Executive Summary

It is with pleasure that I introduce the 2017/2018 Annual Plan for Whanganui Regional Health Network (WRHN). This plan is inclusive of the eleven General Practice members that are aligned to WRHN, who are located within Whanganui city, Marton, Bulls, Taihape and Raetihi.

As at 1 July 2017, WRHN serves a total population of 56,889 patients. Forty-nine percent of the patients are recognised as high need and this represents an increase of 816 high need patients since October 2016 (when three practices exited from WRHN). WRHN have experienced an overall increase in population since October 2016 of 1167 patients.

The focus of this plan is on the important aspects of a healthy and vibrant primary health system, and in particular;

- Achievement of the national health targets
- Workforce retention, capability and capacity (at General Practice and at WAM)
- Patient-centred investment strategies operating in all General Practices, maximising Careplus and Services To Improve Access investment for high need populations
- Support the development of a culturally competent workforce in General Practice
- Working with Whanganui DHB and our alliance partner, National Hauora Coalition, to implement primary options acute care (POAC) models of care, supported by investment and workforce
- Data and business intelligence that drives decision making
- Implementing outreach and integrated strategies that support vulnerable children through demonstration of leadership, commitment and active participation in local and regional intersectorial activities

An overarching objective for WRHN is to support a vibrant and capable primary health system that has sufficient investment and allocation of funding to meet the burgeoning health needs of our population. Delivering health care across our district is tough, as there has been little tangible investment in primary care for some time. WRHN operates a community governed and clinically led organisational model that has sustained risk, adversity, change and opportunity over fourteen years. We look forward to another challenging year.

Judith MacDonald
Chief Executive

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

Whanganui Accident and Medical Board of Directors

- Michael Sewell (Chair)
- Carla Donson
- Dr David Rodgers
- Julie Nitschke
- Dr Rick Nicholson
- Judith MacDonald

Teresa Hague – Business Manager
Louise McFetridge – Practice Manager
Gina Halvorson – Clinical Nurse Lead

Gonville Health Ltd

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

Janine Rider – Services Manager
Dr John McMenamin – Clinical Director

Taihape Health Ltd

- Dr Ken Young (Chair)
- Norman Richardson
- Dr Antonia Hughes
- Barbara Ball
- Judith MacDonald

Gemma Kennedy – Clinical Services Manager

Documents guiding the WRHN Annual Plan 2017/18

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 District Health Board 2017/18 Draft Annual Plan

Whanganui District Health Board (WDHB) four specific commitments to support achievement of the vision of:
"Better health and independence though integrity – fairness – looking forward – innovation"

- Advancing Māori health and Whānau Ora
- Investing to improve health outcomes and live within our means
- Growing the quality and safety culture
- Rising to the Challenge to build resilient communities

Whanganui DHB System Level Measures 2017/18 Plan

Additional to the existing four System Level Measures (SLMs) implemented from 1 July 2016, are two further measures:

- Youth access to and utilisation of youth-appropriate health services
- Proportion of babies who live in a smoke-free household at six weeks postnatal

In 2017/18, 25% of Primary Health Organisation incentive pool funding will be paid on quarter four achievement of the following three SLM improvement milestones and two primary care health targets:

- Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0-4 year olds
- Acute hospital bed days per capita
- Patient experience of care
- Better help for smokers to quit
- Increased immunisation for eight month olds

Peoples Mental Health Report – April 2017

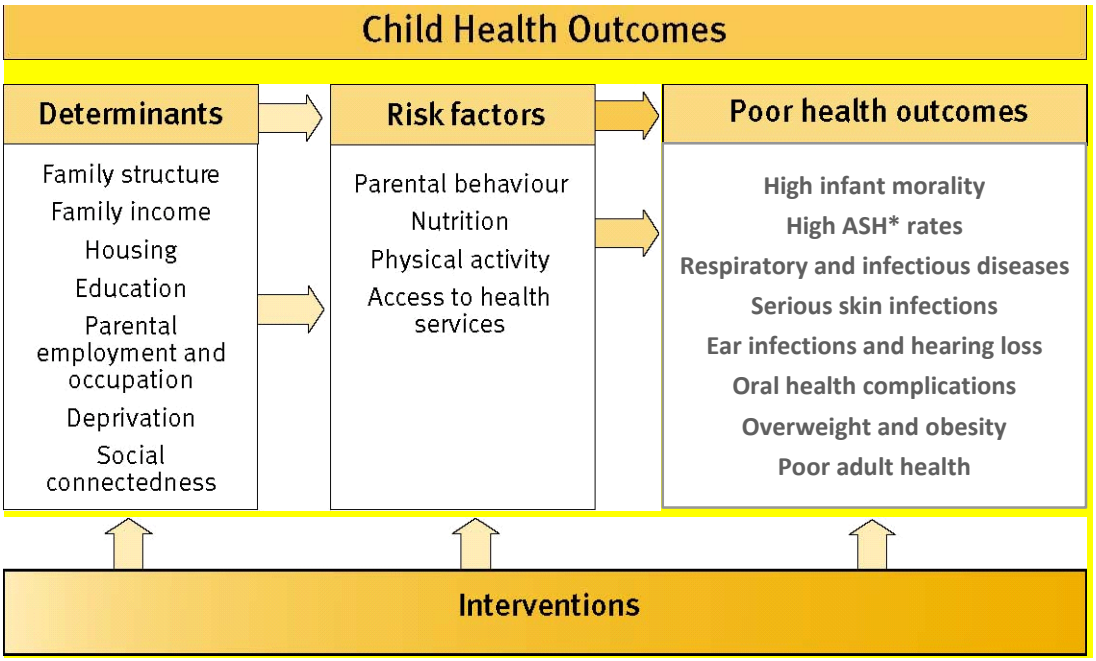
"Factors outside the health system – housing poverty, unemployment, discrimination, erosion of human capital, isolation and loneliness – are also affecting health and wellbeing. These factors also require attention, in their own right and in relation to health and social service."

Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018

Commitment to facilitate the delivery of high quality health services, which meet the needs of the Pacific peoples.

Whanganui Pasifika Health Action Plan (draft)

Causes of poor child health outcomes in Pacific children aged 0–14 years (Ministry of Health, 2008):



(Ministry of Health, 2008. Pacific Child Health: A paper for the Pacific Health and Disability Action Plan Review)

Areas of focus that WRHN will champion in 2017/18

Engaging with the community to provide innovative local delivery of solutions, using both national and local resources:

- High infant mortality – Sudden Unexpected Death in Infancy (SUDI)
- Respiratory disease
- Overweight and obesity
- Positive behavioural lifestyle change
- Health literacy and information
- Cultural competency of workforce
- Specific clinical project, i.e. Gout

Before beginning we require up to date data on the Pacific Island population in our region, so that activities are focused.

Better Public Health Services: A Good Start to Life – May 2017

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 Carers also connect mother and child with other core health services, such as General Practice, immunisation, Well Child Tamariki Ora and oral health services. They connect families to other social services that may be needed.

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.

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

Central Region Regional Services Plan (TAS) 2017/18

Whanganui Regional Health Network will 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
- Major trauma and stroke services

Health Promoting Practices Quality Framework (HPPQF)

Integration of health promotion into the primary healthcare General Practice setting enables General Practices to focus on population health, with the aim of achieving better health outcomes for their patients, whānau and wider community.

The HPPQF is underpinned by the Ottawa Charter, using a settings-based approach to improve health promotion in the primary healthcare setting.

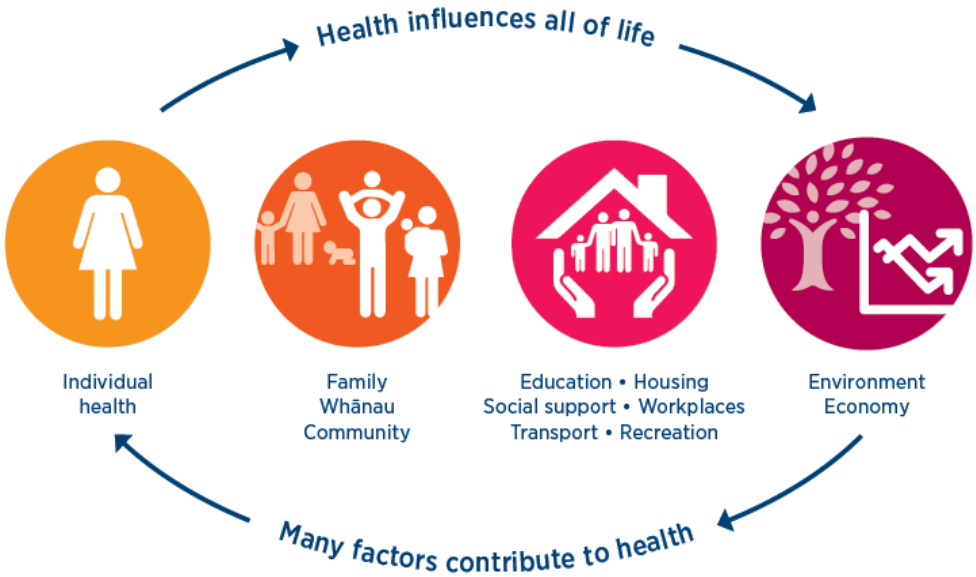
Domain
Population health: Reducing inequalities and reaching the whole population a. Having a knowledge of health inequalities and population health b. Reaching and screening high need populations and those who may not access healthcare or implement preventive actions (i.e. outreach services) c. Having comprehensive systems and processes for screening and prevention of serious health conditions d. Being aware of social and economic determinants of health
Health education: Improving knowledge and awareness around health literacy, self-management education, health information and skill development e. Health information f. Cultural competence g. Health literacy h. Self-management
Workplace wellness: Creating healthy workplace environments where there is an emphasis on the following i. Workplace wellness j. Team work k. Health promotion leadership l. Health promotion planning
Community action and participation: Supporting practices to be involved in their community and linking with other relevant organisations m. Partnerships with community groups n. Partnerships with other healthcare providers
Advocacy: Developing healthy public policy, which meets the healthcare requirements of the population o. Participating in community planning with council or other organisations p. Advocating for positive changes in public policy

The HPPQF can be used to guide General Practice teams when initiating health promotion activities and is supported by a self-assessment tool. This tool is designed to be completed by all practice staff, enabling discussion around the practices' current strengths and areas of possible improvement, with regard to the five domains listed, and an opportunity to identify quality improvement tasks. Completing the self-assessment tool on an annual basis could

indicate what progress has been made across the domains. Toolkits specific to current health priorities, including smoking cessation, diabetes, cardiovascular disease, immunisation and mental health, have also been developed. These toolkits contain information and ideas on training, tools, resources and networks that can be utilised to support the practices in achieving their goals in each area.

