Executive Summary

It is with pleasure that I introduce the 2018/19 Annual Plan for Whanganui Regional Health Network (WRHN), one of two Primary Health Organisations' (PHOs) that are operating within the Whanganui District Health Board (WDHB) region.

This plan considers the aspirations of our governors, the board of WRHN and reflects priority pieces of work that consider sustainability of our General Practice members, now and into the future.

WRHN is a cog in a health system wheel that is servicing a defined population. Our population is challenged by chronic illness, socioeconomic factors, and inequalities in health outcomes for Māori, and geographical and social isolation. All factors which create varying levels of vulnerability. However, that being said, we are a perfect size for creating collective impact, being brave in the face of adversity and being courageous about making disruptive change happen, that will create positive impact for our communities.

The plan reflects our support for effective and sustainable health and social outcomes, through the implementation of a range of integrated responses that are achieved by WRHN working alongside our General Practice Members, WDHB, NGOs, Iwi providers and other stakeholders, such as Ministry of Social Development, Oranga Tamariki, Police, etc.

The WRHN team wish to be part of action and activity that aligns with our attitudes, values and beliefs. We understand that inequity for people within our communities, such as health outcomes for Māori, are not only unacceptable, but must be reversed and the team are passionate about participating in collaborative activity, which improves the wellbeing of people across our communities.

This plan reflects leadership, passion and a desire to make a difference; but not by working singularly or in isolation, but by working in partnership and collaboratively to create collective impact.

A government change inevitably drives policy change and WRHN and its Board and teams' across its member practices and subsidiary companies will embrace the change, and contribute to successful outcomes that really make a difference across our district.

Judith (Jude) MacDonald
Chief Executive
Whanganui Regional Health Network

WRHN Governance Structure

Whanganui Regional Health Network Board of Trustees

- Dr Ken Young (Chair)
- Michael Sewell (Chair Risk and Audit)
- Michael Lamont
- John Maihi
- Alaina Teki-Clark
- Barbara Ball
- Dr Deon Hazelhurst
- Dr Tony Frith

Judith MacDonald – Chief Executive
Dr John McMenamin – Clinical Director WRHN and Chair Clinical Governance
Dr Rick Nicholson – Clinical Director WRHN
Dr Ken Young – Clinical Director WRHN
Julie Nitschke – Clinical Director Primary Care

Whanganui Accident and Medical Board of Directors

- Michael Sewell (Chair)
- Julie Nitschke
- Dr Rick Nicholson
- Judith MacDonald
- Dr Kath Going
- Dr Ian Murphy

Teresa Hague – Business Manager
Louise McFetridge – Practice Manager
Gina Halvorson – Clinical Nurse Lead
Dr Athol Steward – Clinical Director

Gonville Health Ltd Board of Directors

- Darren Hull (Interim Chair)
- Alaina Teki-Clark
- Nan Pirikahu-Smith
- David Robinson
- Judith MacDonald

Janine Rider – Service Manager
Dr John McMenamin – Clinical Director

Taihape Health Ltd Board of Directors

- Dr Ken Young (Chair)
- Norman Richardson
- Dr Antonia Hughes
- Barbara Ball
- Maraea Bellamy
- Susan Benson
- Judith MacDonald

Gemma Kennedy – Service Manager
Sarah Collier – Clinical Nurse Leader
Dr Ken Young – Clinical Director Rural

Ruapehu Health Ltd Board of Directors

- Don Cameron
- Ben Goddard
- Dr Ken Young
- Honey Winters
- Soraya Peke-Mason
- Judith MacDonald

Te Ringa Te Awhe – Service Manager
Dr Ken Young – Clinical Director Rural
Tina van Bussel – Practice Facilitator Support

Documents guiding the WRHN Annual Plan 2018/19

Primary Care Health Strategy 2016:

Strategic Themes
People powered • Developing an understanding of users of health services • Partnering with service users to design services • Encouraging and empowering people to be more involved in their healthcare • Supporting people's navigation of the health system
Care closer to home • Providing health services closer to home • More integrated health services, including better connection with services in the wider community • Seeing health as an investment early in life • A focus on the prevention and management of chronic and long-term conditions
High value and performance • The transparent use of information • An outcome-based approach • Strong performance measurements with a culture of continuous service improvement • An integrated operating model providing clarity of roles • The use of investment approaches to address complex health and social issues
One team • Operating as a team in a high-trust system • The best and flexible use of our health and disability workforce • Leadership and management training • Strengthening the role for people, families and whānau and communities to support health promotion and care • More collaboration with researchers
Smart system • The increased use of analytics and systems to improve management reporting, planning, delivery and clinical audit of healthcare services • The availability of reliable and accurate information, including on-line electronic healthcare records at the first point of care • The healthcare system being a learning system that continuously monitors and evaluates what is being done, with results shared for everyone to use for service quality improvement

Whanganui Alliance Leadership Team 2018/19 Priorities

Whanganui Regional Health Network is a member of the Whanganui Alliance Team, as stated as a requirement within the National PHO contract agreement.

Purpose:
Our purpose as described in the approved and agreed Terms of Reference is;
"To lead and guide our Service Level Alliances as they seek to improve health outcomes, and improve equity for our populations. We aim to provide increasingly integrated and coordinated health services through clinically led service development, and its implementation within a "best for patient, best for system" framework."

Proposed Service Alliances that will be the focus for 2018/19 are;

- Whanganui Mental Health and Addictions Alliance
- Whanganui Child Health Alliance
- Whanganui Healthy Ageing Alliance (incorporating long term conditions)
- Whanganui Clinical Information Systems Alliance

Key Actions:

1. Review the Terms of Reference and membership of all Alliance committees to support shared strategy and actions, and ensure members have delegated authority to progress change strategies
2. Focus on developing a high trust environment that ensures all decisions focus on our people and are considered within a transparent and honest approach
3. Members demonstrate courageous leadership that progresses quality improvement across all identified service alliances, with particular attention on improving outcomes for Māori
4. The Alliance will support clinical leadership and in particular, clinically lead service development
5. We will adopt a person centred, whole of system approach and make decisions on a best for system basis
6. We will adopt and foster an open and transparent approach to sharing information, and make information available to support the service alliance priorities

Better Public Health Services: A Good Start to Life

Result 2: Healthy mums and babies

What is the target?
By 2021, 90% of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80% by 2019, with equitable rates for all population groups.

Why is this important for New Zealand?
Early and continued regular engagement with a Lead Maternity Carer (usually a midwife) is associated with normal healthy births and better pregnancy outcomes.

Having a Lead Maternity Carer helps set up children for a good start in life. A Lead Maternity Carer also is a conduit to connect mother and child with other core health services, such as General Practice, immunisation, Well Child Tamariki Ora and oral health services. They also connect families to other social services that may be needed.

