

Draft

# Southern Primary & Community Care Strategy



# Draft

## 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!

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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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## Overview

## Foreword

Tēnā koutou katoa,

We are pleased to present the Southern Primary and Community Care Strategy, which describes our vision for primary and community care in the Southern health system. This 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.

Given the challenges facing the Southern health system, and the generational opportunity that the rebuild of Dunedin Hospital presents, we have developed a bold and aspirational Primary and Community Care Strategy. Fundamentally, we want to focus primary and community services on fostering wellness, reducing health inequities (particularly for Māori), and providing timely, holistic care close to people's homes. Our aspiration is that consumers will experience primary and community care that is more responsive to their needs, is delivered by practitioners who work in partnership with them, and who in turn are better supported by our hospital services. To develop a Strategy that reflects this aspiration, we have been guided by five questions:

1. What can consumers, whānau and communities achieve for themselves?
2. What can technology help consumers and the workforce to do more effectively?
3. How can care be provided closer to home?
4. How can we develop a more integrated system of care for our population?
5. How can we develop the culture and leadership needed to deliver on this vision?

These questions are important, because we recognise that for too long we have taken the capabilities of our population, whānau, and primary and community services for granted, and have not consistently prioritised investments and other actions that could most cost-effectively improve access and outcomes.

This Strategy has 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. It recognises 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 Strategy will depend on whether we are bold enough and prepared to make tough prioritisation decisions. We will work with our communities and other stakeholders to make these prioritisation decisions, which will require all of us to challenge our attitudes, beliefs and ways of working. We are committed to doing our part in changing how we operate as leaders of the Southern health system, and look forward to working with you to make a positive difference to primary and community services that we can all be proud of. 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.**  
Consumers, whānau and communities are empowered to drive and own their care

**Goal 2.**  
Primary and community care works in partnership to provide holistic, team-based care

**Goal 3.**  
Secondary and tertiary care is integrated into primary and community care models

**Goal 4.**  
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

## Introduction



## Introducing the Southern Primary & Community Care Strategy and Action Plan

Development of the Southern Primary & Community Care Strategy and accompanying Action Plan has been led by the Southern District Health Board (DHB) and Well South Primary Health Network (PHN), with support from the University of Otago, reflecting each organisation's critical role in shaping health care in the Southern health system, commitment to collaboration, and unique teaching and learning environment. Both organisations have recognised the Dunedin Hospital rebuild as a generational opportunity to redistribute investment across the system, and do things differently in primary and community care - delivering a broader range of services through approaches and settings that are effective and convenient for consumers and whānau, and foster professional satisfaction.

Development of this Strategy has required a different way of thinking and actively engaging with consumers, whānau, iwi, tertiary providers, and representatives from across primary, community and secondary care. This approach will be maintained through implementation, and extended to include engagement with social and private sectors.

The Strategy is aligned with the government's priorities and policies, including the New Zealand Health Strategy and He Korowai Oranga. It has been developed to address the unique needs and circumstances of the diverse Southern district, New Zealand's largest DHB area, and with over 40% of its population living rurally. The Strategy and accompanying Action Plan is strongly evidence-based, building upon leading examples of primary and community care in New Zealand and internationally, and analysis of demographic, access and outcome data.

The Strategy recognises that Southern primary and community care performs well in many respects. Most people have timely access to good quality care provided by hard-working and well-intentioned health providers and practitioners. However, the strain on some services is apparent, and in other instances, care providers can improve their responsiveness to population and individual needs. Trusting relationships between many providers are broken or do not exist, and in many cases a provider- or service-centric approach is taken, rather than planning with consumers and whānau at the centre of care.

In particular, there remain longstanding inequities of access and outcomes for Māori, rural and remote populations.

Looking to the future, changes in demographics, disease prevalence and workforce capacity will increase the strain on primary and community care, if current care models persist. Changing how primary and community care providers interact, the services they are capable of delivering, and their relationship with hospital and specialist services is fundamental to meeting tomorrow's challenges.

Stakeholder engagement, research on leading models of primary and community care, and analytics of access and outcomes across the district have led to a focus on:

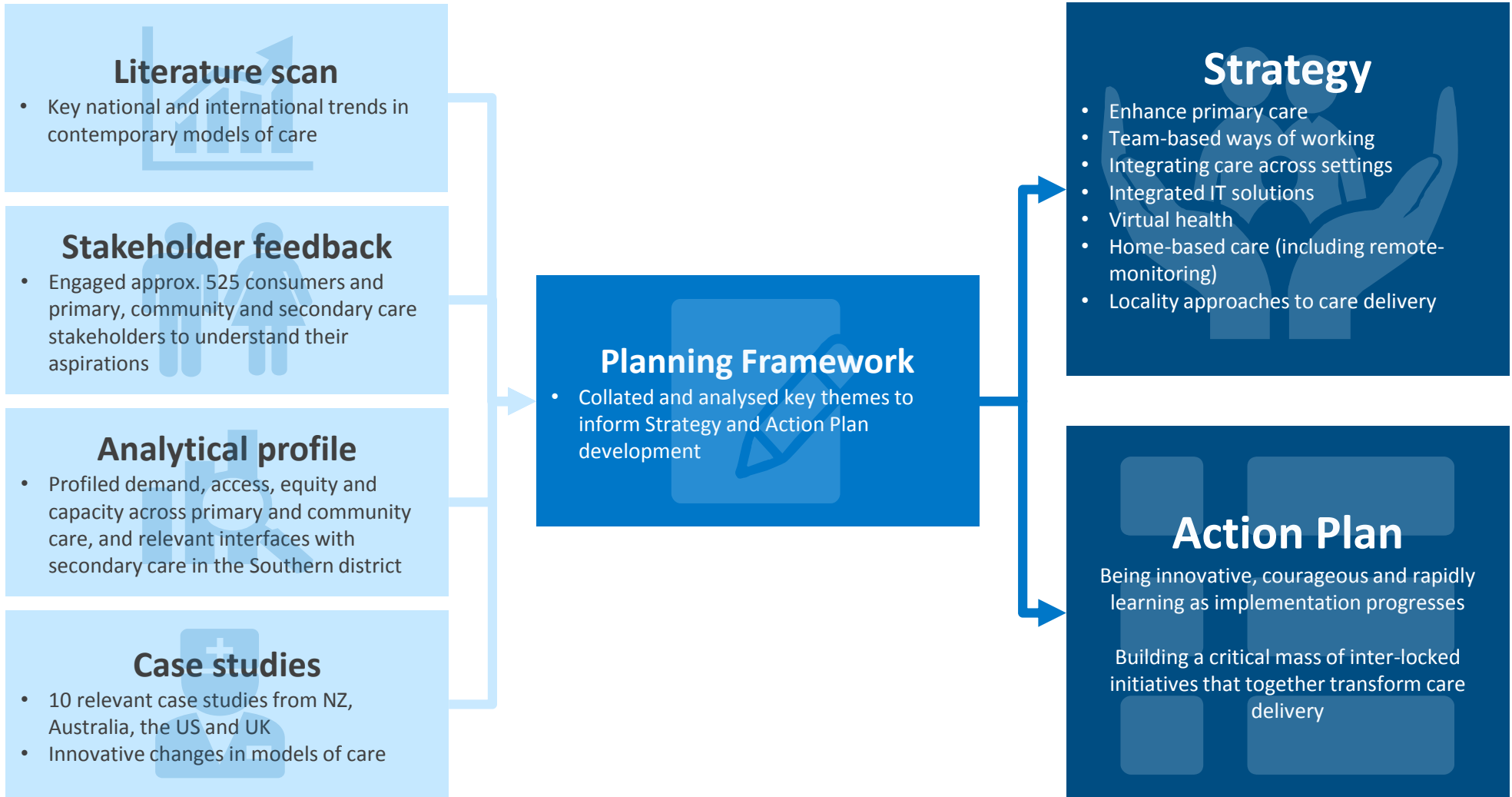
- ▶ Empowering consumers, whānau and communities
- ▶ Strengthening the ability of primary care to provide a broader scope of services close to home
- ▶ Integrating care across primary, community and secondary care.

The underlying direction is enabling primary and community care to focus itself on population health and wellness, delivering care closer to home, and being able to successfully transition people across care settings. This will require changes to the way in which:

- ▶ Consumer and whānau needs are interpreted and met
- ▶ Services are planned, funded and contracted
- ▶ Providers and practitioners interact across primary, secondary and community care.

