Southern Primary & Community Care Action Plan

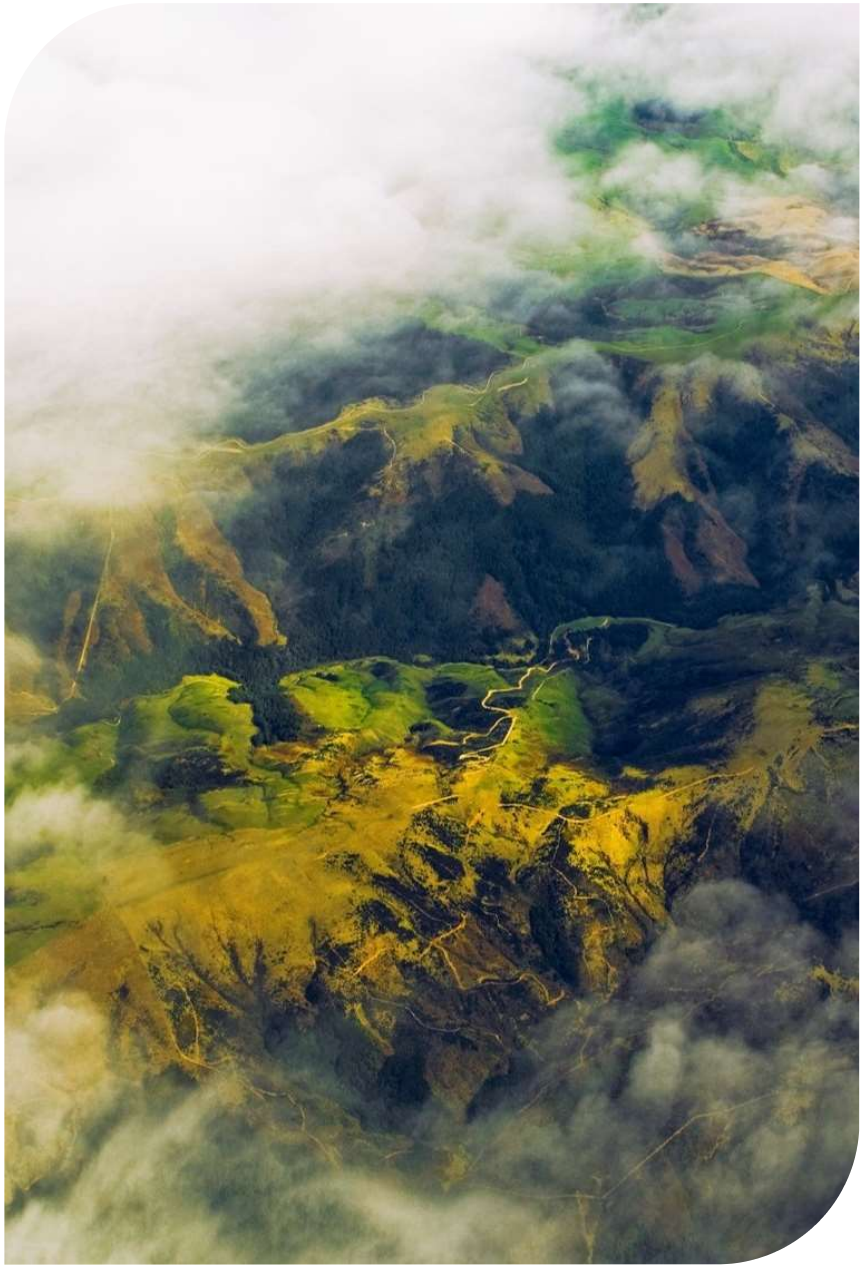
Southern District Health Board
Piki Te Ora

WellSouth
Primary Health Network
Hauora Matua Ki Te Tonga

Mihi

Karanga atu rā ki ngā tangata o te taitonga;
Nei rā mātou, e mihi kau ana ki ā koutou tīpuna kua wehe atu ki tua o Paerau.
Tēnā koutou katoa!

We call to you, the people of the south;
We greet and acknowledge all of our ancestors who have passed beyond the veil.
Greetings to you all!



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Introduction

Introduction

Tēnā koutou katoa,

We are pleased to present the Southern Primary and Community Care Action Plan, which describes how we will deliver on the vision for primary and community care in the Southern health system outlined in Southern Primary and Community Care Strategy. The Strategy's vision centres around our consumers, their whānau and communities, and the role the Southern health system needs to play in caring for and empowering them to live well, stay well, get well and die well. It reflects the call from our communities for better integrated services, and from our workforce to strengthen the capacity and capability of primary and community care to contribute to the wider Southern health system.

In developing this Action Plan to execute the Strategy, we have considered:

- How the system needs to be organised
- How to work with stakeholders to co-design viable care models
- How to build a critical mass of inter-linked actions to deliver improvements at pace and scale
- Actions that need to be:
  - District-wide
  - Tailored to local community needs
  - Targeted to specific population groups
- Learnings from previous planning and action in Southern
- The experiences of other health systems in improving primary and community care.

The Strategy and Action Plan have been developed jointly by Southern District Health Board and WellSouth Primary Health Network, with support from the University of Otago, reflecting our commitment to working together to improve the contribution of primary and community care to the wider Southern health system. They recognise our history, and the challenges we face in responding to the changing needs of our communities, the increasing pressures on our health workforce, and our responsibility to provide equitable access to services across our large and diverse district.

Our ability to implement the actions underpinning this Action Plan will depend on whether we are bold enough and prepared to make tough prioritisation decisions. Given our available funding, we will need to create a virtuous cycle of saving to invest and through our investments, creating new savings to further invest. We will also need to carefully invest any additional funding we receive. Our intention is preferentially invest any additional funding we receive in the actions set out in this Action Plan. In undertaking this approach, we are committed working with our communities and other stakeholders to deliver on this Action Plan. Mauri ora!

Chris Fleming
Chief Executive
Southern DHB

Ian Macara
Chief Executive
WellSouth PHN

Kathy Grant
Commissioner
Southern DHB

Dr. Douglas Hill
Chair
WellSouth PHN

The Southern Primary & Community Care Strategy and Action Plan

WHY?

New Zealand Health Strategy
All New Zealanders live well, stay well, get well

He Korowai Oranga
Healthy futures for Māori, 'Pae Ora'

South Island Region Strategic Direction
A sustainable South Island health & disability system, focused on keeping people well and providing equitable and timely access to safe, effective, high quality services, as close to people's homes as possible

Southern Way Vision
Better health, better lives, Whānau Ora

WHAT?

Vision for Southern primary & community care
Excellent primary and community care that empowers people in our diverse communities to live well, stay well, get well and die well, through integrated ways of working, rapid learning and effective use of technology

Goal 1.	Goal 2.	Goal 3.	Goal 4.
Consumers, whānau and communities are empowered to drive and own their care	Primary and community care works in partnership to provide holistic, team-based care	Secondary and tertiary care is integrated into primary and community care models	The health system is technology-enabled

HOW?

Care models

- Empower consumers, whānau and communities to **self-care**
- Develop **health care homes (HCHs)** to enhance access to primary care
- Create **locality networks** to better coordinate care

Supporting infrastructure

- Strengthened governance and leadership
- Whole-system health and business intelligence
- Building workforce capability and culture
- Integrated technology solutions and cost-effective use of care technologies
- Results-focused funding and contracting

Supporting adoption

- Demonstration
- Communications and engagement
- Provider support

Table of key definitions

Term	Definition
Primary care	Primary care relates to the professional health care provided in the community, usually from a general practitioner (GP), practice nurse, pharmacist or other health professional working within a general practice
Community care	Wide-ranging care provided in a community setting, from supporting consumers to manage long-term conditions, to treating those who are seriously ill with complex conditions, much of which takes place in people's homes
Secondary care	Care provided by a specialist or facility on referral from primary care (usually by a GP), requiring more specialised knowledge, skills, or equipment than can be provided in primary care. This can be provided either by visiting specialists, or in Dunedin, Invercargill, or some rural hospitals in the Southern district
Tertiary care	Specialised care (investigation and treatment) usually provided on referral from clinicians in primary or secondary care by visiting specialists, or in Dunedin Hospital (with some services provided outside the district e.g., highly specialised paediatric care at Starship Hospital in Auckland)
Multi-disciplinary	A team comprised of people from across disciplines within the health sector, supporting the delivery of holistic health care. This could include, for example, GPs, PNs, DNs, pharmacists, health care assistants, allied health and other relevant representatives
Inter-disciplinary	A team comprised of people from the health and social sector, supporting the delivery of holistic health and social care. This could include, for example, multi-disciplinary teams, plus representatives from MSD, Corrections, Housing, Ministry for Vulnerable Children, Oranga Tamariki and other agencies
Care coordination	Supporting the coordinated delivery of consumer / whānau care, either within or across providers. A Care Coordination Centre (CCC) will support this function across primary, community, secondary and tertiary care in the Southern district
Stepped care	A care model approach that segments populations into increasing levels of health (and social) need, with defined care responses matched to population segments. The higher the level of need, the more intense the care response.
Health Care Home (HCH)	A team-based model of care by primary care with strong strategic and operational relationships with community, hospital and specialist services, with the intent to provide the right level of proactive, comprehensive and continuous health care to patients
Locality network	The strategic and operational network of providers and services required to provide timely, responsive care to defined populations based on an agreed minimum level of care, with some local variation for particular health needs and service contexts
HCH community hub	The potential physical infrastructure required to enable integrated ways of working within locality networks, with modification of the scale and scope of the hub determined by population size and existing infrastructure

Action Plan

Introducing the Action Plan

The Southern Primary and Community Care Strategy describes our vision and goals for transforming primary and community care services, within the context of the overall Southern health system. This Action Plan sets out the initial phases for achieving this vision.

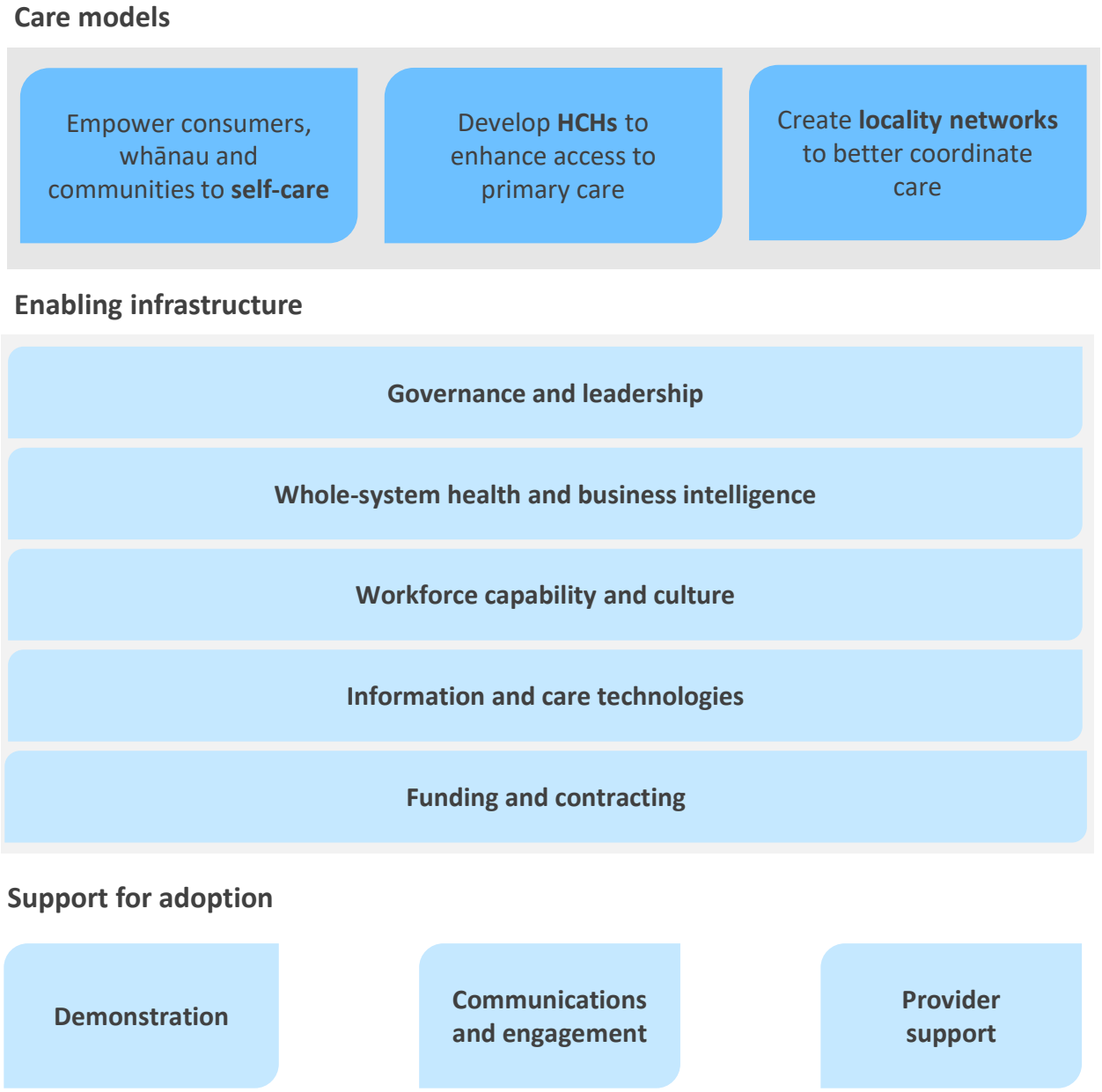
The Action Plan has three action areas for delivering on the Strategy (see right): care models; enabling infrastructure; and support for adoption. These action areas form the basis of the Action Plan.