WRHN Actions 2018/19

1. All women who present for antenatal care will be supported to ensure effective relationships exist with a lead maternity carer and are enrolled in a General Practice of choice, and have a relationship with at least one contact person in the GP clinic.
2. Form an effective alliance with Te Oranganui services, to support women with risk factors who decline antenatal education in the city.
3. Undertake a case review of all SUDI deaths with relevant stakeholders, to understand if the system can contribute to changes that may minimise risk for future babies.
4. Review electronic 'Early Pregnancy Assessment Tool' (EPAT) to ensure mental health screening is captured effectively to identify risk and associated wrap around services in the community.

Result 3: Keeping kids healthy

What is the target?
By 2021, a 25% reduction in hospital admission rates for a selected group of avoidable conditions in children aged 0-12 years, with an interim target of 15% by 2019.

Why is this important for New Zealand?
We want to keep kids healthy and out of hospital. Some hospital admissions could be avoided by government agencies and providers working together to influence the underlying determinants of health. By intervening early, we can stop conditions getting worse, to the point where hospitalisation is needed. These avoidable hospitalisations include dental conditions, respiratory conditions (such as bronchiolitis, pneumonia, asthma and wheeze), skin conditions (such as skin infections, dermatitis and eczema) and head injuries.

WRHN Actions 2018/19

1. WRHN will gather system health data to audit quarterly all children that present at hospital with asthma, to ensure the child and their whānau have an action plan that has been documented with them in partnership with their health providers (General Practice and/or Specialist Children's services).
2. WRHN will audit to ensure all children that have experienced an admission to hospital with asthma and or a respiratory condition have been referred to the Healthy Homes coordinator for assessment for insulation and risk factors assessed.
3. WRHN will audit General Practice members quarterly to evaluate that all children with eczema have a clinical care plan and that it is consistent with the collaborative clinical pathway for eczema.

Māori Health Goals Outlined by Hauora a Iwi

Whanganui Regional Health Network needs to consider the following in all we undertake:

- Effective Whānau Ora
- Achieving health equity
- Improving capacity and enhancing capability
- Recruitment and retention

WRHN Actions 2018/19

1. Employees and contractors will have the opportunity to hui with Iwi / Māori WRHN Board members and subsidiary directors twice per annum, to gain greater understanding of the strategic priorities for Iwi and the WDHB Iwi partner – Hauora a Iwi.
2. WRHN and subsidiary companies will review how they operate services, to ensure there is seamless connection and cooperation between all contracted service team members, so the service operates for Whānau, not within a contract silo.
3. A key focus for WRHN and subsidiary services is to close the inequity gap for service outcomes for Māori (when compared to Non-Māori) in relation to service delivery, i.e. health targets, access , utilisation, referral, etc.

Regional Services Programme Regional Strategy 2018/19

"Central Region DHBs leading together to achieve New Zealand's healthiest communities"

Whanganui Regional Health Network clinical leaders will take their place alongside central region PHO partners to participate in a range of work streams, as required in coordination with the Whanganui DHB. The regional plan includes implementation of the MOH strategies, working across the region and across services, focusing on:

- Cancer
- Cardiac
- Diagnostics
- Elective healthy aging
- Hepatitis C
- Major trauma and stroke services
- Renal

WRHN Actions 2018/19

1. WRHN CE Chair Local Cancer Governance Group to drive collaborative actions across the district.
2. CD Primary Care engaged in regional collaborative clinical pathway development and leadership groups to drive change.

Health Promotion and Prevention

What do we want to achieve?	All General Practice members build awareness, capability and competency of health promotion/prevention concepts within their organisations and everyday work; including building closer connections with consumers, the community and local providers
Why is this important?	Health promotion/prevention strategies across the continuum of care are important to build health literacy and support consumers to self-manage for improved health outcomes. General Practices play an important role in people's lives and are prime sites for wellness strategies.
Who will we work with?	WRHN team, General Practices, Public Health, Whanganui DHB, Iwi providers, NGO's, TLA's, community groups and individuals
WRHN leads	Anne Kauika and Matt Rayner

OUR PERFORMANCE STORY 2018-19

How will we know if we are successful?	***How will we achieve this?***
Practices utilise the framework and/or components of it based on identified priorities that are relevant and meaningful to them. WRHN will facilitate with General Practice members, activity that supports; - Health promotion and Māori health plans - Workforce development training - Linkages with community and providers Population health data is utilised in targeted health promotion campaigns with general practice, i.e. tobacco, diabetes. Quality improvement (QI) initiatives, i.e. health literacy, self-management, and Māori health, using PDSA (Plan-Do-Study-Act) cycles demonstrate improvement. Practices achieving bronze accreditation in 2018 develop plans to work towards silver accreditation by June 2019.	**Q1:** Work with subsidiary practices and practice members to develop health promotion plans (aligned with Cornerstone) and identify practice champions. Measurable outcome is that all practices have a health promotion plan by end November 2018. **Q1-Q4:** Monthly updates on health promotion activity/campaigns (relevant to general practice) at Whanganui Inter-Professional Education (WIPE) sessions. **Q2-Q4:** Practices are supported to access training relevant to population health and health promotion, i.e. determinants of health, cultural competence, health education, health literacy and community links. **Q2-Q4:** Support practices to identify QI initiatives and utilise PDSA cycles to show change.

WorkWell bronze accreditation achieved by at least two new practices by June 2019.

Where are we at now?

Monthly health promotion updates at WIPE, commencing May 2018.

Winter Wellness/Where should I be? Health promotion campaign begins in May 2018.

- Gonville Health has completed more than 12 months as a pilot site. They have completed the self-assessment for the second time, but with a focus on the population health domain only and will be working on this area going forward. Ruapehu Health and Te Oranganui are ready for bronze accreditation. Taihape Health has developed their draft plan and will be working towards accreditation.

- Whanganui Hospice has completed the staff survey and put their working group together. Their next step is their draft plan.

- Gonville Health has chosen to wait until November 2018 before they draft their plan and get underway.

- Whanganui Accident & Medical have had initial start-up, but are yet to write their plan or take the process any further.

- Wicksteed Medical Centre and Aramoho Health Centre have expressed interest in WorkWell.

Q1-Q4: Current and new Work Well sites develop plans for achieving bronze accreditation and are supported to achieve accreditation by June 2019.

Q2-Q4: Interested practices are supported to engage in WorkWell and/or other initiatives that support and value staff wellbeing.

Integrated Community Developments

What do we want to achieve?	Create effective alliances with health and social providers that offer collective impact solutions to improve the health and wellbeing of people within our communities
Why is this important?	Collaborative effort is more effective than silo effort. Partnerships will achieve greater impact and greater learning and potentially create sustainable positive change through reducing fragmented care, improving how we work together and offering a wider perspective than just health to address serious issues experienced by our population.
Who will we work with?	Iwi, NGO providers, Police, Ministry of Social Development, District Councils, Oranga Tamariki, Whanganui DHB, General Practices, local businesses, community, etc
WRHN leads	Jude MacDonald and team leaders

OUR PERFORMANCE STORY 2018-19

How will we know if we are successful?

Evidence of programmes and projects that the organisation has been engaged with.

Evidence of collaborative contracting partnerships.

Evidence of supporting other sectors with significant change management strategies.

Community engagement and participation.

Where are we at now?

