Central Primary Health Organisation
Strategic Plan

2016-2019

CentralPHO

Working together, towards healthy and flourishing communities

July 2016

Excellence every day

FOREWORD

This 3 year plan has set a big vision that we aspire to. The goals in this plan are a response to the significant challenges presenting to us in 2016.

These challenges include that we must:

- Improve people's health experience
- Support General Practice to evolve more efficacious models of care and instil quality as routine
- Renew workforce and business models as a significant portion of our workforce plans retirement
- Achieve more with less resources
- Deploy technology effectively
- Make a tangible difference to access and equity
- Protect our specialist services from being overwhelmed by our growing older population
- Revise contracting methodology to ensure incentives are aligned and administrative burden is minimised
- Devise strategies that deliver health and social services as a package to our priority populations.

Our communities deserve "excellence everyday" - there is a lot to do.

Chiquita Hansen
CEO
Central PHO

July 2016

After three years of consolidation and performance improvement the Central PHO is ready to launch an exciting new strategic direction.

This will build on our excellent relationship with MidCentral DHB and our 32 contracted General Practices plus add a significant new direction reaching out more closely to the NGO sector which has so much to offer primary care.

To attain our goals we will need every single one of us involved in the Primary Health Care sector to deliver "at the top of our licence". Enabling this to happen is a fundamental but less visible part of the plan, hence we are putting a strong emphasis on supporting the clinical, administrative and financial performance of primary care in our area.

Te Tihi Whanau Ora Alliance is a key strategic partner and neatly encapsulates how the future will be different for us all.

Achieving this plan will be a marathon – not a 100 metre dash. We have trained and prepared well. Our approach will be measured and we will move steadfastly towards our vision.

Dr Bruce Stewart
Chair
Central PHO/ALT Board

July 2016

Our Vision Where are we going?

"Working together towards healthy and flourishing communities"

Excellence every day

Our Structure How are we governed?

Who	Function
Central Primary Health Organisation (Central PHO) Board – (14) **Trustees - GPs, Nurses, Community, Māori/Iwi, MidCentral DHB specialists**	**Provides governance over first contact health services and LTC, Child, Older, Mental, Acute, Māori and Pacific Health DHB funded clinical services which support a primary health care driven system to deliver quality care closer to home**

Supported by

Clinical Board	Information Governance Committee	Finance Audit and Risk Committee
Monitors and oversees clinical performance of Central PHO and the Central PHO contracted healthcare providers. Develops and facilitates the processes and tools required to enable health care teams to continuously monitor and improve the quality of their care provided	**Oversees the information and communications technology (ICT) & Business Intelligence (data) investment priorities for Central PHO and general practices and Integrated Family Healthcare Centres "(IFHCs")**	**Oversees the financial management, organisational compliance and risk for Central PHO and its other entities whether fully owned, in partnership or through a partial interest**

Who	Function
Alliance Leadership Team (Central PHO Board Trustees + 8) **Clinical Board Chair, GM Strategy, Planning & Performance, IFHC Leader, Whānau Ora Collective Leaders, MidCentral DHB Specialists**	**ALT is an extension of the Central PHO Board and provides a way of broadening the mandate of the organisation and also extending participation in decision making. The parties work together to transform health services in the district with the emphasis on achieving integrated care, quality health services and improved health outcomes within available resources**
Alliance Management Team (18) **Primary, MidCentral DHB Specialists, Strategy, Planning & Performance Portfolio Managers, IFHC & Whānau Ora Managers**	**AMT is a sector-wide management team which supports the goals of Central PHO by providing management leadership, driving service improvement and whole of system thinking.**

Central PHO and MidCentral DHB Alliance is founded on the following principles:

• Working as a team, in an innovative and open manner, to produce outstanding results; • Supporting clinical leadership and, in particular, clinically-led service development; • Adopting a patient-centred, whole-of-system approach and making decisions on a best for System basis; • Supporting behaviour and leadership that is professional; • Remaining flexible and responsive to support an evolving health environment	• Conducting ourselves with honesty and integrity and developing a high degree of trust; • Promoting an environment of high quality; • performance and accountability, and low bureaucracy; • Striving to resolve disagreements co-operatively and, wherever possible, achieving consensus; • Incorporating Whānau Ora approaches and principles; • Developing, encouraging and rewarding innovation and challenging our status quo	• Seeking to make the best use of finite resources in planning and delivering health services to achieve improved health outcomes for our populations; • Adopting and fostering an open and transparent approach to sharing information; • Monitoring and reporting on our Alliance's achievements, including public reporting; • Actively supporting and building on our successes • Being collectively responsible for all decisions and outcomes of our Alliance;	• Operating as a unified team providing mutual support, appreciation and encouragement; • Conducting ourselves in accordance with Best Practice; • Fully exploring the collective sharing and management of the risks and benefits arising from our Alliance Activities; • Where we cannot manage risk collectively, our principle is to allocate responsibility for each risk to those of us who can best manage it

Our Alliance Scope includes:

• PHO funded LTC services
• Integration of specialist community health services with IFHCs, general practice teams and other PHC providers
• Support for PHC by specialist services
• Achieving health and intersectoral integration for:
  ▪ Child and youth
  ▪ Older people
  ▪ Mental health
	• Whānau Ora
	• Rural
	• PHC workforce development
	• Health Care Development
	• Information and communication technology
	• Joined up quality improvement approach
	• Community radiology/pharms/labs
	• Collaborative Clinical Pathways
	• Clinical Networks

Our High Level Outcomes: Why are we here?

Mauri Ora *"Individual, me, person"*	***Whānau Ora*** *"Whānau, family"*	***Wai Ora*** *"Community"*
Reduce amenable mortality for people with long term conditions **Contribute to reduced acute bed utilisation** **Increase individual, Whānau and communities positive experience of care**	**Improve equity in population health status** **Individual and Whānau centred approach to better co-ordinated integrated services**	**Supported capable PHC workforce** **PHC financial and clinical sustainability improved** **Positive Māori/Iwi relationships** **Cross sector alliances improve equity of outcomes**

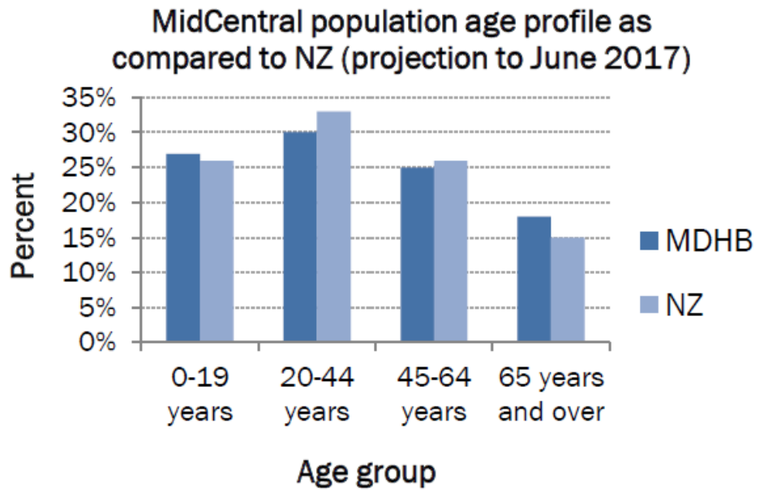
Excellence every day

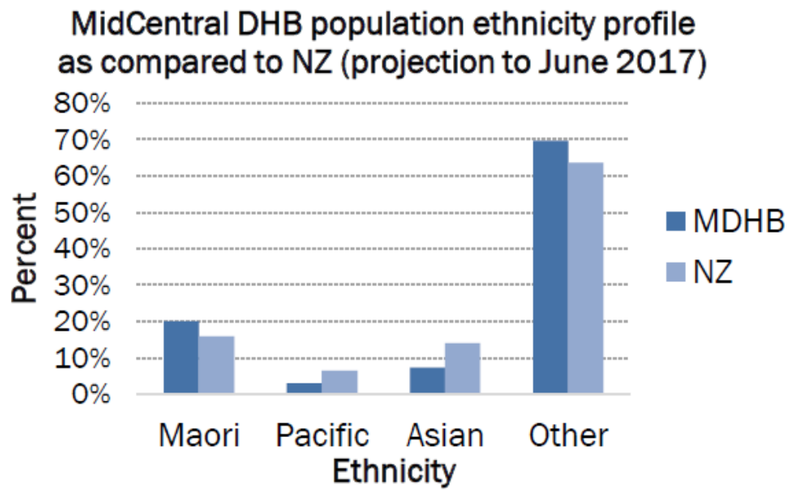
Our Values How do we get there?