The action areas will be progressed concurrently, with sequencing of activities and milestones. Roll-out of new care models will be undertaken in tranches to enable manageable design, adoption and evaluation.

A roadmap for each of the action areas is presented in this Action Plan to guide early progress on achieving the Strategy.

Overall, delivering on our vision and goals for primary and community care will require reconfiguring how parts of the system fit together. This will include:

- How health services are organised
- Care processes and systems that support care models
- Governance and leadership of the system
- Health and business intelligence to support planning, funding and delivery
- Information and communications systems to enable enhanced access to information for consumers and the workforce
- Funding and contracting arrangements that support integrated ways of working and improved performance.



The Action Plan: Transforming primary and community care

The system is configured to enable new care models, and implementation of the Strategy at pace and scale

The **organisation of health services** will reinforce the concept of consumers having a 'health care home' (HCH), which will be the first point of contact for addressing their needs and their source of continuity of holistic care. In most cases, the core of the 'home' will be an extended general practice team. For some population groups, their entry to the HCH will differ - for example, it may be through a school or a youth community hub; a nurse-led clinic in an urban or rural setting, or a kaupapa Māori provider (which may include Rongoa Māori practices) - but these will have a strong connection with general practice. Wrapped around the HCH will be a locality network to integrate services for people with more complex needs, and enable effective step-up and step-down care. Locality networks will bring together personal health, mental health & addictions services, palliative care, and aged care services, with access to specialist support. In some instances, some services will be co-located in large HCHs or community hubs.

Care processes and systems will be based on risk stratification and a stepped care approach. This will be the linchpin that links the HCH and locality network, and access to specialist support. Needs assessment and care planning processes will be consumer-focused, and determine the level and type of support a person requires. Shared care plans, care pathways ('HealthPathways') and service directories will support timely and smooth consumer access to care. A key focus will be on prevention and early intervention.

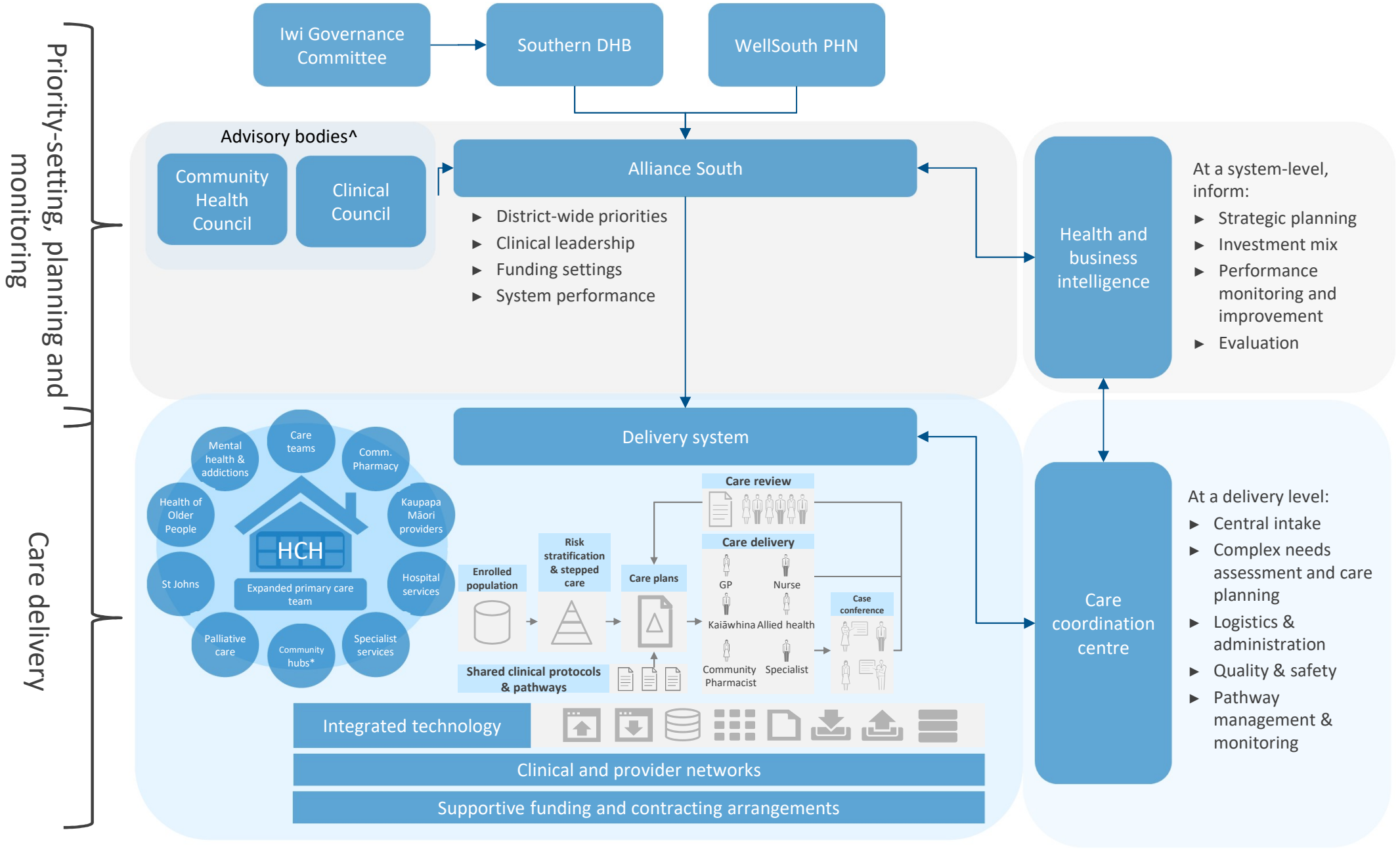
To provide coherence to the system, **governance and leadership** at the district level will be revised to better plan and prioritise resources to address population health needs. The Alliance South arrangement between Southern DHB and WellSouth PHN will be revised. The alliance will determine district-wide primary and community care priorities, set the parameters for service planning, and track and monitor overall system performance, including delivery on the Strategy and Action Plan. At a delivery level, locality networks will be used to translate district-wide priorities into service planning and action. For particular high priority disease groupings (e.g. cardiovascular and respiratory disease) and population groups (e.g., vulnerable children, frail elderly), clinical and provider networks could support district-wide consistency in care access and outcomes, as well as sharing learnings and innovations. This will complement locality networks, which will operationalise models of care locally.

Health and business intelligence will be strengthened at strategic and operational levels through development of a shared health and business intelligence function, and an expanded and enhanced Care Coordination Centre. The health and business intelligence function will inform planning, prioritisation and performance improvement at district-wide, locality and HCH levels. This will include analytical responsibility for Alliance South's System Level Measures Improvement Plan. The Care Coordination Centre will support the smooth operation of the primary and community care system, working with HCHs and locality networks to coordinate complex needs assessment and care planning, administration, logistics, resourcing, and monitoring of care.

Information systems will enable HCHs, locality networks and specialist services to access and share information related to consumer care, and for consumers to access this information through an online portal. A key development will be an electronic health record (EHR) for each consumer. The increasing comprehensiveness of this record over the next decade will eventually allow collection of information from consumer devices, genetics and other factors related to an individual's health. A single data repository and technology solution for enabling enhanced health and business intelligence will be implemented. More integrated communication systems will facilitate consumers to access the right care at the right time for their needs.

Funding and contracting approaches will be revised to reduce duplication of effort and resources, and enable collaboration between providers and care model innovation. They will become more results-focused, and aligned with a transparent performance and incentive framework, cascading from district to locality to provider and practitioner levels.

The Action Plan: How the system will be configured



*Community hub infrastructure to be determined.

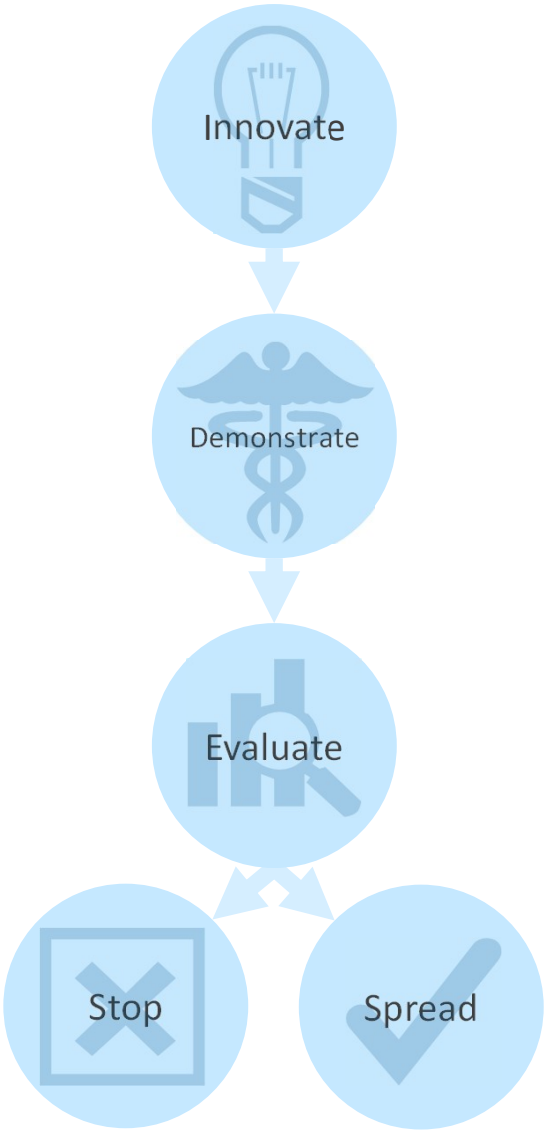
^ Also provides advice directly to Southern DHB on matters outside the scope of the Alliance South work programme

Our commitment

Take a principled approach: We will…

- Improve equity of outcomes, particularly for Māori and rural communities
- Provide equitable access to appropriate 24/7 care across the district
- Make our health system easy to use
- Support our population to live well and self-care
- Make all decisions in the best interests of our population and consumers (using the quadruple aim)
- Take an investment approach that prioritises evidence-based interventions to improve long-term outcomes
- Move from traditional ways of working to be fit-for-the-future
- Treat each other with trust and respect
- Operate as one system, making the best use of available resources
- Utilise our education partners to develop a workforce matched to population need

Innovate and be courageous



Align incentives

Funding and contracting approaches will progressively incentivise primary, community and hospital care to work collaboratively to achieve the optimal mix of services across settings, and to improve access, outcomes and resource use

Action area 1: Care models

Support consumers and whānau to self-care

Helping people develop or further build their **health literacy** is critical for enabling health maintenance, and to knowing when and how to access services. Broadly, health literacy means the ability to access, process and utilise information to make appropriate and informed decisions. People with good health literacy can make informed and appropriate health decisions, and better manage their own health. This leads to better consumer and whānau outcomes and more effective use of health resources. Strengthening health literacy will have two core components:

- A targeted focus on public education about the core role of primary care, including when, how, and where to access services for urgent needs
- Developing the health literacy competencies of the health workforce, particularly in regards to working with Māori (see Workforce Capability Development).

