

# WHANGANUI REGIONAL PRIMARY HEALTH ORGANISATION

## STRATEGIC PLAN

2007-2010

### **Strategic Planning**

"Begin with the end in mind" - Stephen Covey

*Strategic Planning, at its most basic, is a disciplined plan to accomplish your core goals. Studies over decades have shown that a carefully developed strategic plan pays huge dividends in focus and clarity of mission.*

*Strategic planning involves an examination of the current environment, awareness of the pending challenges and opportunities, and regular check-ins so strategic plans become ongoing time-management tools that tell leaders and staff where to focus energy and resources.*

**Board of Directors  
October 2007**

# CONTENTS

## 1.0 PURPOSE

1.1	Introduction	3
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## 2.0 STRATEGIC DEVELOPMENT

2.1	Vision	3
2.2	Mission	3
2.3	Values	3
2.4	Governing principles	4

## 3.0 GOALS AND STRATEGIES

3.1	Goals	5
3.2	Strategies	5
3.3	WRPHO strategic framework	8

## 4.0 APPENDICES

4.1	Background	10
4.2	Sector summary	11
4.3	Population	12
4.4	Environmental scan	13
4.5	Population demographics	14

## **1.0 PURPOSE**

### **1.1 Introduction**

This document represents the second strategic plan developed since Whanganui Regional Primary Health Organisation (WRPHO) was established. The content of the plan provides the organisation, strategic partners and stakeholder groups with a 'roadmap' as to the way forward for Whanganui Regional Primary Health Organisation over the next three year period.

The document has evolved following consultation with all key internal stakeholders such as;

- Governance Board of Trustees
- Clinical Governance Group
- Employees
- Community Advisory Group
- General practice members

## **2.0 STRATEGIC DEVELOPMENT**

### **2.1 Vision**

Whanganui Regional Primary Health Organisation - is a leader in driving high quality health outcomes through innovative partnerships, resulting in healthier communities and improved individual wellbeing.

### **2.2 Mission**

Leading equitable provision of primary health care, through creative and successful decision making with our communities.

### **2.3 Values**

- Integrity
- Honesty
- Value
- Effectiveness
- Commitment
- Cooperation
- Teamwork
- Passion

## 2.4 Governing Principles

The following are principles that will guide the WRPHO over the next three years and beyond.

**P** – Partnership & participation

**A** – Access

**C** – Creative

**E** – Efficient and Equitable

These principles describe how we will work, how we will behave, and how we will make decisions. They will serve as a reference point for setting priorities and form the basis from which we will plan and evaluate health initiatives.

### Will work in partnership and collaboration

- Working in partnership with Māori, Pacific Island people and rural communities and health providers to ensure a seamless and comprehensive health service that is accessible, timely and affordable for the population as a whole.
- Engaging and consulting with our communities and ensure consumer participation when planning and evaluating health service delivery.
- Promoting and actively seeking innovation in planning and delivery of a continuum of health and wellbeing model.
- Promoting patient centred professionalism working pro-actively as a team, collaboratively across practices, using best practice evidence based models.

### Will ensure equity of access and service provision

- Providing health services, which are culturally competent and acceptable to Māori and Pacific Island people.
- Developing strategies to address inequality of health status for Māori, Pacific Island people and low-income groups.
- Providing support and rehabilitation for people with chronic health problems and/or disability.
- Addressing access to service issues to ensure there are opportunities for all citizens to access at a minimum, first line services.

### Will further develop a population health model

- Maintaining and improving the health of the Wanganui region's population and restoring people's health when they are unwell.
- Gaining greater understanding of the health needs of the population.
- Providing population health services to protect, screen and improve people's health status that will support a focus of maintaining wellness.
- Effectively prioritising resource allocation and proactively seek funding to ensure an adequate share of funding is available to meet local health need.
- Maintaining and supporting existing services that continue to meet the needs of its enrolled population whilst channelling new investment into identified priority areas.
- Being creative and innovative in our approach to meeting the needs of people with chronic conditions.