Variable capability to respond in a coordinated way that creates a high trust relationship quickly with those that need our care and support most.

How will we achieve this?

- Leadership and support for Oranga Tamariki local governance group, through WRHN CE and Child Health Coordinator participation.
- Respond to Whanganui District Council, Request for Interest in a pensioner housing contracting relationship with WDC, to improve the holistic needs of tenants in WDC Pensioner accommodation in Whanganui.
- Participate in the organic development of a Whanganui City Whānau Harm Deployment model with Police, Te Oranganui, NGO providers, WDHB and others that will support a community driven response to addressing Family Harm in Whanganui; where the community takes responsibility for leading the development of a programme of action.
- WRHN Communications & Technology Coordinator to work in collaboration with the community, social services, NGOs,

	District Council, local and national businesses, to implement a community fridge in Whanganui. To combat food wastage and provide free nutritious food to vulnerable families. For the community to take ownership, drive positive change and become more cohesive. • Ensure the data share agreement with MSD produces collaborative, integrated and early intervention strategies for our most disconnected and isolated people to ensure they have access to a range of outcomes that support their wellness and ability to live well.

Cultural Competence

What do we want to achieve?	All General Practice members and WAM will build capability and competency in their responsiveness to Māori
Why is this important?	Requirement of the Royal NZ College of General Practitioners Cornerstone and Foundation Standards, that General Practices have cultural competency, Treaty of Waitangi training and a Māori Health Plan. WRHN wish to see improvement in inequalities for Māori and a closing of the equity gap.
Who will we work with?	General Practice members, local Iwi partners
WRHN leads	WRHN Iwi and Māori Board members, Matt Rayner, Andre Mason, Judith MacDonald

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How will we know if we are successful?

Each practice will have a Māori Health Report that demonstrates progress made in reducing inequities for their enrolled population.

General Practice Māori Health Plan reviewed in line with inequities report and new priority areas.

WRHN will facilitate within the organisation and with General Practice members, activity that supports the goals and aspirations of Hauora a Iwi;

- Effective Whānau Ora
- Achieving health equity for Māori
- Improving capacity and enhancing capability

Where are we at now?

Contractors / employees / locums new to General Practice may not receive baseline training in regards to Treaty of Waitangi, therefore will be disadvantaged in personally achieving Whānau Ora.

Need to establish a platform of measures for the primary health system and agreed

How will we achieve this?

Q1: Regular Treaty of Waitangi (ToW) training held for locum practitioners and new staff members, from Rowan Partnership. Practices are supported by WRHN to develop and regularly review Māori Health Plan for their practice; that is relevant to their needs and progresses a journey of Whānau Ora and equity improvement for their Māori patients.

Q2: Agree a suite of measures that monitor and evaluate;

- Inequalities for all Minister's targets
- Inequalities for measures in SLM
- Māori engagement in evaluation activities to ensure the Māori voice is heard

Q2: Māori employees / contractors / locums invited to a hui with WRHN Iwi and Māori Board members to share aspirations, vision and receive cultural support from governing leaders.

Q3: A formal policy statement is developed by WRHN for new General Practice members, highlighting the importance of health equity for our region and also explains how Powhiri

with General Practice; which offers consistency and lines up markers for progress, and is reflective of professional standards, Foundation Standards and Cornerstone Standards. Practices at varying stages of cultural competency and acceptance of cultural training. Māori employees, contractors and locums operate within a system that is disconnected from the vision and values of our Māori/Iwi governors.	and Waiata are a core WRHN cultural activity, and how General Practice members will be supported to access this. **Q3:** Focus on a quality improvement project in partnership with General Practice members, with frontline workforce (inclusive of receptionists) receiving training, education and information to support communication for those people where English is a second language. **Q4:** Evaluate how the programme has made a difference through reviewing a platform of data measures.

New Subsidiary – Waimarino

What do we want to achieve?	Establishment of a General Practice Service for Waimarino community in partnership with key stakeholders and support the local Iwi and community aspirational goal of health services for the district co-located within an integrated facility
Why is this important?	Access and continuity to primary care services for the communities of Raetihi, Ohakune and surrounding districts
Who will we work with?	Ngati Uenuku Trust, Ngati Rangi Trust, Ruapehu Council, Ruapehu Health Ltd employees and community representatives
WRHN leads	Jude MacDonald, Te Ringa Te Awhe, Hilary Ashworth, Janine Rider, Julie Nitschke, Teresa Hague

OUR PERFORMANCE STORY 2018-19

How will we know if we are successful?

WRHN subsidiary company established and functioning by 1 July 2018 with governance, funding, workforce, backroom functions all operational.

Where are we at now?

Dr Jim Corbett exiting from his solo practice at 30th June 2018, that is servicing the Waimarino community.

How will we achieve this?

- Establishment of a legal subsidiary company that is wholly owned by WRHN by May 2018 and will be known as Ruapehu Health Ltd.
- Establishment of Board of Directors that consist of WRHN board, Iwi and Waimarino community representation that are competent and experienced in governance roles.
- Recruitment of an operational workforce that consists of medical, nursing, support and administration, who are a 'right fit' for the team, and are capable and competent.
- Support a smooth transition and transfer of business, through working alongside Ruapehu Doctors owners and operators.
- Provision of a communication plan and outcomes that ensures all stakeholders are fully informed.
- The Directors will explore with other providers and Whanganui District Health Board, the opportunity to create an integrated working environment for the wider health workforce at Waimarino

	Health Centre, to ensure sustainable and effective healthcare is delivered for the district. • Implement Manage My Health – Patient Portal into the practice, to enable patients to access their health information online.

Integrated Care

What do we want to achieve	General Practice teams supported through integrated acute demand strategies
Why is this important?	Traditional models of care are not sustainable given the population demographics, number of presentations, aging workforce and changes in technology
Who will we work with?	Service level alliance (integrated care) General Practice members, Clinical Governance
WRHN leads	Julie Nitschke, Janine Rider, Clinical Directors, WRHN leaders

OUR PERFORMANCE STORY 2018-19

How will we know if we are successful?

Primary care able to deliver better patient and staff experience, improved quality of care and greater efficiency through a common vision district wide for acute demand service co-ordination; supported through a shared/collaborative approach.

Where are we at now?

Currently continuous quality improvement initiatives are under taken as a component of cornerstone, foundation standards or through SIA funded initiatives.

The traditional General Practice model may be difficult to align with the vision that strategists propose within a changing health environment.

Variable evidence of an integrated care model operating across the district.

A transition plan for the district wide collaborative pathways yet to be agreed by Whanganui Alliance Leadership Team (WALT).

A collaborative approach has begun through development of a district wide Winter Plan.

How will we achieve this?

Q1: Factual data will evidence and quantify WRHN observations that General Practice(s) are demonstrating signs of pressure and that demand at times exceeds client access expectations and the definition of access to General Practice in a timely way.

Q2: Findings from the data review will be socialised with all General Practice members and there will be agreed strategies that are co-designed to respond to quantified risk.

Q3: WRHN subsidiary clinic leaders will explore the value and appropriateness of piloting Health Care Home models, to deliver best practice outcomes for patients.