This direction is articulated through a vision and set of strategic goals. The accompanying Action Plan sets out the headline actions and supporting activities that will be progressed during initial phases of executing the Strategy. Through implementation, the Southern health system will be one, collaborating to help consumers and whānau live well, stay well, get well and die well.

## Developing the Primary and Community Care Strategy and Action Plan

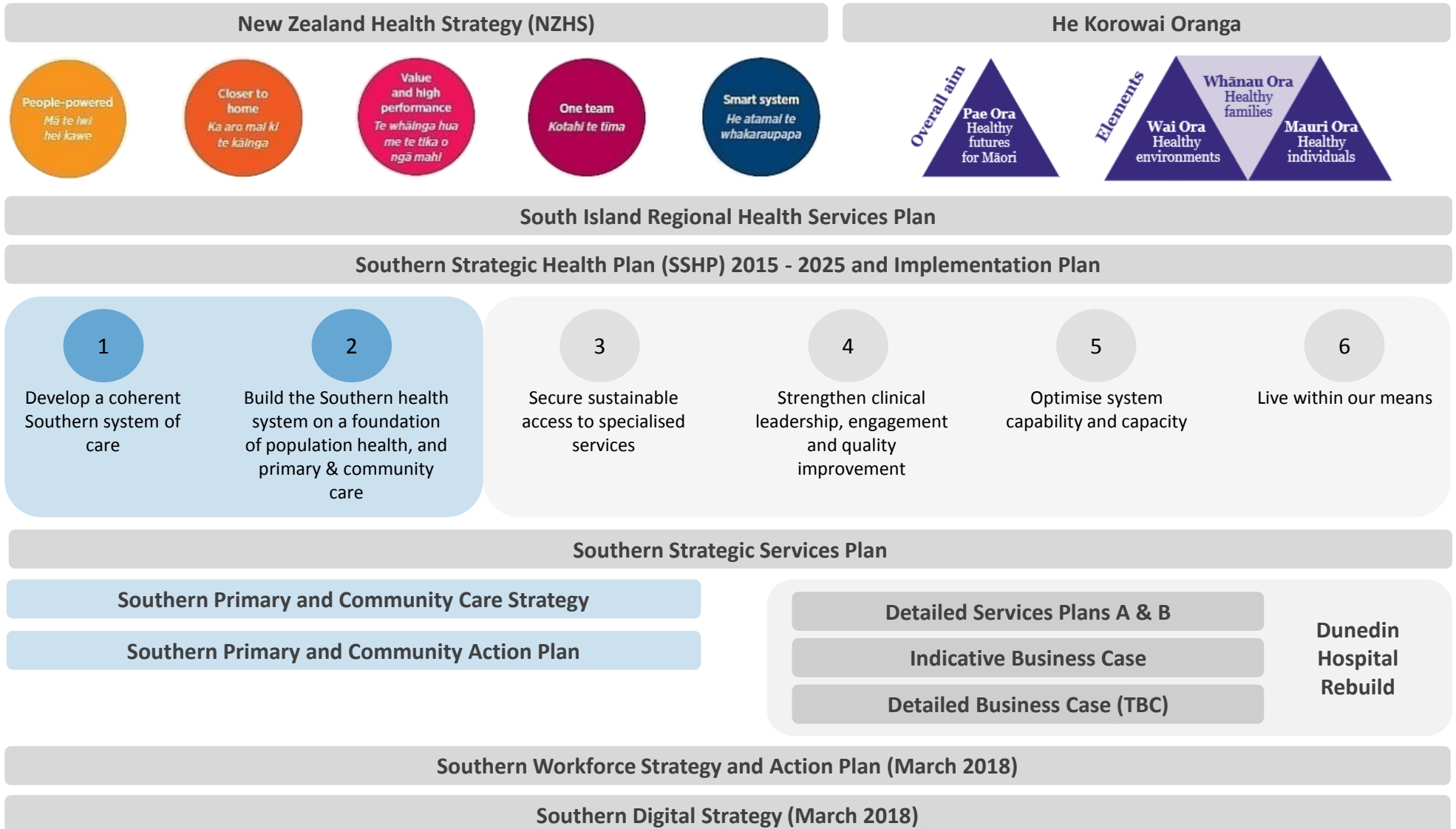


### Ongoing engagement

This occurred throughout the process at key points, with a Steering Group, a Working Group, consumers, and primary, community, and secondary care stakeholders

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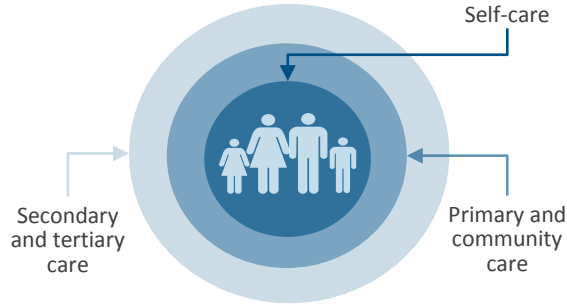
## How the Strategy relates to other national, regional and district strategies and plans



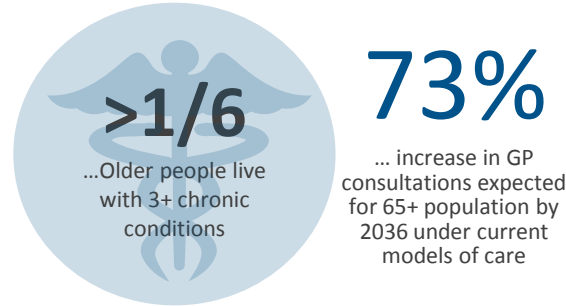
## We can do better for the people of the Southern district...

### Challenges

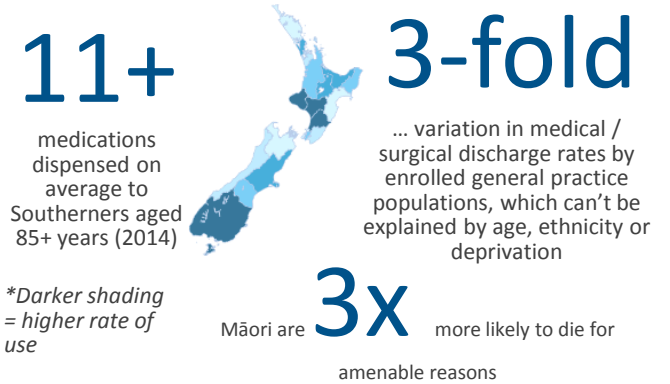
- 1 Consumers and whānau expect a more consistent care experience, in which they play a more active role



- 2 Ageing and increasing complexity suggests a significant increase in demand for health care



- 3 Significant variation in the Southern health system in terms of access, experience and outcomes



### Opportunities

- 4 Southern as a national hub for education and training of health professionals can design local approaches to address workforce shortages and development needs including building the Māori health workforce

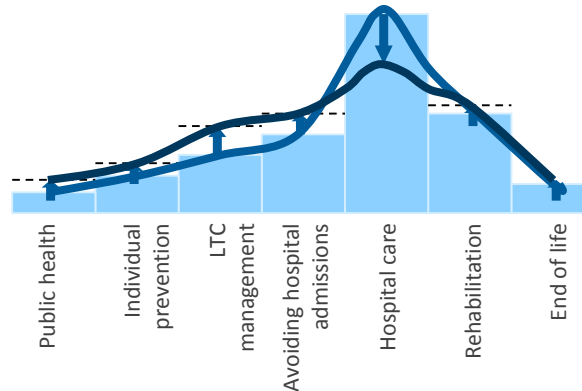
**494** ... Māori DHB employees per 100,000 Māori population<sup>^</sup>

**193** ... DHB allied health professionals per 100,000 population\*

**40%** ... of Southern GPs intend to retire in the next 8 years

<sup>^</sup>cf. 510 in Nelson Marlborough & 392 in Canterbury  
\*cf. 197 in Nelson Marlborough & 280 in Canterbury

- 5 The rebuild of Dunedin Hospital is a major opportunity to optimise the mix of services across settings



- 6 Consumers want to receive care in new ways, supporting the use of new service, workforce, business and funding models



