WHANGANUI REGIONAL HEALTH NETWORK

Annual Plan

2024 - 2025

Implement processes to ensure the Treaty of Waitangi sets a platform for Māori involvement and a true sense of partnership all levels; strategically, operationally and nurtures relationships with our Iwi and community partners and stakeholders.

Risk

1. WRHN as a mainstream organisation must remain relevant to our iwi and community partners and operate a strength-based approach to supporting Iwi / community priorities. There is risk if this level of association is not maintained and valued.

Approach

1. Rural Iwi partnerships with Waimarino Wellness project / Taihape Development and Stewart Street Surgery create high trust and collective outcomes that meet Iwi aspirations.

Outcomes

1.1 Evidence of collaborative strategies to progress the developments at Taihape.

1.2 Waimarino development progresses and RHL relocated.

1.3 Stewart Street surgery achieve measurable outcomes that are a priority for their owners Nga Wairiki Ngati Apa.

Measures

1.1.1 Taihape facility lease signed

Start 2024 ○ In Progress ○ Finish 2025 ○

1.1.2 Consent for Taihape building refurbishment accepted

Start 2024 ○ In Progress ○ Finish 2025 ○

1.1.3 Building modifications completed

Start 2024 ○ In Progress ○ Finish 2026 ○

1.1.4 Public launch of facility

Start 2024 ○ In Progress ○ Finish 2026 ○

1.2.1 Waimarino Development is codesigned with community and Iwi

Start 2024 ○ In Progress ○ Finish 2026 ○

1.2.2 RHL and clinical partners agree clinical model of care

Start 2024 ○ In Progress ○ Finish 2026 ○

1.2.3 RHL Risk Register issues addressed

Start 2024 ○ In Progress ○ Finish 2026 ○

1.3.1 WRHN leaders support SSS with breakeven or better budget annually

Start 2024 ○ In Progress ○ Finish 2025 ○

1.3.2 SSS Workforce matches population need

Start 2024 ○ In Progress ○ Finish 2027 ○

Risk

2. NHC are pitched as a Kaupapa PHO, and this may detract Iwi/ Maori away from WRHN as believe they will get added value.

Approach

2. Strategic risk associated to NHC activity are communicated to the WRHN board enabling a strategy discussion with our Iwi board members, so we remain connected and collective action is achieved.

Outcomes

2. Iwi /Maori leaders on WRHN board are aware of risk and a proactive shared risk mitigation is actioned between WRHN board and leaders.

Measures

2.1 WRHN lever IMPB relationship as local PHO to offset NHC risk.

Start 2024 ○ In Progress ○ Finish 2025 ○

2.2 WRHN maintains front facing relationship with practices, community and Iwi.

Start 2024 ○ In Progress ○ Finish 2027 ○

Risk

3. WRHN need to demonstrate delivery of the intent of Treaty of Waitangi strategically and operationally and invest in meaningful relationships with Iwi partner.

Approach

3. WRHN leaders act as enablers to support collaborative strategy across the rohé to manage risk.

Outcomes

3. Leaders and Board work together.

Measures

3.1 Forge effective relationship with TWO Commissioners and Practice member leaders.

Start 2024 ◯ In Progress ◯ Finish 2027 ◯

Risk

4. Workforce culture at WRHN and subsidiary clinics becomes complacent and views Treaty obligations as 'optional or nice to have" instead of essential.

Approach

4. WRHN enables the Pou Tikanga and Te Koomiti Mana Taurite to highlight cultural risk and recommend strategies to manage risk and Leaders enable actions.

Outcomes

4. Workforce culture is woven with strong tikanga learning and activity throughout parent and subsidiary clinics through evidence of a quality cultural plan and outcomes achieved that shape improved whanau engagement and access.

Measures

4.1 WRHN Iwi board members and Equity Komiti meet quarterly to elevate issues and responses.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

4.2 WRHN policies reflect obligation and commitment to ToW.

Start 2024 ◯ In Progress ◯ Finish 2027 ◯

4.3 WRHN workforce are enabled and supported to demonstrate high level of te tikanga.

Start 2024 ◯ In Progress ◯ Finish 2027 ◯

Risk

5. System change occurs without cognisance that Iwi are our partners and operationally our Maori workforce and whanau are not heard.

Approach

5. Evidence of partnership communication and shared roll out of new initiatives that impact on whanau.

Outcomes

5. Māori workforce are enabled to gather whanau voice that shapes new and existing initiatives.

Measures

5.1 A collaborative approach to gathering whanau feedback from WAM/ED waiting area is achieved.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

5.2 Whanau feedback shapes the design of the hybrid hub to meet unmet need.

Start 2024 ◯ In Progress ◯ Finish 2026 ◯

WRHN will seek opportunities created by the devolution of services from TWO (Te Whatu Ora).

Risk

1. NHC politically lobbies for a percentage share of the clinical contracts operated by WRHN, and this reduces workforce capacity and capability for WRHN and fragments service to whanau.

Approach

1. WRHN leaders articulate risk with TWO Localities leads and front foot every new emerging threat and risk.

Outcomes

1.1 WRHN retained as the place-based PHO for the locality and lead of Outreach and other key contracts.

Measures

1.1 Clinical contracts remain intact during 24/25 contract period and do not create financial risk for WRHN.

Start 2024 ○ In Progress ○ Finish 2025 ○

Risk

2. Longterm Conditions service is fragmented and not integrated with general practice to deliver expanded care for the most complex whanau.

Approach

2. Enter a subregional collaboration with Hawkes Bay, THINK Hauora, WRHN and Collaborative Aotearoa to share learnings / project management resource and innovations to create fresh LTC / General practice model for each region that meets local unmet need.

Outcomes

2.1 All partners are committed to the value of the model.

2.2 Evidence of efficient use of resources and innovative approaches to partnership with patients.

2.3 Whanau Ora approach focuses on literacy and self-management tools and approach.

2.4 Outcomes deliver Te Ikaroa Integrated Plan outcomes for LTCs.

2.5 WRHN are proactive about devolution opportunities from the hospital as they may present.

Measures

2.1 An integrated LTC strategy and way of working merges clinical and whanau ora principles to create a model of care that values self- management and whanau led.

Start 2024 ○ In Progress ○ Finish 2025 ○

2.2 WRHN show cases the woven clinical / whanau ora approach at the Collaborative Aotearoa Conference in 2025.

Start 2024 ○ In Progress ○ Finish 2025 ○

WRHN will focus on strategies to grow clinical primary care workforce capacity and capability across the city and rural communities.

Risk

1.Pay parity risk exists between Primary and Hospital system and impacting on retaining a professional workforce.

Approach

1. Aligned with PSSAP and GPNZ Pay Parity negotiations and actions.

Outcomes

1. Utilise system resource to drive WRHN strategies.

Measures

1. WRHN lobby for practice members and workforce for best deal.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

Risk

2. Local students are not connected to our workplaces early enough so post tertiary training do not drift back into primary care workplaces.