The HPPQF self-assessment tool and toolkits are currently being customised for the Whanganui region, and Gonville Health Ltd will be a development site to trial the framework, prior to its being offered to other General Practice teams.

The trial will include scoping what the mentoring and coaching support required by the practice would be, the resources required and developing links with other providers, i.e. public health and Iwi providers, and establishing who can work with the practice – predominantly around the areas of the framework involving workplace wellness, engaging with the community, and provision of advocacy.



(Ministry of Health 2015)

Health Promoting Practices Quality Framework

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 support consumers to self-manage and have improved health outcomes. General Practices play an important role in people's lives and are prime sites for wellness strategies. This framework is linked to cornerstone objectives, so is a resource to support practices to achieve their Foundation Standards or Cornerstone accreditation.
Who will we work with?	WRHN team, General Practice, Public Health, Iwi providers, NGO's, TLA's, community groups and individuals
WRHN lead(s)	Anne Kauika

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How will we know if we are successful?

Practices utilise the framework based on identified priorities that are relevant and meaningful to them.

WRHN will facilitate with General Practice members, activity that supports adoption of the Health Promoting Practices framework;

- Health promotion and Māori health plans
- Workforce development training
- Linkages with community and providers

Quality improvement (QI) initiatives using the self-assessment tool and PDSA (Plan-Do-Study-Act) cycles show improvement.

WorkWell bronze accreditation achieved by WRHN and at least four practices by June 2018.

Where are we at now?

Gonville Health has completed 12 months as a pilot site.

How will we achieve this?

Q1: Gonville Health to develop a Health Promotion Plan, based on learnings from pre and post assessments

Q1-Q4: The Health Promoting Practices concept and framework are promoted with best practice examples at Whanganui Inter-professional Education (WIPE) sessions

Q2-Q4: Health Promoting Practices training plan developed and facilitated by WRHN for General Practice members, i.e. determinants of health, cultural competence, health education, health literacy, community links

Q2-Q4: Support practices to identify QI initiatives using the self-assessment tool and utilise PDSA cycles to show change

Q1-Q4: Current WorkWell sites develop plans for achieving bronze accreditation in Q1 and are supported to achieve accreditation by June 2018

Whanganui Accident & Medical, Taihape Health, Ruapehu Doctors and WRHN have engaged in the WorkWell workplace health programme. Utilise learnings from Gonville Health and WorkWell sites to engage and support other practices.	**Q2-Q4:** Support other practices to engage in WorkWell

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 RNZCGP 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 lead(s)	WRHN Iwi and Māori Board members, Matt Rayner, Andre Mason, Judith MacDonald, Louise Oskam

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How will we know if we are successful?

All General Practice members will meet either Cornerstone or Foundation Standard level cultural competency in 2017/18.

Each practice will have a Māori Health Plan that is meaningful and relevant to the priorities identified by each practice.

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

1. Effective Whānau Ora
2. Achieving health equity for Māori
3. Improving capacity and enhancing capability

Build a Māori workforce that is reflective of the population of the region and each rural community, and consider other ethnic groups represented within the workforce which are reflective of that practice's population.

Report workforce by ethnicity at WRHN and each practice member to create a benchmark and monitor annually thereafter.

How will we achieve this?

Q1: Practices preparing for Foundation Standard accreditation in the first quarter receive Treaty of Waitangi (ToW) training (Springvale Medical Centre, Impilo Family Practice, Gonville Health, Aramoho Health Centre, Stewart Street Surgery and Whanganui Accident & Medical) from Rowan Partnership and are supported by WRHN to develop a 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.

Q1: 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.

Q1: 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 and Waiata are a core WRHN cultural activity, and how General Practice members will be supported to access this.

Where are we at now?	**Q1:** 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
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.	**Q2:** Second phase of practices are supported to develop their cultural competency plan and training (Wicksteed House, Taihape Health, Ruapehu Doctors, Bulls Medical Centre and St Johns Medical Centre) through attendance at ToW training via Rowan Partnership, and supported to complete their Māori Health Plan.
Need to establish a platform of measures for the primary health system and agreed with General Practice, which offers consistency and lines up markers for progress, which is reflective of professional standards, Foundation Standards and Cornerstone Standards.	**Q2:** 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.
Practices at varying stages of cultural competency.	**Q3:** Evaluate the success of the programme and explore with Te Haumoana team how a cooperative across-system programme can be developed for the WDHB District (taking the learnings of the previous activity).
Māori employees, contractors and locums operate within a system that is disconnected from the vision and values of our Māori/Iwi governors.	**Q4:** All practices have an agreed Māori Health Plan that defines their cultural competency and performance priorities by end June 2018. Evaluate how the programme has made a difference through reviewing a platform of data measures.

