, kaumatua, kohanga reo, kura and community groups to foster connections with child health services.

- Provision of training and supporting WDHB paediatric ward and WAM nurses to deliver opportunistic immunisations, and complete B4School checks with a focus on Māori children within the secondary care setting
- We anticipate the demands on the WRHN outreach team will continue to grow during the pandemic, therefore funding and planning streams will need to be responsive in this climate.

Collaboration and Promotion

- WRHN participation in the newly established Immunisation Governance and Operational group
- WRHN will work closely to strengthen Ngati Rangi, Te Kotuku and Te Oranganui's ability to deliver child immunisations and offer B4School checks to tamariki upholding a by Māori for Māori approach.
- Progression of the 2022 influenza vaccine collaborative delivery plan with WDHB, WRHN, and Iwi Organisations.
- Whanganui Maternal Child & Youth Community Alliance – working towards improving resources and systems to improve whanau outcomes.
- New-born transfer of care project – aiming to ensure no pepe left behind seamless, timely transfer of care from birth to primary care including WCTO.
- Refreshing local communication pathways and networking with Plunket/ Tamariki ora, Family Start, Birthright and MSD advocates to support whanau to access immunisations, B4School checks and General Practice enrolments when required.

Information Technology

- Provision of appropriate mobile technology (i.e portable tablets/laptops, mobile internet access) so outreach kaimahi can access and update information in real time to deliver services appropriate for whanau across the whole of lifespan in one home visit.
- Increased National Immunisation Register access for Iwi organisations to support whanau outreach, particularly for rural communities.
- Access to MoH Qlik database to compliment the National Immunisation register to visualise progress towards targets in real-time.

Milestones *(how we will measure our progress)*

The following measurements will be made at each quarter to track the progress towards our goal:

- General Practice enrolments of Māori and Non-Māori are measured at 6 weeks & 3 months of age. Baseline at July 2022, 2% increase each quarter.
- Māori and Non-Māori childhood immunisation rates are measured at milestone ages of 8 months, 24 months, and 5 years of age. Reduced % equity for completion rates each quarter.
- Māori and Non-Māori B4School check completions are measured at 5 years of age. 2% increase in completion rates for Māori seen each quarter.
- Training in place to support our providers in delivery of the B4SC and immunisations services and increase Māori providers (ongoing). Measure attendance volumes and demographics.

Whanganui Regional Health Network | **ANNUAL PLAN**

Self-management for health and wellbeing (Long term conditions)

Context *(why this is important):*

The Covid-19 pandemic has had a significant impact on whanau and their engagement with health services. This in turn has impacted on the timely treatment and management of their long-term conditions. We know that the structure of services matters to how providing care that is holistic, clinically safe, collaborative and coordinated way, led, and based on the needs of the whanau.

Our primary care data shows inequities are persistent across long term condition care pathways, with Māori and Pasifika people experiencing inequitable access to care at all stages of treatment and management, despite having more complex health needs. Equity needs to be considered in terms of access, opportunity, and outcomes. This includes addressing inequities in access to care among rural communities, people with disabilities and people experiencing mental illness.

Self-management is about enabling people with LTCs to 'make informed choices, to adopt new perspectives and generic skills that can be applied to new problems as they arise, to practice new health behaviours, and to maintain or regain emotional stability' (Lorig 1993).

Self-management support is underpinned by three core principles: health literacy, cultural safety, and person-centred care.

Goal *(what we are trying to achieve)*:

Whānau with Long Term conditions actively manage their condition/s by themselves on a day-to-day basis by collaborating with carers and health professionals to build knowledge, skills, and confidence.

Self-management support is underpinned by three core principles: health literacy, cultural safety, and person-centred care.

Enablers *(things that will help us reach our goal):*

Technology

- Increase the range of self-management programmes/options available to long term condition patients and the mediums in which they can be accessed.
- kaiāwhina/navigators have access to digital support (tablets) when working in the community to enable them to access and provide real time information.
- Develop a central hub of self-management tools and resources for whānau
- Increase use of digital technology to support lifestyle changes i.e., ManageMyHealth, social media, text messaging, TV screens
- address the financial and health literacy barriers around access to technology which supports improved self-management

Workforce

- Workforce training covers motivational interviewing, health literacy, cultural competence and person-centred care
- Improve referral pathways to self-management support for all whānau.