Trust	**Maintaining open and honest relationships**	**Whakapono/ Rangatiratanga**
Respect	**Embracing diversity, uniqueness and ideas**	**Whakaaro nui/ Manaakitanga**
Unity	**Valuing strengths and skills**	**Kotahitanga**
Accountability	**Working in a transparent and responsible manner**	**He mana tō te kupu**
Courage	**Participating with confidence and enjoyment**	**Ka tū te ihiihi/ Whakamanawanui/ Hautoa**

Our Population

Central PHO covers the MidCentral district population approximately (174,340) and is located across the mid-lower North Island and includes the Ōtaki ward of the Kapiti Coast district and the Territorial Local Authority districts of Horowhenua, Palmerston North City, Manawatū and Tararua. The district covers a land area of approximately 8,912 square kilometres.





The MidCentral population has a higher proportion of people living in more deprived neighbourhoods when compared to the national average. People living in Horowhenua, Ōtaki, and Tararua experience the highest levels of deprivation along with people in some parts of Feilding and some areas of Palmerston North City (including Highbury, Roslyn, Central City, Westbrook and Awapuni North). People experiencing socioeconomic disadvantage are also likely to experience health status disadvantage.

The age profile of the MidCentral population is broadly similar to the national average, but with a slightly higher proportion of adults aged over 65 years and a slightly lower proportion of adults in the 20-44 year age group.
The MidCentral population has a higher proportion of Māori and a lower proportion of Pacific and Asian residents when compared to the national average3. In MidCentral approximately 20 percent of residents are Māori, 3 percent are Pacific, 7 percent are Asian and 70 percent are of other ethnicities. The MidCentral district is one of five refugee resettlement areas in New Zealand and the number of residents with refugee status, particularly in Palmerston North City, is growing.

The MidCentral Māori population is youthful with half of all Māori living in the MidCentral district aged less than 23 years in 2013. The MidCentral population, both Māori and non-Māori, is becoming older and this presents a significant challenge for the future provision of services to improve health and wellbeing.

Our People and Services

Central PHO has an enrolled population of just over 155,000 people. We are contracted by MidCentral DHB to deliver a number of first contact care services as well as primary mental health and long term conditions (LTC) services to our community and receive flexible funding from the Ministry of Health to transform services.

Central PHO contracts 8 Integrated Family Health Care Centres (IFHC's) and 22 General Practice Teams (GPT's) and over 145 other providers covering an extensive range of services such as mental health, child, youth, older people and Māori health.

Central PHO supports general practice and IFHCs health home philosophy through aligning/devolving of interdisciplinary clinicians, providing access to programmes and facilitating system enablers. Over sixty percent of staff are clinicians, with the remainder of staff being focussed on infrastructure development and Māori and Pacific health. The Māori Health Team supports Whānau ora approaches and Te Tihi o Ruahine Whānau Ora Alliance. Health Care Development (HCD), a division of MidCentral DHB Strategy, Planning and Performance support the LTC, acute care and child health aspirations outlined in this plan.

Central PHO owns one General Practice, Horowhenua Community Practice (HCP) based in the Horowhenua Healthcare Centre in Levin and operate as a 50/50 partnership with Te Rūnanga o Raukawa in Te Waiora Integrated Community Healthcare Centre in Foxton and Shannon. Both HCP and Te Waiora operate within Annual Plans which are aligned to this Strategic Plan.

Our Strategic Focus Areas: What are we going to do?

The Ministry of Health refreshed the New Zealand Health Strategy in April 2016
"All New Zealanders live well, stay well, get well"

In June 2016 MidCentral DHB has adopted a new Strategic Framework

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Central PHO has engaged with a wide range of key stakeholders to identify five strategic focus areas for the next three years. These focus areas align with the Ministry of Health and MidCentral DHB strategies outlined above.