Q4: WDHB will endorse the pilots through a well worked through collaborative plan and agreement to monitor patient improvements.

Q1-Q4: Participate in regional collaborative clinical pathway development and leadership groups to drive change.

Work to improve equity in outcomes and patient experience as measured by the atlas of variation for diabetes.

	Implement Continuous Quality Improvement initiatives as outlined in district wide priority areas, quality standards for diabetes care. Continue streamline supporting infrastructure within General Practice teams through; - Streamlining outbox documents/ advanced forms utilised in general practice - Amending clinical decision tools to ensure fit for purpose - Increase utilisation of population health data to inform CQI initiatives and priority areas for development - Increasing utilisation of therapeutic drug monitoring tool Targeted ongoing workforce development on long-term conditions, health literacy, self-management, effective use of clinical decision tools, standardised coding. Participation in collaborative of district wide health promotion campaign, which supports prevention and early intervention strategies for diabetes/CVD. General Practice teams up-skilled on assessment tools and community resources, for supporting person with dementia to remain in their own home.

Flexible Funding Pool

What do we want to achieve?	Services able to be purchased to meet the needs of our community
Why is this important?	Currently Care Plus and Services to Improve Access funding is cumbersome for practices to access, with the focus being on accessing funding rather than approaches to care delivery
Who will we work with?	Wide range of stakeholders
WRHN leads	Julie Nitschke, Clinical Directors, GPs, Phil Murphy, Brad van Bakel

OUR PERFORMANCE STORY 2018-19

How will we know if we are successful?

A flexible range of funding/services are available that can meet the needs of individuals who need them.

General Practice teams are able to purchase services that are tailored to the individual needs of their enrolled population, recognising that some people will need more help and care than others.

Funding models align with home-based treatments, condition specific pathways, St Johns local pathways, support acute demand framework.

Where are we at now?

WRHN has two separate funding pools; Careplus and Services to Improve Access (SIA) funding, each of which is claimed for separately. It is now timely to build upon work already undertaken and streamline supporting infrastructure to reduce duplication of effort.

Primary Options Acute Care (POAC) funding model is not in place across the district.

How will we achieve this?

Using a co-design approach, explore changing the claiming model to allow flexibility of service provision by General Practice teams; to ensure their enrolled population funding support that drives better access and utilisation of a range of General Practice health care options.

Q1: WRHN will articulate a range of researched options for consideration by General Practice, to move towards a more flexible funding pool investment.

Q2: WRHN will seek endorsement from WDHB regarding those options that are supported by General Practice members and WRHN via Collaborative CD Forum / Whanganui Alliance Leadership Team.

Q3: A flexible funding pool will be established and the associated processes will be developed prior to go live date (the associated measures will be sensitive to match each practice's population needs and priorities).

Workforce Development

What do we want to achieve?	Develop and implement a five-year nursing workforce development plan to grow a skilled and competent primary care nursing workforce
Why is this important?	Aging workforce, increased expectation of workforce operating at top of scope of practice, increasing complexity of persons presenting
Who will we work with?	HWNZ, DHB, NZNO, practice nurses, specialist nurses
WRHN leads	Julie Nitschke, Tina van Bussel, Janine Rider, Clinical Medical Lead

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How will we know if we are successful?

Workforce capacity and capability within the primary care sector supports a learning environment.

Where are we at now?

- Training needs analyses completed in 2015 and three years' workforce development framework endorsed by clinical governance
- National e-learning platforms accessible to General Practice teams
- Royal NZ College of General Practitioners reinstated locally
- Goodfellow platform accessible locally by GP teams
- Nurse Practitioner and nurses working towards prescribing status growing in primary
- PDRP annual appraisals imbedded in most General Practices
- NETP placements available within GP teams
- Combined orientation day for all new GP staff and nursing students

How will we achieve this?

Q1: An evaluation of the 2015 Workforce Development Framework will be undertaken capturing all key stakeholder views.

Learning's from the evaluation will be shared and discussed with General Practices and key deliverables will be agreed for next steps.

Q2: Collaboration with specialist services creates a robust infrastructure that includes peer support and up-skilling for primary care workforce.

A medical workforce predictive plan calculates the volume of new GPs required to maintain services across the member practices over the next 10 years. This knowledge is utilised to support a training plan that is inclusive of Trainee Interns in General Practice / RMOs and Registrars in General Practice, that is considered within a system wide approach.

Q1-Q4: Explore district wide alliances, inclusive of alternative providers and NGOs, to build capability in the primary care workforce through driving collaborative change for the system.

Q2-Q3: Primary care workforce development plan aligns with integrated district wide approach.

	Q1-Q4: Practices are trained and supported to use structured continuous quality improvement tools to improve patient's access to services.

Very Low Cost Access Practices (VLCA)

What do we want to achieve?	To support VLCA practice members to maintain viability, attract a vibrant workforce and deliver clinical services to high need patients that are integrated and collaborative with the practice, to ensure the population's health needs are met
Why is this important?	Low cost access to General Practice services is essential for those patients who are socio-economically compromised and have complex health and social needs. WRHN supports all people across our district having access to affordable General Practice and primary health services.
Who will we work with?	Gonville Health, Te Oranganui, Taihape Health and Ruapehu Health
WRHN leads	Judith MacDonald, Janine Rider, Gemma Kennedy, Te Ringa Te Awhe

OUR PERFORMANCE STORY 2018-19

How will we know if we are successful?

All VLCA General Practices have cooperative and effective relationships with their Iwi health partners, to ensure services such as Whānau Ora are working collaboratively with the General Practice service.

Where are we at now?

Informal relationships exist in all areas; however, a formalised approach with clear agreed outcomes and measures will build trust and create greater progress for our most vulnerable populations.

Ruapehu Health Ltd established as a WRHN subsidiary company and operational from 1 July 2018.

How will we achieve this?

Q1: All practices and their Iwi partners have a document that describes what their shared vision looks like.

Q2: Evidence of shared initiatives that demonstrate working together achieves best health and social outcomes for their shared population.

Q3: Evidence that working together has addressed inequity in health target performance for Māori in the priority target areas agreed.

Q4: Evaluate success and opportunities for improvement that have occurred with Iwi partners and develop a strategy for the next annual period, before business year end.

Data and Business Intelligence

What do we want to achieve?	The provision of infrastructure, information and applications to health service planners, funders, providers and consumers
Why is this important?	The provision of accurate information and fit for purpose applications is fundamental in achieving WRHN strategic goals
Who will we work with?	General Practice members, WRHN workforce and governors, key external stakeholders such as funders and planners, contractors, suppliers and patients
WRHN leads	Teresa Hague, Phil Murphy, Gerard Gregory, Robin Howard, Darin Bailey, Brad van Bakel

OUR PERFORMANCE STORY 2018-19

How will we know if we are successful?

WRHN business information suite is capable of reporting robust, timely and relevant information that shapes clinical service models and priorities, and creates internal efficiencies.

IT infrastructure and applications are fit for purpose and reliable.

Internal and external stakeholder satisfaction.