### Will use information to improve performance

- Establishing systems and processes, which monitor and evaluate the effectiveness of health care delivery ensuring the population has access to a safe service and one that the community has confidence in.
- Using quality based systems and processes for the provision of assessment, treatment, health information and information for any episodes of ill health.
- Recognising that a framework for continuous quality improvement requires strong leadership and continuous monitoring, review and improvement.
- Utilising informed decision making to ensure financial viability/prudence – best use of resources.
- Will be cognisant of the responsibility it has for ensuring data pertaining to the enrolled population remains confidential and non – identifiable to external parties.

## **3.0 GOALS AND STRATEGIES**

This plan reinforces the vision of the Primary Health Care Strategy that:

*“Primary health care services will focus on better health for a population, and actively work to reduce health inequalities between different groups.”*

WRPHO supports the Primary Health Care Strategy of a changing health system, one better suited to prevention and supporting peoples’ well-being. WRPHO seeks to achieve its vision of *reducing health inequalities - innovation primary health options through;*

### **3.1 Goals**

1. Be proactive in addressing health inequalities within the enrolled population
2. Collaborative coordinated responses to community and peoples’ health needs
3. Grow and support an evolving primary care workforce to meet consumer demand
4. Secure financial viability and sustainability
5. An integrated continuous improvement population health approach into how we plan and deliver care

### **3.2 Strategies**

1. **Be proactive in addressing health inequalities within the enrolled population through**
  - Continue to enhance engagement and interaction of communities at all decision making levels
  - Develop strategies to address inequalities for Māori (with input from Māori governance and operational representatives)
  - Strengthen primary care services to be culturally responsive to the needs of Māori
  - Maintain an effective relationship with Pasifika Health Advisory Group (offering a partnership approach to planning and delivery)

- Clinical indicator rates meet national targets
- Enable health education and prevention
- Increase screening and assessment processes for enrolled patients
- Increased investment in promoting healthy lifestyles
- Take a planned rather than a reactive approach to growth
- Identify opportunities and implement strategies to remove health inequalities
- Promote innovative solutions to improve access
- Maintain an emphasis on prevention and management of chronic diseases
- Implementation of sustainable strategies through focusing on the horizon
- Ensure a continued focus and sufficient resources available within the community for effective treatment and self management
- Whanau ora model integrated within general practice

## **2. Collaborative coordinated responses to community and peoples' health needs**

- Support and strengthen organised general practice to meet the challenges and impact of internal and external factors
- Foster seamless services for people with chronic diseases
- Strengthen and develop effective team work within organised general practice
- Promote the patient and their whanau as the central focal point for all clinical activity
- Streamline linkages/co-ordination processes within community / secondary sector
- Adopt systems approach to delivery of care models
- Strengthen collaboration, co-ordination and continuity across the care continuum
- Community participation in service design, delivery, monitoring and evaluation
- Communication is based as much on the needs of the patients as the needs of the experts
- Increasing development and participation in screening programmes
- Improved capacity of community providers to provide early detection and intervention

## **3. Grow and support an evolving primary care workforce to meet consumer demand**

- Development of strategies to proactively address predicted and actual shortfalls of individual workforce groups
- Participate in the development of primary workforce plan
- Undertake healthy workplace programme
- Manage staff resources effectively
- Participate in the development of workforce innovations, i.e. nurse practitioner model, GP training
- Promote and support GP provider viability and sustainability wherever possible
- Promote and foster an environment of shared learning
- Develop increased workforce expertise and capacity
- Develop and implement strategies for succession planning
- A sustainable and effective rural workforce will be supported to meet the needs of the enrolled rural population
- Support the development of nurse practitioners and nurse led service models
- Workforce development plan will support medical and nursing workforce competency and maintenance of skills

#### **4. Secure financial viability and sustainability**

- Demonstrate clear accountabilities for population health and wellness
- An integrated population health approach in how we plan and deliver care
- Secure financial viability through effective and efficient systems offering flexibility and responsiveness
- Develop prevention, promotion and long term maintenance strategies to achieve an improvement in the health and wellness of the enrolled population
- Ensure robust collection and analysis of data collection forms the foundation of strategic developments
- Data collation will be integrated to identify and monitor population health need and gaps in service delivery
- Invest in an administration/business unit which will competently respond to the opportunities that exist within the current primary environment and capitalise on growth and development opportunities
- Pursue opportunities to gain revenue without adding to cost structure
- Improve match between demand and supply of resources
- Extend depth and relevance of data and information management
- Develop an integrated IT strategy and IS implementation plan
- Increasing use of IT for diagnostics, screening
- Promote integrated information strategies
- Capitalise on shared services opportunities
- Development and implementation of capital asset plan