Approach

2. 'Grow our own' workforce strategy commences with WRHN developing strong connection to education programmes, ranging from secondary school 'gateway' students to tertiary students and providers. Aim is to support enrolments into healthcare, and support students in their journey, with an emphasis on primary healthcare.

Outcomes

2.1 WRHN/ Secondary School student workplace collaborative commences.

2.2 Reconnect with UCOL to offer work experience opportunities in primary care early.

2.3 WRHN is engaged along with Iwi partners with strategy for third university and established as a pipeline for students.

2.4 Measure volumes of rangitahi who are offered workforce entry opportunities via WRHN programme.

Measures

2.1 Gateway student integration and process developed so that initial stages of scaling up can proceed.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

2.2 Established connection with UCOL nurse education and support of tertiary students.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

2.3 Percentage of Maori and Pasifika students that have participated in the Gateway programme.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

2.4 Volume of students that have progressed to a health career pathway.

Start 2024 ◯ In Progress ◯ Finish 2026 ◯

Actively engage in the Whanganui Localities Te Hononga and Te Matuka leadership groups.

Risk

1. Risk of Te Hononga losing relevance as new minister favours IMPB over localities.

Approach

1.1. WRHN joins Te Hononga leaders in forming an effective and high trust relationship with IMPB to drive improvements in health and wellbeing across the district.

1.2. Builds trust and confidence and demonstrates WRHN is a valued partner.

Outcomes

1.1 WRHN continues to champion and lead CST / CPCT/ Dementia initiatives / Taihape Development and Waimarino Development.

1.2 WRHN will be an enabler to achieve enduring outcomes that Improve equity and access to services for our people.

Measures

1.1.1 Evidence of outcomes advance future contracting for dementia.

Start 2024 ○ In Progress ○ Finish 2026 ○

1.1.2 CPCT evaluation shapes future GP teams.

Start 2024 ○ In Progress ○ Finish 2026 ○

1.2.1 WRHN retained as a participating clinical provider partner in primary care.

Start 2024 ○ In Progress ○ Finish 2027 ○

1.2.2 Evidence that equity and access to GPTs has improved for those not enrolled or engaged.

Start 2024 ○ In Progress ○ Finish 2025 ○

1.2.3 GPTs improve process and systems to improve equity and access for pepi and tamariki to achieve early intervention outcomes for whanau.

Start 2024 ○ In Progress ○ Finish 2025 ○

Risk

2. All relevant health providers serving tamariki in wfirst 2000 days will be connected through good relationships and networks.

Approach

2. Collaborative working levering off clinical and whanau ora will be a hallmark of all WRHN service providers model of care.

Outcomes

2.1 WRHN will participate in the across-rohe strategy for whanau to experience good health across the first 2000 days.

Measures

2.1 Evidence of participating in the Healthy Families plan for whanau to drive their wellness journey through responsive health services.

Start 2024 ○ In Progress ○ Finish 2025 ○

WRHN will seek to hear our communities' voices to understand needs.

Risk

1. Whanau lose confidence that the system is collecting their voice but not doing anything with the information.

Approach

1. WRHN partner with Te Oranganui Healthy Families to collaborate in how whanau voice is captured and the learnings from this.

Outcomes

1.1 WRHN resource will be supported within Healthy Families model and create collaborative model for measuring and evaluating CPCT from a consumer perspective.

Measures

1.1 A model/process for WRHN to obtain whanau voice is developed.

Start 2024 ◯ In Progress ◯ Finish 2026 ◯

1.2 The model/process meets equity and tikanga expectations of communities involved.

Start 2024 ◯ In Progress ◯ Finish 2026 ◯

Risk

2. Fragmented Whanau voice collection creates no collective impact for Whanau.

Approach

2. Te Koomiti Mana Taurite partner with Maori leads from TWO Wg to collect whanau voice from the WAM/ED shared waiting area.

Outcomes

2.1 Collective strategies on how to improve service delivery offer best impact for Whanau rather than being driven by a fragmented provider approach.

Measures

2.1 Develop a collaborative approach to collecting and utilising whanau voice so voices remain visible and shape change.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

2.2 Whanau voice is easily accessible/sorted to continue to inform decision making.

Start 2024 ◯ In Progress ◯ Finish 2026 ◯

Risk

3. Pasifika unmet need goes unnoticed.

Approach

3. Pasifika Strategic Advisory Group feeds through community unmet need to WRHN for collective and connected action.

Outcomes

3.1 Measure attendance at events to gauge Pasifika community reach.

3.2 Measure IMMS /Flu uptake.

3.3 Pasifika Advisory group shape and develop priority services for Whanganui rohe.

Measures

3.1 Baseline data obtained for PI engagement to measure success of initiatives.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

3.2 Pasifika meet IMMs performance targets for childhood / Flu.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

3.3 TWO Commissioning fund Pasifika priority needs.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

WRHN will support the growth and development of general practice capacity and assist the clinics in improving equity, access and delivery of quality general practice care.

Risk

1.WRHN lose market share with practice members and subsidiary companies having no capacity to enrol or serve the needs of their existing population with drift of the population to NHC practices.

Approach

1.1 Create a Hybrid Hub model that sheds some services from WAM and GHL to a clinical and welfare Hub established at WRHN resulting in capacity to enrol at GHL and less waiting time at WAM and greater capacity at member practices without incurring clinical risk.

1.2 WRHN maintains collegial workforce links across the subregion to minimise impact for Whanau caught up in system disruption.

Outcomes

1.1 Model codesigned with Whanau.

1.2 A data dashboard is developed to measure outcomes.

1.3 Increased focus on unenrolled population and engagement in primary care by creating seamless pathway from WAM to general practice.

1.4 Complex patients are self-navigating their care-plan utilising a digital device.

Measures

1.1 Evidence whanau voice influences and shapes Hybrid Hub model.

Start 2024 ◯ In Progress ◯ Finish 2026 ◯

1.2 Data dashboard measures and monitors outcomes.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

1.3 Non enrolled volumes decrease.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

Risk

2. Circumstances driven by TWO disrupted processes associated to delay in contract certainty may drive a wedge between WRHN and Private general practice unless communication channels are succinct and private business General practice services are seen as partners with WRHN.

Approach

2.1 WRHN leaders will reconnect with private general practices and support transparency in information and support a collaborative transition until the sector has more certainty through robust contracts and agreed strategy for primary care.

Outcomes

2.1 WRHN will explore GPT education delivery to support best practice and community of practices.

2.2 Evidence leaders' communication plan has been executed and delivered with authenticity and aligns to the values of WRHN.

Measures

2.1 Evidence education programmes are delivered meeting priority needs in a format that is efficient and participation level acceptable.

Start 2024 ◯ In Progress ◯ Finish 2026 ◯

2.2. Leaders profile is known and communication options easy to navigate.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

2.3. WRHN maintain existing practice member organisations.

Start 2024 ◯ In Progress ◯ Finish 2027 ◯

Risk

3. Viability for private business General Practices is precarious and acknowledged by all parties nationally / regionally and locally, with no solutions being offered by the government to date.