To make it easier for consumers and whānau to participate in their health and well-being, and access services more conveniently, **consumer portal** access and technology will be expanded and enhanced. Over time this will become a single point of 'virtual' contact for consumers with the Southern health system.

Through a staged development path, the consumer portal will provide consumers with access to:

- Their health-related information, and eventually, their relevant social care information
- Certified self-care information related to health risks and conditions
- Virtual health consultations (e.g. email, video, telephone)
- Initial diagnosis, triage and care options (public and private)
- Navigation to the right care for their health needs
- Education and research opportunities.

For people with long-term conditions or who suffer from mental health and/or addiction issues, evidence suggests that **peer support approaches** can improve self-management and adherence with care plans. Opportunities to enable peer support through vehicles such as consumer networks, group sessions and social media will be explored and progressed. Efforts will be directed towards conditions and issues where evidence suggests the best self-care gains can be made.

Supporting consumers and whānau to self-care will be achieved through taking a **Health in All Policies (HiAP)** approach, strengthening health literacy, encouraging peer support, and providing enhanced access to care and information for consumers through an online portal.

A HiAP approach to working with other sectors will be used to address the major risk factors that contribute to inequities, avoidable acute demand and amenable mortality. HiAP will form the basis of a joint work programme between Public Health South and WellSouth PHN.

Initial areas of focus will include:

- Health-promoting environments (tobacco control; nutrition and physical activity; alcohol; housing)
- Supporting economic and social development to improve income and employment outcomes
- Improving community resilience to build mental health and wellness
- Building community participation and networking
- Establishing the health sector as one of a number of civic agencies (including local government, education, other government agencies and local NGO and business leaders) that act in concert to improve health and wellbeing.

Making a difference in these areas will require bringing public health, population health and personal health services closer together, as well as building partnerships with community organisations and other sectors including local government.

Support consumers and whānau to self-care – *Building health literacy*

Headline action		Activity	Phases		
			1	2	3
Headline action 1.1 – Build the health literacy of the Southern population and workforce with a particular focus on acute demand management	a.	Identify gaps in existing health literacy information, and develop targeted, culturally appropriate resources (including for people with disabilities), with consumer and provider involvement, taking into consideration the proposed consumer online portal and existing and planned health promotion activities.			
	b.	Using positive messages, actively promote appropriate use of health services, reinforcing primary care as a consumer's gateway to other health care, with tailoring of content to key pressures and priorities. For example, discouraging lower urgency presentations to the Dunedin and Invercargill Emergency Departments.			
	c.	Develop whole of system website, more easily directing users to the services they need.			
	d.	Upskill the health workforce in building community, whānau and consumer health literacy, and making it an expected competency of all health workers - competence in working with Māori and Pacifica being a key area for development (see: Headline Action 5.2, c-d)			

Support consumers and whānau to self-care – *Expanding and enhancing consumer portal access*

Headline action	Activity	Phases		
		1	2	3
Headline action 1.2 – Expand and enhance consumer portal access to provide consumers with access to all of their health information and care team	a. Encourage uptake of the existing consumer portal, based on successful uptake approaches used in New Zealand and internationally	■		
	b. Provide consumers with access to self-care information related to priority health conditions (e.g., diabetes; cardiovascular disease; COPD; asthma; depression; anxiety)	■		
	c. Introduce consumer access to virtual health consultations (e.g. email, video, telephone, appointment bookings)	■		
	d. Progressively integrate community care information into the consumer portal, aligned with HCH and locality network development, and accessible via a whole of system web site		■	
	e. Provide consumers with artificial intelligence-supported access to initial diagnosis, triage and care options (public and private)			■
	f. In addition to their health record, provide consumers with access to their relevant social care information			■

Support consumers and whānau to self-care – *Strengthening peer support*

Headline action	Activity	Phases		
		1	2	3
Headline action 1.3 – Strengthen peer support mechanisms for people experiencing: i. Mental health issues ii. Addiction issues iii. Significant prioritised long-term conditions (COPD, heart failure, stroke) or multi co-morbidities iv. Social isolation v. Obesity	a. Engage with consumers, whānau, communities, and the wider social sector, considering existing initiatives (e.g. *Raise HOPE*) to understand what will work best for peer support including enlisting people into peer support approaches, settings (e.g. church, home, clinic, marae), delivery channels (e.g., social media), and how such approaches can be culturally and socially relevant for different cohorts (e.g., Māori, youth, older people)			
	b. Work with stakeholders to introduce new peer support mechanisms as agreed, (e.g. group sessions and social media-based groups), reviewing and evaluating these (including obtaining feedback from people engaged in the groups) annually or at other agreed intervals, and adjust, scale or stop these depending on their uptake and value.			

Support consumers and whānau to self-care – *Taking a Health in All Policies approach*

Headline action	Activity	Phases		
		1	2	3
Headline action 1.4 – Take a Health In All Policies (HiAP) Approach to address the major risk factors that contribute to inequities, avoidable acute demand and amenable mortality.	a. Develop and implement a Health in All Policies Action Plan to support effective inter-sectoral action on: i. Health-promoting environments (tobacco control; nutrition and physical activity; alcohol; housing) ii. Supporting economic and social development to improve income and employment outcomes iii. Improving community resilience to build mental health and wellness iv. Building community participation and networking v. Establishing the health sector as one of a number of civic agencies (including local government, other Government Ministries and local NGO and business leaders) that act in concert to improve health and wellbeing (and reduce demand pressure on healthcare services)			
	b. Develop a Southern District Health Promotion Strategy outlining how Public Health , WellSouth PHN and other key stakeholders will work together			
	c. Public Health South and WellSouth are co-located (virtually or physically), working together to reduce inefficiencies and avoid duplication			
	d. Review and evaluate HiAP initiatives annually or at other agreed intervals, and adjust, scale or stop initiatives depending on performance			

Support development of health care homes

To enable primary care to better match care with need and provide opportunities for professionally rewarding practice, development of HCHs will be encouraged and supported. This will reinforce and reinvigorate general practice's role as the key source of continuity of holistic care, and gateway to the wider health system for people and their whānau.

The HCH model will enhance the capacity and capability of general practice through development of new roles, skills, and ways of working. This will include new clinical and non-regulated workforce roles to support the traditional practice team members (GP, practice nurse, and receptionist) - enabling clinicians to work at top of their scopes of practice, and freeing up resources to enable timely and responsive care.

The HCH model will also have a strong focus on making the best use of digital technologies, through promotion of 'virtual health' approaches such as telephone, email, and video consultations, and system generated consumer contacts (e.g. screening reminders), and data-driven risk stratification to identify and target people most at-risk of poorer outcomes.

The development of HCHs in Southern will be informed by New Zealand and international models including the design requirements set out by the New Zealand Health Care Home Collaborative*. The Collaborative's requirements have four domains:

- Ready access to urgent and unplanned care
- Proactive care for those with more complex needs
- Better routine and preventative care
- Improved business efficiency for sustainability.

Each domain has a set of indicators, assessment criteria, and measures. The requirements also describe a practice assessment process that leads to certification as an HCH. The requirements build on the Royal New Zealand College of General Practitioners foundational and Cornerstone accreditation standards. General practices in Southern will be encouraged to develop in-line with the Collaborative's requirements, with application of these tailored for different local population needs and service characteristics.

Key components of the HCH model to be developed in Southern are expected to include:

- Being the key source of holistic care for consumers
- Using risk stratification and formalised needs assessment to target workforce time and effort to people with higher needs
- An expanded primary care team through introduction of new workforce roles
- Development of higher skills within scopes of practice, and delegation of clinical and non-clinical functions within the team
- Active engagement in the education of undergraduate and postgraduate students, as well as participation in primary care research networks
- Redesigned care models that streamline operations within the HCH, and enable urgent and extended consultations
- Use of virtual health approaches to enhance access
- Use of system-generated contacts to support proactive practice engagement with consumers
- Use of evidence-based care pathways
- Active involvement in care planning and delivery with DHB and NGO services as part of locality networks
- Movement to a hub and spoke model through development of large HCH community hubs networked with other locality providers (see overleaf) .

HCH development will be undertaken in 'tranches'. Early adopters of the HCH model will be identified through a contestable expressions of interest (EOI) process, and will be considered demonstrators of the new model. Between four and eight HCHs are likely to be early adopters, forming Tranche 1. Some of these HCHs may evolve or consolidate to become community hubs.

* See for more information: New Zealand Health Care Home Collaborative model of care requirements: http://www.healthcarehome.co.nz/resources/

Support development of health care homes *cont'd*

Once practices have undertaken the transition to a HCH, it is likely that the primary care system will be made up of practices or configurations of practices that serve populations of, ideally, between 7,500 and 30,000 enrolled service users. This may vary slightly according to their location and connection with other services, and will need to be flexible enough to respond to varying geography and the local service context. The larger the HCH, the more opportunity there will be to deliver a broader scope of services, culminating in designation as a community hub, which co-locates relevant DHB and NGO community services, and provides for a level of ambulatory specialist care (either by primary practitioners with special interests or DHB / private specialists). HCH community hubs will be developed through either existing infrastructure or new sites. In rural areas, rural hospitals may act as a hub but with the explicit expectation that this includes primary care delivering the HCH model of care. In Dunedin and Invercargill, purpose-built facilities may be developed, which may include delivery of some specialist outpatient services possibly in collaboration with the University of Otago. The current trend towards consolidation of small general practices into larger centres will support generation of critical mass for HCH community hubs. The expected set of services to be delivered from HCH hubs include:

- Primary care using a HCH model of care, with facility and technology enablers to support the care model (see previous page)
- Onsite community and clinical pharmacy services
- Community diagnostics (e.g. radiology; laboratory specimen collection), where this is economically feasible
- Space for visiting specialist clinics and minor procedures, matched to population needs and economic viability (i.e. not duplicating existing infrastructure which cannot be scaled back e.g. Southland Hospital outpatient facility space)
- Provide space for 'housing' DHB and NGO community health services (e.g. district nursing; physiotherapy) including staff, vehicles and supplies, with 'housing' arrangements designed to maximise building strong team-based ways of working with the HCH clinic team
- Urgent care capacity to a suitable scope to handle clinically appropriate emergency care cases (e.g., resuscitation capacity)
- Observation beds, and where a rural hospital is acting as the HCH hub, clinically appropriate overnight stay capacity.

A rule-set for determining the optimal mix and distribution of HCH hubs across the district will be developed. Key principles for HCH selection and development are likely to include:

- Primary and community care will be integrated as part of a HCH hub, and will be delivering a HCH model of care
- Primary care operating within each hub will have strong operational relationships with non-hub HCHs and will accept all consumers referred to hub services irrespective of where they are enrolled
- Primary care hub services will not seek to encourage consumers enrolled with another HCH to enrol at the hub. Where a consumer elects to enrol with the hub, a standard enrolment stand-down period will apply (i.e. 3-months)
- All HCHs operating within a locality served by a hub will contribute to a shared extended hours / after-hours care roster (delivered from the hub), with defined capitation 'clawbacks' or other mechanisms to ensure financial viability (it is expected to be fiscally neutral within capitated funding streams)
- Where DHB-funded specialist services are provided from a hub, the DHB and hub will have a formal agreement related to leasing of clinic space including any financial costs
- The HCH hub will operate a transparent and agreed co-payment policy for DHB services transferred to the hub.

In Dunedin, a key consideration for HCH hub design will be any development of ambulatory care hub infrastructure as part of the hospital rebuild. There will be a range of options that could work including collocation of hub services, standalone ambulatory care hubs serving multiple HCHs or full integration of services. As planning for the hospital rebuild progresses, these options will be explored.

Support development of health care homes *cont'd* - HCH community hub model and relationship with locality networks

^ During transition period this will include non-HCH general practices

** Community nursing, allied health (e.g., physiotherapy, dieticians, occupational therapy), health promotion, dental*

Community hub infrastructure will differ given geographic context, population size and existing infrastructure. The figure opposite provides a stylised example of a HCH hub model.

As an illustration of how this could work in practice, a HCH hub model could be developed in Invercargill. This model would consolidate a number of general practices and their enrolled populations to provide sufficient scale for a wide range of collocated and visiting services. The hub could be developed in north Invercargill to avoid duplication with Southland Hospital services. The hub would provide core primary care bolstered by enhanced urgent care capacity (including clinically appropriate ambulance referrals through defined clinical protocols), on-site pharmacy and diagnostics, and clinical space for hospital specialist care and minor procedures.