- increase focus on earlier intervention. This includes improved access to kaiāwhina support, mental health and wellbeing support, nutritional, social.
- Collaborate with wider community agencies/groups to Increase access to community-led and supported wellbeing initiatives for priority groups
- Endorse and support peer-led approaches and peer support networks

Data

- utilise data to identify high needs patients i.e., diabetes whanau with Hba1c >100
- work with hospital to identify frequent flyers
- utilise data to support general practice to understand their performance and areas in which they can make improvements i.e., identify whanau requiring regular testing, treatment and management i.e., gout, diabetes

Milestones *(how we will measure our progress)*

The following measurements will be made at each quarter to track the progress towards our goal:

- % of Māori and Pasifika people diagnosed with diabetes, COPD and cardiac who have accessed self-management education within 6 months of being diagnosed with a long term condition
- Māori and Pasifika LTC whanau have improved access to comprehensive and culturally appropriate care planning
- Decreased acute hospital admissions for LTC whanau (with a focus on 'frequent flyers').
- # of Māori and Pasifika LTC whanau attending community led wellbeing initiatives i.e., green script
- # of Māori and Pasifika LTC whanau attending peer led approaches and/or support groups
- # of workforce who have participated in motivational interviewing, health literacy and person centred care training or modules
- Increased enrolment and use of MMH software for those with LTC (Q2-3)
- Pilot for LTC and population health Kaiāwhina/navigators accessing digital support (tablets) when working in the community to enable them to access and provide real time information (Q1-2).
- Range of self-management programmes/options available to long term condition patients and the mediums in which they can be accessed has increased (Q2-3)

Whanganui Regional Health Network | **ANNUAL PLAN**

Sustainable workforce

Context *(why this is important):*

With the implementation and roll out of the revised health system, the opening of the boarders and the ongoing, changing impact of Covid, 2022/2023 will be a year of change and uncertainty. Workforce sustainability in the face of change, and to support the delivery of a well-rounded primary care health service needs to guide current and future workforce skill, roles, and ways of working together.

Goal *(what we are trying to achieve)*:

To build the framework for sustainable workforce within WRHN, and its subsidiaries, to support delivery of health services for population health, and to support different workforce models within the rohe.

Workforce is sustainable and able to meet the needs of its key stakeholders through the changes the health reform brings over the next 12 months.

Continue to identify and implement use of smart information technology where appropriate; cloud and electronic payroll system; GPDocs for policy management, work anywhere tools (tablets for clinical workforce in the field, work anywhere set ups for all identified staff, competent use of zoom and teams by those who use them).

Milestones *(how we will measure our progress)*

The following will be tracked each quarter to identify the progress towards our goal:

- Finalise and implement workforce development plan (Q2)
- Ensure our workforce have key learning and development plans in place (Q2)
- Build health professionals preparedness for system change
    - Health literacy development opportunities in place for WRHN and provider network
        - HL training (quarterly) – all WRHN workforce have engaged x1 over 12 months, promoted to GPTs
        - Motivational training – offered quarterly – all clinicians WRHN participated
    - Keep it real approach that enables the workforce to consider the person/whānau context/ aspirations.
        - Challenging conversations/de-escalation strategies – all kaiāwhina and administrators have attended an initial training or update
        - Whanau ora in-service for WRHN employees, and practice member steams (webinar)
    - Ability to work with a wide range of service providers to support population health
        - Whanau ora worker training supported for population health screening
- Coordination of workforce development opportunities established on the intranet (Q2)
- Evolution PMS in place across the rohe (Q1)
- Revise and fine tune the array of services/tools for GPTs to ensure only those that are best fit are in place (i.e Patient dashboard) (Q3).
- Continue to roll out work anywhere workstations (ongoing – completed by Q4)
- Celebrate/value our workforce through recognition of our clinical strengths and outcomes through regular storytelling (ongoing).

Whanganui Regional Health Network | **ANNUAL PLAN**

Managing ongoing impact of Covid

Context *(why this is important):*

We know that Covid will continue to have a significant presence in people's lives for the foreseeable future. For WRHN this requires the ability to remain agile to responding to the needs of the community and the practice network to support Covid related services.

Our workforce is also impacted by Covid, with isolation requirements and decreased tolerance for sickness in the workplace. Support for workforce wellbeing and productivity enablement through this year will be critical to supporting all our mahi.

Goal *(what we are trying to achieve)*:

To maintain team and infrastructure that can respond to health service delivery for Covid and long Covid as needed.

An agile workforce that can work remotely to support practice teams, or to minimise disruptions caused by different tolerance of flu like symptoms in the workplace.

Milestones *(how we will measure our progress)*

- Covid vaccinations and boosters offered through the WRHN clinics (Q1-2)
- WRHN clinical and kaiāwhina WF support to practice teams where needed (Q1-2)
- Streamline access to Covid knowledge/processes/funding for GPTs (Q1)
- Support evolution of the Mauri Ora Covid Clinic to enable respiratory /winter clinic / Covid mahi for remainder of 2022.
- Engage in Care in the Community mahi for vulnerable communities/populations (i.e. LTC long covid)
- Access to information technology in place for all staff who need it.
- Guidelines for virtual & remote work updated. Training for direct reports. (Q1)
- Covid vaccinations /boosters/flu vaccinations for staff (% uptake).
- WRHN formalise the flexible work policy to maximise productivity through the continued disruptions expected for the rest of the year, with individualised remote work plans developed for key identified staff (Q2)