Approach

3. WRHN agree robust strategies to support private General Practices through the contract transition process until TWO commissioning parameters are understood and implemented.

Outcomes

3.1 Board endorse the parameters and support an investment strategy for general practice for a transitional period.

Measures

3.1 Level of interim practice support required for each contract period.

Start 2024 ○ In Progress ○ Finish 2025 ○

3.1 Strategies endorsed by the board and communicated via CGG / R&A.

Start 2024 ○ In Progress ○ Finish 2025 ○

Ensure the approved strategies for WRHN subsidiaries are appropriate and resourced.

Risk

1. Increasing risk of unenrolled and unmet need as primary care becomes increasingly under pressure. Minister Reti has described unenrolled as a significant risk and seeking address.

Approach

1. WRHN and subsidiaries explore potential of hybrid primary care service to enable increased enrolment at GHL and improve immediate access via WAM.

Outcomes

1. 1 Enrolment at GHL will increase showing a reversal in the current trend.

Measures

1.1 Volume of non-enrolled decreases.

Start 2024 ○ In Progress ○ Finish 2025 ○

1.2 Volume of Maori enrolled each quarter.

Start 2024 ○ In Progress ○ Finish 2025 ○

Risk

2. Community reliance on increased provision of primary care to reduce hospital system pressures.

Approach

2. WAM establishes a patient advocacy approach to direct patients with evidence of unmet to comprehensive primary care.

Outcomes

2.1 Record and report number of patients supported to enrol locally; particularly vulnerable whanau identified through the Manaaki Hauora model of care.

Measures

2.1 Record and report number of patients supported to enrol locally; particularly vulnerable whanau identified through the Manaaki Hauora model of care.

Start 2024 ○ In Progress ○ Finish 2025 ○

Risk

3. TWO recognises the need for a new model in GPT to reduce system pressure and improve patient outcomes particularly our most vulnerable and has addressed this by applying CPCT funding 24/25 but not thereafter.

Approach

3.1 WRHN subsidiaries engage in EPCC (Extended Primary Community Care).

3.2 WRHN subsidiary clinics will actively engage in the Manaaki Hauora model design which embeds clinical IDT, whanau voice and cultural expertise as integrated components of holistic wrap around care.

3.3 WRHN will apply a subregional collaborative approach with Hawkes Bay and THINK PHOs to codesign with whanau a LTC service that is embedded and connected with general practice / expanded primary care and hospital specialist services.

Outcomes

3.1.1 All WRHN subsidiaries are engaged in EPCC to reduce Hospital Admissions and results are actively measured.

3.1.2 WAM / ED codesign processes that creates a seamless redirect of patients to the right door right time.

3.2.1 The Manaaki Hauora design will be formally evaluated in a partnership model with Te Oranganui.

3.2.2 Learnings from the evaluation will influence future commissioning decision making locally with IMPB and Commissioners.

WRHN will partner with Iwi, community and others to transfer screening and population wellness strategies to a community-based function to ensure greater reach.

3.3 The model of design will reflect Whanau Ora principles and support general practice teams to deliver wrap around care with partners in an efficient and whanau focused way.

Measures

3.1.1 WRHN facilitates 100% participation by Practice teams.

Start 2024 ◯ In Progress ◯ Finish 2027 ◯

3.1.2 Whanau voice is collected and shapes priorities and partnership working between WAM and ED.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

3.2 The evaluation document is used to lobby long-term investment.

Start 2024 ◯ In Progress ◯ Finish 2026 ◯

3.3 The learning and scale from a sub-regional response creates system notice and investment opportunities.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

Risk

1. With general practice access limited, risk is clients are not presenting for screening and vaccination, so stats show an increased equity gap.

Approach

1. Pasifika Vaccination Programme initiative driven as a a priority need from Pasifika Advisory Group.

2. Evidence of neighbourhood initiatives to drive greater volume of people with completed health screening stats.

3. Collaborate with community partners and respond to the deconstruction of current siloed health system design.

Outcomes

1.1 Buy-in from Pasifika Directorate drives new contract opportunities.

2.1 WRHNs innovative approach drives improved performance in delivering volumes.

3.1 Seek to understand how community and whanau wish the service to respond in the future and consider WRHN and Sub approach.

Measures

1.1 Pasifika Advisory events held in contract period

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

1.2 WRHN maintained as backbone agency for Pasifika

Start 2024 ◯ In Progress ◯ Finish 2027 ◯

2.1 Volume of community events partnered with communities and Iwi providers.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

3.1 WRHN operates as effective and authentic partners evidenced through collaborative events, actions and outcomes.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

WRHN will participate with researchers and clinical leaders in the roll out of local region-based set of measures that describe and measure change that is meaningful for Whanau and assists in evaluation.

Risk

1. Loss of NHC practice data from PowerBI reduces visibility of regional overview for population-based measures and outcomes.

Approach

1. Explore individual data sharing agreement with NHC practices locally to enable reporting for regional based contracts and quality improvement projects.

Outcomes

1.1 Regional overview benefits whole of community, specifically considering our outreach and WAM services.

Measures

1.1 Data sharing agreement with WRHN / NHC practices crosses the line.

Start 2024 ◯ In Progress ◯ Finish 2026 ◯

Risk

2. Targeted clinical indicator and population health-based measures markers of health although not necessarily proven to improve health outcome. Moving to combination of quantitative and narrative-based measures, however with no clear framework currently for measuring meaningful outcomes.

Approach

2. Support national and regional strategies to develop a national data repository accessible by all stakeholders (including the individual).

Outcomes

2.1 Keep informed of developments of HIRA project and other national initiatives.

2.2 Analysis of current survey qualitative data for virtual healthcare delivery throughout the rohe to inform service design.

Measures

2.1 Progress is evidenced.

Start 2024 ◯ In Progress ◯ Finish 2027 ◯

2.2 Leader and CGG review the survey findings and shape strategy.

Start 2024 ◯ In Progress ◯ Finish 2026 ◯

Risk

3. Measures of individual performance or widget contract reporting requirements lack richness of quality improvement.

Approach

3. Partner with Te Oranganui to evaluate Manaaki Hauora programme through a whānau voice framework.

Outcomes

3.1 Understanding what matters to whānau will inform new measures that may have meaningful impact for people to understanding their health conditions and self-manage.

Measures

3.1 Commitment from WRHN to apply learnings to any redesign process for the future.

Start 2024 ◯ In Progress ◯ Finish 2027 ◯

Risk

4. Health investment is currently shaped by hospital measures (ie.hips and knee surgery). Community / whanau measures are necessary evidence to support primary care investment for the future.

Approach

4. Team-based measures and quality improvement initiatives that include narrative of strengths and opportunities.

Outcomes

4.1 Deeper understanding of requirements for change will be understood by the system commissioners.

Measures

4.1 WRHN are known for providing Commissioners with evidential reports to shape investment and direction.

Start 2024 ○ In Progress ○ Finish 2026 ○

4.2 Data menu covers TWO priority measures and reports to Leaders /CGG occur quarterly.

Start 2024 ○ In Progress ○ Finish 2026 ○

Information systems and technology will be an enabler for change and measurement of delivery.