A critical component of hub development would be colocation and integration of community health services, which would provide both mobile services (e.g. community nursing home visits) and in-clinic services such as rehabilitation. With the HCH expanded primary care team, these community services would form the core of multidisciplinary teams delivering care in clinic and home-based settings, including aged residential care.

Through locality network development, the HCH hub and other health and social services would develop strategic and operational relationships for care delivery for the catchment population. This will include developing appropriate relationships with smaller HCHs within the locality including cross referrals to primary and community practitioners with special interests.

With the increased scale of physical infrastructure compared to traditional general practice, the hub would include spaces for peer support sessions, teaching and learning activities, and team-building.

In other settings, hub infrastructure might be configured around a rural hospital site or as a standalone facility incorporating community health and ambulatory care services. Regardless, it is expected that strong relationships will be developed with HCHs and other locality providers as envisaged by the Strategy & Action Plan.

Support development of health care homes – *Designing and implementing a Southern Health Care Home model*

Headline action	Activity	Phases		
		1	2	3
Headline action 2.1 - Early adopter general practices are enlisted to demonstrate and fine-tune the HCH model, with the aim that early adopters to cover about one-third of the Southern population	a. Through a contestable process, identify early adopter Tranche 1 general practices, willing to explore innovative service models and co-design the HCH model in-line with the Health Care Home Collaborative's four domains: i. Urgent and unplanned care ii. Proactive care for those with more complex needs iii. Routine and preventative care iv. Business efficiency			
	b. Understand the population that will be served by a specific Tranche 1 HCH, considering: i. Health and social needs ii. Use of primary, community and hospital care iii. Risk factors for poorer health and social outcomes iv. Access and service preferences			

Support development of health care homes – *Designing and implementing a Southern Health Care Home model cont'd*

Headline action	Activity	Phases		
		1	2	3
Headline action 2.1 ***cont'd*** - Early adopter general practices are enlisted to demonstrate and fine-tune the HCH model, with the aim that early adopters to cover about one-third of the Southern population	c. Working with potential Tranche 1 HCHs: i. Apply the Health Care Home Collaborative's maturity matrix to assess the maturity of the practice's model of care ii. Map current workflows, workforce resourcing and use of technology to identify priorities for redesign iii. Undertake co-design workshops to redesign care and workforce models iv. Provide confidential financial modelling support for the potential HCH practice to understand the business implications of transforming their model of care v. Determine the likely strategic and operational relationships and transition steps within a locality network vi. Develop a transition plan to meet the requirements of a HCH	■		
	d. Commence implementation of Tranche 1 HCH models of care		■	
	e. Evaluate HCH progress and adjust the approach depending on progress and performance			■
	f. Identify Tranche 2 general practices for HCH development		■	
	g. Begin co-design work with Tranche 2 HCHs			■

Support development of health care homes – *Encourage development of HCH community hub infrastructure*

Headline action	Activity	Phases		
		1	2	3
Headline action 2.2 – Encourage the development of HCH community hub infrastructure to support locality networks	a. Develop a rule-set to determine the optimal mix and distribution of HCH community hubs to support locality networks including: i. Catchment population size ii. Distance from an acute hospital iii. Alignment with existing or proposed infrastructure including any ambulatory care hubs developed as part of the Dunedin Hospital rebuild iv. Scope of services proposed to be included in a hub v. Potential to promote integrated ways of working across primary, community and secondary care vi. Principles to guide care model design Note that: i. Potential infrastructure could be developed using Southern DHB, WellSouth PHN, or private funding (including the University of Otago) ii. Rural hospital facilities or large rural general practices may be designated as HCH community hubs, with any development needs identified during HCH model and locality network design			

Support development of health care homes – *Encourage development of HCH community hub infrastructure cont'd*

Headline action	Activity	Phases		
		1	2	3
Headline action 2.2 *cont'd* – Encourage the development of HCH community hub infrastructure to support locality networks	b. Apply the rule-set to determine efficient configuration of HCH community hubs, including consideration of including ambulatory secondary care within the scope of service (with suitable alignment with any development of ambulatory care hubs in Dunedin), with early priorities being*: i. Orthopaedics (e.g. fracture clinics) ii. Dermatology iii. Ophthalmology iv. ENT v. Women's health vi. Mental health & addictions vii. High volume, low complexity medical services viii. Geriatrics			
	c. Identify design, financing and implementation options, and develop a procurement approach for prioritised HCH hub development either as physical infrastructure or as services			
	d. Enact procurement approach			

** These priorities have been identified through prior planning work e.g. the Southern Strategic Services Plan, Southern Detailed Service Plans A&B, Clinical Leadership Group position papers, scan of national and international literature, and engagement with stakeholders.*

Create locality networks to better coordinate care

The Southern district is large, with a diverse range of communities and service contexts. Demographic information suggests that different communities will face very different challenges into the future:

- Dunedin and Invercargill will grow slowly but age significantly
- Queenstown-Lakes will grow rapidly, and likely become the second largest population centre in the district (after Dunedin)
- North and Central Otago will also grow, and age
- Other rural areas of Southern may decline in population, but will age significantly.

Service models also vary considerably across the district, with much of this variation the result of historic decisions rather than reflecting the current or future needs of different communities. Addressing these issues is at the heart of locality network development, which is intended to better align models of care with population health needs within a clear, overall district-wide model of care.

The aim of locality networks will be to support HCHs to integrate care for people with more complex needs, and plan and deliver care closer to where people live, work and play. Risk stratification will be used to identify people who will benefit most from wraparound, integrated care, within a stepped care model. This will build on work that has been progressing through *Do the right thing (long-term conditions)*, *Raise Hope*, and *Health of Older People Wraparound Support.*

Locality networks will bring together personal health, mental health & addictions, health of older people services and palliative care. Core components of the locality networks will be:

- Primary care
- Multi-disciplinary teams, including primary care, community nursing, allied health, community midwifery, and community mental health & addictions services
- NGO providers (e.g. child health; community pharmacy; midwifery; home-based support; hospice; Māori providers)
- Emergency retrieval and transport services
- Residential care and supported living providers
- Primary maternity services (including primary birthing facilities)
- Lower-complexity hospital services.

The locality networks will be supported by an expanded and enhanced Care Coordination Centre (see: Supporting Infrastructure), which will provide a centralised point of intake to and deployment of relevant locality services, as well as oversight of community care delivery.

Integrated care teams will have the strongest operational linkage with HCHs, providing rapid response for acute crises, in-reach to inpatient services to support early discharge, short and long-term restorative care in community settings, and end-of-life care. In a staged approach, the following services will be integrated into community teams:

- Southern DHB Community Health Services (e.g. district nursing; allied health; mental health & addictions services)
- DHB-funded NGO services (e.g. child health; long-term conditions services delivered through WellSouth PHN; home-based support services; palliative care)
- Social care.

Key components of integrated community team development will include:

- Creating strong relationships with HCHs based on defined care pathways and shared care models, and supporting ongoing professional development with an emphasis on team care
- Consolidating significant primary and community health workforces that serve a locality, to deliver the benefits of critical mass, interdisciplinary teamwork, local responsiveness, and shared care for consumers and whānau
- Quality and standard design and implementation
- Identifying and actioning education and learning development opportunities
- Enabling community step-down models of acute care (mental health, older people, and lower acuity medical needs) through tailored support packages for people in their place of residence.

The integrated care teams will include the care coordinator role which will act as a navigator and broker of the journey for people with complex needs. The coordinator will work with HCHs, other locality providers and the Care Coordination Centre to ensure that consumers' care is delivered in-line with their care plans.

Create locality networks to better coordinate care *cont'd*

DHB specialist advice and support will be available to HCHs and integrated care teams for people who require this. Key specialist services - including cardiology, respiratory*, psychiatry, paediatrics, endocrinology (diabetes) and geriatrics - will support primary and community care. To reinforce their active involvement, specialists will be assigned designated localities as their area of responsibility.

Over time, teamwork within the locality network may be further enhanced by co-location of the interdisciplinary team in a 'community hub'. Community hubs will be developed through either existing infrastructure or new sites. Where the size of HCH supports it, the team could be co-located with the HCH (as is the case now for some services at larger general practice sites). In rural areas, the hub is likely to be local rural hospital, where one exists, and larger HCHs where distance makes it more cost-effective to integrate services in this way. In Dunedin and Invercargill, purpose-built facilities may be developed, which may include delivery of some specialist outpatient services, possibly in collaboration with the University of Otago. Where possible, the current trend towards consolidation of small general practices into larger centres will be used as a way of generating critical mass for HCHs. Key development steps for locality networks will include:

- Determining the scope and boundaries of locality networks
- Prioritising and sequencing service development within localities
- Understanding current and future demand, capacity and capabilities within each network, and priority gaps to be addressed. These may include future-proofing locality infrastructure by increasing the capacity and / or scope of services in anticipation of demand, or laying the foundation for future expansion in-line with population needs
- The workforce and capability development needed to meet locality network requirements and the necessary supports from tertiary programmes, such as the University of Otago's rural health training and inter-professional learning programmes
- Determining strategic and operational relationships that are required to support the effective functioning of a network
- Exploring the potential for community hub infrastructure, including the placement of primary birthing facilities and the infrastructure required to support delivery of ambulatory secondary care
- Aligning funding and contracting arrangements to the locality network model, with a progressive focus on shared accountability for population access and outcomes.

Locality network development will be staged through 'tranches' of services. The prioritisation, sequencing, design and implementation of these services take into consideration:

- Size and scale to make a material difference to health and social outcomes
- Readiness of the services to proceed at pace and scale
- Alignment with primary care
- Defining the role of rural hospitals in integrated models of primary and community care for their catchment populations
- Ability to translate learnings from service integration to other services to be progressively included within the locality network
- Alignment with proof of concept locality network initiatives (see below)
- The capability of Southern DHB and WellSouth PHN to successfully advance locality network development over the three year period.

The learnings from implementation of Tranche 1 services will enable the number of services in future tranches to increase. Two 'proof of concept' service models will be also be advanced to test and demonstrate more integrated ways of working across services and settings:

- An integrated respiratory service, which brings together primary, community and secondary care for people with significant lung disease
- An integrated rapid response and enablement team, bringing together primary care, community nursing and allied health, and secondary care specialists, with a focus on the frail elderly.

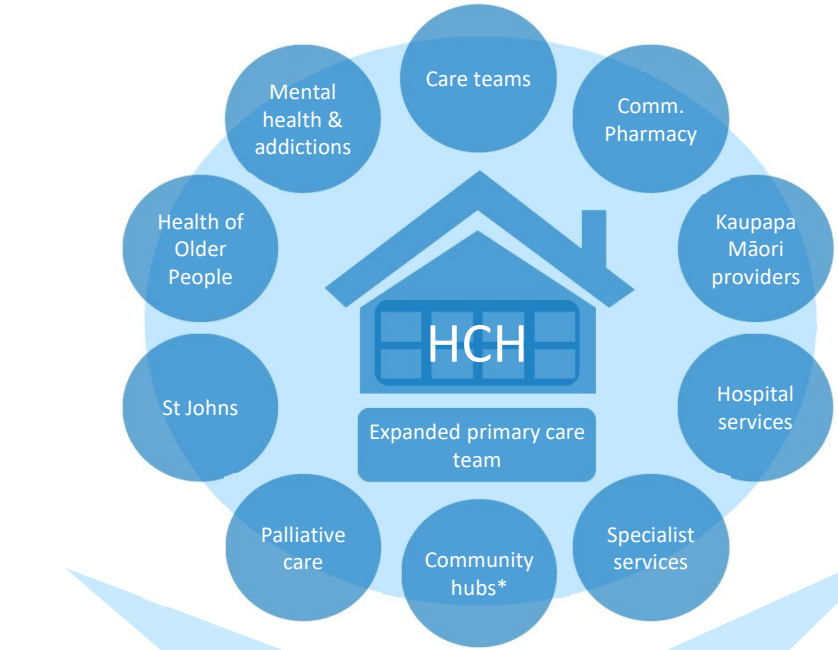
Each of these proof of concept models has undergone co-design and development with stakeholders, making them ready for real-world testing. They build on successful models operating in other parts of New Zealand.