Online presence enables internal and external stakeholders to obtain and provide business information.

Provision of bureau business and information services.

Where are we at now?

Enterprise planning resources produce core reporting but integration, timeliness, range and efficiency could be improved.

WRHN health data platform (WETA) is able to extract and analyse WDHB and WRHN member practice health data.

How will we achieve this?

Q1: Enterprise resource planning (financial) systems are implemented as planned.

Q2: WRHN in-house application (WETA) is automated and includes data from WDHB WebPAS system and the NHC data repository.

Content management solutions are scoped and WRHN website is upgraded.

Business information insights are determined and prioritised. Profiling, financial and clinical measures are prioritised according to strategic, annual, contractual and legislative priorities.

Q3: Information from enterprise resource planning software, WRHN population health database and WRHN in-house clinical database (WETA) is integrated within Microsoft Power Business Intelligence software, to produce business insights that inform WRHN governors and management, General Practice, planner/funders and WRHN community.

Recommendations from IT infrastructure reviews are fully implemented.

GPs are receiving some reporting of key measures, including SIA, Care Plus and ASH. Data is pushed to General Practice, but there is no electronic pull mechanism. Assessment of IT infrastructure risks and capability has been completed for WRHN and its subsidiary companies (including Waimarino). WRHN currently provide IT, management, and financial services and infrastructure to WRHN subsidiary clinics, member practices and outsourcing entities.	**Q4:** Elimination of redundant software applications and platforms. Internal controls, audits and system mitigation plans are in place. Business information is available on the WRHN website.

Manage My Health – Patient Portal and Shared Care Record

What do we want to achieve?	To encourage the uptake of Patient Portal in General Practices, implement the Manage My Health (MMH) software and encourage the registration of enrolled populations. To promote the utilisation of the Shared Care Record throughout primary/secondary care.
Why is this important?	Patient Portal provides patient access to their primary care record and empowers them to take some control of their health and wellbeing. The Shared Care Record allows the patient's primary care record to be accessed by clinicians, across services and regions. Supporting the MoH strategy of a shared electronic health record for all and keeping up with technological advancement.
Who will we work with?	General Practice members, Medtech, Compass Health, Central PHO, MidCentral DHB, Whanganui DHB, Whanganui Accident & Medical, WRHN enrolled population
WRHN leads	Karen Veldhoen and Ken Young

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How will we know if we are successful?

By the number of practices participating in Patient Portal and by the number of their enrolled population who have been registered onto the system.

The utilisation of the Shared Care Record will be identified by the number of patient health records accessed by WAM and WDHB clinicians.

Where are we at now?

As at end June 2018, Aramoho Health Centre, Bulls Medical Centre and Gonville Health Ltd collectively have 1680 patients registered to Patient Portal. Springvale Medical Centre, Taihape Health Ltd and Stewart St Surgery are at varying degrees of implementation, and Ruapehu Health has requested set up during 2018.

The Manage My Health sub-contract with Compass Health concludes 30 June 2018. After Compass Health's PMS review in

How will we achieve this?

Q1-Q4: Complete setup of Patient Portal in participating practices. Promote and encourage further uptake. Implement and support any additional practices wishing to take part.

Q1-Q4: Introduce the Indici product to General Practices, as a future option.

Q1: Determine the need for the Shared Care Record at WAM. Identify the barriers for the GPs and work towards resolving these.

Q1-Q4: Implement a titrated process for practices in sharing patient notes through the Shared Care Record.

Socialise practices towards sharing patient notes in the Shared Care Record, to minimize the practice drop-out of MMH.

2017, the central region is commencing implementation of Indici (inclusive of a Shared Care Record). WRHN will maintain a Manage My Health sub-contract with Compass for a further year, with the intent of reviewing going forward.

Since the Shared Care Record commenced in December 2015, the hospital clinicians have accessed it 68,219 times (primarily for classifications, medical warnings and medications) and WAM clinicians have accessed it 891 times.

Whanganui DHB have agreed to fund the MMH Shared Care Record component (from January 2018 onward), on the proviso that practices include their patients notes within the Shared Care Record from 1 July 2018.

Vulnerable Children – Keeping Kids and Their Families Healthy

What do we want to achieve?	Early identification and intervention in vulnerable children's lives to promote reduced admission to hospital and reverse reliance on social service to achieve vibrant education performance
Why is this important?	Early intervention in children's lives can prevent or indefinitely delay the onset of chronic illness
Who will we work with?	Healthy Homes, Quit smoking service, Healthy Families, General Practices, Oral health team, Well Child services
WRHN leads	Janine Spence, Nicola Metcalfe, Pushpa Wati, Sue Hina, Angela Weekly, Sala Temo

OUR PERFORMANCE STORY 2018-19

How will we know if we are successful?

General Practice teams will be able to confidently identify range of issues related to children including obesity, non-accidental injuries and/or neglect, and ASH conditions, and to have a plan in place to monitor and support or to refer to appropriate agencies.

Reduction in Ambulatory Sensitive Hospitalisation rates – see ASH section.

Reduction in obesity rates, through 95% of clinically obese children identified at Before School Check (B4SC) referred to a health professional for clinical assessment, family based nutrition, activity and lifestyle interventions.

Reduced oral decay in 5 years olds through decreased DNA rate in pre-schoolers.

Increase in smokefree homes.

Where are we at now?

Understanding of Vulnerable Children's Act 2014 is variable and as a result there is inadequate understanding of the responsibilities and referral pathways to engage support for children in need.

How will we achieve this?

Q1: Promote and support early identification of at risk children with specific cultural Māori and Pasifika focus within the community, and to ensure early access and/or referral to appropriate services, to wrap around services.

To assess for impact of family harm and support any declaration to ensure they access the right wrap around services to support positive change for the child and whānau.

To promote Be Smarter and sticker chart tool from HPA to primary health teams.

Use of children's team, Oranga Tamariki Ministry of Children and non-Government organisations to identify and mitigate underlying social determinants.

Q1-Q4: Support General Practice teams to ensure that responsibilities around the Vulnerable Children's Act 2014 are achieved in General Practice.

Q1-Q4: Advocate for all practice staff to complete training in Child Abuse Prevention and Neglect, and all practices having policies and procedures.

92% of clinically obese children identified in the B4SC national report in May 2017, were referred/under care or declined referral as above. Inequity in obesity – 7.1% of Whanganui children (6.7% nationally) who completed B4SC in 6 months to May 2018 were obese = 37 children.	Practices have the support needed to ensure no child continues to be subjected to abuse or neglect. **Q2-Q3:** Ensure that all children identified as clinically obese at the B4SC check are referred to an appropriate practitioner for lifestyle modifications and intervention; enabling families to support their children to maintain or achieve a healthy weight. A specific focus will be placed on our Māori and Pasifika population. **Q1-Q4:** Participation in forums such as Oranga Tamariki panel, Children's Team Panel and Health Education & Disability Services (HEADS) and Family Violence Intervention Services, to strategically/proactively view common needs and formulate plans to manage/address identify health needs, including ensuring health records are accessible for the child wherever they might be. **Q1-Q4:** Continue to provide current demographic information to the oral health service at the time of the Before School Check. To encourage General Practice to complete lift the lip at every opportunity to ensure current demographic information is available to the dental unit. Review electronic 'Early Pregnancy Assessment Tool' (EPAT) to ensure mental health screening is captured effectively to identify risk and associated wrap around services in the community.