Integrated Care

What do we want to achieve?	To improve our populations health through working collaboratively.
Why is this important?	• Whanganui has the sixth highest amenable mortality rate in New Zealand • Ischaemic heart disease, cardiovascular disease, COPD and diabetes are ranked the top conditions for Whanganui DHB • From 2009 to 2013 there are significant inequalities for Māori, with a mortality rate of 264.7 compared to 102.8 for non-Māori
Who will we work with?	General Practice teams, WDHB, Mental Health and AOD service providers, NGOs, Iwi providers, key stakeholders and sub-regional alliances
WRHN lead(s)	Julie Nitschke, Phil Murphy, Louise Oskam, Anne Kauika, Chloe Mercer

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How will we know if we are successful?	***How will we achieve this?***
Collaborative pathways align with national strategy, best practice and contribute to system level measures. Whanganui DHB has agreed to a transition plan for the district wide governance of collaborative pathways. There is a focus on prevention and management of long-term conditions in the community. Health services are provided closer to home. Data will be used to inform decision making. There is agreed best use and flexible of our health and disability workforce. There is an emphasis on performance measurement with a culture of continuous quality improvement.	**Q1-Q4:** Best practice and associated infrastructure support implemented for Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure and Type 2 Diabetes across General Practice teams. **Q1-Q4:** Participation in the development of a district wide POAC payment management system. Implement and embed best practice for cellulitis management in the community (once district wide POAC model agreed). **Q1-Q4:** Development of a localised sub-regional collaborative pathway for gynaecological and prostate cancer, and reviewing breast cancer. **Q1-Q4:** Consumers have improved access and greater choice of self-management and education programmes/resources available. **Q1-Q4:** Build on the diabetes support group and explore options for other peer led groups for other LTC's, i.e. respiratory.

Where are we at now?

Up until 31st December WRHN will lead the development and use of pathways as an enabler to integrate care deliver and to contribute to achieving of system level measures.

WDHB have agreed to fund the contract for the collaborative pathways platform and to support associated costs until December 2017.

Primary Care is committed to implementing the national prostate cancer guidelines.

Positive uptake of PDRP by General Practice nursing workforce, with all General Practice teams having access to Ko Awatea e-learning platform.

Q1-Q4: Collaborate with Te Oranganui to develop and deliver an appropriate self-management programme within prison setting, as a component of the drug treatment programme.

Q1-Q4: Internal support systems streamlined to enable improved connectivity with services in the wider community:

- Adoption of e-referral and management system for all WRHN services, to support quicker access and transparent processes
- Single referral triage and management processes (internal)
- Align with e-referral developments for primary to secondary care services (Central Region project)

Q1-Q4: Use of data informs alternative models of acute care implemented to support prevention and management of person within a community setting.

Q1-Q4: Services to Improve Access (SIA) initiatives contribute to district wide system level measures.

Q1-Q4: Workforce development initiatives support:

- Local development of General Practice and accident and medical workforce
- Enable access to e-learning platforms and specialist mentorship in primary care, i.e. spirometry training, insulin titration, IV training
- Practices are trained in and supported to use structured continuous quality improve tools to improve patients access to services

Very Low Cost Access Practices (VLCA)

What do we want to achieve?	To support the 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, TOIHA, Ruapehu Doctors and Taihape Health
WRHN lead(s)	Janine Rider, 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?

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.

How will we achieve this?

Q1: All practices and their Iwi partners have a document that describes what their shared vision looks like and agreed priority outcomes for the 2017/18 period.

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 year end.

Social Worker in Primary Care

What do we want to achieve	Proactive support for vulnerable adults and/or family prior to entering the hospital system for elective services, and pre and post care management for vulnerable adults that have had an acute presentation/admission to hospital.
Why is this important?	People are assessed and supported in their home, so self-management strategies are explored before care options escalate to higher cost options.
Who will we work with?	Adult people who are enrolled with WRHN General Practice members
WRHN lead(s)	Pam Scott

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How will we know if we are successful?

Vulnerable adults/families who are accessing planned hospital care have determined (with support) the best care package that works for them, that is inclusive of their family, friends and existing social support where possible.

Care coordination includes assessment and care navigation supported by an integrated system to self-care.

General Practice members are supported in coordinating care for enrolled vulnerable patients/whānau prior to the patient experiencing a complex clinical hospital elective procedure and or pre/post a hospital admission.

Where are we at now?

Social Work service is hospital centric, focused on discharge from hospital care.

How will we achieve this?

Q1: Strengthen the equity of referrals to the Social Worker from General Practice, to ensure all General Practice members are participating and referring to the Social Worker, and referrals are appropriate.

Seek approval from the hospital service to enable the primary Social Worker to document directly into the hospital clinical record.

Q2: Formulate measures and data collection priorities that align to system level measures, so there is a framework for reporting data.

Q3: Scope with peers and colleagues across the city, a framework outline that supports a professional integrated social worker service operating across the health system (primary/secondary).

Q4: Mini trial, where patients experience is captured and the gains and opportunities for improvement shape a future model for the city that is collaborative, cooperative and integrated.

Data and Business Intelligence

What do we want to achieve?	The collection, analysis and utilisation of data from internal and external sources is the backbone for shaping health service outcomes and business decisions.
Why is this important?	Data is fundamental in showing the health status of the population, informing business and clinical decisions, and measuring outcomes and performance.
Who will we work with?	General Practice teams, WRHN workforce and governors, key external stakeholders such as funders, contractors and suppliers
WRHN lead(s)	Teresa Hague, Phil Murphy, Ben McMenamin, Gerard Gregory

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How will we know if we are successful?

WRHN business and financial reporting suite is capable of reporting robust, timely and relevant business insights and information, and creates internal efficiencies.

Just-in-time data influences decision making, informs potential and real population clinical risk, and focuses on highlighting inequality for Māori and other identified groups.

Data availability supports the delivery of comprehensive information on the health profile and status of the WRHN enrolled population, and transfers this information to WRHN stakeholders to shape clinical service priority and design.

WRHN provides improved online presence, enabling stakeholders to obtain the information they require.

Provision of bureau IT services to General Practice members.

Where are we at now?

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

How will we achieve this?

Q1: Scoping of enterprise resource planning applications is completed and an implementation plan is in place.