Risk

1. Increasing sophistication of cyber threats.

Approach

1. Regularly update and patch systems to protect against the latest threats.

Outcomes

1.1 Reduced risk of data breaches and cyber-attacks, safeguarding business continuity.

Measures

1.1 Cyber security report to R&A and Board quarterly.

Start 2024 ◯ In Progress ◯ Finish 2027 ◯

Risk

2. Potential downtime and data loss from cyber-attacks.

Approach

2. Implement robust backup and disaster recovery plans to minimize downtime and data loss.

Outcomes

2.1 Enhanced trust from customers and partners due to robust security measures.

Measures

2.1 Monitor each cyber invasion and learnings are communicated to Board and employees.

Start 2024 ◯ In Progress ◯ Finish 2027 ◯

Risk

3. Non-compliance with regulatory requirements, leading to fines and reputational damage.

Approach

3. Conduct regular security audits and compliance checks to ensure adherence to regulations.

Outcomes

3.1 Compliance with regulatory requirements, avoiding fines and enhancing the company's reputation.

Measures

3.1 WRHN has no invasive attacks that significantly disrupts business operations for greater than 4 hours.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

Risk

4. Taihape Data and IT infrastructure is not fit for purpose and does not enable futuristic and flexible work practices.

Approach

4.1 Allocate flexible workspace data options.

4.2 Codesigned with workforce and leaders.

Outcomes

4.1 Delivered on time and within budget.

4.2 evaluation supports that the infrastructure works for the end users.

Measures

1.1 Timeline and detail matches customer needs.

Start 2024 | In Progress | Finish 2026

2.1 Customer satisfaction is recorded.

Start 2024 | In Progress | Finish 2026

Risk

5. Providing Telemedicine Services to General Practices. The following risks are:

5.1 Limited access to necessary technology for some patients.

5.2 Concerns about the quality of care delivered remotely.

5.3 Regulatory and reimbursement challenges.

Approach

5.1 Provide patients with access to telemedicine platforms and necessary support at each subsidiary clinic site.

5.2 Regulation and quality protocols are in place to deliver quality care delivery via telemedicine.

5.3 Pilot LTC self-management App with Hawkes Bay / THINK and WRHN PHOs.

Outcomes

5.1 Increased access to healthcare services for patients in remote or underserved areas.

5.2 Improved patient satisfaction and convenience.

5.3 Present learnings at Collaborative Aotearoa Conference 2025.

Measures

5.1 quantify quarterly to board.

Start 2024 | In Progress | Finish 2027

5.2 Patient satisfaction survey.

Start 2024 | In Progress | Finish 2026

GONVILLE HEALTH

Annual Plan

2024 - 2025

Priority Area 1: Enrolments.

Risk

1. GHL's drop in enrolled patients is negatively affecting capitation and threatening viability.

Approach

1. Create enrolment capacity at GHL to offset risk of potential aggressive enrolment strategies actioned by NHC / Greencross and redirect non-enrolled accessing episodic care from WAM to a general practice with capacity (GHL at this point but may create other partners).

Outcomes

1.1 Increase enrolled population with a focus on servicing the people that the clinic was initially established for – those living in Gonville/Castlecliff area, Maori and Pacific people and those with high needs/ high deprivation.

1.2 Create a collaborative hub response with WAM and WRHN to be a circuit breaker that relieves access pressure for people who are unable to find a practice to enrol at in the city, and to support those most vulnerable and in need of access to general practice services (as opposed to accessing episodic care from WAM).

Measures

1. Determine the range of services that will operate from the Hub that will be responsive (and an enabler) to the system.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

2. To build facility capacity to deliver Iron and Aclasta infusions at GHL as soon as possible for GHL and other city general practice patients that are not able to be delivered 'inhouse' and engage private practice members in a nurse training programme to build their capacity to undertake this service 'inhouse'.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

3. To utilise a collaborative workforce (those employed at WRHN as example) to improve connected social and whanau ora services wrap around so people manage well in the community and remain in the community with all that they need to recover from winter illness.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

4. To utilise existing facility infrastructure- 111 Gonville Ave/ 100 Heads Road WRHN /44 Abbot street to redistribute patient to right place depending on patient need.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

Priority Area 2: Capacity & Capability.

Risk

1. Workforce retention, development and capability fails to meet workforce demands.

Approach

1. GHL remains a critical service option that is responsive to patient need.

2. GHL will focus on strategies to grow clinical care workforce capability and capacity.

Outcomes

1.1 A workforce and facility that is fit for purpose and able to respond to the needs of people in the community that have access barriers to receiving care.

1.2 Maintain a workforce that is culturally and clinically competent that operates a partnership relationship with their whanau and community.

1.3 Recognises their role in partnering with WRHN, WAM and other partners to create shared solutions that result in better outcomes for our people.

2.1 Staff are empowered and supported to work at top of scope to build capacity and capability to serve patients needs.

2.2 Invest in providing additional services to our patients eg LARC, CFOP, steroid injections, all of which helps to improve health outcomes for our patients as well as generate additional income.

2.3 Work with WRHN and other subsidiaries to consider new ways of working so our workforce is effective, efficient and the workforce enjoy high job satisfaction.

Measures

1.1 Free up RN resource to focus on more complex/ acute patients and other top of scope tasks through employment of an enrolled nurse.

Start 2024 ○ | In Progress ○ | Finish 2025 ○

1.2 Increase use of Practice Plus – Refer all appropriate, less acute patients to Practice Plus to allow more in person consults for our at risk patients or complex patients.

Start 2024 ○ | In Progress ○ | Finish 2025 ○

1.3 Utilise the Pou Tikanga and Equity team to support an approach to improve health literacy for patients who have less understanding on receiving virtual health care.

Start 2024 ○ | In Progress ○ | Finish 2025 ○

1.4 Invest and expand in clinical workforce training to provide additional services eg CFOP, LARC, steroid injections and other services as they are devolved from TWO.

Start 2024 ○ | In Progress ○ | Finish 2025 ○

1.5 One Nurse Practitioner progress pathway 2024/25, one Nurse Prescriber completed by end of year 2024/25,

Start 2024 ○ | In Progress ○ | Finish 2025 ○

1.6 Hybrid hub will use include workforce collaborative partners to better support the patient journey whilst maintaining the functionality of the current GHL workforce.

Start 2024 ○ | In Progress ○ | Finish 2025 ○

Priority Area 3: Address inequities and unmet need.

Risk

1. At risk communities continue to have inequitable outcomes leading to increased unmet need.

Approach

1. To create a well-functioning expanded primary care team.

2. Equity, Access and high-quality general practice expanded care will be delivered at GHL.

Outcomes

1.1 Roll out of the Manaaki Hauora Model (CPCT) at GHL.

1.2 The Manaaki Hauora model has been developed to combine primary care services with new roles such as physiotherapists, practice pharmacists, care coordinators and kaiāwhina and improve access to primary care for patients and whānau with high and complex needs to receive early intervention, faster treatment and better support for social and lifestyle factors, addressing the impact of chronic health conditions particularly for Māori, Pacific peoples, tāngata whaikaha and isolated rural communities. Interdisciplinary teams and new ways of working are an essential component of CPCTs and the approach that GHL believes will work best for their enrolled patients.