## We need a new approach...

### If we maintain the status quo...

- 1 Disjointed approaches across sectors result in a growing health inequity gap, particularly for Māori
- 2 Health risk factors such as obesity continue to increase and demand for treatment services grows
- 3 There remain many points of entry to the system, and health services continue to operate in 'silos', with limited connections with social services
- 4 Our GP, nursing and allied health workforce struggles to deliver timely access to services – creating further pressure on hospitals, and making primary and community care careers unattractive to the next generation of the workforce
- 5 Health services continue to be provided in traditional ways, despite technological advances which could improve access, quality and efficiency
- 6 Southern DHB struggles to live within its available funding, and DHB hospital services consume an ever-increasing share of resources, limiting investment opportunities in primary and community care
- 7 Hospital care cannot keep up with increasing acute demand, exacerbated by primary and community care capacity shortages, and the increasing number of consumers with complex needs and long-term conditions
- 8 New initiatives are not regularly monitored and adjusted, and scaled or stopped depending on performance, resulting in inefficient resource use

### If we take a new approach...

- 1 Joined up approaches across health, social and education sectors enable collective action to address factors that contribute to inequity of access and outcomes
- 2 Consumers, whānau and communities understand how to live well, and are supported by preventive care in the community
- 3 Consumers and whānau are able to easily navigate the system, which provides cohesive care across services, settings and organisations, supported by integrated systems and processes
- 4 Our primary and community workforce is engaged and aligned through new models of care, allowing health professionals to focus on higher skilled clinical work through new ways of working and support from new roles (e.g. health care assistants; clinical pharmacists)
- 5 New digital technologies support community health literacy and provide 'virtual' links between consumers and services, supporting the delivery of care in home and community settings
- 6 Investment is planned and prioritised across the system to drive an optimal mix of community and hospital-based services
- 7 Primary and community care is delivered from fit-for-purpose facilities, enabling team-based ways of working, and providing a broader range of services in out-of-hospital settings, allowing hospital care to be focused on those with the highest needs
- 8 A culture of continuous improvement is supported by the monitoring and rapid evaluation of new initiatives, informed by consistent data and use of evidence-based evaluation tools

## The Strategy

## The Strategy: Vision and strategic goals

The Southern health system is built on an overarching vision...



**Better health, better lives, Whānau Ora**

The vision for primary and community care is...



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

The strategic goals supporting this vision are...

1

Consumers, whānau and communities are empowered to drive and own their care

2

Primary and community care works in partnership to provide holistic, team-based care

3

Secondary and tertiary care is integrated into primary and community care models

4

The health system is technology-enabled

## Goal 1. Consumers, whānau and communities are empowered to drive and own their care

*Southern consumers, whānau and communities are supported to drive their own care and wellbeing, and the overall performance of Southern primary and community care*

What this will mean:

- ▶ Consumers will be involved in design and review of primary and community health services
- ▶ Consumers with more complex needs will have a lead carer coordinating services across the care team according to a shared care plan
- ▶ Consumers and whānau will:
  1. have access to culturally-appropriate services to improve their health literacy, and the self-management skills of those with a long-term condition(s)
  2. have a single point of online contact through a portal to access their health information, including shared care plans connected to their health care records; initial diagnosis, triaging and care options; and other reliable health-related information
  3. be able to participate in peer groups of consumers (e.g. via social media, community meetings, and professional-led sessions)
  4. be able to shape the improvement of primary and community care through regular feedback mechanisms, and access to provider performance results
- ▶ Consumers, whānau and communities will be supported to have greater involvement in caring for others through technology support, access to time- and skill-sharing volunteer opportunities, enhancing social participation and resilience.





## Goal 2. Primary and community care works in partnership to provide holistic, team-based care

*Primary and community care is working in partnership to provide holistic care tailored to individual needs, through team-based ways of working across home, clinic and community settings*

What this will mean:

- ▶ Primary and community care will be:
  1. able to proactively match resources with care needs through new ways of working (e.g. extended consultations; extended hours; team-based care; virtual health), and new team roles (e.g. health care assistant, health coach; clinical pharmacist; allied health professionals) based on a HCH model of care
  2. using diagnostic and virtual health technologies to provide efficient and convenient care
  3. using whole-system care pathways tailored to the Southern context
  4. organised into integrated multi-disciplinary teams wrapped around general practice, which provide 24/7 holistic and culturally-appropriate stepped care, with team membership based on skills and capabilities rather than professional demarcation
  5. delivered through integrated primary and community care hubs that foster closer alignment of DHB and NGO community services, and - where cost-effective - ambulatory secondary care services from Dunedin and Invercargill hospitals
  6. able to effectively respond to acute crises (e.g. paramedics and PRIME-trained practitioners in rural communities; access to community diagnostics; clinical observation in a centre or hub)
  7. equipped with enhanced access to clinical advice from secondary and tertiary care
  8. able to provide an increased scope of clinical interventions through defined clinical protocols
  9. delivered in ways that recognise the importance of Te Ao Māori (the Māori world view), te reo Māori, and in settings that recognise the importance of cultural safety and familiarity (e.g. marae; integrated Māori health service clinics)
  10. engaged in teaching and learning
- ▶ Primary and community care will be at the heart of Rural Hospital care provision. Within a district-wide planning framework, they will be able to provide an expanded scope of diagnostics, and step-up / -down care for their catchment populations, with a workforce developed to deliver this model of care, with capacity matched to population needs
- ▶ Primary and community care will be planned to respond effectively to the needs of Māori, Pacific, rural and remote population groups
- ▶ Community pharmacy, aged care, mental health & addictions, and palliative care community providers will be fully integrated into team-based care models
- ▶ Effective intersectoral partnerships will be effectively addressing the social determinants of health, including introducing an explicit Health in All Policies (HiAP) component to all public sector policy development processes.



## Goal 3. Secondary and tertiary care is integrated into primary and community care models

*Secondary and tertiary services join the primary and community team to provide support to enable consumers with complex needs to access timely care close to home*

What this will mean:

► Secondary and tertiary care will:

1. be active supporters of primary and community care teams, providing specialist advice, episodic care for consumers with more complex needs virtually and in clinic-based settings, and contributing to the development and implementation of care pathways
2. support regulated health care professionals to extend their scopes of practice and inter-professional working (e.g. development of nurse practitioner, GP and PN with special interest roles, and allied-nursing inter-professional skills / competencies for shared tasks)
3. have a clear understanding of the range of community options available for consumers, and prioritise community care where clinically appropriate, including step-up / -down care
4. have a single clear point of access for primary and community care providers seeking rapid advice
5. integrated teaching, learning and research
6. accommodate the distinct needs of rural communities through:
  - a) patient-determined primary and community care bookings, and coordination of specialist appointments\*
  - b) local outreach clinics (virtual or visiting)
  - c) tailoring outpatient clinics to the needs of Māori
  - d) preparedness for emergency transfer or retrieval
  - e) arrangement of travel and accommodation options.

\*patient-determined bookings will be across both primary and secondary care, with primary care bookings able to be self-initiated, while patients are prompted to make secondary bookings through a clear single point of access