#### **5. An integrated continuous improvement population health approach into how we plan and deliver care**

- First line services will systematically work towards implementing a continuous quality improvement programme within each practice
- Be nationally and locally recognised as an innovative and high performing organisation
- WRPHO will participate in activities that highlight achievements and benchmark standards of performance
- Fostering a continuous quality improvement clinical excellence environment
- Evidence based decision making
- All GP practices participate in an accreditation process
- Establishment of alternative model for GP Liaison
- Strengthen practice based clinical audit
- Pilot primary health care models and innovations
- Provide patients centred services across the continuum
- Integrated collaborative teams will work across health, social and education sectors delivering a shared vision
- Work alongside community bodies and interest groups to promote population growth, particularly retention of our young people

### 3.3 Strategic Framework 2007 - 2010

<b>Vision</b>	Whanganui Regional Primary Health Organisation - is a leader in driving high quality health outcomes through innovative partnerships, resulting in healthier communities and improved individual wellbeing.				
<b>Mission</b>	Leading equitable provision of primary health care through creative and successful decision making with our communities.				
<b>Outcomes</b>	Health inequalities reduced	Local communities are engaged	Primary care workforce is strengthened	Financial risk minimised & revenue maximised	Clinical standards of practice are assured
<b>Objectives 1 – 5 years</b>	To excel in innovative strategies to improve, maintain and restore people's health	To ensure co ordination of care across services	To grow and support an evolving primary care workforce	To continually improve operational viability and sustainability	To demonstrate a commitment to continuous quality improvement
<b>Strategies 1 – 3 years</b>	<p>Increase screening and assessment processes for enrolled patients</p> <p>Take a planned rather than a reactive approach to growth</p> <p>Identify opportunities and implement strategies to remove health inequalities</p> <p>Promote innovative solutions to improve access</p> <p>Maintain an emphasis on prevention and management of chronic diseases</p> <p>Whanau ora model integrated within general practice</p> <p>Implementation of sustainable strategies</p>	<p>Streamline linkages / coordination processes within communities / secondary sector</p> <p>Adopt systems approach to delivery of care models</p> <p>Strengthen collaboration, coordination and continuity across the care continuum</p> <p>Community participation in service design, delivery, monitoring and evaluation</p> <p>Communication is based as much on the needs of the patients as the needs of the experts</p> <p>Integration of primary and secondary care</p>	<p>Participate in the development of primary workforce plan</p> <p>Undertake healthy workplace programme</p> <p>Manage staff resources effectively</p> <p>Develop sustainable ongoing education models</p> <p>Participate in the development of workforce innovations</p> <p>Promote and support provider viability and sustainability</p> <p>Promote and foster a learning environment</p> <p>Develop and</p>	<p>Pursue opportunities to gain revenue without adding to cost structure</p> <p>Through efficiency reduce operating costs</p> <p>Improve match between demand and supply of resources</p> <p>Relevance of data and information management strengthens health actions</p> <p>Increasing use of IT for diagnostics, screening</p> <p>Promote Integrated information strategies</p>	<p>Further develop a performance culture</p> <p>Incentivisation of quality programmes</p> <p>All GP practices participate in an accreditation process</p> <p>Strengthen medical staff clinical auditing</p> <p>Pilot primary health care models and innovations</p> <p>Provide patient centred services across the continuum</p> <p>Fostering a continuous quality improvement environment</p> <p>Evidence based decision making</p> <p>Annual quality</p>