Complete in-house application development (WETA) to support data extract and analysis, and a system mitigation plan is established.

Scoping of General Practice IT infrastructure, provision of recommendations and a service agreement is in place.

Q2: Enterprise resource planning solutions are implemented as planned.

Profiling and clinical measures are prioritised according to annual, contractual and legislative priorities.

Internal controls, audits and system mitigation plans are in place.

Redundant business and financial applications are identified and contracts terminated.

Q3: Enterprise resource planning solutions are implemented as planned.

Information platform development (WETA) is almost complete for extraction and analysis of health data from WRHN General Practice members and key areas of local secondary services. GP's receive some reporting of key measures, including SIA, Care Plus and ASH. Data pushed to General Practice at regular intervals. No ability for General Practice to run on-demand reporting from WRHN data warehouse. WRHN currently providing IT support and infrastructure for WRHN subsidiary clinics. An expression of interest has been received from a member General Practice in WRHN being the provider of IT support services.	Profiling and clinical reporting is progressed as prioritised (quarter two). **Q4:** Enterprise resource planning solutions are implemented as planned. Key reporting is automated according to identified priorities.

Services to Improve Access (SIA)

What do we want to achieve?	Improved access for Māori, Pacific Island and quintile 5 patients, through provision of SIA funding to General Practices.
Why is this important?	Whanganui has a high Māori, Pacific Island and quintile 5 population. The government provides a funding to reduce inequity and improve access for this population.
Who will we work with?	General Practice members
WRHN lead(s)	Julie Nitschke, Ben McMenamin, Louise Oskam

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How will we know if we are successful?

General Practices will have agreed SIA plans in place, with baseline measures and specific objectives to be achieved using SIA funding.

The WRHN General Practice workforce are aware of and beginning to use quality improvement tools, with quality activity continually refined to meet each practice populations needs.

General Practice teams are informed through a suite of measures.

A claiming process is established that reflects a co-design approach.

SIA initiatives demonstrate improved access and a reduction in inequity for WRHN Māori, Pacific Island and quintile 5 enrolled population.

Successful initiatives are celebrated and shared across primary care.

Where are we at now?

All GP's have written plans in 2016/17 and have started delivery activity to the specified population.

How will we achieve this?

Q1-4: Using a co-design approach, General Practice teams are supported to undertake a structured approach to the utilisation of the SIA funds through;

- Providing each practice with their enrolled population data (analysis and reports) to enable risk profiling
- Provision of transparent communications on funding allocations
- Mentoring and coaching on application of quality improvement tools
- Identifying quality improvement initiatives to reduce inequity
- Developing a suite of measures for claiming to improve access to services
- Evaluating how the programme has made a difference through reviewing a platform of data measures
- Supporting each practice team to review their SIA plans and undertaking iterative change to meet needs of the population

There is varied understanding of the intent of SIA funding and its impact across General Practice teams. Practice teams are time poor and have limited understanding of quality tools and their application within the General Practice setting. A consistent suite of measure that support claiming and enables date analysis is yet to be established.	

Patient Portal

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.
Why is this important?	Patient Portal allows the patient access to their primary care record and empowers them to take some control of their health and wellbeing. It is a further step forward in the use of technology within health care.
Who will we work with?	General Practice teams, Compass Health, Medtech, WRHN enrolled population
WRHN lead(s)	Karen Veldhoen

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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.

Where are we at now?

Aramoho Health Centre, Bulls Medical Centre and Gonville Health Ltd commenced as pilots in early 2016. Bulls started registering patients straight away and numbers have steadily increased. Gonville was on hold until staff numbers were more stable and Aramoho has been on hold due to Evolution implementation, and the ongoing technical issues with this system.

The process has been lengthy; requiring resource development, data gathering, staff training, practice meetings and staff decision making, software implementation, testing and working through technical issues.

As the MMH contract is expected to be extended for a further year, we are able to maintain the Patient Portal implementation to practices who are interested in participating.

How will we achieve this?

Q1-Q4: Aramoho Health Centre and Gonville Health – Implement software updates. Encourage patient registration in practices. Provide support with staff education and technical issues.

Q1-Q4: Springvale Medical Centre and Taihape Health – Set up software and processes, test system, develop supporting resources, educate staff, encourage patient registration and support the resolution of technical issues.

Q1-Q4: Promote and encourage Patient Portal uptake. Implement and support any additional practices wishing to participate.

Manaaki Te Whānau – Immunisations and Enrolment

What do we want to achieve?	Sustain immunisation rates and follow-up non-enrolled clients who have been referred to us.
Why is this important?	Immunisation can protect people against harmful infections, which can cause serious complications, including death. It is one of the most effective and cost effective medical interventions to prevent disease. Enrolment with a General Practice ensures better access to all services.
Who will we work with?	General Practice teams, Paediatric ward, MoH, NIR, IMAC, Public Health, WDHB Immunisation Steering Group, Plunket, Tamariki Ora, Whanganui Accident & Medical, A&E, Iwi providers, Oranga Tamariki, Te Kōhanga Reo & early childhood centres, NGOs, WINZ and the Whanganui community
WRHN lead(s)	Sue Hina, Roz Jamieson

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How will we know if we are successful?

We aim to reach and maintain our 8 month, 2 year and 5 year immunisation rate targets (95%).

- 75% of the over 65 years population receives the influenza immunisation
- An increase in the number of children under 4 years old vaccinated
- An increase in the number of pregnant women vaccinated
- 75% of WRHN staff will be vaccinated for influenza

Where are we at now?