## Goal 4. The health system is technology enabled

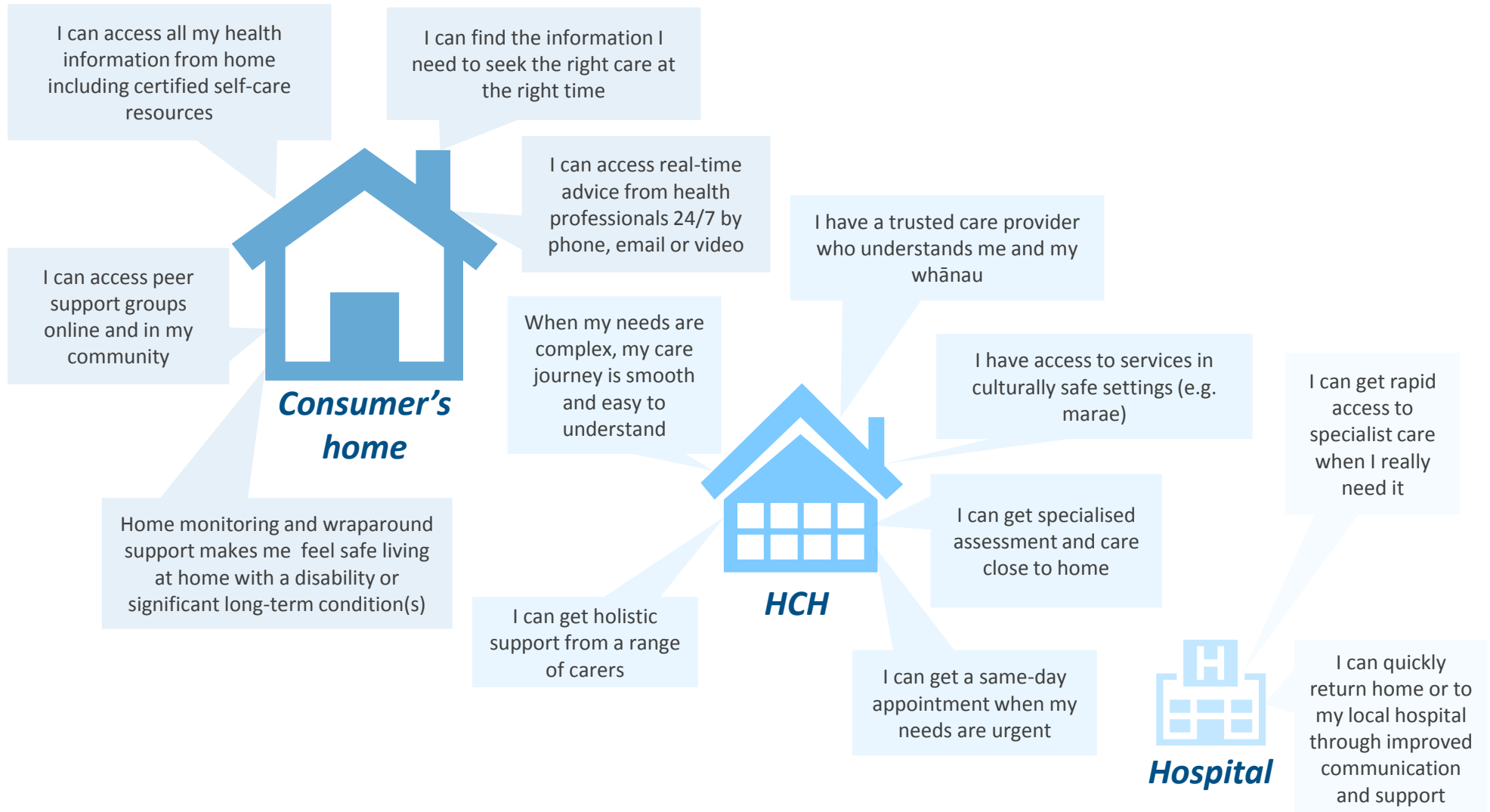
*Technology solutions are systematically deployed to support seamless care and continuous improvement of primary and community care*

What this will mean:

- ▶ Every consumer will have an electronic health record (EHR) accessible to them and members of their care team, accessible from any device, and with a consumer-nominated lead carer as custodian
- ▶ The health workforce will use digital platforms for professional development and fostering of peer support networks
- ▶ An integrated set of technology solutions will enable a single point of contact to the Southern health system, shared care planning and efficient administration. It will support e-ordering and instant communication regardless of device, reducing barriers to access and supporting the primary and community workforce to operate at the top of their scopes
- ▶ Virtual health technologies supporting the delivery of virtual consultations by the primary, community, secondary and tertiary care workforce
- ▶ Clearly specified processes for data collection, analysis, and performance improvement initiatives driven by insights, with the use of AI to augment human input
- ▶ New technologies to support home-based care and remote monitoring will be commonplace, including in-home sensors for people with relevant physical and/or cognitive needs (e.g. heart disease; dementia), with real-time data being collected and acted on by care professionals
- ▶ Consumer genomic information and health data from both home-based and wearable technologies will be incorporated into the consumer's EHR, informing discussions and decisions with their care team
- ▶ Where feasible, cost-effective emerging technologies will be in use by consumers (e.g. home-based support for older people) and by providers (e.g. community pharmacy)
- ▶ The introduction of emerging technologies will have a clear process for prioritisation, seed funding, structured adoption, and evaluation (including return on investment)
- ▶ Southern will be a fast-follower of national and other regional trends, adopting others' proven solutions where possible and innovating as required, depending on needs and technology trends.

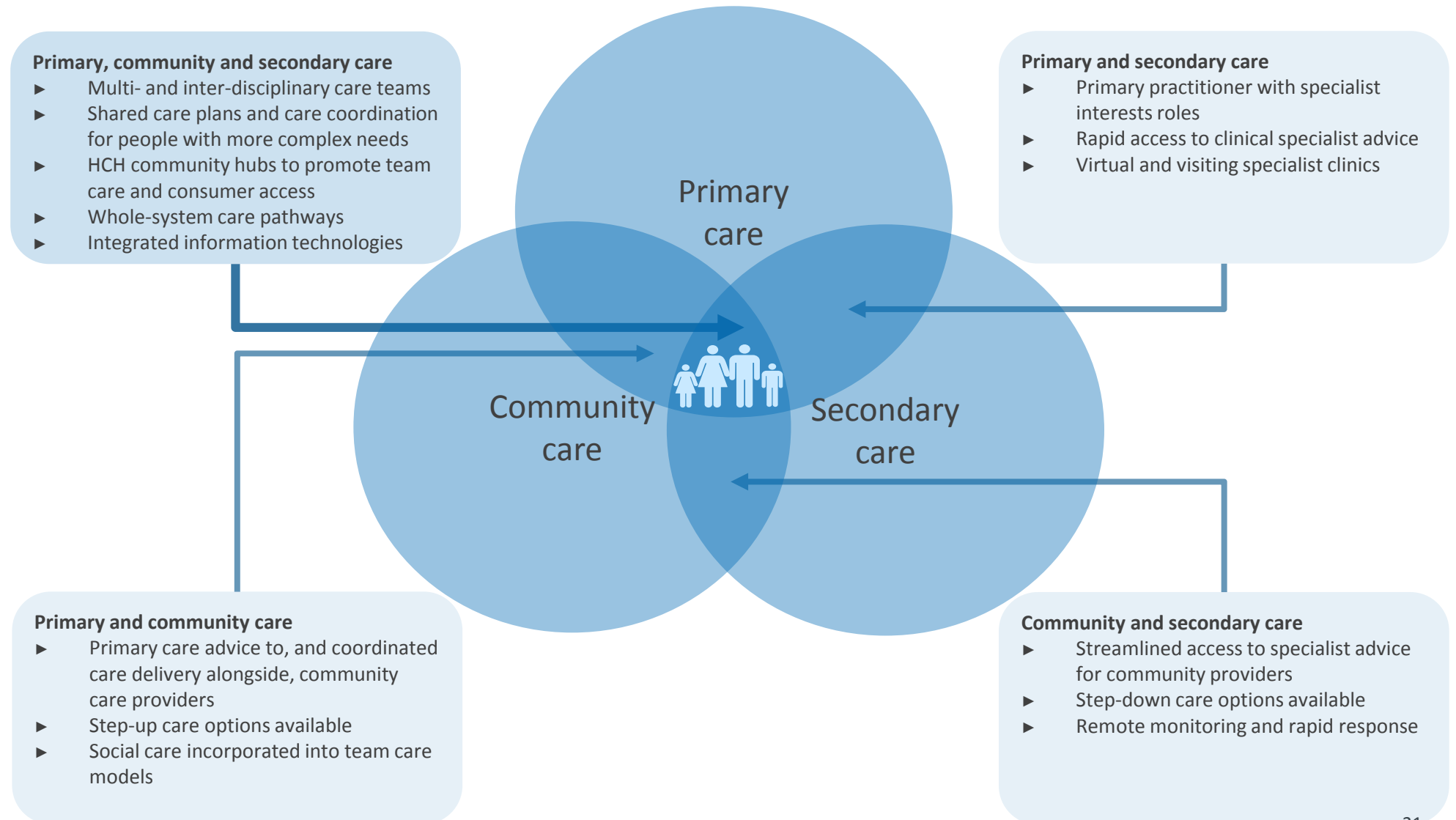


## Bringing it all together – the consumer and whānau experience



## Bringing it all together - integration of primary, community and secondary care

The delivery of better coordinated ways of working across primary, community and secondary care will improve efficiency and consumer experience. Core components are shown below.