Our Challenges and Opportunities

Central PHO, along with the health sector more generally, faces a number of challenges and opportunities. These have influenced the development of this plan and the identification and understanding of factors that could affect our performance, how we mitigate unacceptable levels of risk, and how we address improvement or change. Equally, there are opportunities that could enhance our performance, particularly when we work collectively with our stakeholders (partners, consumers and whānau, providers and staff), make better use of information and intelligence, and capitalise on the talent and leadership offered by our primary health care network. Below is a table that provides a high level summary of the key challenges and opportunities and how they are integrated into the Plan.

Challenges	Opportunities	Organisation Plan Strategic Focus
Changing demographics ▸ Ageing population ▸ Priority/vulnerable populations access to services ▸ Growing socioeconomic gap ▸ Increasingly sedentary population ▸ Increased complexity of people with long term conditions, including mental health ▸ Social, cultural, economic and geographical barriers to access	▸ Increase focus on culturally appropriate service delivery models ▸ Population health education and promotion, health literacy ▸ Whānau Ora based approach ▸ Increase consumer engagement ▸ Service co-design focuses on patient centric approach ▸ Risk stratification to understand and prioritise resources to support general practice to manage complexity ▸ Early detection and intervention ▸ Partnering with others	▸ Improve **access** and **equity** ▸ Co-design **integrated** care for **priority populations** ▸ **Partner** with people, community and providers to collectively meet needs of population
Sustainability ▸ Central PHO Funding ▸ General Practice funding ▸ IFHC funding ▸ Funding models support status quo rather than model of care change ▸ Central PHO's ICT services ▸ General Practice PMS ▸ Overburden of report writing at PHO and practice ▸ Central PHO governance and sub-committees performance ▸ Increased volume of ED presentations and ASH admissions ▸ Increase PHO enrolment ▸ Promote an environment of high quality, performance and accountability and low bureaucracy	▸ Align/devolve Central PHO clinicians to IFHCs/Whānau Ora Providers ▸ Refresh GP ownership strategy ▸ Develop partnerships with social sector organisations ▸ Support patient centred PMS system ▸ Contribute to local, regional and national service plans ▸ Financial and risk management strategies ▸ Contribute to development of High Trust Agreements ▸ Change from input reporting to outcome reporting ▸ Governance and sub-committee training ▸ Develop relationships with research agencies ▸ Review contract arrangements and develop high trust agreements with alliance partners ▸ Risk sharing approaches	▸ Co-design i**ntegrated** care for **priority populations** ▸ **Partner** with people, community and providers to collectively meet needs of population ▸ Activate **smart systems** to support GPT/IFHC's to thrive through effective relationships
Capability and capacity ▸ Retain/recruit skilled, culturally-able clinical/business workforce across PHC system ▸ Ageing workforce ▸ Low number of GPs ▸ Lack of investment in IT & systems & staff to support the same ▸ ICT network and system disconnected making integration and information sharing difficult ▸ Business intelligence/performance data not well understood or , well utilised for service planning &/or continuous improvement ▸ Unwanted variation across practices	▸ PHC Workforce development plan ▸ Talent development and succession planning ▸ Care delivered by broader range of professionals & in different settings ▸ ISSP ▸ Maximise use of technology ▸ Cross sector engagement ▸ Service design ▸ Productive general practice ▸ IFHC maturity matrix ▸ Models of care ▸ Drive ICT and business intelligence across the system ▸ Investment in ICT infrastructure development and business intelligence skills	▸ **Quality** Foundation for Success ▸ Activate **smart systems** to support GPT/IFHCs (health home) to thrive ▸ Improve **access** and **equity**

How do we Ensure the Strategic Plan is Fit for Purpose?

The strategic focus, key activities and high level outcomes will be reviewed each year and will be supported by an Annual Work Programme and an Annual Organisation Development Programme.