Quarter 4 for 2017 – 8 months 87%, 2 years 91%, and 5 years 90%.

The population that decline immunisations is increasing in an environment where the anti-vax movement is growing and are using social media as a vehicle to spread their ideas.

This presents a challenge to meeting targets, but the team will continue to monitor with specific strategies, to try and keep the

How will we achieve this?

Q1-Q4: General Practices are being encouraged to concentrate on families declining their baby's 6 week immunisation, making a special effort to recheck at each subsequent immunisation due date.

Q1-Q4: National Immunisations Register and our Outreach Immunisation service continue to provide a targeted service, working specifically with those children overdue for their immunisations; with an emphasis on those who are not connected to a General Practice or are Māori and Pacific people.

Q1-Q4: Review and strengthen relationships with NIR, General Practice MOH and WINZ to ensure the information available is up to date and relevant so that providers and support services are interacting to ensure the most a vulnerable receive on time immunisations.

Q1-Q4: Newborn enrolment processes will continue to be enhanced and monitored.

number at the lowest level possible. This along with a growing housing shortage within the WDHB region.	**Q1-Q4:** Practices will be encouraged to prioritise Māori and Pacific people, pregnant women and children under 4 years old, and people with co-morbidities, to get the influenza vaccination.

Manaaki Te Whānau – B4 School Checks

What do we want to achieve?	B4 School checks in the WDHB region, at or above target rates, with no inequity between populations.
Why is this important?	The B4 School Check aims to identify and address any health, behavioural, social or developmental concerns, which could affect a child's ability to get the most benefit from school; such as a hearing problem or communication difficulty.
Who will we work with?	Whanganui DHB, Active Family – Sport Whanganui, Healthy Families partnered organisations, Community Dietician, General Practice teams, Well Child providers, Iwi health organisations
WRHN lead(s)	Nicola Metcalfe

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How will we know if we are successful?

90% of the eligible population of 4 year olds will have completed a B4SC check during the year.

Where are we at now?

In the six months ending January 2016, 10% of children at B4SC checks were obese.

The obesity rate for Māori children is twice that of European, while the rate for Pacific children is four times the rate of European.

How will we achieve this?

Q1-Q4: All families/whānau/caregivers of 4-5 years olds who are identified as clinically obese, will have planned strategies in place to support the reduction of weight through healthy lifestyle interventions.

Q1-Q4: Monitor the B4SC equity of service to Māori and Pacific people families, ensuring all have access to strategies, including dietician support and Active Families programmes.

Q1-Q4: B4SC coordinator will work with General Practice teams, Te Kōhanga Reo, early childhood centres and WDHB Paediatric Wards, to ensure all eligible four-year olds are offered a B4SC check prior to 4 years 4 months old; with an emphasis on Māori, Pasifika and quintile 5 children.

Q1-Q4: B4SC coordinator will provide annual training to both new and those requiring updates, so that the General Practice teams have the capability to deliver B4 School checks to their enrolled population.

Manaaki Te Whānau – Cervical Screening

What do we want to achieve?	To increase the overall cervical smear rate and to achieve equity in the numbers of women from all populations who have a cervical smear completed within the recommended timeframe.
Why is this important?	Achieving equity will mean that Māori and Pacific people enjoy the same level of health status as non-Māori.
Who will we work with?	General Practice teams, Outreach team, Family Planning, Iwi providers, NSCP, Whanganui DHB, MoH, Public Health
WRHN lead(s)	Sue Hina, Nicola Metcalfe, Ben McMenamin

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How will we know if we are successful?

80% of women aged 20-69 will have completed a cervical screen within the previous three years.

Where are we at now?

Our three year total coverage to 30 June 2017 is 76%, with Māori 70% and Pacific 67% and 68% Asian.

How will we achieve this?

Q1: Deliver the annual 'smear taker update' to support smear takers to remain up to date on all information and/or any developments.

Q2: Utilise September national cervical screening month, as an opportunity to raise awareness of the importance of cervical screening. This includes community clinics being available during this month.

Q1-Q4: The Outreach team will follow-up, by a combination of letter, phone calls and face-to-face home visits, priority women who have not had a cervical smear. Transport, personal support and education will also be delivered as required.

Q1-Q4: Ensure Māori and Pasifika women aged 20-69 have access to culturally appropriate services in a wide range of settings and times.

Have the staff capacity to perform opportunistic services via the Outreach clinic settings.

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 burden on social service and education.
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 Practice, oral health team, Well Child services
WRHN lead(s)	Janine Spence, Nicola Metcalfe, Pushpa Wati, Tracy Matthews, Sue Hina, Angela Weekly, Sala Temo

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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 put 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.

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 Pasifica focus within the community and to ensure early referral to appropriate social work support, to wrap around services.

Use of children's team, Ministry of Vulnerable Children (MVCOT) and He Mokopuna He Taonga, as well as non-Government organisations to identify and mitigate underlying social determinants.

Q1-Q4: Work with General Practice teams to ensure that responsibilities around the Vulnerable Children's Act 2014 are understood and that there are processes in place to ensure these responsibilities can be achieved in General Practice.

Q1-Q4: Promotion of all practice staff having completed training in Child Abuse Prevention and Neglect and all practices having policies and procedures. Practices have the support needed to ensure no child continues to be subjected to abuse or neglect.

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 – 9.2% of Whanganui children (7.9% nationally) who completed B4SC in 6 months to May 2017 were obese = 37 children.