## Transforming primary and community care for Māori

Whilst there has been improvement in Māori health outcomes over the past three decades, the fact that significant inequities remain is of great concern. Transforming primary and community care for Māori is therefore a priority in addressing these long-term issues. Within the context of this Strategy, efforts to eliminate these persistent inequities will require focusing on the social determinants of health, lifting the capability and performance of both Māori health and mainstream services, and building more effective ways of working these services. The key ways to achieve this will be a willingness to understand those measures that haven't worked well enough, and leadership in respect of approaching and implementing those that may. Data, analysis and reporting will be used to help drive a concerted focus in this regard.

Addressing the social determinants of health will include working with health and social sectors using a Health in All Policies approach, which focuses on addressing the major determinants of health inequities. Iwi will be actively engaged through this process to help design and implement effective and innovative approaches for connecting with Māori whānau and communities.

Building the capability of the Māori provider sector will include:

- ▶ Strengthening the breadth and depth of delivery of care from Māori health clinics through HCH development
- ▶ Integration of Māori health providers into locality networks supported by care pathways aligned with the stepped care model, allowing kaupapa Māori support for consumers with complex needs
- ▶ Workforce development, including increasing Māori participation and fostering greater cultural inclusivity
- ▶ Recognising the role of rongoā Māori and other traditional Māori health care practices in care models.

Lifting the responsiveness of mainstream primary and community care services will include:

- ▶ HCH model of care design to reduce barriers to equity of access by (for example) targeting high risk populations, including Māori, through stratification and stepped care
- ▶ Locality network models to include explicit key performance indicators for improving Māori health access, experience and outcomes
- ▶ Increasing workforce capability, particularly in relation to cultural competency, and understanding and using te reo Māori and te ao Māori values.

Transparent equity analysis and reporting will include:

- ▶ Health and business intelligence to quantify and benchmark Māori and non-Māori access and outcomes
- ▶ Locality health needs and service profile analysis to include assessment of current and future Māori health needs and service gaps.

With Māori consumer feedback speaking clearly to feelings of lack of understanding and respect (and consequent loss of mana), geographical isolation and distance from their traditional methods of health care, efforts to address these issues is vital. Enabling Southern Māori to regain their aspirational health focus, feel culturally safe and respected, and access primary and community health services without undue barriers through the HCH and implementation of effective technology will begin (at least) to address the inequities in meaningful ways.

## Transforming primary and community care in rural communities

Rural models of care will be progressively based on a district-wide planning framework, with tailoring for the unique needs of different communities. The planning framework will include the transformation of primary and community care into HCH models of care, including, as appropriate, development of HCH community hubs that co-locate a broader range of services. There will also be planned development of primary and community care practitioners with special interests that deliver care from and across HCHs. Rural hospitals will increasingly operate in an integrated way with primary and community health services, with medical staffing by rural hospital medicine specialists who are part of the unified medical team serving the catchment population. This will include ensuring appropriate medical support for health centres operating in more remote towns.

Within each locality, delivery of a minimum set of services will be required, with funding and contracting arrangements to support broadening scopes of practice, increased access to cost-effective clinical technologies, and locally tailored service interventions. There will be an explicit focus on reducing rural and remote inequities related to cost, transport, and other access barriers. In some cases, more specialised services will operate across multiple communities or HCHs in order to be cost-effective - while still delivering care close to home for consumers.

Care models will be based on a stepped care approach, supported by care pathways, shared care planning and delivery, EHRs, and other key enablers. This will not only support the integration of the rural hospital with other primary care services, but also the extension of primary and community care through stronger strategic and operational connections with local providers, and local support services (e.g. health of older people) and social care services (e.g. housing, MSD, education).

As part of the primary and community service for the catchment population, the rural hospital will offer acute care integrated with local primary care services, extended diagnostics, and have the clinical capability to deliver care at an appropriate level of acuity.

The rural hospital's clinical capability will increase with the distance from a base hospital, and the size and structure of its population.

Other considerations in defining the range of services to be offered by rural hospitals include:

- ▶ Moderately specialised procedures could be delivered locally, such as chemotherapy infusions under the supervision of the Southern regional blood and cancer service, minor operations for skin lesions, and injections for wet macular degeneration (in some instances, HCHs may provide some of these services)
- ▶ Expanded diagnostics would save time, enhance local care, and provide visiting or remote specialists with additional clinical information. Electrocardiograms for tests of heart conditions and spirometry for respiratory function could be available. Some level of imaging, such as X-ray, CT scanning (where the workforce permits), and less complex ultrasound is desirable. Over time, the ability to perform a wider range of 'scopes' is likely
- ▶ Close local management of acute presentations, aligned with an integrated ED network across the district, would reduce the need for transfer and transport, and ensure patients who do need care from a base hospital are sent to the correct destination. Rural hospitals could offer primary care acute management backed up with support from Invercargill and Dunedin hospital EDs, close on-site integration with St John paramedic capacity, and short-stay observation/assessment beds
- ▶ Depending on local circumstances, the acute capability of the rural hospital could be complemented by: 'step-down' subacute capacity, including rehabilitation following an acute medical or surgical intervention at Invercargill and Dunedin hospitals; aged residential care; and primary birthing. Such co-location of services could provide the scale needed to meet clinical and financial requirements
- ▶ An enhanced 'hospital in the home' community nursing service could provide acute, sub-acute and post-acute care to adults and children to avoid the need for inpatient care in a rural (or base) hospital
- ▶ Locality planning will also work within district-wide parameters to determine the availability of specialist clinics (visiting and virtual) to match population needs.

## Strategic aspirations and success factors

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### We will be able to say...

Our population has equitable access to primary and community care, and specialist support when needed

Primary and community care responds effectively to the needs of Māori

Primary and community care responds effectively to the needs of other vulnerable population groups (e.g. Pacific, rural, remote, and disabled)

Our consumers, whānau and communities know how to live well, and are actively participating in caring for themselves and others

Our health workforce is working as 'one team', within an integrated system of care, centred on the HCH, and with delivery through team-based care (including health and broader social service representation)

We have better matched our workforce capacity, capability and mix to population physical, mental, and social needs

Virtual health care approaches have become pervasive across our system, supporting consumers to gain faster and more convenient access to health information, advice and care

We have become a nimble and sustainable system, able to make effective investment decisions that ensure ongoing improvement in population health outcomes and cost-effective use of resources

We are actively involved in training our future workforce, and research is actively supported to improve health and outcomes

### We will know we've been successful when...

We have significantly reduced inequities of access for rural and remote communities, Māori and other vulnerable populations

Our primary and community care workforce is culturally competent, and is addressing the needs of Māori in partnership with (rather than dependent on) Māori and other specialised care providers

Our primary and community care workforce is culturally competent, and is addressing the needs of Pacific, rural, remote and disabled population groups in partnership with specialised care providers

As a result of consumer aspirations, more of our population is supported to effectively self-manage their health and wellbeing

We have implemented proactive risk stratification and stepped care models based on health and social needs, including care coordination for people with complex conditions

We have a planned approach to workforce development that is based on the desired models of care, new workforce roles and system priorities, and is strongly linked with education and training providers and professional bodies

Consumers and whānau say it is quicker and easier to get the health care and advice they need in community settings

Our investment in primary and community care has significantly reduced the rate of acute demand for hospital services, and has enabled a greater number of older people to live safely at home

We are recognised for the responsive development of a workforce matched to population needs, and a commitment to continuous learning



## Executing the Strategy: The Action Plan

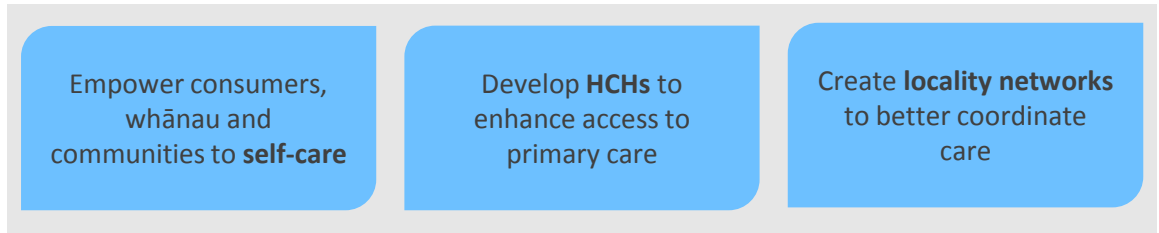
The Strategy describes our vision and strategic goals for transforming primary and community care services, within the context of the overall Southern health system. An Action Plan to deliver on the vision and goals has been developed. In developing the Action Plan, we have considered:

- ▶ How the system is best configured
- ▶ The importance of consumers, clinicians and providers understanding the rationale for change, and supporting its direction
- ▶ How to build a critical mass of inter-linked actions
- ▶ 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.