2.1 Priority will be placed on people and whānau identified at greatest need for high quality care coordination are those who are receiving care from multiple providers, in multiple settings (e.g., social, allied health, community medical, hospital medical, mental health, etc).

2.2 Improve equity of access and health outcomes for Māori, Pacific peoples, Tāngata Whaikaha and people living in rural and highly deprived areas.

2.3 Improve the access, continuity, comprehensiveness, and coordination of care.

2.4 Enable assessment, early diagnosis, treatment and condition management, extended care services, hospital avoidance/early supported discharge activity as well as acute, planned and preventative care.

2.5 Build a sustainable primary and community sector with increased capacity and capability through broadening the range and diversity of roles and services available, operating collectively and collaboratively to best meet the priorities and needs of their community.

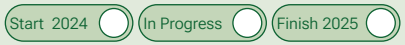
2.6 Deliver services and supports to enhance wellbeing of whānau, including having a focus on health, Manaaki or wellbeing and the social determinants of health.

2.7 Increase the range of roles and services available in the community with flexible models of care that are more effective and centred on people, whānau and community needs.

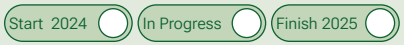
Measures

GHL team will collectively function to provide comprehensive, seamless, primary and community health care to the Manaaki Hauora identified population by:

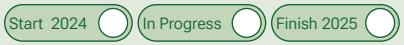
1.1 Establish where needed data and digital enablement, including piloting the self-management APP delivered through Collaborative Aotearoa / HB PHO/ THINK / WRHN integrated LTC plan.



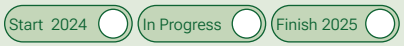
1.2 Support workforce capacity building, skill sharing and other workforce initiatives to create capacity within Manaaki Hauora for new and existing team members, including the use of delegation and skill sharing frameworks.



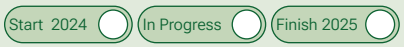
1.3 Promote working at top of scope for new and existing team members.



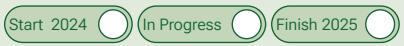
1.4 IDT meetings (weekly) for all Manaaki Hauora team members.



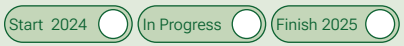
2.1 Meet the monitoring and reporting obligations and participation in the quality improvement and clinical governance component.



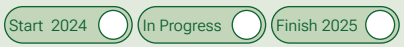
2.2 Ensure services and activities are focused on priority cohorts with an equity approach.



2.3 Develop and strengthen partnerships with other providers and organisations; for example, those entities that employ kaiāwhina, or collaborate with other private health providers such as pharmacists or physiotherapists within general practice.



2.4 Focus on a seamless experience of care and support for the person and their whanau.



Priority Area 4: Whānau Voice.

Risk

1. Whānau lose confidence that the system is collecting their voice but not doing anything with the information.

2. Fragmented Whānau voice collection creates no collective impact for Whānau.

Approach

1. GHL will shape service and approaches to care models through partnering with our people to achieve the best outcomes.

2. WRHN and its subsidiary companies will seek to hear our communities' voices to understand needs.

Outcomes

1.1 The Pae Ora Act describes the obligation that primary care has to hear whānau voice and respond.

1.2 Gonville Health was established to serve whānau and their needs; it is crucial that we hear their voices to understand what their needs are and continue to adapt the model accordingly.

2.1 GHL will take findings collected from whānau from hospital front door that describes unmet need and adapt the GHL model accordingly.

2.2 Findings from the He Waka Eke Noa evaluation will be shared with the GHL team and recommendations applied to the GHL model.

2.3 GHL will any other opportunities in addition to the above to gather whānau voice and apply appropriate change to the GHL model.

2.4 The findings of the Manaaki Hauora whānau voice evaluation will support GHL direction.

Measures

1.1 WRHN Team will analyse within the scope and context of the hub project (WAM / GHL and community) and understand what needs to change or be improved and apply findings to GHL model.

Start 2024 ○ In Progress ○ Finish 2025 ○

1.2 A He Waka Eke Noa GHL steering group will be established and 2024/25 will include regular updates from the He Waka Eke Noa evaluation team.

Start 2024 ○ In Progress ○ Finish 2025 ○

1.3 GHL Team will be regular attendees of the Stone Soup community day gatherings.

Start 2024 ○ In Progress ○ Finish 2025 ○

2.1 GHL will have an employee join the WRHN equity group.

Start 2024 ○ In Progress ○ Finish 2025 ○

2.2 GHL will apply a CQI process to the Manaaki Hauora model priority to 2025/262.4 Focus on a seamless experience of care and support for the person and their whanau.

Start 2024 ○ In Progress ○ Finish 2025 ○

RUAPEHU HEALTH

Annual Plan

2024 - 2025

Implement a process that ensures the Treaty of Waitangi sets a platform for Māori involvement in the true sense of partnership at all levels, strategically, operationally and nurtures relationships with our communities and Iwi partners.

Risk

1. At risk communities feel disconnected to healthcare.

Approach

1. Establish formal agreements with local Iwi and Māori health organisations to outline roles, responsibilities and shared goals.

Outcomes/Measures

1.1 Strengthen partnerships with Iwi and community key stakeholders to support community health and wellbeing.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

1.2 Hold regular community hui to establish shared goals/visions and identify unmet need.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

Risk

2. Lack of cultural literacy alienates at risk communities.

Approach

2. Work alongside Iwi, Whanganui Regional Health Network (WRHN) cultural advisor and the Ruapehu Health Ltd (RHL) equity champion to develop a Māori Health Plan in the 2024/25 year.

Outcomes/Measures

2.1 Set clear, measurable goals for improving Māori health outcomes and address health inequities.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

2.2 Embed Rongoā Māori into care plans to respect cultural practices.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

2.3 Establish professional development opportunities for staff to enhance their cultural knowledge and learning.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

Risk

3. Healthcare operates in isolation of wider holistic wellbeing activitiy, leading to low quality outcomes.

Approach

3. Through the Comprehensive Primary Care Team (CPCT) facilitate high quality coordination of care for people and whanau.

Outcomes/Measures

3.1 Establishment of a Manaaki Hauora team.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

3.2 Māori people with complex needs will be identified and a plan of care developed that incorporates a combination of Te Aue Māori values/treatments and clinical best practices. The plan will be whānau centred empowering whānau to be partners in their own health. The CPCT will work collaboratively across health and social services.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

Actively engage in the Whanganui Localities Prototype.

Risk

1. Healthcare fails to adapt to localised community need.

Approach

1. RHL has its own subsection of the Whanganui District Locality Plan. Locality priorities will be included in how RHL responds to its population.