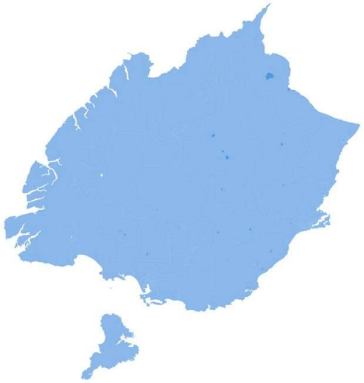
An action will also be progressed to optimise primary care and emergency care in Invercargill based on a review of services being developed in early 2018.

**The Acute Demand Management Programme Team has chosen to focus on implementing services that address COPD in 2017/18 because there is high relative need and utilisation, good data, motivated clinicians and managers, and a proven improvement model to follow.*

Create locality networks to better coordinate care *cont'd*

Locality networks and HCH community hubs





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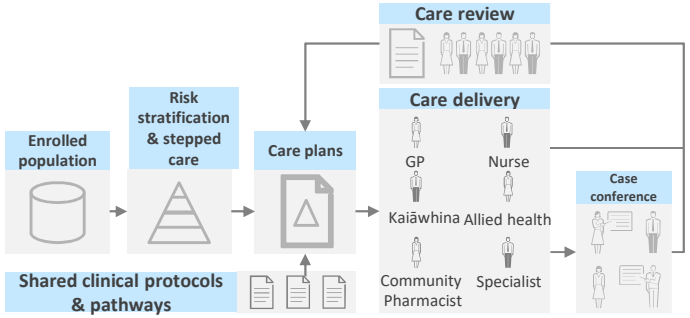
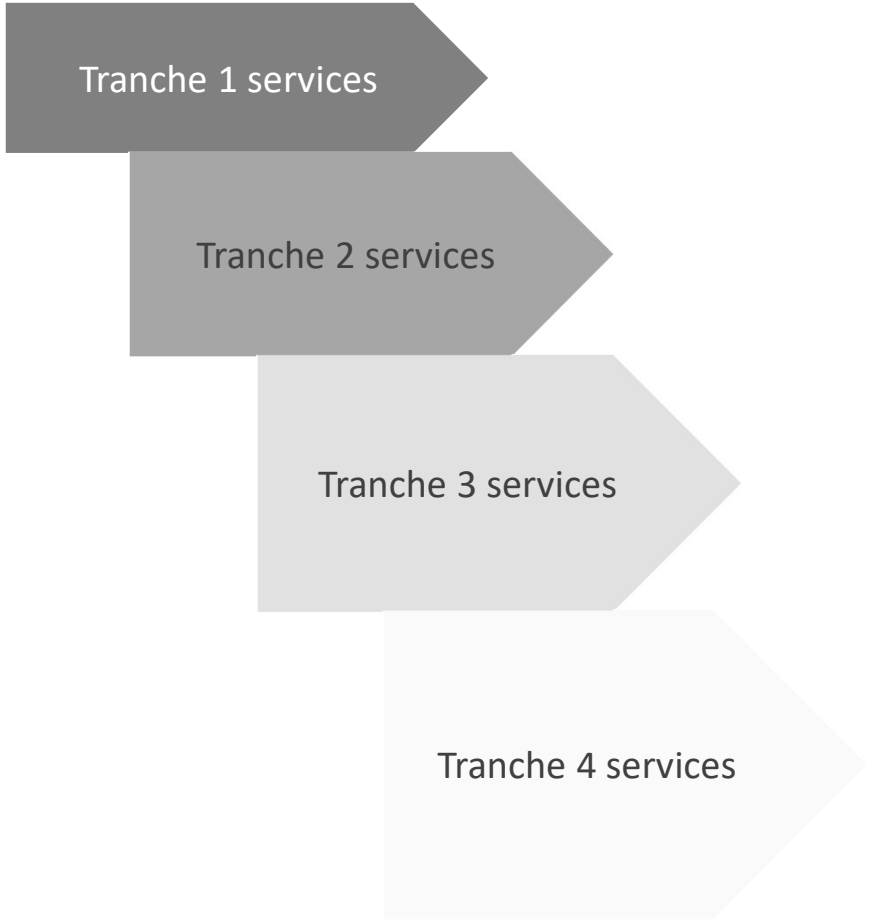


Delivering a proactive, integrated system of care within a district-wide framework

Implementation and sequencing

Services to be prioritised into tranches for design and roll-out



Implementation of services over time

The number of services in each tranche will progressively increase

** Community hub infrastructure to be determined.*

Create locality networks to better coordinate care – *Defining locality network services*

Headline action	Activity	Phases		
		1	2	3
Headline action 3.1 – Define locality network services, and prioritise implementation sequence	a. Define a minimum set of service and workforce requirements and associated models of care to form a locality network, with this expected to include (on a staged basis): i. Integration of DHB Community Services and WellSouth PHN community services (e.g. LTC service) into multidisciplinary teams wrapped around primary care ii. Formal specialist support for primary and community care from prioritised secondary care services*: i. Emergency medicine ii. Cardiology iii. Respiratory iv. ENT v. Paediatrics vi. Geriatrics vii. Women's Health iii. Development of advanced primary and community care practitioner roles iv. Integrating rural hospitals in rural primary and community models of care, and strengthening their relationships with Dunedin and Invercargill hospitals v. Further development opportunities for rural primary care supporting increased access to technology-enabled clinical interventions vi. Integration with public health, population health and NGO community services vii. Coordinated ways of working with social sector providers (e.g. representatives from or clear referral pathways to Housing, MSD, Corrections etc.) viii. Primary care research network development ix. Learning and training network development			
	b. Considering geography, population size and other agreed factors, and through engagement with key stakeholders (e.g. health and wider social sector representatives, community representatives), clearly define the coverage of population-bound locality networks			
	c. Develop a for each defined locality a strategic view of: i. Population health needs ii. Service use iii. Service availability and configuration iv. An explicit equity of access and outcome assessment (see: 8.5.a).			

** These priorities have been identified through prior planning work e.g. the Southern Strategic Services Plan, Southern Detailed Service Plans A&B, Clinical Leadership Group position papers, scan of national and international literature, and engagement with stakeholders.*

Create locality networks to better coordinate care – *Defining locality network services cont'd*

Headline action	Activity	Phases		
		1	2	3
Headline action 3.1 *cont'd* – Define locality network services, and prioritise implementation sequence	d. Based on activities a through c, prioritise the design and implementation of services to be progressively incorporated into locality networks and define implementation tranches, with consideration of: i. Size and scale to make a material difference on health and social outcomes ii. Readiness of the services to proceed at pace and scale iii. Alignment with primary care iv. Defining the role of rural hospitals in integrated models of primary and community care for their catchment populations v. Ability to translate learnings from service integration to other services to be progressively included within the locality network vi. Alignment with proof of concept locality network initiatives vii. The capability of Southern DHB and WellSouth PHN to successfully advance locality network development over the three year period viii. Quality and safety requirements ix. Education and learning development opportunities			

Create locality networks to better coordinate care - *Design and implement locality network services*

Headline action		Activity	Phases		
			1	2	3
Headline action 3.2 - Design and implementation of locality network services, which integrate care for defined populations	a.	For Tranche 1 locality network services, develop a comprehensive understanding of current and future population health needs for their covered population			
	b.	Understand the scope and capacity of Tranche 1 locality network services and workforces, and their existing operational configuration, including service catchments, policies and procedures, and current engagement with primary care. Identify significant service and workforce gaps based on projected future population health needs			
	c.	Conduct a quality assessment to determine the extent that services within Tranche 1 locality network services are addressing population health needs through evidence-based, culturally responsive and coordinated ways of working			
	d.	Refine as necessary existing risk stratification and stepped care approaches used in Southern to enable Tranche 1 locality network operations			
	e.	Ensure shared care planning processes and systems are in place to enable integrated ways of working between locality network providers			
	f.	Extend Health Pathways to become whole-system pathways to support safe and effective transitions of care for Tranche 1 locality services			

Create locality networks to better coordinate care – *Design and implement locality network services cont'd*

Headline action	Activity	Phases		
		1	2	3
Headline action 3.2 *cont'd* - Design and implementation of locality network services, which integrate care for defined populations	g. Identify potential NGO capability requirements to deliver on proposed models of care for Tranche 1 services, including *inter alia*: i. Retrieval and transfer infrastructure (e.g. air and land ambulances and storage facilities) to support efficient flows ii. Rural Hospital redevelopment as appropriate to meet future demand needs and enable delivery of broader services as agreed within role development, based on catchment population need iii. Increasing the capability and capacity of aged residential care providers to provide step-up or step-down care for older patients, through redevelopment of existing facilities or development of additional ARC capacity iv. Working with the NGO sector and wider social agencies to provide an increased range of accommodation options (including respite care) for people with mental health and/or addiction needs, and end of life care, across the Southern district		■	
	h. Tranche 1 locality network services operational implementation commenced		■	
	i. Tranche 2 locality network service planning started			■

Create locality networks to better coordinate care – *Design and implement integrated respiratory service*

Headline action		Activity	Phases		
			1	2	3
Headline action 3.3 – Working through a clinically-led Service Development Group, design and implement proof of concept integrated respiratory service to generate early improvement, and inform ongoing service design and implementation	a.	Ensure 90% of smokers with a respiratory illness diagnosis are offered smoking cessation advice and referral to the Southern Smoking Cessation Service at every clinical interaction, including by St John	■		
	b.	Establish a funded community-based laboratory-quality spirometry service, which accommodates appropriate close to home access to this service	■		
	c.	Establish a community pulmonary rehabilitation programme to standardised and agreed criteria of assessment and programme delivery based on international standards in all localities		■	
	d.	Ensure an ambulance diversion pathway for COPD is operational in all localities		■	
	e.	Ensure planned care initiatives for respiratory patients are in place, including acute plans, blue cards, a winter WoF, the CAT assessment, medicines optimisation, and advanced care plans		■	
	f.	Ensure a discharge bundle is in place for all patients with a severe respiratory diagnosis		■	
	g.	Work with stakeholders to determine extent and time of introducing an integrated cardiology service			■

Create locality networks to better coordinate care – *Design and implement rapid response and enablement team*

Headline action	Activity	Phases		
		1	2	3
Headline action 3.4 – Design and implement proof of concept integrated rapid response and enablement community team to generate early improvement, and inform ongoing locality network design and implementation	a. Map and consolidate existing DHB rapid response and enablement services			
	b. Select proof of concept testing locality			
	c. Design the service model required to deliver an enhanced rapid response and enablement service (including POAC Level 2 & 3), with a transition plan for progressively including: i. DHB services ii. WSPHN services iii. NGO services			
	d. Test (as a proof of concept) an enhanced rapid response and enablement service			
	e. With the support of the shared health and business intelligence function, test and evaluate the performance of the integrated rapid response and enablement team			
	f. Consider scaling the proof of concept service to additional localities for further refinement and testing			

Create locality networks to better coordinate care – *Design and initial implementation of a new primary maternity system of care*

Headline action	Activity	Phases		
		1	2	3
Headline action 3.5 – Design and begin implementation of a new primary maternity system of care	a. Applying the principles of critical mass, future population trends and promoting equity for communities, develop a plan for future development of a primary maternity system across the district. The system will be midwifery-led, woman- and-family centred, promote primary birthing facilities and home birth for well women with normal pregnancies, use consistent policies procedures and quality improvement frameworks while operating as a network across all facilities. Services will be provided in i. Tier 1 – non birthing units ii. Tier 2- primary birthing units iii. Tier 3 – obstetric services units			
	b. Map the overall network of maternity services including LMC midwives, rural hospitals, emergency services, PRIME doctors, laboratory and imaging services, pregnancy and parenting community-based breastfeeding support, and general practices. Identify gaps and: i. strengthen information technology platforms to link the network – telemedicine ii. develop a communications strategy / plan to promote primary birthing iii. gather information for feasibility studies in Invercargill and Dunedin and complete iv. agree the business model and implement			
	c. Work with local stakeholders, to implement the system of care – tier 1 and tier 2 – and ensure they are well linked to tier 3 obstetric services			
	d. Feasibility study to determine the need for a primary birthing facility in Dunedin and Invercargill, and determine the impact of both Balclutha and Winton primary birthing facilities			

Create locality networks to better coordinate care – *Design and initial implementation of access to diagnostics (ATD) programme*