Three action areas have been identified 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 for the initial phases of executing the Strategy has been developed to guide early progress on achieving the vision for primary and community care in Southern (see the Primary & Community Care Action Plan).

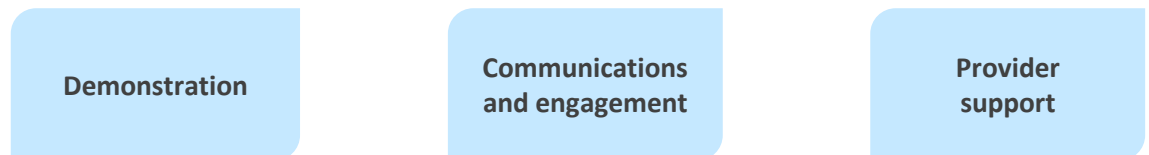
### Care models



### Enabling infrastructure



### Support for adoption



## Executing the Strategy: Our commitment

### Take a principled approach

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

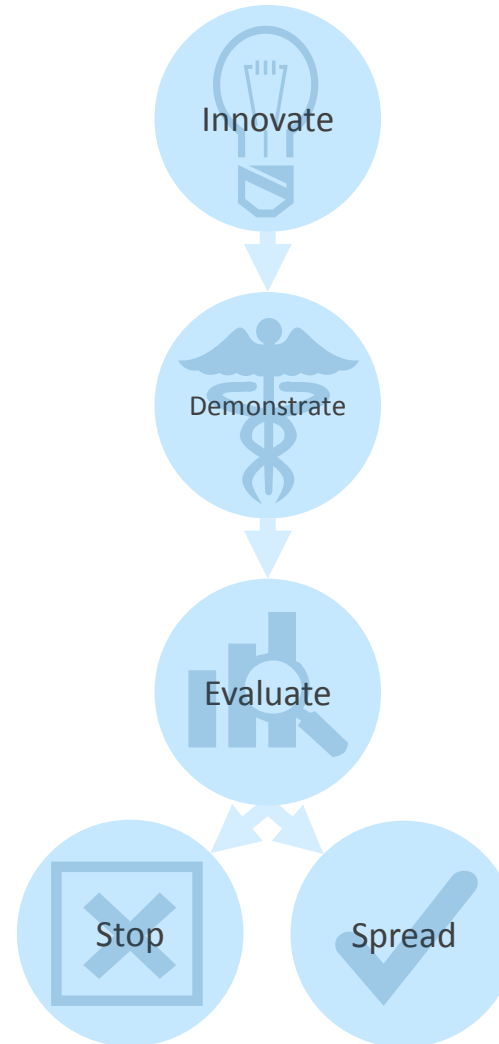
Move from traditional ways of working to be fit-for-the-future

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



## Appendix - Planning framework

## How the Strategy was developed

A wide range of information informed the development of the Strategy and its supporting Action Plan. This information is included in the Planning Framework that accompanies the Strategy and Action Plan.

A review of key national, regional and local strategies and plans was undertaken, with relevant themes from these documents being used to help identify focus areas for Strategy development. In particular, the New Zealand Health Strategy and its five pillars ('people-powered', 'close to home', 'value and performance', 'one team' and 'smart system') and the He Korowai Oranga framework (overall aim of 'Pae Ora', supported by 'Wai Ora', 'Whānau Ora', and 'Mauri Ora') informed the priorities of the Strategy, alongside service planning work undertaken to inform the Dunedin Hospital Indicative Business Case.

A scan of local and international literature was undertaken to identify innovative models of care and evidence for what works in improving access, quality and outcomes, including learnings for how to transform models of care and system design. Case studies of innovative care models from New Zealand, Australia, the United Kingdom and the United States were also developed to provide a practical sense of what changes other local health systems and providers are undertaking.

An analytical profile of the Southern district was also developed, updating relevant parts of the 2013 Southern Health Needs and Service Profile. The analytical profile examined demographic trends, population health risk factors, and service use across a range of primary, community and hospital services. The profile informed the Strategy and Action Plan through sizing current and future opportunities for improving system performance, and matching care with population needs across the Southern district. A snapshot of key findings from the profile is provided on page 34.

A key part of developing the Strategy was gaining the perspectives of stakeholders on what is most important for further developing primary and community care in Southern. Stakeholder engagement activities included:

- ▶ Four consumer focus groups, with 32 participants
- ▶ Four in-depth interviews with consumers with existing health and/or disability conditions
- ▶ Two wānanga with approximately 50 Māori consumers
- ▶ A direction-setting workshop with Southern DHB Commissioners, WellSouth PHN Board, Southern DHB executive team and the project's Steering Group
- ▶ Eight workshops with sector representatives
- ▶ Online forum for sector representatives, and follow-up in-depth interviews
- ▶ A roadshow of the initial strategic thinking in Dunedin, Invercargill and Central Otago, with more than 300 stakeholders providing feedback.

## Key inputs...



**Key national, regional and local strategies and plans**



**Scan of innovative models of care and evidence of what works**



**Analytical profile of the Southern district**



**Stakeholder engagement including consumers**

## National strategies and plans

The **New Zealand Health Strategy (NZHS)** and **He Korowai Oranga** were used in combination as a key conceptual framework for translating national and regional aspirations into local priorities for primary and community care in Southern.

The NZHS reflects the government's commitment to addressing the health system sustainability challenge, and ultimately shifting towards a better integrated model of care centred on consumers and their whānau. It's vision is that all New Zealanders live well, stay well, and get well in a system that is **people-powered**, provides services **closer to home**, is designed for **value and high performance**, and works as **one team** in a **smart system**.

He Korowai Oranga is New Zealand's Māori Health Strategy, setting the overarching framework that guides the Government and the health and disability sector to achieve the best health outcomes for Māori. It's overall aim is **Pae Ora**, 'healthy futures for Māori', recognising the multifaceted needs of Māori through a holistic approach and three interconnected elements: **mauri ora** (healthy individuals), **whānau ora** (healthy families), and **wai ora** (healthy environments). The approach reinforces the need to ensure that Māori are involved in both decision-making and service delivery. Pae Ora guided thinking on how the Strategy needs to address the needs of Māori in Southern.

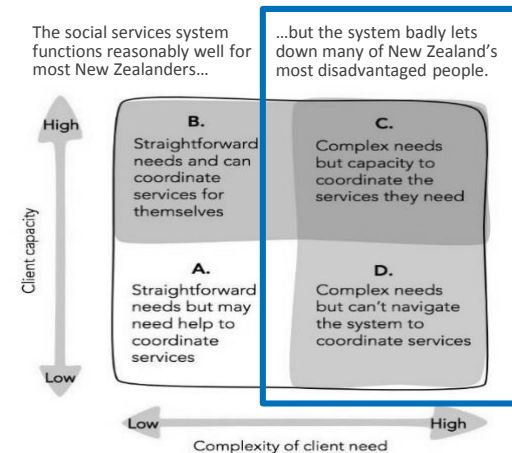
The NZHS and He Korowai Oranga provide the framework for a range of more specific national strategies and plans such as the Healthy Ageing Strategy, Pharmacy Action Plan, and the Mental Health & Addictions Service Development Plan. These strategies and plans were also considered during Strategy development.



The government's **social investment policy** acknowledges that traditional approaches are not meeting the needs of the most vulnerable – particularly children and youth. In response, government has challenged agencies to:

- Prioritise efforts for improving the lives of the most vulnerable
- Take a data- and evidence-led approach to commissioning and contracting for outcomes
- Join up planning and action across agencies and sectors including integrated funding and contracting models
- Design new models of care that overcome barriers to access for people with the most complex needs
- Involve individuals, whānau and communities in priority setting and service design.

This thinking has been incorporated into the Strategy through recognising that some members of our communities will require more time, effort and resources than others, to lift their health and social outcomes.