Reducing Sudden Unexplained Death in Infants (SUDI)

What do we want to achieve?	Targeted distribution of safe sleep devices to vulnerable unborn and newborn's
Why is this important?	To reduce SUDI rates by ensuring that every vulnerable infant has a safe sleep space for first four months of life. Ensure that partnerships enable wrap-around services to assess, educate and promote safe sleep messages.
Who will we work with?	General Practices, Lead Maternity Carers (LMC's), Well Child providers, Māori health services
WRHN leads	Janine Spence and Angela Weekly

OUR PERFORMANCE STORY 2018-19

How will we know if we are successful?

The Whanganui DHB SUDI rate will decrease to 0.4/1000 live births.

Where are we at now?

Current death rate of 3.02 per 1000 Māori infants between 2010-2014.

Total population death rate of 1.65 per 1000 between 2010-2014.

How will we achieve this?

Q1-Q4: Work with regional SUDI coordinator to implement and promote any national specifications as these become available.

Engage with Te Oranganui leaders to agree a shared strategy that supports a proactive response for those wahine that are not accessing services such as an LMC / Antenatal care / Whakakura.

Q1-Q4: Provide wrap around best practice options for Healthy Homes, pregnancy and parenting and safe sleep device distribution for individuals and/or populations, to reduce SUDI and promote Healthy Homes General Practice base.

Q2: Provide bi-weekly electronic update and bi-annual face to face education and support to distributors around new specifications, ensuring consistent messaging about safe sleeping and services ancillary to safe sleep (immunisation, smoking cessation, Healthy Homes).

Q1-Q4: Engage with and support discussion with wahakura weavers to investigate Wahakura Wananga mode of provision of safe sleep devices in partnership with Te Oranganui leaders.

Reducing Ambulatory Sensitive Hospitalisation Rates for Tamariki

What do we want to achieve?	Focus on eczema and asthma support/case management, to ensure all available support is wrapped around the young person and their whānau. Reduction in acute presentations to hospital for preventable admissions.
Why is this important?	Reduction in costs, financial and social for parents through education and appropriate self management
Who will we work with?	General Practice members, Secondary Care, Paediatric teams, Public Health
WRHN leads	Janine Spence, Phil Murphy, Sala Temo, Anne Kauika

OUR PERFORMANCE STORY 2018-19

How will we know if we are successful?

Decrease in ASH admissions rate for Māori by 1% from 9,421 per 100,000 to 8,337 per 100,000.

Parental awareness of self management strategies for children will result in decreased presentations to WAM/hospital. Less WAM/ED presentations through, increases GP access, resulting in reduced episodic care.

Where are we at now?

Through number of presentations anecdotally, indicates lack of confidence of parents to self manage childhood illnesses.

Increased presentations for under 13 year olds at WAM and General Practice.

Remain above national norm for ASH presentations in 0-4 years.

How will we achieve this?

Q1-Q4: Review WAM presentations regularly and implement strategies to promote self management resilience.

Participate / lead integrated initiatives arising from Child Youth alliance.

Use data to inform change within primary care.

Develop and utilise local and regional networks to support at risk families.

Pregnancy and Parenting

What do we want to achieve?	Antenatal education which is accessible, appropriate and responsive to the needs of the participants
Why is this important?	To promote safe birth experiences, by ensuring that women are well informed and prepared for the changes associated with labour, delivery and early parenthood. This will prevent Sudden Infant Death Syndrome (SUDI), non-accidental injuries and allow unborn to have better incubation conditions.
Who will we work with?	Lead Maternity Carers, Midwives, Childbirth educators, Well Child providers, General Practices
WRHN leads	Janine Spence and Angela Weekly

OUR PERFORMANCE STORY 2018-19

How will we know if we are successful?

Whanganui DHB target is 30% of primipara women birthing per annum attend antenatal education classes.

Where are we at now?

One Hapū Wahine class each quarter.

Two concurrent six-week classes quarterly.

Rural classes in Taihape/Waiouru, Marton and Waimarino, on as needs basis – aim to have a session in each rural region quarterly.

One-on-one classes for at risk women unable to attend group classes – one two-day weekend class per month.

How will we achieve this?

Q1-Q4: Build on and facilitate Māori (Hapū Wahine) antenatal short class concept, to specifically engage young Māori women to improve attendance by 50% for Māori wahine.

Q1: Hui to review/restructure and promote Hapū Wahine class.

Q1: Review and update evaluation survey.

Q1-Q3: Promote and facilitate quarterly antenatal classes in Southern Rangitikei, Waimarino and Taihape, as the need arises.

Q1: Promote WRHN antenatal classes via social media and print media.

Q1-Q4: Attend and support Whanganui Maternity Quality & Safety forum and facilitate initiatives to improve pregnancy and parenting outcomes including breastfeeding, Smokefree and Safe Sleep device use.

Q1-Q4: Continue to review/restructure antenatal education options, to engage vulnerable women with fit for purpose antenatal education options.

	To continue to provide a General Practice view and support collaboratively with Te Rerenga Tahi – Maternal Care & Wellbeing Group (MCWG). Promotion of Well Child app to enable families to track Well Child checks and health information. To encourage and support early engagement with LMC through Early Pregnancy Assessment Tool (EPAT). Target 90% pregnant women registered with LMC in first trimester with specific focus on equity. To promote and review electronic EPAT, to ensure mental health screening is captured effectively to identify risk and associated wrap around services in the community. To encourage primary care providers using EPAT tool, to refer first time pregnant first trimester women to WDHB dental unit for free check-up and clean (must be completed in first trimester). To encourage, via General Practice, the early registration of pregnant women with Lead Maternity Carer, using principles of 5 in 10 resources.

Reduce Prevalence of Tobacco

What do we want to achieve?	Reduction of prevalence of smoking in WRHN enrolled patients, with a focus on reducing smoking rates for priority groups, including Māori, Pacific and in pregnancy
Why is this important?	Tobacco remains the lead cause of preventable death
Who will we work with?	WRHN General Practice members, Ngā Taura Tūhono (Stop Smoking Service) including Te Oranganui, Health Solutions Trust, Whanganui DHB Tobacco Advisory Group and Smokefree staff, and other stake holders as appropriate
WRHN leads	Anne Kauika and Tai Turia

OUR PERFORMANCE STORY 2018-19

How will we know if we are successful?

- Decrease in prevalence rates of WRHN enrolled patient smoking cohorts
- Increase of priority groups accessing the Stop Smoking Service
- Increase referral rate from General Practice prescribing Stop Smoking Medication (Champix/Zyban)
- Increase awareness among WRHN primary care teams and patients of 'Vape to Quit'

Where are we at now?