Outcomes/Measures

1.1 Relevant locality plans are identified and implemented.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

RHL will seek to hear our community's voice to understand their needs.

Risk

1. Healthcare is unresponsive to at risk communities needs.

Approach

1. RHL will develop a plan in the 2024/25 year to ensure tāngata whaikaha/disabled persons have better access to preventative health care.

Outcomes/Measures

1.1 Ensure tāngata whaikaha/disabled persons have a voice and are in control of their own health.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

1.2 Provide better access to supportive, community based primary and preventative health care.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

1.3 Coordinated health care plans to facilitate access to wider health and social services.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

1.4 Use of telehealth to improve access to services.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

1.5 Development of a register of all health providers in the rohe to improve access to services that are closer to home for whānau.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

By connecting with whānau to deeply understand what matters to them and their communities, leaders will then work together with communities and whānau on how best to respond to achieve wellness outcomes.

Risk

1. Healthcare is unresponsive to at risk communities needs.

Approach

1. RHL will continue to work alongside the Waimarino Development Board and Waimarino project lead to realise the community's aspirations of a truly integrated wellness centre.

Outcomes/Measures

1.1 Progress made towards a viable and sustainable model for the future, offering a range of essential services that meet community and whānau priorities.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

1.2 Evidence of genuine whānau voice to establish a clear relationship and journey with community.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

1.3 Progress towards building a collaborative, respectful Iwi led community model.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

1.4 Community well informed of all developments of the Waimarino Wellness Centre.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

Risk

2. Waimarino development exposes any involved parties to undue risk.

Approach

2. Utilise the RHL Board of Directors due diligence report associated to the Waimarino wellness centre development centre to identify risk and required actions.

Outcomes/Measures

2.1 Agreement with Te Whatu Ora (TWO) Whanganui to a collaborative strategy for minimising risk.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

RHL will focus on strategies to grow clinical primary care workforce capacity and capability across all serviced communities.

Risk

1. Workforce retention continues to worsen.

Approach

1. RHL will continue to be purposeful about how they employ and maintain valued workforce and how they access external and in-service education programmes so that workforce continues to work towards top of scope.

Outcomes/Measures

1.1 Encourage and support of professional development plans for all registered nurses to work towards nurse prescriber and nurse practitioner.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

1.2 Continue implementation of practices that accommodates the needs of employees: Remote work options, Flexible shift options, Adjustable hours, Staff wellness programmes.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

1.3 FTE and workforce discrepancies/risk reported at Governance meetings.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

Risk

2. Clinicial and non-clinical roles become inefficient, confused, and/or non-communicative between them.

Approach

2. Unregulated workforce are employed under the clinical delegation of regulated workforce and are seen as a strength to the RHL team from both a cultural and lived experience perspective.

Outcomes/Measures

2.1 Continued development and cultural weave of non-regulated roles where appropriate to support the clinical team.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

Risk

3. A lack of cultural literacy looks unattractive for attaining & retaining staff.

Approach

3. The Māori Health Plan will be purposeful about cultural development opportunities within the RHL workforce.

Outcomes/Measures

3.1 Implementation of tikanga practices to foster cultural competence into everyday practices.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

RHL will partner with Iwi / community and others to transfer screening and population wellness strategies to a community-based function from a core general practice-based function.

Risk

1. Healthcare fails to adapt to localised community need.

Approach

1. RHL will work with Iwi and outreach teams to ensure a whanau ora based approach is delivered.

Outcomes/Measures

1.1 RHL and Iwi will deliver dual immunisation and screening clinics.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

1.2 RHL will be purposeful in recognising their responsibility to opportunistic screening and interventions.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

RHL will have access to appropriate resources to deliver the agreed outcomes to support our vision and mission.

Risk

1. Healthcare is unresponsive to at risk communities needs.

Approach

1. Provision of appropriate planning documents to support a population focused service that improves inequity outcomes.

Outcomes/Measures

1.1 In place for 24/25 and signed off by WRHN Board.

- Annual Plan
- Operational Budget
- Capital Plan

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

Information Systems and technology will be an enabler for change and measurement of delivery.

Risk

1. Healthcare is unresponsive to at risk communities needs.

Approach

1. RHL will be proactive about IT being an enabler for: Virtual consultations, Assisted AI technologies for virtual clinical assessments, Self-management, Whānau and clinical team linkages for vulnerable population, Patient surveys, Assisted AI technologies for patient assessments.

Outcomes/Measures

1.1 Engagement of Ka Ora and Practice Plus services to provide connected after hours care and extended general practice consultations to improve access for rural communities.

Start 2024 ○ In Progress ○ Finish 2025 ○

1.2 Utilisation of patient portal systems – Manage My Health (MMH) to aid connectivity for whānau to the general practice team.

Start 2024 ○ In Progress ○ Finish 2025 ○

1.3 Encourage participation of whānau in the quarterly patient survey to gather feedback to improve service planning and delivery.

Start 2024 ○ In Progress ○ Finish 2025 ○

TAIHAPE HEALTH

Taihape Health Ltd

Annual Plan

2024 - 2025

Actively engage in the Whanganui Localities Prototype.

Approach

1. Taihape has its own subsection of the Whanganui District Locality Plan. Locality priorities will be included in the Wellness Hub model of care.

Outcomes/Measures

1.1 Any locality plans relevant to Taihape will be actioned.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

THL will seek opportunities created by the devolution of services from Te Whatu Ora.

Approach

1. The establishment of the Manaaki hauora team is intrinsic to the way in which THL and MPS will deliver health care services within the Taihape and surrounding rural area. To ensure that the model of care is one that can be sustainable whether or not financial resource is attached.

Outcomes/Measures

1.1 Mahi tahi (collaborative work), that the THL & MPS teams have already begun lends credibility to the model of care that has been created with the natural inter weaving of Whānau Ora & clinical services.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

1.2 When both THL & MPS are operating as a cohesive team our patients, whānau Hapu & Iwi and community are accessing services that are conducive to positive experiences and creating equitable access to services for those most vulnerable in our community.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

1.3 Proactive Care for those with complex needs, is one that results in whānau Ora, health wellness and social services connected in a way that creates healthy lifestyles and social connectedness integrated population health and community wellness.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

1.4 Vulnerable whānau and individuals who present for urgent and unplanned care will, as defined by the model of care, be afforded access to relevant health and social services.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

Implement a process that ensures the Treaty of Waitangi sets a platform for Māori involvement in the true sense of partnership at all levels, strategically, operationally and nurtures relationships with our communities and Iwi partners.

Approach

1. A refresh of the Maori Health Plan between MPS and THL will occur during the 2024/25 year which will be Governed by the THL Board and in particular Iwi Governance members.

Outcomes/Measures

1.1 Shared Maori Health Plan signed by both Governance Board prior to budget and annual planning 2024/25.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

Approach

2. Whānau ora lead will be part of THL leadership group and will guide cultural safety in relation to clinical practice.

Outcomes/Measures

2.1 Model of care designed based on information gained from whanau voice and the organic relationship that has emerged between THL and MPS, particularly the Manaaki Hauora model.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

2.2 The model of care reflects an authentic partnership between the THL and MPS operational team and is signed off by both Governance Boards.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

Approach

3. Establish an operational process to identify and prioritise access for Taihape Health's most vulnerable populations and applies a plan of care that prioritises welfare, wellness, acute chronic condition management for this population.