- 12% Māori =19 children (42% declined referral = 8 children)
- 21% Pasifica = 3 children (67% declined referral = 2 children)
- 6% = 14 other ethnicities identified as obese (43% declined referral = 6 children)

43% DNA rate at oral health check-ups for 0-5 year olds in year to March 2017, supplied by dental team at DHB.

Q2-Q3: Investigate Pasifica child health, including obesity, and consider strategies to support lifestyle changes and improve health literacy.

Q2-Q3: Investigate Māori child health and consider population strategies to mitigate onset of chronic disease.

Q2-Q3: Identify and support high deprivation populations of children to target identified needs particular to these families.

Q1-Q4: Participation in forums such as MVCOT panel, Children's Team Panel and HEADS, FVIAS 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.

Children's Team – Oranga Tamariki

What do we want to achieve?	Guide implementation of the Children's Team approach across General Practice in a collaborative across sector approach with other agencies, such as DHB, Iwi and NGO providers, Education, MSD, Police, Justice and Corrections.
Why is this important?	To provide and endorse a new way of working together; a partnership approach between local providers of children's services that will improve access and outcomes for vulnerable children across our district.
Who will we work with?	Whanganui Children's Team operations and governance group, General Practice members, WDHB and NGOs and Iwi
WRHN lead(s)	Jude MacDonald, Janine Spence, Tracey Matthews

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How will we know if we are successful?

Active participation at governance and community levels, in the shaping of how Children's Team and services work for our communities.

Where are we at now?

Referrals to Children's Team less than five per month.

Capacity for Lead Professionals exhausted in the city.

Reputation of Children's Team not favourable.

Confidence and capability of lead professional workforce requires rebuilding and motivation for the actions reignited.

Children Team vacancies for a Director, workforce lead and administrator currently exist.

How will we achieve this?

Q1-Q4: WRHN active member of local governance group attending monthly meetings.

WRHN host two whānau hui to identify opportunities to improve how the service operates, resulting in an increase in referral volume.

Child Health Services Coordinator and He Mokopuna He Taonga Coordinator interface;

- General Practice to improve capability in early identification of vulnerable children, through delivery of training, education and mentoring
- Provision of training and mentoring by facilitator, for the Lead Professional workforce to build confidence and capability
- Child Health Services Coordinator connects with all entry points of the health system and contributes to solution focused outcomes for children that improves timely access to services
- WRHN offer Lead Professional workforce capability to support a Whanganui city and Taihape Health response

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 Practice, Lead Maternity Carers (LMC's), Well Child providers, Māori health services
WRHN lead(s)	Janine Spence, Angela Weekly

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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: Review of safe sleep distribution, with focus on performance to date and how we can deliver the pepi-pods service most effectively, with the least coordination hours possible.

Q1-Q2: Roll-out of safe sleep calculator to LMC's, General Practice teams, Well Child providers and Māori health organisations to support decision making healthy conversations and targeted distribution of safe sleep devices.

Q1: Use of safe sleep calculator tool in distribution of pepi-pods. Review of pepi-pod distribution paperwork to ensure information for safe sleep calculator is obtained at time of distribution.

Q2: Determine new contract specifications, review and adopt national specifications. Provide 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).

Q2: Wahakura suppliers build on and increase amounts available for distribution. Dependant on contract.

	Q1-Q4: Wrap around 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.

Reducing Ambulatory Sensitive Hospitalisation Rates for Tamariki 0-4

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.
Why is this important?	Reduction in costs, financial and social for parents through hospitalisation or Emergency Department visits.
Who will we work with?	General Practice teams, Secondary Care, Paediatric teams, Public Health teams
WRHN lead(s)	Janine Spence, Phil Murphy, Sala Temo

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How will we know if we are successful?

Decrease in ASH rate for Māori by 1% from 9,421 per 100,000 to 9,327 per 100,000.

Where are we at now?

Baseline performance 12,312 per 100,000 year ending March 2016.

Performance target 2016/17 12,189 per 100,000.

Focus moved to Māori 2017/18 with a baseline 9,421 per 100,000 for 2016/17.

And the target for 2017/18 9,327 per 100,000.

How will we achieve this?

System Level Measures focus areas:

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

Q1: Investigate ability of WAM to begin coding ASH presentations, audit of outcomes – if enrolled and engaged with GP.

Q1-Q4: Work with Children's Ward and Public Health team to promote the referral of children from the ward to the appropriate back up service – Healthy Homes, pharmaceutical review, Public Health for review of school plan and supports.

Q1-Q4: Consider hospital ward visits to see who needs Healthy Homes referral – this would enable checking of Community Services Card eligibility at point of admission.

Q1-Q4: On-going monitoring of collaborative pathways uptake, education and promotion of action plans.

Q1-Q4: CGG to regularly review ASH rates, with particular attention to ethnicity and deprivation. Also to look at under 13 rates pertaining to lower respiratory tract infection and eczema.

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
WRHN lead(s)	Janine Spence, Angela Weekly

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How will we know if we are successful?

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

To increase attendance rate by 1%.

Where are we at now?

140 in 2016/17 to end of March.

715 births in 2016, therefore 215 needed annually to attend antenatal classes.

To end March 2017 we have had 187 (80 Māori) referrals to classes, but only 130 attended (43 of whom were Māori).

How will we achieve this?

Q1-Q4: Regularly run and build on Māori antenatal short class concept, to specifically capture young Māori women.