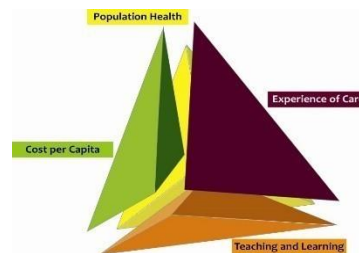
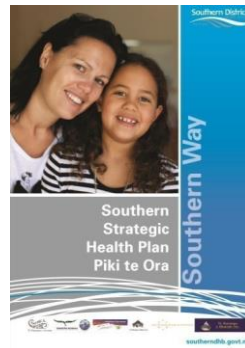
## Local strategies and plans

Within the context of the Southern Way, the **Southern Strategic Health Plan** describes how health services in Southern should evolve between 2015 and 2025. It describes a system in which family doctors, community health and disability providers, and hospital care work together around community health and disability needs. The Plan has six priority areas, with the most relevant ones for the Strategy being:

1. Developing a coherent Southern system of care
2. Building the system on a foundation of population health, and primary and community care.

The Southern health system has adopted a **Quadruple Aim framework** to guide planning and decision-making. The four dimensions of the framework are: population health; experience of care; cost per capita; and teaching and learning. The purpose of the framework is to ensure that each of these dimensions is considered simultaneously when deciding priorities and actions. The framework has been used to help shape the Strategy and Action Plan.

**Alliance South** is a partnership between Southern DHB and WellSouth PHN to drive collaboration and progress on key initiatives across the Southern health system. The Alliance has driven collaboration and progress through a number of networks focused on particular parts of the Southern health system. Across these networks, its priority areas of focus have been: care planning and management of complex consumers, enablers, a locality approach, communication, and care closer to home. Alliance achievements and learnings have been factored into the development of the Strategy and Action Plan.



A number of strategy and planning documents have been developed to inform the **rebuild of Dunedin Hospital** business case process. These include:

- ▶ A Strategic Services Plan
- ▶ Detailed Service Plans (A&B) for Dunedin Hospital services
- ▶ An Indicative Business Case for the Hospital rebuild
- ▶ A number of clinically-led position papers regarding possible future models of care.

These documents point to the significant opportunity the rebuild presents to radically redesign care models both within the Dunedin Hospital setting and in primary and community care. From a strategic perspective, the Strategic Services Plan made the following recommendations related to primary and community care:

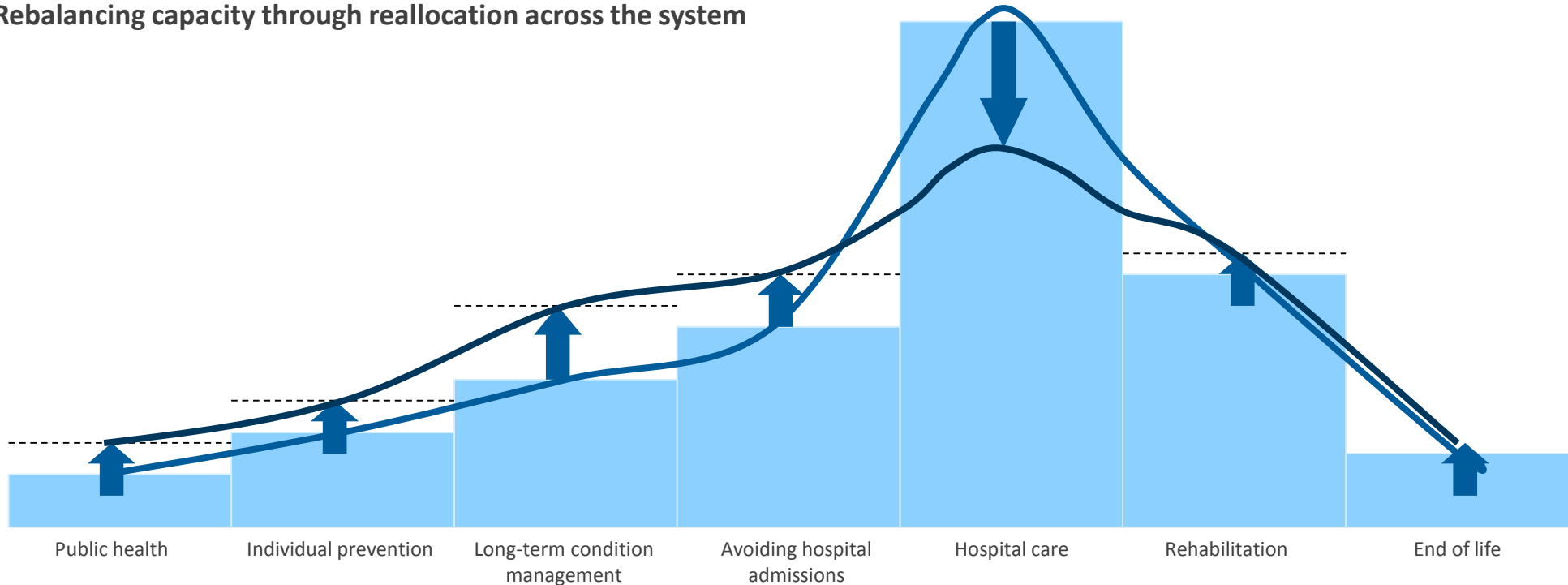
- a) Actively support aggregation of general practices into larger groupings and invest in enhanced models of primary care
- b) Proactively deliver well-organised and connected primary care through the development of leadership positions and networks
- c) Consider comprehensive wraparound services for highly complex consumers, including partnerships with community or hospital-based pharmacy
- d) Consider a clinically-led review of how Health Pathways are determined, marketed and utilised, and establish near-term priorities for further expansion of pathways.

The Strategy and Action Plan have incorporated the thinking emerging from the business case process, while also considering district-wide issues and opportunities, and the particular nuances of Southern's diverse communities.

## Trends in system design

Health systems are focusing on better integrating care across professions, services and settings, with a strong focus on moving investment 'upstream' to prevention and strengthened primary and community care delivery. There is also a strong emphasis on active rehabilitation that reduces risk of recurrent acute presentations, and end-of-life care that provides people with appropriate supports to enable a dignified death. Achieving these outcomes requires prioritising future investments towards prevention and community-based models of care.

### Rebalancing capacity through reallocation across the system



*“The cost of providing health services through the current model is unsustainable in the long term. The Treasury estimates that, if nothing were to change in the way we fund and deliver services, government health spending would rise from about 7 percent of GDP now, to about 11 percent of GDP in 2060. It is essential that we find new and sustainable ways to deliver services, investing resources in a way that will provide the best outcomes possible for peoples’ health and wider wellbeing.”*

**The New Zealand Health Strategy: Future Direction (Ministry of Health, 2016)**

## Trends in models of care

Innovative care models are emerging in New Zealand and internationally. These were scanned to see what other systems have been doing or are trialing, and their lessons and learnings. Some key themes emerged from the scan, irrespective of jurisdiction or system. These themes include:

- ▶ Actively involving consumers and whānau in determining care needs and approaches
- ▶ Taking a population health focus that prioritises wellness, prevention, health literacy and self-management
- ▶ Focusing on individuals and populations rather than specific conditions such as diabetes, heart failure or depression
- ▶ Reinforcing the pivotal role of primary health care in the health system through approaches such as the HCH
- ▶ Proactively targeting resources to individual and population needs through risk stratification – led from primary health care
- ▶ Building the primary and community care workforce through new workforce roles (e.g., clinical pharmacy; health coaches; kaiāwhina) and enabling practitioners to work at the top of their scopes of practice
- ▶ Using team-based approaches for people with more complex needs, which integrate skills and capabilities from across the health and social sectors
- ▶ Maximising the use of technology to support consumers and the wider health and social care team
- ▶ Developing fit-for-purpose facilities that enable integrated ways of working

- ▶ Simplifying the system for both consumers and carers through mechanisms such as consumer portals, single points of access, and care pathways
- ▶ Re-engineering clinical and business processes to streamline consumer flow, releasing time to care
- ▶ Organising services around defined populations, including on a locality basis.

Many of these innovative models are new. However, there are early signs of success, such as:

- ▶ Improved consumer satisfaction with access and experience of care
- ▶ Improved workforce satisfaction resulting in better recruitment and retention
- ▶ Increased capacity within primary and community care as evidenced by more consumer interactions within similar resources
- ▶ Some evidence of reductions in:
  - ▶ Urgent care
  - ▶ Polypharmacy
  - ▶ Acute hospitalisations
  - ▶ Hospital bed-days
  - ▶ Entry into aged-related residential care.

These leading practice design features of contemporary models of care have been incorporated in the Strategy and Action Plan.