What? Our strategic focus	How? Our 2016-2019 key activities	Why? Our high level outcomes *Mauri Ora-Whānau Ora-Wai Ora*
Improve **access** and **equity**	• Co-design a district wide model of urgent and acute care inclusive of afterhours • Preventative, early detection and pro-active interdisciplinary management of Long Term Conditions ("LTC") is consistently delivered • Complete LTC longitudinal research to inform ongoing improvements of LTC service delivery • Develop innovative solutions that bridge gaps to access and appropriateness of care • New PHC funding models and risk sharing approaches developed	*Mauri Ora* **Reduce amenable mortality for people with long term conditions** **Contribute to reduced acute bed utilisation** *Whānau Ora* **Increase individual, Whānau and communities positive experience of care** **Improve equity in population health status** **Individual and Whānau centred approach to better co-ordinated integrated services** *Wai Ora* **Supported capable PHC workforce** **PHC financial and clinical sustainability improved** **Positive Māori/Iwi relationships** **Cross sector alliances improve equity of outcomes**
Co-design i**ntegrated** care for **priority populations**	• Reduce amenable mortality for people with respiratory, cardiac, diabetes and chronic kidney disease • Co-design an improved integrated mental health model of care • Equitable access to community older persons specialist services are co-designed • Ensure individual, Whānau and community voice informs our approach to improve health literacy and self-management support • Continue to evolve and support child and youth health model of care	
Partner with people, community and providers to collectively meet needs of population	• Partner with local, national and international organisations to improve our approach to performance measurement, research and development • Contribute to development of locality plans to drive health and social system integration • Cross sector alliances developed which identify and address areas of inequality • Seek authentic opportunities to contribute and invest with Te Tihi o Ruahine, Raukawa Whānau Ora and Muaūpoko to strengthen a Whānau Ora approach to improving, whānau and communities health and wellbeing • Further engage and build opportunities and innovations to improve Pasifika health outcomes • Develop investment approaches to address complex health and social issues	
Quality Foundation for Success	• Improve use of data analytics to improve equitable service delivery and allocation of available resources at practice and PHO level • Develop shared PHC clinical governance and high trust agreements to drives equity of outcomes • Support IFHCs strategic planning through productive general practice and adoption of maturity matrix • Determine suitability and scalability of evidence based tools and resources • Enable primary and community providers to actively contribute to clinical networks and collaborative clinical pathways • Co-design and deliver on MoH new system level measures	
Activate **smart systems** to support GPT/IFHCs (health home) to thrive through effective relationships	• Co-design strategies and business models to position General Practice/IFHCs as an attractive option for the next generation • Refresh Central PHO current GP Ownership Strategy • Ensure the core operating PMS for Primary care is effective • Cultivate innovative approaches to PHC workforce development • Offer a range of credible back room services (ICT,HR, finances etc) to GP/IFHCs • Drive innovative ICT approaches (NES, portals, e-referrals etc) to improve PHC clinical and financial sustainability	

Our Values : ***Trust*** ***Respect*** ***Unity*** ***Accountable*** ***Courage***

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What we will focus on?	How do we align with others?	
• Improve **access** and **equity** • Co-design **integrated** care for **priority populations**	**DHB Strategic Imperative Alignment** • Achieve equity of outcomes across communities • Connect and transform primary, community & specialist care • Partnering with people and Whānau to support and wellbeing	**MoH NZ Health Care Strategy Alignment** • One team • People powered • Closer to home

How do we plan to go about it?

Activities to complete in the next 3 years ↓	Who does this involve and what does it mean for each stakeholder?			Our primary and system outcome measures
	What it means for individuals, Whānau and community	**What it means for GPT/IFHC**	**What it means for system**	

Co-design a district wide model of urgent and acute care inclusive of afterhours
 	
Preventative, early detection and pro-active interdisciplinary management of LTC is consistently delivered
 	
Complete LTC longitudinal research to inform ongoing improvements of LTC service delivery
 	
Develop innovative solutions that bridge gaps to access and appropriateness of care
 	
New PHC funding models and risk sharing approaches developed
 	
Reduce amenable mortality for people with respiratory, cardiac, diabetes and CKD
 	
Co-design an improved integrated mental health model of care
 	
Equitable access to community older persons specialist services are co-designed
 	
Ensure individual, Whānau and community voice informs our approach to improve health literacy and self-management support
 	
Continue to evolve and support child and youth health model of care
	Healthier individuals, Whānau and communities
	
	People will feel more in control of their lives and health
	
	More people being able to manage their long term health conditions so that they stay well
	
	The demand for services related to "lifestyle" disease will decrease
	
	People, Whānau and the community are engaged in co-designing services
	
	People will be able to prioritise their health as other significant stresses are reduced
	
	Care will be provided in non-traditional locations
	
	People will understand the health options open to them
	
	Better and more consistent access to PHC and after hours services for acute and urgent care
	