	<p>through focusing on the horizon</p> <p>Continued focus on self management initiatives</p> <p>Targeted at risk health focus</p>	<p>systems</p> <p>Consumer education to enable self care</p>	<p>implement strategies for succession planning</p>	<p>Capitalise on shared services opportunities</p> <p>Improve operational effectiveness and efficiency</p>	<p>plan</p> <p>Establishment of viable model for GP Liaison</p> <p>Participate in activities that highlight achievements and benchmark standards of performance</p> <p>Increase consumer satisfaction</p>
<p><b>Indicators /Measures</b></p>	<p>Specified clinical outcomes measured</p> <p>Performance indicators as per contracts</p> <p>Utilisation of standardised screening tools and measures</p> <p>Māori Health plan measures reduced inequalities for Māori</p> <p>Increased access for Māori, Pacific Islanders, rural consumers</p> <p>Immunisation rates</p> <p>Improved screening among health risk groups</p>	<p>Collaborative working relationships with providers</p> <p>Evidence of community consultation and engagement</p> <p>Community confidence demonstrated through positive media messages</p> <p>Improve consumer satisfaction through proactive strategies</p>	<p>Workforce initiatives undertaken</p> <p>Ratio of GPs and nurses to enrolled population</p> <p>Workforce demographics quantified</p> <p>Measure access to ongoing education</p> <p>Succession planning</p>	<p>Progress against IT annual plan, capital plan</p> <p>Revenue verse contract deliverables</p> <p>Budget variance combined with narrative comment monitors risk</p> <p>Contract deliverables meet contract expectations</p> <p>Utilisation rates for appropriate volume driven contracts</p>	<p>Patient satisfaction rate measured</p> <p>Occurrence of incidents</p> <p>Outcome measures</p> <p>Number of innovations implemented and sustained and/or evaluated</p> <p>Clinical risk monitoring and measurement</p> <p>Clinical indicators targets achieved</p> <p>Credentialed workforce</p> <p>Development of WRPHO clinical indicators</p> <p>Measure level of incentive funding achieved</p>

## 4.0 APPENDICES

### 4.1 Background

Whanganui Regional Primary Health Organisation was established in 2003 as a charitable trust, with not for profit status. The organisation was generated from a proactive Independent Practitioner Association organisation – Progressive Health Inc. During the first year of establishment Progressive Health Inc. merged with Whanganui Regional Primary Health Organisation. However, the philosophy of clinically led activity has been retained and built upon, with a strengthened business model and a strong emphasis on community partnership and engagement.

Over the last three years WRPHO has gone through a development phase of rapid growth, over the next three years the focus will be on seeking to consolidate infrastructure activities, while at the same time influencing the way care is delivered across the health continuum.

To date four paradigm changes that the team and WRPHO practice members have focused on are;

- Care customised according to patient needs and values
- The patient as the source of control
- Shared knowledge and information flows
- Evidence based decision making

While there have been a number of initiatives implemented to support these four paradigm changes, the two key areas of focus have been:

- To improve access to general practice services, given that a majority of general practices are at maximum capacity. Therefore, when a practitioner has traditionally withdrawn from general practice or left the area, access for registered patients has been difficult. The establishment of WRPHO owned Whanganui Accident and Medical clinic (with a capability to enrol general practice patients) and two salaried general practices has been an effective mechanism for managing patient enrolment within the PHO.
- The development of an interdisciplinary clinical team that is accessible and works collaboratively with general practice. It is pleasing to see improved health outcomes and early intervention strategies being delivered within the general practice environment. This is through input from Counsellors, a Social Worker, High Needs Nurses, Kaiawhina, Immunisation team, PATHS Health Co-ordinator, Pharmacist Facilitators, Pasifika Nurse, Diabetes Nurse Educators, Podiatry services, and others who work within the PHO environment. Services are provided through a contract relationship.

It is timely for the Primary Health Organisation to both influence and challenge existing models of care delivery. District Health Boards are increasingly struggling to live within their means, therefore the time is right to develop a more seamless approach across providers, ensure care is delivered in the most effective, efficient and appropriate environment; duplication is eliminated and hospitals are only providing core services appropriate to a specialist resourced environment. The focus is community driven early intervention strategies and management of chronic disease states.

Over the next three years WRPHO will focus on developing an integrated sustainable primary health care workforce, developing quality processes and systems that integrate across secondary care, and maintain and further develop evidence based models of care that offer local solutions to local problems.

## **4.2 Sector Summary**

Primary Health Organisations have been established as the main vehicle through which the primary health care strategy has been implemented. Primary Health Organisations are the local structure for delivering and co-ordinating services, bringing together general practices and other primary health services in the community to service the needs of their enrolled population.