Outcomes/Measures

3.1 People living remotely will be identified and virtual acute service options prioritised and seamlessly available for this population.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

By connecting with whānau to deeply understand what matters to them and their communities, THL leaders will then work together with communities and whānau on how best to respond to achieve wellness outcomes.

Approach

4. THL, MPS, WRHN Pou Tikanga and Te Kōmiti Mana Taurite (WRHN equity team) collaborate to develop a cultural competency framework that encourages a diverse and inclusive workplace and workforce that designs and delivers services to meet the need of our community in a culturally safe manner.

Outcomes/Measures

4.1 A training tool is developed that can be utilised across all subsidiary clinics relevant to their location.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

4.2 Staff will have developed an understanding of the organisations values that guide us in how we behave toward and provide services to our community.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

4.3 Staff have visited at least one local marae as part of the framework as a means of increasing local knowledge of whānau hapu & iwi and of wider cultural tikanga (practices) from a tangata/mana whenua perspective.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

Approach

1. Whanau voice will continue to drive the THL Wellness Facility and Model of Care development.

Outcomes/Measures

1.1 Verbatim feedback from whānau will be included in the model of care write up, along with trends and actions.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

1.2 Architectural facility plans are designed around patient voice, population data, clinical safety, effectiveness and efficiency.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

1.3 All project plans and CQI updates include evidence of genuine whānau voice that influences any chance in service or processes.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

THL will focus on strategies to grow clinical primary care workforce capacity and capability across the city and rural communities.

Approach

1. Operational strengths-based sustainability workforce plan established inclusive of workforce, across system opportunities and business and workforce efficiency.

Outcomes/Measures

1.1 Workforce plan completed in time for 24/25 budget setting and annual plan.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

Approach

2. THL will continue to be purposeful about how they employ and access external and in-service education programmes so that workforce continues to work towards top of scope. Unregulated workforce are employed under the clinical delegation of regulated workforce and are seen as a strength to THL dynamics from both a cultural and lived experience perspective.

Outcomes/Measures

2.1 Implement a mentoring programme in place that supports the progress of clinical workforce purposely toward Nurse prescriber/Nurse Practitioner pathways.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

2.2 Midwife in training currently completing 2nd year of midwifery training.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

2.3 Paramedic to undertake Postgraduate diploma in health science extended Care Paramedic.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

2.4 As a means of 'growing our own' engage with local education providers to connect with potential rangatahi who aspire to undertake studies in the health sector pathways.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

2.5 Professional development opportunities will be made available for non-regulated THL/MPS kaiāwhina & Whānau Ora Iwi navigators.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

Approach

3. MPS and the Maori Health Plan will be purposeful about cultural development opportunities within the THL workforce..

Outcomes/Measures

3.1 A 0.6 FTE Social Worker has been recruited to integrate within the Manaaki Hauora team and practice team supporting vulnerable people with complex.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

3.2 Access to InterRAI assessments is easily accessible for the aging population so that appropriate care can be coordinated via the manaaki hauora/THL practice team.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

3.3Included within the Maori Health Plan..

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

THL will partner with Iwi / community and others to transfer screening and population wellness strategies to a community-based function from a core general practice-based function.

Approach

1. THL will network with MPS and relevant community networks to plan, develop and implement a community activity programme that offer the elderly population within the Taihape community an opportunity to connect with a like-minded community, socialise in a stimulating environment and participate in a range of meaningful activities with the aim of keeping healthy vibrant kaumatua/elderly people in the Taihape and surrounding community.

Outcomes/Measures

1.1 Using the gathering of whanau voice exercise SM/ MPS Pou Hauora will meet with various elderly roopu to gather 'kaumatua voice' as to what is important to keep them well.

Start 2024 ○ In Progress ○ Finish 2025 ○

1.2 Relevant programmes planned consist of activities and korero that include aspects of Te Whare Tapa wha covering Te taha Tinana, Te taha wairua, Te taha hinengaro and Te taha hauora.

Start 2024 ○ In Progress ○ Finish 2025 ○

1.3 Cultural learning opportunities included in all programmes enabling our kaumatua/elderly population to become more aware of the diverse cultures around them.

Start 2024 ○ In Progress ○ Finish 2025 ○

1.4 The combined effects of physical fitness, social engagement and mental stimulation addresses the multifaceted aspects of well-being with the aging population so that they are able to remain safely in the community.

Start 2024 ○ In Progress ○ Finish 2025 ○

1.5 Health Promotion education sessions facilitated by THL/MPS and identified networks are such that our cohort of elderly people are empowered with knowledge, tools and are connected and improve access to health & social services.

Start 2024 ○ In Progress ○ Finish 2025 ○

THL will participate in research projects relevant to the population.

Approach

1. Community engagement increases the visibility and understanding of issues and empowers communities to have a voice and fosters a sense of responsibility and commitment to achieving sustainable outcomes, equitable decision making processes and build trust between THL and the Taihape Community.

Outcomes/Measures

Develop a communication strategy plan that includes:

1.1 Participation at Mōkai Pātea services community events such as Waitangi Big Day Out/Matariki programmes and initiatives.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

1.2 Attendance, participation and support at relevant fortnightly/monthly kaumatua/elderly gatherings occurring within the Taihape community and surrounding district if applicable.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

1.3 Liaise with WRHN Communications Quality systems lead to develop a communication strategy using social media/review of THL website.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

1.4 Undertake surveys to garner community feedback at regular intervals.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

Information Systems and technology will be an enabler for change and measurement of delivery.

Approach

1. THL will be proactive about ICT being an enabler for:

- Education
- Virtual consultation
- Self-management
- Whanau and clinical team linkages for vulnerable populations
- THL will have innovative and functional ICT systems and explore the use of AI for workplace efficiencies and accuracy.

Outcomes/Measures

1.1 Shared systems and whanau centric information flow between THL and MPS in place.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

1.2 Establishment of Tyto platform.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

THL will have access to appropriate resources to deliver the agreed outcomes to support our vision and mission.

Approach

1. Provision of appropriate planning documents to support a population focused service that improves inequity outcomes.

Outcomes/Measures

1.1 In place for 24/25 and signed off by WRHN Board

- Annual Plan
- Operational Budget
- Capital Plan
- Workforce sustainability plan
- Maori Health Plan

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

WHANGANUI ACCIDENT & MEDICAL

Annual Plan

2024 - 2025

Priority area 1: Whanau voice.

Risk

1. Communication and whānau experience identified as an area for improvement.

Approach

1. WAM will shape service and approaches to care models through seeking to hear our communities' voices to understand needs.