	People have timely access to GPT/IFHC though:
	• information via a health portal
	• non face to face care
	• home (or place of patients choice) visits for priority populations
	• Interdisciplinary practice team and range of community based service:
	  ○ LTC – Enhanced Care+ ("EC+") & lifestyle services
	  ○ Whānau ora navigation
	  ○ Acute Care – Primary Options for Acute Care ("POAC")
	  ○ Primary Mental Health
	  ○ Specialist child health & older persons
	  ○ Sexual Health
	  ○ Palliative Care
	  ○ Community Radiology, Retinal screening
	• Self-Management support programmes
		I am supported by Central PHO to deliver:
		
		• acute care planning that enables our Practice to meet seasonal demand so that we can reduce ASH & ED admissions
		• quality programmes and support groups for people with long term conditions
		• preventative initiatives and education for people who could develop long term conditions
		• quality programmes that respond to the needs of our priority populations
		• Comprehensive Health Assessment ("CHA") and care plan to drive improved self and clinical management
		
		Central PHO helps us with a range of practice support initiatives that include:
		
		• a wider range of standardised options to access broader and more comprehensive care, advice and interventions to enable us to manage enrolled population health needs
		• further alignment/devolvement of LTC clinicians
		• innovations and funding opportunities that provide us with flexibility around delivery of affordable care
		• targeting additional capacity for those with greatest social, clinical or physical needs to help us plan and deliver enhanced care
		• coordination of preventive health services e.g. immunisation, cervical screening
		• initiatives that ensure patients have more control over their own care by being better informed
		
		Central PHO helps us with a range of quality improvement strategies that include:
		
		• easy access to community child and older persons specialist service
		• cultural responsiveness and health equity approach
		• data analysis to help us reflect on our performance across a range of population health targets
			Enrolled population can easily access GPT/IFHC team based care
			
			Quality, responsive, consistent acute and urgent services are available
			
			Health home philosophy is strengthened through improved relationships with key stakeholders
			
			Patients demonstrably take control of, and are actively involved in, their healthcare
			
			Specialist services are aligned to IFHCs and provide collaborative consults, peer review case review and clinical teaching
			
			Information sharing improves between health professionals
			
			Less duplication resulting in more appropriate use of health professionals time and better coordination of services
			
			Traditional barriers to access will be reduced
			
			Primary and community services are more aligned
			
			People's care is more joined up across health and social services
			
			More time / access is available in community settings to manage acute illness, reducing demand on hospital care for unplanned or low acuity care
			
			Health and social care provision is integrated around the individual patient and family/Whānau needs
				Primary level
				• Positive increase in number of enrolled population accessing their primary care provider through patient portal
				• Patient wait times in GPT/IFHCs improve
				• Access to non-face to face care increases
				• Access to afterhours care is equitable
				• Increase in community orientated specialist services accessed by priority populations
				• Increase in number of priority populations home visits/visits to patient place of choice
				• Increase in range of self-management support programmes accessed by priority populations
				• Number of acute presentations to primary options for acute care
				• Increase in non-traditional patient contacts through an interdisciplinary primary health care team
				• Increased number of GPT/IFHC created care plans for people with complex co-morbidities
				
				System Level
				• Reduced number of ED presentations
				• Reduced number of ASH admissions
				• Impact of new PHC funding is measured
				• Longitudinal LTC research identifies improvement from clinician and patient perspective
				• Actions within the Manawatū, Horowhenua, Tararua Diabetes Trust and Manawatū Community Pharmacy Group ("MCPG") MOUs are met

What we will focus on?

- **Partner** with people, community and providers to collectively meet needs of population

How do we align with others?

DHB Strategic Imperative Alignment

- Partnering with people and Whānau to support health and wellbeing
- Achieve equity of outcomes across communities

MoH NZ Health Care Strategy Alignment

- People powered
- One team

How do we plan to go about it?