The six key directions of the Primary Care Strategy are to:

- Work with local communities and enrolled populations
- Identify and remove health inequalities
- Offer access to comprehensive services to improve, maintain and restore peoples health
- Co-ordinate care across services
- Develop the primary care workforce
- Continuously improve quality using good information

The Primary Care Strategy identifies Primary Health Organisations as the vehicle to achieving these goals and improving the health of the population.

The key features of Primary Health Organisations include:

- District Health Boards working through and with primary health organisations to achieve health goals
- Primary Health Organisations to be funded by District Health Boards for the provision of essential primary health care services for all people enrolled within them
- Primary Health Organisations to involve their communities in governing their processes
- All practitioners and providers must be involved in the Primary Health Organisation decision making with no one group dominant
- Primary Health Organisations must be not for profit and accountable for use of public funds
- Participation by practitioners will be voluntary

The Wanganui and district communities have access to two PHOs. It is acknowledged that as iwi graft out new models of organisations that best meet their needs, WRPHO will continue to strive for open and transparent relationships, through working either alongside each other or through delivering different models of care, so our communities continue to have access to choice in how their services are delivered. WRPHO will continue to commit to iwi maintaining a voice at governance through two iwi representatives and operationally the team will continue to ensure effective communication and collegial support to ensure health inequalities for Māori continue to reduce.

### **4.3 Our Population**

WRPHO is responsible for a register of 57,509 patients and of these 10,832 are of Māori / Pacific Island ethnicity (19%) as well as 11,470 patients of other ethnic groups living in deprivation five. WRPHO is therefore supporting 39% of the enrolled population with known inequalities in health due to ethnicity or socio-economic status. 3076 people are Care Plus users which represents 5% of the total population (see appendix – 4.5).

## 4.4 Environmental Scan

### **Political**

Government policy/strategy  
Three year planning cycle  
Pending elections  
Variability in how each PHO has interpreted and implemented government policy  
DHB strategy and expectations  
DHB currently under intensive monitoring/review  
Two PHO's  
Current funding models  
Iwi health model changes  
DHB not maximising investment in primary care sector  
High patient need with patient demand on services growing

### **Economic/demographic**

Health disparities  
Access to health services  
A shift to working with intersectorial agencies, e.g. Ministry of Social Development  
Rural based communities  
Economic barriers to health care (lower than national average household income)  
Incidence of chronic disease  
A projected decreasing population  
Aging population  
A high proportion of older peoples 14.3%  
Rural versus urban  
Population health and wellness versus chronic disease and co-morbidities

### **Social well being**

Sub-standard housing with low level of insulation  
Access to health services particularly in rural areas  
Transport barriers  
High deprivation (overall 52% live in deprivation decile 8-10)

### **Infrastructure**

Advances in information technology  
Aging workforce  
Workforce capacity and capability  
Lack of primary secondary integration  
Self management strategies

### **Cultural**

Within the Whanganui region there is; a high proportion of Māori 22%, Pacific Island people 2%  
Increasing consumer expectation of culturally responsive services

## 4.5 Whanganui Regional PHO Population Demographics as at 1 July 2007

Number of Patients: 57,509

Age Breakdown		
Age	Number of Patients	%
00-04 yrs	3,659	6.36%
05-14 yrs	8,641	15.03%
15-24 yrs	7,766	13.50%
25-44 yrs	13,205	22.96%
45-64 yrs	14,617	25.42%
65+ yrs	9,616	16.72%
No Dob	5	0.01%
Grand Total	57,509	100.00%

Care Plus Breakdown		
Ethnicity	Total	%
European	2481	80.66%
Māori	526	17.10%
Pasifika	15	0.49%
Other	54	1.76%
Grand Total	3076	100.00%

High User Health Card Breakdown		
HUHC Status	Number of Patients	%
Non-HUHC holder	57,344	99.71%
HUHC holder	165	0.29%
Grand Total	57,509	100.00%

Deprivation Breakdown by Ethnicity							
	Dep 1-4	% Dep 1-4	Dep 5	% Dep 5	Blank Dep	% blank	Total
European	29740	66.5%	10838	24.2%	4115	9.2%	44693
Māori	4121	40.5%	4864	47.8%	1182	11.6%	10167
Pasifika	270	40.6%	306	46.0%	89	13.4%	665
Other	1095	55.2%	632	31.9%	257	13.0%	1984
Grand Total	35226	61.3%	16640	28.9%	5643	9.8%	57509