Headline action	Activity	Phases		
		1	2	3
Headline action 3.6 – Develop an access to diagnostics (ATD) programme to improve ATD in primary and community care settings	a. Establish a clinical partnership group to develop clinical guidance for the programme, and a framework for the programme moving forward	■		
	b. Identify conditions for which diagnostics can be ordered and delivered in the community as a safe and more convenient alternative to referral to secondary care outpatients services	■		
	c. Develop processes for payment and claiming specifications in line with POAC	■		
	d. Align the ATD criteria with the hospital referral criteria to ensure consistency of access	■		
	e. Develop clinical audit processes to monitor appropriateness of use	■		
	f. Establish shared governance for the routine review of the programme, as well as risk management	■		
	g. Develop a systems approach to ATD in-line with the development of Health Pathways, to shift an increasing number of diagnostics to the community, and to accommodate key enablers of Health Pathways as these are developed		■	

Create locality networks to better coordinate care – *Deliver on optimisation of Primary and Emergency Care Services in Invercargill*

Headline action	Activity	Phases		
		1	2	3
Headline action 3.7 – Deliver on optimisation of Primary and Emergency Care Services in Invercargill	i. Based on the review of primary and emergency care demand and capacity undertaken in early 2018: i. Address gaps and barriers to achieving high quality and equitable access to primary care such as workforce issues, funding settings, and standards of care ii. Address barriers that impede acute patient flow across the system and best practice recommendations to address barriers iii. Undertake actions to improve an integrated and clear pathway of care between primary care and Southland Hospital ED, and into an inpatient setting where required iv. Consider the potential for reducing variation through the identification of priority Health Pathways			
	b. Align work undertaken to optimise primary and emergency care services in Invercargill with actions planned for development of HCHs and locality networks			

Action area 2: Supporting infrastructure

Governance and leadership

Given the Southern district's geography and dispersed population, the primary and community care system needs a clear district-wide framework for planning, funding and monitoring system performance and care delivery. The framework needs clear roles and responsibilities for prioritising resources, leading overall development of services to address population health needs, and continuous quality improvement (CQI). At a delivery level, clinical and provider relationships need to be fostered through building local champions and leaders that can successfully translate district priorities into local action.

At a **district level**, the alliancing approach between Southern DHB and WellSouth PHN will be refreshed. This will include revising Alliance leadership structures, membership and terms of reference. The Alliance approach will provide the district-wide framework for planning, funding and monitoring system performance and care delivery. The overarching role of the Alliance will be driving, overseeing, and supporting the delivery of the actions and activities outlined in this Action Plan, and the longer term strategic direction of the Strategy. In fulfilling this role, the Alliance will ensure that the system remains focused on the Strategy and Action Plan, and where any new initiatives or calls for funding are proposed, these are stringently prioritised against the direction of the Strategy and the Action Plan's headline actions.

The other roles of the Alliance are expected to be:

- Setting funding parameters to inform delivery on the Action Plan
- Providing advice to the Southern DHB Board and WellSouth PHN Board regarding investment decisions to achieve the Strategy and Action Plan
- Convening service-level teams to drive particular planning and design initiatives
- Driving and monitoring progress on the Strategy and Action Plan, and the performance of primary and community care
- Fostering consumer and clinical engagement, and leadership
- Holding locality networks to account for delivering measurable improvement in consumer access, outcomes and system sustainability.

Over time, the Alliance will build partnerships with the wider social sector and local government to support closer multi-agency engagement and a more holistic understanding of the health and social needs of our consumers. This will improve the health literacy of broader social agencies and create a foundation for targeted joint planning and co-investment, both in health and social initiatives, and initiatives that combine the two.

Strong **clinical and provider leadership** will be essential to effect the transformational change that will be required in the system at district and locality levels. Changing workforce behaviours requires acceptance of the need for new ways of working, and recognition of personal and professional responsibilities. Identifying key leaders throughout Southern, building their leadership capability, and providing the support they require will be a critical investment to support execution of the Strategy. This will include:

- Southern DHB's Clinical Council being a mechanism for district-wide clinical leadership through the reconfigured Alliance, with the Council's terms of reference and membership to be extended to a whole-of-system role
- Clinically-led service level teams to drive particular planning and design initiatives
- Active engagement of key providers and practitioners in locality networks.

Building clinical and provider leadership and engagement will:

- Align the culture of primary, community and secondary health services across Southern with the principles of transparency, comparison, learning and improvement
- Articulate a clear and consistent vision at the 'coal face'
- Build trusting inter-organisational, -professional and -personal relationships , and create a culture of learning from each other
- Demonstrate, enable and communicate the future vision for primary and community care in the district
- Generate momentum by modelling new ways of working.

Governance & leadership – *Refresh alliancing approach*

Headline action	Activity	Phases		
		1	2	3
Headline action 4.1 – Refresh the alliancing approach implemented in Southern, including terms of reference, membership and structure	a. Determine the future Terms of Reference (ToR) for alliancing in Southern including: i. Purpose ii. Guiding principles iii. Scope and objectives iv. Decision-making framework v. Dispute resolution mechanisms vi. Clarifying progress, performance and other agreed reporting lines vii. Relationship with other bodies in the Southern health system including but not limited to the Iwi Governance Committee, Community Health Council and Clinical Council			
	b. Refresh Alliance membership (including at least members from Southern DHB, WellSouth PHN and the University of Otago) and ensure all members have undergone alliancing training			
	c. Clarify and delegate accountabilities for delivering on the Primary & Community Care Strategy and Action Plan either through: i. Service level leadership teams for time-bound initiatives ii. Dedicated workstreams for enduring activity			
	d. Confirm an investment strategy and joint approach for delivering on the Primary & Community Care Strategy and Action Plan			
	e. Implement a simplified and consistent business case process for Alliance service-level and workstream activity development and decision-making			

Governance & leadership – *Encourage establishment of clinical and provider networks*

Headline action	Activity	Phases		
		1	2	3
Headline action 4.2 – Encourage clinical and provider networks to support locality network strategic and operational delivery	a. Identify and build the capability of local leaders and champions of integrated approaches to care delivery, as envisaged by locality networks, through a leadership development programme. Key roles for local leaders and champions to include: i. Aligning the culture of primary, community and secondary health services across Southern with the values of transparency, comparison, learning and improvement ii. Articulating a clear and consistent vision at the 'coal face' iii. Building trusting inter-organisational, -professional and -personal relationships , and creating a culture of learning from each other iv. Demonstrating, enabling and communicating the future vision for primary and community care in the district v. Generating momentum by modelling new ways of working vi. Develop visual resources to reflect the shared purpose of participants across the sector, for use across all providers' communications materials	■		
	b. Through the shared health and business intelligence function, provide regular transparent analytics reports to locality networks that benchmark locality performance on agreed measures. The reports are to be available to all members of the locality network		■	
	c. Encourage participation in professional development activities that include but are not limited to: i. Peer review ii. Fostering team based ways of working iii. Professional relationships across care settings (e.g., nursing) iv. Research and learning		■	
	d. Review and align funding and contracts across locality network providers with a focus on moving towards a results-based model for locality networks, with the intention that this supports local problem solving and service development			■

Workforce capability and culture

Delivering on the Strategy will require development of new care models and workforce roles, and additional workforce capacity. Currently workforce planning is fragmented across services and organisations. It is also reactive to emerging issues rather than proactive in aligning capability and capacity with planned future care models.

A **Southern Workforce Strategy and Action Plan** will be developed in 2018. The Strategy and Action Plan are expected to determine the workforce roles, capacity and capability needed across the system to deliver the intended care models, access and outcomes, and development needs at district and locality levels. This will include the training needs of existing staff, the roles they need to perform in the future, and the number of staff needed with different skills to deliver within the new care models.

From a primary and community care perspective, the key considerations for the Southern Workforce Strategy and Action Plan Plan will include:

- Better matching workforce distribution with population need through a primary and community care workforce census and projected development survey to establish current demographic and clinical/business needs. This will be supported by a gap analysis to inform and deliver further training/development/workforce needs
- Expanding the primary care team through the HCH model
- Promoting top of scope practice including designated pathways for regulated health professionals to extend their scopes of practice (e.g. nurse practitioner, GPSI, PNSI, rural hospital medicine, pharmacist)
- Enabling care to be delivered in ways which recognise the importance of te reo Māori and provide for its appropriate use, including the potential to introduce mandatory training for the health workforce
- Promoting non-regulated workforce roles such as health care assistants, health coaches, kaiāwhina and physician assistants
- Increasing Māori and Pacific peoples' participation in the regulated and unregulated workforce
- Addressing any existing local policy settings that get in the way of the efficient use of resources and team based ways of working
- Identifying the appropriate balance between generalism and specialism within the workforce
- Developing capabilities in team-based ways of working across primary, community, secondary and social care
- Developing a technology-capable health workforce
- How the professional development curricula and delivery media can help to build relationships within the primary and community care workforce (district-wide and locality specific), support new care models, and provide training for emerging clinical leaders
- Opportunities to better support teaching, training and research in primary and community care, including in partnership with the University of Otago
- Fostering capable primary and community clinical leaders
- Recognise changing professional expectations such as: feminisation; work / life balance; and employment rather than ownership
- Describing the actions needed to foster a workforce culture that is:
  - Consumer-focused, including promoting health literacy and self-care
  - Committed to reducing inequities and population health
  - Collaborative
  - Identifying opportunities to increase community volunteering activity to support participation and resilience.

Workforce capacity and capability development will need to be supported by tertiary programmes (e.g. the University of Otago's rural health training and inter-professional learning programmes). Strong engagement with tertiary education institutions will therefore be critical during Strategy and Action Plan development to ensure alignment between workforce requirements, and education and training programmes.

Workforce capability and culture - *Build the primary and community care workforce*

Headline action	Activity	Phases		
		1	2	3
Headline action 5.1 - Build the primary and community care workforce in-line with the Southern Health System Workforce Strategy & Action Plan and implementation of HCH and locality networks	a. Undertake a primary and community care Demographic and Workforce Development Survey to establish current demographic and clinical/workforce development needs. As part of this, undertake a gap analysis on the data provided to inform and deliver further training/development/workforce needs	■		
	b. Partner with tertiary and education providers to ensure a sufficient future supply of primary and community care professionals aligned with desired models of care and future demand, and to better support teaching and learning	■		
	c. Promote interprofessional top of scope practice through designated pathways for regulated health professionals to extend their scopes of practice (e.g. nurse practitioner, GPSI, PNSI, rural hospital medicine, advanced allied health professionals, pharmacist)		■	
	d. Promote and develop a framework for interprofessional clinical practice and safe delegation/skill sharing (e.g. interprofessional team models, use of Calderdale Framework for skill sharing/delegation).		■	
	e. Develop a primary care research network in partnership with Health Research South		■	
	f. Health of older people: i. Provide support to upskill the Aged Residential Care nursing workforce through: a. professional development opportunities b. increased visiting presence of clinical nurse specialists in care facilities c. streamlined access to specialist advice to manage more complex residents ii. Closer working relationships between home-based support services and community health services, as progressed through locality network development		■	
	g. Primary maternity care: i. Strengthen the primary maternity workforce based on current and projected population needs, including appropriate integration with other primary and community care services *(see: Primary Maternity Strategy)* ii. Encourage provider and facility networks to support the development of a primary maternity system of care		■	

Workforce capability and culture - *Build the primary and community care workforce cont'd*

Headline action	Activity	Phases		
		1	2	3
Headline action 5.1 *cont'd* - Build the primary and community care workforce in-line with the Southern Health System Workforce Strategy & Action Plan and implementation of HCH and locality networks	h. Community pharmacy: i. Implement as appropriate *Integrated Pharmacist Services in the Community* including: - promoting clinical pharmacy roles as part of HCH and locality network development - participation in shared care planning - locally determined services to be developed from pharmacies (e.g. medicines optimisation; minor ailment interventions) i. As applicable, encourage the use of pharmacy technicians to free up pharmacist time to provide higher complexity services ii. Encourage pharmacies' role in promoting improved population health		■	
	i. Emergency care: i. Work with St Johns to upskill their workforce to enable top of scope practice ii. Support the ongoing development of the PRIME-trained workforce in rural and remote areas		■	
	j. Address immediate capacity pressures in: i. Rural primary maternity care ii. Allied health services iii. GP and nursing cover in rural and remote areas		■	
	k. Actively promote, and preferentially invest in, growing the Māori and Pacifica primary and community care workforce in partnership with education providers, including potential incentives or priority placements to encourage Māori/Pacifica students to develop in required roles, or existing Māori/Pacifica members of the workforce to develop into extended roles (engage with iwi and community agencies and other key stakeholders in relation to this)	■		
	l. Through locality network development, identify workforce capacity development needs to deliver desired models of care, and put in place action plans to address these needs		■	
	m. Work with wider social sector representatives to identify and action opportunities to increase community volunteering activity to support participation and resilience (e.g. visiting ARC facilities, Meals on Wheels)		■	