Activities to complete in the next 3 years ↓	Who does this involve and what does it mean for each stakeholder?			Our primary and system outcome measures
	What it means for individuals, Whānau and community	**What it means for GPT/IFHC**	**What it means for system**	
Partner with local, national and international organisations to improve our approach to performance measurement, research and development Contribute to development of locality plans to drive health and social system integration Cross sector Alliances developed which identify and address areas of inequality Seek authentic opportunities to contribute and invest with Te Tihi o Ruahine, Raukawa Whānau Ora and Muaūpoko Tribal Authority to strengthen a Whānau Ora approach to improving, whānau and communities health and wellbeing Further engage and build opportunities and innovations to improve Pasifika health outcomes Develop investment approaches to address complex health and social issues	The community actively knows about and contributes to the Locality Plan for their community Whānau Ora approach is known and understood by the community Māori are actively aware of the range of programmes and opportunities offered by Te Tihi Home Organisations. Pasifika are engaged in planning the types of services and the delivery of these services to Pasifika people Pasifika are actively aware of, and use, the Pasifika programmes Community are invited to participate in a number of co-design opportunities Through feedback mechanisms, Whānau state that services are more Whānau centred and responsive to diverse Whānau realities Whānau are responsible stewards of their living and natural environments Whānau and families confidently participate in Te Ao Māori Whānau and families are economically secure and successfully involved in wealth creation The community knows the health services available to them, the outcome measures the sector is aiming to achieve and our performance against these measures	Central PHO ensure that we are actively aware of and contribute to: • the Locality Plan for their community • the Whānau Ora service • the range of programmes and opportunities offered by Te Tihi Home Organisations • the Pasifika programmes. Central PHO ensure that we know about and empower us, where possible, to contribute to: • cross sector alliances • research and development initiatives Central PHO helps us to take an equity lens and improve inequalities through: • support to use equity tools and resources • presenting data that has an equity lens applied • analysing our data with an equity lens to help us reflect on our performance and how to improve our approach and services Central PHO strongly encourages us to strengthen relationships that help improve the health and social outcomes of our enrolled population GPT/IFHC's know the outcome measures the district is aiming to achieve and their performance against those measures	District equity outcome performance measures are clearly described and measured System providers can clearly articulate the district's equity outcome measures and other health outcome measures; and the districts performance against these measures Mutually beneficial relationships are formed with identified local, national and international organisations Collective impact methodology is used to measure performance across the system A cross sector approach is taken to the compilation of community Locality Plans and resulting alliances formed to deliver the outcomes identified in the Plan Cross sector relationships are explicit and developed for the benefit of system change and integration The Whānau ora programme contributes to the reduction ASH and ED admissions	**Primary level** • Relationship with HQSC established • Health Quality Ontario partnership is agreed in a MoU • Research topics/funding is approved and academia partnerships secured • Collective impact methodology is used to drive population health improvement **Whānau Ora Outcomes** • Whānau are self-managing and empowered leaders • Whānau are leading healthy lifestyles • Whānau are participating fully in society • Whānau and families are economically secure and successfully involved in wealth creation • Whānau are cohesive, resilient and nurturing • Whānau and families are responsible stewards of their living and natural environments • The number of Whānau participating in Te Ao Māori is increasing **System Level** • Central PHO contributes to development of locality plans. • Cross sector alliances are established • Whānau ora approach is strengthened through partnerships with Te Tihi, Raukawa • Whānau Ora and Muaūpoko Tribal Authority/Pasifika/Māori Clinical indicators improve each quarter

What we will focus on?

- **Quality** Foundation for Success
- Activate **smart systems** to support GPT/IFHCs (health home) to thrive through effective relationships

How do we align with others?

DHB Strategic Imperative Alignment

- Achieve quality and excellence by design
- Achieve equity of outcomes across communities

MoH NZ Health Care Strategy Alignment

- Value and high performance
- Smart System

How do we plan to go about it?