## New and emerging technologies

New and emerging technologies are rapidly transforming how people engage with each other and the services they use. In health care, this means how people access health information (including their own records), how they engage with services, and the health checks (like simple diagnostics) they can do for themselves. Together these trends, and the further promise of new technologies, have the potential to radically change consumer experience of care. The promise of these technologies is a health system that can more efficiently and effectively deliver consumer-centred care, making the best use of workforce and infrastructure. Some of the changes that new technology promises are as follows:

- ▶ People are more actively involved in managing their lifelong health and wellness. They can drive their health experience through use of tools like wearable technologies, online access to their health and wellness information, and games that support memory function, pain relief, and self-management of long-term conditions
- ▶ Social networking mechanisms that support peer-to-peer shared experiences, information and motivational encouragement
- ▶ Encouraging a strengthened relationship between consumers and the health workforce that enables consumers to be co-producers of their wellness, with physicians as expert advisors
- ▶ At a service delivery level, technologies such as clinical and decision-making algorithms, artificial intelligence (AI) diagnostics, and online pathways and service directories to systematise care delivery systems and processes efficiently and effectively
- ▶ People with long-term conditions being able to monitor clinical measures (e.g., temperature, blood pressure) and relay these in real-time through smart devices to their care team, with their care team being able to respond when there are clinically meaningful changes in a person's health status. This frees up both consumer and provider time
- ▶ The 'internet of things' enabling safe and effective home monitoring of people who historically would have needed short-term care in a hospital setting or long-term care in a residential setting

- ▶ New robotic technologies are making possible a vast range of new ways to provide care and deliver system efficiency improvements. This includes robots that provide companionship for people living alone, robots that support care delivery (e.g. helping people have safe transitions out of bed in aged care), and drones that can deliver medicines to consumers
- ▶ AI and machine learning offer the promise of analysing vast amounts of data quickly, improving health and business intelligence.

### Consumer interest in using new technologies\*

Interested	Interest in service	Not interested
87%	Make an appointment online to see a doctor or organise a hospital service/appointment	13%
83%	Complete doctor or hospital registration details online before your visit	17%
74%	Use an at-home diagnostic test kit (e.g. for strep throat, cholesterol levels) and send the information to your doctor	26%
70%	Communicate electronically with a doctor or other health professional (e.g. email, text, social media site)	30%
70%	Order prescription drug refills using mobile apps on your phone	30%
66%	Use a device that connects to your smartphone (e.g. temperature, blood pressure or heart rate) and send the information to your doctor	34%
61%	Consult a doctor by video on your computer rather than in-person in a clinic	39%
60%	Send a photo of your injury/health problem to a doctor using your computer or mobile device	40%

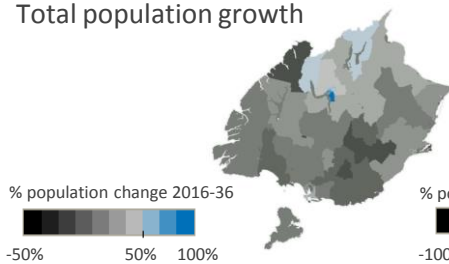


## Southern analytics profile: key findings

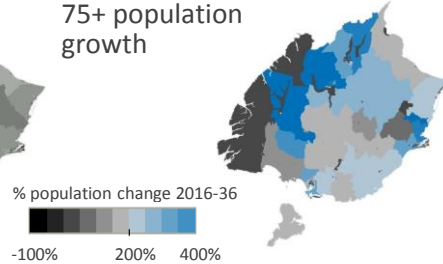
A Southern analytics profile was developed to inform priority setting for the Strategy. This considered a range of measures across primary and community care in the Southern district, and also broader system measures related to use of hospital services. It shows that we perform well on many measures; however, there remains ample room for improvement, particularly in the context of rising demand for services and emerging capacity issues. Key findings are summarised below.

### 1 Demographic change will be uneven across the district

Total population growth



75+ population growth



### 4 Urgent care demand is increasing

# 33%

...increase in non-admitted ED attendances at Dunedin, Southland and Lakes Hospitals from 2014 - 2016

In 2016/17 there are approximately ...

# 56

... more non-admitted ED attendances per day than in 2013/14

### 2 Variation in access and outcomes is evident

# 29%

... of Southern consumers experienced an unmet primary care need in the past 12 months

# 3-fold

... variation in medical / surgical discharges by enrolled general practice populations

### 5 Workforce capacity issues exist, and will intensify in the context of rising demand

# 40%

... of Southern GPs intended to retire in the next 10 years in 2015

Highest rate of...  
**Rural GP vacancies**  
... per capita

# 73%

... increase in GP consults for 65+ population with current care models by 2036

### 3 Utilisation rates are higher than peer districts on some key measures

11+ medications aged 85+ years - 2014



\*Darker shading = higher rate of use

# 2nd

... highest low urgency ED attendance rate of peer DHBs

# 2nd

... highest aged residential care use of peer DHBs

### 6 Many small-scale primary and community providers exist, presenting an opportunity for consolidation to broaden the scale and scope of services

Type

- + Practice
- X Pharmacy
- Hospital
- ARC



## Stakeholder perspectives

A wide range of stakeholders were engaged during the development of the Strategy, including consumers, health professionals, non-governmental organisations (NGOs), and DHB and PHN staff. Stakeholders shared their perspectives on their experience of primary and community services, and opportunities for the future. A number of key themes emerged from conversations with Southern stakeholders:

- ▶ Consumers continue to experience barriers to accessing services, particularly those who live in more rural settings
- ▶ Consumers report inconsistent experiences of care from similar providers
- ▶ Māori consumers continue to experience prejudice and disrespect, and would value greater access to rongoā Māori / traditional Māori medicine and practitioners
- ▶ One size does not fit all for Māori consumers, and many feel that the current model of care does not cater to their needs
- ▶ Consumers desire greater empowerment in their care, and the information and support needed to realise this
- ▶ There is a general view that health services have been slow to adapt to changing health needs and consumer preferences
- ▶ All stakeholders are united in their desire for greater sharing of clinical information through means such as an electronic health record
- ▶ There is a general desire to develop a more collaborative and integrated system, founded on a shared purpose and set of values
- ▶ While good progress has been made on particular service areas, there remains a pressing need to describe the overarching organisation of care delivery in primary and community settings, and their relationship with hospital services
- ▶ There are significant opportunities to improve how primary and community care providers and practitioners work in terms of clinical and business models
- ▶ People are excited by the promise of new technologies, and their ability to improve access to information and care.

### Direction setting workshop



#### Using technology to enhance current interactions...

*“Having to drive to Invercargill for two hours for appointments that can sometimes only be 10 minutes long can put you at risk. I’d much prefer this.”*  
(Queenstown consumer)

#### Co-located services...

*“I like this but some services can cost more at the GP – I went to hospital for eye tests and it was way cheaper, so as long as the price doesn’t go up...”*  
(Dunedin consumer)

### Wananga



## Steering Group, Working Group and University of Otago

This project was overseen by a Steering Group with broad representation from across the Southern district. A Working Group co-developed the detailed activity tables to support implementation of the first three years of the Action Plan. To assist with demonstrating change, the University of Otago developed five case studies to support Strategy and Action Plan development.

### Steering Group

The Steering Group guided development of the Strategy and Action Plan, reviewing and providing feedback on key documentation, meeting five times at key points across the project. Membership was as follows:

- ▶ Chris Fleming (SDHB, CEO)
- ▶ Lisa Gestro (SDHB, Executive Director Strategy, Primary and Community)
- ▶ Ian Macara (WSPHN, CEO)
- ▶ Wendy Findlay (WSPHN, DON)
- ▶ Professor Barry Taylor (University of Otago, Dean Medical School)
- ▶ Bronnie Grant (Consumer representative)
- ▶ Sue Crengle (Provider and iwi representative)
- ▶ Karl Metzler (Rural Hospital representative)
- ▶ Dr. Murray Tilyard (GP)
- ▶ Dr. Nigel Millar (SDHB, CMO)

### Working Group

A Working Group was established to support Action Plan development, with representation from across primary, community and secondary care. In particular, this group supported development of the detailed activity tables.

### University of Otago

Representatives from the University of Otago developed five case studies as part of the Planning Framework, used to support Strategy and Action Plan development.

\*Liz Disney (SDHB ED P&F (Acting)) was a Steering Group member until leaving in October 2017

Draft

**Southern District**  
Health Board



Piki Te Ora



**WellSouth**

**Primary Health Network**

*Hauora Matua Ki Te Tonga*