Workforce capability and culture – *Identify actions to develop the workforce culture*

Headline action	Activity	Phases		
		1	2	3
Headline action 5.2 - Identification of actions needed to develop the workforce culture required to deliver on the Strategy	a. Identify and implement evidence-based ways of promoting effective team working between primary, community and secondary care as part of HCH and locality network design and implementation		■	
	b. Develop a values-based charter that outlines the expected behaviour of all workforce participants, and a training module to introduce existing and new workforce members to these new ways of working, with this to include commitments to: i. person-centred care delivery ii. eliminate inequities in access and outcomes, particularly for Māori iii. work collaboratively across professions, organisations and sectors iv. constructively engage in open and honest appraisal of data, performance and opportunities for improvement	■		
	c. Develop mandatory education modules to train all workforce members on values-based ways of working, and engaging in a respectful way with Māori people, understanding their world view to enable the delivery of culturally appropriate care	■		
	d. Require completion of both the values-based and Māori education modules by all existing staff, and new staff through induction activities		■	
	e. Create a channel for ongoing feedback from all system participants (workforce and consumers), encouraging transparency around performance in relation to both the system value-set and ways of working, and engaging with Māori		■	
	f. Leverage expertise within the University of Otago to promote quality and safety, research, and evaluation		■	

Health and business intelligence

Health and business intelligence plays a vital role in supporting evidence-based planning, funding and care delivery, including supporting the rapid evaluation of initiatives and provision of feedback for performance improvement. This requires a robust system of data collection, analysis, interpretation and reporting. Improved health and business intelligence will be progressed at two levels in the Southern system:

- Strategic: development of a shared health and business intelligence function
- Operational: an expanded and enhanced Care Coordination Centre.

A shared health and business intelligence function will be developed across Southern DHB and WellSouth PHN, and potentially with the University of Otago (e.g. evaluation; research; health economics). The function will consolidate existing resources to drive efficiencies and best use of scarce skills. The key roles of the function will be:

- Maintaining and improving the quality of source data within key databases (including from PMS's), managing access to data, and developing analytical tools
- Supporting strategic planning through the provision of analytical and evidence-based advice, including identifying opportunities to reprioritise investment to achieve better population health access and outcomes
- Supporting performance improvement through data analysis and interpretation; assistance in developing key indicators, health need and services profiles; and identifying unwarranted variation in access and outcomes
- Supporting planning and development within individual services and localities, including making information publicly available
- Providing performance and health outcome information on organisational priorities, including through the System Level Measures Framework
- Supporting the rapid, evidence-based evaluation of initiatives, programmes and models of care. This would include recommendations to adjust, continue, scale or stop, depending on performance over a reasonable time period, potentially through collaboration with the University of Otago.

To support the health and business intelligence function, data will be integrated across the system into a single data repository. Data will be integrated at an individual consumer level, with need, activity, experience and cost information. This will allow health and care analysis at a population level, as well as locality and consumer cohort levels.

The foundation of the data repository will be consumer level data from general practice, developed to consistent data specifications and business rules. This data will then be integrated with Southern DHB hospital, specialist and community health data. Over time, health and support data from kaupapa Māori providers and other NGOs will also be incorporated into the dataset (including social care where possible).

The dataset will be used to understand how Southern compares with other health systems and how access, quality, and outcomes vary across the district. The dataset will also be used to benchmark general practice, community providers and hospital services against desired metrics, and for defining and actively monitoring performance against appropriate KPIs to identify opportunities for improving access, quality and costs. Performance against KPIs will be shown for Māori and non-Māori populations. This will be linked to the System Level Measures Framework and local contributory measures.

At an operational level, informed by the shared health and business intelligence function, an expanded and enhanced **Care Coordination Centre** will be progressed. The key roles of the Centre will be:

- Central intake of consumers requiring wraparound care from locality network services
- Assessment of consumers with complex needs, and deployment of resources
- Administrative management of funding streams and packages of care
- Maintenance and monitoring of care pathways
- Logistics related to consumer transport and accommodation
- Oversight of community care performance.

Health & business intelligence – *Establish a shared health intelligence function*

Headline action		Activity	Phases		
			1	2	3
Headline action 6.1 – Establish a shared health and business intelligence function to guide district-wide and specific service or population analysis	a.	Define the scope and objectives of the shared health and business intelligence function, informed by New Zealand and international leading practice, including an equity approach to support improving access and outcomes for Māori and rural populations. Scope and objectives to include consideration of: i. Strategic population needs assessment (includes equity considerations) ii. Overall health system outcomes iii. Operational health system operational performance iv. Ability to match expenditure and resource allocation to service utilisation and outcomes.	■		
	b.	Map capabilities required for the health and business intelligence function with existing Southern DHB and WellSouth PHN health and business intelligence capabilities (people, process, technology), and explore opportunities to work with the University of Otago	■		
	c.	Based on capability mapping, identify and action the necessary development steps for the shared health & business intelligence function		■	
	d.	Determine governance, structure and location of the shared health and business intelligence function		■	
	e.	Establish a quality improvement framework aligned with the quadruple aim approach, to underpin Action Plan delivery (see: 8.5.a)		■	
	f.	Develop and introduce a Southern-tailored methodology for the use of equity indexes, particularly to support improving access and outcomes for Māori and rural populations, engaging with the rural health workforce, and iwi and Māori health providers to support culturally appropriate responses		■	
	g.	Develop an integrated system-wide data repository design brief and implementation plan to support the health and business intelligence function, utilising existing infrastructure where possible		■	
	h.	Commence development of the integrated system-wide data repository		■	
	i.	Analytical support provided to Tranche 1 HCH sites		■	
	j.	Analytical support provided to Tranche 1 locality networks		■	

Health & business intelligence – *Establish a care coordination approach*

Headline action	Activity	Phases		
		1	2	3
Headline action 6.2 – Establish a care coordination approach	a. Scope the establishment of an expanded and enhanced district-wide Care Coordination Centre with the following functions: i. Central intake of consumers requiring wraparound care from locality network services ii. Consistent assessment of consumers with complex needs, and deployment of resources iii. Administrative management of funding streams and packages of care iv. Scheduling and rostering of community based teams v. Maintenance and monitoring of care pathways vi. Logistics related to consumer transport and accommodation vii. Oversight of community care operational performance	■		
	b. Determine the additional services to be covered by the Care Coordination Centre, with early areas of focus being: i. Rapid enablement and response team ii. Integrated respiratory service iii. Discharge planning iv. Agreed Tranche 1 HCH and locality network services	■		
	c. Develop an implementation plan for an expanded and enhanced Care Coordination Centre		■	
	d. Commence implementation of the expended and enhanced Care Coordination Centre			■

Information and care technologies

New and emerging technologies are rapidly transforming how people engage with each other and with the services they use. In health care, this means how people access health information (including their own records), how they engage with health services, how they interact with people with similar needs, and the health checks (like simple diagnostics) they can do for themselves. It also is transforming how the health workforce interacts with each other, and the range of information they can use to diagnose and care for people.

It is easy to be overly optimistic about technologies in the short-term. However, in the long-term the transformational impact on health care through technology can be easily under-estimated. Given this, a structured and considered approach will be taken to introducing new technology into the Southern health system.

A **Southern Technology Strategy and Action Plan** will be developed in 2018. The Strategy and Action Plan are expected to determine the technology capacity and capability needed across the system to deliver desired care models and ways of working. The Strategy and Action Plan will consider the technology development needs for the system as a whole, and more specific areas of focus such as primary and community care integration with hospital and specialist services.

The South Island health system is comparatively advanced in **information sharing** across the health workforce, with many professionals able to quickly access relevant consumer information across care settings. Our primary health care workforce can also access a wide range of clinical pathways and referral guidelines through Health Pathways, helping them make timely, evidence-based decisions for their registered populations. While we have made progress on improving clinician access to patient information and aspects of clinical communication, we have yet to fully develop the communications and information technology infrastructure to support shared care planning and care delivery, and consumer access to their information.

Approaches to **virtual health**, such as through smart phone, video and email consultations are rapidly being implemented internationally and in New Zealand. Such approaches are underway in Southern, although this tends to be at the margins of care delivery. As part of improving access to services, particularly for our rural populations, we will encourage the development of virtual health approaches. For example, we will encourage the use of online video consultations for consumers to access timely advice, with such approaches expected to be a core specification for HCH development. We will also encourage the use of technology in 'front-door' flows at HCHs (e.g. smart kiosks), and preparing HCHs and locality networks for the gradual introduction of technology-enabled home care approaches.

More use of **home care technologies** that enable consumers to safely care for themselves in their own homes, with support from their HCH and locality networks, will be encouraged. This will include consumers with chronic disease monitoring and managing their physiological markers, and health professionals remotely monitoring consumers with dementia at home so that they can intervene quickly to reduce the risk of adverse events.

In the longer-term we will also explore opportunities:

- to encourage the introduction of emerging technologies:
  - into care delivery (e.g. dispensing in community pharmacy)
  - to support consumers to live well at home (e.g. 'smart home' technology)
  - into the supply chain to provide quicker access to medicines and clinical supplies for consumers and the health workforce (e.g. drones; self-driving cars)
- to incorporate genomic information into consumer health care records to enable more personalised care approaches tailored to individual biology (e.g. medicine management based on a person's genomic profile)
- the use of artificial intelligence (AI) in health and business intelligence, operational management and clinical decision support.

Information and care technologies – *Prioritise and introduce new technologies*

Headline action	Activity		Phases		
			1	2	3
Headline action 7.1 – Prioritise and roll-out new technologies in primary and community care in-line with the Southern Digital Health Strategy and implementation of HCH and locality networks	a.	Through development and delivery of the Southern Health System Digital Health Strategy, leverage existing infrastructure, and where required design and implement new ways of working to develop the integrated set of technology solutions that provide a consumer-owned EHR			
	b.	Establish an R&D project in partnership with University of Otago and other international partners to determine appropriate health technology enablement opportunities aligned with HCH, integrated care and home-based care models			
	c.	As part of locality networks, develop secondary outreach services delivered through a structured telehealth outreach model via fixed to mobile end-points established on the DHB network. e.g. Vidyo			
	d.	Develop consumer access to health care through Consumer Portal Telehealth Services, with fluid access to Online Doctor and Virtual After-Hours Services, accessible via an integrated Southern health system online communications framework			
	e.	Develop remote monitoring capability of inpatient beds and step down facilities in rural and regional areas. This should utilise proactive data analytics and bi-directional video conferencing to alleviate occupancy pressures on Dunedin and Invercargill hospitals			
	f.	Implement remote telehealth support for paramedic and emergency clinicians to improve remote triage of patients in their communities			
	g.	Explore opportunities to develop Healthpod-style kiosks for routine self-service checks, leveraging existing connected health services or new initiatives through the Southern Technology Strategy			
	h.	Begin to explore the potential of emerging technologies and opportunities to leverage artificial intelligence			

Funding and contracting

Implementation of the care models and supporting infrastructure envisaged by the Strategy will require changes in funding and contracting approaches. Existing funding and contracting models lead to duplication of effort and resources, are too output-focused, and restrict collaboration between providers and innovation in care models. Actions to promote new funding and contracting approaches will include:

- Supporting the development of HCHs - for example, through enhanced capitation, transitional resources, and performance incentives
- Addressing urgent care needs and avoiding hospital demand through design and roll-out of a tailored Primary Options for Acute Care model, including as appropriate mechanisms to address consumer cost barriers (in-line with national policy developments)
- Introducing a funding model that supports extension of scopes of practice
- Designing a funding and contracting approach for rural hospitals that reflects and incentivises the desired scale and mix of services, integration with primary and community services, and effective linkages with base hospital acute and visiting specialist services
- Improving service coordination and reducing duplication - for example, through locality network fund-holding; and/or packages of care approaches with a lead provider(s) for defined populations and/or consolidation of services under a single provider arrangement, supported by the Care Coordination Centre
- Increasing accountability for improving outcomes such as through results-focused funding and contracting arrangements
- Exploring opportunities to use multi-year funding and contracting arrangements. These arrangements are intended to provide a level of financial security to enable provider investment in innovation, broadening the scope and/or scale of services offered, and fostering integrated care approaches
- Exploring opportunities to pool funding across health and social care at a district-level, operationalised at a locality network level, to support holistic care for more vulnerable populations.