Activities to complete in the next 3 years ↓	Who does this involve and what does it mean for each stakeholder?			Our primary and system outcome measures
	What it means for individuals, Whānau and community	**What it means for GPT/IFHC**	**What it means for system**	
Improve use of data analytics to improve equitable service delivery and allocation of available resources at practice and PHO level Develop shared PHC clinical governance and high trust agreements to drive equity of outcomes Support IFHCs strategic planning through productive general practice & adoption of maturity matrix Determine suitability and scalability of evidence based tools and resources Enable primary and community providers to actively contribute to clinical networks and collaborative clinical pathways Co-design and deliver on MoH new system level measures Co-design strategies and business models to position General Practice/IFHCs as an attractive option for the next generation Refresh Central PHO current GP Ownership Strategy Ensure the core operating PMS for Primary care is effective Cultivate innovative approaches to PHC workforce development Offer a range of credible back room services (ICT,HR, finances etc) to GP/IFHCs Drive innovative ICT approaches to improve PHC clinical and financial sustainability	People will use tools to feel more in control of their lives and health Priority people have the ability to view and share their health care plan with approved others The community will understand the range of literature, tools and services available to them Tools will help people, Whānau and community engage with the health sector in a more timely manner People will have control over their own care and be better informed through easy access to their health records People, Whānau and community will provide regular feedback to IFHC's and GP's to help shape delivery, and the type of services that impact them People and Whānau will be contacted by their IFHC / GPT to remind them of check-ups, tests, activities etc that will proactively enhance their health and lifestyle People, Whānau and community will have confidence that their GP/IFHC: • has longevity into the future • provides them with the services they need, in the manner that they can receive them • help facilitate activity/services with other entities (cross sector collaboration) • is actively utilising an evidence based approach service delivery • can easily access diagnostics when required	I am supported by Central PHO to understand: • Our performance against a range of targets e.g. ASH & ED admissions, health targets etc, • Our performance by clinician • Our performance benchmarked against other like sized IFHC, GPT • Our population by demographics and conditions • Clinical pathways that helps safe decision making I am supported by Central PHO through: • Increasing our capacity and realising revenue through adopting the IFHC maturity matrix • Maximise benefit of PMS and patient portal • Increasing our capacity through re-engineering and standardising clinical and business processes • Developing high trust agreements that help empower us to build our capability while reducing administration • Developing strategic and annual plans through the use of PGP • Exit and succession planning • Developing an IFHC maturity matrix that helps ensure the long term viability of our IFHC and provides us with the opportunity to retire from our positions with dignity and for business owners, without an economic penalty • Business continuity & emergency response planning • Cultural responsiveness training • Advice on legislation updates • Helping us achieve Cornerstone accreditation • Providing information, communications and technology (ICT) and system Integration advice and support e.g. referrals, clinical portals, NES etc • Supporting workforce professional development so that we are a first choice option for clinicians and health staff in our district • Helping us broaden our core teams to include health care assistants, physician assistants etc • Seeking economy of scale opportunities that can be scaled to better support the delivery of personal care	• Technology and information is maximised to support health/social teams to support patients well being • Social and healthcare services are focused around individuals/whanu needs • Patients health records will be proactively, safely and appropriately shared between providers • IFHC's flourish and are viable for the long-term • IFHC's & GPT's understand and respond to the needs of their communities • The Health Home philosophy is strengthened through consistent infrastructure and shared system and information approaches with key stakeholders • Health workforce will be better developed and aligned to meet demand in the medium to long term • The current workforce challenge is resolved by developing and expanding the primary care workforce • Sustainability of high quality GPT/IFHC and community providers by achieving economies of scale infrastructure to better support the maintenance of personal care • Significant economic benefits are generated across the health system as a whole by acting collectively • Integration is achieved with other health and social providers through national tele-health services, electronic portals, e-prescribing	**Primary level** • MoH System Level Measures understood and met • Innovative IFHC business models established • Collaborative clinical pathways are adopted at all GPT/IFHC's • Uptake and usage of collaborative clinical pathways increases • The number of clinical pathways available increases • Standardised core operating PMS is available across district • Standardised backroom functions are available to GP/IFHCs across district • 75% of the population are utilising patient portal by December 2018 • All IFHCs participate in PGP **System Level** • Workforce development strategy improves number and capability of PHC clinicians across district • 80% of PHO, IFHC and GPT staff have completed the cultural responsiveness programme by June 2018 • Positive impact are evident from Clinical networks activities • GPT/IFHC use of the provider reporting portal increases • GPT/IFHC have access to performance information that helps future planning • PHC has integrated with national tele-health services, electronic portals and e-prescribing tools • Central PHO ownership strategy has been reviewed & accepted • A district agreed IFHC Maturity matrix has been co-designed & implemented at all IFHC's • Capacity at IFHC's has been increased by 15% through re-engineering clinical and business processes.