2. WAM will review learnings from previous whānau voice continue to align with whānau expectations.

Outcomes

1.1 The Pae Ora Act describes the obligation that primary care must hear whānau voice and respond.

1.2 WAM was established to serve whānau and their needs; it is crucial that we hear their voices to understand what their needs are and continue to adapt the model accordingly.

1.3 WAM will take learnings collected from whānau from hospital front door, waiting room and service experience surveys that describe unmet need.

2.1 WAM will revisit previous collection of whānau voice with a focus to realign the current and future models of care.

Measures

1.1. WAM will analyse whānau voice with relevant partners, including WRHN and its subsidiaries, hospital specialist services and Haumoana team to understand what needs to change or be improved and apply findings to the WAM model.

Start 2024 ○ In Progress ○ Finish 2025 ○

1.2 WAM will analyse patient and whanau complaints related to their experience and adapt models of care to improve patient and whānau experience.

Start 2024 ○ In Progress ○ Finish 2025 ○

1.3 WAM will update the WRHN equity committee on a regular basis.

Start 2024 ○ In Progress ○ Finish 2025 ○

2.1 WAM will apply a CQI process to previous whānau voice collection to ensure outcomes are met.

Start 2024 ○ In Progress ○ Finish 2025 ○

Priority area 2: Capacity and Capability.

Risk

1. Wait times for medical assessment continue to increase due to increased demand for the care of complex patient presentations.

2. Workforce recruitment and retention, development and capability fails to meet workforce demands.

Approach

1.1 WAM remains a critical service option for increasing access and capacity to accident and urgent medical needs that is responsive to patient need.

1.2 WAM will continue to reconnect patients back to their own enrolled practices who are often presenting to WAM during General Practice opening hours to increased capacity at WAM and ensure comprehensive and continuity of care for patients and whanau with their enrolled general practice.

2.1 WAM will focus on strategies to grow clinical care workforce capability and capacity.

Outcomes

1.1 A workforce and facility that is fit for purpose and able to respond to the needs of people in the community that have access barriers to receiving care.

1.2 Explore alternate strategies to improve wait times by providing streamlined care to low acuity, uncomplex, patients and whanau, such as virtual medical services.

1.3 Work actively in partnership with WRHN and GHL and other partners to work towards shared goals and create shared solutions – within a hub project - to meet patient care needs to improve outcomes for whanau and rohe.

2.1 Maintain a workforce that is culturally and clinically competent that operates a partnership relationship with their whānau and community.

2.2. Staff are empowered and supported to work at top of scope – including unregulated workforce - to build capacity and capacity to serve patient needs.

2.3 WAM works with WRHN and other subsidiaries to consider new ways of working so our workforce is effective, efficient and the workforce enjoy high job satisfaction.

3. Develop and strengthen relationships and communication with GP practices and wider allied health organisations.

Measures

1.1. Reduced current wait times by utilising alternative virtual service options for people and whānau with less acute medical concerns to allow more in-person consults for people who are at risk or have complex conditions.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

1.2 Hybrid hub engages staff working collaboratively to better support the patient journey whilst maintaining the functionality of the current WAM workforce.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

2.1 Utilise the Pou Tikanga, Equity team and Haumoana team to support health literacy, particularly surrounding receiving virtual health care and the use of digital monitoring technology.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

2.2 Invest and expand clinical workforce to support virtual medical services with non-regulated workforce to free up RN resource to focus on more complex tasks.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

2.3 Invest and expand in clinical workforce training to provide additional services, such as EPCC acute packages of care, to increase capacity and capability of WAM workforce to care for people and whānau with more complex conditions.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

2.4 Support Nurse practitioner integration into RNZCUC training and scope to allow for practice independence of Nurse Practitioners in an Urgent Care.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

2.5 Workforce retention remains at an acceptable balance.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

3. Reduce frequent and multiple presentation rates to WAM for people enrolled with a general practice in Whanganui.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

Priority Area 3. Financial viability.

Risk

1. Financial viability.

Approach

1. WAM business and service models will remain financially viable and responsive to acute demand needs.

2. WAM will focus on strategies that generate maximum income opportunities.

Outcomes

1.1 WAM remains financially viable and acts in a fiscally responsible way to be well placed to continue to contribute value.

1.2. WAM works to remain viable to ensure afterhours care is available to the whole Whanganui rohe.

1.3 Explore strategies to reduce patient debt.

1.4 Business Support lead to continue to support and teach ongoing quality processes/systems for accurate invoicing of revenue streams for the Wam team.

2.1 Invest in providing additional services to our people e.g. EPCC, all of which helps to improve health outcomes for our patients, prevent ED admission and generates additional income.

Measures

1.1 Increased payments on the day of consultation KPI 80%.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

1.2 Debt management is showing an impact with a notable increase of APs and Winz redirections.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

1.3 Achieve forecast position or better.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

2.1 Contracts maximised and linked to funding options supporting models of care.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

Priority Area 4: Front door: Patients safe first point of contact requires timely care at right place in right time and transparency within current co-located model (located bedside ED).

Risk

1. Delay in treatment continues to lead to negative patient outcomes.

2. Poor patient/ whānau experience with current co-located model (located bedside ED).

Approach

1.1 WAM will ensure a clinically safe approach with first point of contact with a nurse to navigate patients and whānau to the right place, at the right time.

2.1 WAM leadership will continue to work with the ED leadership to maintain momentum in the arrangements to provide a patient/whānau focused accident and urgent medical care services within a seamless 'one door' approach with Emergency Department.

Outcomes

1.1 Implement a clinically safe model of care that allows for a nurse as the first point of contact for all patients presenting for health care.

2.1 Improved relationships between departments/clinic with a purpose to improve patient experience and quality patient care.

Measures

1.1 Reduce sentinel events and complaints regarding clinical care at first point of contact.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

1.2 Reduction in wait time to triage.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

1.3 Reduced waiting times to be seen in clinic.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

2.1 Whānau voice informs WAM/ED leaders team regarding ongoing developments in process and design of front door to nurse first, waiting room environment and WAM service.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

2.2 Improved transparency of service allocation for patients directed to either WAM or ED - the right service at the right time – to improve patient / whānau experience.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

Priority Area 5: Unenrolled population – unmet need.

Risk

1. The unenrolled population are at risk of having complex unmet needs leading to inequitable outcomes.

Approach

1. Identify unenrolled patients accessing episodic care from WAM and connect to a general practice with capacity.

Outcomes

1.1 Actively identify and encourage the unenrolled population to connect with an enrolling general practice.

1.2 In collaboration with WRHN and GHL and other partners, create a hub response to assist patients who are unable to find a General Practice Team to enrol within Whanganui.

Measures

1.1 Reduction in unenrolled population accessing WAM in 24/25 with symbiotic increase in enrolments to GPTs.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

1.2 WRHN team, GHL and WAM will explore the Hub concept to understand where opportunities exist for improvement of patient engagement and enrolment with primary care.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯

1.3. Utilise the hub concept to increase opportunistic population screening and referrals to services during pre-enrolment to enable early identification of other wellness needs.

Start 2024 ◯ In Progress ◯ Finish 2025 ◯