Any adjustments to funding and contracting settings will be married to transparent performance evaluation delivered through the proposed shared health and business intelligence function, and operationalised through HCH and locality network development. They will also consider the cost to consumers of accessing services, and will make consumer service costs more consistent across the district (particularly for after-hours services).

Funding and contracting – *Develop HCH transitional funding approach*

Headline action	Activity	Phases		
		1	2	3
Headline action 8.1 – Develop a HCH transitional funding approach tied to model of care and performance specification	a. Discuss with other implementers of HCH models of care (e.g. Health Care Home Collaborative) to understand transitional funding arrangements and how they have been linked to performance expectations			
	b. Design the transitional funding arrangements for Tranche 1 HCHs, with this expected to include: i. Adoption of the Health Care Home Collaborative's national dataset measures ii. Locally determined performance measures iii. Transitional funding arrangements explicitly tied to model of care development milestones iv. Co-sharing of HCH model of care design costs through financial recognition of clinical participation in the process v. Collaboration values between Southern DHB, WellSouth PHN and HCHs			
	c. Implement the transitional funding arrangements for Tranche 1 HCHs			

Funding and contracting – *Roll out Primary Options for Acute Care programme*

Headline action	Activity	Phases		
		1	2	3
Headline action 8.2 – Roll-out Primary Options for Acute Care programme	a. Implement the Acute Demand Management Project POAC model, provided at the following three levels: i. Level 3: Most acute patients - the patient requires access to enhanced community supports such as the rapid response and enablement service, community allied health, a medical assessment and planning unit (MAPU), or an Accident and Medical Centre ii. Level 2: Moderately acute patients - the patient requires extra support coordinated by the general practice or HCH. This will include additional support from an allied health team (whether based in primary or secondary care, likely locality-based) that would provide capacity, particularly to smaller practices iii. Level 1: Least acute patients - the patient requires a one-off service or activity such as IV antibiotics, diagnostic test, or direct access to specialist advice			
	b. Confirm and implement priority populations and services for Tranche 2, level 1 POAC services			
	c. Working with locality networks, design and commence implementation of level 2 and 3 POAC services			
	d. Supported by the health and business intelligence function, evaluate and adjust POAC initiatives depending on their cost-effectiveness, stopping or scaling if necessary			

Funding and contracting – *Introduce a funding model to support the designated pathway for extended scopes of practice*

Headline action	Activity		Phases		
			1	2	3
Headline action 8.3 – Introduce a funding model to support the designated pathway for the extension of scopes of practice (e.g. GPSI / PNSI / NPSI)	a.	Develop an appropriate funding model for GPSI / PNSI / NPSI roles matched to current and / or future demand	■		
	b.	Follow an expression of interest (EOI) process to identify opportunities for role development and select appropriate people within and outside of the existing workforce to develop into these roles. For existing members of the workforce, the potential to train where they live and work must be considered, either extramurally or through training by visiting specialists in their chosen area(s) of expertise		■	
	c.	Supported by the health and business intelligence function, evaluate and improve the cost-effectiveness, and approach to development for / funding of these roles			■

Funding and contracting – *Introduce a results-based funding approach*

Headline action	Activity	Phases		
		1	2	3
Headline action 8.4 – Institute a results-based approach to funding and contracting to support alignment of locality network delivery with district-wide and local priorities	a. Determine a performance framework for locality networks which: i. Shares accountability for whole of system outcomes ii. Enhances and incentivises integrated network decision-making iii. Stipulates responsibilities for locality network clinical oversight and quality improvement iv. Takes a lifecourse approach to better aligning service delivery with desired population health outcomes v. Enables improvement in capacity and capability	■		
	b. Apply the locality network performance framework with Tranche 1 localities to inform model of care design		■	
	c. Identify and address funding and contracting barriers to locality network collaboration and duplication of service delivery		■	
	d. Determine locality network-wide KPIs to be incorporated into all contracts held by Tranche 1 network providers to support integrated ways of working		■	
	e. Formulate a funding model to support the locality network performance framework, with appropriate consideration of factors that influence delivery costs		■	
	f. Explore opportunities for risk / gain sharing approaches at a locality network or provider level			■

Action area 3: Supporting adoption

Supporting adoption

Proof of concept

HCH demonstration sites and localities will have a proof of concept (POC) role. This will involve testing of HCH and locality network models to ensure they are feasible for wider application, and fine-tuning the models based on this experience. POC can be thought of as trialling a prototype of a new model in the field to establish operational viability, identify and resolve technical issues, and suggest overall direction. POC involves extensive review to inform fine-tuning of the prototype, as well as providing feedback for decision-making processes.

Design and implementation at the demonstration sites or localities will involve putting in place site-specific supporting infrastructure, so that they can deliver the intended model of care. It will also involve the application of district-wide supporting infrastructure such as early stage whole-system health and business intelligence. As implementation progresses, care models and infrastructure will continue to evolve both through a planned development path, and in response to learnings from review and feedback.

Learnings from the demonstration sites will play a central role in shaping delivery of primary and community care in Southern, and in contributing to realisation of the Strategy's vision. Minimum requirements for demonstration site selection are likely to include:

- Local clinical champion(s) committed to innovative service redesign
- Commitment to the key directions of the Primary and Community Care Strategy
- Economy of scale to undertake early testing and development of new care models and infrastructure
- Cooperative working relationships with DHB services
- Cooperative working relationships with other locality providers
- Evidence of participation in primary and community care innovation, or intention to participate in the near future
- Support for the shift of service activity from secondary to primary care (especially for long-term condition management)
- Willingness to share data
- Standard and quality of information systems and facilities, and willingness to invest where required.

The number and sequencing of demonstration sites will be determined during the first 12 months of Action Plan implementation, which will include an expression of interest (EOI) process for HCHs, and an engagement process to define and prioritise locality network development. As part of creating locality networks, a small set of service-based POCs (integrated respiratory services and rapid response / enablement teams) will be designed and implemented for trialing before potentially being scaled district-wide.

Consumer engagement and communications

Communications and engagement with consumers and communities will be critical to the design and application of new care models and supporting infrastructure. A 'one team' approach will be taken to communications and engagement with consumers, as 'Southern Health' rather than individual organisations. In the first instance, model of care co-design approaches with consumers and communities will provide an avenue through which to do this, and the values-based charter will provide the framework for consistent, ongoing engagement.

Consumer engagement with the district-wide Alliance will be encouraged through Southern DHB's Community Health Council; and through consumer participation in the DHB's Clinical Council.

Consideration will be given to how this consumer participation can be extended to the locality level, where close engagement with local government in particular will enable community leaders to identify, advocate and support local health priorities and initiatives. Social care providers will also be engaged at the locality level.

Supporting adoption *cont'd*

Workforce engagement and communications

The health care workforce will be actively engaged in the design and application of care models and supporting infrastructure. The focus of engagement will be on breaking down the traditional silos that characterise relationships between primary, community, and secondary care. This will be achieved through:

- Co-design methodologies, which bring health care representatives together to challenge traditional ways of working, and identify practical approaches to delivering on the Strategy. Co-design will be facilitated through HCH and locality networks design and execution
- Development of a clear strategic direction for secondary and tertiary care, aligned with the Primary and Community Care Strategy over the same time horizon, and work undertaken as part of the Dunedin Hospital rebuild process
- Specially convened Alliance service development activities (e.g. access to diagnostics) which involve primary and hospital clinicians in design and implementation, with a focus on building trust-based relationships
- Workforce development, including lifting capabilities in clinical leadership and in team-based care.

Over time the social care sector will be progressively involved in co-design approaches.

Iwi engagement

Southern DHB and Ngāi Tahu have a history of working together, largely through their engagement with the Iwi Governance Committee. This working relationship will be enhanced through active engagement with the Committee during detailed design and implementation of the Strategy and Action Plan. In the context of Strategy and Action Plan implementation, this will mean:

- Continuing to build the network of kaupapa Māori providers across Southern through specific development work, and integration with other health and social services
- Strengthening the Māori consumer voice in model of care design
- Lifting the performance of mainstream service providers so that they are effectively meeting the specific needs of Māori
- Identifying and actioning opportunities for iwi to participate in innovative models of health and social care.

Co-design approach

A structured approach to co-design will be progressed for HCH and locality network development (including POC initiatives). The approach will involve six steps:

1. Engage – proactively establishing and maintaining meaningful relationships with consumers, whānau, the health workforce (e.g. clinicians, non-clinical staff), iwi, tertiary providers, and wider social sector agencies ('key stakeholders') to understand health and service needs, and identify opportunities to lift performance
2. Explore – exploring the experiences of key stakeholders (particularly consumers and whānau) to identify model of care design and performance improvement activities
3. Develop – working with key stakeholders to turn ideas into improvements and better consumer and whānau experiences
4. Decide – using a transparent engagement process, prioritise model of care design and performance improvement activities in line with the principled approach set out on page 9.
5. Plan – work with key stakeholders to plan model of care design and performance improvement activities, including implementation steps and delivery
6. Change – work with key stakeholders to turn model of care design and performance improvement activities into action, supported by resourced change management capability.

Supporting adoption *cont'd*

Provider capability development

To encourage adoption of new care models and supporting infrastructure, some provision of transitional investment will be made available to early adopter HCHs and locality network participants. Investment will be linked to a transition plan that sets out agreed model of care specifications, timeframes, provider co-investment of time and effort, and potentially capital. Over time the transitional investments will be translated into incentives for outcomes following certification of a practice as an HCH.

Technical support will be provided to early adopter HCHs and locality networks. This support will include:

- Health intelligence: locality needs assessment and service profiles, and practice benchmarking
- Evaluation expertise: support to assess the maturity of existing systems and processes, and priorities for transformation
- Business intelligence: financial modelling to help providers understand how to optimise care and business models
- Redesign expertise: dedicated professional support to help facilitate change in care models
- Data management: assistance with improving data capture and accuracy.

Transitional investment and technical support will help to guide the implementation of tailored solutions to ensure HCH and locality network sustainability and performance.

Planning & funding

Southern DHB, the main funder of health services for the Southern population, is unlikely to receive a significant increase in its available funding, given the demographic characteristics of the district. Moreover, the DHB is still working towards a break-even financial position after a long period of spending more than it receives in revenue. Overall, this means that the DHB, and the health system more broadly, needs to do better within existing resources, while prioritising any additional discretionary funding to areas of greatest return in improving health outcomes and sustainability. Delivering on the Primary and Community Care Strategy and Action Plan will require:

- Doing better with the funding already available in the system through new care models and more integrated ways of working
- Prioritising investment of any discretionary funding to initiatives that will:
    - Modify demand for acute hospital services, which will unlock additional resources over time
    - Cost-effectively substitute demand for hospital care, reducing the need for additional hospital capacity
    - Improve longer-term health outcomes through targeted investments that reduce the burden of disease.

As a consequence, there will be an early review of funding levels and contracting within the system to test their alignment with the Primary and Community Care Strategy and Action Plan. This will inform the proposed investment strategy and joint approach between Southern DHB and WellSouth PHN (through the alliance) for delivering on the Strategy & Action Plan.

As Southern DHB receives its funding and planning package each year from the Ministry of Health, the size of available discretionary funding will become clearer. It is expected that delivering on the goals and actions of the Strategy and Action Plan will be prioritised for preferential investment within the DHB's overall available funding.

The extent of available funding will determine how quickly actions in the Action Plan can be advanced. If more funding becomes available, then some actions will be brought forward. In other instances, it may mean some are deferred. These decisions will be progressed through the Alliance, and codified through the DHB's annual planning cycle. This will ensure that they are factored into each year's Annual Plan and budget, and associated monitoring and reporting.


Southern District
Health Board
Piki Te Ora
WellSouth
Primary Health Network
Hauora Matua Ki Te Tonga