Ngā Taura Tūhono is in their second year of operation as an integrated service. Data to the end of March (Q3) shows the service has received 1095 referrals and enrolled 505 clients (in the first three quarters of the service); the service target for enrolled smokers is 510.

How will we achieve this?

Q1-Q4: Ngā Taura Tūhono Stop Smoking Service.

- Maintains four week quit rate of 50%
- Minimum of 5% of current smokers access service (equitably) in third year. Number = 510

Q1-Q4: General Practice meets and maintains tobacco target supported by stop smoking service and WRHN population health team.

Work with General Practice teams to increase referrals for behavioural support, alongside prescribed medication.

Introduce 'Vape to Quit' options, where NRT and cessation medication has been ineffective.

Mental Health, Alcohol and Other Addictions – Wellbeing Approach

What do we want to achieve?	That the Wellbeing Approach is fully embedded in General Practice and that the system will continue to move towards integration between primary, secondary and NGO services. A seamless stepped-care model with no barriers to the 'right person, right place, right time' principles.
Why is this important?	Mental health and physical health are closely connected; an early intervention whole of person approach, providing services and support in the right place, is required to reduce the inequities which have traditionally existed.
Who will we work with?	WDHB, General Practice members, NGO and consumer advocates
WRHN leads	Julie Nitschke, Sarah Murphy, Janine Rider, Sala Temo

OUR PERFORMANCE STORY 2018-19

How will we know if we are successful?

- The Wellbeing Modules are being used by all General Practice teams to support assessment, care planning and referrals
- Evidence of application of learning's from primary mental health nurse credentialing programme
- Provision of quality referrals results in improved access to primary, secondary and community services
- Reducing inequity for persons with mental health and addictions through metabolic monitoring
- Enhanced outcomes for patients accessing services across the sector

Where are we at now?

- All practices have access to and are trained in the use of the wellbeing modules
- Updated referral management system implemented
- Number of nurses participating in current round of credentialing
- Volume of extended consults used 2017/18
- Variance in monitoring metabolic syndrome

How will we achieve this?

Practices which use extended mental health consults have a minimum of one nurse who has completed the primary mental health credentialing programme.

Promoting nurse extended consults by credentialed nurses and exploring whether funding should be on provision of credentialing to assure quality.

Responding to priorities that arise from national mental review.

WRHN promotes redeveloped model of care being rolled out by WDHB Community and Mental Health Addictions Services.

Support a process in General Practice to appropriately manage metabolic monitoring.

Gonville Health Ltd

What do we want to achieve?	Provision of clinically safe and consumer focused, sustainable and integrated primary care services that are co-designed with the consumer so that we continue to reduce health inequalities and improve in overall wellness of a high needs population
Why is this important?	Improved and sustainable access to primary care services with a focus on reducing inequities that have traditionally existed for high need populations, most specifically Māori, Pacific Island and low income whānau
Who will we work with?	Consumers, Gonville Centre partners, other health and social services, Gonville Health consumers and the Gonville community
WRHN leads	Janine Rider, John McMenamin, Bev Foster, Colleen Dudley

OUR PERFORMANCE STORY 2018-19

How will we know if we are successful?

- Integration or collaboration with other health and social services, which will result in improved outcomes for the Gonville Health Ltd (GHL) population, e.g. GH Pharmacy, Iwi services, mental health services, district nursing, Ministry of Social Development.
- GHL will continue to be a preferred and clinically safe practice for high need patients seeking low cost care. The practice will maintain an enrolled population of 70% of patients that meet high needs criteria and evidence of a reducing gap in inequities for Māori, Pacific Island and Quintile 5.
- Continued growth of high need patients enrolled in Gonville Health, as evidence of cultural responsiveness and patient satisfaction. Infrastructure is developed and managed to support expected the growth.
- Sustainable and innovative workforce model that is future proofed for local General Practice. The model progresses a comprehensive and responsive service

How will we achieve this?

Q1-Q4: Explore integration and collaboration opportunities with MSD, WDHB, TOIHA and WRHN, in a way that promotes the principles of 'right place, right, person right, right time', particularly for our high need population.

Q1-Q4: Specific focus on reducing the inequities that exist for our high needs population, particularly for service level measures, population health targets and clinical indicators.

Q1-Q4: Infrastructure plan is developed and agreed by governance/community leaders, which enables GHL to respond to a continually increasing population.

Q1-Q4: Specific actions from the principles of the Healthcare Home are agreed with consumers and embedded as part of standard practice.

Q1-Q4: Establish GHL as a training site for clinical workforce, e.g. Trainee Interns, Registrars, nursing students, nurse prescribers and Nurse Practitioners, as an opportunity to bring skilled workforce to the

for high need individuals. A business case developed and approved by the GHL Board of Directors, that supports GHL as a training site. • Consumer Group and Health Quality and Safety Commission are partners in whakakotahi project, which is rolled out successfully by June 2019.	region and work in a way that reduces health inequalities for our high need populations. **Q1-Q4:** Successful roll out of whakakotahi project, Health Quality and Safety Commission that evidences consumers as partners in improved services and systems for high need patients. **Q1-Q4:** Volunteers demonstrating interest in supporting the Gonville Health team to be successful in engaging with the enrolled population.

Taihape Health Ltd – Health Promoting Practices Quality Framework

What do we want to achieve?	A positive and supportive working environment
Why is this important?	It will aid recruitment and retention of staff, as people who feel valued are more productive. It encourages and strengthens teamwork. Promoting health and wellbeing in our workplace is positive role modelling for our community.
Who will we work with?	THL staff and WRHN Health Promotion staff
WRHN leads	Sarah Collier and THL Workwell Team

OUR PERFORMANCE STORY 2018-19

How will we know if we are successful?

In the 2017/18 year, Taihape Health Ltd (THL) received education from the WRHN Health Promotion about the WORKWELL programme.

Staff were surveyed and the results used to formulate a Health Practice Plan.
THL staff have formed a Work Well Team.

We will know if we are successful when Work Well practices are embedded in the Team and the staff report an improvement in their wellbeing on resurvey.

How will we achieve this?

Q1-Q4: Work Well team will have a regular slot in Team meetings. Healthy Activities and Recipes are shared as part of our routine.

Q1-Q4: Bronze Standard Action and Evaluation Plan will be completed.