Q1-Q4: Investigate ways of gaining referrals for early pregnancy lifestyle class, aimed at 6-14 weeks of gestation.

Q1-Q4: Create video clips of services, such as SUDI, Wahakura, Well Child services, smoking cessation, etc, using mix of professionals and parent voices. Available for antenatal classes and on the WRHN website.

Q1: Review and amend evaluation survey.

Q1-Q3: Commence antenatal classes in Southern Rangitikei region.

Q1-Q4: Attend and support Whanganui Maternity Quality & Safety Programme Governance Group initiatives to improve pregnancy and parenting outcomes, including breastfeeding.

Q1-Q4: Grow antenatal education options, including more one-on-one classes for vulnerable women.

	To engage with Te Rerenga Tahi – Maternal Care & Wellbeing Group (MCWG). Multi-agency forum to ensure primary care voice. Not yet funded by Whanganui DHB, but hope will be in 2018/19. Some funding for half a role from Whanganui Maternity Quality & Safety Programme Governance Group. To review outcomes of rural antenatal education programme and build on experiences and lessons learnt, once this is available through Whanganui Maternity Quality & Safety Programme Governance Group. 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.

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?	Te Oranganui, General Practice teams, Heath Solutions Trust, Ngā Taura Tūhono, Whanganui DHB, Tobacco Advisory Group and other stakeholders
WRHN lead(s)	Anne Kauika, John McMenamin, Ben McMenamin, Janine Rider

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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

Where are we at now?

Ngā Taura Tūhono exceeded first year target for volume. Data to the end of March (Q3) shows that the service has received 1059 referrals and enrolled 530 clients (in first three quarters of service), which means it has already exceeded the 2016/17 goal of 510 smokers enrolled.

How will we achieve this?

Q1-Q4: Ngā Taura Tūhono

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

Q1-Q2: Continue to roll-out community, NGO and General Practice training, aligned to NTS Standards.

Use training as a platform to encourage increased pharmacotherapy prescribing.

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

Partner with Whanganui DHB and LMCs, to find innovative solutions to improve referrals for pregnant woman and support smoke free homes for babies.

Mental Health, Alcohol and Other Addictions – Wellbeing Approach

What do we want to achieve?	Support the embedding of the Wellbeing Approach in General Practice and improve integration between primary, secondary and NGO services to create a seamless stepped-care model.
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 exist.
Who will we work with?	WDHB, General Practice teams, NGO and consumer advocates
WRHN lead(s)	Chloe Mercer, Sarah Murphy

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How will we know if we are successful?

- Wellbeing modules being used to plan care by all GPs
- Workforce development plans in place for all General Practice team (aligned with WDHB)
- Community Mental Health and Addictions Network Model supports improved primary/secondary interface
- Referral management infrastructure enables improved responsiveness between General Practice, contracted providers and NGO
- Contract is within means and sustainable

Where are we at now?

- All practices have access to the wellbeing modules
- Adult extended consultations (FFS) available
- All SLAs and provider contracts updated in alignment with the wellbeing approach

How will we achieve this?

Q1-**Q4:** Workforce development plan finalised for primary care in Q1 and delivered (WDHB led activity).

Q1: Quality plan and Dashboard developed.

Q2-Q3: All practices are included in a capacity and capability plan, to ensure sustainability of the model (aligned with workforce development).

Practices agree sustainable funding mechanism for practice delivered services.

Q1-Q4: Practices have access to support, operational and strategic.

Q1-Q2: Updated referral management system implemented.

Q1-Q4: WRHN supported WDHB Community and Mental Health Addictions Services to redevelop model of care that works in an integrated way with General Practice teams, to enhance outcomes for patients accessing services across the sector.

Fee Schedule for Patient Co-Payments for a Standard Consultation (August 2017)

General Practice Fees Schedule						
Practice	**0-12 yrs**	**13-17 yrs**	**18-24 yrs**	**25-44 yrs**	**45-64 yrs**	**65 yrs and over**
Aramoho Health Centre	No charge	$20.00	$40.00	$40.00	$40.00	$40.00
Bulls Medical Centre	No charge	$29.00	$34.00	$35.00	$35.00	$35.00
Impilo Family Practice	No charge	$31.00	$31.00	$41.00	$41.00	$41.00
Springvale Medical Centre	No charge	$41.00	$41.00	$41.00	$41.00	$41.00
St John's Medical Centre	No charge	$30.00	$40.00	$40.00	$40.00	$40.00
Stewart Street Surgery	No charge	$28.00	$36.00	$36.00	$36.00	$36.00
Wicksteed Medical Centre	No charge	$41.00	$41.00	$41.00	$41.00	$41.00

Very Low Cost Access Practices						
Practice	**0-12 yrs**	**13-17 yrs**	**18-24 yrs**	**25-44 yrs**	**45-64 yrs**	**65 yrs and over**
Gonville Health	No charge	$12.00	$18.00	$18.00	$18.00	$18.00
Ruapehu Doctors	No charge	No charge	No charge	$18.00	$18.00	$18.00
Taihape Health	No charge	$12.00	$18.00	$18.00	$18.00	$18.00

Access Funded Practices						
Practice	**0-12 yrs**	**13-17 yrs**	**18-24 yrs**	**25-44 yrs**	**45-64 yrs**	**65 yrs and over**
Te Oranganui Medical Centre - Whanganui	No charge	$11.50	$17.50	$17.50	$17.50	$12.00
Te Oranganui Medical Centre - Waverley	No charge	$11.50	$17.50	$17.50	$17.50	$12.00