Taihape Health Ltd – Working Collaboratively

What do we want to achieve?	To improve our populations health through working collaboratively
Why is this important?	We need to work collaboratively in a rural area to ensure our services are strong and sustainable. Geographic isolation can cause inequity of access to services.
Who will we work with?	Mokai Patea, Older & Bolder, Taihape Physio, Jigsaw, Arohanui Hospice, Accessibility, Homecare NZ, WDHB Mental Health, CART & Specialist Services
WRHN leads	Inter-disciplinary Team

OUR PERFORMANCE STORY 2018-19

How will we know if we are successful?	***How will we achieve this?***
Taihape Health Ltd (THL) patients and whānau will experience a 'no wrong door' approach to accessing services. Rural services have traditionally worked well together to find local solutions to services gaps. THL holds MOU with MPS and Arohanui Hospice. THL has contractual relationships with other local providers. There is an established Multidisciplinary team for both Mental Health Service Providers and Primary Health Clinical Team. THL has begun to utilise data provided by the WRHN team, to identify groups within the population who need additional support. We have begun to establish regular clinics with WDHB Nurse Specialists and WRHN Pharmacy Facilitator to monitor patients with long-term conditions. THL has a Services to Improve Access Plan, to ensure patients have access to screening and diagnostics to support self-management.	**Q1:** Evaluation of a range of population health data from a variety of data repositories will inform and shape strategy and respond to unmet or emerging need. This will guide the THL Directors to consider alternative models of care to support prevention and management within a community setting. Service Level Agreements with local providers helps sustain those services in the community. Services to Improve Access (SIA) initiatives facilitate access to services for priority need within the enrolled population. Workforce development initiatives; - Enable access to e-learning platforms and specialist mentorship in primary care, i.e. spirometry training, insulin titration, IV training

Taihape Health Ltd – Very Low Cost Access Practices (VLCA)

What do we want to achieve?	To work with the support the VLCA practice members are offered to maintain viability, attract a vibrant workforce and deliver clinical services to high need patients that are integrated and collaborative with the practice, to ensure the population's health needs are met
Why is this important?	Low cost access to General Practice services is essential for those patients who are socio-economically compromised and have complex health and social needs. WRHN supports all people across our district having access to affordable General Practice and primary health services.
Who will we work with?	WRHN, Mokai Patea Services, Taihape Health
WRHN leads	Gemma Kennedy

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How will we know if we are successful?

All VLCA General Practices have cooperative and effective relationships with their Iwi health partners, to ensure services such as Whānau Ora are working collaboratively with the General Practice service.

Where are we at now?

Taihape Health has a formal Memorandum of Understanding with Mokai Patea Services and a Service Level Agreement for the provision of Health Navigator services.

Our Iwi Health Partners are represented on THL Board of Directors.

How will we achieve this?

Q1: Taihape Health Ltd (THL) will review and evaluate partnership MOU document this year with our Iwi partner Mokai Patea.

Evidence of shared initiatives that demonstrate working together achieves best health and social outcomes for their shared population.

Q1-Q4: Evidence that working together has closed the inequity gap in health target performance for Māori in the priority target areas agreed.

Evaluate success and opportunities for improvement that have occurred with Iwi partners and develop a strategy for the next annual period, before year end.

Taihape Health Ltd – Review Hospital Admissions

What do we want to achieve?	Ensure that patients who are admitted to hospital have the appropriate care plan or monitoring processes in place, to assist them with self management
Why is this important?	Reduction in costs, financial and social for parents through hospitalisation or Emergency Department visits
Who will we work with?	Secondary Care, Paediatric teams, Public Health teams, WRHN
WRHN leads	Taihape Health team

OUR PERFORMANCE STORY 2018-19

How will we know if we are successful?

Decrease in ASH rate.

Care plans in place for COPD patients, asthma and eczema children, vulnerable older adults and other frequent fliers.

Where are we at now?

Taihape Health Ltd (THL) has started utilising WRHN data to review hospital admissions and follow up patients discharged from hospital with telephone calls.

THL is utilising SIA funding to ensure patients are offered follow up with the Public Health Nurse and GP to ensure plans are in place.

How will we achieve this?

System Level Measures focus areas:

- Preschool dental enrolment
- 8/12 immunisation rate
- Asthma and eczema admissions
- Newborn enrolment rates

Focus on eczema and asthma support/case management, to ensure all available support is wrapped around the young person and their whānau.

Children who have been admitted to hospital are offered flu vaccinations and referral for Healthy Homes.

Adults with COPD are offered flu and pneumococcal vaccinations, and referral for Healthy Homes.

At risk patients with Long Term Conditions to have access to extended consultations and diagnostic service not otherwise funded.

Patients with Long Term Conditions are referred and monitored by the appropriate Specialist Service.

Encourage patients to register with the Patient Portal.

Taihape Health Ltd – Reduce Prevalence of Tobacco

What do we want to achieve?	Reduction of prevalence of smoking in our community, with a focus reducing smoking rates of priority groups where inequity exists
Why is this important?	Tobacco remains the lead cause of preventable death
Who will we work with?	Ngā Taura Tūhono and WRHN
WRHN leads	Sarah Collier and Jhan Power

OUR PERFORMANCE STORY 2018-19

How will we know if we are successful?

- Decrease in prevalence rates
- Increase in priority groups accessing Stop Smoking Service
- Increase in General Practice pharmacotherapy use

This year THL has worked with Nga Taura Tuhono to employ a Quit Practitioner, who has undertaken her initial training and is completing her qualifications. She has established the service in Taihape, Waiouru and Waimarino.

How will we achieve this?

Taihape Health Ltd (THL) meets and maintains tobacco target supported by Stop Smoking Service.

Monitor quit rates.

Use training as a platform to encourage increased pharmacotherapy prescribing.

Smokefree initiative to include oral health - "Brush your teeth after each meal and when you want to have a smoke" – give out toothbrushes and toothpaste to support this message.

Whanganui Accident and Medical Clinic Ltd

What do we want to achieve?	Provision of patient/whānau focused accident and urgent care services within a seamless 'one door' approach with WDHB Emergency Department
Why is this important?	To reduce health inequalities, reduce hospital admissions and improve the overall wellness of the Whanganui community
Who will we work with?	WAM patients, WRHN General Practice members, WDHB Emergency Department, funders and the Whanganui community
WRHN leads	Teresa Hague, Gina Halvorson, Athol Steward, Louise McFetridge

OUR PERFORMANCE STORY 2018-19

How will we know if we are successful?

WRHN member practices remain satisfied that WAM is the appropriate solution for them in meeting their after-hours obligations.

WAM supports General Practice, WRHN and WDHB in winter peak management.

WAM delivers patient focused services validated by acceptable waiting times and patient satisfaction.

WAM provides best practice triage services.

WAM contributes to preventable admissions and improved population health outcomes.

Where are we at now?

WRHN member practices have reduced on-call obligations but sometimes feel that they are called when the clinic isn't 'really' busy.

WAM has increased salaried medical FTE to further reduce reliance on General Practice to contribute to the after-hours roster and to increase medical cover over the winter season.

How will we achieve this?

Q1: Formalise policy and processes for activating third on call support.

Recruitment of medical FTE to further reduce requirement for third on call and to manage patient wait times during peak and winter peak times.

Formalise policy and strategies for managing peak times.

Q2: WAM has an equal voice in the progression of waiting area, triage and reception improvements.

Triage services are reviewed and new model is trialled with a secondary assessment nurse preparing patients and delivering population health screening and services.
Progress funding of POAC and pop health services.

Q3: Implement, evaluate and seek feedback from General Practice regarding on call requirements.

Evaluate peaks, wait times and medical workforce downtime.

Progress agreed waiting area management strategies.

WAM provides unfunded DVT services and opportunistic population health screening/services.	Evaluate triage and secondary assessment nurse. **Q4:** Final waiting room/reception, triage, waiting time, POAC and General Practice on call models in place.